journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Public – To be published on the Trust external website

Acute respiratory infection patient management

(including SARS-CoV-2 and Influenza)

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1 Introduction

1.1 Why this procedure is needed

An acute Respiratory Tract Infection (RTI) is an acute infectious process affecting the upper and/or lower airways, causing disease ranging from mild to severe that can spread from person to person.

Symptoms can include any of the following: fever, rhinorrhoea (runny nose), sore throat and cough, limb or joint pain, headache, lethargy, chest pain and breathing difficulties.

The most common causes of acute upper RTI are viruses such as rhinoviruses, coronavirus, influenza and respiratory syncytial virus (RSV). Lower respiratory tract infections are commonly caused by bacteria such as Streptococcus pneumoniae and Haemophilus influenzae. Infections with these organisms often occur secondarily to a viral infection as S. pneumoniae and H. influenzae are components of the normal upper respiratory tract flora.

Although RTIs can happen at any time of year, they are most common from September to March. Peak activity for RTI caused by influenza occurs during the autumn and winter seasons in temperate regions. In some tropical countries, influenza viruses circulate throughout the year with one or two peaks of activity during rainy seasons. Most deaths associated with influenza in industrialised countries occur among people aged 65 or older

It is important that patients/service users with any of the following symptoms are identified to a clinician as soon as possible to ensure appropriate treatment. Respiratory illnesses can spread rapidly within closed communities and it is important that potential outbreaks are identified early so that immediate steps are taken to prevent the spread of illness.

1.2 Our Journey To Change (OJTC)

This procedure is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health, a learning disability or autism.

This procedure supports the trust to co-create a great experience for all patients, carers and families from its diverse population by accessing care that is right for you and providing outstanding and compassionate care all of the time through setting standards for managing respiratory illness and implementing IPC measures.

2 Purpose

Following this procedure will help the Trust to:-

- Identify those patients who are showing signs and symptoms of a respiratory illness and provide the appropriate management guidance for individual patients.
- Ensure the safety of all patients in our care by implementing infection prevention and control controls and measures promptly.

3 Who this procedure applies to

- This procedure applies to all trust staff.
- The Infection Prevention and Control Team (IPCT) provide education, training and support to all trust staff to ensure trust wide engagement with all clinical teams informing this procedure.
- This procedure aligns with Trust values as we listen to staff and respect their views. We ensure any staff member who has difficulties with the measures detailed in this procedure can discuss their needs so that standards are maintained while individual differences are recognised and supported

4 Related documents

The Standard (universal) precautions for infection prevention and control Policy which you must read, understand and be trained in before carrying out the procedures described in this document.

This procedure also refers to:-

Hand Hygiene
Decontamination
Waste management policy
Infectious diseases
Outbreak of infection
Laundering and safe handling of linen and clothing
Consent to examination or treatment policy
Procedure for Using the National Early Warning Score (NEWS) 2 for the Early Detection and Management of the Deteriorating Patient in Adults (aged 16 and above)

5 Case definition and Clinical presentation

The case definition may change according to the prevalent circulating RTI and may be redefined according to the circumstances if an outbreak of an RTI is declared.

It is important that patients who may have an RTI are identified as soon possible to reduce the risk of transmission to other patients and staff. Any patient who presents with the below symptoms and a RTI is suspected the patient must be isolated until a confirmed diagnosis is made. Refer to appendix 2 patient management respiratory flowchart.

NB. If an outbreak of a respiratory illness is suspected/confirmed, this procedure should be read in conjunction with Outbreak of infection procedure.

Consider measles in any patient presenting with respiratory symptoms who is non-immune to measles or unable to clarify their measles status. Measles Non-immune refers to people who have not had measles in the past or have not had 2 doses of the MMR vaccine. Please refer to the Measles procedure for further information.

5.1 Clinical presentation of an RTI

- new continuous cough and/**or**
- temperature ≥37.8°C and/**or**
- loss of, or change in, normal sense of smell (Anosmia) or taste (Ageusia)
- Shortness of breath
- Unexplained tiredness /lack of energy
- Muscle ache or pains that er not due to exercise
- Not wanting to eat or feeling hungry
- Headache that is unusual or longer lasting than usual
- Sore throat /stuffy or runny nose
- Diarrhoea /feeling sick or being sick

All the above symptoms may not be present

5.2 Diagnostic investigations

In discussion with the Infection, Prevention and Control Team (IPCT) the following should be considered:

- PCR Nose and Throat swabs should be taken where the patient meets the case definition.
- Viral swabs should be sent for SARS-CoV-2, Influenza and RSV testing.
- During an outbreak of an RTI the outbreak control group will decide if swabs are required

Appendix 1 – Taking viral swab, describes the process for collecting nose and throat swabs.

