

V-C 1035

Urgent Care Division

Infection Prevention and Control
Guidance (COVID-19)

1. Document Control

1.1. Document Approval

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1. Background

In a healthcare setting infection prevention and control (IPC) is essential at all times. During emergency outbreaks, such as COVID-19, procedures are often enhanced or altered to meet the needs of the public, staff and continued service provision. This helps to ensure that novel infectious agents are not spread to staff and members of the public that access Vocare services.

2. Purpose

The purpose of this document is to provide guidance to supplement current Infection Prevention and Control Policies and Standard Operating Procedures. It has brought together current national guidance and has been developed in the context of a changing situation and extreme pressure on some NHS services and the resources required to deliver them.

This does not replace infection prevention and control guidance which is available on the government website: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>. Its purpose is to help staff to understand how that guidance applies to the Urgent Care Division's services.

3. Scope

This guidance is applicable to all staff working in the Totally Urgent Care Division. The guidance is relevant for staff working in all areas, including patient facing services and in general office and contact centres.

For clinicians who may be required to undertake a visit to a patient's place of residence, this guidance should be read in conjunction with the Urgent Care Division Infection Prevention and Control Guidance for Home Visiting.

For staff working predominantly in contact centres and offices, and for those utilising communal areas this guidance should be read in conjunction with the Urgent Care Division Infection Prevention and Control Guidance for Contact Centres, Offices and Communal Areas.

This guidance should also be read in conjunction with:

- V-C 1035 IPC Guidance Including PPE
- Vocare and Greenbrook Infection Prevention and Control Policies and Procedures
- Vocare and Greenbrook Health and Safety Policies and Procedures
- COVID-19: infection prevention and control guidance, Public Health England, (current version on the website: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>)
- Resuscitation Council UK Statement on PHE PPE Guidance, 28 April 2020 (<https://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/statement-on-phe-ppe-guidance/>)

4. Responsibilities

4.1. The Organisation

The organisation is responsible for:

- Ensuring that risk assessments for vulnerable staff are undertaken

- Enabling staff to work from home wherever this is possible
- Undertaking risk assessments and implementing actions to prevent or reduce risk to patients, staff and visitors
- Ensuring that where staff work on the premises of partner organisations adequate measures have been taken to protect the health and safety of the workforce
- Providing the equipment and resources to ensure that staff can work safely. This includes PPE and resources to consistently adhere to infection prevention and control measures
- Providing guidance to staff to enable them to work safely
- Ensuring that workplaces are kept clean thereby reducing the risk of transmission of infection

4.2. All Staff

All Urgent Care Division staff regardless of where they work are responsible for:

- Not attending work if they are displaying any symptoms which may suggest coronavirus infection, which currently include:
 - A high temperature
 - A new, continuous cough
 - Shortness of breath or difficulty breathing
 - Chills
 - Muscle pain
 - Sore throat
 - New loss of taste or smell
 - Diarrhoea and/or vomiting
- Reporting to their line manager/shift lead should they become unwell at work with any of the symptoms listed above
- Being aware of good hygiene technique and practicing it rigorously
- Being aware of the routes of transmission for COVID-19 infection and thereby understanding how to practice in a way that breaks the chain of infection
- Following all infection prevention and control guidance including any guidance provided by partner organisations who may be hosting a service
- Promptly highlighting any infection prevention and control issues to a shift lead or line manager. This includes any issues or concerns with PPE
- Completion of online infection prevention and control training

4.3. Managerial Staff

Managerial staff are responsible for ensuring that all staff under their supervision:

- Apply the principles of standard infection control precautions
- Have access to all IPC guidance provided by the organisation and are made aware of any changes as they occur
- Have access to instruction on the principles of managing care equipment and controlling the environment which will include standard infection control precautions
- Have access to adequate resources to allow for recommended infection prevention and control measures such as medical device cleaning, staff training and appropriate storage of medical and computer equipment

In addition, managerial staff are responsible for:

- Undertaking and/or facilitating risk assessments, where necessary, to optimise patient and staff safety, such as the use of chlorine-based solutions, consulting relevant Vocare, Greenbrook and Public Health England infection control and prevention policies as required
- Ensuring that daily IPC walkabouts are completed for their service (see V-C 1029 Infection

- Prevention and Control Walkabout)
- Reporting any concerns regarding the IPC guidance
- Ensuring that cleaning schedules are completed, noting that cleaning schedules and standards are defined, monitored, documented and should be available within each site
- Ensuring that all sites have a range of visual displays to support the implementation of the required IPC measures

4.4. Cleaning Staff

Cleaning staff are responsible for:

