INFECTION PREVENTION AND CONTROL

PRIMARY CARE COVID-19 HOT HUBS AND HOME VISITING GUIDANCE
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General Guidance

Please be aware this information is correct and up to date at the time of writing 20.04.2020

General Practice (GP) led ‘Hot Hubs’ are being set up nationally to diagnose and advise patients with suspected or confirmed Coronavirus (CoVID-19) who are not in hospital. These dedicated clinics should be placed in a suitable practice or location for patients to access i.e. this may be based at a general practice within a primary care network (PCN) collaborative or a separate site. The Hot Hubs are designed as environments to minimise any potential CoVID-19 transmission and to separate people who are potentially infectious from other people seeking healthcare in Cold Hubs. People attending Hot Hubs may have any clinical condition requiring a face-to-face assessment.

Individuals will be triaged remotely to ensure they meet the case definition for suspected/confirmed CoVID-19; this process will be undertaken either by NHS 111 or the individual’s own GP.

Following this individuals will be directed to the hubs for face-to-face clinical assessment, treatment, and care where strict infection prevention and control precautions will be taken to minimise the risk of any onward transmission. If the individual is unable to access a ‘Hot Hub’ site via a personal car (the individual should not use public transport) then a home visit will be required.

Once at the designated ‘Hot Hub’ site, the individual should wait in their car in the car park until called / directed into the building. Should it be necessary for the individual to wait in the building prior to being seen (i.e. the selected site has no car park) a designated non-carpeted ‘waiting area’ must be identified where individuals can observe social distancing and sit in non-fabric chairs a minimum of two metres apart.

Appointments should be spread-out where possible to avoid patients congregating within the Hub.

Clinicians should ideally collect the patient upon entry to the practice and escort them straight to the consultation room wearing appropriate PPE.

Patients and carers should be requested, if comfortable to do so, to wear a fluid resistant surgical facemask from the time they enter the Hub, until the time they leave.

See Appendix 1 for Flow diagram of patient pathway in Primary Care COVID-19 Hot Hubs.
1. Designated ‘Hot Hub’ Site Requirements

1.1 Key Considerations

To be deemed an appropriate space to use for a ‘Hot Hub’ the site should be / have the following:

- Be physically unattached to other providers or services
- If it is a dispensing practice and the patient requires a prescription, ensure there are processes in place to ensure the Pharmacy is safe
- Car parking for staff and individuals attending the site as patients, where possible
- A controlled entry system / access to the site for authorised entry
- Disabled access
- Toilet facilities, preferably including facilities for those who are disabled (if disabled facilities are not available please state this as part of the triage to the individual so they are aware)
- Natural ventilation - air is supplied and removed from a space without using mechanical systems
- Rest/break area for staff
- Adequate / appropriate storage for and access to personal protective equipment and other supplies e.g. liquid soap, paper towels, alcohol hand rub or gel, decontamination products for the environment and patient equipment
- Adequate secure storage for clinical, infectious and hazardous waste (DoH,2013), consider risk assessment and increase scheduled clinical waste removal with the contractor
- Non-carpeted and non-fabric chairs in the assigned waiting area(s) and consultation room(s) (DoH, 2013a)
- All consultation rooms should have suitable hand decontamination facilities
- No unnecessary equipment or soft furnishings to enable effective and frequent cleaning of the consultation and waiting area environments

2. Hot Hub Staffing

2.1 Hot Hub Staff Risk Assessment

Staff must be risk assessed to review if it is safe for them to work at the ‘Hot Hub’. Staff should be excluded from working at the ‘Hot Hub’ if they are classified as ‘at increased risk’ (NHS, 2020).

- 70 years of age or older
- Have an underlying health condition that could increase their risk from COVID-19 i.e. severe respiratory conditions, heart disease, kidney disease, liver disease, diabetes, cancer, immunosuppressed or immunocompromised etc.
• Pregnant, because in a small proportion of women, pregnancy can alter how their body handles severe viral infection, (RCOG, 2020)

At the current time and based on the understanding of what is known of COVID-19 and other similar respiratory viruses, it is likely that older people and those with chronic medical conditions may be vulnerable to severe disease. As more information emerges, recommendations may change, (PHE, 2020).

2.2 Hot Hub Staff Uniforms / Work Attire

The appropriate use of personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Staff must change into and out of uniform or scrub/work attire on site at the ‘hot hub’ and transport the work wear home in a disposable plastic bag. They should be washed separately from normal household linen, in a washing machine not more than half full, at the highest temperature permitted by the fabric, (DoH, 2016).

2.3 Hot Hub Social Distancing and Signage

Staff should minimise opportunities for the virus to spread by maintaining two metres distance between individuals and themselves and by putting up signage to remind people to always keep two metres apart.

If feasible, you should also put up plexi-glass barriers at reception to further reduce the risk of infection for all parties involved, cleaning the barriers regularly.

The ‘Hot Hub’ should have segregation signage if the location is designated to have ‘dirty’ and ‘clean’ areas to help control who enters the areas.

Non ‘Hot Hub’ patients should not be able to access the practice and clear signage should be available signposting them to appropriate services and alternative contract points.

2.4 Hot Hub Housekeeping

There should be a minimum of a daily clean at the ‘Hot Hub’ every day the hub is open. Assurance should be sought about the competency and training housekeeping staff have had in the use of PPE and decontamination products including any COSSH risk assessments or data safety sheets.
2.5 Hot Hub Staff Rest Area

Staff must be able to access an area for breaks and toilet facilities; this area can be cleaned as per the routine daily cleaning process.

3. Infection Prevention and Control

3.1 Description of Transmission Routes

Contact Precautions are used to prevent and control infection transmission via direct contact or indirectly from the immediate care environment (including care equipment). This is the most common route of infection transmission.

