LocCOV.075 - COVID-19 In-Patient Settings Outbreak Control Process and Management

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Clinical Lead	Sharon Daniel	CL Approved	Yes	Date of CL approval:	21.12.2020

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1		Mr Mark Henwood, Deputy Medical Director (on behalf of Dr Phil Kloer, Medical Director & Deputy CEO) Mandy Rayani, Director of Nursing, Quality and Patient Experience	05/01/2021	05/01/2021	March 2021

Brief Summary of Document:	Healthcare Associated COVID-19 infection is associated with increased harm and mortality and reducing these is a clear patient safety issue. Early identification of increased incidences of infection and outbreaks are key components in reducing Healthcare Associated COVID-19 infection and are central to understanding COVID-19 transmission within healthcare, providing transparency on performance and supporting a focus on the culture of continuous improvement
Scope	All staff should adhere to the UK COVID-19 IP&C guidance for remobilisation of services to prevent outbreaks and incidents of COVID-19 infection.

To be read in conjunction with:	COVID-19 16 Point Plan to limit, minimise and mitigate the risks associated with transmission in a healthcare setting (Appendix 1) and Section 2.8 of the Communicable Disease Outbreak Plan for Wales (2020) which outlines arrangements for the control of an outbreak or incident of infection in NHS Hospitals.
Patient Information:	Include links to Patient Information Library

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	05/01/2021

Glossary of Terms	
Term	**Definition**

Keywords	COVID-19, In-Patient Settings, Outbreak Control, Process, Management
Lead Author	Sharon Daniel, Assistant Director of Nursing
Owning committee/ group	IPC Strategic Steering Group

Reviewed/Approved by: *(Local and National Committees and Command meetings)*	**Date:**
Mandy Rayani, Director of Nursing, Quality and Patient Experience	05/01/2021
Mr Mark Henwood, Deputy Medical Director (on behalf of Dr Phil Kloer, Medical Director & Deputy CEO)	22/12/2020
Tactical Group	25/11/2020
Executive lead	Mandy Rayani, Director of Nursing, Quality and Patient Experience

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Background:
Healthcare Associated COVID-19 infection is associated with increased harm and mortality and reducing these is a clear patient safety issue. Early identification of increased incidences of infection and outbreaks are key components in reducing Healthcare Associated COVID-19 infection and are central to understanding COVID-19 transmission within healthcare, providing transparency on performance and supporting a focus on the culture of continuous improvement.

All staff should adhere to the UK COVID-19 IP&C guidance for remobilisation of services to prevent outbreaks and incidents of COVID-19 infection.

This document should be read in communion with the COVID-19 16 Point Plan to limit, minimise and mitigate the risks associated with transmission in a healthcare setting (Appendix 1) and Section 2.8 of the Communicable Disease Outbreak Plan for Wales (2020) which outlines arrangements for the control of an outbreak or incident of infection in NHS Hospitals.

Aim:
The purpose of the document is to provide a clear process to aid the identification, management and reporting of Healthcare Associated COVID-19 infection and outbreaks of Healthcare Associated COVID-19.

Objectives:
The process set out in this document must be adhered to ensuring that:

- Outbreaks of COVID-19 are identified rapidly and managed according to national guidance
- The Rapid Reviews investigation process is completed ……with lessons learned identified and shared (Appendix 2)
- Processes for management of COVID 19 cases are in line with national guidance
- All potential outbreaks are escalated to the Hywel Dda University Health Board (HB) Command Centre (CC) via daily sit rep reporting (Appendix 3). Outbreak procedures in line with COVID guidance should be followed
- Processes for management of COVID 19 cases are in line with national guidance

Identifying an Outbreak

At the first OCT a case definition for the outbreak should be agreed, to aid with management and subsequent closure of the outbreak.

<u>Definition of an outbreak of healthcare-associated COVID-19 infection in an inpatient setting</u>:

Two or more confirmed or clinically suspected cases of COVID-19 among individuals (e.g. patients, healthcare workers (HCW), other hospital staff and regular visitors e.g. volunteers, chaplains) associated with a specific setting (e.g. bay, ward or shared space), where at least one case (if a patient) may have been acquired after admission to hospital / or for staff acquisition linked to the healthcare setting.

