Royal Devon University Healthcare NHS Foundation Trust

Title
PPE / Disciplinary Policies

Reference Number: RDF1803-23
Date of Response: 20/10/23

Further to your Freedom of Information Act request, please find the Trust's response(s) below:

Please be aware that the Royal Devon University Healthcare NHS Foundation Trust (Royal Devon) has existed since 1st April 2022 following the integration of the Northern Devon Healthcare NHS Trust (known as Northern Services) and the Royal Devon and Exeter NHS Foundation Trust (known as Eastern Services).

As per the Freedom of Information Act 2000, I would like to request the following information from you:

1. Can I have a copy of the hospital policy pertaining to the requirement of face masks, face coverings, and/or personal protective equipment for staff, students, volunteers etc. for the period between 15/08/2020 and 15/08/2021 at the Royal Devon and Exeter (Wonford) and North Devon District Hospitals?
   Please find attached the following:

- Community PPE SOP v6.1 CRG approved 161120_Redacted
- Community PPE SOP V6.2 100221_Redacted
- COVID IC PHE Pathways CRG approved 240621 _Redacted
- COVID19 IPC Recommendations v1.1 CRG approved 120321_Redacted
- COVID19 IPC Recommendations v1.2 CRG approved 070521_Redacted
- Facemasks Visors in Speech language Therapy v2 CRG approved 021120_Redacted
- FINAL PPE guidance tables poster A3 Oct2020 RDE 01-10-2020 (2)
- FINAL PPE Guidance v3.0 updated Sep 2020_Redacted
- Guidance for contacts of COVID-19 positive patients v2.0 CRG approved 231120_Redacted
- Guidance for COVID positive cohort wards v2.0 CRG approved 231120_Redacted
- Guidance to support CEV patients in hospital CEC approved 090721
- Guideline for PPE and management of suspected and confirmed COVID V4.1 C... _Redacted
- Guideline for PPE and management of suspected and confirmed COVID V4.2 C... _Redacted
- Guideline for PPE and management of suspected and confirmed COVID-19 CRG approval 040121_Redacted.
- Joint CRG COVID Patient Pathway Approved 100920_Redacted
- Managing volunteer and patient visits to the NIHR Exeter CRF V7.1 CRG Chairs approval 191020_Redacted
- Powered Respirator Provision CRG approved 211020_Redacted.

- Restricted visiting during COVID-19 pandemic SOP V1.1 CRG approved -- Redacted
- Revised PPE Guidance 051120 Gold & CRG approved-Redacted
- Theatre PPE SOP V2 CRG Chairs approved 021120_Redacted
- Updated CPR Guidance 091020_Redacted
- COVID-19 v2.1 Managing patients with possible or confirmed COVID-19
- Current Management of COVID-19 patients 16 April 2021 v3.5_Redacted
- Current Management of COVID-19 patients Oct 20 v3.1 draft for CRG updated 20.10.20_Redacted
- Current Management of COVID-19 patients Oct 20 v3.3 4.12.2020_Redacted
- Current Management of COVID-19 patients v3.6 22.07.2021_Redacted

2. Can I have a copy of the hospital policy and procedures pertaining to the disciplinary action towards, or suspension, termination, dismissal (or other related terms) of staff, etc. for the period between 15/08/2020 and 15/08/2021 at the Royal Devon and Exeter (Wonford) and North Devon District Hospitals?
   Please find attached the following:

- disciplinary-and-appeals-policy-v5.1_Redacted
- Disciplinary-Policy-WEB-VERSION-V2.1-13.01.16 (1)
- Health and Safety Policy v5.0 Nov2019
- health-safety-policy-2017-v5_Redacted
- managing-performance-capability-policy-v3 170119_Redacted

Please note: The Trust applies the following exemption:

Section 40(2) – Personal Information

The Trust has redacted any details of Trust staff in the attached documents (when indicated). The data redacted is relating to a named individual and if held by the Trust, would be exempt under Section 40(2) of the Freedom of information Act 2000, which exempts the release of personal information. The Trust believes that the release (if held) of such information meets the definition of personal data and disclosing the information would contravene Principle (a and b) as set out in Article 5 of the UK GDPR as the processing would not be lawful, fair and transparent.

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Community PPE Guidance for visiting people in their own homes

Summary of recommendation for change/development:
This Guideline is designed to explain the actions to take whilst providing care via RD&E Community Services Division to patients whether they have signs of COVID-19 or not.

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	5.4 (02/07/2020). CRG 29/10/20 subject to amends. Chairs approval v6.1 16/11/20
Document Version:	V 6.1
Date notified Gold Command:	17 November 2020
Date document becomes live:	3 July 2020

CONTENTS

1. Introduction

1.1 COVID-19 is a respiratory infection caused by a novel coronavirus. It is spread through respiratory droplets either directly or indirectly through contact with contaminated surfaces. In some circumstances aerosols can be generated needing a higher level of respiratory protection. It causes a range of symptoms from very mild to severe needing hospital admission.

1.2 During the current COVID-19 outbreak, Public Health England (PHE) are providing guidance on personal protective equipment (PPE) to help maintain safety of staff and patients. As the numbers of COVID-19 infections has increased, the use of PPE has changed to increase its use in order to protect staff/patients more. The Trust guidelines inform our staff how to follow PHE guidelines within different areas of the organisation.

1.3 The Health and Social Care Secretary announced that from the 15th June 2020, all visitors to hospital should wear a face covering and that all healthcare workers should wear a surgical mask.

1.4 This Guideline is designed to explain:-

- the actions to take whilst providing care via RD&E Community Services Division to patients in their own homes, whether they have signs of COVID-19 or not.
- The actions to take for community staff whilst working in non-clinical settings, such as their team ‘hub’.
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1.5 Staff working in inpatient settings are to refer to the Trust document ‘Personal Protective Equipment (PPE) Guidance during COVID-19 pandemic’ https://hub.exe.nhs.uk/a-z/coronavirus-covid-19-info-hub/clinical-guidance/clinical-guidance-documents-including-resuscitation-ppe-and-face-masks/

2. Purpose

2.1 This SOP promotes safe practice to minimise the risk of transmission of COVID-19 to staff, patients and members of the public.

2.2 This document represents drawing together of information for staff in the community to help with maintaining infection control standards and decontamination procedures.

3. Duties and Responsibilities of Staff

3.1 Lead Nurse/Midwife and Lead Therapist –

- Disseminating and supporting teams with current information and trust guidance
- Ensuring provision of PPE as identified

3.2 Senior Infection Control Nurse for Community –

- Ensuring accuracy of advice to community staff in line with PHE guidance and Trust recommendation.
- Provision of training and support to practice

3.3 Senior Nurse/Midwife and Therapists –

- Sharing and discussing information with locality teams
- Ensuring education and training is coordinated and accessed.
- Ensure staff adheres to the Trust Guidance

3.4 All staff

- Ensures that they as individuals follow Trust guidance and adhering to agreed trust processes regarding :-
  - Risk assessment
  - Use of PPE
  - Decontamination protocols
  - Management of waste
  - Identifying risks to ensure patient safety is maintained

4. Information to be gathered pre-visit / COVID-19 phone screening questions

4.1 Guidelines promote the use of PPE for all clinical care, regardless of COVID-19 status, however, it is still important to consider patient's signs/symptoms to help plan your visit and the requirements.

There are four main things to establish:

1. Who lives at the property?
2. Is either the patient or any household contact currently unwell?
3. Is either the patient or any household contact currently self-isolating?
4. Is anyone in the household in the extremely vulnerable group (see below)?

4.2 Questions to assess for symptoms in the last 8 days. (Appendix 2)

- Are you currently self-isolating due to COVID-19 symptoms?
- Is anyone else in the household self-isolating due to COVID-19 symptoms?
- Do you have a new persistent cough?
- If you have a cough is it productive?
- Do you have a fever? (if they have a thermometer, request they record it and if 37.8c or above, take as a positive response. If they do not have a thermometer but report feeling feverish, take as positive)
- Have you experienced a loss of the senses of smell or taste?

<u>Extremely Vulnerable patients can be described as:</u>

1. Solid organ transplant recipients.

2. People with specific cancers:

a) people with cancer who are undergoing active chemotherapy
b) people with lung cancer who are undergoing radical radiotherapy
c) people with cancers of the blood or bone marrow such as leukemia, lymphoma or myeloma who are at any stage of treatment
d) people having immunotherapy or other continuing antibody treatments for cancer
e) people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
f) 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 COPD.
4. People with rare diseases 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.
7. Other people who have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs.

4.3 If there are others in the house with symptoms or who are considered extremely vulnerable but not the person to be visited, explain the importance of those others excluding themselves from the area for the duration of the visit.

4.4 If the patient has COVID-19 symptoms, consider whether the visit is required or if it can be postponed. Arrange for the patient to be tested for SARS-CoV2 (the swab test for COVID-19). Please refer to the service RAG within your own service.

4.5 If the visit is going to go ahead, explain to the patient that PPE will be worn and establish preferred access to the building.

5. Planning the Visit

5.1 For patients who are suspected/confirmed COVID-19 with active symptoms, plan a maximum of two practitioners for home visits; unless the practitioner is confident in the process of donning an doffing, one to access the building and provide care and a further person to act as the assistant outside the property and guide the donning, doffing and decontamination.

5.2 Consider clinical equipment to be used and whether it will be:

- disposed of due to being single use.
- left at the property due to being single patient use, e.g. pulse oximeters
- brought away following the visit and decontaminated. – e.g. stethoscopes or reusable eye protection.

5.3 Ensure all equipment is available in advance.

5.4 Visits to confirmed or suspected COVID-19, within their infectious period, cases should ideally happen at the end of the day where possible.

6. Uniform and Workwear

6.1 Uniform – staff must adhere to the Uniform policy.

6.2 NHS England and NHS Improvement have produced guidance relating to uniforms worn during COVID-19.

6.3 Uniforms can be laundered at home in the following way, daily:

- taken home in a standard bag (not alginate as this may damage domestic machines), or a cotton scrub bag/pillow case
- emptied directly into the drum if in standard bag or place cotton bag with contents in the drum
- standard bag, if used, can be disposed of via general domestic waste
- wipe the seal and door of the machine before closing
- wash at the hottest temperature available – ideally 60C.
- clean hands

6.4 Scrub bags have been made and donated by the public for you to take laundry home in. These are being delivered to wards and clinical areas as they are received. These bags should be placed in the washing machine with your uniform each time they are used. Cotton tote bags or pillow cases can also be used if scrub bags not available.

6.5 If you do not have easy access to a washing machine or you use a launderette or the washing facilities in the residences onsite and would like assistance with laundering your uniform, please discuss with your line manager in the first instance, who can escalate to the relevant divisional hub.

6.6 There is no requirement for uniforms or scrubs to be changed during a shift unless they become soiled. If staff clothing becomes contaminated with secretions or body fluids during a home visit, the member of staff must return to base or home to change uniform. Contaminated skin surfaces can be washed and cleaned with soap and water or appropriate wipes.

6.7 Community-based staff should not enter supermarkets in their uniform (unless to use the toilet facilities or collection of prescriptions). Please be mindful of the public perception of uniform and infection risk and ensure uniform is covered as appropriate ensuring that the NHS logo and Trust name are covered. Staff should remove their uniform as soon as possible at the end of a shift, following the laundry instructions above.

6.8 Staff who wish to change out of uniform prior to going home, showers are accessible at most of the hospital sites. Please bring your own shower items, towel and a

change of clothes. Please contact your line manager to find out how to access the showers

6.9 Foot wear should be able to be cleaned with a disposable wipe therefore canvas or fabric shoes are not appropriate

7. Personal Protective Equipment (PPE)

7.1 PPE is only effective when used properly and in conjunction with good hand hygiene

7.2 Important changes have been made to RD&E Trust PPE guidance following PHE guidance, most recently in October 2020. Changes may continue as the pandemic progresses and we learn more about the virus.

7.3 All staff must adhere to Trust PPE guidance. It can be viewed on the HUB. PHE guidance can be updated so please refer to the HUB to ensure you keep up-to-date. Any significant changes will lead to this document being updated.

7.4 Staff will consider, the likelihood of splashes of body fluids including those generated through normal coughing, the need for very close contact and the patient's ability to manage their own secretions. Staff must risk assess each patient to plan the required PPE.

7.5 The way that patients groups are being categorized and the PPE associated with each group has changed (see appendix 3) Risk assessed care pathways provide greater clarity and detail on IPC measures for the management of patient treatment, care, and support:

- High risk - RED Pathway: There is no change in recommendations for IPC or for the use of PPE by staff when managing patients/individuals who have, or are likely to have, COVID-19. This will include some people being visited at home.

- Medium risk- AMBER Pathway: This includes patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 SARS- CoV-2 PCR test result This includes all patients being visited in their home setting and those attending outpatient clinics

- Low risk- GREEN Pathway: This pathway is used within inpatient settings and limited outpatient settings (eg for ENT outpatient appointments) Patients/individuals with no symptoms and a negative COVID-19 SARS- CoV-2 PCR test who have self-isolated prior to admission/an appointment, for example, following NICE guidance. This will NOT apply to people being visited in their own homes nor those attending the majority of outpatient appointments.

7.6 Masks

7.6.1. There are different types of mask for use in different settings:

1. Cloth face coverings – used on public transport, in shops and by patients/visitors in the clinical environment. The trust have provided all staff with reusable fluid resistant cloth masks (FRCM) and are encouraged to use these outside of work (see appendix 9 for washing)
2. Surgical masks - disposable
    a) Type IIR for use in clinical setting and non-clinical settings, these are also known as fluid resistant surgical facemasks (FRSM).
    b) Type I and type II (currently not in use) may be issued for use in non-clinical areas again in the future. These masks are in will be clearly labelled to be only for non-clinical use if this happens.

3. FFPR – filtering face piece respirators, often specifically named 'FFP3'. These are used for aerosol generating procedures in patients with known or suspected COVID-19 or other infections such as TB. They require fit testing and are disposable.

7.6.2 An important part of the PPE policy is the wearing of a FRSM at all times in clinical areas. Staff should risk assess each care episode to consider the use of sessional mask use which is promoted by PHE to reduce the number of times the masks are touched and promotes continuous use, reducing the time without a mask on.

7.6.3 The facemask is not in direct contact with the patient and should not be touched whilst in place and therefore does not pose a risk of infection to you or your patient if worn properly. This is in line with PHE guidance. A risk assessment can be made regarding wearing a facemask in a car between care episodes.

7.6.4 In certain circumstances, a FRSM can be removed and stored in a clean receptacle for example while travelling in a car between care episodes. The masks must be in good condition in order to continue with use for the rest of the session on arrival at the next care setting

7.6.5 For sessional periods, it is important to keep hydrated and be mindful that you will need to pre-hydrate. The advice is to pre-hydrate before putting on/donning the mask and to take a break at around the 4 hour mark. Please try and plan your breaks to hydrate and eat. This might mean working in a different way to what you are used to.

7.6.6 By following this advice we will be keeping our staff as safe as possible in the workplace, as well as our patients, and we will ensure the continuity of availability of this resource for when we need it.

7.7 Eye Protection

7.7.1 Eye protection is now to be worn by all staff having patient contact within 2 metres, irrespective of perceived risk or symptoms.

7.7.2 Eye protection must be worn for all home visits and outpatient clinics

7.7.3 Eye protection may be single use or reusable depending on style. Reusable eye protection should be removed, decontaminated and stored after each visit. (Appendix 9)

7.7.4 Eye protection should be disposed of if it becomes damaged, unable to be secured adequately or loose uncomfortable or difficult to see through.

7.7.4 The choice of whether to use goggles or visors will depend on wearer comfort and confidence, use of spectacles, face shape and availability. Spectacles, on their own, are not appropriate eye protection

7.7.5 Full face visors must be worn when AGPs are being conducted and within 1 hour of that procedure having finished if within 2m of the patient.

7.8 What does this mean in practice?

- If you are visiting an extremely vulnerable patient in their own home, or any member of the household is extremely vulnerable, then single mask use applies:
    - Put on/don PPE (FRSM, gloves, apron and eye protection) before entering and remove/doff PPE when you leave. Decontaminate eye protection if it is reusable (Appendix 9)

- If you are visiting a patient (non-AGP related) who does not fall into the extremely vulnerable group then sessional mask use applies:
    - Put on/don a FRSM and eye protection before you enter the first premises, ensuring pre-hydration. The mask should be worn colour side outwards.
    - The mask can remain in place between patients, they can be worn sessionally for 2-6 hours
    - You must avoid touching your face for the duration of mask wearing. If you inadvertently touch your mask, perform hand hygiene
    - During sessional use, masks should only be removed before the end of the session if visibly soiled, uncomfortable or damaged as per PHE guidance
    - In certain circumstances, a mask can be removed before the end of a session in order for staff to have a drink or drive to the next clinical setting. In this case, the mask should be removed and if it is in good condition, placed coloured side down into a clean container or bag and store ready for the session to continue. Hand hygiene must be performed before and after touching the mask. Masks must be doffed, stored and donned safely according to guidance (see Appendix 1)
    - If you need to remove the mask due to a medical condition or great discomfort please remove correctly and clean your hands
    - In line with PHE guidance, once you have provided close personal care to a patient with known COVID-19 there is no automatic need to change your mask. However if you have assessed the risk to your subsequence patients doffing of the mask post visit would be recommended.
    - Eye protection must be removed and disposed of or decontaminated if reusable (Appendix 9)

- If you are visiting a patient who is receiving or has received an AGP within the last hour:

    - An FFP3 mask and full face visor or shield must be worn. Within the community these activities are, predominantly, associated with induction of sputum and suctioning but can also include non-invasive ventilation, NIV, such as C-PAP or Bi-PAP. If the use of either of these NIV's is continuous, then an FFP3 mask is required for the entirety of your visit, however if the use

is intermittent allow an hour prior to your visit for aerosols to disperse and then a FRSM or reusable mask is appropriate level of PPE. Please see Appendix 8 for a list of Aerosol Generating Procedures.

- o FFP3 masks are single use items in the context of home treatment.

- o A long sleeved apron and gloves must be worn and removed and disposed of at the end of the visit.

7.9 **Disposal of single use items**

At the end of the four hour session, please dispose of your mask in either an orange (clinical waste) bag or household waste as per NHSE guidelines.
It is deemed safe to have an orange bag within a clinical waste bin in your car.

Whilst PHE guidelines allow for 'sessional' use of other PPE, in the community setting, this will be limited to disposable surgical face masks. Gloves, aprons and eye protection must always be removed between patients. Eye protection can be cleaned and reused whilst still in good condition.

7.10 **Ordering**

Central ordering of the PPE stock has been arranged and the process has been disseminated.

7.10.1 A maximum order has been set to aid the preservation of PPE stock throughout the trust.
This will be reviewed weekly and the maximum order will either increase or decrease depending on use. The maximum order and emergency process has been sent to your cluster rep.

8. Equipment Required for Home Visits

- Clinical equipment as required
- PPE in accordance with Appendix 3, 5 and 7
- 2 buckets, one to go into the property (hot) and one to stay outside (cold)
- 1 WIVA bin for doffing into a waste bag and for transporting waste in, when necessary.
- Orange waste bags
- Advised disinfectant products
- Detergent wipes
- Personally allocated goggles or visor

9. Donning and Doffing Procedure

9.1 Before donning PPE, if not already done so, remove wrist watches and ID badges if worn with a lanyard.

9.2 An assessment of the property you are visiting is advisable. Consideration needs to be given to the privacy of the patient and also the risks associated with the environment, such as, prevailing weather and neighbourhood. We need to consider where donning and doffing should take place. If it is not deemed appropriate or safe to complete donning or doffing on the door step then this can take place inside the

property but ensuring a clear 2 meter safe distance between you and the patient or in an adjacent room.

9.3 It is helpful that all aspects of PPE doffing are witnessed in accordance with the checklist in Appendix 5 and 6 unless confident in doffing.

9.4 Hand hygiene remains highly important as part of infection control and preventing the spread of COVID-19.

10. Decontamination of Equipment

If visiting with a 'buddy'

On exiting the property when working as a pair, the first person should doff their PPE adding their goggles or visor to the used the equipment box. The first person should then don clean gloves and an apron and start decontaminating the equipment with the recommended cleaning product. The cleaned equipment will be placed in the clean box once fully wiped.

The final piece of equipment to decontaminate is the box/bucket that has been in the property.

If visiting without a buddy

Prior to exiting the property, before doffing, each piece of equipment that has been removed from the premises will be placed in the hot bucket/box. Once completion of doffing, you will need to put on clean gloves and standard apron to clean the equipment.

11 Staff working in Non-patient Facing Areas

11.1 All staff

11.1.2 FRCMs are provided to staff by the Trust to encourage use outside of the workplace, along with alcohol gel to clean their hands, to reduce the risk of community transmission. Information leaflets are available which include care instructions.

11.1.3 If staff travel to work on public transport, they should wear a FRCM for the journey. Once at work, staff should perform hand hygiene and remove the FRCM, which should be folded (outside in) and placed in a clean container, labelled with your name for the journey home.

11.1.4 Staff should follow infection control guidance for safe donning and doffing and disposal or storage of masks

11.1.5 Careful attention should be paid to hand hygiene with either alcohol gel or soap and water after the mask has been touched for any reason

11.1.6 Staff in non-clinical areas should be provided with the means to clean high touch surfaces in their working environments to reduce the risk of fomite transmission

11.1.7 Staff working alone in an office do not need to wear a mask but need to be alert when people are entering their work space, ready to don a mask as required.

11.1.8 During rest periods it is vital that staff continue to adhere to social distancing and hygiene measures as masks will be off for refreshment. Refreshment periods must be staggered so that masks can be removed safely at a distance more than 2m from others.

11.3 Working in PPE for Staff in Non-patient Facing Areas (

11.3.1 All staff in non-patient facing environments should wear a SM (when available) or FRSM for four hour sessions, only changing the mask when damaged, soiled/wet or uncomfortable unless alone in the office

11.3.2 Staff with respiratory conditions or other concerns around wearing a sessional mask should contact occupational health and their line manager

12. Waste – COVID 19 Guidance to manage infectious waste for community patients in their own home

12.1 Currently waste generated by a healthcare intervention is either disposed of in the patient's own household waste or a waste collection is arranged by a registered waste collector through the Local Authority. Different types of clinical or healthcare related waste are identified including:

- Offensive waste ; items contaminated with body fluids not believed to be infectious, for example wound dressings, stoma or catheter equipment or continence products. This waste is still being produced by people in the community NOT identified as possible or confirmed COVID-19. This is managed differently depending on the area that you work as waste collections by the Local Authority's differ.

- Infectious waste - any item with the potential to cause infection. This process is currently managed through local councils and is to ensure patients, staff and disposable of such waste is safe. This includes all waste coming from patients with possible or confirmed COVID-19

- Sharps waste – any waste including sharps contaminated with body fluids or pharmaceuticals. This waste stream is largely unaffected by COVID-19

12.2 Removal of waste generated by patient's own self-care is the responsibility of the Local Authority. The removal of waste generated through healthcare intervention by an NHS professional is the provider's responsibility.

12.3 During this current period of COVID 19 pandemic our staff are now wearing fluid resistant face masks and eye protection for all patient contact in the community settings. Staff should also wear gloves and aprons if there is a risk of exposure to bodily fluids (see appendix 3)
If the patient you are visiting (prior to the triage) has no symptoms of COVID 19 then the gloves and aprons that you will use can be disposed of in the normal household waste. The mask can continue to be worn from the property as part of sessional use and the eye protection cleaned for reuse.

12.4 If you are visiting a patient that is suspected or confirmed COVID positive and they have no other clinical waste produced as part of the visit then your PPE can be doffed into a **black** bag and the patient/relative/carer advised to put out for normal household waste collection after 72 hours. If additional **infectious waste** is produced during the visit a collection may need to be to be set up as per your local council guidelines. You need to state this is for a patient that has COVID 19.

12.5 You will need to source the orange bag for this waste from either your closest hospital site/housekeeping team or order via EROS using the following codes:

- MVN493 – 80 Litre
- MVN022 – 24 Litre
- MVN013 – 17 Litre

12.6 Infectious (orange bag) waste in this context is largely that which is contaminated with body fluids associated with the community healthcare intervention. This will need to be kept inside the patient's property prior to collection. PPE being used as part of a visit that generates infectious waste should also be disposed of as infectious waste. As before, on leaving the property and doffing the PPE it needs to be placed in a small bag which is left just inside the property assessing for risk of obstruction or trip hazard.

12.7 The next visiting healthcare professional, once donned in PPE, can pick up the small bag and place in the larger orange bag with the other infectious waste. When the large orange bag is 2/3 full it is the responsibility of the healthcare professional, whilst in PPE, to tie the bag and then instruct the patient relative or care that this needs to be put out for the scheduled collection date/time. Reiteration must be made that bags should not be put out days earlier and should the collection not occur then the patient relative or carer should contact the council to rearrange and the bag not left on the doorstep.

12.8 It is the responsibility of the first visiting healthcare professional to assess and set up the required clinical waste collection and explain the procedure to the patient/relative/carer including the day the collection will take place and when/where to put out for collection. Some patients will already have a waste collection for sharps and this process will remain unchanged.

12.9 **Waste Summary**

Non clinical waste (PPE and items not contaminated with body fluids)	Put all PPE equipment into a black bag Tie bag and label "Please put into your household waste after 72hrs date _____"
Clinical Waste (items contaminated with body fluids), those involving other types of infection, such as multi drug resistant organisms or bulky waste that cannot reasonably be left for 72 hours.	Put all clinical waste and PPE into an Orange bag Contact local authority to arrange collection.

13. MYCare and other equipment/resources

13.1 Mycare Roving devices can be cleaned using disinfectant wipes.

13.2 Equipment used in patient care should either be left at the property until the infectious period is over, plus afinal 72 hours quarantine, or removed and decontaminated.

13.3 Decontamination of equipment is through the use of products that contain detergent/disinfectant products such as Chlorclean or Tristel or wipes which include the standard EN14776 such as Clinell Universal Wipes. Other wipes may be permissible, please refer to the Infection Control Team for review.

13.2 Paper items, such as records, that need to be brought away from the property should be placed in a plastic bag at the door and, ideally, quarantined for 72 hours. If the document has to be referred to within that time, staff touching paper documents must remember to complete hand hygiene and avoid touching their faces.

14. Stepping Down of Infection Control Precautions

14.1 The majority of people with COVID-19 will cease to be infectious 10 days after onset of symptoms provided they have been asymptomatic of pyrexia for 48 hours. Although they are no longer considered infectious and do not need to self- isolate, for simplicity, staff should continue to use AMBER precautions.

14.2 Patients being discharged from hospital with confirmed infection will have advisory information in the referral regarding the duration of self-isolation. It is estimated that patients who have been hospitalised with severe infection may remain infectious for 14 days after onset of symptoms.

14.3 Discharge and de-isolation guidance is available on HUB.

15. Staff Health

15.1 Staff must report skin sensitivities to their line manager and/or Occupation Health arising from increased use of personal protective clothing and decontamination products. Advice is also available on the Hub.

15.2 Should staff develop any symptoms suggestive of COVID-19, self-isolate and call line manager and follow Trust procedures (this will be advised by the staffing and testing hub) .

15.3 Please ensure your manager is aware of any health issues related to your PPE.

16. Attending a Care Home where an Outbreak is Occurring

16.1 Where an outbreak in a care home has been confirmed by PHE or is suspected by your team, please contact the Community Infection Control Team to discuss case management, PPE and ongoing support.

17. Testing and Swabbing

17.1 Please see the COVID-19 HUB pages for the latest testing strategy and process.

18. Travelling in shared vehicles

18.1 Staff should avoid traveling in shared vehicles during where possible

18.2 Staff should follow PHE guidance on travelling, available at : **https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/vehicles**

Where shared travel is unavoidable the following should be ensured:-

- Where possible, the same people should share the vehicle with the driver rather than there being a mixture of passengers riding in it.
- Numbers sharing the vehicle should be minimised – two people maximises social distancing
- Both parties must wear a FRSM at all times within the vehicle
- Hands must be cleaned before getting in the car
- The passenger must sit beside or behind the staff member and should face away from the driver when possible
- Ensure good ventilation through having the side window open
- Air conditioning should not be set to circulate internal air but rather draw from outside the vehicle
- The car owner should clean the car between journeys using standard cleaning products, particularly high touch surfaces like the door handle.

Appendix 1 – Guidance For Temporarily Removing a Disposable Mask

Doffing

- Clean hands with alcohol gel before touching the mask
- Remove mask, ensuring you do not touch the front of the mask
- Put the mask into a box or bag. The coloured side must be facing down.
- Clean hands with alcohol gel once removed

Donning

- Clean hands with alcohol gel before touching the mask
- Open the box or bag and remove the mask, **do not touch the outside of the mask**
- Put the mask back on
- Clean your hands with alcohol gel after replacing the mask

The container that your mask is stored in must be cleaned at the end of the day, this can be with a Clinell Universal or Clorox wipe or it can be taken home and washed with soap and water.

https://www.cebm.net/covid-19/extended-use-or-re-use-of-single-use-surgical-masks-and-filtering-facepiece-respirators-a-rapid-evidence-review/

Appendix 2

GUIDANCE FOR STAFF UNDERTAKING DOMICILIARY/HOME VISITS

ASK SCREENING QUESTIONS TO ALL PATIENTS BY TELEPHONE PRIOR TO VISITING:

In the last 8 days, have you had either of the following:

- Are you currently self-isolating due to covid-19 symptoms?
- Are you living in a household with someone who is self-isolating due to covid-19 symptoms?
- Do you have a new and persistent dry cough or one which is highly expectorant?
- Do you have a fever? (get them to take temp if they have a thermometer, if over 37.8c then take as a positive response)
- Have you experienced changes to your sense of smell or taste?
- Does the patient use non-invasive ventilation e.g. BiPAP continuously, or will it have been used within 1 hour of start of appointment?

Also enquire if there are any extremely vulnerable people in the household.

YES ANY QUESTION

NO: Arrange visit as planned using required PPE

IS THE VISIT ABSOLUTELY ESSENTIAL / CLINICALLY NECESSARY?

YES – PLAN FOR ANY ADDITIONAL PPE BASED ON RISK ASSESSMENT OF LIKELIHOOD OF SPLASH ETC
DON PPE AS PER TABLE BELOW PRIOR TO ENTERING THE HOUSE

Appendix 3

PPE BASED ON SYMPTOMS, PROCEDURES AND NATURE OF CARE PROVIDED

Low Risk GREEN Pathway – Key Principles

This pathway is used for patients that have either been admitted as inpatients to the hospital and have tested negative with no clinical suspicion of COVID-19 or are elective patients who have received a negative test result, self-isolated following the test and who are then admitted to hospital for elective surgery or selected procedures.
As patients in their own homes may have multiple contacts and are not routinely tested, it is not anticipated that this pathway will be used by community staff visiting people at home or in the majority of community outpatient departments. It is included below to allow clarity of the pathways as a whole.
Please note that eye protection is to be worn for all patient contact within 2m.

SICPs/PPE	Disposable gloves	Disposable apron	Face masks	Eye Protection
All settings/all patients/individuals	Single use (risk of exposure	Single use apron (risk of	Type IIR FRSM	Single use or re-usable eye

	to body fluids only)	exposure to body fluids only)	at all times	protection (goggles or visor)

Medium Risk (Amber) Pathway – Key Principles

This pathway is used for people who have never been tested or who have not had a recent COVID-19 negative result and present or require care interventions without symptoms of COVID-19 infection.
This pathway is relevant for all home visits, currently, and for those attending the majority of community outpatient departments (exception – some ENT clinics)

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Patients with no COVID-19 symptoms and no test result	Single use (risk of exposure to body fluids only)	Single use apron (risk of exposure to body fluids only)	Type IIR FRSM	Single use or re-usable eye protection (goggles or visor)
Airborne	Disposable gloves	Gown	Face masks	Eye protection
When undertaking AGPs on patients with no COVID-19 symptoms and no test result	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

High Risk Pathway (Red and Unconfirmed Red) – Key principles

11.1 This pathway is used for patients who are confirmed positive cases of COVID-19 or who have symptoms of COVID-19 infection. This pathway will be relevant for some home visits.

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Suspected or confirmed COVID-19	Single use	Single use apron (nb a long sleeved gown is only required if	FRSM Type IIR for direct patient care	Single use or re-usable eye protection (goggles or

		risk of spraying / splashing or gross contamination of home environment)		visor)
Airborne	Disposable gloves	Gown	Face masks	Eye protection
When undertaking AGPs on confirmed or suspected COVID-19	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

Patients must be encouraged as much as possible to use tissues and to turn their faces away when coughing whilst staff members are present.

Appendix 4

Community Staff working in Non-Patient facing areas.

Category	Areas	PPE
Blue Non-clinical area staff	Non-clinical areas including offices, kitchens, corridors, reception areas and in Trust grounds if within 2m of a colleague Lone working in an office	Surgical mask type I or II depending on availability Also PRACTICE:- • Hand hygiene • Social distancing • Be particularly careful in rest areas. Masks must not be removed if within 2m of an unmasked colleague. • No PPE required
Patients and visitors to community hospital sites	Visits to all areas	Patient/visitor should arrive in own face covering Offer a surgical mask if they do not have a face covering with them

Hand hygiene is extremely important and staff should maintain social distancing at all times, particularly when masks are not worn.

Appendix 5

Public Health England

Guide to donning and doffing standard Personal Protective Equipment (PPE)

for health and social care settings

Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back.

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

3. Put on your eye protection if there is a risk of splashing.

4. Put on non-sterile nitrile gloves.

5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.

2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waste ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection.

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

If you require the PPE for aerosol generating procedures (AGPs) please visit:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Appendix 6

PPE for COVID-19 Donning Checklist: All

The 'buddy' checking the practitioner who is donning PPE prior to entering the area should read out the actions and check that PPE is put on correctly.

Ensure hair is tied back securely and off the neck and collar. Remove jewellery/pens. Plan ahead.	
Put on apron This may be a standard single use plastic apron OR a long sleeved apron depending on risk assessment of likely body fluid contamination. (**Note: long sleeved required for AGP**)	
Fit the single use surgical mask (or FFP3 for AGP) make sure it is:-	
	Symmetrical to the face and opened out fully,
	The nose bar must be pressed down to the bridge of the nose
	The bottom section must be pulled down under the chin
	One strap should be over the ears and one under the ears
	Press the mask around the face to check it is flush to the skin
	The wearer should check that the mask fits the face snuggly to cover nose and mouth.
	If using a FFP3 mask, the wearer must complete a 'fit check' by forcible exhaling to check for leakage of air towards eyes or onto neck.
Put on full face visor/shield making sure that the strap is tight enough to secure in position (some staff may be provided with surgical masks that have integral visors, dependent on supply) **or reusable goggles. (Note: AGPs require the use of visors)**	
Put on gloves. If a long sleeved apron is used, it is useful to tape the cuff of the gloves to the sleeve so that eventual removal is facilitated as one action. Micro-pore tape should be used in 4 strips, 8-10cm long and going up the arm. Do not tape around the wrist.	

Doffing Checklists

The 'buddy' should read out and observe the actions and verify when all elements have been completed correctly.

Single use apron and gloves (non-aerosol generating procedure)

Gloves
Remove the first glove by only touching the outer surface with the other, still gloved, hand and dispose of into waste bag. Remove second glove with a bare finger peeling inside out from the wrist.
Gel Hands
Apron
Avoid touching the front of the apron
Snap the loop at the back of the neck and let the 'bib' of the apron fold forward and downwards. Snap waist ties at the back and fold forward
Fold or roll into bundle, touching only the inside surface, and place in waste bin
Gel hands
Full face visor/shield or goggles: Remove visor by pulling away from face, lifting strap up over head and forwards. **OR** Lift goggles forward away from the face. Dispose of into waste bag if single use, place in equipment bucket or box if re-usable for decontamination.
Surgical face mask: (at the end of sessional use or if contaminated etc) Untie bottom strap followed by top one, or unhook loops and allow mask to separate away from the face. Do not allow the mask to touch clothing or skin. Dispose of into waste bag.
Wash or gel hands

Long Sleeved Apron and Gloves (aerosol generating procedures)

Long sleeved apron and gloves
Pull forward front of apron at waist to break ties
Pull forward front of apron towards the top to break neck loop
Pull gown forward from front of shoulders
Pull arms out so that sleeves end up inside out
Gloves will come off with apron if taped or, if not, remove gloves after gown.
Fold or roll apron (& gloves) into a bundle, touching only the inside surface, and place in waste bin.
Gel hands
Full face visor/ shield: Remove by pulling away from face, lifting strap up over head. Dispose of into waste bag if single use, or place in place in equipment bucket or box if re-usable for decontamination
FFP3 Mask: Gather up the elastic bands over the head and allowing the mask to separate from the face. Do not allow the mask to drop down on clothing and do not touch the outside of the mask with bare hands. Dispose of into clinical waste.
Gel hands

Appendix 7

Laundering of reusable masks Care of Fluid Resistant Cloth Masks (used for travelling to and from work)

- Place all used masks along with your uniform into a washing machine
- Machine wash the mask as hot as possible, ideally 60°C.
- Do not use bleaches or other harsh chemicals.
- Tumble dry or air dry followed by a cool iron after wash. Heat will reactivate the fluorocarbon finish.
- After each wash and dry, inspect the mask and the elastic for any damage. Report any damage to a member of the renal team. Visibly damaged masks will be replaced. Hang up to dry outside on a washing line, inside on a clothes horse or radiator.
- Each mask can be washed up to 10 times – please ensure you are aware of which mask you have washed and how often
- Do not bleach

Appendix 8 - Aerosol Generating Procedures – PHE guidance

This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum/chest physio using nebulised saline
- respiratory tract suctioning
- upper ENT airway procedures that involve respiratory suctioning
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. Community staff working in peoples' homes should follow Trust guidance 'COVID-19 CLINICAL GUIDANCE: Updated CPR guidance' available on the Hub.

Appendix 9

Cleaning Reusable Goggles or Visor Using Universal Wipes in the Community

Eye Protection (reusable goggles or visor) must be worn:

- For all community visits to people in their own homes
- For all patient contact within 2m, irrespective of symptoms

Cleaning protocol: to be followed after wearing reusable goggles or visor:

1. Remove your goggles/glasses ensuring the front is not touched. If goggles with an elastic strap** are used, lift over head to release.

2. Place the goggles or visor carefully onto a designated cleanable surface e.g. trolley/ tray or into a cleanable container.

3. Clean your hands and put on a pair of clean gloves.

4. Wipe the inside; followed by the outside of the goggles along with the arms or elastic strap using a universal wipe which is a disinfectant and detergent wipe (see below). The required contact time is 60 seconds.

5. Allow the goggles to fully air dry, if the surface is not air dried then the goggles will not be cleaned sufficiently. Place into clean container or bag for later use.

6. Clean the contaminated surface/container with a universal wipe.

7. Remove gloves and clean your hands.

8. Return container with clean goggles to storage area.

9. Rinse goggles or visor with water and dry with paper towels if the disinfectant/detergent liquid hasn't dried and immediate reuse is required (ensuring cleaning contact time of 60seconds has elapsed as above)

*__Sessional use__ refers to a period of time where a worker is undertaking duties in a specific setting/exposure environment and a session ends when the worker leaves the care setting/exposure environment for a break or at the end of their shift.

**__Goggles with an elastic strap__ must be allocated to individual staff and not shared between staff. The elastic strap must be cleaned with universal wipes, with the rest of the goggles, each time they are removed. Goggles must be disposed of and replaced if the elastic is damaged or visibly soiled. Hand hygiene before and after touching goggles and elastic is vital.

Figure 1

Name of document	Community PPE Guidance during COVID-19
Division/Directorate and service area	Community Services Division
Name, job title and contact details of person completing the assessment	[redacted]
Date completed:	

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

COVID-19 is a respiratory infection caused by a novel coronavirus. It is spread through respiratory droplets either directly or via indirect through contact with contaminated surfaces. In some circumstances aerosols can be generated needing a higher level of respiratory protection. It causes a range of symptoms from very mild to severe needing hospital admission.

During the current COVID-19 outbreak, Public Health England (PHE) are providing guidance on personal protective equipment (PPE) to help maintain safety of staff and patients. As the numbers of COVID-19 infections has increased, the use of PPE has changed to increase its use in order to protect staff/patients more. The Trust guidelines inform our staff how to follow PHE guidelines within different areas of the organisation.

This Guideline is designed to explain the actions to take whilst providing care via RD&E Community Services Division to patients whether they have signs of COVID-19 or not.

Purpose of the document.

This guidance promotes safe practice to minimise the risk of transmission of COVID-19 to staff, patients and members of the public.

This document represents drawing together of information for staff in the community to help with maintaining infection control standards and decontamination procedures.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☒	☐
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☒	☐
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way
Staff who wear glasses where sessional use of masks are required to be worn.

Staff who may require breaks in wearing PPE due to other health reasons such as menopause and pregnancy.

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:

- ***Fairness – recommendation have been made for all staff to wear sessional masks. If the wearing of sessional masks is considered uncomfortable then the staff may choose to wear reusable masks.***
- ***Respect – the guidance gives information for all of community staff and is not altered for discipline or grade of staff.***
- ***Equality – risk assessment will allow a good conversation with all staff where they have identified a problem with a sessional use of mask.***
- ***Dignity – all conversations about difficulties will be carried out by line managers and not subject to wider debate.***
- ***Autonomy – Staff are able to use sense and judgement to follow the guidance and have access to help where they cannot resolve the issues themselves.***

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

1.) With regard sessional use of masks, staff and patient safety and concerns were raised and considered. In depth discussions within Infection Control, Microbiology and The Clinical Reference Group did not support the concerns with sessional use of PPE. Questions have been answered throughout the PPE document and risk assessment has been completed.

2.) The sessional use of masks is in line with PHE advice.

3.) Following discussion and debate with staff groups, Staffside, Infection Control, Microbiology, The Clinical Reference Group and Chief Nurse we have created version control of the document.

Royal Devon and Exeter NHS Foundation Trust

Community PPE Guidance for visiting people in their own homes

Post holder responsible for Procedural Document	[redacted], Assistant Director of Nursing, Community Services
Author of Standard Operating Procedure	[redacted], Consultant in Medical Microbiology and Infection Control
Division/ Department responsible for Procedural Document	Community Services/ Infection Control
Contact details	Community Services
Date of original standard operating procedure	13 May 2020
Impact Assessment performed	**Yes**/ No
Approving body and date approved	Clinical Reference Group 13 May 2020
Date document becomes live	26 May 2020

Full History		**Status: Final**	
Version	Date	Author (Title not name)	Reason
5.5	13/05/20	[redacted]	New guidance
5.4	02/07/20		Clarification re reusable masks
	29/10/20		Amends to patient pathways & visors/goggle use
6.1	16/11/20	[redacted]	Amends following CRG review
6.2	10/02/21	[redacted]	Updates in line with Trust PPE guidance adapted for community. Main points around the wearing of FFP3 masks.

CONTENTS

1. Introduction & Key Messages

1.1 COVID-19 is a respiratory infection caused by a novel coronavirus, SARS-CoV-2. It is spread largely through respiratory droplets either directly or indirectly through contact with contaminated surfaces. In some circumstances aerosols can be generated needing a higher level of respiratory protection. It causes a range of symptoms from very mild to severe needing hospital admission. Currently the incubation period is thought to be 1-14 days with the majority of symptomatic cases appearing at days 3-5.

1.2 Multiple new strains of the virus are being detected. As of December 2020 there were over 4,000 new strains being tracked. Three of these appear to have characteristics that may either change their transmissibility or virulence. These include UK B1.1.7 strain, the cluster 5 Danish variant and the South African 501.V2 strain. Any patient returning from a foreign country should be COVID tested and any positive results to be discussed with the microbiologist. During the current COVID-19 outbreak, Public Health England (PHE) is providing guidance on personal protective equipment (PPE) to help maintain safety of staff and patients.

1.3 Trust guidelines inform our staff how to follow PHE guidelines within different areas of the organisation and regular review and updating guidance is carefully considered via trust process's, such as outbreak meetings and the Clinical Reference Group.

1.4 Staff working in inpatient settings are to refer to the Trust document 'Personal Protective Equipment (PPE) Guidance during COVID-19 pandemic'
COVID-19 Clinical Guidance Information on Hub

2. Purpose

2.1 This guideline promotes safe practice to minimise the risk of transmission of COVID-19 to staff, patients and members of the public.

2.2 This Guideline is designed to explain:-

- **a**ctions to take whilst providing care via RD&E Community Services Division to patients in their own homes, whether they have signs of COVID-19 or not.
- actions to take for community staff whilst working in non-clinical settings, such as their team 'hub'.

3. Duties and Responsibilities of Staff

3.1 Lead Nurse/Midwife and Lead Therapist –

- Disseminating and supporting teams with current information and trust guidance
- Ensuring provision of PPE as identified

3.2 Senior Infection Control Nurse for Community –

- Ensuring accuracy of advice to community staff in line with PHE guidance and Trust recommendation.
- Provision of training and support to practice

3.3 Senior Nurse/Midwife and Therapists –

- Sharing and discussing information with locality teams
- Ensuring education and training is coordinated and accessed.
- Ensure staff adheres to the Trust Guidance

3.4 All staff

- Ensures that they as individuals follow Trust guidance and adhering to agreed trust processes regarding :-
  - Risk assessment
  - Use of PPE
  - Decontamination protocols
  - Management of waste
  - Identifying risks to ensure patient safety is maintained

4. Patient Pathways

4.1 Three care pathways have been structured to enable organisations to distinguish COVID-19 risk at a local level (see appendix 3) Risk assessed care pathways provide greater clarity and detail on IPC measures for the management of patient treatment, care, and support (see Appendix 3)

4.2 High risk - RED Pathway: patients/individuals with confirmed or suspected COVID-19, At the RD&E enhanced PPE is optional for staff caring for patients on RED pathways.

4.3 Medium risk- AMBER Pathway: This includes patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 PCR test result to confirm the absence or presence of infection. This includes all patients being visited in their home setting and those attending outpatient clinics

4.4 Low risk- GREEN Pathway: This pathway is used within inpatient settings and limited outpatient settings (eg for ENT outpatient appointments) and would include patients/individuals with no symptoms and a negative COVID-19 PCR test who have self-isolated prior to admission/an appointment, for example, following NICE guidance. This will NOT generally apply to people being visited in their own homes nor those attending the majority of outpatient appointments. Recovered/resolved cases of COVID-19 can also be deemed green but please be mindful of the potential for reinfection and consider re-testing patients who develop new key symptoms.

4.5 At times of high prevalence of COVID-19, all AGPs for patients in GREEN require enhanced PPE but patients on AMBER and RED pathways require AGP PPE

5. Information to be gathered pre-visit / COVID-19 phone screening questions

5.1 Guidelines promote the use of PPE for all clinical care, regardless of COVID-19 status, however, it is still important to consider patient's signs/symptoms to help plan your visit and the requirements.

There are four main things to establish:

- Who lives at the property?
- Is either the patient or any household contact currently unwell?
- Is either the patient or any household contact currently self-isolating?
- Is anyone in the household in the extremely vulnerable group (see below)?

5.2 Questions to assess for symptoms in the last 10 days. (Appendix 2)

<u>Extremely Vulnerable patients can be described as:</u>

1. solid organ transplant recipients
2. people with specific cancers:
   a) people with cancer who are undergoing active chemotherapy
   b) people with lung cancer who are undergoing radical radiotherapy

c) people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
d) people having immunotherapy or other continuing antibody treatments for cancer
e) people having other targeted cancer treatments that can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
f) 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 disease (COPD)
4. people with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell disease)
5. people on immunosuppression therapies sufficient to significantly increase risk of infection
6. problems with your spleen, for example splenectomy (having your spleen removed)
7. adults with Down's syndrome
8. adults on dialysis or with chronic kidney disease (stage 5)
9. women who are pregnant with significant heart disease, congenital or acquired
10. other people who have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions

5.3 If there are others in the house with symptoms or who are considered extremely vulnerable but not the person to be visited, explain the importance of those others excluding themselves from the area for the duration of the visit.

5.4 If the patient has COVID-19 symptoms, consider whether the visit is required or if it can be postponed. Arrange for the patient to be tested for COVID-19. Please refer to the service RAG within your own service.

5.5 If the visit is going to go ahead, explain to the patient that PPE will be worn and establish preferred access to the building.

5.6 Following screening, if you are considering that a patient is symptomatic, arrange for the patient to be tested for COVID-19 as per the trust testing strategy.

6. Planning the visit

6.1 For patients who are suspected/confirmed COVID-19 with active symptoms, plan a maximum of two practitioners for home visits, unless the practitioner is confident in the process of donning and doffing, one to access the building and provide care and a further person to act as the assistant outside the property and guide the donning, doffing and decontamination.

6.2 Consider clinical equipment to be used and whether it will be:

- Single use and disposable
- Single patient use and can leave at the property e.g. pulse oximeters
- Brought away following the visit and decontaminated. – e.g. stethoscopes or reusable eye protection.

6.3 Ensure all equipment is available in advance.

6.4 Visits to confirmed or suspected COVID-19, within their infectious period, cases should ideally happen at the end of the day where possible.

7. Uniform and Workwear

7.1 Uniform – staff must adhere to the Uniform policy.

7.2 Uniforms can be laundered at home in the following way, daily:

- taken home in a standard bag (not alginate as this may damage domestic machines), or a cotton scrub bag/pillow case
- emptied directly into the drum if in standard bag or place cotton bag with contents in the drum
- standard bag, if used, can be disposed of via general domestic waste
- wipe the seal and door of the machine before closing
- wash at the hottest temperature available – ideally 60C.
- clean hands

7.3 If you do not have easy access to a washing machine or you use a launderette or the washing facilities in the residences onsite and would like assistance with laundering your uniform, please discuss with your line manager in the first instance, who can escalate to the relevant divisional hub.

7.4 There is no requirement for uniforms or scrubs to be changed during a shift unless they become soiled. If staff clothing becomes contaminated with secretions or body fluids during a home visit, the member of staff must return to base or home to change uniform. Contaminated skin surfaces can be washed and cleaned with soap and water or appropriate wipes.

7.5 Community-based staff should not enter supermarkets in their uniform (unless to use the toilet facilities or collection of prescriptions). Please be mindful of the public perception of uniform and infection risk and ensure uniform is covered as appropriate ensuring that the NHS logo and Trust name are covered. Staff should remove their uniform as soon as possible at the end of a shift, following the laundry instructions above.

7.6 Staff who wish to change out of uniform prior to going home, showers are accessible at most of the hospital sites. Please bring your own shower items, towel and a change of clothes. Please contact your line manager to find out how to access the showers.

7.7 Foot wear should be able to be cleaned with a disposable wipe therefore canvas or fabric shoes are not appropriate.

8. Personal Protective Equipment (PPE)

8.1 Definitions:

Contact PPE

- used to prevent and control infections that spread via direct contact with the patient or indirectly form the patient immediate care environment, including care equipment.
- FRSM and eye protection
- Gloves and apron if at risk of bodily fluids.

Droplet PPE

- Used to prevent and control infections spread over short distances, at least 1 metre via droplets from respiratory track of individual directly onto a mucosal surface or conjunctivae of another individual.
- FRSM and eye protection
- Gloves and apron

Enhanced PPE

- A combination of airborne and droplet precautions to provide additional respiratory protection for use in the following setting
- For use if having prolonged direct contact, of over an hour, eg, complex wound dressings for patient who are suspected or positive COVID-19.
- FFP3 mask and visor (full face protection)
- Gloves and aprons
- The use of enhanced PPE as described during the care of COVID-19 positive patients is optional. Staff may choose to continue to wear droplet PPE as National Guidance.

Full Aerosol generating procedure (AGP) PPE

- AGP precautions are for use in the following setting.
- On all Pathways
- FFP3 and visor (full face protection)
- Long sleeve gown or long sleeved apron and gloves

8.2 PPE is only effective when used properly and in conjunction with good hand hygiene.

8.3 Staff will select PPE based on the procedure they are carrying out in conjunction with the infection they suspect/know the patient has. Remember during COVID-19, other infections remain a possibility and should not be overlooked. Staff may also consider PPE requirements to protect vulnerable patients requiring barrier nursing.

8.4 Staff will consider, the likelihood of splashes of body fluids including those generated through normal coughing, the need for very close contact and the patient's ability to manage their own secretions. Staff must risk assess each patient and plan the required PPE.

8.5 **Masks**

There are different types of mask for use in different settings:

8.5.1 **Cloth face coverings** – used on public transport, in shops and by patients/visitors in the clinical environment. The trust have provided all staff with reusable fluid resistant cloth masks (FRCM) and are encouraged to use these outside of work (see appendix 9 for washing)

8.5.2 **Fluid resistant surgical masks (FRSM)**

- Type IIR for use in clinical setting and non-clinical settings

8.5.3 **Filtering face piece respirators**, often specifically named '**FFP3**'.

- For AGPs the FFP3 MUST be fit tested
- Where the FFP3 is used as part of enhanced PPE, it is to provide a mask with increased levels of filtration over an FRSM and a more secure fit. It should ideally be fit tested, but for staff not yet fit tested the mask with the best fit should be selected and a fit check performed prior to use. (Appendix 5) Staff should seek fit testing at the first available opportunity.
- FFP3s are not fully fluid-resistant., A full-face shield (visor) must be worn to provide fluid resistance. A FRSM is not required over the top of a FFP3 face mask.

- FFP3 masks are to be used for individual patient encounters in their own home and must be removed on exiting the property with other PPE. In care home settings, if community staff are attending several positive patients, masks can be worn sessionally between rooms and then removed on completing those visits.

Where fit testing fails, suitable alternative equipment must be provided such as a powered respirator, or the healthcare worker should be moved to an area where FFP3 respirators for AGPs are not required. Staff can continue to work in enhanced PPE using fit checked masks but not engage with AGPs. (Appendix 5)

Enhanced PPE includes the wearing of a fit checked FFP3 mask. Please be mindful that enhanced PPE is above National PHE guidance and will not be worn by services outside of the NHS. This was an RD&E organisational decision

An important part of the PPE policy is the wearing of a FRSM in both clinical and non-clinical areas.

- The facemask is not in direct contact with the patient and should not be touched whilst in place and therefore does not pose a risk of infection to you or others if worn properly. This is in line with PHE guidance. A risk assessment can be made regarding wearing a facemask in a car between care episodes.
- In certain circumstances, a FRSM can be removed and stored in a clean receptacle for example while travelling in a car between care episodes. The masks must be in good condition in order to continue with use for the rest of the session on arrival at the next care setting. This arrangement does not apply to FFP3 masks which should continue to be worn until disposal.
- For sessional periods, it is important to keep hydrated and be mindful that you will need to pre-hydrate. The advice is to pre-hydrate before putting on/donning the mask and to take a break at around the 4 hour mark. Please try and plan your breaks to hydrate and eat. This might mean working in a different way to what you are used to.

8.6 Eye Protection

Eye protection comes in several forms – goggles, safety glasses and visors. Standard glasses are not deemed PPE level eye protection.

8.6.1 Eye protection must be worn by all staff having patient contact within 2 metres, irrespective of perceived risk or symptoms.

8.6.2 Eye protection may be single use or reusable depending on style. Reusable eye protection should be removed, decontaminated and stored after each visit. (Appendix 9). Some visors are partially reusable in that they can be allocated to a single staff member for a shift, decontaminated during that period and then disposed of at the end of the shift. An example would be those with a foam headband.

8.6.3 Eye protection should be disposed of if it becomes damaged, unable to be secured adequately, uncomfortable or difficult to see through.

8.6.4 In GREEN/AMBER settings, the choice of whether to use goggles or visors will partially depend on wearer comfort and confidence, use of spectacles, face shape and availability. Spectacles, on their own, are not appropriate eye protection.

8.6.5 Visors must be worn when AGPs are being conducted and within 1 hour of that procedure having finished if within 2m of the patient.

8.6.6 Visors are required for the RED pathway and should be worn if wearing a FFP3 mask where there is risk of splashing of body fluids.

8.7 Aprons and gowns

8.7.1 **Aprons** must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres as per droplet and standard precautions
- changed between patients
- used in conjunction with thorough hand and arm washing up to the elbow.

8.7.2 **Gowns/long sleeved aprons** must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients

8.7.3 The Trust uses both disposable and re-usable gowns. It is anticipated that Community Staff will use single use gowns and long sleeved aprons and not the reusable gowns.

8.8 Head/footwear

There is currently insufficient evidence around the use of hair and shoe coverings. They do not need to be worn routinely in COVID-19 areas (even if undertaking an AGP).

Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres

8.9 What does this mean in practice?

8.9.1 If you are visiting an extremely vulnerable patient in their own home, or any member of the household is extremely vulnerable, then single mask use applies:

- Put on/don PPE (FRSM, gloves, apron and eye protection) before entering and remove/doff PPE when you leave. Decontaminate eye protection if it is reusable (Appendix 9)

8.9.2 If you are visiting a patient (non-AGP related) who does not fall into the extremely vulnerable group then sessional mask use applies:

- Put on/don a FRSM and eye protection before you enter the first premises, ensuring pre-hydration. The mask should be worn colour side outwards.
- The mask can remain in place between patients and can be worn sessional for 2-6 hours
- You must avoid touching your face for the duration of mask wearing. If you inadvertently touch your mask, clean your hands
- During sessional use, masks should only be removed before the end of the session if visibly soiled, uncomfortable or damaged as per PHE guidance

- In certain circumstances, a mask can be removed before the end of a session in order for staff to have a drink or drive to the next clinical setting. In this case, the mask should be removed and if it is in good condition, placed coloured side down into a clean container or bag and store ready for the session to continue. Hand hygiene must be performed before and after touching the mask. Masks must be doffed, stored and donned safely according to guidance (see Appendix 1)
- If you need to remove the mask due to a medical condition or great discomfort please remove correctly and clean your hands
- In line with PHE guidance, once you have provided close personal care to a patient with known COVID-19 there is no automatic need to change your mask. However if you have assessed the risk to your subsequence patients doffing of the mask post visit would be recommended.
- Eye protection must be removed and disposed of or decontaminated if reusable (Appendix 9)

8.9.3 If you are visiting any patient who is receiving or has received an AGP within the last hour:

- An FFP3 mask and visor must be worn. Within the community these activities are, predominantly, associated with induction of sputum and suctioning but can also include non-invasive ventilation (NIV) such as C-PAP or Bi-PAP. If the use of either of these NIV's is continuous, then an FFP3 mask is required for the entirety of your visit, however if the use is intermittent allow an hour prior to your visit for aerosols to disperse after which a FRSM is the appropriate level of PPE. Please see Appendix 8 for a list of Aerosol Generating Procedures.
- FFP3 masks are single use items in the context of home treatment.
- VIsor must be removed and disposed of or decontaminated if reusable (Appendix 9)
- A long sleeved apron or gown and gloves must be worn and removed and disposed of at the end of the visit.

8.9.4 If you are visiting a patient who is COVID-19 positive or strongly suspected and awaiting a test or a result (Non-AGP related visit):

- All community staff can wear FFP3 masks on a fit checked basis. (see Appendix 5)
- Mask and eye protection must be worn on all visits and donned and doffed according to guidelines. Working with a 'buddy' to guide those processes is advised. All staff must be fully aware of procedures for PPE use.
- Aprons or long sleeved gowns/aprons must be worn for all cases as above and disposed of at the end of the visit.
- Gloves must be worn and disposed of at the end of the visit but can be changed during the visit if the 5 Moments for Hand Hygiene requires it. Double gloving is not required in community settings. Consideration needs to be given to a change of gloves when dealing with complex episodes of care such as catheterisation and dealing with body fluids.

8.10 **Disposal of single use items**

At the end of the sessional period, please dispose of your mask in either an orange (clinical waste) bag or household waste as per NHSE guidelines.
It is deemed safe to have an orange bag within a clinical waste bin in your car.

Whilst PHE guidelines allow for 'sessional' use of other PPE, in the community setting, this will be limited to disposable FRSMs. Gloves, aprons and eye protection must always be removed between patients. Eye protection can be cleaned and reused whilst still in good condition.

8.11 **Ordering**
Central ordering of PPE stock is via EROS.

A maximum order has been set to aid the preservation of PPE stock throughout the trust.

9. Equipment Required for Home Visits

- Clinical equipment as required
- PPE in accordance with Appendix 3, 5 and 7
- 2 buckets, one to go into the property (hot) and one to stay outside (cold)
- 1 WIVA bin for doffing into a waste bag and for transporting waste in, when necessary
- Orange waste bags
- Advised disinfectant products
- Detergent wipes
- Personally allocated eye protection (e.g. goggles or visor)

10. Donning and Doffing Procedure

10.1 Before donning PPE, if not already done so, remove wrist watches and ID badges if worn with a lanyard.

10.2 An assessment of the property you are visiting is advisable. Consideration needs to be given to the privacy of the patient and also the risks associated with the environment, such as, prevailing weather and neighbourhood. We need to consider where donning and doffing should take place. If it is not deemed appropriate or safe to complete donning or doffing on the door step then this can take place inside the property but ensuring a clear 2 meter safe distance between you and the patient or in an adjacent room.

10.3 It is helpful that all aspects of PPE doffing are witnessed in accordance with the checklist in Appendix 5 and 6 unless confident in doffing.

10.4 Hand hygiene remains essential as part of infection control and preventing the spread of COVID-19.

11. Decontamination of Equipment

11.1 **If visiting with a 'buddy'**
On exiting the property when working as a pair, the first person should doff their PPE adding their goggles or visor to the used equipment box. The first person should then don clean gloves and an apron and start decontaminating the equipment with the recommended cleaning product. The cleaned equipment will be placed in the clean box once fully wiped.

The final piece of equipment to decontaminate is the box/bucket that has been in the property.

11.2 **If visiting without a buddy**
Prior to exiting the property, before doffing, each piece of equipment that has been removed from the premises will be placed in the hot bucket/box. Once completion of doffing, you will need to put on clean gloves and standard apron to clean the equipment.

12. Staff working in Non-patient Facing Areas

12.1 All staff

12.1.1 If staff travel to work on public transport, they should wear a FRCM for the journey. Once at work, staff should perform hand hygiene and remove the FRCM, which should be folded (outside in) and placed in a clean container, labelled with your name for the journey home. Perform hand hygiene then don a clean FRSM.

12.1.2 Staff should follow infection control guidance for safe donning and doffing and disposal or storage of masks

12.1.3 Careful attention should be paid to hand hygiene with either alcohol gel or soap and water after the mask has been touched for any reason

12.1.4 Staff in non-clinical areas should be provided with the means to clean high touch surfaces in their working environments to reduce the risk of fomite transmission, this includes equipment in offices, shared kitchen/break areas, toilets etc.

12.1.5 Staff working alone in an office do not need to wear a mask but need to be alert when people are entering their work space, ready to don a mask as required. People should knock before entering a room to allow the lone worker to don their mask.

12.1.6 During rest periods it is vital that staff continue to adhere to social distancing and hygiene measures as masks will be removed during refreshment. Refreshment periods must be staggered so that masks can be removed safely at a distance more than 2m from others.

12.2 Working in PPE for Staff in Non-patient Facing Areas

12.2.1 All staff in non-patient facing environments should wear a FRSM for four hour sessions, only changing the mask when damaged, soiled/wet or uncomfortable unless alone in the office

12.2.2 Staff with respiratory conditions or other concerns around wearing a sessional mask should contact occupational health and their line manager

13. Waste
COVID 19 Guidance to manage infectious waste for community patients in their own home

13.1 Currently waste generated by a healthcare intervention is either disposed of in the patient's own household waste or a waste collection is arranged by a registered waste collector through the Local Authority. Different types of clinical or healthcare related waste are identified including:

- Offensive waste ; items contaminated with body fluids not believed to be infectious, for example wound dressings, stoma or catheter equipment or continence products. This waste is still being produced by people in the community NOT identified as possible or confirmed COVID-19. This is managed differently depending on the area that you work as waste collections by the Local Authority's differ.
- Infectious waste - any item with the potential to cause infection. This process is currently managed through local councils and is to ensure patients, staff and

disposable of such waste is safe. This includes all waste coming from patients with possible or confirmed COVID-19

- Sharps waste – any waste including sharps contaminated with body fluids or pharmaceuticals. This waste stream is largely unaffected by COVID-19

13.2 Removal of waste generated by patient's own self-care is the responsibility of the Local Authority. The removal of waste generated through healthcare intervention by an NHS professional is the provider's responsibility.

13.3 If the patient you are visiting (prior to the triage) has no symptoms of COVID-19 then the gloves and aprons that you will use can be disposed of in the normal household waste. The mask can continue to be worn from the property as part of sessional use and the eye protection cleaned for reuse.

13.4 If you are visiting a patient who is suspected or confirmed COVID-19 positive and they have no other clinical waste produced as part of the visit then your PPE can be doffed into a **black** bag and the patient/relative/carer advised to put out for normal household waste collection after 72 hours. If additional **infectious waste** is produced during the visit a collection may need to be to be set up as per your local council guidelines. You need to state this is for a patient that has COVID-19.

13.5 You will need to source the orange bag for this waste from either your closest hospital site/housekeeping team or order via EROS using the following codes:

- MVN493 – 80 Litre
- MVN022 – 24 Litre
- MVN013 – 17 Litre

13.6 Infectious (orange bag) waste in this context is largely that which is contaminated with body fluids associated with the community healthcare intervention. This will need to be kept inside the patient's property prior to collection. PPE being used as part of a visit that generates infectious waste should also be disposed of as infectious waste. As before, on leaving the property and doffing the PPE it needs to be placed in a small bag which is left just inside the property assessing for risk of obstruction or trip hazard.

13.7 The next visiting healthcare professional, once donned in PPE, can pick up the small bag and place in the larger orange bag with the other infectious waste. When the large orange bag is 2/3 full it is the responsibility of the healthcare professional, whilst in PPE, to tie the bag and then instruct the patient relative or care that this needs to be put out for the scheduled collection date/time. Reiteration must be made that bags should not be put out days earlier and should the collection not occur then the patient relative or carer should contact the council to rearrange and the bag not left on the doorstep.

13.8 It is the responsibility of the first visiting healthcare professional to assess and set up the required clinical waste collection and explain the procedure to the patient/relative/carer including the day the collection will take place and when/where to put out for collection. Some patients will already have a waste collection for sharps and this process will remain unchanged.

13.9 **Waste Summary**

Non clinical waste (PPE and items not contaminated with body fluids)	Put all PPE equipment into a black bag Tie bag and label "Please put into your household waste after 72hrs date _____"

Clinical Waste (items contaminated with body fluids), those involving other types of infection, such as multi drug resistant organisms or bulky waste that cannot reasonably be left for 72 hours.	Put all clinical waste and PPE into an Orange bag Contact local authority to arrange collection.

14. MyCare and other equipment/resources

14.1 MyCare Roving devices can be cleaned using disinfectant wipes.

14.2 Equipment used in patient care should either be left at the property until the infectious period is over, plus a final 72 hours quarantine, or removed and decontaminated.

14.3 Decontamination of equipment is through the use of products that contain detergent/disinfectant products such as Chlorclean or Tristel or wipes which include the standard EN14776 such as Clinell Universal Wipes. Other wipes may be permissible, please refer to the Infection Control Team for review.

14.4 Paper items, such as records, that need to be brought away from the property should be placed in a plastic bag at the door and, ideally, quarantined for 72 hours. If the document has to be referred to within that time, staff touching paper documents must remember to complete hand hygiene and avoid touching their faces.

15. Stepping Down of Infection Control Precautions

15.1 The majority of people with asymptomatic/mild/moderate COVID-19 will cease to be infectious after 10 days. The day of the positive test, or onset of symptoms is day zero. Provided they have had absence of fever for 48 hours and are clinically improving they can be deemed resolved after 10 days.

15.2 For the patients with severe COVID-19 who require hospital admission, they are deemed infectious for a longer period of 14 days. Provided they have had absence of fever for 48 hours and are clinically improving they can be deemed ‘recovered’ after 14 days. Patients being discharged from hospital will have advisory information in the referral regarding the duration of self-isolation.

15.3 Recovered/resolved patients can be considered as Green patients and a consideration can be given to deescalate their PPE as per the Green pathway. Please be mindful of the potential for reinfection and consider re-testing patients who develop new key symptoms (fever >37.8, new persistent cough, anosmia).

15.4 For patients with COVID-19 who are severely immunocompromised (as per the Green book) testing is required to deem them recovered/resolved. Patients should be tested as per the testing policy (at day 14 and then repeated every 7 days until test negative).

15.5 Discharge and de-isolation guidance is available on HUB.

16. Attending a Care Home where an Outbreak is Occurring

16.1 Where an outbreak in a care home has been confirmed by PHE or is suspected by your team, please contact the Community Infection Control Team to discuss case management, PPE and ongoing support.

17. Staff Health

17.1 Staff must report skin sensitivities to their line manager and/or Occupation Health arising from increased use of personal protective clothing and decontamination products. Advice is also available on the Hub.

17.2 The trust wants to ensure cases of COVID-19 are detected ASAP.

- Staff with low level symptoms (e.g. runny nose, headache) can get tested whilst at work
- Staff who test positive on lateral flow must self-isolate, notify their line manager and call staff absence HUB to arrange a PCR test
- Staff who develop key symptoms (fever 37.8, new persistent cough or anosmia) must self-isolate and call staff absence HUB and arrange a PCR test
- Family contacts who develop key symptoms (fever 37.8, new persistent cough or anosmia) must ensure the household self-isolate and call staff absence HUB and arrange a PCR test

17.3 Please ensure your manager is aware of any health issues related to your PPE.

18. Testing and Swabbing

18.1 Please see the COVID-19 HUB pages for the latest testing strategy and process.

19. Travelling in shared vehicles

19.1 Staff should avoid traveling in shared vehicles during where possible

19.2 Staff should follow PHE guidance on travelling, available at: **https://www.gov.uk/guidance/working-safely-during-coronavirus-covid-19/vehicles**

19.3 Where shared travel is unavoidable the following should be ensured:

- Where possible, the same people should share the vehicle with the driver rather than there being a mixture of passengers riding in it.
- Numbers sharing the vehicle should be minimised – two people maximises social distancing
- Both parties must wear a FRSM at all times within the vehicle
- Hands must be cleaned before getting in the car
- The passenger must sit beside or behind the staff member and should face away from the driver when possible
- Ensure good ventilation through having the side window open
- Air conditioning should not be set to circulate internal air but rather draw from outside the vehicle
- The car owner should clean the car between journeys using standard cleaning products, particularly high touch surfaces like the door handle.

Appendix 1 Guidance For Temporarily Removing a FRSM (not applicable to FFP3)
Doffing

- Clean hands with alcohol gel before touching the mask
- Remove mask, ensuring you do not touch the front of the mask
- Put the mask into a box or bag. The coloured side must be facing down.
- Clean hands with alcohol gel once removed

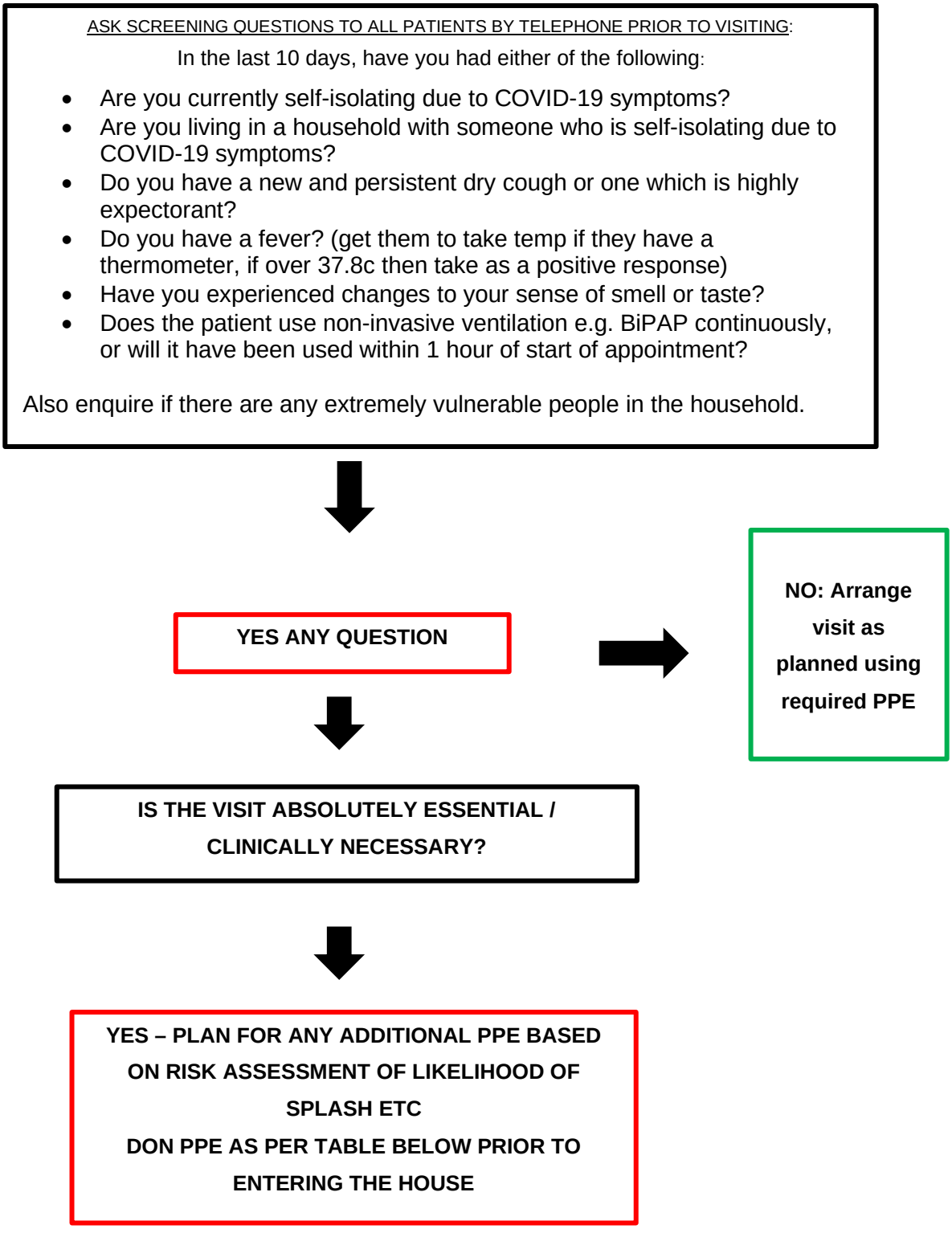
Donning

- Clean hands with alcohol gel before touching the mask
- Open the box or bag and remove the mask, **do not touch the outside of the mask**
- Put the mask back on
- Clean your hands with alcohol gel after replacing the mask

The container that your mask is stored in must be cleaned at the end of the day, this can be with a Clinell Universal or Clorox wipe or it can be taken home and washed with soap and water.

https://www.cebm.net/covid-19/extended-use-or-re-use-of-single-use-surgical-masks-and-filtering-facepiece-respirators-a-rapid-evidence-review/

Appendix 2 Guidance for Staff Undertaking Domicilary/Home Visits



Appendix 3 PPE based on symptoms, procedures and nature of care provided

Low Risk (Emergency and Elective Green) Pathway

In hospital settings, this pathway is used for patients that have either been admitted as inpatients to the hospital and have tested negative with no clinical suspicion of COVID-19 or are elective patients who have received a negative test result, self-isolated following the test and who are then admitted to hospital for elective surgery or selected procedures.

As patients in their own homes may have multiple contacts and are not routinely tested, it is not anticipated that this pathway will be used widely by community staff visiting people at home.

Currently, the only patients who can be considered to be 'green' at home in their community settings are those who have had infection with COVID-19 and have fully recovered/resolved.

COVID-Green	
For patients who have fully resolved from COVID 19 infection and who also live in households without known infection.	
Infection Control Measures	Standard Precautions for every patient, every time.
Personal Protective Equipment	Within 2 metres of a patient: fluid-resistant surgical mask and eye protection. Not within 2 metres of a patient: fluid-resistant surgical mask.
Waste	PPE can be disposed of into patient's domestic waste stream

Medium Risk (Amber) Pathway

Patients whose COVID PCR status is unknown and have no classic symptoms of COVID.
Identified COVID-19 contacts

This group will form the majority of Community patients being visited at home.

COVID-Amber	
Unknown or Suspected cases, COVID contacts and low viral load in the area	
Infection Control Measures	Droplet and contact precautions Dedicated clinical equipment to be cleaned before and after every use with chlorclean or clinell universal wipes.
Personal Protective Equipment	FRSM and eye protection with the addition of gloves and apron for exposure to bodily fluids.

Special Measures	Donning and doffing of PPE should be complete in the designated areas Aerosol generating procedures for unknown or suspected cases of COVID-19 and contacts should be completed using the following single-use PPE as per COVID-Red: - long sleeved fluid repellent gown or apron, - FFP3 respirator, - face visor, - gloves. Symptomatic patients can be offered a surgical face mask, unless there is potential for their clinical care to be compromised (such as when receiving oxygen therapy).
Equipment	Essential clinical equipment should be taken into the property only Single use (disposable) equipment and supplies should be used where possible.
Waste	Manage all waste as clinical waste. (Section

High Risk Pathway (Red and Unconfirmed Red)

Confirmed COVID-19 positive patients, or those with classic COVID symptoms pending confirmatory PCR (including those clinical positive, test negative patients)

COVID-Red	
Positive and suspected cases as above: High viral load in the area and/or completion of Aerosol Generating Procedures. Patients within 14 days of travel from Denmark requiring inpatient admission (admit into a negative pressure single-room only).	
Infection Control Measures	Enhanced respiratory isolation precautions
Personal Protective Equipment	Donning and doffing of PPE should be complete in the designated areas, 1. Enhanced PPE – scrubs, apron, gloves, FFP3 respirator and face visor. (Long sleeved aprons may be used where exposure to body fluid is likely for very prolonged episodes of more than 4 hours continuous care and when coverage of workwear by standard aprons is not sufficient.) 2. AGP PPE and PPE for prolonged, direct patient contact – scrubs, long sleeve apron or gown, single use apron, gloves, FFP3 respirator and face visor
Equipment	Essential clinical equipment should be taken into the property only, Single use (disposable) equipment and supplies should be used where possible.
Waste	Manage all waste as clinical waste. (Section ??

Special Measures	Strongly suspected cases are defined by history of close contact with confirmed case of COVID-19 and meeting clinical criteria. Patients should be invited to wear a mask unless there is potential for their clinical care to be compromised
De-escalation of precautions	De-escalation of COVID-19 patients should be carried out based on their clinical condition

Appendix 4 Community Staff working in Non-Patient facing areas.

Category	Areas	PPE
Blue Non-clinical area staff	Non-clinical areas including offices, kitchens, corridors, reception areas and in Trust grounds Lone working in an office	Surgical mask type I or II at all times. Also PRACTICE:- • Hand hygiene • Social distancing • Be particularly careful in rest areas. Masks must not be removed if within 2m of an unmasked colleague. • No PPE required
Patients and visitors to community hospital sites	Visits to all areas	Patient/visitor should arrive in own face covering Offer a surgical mask if they do not have a face covering with them

Hand hygiene is extremely important and staff should maintain social distancing at all times, particularly when masks are not worn (e.g. when eating/drinking).

Appendix 5 PHE how to put on & fit check FFP3 respirator

Public Health England

NHS England

How to put on and fit check an FFP3 respirator

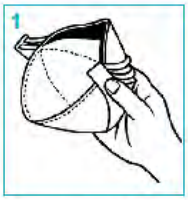
Key facts

- FFP3 respirators are designed to protect the wearer from breathing in small airborne particles which might contain viruses.
- They should be worn when carrying out potentially infectious aerosol-generating procedures on patients with symptoms of a viral respiratory infection, or where a patient is known/suspected to have an infection spread via the aerosol route or when caring for patients known/suspected to be infected with a newly identified respiratory virus.
- FFP3 respirators are available in different sizes and designs, use only the model and size which a fit test has shown is correct for the wearer.
- The respirator images shown below are for illustrative purposes only. Always follow the manufacturer's instructions.