Droplet Precautions are used to prevent and control infection transmission over short distances via droplets (>5μm in size) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. The maximum distance for cross transmission from droplets has not been definitively determined. However, a precautionary approach is recommended, and close contact has been defined as within two metres (approximately 6 feet) of a patient, as droplets only travel short distances through the air.

Airborne Precautions are used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5μm in size) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Interrupting transmission of COVID-19 requires both droplet and contact precautions; if an aerosol generating procedure (AGP) is being undertaken then airborne precautions are required in addition to contact precautions.

3.2 Aerosol Generating Procedures (AGPs)

Aerosol generating procedures are described as medical and patient care procedures that result in the production of airborne particles (aerosols) that create the potential for airborne transmission of infections that may otherwise only be transmissible by the droplet route, (PHE, 2020a).
3.2.1 Potentially Infectious APG Procedures for COVID-19 currently (14.04.2020)

- Intubation, extubation and related procedures, for example, manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- Tracheotomy or tracheostomy procedures (insertion or open suctioning or 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 (for example, high-speed drilling)
- Non-invasive ventilation (NIV); 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)

3.2.2 Not Considered Potentially Infectious APG Procedures for COVID-19 currently (14.04.2020)

**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 combines with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

**Chest Compressions and Defibrillation** (as part of resuscitation) are not considered AGPs by Public Health England. Their advice is that first responders (any setting) can commence chest compressions and defibrillation without the need for AGP PPE while awaiting the arrival of other clinicians with Level 3 PPE to undertake airway manoeuvres.

However, information released on 20th April 2020 by the Resuscitation Council states “The absence of high-quality evidence for this should not be interpreted as the absence of risk. The clinical reality is that chest compressions produce excretions from a patient’s nose and mouth, (…) Resuscitation Council UK (RCUK) COVID-19 guidance recognises this risk and designates that Level 3 PPE should be donned before chest compressions are undertaken by Healthcare workers. We also advise that a defibrillator be employed at the earliest opportunity”. Their guidance also states that healthcare workers who are working outside of a hospital setting e.g. in patients’ homes, should follow their community guidelines – “If there is a perceived risk of infection, rescuers should place a cloth/towel over the victims
“mouth and nose and attempt compression only CPR and early defibrillation until the ambulance (or advanced care team) arrives. Put hands together in the middle of the chest and push hard and fast.”

Clinicians should feel empowered to make individual risk-based judgements on the appropriate levels of PPE required in the context of a cardiac arrest based on this national guidance. They should not undertake procedures that they believe would put them in harm’s way.

Further clarity is being sought nationally in relation to this for primary and this documentation will be updated when received.

3.3 PHE Single Use, Sessional and Reusable PPE definitions

3.3.1 Single Use PPE

Public Health guidance currently states that aprons used to protect clothing against splashes and sprays and examination gloves for clinical care are single use as per standard infection control precautions (SICPs), with disposal and hand hygiene after each use (PHE, 2020b).

3.3.2 Single Session PPE

PPE worn by one health or care worker during one shift while working. Face masks/respirators, gowns/coveralls and eye protection should only be changed when taking a break or when visibly contaminated or damaged (PHE, 2020b).

3.3.3 Reusable

Using the same item again, with appropriate precautions, by the same healthcare worker, (PHE, 2020b).

3.4 Hand Decontamination / Hand Hygiene

Effective hand hygiene protects both patients and staff from acquiring microorganisms and results in significant reduction of the carriage of potential pathogens on the hands.
Hand hygiene is readily achieved by using liquid soap & water with an effective technique or by using alcohol hand rub (AHR) on visibly clean hands (the AHR will need to comply with EN 14476 to provide virocidal activity). Ensure that the ‘Hot Hub’ has enough stock of wall mounted hand soap, alcohol hand rub and paper towels.

Cross infection (or transfer) of microorganisms from one person to another can occur:

**Directly** – by physical contact (body surface to body surface i.e. hands) transferring microorganisms between one person and another by touch.

Or

**Indirectly** - through contact between a person and a contaminated object. The microorganism remains on the surface to be picked up by the next person who touches it.

All staff must be able to demonstrate good hand decontamination compliance practices with both liquid soap & water and alcohol hand rub according to the World Health Organisation five moments of hand hygiene,(see picture below, WHO, 2009) or when hands become visibly soiled, e.g. emptying bins, cleaning equipment, removing PPE.

Clinical hand washing sinks should only be used for hand washing and have lever or sensor-operated taps that are not aligned to run directly into the drain aperture. The sink should not have a plug or a recess capable of taking a plug and should not have an overflow. (DoH, 2013a). The waste bins should be a pedal style lidded bin to avoid re-
contamination of the hands post washing.

3.4.1 Effective Hand Hygiene

Staff need to:

- Remove all hand and wrist jewellery (a single, plain metal finger ring is permitted).
- Ensure fingernails are clean, short and that artificial nails or nail products are not worn.
- Cover all cuts or abrasions with a waterproof dressing.
- Be bare below the elbow.

3.4.2. Hand Hygiene Technique

The hand decontamination process must include the wrists as a step to ensure maximum coverage before rinsing hands with water, see depiction on next page.
Best Practice: how to hand wash

Steps 3-8 should take at least 15 seconds.

1. Wet hands with water.
2. Apply enough soap to cover all hand surfaces.
3. Rub hands palm to palm.
4. Right palm over the back of the other hand with interlaced fingers and vice versa.
5. Palm to palm with fingers interlaced.
6. Backs of fingers to opposing palms with fingers interlocked.
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.
4 Personal Protective Equipment (PPE)

Personal Protective Equipment (PPE) is designed to protect the user against health or safety risks at work and is an integral part of infection prevention and control (IPC) standard precautions which are precautions taken for all patients in all healthcare settings all of the time on the assumption that all contact with blood, or bodily fluids, along with contact with the healthcare environment, may result in the transmission of microorganisms and therefore create fewer opportunities for cross infection to occur.

