# RESPIRATORY TRACT INFECTION (SUSPECTED OR CONFIRMED) POLICY

| | POLICY |
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| **Reference** | ICP 33 | | |
| **Approving Body** | Infection Prevention and Control Committee | | |
| **Date Approved** | 13/04/2021 | | |
| **For publication to external SFH website** | **Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:** | | |
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| | **X** | | |
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| **Summary of Changes from Previous Version** | *Added in link to COVID 19 Pneumonia treatment Guideline* | | |
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| **Date of Completion of Equality Impact Assessment** | 01.02.2021 | | |
| **Date of Environmental Impact Assessment (if applicable)** | 01.02.2021 | | |
| **Legal and/or Accreditation Implications** | In accordance with Public Health England and NICE Guidance | | |
| **Target Audience** | Trust wide | | |
| **Review Date** | April 2024 | | |
| **Sponsor (Position)** | Director of Infection Prevention and Control | | |
| **Author (Position & Name)** | Nurse Consultant for Infection Prevention and Control, Sally Palmer | | |
| **Lead Division/ Directorate** | Diagnostics and Outpatients | | |
| **Lead Specialty/ Service/ Department** | Infection Prevention and Control Team | | |
| **Position of Person able to provide Further Guidance/Information** | Infection Prevention and Control Team | | |

| **Associated Documents/ Information** | **Date Associated Documents/ Information was reviewed** |
|---|---|
| Not Applicable | Not Applicable |
| Template control | June 2020 |

## CONTENTS

## 1.0 INTRODUCTION

Respiratory infections are common, principally causing colds in both adults and children. Most are fairly mild, self-limiting and confined to the upper respiratory tract. These microorganisms can progress and cause more severe infections and even death. There are many viral causes of respiratory infection; with the most common ones seen in the Trust being pertussis (whooping cough), rhinoviruses, respiratory syncytial virus (RSV), influenza viruses' types A, B and C, para-influenza viruses. Some viruses to be aware of include Human Metapneumonvirus and the Coronavirus infections COVID-19, Severe Acute Respiratory Syndrome (SARS) and Middle East Respiratory Syndrome Coronavirus (MERS-CoV). These can cause severe illness requiring higher level precautions. It is likely that other respiratory illness will emerge elsewhere in the world and details of the presentation and epidemiology made available by the World Health Organisation and Public Health England as soon as possible.

Bacteria may cause lower respiratory tract infections, secondary to an initial viral infection. Outbreaks of respiratory virus infection are associated with increased hospitalisations and mortality. People with compromised immune, cardiac and/or pulmonary systems are at increased risk of serious complications of infection.

## 2.0 POLICY STATEMENT

To ensure patients with respiratory infections are cared for appropriately and actions are taken to minimise the risk of cross- infection and severe infection.
This clinical document applies to:

- All staff that enter clinical areas
- All patients cared for within our services

## 3.0 DEFINITIONS/ ABBREVIATIONS

### 3.1 Definitions

| | |
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| **Trust** | Sherwood Forest Hospitals NHS Foundation Trust |
| **Staff** | All employers of the Trust including those managed by a third party on behalf of the Trust |
| **Immunocompromised** | A term applied to patients whose immune mechanisms are deficient |
| **Neutropenia** | Refers to a neutrophil count of less than 0.5 |
| **Infection** | Host reaction to organisms lodging and multiplying in the tissue e.g. abscesses, wound infections or chest infections. The host exhibits symptoms of infection for example temperature of >38°C and associated symptoms at/in the site of infection i.e. inflammation, accumulation of pus, diarrhoea. |
| **Hazard Group Pathogens** | Causes severe human disease and is a serious hazard to Employees, it is likely to spread to the community and there is usually no effective prophylaxis or treatment available. |
| **HCAI** | Healthcare associated infections are any infection that arises as a result of healthcare regardless of the care setting. It includes hospital, primary and community care acquired infections. |
| **HAI** | Hospital acquired infection is any infection that arises as a result of hospital care. |

