Health Protection Scotland

COVID-19: Information and Guidance for Care Home Settings

Version 1.2

Publication date: 1 May 2020

This document is uncontrolled when printed.

Before use check the HPS COVID-19 page to verify this is the latest publication.

NHS National Services Scotland

Public Health Scotland

Version history

Version	Date	Summary of changes
V1.0	26/04/2020	First version of document
V1.1	28/04/2020	Testing and admission information updated Providing care for residents during pandemic section updated
V1.2	01/05/2020	Testing information updated

Contents

Scope of the guidance

This guidance is to support those working in care home settings to give advice to their staff and users of their services about COVID-19. It should be used for care home settings including nursing homes and residential care where appropriate.

This guidance is based on what is currently known about COVID-19.

Health Protection Scotland (HPS) (now part of Public Health Scotland) will update this guidance as needed and as additional information becomes available.

Introduction

The disease COVID-19 is caused by a new strain of coronavirus which was first identified in Wuhan City, China in December 2019. Symptoms range from mild to moderate respiratory illness to pneumonia or severe acute respiratory infection requiring hospital care. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020. We now have spread of COVID-19 within communities across Scotland.

1. Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness.

There is currently no vaccine to prevent COVID-19. The following measures are recommended to help reduce the spread of COVID-19 and to protect people at increased risk of severe illness:

Stay at home guidance for households with possible COVID-19 should be followed by people with symptoms and their household contacts to reduce the community spread of COVID-19. This means that anyone who has symptoms of COVID-19 and anyone else living in the same household should follow 'stay at home' advice on **NHS Inform**.

Physical (social) distancing measures should be followed by everyone, including children, in line with the government advice to **stay at home**. The aim of physical (social) distancing measures is to reduce the transmission of COVID-19. People who are at increased risk of severe illness from coronavirus should strictly follow physical (social) distancing measures (this includes those with certain medical conditions, pregnant or aged 70 or older). Up to date information can be found on the **NHS Inform** website. There are some groups of people who are considered to be at extremely high risk of severe illness. This is a different group and information can be found in shielding below.

Shielding is a measure to protect people, including children, who are extremely vulnerable to severe illness from COVID-19 because of certain underlying health conditions. The aim of shielding is to minimise interaction between these individuals and others to protect them from coming into contact with the virus that causes COVID-19. People with these serious underlying health conditions are strongly advised to rigorously follow shielding measures in order to keep themselves safe. Further information, including the list of underlying health conditions that make people extremely vulnerable, is available on the **NHS Inform** website.

Staff (such as health care workers) with underlying health conditions that put them at increased risk of severe illness from COVID-19, including those who are immunosuppressed, should not provide direct care to patients with possible or confirmed COVID-19. Staff who think they may be at increased risk should seek advice from their line manager or local Occupational Health service. Pregnant staff should also seek advice from their line manager or local Occupational Health service. Information for at risk or pregnant healthcare workers can be found in **Guidance for NHS Scotland workforce Staff and Managers on Coronavirus**.

Symptoms of COVID-19 for residents in care homes

Common symptoms include:

- Recent onset (within the last 7 days) new continuous cough

  and / or

- high temperature

Elderly residents may present with atypical or non-specific symptoms.

Spread of COVID-19 in care homes

COVID-19 is spread through respiratory droplets produced when an infected person coughs or sneezes. This is thought to be the main way the infection is transmitted between people and is most likely to happen when there is close contact (within 2 metres) with an infected person who is symptomatic. It is likely that the risk of infection transmission increases the longer someone has close contact with an infected person.

There are two routes by which COVID-19 can be spread:

- **Directly:** from close contact with an infected person (within 2 metres) where respiratory secretions can enter the eyes, mouth, nose or airways. This risk increases the longer someone has close contact with an infected person who has symptoms.
- **Indirectly:** by touching a surface, object or the hand of an infected person that has been contaminated with respiratory secretions and then touching own mouth, nose or eyes.

Further HPS guidance for other settings is available on the **HPS website**.

1.1. Preventing spread of infection in Care Home Settings

National Infection Prevention and Control Manual (NIPCM) provides information and evidence on Standard Infection Control Precautions and Transmission Based precautions which should be applied for COVID-19 disease.

Hand hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings. All staff, residents and visitors should decontaminate their hands with soap and water or alcohol-based hand rub (ABHR) when entering and leaving areas where patient care is being delivered. See **Appendix 2** for best practice on hand washing.

