COVID-19- Infection Prevention and Control Policy

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Services	Applicable To
Trust Wide -Mental Health and Learning Disabilities & Community Health Services	✓

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Glossary

Aerosol-generating procedures (AGPs)

Certain medical and patient care activities that can result in the release of airborne particles (aerosols). AGPs can create a risk of airborne transmission of infections that are usually only spread by droplet transmission.

Airborne transmission

The spread of infection from one person to another by airborne particles (aerosols) containing infectious agents.

Airborne particles

Very small particles that may contain infectious agents. They can remain in the air for long periods of time and can be carried over long distances by air currents. Airborne particles can be released when a person coughs or sneezes, and during aerosol generating procedures (AGPs). 'Droplet nuclei' are aerosols formed from the evaporation of larger droplet particles (see droplet transmission). Aerosols formed from droplet particles in this way behave as other aerosols.

Airborne precautions

Measures used to prevent and control infection spread without necessarily having close patient contact via aerosols (less than or equal to 5µm) from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols can penetrate the respiratory system to the alveolar level.

BS/EN standards

Mandatory technical specifications created by either the British Standards Institute (BS) or European Standardisation Organisations (EN) in collaboration with government bodies, industry experts and trade associations. They aim to ensure the quality and safety of products, services and systems.

Cohort area

An area (room, bay, ward) in which 2 or more patients (a cohort) with the same confirmed infection are placed. A cohort area should be physically separate from other patients.

Contact precautions

Measures 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.

Contact transmission

Contact transmission is the most common route of transmission, and consists of two distinct types: direct contact and indirect contact. Direct transmission occurs when microorganisms are transmitted directly from an infectious individual to another individual without the involvement of another contaminated person or object (fomite). Indirect transmission occurs when microorganisms are transmitted from an infectious individual to another individual through a contaminated object or person (fomite) or person.

COVID-19

COVID-19 is an infectious respiratory disease caused by a novel coronavirus. The disease was discovered in China in December 2019 and has since spread around the world.

Droplet precautions

Measures used to prevent and control infections spread over short distances (at least 1 metre or 3 feet) via droplets (greater than 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.

Droplet transmission

The spread of infection from one person to another by droplets containing infectious agents.

Eye or face protection

Worn when there is a risk from splashing of secretion (including respiratory secretions). Eye or face protection can be achieved by the use of any one of the following:

- a surgical mask with integrated visor
- a full face visor or shield
- polycarbonate safety spectacles or equivalent

Fluid-resistant (Type IIR) surgical face mask (FRSM)

A disposable fluid-resistant mask worn over the nose and mouth to protect the mucous membranes of the wearer's nose and mouth from splashes and infectious droplets. FRSMs can also be used to protect patients. When recommended for infection control purposes a 'surgical face mask' typically denotes a fluid-resistant (Type IIR) surgical mask.

Fluid-resistant

A term applied to fabrics that resist liquid penetration, often used interchangeably with 'fluid-repellent' when describing the properties of protective clothing or equipment.

Frequently touched surfaces

Surfaces of the environment which are commonly touched or come into contact with human hands.

Healthcare or clinical waste

Waste produced as a result of healthcare activities for example soiled dressings, sharps.

High-flow nasal cannula (HFNC) therapy

HFNC is an oxygen supply system capable of delivering up to 100% humidified and heated oxygen at a flow rate of up to 60 litres per minute.

Incubation period

The period between the infection of an individual by a pathogen and the manifestation of the illness or disease it causes.

Induction of sputum

Induction of sputum typically involves the administration of nebulised saline to moisten and loosen respiratory secretions (this may be accompanied by chest physiotherapy (percussion and vibration)) to induce forceful coughing.

Infectious linen

Linen that has been used by a patient who is known or suspected to be infectious and or linen that is contaminated with blood and or other body fluids, for example faeces.

Long term health condition

This covers:

- chronic obstructive pulmonary disease, bronchitis, emphysema or asthma
- heart disease
- kidney disease
- liver disease
- stroke or a transient ischaemic attack (TIA)
- diabetes
- lowered immunity as a result of disease or medical treatment, such as steroid medication or cancer treatment
- a neurological condition, such as Parkinson's disease, motor neurone disease, multiple sclerosis (MS), cerebral palsy, or a learning disability
- any problem with the spleen, including sickle cell disease, or had spleen removed
- a BMI of 40 or above (obese)

Personal Protective Equipment (PPE)

Equipment a person wears to protect themselves from risks to their health or safety, including exposure to infection agents. The level of PPE required depends on the:

- suspected or known infectious agent
- severity of the illness caused
- transmission route of the infectious agent
- procedure or task being undertaken

Respiratory droplets

A small droplet, such as a particle of moisture released from the mouth during coughing, sneezing, or speaking.

Respiratory protective equipment

Respiratory protection that is worn over the nose and mouth designed to protect the wearer from inhaling hazardous substances, including airborne particles (aerosols). There are 2 types of respiratory protection that can be used, tight-fitting disposable FFP respirators and loose-fitting powered hoods (TH2).

FFP stands for filtering face piece. There are three categories of FFP respirator: FFP1, FFP2 and FFP3. FFP3 and loose fitting powered hoods provide the highest level of protection and are recommended when caring for patients in areas where high risk aerosol generating procedures (AGPs) are being performed. Where the risk assessment shows an FFP2 respirator is suitable, they are recommended as a safe alternative. N95 respirators are tested against different standards but are broadly equivalent to a FFP2.

Respiratory symptoms

Respiratory symptoms include:

- rhinorrhoea (runny nose)
- sore throat
- cough
- difficulty breathing or shortness of breath

Segregation

Physically separating or isolating from other people.

SARS-CoV-2

Severe acute respiratory syndrome coronavirus 2, the virus responsible for the 2019 outbreak of COVID-19 disease.

Standard infection control precautions (SICPs)

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

Single room

A room with space for one patient and usually contains (as a minimum) a bed, a locker or wardrobe and a clinical wash-hand basin.

Staff cohorting

When staff care for one specific group of patients and do not move between different patient cohorts. Patient cohorts may include for example ‘symptomatic’, ‘asymptomatic and exposed’, or ‘asymptomatic and unexposed’ patient groups.

Transmission based precautions

Additional precautions to be used in addition to SICPs when caring for patients with a known or suspected infection or colonisation.

1. Background

On 31 December 2019, the World Health Organization (WHO) was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province, China.

On 12 January 2020 it was announced that a novel coronavirus had been identified. This virus is referred to as SARS-CoV-2, and the associated disease as *Coronavirus* infectious disease (COVID-19).

2. Introduction

Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses.

Human coronaviruses can survive on inanimate objects and can remain viable for up to 5 days at temperatures of 22 to 25°C and relative humidity of 40 to 50% (which is typical of air-conditioned indoor environments).

Survival on environmental surfaces is also dependent on the surface type. SARS-CoV-2 strain can survive on plastic for up to 72 hours, for 48 hours on stainless steel and up to 8 hours on copper. Extensive environmental contamination may occur following an Aerosol Generating Procedure (AGPs).

3. Transmission

The transmission of COVID-19 is thought to occur mainly through respiratory droplets generated by coughing and sneezing, and through contact with contaminated surfaces.

During Aerosol Generating Procedure (AGPs) there is an increased risk of aerosol spread of SARS-CoV-2 irrespective of the mode of transmission (contact, droplet,) therefore airborne precautions must be implemented when performing AGP, on a suspected or confirmed case of COVID-19.

SARS-CoV-2 has been detected in blood, faeces conjunctival secretions and urine of confirmed cases should be regarded as potentially infectious when handling.

4. Incubation & Infectious Period

The incubation period is from 1 to 14 days (median 5 days). In most cases, individuals are usually considered infectious while they have symptoms; how infectious individuals are, depends on the severity of their symptoms and stage of their illness.

The median time from symptom onset to clinical recovery for mild cases is approximately 2 weeks and is 3 to 6 weeks for severe or critical cases.

As this is an emerging infection further research is required to determine asymptomatic and pre-symptomatic infection and associated transmission risk.

On the balance of current evidence is that most people will have sufficiently reduced infectivity 7 days after the onset of symptoms.

5. Case definition

Current Public Health England case definition is

- New continuous cough and/or
- fever ≥37.8°C
- A loss of, or change in, your normal sense of taste or smell (anosmia)

Clinicians should consider testing inpatients with new respiratory symptoms or fever without another cause or worsening of a pre-existing respiratory condition. Clinicians should be alert to the possibility of atypical presentations in patients who are immune-compromised.

6. Diagnostic investigations

Clinicians must arrange diagnostic sampling for individuals meeting the case definition.

Influenza testing should be considered where SARS-CoV2 is negative, in severe infections and immune-compromised patients, and in other cases where it is relevant for clinical management.

See appendix 1 on how to collect specimen sample to test for COVID-19 infection.

7. Management pathway for suspected/ confirmed cases of COVID-19 infection

For management pathway of suspected/ confirmed COVID-19 patients see appendix 2 for further details. It is encouraged to use SPACES to care approach for COVID-19 cases. See appendix 3 for further information. See appendix 4 for Do's and Don'ts on COVID-19 management.