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| **IPC** | Infection prevention and control processes to prevent and reduce to an acceptable minimum the risk of the acquisition of an infection amongst patients, healthcare workers and any others in the healthcare setting. |
| **Isolation of patients** | The aim of patient isolation or single room care is to contain and prevent the spread of potential or known pathogenic or epidemiologically important organisms in order to reduce the risk of transmission of infection to and from patients, visitors or staff. |
| **Communicable disease** | Infection which is capable of spreading from person to person. Spread of infection is usually spread by one of the following means:<br>1) Direct contact: with contaminated blood, or body secretions particularly by staff hands that have become contaminated by body or body contact, and by transfusion of contaminated blood.<br>2) Indirect contact: through equipment such as razors, needles, other equipment such as bedpans, commodes, beds.<br>3) Airborne: contaminated skin scales, aerosol spread via droplets from coughing and sneezing.<br>4) Vectors: third parties such as cockroaches, fleas, flies, mosquitoes can carry infectious agents. |
| **Respiratory syncytial virus** | The commonest cause of severe respiratory illness such as bronchiolitis (inflammation of the bronchioles) in young children aged less than 2 years. It is also the commonest cause of hospital admissions due to acute respiratory illness in children. |
| **Human metapneumovirus** | The most severe form of inherited deficiency of immunity, affected infants are unable to mount either t-cell responses or produce antibody against infectious agents. |

### 3.2 Abbreviations

| | |
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| **RTI** | Respiratory Tract Infection |
| **HCAI** | Healthcare Associated Infection |
| **HAI** | Hospital Acquired Infections |
| **IPCT** | Infection Prevention and Control Team |
| **DIPC** | Director of Infection Prevention and Control |
| **IPCD** | Infection Prevention and Control Doctor |
| **IPCN** | Infection Prevention and Control Nurse |
| **IPCC** | Infection Prevention and Control Committee |
| **RSV** | Respiratory syncytial virus |
| **SARS** | Severe Acute Respiratory Syndrome |
| **CNH** | Central Nottinghamshire Hospital Plc |
| **SFS** | Skanska Facilities Services |
| **CCDC** | Consultant in Communicable Disease Control |
| **DH** | Department of Health |
| **NaDCC** | Sodium Dichloroisocyanurate |
| **NOID** | Notification of infectious diseases |
| **AGP** | Aerosol generating procedures |
| **CVC** | Central venous catheter |
| **PICC** | Peripherally inserted central catheter |

## 4.0 ROLES AND RESPONSIBILITIES

### 4.1 Trust Board
The Trust Board has overall responsibility for ensuring there are effective strategic, corporate and operational arrangements in place to maintain effective infection prevention and control programme and that appropriate financial resources are place to support that programme.

### 4.2 Chief Executive
The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

### 4.3 Director of Infection Prevention and Control
The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

- Ensuring that there are effective and appropriate arrangements in place for the isolation of patients when required
- Funding additional resources necessary to prevent/control an outbreak as appropriate
- Ensuring that the provision of existing isolation facilities or single rooms are not compromised by future service developments and ward reconfigurations

### 4.4 Infection Prevention and Control Team
The Infection Prevention and Control Team (IPCT) will inform and support all staff in relation to the identification, and management requirements of patients with suspected/known infection. The IPCT are also responsible for:

- Providing education to clinical staff on the early detection of possible infectious conditions and possible outbreaks
- Communicating up to date information relating to isolation issues and outbreaks to appropriate personnel within the Trust
- Advising and co-ordinating the appropriate action to be taken to isolate patients and prevent/limit hospital outbreaks

### 4.5 Chief Operating officer
Chief Operating Officer (COO) will ensure that the divisions have well developed clinical governance forum which monitors the application of this policy.

### 4.6 General Managers/Divisional Nurse/Clinical Leads
These Managers will ensure that the necessary management arrangements and structures are in place to support all employees to fulfil their obligations in their role of infection prevention and control practices.

