Public Health England

Protecting and improving the nation's health

COVID-19: Infection prevention and control for mental health and learning disability settings

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About this guidance

The guidance is issued jointly by the Department of Health and Social Care (DHSC), Public Health England and NHS England as official guidance.

This guidance is for England only.

Please note that this guidance is of a general nature and that an employer should consider the specific conditions of each individual place of work and comply with all applicable legislation, including the Health and Safety at Work etc. Act 1974.

Contents

1. Key messages for mental health and learning disability settings

Patients or individuals will fall into either low, medium or high risk COVID-19 pathways.

Patients must be triaged and tested on admission. A SARS-CoV-2 PCR test is required on admission, that is day 1,day 3 and day 5 to 7 of admission.

Patients will require to be re-tested on their return if they leave the ward or unit over a 24 hour period.

Patients who do not consent to testing, should undergo a dynamic clinical risk[1] assessment to take into consideration their individual risk factors and whether they have had contact with a known COVID-19 case. These patients will be managed on the medium risk COVID-19 pathway for 14 days unless testing can be undertaken.

Patients who are known to have been exposed to a confirmed COVID-19 patient while on the ward should be isolated or cohorted (grouped together) with other similarly exposed patients who do not have COVID-19 symptoms, until their hospital admission ends or until 14 days after last exposure.

If symptoms of COVID-19 occur in the 14 days after exposure then SARS-CoV-2, PCR testing should be undertaken. These patients should be isolated or cohorted in the high risk pathway. Patients can still be discharged during the period of isolation and isolation would continue at home. Refer to the relevant pathway discharge section within the Infection Prevention Control guidance.

Patients requiring management on a high-risk COVID-19 pathway may require a dynamic clinical risk assessment by a multi-disciplinary team to determine the most appropriate care setting. Patient placement and assessment for infection risk as per care pathways should always be guided by their clinical needs.

Airborne precautions are required for all patients on the medium and high-risk pathways if an AGP is undertaken.

Sessional use of single use personal protective equipment (PPE) items only applies to the extended use of facemasks and eye or face protection for healthcare workers.

[1] Dynamic risk assessment refers to the continuous process of identifying hazards and need to ensure clinical risk assessments are updated and refreshed to reflect changes in circumstances and presentation on a regular and as required basis and can mean adaption to practice in the moment as actions to eliminate or reduce risk are made. Dynamic clinical risk assessments are not just of the person but the surroundings and other patient presentations too in this setting.

Staff should use a dynamic risk assessment when making decisions around the use of PPE in the medium and high risk COVID-19 pathways. A hierarchy of control approach that considers all hazards to patients and staff should be followed, for example when conducting a risk assessment regarding patient restraint.

2. Background

This document is an appendix to the 'COVID-19: Guidance for the maintaining of services within health and care settings' and covers the specific mental health and learning disabilities requirements in terms of applying the main guidance document in these specific settings. This should therefore be read in conjunction with this guidance.

DISCLAIMER

If an organisation deviates from this guidance, it is their resposibility for ensuring safe systems of work including the completion of a risk assessment approved through local governance procedures, preferably at Integrated Care System and regional level.

3. Administration measures for the care pathways in mental health and learning disability settings

Wherever possible triaging and testing must be undertaken prior to the admission to the hospital or care setting or immediately on arrival or admission.

The clinical environment should be assessed and zoned to allow for patient triaging and cohorting according to the COVID-19 patient pathways. This is to ensure early recognition of COVID-19 cases.

Physical or social distancing of 2 metres should be maintained throughout in-patient/out-patient stay or appointments. If this is not possible, an individual risk assessment should be considered and mitigating measures used such as the use of physical barriers, regular testing or PPE specific to the care pathway.

Patients that have tested negative for SARS-CoV-2 must be re-tested 48 hours prior to discharge to a shared care setting for example a care home, residential home, shared living facilities in commissioned social care. This information in addition to any supporting care information, must be communicated and transferred to the relevant care setting. Refer to the guidance on management of staff and exposed patients or residents in health and social care settings for further information on re-testing for SARS-CoV-2.

Patients with COVID-19 symptoms fulfilling the clinical case definition will require a risk assessment to determine the most appropriate care setting for their treatment. If they are to remain or require admission to a mental health or learning disabilities setting, they must be managed in the high-risk pathway.

If possible, in the high-risk pathway dedicated staff (staff or patient cohorting) should be used to provide care.

COVID-19 care pathways are outlined below in table 1. The majority of mental health and learning disabilities patients will fall into the medium risk COVID-19 pathway. There may be settings where the low risk COVID-19 pathway may be followed, for example, if a patient has evidence of a recent (72 hours) negative SARS-CoV-2 PCR test and no triaging risks are identified.

Patients on the low risk pathway require SICPs alone unless another infectious agent is present.

