

Preliminary Guideline on Infection Prevention Control Related to Community Based Centres Collecting Samples for Testing for COVID-19

V1.4. 24.02.2021

Version	Date	Changes from previous version	Drafted by
1.4	24.02.2021	Updated to include NPHEP recommendation for implementation of day 0 and day 10 testing for persons designated as close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' and asymptomatic	AMRIC Team
1.3	11.02.2021	Statement that vaccination does not change the requirement for IPC precautions Updated to include NPHEP recommendation for implementation of day 5 and day 10 testing for HCWs designated as close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' Update to guidance on FFP2 mask use when exposed to people with suspected or confirmed COVID-19 or COVID-19 Contacts Reference to maximising ventilation in so far as practical	AMRIC Team
1.2	17.09.2021	Duration of self-isolation for community cases of COVID-19	AMRIC Team
1.1	02.09.2020	Restructure of the document to include Purpose, Scope and Introductory Material. Reference to Interim Infection Prevention and Control Guidance for the HSE. Environment: Rephrasing of guidance on distancing to specify adherence to current public health guidance. Requirement for a designated space in which staff who develop symptoms can wait for pick up. Operation: Requirement to adhere to current guidance of face coverings. Requirement for wellness declaration on arrival. Requirement for people to work in consistent groups in so far as possible. Clarification of IPC and PPE requirements for collecting Nasopharyngeal Samples. Environmental cleaning is addressed as an appendix to provide some additional detail.	AMRIC Team in collaboration with Community Operations
1.0	23.03.2020	Initial Guidance	AMRIC Team

Purpose

The purpose of this document is to provide guidance related to the operation of community-based centres for collecting upper respiratory samples for testing for COVID-19.

Scope

This guidance document is intended to support those responsible for planning, organizing, managing or working in a community-based facility to collect upper respiratory samples for testing COVID-19. This guidance outlines an approach to achieve a basic level of infection prevention and control in these settings acknowledging that implementation may be challenging given the improvised nature of the facilities. Facilities that do not meet all of the requirements should be progressively improved or replaced as soon as practical to do so.

Introduction

The virus, which causes COVID-19 infection, is called SARS-CoV-2 and belongs to the broad family of viruses known as coronaviruses. It was first identified in the Wuhan province in China in December 2019 and a global pandemic event was declared in March 2020.

Transmission

Like other respiratory viruses, the transmission of SARS-CoV-2 occurs mainly through respiratory droplets generated from the mouth and nose of an infected person during activities such as coughing, sneezing, talking or laughing. The droplets may carry virus directly to the mouth, nose and eyes of person standing nearby or may land on a nearby surface. A scientific brief from the World Health Organization (09 July 2020) entitled Transmission of SARS-CoV-2: implications for infection prevention precautions – outlines new scientific evidence available on the virus that causes COVID-19. The conclusion of this report is that the virus is primarily spread through contact and respiratory droplets, but that under certain circumstances airborne transmission may occur (such as when aerosol generating procedures are conducted in health care settings or potentially, in indoor crowded poorly ventilated settings elsewhere). There has been an increase in concern regarding the risk of airborne

transmission in the context of new variants of the SARS-CoV-2 virus that emerged in late 2020 early 2021 some of which are associated with increased risk of transmission.

In general, higher levels of virus are present and people are most infectious around the time of first onset of symptoms.

Some people who never notice any symptoms may be infectious to others (asymptomatic transmission).

Survival in the environment

The SARS-CoV-2 virus has an outer coating called a lipid envelope. The presence of the lipid envelope means that virus is likely to survive for shorter periods outside the human body compared to a non-enveloped virus like Norovirus (Winter-vomiting virus).

The virus is easily killed by common household cleaning products, including bleach and disinfectants.

Survival on environmental surfaces depends on the type of surface and the environmental conditions. Virus can remain infectious on surfaces for some time and be transferred to the mouth, nose and eyes of another person on their hands after they touch the contaminated surface. The virus does not penetrate through the skin.

Duration of Infectivity

People may be infectious for up to two days before they develop symptoms (pre-symptomatic transmission). People with a positive COVID-19 test should self-isolate for 10 days from the date of onset of symptoms, the last 5 days of which there must be no fever. If the person had no symptoms of COVID-19 and the test result was positive, then the person should self-isolate for 10 days from the day the test was performed, the last 5 days of which should be fever free also.

Note, however, that if the person requires hospitalisation or is in a residential care facility or a nursing home, then the period of isolation is 14 days with no fever for the last 5 days of that period.

HCWs who have tested positive for COVID-19 and who are medically well can return to work 10 days after symptom onset (or date of test if no symptoms) AND 5 days with no fever.