Both employer and employee responsibilities as per the Personal Protective Equipment at Work Regulations (1992) to provide PPE equipment to employees and for the employee to wear the provided PPE (HSE, 2015 Regulation 4, pg. 11, Regulation 9, pg. 19 and Regulation 10, pg. 20).

4.1 PPE Considerations

When choosing PPE ensure they are CE marked and comply with European and British Standards relating to PPE e.g. EN149. Consider the size, fit and weight of the PPE.

- If more than one item of PPE needs to be worn at the same time, can they be used together?
- Does it offer the right level of protection?
- If PPE needs maintenance of decontamination how is this done?
- Is training and instruction required before PPE can be used effectively and safely i.e. FFP3 masks

It is recognised that in contexts where Coronavirus COVID-19 is circulating in the community, health and social care workers may be subject to repeated risk of contact and droplet transmission during their daily work. It is also understood that in routine work there may be challenges in establishing whether patients and individuals meet the case definition for COVID-19 prior to a face-to-face assessment or care episode.

4.2 Safe Ways for Working with PPE

- Staff should know what PPE they should wear for each setting and context i.e. donning before they see the patient for assessment, (see section 4.3 to 4.6)
- Staff should have access to PPE i.e. at point of use
- Staff should be trained on donning and doffing PPE
- Hand hygiene should be practiced, before donning and after doffing PPE, with staff being bare below the elbow
- Gloves and aprons are single use as per Standard Infection Control Precautions (SICPs) and to be disposed of after each patient contact or task
- Fluid repellent surgical mask (Type IIR FRSM), and eye protection can be used for a session of work rather than a single patient contact
- Masks should be removed outside of consulting rooms and disposed of in clinical waste, unless being worn as part of cleaning PPE, in which case it can be removed at the end of the cleaning procedure, inside the room
- All PPE should be disposed of after use into the clinical waste stream (orange waste bags)
- Staff should take regular breaks and rest periods

4.3 PPE Risk Assessment, and what to wear when

Epic3 guidelines (Loveday, et al, 2014) and National Institute for Health and Clinical Excellence (NICE, 2012) clearly state the purpose and selection of PPE (gloves, aprons, masks, and eye protection) must be based on a risk assessment asking two questions:

a) What is the task to be undertaken and
b) What is the risk of exposure to blood, bodily fluids, or chemicals and
   the risk of transmission of microorganisms to staff and patients?

Initial risk assessment where possible should have taken place by phone, other remote triage, prior to entering the ‘Hot Hub’ as discussed in general guidance. This risk assessment will allow the healthcare worker to put on the appropriate PPE prior to providing care.

Where the potential risk to healthcare workers cannot be established prior to face-to-face assessment or delivery of care (within two metres), the recommendation is for healthcare workers to have access to and where required wear aprons, fluid repellent surgical mask (FRSM), eye protection and gloves.

4.4 Currently Recommended Primary Care PPE Guidance

For Primary Care PPE recommendations please see table on the page 12, (PHE, 2020c). Plastic aprons, FRSMs, eye protection (prescription glasses are not considered PPE) and gloves should be used for any direct care of possible and confirmed cases. Such PPE may
be indicated for work in such settings regardless of case status, subject to local risk assessment.
## Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector

<table>
<thead>
<tr>
<th>Setting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable fluid-repellent coveralls/gown</th>
<th>Surgical mask</th>
<th>Fluid-resistant (Type IIR) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any setting</td>
<td>Performing an aerosol-generating procedure on a possible or confirmed case¹</td>
<td>✓ single user¹</td>
<td>×</td>
<td>✓ single use¹</td>
<td>×</td>
<td>×</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
</tr>
<tr>
<td>Primary care, ambulatory care, and other non-emergency outpatient and other clinical settings (e.g., optometry, dental, maternity, mental health)</td>
<td>Direct patient care – possible or confirmed case(2) (within 2 metres)</td>
<td>✓ single user²</td>
<td>✓ single user²</td>
<td>×</td>
<td>×</td>
<td>✓ single or occasional user²</td>
<td>×</td>
<td>✓ single or occasional use²</td>
</tr>
<tr>
<td></td>
<td>Working in reception/community area with possible or confirmed case(2) and unable to maintain 2 metres social distance(3)</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>✓ occasional use³</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td>Individuals own home (current place of residence)</td>
<td>Direct care to any member of the household where any member of the household is a possible or confirmed case(2)</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
<td>×</td>
<td>×</td>
<td>✓ single or occasional user²</td>
<td>×</td>
<td>✓ risk assess single or occasional use²³</td>
</tr>
<tr>
<td></td>
<td>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(2)</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
<td>×</td>
<td>×</td>
<td>✓ single or occasional use²</td>
<td>×</td>
<td>×</td>
</tr>
<tr>
<td></td>
<td>Home birth where any member of the household is a possible or confirmed case(2)</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
<td>×</td>
<td>×</td>
<td>✓ single or occasional use²</td>
<td>×</td>
</tr>
<tr>
<td>Community and social care, care home, mental health inpatients and other overnight care facilities (e.g., learning disability, hospices, prisons, healthcare)</td>
<td>Facility with possible or confirmed case(2) – and direct resident care (within 2 metres)</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
<td>×</td>
<td>×</td>
<td>✓ occasional use²</td>
<td>×</td>
<td>✓ risk assess occasional use²³</td>
</tr>
<tr>
<td>Any setting</td>
<td>Collection of nasopharyngeal swab(s)</td>
<td>✓ single use¹</td>
<td>✓ single or occasional use²³</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>✓ single or occasional use²³</td>
</tr>
</tbody>
</table>