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.

Before performing hand hygiene:

- expose forearms (bare below the elbows)
- remove all hand and wrist jewellery (a single, plain metal finger ring is permitted but should be removed (or moved up) during hand hygiene)
- ensure finger nails are clean, short and that artificial nails or nail products are not worn
- cover all cuts or abrasions with a waterproof dressing

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands.

Staff should support any residents with hand hygiene regularly where required.

Respiratory and cough hygiene – 'Catch it, bin it, kill it'

Residents, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin
- tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients, visitors and staff
- hands should be cleaned (using soap and water if possible, otherwise using ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage patients to keep hands away from the eyes, mouth and nose
- some patients (such as the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues

1.2. Providing care for residents during COVID-19 pandemic

Ensure daily monitoring of all individuals for COVID-19 symptoms, such as a new continuous cough and/or high temperature or other signs of illness. Residents with cognitive impairment may be less able to report symptoms. Elderly or frail residents with co-morbidities may also present with atypical and non-specific signs of illness. Further information can accessed **here**. If a resident becomes unwell contact the GP for clinical advice.

- If it is an emergency and you need to call an ambulance, dial 999 and inform the call handler or operator that the unwell person may have coronavirus (COVID-19).

If an outbreak of COVID-19 is suspected within the care home, please ensure you contact your HPT. An outbreak is normally defined as two linked cases of a disease. However, with respect to COVID-19, an outbreak should be suspected when there is a single new case with

symptoms consistent with COVID-19 infection arising in the care home, likely to be due to spread of the virus within the care home. Assessment of resident cases when considering any potential outbreak should also include symptomatic cases who have either been transferred from the facility to hospital as a result of infection or a suspected COVID-19 individual who has died within the same time period.

A control measure tool for the control of incidents and outbreaks in Social or Community Care & Residential Settings, specific for COVID-19, is available **here**.

On identification of a new suspect COVID-19 case, your local HPT will advise on the need for testing of residents and staff as well as other IPC measures to help limit further spread of the virus and control the outbreak

1.3. Measures to protect residents in the shielding category

To help reduce the spread of COVID-19 and to protect people at increased risk of severe illness, i.e. in the **shielding** category, the following measures should be followed for patients in this category:

- Residents
    - Should have their own single room with en-suite facilities or provided with a dedicated commode where possible
    - **Must not be placed in cohorts**
- Staff
    - Must minimise interaction to essential purposes only
    - Must wear PPE when entering their room and within 2m of the resident

1.4. Measures for residents exposed to a case of COVID-19

Where an individual has developed symptoms within a care home, an assessment of risk should be undertaken to establish the nature and duration of exposure and contact with others. This should be discussed with your HPT.

Where possible, contacts should be isolated individually in single rooms for 14 days after last exposure to a possible or confirmed case. This should be the preferred option whenever possible. Where all single occupancy rooms are occupied, cohorting of exposed residents may be considered. Residents who are undergoing shielding should never be placed in a cohort. Cohorting of patients should be discussed with your HPT.

These contacts should be carefully monitored for any symptoms of COVID-19 during the 14 day period from last exposure.

Ensure that residents who have had no contact with COVID-19 cases are separated from residents with symptoms.

1.5. Admission of individuals to the care home facility

The Health Secretary's statement on 21st April stated that the following groups should be tested:

- All COVID-19 patients in hospital who are to be admitted to a care home
- All other admissions to care homes

Admission of COVID-19 recovered patients from hospital

Patients should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics). They also require 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should have been taken at least 24 hours apart and preferably within 48 hours of discharge.

Where testing is not possible (e.g. patient doesn't consent or it would cause distress) and if discharged to care home within the 14 day isolation period then there must be an agreed care plan for the remaining period of isolation up to 14 days.

Further details can be found in **Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.**

Admission of non-COVID-19 patients from hospital

Testing should be done within 48 hours prior to discharge from hospital. A single test is sufficient. The patient may be discharged to the care home prior to the test result being available. The patient should be isolated for 14 days from the date of discharge from hospital. Risk assessment prior to discharge from hospital should be undertaken in conjunction with the care home. Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E that didn't result in an admission would not constitute an admission.

Further details on testing requirements can be found in **Guidance for Sampling and Laboratory Investigations**.

Admissions from the community

All other admissions from the community should have at least one test performed before or on admission, and be isolated on admission for 14 days. Risk assessment prior to admission should be undertaken to ensure that appropriate isolation facilities are available, taking into account requirements for the patient's care.