- Complying with the IPC guidance of the site where they are undertaking cleaning duties, and reporting any issues with where this may differ from any guidance issued by their employing organisation
- Ensuring that cleaning schedules are fully complied with and where this cannot be undertaken immediately escalating this to their manager
- Reporting any deficits in resources that may prevent adherence to cleaning schedules
- Reporting any issues of non-compliance with guidance in a timely fashion

4.5. Health and Safety Manager

The Vocare Health and Safety Manager and Greenbrook Central Operations Manager are responsible for:

- Ensuring that cleaning schedules are kept under constant review to ensure that they are meeting the needs of individual sites
- Ensuring that IPC walk rounds are undertaken and recorded in respect of office areas and communal areas
- Ensuring that risk assessments undertaken by partner organisations and associated action plans have been reviewed and where required outstanding actions are escalated to the relevant Vocare Regional Director or Greenbrook Regional Service Director

5. Introduction

The importance of a clean, safe environment for all aspects of healthcare should not be underestimated. Healthcare equipment must be maintained to good infection prevention and control practices with thorough cleaning and maintenance performed before and after use. Good standards of basic hygiene, cleaning and regular planned maintenance will assist in preventing healthcare-associated infections (HCAIs), including novel virus strains with only emerging evidence in terms of survival outside a host and means of transmission.

Good hygiene is essential and is one of the easiest and most effective ways of infection control.

5.1. Chain of Infection

A person becomes infected when a chain of events occurs. The chain of infection is made up of six different links, these being as shown below (Figure 1).



Figure 1

Breaking any link in the chain will help to prevent the spread of infection.

5.2. Routes of Transmission for Respiratory Tract Infections

Respiratory tract infections (RTIs) such as COVID-19 are spread through one or more of three main routes.

5.3. Droplet Transmission

Droplets greater than five microns in size may be generated from the respiratory tract during coughing, sneezing or talking. If droplets from an infected person come into contact with the mucous membranes (mouth or nose) or surface of the eye of a recipient, they can transmit infection. These droplets remain in the air for a short period of time and can travel one to two metres, so physical closeness is required for transmission.

Complying with social distancing (that is staying 2m or 6 feet or 3 steps apart) helps prevent droplet transmission. Where social distancing cannot be practised both people (staff member and patient, staff member and staff member) should wear a fluid-resistant (Type IIR) surgical mask; staff working with patients should in addition wear aprons, gloves and eye protection (see Section 6).

5.3.1. Airborne Transmission

Aerosol generating procedures (AGP) are considered to have a greater likelihood of producing aerosols compared to coughing for instance. Aerosols are smaller than the droplets described above and can remain in the air for longer and, therefore, potentially transmit infection by mucous membrane contact or inhalation.

Aerosol generating procedures such as ventilation, suction and bronchoscopy, are not normally practised in urgent care services. Staff should however be aware that they may come into contact with patients where an aerosol generating procedure is routinely used (non-invasive ventilation) or is required to address an emergency situation (cardio-pulmonary resuscitation for example).

5.3.2. Contact Transmission

Contact transmission may be direct or indirect. Infectious agents can be inadvertently passed directly from an infected person (for example after coughing into their hands) to a recipient who, in the absence of correct hand hygiene, may then transfer the organism to the mucous membranes of their mouth, nose or eyes.

Indirect contact transmission takes place when a recipient has contact with a contaminated object, such as surfaces, furniture or equipment that an infected person may have coughed or sneezed on or touched. In the absence of correct hand hygiene, the recipient may transfer organisms from the contaminated object to the mucous membranes of their mouth, nose or eyes.

Robust hand hygiene and cleaning of equipment and surfaces helps to reduce contact transmission.

6. Standard Infection Control Precautions

Standard infection control precautions (SICPs) are to be used by all staff for all face to face patient contacts whether infection is known to be present or not. This ensures the safety of patients, staff and visitors.

In addition, some SPCs are applicable to staff working in non-patient environments; this includes staff in general office areas and in training (see IPC Guidance for Contact Centres, Offices and Communal Areas).

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.

Sources of infection may 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 SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To protect effectively against infection risks, SICPs must be used consistently by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff and visitor safety.