### Table 2

1. The use of single or reusable bacterial protection full task wear or goggles.
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. Disposal of reusable items after each patient contact as per Standard Infection Control Precautions (SICPs).
5. A single session refers to a period of time when a health care worker is undertaking duties in a specific care setting/patient environment e.g., one ward round, providing ongoing care for inpatients. A session ends when the health care worker leaves the care setting/patient environment.
6. Personal protective equipment (PPE) should always be risk assessed and considered where there are high rates of hospital cases. PPE should be disposed of after each session or when wetted, soiled, or contaminated.
7. Initial risk assessment should take place prior to entering the premises or at 2 metres social distance or 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 utilizing PPE when there is an unanticipated risk of contamination with sputum, sputum, blood or body fluids.
For healthcare workers working in reception and communal areas but not involved in direct patient care, maintain social distancing of two metres. Where this is not practical use of a fluid repellent surgical mask is recommended.

4.5 Face Filter Piece Respirators (FFP2 and FFP3) for AGPs (current guidance)

Respirator masks cover the nose and mouth when fitted properly and are made of a fabric designed to filter the air or impurities. They are available based on a grading system to indicate how much protection they offer, and could be valved (this allows air to be let out of the mask making then potentially feel less confined) or unvalved (where the filtration is built into the fabric).

**Note:** Valved respirators are not fully fluid-resistant unless they are also ‘shrouded’. Valved, non-shrouded FFP3 respirators are not considered to be fluid resistant and therefore should be worn with a full-face shield if blood or body fluid splashing is anticipated. While performing AGPs, a full-face shield or visor is recommended.

4.5.1 All Respirators should:

- Be well fitted, covering both nose and mouth
- Not be allowed to dangle around the neck of the wearer after or between each use
- Not be touched once put on
- Be removed outside the room

The respirator should be discarded and replaced and **NOT** be subject to continued use in any of the following circumstances:

- Is damaged
- Is soiled (for example, with secretions, body fluids)
- Is damp
- Facial seal is compromised
- Is uncomfortable
- If it is difficult to breathe through
4.5.2 FFP2 or N95

The UK recommends the use of FFP3 respirators when caring for patients in areas where high risk aerosol generating procedures (AGPs) are being performed. When FFP3 respirators are not available, then FFP2 respirators may be used (PHE, 2020c). These masks offer protection against respiratory viruses with a minimum filtration efficiency 94%. HSE (2020) suggest that PFFP2 and N95 respirators may be used for some aerosol-generating procedures if FFP3 respirators are not available. There is no material difference between the N95 respirator and the FFP2 disposable respirator. Both provide comparable protection against coronavirus as long as the wearer has passed a face fit test (See https://www.hse.gov.uk/news/face-mask-equivalence-aprons-gowns-eye-protection-coronavirus.htm [accessed 22.04.2020] and https://www.hse.gov.uk/news/face-mask-ppe-rpe-coronavirus.htm [accessed 23.04.2020]).

4.5.3 FFP3

FFP3 respirators provide the highest level of protection with a minimum filtration efficiency of 99% and are used for protection against infectious aerosols in healthcare settings in the UK (Coia et al, 2013).

Healthcare workers must undergo fit testing for FFP3 masks, to ensure that the respirator is a suitable and a close fit for the shape of their face. There must be no gaps under or around the mask for unfiltered air to pass through.

Fit testing is a trained procedure and Healthcare workers cannot use an FFP3 without being trained to fit check the FFP3.

To book Fit Test training – please send your enquiry to the following email address sxccg.fittesttraining@nhs.net

4.5.4 Facial Hair and FFP3 Respirators

It is important to ensure that facial hair does not cross the respirator sealing surface.

If the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve.
Respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection.

**4.6 Donning and Doffing PPE**

Below is the order that PPE should be put on and taken off. Before putting on PPE, make sure your hair is tied back and perform hand hygiene. Use alcohol hand rub (AHR) / alcohol hand gel or soap and water. Make sure you are bare below the elbow and not wearing any artificial or painted nails, jewellery, bracelets, watches, or stoned rings.
4.6.1 Putting On and Taking Off PPE for Non-Aerosol Generating Procedures (AGPs)

<table>
<thead>
<tr>
<th>Donning (Putting on)</th>
<th>Doffing (Taking off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform hand hygiene alcohol hand rub (AHR) and put on apron followed by</td>
<td>1. Remove gloves then perform hand hygiene with AHR followed by</td>
</tr>
<tr>
<td>2. Fluid repellent surgical mask then</td>
<td>2. Apron removal then</td>
</tr>
<tr>
<td>3. Eye protection and finally</td>
<td>3. Eye protection then perform hand hygiene with AHR and finally</td>
</tr>
<tr>
<td>4. Gloves</td>
<td>4. Fluid repellent surgical mask then perform hand hygiene with soap and water</td>
</tr>
</tbody>
</table>

4.6.2 Putting On and Taking Off PPE for Aerosol Generating Procedures (AGPs)

<table>
<thead>
<tr>
<th>Donning (Putting on)</th>
<th>Doffing (Taking off)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Perform hand hygiene alcohol hand rub (AHR) and put on Gown or apron followed by</td>
<td>1. Remove gloves then perform hand hygiene with AHR followed by</td>
</tr>
<tr>
<td>2. FFP3 Respirator then</td>
<td>2. Gown or Apron removal then</td>
</tr>
<tr>
<td>3. Eye protection with face visor and finally</td>
<td>3. Eye protection with face visor then perform hand hygiene with AHR and finally</td>
</tr>
<tr>
<td>4. Gloves</td>
<td>4. FFP3 Respirator then perform hand hygiene with soap and water</td>
</tr>
</tbody>
</table>

4.6.3 Detailed Instruction for PPE Doffing (Taking off)

**Glove removal** grasp the outside of the glove with the opposite gloved hand; peel off. Hold the removed glove in gloved hand and slide the fingers of the un-gloved hand under the remaining glove at the wrist, peel the remaining glove off over the first glove and discard both into a clinical waste bin. **DO NOT** reuse once removed.

