Public – To be published on the Trust external website

Acute respiratory infections

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Status: Approved
Document type: Procedure
Overarching policy: Infection Prevention and Control Policy

Contents

1 Introduction

1.1 Why this procedure is needed

A respiratory tract infection (RTI) is an acute infectious process affecting the airways, causing disease ranging from mild to severe that can spread from person to person.

There are several different types of RTI; they're usually grouped into upper RTIs and lower RTIs.

Upper RTI affect the sinuses and throat. They include:

- common cold
- sinusitis (sinus infection)
- tonsillitis
- laryngitis

Lower RTIs affect the airways and lungs. They include:

- bronchitis
- bronchiolitis
- chest infection
- pneumonia (lung infection)

Flu and COVID-19 can both be upper or lower RTIs.

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. For

additional information please refer to NICE guidance: Suspected acute respiratory infection in over 16s: assessment at first presentation and initial management (NG237) (last updated 16 Nov 2023).

This procedure supports Our Journey to Change as set out in the overarching Infection, Prevention and Control Policy.

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

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.

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

Consider other viral illnesses including measles in any patient presenting with respiratory symptoms who is non-immune to measles or unable to clarify their measles status and has developed a rash. 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. Measles IPC-0001-025

5.1 Clinical presentation of an RTI / Case definition

- New continuous cough and/**or**
- Temperature ≥37.8°C and/**or**
- Loss of, or change in, normal sense of smell (Anosmia) or taste (Ageusia)
- Sneezing
- Shortness of breath / tight chest or wheezing
- Unexplained tiredness / lack of energy
- Muscle ache or pains that are 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
- Feeling generally unwell

All the above symptoms may not be present

5.2 Diagnostic investigations

In discussion with 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 A & B 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 throat and nose 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 personal protective equipment (PPE) as per transmission-based precautions see 8.3 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 8.4 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 'infectious 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 be 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
- Please discuss with IPCT should any relatives wish to visit during the period of isolation.

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 4 hourly as a minimum. Early detection of the deteriorating patient is essential and must be 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 / RSV positive patients will be required to remain in isolation for 5-7days, depending on symptoms and risk assessment of other vulnerable service users. 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 airborne precautions section 8.4.

- 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)

Standard infection control precautions (SICPs) are to be used by all staff, in all care settings, always, for all patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment.

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

8.2 Transmission-Based Precautions (TBP)

Standard infection control precautions may be insufficient to prevent cross transmission of specific infectious agents and additional precautions called “transmission-based precautions”

(TBP) may be required when caring for patients with known / suspected infection or colonisation.

Transmission based precautions are categorised by the route of transmission of infectious agents (some infectious agents can be transmitted by more than one route).

Clinical judgement and decisions should be made by staff on what additional precautions are required and this will be based on:

- suspected/known infectious agent
- severity of the illness caused
- transmission route of the infectious agent
- care setting and procedures undertaken.

8.3 Type of precautions

Contact precautions:

Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of cross-infection transmission.

Droplet precautions:

Measures used to prevent, and control infections spread over short distances (at least 1 metre) via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

Airborne precautions:

Measures used to prevent, and control infection spread without necessarily having close patient contact via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

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

Inpatients with suspected or confirmed respiratory infection should be requested to wear a facemask (FRSM) if deemed safe to do so following risk assessment, unless isolated in a single room.

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

If cluster transmission of a respiratory pathogen is known or suspected, consider extending the use of FRSM as source control to health and care staff in the affected clinical areas(s). This should be guided by local risk assessment and IPCT.

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

Type of precautions	Disposable gloves	Disposable apron/gown	Face mask	Eye/face protection
Droplet precautions	Yes, if providing direct care. Single use.	Yes, if providing direct care. Single use. (Gown if risk of extensive spraying or splashing)	Yes. Type IIR Fluid resistant surgical mask **Always Worn.** (Risk assess/consult with IPCT re use of FFP3 in some patient situations)	Yes. Visor **Always worn.** When taking nose/throat swabs) and if there is a risk of coughing / spitting.
Airborne precautions (Inc AGP)	Yes. Single use for direct care	Yes. Single use for direct care (gown if risk of extensive spraying or splashing)	Yes. FFP3 staff must be fit tested*	Yes. Visor

8.5 Donning and doffing procedures

All PPE should be removed in the patient care area. All staff must be aware of the correct order of removal of PPE to prevent accidental contamination of themselves. Please refer to donning and doffing posters in appendix 3.

