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Infection Prevention and Control Measures for Acute Respiratory Infections (ARI) for Health and social Care Settings - WALES

2026 Version 5.0

Version Control

Version	Author	Date	Changes
1	HARP IPC team	May 2022	Amended for use in Wales by health and social care teams, from original document prepared by NHSE and IPC team.
2	Consultant nurse HCAI, IPC HARP.	November 2023.	Review of isolation. Testing.
3	Consultant nurse HCAI, IPC HARP	November 2024	4.2 Isolation guidance reviewed CV-19. Links updated.
4	Consultant Nurse HCAI, IPC HARP.	October 2025	4. Use of RPE. 4.1 Source control amended to all Winter respiratory infections. Links updated.
5	Consultant Nurse HCAI, IPC HARP Lead Health Protection Practitioner. Health protection Team	September 2026	Terminology changed in line with TBPs. Addition of appendix 3. Links updated.

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Acknowledgement: Amended for use in Wales by health and social care teams, from original document prepared by NHSE and IPC team May 2022.

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1. Introduction

This guidance outlines the infection prevention and control (IPC) principles and minimum precautions required to prevent transmission of viral Acute Respiratory Infection (ARI) including SARS-CoV-2 (COVID-19) Influenza (Non - High Consequence Infectious Disease strain e.g. Avian influenza) and Respiratory Syncytial Virus (RSV), within healthcare settings in Wales.

While Human metapneumovirus, Human parainfluenza and rhinovirus are not usually considered to be of public health concern, they can be significant and also spread within healthcare settings especially in vulnerable patient's/residents/service users.

This guidance is of a general nature. Healthcare organisations in Wales may adopt practices that differ from those recommended/stated in this IPC guidance. However, organisations are responsible for ensuring safe systems of work, including managing the risk associated with infectious agents through the completion of risk assessments using the Hierarchy of Controls as a basis. They must also consider the specific conditions of each individual place of work and comply with all applicable legislation and regulations, including the Health and Safety at Work etc. Act 1974 and Health and Safety Executive (HSE) guidance on use of PPE and RPE.

Appendix 16 of NIPCM Wales: Risk Assessment Principles for Health and Care Settings – Hierarchy of Controls Appendix 16 - Hierarchy of controls

The following link may also be helpful: About Hierarchy of Controls | Hierarchy of Controls | CDC.

Risk Assessment Tools:

- EAC risk assessment tools – Criteria for completing a local risk assessment – Acute inpatient areas - Public Health Wales
- EAC risk assessment tools – Criteria for completing a local risk assessment – Primary care and outpatient settings - Public Health Wales
- EAC risk assessment tools – Criteria for completing a local risk assessment – Social care - Public Health Wales

Where an unacceptable risk of transmission remains following the hierarchy of controls risk assessment, it may be necessary to consider the use of Respiratory Protective Equipment (RPE) for patients being cared for with respiratory infectious agents, in a wider range of clinical situations than those outlined in this guidance.

All health and social care organisations must make sure that appropriate supplies and training in use of Personal Protective Equipment (PPE) including fit testing for the use of RPE (where required) is in place to implement this IPC Guidance.

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This guidance should be read in conjunction with National Infection Prevention and Control Manual: Home, which describes the application of Standard Infection Prevention and Control Precautions (SICPs), and Transmission Based Precautions (TBPs).

All health and social care staff must be familiar with the principles of SICPs and TBPs for preventing the spread of infection in health and social care settings:

- National Infection Prevention and Control Manual: Chapter 1 - Standard Infection Control Precautions (SICPs)
- National Infection Prevention and Control Manual: Chapter 2 - Transmission Based Precautions (TBPs)

The IPC principles in this document apply to health and social care settings in Wales. This includes mental health and learning disabilities, primary care, maternity, and paediatrics as well as the social care sector including care homes (this list is not exhaustive).