**Apron / Gown** Unfasten/ break at the neck then the waist ties. Pull away from the neck and shoulders, touching the inside only using a peeling motion as the outside will be contaminated. Turn inside out, fold or roll into a bundle and discard into a clinical waste bin.
If it is a disposable plastic **Apron** used to protect clothing against splashes and sprays this is single use **DO NOT** reuse once removed.

A long sleeved/ fluid repellent reusable or washable **gown** can be reused with appropriate precautions and decontamination considering PPE shortages.

**Eye protection – Goggles** can be reusable if made of plastic and are able to be appropriately decontaminated.

**Full face visor** remove using both hands to handle the retraining straps by pulling away from behind. These are available in disposable or reusable options – please check which you have and either dispose into clinical waste bin or decontaminate as appropriate.

**Fluid repellent surgical mask** remove by Untying or breaking the bottom ties, followed by top ties or elastic, and remove by handling the ties only. Lean forward slightly. Discard into a clinical waste bin at the end of sessional use or if it becomes moist, damaged or visibly soiled, considering PPE shortages.

**Respirator** remove FFP3 respirators in a safe area (e.g., outside the room). Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated. Lean forward slightly, reach to the back of the head with both hands to find the bottom retaining strap and bring it up to the top strap, lift straps over the top of the head, let the respirator fall away from your face.

Once removed for any reason i.e. taking a break, completing a session of work they are to be disposed of as clinical waste bin, considering PPE shortages.

### 5. General Environment Etiquette, Decontamination and Waste

#### 5.1 Environmental Etiquette

- Remove all non-essential items from the ‘hot hub’ i.e. toys, magazines, leaflets, and any staff personal belongings
- Consider the removal of fabric privacy curtains and fabric window curtains and replace with disposable curtains or window frosting
- Do not use any areas with carpet for patient waiting spaces or consultation rooms for face to face assessments
- Switch off air conditioning units and open external windows for ventilation
- Remove any soft furnishings including fabric chairs to aid in environmental decontamination
• Always keep doors closed
• Do not consume any food or drink in the clinical or patient waiting areas

5.2 Environmental Decontamination

The Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Infections and Related Guidance (DoH, 2010) states that Care Quality Commission (CQC) registered providers must provide and maintain a clean and appropriate environment in managed premises that facilitates the control of infection and secondly, effective arrangements for the appropriate cleaning of equipment that is used at the point of care should be incorporated within appropriate cleaning, disinfection, and decontamination policies. With which registered providers compliance is assessed against these criteria by the CQC. There are also National Specifications for Cleanliness in the NHS (NPSA, 2010) which provide a framework for cleaning standards and the delivery of cleaning services.

Human coronaviruses can survive on inanimate objects and can remain viable for up to five days. Survival on environmental surfaces is dependent on the surface type, however, SARS-CoV-2 strain has reportedly been viable in experimental conditions on plastic for up to 72 hours, and for 48 hours on stainless steel, (PHE, 2020d)

5.3 Cleaning definitions

Cleaning is the process, which physically removes micro-organisms and organic matter but does not necessarily destroy infectious agents. It is carried out using detergent to help remove debris.

Disinfection is the removal of micro-organisms to a safe level, carried out by heat or chemicals. Disinfection cannot take place on unclean surfaces as organic matter will interfere with disinfectant. Therefore, surfaces must be cleaned before they can be disinfected.

5.4 Determining is something is clean or not

Once something has been cleaned it should not feel gritty or grainy and there should not be a high dust burden (thick grey dust). Contamination is often visible, so it is important to
ensure that cleaning standards are being adhered to and monitoring or auditing of cleaning is undertaken frequently.

5.4.1 Decontamination must occur at the following times:

a) Before patient and after patient use,

b) After exposure to blood or body fluid contamination and,

c) At regular intervals as part of equipment cleaning.

5.5 Decontamination Best Practice

- Most patient equipment that is frequently used, can easily withstand decontaminated with detergent or disinfecting wipes, (however check manufacturer guidance for assurance). Specialised equipment would need to be cleaned as per the manufacturer’s instructions only.

- Computer keyboards and phones etc., should be checked to confirm that they can withstand decontamination by a combined detergent/disinfectant or with a detergent followed by a disinfectant process. If the item cannot then a suitable cover that can withstand the frequent decontamination and exposure to detergent/disinfectant products should be obtained.

- Hand touched surfaces have frequent contact with patients or staff hands and therefore are likely to become heavily contaminated with pathogens, (Dancer, 2006). Increased cleaning (at least twice a day) of these surfaces should be undertaken to assist with reducing opportunities for carriage and transmission of micro-organisms on peoples’ hands.

- Cleaning and decontamination should only be performed by staff trained in the use of the appropriate personal protective equipment (PPE). This may need to be trained clinical staff rather than domestic staff, and clinical staff may require additional training on order of cleaning and product use.

- Ensure there is enough equipment (e.g. blood pressure cuffs) and products to facilitate effective and frequent decontamination. Making certain that the decontamination products used and stored safely in line with Control of Substances Hazardous to Health Regulations (COSSH, HSE, 2002) and specific product data safety sheet requirements.
• Ensure there is an adequate level of equipment and decontamination products available for staff at the point of use e.g. in the consultation rooms.