8. Infection Prevention & Control measures- Hand Hygiene

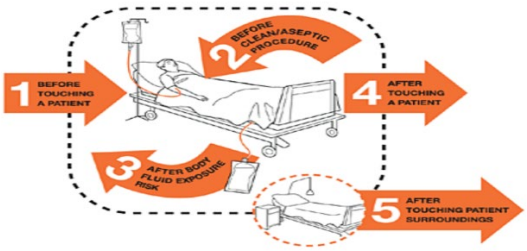
Hand hygiene is essential to reduce the transmission of infection in healthcare settings. All staff, patients and visitors should decontaminate their hands with alcohol-based hand rub (ABHR) when entering and leaving areas where patient care is being delivered.

Before performing hand hygiene:

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

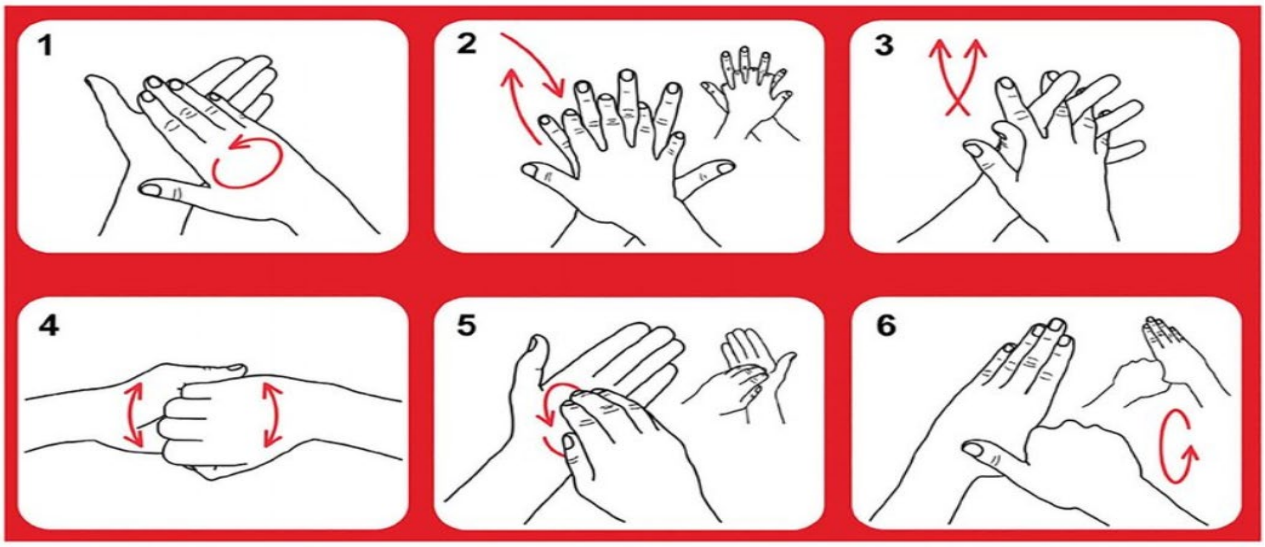
Hand hygiene must be performed during these 5 moments:

1. before touching a patient,
2. before clean/aseptic procedures,
3. after body fluid exposure/risk,
4. after touching a patient, and
5. after touching patient surroundings.



If wearing an apron, forearms may have been exposed to respiratory secretions (for example cough droplets) or other body fluids, hand washing should be extended to include both forearms. Wash the forearms first and then wash the hands using six step hand hygiene.

Six steps of hand hygiene:



9. Respiratory Cough Etiquette

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.

10. Personal protective equipment

10.1 Fluid repellent surgical mask

Fluid-resistant surgical masks (FRSM) provide barrier protection against respiratory droplets reaching the mucosa of the mouth and nose. FRSMs should be well fitted.

FRSMs are for single use or single sessional use.

Ensure fluid-resistant (blue side) side is facing outwards when wearing. FRSM must be discarded:

- when damp
- is damaged
- is soiled (for example, with secretions, body fluids)
- when uncomfortable.

10.2 Face and eye protection

Eye and face protection provides protection against contamination to the eyes from respiratory droplets, aerosols arising from AGPs and from splashing of secretions (including respiratory secretions), blood, body fluids or excretions.

Eye and face protection can be achieved by the use of any one of the following:

- surgical mask with integrated visor
- full face shield or visor
- polycarbonate safety spectacles or equivalent

*Regular corrective spectacles are not considered adequate eye protection.

While performing AGPs, a full-face shield or visor is recommended.

Disposable, single-use, eye and face protection is recommended.

Single use Sign:

However, re-usable eye and face protection is acceptable if decontaminated between use with disinfectant wipe.

It is important that the eye protection maintains its fit, function and remains tolerable for the user. Eye and face protection should be discarded and replaced if damaged, soiled (for example, with secretions, body fluids.

10.3 Disposable Aprons and Gowns

Disposable plastic aprons must be worn to protect staff uniform or clothes from contamination when providing direct patient care and during environmental and equipment decontamination.

Long sleeved disposable fluid repellent gowns/coveralls must be worn when a disposable plastic apron provides inadequate cover of staff uniform / clothes for the procedure or task being performed and when there is a risk of splashing of body fluids such as during AGPs. If non-fluid-resistant gowns are used, a disposable plastic apron should be worn.

Disposable aprons are subject to single use and must be disposed of immediately after completion of a procedure or task. Long sleeved disposable fluid repellent gowns are for single use or for single sessional use and must be discarded at the end of a session or earlier if damaged or soiled.

10.4 Disposable gloves

Disposable gloves must be worn when providing direct patient care and when exposure to blood and or other body fluids is anticipated or likely, including during equipment and environmental decontamination. Disposable gloves are subject to single use and must be disposed of immediately after completion of a procedure or task and after each patient contact. This must be followed by hand hygiene.

10.5 Filtering Face Piece Class 3 (FFP3) Respirators

Filtering face piece class 3 (FFP3) respirators are used to prevent inhalation of small airborne particles arising from Aerosol Generating Procedure (AGP). FFP3 must be worn when undertaken an AGP- See section 14 for further details on APG

All FFP3 respirators should:

- be well fitted, covering both nose and mouth
- not be allowed to dangle around the neck of the wearer after or between each use
- not be touched once put on
- be removed outside the patient room or cohort area or COVID-19 ward

Respirators can be single use or single session use (disposable) and fluid-resistant.

The Health and Safety Executive (HSE) state that all staff who are required to wear an FFP3 respirator must be fit tested for the relevant model to ensure an adequate seal or fit (according to the manufacturers' guidance). Fit checking (according to the manufacturers' guidance) is necessary when a respirator is donned to ensure an adequate seal has been achieved.

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 on the following:

- is damaged
- is soiled (for example, with secretions, body fluids)
- is damp
- facial seal is compromised
- is uncomfortable
- is difficult to breathe through

The manufacturers' guidance should be followed in regard to the maximum duration of use. FFP3 Masks can we worn up can to 6-8 hours per sessional use.

11. Sessional Use of PPE

Fluid-resistant surgical masks (FRSM), FFP3 mask, eye protection and long sleeved disposable fluid repellent gowns can be subject to single sessional use.

A single session refers to a period of time where a healthcare worker is undertaking duties in a specific clinical care setting or exposure environment. For example, a session might include taking observations of several patients in a cohort COVID-19 positive ward. A session ends when the healthcare worker leaves the clinical care. 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.

PPE should not be use if damaged, damp, soiled, compromised, uncomfortable. The duration of use of PPE items should not exceed manufacturer's instructions.

12. PPE in different environment/ settings

See appendix 5 for PPE requirements in different healthcare settings.

13. Donning and Doffing of Personal Protective Equipment

All staff using personal protective equipment must be trained on how to safely donning and doffing of PPE including the correct order to avoid cross contamination.

See appendix 6 for further details on donning and doffing of Personal Protective Equipment.

14. PPE use in Aerosol generating procedures

The highest risk of transmission of respiratory viruses is during AGPs of the respiratory tract, and use of enhanced respiratory protective equipment is indicated for healthcare workers performing or assisting in such procedures.

A long sleeved disposable fluid repellent gown /coveralls (covering the arms and body), a filtering face piece class 3 (FFP3) respirator, a full-face shield or visor and gloves are recommended during AGPs on possible and confirmed cases, regardless of the clinical setting. PPE is subject to single use with disposal after each patient contact or procedure as appropriate.

The following procedures are currently considered to be potentially infectious AGPs for COVID-19:

- manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract)
- tracheotomy or tracheostomy procedures (insertion or open suctioning or removal)
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- High Frequency Oscillatory Ventilation (HFOV)
- induction of sputum (cough)
- high flow nasal oxygen (HFNO)
- Cardiopulmonary resuscitation (*Local policy for ELFT)

For patients with possible or confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential.

15. Nebulisers

Nebulisers are not considered an AGP. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks

16. Isolation & cohort nursing

16.1 Patient placement

Wherever possible, patients with possible COVID-19 should be placed in single rooms with en-suite facilities. Confirmed COVID-19 cases should be nursed in dedicated cohort COVID-19 wards.

The prioritising of patients for isolation other than suspected or confirmed COVID-19 patients should be decided locally, in conjunction with the Infection Prevention & Control team based on the infection risk, patient's need and local resources.