### 4.7 Duty Nurse manager
They are responsible for:

- Adhering to the isolation priority scoring system (ICP31) and prioritises patients accordingly
- Liaising with ward staff to ensure that patients are placed appropriately within isolation/single rooms where possible
- Where the above is not possible due to limited availability, liaising with ward staff to ensure that a risk assessment is undertaken in conjunction with IPCT to identify the most appropriate and safe placement of the ‘infected’ patient
- Facilitating the movements of patients requiring isolation to other wards where appropriate

- Ensuring that patients admitted with neutropenic sepsis are admitted into bespoke isolation rooms (Side room 1), if this is not available then to a normal side room

### 4.8 Matrons

Matrons are responsible for ensuring that all staff accountable to them are aware of this policy and adhere to its statement. They will actively promote and support all current infection prevention and control measures.

### 4.9 Ward Sister/Charge Nurses/Departmental Lead

They will act as excellent role models and are responsible and accountable for infection prevention and control within their sphere of responsibility. They will ensure that all staff are aware of all relevant infection prevention and control measures. They are also responsible for:

- Ensuring dissemination of this policy
- Ensuring compliance with this policy and ensuring patient safety is maintained
- Facilitating the delivery of education provided by the IPCT
- Ensuring staff in their area have the knowledge and skills to work safely
- Co-ordinating staff, linen and gloves supplies etc during an outbreak
- Taking action when staff fail to follow the principles of this policy

### 4.10 Infection Prevention and Control Link Representatives

Infection Prevention and Control Link Representatives will disseminate all relevant infection prevention and control information to staff within their own work environment.

### 4.11 Occupational Health

The Trust Occupational Health Department is responsible for:

- Alerting the IPCT of any infectious conditions amongst Trust employees that could be transmitted during the course of their work
- Participating in the contract tracing of staff exposed to infectious conditions as applicable
- Co-ordinating staff treatment of any infectious disease
- Reporting of any staff symptoms during an outbreak

### 4.12 Clinical Team

Clinical teams are responsible for the prompt notification of infectious diseases to the Public Health England (PHE), communicating to the IPCT details of patients known or suspected of having an infectious disease or who are at an increased risk of acquiring an infection, and ensuring that they comply with this policy.

### 4.13 All Staff

All staffs are responsible for:

- Implementing standard infection prevention and control precautions for all patients and abiding by the guidance of this policy
- Providing the special requirements for the management of patients with specific infections that are either known or suspected or for the management of patients who are at an increased risk of acquiring an infection
- Gaining the appropriate lawful consent prior to examination, treatment or care and where necessary undertaking a two stage test and planning care in a patient's best interests as required.

### 4.14 Strategic Planning and Commercial Development Division

Strategic Planning and Commercial Development Division along with Central Nottinghamshire Hospital Plc (CNH) and Skanska Facilities Services (SFS) are responsible for ensuring the on-going maintenance of the ventilation systems and the general environment of the isolation rooms and side rooms used for the purpose of isolation.

### 4.15 Medirest

Medirest, as the Trust cleaning contractors are responsible for:

- Ensuring that the room/bed space used for patients with known or suspected infections are cleaned daily
- Ensuring that the room/bed space used for patients with known or suspected infections are clean according to the Cleaning guidance: Isolation Level Clean' specifications following the discharge/transfer of the patient
- Ensuring that the room/bed space is cleaned in accordance with the cleaning guidance: Isolation Level Clean' specifications prior to the admission of a patient who requires protective isolation
- Ensuring that all healthcare cleaners have the knowledge and skills required to undertake daily and isolation cleaning of single rooms used for isolation purposes
- Ensuring that all Medirest staff comply with this policy

## 5.0 APPROVAL

Following appropriate consultation this policy (v3.0) has been approved by the Infection Prevention and Control Committee.

## 6.0 DOCUMENT REQUIREMENTS

A respiratory tract infection (RTI) is an infection process affecting any part of the upper and/or lower airways. Symptoms of RTI can include any of the following: fever, rhinorrhoea (runny nose), sore throat and cough, limb or joint pain, headache, lethargy, chest pain and breathing difficulty. They can infect any age group although the severe complications of such infections are often restricted to children and the elderly. These viruses are most commonly transmitted by airborne droplets or nasal secretions and can lead to a wide spectrum of illness.