Note: If there is a single laboratory confirmed case, this would initiate further investigation and risk assessment. Similar approaches can be taken for other clinical settings, such as day-care units including renal dialysis or chemotherapy settings. Responses would need to be individualised to each occurrence

Although there are technically three categories for determining potential healthcare acquired cases, for the purposes of defining an outbreak the Nosocomial Transmission Group advise that only probable and definite cases of Healthcare Associated COVID-19 infection will be considered as below:

1. Healthcare-Onset Probable Healthcare-Associated (HO-pHA) – First positive specimen date 8-14 days after admission to hospital
2. Healthcare-Onset Definite Healthcare-Associated (HO-dHA) – First positive specimen date 15 or more days after admission to hospital.

HCAI category	**Criteria**
Community onset	Positive specimen date ≤2 days after admission to Trust
Hospital onset - **Indeterminate** healthcare-associated	Positive specimen date 3-7 days after admission to Trust
Hospital onset - **Probable** healthcare-associated	Positive specimen date 8-14 days after admission to Trust
Hospital onset - **Definite** healthcare-associated	Positive specimen date 15 or more days after admission to Trust

<u>Definition of case:</u>

- Confirmed cases are defined as those who have received an initial positive test result for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).
- Clinically suspected cases are defined as those with symptoms fitting the case definition who are awaiting testing or the results of a test, or if the result is negative but there remains a strong clinical suspicion of SARS-CoV-2 being the causative agent.
- Possible cases are defined as those who have an initial low positive test result for SARS-CoV-2, who require further clinical evaluation and re-testing to confirm status. Definition of a contact

- Direct contact: Face to face contact with a case (confirmed or clinically suspected) for any length of time, within 1m, including being coughed on, a face to face conversation, unprotected physical contact (skin to skin)*. This includes exposure within 1 metre for 1 minute or longer.
- Proximity contact: Extended close contact (within 2 metres for more than 15 minutes) with a case**. This would include a person who has spent a significant amount of time in an area shared with the case or shared washing/cooking facilities. In an inpatient setting this will normally include those within a bay, patient lounge, therapy area or within the same area not physically separated from the rest of the ward/other patients by a wall or door, or same toilet facilities. The relevant time period for these to be considered contacts is 48 hours prior to the onset of symptoms (or first positive test result if asymptomatic) in the index case.

*Please note that for some clinical outpatient settings, such as vaccination/injection clinics, where contact with individuals is minimal, and the need for single use PPE items for example, gloves and aprons is not necessary. Gloves and aprons are recommended when there is (anticipated) exposure to blood/body fluids or non-intact skin. Staff administering vaccinations/injections must apply hand hygiene between patients and as long as they are wearing a sessional face mask they will not be considered a contact.

** If an individual has been correctly wearing the appropriate PPE and following the approved donning and doffing guidance then they are NOT considered to be a contact. For healthcare associated cases it would be worth considering a review of the patient contacts along the patient journey up to 14 days prior to the symptoms / positive test result to ascertain possible sources for the healthcare associated infection.

Specific considerations for COVID-19 outbreak management (Please refer to Appendix 4, 5 and 6).

The Executive Nurse Director is the designated lead for IP&C in the HB Level and all Executive Officers need to provide support during outbreaks, as required by the OCT. It is recognised that the HB will try to keep services running during an outbreak but this should be done in a way that supports any containment measures brought in to bring the outbreak to a close. Thus consideration will need to be given what services are not delivered.

- An Executive will designate a member of the relevant Triumvirate Team to lead the outbreak response within the hospital setting with support from the Infection Prevention & Control Team (IP&C) / IP&C Doctor / Medical Microbiologists and healthcare epidemiologists.
- When a COVID related incident or outbreak is declared in, the Consultant in Communicable Disease (CCDC) should be informed at an early stage and invited to the Outbreak Controls Team (OCT). The CCDC can offer guidance on the overall investigation including establishment of the OCT processes, standard data collection and other tools (with Healthcare Epidemiologist and IPC

involvement) and Sitrep reporting, as well as sharing learning from other similar Outbreaks that may assist.