16.2 Cohort Areas (Dedicated COVID-19 wards)

A designated self-contained area (ward) or wing of the ward (Exception for Forensic services) should be used for the treatment and care of patients with confirmed COVID-19 cases. This area should:

- Include a reception area that is separate from the rest of the ward.
- There must be a separate entrance/exit
- Not be used as a thoroughfare by other staff, including patients being transferred, staff going for meal breaks.
- Be separated from non-segregated areas by closed doors.
- Have signage displayed warning of the segregated area to control entry
- Please contact IPC team for support and further advice in organising dedicated COVID-19 wards/ areas.

17. Staff Cohorting

Where possible particularly in dedicated COVID-19 wards, it is advice that nursing staff are cohort to look after confirmed cases to minimise cross transmission.

In the event rapid response teams are responding emergences, it is advices that appropriate PPE is worn to ensure safety of staff.

Staff who have had confirmed COVID-19 and recovered should continue to follow the infection control precautions, including using personal protective equipment (PPE).

18. De-isolation & Discharge of patients with COVID-19

For de-isolation and discharge of patients with COVID-19 infection. Please refer to appendix 7.

19. Transfer of Suspected/Confirmed Cases and Other Duties Requiring Close Contact

Aprons, FRSMs and gloves should be used by healthcare workers transferring possible or confirmed COVID-19 cases and for other duties which require direct contact or that within 1 metre of a possible/confirmed case. Eye protection is recommended subject to risk assessment.

20. Transferred/discharge of patients with COVID-19- Moving Patients Within ELFT

- The movement and transport of patients from their single room/cohort area should be limited to essential purposes only. Staff at the receiving destination must be informed that the patient has possible or confirmed COVID-19
- where transport/movement is necessary, consider offering the patient a surgical face mask to be worn during transportation, to minimise the dispersal of respiratory droplets when this can be tolerated and providing this does not compromise clinical care
- patients must be taken straight to and returned from clinical departments and must not wait in communal areas
- If possible, patients should be placed at the end of clinical lists

21. Moving Patients between Different Hospitals

Patient transfer from one healthcare facility may be undertaken if medically necessary for specialist care arising out of complications or concurrent medical events. If transfer is essential, the ambulance service and receiving hospital must be advised in advance of the infectious status of the patient.

22. Environmental Cleaning- Covid- 19 ward areas

There is evidence for other coronaviruses of the potential for widespread contamination of patient rooms or environments, so effective cleaning and decontamination is vital.

This type of virus has been shown to be susceptible to a broad range of disinfectants including chlorine and alcohol, and to thermal inactivation (1 hour at 58 – 600C, or 30 minutes at 750C). Survival of viruses outside the body is dependent on several factors. Survival on different surfaces is dependent on a number of environmental factors (type of surface, humidity, light, concentration of virus present, etc.). It can survive for several hours when dried onto surfaces such as doorknobs and worktops, and up to several days in body fluids such as blood at room temperature. However, it is easily inactivated at higher temperatures and by soap and water.

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, in which case, clinical staff may require additional training on standards and order of cleaning. See Appendix 8 for further details

Cleaning should be with a chlorine-based disinfectant in the form of a solution at a minimum strength of 1,000ppm available chlorine. If an alternative disinfectant is used within the organisation, the local infection prevention and control team (IPCT) should be consulted on this to ensure that this is effective against enveloped viruses.

The main patient isolation room should be cleaned at least once a day. Blood and bodily fluid spills should be decontaminated promptly by clinical staff using spillage kits. Domestic staff will then provide a further clean.

There should be more frequent cleaning and disinfection of commonly used hand-touched surfaces and of anteroom or lobby areas (at least twice per day). See Appendix 8 for further details

Patient isolation rooms, cohort areas and clinical rooms must be decontaminated at least daily. Clinical rooms should also be decontaminated after clinical sessions for patients with suspected/ confirmed COVID-19 infection. See Appendix 8 for further details.

Cleaning of COVID 19 ward areas isolation areas is should be undertaken separately to the cleaning of other areas of the ward, clinical areas. (Some boroughs/units may have Rapid response COVID-19 teams). Please liaise with local Facilities monitoring offices and Estates helpdesk for further information.

23. Cleaning of re-usable Equipment

Patient care equipment should be single-use items if possible. Reusable non-invasive equipment should as far as possible be allocated to the individual patient or cohort of patients.

Reusable non-invasive equipment must be decontaminated:

- between each patient and after patient use
- after blood and body fluid contamination
- 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 using disinfectant wipes. Please refer to the Trust Infection Prevention & Control Policy manual - decontamination section for further guidance.

24. Linen and laundry Management

All linen used in the direct care of patients with possible and confirmed COVID-19 should be managed as 'infectious' linen. Linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment:

- Don PPE as donning guidance (gloves, apron, Fluid resistant surgical mask, visor/googles- if risk of splashing) when handling infectious linen
- All linen should be handled inside the patient room/cohort area. A laundry receptacle should be available as close as possible to the point of use for immediate linen deposit

When handling linen:

- do not rinse, shake or sort linen on removal from beds/trolleys
- do not place used/infectious linen on the floor or any other surfaces such as a locker/table top
- do not re-handle used/infectious linen once bagged
- do not overfill laundry receptacles
- do not place inappropriate items, such as used equipment/needles, in the laundry receptacle

When managing infectious linen:

- place directly into a water-soluble/alginate bag/ red canvas bag and secure
- place the water-soluble bag inside a clear polythene bag and secure
- place the polythene bag into in the appropriately coloured (as per local policy) linen bag

All linen bags/receptacles must be tagged with Hospital ward/care area and date. Store all used/infectious linen in a designated, safe, lockable area whilst awaiting uplift.

25. Clinical wastes

Disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment.

Clinical waste from a possible / confirmed case must be disposed of as Category B waste in line with Health Technical Memorandum 07-01: Safe management of healthcare waste.

25.1 In-patient sites and Community Clinics

The handling and removal of waste remains the same within sites which already have a clinical waste removal setup in place. However offensive waste (tiger stripe) bags should not be used for suspected or confirmed COVID- 19 cases, instead orange bio-bins or bins with orange bags should be used and the waste placed into the external clinical waste bins as per normal procedures.

25.2 Community Nursing/District Nursing (treatment at domestic properties)

These bags should be placed into another bag, tied securely and kept separate from other waste within the room. This should be put aside for at least 72 hours before being put in the usual household waste bin. PHE have confirmed that a black bag is permissible for this and it does not have to be a clinical waste sack. If clinical waste sacks were used it would cause issues with domestic waste removal companies not collect the waste.

This treatment of COVID-19 clinical waste does not then supersede any process in place for the removal of infectious waste if the service user is known to have other infectious diseases (MRSA, C.diff etc).

26. Food Service in COVID-19 areas

Food should be prepared in the same way and normal service maintained.

All food going into a contaminated area should be placed on paper disposables, covered and placed on a tray – the tray goes to the door of the contaminated area and is collected by staff behind the main barrier (wearing full PPE).

No contact is made person to person.

Food Service within the contaminated area must be managed within this space – all paper plates and plastic cutlery used must be bagged up within the area and disposed of as contaminated waste – double bag, placed within domestic waste after a period of time being stored in sluice room.

Trays wiped with clinell wipe, stacked and collected from outside of the door by Housekeeper.

Units are provided with all disposable consumables and stocked with sufficient dry stores to enable service from behind the infected area.

27. Outbreak Management

Where 2 or more cases of confirmed COVID-19 are identified Outbreak management must be followed. Please refer to the Trust Infection Prevention & Control Policy manual -outbreak management section for further guidance. Please refer to Appendix 10.

28. Identification of Contacts Patient Exposures

In-patients who are known to have been exposed to a confirmed COVID-19 patient should be isolated or cohorted until 14 days after last exposure.

If symptoms or signs consistent with COVID-19 occur in the 14 days after exposure, then relevant COVID-19 diagnostic tests 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. Please refer to Appendix 11.

29. Reporting to Public Health England (PHE)

During outbreaks, the local PHE health protection team should be informed of confirmed COVID-19 cases of outbreak. Local Clinicians/ Borough Lead Nurses/IPC nurses need to call PHE when outbreak has been declared. An ILOG number is provided from PHE- please ensure this ILOG is shared with Infection Prevention & Control team.

29.1 Contact Details for Notification of Infectious Disease

Area	Address & Contact details
East London	PHE North East and North Central London Health Protection Team, Ground Floor South Wing, Fleetbank House 2-6 Salisbury Square, London, EC4Y 8AE necl.team@phe.gov.uk; nencl.hpu@nhs.net Phone: 020 3837 7084 (option 1) Fax: 020 3837 7086 Out of hours: 020 7191 1860
Luton & Bedfordshire	PHE East of England Health Protection Team, Second Floor Goodman House, Station approach Harlow, Essex, CM20 2ET EastofEnglandHPT@phe.gov.uk; phe.EoEHPT@nhs.net Phone: 0300 303 8537 option 1 Out of hours for health professionals only: phone 01603 481 221

30. Notifiable disease – reporting to Public Health England

Covid-19 is a notifiable disease and must be reported to Public Health England –local Health Protection team.

Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local health protection team (HPT) of suspected cases of certain infectious diseases.

All suspected and confirmed cases of COVID-19 need to be reported by medical/ nursing team to Infection Prevention & Control department. The Infection Prevention & Control team will report centrally to Public Health England Local Health Protection team of NOIDS infection.

31. Managing visitors

Visitors to all areas of the healthcare facility should be line with Visitor guidance standard operating procedure (please refer to this document). A local risk assessment and practical management should be considered, ensuring this is a pragmatic and proportionate response, including the consideration of whether there is a requirement for visitors to wear PPE.