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).

*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 have full beards alternative respiratory protection must be sourced or they are unable to participate in AGP.

Please see **Appendix 3 for 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.

10.1 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All clinical staff	IPC Online	1hr	Yearly
Nonclinical	IPC online	1hr	3 years

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 surveillance of infection	Frequency = As and when required Method = Notification from microbiological lab and or clinical staff Responsible = IPCT	IPCC IPCC / Care group governance meetings

12 References

Home - Royal Marsden Manual (rmmonline.co.uk) accessed 04 June 2025

NICE guidance/ng237/resources/suspected-acute-respiratory-infection-in-over-16s-assessment-at-first-presentation-and-initial-management-pdf-66143901172165
accessed 4 June May 2025

https://www.nhs.uk/conditions/respiratory-tract-infection/ accessed 02 June 2025

https://www.england.nhs.uk/national-infection-prevention-and-control-manual-nipcm-for-england/
accessed 02 June 2025

13 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	8th July 2025 (virtual)
Next review date	8th July 2028
This document replaces	Acute Respiratory Infections including SARS-CoV-2 and Influenza IPC-0001-023-v1.4
This document was approved by	IPCC (virtual)
This document was approved	8th July 2025
This document was ratified by	n/a
This document was ratified	n/a

An equality analysis was completed on this policy on	05 June 2025
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
v1.3	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.	Withdrawn
V1.4	19 May 2025	All procedure links accessed and working. Added information for clinical teams to refer to NICE guidance. Added link to measles procedure Added information to clinical presentation section	Withdrawn
V1.5	08 July 2025	All procedure links accessed and working. Procedure title updated. Reference UKSHA (2022) Infection prevention and control for seasonal respiratory infections in health and social care settings (including SARS-CoV-2) for	Approved (virtual)

		winter 2021-2022, removed as guidance withdrawn. Minor clarifications made throughout document to outline existing current practice to help staff understanding: Updated information relating to what is an RTI, section 1.1. Updated section 8.1 and 8.2 relating to SICP and TBP. Added 8.3 detailing types of precautions. Deleted appendix 2 respiratory management flowchart for admission (which applied during COVID-19 pandemic) Added appendices 4 PPE for SICPs and 5 PPE for TBP. Updated posters: updated donning and doffing posters and renamed as appendix 2 (sourced from current National Infection Control Manual online resource) Note - Pending formal retrospective inclusion in minutes of IPCC 01 Oct 2025.	

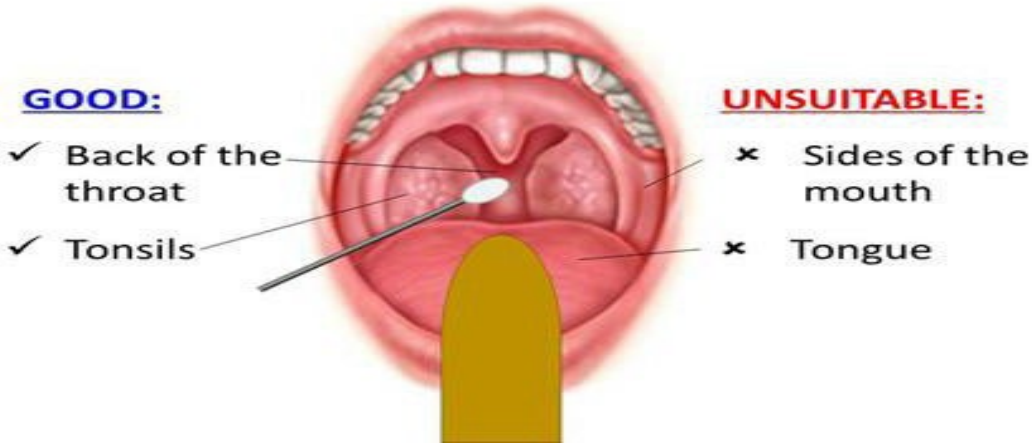
Appendix 1 - How to take a viral throat and nose swab