1.6. Testing in the care home

Currently all care home residents who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19.

The First Minister announced changes to testing of residents and staff in care homes on 1st May 2020.

"We now intend to undertake enhanced outbreak investigation in all care homes where there are any cases of COVID - this will involve testing, subject to individuals' consent, all residents and staff, whether or not they have symptoms.

In addition, where a care home with an outbreak is part of a group or chain and staff might still be moving between homes, we will also carry out urgent testing in any linked homes.

We will also begin sampling testing in care homes where there are no cases. By definition this will also include testing residents and staff who are not symptomatic.

This is a significant expansion and we do not underestimate the logistical and workforce requirements.

Now we have the increasing testing capacity, we will make it happen as swiftly as practicable."

Further details can be found on the **Scottish Government** website.

1.7. Resident placement

All symptomatic residents in the facility should be isolated immediately for 14 days from the date of symptom onset (or date of first positive test if symptom onset undetermined). The individual should be placed in a single room with en-suite facilities, where possible. The door should be kept closed to the room. Where this is not possible, ensure the bed is moved to the furthest safe point in the room to achieve a 2 metre physical distance to the open door. Clearly sign the rooms by placing IPC signs, indicating droplet precautions, at the entrance of the room or area. Confidentiality must be maintained.

If an en-suite is not available, designate a commode that only that individual will use if possible. If a commode is used and cannot be dedicated to the resident, ensure it is cleaned as per **Appendix 4**.

Only essential staff should enter the individuals room, wearing appropriate PPE as per **section 1.8.** All necessary procedures and care should be carried out within the individual's room. Entry and exit from the room should be minimised during care, especially when care procedures produce aerosols or respiratory droplets.

If a transfer from the facility to hospital is required, the ambulance service should be informed if the individual is a suspected or confirmed COVID-19. Staff in the receiving ward/ department should also be notified of this in advance of any transfer and informed of the requirement for isolation on arrival.

Infection Prevention and Control measures can be discontinued once the 14-day isolation period is complete and there has been an absence of fever for 48 hours (without the use of antipyretics). Before IPC measures are stepped down for COVID-19, ensure you consider any additional ongoing IPC measures which may be required for loose stools or any other infectious organisms.

Cohorting of symptomatic individuals:

Cohorting in care homes should be avoided where possible. Individuals who are shielding (extremely high risk) should not be placed in cohorts and should be prioritised for single occupancy rooms. Where all single isolation room facilities are occupied and cohorting is unavoidable, then cohorting can be arranged so that

- Confirmed COVID-19 individuals are placed in multi-occupancy rooms together.
- Suspected COVID-19 individuals are placed in multi occupancy rooms together.
- Confirmed and suspected cases should not be cohorted together.

1.8. PPE

Personal Protective Equipment (PPE)

A PPE statement was issued by the Scottish Government with COSLA and SJC Unions – it can be accessed **here** and states that social and home workers can wear a fluid resistant surgical mask (FRSM) along with other appropriate PPE where the person they are visiting or otherwise attending to is neither confirmed nor suspected of having COVID-19, if they consider doing so is necessary to their own and the individuals safety.

Table 2 is contained within the **COVID-19 – Infection Prevention and Control guidance** and describes the PPE applicable to the facilities described in this guidance when caring for suspected or confirmed cases – also available in **Appendix 6**.

Sustained transmission of COVID-19 is occurring within Scotland. **Table 4** provides additional PPE considerations where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen – also available in **Appendix 7**.

Appendix 3 describes the procedures for putting on and removing PPE. All staff must be trained on how to use PPE appropriate for their role to limit the spread of COVID-19.

Table 2 also describes the additional PPE required if undertaking an Aerosol Generating Procedure (AGP) – Table 2 can be accessed **here** and in **Appendix 6**. The local Health Protection Team can advise on this. AGPs should be avoided where possible.

The following procedures are considered AGPs:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)*
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)

- Bronchoscopy and upper ENT airway procedures that involve suctioning
- Upper Gastro-intestinal Endoscopy where there is open suctioning of the upper respiratory tract
- Surgery and post-mortem procedures involving high-speed devices
- Some dental procedures (e.g. high-speed drilling)
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure Ventilation
- (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- High Flow Nasal Oxygen (HFNO)

*Chest compressions and defibrillation (as part of resuscitation) are **not** considered AGPs; first responders can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other personnel who will undertake airway manoeuvres. On arrival of the team, the first responders should leave the scene before any airway procedures are carried out and only return if needed and if wearing AGP PPE.