2. General information

2.1. Infectious period

- SARS CoV-2 (COVID-19) - Individuals are infectious around 2 days before symptom onset to 10 days after. People are most infectious during their symptomatic period, usually in the first 5 days (after the day they took the positive test or from the day symptoms started). However, children and young persons under 18 years old are most infectious in the first 3 days.
- Influenza (Flu) – May be infectious 1 day before onset of symptoms, peaks after 1-2 days of symptoms and then declines, so that infectivity is very low after 7 days in adults. It is more likely to spread to others in the first 5 days after onset of symptoms. The time from exposure to developing the first symptom (incubation period) is usually 1 to 3 days.
- Other ARI – (RSV, Metapneumovirus, H. Influenza, human parainfluenza, rhinovirus) - Have similar incubation and transmission periods. May be infectious 1 to 2 days before onset of symptoms and is more likely to spread to others in the first 5 days. The time from exposure to developing the first symptom (incubation period) is typically 2-5 days but can be as long as 8 days.

Severely immunocompromised individuals may remain infectious for a longer period of time, even in the absence of symptoms. Refer to section 4.3 duration of precautions, for further information.

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2.2. High risk groups/individuals

Individuals who are immunosuppressed or have certain medical conditions may be at higher risk of contracting ARI or at higher risk of serious illness and complications. A clinical risk assessment is required for those individuals considered to be high risk, COVID-19 treatments | GOV.WALES.

Additionally, individuals who are unvaccinated or partially vaccinated for COVID-19 or unvaccinated for Flu or RSV (in older adults, infants and pregnant women) are at higher risk of infection and serious illness.

2.3. High risk settings

High risk settings for ongoing transmission of ARI are those that cannot mitigate the risk of transmission through the application of the hierarchy of controls (HoC) for example care homes.

Setting-specific risk assessment tools (acute sector, community / primary care and care home sector) are available to support organisations in applying the HoC.

Managing risk using PPE - Using personal protective equipment (PPE) to control risks at work - HSE.

3. Triaging and Testing for Acute Respiratory Viral Infection

3.1. Triaging/assessment of infection risk in primary and secondary care

Triaging including travel history within all healthcare facilities should be undertaken to enable early recognition of patients with acute respiratory viral infections. Triage should be undertaken by clinical staff who are trained and competent in the application of clinical case definitions as soon as possible on arrival and used to inform patient placement.

Patients with respiratory infection symptoms should be assessed in a segregated area, ideally a single room, and away from other patients pending their test result.

At times of high levels of respiratory infectious illness, it may be worth segregating unscheduled / emergency admissions into respiratory and non-respiratory pathways, ensuring that separation of patients (single room assessment areas ideally), ventilation and use of FRSM masks by all staff are optimised in the respiratory pathway.

In care homes, residents need to be assessed for ARI symptoms and local policy for management followed (appendix 3).

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3.2. Testing

Testing for patients and residents should be carried out in line with local policies and guidance, taking into account individual risk factors, clinical presentation, and any ongoing outbreak or incident management arrangements.

3.3. Cohorting

Infectious patients/ residents should ideally be isolated in single rooms away from others. Where infectious cases exceed single room capacity cohorting of patients/ residents may be implemented and should be according to infecting organism. Cohort nursing is a dedicated area in which a group of *patients with the same infection are placed together

**Patients with different infections should not be cohorted together and where a patient tests positive for more than one ARI e.g., Flu and COVID-19 then single room isolation should be prioritised.*

In hospital, to ensure the most appropriate clinical care for patients, cohort areas should be set up within the specialty area where the required clinical care is best provided. Patients should not be moved to a "respiratory ward" cohort area simply on the basis of a test result but may need to be moved if clinically they require enhanced respiratory management.

4. Additional infection prevention and control measures for ARI in healthcare settings

The application of SICPs and TBPs as per chapters 1 and 2 of the National Infection Prevention and Control Manual: Home should be followed. Refer to National Infection Prevention and Control Manual: A-Z Pathogens for pathogen specific information and Appendix 11 for guidance on patient placement and the use of RPE, National Infection Prevention and Control Manual: Appendices.