6 Management of the patient with an RTI

Patients with suspected or confirmed RTI must be nursed in a single room, with en-suite facilities if possible and the door must be closed. If there is no en-suite facility, a dedicated commode (which should be cleaned as per local cleaning schedule after each use) should be used with arrangements in place for the safe removal of the bedpan to an appropriate disposal point.

- Staff must wear the appropriate PPE as per transmission based precautions see 8.2 when entering the patient's room. As a minimum a FRSM and face visor must be worn.
- If performing Aerosol Generating Procedures (AGP) please see 8.0 and refer to 8.2 for increased PPE.
- Ensure appropriate donning & doffing stations are in place
- Ensure appropriate hand hygiene is performed by staff
- Encourage and assist patients with their own hand hygiene
- Inform hotel services and increase routine cleaning to chlorine releasing agent
- All linen must be handled as 'infectious linen'
- All waste must be disposed of as 'clinical waste'
- Crockery and cutlery must be sanitised following use in a dishwasher
- All patient equipment should be dedicated to individual, when possible, if not all equipment should cleaned using chlorine releasing agent / universal cleaning wipes
- When isolation has been completed arrange for terminal clean of the patient's bedroom
- IPCT must be informed of any suspected / confirmed RTI cases. Please contact via email tewv.ipc@nhs.net

Treatment of an RTI is mostly conservative and consists of relieving symptoms while awaiting recovery. However, in some individuals RTI can progress from a mild illness into one in which there is an increase in shortness of breath, chest pain and confusion suggestive of pneumonia which may require, antibiotic or antiviral therapy. Patients presenting with these symptoms will need immediate assessment and treatment and may require transfer to an acute service.

Please follow the below link for advice regarding emergency treatment in relation to Covid. Any further treatment advice should be sought directly from pharmacy.

T:\Intranet Published Documents\Services\Medicines and Pharmacy\COVID-19\COVID-19 Medicines Guidance

Patients NEWS2 observations should be recorded 4hrly as a minimum. Early detection of the deteriorating patient is essential and acted upon immediately and appropriately.

The length of time the patient will be required to isolate is dependent upon the result of any swabbing that has taken place. Typically SARs CoV-2 isolation would be 5 days. Influenza positive patients will be required to remain in isolation for 5-7days. Please contact IPCT for advice on isolation period in individual cases.

For staff experiencing symptoms or a RTI please contact occupational health for support and advice. If an RTI is suspected staff must follow the IPC guidance in the Covid Management flowcharts see IPC intranet page

7 Outbreak of RTI

If two or more test confirmed cases or clinically suspected cases of RTI among individuals, including patients and staff, associated within a specific setting (e.g. ward or a clinical team) are identified please contact IPCT for advice and support. Refer to outbreak procedure.

8 Transmission

Existing evidence supports a potential role for droplet, contact and aerosol transmission when caring for patients with a suspected or confirmed RTI.

- Droplets are generated by coughing, sneezing and talking and remain in the air for a short period of time and travel about one metre. If droplets encounter the mucous membranes or surface of the eye of a person, they can cause infection.

- Indirect contact. Surfaces can become contaminated from the droplets of an infected person passed on usually through hand contact.

- Aerosol Generating Procedure (AGP). The following procedures are considered likely to generate aerosols capable of transmitting respiratory pathogens. When performing any of these procedures on a patient with suspected / confirmed RTI the PPE requirements are different please refer to TBP section 8.3.

    - 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)

Procedures which are NOT considered to generate aerosol that would pose a significant infectious risk:

- Administration of pressurised humidified Oxygen
- Administration of medication via a nebuliser

8.1 Standard Infection Control Procedures (SICP)

SICP are the basic IPC measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

The application of SICP during the delivery of care is determined by an assessment of risk to and from individuals and includes the task, level of interaction and /or the anticipated level of exposure to blood and/or other bodily fluids.

