

29th July 2026

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Further to your recent request for information made under the Freedom of Information Act (FOIA) 2000, I now set out our answers to your specific questions, and any clarifications sought and provided, as follows:

- 1. Your definition of an active case of influenza.**
- 2. The methods used to confirm an influenza case and distinguish it from other acute respiratory infections.**

Please see the attached - 'Respiratory virus infection policy-Redacted' for the information requested above.

Please note that we have redacted the names of the Trust's IT Systems from the policy and are applying Section 31(1)(a) accordingly, please see below:

Under Section 31(1)(a) of the Freedom of Information Act (FOIA), the Trust can confirm that it holds information relevant to your request, however, we are unable to disclose it for the reasons explained below.

Historically, we would disclose information relevant to the Trust's IT systems, infrastructure and software as part of our transparency agenda under the terms of the Freedom of Information Act (FOIA). However, in light of the recent cyber-attacks on NHS hospitals and the serious impact these have had on patient services and the loss of patient data, we are having to reconsider this approach. Please see several links to news articles about these recent cyber incidents provided below for your information.

- [NHS England — London » Synnovis Ransomware Cyber-Attack](#)
- [NHS England confirm patient data stolen in cyber attack - BBC News](#)
- [Merseyside: Three more hospitals hit by cyber attack - BBC News](#)

As a result of these attacks, thousands of hospital and GP appointments were disrupted, operations were cancelled, and confidential patient data was stolen which included patient names, dates of birth, NHS numbers and descriptions of blood tests.

When we respond to a Freedom of Information request, we are unable to establish the intent behind the request. Disclosure under the FOIA involves the release of information to the world at large, free from any duty of confidence. Providing information about our systems or security

measures to one person is the same as publishing it for everyone. While most people are honest and have no intention of misusing information to cause damage, there are criminals who look for opportunities to exploit system weaknesses for financial gain or to cause disruption.

In the context of the FOIA, the term “public interest” does not refer to the private or commercial interests of a requestor; its meaning is for the “public good”. The Trust receives a significant number of requests each year regarding our IT systems, infrastructure and cyber security measures. Most of these requests are commercially driven and serve no direct public interest. Information relevant to our IT portfolio is often requested by consultancy companies who then pass on this information to their client base. Many of these requests are submitted through the FOI portal whatdotheyknow.com who publish our responses, making this information available to an even wider audience.

As a large NHS Trust we hold extensive personal data relevant to our patients and staff, much of which is considered very sensitive. A lot of this information is held electronically on various administration and clinical systems. We have a duty under the Data Protection Act 2018 and the UK GDPR to protect this personal information and take all necessary steps to ensure this data is kept safe. This means not disclosing information that could allow criminals to gain unlawful access to our systems and infrastructure. The Trust can be heavily fined should it be found to have acted in a negligent way which results in a personal data breach. We need to demonstrate that we comply with our legal obligations under data protection and freedom of information legislation, but we must be careful that too much transparency does not result in harm to our patients or staff, or cause disruption to our services.

Moreover, under the Network and Information Systems (NIS) Regulations Act 2018, operators of essential services such as NHS organisations like ours have a legal obligation to protect the security of our networks and information systems in order to safeguard our essential services. By releasing information that could increase the likelihood or severity of a cyber-attack, the Trust would fail to meet its security duties as stated in Section 10 of the Network and Information Systems Regulations 2018. Should we not comply with these requirements regulatory action can be taken against the Trust. Further information about the Network and Information Systems (NIS) Regulations Act 2018 can be found here – [The Network and Information Systems Regulations 2018: guide for the health sector in England - GOV.UK](https://www.gov.uk/guidance/the-network-and-information-systems-regulations-2018-guide-for-the-health-sector-in-england)

Your request asks for policy documents which unfortunately mention specific details regarding our IT Systems which, for the reasons explained above, would be inappropriate to release into the public domain. If disclosed, it is possible that patient data as well as other confidential information would be put at risk. Such disclosure could also impact on the security of our systems and result in serious disruption to the health services we deliver to the local community. Section 31(1)(a) of FOIA provides that information is exempt if its disclosure would, or would be likely to, prejudice (a) the prevention or detection of crime. In this case, disclosure would be likely to prejudice the prevention of crime by enabling or encouraging malicious acts which could compromise the Trust’s IT systems and infrastructure. The Trust’s capacity to defend itself from such acts relates to the purposes of crime prevention and therefore Section 31(a) exemption is applicable in these circumstances. For these reasons, the Trust considers disclosure of the information you are seeking to be exempt under Section 31(1)(a) [law enforcement] of the FOIA and the names of the IT systems within the policy is being withheld. The full wording of Section 31 can be found here: [Freedom of Information Act 2000](https://www.legislation.gov.uk/ukpga/2000/54/section-31)

Section 31 is a qualified exemption and therefore we must consider the prejudice or harm that may be caused by disclosure of the information you have requested, as well as apply a public interest test that weighs up the factors in maintaining the exemption against those in favour of disclosure.

In considering the prejudice or harm that disclosure may cause, as explained should the Trust release information into the public domain which draws attention to any weaknesses relevant to the security of our systems or those of a supplier, this information could be exploited by individuals with criminal intent. Increasing the likelihood of criminal activity in this way would be irresponsible and could encourage malicious acts which could compromise our IT systems or infrastructure, result in the loss of personal data and/or impact on the delivery of our patient services. We consider these concerns particularly relevant and valid considering the increasing number of cyber incidents affecting NHS systems in recent years and the view by government, the ICO and NHS leaders that the threat of cyber incidents to the public sector is real and increasing.

- [Organisations must do more to combat the growing threat of cyber attacks | ICO](#)

In the Government's Cyber Security Strategy 2022-2030, the Chancellor of the Duchy of Lancaster and Minister for the Cabinet Office states on page 7:

"Government organisations - and the functions and services they deliver - are the cornerstone of our society. It is their significance, however, that makes them an attractive target for an ever-expanding army of adversaries, often with the kind of powerful cyber capabilities which, not so long ago, would have been the sole preserve of nation states. Whether in the pursuit of government data for strategic advantage or in seeking the disruption of public services for financial or political gain, the threat faced by government is very real and present.

Government organisations are routinely and relentlessly targeted: of the 777 incidents managed by the National Cyber Security Centre between September 2020 and August 2021, around 40% were aimed at the public sector. This upward trend shows no signs of abating."

With this in mind, we then considered the public interest test for and against disclosure. It should be noted that the public interest in this context refers to the public good, not what is 'of interest' to the public or the private or commercial interests of the requester. In this case we consider the public interest factors in favour of disclosure are:

- Evidences the Trust's transparency and accountability
- Provides information relevant to the IT systems and applications the Trust uses
- Reassures the public and partners that the Trust procures these systems in line with Procurement legislation
- Reassures the public and partners that the Trust's IT infrastructure and systems are secure

Factors in favour of withholding this information are:

- Public interest in crime prevention
- Public interest in avoiding disruption to our health services

- Public interest in maintaining the integrity and security of the Trust's systems
- Public interest in the Trust avoiding the costs associated with any malicious acts (e.g. recovery, revenue, regulatory fines)
- Public interest in complying with our legal obligations to safeguard the sensitive confidential information we hold

In considering all of these factors, we have concluded that the balance of public interest lies in upholding the exemption and not releasing the information requested. Although disclosure would provide transparency about our software systems and IT infrastructure, this is outweighed by the harm that could be caused by people who wish to use this information to assess any vulnerabilities in our security measures and consequently use this information for unlawful purposes. Cybercrime can not only lead to major service disruption but can also result in significant financial losses. As a publicly funded organisation, we have a duty for ensuring our public funding is protected and spent responsibly. Moreover, as a public body the Trust must demonstrate that it keeps its confidential data and IT infrastructure safe and complies with relevant legislation, but at the same time we must be vigilant that transparency does not provide an opportunity for individuals to act against the Trust. In considering the impact that recent cyber-attacks have had on NHS services, including the cancellation of thousands of patient appointments and procedures as well as the loss of confidential patient data, we consider the overriding public interest lies in withholding this information. The private or commercial interests of a requester should not outweigh the public interest in protecting the integrity of our systems and continuity of our essential patient services. Although we appreciate there may be legitimate intentions behind requesting this information, we must take a cautious approach to requests of this nature and appreciate your understanding in this matter.

I trust this information is helpful in its detail or explanation however, if you are dissatisfied with the response, then you have the right to request an internal review. If you wish to seek an internal review, please write to the Freedom of Information Team at esh-tr.foi@nhs.net quoting the above FOI reference number, within 40 working days. Please note the Trust is not obliged to accept a request for an internal review after this time period.

Yours faithfully

Freedom of Information (FOI) Team
East Sussex Healthcare NHS Trust
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Core Hours of Business: Monday to Friday 9.00am to 4.00pm

Management of Patients with Respiratory Viral Infection

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Did you print this yourself?

Please be advised the Trust discourages retention of hard copies of the procedural document and can only guarantee that the procedural document on the Trust website is the most up to date version.

Version Control Table

Version number and issue number	Date	Author	Reason for Change	Description of Changes Made
V1.0	October 2023	Helen Tingley, Senior Infection, Prevention and Control Nurse	New Policy	New Policy

Consultation Table

This document has been developed in consultation with the groups and/or individuals in this table:

Name of Individual or group	Title	Date
Consultant Microbiologists	Consultants	September 2023
Clinical Advisory Group	All members	October 2023
Trust Infection Prevention and Control Group	All Members	September 2023
Respiratory Clinicians	Dr R. Reddy, Dr. O. Kankam, Dr T. Christopherson, Dr. J. Wilkinson, Dr S. Merritt	September 2023 & October 2023.

This information may be made available in alternative languages and formats, such as large print, upon request. Please contact the document author to discuss.

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1. Introduction

Respiratory viral infections are common and can be easily spread between people such as colds in both adults and children. Most are frequently mild, self-limiting, and confined to the upper respiratory tract. However, these can cause more severe infections and even death. Symptoms for respiratory viral infections, such as Influenza, COVID-19 and Respiratory Syncytial Virus (RSV), can be very similar so it is important that staff are aware of the symptoms and the infection control precautions to take to ensure they reduce the risk of spreading the infection to other people. Common viral respiratory tract infections include rhinoviruses, coronavirus, influenza, parainfluenza and Respiratory Syncytial Virus (RSV). Some people with COVID-19 may not have any symptoms but are still able to pass infection to others. Most people with respiratory viral infections will have a relatively mild illness, especially if they have been vaccinated.

More severe disease with a high mortality rate has been associated with emerging respiratory viral infections such as MERS (Middle East Respiratory Syndrome), coronavirus and avian influenza, therefore such infections require higher levels of precautions.

Pandemics of respiratory viral infections, such as influenza, also require separate consideration given the potential for both high morbidity and mortality and high pressure on healthcare facilities, staffing and resources.

It is not possible to determine whether a person has a respiratory viral infection by symptoms alone and therefore testing is extremely important.

The risk of catching or passing on a respiratory viral infection is greatest when someone who is infected is physically close to or sharing an enclosed and/or poorly ventilated space with other people. When someone with a respiratory viral infection breathes, speaks, coughs, or sneezes they release small particles that contain the virus which causes the infection. These particles can then be breathed in or can come into contact with the eyes, nose or mouth. They can also land on surfaces and be passed from person to person by touch.

Symptoms of respiratory viral infections include:

- Continuous cough (with or without mucus)
- Sneezing
- High temperature, fever or chills
- Shortness of breath
- Unexplained tiredness, lack of energy
- Muscle aches or pains that are not due to exercise
- Headache that is unusual or longer lasting than usual
- Sore throat, stuffy or runny nose
- Diarrhoea

2. Purpose

The purpose of this policy is to provide healthcare staff at East Sussex Healthcare NHS Trust (ESHT) with the knowledge and guidance to ensure that they know how to manage patients with respiratory viral infection and therefore prevent transmission of infection.

2.1 Rationale

To provide ESHT staff with the information they need to identify and manage patients that have respiratory viral infections and those who are at risk. To ensure that patients have effective and

appropriate care wherever that care is delivered. To reduce the risk of transmission of respiratory viral infections.

2.2 Principles

Prevention of transmission of respiratory viral infections to patients and staff within ESHT can be achieved by ensuring the early detection of patients with infections and appropriate isolation and infection control precautions. Additionally, it can be prevented by testing patients for respiratory viral infections including Influenza, COVID-19 and RSV.