Certain other procedures/equipment may generate an aerosol from material other than an individual's secretions but are not considered to represent a significant infection risk and do not require AGP PPE. Procedures in this category include:

- administration of pressurised humidified oxygen;
- administration of medication via nebulisation.

Note: During nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol.

For individuals with suspected/confirmed COVID-19, any of the potentially infectious AGPs listed above should only be carried out when essential. The required PPE for AGPs should be worn by those undertaking the procedure and those in the room, as detailed above. Where possible, these procedures should be carried out in a single room with the doors shut. Only those staff who are needed to undertake the procedure should be present.

If you do not anticipate the need for FFP respirators and are not caring for anyone currently receiving AGPs such as CPAP, these should not be ordered or stockpiled and any surplus stock should be returned.

PPE used for sessional use

Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), and **must be changed between residents**. Respirators, fluid-resistant (Type IIR) surgical masks (FRSM), eye protection and disposable fluid repellent coveralls or long-sleeved disposable fluid repellent gowns can be subject to sessional use in circumstances outlined in the PPE tables.

A single session refers to a period of time where health and care staff are undertaking duties in a specific setting within the facility e.g. providing direct care for individuals. Staff can go between residents in sessional PPE. A session ends when the health and care worker leaves the specific setting within the facility, for example the COVID-19 cohort area.

Sessional use should always be risk assessed and considered where there are high rates of cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.

Access to personal protective equipment (PPE)

All services who are registered with the Care Inspectorate that are providing health and care support and have an urgent need for PPE after having fully explored local supply routes/discussions with NHS Board colleagues, can contact a triage centre run by NHS National Services for Scotland (NHS NSS).

Please note that in the first instance, this helpline is to be used only in cases where there is an urgent supply shortage after “business as usual” routes have been exhausted.

The following contact details will direct providers to the NHS NSS triage centre for social care PPE: Email: **support@socialcare-nhs.info** Phone: 0300 303 3020. The helpline will be open (8am - 8pm) 7 days a week.

1.9. Care Equipment

Where possible use single-use equipment and dispose of after use.

Where single use is not possible, use dedicated care equipment in the individual’s room. This should not be shared with other individuals receiving care. If it is not possible to dedicate pieces of equipment to the individual, such as commodes or moving aides, these must be decontaminated immediately after use and before use of any other individual following the guidance in **Appendix 4**.

Do not use fans that re-circulate the air and open windows for ventilation if it is safe to do so.

Try to keep the room clutter-free and avoid storing any unnecessary equipment or soft furnishings in individuals' own rooms to prevent unnecessary contamination of items.

1.10. Environmental decontamination (cleaning and disinfection)

Those carrying out the cleaning must be familiar with the required environmental and equipment decontamination processes, be trained in these accordingly and ensure they are wearing the appropriate PPE. People responsible for cleaning should be advised to clean the COVID-19 areas and isolation room(s) after all other unaffected areas of the facility have been cleaned.

COVID-19 affected areas should be cleaned twice daily paying particular attention to common touch surfaces such as door handles, tablets, mobile phones, light switches, remote controls and bed rails.

Coronaviruses are readily inactivated by commonly available disinfectants such as alcohol (70% ethanol) and chlorine-releasing agents (sodium hypochlorite at 1,000 ppm av. cl.). Therefore, decontamination of the environment should be performed as per **Appendix 5** using either;

- A combined detergent disinfectant solution at a dilution of 1000 parts per million available chlorine (ppm available chlorine (av.cl.));

or

- A detergent clean followed by disinfection (1000ppm av.cl.).

In the event of a blood or body fluid spillage, keep people away from the area. Use a spill-kit if available, using the PPE within the kit or PPE provided by the employer/organisation and follow the instructions provided with the spill-kit.

Environmental decontamination where the suspected or confirmed case is no longer in the room/ environment

The immediate area occupied by the individual and any equipment used by the individual, should be cleaned using the methods described above. Once this process has been completed, the area can be put back into use.

Any public areas where a symptomatic individual has only passed through (spent minimal time in), e.g. corridors, and which are not visibly contaminated with any body fluids, do not need to be further decontaminated beyond routine cleaning processes.