- The Healthcare Epidemiologists can provide epidemiological support on site and working closely with the IPCT bring together RCA review of cases and other Health Board data with the epidemiological analysis of data available through ICNET
- For COVID-19 incidents / outbreaks please inform the Incident Directors of PHW via e-mail PHW.2019ncov@wales.nhs.uk and the Healthcare Associated Infection, Antimicrobial Resistance and Prescribing Programme team (HARP) via HARP@wales.nhs.UK as soon as possible, so that there is awareness of the issue in the system and an ability to draw on 2 support from PHW Microbiology - Virology / CDSC – epidemiology / HARP – IP&C expertise as required
- Welsh Government MUST be informed using the revised form without delay to: nosocomialoutbreak@gov.wales by no later than 18:00 daily until the outbreak/incident is declared over.
- Ensure consistent implementation of the UK COVID-19 IP&C Guidance, including in staff areas
- Establish an outbreak control team in line with the HB Outbreak Policy 236-OutbreakManagementPolicy-v3.pdf (wales.nhs.uk).
- Identify all cases and contacts including contacts in other ward or clinical areas who fit the contact definition when the patient pathway is reviewed (up to 14 days pre development of symptoms / testing positive).
    - Consider all previous staff and patient exposures in the previous 14 days, to identify common likely sources of infection, particularly if there is more than one case where such lookback may be more fruitful
- Agree a testing plan based on national guidance to support the investigation and management of the outbreak – ensure it is developed with input from local Medical Microbiologist(s) and in conjunction with the sampling team and the testing laboratory.
    - The wider outbreak testing plan should include:
        - Patient contact testing plan
        - Staff Testing plan
        - Considerations of wider testing e.g. expanding testing to specific groups of patients or units.
- Management of Healthcare Worker (HCW) / Employee testing and working arrangements during the outbreak needs to managed with support from occupational health departments and workforce / operational planning teams (Appendix 8).
- Inpatients who are known to have been exposed to another patient with confirmed COVID-19 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.
- Reduce movements of patients between pathways / areas. Ensure that there is a clear plan for patient pathways and access to those pathways based on high, medium and low risk categories as per the UK IP&C guidance.
- Ensure that there are good step-down arrangements / step down facilities to support patient flow / capacity and protecting the pathways.
- Ensure clear plans for managing regional services / appropriate isolation and testing plans for moving patients in and out of regional services.

- Reduce staff movements between pathways and within ward e.g. cohorting staff; reduce staff movement between wards/hospitals/depts e.g. per shift , bank and agency.
- Close contact between staff over prolonged periods should be minimised including in non-clinical areas; for example, by the appropriate wearing of masks in both clinical and non-clinical areas, avoiding congregating at central work stations, restricting the number of staff on ward rounds, conducting handover sessions in a setting where there is space for social distancing, moving to 'virtual' multi-disciplinary team meetings, and considering staggering staff breaks to limit the density of healthcare workers in specific areas
- If a member of staff develops symptoms of COVID-19 they should follow the self-isolation household guidance for Wales and get tested as soon as possible. https://gov.wales/self-isolation-stay-home-guidance-households-possible-coronavirus
    - Once well and ready to return to work they should follow the return to work guidance in Management of Staff and Exposed Patients COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk) Section 7.
- Staff members contacted by the NHS Wales Test, Trace and Protect (TTP) Service and advised to isolate should do so.
- On the wards:
    - Increase frequency of cleaning as per national guidance
    - Audit and report to OCT compliance with infection prevention and control measures:
    - Hand hygiene compliance
    - PPE use and doffing practice
    - Social distancing measures and compliance
    - Inappropriate use of gloves o cleaning frequencies and environmental issues
- All organisations to do multi-disciplinary root cause analyses (RCAs) for every probable and definite healthcare-associated COVID-19 inpatient infection i.e. for patients with a positive specimen date 8 days or more after admission to hospital, and all deaths associated with the outbreak.
- Agree communications and media approach for outbreak
- Agree reporting arrangements within the HB / Trust and to external partners. The HB has access to the ICNet reporting tool and is expected to use it in full.