All visitors entering a segregated/cohort area must be instructed on hand hygiene. They must not visit any other care area.

Signage to support restrictions is critical. Visitors with COVID-19 symptoms must not enter the healthcare facility. Visitors who are symptomatic should be encouraged to leave and must not be permitted to enter areas where there are extremely vulnerable (shielding) patients.

32. Staff Uniform

The appropriate use of personal protective equipment (PPE) will protect staff uniform/work clothing from contamination in most circumstances.

- Staff working in high risk areas can wear scrubs/ uniform (polo t-shirt & trousers).
- Staff working in low risk areas can wear their work clothing in line with Trust Uniform policy.
- In services where scrubs have been arranged to be laundered within the local health care facility. Scrubs need to be placed into a red bag and follow the Trust's policy of 'infectious linen' management.
- Only change your scrubs on a shift basis unless they become soiled and please do not take them home or stockpile.
- All staff must change into personal clothes for travel to and from work whether they are wearing uniform or scrubs.
- Uniforms and scrubs must be transported home in a disposable plastic bag or a donated uniform bag that can be washed with the uniform. If using a plastic bag, then this should be disposed of into the household waste stream.

Uniforms/wear clothing should be laundered:

- Separately from other household linen
- Do not load more than half the machine capacity
- Washed at 60 degrees for 10 minutes- effective to kill COVID-19
- For work wear, wash clothing at the maximum temperature the fabric can tolerate, then ironed or tumbled-dried

33. Claim the Cost of Uniform Cleaning

If you are now wearing a uniform at work, you can claim laundry tax relief costs online. Find out more from the Royal College of Nursing website here. Complete a HMRC Online Claim Form.

Note: It is best practice to change into and out of uniforms at work. This does not apply to community healthcare workers who are required to travel between patients. However, staff are advise changing out of uniforms at the end of shifts.

34. Fans

Avoid the use of fans that re-circulate the air. Please refer to IPC policy manual on further guidance on fan use.

35. Crockery & Cutlery

There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed in a dishwasher. If there is no access to dishwashing processing, disposable cutlery should be used.

36. Resuscitation

Cardiopulmonary resuscitation is considered an aerosol generating procedure and therefore staff must wear full PPE (long sleeve gown, apron, including FFP3 mask and visor to safely perform CPR).

For resuscitation- please refer to COVID-19 Cardiopulmonary resuscitation Standard Operating procedure.

37. Management of Patient's property

Patients clothing/ fabric items to be washed in 60 degrees. Hard items to be cleaned with disinfectant wipes (Clinell). Items unable to clean or disinfect should be double bagged stored for 72 hours and then discarded as domestic waste.

38. Handling the deceased

Those handling bodies should be aware that there is likely to be a continuing risk of infection from the body fluids and tissues of cases where COVID-19 (SARS-CoV2) infection is confirmed.

Whilst deceased individuals remain in the care environment, FRSM, apron, gloves, and visor (if risk of splashing) should be used, this is due to the ongoing risk of infectious transmission via contact. No additional precautions are needed unless Aerosol Generating Procedures (AGPs) are being undertaken.

Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag. However body bags may be used at the request of funeral director. For handling the decease please refer to the Standard Operating Procedure Care after death with confirmed or suspected COVID-19.

39. Healthcare Staff Exposure

Healthcare staff exposure should be on an individual risk assessment based on staff circumstances, for example for those who are immunocompromised. Please refer to appendix 12 and https://www.gov.uk/government/publications/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings/covid-19-management-of-exposed-healthcare-workers-and-patients-in-hospital-settings

HCWs should:

- Not attend work if they develop symptoms (cough & or fever above 37.8 degrees, a loss of, or change in, your normal sense of taste or smell (anosmia) while at home (off-duty), and notify their line manager immediately
- while at work, they should put on a surgical face mask immediately, inform their line manager and return home
- Staff can get tested for COVID-19. For further details see here https://www.gov.uk/guidance/coronavirus-covid-19-getting-tested

If the HCW's symptoms do not get better after 7 days, or their condition gets worse, they should speak to their occupational health department Team Prevent or use, call NHS 111. For a medical emergency dial 999.

References

- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/881489/COVID-19_Infection_prevention_and_control_guidance_complete.pdf
- https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/transmission-characteristics-and-principles-of-infection-prevention-and-control
- https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/reducing-the-risk-of-transmission-of-covid-19-in-the-hospital-setting
- https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe
- https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/phe-statement-regarding-nervtag-review-and-consensus-on-cardiopulmonary-resuscitation-as-an-aerosol-generating-procedure-agp
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877533/Routine_decontamination_of_reusable_noninvasive_equipment.pdf
- https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/877531/Best_Practice_management_of_blood_body_fluid_spillages.pdf

Appendices

Appendix 1- How to take a specimen for COVID-19

1. Collection of nasopharyngeal swab(s)

- For collection of nasopharyngeal swabs (for example, for COVID-19 diagnostic purposes) plastic aprons, FRSMs, eye protection and gloves should be used.

2. Samples required for initial diagnostic testing

2.1 Upper respiratory tract sample(s): single swab used for throat then nose into one pot of viral transport medium; a viral nose swab and a viral throat swab combined into one pot of viral transport medium, or a nasopharyngeal aspirate in a universal transport pot. Bacterial or charcoal swabs are not suitable.

2.2 Lower respiratory tract sample (sputum) if obtainable, in universal container

2.3 Important points about sample-labelling and request forms include:

- label each sample with ID, date of birth and type of sample
- use the specific form for requesting COVID-19 acute respiratory disease testing (E28), one form for each sample
- do not place paperwork (request forms) in the primary container for Category B transport
- request form must include a contact phone number for sharing of results
- samples without appropriate paperwork will not be tested or testing will be delayed

3. Sending samples to the testing laboratory

All samples for COVID-19 testing should be packaged and transported in accordance with Category B transportation regulations and labelled 'Priority 10'. UN 3373 packaging must be used for sample transport.

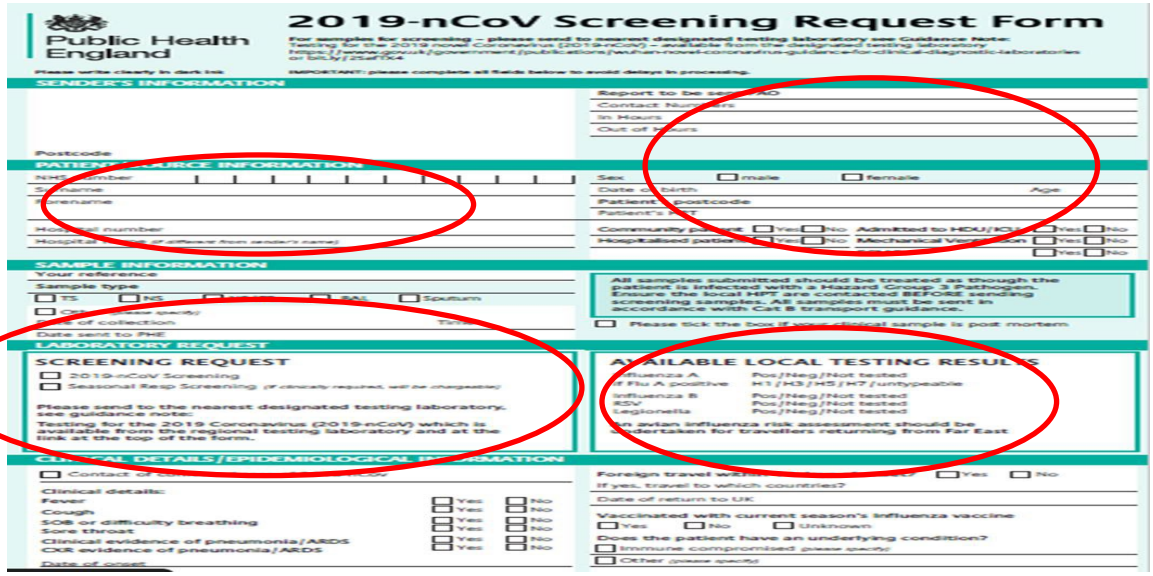
Further guidance is given on packaging and transport of samples in safe handling and processing for laboratories. PHE follows the World Health Organization (WHO) guidance on regulations for the transport of infectious substances 2019-2020.