Decontamination of soft furnishings may require to be discussed with the local Health Protection Team. If the furnishing is heavily contaminated, you may have to discard it. If it is safe to clean with standard detergent and disinfectant alone then follow appropriate procedure. If it is not safe to clean the item should be discarded.

In situations where belongings are being removed from a deceased person, the belongings should first be cleaned with a general household detergent active against viruses and bacteria.

1.11. Waste

If the care home has a clinical waste contract, all waste belonging to the affected individual can be placed in the clinical waste and disposed of immediately. There is no need to hold waste for 72 hours where a clinical waste stream is available.

If the care home does not have a clinical waste contract, ensure all waste items that have been in contact with the individual (e.g. used tissues and disposable cleaning cloths) are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.

1.12. Safe Management of Linen

Any, towels or other laundry used by the individual should be treated as infectious and placed in a bag before removing from the isolation room and placing directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, do not take inside the isolation room. When handling linen do not:

- Rinse, shake or sort linen on removal from beds
- Place used/infectious linen on the floor or any other surface e.g. table top
- Re-handle used/infectious linen when bagged
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

1.13. Staff Uniforms

If available, laundry services should be used to launder staff uniforms. If this is not available uniforms should be transported home in a disposable plastic bag. Uniforms should be laundered daily, and:

- separately from other household linen
- in a load not more than half the machine capacity
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

1.14. Staffing

Staff Cohorting (working in dedicated teams)

Assigning a dedicated team of staff to care for individuals with COVID-19 is an additional IPC measure which can help prevent onward spread of infection. This should be implemented whenever there are sufficient levels of staff available (so as not to have negative impact on non-affected individual care).

Minimise external staff

- The use of bank or agency staff should be minimised. Where used then they should only work for one facility where possible.
- Contractors on site should be kept to a minimum and only essential work carried out.

Ensure staff are enabled to follow key measures described in this guidance to prevent spread

- Ensure that all individuals in the facility are aware of the requirement to self-isolate if they develop symptoms of COVID-19 and support them in doing so.
- Consider the additional demands that will be placed on people by requirements for household isolation and put in place resilience planning to support this.

Staff who have contact with a case of COVID-19 at work

Staff who come into contact with a COVID-19 individual at the workplace while not wearing PPE can remain at work, using PPE appropriately. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances.

All staff should be vigilant for respiratory symptoms during the incubation period following exposure (up to 14 days). If staff develop symptoms they should stay at home and seek advice from NHS Inform or occupational health department as per the local policy

Staff who have recovered from COVID-19

Staff who have had confirmed COVID-19 and have since recovered must continue to follow the IPC measures as for all other staff including PPE.

1.15. Restriction of Visitors

Facilities must review their visiting policy. The guidance outlined on **NHS Inform** on physical (social) distancing, shielding and household isolation must be followed by visitors. This advice will significantly limit face-to-face interaction with friends and family in residential settings. Visitors should be restricted to essential visitors only. Efforts should be made to allow loved ones of a resident receiving end of life care to visit. All visitors must be informed of and adhere to IPC measures in place. Local risk assessment should ensure a pragmatic and proportionate response, including the consideration of whether there is a requirement for visitors to wear PPE. Visitors must not visit any other rooms or shared areas and should stay within the residents own room for the duration of the visit. A log of all visitors should be kept. Visiting may be suspended if considered appropriate by the facility. Consider alternative measures of communication including phoning or face-time.

1.16. Caring for someone who has died

The IPC measures described in this document continue to apply whilst the individual who has died remains in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living individuals. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage.