4.1 Respiratory Protective Equipment (RPE)

PPE must still be used in accordance with SICPs when using Respiratory Protective Equipment (RPE) 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 air transmission) the hazard must be adequately controlled by applying protection measures appropriate to the activity and consistent with the assessment of risk. If the hazard is unknown the clinical judgement and expertise of IPC/HP staff is crucial, and the precautionary principle should apply. RPE, for instance FFP3 and facial protection, must be considered when:

- A patient is admitted with a known/suspected infectious agent/disease spread wholly or partly via air transmission
- Carrying out aerosol generating procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by air transmission

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Appendix 1 of this guidance describes mask selection for infectious respiratory agents.

As a minimum, contact and air transmission precautions should be applied when caring for patients with known or suspected ARI. In specific circumstances air transmission precautions should also be applied, for example, when performing AGPs, and in high-risk settings. Appendix 2 of this guidance has an updated AGP list as published in the NIPCM England from 14th April 2022.

4.2. Source control

Cough etiquette/respiratory hygiene can be defined as source control measures intended to contain respiratory secretions in order to limit transmission of respiratory pathogens spread by air transmission, especially during seasonal outbreaks of viral respiratory tract infections. Respiratory and Cough Hygiene Literature Review

Mask wearing is a form of source control that can be applied to staff, patients, residents and visitors in healthcare settings during winter months when respiratory viruses are generally at their peak. The requirement for *patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required or cause distress e.g. paediatric/mental health settings.

Health and social care staff

Health and Social care staff should continue to maintain source control by wearing FRSM (TYPE IIR) when working in respiratory care pathways and when clinically caring for patients suspected/confirmed of having Acute Respiratory Infections (appendix 1)

All other clinical care areas, outside of designated respiratory care pathways, universal masking should be applied when there is known or suspected cluster transmission of ARI e.g., during an incident / outbreak, universal masking should also be considered in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology. This should be guided by local risk assessment. This includes primary and community care staff.

FRSM are not required in non-clinical areas e.g. offices, social settings. Where patients are supported in community settings e.g. mental health/learning disabilities support in the community, staff are not routinely required to wear masks, similar to public health messaging in these settings, unless this is their personal preference.

Approved transparent face masks are now available to purchase for use in place of an FRSM (Type IIR) if needed following a risk assessment. Any product must be an NHS Wales Shared Services Partnership (NWSSP) approved product that meets the national technical standard. They are not intended for routine use and must be worn in accordance with manufacturer instructions for use (IFU).

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Inpatients

Non-infectious inpatients are not required to wear a FRSM unless this is a personal preference. However, in settings where patients are at high risk of infection due to immunosuppression e.g. oncology/haematology, non-infectious patients may be encouraged to wear a FRSM following a local risk assessment.

Inpatients with **suspected or confirmed ARI** should be provided with a FRSM (Type II or Type IIR) on admission. This should be worn in multi-bedded bays and communal areas e.g. waiting areas for diagnostics, if this can be tolerated and is deemed safe for the patient.

FRSM are not required to be worn by **suspected or confirmed ARI** patients in single rooms unless a visitor enters, or the room door is required to remain open. Patients with **suspected or confirmed ARI** transferring to another care area should wear a facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination. Patients should be provided with a new FRSM **at least** daily or when wet, soiled or damaged.

The requirement for patients to wear a facemask must never compromise their clinical care, such as when oxygen therapy is required, or cause distress e.g., paediatric/mental health settings.

Outpatients/primary care

Outpatients with **suspected or confirmed ARI** should wear a facemask/covering, if tolerated, or offered a facemask on arrival.

Visitors

Visitors and individuals accompanying patients to appointments are not routinely required to wear a facemask/covering unless this is a personal preference. If visiting an area where there is a high risk of respiratory infection, as part of the risk assessment a facemask, and IPC precautions will be advised prior to them entering the clinical area, posters should be on display to advise. There will be occasions for example in inpatient settings where patients are at high risk of infection due to immunosuppression e.g., oncology/haematology, where visitors may be asked to wear a facemask following a local risk assessment.

4.3. Duration of precautions

TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team) and should take into consideration the individual's test results (if available), transmissibility of the pathogen and resolution of clinical symptoms: National Infection Prevention and Control Manual: A-Z Pathogens.