### 6.1 When to contact the Infection Prevention and Control Team

The IPCT **must** be informed about:

- Suspected or confirmed respiratory infections i.e. Influenza, pertussis (whooping cough) and COVID-19
- Suspected or confirmed respiratory infections from patients that have recently travelled to countries with infections alerted by external agencies (WHO/PHE)
- Potential outbreaks so that advice about appropriate isolation of patients can be given
- Where side rooms are not available for patients requiring isolation
- When patients required to be cared for in the bespoke isolation room (side room with the lobby and separate ventilation) rather than a standard side room

### 6.2 Notification of Infectious Diseases

Certain diseases (or suspicion of) are notifiable by law to the Consultant in Communicable Disease Control (CCDC) at the Public Health England (PHE). The clinician who considers or diagnoses the infection is responsible for the notification. The Trust IPCT and/or the Infection Prevention and Control Doctor (IPCD) must also be informed of these disease/infections. The notification of infectious diseases (NOID) forms can be obtained via the Trust Infection Prevention and Control web page. However serious notifications must be made by telephone in the first instance followed by written notification. East Midlands Public Health England Centre contact details are: Public Health England East Midlands Seaton House, City Link, London Road, Nottingham, NG2 4LA.
Telephone: **0344 225 4524 option 1**

### 6.3 Increased risk of developing complications

Some individuals will be more at risk of developing complications, typically pneumonias from RTIs:

- People aged 5 to 65 years with:
    - chronic lung disease
    - chronic heart disease
    - chronic kidney disease
    - chronic liver disease
    - chronic neurological disease
    - immuno-suppression (whether caused by disease or treatment)
    - diabetes mellitus
- Pregnant women
- Young children under 5 years old
- People aged 65 years and older
- Haematology patients; all respiratory viruses pose a risk to clinical haematology patients as they can cause severe viral pneumonitis and may lead to secondary bacterial infections

### 6.4 What to do if you have a patient with suspected viral respiratory infection

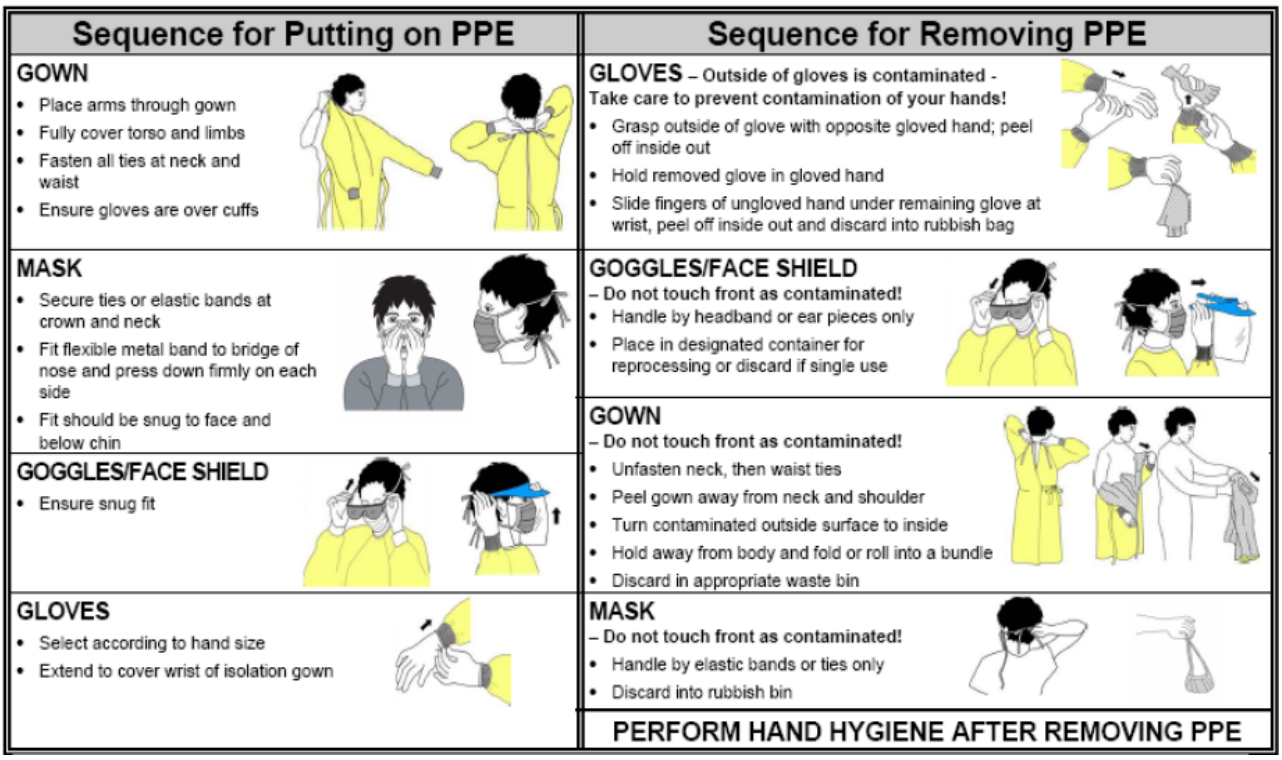
All adults and children admitted with signs and symptoms of a viral upper respiratory tract infection must be care for under source isolation with respiratory isolation precautions in place. All patents should be screened for COVID-19, following the latest swabbing guidance. Patients should be screened for recent travel to countries known to have any incidence of Severe Acute Respiratory Syndrome (SARS), Middle East Respiratory Syndrome Coronavirus (MERS-CoV), Human Metapneumonvirus. Inform the Infection Prevention and Control Team (IPCT)/Consultant Microbiologist, who will advise on which viral screening will be required, the throat swabs are obtained from the microbiological laboratory. Remember that a normal chest x-ray does not rule out respiratory virus infection. It is vital that visitors with signs and symptoms of a viral upper respiratory tract infection are encouraged not to visit, a full explanation must be provided to them, to ensure that they are aware of the potential risk to their relative and others within the hospital environment.