Equipment for Specimens Collection:

Items for taking a COVID-19 swab		
Virology swabs	1	
Pathology Bio Hazard plastic sample bag **(Double bag specimen)**	2	
Specimen form	1	https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/875209/COVID19_E28_form_V4_24-03-2020.pdf

Preparation

- Take appropriate PPE and waste
- Take sufficient virology swabs and bags for sample collection – each swab will be placed in a regular sample bag and a second **BIOHAZARD** - labelled bag
- Pre-label each swab container with name, date of birth,
  NHS or hospital number if known
- Print out and Complete PHE form as shown before taking swab
- Place completed PHE form in the **BIOHAZARD**-labelled bag to be used

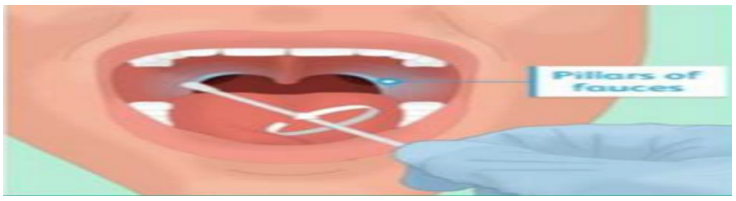


2019-nCoV Screening Request Form

Public Health England

- Enter patient information
- Name
- Date of birth
- NHS number

1. Once PPE has been put on take the swab & pre-labelled swab container as well as a plastic sample bag
2. Collect a throat and nose swab using a single swab. This can be done by swabbing the throat or nose first
3. Place swab in the swab container, break swab and seal container as in picture to the left
4. Place sealed sample container in the sample bag & seal bag
5. Keep the broken end of the swab to discard in waste bag
6. Discard broken swab end into the waste bag
7. Remove your PPE
8. Clean hands with alcohol gel / wash hands with soap and water



Public Health England

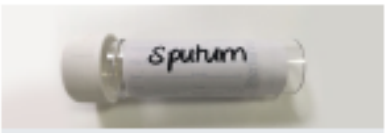
NHS

Suspected COVID-19 cases

Sampling and Packaging

Diagnostic samples for suspected cases

1. Upper respiratory tract sample options:
   - individual nose and throat swabs in separate collection tubes OR
   - combined nose and throat swab in one collection tube containing universal transport medium OR
   - single swab used for throat then nose OR
   - nasopharyngeal aspirate.



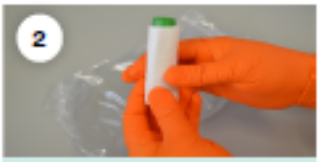
2. Lower respiratory tract sample in universal container (sputum) if obtainable.

If the patient is admitted, take a sample for acute serology: 5mL in either serum tube or plain (no additive) tube. For children <12 years, 1mL is acceptable.

Packaging

Note: Picture uses the example of a bio bottle. Other packaging can be used providing either the primary receptacle or the secondary packaging is capable of withstanding an internal pressure of 95 kPa.

Ensure lids are tight and decontaminate outside. Careful not to cross thread



Wrap sample with absorbent material

Individually place into zip-lock bag

Seal zip-lock bag & change gloves

Add all wrapped samples into second bag

Wrap bagged samples in ample packaging & place into secondary packaging (bio bottle example as shown)

Firmly attach lid (or seal bag if alternative packaging used)

Ensure E28 request forms for each individual sample are OUTSIDE the secondary packaging

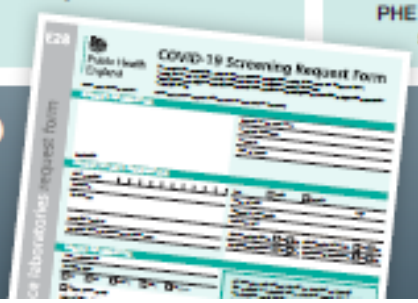
Place E28 request forms & bio-bottle into transport box & add security seal

Label box with 'Priority 10', you can download the labelling template at bit.ly/2vrRNxT

Courier all samples to PHE via Category B UN3373. PHE is open to receive samples 24/7

Download the request form for COVID-19 (formerly novel coronavirus 2019-nCoV)

www.gov.uk/government/publications/testing-for-wuhan-novel-cov-2019-ncov



Appendix 2- Management pathway of COVID-19 infection- Mental Health Inpatient settings

Management Pathway of COVID-19 infection- Mental Health Inpatient settings

Swab new admission or patient with new continuous cough and/or fever ≥37.8°C or a loss of, or change in, your normal sense of taste or smell (anosmia)

New admission/ patients that meet the current case definition for Covid-19 infection commence Respiratory Isolation immediately – give patient surgical mask if it's save to do so, ask to stay in the bedroom and keep door closed. Ideally the patient should be placed in a room with en- suite facility.

In the event of non-compliance with isolation please refer to compulsory isolation guidance on ELFT intranet

Samples should be collected as per Collection of Covid-19 Lab Samples guidance. Immediate review with involving Senior Duty Nurse & Infection Prevention Control team –telephone: 0208 121 5562 or email elft.infectioncontrol@nhs.net

Wear Fluid repellent surgical mask, apron, gloves, & eye protection if blood/ body fluids splashing. Follow PHE guidance for both: Putting on PPE and Removal of PPE. Staff entering the room should be kept to minimal. Use SPACES to care approach. PPE should be removed immediately on exiting the room/ward and placed in a foot pedal clinical waste bin.

Physical examination including observations should be performed as required. Use disposable equipment if possible or decontaminate with Green Clinell / disinfectant wipe. The patient should remain in the room with the door closed. Belongings and waste should be placed in paper bags only and should remain in the patient's room.

Avoid patient movement/transfer.

If the patient is critically ill and requires urgent ambulance transfer to acute hospital, inform the ambulance call handler of the concerns about suspected/confirmed Covid-19 infection. Please also contact IPC team for further advice.

Patient to be nursed in isolation for 14 days, until step down from isolation measures. Follow de-isolation pathway. Contact Infection Control team for further advice.

Appendix 2- Management pathway of COVID-19 infection- Physical Health Inpatient setting

Management Pathway of COVID-19 infection- Physical Health Inpatient settings

Swab new admission or patient with new continuous cough and/or fever ≥37.8°C or a loss of, or change in, your normal sense of taste or smell (anosmia)

↓

New admission/ patients that meet the current case definition for Covid-19 infection commence Respiratory Isolation immediately – give patient surgical mask if it's save to do so, ask to stay in the bedroom and keep door closed. Ideally the patient should be placed in a room with en- suite facility.

↓

Samples should be collected as per Collection of Covid-19 Lab Samples guidance. Immediate review with involving Senior Nurse & Infection Prevention Control team –telephone: 0208 121 5562 or email elft.infectioncontrol@nhs.net

↓

Wear Fluid repellent surgical mask, apron, gloves, & eye protection if blood/ body fluids splashing. Follow PHE guidance for both: Putting on PPE and Removal of PPE. Staff entering the room should be kept to minimal. Use SPACES to care approach. PPE should be removed immediately on exiting the room/ward and placed in a foot pedal clinical waste bin.

↓

Physical examination including observations should be performed as required. Use disposable equipment if possible or decontaminate with Green Clinell / disinfectant wipe. The patient should remain in the room with the door closed. Belongings and waste should be placed in paper bags only and should remain in the patient's room.

↓

Avoid patient movement/transfer.

If the patient is critically ill and requires urgent ambulance transfer to acute hospital, inform the ambulance call handler of the concerns about suspected/confirmed Covid-19 infection. Please also contact IPC team for further advice.

Appendix 2- Management pathway COVID-19 infection- Community Mental & Physical Health Services

Management pathway COVID-19 infection- Community Mental & Physical Health Services

Pre Home Visit Checklist

Phone call to the patient and ask the following:

- Do they have a new continuous cough?
- Do they have a high temperature?
- Do they have a loss of, or change in, your normal sense of taste or smell (anosmia)?
- Does anyone in the household have the above?
- Has the patient been discharged from an inpatient unit in last 7 days?

Complete visit with 1 nurse, 2 if the patient is a 'double up' visit.

PPE to be worn – Gloves/aprons/face mask with visor or goggles. Goggles need to be thoroughly cleaned after each use with Green Clinell wipes, and allow to dry thoroughly before use.

Clinical waste must be double bagged, dated and transported back to base for disposal or stored for 72 hours

Remember to document on RIO/EMIS/ S1 reminders that the patient is either 'suspected' or 'confirmed positive' so all staff are aware.

Complete Datix for possible or suspected COVID-19

Ensure that all COVID-19 related care plans are implemented onto the patients records on RIO/EMIS/ S1

No

- Visit to be completed by 1 nurse
- PPE to be worn – Gloves/aprons/mask without visor /goggles if risk of splashing.
- Waste must be double bagged; then transported back to base and disposed of as clinical waste.
- **DO NOT REUSE MASKS. Changed at each visit.**

Document visit as required on RIO/EMIS/ S1

Appendix 2- Management pathway COVID-19 infection- Specialist Children & Young people's Services

Management pathway COVID-19 infection- Community Health Services

Pre Home Visit Checklist

Phone call to the patient and ask the following:

- Do they have a new continuous cough?
- Do they have a high temperature?
- Do they have a loss of, or change in, your normal sense of taste or smell (anosmia)?
- Does anyone in the household have the above?
- Has the patient been discharged from an inpatient unit in last 7 days?

Complete visit with 1 nurse, 2 if the patient is a 'double up' visit.

Enhanced PPE to be worn – Gloves/gowns/ FFP3 face mask with visor /goggles. Goggles need to be thoroughly cleaned after each use with Green Clinell wipes, and allow to dry thoroughly before use.

Clinical waste must be double- bagged, dated and transported back to base for disposal or kept separate from other waste within a room in safe storage for at least 72 hours before being put in the usual household waste bin

Remember to document on RIO reminders that the patient is either 'suspected' or 'confirmed positive' so all staff are aware.