Prepare Equipment

- Gloves, apron, eye protection/visor & surgical mask (PPE)
- Green or Red viral swab x1 for throat and nose (Please check swab expiry date before use)
- Specimen bags
- Microbiology form
- Tongue Depressor
- Use a single viral swab for the throat and then nose.

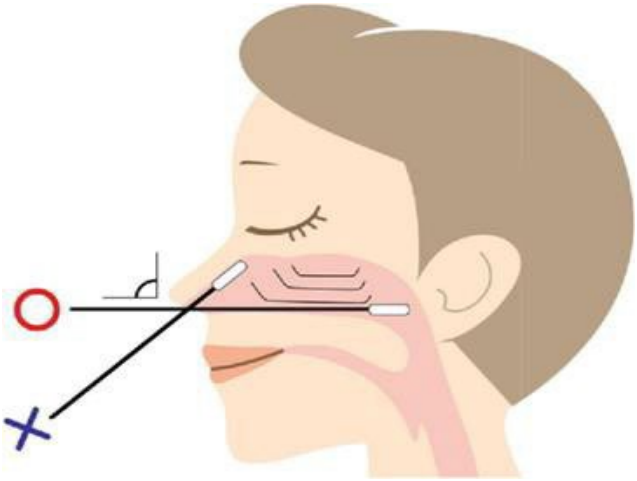
How to take a throat swab

- Ensure you are bare below the elbows (BBE) and wash hands.
- Don appropriate PPE
- Ask individual to sit upright facing a strong light, tilt head backwards, open mouth and stick out tongue
- Depress tongue with a spatula
- Ask individual to say ‘Ah’
- 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.



How to take a nasal swab

- Ask patient to blow their nose in to a tissue if able. Then ask them to wash their hands.
- Put on appropriate PPE.
- Insert dry swab straight backwards through the nostril (not upwards) along the floor of the nasal passage until you feel resistance.
- Rotate the swab five times and leave in place for 10 seconds (count to 10). Remove the swab and package specimen up
- Remove PPE, gloves then apron, eye protection and mask into clinical waste before performing hand hygiene



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

- Ensure each specimen is clearly labelled with the patient's name, date of birth, NHS number and location e.g. 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 PPE 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 - Donning and Doffing PPE

https://www.england.nhs.uk/wp-content/uploads/2022/09/PRN00908ii-app-6-putting-on-and-removing-ppe.pdf