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4.3.1. Stepping down precautions if the patient is staying in hospital

COVID-19:

- Most people will no longer be infectious after 5 days; it is therefore advised that TBPs and isolation should continue for at least 5 days. It is important to note that some patients may be infectious for longer.
- A locally decided protocol based on advice from medical directors, nursing directors and/or directors of infection prevention and control should be used to determine if isolation of inpatients with COVID-19 is needed after 5 days.
- For inpatients, TBPs and isolation is recommended for at least five days after the onset of symptoms (or their first COVID 19 test), provided the clinical criteria described later in the document have been met.
- A cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals with COVID-19 for several weeks, and are not considered an indication of ongoing infection when other symptoms have resolved.
- For clinically suspected ARI patients who have tested negative for COVID-19 and have not been tested for other ARI's and whose condition is severe enough to require hospitalisation, the isolation period should be measured from the day of admission.

Influenza:

For in-patients, and residents TBPs/isolation should continue for at least 5 days after the onset of symptoms (or their first positive flu test if they do not have any symptoms), provided the clinical criteria below have been met.

Other ARI – (RSV, H. metapneumovirus, Human parainfluenza, rhinovirus): National Infection Prevention and Control Manual: A-Z Pathogens.

For inpatients and residents' transmission-based precautions/isolation should continue up to 7-8 days after the onset of symptoms (or their first positive test if they do not have any symptoms), provided the clinical criteria below have been met.

Note: Where a patient or resident or service user tests positive for more than one ARI e.g. Influenza and COVID-19 then stepping down precautions needs to be assessed against transmission risks and clinical criteria.

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Clinical criteria:

- Clinical improvement with at least some respiratory recovery
- Absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- No underlying severe immunosuppression

Re-testing is not required for patients who have tested positive for ARI pathogens unless there is underlying immunosuppression. These cases should be considered in consultation with clinicians (including microbiology/IPC team).

Note: This guidance does not apply if there are any additional indications for ongoing isolation and transmission-based precautions (for example MRSA carriage, C. difficile infection, diarrhoea).

4.3.2. Severely immunocompromised patients/residents

It is possible for severely immunocompromised patients or residents to remain infectious for prolonged periods, even if they do not display any symptoms of ARI. There should be a locally decided protocol based on advice from medical directors, nursing directors, directors of infection prevention and control and GPs should be used to determine if isolation of inpatients with ARI is needed after the required period.

4.3.3. Outpatients/primary care

Patients who are known or suspected to be positive with a respiratory pathogen and whose treatment cannot be deferred should receive care from services who are able to operate in a way which minimises the risk of spread of the virus to other patients. If required advice can be sought from Health Board/Trust IPC Teams or Health Protection Teams.

To support primary care specific risk assessment, tools are available to support organisations in applying the HoC here: EAC risk assessment tools – Criteria for completing a local risk assessment – Primary care and outpatient settings - Public Health Wales.

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4.3.4. Care home or other non-acute healthcare settings

Management of **influenza-like illness (ILI) and acute respiratory infection (ARI)** in care homes and other social care settings differs from that in acute healthcare settings.

Refer to Appendix 3: Management of Influenza-Like Illness (ILI) and Acute Respiratory Infection (ARI)

in Care Homes and Other Social Care Settings for setting-specific advice on the management of residents, including infection prevention and control measures, testing, isolation/cohorting, visiting and outbreak management.

5. Surveillance and monitoring / outbreak management / reporting

Ongoing surveillance of Severe Acute Respiratory Illness (SARI) should continue within healthcare settings and for hospital/organisation onset cases (staff and patients/individuals).

Positive cases of an ARI identified after admission who fit the criteria for a healthcare associated infection (HCAI) should trigger a case investigation. If two or more cases are linked in time and place, an outbreak should be declared and investigation should be undertaken Outbreak framework for acute healthcare settings - Public Health Wales.

COVID-19 and Flu are notifiable organisms/diseases. Further information on reporting can be found here: The Health Protection (Notification) (Wales) Regulations 2010.

6. IPC considerations for contacts of cases (inpatients)

Inpatients who are considered contacts of COVID-19/Flu cases (not part of an outbreak) are no longer required to isolate if they are asymptomatic. Asymptomatic testing of inpatients may be used as part of the actions agreed by an Outbreak Control Team (OCT) to monitor contacts and mitigate risks if the patient remains in hospital or other care setting e.g. LFD or rapid antigen testing or local protocol.

