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

2025 Version 4.0

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 & 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.

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Acknowledgement: Amended for use in Wales by health and social care teams, from original document prepared by NHSE & 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 patients/residents/service users. Hence the introduction of the RSV vaccination programme introduced in Wales in September 2024.

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 17 of NIPCM Wales: Risk Assessment Principles for Health and Care Settings – Hierarchy of Controls Appendices - Public Health Wales (nhs.wales).

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

Risk Assessment Tools:

- Criteria for completing a local risk acute inpatient area
- Criteria for completing a local risk primary care and outpatient settings
- Criteria for completing a local risk social care

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.

This guidance should be read in conjunction with NIPCM - Public Health Wales, which describes the application of Standard Infection Prevention and Control Precautions (SICPs), and Transmission Based Precautions (TBPs).

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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.

The elements of SICPs are:

- *Patient placement and assessment for infection risk (screening /triaging/ testing).
- Hand hygiene.
- Respiratory and cough hygiene.
- Personal Protective Equipment (PPE).
- Safe management of the care environment.
- Safe management of patient care equipment.
- Safe management of healthcare linen.
- Safe management of blood and body fluids.
- Safe disposal of waste (including sharps).
- Occupational safety: prevention and exposure management.

TBPs are the additional measures to SICPs that may be required when caring for *patients with known / suspected infection or colonisation, these are:

- Assessment for infection risk and patient placement.
- Assessment for infection risk and management of contacts.
- Safe management of patient care equipment in an isolation/cohort area.
- Safe management of the care environment.
- PPE: including Fluid Repellent Surgical Masks (FRSM) respiratory protective equipment (RPE), eye protection, gloves, aprons/gowns etc.
- Aerosol generating procedures (AGPs) and associated PPE – (see Appendix 2).
- Care of the deceased.

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).

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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.

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.

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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 - ARI - Acute Respiratory Infections - Public Health Wales.

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.

3.2. Testing

Testing for patients, and residents should be as local policy/guidance.

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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. In a care home, this may mean caring for residents with the same infection on the same floor.

*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 NIPCM - Public Health Wales should be followed. Refer to A to Z of pathogens for pathogen specific information and Appendix 11 for guidance on patient placement and the use of RPE, NIPCM 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 airborne micro-organisms) 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 by the airborne route
- Carrying out aerosol generating procedures (AGPs) on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route

Appendix 1 of this guidance describes the personal protective equipment (PPE) required when providing direct care for suspected or confirmed ARI patients.

As a minimum, contact and droplet precautions should be applied when caring for patients with known or suspected ARI. In specific circumstances airborne precautions should also be applied, for example, when performing AGPs, and in high-risk settings. Appendix 2 of this guidance has an

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updated ACP 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 droplet or airborne routes, especially during seasonal outbreaks of viral respiratory tract infections. (Standard Infection Precautions Literature Review Cough etiquette)

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.

Infection prevention and control in the context of coronavirus disease (COVID-19): A living guideline makes a strong recommendation (based on very low certainty of evidence) that in areas of known or suspected community or cluster of COVID-19 transmission, universal masking is recommended in health and social care facilities

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.

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).

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.

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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: A-Z Pathogens - Public Health Wales.

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.

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- 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.

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): A-Z Pathogens - Public Health Wales.

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.

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

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.

Re-testing is not required for patients who have tested positive for other ARI pathogens (flu, RSV etc) 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).

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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 COVID-19 is needed after 5 days.

For all ARI including COVID-19 in severely immunocompromised patients' resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated in side (single) rooms, cubicles or cohorted and a step-down protocol agreed with the local Microbiology / IPC team.

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: Criteria for completing a local risk primary care and outpatient settings.

4.3.4. Care home or other non-acute healthcare settings

For those with symptoms of ARI – no test results:

- Symptoms of a respiratory infection, with high temperature or not feeling well enough to do their usual activities. It is best practice to avoid communal areas for the recommended exclusion period.
- This should be maintained until they no longer have a high temperature or no longer feel unwell.
- Note that those in vulnerable groups who may benefit from antiviral treatments will need to be tested –Patient testing framework for autumn/winter 2023 (WHC/2023/037) | GOV.WALES.
- Consideration needs to be given to health and wellbeing of residents while in isolation and contact maintained with family and friends. Refer to Care Home Infection Prevention and Control Manual (CH IPCM) - Public Health Wales

For those residents with a positive COVID-19 test result:

- Stay away from others (isolation in own room) for a minimum of 5 days after the day of positive result from taking the test.
- Access appropriate treatments as quickly as possible if they are eligible: COVID-19 treatments | GOV.WALES.

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- Avoid contact with other people who are eligible for COVID-19 treatments for example immunocompromised for 10 days after a positive test.
- After 5 days, the resident can return to their normal activities if they feel well and no longer have a high temperature without the use of medication such as paracetamol.

Residents who have tested positive for COVID-19 do not need to stay away from others for more than 10 days regardless of symptoms.

4.3.5. High risk / vulnerable patients

- Precautions/isolation should continue up to 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms), provided the clinical criteria below have been met.
- 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.
- It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms of ARI.
- If a patient / resident is severely immunosuppressed consideration should be given to increasing the isolation period for to at least 14 days. Particularly if other residents are also in the highly immunosuppressed category.

To support setting specific risk assessment tools are available to support organisations in applying the HoC here: Criteria for completing a local risk social care.

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 COVID-19 and Flu 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 investigation should be undertaken Outbreak Management - 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.

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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.

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) (including COVID-19)

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:

- Appendix 6 - Guidance on donning (putting on) and doffing (removing) PPE.
- Appendix 15 - Selection of Personal Protective Equipment (PPE) by Healthcare Workers (HCWs) during the provision of patient care.

PPE required by transmission/exposure	Disposable gloves	Disposable/reusable fluid-resistant apron/gown	FRSM/RPE	Eye/face protection (goggle/visor)
Droplet PPE	Single use	Single use apron or fluid-resistant gown if risk of extensive spraying/splashing	Single use FRSM Type IIR for direct patient care[1]	Single use or reusable[1]
Airborne PPE (When undertaking or if AGPs are likely)[3] Or if an unacceptable risk of transmission remains following application of the hierarchy of controls[4]	Single use	Single use fluid-resistant gown	Single use FFP3[2] or reusable respirator/powered respirator hood (RPE)	Single use or reusable[2]

1*FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

2 - RPE can be worn sessionally (includes eye/face protection) in high-risk areas where AGPs are undertaken for cohorted patients (see footnote 4). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

3- Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

4 - Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

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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 (COVID-19) AGP list. It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, which means that oral/pharyngeal suctioning is NOT an AGP.

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