There are 10 elements of SICPs that must be followed **at all times**:

- i. Patient placement/assessment for infection risk
- ii. Hand hygiene
- iii. Respiratory and cough hygiene
- iv. Personal protective equipment (PPE)

- v. Safe management of care equipment
- vi. Safe management of the care environment
- vii. Safe management of linen
- viii. Safe management of blood and body fluids
- ix. Safe disposal of waste (including sharps)
- x. Occupational safety/managing prevention of exposure (including sharps)

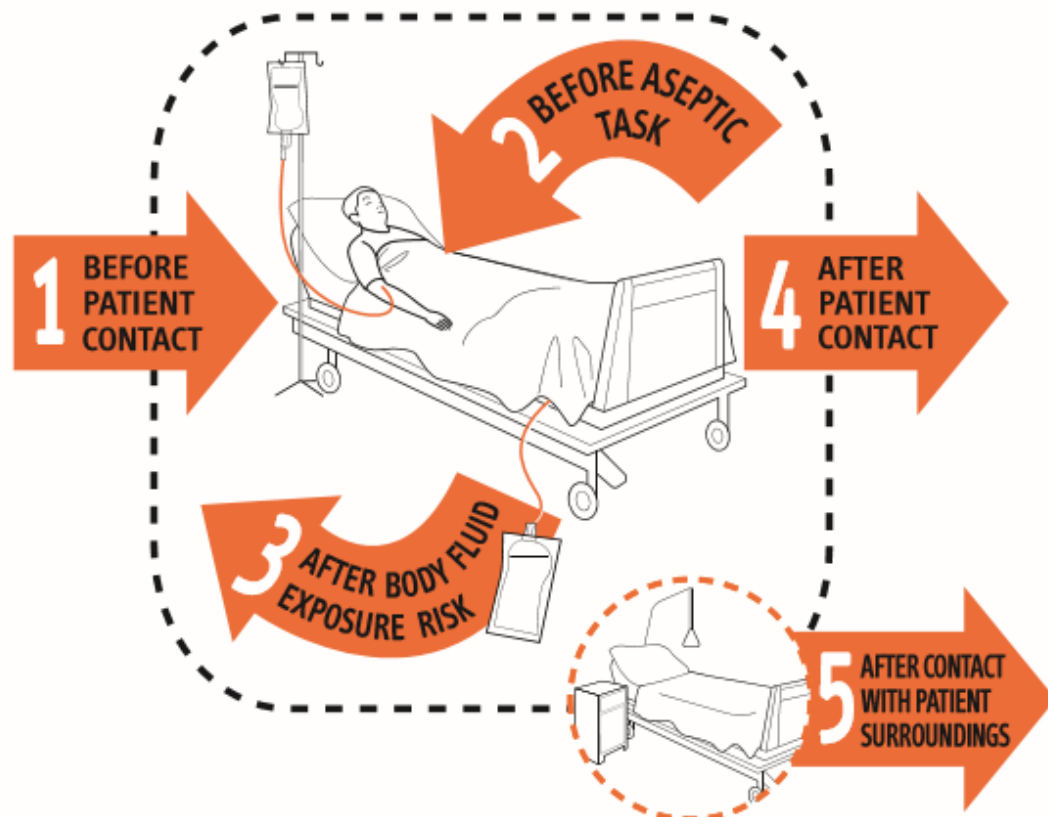
7. Hand Hygiene

Hand hygiene remains the most essential aspect of infection prevention and control for the entire population. In the workplace all staff should practice hand hygiene at every opportunity and in particular:

- After moving from one site to another where there is the possibility of hands coming into contact with any surface, such as handrails, door pushes, keypads. This includes your initial entry to any site and before leaving the building
- Before and after touching any communal equipment, for example water boilers, photocopiers, printers, milk cartons, coffee jars
- Before and after any using the toilet
- Before and after eating and drinking
- After sneezing and coughing

Staff working directly with patients should adhere to undertaking hand hygiene in line with the 5 moments for hand hygiene described by the World Health Organisation (Figure 2).

Your 5 moments for HAND HYGIENE



1 BEFORE PATIENT CONTACT	<p>WHEN? Clean your hands before touching a patient when approaching him or her</p> <p>WHY? To protect the patient against harmful germs carried on your hands</p>
2 BEFORE AN ASEPTIC TASK	<p>WHEN? Clean your hands immediately before any aseptic task</p> <p>WHY? To protect the patient against harmful germs, including the patient's own germs, entering his or her body</p>
3 AFTER BODY FLUID EXPOSURE RISK	<p>WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal)</p> <p>WHY? To protect yourself and the health-care environment from harmful patient germs</p>
4 AFTER PATIENT CONTACT	<p>WHEN? Clean your hands after touching a patient and his or her immediate surroundings when leaving</p> <p>WHY? To protect yourself and the health-care environment from harmful patient germs</p>
5 AFTER CONTACT WITH PATIENT SURROUNDINGS	<p>WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving - even without touching the patient</p> <p>WHY? To protect yourself and the health-care environment from harmful patient germs</p>



WHO acknowledges the Hôpitaux Universitaires de Genève (HUG), in particular the members of the Infection Control Programme, for their active participation in developing this material.