Complete Datix for possible or suspected COVID-19

Ensure that all COVID-19 related care plans are implemented onto the patients records on RIO

No

- Visit to be completed by 1 nurse
- PPE to be worn – Gloves/Gowns / FFP3 mask without visor /goggles if risk of splashing.
- Waste must be double bagged; then transported back to base and disposed of as clinical waste.
- **DO NOT REUSE MASKS. Changed at each visit.**

Document visit as required on RIO/EMIS/ S1

Appendix 2- Management pathway COVID-19 infection- Learning Disabilities Setting

Management pathway COVID-19 infection- Learning Disabilities Services

Pre Home Visit Checklist

Call the person or their carer/s and ask do they have the most common symptoms of coronavirus (COVID-19) and ask the following:

- Do they have a new continuous cough?
- Do they have a high temperature?
- Do they have a loss of, or change in, your normal sense of taste or smell (anosmia)?
- Does anyone in the household have the above?

*For most people, coronavirus (COVID-19) will be a mild infection but people who have a learning disability fall into a high risk group due to physical health co-morbidities

Yes

HOLD VISIT – Please escalate this via your clinical team for discussion - consider the need for reasonable adjustments. Is this person shielding? Does this need an alternative approach?

Clinical Team to assess the need for the visit

If visit is required, 2 members of staff must visit, one to complete the visit, one to assist with donning and doffing procedure.

Ensure that appropriate PPE is used (for Dysphagia, Ear Care and Physio visits, please consider whether this will be an AGP). – Gloves/gowns/ FFP3 face mask with visor /goggles.

If visit can be delayed, please consider alternative contact – video/phone call and record reasons for decision to delay

Provide Clinical Advice via the telephone as necessary recorded on the relevant clinical system (MOSAIC/RIO/alternative systems)

No

Visit as normal with one member of staff with PPE – gloves, mask and aprons. Mask/googles where necessary

Appendix 3- SPACES to care approach for COVID-19

British Thoracic Society | Royal College of Nursing | Royal College of Physicians

ADD SPACES

To your COVID ward care approach

TO MINIMISE TEAM MEMBER CONTACT WITH SUSPECTED OR PROVEN COVID-19 PATIENTS

SHARING

PATIENT

ASSESSMENTS

CUTS

EXPOSURE (FOR)

STAFF

ANY HEALTHCARE WORKER ATTENDING TO A SUSPECTED OR A PROVEN COVID-19 PATIENT SHOULD DO THE FOLLOWING IN ONE VISIT.

CHECK COMFORT/POSITION

TAKE IN NEW FOOD TRAY, REMOVE OLD FOOD TRAY

ASSESS AND REPORT:
PULSE AND BLOOD PRESSURE
SpO_2 WITH FiO_2 DOCUMENTED
RESPIRATORY RATE (RHYTHM, EFFORT)
TEMPERATURE

AND ASK HOW IS/ARE YOUR:
COUGH AND BREATHLESSNESS
APPETITE
FLUID INTAKE
PAIN
BOWELS AND PASSING URINE

RECORD ALL THE ABOVE OBSERVATIONS (including NEWS chart)

SWITCH TO REMOTE CONSULTATIONS
WHERE POSSIBLE, USE:

PHONES
2-WAY RADIOS
INTERCOMS

AND ANY OTHER SUITABLE WAY THAT REDUCES FACE TO FACE CONTACT

WHERE THIS IS FEASIBLE AND DOES NOT COMPROMISE:

PATIENT CARE/SAFETY/WELLBEING

PHE personal protective equipment guidance should be followed at all times

Appendix 4-Do & Don'ts for suspected or known COVID-19

Do's ✓	Don'ts X
Wear the correct PPE every time you enter the room regardless of the reason or length of time you will be in the room? *(Gloves, Apron and Fluid Resistant Surgical Face Mask (FRSFM) Unless undertaking an aerosol generating procedure)*	Don't come out of the room in your PPE – even just to collect something *(All PPE should be removed inside the room other than FFP3 Masks)*
Undertake hand hygiene following removal of PPE *(Even if your hands look clean)*	Don't take anything into the room that isn't essential equipment *(Complete paperwork outside the room)*
Remove wristwatches, Fitbits, stoned rings and expose forearms before undertaking hand hygiene*(This is required even if hands are decontaminated with alcohol based hand rub)*	Don't remove equipment from the room unless it has been cleaned with disinfectant wipes.
Treat all linen as contaminated*(Place directly into in a water soluble/alginate bag; then into a clear plastic bag before placing in the laundry receptacle) Mental Health use red bag*	When wearing FRSFM/FFP3 don't touch the front of the mask *(The front of your mask will be at higher risk of being contaminated)*
Wear visor if there is a risk of splashing/spraying from patients coughing or sneezing	Don't eat in the clinical area. *Surfaces could be contaminated*
Avoid touching surfaces in the patients room*(Organisms can live on hard surfaces and fabrics)*	Don't re-use single use equipment *Look for the single use symbol*
Educate the patient on respiratory and cough etiquette. Provide tissues, disposable bag and hand hygiene advice. *(Catch it, bin it, kill it)*	Don't use Alcohol Based Hand Rub on your gloves. *Gloves should be changed immediately after each patient and/or following completion of a procedure or task*
Use single use items if possible or equipment is dedicated to patient while in isolation/cohort room	Don't use disposable crockery, cutlery, trays or water jugs Items can be processed as normal.
Remove all PPE inside the room other than FFP3 Masks which must be removed outside the room.	**Don't hesitate to contact the IPCT with your questions. No question is too silly**

Appendix 5- Personal Protective Equipment

All Inpatient and Community Mental/ physical Health services PPE requirements:

Item	Amount required	Use
Apron	1	Single use
Gloves	1	Single use gloves- Must not be re-used
Visor/ googles *risk assess for risk of splashing/splitting	1	Can be cleaned with disinfectant wipe and re-used
Fluid repellent surgical mask	1	Can be used up to 4- 6 hours per sessional activity or when damp. Follow manufacturer recommendations

Appendix 5- Personal Protective Equipment

For Aerosol generating procedures & CPR PPE:

Item	Amount required	Use
Gown /coveralls	1	Can be used per sessional activity
Visor/googles	1	Can be cleaned with disinfectant wipe and re-used
Gloves	1	Single use
FFP3 mask	1	Can be used up to 6- 8 hours or depending on manufacturer recommendations

Appendix 5- Personal Protective Equipment

For Healthcare staff in NHS environments/Health & Social care environments:

Item	Amount required	Use
Fluid repellent surgical mask	1	Can be used up to 4- 6 hours per sessional activity or when damp. Follow manufacturer recommendations

Appendix 6- Donning Personal Protective Equipment

Public Health England

Putting on personal protective equipment (PPE)

for non-aerosol generating procedures (AGPs)*

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

Pre-donning instructions:

- Ensure healthcare worker hydrated
- Tie hair back
- Remove jewellery
- Check PPE in the correct size is available

1. Perform hand hygiene before putting on PPE.

2. Put on apron and tie at waist.

3. Put on facemask – position upper straps on the crown of your head, lower strap at nape of neck.

4. With both hands, mould the metal strap over the bridge of your nose.

5. Don eye protection if required.

6. Put on gloves.

*For the PPE guide for AGPS please see:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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Appendix 6- Doffing Personal Protective Equipment

Public Health England

Taking off personal protective equipment (PPE)

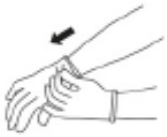
for non-aerosol generating procedures (AGPs)*

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

- **PPE should be removed in an order that minimises the risk of self-contamination**
- **Gloves, aprons (and eye protection if used) should be taken off in the patient's room or cohort area**

1 Remove gloves. Grasp the outside of glove with the opposite gloved hand; peel off.

Hold the removed glove in the remaining gloved hand.



Slide the fingers of the un-gloved hand under the remaining glove at the wrist.

Peel the remaining glove off over the first glove and discard.

2 Clean hands.

3 Apron.

Unfasten or break apron ties at the neck and let the apron fold down on itself.

Break ties at waist and fold apron in on itself – do not touch the outside – **this will be contaminated.** Discard.

4 Remove eye protection if worn.

Use both hands to handle the straps by pulling away from face and discard.

5 Clean hands.

6 Remove facemask once your clinical work is completed.

Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only. Lean forward slightly. Discard. DO NOT reuse once removed.

7 Clean hands with soap and water.

*For the PPE guide for AGPS please see: www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

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Appendix 6- Donning AGP Personal Protective Equipment

COVID-19

Public Health England

Quick guide – gown version

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

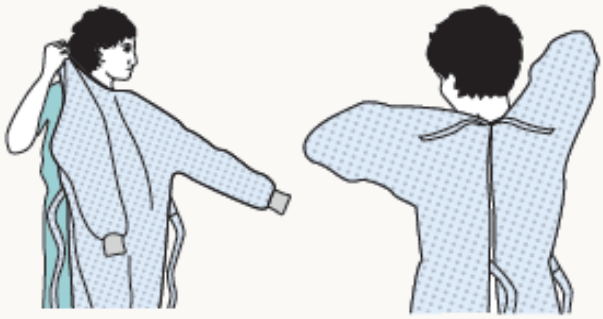
This is undertaken outside the patient's room.

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Perform hand hygiene before putting on PPE

1 **Put on the long-sleeved fluid repellent disposable gown**



2 **Respirator**

Perform a fit check.