### 6.5 General management of patients with viral respiratory infection

This section should be read in conjunction with ICP 31 Isolation precautions for patients with confirmed or suspected infectious illness policy. Regular assessment and evaluation of the situation is required, in conjunction with the medical staff, the IPCT to decide if isolation remains the most appropriate form of care.

- **Isolation:** source isolation with respiratory isolation precautions. Respiratory Precautions sign must be placed on the door and the door kept closed. The physical isolation of a person for medical reasons is one element, however it is important to remember that an isolation room is only part of the process in dealing with individual patients suspected or known to have a respiratory infection. Negative pressure rooms (bespoke side room) **are not** required for most microorganisms but are of particular value when dealing with highly infectious airborne agents e.g. SARS, Novel coronavirus. Psychological support and reassurance must also be given to the patient whilst in isolation
- **Hand hygiene:** hand washing before and after contact with the patient is the single most important measure in preventing the spread of infection. Hands must be washed after the removal of PPE. For COVID 19 hand hygiene follow the Donning and Doffing guidance. Alcohol based hand rub for hand decontamination must be available both in the room (except under enteric precautions) and outside the isolation room
- **Personal protective equipment (PPE):** must be worn when entering the room and for prolonged direct contact, which involves a disposable plastic apron and non-sterile gloves, and when handling blood or body fluids and secretions. For COVID 19 follow the Donning and Doffing guidance.
    - Exclusions, this policy does not cover the use of PPE for category 4/Hazard Group 4 pathogens. Recommendations will be available from the IPCT and the Advisory Committee on Dangerous Pathogens
- **Sterile glove:** sterile glove must be worn for aseptic techniques or when handling all invasive device for neutropenic patients, and when handling parenteral feeding via a central venous catheter (CVC) or a peripherally inserted central catheter (PICC)
- **Mask:** masks are not generally necessary; However during the COVID 19 Pandemic follow the guidance on mask wearing. Advice should be sought from IPCT if in doubt.
- **Eye Protection:** to be worn if mandated by the current Trust PPE guidance.