2.3 Scope

This policy applies to all hospital, community and contracted staff employed to care for patients within ESHT. This includes employees, volunteers, agency/locum/bank staff and contractors whilst working on the Trust premises.

3. Definitions

Close contact: a person living in the same house or a patient sharing the same hospital room or bay.

COVID: Coronaviruses are a family of viruses that can cause illnesses in humans, such as the common cold, Severe Acute Respiratory Syndrome (SARS) and MERS. They can range from mild, severe to even death.

Filtering Facepiece (FFP) Respirators: Respiratory Protective Equipment (RPE) i.e., a Filtering Facepiece (FFP) must be worn when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route and when carrying out Aerosol Generating Procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route.

Healthcare associated infection: An infection that occurs following or during a healthcare intervention undertaken either in the community (including the patient's home) or in the healthcare setting.

Influenza: A contagious respiratory illness caused by Influenza viruses that can be responsible for upper respiratory tract infection and sometimes may progress to pneumonia. It can cause mild to severe illness and at times can lead to death.

RSV: Respiratory Syncytial Virus is a common respiratory virus that usually causes mild, cold-like symptoms. For most people RSV infection causes a mild respiratory infection. The very young (under 1 year of age) and the elderly are at the greatest risk. Whilst most RSV infections usually cause mild illness, infants aged less than 6 months frequently develop the most severe disease such as bronchiolitis and pneumonia, which may result in hospitalisation. Children born prematurely, or with underlying chronic lung disease, and the elderly with chronic disease are also at increased risk of developing severe disease.

SICPS: Standard Infection Control Precautions are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.

TBPs: Transmission Based Precautions are a set of infection control measures that should be implemented as required when patients are known or suspected to be infected with an infectious agent in addition to standard infection precautions in all care settings to prevent onwards transmission of infection. TBPs are categorised according to the route of transmission

of the infectious agent i.e., airborne, droplet or contact transmission. The routes of transmission depend on the type of organism; some infectious agents may have multiple routes of transmission and therefore require more than one type of precaution.

4. Accountabilities and Responsibilities

4.1 Corporate

The Trust Board must ensure that adequate resources are made available to effectively manage patients with respiratory viral infections. There must be effective leadership at corporate and clinical level developing a supportive environment for the Infection Prevention and Control Team (IPCT) to implement the policy.

4.2 Infection Prevention and Control Team (IPCT)

Responsible for:

- Ensuring all staff are made aware of this policy.
- Advising on screening of patients with regards to respiratory viral infections.
- Ensuring that patients with COVID-19 are alerted on [REDACTED] and results from patients with respiratory viral infections are documented on [REDACTED]
- Ensuring patients with respiratory viral infections are isolated based on risk assessment.
- Acting as a source of best practice for clinical/non-clinical staff.
- Investigating potential healthcare acquired respiratory viral infections and implementing measures to prevent further spread.
- Detecting potential outbreaks and be part of the Outbreak Control Team.
- Ensuring that the policy is updated in a timely manner in accordance with the clinical governance framework and in response to changing need or National guidance.

4.3 Site Management Team

The site management team is responsible for:

- Ensuring that patients are transferred to a clinical area that is the correct specialty for them, subject to operational pressures.
- Assisting ward staff to identify single room accommodation for patients with suspected or confirmed respiratory viral infection where a risk assessment has shown that this is appropriate. Co-horting patients with the same respiratory viral infection together if no single room is available with guidance from the infection prevention and control team.

4.4 All Staff

- The admitting team (nursing and medical) is responsible for checking for an Infection Control alert on [REDACTED] or documentation on [REDACTED] to identify patients with a history of respiratory viral infection such as COVID-19 on admission or pre-admission to hospital.
- Commencing treatment of patients with respiratory viral infection in accordance with microbiology advice.
- Ensuring that patients are provided with information regarding their respiratory infection.
- Ensuring that ward vacated bed spaces/rooms and associated equipment used by patients with respiratory viral infection are deep cleaned prior to use by another patient.
- Ensuring that the patient's respiratory viral infection status is communicated at the time of referral to community teams who will care for the patient in their own home or to other care settings. (This is the responsibility of the nursing and medical staff discharging the patient if the patient is discharged at the weekend).

4.5 Microbiology department

- Ensuring that appropriate tests are available for identification of respiratory viral infection.
- Ensuring that results are communicated promptly to clinical teams.
- Providing timely advice to clinicians regarding appropriate treatment, where relevant.
- Monitoring the use of antimicrobial agents within the Trust and feedback on areas for improvement.

4.6 Housekeepers and Ward Orderlies

Housekeepers are responsible for:

- Maintaining a clean environment to reduce environmental contamination.
- Providing appropriate cleaning of vacated bed spaces/isolation rooms/co-hort bays on discharge/transfer of patients with respiratory viral infection using products advised by the Infection Prevention and Control Team and National guidance. (See Deep Cleaning Policy).
- Maintaining housekeeping hours as per establishment.
- Ward Orderlies are responsible for the cleaning of equipment and completing the documentation on the cleaning checklist.

4.7 Procurement

Procurement are responsible for liaising with the IPCT in the selection and associated management process of any personal protective equipment necessary in relation to the management of patients with respiratory viral infections.

5. Respiratory Virus Transmission

The pathogens that cause respiratory viral infections are spread through one or more of the following routes:

Droplet Transmission

Virus containing droplets greater than 5 microns in size may be generated from the respiratory tract during coughing, sneezing, or talking. If droplets from an infected person come into contact with the mucous membranes (mouth or nose) or surface of the eye of a recipient, they can cause infection. These droplets remain in the air for a short period and travel about one metre, so closeness is required for transmission.

Direct Contact Transmission

Infectious agents are passed directly from an infected person to a recipient who then transfers the organism into their mouth, nose, or eyes.

Indirect Contact Transmission

A recipient has contact with a contaminated object (fomite) e.g., furniture or equipment. The recipient then transfers the organism from the object to their mouth, eyes, or nose.

Aerosol Generating Procedures

Airborne transmission during and after Aerosol Generating Procedures (AGPs)

Aerosol Generating Procedures (AGPs) are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory viral infection).

The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- **awake* bronchoscopy** (including awake tracheal intubation)
- **awake* ear, nose, and throat (ENT)** airway procedures that involve respiratory suctioning.
- **awake* upper gastro-intestinal endoscopy.**
- **dental procedures** (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
- induction of sputum
- **respiratory tract suctioning****
- **surgery or post-mortem procedures** (like high-speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses.
- tracheostomy procedures (insertion or removal).
- Patients coughing***

*Awake including 'conscious' sedation (excluding anaesthetised patients with secured airway)

** 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.

*** Coughing is not a clinical procedure, but it is recognised that it does produce aerosols and therefore staff need to consider the wearing of correct PPE when caring for these patients.

In the Royal College of Anaesthetists article entitled Introduction of a national infection prevention and control manual for England, implications for anaesthetists and intensivists (published 07/06/22) the following is discussed:

"Although not considered in the IPC manual, there is evidence that cough, sneeze, and natural exertional respiratory activities, e.g., talking, shouting, deep breathing, exercise and – by implication – dyspnoea, can be associated with significant aerosol generation. In the context of anaesthesia and critical care involving close or prolonged contact with a patient who may be infected with a disease that is wholly or partly spread by airborne transmission, e.g., SARS-CoV-2, a risk assessment is likely to conclude that personal protective equipment (PPE) that includes respiratory protective equipment (RPE) is required, and particularly if the patient is coughing, sneezing or dyspnoeic.

Regarding **RPE**, the document states that '*a filtering face piece (FFP) must be considered when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route*'. However, although it subsequently states that the '*RPE for healthcare workers while a patient is considered infectious*' is '*Fluid resistant surgical mask (FRSM) for routine care and FFP3 or Hood for AGPs*' we interpret the overall advice as indicating that FFP3 masks are likely to be indicated for anaesthetists and other healthcare workers when delivering care that involves being in close proximity to patients known or suspected to have COVID-19 who may emit aerosols through respiratory activities and when undertaking AGPs".

6. Standard Infection Control Precautions and Transmission Based Precautions

Standard Infection Control Precautions (SICPs) are to be used by all staff, in all care settings, at all times, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment. However, these may be insufficient to prevent cross transmission of specific infectious agents and additional precautions called “Transmission Based Precautions” (TBP) may be required when caring for patients with known / suspected infection. Some infectious agents can be transmitted by more than one route. TBPs are categorised by the route of transmission of infectious agents. Clinical judgement and decisions should be made by staff on what additional precautions are required and this will be based on:

- suspected/known infectious agent
- severity of the illness caused
- transmission route of the infectious agent
- care setting and procedures undertaken.

Please see Appendix C for PPE when applying transmission-based precautions.

6.1 Type of Precautions

Contact precautions:

- Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient’s immediate care environment (including care equipment). This is the most common route of cross-infection transmission.

Droplet precautions:

- Measures used to prevent and control infections spread over short distances (at least 1 metre) via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

Airborne precautions:

- Measures used to prevent and control infection spread without necessarily having close patient contact via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

7. Personal Protective Equipment

Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear Personal Protective Equipment (PPE) that protects adequately against the risks associated with the procedure.

Where it is not reasonably practicable to prevent exposure to a substance hazardous to health (as may be the case where healthcare workers are caring for patients with suspected or known airborne pathogens), the hazard must be adequately controlled by applying protection measures appropriate to the activity and consistent with the assessment of risk in accordance with the hierarchy of controls.

In routine clinical practice healthcare workers do not commonly wear masks when dealing with patients presenting with the “common cold” or “influenza like illness”. However, in a patient with undiagnosed respiratory illness where coughing and sneezing are significant features, or in the context of known widespread respiratory virus activity in the community or a suspected or confirmed outbreak of a respiratory illness in a closed or semi-closed setting, the need for appropriate respiratory and facial protection to be worn should be considered.

The Infection control manual states in Appendix G, Aide memoire for optimal patient placement and respiratory protective equipment (RPE) for infectious agents to hospital inpatients the following:

“The distinction between droplet and aerosol transmission is not always clearly defined. A dynamic clinical risk assessment should be performed using the hierarchy of controls to inform the assessment and should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection in the local area. Staff should be provided with training on the correct use of RPE. Current guidance is that an FFP3 respirator must be worn by staff when caring for patients with a suspected or confirmed infection spread by the airborne route, when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet and airborne route, and when deemed necessary after risk assessment”.

7.1 Fluid Repellent Surgical Masks (FRSM)

Fluid repellent surgical masks must be worn by staff when providing care within 1 metre of a patient when droplet precautions are applied. If cluster transmission of a respiratory pathogen is known or suspected, extend the use of FRSM as source control to staff in the affected clinical areas(s). This should be guided by local risk assessment (please see advice in paragraph above from IPC Manual).

7.2 Eye Protection

Staff must wear eye protection i.e., goggles or a visor, if blood and/or body fluid contamination to the eyes or face is anticipated or likely and always during aerosol generating procedures. Regular corrective spectacles are not considered eye protection.

7.3 Gloves and Plastic Aprons

Wear gloves and a plastic apron for activities that involve direct contact with the patient and their immediate environment. If extensive soiling of clothing, contact of skin with blood and other body fluids or carrying out AGPs wear a long-sleeved gown. Gloves and aprons must be changed in between each patient contact and are single use items.

7.4 Respiratory Protective Equipment (RPE)

A Filtering Facepiece (FFP) must be worn by staff when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route and when carrying out Aerosol Generating Procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route. Wear an FFP3 respirator mask and visor (if risk of splashes) if looking after patients with suspected or confirmed COVID-19 and if undertaking aerosol generating procedures. If a severe emerging respiratory virus is suspected (e.g., avian influenza, MERS Coronavirus) wear an FFP3 respirator and a visor if there is a risk of splashes.

To wear an FFP3 respirator staff must be fit tested to ensure an adequate seal has been achieved. Staff must perform a fit check each time one is worn. Powered respirator hoods are available if a fit test cannot be achieved. They must be 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. Powered respirator hoods must be decontaminated and maintained according to manufacturer's instructions.

Hand hygiene must always be carried out before putting on PPE and following the removal of PPE.

For Donning and Doffing of PPE please see Appendix B.