October 2006, version 1.

Figure 2

Before performing hand hygiene:

- Expose forearms (bare below the elbow)
- Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene. Ideally, during working hours jewellery of any sort should not be worn.
- Ensure fingernails are clean and short, and do not wear artificial nails or nail products
- Cover all cuts or abrasions with a waterproof dressing

To perform hand hygiene:

Perform hand hygiene before putting on and after removing gloves (if being used).

Using soap and water is the preferred method with alcohol-based hand rubs (ABHRs) providing a suitable alternative. ABHRs should be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used.

Use ABHRs:

- Before touching a patient
- Before clean or aseptic procedures
- After body fluid exposure risk (including from sneezing or coughing patients)
- After touching a patient
- After touching a patient's immediate surroundings

Always wash hands with non-antimicrobial liquid soap and water if:

- Hands are visibly soiled or dirty
- Caring for patients with vomiting or diarrhoeal illnesses
- Caring for a patient with a suspected or known gastrointestinal infection e.g. norovirus or a spore-forming organism such as *Clostridium difficile*

Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

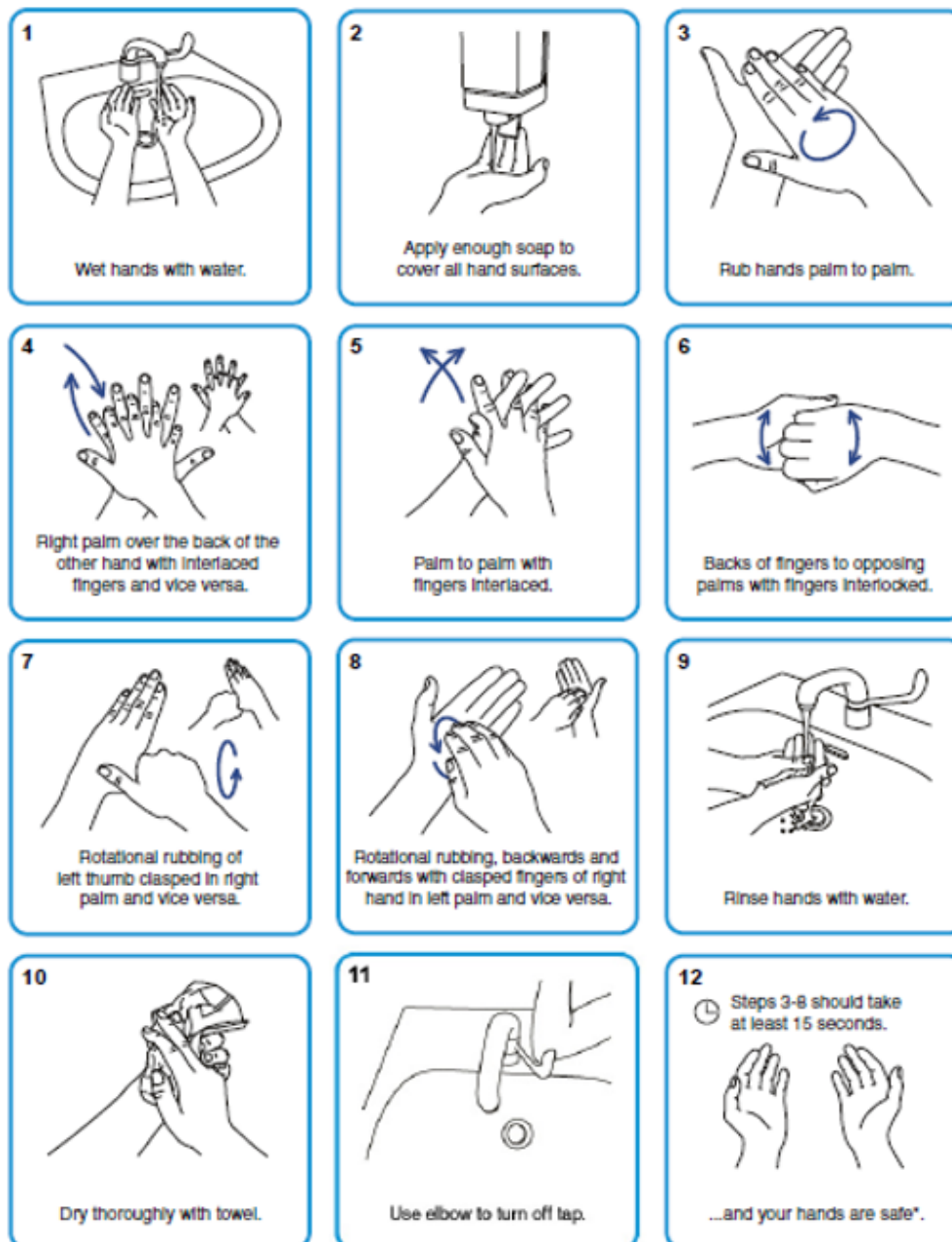
7.1. Hand Washing and ABHR Guidance

The following hand washing guidance is an essential element of infection control. This must be considered as the first step in effective hygiene.