- **Removing PPE:** make sure that neither the environment outside of the isolation room, not other persons can be contaminated from the use of PPE
    - Remove PPE in a manner that prevents self-contamination or self-inoculation with contaminated PPE or hands
    - Discard disposable items immediately into a foot controlled lidded clinical waste bin
    - Remove the most heavily contaminated items first i.e. gloves
    - If wearing full PPE, the last items to be removed must be eye protection and the face mask
    - Hand hygiene must be performed immediately after the removal of PPE
    - For COVID 19 follow the Donning and Doffing guidance




- **Patient's personal hygiene**: must be of a high standard, to prevent skin colonisation or infection. Liquid soap or shower gel should be used rather than bars of soap. It is important that the patient receive education on good hand hygiene practices, including washing hands before eating and after toileting. Dental hygiene must be performed at least twice a day. When shaving an electric razor is preferred to a wet razor, which **must** be the patient's own razor and not a communal one
- **Equipment:** where ever possible equipment should be single patient use or single use, where this is not possible equipment must be thoroughly cleaned with a Clinell® Universal wipe while being used within the room (refer to last section for discharge cleaning)
- **Laundry:** nightwear and bed linen must be changed daily and when soiled. Linen must be disposed of at the point of use. Used linen must be placed into a red alginate bag inside the room, and then placed in a white plastic laundry bag outside of the room
- **Waste: c**linical waste must be placed into a clinical waste bag inside the room, the bag must be sealed and labelled in the room prior to being removed and taken to the ward waste hold
- **Patient charts/notes:** patient's charts and notes must be kept outside of the isolation room/area

- **Cutlery and crockery:** the use of disposable cutlery or crockery is not required. Patients can use normal cutlery and crockery, the risk of cross infection from these is minimal if they have been thoroughly washed in a dish washer (thermal disinfection). **They must not be washed by hand**

- **Visitors**: must be instructed to wash their hands on entering the room. Exclude those with any infection, or who have been in contact with infection. During the neutropenic phase, visitors must be advised to keep to two visitors at a time, children especially young children should be discouraged form visiting as they often have minor infections. This needs to be balanced with the psychological needs of the patient and their family

- **Cleaning of source isolation rooms:** A high standard of cleanliness as a daily minimum must be maintained by damp dusting, for the duration of the isolation using the micro-fibre system must continue to be used. A peracetic acid based product is used in conjunction with the micro-fibre system for all surfaces (Medirest staff). Nursing staff wipe bed frame and nursing/medical equipment with Clinell® universal sanitising wipes. Commodes to be cleaned with Clinell® wipes after each use)

### 6.6 Respiratory precautions

Respiratory precautions can be divided into droplet precautions, airborne precaution and aerosol generating procedure (AGP) precautions.

**Droplet precaution:** are designed to minimise the transmission of respiratory pathogens from infected patients to the mucous membranes of susceptible persons. They are used to prevent the transmission of infectious diseases over short distance through the air i.e. pulmonary tuberculosis, chickenpox, and influenza. A single room must be used

**Airborne precaution:** are designed to prevent transmission of infectious agents that remain infectious when suspended in the air and can travel over long distances. Unless an AGP is performed this mode of transmission is not considered important in the transmission of respiratory pathogens causing RTIs.

- Visitors and members of staff from other department must report to the Nurse-in-Charge before entering the room
- Patients should not leave the room to attend other departments without prior arrangements
- The door of the room must be kept closed at all times unless the clinical need of the patient dictates otherwise
- Instruct symptomatic persons to cover mouth/nose when sneezing/coughing, use tissues and dispose in non-touch receptacle, observe hand hygiene after soiling of hands with respiratory secretions
- Don appropriate PPE prior to entering and removed prior to leaving the isolation/single room, and disposed of as clinical waste
- During aerosol generating procedures on patients with suspected or proven infections transmitted by respiratory aerosols (i.e. influenza, SARS, Coronavirus), wear a fit tested FFP3 in addition to gloves, repellent gown (not apron) and eye protection
- Hands must be washed with soap and water and then disinfected with an alcohol based hand rub before entering the room, after patient contact, after contact with potentially infected materials and after removal of PPE
- Respiratory hygiene/cough etiquette (catch it, bin it, kill it). Patient should be instructed to follow the recommendations for respiratory hygiene/cough etiquette. Use a disposable, single use tissue to cover mouth and nose when coughing, sneezing, wiping or blowing noses. The tissue must be disposed of promptly and hands washed immediately.