See Appendix C For Personal Protective Equipment (PPE) when applying Transmission-Based Precautions (TBPs)

For PPE for other respiratory viral infections please see Appendix G: Aide memoire for optimal patient placement and respiratory protective equipment (RPE) for infectious agents in hospital inpatients (based on evidence from WHO, CDC and UKHSA). Taken from the National Infection Control Manual.

8. Management of Patients with Respiratory Viral Infection

All patients with respiratory viral symptoms or confirmed respiratory viral infection should be assessed away from other patients pending their results. Patients must not sit in waiting areas or other public spaces. Patients with excessive cough and sputum production and those at higher risk of severe outcomes should be prioritised for placement in single rooms whilst awaiting results. (For information regarding what PPE staff should wear please see Section 7). (Please see Appendix F, Isolation management flowchart of patients with viral respiratory symptoms).

Microbiological specimens should be sent at the earliest opportunity, staff must wear the correct PPE when taking samples i.e., fluid repellent surgical facemask. An FFP3 mask and visor, if on risk assessment, it is likely you may receive droplet splash on your face and eyes (i.e., severe disease or patient coughing), apron and gloves. For testing guidance see Appendix H.

When assessing patients with respiratory infection, consider whether the patient is physiologically unwell enough to require admission to hospital or can be managed in the community (with support if needed).

General pathway principles:

- Patients that are admitted should be transferred to a clinical area that is the correct specialty for them.
- Patient pathways should be based on clinical need/speciality rather than their COVID/flu/RSV status as this will provide appropriate patient care and keep respiratory beds available for those who require specialist respiratory support.
- Patients with COVID/RSV/Flu will be cared for by the most appropriate admission presentation specialty.
- Non- elective patients will be streamed to gateways based on symptoms and if required, Lateral flow test result.
- Patients with COVID/flu/RSV will be cared for in single rooms within specialty wards.
- Where there are higher numbers of COVID than side rooms on a specialty ward – a cohort bay will be created within that ward.
- Seek advice, if you feel the patient may need specialist respiratory support e.g., significantly worsening respiratory failure.

When caring for patients in isolation rooms single-use equipment should be used. If re-usable non-invasive care equipment has to be used, it should be dedicated to the isolation room/cohort area and decontaminated prior to use on another patient. An increased frequency of decontamination should be carried out for reusable non-invasive care equipment when used in isolation/cohort areas. Cleaning must be documented on an equipment cleaning checklist.

Signage should be used on doors/areas to communicate isolation requirements and prevent entry of unnecessary visitors and non-essential staff. Patient confidentiality must be maintained. Isolation room doors should remain closed, if this is not possible, there should be a documented risk assessment and correct signage on side room doors which states the door can remain open.

Immunocompromised patients at risk of respiratory viral infections must always be isolated and will require a longer isolation period than non-immunocompromised patients.

If patients need to be cohorted due to no single rooms being available a patient with a confirmed respiratory viral infection can be cohorted in a bay with patients with the same infection. This should be discussed with the Consultant Microbiologist and Infection control team. (Please note do not cohort patients with Influenza A and B together. Do not cohort patients with COVID, Influenza and RSV together). Patients cohorted in a bay with respiratory symptoms/infection should be separated by at least 1 metre. Every effort should be made to support good ventilation in the clinical environment. This can be via air exchanges, opening windows and ensuring a HEPA filter machine is put into the bay or side room to assist with air filtration. The use of fans and air conditioning units must be risk assessed, see Section 11.

If a patient develops respiratory symptoms/infection whilst in a bay pull the curtains around the patient, if safe to do so, and isolate the patient in a single room as soon as possible. Ask the patient to wear a surgical face mask if they are able to tolerate one and it does not compromise their clinical care, such as when oxygen therapy is required. This will reduce the risk of spread of infection to other patients and staff. The curtains require removal after the patient leaves the bedspace and the bedspace deep cleaned with new curtains provided.

If aerosol generating procedures (see Section 5) are being carried out, wherever possible, isolate the patient in a negative pressure side room. If this is not possible, please ensure that a HEPA filter machine is in place and good air exchange is promoted.

If bays/wards are source isolated staff allocation must be carefully considered to minimise the risk of cross infection. Staff should work in the affected bay only and not work in other areas if this does not compromise patient care or safety.

When patients with respiratory tract viral infection are cohorted in one area and multiple patients require care, staff must wear a surgical face mask or an FFP3 mask, depending on risk assessment, on entry to the area and keep it on for the duration of all care activities or until the mask requires replacement (when it becomes moist or damaged). Inpatients with suspected or confirmed respiratory infection should be asked to wear a facemask (FRSM) unless isolated in a single room. FRSM should be worn by patients in multi-bedded bays if this can be tolerated and is deemed safe for the patient.

Housekeeping staff must wear an FFP3 mask and visor, gloves, and aprons if cleaning in an area where there is suspected or confirmed patients with COVID-19. Housekeeping staff must discuss PPE required with the nurse in charge of the clinical area before going into a bay or side room with suspected or confirmed patient/s with respiratory viral infection so that they know the correct precautions to take.

Infectious patients should only be transferred to other departments if clinically necessary. The patient should wear a surgical face mask, if safe to do so and can tolerate one, in communal areas during transfer if they have an infectious agent transmitted by the airborne/droplet route. If unable to tolerate a mask, staff must wear a surgical face mask. If the patient has suspected or confirmed COVID-19 staff must wear an FFP3 mask or respirator hood. The receiving department/hospital and transporting staff must be aware of the necessary precautions.

With regards to critical care patients, please see the Policy for the Management of Critical Care Beds, regarding escalation in cases of multiple admissions that need isolating.

In response to COVID-19, it is recommended that staff and organisations continue to undertake risk assessments using the hierarchy of controls which include an evaluation of the ventilation in the area, operational capacity, physical distancing, and prevalence of COVID-19.

8.1 Outpatient Settings

Staff in outpatient settings must wear a fluid repellent surgical mask if caring for a patient with a suspected or confirmed respiratory infection. If suspecting COVID-19 staff must wear an FFP3 mask, a visor if risk of body fluid splashes, gloves, and aprons.

Patients that visit outpatient departments (including urgent and emergency care) with respiratory symptoms who present for treatment should be asked to wear a surgical facemask (or offered one on arrival unless placed in a single room) if this can be tolerated and is deemed safe for the patient. Patients known to have COVID-19 should not visit outpatient departments until they are non-infectious. Outpatients without respiratory symptoms are not required to wear a facemask unless this is a personal preference.

8.2 Community Staff and Patient Management with Respiratory Viral Infections

Community staff must wear the correct PPE i.e., a fluid resistant surgical facemask when entering a patient's home if the patient is suspected to have a respiratory viral infection (See section 7). Gloves and aprons must be worn if providing direct patient care. If there is a risk of body fluid splashes a visor or goggles must be worn. If a patient has confirmed COVID-19 staff must wear an FFP3 respirator, visor, gloves, and apron. If AGPs are being carried out an FFP3 mask, visor, gloves, and long-sleeved gown must be worn.

Staff must carry a hand hygiene pack with them into the patient's home in order to be able to carry out hand hygiene.

Patient equipment must be cleaned in between each patient with disinfectant wipes.

The patient will require referring to their general practitioner if there is suspicion of respiratory viral infection and they are extremely vulnerable. They should also be referred if testing is required, and they require antiviral medication. Vulnerable household contacts will also need to contact their GPs to be assessed for prophylaxis.

8.3 Contact Tracing of Patients

Contact tracing of patients will be carried out by the Infection Prevention and Control team as per risk assessment and any actions required communicated to the nursing and medical teams.

9. Respiratory and Cough Hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of known or suspected respiratory illness (pathogens):

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose, if unavailable use the crook of the arm
- dispose of all used tissues promptly into a waste bin
- wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions.

- where there is no running water available or hand hygiene facilities are lacking, staff may use hand wipes followed by Alcohol Based Hand Rub (ABHR) and should wash their hands at the first available opportunity.
- keep contaminated hands away from the eyes, nose and mouth.

10. Laboratory Diagnosis of Respiratory Virus Infections

For patients admitted to hospital with suspected influenza or respiratory viral infection, viral swabs should be taken. These are sent to a reference laboratory where they will undergo molecular PCR (Polymerase Chain Reaction) testing for a panel of respiratory viruses including influenza. Nose/throat swabs in VIRAL transport medium (green swab) should be sent directly to the Microbiology laboratory. Staff taking viral swabs must wear a surgical facemask, gloves, apron. An FFP3 mask and visor should be worn, if on risk assessment, it is likely you may receive droplet splash to your face and eyes (i.e., severe disease or patient coughing), apron and gloves.

An episode of COVID-19 may result in prolonged detection of SARS-CoV-2 by RT-PCR; therefore, it does not exclude that a patient's recent onset symptoms are due to influenza or another respiratory virus.

Please see Appendix D: Testing for Influenza.

11. Ventilation

Ventilation is the process by which 'fresh' air (normally outdoor air) is intentionally provided to a space and stale air is removed. This may be achieved by mechanical systems using ducts and fans, or natural ventilation most commonly provided through opening windows. The local redistribution of air may also be construed as ventilation.

Ventilation is an important feature in the control of airborne infection. However, the emergence of SARS-CoV-2 as a highly contagious virus has demanded new and innovative solutions to safeguard patients, staff, and visitors. [Health Technical Memorandum 03-01 Specialised Ventilation for Healthcare Premises \(HTM-03-01\)](#) is a robust standard for ventilation of higher risk clinical spaces based on high air change rates using outdoor air to continually flush indoor spaces. The COVID-19 pandemic has shown that greater attention must be paid to the improvement and maintenance of ventilation in healthcare settings.

The focus on ventilation has also highlighted areas of high risk due to poorly performing and inadequate ventilation, particularly in older hospitals and other healthcare settings such as primary care and dental suites, which increase risks of nosocomial infections. Currently ventilation at ESHT does not meet the HTM-03-01 guidance. Therefore, as part of the hierarchy of controls good ventilation should be promoted by staff opening windows and using HEPA filters to provide better ventilation and consideration given to increasing the level of respiratory protection in areas which are not HTM compliant.

11.1 HEPA Filter Air Cleaner

Local HEPA filter-based air cleaners are one option for improving and supplementing ventilation. The installation of a high efficiency particulate air (HEPA) filter air cleaner can reduce the risk of airborne transmission. A HEPA filter air cleaner can be put into the bay or side room to assist with air filtration.

11.2 Portable Fans and Air Conditioning Units

Portable fans should not be used in high-risk areas. These include COVID-19 cohort wards or bays, operating rooms, critical care units, transplant units or dialysis units. Areas where immunocompromised patients receive care, for example Oncology units should not use fans. They should not be used in rooms where a patient is on airborne precautions, droplet or contact precautions for example COVID-19, or in rooms with directed airflow e.g. positive or negative pressure rooms.

If air conditioning units are used a risk assessment should be undertaken to determine their placement on the ward.

12. Respiratory Viruses

12.1 Influenza

Influenza is one of the great epidemic diseases. The most severe pandemic recorded was in the winter of 1918-19 when more than 20 million people died. Transmission of this viral infection is by inhalation of respiratory secretions from an infected person. Following an incubation period of one to four days, symptoms of fever, malaise, headaches, generalised aches, sometimes with nasal discharge, and sneezing develop. A non-productive cough is common and there may be a sore throat and hoarseness. Symptoms usually last for about four days, but tiredness and weakness often persist for longer. In a small proportion of cases a secondary bacterial pneumonia may develop especially in the elderly or patients with pre-existing cardiac or pulmonary disease.

There are three influenza viruses: A, B and C. Type A usually cause more severe infections, often as epidemics. Type B produce milder infections but may also cause winter outbreaks. Type C are rarely associated with human disease. All influenza viruses have surface proteins called Haemagglutinin (H) and Neuraminidase (N). Different strains of viruses have different combinations of these antigens e.g., H1N1, H3N2 etc. Influenza viruses are uniquely able to undergo frequent antigenic change. Epidemics (higher number of influenza cases in a community than expected over a period of time) are due to the emergence of a new virus strain caused by minor changes of viral antigens. Major antigenic changes of these antigens can cause a pandemic; these are only due to the Influenza A virus. Only viruses of the H1, H2 with H3 lineage have caused widespread human infections so far. The H1N1 strain which caused a pandemic in 2009 was called “swine flu” since it was first detected in infected pigs.