If you are aware of any facilities with inadequate supply of hand washing products or alcohol-based hand rubs, please report this immediately to the shift lead, or your line manager.

Best Practice: how to hand wash

Steps 3-8 should take at least 15 seconds.



*Any skin complaints should be referred to local occupational health or GP.

From: COVID-19. Guidance for infection prevention and control in healthcare settings

Figure 3

7.1.1.Using Alcohol Based Hand Rub

Best Practice: how to hand rub

Duration of the process: 20-30 seconds.



From: COVID-19. Guidance for infection prevention and control in healthcare settings

Figure 4

Further guidance from Public Health England, for example the PHE hand washing poster and related advice, can be found here:

<https://campaignresources.phe.gov.uk/resources/campaigns/101-coronavirus-/resources> and <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control>.

7.2. General Skin Care

Looking after the skin is essential especially during times when skin is subject to frequent washing and sanitising. In order to keep skin in good condition:

- Dry hands thoroughly after hand washing, using disposable paper towels
- Use an emollient hand cream during work and when off duty
- Do not use or provide communal tubs of hand cream in the care setting

Staff with skin problems should seek advice from occupational health.

8. Personal Protective Equipment

Current PPE guidance is shown in Appendix 1 and 2.

This revised guidance recognises that in the context where coronavirus is “*circulating in the community in high rates, health and social care works may be subject to repeated risk of contact with droplet transmission during their daily work*”. It also recognises that “*there may be challenges in establishing whether patients and individuals meet the case definition for COVID-19*” (Public Health England, Guidance COVID-19 Personal protective equipment (PPE), Updated 2 April 2020).

8.1. PPE and Sanitising Products

In line with current guidance the following equipment should be routinely available:

- FRSM IIR – fluid repellent surgical masks, which are advised for close contact with patients who have or may have COVID-19 infection. In practice because of the level of infection circulating in the community this now refers to any patient contact.

In line with current guidance masks may now be used for a single session. A session can be classified as undertaking duties in a specific clinical setting or exposure environment. This can equate to a defined period of time, such as in between shift start times and breaks.

- FFP3 masks for contact when carrying out aerosol generating procedures (such as open suction, tracheotomy, ventilation, bronchoscopy) with patients who have or may have COVID-19 infection. Nebulisation and defibrillation are not considered to be aerosol generating procedures.
- Other surgical masks which meet FRSM IIR and FFP2 requirements. These have been purchased as a back up supply and will not normally be used.
- Nitrile gloves (small, medium and large)

- Plastic aprons
- Eye protection such as goggles or face visors.

In line with current guidance eye protection may now be used for a single session. A session can be classified as undertaking duties in a specific clinical setting or exposure environment. This can equate to a defined period of time, such as in between shift start and breaks.

“The rationale for sessional use of facemasks and eye protection is to reduce the risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care” (Public Health England, Guidance COVID-19 Personal protective equipment (PPE), Updated 2 April 2020).

In addition, the following are routinely available:

- Hand gel, both in wall mounted dispensers, desk-top dispensers and free-standing units
- Sanitising wipes (e.g. Clinell)

If the clinician feels that there are other risks post patient contact, for example soles of shoes that have been in contact with flooring that may have residual body fluids, a pragmatic approach to decreasing risks must be taken. This may include using shoe covers, or sanitising wipes or sprays on soles of shoes.

8.2. Aerosol Generating Procedures

Undertaking aerosol generating procedures in the urgent care setting is relatively rare. However, there may be a requirement for cardiopulmonary resuscitation and visits to patients who are receiving non-invasive ventilation (NIV: Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)).

Administering chest compressions is not aerosol generating and should be commenced as soon as possible, however being cautious of increased droplet generation. Undertaking advanced airway procedures and using a bag and mask may generate aerosol and therefore staff should not perform this until enhanced PPE is donned, that is FFP3 mask, gown, gloves and eye protection. Whilst enhanced PPE is being donned another member of staff in standard PPE can ensure defibrillation pads are in place and commence chest compressions. Lightly covering the patient’s mouth and nose with a tissue, paper towel or thin drape may prevent droplet spread; care should be taken to ensure that this is not inhibiting air flow in and out of the patient’s lungs which will occur during chest compressions.