Follow these five steps to fit your respirator correctly

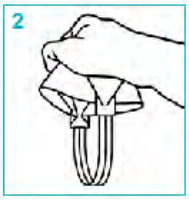
Tip: It may be helpful to look in the mirror when fitting your respirator

1



Hold the respirator in one hand and separate the edges to fully open it with the other hand. Bend the nose wire (where present) at the top of the respirator to form a gentle curve.

2



Turn the respirator upside down to expose the two headbands, and then separate them using your index finger and thumb. Hold the headbands with your index finger and thumb and cup the respirator under your chin.

3

Position the upper headband on the crown of your head, above the ears, not over them. Position the lower strap at the back of your head below your ears.

4

Ensure that the respirator is flat against your cheeks.

5

Mould the nosepiece across the bridge of your nose by firmly pressing down with your fingers until you have a good facial fit, if a good fit cannot be achieved, do not proceed.

Now perform a fit check

Cover the front of the respirator with both hands, being careful not to disturb the position of the respirator on the face.

For an unvalved product – exhale sharply; for a valved product – inhale sharply.

If air flows around the nose, readjust the nosepiece; if air flows around the edges of the respirator, readjust the headbands.

A successful fit check is when there is no air leaking from the edges of the respirator. Always perform a fit check before entering the work area.

If a successful fit check cannot be achieved, remove and refit the respirator.

If you still cannot obtain a successful fit check, do not enter the work area.

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

Remember

- Respirators must be used with other necessary personal protective equipment (PPE) such as gowns, gloves and compatible eye protection.
- Respirators should be discarded after each use.
- Respirators should be disposed of as healthcare waste.
- Hand hygiene must always be performed following removal and disposal of PPE.
- The fit check is not a substitute for fit testing

Fit testing should be carried out by a properly trained competent fit tester.
Other guidance is available on bacterial infections and pulmonary tuberculosis.

HSE

Appendix 6 PPE for COVID-19 Donning Checklist: All

The 'buddy' checking the practitioner who is donning PPE prior to entering the area should read out the actions and check that PPE is put on correctly.

Ensure hair is tied back securely and off the neck and collar. Remove jewellery/pens. Plan ahead.	
Put on apron This may be a standard single use plastic apron OR a long sleeved apron depending on risk assessment of likely body fluid contamination. (**Note: long sleeved required for AGP**)	
Fit the single use surgical mask (or FFP3 for AGP or RED (Pathway) make sure it is:-	
	Symmetrical to the face and opened out fully,
	The nose bar must be pressed down to the bridge of the nose
	The bottom section must be pulled down under the chin
	One strap should be over the ears and one under the ears
	Press the mask around the face to check it is flush to the skin
	The wearer should check that the mask fits the face snuggly to cover nose and mouth.
	If using a FFP3 mask, the wearer must complete a 'fit check' by forcible exhaling to check for leakage of air towards eyes or onto neck.(Appendix 5)
Put on full face visor/shield making sure that the strap is tight enough to secure in position (some staff may be provided with surgical masks that have integral visors, dependent on supply) **or reusable goggles. (Note: AGPs require the use of visors and visors must also be used when there is risk of body fluid splash to the face)**	
Put on gloves. If a long sleeved apron is used, it is useful to tape the cuff of the gloves to the sleeve so that eventual removal is facilitated as one action. Micro-pore tape should be used in 4 strips, 8-10cm long and going up the arm. Do not tape around the wrist.	

Doffing Checklists

The 'buddy' should read out and observe the actions and verify when all elements have been completed correctly.

Single use apron and gloves (non-aerosol generating procedure)

Gloves
Remove the first glove by only touching the outer surface with the other, still gloved, hand and dispose of into waste bag. Remove second glove with a bare finger peeling inside out from the wrist.
Gel Hands
Apron
Avoid touching the front of the apron
Snap the loop at the back of the neck and let the 'bib' of the apron fold forward and downwards. Snap waist ties at the back and fold forward
Fold or roll into bundle, touching only the inside surface, and place in waste bin
Gel hands
Full face visor/shield or goggles: Remove visor by pulling away from face, lifting strap up over head and forwards. **OR** Lift goggles forward away from the face. Dispose of into waste bag if single use, place in equipment bucket or box if re-usable for decontamination.
Surgical face mask: (at the end of sessional use or if contaminated etc) Untie bottom strap followed by top one, or unhook loops and allow mask to separate away from the face. Do not allow the mask to touch clothing or skin. Dispose of into waste bag. **FFP3 Mask: Gather up the elastic bands over the head and allowing the mask to separate from the face. Do not allow the mask to drop down on clothing and do not touch the outside of the mask with bare hands. Dispose of into clinical waste.**
Wash or gel hands

Long Sleeved Apron and Gloves (aerosol generating procedures)

Long sleeved apron and gloves
Pull forward front of apron at waist to break ties
Pull forward front of apron towards the top to break neck loop
Pull gown forward from front of shoulders
Pull arms out so that sleeves end up inside out
Gloves will come off with apron if taped or, if not, remove gloves after gown.
Fold or roll apron (& gloves) into a bundle, touching only the inside surface, and place in waste bin.
Gel hands
Full face visor/ shield: Remove by pulling away from face, lifting strap up over head. Dispose of into waste bag if single use, or place in place in equipment bucket or box if re-usable for decontamination
FFP3 Mask: Gather up the elastic bands over the head and allowing the mask to separate from the face. Do not allow the mask to drop down on clothing and do not touch the outside of the mask with bare hands. Dispose of into clinical waste.
Gel hands

Appendix 7 Laundering of reusable masks

Care of Fluid Resistant Cloth Masks (used for travelling to and from work)

- Place all used masks along with your uniform into a washing machine
- Machine wash the mask as hot as possible, ideally 60°C.
- Do not use bleaches or other harsh chemicals.
- Tumble dry or air dry followed by a cool iron after wash. Heat will reactivate the fluorocarbon finish.
- After each wash and dry, inspect the mask and the elastic for any damage. Report any damage to a member of the renal team. Visibly damaged masks will be replaced. Hang up to dry outside on a washing line, inside on a clothes horse or radiator.
- Each mask can be washed up to 10 times – please ensure you are aware of which mask you have washed and how often
- Do not bleach

Appendix 8 Aerosol Generating Procedures – PHE guidance

This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum/chest physio using nebulised saline
- respiratory tract suctioning
- upper ENT airway procedures that involve respiratory suctioning
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. Community staff working in peoples' homes should follow Trust guidance 'COVID-19 CLINICAL GUIDANCE: Updated CPR guidance' available on the Hub.

Appendix 9 Cleaning Reusable Goggles or Visor Using Universal Wipes in the Community

Cleaning Reusable Goggles or Visor Using Universal Wipes in the Community

Eye Protection (reusable goggles or visor) must be worn:

- For all community visits to people in their own homes
- For all patient contact within 2m, irrespective of symptoms

Cleaning protocol: to be followed after wearing reusable goggles or visor:

1. Remove your goggles/glasses ensuring the front is not touched. If goggles with an elastic strap** are used, lift over head to release.

2. Place the goggles or visor carefully onto a designated cleanable surface e.g. trolley/ tray or into a cleanable container.

3. Clean your hands and put on a pair of clean gloves.

4. Wipe the inside; followed by the outside of the goggles along with the arms or elastic strap using a universal wipe which is a disinfectant and detergent wipe (see below). The required contact time is 60 seconds.

5. Allow the goggles to fully air dry, if the surface is not air dried then the goggles will not be cleaned sufficiently. Place into clean container or bag for later use.

6. Clean the contaminated surface/container with a universal wipe.

7. Remove gloves and clean your hands.

8. Return container with clean goggles to storage area.

9. Rinse goggles or visor with water and dry with paper towels if the disinfectant/detergent liquid hasn't dried and immediate reuse is required (ensuring cleaning contact time of 60seconds has elapsed as above)

*__Sessional use__ refers to a period of time where a worker is undertaking duties in a specific setting/exposure environment and a session ends when the worker leaves the care setting/exposure environment for a break or at the end of their shift.

**__Goggles with an elastic strap__ must be allocated to individual staff and not shared between staff. The elastic strap must be cleaned with universal wipes, with the rest of the goggles, each time they are removed. Goggles must be disposed of and replaced if the elastic is damaged or visibly soiled. Hand hygiene before and after touching goggles and elastic is vital.

Figure 1

Appendix 10: Equality Impact Assessment Tool

Name of document	Community PPE Guidance during COVID-19
Division/Directorate and service area	Community Services Division
Name, job title and contact details of person completing the assessment	[redacted] Assistant Director of Nursing, Community Services
Date completed:	May 2020

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

COVID-19 is a respiratory infection caused by a novel coronavirus. It is spread through respiratory droplets either directly or via indirect through contact with contaminated surfaces. In some circumstances aerosols can be generated needing a higher level of respiratory protection. It causes a range of symptoms from very mild to severe needing hospital admission.

During the current COVID-19 outbreak, Public Health England (PHE) are providing guidance on personal protective equipment (PPE) to help maintain safety of staff and patients. As the numbers of COVID-19 infections has increased, the use of PPE has changed to increase its use in order to protect staff/patients more. The Trust guidelines inform our staff how to follow PHE guidelines within different areas of the organisation.

This Guideline is designed to explain the actions to take whilst providing care via RD&E Community Services Division to patients whether they have signs of COVID-19 or not.

This guidance promotes safe practice to minimise the risk of transmission of COVID-19 to staff, patients and members of the public. It represents the drawing together of information for staff in the community to help with maintaining infection control standards and decontamination procedures.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below?

Protected characteristic	Relevant	Not relevant
Age	x	☐
Disability	x	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	x	☐
Race	☐	x
Religion / belief	☐	x
Sexual orientation – *including: Marriage / Civil Partnership*	☐	x

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Staff who wear glasses where sessional use of masks are required to be worn. Staff who may require breaks in wearing PPE due to other health reasons such as menopause and pregnancy.

5. **Do you think the document meets our human rights obligations?** ☒

A quick guide to human rights:
• Fairness – recommendation have been made for all staff to wear sessional masks. If the wearing of sessional masks is considered uncomfortable then the staff may choose to wear reusable masks. • Respect – the guidance gives information for all of community staff and is not altered for discipline or grade of staff. • Equality – risk assessment will allow a good conversation with all staff where they have identified a problem with a sessional use of mask. • Dignity – all conversations about difficulties will be carried out by line managers and not subject to wider debate. • Autonomy – Staff are able to use sense and judgement to follow the guidance and have access to help where they cannot resolve the issues themselves.

6. **Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?**

With regard sessional use of masks, staff and patient safety and concerns were raised and considered. In depth discussions within Infection Control, Microbiology and The Clinical Reference Group did not support the concerns with sessional use of PPE. Questions have been answered throughout the PPE document and risk assessment has been completed. The sessional use of masks is in line with PHE advice. Following discussion and debate with staff groups, Staffside, Infection Control, Microbiology, The Clinical Reference Group and Chief Nurse we have created version control of the document.

Royal Devon and Exeter NHS Foundation Trust

COVID-19 CLINICAL GUIDANCE: COVID-19 Infection Control PHE Pathways

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	24 June 2021
Document Version:	V1.0
Date notified to Gold Command:	1 July 2021
Date document becomes live:	25 June 2021

1. Background

In managing occupational risks of COVID-19, employers must control exposure to the virus as far as is reasonably practicable, taking into account the possibility that some workers will be more vulnerable than others should they contract the disease. Strategies to achieve this may include changes to the way in which work is carried out, use of personal protective equipment (PPE), and in some cases, redeployment or other considerations of individuals who are more vulnerable to pathways of lower risk.

2. Alert level of COVID and work categorisation tool/ matrix

A risk assessment matrix outlined below has been developed and approved by CRG in April 2021 to align with the government's alert levels which are based on current prevalence, the R number, hospital admission rates and % ITU beds occupied for an area.

Trust COVID alert status	**LOW**	Transitioning low to high / high to low	← HIGH →		
Local community prevalence in Devon, data produced regularly by PHE	**Very Low in Devon (<10 per 100k population)**	**Low Level in Devon (10-50 per 100k population)**	**Medium Level in Devon (50-250 per 100k population)**	**High Level in Devon (250-750 per 100k population)**	**Very High Level in Devon (>750 per 100k population)**
Low vulnerability Pregnant <28/40 & no COVID risk factors (BMI/BAME/significant medical conditions)	Normal duties	Normal duties	Normal duties	Normal duties	Normal duties
Moderate vulnerability Pregnant <28/40 & no COVID risk factors (BMI/BAME/significant medical conditions)	Normal duties	Normal duties	Normal duties	Normal duties	Normal duties

High vulnerability (clinically vulnerable) In clinical Areas Pregnant <28/40 with COVID risk factors	Normal duties Avoid exposure to AGPs in amber/ red pathways	Normal duties within PHE defined 'green & amber pathways' Avoid exposure to AGPs in green/amber pathways Individual conversation with OH	Normal duties within PHE defined 'green & amber pathways' Avoid exposure to AGPs in amber pathways	Work within PHE defined 'green pathways' only.	Work from home or office based COVID-19 risk assessed area
High vulnerability (clinically vulnerable) In non-clinical areas Pregnant <28/40 with COVID risk factors	Normal duties	Normal duties	Normal duties	Work from home or office based COVID-19 risk assessed area	Work from home or office based COVID-19 risk assessed area
Very High vulnerability (clinically extremely vulnerable) Pregnant > 28/40	Work in green pathways only	Work from home or office based COVID-19 risk assessed area	Work from home or office based COVID-19 risk assessed area	Work from home	Work from home

3. Updated pathways for approval

The risk assessment matrix determines where staff are able to work depending on the COVID vulnerability risk category. Depending on their risk category in this matrix staff can work in certain defined pathways. There have been a number of queries about what constitutes a particular pathway especially the green pathway, this document will provide some examples to clarify as well as incorporating updates in the latest PHE document dated 1st June 2021 (Ref 1).

The current definition of PHE Pathways previously approved by CRG is as below

PHE Pathway	High Risk RED	High Risk UNCONFIRMED RED	Medium Risk AMBER	Low Risk EMERGENCY GREEN	Low Risk ELECTIVE GREEN
	Confirmed or clinically positive COVID-19 OR Symptomatic and declined testing	Suspected COVID-19 with possible symptoms waiting a result	Asymptomatic and waiting a COVID-19 result OR Asymptomatic and declined testing OR Asymptomatic and testing not required	Asymptomatic and negative PCR COVID-19 result within the last 3 calendar days	Negative COVID-19 result and self-isolated since test date

The new proposed pathway in the PHE document released 1st June 2021 is as follows:-

High-Risk (Red)COVID-19	Medium Risk (Amber) COVID-19	Low Risk (Green) COVID-19
Any care facility where: **a)** untriaged individuals present for assessment or treatment (symptoms unknown) OR **b)** confirmed SARS-CoV-2 PCR positive individuals are cared for OR **c)** symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case, who have been triaged/clinically assessed and are waiting test results OR **d)** symptomatic individuals decline testing	Any care facility where: **a)** triaged/clinically assessed individuals are asymptomatic and are waiting a SARS-CoV-2 PCR test result OR **b)** triaged/clinically assessed individuals are asymptomatic with COVID19 contact/exposure identified OR **c)** testing is not required or feasible on asymptomatic individuals and infectious status is unknown OR **d)** asymptomatic individuals decline testing	Any care facility where: **a)** triaged/clinically assessed individuals with no symptoms or known recent COVID-19 contact/exposure AND have a negative SARS-CoV-2 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date OR **b)** Individuals who have recovered (14 days) from COVID19 and have had at least 48 hours without fever or respiratory symptoms OR **c)** patients or individuals including staff who are part of a regular formal NHS testing

• Designated areas within Emergency/Resuscitation Departments
• GP surgeries/walk in centres
• Facilities where confirmed or suspected/symptomatic COVID-19 individuals are cared, for example:-
  • emergency admissions to inpatient areas (adult and children)
  • Mental health
  • Maternity
  • Critical Care Units
  • Renal dialysis units
	• Designated areas within Emergency/Resuscitation , GP surgeries and walk-in centres
	• Non elective admission
	• Primary care facilities, for example general dental and general practice
	• Facilities where individuals are cared, for example inpatients; adult and children, Mental health, Maternity, Critical Care Units
	• Outpatient depts. including Diagnostics and Endoscopy
		• Planned/elective surgical procedures including day cases
		• Oncology/chemotherapy patients and/or facilities
		• Planned in-patient admissions (adult and children), Mental health, Maternity
		• Outpatients including Diagnostics/Endoscopy

Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

For staff who can only work in the Green pathway, they should avoid coming into contact within less than 2m of patients who have not had a negative PCR COVID test within the last 72 hours.

Staff who can only work on Green pathways may continue working in a ward/ department designated as a Green pathway as long as untested patients are placed in a single room or bay and the staff member does not access the single room or bay until a negative COVID PCR result is known (see designated areas info in amber pathway).

When there is a positive patient in a ward or area which was previously a Green pathway, the bay where the patient resides as well as their contacts will be reclassified as an Amber pathway. If an outbreak is declared in a ward/ area, the ward/ area will be reclassified as an Amber pathway even though all bays or areas may not have COVID positive patients.

Most areas in the community hospitals and the community setting are likely to be classed as Amber pathways as the patients/visitors in these areas are unlikely to have a negative COVID PCR test done within the last 72 hours.

4. Recommendation

It is recommended that these new pathways proposed by PHE are approved.

5. Reference

PHE Covid infection control guidance https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Royal Devon and Exeter NHS Foundation Trust

COVID-19: Infection Prevention and Control Recommendations

Post holder responsible for Procedural Document	[redacted], Consultant Nurse/Joint DIPC [redacted], Consultant in Medical Microbiology and Infection/Joint DIPC
Author of Standard Operating Guideline	[redacted], Consultant Nurse/Joint DIPC
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
Contact details	[redacted]
Date of original guideline	March 2021
Impact Assessment performed	Yes/ **No**
Approving body and date approved	Clinical Reference Group: 12 March 2021
Review date (and frequency of further reviews)	August 2021
Expiry date	March 2022
Date document becomes live	

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1	02/03/2021	Joint DIPCs	This guidance supersedes the *Guideline for PPE use and management of suspected and confirmed cases of SARS-CoV-2 Infectious Disease 2019 (COVID-19)* and the title change reflects the ongoing pandemic situation across the UK.

Associated Trust Policies/ Procedural documents:	SOP for declaring COVID alert level during the COVID-19 pandemic PHE guidance COVID-Secure guidelines the source isolation policy
Key Words:	COVID-19, Personal protective equipment, PPE Universal precautions
In consultation with and date: Clinical Reference Group 12 March 2021	
Contact for Review:	Joint DIPCs

CONTENTS

1. INTRODUCTION & KEY MESSAGES

1.1 This document sets out the Infection Prevention and Control (IPC) guidance for the RD&E as the organisation continues to maintain healthcare services during the ongoing pandemic. It includes key IPC control recommendations and risk assessed patient pathways to help guide the implementation of measures to provide safe and effective care and is based on National guidance.

1.2 The challenge facing the RD&E is to maintain healthcare services and manage capacity whilst providing a safe and equitable service for staff, visitors and patients/individuals including those who may present with COVID-19, those who have recovered from COVID-19 and those with no history of COVID-19 until public health strategies such as mass vaccination are complete.

1.3 Local and national prevalence and incidence data will continue to guide services. Periods of high COVID-19 prevalence/activity will be periodically declared by the RD&E based on data from regional test and trace, admissions, and modelling. This will be declared on The HUB.

1.4 Identification of new variants of concern have been considered in this guidance (for example, UK VOC 202012/01, lineage B1.1.7, the South African and Brazilian variants). COVID-19 positive patients who have returned from any foreign country in the last 14 days must be isolated and these cases urgently discussed with the on-call Microbiology Consultant and Infection Prevention and Control (IPC) team.

1.5 Data will continue to be used to ensure patients/individuals' treatment, care and support can be managed in the three COVID-19 pathways.

1.6 The use of face masks is recommended in addition to social distancing, hand hygiene in both clinical and non-clinical areas, and ventilation to reduce the risk of transmission.

1.7 Patients will be provided with COVID-19 comfort packs and must be encouraged and supported to wear a face mask in all care settings, providing it is tolerated and is not detrimental to their medical or care needs.

1.8 Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE. Bed-spaces and waiting areas should maintain a 2 metre distance where possible. Curtains should be drawn between patients as far as is safe.

1.10 If the prevalence/incidence rate for COVID-19 is high, where possible, assign separate teams of healthcare workers including domestic staff, to care for individuals in isolation/cohort rooms or areas/pathways. If a member of staff is required to move between sites/hospitals/cohort areas due to the unique function of their role, all IPC measures including physical distancing must be maintained.

1.11 Triaging and testing must be undertaken to enable early recognition of COVID-19 cases as per the testing guidance available on HUB.

1.12 Valved respirators should not be worn by a healthcare worker/operator in a sterile area such as theatres/surgical settings or undertaking a sterile procedure such as central line insertion, as the exhaled breath is unfiltered.

1.13 The number of visitors should be minimised to essential only as per Trust visiting guidelines.

1.14 This guidance is COVID-19 specific. For IPC measures relating to other infection control alert organisms please see the source isolation policy.

2. DEFINITIONS

2.1 **FRSM** – Fluid Resistant Surgical Face Mask

2.2 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route. A full list of AGPs can be found in appendix 1.

2.2 **Standard Precautions** – are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times and for all patients/individuals, whether infection is known or not, to ensure the safety of patients/individuals, staff and visitors

2.3 **TBP** – Transmission based precautions are additional measures (to SICPs) required when caring for patients/ individuals with a known or suspected infection such as COVID-19. TBPs are based upon the route of transmission and include:

2.3.1 **Contact Precautions**

- Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of infection transmission.
    - FRSM and eye protection
    - Gloves and apron if risk of bodily fluid exposure

2.3.2 **Droplet Precautions**

- Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been maintained at 2 metres in care settings.
    - FRSM and eye protection
    - Gloves and apron

2.3.3 **Enhanced Precautions**

- A combination of droplet and airborne precautions (Fit checked* FFP3 face mask and visor) to provide additional respiratory protection is encouraged during high prevalence in the following settings:
    - COVID-19 positive cohort and defined outbreak wards
    - Confirmed COVID-19 patients in isolation rooms in specialist/other areas e.g. maternity
    - Prolonged, direct patient contact e.g. complex wound dressing for a patient on the red pathway.
    - Performing an Aerosol Generating Procedure (and within 2m of the procedure) for a patient on the green pathway
- 'Outbreak' scrubs are required as part of enhanced PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.
- *A fit checked FFP3 will reduce the risk of acquiring COVID-19 from a patient having an AGP on the green pathway who subsequently tests positive but may not negate the need to self-isolate if contact traced by Occupational Health.

2.3.4 **AGP/Airborne Precautions**

- Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a

mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. COVID-19 can spread via this route when AGPs are undertaken.

- Fit tested FFP3 or powered respirator and visor
- Gown, apron and gloves

3. COVID-19 PREVALENCE

3.1 Periods of high and low COVID-19 prevalence/activity will be declared by the organisation based on data from regional test and trace, admissions, and modelling. This will be declared on The HUB. [redacted]

4. PERSONAL PROTECTIVE EQUIPMENT (PPE)

4.1 Staff must be trained and confident in the donning and doffing of PPE. Training and refresher sessions are available from the Infection Prevention and Control and Learning and Development Teams. Refer to instruction posters on safe donning and doffing of PPE.

4.2 PPE is only effective when worn correctly

5. EATING AND DRINKING

5.1 Face masks can be removed when 2 metre social distancing can be maintained following correct removal/doffing process and appropriate hand hygiene.

5.2 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.3 A face mask must be put back on immediately after eating, unless you are alone in an office.

6. PPE FOR VISITORS (INCLUDING OUTPATIENTS)

6.1 Visitors to RD&E grounds will be expected to arrive wearing a cloth face covering (CFC) as a minimum. Patients attending the Emergency Department and resident parents on NNU and Bramble will be encouraged to wear a FRSM and provided with one on arrival.

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment (see *Face Masks: Risk Assessment and Exemption Process* on HUB)

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Ideally visitors should not be present during AGPs for any patients but in the rare event they are, they should be offered a fit checked FFP3 mask and visor but excludes end of life visiting in ICU where visitors must wear a FRSM.

7. COVID-19 CARE PATHWAYS

7.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration:

7.1.1 **Low Risk (Green) Pathway**

a) Triaged/clinically assessed individuals with no symptoms nor known recent COVID-19 contact/exposure AND have a negative COVID-19 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date OR

b) Individuals who have recovered (14 days) from COVID-19 and have had at least 48 hours without fever or respiratory symptoms OR

c) Patients or individuals are part of a regular formal NHS testing plan and remain negative and asymptomatic (e.g. research study)

7.1.2 **Medium Risk (Amber) Pathway**

a) Triaged/clinically assessed individuals are asymptomatic and are waiting a COVID-19 PCR test result OR

b) triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified OR

c) infectious status is unknown as testing is not required or feasible on asymptomatic individuals OR

d) asymptomatic individuals decline testing

e) returning travellers from a travel ban country

7.1.3 **High Risk (Red) Pathway**

a) Untriaged individuals present for assessment or treatment OR

b) Confirmed COVID-19 PCR positive patients are cared for OR

c) Symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case who have been triaged/clinically assessed and are waiting test results OR

d) Symptomatic individuals declining testing

e) Patients who are clinically positive for COVID-19 but have tested negative

8. PATIENTS REQUIRING SPECIALIST CARE

8.1 Some COVID-19 positive patients will not be suitable to move to a COVID-19 cohort ward. Examples include but are not limited to haematology, oncology, maternity and cardiology.

8.2 In these exceptional circumstances COVID-19 positive patients will remain in a single room with en suite facilities where possible following the COVID-19 high risk/red pathway.

9. CATEGORISING COVID-19 RISK FOR THE NEWBORN

9.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

9.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

9.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/green pathway
- Mother positive – baby medium/amber pathway
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
- Mother asymptomatic and maternal swab pending.
    - Low prevalence in local population – baby low/emergency green pathway
    - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway

- Baby swab negative – baby low/emergency green pathway
- Baby swab positive – baby high/red pathway

10. PATIENT TRANSFERS

10.1 For COVID-19 Amber and Red pathways, where possible, all procedures and investigations should be carried out in the patient's single room or cohort. Only a minimal number of staff should be present in room during any procedures.

10.2 Only if clinical need dictates should patients be transferred to other departments and the following procedures then apply:

- the department must be informed in advance and prepare the room to receive an infectious or potentially infectious patient,
- the patient must be taken straight to, and return from the investigation/treatment room, and must not wait in a communal area,
- where possible patients should be at the end of a list to allow appropriate decontamination after any procedure,
- the patient should wear an FRSM - this will prevent large droplets being expelled into the environment by the wearer
- portering and escort staff should wear droplet PPE and should be kept to a minimum,
- the trolley/chair should be cleaned with Chlorclean or Clinell Universal Wipes after use,
- staff carrying out procedures should wear the PPE appropriate to the task and patient pathway.
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- when a recovered patient is transferred off the COVID-19 positive ward, they should be transferred on a clean bed or in a wheelchair

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11.3 Any equipment taken in to the room which must be subsequently removed, must be cleaned with Chlorlean or Clinell Universal wipes. Any additional items such as ultrasound probes or a cassette will also need to be cleaned, regardless of whether there has been direct contact with the patient or not.

11.4 The management of patients requiring more complex imaging (e.g. CT) will be dealt with on a case-by-case basis in consultation with the Infection Prevention and Control and clinical teams.

12. CLEANING

12.1 In the absence of obvious contamination with blood or bodily fluids, the room and equipment of Amber and Red patients should be cleaned at least twice-daily with a bleach solution (1,000 ppm chlorine, using Chlorclean or Tristel).

13. WASTE, LINEN AND CROCKERY/CUTLERY

13.1 Waste must be disposed of in accordance with Trust policy.

13.2 All waste bags should be tied and sealed before removal from the patient area. Gloves and disposable plastic aprons should be worn when handling all clinical waste and hand decontamination performed after removal of gloves.

13.3 Liquid waste such as urine and faeces can be safely disposed of into the sewerage system

13.4 Crockery and cutlery should be removed from the single-room or cohort and taken directly into the kitchen for washing in dishwasher

13.5 Linen should be classified as infected.

13.6 All staff handling linen will be required to wear gloves and apron. Hand hygiene should be performed after removal of gloves.

14. STAFF

14.1 Staff involved in the care of COVID-19 patients should avoid working in other parts of the hospital. Staff movement between wards must be limited where possible.

14.2 Staff must comply with all infection control procedures as detailed above.

14.3 Staff are required to comply with the COVID-19 preventative measures ‘hands, face, space’

14.4 The Trust recognises that staff may feel apprehensive about their involvement in the care of a patient with suspected or confirmed COVID-19. However, with the appropriate PPE and training provided, and as long as there is no medical reason preventing the wearing of PPE, the Trust would expect all staff to carry out their normal work. This is line with their job description and where relevant, professional codes of conduct. Where a member of staff has on-going concerns, personal support is available via the Occupational Health Department on extension 5800.

APPENDIX 1 – AEROSOL GENERATING PROCEDURES

1. The following medical procedures have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

    - tracheal intubation and extubation
    - manual ventilation
    - tracheotomy or tracheostomy procedures (insertion or removal)
    - bronchoscopy
    - dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills)
    - non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
    - high flow nasal oxygen (HFNO)
    - high frequency oscillatory ventilation (HFOV)
    - induction of sputum using nebulised saline
    - respiratory tract suctioning*
    - upper ENT airway procedures that involve respiratory suctioning*
    - upper gastro-intestinal endoscopy where open suction of the upper respiratory tract* occurs
    - high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

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Certain other procedures or equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk for COVID-19. Procedures in this category include administration of humidified oxygen, administration of Entonox or medication via nebulisation.

APPENDIX 2 – PPE AND COVID-19 PATHWAYS DURING HIGH PREVALENCE

COVID-Green (Low risk) during high prevalence	
Staff PPE	**Non-AGP**: Contact precautions within 2 metres of a patient or FRSM only if greater than 2m from a patient **AGP**: Enhanced PPE (encouraged but not mandated, otherwise droplet PPE) (unless other respiratory infections such as TB when AGP PPE must be worn): Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	**Non-AGP:** Routine patient placement **AGP:** Isolation room preferable for AGPs but these can occur in any clinical area. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Environment	Routine environmental cleaning as per local practice.

COVID-Amber (Medium risk) during high prevalence	
Staff PPE	**Non-AGP**: Droplet precautions within 2m or FRSM only if greater than 2m from a patient **AGP**: AGP/Airborne PPE Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	**Non-AGP**: Routine patient placement **AGP:** Wherever possible isolation room, rediroom or respiratory HDU. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	Patients with chronic respiratory conditions are considered Amber until 5 consecutive days of negative PCR tests and no COVID-19 contact. Please discuss placement and ongoing carte with clinical team and IPC/microbiology. For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.
Environment	Enhanced environmental cleaning, and curtain change on discharge or transfer. Some areas such as Hot ED and MTU will vary – please discuss with IPC team. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. If possible, patients should use en suite toilet facilities or dedicated

	toilet/commode, particularly while not on a cohort ward. For non-ambulant patients, disposable bedpans should be used. For single-rooms without en suite facilities, commodes or bathrooms need to be designated for patient or bay use only. Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning. Placement of portable air scrubbers/cleaners in COVID-19 contact bays

COVID-Red (High risk) during high prevalence	
Staff PPE	**Non-AGP**: Enhanced PPE (encouraged but not mandated for COVID-19 cohort wards, otherwise droplet PPE) **AGP**: AGP PPE
Patient placement	**Non-AGP**: COVID-19 cohort ward or isolation room with en suite facilities in specialist area. **AGP**: Isolation room, rediroom, ITU or respiratory HDU. If isolation room not available on a COVID-19 cohort ward discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID cases.
Environment	Enhanced environmental cleaning and curtain change (if not on cohort ward) on discharge or transfer. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points. If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment. Placement of portable air scrubbers/cleaners within COVID-19 positive cohort wards

APPENDIX 3 – PPE AND COVID-19 PATHWAYS DURING LOW PREVALENCE

COVID-Green (Low risk) during low prevalence	
Staff PPE	FRSM and standard precautions for all care (including AGP) In bays/areas where amber and green patients may mix while awaiting PCR result eye protection is recommended within 2m from a patient
Patient placement	Routine patient placement
Environment	Routine environmental cleaning as per local practice.

COVID-Amber (Medium risk) during low prevalence	
Staff PPE	**Non-AGP:** Droplet precautions within 2m or FRSM only if greater than 2m from a patient **AGP:** AGP/Airborne PPE Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	As per high prevalence
Special Measures	As per high prevalence
Environment	As per high prevalence

COVID-Red (High risk) during low prevalence	
Staff PPE	**Non-AGP**: Enhanced PPE (encouraged but not mandated for COVID-19 cohort wards, otherwise droplet PPE) **AGP**: AGP PPE
Patient placement	As per high prevalence
Special Measures	As per high prevalence
Environment	As per high prevalence Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment.

Royal Devon and Exeter NHS Foundation Trust

COVID-19: Infection Prevention and Control Recommendations

Post holder responsible for Procedural Document	[redacted], Consultant Nurse/Joint DIPC [redacted] Consultant in Medical Microbiology and Infection/Joint DIPC
Author of Standard Operating Guideline	[redacted] Consultant Nurse/Joint DIPC
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
Contact details	[redacted]
Date of original guideline	March 2021
Impact Assessment performed	Yes/ **No**
Approving body and date approved	Clinical Reference Group: 12 March 2021 V1.2 - 7 May 2021
Review date (and frequency of further reviews)	August 2021
Expiry date	March 2022
Date document becomes live	12 March 2021

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1	02/03/2021	Joint DIPCs	This guidance supersedes the *Guideline for PPE use and management of suspected and confirmed cases of SARS-CoV-2 Infectious Disease 2019 (COVID-19)* and the title change reflects the ongoing pandemic situation across the UK.
1.1	12/03/2021	Joint DIPCs	•Removal of use of routine eye protection on Green Pathways in low prevalence (other than for standard precautions) •Removal of Enhanced PPE for AGPs on Green Pathway in low prevalence. Enhanced PPE remains regardless of prevalence for RED and AMB Pathways. •Updated Key Messages in line with National guideline updates and variant strains •Updated Care Pathway definitions and AGP list in line with National guideline definitions •Updated tables in Appendices two and three to reflect high/low prevalence
1.2	07/05/2021	Joint DIPCs	Inclusion of section 1.14 in line with National guidance

Associated Trust Policies/ Procedural documents:	SOP for declaring COVID alert level during the COVID-19 pandemic PHE guidance COVID-Secure guidelines the source isolation policy
Key Words:	COVID-19, Personal protective equipment, PPE Universal precautions
In consultation with and date: Clinical Reference Group 12 March 2021	
Contact for Review:	Joint DIPCs

CONTENTS

1. INTRODUCTION & KEY MESSAGES

1.1 This document sets out the Infection Prevention and Control (IPC) guidance for the RD&E as the organisation continues to maintain healthcare services during the ongoing pandemic. It includes key IPC control recommendations and risk assessed patient pathways to help guide the implementation of measures to provide safe and effective care and is based on National guidance.

1.2 The challenge facing the RD&E is to maintain healthcare services and manage capacity whilst providing a safe and equitable service for staff, visitors and patients/individuals including those who may present with COVID-19, those who have recovered from COVID-19 and those with no history of COVID-19 until public health strategies such as mass vaccination are complete.

1.3 Local and national prevalence and incidence data will continue to guide services. Periods of high COVID-19 prevalence/activity will be periodically declared by the RD&E based on data from regional test and trace, admissions, and modelling. This will be declared on The HUB.

1.4 Identification of new variants of concern have been considered in this guidance (for example, UK VOC 202012/01, lineage B1.1.7, the South African and Brazilian variants). COVID-19 positive patients who have returned from any foreign country in the last 14 days must be isolated and these cases urgently discussed with the on-call Microbiology Consultant and Infection Prevention and Control (IPC) team.

1.5 Data will continue to be used to ensure patients/individuals' treatment, care and support can be managed in the three COVID-19 pathways.

1.6 The use of face masks is recommended in addition to social distancing, hand hygiene in both clinical and non-clinical areas, and ventilation to reduce the risk of transmission.

1.7 Patients will be provided with COVID-19 comfort packs and must be encouraged and supported to wear a face mask in all care settings, providing it is tolerated and is not detrimental to their medical or care needs.

1.8 Physical distancing of 2 metres is considered standard practice in all health and care settings, unless providing clinical or personal care and wearing appropriate PPE. Bed-spaces and waiting areas should maintain a 2 metre distance where possible. Curtains should be drawn between patients as far as is safe.

1.10 If the prevalence/incidence rate for COVID-19 is high, where possible, assign separate teams of healthcare workers including domestic staff, to care for individuals in isolation/cohort rooms or areas/pathways. If a member of staff is required to move between sites/hospitals/cohort areas due to the unique function of their role, all IPC measures including physical distancing must be maintained.

1.11 Triaging and testing must be undertaken to enable early recognition of COVID-19 cases as per the testing guidance available on HUB.

1.12 Valved respirators should not be worn by a healthcare worker/operator in a sterile area such as theatres/surgical settings or undertaking a sterile procedure such as central line insertion, as the exhaled breath is unfiltered.

1.13 The number of visitors should be minimised to essential only as per Trust visiting guidelines.

1.14 In some clinical outpatient settings, such as vaccination/outpatient clinics, where contact with individuals is minimal, the need for PPE items for each encounter, for example gloves and aprons are only recommended when there is (anticipated) exposure to blood/body fluids or non-intact skin.

1.15 This guidance is COVID-19 specific. For IPC measures relating to other infection control alert organisms please see the source isolation policy.

2. DEFINITIONS

2.1 **FRSM** – Fluid Resistant Surgical Face Mask

2.2 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or known to be suffering from an infectious agent transmitted wholly or partly by the airborne or droplet route. A full list of AGPs can be found in appendix 1.

2.2 **Standard Precautions** – are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times and for all patients/individuals, whether infection is known or not, to ensure the safety of patients/individuals, staff and visitors

2.3 **TBP** – Transmission based precautions are additional measures (to SICPs) required when caring for patients/ individuals with a known or suspected infection such as COVID-19. TBPs are based upon the route of transmission and include:

2.3.1 **Contact Precautions**

- Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of infection transmission.
    - FRSM and eye protection
    - Gloves and apron if risk of bodily fluid exposure

2.3.2 **Droplet Precautions**

- Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been maintained at 2 metres in care settings.
    - FRSM and eye protection
    - Gloves and apron

2.3.3 **Enhanced Precautions**

- A combination of droplet and airborne precautions (Fit checked* FFP3 face mask and visor) to provide additional respiratory protection is encouraged during high prevalence in the following settings:
    - COVID-19 positive cohort and defined outbreak wards
    - Confirmed COVID-19 patients in isolation rooms in specialist/other areas e.g. maternity
    - Prolonged, direct patient contact e.g. complex wound dressing for a patient on the red pathway.
    - Performing an Aerosol Generating Procedure (and within 2m of the procedure) for a patient on the green pathway
- 'Outbreak' scrubs are required as part of enhanced PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.
- *A fit checked FFP3 will reduce the risk of acquiring COVID-19 from a patient having an AGP on the green pathway who subsequently tests positive but may not negate the need to self-isolate if contact traced by Occupational Health.

2.3.4 **AGP/Airborne Precautions**

- Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. COVID-19 can spread via this route when AGPs are undertaken.
    - Fit tested FFP3 or powered respirator and visor
    - Gown, apron and gloves

3. COVID-19 PREVALENCE

3.1 Periods of high and low COVID-19 prevalence/activity will be declared by the organisation based on data from regional test and trace, admissions, and modelling. This will be declared on The HUB. Further guidance can be found here.

4. PERSONAL PROTECTIVE EQUIPMENT (PPE)

4.1 Staff must be trained and confident in the donning and doffing of PPE. Training and refresher sessions are available from the Infection Prevention and Control and Learning and Development Teams. Refer to instruction posters on safe donning and doffing of PPE.

4.2 PPE is only effective when worn correctly

5. EATING AND DRINKING

5.1 Face masks can be removed when 2 metre social distancing can be maintained following correct removal/doffing process and appropriate hand hygiene.

5.2 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.3 A face mask must be put back on immediately after eating, unless you are alone in an office.

6. PPE FOR VISITORS (INCLUDING OUTPATIENTS)

6.1 Visitors to RD&E grounds will be expected to arrive wearing a cloth face covering (CFC) as a minimum. Patients attending the Emergency Department and resident parents on NNU and Bramble will be encouraged to wear a FRSM and provided with one on arrival.

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment (see *Face Masks: Risk Assessment and Exemption Process* on HUB)

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Ideally visitors should not be present during AGPs for any patients but in the rare event they are, they should be offered a fit checked FFP3 mask and visor but excludes end of life visiting in ICU where visitors must wear a FRSM.

7. COVID-19 CARE PATHWAYS

7.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration:

7.1.1 **Low Risk (Green) Pathway**

a) Triaged/clinically assessed individuals with no symptoms nor known recent COVID-19 contact/exposure AND have a negative COVID-19 PCR test within 72 hours of treatment and, for planned admissions, have self-isolated for the required period or from the test date OR

b) Individuals who have recovered (14 days) from COVID-19 and have had at least 48 hours without fever or respiratory symptoms OR

c) Patients or individuals are part of a regular formal NHS testing plan and remain negative and asymptomatic (e.g. research study)

7.1.2 **Medium Risk (Amber) Pathway**

a) Triaged/clinically assessed individuals are asymptomatic and are waiting a COVID-19 PCR test result OR

b) triaged/clinically assessed individuals are asymptomatic with COVID-19 contact/exposure identified OR

c) infectious status is unknown as testing is not required or feasible on asymptomatic individuals OR

d) asymptomatic individuals decline testing

e) returning travellers from a travel ban country

7.1.3 **High Risk (Red) Pathway**

a) Untriaged individuals present for assessment or treatment OR

b) Confirmed COVID-19 PCR positive patients are cared for OR

c) Symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case who have been triaged/clinically assessed and are waiting test results OR

d) Symptomatic individuals declining testing

e) Patients who are clinically positive for COVID-19 but have tested negative

8. PATIENTS REQUIRING SPECIALIST CARE

8.1 Some COVID-19 positive patients will not be suitable to move to a COVID-19 cohort ward. Examples include but are not limited to haematology, oncology, maternity and cardiology.

8.2 In these exceptional circumstances COVID-19 positive patients will remain in a single room with en suite facilities where possible following the COVID-19 high risk/red pathway.

9. CATEGORISING COVID-19 RISK FOR THE NEWBORN

9.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

9.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

9.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/green pathway
- Mother positive – baby medium/amber pathway
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
- Mother asymptomatic and maternal swab pending.
    - Low prevalence in local population – baby low/emergency green pathway
    - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway

- Baby swab negative – baby low/emergency green pathway
- Baby swab positive – baby high/red pathway

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Environment	Routine environmental cleaning as per local practice.

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Staff PPE	**Non-AGP**: Droplet precautions within 2m or FRSM only if greater than 2m from a patient **AGP**: AGP/Airborne PPE Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	**Non-AGP**: Routine patient placement **AGP:** Wherever possible isolation room, rediroom or respiratory HDU. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	Patients with chronic respiratory conditions are considered Amber until 5 consecutive days of negative PCR tests and no COVID-19 contact. Please discuss placement and ongoing carte with clinical team and IPC/microbiology. For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.
Environment	Enhanced environmental cleaning, and curtain change on discharge or transfer. Some areas such as Hot ED and MTU will vary – please discuss with IPC team. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. If possible, patients should use en suite toilet facilities or dedicated

	toilet/commode, particularly while not on a cohort ward. For non-ambulant patients, disposable bedpans should be used. For single-rooms without en suite facilities, commodes or bathrooms need to be designated for patient or bay use only. Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning. Placement of portable air scrubbers/cleaners in COVID-19 contact bays

COVID-Red (High risk) during high prevalence	
Staff PPE	**Non-AGP**: Enhanced PPE (encouraged but not mandated for COVID-19 cohort wards, otherwise droplet PPE) **AGP**: AGP PPE
Patient placement	**Non-AGP**: COVID-19 cohort ward or isolation room with en suite facilities in specialist area. **AGP**: Isolation room, rediroom, ITU or respiratory HDU. If isolation room not available on a COVID-19 cohort ward discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID cases.
Environment	Enhanced environmental cleaning and curtain change (if not on cohort ward) on discharge or transfer. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points. If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment. Placement of portable air scrubbers/cleaners within COVID-19 positive cohort wards

APPENDIX 3 – PPE AND COVID-19 PATHWAYS DURING LOW PREVALENCE

COVID-Green (Low risk) during low prevalence	
Staff PPE	FRSM and standard precautions for all care (including AGP) In bays/areas where amber and green patients may mix while awaiting PCR result eye protection is recommended within 2m from a patient
Patient placement	Routine patient placement
Environment	Routine environmental cleaning as per local practice.

COVID-Amber (Medium risk) during low prevalence	
Staff PPE	**Non-AGP:** Droplet precautions within 2m or FRSM only if greater than 2m from a patient **AGP:** AGP/Airborne PPE Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	As per high prevalence
Special Measures	As per high prevalence
Environment	As per high prevalence

COVID-Red (High risk) during low prevalence	
Staff PPE	**Non-AGP**: Enhanced PPE (encouraged but not mandated for COVID-19 cohort wards, otherwise droplet PPE) **AGP**: AGP PPE
Patient placement	As per high prevalence
Special Measures	As per high prevalence
Environment	As per high prevalence Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment.

Royal Devon and Exeter NHS
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COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Facemasks/Visors in Speech and Language Therapy

Summary of recommendation for change/development:

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	21 October 2020, Chair's approval following amendments 2 November 2020
Document Version:	V 2.0
Date notified to Gold Command:	3 November 2020
Date document becomes live:	3 November 2020

There are some specific Speech and Language Therapy interventions where the wearing of a face mask has been identified as a potential barrier to effective intervention, and/or where providing the therapy remotely by video is not viable. It is proposed that in these specific contexts, Speech and Language Therapist staff can make a judgement to follow similar Trust-agreed guidelines as for staff working with patients who are hard of hearing.
This is not to be used for COVID positive patients.

	Speech and Language Therapy interventions where the wearing of a face mask has been identified as a potential barrier to effective intervention	Barrier
1.	Articulation therapy, where there is a requirement to provide the patient with clear visual cues to model articulatory placement (eg precise lip/tongue positions for specific sounds)	The facemask obscures visual cues.
2.	Voice therapy, where the therapist typically demonstrates and then practises together with the patient. For example an exercise where we breathe closely and softly onto the palm of our hands, and exercises where the therapist and patient breathe and make sound through a tube into (separate) cups of water (under slightly more pressure than normal).	It is not possible to blow through the mask or tube whilst mask is in place.
3.	Loudness therapy, where there is a requirement to provide the patient with clear auditory and visual cues in order to effectively model the exercises. There is also a requirement to see the patient's mouth to note and give effective feedback on success and accuracy. This therapy is difficult to deliver remotely as it can be difficult to know exactly how loud the person's voice is (problems with volume settings on the technology) and it can be difficult to accurately perceive vocal strain.	The facemask obscures visual cues and impacts on speech volume.
4.	Oro-motor assessments (part of the swallowing assessment). For some patients who present with an oral apraxia, receptive aphasia or cognitive impairments (comprehension difficulties), it is often necessary to demonstrate and model the instructions (eg open your mouth, stick out your tongue, purse your lips) in order to complete the assessment accurately and for differential diagnosis.	The facemask obscures visual cues.

Proposed solution:

In the specific contexts described above, there may be occasions when Speech and Language Therapy staff need to remove their face masks for short periods of time (up to a maximum of 15 minutes within a session) to deliver the intervention effectively.

If it is necessary to remove a face mask to facilitate the intervention, staff should:

- clean hands
- temporarily remove face mask and place on hard surface
- clean hands
- briefly remove mask to demonstrate/model the specific speech and language therapy exercise
- clean hands
- replace mask
- clean surface
- clean hands
- the patient must wear a face mask or covering: the patient may need to remove their mask briefly for the task and the speech therapist must put theirs back on.
- where possible, maintain 2m social distancing at all times while mask removed
- Patients must clean their hands on entry to a clinic room or other clinical area
- If possible, open a window to aid ventilation
- Avoid coughing while masks are removed
- Clean hands regularly with alcohol hand gel or soap and water
- Clean surfaces regularly

*****Visors are not recommended by PHE as a direct alternative to a type IIR surgical face mask, and there has been no official guidance on whether a face shield or visor can be worn instead of a covering, or if it offers better protection. However, in these specific situations the wearing of a visor that covers the nose and mouth completely provides an additional barrier whilst still allowing the patient to see the required visual cues.

Potential Outcome

It is hoped that there can be Trust agreement in writing. It is understood that this may need to be agreed at CRG level.

[redacted]

Speech and Language Therapist (Neuro Lead)

09.09.2020

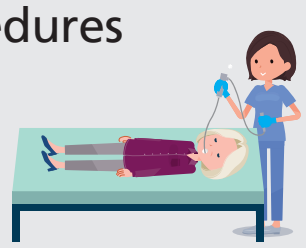
[redacted]

Head of Speech & language Therapy

Personal protective equipment (PPE)

Royal Devon and Exeter
NHS Foundation Trust

Always clean your hands and consider eye protection!

Risk / colour categorisation	High Risk Red	High Risk Unconfirmed Red	Medium Risk Amber	Low Risk Emergency Green	Low Risk Elective Green
	Confirmed COVID -19 positive or COVID-19 typical symptoms **or** symptomatic and declined testing **or** clinically positive but tested negative	Suspected COVID-19 with possible COVID-19 symptoms waiting a result	Asymptomatic and waiting a COVID-19 result **or** Asymptomatic and declined testing **or** Asymptomatic and testing not required	Asymptomatic and negative COVID-19 result	Asymptomatic and negative COVID-19 result and self-isolated since test date
Clinical area, no patient contact 	FRSM only	FRSM only	FRSM only	FRSM only	FRSM only
Direct patient contact – no risk of exposure to bodily fluids 	Droplet	Droplet	FRSM + eye protection	FRSM only	FRSM only
Direct patient contact – risk of exposure to bodily fluids 	Droplet	Droplet	Droplet	Standard	Standard
Aerosol generating procedures 	Airborne (within 2m)	Airborne (within 2m)	Airborne (within 2m)	Droplet*	Droplet*

* If respiratory risk factors other than COVID-19 e.g. known / suspected TB, Flu, Airborne precautions are required.
('FRSM' = Fluid Resistant Surgical Mask)

- **Standard precautions PPE** – FRSM. Single use disposable gloves, apron and eye protection if risk of exposure to bodily fluids
- **Droplet (& contact) precautions PPE** – single use disposable gloves, apron, eye protection and FRSM
- **Airborne (& contact) precautions PPE** – single use disposable gloves, single use disposable or reusable long-sleeved gown, visor and FFP3 mask or powered respirator

Updated on 01.10.2020

Royal Devon and Exeter NHS Foundation Trust

Personal Protective Equipment (PPE) Guidance during COVID-19 Pandemic

Post holder responsible for Procedural Document	[redacted], Consultant Nurse, Infection Control [redacted], Consultant in Medical Microbiology and Infection, Infection Control Doctor
Author of Standard Operating Guideline	[redacted] Consultant in Medical Microbiology and Infection
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
Contact details	[redacted]
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Expiry date	03/04/2022
Date document becomes live	V2 15/06/2020 V3 01/10/2020

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1	03/04/2020	Consultant in Medical Microbiology and Infection	New document in response to Covid19
1.1	22/04/2020	Consultant in Medical Microbiology and Infection	Update details and addition of appendix 3 and 4
1.2	11/05/2020	Consultant in Medical Microbiology and Infection	Addition of definitions section. Restructure sections of PPE. Addition of risk assessment for AGP PPE in non-COVID-19 patients. Update of distance from AGP for AGP PPE as per PHE (1 to 2m). AGP PPE changed from eye/face protection to full face shield. Removal of LMA insertion/extraction as AGP. Appendix 1 = Addition of NNU exclusion and addition of resus guidance. Appendix 2 = Additions to list of non-AGPs. Appendix 3 = removal of Scrubs/uniform and addition of PPE summary table
1.22	04/06/2020	Consultant in Medical Microbiology and Infection	Neonatal exceptions amended in appendix 1
2.0	15/06/2020	Consultant in Medical Microbiology and Infection	Masks/face coverings for all staff, patients and visitors in non-COVID-19-Secure areas.
3.0	28/09/2020	Consultant Nurse/DIPC	Updated in line with revised PHE guidance

Associated Trust Policies/ Procedural documents:	PHE guidance COVID-Secure guidelines
Key Words:	COVID-19 Personal protective equipment, PPE Universal precautions

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CONTENTS

1. Scope

1.1 Infection prevention and control (IPC) precautions, including hand hygiene and personal protective equipment (PPE), are essential to help protect staff, patients and visitors during the COVID-19 pandemic. Public Health England (PHE) produce guidance on the use of PPE, this guidance explains how it is to be used at RD&E.

1.2 This guidance covers:

- all staff in clinical and non-clinical areas
    - (community home visiting have a separate document as of 13/05/2020)
- all patients, including those in the extremely vulnerable group as defined by PHE, 'shielded patients'
- all visitors to clinical sites including parents, carers, birthing partners, volunteers, contactors

1.3 The IPC principles in the document apply to all health settings (excluding adult social care) and are underpinned by the best available evidence.

2. Guidance and Key Messages

2.1 IPC measures are critical to minimise the risk of transmission of COVID-19 and other infections in health and care settings.

2.2 2 metres social distancing is considered standard practice in all healthcare areas

2.3 We all have a role to play; it is important that we take steps to reduce the risk of transmission by asking everyone to follow all IPC measures to include hand hygiene and wearing PPE as advised in the document. Avoid touching your face as much as possible, keep hair tied back and adhere to uniform policy.

2.4 Comprehensive RDE PPE guidance, including donning/doffing and cleaning of equipment can be found on the HUB. PHE guidance can be found online.

2.5 Please use PPE appropriately and responsibly, it is a valuable resource. Protection is provided by its proper use and disposal/cleaning.

2.6 Sessional use of single use PPE has been minimised and only applies to extended use of facemasks for health and care workers.

2.7 Risk assessed care pathways provide greater clarity and detail on IPC measures for the management of patient treatment, care, and support:

- High risk: There is no change in recommendations for IPC or for the use of PPE by staff when managing patients/Individuals who have, or are likely to have, COVID-19.
- Medium risk: This includes patients/Individuals who have no symptoms of COVID-19 but do not have a COVID-19 SARS- CoV-2 PCR test result.
- Low risk: Patients/Individuals with no symptoms and a negative COVID-19 SARS- CoV-2 PCR test who have self-isolated prior to admission, for example following NICE guidance.

2.8 In some clinical outpatient settings where contact with individuals is minimal, the need for single use PPE items for each encounter, for example, gloves and aprons is not necessary.

2.9 Staff administering vaccinations/injections must apply hand hygiene between patients and wear a sessional facemask

3. Definitions

3.1 **SICP** – Standard Infection Control Precautions are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources include, blood and other body fluids, non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times, for all patients/individuals whether infection is known to be present or not. SICPs include hand and respiratory hygiene, frequent surface decontamination of environment and equipment, and social distancing.

3.2 **TBP** – Transmission Based Precautions are additional precautions to be used in addition to SICPs when caring for patients/individuals with a known or suspected infection and are required when caring for patients/individuals with known or suspected COVID-19. These are referred to throughout the guidance and take into consideration the additional precautions required for contact, droplet and airborne spread of COVID-19 and the PPE required by health and care staff.

- **Contact precautions**
  - Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).

- **Droplet precautions**
  - Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.

- **Airborne precautions**
  - Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level.

3.3 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of tiny droplets of fluid from the respiratory tract. These go into the air and may be breathed in or can settle on surfaces where infectious particles can live for a few days if not removed by ventilation or cleaning. AGPs are associated with an increased risk of respiratory transmission. A full list of AGPs can be found in appendix 1.

3.4 **Facemasks** –The trust stock both disposable and reusable masks for different situations.

Types of Facemask

- **Surgical masks** (SM) are single use
  - Type II – blue sticker box (non-clinical areas)
  - Type IIR fluid resistant (FRSM) – red sticker box (clinical areas)

- **Cloth masks** can be washed and are therefore reusable
    - Fluid repellent cloth masks (FRCM) have been provided by the trust
    - Cloth face covering (CFC) refers to any non-medical grade mask which covers the mouth and nose

3.5 **COVID-19 Secure** – the government has produced guidelines to reduce the risk of COVID-19 transmission. COVID-19 Secure areas, sites or buildings are those with no patient activity and require signage at entry points to notify people of the status.

4.0 Personal Protective Equipment (PPE)

4.1 For the purpose of this document, the term 'personal protective equipment' is used to describe products that are either PPE or medical devices that are approved by the Health and Safety Executive (HSE) and the Medicines and Healthcare products Regulatory Agency (MHRA) as protective solutions in managing the COVID-19 pandemic.

4.2 **Gloves** must be:

- worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between use
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases.

4.3 **Aprons** must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres of suspected/confirmed COVID-19 cases
- changed between patients and/or after completing a procedure or task

4.4 **Gowns** must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- single use disposable or reusable
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

4.5 **Eye or face protection** (goggles or visor) must:

- be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely – for example, by members of the surgical theatre team and always during aerosol generating procedures, regular corrective spectacles are not considered eye protection
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn
- be worn to protect mucous membranes
- be worn when delivering care within 2 metres of a suspected/confirmed COVID-19 case

4.6 **Fluid resistant surgical face mask** (FRSM Type IIR) masks must:

- be worn with eye protection if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely
- be worn when delivering direct care within 2 metres of a suspected/confirmed COVID-19 case
- be well-fitting and fit for purpose, fully cover the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection)
- not touched once put on or allowed to dangle around the neck
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through

4.6 **FFP3 (filtering face piece) or Powered respirator** should:

- be fit tested and fit checked
- always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient/individual
- 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 patient's/individual's room or cohort area or COVID-19 ward
- respirators can be single or sessional use, disposable or reusable and fluid-resistant
- valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated
- where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker should be moved to an area where FFP3 respirators are not required
- respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- the respirator should be discarded and replaced and NOT be subject to continued use if the facial seal is compromised, it is uncomfortable, or it is difficult to breathe through
- Reusable respirators should be decontaminated according to the manufacturer's instructions

4.7 **Head/footwear**

- headwear is not routinely required in clinical areas (even if undertaking an AGP) unless part of theatre attire or to prevent contamination of the environment such as in clean rooms
- headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres
- foot/shoe coverings are not required or recommended for the care of COVID-19 cases

4.8 **PPE for COVID-19 Secure Areas**

4.8.1 Within a COVID-19 Secure area, PPE is not required. Staff should maintain social distancing, follow good principles of hand hygiene and frequently clean high touch surfaces. Where possible windows should be open to allow for adequate ventilation.

4.8.2 Face masks must be worn outside of COVID-19 Secure areas.

5. Eating and Drinking

5.1 Face masks should be removed for eating or drinking, following correct removal/doffing process with appropriate hand hygiene and only when 2 metre social distancing can be maintained.

5.2 Eating and drinking should be limited to your break periods for staff wearing masks in sessional periods.

5.3 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. If entering a food area to purchase food and eat elsewhere, then your mask should remain on, until you reach the area you intend to eat your food

5.4 A clean mask should be put back on immediately after eating, unless in a COVID-19 Secure area. You may need to bring a clean mask with you in a clean container to enable you to do this. The approach of wearing a mask at all times (except COVID-19 Secure areas), removing and discarding it to eat, and then putting on a clean mask, with appropriate hand hygiene, applies where ever you plan to eat, even outside areas on Trust grounds.

6. PPE for Visitors (including outpatients)

6.1 Visitors to clinical sites will be expected to arrive wearing a cloth face covering (CFC) as a minimum

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment which must be documented in their medical notes.

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Hand hygiene and education on donning and doffing a mask/face covering will be provided at some entrances to clinical areas.

6.5 Patients in the extremely vulnerable group (as defined by PHE) are eligible for reusable FRCM to take home and wear outside of the healthcare setting.

6.6 Ideally visitors should not be present during AGPs, but in the rare event they are, they should be offered the same level of PPE as staff. This excludes end of life visiting in ICU where visitors must wear a FRSM and be offered an apron.

7. PPE for Inpatients

7.1 Inpatients whose COVID-19 status is positive or unknown pending swab result, should be given a FRSM to wear, if they can tolerate it. COVID-19 positive patients are not required to wear a mask once in a side room or positive cohort bay. COVID-19 negative patients are not required to wear a mask.

7.2 Patients should be given an information leaflet on mask use to guide its safe use, including hand hygiene, storage and disposal.

7.3 Patients wearing masks should be encouraged to wear them for sessional periods, ideally four hours, changing the mask when wet, soiled, damaged or uncomfortable.

7.4 Inpatients in the extremely vulnerable group (as defined by PHE) should be offered a mask to wear if they can tolerate it.

7.5 All other patients can be provided with a SM to wear if they request one

8. COVID-19 Care Pathways

8.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration and are detailed below in section 9, 10 and 11.

8.2 The three pathways are specific to the COVID-19 pandemic and are examples of how to separate COVID-19 risks. It is important to note, that these pathways do not necessarily define a service to a particular pathway and should not impact the delivery and duration of care for the patient or individual. Implementation strategies must be underpinned by patient/procedure risk assessment, appropriate testing regimens and epidemiological data.

8.2 Screening and triaging on admission to the RDE must be undertaken to enable early recognition of COVID-19 cases.

9.0 Low Risk (Emergency and Elective Green) Pathway – Key Principles

9.1

SICPs/PPE	Disposable gloves	Disposable apron	Face masks	Eye Protection
All settings/all patients/individuals	Single use (risk of exposure to body fluids only)	Single use apron (risk of exposure to body fluids only)	Type IIR FRSM at all times	Risk assess and use if required for care procedure/task where anticipated blood/body fluids spraying/splashes

9.2 **AGPs** – Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other infectious agent transmitted via the droplet or airborne route.

9.3 **Cleaning** – The frequency of cleaning of both the environment and equipment in patient areas should be increased from daily to at least twice daily, in particular, frequently touched sites/points.

9.4 In the low risk COVID-19 pathway general purpose detergents for cleaning are suitable (with the exception of blood and body fluids, where a chlorine releasing agent solution should be used).

9.5 **Theatre** – Within the low risk COVID-19 pathway, standard theatre cleaning and time for air changes provides appropriate levels of IPC and there is no requirement for additional cleaning unless the patient has another infectious agent that requires additional IPC measures. There is no additional requirement for ventilation or downtime in this pathway, providing safe systems of work, including engineering controls are in place.

9.6 Patients/individuals in the low risk COVID-19 pathway do not need to be anaesthetised or recovered in the operating theatre if intubation/extubation (AGP) is required.

10. Medium Risk (Amber) Pathway – Key Principles

10.1

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Patients with no COVID-19 symptoms and no test result	Single use (risk of exposure to body fluids only)	Single use apron (risk of exposure to body fluids only)	Type IIR FRSM	Single use or re-usable eye protection (goggles or visor)
Airborne	**Disposable gloves**	**Gown**	**Face masks**	**Eye protection**
When undertaking AGPs on patients with no COVID-19 symptoms and no test result	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

10.2 **Patient placement** – ensure cohorted patients/individuals are physically separated from each other, for example use screens, privacy curtains between the beds to minimise opportunities for close contact, this should be locally risk assessed to ensure patient safety is not compromised

10.3 **AGPs** – Should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE. (see section 11.3)

AGPs should be performed in a dedicated space, preferably in a room with doors shut, and as a minimum separated by at least 2 metres from other staff, patients and procedures.

10.4 **Cleaning** – Patient care equipment should be single-use where practicable. Reusable/communal non-invasive equipment (e.g. observation machine) should be allocated to an individual patient or cohort of patients/individuals. Cleaning of care equipment as per manufacturer's guidance/instruction and recommended product 'contact time' must be followed for all cleaning products.

10.5 Reusable non-invasive equipment must be decontaminated

- between each and after patient/individual

- after blood and body fluid contamination
- at regular intervals as part of routine equipment cleaning

10.6 Decontamination of equipment must be performed using either
- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (Chlorclean or Tristel)
- green clinell wipes, which have virucidal activity

10.7 **Theatre** – Patients/individuals should be anaesthetised and recovered in the operating theatre if intubation/extubation (AGP) is required. For local, neuraxial or regional anesthesia the patient is not required to be anaesthetised/ recovered in theatre.

10.8 **Critical care** – Droplet precautions apply. However, consideration may need to be given to the application of airborne precautions where the number of cases of suspected/confirmed COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms

10.9 TBPs should only be discontinued in consultation with clinicians and should take into consideration the individual's test results and clinical symptoms. If test results are not available (for example the patient/individual declines) TBPs can be discontinued after 14 days (inpatients) depending on contact exposure and providing the patient/individual remains symptom free.

10.10 There is no restriction on discharge if the patient/individual is well, unless the patient/individual is entering a long-term facility and testing may be required. Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members. Ambulance services and the receiving facilities must be informed of the infectious status of the individual

11. High Risk Pathway (Red and Unconfirmed Red) – Key principles

11.1

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Suspected or confirmed COVID-19	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care	Single use or re-usable eye protection (goggles or visor)
Airborne	**Disposable gloves**	**Gown**	**Face masks**	**Eye protection**
When undertaking AGPs on confirmed or suspected COVID-19	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

11.2 **Patient placement** – If the patient has symptoms or a history of contact with a case, they should be prioritised for single room isolation or cohorted (if an isolation room is unavailable) until their test results are known, for example use privacy curtains between bed spaces to minimise opportunities for close contact between patients. This should be locally risk assessed to ensure this does not compromise patient safety.

If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production, diarrhoea or vomiting and to those in the high risk/extremely high risk of severe illness.

11.3 **AGPs** – Should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE

PHE guidance recommends that staff performing an AGP and those within 2 metres wear AGP PPE but other staff working within the same space/room as an AGP, at a distance of 2 metres or more are not required to wear AGP PPE.

AGP PPE is also required for staff performing an AGP and those within 2 metres for a period of time afterwards depending on the air changes in that area, (5 minutes in theatres and 60 minutes on a ward or 6ACH). However, cleaning can commence immediately by staff in AGP PPE. After the 5 or 60 minute time frame, staff can enter the 2 metre zone without AGP PPE.

AGPs should be performed in a dedicated space, preferably in a room with doors shut, and as a minimum separated by at least 2 metres from other staff, patients and procedures.

11.4 **Cleaning** – See section 10.4

11.5 **Theatre** – Patients should be anaesthetised and recovered in the theatre if intubation/extubation (AGP) is required using airborne precautions. This is not required for regional, neuraxial or local anaesthesia.

Ventilation in both laminar flow and conventionally ventilated theatres should remain fully on during surgical procedures where patients/individuals have suspected/confirmed COVID-19. Air passing from operating theatres to adjacent areas will be highly diluted and is not considered to be a risk.

11.6 **Critical care** – Droplet precautions would apply however, consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms

11.7 Patients should remain in isolation/cohort with TBPs applied for at least 14 days after onset of symptoms and at least 3 consecutive days without a fever or respiratory symptoms. For asymptomatic patients, TBPs may be discontinued 14 days after initial positive result. The decision to modify the duration of, or ‘stand down’ TBPs (Contact/Droplet/Airborne) should be made by the clinical team managing the Individuals care.

11.8 Step down of TBPs for COVID-19 for home discharge may require some individual clinical assessment at local level depending on the severity of the disease and underlying conditions, including testing requirements.

11.9 In this pathway, visiting should continue to be limited to only essential visitors, for example birthing partner, carer/parent/guardian.

11.10 Discharge from an inpatient facility can occur when the individual is well enough and the clinician has provided them with advice to self -isolate for 14 days post discharge from the date of the positive SARS-CoV-2 PCR test (providing their symptoms resolve).

11.11 Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members. Ambulance services and the receiving facilities must be informed of the infectious status of the individual

12. Additional advice for AGPs

12.1 Sessional use AGP/Airborne PPE requires additional PPE between patient care episodes. In addition don:

- A clean disposable apron
- A clean pair of gloves
- The five moments of hand hygiene must be followed during sessional use

12.1 The following procedures may generate an aerosol from material other than patient secretions and that are not considered to represent a significant infectious risk.

- Administration of pressurised humidified oxygen;
- Administration of medication via nebulisation.
- Removal of plaster casts
- Insertion and removal of Nasogastric (NG) tubes
- Insertion and removal of Radiologically Inserted Gastrostomy (RIG) tubes
- CT guided lung biopsies

13. Categorising COVID-19 Risk for the Newborn

13.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU) – specifically if any AGP is required (including suctioning of the airway at birth). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

13.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

13.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/emergency green pathway
  - Standard PPE
- Mother positive – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs

    - Swab baby if admitted to NNU
- Mother asymptomatic and maternal swab pending.
    - Low prevalence in local population – baby low/emergency green pathway
        - Standard PPE
        - Swab baby only if mother subsequently confirmed positive or baby becomes symptomatic
    - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway
        - Airborne PPE for AGP
        - Droplet PPE for non-AGPs
        - Swab baby if admitted to NNU
- Baby swab negative – baby low/emergency green pathway
    - Standard PPE
- Baby swab positive – baby high/red pathway
    - Airborne PPE for AGP
    - Droplet PPE for non-AGPs

Appendix 1 - Aerosol Generating Procedures – PHE guidance

This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum/chest physio using nebulised saline
- respiratory tract suctioning
- upper ENT airway procedures that involve respiratory suctioning
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. From 11/05/2020, the trust will follow the resus council guidance for resuscitation; hence AGP PPE is available on resus trollies in the hospital setting

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 CLINICAL GUIDANCE: Guidance for contacts of COVID-19 positive patients

Summary of recommendation for change/development: Update to guidance

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
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As per Public Health England guidance, in-patients who are known to have been exposed to a confirmed COVID-19 patient should be isolated or cohorted until their hospital admission ends, or until 14 days after last exposure.

If symptoms or signs consistent with COVID-19 occur in the 14 days after exposure then relevant diagnostic tests, including the COVID-19 test, should be performed.

On discharge, patients should be given written advice to stay at home and referred to the stay at home guidance if less than 14 days has elapsed since their exposure.

1. **Designated COVID-19 admission areas (e.g. MTU west, SDEC, ED hot)**
    - Patients are spatially isolated within the admission area and should not remain together with a known COVID-19 positive patient for more than 4 hours. If a COVID-19 positive patient remains in this area for 12 hours or more contact tracing must be instigated. The definition of a contact is described below

2. **Inpatient and admission wards areas:**
    - Patients who have been in the same bay as a COVID-19 positive patient for four hours or more, up to 48 hours before the onset of symptoms (or positive test date if asymptomatic) are defined as COVID-19 contacts.

3. **Process**
    - If a patient tests positive in an inpatient area (excluding designated COVID-19 admission areas) the bay will be closed and become a contact bay. The vacated bed space of the COVID-19 positive patient must receive a terminal clean (Chlor-clean or Tristel and a curtain change).

- All horizontal surfaces within the bay must be cleaned with Chlor-clean or Tristel.
- The doors to the cohort area must remain closed with appropriate signage displayed.
- EPIC will be used by the IPC team to contact trace using defined criteria to determine who the contacts are.
- The identified contacts will be tagged with a COVID-19 contact alert in EPIC and droplet precautions added. A contact expiry date will also be added, this will be day 14 from exposure where day of exposure is day 0.
- COVID-19 contacts must be cared for on the amber pathway with appropriate PPE.
- COVID-19 contacts must be isolated or cohorted, away from the positive patient.
- Isolation is preferable to cohorting, but if cohorting, patients must wear face masks if safe for them to do so.
- When COVID-19 contacts are discharged from the bay or side room the bed space will require a terminal clean and curtain change.
- In exceptional circumstances and only after agreement from the IPC team, COVID-19 contact bays can be 'topped up' with COVID-19 contacts from other areas. In this instance contact times must not be extended by 48-72 hours.
- Contacts must be verbally informed by ward staff that they have had contact with a case of COVID-19 and document this in EPIC.
- If the patient has already been discharged the ward is responsible for informing the patient of the above by phone. This will be followed up with a warn and inform letter to the patient and GP generated by the IPC team.
- If a patient is discharged home within the isolation period, they must be given advice about the need to remain isolated until the contact time is complete.
- COVID-19 contacts being discharged to a nursing/residential home or a community hospital, or any other inpatient facility must be tested and the result known, prior to transfer. The onward care facility must be informed of the exposure and need to keep the patient isolated for the remaining isolation period even if PCR testing is negative.
- If a COVID-19 contact cohort is emptied, or amalgamated with another contact cohort, the empty cohort must receive a terminal clean of each bed space with Chlor-clean or Tristel.
- If a COVID-19 contact becomes symptomatic, they must be tested for COVID-19 and cared for as per the red pathway with appropriate PPE.
- Contacts who have completed their 14 day isolation/cohort period and are asymptomatic can be removed from the cohort and placed in a non-COVID-19 bay on another ward or another inpatient area. If the patient is unable to be transported by wheelchair they must move to another bay/ward on a clean bed.
- COVID-19 contacts amalgamating with other COVID-19 contacts can remain on their bed for transfer, this situation does not require a clean bed.
- All COVID-19 contacts must be swabbed daily for 14 days or until discharge, whichever is sooner.

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Guidance for COVID-19 positive cohort wards

Summary of recommendation for change/development:
Update to guidance

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1. Background

- COVID-19 is a Coronavirus, a group of viruses which are common viruses. There are 7 coronaviruses.
- Human coronaviruses usually cause mild to moderate upper-respiratory tract illnesses. However, COVID-19, MERS and SARS have the potential to cause severe illness.
- The method of transmission is via respiratory droplets, hand/mucous membrane contamination and aerosols during aerosol generating procedures
- The main symptoms of infection are a new persistent cough, a fever of 37.8 or above, a loss of, or change in sense of taste or smell (anosmia).
- The following information identifies the IPC measures required for COVID-19 positive wards.

2. Infection Control Measures

- Patients who test positive for COVID-19 must be isolated in a single room on their base ward if specialist care is required or transferred to a COVID-19 cohort on a designated ward.
- Patients must have allocated toilet and bathroom facilities. If the single room or cohort bay is not en-suite or the patient cannot use the en-suite facilities, a commode must be allocated.
- Visiting staff to the ward, such as Allied Health Professionals (AHP) should where practical see all non-COVID-19 patients prior to those with confirmed COVID-19 and adherence to IPC and PPE guidance must be maintained. Visits to the

affected ward by non-ward based staff must be kept to an unavoidable minimum (both in frequency and numbers).
- Although not a requirement in either local or Public Health England IPC guidance on uniform/ work, COVID-19 cohort wards, may, if they choose where raspberry scrubs (see appendix 1)
- Windows must be opened frequently to increase ventilation in the cohort or side room.
- Cleaning of all multi use equipment such as BP and ECG machines, thermometer, WOWs etc. must occur frequently throughout the day using a universal clinell wipe.

3. Hand Hygiene

- Hand hygiene is the single most important measure to reduce transmission of the infection. Coronaviruses are susceptible to alcohol hand gel. Hand hygiene must be performed using soap and water if visible soiling is present on hands.
- Hand hygiene must be performed before and after removing PPE along with the '5 Moment for Hand Hygiene'

4. Personal Protective Equipment (PPE)

- PPE must be worn by all staff within 2 meters of patients. The following PPE is required:

Standard care	**Aerosol Generating Procedures (AGP)**
Disposable gloves	Disposable gloves
Disposable plastic apron	Disposable gown
Fluid resistant surgical mask	FFP3 face mask or powered respirator
Eye protection	Face visor

For a full list of AGPs refer to the Trust PPE guidance (here)

- PPE must be removed/doffed in the correct order and in the correct place. Please speak to the nurse in charge if you are unsure where to remove your PPE and in which order.
- When working in a cohort bay where no AGPs are undertaken, you must change your gloves and apron and perform hand hygiene between patients. FRSMs and eye protection can be worn on a sessional basis.
- When working in a cohort bay where AGPs are undertaken you must change your gloves and clean your hands between patients. FRSMs, eye protection and long sleeve gown can be worn on a sessional basis.

5. Waste

- All waste must be disposed of as clinical waste using the designated waste streams.

6. Laundry

- All laundry, including raspberry scrubs (if worn) must be disposed of in a water-soluble bag, followed by a red outer bag. Laundry will be collected in the normal way.

7. Food Service

- For information about the food service on affected wards, please see Appendix 2

8. Cleaning

- Daily cleaning of the ward environment to minimise environmental contamination should continue using Chlor-clean or Tristel. PPE must be worn as per guidance above and will be determined by the area being cleaned.
- When a patient is discharged or transferred to another area, the bed space/isolation room must be cleaned as above and the curtains must be changed.
- If AGPs have occurred in the room, windows should be opened and the room must be left for 1 hour prior to cleaning unless in airborne PPE. After the 1 hour fallow period standard PPE can be worn for cleaning.

9. Visits to other departments

- Visits to other departments should be kept to a minimum but can occur to aid the patient's diagnosis and recovery. IPC precautions must be adhered to during transfer and the receiving department must be informed of the patient's status. The patient must be taken straight down for the procedure/investigation and straight back to the ward to ensure they are not waiting unnecessarily in other departments. If safe to do so, the patient must wear a FRSM while travelling to and from their procedure. Staff transferring the patient and staff in the receiving department must wear the correct PPE.
- Equipment must be decontaminated with a chlorine releasing agent or universal clinell wipe in accordance with the decontamination policy.

10. Transfer to Augmented Care Area

- If a patient requires transfer to an augmented care area such as ITU, staff who are transferring the patient must wear the appropriate PPE. The appropriate PPE will be dictated by the level of care required by the patient (e.g. whether AGPs are occurring).
- The patients bed must returned to the area it came from where it will be decontaminated using a chlorine releasing agent as part of the bed space clean.

11. Care of the Deceased

- The principles of IPC continue to apply whilst a deceased individual remains in the care environment due to 'the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients' (PHE, 2020).
- Staff who are transferring the deceased to the mortuary should wear, in addition to a FRSM, gloves and a disposable apron and perform hand hygiene on removal of PPE.
- For further detail refer to Care of the Deceased Adult Patients Policy

12. Patient Property

- Patient property should be placed into a property bag and wiped with a universal clinell wipe or placed into a second clean bag held by a colleague before being given to family/friends to take home.

13. Visitors

- No visiting will be allowed unless for specific reasons of safety (dementia or learning disability where anxiety would be increased significantly), inpatients who are under the age of 18 years old (one parent/guardian only) or a patient receiving end-of -life care.
- Even under these circumstances visitors should not visit if they have any signs of COVID-19.
- If visiting has been agreed, then only one person is permitted to visit. All visitors should be provided with a FRSM to wear. Visitors must always be advised to clean their hands immediately prior to leaving the cohort bay/isolation room and leave Trust premises directly.

14. Discharge Home

- When a COVID-19 positive patient is discharged home or transferred to another care area/facility, the bed space/single room must receive a terminal clean using a chlorine releasing agent and curtains must be changed. All patients must be given a surgical face FRSM to wear for their journey through the hospital and advised to go directly home.

Appendix 1 – Provision of raspberry scrubs for COVID-19 cohort wards

Purpose:

- To provide staff working on affected wards with clothing that can be laundered on site
- To ensure that staff have clean clothes to change into following a shift on the Covid-19 ward
- Raspberry scrubs are not a requirement in either local or Public Health England IPC guidance but are recognised to increase staff morale and wellbeing.