Pandemic influenza occurs if epidemics with a new strain of Influenza A virus occur world-wide. A pandemic spread rapidly since people have little or no immunity to the new strain.

The influenza virus is mainly transmitted from person to person through close contact. It is spread via droplets (released during coughing and sneezing with the range of about 2 metres), through direct (‘kissing contact’) and indirect contact (contaminated fomites) as the most important routes. Aerosol transmission may occur in certain situations, e.g., during aerosol generating procedures (see Section 5). These aerosols can persist in the air for many hours unless the air is exchanged through adequate ventilation.

12.1.1 Clinical Criteria in Hospital

Case definitions may vary depending on the likelihood of influenza, which is a function of the level of the activity in the community at the time. During high level of community activity, the following criteria are appropriate.

Fever ($>38^{\circ}\text{C}$) or history of fever and flu like illness (2 or more of the following symptoms: cough, sore throat, rhinorrhoea, headache, limb/joint pain, vomiting/diarrhoea)

OR

Severe/life threatening illness suggestive of an infectious process (e.g., severe community acquired pneumonia).

The diagnosis of influenza is generally made using clinical features alone when it is known to be circulating in the community (for weekly influenza surveillance reports, visit: <https://www.gov.uk/government/collections/weekly-national-flu-reports>).

- Diagnosis of influenza can only be confirmed by laboratory testing, although the probability that an influenza-like illness is caused by influenza is higher if influenza is known to be circulating and if a person has a high fever.
- Rapid testing for influenza should be undertaken in all people with complicated influenza (although often this takes place in hospital).
- Initiation of antiviral treatment should not be delayed while awaiting laboratory confirmation, if no direct or severe viral infection is suspected.
- Laboratory testing to confirm or exclude influenza is particularly important if an individual develops symptoms despite antiviral prophylaxis, or has a persistent infection despite antiviral treatment, in order to identify the potential development of antiviral resistance.

Symptoms of influenza appear abruptly, around 2 days after exposure.

Uncomplicated influenza signs and symptoms include:

- Coryza, nasal discharge.
- Cough.
- Fever.
- Gastrointestinal symptoms.
- Generalised symptoms (headache, malaise, myalgia, arthralgia).
- Ocular symptoms (such as photophobia, conjunctivitis, lacrimation, and pain upon eye movement).
- Sore throat.
- No clinical features of complicated influenza.

Complicated influenza clinical features include:

- Signs and symptoms that require hospital admission.
- Presence of a lower respiratory tract infection (hypoxaemia, dyspnoea, lung infiltrate).
- Central nervous system involvement.
- Significant exacerbation of an underlying medical condition.

Symptoms of influenza-like illness can be different in infants and children and may include:

- Cervical adenopathy.
- Conjunctival erythema.
- Diarrhoea and vomiting — gastrointestinal symptoms are more common in children than in adults.
- Fatigue.
- Fever (typically $38\text{--}40^{\circ}\text{C}$) — children can have a higher maximum temperature. They may also present with undifferentiated fever or febrile seizures.
- Hyperaemia of oropharynx.
- Irritability.
- Laryngotracheobronchitis (croup), bronchiolitis, or bronchitis.
- Myalgia, or myositis — this can affect the calf muscles and be severe. It is a more common complication in children compared to adults.
- Tachypnoea.

'At risk' groups

'At risk group' includes people aged over 65 years, children aged under 6 months, pregnant women (at any stage of pregnancy, or women up to two weeks post-partum), and people with any of the following conditions:

- **Asplenia or dysfunction of the spleen** — including conditions such as homozygous sickle cell disease and coeliac syndrome that may lead to splenic dysfunction.
- **Chronic respiratory disease**, including:
 - Chronic obstructive pulmonary disease, chronic bronchitis and emphysema, bronchiectasis, cystic fibrosis, interstitial lung fibrosis, pneumoconiosis, and bronchopulmonary dysplasia.
 - Asthma that requires continuous or repeated use of inhaled or systemic corticosteroids or with previous exacerbations requiring hospital admission.
 - Children who have previously been admitted to hospital for lower respiratory tract disease.
- **Chronic heart disease** — including congenital heart disease, hypertension with cardiac complications, chronic heart failure, and individuals requiring regular medication or follow up for ischaemic heart disease.
- **Chronic kidney disease** — including chronic kidney disease stage 3, 4 or 5, chronic kidney failure, nephrotic syndrome, and kidney transplantation.
- **Chronic liver disease**, including cirrhosis, biliary atresia, and chronic hepatitis.
- **Chronic neurological conditions**, including stroke and transient ischaemic attack. Conditions in which respiratory function may be compromised (for example, polio syndrome). Individual assessment should also be considered in clinically vulnerable individuals including those with cerebral palsy, learning disabilities, multiple sclerosis and related or similar conditions; or hereditary and degenerative disease of the nervous system or muscles; or severe neurological disability.
- **Diabetes mellitus**, including type 1 diabetes and type 2 diabetes (requiring oral hypoglycaemic drugs or a controlled diet).
- **Immunosuppression** due to disease or treatment, including:
 - People undergoing chemotherapy (or radiotherapy) leading to immunosuppression.
 - People undergoing bone marrow transplant.
 - HIV infection (all stages).
 - Individuals treated with, or likely to be treated with, systemic steroids for more than 1 month at dosages equivalent to prednisolone 20 mg or more daily (at any age) or, for children weighing less than 20 kg, a dose of 1 mg or more per kg body weight per day.
 - Multiple myeloma.
 - Genetic disorders affecting the immune system (for example, IRAK-4, NEMO, complement disorder).
- Morbid obesity (body mass index of 40 or more).

For information on swine flu, please see: <https://www.gov.uk/guidance/classical-swine-fever>

12.1.2 Timely Recognition of Cases

The dominant circulating strain of influenza is obtainable from the UKHSA weekly influenza reports.

During a pandemic, updates of algorithms will be regularly sent out to consultants during a pandemic alert phase 5 (pandemic imminent) and 6 (pandemic declared).

12.1.3 Treatment of Patients

The clinical management algorithm will be circulated based on advice from UKHSA and other professional bodies. Please see UKHSA guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza (Version 11, November 2021) for the latest treatment and infection control algorithm. Available at: [Guidance on use of antiviral agents for the treatment and prophylaxis of seasonal influenza \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/guidance/2021-11-11-ukhsa-guidance-on-use-of-antiviral-agents-for-the-treatment-and-prophylaxis-of-seasonal-influenza)

Please also see Influenza: the Green Book, Chapter 19 and ESHT Adult Antimicrobial Guide, Influenza.

12.1.4 Infection Control Precautions and Management of Influenza Patients

Patients with influenza must be isolated for 7 days or until completion of their Oseltamivir treatment. A patient with the same strain of influenza may be cohorted together if a single room is unavailable. Contacts of influenza patients must be risk assessed by the Medical team to determine if they are high risk and require prophylaxis. The bay they are in (providing the positive influenza patient has been isolated) can remain open to admissions if they have been assessed by the Medical team and are given prophylaxis. If an exposed patient develops symptoms of influenza a viral screen should be taken, and the patient isolated in a single room.

12.1.4.1 Personal Protective Equipment

For suspected or confirmed cases staff must wear a fluid-resistant surgical facemask, gloves, and apron. If there is a risk of extensive spraying/splashes with body fluids, a fluid resistant gown must be worn and eye or face protection (full face visors or goggles). If carrying out Aerosol Generated Procedures (AGPs) wear an FFP3 mask (fit tested) or a respirator hood, gown and eye or face protection.

Please see Section 7 regarding the distinction between droplet and aerosol transmission which is not always clearly defined. Current guidance is that an FFP3 respirator must be worn by staff when caring for patients with a suspected or confirmed infection spread by the airborne route, when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet or airborne route, and when deemed necessary after risk assessment.

Staff are required to be fit tested to wear an FFP3 respirator and perform a fit check each time one is worn.

12.1.4.2 Vaccination

Some people are more susceptible to the effects of influenza, for them it can increase the risk of developing more serious illness such as bronchitis and pneumonia, or can make existing conditions worse. Vaccination is the best way to avoid catching and spreading influenza.

For people with long-term health conditions the effects of influenza can make it worse even if the condition is well managed and the person is normally well. A vaccination should be given to patients with long-term health conditions. Please see:

<https://www.gov.uk/government/publications/national-flu-immunisation-programme-plan>

12.2 COVID-19 (SARS-COV-2).

Coronaviruses are a family of related RNA respiratory viruses that can cause illnesses such as the common cold, Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome (MERS). In 2019 a new coronavirus was identified as the cause of a disease outbreak that originated in China. The virus is known as Severe Acute Respiratory Syndrome

Coronavirus 2 (SARS-CoV-2). The disease it causes is called coronavirus disease 2019 (COVID-19).

Common symptoms include headache, fatigue, cough, and myalgia (aching muscles). Loss of sense of smell and taste has also been reported. In severe cases COVID-19 can lead to pneumonia, acute respiratory distress syndrome, multiple organ failure and death.

Transmission of COVID-19 is greatest when an infected person is physically close to or sharing an enclosed and/or poorly ventilated space with other people. Small particles that contain the virus, which causes infection, can be released when a person breathes, speaks, coughs or sneezes. These can be breathed in or come into contact with the eyes, nose or mouth. They can be passed from person to person via touch if these particles land on surfaces.

Some people can be infectious for up to 10 days, many people will no longer be infectious after 5 days.

For Clinical risk groups for individuals aged 16 years and over and 16 years and under please see the COVID-19: the green book, chapter 14a.

For treatment of COVID-19 including neutralising Monoclonal Antibodies (nMABs) please see East Sussex Healthcare NHS Trust Adult Antimicrobial guidelines with regards to patients hospitalised with acute COVID-19 or patients with hospital-onset COVID-19.

12.2.1 Infection Control Precautions and Management of Patients with COVID-19

Patients with suspected COVID-19 must be isolated until their lateral flow test/PCR test is known and COVID infection prevention and control precautions taken. Positive patients should be isolated as soon as possible.

Patients do not have to be on a respiratory ward unless under the direct care of the respiratory team and needing specialist respiratory intervention.

Depending on operational pressures, COVID positive patients and patients that are exposed to a positive case are sometimes cohorted in a bay together due to lack of single rooms being available. Immunocompromised patients should always be isolated. Daily lateral flow tests must be carried out on the exposed patients in the bay/or side room and the results uploaded to [REDACTED] and [REDACTED]. The bay door must be kept closed, windows can be opened to improve ventilation and a HEPA filter machine must be placed in the bay or side room. Staff must wear the correct personal protective equipment (See Section 7). Patients who are COVID positive will be stepped down as per testing guidance. Immunocompromised patients may need to be isolated for a longer period, up to 14 days and there needs to be some clinical improvement (See Management of Respiratory Testing, Appendix H, which includes when patients can be stepped down).

In response to COVID-19, Omicron, and other variants of concern, it is recommended that staff and organisations continue to undertake risk assessments using the hierarchy of controls which include an evaluation of the ventilation in the area, operational capacity, physical distancing, and prevalence of COVID-19.

12.2.1.1 Personal Protective Equipment

Staff must wear an FFP3 mask (fit tested and fit checked each time worn) or respirator hood, full face visor (if risk of splashes), gloves and apron when looking after suspected or confirmed cases of COVID-19. If carrying out aerosol generated procedures or there is a risk of spraying/splashes of body fluids staff must wear a long-sleeved gown.

12.2.1.2 Vaccination

With regards to COVID vaccine eligibility, for details of at-risk conditions please see COVID-19: the green book, chapter 14a.

12.3 Respiratory Syncytial Virus (RSV)

RSV is a common respiratory virus that usually causes mild, cold-like symptoms. RSV is an enveloped RNA virus, in the same family as the human parainfluenza viruses and mumps and measles viruses. It causes coughs and colds in the winter. For most people RSV infection causes a mild respiratory viral infection. It can cause pneumonia or death in people that are at risk of more severe infection. In infants RSV is the most common cause of bronchiolitis. The antibodies that develop following early childhood infection do not prevent further RSV infections throughout life. Adults are affected by RSV but the full extent remains unknown.