Repeat testing at the end of the isolation period is generally not appropriate though exceptions may arise in the context of discussion with Microbiology, Infectious Disease or Public Health.

COVID-19 Contacts

For all close contacts, in line with advice from NPHE there will be day 0 and day 10 testing, with exit from restricted movements if the Day 10 test is reported as 'not detected' and if asymptomatic.

Vaccination

Vaccination for COVID-19 began in Ireland in late December 2020. A significant number of healthcare workers have now been vaccinated. While it is expected that vaccination is likely to offer a high degree of protection to healthcare workers after completion of vaccination and it may help reduce risk of transmission from healthcare worker to patient, the degree of protection afforded to healthcare workers in the context of intense exposure and the extent of protection afforded to patients as a result of healthcare worker vaccination is not yet fully established. At this time partially or fully vaccinated healthcare workers are advised to adhere to all IPC measure in this guideline in the same way as they did prior to vaccination. This advice will be reviewed regularly on the basis of emerging evidence and experience.

Comprehensive Infection Prevention and Control Guidance

Detailed Infection Prevention and Control guidance for the healthcare services is available in Interim Guidance on Infection Prevention and Control for the Health Service Executive. IPC guidance for the healthcare system is not directly applicable in this non-healthcare setting however many of the principles are relevant and the document may be a useful point of reference.

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/>

1. The Environment

The facility should be such as to allow all surfaces, particularly all contact surfaces to be readily cleaned and disinfected. Consideration should be given as to how to maximise ventilation with due regard to the weather and comfort of staff and people attending for testing.

Where possible the facility should be laid out to enable people who arrive by car to park at a convenient location and remain in their car until their appointment time. The space should be large enough to ensure that anyone waiting for testing can adhere to current guidance regarding safe distance from other patients and from staff. Note that maintaining distance is not possible when collecting the sample for testing. The facility should be secure so that healthcare risk waste can be protected until disposed of safely.

The facility should be free of any unnecessary objects.

Alcohol hand rub should be provided at the entrance and exit and patients required to perform hand hygiene on entry and before exit.

If toilet facilities are provided, they must be cleaned at least twice a day and checked for cleanliness at least 4 times per day.

There should be a designated area where a staff member who develops symptoms can wait for pick up if they develop symptoms and are unable to travel home on their own.

2. The Operation

There should be effective supervision at all times to ensure that guidance is implemented.

All staff should be required to declare that they are symptom free on arrival for work and should inform their manager and leave promptly if they develop symptoms that may suggest COVID-19.

In so far as possible staff should be rostered to work in consistent groups to minimise mixing. It is acknowledged that this will not always be practical.

Staff should not eat, drink or smoke/vape smoke in the testing area and should minimise social interaction.

Dining/break facilities should be separate from the testing area and guidance on hand hygiene, social distancing and mask use observed.

Staff should follow good infection prevention and control practice in particular careful

attention to hand hygiene, respiratory hygiene and cough etiquette and should use appropriate PPE as per national guidelines (please see link below).

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/>

When collecting a sample there is a risk of droplet transmission. In the context of increased concern regarding the potential for airborne transmission staff exposed to people with suspected or confirmed COVID-19 or COVID-19 Contacts should have access to a respirator mask (for example FFP2 mask) and eye protection. In the context of a COVID-19 assessment hub it is appropriate to consider all patients in the setting as suspected or confirmed COVID-19 cases or COVID-19 contacts. A surgical mask and eye protection also provide considerable protection and may be preferred by some staff.

When staff are in contact with other staff but not with people attending for testing use of a surgical mask is appropriate.

In keeping with general IPC guidance staff collecting nasopharyngeal samples should be bare below the elbows (or bare above the wrist). In addition to a mask and eye protection, staff should wear gloves and a plastic apron.

In some circumstances community testing has been provided in settings where staff report that it is too cold to work in garments that leave the forearms exposed. If staff feel that it is essential to wear long sleeve garments because of the environmental conditions, there is potential for contamination of the lower part of the sleeves and they are not amenable to cleaning in the same way as the skin. In such circumstances, use of a long sleeve gown in preference to an apron to ensure that the sleeves of garments are not contaminated is reasonable as an interim measure pending provision of a more suitable working environment.

Where possible people attending for testing should be by appointment to avoid people congregating while waiting for testing.

Where possible people who drive to the centre by private car should remain in their car until called for testing or be tested in the car if that is practical.

Signage should indicate that people waiting for testing should adhere to current guidance on use of face coverings and should not eat, drink or smoke/vape smoke. They should have no contact with or speak with others awaiting testing and should leave promptly after testing.

