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BY EMAIL ONLY

12th July 2022

Ms Phil Ní Sheaghdha
General Secretary
Irish Nurses and Midwives Organisation
The Whitworth Building
North Brunswick Street
Dublin 7

Re: INMO concerns re: COVID-19

Dear Ms Ní Sheaghdha,

Many thanks for your letter received on the 5th of July.

1. Reintroduction of COVID Screening for hospital arrivals

The current AMRIC Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting V2.14 01.07.2022 guidance outlines that admission testing is not required but can be done if local risk assessment indicates it is appropriate.
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/guidanceforhealthcareworkers/acutehospitalsguidance/InfectionPreventionandControlPrecautionsforAcuteSettings.pdf

I am aware that at least two centres have reinstated testing on admission due to current wave and rising case numbers. This will be kept under continuous review. Whilst AMRIC issue guidance it is expected that hospital settings are free to make a risk assessed decision to do more or less testing than is in the guidance, depending on what is happening in the population that they serve.

2. Strengthening advice around mask- wearing

Separate guidance (3) are in place to support staff in acute and community residential settings. They are addressed below.

V 2.8 Current recommendations for the use of Personal Protective Equipment (PPE) for Possible or Confirmed COVID-19 in a pandemic setting as at 02.06.2022 is available at:
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/Current%20recommendations%20for%20the%20use%20of%20PPE.pdf

For staff working in acute hospitals, V2.14 Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting as at 01/07/2022 (For Implementation 4th of July 2022) refers.

This guidance sets out the following in relation to appropriate use of PPE:

- Respirator masks should continue to be worn by healthcare workers in all settings where they are caring for patients with suspected or confirmed COVID-19.
- Respirator masks should also be worn in settings where the infection prevention and control team advice indicates that there is a high risk that patients with unsuspected COVID-19 are likely to be present.
- Healthcare workers in low-risk settings, when caring for those who do not have suspected or confirmed COVID-19, can revert to wearing a surgical mask.
- Recognising that health care workers' preferences are an important consideration, respirator masks should continue to be available to healthcare workers in all settings, although they are not required.
- Carer staff who live and work with residents in health and social care settings should, when caring for those who do not have suspected or confirmed COVID-19, revert to wearing a surgical mask.
- Surgical masks should be worn by all healthcare workers for interactions with other healthcare workers in healthcare settings where patients are not cared for.
- HCWs in non-clinical settings where patients are not cared for may revert to public health guidance and may choose to continue to wear a surgical mask.

For staff working in community residential settings, V1.7 Public Health & Infection Prevention & Control Guidelines on the Prevention and Management of Cases and Outbreaks of COVID-19, Influenza & other Respiratory Infections in Residential Care Facilities as at 01/07/2022 (For Implementation 4th July 2022) refers

Personal Protective Equipment (PPE)

As part of Standard Precautions, it is the responsibility of every HCW to undertake a risk assessment PRIOR to performing a clinical care task, as this will inform the level of IPC precautions needed, including the choice of appropriate PPE for those who need to be present.

Full guidelines on the appropriate selection and use of PPE Appendix F and G and https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/.

Current guidance for the use of masks by HCW in the context of COVID-19 states that:

1. Respirator masks should continue to be worn by healthcare workers in all settings where they are caring for patients with suspected or confirmed COVID-19.

2. Respirator masks should also be worn in settings where the infection prevention and control team advice indicates that there is a high risk that patients with unsuspected COVID-19 are likely to be present.

3. Healthcare workers in low-risk settings, when caring for those who do not have suspected or confirmed COVID-19, can revert to wearing a surgical mask.

4. Recognising that health care workers' preferences are an important consideration, respirator masks should continue to be available to healthcare workers in all settings, although they are not required.

5.Carer staff who live and work with residents in health and social care settings should, when caring for those who do not have suspected or confirmed COVID-19, revert to wearing a surgical mask.

6. HCWs in non-clinical settings when not caring for residents should apply general public health advice, and may choose to continue to wear a surgical mask.

7. HCWs may choose to wear a surgical mask in busy public areas of healthcare facilities.

8. Facemasks that are worn by HCW's in circumstances other than contact with residents with suspected or confirmed COVID-19 may be disposed of in the domestic waste stream;

9.Educational videos are also available on www.hpsc.ie at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/ ;

All staff must be trained in the proper use of all PPE that they may be required to wear;

The Health and Safety Authority indicates that where a risk assessment indicates that workers need to use a close-fitting respirator mask for their protection that every effort should be made to comply with the requirement for fit testing of the workers, as far as is reasonably practicable. When fit testing of all staff is not immediately possible, then fit testing should be prioritised for those at greatest risk;

Note that in outbreak situations or other exceptional circumstances where extended use of some items of PPE (other than gloves) when moving between people care for with a confirmed diagnosis of COVID-19 might be considered, it is important to make every effort to avoid generalised use of PPE throughout the facility without considering the level of risk. Note that extended use of PPE for the sole purpose of reducing PPE use is not appropriate, as PPE supplies should be sufficient to meet requirements;

3. A second booster for healthcare workers

You will be aware that the Department of Health sets the policy for all national immunisation programmes, including the COVID-19 vaccine programme. This policy is based on NIAC guidance, which is kept under constant review.