Definitions for declaring the end of an outbreak of healthcare associated COVID-19

A healthcare-associated COVID-19 outbreak can be declared over once there are no confirmed cases (meeting the definition of hospital onset) with onset dates in the last 28 days in the specific setting. However, it is acknowledged that local operational challenges will have to be addressed – thus it is recommended that clear patient pathways and agreed criteria for opening areas to new patients are agreed at OCT.

Recent evidence suggest that:

- The duration of RNA shedding detected by PCR was far longer compared to detection of live culture. Six out of eight studies reported RNA shedding for longer than 14 days. Yet,

infectivity declines after day 8 even among cases with ongoing high viral loads. A very small proportion of people re-testing positive after hospital discharge or with high Ct are likely to be infectious https://www.medrxiv.org/content/10.1101/2020.08.04.20167932v4

Issues to consider when stopping of COVID-19 isolation and IPC measures if patient staying in hospital:

For suspect or confirmed COVID-19 patients, IPC measures should continue until 14 days have elapsed since their first positive SARS-CoV-2 PCR test, provided the clinical improvement criteria below have been met. This is due to uncertainties about the duration of infectiousness for patients with more severe illness or underlying immune problems that may delay them clearing the virus. Guidance for stepdown of infection control precautions and discharging COVID-19 patients - GOV.UK (www.gov.uk)

Clinical improvement criteria:

- clinical improvement with at least some respiratory recovery
- absence of fever (> 37.8°C) for 48 hours without the use of medication
- no underlying severe immunosuppression

Consider testing:

- severely immunocompromised patients to support the optimal use of side rooms, or where side rooms are not available
- where it optimises patient flow through the hospital, such as:
    - long-stay patients who are unable to otherwise be discharged
    - those being discharged to a household where someone is clinically extremely vulnerable

In Patient step down of IPC in Hospitalised patients:

With this in mind, based on assumption that post COVID patients will not present a COVID infection risk to patients other patients or indeed are at risk of re-infection in the short term it is proposed that COVID recovered patients, meeting the criteria below, can be stepped down and placed on existing outbreak wards when bed capacity in the hospital can no longer support patient flow. Consideration may be given to obtaining further PCR test recognising that the duration of RNA shedding detected by PCR is far longer compared to detection of live culture and thus not helpful in making clinical decisions. A positive COVID antibody test could assume a non-infectious status and is worth undertaken to aid clinical decision making.

Before control measures are stepped down for COVID-19, clinical teams must first consider the patient's ongoing need for transmission based precautions (TBPs) necessary for any other alert organisms (for example, MRSA carriage or C. difficile infection), or patients with ongoing diarrhoea.

For severely immunocompromised individuals, one negative test is acceptable for stepdown. If repeat testing remains positive after 14 days, and only if local testing capacity allows, patient samples should be tested after a further 7 days if the patient remains in hospital, or at

intervals of 2 weeks in the community (for example, at repeat hospital appointments if attending for another pressing indication).

If the patient is producing sputum or is intubated, a lower respiratory tract sample should be preferentially tested as the priority sample, as SARS-CoV-2 can be present in the lower respiratory tract despite being undetectable in the upper respiratory tract.

References:

Communicable Disease Plan for Wales: (https://phw.nhs.wales/topics/latest-information-onnovel-coronavirus-covid-19/the-communicable-disease-outbreak-plan-for-wales/) 20201106 - COVID-19 - PART 6 - Hospital Outbreaks.pdf

COVID-19: Infection Prevention and Control Guidance COVID-19: Management of HCW and exposed patients or residents in health and social care settings

COVID-19: Guidance for the remobilisation of services within health and care settings Infection prevention and control recommendations COVID-19 infection prevention and control guidance (publishing.service.gov.uk)

COVID_19: Management fo staff and exposed patients or residents in health & social care settings. COVID-19: management of staff and exposed patients or residents in health and social care settings - GOV.UK (www.gov.uk)