Procedure:

- Raspberry scrubs are available in a variety of sizes and will be stored in the central linen room. They are a distinctive colour (raspberry) and are different to those used currently in theatres and the cardiac cath lab.
- In normal working hours (Monday-Friday 8am- 4pm) raspberry scrubs can be delivered to the cohort ward once the linen room has been notified by the IPC team. Out of hours, the site practitioner can contact the porters to request that they collect a supply of scrubs from the linen room and take them to the affected ward. Three cages of scrubs will be kept in the Linen Room for this purpose - each cage containing a 24 hour supply.
- A cage will be delivered to the ward. Do not decant into the linen cupboard as there will not be enough room.
- The cage will usually contain 50 sets of scrub suits for a 24 hour period in a variety of sizes (5 small, 15 medium, 25 large, 5 extra large). If additional scrub suits are required or more of a particular size, contact the Linen Room or out of hours the Site Practitioner who will contact the porters.
- The cohort ward will identify a staff changing room. If the room chosen is large enough, the delivery cage containing the scrubs can be kept in the room. If not large enough, the cage will have to be kept elsewhere on the ward – for local determination.
- All ward based staff can change into scrubs at the start of their shift if they choose.
- Appropriate PPE is still required when working in bays/side rooms.
- Visits to the affected ward by non-resident ward staff must be kept to an unavoidable minimum (both in frequency and numbers).
- When scrubs are removed they should be placed in a water soluble laundry bag and then into a red laundry bag. Make sure that any badges, watches, tissues etc. are removed from tunic and pockets first. Do not put any other laundry in the bag – scrubs only. Secure neck of full laundry sacks and put in the waste disposal cupboard/room for collection in the usual way.
- Scrubs are not intended for use by visitors.

Appendix 2 – Food Service on Wards Affected by Covid-19

The role of the Domestic Assistant

- At the start of the day the domestic assistant will, wearing a clean uniform, prepare the breakfast trolley and deliver food to the patients as his/her first job of the day.
- The breakfast trolley must not be taken in to bays/side rooms. Food must be passed into ward nursing staff within these bays where possible.
- Strict hand hygiene must be observed at all times.
- Following breakfast, the foodstuffs can be put away with clean hands prior to collecting used crockery and cutlery from the ward.
- The domestic assistant should collect crockery/cutlery by positioning the trolley just outside the doors of the affected bay/side room.
- No used crockery or cutlery should be placed on the trolley during food service.
- Crockery and cutlery can be returned to the main kitchen for cleaning.

The role of the Catering Assistant

- On template wards where there is a shared kitchen, the unaffected ward's catering assistant should fill the catering trolleys for the affected ward for service and push them to the ward doors for collection at the appropriate times.
- The catering assistant of the affected ward should limit entry to the shared kitchen once he/she has been on his or her ward.
- Water jug refreshment should be carried out in the same way.

Nursing staff

- Where possible, staff working on COVID-19 cohort wards should avoid going into the kitchen.
- Overnight, when alternatives are unavailable, nurses should only go into the kitchen having removed all PPE and cleaned hands.
- Other measures, such as taking flasks of water onto the ward in advance should be explored if they will limit the need for kitchen access.

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 Guidance to Support Clinically Extremely Vulnerable (CEV) Adult Patients in Hospital

This guidance applies to clinically extremely vulnerable adults only. Other patients living in a household with someone who is clinically extremely vulnerable are not included in this guidance. They should instead follow the general advice and regulations set out in the national lockdown guidance that came into effect on 5 January 2021.

Point of Contact/author	
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1. Introduction

People who are defined as clinically extremely vulnerable (CEV) are thought to be at very high risk of serious illness from COVID-19. There are 3 ways a patient may be identified as clinically extremely vulnerable:

a. They have one or more of the conditions listed below.
b. A clinician or GP has added them to the Shielded Patient List based on their clinical judgement.
c. They have been identified through the COVID-19 Population Risk Assessment as potentially being at high risk of serious illness associated with COVID-19

1.1 People with the following conditions are automatically deemed clinically extremely vulnerable:

- solid organ transplant recipients
- 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 that 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
- people with severe respiratory conditions including all cystic fibrosis, severe asthma and severe chronic obstructive pulmonary disease (COPD)
- people with rare diseases that significantly increase the risk of infections (such as severe combined immunodeficiency (SCID), homozygous sickle cell disease)
- people on immunosuppression therapies sufficient to significantly increase risk of infection
- problems with your spleen, for example splenectomy (having your spleen removed)
- adults with Down's syndrome
- adults on dialysis or with chronic kidney disease (stage 5)
- women who are pregnant with significant heart disease, congenital or acquired
- other people who have also been classed as clinically extremely vulnerable, based on clinical judgement and an assessment of their needs. GPs and hospital clinicians have been provided with guidance to support these decisions
  (CEV government list checked & verified 6 July 2021)

The following guidance has been broken down into 4 areas: general advice, precautions for adult patients admitted to hospital, those who require outpatient care and those having care in the community.

2. General Advice

2.1 All CEV patients on the RDE register have been issued with reusable face coverings that they can use when attending hospital or receiving care in the community. There are general principles patients and staff should follow to help prevent the spread of the viruses:

- wash your hands more often with soap and water for at least 20 seconds or use alcohol gel. Do this after you blow your nose, sneeze or cough, and before you eat or handle food
- avoid touching your eyes, nose, and mouth with unwashed hands
- cover your cough or sneeze with a tissue, then throw the tissue in a bin
- clean and disinfect frequently touched objects and surfaces
- stay 2 meters away from other people when possible

3. Inpatients

3.1 Wherever possible we must facilitate the protective isolation of patients during their hospital stay. To ensure this we should consider the following:

- Early identification of CEV patients via:
    - Pre-alerts by paramedics
    - Pre-alerts when referred to specialties
    - Patients being flagged on EPIC (this function is live; the addition of a flag on patient records has been devolved to specialties as to whether this flag is applied proactively or at the point of contact with that RDE service)

- Patients should be offered a fluid resistant surgical face mask on arrival and encouraged to wear this for the duration of their stay (with replacements offered as required) unless a mask would cause distress. Hand gel and surface wipes should also be offered as part of the patient comfort pack.

- Patients should be encouraged to wash their hands frequently with soap and water. If available, patients can be provided with alcohol hand gel (excluding gastroenterology where wall mounted hand gel is provided)

- Ideally placing CEV patients in a side room in assessment areas where there are numerous patients whose COVID-19 status is unknown.

- Ideally placing patients in a side room on the most appropriate ward for their condition. Where a side room on the specialist ward is not available an individual assessment should be made as to whether the patient is best placed in a low risk bay on their specialist ward or a side room on a different ward.

- Staff caring for CEV patients should implement protective isolation precautions/reverse barrier nursing regardless of patient placement.

- Where possible CEV patients should have their own toilet facilities. If this is not possible encourage patients to use a commode in their room or the bay. Where patients opt to share a bathroom, it's important that they are cleaned prior to CEV patient use.

- Visitors are currently limited to specific groups as defined by the Trust. All visitors must to wear a face covering. Some specialities will ask visitor screening questions prior to a visit

- Patients should be encouraged to stay in touch with friends and relatives over the phone or online.

4. Hospital appointments

4.1 Wherever possible we must facilitate the protective isolation of patients attending an outpatient appointment by considering the following:

- Patients should be offered online or telephone appointments wherever possible and appropriate.
- All CEV patients should wear a mask whilst on hospital premises
- Where possible patients should avoid waiting rooms either by:
    - Being accommodated in a separate room to others
    - Waiting in their car and being called directly into the consultation room
    - As a minimum strict social distancing should be observed in waiting areas

5. Community

5.1 We must recognise the importance of CEV patients on our community caseloads.

- Healthcare Professionals caring for CEV patients should ensure that the patient has implemented self-isolation.
- Patients should wear a face mask during community visits unless the mask would cause distress.
- Prior to entering a CEV patients house, the healthcare professionals should ensure that their have donned clean PPE appropriate to the clinical activity.
- Healthcare Professionals should wash their hands with soap and water or clean with alcohol hand gel observing the 5 moments of hand hygiene after entering the patient property, where possible.
- If the patient being visited is not from a CEV group but another resident in the household is CEV the Healthcare Professionals should advise the CEV person to stay in a separate room whilst the visit takes place.
- Healthcare Professionals should be aware of the community support available in their area and ensure the patient is aware, referring where permission is given.

6. Children

- The definition of CEV children and advice for management is covered in the following national guidance documents:-
- www.cclg.org.uk/Coronavirus-advice
- RCPCH COVID-19 guidance on CEV children and young people

Royal Devon and Exeter NHS Foundation Trust

Guideline for PPE use and management of suspected and confirmed cases of SARS-CoV-2 Infectious Disease 2019 (COVID-19)

Post holder responsible for Procedural Document	[redacted], Consultant Nurse, Infection Control Consultant in Medical Microbiology and Infection, Infection Control Doctor
Author of Standard Operating Guideline	[redacted], Consultant in Medical Microbiology and Infection
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
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Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
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Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
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Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

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1	03/04/2020	Consultant in Medical Microbiology and Infection	New document in response to COVID19
1.1	22/04/2020	Consultant in Medical Microbiology and Infection	Update details and addition of appendix 3 and 4
1.2	11/05/2020	Consultant in Medical Microbiology and Infection	Addition of definitions section. Restructure sections of PPE. Addition of risk assessment for AGP PPE in non-COVID-19 patients. Update of distance from AGP for AGP PPE as per PHE (1 to 2m). AGP PPE changed from eye/face protection to full face shield. Removal of LMA insertion/extraction as AGP. Appendix 1 = Addition of NNU exclusion and addition of resus guidance. Appendix 2 = Additions to list of non-AGPs. Appendix 3 = removal of Scrubs/uniform and addition of PPE summary table
1.22	04/06/2020	Consultant in Medical Microbiology and Infection	Neonatal exceptions amended in appendix 1
2.0	15/06/2020	Consultant in Medical Microbiology and Infection	Masks/face coverings for all staff, patients and visitors in non-COVID-19-Secure areas.
3.0	28/09/2020	Consultant Nurse/DIPC	Updated in line with revised PHE guidance
3.1	04/11/2020	IPCN/Consultant Nurse	Amendment of COVID secure guidance, FRSM and eye protection use.
4.0	22/12/2020	Consultant in Medical Microbiology and Infection & Consultant Nurse, IPC	Change to enhanced PPE (FFP3) for care of COVID patients. Title change Addition of information relating to waste, linen, cleaning, visitors and staff
4.1	13/01/21	Consultant in Medical Microbiology and Infection & Consultant Nurse, IPC	Input from JDIPC, refining of terminology

Associated Trust Policies/ Procedural documents:	PHE guidance COVID-Secure guidelines
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CONTENTS

1. Introduction

1.1 This guidance has been specifically produced in response to the outbreak of novel coronavirus, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), and the associated disease COVID-19. The outbreak originated in Wuhan province in China on 31st December 2019 and since then has caused a global pandemic.

1.2 Infection prevention and control (IPC) precautions, including hand hygiene and personal protective equipment (PPE), are essential to help protect staff, patients and visitors during the COVID-19 pandemic.

1.3 Correct use of appropriate Personal Protective Equipment and adherence to protective measures such as correct hand washing reduces the risk of transmission of infection between the patients, healthcare workers and visitors

2. Key Messages

2.1 Transmission of the SARS-CoV-2 virus is thought to be largely via large respiratory droplets and direct or indirect contact with respiratory secretions. There is increasing data around the potential for aerosol transmission in certain settings. Government and local advice continues to evolve as new information becomes available. Currently the incubation period is thought to be 1-14 days with the majority of symptomatic cases appearing at days 3-5.

2.2 Multiple new strains of the virus are being detected. As of December 2020 there were over 4,000 new strains being tracked. Three of these appear to have characteristics that may either change their transmissibility or virulence. These include the UK B1.1.7 strain, the cluster 5 Danish variant and the S. African 501.V2 strain. Any patient returning from S. Africa or Denmark should currently be isolated and tested for COVID. Any COVID positive patient who has returned from any foreign country in the last 14 days should also be isolated and these cases urgently discussed with the on-call Microbiology Consultant and IPCT.

2.3 All patients should be screened according to the latest testing guidance available on HUB.

2.4 Patients admitted with symptoms of COVID-19 will be screened and nursed in COVID-Amber zones, under droplet isolation precautions.

2.5 Patients are provided with COVID-19 comfort packs and should be encouraged to wear FRSMs as much as they can tolerate.

2.6 As a minimum level of PPE, fluid-resistant surgical masks must be worn at all times by all members of staff in both clinical and non-clinical areas (unless alone in an office).

2.7 Enhanced respiratory PPE should be used in COVID-Red zones: apron, FFP3 respirator masks, eye protection and gloves, with the addition of a long sleeved gown for prolonged patient contact or close working where body fluid splashes may occur to exposed areas.

2.8 When completing Aerosol Generating Procedures (AGP) wear AGP PPE as per COVID-Red.

2.9 Enhanced environmental cleaning using chlorclean or hydrogen peroxide vapour solution is required, along with a curtain change on discharge of all Red and Amber patients.

2.10 The number of visitors should be minimised to essential only as per Trust visiting guidelines.

2.11 Adhere to COVID-19 preventative measures at all times*: 'hands, face, space'*

3. Definitions

3.1 **SICP** – Standard Infection Control Precautions are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources include, blood and other body fluids, non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times, for all patients/individuals whether infection is known to be present or not. SICPs include hand and respiratory hygiene, frequent surface decontamination of environment and equipment, and social distancing.

3.2 **TBP** – Transmission Based Precautions are additional precautions to be used in addition to SICPs when caring for patients/individuals with a known or suspected infection and are required when caring for patients/individuals with known or suspected COVID-19. These are referred to throughout the guidance and take into consideration the additional precautions required for contact, droplet and airborne spread of COVID-19 and the PPE required by health and care staff.

3.2.1 Contact PPE

- Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).
    - FRSM and eye protection
    - Gloves and apron if risk of bodily fluid exposure

3.2.2 Droplet PPE

- Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual.
    - FRSM and eye protection
    - Gloves and apron

3.2.3 Enhanced PPE

- A combination of droplet and airborne precautions to provide additional respiratory protection for use in the following settings:
    - COVID-19 positive cohort and defined outbreak wards
    - Confirmed COVID-19 patients in isolation rooms in specialist areas e.g. maternity
    - Prolonged, direct patient contact e.g. complex wound dressing for a patient on the red pathway.
    - Performing an Aerosol Generating Procedure (and within 2m of the procedure) for a patient on the green pathway
    - FFP3 face mask and visor
    - Gloves and apron
- 'Outbreak' scrubs are required as part of enhanced PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.

3.2.4 Full AGP (Airborne) PPE

- AGP Precautions are for use in the following settings:
    - AGPs on the Amber and Red pathway
    - FFP3 and visor
    - Gown, apron and gloves
    - 'Outbreak' scrubs are required as part of Airborne PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.

3.3 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of tiny droplets of fluid from the respiratory tract. These go into the air and may be breathed in or can settle on surfaces where infectious particles can live for a few days if not removed by ventilation or cleaning. AGPs are associated with an increased risk of respiratory transmission. A full list of AGPs can be found in appendix 1.

4. Personal Protective Equipment (PPE)

4.1 Staff must be trained and confident in the donning and doffing of PPE. Training and refresher sessions are available from the Infection Prevention and Control and Learning and Development Teams. Refer to instruction posters on safe donning and doffing of PPE.

4.2 Following removal, PPE will need to be disposed of as clinical infectious waste.

4.3 **Gloves** must:

- Be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- Be changed (with hand hygiene) immediately after each patient and/or after completing a procedure/task even on the same patient
- Never replace hand hygiene
- Double gloving is **NOT** recommended for routine clinical care of COVID-19 cases.

4.4 **Aprons** must be:

- Worn to protect uniform or clothes when contamination is anticipated or likely
- Worn when providing direct care within 2 metres as per droplet and standard precautions
- Changed between patients and/or after completing a procedure or task
- Used in conjunction with thorough hand and arm washing up to the elbow.

4.5 **Gowns** must be:

- Worn when there is a risk of extensive splashing of blood and/or body fluids
- Worn when undertaking aerosol generating procedures
- Worn when a disposable apron provides inadequate cover for the procedure or task being performed
- Changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

The Trust uses both disposable and re-usable gowns. Ensure that you know which you are using and do not dispose of reusable gowns, nor put disposable gowns in the linen bin.

4.6 **Eye or face protection** (goggles or visor) must:

- Not be touched when being worn, nor pushed into the hair or onto the forehead
- Be worn to protect mucous membranes
- Be worn when delivering care within 2 metres of all patients (inpatients, outpatients and day cases) regardless of the pathway they are on.
- Be worn for sessional periods and cleaned at regular intervals.
- Be worn in addition to regular corrective spectacles as they are not considered eye protection
- If Perspex screens are in place e.g at reception desks then eye protection is not required but can be worn if desired
- Each ward area should have eye protection cleaning stations.

4.7 **Fluid resistant surgical face mask** (FRSM Type IIR) masks must:

- Be worn at all times in all clinical areas
- Be worn at all times in non-clinical areas unless staff are alone in an office environment.
- Be well-fitting and fully cover the mouth and nose, not touched once put on
- Be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through
- If an FRSM does need adjusting, hand hygiene should be performed immediately afterwards.

4.8 **FFP3 face mask or Powered respirator** should:

- Be fit tested (user must know which mask they are fit tested to) and fit checked on each use
- Always be worn when undertaking an AGP on all patients in times of high prevalence
- Not be touched once put on
- Be removed outside the patient's/individual's room or cohort area or COVID-19 ward

- Be covered by a full face shield. Valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated. An FRSM is not required over the top of a valved FFP3 face mask.
- **ALWAYS** be fit tested for use during AGPs on a patient in the Red and Amber pathways. Where fit testing fails, suitable alternative equipment must be provided such as a powered respirator, or the healthcare worker should be moved to an area where AGPs are not performed.
- Be used as part of enhanced PPE to provide increased levels of filtration over an FRSM and a more secure fit. It should ideally be fit tested, but for staff not yet fit tested the mask with the best fit should be selected and a fit check performed prior to use. Staff should seek fit testing at the first available opportunity.

4.9 **Head/footwear**

- There is currently insufficient evidence around the use of hair and shoe coverings. They do not need to be worn routinely in COVID-19 areas (even if undertaking an AGP).
- Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire intheatres for example.

5. Eating and Drinking

5.1 Face masks should be removed for eating or drinking, following correct removal/doffing process with appropriate hand hygiene and only when 2 metre social distancing can be maintained.

5.2 Eating and drinking should be limited to your break periods for staff wearing masks in sessional periods.

5.3 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.4 An FRSM must be put back on immediately after eating, unless you are alone in an office. The approach of wearing a mask at all times, removing and discarding it to eat or drink, and then replacing with current or clean mask, with appropriate hand hygiene, applies where ever you plan to eat, even outside areas on Trust grounds.

6. PPE for Visitors (including outpatients)

6.1 Visitors to clinical sites will be expected to arrive wearing a cloth face covering (CFC) as a minimum. Patients attending the Emergency Department and resident parents on NNU and Bramble will be encouraged to wear a FRSM and provided with one on arrival.

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment which must be documented in their electronic patient record.

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Hand hygiene and education on donning and doffing a mask/face covering will be provided at some entrances to clinical areas.

6.5 Ideally visitors should not be present during AGPs for any patients but in the rare event they are, they should be offered the same level of PPE as staff. This includes a fit checked FFP3 mask but excludes end of life visiting in ICU where visitors must wear a FRSM.

7. PPE for Inpatients

7.1 Patients are provided with COVID-19 comfort packs and should be encouraged to wear FRSMs as much as they can tolerate particularly while in a bay with other patients.

7.2 Patients should be given an information leaflet on mask use to guide its safe use, including hand hygiene, storage and disposal.

7.3 Patients wearing masks should be encouraged to wear them for sessional periods, ideally four hours, changing the mask when wet, soiled, damaged or uncomfortable.

8. COVID-19 Care Pathways

8.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration and are detailed below in section 9, 10 and 11.

8.2 All clinical areas are required to comply with social distancing measures, including social distancing within patient bays. The bed-spaces should be minimum 2 meters apart and curtains should be drawn between patients as far as is safe. Patients should not be wandering through clinical areas and should be encouraged to remain within their bed-space. If possible and clinically safe, patients should be encouraged to wear fluid-resistant surgical face masks if they are away from their bed-space.

9. Low Risk (Green) Pathway

9.1 Patients who are COVID PCR test negative prior to or on admission and been shielding or isolating prior to admission with no COVID-19 symptoms.

COVID-Green	
Clinical areas with no suspected cases of COVID-19 to include patients with resolved COVID-19 infection	
Infection Control Measures	Standard Precautions for every patient, every time.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Contact PPE within 2 metres of a patient: • FRSM • Eye protection • Gloves and apron for bodily fluid exposure. Greater than 2 metres of a patient: • FRSM Staff performing an AGP for patients in the green pathway should wear enhanced PPE (unless other respiratory infections such as TB when full AGP PPE must be worn): • Apron or gown • FFP3 face mask or powered respirator (fit check can be used while awaiting fit test*) • Visor • Gloves *A fit checked FFP3 will reduce the risk of acquiring COVID-19 from a patient on the green pathway who subsequently tests positive but may

	not negate the need to self-isolate if contact traced by Occupational Health. A fit tested FFP3 provides full protection. Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	Non-AGP: Routine patient placement AGP required: Isolation room preferable for AGPs but these can occur in any clinical area. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Environment	Routine environmental cleaning as per local practice. Crockery and cutlery should be washed in dishwasher. In case of dishwasher fault and pending repair, dishes can be taken across to the nearest COVID-Green zone for washing.
Linen	Routine linen management practices as per Trust guidelines.
Waste	Routine waste management practices as per Trust guidelines.
Visitor Arrangements	Current visitor arrangements as per Trust guideline.

10. Medium Risk (Amber) Pathway

10.1 Patients whose COVID PCR test status is unknown or is a COVID-19 contact. Patients with chronic respiratory conditions are considered Amber until 5 consecutive days of negative PCR tests and no COVID-19 contact. Refer to the COVID-19 testing strategy for further testing guidance.

COVID-Amber	
Unknown or suspected cases as above, COVID contacts and low viral load in the area	
Infection Control Measures	Droplet isolation Dedicated clinical equipment to be cleaned before and after every use with chlorclean or clinell universal wipes. Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised.
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Droplet PPE within 2 metres of a patient: • FRSM • Eye protection • Apron • Gloves Greater than 2 metres of a patient:

	• FRSM Staff performing AGPs for Amber patients should be wear AGP PPE: • Gown • Fit tested FFP3 face mask or powered respirator • Visor • Gloves Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	Non-AGP: Routine patient placement AGP required: Wherever possible isolation room, rediroom or respiratory HDU. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.
Environment	Enhanced environmental cleaning, and curtain change on discharge or transfer. Some areas such as Hot ED and MTU will vary – please discuss with IPC team. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. If possible, patients should use en suite toilet facilities or dedicated toilet/commode, particularly while not on a cohort ward. For non-ambulant patients, disposable bedpans should be used. For single-rooms without en suite facilities, commodes or bathrooms need to be designated for patient or bay use only. Crockery and cutlery should be removed from the single-room or cohort and taken directly into the kitchen for washing in dishwasher Increase frequency of cleaning of frequently touched points.
Linen	Manage all linen as infectious, use water-soluble and red linen bags.
Waste	Manage all waste as clinical waste. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
Visitor Arrangements	Defer non-essential visits until patient's COVID-19 status is known. Current visitor arrangements as per Trust guideline

11. High Risk (Red) Pathway

11.1 Confirmed COVID-19 positive patients, or those with classic COVID-19 symptoms pending confirmatory PCR test (including those clinically positive, test negative patients)

COVID-Red

High viral load in the area	
Infection Control Measures	Enhanced respiratory isolation precautions in a single-room or cohort.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Enhanced PPE (refer to section 3.2.3 for settings required) • Scrubs • FFP3 • Visor • Apron • Gloves Droplet PPE • FRSM • Eye protection • Apron • Gloves AGP PPE • Gown • Fit tested FFP3 face mask or powered respirator • Visor • Gloves
Patient placement	Non-AGP: COVID-19 cohort ward or isolation room with en suite facilities in specialist area. AGP: Isolation room, rediroom, ITU or respiratory HDU. If isolation room not available on a COVID-19 cohort ward discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID cases.
Environment	Enhanced environmental cleaning, and curtain change (if not on cohort ward) on discharge or transfer. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points. Crockery and cutlery should be removed from the single-room and taken directly into the kitchen for washing in dishwasher. Single use (disposable) equipment and supplies should be used where possible.

	If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment.
Linen	Manage all linen as infectious, use water-soluble and red linen bags.
Waste	Manage all waste as clinical waste. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
Visitor Arrangements	Current visitor arrangements as per Trust guideline

12. Patients requiring specialist care

12.1 Some COVID-19 positive patients will not be suitable to move to a COVID cohort ward. Examples include but are not limited to haematology, oncology, maternity and cardiology.

12.2 In these exceptional circumstances COVID-19 positive patients will remain in a single room with en suite facilities where possible following the COVID red pathway.

13. Categorising COVID-19 Risk for the Newborn

13.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU) – specifically if any AGP is required (including suctioning of the airway at birth). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

13.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

13.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/emergency green pathway
  - Standard PPE
- Mother positive – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother asymptomatic and maternal swab pending.
  - Low prevalence in local population – baby low/emergency green pathway
    - Standard PPE
    - Swab baby only if mother subsequently confirmed positive or baby becomes symptomatic
  - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway
    - Airborne PPE for AGP
    - Droplet PPE for non-AGPs
    - Swab baby if admitted to NNU
- Baby swab negative – baby low/emergency green pathway
  - Standard PPE
- Baby swab positive – baby high/red pathway

- Airborne PPE for AGP
- Enhanced PPE for non-AGPs

14. Patient transfers

14.1 For COVID-19 Amber and Red pathways, where possible, all procedures and investigations should be carried out in the patient's single room or cohort. Only a minimal number of staff should be present in room during any procedures.

14.2 Only if clinical need dictates should patients be transferred to other departments and the following procedures then apply:

- the department must be informed in advance and prepare the room to receive an infectious or potentially infectious patient,
- the patient must be taken straight to, and return from the investigation/treatment room, and must not wait in a communal area,
- where possible patients should be at the end of a list to allow appropriate decontamination after any procedure,
- the patient should wear an FRSM - this will prevent large droplets being expelled into the environment by the wearer
- portering and escort staff should wear droplet PPE and should be kept to a minimum,
- the trolley/chair should be cleaned with Chlorclean or Clinell Universal Wipes after use,
- staff carrying out procedures should wear the PPE as detailed in sections 10.
- the treatment/procedure room and all equipment should be cleaned with Chlorclean or Clinell Universal Wipes after use
- when a recovered patient is transferred off the COVID-19 positive ward, they should be transferred on a clean bed or in a wheelchair

15. Imaging

15.1 For COVID-19 Amber and Red pathways, where possible clinically essential imaging should be performed at the patient's bedside by imaging staff wearing appropriate PPE (see section 10).

15.2 Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room or bay. The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE. The operator should wear PPE as described in section 10 and 11 when in the isolation room or cohort bay/ward.

15.3 Any equipment taken in to the room which must be subsequently removed, must be cleaned with Chlorlean or Clinell Universal wipes. Any additional items such as ultrasound probes or a cassette will also need to be cleaned, regardless of whether there has been direct contact with the patient or not.

15.4 The management of patients requiring more complex imaging (e.g. CT) will be dealt with on a case-by-case basis in consultation with the Infection Prevention and Control and clinical teams.

16. Cleaning

16.1 Decontamination and cleaning must be conducted wearing PPE, appropriate to the level of isolation (standard, droplet, enhanced or AGP PPE) as per COVID-Green, COVID-Amber and COVID-Red.

16.2 When cleaning single-rooms in COVID-Amber or Red zones, if the last clinical procedure in the room was aerosol generating and the cleaning is required immediately (within 1hour) the staff attending the clean are required to wear AGP PPE (fit tested FFP3).

16.3 In the absence of obvious contamination with blood or bodily fluids, the room and equipment of Amber and Red patients should be cleaned at least twice-daily with a neutral detergent followed by a bleach solution (1,000 ppm chlorine, using Chlorclean or Tristel).

17. Waste

17.1 Waste must be disposed of in accordance with Trust policy.

17.2 All waste bags should be tied and sealed before removal from the patient area. Gloves and disposable plastic aprons should be worn when handling all clinical waste and hand decontamination performed after removal of gloves.

17.3 Liquid waste such as urine and faeces can be safely disposed of into the sewerage system

18. Linen

18.1 Linen should be classified as infected.

18.2 All staff handling linen will be required to wear gloves and apron. Hand hygiene should be performed after removal of gloves.

19. Staff

19.1 Staff involved in the care of COVID-19 patients should avoid working in other parts of the hospital. Staff movement between wards must be limited where possible.

19.2 Staff must comply with all infection control procedures as detailed above.

19.3 Staff are required to comply with the COVID-19 preventative measures ‘hands, face, space’

19.4 The Trust recognises that staff may feel apprehensive about their involvement in the care of a patient with suspected or confirmed COVID-19. However, with the appropriate PPE and training provided, and as long as there is no medical reason preventing the wearing of PPE, the Trust would expect all staff to carry out their normal work. This is line with their job description and where relevant, professional codes of conduct. Where a member of staff has on-going concerns, personal support is available via the Occupational Health Department on extension 5800.

Appendix 1 - Aerosol Generating Procedures – PHE guidance

1. The following are procedures that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

    - tracheal intubation and extubation
    - manual ventilation
    - tracheotomy or tracheostomy procedures (insertion or removal)
    - bronchoscopy
    - dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
    - non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
    - high flow nasal oxygen (HFNO)
    - high frequency oscillatory ventilation (HFOV)
    - induction of sputum/chest physio using nebulised saline
    - respiratory tract suctioning
    - upper ENT airway procedures that involve respiratory suctioning
    - upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
    - high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. From 11/05/2020, the trust will follow the resus council guidance for resuscitation; hence AGP PPE is available on resus trollies in the hospital setting

Royal Devon and Exeter NHS Foundation Trust

Guideline for PPE use and management of suspected and confirmed cases of SARS-CoV-2 Infectious Disease 2019 (COVID-19)

Post holder responsible for Procedural Document	[redacted], Consultant Nurse, Infection Control [redacted], Consultant in Medical Microbiology and Infection, Infection Control Doctor
Author of Standard Operating Guideline	[redacted], Consultant in Medical Microbiology and Infection
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
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Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

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1	03/04/2020	Consultant in Medical Microbiology and Infection	New document in response to COVID19
1.1	22/04/2020	Consultant in Medical Microbiology and Infection	Update details and addition of appendix 3 and 4
1.2	11/05/2020	Consultant in Medical Microbiology and Infection	Addition of definitions section. Restructure sections of PPE. Addition of risk assessment for AGP PPE in non-COVID-19 patients. Update of distance from AGP for AGP PPE as per PHE (1 to 2m). AGP PPE changed from eye/face protection to full face shield. Removal of LMA insertion/extraction as AGP. Appendix 1 = Addition of NNU exclusion and addition of resus guidance. Appendix 2 = Additions to list of non-AGPs. Appendix 3 = removal of Scrubs/uniform and addition of PPE summary table
1.22	04/06/2020	Consultant in Medical Microbiology and Infection	Neonatal exceptions amended in appendix 1
2.0	15/06/2020	Consultant in Medical Microbiology and Infection	Masks/face coverings for all staff, patients and visitors in non-COVID-19-Secure areas.
3.0	28/09/2020	Consultant Nurse/DIPC	Updated in line with revised PHE guidance
3.1	04/11/2020	IPCN/Consultant Nurse	Amendment of COVID secure guidance, FRSM and eye protection use.
4.0	22/12/2020	Consultant in Medical Microbiology and Infection & Consultant Nurse, IPC	Change to enhanced PPE (FFP3) for care of COVID patients. Title change Addition of information relating to waste, linen, cleaning, visitors and staff
4.1	13/01/21	Consultant in Medical Microbiology and Infection & Consultant Nurse, IPC	Input from JDIPC, refining of terminology
4.2	08/02/21	Consultant Nurse/DIPC	Clarification Enhanced PPE is recommended rather than mandatory

Associated Trust Policies/ Procedural documents:	PHE guidance COVID-Secure guidelines
Key Words:	COVID-19, Personal protective equipment, PPE Universal precautions
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CONTENTS

1. Introduction

1.1 This guidance has been specifically produced in response to the outbreak of novel coronavirus, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), and the associated disease COVID-19. The outbreak originated in Wuhan province in China on 31st December 2019 and since then has caused a global pandemic.

1.2 Infection prevention and control (IPC) precautions, including hand hygiene and personal protective equipment (PPE), are essential to help protect staff, patients and visitors during the COVID-19 pandemic.

1.3 Correct use of appropriate Personal Protective Equipment and adherence to protective measures such as correct hand washing reduces the risk of transmission of infection between the patients, healthcare workers and visitors

2. Key Messages

2.1 Transmission of the SARS-CoV-2 virus is thought to be largely via large respiratory droplets and direct or indirect contact with respiratory secretions. There is increasing data around the potential for aerosol transmission in certain settings. Government and local advice continues to evolve as new information becomes available. Currently the incubation period is thought to be 1-14 days with the majority of symptomatic cases appearing at days 3-5.

2.2 Multiple new strains of the virus are being detected. As of December 2020 there were over 4,000 new strains being tracked. Three of these appear to have characteristics that may either change their transmissibility or virulence. These include the UK B1.1.7 strain, the cluster 5 Danish variant and the S. African 501.V2 strain. Any patient returning from S. Africa or Denmark should currently be isolated and tested for COVID. Any COVID positive patient who has returned from any foreign country in the last 14 days should also be isolated and these cases urgently discussed with the on-call Microbiology Consultant and IPCT.

2.3 All patients should be screened according to the latest testing guidance available on HUB.

2.4 Patients admitted with symptoms of COVID-19 will be screened and nursed in COVID-Amber zones, under droplet isolation precautions.

2.5 Patients are provided with COVID-19 comfort packs and should be encouraged to wear FRSMs as much as they can tolerate.

2.6 As a minimum level of PPE, fluid-resistant surgical masks must be worn at all times by all members of staff in both clinical and non-clinical areas (unless alone in an office).

2.7 Enhanced PPE is encouraged in COVID-Red zones: apron, FFP3 respirator masks, eye protection and gloves, with the addition of a long sleeved gown for prolonged patient contact or close working where body fluid splashes may occur to exposed areas. Enhanced PPE is over and above National guidelines and not mandated within the RD&E.

2.8 When completing Aerosol Generating Procedures (AGP) wear AGP PPE as per COVID-Red.

2.9 Enhanced environmental cleaning using chlorclean or hydrogen peroxide vapour solution is required, along with a curtain change on discharge of all Red and Amber patients.

2.10 The number of visitors should be minimised to essential only as per Trust visiting guidelines.

2.11 Adhere to COVID-19 preventative measures at all times*: 'hands, face, space'*

3. Definitions

3.1 **SICP** – Standard Infection Control Precautions are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources include, blood and other body fluids, non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times, for all patients/individuals whether infection is known to be present or not. SICPs include hand and respiratory hygiene, frequent surface decontamination of environment and equipment, and social distancing.

3.2 **TBP** – Transmission Based Precautions are additional precautions to be used in addition to SICPs when caring for patients/individuals with a known or suspected infection and are required when caring for patients/individuals with known or suspected COVID-19. These are referred to throughout the guidance and take into consideration the additional precautions required for contact, droplet and airborne spread of COVID-19 and the PPE required by health and care staff.

3.2.1 Contact PPE

- Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).
    - FRSM and eye protection
    - Gloves and apron if risk of bodily fluid exposure

3.2.2 Droplet PPE

- Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual.
    - FRSM and eye protection
    - Gloves and apron

3.2.3 Enhanced PPE

- A combination of droplet and airborne precautions to provide additional respiratory protection is encouraged in the following settings:
    - COVID-19 positive cohort and defined outbreak wards
    - Confirmed COVID-19 patients in isolation rooms in specialist areas e.g. maternity
    - Prolonged, direct patient contact e.g. complex wound dressing for a patient on the red pathway.
    - Performing an Aerosol Generating Procedure (and within 2m of the procedure) for a patient on the green pathway
    - FFP3 face mask and visor
    - Gloves and apron
- 'Outbreak' scrubs are required as part of enhanced PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.

3.2.4 Full AGP (Airborne) PPE

- AGP Precautions are for use in the following settings:
    - AGPs on the Amber and Red pathway
    - FFP3 and visor
    - Gown, apron and gloves
    - 'Outbreak' scrubs are required as part of Airborne PPE for prolonged direct patient contact or where a visit to a COVID-19 positive cohort or outbreak ward will exceed 30 minutes.

3.3 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of tiny droplets of fluid from the respiratory tract. These go into the air and may be breathed in or can settle on surfaces where infectious particles can live for a few days if not removed by ventilation or cleaning. AGPs are associated with an increased risk of respiratory transmission. A full list of AGPs can be found in appendix 1.

4. Personal Protective Equipment (PPE)

4.1 Staff must be trained and confident in the donning and doffing of PPE. Training and refresher sessions are available from the Infection Prevention and Control and Learning and Development Teams. Refer to instruction posters on safe donning and doffing of PPE.

4.2 Following removal, PPE will need to be disposed of as clinical infectious waste.

4.3 **Gloves** must:

- Be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- Be changed (with hand hygiene) immediately after each patient and/or after completing a procedure/task even on the same patient
- Never replace hand hygiene
- Double gloving is **NOT** recommended for routine clinical care of COVID-19 cases.

4.4 **Aprons** must be:

- Worn to protect uniform or clothes when contamination is anticipated or likely
- Worn when providing direct care within 2 metres as per droplet and standard precautions
- Changed between patients and/or after completing a procedure or task
- Used in conjunction with thorough hand and arm washing up to the elbow.

4.5 **Gowns** must be:

- Worn when there is a risk of extensive splashing of blood and/or body fluids
- Worn when undertaking aerosol generating procedures
- Worn when a disposable apron provides inadequate cover for the procedure or task being performed
- Changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

The Trust uses both disposable and re-usable gowns. Ensure that you know which you are using and do not dispose of reusable gowns, nor put disposable gowns in the linen bin.

4.6 **Eye or face protection** (goggles or visor) must:

- Not be touched when being worn, nor pushed into the hair or onto the forehead
- Be worn to protect mucous membranes
- Be worn when delivering care within 2 metres of all patients (inpatients, outpatients and day cases) regardless of the pathway they are on.
- Be worn for sessional periods and cleaned at regular intervals.
- Be worn in addition to regular corrective spectacles as they are not considered eye protection
- If Perspex screens are in place e.g at reception desks then eye protection is not required but can be worn if desired
- Each ward area should have eye protection cleaning stations.

4.7 **Fluid resistant surgical face mask** (FRSM Type IIR) masks must:

- Be worn at all times in all clinical areas
- Be worn at all times in non-clinical areas unless staff are alone in an office environment.
- Be well-fitting and fully cover the mouth and nose, not touched once put on
- Be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through
- If an FRSM does need adjusting, hand hygiene should be performed immediately afterwards.

4.8 **FFP3 face mask or Powered respirator** should:

- Be fit tested (user must know which mask they are fit tested to) and fit checked on each use
- Always be worn when undertaking an AGP on all patients in times of high prevalence
- Not be touched once put on
- Be removed outside the patient's/individual's room or cohort area or COVID-19 ward

- Be covered by a full face shield. Valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated. An FRSM is not required over the top of a valved FFP3 face mask.
- **ALWAYS** be fit tested for use during AGPs on a patient in the Red and Amber pathways. Where fit testing fails, suitable alternative equipment must be provided such as a powered respirator, or the healthcare worker should be moved to an area where AGPs are not performed.
- Be used as part of enhanced PPE to provide increased levels of filtration over an FRSM and a more secure fit. It should ideally be fit tested, but for staff not yet fit tested the mask with the best fit should be selected and a fit check performed prior to use. Staff should seek fit testing at the first available opportunity.

4.9 **Head/footwear**

- There is currently insufficient evidence around the use of hair and shoe coverings. They do not need to be worn routinely in COVID-19 areas (even if undertaking an AGP).
- Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in theatres for example.

5. Eating and Drinking

5.1 Face masks should be removed for eating or drinking, following correct removal/doffing process with appropriate hand hygiene and only when 2 metre social distancing can be maintained.

5.2 Eating and drinking should be limited to your break periods for staff wearing masks in sessional periods.

5.3 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.4 An FRSM must be put back on immediately after eating, unless you are alone in an office. The approach of wearing a mask at all times, removing and discarding it to eat or drink, and then replacing with current or clean mask, with appropriate hand hygiene, applies where ever you plan to eat, even outside areas on Trust grounds.

6. PPE for Visitors (including outpatients)

6.1 Visitors to clinical sites will be expected to arrive wearing a cloth face covering (CFC) as a minimum. Patients attending the Emergency Department and resident parents on NNU and Bramble will be encouraged to wear a FRSM and provided with one on arrival.

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment which must be documented in their electronic patient record.

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Hand hygiene and education on donning and doffing a mask/face covering will be provided at some entrances to clinical areas.

6.5 Ideally visitors should not be present during AGPs for any patients but in the rare event they are, they should be offered the same level of PPE as staff. This includes a fit checked FFP3 mask but excludes end of life visiting in ICU where visitors must wear a FRSM.

7. PPE for Inpatients

7.1 Patients are provided with COVID-19 comfort packs and should be encouraged to wear FRSMs as much as they can tolerate particularly while in a bay with other patients.

7.2 Patients should be given an information leaflet on mask use to guide its safe use, including hand hygiene, storage and disposal.

7.3 Patients wearing masks should be encouraged to wear them for sessional periods, ideally four hours, changing the mask when wet, soiled, damaged or uncomfortable.

8. COVID-19 Care Pathways

8.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration and are detailed below in section 9, 10 and 11.

8.2 All clinical areas are required to comply with social distancing measures, including social distancing within patient bays. The bed-spaces should be minimum 2 meters apart and curtains should be drawn between patients as far as is safe. Patients should not be wandering through clinical areas and should be encouraged to remain within their bed-space. If possible and clinically safe, patients should be encouraged to wear fluid-resistant surgical face masks if they are away from their bed-space.

9. Low Risk (Green) Pathway

9.1 Patients who are COVID PCR test negative prior to or on admission and been shielding or isolating prior to admission with no COVID-19 symptoms.

COVID-Green	
Clinical areas with no suspected cases of COVID-19 to include patients with resolved COVID-19 infection	
Infection Control Measures	Standard Precautions for every patient, every time.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Contact PPE within 2 metres of a patient: • FRSM • Eye protection • Gloves and apron for bodily fluid exposure. Greater than 2 metres of a patient: • FRSM Staff performing an AGP for patients in the green pathway are encouraged but not mandated to wear enhanced PPE (unless other respiratory infections such as TB when full AGP PPE must be worn): • Apron or gown • FFP3 face mask or powered respirator (fit check can be used while awaiting fit test*) • Visor • Gloves *A fit checked FFP3 will reduce the risk of acquiring COVID-19 from a patient on the green pathway who subsequently tests positive but may

	not negate the need to self-isolate if contact traced by Occupational Health. A fit tested FFP3 provides full protection. Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	Non-AGP: Routine patient placement AGP required: Isolation room preferable for AGPs but these can occur in any clinical area. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Environment	Routine environmental cleaning as per local practice. Crockery and cutlery should be washed in dishwasher. In case of dishwasher fault and pending repair, dishes can be taken across to the nearest COVID-Green zone for washing.
Linen	Routine linen management practices as per Trust guidelines.
Waste	Routine waste management practices as per Trust guidelines.
Visitor Arrangements	Current visitor arrangements as per Trust guideline.

10. Medium Risk (Amber) Pathway

10.1 Patients whose COVID PCR test status is unknown or is a COVID-19 contact. Patients with chronic respiratory conditions are considered Amber until 5 consecutive days of negative PCR tests and no COVID-19 contact. Refer to the COVID-19 testing strategy for further testing guidance.

COVID-Amber	
Unknown or suspected cases as above, COVID contacts and low viral load in the area	
Infection Control Measures	Droplet isolation Dedicated clinical equipment to be cleaned before and after every use with chlorclean or clinell universal wipes. Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised.
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Droplet PPE within 2 metres of a patient: • FRSM • Eye protection • Apron • Gloves

	Greater than 2 metres of a patient: • FRSM Staff performing AGPs for Amber patients should be wear AGP PPE: • Gown • Fit tested FFP3 face mask or powered respirator • Visor • Gloves Staff within the cohort / bay / theatre / anaesthetic room or isolation room at a distance greater then 2m can remain in FRSM.
Patient placement	Non-AGP: Routine patient placement AGP required: Wherever possible isolation room, rediroom or respiratory HDU. If isolation room not available discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.
Environment	Enhanced environmental cleaning, and curtain change on discharge or transfer. Some areas such as Hot ED and MTU will vary – please discuss with IPC team. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. If possible, patients should use en suite toilet facilities or dedicated toilet/commode, particularly while not on a cohort ward. For non-ambulant patients, disposable bedpans should be used. For single-rooms without en suite facilities, commodes or bathrooms need to be designated for patient or bay use only. Crockery and cutlery should be removed from the single-room or cohort and taken directly into the kitchen for washing in dishwasher Increase frequency of cleaning of frequently touched points.
Linen	Manage all linen as infectious, use water-soluble and red linen bags.
Waste	Manage all waste as clinical waste. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
Visitor Arrangements	Defer non-essential visits until patient's COVID-19 status is known. Current visitor arrangements as per Trust guideline

11. High Risk (Red) Pathway

11.1 Confirmed COVID-19 positive patients, or those with classic COVID-19 symptoms pending confirmatory PCR test (including those clinically positive, test negative patients)

COVID-Red	
High viral load in the area	
Infection Control Measures	Enhanced respiratory isolation precautions in a single-room or cohort.
Patient PPE	Patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised
Staff PPE	Donning and doffing of PPE should be completed in the designated areas. Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Enhanced PPE encouraged but not mandated (refer to section 3.2.3 for settings required) • Scrubs • FFP3 • Visor • Apron • Gloves Droplet PPE • FRSM • Eye protection • Apron • Gloves AGP PPE • Gown • Fit tested FFP3 face mask or powered respirator • Visor • Gloves
Patient placement	Non-AGP: COVID-19 cohort ward or isolation room with en suite facilities in specialist area. AGP: Isolation room, rediroom, ITU or respiratory HDU. If isolation room not available on a COVID-19 cohort ward discuss with clinical team and consider risk to other patients and staff along with other mitigating factors (curtains, ventilation, windows, and patients in FRSM etc.)
Special Measures	For ward and bay closures, use floor tape to distinguish hot and cold areas to support correct use and doffing of PPE. Ensure appropriate signage is in place to identify that bay or ward closed due to COVID cases.
Environment	Enhanced environmental cleaning and curtain change (if not on cohort ward) on discharge or transfer. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points. Crockery and cutlery should be removed from the single-room and taken directly into the kitchen for washing in dishwasher.

	Single use (disposable) equipment and supplies should be used where possible. If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Only the venepuncture/cannulation trollies on COVID-19 cohort and outbreak wards should be used. Phlebotomists must not take in their own phlebotomy trollies and equipment.
Linen	Manage all linen as infectious, use water-soluble and red linen bags.
Waste	Manage all waste as clinical waste. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
Visitor Arrangements	Current visitor arrangements as per Trust guideline

12. Patients requiring specialist care

12.1 Some COVID-19 positive patients will not be suitable to move to a COVID cohort ward. Examples include but are not limited to haematology, oncology, maternity and cardiology.

12.2 In these exceptional circumstances COVID-19 positive patients will remain in a single room with en suite facilities where possible following the COVID red pathway.

13. Categorising COVID-19 Risk for the Newborn

13.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU) – specifically if any AGP is required (including suctioning of the airway at birth). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

13.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

13.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/emergency green pathway
  - Standard PPE
- Mother positive – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother asymptomatic and maternal swab pending.
  - Low prevalence in local population – baby low/emergency green pathway
    - Standard PPE
    - Swab baby only if mother subsequently confirmed positive or baby becomes symptomatic
  - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway
    - Airborne PPE for AGP
    - Droplet PPE for non-AGPs
    - Swab baby if admitted to NNU

- Baby swab negative – baby low/emergency green pathway
    - Standard PPE
- Baby swab positive – baby high/red pathway
    - Airborne PPE for AGP
    - Enhanced PPE for non-AGPs

14. Patient transfers

14.1 For COVID-19 Amber and Red pathways, where possible, all procedures and investigations should be carried out in the patient's single room or cohort. Only a minimal number of staff should be present in room during any procedures.

14.2 Only if clinical need dictates should patients be transferred to other departments and the following procedures then apply:

- the department must be informed in advance and prepare the room to receive an infectious or potentially infectious patient,
- the patient must be taken straight to, and return from the investigation/treatment room, and must not wait in a communal area,
- where possible patients should be at the end of a list to allow appropriate decontamination after any procedure,
- the patient should wear an FRSM - this will prevent large droplets being expelled into the environment by the wearer
- portering and escort staff should wear droplet PPE and should be kept to a minimum,
- the trolley/chair should be cleaned with Chlorclean or Clinell Universal Wipes after use,
- staff carrying out procedures should wear the PPE as detailed in sections 10.
- the treatment/procedure room and all equipment should be cleaned with Chlorclean or Clinell Universal Wipes after use
- when a recovered patient is transferred off the COVID-19 positive ward, they should be transferred on a clean bed or in a wheelchair

15. Imaging

15.1 For COVID-19 Amber and Red pathways, where possible clinically essential imaging should be performed at the patient's bedside by imaging staff wearing appropriate PPE (see section 10).

15.2 Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room or bay. The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE. The operator should wear PPE as described in section 10 and 11 when in the isolation room or cohort bay/ward.

15.3 Any equipment taken in to the room which must be subsequently removed, must be cleaned with Chlorlean or Clinell Universal wipes. Any additional items such as ultrasound probes or a cassette will also need to be cleaned, regardless of whether there has been direct contact with the patient or not.

15.4 The management of patients requiring more complex imaging (e.g. CT) will be dealt with on a case-by-case basis in consultation with the Infection Prevention and Control and clinical teams.

16. Cleaning

16.1 Decontamination and cleaning must be conducted wearing PPE, appropriate to the level of isolation (standard, droplet, enhanced or AGP PPE) as per COVID-Green, COVID-Amber and COVID-Red.

16.2 When cleaning single-rooms in COVID-Amber or Red zones, if the last clinical procedure in the room was aerosol generating and the cleaning is required immediately (within 1hour) the staff attending the clean are required to wear AGP PPE (fit tested FFP3).

16.3 In the absence of obvious contamination with blood or bodily fluids, the room and equipment of Amber and Red patients should be cleaned at least twice-daily with a neutral detergent followed by a bleach solution (1,000 ppm chlorine, using Chlorclean or Tristel).

17. Waste

17.1 Waste must be disposed of in accordance with Trust policy.

17.2 All waste bags should be tied and sealed before removal from the patient area. Gloves and disposable plastic aprons should be worn when handling all clinical waste and hand decontamination performed after removal of gloves.

17.3 Liquid waste such as urine and faeces can be safely disposed of into the sewerage system

18. Linen

18.1 Linen should be classified as infected.

18.2 All staff handling linen will be required to wear gloves and apron. Hand hygiene should be performed after removal of gloves.

19. Staff

19.1 Staff involved in the care of COVID-19 patients should avoid working in other parts of the hospital. Staff movement between wards must be limited where possible.

19.2 Staff must comply with all infection control procedures as detailed above.

19.3 Staff are required to comply with the COVID-19 preventative measures ‘hands, face, space’

19.4 The Trust recognises that staff may feel apprehensive about their involvement in the care of a patient with suspected or confirmed COVID-19. However, with the appropriate PPE and training provided, and as long as there is no medical reason preventing the wearing of PPE, the Trust would expect all staff to carry out their normal work. This is line with their job description and where relevant, professional codes of conduct. Where a member of staff has on-going concerns, personal support is available via the Occupational Health Department on extension 5800.

Appendix 1 - Aerosol Generating Procedures – PHE guidance

1. The following are procedures that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

    - tracheal intubation and extubation
    - manual ventilation
    - tracheotomy or tracheostomy procedures (insertion or removal)
    - bronchoscopy
    - dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
    - non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
    - high flow nasal oxygen (HFNO)
    - high frequency oscillatory ventilation (HFOV)
    - induction of sputum/chest physio using nebulised saline
    - respiratory tract suctioning
    - upper ENT airway procedures that involve respiratory suctioning
    - upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
    - high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. From 11/05/2020, the trust will follow the resus council guidance for resuscitation; hence AGP PPE is available on resus trollies in the hospital setting

Royal Devon and Exeter NHS Foundation Trust

Guideline for PPE use and management of suspected and confirmed COVID-19

Post holder responsible for Procedural Document	[redacted], Consultant Nurse, Infection Control [redacted], Consultant in Medical Microbiology and Infection, Infection Control Doctor
Author of Standard Operating Guideline	[redacted], Consultant in Medical Microbiology and Infection
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
Contact details	[redacted]
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Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

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Version	Date	Author (Title not name)	Reason
1	03/04/2020	Consultant in Medical Microbiology and Infection	New document in response to COVID19
1.1	22/04/2020	Consultant in Medical Microbiology and Infection	Update details and addition of appendix 3 and 4
1.2	11/05/2020	Consultant in Medical Microbiology and Infection	Addition of definitions section. Restructure sections of PPE. Addition of risk assessment for AGP PPE in non-COVID-19 patients. Update of distance from AGP for AGP PPE as per PHE (1 to 2m). AGP PPE changed from eye/face protection to full face shield. Removal of LMA insertion/extraction as AGP. Appendix 1 = Addition of NNU exclusion and addition of resus guidance. Appendix 2 = Additions to list of non-AGPs. Appendix 3 = removal of Scrubs/uniform and addition of PPE summary table
1.22	04/06/2020	Consultant in Medical Microbiology and Infection	Neonatal exceptions amended in appendix 1
2.0	15/06/2020	Consultant in Medical Microbiology and Infection	Masks/face coverings for all staff, patients and visitors in non-COVID-19-Secure areas.
3.0	28/09/2020	Consultant Nurse/DIPC	Updated in line with revised PHE guidance
3.1	04/11/2020	IPCN/Consultant Nurse	Amendment of COVID secure guidance, FRSM and eye protection use.
4.0	22/12/2020	Consultant in Medical Microbiology and Infection & Consultant Nurse, IPC	Change to enhanced PPE (FFP3) for care of COVID patients. Title change Addition of information relating to waste, linen, cleaning, visitors and staff

Associated Trust Policies/ Procedural documents:	PHE guidance COVID-Secure guidelines
Key Words:	COVID-19, Personal protective equipment, PPE Universal precautions
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1. Introduction

1.1 This guidance has been specifically produced in response to the outbreak of novel coronavirus, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS-CoV-2), and the associated disease COVID-19. The outbreak originated in Wuhan province in China on 31st December 2019 and since then cases have been exported to other countries, including the United Kingdom.

1.2 Infection prevention and control (IPC) precautions, including hand hygiene and personal protective equipment (PPE), are essential to help protect staff, patients and visitors during the COVID-19 pandemic.

1.3 Transmission of Coronavirus Infectious Disease 2019 (COVID-19) is via large respiratory droplets and direct or indirect contact with respiratory secretions. Symptoms include influenza-like illness of acute onset or acute respiratory distress syndrome. The incubation period is 0- 14 days. Correct use of appropriate Personal Protective Equipment and adherence to protective measures such as correct hand washing reduces the risk of transmission of infection between the patients, healthcare workers and visitors

2. Key Messages

2.1 Transmission of Coronavirus Infectious Disease 2019 (COVID-19) is via large respiratory droplets and direct or indirect contact with respiratory secretions. The incubation period is 0-14 days.

2.2 Patients with recent travel history to Denmark or South Africa (within the last 14 days) requiring inpatient admission should be admitted directly into a negative-pressure single-room and managed under COVID-Red precautions. On-Call Microbiology Consultant and IPCT to be informed immediately.

2.3 All non-elective patients, including patients undergoing pre-operative assessment, will be screened for COVID-19 on admission, and re-screened on day 3 and 5 of admission. All inpatients require COVID-19 screening every 5 days thereafter for the duration of their inpatient admission.

2.4 Patients admitted with symptoms of COVID-19 will be screened and nursed in COVID-Amber zones, under droplet isolation precautions.

2.5 One viral respiratory swab is required for COVID-19 laboratory testing.

2.6 Patients should be offered a fluid-resistant surgical masks to wear until a negative COVID-19 result is known, on transfer throughout the hospital and when clinically tolerated without compromising care.

2.7 Fluid-resistant surgical masks must be worn at all times by all members of staff

2.8 Droplet Personal Protective Equipment should be used in COVID-Amber zones: fluid-resistant surgical mask and eye protection with the addition of gloves and apron for exposure to bodily fluids.

2.9 Single-use enhanced respiratory PPE should be used in COVID-Red zones: apron, FFP3 respirator masks, eye protection and gloves, with the addition of a long sleeved gown for prolonged patient contact.

2.10 When completing Aerosol Generating Procedures (AGP) wear single-use AGP PPE as per COVID-Red. AGPs for COVID-19 negative patients should be completed wearing droplet PPE (COVID-Amber).

2.11 Enhanced environmental cleaning using chlorclean or hydrogen peroxide vapour solution is required, along with a curtain change on discharge. The number of visitors should be minimised to essential only as per Trust visiting guidelines.

2.12 Adhere to COVID-19 preventative measures at all times*: 'hands, face, space'*

3. Definitions

3.1 **SICP** – Standard Infection Control Precautions are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources include, blood and other body fluids, non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times, for all patients/individuals whether infection is known to be present or not. SICPs include hand and respiratory hygiene, frequent surface decontamination of environment and equipment, and social distancing.

3.2 **TBP** – Transmission Based Precautions are additional precautions to be used in addition to SICPs when caring for patients/individuals with a known or suspected infection and are required when caring for patients/individuals with known or suspected COVID-19. These are referred to throughout the guidance and take into consideration the additional precautions required for contact, droplet and airborne spread of COVID-19 and the PPE required by health and care staff.

- **Contact precautions**
  - Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).

- **Droplet precautions**
  - Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.

- **Enhanced PPE**
  - A combination of droplet and airborne precautions for use in COVID-19 positive cohort and outbreak wards.

- **Airborne precautions**
  - Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level.

3.3 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of tiny droplets of fluid from the respiratory tract. These go into the air and may be breathed in or can settle on surfaces where infectious particles can live for a few days if not removed by ventilation or cleaning. AGPs are associated with an increased risk of respiratory transmission. A full list of AGPs can be found in appendix 1.

3.4 **COVID-19 Secure** – single staff occupancy, non-clinical environments that require signage at entry points to notify people of the status. Only staff in these areas who are on their own are able to remove their masks.

4. Personal Protective Equipment (PPE)

4.1 Staff must be trained and confident in the use and removal of PPE. Training and refresher sessions are available from the Learning and Development Team. Refer to instruction posters on safe removal of PPE.

4.2 Following removal, PPE will need to be disposed of as clinical infectious waste in waste bags.

4.3 **Gloves** must:

- be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- be changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never replace hand hygiene

Double gloving is **NOT** recommended for routine clinical care of COVID-19 cases.

4.4 **Aprons** must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres as per droplet and standard precautions
- changed between patients and/or after completing a procedure or task
- used in conjunction with thorough hand and arm washing up to the elbow.

4.5 **Gowns** must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

The Trust uses both disposable and re-usable gowns. Ensure that you know which you are using and do not dispose of reusable gowns, nor put disposable gowns in the linen bin.

4.6 **Eye or face protection** (goggles or visor) must:

- not be touched when being worn, nor pushed into the hair or onto the forehead
- be worn to protect mucous membranes
- be worn when delivering care within 2 metres of all patients (inpatients, outpatients and day cases) regardless of the pathway they are on.
- If Perspex screens are in place e.g at reception desks then eye protection is not required but can be worn if desired
- regular corrective spectacles are not considered eye protection

Each ward area should have eye protection cleaning stations.

Eye protection is considered contaminated after any patient contact. This is a transmission risk until the eye protection is cleaned.

4.7 **Fluid resistant surgical face mask** (FRSM Type IIR) masks must:

- be worn at all times in all clinical areas
- be worn at all times in non-clinical areas unless staff are alone in an office environment.
- be well-fitting and fit for purpose, fully cover the mouth and nose not touched once put on or allowed to dangle around the neck or off ear
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through

If an FRSM does need adjusting hand hygiene should be performed immediately afterwards.

4.8 **FFP3 (filtering face piece) or Powered respirator** should:

- be fit tested and fit checked
- always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient/individual
- 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 patient's/individual's room or cohort area or COVID-19 ward
- valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated. An FRSM is not required over the top of a valved FFP3 face mask.
- where fit testing fails, suitable alternative equipment must be provided such as a powered respirator, or the healthcare worker should be moved to an area where FFP3 respirators for AGPs are not required. Staff can continue to work in enhanced PPE using fit checked masks but not engage with AGPs.
- for AGPs the FFP3 is required to provide its designated approved protection factor (APF) and MUST be fit tested
- where the FFP3 is used as part of enhanced PPE it is to provide a mask with increased levels of filtration over an FRSM and a more secure fit. It should ideally be fit tested, but for staff not yet fit tested the mask with the best fit should be selected and a fit check performed prior to use. Staff should seek fit testing at the first available opportunity.

4.9 **Head/footwear**

- There is currently insufficient evidence around the use of hair and shoe coverings. They do not need to be worn routinely in COVID-19 areas (even if undertaking an AGP.
- Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres

5. Eating and Drinking

5.1 Face masks should be removed for eating or drinking, following correct removal/doffing process with appropriate hand hygiene and only when 2 metre social distancing can be maintained.

5.2 Eating and drinking should be limited to your break periods for staff wearing masks in sessional periods.

5.3 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.4 A clean mask should be put back on immediately after eating, unless in a COVID-19 Secure area. You may need to bring a clean mask with you in a clean container to enable you to do this. The approach of wearing a mask at all times (except COVID-19 Secure areas), removing and discarding it to eat, and then putting on a clean mask, with appropriate hand hygiene, applies where ever you plan to eat, even outside areas on Trust grounds.

6. PPE for Visitors (including outpatients)

6.1 Visitors to clinical sites will be expected to arrive wearing a cloth face covering (CFC) as a minimum. Patients attending the Emergency Department will be encouraged to wear a FRSM and provided with one on arrival.

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment which must be documented in their electronic patient record.

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Hand hygiene and education on donning and doffing a mask/face covering will be provided at some entrances to clinical areas.

6.5 Ideally visitors should not be present during AGPs, but in the rare event they are, they should be offered the same level of PPE as staff. This excludes end of life visiting in ICU where visitors must wear a FRSM and be offered an apron.

7. PPE for Inpatients

7.1 All inpatients should be given an FRSM to wear, if they can tolerate it.

7.2 Patients should be given an information leaflet on mask use to guide its safe use, including hand hygiene, storage and disposal.

7.3 Patients wearing masks should be encouraged to wear them for sessional periods, ideally four hours, changing the mask when wet, soiled, damaged or uncomfortable.

8. COVID-19 Care Pathways

8.1 All clinical areas are required to comply with social distancing measures, including social distancing within patient bays. The bed-spaces should be minimum 2 meters apart and curtains should be drawn between patients as far as is safe. Patients should not be wandering through clinical areas and should be encouraged to remain within their bed-space. If possible and clinically safe, patients should be encouraged to wear fluid-resistant surgical face masks if they are away from their bed-space.

9. Low Risk (Emergency and Elective Green) Pathway

9.1 Patients who are PCR negative and been shielding, or patients who are PCR negative on the first, third and fifth days of admission.

COVID-Green	
Clinical areas with no suspected cases of COVID-19 to include patients with resolved COVID-19 infection	
Infection Control Measures	Standard Precautions for every patient, every time.
Personal Protective Equipment	Within 2 metres of a patient: fluid-resistant surgical mask and eye protection. Not within 2 metres of a patient: fluid-resistant surgical mask.
Environmental Cleaning	Routine environmental cleaning as per local practice.
Linen	Routine linen management practices as per Trust guidelines.
Waste	Routine waste management practices as per Trust guidelines.
Visitor Arrangements	Current visitor arrangements as per Trust guideline.

Special Measures	Location of donning and doffing of PPE should be consistent with the clinical activity and risk. Aerosol generating procedures for patients confirmed as COVID-19 negative should be completed using droplet precaution PPE (unless other respiratory infections such as TB): - Apron, - FRSM, - Eye protection - Gloves.

9.2 Infection control measures for COVID-Green:

- Continue with standard precautions for every patient, every time.
- Continue to review clinical alerts for newly admitted patients and carry out required actions for the clinical alerts.
- Symptomatic patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised (such as when receiving oxygen therapy).
- Crockery and cutlery should be washed in dishwasher. In case of dishwasher fault and pending repair, dishes can be taken across to the nearest COVID-Green zone for washing.

10. Medium Risk (Amber) Pathway

10.1 Patients whose COVID PCR status is unknown, or who have not yet had a day 5 negative PCR, and have no classic symptoms of COVID. Identified COVID-19 contacts

COVID-Amber	
Unknown or Suspected cases, COVID contacts and low viral load in the area	
Infection Control Measures	Droplet isolation precautions in single-room for suspected cases. Droplet precautions for COVID contacts in bays and single rooms. Dedicated clinical equipment to be cleaned before and after every use with chlorclean or clinell universal wipes.
Personal Protective Equipment	FRSM and eye protection with the addition of gloves and apron for exposure to bodily fluids.

Special Measures	Donning and doffing of PPE should be complete in the designated areas Aerosol generating procedures for unknown or suspected cases of COVID-19 and contacts should be completed using the following single-use PPE as per COVID-Red: - long sleeved fluid repellent gown or apron, - FFP3 respirator, - face visor, - gloves.
Environmental Cleaning	Enhanced environmental cleaning, and curtain change on discharge. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points.
Linen	Manage all linen as infectious, use water-soluble and red linen bags.
Waste	Manage all waste as clinical waste.
Visitor Arrangements	Defer non-essential visits until patient's COVID-19 status is known. Current visitor arrangements as per Trust guideline

10.2 Infection control measures for COVID-Amber:

- Adhere to standard precautions and droplet transmission precautions.
- Continue to review clinical alerts for newly admitted patients and carry out required actions for the clinical alerts.
- Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning.
- Symptomatic patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised (such as when receiving oxygen therapy).
- Single use (disposable) equipment and supplies should be used where possible.
- If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system. For single-rooms without en suite facilities, commodes or bathrooms need to be designated for patient or bay use only.
- Crockery and cutlery should be removed from the single-room or cohort and taken directly into the kitchen for washing in dishwasher
- Confirmed cases will be transferred to COVID-Red areas, confirmed cases will be cohorted in bays with closed doors
- If patients are nursed in a bay with droplet isolation precautions around their bed-space due to clinical needs, curtains should be drawn as far as it is safe to do so.
- For ward closures, use floor tape to distinguish clean and dirty areas to support correct use and doffing of PPE.
- Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.

11. High Risk Pathway (Red and Unconfirmed Red)

11.1 Confirmed COVID-19 positive patients, or those with classic COVID symptoms pending confirmatory PCR (including those clinical positive, test negative patients)

COVID-Red	
High viral load in the area and/or completion of Aerosol Generating Procedures. Patients within 14 days of travel from Denmark requiring inpatient admission (admit into a negative pressure single-room only).	
Infection Control Measures	Enhanced respiratory isolation precautions in a single-room or cohort.
Personal Protective Equipment	Donning and doffing of PPE should be complete in the designated areas, 1. Enhanced PPE – scrubs, apron, gloves, FFP3 respirator and face visor 2. AGP PPE and PPE for prolonged, direct patient contact – scrubs, long sleeve apron or gown, single use apron, gloves, FFP3 respirator and face visor
Special Measures	Strongly suspected cases are defined by history of close contact with confirmed case of COVID-19 and meeting clinical criteria.
Environmental Cleaning	Enhanced environmental cleaning, and curtain change on discharge. Use chlorclean with disposable mops and cloths or hydrogen peroxide vapour. Increase frequency of cleaning of frequently touched points.
Visitor Arrangements	Current visitor arrangements as per Trust guideline

11.2 Infection control measures for COVID-Red:

- Adhere to standard precautions and droplet transmission precautions.
- Continue to review clinical alerts for newly admitted patients and carry out required actions for the clinical alerts.
- Essential clinical equipment should be allocated to the single-room, unnecessary equipment needs to be removed and cleaned to declutter the room and facilitate environmental cleaning.
- Symptomatic patients should wear a surgical face mask, unless there is potential for their clinical care to be compromised (such as when receiving oxygen therapy).
- Single use (disposable) equipment and supplies should be used where possible.
  If possible, patients should use en suite toilet facilities. For non-ambulant patients, disposable bedpans should be used. Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.
- Crockery and cutlery should be removed from the single-room and taken directly into the kitchen for washing in dishwasher.
- Confirmed cases will be transferred to COVID-Red zone and cohorted in bays with closed doors as directed by the IPCT.

- For ward closures, use floor tape to distinguish clean and dirty areas to support correct use and doffing of PPE.

- Ensure appropriate signage is in place to identify that bay or ward closed due to COVID contacts.

- De-escalation of COVID-19 patients should be carried out based on their clinical condition,

12. Patients requiring specialist care

12.1 Some COVID-19 positive patients will not be suitable to move to a COVID cohort ward. Examples include but are not limited to haematology, oncology, maternity and cardiology.

12.2 In these exceptional circumstances COVID-19 positive patients will remain in a single room with en suite facilities where possible following the COVID red pathway.

13. Categorising COVID-19 Risk for the Newborn

13.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU) – specifically if any AGP is required (including suctioning of the airway at birth). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

13.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

13.3.1 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/emergency green pathway
  - Standard PPE
- Mother positive – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother asymptomatic and maternal swab pending.
  - Low prevalence in local population – baby low/emergency green pathway
    - Standard PPE
    - Swab baby only if mother subsequently confirmed positive or baby becomes symptomatic
  - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway
    - Airborne PPE for AGP
    - Droplet PPE for non-AGPs
    - Swab baby if admitted to NNU
- Baby swab negative – baby low/emergency green pathway
  - Standard PPE
- Baby swab positive – baby high/red pathway
  - Airborne PPE for AGP
  - Enhanced PPE for non-AGPs

14. Patient Transfers

14.1 For COVID-19 Amber and Red pathways, where possible, all procedures and investigations should be carried out in the patient's single room or cohort. Only a minimal number of staff should be present in room during any procedures.

14.2 Only if clinical need dictates should patients be transferred to other departments and the following procedures then apply:

- the department must be informed in advance and prepare the room to receive an infectious or potentially infectious patient,
- the patient must be taken straight to, and return from the investigation/treatment room, and must not wait in a communal area,
- where possible patients should be at the end of a list to allow appropriate decontamination after any procedure,
- the patient should wear a FRSM - this will prevent large droplets being expelled into the environment by the wearer
- portering and escort staff should wear droplet PPE and should be kept to a minimum,
- the trolley/chair should be cleaned with Chlorclean or Clinell Universal Wipes after use,
- staff carrying out procedures should wear the PPE as detailed in section XX,
- the treatment/procedure room and all equipment should be cleaned with Chlorclean or Clinell Universal Wipes after use

15. Imaging

15.1 For COVID-19 Amber and Red pathways, where possible clinically essential imaging should be performed at the patient's bedside by imaging staff wearing appropriate PPE (see section XX).

15.2 Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room or bay. The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE. The operator should wear PPE as described in section XX when in the isolation room or cohort bay/ward.

15.3 Any equipment taken in to the room which must be subsequently removed, must be cleaned with Chlorlean or Clinell Universal wipes. Any additional items such as ultrasound probes or a cassette will also need to be cleaned, regardless of whether there has been direct contact with the patient or not.

15.4 The management of patients requiring more complex imaging (e.g. CT) will be dealt with on a case-by-case basis in consultation with the Infection Prevention and Control and clinical teams.

16. Cleaning

16.1 Decontamination and cleaning must be conducted wearing PPE, appropriate to the level of isolation (standard, droplet or enhanced respiratory PPE) as per COVID-Green, COVID-Amber and COVID-Red.

16.2 When cleaning single-rooms in COVID-Amber zones, if the last clinical procedure in the room was aerosol generating and the cleaning is required immediately (within 1hour) the staff

attending the clean are required to wear single-use AGP PPE as per COVID-Red. All domestic staff in COVID-Red zones are required to wear single-use enhanced PPE as per the infection control measures.

16.3 Domestic Services will remain responsible for cleaning the isolation room or cohort bay for patients with suspected COVID-19.

16.4 For patients with confirmed COVID-19, a small dedicated team of Domestic Services staff will be available who are trained in the use of appropriate PPE. The disposable cleaning system will be used throughout the duration of the patient's stay, and will be disposed as infectious waste.

16.5 In the absence of obvious contamination with blood or bodily fluids, the room and equipment should be cleaned twice-daily with a neutral detergent followed by a bleach solution (1,000 ppm chlorine, using Chlorclean). There should be more frequent cleaning of commonly used hand-touched surfaces (at least twice per day).

16.6 Following patient discharge, the room, bay or ward should receive an enhanced 'terminal' clean with either Chlorclean or Hydrogen Peroxide Vapour and a curtain change.

17. Waste

17.1 Waste must be disposed of in accordance with Trust policy.

17.2 All waste bags should be tied and sealed before removal from the patient area. Gloves and disposable plastic aprons should be worn when handling all clinical waste and hand decontamination performed after removal of gloves.

17.3 Liquid waste such as urine and faeces can be safely disposed of into the sewerage system.

18. Linen

18.1 Linen should be classified as infected. The linen should be put in the water soluble bag and red bag inside the isolation room or cohort prior to transfer to the linen disposal room.

18.2 All staff handling linen will be required to wear gloves and apron. Hand hygiene should be performed after removal of gloves.

19. Visiting family and friends

19.1 The following should be observed for visitors of patients with COVID-19:

- The number of visitors should be restricted to exclude all but essential visitors
- Close contacts of a probable or confirmed case should be screened for signs and symptoms and seek further advice from NHS 111 whilst self-isolating.
- Visitors entering the isolation room must wear PPE as detailed in section XX.
- Visitors should be assisted in the correct application and removal of PPE
- Appropriate information should be given to family or other contact of patients with COVID-19

20. Staff

20.1 Staff involved in the care of COVID-19 patients should avoid working in other parts of the hospital. Staff movement between wards must be limited where possible.

20.2 Staff must comply with all infection control procedures as detailed above.

20.3 Staff are required to comply with the COVID-19 preventative measures ‘hands, face, space’

20.4 The Trust recognises that staff may feel apprehensive about their involvement in the care of a patient with suspected or confirmed COVID-19. However, with the appropriate PPE and training provided, and as long as there is no medical reason preventing the wearing of PPE, the Trust would expect all staff to carry out their normal work. This is line with their job description and where relevant, professional codes of conduct. Where a member of staff has on-going concerns, personal support is available via the Occupational Health Department on extension 5800.

Appendix 1 - Aerosol Generating Procedures – PHE guidance

1. This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

    - tracheal intubation and extubation
    - manual ventilation
    - tracheotomy or tracheostomy procedures (insertion or removal)
    - bronchoscopy
    - dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
    - non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
    - high flow nasal oxygen (HFNO)
    - high frequency oscillatory ventilation (HFOV)
    - induction of sputum/chest physio using nebulised saline
    - respiratory tract suctioning
    - upper ENT airway procedures that involve respiratory suctioning
    - upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
    - high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

2. The following procedures may generate an aerosol from material other than patient secretions and that are not considered to represent a significant infectious risk.

    - Administration of pressurised humidified oxygen;
    - Administration of medication via nebulisation.
    - Removal of plaster casts
    - Insertion and removal of Nasogastric (NG) tubes
    - Insertion and removal of Radiologically Inserted Gastrostomy (RIG) tubes
    - CT guided lung biopsies

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. From 11/05/2020, the trust will follow the resus council guidance for resuscitation; hence AGP PPE is available on resus trollies in the hospital setting

Northern Devon Healthcare NHS Trust

Royal Devon and Exeter NHS Foundation Trust

COVID-19 CLINICAL GUIDANCE: COVID-19: Guidance for the remobilisation of services within health and care settings

Summary of recommendation for change/development:

Changes to National IPC Guidance as it potentially applies to both RD&E and NDHT

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The main changes to the national guidance are:

1. Local and national prevalence and incidence data will be used to guide returning services as advised by Country specific/public health organisations.

2. Patients/individuals to be managed in 3 COVID-19 pathways, high, medium and low risk.

    - **High risk**: Patients/individuals with confirmed positive SARS-CoV-2 (COVID-19), symptomatic or suspected COVID-19 or symptomatic individuals who decline testing. There is no change in recommendations for IPC or for the use of PPE by staff when managing patients/individuals who have, or are likely to have, COVID-19.

    - **Medium risk**: Patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 PCR test result.

    - **Low risk**: Patients/individuals with no symptoms and a negative COVID-19 PCR test who have self-isolated prior to admission, for example following NICE guidance

3. Sessional use of single use PPE items has been minimised and only applies to extended use of facemasks for healthcare workers.

4. The use of facemasks (for staff) and face coverings (if tolerated by the individual) is recommended in England and Scotland, in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce transmission risk.

5. Physical distancing of 2 metres is considered standard practice in all health and care settings.

6. Patients/individuals on a low risk pathway require Standard Infection Prevention & Control Precautions for surgery or procedures.

Suggested pathway following Joint CRG 10 September 2020:-

	Confirmed or clinically positive COVID-19 OR Symptomatic and declined testing	Suspected COVID-19 with possible symptoms waiting a result	Asymptomatic and waiting a COVID-19 result OR Asymptomatic and declined testing OR Asymptomatic and testing not required	Asymptomatic and negative COVID-19 result	Negative COVID-19 result and self-isolated since test date
Proposed NDHT/RDE Pathway	**RED**	**UNCONFIRMED RED**	**AMBER**	**EMERGENCY GREEN**	**ELECTIVE GREEN**
Updated PHE guidance	High/Red		Medium/Amber		Low/ Green
Current NDHT	Blue			Green	Green
Current RDE	Red/High	Amber/ Intermediate	Green/Low	Green/Low	Blue
UHP	High / Red	Amber	Amber	Green	
SDFT	Blue	Red	Amber	Green	

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 CLINICAL GUIDANCE: Managing Volunteer and Patient Visits to the NIHR Exeter Clinical Research Facility	
Post holder responsible for Procedural Document	[redacted] NIHR Exeter CRF Manager
Author of Guideline	[redacted] R&D Director [redacted] Scientific Director NIHR Exeter CRF [redacted] Director Joint Research Office
Division/ Department responsible for Procedural Document	Research and Development
Contact details	[redacted]
Date of original policy / strategy/ standard operating procedure/ guideline	September 2020
Impact Assessment performed	Yes/ **No**
Approving body and date approved	Clinical Reference Group: Chair's approval 19 October 2020
Review date (and frequency of further reviews)	September 2021
Expiry date	December 2021
Date document becomes live	20 October 2020

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience	✓	Maintain Operational Service Delivery	✓
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1.0	18/09/2020	R&D Director, Scientific Director NIHR CRF & Director Joint Research Office	New document

Associated Trust Policies/ Procedural documents:	Infection Prevention & Control Policy Standards of Business Conduct Policy COVID Hub Page
Key Words:	COVID, research, Clinical Research Facility
In consultation with and date: R&D Governance and Oversight Group R&D Group University of Exeter College of Medicine and Health Clinical Reference Group : TBC	
Contact for Review:	Andrew Hattersley, Angela Shore and Helen Quinn

CONTENTS

1. INTRODUCTION

1.1 As the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as "the Trust") moves into the recovery phase with an increase in research onsite, the health, safety and wellbeing of our patients, communities, individuals and teams remains our absolute priority. This document considers the management of volunteer and patient visits to the National Institute of Health Research (NIHR) Exeter Clinical Research Facility (CRF) to reduce the risk of transmission of COVID-19 to volunteers and patients by asymptomatic healthcare staff or vice versa.

1.2 This guideline covers all NIHR Exeter CRF rooms. All staff of the Trust and University of Exeter who work in the CRF or whose patients/research volunteers are seen for research visits in the CRF outpatients should be aware of this guideline.