3 **Eye protection**

4 **Gloves**

Appendix 6- Doffing AGP Personal Protective Equipment

COVID-19

Public Health England

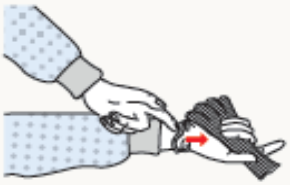
Quick guide – gown version

Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

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

The order of removal of PPE is as follows:

1 **Gloves –** the outsides of the gloves are contaminated



Clean hands with alcohol gel

2 **Gown –** the front of the gown and sleeves will be contaminated

3 **Eye protection -** the outside will be contaminated

4 **Respirator**

Clean hands with alcohol hand rub. Do not touch the front of the respirator as it will be contaminated

5 Wash hands with soap and water

Appendix 6- Donning Coveralls Personal Protective Equipment

Public Health England

Putting on (donning) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

Use safe work practices to protect yourself and limit the spread of infection

- keep hands away from face and PPE being worn
- change gloves when torn or heavily contaminated
- limit surfaces touched in the patient environment
- regularly perform hand hygiene
- always clean hands after removing gloves

Pre-donning instructions

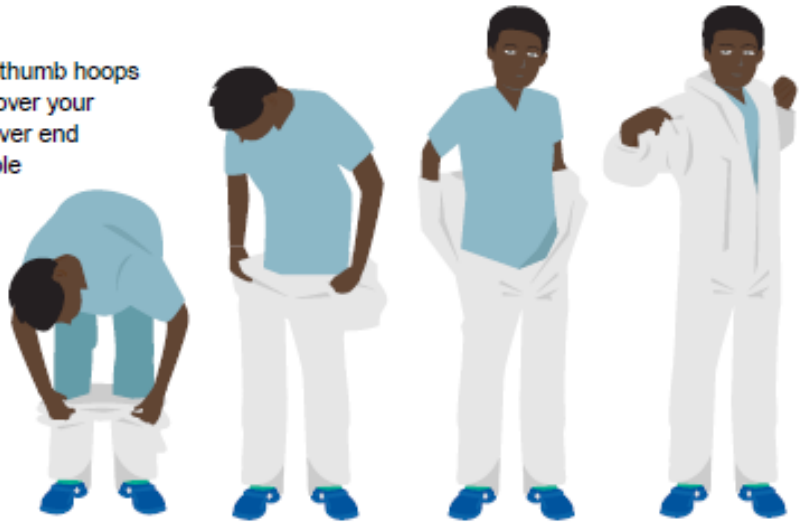
- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Putting on personal protective equipment (PPE). The order for putting on is coverall, respirator, eye protection and gloves. This is undertaken outside the patient's room.

1 Don the coveralls

- Step into coveralls
- Pull up over waist
- Insert arms into sleeves, if thumb hoops available then hoop these over your thumbs, ensure sleeves cover end of gloves so no skin is visible
- Pull up over the shoulders
- Fasten zip all the way to the top

Do not apply the hood of the coverall as there is no requirement for airborne transmission.



Appendix 6- Donning Coveralls Personal Protective Equipment

Putting on (donning) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

2 Respirator

Note: this must be the respirator that you have been fit tested to use. Eye protection always be worn with a respirator. Where goggles or safety spectacles are to be worn with the respirator, these must be worn during the fit test to ensure compatibility.

Position the upper straps on the crown of your head, above the ears and the lower strap at the nape of the neck.

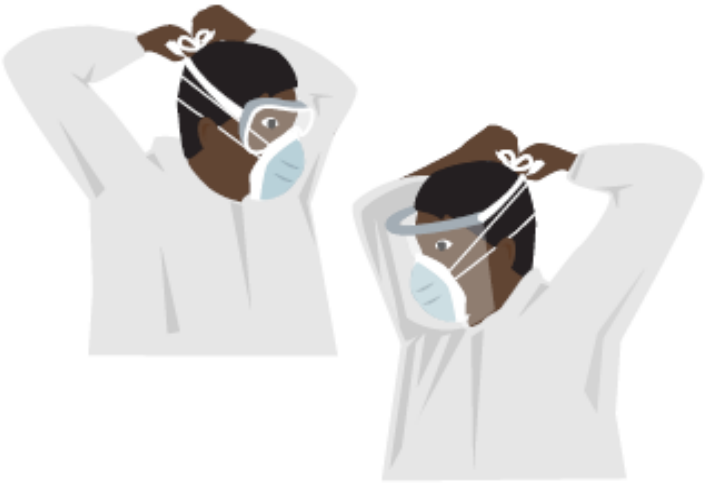
Ensure that the respirator is flat against your cheeks. With both hands mould the nose piece from the bridge of the nose firmly pressing down both sides of the nose with your fingers until you have a good facial fit.

If a good fit cannot be achieved DO NOT PROCEED. Perform a fit check.

The technique for this will differ between different makes of respirator. Instructions for the correct technique are provided by manufacturers and should be followed for fit checking.

3 Eye protection

Place over face and eyes and adjust the headband to fit



4 Gloves

- Select according to hand size
- ensure cuff of coverall is covered by the cuff of the glove

Appendix 6- Doffing Coveralls Personal Protective Equipment

Public Health England

Removal of (doffing) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination. PPE is to be removed carefully in a systematic way before leaving the patient's room i.e. gloves, then gown/coverall and then eye protection.

The FFP2/3 respirator must always be removed outside the patient's room. Where possible in a dedicated isolation room with ante room or at least 2m away from the patient area.

This is to reduce the risk of the healthcare worker removing PPE and inadvertently contaminating themselves or the patient while doffing.

The FFP2/3 respirator should be removed in the anteroom/lobby. In the absence of an anteroom/lobby, remove FFP2/3 respirator in a safe area (e.g., outside the isolation room). All PPE must be disposed of as infectious clinical waste.

1 Firstly, grasp the outside of the outside of the glove with the opposite gloved hand; peel off

Hold the removed glove in gloved hand

Then, slide the fingers of the ungloved hand under the remaining glove at the wrist

Peel the remaining glove off over the first glove and discard

Clean hands with alcohol hand gel or rub

Appendix 6- Doffing Coveralls Personal Protective Equipment

Removal of (doffing) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

2 Remove coveralls

- Tilt head back and with one hand pull the coveralls away from your body
- With other hand run your hand up the zip until you reach the top and unzip the coveralls completely without touching any skin, clothes or uniform following the guidance of your buddy
- Remove coveralls from top to bottom. After freeing shoulders, pull arms out of the sleeves
- Roll the coverall, from the waist down and from the inside of the coverall, down to the top of the shoes taking care to only touch the inside of the coveralls
- Use one shoe covered foot to pull off the coverall from the other leg and repeat for second leg. Then step away from the coverall and dispose of it as infectious waste

3 Clean hands with alcohol hand gel or rub

4 Eye protection

(preferably a full face visor – goggles can be used as an alternative) – the outside will be contaminated

To remove, use both hands to handle the restraining straps by pulling away from behind and discard

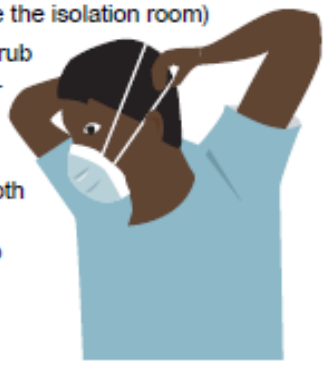
5 Respirator

In the absence of an anteroom/lobby remove FFP2/3 respirators in a safe area (e.g., outside the isolation room)

Clean hands with alcohol hand gel or rub

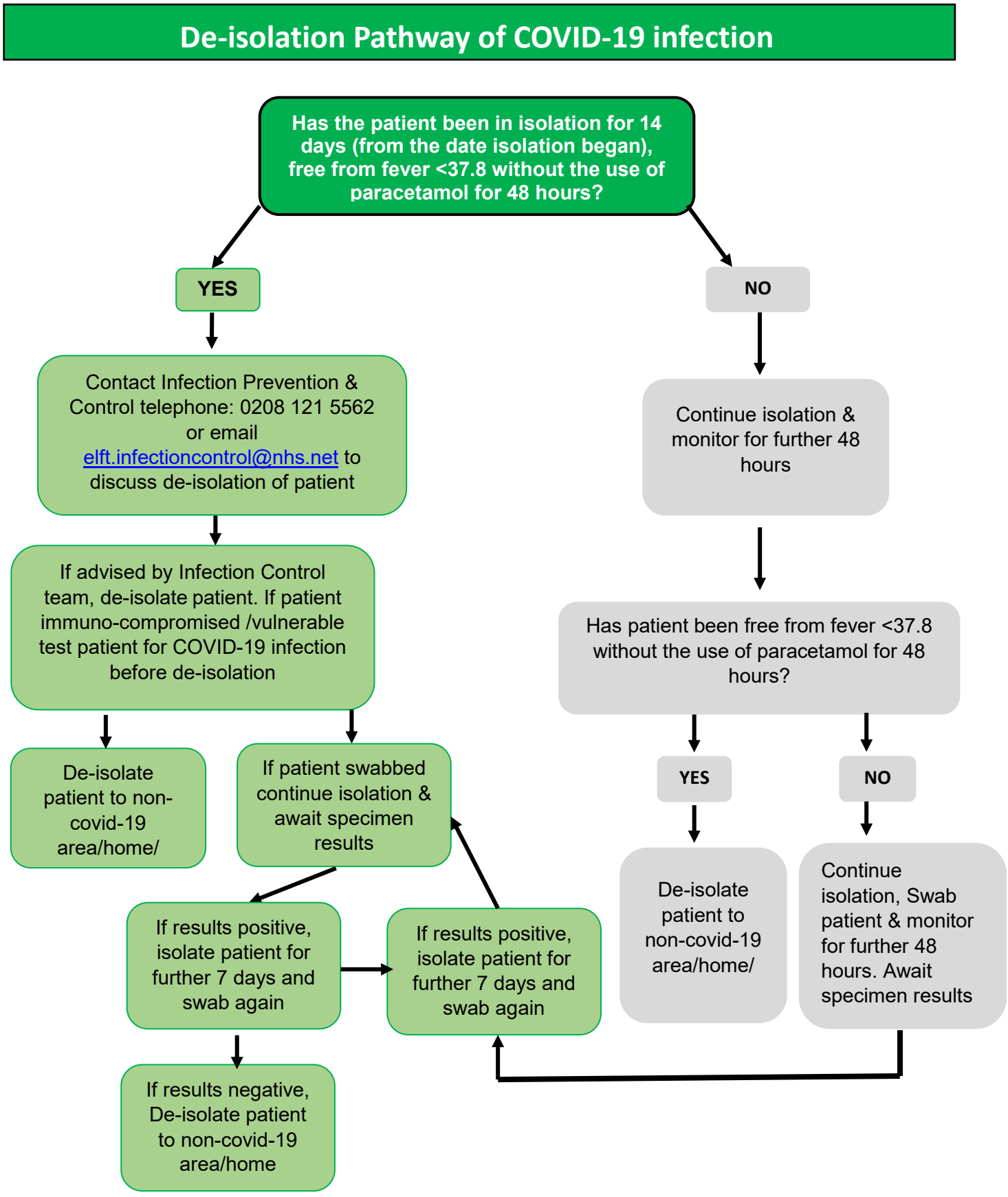
Do not touch the front of the respirator as it will be contaminated