RSV is transmitted by large droplets and by secretions from contact with an infected person. The virus can survive on surfaces or objects for about 4 to 7 hours. The incubation period is about 3 to 5 days. Symptoms generally last an average of 5 to 7 days.

For treatment of RSV please see East Sussex Healthcare NHS Trust Antimicrobial guidelines. For RSV immunisation please see Immunisation against infectious disease: the Green book.

12.3.1 Infection Control Precautions and Management of Patients with RSV

Children with suspected or confirmed RSV are isolated in side rooms or co-horted in bays if a single room is not available. A viral screen is taken to confirm a diagnosis. Adults with RSV are only isolated if they are symptomatic, and this is for 5 days when they can be reviewed by the Medical team and de-isolated.

12.3.1.1 Personal Protective Equipment

Wear a Fluid Resistant Surgical Facemask (FRSM) for routine care, gloves and aprons and FFP3 Respirator or respirator hood for AGPs. If risk of spraying/splashes of body fluids or carrying out aerosol generated procedures, please wear a fluid resistant gown and eye/face protection. Please also see section 7

13. Hand Hygiene

The hands of healthcare staff can provide the vehicle for the transmission of infection. It is essential that all staff perform hand hygiene before and after patient contact and after contact with equipment, the environment, or other fomites. If hands are visibly dirty or have been in contact with a patient with diarrhoea and vomiting hands must be washed with soap and water.

Patients must be provided with the opportunity to wash their hands or use hand wipes after each toileting episode and before each meal.

Please see ESHT Hand Hygiene Policy for Healthcare Workers.

14. Visitors

Visitors who have respiratory viral symptoms must not visit. They must inform the area they are visiting that they have symptoms and/or that they have had COVID/respiratory illness recently prior to visiting.

During periods of ward/bay closures wherever possible visiting should be allowed and always for compassionate visiting. Visitors should be asked to wear a surgical mask when visiting a patient with suspected or confirmed COVID-19 in a side room or in a cohort bay. They should be advised how to remove the mask correctly before leaving the room/cohort bay and be advised regarding the importance of hand hygiene. Visitors must use personal protective equipment and take infection control precautions as advised by the person in charge of the area they are visiting.

Visitors and individuals accompanying patients to inpatient areas, outpatient appointments or the emergency department are not required to wear a facemask unless this is a personal preference.

15. Staff Health

All patient facing clinical staff are encouraged to have their occupational seasonal vaccines including their flu vaccine and COVID-19 boosters. (Some staff may be invited to more than one booster a year). The green book recommends to health care workers that the purpose of vaccination against vaccine preventable infections is to:

- protect our people and their family from a vaccine preventable infection.
- protect patients and service users, in our care from a vaccine preventable infection.
- protect our colleagues and other members of our team from the spread of a vaccine preventable infection.
- protect the efficient running of our services from avoidable disruption due to a vaccine preventable infection.

Hospital and community staff and who care for, or who have direct care with respiratory secretions and/or body fluids of a person with a viral respiratory infection will, by definition, be close contacts. Staff contacts who are well can continue with usual activities. Anyone who has symptoms of a respiratory infection and has a high temperature or does not feel well enough to go to work, is advised to stay at home and avoid contact with other people. For staff contact letter please see Appendix E.

Staff suffering from persistent, unexplained respiratory symptoms, especially from foreign travel should not attend work and should inform their line manager and discuss with their General Practitioner.

For information regarding staff respiratory testing please see Appendix H: Management of Respiratory Testing and Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 test result. <https://www.gov.uk/government/publications/covid-19-managing-healthcare-staff-with-symptoms-of-a-respiratory-infection>

16. Environmental Decontamination

Areas used for isolating/cohorting patients such as single rooms or bays must be deep cleaned following the patient's transfer/discharge with a combined detergent and hypochlorite solution (1,000ppm av.cl). This is required for the environment including furniture, surfaces and all floors after discharge. All disposable items must be disposed of in clinical waste. Facilities staff must be trained in the correct methods of PPE and the precautions to take when cleaning source isolation/cohort areas. Special attention must be given to frequently touched items such as door/toilet handles, telephones, locker tops, over bed tables and bed rails. These must be cleaned at least once daily and when known to be contaminated with secretions, excretions, or body fluids. The frequency of cleaning may be increased on the advice of the infection prevention and control team. Please refer to the National Cleaning Standards.

Vacated rooms should also be decontaminated following an AGP. Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room. This is a minimum of 20 minutes in hospital settings where the majority of these procedures occur. In general wards and single rooms there should be a minimum of 6 air changes per hour, in negative-pressure isolation rooms there should be a minimum of 10 air changes per hour. Advice should be sought from the IPCT.

17. Decontamination of Patient Equipment

Re-usable equipment must be decontaminated after every use/between patients. Where possible single use equipment should be used for source isolation patients.

Decontamination of reusable non-invasive care equipment must be undertaken:

- between each use/between patients.
- after blood and/or body fluid contamination.
- at regular predefined intervals as part of an equipment cleaning protocol.
- before inspection, servicing or repair.

If providing domiciliary care, equipment should be transported safely and decontaminated as above before leaving the patient's home.

18. Linen

All linen used from patients with respiratory viral infections is treated as infectious linen. Linen must be bagged at point of use in a red, water soluble, alginate bag and sealed. The red bag is placed into a white linen bag, sealed and removed immediately from the clinical area. Infectious linen bags/receptacles must be tagged (e.g., hospital ward/care area) and dated.

19. Clinical Waste

Within source isolation rooms/cohort bays orange infectious waste bags must be used for infectious waste. (Please see Policy and Procedure for Management of Waste). Waste bags must be no more than $\frac{3}{4}$ full and should be tied and sealed before removal from the patient area. Waste bags must be disposed of as soon as possible and not left in the patient area.

20. Utensils and Crockery

There is no need to use disposable plates and cutlery. Hot water and detergent used in dishwashers is sufficient to decontaminate dishes and eating utensils used by patients with respiratory viral infections.

21. Mortuary

Mortuary/Post-mortem Examination:

- The deceased patient should be fully wrapped in a sheet and transferred to the mortuary as soon as possible after death. Body bags are used for patients if an infection risk is suspected or confirmed, or the patients are otherwise compromised, e.g., infested. The mortuary risk assessment form must be completed to highlight the patient has an infection and the transmission routes.
- The mortuary will contact the ward to confirm what the infection is and will take appropriate steps to ensure other service users use the correct precautions. Where necessary the precautions will be upgraded or downgraded according to the information available.
- Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) should be sufficient to protect those handling the deceased with suspected or

confirmed COVID-19 while deceased individuals remain in the care environment. This includes under refrigeration conditions.

- Family members viewing the patient should wear appropriate PPE, aprons and gloves. Viewing and touching should be allowed, kissing should be discouraged. Hand hygiene and using alcohol gel must be carried out after removing PPE and before leaving the mortuary.
- The PME may be carried out in a high-risk post-mortem room or in the main post mortem room at the end of a session. In accordance with HSE guidance, a powered respirator and full PPE should be worn. The pathologist should contact the consultant microbiologist before the PM is performed if the diagnosis is unclear (e.g., outstanding microbiology results).
- Funeral directors should be informed of the transmission routes. If they require further information the mortuary staff will signpost them to the correct person/department.
- The mortuary Anatomical Pathologist Technologists (APTs) are available for advice regarding preparation of the patient for the mortuary.

22. Competencies and Training Requirements

Please refer to East Sussex Healthcare NHS Trust Mandatory Training Policy. Accurate training records for mandatory infection control training will be maintained by the Learning & Development department and made available to the Infection Prevention and Control Team and individual Clinical Units in a timely manner. The Learning & Development department will alert managers if their staff fail to attend training. Line Managers will follow up non-compliance as per the mandatory training policy. Attendance at infection prevention and control training will be performance managed by every Clinical Unit in order to achieve full compliance with Trust policy. There is a need to ensure awareness amongst employees on the relevance and application of this policy. The IPCT will provide training to highlight the key policy changes to the Infection Control Link Facilitators (ICLF). The ICLF will then disseminate the relevant changes to their ward/department colleagues.

23. Monitoring Arrangements

Monitoring is achieved through regular clinical audits along with a review of clinical incidents. Non-compliance will be addressed via the Clinical Units' governance process.

Matrons, Managers, and the Infection Prevention and Control Team will ensure training is carried out and provide individual support and education as required.

Compliance will be addressed via the Clinical Governance Processes.

Monitoring Compliance with the Document

Element to be Monitored	Lead	Tool for Monitoring	Frequency	Responsible Individual/Group/ Committee for review of results/report	Responsible individual/ group/committee for acting on recommendations/ action plan	Responsible individual/group/ committee for ensuring action plan/lessons learnt are Implemented
Compliance with Policy	IPCT	Audit	Annually	IPCT, Clinical Units Clinical Governance meetings	TIPCG	ICLF, HON, Matrons, ADNs
Mandatory and Ad hoc education and training	Learning and Development IPCT	Attendance Records	Quarterly	IPCT, Clinical units, Clinical Governance meetings	TIPCG	Matron, HONs, ADNs
Incident Reporting	IPCT / Head of Department		As required	IPCT, Clinical Units Clinical Governance meetings	TIPCG	IPCT, HON, Matrons, ADNs

24. References

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25. Equality and Human Rights Statement

The policy considers that staff conduct interventions which meet the needs of all patients and take steps to ensure they have understanding, even if English is not their first language or mental capacity may be indicated. If for any reason staff, patients or visitors require or request adjustment to the policy to meet their individual needs; these will be assessed on a case-by-case basis. It is the responsibility of the nurse in charge to refer to relevant person / team (e.g. IPCT, Clinical Site Manager). Information is available in alternative formats such as large print or electronically on request. Interpreters can also be booked. Please contact the Patient Advice and Liaison Service (PALS) offices, found in the main reception areas. In the event of an outbreak the IPCT carry out daily outbreak review liaising with clinical leads regarding impact on service. Clinical need and patient safety is assessed regularly and taken into account. Please see Appendix A EIA Form.

Equality Impact Assessment Form

1. Cover Sheet

Please refer to the accompanying guidance document when completing this form.

Strategy, policy or service name	Management of Patients with Respiratory Viral Infection
Date of completion	August 2023
Name of the person(s) completing this form	Helen Tingley
Brief description of the aims of the Strategy/ Policy/ Service	This policy aims to prevent the transmission of Respiratory Viral Infections within East Sussex Healthcare Trust (ESHT)
Which Department owns the strategy/ policy/ function	ESHT
Version number	Version 1.0
Pre Equality analysis considerations	Click here to enter text.
Who will be affected by this work? E.g. staff, patients, service users, partner organisations etc.	This policy applies to all hospital and contracted staff employed to care for patients within ESHT. This includes: employees, volunteers, agency/locum/bank staff and contractors whilst working on the Trust premises.
Review date	2025
If negative impacts have been identified that you need support mitigating, please escalate to the appropriate leader in your directorate and contact the EDHR team for further discussion.	
Have you sent the final copy to the EDHR Team?	Choose an item.