1.3 The NIHR Exeter CRF is a collaboration between the Trust and the University of Exeter (hereafter referred to as the University). The facility is designed to support the development and delivery of early phase trials and experimental medicine clinical studies as well as providing three rooms designated for clinical research network use to support the delivery of later phase research (CRF rooms 1-3). Both healthy volunteers and patients supporting experimental medicine studies as well as patients enrolled in early and later phase clinical trials therefore visit the facility.

1.4 Participation in clinical research is voluntary and is not designed to offer an individual participant a health benefit, rather it relies on patients taking part knowing that they will advance knowledge which may later lead to improved clinical care but they will not necessarily gain health benefit themselves. This differs from normal visits to hospital where the individual gains health benefits from diagnostic investigations or treatment in standard clinical settings. Research also often requires participants to be in close contact with researchers for prolonged social distancing is not possible.

1.5 In the setting described in 1.4 the proposed plan takes account of the need to provide capacity to deliver trials as well as ensuring that volunteers and patients taking part in experimental medicine studies consider the CRF to be a safe environment to visit. This guidance is additional to other Trust requirements.

2. PURPOSE

2.1 To introduce measures that minimise the risk of volunteers and patients contracting COVID-19 when attending the NIHR Exeter NIHR CRF for experimental medicine projects, and early and late phase clinical trials.

2.2 To minimise risks to NHS and University staff of contracting COVID-19 from research volunteers and patients attending for research studies or from each other.

3. DUTIES AND RESPONSIBILITIES OF STAFF

3.1 It is the duty and responsibility of all Trust and University staff utilising the NIHR Exeter CRF to adhere to this guideline.

4. GUIDANCE

4.1 Regular safety briefings will be provided to staff working in the CRF to ensure all staff are up to date with Trust guidance specifically: infection prevention and control (IPC) training, briefing on COVID-19 specific information including access and exit to the CRF, using the one-way system and not attending work if unwell.

4.2 Staff working in the CRF will be tested for COVID-19 in line with the current local RD&E patient and staff testing strategy.

4.3 Hand sanitisation stations will be in place at all entrances to the facility.
Infection control personal protective equipment (PPE) is provided to all users of the CRF. All users are required to wear Type IIR fluid resistant surgical face masks on arrival at the building. Any users who arrive at the department without appropriate face coverings will be provided with them before entering.

4.4 Current Trust guidelines on social distancing will be applied and enforced.

4.5 COVID-19 secure compliance assessments will be undertaken across the facility and monitored weekly.

4.6 All volunteer/patient visits to the CRF must be kept short with as many protocol requirements as possible being conducted remotely prior to the visit to the CRF. It is anticipated that visits to CRF rooms 1-7 will be limited to <1 hour, with expected exceptions noted on a study by study basis.

4.7 In order to reduce exposure to COVID -19, staff who are working in/ attend the main hospital footprint will see patients in the CRF clinic rooms 1-7.

4.8 Staff working in the main hospital footprint will not use the CRF wards, single investigation rooms (CRF rooms 10-15), diabetes and vascular research centre (DVRC) unless a specific exception has been applied for and approved (see 4.11 below).

4.9 Where it is not possible for a study to comply with 4.7 and 4.8, an application for an exception can be made to allow an individual who visits the main hospital template to work in the main CRF rooms. This will be considered only in exceptional circumstances. The following questions will need to be answered:

I. What is the aim of the study? This is to allow assessment of the potential for direct or indirect clinical benefit for the participant that will need to be balanced against the risks of taking part and contracting COVID-19 (however small these are)

II. What procedures / investigations must take place at a clinical visit where social distancing (1 M +) will be impossible?

III. Why this study must be done in either: the main CRF wards, CRF single investigations rooms (CRF rooms 10-15) or DVRC and NOT in CRF rooms 1-7 or another clinical area elsewhere in the hospital? This should include what specific facilities/expertise are in these CRF areas but not available elsewhere.

IV. Describe exactly which areas of the CRF you are requesting access to, the CRF wards, CRF single investigations rooms (CRF rooms 10-15) or DVRC? Are the subjects likely to be of high risk of either catching COVID-19 (eg immune compromised) or are likely to have a bad outcome if they do get it (eg elderly, obese male subjects with diabetes, BAME individuals)

V. Does this study need to be undertaken by research nursing staff who work on/visit the main hospital footprint? Can this study be performed using research nursing staff from the CRF or CRN who do not work on the main hospital footprint?

VI. Does this study need to be undertaken by research medical staff who work on/visit the main hospital footprint? Can this study be performed using research medical staff from the CRF or CRN who do not work on the main hospital footprint?

VII. In the cases of the study not being able to be done by anyone else in reply to question V or VI, please state how the risk of infection would be minimised – i.e. by timing of visits, etc.

VIII. What is the expected number of patient visits in a month?

4.10 The application for exemption will be reviewed by the Directors of the CRF. The CRF Manager, R and D Manager and researchers will be advised of the outcome within five working days of their application as long as comprehensive answers are given to all points in 4.9 above.

4.11 Staff who are working/attending in the main hospital footprint should minimise contact with other CRF staff maintaining social distancing at all times, avoid entry to other CRF clinical rooms (other than the CRF rooms 1-7 or areas they have gained approval to access), offices or other common spaces and use the stairs adjacent to clinic rooms 1-7 to exit the facility (Stair 2.02).

4.12 Each procedure undertaken in the CRF must have been COVID-19 risk assessed by the study lead nurse together with the PI. Trust PPE and IPC procedures must be followed. Additional safety precautions will be routinely applied eg Perspex screens between volunteer and staff when completing supervised questionnaires.

4.13 All Volunteer/patient visits must be recorded on the CRF booking system (CRF Manager®).

4.14 All staff working on a particular subject visit must be recorded on the CRF booking system.

4.15 Patients/volunteers will receive an information sheet about the CRF COVID-19 security measures before their visit to the CRF (Appendix 1).

4.16 The volunteer/patient will have a symptom check telephone call the day (Appendix 2) before their scheduled visit during which they will be asked if they have any of the symptoms described on the current Trust COVID-19 symptom list and whether they have been in close contact with individuals with COVID-19. Individuals with symptoms or close contact with individuals with COVID-19 will have their proposed visit rearranged.

4.17 The volunteer/patient will be met at the RILD entrance and have a symptom check (Appendix 2). They will then be escorted to the CRF room for their appointment. Subjects will not enter the CRF without being escorted. At the end of their appointment, they will be escorted out of the building.

4.18 Only the volunteer/patient should enter the RILD building unless the volunteer/patient requires the support of a carer or is a child in which case one carer or a parent can accompany the volunteer/patient.

5. ARCHIVING ARRANGEMENTS

The original of this guideline will remain with the author. An electronic copy will be maintained on the Trust intranet. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

6. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE GUIDELINE

6.1 To evidence compliance with this policy, the following elements will be monitored:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
Patient/Volunteer/staff bookings on CRF system	Review of booking system for number and length of visits	CRF Senior Management Team
Applications for exceptional use of the CRF	Review of number, type and outcome of applications	CRF Senior Management Team and R&D Governance and Oversight Group
COVID-19 compliance assessments will be undertaken across the facility	Weekly review of compliance	CRF Senior Management Team

APPENDIX 1: Patients/volunteers will receive an information sheet about the CRF COVID-19

COVID -19 related information for your proposed Clinical research visit to the RILD

We understand that you may have concerns regarding your upcoming research visit, and we have taken the following steps to reduce the risk of COVID-19 while taking part in any of our studies.

- Face to face appointments have been reduced to only those that are essential.
- Where possible you will see only one member of staff for your study visit. This may not be possible for certain studies, and if so this will be discussed with you prior to your attendance.
- On the day before your visit, a member of your study team will telephone you to check for any symptoms of COVID -19 e.g. high temperature, a cough and/or a loss of sense of smell and taste. If you have any of these symptoms your visit will be postponed.
- The study team will remind you of the reason for your visit, what will happen during it, and confirm if you still wish to take part in the study. You may wish to withdraw at this point and your wishes will be respected.
- If you are happy to continue, you will be asked to confirm if you have a mobile telephone number for use on the day of your visit. If not arrangements for your visit will be confirmed during your pre-visit telephone call.
- On the day of your visit we will ask you to contact our reception on 01392 40 8181 to let us know when you arrive at the hospital site and we will arrange to meet you.
- You will be met by a member of your study team at the main entrance to the building hosting your visit.
- You will have been advised how to approach the main entrance in the accompanying site map.
- All visitors to the hospital site are required to wear a face covering as it is a designated public space. On entry to the specific research area we may ask you to change from your own mask to one of our disposable mask for the duration of your study visit. The member of staff who meets you will also be wearing a mask.
- Depending on the study you are taking part in, both you and the member(s) of staff seeing you may need extra personal protective equipment. If that is the case this will be explained to you both before and during the visit.
- You will be asked to use the hand sanitiser before entering the department.
- You will be guided through our one way system which has been set up to reduce contact with others and ensure social distancing is maintained. You will be taken straight to the room where your visit will take place undertaken.
- Should you need to use the toilet facilities you will be advised of the measures to be undertaken by the member of staff seeing you for your visit.
- At the end of your visit, you will be escorted out of the building via our one way system.

We have also made these changes.

- The research staff that see you for your visit will be covered by the COVID-19 staff surveillance required by the current local RD&E policies in place at the time of your visit.
- The staff looking after you will normally work only in the research areas.

- If the staff you are seeing do go to the main hospital site, you will be made aware of this prior to your attendance, so that you can decide whether or not you want to be seen by them.
- All room spaces will be cleaned before you visit and after you have left. The same area will not be used straight after the last person has left them, to allow enough time for cleaning before the next person attends.
- In the event of a case of COVID-19 amongst the staff that have seen you, you will be contacted and told to self-isolate as per guidelines in place at the time of your visit.

We hope this information helps to explain what to expect during your visit and the steps we have taken to adapt to reduce risk to you and our staff. If you have any queries, please discuss these prior to your visit with your research team

APPENDIX 2: COVID-19: symptom telephone checklist for participants *due* an appointment in the NIHR Exeter CRF

Participant Name: …….Study Name……

If your participant reports 'yes' to **any** of the items listed below during the COVID-19 symptom check telephone call (which takes place the day before their planned visit) the appointment must be re-arranged.

The participant must remain at home and follow current Government COVID-19 testing and isolation procedures.

Please tick appropriate box

Symptom	**Yes**	**No**
A high fever and/or a new cough	☐	☐
Experienced a loss of or change to sense of smell in the last 10 days	☐	☐
A member of their household has developed COVID-19 symptoms and they are self-isolating as a result	☐	☐
Your participant or a member of their household has tested positive for COVID-19 in the last 10 days	☐	☐
Your participant has been identified as a contact of COVID-19 through the test and trace process	☐	☐
Your participant is returning from a country that requires travelers to self-isolate for 14 days	☐	☐

If any box is ticked as 'yes' then the appointment must not proceed

Name of staff member undertaking check……..

Date symptoms checked……..……..…

Date of planned appointment…….....

COVID-19: symptom checklist for participants *arriving* for an appointment in the NIHR Exeter CRF

Participant Name: ……Study Name……

If your participant reports **any** of the items listed below on arrival for their appointment they should be asked to leave the building immediately. They must return home, follow current Government COVID-19 testing and isolation procedures. Their appointment will need to be re-arranged by telephone.

Please tick appropriate box

Symptom	**Yes**	**No**
A high fever and/or a new cough	☐	☐
Experienced a loss of or change to sense of smell in the last 10 days	☐	☐
A member of their household has developed COVID-19 symptoms and they are self-isolating as a result	☐	☐
Your participant or a member of their household has tested positive for COVID-19 in the last 10 days	☐	☐
Your participant has been identified as a contact of COVID-19 through the test and trace process	☐	☐
Your participant is returning from a country that requires travelers to self-isolate for 14 days	☐	☐

If any box is ticked as 'yes' then the appointment must not proceed

Name of staff member undertaking check……..

Date symptoms checked……..……..…

Date attendance/appointment…….....

APPENDIX 3: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the guideline	All staff involved in the care of patients and volunteers attending the NIHR Exeter CRF
The key changes if a revised document	NA
The key objectives	This document is to ensure that CRF volunteer and patient visits are managed in a manner that minimises risk of COVID-19 transmission.
How new staff will be made aware of the procedure/guideline and manager action	Cascade by email from CRF Operations Manager and R and D manager to all PIs/Research Teams whose patients/participants may use the CRF. Highlight policy at team meetings and briefings.
Specific Issues to be raised with staff	n/a
Training available to staff	n/a
Any other requirements	none
Issues following Equality Impact Assessment (if any)	None
Location of hard / electronic copy of the document etc.	*This document will be stored as an electronic copy in the COVID- 19 Documents section of the NIHR Exeter Clinical Research Facility Sharepoint site.*

APPENDIX 4: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	*COVID-19 CLINICAL GUIDANCE: Managing Volunteer and Patient Visits to the NIHR Exeter Clinical Research Facility*
Division/Directorate and service area	*Research and Development*
Name, job title and contact details of person completing the assessment	[redacted] *NIHR Exeter CRF Manager*
Date completed:	*18.09.2020*

The purpose of this tool is to:

- ***identify*** *the equality issues related to a policy, procedure or strategy*
- ***summarise the work done*** *during the development of the document to reduce negative impacts or to maximise benefit*
- ***highlight unresolved issues*** *with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.*

1. What is the main purpose of this document?
This document considers the management of volunteer and patient visits to the National Institute of Health Research (NIHR) Exeter Clinical Research Facility (CRF) to reduce the risk of transmission of COVID-19 to volunteers and patients by asymptomatic healthcare staff or vice versa

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	***Relevant***	***Not relevant***
Age	☐	☒
Disability	☐	☒
Sex - including: Transgender, and Pregnancy / Maternity	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – including: Marriage / Civil Partnership	☐	☒

4. ***Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…*** *(e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?*

Not relevant

5. ***Do you think the document meets our human rights obligations?*** ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

This guideline has been produced to supplement all processes currently in place to support all participants found to be appropriate for inclusion in a research study undertaken in the NIHR Exeter CRF. Issues related to support our equality / human rights / inclusion commitments are addressed at the point at which we commence a research project. This guideline does not change that responsibility or our commitment to make clinical research participation accessible to all patients of the Trust. The NIHR Exeter will be able provide an open and clear dialogue with all users of the service to ensure that their rights and wellbeing are taken into account at all stages of their involvement with the service provided by the CRF.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact *please note this below and how this will be monitored/addressed.*

"Protected characteristic":	*Not Applicable*
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Powered Respirator Provision

Summary of recommendation for change/development: to increase the availability of powered respirator provision at the RD&E prior to financial sign off through strategic command.

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	Adoption of Option 3 approved CRG 21 October 2020
Document Version:	V1.0
Date ratified by Gold Command:	Date
Date document becomes live:	Date

Introduction

The Trust acquired 32 JSP Jetstream powered respirators, as well as 8 MaxAir respirators prior to the first surge of COVID in spring 2020. These provided sufficient coverage during the first phase, but consumables for the devices have become hard to source. 30 Translas powered respirators have also been purchased for the Nightingale Exeter hospital.

Current Respirator Provision

30 working JSP Jetstream respirators with 2 months of consumables

- Jetstream is a belt-mounted rechargeable respirator with a large capacity TH2P dust filter.
- Jetstream delivers 180 litres/min of air through the filter via a flexible hose to the helmet.
- MK7 safety helmet (EN 397) with a full-face polycarbonate visor (EN 166 1.B) helmet.
- Adjustable helmet, with a skirt that covers under the neck.
- Re-chargeable battery offers 8 hours continuous use (requires 18 hours charging).
- Adjustable waist belt and power unit weighs just 765g.
- Approved to EN 12941.
- Filter- TH2P offers assigned protection factor (APF) of 20 x Workplace Exposure Limit (WEL) for very fine dusts and fibres.
- Alarm system on blower unit.

2 working MaxAir respirators with 10 days of consumables

- Disposable hood - full 360 contact protection and covers to waist (with ties)
- Integrated helmet design that is hose-free
- Air pulled in by motor under the filter cover cap, then through the filter and cleansed
- Clean air passes through motor-blower and down laminar flow channel to front diffusers and air outlet
- Diffused, clean, cool air passes down around wearers' face and CO2 exhausted automatically
- Air diffusers assist in low noise operation, typically less than 62dB
- Evenly dispersed air for comfort and anti-lens fogging
- Easy grasp-and-turn rachet to adjust head circumference to secure the helmet to your head
- Front mounted LED's display critical information from system/airflow computer controller
- Adjustable waist belt with attachable small battery and lead
- Re-chargeable battery offers 8-10 continuous use (requires 8 hours charging).

30 Translas respirators with 200 filters (8 days)

- Protective hood with composite fabric that covers both neck and shoulders
- Adjustable helmet
- FreFlow V1 PAPR delivers between 165-210 litres/min of air through the filter via a flexible hose to the protective hood
- TH-2 filter system consists of a metal mesh, pre-filter and particle filter (P3 filter)
- Approved to EN 12941

Fit Testing

Health and Safety have taken over fit testing and have proactively provided extensive testing with minimal failures. There are very few individuals who truly need a powered respirator due to failure to fit test. There are certain procedures that require a powered respirator to enable safe working, but most of these procedures are now pre-tested and test negative patients do not need AGP PPE during an AGP.

COVID Predictions

Current models struggle with multiple unknowns and have routinely failed to accurately predict the future as policy and behaviour alter based on the modelled outcome. Locally there may be a second surge between November and March. Experience in Europe suggests that this may be seen predominantly in younger individuals with fewer patients requiring admission. However, the advent of winter and flu/RSV may substantially alter this picture. Vaccination, social distancing, test and trace and a host of other influences may help to mitigate a second surge. However, we are likely to struggle with total testing capacity, which means that we may be seeing a larger number of 'test unknown' patients, requiring full PPE whilst pending a result.

Options

1. No further provision required = £0.00

2. Attempt to purchase 2 further months' supply of JSP Jetstream filters and all replacement parts;
    - Filters (x60) = £1,175.04 inc VAT
    - Replacement parts (x30) = £8,129.52 inc VAT
    - **Total = £9,304.56 inc VAT**

3. Purchase further 30 Translas respirators (with 30 already owned at the Nightingale) plus filters for 60 units for 4 months;

   BEST CASE (x15 sessional usages twice a day)
   - Powered respirator units (x30) = £26,244.00 inc VAT
   - Filters (x3,360) = £92,736.00 inc VAT
   - **Total = £118,980.00 inc VAT**

   WORST CASE (x60 sessional usages twice a day)
   - Powered respirator units (x30) = £26,244 inc VAT
   - Filters (x13,440) = £370,944.00 inc VAT
   - **Total = £397,118.00 inc VAT**

4. Purchase further 100 Translas respirators with 4 months' consumables

   BEST CASE (x25 sessional usages twice a day)
   - Powered respirator units (x100) = £87,480.00 inc VAT
   - Filters (x5,600) = £154,560.00 inc VAT
   - **Total = £242,040 inc VAT**

   WORST CASE (x100 sessional usages twice a day)
   - Powered respirator units (x100) = £87,480.00 inc VAT
   - Filters (x22,400) = £618,240.00 inc VAT
   - **Total = £705,720.00 inc VAT**

NB.
We have no adequate reassurance over JSP consumable supplies (option 2). JSP filters can be used for 28 days whereas the Translas filters need to be replaced after each sessional usage

Recommendation
Given that option 2 is currently unavailable due to insufficient supply, if a further surge occurred with less than or an equal number of hospitalised patients as the first surge then we would recommend option 3.
If a larger surge were expected then we would recommend option 4.

Restricted visiting during COVID 19 pandemic

Post holder responsible for Procedural Document	[redacted], Director of Nursing
Author of Standard Operating Procedure/	[redacted], Assistant Director of Nursing
Division/ Department responsible for Procedural Document	Corporate Nursing
Contact details	[redacted]
Date of original policy / strategy/ standard operating procedure/ guideline	08/04/2021
Impact Assessment performed	**Yes**/ No
Approving body and date approved	Gold Command 8th April 2021 V1.1 Clinical Reference Group: 14 May 2021
Review date (and frequency of further reviews)	SOP will be reviewed in response to prevalence of COVID 19 locally, national COVID alert levels and national guidance
Expiry date	N/A see above
Date document becomes live	12/04/2021

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience	✓	Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		**Status: Final**	
Version	Date	Author (Title not name)	Reason
1.0	08/04/2021	Assistant Director Nursing- Quality Projects	In response to reduced prevalence of COVID 19 and new national guidance issued March 2021.
1.1	17/5/2021	Assistant Director Nursing- Quality Projects	Update in response to continued low prevalence and next stage of roadmap out of restrictions for the wider public, feedback from patients, visitors, nurses and ward clerks. There are no changes for outpatient settings. The following changes have been made for in-patient visiting. Except for COVID +ve, clinically +ve or COVID contacts, allow the 1 visitor for 1 hour per day to be a different visitor each day if so desired. Visiting will still be by appointment. Period for allowing up to 4 visitors for patients at the end of life extended from last hours/days to 2 weeks. Contact details of each visitor will be recorded when the person makes an appointment to visit as this is a national requirement. The requirement for staff to carry out a written risk assessment/checklist for each visitor each time they visit is not a requirement in national guidance and is unduly burdensome to ward staff. Posters will be put on every ward door to reinforce the need to be free of COVID symptoms with the onus being on the visitor to comply. Appendix 1 - flowchart - amended to reflect the above points.

Associated Trust Policies/ Procedural documents:	Infection Prevention and Control Policy
Key Words:	Visiting, Visitors, Restricted visiting COVID-19
In consultation with and date: Various dates between 8/4/21 and 10/5/2021 Chief Nurse Director of Nursing Consultant Nurse/Joint DIPC Facilities Manager Comms Dept Lead Cancer Nurse Lead Paediatric Nurse ED Matron Relevant Cluster Managers Patient Experience Manager Outpatient Manager Head of Midwifery Assistant Director Nurse - Specialist Services	
Contact for Review:	Assistant Director of Nursing- Quality Projects

CONTENTS

KEY POINTS OF THIS PROCEDURAL DOCUMENT:

- As restrictions for the public relax, coming further out of lockdown and both local and national prevalence of COVID-19 decreases there is a need to increase the opportunities for people who are important to our patients' i.e. relatives, partners and carers etc. to visit the hospital sites.

- However, social distancing remains a requirement and this influences how many people can visit/accompany patients in both in-patient and outpatient settings.

- For in-patients, a named person may visit for one hour daily between 11am and 7 pm. This will be arranged by appointment to enable ward staff to ensure social distancing whilst visiting.

- For patients who are COVID-19 positive, clinically COVID-19 or contacts of COVID-19 the visitor should be the same person each day, wherever possible.

- More extensive visiting is allowed for patients with specific needs e.g. end of life, dementia, learning disability, women in labour etc.

  Refer Appendix 1 – Flow chart

- For outpatients, the limitation on allowing out-patients to bring an accompanying person with them is entirely dependent on the space available within clinic rooms and, particularly, in waiting areas. Therefore, out-patients will continue to be advised to attend alone unless there are exceptional reasons.

1. INTRODUCTION

1.1 A careful and COVID-19 secure approach to facilitating visitors to inpatients and accompanying outpatients remains appropriate whilst COVID-19 continues to circulate in the population. The health, safety and wellbeing of our patients, communities and staff remain the priority.

1.2 In line with national guidance, this local guidance for the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) provides staff with information to facilitate patient contact/communication with families, nominated friend, somebody important. It does not cover other people attending our sites or external visitors not visiting patients, contractors or staff.

2. PURPOSE

2.1 Visiting restrictions are currently still in place to reduce the risk COVID-19 transmission, however, a compassionate approach is essential in balancing the importance of close family visits and the need to manage infection risk and maintain the safety of the visitor, staff and other patients.

3. DEFINITIONS

N/A

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Chief Nursing Officer, through the Director of Nursing, is responsible for commissioning, approving this document and ensuring it is reviewed in light of changes to local prevalence of COVID 19, national guidance and national alert levels.

4.2 The Consultant Nurse/Joint Director for Infection Prevention and Control is responsible for ensuring that the SOP is consistent with infection control policy and guidance.

4.3 Assistant Directors of Nursing and Clinical Matrons are responsible for ensuring that their teams are aware of and implement the SOP

4.4 Heads of Department and Clinical Nurse Managers are responsible for ensuring that the SOP is implemented within their wards and departments

5. OUTPATIENT APPOINTMENTS AND DIAGNOSTIC ATTENDANCES

5.1 Whilst many patients would prefer to have an accompanying person with them, the requirement for social distancing currently remains in place and therefore the limitation on the accompanying persons relates to space within clinic waiting rooms. Patients will continue to be advised that wherever possible, they should attend their appointment alone.

5.2 There are exceptions when the patient may be accompanied by one other person and these include:

- Children (under 18 years of age) – one parent or guardian
- Anyone with a learning disability or dementia can be accompanied by one family member/companion/carer
- Pregnant women attending antenatal clinic or scans (see Maternity specific guidance)
- Anyone with a disability who would not be able to access information or would require assistance during an examination – one family member/companion/carer
- Any patient who may need emotional support or help to understand complex information about diagnosis or treatment during an appointment may be accompanied (but this should be arranged in advance).

If a patient does not meet any of the above criteria but they feel it is essential for them to be accompanied to their appointment they are advised to contact the department at the top of their appointment letter in advance to confirm they are able to accommodate this.

6. EMERGENCY DEPARTMENT (ED) AND ADMISSION AREAS (E.G. STAU/MTU)

6.1 The ED at the Royal Devon and Exeter Hospital is undergoing a major rebuild and, having reviewed the environment; it is clear that allowing a greater number of accompanying persons than is already permitted cannot be facilitated safely. Other admission environments also have limited waiting space and any significant increase in people accompanying patients will impede social distancing measures. Therefore, current arrangements will remain in place, namely:

- Children (under 18 years of age) – one parent or guardian
- Anyone with a learning disability or dementia can be accompanied by one family member/companion/carer
- Anyone with a disability who would not be able to access information or would require assistance during an examination – one family member/companion/carer
- Any patient who may need emotional support or help to understand complex information about diagnosis or treatment may be accompanied (at the discretion of the nurse in charge)
- Critically ill patients (at the discretion of the nurse in charge).

7. IN-PATIENT VISITING

7.1 A return to pre-pandemic visiting policy is not yet possible, however, a compassionate approach is essential in balancing the importance of close family visits and the need to manage infection risk and maintain the safety of the visitor, staff and other patients.

7.2 From 17th May, every adult in patient may receive one visitor each day who may visit for 1 hour between 11am and 7 pm. Patients can have up to 3 named visitors for the duration of their inpatient stay if that is desirable to the patient and their family and friends. Appointments to visit must be made by contacting the appropriate ward at least one day prior to visiting.

7.3 Wards must ensure that social distancing is maintained and this should be considered when booking appointments.

7.4 Patients who are COVID-19 positive or who have been diagnosed as clinically positive or who are contacts of COVID-19 may also have one visitor for one hour per day but this should be the same person each day where ever reasonably practicable to do so.

7.5 **Exceptional circumstances for extended inpatient visiting (in terms of numbers of visitors and/or duration) include:**

- a familiar carer/relative may visit for extended periods if there are specific reasons of safety – dementia or learning disability where anxiety would be increased significantly
- up to four visitors for patients identified as receiving end-of-life care. Patients who are at the end of their life, where death is imminent will usually be in a single room and can be supported by up to four visitors in the period of 2-3 weeks prior to death. Although up to four visitors are allowed, the four designated visitors should be encouraged to stagger their visiting, where possible, and avoid visiting at one time.
- both parents/guardians of patient under 18 years of age where the family bubble can be maintained
- a relative/carer for patients who do not meet the above criteria but may require assistance with their communication and/or to meet their health, emotional, religious or spiritual care needs at the discretion of the nurse in charge
- Support Person of women during induction of labour, during labour, as well as in the postnatal period (see Maternity specific guidance).

7.6 If staff require advice with regard to a relative visiting they should contact:

- Infection Prevention and Control team during working hours
- Site Management team out of hours.

Where patients are moved to a different ward but have a visit booked, the staff of the ward who booked the visit should contact the designated visitor explaining that the receiving ward may not be able to accommodate the exact visit time, but will make every effort to accommodate.

7.7 If a face to face visit is not practical then Virtual Visiting and Patient Messages can be offered as an alternative.

7.8 Preparation for an in-patient face to face visit

7.8.1 The visitor MUST contact the ward prior to visiting to arrange the day/time. This will limit the number of visitors visiting at the same time and therefore allow social distancing to be maintained.

7.8.2 Staff should discuss the following with the visitor/representative before the visit takes place:

- Children will not normally be allowed to visit (any exceptions must be for the benefit of the patient and agreed with the nurse in charge)
- A face covering must be worn at all times, including when entering and moving through any part of the hospital, unless the person has an exemption to not to wear a mask
- Visitors to COVID-19 positive or COVID-19 contact patients will be provided with a fluid resistant surgical mask to replace their face covering
- Parents/guardians of children must always wear a face covering when entering and moving through the healthcare setting and when a healthcare professional is treating their child/young person. If they are with their child and/or young person and within their 'family bubble' in side rooms or physical environments that afford separation, they can remove their face covering
- All visitors must clean their hands when entering and leaving the clinical area

- They MUST NOT visit before contacting the ward to discuss arrangements
- They MUST NOT attend if they have been otherwise informed that they are a close contact of a confirmed case of COVID-19 and have been advised to self-isolate or have to self-isolate for another reason (e.g. travel from a country requiring quarantine)
- Anyone showing any symptoms of coronavirus (a new continuous cough, a high temperature or a loss of, or change in, your normal sense of smell or taste) should not visit even if these symptoms are mild or intermittent, due to the risk they pose to others. This is essential for infection prevention and control.

7.9 **On the day of the visit**

7.9.1 Posters detailing expectations of visitors will be placed on all ward entrance doors. This will replace the need for a documented risk assessment/safety checklist to be completed by a member of the ward staff when the visitor arrives on the ward.

7.9.2 If visitors display symptoms of coronavirus they should be asked to leave, self-isolate at home organise a test; members of their household should also self-isolate while a COVID-19 result is awaited.

7.9.3 All visitors should be reminded of the importance of hand hygiene and face coverings and in addition:

- be informed about what to expect when they see the patient
- be advised on the requirement for any additional personal protective equipment
- remain on the ward during the visiting period unless they need to use the toilet facilities
- use toilet facilities that are provided for members of the public only and must keep their mask on
- refrain from sitting on the beds and must not visit other patients
- maintain the recommended social distancing requirements and refrain from having any physical contact with patients
- not bring in large food parcels, flowers, helium balloons or similar items
- enter and leave the hospital as quickly as possible using the most direct route
- avoid touching their eyes, nose and mouth with unwashed hands
- cover any coughs or sneezes with a tissue, and then throw the tissue in a bin
- follow 'stay at home' guidance if they become unwell.

8. ARCHIVING ARRANGEMENTS

The original of this SOP, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely.

9. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE STANDARD OPERATING PROCEDURE/ GUIDELINE

9.1 To evidence compliance with this policy, the following elements will be monitored:

N/A

10. REFERENCES

NHS England (2021) Visiting healthcare inpatient settings during the COVID-19 pandemic Available at **https://www.england.nhs.uk/coronavirus/publication/visitor-guidance/** Accessed 08/04/2021

APPENDIX 1: PROCESS FLOWCHART: INPATIENT VISITORS

Summary of Exceptional Circumstances for allowing extended visiting
For specific reasons of safety e.g.dementia or learning disability where anxiety would be increased
Up to four visitors for patients identified as receiving end-of-life care.
Both parents/guardians of patient under 18 years of age
A relative/carer for patients who do not meet the above criteria but may require assistance with communication or health, emotional, religious or spiritual care needs at the discretion of the nurse in charge
Partners/supporters of women during induction of labour, during labour, as well as in the postnatal period (see Maternity specific guidance)

APPENDIX 2: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the guideline/SOP	Clinical staff in inpatient and outpatient wards and departments, including clinical admin staff.
The key changes if a revised document	The following changes have been made for in-patient visiting: Except for COVID +ve, clinically +ve or COVID contacts, allow the 1 visitor for 1 hour per day to be a different visitor each day if so desired. Visiting will still be by appointment. Period for allowing up to 4 visitors for patients at the end of life extended from last hours/days to 2 weeks. Contact details of each visitor will be recorded when the person makes an appointment to visit as this is a national requirement. The requirement for staff to carry out a written risk assessment/checklist for each visitor each time they visit is not a requirement in national guidance and is unduly burdensome to ward staff. Posters will be put on every ward door to reinforce the need to be free of COVID symptoms with the onus being on the visitor to comply. Appendix 1 - flowchart - amended to reflect the above points.
The key objectives	Visiting restrictions are currently still in place to reduce the risk COVID transmission, however, a compassionate approach is essential in balancing the importance of close family visits and the need to manage infection risk and maintain the safety of the visitor, staff and other patients.
How new staff will be made aware of the procedure/guideline and manager action	Cascade Gold Command Updates
Specific Issues to be raised with staff	Particular attention should be drawn to the requirement to arrange appointments for visitors to in-patient areas; requirement to maintain social distancing; where to seek further advice if clarity is required regarding special circumstances

Training available to staff	Advice can be sought from Infection Prevention and Control Team in normal working hours and Site Management Team outside normal working hours.
Any other requirements	
Issues following Equality Impact Assessment (if any)	No negative impacts. This SOP allows an increase in visiting.
Location of hard / electronic copy of the document etc.	The original of this SOP, will remain with the author. An electronic copy will be maintained on the Trust Intranet Hub. Archived electronic copies will be stored on the Trust's "archived policies"

APPENDIX 4: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Restricted visiting during COVID 19 pandemic
Division/Directorate and service area	Corporate Nursing
Name, job title and contact details of person completing the assessment	[redacted] - ADN for Quality Projects
Date completed:	08/04/2021

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

Visiting restrictions are currently still in place to reduce the risk COVID transmission, however, a compassionate approach is essential in balancing the importance of close family visits and the need to manage infection risk and maintain the safety of the visitor, staff and other patients. ...

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify) Visitors

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	x	☐
Disability	x	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	x	☐
Race	x	☐
Religion / belief	x	☐
Sexual orientation – *including: Marriage / Civil Partnership*	**x**	☐

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Patients who are receiving end of life care *Those with carers* *Birthing partners/maternity supporters*

5. Do you think the document meets our human rights obligations? Yes

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it trex everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Involvement of key representatives of people with the relevant protected characteristics in the writing of this SOP. Refer front cover of SOP for those consulted. The aim of the SOP is to relax the restrictions implemented during lockdown and throughout the third wave of COVID. Therefore this will have a positive impact of all patients/service users.

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

N/A

Royal Devon and Exeter NHS Foundation Trust

Personal Protective Equipment (PPE) Guidance during COVID-19 Pandemic

Post holder responsible for Procedural Document	[redacted], Consultant Nurse, Infection Control [redacted], Consultant in Medical Microbiology and Infection, Infection Control Doctor
Author of Standard Operating Guideline	[redacted], Consultant in Medical Microbiology and Infection
Division/ Department responsible for Procedural Document	Specialist Services/Infection Control
Contact details	[redacted]
Date of original policy / strategy/ standard operating procedure/ guideline	3rd April 2020
Impact Assessment performed	Yes/ **No**
Approving body and date approved	Covid Gold Command Meeting, 03/04/2020
Review date (and frequency of further reviews)	03/04/2021
Expiry date	03/04/2022
Date document becomes live	V2 15/06/2020, V3 01/10/2020, V3.1 05/11/2020

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		Strategic Directions – Key Milestones	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute Services	
CQC Fundamental Standards Regulations No:		Delivery of Care Closer to Home	✓
		Infection Control	✓
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1	03/04/2020	Consultant in Medical Microbiology and Infection	New document in response to Covid19
1.1	22/04/2020	Consultant in Medical Microbiology and Infection	Update details and addition of appendix 3 and 4
1.2	11/05/2020	Consultant in Medical Microbiology and Infection	Addition of definitions section. Restructure sections of PPE. Addition of risk assessment for AGP PPE in non-COVID-19 patients. Update of distance from AGP for AGP PPE as per PHE (1 to 2m). AGP PPE changed from eye/face protection to full face shield. Removal of LMA insertion/extraction as AGP. Appendix 1 = Addition of NNU exclusion and addition of resus guidance. Appendix 2 = Additions to list of non-AGPs. Appendix 3 = removal of Scrubs/uniform and addition of PPE summary table
1.22	04/06/2020	Consultant in Medical Microbiology and Infection	Neonatal exceptions amended in appendix 1
2.0	15/06/2020	Consultant in Medical Microbiology and Infection	Masks/face coverings for all staff, patients and visitors in non-COVID-19-Secure areas.
3.0	28/09/2020	Consultant Nurse/DIPC	Updated in line with revised PHE guidance
3.1	04/11/2020	IPCN/Consultant Nurse	Amendment of Covid secure guidance, FRSM and eye protection use.

Associated Trust Policies/ Procedural documents:	PHE guidance COVID-Secure guidelines
Key Words:	COVID-19, Personal protective equipment, PPE Universal precautions
In consultation with and date: 01-03/04/2020 [redacted], Head of Workforce Development, Northern Devon Healthcare Trust [redacted], ED Senior Nurse, RD&E [redacted], Consultant Nurse, Infection Control, RD&E [redacted], ITU consultant, RD&E [redacted], Medical Director, RD&E [redacted], Orthopaedic Consultant, RD&E [redacted], Consultant in Medical Microbiology and Infection, Infection Control Doctor, RD&E [redacted], Consultant in Medical Microbiology and Infection, RD&E [redacted], Consultant Medical Microbiologist & Infection Control Doctor Northern Devon Healthcare Trust [redacted], Orthopaedic Consultant, RD&E [redacted], Consultant in Medical Microbiology and Infection, RD&E	
Contact for Review:	Jen Poyner

CONTENTS

1. Scope

1.1 Infection prevention and control (IPC) precautions, including hand hygiene and personal protective equipment (PPE), are essential to help protect staff, patients and visitors during the COVID-19 pandemic. Public Health England (PHE) produce guidance on the use of PPE, this guidance explains how it is to be used at RD&E.

1.2 This guidance covers:

- all staff in clinical and non-clinical areas
    - (community home visiting have a separate document as of 13/05/2020)
- all patients, including those in the extremely vulnerable group as defined by PHE, 'shielded patients'
- all visitors to clinical sites including parents, carers, birthing partners, volunteers, contactors

1.3 The IPC principles in the document apply to all health settings (excluding adult social care) and are underpinned by the best available evidence.

2. Guidance and Key Messages

2.1 IPC measures are critical to minimise the risk of transmission of COVID-19 and other infections in health and care settings.

2.2 2 metres social distancing is considered standard practice in all healthcare areas

2.3 We all have a role to play; it is important that we take steps to reduce the risk of transmission by asking everyone to follow all IPC measures to include hand hygiene and wearing PPE as advised in the document. Avoid touching your face as much as possible, keep hair tied back and adhere to uniform policy.

2.4 Comprehensive RDE PPE guidance, including donning/doffing and cleaning of equipment can be found on the HUB. PHE guidance can be found online.

2.5 Please use PPE appropriately and responsibly, it is a valuable resource. Protection is provided by its proper use and disposal/cleaning.

2.6 Sessional use of single use PPE has been minimised and only applies to extended use of facemasks for health and care workers.

2.7 Risk assessed care pathways provide greater clarity and detail on IPC measures for the management of patient treatment, care, and support:

- High risk: There is no change in recommendations for IPC or for the use of PPE by staff when managing patients/Individuals who have, or are likely to have, COVID-19.
- Medium risk: This includes patients/Individuals who have no symptoms of COVID-19 but do not have a COVID-19 SARS- CoV-2 PCR test result.
- Low risk: Patients/Individuals with no symptoms and a negative COVID-19 SARS- CoV-2 PCR test who have self-isolated prior to admission, for example following NICE guidance.

2.8 In some clinical outpatient settings where contact with individuals is minimal, the need for single use PPE items for each encounter, for example, gloves and aprons is not necessary.

2.9 Staff administering vaccinations/injections must apply hand hygiene between patients and wear a sessional facemask

3. Definitions

3.1 **SICP** – Standard Infection Control Precautions are the basic IPC measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources of infection. Sources include, blood and other body fluids, non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated. SICPs must be used by all staff, in all care settings, at all times, for all patients/individuals whether infection is known to be present or not. SICPs include hand and respiratory hygiene, frequent surface decontamination of environment and equipment, and social distancing.

3.2 **TBP** – Transmission Based Precautions are additional precautions to be used in addition to SICPs when caring for patients/individuals with a known or suspected infection and are required when caring for patients/individuals with known or suspected COVID-19. These are referred to throughout the guidance and take into consideration the additional precautions required for contact, droplet and airborne spread of COVID-19 and the PPE required by health and care staff.

- **Contact precautions**
  - Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment).

- **Droplet precautions**
  - Used to prevent and control infections spread over short distances (at least 3 feet/1metre) via droplets (>5µm) from the respiratory tract of individuals directly onto a mucosal surfaces or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.

- **Airborne precautions**
  - Used to prevent and control infection spread without necessarily having close patient contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level.

3.3 **AGP** – Aerosol Generating Procedures are medical procedures that can result in the release of tiny droplets of fluid from the respiratory tract. These go into the air and may be breathed in or can settle on surfaces where infectious particles can live for a few days if not removed by ventilation or cleaning. AGPs are associated with an increased risk of respiratory transmission. A full list of AGPs can be found in appendix 1.

3.4 **Facemasks** –The trust stock both disposable and reusable masks for different situations.

Types of Facemask

- **Surgical masks** (SM) are single use
  - Type IIR fluid resistant (FRSM)

- **Cloth masks** can be washed and are therefore reusable

- Fluid repellent cloth masks (FRCM) have been provided by the trust
- Cloth face covering (CFC) refers to any non-medical grade mask which covers the mouth and nose

3.5 **COVID-19 Secure** – single staff occupancy, non-clinical environments that require signage at entry points to notify people of the status. Only staff in these areas who are on their own are able to remove their masks.

4.0 Personal Protective Equipment (PPE)

4.1 For the purpose of this document, the term 'personal protective equipment' is used to describe products that are either PPE or medical devices that are approved by the Health and Safety Executive (HSE) and the Medicines and Healthcare products Regulatory Agency (MHRA) as protective solutions in managing the COVID-19 pandemic.

4.2 **Gloves** must be:

- worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- changed immediately after each patient and/or after completing a procedure/task even on the same patient
- never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between use
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases.

4.3 **Aprons** must be:

- worn to protect uniform or clothes when contamination is anticipated or likely
- worn when providing direct care within 2 metres as per droplet and standard precautions
- changed between patients and/or after completing a procedure or task

4.4 **Gowns** must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids
- single use disposable or reusable
- worn when undertaking aerosol generating procedures
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients /individuals and immediately after completing a procedure or task unless sessional use is advised due to local/national data

4.5 **Eye or face protection** (goggles or visor) must:

- not be touched when being worn
- be worn to protect mucous membranes
- be worn when delivering care within 2 metres of all patients (inpatients, outpatients and day cases) regardless of the pathway they are on.
- regular corrective spectacles are not considered eye protection

4.6 **Fluid resistant surgical face mask** (FRSM Type IIR) masks must:

- be worn at all times in all clinical areas

- be worn at all times in non-clinical areas unless staff are alone in an office environment.
- If Perspex screens are in place e.g at reception desks then eye protection is not required but can be worn if chosen to.
- be well-fitting and fit for purpose, fully cover the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection)
- not touched once put on or allowed to dangle around the neck
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through

4.6 **FFP3 (filtering face piece) or Powered respirator** should:

- be fit tested and fit checked
- always worn when undertaking an AGP on a COVID-19 confirmed or suspected patient/individual
- 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 patient's/individual's room or cohort area or COVID-19 ward
- respirators can be single or sessional use, disposable or reusable and fluid-resistant
- valved respirators are not fully fluid-resistant unless they are also 'shrouded'. Valved non-shrouded FFP3 respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated
- where fit testing fails, suitable alternative equipment must be provided, or the healthcare worker should be moved to an area where FFP3 respirators are not required
- respirators should be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- the respirator should be discarded and replaced and NOT be subject to continued use if the facial seal is compromised, it is uncomfortable, or it is difficult to breathe through
- Reusable respirators should be decontaminated according to the manufacturer's instructions

4.7 **Head/footwear**

- headwear is not routinely required in clinical areas (even if undertaking an AGP) unless part of theatre attire or to prevent contamination of the environment such as in clean rooms
- headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres
- foot/shoe coverings are not required or recommended for the care of COVID-19 cases

4.8 **PPE for COVID-19 Secure Areas**

4.8.1 In order for an area to be considered COVID Secure staff must be working alone, following good principles of hand hygiene and frequently cleaning high touch surfaces. Where possible windows should be open to allow for adequate ventilation. Cleaning before and after eating in a COVID-19 secure environment is paramount and this can be achieved with clinell universal wipes.

4.8.2 Face masks must be worn at all times outside of COVID-19 Secure areas and when there is more than one person in a COVID-19 secure environment.

5. Eating and Drinking

5.1 Face masks should be removed for eating or drinking, following correct removal/doffing process with appropriate hand hygiene and only when 2 metre social distancing can be maintained.

5.2 Eating and drinking should be limited to your break periods for staff wearing masks in sessional periods.

5.3 On entering an area serving food, or where food is eaten, hand hygiene must be performed regardless of whether you are wearing a mask or not. Face masks must be worn until you reach the area you intend to eat your food.

5.4 A clean mask should be put back on immediately after eating, unless in a COVID-19 Secure area. You may need to bring a clean mask with you in a clean container to enable you to do this. The approach of wearing a mask at all times (except COVID-19 Secure areas), removing and discarding it to eat, and then putting on a clean mask, with appropriate hand hygiene, applies where ever you plan to eat, even outside areas on Trust grounds.

6. PPE for Visitors (including outpatients)

6.1 Visitors to clinical sites will be expected to arrive wearing a cloth face covering (CFC) as a minimum

6.2 Some visitors will be unable to wear a CFC due to age or health related concerns (e.g. breathing difficulties). These patients require a risk assessment which must be documented in their medical notes.

6.3 Patients/visitors attending without a CFC should not be refused entry, but should be educated regarding the requirement for future visits and offered a mask to wear for the current visit.

6.4 Hand hygiene and education on donning and doffing a mask/face covering will be provided at some entrances to clinical areas.

6.5 Patients in the extremely vulnerable group (as defined by PHE) are eligible for reusable FRCM to take home and wear outside of the healthcare setting.

6.6 Ideally visitors should not be present during AGPs, but in the rare event they are, they should be offered the same level of PPE as staff. This excludes end of life visiting in ICU where visitors must wear a FRSM and be offered an apron.

7. PPE for Inpatients

7.1 Inpatients whose COVID-19 status is positive or unknown pending swab result, should be given a FRSM to wear, if they can tolerate it. COVID-19 positive patients are not required to wear a mask once in a side room or positive cohort bay. COVID-19 negative patients are not required to wear a mask.

7.2 Patients should be given an information leaflet on mask use to guide its safe use, including hand hygiene, storage and disposal.

7.3 Patients wearing masks should be encouraged to wear them for sessional periods, ideally four hours, changing the mask when wet, soiled, damaged or uncomfortable.

7.4 Inpatients in the extremely vulnerable group (as defined by PHE) should be offered a mask to wear if they can tolerate it.

7.5 All other patients can be provided with a SM to wear if they request one

8. COVID-19 Care Pathways

8.1 Three care pathways have been structured to enable organisations to separate COVID-19 risk at a local level and enable service restoration and are detailed below in section 9, 10 and 11.

8.2 The three pathways are specific to the COVID-19 pandemic and are examples of how to separate COVID-19 risks. It is important to note, that these pathways do not necessarily define a service to a particular pathway and should not impact the delivery and duration of care for the patient or individual. Implementation strategies must be underpinned by patient/procedure risk assessment, appropriate testing regimens and epidemiological data.

8.2 Screening and triaging on admission to the RDE must be undertaken to enable early recognition of COVID-19 cases.

9.0 Low Risk (Emergency and Elective Green) Pathway – Key Principles

9.1

SICPs/PPE	Disposable gloves	Disposable apron	Face masks	Eye Protection
All settings/all patients/individuals	Single use (risk of exposure to body fluids only)	Single use apron (risk of exposure to body fluids only)	Type IIR FRSM at all times	Single use or re-usable eye protection (goggles or visor)

9.2 **AGPs** – Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other infectious agent transmitted via the droplet or airborne route.

9.3 **Cleaning** – The frequency of cleaning of both the environment and equipment in patient areas should be increased from daily to at least twice daily, in particular, frequently touched sites/points.

9.4 In the low risk COVID-19 pathway general purpose detergents for cleaning are suitable (with the exception of blood and body fluids, where a chlorine releasing agent solution should be used).

9.5 **Theatre** – Within the low risk COVID-19 pathway, standard theatre cleaning and time for air changes provides appropriate levels of IPC and there is no requirement for additional cleaning unless the patient has another infectious agent that requires additional IPC measures. There is no additional requirement for ventilation or downtime in this pathway, providing safe systems of work, including engineering controls are in place.

9.6 Patients/individuals in the low risk COVID-19 pathway do not need to be anaesthetised or recovered in the operating theatre if intubation/extubation (AGP) is required.

10. Medium Risk (Amber) Pathway – Key Principles

10.1

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Patients with no COVID-19 symptoms and no test result	Single use (risk of exposure to body fluids only)	Single use apron (risk of exposure to body fluids only)	Type IIR FRSM	Single use or re-usable eye protection (goggles or visor)
Airborne	**Disposable gloves**	**Gown**	**Face masks**	**Eye protection**
When undertaking AGPs on patients with no COVID-19 symptoms and no test result	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

10.2 **Patient placement** – ensure cohorted patients/individuals are physically separated from each other, for example use screens, privacy curtains between the beds to minimise opportunities for close contact, this should be locally risk assessed to ensure patient safety is not compromised

10.3 **AGPs** – Should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE. (see section 11.3)

AGPs should be performed in a dedicated space, preferably in a room with doors shut, and as a minimum separated by at least 2 metres from other staff, patients and procedures.

10.4 **Cleaning** – Patient care equipment should be single-use where practicable. Reusable/communal non-invasive equipment (e.g. observation machine) should be allocated to an individual patient or cohort of patients/individuals. Cleaning of care equipment as per manufacturer's guidance/instruction and recommended product 'contact time' must be followed for all cleaning products.

10.5 Reusable non-invasive equipment must be decontaminated

- between each and after patient/individual

- after blood and body fluid contamination
- at regular intervals as part of routine equipment cleaning

10.6 Decontamination of equipment must be performed using either
- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (Chlorclean or Tristel)
- green clinell wipes, which have virucidal activity

10.7 **Theatre** – Patients/individuals should be anaesthetised and recovered in the operating theatre if intubation/extubation (AGP) is required. For local, neuraxial or regional anesthesia the patient is not required to be anaesthetised/ recovered in theatre.

10.8 **Critical care** – Droplet precautions apply. However, consideration may need to be given to the application of airborne precautions where the number of cases of suspected/confirmed COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms

10.9 TBPs should only be discontinued in consultation with clinicians and should take into consideration the individual's test results and clinical symptoms. If test results are not available (for example the patient/individual declines) TBPs can be discontinued after 14 days (inpatients) depending on contact exposure and providing the patient/individual remains symptom free.

10.10 There is no restriction on discharge if the patient/individual is well, unless the patient/individual is entering a long-term facility and testing may be required. Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members. Ambulance services and the receiving facilities must be informed of the infectious status of the individual

11. High Risk Pathway (Red and Unconfirmed Red) – Key principles

11.1

Droplet/Contact PPE	Disposable gloves	Disposable apron	Face masks	Eye protection
Suspected or confirmed COVID-19	Single use	Single use apron (gown required if risk of spraying / splashing)	FRSM Type IIR for direct patient care	Single use or re-usable eye protection (goggles or visor)
Airborne	**Disposable gloves**	**Gown**	**Face masks**	**Eye protection**
When undertaking AGPs on confirmed or suspected COVID-19	Single use	Single use or reusable long sleeved gown	FFP3 or powered respirator for AGPs	Single use or reusable **visor**

11.2 **Patient placement** – If the patient has symptoms or a history of contact with a case, they should be prioritised for single room isolation or cohorted (if an isolation room is unavailable) until their test results are known, for example use privacy curtains between bed spaces to minimise opportunities for close contact between patients. This should be locally risk assessed to ensure this does not compromise patient safety.

If single rooms are in short supply, priority should be given to patients with excessive cough and sputum production, diarrhoea or vomiting and to those in the high risk/extremely high risk of severe illness.

11.3 **AGPs** – Should only be carried out when essential and only staff who are needed to undertake the procedure should be present, wearing airborne PPE

PHE guidance recommends that staff performing an AGP and those within 2 metres wear AGP PPE but other staff working within the same space/room as an AGP, at a distance of 2 metres or more are not required to wear AGP PPE.

AGP PPE is also required for staff performing an AGP and those within 2 metres for a period of time afterwards depending on the air changes in that area, (5 minutes in theatres and 60 minutes on a ward or 6ACH). However, cleaning can commence immediately by staff in AGP PPE. After the 5 or 60 minute time frame, staff can enter the 2 metre zone without AGP PPE.

AGPs should be performed in a dedicated space, preferably in a room with doors shut, and as a minimum separated by at least 2 metres from other staff, patients and procedures.

11.4 **Cleaning** – See section 10.4

11.5 **Theatre** – Patients should be anaesthetised and recovered in the theatre if intubation/extubation (AGP) is required using airborne precautions. This is not required for regional, neuraxial or local anaesthesia.

Ventilation in both laminar flow and conventionally ventilated theatres should remain fully on during surgical procedures where patients/individuals have suspected/confirmed COVID-19. Air passing from operating theatres to adjacent areas will be highly diluted and is not considered to be a risk.

11.6 **Critical care** – Droplet precautions would apply however, consideration may need to be given to the application of airborne precautions where the number of cases of COVID-19 requiring AGPs increases and patients/individuals cannot be managed in single or isolation rooms

11.7 Patients should remain in isolation/cohort with TBPs applied for at least 14 days after onset of symptoms and at least 3 consecutive days without a fever or respiratory symptoms. For asymptomatic patients, TBPs may be discontinued 14 days after initial positive result. The decision to modify the duration of, or ‘stand down’ TBPs (Contact/Droplet/Airborne) should be made by the clinical team managing the Individuals care.

11.8 Step down of TBPs for COVID-19 for home discharge may require some individual clinical assessment at local level depending on the severity of the disease and underlying conditions, including testing requirements.

11.9 In this pathway, visiting should continue to be limited to only essential visitors, for example birthing partner, carer/parent/guardian.

11.10 Discharge from an inpatient facility can occur when the individual is well enough and the clinician has provided them with advice to self -isolate for 14 days post discharge from the date of the positive SARS-CoV-2 PCR test (providing their symptoms resolve).

11.11 Discharge information for patients/individuals should include an understanding of their need for any self-isolation and/or quarantine, as well as their family members. Ambulance services and the receiving facilities must be informed of the infectious status of the individual

12. Additional advice for AGPs

12.1 Sessional use AGP/Airborne PPE requires additional PPE between patient care episodes. In addition don:

- A clean disposable apron
- A clean pair of gloves
- The five moments of hand hygiene must be followed during sessional use

12.1 The following procedures may generate an aerosol from material other than patient secretions and that are not considered to represent a significant infectious risk.

- Administration of pressurised humidified oxygen;
- Administration of medication via nebulisation.
- Removal of plaster casts
- Insertion and removal of Nasogastric (NG) tubes
- Insertion and removal of Radiologically Inserted Gastrostomy (RIG) tubes
- CT guided lung biopsies

13. Categorising COVID-19 Risk for the Newborn

13.1 Categorisation of risk status for the neonate has implications for use of PPE within the labour ward and neonatal unit (NNU) – specifically if any AGP is required (including suctioning of the airway at birth). Airborne PPE should be worn unless the baby can be classified into the low/emergency green pathway.

13.2 Any untested asymptomatic woman in labour should be regarded in the medium/amber pathway and appropriate IPC measures employed pending the result of admission swab.

13.3 The following assignment of risk to the newborn should be followed:

- Mother confirmed negative – baby low/emergency green pathway
  - Standard PPE
- Mother positive – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs
  - Swab baby if admitted to NNU
- Mother suspected COVID-19, maternal swab pending – baby medium/amber pathway
  - Airborne PPE for AGP
  - Droplet PPE for non-AGPs

    - Swab baby if admitted to NNU
- Mother asymptomatic and maternal swab pending.
    - Low prevalence in local population – baby low/emergency green pathway
        - Standard PPE
        - Swab baby only if mother subsequently confirmed positive or baby becomes symptomatic
    - High prevalence in local population (defined as current local restrictions in place) – baby medium/amber pathway
        - Airborne PPE for AGP
        - Droplet PPE for non-AGPs
        - Swab baby if admitted to NNU
- Baby swab negative – baby low/emergency green pathway
    - Standard PPE
- Baby swab positive – baby high/red pathway
    - Airborne PPE for AGP
    - Droplet PPE for non-AGPs

Appendix 1 - Aerosol Generating Procedures – PHE guidance

This is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

- tracheal intubation and extubation
- manual ventilation
- tracheotomy or tracheostomy procedures (insertion or removal)
- bronchoscopy
- dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- high flow nasal oxygen (HFNO)
- high frequency oscillatory ventilation (HFOV)
- induction of sputum/chest physio using nebulised saline
- respiratory tract suctioning
- upper ENT airway procedures that involve respiratory suctioning
- upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs
- high speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

PHE do not include chest compressions as AGP but resus council advises use of AGP PPE whilst performing resuscitation. From 11/05/2020, the trust will follow the resus council guidance for resuscitation; hence AGP PPE is available on resus trollies in the hospital setting

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: COVID-19 Pandemic Theatre PPE SOP

Summary of recommendation for change/development:
PHE have updated their guidance for PPE use in theatre

Point of Contact/author	[redacted]
Approved by:	Clinical Reference Group
Date approved:	Chair's approval 2 November 2020
Document Version:	V 2.0
Date notified to Gold Command:	3 November 2020
Date document becomes live:	3 November 2020

PHE have updated their guidance for PPE use in theatre.

Risk assessment based upon the patient and the risk of an Aerosol Generating Procedure.

GREEN Pathway Asymptomatic and COVID 19 negative swab result

AMBER Pathway Asymptomatic but no COVID 19 swab result

RED Pathway COVID 19 swab POSITIVE or clinical symptoms

GREEN Pathway

Standard infection control precautions SICP (AKA universal precautions) including fluid resistant surgical face mask (FRSM) for all staff. Staff should wear eye protection where there is a risk of splash contamination. Patients can be anaesthetised in the anaesthetic room or theatre. There are no additional cleaning or down time requirements unless other infectious conditions have been identified.

AMBER Pathway

Patients must be anaesthetised and extubated in theatre where appropriate. Staff within 2m of the AGP should wear full AGP PPE for 5 minutes after the AGP. Positive pressure theatre ventilation changes the air at least 20 times per hour. 63% of airborne contaminants are removed in one air change (3 minutes). Non-essential theatre staff wearing SICP should remain > 2m from the AGP during and for 5 minutes following the AGP but may safely remain in the room. Staff outside the room do not need to wear SICP but will be wearing

FRSM and visor eye protection. Air passing from the operating theatre to adjacent areas is highly diluted and is not considered a risk. Recovery staff may attend in SICP after 5 minutes. The patient may also be taken to the recovery area after 5 minutes. All staff should be aware of the risk of splash contamination and wear eye protection. Amber patients can complete their recovery in the recovery area 5 minutes after extubation.

Where there is a risk of regional anaesthesia requiring conversion to general anaesthesia with an AGP (intubation) such as Cat 1 and 2 LSCS staff who must remain within the 2m zone throughout (surgeon, assistant and scrub staff) may need to commence surgery in AGP PPE. Anaesthesia staff are likely to have time to don AGP PPE before intubation. These patients can be recovered back in their labour ward room 5 minutes after extubation.

RED Pathway

Patients should be anaesthetised, extubated and recovered in theatre (where appropriate). All staff within 2m of the AGP should wear full AGP PPE for 5 minutes after the AGP. Non-essential staff should be kept to a minimum, particularly during AGPs and should remain >2m from the AGP for 5 minutes. Cleaning within the 2m zone may commence in SICP after 5 minutes following the AGP. All staff in theatre should wear visor eye protection.

Royal Devon and Exeter NHS
NHS Foundation Trust

COVID-19 Clinical Guidance Front Sheet

COVID-19 CLINICAL GUIDANCE: Updated CPR guidance

Summary of recommendation for change/development:
In response to a statement from the Resuscitation Council UK (September 2020) and Public Health England (Sept 2020) guidance for staff has been updated.

Point of Contact	[redacted]
Input from:	[redacted] and [redacted]
Approved by:	Clinical Reference Group
Date approved:	1 October 2020
Document Version:	
Date ratified by Gold Command:	6 October 2020
Date document becomes live:	12 October 2020

In response to a statement from the Resuscitation Council UK (September 2020) and Public Health England (Sept 2020), which categorises patients into low, medium and high risk for COVID-19, staff should follow the below advice when dealing with a patient in cardiac arrest. This has been agreed by the Clinical Reference Group on 01/10/2020.

Only people with a negative COVID-19 test (PCR) are considered to be in the low risk group.

All other patients/individuals are to be considered medium or high risk.

MOST PATIENTS in hospital will have had a COVID swab, and thus their COVID status will be known. Thus, for the majority of inpatients, CPR can be commenced using standard PPE, which is in line with current RDEFT guidance.

For Low Risk groups (Green pathway)

Only people with a negative COVID-19 test (PCR) are considered to be in the low risk group, which means staff may commence standard RCUK guidance wearing FRSM and eye protection. Gloves and standard apron are also required if risk of exposure to bodily fluids.

For Medium or High Risk Groups (Amber or Red pathway)

You should not attempt chest compressions or assisted ventilation in an arrested person without wearing full Aerosol Generating Procedure Personal Protective Equipment (AGP PPE.) (An FFP3 mask that you have been fit tested for, fluid repellent long sleeve gown, gloves and a visor).

Defibrillation can be performed on ANY patient in any pathway by a rescuer wearing a fluid resistant surgical mask (FRSM) and eye protection. Gloves and standard apron are also required if risk of exposure to bodily fluids.

Patient facing clinical members of staff must ensure they are fit tested and are aware of the make/model of FFP3 mask that they have been fit tested with and they know where to locate the correct mask in their workplace.
Only Medical or clinical staff who form part of the response to cardiac arrest and MET calls should carry with them an FFP3 mask that they have been fit tested with.

Staff members that require fit testing should contact the relevant division on the email below.

Community Services [redacted]
Facilities and Estates
Medical Services
Specialist Services
Surgical Services
Research & Development

For any concerns or advice relating to the updated guidance please contact the Resuscitation service:

[redacted] [redacted]

Northern Devon Healthcare NHS Trust

Management of possible or confirmed COVID-19 cases

Contents

COVID-19 is potentially transmissible through droplet, airborne and contact routes.

Although respiratory secretions are the main route of transmission other bodily fluids are potentially infectious.

The correct PPE must be worn when entering the isolation room / cohort bay or ward

Correct removal of PPE is particularly important in preventing infection

Hand Hygiene reduces the risk of transmission through contact

1 Isolation

Patients must be isolated in a designated room or cohort bay at all times with the door closed.

Putting on PPE must be performed in a quiet area to ensure that it is correctly worn

Correct removal of PPE must be carried out in an area where there is sufficient space to do this safely. The assistance of a buddy can be helpful.

2 Cohort areas

If a single/isolation room is not available, cohort confirmed respiratory infected patients with other patients confirmed to have COVID-19.

Ensure patients are physically separated; a distance of at least 1 metre, use privacy curtains between the beds to minimise opportunities for close contact.

The reception area / ward clerk area should be separated from the rest of the ward and relocated to an office area with a door.

The ward must not be used as a thoroughfare by other patients, visitors or staff.

Staff entering the cohort area must be kept to a minimum.

In a cohort ward, staff must put on a surgical mask when entering the ward

The appropriate personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Staff must not travel to and from work in uniform. It is expected that they will change into uniform or, theatre scrubs (where available) on arrival at work. Staff must change out of uniform when leaving work. Place uniform into a bag to transport home (Changing out of uniform is based on public perception rather than evidence of infection risk). Uniforms should be laundered separately from household laundry, on the maximum temperature for the fabric and then ironed or tumble dried.

As per staff Uniform Policy, staff should wear shoes that can be wiped, there is no need for staff to wear overshoes; this is not recommended PPE and increases the risk of contaminating hands when removing shoe covers.

Elastic theatre caps are not recommended PPE.

3 Staff cohorting

Assigning a dedicated team of staff to care for patients in isolation/cohort rooms/areas is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available (so as not to have a negative impact on non-affected patients' care).

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including personal protective equipment (PPE), as outlined in this document

4 Standard Precautions

'Standard Precautions' refers to the application of infection control practices to prevent exposure to and the transmission of micro-organisms, which may be pathogenic (cause disease). These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps.
- Safe handling of linen.

Healthcare workers must comply with and use standard infection prevention and control precautions when caring for all patients and the patients' environment to prevent cross-transmission from both suspected and confirmed sources of infection.

5 Transmission Based Precautions

Transmission based precautions (TBPs) are applied when Standard Infection Control Precautions alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

6 Precautions (TBPs) definition

- Contact precautions: 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: Used to prevent and control infection transmission over short distances via droplets (>5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. The maximum distance for cross transmission from droplets has not been definitively determined, although a distance of approximately 1 metre (3 feet) around the infected individual has frequently been reported in the medical literature as the area of risk.

- Airborne precautions: Used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. 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.

7 Hand hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings and is a critical element of standard infection control precautions (SICPs).

All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving areas where care for – suspected and confirmed COVID-19 patients is being delivered.

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:

https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf

Rings (other than a plain smooth band), wrist watches and wrist jewellery must not be worn by staff.

8 Personal Protective Equipment (PPE)

The PPE to be used depends on the precautions required

Possible and confirmed COVID patients must be cared for using droplet precautions unless an aerosol generating procedure (AGP) is being performed.

For patients undergoing an AGP (in a side room or cohort ward) and those on ICU airborne precautions are required.

Gloves and aprons must be changed between each patient and / or following completion of a procedure or task.

9 Droplet Precautions

The patient must be isolated in a single room or cohort bay, the following PPE is to be worn by all persons entering the area:

- **Single use disposable apron** (long sleeved, thumb-looped, disposable gown should be worn if risk assessment indicates risk of splash of bodily fluids. If available Staff may find the use of longer cuffed gloves helpful as these help to hold the sleeves in place)

- **Fluid resistant surgical mask**

  Surgical masks should:

  - cover both nose and mouth
  - not be allowed to dangle around the neck after or between each use
  - not be touched once put on
  - be changed when they become moist or damaged
  - Discarded as clinical waste – hand hygiene must be performed after disposal
  - Worn in all clinical areas

- **Eye protection**, such as single use goggles or full-face visors. Full face visors should be used if blood and/or body fluid contamination to the eyes or face is anticipated or likely (note prescription glasses do not provide adequate protection)
- **Gloves** are single use and must be changed between patients refrain from touching mouth, eyes or nose with potentially contaminated gloves

10 Airborne Precautions (required for Aerosol generating procedures).

The patient must be isolated in a single room or in a cohort area with other patients undergoing AGPs. The following PPE is to be worn by all persons entering the area:

- **Long sleeved, fluid-repellent disposable gown**
- **FFP3 respirator** conforming to EN149 must be worn by all personnel in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used
- **Eye protection**, such as full-face visors or goggles, must be worn (note prescription glasses do not provide adequate protection)
- **gloves with longer tight-fitting cuffs or ordinary disposable gloves**
- refrain from touching mouth, eyes or nose with potentially contaminated gloves

The PPE described above must be worn at all times when in the patient's single room or cohort bay.

11 Putting on PPE

https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

Before putting on (donning) PPE, healthcare workers should ensure hair is tied back securely and off the neck and collar, remove jewellery/pens, ensure they are hydrated, and perform hand hygiene. The wearing of scrubs may be considered, especially for airborne precautions (ITU/ Theatres / All cohort wards).

Staff should put on PPE in the following order:

1. long sleeved gown or plastic apron
2. FFP3 respirator and fit check or surgical mask
3. eye protection (goggles or face shield)
4. disposable gloves with longer cuffs or ordinary disposable gloves

The order given above is practical but the order for putting on is less critical than the order of removal given below. During the putting on each item must be adjusted as required to ensure it fits correctly and interfaces well with other PPE items.

12 Removal of PPE

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated

The order of removal of PPE is suggested as follows, consistent with WHO guidance:

1. PPE removal can be started in the isolation room or cohort bay if there is sufficient space i.e. 2m distance from the patient. Otherwise leave patient isolation room and enter area for removal of PPE.
2. Peel off gloves and dispose in orange waste bin
3. Perform hand hygiene with alcohol gel or wash hands.
4. Remove apron/gown by using a peeling motion, fold gown in on itself and place in orange waste bin
5. Perform hand hygiene using alcohol gel or wash hands.
6. Remove goggles/visor only by touching the headband or sides and dispose in clinical waste. (If goggles are being reused they must be cleaned firstly with detergent wipes then alcohol wipes and disposed of at the end of shift / or if damaged).
7. If not already outside patient isolation area and wearing FFP3 then move outside isolation area before removing FFP3 respirator
8. Remove FFP3 respirator / surgical mask from behind and dispose in clinical waste
9. Perform hand hygiene

13 Sessional use of PPE

Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact. Respirators, fluid-resistant surgical masks (FRSM), eye protection and long sleeved disposable fluid repellent gowns can be subject to single sessional use in circumstances outlined below

A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward. A session ends when the health and social care worker leaves the clinical care setting or exposure environment. Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.

While generally considered good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient. Indeed, frequent handling of this equipment to discard and replace it could theoretically increase risk of exposure in high demand environments, for example by leading to increasing face touching during removal. The rationale for recommending sessional use in certain circumstances is therefore to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.

PPE should not be subject to continued use if damaged, soiled, compromised or uncomfortable and a session should be ended. The duration of a session could be up to 4 hours. Appropriateness of single vs sessional use is dependent on the nature of the task or activity being undertaken and the local context.

14 Aerosol generating procedures (AGP)

Aerosols generated by medical procedures are one route for the transmission of the COVID-19 virus.

The following procedures are considered to be potentially infectious 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;

For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut or in a cohort area with other patients having AGPs.

Only those healthcare staff who are needed to undertake the procedure should be present. A disposable, fluid repellent surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk.

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. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

If an aerosol generating procedure takes place the room it should be left for 60 minutes, then cleaned and disinfected before being put back into use. Anyone entering the room within 60 minutes must wear PPE used for aerosol generating procedures.

15 Equipment

- Patient care equipment should be single-use items if possible.
- Reusable (communal) non-invasive equipment should if possible be allocated to the individual patient or a cohort of patients.
- Reusable non-invasive equipment in the cohort area must be decontaminated between each patient and after blood and body fluid contamination. Clean with a neutral detergent and a chlorine-based disinfectant (Tristel).
- Equipment must be cleaned at regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.
- Avoid the use of bed side fans that re-circulate the air.

- Patient notes should be kept out of the patient's room or cohort bay. Hand hygiene must be performed after handling patients' notes.

- There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

16 Environmental decontamination

There is evidence from other coronaviruses of the potential for widespread contamination of patient rooms/environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

For cleaning, a neutral detergent and a chlorine-based disinfectant should be used (Tristel).

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces e.g. door handles (at least twice per day).

An increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.

- toilets/commodes particularly if patients have diarrhoea; and

- "frequently touched" surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment must be used for environmental decontamination. Reusable equipment must be decontaminated after use with a chlorine-based disinfectant as described above.

17 Staff considerations

Pregnant staff: Although no particular risk have been identified it is advised that pregnant staff do not care for patients with possible or confirmed COVID-19

The use of bank or agency staff should be avoided if staffing levels allow. If agency staff are working they must be fit tested for the FFP3 masks available in areas undertaking AGPs and be advised on donning & doffing PPE or be allocated to work in lower risk area.

Staff involved in care of possible and confirmed cases should contact their line manager if they develop COVID-19 compatible symptoms.

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

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

- 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 (e.g. the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In common waiting areas or during transportation, symptomatic patients may wear a fluid-resistant surgical face mask (FRSM), if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination. A FRSM is not required if the patient is wearing an oxygen mask.

19 Visitors

To reduce the risk to patients and staff, no visiting is allowed at North Devon District Hospital or South Molton Community Hospital except under certain circumstances. End of life (EOL) care is one of those circumstances. The following guidance should be followed.

Visitors in clinical areas must be immediate family members, significant others or carers.

People should not visit if they are; unwell (especially with a high temperature or a new persistent cough), vulnerable as a result of medication / medical condition or are over 70 years of age.

All visitors must be advised of and adhere to national & local hand hygiene guidance.

EOL COVID-19 patients on ICU

- All EOL visits must be prearranged with the nurse in charge of ICU.

- Visits will be limited to one visitor, for one visitor for one hour only.
- Visitors must wear all personal protective equipment as advised by the staff.

EOL COVID-19 patients on the ward

- All EOL visits must be prearranged with the nurse in charge of the ward.
- Visitors must wear all personal protective equipment as advised by the staff.
- Patients will have a maximum of two named visitors. No one else will be admitted.
- Visits will be limited to one visitor, for one hour only per day.
- No children under 16 should visit, except under exceptional circumstances and agreed with the nurse in charge beforehand.

It is important that clear sensitive communication takes place with these visitors to ensure that they understand the reasons for these restrictions. If you need help with these conversations the supportive and palliative care team will be available to support you ndht.specialistpalliativecare@nhs.net

Communication with electronic devices, whatsapp, facetime, skype should be encouraged.

The risk assessment should include whether it would be feasible for the visitor to learn the correct usage of PPE (donning and doffing under supervision), and should determine whether a visitor, even if asymptomatic, may themselves be a potential infection risk when entering or exiting the unit. It must be clear, documented and reviewed. If correct use of PPE cannot be established then the visitor must not proceed in visiting.

A list of all visitors must be kept

Visitors should be advised not to go to any other departments or locations within the hospital or healthcare facility after visiting.

PPE must be made available to visitors, including instruction and supervision of correct usage and donning and doffing.

The hospital should be mindful of its responsibilities to persons who are not employees, under The Control of Substances Hazardous to Health Regulations 2002 and The Management of Health and Safety at Work Regulations 1999.

20 Linen

Dirty used linen should be placed in an alginate bag before putting into a white bag inside the patient isolation room in accordance with procedures for infectious linen. Unbagged linen must not be carried through the ward or other clinical areas.

Bagged linen should be taken from the patient room and placed directly in the dirty linen cage for collection.

In cohort areas only a dirty linen cage will be placed in the sluice, the ward should contact Sodexo to remove of the dirty linen cage from area and arrange replace with clean cage.

21 Waste

Large volumes of waste may be generated by frequent use of PPE;

Waste from a possible or confirmed case must be disposed of as infectious (Category B) waste. This requires orange bags. See Trust Waste Management Manual.

Dispose of all waste as clinical waste (orange bags). In a cohort ward the waste orange waste bags should be placed into a yellow wheelie bin. When the wheelie bin is full, the ward should contact Sodexo to arrange for collection and replacement bin.

In a non- cohort area, clinical waste should be removed and collected from the waste storage areas outside the wards for collection.

If ambulant, the patient can use the ensuite WC. If bedpans are used, the excreta should solidified using superabsorbent polymer gel granules and then disposed of as clinical waste. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert. Communal facilities must not be used.

22 Mobile healthcare equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines:

- Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room
- The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE
- The operator should wear PPE as described above when in the isolation room / cohort bay.
- Any equipment taken in to the room and which must be subsequently removed, must be disinfected prior to leaving the anteroom.
- Any additional items such as a digital detector or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

23 Critical care

- All respiratory equipment must be protected with a high efficiency filter (eg BS EN 13328-1). This filter must be disposed of after use
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions
- A closed suctioning system must be used
- Ventilator circuits should not be broken unless necessary
- Ventilators must be placed on standby when carrying out bagging
- PPE must be worn

- Water humidification should be avoided, and a heat and moisture exchanger should be used

24 Theatres

There is a separate protocol for managing all patients attending theatre.

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated
- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, ie during intubation need to wear FFP3 respirators and full gowns. Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above
- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice. Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.
- Instruments must be transported safely to decontamination, following use
- The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine
- Theatres should not be used by staff or patients for 20 minutes after the patient leaves

25 Transfers to other departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need dictates, and in consultation with the infection control team, should patients be transferred to other departments. The following procedures then apply:

- the trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing PPE as described previously
- the department must be informed in advance of the patient's arrival
- any extraneous equipment to be removed safely from the investigation/treatment room
- the patient must be taken straight to and from the investigation/treatment room and must not wait in a communal area
- the patient should wear a 'surgical ' mask if this can be tolerated - this will prevent large respiratory droplets being expelled into the environment by the wearer. This is not required if the patient is wearing an oxygen mask.
- the treatment/procedure room, trolley/chair and all equipment should be decontaminated after use, as per the cleaning instructions above

- to enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- during patient transfers a process to ensure that no individuals not wearing PPE come within 2 metres of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

26 Transfers to other hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care

- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control measures can be take

27 Handling dead bodies

The principles of SICPs and TBPs continue to apply whilst deceased individuals remain 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 patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

DOCUMENT CONTROL

Title

Infection Prevention & Control management of COVID-19 patients Guideline

Author	**Author's job title**
	Infection Prevention & Control Nurse
Directorate	**Department**
Nursing	Infection Prevention & Control

Version	Date Issued	Status	Comment / Changes / Approval
1.0	Jan 2020	Draft	Wuhan Novel Coronavirus guidance NDHT, updated 12 times between 27.01.2020 – 03.04.2020 in accordance with local and national guidance.
2.0	April 2020	Draft	Updated 4 times between 21.04.2020 – 25.09.2020 in accordance with local and national guidance.
3.0	Oct 2020	Draft	Updates to reflect Care Pathways specific to COVID-19, placement of patients with suspected or confirmed COVID-19, Transmission Based Precautions, Personal Protective Equipment, Cohort areas, Visitors, Staff considerations, Environmental decontamination.
3.1	Oct 2020		Minor changes prior to submission to CRG
3.3	Dec 2020		Added statements re placement of CPAP BiPAP patients on green pathway
3.4	Dec 2020		Changes to IPC & PPE for COVID-19 poster section 4.5 Changes to number of days staff isolate following positive result.
3.5	April 2021		Changes to IPC & PPE for COVID-19 poster section 4.5

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Superseded Documents	

Issue Date	Review Date	Review Cycle
October 2020	September 2023	Three years

Consulted with the following stakeholders:

- Infection Prevention & Control Team
- Clinical Medical Microbiologist
- Clinical Reference Group

Approval and Review Process

- Infection Prevention & Decontamination Group

Local Archive Reference

G:\INFECTION CONTROL

Local Path

G:\INFECTION CONTROL\IC Manual - Policies\Guidelines\COVID 19 management guidelines Sept 2020

Filename

Management of COVID-19 patients Sept 20 v3.1

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
Infection Prevention & Control	COVID-19, PPE, Infection Control, AGPs, Transmission based precautions.

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the infection Prevention & Control management of COVID-19 patients admitted to Northern Devon Healthcare NHS Trust.

1.2. The guidance applies to all Trust staff.

1.3. Implementation of this guidance will ensure that:

- Patients are managed safely in line with the National care pathways specific to the COVID-19 pandemic through screening and triaging to enable early recognition and identification of COVID-19 cases.