Where possible flow of people for testing should avoid overlap between people arriving for testing and those leaving (to avoid social interaction).

Staff must not perform testing on people who have not been referred by the appropriate pathway.

3. Training of staff

Training of staff should at a minimum require familiarising themselves with good infection prevention and control practice for example by reading relevant guidance at

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/>

and watching relevant videos at

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/sampling/>

Ideally, face-to-face hand hygiene training should be performed by a hand hygiene trainer who has already completed the National Hand Hygiene Train the Trainer programme. If not available training in performing hand hygiene should be completed and assessed on: <https://www.hseland.ie>.

Donning and doffing PPE should be assessed by a Test Centre lead and documented as satisfactory.

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/>

Training in sample collection (both nasopharyngeal samples and deep nasal/mid-turbinate samples) and packaging should at a minimum include familiarity with the content of the guidance on sample collection. A video resource for sampling is set out at:

<https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/sampling/>

There is no evidence that requesting that people to blow their nose in advance of collection of a nasopharyngeal swab is required.

For those without previous experience taking such samples observation of at least 5 sample collections is appropriate. For those with previous experience this may not be required.

Competency on sample collection and packaging should be assessed. Competency may be assessed by performing swabbing on a staff member volunteer. For those without previous experience taking such samples, observation of at least 2 sample collections is appropriate with subsequent self-assessment of competence thereafter.

Staff should be trained in their obligation to respect confidentiality as per HSE Confidentiality Policy and should sign a declaration of their commitment to respect that obligation.

4. Staff Uniforms/Personal Clothes

There is no evidence that uniforms/personal clothing pose a significant hazard in terms of spreading infection and normal household laundry practices can be expected to inactivate the COVID-19 virus and most other common pathogens. A ten-minute wash at 60°C is sufficient to remove most micro-organisms. Using detergents means that many organisms can be removed from fabrics at lower temperatures however; it is recommended that uniforms are washed at the hottest temperature suitable for the fabric.

Change immediately if uniform or clothes become visibly soiled or contaminated.

Appendix

COVID-19 Preliminary Infection Prevention and Control Cleaning Guidance for Community based COVID-19 Testing Centres

Key points

- Cleaning of an area with water and detergent and disinfection of the area after someone with suspected coronavirus (COVID-19) is expected to reduce the risk of transmission of the infection on to other people.
- Staff should be trained in relation to hand hygiene, PPE use and maintaining distance from potentially infected people.
- Staff should have access to hand hygiene facilities and PPE.
- Wear disposable or washing-up gloves and aprons for cleaning. Disposable items should be double-bagged in a waste bag after use.
- When cleaning, pay particular attention to frequently touched areas and surfaces such as bathrooms, grab-rails in corridors and stairwells and door handles.
- Clean hands regularly with soap and water for 20 seconds or use an alcohol gel and
- Always clean hands after removing gloves, aprons and other PPE used while cleaning.

Personal protective equipment (PPE)

PPE should be worn to support other good infection prevention and control practice for cleaning an area occupied by a person with possible or confirmed COVID-19. Generally, disposable gloves and an apron are appropriate. Hands should be cleaned with soap and water or alcohol hand rub for 20 seconds after all PPE has been removed.

In the unlikely event that there is a risk of splash to the face, goggles and a face mask maybe required in addition to gloves and a plastic apron.

Cleaning and disinfection

A high standard of cleaning is required in all areas in particular those areas where members of the public wait and are tested.

Cleaning public areas

Public areas where symptomatic individuals have passed through and spent minimal time, such as corridors, but which are not visibly contaminated with body fluids can be cleaned thoroughly at least twice per day. Frequently touch surfaces such as door handles, lift buttons, handrails and stair rails should be cleaned more often.

Cleaning materials and equipment

- Use disposable cloths to clean all hard surfaces.
- Use disposable mop heads to clean floors or use mop heads that can be laundered at an industrial standard at a minimum of 60 degrees Celsius.
- Disposable damp combined detergent and disinfectant wipes may be preferable for electric switches and electric appliances.
- A household detergent followed by disinfection (1000 parts per million available chlorine) may be used. Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.

Or

If an alternative disinfectant is used, this should be checked and ensure that it is effective against COVID-19.

- Avoid creating splashes and spray when cleaning.
- Any disposable cloths and mop heads used must be disposed of and should be put into waste bags as outlined below.
- Any items that are heavily contaminated with body fluids and cannot be cleaned by washing should be disposed of.

Waste

Waste should be put in a plastic waste bag and tied when full. If there is no clinical waste collection, waste should be double bagged and stored safely for 72 hours before it is left for removal as domestic waste.

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