2. EIA Analysis

	😊 😐 😞	Evidence:																								
Will the proposal impact the safety of patients', carers' visitors and/or staff? <i>Safe: Protected from abuse and avoidable harm.</i>	Positive	This policy is designed to protect patients and staff from respiratory viral infection. It aims to prevent the spread of infection whilst patients are in hospital including staff who work in hospital and to protect the more vulnerable from contracting respiratory viral infection.																								
Equality Consideration <i>Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</i>		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>	Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐				
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Is the proposal of change effective? Effective: Peoples care, treatment and support achieves good outcomes, that staff are enabled to work in an inclusive environment. That the changes are made on the best available evidence for all involved with due regards across all 9 protected Characteristics	Positive	This policy is based on current guidance available for managing respiratory viral infections. See reference page.																								
Equality Consideration <i>Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</i>		<table><tr><td>Race</td><td>Gender</td><td>Sexual orientation</td><td>Age</td><td>Disability & carers</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><td>Gender reassignment</td><td>Marriage & Civil Partnership</td><td>Religion and faith</td><td>Maternity & Pregnancy</td><td>Social economic</td></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>	Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐				
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What impact will this have on people receiving a positive experience of care?	Positive	This policy aims to prevent patients and staff acquiring respiratory viral infection whilst in hospital. However, sometimes staff and patients can acquire respiratory viral infection outside of the hospital in the Community and bring the infection into hospital with them. This policy provides guidance on management of respiratory viral infections for staff and patients. Some patients may have to be isolated in single rooms if they have a respiratory viral infection which they may not like. They also may have to be cohorted in mixed sex bays. Staff will support these patients who do not want to be in isolation or cohorted with other patients by explaining the reason to the patient and their families as to why they are where they are.																								
Equality Consideration <i>Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</i>		<table><tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><th>Gender reassignment</th><th>Marriage & Civil Partnership</th><th>Religion and faith</th><th>Maternity & Pregnancy</th><th>Social economic</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>	Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐				
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Does the proposal impact on the responsiveness to people's needs?	Neutral	The policy looks to be responsive to patients needs i.e. if patients in isolation are lonely staff would help the patient to use the telephone to contact family.																								
Equality Consideration <i>Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)</i>		<table><tr><th>Race</th><th>Gender</th><th>Sexual orientation</th><th>Age</th><th>Disability & carers</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr><tr><th>Gender reassignment</th><th>Marriage & Civil Partnership</th><th>Religion and faith</th><th>Maternity & Pregnancy</th><th>Social economic</th></tr><tr><td>☐</td><td>☐</td><td>☐</td><td>☐</td><td>☐</td></tr></table>	Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐				
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What considerations have been put in place to consider the organisations approach on improving equality and diversity in the workforce and leadership?	Positive	The policy considers the needs of different staff groups and makes adjustments i.e. staff are fit tested, if they do not pass a fit test or are unable to wear a mask if they have a beard, respirator hoods are available to be worn.																								
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table border="1"> <tr> <td>Race</td> <td>Gender</td> <td>Sexual orientation</td> <td>Age</td> <td>Disability & carers</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Gender reassignment</td> <td>Marriage & Civil Partnership</td> <td>Religion and faith</td> <td>Maternity & Pregnancy</td> <td>Social economic</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> </table>					Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐
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Access Could the proposal impact positively or negatively on any of the following:																										
• Patient Choice	Negative	In order to manage respiratory viral infections we have to follow guidance and policy. Patients may not want to be isolated or cohorted. Staff would explain the reason to patients.																								
• Access	Neutral	All who are eligible that fit the criteria are managed the same.																								
• Integration	Neutral	All who are eligible that fit the criteria are managed the same.																								
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table border="1"> <tr> <td>Race</td> <td>Gender</td> <td>Sexual orientation</td> <td>Age</td> <td>Disability & carers</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Gender reassignment</td> <td>Marriage & Civil Partnership</td> <td>Religion and faith</td> <td>Maternity & Pregnancy</td> <td>Social economic</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> </table>					Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐
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Engagement and Involvement How have you made sure that the views of stakeholders, including people likely to face exclusion have been influential in the development of the strategy / policy / service:	Positive	This policy is based on National Guidance i.e. UKHSA, NICE, National Infection Control Manual which includes evidence from WHO, UKHSA, CDC.																								
Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)		<table border="1"> <tr> <td>Race</td> <td>Gender</td> <td>Sexual orientation</td> <td>Age</td> <td>Disability & carers</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> <tr> <td>Gender reassignment</td> <td>Marriage & Civil Partnership</td> <td>Religion and faith</td> <td>Maternity & Pregnancy</td> <td>Social economic</td> </tr> <tr> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> <td>☐</td> </tr> </table>					Race	Gender	Sexual orientation	Age	Disability & carers	☐	☐	☐	☐	☐	Gender reassignment	Marriage & Civil Partnership	Religion and faith	Maternity & Pregnancy	Social economic	☐	☐	☐	☐	☐
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Duty of Equality Use the space below to provide more detail where you have identified how your proposal of change will impact. Equality Consideration Highlight the protected characteristic impact or social economic impact (e.g. homelessness, poverty, income or education)	Neutral	The policy considers the needs of everyone with regards to the management of respiratory viral infection i.e. population groups who are more likely to experience health inequalities, the homeless, low incomes etc. Specific consideration and advice will be given as required, for some patients on discharge to help them manage respiratory viral infections like COVID-19 etc and the risk to others such as their families.																								
Characteristic	Rating 😊 😐 😞	Description																								
Race	Neutral	Ethnic groups may be more likely to experience poorer outcomes than others if they have respiratory viral infections such as COVID-19. The policy on the management of patients with respiratory viral infections aims to prevent infections by applying infection control measures.																								

Age	Positive	This policy is for all age groups and is to protect everyone including the more vulnerable, the elderly and very young. The majority of hospital in-patients are usually older, over 65, however respiratory viral infections affect everyone. Management and treatment is as per policy and guidance for everyone.
Disability and Carers	Positive	All patients with disabilities and their carers would be managed and treated as per guidance, the same as everyone else with regards to this policy. The trust has a Privacy and Dignity policy which is followed.
Religion or belief	Positive	This policy is for all patients and staff whatever their religion or belief. If they have special religious requirements advice would be sought from the Chaplaincy.
Sex	Neutral	Patients may be cohorted in mixed sex bays if side rooms are not available. This would be discussed with patients and their relatives. The Trust has a patient Privacy and Dignity policy in place.
Sexual orientation	Neutral	All patients are treated the same.
Gender re-assignment	Neutral	This policy treats all people the same with regards to management and treatment of respiratory viral infection.
Pregnancy and maternity	Positive	Patients on Maternity can be isolated in single rooms or cohorted in bays. This is discussed with the patients at the time. Management and treatment of respiratory viral infections is the same for pregnant women and those in maternity, as per guidance.
Marriage and civil partnership	Neutral	The policy treats everyone the same.

Human Rights

Please look at the table below to consider if your proposal of change may potentially conflict with the Human Right Act 1998

Articles		Y/N
A2	Right to life	N
A3	Prohibition of torture, inhuman or degrading treatment	N
A4	Prohibition of slavery and forced labour	N
A5	Right to liberty and security	N
A6 & 7	Rights to a fair trial; and no punishment without law	N
A8	Right to respect for private and family life, home and correspondence	N
A9	Freedom of thought, conscience and religion	N
A10	Freedom of expression	N
A11	Freedom of assembly and association	N
A12	Right to marry and found a family	N
Protocols		
P1.A1	Protection of property	N
P1.A2	Right to education	N
P1.A3	Right to free elections	N

Appendix B: Donning and Doffing of PPE

Guide to donning and doffing PPE: Droplet Precautions

for health and social care settings

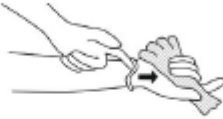
Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1 Put on your plastic apron, making sure it is tied securely at the back. 	2 Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin. 	3 Put on your eye protection if there is a risk of splashing. 	4 Put on non-sterile nitrile gloves. 	5 You are now ready to enter the patient area. 
---	---	---	--	--

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1 Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove. 	2 Perform hand hygiene using alcohol hand gel or rub, or soap and water. 	3 Snap or unfasten apron ties the neck and allow to fall forward. 	
Snap waist ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.			
4 Once outside the patient room. Remove eye protection. 	5 Perform hand hygiene using alcohol hand gel or rub, or soap and water. 	6 Remove surgical mask. 	7 Now wash your hands with soap and water. 

Please refer to the standard PPE video in the COVID-19 guidance collection:

www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

<https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures>

Appendix C: PPE when applying Transmission Based Precautions (TBPs)

Appendix 5b: Personal protective equipment (PPE) when applying transmission based precautions (TBPs)



SICPs may be insufficient to prevent cross transmission of specific infectious agents and additional precautions (TBPs) may be required. PPE must protect adequately against the risks associated with the procedure or task. Refer to appendix 11a for additional information.

Hand hygiene must be performed before putting on and after removal of PPE.

TBPs	Gloves	Apron	Gown	Fluid resistant surgical mask (FRSM)	Respiratory Protective Equipment (RPE)	Eye/face protection
Contact precautions	Unless exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated or footnote 1 applies ¹		Unless in place of an apron if extensive spraying or splashing is anticipated	Unless risk of splashing or spraying of blood or body fluids is anticipated or footnote 2 applies ²		Unless risk of splashing or spraying of blood or body fluids is anticipated
Droplet precautions			Unless in place of an apron if extensive spraying or splashing is anticipated			
Airborne precautions						

Where to put on and remove PPE

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

Contact precautions: required PPE should be put on within the patient room/care area immediately **before** direct contact with the patient or their environment and should be removed and disposed of **before** leaving the patient room/care area.

Droplet and airborne precautions: required PPE should be put on **before** entering the patient room/care area. Unless there is a dedicated isolation room with anteroom, gowns, aprons and gloves should be removed and disposed of before leaving the patient room/care area. Eye/face protection and RPE (if worn) must be removed and disposed of **after** leaving the patient room/care area.

1. Clinical risk assessment may also indicate the use of gloves for specific organisms such as scabies, multi-drug resistant organisms or those with increased potential for hand and environmental contamination such as spore forming organisms e.g. *C. difficile*. This list is not exhaustive.

2. Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

PPE requirements for high consequence infectious diseases should be discussed with specialist teams as per appendix 11b.

Appendix D: Testing for Influenza Protocol ESHT

N.B. testing might be ceased in outbreak situations, i.e., in an epidemic or pandemic.

Flu testing is only available for in-patients for reasons of infection control purposes.

Clinical Criteria for testing in-patients for Influenza

- Fever greater or equal to 38°C or history of fever AND flu-like illness (two or more of the following symptoms: cough, sore throat, rhinorrhoea, limb / joint pain, headache) within the last seven days **OR**
- Other severe / life threatening illness suggestive of an infective process.

When to test

- Ideally before commencing Tamiflu or within the first three days of treatment **OR**
- If symptoms persist or worsen beyond three days of treatment.

Specimens required:

- One swab of combined throat and nose samples using virology swabs.
- **A throat swab for babies in SCBU.**
- Swabs are available from Pathology (Microbiology). A small supply will be provided to the admission areas (ITU, MAU, SAU, Maternity and Paediatrics) once flu cases are regularly seen for admission.

Equipment required:

Personal Protective Equipment (PPE)

- Fluid-repellent surgical mask.
- FFP3 mask and face shield if on risk assessment it is likely you may receive droplet splash on your face and eyes (i.e. severe disease or patient coughing).
- Apron (or gown for severe disease and/or aerosol procedures).
- Gloves.

Other equipment

- Virology swabs
- 2 patient PAS labels.
- Microbiology request form with integral specimen bag.
- Specimen bag to double bag.
- Hand washing facilities.
- Clinical waste disposal facilities.

Taking the swabs (throat and nose)

- Using the virology swab, vigorously swab only the posterior pharyngeal wall (back) of the throat. Tilt the patients head back slightly, insert the same swab along the medial part of the nasal septum as far as possible (in parallel to skull base, see picture)



- Rotate the swab slightly several times, then remove.
- Insert the swab into the tube provided.
- Remove PPE and dispose in clinical waste.
- Wash hands.
- Label specimen and one copy of the Microbiology request form with patient PAS label.
- Double bag in specimen bag.
- Complete Microbiology request form fully including:
 - Clinical details (reason for admission and relevant underlying illness).
 - Symptoms relevant to testing.
 - Date of onset.
 - Any treatment and start date.
- Record in patient's medical and nursing notes date and time of specimen collection.
- Send to Pathology.

Processing, Results and Notification:

Processing: The Cepheid assay is a multiplex assay for COVID, Influenza and RSV. It does not identify H1N1 and solely reports Influenza A or Influenza B. Influenza tests are not performed out of hours. The test is available 8am – 8pm, 7 days a week on both sites. Typing is not performed routinely, and samples are only sent for typing at the request of the Consultant Microbiologist

Results: The test has a 2-hour turnaround time. It is not done on a once only basis, but the test is performed continuously throughout the day, as samples come in.

Notification: No results are phoned out; results are available on [REDACTED].

Informing of suspected or confirmed cases.

Inform the Infection Prevention and Control Team (IPCT) of any suspected or confirmed cases of respiratory infection on:

Eastbourne DGH: 735407

Conquest: 773305

Out of hour's contact the Clinical Site Manager regarding suspected cases who will contact the Consultant Microbiologist via the hospital switchboard if there are any concerns or queries.

At night: leave swab in specimen fridge in Pathology and inform as above the following morning.

The Consultant Microbiologist will inform Clinicians and the Infection Prevention and Control Team of any laboratory confirmed cases.