4. Ventilation in hospitals and other healthcare settings

Separate guidance is in place to support staff in acute and community residential settings. They are both addressed below.

V2.14 Acute Hospital Infection Prevention and Control Precautions for Possible or Confirmed COVID-19 in a Pandemic Setting as at 01/07/2022 (For Implementation 4th of July 2022) refers.
This guidance sets out the following in relation to ventilation:

Experience with SARS-CoV-2 has emphasised that transmission of virus through the air is complex and that the categories of droplet and airborne should be seen more as describing general patterns of transmission through the air rather than as discrete phenomena. This is particularly the case with experience in hospitals in Ireland since the dissemination of the alpha and delta variants and in the context of use of high flow oxygen devices (an aerosol

generating procedure associated with increased risk of transmission). Although transmission of COVID-19 is typically by droplet pattern, a pattern of airborne type spread has been associated with closed poorly ventilated spaces in which many people stay for long periods of time. A recent update from the European Centre for Disease Control provides a perspective on ventilation and air conditioning in the context of COVID-19 at the following link.

https://www.ecdc.europa.eu/en/publications-data/heating-ventilation-air-conditioning-systems-covid-19

In the general clinical environment, strict adherence to contact and droplet precautions remains very important in managing the risk of transmission in the absence of AGPs. However, given the experience of airborne patterns of transmission in some circumstances it is important that staff should use respirator masks when caring for patients with suspected or confirmed COVID-19 and it is prudent to maximise ventilation to the greatest extent that is practical consistent with comfort and without introducing other potentially greater risks.
There is evidence that novel air cleaning methods in healthcare environment reduces the burden of SARS-CoV-2 in the air in poorly ventilated spaces. There remains little or no clinical evidence that demonstrates that this technology reduces the risk of acquiring infection in a clinical environment. In the absence of such evidence deployment of such systems is not generally recommended but this may be a consideration in certain settings based on risk assessment.

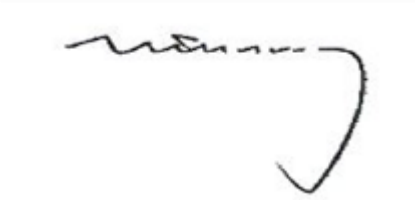
In this context the following is recommended:

1. In clinical areas where there is established mechanical ventilation that has been appropriately commissioned, meets current standards for the healthcare environment and is well maintained, no modification of the operation of this system is required;
2. In areas where there is no mechanical ventilation, it is appropriate to increase natural ventilation in clinical areas by opening windows and doors in so far as practical and consistent with comfort and security of patients and staff; the goal is gentle air circulation rather than strong air currents;
3. In circumstances where entry of unfiltered external air is assessed as associated with a high risk for introduction of aspergillus spores into an environment where there are vulnerable patients, the exclusion of aspergillus spores takes priority over increasing natural ventilation with a view to reducing the risk of transmission of COVID-19;
4. If exhaust fans are used they must be installed so that the air is released directly outdoors. The number and technical specification of exhaust fans must take account of the size of the room and the desired ventilation rate. Positioning the exhaust fan should be done so that it is not close to a ventilation air intake;
5. Installation of whirlybirds (for example whirligigs, wind turbines) may be useful to increase air flow in settings where they can be deployed;
6. When appropriately selected, deployed and maintained, single-space air cleaners with HEPA filters (either ceiling mounted or portable) can be effective in reducing/lowering concentrations of infectious aerosols in a single space, however they have not been shown to reduce the risk of patients acquiring infection with COVID-19 in a healthcare setting;
7. Some healthcare settings have found it helpful to use carbon dioxide (CO_2) monitors, mobile or fixed, to identify areas of poor ventilation and or to monitor ventilation. The deployment of monitors may help to identify specific areas where ventilation is poor and where particular efforts to increase ventilation are required.

5. **Publication of COVID cases among Healthcare Workers**
   The collation of COVID positive cases amongst healthcare workers is currently being reviewed by national human resources and operations.

6. **PCR screening for healthcare staff**
   As part of the test and tracing transition consideration is being given the requirement for PCR testing for Healthcare staff and guidance is currently being reviewed.

Yours sincerely,



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Dr Colm Henry
Chief Clinical Officer