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Guidance

9. COVID-19 infection prevention and control guidance: medium risk pathway - key principles

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This publication is available at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-guidance-medium-risk-pathway-key-principles

This pathway applies to any care facility where:

a) Triaged/clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 test result.

OR

b) Triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified.

OR

c) Testing is not required or feasible on asymptomatic individuals and therefore infectious status is unknown.

OR

d) Asymptomatic individuals decline testing.

9.1 Maintaining physical distancing and patient placement

It is important to:

- maintain physical distancing of 2 metres at all times (unless the member of staff is wearing appropriate PPE to provide clinical care) and advise other patients/visitors to comply
- ensure cohorted patients/individuals are physically separated from each other, for example with screens and privacy curtains between the beds to minimise opportunities for close contact. This should be locally risk assessed to ensure patient safety is not compromised

9.2 Personal protective equipment: patients/individuals with no COVID-19 symptoms and no test results

PPE required by type of transmission/exposure	**Disposable gloves**	**Disposable apron/gown**	**Face masks**	**Eye/face protection (visor*)**
Droplet/Contact PPE for direct patient care <2 metres	Single use	Single use apron (gown required if risk of spraying/ splashing)	FRSM Type IIR†	Single use or re-usable*
Airborne PPE (When undertaking or if AGPs are likely)	Single use	Single use apron or gown	FFP3†† or Respirator/ Hood for AGPs	Single use or re-usable

† FRSM can be worn sessionally if providing care for COVID-19 cohorted patients/individuals.

††FFP3 can be worn sessionally (includes eye/face protection) in high risk areas where AGPs are undertaken for COVID-19 cohorted patients/individuals.

*Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes below single use/reusable.

9.3 Safe management of care environment/equipment/blood and body fluids

9.3.1 Equipment

Important considerations in the use of equipment are:

- patient care equipment should be single-use items where practicable
- reusable (communal) non-invasive equipment should be allocated to an individual patient or cohort of patients/individuals
- all reusable (communal) non-invasive equipment must be decontaminated:
  - between each and after patient/individual
  - after blood and body fluid contamination
  - at regular intervals as part of routine equipment cleaning
- decontamination of equipment must be performed using either:
  - a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
  - a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl.
- alternative cleaning agents/disinfectant products may be used with agreement of the local infection prevention and control (IPC) Team/health protection team (HPT)
- cleaning of care equipment as per manufacturers guidance/instruction and recommended product ‘contact time’ must be followed for all cleaning/disinfectant solutions/products
- an increased frequency of decontamination should be considered for all reusable non-invasive care equipment when used in isolation/cohort areas
- the use of fans in high and medium risk pathways should be risk assessed. Refer to Estates guidance

9.3.2 Environment

Important considerations for environmental cleaning and disinfection are:

- cleaning frequencies of the care environment in COVID-19 care areas must be enhanced and single rooms, cohort areas and clinical rooms (including rooms where PPE is removed) cleaned at least twice daily
- routine cleaning must be performed using either:
  - a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
  - a general-purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm av.cl
- alternative cleaning agents/disinfectants may be used with agreement of the local IPC/HPT

- the increased frequency of decontamination/cleaning should be incorporated into the environmental decontamination schedules for all COVID-19 areas, including where there may be higher environmental contamination rates, including for example:
    - toilets/commodes particularly if patients/individuals have diarrhoea
    - ‘frequently touched’ surfaces such as medical equipment, door/toilet handles, locker tops, patient call bells, over bed tables, bed rails, phones, lift buttons/communal touch points and communication devices (for example, mobile phones, tablets, desktops, keyboards) particularly where these are used by many people, should be cleaned at least twice daily with solution of detergent and 1000ppm chlorine or an agreed alternative when known to be contaminated with secretions, excretions or body fluids
- dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination
- reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant or locally agreed disinfectant
- single (isolation) rooms must be terminally cleaned as above following resolution of symptoms, discharge or transfer (this includes removal and laundering of all curtains and bed screens)

9.4 Aerosol generating procedures (AGPs): procedures that create a higher risk of respiratory infection transmission

AGPs should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE/ respiratory protective equipment (RPE) precautions (see information in the high risk pathway guidance (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-infection-prevention-and-control-guidance-high-risk-pathway-key-principles).

Critical care areas

Droplet precautions apply. However, consideration may need to be given to the application of airborne precautions where the number of cases of suspected/confirmed COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms.

Operating theatres

Patients/individuals should be anaesthetised and recovered in the operating theatre if intubation/extubation (AGP) is required. For local, neuraxial or regional anesthesia the patient is not required to be anaesthetised/recovered in theatre.

9.5 Duration of transmission based precautions

Transmission based precautions should only be discontinued in consultation with clinicians and should take into consideration the individual’s PCR test results and clinical symptoms. If test results are not available (for example the patient/individual declines) TBPs can be discontinued after 14 days (inpatients) depending on contact exposure and providing the patient/individual remains symptom free.

9.6 Visitor guidance

Visiting has been limited during increases in incidence and prevalence of COVID-19, however as cases decline and restrictions ease, visitors should be permitted to enter the facility and be educated in the IPC measures required as outlined in the information on administration measures for the pathways (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/care-pathways#IPCmeasures). All visitors should be triaged.

This includes accompanying individuals when attending outpatient appointments such as, antenatal appointments and therapy groups.

9.7 Discharge or transfer

There is no restriction on discharge if the patient/individual is well, unless the patient/individual is entering a long-term facility and testing may be required. If someone in the patient's household has COVID-19 or is a contact of a COVID-19 case and is self-isolating, the discharge guidance will be provided by the clinician.

Discharge information for patients/individuals should include an understanding of their need for any self-isolation, as well as their family members (where applicable).

Ambulance services and the receiving facilities must be informed of the infectious status of the individual.

Discharge arrangements may differ between countries, Refer to country specific information.

In England, to ensure testing does not delay a timely discharge to a care home, all patients who have previously tested negative should be re-tested for SARS-CoV-2 again 48 hours prior to discharge. Immunocompetent patients who have tested positive within the previous 90 days, and remain asymptomatic, do not need to be re-tested. The information from the test results, with any supporting care information, must be communicated and transferred to the relevant care home. No-one should be discharged from hospital directly to a care home without the involvement of the local authority.

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