If symptoms occur contacts should be tested as per local policy/guidance and isolated or cohorted with other symptomatic contacts of the same case.

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7. Occupational health, vaccinations and IPC considerations for health and care staff

Systems should remain in place to ensure vaccination policies are implemented as advised by occupational health/public health teams.

The vaccination status of staff may be considered when making staffing decisions for areas where suspected or confirmed COVID-19/Flu patients/individuals are cared for.

A risk assessment is required for health and social care staff who may be at high risk of complications from COVID-19 or Flu and, also, may be available for anti-viral treatments.

Staff who have symptoms of a respiratory tract infection including a high temperature or do not feel well enough to go to work or carry out normal activities, is advised to stay at home and notify their employer as soon as possible. They are to avoid contact with other people.

When they no longer feel unwell and do not have /not had a high temperature without the use of medication such as paracetamol and are ready to return to work they may wish to discuss with their employer ways to minimise any risk as some may still be infectious. This may include undertaking a risk assessment if the staff member works with patients whose immune system means that they are at higher risk of serious illness despite vaccination.

Symptomatic staff should avoid contact with people both in the healthcare setting and in the general community. Bank, agency and locum staff should follow the same deployment advice as permanent staff.

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Appendix 1: Personal protective equipment (PPE) required while providing direct care for patients with suspected or confirmed acute respiratory infection (ARI).

Before undertaking any procedure, staff should assess any likely blood and body fluid exposure risk and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

If there is no direct contact with the patient or their environment, gloves and aprons/gowns are not required.

Refer to NIPCM Wales:

- National Infection Prevention and Control Manual: Appendix 6 - Putting On and Removing PPE - Guidance on donning (putting on) and doffing (removing) PPE.
- National Infection Prevention and Control Manual: Appendix 15 - Selection of Personal Protective Equipment (PPE) by Healthcare Workers (HCWs) during the provision of patient care.

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Appendix 2: Aerosol generating procedures (Current Aerosol Generating Procedures List for Healthcare)

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 infection).

The list of medical procedures that 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)

*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 AGP list. Only open suctioning beyond the oro-pharynx is currently considered an AGP. Oral/pharyngeal suctioning is **not** considered an AGP.

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Appendix 3 Management of Influenza-Like Illness (ILI) and Acute Respiratory Infection (ARI) in Care Homes

Section 1. What You Need to Do

This appendix provides practical advice for care homes on what to do when a resident or member of staff develops symptoms of an acute respiratory infection (ARI) or when people become unwell within the setting.

Care homes are people's homes. Infection prevention and control measures should therefore be proportionate to the risk and take account of people's dignity, independence, safety and wellbeing. In this appendix the term 'resident' is used for a person living in the care home. Where advice applies to both residents and staff this is stated.

1.1. What is an acute respiratory infection?

An **acute respiratory infection (ARI)** is an infection that affects the respiratory system.
ARI includes:

- Influenza (flu)
- COVID-19
- Respiratory syncytial virus (RSV)
- Rhinovirus
- Human metapneumovirus
- Parainfluenza
- Other respiratory infections.

Different respiratory infections can cause similar symptoms, and it may not be possible to tell which infection someone has from the symptoms alone. Older people may also develop less typical symptoms.

Look out for:

- New or worsening cough
- Sore throat
- Runny or blocked nose
- Shortness of breath

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- Wheezing
- Fever or high temperature
- Tiredness or lethargy
- Muscle or body aches
- Other new symptoms of a respiratory illness
- An unexplained deterioration in physical health or mental ability

Remember: Act on symptoms. You do not need to know which virus is causing the illness before taking appropriate precautions.
If you are concerned about a resident's condition, their symptoms are worsening, or there is an unexplained deterioration in their physical or mental health, **seek clinical advice promptly**. Do not wait for test results or for other residents to become unwell before seeking advice.

Section 2. ONE resident has respiratory symptoms: What should you do?

Step 1: Assess the resident

Check how unwell they are and continue to monitor their condition.
Seek clinical advice if you are concerned about their condition or they become more unwell.