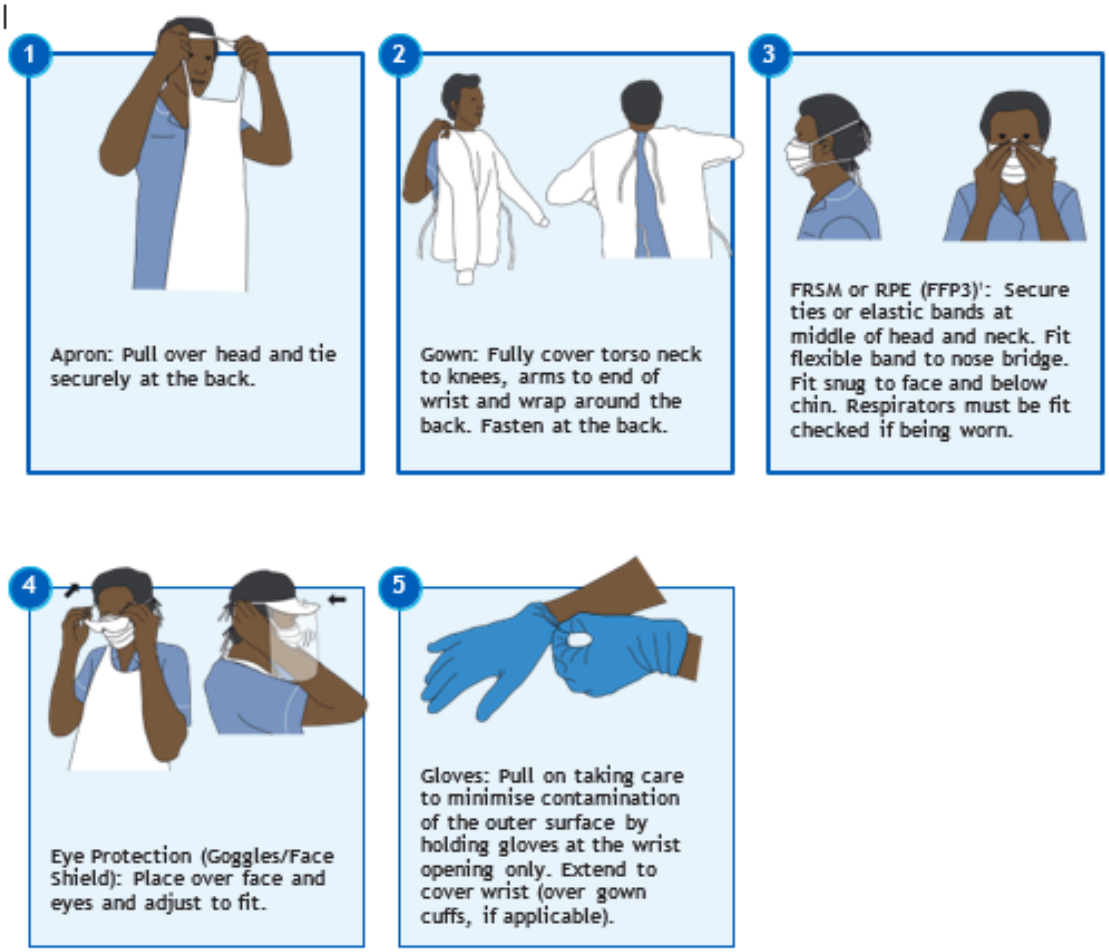
Putting on and Removing Personal Protective Equipment (PPE)

Before undertaking any procedure or task, staff should assess the risk of likely exposure to blood and/or other body fluids, non-intact skin, mucous membranes, or any equipment or items in the care environment that could be contaminated, and wear PPE if required. PPE must protect adequately against the risks associated with the procedure or task. The items of PPE worn will vary based on the type of exposure anticipated, and not all items of PPE may be required.

Putting on Personal Protective Equipment (PPE)

Before beginning, check which items of PPE are required and that these are available in the correct size.

The order for putting on PPE is Apron or Gown, Fluid-Resistant Surgical Mask (FRSM)/ Respiratory Protection Equipment (RPE) (FFP3),[1] Eye Protection, then Gloves.



Removing Personal Protective Equipment (PPE)

When removing PPE, the correct technique is essential to avoid touching the most contaminated areas of PPE e.g., the outside of gloves and front of aprons/gowns, eye protection, and FRSM/RPE.

The order for removing PPE is Gloves, Apron or Gown, Eye Protection, then FRSM/RPE (FFP3)[1].

6

Gloves: Pinch and lift the outside of the glove in the palm area with the opposite gloved hand; peel off while turning inside out. Hold the removed glove in the gloved hand. Slide two fingers of the ungloved hand under the remaining glove at the wrist. Peel the second glove off over the first glove and discard.

7

Apron: Unfasten or break neck ties and allow apron to fall forward. Unfasten or break waist ties and pull apron away from the body touching the inside only. Fold or roll into a bundle and discard.

8

Gown: Unfasten neck, then waist ties. Remove using a peeling motion; pull gown from each shoulder towards the same hand turning gown inside out. Hold removed gown away from body, fold or roll into a bundle and discard.