A stock of enhanced PPE (as per Appendix 2) is kept in stock for these situations and can be accessed through local arrangements. Enhanced PPE should not be used routinely and only by staff who have undertaken a fit test for FFP3 masks.

8.3. PPE Management

PPE stocks are being managed at a divisional level to ensure that there is on-going stock control and thus ensure there is consistent supply to meet staff needs.

PPE supplies are obtained through recognised supply chains to ensure that should there be a requirement to recall any items they can be easily tracked. Staff are advised to utilise the PPE that has been supplied by the organisation or by one of its partners.

There have been problems reported with the supply chain at an NHS England level, which wherever possible is being overcome by moving stock between sites. Where there are particular supply issues these should immediately be highlighted to the shift lead who can if required look to utilise alternative supply routes such as working with partners where on a co-located site. Where further support is needed this can be sought via Operations and Clinical on Call.

PPE should be:

- Located close to the point of use
- Stored to prevent contamination in a clean, dry area until required for use (expiry dates must be adhered to)
- Treated as single-use only items unless specified by the manufacturer
- Changed immediately after each patient and/or after completing a procedure or task
- Disposed of after use into the correct waste stream i.e. healthcare waste or domestic waste.
- Reusable PPE items – e.g. non-disposable goggles, face shields, visors must be decontaminated after each use

Gloves must be:

- Worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- Changed immediately after each patient and/or after completing a procedure or task
- Changed if a perforation or puncture is suspected
- Nitrile gloves when dealing with infectious or potentially infectious cases during the COVID-19 outbreak

Plastic aprons must be:

- Worn to protect uniform or clothes when contamination is anticipated or likely e.g. when in direct care contact with a patient
- Changed between patients and/or after completing a procedure or task

Fluid repellent surgical masks must be:

- Worn when in direct contact with any patient and/or visitor, that is when within 2 metres of the patient and/or visitor
- Changed after a session of work or if the mask's integrity is breached, e.g. from moisture build-up after extended use
- Worn over the face and nose and not left dangling around the neck

Eye and face protection (including full-face visors) should:

- Be worn when in direct contact with any patient and/or visitor, that is when within 2 metres of the patient and/or visitor
- Be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely (this is unlikely in the case of a potential virus infection attending a UTC)
- Not be impeded by accessories such as piercings or false eyelashes
- Removed or changed at the end of a session

Further information can be found here: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control> .

For the recommended method of putting on and removing PPE can be found here:

<https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures>

https://youtu.be/-GncQ_ed-9w

8.4. Actions to Take if PPE or Sanitising Products Are Limited

In cases where PPE demand exceeds supply, a safe but pragmatic approach must be used, which is the ultimate decision of the clinician. This may include:

- Considering conducting the assessment at a distance, with the help of a carer if available
- Delaying or re-arranging the patient contact to enable PPE and/or sanitising equipment to be made available

Single use products may be used for more than one presentation providing that the clinician is satisfied that there are no significantly increased risks in doing so. Guidance for times when there may be acute shortage of PPE has been provided by Public Health England: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/managing-shortages-in-personal-protective-equipment-ppe>. For additional guidance can be sought from the Vocare or Greenbrook Clinical on-Call arrangements.

9. Staff Uniforms and Clothing

Regular washing and changing of clothes is an effective method for reducing the spread of infection. Uniforms or workwear should be laundered separately from other household linen, in a load not more than half the machine capacity and at the maximum temperature the fabric can tolerate. It should then be ironed or tumbled dried. Uniforms or workwear can be tumble dried with other household laundry as correct washing will remove any infectious micro-organisms on the uniform (Uniform and workwear guidance, Publication code: 009 245, Royal College of Nursing, April 2020

Ref <https://www.rcn.org.uk/professional-development/publications/rcn-uniform-and-workwear-guidance-covid-19-uk-pub-009245>).

Uniforms should be transported home in a disposable plastic bag. This bag should be disposed of into the household waste stream.

10. Clinical Equipment and Consumables

All standard diagnostic equipment must be clean upon inspection, functioning correctly, calibrated where necessary and sanitised using appropriate sanitising wipes before and after patient contact.

Clinical equipment must be sanitised before first use, in between patients and at the end of the session in all cases (when used in centres or when use is expected during home visits). This is the responsibility of the clinician using the equipment.