2. Responsibilities

2.1 Role of Chief Nurse

The Chief Nurse is responsible for:

- Acting as a point of contact for support
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation

2.2 Role of Clinical Reference Group

The Clinical Reference Group is responsible for:

- Acting as a point of contact providing for support for Clinicians

2.3 Role of Infection Prevention & Decontamination Group

The Infection Prevention & Decontamination Group is responsible for:

- Monitoring compliance with the policy
- Ensuring that the policy is approved after review and prior to publishing

3. Contacting the Infection Prevention and Control Team

The Infection Prevention and Control Team can be contacted in hours on 01271 322680 (ext. 2680 internal at North Devon District Hospital), via bleep 011 or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

4. Infection Prevention & Control guidance for the management of COVID-19 - patients

4.1 Introduction

The management of patients with COVID-19 is based on PHE guidance; refer to website for current guidance:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/906096/COVID-19_flow_chart.pdf

SARS coronavirus (SARS-CoV-2), previously known as Wuhan novel coronavirus causes a respiratory disease known as COVID-19.The criteria for identifying suspected cases of COVID-19 can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

COVID-19 is potentially transmissible through droplet, airborne and contact routes.

Although respiratory secretions are the main route of transmission other bodily fluids are potentially infectious.

The correct PPE must be worn according to the patients risk categories, the type of contact with the patient and the procedures being performed.

Correct removal of PPE is particularly important in preventing infection https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

The following IPC practices will also reduce the risk of transmission:

• Effective Hand Hygiene

• Good respiratory etiquette –

- Patients, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures e.g. using single-use tissues to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose, tissues should be disposed of promptly in the nearest waste bin.

- Hands should be washed (using soap and water if possible, otherwise using alcohol based hand rub) 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 (e.g. the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In waiting areas or during transportation, symptomatic patients may wear a fluid-resistant surgical face mask (FRSM), if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- A FRSM is not required if the patient is wearing an oxygen mask.

- Decontamination of equipment and the environment.

- Use of face coverings/facemasks by staff in clinical and non-clinical areas and by patients and visitors:

  - Fluid resistant surgical facemask (FRSM) to be worn by all healthcare workers when entering the hospital and in the care setting.

  - Face coverings should be worn by patients in their own home (if tolerated) when being visited by a Health Care Worker (HCW)

  - Face coverings should be worn by all outpatients (if tolerated) and visitors when entering the hospital.

  - Surgical facemasks (Type II or Type IIR) should be worn by all inpatients in the medium and high-risk pathways as long as they can be tolerated and does not compromise their clinical care e.g. when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination.

  - All visitors should wear a face covering in healthcare settings.

  - If visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in place, such as 2m physical distancing, to ensure sufficient access depending on the patient's condition.

Follow government guidance: 'Hands. Face. Space'

- Screening – All emergency patients will be swabbed on admission, elective and patients attending for day case procedures will also be COVID-19 swabbed 72 hours prior to admission. See Trust COVID testing SOP.

4.2 Identifying suspected cases of COVID-19

Possible cases:

The current national guidance sets out the following criteria for identifying a possible case of COVID-19:

Patients who meet the following criteria (inpatient definition)

- requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night)

and

- have either clinical or radiological evidence of pneumonia

or

- acute respiratory distress syndrome

or

- influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

or

- a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

Note: Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.

Patients who meet the following criteria and are well enough to remain in the community

new continuous cough

or

high temperature

or

a loss of, or change in, normal sense of taste or smell (anosmia)

Individuals with any of the above symptoms but who are well enough to remain in the community should follow the 'Stay at home guidance' and get tested.

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

Alternative clinical diagnoses and epidemiological risk factors should be considered.

4.3 Priority Actions for Suspected COVID-19 Patients in Hospital.

Staff who work in receiving units, and especially those with first contact with patients, must be alert to the possibility of COVID-19, **if COVID-19 is suspected the patient must be isolated immediately:**

- In ED patients should be directed according to the ED pathway

For inpatients Clinicians should:

- Implement infection prevention and control measures whilst awaiting test results and assess / prioritise patients in a single occupancy rooms.
- Wear personal protective equipment (PPE) – for droplet precautions; fluid resistant surgical mask, single use disposable apron, gloves and eye protection. If a patient meeting the case definition undergoes an aerosol generating procedure (AGP), airborne precautions must be used; FFP2/FFP3 respirator, long-sleeved disposable fluid-repellent gown/coverall, gloves and eye protection.
- Patient to wear a fluid-resistant (Type IIR) surgical face mask (FRSM) if they are in a clinical or communal area, or are being transported (if the patient can tolerate it) in order to minimise the dispersal of respiratory secretions
- A FRSM should not be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). An FRSM can be worn until damp or uncomfortable
- Wearing a face mask or face covering during COVID-19 leaflet: https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/06/Face-mask-leaflet-NDHT-FINAL.pdf

4.4 Placement of Patients with Suspected or Confirmed COVID-19

In NDDH the areas identified for patients are:

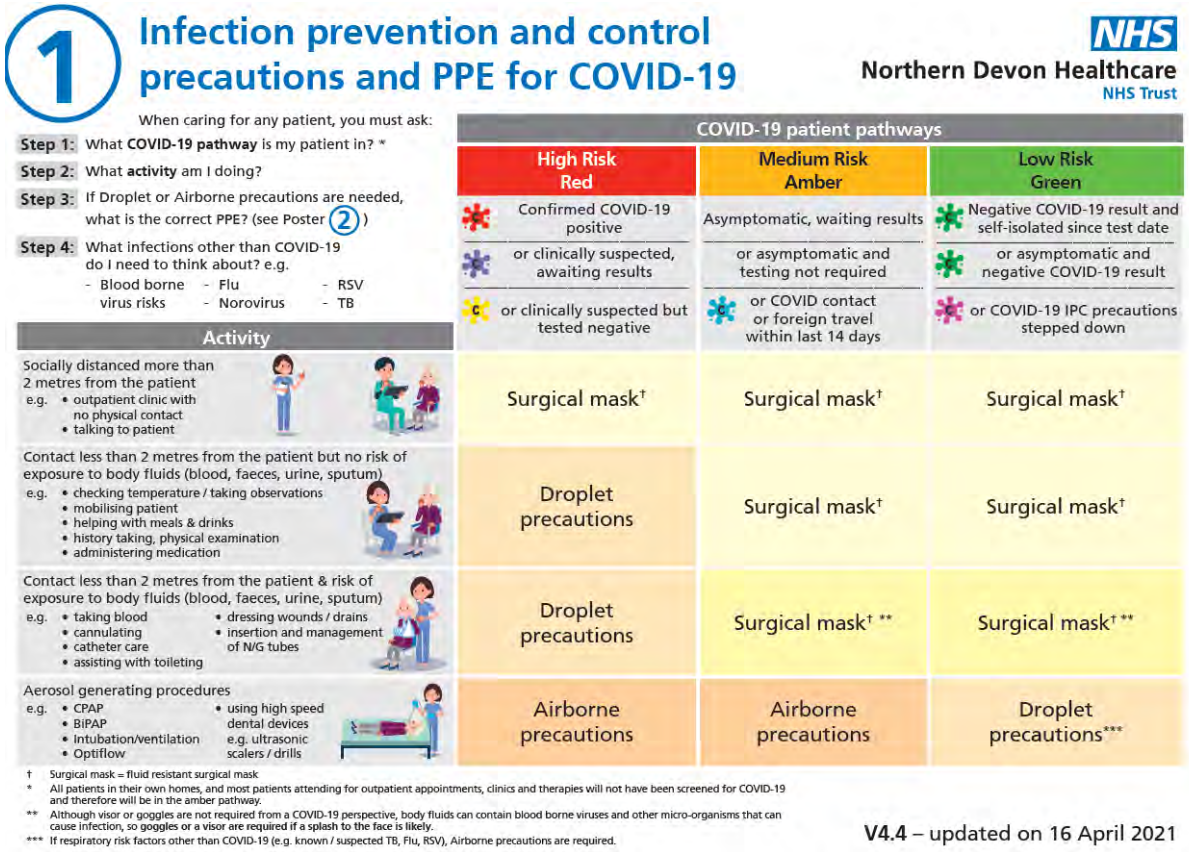
- Emergency department
- Alex / MAU ward – single rooms
- Caroline Thorpe – use side rooms 5 & 6 (side rooms 3&4 are alternatives)
- ICU
- Tarka Ward
- Capener Ward
- King George V ward single rooms only (for suspected patients awaiting results)
- Maternity

Patients with possible / confirmed COVID-19 must not be admitted to other areas within NDHT without prior discussion with the Infection Prevention & Control Team / Medical Microbiologist on-call.

All patients receiving CPAP or BiPAP should be cared for in single rooms or cohort areas. Select the PPE using pathways in section 4.5.

4.5 Patient Pathways.

National Guidance identifies care pathways, specific to COVID-19 for the management of patients using services, the pathways will ensure patients within health and other care facilities are screened and triaged in order to minimise risk. The following pathways detail risk categorisation and PPE requirements which take into account a patient's symptoms:



4.6 Infection Prevention & Control Measures

4.6.1 Isolation

Patients must be isolated in a designated room or cohort bay at all times with the door closed.

Putting on PPE must be performed in a quiet area to ensure that it is correctly worn

Correct removal of PPE must be carried out in an area where there is sufficient space to do this safely. The assistance of a buddy can be helpful.

4.6.2 Cohort Wards

If a single/isolation room is not available, patients with confirmed COVID -19 can be placed in a cohort bay with other confirmed COVID-19 respiratory infected patients.

The following measures are best practice for a COVID-19 area:

- Ensure patients are physically separated; a distance of at least 2 metre, use privacy curtains between the beds to minimise opportunities for close contact.
- The reception area / ward clerk area should be separated from the rest of the ward and relocated to an office area with a door.
- The ward must not be used as a thoroughfare by other patients, visitors or staff.
- Staff entering the cohort area must be kept to a minimum.

The appropriate personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Theatre scrubs are not routinely required but staff may find them more comfortable under PPE.

Staff must not travel to and from work in uniform. It is expected that they will change into uniform or, theatre scrubs (where available) on arrival at work. Staff must change out of uniform when leaving work. Place uniform into a bag to transport home.

Changing out of uniform is based on public perception rather than evidence of infection risk. Uniforms should be laundered separately from household laundry, on the maximum temperature for the fabric and then ironed or tumble dried.

As per staff Uniform Policy, staff should wear shoes that can be wiped,

4.6.3 Staff working in cohort areas

Assigning a dedicated team of staff to care for patients in isolation/cohort rooms/areas is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available, so as not to have a negative impact on non-affected patients' care.

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including personal protective equipment (PPE), as outlined in this document

4.6.4 Identifying Hospital acquired cases of COVID -19 / Outbreaks

The swabbing of all admissions and managing patients in the risk pathways will reduce the possibility of transmission of COVID-19 in the hospital; however transmission and outbreaks can still occur for a number of reasons e.g. failure of PPE or non-compliance with IP&C precautions by staff, patients and visitors.

An outbreak of COVID-19 may be defined as two or more confirmed cases among individuals associated with a specific setting with onset dates within 14 days. There is a national definition of a COVID-19 outbreak.

If transmission or an outbreak is identified in the Trust the IPC team will implement outbreak control measures which will include restriction of movement and contact tracing of staff, patients and visitors as per Outbreak Policy.

4.6.5 Contacts

Patients or staff who have had significant exposure to COVID-19 will be identified as contacts. The IPC team in conjunction with the Contact Tracing Lead will assess the exposure and determine if isolation is required.

Identified patient contacts must be isolated in a single room or in a cohort bay for 14 days from their first exposure to a COVID-19 positive case or as advised by the IPC team. Patients identified as a contact must be managed in the 'Medium Risk Amber'

pathway. If patients are being discharged within the 14 days isolation period they must be informed to continue to isolate at home as per national guidance. Patients can be discharge home but if a package of care is required care agencies must be informed.

Staff identified as having significant contact will be required to self-isolate at home for 10 days as per national guidance.

4.7 Infection Prevention and Control Precautions

It is important to use the right precautions when caring for patients with COVID-19, these precautions will be a combination of the following:

4.7.1 Standard Precautions

'Standard Precautions' refers to the application of infection control practices to prevent exposure to and the transmission of micro-organisms, which may be pathogenic (cause disease). These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps
- Safe handling of linen
- Patient placement and assessment for infection risk (screening/triaging)
- Respiratory and cough hygiene
- Occupational safety: prevention and exposure management
- Maintaining social/physical distancing

Healthcare workers must comply with and use standard infection prevention and control precautions when caring for all patients and the patients' environment to prevent cross-transmission from both suspected and confirmed sources of infection.

4.7.2 Transmission Based Precautions

Transmission based precautions (TBPs) are applied when Standard Infection Control Precautions (SICPs) alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

4.7.3 Transmission Based Precautions (TBPs) Definitions

- **Contact precautions:** 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**: Used to prevent and control infection transmission over short distances via droplets (>5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been increased to 2 metres.
- **Airborne precautions**: Used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

Aerosols penetrate the respiratory system to the alveolar level. 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.

4.7.4 Hand Hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings and is a critical element of standard infection control precautions (SICPs).

All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving all clinical areas.

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:

https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf

All staff in clinical areas must be bare below the elbows and rings (other than a plain smooth band). Wrist watches and wrist jewellery must not be worn.

4.7.5 Personal Protective Equipment (PPE)

The PPE to be used depends on the IPC precautions required.

Possible and confirmed COVID patients must be cared for using droplet precautions unless an aerosol generating procedure (AGP) is being performed.

For patients undergoing an AGP (in a side room or cohort ward) and those on ICU airborne precautions are required.

Gloves and aprons must be changed between each patient and / or following completion of a procedure or task.

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated (see section 5.5).

Head/footwear:

• Headwear is not routinely required in clinical areas, even if undertaking an AGP, unless it is part of theatre attire or to prevent contamination of the environment such as in clean rooms.

• Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres.

• foot/shoe coverings are not required or recommended for the care of COVID-19 cases and increases the risk of contaminating hands when removing shoe covers.

In some cases PPE / face masks can restrict communication with individuals and other ways of communicating may need to be considered

4.7.6 Sessional use of PPE

- Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact.
- Respirators, fluid-resistant surgical masks (FRSM), eye protection and can be subject to single sessional use in circumstances outlined below:
- A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward. A session ends when the health and social care worker leaves the clinical care setting or exposure environment.
- Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.
- While generally considered good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient. Indeed, frequent handling of this equipment to discard and replace it could theoretically increase risk of exposure in high demand environments, for example by leading to increasing face touching during removal. The rationale for recommending sessional use in certain circumstances is therefore to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.
- PPE should not be subject to continued use if damaged, soiled, compromised or uncomfortable and a session should be ended. The duration of a session could be up to 4 hours. Appropriateness of single vs sessional use is dependent on the nature of the task or activity being undertaken and the local context.

4.7.7 Droplet Precautions

The patient must be isolated in a single room or cohort bay, the following PPE is to be worn by all persons entering the area:

Single use disposable apron must be worn:

- To protect uniform when contamination is anticipated or likely and when providing direct care within 2 metres of suspected/confirmed COVID-19 case.
- Must be changed between patients and/or after completing a procedure or task.

Fluid resistant surgical mask (Type IIR)

Surgical masks must:

- Cover both nose and mouth.
- Not be allowed to dangle around the neck after or between each use.
- Not be touched / adjusted once put on (hand hygiene must be performed if the mask is adjusted).
- Sessional use of up to 4 hours but must be changed immediately when they become moist / damaged.
- Discarded as clinical waste – hand hygiene must be performed after disposal.

- Worn whenever in the hospital environment.

Eye protection (single use goggles or full-face visors).

- Full face visors must be used if contact with blood and/or body fluid contamination to the eyes or face is anticipated or likely (prescription glasses do not provide adequate protection).

Disposable Gloves:

- Must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
- Must be changed immediately after each patient and/or after completing a procedure/task even on the same patient.
- Never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between tasks.
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases and vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids

4.7.8 Airborne Precautions (required for Aerosol generating procedures).

Patients in the High Risk / Amber COVID-19 pathways must be isolated in a single room or in a cohort bay with other patients undergoing AGPs. The following PPE is to be worn by all persons entering the single room or in a cohort bay:

- **Long sleeved, fluid-repellent disposable gown**
- **FFP3 respirator** conforming to EN149 must be worn by all staff in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used.
- **Eye protection-** full-face visors or goggles, must be worn (prescription glasses do not provide adequate protection)
- **Disposable gloves-** refrain from touching mouth, eyes or nose with potentially contaminated gloves.

The PPE described above must be worn at all times when in the patient's single room or cohort bay.

4.7.9 Putting on PPE

Before putting on (donning) PPE, healthcare workers should ensure hair is tied back securely (so as not to interfere with PPE) and off the neck/collar, remove jewellery/pens, ensure they are hydrated, and perform hand hygiene. For staff comfort the wearing of scrubs may be considered, especially for airborne precautions (ITU/ Theatres / cohort wards).

After cleaning hands staff should put on PPE in the following order:

1. Long sleeved gown or plastic apron

2. FFP3 respirator and fit check, or surgical mask

3. Eye protection (goggles or face shield)

4. Disposable gloves

The order given above is practical but the order for putting on is less critical than the order of removal given below. When putting on each item must be adjusted as required to ensure it fits correctly and interfaces well with other PPE items.

4.7.10 Removal of PPE

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated

The order of removal of PPE is as follows, and is consistent with WHO guidance:

1. PPE removal can be started in the isolation room or cohort bay if there is sufficient space i.e. 2m distance from the patient. Otherwise leave patient isolation room and enter area for removal of PPE.

2. Peel off gloves and dispose in orange waste bin

3. Perform hand hygiene with alcohol gel or wash hands.

4. Remove apron/gown by using a peeling motion, fold gown in on itself and place in orange waste bin

5. Perform hand hygiene using alcohol gel or wash hands.

6. Remove goggles/visor only by touching the headband or sides and dispose in clinical waste. (If goggles are being reused they must be cleaned, firstly with detergent wipes then alcohol wipes and disposed of at the end of shift / or if damaged).

7. Perform hand hygiene using alcohol gel or wash hands

8. If not already outside patient isolation area and still wearing FFP3 then move outside isolation area before removing the FFP3 respirator.

9. Remove FFP3 respirator / surgical mask from behind and dispose in clinical waste.

10. Perform hand hygiene

PPE videos are available to watch on BOB:
https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

4.8 Definition of Aerosol generating procedures (AGP)

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols from the respiratory tract when treating

someone who is suspected or known to have an infection transmitted wholly or partly by the airborne or droplet route.

The following is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

• Tracheal intubation and extubation

• Manual ventilation

• Tracheotomy or tracheostomy procedures (insertion or removal)

• Bronchoscopy

• Dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills.

• Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)

• High flow nasal oxygen (HFNO)

• High frequency oscillatory ventilation (HFOV)

• Induction of sputum using nebulised saline

• Respiratory tract suctioning

• Upper ENT airway procedures that involve respiratory suctioning

• Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs

• High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut or in a cohort area with other patients having AGPs.

Only those healthcare staff who are needed to undertake the procedure should be present. A disposable, fluid repellent surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk.

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. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

Clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room. In a room with 10-12 air changes per hour (ACH) a minimum of 20 minutes is considered pragmatic: in a side room with 6 ACH this would be approximately one hour.

If an AGP takes place in the room it should be left for 60 minutes before being cleaned. At this time staff entering the room must wear PPE for Airborne precautions; further advice should be sought from IPCT if required. The patients' room must have an isolation clean following resolution of symptoms, discharged or transferred.

The Trust Resuscitation Policy is consistent with the Resuscitation Council guidance and includes the use of airborne precautions.

4.9 Equipment

- Patient care equipment should be single-use items if possible.
- Reusable non-invasive equipment should if possible be allocated to the individual patient or a cohort of patients.
- Reusable non-invasive equipment in the cohort area must be decontaminated between each patient and after blood and body fluid contamination. Clean with a neutral detergent and a chlorine-based disinfectant (Tristel).
- Equipment must be cleaned at regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.
- Where possible, avoid the use of bed side fans that re-circulate the air.
- Patient medical notes should be kept out of the patient's room or cohort bay. Hand hygiene must be performed after handling patients' notes.
- There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

4.10 Environmental Decontamination

There is evidence from other coronaviruses of the potential for widespread contamination of patient rooms/environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

For cleaning, a neutral detergent and a chlorine-based disinfectant should be used (Tristel).

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces e.g. door handles (more than twice a day).

An increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.

- toilets/commodes particularly if patients have diarrhoea; and

- "frequently touched" surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails should be cleaned more than twice a day and when known to be contaminated with secretions, excretions or body fluids.

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment must be used for environmental decontamination. Reusable equipment must be decontaminated after use with a chlorine-based disinfectant as described above.

4.11 Linen

Dirty used linen should be placed in an alginate bag before putting into a white bag inside the patient isolation room in accordance with procedures for infectious linen. Unbagged linen must not be carried through the ward or other clinical areas.

Bagged linen should be taken from the patient room and placed directly in the dirty linen cage for collection.

In cohort areas only a dirty linen cage will be placed in the sluice, the ward should contact Sodexo to remove of the dirty linen cage from area and arrange replace with clean cage.

4.12 Waste

Large volumes of waste may be generated by frequent use of PPE;

Waste from a possible or confirmed case must be disposed of as infectious (Category B) waste. This requires orange bags. See Trust Waste Management Manual.

Dispose of all waste as clinical waste (orange bags). In a cohort ward the orange waste bags should be placed into a yellow wheelie bin. When the wheelie bin is full, the ward should contact Sodexo to arrange for collection and replacement bin.

In a non-cohort area, clinical waste should be removed and collected from the waste storage areas outside the wards for collection.

If ambulant, the patient can use the ensuite WC. If bedpans are used, the excreta should solidified using superabsorbent polymer gel granules and then disposed of as clinical waste. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert. Toilet facilities within a cohort bay may be shared but toilet the facilities must not be shared with other patients in the ward area.

4.13 Staff Considerations

Prompt recognition / management of positive staff and also staff exposed to COVID-19 is essential to limit the spread of the virus.

If staff or members of their household have possible symptoms of COVID-19 they should refer to the COVID-19 testing SOP to determine if testing is required and whether they are able to come to work / remain at work.

A staff risk assessment is required for all health and social care staff, especially those at higher risk of complications from COVID-19, including pregnant staff.

Managers should:

- Discuss with employees who are at higher risk or are pregnant the need to be deployed away from areas used for the care of those who have or may have COVID-19.
- Ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications.
- Bank, agency and locum staff should follow the same deployment advice as permanent staff.
- In the event of a breach in infection control procedures or failure of PPE, staff should to be reviewed by the IPC team and Occupational Health. Occupational health departments should lead on the implementation of systems to monitor staff illness and absence.
- In the event of staff exposure to a patient whose COVID-19 status was not known, the COVID-19 Contact Tracing Lead will identify staff who are considered to be contacts.

4.14 Visitors

Visiting is restricted at NDDH and South Molton to reduce the risk of COVID-19 transmission. Our staff can support patients and their families to stay in contact by using other methods such as video calls, letter printing etc. instead, where possible. Please contact our patient experience team for more information at ndht.patientexperience@nhs.net

Visitors will also be required to wear a mask or face covering when in the hospital, may be temperature checked and must follow social distancing and hand hygiene guidelines. Visitors must not visit if unwell.

Visiting is only allowed as follows:

- If there are specific reasons of safety (dementia or learning disability where anxiety would be increased significantly).
- Inpatients under the age of 18 years old – one parent/guardian only (both parents are permitted in the special care baby unit).
- Adult inpatients – one person per patient, from the same household or support bubble, this will need to be agreed with the ward staff to ensure social distancing is maintained.
- Visiting times may be staggered to accommodate visiting for all patients.
- All visitors should wear a face covering
- Visitors will be asked to wear a surgical facemask if visiting a high risk area or a patient with suspected/known COVID-19
- Parents/guardians must always wear a face covering when entering and moving through the healthcare setting and when a healthcare professional is treating their child/young person. If they are with their child and/or young person and within their ‘family bubble’ in side rooms or physical environments that afford separation, they can remove their face covering.
- Anyone showing symptoms of coronavirus should not visit. If visitors display symptoms of coronavirus they should be asked to leave, self-isolate at home for 14 days and organise a test; members of their household should also self-isolate for 14 days.
- Wards/departments/units must keep a list of visitors’ names and contact details to aid the NHS Test and Trace teams if contact tracing is indicated.
- Admission areas e.g. ED/MAU/AAA will have the discretion to allow one person to accompany the patient to ensure the correct patient history etc. is obtained.

- At outpatient and diagnostic appointments where a patient may need emotional support they can be accompanied by one person from the same household or support bubble.
- A patient receiving end of life care can receive more than one visitor from the same household or support bubble within a 24 hour period. Where a face to face visit is not practical then virtual visits can be facilitated by contacting the outreach and resuscitation team on bleep 007 Monday – Friday, and clinical site team out of hours.

Maternity visiting

- One partner or designated individual is able to attend the dating scan (at approx. 12 weeks) and the anomaly scan (at 20 weeks), they are not able to stay for any subsequent appointments with a doctor or midwife.
- All other scans, such as growth scans, should be attended alone, though an exception can be made if it is anticipated that bad news might have to be given.
- If a woman is being induced, they can have a partner, or designated individual attend, with them between the hours of 10am and 6pm. Outside of these hours our staff will continue to contact partners and ask them to attend the unit if, due to pain or distress, support is required.
- One partner, or designated individual, may make an appointment with ward staff to visit Bassett Ward between the hours of 10am and 6pm. They can stay for as long as they like during that period but we are encouraging people to contact their individual midwife to arrange this.
- As throughout the whole of the COVID-19 pandemic, if a woman is being cared for in labour ward or in theatre, they can have one birth partner with them. This is usually when they are in labour, having a caesarean or in the immediate postnatal period.

Ward managers and clinical matrons have autonomy to manage extensions to these restrictions in exceptional circumstances.

4.15 Mobile Healthcare Equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines:

- Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room
- The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE
- The operator should wear PPE as described above when in the isolation room / cohort bay.
- Any equipment taken in to the room and which must be subsequently removed must be disinfected prior to leaving the room.
- Any additional items such as a digital detector or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

4.16 Critical Care

- All respiratory equipment must be protected with a high efficiency filter (eg BS EN 13328-1). This filter must be disposed of after use
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions
- A closed suctioning system must be used
- Ventilator circuits should not be broken unless necessary
- Ventilators must be placed on standby when carrying out bagging
- PPE must be worn
- Water humidification should be avoided, and a heat and moisture exchanger should be used

4.17 Theatres

There is a separate protocol for managing all patients attending theatre.

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated
- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, i.e. during intubation need to wear FFP3 respirators and full gowns. Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above
- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice. Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.
- Instruments must be transported safely to decontamination, following use
- The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine
- Theatres should not be used by staff or patients for 20 minutes after an aerosol generating procedure.

4.18 Transfers to other Departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need dictates, and in consultation with the infection prevention & control team, should patients be transferred to other departments. The following procedures then apply:

- The trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing PPE as described previously
- The department must be informed in advance of the patient's arrival

- any extraneous equipment to be removed safely from the investigation/treatment room
- The patient must be taken straight to and from the investigation/treatment room and must not wait in a communal area
- The patient should wear a fluid resistant surgical mask if this can be tolerated - this will prevent large respiratory droplets being expelled into the environment by the wearer. This is not required if the patient is wearing an oxygen mask.
- The treatment/procedure room, trolley/chair and all equipment should be decontaminated after use, as per the cleaning instructions above
- To enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- During patient transfers a process to ensure that no individuals not wearing PPE come within 2 metres of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

4.19 Transfers to other Hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care
- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control measures can be taken.

4.20 Community

NDHT staff working at other Trust locations and community staff visiting patients in their own home / care homes must follow the correct standard infection control and transmission based precautions (detailed in section 4.7) using the same COVID-19 pathways for High, Medium and Low risk patients. If tolerated, face coverings should be worn by patients in their own home when being visited by a Health Care Worker.

4.21 Handling the Deceased

The principles of SICPs and TBPs continue to apply whilst deceased individuals remain 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 patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

5 Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

5.1 Key performance indicators comprise:

5.2 The numbers of incidents relating to inappropriate management of patients with suspected or confirmed COVID-19.

5.3 The number of COVID-19 infections involving patients and staff

Process for Implementation and Monitoring Compliance and Effectiveness

5.4 After final approval, the author will arrange for a copy of the policy to be placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release. Information will also be included in the Chief Executive's Bulletin which is circulated electronically to all staff. Line managers are responsible for ensuring this policy is implemented across their area of work.

Monitoring compliance with this policy will be the responsibility of the Infection Prevention and Control team. This will be undertaken by Weekly monitoring of incident forms at the Infection Prevention and Control team meetings

- Where non-compliance is identified, support and advice will be provided to improve practice.
- Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by weekly review of incident forms by the Infection Control Team and daily operational oversight by Infection prevention and control Nurses during hours and out of hours by on-call Microbiologist.
- For staff exclusion matters there will be case by case liaison with Occupational Health.
- Where non-compliance is identified, support and advice will be provided to improve practice. This may involve additional training to specific groups of staff; increased frequency of audit; and observation of clinical practice.

6 References

- PHE (2020).COVID-19: Guidance for the remobilisation of services within health and care settings; Infection prevention and control recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
- PHE (2020). Coronavirus (COVID-19)

https://www.gov.uk/coronavirus

- PHE (2020). COVID-19: investigation and initial clinical management of possible cases (July 2020). https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

- Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection. Updated 28 September 2020 https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

- PHE (2020). COVID-19: personal protective equipment use for aerosol generating procedures. https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

7 Associated Documentation

- Covid-19 Testing Standard Operating Procedure
- Decontamination Policy
- EASIAIR 2020 Powered Air Purifying Respirator
- Standard Operating Procedure Influenza-like illness Policy
- Laundry Policy
- Outbreak
- Outbreak of Infection Policy
- Patient Isolation and staff exclusion policy
- Respiratory Infections policy
- Standard Infection Control Precautions Policy
- Waste Management Manual

DOCUMENT CONTROL

Title

Infection Prevention & Control management of COVID-19 patients Guideline

Author	**Author's job title** Infection Prevention & Control Nurse
Directorate Nursing	**Department** Infection Prevention & Control

Version	Date Issued	Status	Comment / Changes / Approval
1.0	Jan 2020	Draft	Wuhan Novel Coronavirus guidance NDHT, updated 12 times between 27.01.2020 – 03.04.2020 in accordance with local and national guidance.
2.0	April 2020	Draft	Updated 4 times between 21.04.2020 – 25.09.2020 in accordance with local and national guidance.
3.0	Oct 2020	Draft	Updates to reflect Care Pathways specific to COVID-19, placement of patients with suspected or confirmed COVID-19, Transmission Based Precautions, Personal Protective Equipment, Cohort areas, Visitors, Staff considerations, Environmental decontamination.
3.1	Oct 2020		Minor changes prior to submission to CRG

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Lead Director
Chief Nurse

Superseded Documents

Issue Date	Review Date	Review Cycle
October 2020	September 2023	Three years

Consulted with the following stakeholders:

- Infection Prevention & Control Team
- Clinical Medical Microbiologist
- Clinical Reference Group

Approval and Review Process

- Infection Prevention & Decontamination Group

Local Archive Reference
G:\INFECTION CONTROL
Local Path

G:\INFECTION CONTROL\IC Manual - Policies\Guidelines\COVID 19 management guidelines Sept 2020 **Filename** Management of COVID-19 patients Sept 20 v3.1	
Policy categories for Trust's internal website (Bob) Infection Prevention & Control	**Tags for Trust's internal website (Bob)** COVID-19, PPE, Infection Control, AGPs, Transmission based precautions.

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the infection Prevention & Control management of COVID-19 patients admitted to Northern Devon Healthcare NHS Trust.

1.2. The guidance applies to all Trust staff.

1.3. Implementation of this guidance will ensure that:

- Patients are managed safely in line with the National care pathways specific to the COVID-19 pandemic through screening and triaging to enable early recognition and identification of COVID-19 cases.

2. Responsibilities

2.1 Role of Chief Nurse

The Chief Nurse is responsible for:

- Acting as a point of contact for support
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation

2.2 Role of Clinical Reference Group

The Clinical Reference Group is responsible for:

- Acting as a point of contact providing for support for Clinicians

2.3 Role of Infection Prevention & Decontamination Group

The Infection Prevention & Decontamination Group is responsible for:

- Monitoring compliance with the policy
- Ensuring that the policy is approved after review and prior to publishing

3. Contacting the Infection Prevention and Control Team

The Infection Prevention and Control Team can be contacted in hours on [redacted] ([redacted] internal at North Devon District Hospital), via bleep [redacted] or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

4. Infection Prevention & Control guidance for the management of COVID-19 - patients

4.1 Introduction

The management of patients with COVID-19 is based on PHE guidance; refer to website for current guidance:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/906096/COVID-19_flow_chart.pdf

SARS coronavirus (SARS-CoV-2), previously known as Wuhan novel coronavirus causes a respiratory disease known as COVID-19.The criteria for identifying suspected cases of COVID-19 can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

COVID-19 is potentially transmissible through droplet, airborne and contact routes.

Although respiratory secretions are the main route of transmission other bodily fluids are potentially infectious.

The correct PPE must be worn according to the patients risk categories, the type of contact with the patient and the procedures being performed.

Correct removal of PPE is particularly important in preventing infection https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

The following IPC practices will also reduce the risk of transmission:

• Effective Hand Hygiene

• Good respiratory etiquette –

- Patients, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures e.g. using single-use tissues to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose, tissues should be disposed of promptly in the nearest waste bin.

- Hands should be washed (using soap and water if possible, otherwise using alcohol based hand rub) 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 (e.g. the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In waiting areas or during transportation, symptomatic patients may wear a fluid-resistant surgical face mask (FRSM), if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- A FRSM is not required if the patient is wearing an oxygen mask.

- Decontamination of equipment and the environment.

- Use of face coverings/facemasks by staff in clinical and non-clinical areas and by patients and visitors:

  - Fluid resistant surgical facemask (FRSM) to be worn by all healthcare workers when entering the hospital and in the care setting.

  - Face coverings should be worn by patients in their own home (if tolerated) when being visited by a Health Care Worker (HCW)

  - Face coverings should be worn by all outpatients (if tolerated) and visitors when entering the hospital.

  - Surgical facemasks (Type II or Type IIR) should be worn by all inpatients in the medium and high-risk pathways as long as they can be tolerated and does not compromise their clinical care e.g. when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination.

  - All visitors should wear a face covering in healthcare settings.

  - If visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in place, such as 2m physical distancing, to ensure sufficient access depending on the patient's condition.

Follow government guidance: 'Hands. Face. Space'

- Screening – All emergency patients will be swabbed on admission, elective and patients attending for day case procedures will also be COVID-19 swabbed 72 hours prior to admission. See Trust COVID testing SOP.

4.2 Identifying suspected cases of COVID-19

Possible cases:

The current national guidance sets out the following criteria for identifying a possible case of COVID-19:

Patients who meet the following criteria (inpatient definition)

- requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night)

and

- have either clinical or radiological evidence of pneumonia

or

- acute respiratory distress syndrome

or

- influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

or

- a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

Note: Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.

Patients who meet the following criteria and are well enough to remain in the community

new continuous cough

or

high temperature

or

a loss of, or change in, normal sense of taste or smell (anosmia)

Individuals with any of the above symptoms but who are well enough to remain in the community should follow the 'Stay at home guidance' and get tested.

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

Alternative clinical diagnoses and epidemiological risk factors should be considered.

4.3 Priority Actions for Suspected COVID-19 Patients in Hospital.

Staff who work in receiving units, and especially those with first contact with patients, must be alert to the possibility of COVID-19, **if COVID-19 is suspected the patient must be isolated immediately:**

- In ED patients should be directed according to the ED pathway

For inpatients Clinicians should:

- Implement infection prevention and control measures whilst awaiting test results and assess / prioritise patients in a single occupancy rooms.
- Wear personal protective equipment (PPE) – for droplet precautions; fluid resistant surgical mask, single use disposable apron, gloves and eye protection. If a patient meeting the case definition undergoes an aerosol generating procedure (AGP), airborne precautions must be used; FFP2/FFP3 respirator, long-sleeved disposable fluid-repellent gown/coverall, gloves and eye protection.
- Patient to wear a fluid-resistant (Type IIR) surgical face mask (FRSM) if they are in a clinical or communal area, or are being transported (if the patient can tolerate it) in order to minimise the dispersal of respiratory secretions
- A FRSM should not be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). An FRSM can be worn until damp or uncomfortable
- Wearing a face mask or face covering during COVID-19 leaflet: https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/06/Face-mask-leaflet-NDHT-FINAL.pdf

4.4 Placement of Patients with Suspected or Confirmed COVID-19

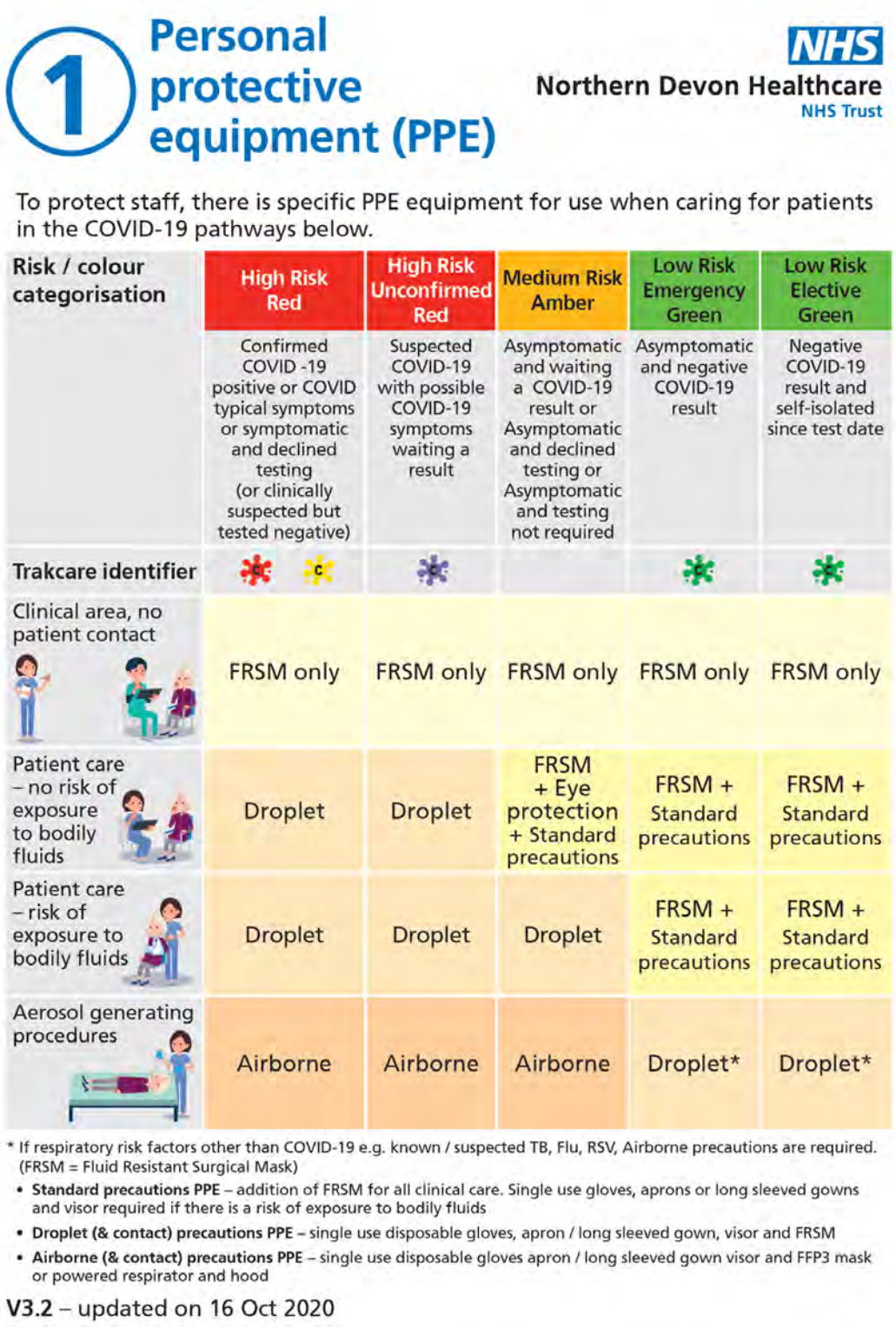
In NDDH the areas identified for patients are:

- Emergency department
- Alex / MAU ward – single rooms
- Caroline Thorpe – use side rooms 5 & 6 (side rooms 3&4 are alternatives)
- ICU
- Tarka Ward
- Capener Ward
- King George V ward single rooms only (for suspected patients awaiting results)
- Maternity

Patients with possible / confirmed COVID-19 must not be admitted to other areas within NDHT without prior discussion with the Infection Prevention & Control Team / Medical Microbiologist on-call.

4.5 Patient Pathways.

National Guidance identifies care pathways, specific to COVID-19 for the management of patients using services, the pathways will ensure patients within health and other care facilities are screened and triaged in order to minimise risk. The following pathways detail risk categorisation and PPE requirements which take into account a patient's symptoms:



1 Personal protective equipment (PPE)

NHS
Northern Devon Healthcare
NHS Trust

To protect staff, there is specific PPE equipment for use when caring for patients in the COVID-19 pathways below.

Risk / colour categorisation	High Risk Red	High Risk Unconfirmed Red	Medium Risk Amber	Low Risk Emergency Green	Low Risk Elective Green
	Confirmed COVID -19 positive or COVID typical symptoms or symptomatic and declined testing (or clinically suspected but tested negative)	Suspected COVID-19 with possible COVID-19 symptoms waiting a result	Asymptomatic and waiting a COVID-19 result or Asymptomatic and declined testing or Asymptomatic and testing not required	Asymptomatic and negative COVID-19 result	Negative COVID-19 result and self-isolated since test date
Trakcare identifier					
Clinical area, no patient contact	FRSM only	FRSM only	FRSM only	FRSM only	FRSM only
Patient care – no risk of exposure to bodily fluids	Droplet	Droplet	FRSM + Eye protection + Standard precautions	FRSM + Standard precautions	FRSM + Standard precautions
Patient care – risk of exposure to bodily fluids	Droplet	Droplet	Droplet	FRSM + Standard precautions	FRSM + Standard precautions
Aerosol generating procedures	Airborne	Airborne	Airborne	Droplet*	Droplet*

* If respiratory risk factors other than COVID-19 e.g. known / suspected TB, Flu, RSV, Airborne precautions are required. (FRSM = Fluid Resistant Surgical Mask)

- **Standard precautions PPE** – addition of FRSM for all clinical care. Single use gloves, aprons or long sleeved gowns and visor required if there is a risk of exposure to bodily fluids
- **Droplet (& contact) precautions PPE** – single use disposable gloves, apron / long sleeved gown, visor and FRSM
- **Airborne (& contact) precautions PPE** – single use disposable gloves apron / long sleeved gown visor and FFP3 mask or powered respirator and hood

V3.2 – updated on 16 Oct 2020

4.6 Infection Prevention & Control Measures

4.6.1 Isolation

Patients must be isolated in a designated room or cohort bay at all times with the door closed.

Putting on PPE must be performed in a quiet area to ensure that it is correctly worn

Correct removal of PPE must be carried out in an area where there is sufficient space to do this safely. The assistance of a buddy can be helpful.

4.6.2 Cohort Wards

If a single/isolation room is not available, patients with confirmed COVID -19 can be placed in a cohort bay with other confirmed COVID-19 respiratory infected patients.

The following measures are best practice for a COVID-19 area:

- Ensure patients are physically separated; a distance of at least 2 metre, use privacy curtains between the beds to minimise opportunities for close contact.
- The reception area / ward clerk area should be separated from the rest of the ward and relocated to an office area with a door.
- The ward must not be used as a thoroughfare by other patients, visitors or staff.
- Staff entering the cohort area must be kept to a minimum.

The appropriate personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Theatre scrubs are not routinely required but staff may find them more comfortable under PPE.

Staff must not travel to and from work in uniform. It is expected that they will change into uniform or, theatre scrubs (where available) on arrival at work. Staff must change out of uniform when leaving work. Place uniform into a bag to transport home.

Changing out of uniform is based on public perception rather than evidence of infection risk. Uniforms should be laundered separately from household laundry, on the maximum temperature for the fabric and then ironed or tumble dried.

As per staff Uniform Policy, staff should wear shoes that can be wiped,

4.6.3 Staff working in cohort areas

Assigning a dedicated team of staff to care for patients in isolation/cohort rooms/areas is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available, so as not to have a negative impact on non-affected patients' care.

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including personal protective equipment (PPE), as outlined in this document

4.6.4 Identifying Hospital acquired cases of COVID -19 / Outbreaks

The swabbing of all admissions and managing patients in the risk pathways will reduce the possibility of transmission of COVID-19 in the hospital; however transmission and

outbreaks can still occur for a number of reasons e.g. failure of PPE or non-compliance with IP&C precautions by staff, patients and visitors.

An outbreak of COVID-19 may be defined as two or more confirmed cases among individuals associated with a specific setting with onset dates within 14 days. There is a national definition of a COVID-19 outbreak.

If transmission or an outbreak is identified in the Trust the IPC team will implement outbreak control measures which will include restriction of movement and contact tracing of staff, patients and visitors as per Outbreak Policy.

4.6.5 Contacts

Patients or staff who have had significant exposure to COVID-19 will be identified as contacts. The IPC team in conjunction with the Contact Tracing Lead will assess the exposure and determine if isolation is required.

Identified patient contacts must be isolated in a single room or in a cohort bay for 14 days from their first exposure to a COVID-19 positive case or as advised by the IPC team. Patients identified as a contact must be managed in the 'Medium Risk Amber' pathway. If patients are being discharged within the 14 days isolation period they must be informed to continue to isolate at home as per national guidance. Patients can be discharge home but if a package of care is required care agencies must be informed.

Staff identified as having significant contact will be required to self-isolate at home for 14 days as per national guidance.

4.7 Infection Prevention and Control Precautions

It is important to use the right precautions when caring for patients with COVID-19, these precautions will be a combination of the following:

4.7.1 Standard Precautions

'Standard Precautions' refers to the application of infection control practices to prevent exposure to and the transmission of micro-organisms, which may be pathogenic (cause disease). These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps
- Safe handling of linen
- Patient placement and assessment for infection risk (screening/triaging)
- Respiratory and cough hygiene
- Occupational safety: prevention and exposure management
- Maintaining social/physical distancing

Healthcare workers must comply with and use standard infection prevention and control precautions when caring for all patients and the patients' environment to prevent cross-transmission from both suspected and confirmed sources of infection.

4.7.2 Transmission Based Precautions

Transmission based precautions (TBPs) are applied when Standard Infection Control Precautions (SICPs) alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

4.7.3 Transmission Based Precautions (TBPs) Definitions

- **Contact precautions:** 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**: Used to prevent and control infection transmission over short distances via droplets (>5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been increased to 2 metres.
- **Airborne precautions**: Used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. 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.

4.7.4 Hand Hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings and is a critical element of standard infection control precautions (SICPs).

All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving all clinical areas.

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:

https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf

All staff in clinical areas must be bare below the elbows and rings (other than a plain smooth band). Wrist watches and wrist jewellery must not be worn.

4.7.5 Personal Protective Equipment (PPE)

The PPE to be used depends on the IPC precautions required.

Possible and confirmed COVID patients must be cared for using droplet precautions unless an aerosol generating procedure (AGP) is being performed.

For patients undergoing an AGP (in a side room or cohort ward) and those on ICU airborne precautions are required.

Gloves and aprons must be changed between each patient and / or following completion of a procedure or task.

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated (see section 5.5).

Head/footwear:

• Headwear is not routinely required in clinical areas, even if undertaking an AGP, unless it is part of theatre attire or to prevent contamination of the environment such as in clean rooms.

• Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres.

• foot/shoe coverings are not required or recommended for the care of COVID-19 cases and increases the risk of contaminating hands when removing shoe covers.

In some cases PPE / face masks can restrict communication with individuals and other ways of communicating may need to be considered

4.7.6 Sessional use of PPE

- Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact.
- Respirators, fluid-resistant surgical masks (FRSM), eye protection and can be subject to single sessional use in circumstances outlined below:
- A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward. A session ends when the health and social care worker leaves the clinical care setting or exposure environment.
- Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.
- While generally considered good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient. Indeed, frequent handling of this equipment to discard and replace it could theoretically increase risk of exposure in high demand environments, for example by leading to increasing face touching during removal. The rationale for recommending sessional use in certain circumstances is therefore to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.
- PPE should not be subject to continued use if damaged, soiled, compromised or uncomfortable and a session should be ended. The duration of a session could be up to 4 hours. Appropriateness of single vs sessional use is dependent on the nature of the task or activity being undertaken and the local context.

4.7.7 Droplet Precautions

The patient must be isolated in a single room or cohort bay, the following PPE is to be worn by all persons entering the area:

Single use disposable apron must be worn:

- To protect uniform when contamination is anticipated or likely and when providing direct care within 2 metres of suspected/confirmed COVID-19 case.
- Must be changed between patients and/or after completing a procedure or task.

Fluid resistant surgical mask (Type IIR)

Surgical masks must:

- Cover both nose and mouth.
- Not be allowed to dangle around the neck after or between each use.
- Not be touched / adjusted once put on (hand hygiene must be performed if the mask is adjusted).
- Sessional use of up to 4 hours but must be changed immediately when they become moist / damaged.
- Discarded as clinical waste – hand hygiene must be performed after disposal.
- Worn whenever in the hospital environment.

Eye protection (single use goggles or full-face visors).

- Full face visors must be used if contact with blood and/or body fluid contamination to the eyes or face is anticipated or likely (prescription glasses do not provide adequate protection).

Disposable Gloves:

- Must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
- Must be changed immediately after each patient and/or after completing a procedure/task even on the same patient.
- Never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between tasks.
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases and vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids

4.7.8 Airborne Precautions (required for Aerosol generating procedures).

Patients in the High Risk / Amber COVID-19 pathways must be isolated in a single room or in a cohort bay with other patients undergoing AGPs. The following PPE is to be worn by all persons entering the single room or in a cohort bay:

- **Long sleeved, fluid-repellent disposable gown**

- **FFP3 respirator** conforming to EN149 must be worn by all staff in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used.

- **Eye protection-** full-face visors or goggles, must be worn (prescription glasses do not provide adequate protection)

- **Disposable gloves-** refrain from touching mouth, eyes or nose with potentially contaminated gloves.

  The PPE described above must be worn at all times when in the patient's single room or cohort bay.

4.7.9 Putting on PPE

Before putting on (donning) PPE, healthcare workers should ensure hair is tied back securely (so as not to interfere with PPE) and off the neck/collar, remove jewellery/pens, ensure they are hydrated, and perform hand hygiene. For staff comfort the wearing of scrubs may be considered, especially for airborne precautions (ITU/ Theatres / cohort wards).

After cleaning hands staff should put on PPE in the following order:

1. Long sleeved gown or plastic apron
2. FFP3 respirator and fit check, or surgical mask
3. Eye protection (goggles or face shield)
4. Disposable gloves

The order given above is practical but the order for putting on is less critical than the order of removal given below. When putting on each item must be adjusted as required to ensure it fits correctly and interfaces well with other PPE items.

4.7.10 Removal of PPE

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated

The order of removal of PPE is as follows, and is consistent with WHO guidance:

1. PPE removal can be started in the isolation room or cohort bay if there is sufficient space i.e. 2m distance from the patient. Otherwise leave patient isolation room and enter area for removal of PPE.
2. Peel off gloves and dispose in orange waste bin
3. Perform hand hygiene with alcohol gel or wash hands.
4. Remove apron/gown by using a peeling motion, fold gown in on itself and place in orange waste bin
5. Perform hand hygiene using alcohol gel or wash hands.

6. Remove goggles/visor only by touching the headband or sides and dispose in clinical waste. (If goggles are being reused they must be cleaned, firstly with detergent wipes then alcohol wipes and disposed of at the end of shift / or if damaged).

7. Perform hand hygiene using alcohol gel or wash hands

8. If not already outside patient isolation area and still wearing FFP3 then move outside isolation area before removing the FFP3 respirator.

9. Remove FFP3 respirator / surgical mask from behind and dispose in clinical waste.

10. Perform hand hygiene

PPE videos are available to watch on BOB:
https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

4.8 Definition of Aerosol generating procedures (AGP)

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols from the respiratory tract when treating someone who is suspected or known to have an infection transmitted wholly or partly by the airborne or droplet route.

The following is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

• Tracheal intubation and extubation

• Manual ventilation

• Tracheotomy or tracheostomy procedures (insertion or removal)

• Bronchoscopy

• Dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills.

• Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)

• High flow nasal oxygen (HFNO)

• High frequency oscillatory ventilation (HFOV)

• Induction of sputum using nebulised saline

• Respiratory tract suctioning

• Upper ENT airway procedures that involve respiratory suctioning

• Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs

• High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut or in a cohort area with other patients having AGPs.

Only those healthcare staff who are needed to undertake the procedure should be present. A disposable, fluid repellent surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk.

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. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

Clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room. In a room with 10-12 air changes per hour (ACH) a minimum of 20 minutes is considered pragmatic: in a side room with 6 ACH this would be approximately one hour.

If an AGP takes place in the room it should be left for 60 minutes before being cleaned. At this time staff entering the room must wear PPE for Airborne precautions; further advice should be sought from IPCT if required. The patients' room must have an isolation clean following resolution of symptoms, discharged or transferred.

The Trust Resuscitation Policy is consistent with the Resuscitation Council guidance and includes the use of airborne precautions.

4.9 Equipment

- Patient care equipment should be single-use items if possible.

- Reusable non-invasive equipment should if possible be allocated to the individual patient or a cohort of patients.

- Reusable non-invasive equipment in the cohort area must be decontaminated between each patient and after blood and body fluid contamination. Clean with a neutral detergent and a chlorine-based disinfectant (Tristel).

- Equipment must be cleaned at regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.

- Where possible, avoid the use of bed side fans that re-circulate the air.

- Patient medical notes should be kept out of the patient's room or cohort bay. Hand hygiene must be performed after handling patients' notes.

- There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

4.10 Environmental Decontamination

There is evidence from other coronaviruses of the potential for widespread contamination of patient rooms/environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

For cleaning, a neutral detergent and a chlorine-based disinfectant should be used (Tristel).

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces e.g. door handles (more than twice a day).

An increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.

- toilets/commodes particularly if patients have diarrhoea; and
- “frequently touched” surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails should be cleaned more than twice a day and when known to be contaminated with secretions, excretions or body fluids.

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment must be used for environmental decontamination. Reusable equipment must be decontaminated after use with a chlorine-based disinfectant as described above.

4.11 Linen

Dirty used linen should be placed in an alginate bag before putting into a white bag inside the patient isolation room in accordance with procedures for infectious linen. Unbagged linen must not be carried through the ward or other clinical areas.

Bagged linen should be taken from the patient room and placed directly in the dirty linen cage for collection.

In cohort areas only a dirty linen cage will be placed in the sluice, the ward should contact Sodexo to remove of the dirty linen cage from area and arrange replace with clean cage.

4.12 Waste

Large volumes of waste may be generated by frequent use of PPE;

Waste from a possible or confirmed case must be disposed of as infectious (Category B) waste. This requires orange bags. See Trust Waste Management Manual.

Dispose of all waste as clinical waste (orange bags). In a cohort ward the orange waste bags should be placed into a yellow wheelie bin. When the wheelie bin is full, the ward should contact Sodexo to arrange for collection and replacement bin.

In a non-cohort area, clinical waste should be removed and collected from the waste storage areas outside the wards for collection.

If ambulant, the patient can use the ensuite WC. If bedpans are used, the excreta should solidified using superabsorbent polymer gel granules and then disposed of as clinical waste. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert. Toilet facilities within a cohort bay may be shared but toilet the facilities must not be shared with other patients in the ward area.

4.13 Staff Considerations

Prompt recognition / management of positive staff and also staff exposed to COVID-19 is essential to limit the spread of the virus.

If staff or members of their household have possible symptoms of COVID-19 they should refer to the COVID-19 testing SOP to determine if testing is required and whether they are able to come to work / remain at work.

A staff risk assessment is required for all health and social care staff, especially those at higher risk of complications from COVID-19, including pregnant staff.

Managers should:

- Discuss with employees who are at higher risk or are pregnant the need to be deployed away from areas used for the care of those who have or may have COVID-19.
- Ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications.
- Bank, agency and locum staff should follow the same deployment advice as permanent staff.
- In the event of a breach in infection control procedures or failure of PPE, staff should to be reviewed by the IPC team and Occupational Health. Occupational health departments should lead on the implementation of systems to monitor staff illness and absence.
- In the event of staff exposure to a patient whose COVID-19 status was not known, the COVID-19 Contact Tracing Lead will identify staff who are considered to be contacts.

4.14 Visitors

Visiting is restricted at NDDH and South Molton to reduce the risk of COVID-19 transmission. Our staff can support patients and their families to stay in contact by using other methods such as video calls, letter printing etc. instead, where possible. Please contact our patient experience team for more information at ndht.patientexperience@nhs.net

Visitors will also be required to wear a mask or face covering when in the hospital, may be temperature checked and must follow social distancing and hand hygiene guidelines. Visitors must not visit if unwell.

Visiting is only allowed as follows:

- If there are specific reasons of safety (dementia or learning disability where anxiety would be increased significantly).
- Inpatients under the age of 18 years old – one parent/guardian only (both parents are permitted in the special care baby unit).
- Adult inpatients – one person per patient, from the same household or support bubble, this will need to be agreed with the ward staff to ensure social distancing is maintained.
- Visiting times may be staggered to accommodate visiting for all patients.
- All visitors should wear a face covering
- Visitors will be asked to wear a surgical facemask if visiting a high risk area or a patient with suspected/known COVID-19
- Parents/guardians must always wear a face covering when entering and moving through the healthcare setting and when a healthcare professional is treating their child/young person. If they are with their child and/or young person and within their 'family bubble' in side rooms or physical environments that afford separation, they can remove their face covering.
- Anyone showing symptoms of coronavirus should not visit. If visitors display symptoms of coronavirus they should be asked to leave, self-isolate at home for 14 days and organise a test; members of their household should also self-isolate for 14 days.
- Wards/departments/units must keep a list of visitors' names and contact details to aid the NHS Test and Trace teams if contact tracing is indicated.
- Admission areas e.g. ED/MAU/AAA will have the discretion to allow one person to accompany the patient to ensure the correct patient history etc. is obtained.
- At outpatient and diagnostic appointments where a patient may need emotional support they can be accompanied by one person from the same household or support bubble.
- A patient receiving end of life care can receive more than one visitor from the same household or support bubble within a 24 hour period. Where a face to face visit is not practical then virtual visits can be facilitated by contacting the outreach and resuscitation team on bleep 007 Monday – Friday, and clinical site team out of hours.

Maternity visiting

- One partner or designated individual is able to attend the dating scan (at approx. 12 weeks) and the anomaly scan (at 20 weeks), they are not able to stay for any subsequent appointments with a doctor or midwife.
- All other scans, such as growth scans, should be attended alone, though an exception can be made if it is anticipated that bad news might have to be given.
- If a woman is being induced, they can have a partner, or designated individual attend, with them between the hours of 10am and 6pm. Outside of these hours our staff will continue to contact partners and ask them to attend the unit if, due to pain or distress, support is required.
- One partner, or designated individual, may make an appointment with ward staff to visit Bassett Ward between the hours of 10am and 6pm. They can stay for as long as they like during that period but we are encouraging people to contact their individual midwife to arrange this.
- As throughout the whole of the COVID-19 pandemic, if a woman is being cared for in labour ward or in theatre, they can have one birth partner with them. This is usually when they are in labour, having a caesarean or in the immediate postnatal period.

Ward managers and clinical matrons have autonomy to manage extensions to these restrictions in exceptional circumstances.

4.15 Mobile Healthcare Equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines:

- Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room
- The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE
- The operator should wear PPE as described above when in the isolation room / cohort bay.
- Any equipment taken in to the room and which must be subsequently removed must be disinfected prior to leaving the room.
- Any additional items such as a digital detector or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

4.16 Critical Care

- All respiratory equipment must be protected with a high efficiency filter (eg BS EN 13328-1). This filter must be disposed of after use
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions
- A closed suctioning system must be used
- Ventilator circuits should not be broken unless necessary
- Ventilators must be placed on standby when carrying out bagging
- PPE must be worn
- Water humidification should be avoided, and a heat and moisture exchanger should be used

4.17 Theatres

There is a separate protocol for managing all patients attending theatre.

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated
- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, i.e. during intubation need to wear FFP3 respirators and full gowns.

Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above

- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice. Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.
- Instruments must be transported safely to decontamination, following use
- The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine
- Theatres should not be used by staff or patients for 20 minutes after an aerosol generating procedure.

4.18 Transfers to other Departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need dictates, and in consultation with the infection prevention & control team, should patients be transferred to other departments. The following procedures then apply:

- The trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing PPE as described previously
- The department must be informed in advance of the patient's arrival
- any extraneous equipment to be removed safely from the investigation/treatment room
- The patient must be taken straight to and from the investigation/treatment room and must not wait in a communal area
- The patient should wear a fluid resistant surgical mask if this can be tolerated - this will prevent large respiratory droplets being expelled into the environment by the wearer. This is not required if the patient is wearing an oxygen mask.
- The treatment/procedure room, trolley/chair and all equipment should be decontaminated after use, as per the cleaning instructions above
- To enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- During patient transfers a process to ensure that no individuals not wearing PPE come within 2 metres of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

4.19 Transfers to other Hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care

- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control measures can be taken.

4.20 Community

NDHT staff working at other Trust locations and community staff visiting patients in their own home / care homes must follow the correct standard infection control and transmission based precautions (detailed in section 4.7) using the same COVID-19 pathways for High, Medium and Low risk patients. If tolerated, face coverings should be worn by patients in their own home when being visited by a Health Care Worker.

4.21 Handling the Deceased

The principles of SICPs and TBPs continue to apply whilst deceased individuals remain 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 patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

5 Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

5.1 Key performance indicators comprise:

5.2 The numbers of incidents relating to inappropriate management of patients with suspected or confirmed COVID-19.

5.3 The number of COVID-19 infections involving patients and staff

Process for Implementation and Monitoring Compliance and Effectiveness

5.4 After final approval, the author will arrange for a copy of the policy to be placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release. Information will also be included in the Chief Executive's Bulletin which is circulated electronically to all staff. Line managers are responsible for ensuring this policy is implemented across their area of work.

Monitoring compliance with this policy will be the responsibility of the Infection Prevention and Control team. This will be undertaken by Weekly monitoring of incident forms at the Infection Prevention and Control team meetings

- Where non-compliance is identified, support and advice will be provided to improve practice.

- Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by weekly review of incident forms by the Infection Control Team and daily operational oversight by Infection prevention and control Nurses during hours and out of hours by on-call Microbiologist.

- For staff exclusion matters there will be case by case liaison with Occupational Health.

- Where non-compliance is identified, support and advice will be provided to improve practice. This may involve additional training to specific groups of staff; increased frequency of audit; and observation of clinical practice.

6 References

- PHE (2020).COVID-19: Guidance for the remobilisation of services within health and care settings; Infection prevention and control recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
- PHE (2020). Coronavirus (COVID-19) https://www.gov.uk/coronavirus

- PHE (2020). COVID-19: investigation and initial clinical management of possible cases (July 2020). https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

- Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection. Updated 28 September 2020 https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

- PHE (2020). COVID-19: personal protective equipment use for aerosol generating procedures. https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

7 Associated Documentation

- Covid-19 Testing Standard Operating Procedure
- Decontamination Policy
- EASIAIR 2020 Powered Air Purifying Respirator
- Standard Operating Procedure Influenza-like illness Policy
- Laundry Policy
- Outbreak

- Outbreak of Infection Policy
- Patient Isolation and staff exclusion policy
- Respiratory Infections policy
- Standard Infection Control Precautions Policy
- Waste Management Manual

DOCUMENT CONTROL

Title

Infection Prevention & Control management of COVID-19 patients Guideline

Author	**Author's job title**
	Infection Prevention & Control Nurse
Directorate	**Department**
Nursing	Infection Prevention & Control

Version	Date Issued	Status	Comment / Changes / Approval
1.0	Jan 2020	Draft	Wuhan Novel Coronavirus guidance NDHT, updated 12 times between 27.01.2020 – 03.04.2020 in accordance with local and national guidance.
2.0	April 2020	Draft	Updated 4 times between 21.04.2020 – 25.09.2020 in accordance with local and national guidance.
3.0	Oct 2020	Draft	Updates to reflect Care Pathways specific to COVID-19, placement of patients with suspected or confirmed COVID-19, Transmission Based Precautions, Personal Protective Equipment, Cohort areas, Visitors, Staff considerations, Environmental decontamination.
3.1	Oct 2020		Minor changes prior to submission to CRG
3.3	Dec 2020		Added statements re placement of CPAP BiPAP patients on green pathway

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Superseded Documents

Issue Date	Review Date	Review Cycle
October 2020	September 2023	Three years

Consulted with the following stakeholders:

- Infection Prevention & Control Team
- Clinical Medical Microbiologist
- Clinical Reference Group

Approval and Review Process

- Infection Prevention & Decontamination Group

Local Archive Reference
G:\INFECTION CONTROL

Local Path G:\INFECTION CONTROL\IC Manual - Policies\Guidelines\COVID 19 management guidelines Sept 2020 **Filename** Management of COVID-19 patients Sept 20 v3.1	
Policy categories for Trust's internal website (Bob) Infection Prevention & Control	**Tags for Trust's internal website (Bob)** COVID-19, PPE, Infection Control, AGPs, Transmission based precautions.

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the infection Prevention & Control management of COVID-19 patients admitted to Northern Devon Healthcare NHS Trust.

1.2. The guidance applies to all Trust staff.

1.3. Implementation of this guidance will ensure that:

- Patients are managed safely in line with the National care pathways specific to the COVID-19 pandemic through screening and triaging to enable early recognition and identification of COVID-19 cases.

2. Responsibilities

2.1 Role of Chief Nurse

The Chief Nurse is responsible for:

- Acting as a point of contact for support
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation

2.2 Role of Clinical Reference Group

The Clinical Reference Group is responsible for:

- Acting as a point of contact providing for support for Clinicians

2.3 Role of Infection Prevention & Decontamination Group

The Infection Prevention & Decontamination Group is responsible for:

- Monitoring compliance with the policy
- Ensuring that the policy is approved after review and prior to publishing

3. Contacting the Infection Prevention and Control Team

The Infection Prevention and Control Team can be contacted in hours on [redacted] internal at North Devon District Hospital), via [redacted] or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

4. Infection Prevention & Control guidance for the management of COVID-19 - patients

4.1 Introduction

The management of patients with COVID-19 is based on PHE guidance; refer to website for current guidance:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/906096/COVID-19_flow_chart.pdf

SARS coronavirus (SARS-CoV-2), previously known as Wuhan novel coronavirus causes a respiratory disease known as COVID-19.The criteria for identifying suspected cases of COVID-19 can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

COVID-19 is potentially transmissible through droplet, airborne and contact routes.

Although respiratory secretions are the main route of transmission other bodily fluids are potentially infectious.

The correct PPE must be worn according to the patients risk categories, the type of contact with the patient and the procedures being performed.

Correct removal of PPE is particularly important in preventing infection https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

The following IPC practices will also reduce the risk of transmission:

• Effective Hand Hygiene

• Good respiratory etiquette –

- Patients, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures e.g. using single-use tissues to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose, tissues should be disposed of promptly in the nearest waste bin.

- Hands should be washed (using soap and water if possible, otherwise using alcohol based hand rub) 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 (e.g. the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In waiting areas or during transportation, symptomatic patients may wear a fluid-resistant surgical face mask (FRSM), if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- A FRSM is not required if the patient is wearing an oxygen mask.

- Decontamination of equipment and the environment.

- Use of face coverings/facemasks by staff in clinical and non-clinical areas and by patients and visitors:

  - Fluid resistant surgical facemask (FRSM) to be worn by all healthcare workers when entering the hospital and in the care setting.

  - Face coverings should be worn by patients in their own home (if tolerated) when being visited by a Health Care Worker (HCW)

  - Face coverings should be worn by all outpatients (if tolerated) and visitors when entering the hospital.

  - Surgical facemasks (Type II or Type IIR) should be worn by all inpatients in the medium and high-risk pathways as long as they can be tolerated and does not compromise their clinical care e.g. when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination.

  - All visitors should wear a face covering in healthcare settings.

  - If visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in place, such as 2m physical distancing, to ensure sufficient access depending on the patient's condition.

Follow government guidance: 'Hands. Face. Space'

- Screening – All emergency patients will be swabbed on admission, elective and patients attending for day case procedures will also be COVID-19 swabbed 72 hours prior to admission. See Trust COVID testing SOP.

4.2 Identifying suspected cases of COVID-19

Possible cases:

The current national guidance sets out the following criteria for identifying a possible case of COVID-19:

Patients who meet the following criteria (inpatient definition)

- requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night)

and

- have either clinical or radiological evidence of pneumonia

or

- acute respiratory distress syndrome

or

- influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

or

- a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

Note: Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.

Patients who meet the following criteria and are well enough to remain in the community

new continuous cough

or

high temperature

or

a loss of, or change in, normal sense of taste or smell (anosmia)

Individuals with any of the above symptoms but who are well enough to remain in the community should follow the 'Stay at home guidance' and get tested.

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

Alternative clinical diagnoses and epidemiological risk factors should be considered.

4.3 Priority Actions for Suspected COVID-19 Patients in Hospital.

Staff who work in receiving units, and especially those with first contact with patients, must be alert to the possibility of COVID-19, **if COVID-19 is suspected the patient must be isolated immediately:**

- In ED patients should be directed according to the ED pathway

For inpatients Clinicians should:

- Implement infection prevention and control measures whilst awaiting test results and assess / prioritise patients in a single occupancy rooms.
- Wear personal protective equipment (PPE) – for droplet precautions; fluid resistant surgical mask, single use disposable apron, gloves and eye protection. If a patient meeting the case definition undergoes an aerosol generating procedure (AGP), airborne precautions must be used; FFP2/FFP3 respirator, long-sleeved disposable fluid-repellent gown/coverall, gloves and eye protection.
- Patient to wear a fluid-resistant (Type IIR) surgical face mask (FRSM) if they are in a clinical or communal area, or are being transported (if the patient can tolerate it) in order to minimise the dispersal of respiratory secretions
- A FRSM should not be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). An FRSM can be worn until damp or uncomfortable
- Wearing a face mask or face covering during COVID-19 leaflet: https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/06/Face-mask-leaflet-NDHT-FINAL.pdf

4.4 Placement of Patients with Suspected or Confirmed COVID-19

In NDDH the areas identified for patients are:

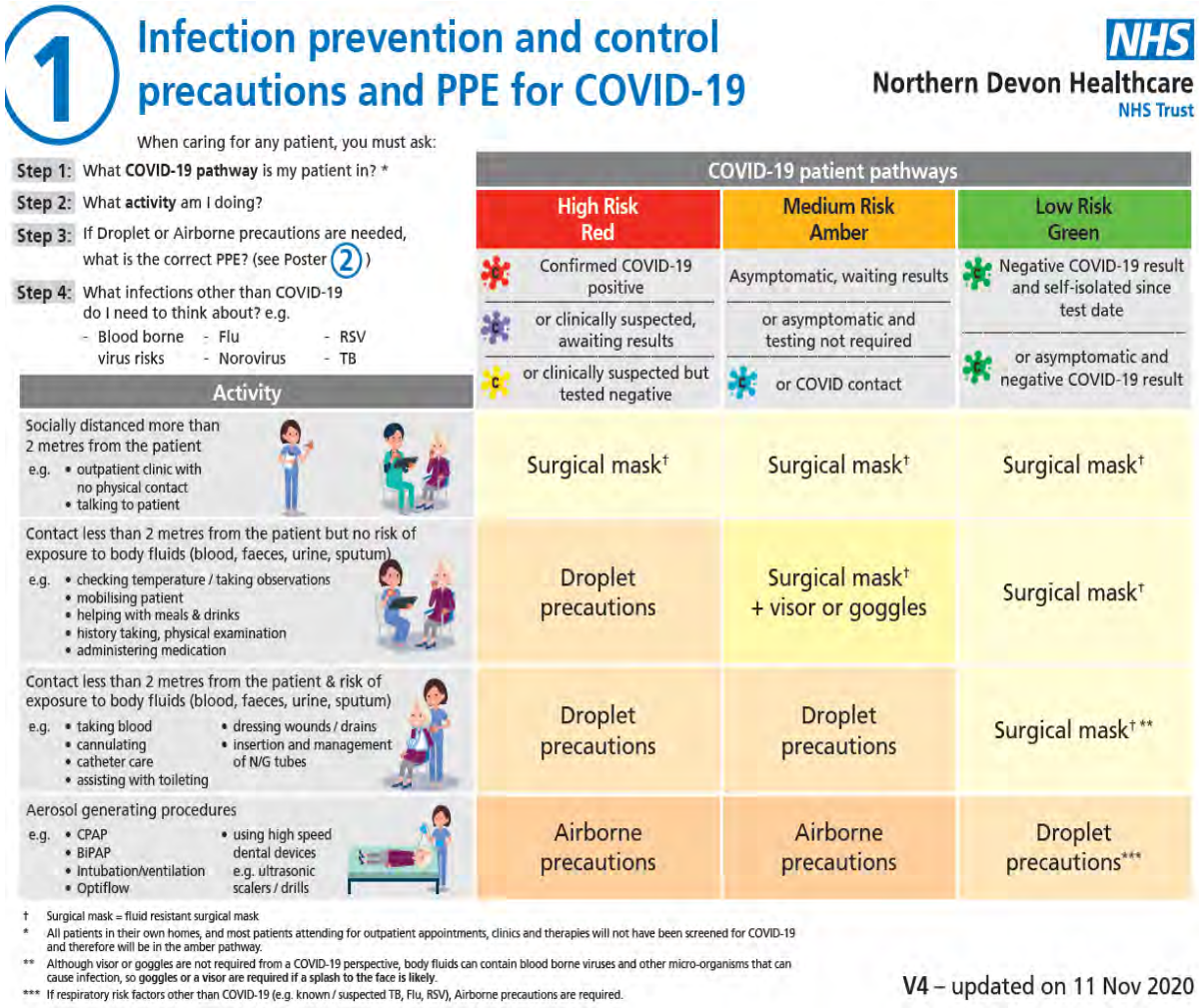
- Emergency department
- Alex / MAU ward – single rooms
- Caroline Thorpe – use side rooms 5 & 6 (side rooms 3&4 are alternatives)
- ICU
- Tarka Ward
- Capener Ward
- King George V ward single rooms only (for suspected patients awaiting results)
- Maternity

Patients with possible / confirmed COVID-19 must not be admitted to other areas within NDHT without prior discussion with the Infection Prevention & Control Team / Medical Microbiologist on-call.

All patients receiving CPAP or BiPAP should be cared for in single rooms or cohort areas. Select the PPE using pathways in section 4.5.

4.5 Patient Pathways.

National Guidance identifies care pathways, specific to COVID-19 for the management of patients using services, the pathways will ensure patients within health and other care facilities are screened and triaged in order to minimise risk. The following pathways detail risk categorisation and PPE requirements which take into account a patient's symptoms:



4.6 Infection Prevention & Control Measures

4.6.1 Isolation

Patients must be isolated in a designated room or cohort bay at all times with the door closed.

Putting on PPE must be performed in a quiet area to ensure that it is correctly worn

Correct removal of PPE must be carried out in an area where there is sufficient space to do this safely. The assistance of a buddy can be helpful.

4.6.2 Cohort Wards

If a single/isolation room is not available, patients with confirmed COVID -19 can be placed in a cohort bay with other confirmed COVID-19 respiratory infected patients.

The following measures are best practice for a COVID-19 area:

- Ensure patients are physically separated; a distance of at least 2 metre, use privacy curtains between the beds to minimise opportunities for close contact.
- The reception area / ward clerk area should be separated from the rest of the ward and relocated to an office area with a door.
- The ward must not be used as a thoroughfare by other patients, visitors or staff.
- Staff entering the cohort area must be kept to a minimum.

The appropriate personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Theatre scrubs are not routinely required but staff may find them more comfortable under PPE.

Staff must not travel to and from work in uniform. It is expected that they will change into uniform or, theatre scrubs (where available) on arrival at work. Staff must change out of uniform when leaving work. Place uniform into a bag to transport home.

Changing out of uniform is based on public perception rather than evidence of infection risk. Uniforms should be laundered separately from household laundry, on the maximum temperature for the fabric and then ironed or tumble dried.

As per staff Uniform Policy, staff should wear shoes that can be wiped,

4.6.3 Staff working in cohort areas

Assigning a dedicated team of staff to care for patients in isolation/cohort rooms/areas is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available, so as not to have a negative impact on non-affected patients' care.

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including personal protective equipment (PPE), as outlined in this document

4.6.4 Identifying Hospital acquired cases of COVID -19 / Outbreaks

The swabbing of all admissions and managing patients in the risk pathways will reduce the possibility of transmission of COVID-19 in the hospital; however transmission and outbreaks can still occur for a number of reasons e.g. failure of PPE or non-compliance with IP&C precautions by staff, patients and visitors.

An outbreak of COVID-19 may be defined as two or more confirmed cases among individuals associated with a specific setting with onset dates within 14 days. There is a national definition of a COVID-19 outbreak.

If transmission or an outbreak is identified in the Trust the IPC team will implement outbreak control measures which will include restriction of movement and contact tracing of staff, patients and visitors as per Outbreak Policy.

4.6.5 Contacts

Patients or staff who have had significant exposure to COVID-19 will be identified as contacts. The IPC team in conjunction with the Contact Tracing Lead will assess the exposure and determine if isolation is required.

Identified patient contacts must be isolated in a single room or in a cohort bay for 14 days from their first exposure to a COVID-19 positive case or as advised by the IPC team. Patients identified as a contact must be managed in the 'Medium Risk Amber' pathway. If patients are being discharged within the 14 days isolation period they must be informed to continue to isolate at home as per national guidance. Patients can be discharge home but if a package of care is required care agencies must be informed.

Staff identified as having significant contact will be required to self-isolate at home for 14 days as per national guidance.

4.7 Infection Prevention and Control Precautions

It is important to use the right precautions when caring for patients with COVID-19, these precautions will be a combination of the following:

4.7.1 Standard Precautions

'Standard Precautions' refers to the application of infection control practices to prevent exposure to and the transmission of micro-organisms, which may be pathogenic (cause disease). These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps
- Safe handling of linen
- Patient placement and assessment for infection risk (screening/triaging)
- Respiratory and cough hygiene
- Occupational safety: prevention and exposure management
- Maintaining social/physical distancing

Healthcare workers must comply with and use standard infection prevention and control precautions when caring for all patients and the patients' environment to prevent cross-transmission from both suspected and confirmed sources of infection.

4.7.2 Transmission Based Precautions

Transmission based precautions (TBPs) are applied when Standard Infection Control Precautions (SICPs) alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

4.7.3 Transmission Based Precautions (TBPs) Definitions

- **Contact precautions:** 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**: Used to prevent and control infection transmission over short distances via droplets (>5µm) from the respiratory tract of one individual directly

onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been increased to 2 metres.

- **Airborne precautions**: Used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. 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.

4.7.4 Hand Hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings and is a critical element of standard infection control precautions (SICPs).

All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving all clinical areas.

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:

https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf

All staff in clinical areas must be bare below the elbows and rings (other than a plain smooth band). Wrist watches and wrist jewellery must not be worn.

4.7.5 Personal Protective Equipment (PPE)

The PPE to be used depends on the IPC precautions required.

Possible and confirmed COVID patients must be cared for using droplet precautions unless an aerosol generating procedure (AGP) is being performed.

For patients undergoing an AGP (in a side room or cohort ward) and those on ICU airborne precautions are required.

Gloves and aprons must be changed between each patient and / or following completion of a procedure or task.

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated (see section 5.5).

Head/footwear:

• Headwear is not routinely required in clinical areas, even if undertaking an AGP, unless it is part of theatre attire or to prevent contamination of the environment such as in clean rooms.

• Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres.

• foot/shoe coverings are not required or recommended for the care of COVID-19 cases and increases the risk of contaminating hands when removing shoe covers.