9

Eye Protection (Goggles/Face shield): Handle eye protection only by the headband or the sides. Face shields/glasses should be removed by grasping sides and pulling directly forward, away from face. To remove goggles with an elasticated headband, tilt head forward and grasp the headband with index fingers and thumbs, lift the headband upwards whilst pushing frame away from face, lower goggles away from face and discard.

10

FRSM or RPE (FFP3)[1]: Unfasten the ties - first the bottom, then the top or, if elasticated, pull top and bottom elastics together. Handling the ties/elastics only pull away from the face without touching front of mask/respirator and discard.

- All PPE should be removed before leaving the care area and immediately disposed of directly into the appropriate waste stream, or a designated receptacle for reusable PPE.
- Perform hand hygiene immediately upon removal of PPE.

Appendix 3 - PPE when applying SICPS

https://www.england.nhs.uk/wp-content/uploads/2022/09/national-infection-prevention-and-control-manual-appendix-5a.pdf

Appendix 5a: Personal protective equipment (PPE) when applying standard infection control precautions (SICPs)

NHS

Before undertaking any procedure or task, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin, mucous membranes or any equipment or items in the care environment that could be contaminated and wear personal protective equipment (PPE) if required. PPE must protect adequately against the risks associated with the procedure or task.

Hand hygiene must be performed before putting on and after removal of PPE.

SICPs	Gloves	Apron	Gown (ambulance staff use coveralls)	Fluid resistant surgical mask (FRSM)	Eye/face protection
No anticipated exposure to blood or body fluid, mucous membranes, or non-intact skin.	✗	✗	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated but **NO risk of splashing or spraying.**	✓	✓	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated **AND risk of spraying or splashing**.	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated.	✓	✓

Where to put on and remove PPE

If required as above, PPE should be put on within the patient room/care area.

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

All PPE must be removed and disposed of before leaving the patient room/care area on completion of care episode.

NB. Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

Appendix 4 - PPE when applying TBP

https://www.england.nhs.uk/wp-content/uploads/2022/09/national-infection-prevention-and-control-manual-appendix-5b.pdf

Appendix 5b: Personal protective equipment (PPE) when applying transmission based precautions (TBPs)

NHS

SICPs may be insufficient to prevent cross transmission of specific infectious agents and additional precautions (TBPs) may be required. PPE must protect adequately against the risks associated with the procedure or task. Refer to appendix 11a for additional information.

Hand hygiene must be performed before putting on and after removal of PPE.

TBPs	Gloves	Apron	Gown	Fluid resistant surgical mask (FRSM)	Respiratory Protective Equipment (RPE)	Eye/face protection
Contact precautions	✗ Unless exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated or footnote 1 applies[1]	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated or footnote 2 applies[2]	✗	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated
Droplet precautions	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✓	✗	✓
Airborne precautions	✓	✗	✓	✗	✓	✓

Where to put on and remove PPE

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

Contact precautions: required PPE should be put on within the patient room/care area immediately **before** direct contact with the patient or their environment and should be removed and disposed of **before** leaving the patient room/care area.

Droplet and airborne precautions: required PPE should be put on **before** entering the patient room/care area. Unless there is a dedicated isolation room with anteroom, gowns, aprons and gloves should be removed and disposed of before leaving the patient room/care area. Eye/face protection and RPE (if worn) must be removed and disposed of **after** leaving the patient room/care area.

1. Clinical risk assessment may also indicate the use of gloves for specific organisms such as scabies, multi-drug resistant organisms or those with increased potential for hand and environmental contamination such as spore forming organisms e.g. *C. difficile*. This list is not exhaustive.
2. Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

PPE requirements for high consequence infectious diseases should be discussed with specialist teams as per appendix 11b.

Appendix 5 - 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	Respiratory Infection patient management
Type	Procedure
Geographical area covered	Trust wide
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	02 June 2025
End date of Equality Analysis Screening	02 June 2025

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 6 – 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**		

	Title of document being reviewed:	Yes/No/ Not applicable	Comments
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	E&D reviewed and provided feedback June 2025.
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	IPCC – July 2025
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	