Single use equipment (for example tongue depressors, earpieces, specimen bottles) containers must be disposed of after use in the infectious waste bins. This is the responsibility of the clinician using the equipment and should not be left for other staff to clear up.

Single use equipment coming into direct contact with a patient must never be re-used.

11. Disposal Process for Clinical Waste

11.1. Home visits

All consumable waste items that have been in contact with the individual, including used tissues, gloves, masks, gowns and aprons should be put in an orange plastic rubbish bag, double bagged in a clear plastic bag and securely tied with a plastic tie or securely knotted and consigned as infectious clinical waste suitable for treatment.

The bag should be placed securely in the boot of the car and **not** returned to the main bag/box. This will reduce the potential for transmission of pathogens.

On return to base it must be placed in the designated clinical waste bin. The bag should be placed securely in the boot of the car and **not** returned to the main bag/box. This will reduce the potential for transmission of pathogens. Arrangements for disposal of bags from visits is shown in Figure 5.

Site	Disposal Arrangements
Maple House	Drivers place the bags directly into the larger designated clinical waste bin
Queen Elizabeth Hospital	Drivers place the bags directly in the large designated clinical waste bin within the UTC.
Staffordshire House	Drivers place the bags directly into the larger designated clinical waste bin
Vocare House	Metal bins with orange bags lining them, stored in the back stairs' recess area. These bins are checked daily and emptied into the large external clinical waste bin once nearly full by the Pharmacy Technician.

Figure 5

11.2. Centre Waste

All consumable waste items that have been in contact with the individual, including used tissues, gloves, masks, gowns and aprons should be put in an orange plastic rubbish bag, double bagged in a clear plastic bag and securely tied with a plastic tie and consigned as infectious clinical waste suitable for treatment.

These bags must be directly placed in the centres' clinical waste bins following the standard waste disposal processes.

11.3. Office and Call Centre PPE Waste

PPE worn in the contact centre or office can usually be disposed of in the normal waste. Hands should be washed or sanitised before putting a face covering or mask on **and** after taking it off and after use. Staff should avoid touching their eyes, nose, or mouth at all times.

Where an individual becomes unwell at work in which case the PPE worn by them should be treated as infectious waste. A clinical waste bin should be available in all offices and contact centres for this purpose and should be situated near a hand sanitising point so that staff can practise hand hygiene immediately following disposal.

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APPENDIX 1



Recommended PPE for primary, outpatient and community care by setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-repellent coverall/gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection ¹
Any setting	Performing an aerosol generating procedure ² on a possible or confirmed case ³	✓ single use ⁴	✗	✓ single use ⁴	✗	✗	✓ single use ⁴	✓ single use ⁴
Primary care, ambulatory care, and other non emergency outpatient and other clinical settings e.g. optometry, dental, maternity, mental health	Direct patient care – possible or confirmed case(s) ³ (within 2 metres)	✓ single use ⁴	✓ single use ⁴	✗	✗	✓ single or sessional use ^{4,5}	✗	✓ single or sessional use ^{4,5}
	Working in reception/communal area with possible or confirmed case(s) ³ and unable to maintain 2 metres social distance ⁶	✗	✗	✗	✗	✓ sessional use ⁵	✗	✗
Individuals own home (current place of residence)	Direct care to any member of the household where any member of the household is a possible or confirmed case ^{3,7}	✓ single use ⁴	✓ single use ⁴	✗	✗	✓ single or sessional use ^{4,5}	✗	✓ risk assess single or sessional use ^{4,5,8}
	Direct care or visit to any individuals in the extremely vulnerable group or where a member of the household is within the extremely vulnerable group undergoing shielding ⁹	✓ single use ⁴	✓ single use ⁴	✗	✓ single use ⁴	✗	✗	✗
	Home birth where any member of the household is a possible or confirmed case ^{3,7}	✓ single use ⁴	✓ single use ⁴	✓ single use ⁴	✗	✓ single or sessional use ^{4,5}	✗	✓ single or sessional use ^{4,5}
Community-care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare	Facility with possible or confirmed case(s) ³ – and direct resident care (within 2 metres)	✓ single use ⁴	✓ single use ⁴	✗	✗	✓ sessional use ⁵	✗	risk assess sessional use ^{5,8}
Any setting	Collection of nasopharyngeal swab(s)	✓ single use ⁴	✓ single or sessional use ^{4,5}	✗	✗	✓ single or sessional use ^{4,5}	✗	✓ single or sessional use ^{4,5}