Revised July 2023

Appendix E: Staff Contact Letter



East Sussex Healthcare
NHS Trust

INFECTION PREVENTION & CONTROL DEPARTMENT

Dear Colleague

Contact with patient with infectious Influenza

You are a member of staff who was potentially in close contact (within 2 metres) with a patient known to have influenza during the infective period.

You are at risk of developing influenza if you did not take respiratory precautions whilst in close contact.

Were you in close contact (within 2 metres) of a suspected patient without you or the patient wearing respiratory mask? Yes / No

If the answer is 'No' to the above question, no further action is required.

If you answered 'Yes' to the above question, continue with the questions below

Are you over the age of 65?

Do you have any of the following conditions?

Chronic neurological disease (for example neuromuscular, neurocognitive and seizure disorders and learning disabilities)

Chronic hepatic disease (for example cirrhosis)

Chronic kidney disease (for example CKD requiring dialysis or transplantation)

Chronic pulmonary disease (for example COPD, asthma, cystic fibrosis)

Chronic cardiovascular disease (for example congestive cardiac failure, atherosclerotic disease)

Diabetes and adrenal insufficiency

Severe immunosuppression

Asplenia/splenic dysfunction

Pregnancy (including up to 2 weeks post-partum)

Morbid obesity (BMI ≥ 40)

If you answered 'Yes' to any of the above, please contact Occupational Health who will liaise with the Consultant Microbiologist to determine whether post exposure prophylaxis is indicated.

Occupational Health

Conquest – Ext. 734350 (or 0300 131 4350) or email: esh-tr.occupationalhealth@nhs.net

Alternatively, you can go to your GP for advice.

Regardless of answers to the above questions, or whether you have had influenza vaccine this season, if you should develop symptoms of influenza within 2-4 days of contact with this patient please remain off work and if required seek medical advice by telephone from your GP. Return to work when you feel well, this will be at least 7 days from onset date.

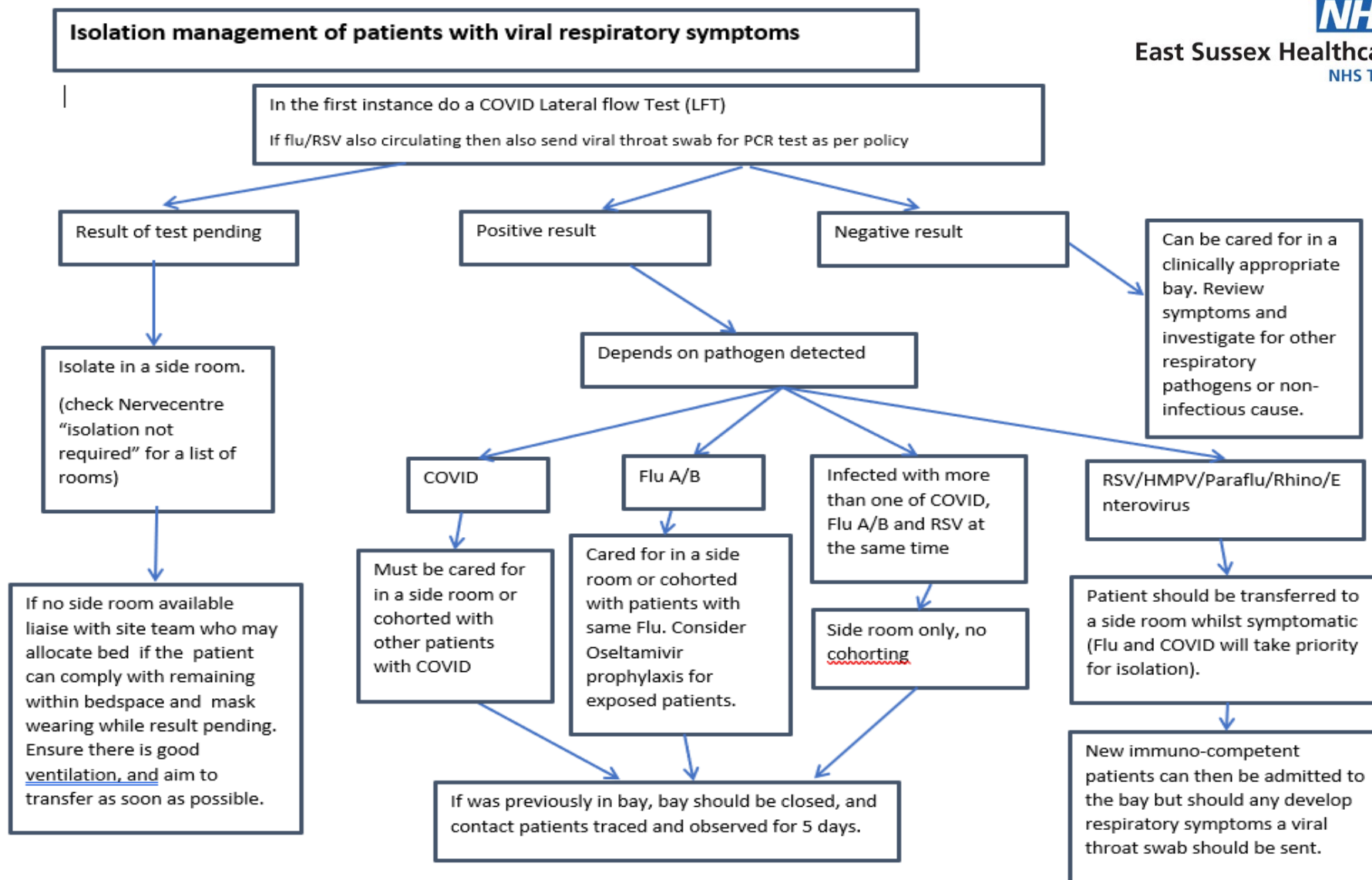
Clinical features of influenza include a rapid onset of cough and fever ($> 38^{\circ}\text{C}$). Other symptoms are headache, sore throat, a runny or stuffy nose, aching muscles and joints, and extreme tiredness. People are most infectious soon after they develop symptoms, although typically they can continue to excrete viruses for up to seven days.

The influenza virus is mainly transmitted from person to person through close contact. It is spread **via droplets** (released during coughing and sneezing with the range of about 2m) or through direct contact ('kissing contact').

Appendix F: Isolation Management Flowchart of Patients with Viral Respiratory Symptoms



East Sussex Healthcare
NHS Trust



Appendix G: Aide memoire for optimal patient placement and respiratory protective equipment (RPE) for infectious agents in hospital inpatients

Based on evidence from WHO, CDC and UKHSA. This appendix is taken from [The National Infection Prevention and Control Manual for England](#)

The clinical judgement and expertise of the IPC and Health Protection Teams should be sought for novel, unusual pathogens or where an increase in cases has been detected in any care setting. Advice can also be sought from the bacterial reference departments at UKHSA for rare / unusual pathogens, exceptional phenotypes or for advice regarding typing of outbreak strains.

The following table outlines the transmission-based precautions (TBPs) required for several infectious agents / diseases which will minimise cross transmission events from and between patients, and healthcare workers. The details included in the table below are drawn from published evidence from a number of validated sources, for example, WHO, CDC, and UKHSA. The table is intended to function as a quick reference guide, is not exhaustive, and is not intended to replace appropriate risk assessment and clinical judgement or formal assessments by public health agencies. The table summarises:

- Optimal patient placement while the patient is considered infectious; and
- The recommended RPE (recognising other PPE is required) to minimise risk of cross infection to staff, patients and visitors.
- Decisions made by staff regarding use/non-use of RPE will depend on the completion of clinical risk assessment, considering presenting symptoms, available treatments, the risk of acquisition, the level of interaction, task to be performed, and / or the anticipated level of exposure to blood and / or other body fluids.
- In the hospital setting patients with suspected or confirmed respiratory symptoms should, whenever possible, be placed in a single room, ideally with en-suite facilities. If a single / isolation room is not available, cohort patients with confirmed respiratory infection with other patients confirmed to have the same infectious agent. Patients with suspected or confirmed respiratory infection should be provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated, and where the patient cannot be isolated in a single room.

Note: *The distinction between droplet and aerosol transmission is not always clearly defined. A dynamic clinical risk assessment should be performed using the hierarchy of controls to inform the assessment and should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection in the local area. Staff should be provided with training on the correct use of RPE. Current guidance is that an FFP3 respirator must be worn by staff when caring for patients with a suspected or confirmed infection spread by the airborne route, when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet or airborne route, and when deemed necessary after risk assessment.

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010⁴
Acute infectious hepatitis of unknown aetiology	Acute hepatitis	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	Yes
Adenovirus ¹	Upper +/- lower respiratory tract infection	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No
	Conjunctivitis, gastroenteritis	Contact	Single en-suite room	No requirement for RPE	No
Bordetella pertussis	Whooping Cough	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs until patient has been established on appropriate antimicrobial treatment ⁵	Yes
Chlamydia pneumoniae	Pneumonia	Droplet	Single en-suite room in high-risk settings e.g. ICU/PICU/NICU, oncology/haematology	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious ³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010 ⁴
Coronavirus1 (Seasonal) including SARS- CoV-2	Respiratory symptoms including asymptomatic presentations COVID-19	Droplet/Airborne * please see note above	Single en-suite room	FRSM for routine care and FFP3 or Hood for AGPs* ESHT policy is for staff to wear FFP3 mask or hood for routine care.	No Yes SARS-CoV-2
Corynebacterium diphtheria or Corynebacterium ulcerans	Diphtheria – Cutaneous, Pharyngeal (toxigenic strains)	Contact, Droplet (If Pharyngeal)	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs (if pharyngeal)	Yes
Enterovirus D68	Mild to moderate upper respiratory tract infections. Can cause severe respiratory illness and rarely acute flaccid myelitis (AFM)	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No
Haemophilus influenzae (all invasive*)	Epiglottitis, *meningitis, pneumonia, *bacteraemia	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs until patient has been established on appropriate antimicrobial treatment ⁵	Yes *Only

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010⁴
Herpes zoster (Shingles) (varicella-zoster) 2	Shingles (vesicle fluid)	Contact	Single en-suite room If lesions cannot be covered.	No requirement for RPE	Notifiable organism but not notifiable disease
	Disseminated zoster	Airborne	Isolation room/suite	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	Notifiable organism but not notifiable disease
Influenza virus (Endemic strains)	Influenza	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	Yes
Measles virus ²	Measles (rubeola)	Droplet/ Airborne	Isolation room/suite	FFP3 or Hood for routine care and AGPs	Yes
Mumps virus ²	Mumps (infectious parotitis)	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	Yes

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010⁴
Mycobacterium tuberculosis complex	Extrapulmonary Tuberculosis	Contact	Single en-suite room	FFP3 or Hood for AGPs	Yes
	Pulmonary or laryngeal disease	Airborne	Isolation room/suite until patient has been established on appropriate antimicrobial treatment ⁵ and always if the patient has MDR or XDR TB	FFP3 or Hood for routine care and AGPs until patient has been established on appropriate antimicrobial treatment ⁵ and always if the patient has MDR or XDR TB	Yes
Mycoplasma pneumoniae	Pneumonia	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No
Neisseria meningitidis	Meningitis – meningococcal (Or presentation of clinical meningitis of unknown origin), septicaemia	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs until patient has been established on appropriate antimicrobial treatment ⁵	Yes

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010⁴
Parainfluenza virus ¹	Upper +/- lower respiratory tract infection	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No
Parvovirus B19 – (Erythema infectiosum – Erythrovirus B19)	Slapped cheek syndrome	Droplet	Single en-suite room until the rash+/- arthralgia has developed	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs (Not required if the rash+/- arthralgia has developed)	No
Pneumocystis jirovecii	Pneumonia	Droplet	Single en-suite room in high risk settings e.g. ICU/PICU/NICU, oncology/haematology	No requirement for RPE	No
Pseudomonas aeruginosa	Pneumonia, bacteraemia, wound or surgical site infections, catheter associated urinary tract infections, conjunctivitis in neonates	Droplet	Single en-suite room in high risk settings e.g. ICU/PICU/NICU, oncology/haematology	No requirement for RPE	No
Respiratory syncytial virus (RSV) ¹	Upper +/- lower respiratory tract infection	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	No