Step 2: Reduce contact with others

Support the resident to **stay in their own room, where possible, until their acute symptoms have been resolved**.

Consider their individual needs, safety and wellbeing. Measures should be proportionate and should not cause unnecessary distress or compromise the resident's care or safety.
Symptomatic residents should be isolated where possible, but you should also maintain normality and consider any wider harms from restrictions.

Step 3. Use appropriate PPE and infection prevention measures

Staff should:

- Wash their hands before and after providing care
- Wear a fluid-resistant surgical mask (FRSM) when working within 2 metres of a symptomatic resident
- Wear gloves and an apron when required for the care being provided
- Wear eye or face protection if there is a risk of splashes to the eyes or face
- Clean shared equipment appropriately

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- Maintain appropriate ventilation where this can be done safely
- Follow good respiratory and cough hygiene

PPE should be used in accordance with current national infection prevention and control manual (NIPCM) and other relevant ILI/ARI infection prevention and control advice.
National Infection Prevention and Control Manual: Care Home Infection Prevention and Control Manual (CH IPCM).

Step 4. Consider whether testing is needed

Not everyone with respiratory symptoms needs to be tested if they are a single case in the setting. Testing should be considered where:

- the resident may be eligible for antiviral or other specific treatment
- the result would affect their clinical treatment
- testing is required as part of an incident or outbreak investigation
- testing has been advised by the Health Board, Health Protection Team, or the resident's clinical team.

Routine asymptomatic testing is **not recommended.**

Step 5. Watch for other people becoming unwell

Monitor residents and staff for new respiratory symptoms.
Residents and staff who remain well **do not normally need to isolate simply because they have been in contact with a symptomatic resident**.

Section 3. TWO OR MORE residents or staff have respiratory symptoms: What should you do?

If **two or more residents and/or staff develop acute respiratory symptoms**, consider whether there may be a cluster or outbreak and follow the agreed local pathway

Step 1. Isolate or cohort symptomatic residents

Support symptomatic residents to stay in their own rooms where possible.
If this is not possible, residents with similar symptoms may be cared for together. This is known as cohorting.
Symptomatic residents should be isolated or cohorted where possible until their symptoms have been resolved. If a specific ARI is identified, follow the appropriate infection- specific advice.

Step 2. Contact the appropriate Health Protection service

Follow the agreed local pathway for reporting and managing suspected ARI clusters or outbreaks. The Health Protection service will assess the situation and provide advice on any additional actions required.

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Have the relevant information ready

Where it is possible, have the relevant information available:

- Number of residents who are unwell
- Number of staff who are unwell and what areas they work in
- Symptoms
- Dates symptoms started
- Where affected residents are located within the setting
- Any test results available
- Hospital admissions
- Any deaths
- Vaccination information for residents that have been vaccinated for COVID-19 and Influenza within the setting including staff

Step 3. Arrange testing

Where two or more people are symptomatic, follow the agreed local pathway for testing.
Do not delay seeking clinical advice for unwell residents while waiting for testing or test results.

Step 4. Strengthen infection prevention and control measures

- Reinforce good hand hygiene
- Reinforce respiratory and cough hygiene.
- Ensure appropriate PPE is being used
- Keep symptomatic residents separate from other residents who are well, where possible
- Increase attention to cleaning frequently touched surfaces
- Clean shared equipment between use
- Keep rooms appropriately ventilated where this can be done safely
- Reduce unnecessary movement between affected and unaffected areas where possible

Step 5. Keep a record and continue monitoring

Maintain an up-to-date record of:

- Who is unwell
- Their symptoms

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- When symptoms started
- Test results
- Recovery
- Hospital admissions
- Deaths

Report significant changes to the **Public Health Wales Health Protection Team** through the agreed pathway. **Face masks for residents.**

Residents who are well do **not routinely need to wear a face mask**.
A symptomatic resident who is staying in their room or being cohorted with other symptomatic residents can be supported to wear a face mask when other people are in the room, if they can tolerate it and it can be worn safely.

Do not insist on a mask if it:

- Causes distress
- Cannot be worn safely
- Interferes with care
- Is unsuitable because of the residents' individual needs

Step 6. Flu, COVID-19 and antiviral treatment?