The elements of SICPs are:

- Patient placement and assessment for infection risk
- Hand hygiene
- Respiratory and cough hygiene
- PPE
- Safe management of the care environment
- Safe management of care equipment
- Safe management of healthcare linen
- Safe management of blood and body fluids
- Safe disposal of waste
- Occupational safety

The table below identifies the PPE requirement associated with SICP:

Standard IPC precautions (SICPS)

Disposable Gloves	Disposable Apron/Gown	Face Masks	Eye/Face protection(visor)
Single use. contact with blood and/or body fluids or contact with non-intact skin or membrane **Always maintain good hand hygiene**	Single use apron for direct patient care	Type IIR surgical Mask (Risk assess individual need /activity for FFP3)	Risk assessed, visor use in outbreak measures or if patient is symptomatic and positive

8.2 Transmission-Based Precautions (TBP)

TBP are additional infection prevention control precautions and are to be used in addition to SICP's for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent infection transmission.

Exposure risk	Disposable gloves	Disposable Apron/Gown	Face Mask (FRSM)	Eye/face protection (visor)

Droplet precautions	Single use for direct / prolonged care	Single use for direct care (gown if risk of extensive spraying or splashing)	Type IIR Fluid resistant surgical mask (risk assess/consult with IPC re use of FFP3 in some patient or outbreak situations)	Visor Risk assessed, visor use in outbreak measures Risk of coughing / spitting
Airborne precautions (inc AGP)	Single use for direct care	Single use fluid resistant gown	FFP3 staff must be fit tested	Visor

8.3 PPE requirements when providing care for patients with suspected or confirmed RTI

The table below shows PPE required while providing direct care for patients with suspected or confirmed RTI.

PPE required depending on exposure risk	**Disposable gloves**	**Disposable apron/gown**	**Face mask**	**Eye/face protection**
Droplet precautions	Single use for direct care.	Single use for direct care. (Gown if risk of extensive spraying or splashing)	Type IIR Fluid resistant surgical mask **Worn at all times.** (Risk assess/consult with IPC re use of FFP3 in some patient or outbreak situations)	Visor For direct care and when taking nose/throat swabs) and if there is a risk of coughing / spitting.
Airborne precautions (Inc AGP)	Single use for direct care	Single use for direct care (gown if risk of extensive spraying or splashing)	FFP3 staff must be fit tested*	Visor

Removing (doffing) PPE. In the absence of an anteroom/lobby remove FFP3 respirator and eye/face protection in a safe area (e.g. outside the patient's room).

All other PPE should be removed in the patient care area.

*Staff must be fit tested prior to wearing an FFP3. The purpose of fit testing is to ensure the respirator / mask has good contact and seal to the wearers face, any staff with beards / facial hair must be clean shaven to achieve this contact. There are some exceptions please discuss with IPCT. For staff who for religious purposes have full beards alternative respiratory protection must be sourced or they are unable to participate in AGP

Appendix 3 PPE Donning and doffing procedure posters

9 Definitions

Term	Definition
RTI	• Respiratory Tract Infection
RSV	• Respiratory Syncytial Virus
IPCT	• Infection Prevention Control Team
NEWS	• National Early Warning Score
PPE	• Personal Protective Equipment
SICP	• Standard Infection Control Procedures
TBP	• Transmission Based Precautions
FFP3	• Filtering Face Piece
AGP	• Aerosol Generating Procedure
FRSM	• Fluid resistant surgical mask

10 How this procedure will be implemented

- This procedure will be published on the Trust's intranet and external website.
- Line managers will disseminate this procedure to all Trust employees through a line management briefing.

10.1Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff	IPC Online	1hr	Yearly

11 How the implementation of this procedure will be monitored

Auditable Standard/ Key Performance Indicators	**Frequency/Method/Person Responsible**	**Where results and any Associate Action Plan will be reported to, implemented and monitored; (this will usually be via the relevant Governance Group).**
IPC Audit	Yearly environment and IPC audit undertaken by IPCN or Modern Matron	IPCC

12 References

UKSHA (2022) Infection prevention and control for seasonal respiratory infections in health and social care settings (including SARS-CoV-2) for winter 2021-2022.

NHS England and NHS Improvement (2022) National infection prevention and control manual for England V2.0.