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious ³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010 ⁴
Rubella virus ²	German Measles	Droplet	Single en-suite room	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs	Yes
Streptococcus pneumoniae	Pneumonia	Droplet	Single en-suite room (until patient has been established on appropriate antimicrobial treatment ⁵)	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs until patient has been established on appropriate antimicrobial treatment ⁵	Yes
	Bacteraemia, meningitis, wound infection or infection in other normally sterile site	Contact	Single en-suite room (until patient has been established on appropriate antimicrobial treatment ⁵)	No requirement for RPE	Yes (presence in the wound is not notifiable)

Suspected or confirmed Pathogen	Disease	Transmission based precautions (TBPs) required	Optimal placement while patient is considered infectious and until resolution of symptoms	Respiratory protection (RPE) for healthcare workers while patient is considered infectious ³	Notifiable under Public Health Act 1984 and Health Protection Regulations 2010 ⁴
Streptococcus pyogenes (Group A Strep)	Respiratory infection	Droplet	Single en-suite room (until patient has been established on appropriate antimicrobial treatment ⁵)	Fluid resistant surgical facemask (FRSM) for routine care and FFP3 or Hood for AGPs until patient established on appropriate antimicrobial treatment ⁵	No
	Invasive Group A strep Bacteraemia, meningitis, wound infection/infection in other normally sterile site	Contact	Single en-suite room (until patient has been established on appropriate antimicrobial treatment ⁵)	No requirement for RPE	Yes
Varicella virus ² See Herpes Zoster	Chickenpox	Airborne	Isolation room/suite	FFP3 or Hood for routine care and AGPs	Yes

Footnote 1

In routine clinical practice healthcare workers do not commonly wear masks when dealing with patients presenting with the “common cold” or “influenza – like illness”. However, in a patient with undiagnosed respiratory illness where coughing and sneezing are significant features, or in the context of known widespread respiratory virus activity in the community or a suspected or confirmed outbreak of a respiratory illness in a closed or semi-closed setting, the need for appropriate respiratory and facial protection to be worn should be considered.

Footnote 2

In relation to childhood illnesses and use of RPE, no vaccine offers 100% protection and a small proportion of individuals acquire/become infected despite vaccination or known IgG immunity (previous infection). Vaccination is still the best protection against many infectious diseases. If staff are uncertain of their immunisation status, they should discuss this with their occupational health provider. It is recommended

that vaccinated individuals wear RPE as detailed in this appendix to minimise any residual risk, and to promote consistency in practice across all staff groups.

Footnote 3

The ocular route of transmission for pathogens spread by the droplet/airborne route while plausible lacks scientific evidence. This lack of evidence includes having very little certainty about what the incremental benefit of using eye protection routinely 59 | National infection prevention and control manual for England when using a FRSM/FFP3 respirator. Eye protection is considered to be necessary and worn if there is a risk of spraying or splashing of blood/body fluids from patient contact or procedure, and always when used with respirators during the performance of AGPs. This is line with published infection control guidance.

Footnote 4

Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local council or local health protection team (HPT) of suspected cases of certain infectious diseases. Complete a notification form immediately on diagnosis of a suspected notifiable disease. Don't wait for laboratory confirmation of a suspected infection or contamination before notification. Consult the [UKHSA Notifiable Diseases poster](#) for further information. Send the form to the proper officer within 3 days, or notify them verbally within 24 hours if the case is urgent by phone, letter, encrypted email or secure fax machine. If you need help, contact your local HPT using the postcode lookup. For more detail on reporting responsibilities of RMPs, see page 14 of [Health Protection Legislation \(England\) Guidance 2010](#). All proper officers must pass the entire notification to UKHSA within 3 days of a case being notified, or within 24 hours for urgent cases.

Footnote 5

Appropriate antimicrobial treatment will include the choice of treatment, dose, frequency and number of days of treatment. It will vary by organism and should be determined by the clinical team and informed by local and national prescribing guidance where available.

Footnote 6

Anthrax: during the bacteraemia phase split blood products should be removed immediately using sodium dichloroisocyanurate granules to prevent subsequent sporulation on contact with air / soil.

Appendix H: Management of Respiratory Testing

Please note testing may change depending on UKHSA guidelines.

Management of Respiratory Testing

The UK Health Security Agency (UKHSA) has published a revised approach to testing and surveillance for COVID-19, recommending that testing be offered only to individuals and settings at highest risk from COVID-19.

COVID-19 testing will continue as part of a diagnostic pathway if patients or staff are symptomatic. However, when it is required, testing has now moved from PCR to lateral flow tests (LFT). LFTs have proven to be effective, rapid, and safe. These tests are regularly monitored against new variants and continue to be effective at detecting COVID-19.

Seasonal use of PCR to detect common respiratory viruses such as RSV and Influenza as well as COVID will continue to be available and initiated as part of winter planning.

The revised guidance has been considered by the Clinical Advisory Group. Our local patient risk and vulnerability has been considered. As part of the assessment, the presenting clinical complaint of patients who tested positive during May 2023 was also reviewed to understand which of our patients are most likely to test positive for COVID.

The following symptoms will warrant testing for COVID.

- a high temperature or shivering (chills) – a high temperature means you feel hot to touch on your chest or back (you do not need to measure your temperature)
- a new, continuous cough – this means coughing a lot for more than an hour, or 3 or more coughing episodes in 24 hours
- a loss or change to your sense of smell or taste
- shortness of breath
- feeling tired or exhausted
- an aching body
- a headache
- a sore throat
- a blocked or runny nose
- loss of appetite
- diarrhoea
- feeling sick or being sick

Additional symptoms that also warrant testing to exclude COVID

- patients with new onset delirium
- patients who present with a *recent* history of falls/significant deterioration in mobility.
-

The approach will be reassessed if increased risk is identified or new guidance emerges.

Patient Testing

Patient Category	ESHT Testing from July 2023
Symptomatic adults/children admitted for emergency or planned care or developing symptoms within hospitals.	LFT Negative - further in lab, in hours Respiratory Virus PCR testing as per seasonal testing pathway (below). LFT Positive – If surgery required risk assess as per guidance below*. – high risk patients assessed for COVID- 19 monoclonal antibody and antiviral treatment.
Asymptomatic emergency, elective pathway (day case and overnight), and transfer of care admissions in all settings.	Adopt UKHSA guidance No routine asymptomatic testing. LFT may be used on the day for admission of asymptomatic patients in the following circumstances: • Admission to Haematology wards and Critical Care. • Admission for high-risk surgery. • Cardiology interventions requiring general anaesthesia. • Bronchoscopy and upper GI endoscopy.
Discharge of asymptomatic patients to other care settings, including care homes and hospices.	Adopt UKHSA guidance A single LFT within 48 hours before discharge from hospital.
Outbreak testing in healthcare settings.	Symptomatic patients - LFT. If negative further in lab, in hours Respiratory Virus PCR testing as per seasonal testing pathway. PCR for clinical diagnostic purposes for symptomatic patients where having COVID-19 will affect their clinical management. Asymptomatic contact patients –Isolate or cohort contacts. LFT on day 3 (or if needs to move for clinical reasons), then review by IPC. Isolation maximum 5 days if remains asymptomatic.

Release from isolation/stepdown respiratory precautions for previously symptomatic or positive patients in all settings.	Immunocompetent patients: Isolate minimum 5 full days. De-isolate/stepdown IPC precautions in the following circumstances: Clinical review on day 6, patient feels well and is afebrile for 48hrs. Or Two consecutive negative LFTs (24hrs apart) from day 5 and afebrile for >48hrs Or Day 10 is reached and there is some clinical improvement. Severely Immunocompromised patients: LFT daily from day 5 onwards. Step down IPC precautions if: - Two consecutive negative LFTs (24hrs apart), and afebrile for >48hrs Or - Day 14 is reached and there is some clinical improvement.
Asymptomatic transfers between or within hospitals.	No routine testing.

*COVID and Surgery

A multidisciplinary consensus statement on behalf of the Association of Anaesthetists, Federation of Surgical Specialty Associations, Royal College of Anaesthetists and Royal College of Surgeons of England had been published in July 2023. The risk of COVID for surgery has been reassessed. In summary:

“Patients who develop symptoms of SARS-CoV-2 infection within 7 weeks of planned surgery, including on the day of surgery, should be screened for SARS-CoV-2. Elective surgery should not usually be undertaken within 2 weeks of diagnosis of SARS-CoV-2 infection. For patients who have recovered from SARS-CoV-2 infection and who are low risk or having low-risk surgery, most elective surgery can proceed 2 weeks following a SARS-CoV-2 positive test. For patients who are not low risk or having anything other than low-risk surgery between 2 and 7 weeks following infection, an individual risk assessment must be performed.”

The full guideline can be viewed here:

[Timing of elective surgery and risk assessment after SARS-CoV-2 infection: 2023 update - El-Boghdadly - Anaesthesia - Wiley Online Library](#)

Staff Testing

If a staff member is symptomatic, they should not be at work

The new approach also includes changes for symptomatic staff testing, as set out in the table below.

Case Type	ESHT approach from July 2023
Symptomatic NHS staff who are not providing direct inpatient care to those who are severely immunosuppressed	No routine testing. No return-to-work testing. Staff come to work if feeling well enough and afebrile. Staff with minor cold symptoms should wear a facemask when with other staff and patients and observe good IPC precautions. A return-to-work LFT is not required unless the staff member is immunocompromised. If so, seek guidance from Occupational Health.
Symptomatic NHS staff providing direct care to inpatients who are severely immunosuppressed	LFT Negative – staff can attend work if well enough and are afebrile. Staff with minor cold symptoms should wear a facemask when with other staff and patients and observe good IPC precautions. Staff with respiratory symptoms should avoid interaction with severely immunocompromised patients where possible. LFT Positive - do not attend work for a minimum of 5 full days. Return when feeling well enough and afebrile. Discretion for return-to-work testing for staff working on these inpatient wards: - Pevensey ward - Pevensey Day Unit LFT available from: Order COVID-19 rapid lateral flow tests - GOV.UK (www.gov.uk)

¹ Severely immunocompromised refers to patients who are unlikely to mount an effective vaccine response, such as haemato-oncology and solid organ or stem cell or bone marrow transplant patients.

Points of Clarification

For a small cohort of staff caring for severely immunosuppressed patients, who will continue to test under the new approach, the actions they should take on receipt of a positive test will not change, as per UKHSA guidance.

Routine testing for asymptomatic staff was paused in August 2022 and remains in place.

All staff should follow the '[Managing healthcare staff with symptoms of a respiratory infection or a positive COVID-19 test result](#)' and [COVID-19: information and advice for health and care professionals](#) guidance.

Staff who are working in a clinical area should wear appropriate PPE as directed by Trust policy and the national Infection Prevention and control manual ([NHS England » National infection prevention and control manual \(NIPCM\) for England](#)).

'Staff who provide direct care to inpatients' includes any staff who work predominantly in a clinical ward or department where patients are being seen or cared for.

CPAP and BiPAP are not classed as aerosol generating procedures.
https://www.england.nhs.uk/wp-content/uploads/2022/04/C1632_rapid-review-of-aerosol-generating-procedures.pdf

Lab based PCR will only be used for symptomatic patients with a negative lateral flow or clinician request to direct treatment. It will not be used to confirm lateral flow unless directed by an infection specialist. Please follow ESHT Respiratory virus testing of adults and children (below).

Please continue to order LFTs via the procurement link on the Extranet. Avoid over ordering as tests may have a short shelf life. Procurement will continue to monitor supply.

COVID-19 TESTING

of non-elective and elective patients requiring admission to hospital

*and not for
haematology,
critical care,
cardiology with GA,
high risk surgery,
Bronchoscopy or
upper GI endoscopy

Asymptomatic*

NO TEST

Symptomatic

Lateral Flow Test

*** note that if this
patient is placed in a
bay with covid patients
and they turn out to be
negative, they would
have been exposed and
likely would need to
stay in the covid area
despite being negative.

LFT Negative
& low clinical suspicion

Admit to a suitable
non COVID19 bed. If
COVID symptoms develop retest
LFT

LFT Negative but
high ***
clinical suspicion

^COVID PCR and other
relevant tests to identify
infection 8am-8pm

Positive

Admit to a suitable COVID-19 bed
and agree treatment plan
or additional PCR^

Agreed at CAG July 2023

Please note: this flowchart is subject to change. Please check for updates on the extranet.