Influenza

If **influenza is suspected or confirmed**, some residents may be eligible for antiviral medicines to treat their illness or, in some circumstances, to help prevent further cases.
The relevant **clinical teams and /or Public Health Wales will advise whether antiviral treatment or prophylaxis is required.**
If influenza is suspected, do not unnecessarily delay seeking advice about antiviral treatment or prophylaxis while waiting for all outbreak test results.

COVID-19

Residents who may be eligible for specific COVID-19 treatment should be identified promptly and a discussion should occur with the relevant clinical team (i.e. GP) to discuss antiviral treatment.

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Step 7. Visting during an ARI incident or outbreak

Visiting should remain as open and flexible as possible.

Do not automatically stop all visiting because there is a case, cluster or outbreak of ARI. Any restrictions to visiting should follow a risk assessment and be proportionate to the situation.

Keep relatives and visitors informed

Where an outbreak has been identified, ensure that residents, relatives and visitors are informed about the outbreak and any additional precautions in place. This will help them make an informed decision about visiting.

Visitors should be asked **not to visit if they are unwell**, particularly if they:

- Have symptoms of a respiratory or other infection
- Have a high temperature
- Otherwise feel unwell

Essential visiting should continue to be able to visit during a cluster or outbreak.

Where necessary, undertake an individual risk assessment and advise visitors about any additional precautions they should take, including appropriate PPE.

Step 8. Admissions, transfers and healthcare appointments

An ARI cluster or outbreak should **not automatically stop all admissions, transfers or necessary healthcare appointments**.

Consider each situation individually, taking account of:

- The resident's clinical needs
- Whether they have symptoms
- The risk of spreading infection
- The vulnerability of other residents
- Whether the receiving setting can safely manage the risk
- Advice provided as part of the cluster/outbreak risk assessment

If a resident with suspected or confirmed ARI needs to go to hospital or another health or care setting:

Tell the ambulance or transport service and the receiving setting about the suspected or confirmed infection before the resident is transferred.

**The term patient is used to denote any individual being cared for in a health or care setting therefore includes service users, care home residents for example*

Section 4. General advice

4.1. What should staff do if they become unwell?

Staff with symptoms of a respiratory infection or a high temperature who normally work closely with residents should:

- Stay away from work
- Tell their employer as soon as possible

When they are no longer unwell, do not have a high temperature and feel ready to return to work, they should discuss any concerns or measures needed to minimise further transmission with their employer.

Staff who live with or have had close contacts with someone with a respiratory infection but remain well should discuss with their line manager any measures needed to minimise onwards transmission at work.

Staff should be encouraged to have all vaccinations for which they are eligible for.

4.2. Remember residents' wellbeing

Care homes are people's homes.
Preventing infection is important, but so are residents' quality of life, dignity, independence and wellbeing.

Where it can be done safely, residents should continue to have:

- Contact with family and friends
- Meaningful activities
- Social interaction
- Good nutrition and hydration
- Mobility and exercise
- Access to fresh air
- Emotional and psychological support
- Access to routine and urgent healthcare

Any restrictions used to control infection should be necessary, proportionate and regularly reviewed.

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4.3 Further information and guidance

This appendix should be used alongside the current national guidance, as recommendations may change.

Key resources

Welsh Government: Social care guide to controlling acute respiratory infections. This is the primary Wales-specific guidance covering PPE, testing, isolation and visiting in social care settings. Social care guide to controlling acute respiratory infections [HTML] | GOV.WALES.

National Infection Prevention and Control Manual (NIPCM), including Standard Infection Control Precautions and Transmission Based Precautions. National Infection Prevention and Control Manual: Home.

Public Health Wales ARI infection prevention and control guidance, including disease-specific isolation periods where an ARI has been identified.

UKHSA adult social-care ARI guidance may provide additional supporting information and principles, but it applies to England, so Wales-specific guidance and local arrangements should take precedence where these differ. Infection prevention and control in adult social care: acute respiratory infection - GOV.UK.

**The term patient is used to denote any individual being cared for in a health or care setting therefore includes service users, care home residents for example*

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