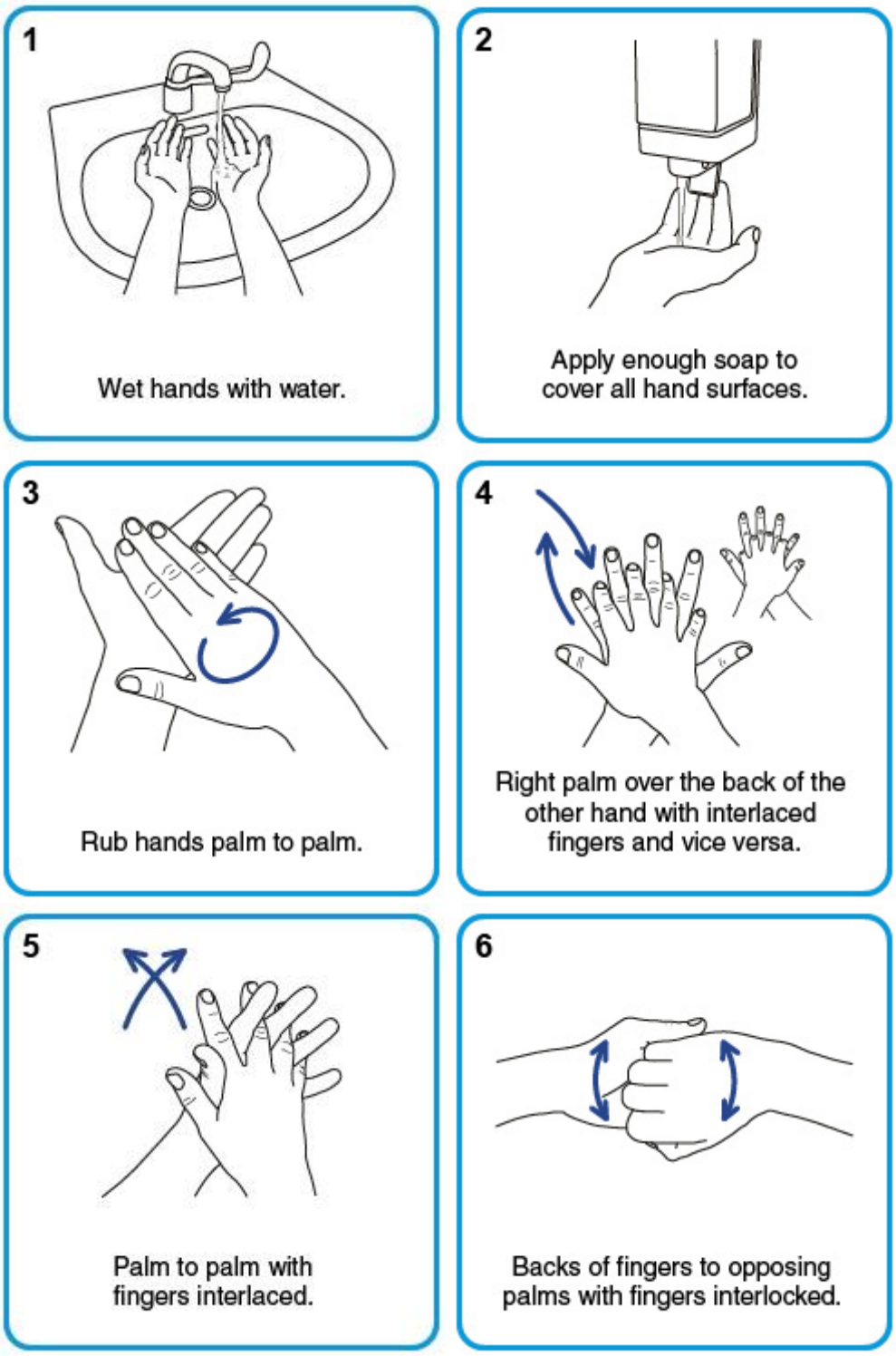
For further information, please see the following guidance produced by Scottish Government **Coronavirus (COVID-19): guidance on preparation for burial or cremation for religious organisations, faith and cultural groups.**

Appendix 1 - Contact details for local Health Protection Teams

Organisation	Office Hours Telephone Number	Out of Hours Telephone Number
Ayrshire and Arran	01292 885 858	01563 521 133
Borders	01896 825 560	01896 826 000
Dumfries and Galloway	01387 272 724	01387 246 246
Fife	01592 226 435/798	01383 623 623
Forth Valley	01786 457 283	01324 566 000
Grampian	01224 558 520	0345 456 6000
Greater Glasgow & Clyde	0141 201 4917	0141 211 3600
Highland	01463 704 886	01463 704 000
Lanarkshire	01698 858 232/228	01236 748 748
Lothian	0131 465 5420/5422	0131 242 1000
Orkney	01856 888 034	01856 888 000
Shetland	01595 743 340	01595 743 000
Tayside	01382 596 976/987	01382 660111
Western Isles	01851 708 033	01851 704 704

Appendix 2 - Best Practice How to Hand Wash

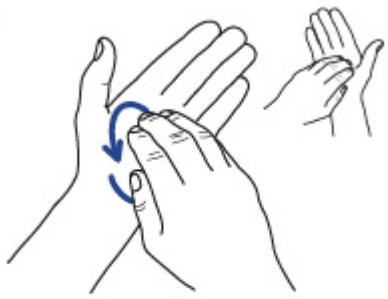
Steps 3-8 should take at least 15 seconds.