Table 2

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. The full list of aerosol generating procedures (AGPs) is within the IPC guidance [note AGPs are undergoing a further review at present].
3. A case is any individual meeting case definition for a possible or confirmed case: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wm-cov-infection>
4. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time where a health care worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. Non clinical staff should maintain 2m social distancing, through marking out a controlled distance; sessional use should always be risk assessed and considered where there are high rates of community cases.
7. Initial risk assessment should take place by phone prior to entering the premises or at 2 metres social distance on entering; where the health or social care worker assesses that an individual is symptomatic with suspected/confirmed cases appropriate PPE should be put on prior to providing care.
8. Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets or blood or body fluids.
9. For explanation of shielding and definition of extremely vulnerable groups see guidance: <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>

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APPENDIX 2



Recommended PPE for healthcare workers by secondary care inpatient clinical setting, NHS and independent sector

Setting	Context	Disposable Gloves	Disposable Plastic Apron	Disposable fluid-resistant gown	Surgical mask	Fluid-resistant (Type IIR) surgical mask	Filtering face piece respirator	Eye/face protection ¹
Acute hospital inpatient and emergency departments, mental health, learning disability, autism, dental and maternity settings	Performing a single aerosol generating procedure ² on a possible or confirmed case ³ in any setting outside a higher risk acute care area ⁴	✓ single use ⁵	✗	✓ single use ⁵	✗	✗	✓ single use ⁵	✓ single use ⁵
	Working in a higher risk acute care area ⁴ with possible or confirmed case(s) ³	✓ single use ⁵	✓ single use ⁵	✓ sessional use ⁵	✗	✗	✓ sessional use ⁵	✓ sessional use ⁵
	Working in an inpatient, maternity, radiology area with possible or confirmed case(s) ³ – direct patient care (within 2 metres)	✓ single use ⁵	✓ single use ⁵	✗	✗	✓ sessional use ⁵	✗	✓ sessional use ⁵
	Working in an inpatient area with possible or confirmed case(s) ³ (not within 2 metres)	✗	✗	✗	✗	✓ sessional use ⁵	✗	✓ risk assess sessional use ^{5,7}
	Working in an emergency department/acute assessment area with possible or confirmed case(s) ³ – direct patient care (within 2 metres)	✓ single use ⁵	✓ single use ⁵	✗	✗	✓ sessional use ⁵	✗	✓ sessional use ⁵
	All individuals transferring possible or confirmed case(s) ³ (within 2 metres)	✓ single use ⁵	✓ single use ⁵	✗	✗	✓ single or sessional use ^{5,6}	✗	✓ risk assess single or sessional use ^{5,6,7}
	Operating theatre with possible or confirmed case(s) ³ – no AGPs ²	✓ single use ⁵	✓ single use ⁵	✓ risk assess single use ^{5,7}	✗	✓ single or sessional use ^{5,6}	✗	✓ single or sessional use ^{5,6}
	Labour ward/area – 2nd/3rd stage labour vaginal delivery (no AGPs ²) – possible or confirmed case ³	✓ single use ⁵	✓ single use ⁵	✓ single use ⁵	✗	✓ single or sessional use ^{5,6}	✗	✓ single or sessional use ^{5,6}
	Inpatient care to any individuals in the extremely vulnerable group undergoing shielding ⁸	✓ single use ⁵	✓ single use ⁵	✗	✓ single use ⁵	✗	✗	✗

Table 1

- This may be single or reusable face/eye protection/full face visor or goggles.
 - The full list of aerosol generating procedures (AGPs) is within the COVID-19 IPC guidance [note AGPs are undergoing a further review at present].
 - A case is any individual meeting case definition for a possible or confirmed case: <https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wt-cov-infection>
 - Higher risk acute areas include: ICU/HDUs; ED resuscitation areas; wards with non-invasive ventilation; operating theatres; endoscopy units for upper Respiratory, ENT or upper GI endoscopy; and other clinical areas where AGPs are regularly performed.
 - Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose or decontaminate reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
 - A session refers to a period of time where a healthcare worker is undertaking duties in a specific care setting/exposure environment e.g. on a ward round; providing ongoing care for inpatients. A session ends when the healthcare worker leaves the care setting/exposure environment. Sessional use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
 - Risk assessed use refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids.
 - For explanation of shielding and definition of extremely vulnerable groups see guidance: <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>
- Patient use of PPE:** In cohort wards, communal waiting areas and during transportation, it is recommended that suspected or confirmed cases wear a surgical face mask if this can be tolerated. The aim of this is to minimise the dispersal of respiratory secretions, reduce both direct transmission risk and environmental contamination. A surgical face mask should not be worn by patients if there is potential for their clinical care to be compromised (e.g. when receiving oxygen therapy).