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 19 January 2023

13 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	16 April 2024
Next review date	25 July 2025
This document replaces	Acute Respiratory Infections including SARS-CoV-2 and Influenza IPC-0001-023-v1.3
This document was approved by	IPCC
This document was approved	16 April 2024
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	22 June 2022 (v1)
Document type	Public
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
v1	25 July 2022	New document	Withdrawn
v1.1	10 Jan 2022	Revised Appendix 3 Respiratory Admission Screening Tool – China Travel question included	Withdrawn
v1.2	19 Jan 2023	Information regarding safe labelling and transportation of specimens added to Appendix 1, due to withdrawal of procedure Ref IPC-0001-015 v3 for specimen collection Royal Marsden online added to references	Withdrawn
v1.3	23 Jan 2024	Removed admission screening tool as any patient that develops respiratory symptoms will be managed using this procedure and removed information regarding lateral flow testing for staff as this is no longer national guidance.	Withdrawn
v1.4	16 April 2024	Section 5 added information on Measles to remind staff to consider measles in symptomatic patients with no measles immunity – link to measles procedure also added.	Published

Appendix 1 Taking a viral nose and throat swab

Prepare Equipment:

Gloves, apron, eye protection/visor & surgical mask (PPE)
**Green or Red viral swab x1 for throat and nose
Biohazard label /High Risk Sticker
X2 Specimen bags
Microbiology form – please indicate on the form if the patient has previously tested positive for COVID-19 and the date
Tongue Depressor
**Use a single viral swab for the throat and then nose.

<u>Specimen collection</u>

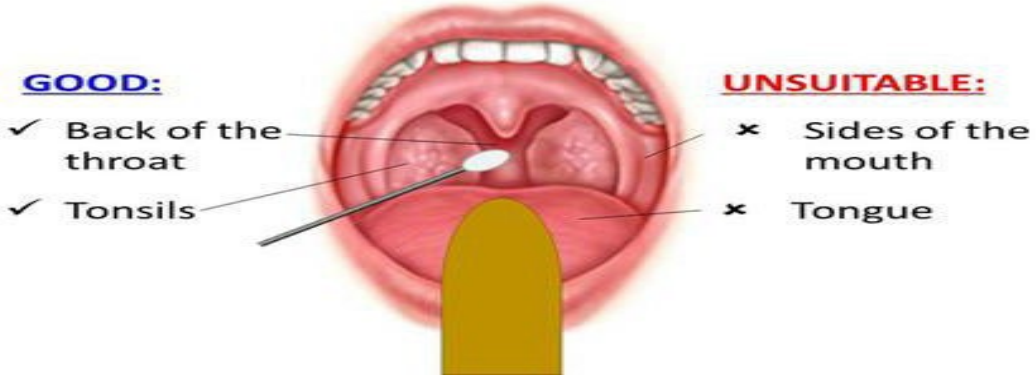
Upper respiratory tract sample

Throat swab

Please check swab expiry date before use <u>How</u>

<u>to take a throat swab</u>

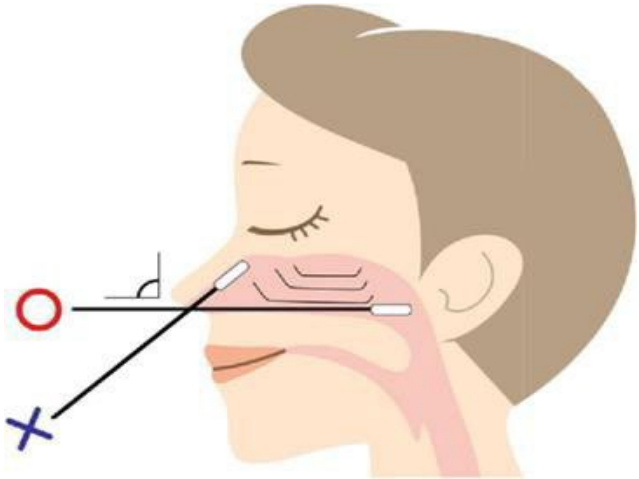
1. Clean hands and put on appropriate PPE
2. Ask individual to sit upright facing a strong light, tilt head backwards, open mouth and stick out tongue
3. Depress tongue with a spatula
4. Ask individual to say ‘Ah’
5. Insert the dry viral swab into mouth and swab the posterior pharynx and tonsillar areas using 5 firm strokes for up to 10 seconds (count to 10). Avoid the tongue.