7

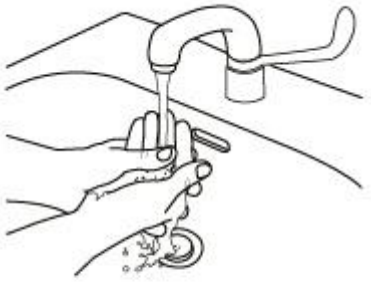
Rotational rubbing of left thumb clasped in right palm and vice versa.

8



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.

9

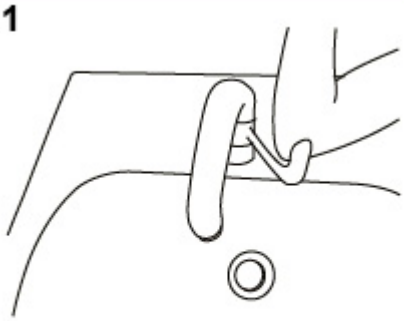


Rinse hands with water.

10

Dry thoroughly with towel.

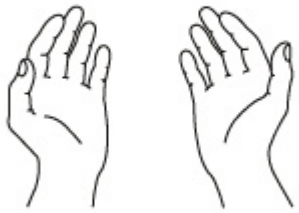
11



Use elbow to turn off tap.

12

Steps 3-8 should take at least 15 seconds.



...and your hands are safe*.

Appendix 3 - Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE

PPE should be put on before entering the room.

- Keep hands away from face and PPE being worn
- Change gloves when torn or heavily contaminated
- The order for putting on is apron, surgical mask, eye protection (where required)

The order given above is a practical one; the order for putting on is less critical than the order of removal given below.

Removal of PPE

PPE should be removed in an order that minimises the potential for cross-contamination.

Gloves

- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the glove off and discard appropriately.

Gown

- Unfasten or break ties.
- Pull gown away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown inside out, fold or roll into a bundle and discard.

Eye Protection

- To remove, handle by headband or earpieces and discard appropriately.