Specialist or visiting staff, who have a specific role within units should plan their care or visits to high risk care pathways at the end of their working day or shift wherever practicable. Staff moving between wards and departments should be kept to a minimum. A risk assessment must be undertaken prior to home visits with staff assigned to dedicated cohorts of patients wherever practicable.

Face coverings are required by members of the public and patients when visiting health care settings, unless exempt. This includes conducting a risk assessment of the individual for possible self-harm or harm to others risk.

The use of a surgical face mask (Type I or II) by a patient should be subject to the dynamic risk assessment based on the care pathway and the decision documented in patient records.

A risk assessment should be undertaken in regard to the placement and storage of PPE, alcohol based hand products and cleaning materials. These must be stored safely, for example locating waste bins for PPE behind locked doors. Staff may need access to replacement masks and alcohol based hand rubs, in order to safely remove and re-apply a face mask. Safe working systems are an integral part of IPC measures.

Table 1: COVID-19 Care Pathways

High-Risk COVID-19 Pathway	Medium Risk COVID-19 Pathway	Low Risk COVID-19 Pathway
Any care facility where: a) untriaged individuals present for assessment or treatment (symptoms unknown) OR b) confirmed SARS-CoV-2 PCR positive individuals are cared for OR c) symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR d) symptomatic individuals decline testing	Any care facility where: a) triaged or clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 PCR test result OR b) triaged cinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified OR c) testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR d) asymptomatic individuals decline testing	Any care facility where: a) triaged or clinically assessed individuals with no symptoms or known recent COVID-19 contact/exposure AND have a negative SARS-CoV-2 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date OR b) Individuals who have recovered (14 days) from COVID-19 and have had at least 48 hours without fever or respiratory symptoms OR c) patients or individuals are part of a regular formal NHS testing plan and remain negative and asymptomatic

Examples of patient (individual) groups or facilities within these pathways: these lists are not exhaustive

• facilities where confirmed or suspected or symptomatic COVID-19 individuals are cared for, for example:
  ○ emergency admissions to inpatient areas
  ○ inpatient mental health services for older people
  ○ acute wards
  ○ PICU
  ○ shared supportive community living
	• community mental health and learning disability services
	• community crisis resolution and home treatment teams
	• emergency admissions to inpatient areas
	• inpatient mental health services for older people
	• acute wards
	• PICU
	• shared supportive community living
		• shared community living or care facilities with regular screening in place
		• planned admissions

4. Standard infection control precautions (SICPs)

SICPs are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources and are required across all COVID-19 pathways. SICPS must be used by all staff, in all care settings, **at all times** and for all patients or individuals whether infection is known or not to ensure patient, staff and visitor safety.

There are 11 SICPs:

1. Patient placement and assessment for infection risk

There must be triaging and testing as outlined in the administrative measures set out in the IPC Guidance for the pathways to ensure early recognition of COVID-19 cases.

2. Hand hygiene

Hand hygiene must be performed as per the World Health Organisation (WHO) '5 moments' in all care settings. This includes:

- before touching a patient
- before clean or aseptic procedures
- after body fluid exposure risk
- after touching a patient; and
- after touching a patient's immediate surroundings

In addition, hand hygiene should be conducted before putting on/removing PPE. Staff should, be 'Bare Below the Elbows' to ensure effective hand hygiene can take place.

Alcohol Based Hand Rubs (ABHR) are the preferred method for hand hygiene in any setting. Personal dispensers may be preferable in mental health units for accessibility.

Plain non-antibacterial liquid soap and water should be used if hands are physically soiled or the patient is suffering from a gastrointestinal infection.

See step by step guide for how to hand wash or hand rub step by step guide.

3. Respiratory and cough hygiene

Display information on the need to cover the nose or mouth when coughing or sneezing with disposable tissues. Used tissues should be disposed of promptly in the nearest waste bin and hand hygiene undertaken.

Tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients, visitors and staff.

Patients in all care pathways should be encouraged and supported to wear a face covering, provided it can be tolerated and will not impact their medical or care needs.

Surgical face masks (Type I or II) must be worn for extended use by healthcare workers (clinical and non-clinical) when entering a hospital or care setting.Face coverings must be worn by visitors unless exempt.

4. Personal protective equipment

If PPE is not procured via an NHS approved source, it must meet the necessary **BS/EN standards** for the equipment, to ensure the quality and safety of the products, services and systems. More information is available here: COVID-19 Infection prevention and control guidance.