In some cases PPE / face masks can restrict communication with individuals and other ways of communicating may need to be considered

4.7.6 Sessional use of PPE

- Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact.
- Respirators, fluid-resistant surgical masks (FRSM), eye protection and can be subject to single sessional use in circumstances outlined below:
- A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward. A session ends when the health and social care worker leaves the clinical care setting or exposure environment.
- Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.
- While generally considered good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient. Indeed, frequent handling of this equipment to discard and replace it could theoretically increase risk of exposure in high demand environments, for example by leading to increasing face touching during removal. The rationale for recommending sessional use in certain circumstances is therefore to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.
- PPE should not be subject to continued use if damaged, soiled, compromised or uncomfortable and a session should be ended. The duration of a session could be up to 4 hours. Appropriateness of single vs sessional use is dependent on the nature of the task or activity being undertaken and the local context.

4.7.7 Droplet Precautions

The patient must be isolated in a single room or cohort bay, the following PPE is to be worn by all persons entering the area:

Single use disposable apron must be worn:

- To protect uniform when contamination is anticipated or likely and when providing direct care within 2 metres of suspected/confirmed COVID-19 case.
- Must be changed between patients and/or after completing a procedure or task.

Fluid resistant surgical mask (Type IIR)

Surgical masks must:

- Cover both nose and mouth.
- Not be allowed to dangle around the neck after or between each use.

- Not be touched / adjusted once put on (hand hygiene must be performed if the mask is adjusted).
- Sessional use of up to 4 hours but must be changed immediately when they become moist / damaged.
- Discarded as clinical waste – hand hygiene must be performed after disposal.
- Worn whenever in the hospital environment.

Eye protection (single use goggles or full-face visors).

- Full face visors must be used if contact with blood and/or body fluid contamination to the eyes or face is anticipated or likely (prescription glasses do not provide adequate protection).

Disposable Gloves:

- Must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
- Must be changed immediately after each patient and/or after completing a procedure/task even on the same patient.
- Never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between tasks.
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases and vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids

4.7.8 Airborne Precautions (required for Aerosol generating procedures).

Patients in the High Risk / Amber COVID-19 pathways must be isolated in a single room or in a cohort bay with other patients undergoing AGPs. The following PPE is to be worn by all persons entering the single room or in a cohort bay:

- **Long sleeved, fluid-repellent disposable gown**
- **FFP3 respirator** conforming to EN149 must be worn by all staff in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used.
- **Eye protection-** full-face visors or goggles, must be worn (prescription glasses do not provide adequate protection)
- **Disposable gloves-** refrain from touching mouth, eyes or nose with potentially contaminated gloves.

The PPE described above must be worn at all times when in the patient's single room or cohort bay.

4.7.9 Putting on PPE

Before putting on (donning) PPE, healthcare workers should ensure hair is tied back securely (so as not to interfere with PPE) and off the neck/collar, remove jewellery/pens, ensure they are hydrated, and perform hand hygiene. For staff comfort the wearing of scrubs may be considered, especially for airborne precautions (ITU/ Theatres / cohort wards).

After cleaning hands staff should put on PPE in the following order:

1. Long sleeved gown or plastic apron
2. FFP3 respirator and fit check, or surgical mask
3. Eye protection (goggles or face shield)
4. Disposable gloves

The order given above is practical but the order for putting on is less critical than the order of removal given below. When putting on each item must be adjusted as required to ensure it fits correctly and interfaces well with other PPE items.

4.7.10 Removal of PPE

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated

The order of removal of PPE is as follows, and is consistent with WHO guidance:

1. PPE removal can be started in the isolation room or cohort bay if there is sufficient space i.e. 2m distance from the patient. Otherwise leave patient isolation room and enter area for removal of PPE.
2. Peel off gloves and dispose in orange waste bin
3. Perform hand hygiene with alcohol gel or wash hands.
4. Remove apron/gown by using a peeling motion, fold gown in on itself and place in orange waste bin
5. Perform hand hygiene using alcohol gel or wash hands.
6. Remove goggles/visor only by touching the headband or sides and dispose in clinical waste. (If goggles are being reused they must be cleaned, firstly with detergent wipes then alcohol wipes and disposed of at the end of shift / or if damaged).
7. Perform hand hygiene using alcohol gel or wash hands
8. If not already outside patient isolation area and still wearing FFP3 then move outside isolation area before removing the FFP3 respirator.
9. Remove FFP3 respirator / surgical mask from behind and dispose in clinical waste.

10. Perform hand hygiene

PPE videos are available to watch on BOB:
https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

4.8 Definition of Aerosol generating procedures (AGP)

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols from the respiratory tract when treating someone who is suspected or known to have an infection transmitted wholly or partly by the airborne or droplet route.

The following is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

• Tracheal intubation and extubation

• Manual ventilation

• Tracheotomy or tracheostomy procedures (insertion or removal)

• Bronchoscopy

• Dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills.

• Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)

• High flow nasal oxygen (HFNO)

• High frequency oscillatory ventilation (HFOV)

• Induction of sputum using nebulised saline

• Respiratory tract suctioning

• Upper ENT airway procedures that involve respiratory suctioning

• Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs

• High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut or in a cohort area with other patients having AGPs.

Only those healthcare staff who are needed to undertake the procedure should be present. A disposable, fluid repellent surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk.

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. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

Clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room. In a room with 10-12 air changes per hour (ACH) a minimum of 20 minutes is considered pragmatic: in a side room with 6 ACH this would be approximately one hour.

If an AGP takes place in the room it should be left for 60 minutes before being cleaned. At this time staff entering the room must wear PPE for Airborne precautions; further advice should be sought from IPCT if required. The patients' room must have an isolation clean following resolution of symptoms, discharged or transferred.

The Trust Resuscitation Policy is consistent with the Resuscitation Council guidance and includes the use of airborne precautions.

4.9 Equipment

- Patient care equipment should be single-use items if possible.
- Reusable non-invasive equipment should if possible be allocated to the individual patient or a cohort of patients.
- Reusable non-invasive equipment in the cohort area must be decontaminated between each patient and after blood and body fluid contamination. Clean with a neutral detergent and a chlorine-based disinfectant (Tristel).
- Equipment must be cleaned at regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.
- Where possible, avoid the use of bed side fans that re-circulate the air.
- Patient medical notes should be kept out of the patient's room or cohort bay. Hand hygiene must be performed after handling patients' notes.
- There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

4.10 Environmental Decontamination

There is evidence from other coronaviruses of the potential for widespread contamination of patient rooms/environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

For cleaning, a neutral detergent and a chlorine-based disinfectant should be used (Tristel).

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces e.g. door handles (more than twice a day).

An increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.

- toilets/commodes particularly if patients have diarrhoea; and
- "frequently touched" surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails should be cleaned more than twice a day and when known to be contaminated with secretions, excretions or body fluids.

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment must be used for environmental decontamination. Reusable equipment must be decontaminated after use with a chlorine-based disinfectant as described above.

4.11 Linen

Dirty used linen should be placed in an alginate bag before putting into a white bag inside the patient isolation room in accordance with procedures for infectious linen. Unbagged linen must not be carried through the ward or other clinical areas.

Bagged linen should be taken from the patient room and placed directly in the dirty linen cage for collection.

In cohort areas only a dirty linen cage will be placed in the sluice, the ward should contact Sodexo to remove of the dirty linen cage from area and arrange replace with clean cage.

4.12 Waste

Large volumes of waste may be generated by frequent use of PPE;

Waste from a possible or confirmed case must be disposed of as infectious (Category B) waste. This requires orange bags. See Trust Waste Management Manual.

Dispose of all waste as clinical waste (orange bags). In a cohort ward the orange waste bags should be placed into a yellow wheelie bin. When the wheelie bin is full, the ward should contact Sodexo to arrange for collection and replacement bin.

In a non-cohort area, clinical waste should be removed and collected from the waste storage areas outside the wards for collection.

If ambulant, the patient can use the ensuite WC. If bedpans are used, the excreta should solidified using superabsorbent polymer gel granules and then disposed of as clinical waste. The use of these granules must be strictly controlled as described in this NHS National Patient Safety Alert. Toilet facilities within a cohort bay may be shared but toilet the facilities must not be shared with other patients in the ward area.

4.13 Staff Considerations

Prompt recognition / management of positive staff and also staff exposed to COVID-19 is essential to limit the spread of the virus.

If staff or members of their household have possible symptoms of COVID-19 they should refer to the COVID-19 testing SOP to determine if testing is required and whether they are able to come to work / remain at work.

A staff risk assessment is required for all health and social care staff, especially those at higher risk of complications from COVID-19, including pregnant staff.

Managers should:

- Discuss with employees who are at higher risk or are pregnant the need to be deployed away from areas used for the care of those who have or may have COVID-19.
- Ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications.
- Bank, agency and locum staff should follow the same deployment advice as permanent staff.
- In the event of a breach in infection control procedures or failure of PPE, staff should to be reviewed by the IPC team and Occupational Health. Occupational health departments should lead on the implementation of systems to monitor staff illness and absence.
- In the event of staff exposure to a patient whose COVID-19 status was not known, the COVID-19 Contact Tracing Lead will identify staff who are considered to be contacts.

4.14 Visitors

Visiting is restricted at NDDH and South Molton to reduce the risk of COVID-19 transmission. Our staff can support patients and their families to stay in contact by using other methods such as video calls, letter printing etc. instead, where possible. Please contact our patient experience team for more information at ndht.patientexperience@nhs.net

Visitors will also be required to wear a mask or face covering when in the hospital, may be temperature checked and must follow social distancing and hand hygiene guidelines. Visitors must not visit if unwell.

Visiting is only allowed as follows:

- If there are specific reasons of safety (dementia or learning disability where anxiety would be increased significantly).
- Inpatients under the age of 18 years old – one parent/guardian only (both parents are permitted in the special care baby unit).
- Adult inpatients – one person per patient, from the same household or support bubble, this will need to be agreed with the ward staff to ensure social distancing is maintained.
- Visiting times may be staggered to accommodate visiting for all patients.
- All visitors should wear a face covering
- Visitors will be asked to wear a surgical facemask if visiting a high risk area or a patient with suspected/known COVID-19
- Parents/guardians must always wear a face covering when entering and moving through the healthcare setting and when a healthcare professional is

treating their child/young person. If they are with their child and/or young person and within their 'family bubble' in side rooms or physical environments that afford separation, they can remove their face covering.

- Anyone showing symptoms of coronavirus should not visit. If visitors display symptoms of coronavirus they should be asked to leave, self-isolate at home for 14 days and organise a test; members of their household should also self-isolate for 14 days.
- Wards/departments/units must keep a list of visitors' names and contact details to aid the NHS Test and Trace teams if contact tracing is indicated.
- Admission areas e.g. ED/MAU/AAA will have the discretion to allow one person to accompany the patient to ensure the correct patient history etc. is obtained.
- At outpatient and diagnostic appointments where a patient may need emotional support they can be accompanied by one person from the same household or support bubble.
- A patient receiving end of life care can receive more than one visitor from the same household or support bubble within a 24 hour period. Where a face to face visit is not practical then virtual visits can be facilitated by contacting the outreach and resuscitation team on bleep 007 Monday – Friday, and clinical site team out of hours.

Maternity visiting

- One partner or designated individual is able to attend the dating scan (at approx. 12 weeks) and the anomaly scan (at 20 weeks), they are not able to stay for any subsequent appointments with a doctor or midwife.
- All other scans, such as growth scans, should be attended alone, though an exception can be made if it is anticipated that bad news might have to be given.
- If a woman is being induced, they can have a partner, or designated individual attend, with them between the hours of 10am and 6pm. Outside of these hours our staff will continue to contact partners and ask them to attend the unit if, due to pain or distress, support is required.
- One partner, or designated individual, may make an appointment with ward staff to visit Bassett Ward between the hours of 10am and 6pm. They can stay for as long as they like during that period but we are encouraging people to contact their individual midwife to arrange this.
- As throughout the whole of the COVID-19 pandemic, if a woman is being cared for in labour ward or in theatre, they can have one birth partner with them. This is usually when they are in labour, having a caesarean or in the immediate postnatal period.

Ward managers and clinical matrons have autonomy to manage extensions to these restrictions in exceptional circumstances.

4.15 Mobile Healthcare Equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines:

- Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room

- The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE
- The operator should wear PPE as described above when in the isolation room / cohort bay.
- Any equipment taken in to the room and which must be subsequently removed must be disinfected prior to leaving the room.
- Any additional items such as a digital detector or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

4.16 Critical Care

- All respiratory equipment must be protected with a high efficiency filter (eg BS EN 13328-1). This filter must be disposed of after use
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions
- A closed suctioning system must be used
- Ventilator circuits should not be broken unless necessary
- Ventilators must be placed on standby when carrying out bagging
- PPE must be worn
- Water humidification should be avoided, and a heat and moisture exchanger should be used

4.17 Theatres

There is a separate protocol for managing all patients attending theatre.

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated
- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, i.e. during intubation need to wear FFP3 respirators and full gowns. Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above
- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice. Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.
- Instruments must be transported safely to decontamination, following use
- The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine

- Theatres should not be used by staff or patients for 20 minutes after an aerosol generating procedure.

4.18 Transfers to other Departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need dictates, and in consultation with the infection prevention & control team, should patients be transferred to other departments. The following procedures then apply:

- The trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing PPE as described previously
- The department must be informed in advance of the patient's arrival
- any extraneous equipment to be removed safely from the investigation/treatment room
- The patient must be taken straight to and from the investigation/treatment room and must not wait in a communal area
- The patient should wear a fluid resistant surgical mask if this can be tolerated - this will prevent large respiratory droplets being expelled into the environment by the wearer. This is not required if the patient is wearing an oxygen mask.
- The treatment/procedure room, trolley/chair and all equipment should be decontaminated after use, as per the cleaning instructions above
- To enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- During patient transfers a process to ensure that no individuals not wearing PPE come within 2 metres of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

4.19 Transfers to other Hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care
- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control measures can be taken.

4.20 Community

NDHT staff working at other Trust locations and community staff visiting patients in their own home / care homes must follow the correct standard infection control and transmission based precautions (detailed in section 4.7) using the same COVID-19 pathways for High, Medium and Low risk patients. If tolerated, face coverings should be worn by patients in their own home when being visited by a Health Care Worker.

4.21 Handling the Deceased

The principles of SICPs and TBPs continue to apply whilst deceased individuals remain 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 patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

5 Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

5.1 Key performance indicators comprise:

5.2 The numbers of incidents relating to inappropriate management of patients with suspected or confirmed COVID-19.

5.3 The number of COVID-19 infections involving patients and staff

Process for Implementation and Monitoring Compliance and Effectiveness

5.4 After final approval, the author will arrange for a copy of the policy to be placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release. Information will also be included in the Chief Executive's Bulletin which is circulated electronically to all staff. Line managers are responsible for ensuring this policy is implemented across their area of work.

Monitoring compliance with this policy will be the responsibility of the Infection Prevention and Control team. This will be undertaken by Weekly monitoring of incident forms at the Infection Prevention and Control team meetings

- Where non-compliance is identified, support and advice will be provided to improve practice.
- Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by weekly review of incident forms by the Infection Control Team and daily operational oversight by Infection prevention and control Nurses during hours and out of hours by on-call Microbiologist.
- For staff exclusion matters there will be case by case liaison with Occupational Health.
- Where non-compliance is identified, support and advice will be provided to improve practice. This may involve additional training to specific groups of staff; increased frequency of audit; and observation of clinical practice.

6 References

- PHE (2020).COVID-19: Guidance for the remobilisation of services within health and care settings; Infection prevention and control recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
- PHE (2020). Coronavirus (COVID-19) https://www.gov.uk/coronavirus
- PHE (2020). COVID-19: investigation and initial clinical management of possible cases (July 2020). https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases
- Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection. Updated 28 September 2020 https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection
- PHE (2020). COVID-19: personal protective equipment use for aerosol generating procedures. https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

7 Associated Documentation

- Covid-19 Testing Standard Operating Procedure
- Decontamination Policy
- EASIAIR 2020 Powered Air Purifying Respirator
- Standard Operating Procedure Influenza-like illness Policy
- Laundry Policy
- Outbreak
- Outbreak of Infection Policy
- Patient Isolation and staff exclusion policy
- Respiratory Infections policy
- Standard Infection Control Precautions Policy
- Waste Management Manual

DOCUMENT CONTROL

Title

Infection Prevention & Control management of COVID-19 patients Guideline

Author	**Author's job title** Infection Prevention & Control Nurse
Directorate Nursing	**Department** Infection Prevention & Control

Version	Date Issued	Status	Comment / Changes / Approval
1.0	Jan 2020	Draft	Wuhan Novel Coronavirus guidance NDHT, updated 12 times between 27.01.2020 – 03.04.2020 in accordance with local and national guidance.
2.0	April 2020	Draft	Updated 4 times between 21.04.2020 – 25.09.2020 in accordance with local and national guidance.
3.0	Oct 2020	Draft	Updates to reflect Care Pathways specific to COVID-19, placement of patients with suspected or confirmed COVID-19, Transmission Based Precautions, Personal Protective Equipment, Cohort areas, Visitors, Staff considerations, Environmental decontamination.
3.1	Oct 2020		Minor changes prior to submission to CRG
3.3	Dec 2020		Added statements re placement of CPAP BiPAP patients on green pathway
3.4	Dec 2020		Changes to IPC & PPE for COVID-19 poster section 4.5 Changes to number of days staff isolate following positive result.
3.5	April 2021		Changes to IPC & PPE for COVID-19 poster section 4.5
3.6	July 2021		Changes to IPC & PPE for Covid-19 poster section 4.5 Changes to use of Superabsorbant polymer gel granules section 4.12.

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Lead Director Chief Nurse	
Superseded Documents	

Issue Date	Review Date	Review Cycle
July 2021	June 2024	Three years

Consulted with the following stakeholders: • Infection Prevention & Control Team • Clinical Medical Microbiologist • Clinical Reference Group
Approval and Review Process • Infection Prevention & Decontamination Group
Local Archive Reference G:\INFECTION CONTROL **Local Path** G:\INFECTION CONTROL\IC Manual - Policies\Guidelines\COVID 19 management guidelines Sept 2020 **Filename** Management of COVID-19 patients Sept 20 v3.1

Policy categories for Trust's internal website (Bob)	**Tags for Trust's internal website (Bob)**
Infection Prevention & Control	COVID-19, PPE, Infection Control, AGPs, Transmission based precautions.

CONTENTS

1. Purpose

1.1. The purpose of this document is to detail the process for the infection Prevention & Control management of COVID-19 patients admitted to Northern Devon Healthcare NHS Trust.

1.2. The guidance applies to all Trust staff.

1.3. Implementation of this guidance will ensure that:

- Patients are managed safely in line with the National care pathways specific to the COVID-19 pandemic through screening and triaging to enable early recognition and identification of COVID-19 cases.

2. Responsibilities

2.1 Role of Chief Nurse

The Chief Nurse is responsible for:

- Acting as a point of contact for support
- Ensuring that a replacement main contact is identified should the original author be re-deployed or leave the organisation

2.2 Role of Clinical Reference Group

The Clinical Reference Group is responsible for:

- Acting as a point of contact providing for support for Clinicians

2.3 Role of Infection Prevention & Decontamination Group

The Infection Prevention & Decontamination Group is responsible for:

- Monitoring compliance with the policy
- Ensuring that the policy is approved after review and prior to publishing

3. Contacting the Infection Prevention and Control Team

The Infection Prevention and Control Team can be contacted in hours on 01271 322680 (ext. 2680 internal at North Devon District Hospital), via bleep 011 or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

4. Infection Prevention & Control guidance for the management of COVID-19 - patients

4.1 Introduction

The management of patients with COVID-19 is based on PHE guidance; refer to website for current guidance:

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/906096/COVID-19_flow_chart.pdf

SARS coronavirus (SARS-CoV-2), previously known as Wuhan novel coronavirus causes a respiratory disease known as COVID-19.The criteria for identifying suspected cases of COVID-19 can be found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases

COVID-19 is potentially transmissible through droplet, airborne and contact routes.

Although respiratory secretions are the main route of transmission other bodily fluids are potentially infectious.

The correct PPE must be worn according to the patients risk categories, the type of contact with the patient and the procedures being performed.

Correct removal of PPE is particularly important in preventing infection https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

The following IPC practices will also reduce the risk of transmission:

• Effective Hand Hygiene

• Good respiratory etiquette –

- Patients, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures e.g. using single-use tissues to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose, tissues should be disposed of promptly in the nearest waste bin.

- Hands should be washed (using soap and water if possible, otherwise using alcohol based hand rub) 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 (e.g. the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. a plastic bag) readily at hand for immediate disposal of tissues.
- In waiting areas or during transportation, symptomatic patients may wear a fluid-resistant surgical face mask (FRSM), if tolerated, to minimise the dispersal of respiratory secretions and reduce environmental contamination.
- A FRSM is not required if the patient is wearing an oxygen mask.

- Decontamination of equipment and the environment.

- Use of face coverings/facemasks by staff in clinical and non-clinical areas and by patients and visitors:

  - Fluid resistant surgical facemask (FRSM) to be worn by all healthcare workers when entering the hospital and in the care setting.

  - Face coverings should be worn by patients in their own home (if tolerated) when being visited by a Health Care Worker (HCW)

  - Face coverings should be worn by all outpatients (if tolerated) and visitors when entering the hospital.

  - Surgical facemasks (Type II or Type IIR) should be worn by all inpatients in the medium and high-risk pathways as long as they can be tolerated and does not compromise their clinical care e.g. when receiving oxygen therapy, to minimise the dispersal of respiratory secretions and reduce environmental contamination.

  - All visitors should wear a face covering in healthcare settings.

  - If visitors are unable to wear face coverings due to physical or mental health conditions or a disability, clinicians should consider what other IPC measures are in place, such as 2m physical distancing, to ensure sufficient access depending on the patient's condition.

Follow government guidance: 'Hands. Face. Space'

- Screening – All emergency patients will be swabbed on admission, elective and patients attending for day case procedures will also be COVID-19 swabbed 72 hours prior to admission. See Trust COVID testing SOP.

4.2 Identifying suspected cases of COVID-19

Possible cases:

The current national guidance sets out the following criteria for identifying a possible case of COVID-19:

Patients who meet the following criteria (inpatient definition)

- requiring admission to hospital (a hospital practitioner has decided that admission to hospital is required with an expectation that the patient will need to stay at least one night)

and

- have either clinical or radiological evidence of pneumonia

or

- acute respiratory distress syndrome

or

- influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing

or

- a loss of, or change in, normal sense of taste or smell (anosmia) in isolation or in combination with any other symptoms

Note: Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition.

Patients who meet the following criteria and are well enough to remain in the community

new continuous cough

or

high temperature

or

a loss of, or change in, normal sense of taste or smell (anosmia)

Individuals with any of the above symptoms but who are well enough to remain in the community should follow the 'Stay at home guidance' and get tested.

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

Alternative clinical diagnoses and epidemiological risk factors should be considered.

4.3 Priority Actions for Suspected COVID-19 Patients in Hospital.

Staff who work in receiving units, and especially those with first contact with patients, must be alert to the possibility of COVID-19, **if COVID-19 is suspected the patient must be isolated immediately:**

- In ED patients should be directed according to the ED pathway

For inpatients Clinicians should:

- Implement infection prevention and control measures whilst awaiting test results and assess / prioritise patients in a single occupancy rooms.
- Wear personal protective equipment (PPE) – for droplet precautions; fluid resistant surgical mask, single use disposable apron, gloves and eye protection. If a patient meeting the case definition undergoes an aerosol generating procedure (AGP), airborne precautions must be used; FFP2/FFP3 respirator, long-sleeved disposable fluid-repellent gown/coverall, gloves and eye protection.
- Patient to wear a fluid-resistant (Type IIR) surgical face mask (FRSM) if they are in a clinical or communal area, or are being transported (if the patient can tolerate it) in order to minimise the dispersal of respiratory secretions
- A FRSM should not be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). An FRSM can be worn until damp or uncomfortable
- Wearing a face mask or face covering during COVID-19 leaflet: https://www.northdevonhealth.nhs.uk/wp-content/uploads/2020/06/Face-mask-leaflet-NDHT-FINAL.pdf

4.4 Placement of Patients with Suspected or Confirmed COVID-19

In NDDH the areas identified for patients are:

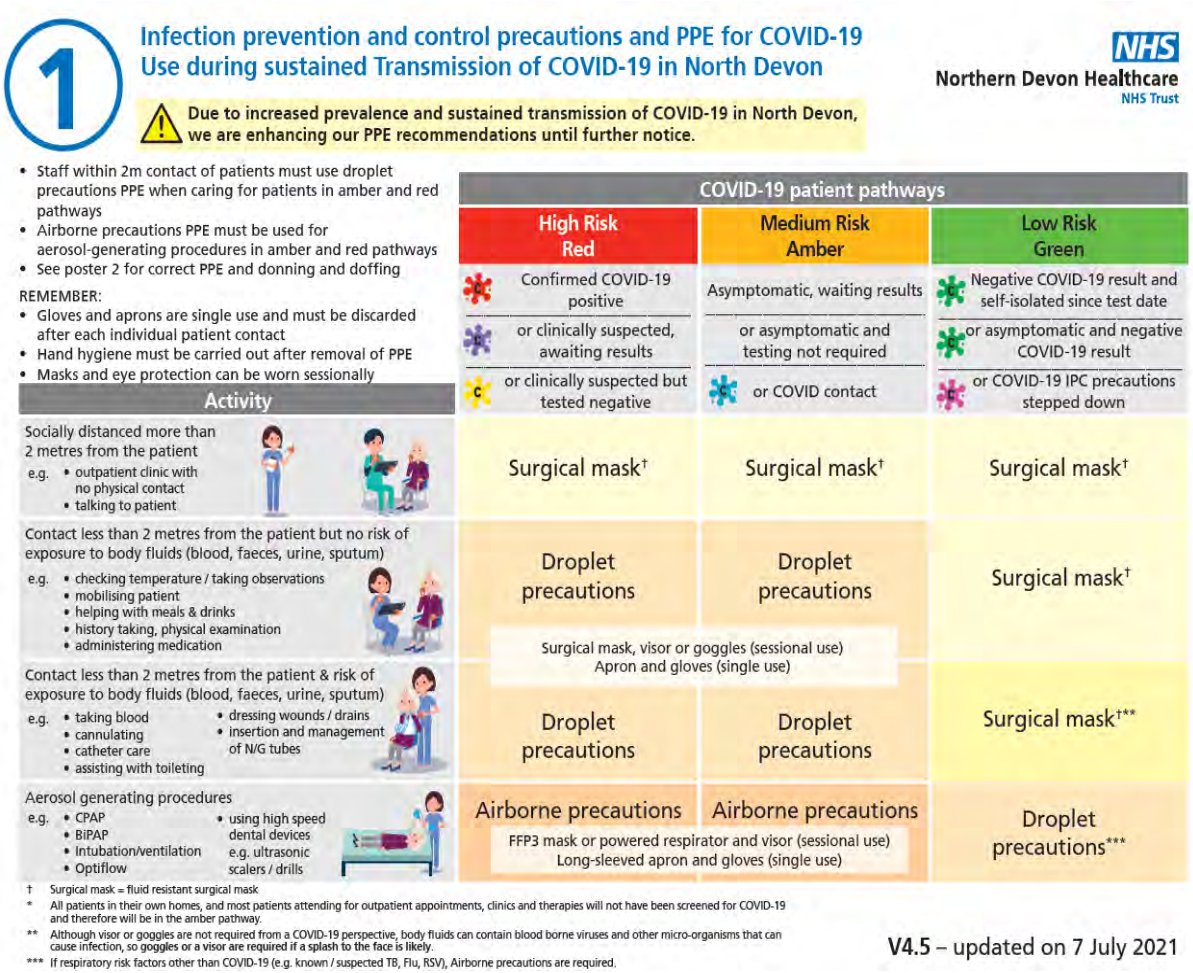
- Emergency department
- Alex / MAU ward – single rooms
- Caroline Thorpe – use side rooms 5 & 6 (side rooms 3&4 are alternatives)
- ICU
- Tarka Ward
- Capener Ward
- King George V ward single rooms only (for suspected patients awaiting results)
- Maternity

Patients with possible / confirmed COVID-19 must not be admitted to other areas within NDHT without prior discussion with the Infection Prevention & Control Team / Medical Microbiologist on-call.

All patients receiving CPAP or BiPAP should be cared for in single rooms or cohort areas. Select the PPE using pathways in section 4.5.

4.5 Patient Pathways.

National Guidance identifies care pathways, specific to COVID-19 for the management of patients using services, the pathways will ensure patients within health and other care facilities are screened and triaged in order to minimise risk. The following pathways detail risk categorisation and PPE requirements which take into account a patient's symptoms:



4.6 Infection Prevention & Control Measures

4.6.1 Isolation

Patients must be isolated in a designated room or cohort bay at all times with the door closed.

Putting on PPE must be performed in a quiet area to ensure that it is correctly worn

Correct removal of PPE must be carried out in an area where there is sufficient space to do this safely. The assistance of a buddy can be helpful.

4.6.2 Cohort Wards

If a single/isolation room is not available, patients with confirmed COVID -19 can be placed in a cohort bay with other confirmed COVID-19 respiratory infected patients.

The following measures are best practice for a COVID-19 area:

- Ensure patients are physically separated; a distance of at least 2 metre, use privacy curtains between the beds to minimise opportunities for close contact.
- The reception area / ward clerk area should be separated from the rest of the ward and relocated to an office area with a door.
- The ward must not be used as a thoroughfare by other patients, visitors or staff.
- Staff entering the cohort area must be kept to a minimum.

The appropriate personal protective equipment (PPE) will protect staff uniform from contamination in most circumstances. Theatre scrubs are not routinely required but staff may find them more comfortable under PPE.

Staff must not travel to and from work in uniform. It is expected that they will change into uniform or, theatre scrubs (where available) on arrival at work. Staff must change out of uniform when leaving work. Place uniform into a bag to transport home.

Changing out of uniform is based on public perception rather than evidence of infection risk. Uniforms should be laundered separately from household laundry, on the maximum temperature for the fabric and then ironed or tumble dried.

As per staff Uniform Policy, staff should wear shoes that can be wiped,

4.6.3 Staff working in cohort areas

Assigning a dedicated team of staff to care for patients in isolation/cohort rooms/areas is an additional infection control measure. This should be implemented whenever there are sufficient levels of staff available, so as not to have a negative impact on non-affected patients' care.

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including personal protective equipment (PPE), as outlined in this document

4.6.4 Identifying Hospital acquired cases of COVID -19 / Outbreaks

The swabbing of all admissions and managing patients in the risk pathways will reduce the possibility of transmission of COVID-19 in the hospital; however transmission and outbreaks can still occur for a number of reasons e.g. failure of PPE or non-compliance with IP&C precautions by staff, patients and visitors.

An outbreak of COVID-19 may be defined as two or more confirmed cases among individuals associated with a specific setting with onset dates within 14 days. There is a national definition of a COVID-19 outbreak.

If transmission or an outbreak is identified in the Trust the IPC team will implement outbreak control measures which will include restriction of movement and contact tracing of staff, patients and visitors as per Outbreak Policy.

4.6.5 Contacts

Patients or staff who have had significant exposure to COVID-19 will be identified as contacts. The IPC team in conjunction with the Contact Tracing Lead will assess the exposure and determine if isolation is required.

Identified patient contacts must be isolated in a single room or in a cohort bay for 14 days from their first exposure to a COVID-19 positive case or as advised by the IPC team. Patients identified as a contact must be managed in the 'Medium Risk Amber' pathway. If patients are being discharged within the 14 days isolation period they must be informed to continue to isolate at home as per national guidance. Patients can be discharge home but if a package of care is required care agencies must be informed.

Staff identified as having significant contact will be required to self-isolate at home for 10 days as per national guidance.

4.7 Infection Prevention and Control Precautions

It is important to use the right precautions when caring for patients with COVID-19, these precautions will be a combination of the following:

4.7.1 Standard Precautions

'Standard Precautions' refers to the application of infection control practices to prevent exposure to and the transmission of micro-organisms, which may be pathogenic (cause disease). These routine practices when caring for all patients include:

- Hand decontamination
- Wearing appropriate personal protective clothing
- Safe disposal of clinical waste
- Decontamination of equipment and the environment
- Safe disposal of sharps
- Safe handling of linen
- Patient placement and assessment for infection risk (screening/triaging)
- Respiratory and cough hygiene
- Occupational safety: prevention and exposure management
- Maintaining social/physical distancing

Healthcare workers must comply with and use standard infection prevention and control precautions when caring for all patients and the patients' environment to prevent cross-transmission from both suspected and confirmed sources of infection.

4.7.2 Transmission Based Precautions

Transmission based precautions (TBPs) are applied when Standard Infection Control Precautions (SICPs) alone are insufficient to prevent cross transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

4.7.3 Transmission Based Precautions (TBPs) Definitions

- **Contact precautions:** 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**: Used to prevent and control infection transmission over short distances via droplets (>5µm) from the respiratory tract of one individual directly

onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level. COVID-19 is predominantly spread via this route and the precautionary distance has been increased to 2 metres.

- **Airborne precautions**: Used to prevent and control infection transmission without necessarily having close contact via aerosols (≤5μm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. 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.

4.7.4 Hand Hygiene

Hand hygiene is essential to reduce the transmission of infection in health and other care settings and is a critical element of standard infection control precautions (SICPs).

All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving all clinical areas.

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:

https://www.who.int/gpsc/5may/Your_5_Moments_For_Hand_Hygiene_Poster.pdf

All staff in clinical areas must be bare below the elbows and rings (other than a plain smooth band). Wrist watches and wrist jewellery must not be worn.

4.7.5 Personal Protective Equipment (PPE)

The PPE to be used depends on the IPC precautions required.

Possible and confirmed COVID patients must be cared for using droplet precautions unless an aerosol generating procedure (AGP) is being performed.

For patients undergoing an AGP (in a side room or cohort ward) and those on ICU airborne precautions are required.

Gloves and aprons must be changed between each patient and / or following completion of a procedure or task.

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated (see section 5.5).

Head/footwear:

• Headwear is not routinely required in clinical areas, even if undertaking an AGP, unless it is part of theatre attire or to prevent contamination of the environment such as in clean rooms.

• Headwear worn for religious reasons (for example, turban, kippot veil, headscarves) are permitted provided patient safety is not compromised. These must be washed and/or changed between each shift or immediately if contaminated and comply with additional attire in, for example theatres.

• foot/shoe coverings are not required or recommended for the care of COVID-19 cases and increases the risk of contaminating hands when removing shoe covers.

In some cases PPE / face masks can restrict communication with individuals and other ways of communicating may need to be considered

4.7.6 Sessional use of PPE

- Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), with disposal and hand hygiene after each patient contact.
- Respirators, fluid-resistant surgical masks (FRSM), eye protection and can be subject to single sessional use in circumstances outlined below:
- A single session refers to a period of time where a health and social care worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might comprise a ward round or taking observations of several patients in a cohort bay or ward. A session ends when the health and social care worker leaves the clinical care setting or exposure environment.
- Once the PPE has been removed it should be disposed of safely. The duration of a single session will vary depending on the clinical activity being undertaken.
- While generally considered good practice, there is no evidence to show that discarding disposable respirators, facemasks or eye protection in between each patient reduces the risk of infection transmission to the health and social care worker or the patient. Indeed, frequent handling of this equipment to discard and replace it could theoretically increase risk of exposure in high demand environments, for example by leading to increasing face touching during removal. The rationale for recommending sessional use in certain circumstances is therefore to reduce risk of inadvertent indirect transmission, as well as to facilitate delivery of efficient clinical care.
- PPE should not be subject to continued use if damaged, soiled, compromised or uncomfortable and a session should be ended. The duration of a session could be up to 4 hours. Appropriateness of single vs sessional use is dependent on the nature of the task or activity being undertaken and the local context.

4.7.7 Droplet Precautions

The patient must be isolated in a single room or cohort bay, the following PPE is to be worn by all persons entering the area:

Single use disposable apron must be worn:

- To protect uniform when contamination is anticipated or likely and when providing direct care within 2 metres of suspected/confirmed COVID-19 case.
- Must be changed between patients and/or after completing a procedure or task.

Fluid resistant surgical mask (Type IIR)

Surgical masks must:

- Cover both nose and mouth.
- Not be allowed to dangle around the neck after or between each use.

- Not be touched / adjusted once put on (hand hygiene must be performed if the mask is adjusted).
- Sessional use of up to 4 hours but must be changed immediately when they become moist / damaged.
- Discarded as clinical waste – hand hygiene must be performed after disposal.
- Worn whenever in the hospital environment.

Eye protection (single use goggles or full-face visors).

- Full face visors must be used if contact with blood and/or body fluid contamination to the eyes or face is anticipated or likely (prescription glasses do not provide adequate protection).

Disposable Gloves:

- Must be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
- Must be changed immediately after each patient and/or after completing a procedure/task even on the same patient.
- Never decontaminated with Alcohol Based Hand Rub (ABHR) or soap between tasks.
- Double gloving is NOT recommended for routine clinical care of COVID-19 cases and vinyl medical gloves should only be worn in care situations where there is no anticipated exposure to blood and/or body fluids

4.7.8 Airborne Precautions (required for Aerosol generating procedures).

Patients in the High Risk / Amber COVID-19 pathways must be isolated in a single room or in a cohort bay with other patients undergoing AGPs. The following PPE is to be worn by all persons entering the single room or in a cohort bay:

- **Long sleeved, fluid-repellent disposable gown**
- **FFP3 respirator** conforming to EN149 must be worn by all staff in the room. Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used.
- **Eye protection-** full-face visors or goggles, must be worn (prescription glasses do not provide adequate protection)
- **Disposable gloves-** refrain from touching mouth, eyes or nose with potentially contaminated gloves.

The PPE described above must be worn at all times when in the patient's single room or cohort bay.

4.7.9 Putting on PPE

Before putting on (donning) PPE, healthcare workers should ensure hair is tied back securely (so as not to interfere with PPE) and off the neck/collar, remove jewellery/pens, ensure they are hydrated, and perform hand hygiene. For staff comfort the wearing of scrubs may be considered, especially for airborne precautions (ITU/ Theatres / cohort wards).

After cleaning hands staff should put on PPE in the following order:

1. Long sleeved gown or plastic apron
2. FFP3 respirator and fit check, or surgical mask
3. Eye protection (goggles or face shield)
4. Disposable gloves

The order given above is practical but the order for putting on is less critical than the order of removal given below. When putting on each item must be adjusted as required to ensure it fits correctly and interfaces well with other PPE items.

4.7.10 Removal of PPE

PPE should be removed (doffed) in an order that minimises the potential for cross-contamination. The gloves and the front of the visor, mask and gown will be contaminated

The order of removal of PPE is as follows, and is consistent with WHO guidance:

1. PPE removal can be started in the isolation room or cohort bay if there is sufficient space i.e. 2m distance from the patient. Otherwise leave patient isolation room and enter area for removal of PPE.
2. Peel off gloves and dispose in orange waste bin
3. Perform hand hygiene with alcohol gel or wash hands.
4. Remove apron/gown by using a peeling motion, fold gown in on itself and place in orange waste bin
5. Perform hand hygiene using alcohol gel or wash hands.
6. Remove goggles/visor only by touching the headband or sides and dispose in clinical waste. (If goggles are being reused they must be cleaned, firstly with detergent wipes then alcohol wipes and disposed of at the end of shift / or if damaged).
7. Perform hand hygiene using alcohol gel or wash hands
8. If not already outside patient isolation area and still wearing FFP3 then move outside isolation area before removing the FFP3 respirator.
9. Remove FFP3 respirator / surgical mask from behind and dispose in clinical waste.

10. Perform hand hygiene

PPE videos are available to watch on BOB:
https://www.northdevonhealth.nhs.uk/coronavirus-covid-19/ppe-and-hand-hygiene/ppe-videos/

4.8 Definition of Aerosol generating procedures (AGP)

An Aerosol Generating Procedure (AGP) is a medical procedure that can result in the release of airborne particles (aerosols from the respiratory tract when treating someone who is suspected or known to have an infection transmitted wholly or partly by the airborne or droplet route.

The following is the list of medical procedures for COVID -19 that have been reported to be aerosol generating and are associated with an increased risk of respiratory transmission:

• Tracheal intubation and extubation

• Manual ventilation

• Tracheotomy or tracheostomy procedures (insertion or removal)

• Bronchoscopy

• Dental procedures (using high speed devices, for example ultrasonic scalers/high speed drills.

• Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)

• High flow nasal oxygen (HFNO)

• High frequency oscillatory ventilation (HFOV)

• Induction of sputum using nebulised saline

• Respiratory tract suctioning

• Upper ENT airway procedures that involve respiratory suctioning

• Upper gastro-intestinal endoscopy where open suction of the upper respiratory tract occurs

• High speed cutting in surgery/post-mortem procedures if respiratory tract/paranasal sinuses involved

For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut or in a cohort area with other patients having AGPs.

Only those healthcare staff who are needed to undertake the procedure should be present. A disposable, fluid repellent surgical gown, gloves, eye protection and a FFP3 respirator should be worn by those undertaking the procedure and those in the room.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk.

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. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

Clearance of infectious particles after an AGP is dependent on the ventilation and air changes within the room. In a room with 10-12 air changes per hour (ACH) a minimum of 20 minutes is considered pragmatic: in a side room with 6 ACH this would be approximately one hour.

If an AGP takes place in the room it should be left for 60 minutes before being cleaned. At this time staff entering the room must wear PPE for Airborne precautions; further advice should be sought from IPCT if required. The patients' room must have an isolation clean following resolution of symptoms, discharged or transferred.

The Trust Resuscitation Policy is consistent with the Resuscitation Council guidance and includes the use of airborne precautions.

4.9 Equipment

- Patient care equipment should be single-use items if possible.
- Reusable non-invasive equipment should if possible be allocated to the individual patient or a cohort of patients.
- Reusable non-invasive equipment in the cohort area must be decontaminated between each patient and after blood and body fluid contamination. Clean with a neutral detergent and a chlorine-based disinfectant (Tristel).
- Equipment must be cleaned at regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.
- Where possible, avoid the use of bed side fans that re-circulate the air.
- Patient medical notes should be kept out of the patient's room or cohort bay. Hand hygiene must be performed after handling patients' notes.
- There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

4.10 Environmental Decontamination

There is evidence from other coronaviruses of the potential for widespread contamination of patient rooms/environments, so effective cleaning and decontamination is vital.

Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff.

For cleaning, a neutral detergent and a chlorine-based disinfectant should be used (Tristel).

The main patient isolation room should be cleaned at least once a day, and following aerosol generating procedures or other potential contamination.

There should be more frequent cleaning of commonly used hand-touched surfaces e.g. door handles (more than twice a day).

An increased frequency of decontamination should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates e.g.

- toilets/commodes particularly if patients have diarrhoea; and
- "frequently touched" surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails should be cleaned more than twice a day and when known to be contaminated with secretions, excretions or body fluids.

To ensure appropriate use of PPE and that an adequate level of cleaning is undertaken which is consistent with the recommendations in this document, it is strongly recommended that cleaning of the isolation area is undertaken separately to the cleaning of other clinical areas.

Dedicated or disposable equipment must be used for environmental decontamination. Reusable equipment must be decontaminated after use with a chlorine-based disinfectant as described above.

4.11 Linen

Dirty used linen should be placed in an alginate bag before putting into a white bag inside the patient isolation room in accordance with procedures for infectious linen. Unbagged linen must not be carried through the ward or other clinical areas.

Bagged linen should be taken from the patient room and placed directly in the dirty linen cage for collection.

In cohort areas only a dirty linen cage will be placed in the sluice, the ward should contact Sodexo to remove of the dirty linen cage from area and arrange replace with clean cage.

4.12 Waste

Large volumes of waste may be generated by frequent use of PPE;

Waste from a possible or confirmed case must be disposed of as infectious (Category B) waste. This requires orange bags. See Trust Waste Management Manual.

Dispose of all waste as clinical waste (orange bags). In a cohort ward the orange waste bags should be placed into a yellow wheelie bin. When the wheelie bin is full, the ward should contact Sodexo to arrange for collection and replacement bin.

In a non-cohort area, clinical waste should be removed and collected from the waste storage areas outside the wards for collection.

If ambulant, the patient can use the ensuite WC. If commodes are used, the used bedpan can be taken and disposed of in the sluice macerator but you must change gloves and apron or pass the bedpan to a colleague wearing gloves and apron outside the room to transport to the sluice.

The macerator should be started immediately after disposal of bedpan. Solidifying

Superabsorbent polymer gel granules are no longer routinely required but are available to use in some circumstances.

4.13 Staff Considerations

Prompt recognition / management of positive staff and also staff exposed to COVID-19 is essential to limit the spread of the virus.

If staff or members of their household have possible symptoms of COVID-19 they should refer to the COVID-19 testing SOP to determine if testing is required and whether they are able to come to work / remain at work.

A staff risk assessment is required for all health and social care staff, especially those at higher risk of complications from COVID-19, including pregnant staff.

Managers should:

- Discuss with employees who are at higher risk or are pregnant the need to be deployed away from areas used for the care of those who have or may have COVID-19.
- Ensure that advice is available to all health and social care staff, including specific advice to those at risk from complications.
- Bank, agency and locum staff should follow the same deployment advice as permanent staff.
- In the event of a breach in infection control procedures or failure of PPE, staff should to be reviewed by the IPC team and Occupational Health. Occupational health departments should lead on the implementation of systems to monitor staff illness and absence.
- In the event of staff exposure to a patient whose COVID-19 status was not known, the COVID-19 Contact Tracing Lead will identify staff who are considered to be contacts.

4.14 Visitors

Visiting is restricted at NDDH and South Molton to reduce the risk of COVID-19 transmission. Our staff can support patients and their families to stay in contact by using other methods such as video calls, letter printing etc. instead, where possible. Please contact our patient experience team for more information at ndht.patientexperience@nhs.net

Visitors will also be required to wear a mask or face covering when in the hospital, may be temperature checked and must follow social distancing and hand hygiene guidelines. Visitors must not visit if unwell.

Visiting is only allowed as follows:

- If there are specific reasons of safety (dementia or learning disability where anxiety would be increased significantly).
- Inpatients under the age of 18 years old – one parent/guardian only (both parents are permitted in the special care baby unit).
- Adult inpatients – one person per patient, from the same household or support bubble, this will need to be agreed with the ward staff to ensure social distancing is maintained.
- Visiting times may be staggered to accommodate visiting for all patients.
- All visitors should wear a face covering

- Visitors will be asked to wear a surgical facemask if visiting a high risk area or a patient with suspected/known COVID-19
- Parents/guardians must always wear a face covering when entering and moving through the healthcare setting and when a healthcare professional is treating their child/young person. If they are with their child and/or young person and within their 'family bubble' in side rooms or physical environments that afford separation, they can remove their face covering.
- Anyone showing symptoms of coronavirus should not visit. If visitors display symptoms of coronavirus they should be asked to leave, self-isolate at home for 14 days and organise a test; members of their household should also self-isolate for 14 days.
- Wards/departments/units must keep a list of visitors' names and contact details to aid the NHS Test and Trace teams if contact tracing is indicated.
- Admission areas e.g. ED/MAU/AAA will have the discretion to allow one person to accompany the patient to ensure the correct patient history etc. is obtained.
- At outpatient and diagnostic appointments where a patient may need emotional support they can be accompanied by one person from the same household or support bubble.
- A patient receiving end of life care can receive more than one visitor from the same household or support bubble within a 24 hour period. Where a face to face visit is not practical then virtual visits can be facilitated by contacting the outreach and resuscitation team on bleep 007 Monday – Friday, and clinical site team out of hours.

Maternity visiting

- One partner or designated individual is able to attend the dating scan (at approx. 12 weeks) and the anomaly scan (at 20 weeks), they are not able to stay for any subsequent appointments with a doctor or midwife.
- All other scans, such as growth scans, should be attended alone, though an exception can be made if it is anticipated that bad news might have to be given.
- If a woman is being induced, they can have a partner, or designated individual attend, with them between the hours of 10am and 6pm. Outside of these hours our staff will continue to contact partners and ask them to attend the unit if, due to pain or distress, support is required.
- One partner, or designated individual, may make an appointment with ward staff to visit Bassett Ward between the hours of 10am and 6pm. They can stay for as long as they like during that period but we are encouraging people to contact their individual midwife to arrange this.
- As throughout the whole of the COVID-19 pandemic, if a woman is being cared for in labour ward or in theatre, they can have one birth partner with them. This is usually when they are in labour, having a caesarean or in the immediate postnatal period.

Ward managers and clinical matrons have autonomy to manage extensions to these restrictions in exceptional circumstances.

4.15 Mobile Healthcare Equipment

The following advice applies to devices that cannot be left in the isolation room, such as portable X-ray machines:

- Use of mobile healthcare equipment should be restricted to essential functions as far as possible to minimise the range of equipment taken into and later removed from the room
- The operator of the device, if not routinely looking after the patient, must be trained and supervised in infection prevention and control procedures, including the use of PPE
- The operator should wear PPE as described above when in the isolation room / cohort bay.
- Any equipment taken in to the room and which must be subsequently removed must be disinfected prior to leaving the room.
- Any additional items such as a digital detector or a cassette will also need to be disinfected, regardless of whether there has been direct contact with the patient or not. This is due to the risk of environmental contamination of the equipment within the isolation room

4.16 Critical Care

- All respiratory equipment must be protected with a high efficiency filter (eg BS EN 13328-1). This filter must be disposed of after use
- Disposable respiratory equipment should be used wherever possible. Re-usable equipment must, as a minimum, be decontaminated in accordance with the manufacturer's instructions
- A closed suctioning system must be used
- Ventilator circuits should not be broken unless necessary
- Ventilators must be placed on standby when carrying out bagging
- PPE must be worn
- Water humidification should be avoided, and a heat and moisture exchanger should be used

4.17 Theatres

There is a separate protocol for managing all patients attending theatre.

- Theatres must be informed in advance of a patient transfer of a confirmed or possible COVID-19 positive case
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated
- The patient should be anaesthetised and recovered in the theatre. Staff should wear protective clothing but only those at risk of exposure from aerosol generating procedures, i.e. during intubation need to wear FFP3 respirators and full gowns. Considerations about the use of respiratory/anaesthetic equipment are addressed in the critical care section above
- Instruments and devices should be decontaminated in the normal manner in accordance with manufacturers' advice. Both laryngoscope handle and blade should either be single use or reprocessed in the Sterile Supply Department. Video laryngoscope blades should be single use and scope/handle decontaminated as per manufacture instructions.
- Instruments must be transported safely to decontamination, following use

- The theatre should be cleaned as per local policy for infected cases, paying particular attention to hand contact points on the anaesthetic machine
- Theatres should not be used by staff or patients for 20 minutes after an aerosol generating procedure.

4.18 Transfers to other Departments

Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present. Only if clinical need dictates, and in consultation with the infection prevention & control team, should patients be transferred to other departments. The following procedures then apply:

- The trolley used to transport the patient from the isolation room, should be disinfected as far as possible (see environmental decontamination immediately before leaving the room by an individual wearing PPE as described previously
- The department must be informed in advance of the patient's arrival
- any extraneous equipment to be removed safely from the investigation/treatment room
- The patient must be taken straight to and from the investigation/treatment room and must not wait in a communal area
- The patient should wear a fluid resistant surgical mask if this can be tolerated - this will prevent large respiratory droplets being expelled into the environment by the wearer. This is not required if the patient is wearing an oxygen mask.
- The treatment/procedure room, trolley/chair and all equipment should be decontaminated after use, as per the cleaning instructions above
- To enable appropriate decontamination after any procedure, patients should be scheduled at the end of a list, as far as possible. After the procedure, access to such spaces should be restricted and environmental decontamination implemented
- During patient transfers a process to ensure that no individuals not wearing PPE come within 2 metres of the patient should be followed. Anyone in the vicinity of the patient (for example carrying out procedures, transferring the patient or standing within 2m of the patient) must wear the PPE previously described

4.19 Transfers to other Hospitals

- transfer of cases to another hospital should be avoided unless it is necessary for medical care
- if transfer is essential, the IPCT at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer, so that appropriate infection control measures can be taken.

4.20 Community

NDHT staff working at other Trust locations and community staff visiting patients in their own home / care homes must follow the correct standard infection control and transmission based precautions (detailed in section 4.7) using the same COVID-19 pathways for High, Medium and Low risk patients. If tolerated, face coverings should be worn by patients in their own home when being visited by a Health Care Worker.

4.21 Handling the Deceased

The principles of SICPs and TBPs continue to apply whilst deceased individuals remain 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 patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

5 Monitoring Compliance with and the Effectiveness of the Guideline

Standards/ Key Performance Indicators

5.1 Key performance indicators comprise:

5.2 The numbers of incidents relating to inappropriate management of patients with suspected or confirmed COVID-19.

5.3 The number of COVID-19 infections involving patients and staff

Process for Implementation and Monitoring Compliance and Effectiveness

5.4 After final approval, the author will arrange for a copy of the policy to be placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release. Information will also be included in the Chief Executive's Bulletin which is circulated electronically to all staff. Line managers are responsible for ensuring this policy is implemented across their area of work.

Monitoring compliance with this policy will be the responsibility of the Infection Prevention and Control team. This will be undertaken by Weekly monitoring of incident forms at the Infection Prevention and Control team meetings

- Where non-compliance is identified, support and advice will be provided to improve practice.
- Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by weekly review of incident forms by the Infection Control Team and daily operational oversight by Infection prevention and control Nurses during hours and out of hours by on-call Microbiologist.
- For staff exclusion matters there will be case by case liaison with Occupational Health.

- Where non-compliance is identified, support and advice will be provided to improve practice. This may involve additional training to specific groups of staff; increased frequency of audit; and observation of clinical practice.

6 References

- PHE (2020).COVID-19: Guidance for the remobilisation of services within health and care settings; Infection prevention and control recommendations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/910885/COVID-19_Infection_prevention_and_control_guidance_FINAL_PDF_20082020.pdf
- PHE (2020). Coronavirus (COVID-19) https://www.gov.uk/coronavirus
- PHE (2020). COVID-19: investigation and initial clinical management of possible cases (July 2020). https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases
- Stay at home: guidance for households with possible or confirmed coronavirus (COVID-19) infection. Updated 28 September 2020 https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection
- PHE (2020). COVID-19: personal protective equipment use for aerosol generating procedures. https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

7 Associated Documentation

- Covid-19 Testing Standard Operating Procedure
- Decontamination Policy
- EASIAIR 2020 Powered Air Purifying Respirator
- Standard Operating Procedure Influenza-like illness Policy
- Laundry Policy
- Outbreak
- Outbreak of Infection Policy
- Patient Isolation and staff exclusion policy
- Respiratory Infections policy
- Standard Infection Control Precautions Policy
- Waste Management Manual

Royal Devon and Exeter NHS Foundation Trust

Disciplinary and Appeals Policy

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Assurance Framework	✓	Integrated Community Pathways	
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CQC Fundamental Standards - Regulation**:**		Infection Control	
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Note: This document has been assessed for any equality, diversity or human rights implications			

Controlled document

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1.0	15/03/12	Snr HR Manager	Minor amendments
2.0	04/2014	HR Manager	Improvements to process
2.1	02/06/2014; 01/10/2014	HR Manager	Alteration following feedback by Legal, PEP, JSCNC
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5.0	12/03/2018	HR Manager	Updated & Harmonised for RD&E & ND Staff
5.1	03/2018; 11/2018	HR Manager	Alteration following feedback by JSPRG & PEP

Associated Trust Policies/ Procedural documents:	Alcohol and Substance Abuse Policy Counter Fraud Policy Disclosure & Barring Service (DBS) Policy Grievance Policy Incident Reporting, Analysing, Investigating and Learning Policy And Procedures. Information Governance Policy Information (IT) Security Policy Maintaining High Professional Standards Policy Managing Performance (Capability) Policy Prevention of Harassment and Bullying At Work Policy Probationary Period Policy Supporting Staff in Adverse Events Procedure Whistleblowing Policy
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Contact for Review:	Head of Specialist Employee Relations Services
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	 **Director of People**

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KEY POINTS OF THIS POLICY:

This Policy will inform employees and guide managers through the process for managing misconduct.

The associated Managers Toolkit includes a flowchart, standard wording for letters and templates used in the process. The policy, guide and toolkit should be supplemented with advice from HR as required who can also advise throughout the process.

This policy is designed to help and encourage employees to achieve and maintain standards of conduct expected by the Trust. It aims to provide a fair and consistent method of dealing with problems of misconduct.

The aim is to take corrective, rather than punitive action where appropriate. The severity of incidents may result in the Trust needing to take disciplinary action in certain instances.

The Trust is committed to ensuring that its employees have an equal opportunity to benefit from a fair and inclusive process which is in line with its values.

The policy applies to all employees of the Trust. Employees will have an equal opportunity to benefit from a fair and inclusive process. Adjustments will be made as required in accordance with the Equality Act 2010.

1. INTRODUCTION

1.1 This policy ensures that the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as "the Trust") has a fair, effective and consistent means of dealing with matters of misconduct. These will be dealt with in accordance with the Trust's values of:

- Honesty, openness and integrity
- Fairness
- Inclusion and collaboration
- Respect and dignity

1.2 This policy is to be applied equitably and consistently across the Trust, whether employees are on permanent or fixed term contracts of employment. This excludes temporary workers e.g. bank staff.

1.3 The Management Toolkit should be utilised alongside this policy as a guide for employees and managers on how disciplinary matters will be dealt with.

1.4 Where appropriate, matters of misconduct should be dealt with informally in the first instance.

1.5 Where a matter of misconduct arises during an employee's probationary period the Probationary Period Policy should be referenced.

1.6 This policy does not cover cases related to poor performance. Please refer to the Managing Performance (Capability) Policy.

1.7 **Failure to comply with this policy may result in disciplinary action**.

2. PURPOSE

2.1 This policy is designed to help and encourage employees to achieve and maintain conduct standards expected by the Trust. It aims to provide a fair and consistent method of dealing with problems of misconduct.

2.2 The aim is to take corrective, rather than punitive action where appropriate. The severity of incidents may result in the Trust needing to take punitive action in certain instances.

2.3 The Trust is committed to ensuring that its employees have an equal opportunity to benefit from a fair and inclusive process. Where required, reasonable adjustments will be made in accordance with the Equality Act 2010.

3. DEFINITIONS

3.1 **Disciplinary sanction** - Formal sanction applied following a hearing. See Section 13.

3.2 **Datix** – Incident report

3.3 **Management Toolkit** – Supporting document to be used in conjunction with the policy. To inform employees and guide managers through the process for managing misconduct.

3.4 **Suspension -** is the process of placing an employee on paid leave, with a

requirement that they do not attend work, while an investigation is undertaken into the allegations or concerns reported. Suspension is a neutral act; it is neither a disciplinary action nor an assumption of guilt.

3.5 **Misconduct -** is improper, unacceptable or unprofessional behaviour. This list is not intended to be exhaustive, but examples can include a breach of Trust rules, regulations, policies, procedures and guidance or negligence, carelessness, thoughtlessness which causes loss, damage, injury or distress to others.

3.6 **Gross Misconduct -** is misconduct or gross negligence which is of such a nature, that it fundamentally breaches the contractual relationship between the employee and the Trust and justifies the employer in no longer accepting the continued presence of the employee at the workplace and potentially so serious as to justify the summary dismissal of a member of staff without notice or payment in lieu of notice. See further details under Summary Dismissal.

3.7 **Terms of Reference** - is the framework provided to the investigating officer setting out the issues to be investigated and matters to be considered as part of the investigation.

3.8 **Commissioning Manager** - is the manager responsible for requesting that an investigation takes place into an alleged incident or matter of concern. The Commissioning Manager is responsible for appointing the investigating manager.

3.9 **Investigation Meeting** - is a formal meeting held with employees to establish the facts of the concern / issue raised and is often referred to as a fact-finding meeting. Employees against whom allegations have been lodged are entitled to be accompanied by a Trade Union Representative or workplace colleague at this meeting.

3.10 **Chair –** The Chair of the panel will be the Manager hearing the case at the Disciplinary Hearing, who may also be referred to as the Disciplining Officer.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **Executive Director Responsibilities:**

- The Director of Transformation and Organizational Development has overall responsibility for the policy

Deputy Director of People Responsibilities:

- The Deputy Director of People is the designated senior manager to which appeals should be sent. They will then delegate the appeal as appropriate

4.2 **Employee Relations Responsibilities:**

- The Employee Relations Team will support line managers in applying the policy to ensure a fair and consistent approach.

4.3 **Manager Responsibilities:**

- To be clear with employees regarding the standards of behaviour required
- To act early to correct behaviours
- To resolve matters of misconduct informally in the first instance where appropriate
    - To clarify issues and plan an approach to dealing with a matter of misconduct using the Management Toolkit

- To ensure discussions and outcomes are clearly documented and copies provided to the employee as appropriate.

4.4 **Employee Responsibilities:**

- To be responsible for their own conduct and demonstrating an appropriate standard of behaviour in the workplace at all times
- To be aware that it is not appropriate to record day to day conversations at work and that any such recordings may be considered covert and warrant disciplinary action.
- To engage with any action taken in line with the policy
- To arrange their own representation/support for formal meetings. In situations where their representation/support is unavailable e.g. due to sickness or annual leave they should liaise with them to arrange alternative support.

4.5 **Trade Union Representatives / Workplace Colleague**

- To represent/support employees during a formal process in line with the policy

4.6 **Investigation Manager**

- To conduct and coordinate a fair, prompt and proportionate investigation
- To define terms of reference for a formal investigation and ensure a planned approach to dealing with a matter of misconduct using the Management Toolkit
- To attend training in conducting investigations
- To fully document all information regarding investigation meetings and correspondence with employees (see Management Toolkit)

4.7 **Chair of Panel**

- To attend training in chairing hearings
- To ensure that all parties are permitted to state their case appropriately and professionally
- To ensure a fair process is followed during a hearing and a reasonable outcome decision is made considering the facts presented by both parties

4.8 **Workforce and Diversity Committee Responsibilities:**

- The Workforce and Diversity Committee will ratify the policy. In each financial year the Committee will audit the adherence to this policy in line with Section 14.

5. OTHER PROCESSES

5.1 **Counter Fraud Procedure**

When an allegation has been made against an employee of the Trusts relating to fraud or corruption the line manager should ensure that the suspected employee is NOT informed and that the process detailed in the Counter Fraud Policy is followed in the first instance. Once the Local Counter Fraud Specialist has been informed an investigation may be instigated to establish the facts – the report will then be shared with the relevant Senior Manager to decide whether a Disciplinary Investigation is required.

5.2 **Police Investigations**

If the police are carrying out a criminal investigation into a matter that is also the subject of an internal disciplinary investigation, the Trust has a responsibility to ensure that any internal investigation does not prejudice or disrupt the police proceedings.

The Trust will investigate the facts before deciding whether to take formal disciplinary action. If a Police investigation does not result in a prosecution, the Trust may still conclude that disciplinary action is justified on the basis of its own investigation if there are reasonable grounds for believing that the employee committed the alleged misconduct (balance of probabilities).

The Trust will not always wait for the outcome of any prosecution before deciding what action, if any, to take. Employees concerned may be less likely to cooperate with an internal investigation if they believe it could prejudice their defence with regards to the Police. Where an employee is unable or has been advised not to attend a disciplinary hearing or say anything about a pending criminal matter, the Trust may, depending on the circumstances, have to take a decision based on the available evidence.

5.3 **Safeguarding Issues**

Where there is a safeguarding issue the Trust's Safeguarding Lead should be contacted to determine if a referral to the Local Authority Designated Officer (LADO) is required to be reported within required timeframes. The Safeguarding Children Policy and Safeguarding Vulnerable Adults Policy should be referenced as appropriate.

5.4 **Reported Incidents**

The Trust's Incident reporting, analysing, investigating and learning policy should be followed in the first instance. The Incident Decision Tree (see Management Toolkit) should be used to promote fair and consistent staff treatment for all cases prior to invoking any disciplinary process.

5.5 **Multiple HR Procedures (i.e. Where two policies clash)**

Normally this procedure will apply as set out. However, in some circumstances, two or more policies may apply to a situation, e.g. where a member of staff is taken through the disciplinary procedure and a grievance is raised. In these circumstances the most appropriate procedures will be determined by the manager/HR using the principles of ACAS best practice and employment law. This decision will be reached following discussion with the employee and/or their representative, the final decision of the most appropriate process will remain with management. The aim should be to incorporate the essential elements from each procedure but minimise the number of meetings and correspondence to the benefit of all parties to resolve and manage issues promptly. Where an employee's misconduct and capability are under question and both are referred to a formal hearing, the Trust may choose to hold one hearing to hear all of the information if it is believed that the cases are interlinked with the possibility of a sanction issued under either policy or both.

5.6 Where the employee being investigated is a Trade Union Representative the investigation manager (with the consent of the individual concerned) will contact the appropriate full time union official or equivalent regional representative before proceeding.

6. PROCEDURE FOR MANAGING MISCONDUCT

6.1 Preliminary Investigation

6.1.1 Where a potential disciplinary matter arises, the manager should carry out a preliminary investigation. This will involve establishing the facts of the incident and may involve a brief discussion with a complainant, a witness, or where necessary, the employee concerned, whenever possible an initial written account of the events should be obtained. If it is necessary to discuss the incident with the employee, they should be advised that it is not a formal disciplinary meeting and is solely to establish the facts. There is no right to representation at this meeting.

6.1.2 Where the matter appears to be of a minor and straightforward nature the manager should deal with the issue informally, as in accordance with section 7.1.2

6.1.3 If, following the preliminary investigation, it is felt that the matter requires further investigation, or that the matter is a potential disciplinary incident, a formal investigation should be conducted. Using the Management Toolkit, the line manager will undertake a review with a senior manager. This will determine whether or not formal action is required.

7. SUSPENSION/TEMPORARY REDEPLOYMENT/TEMPOARY AMENDMENTS TO DUTIES

7.1 Suspension is not a disciplinary sanction and is not an assumption of guilt but may be appropriate in potentially serious circumstances where it is considered that allowing the employee to continue working could place the safety and/or well-being of patients, employees or the employee at risk, or where it is felt that the continued presence of the employee may impair the investigation, or in the interests of protecting the Trust and/or in certain cases where police inquiries take place consideration must be given to suspending the employee.

7.2 In certain circumstances it may be appropriate to consider temporary redeployment to an alternative work area whilst the investigation takes place.

7.3 During suspension an employee will receive their normal rate of pay including enhancements.

7.4 The decision to suspend should be reviewed on a regular basis during the formal investigation and suspension may take place or be lifted at any point during a formal process. Suspension should be kept as brief as possible.

7.5 At any point during the investigation dependent on the information ascertained, it may be necessary to reconsider a decision to suspend or find temporary redeployment.

7.6 No action should be taken without completing the Suspension Risk Assessment Tool (reference Management Toolkit). Where a risk assessment indicates that suspension is appropriate, this must be discussed with an Employee Relations Representative or on-call Manager. Where an individual holds two assignments within the Trust (including a bank assignment), the risk assessment should consider the full risk of allowing the employee to continue in any capacity.

7.7 Where a completed suspension risk assessment establishes the need for action, the employee should be invited to a meeting to inform them of this. The manager must be accompanied by either a management colleague or HR representative.

7.8 At the meeting the employee should be given a brief outline of the reasons for the commencement of formal action. This is not an investigation meeting and the employee does not have the right to be accompanied at this meeting. The employee will be sent a letter following the meeting and informed of Staff Support and Counselling contact details and the EAP Service. Consideration should also be given to referring the employee to Occupational Health. Please see Management Toolkit.

7.9 Employees who are member of a Trade Union are reminded that they may seek advice from their Trade Union Representative should they wish to do so.

7.10 During a period of suspension the line manager or a designated manager will keep in touch with the employee on a regular basis.

7.11 Where employees are suspended or alleged to have breached the Trust's IT policies (Information Security Policy, Computer and IT Usage Policy and Network Security Policy), the line manager or suspending manager should notify the IT Operations Manager of the need to suspend the employee's network account.

7.12 **Informal Action**

7.12.1 In the interests of good management and employee relations, minor disciplinary matters should wherever possible, be resolved informally. It should be regarded as a means of avoiding formal disciplinary action rather than as an early stage of the disciplinary procedure.

7.12.2 An informal discussion that should be documented will usually take place regarding minor conduct matters. This process should always take place in a private and confidential setting and should be undertaken on a one-to-one basis between the manager and employee concerned.

7.12.3 The aim of advice and support should be to assist and encourage the employee in meeting the standards of conduct required of them.

7.12.4 Notes of the key points referred to in the one-to-one session must be made and issued to the employee making clear future expectations and documenting evidence on file in the form of an informal action letter (Management Toolkit) and retained on the personal file.

7.12.5 The employee must be informed that if there is no improvement or if an offence is committed again, the next stage may be to invoke the formal disciplinary procedure.

7.12.6 However if during the discussion it becomes evident that the matter is more serious the meeting should be adjourned and the formal investigation process should be invoked.

8. FORMAL INVESTIGATIONS

8.1 Following the decision to investigate, an investigation manager will be appointed. This will be a manager trained in HR investigations and independent i.e. they will not have been involved in the incident and may be from a different department. The investigating manager will be responsible for conducting the investigation process supported by a HR representative.

8.2 The investigation is a process of gathering information and establishing facts of a complaint, incident or allegation. No formal sanction will be imposed on the basis of an investigation alone. The investigation should start as soon as possible after the alleged incident has occurred or complaint received. The investigation manager will define terms of reference for the investigation and plan their approach to the investigation using the Management Toolkit.

8.3 The level of investigation required will vary from case to case. Where appropriate the investigation manager may choose to request written statements from witnesses. This may be followed up by an investigation meeting. Depending on the nature of the disciplinary allegation, the investigation manager may meet with relevant witnesses, complainant, accused and review relevant documentation e.g. Datix forms, patient notes, departmental records, personal files.

8.4 Employees will be given sufficient notice to arrange representation for a formal investigation meeting; this will normally be a minimum of 7 calendar days' notice. During any formal investigation meeting brief notes will be taken. Whilst the interview notes / transcripts are not intended to be verbatim, a digital recording may be taken by the Trust to ensure accuracy (see 11.5). A template is available in the Management Toolkit.

8.5 Witnesses must be made aware that their statement may be seen at a later date by the employee subject to investigation (reference Management Toolkit).

8.6 Where the employee being investigated is a Trade Union Representative the investigation manager (with the consent of the individual concerned) will contact the appropriate full time union official or equivalent regional representative before proceeding.

8.7 When the investigation is complete, the Investigating Manager will be responsible for completing the investigation report, which must include their findings as a result of the investigation and restrict their recommendations to only suggesting whether further action may be necessary or beneficial.

8.8 The investigation report will be sent to the senior manager responsible for the department, service or team involved. This manager, together with advice from Human Resources will have the responsibility for making a decision as to whether:

- No substance to the allegations is found
- Informal route / management action is appropriate
- The matter should proceed to a formal hearing.

The investigating manager, the employee and their nominated representative will receive written confirmation of the senior manager's decision.

9. RETURNING TO WORK FOLLOWING SUSPENSION OR AMENDED DUTIES

If at any time after the individual has been suspended from work, investigation reveals that either the allegations are without foundation or that further investigation can continue with the individual working normally or with restrictions, the suspension should be lifted and arrangements made for the individual to return to work with any appropriate support as soon as practicable. It should be clear at that point whether any responsibilities are to remain unchanged or what the duties and restrictions are to be and any monitoring arrangements

10. RIGHT OF ACCOMPAINMENT

10.1 Employees have the right to be accompanied and/or represented by a Trade Union representative to which they belong or workplace colleague not acting in a legal capacity and unconnected with this incident

10.2 All parties should make every effort in securing representation promptly so that the matter can be resolved without unnecessary delay.

10.3 If the employee's representative/workplace colleague is unable to attend the date originally proposed, the employee must contact the Investigating Manager and agree another date for the meeting to convene, provided that it is reasonable and is not more than 7 calendar days after the originally proposed date. This 7 calendar day limit will only be extended in exceptional circumstances. This may mean the employee needs to consider being accompanied by an alternative representative/workplace colleague.

10.4 The representative may address the investigation and hearing, ask questions and confer privately with the employee, but has no legal right to answer questions on behalf of the employee.

NB - Medical and Dental Staff who have entered this process through the Trust' Maintaining High Professional Standards Policy may still be represented in the process by a friend, partner or spouse, colleague, or a representative who may be from or retained by a trade union or defence organization.

11. FORMAL DISCIPLINARY HEARING

11.1 If following receipt of the investigation report the senior manager believes there is a case to answer and the incident potentially warrants disciplinary action, then a formal disciplinary hearing will be arranged. The hearing will be arranged without unreasonable delay taking into account the availability of all parties.

11.2 Employees will be given sufficient notice to arrange representation; The Chair will write to the Investigating Manager and the employee at least 14 calendar days prior to the hearing to confirm:

- The meeting is being held in accordance with the Trust's disciplinary procedure and who will be present;
- The alleged misconduct, the classification of the misconduct, i.e. minor, serious, gross and pending the outcome of the meeting, disciplinary action up to and including what level may be taken;
- The date, time and location of the meeting;

- The names and roles of the disciplinary panel, confirmation of the name of the manager presenting the management case, the representative presenting the employee case.
- Reference to any previous disciplinary action;
- Confirmation of the employees of the right of representation at the meeting by a Trade Union Representative or workplace colleague.
- Requirement to exchange cases and confirm witnesses.

All Disciplinary Hearings will be undertaken in accordance with the guidance in the Management toolkit.

11.3 **Prior to a Disciplinary Hearing**

11.3.1 The invite letter should be accompanied by copies of any written evidence e.g. witness statements. This will usually take the form of the management pack and supporting documents from the presenting manager.

11.3.2 If the employee wishes to submit, prior to the Hearing, any written response to the allegation(s), for consideration at the Hearing by the panel, all evidence should be submitted to the chair of the panel 7 calendar days prior to the disciplinary hearing. Managers will supply a copy of the management information to be presented and the Employee may choose to submit any written evidence for consideration. These documents will then be simultaneously shared with the employee and investigating manager.

11.3.3 Only in exceptional circumstances and at the discretion of the chair will new evidence be permitted at the hearing itself.

11.3.4 At the hearing a statement of case can be read out, it is not however a requirement that a written response is provided.

11.4 **Witnesses**

11.4.1 The confidential nature of witness statements, records and reports must be respected by all parties and must not be disclosed to anyone not directly involved in the case. Any breach of confidentiality may be the subject of further disciplinary action.

11.4.2 It is not a requirement to call all witnesses who have been party to the investigation. It may be sufficient to include their statement within the investigation report. It will be the responsibility of management and the employee to call and brief their own witnesses.

11.4.3 Whilst both management and the employee will have the opportunity to decide which witnesses they may wish to call at the meeting, the panel will in addition have the authority to request the attendance at the hearing of any witnesses they deem to be relevant to the case. The anonymity of witnesses will be considered in exceptional circumstances where there is a genuine belief of intimidation.

11.4.4 Witnesses should be provided with a copy of the guidelines for witnesses within the Management Toolkit.

11.5 **Note taking and recordings**

11.5.1 Handwritten notes can be taken by all parties during the hearing.

11.5.2 Hearings will be digitally recorded by the Trust. Digital recordings will be stored electronically by the HR team in accordance with the Data Protection Act 2018.

11.5.3 A copy of the digital recording will not be made available to the employee. If the employee wishes to listen to the recording for the purposes of receiving legal advice or appealing a hearing, they may request to do so on site. Alternatively, the employee's Trade Union Representative can request permission for a copy that will be stored in accordance with the Data Protection Act 2018. Unauthorised copying or disclosure of the recording will be grounds for disciplinary action.

11.5.4 Fact-finding meetings may be recorded to aid the process of creating interview notes. At no point will it be acceptable for the employee or their representative to record a meeting or the hearing without permission. This is considered to be covert recording and may result in disciplinary action being taken.

11.5.5 Where cases relate to a patient death, police investigation or injury, recordings may be kept for up to 10 years.

11.5.6 Transcripts are not made routinely available to employees. Where an individual wishes to request a transcript for the purposes of an appeal or legal proceedings they should make their request in writing within 14 calendar days of the hearing.

11.6 **Outcome**

11.6.1 In certain circumstances the hearing may have to be adjourned pending additional information e.g. a specialist report or medical assessment before a final decision can be reached. Where appropriate the employee, their representative and the manager presenting the case should be recalled and informed of the chairperson's decision. Where this is not possible or should the employee wish, the outcome of the Disciplinary Hearing can be communicated in writing.

11.6.2 If disciplinary action is the result, the employee should be informed of the salient points of the decision, which should be confirmed in writing within 7 calendar days. This will include 11.6.3 reasons for any sanctions and advice on their right to appeal (reference the Management Toolkit).

11.6.4 The decision should be given on the day wherever possible but the decision may be deferred for further consideration up to a maximum of 5 working days.

11.6.5 In all cases, the employee should be written to within 7 calendar days with the details of the decision reached.

11.7 Non-attendance

11.7.1 Employees, whether the subject of an investigation / meeting or as a witness, are obliged to attend investigative meetings and disciplinary hearings as a requirement of their contract of employment and must take all reasonable steps to do so. Failure to do so may result in disciplinary action, including dismissal, being taken in their absence.

11.7.2 The employee may send a written statement or a representative to attend the hearing on their behalf - this could be a Trade Union Representative or workplace colleague.

However the Trust strongly encourages employees who are subject to disciplinary action to attend the hearing in addition to their representative.

11.7.3 If the employee is unable to attend the disciplinary hearing, they should notify the chair of the panel and give the reason for non-attendance as soon as possible and in advance of the meeting. Where an employee fails to attend because of extenuating circumstances, they will be invited to another disciplinary meeting, where possible within five days of the original meeting.

11.7.4 If no prior notice of non-attendance is provided, or where an employee has failed to reasonably attend a formal disciplinary process and is unwilling or unable to give a reasonable explanation; the chair may make the decision to proceed with the hearing and make a decision based on the information available to them.

12. RESIGNATION PRIOR TO A DISCIPLINARY HEARING

12.1 In cases where an employee resigns prior to a disciplinary hearing, the chair, with support from HR, will decide whether it is appropriate for the disciplinary hearing to proceed as an evidence review meeting or disciplinary hearing. This decision will be communicated to the individual in writing.

12.2 In circumstances where a decision is reached that it is necessary to proceed, the individual will be given the right to be in attendance. If the individual declines this opportunity or fails to attend, then the hearing (or meeting) will proceed and a decision made in the individuals absence.

13. SANCTIONS

The gravity of offence(s) will dictate the disciplinary sanction or penalty imposed and will only be applied once all evidence and circumstances have been considered by a hearing panel. Therefore the potential sanctions set out below should not be treated as cumulative.

13.1 Formal Written Warning

For more serious offences or an accumulation of minor offences. A time limit of up to 12 working months will be applied to the sanction.

13.2 Final Written Warning

When misconduct is considered not to be so serious as to justify dismissal, or where there has been a previous written warning. A time limit of up to 12 working months will usually be applied to the sanction.

13.3 Redeployment/Transfer to a Lower Grade Post

13.3.1 In cases of misconduct where the panel have evidence that the employee is not capable of performing the role for which they were employed. This may be considered as an alternative to dismissal where deemed appropriate.

13.3.2 Pay protection will not be provided where redeployment is to a lower graded post. Redeployment will be effected as soon as possible, usually within a month.

13.3.3 Where redeployment is unsuccessful the Trust reserves the right to take the case back to the original panel for further review. Employees are expected to accept all

reasonable offers of redeployment. Failure to accept a reasonable offer may lead to termination of contract.

13.4 **Dismissal with notice**

May be issued where the panel believe the employee has committed gross misconduct but has significant mitigation for the act. Dismissal may also be appropriate where an additional offence is committed with an in date sanction on file.