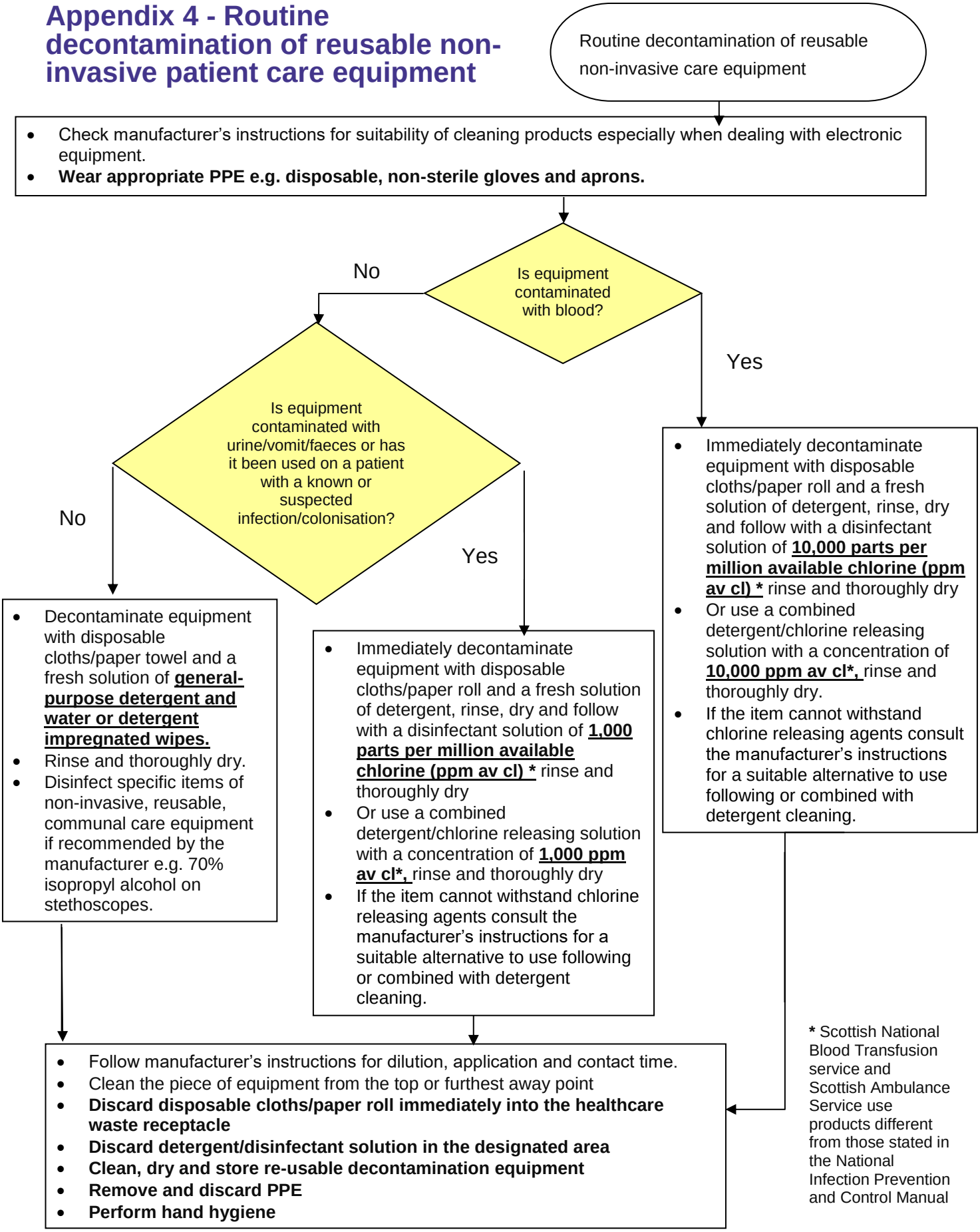
Fluid Resistant Surgical facemask

- Remove after leaving care area.
- Untie or break bottom ties, followed by top ties or elastic and remove by handling the ties only and discard as clinical waste.

To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.

Perform hand hygiene immediately after removing all PPE.

Appendix 4 - Routine decontamination of reusable non-invasive patient care equipment



* Scottish National Blood Transfusion service and Scottish Ambulance Service use products different from those stated in the National Infection Prevention and Control Manual

Appendix 5: Decontamination and cleaning processes for facilities with possible or confirmed cases of COVID-19

a. In preparation

- Collect any cleaning equipment and waste bags required before entering the room.
- Any cloths and mop heads used must be disposed of as single use items.
- Before entering the room, perform hand hygiene then put on a FRSM, disposable plastic apron and gloves.

b. On entering the room

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste.

c. Cleaning process

- Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:
- Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)

  or
- A neutral purpose detergent followed by disinfection (1000 ppm av.cl.).
- Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants.
- Any cloths and mop heads used must be disposed of as single use items.

Cleaning and disinfection of reusable equipment

- Clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal.
- Clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

- For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

d. On leaving the room

- Discard detergent/disinfectant solutions safely at disposal point.
- Dispose of all waste as clinical waste.
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles.
- Remove and discard PPE as clinical waste as per local policy.
- Perform hand hygiene.

Appendix 6: PPE Table 2

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES – Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

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[9]	✗	✗	✗	✗	✓ 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[4,5,6]
	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[5,6]
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 APGs 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-wn-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

Appendix 7: PPE Table 4

Public Health England | Academy of Medical Royal Colleges | GIG CYMRU NHS WALES | Iechyd Cyhoeddus Cymru Public Health Wales | Health Protection Scotland | HSC Public Health Agency | NHS

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, 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	Direct patient/resident care assessing an individual that is not currently a possible or confirmed case[2] (within 2 metres)	✓ single use[3]	✓ single use[3]	✗	✗	✓ risk assess sessional use[4,5]	✗	✓ risk assess sessional use[4,5]
Any setting	Performing an aerosol generating procedure[6] on an individual that is not currently a possible or confirmed case[2,7]	✓ single use[3]	✗	✓ single use[3]	✗	✗	✓ single use[3]	✓ single use[3]
Any setting	Patient transport service driver conveying any individual to essential healthcare appointment, that is not currently a possible or confirmed case in vehicle without a bulkhead, no direct patient care and within 2 metres	✗	✗	✗	✓ single use[3]	✗	✗	✗

Table 4

1. This may be single or reusable face/eye protection/full face visor or goggles.
2. 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-wn-cov-infection
3. 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).
4. Risk assess refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets of blood or body fluids. **Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/single session.**
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 consider the risk of infection to and from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
6. The list of aerosol generating procedures (AGPs) is included in section 8.1 at: www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe. (Note APGs are undergoing a further review at present)
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.