All PPE should be:

- located close to the point of use
- well fitting
- stored to prevent contamination in a clean, dry area
- within expiry date
- single use/disposable, unless specified by the manufacturer that it is reusable (eye protection)
- changed immediately after each patient and/or completing a procedure or task
- discarded if damaged or contaminated
- disposed of after use into the correct waste stream
- safely doffed (removed) to avoid self-contamination

Aprons must be:

- worn to protect staff uniform or clothes from contamination when providing direct patient care and during environmental and equipment decontamination.
- worn when in close contact (<2 metres) of a suspected/confirmed COVID-19 case

Full body gowns /Fluid-resistant /coverall must be:

- worn when a disposable apron provides inadequate cover of staff uniform or clothes for the procedure or task being performed, and when there is a risk of extensive splashing of blood and/or other body fluids, for example, during AGPs

Gloves must:

- be worn when exposure to blood and/or other body fluids non-intact skin or mucous membranes is anticipated/likely, including during equipment and environmental decontamination.
- be changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never be decontaminated with Alcohol Based Hand Rub (ABHR) or soap between uses.
- worn when in close contact (<2 metres) of a suspected/confirmed COVID-19 case

N.B. Double gloving is NOT recommended for routine clinical care of COVID-19 cases.

Eye or face protection must be:

- worn when there is a risk of contamination to the eyes, nose or mouth from splashing of secretions (including respiratory secretions), blood, body fluids or excretions.
- always worn during an AGP

5. Safe management of the care environment

The care environment must be well maintained and in a good state of repair (in line with HBN 00-09 Infection control in the built environment).

The environment must be visibly clean and free from non-essential items and equipment to facilitate effective cleaning**.** The frequency of cleaning across all risk pathways should be increased during the pandemic to at least twice daily. Frequently touched sites / points should be cleaned between patients.

In the low risk pathway routine cleaning should be carried out using a general-purpose detergent or wipe. If solutions are used, then they should be changed when dirty or when changing tasks.

It is the responsibility of the person in charge to ensure that the care environment is safe for practice (this includes environmental cleanliness/maintenance). The person in charge must act if this is deficient.

Staff groups should be aware of their environmental cleaning schedules for their area and clear on their specific responsibilities.

Cleaning protocols should include responsibility for; frequency of; and method of environmental decontamination.

Following discharge of a patient (where there has been no known or suspected infection), the patient room or bed space should be decontaminated using a general purpose detergent.

6. Safe management of the care equipment

Decontaminate all re-usable non-invasive equipment between every patient using a general purpose detergent (unless contaminated with blood or body fluids).

Patient care equipment should be single use where possible. Reusable non-invasive equipment should be allocated to the individual patient or cohort of patients or decontaminated between patients.

7. Safe management of healthcare linen

Clean linen should be stored in a designated enclosed cupboard and should be managed/segregated in line with the following guidance.

Used linen should be placed into an impermeable bag and infectious linen should be placed in a water-soluble bag inside an impermeable bag/hamper.

8. Safe management of blood and body fluid spillages

Spillages must be decontaminated immediately by staff trained.

Responsibilities for decontamination of blood or body fluid spills must be clear within each area or care setting.

Further information on management of blood or body fluid spillages can be accessed here.

9. Safe disposal of waste (including sharps)

Waste must be disposed of in line with the regulations in the following guidance:

- HTM 07:01 Waste Management Guidance
- NHS England COVID-19 waste management standard operating procedure

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to the safe disposal of sharps.

10. Occupational safety, prevention and exposure management

All staff should have up to date immunisations or vaccinations/health clearance applicable for their area of work. Further information can be found in the IPC guidance (sections 3 and 11).

11. Maintaining physical or social distancing (2 metres)

In all healthcare settings unless staff are wearing PPE when providing direct care then a distance of 2 metres must be in place. If it is not possible to achieve this distance then physical barriers should be used, for example clear screens in reception areas. If space in staff rest rooms is limited, consider allocating separate break times.

5. Transmission-based precautions (TBPs)

These are additional infection control precautions required when caring for a patient with known or suspected infections such as COVID-19 in the medium and high-risk pathways.

These are categorised by the route of transmission of the infectious agent and include:

Contact precautions

Prevents and controls infections that spread via direct contact with the patient for example, hands, or indirectly from the immediate care environment (including frequently touched surfaces and care equipment). This is the most common route of infection transmission. **COVID-19 can be spread via this route.**

Droplet precautions

Prevents and control infections spread over short distances (at least 3 feet (1 metre)) via droplets (>5μm) from the respiratory tract of one individual onto the nose/mouth or eyes of another non-immune individual. Droplets penetrate the respiratory system to the alveolar level. **COVID-19 is predominately spread via this route and the precautionary distance has been maintained at 2 metres in care settings.**

Airborne precautions

Prevents and controls infection spread without necessarily having close contact via aerosols (≤5μm) from the respiratory tract of one individual, directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. **COVID-19 can be spread via this route when an AGP is undertaken.**

6. Personal protective equipment including respiratory protective equipment (RPE)

Table 2: Personal protective equipment (PPE) in mental health and learning disability settings