• Dedicated or disposable equipment (such as cloths) must be used for environmental decontamination.

• Dedicated equipment (such as mop handles, buckets) must be decontaminated after use with a chlorine-based disinfectant and dried thoroughly.

• All patient equipment in the room must be decontaminated even if it was not used in the consultation. Please remember if the sphygmomanometer and oxygen saturation are on a wheeled platform this needs to be decontaminated as well including the underside and wheels.

• The ‘Hot Hub’ should receive a chlorine disinfection clean at least daily.

• Body fluid spills within the site should be decontaminated as soon as they occur, wherever they occur.

5.6 Decontamination for the Environment or Patient Equipment

Before decontaminating the environment or patient equipment review and check

The clinical areas should not have any non-essential equipment or other items removed to assist with decontamination and to prevent the need for disposal due to contamination including fabric curtains. If fabric privacy curtains or window curtains are used, they will have to be changed at the end of the session (see section 3.3 for definition or if visibly soiled). There should not be any fabric/non-wipe able chairs in the environment and carpeted rooms/areas should not be used for assessing patients or in areas where they will be waiting.

The responsible person undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures.

Equipment used in the ‘Hot Hub’ should be single use/ disposable wherever possible and disposed of in the orange clinical waste stream for category B waste, (Category B waste is clinical waste that is potentially infectious, see DoH, 2013). Reusable equipment must be identified as ‘dedicated equipment’ and decontaminated appropriately according to manufacturer’s instructions and contact times.
Perform hand hygiene then put on a disposable plastic apron and gloves. Goggles/face visor can be used when working with chlorine products i.e. Actichlor Plus, Chlor-clean, So-Chlor DST etc. (liquid form available chlorine) to protect against splashes.

Ensure you have all cleaning equipment (cloths, mops, buckets, wipes, chlorine solution and clinical waste bags etc.) available before starting the decontamination process.

Keep the door closed and open windows if possible, to improve airflow and ventilation.

Put all items that have been used for the care of the patient in an orange clinical waste bag e.g. contents of the waste bin and any single use consumables or items that cannot be cleaned with detergent and disinfectant.

5.7 Decontamination process for consultation rooms

Between patients
Staff must wear PPE consisting of gloves, apron, and fluid repellent facemask. If using a chlorine product wear goggles/full face visors to protect against splashing. This can be the same set of PPE on from seeing the patient. Clean systematically from high to low, and dirty to clean.

Clean and disinfect, chairs, examination couch, handles (door/draw etc.) switches and hand hygiene receptacles and clean all reusable non-invasive care equipment (blood pressure monitors, digital thermometers, glucometers, otoscopes etc.) whether used in the consultation or not, any sanitary fittings (e.g. Hand Washing sink and taps), computer keyboard, mouse, phone etc. using decontamination products identified in 5.7.1 Decontamination products.

At the end of a session
Clean and disinfect all hard surfaces, floors, chairs, examination couch, handles (door/draw etc.) switches and hand hygiene receptacles as well as closing and wiping over sharps bins and clinical waste bins. Clean all reusable non-invasive care equipment (blood pressure monitors, digital thermometers, glucometers, otoscopes etc.) sanitary fittings in the room
(e.g. Hand Washing sink and taps), computer keyboard, mouse, phone etc. using decontamination products identified in 5.7.1 Decontamination products.

5.7.1 Decontamination products

Made up cleaning products in liquid form:

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.). You should refer to manufacturer’s instructions for dilution, application and contact times for all detergents and disinfectants e.g.

<table>
<thead>
<tr>
<th>Product</th>
<th>Make up</th>
<th>Contact time</th>
<th>Storage / Discard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlor-clean OR</td>
<td>1 tablet per litre of cold water</td>
<td>5 minutes</td>
<td>Solution active for 24 hours&lt;br&gt;Pour out solution amount needed for cleaning into a smaller container.&lt;br&gt;Do not put back unused solution in the storage container as this contaminates the solution&lt;br&gt;Discard unused solution safety in the sluice or toilet (be mindful of splashes)&lt;br&gt;discard solution if over 24 hours and make up new solution</td>
</tr>
<tr>
<td>Actichlor-Plus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Or So Chlor DST</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Any cloths and mop heads used must be disposed of as single use items.

Cleaning wipes

Alternatively, use a combined detergent/disinfectant such as Clinell Universal Wipes, Azowipes or Medipal red wipes. If using Clinell Universal Wipes, the surface should be cleaned using an ‘S’ shaped motion and, and then left wet for 60 seconds for disinfectant to be effective (Gama, 2020)

However, do confirm that the product used does conform to EN standard 14476 for virocidal activity against enveloped viruses.

If no combined detergent/disinfectant wipes are available, detergent wipes, dried, followed by alcohol wipes with a content of 70% alcohol or higher (and allowed to dry naturally), can be used.
5.7.2 Once the cleaning process has been completed

- Discard liquid detergent or disinfectant solutions safely. If solution was decanted into a small container/receptacle use the paper roll/paper towel to soak up remaining solution and discard into clinical waste
- All waste should be removed from the room and stored appropriately for collection
- Clean, dry and store re-usable parts of cleaning equipment, such as mop handles and buckets
- Remove and discard PPE as clinical waste
- Perform hand hygiene

Cleaning of Waiting or Communal Areas (including staff rest room and toilets)
These areas should be cleaned with detergent and disinfectant (described in section 5.7.1) at the end of a single session (definition in 3.3.2) unless there has been a blood or body fluid spill which should be dealt with immediately.

5.8 Waste

Healthcare Waste can be segregated in different ways for the purpose of storage, treatment transport and disposal.