13.5 **Summary Dismissal**

13.5.1 Where gross misconduct is proven. The misconduct is serious enough to overturn the contract between the Trust and employee. This is dismissal, without notice or pay in lieu of notice.

13.5.2 Examples of the type of conduct which could constitute gross misconduct and lead to summary dismissal are:

- Breach of contract
- Assault/physical violence or threat of
- Dishonesty
- Bringing the Trust into disrepute
- Negligence
- Endangering life
- Gross dereliction of duty
- Bullying and harassment/victimisation
- Acts of discrimination or harassment
- Fraud and/or theft
- Breach of confidentiality / the Information Governance Policy
- Serious insubordination to undertake a reasonable management request
- Failure to disclose a criminal offence or conviction prior to employment or relevant offence / conviction during employment
- Deliberately accessing internet sites containing pornographic, offensive of obscene material
- A series of minor offences
- An additional offence with an in date sanction on file
- Any other misconduct judged to be of similar gravity to those examples quoted

13.5.3 The examples above are for guidance only and are not intended to be exhaustive. Any misconduct can potentially be gross misconduct and therefore subject to summary dismissal, dependent on the circumstances of the individual case.

13.5.4 Any dismissal where the employee has committed a negligent, criminal, fraudulent act or omission should be aware that this *could* impact on their pension.

14. PROFESSIONAL MISCONDUCT / REFERRAL TO PROFESSIONAL BODY (E.G. NMC)

14.1 Employees who are subject to disciplinary proceedings due to professional misconduct are reminded that where the Trust has investigated the circumstances and has taken disciplinary action, it may be reported to the appropriate professional body. These bodies may then choose to investigate the case further.

14.2 The Trust also has a legal duty to make a referral to the Disclosure and Barring (DBS) when an individual has harmed or poses a risk of harm to a child or vulnerable adult.

14.3 Where an employee is subject to disciplinary proceedings and also registered with the Temporary Staffing Central Bank, any suspension or disciplinary action will also apply to their Bank work. Therefore where an employee is dismissed or has restrictions on their practice this will also be applicable to their work with Temporary Staffing Central Bank, who will be notified accordingly.

15. APPEAL

15.1 An employee who wishes to lodge an appeal against the outcome of a disciplinary meeting must do so to in writing to the designated manager within 15 calendar days' of the date of the letter confirming the outcome and clearly state the grounds for the appeal.

15.2 Where a dismissal took place, the appeal should be address to:
The Deputy Director of People.
Bowmoor House
Royal Devon & Exeter Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

15.3 An appeal must be raised in writing under one or more of the following grounds:

- Identified flaws in the investigation or hearing process
- Additional information that they believe would affect the outcome which was not available at the time of the hearing
- Failure of the panel to consider all the information raised
- Overly harsh sanction issued

15.4 Appeal hearings will normally be set up within 28 calendar days of receipt of the appeal letter.

15.5 A senior manager will be appointed to chair the appeal hearing. They will not rehear the initial case but will review the fairness of the original decision in light of any new evidence.

15.6 It is the responsibility of the employee to state their case for appeal. Therefore there will be no expectation of a management pack sent in advance of the appeal hearing. The panel will have available to them the original hearing information and any further information submitted by the employee in advance of the appeal hearing.

15.7 In cases such as probation, where an initial hearing did not take place. Both parties will have an opportunity to present their case. The invite letter should be accompanied by copies of any written evidence used by management in reaching their initial decision. If an employee wished to use any documents in their case their evidence should be submitted to the chair of the appeal panel 5 working days prior to the appeal hearing.

15.8 The chair will conduct the hearing in accordance with the Management Toolkit.

15.9 If the employee is unable to attend an appeal hearing, they should notify the chair of the panel and give the reason for non-attendance as soon as possible and in advance of the meeting. Where an employee fails to attend because of extenuating circumstances, they will be invited to another disciplinary meeting, where possible within five days of the original meeting. If no prior notice of non-attendance is provided or where an employee has failed to reasonably attend and is unwilling or

unable to give a reasonable explanation, the chair may make the decision to proceed with the case and make a decision based on the information available to them.

15.10 The decision should be given on the day but in exceptional circumstances the decision may be deferred for further consideration up to a maximum of 5 working days. The employee should be written to within 7 working days with the details of the decision reached.

15.11 The outcome is final and there is no further right of appeal.

16. CASE REVIEW

Following the conclusion of a complex case consideration will be given to conducting a case review. This may include for example the investigation manager, hearing chair, HR representative, line manager. In some situations this may also include Trade Union Representatives This will help to identify where improvements can be made in the process, any trends, training needs etc.

17. ACCESS TO INFORMATION

If an employee wishes to access personal information they should contact the Information Governance team. This may include situations where a member of staff is suspended.

18. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author, Employee Realtions Manager, Human Resources Operations department. An electronic copy will be maintained on the Trust Intranet, P – Policies – D – Disciplinary and Appeals. Archived copies will be stored on the Trust's "archived policies" shared drive, and will be held for 10 years.

19. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY/ STRATEGY

In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

What areas need to be monitored?	How will this be evidenced?	Where will this be reported and by whom?
All formal hearing outcomes will be recorded on ESR.	Records on ESR	Reported to Work Force Governance Committee by ER Specialist Team
All investigating managers and hearing chairs will be trained	Register held in HR ER Specialist Team	Reported to Work Force Governance Committee by ER Specialist Team
Each case will be reviewed (Section 12) to ensure application of the policy and the appropriate timescales have been followed	Documentation in investigation case files	Reported to Work Force Governance Committee by ER Specialist Team
Review (quarterly) incidences of disciplinary cases to see any	Records on ESR, HR case log	Reported to Work Force Governance Committee by ER Specialist Team

trends and if training is required		

20. REFERENCES

- Advisory, Conciliation and Arbitration Service (2015): *Code of Practice 1 – Disciplinary and grievance procedures.* Available at: http://m.acas.org.uk/media/pdf/f/m/Acas-Code-of-Practice-1-on-disciplinary-and-grievance-procedures.pdf

- Advisory, Conciliation and Arbitration Service (2017): *Discipline and grievances at work – The ACAS guide*. Available at: http://m.acas.org.uk/media/pdf/9/g/Discipline-and-grievances-Acas-guide.pdf

- ACAS Conducting Workplace Investigations - Guidance October 2015. Available at: http://www.acas.org.uk/index.aspx?articleid=5507

- NHS National Clinical Assessment Service (2012). *Handling Concerns about a practitioner's behaviour and conduct, An NCAS good practice guide*. June 2012. [online]. Available at: http://www.ncas.nhs.uk/resources/handling-concerns-about-a-practitioners-behaviour-and-conduct/

- *Data Protection Act 2018* (revised 01/11/2018) London: Stationery Office. Available at: https://www.legislation.gov.uk/ukpga/1998/29/contents

- *Equality Act 2010*. London: Stationery Office. Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents

- NMC Advice and information for employers of nurses and midwives –

  https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/advice-for-employers.pdf

APPENDIX 1: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	Executive Directors, Deputy Director of People, Specialist HR Services, Line Managers, All Employees, Trade Union Representatives, Investigating Managers, Workforce and Diversity Committee
The key changes if a revised policy/strategy	Harmonisation of RD&E and North Devon Policy. Timeframes Addition of signpost to other relevant policies and a preliminary Investigation
The key objectives	This policy is designed to help and encourage employees to achieve and maintain conduct standards expected by the Trust. It aims to provide a fair and consistent method of dealing with problems of misconduct.
How new staff will be made aware of the policy and manager action	Cascade by email from HR Business Partners & Line Managers. Induction process. CommCells. The Hub.
Specific Issues to be raised with staff	All staff should be made aware of the policy.
Training available to staff	Policy update slides will be published to demonstrate the key differences. The new policies will be applicable in 'Managers Essential Training' and the 'Investigators Training'.
Any other requirements	
Issues following Equality Impact Assessment (if any)	1 positive impact for investigations commissioned following a Bullying and Harassment complaint against a protected Characteristic.
Location of hard / electronic copy of the document etc.	The original of this policy will remain with the author, Employee Relations, Human Resources Operations department.

	An electronic copy will be maintained on the Trust Intranet, P – Policies – D – Disciplinary and Appeals. Archived copies will be stored on the Trust's "archived policies" shared drive, and will be held for 10 years.

APPENDIX 2: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Disciplinary And Appeals Policy
Division/Directorate and service area	Transformation and Organisational Development; Human Resources; Employee Relations
Name, job title and contact details of person completing the assessment	[redacted], Employee Relations Manager
Date completed:	30 July 2018

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

This policy ensures that the Trust has a fair, effective and consistent means of dealing with matters of misconduct. .

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☐ Staff ☒ Patients ☐ Other (please specify)

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below? (By *differential* we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☒	☐
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☒	☐
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☒	☐

4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to… (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

The policy may have a positive impact on those raising complaints via the Trusts prevention of Bullying and Harassment Policy.

5. Do you think the document meets our human rights obligations? ☒

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The toolkit offers additional support to those with a protected characteristic to avoid any accidental disadvantages. *Those with a disability may need alterations to the process, for example a change of venue to allow easy access – the toolkit also covered this.*

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	N/A
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Document Control

Title			
Disciplinary Policy & Procedure			
Author Assistant Director of HR			**Author's job title** Assistant Director of HR
Directorate Human Resources			**Department** Operations
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
1.0	Feb 2014	Draft	Initial version for consultation
2.0	July 2014	Final	Amended and agreed by Policy Development Group
2.1	Dec 2015	Final	Updated with Appeal Procedure (Appendix K)
Main Contact Director of Workforce and Organisational Development North Devon District Hospital Raleigh Park Barnstaple, EX31 4JB			
Lead Director Director of Workforce and Organisational Development			
Superseded Documents NDHT Disciplinary Policy/Procedure NHS Devon Disciplinary Policy/Procedure			
Issue Date January 2016	**Review Date** January 2019		**Review Cycle** Three years
Consulted with the following stakeholders: (list all) • **Infection Control** • **Medicines Management** • Policy Development Group • Staff-side			
Approval and Review Process • Partnership Forum • WODC			
Local Archive Reference G:\Corporate Governance\Policies and Procedures **Local Path** Workforce Development **Filename** Disciplinary Policy v2.1 - Final - Dec 2015.docx			
Policy categories for Trust's internal website			**Tags for Trust's internal website (Bob)**

(Bob) Location(s) on Bob Harmonised	None

2. Contents

3. Introduction

This document sets out Northern Devon Healthcare NHS Trust's policy and processes where there are concerns regarding the conduct of an employee. It provides a robust framework to ensure a consistent approach across the whole organisation.

4. Purpose

Northern Devon Healthcare NHS Trust recognises its obligation outlined in the Employment Rights Act 1996, the Employment Act 2002 and Employment Act 2008 to provide a fair and consistent procedure for all its employees and therefore the purpose of this policy is to:

- Provide a framework within which the Trust can ensure the safe and effective operation of its services by promoting fair treatment of individual employees. It outlines the procedures to be followed for promoting a prompt, fair, non-discriminatory, effective and systematic approach to the enforcement of standards of conduct in line with ACAS (Advisory, Conciliation and Arbitration Service) guidance and best practice.
- Enable members of staff to understand the circumstances which may lead to disciplinary action, the procedures to be followed, the penalties and remedies which may be imposed, and the available rights of representation and appeal.

This policy is to be applied equitably and consistently across the Trust, whether employees are on permanent or fixed term contracts of employment.

Relevant operational policies and protocols must be fully considered and invoked, if appropriate, prior to any disciplinary action being taken.

The policy applies to all employees of the Trust. However, for matters relating to the professional conduct and performance of medical staff, the Trust's policy on Managing Performance Concerns for Medical and Dental Staff should be referred to in the first instance. Where issues of personal misconduct are raised in connection with medical staff then this policy will apply.

Where an employee is an accredited representative of a recognised trade union, no action should be taken until the case has been brought to the attention of the Human Resources (HR) Operations Team, who will discuss the circumstances of the case with the appropriate trade union full time officer. No action under the procedure, other than suspension in instances of apparent gross misconduct will be taken against any accredited staff side representative until the case has been discussed with a full time officer of the relevant trade union or professional body.

5. Definitions

5.1. Suspension

Suspension is the process of placing an employee on paid leave, with a requirement that they do not attend work, while an investigation is undertaken into the allegations or concerns reported. Suspension is a neutral act; it is neither a disciplinary action nor an assumption of guilt. Please refer to the Trust's Suspension Policy for further information.

5.2. Misconduct

"Misconduct" is improper, unacceptable or unprofessional behaviour. This can include a breach of Trust rules, regulations, policies, procedures and guidance or negligence, carelessness, thoughtlessness which causes loss, damage, injury or distress to others. See Appendix A for further details of employee rules.

5.3. Gross Misconduct

"Gross Misconduct" is misconduct or gross negligence which is of such a nature, that it fundamentally breaches the contractual relationship between the employee and the Trust and justifies the employer in no longer accepting the continued presence of the employee at the workplace and potentially so serious as to justify the summary dismissal of a member of staff without notice or payment in lieu of notice. See Appendix A for further details and examples.

5.4. Prima Facie Facts (See Section 5)

These are the facts as they appear on initial presentation before the benefit of detailed consideration and/or investigation.

5.5. Terms of Reference

For the purpose of this policy the terms of reference is the framework provided to the investigating officer setting out the issues to be investigated and matters to be considered as part of the investigation.

5.6. Commissioning Manager

The Commissioning Manager is the manager responsible for requesting that an investigation takes place into an alleged incident or matter of concern. The Commissioning Manager is responsible for drawing up the terms of reference for the investigation and appointing the investigating manager. See section 4.3 below for full details on the role and responsibilities of the Commissioning Manager.

5.7. Investigation Meeting

An investigation meeting is a formal meeting held with employees to establish the facts of the concern / issue raised and is often referred to as a fact-finding meeting. Employees against whom allegations have been lodged are entitled to be accompanied by a Trade Union Representative or workplace colleague at this meeting.

5.8. Chair

The Chair of the panel will be the Manager hearing the case at the Disciplinary Hearing, who may also be referred to as the Disciplining Officer.

5.9. Working Days

For the purposes of the timescales within this Policy the expression 'working day' refers to Monday through Friday and does not include Saturdays or Sundays.

6. Responsibilities

6.1. Role & Responsibilities of the Chief Executive

The Chief Executive has the overall responsibility for all matters of Human Resources and ensuring that all mechanisms are in place for the overall implementation, monitoring and revision of this Policy. The Chief Executive has nominated the Director of Workforce and Organisational Development as lead for all Human Resources matters.

6.2. Role & Responsibilities of the Workforce and Organisational Development Directorate and HR Operations Team

It is the role of the HR Operations Team to ensure that employees and line managers receive appropriate advice and guidance in the implementation of this policy. The Directorate is also responsible for providing assurance that this policy has been adhered to in safeguarding the Trust against claims for constructive dismissal.

Where appropriate a representative from the HR Operations Team will work with the Investigating Officer through the formal stages of the disciplinary process where such assistance can be provided in a timely manner. It is not the role of the representative of the HR Operations Team to provide clerical assistance to the investigation.

6.3. Role & Responsibilities of the Line Manager / Commissioning Manager

Line managers are responsible for implementing this Policy when considering invoking the Disciplinary Procedure. The Line Manager/Commissioning Manager is responsible for reporting all disciplinary matters to the appropriate representative of the HR Operations Team.

Line managers have an important role in seeking to rectify problems of minor lapses in conduct, performance and attendance through discussion with their staff members where the emphasis is on improvement, without using the formal disciplinary procedures. Therefore, managers should ensure that regular meetings are in place, which includes; proper local induction (for new employees, internal transfers and those who have been promoted), management and clinical supervision, 1:1's and Development and Review (Appraisal) meetings. All reasonable efforts should be made to identify the cause of the problem and to identify appropriate support and guidance.

It is normally the role of the line manager or Commissioning Manager to decide whether an employee needs to be suspended, redeployed to alternative duties and/or workplace and/or requires increased supervision for the duration of the investigation or the until the disciplinary process has been completed.

The "Commissioning Manager" will be the manager who instigates the formal procedure and "commissions" the investigation process. Depending on the circumstances of the case this may be the line manager. In more serious cases or where the line manager may be required to undertake the investigation or be a witness, a more senior manager will undertake the role of "Commissioning Manager". The "Commissioning Manager" will set the Terms of Reference and timescale for the investigation. They will be responsible for ensuring that appropriate administrative support is provided to the Investigating Officer, for monitoring the progress of the investigation and ensuring that process is completed robustly and in a timely manner. The "Commissioning Manager" may be called upon to review the Terms of Reference as the investigation progresses. On completion of the investigation, the "Commissioning Manager" will determine whether there is a case to be considered and if so whether the matter should be dealt with under the informal procedure (see 5.1 below) or needs to be dealt with at a formal level. This will normally be at a Disciplinary Hearing. However there may be situations where there is a disciplinary case to be considered but where the Commissioning Manager considers the matter may be more appropriately dealt with through an alternative to a full formal disciplinary hearing. Where this is the case, the Commissioning Manager must discuss the case with an Assistant Director of HR before any alternative option is put to the individual and their representative. (See Appendix B for further information.)

Depending on the circumstances, the seriousness of the matter and the extent of their involvement in the investigatory process, the Commissioning Manager may be the manager who will hear the case at a Disciplinary Hearing and in these circumstances would be the Disciplining Officer.

6.4. Role & Responsibilities of the Investigating Officer

The "Investigating Officer" may be the line manager, an appropriate manager from within the department or may be from another department within the Trust, who should have gained relevant training / experience in carrying out, or assisting in, investigations. In exceptional circumstances, it may be necessary to appoint an Investigating Officer from another organisation. The Investigating Officer will not be permitted to hear the case.

The Investigating Officer will be responsible for leading and co-ordinating the investigation (i.e. arranging and conducting interviews, issuing paperwork, preparing the investigation report and management case). The Investigating Officer must ensure that the investigation is carried out in a prompt and timely manner and is responsible for supervising the administrative support provided for the investigation. The Investigating Officer is responsible for the quality of the investigation and the Investigation Report/Management Case. Where necessary the Investigating Officer should seek advice and support from a representative of the HR Operations Team.

6.5. Role & Responsibilities of the Employee

All employees are expected to behave in a manner that is conducive to good relations with their colleagues, managers and the users of the Trust's services. As employees of the Trust, all staff are looked upon to present a good impression to the general public, patients and their relatives/carers, and to avoid any actions that might jeopardise the good reputation of the Trust or its employees.

The responsibilities of employees are to:

- Participate fully in the process
- Seek support as required
- Provide an honest and accurate account when asked
- Maintain confidentiality
- Respond in a timely manner to communication
- Make every effort to attend meetings and maintain open communication with the investigating officer or HR representative supporting the investigation
- Ask questions when unsure
- Escalate any relevant concerns appropriately

6.6. Role & Responsibilities of the Chair of the Panel/Disciplining Officer

The Chair of the Panel/Disciplining Officer is responsible for ensuring that due process has been followed during the Disciplinary Hearing. The Chair is responsible for confirming the outcome in writing to the employee. Appendix C confirms the Level of Authority for managers involved in Suspension and Chairing Disciplinary Hearings and Appeal Panels.

6.7. Role & Responsibilities of the Hearing Panel

The Hearing Panel is responsible for considering all of the information presented to them from both parties, determining whether a disciplinary sanction is appropriate and if so the level of sanction. The panel will be comprised of a Chair and if necessary another manager. An expert to provide subject matter advice may attend to support the hearing panel.

A member of the HR Operations Team will be available, but depending on the seriousness of the case, not necessarily present, to provide procedural advice and support to the hearing panel. The member of the HR Operations Team may also be a formal member of the panel.

6.8. Role & Responsibilities of the Trade Union Representative

To make themselves available in a timely manner to participate in formal meetings relating to any stage of the disciplinary process and, where they cannot make themselves available in a timely manner, to ensure alternative representation from within the relevant Trade Union is provided to the employee.

To be familiar with and work with the policy and its requirements; they should be consulted with as part of the regular review of this policy.

6.9. Role & Responsibilities of Workplace Colleague

In place of a Trade Union Representative, staff may choose to be accompanied by a workplace colleague at the formal investigation meeting, Disciplinary Hearing or Appeal Hearing. The workplace colleague should be allowed to address meetings and hearings and at a hearing to put and sum up the employee's case, respond on behalf of the employee to any views expressed at the meeting and confer with the employee during the hearing. The workplace colleague does not however have the right to answer questions on the employee's behalf, address the hearing if the employee does not wish it or prevent the employee or employer from explaining their case.

6.10. Role & Responsibilities of Witnesses

To provide an honest and accurate account of what they personally witnessed or heard.

To respect the confidentiality of the investigation process and the rights of those involved with it.

If required, to attend the Disciplinary Hearing or Appeal Hearing and answer questions on their evidence. In some cases witnesses may be required to attend, give evidence and undergo cross examination at an Employment Tribunal or professional body Hearing e.g. Nursing & Midwifery Council. Guidance for Witnesses is attached at Appendix D.

6.11. Confidentiality – Responsibility of All

All individuals involved in the investigation of a potential disciplinary issue or in any hearings or other associated processes have a duty and responsibility to treat all information provided or received in the strictest confidence.

7. Procedure

Managers and supervisors will, through day-to-day management, aim to achieve change and improvement in matters of conduct, performance and attendance on the part of their employees. Where this is not effective, managers will initially consider the need for an informal meeting to raise and address any concerns.

Where misconduct is identified or alleged, the responsible manager may carry out an informal initial investigative meeting to clarify the prima facie facts and to determine whether further investigation is necessary. Following this meeting, the responsible manager will advise the employee accordingly of their decision and ensure this is documented. The informal initial investigative meeting should not be allowed to develop into a full and formal investigative meeting. It will usually be a brief meeting to establish whether the formal process needs to be instigated. Employees will not normally be entitled to be accompanied by a Trade Union representative or workplace colleague during this informal meeting.

Appendix E provides a summary flowchart of the key stages of the Disciplinary Procedure.

7.1. Informal Procedure

In cases of minor misconduct or shortfalls in standards that do not warrant formal disciplinary action, the line manager will, having given reasonable notice, meet with the employee to discuss the nature and cause of the problem, and ensure that a remedial course of action is agreed. Advice on how to manage the informal stage of the disciplinary procedure should be sought from a representative of the HR Operations Team.

The meeting should be a two-way discussion examining possible causes and encouraging improvement. Criticism should be constructive with the emphasis being on finding ways for sustained improvement.

The action will clearly identify the standards that are required to be met and the timescales within which these are to be achieved. The manager will also explain to the employee that if they fail to meet the required standards, or should any repetition occur, this may result in the implementation of the formal disciplinary procedure.

It is essential that notes are kept of the meeting and that the improvements required are confirmed in writing to the employee with a copy placed on their personal file (see *toolkit*).

7.2. Formal Procedure

Where it is not appropriate for an issue to be dealt with at an informal level, the formal disciplinary procedure will be invoked.

5.2.1 Suspension / Restricted Duties / Temporary Redeployment / Transfer of Workplace / Increased Supervision

The Trust reserves the right where the circumstances warrant it, to suspend an employee with pay, restrict their duties and/or redeploy an employee to an alternative work base while either it carries out an internal investigation or to resolve an issue pertaining to an individual's employment. Temporary redeployment can be anywhere in the Trust (within reason), in a role that the employee has the skills to undertake. In some circumstances registered professional staff may be redeployed to work in a non-registered capacity with increased supervision. The employee should suffer no financial detriment as a result of the temporary redeployment or adjustments which may continue for the duration of the investigation or until the disciplinary process has been completed.

Please refer to the Suspension Policy for further details and guidance.

After establishing the need for suspension or other restriction the employee should be called to a meeting to inform them of the reason for the action. The line manager should conduct this meeting and must be accompanied during that meeting by another appropriate manager/supervisor or a representative from the HR Operations Team and must not meet with the employee alone. The employee should be offered the opportunity to bring a colleague with them for support, but the manager does not have to postpone the meeting in order for this to be arranged. The employee should receive a letter confirming the outcome of the meeting, the reason(s) for the action and the next steps (see *template letter in Suspension Policy*).

7.3. Formal Investigations

When a situation is identified which may potentially require formal disciplinary action, it is the responsibility of the Line Manager to instigate the commissioning of a full investigation. However, if the situation is a fraud related matter it should be reported to either the Director of Finance or the Local Counter Fraud Specialist before implementing this disciplinary policy. See Section 5.4 below and Appendix F.

In deciding how the matter should be investigated, the Commissioning Manager will consider: -

- The nature of the alleged breach
- The seriousness of the alleged breach
- The Trust's policies/protocols and documents
- The Manager's authority level
- What is the lowest level at which the matter can be appropriately handled
- And complete the Terms of Reference for the investigation

An objective Investigating Officer will be appointed in line with the Selection Criteria detailed in Appendix G to lead investigative process. The Commissioning Manager will commission the investigation by giving a factual briefing to the Investigating Officer on the scope and parameters of the investigation ensuring that terms of reference for the investigation are provided (See Appendix H for Terms of Reference guidance).

The employee will be issued with a copy of the Guidance for Employees as attached at Appendix I.

The Line Manager or Commissioning Manager will advise the employee in writing that the matter will be formally investigated and that the employee will be required to meet with the Investigating Officer. The employee will be informed of their right to be accompanied by a Trade Union representative or workplace colleague (see toolkit).

The employee will be issued with a copy of Rights of Staff as attached at Appendix J.

Consideration should be given to the provision of an interpreter or facilitator if there are understanding or language difficulties on the part of the employee. This person may need to attend in addition to the trade union representative or workplace colleague though ideally one person should carry out both roles.

Provision should be made for any reasonable adjustments to accommodate the needs of a person with disabilities.

The Investigating Officer will complete their investigation of the case as soon as feasible taking into account all of the circumstances. The Investigating Officer may consult with professional colleagues and experts as appropriate. If the investigation exceeds the expected timescales, it is the responsibility of the Investigating Officer to provide the Commissioning Manager, the employee and their representative with an explanation and an estimation of revised timescales.

Actions on Outcome of Investigation

In the event that there is no case to answer, the employee will be advised in writing that no further investigation or action will be taken on this matter (See *toolkit*). This letter will be kept in the individual's personal file however all other information relating to the investigation should be held confidentially by the HR Operations Team.

In circumstances where the investigation has identified specific recommendations, the relevant line manager will be accountable for the implementation and monitoring of such recommendations and placing a record of this on the personal file.

In the event that the Commissioning Manager finds from the investigation outcome that there is a potential case for disciplinary action they will first decide whether the matter needs to automatically referred to a full Disciplinary Hearing for deliberation or could potentially be dealt with through an agreed alternative mechanism. The process for agreeing alternative options and examples of potential options that can be considered are set out in Appendix B. NOTE: An alternative option to a full Hearing can only be agreed with the support of the individual facing disciplinary action. They will retain the right for the case to be considered at a full formal Disciplinary Hearing if that is their choice. The procedure for conducting a Disciplinary Hearing is set out in Section 6 below.

Procedure for Medical & Dental Staff

Matters relating to the professional conduct and performance of medical staff Medical and Dental Staff are covered by the Trust's Policy and Procedure for Managing Performance Concerns for Medical and Dental Staff which is available on BOB. However, personal conduct issues for these staff, as for all other staff groups, are dealt with under this Disciplinary Policy. Where cases cover both performance and personal conduct concerns it will be for the Medical Director to decide upon which is the most appropriate procedure to use, having consulted the National Clinical Assessment Service (NCAS) and the Director or Workforce & Organisational Development.

Where the alleged misconduct being investigated under the Trust's Disciplinary Policy relates to matters of a professional nature, or where an investigation identifies issues of professional conduct, the investigating officer must obtain appropriate independent professional advice (i.e. NCAS). Similarly where a case involving issues of professional conduct proceeds to a hearing under this procedure the panel must include a member who is medically qualified (in the case of doctors) or dentally qualified (in the case of dentists) and who is not currently employed by the organisation. The Trust will agree the selection of the medical or dental panel member with the Medical Advisory Committee (MAC).

7.4. Counter Fraud Procedure

When an allegation or suspicion has been made against an employee of the Trust relating to Fraud or Corruption the line manager should ensure that the suspected employee is NOT informed and that the process detailed in Appendix F is followed.

7.5. Safeguarding Issues

Where the matter specifically relates to a safeguarding issue for either children or adults then a strategy meeting should be convened in accordance with the Trust's Safeguarding policies and procedures. **NOTE**: should the disciplinary investigation be conducted under the Multi-Agency Safeguarding Adults or Child Protection provisions, this should be made clear to the employee. Any police or social services investigation may preclude the initial disclosure of information to the employee. In these cases advice and guidance should be sought from the HR Operations Team.

7.6. Significant Event Audits (SEA) / Serious Incidents Requiring Investigation (SIRI)

The purpose and key focus of any SEA and/or SIRI investigation is to identify learning. If issues arise through the course of the investigation which may have implications under the Trust's Disciplinary Policy, consideration should be given by the manager to conducting an HR investigation alongside, but separate from, the SEA or SIRI.

Any witness interviews or statements may be used for both investigations to reduce the need for duplication. In these circumstances all parties who have provided statements to any SEA/SIRI investigation should be informed in writing of the provision of their statements to the Investigating Officer conducting the Disciplinary investigation and provided with the Guide for Witnesses set out in Appendix D. On completion of the SEA/SIRI investigation, the report and any further supporting evidence may also be provided to the Investigating Officer conducting the disciplinary investigation.

8. Procedure for Conducting a Disciplinary Hearing

Where a decision is taken that a full Disciplinary Hearing is required the following process shall be implemented.

8.1. Preparation

A Disciplinary Hearing should be held as soon as possible after the conclusion of the investigation but allowing for a reasonable amount of notice to be given to all parties (7 working days as a minimum). The purpose of the Hearing is to ensure that all of the relevant facts and the circumstances of the allegation(s) are fully heard and to decide whether or not disciplinary action should be taken and the appropriate disciplinary sanction issued.

The Hearing will be chaired by a manager with the requisite level of authority to take the potential level of action the case may merit (see Appendix C). Care will be taken to ensure there is no conflict of interest and the Chair of the Disciplinary Hearing will always be a different manager to the Investigating Officer.

Where it is deemed that professional advice may be required, a professional advisor to the Panel should be nominated. This advisor could be internal to the Trust or from an external organisation. The Chair shall be responsible for the proper conduct of the Hearing, which should be conducted on a formal basis.

An HR representative will be available, though not necessarily present, to provide procedural advice and support to the Chair and Panel. The HR representative may also attend and be a full formal member of the panel. Where the HR representative is a formal member of the panel they will be involved in the decision making process. Where an HR representative is only available to provide procedural advice and support to the Chair/Panel if needed, they will not be part of the Panel or the decision making process. The role of the HR representative will be made clear at the outset of the Hearing.

Consideration should be given to the provision of an interpreter or facilitator if there are understanding or language difficulties on the part of the employee. This person may need to attend in addition to the trade union representative or workplace colleague though ideally one person should carry out both roles.

Provision should be made for any reasonable adjustments to accommodate the needs of a person with disabilities.

The Trust may at its discretion choose to make a digital audio recording of the proceedings at the Hearing. Alternatively notes will be taken and this may require a note-taker to be present at the Hearing. Should an appeal be lodged this record may but will not necessarily form part of the documentation available to the management and employee sides and Appeal Panel.

At least 7 working days before the Hearing is due to take place the line manager (or other manager hearing the case) should write to the employee confirming:-

- The date, time and venue of the Hearing
- That the Hearing is to be held under the Trust's Disciplinary Policy, who will be present and in what role
- The alleged misconduct and the classification of the alleged misconduct i.e. minor, serious or gross
- If appropriate, refer to any previous disciplinary action
- The right to be accompanied by a Trade Union representative or workplace colleague not associated with the case being considered
- The right to submit, prior to the hearing, a written reply to the allegation(s) and any additional evidence for consideration, together with advice that the written reply should be provided no less than two working days in advance of the Hearing.
- The right to call relevant witnesses
- Instructions for the employee to confirm their attendance at the Hearing
- The action which will be taken should the employee fail to attend the Hearing i.e. that the Trust reserves the right to proceed in their absence
- The fact that should the allegation be substantiated, disciplinary action may be taken. If dismissal or summary dismissal is a potential outcome of the Hearing then this must be detailed in the letter.

The letter should be accompanied by copies of any written evidence e.g. witness statements. This will usually take the form of a statement of case and supporting documents from the presenting manager. An additional copy of the letter and documents should be provided to the employee for their representative or sent direct to the representative with the permission of the employee. Copies will also be sent to the panel hearing the case.

Please note that all correspondence to the employee relating to the disciplinary hearing should be either available for collection by the individual or issued to them by Recorded Delivery ™signed for. The same applies to any appeal process.

If the employee wishes to submit, prior to the Hearing, any written response to the allegation(s), for consideration at the Hearing by the panel, this must be received at least 2 working days before the hearing. This information will be provided to the panel and to the presenting manager. Note however, that it is not a requirement that the employee submits a written response to the allegations.

A statement must be included in the letter requiring attendance at a Disciplinary Hearing, warning the individual that the Trust reserves the right to proceed with a Disciplinary Hearing if the member of staff fails to attend, however all the circumstances must be taken into account prior to a decision being made to proceed.

If the employee's representative or chosen companion is unable to attend the date originally proposed for the meeting, the employee must contact the manager organising the Disciplinary Hearing and agree another date for the Hearing to convene provided that it is reasonable and is not unduly delayed due to the repetitive unavailability of any party.

8.2. Non Attendance at a Disciplinary Hearing

If an employee fails to attend a Hearing all reasonable steps should be taken to establish the reason and where appropriate one alternative date may be arranged. Where the employee or their representative cannot be contacted, all reasonable steps should be taken to advise them of an alternative date for the Hearing and warn them that failure to attend without reasonable cause may result in a decision being made in their absence. In these circumstances, a representative from the HR Operations Team must be consulted before any decision is taken.

If an employee refuses to attend a scheduled Disciplinary Hearing, but reports for duty, or fails to attend the Hearing without giving a reasonable explanation, the Hearing may be held in the employee's absence. It will be the responsibility of the employee to confirm their attendance in accordance with instructions provided in the letter requiring their attendance which may have been issued by the Investigating Officer, Chair of the Hearing or their line manager

If the employee presents a medical certificate that covers the period when the Hearing is due to be held advice should be sought from HR on the appropriate action to be taken which may include a referral to Occupational Health to assess fitness to attend. The Hearing may therefore need to be re-scheduled in accordance with medical advice.

Where an employee is certified as sick for more than 8 weeks, and depending upon the type of medical condition and prognosis, the Trust reserves the right to proceed with the Hearing, in the absence of the employee. The employee and their representative will be made aware of any decision to proceed and the representative will be allowed to present the employee's case in their absence if that is the wish of the employee and is confirmed in writing by the employee and the representative.

8.3. Resignation of employee

Should an employee choose to resign from their post, they should be made aware that the disciplinary process may not automatically be cancelled in order to obtain an appropriate outcome. Any disciplinary sanction decided at the conclusion of the disciplinary procedure would be included in any reference provided by the Trust and the information would, where appropriate, be provided to the employee's professional regulatory body. If it is not possible to reach a conclusion on a disciplinary matter relating to an employee who resigns during the process, for example if they have not been interviewed and afforded an opportunity to state their case, then references will include the fact that there was an incomplete formal disciplinary investigation at the time the employee resigned from the Trust.

8.4. Witnesses

All witnesses should be made aware at the investigatory meeting that they may be required to attend and give evidence at a Disciplinary Hearing and that their statement will be made available as part of the management / employee case. The normal expectation will be that any individual whose statement is put forward as evidence to a Disciplinary Panel will be available to be called as a witness at the Disciplinary Hearing. If the presenting manager does not consider it necessary to call a witness in person, they should seek to reach agreement on this with the defending employee and/or their representative. Even where agreement is reached between the presenting manager and the defending employee and/or their representative that a witness does not need to attend in person, the Disciplinary Panel may consider it necessary to question the witness in order to be able to reach a fair decision.

It is the responsibility of the employee to notify the Investigating Officer of any witnesses who have given evidence during the investigation they wish to call no less than 3 working days before the Hearing. The Investigating Officer will co-ordinate the attendance requests of these witnesses and will confirm to the employee whether they are able to attend, in writing.

If it is not practical for witnesses to attend, the Hearing would normally proceed so long as it is clear that the witness' verbal evidence would not affect the substance of the complaint. An adjournment of the Disciplinary Hearing to enable the attendance of witnesses may be considered by the Hearing Chair who will seek advice from a senior representative from the HR Operations Team. Any adjournment should be of no more than five working days.

Intimidation or victimisation of witnesses will not be tolerated. If a witness considers that they are being intimidated or experiences pressure to alter their evidence, they should bring this to the attention of the relevant representative of the HR Operations Team. Appropriate arrangements will be agreed to protect the witness. This may include arrangements for them to present their evidence to the Panel without the defending employee being present. Any victimisation of witnesses will result in further disciplinary action being taken.

If the defending employee and/or their representative wishes to call additional witnesses who were not interviewed as part of the investigation or whose statement is not put forward in evidence by the presenting manager, then it will be the responsibility of the individual or their representative to advise the Trust of the names of the additional witness(es) they wish to call and the purpose for which they are being called (e.g. to provide evidence specific to the case, an expert witness or a character witness etc.). The Chair of the Disciplinary Hearing will have the authority to refuse permission for additional witnesses to be called where they consider the evidence to be presented will have little or no additional value. They may also limit the number of additional witnesses who can attend where similar evidence is being presented. For example if a defending employee and/or their representative wish to call 10 character witnesses the Chair of the Disciplinary Hearing may restrict attendance to say 1 or 2 witnesses and accept written statements from the other character witnesses.

Where approval is granted for additional witnesses to be called, it will be the responsibility of the defending employee and/or their representative to co-ordinate the attendance of those witnesses. It will be the responsibility of each individual witness to ensure that they discuss their attendance at a Disciplinary Hearing with their manager so that they can be released from duty to attend. It will also be the responsibility of the employee or the representative to appraise their own witness(es) regarding the case they will be making in support of the employee and what they should expect at the Hearing. A copy of the Guidance for Witnesses attached at Appendix D should be provided to all witnesses attending prior to the Hearing.

8.5. Disciplinary Hearing Process:

All Disciplinary Hearings will be undertaken in accordance with the following process:-

Introductions

- The Chair of the Panel will:
- Introduce the panel and then ask the management and employee sides to introduce themselves
- Confirm the Hearing is being held in accordance with the Trust's Disciplinary Policy and Procedure
- Summarise the steps below
- Explain any housekeeping issues
- Check that both sides are in possession of all paperwork pertinent to the case
- Summarise the allegation to set the scene

The Case in support of the Trust

- The Trust's representative i.e. the Investigating Officer will present the Trust's management case to the Hearing Panel, in the presence of the employee and their representative, and may call witnesses.
- The employee or their representative will have the opportunity to ask questions of the Trust's representative and any witnesses they have called.
- In circumstances where the employee and/or their representative wish/es to ask questions of any witnesses, these should be directed through the Chair of the Panel. This is to avoid the witness feeling harassed or intimidated by cross questioning. It is for the Chair of the Panel to decide whether questions can be allowed.
- The Hearing Panel will have the opportunity to ask questions of the Trust's representative and any witnesses.
- The Trust's representative will have the opportunity to ask their witness further questions on any matter that has been raised in stages above.
- Witnesses will be present only when required to be and shall withdraw immediately afterwards. However, if necessary, they must be readily available for recall until the Hearing is concluded.

The Case in support of the Employee

- The employee or their representative shall put their case to the Hearing Panel, in the presence of the Trust's representative. The employee may call witnesses in support of their case.
- The Trust's representative shall have the opportunity to ask questions of the employee, their representative and any witnesses.
- In circumstances where the management side wishes to ask questions of any witnesses, these should be directed through the Chair of the Panel. This is to avoid the witness feeling harassed or intimidated by cross questioning. It is for the Chair of the Panel to decide whether questions can be allowed.
- The Hearing Panel shall have the opportunity to ask questions of the employee, their representative or any witnesses.

- The employee will have the opportunity to ask their witness(s) further questions on any matter that has been raised in the stages above.

Summing Up

- The Trust's representative will have the opportunity to sum up their case if they so wish.
- The employee or their representative will have the opportunity to summarise their case or speak last.
- Neither party may introduce any new matter at this stage.

The Hearing Panel

The Hearing Panel may be supported by a representative of the HR Department who will arrange for a written record of the Hearing to be made, unless the Hearing has been digitally audio recorded.

Nothing stated above will prevent the Hearing Panel from seeking amplification on any statement made or from asking questions to ascertain whether statements will be supported by evidence.

Where it is identified that insufficient evidence has been submitted to support the case, or that a decision cannot be made due to lack of material evidence, then the Hearing Panel have the right to suspend a decision until appropriate evidence is provided. In such circumstances, the Hearing will be reconvened at the earliest opportunity or the final decision will be communicated in writing.

Adjournments

- Either side may request an adjournment during the Disciplinary Hearing and should do so if time is needed to gather thoughts or if things take an unexpected turn. Permission should be sought through the Chair who will give timescales for adjourning and reconvening.
- The Hearing Panel may at their discretion adjourn the Hearing in order that further evidence may be produced by either party, or adjourn for any other reason.
- During an adjournment, the employee, their representative, the Trust's representative and all witness shall withdraw.

Reaching a decision

- The Hearing Panel will deliberate in private only recalling both parties to clear points of uncertainty on evidence already given. If recall is necessary both parties shall return notwithstanding only one is concerned with the point giving rise to doubt.

- Where possible decisions will be made on the day of the Hearing and will be communicated to both parties by recall. Where this is impractical the Hearing Panel has discretion to make alternative arrangements (e.g. re-convene at a later date or inform by telephone, email or letter).
- Written confirmation of a decision will normally be provided within 5 working days and no longer than 7 working days from the Disciplinary Hearing unless an alternative agreed date is provided during the Hearing.

Possible Outcomes

- No formal warning issued
- First written warning
- Final written warning
- Dismissal with Notice or Summary Dismissal (where this was indicated in advance as a possible outcome of the hearing)

Where a disciplinary sanction is issued, the rationale for the decision and the level of this action will be explained, together with the employee's right of appeal.

Where deemed appropriate the outcome of a Disciplinary Hearing will be provided to the employee's professional body (see Section 10).

Appeal

- The employee will be advised at the Disciplinary Hearing of their right of appeal and this will be confirmed in the letter confirming the outcome of the Disciplinary Hearing.
- A written letter of appeal must be received by the Director of Workforce and Organisational Development no later than 10 working days from the date of the Disciplinary Hearing.
- All disciplinary appeals will be conducted in accordance with the procedures laid out in Appendix K (also see Section 8).

9. Disciplinary Hearing Outcomes

In circumstances of serious or gross misconduct, or where attendance becomes a potential risk to the Trust or the staff team concerned, the matter can be considered as potentially resulting in a sanction of Dismissal or Summary Dismissal.

Wherever possible minor conduct issues will initially be dealt with via the Informal Procedure (see section 5.1), however if the problem persists or where the concern is of a more serious nature the disciplinary sanctions below would be instigated. Other than in circumstances of serious or gross misconduct the following stages would normally be sequential and would follow after reasonable and appropriate support procedures had been applied. However there may be circumstances where the issues under consideration are not considered so serious as to warrant potential dismissal/summary dismissal but are considered serious enough, if proven, to warrant of a sanction up to and including a Final Written Warning even though no previous warning has been issued. In these circumstances the Trust retains discretion to proceed at the level considered most appropriate.

The employee or ex-employee has the right to be represented by a Trade Union representative or supported by a workplace colleague at each formal stage of the procedure.

Legal representation at Disciplinary Hearings will not usually be permitted and will only be considered in exceptional circumstances. Where an employee makes request to be allowed to be legally represented, advice and guidance should be sought from a senior member of the HR Operations Team.

9.1. First Written Warning

A First Written Warning may be issued for any breach of conduct (see definitions above and examples in Appendix A). The minimum duration that a First Written Warning can be issued for is 12 months and the maximum duration it can be issued for is 2 years. In order to avoid any possible misunderstanding, the panel Chair must advise the member of staff during the Hearing and issue a letter to the individual, which should include the following:

- The reasons for the first written warning
- The standards of conduct expected in the future and how this will be monitored
- The duration of the warning
- That further disciplinary action will result if there is a recurrence or failure to maintain sustained standards
- That the first written warning will be cited in the event of any further act of misconduct for the duration of the warning
- That the member of staff can seek a review of the decision by lodging an appeal to the Director of Workforce and Organisational Development within 10 working days of the date of the Disciplinary Hearing; the date by which any appeal must be lodged should be included in the outcome letter
- That the warning will be recorded as spent after the designated period subject to satisfactory conduct, but will not be removed from the personal file.

The warning will remain on the employee's personal file for the stated period. If authorised by the employee a copy of the letter should be sent in confidence to their trade union representative or workplace colleague. At the date of expiry, the letter should be crossed through stating that the sanction has been spent, but must not be removed from the personal file.

9.2. Final Written Warning

If there is a further breach of conduct or failure to improve; a final written warning may be issued at the Hearing. If there have not been previous breaches but the shortfall in standards of conduct is sufficiently serious to warrant a final warning but insufficient to justify dismissal then the sanction issued may be a final written warning. The minimum duration that a Final Written Warning can be issued for is 1 year and the maximum duration it can be issued for in exceptional circumstances is 3 years. In order to avoid any possible misunderstanding, the chair of the panel must advise the member of staff during the Hearing and issue a letter to the individual, which should include the following:

- The reasons for the final written warning
- The standards of conduct expected in the future and how this will be monitored
- The duration of the warning
- That further disciplinary action will result if there is a recurrence or failure to maintain sustained standards
- That the final written warning will be cited in the event of any further act of misconduct during the duration of the warning
- That the member of staff can seek a review of the decision by lodging an appeal to the Director of Workforce and Organisational Development within 10 working days of the date of the Disciplinary Hearing; the date by which any appeal must be lodged should be included in the outcome letter
- That the warning will be recorded as spent after the designated period subject to satisfactory conduct, but will not be removed from the personal file.

This warning will also state that failure to improve may result in dismissal. The reason for this decision would be outlined at the conclusion of the Disciplinary Hearing.

The warning will remain on the employee's personal file for the stated period. If authorised by the employee a copy of the letter should be sent in confidence to their trade union representative or workplace colleague. At the date of expiry, the letter should be crossed through stating that the sanction has been spent, but must not be removed from the personal file.

9.3. Impact of Disciplinary Sanctions on Career Progression

When disciplinary sanctions have been put in place, there will not normally be an opportunity for the individual to gain promotion to any other post until the sanction is spent. However, depending upon the circumstances and seriousness of the case and/or the improvements achieved, there may be circumstances where career development can be achieved. The Line Manager will therefore be responsible for reviewing progress within the disciplinary sanction in liaison with the appropriate representative from the HR Operations Team.

9.4. Expiry of Warnings

Expired warnings must not be removed from the personal file at the end of the stated period, but must be crossed through and marked spent. Whilst the details of the investigation cannot be used in future Disciplinary Hearings the information relating to the level and duration of any spent sanction(s) will be included in the informed employment history of that employee.

9.5. Dismissal

Normally an employee will not be dismissed for a first offence, or without at least one prior warning, except in cases of gross misconduct or a breach of a statutory requirement.

Only a manager with the authority to dismiss can dismiss an employee (See Appendix C) and therefore the chair of the panel must have the appropriate level of authority.

Dismissal with Notice

In cases where a final written warning has been issued and where there has been no improvement, failure to sustain improvement and/or where further breaches of a serious nature have occurred the employee may be dismissed.

Where the employee is dismissed in these circumstances, notice will be given in line with the terms and conditions of employment (contractual notice) or payment in lieu may be ordered by the Chair. Regardless of being dismissed, the employee will be entitled to payment of any outstanding annual leave accrued as at the date of the termination of their employment.

Summary Dismissal (Dismissal Without Notice)

In cases where the panel finds there has been gross misconduct, (examples of which are set out in Appendix A) the employee may be summarily dismissed and their employment will terminate immediately without payment in lieu of notice.

Regardless of being summarily dismissed, the employee will be entitled to payment of any outstanding annual leave accrued up to the date of dismissal.

In all cases of dismissal, the employee will receive written confirmation of their dismissal and this will include the grounds for the decision for their dismissal, the effective date of the dismissal and their right of appeal which must be lodged with the Director of Workforce & Organisational Development within 10 working days of the date of the Disciplinary Hearing; the date by which any appeal must be lodged should be included in the outcome letter. The letter of confirmation should be issued normally within five working days of the hearing but no later than 7 working days.

9.6. Action Short of Dismissal/Alternative Sanctions

There may, exceptionally, be cases where management take the view that whilst dismissal or summary dismissal may be warranted, organisational and employee circumstances may best be served by action short of dismissal/summary dismissal itself. In these circumstances, one of the following sanctions may be considered as an alternative sanction to dismissal/summary dismissal only. These sanctions will normally be applied immediately and on a substantive basis, and will not attract any pay protection. If the employee does not agree with this course of action, then dismissal or summary dismissal as appropriate (notwithstanding the outcome of any appeal) will be the only alternative.

1. Final written warning for no less than 3 years duration

2. Final written warning with demotion and disciplinary transfer

3. Final written warning and disciplinary transfer

The Trust cannot create posts to accommodate demotion or disciplinary transfers, and consideration of such a course of action will only be possible where a suitable vacancy exists at the time of the Disciplinary Hearing.

10. Right of Appeal

The opportunity to appeal against a disciplinary decision is essential to natural justice and will not normally result in any increase in penalty. Employees may choose to raise appeals on a number of grounds, which could include:

- perceived unfairness of the judgement through the Disciplinary Hearing Panel failing to consider all the information raised,
- overly harsh sanction issued,
- new evidence coming to light that they believe would affect the outcome which was not available at the time of the Disciplinary Hearing,
- procedural irregularities or
- the findings of the Disciplinary Hearing on a point of fact.

The employee will be advised at the Disciplinary Hearing of their right of appeal.

Based on the grounds notified for the appeal, the purpose of an appeal is to consider whether the disciplinary action taken was fair and reasonable taking into account all the circumstances, and whether the correct procedures were applied in deciding on the disciplinary action. The appeal must take account of any evidence that has emerged since the initial Disciplinary Hearing, but the role is not to re-hear the original case.

All disciplinary appeals will be conducted in accordance with the appeals procedure laid out in Appendix K.

11. Actions Outside the Workplace and Criminal Proceedings

Any employee who is arrested on any charge or served with a summons on a criminal charge must inform his/her manager as quickly as possible. Failure to do so will be treated as a disciplinary offence in itself.

In circumstances where actions outside of the workplace take place the Trust has a duty of care to protect the integrity of the Trust and its staff, service users and stakeholders.

In the event of misconduct or gross misconduct outside of the workplace, action may be taken in accordance with the procedures in the following cases.

- Where an employee's actions are liable to bring the Trust into disrepute. Examples include misuse of funds, media publicity which could damage the Trust's good reputation or breaches of confidentiality
- Where an employee is charged with a criminal offence which is considered relevant to their employment

Managers must consult with their designated representative from the HR Operations Team whenever there is a police investigation for advice on whether and at what stage disciplinary action should be taken. If an employee is accused of a crime which might lead to a custodial sentence, any internal disciplinary enquiry/hearing should always take place in addition to the police enquiry.

Where the police are material witnesses to the incident, it may be appropriate for them to produce a written statement or (where operationally practical) to attend an internal Disciplinary Hearing.

A criminal offence unconnected with employment will not automatically be treated as a reason for disciplinary action. However, if the offence is one which makes the person unsuitable for his or her type of work or unacceptable to other employees, disciplinary action may be taken, including dismissal, if in the circumstances this is regarded as a fair and reasonable action.

Written records of all instances referred to in these circumstances should be retained within the Workforce and Organisational Development Directorate.

12. Conflict of Interest Employment – Outside Employment

Employees must not engage in outside employment that may conflict with their Trust employment or be detrimental to it. The Trust will be responsible for judging whether a conflict of interest exists and the individual will be responsible for ensuring that the employer is aware of any activity which may present a potential conflict. This includes the Trust's duty of care under the Working Time Regulations. Employees and workers must declare in writing outside employment which may conflict with their Trust employment.

It is essential that a member of staff who wishes to undertake paid work outside of their contracted working hours discuss this with their manager and seek authorisation to ensure that no conflict of interest is identified. If a conflict is identified the appropriate Director will be consulted and a decision will be made as to whether the outside activity breaches any of the Trust's policies or disciplinary rules, and appropriate action will be taken. A written record of the decision must be retained on the employee's personal file.

13. Reporting to Professional Bodies

The Trust may notify the specified statutory body that is responsible for the professional registration of particular groups of staff in all cases of dismissal or resignation connected with adverse findings in civil proceedings or a criminal conviction.

The Trust will also be at liberty to report any other factual information which in its reasonable opinion, believes ought to be in the possession of the employee's professional body, or statutory regulating organisation. The individual affected by disciplinary sanction or dismissal will be notified of this action in the letter confirming disciplinary action or dismissal.

The Trust will ensure that any guidance issued by the relevant statutory body relating to professional registrations which have lapsed or about to lapse is followed when making the notification.

14. Reporting to the Disclosure & Barring Service (DBS)

Where a proven allegation of misconduct pertains to, or has implications for, the safeguarding of children or vulnerable adults the disciplinary panel must make an assessment whether the matter requires referral to the Disclosure & Barring Service (DBS). Advice and guidance should be sought from the Trust's Safeguarding Leads and/or HR as appropriate.

15. Support for Employees

It is recognised that the disciplinary process is likely to be a stressful experience for all employees concerned. The organisation has therefore produced Guidance for Employees Involved in the Disciplinary Procedure, which can be found at Appendix I and this will be sent to all employees involved in the disciplinary process. Additionally, advice and guidance on how to cope with stress can be found on the Trust's intranet and the staff counselling service can be accessed through Occupational Health. The rights of staff involved in a disciplinary procedure can be found at Appendix I.

The disciplinary process can also be as equally stressful for witnesses and they should be provided with Guidance for Witnesses, which can be found at Appendix D. Witnesses should also be made aware of the support services available.

16. Development of the Policy

16.1. Prioritisation of Work

This is the harmonised Managing Performance policy reflecting the incorporation of the community services in Exeter, East and Mid Devon policy with Northern Devon Healthcare NHS Trust policy in April 2011.

16.2. Document Development Process

As the approving manager, the Director of Personnel and Development is responsible for developing the policy and for ensuring stakeholders were consulted with.

Draft copies were circulated for comment before approval was sought from the relevant committees.

16.3. Equality Impact Assessment

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment Screening has been undertaken and there are no adverse or positive impacts (Appendix K).

17. Consultation, Approval and Ratification Process

17.1. Consultation Process

The author consulted widely with stakeholders, including:

- Policy Development Group
- HR Team

- Staff Side Representatives

Consultation took the form of a request for comments and feedback via email and also during relevant committee meetings. Hard copies were available on request.

17.2. Policy Approval Process

Approval of the policy will be sought from the Partnership Forum and the Workforce & Organisational Development Committee.

18. Review and Revision Arrangements including Document Control

18.1. Process for Reviewing the Policy

The policy will be reviewed every three years. The author will be sent a reminder by the Corporate Governance Manager four months before the due review date. The author will be responsible for ensuring the policy is reviewed in a timely manner.

The reviewed policy will be approved by the Partnership Forum and the Workforce & Organisational Development Committee.

If this policy has been identified as required by the NHS Litigation Service (NHSLA), the author will ensure the Compliance Manager is sent an electronic copy.

The author must update the Document Control Report each time the policy is reviewed. Details of what has changed between versions should be recorded in the Document Control Report.

18.2. Process for Revising the Policy

In order to ensure the policy is up-to-date, the author may be required to make a number of revisions, e.g. committee changes or amendments to individuals' responsibilities. Where the revisions are minor and do not change the overall policy, the author will make the amendments, record these in the document control report and send to the Corporate Governance Manager for publishing.

Significant revisions will require approval by the Partnership Forum and the Workforce & Organisational Development Committee.

For NHS Litigation Authority (NHSLA) policies, the author will notify the Compliance Manager when a revision is being made or when the document is reviewed. The Compliance Manager will ensure that the revised document meets the NHSLA/CNST standards.

The author must update the Document Control Report each time the policy is revised.

18.3. Document Control

The author will comply with the Trust's agreed version control process, as described in the organisation-wide Guidance for Document Control.

19. Dissemination and Implementation

19.1. Dissemination of the Policy

After approval by the Partnership Forum, the author will provide a copy of the policy to the Corporate Governance Manager to have it placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release and staff will be informed that this policy replaces any previous versions.

Information will also be included in the weekly Chief Executive's Bulletin which is circulated electronically to all staff.

19.2. Implementation of the Policy

Line managers are responsible for ensuring this policy is implemented across their area of work.

Support for the implementation of this policy will be provided by the HR Team.

20. Document Control including Archiving Arrangements

20.1. Library of Procedural Documents

The author is responsible for recording, storing and controlling this policy.

Once the final version has been approved, the author will provide a copy of the current policy to the Corporate Governance Manager so that it can be placed on the Trust's Intranet site (Bob). Any future revised copies will be provided to ensure the most up-to-date version is available on the Trust's Intranet site (Bob).

20.2. Archiving Arrangements

All versions of this policy will be archived in electronic format within the HR Team policy archive. Archiving will take place by the HR Administrator once the final version of the policy has been issued.

Revisions to the final document will be recorded on the Document Control Report. Revised versions will be added to the policy archive held by HR Team.

20.3. Process for Retrieving Archived Policy

To obtain a copy of the archived policy, contact should be made with the HR Team.

21. Monitoring Compliance with and the Effectiveness of the Policy

21.1. Process for Monitoring Compliance and Effectiveness

Monitoring compliance with this policy will be the responsibility of the HR Team.

Where non-compliance is identified, support and advice will be provided to improve practice.

22. References

Employment Rights Act 1996

Employment Act 2002

Employment Act 2008

Advisory, Conciliation and Arbitration Service (ACAS)
(http://www.acas.org.uk/index.aspx?articleid=1461)

23. Associated Documentation

Capability Procedure

Bullying & Harassment Policy

Equal Opportunities Policy

Grievance/Dispute Policy

IT Security Policy

Maintaining High Professional Standards in the Modern NHS and the Trust's Disciplinary Framework

Recruitment & Selection Policy and Procedure

Sickness Absence Management Policy

Smoking Policy

Suspension Policy

Trust's Standing Financial Instructions

Whistle-blowing Policy

Document Control

Title			
Health and Safety Policy			
Author			**Author's job title** Health and Safety Manager and Local Security Management Specialist
Directorate Nursing			**Department** Corporate Governance
Version	**Date Issued**	**Status**	**Comment / Changes / Approval**
1.0	Aug 2005	Final	Ratified by Trust Board and published on Tarkanet.
1.1	Mar 2010	Revision	Completely updated and dropped into Trust template and name changed to policy.
1.2	May 2011	Revision	Amendments following consultation prior to approval by Health and Safety Committee.
2.0	Jul 2011	Final	Approved by Health and Safety Committee on 2nd June 2011. Minor amendments by Corporate Affairs to template. Published on Trust's intranet site.
2.1	Feb 2012	Revision	Harmonised policy as a result of the merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. A summary of key issues and differences is on page 3. The reporting and monitoring section have been strengthened as a result of revised NHSLA requirements.
3.0	Feb 2012	Final	Approved by Health and Safety Committee on 02.02.12 following consultation.
3.1	Jul 2012	Revision	Role of Occupational Health Department added (section 4.8). Role of Health and Safety Adviser added (section 4.12). Control of noise at work added (section 5.1). This policy supersedes the Control of Noise at Work policy. Additions approved at the Health and Safety Committee on Thursday 26th July.
4.0	Nov 2014	Final	Revised Chief Executive's Statement. Various amendments to roles and responsibilities. Medical Sharps, Moving and Handling, PPE and Electrical Safety added under sections 5.10 to 5.13
4.1	July 2016	Revision	Various minor amends, job titles, roles etc. Health Surveillance information added (sections 3.8 & 4.9). Working Time Regulations added (section 5.14). Disciplinary actions added (section 5.15).
4.2	July 2018	Revision	Chief Executives Health and Safety Statement updated July 2018 following announcement of collaborative working agreement with RD&E. Approved by H&S Committee July 2018.
4.3	Oct 2019	Revision	Compassionate care, inclusive and compassionate leadership added to Chief Exec Safety Statement. Definitions of Risk and Hazard amended. Roles and responsibilities updated. Reference to apprentices and hyperlink to young person risk assessment added. For

			submission at H&S Group meeting 19th Nov 2019
5.0	Nov 2019	Final	Final version approved at Health and Safety Group meeting 19th Nov 2019 with ratification at the Safety and Risk Committee meeting 4th December 2019

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Lead Director
Chief Nurse

Superseded Documents
Health and Safety Statement. The Control of Noise at Work Policy. Personal Protective Equipment Policy

Issue Date	Review Date	Review Cycle
Nov 2019	Nov 2022	Three years

Consulted with the following stakeholders: (list all)
Chief Executive
Clinical Matron - Community
COSHH Working Group members
DATIX and Incident Manager
Director of Finance
Divisional Nurse Planned Care
Divisional Nurse Unscheduled Care
Emergency Preparedness, Resilience and Response Officer
Energy and Compliance Manager, Facilities Department
Head of Governance
Head of Estates, Facilities Department
Head of Physiotherapy & Occupational Therapy
Head of Quality and Safety
Health and Safety Group members
Health and Social Care Community Services Managers
HR Manager Medical Staffing & Temporary Workforce
Patient Safety Lead
Professional Lead for Community Physiotherapy and Occupational Therapy
Risk Lead, Corporate Governance
Specialist Services Business Manager
Training Manager and Apprentice Lead
Training Manager, Workforce Development

Approval and Review Process
- Health and Safety Group

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Health and Safety Policy v4.2 Oct2019

Policy categories for Trust's internal website (Bob)	Tags for Trust's internal website (Bob)
Health and Safety, All Staff	RIDDOR, COSHH, incident, risk, slips, trips, falls, health and safety, accident

CONTENTS

Chief Executive's Statement

Northern Devon Healthcare NHS Trust is committed to maintaining a healthy workforce within a safe working environment applying the core values of diversity, integrity, compassion, excellence and support.

This is recognised as a key priority as any implications on staff health, safety or wellbeing has a direct impact on the ability to deliver high quality and compassionate patient care.

The Trust supports the principles of compassionate and inclusive leadership and acknowledges that the patient is the reason for the existence of the organisation, which has no life, purpose, or value without them.

The Trust recognises its statutory responsibilities regarding the health, safety and welfare of staff, patients, trainees, apprentices, agency workers, contractors, volunteers, visitors, members of the public and employees from other organisations who share our premises.

The Trust will ensure sufficient resources are allocated so that safe systems of work are in place to maintain, control, monitor and where necessary, improve safety performance and standards of health and safety.

The Trust promotes a positive culture and open attitude towards health and safety issues and will communicate and consult with staff on issues affecting health and wellbeing at work.

All staff are personally responsible for providing and safeguarding health and safety. This includes co-operating with the Trust on safety matters, undertaking training as required by job role, completing authorised duties, working within competencies, maintaining professional standards, following safe systems of work, complying with policy and taking care of their own safety and that of others, who may be affected by what they do or fail to do.

This policy outlines the Trust's approach regards the organisation of and the arrangements in place in respect of the management of health and safety. The Policy will be reviewed on a regular basis to ensure it remains current and relevant as the organisation develops.

Suzanne Tracey

Chief Executive
Northern Devon Healthcare NHS Trust

November 2019

1. Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for managing health and safety. It provides a robust framework to ensure a consistent approach across the whole organisation, to satisfy statutory standards set by the Health and Safety Executive, the Care Quality Commission, NHS Resolution and other external regulatory bodies.

2. Purpose

The purpose of this document is to enable the Trust to demonstrate its commitment towards the successful management of health and safety and outline the means by which this will be achieved. The Trust promotes a positive health and safety culture at all levels throughout the Trust.

The Health and Safety Policy applies to all Trust staff.

Implementation of this policy will ensure that:

- Health and safety risks are reduced, so far as is reasonably practicable, for all patients, staff, trainees, apprentices, agency workers, contractors, volunteers, visitors, members of the public and employees from other organisations who share the premises.
- Staff at all levels are aware of their personal responsibilities and accountability in relation to maintaining and improving good standards of health and safety for the benefit of themselves, staff, patients and any other persons who may be affected by the Trust's undertakings.
- The arrangements for the successful management of health and safety such as risk management are outlined and other supporting policies are brought to the attention of all staff.

This policy supports the Trust's statutory duties, including (but not limited to) those under:

- Control of Substances Hazardous to Health Regulations 2002 (as amended).
- Corporate Manslaughter and Corporate Homicide Act 2007.
- Health and Safety at Work etc. Act 1974.
- Health and Safety Offences Act 2008.
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
- Management of Health and Safety at Work Regulations 1999.
- NHS Constitution for England (updated 2015).
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013.
- Working Time Regulations 1998 (as amended).

The policy includes:

- The Chief Executives statement of general policy on health and safety at work.
- Details of the responsibilities and accountabilities to manage health and safety.
- The arrangements and procedures for ensuring health and safety across the Trust.

3. Definitions

3.1. Risk

The Risk Management Policy defines risk as:

- Risk "is the chance that something will happen that has an adverse impact on the achievement of the Trust's aims and objectives. It is measured in terms of likelihood (frequency or probability of the risk occurring) and severity (impact or magnitude of the effect of the risk occurring".

The Health and Safety Executive (HSE) defines risk as:

- Risk "is the chance, high or low, that somebody could be harmed" by any hazards present in the workplace, "together with an indication of how serious the harm could be".

A risk expresses the likelihood that a hazard will realise its potential to cause harm.

Risk = likelihood of an event occurring x consequence (severity of outcome)

This is expressed in more detail using the Trust's Risk Scoring Matrix attached to the Risk Management Policy. The risk score is determined by multiplying the risk consequence score by the risk likelihood score.

The risk score = risk consequence score x risk likelihood score

3.2. Hazard

The Risk Management Policy defines a hazard as:

- "A hazard is something with the potential to cause harm (e.g. bleach) or the potential for not meeting an objective (e.g. finance)".

3.3 Harm

Harm is defined as "injury (physical or psychological), ill health, suffering, disability, death, loss, damage to property or services.

3.4 Incident

An incident is any unplanned event resulting in, or having a potential for injury, ill-health, damage or other loss.

3.5 Near miss incident

A near miss is recorded when an incident did not lead to harm but could have. This is consistent with the terms “adverse health care event” and “health care near miss” first set out in An Organisation with a Memory (Department of Health, 2000)

Relating to health and safety, a near miss is an unplanned event that occurred which did not lead to, or realise its potential to cause harm, damage or loss.

3.6 RIDDOR

The Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013 place a legal duty on the Trust to report certain categories of incident. RIDDOR reportable incidents include, work related:

- Deaths
- Specified Injuries
- Injured person unable to perform their full range of normal work duties and / or absence from work for more than seven days
- Occupational Diseases
- Certain dangerous occurrences
- Patient accidents resulting in a specified injury
- Certain visitor accidents

Over seven day injuries are applicable where a person is unable to work as a result of a work related injury for more than seven consecutive days (including non-work days) An example being, should a doctor break their finger when it is trapped by a closing door at work and is unable to do their full normal range of work duties for more than seven days (including any rest days), this would be reportable under “over seven day injuries”.

3.7 Staff

This policy applies to all staff, both clinical and non-clinical. In addition to those with full time contracts of employment, the term staff also includes those on fixed term or temporary contracts and those with honorary contracts undertaking work duties as instructed by and on behalf of the Trust.

3.8 Health Surveillance

Health surveillance is a requisite for ensuring the maintenance of adequate controls of exposure of employees to substances hazardous to health where a Control of Substances Hazardous to Health (COSHH) risk assessment is indicated. The frequency of health surveillance should be determined by the outcomes of the risk assessment and implementation of appropriate control measures.

These following factors are elements of COSHH and Risk Assessments and will be the criteria used to identify those staff requiring health surveillance;

- What is the Substance?
- Who uses the substance?
- System of work (How is it used)?
- How often is it used?
- In what circumstances is it used?
- Environmental control measures in use?
- Environmental monitoring results?

4. Responsibilities

4.1 Role of the Trust Board

The Trust Board is responsible for demonstrating the commitment of the Trust to all matters relating to health and safety and for leading the health and safety agenda.

4.2 Role of Chief Executive

The Chief Executive has ultimate responsibility to the Trust Board for all aspects of health and safety within the Trust. The Chief Executive will ensure that:

- Appropriate structures and processes are in place for the discharge of health and safety requirements.
- Adequate resources are provided to comply with health and safety requirements.
- All staff are fully aware of their statutory responsibilities by the inclusion of health and safety in all job descriptions and the annual development and review process.

4.3 Role of the Chief Nurse

The Chief Nurse is the nominated lead director for health and safety and is accountable to the Chief Executive.

The Chief Nurse will ensure that:

- Responsibility for health and safety matters is appropriately delegated through Directors, Managers and Heads of Department, who are responsible for implementing the Health and Safety Policy in the areas/services for which they are responsible.
- The Chief Executive and the Trust Board of Executive Directors are kept informed of matters relating to Health and Safety achieved through summary reports presented to the Safety and Risk Committee.
- The Health and Safety Group fulfils its aims and objectives.

- Health and safety performance is monitored via appropriate Groups (e.g. COSHH Working Group, Fire Safety Group, Medical Gas Group and Operational Security Group).
- Arrangements for consultation with staff on health and safety matters are put in place as required.

4.4 Role of Executive Directors and Divisional Directors

Executive Directors and Divisional Directors (Planned Care, Surgery and Unscheduled Care) are responsible for ensuring this policy is effectively implemented in all areas.

They will ensure that:

- Health and safety responsibilities are included in job descriptions and included in the annual development and review process.
- Responsibilities for health and safety are clearly assigned, understood and implemented by their managers.
- Managers are competent to undertake their health and safety responsibilities.
- Health and safety performance measures are agreed and monitored.
- Appropriate resources are identified to maintain or improve health and safety.

4.5 Role of Director of Finance, Performance and Facilities

In addition to the general duties set out in section 4.4, the Director of Finance, Performance and Facilities is responsible for:

- Ensuring the financial implications are identified of proposals arising from the Trust's commitment to health and safety in relation to the Trust estate.
- Ensuring that appropriate organisation and arrangements are put in place for the control of fire and building security, water services management and legionella prevention, asbestos management, management of contractors, control of waste and building and engineering services.

4.6 Role of Director of People

In addition to the general duties set out in section 4.4, the Director of People is responsible for the provision of Workforce Development programmes and the provision of Occupational Health services.

4.7 Role of Workforce Development

Workforce Development run or facilitate in-house and external training which includes a blend of taught and e-learning programmes. The Workforce Development Team maintain the:

- The Training Prospectus which provides information relating to statutory, mandatory and general training. The prospectus can be accessed through the Staff Training Access Resources Platform (STAR).

Health and Safety training includes induction and refresher training with access to e-learning, work books, and self-directed study as well as face-to-face taught sessions. Topics covered include:

- Breakaway and Physical Intervention
- Conflict Resolution
- Fire and security
- General health and safety
- Infection prevention and control
- Patient and non-patient moving and handling
- Risk assessment
- Slips, trips and falls

Staff receive a local induction for their service, ward or department in addition to attending the Health and Safety general induction as part of the Trust's Corporate Induction / Welcome Day.

Policies and other procedural documents are available via the Trust's intranet site. All staff are required to comply with agreed Trust policies, making themselves aware of procedural documents that relate to their roles and responsibilities.

4.8 Role of Occupational Health Department

The Occupational Health Department provides a range of confidential services including pre-employment screening and immunisation. Responsibilities include:

- Undertaking health surveillance where managers have indicated that staff are exposed to substances where the risks and the potential for harm is significant should control measures fail. Managers must inform Occupational Health of the type of exposure and staff can self-refer where they have concerns.
- Providing advice support and assistance for staff on return to work programmes.

- Informing relevant committees (e.g. Health and Safety Group) should patterns of occupational illnesses or diseases be identified following staff referrals.
- Informing the Health and Safety Manager of incidents where staff have contracted occupational illnesses or diseases notifiable under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.
- Offering any additional support and advice where appropriate to do so.

4.9 Role of Managers, Heads of Department and Supervisors

Managers, Heads of Department and Supervisors are responsible ensuring that this policy is effectively implemented in all areas relating to their own ward, service or department.

They will ensure that:

- Health and safety responsibilities are included in job descriptions and included in the annual development and review process.
- The Health and Safety Policy is brought to the attention of all staff.
- Staff, trainees, apprentices, volunteers, those with honorary contracts and anyone carrying out work duties on behalf of the Trust must:
    - Complete a Corporate induction.
    - Receive a local workplace induction, which includes bringing to their attention any specific health and safety issues relevant to their job role.
- All members of staff, trainees, apprentices, volunteers, those with honorary contracts are properly trained, instructed, informed, supervised and equipped to perform the required tasks safely.
- Records of training, refresher training, including health and safety, moving and handling, use of equipment, fire and security, infection prevention and control are maintained, monitored and reviewed as per Trust policy and procedures.
- So far as is reasonably practicable create and maintain rotas managing the allocation of study leave fairly in accordance with Trust policy and procedures such as eRoster to enable staff to attend statutory and / or other training as is required relevant to their job role.
- Risk assessments are completed and recorded on the Corporate Risk Register for all significant health and safety risks identified in their ward, service or department, in accordance with the Trust's Risk Management Policy.
- Staff are made aware of any hazards associated with their work and the appropriate control measures to be followed. For example: standing on an office swivel chair to reach items from a shelf is hazardous. There is a risk harm should they fall which is likely as a swivel chair is not a suitable or stable working platform. Staff may be

unaware of the risk and must be informed of the correct procedures to ensure their safety.

- Appropriate actions are agreed to address hazards and manage risks, including the development and implementation of safe systems of work, where required, which are then supervised and monitored appropriately.
- All incidents and near miss incidents are properly documented, reported and investigated in accordance with the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures and RIDDOR requirements.
- Actions are implemented with the aim of preventing a re-occurrence of incidents.
- Safety inspections are carried out in their ward, service or department, as appropriate.
- Where it is identified that the Trust may need to commit additional resources, in excess of normal budget allocations to maintain or improve health and safety, the relevant Executive Director or Divisional Director is supplied with the appropriate information.

4.10 Role of Head of Corporate Governance Department

The Head of Corporate Governance is responsible for the provision of a "competent person" as required by the Management of Health and Safety at Work Regulations 1999.

Responsibilities include ensuring there are robust arrangements in place for:

- Management of clinical and non-clinical risks.
- Incident reporting and investigation processes.
- Health and Safety arrangements.

The Head of Governance is the nominated line manager for the Trust's Health and Safety Manager and Local Security Management Specialist.

4.11 Role of Health & Safety Manager & Local Security Management Specialist

The Health and Safety Manager and Local Security Management Specialist (LSMS) is responsible for advising and guiding the Trust to ensure that it is meeting or working towards meeting its legislative requirements.

The Health and Safety Manager and LSMS reports to the Head of Governance and works within the Compliance Team.

The Health and Safety Manager and LSMS will ensure that:

- The organisation has arrangements in place to comply with statutory legislation and national guidance in health and safety.
- Competent advice, support and guidance is provided to managers and other staff, raising awareness of health and safety matters such

as the management of slips, trips and falls and promoting a positive health and safety culture across the Trust.

- Managers are supported to investigate health and safety incidents including RIDDOR reportable incidents and to take appropriate remedial actions to prevent reoccurrences.
- The Trust has appropriate policies, procedures and guidance in place for the protection of patients, staff, trainees, contractors, volunteers, visitors, members of the public and employees from other organisations who share our premises.
- The Trust liaises with appropriate health and safety enforcing agencies or other regulatory bodies, ensuring that appropriate information is provided on request and when appropriate ensuring work is undertaken to mitigate any risks identified by these bodies.
- Health and safety management is monitored via the Trust's Health and Safety Audit programme.
- Advice and support is given to Managers or other staff for the completion of risk assessments and action plans relating to health and safety.
- Reported health and safety incidents are monitored via the Trust's Incident Management Policy and procedures.
- Appropriate training programmes are developed and implemented, in association with the Workforce Development Team and other specialist advisors.
- Support the Legal Claims Manager in investigations relating to civil claims.
- Support the Head of Governance in respect of satisfying CQC fundamental standards.

4.12 Role of Legal Claims Manager

The Legal Claims Manager will deputise for the Health and Safety Manager and LSMS providing the Trust with two qualified and competent persons to manage Health and Safety issues. Duties include but are not limited to:

- Development and participation in the Trusts Health and Safety Audit programme.
- Safety inspections of sites, wards, services and departments.
- Review of staff and patient accidents escalated for further investigation for the identification and reporting of incidents to the HSE that meet criteria under the RIDDOR Regulations.
- Reporting and escalating any relevant RIDDOR concerns/issues to external regulators

4.13 Role of Corporate Governance Support Officer (Compliance Team)

The Governance Support Officer (Compliance) will support the Health and Safety Manager & LSMS to achieve aims and objectives in relation to the management of health and safety as required, including:

- Provide cover and support for the Health and Safety Manager.
- Co-ordination of the Health and Safety Group arrangements.
- Participation in and the co-ordination of health and safety "projects" such as chemical safety under COSHH.
- Review and undertake initial investigation of health and safety related incidents reported on the incident reporting module (DATIX).
- Assist as directed by the Health and Safety Manager & LSMS or the Legal Claims Manager with investigations including RIDDORs and the gathering of statements and evidence.

4.14 Role of Compliance Administrator

The Compliance Administrator will support the Health and Safety Manager & LSMS in relation achieve aims and objectives in relation to the management of health and safety as required, including:

- Administration of the lone worker project, including day to day management of SkyGuard MySOS devices issued to community staff, provide support and advice, completion and presentation of quarterly reports.
- Assist as directed by the Health and Safety Manager & LSMS or the Legal Claims Manager in health and safety related matters.

4.15 Role of Specialist Advisers

Specialist advisors will ensure within their relevant fields of expertise that:

- Policies, procedures and practices satisfy requirements for the management of health and safety.
- Provide support to staff, managers and others in respect of the arrangements for the implementation of this policy.
- Promote a positive safety culture through commitment, visible management, communication and active participation in the management of health and safety.
- Participate in and support incident investigations providing assurance to the Trust that any actions taken following an incident are suitable and sufficient. The aim being preventing a recurrence of such an incident.
- Advice and guidance will be provided to the Capital Team, Facilities Department at design stage for new builds and refurbishments relevant to areas of expertise and specialism.

Specialist advisors include the:

- Back Care Advisor
- Fire and Security Advisor
- Health & Safety Manager & Local Security Management Specialist
- Infection Prevention and Control Team
- Legal Claims Manager (and Health and Safety Advisor)
- Occupational Health Department

4.16 Role of Staff Safety Representatives

The Trust acknowledges the right of recognised unions and professional associations to appoint health and safety representatives to represent their members regarding health and safety related matters. In addition, the Trust will also recognise nominated non-union appointed staff representatives within the Trust in accordance with the:

- Safety Representatives and Committees Regulations 1977 (as amended)
- Health and Safety (Consultation with Employees) Regulations 1996 (as amended)

The Trust will consult with such representatives with a view to developing and maintaining arrangements which will enable the Trust and staff to co-operate fully and effectively in the promotion of health and safety.
The Trust will provide facilities, support and assistance so that health and safety representatives may reasonably carry out their role, including allowing reasonable access to appropriate training to ensure competency.

The functions of the staff health and safety representatives are:

- To investigate health and safety concerns brought to their attention, potential hazards and dangerous occurrences and the causes of incidents.
- To make representation to appropriate managers on the above matters and on general health and safety matters.
- To carry out local health and safety inspections, if they have not inspected in the last three months, where there has been a substantial change in the condition of work and after a notifiable incident, illness or dangerous occurrence.
- To actively participate in Health and Safety Group meetings.
- To represent staff in consultation with Health and Safety Executive or Care Quality Commission inspectors and other enforcing authorities.