	High Risk Pathway Transmission Based Precautions	**Medium Risk Pathway Transmission Based Precautions**	**Low risk pathway SICPs***
Staff in patient areas with no direct patient contact and more than 2 metres away	Fluid resistant surgical facemask (FRSM Type IIR)	Fluid resistant surgical facemask (FRSM Type IIR)	Fluid resistant surgical facemask (FRSM Type IIR)
Physical restraint	Fluid resistant surgical facemask (FRSM Type IIR) Eye / Face protection** Disposable gloves risk assess the use of an apron	Fluid resistant surgical facemask (FRSM Type IIR) Risk assess the use of disposable gloves, apron and Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR)
Direct contact with patients within 2 metres, for example, patient transfer or in a patient's home or an emergency assessment centre	Fluid resistant surgical facemask (FRSM Type IIR) Disposable gloves and apron Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR) Risk assess the use of disposable gloves and apron Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR)
Direct personal care within 2 metres, for example, administration of depot medication, including rapid tranquillisation, NG feeding, taking blood	Fluid resistant surgical facemask (FRSM Type IIR) Disposable gloves, apron and Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR) Disposable gloves, apron and Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR) Disposable gloves and apron Eye / Face protection**

	High Risk Pathway Transmission Based Precautions	**Medium Risk Pathway Transmission Based Precautions**	**Low risk pathway SICPs***
Direct patient care within 2 metres performing an AGP for example, intubation	FFP3 respirator Single use disposable gown / coverall, gloves Eye / Face protection**	FFP3 respirator Single use disposable gown / coverall, gloves Eye / Face protection**	Fluid resistant surgical facemask (FRSM Type IIR) Disposable gloves and apron Eye / Face protection

* Aprons and gloves should always be worn if any contact with blood or body fluids is expected as part of Standard Infection Control Precautions
** Eye/Face protection may be used for one session before disposal. The use may be risk assessed in the medium/low risk pathway.

If an infectious patient has an unexpected episode of violence and aggression where PPE has not been worn, the staff member should undertake a risk assessment to determine if they need to change their clothing. Organisations should put in place appropriate arrangements to facilitate this. This incident may require investigation.

7. Aerosol generating procedures (AGPs)

AGPs are procedures that create a higher risk of respiratory infection transmission and are defined as any medical, dental or patient care procedure that can result in the release of airborne particles <5um in size from the respiratory tract of an individual. These can remain suspended in the air, may travel over a distance and may cause infection if they are inhaled when treating someone who is suffering from an infectious disease, transmitted wholly or partly by the airborne or droplet route.

FFP3 respirator masks will be required when undertaking an AGP on a patient in a medium or high-risk COVID-19 pathway. This is most likely to occur if a patient is intubated prior to recieiving electroconvulsive therapy (ECT).

Airborne precautions are NOT required for patients or individuals in the low risk COVID-19 pathway, provided that the patient has no other known or suspected infectious agent transmitted via the droplet or airborne route.

During an AGP and the subsequent fallow time, only clinical staff required for the procedure should be in the room.

8. Transmission-based precautions in mental health and learning disability settings in the medium and high risk COVID-19 pathways

Safe management of the care environment

Decontamination of the environment must be performed using a combined detergent or disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)).

Alternative cleaning agents or disinfectant products may be used with agreement of the local Infection Prevention and Control Team.

Staff performing environmental decontamination (cleaning) should:

- be allocated to specific area(s) and not be moved between COVID-19 and non-COVID-19 areas
- be trained in which PPE to use and the correct methods of putting on and removing PPE

Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination.

Reusable equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant.

Safe management of care equipment

As above for decontamination of environment and re-usable equipment. Equipment should be cleaned in line with manufacturers guidance.

Avoid the use of fans that re-circulate the air where caring for patients with infectious agents transmitted by droplet or airborne route.

Patient Placement: medium or high risk pathway

Patients referred to the high risk pathway with COVID-19 symptoms or individuals who are symptomatic with a history of contact/exposure with a confirmed case, should be prioritised for single room isolation (or cohorted if an isolation room is unavailable) until their test results are known. If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production.

Inpatients who are known to have been exposed to a confirmed COVID-19 patient while on the ward should be isolated or cohorted (grouped together) with other similarly exposed patients who do not have COVID-19 symptoms, until 14 days after last exposure if they remain in hospital. Patients can still be discharged during the period of isolation; isolation would continue at home. Refer to the medium and high risk care pathways of the IPC guidance.

In facilities where patients refuse isolation or are unable to isolate, a risk assessment must be conducted to consider the risk of transmission to other patients. Mitigations include; increasing cleaning, use of personal protective equipment, hand hygiene and physical distancing. It may be necessary to consider all the patients in a specific part of the facility as one cohort. In these scenarios, risk assessments must be conducted in liaison with Infection Prevention Teams and documented in the care record.

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, research, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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