Nose Swab

How to take a nasopharyngeal swab

1. Ask patient to blow their nose in to a tissue if able. Then ask them to wash their hands.
2. Put on appropriate PPE.
3. Insert dry swab straight backwards through the nostril (not upwards) along the floor of the nasal passage until you feel resistance.
4. Rotate the swab five times and leave in place for 10 seconds (count to 10). Remove the swab and package specimen up



Useful YouTube instructional video: https://www.youtube.com/watch?v=DVJNWefmHjE

Remove PPE, gloves then apron, eye protection and mask into clinical waste before performing hand hygiene

Safe labelling of specimens

Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location eg. ward name.

The pathology request form must also identify the patients details as well as relevant clinical details, reason for the specimen request and any current antibiotic treatment.

Ensure the laboratory request form is also signed by the clinician who has requested the specimen.

The specimen must be secured in the specimen container and placed into a leak proof sealed specimen bag along with the request form.

Any specimens deemed as high risk of infection (e.g. from patients with blood borne viruses or diseases such as Creutzfeldt-Jacob Disease) must be placed into a mini grip plastic bag before being placed into the bag with the pathology request form, they should also be labelled as ‘high risk’ (high risk stickers can be ordered via cardea).

Unlabelled or incorrectly labelled specimens will be discarded by the receiving laboratory department.

Transportation of laboratory specimens

All pathology specimens must be transported in a leak proof, washable container. The container must be secure and must comply with UN 3373 standards.

Specimen transport containers must not be left unattended in a patient access area.

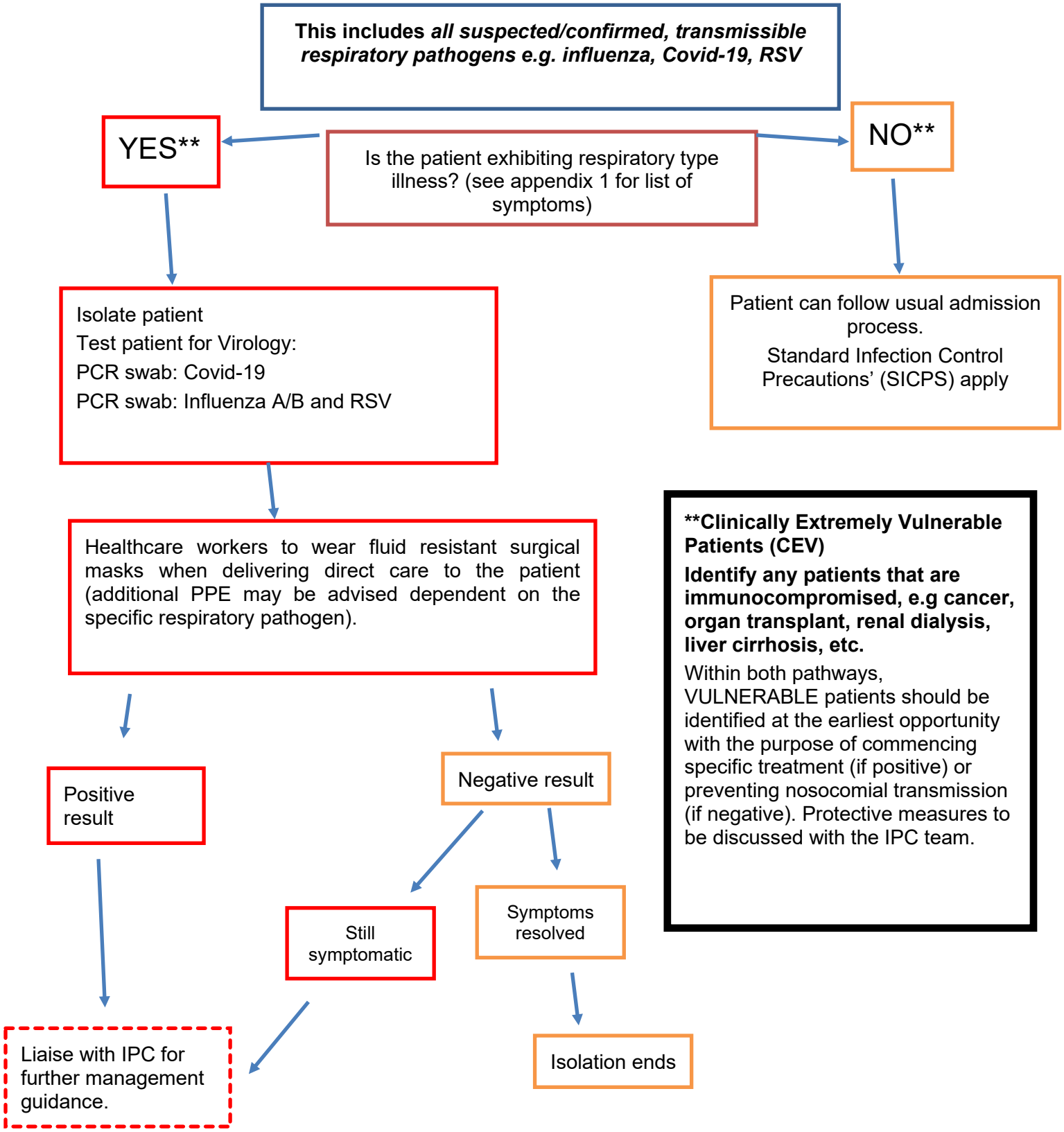
Specimen transport containers must be cleaned at least weekly, or immediately if they become contaminated.