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SARS-CoV-2, SARS-CoV, and MERS-CoV viral load dynamics, duration of viral shedding, and infectiousness: a systematic review and meta-analysis PIIS2666524720301725 Lancet microbe.pdf

Self-isolation: stay at home guidance for households with possible coronavirus **Self-isolation: stay at home guidance for households with possible coronavirus | GOV.WALES**

Viral cultures for COVID-19 infectivity assessment. Systematic review **Viral cultures for COVID-19 infectivity assessment. Systematic review | medRxiv**

Viral cultures for COVID-19 infectivity assessment. **https://www.medrxiv.org/content/10.1101/2020.08.04.20167932v4**

Appendix 1: 20201105 - COVID-19 - 16 point plan - to limit minimise and mitigate the risks associated with COVID-19 (003).pdf

Appendix 2: Staff Investigation Protocol/ Rapid Review Investigation Toolkit

Staff Investigation Protocol

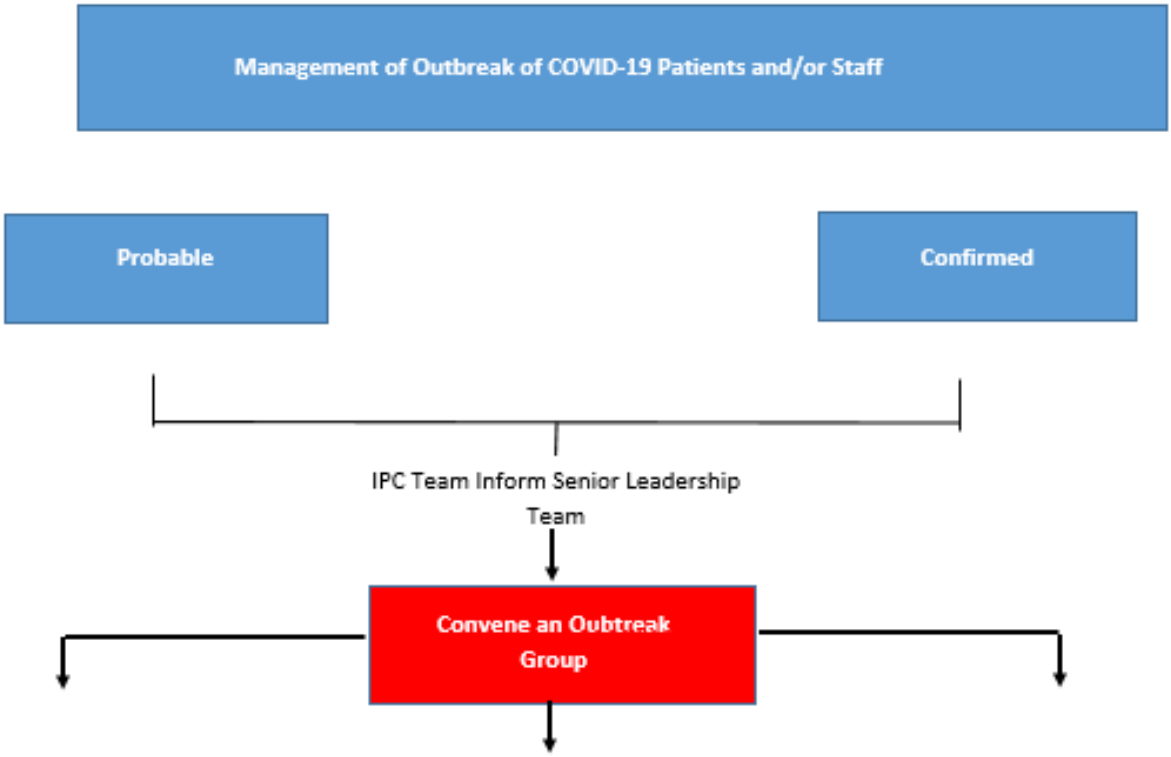
Rapid Review Investigation Toolkit

Appendix 3: Situation Reporting

Outbreak Reporting Form

Appendix 4:

Appendix 4 Management of Outbreak of COVID 19



OCT Membership

- Triumvirate team/Executive Lead
- IPCT
- Consultant microbiologist
- CCDC/CHP (
- Epidemiologist
- Senior professional (medical, nursing and departmental) representatives from the area(s) affected
- Administrative support
- Communications
- Facilities
- Occupational Health
- ASI Team
- Co-opted members

OCT

- Collate outbreak timeline and review cases
- Review IPC measures and checklist
- Advise on outbreak control measures including:
  -contact tracing -patient testing
  -staff testing
  -operational measures (ward closure etc)
  -cleaning
  -communications plan
  -Frequency of meetings
  -re-opening of any closed areas

- Identifies and confirms outbreak information submitted to correct source

- Declares when outbreak is over (no new cases within 14 days).

- Ensures outbreak information is submitted for to WG daily

Outbreak Information Required

- At outbreak start completed No Surprises proforma to be sent to DoN
- Lead Nurse to Complete Daily Sit-rep* send to: COVIDenquires.hdd@wales.nhs.uk for collation and then onto nosocomialoutbreak@gov.wales
- Minutes of OCG
- Completed No Surprises* once outbreak declared over
- Outbreak report summary and learning identified to be presented through Quality Safety Experience and Assurance Committee

*Lead Nurse/Outbreak manager responsibility. Sit reps must be submitted no later than 5pm daily, 7 days a week for 28 days following commencement of outbreak. If no outbreaks a nil return must also be made daily.

Appendix 5:

Appendix 5 Escalation Process

Appendix 6 COVID Measures Implementation Checklist

COVID-19 MEASURES IMPLEMENTATION CHECKLIST	
Standard Infection Control Precautions-Applies to all staff, in all care settings Patients, staff and visitors are encouraged to minimise COVID-19 transmission through: **• Good hand hygiene and respiratory hygiene** **• Social distancing wherever possible In addition, all staff are requested to:** **• Adhere to social distancing, particularly when in non-clinical areas eg during work breaks and in communal areas.** **• Stagger breaks to limit the density of staff in any one specific area(s).**	
Patient placement/assessment of risk/cohort area	**Comments/notes**
Emergency department, admission and waiting areas Patients are triaged rapidly to segregate and maintain separation in space and/or time between possible and confirmed COVID19 patients and non-COVID-19 patients. Suspected cases are asked to wear a face mask. There is physical separation of reception staff eg perspex screens. **On admission** Possible cases (awaiting lab confirmation) and confirmed cases are isolated in a single room with clinical wash hand basin and en-suite facilities. If single rooms are in short supply, priority is given to patients who have excessive cough and sputum production. Single rooms in non-COVID-19 areas are reserved for patients requiring isolation for other (non-influenza-like illness) reasons. Prioritising of patients for isolation other than suspected or confirmed COVID-19 patients is decided locally, based on patient need and local resources. Possible cases (awaiting lab confirmation) should be cohorted separately (ideally in single rooms) until confirmed. Patients with new onset symptoms are isolated immediately and contacts traced. **Cohort areas** are established for multiple cases of confirmed COVID-19, ideally in a designated, self-contained area. Patients should be separated by at least 2 metres and privacy curtains/screens used between bed spaces to minimise opportunities for close contact. The segregated area is not being used as a thoroughfare by other patients, visitors or staff. Doors to isolation/cohort rooms/areas are closed and	