**Category A:** an infectious substance that is transported in a form that, when exposure to it occurs, is capable of causing permanent disability, life-threatening or fatal disease to humans or animals. (DoH, 2013).

**Category B:** an infectious substance that does not meet the criteria for inclusion in Category A.

Waste from a suspected or confirmed Coronavirus COVID-19 case is considered Category B waste. Disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment, unless the waste has other properties that would require it to be incinerated. (DoH, 2013).
5.8.1 Bagged clinical waste

Infectious clinical waste (no chemicals or pharmaceuticals) - orange bag or Infectious clinical waste - yellow bag both are considered hazardous waste (DoH, 2013).

Healthcare Offensive waste is non-clinical waste that is non-infectious and non-hazardous and doesn’t contain pharmaceutical or chemical substances – tiger striped bag (DoH, 2013).

5.8.2 Sharps waste

Is considered hazardous Clinical waste that is either cytotoxic or cytostatic contaminated, other medicinally contaminated or non-medicinally contaminated waste, Sharps contaminated with body fluids (for example blood) should be classified as infectious (DoH, 2013).

6. Home visit pre checks including equipment to take on a home visit

When attending an individual at home consider what equipment will be needed?

How will you keep in touch with colleagues at the Hot Hub if needed?

Do you have boot and plastic seat covers to allow for easy vehicle decontamination detergent and disinfection products?

Do you have appropriate storage in the vehicle of clean equipment and dirty equipment and where will these be stored e.g. dirty equipment in plastic boxes, clinical waste bags in a separate transport container plastic box and used sharps bins in the boot, and clean equipment on the back seat in plastic boxes.

During the visit should specimens be taken (blood, urine, sputum, swabs etc.) for sending to the laboratory please ensure that you can transport these in the appropriate containers and transportation boxes in your vehicle?

Do you need to review for assurance around insurance/indemnity cover relating to COVID-19 for example if there was an accident in the vehicle post visiting an individual with COVID-19 symptoms, given the contaminated and potentially equipment and potentially infectious specimens?
Equipment to take on a home visit (not an exhaustive list)

- Stethoscope and pocket diagnostic set.
- Sphygmomanometer and infrared thermometer.
- Pulse oximeter.
- Glucometer including appropriate strips and lancets.
- Alcohol wipes – for cleaning skin
- Lubricating jelly
- Alcohol gel for hands
- PPE (Gloves, aprons, fluid repellent surgical masks, eye protection, facial visor)
- Specimen containers (Blood, urine, sputum, bacterial and viral swabs etc.)
- Specimen bags
- Clinical waste bag
- Sharps bin
- Detergent/disinfectant wipes

It would be worth discussing with colleagues at the ‘Hot Hub’ to decide what is equipment appropriate and essential to take in a plastic transport box for the home visit.

Any equipment in this container will need to be cleaned back at the ‘Hot Hub’. Ensure that it is only reusable equipment that is placed back in the transport box.

Waste transportation

When triaging the patient conduct a risk assessment to determine which clinical waste category you will be dealing with waste from a suspected or confirmed Coronavirus COVID-19 case is considered Category B waste for transportation. Disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment, unless the waste has other properties that would require it to be incinerated. (See section 5.8 for further information).

Any single use items will be disposed of into clinical waste at the home visit location and the clinical waste bag put in the boot of the vehicle in a plastic transport box along with the now dirty equipment plastic transport box contents.

If the vehicle has a driver then social distancing cannot be maintained with two people in the vehicle and surgical masks must be worn (by both individuals in the vehicle) and the windows of the vehicle are to remain opened at all times where possible, with the driver discarding the mask at the end of the session and performing hand hygiene.
6.1 Home visit for individual with symptoms of COVID-19

If the individual receiving a home visit has been risk assessed as having symptoms of COVID-19, then the risk of transmission should be minimised by using hand hygiene and personal protective equipment (PPE) for non-aerosol generating procedures when in close personal contact that is under two metres, (PHE, 2020e and see PPE section 4.6.1, Aprons, gloves and fluid repellent surgical masks should be used in these situations. If there is a risk of splashing, then eye protection will minimise risk).

6.2 Home visit for individual without symptoms of COVID-19

If a home visit is required for a patient without symptoms of COVID 19, then no personal protective equipment is required above and beyond normal Standard Infection Control including a PPE risk assessment (see section 4.3) based on exposure to blood and bodily fluids and risk of infection as well as good respiratory hygiene (Catch it, Kill it, Bin it) and good hygiene practice as long as social distancing can be maintained.

If social distancing cannot be maintained the healthcare worker should wear PPE for non-aerosol generating procedures when in close personal contact that is under two metres.

6.3 Home visit for a patient who is being shielded

If the individual requiring the visit is being ‘shielded’ they can be visited by a healthcare worker using PPE for non-aerosol generating procedures when in close personal contact that is under two metres, (PHE, 2020e and see PPE section 4.6.1, Aprons, gloves and fluid repellent surgical mask should be used in these situations, as a minimum.

If the Shielded individual is living with other people and they are observing social distancing, (two metres distance, frequent hand hygiene, minimising time spent in the same space e.g. kitchen, bathroom, sitting areas etc. and cleaning frequently touched surfaces) then the guidance for the visiting healthcare worker remains as identified in the above paragraph.

If the individual is clinically extremely vulnerable, including children, they should have received a letter telling them they are in this group or been told by their GP. Some
individuals with life limiting illnesses (prognosis of six months or less, or other special circumstances may choose to not undertake shielding), please check before visiting the individual if this is the case, (PHE, 2020f).

Clinically extremely vulnerable people may include the following people. Disease severity, history or treatment levels will also affect who is in the group.