4.17 Role of all Staff

All staff have a legal obligation to co-operate with the Trust in the implementation of health and safety at work. This obligation extends not only

to their own health and safety but also to others who may be affected by their actions or omissions (what we do or fail to do).

All staff will ensure that they:

- All staff must comply with the Health and Safety Policy. Failure to do so could be deemed to be a disciplinary matter.
- Take reasonable care of their own health and safety.
- Consider what they do or fail to do and how that might affect their safety and that of others. For example, over-riding a window restrictor could result in a vulnerable patient falling from height with severe consequences or failing to deal with a spillage could result in a person slipping and injuring themselves.
- Never participate in horseplay or practical jokes during working hours. Acts of horseplay could have tragic consequences with implications in respect of patient as well as staff safety.
- Co-operate with the Trust on matters relating to health and safety.
- Comply with Trust policies, procedures and working guidelines, following safe systems of work in accordance with training or instruction received, making full and proper use of any available control measures.
- Complete any duties within competencies.
- Never complete duties outside of current job role (unless authorised by the manager or person in control for example in emergency situations)
- Meet the principles and expectations outlined in the Trusts Code of Conduct, the NHS Constitution in relation to health and safety and comply with relevant Codes of Conduct under professional registrations such as (but not limited to) the;
    - Nursing and Midwifery Council Code of Conduct, Performance and Ethics for nurses and midwives.
    - Code of Conduct for Healthcare Support Workers, published by Skills for Care and Skills for Health.
- Undertake all required training, including refresher training as identified on the Training Needs Analysis document, updating STAR, Managers and / or the Workforce Development Team of completed training as required.
- Correctly use work items provided, including personal protective equipment.
- Inform their Manager, in the first instance, of any concerns around precautions in place, where they consider anyone's health and safety might be at risk.
- Do not interfere with, or misuse anything provided for their health, safety or welfare.
- Report incidents, including near misses, to their manager and ensure that incidents are reported in accordance with the Incident Reporting,

Analysing, Investigating and Learning Policy and Procedures without delay.

- Take immediate preventative action following an incident (if required) to avoid a similar incident or event.
- Are conversant with emergency arrangements, including emergency spill containment, evacuation procedures and first aid provision..

4.18 Role of Committees and Groups

The aim of the Health and Safety Group is to provide assurance to the Trust Board that the organisation and arrangements for the management of health and safety satisfy statutory requirements to ensure so far as is reasonably practicable the health, safety and welfare of staff, trainees, apprentices, agency workers, volunteers, service users, visitors and any other persons who may be affected by the Trust's activities.

The Group provides a forum that promotes a culture of co-operation between management and staff representatives. In respect of both proactive and reactive measures relating to the management of health and safety. Staff representatives are communicated and consulted with.

The Group is accountable to the Chief Nurse. Membership of the Group includes the Chief Nurse (Chair), Legal Claims Manager (Deputy Chair), Health and Safety Manager, specialist advisers, senior management, appointed union safety representatives and non-union appointed staff representatives. The meetings are held bi-monthly. Summary reports from the Health and Safety Group are presented to the Safety and Risk Committee (Chaired by the Chief Executive).

Other working groups with health and safety responsibilities include:

- Control of Substances Hazardous to Health Working Group
- Fire Safety Group
- Infection Control and Decontamination Group
- Medical Gas Group
- Operational Security Group

5. Arrangements

5.1 Risk Management

The patient is the reason for the existence of the whole organisation, which has no life, no purpose, no value without them.

Providing patient care will never be risk free. Effective management of risks provides a means to monitor, review and make changes to improve health and safety by looking at the significant risks that arise in the workplace and then putting reasonable, proportionate and sensible measures in place to control risks as low as is reasonably practicable.

Certain situations may arise where there is a need to balance risks. Circumstances may present the need for temporary or emergency control measures to manage risks at an acceptable level.

All staff are expected to follow the Trust's Risk Management Policy which outlines the procedures for the identification, recording, management and monitoring of risks and associated action plans.

The Risk Management Policy and Risk Management Strategy support the on-going development of a robust patient and staff safety culture throughout the Trust.

Risk assessments based on hazards that may be encountered in a healthcare, office or maintenance environment and those required by some health and safety and other regulations include:

- Asbestos
- Control of Substances Hazardous to Health (COSHH)
- Display Screen Equipment (DSE)
- Driving
- Fire and Site Security
- Inexperienced persons (young person, apprentice, agency, new staff)
- Legionella
- Lone Working
- Moving and handling (patient and non-patient)
- New and expectant mothers
- Noise
- Personal Protective Equipment (PPE)
- Scalding
- Security Management
- Sharps
- Slips, trips and falls (including falls from height)
- Smoking
- Stress
- Violence and Aggression

This is not an exhaustive list of risk assessments that may be required. The risk assessment form and scoring matrix are attached to the Risk Management Policy

Certain risk assessments such as moving and handling, patient falls, violent or aggressive patient, new and expectant mothers and COSHH have specialist forms that are available on the Trust's intranet.

Should a member of staff believe a workplace hazard has caused a health problem affecting work performance or attendance, the Occupational Health Department can be contacted to make a confidential appointment (for contact details, see Occupational Health pages on the Trust's Intranet).

5.2 Incident Management

5.1.1 Incident reporting

The incident reporting system allows all staff to record any clinical or non-clinical incident which causes harm, damage or loss and also near miss incidents.

All staff are expected to follow the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures which outlines arrangements for reporting and managing incidents.

Where appropriate reports are submitted to external agencies in compliance with any statutory requirements. This will be managed and co-ordinated by the Corporate Governance Department.

5.1.2 Incident Investigation

All staff are expected to follow the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures The level of investigation undertaken will depend on the severity of the incident.

In the case of a significant incident, the Corporate Governance Department will review and, where appropriate escalate the incident to the relevant executive directors and senior managers who are responsible for taking follow up actions.

The application of root cause analysis techniques are appropriate for high level incidents.

The aim of the investigation process is to monitor and learn from incidents, act on findings and implement measures to prevent similar incidents occurring.

Serious Incident investigation will be managed and coordinated by the Corporate Governance Department.

5.3 RIDDOR

The Reporting of Injuries, Diseases & Dangerous Occurrences Regulations (RIDDOR) 2013 place a legal duty on the Trust to report certain categories of incident

If any persons are involved in an incident at work which meets RIDDOR reportable criteria, in addition to completing an on line incident report without delay in accordance with the Incident Management Policy, the Health & Safety Manager must be informed on (01271) 311725 (Ext: 3725).

All RIDDOR reports are completed and submitted to the Health and Safety Executive by the Health and Safety Manager or nominated deputy (e.g. Legal Claims Manager).

All staff must co-operate with the investigation process and complete written statements as required and if requested to do so.

For further information on reportable incidents refer to RIDDOR guidance published on Bob: RIDDOR Guidance

5.4 COSHH

The Control of Substances Hazardous to Health Regulations 2002 (as amended) places a duty on the Trust to either prevent staff and other persons from being exposed to substances hazardous to health or if prevention is not reasonably practicable to adequately control exposure.

All staff are expected to be aware of their responsibilities under COSHH as detailed in the Control of Substances Hazardous to Health Policy. The policy outlines the arrangements in place for the management of COSHH.

5.5 Control of Contractors

The Facilities Department has overall responsibility for the management of buildings and grounds occupied by staff and other persons. The Facilities Department maintain a list of preferred contractors for certain types of work.

There may be certain circumstances where contractors are appointed by Managers of other Services, Departments or Directorates.

The appointing officer or manager from any Service, Department or Directorate involved in the requesting of contractors to site are responsible for ensuring that adequate arrangements are in place in accordance with the Control of Contractors Policy and Guidance.

Responsibilities include:

- Ensuring the competency of Contractors or self-employed persons, appointed to undertake any work on behalf of the Trust.
- Ensuring that the contractor signs in through the Facilities office or that the contractor remains accompanied throughout their time onsite.
- Ensure all contractors receive an induction and are provided with any relevant information relating to health and safety, for example, presence of asbestos in the fabric of buildings, vulnerable persons, confidentiality, discreet working, consideration of patients, infection prevention and control requirements, public and staff safety.
- Assigning a project manager to manage any project, ensuring that risk assessments completed by Contractors are approved prior to commencement of any projects. The principles of permit to work systems are applied for particularly hazardous non-routine work such as working from height, hot works or work in confined spaces.
- Ensuring an appropriate level of supervision is in place for the project and that incidents are reported via the Trust's incident reporting procedures.
- Comply with the Construction Design and Management (CDM) Regulations 2015 ensuring all responsibilities as the Commercial Client are satisfied including the appointment of duty holders with the necessary and relevant skills, experience, competencies and capacity to complete the task.

5.6 Control of Asbestos

The Capital Contracts Manager, Facilities is the named responsible and competent person for the management of asbestos for the Trust.

All staff are expected to be aware of their responsibilities and the arrangements in place to manage risks associated with asbestos containing materials that are present within the fabric of Trust controlled buildings in accordance with the Asbestos Policy and the Asbestos Management Plan.

5.7 Control of Legionella

The Energy and Compliance Manager, Facilities is the responsible person for water management.

The Facilities Department are responsible for providing specialist support and advice relating to the management of water services within the Healthcare estate that could harbour and support potentially infectious bacteria and other water borne pathogens such as Legionella and Pseudomonas Aeruginosa.

All staff are expected to be aware of their responsibilities and the arrangements in place in accordance with the Water Services Managements Policy.

5.8 Slips, Trips and Falls

Slips, trips and falls (including falls from height) provide a significant risk for staff, contractors and any other persons who work or are present on any grounds or premises under the control of the Trust. Similar risks apply to community based staff visiting patient's homes. Slips, trips and falls consistently factor within the top categories of reported staff accidents.

Staff who identify any hazards that may result in a slip, trip or fall should take appropriate actions to manage this risk in accordance with this policy and associated documentation such as the Risk Management Policy and Falls Policy.

Where appropriate the responsible person must ensure that risk assessments and action plans are completed in accordance with the Risk Management Policy to address identified hazards such as slippery surfaces, obstructions, uneven surfaces or working from height to ensure that appropriate controls are in place to manage the risk.

The principles of permit to work systems must be applied for particularly hazardous non-routine work for example working from height by Trust maintenance staff.

5.9 Patients, visitors and the public

The principles or risk management (see section 5.1) and incident management (see section 5.2) are applied to ensure reasonable care is taken for the safety of all persons who may be affected by the Trust's activities.

The Trust acknowledges its duties under the Occupiers Liability Acts 1957 and 1984 towards legitimate and unlawful visitors to premises and grounds that are under the Trust's control.

The Trust will take such care to ensure visitors are reasonably safe and do not suffer injury on premises or grounds from any dangers present. The Trust acknowledges that children and vulnerable persons may be at greater risk of harm. For example, a no entry sign will not be sufficient to prevent a vulnerable adult from entering an electrical plant room or a child from accessing an area under construction. Further control measures such as locking doors and providing physical barriers are required.

The Trust will co-operate with support services and maintenance contractors and other organisations where premises are shared for the purposes of managing health and safety and will take all reasonably practicable measures to ensure its activities do not cause harm to the wider public.

5.10 Control of noise at work

The Control of Noise at Work Regulations 2005 outline exposure action and limit values. It places a duty upon the Trust to ensure that staff and other persons present are not exposed to excessive noise at work that may cause hearing loss, tinnitus or other hearing problems.

Noise can be defined as loud, undesired or unwanted sound. Noise can be a safety hazard at work, interfering with communication. Noise may affect patient well-being, for example, by disturbing sleep or agitating a patient with dementia.

Managers of Wards, Services and Departments are responsible for ensuring that where appropriate noise hazards are identified and risk assessments with action plans are completed to either eliminate noise at source or reduce to as low a level as is reasonably practicable to do so.

Typically noise should not be a problem working in a busy office. Problems may occur should noise be intrusive for most of the working day or if staff have to raise their voices to speak normally when two metres apart for at least part of the day. Such issues may typically arise for maintenance staff operating power tools, machinery and equipment or whilst working within areas such as plant rooms.

Table 1 provides a guide as to if a noise risk assessment is required.

Table 1: Noise Levels & Exposure Times

Test	Probable noise level (Db)	Risk assessment required for exposure greater than
Noise is intrusive but normal conversation is possible	80	6 hours
Shouting is required to communicate with someone 2 metres away	85	2 hours
Shouting is required to communicate with someone 1 metre away	90	45 minutes

The Trust's Health and Safety Manager or nominated deputy is responsible for providing support and assistance to Managers for the completion of noise risk assessments, with the support of the Facilities Maintenance Team (provision of technical support such as taking noise metre readings).

On completion of risk assessments, Managers must inform staff of any measures that have been implemented and ensure any training requirements are met.

Locations and workspaces identified that present unacceptable noise levels that cannot be eliminated by other means must have appropriate signage that visually indicates the need for personal protective equipment (PPE issued as a last resort).

Staff must take responsibility for following standard operating procedures and comply with requirements such as ensuring hearing PPE is worn when authorised to enter “ear protection zones”.

5.11 Medical Sharps

The Trust has legal obligations to protect staff and others in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

The Trust will substitute traditional unprotected medical sharps with “safer sharps” where it is reasonably practicable to do so, subject to risk assessment.

The term ‘safer sharp’ means medical sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury. For example, a range of syringes and needles are available with a shield or cover that slides or pivots to cover the needle after use.

All staff are responsible to use safer sharps devices as per information, instruction and training provided by the Trust and must report all inoculation injuries including non-contaminated or “clean” needle sticks without delay following the Incident Reporting, Analysing, Investigating and Learning Policy and Procedures

Staff must never re-cap / re-sheath used and contaminated needles. Further information and requirements are outlined in the Prevention of Inoculation Injuries Policy.

Further information in relation to support available from the Infection Prevention and Control Team regarding the prevention and management of inoculation injuries can be found on the Trusts intranet site:

Further information regarding safer sharps can be found on the Trust’s intranet site:

- Safer Sharps (Overview)

5.12 Moving and Handling

The moving and handling of patients is a regular task in our Hospitals, clinics and patient’s own home, which if not done safely, can cause serious injury to patients and staff.

To enable patient care, non-patient moving and handling activities are a key part of the working day for most staff; such as moving equipment, laundry, catering, clinical or office supplies and waste.

The Back Care Team provides specialist advice, support, training and resources to manage moving and handling risks. Further information in relation to policies, procedures and services can be found on the Trust’s intranet:

- Moving and Handling Policy

- Back Care Pages

5.13 Personal Protective Equipment

Personal Protective Equipment (PPE) is equipment that will protect the user against health or safety risks at work. It can include items such as safety helmets, gloves, eye protection, high-visibility clothing and safety footwear. It also includes respiratory protective equipment.

Once a risk assessment has been completed, the methods chosen to adequately control the identified risks should, as far as possible, apply the following hierarchical approach:

- eliminate risk;
- control risk at source or by safer design;
- use physical engineering controls and safeguards supported by;
- safe systems of work;
- use of personal protective equipment; and
- immunisation

There are instances where personal protective equipment (PPE) must be considered, i.e. where the risk to health and safety cannot be adequately controlled by other means or it would not be reasonable to implement other control measures.

When PPE is deemed necessary, consideration must be given to the type of PPE needed, its safe use, maintenance and disposal. Staff cannot be charged for any PPE that is required to enable work duties to be completed.

Clinical staff cannot provide patient care without patient contact. The use of PPE as a last resort is required due to the risks associated such as contact with blood and other bodily fluids. This can include disposable gloves, aprons, visors or other eye protection and respiratory protection. Use of PPE such as aprons will also reduce the risk of contamination of uniforms.

In support service roles and as a last resort PPE may be required for example:

- Estates staff completing maintenance tasks and activities, such as working with materials containing asbestos whilst undertaking authorised non-licensed remedial works may require protective clothing and respiratory protection.
- Hotel services staff providing catering services exposed to cold environments in chiller rooms or walk in freezers may require thermal protection for hands, feet and body.

Non-disposable PPE, such as (but not limited to) laboratory coats, lead aprons, overalls. ear defenders and specialist gloves, must be stored appropriately, checked and kept clean and, if faulty, repaired or replaced. If non-disposable PPE is suspected to of, or has been, contaminated with substances such as chemicals or blood or other body fluids, it must be removed safely before leaving the workplace and kept apart from uncontaminated PPE and normal clothes. It should be cleaned and decontaminated or, if necessary, disposed of safely.

A key piece of PPE for working with blood borne viruses is gloves, which play an important role. Further information relating to gloves can be found in the Trust's Standard Infection Control Precautions Policy.

5.14 Electrical Safety

In our hospitals and other healthcare settings the main electrical risks are:

- Contact with live parts causing shock and burns;
- Faults that could cause fires.

The Trust's Electrical Safety Policy details the arrangements in place to manage the risks associated with the use of electricity in both fixed and portable systems and provides practical advice regarding the management of personal items of electrical equipment brought into hospitals by patients.

All staff must comply with the Electrical Safety Policy.

5.15 Working Time Regulations

The Working Time Regulations (1998) implement the European Working Time Directive.

The Health and Safety Executive (HSE) are responsible for the enforcement of:

- Maximum weekly working time limit;
- Night time work limits; and
- Health assessments for night work.

The Arbitration Conciliation and Advisory Service (ACAS) support employers and employees concerning:

- Time off;
- Rest Break Entitlements; and
- Paid Annual Leave Entitlements.

Staff (including junior doctors) are restricted to working a maximum of 48 hours per week on an average, (taking a 20 minute rest break where shifts exceed 6 hours) unless staff have applied the individual right to voluntarily "opt out" where it is safe to do so.

Young adults (16 and 17 year olds) normally cannot "opt out" as they may not routinely work more than 40 hours per week, with a 30 minute rest break if their shift exceeds 4.5 hours.

The eRoster Policy outlines requirements regarding the management and monitoring of clinical shifts.

Fatigue

All staff are responsible to ensure that they work within contracted and agreed hours, not voluntarily working additional shifts to the extent that tiredness from working excessive hours jeopardises the safety of themselves, other staff, contractors, patients or the public.

Managers are responsible to monitor shift patterns and address issues associated with individuals working excessive hours, where it is believed significant health, safety or welfare risks are identified.

All staff are responsible to incident report any issues associated with working shift patterns that may result in a health and safety risk either to themselves or others. For example, a member of staff working a night shift for another employer reporting the very next morning to work the day shift for the Trust.

Other Employment

Staff are required to comply with the Working Time Regulations including full declaration of hours worked and breaks taken. Staff must declare in writing to their line manager if they are employed in any roles outside of their primary role (either internal or external to the Trust). In turn their line manager will acknowledge the declaration by replying in writing and copies entered into the staff member's personal file. Staff with other employment must inform their line manager on a weekly basis of hours worked in addition to their primary role. This will provide the necessary information for their line manager to calculate accumulative hours worked per week.

Staff must not undertake employment outside of their contracted role for the Trust whilst on sick leave, this include any work during "off peak" times such as weekends and evenings unless a GP certificate advises otherwise.

Health and Wellbeing

The Trust has responsibilities under Health and Safety law to ensure the safety of staff, patients and others and it is recognised that managing hours of work is an integral part of promoting staff health and wellbeing.

5.16 Non-Compliance with Health and Safety Policy

Failure to comply with requirements of the Health and Safety Policy may result in actions taken against staff in accordance the Disciplinary Policy and Procedure and / or Counter Fraud Bribery and Corruption Policy.

6. Training Requirements

The Workforce Development Team run or facilitate in-house and external training which includes a blend of taught and e-learning programmes. The Workforce Development Team maintain the:

- The Training Prospectus which provides information relating to statutory, mandatory and general training. The prospectus can be accessed through the Staff Training Access Resources Platform (STAR).

Booking for all health and safety training will be undertaken through Workforce Development via the Electronic Staff Record. Records must be kept of all training undertaken in the Trust. These records will be held centrally and reported Trust wide through ESR records. Individuals are encouraged to keep a copy of this in their portfolio.

7. Monitoring Compliance

7.1 Monitoring Arrangements

Compliance of this policy against all minimum statutory requirements will be monitored with an agreed audit programme (at least three yearly). Reactive monitoring of reported incidents in accordance with the Incident Management Policy will be completed by the Health and Safety Manager and / or Legal Claims Manager or Governance Support Officer (Compliance) on a rolling basis.

Completion of risk assessments and associated action plans in accordance with the Health and Safety Policy, Incident Reporting, Analysing, Investigating and Learning Policy and Procedures and Risk Management Policy are performance monitored via the Trust's risk management arrangements.

Quarterly incident reports are presented to the Health and Safety Group for information. Where appropriate, a category of Health and Safety incidents from the report will be extracted and presented to another relevant group or committee, for example incidents involving medical gases are presented at the Medical Gas Group and incidents involving chemicals are presented at the COSHH Working Group. This ensures the same information is shared across relevant groups. Incidents, associated action plans and / or actions taken following an incident are discussed and reviewed by the relevant group or committee.

The identification of trends or themes initiates where appropriate the sharing of information by Groups, Committees and / or specialists advisers. For example should a COSHH related incident occur on one community site, it may be necessary to share information from actions taken or identification of best practices with other Matrons or locality managers.

Quarterly incident reports are presented to specialist advisors for monitoring and review of accidents by category. For example, staff slips trips and falls are reviewed the Trust's Health and Safety Manager who will where appropriate seek assurance from the managers of a risk that appropriate actions have been taken. Advice and support is provided by specialist advisors to the managers of risks relating to the completion of action plans and / or appropriate actions to be taken.

7.2 Responsibility

The Health and Safety Manager and Local Security Management Specialist will be responsible for monitoring and reporting to the Health and Safety Group.

The Health and Safety Manager Local Security Management Specialist will be responsible for monitoring the management of slips, trips and falls involving staff and others (including falls from height).

Monitoring compliance with this policy will be the responsibility of the Health and Safety Manager and Local Security Management Specialist as part of the Health and Safety Audit programme for the Trust,

Health and Safety incidents that meet the criteria of a reportable incident under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR) are submitted to the Health and Safety Executive by the Health and Safety Manager and Local Security Management Specialist and / or Legal Claims Manager.

Support and advice will be provided to improve practice by the Trust's Health and Safety Manager and Local Security Management Specialist and /or specialist advisers as appropriate.

7.3 Methodology

Audits will be achieved by the use of a standard health and safety audit tool, which includes checks on compliance with Trust working practices, organisation arrangements and procedures including:

- Incident reporting
- Risk assessments
- Staff training
- Safe use of work equipment
- Electrical safety
- Lone working
- Control of substances harmful to health
- Workplace environment
- Display screen equipment
- Managing stress
- Flammable and explosive substances

This is not an exhaustive list. Audits will be undertaken by the Health and Safety Manager and / or other staff working within Corporate Governance such as (but not limited to) the Legal Claims Manager, Governance Support Officer (Compliance) and Compliance Administrator on at least a three yearly basis. The audit process includes completion of a walk around which may identify issues that require addressing. Key members of staff at each location will take part in the audit process for example a Matron, Ward Manager or equivalent.

Where non-compliance is identified, action plans are formulated and agreed with the locality manager or nominated responsible person.

The Risk and Incident Team facilitate reports that enable the reactive monitoring of incidents reported and entered onto the Datix system.

7.4 Reporting Arrangements

The result of the audit will be reviewed by the Corporate Governance Team. Executive summaries of audits will be submitted to the Health and Safety Group to note.

Audit results

The Health and Safety Manager and /or Legal Claims Manager will develop an action plan to improve compliance and ensure improvements in performance occur. Action plans will be implemented by the Health and Safety Manager and /or Legal Claims Manager who will nominate managers with responsibilities to ensure identified and agreed actions are completed.

Where non-compliance is identified, support and advice will be provided to improve practice.

Lesson learned and the sharing of best practices is achieved locally through training and governance days and if necessary externally with the Health and Safety Executive.

8. Equality Impact Assessment

The following equality impact assessment has been completed, no negative impacts have been identified. Positive impacts are identified for young persons e.g. apprentices and new and expectant mothers.

Table 1: Equality impact Assessment

Group	Positive Impact	Negative Impact	No Impact	Comment
Age	x			Working Time Directive requirements positively impact for the protection of workers under the age of 18.
Disability			x	
Gender			x	
Gender Reassignment			x	
Human Rights (rights to privacy, dignity, liberty and non-degrading treatment)			x	
Marriage and civil partnership			x	
Pregnancy	x			Health and Safety Policy and supporting New and Expectant Mothers Policy, prevents certain work duties from being undertaken to protect mother and baby
Maternity and Breastfeeding	x			As above
Race (ethnic origin)			x	
Religion (or belief)			x	
Sexual Orientation			x	

9. References

- Control of Substances Hazardous to Health (Fifth Edition) Approved Code of Practice (L5). HSE Books.
- Commons Topic 4: Safety Culture. HSE Information Sheet. Human Factors. HSE website.

- Health and Safety at Work etc Act 1974. HSE Books.
- Health and Safety Executive (HSE). (2003). *Health and Safety Regulation: A short guide*. London: HSE. Available at: www.hse.gov.uk
- Health and safety executive (HSE). (2005). *The Work at Height Regulations 2005 (as amended): A brief guide*.
- http://www.hse.gov.uk/
- http://www.hse.gov.uk/healthservices/
- Management of Health and Safety at Work Regulations 1999 approved code of practice and guidance. L21. HSE Books.
- NHS Employers. (2010). 'Health and safety essential guide'. NHS Employers website.
- Occupiers' Liability Act 1957
- Occupiers' Liability Act 1984
- Reporting accidents and incidents at work. Brief Guide. INDG453 Rev 1. HSE books.
- Safety Representatives and Committees Regulations 1977 and Health and Safety (Consultation with Employees) Regulations 1996. Approved Code of Practice and Guidance. HSE Books.
- Successful health and safety management. HSG 65. HSE Books.
- The Control of Noise at Work Regulations 2005
- The Health and Safety (Sharps Instruments in Healthcare) Regulation 2013
- The Health and Safety at Work etc. Act 1974
- The Management of Health and Safety at Work Regulations 1999 SI 1992/3242
- The NHS Constitution for England. Department of Health. Oct 2015.
- The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013: Guidance for employers in the healthcare sector. HSE Books.
- The Work at Height Regulations 2005 SI 2005/735
- The Working Time Regulations (as amended). HSE website.
- Workplace (Health, Safety and Welfare) Regulations 1992 SI 1992/3004

The Health and Safety Executive (HSE) website provides further information on managing the risks associated with slips, trips and falls: www.hse.gov.uk.

- 'Falls from Height'. HSE website page.
- 'Slips Resources'. HSE website page
- 'Watch Your Step Campaign'. HSE website page.
- 'Slips Assessment Tool'. Online tool.
- 'Local Authority Circular: Falls from Windows in Health and Social Care'. HSE website. (2007)

- 'Local authority circular: Reducing the Risk of Falls from Tail Lifts'. HSE website. (2009)
- *Slips and Trips in the Health Services. Health Services Sheet Number 2*. (2003)
- Preventing Slips and Trips at Work. (2007)
- Personal Protective Equipment: http://www.hse.gov.uk/toolbox/ppe.htm

10. Associated Documentation

- Asbestos Policy
- Asbestos Management Plan
- Control of Contractors Policy and Guidance
- Control of Substances Hazardous to Health Policy
- Counter Fraud Bribery and Corruption Policy
- Decontamination Policy
- Display Screen Equipment (DSE) Policy
- Disciplinary Policy and Procedure
- Drugs and Alcohol at Work Policy
- Electrical Safety Policy
- Falls Policy
- Fire Safety Policy
- First Aid Policy
- Gritting at North Devon District Hospital Procedure
- Incident Reporting, Analysing, Investigating and Learning Policy and Procedures
- Patient Isolation and Staff Exclusion Policy
- Lone Working Policy
- Management of Inoculation Injuries Policy
- Management of Work Related Stress Policy
- Moving and Handling Policy
- New and Expectant Mothers at Work Policy
- eRoster Policy
- Prevention of inoculation injuries policy
- Risk Management Policy
- Risk Management Strategy
- Staff Screening and Staff Immunisation Policy
- Standard Infection Control Precautions Policy
- Supporting Staff involved in an incident, complaint or claim Policy

- Violence and Aggression Policy
- Water Services Management Policy

Royal Devon and Exeter NHS Foundation Trust

Health and Safety Policy

Post holder responsible for Procedural Document	[redacted] Risk Manager
Author of Policy	[redacted], Risk Manager
Division/ Department responsible for Procedural Document	Nursing, Quality and Professional Development / Safety and Risk Department
Contact details	x[redacted]
Date of original document	April 2003
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Health and Safety Group: 27 April 2017
Review date (and frequency of further reviews)	October 2021 (5 years)
Expiry date	27/04/2022
Date document becomes live	18 May 2017

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Maintain Operational Service Delivery	
Assurance Framework		Integrated Community Pathways	
Monitor/Finance/Performance		Develop Acute services	
CQC Fundamental Standards - Regulation**:**		Infection Control	
Other *(please specify)*:			
Note: This document has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1.0	April 2003	Risk Manager	To meet legal requirements
2.0	November 2007	Risk Manager	Minor Amendments
3.0	August 2009	Risk Manager	Minor Amendments
4.0	December 2013	Risk Manager	Minor Amendments and clarification
5.0	March 2017	Risk Manager	Review

Associated Trust Policies/ Procedural documents:	Risk Management Policy Risk Assessment Policy Incident Reporting, Analysing, Investigating and Learning Policy and Procedure
Key Words	Health, Safety, HSE
In consultation with and date: Governance Managers: 30/03/2017 Divisional Directors: 30/03/2017 Policy Expert Panel : 05/04/2017 Health and Safety Group: ratified 27/04/2017	
Contact for Review:	Risk Manager
Executive Lead Signature: *(Applicable only to Trust Strategies & Policies)*	Tracey Cottam Director of Transformation & Organisational Development

CONTENTS

Royal Devon and Exeter NHS
NHS Foundation Trust

HEALTH AND SAFETY POLICY STATEMENT

The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) recognises that the achievement of good health and safety of its employees, and others that could be affected by its activities, is an integral part of its service provision.

The Trust aims to provide and maintain safe working conditions, equipment and systems of work for all its employees, at least to the standards required by legislation and recognised good working practices.

Management of health and safety in the Trust is a prime responsibility of line management from Directors and Senior Managers to supervisory staff. The Trust will provide adequate and appropriate resources to enable the aims and objectives of this policy to be met.

Appropriate preventative and protective measures will be resourced and implemented following the identification of work-related hazards and the assessment of the risk to safety and health associated with them. Expert advice will be sought as necessary when determining health and safety risks, and the measures required for guarding against them.

The Trust recognises the importance of employer/employee consultation on matters of health and safety, and the value of individual consultation prior to allocating specific health and safety functions. The allocation of duties for safety matters, the identification of competent persons appointed to particular responsibilities, arrangements to implement these objectives can be found within this document.

The objectives of this General Policy Statement can only be achieved through the competence, support and co-operation of employees and all other persons on the premises, e.g. patients / service users, contractors and visitors. Suitable and sufficient information, instruction and training will be given to employees and others so that they are competent to carry out their duties and responsibilities.

The content of this statement will be reviewed and kept up-to-date to reflect any changes in the nature of the Trust, activities undertaken by it, changes in health and safety legislation, or following periodic review of the policy.

Signed: ..... Date: 15.5.2017

Suzanne Tracey
Chief Executive Officer

1. INTRODUCTION

1.1 The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust) is required to discharge its duties under the Health and Safety at Work etc. Act (1974), the Management of Health and Safety at Work Regulations (1999) and allied legislation and European Directives. This will be achieved by maintaining safe conditions and working environments for all areas of activity under its control so far as is reasonably practicable.

1.2 Under Section 2 of the Health and Safety at Work etc. Act (1974), the responsibilities of the Trust as an employer are to:-

- Provide and maintain plant and systems of work that are safe and without risks to health;
- Make arrangements to ensure that substances and articles can be used, handled, stored, transported and disposed of safely;
- Provide information, instruction, training and supervision, to ensure the health, safety and welfare of employees;
- Maintain the place of work in a safe condition, without risk to health;
- Ensure safe means of access and egress;
- Provide and maintain a safe and healthy working environment with the provision of adequate welfare facilities.

1.3 The Trust also recognises its responsibilities under Section 3 and 5 of the Health and Safety at Work etc. Act (1974) to protect non-employed persons from being exposed to the risks of its activities, and its responsibility under Section 4 of the Act to other users of its premises.

1.4 The Trust aims to ensure that all employees are made aware of, and understand their duties under of the Health and Safety at Work etc. Act (1974) prior to commencing normal working duties.

1.5 This policy applies equally to patients, visitors, contractors and employees of the Trust whether permanent, temporary, voluntary, student or agency / locum staff. The policy also applies to staff seconded to the Trust.

1.6 **Failure to comply with this policy could result in disciplinary action.**

2. PURPOSE

2.1 The Trust undertakes to: -

- Reduce risks, so far as is reasonably practicable, to the health and safety of all patients, staff, contractors, visitors and members of the public who may be affected by its activities.
- Consult with staff, seek specialist advice and provide information, training and supervision.
- Recognise and support the participation of all employees in discharging their personal responsibilities under the Health and Safety at Work etc. Act (1974) and promote an active and successful health and safety culture;
- Ensure a health and safety management system and audit process is in place (see Appendix 1).

3. DEFINITIONS

3.1 **Risk Assessors** - Are appropriately trained employees identified by their Line Manager to undertake risk assessments in their area, raise any health and safety concerns through their line management chain and keep staff within their area informed of any risks or health and safety issues.

3.2 **Safety Representatives** - Means employees appointed either by unions or professional bodies, or at the request of staff in the relevant area/department to represent the staff in consultation with management on any general or specific matters affecting their health, safety and welfare.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 An effective health and safety culture can only be achieved by the active participation and co-operation of managers and staff at all levels of the organisation.

4.2 **Executive Leads**

4.2.1 Overall responsibility for compliance with health and safety legislation within the Trust rests with the Chief Executive (co-ordination is delegated to the Director of Transformation & Operation Development).

4.2.2 The Trust Board is responsible for demonstrating the commitment of the Trust to all matters relating to health and safety and for driving the health and safety agenda.

4.2.3 Responsibility for the overall co-ordination of health and safety matters within the Trust rests with the Director of Transformation and Operation Development.

4.2.4 This responsibility is exercised via delegation to the Risk Manager and the Safety and Risk Team and empowerment of the Trust's Divisional structures.

4.2 **Competent Persons**
The nominated competent person to fulfil the requirements of Regulation 7 of the Management of Health and Safety Regulations (1999) is the Risk Manager. The Risk Manager co-ordinates the health and safety programme in an advisory capacity, through the organisational structure described below, with further help available from experts within the Trust e.g.:

- Health and Safety Officers
- Occupational Health Consultant / Occupational Health Nurse Manager
- Fire Advisors
- Radiation Protection Advisor
- Moving and Handling Advisor
- Manual Handling Trainer
- Lead Nurse / Director of Infection Control
- Head of Estates

4.3 **Safety and Risk Team**
The Safety and Risk Team is responsible for:

- The provision of a Competent Person for Health and Safety as required by the Management of Health and Safety at Work Regulations;
- Managing and maintaining risk management systems e.g. Datix;
- Provision of Risk Management Training
- Undertaking Health and Safety Inspections annually

4.4 **Management Leads**

Management Leads are responsible for:

- Monitoring of incidents and investigations to staff, patients and visitors;
- Take corrective action to prevent recurrence of incidents;
- Ensuring programmes of risk assessments are carried out within the specified timetable;
- Taking corrective action when a risk assessment report reveals higher levels of risk than anticipated;
- Ensuring adequate training is in place to maintain safe systems of work;
- Identifying to the Trust any areas where the organisation needs to commit additional resources to ensure health and safety is maintained and improved;
- Producing and managing Divisional Risk Registers informing the Head of Governance of all risk rating numbers >15;

4.5 **Heads of Departments / Senior Nurses**

Heads of Departments and Senior Nurses are responsible for:

- Ensuring all staff report all incidents / near misses;
- Take corrective action whenever this is required to prevent recurrence of incidents and absence from work;
- Undertaking investigations into incidents / near misses;
- Ensuring all staff attend mandatory training;
- Monitoring that all Health and Safety policies are being adhered to;
- Highlighting any areas where there are felt to be inadequate policies to deal with any health and safety issues;
- Ensuring they have risk officers in their areas and ensure they have protected time to undertake this role;
- Co-operating fully with all risk assessment programmes;
- Identifying to Divisional Directors any areas where additional resources are needed to ensure health and safety is maintained or improved.

4.6 **Governance Manager**

Governance Managers are expected to ensure that all health and safety inspection reports are uploaded on Datix and all findings, and action plans are discussed at Specialty and/or Divisional Governance Groups as required.

4.7 **Risk Assessors**

Risk Assessors are expected to: -

- Undertake the risk assessment training programme, together with updates as required;
- Be able to devote necessary time and energy to the task;
- Have a clear reporting line through line managers to senior management;

- Feed irresolvable issues to managers and ultimately to the Safety and Risk Department;
- Communicate health and safety and risk issues to all staff in the ward / department, ensure that they receive necessary training and that all incidents in the area are promptly and properly recorded;
- Undertake risk assessments including Control of Substances Hazardous to Health (COSHH), Display Screen Equipment (DSE) and Manual Handling;
- Undertake other miscellaneous duties e.g. device alerts.

4.8 Health and Safety Accredited Representatives

4.8.1 The role of Health and Safety Accredited Representatives is to assist in the process of inspection and risk assessment and to assist in representing the views of staff on any issues associated with health and safety. Health and Safety Accredited Representatives also have the right to carry out independent inspections and to represent their findings, on behalf of staff, to managers.

4.8.2 The Trust is committed to effective consultation with employees and the Health and Safety Group provides a forum for this. Further information on the role of this Group is contained in the Group's Terms of Reference.

4.9 Employee Responsibilities

4.9.1 All employees have a legal obligation to co-operate with their employer in the implementation of health and safety at work. This obligation extends not only to their own safety but also to other's who may be affected by their acts or omissions. This obligation includes: -

- Complying with safe working practices and risk assessments produced to help minimise accidents;
- Reporting risks, either to their own health and safety, or that of other people including near misses;
- Following set systems of work, correct use of protective clothing and appropriate equipment provided for their health and safety and reporting any loss or damage.
- Not interfering with, or misuse of anything provided in the interests of health and safety.
- Using the correct equipment or tools for the task and not improvising.
- Attending training as required.
- Familiarising themselves with the health and safety aspects of their work and avoid conduct which would endanger themselves or others.

4.10 Safety and Risk Committee

4.10.1 It is the responsibility of the Committee to ensure that the organisation understands the process of risk management and how it can be effectively utilised to address risk issues.

4.10.2 This is achieved by receiving reports from the Health and Safety Group and being assured that Health and Safety is being managed effectively.

4.11 Health and Safety Group

The Group provides a forum for the Trust and its employees to co-operate effectively in instigating, promoting and developing measures to ensure the health, safety and welfare of employees, patients and service users and other visitors to the Trust.

5. ARRANGEMENTS FOR HEALTH AND SAFETY

5.1 The fundamental tool for ensuring compliance with health and safety legislation will be the process of risk assessment.

5.2 Risk Assessment

5.2.1 In order to comply with Health and Safety legislation it is essential that risk assessments are carried out prior to the implementation of a new system process or task on an annual basis or earlier where changes or incidents have taken place.

5.2.2 To fulfil this requirement each Ward / Departmental manager will identify a named person to undergo training provided by the Safety and Risk Department. The training will cover identifying hazards, assessing, controlling and reviewing the risks associated with that hazard in line with the requirements of the Management of Health and Safety Regulations. On completion of training the person will be a Risk Assessor and will be expected to take on the duties as outlined in section 4.6 of this policy.

5.2.3 Divisions will hold details of risk assessments in Divisional and Departmental Risk Registers.

5.2.4 All risks which have a risk rating number of >15 or are Trust-wide risks will be held on the Corporate Risk Register.

5.2.5 The Trust Board will be responsible for reviewing the Corporate Risk Register on a quarterly basis.

5.3 Training and Communication

5.3.1 All new members of staff must attend induction, which includes information about health and safety and be made aware of the health and safety procedures that apply within their own department before they begin their normal working duties. They must also receive corporate 'refresher' training on health and safety issues on a regular basis. This requirement is set out in the Trust's Training Needs Analysis.

5.3.2 The importance of good communication about health and safety matters cannot be overstated. Whilst it is essential for certain information to be written down, this is no substitute for verbal discussion and relevant practical demonstrations. Information should be readily available, comprehensive and presented in a form that is easily understood by all staff.

5.4 Recognising Health and Safety Representatives

The Trust, Divisions, Wards and Departments will:

- Support the appointment of health and safety representatives to represent staff in consultation with managers about health and safety issues, their management, administration and practice.
- Recognise health and safety representatives from those staff side organisations who are recognised for negotiating purposes.
- Ensure that any agreement regarding the number of health and safety representatives, the groups of staff they represent and the arrangement for their appointment is in accordance with the approved codes of practice
- Ensure that recognised health and safety representatives are provided with reasonable facilities and information to undertake their proper functions and this

will include reasonable time off with pay to undergo approved health and safety training.
- Recognise the value of management and staff working together on health and safety issues and strongly encourage development of pro-active and effective approaches towards Trust health and safety.
- Consult on reports from Statutory Bodies (Health and Safety Executive)
- Ensure the conduct and constitution of the Health and Safety Group in accordance with the Management of Health and Safety at Work Regulations (1999) and guidance to the Health and Safety (Consultation with Employees) Regulations 1996.

5.5 Reports from statutory bodies e.g. Health and Safety Executive (HSE) will be received and disseminated via the Chief Executive through the Risk Manager. The Divisions / Departments will immediately notify the Risk Manager of action taken without delay.

5.6 Receipt of formal improvement or prohibition notices will be reported to the Chief Executive and a report on subsequent action to be taken will be provided by the Risk Manager.

5.7 Other parties

5.7.1 Where members of staff are working on premises which are owned and / or managed by a third party, including domestic premises, the Trust will ensure that the other party understands and accepts the respective responsibilities of the Trust, the employees of the Trust, and the third party in respect of health and safety. To ensure this is carried out, all risk assessments, whether of the environment, or of work activity risks will be carried out jointly by the Trust and the third party or the third parties agreed representative. The manager directly responsible for activity within the premises owned by a third party, will therefore, be responsible for acting on the findings of the joint risk assessors. This process may involve external agencies, such as Devon County Council's Social Care and Health Department and / or carers and patients.

5.7.2 Specific discrete responsibilities however, are defined as follows:

- The Trust and the third party will jointly agree the details of the local Unit / Department Health and Safety Guidelines.
- The Trust will ensure that staff are suitably trained in adopting safe systems of work.
- Employees are responsible for practising safe systems of work as instructed by the Trust, or through their professional training.
- For any work related activities undertaken outside the premises owned / managed by a third party, the Trust, as direct employers of the staff will ultimately be accountable for ensuring those activities are carried out safely through application of safe system of work, and / or professional standards.
- The third party will be responsible for ensuring the environment in which the employee is working is safe.
- Where the third party is responsible for managing the work, on a day to day basis, the Trust and the third party are responsible for independently monitoring accidents, jointly assessing risks, and auditing systems of work. The third party, including agreed external agencies and / or carers and patients, will be responsible for taking management action to correct any shortfalls in the first instance, only referring to the Trust if such shortfalls are not adequately addressed within the time specified.
- Where such management action / external agency and / or carer/ patient fails to result in improvements to health and safety within a reasonable time period, the

third party must inform the Trust, so that the Trust can take whatever action is appropriate, as the employer of the staff, to ensure safe systems of work are practised and maintained.

6. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author, (Risk Manager, Safety, Risk and Patient Experience Department). An electronic copy will be maintained on the Trust Intranet (A-Z) – P – Policies (Trust-wide) – H – Health & Safety. Archived copies will be stored on the Trust's "archived policies" shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

7. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

7.1 To monitor compliance with this policy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by
1.	Quarterly reports on performance, training, incident reporting to the Health and Safety Group.	Minutes and reports
2.	Quarterly reports to the Safety and Risk Committee on health and safety matters.	Minutes, reports and compliance with reporting schedule
3.	Quarterly reports to the Safety and Risk Committee on compliance with the health and safety action plan.	Minutes, reports and compliance with reporting schedule
4.	Annual audit of the health and safety management system.	Full report presented to group and resulting action plan

7.2 **Frequency**
In each financial year, the Risk Manager will audit compliance to ensure that this policy has been adhered to and a formal report will be written and presented at the Health and Safety Group.

7.3 **Undertaken by**
Risk Manager

7.4 **Dissemination of Results**
At the Health and Safety Group which is held 4 times per year and at the Safety & Risk Committee

7.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Health and Safety Group, which meets 4 times per year.

7.6 Any barriers to implementation will be risk-assessed and added to the risk register.

7.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

8. REFERENCES

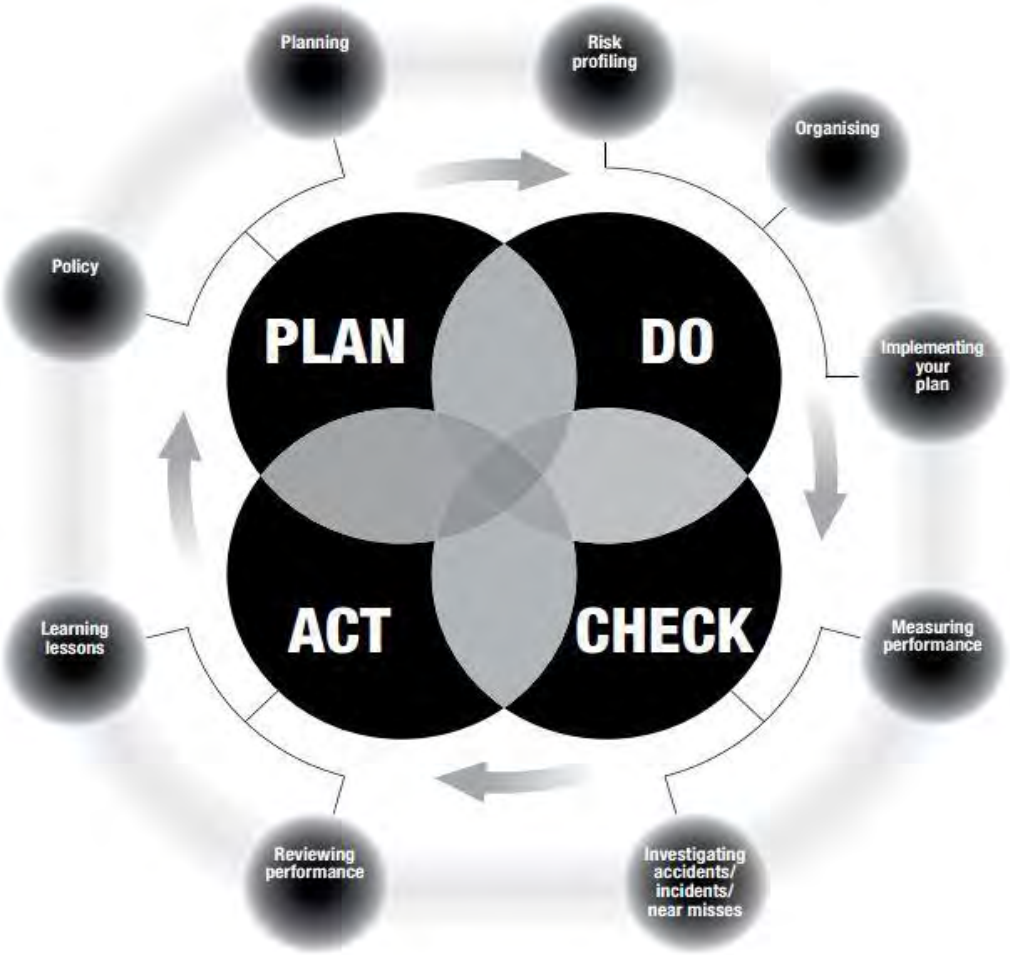
Health and Safety at Work etc. Act 1974 (c.37). London, Stationery Office. http://www.legislation.gov.uk/ukpga/1974/37

Health and Safety Executive (2013): *Managing for health and safety (HSG65).* London: Health and Safety Executive: http://www.hse.gov.uk/pubns/books/hsg65.htm

Management of Health and Safety at Work Regulations 1999 (SI 1999/3742). London: Stationery Office. http://www.legislation.gov.uk/uksi/1999/3242/contents/made

APPENDIX 1: HEALTH AND SAFETY MANAGEMENT SYSTEM AND AUDIT PROCESS

The Health and Safety Management System adopted by the Trust is based on HS(G)65 and can be depicted diagrammatically as follows:



Plan, Do, Check, Act helps achieve a balance between the systems and behavioural aspects of management. It also treats health and safety management as an integral part of good management generally, rather than as a stand-alone system.

Plan, Do, Check, Act	Conventional health and safety management	Process Safety
Plan	Determine your policy / plan for implementation	Define and communicate acceptable performance and resources needed
Do	Profile risks / organise for health and safety / implement your plan	Identify and assess risks / identify controls / record and maintain process safety knowledge Implement and manage control measures
Check	Measure performance (monitor before events, investigate after events)	Measure and review performance / learn from measurements and findings of investigations
Act	Review performance / act on lessons learned	

APPENDIX 2: COMMUNICATION PLAN

Royal Devon and Exeter NHS
NHS Foundation Trust

COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

Staff groups that need to have knowledge of the strategy/policy	All staff
The key changes if a revised policy/strategy	Minor changes to bring the policy in line with the new management structures and job titles
The key objectives	To ensure compliance with health and safety legislation
How new staff will be made aware of the policy and manager action	Cascade by email
Specific Issues to be raised with staff	Not applicable / None
Training available to staff	N/A
Any other requirements	N/A
Issues following Equality Impact Assessment (if any)	No negative impacts
Location of hard / electronic copy of the document etc.	Held on Hub and notice boards

APPENDIX 3: EQUALITY IMPACT ASSESSMENT TOOL

Name of document	Health and Safety Policy
Division/Directorate and service area	Safety, Risk and Patient Experience
Name, job title and contact details of person completing the assessment	[redacted], Risk Manager ext. [redacted]
Date completed:	30/03/2017

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. What is the main purpose of this document?

To ensure the organisation has a robust process for the management of health and safety to comply with legal requirements.

2. Who does it mainly affect? *(Please insert an "x" as appropriate:)*

Carers ☒ Staff ☒ Patients ☒ Other (please specify)x

3. Who might the policy have a 'differential' effect on, considering the "protected characteristics" below?

Please insert an "x" in the appropriate box *(x)*

Protected characteristic	Relevant	Not relevant
Age	☐	☒
Disability	☐	☒
Sex - *including: Transgender, and Pregnancy / Maternity*	☐	☒
Race	☐	☒
Religion / belief	☐	☒
Sexual orientation – *including: Marriage / Civil Partnership*	☐	☒

4. **Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to…** (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

Please specify any groups you think may be affected in any significant way

5. **Do you think the document meets our human rights obligations?** ☐

Feel free to expand on any human rights considerations in question 6 below.

A quick guide to human rights:
• ***Fairness –*** *how have you made sure it treat everyone justly?* • ***Respect –*** *how have you made sure it respects everyone as a person?* • ***Equality –*** *how does it give everyone an equal chance to get whatever it is offering?* • ***Dignity –*** *have you made sure it treats everyone with dignity?* • ***Autonomy –*** *Does it enable people to make decisions for themselves?*

6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

Please give a brief summary- identifying:

No issues identified with the policy

7. If you have noted any 'missed opportunities', or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

"Protected characteristic":	*N/A*
Issue:	
How is this going to be monitored/ addressed in the future:	
Group that will be responsible for ensuring this carried out:	

Royal Devon and Exeter NHS Foundation Trust

Extension granted until 30 June 2019 by WGC Chair on 10 January 2019

Managing Performance (Capability) Policy

Post holder responsible for Procedural Document	Head of Specialist HR Services
Author of Policy	Employee Relations Manager
Division/ Department responsible for Procedural Document	Human Resources
Contact details	x4555
Date of original policy	18/10/2012
Impact Assessment performed	**Yes**/ No
Ratifying body and date ratified	Workforce Governance Committee Chair's approval: 20 July 2016
Review date (and frequency of further reviews)	November 2017 (every 2 ½ years)
Expiry date	20 May 2018 (extension 30 June 2019)
Date document becomes live	20 July 2016

Please *specify* standard/criterion numbers and tick ✓ other boxes as appropriate

Monitoring Information		**Strategic Directions – Key Milestones**	
Patient Experience		Waiting	
Assurance Framework		Privacy and Dignity	
Monitor/Finance/Performance		Efficiency and Effectiveness	**X**
CQC Regulations/Outcomes:	**n/a**	Delivery of Care Closer to Home	
		Infection Control	
NHSLA Risk Management Standards for Acute Trusts			
NHSLA CNST Maternity Clinical Risk Management Standards:			
Other *(please specify)*:			
Note: This policy has been assessed for any equality, diversity or human rights implications			

Full History		Status: Final	
Version	Date	Author (Title not name)	Reason
1.0	February 2011	Director of Human Resources	*Original policy on record*
1.1	June 2011	Director of Human Resources	*Minor amendments*
1.2	18/10/12	Senior HR Manager	*Minor amendments*
1.3	06/03/15	Employee Relations Manager	*Routine revision; alterations following feedback from PEP*
2.0	13/07/15	Employee Relations Manager	*Conclusion of routine review, ratification and publication*
3.0	29/06/16	Employee Relations Manager	*Clarification to Pay Protection arrangements, see Section 6.5*

Associated Trust Policies/ procedural documents:	Disciplinary and Appeals Policy Attendance Management Policy and Procedure Management of Organisational Change Policy Probationary Period Policy Personal Development Review and Pay Progression Policy
In consultation with and date: • HR Operations Team – 20 March 2015 • Equality & Diversity Manager – 2 April 2015 • JSCNC – 9 April 2015 • PEP – 1 June 2015 • Governance Leads, Divisional Directors, General Managers and Assistant Directors of Nursing – 23 June 2015 • Workforce Governance Committee Chair – 13 July 2015 (v. 2.0) • Workforce Governance Committee Chair: approval of clarification regarding Pay Protection arrangements – 20 July 2016.	
Contact for Review:	Employee Relations Manager; Specialist HR Team
Executive Lead Signature: *(Only applicable for Strategies & Policies)*	Tracey Cottam Director of Transformation & Organisational Development

CONTENTS

1. INTRODUCTION

1.1 The Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as 'the Trust') will at all times endeavour to ensure that employees achieve and maintain a high standard of performance in their work to ensure the quality of care for patients is achieved and maintained. To this end the Trust will establish standards, monitor performance and provide employees with the appropriate training and support to meet these standards.

1.2 It is acknowledged that there may be times when employees do not perform, or are unable to perform at the level required by the Trust. In dealing with cases of poor performance, the Trust will distinguish between those where the reason is within the employee's control, e.g. a conduct issue such as negligence, lack of application or attitude problems and those where the reason is outside of the employee's control, e.g. ill health, a disability or a lack of skills, qualifications or training.

1.3 It is further acknowledged that performance issues may also be driven by 'conscientious objection' on the grounds of belief. In these cases, the Trust will seek to identify this at the earliest opportunity to ensure that employees are not discriminated against on the grounds of their beliefs. Managers should seek advice from the Specialist HR Team before taking any action.

1.4 In cases of poor performance due to conduct, the Trust's Disciplinary and Appeals Policy should be used.

1.5 In cases where poor performance is found to be outside of the employee's control, the capability procedure will be applied. However in cases where an employee's performance is due to ill health or a disability, managers should follow the Attendance Management Policy and Procedure and seek support from the HR team.

Any employee who wishes to appeal against the outcome of the formal process contained within this policy should refer to the formal appeal process laid out in the Disciplinary and Appeals Policy.

1.6 This policy applies to all employees directly employed by the Trust (excluding bank staff) and is designed to ensure that cases of underperformance are dealt with consistently and fairly, with the prime objective of improving an individual's performance to the required level.

1.7 The Managers Toolkit should be utilised alongside this policy as a guide for employees and managers on how performance matters will be dealt with.

1.8 Failure to comply with this policy could lead to disciplinary action.

2. PURPOSE

2.1 To assist both managers and employees in understanding how to manage performance and the process to be followed if an employee's performance falls below the required standard.

2.2 Employees will be treated as an equal partner in the management of their performance. This means working together with their line manager, staff side representative or workplace colleague, constructively and positively to identify solutions and to resolve problems relating to poor performance.

2.3 It is recognised that people have different ways of working and that in order to be fair to all staff, any decisions made as part of this process will be based on merit, and will be underpinned by the Trust's values, which are:

- Honesty, Openness and Integrity
- Fairness
- Inclusion and Collaboration
- Respect and Dignity

3. DEFINITIONS

3.1 **Capability**: – 'an employee's capability assessed by reference to skill, aptitude, health or any other physical or mental quality' (Employment Rights Act, 1996).

3.2 **Capability – conduct**: includes negligence, lack of application or an attitudinal problem.

3.3 **Capability – performance** – a lack of skills, qualifications or training.

3.4 **Capability – health** – a medical condition (physical or mental) which impacts upon the employee's ability to undertake their role, with or without adjustments where appropriate.

3.5 **Reasonable adjustments** – made under the provisions of the Equality Act (2010), which aim to make sure that, as far as is reasonable, a disabled worker has the same access to everything involved in doing and keeping their job as a non-disabled worker

3.6 **Disability** – 'a physical or mental impairment that has a substantial and long term negative effect on a person's ability to carry out their normal daily activities'

3.7 **Conscientious Objection** – when an individual is unable to fulfil either all (or part) of their duties on the grounds of conscientious objection, i.e. based on their religion or religious beliefs

3.8 **Managers Toolkit** – a supporting document to be used in conjunction with this policy, to inform employees and to guide managers through the process to manage under or poor performance.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 **Executive Director Responsibilities:** The Director of Transformation and Organisational Development has overall responsibility for this policy.

4.2 **Deputy Director of Transformation and Organisational Development (OD) Responsibilities:** The Deputy Director of Transformation and Organisational Development is the designated senior manager to which any appeals should be sent. They will then delegate the appeal as appropriate.

4.3 **Human Resources Responsibilities:** The Human Resources (HR) Department will support line managers in applying the policy to ensure a fair and consistent approach and will undertake an annual audit to ensure that all stages have been completed and compliance with the policy.

4.4 Managers Responsibilities:

- Address problems relating to poor performance at the earliest opportunity , to avoid the issue escalating further
- Actively support, guide and train employees, where appropriate, to enable them to fulfil their role competently
- Communicate effectively with employees, to ensure that the expected standards are clear
- Provide regular and constructive feedback regarding the individual's performance
- Advise employees as soon as their performance falls below the required standard and review any adjustments already in place
- Agree clear objectives with the employee, detailing how these will be measured and an appropriate timescale in which to achieve these
- Maintain a complete, written record of performance levels during all stages of the process
- Give consideration to withholding the employee's incremental pay progression in accordance with the Trust's Personal Development Review (PDR) and Pay Progression Policy.

4.5 Employees Responsibilities:

- Undertake their role as described in the job description and person specification and to perform those duties to the required standard
- Act promptly and appropriately to raise any concerns in relation to their own capability or performance
- Be open with managers about any health problems/disability which may require adjustments to their role to enable them to perform satisfactorily
- Ensure their line manager is made aware of any issues that might reasonably impact on their ability to perform their job to the required standard

4.6 **Staff Side Responsibilities:** Advise and support members through the formal process in line with Trust policy.

5. PROCEDURE FOR MANAGING UNDER-PERFORMANCE

Regular reviews and support will help to minimise under-performance. However there may be occasions when, despite adequate support, an employee's performance fails to reach the required standard. Under-performance may have a variety of causes and some of these may be outside of the employee's control. It is therefore important that any concerns are discussed openly and at the earliest opportunity.

5.1 Preliminary Discussion – Stage 1

5.1.1 This should be undertaken when either:

- The manager first notices that an employee's performance is of concern and this may be a minor issue only. This may be the case if the manager feels this is out of character for the employee or if they become aware of circumstance(s) surrounding the employee which is/are impacting on their performance (e.g. a personal or family difficulty, or a distressing event)

  OR:

- When an employee first raises any concerns or difficulties to their line manager

5.1.2 The manager should arrange an informal discussion with the employee, on a 1-1 basis, to discuss their concerns, giving clear examples and to identify any support or adjustments which may be required. It is likely that a brief discussion only will be required at this point.

5.1.3 Any such support or adjustments may only be required on a short term, temporary basis to assist the employee to 'get back on track' or to assist them through an isolated difficult period. It may also be appropriate to consider Occupational Health support or the Staff Counselling service at this stage.

5.1.4 The manager should keep an informal file note of the discussion on the employee's personal file, which may then be referred to if there are continued concerns. A copy of the informal file note should also be given to the employee for their records (see Managers Toolkit).

5.1.5 The preliminary discussion (Stage 1) should be undertaken by the manager **prior to** commencing the informal stage (Stage 2) and it is possible that this discussion may be sufficient for the employee to improve, with no further action or support required.

5.1.6 The aim of the preliminary stage is to ensure that performance concerns are addressed and that employees are supported from the outset. This may help to reduce the number of occasions when the informal and formal stages of this policy are invoked.

5.2 Informal Monitoring – Stage 2

5.2.1 When it is clear that the employee's performance has continued to fall short of an acceptable standard, following the preliminary discussion, the line manager will hold an informal meeting with the employee on a 1-1 basis to establish the reason(s) for their poor performance (see template invite letter -Managers Toolkit).

5.2.2 This meeting will be an opportunity to review any adjustments or support put in place after the preliminary discussion and to review whether these remain appropriate. It will also act as an opportunity to address any further issues that have come to light which may continue to affect the individual's performance.

5.2.3 The following outcomes and actions **may** be appropriate:

- a referral to Occupational Health and/or Staff Support and Counselling service
- (temporary) adjustments to the employee's working hours, pattern or job role
- additional or further training or coaching for the employee

5.2.4 During the informal stage, the employee's performance should be monitored for a period of 1 month. An informal meeting should be held at the start and end of the month (2 meetings in total) and a record of these meetings should be kept using the Managers Toolkit.

5.2.5 It may be necessary to extend this period, for example to take account of a period of sickness absence which occurs during the month. Please refer to the guidance within the Managers Toolkit for further advice, prior to extending the informal monitoring period.

5.2.6 If the employee's performance problems are related to their health, the manager should refer to the Attendance Management Policy for further guidance. This may be apparent at the start of the process or may not become clear until after the process has commenced, in which case, managers may be required to switch from one policy to another (i.e. from the Capability policy to the Attendance policy).

5.2.7 If the employee's poor performance results from or may constitute misconduct, the manager should refer to the Disciplinary and Appeals Policy for further guidance. Again, managers may be required to switch from one policy to another if and when this becomes clear (i.e. from the Capability policy to the Disciplinary policy).

5.2.8 However, HR advice should be sought if the manager feels that the employee's poor performance is caused by another issue not included above

5.3 Formal Monitoring – Stage 3

5.3.1 General

5.3.1.1 Following completion of Stages 1 (preliminary discussion) and 2 (informal monitoring), should the employee's performance continue to be of concern, the manager should progress to Stage 3: Formal Monitoring.

5.3.1.2 The manager must write to the employee, detailing the shortfalls in their performance and inviting them to a formal meeting (see Managers Toolkit). The employee will have the right to be accompanied by a Staff Side representative or workplace colleague, not acting in a legal capacity. A representative from the HR team will also be present at the first meeting.

5.3.1.3 During the formal stage, the employee's performance should be monitored for a period of 3 months. The process may be extended under certain circumstances where appropriate and HR advice should be sought before extending the process. In addition, if this relates to a disability or health related issue, the process may again be extended following discussions with the HR Lead.

5.3.1.4 There should be a meeting at the start of the process, followed by a meeting at the end of each month for 3 months (4 meetings in total) and a formal outcome letter should be issued to the employee after each meeting, using the relevant template contained within the Managers Toolkit.

5.3.1.5 Managers should also consider withholding the employee's incremental pay progression at the start of the formal monitoring process. In this case, further advice should be sought from HR before any such decision is made, and if this is agreed, this should be clearly communicated to the employee from the outset. Managers may also wish to refer to the Trust's Personal Development Review and Pay Progression Policy for further information.

5.3.2 Formal Meeting – beginning of Month 1

5.3.2.1 The aim of the first formal meeting is to:

- Explain clearly the shortfall between the employee's performance and the required standard
- Identify the cause(s) of their poor performance and to identify any additional support or reasonable adjustments which may be required to help the employee to reach the required standard
- Agree clear, measurable objectives with the employee using the SMART principles (see Managers Toolkit)
- Confirm the next steps if the required standard is not achieved

5.3.2.2 Following this meeting, the employee should be provided with:

- a copy of the agreed objective plan

- an outcome letter detailing the discussions held
- a copy of the Managing Performance (Capability) policy for information

5.3.3 Formal Meeting – end of Months 1 and 2

5.3.3.1 Further formal meetings should be held at the end of months 1 and 2. These meetings should be used as an opportunity to review the employee's progress against the objectives agreed during the first formal meeting. Any support or adjustments already in place should be reviewed to ensure they remain fit for purpose.

5.3.3.2 The employee should be given the right to be accompanied to all formal meetings by a Staff Side representative, or workplace colleague, not acting in a legal capacity.

5.3.3.3 An outcome letter should be sent to the employee after each meeting (see the Managers Toolkit).

5.3.4 Formal Meeting – end of Month 3

5.3.4.1 The purpose of this meeting is to review the employee's overall progress and determine whether they have reached the required standard, either fully, partially or not at all. The employee should be offered the right to be accompanied and a HR representative will also be in attendance. The outcome of this meeting should be documented in a letter to the employee as follows:

5.3.5 At the end of the 3 month formal performance monitoring period:

- **Where the required performance is achieved:** If the required improvement has been made, the employee should be advised that the formal process has concluded. This should be confirmed in writing to the employee which will also include:

  - The expectation that the employee will sustain the required standards
  - That any further concerns regarding their performance may lead to a return to the formal process

- **Where a partial improvement is made:** If a partial improvement has been made, but the standard required has not yet been met, the review period may be extended for a further month to support the employee to reach the standard required. At the end of this additional month, a further formal meeting will be arranged. If the required improvement has then been made, the employee will be advised in accordance with the above.

- **Where little or no improvement is made:** If little or no improvement is made, the employee should be advised that their performance continues to fall below the required standard. The employee should be advised that a hearing will be convened on capability grounds.

5.4 Capability Hearing – Stage 4

5.4.1 If a decision is taken to proceed to a formal hearing, the employee must be notified of this in writing as soon as possible once a date has been confirmed.

5.4.2 An independent senior manager will be appointed to chair a capability hearing and will be supported by an independent HR representative, neither of whom will have been involved in the performance management process.

5.4.3 The Chair will conduct the hearing in accordance with the guidance contained within the Managers Toolkit.

5.4.4 Employees will be given sufficient notice to arrange representation and this will normally be a minimum of 10 working days' notice of a formal hearing. Employees will be informed of the details of the hearing in writing, including their right to be accompanied, and the nature of the performance concerns to be discussed, including the possible sanction which may be applied at the hearing (see Managers Toolkit for template letter).

5.4.5 Employees are strongly encouraged to attend a capability hearing in person, where possible. However, in exceptional circumstances, for example where the employee is seriously ill, or in cases of Ill Health Retirement, where the potential outcome may be dismissal, the employee may choose to send a representative to attend the hearing on their behalf. This can be either a Staff Side representative or workplace colleague. This may be appropriate so as to prevent further and unnecessary distress to the employee.

5.4.6 Hearings will not be unduly delayed if the employee's chosen representative is not available on the proposed date. Employees will have the opportunity to suggest an alternative time and date as long as it is reasonable and is not more than 5 working days after the original date. If the chosen representative is not available for more than 5 working days after the original date, the employee may be asked to nominate an alternative representative.

5.4.7 Employees will be sent in advance of the hearing a copy of the management information to be presented (in accordance with the Managers Toolkit).

5.4.8 Employees or management may request the attendance of witnesses at the hearing. Advance notice should be given by both parties of the identity of any witnesses.

5.4.9 Where an employee has failed to reasonably attend or to send a representative and is unwilling or unable to give a reasonable explanation, the chair may decide to proceed with the case and make a decision based on the information available to them.

6. SANCTIONS

6.1 General

6.1.1 Following a capability hearing, a formal sanction may be applied which could eventually result in dismissal if the employee fails to make the necessary improvement. The gravity of the poor performance will dictate the disciplinary sanction or penalty imposed, and will only be applied once all the evidence and mitigation has been considered by the hearing panel. Therefore the sanctions listed below should not be considered to be cumulative.

6.1.2 Where a formal sanction is applied, this will be in accordance with the Trust's Disciplinary and Appeals Policy as follows:

6.2 Formal Written Warning

Where the employee is found to be performing unsatisfactorily it is usual to issue a written warning. A formal written warning can be issued for more serious offences or an accumulation of minor offences. A time limit of between 6-12 months will be applied to the sanction. The written warning should set out the nature of the poor

performance and the improvement required (including the timescale to achieve this). The employee should also be informed of the potential consequences of a further failure to improve their performance within the set period, which could result in a final written warning or dismissal, depending on the impact and severity of the issues/poor performance

6.3 Final Written Warning

If an employee's poor performance is sufficiently serious, it may be appropriate to move directly to a final written warning. This should be considered when the poor performance is considered not so serious as to justify dismissal or where there has been a previous written warning. This may be appropriate where the employee's actions have had, or are liable to have, a serious or harmful impact on the organisation, patients or other employees. A time limit of a maximum of 12 months will usually be applied to the sanction. An outline of the possible consequences of further poor performance, e.g. dismissal or another penalty such as demotion should be made clear to the employee.

6.4 Redeployment/Transfer to a Lower Grade Post

In cases of poor performance, or capability relating to ill health, and where there is evidence that the employee is not capable of performing the role for which they were employed, redeployment or a transfer to a lower grade post should be considered as an alternative to dismissal. This may be despite training, support and reasonable adjustments being made and may also be supported by Occupational Health.

6.5 Pay Protection

In cases of redeployment to a lower graded post as a disciplinary sanction, pay protection will not be awarded. However in cases where employees are permanently redeployed to a position on at a lower grade due to **a work related injury, work related illness and/or other work related health condition only**, employees will receive a period of protected pay that is the same as local provision for pay protection during organisational change. Therefore, medical redeployment for reasons not work related will not be afforded pay protection.

6.5.1 Employees are expected to accept all reasonable offers of alternative employment and failure to do so will lead to a further hearing being convened which may lead to termination of employment.

6.6 Dismissal with Notice (Contractual Dismissal)

Dismissal may occur as a consequence of a single act of poor performance or where there have been previous warnings issued for poor performance. Dismissal may also be appropriate where an additional instance of poor performance occurs with an in date sanction on file.

6.6.1 It should be noted that all capability related dismissals are with notice, including those resulting from ill health.

6.6.2 Dismissal may also apply where:

- an employee has applied and been accepted for ill health retirement;
- an employee has applied for and been refused ill health retirement and where medical advice shows that they are unfit to return to any work;
- Occupational Health advice is clear that there is no reasonable expectation that there will be a return to work within the foreseeable future;
- where all attempts at reasonable adjustments have failed and where there is no prospect of suitable alternative employment or where Occupational

Health have advised that suitable alternative employment will not be possible;
- where the employee refuses to engage with the redeployment process or to accept an offer of suitable alternative employment;
- where an employee refuses to engage with and accept reasonable adjustments

6.6.3 This list gives examples only and is not exhaustive.

7. POTENTIAL FOR REFERRAL TO PROFESSIONAL BODY OR SAFEGUARDING LEAD

7.1 In cases where a health professional is dismissed for reasons of capability, consideration should be given as to whether to refer to the appropriate professional body. Consultation should take place with the Trust Lead for the relevant profession, the line manager and Senior HR Manager prior to any referral. There should also be consideration of whether any safeguarding issues apply and whether the safeguarding lead for the Trust should be alerted.

7.2 If a decision is taken to refer to the professional body, it will be for the Trust Lead for the profession to make any such referral in writing.

8. APPEAL

Employees have the right to appeal against a disciplinary sanction or dismissal. Employees should refer to the appeal process as set out in the Disciplinary and Appeals Policy (see Section 11 for further guidance).

9. ARCHIVING ARRANGEMENTS

The original of this policy will remain with the author, HR Manager, within the Employee Relations (ER) Specialist Team. An electronic copy will be maintained on the Trust Intranet, Policies – M - Managing Performance (Capability) Policy. Archived electronic copies will be stored indefinitely on the Trust's "archived policies" shared drive, and a paper copy (where one exists) will be held for 10 years.

10. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE POLICY

10.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

No	Minimum Requirements	Evidenced by	NHSLA Standard
1.	All formal hearing and appeal outcomes will be recorded on ESR and the ER database	Records on ESR and ER database	
2.	All cases requiring HR support will be recorded on the ER database and via calls received via the HR Helpdesk. This information will be used for reporting purposes to monitor the effectiveness of the policy	Records on ER database	

3.	Review (annually) of sample cases to identify any trends, compliance with policy and any training needs required	Records on ER database; annual audit of 15% of formal performance/ capability related cases by the Specialist ER Team to ensure that all stages have been completed	
4.	Associated policies have been listed in the policy for guidance	Reading the policy	
5.	The Equality Impact Assessment was completed and attached as a final appendix to the policy	Reading the policy	

10.2 Frequency
In each financial year, the Employee Relations (ER) Specialist Team will undertake an annual audit of 15% of formal performance/ capability related cases to ensure that this policy has been adhered to and a formal report will be written and presented at the Workforce Governance Committee.

10.3 Undertaken by
ER Specialist Team with Line Managers as appropriate.

10.4 Dissemination of Results
At the Workforce Governance Committee which is held monthly.

10.5 Recommendations/ Action Plans
Implementation of the recommendations and action plan will be monitored by the Workforce Governance Committee, which meets monthly.

10.6 Any barriers to implementation will be risk-assessed and added to the riskregister.

10.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers' cascade system.

11. REFERENCES

Advisory, Conciliation and Arbitration Service (2015): *How to Manage Performance.* Available at: http://www.acas.org.uk/media/pdf/m/0/How-to-manage-performance-advisory-booklet.pdf

Equality Act (2010) London: Stationary Office. Available at: http://www.legislation.gov.uk/ukpga/2010/15/contents

Employment Rights Act (1996) London: Stationary Office. Available at: http://www.legislation.gov.uk/uksi/2014/3091/contents/made

APPENDIX 1: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live:

Staff groups that need to have knowledge of the strategy/policy	All staff and managers Staff Side organisations
The key changes if a revised policy/strategy	Introduction of a staged process (stages 1-4) for managing performance, to bring into line with other associated HR policies; clarification regarding entitlement to pay protection for those redeployed as part of this process to a lower graded post as a result of ill health
The key objectives	To ensure a clear, consistent framework in the management of performance for managers to follow
How new staff will be made aware of the policy and manager to action	Induction and Intranet
Specific issues to be raised with staff	None
Training available to staff	Support and guidance provided by the Managers Toolkit
Any other requirements	None
Issues following Equality Impact Assessment (if any)	None
Location of hard/electronic copy of the document	On the Trust intranet, under Trust policies (M)

APPENDIX 2: RAPID IMPACT ASSESSMENT SCREENING FORM

Name of procedural document	Managing Performance (Capability) Policy
Directorate and Service Area	Human Resources, Specialist Services Team
Name, job title and contact details of person completing the assessment	[redacted] Employee Relations Manager [redacted]
Date:	25th January 2011 *Reviewed: 11th May 2015*

EXECUTIVE SUMMARY

This section summarises:

- the impacts identified for action
- mitigating action
- the likely severity of the impact as a result of that action ("result").

Impact	Action	Result
Performance issues may be caused by a disability. We could be discriminating if we do not thoroughly consider reasonable adjustments	Reasonable adjustments and appropriate support are considered throughout this policy	Risk minimised
Performance issues may be driven by conscientious objection on the grounds of belief (including religious belief). We could be discriminating if these issues are not managed appropriately	Policy highlights the possibility that performance issues could be driven by conscientious objection	Risk minimised

1. What is the main purpose of this policy / plan / service?

To set out an approach to performance management which is rigorous, fair and appropriately supportive.

2. Who does it affect? Please tick as appropriate.

Carers ☐ Staff x Patients ☐ Other (please specify)

3. What impact is it likely to have on different sections of the community / workforce, considering the "protected characteristics" below?

Protected Characteristics	Positive impact -- it could benefit	Negative impact -- it treats them less favourably or could do	Negative impact -- they could find it harder than others to benefit from it or they could be disadvantaged by it	Non-impact – missed opportunities to promote equality	Neutral -- unlikely to have a specific effect
Age	☐	☐	☐	☐	√☐
Disability	√☐	☐	☐	☐	☐
Sex *including Transgender and Pregnancy / Maternity*	☐	☐	☐	☐	√☐
Race	☐	☐	☐	☐	√☐
Religion / belief	√☐	☐	☐	☐	☐
Sexual orientation including Marriage / Civil Partnership	☐	☐	☐	☐	☐√

In identifying the impact of your policy across these characteristics, please consider the following issues:

- **Fairness -** Does it treat everyone justly?
- **Respect -** Does it respect everyone as a person?
- **Equality -** Does it give everyone an equal chance to get whatever it is offering?
- **Dignity -** Does it treat everyone with dignity?
- **Autonomy -** Does it recognise everyone's freedom to make decisions for themselves?

If you have any negative impacts, you will need to progress to a full impact assessment.

In sections 4 and 5, please copy and repeat the tables below, for each "protected characteristic" considered. Alternatively, you can use one table for more than one "protected characteristic", if the outcomes are similar.

4. If you have identified any positive impacts (see above), what will you do to make the most of them?

"Protected characteristic" affected:	Disability	
Issue	Performance issues may be caused by a disability. We could be discriminating if we do not thoroughly consider reasonable adjustments.	
Who did you ask to understand the issues or whose work did you look at?	What did you find out about?	What did you learn or confirm?
Equality & Diversity Manager, who drew upon consultation with: - Diversity Lead specialising in disability issues - Individual staff members with disabilities - Unison equality reps	Staff members' experiences of the Trust's management of disability	That performance management where a disability is driving a performance issue needs to be sensitive and supportive, avoiding the impression of being a disciplinary process That disability may go undeclared, even when it is causing performance difficulties. Managers need encouragement to sensitively draw out disability issues in such cases, so that reasonable adjustments can be made
Action as a result of above		
Action	By who?	When?
The possibility that performance issues can be disability-driven and the need to provide reasonable adjustments and seek specialist support is thoroughly integrated in the policy In policy terms, performance management and discipline are separate	Policy writer	During drafting
"Protected characteristic" affected:	Religion	
Issue	Performance issues may be caused by a conscientious objection, if staff find certain duties difficult on grounds of religion or belief	
Who did you ask to understand the issues or whose work did you look at?	What did you find out about?	What did you learn or confirm?
Equality & Diversity Manager, who drew upon: - recent articles in specialist press, especially with	Best practice and legal requirements in managing diversity of religion and belief	That this is a difficult area and the range of potential objections so broad that it would be hard to legislate for each of them directly and

regard to the Chaplin case - learning in the Trust after a previous employment case concerning religion and belief - feedback from staff during training asking for guidance on how the Trust would manage conscientious objection		specifically in the policy. The policy should therefore recognise the possibility of conscientious objection and signpost managers to HR advice, so that cases can be individually managed
Action as a result of above		
Action	By who?	When?
The policy recognises that performance issues could be driven by conscientious objection and signposts managers to HR advice where this is the case	Policy writer	During drafting

5. **If you have identified any missed opportunities ("non-impacts"), what will you do to take up any opportunities to promote equality?**

   None.

6. **If you have identified a neutral impact, show who you have consulted or asked to confirm that this is the case, in the table below:**

Who did you ask or consult to confirm your neutral impacts? (Please list groups or individuals below. These may be internal or external and should include the groups approving the policy.)

If you need help with any aspect of this assessment, please contact:
[redacted] Equality and Diversity Manager
[redacted] [redacted]