signage is clear Patient placement is reviewed daily as the care pathway changes	
Staff cohorting Dedicated teams of staff are assigned to care for patients in isolation/cohort rooms/areas for their entire shift. There is consistency in staff allocation, reducing movement of staff and the crossover of care pathways between planned and elective care pathways and urgent and emergency care pathways; reducing movement of staff between different areas.	
Ensure all patient placement decisions and assessment of infection risk (including isolation requirements) is clearly documented in the patient notes and reviewed throughout inpatient stay	
Personal Protective Equipment (PPE)	
General ward All staff working in designated COVID-19 areas routinely wear fluid resistant surgical masks (FRSM). Staff providing direct care within 2 metres of a possible/confirmed case are wearing disposable aprons, gloves, FRSM and eye/face protection, when in the patients' immediate care environment. Link to PPE table.	
PPE must be: • Available at point of use and stored in a clean dry area. All staff (clinical and non-clinical): • are trained in putting on and removing PPE. • know what PPE they should wear for each setting and context. • have access to the PPE that protects them for the appropriate setting and context. • perform hand hygiene following removal of PPE. Single/sessional use Gloves and aprons are single use as per standard infection control precautions (SICPs), with disposal after each patient contact, task or procedure. Respiratory and eye/facial protection may be used for a session of work. Gown/coverall may be worn for a session of work in high risk areas	
Surgical facemasks All possible/confirmed inpatients wear a surgical facemask (if	

tolerated and does not compromise clinical care).	
Safe management of care equipment	
Single-use items are in use where possible. Dedicated, reusable, non-invasive care equipment is in use and decontaminated between each use and prior to use on another patient. See Routine decontamination of reusable non-invasive patient care equipment flowchart. Fans that re-circulate the air are not in use.	
Decontamination of the care environment	
Domestic teams are assigned to COVID-19 cohort area/wards. All areas are free from non-essential items and equipment.	
Isolation room/cohort area (cleaning of isolation areas is undertaken separately to the cleaning of other clinical areas.)	
There is at least twice daily decontamination of the patient isolation room/cohort area, toilet and bathroom and staff areas, including areas where PPE is removed. Manufacturers' guidance and contact times for cleaning and disinfection products are followed. There is decontamination of 'Frequently touched' surfaces at least twice daily and when they are known to be contaminated with secretions/blood/bodily fluids. Frequently touched surfaces include: • Toilets and commodes (particularly if patients have diarrhoea). • Door/toilet handles, locker tops, over bed tables, bed rails, desktops and electronic equipment – eg mobile phones, desk phones and other communication devices, tablets, keyboards; particularly where these are used by used by many people. • Rooms once vacated by staff following AGP (clearance times in isolation room 10-12 ACH wait minimum 20 minutes or single room with 6 ACH wait minimum of 1hr). 'Terminal' decontamination is undertaken following transfer, discharge, or once the patient(s) is no longer considered infectious. Communal cleaning trollies are not taken into patient rooms.	
Hand Hygiene	
Staff undertake hand hygiene as per WHO 5 moments, using either an alcohol-based hand rub (ABHR) or soap and water. Hands	

are dried with soft absorbent, disposable paper towels from a dispenser are available for use to dry hands, located close to handwash sinks and beyond risk of splash contamination. How to wash and dry hands posters are clearly displayed in all public toilets and staff areas. Staff are aware of the importance of skin care.	
Movement restrictions/transfer/discharge	
Moving patients within healthcare Patients with possible/confirmed COVID are not moved to other wards/departments unless for essential care. If necessary: • Staff at the receiving destination are informed that the patient has possible or confirmed COVID-19. • Patient is wearing a surgical face mask during transportation. • Patients are taken straight to and returned from clinical departments. • If possible, patients are placed at the end of clinical lists.	
Waste	
Disposal and transport of all waste related to possible/confirmed cases is classified as Category B clinical waste (orange bag).	
Linen	
All linen is managed as 'infectious' linen. Disposable gloves and apron are worn when handling infectious linen. All linen is handled inside the patient room/cohort area. A laundry receptacle is available as close as possible to the point of use for immediate linen deposit. All linen bags/receptacles are tagged with ward/care area and date. All used/infectious linen is stored in a designated area whilst awaiting collection	
Respiratory Hygiene	
Patients are supported with hand hygiene and provided with disposable tissues and a waste bag. Symptomatic patients may wear a surgical face mask if tolerated: • In common waiting areas. • During transportation. • In clinical areas. A surgical face mask should not be worn by patients if there is potential for their clinical care to be compromised.	
Visitors	

Signage regarding any visitor restrictions is clearly visible.	

Appendix 7: Staff Contacts Tracing Managemen