**Aerosol generating procedures precautions**

- a full face shield over the standard eye protection (not instead of)
- full body disposable water repellent gown
- FFP3 respiratory; any healthcare staff required to wear an FFP3 respiratory must have undertaken FFP3 respiratory fit testing prior to using it
- only those healthcare staff who are required to undertake the procedure should be present

- staff must be careful to contain he area of contamination, as these procedures can produce high concentrations of virus in the air and on environmental surfaces
- in the event of a breach in infection control procedures for instance incorrectly worn FFP3 respiratory during an AGP, staff must be reviewed by occupational Health

The evidence necessary to establish which aerosol generating procedure (AGPs) are associated with transmission of respiratory pathogens is poorly establish and mostly anecdotal (PHE 2021). From the available literature and incorporating UK expert opinion, the following procedures are considered likely to generate aerosols capable of transmitting respirator pathogens when undertaken on patient with a RTI (PHE 2021):
Certain other procedures/equipment may generate an aerosol from material other than the patients secretions, but are **not** considered to represent a significant infectious risk, these include:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills*
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum using nebulised saline
- respiratory tract suctioning*
- upper ENT airway procedures that involve respiratory suctioning*
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs*
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved*
  *Relating to COVID 19 PHE COVID 19 Infection Prevention and Control Guidance: Aerosol Generating Procedures January 2021

During nebulisation, the aerosol derives from a non-patient source, the fluid in the nebuliser chamber and does not carry patient derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will ceases to be airborne and therefore ill not be part of an aerosol.

### 6.7 Duration of isolation requirements

The duration of isolation precautions must continue for 24 hours after the resolution of fever and respiratory symptoms. For prolonged illness with complications, control measures must be used during the duration of the acute illness (PHE 2012). Immuno-suppressed patients may remain infectious for a much longer period of time, and are at risk for the development of antiviral-resistant virus. The decision to discontinue isolation must be based on assessment of the patient's clinical condition and agreement with the IPCT.

## 7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

| Minimum Requirement to be Monitored<br><br>(WHAT – element of compliance or effectiveness within the document will be monitored) | Responsible Individual<br><br>(WHO – is going to monitor this element) | Process for Monitoring e.g. Audit<br><br>(HOW – will this element be monitored (method used)) | Frequency of Monitoring<br><br>(WHEN – will this element be monitored (frequency/ how often)) | Responsible Individual or Committee/ Group for Review of Results<br><br>(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who) |
|---|---|---|---|---|
| Use of Standard Precautions | IPCT | Audit | Weekly | IPCC |
| Hand hygiene compliance | IPCT | Audit | Weekly | IPCC |

## 8.0 TRAINING AND IMPLEMENTATION

Clinical staff should receive induction training on all aspects of infection prevention and control precautions, to prevent the spread of all known or undisclosed transmissible infection, every year thereafter as part of the Trust mandatory training program. Training will be provided by the Infection Prevention and Control Team.

All staff should receive PPE donning and doffing training.

All staff involved in aerosol generating procedures will be fit tested and trained in the use of FFP3 masks. This training will be facilitated through key trainers and health and safety lead. Training records to be managed by training and development

## 9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix B

## 10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

**Evidence Base:**


- Loveday. H., Wilson. J Pratt. R., Pellowe. C; Golsorkhi, A. Tingle, A. Bak, J. Browne, J, Prieto, J.., Wilcox. M. 2014. ***Epic 3. National evidence based guidelines for preventing healthcare associated infections in NHS hospitals in England.*** Journal of Hospital Infection https://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

- Coia. J., Ritchie. L., Adisesh. A., Makinson Booth. C., Bradley. C., Bunyan. D., Carson. G., Fry. C., Hoffman. P., Jenkins. D., Phin. N., Taylor. B., Nguyen-Van-Tam. J., Zuckerman. M., (The Healthcare Infection Society Working Group on Respiratory and Facial Protection). 2013. ***Guidance on the use of respiratory and facial protection equipment***. Journal of Hospital Infection. 85 p. 170-182
- Public Health England. 2017. ***PHE Guidelines for the Public Health Management of Pertussis Incidents in Healthcare Settings*** *https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/564657/Guidelines_for_the_Public_Health_Management_of_Pertussis_in_Healthcare_Settings_2016.pdf* accessed November 2017