1. Solid organ transplant recipients
2. People with specific cancers:
   - people with cancer who are undergoing active chemotherapy
   - people with lung cancer who are undergoing radical radiotherapy
   - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
   - people having immunotherapy or other continuing antibody treatments for cancer
   - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
   - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary (COPD)
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as Severe combined immunodeficiency (SCID), homozygous sickle cell)
5. People on immunosuppression therapies sufficient to significantly increase risk of infection
6. Women who are pregnant with significant heart disease, congenital or acquired

6.4 Home visit for individual without symptoms but part of an isolating household

If the individual requiring a home visit and the visiting healthcare worker can remain at a safe protected distance from the symptomatic member of the household, then the visit can go ahead as per section 6.2, E.g. the symptomatic family member remains in their own room, is using separate bathroom facilities and is observing robust isolation procedures, staying two metres away from other family members. (PHE, 2020g)

Where this is not possible, (This will vary on a case-by-case basis) the same procedures should be adopted as if the person being cared for did have symptoms of COVID-19 (see section 6.1).
6.5 At the Home Visit

Perform hand hygiene (use AHR that has virocidal activity) and put on the appropriate PPE (if required see section 6.1 to 6.4) either outside or just inside the door.

Take in the essential equipment in the transportation plastic box (with a lid) and conduct the visit/assessment.

6.6 After the assessment is finished

Once the assessment has taken place and all reusable equipment places back in the transportation plastic box use detergent/disinfectant wipes to clean the outside of the box and lid, and the sharps bin if taken into the premises for the home visit (use the temporary closure mechanism when transporting to or from the home visit and whilst in the vehicle).

- Remove PPE and discard into the clinical waste bag.
- Perform hand hygiene with AHR
- Leave the premises and put ‘dirty items’ into the boot of the car in appropriate transportation plastic boxes.
- Perform hand hygiene with AHR.

6.7 Back at the Hot Hub

**Removal of clinical waste from the vehicle**

- Perform hand hygiene (AHR) and put on gloves and apron
- Take clinical waste to the appropriate storage area including any ¾ full sharps bins, decontaminate the transportation plastic box.
- Remove PPE and discard in clinical waste
- Perform hand hygiene

**Removal of essential equipment box from the vehicle**

Reusable equipment must be decontaminated before its use on another patient as a standard infection control precaution. Use of PPE for cleaning must be worn (gloves and
aprons) with additional precautions of fluid repellent surgical mask and eye protection if post a visit for a patient with COVID-19 symptoms.

- Perform hand hygiene (AHR) and put on gloves and apron (additional PPE as above if visited a patient with COVID-19 symptoms)
- Take the transportation plastic box of equipment to the sluice or designated decontamination areas and clean as per section 5.7 including the plastic box and allow to dry thoroughly
- Remove PPE and discard in clinical waste
- Perform hand hygiene
- When dry replace in the box replenish the single use items so the plastic box is now ready for another visit.

**Removal of clinical specimens from the vehicle**

Any specimens should be processed and sent to the hospital laboratory via the appropriate routes.

Based on knowledge of other coronaviruses, infection with SARS-CoV-2 could occur by inhalation of aerosolised virus or by contact with droplets and contaminated fomites.

Exposure to upper and lower respiratory tract specimens in the absence of appropriate containment and control measures is likely to represent the greatest risk of SARS-CoV-2.

Sample types from the following are considered Category B (under dangerous goods, PHE, 2020h):

- Suspect patient samples
- Presumptive positive patient samples
- Confirmed positive samples for follow up
- Contacts of known positive patients

With Cultured samples for research or calibration are considered Category A, (PHE, 2020h).

**Cleaning the vehicle**
It is prudent to clean the hard surfaces/ high touch points of the vehicle between each patient visit, such as the steering wheel, door handles, car key hand break, seatbelt etc. If it is post visit to a patient with COVID-19 symptoms

- Perform hand hygiene (AHR) and put on gloves and apron
- Wipe down boot and seat covers
- Clean the vehicle including the boot area, door handles (inside and out) steering wheel, seatbelt and dashboard, mirror, car key etc. with the cleaning products identified in section 5.1 and 5.7) using the principles of the end of a single session (considering section 5.4.1 and section 5.6)
- Leave to dry
- Remove PPE and discard in clinical waste
- Perform hand hygiene
Appendix 1 Flow diagram of patient pathway in Primary Care COVID-19

Hot Hubs

Patient is triaged and allocated an appointment at the Covid19 Hub. They will be checked they can arrive by private car, no non-essential carers/dependents, not to arrive earlier than appointment. Patients and carers should be requested, if comfortable to do so to wear a facemask upon entry to the practice.

On arrival, where there is car parking facility, the patient will park in the car park and phone the number provided. When the clinician is ready for the patient, they will be contacted on their mobile by the HCA/receptionist who will then provide the patient with clear instructions on where to go.

Clinician will greet patients in reception wearing full PPE (gloves, aprons, and fluid repellent face mask) and ask the patient to get their hands and avoid touching anything such as check-in systems, door handles etc.

If clinician is not present, reception staff wearing full PPE should ask the patient to get their hands upon entry. Direct patient to sit spaced apart from other patients in the waiting area or direct them straight to the consultation room (avoiding touching surfaces/ handles where possible)

The consultation room door must remain closed, air conditioning turned off and external windows open. All equipment used or exposed during the consultation must be disposed of or decontaminated.
The patient must be escorted out of the practice by clinician the same way they came in and asked to get their hands upon leaving.

Equipment must be cleaned by either a combined detergent/disinfectant or separate solutions and must be effective against coronavirus (see advice). All surfaces to be cleaned including door handles, cupboards, computer keyboards etc.

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