Where specimens are transported to the laboratory by vehicle, the transport specimen container must be placed into a cardboard transport box labelled with both the destination and senders name and address.

Each specimen container must be in a separate plastic bag with sufficient material to fully absorb any leakage of the specimen

Vehicles used for specimen transportation must be equipped with personal protective equipment and a spill kit. Any spillages must be cleaned immediately, and the specimen requester informed as a further specimen will need to be obtained.

Appendix 2 Patient Respiratory Flowchart



Appendix 3 Donning and Doffing procedures (Non-AGP and AGP)

Please see pages overleaf

Public Health England

Putting on personal protective equipment (PPE)

for non-aerosol generating procedures (AGPs)*

Pre-donning instructions:

- Ensure healthcare worker hydrated
- Tie hair back
- Remove jewellery
- Check PPE in the correct size is available

1 Perform hand hygiene before putting on PPE.

2 Put on apron and tie at waist.

3 Put on facemask – position upper straps on the crown of your head, lower strap at nape of neck.

4 With both hands, mould the metal strap over the bridge of your nose.

5 Don eye protection if required.

6 Put on gloves.

*For the PPE guide for AGPS please see:
www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

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Public Health England

Taking off personal protective equipment (PPE)

for non-aerosol generating procedures (AGPS)*

- **PPE should be removed in an order that minimises the risk of self-contamination**
- **Gloves, aprons (and eye protection if used) should be taken off in the patient's room or cohort area**

1 Remove gloves. Grasp the outside of glove with the opposite gloved hand; peel off.

Hold the removed glove in the remaining gloved hand.

Slide the fingers of the un-gloved hand under the remaining glove at the wrist.

Peel the remaining glove off over the first glove and discard.

2 Clean hands.

3 Apron.

Unfasten or break apron ties at the neck and let the apron fold down on itself.

Break ties at waist and fold apron in on itself – do not touch the outside – **this will be contaminated**. Discard.

4 Remove eye protection if worn.

Use both hands to handle the straps by pulling away from face and discard.

5 Clean hands.

6 Remove facemask once your clinical work is completed.

Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only. Lean forward slightly. Discard. DO NOT reuse once removed.

7 Clean hands with soap and water.

*For the doffing guide to PPE for AGPs see:
www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

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Appendix 4 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Infection prevention and control
Title	Acute Respiratory Infection patient management (including SARS-CoV-2 and Influenza)
Type	Procedure
Geographical area covered	Trustwide
Aims and objectives	To set standards in practice to ensure the delivery of patient care is carried out safely and effectively by trust staff.
Start date of Equality Analysis Screening	15 June 2022
End date of Equality Analysis Screening	22 June 2022

Section 2	Impacts
Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Trust staff and patients
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO**

	• **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Veterans** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	
Describe any positive impacts	

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Yes, see References Section.
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	n/a
If you answered Yes above, describe the engagement and involvement that has taken place	n/a

If you answered No above, describe future plans that you may have to engage and involve people from different groups	n/a

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	n/a
Describe any training needs for Trust staff	n/a
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 5 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	N/A	
	Have any related documents or documents that are impacted by this change been identified and updated?	N/A	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	IPCC – July 2022
10.	**Publication**		
	Has the document been reviewed for harm?	Yes	
	Does the document identify whether it is private or public?	Yes	public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	