- Department of Health. 2015. ***Health and Social Care Act 2008: Code of practice for health and adult social care on the prevention and control of infections and related guidance***

- Heath and Safety Executive. 2013. **The approved list of biological agents. Advisory committee on dangerous pathogens**. http://www.hse.gov.uk/pubns/misc208.pdf Accessed November 2017

- Public Health England (2017) **Acute respiratory infection outbreak: reporting form** *https://www.gov.uk/government/publications/acute-respiratory-infection-outbreak-reporting-form* accessed November 2017

- Public Health England (2016) **Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings** https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/585584/RTI_infection_control_guidance.pdf accessed November 2017

- Public Health England (2021) **COVID-19 infection prevention and control guidance: aerosol generating procedures. Available at:** 6. COVID-19 infection prevention and control guidance: aerosol generating procedures - GOV.UK (www.gov.uk) Accessed 01.02.2021

- **Clinical guide for the management of respiratory patients during the coronavirus pandemic** NHS March 2020


**Related SFHFT Documents:**

- Covid-19 Pneumonia Treatment in Adult Inpatient Guideline
- Respiratory tract infections in adults management guideline

## 11.0 KEYWORDS

COVID 19, Isolation, Precautions, RTI, pertussis, whooping cough, rhinovirus, RSV, influenza, SARS, severe acute respiratory syndrome, lower, upper, pulmonary

## 12.0 APPENDICES

Appendix A – Equality Impact Assessment Form
Appendix B – Environmental Impact Assessment Form

## APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

| | | | |
|---|---|---|---|
| **Name of service/policy/procedure being reviewed:** Respiratory Tract Infections (Suspected or Confirmed) Policy | | | |
| **New or existing service/policy/procedure:** Existing | | | |
| **Date of Assessment:** 01.02.2021 | | | |
| **For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)** | | | |
| **Protected Characteristic** | **a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?** | **b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?** | **c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality** |
| **The area of policy or its implementation being assessed:** | | | |
| **Race and Ethnicity** | LOW | LOW | LOW |
| **Gender** | LOW | LOW | LOW |
| **Age** | LOW | LOW | LOW |
| **Religion** | LOW | LOW | LOW |
| **Disability** | LOW | LOW | LOW |
| **Sexuality** | LOW | LOW | LOW |
| **Pregnancy and Maternity** | LOW | LOW | LOW |
| **Gender Reassignment** | LOW | LOW | LOW |
| **Marriage and Civil Partnership** | LOW | LOW | LOW |
| **Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)** | LOW | LOW | LOW |

| |
|---|
| **What consultation with protected characteristic groups including patient groups have you carried out?**<br>• NA |
| **What data or information did you use in support of this EqIA?**<br>• NA |
| **As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?**<br>• No |
| **Level of impact**<br><br>From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:<br><br>Low Level of Impact<br><br>For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting. |
| Name of Responsible Person undertaking this assessment:<br>Deborah King |
| Signature:<br>*D king* |
| Date:<br>01.02.2021 |

## APPENDIX B – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

| Area of impact | Environmental Risk/Impacts to consider | Yes/No | Action Taken (where necessary) |
|---|---|---|---|
| **Waste and materials** | • Is the policy encouraging using more materials/supplies?<br>• Is the policy likely to increase the waste produced?<br>• Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled? | YES | The trust has a Waste management System in place for PPE disposal. |
| **Soil/Land** | • Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals)<br>• Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.) | NO | |
| **Water** | • Is the policy likely to result in an increase of water usage? (estimate quantities)<br>• Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water)<br>• Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal) | NO | |
| **Air** | • Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.)<br>• Does the policy fail to include a procedure to mitigate the effects?<br>• Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations? | NO | |
| **Energy** | • Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities) | NO | |
| **Nuisances** | • Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)? | NO | |