- lean forward slightly
- reach to the back of the head with both hands to find the bottom restraining straps and bring it up to the top strap
- lift straps over the top of the head
- let the respirator fall away from your face and place in bin

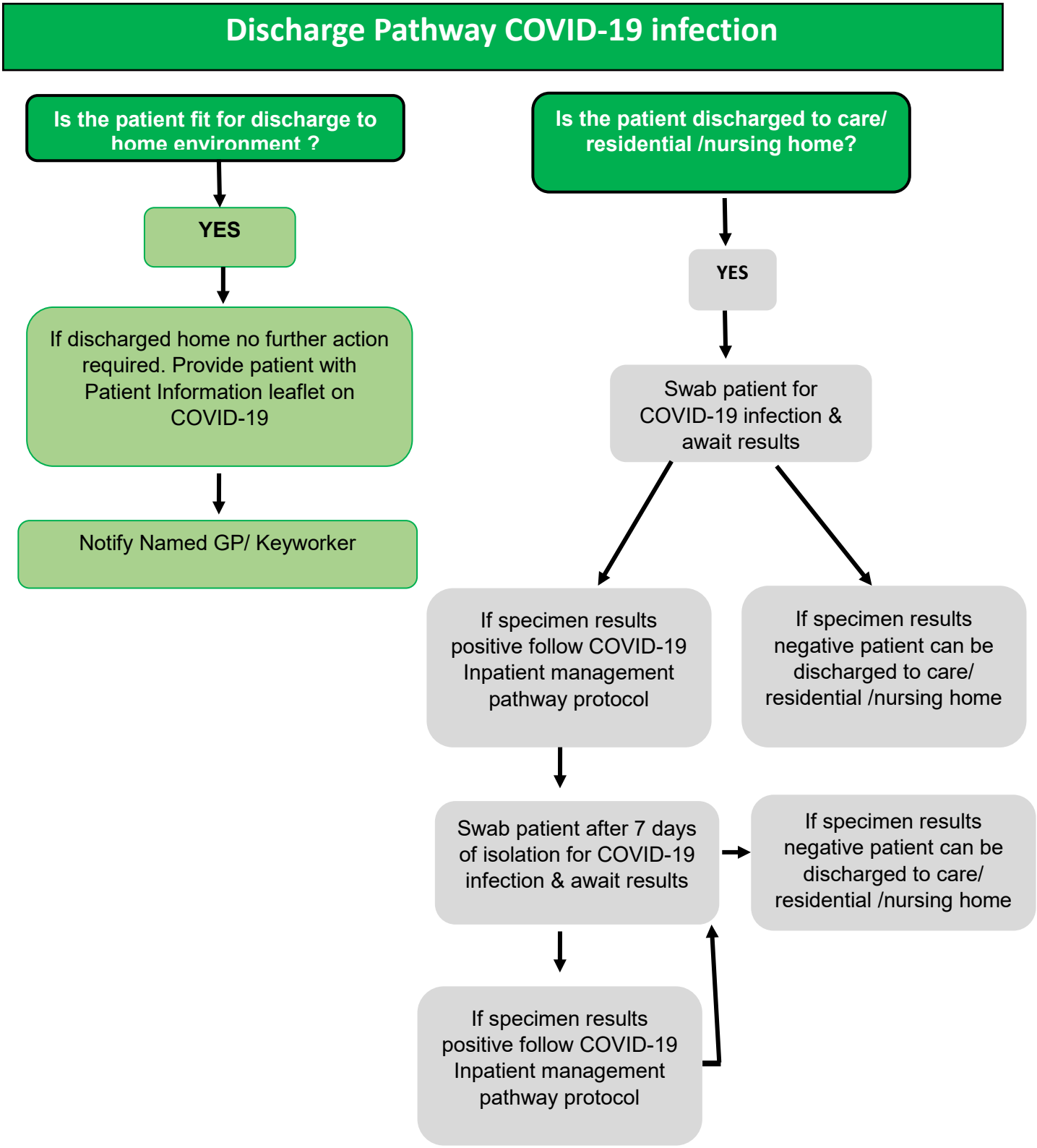


6 Clean hands with soap and water

Appendix 7 – De-isolation Pathway of COVID-19 infection



Appendix 7 – Discharge Pathway of COVID-19 infection



Appendix 8 –Environmental Cleaning

For COVID-19 wards or where there is an outbreak of COVID-19 the following cleaning of the environment will take place. For areas that are not identified as dedicated wards caring for COVID-19 infections domestic cleaning will be provided as normal.

Cleaning products/ solutions

Decontamination of equipment and the care environment must be performed using a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) of chlorine

Only cleaning (detergent) and disinfectant products supplied, are to be used. Products must be prepared and used according to the manufacturers' instructions and recommended product 'contact times' must be followed. If alternative cleaning agents/disinfectants are to be used, they should only on the advice of the IPC Team and conform to EN standard 14476 for virucidal activity. The person responsible for undertaking the cleaning with detergent and disinfectant should be trained in the process.

Cleaning the room/ ward/ environment:

1. Before cleaning the environment, domestic staff to liaise with Ward nursing staff and exchange information on cleaning and any potential risk.
2. Domestic staffs to collect PPE form ward nursing staff.
3. Before entering the room, perform hand hygiene.
4. Don PPE as donning guidance (gloves, apron, Fluid resistant surgical mask, visor/googles- if risk of splashing).
5. Collect all cleaning equipment (should be single use where possible) and healthcare waste bags before entering the room.
6. The following staff will undertake cleaning duties shown in table 1 with a chlorine-based disinfectant at a minimum strength of 1,000ppm
7. Equipment to be discard if not sent off to laundry
8. Patient care equipment should be cleaned with disinfectant wipes.
9. Dedicated disposable equipment (such as mop heads, cloths) must be used for environmental cleaning and disposed as clinical waste.
10. Communal cleaning trollies should not enter the room.
11. Doff PPE as doffing guidance
12. Wash hands including up to elbows with soap and water.
13. Cream hands

Patient isolation rooms must be cleaned:

- daily
- during discharge
- transfer
- after an AGP (this includes removal and laundering of all curtains)

Domestic/cleaning staff performing environmental decontamination should:

- Ideally be allocated to specific area(s) and not be moved between COVID-19 positive wards and non-COVID-19 care areas
- Be trained in which personal protective equipment (PPE) to use and the correct methods of wearing, removing and disposing of PPE.

The care environment should be kept clean and clutter free. In COVID-19 positive wards all non-essential items including toys, books, and games should be removed from reception, waiting areas,

day rooms and lounges. When made available, these items should not be shared. All toys must be cleanable and should be cleaned regularly by nursing staff in line with the Trust Infection Prevention & Control Policy Manual.

Table 1: Cleaning duties of all staff disciplines:

Clinical staff	Frequency	Domestic staff	Frequency
All hard surfaces in COVID-19 positive rooms	Daily	Corridors	Daily
Beds	Daily	Bathrooms	Daily
Bed linen. Do not shake linen and avoid all necessary agitation	Daily	Toilets	Daily
Toilets – where soiling	Ad-hoc	Floors	Daily
Mattress	Daily	Staff toilets/ changing rooms	Daily
Cupboard Tables Chairs	Daily	Showers	Daily
High touch surfaces- keyboard, phones, light switches, Fobs ,Keys	Daily- A minimum of 3 times a day with disinfectant wipe	Communal areas- dining room/ lounge	Daily
All re-usable medical equipment (BP cuffs, dynamaps, blood glucose machines, oxygen cyclinders	Before /after patients use/In between patients with disinfectant wipe	Collection of clinical waste – as per local arrangements	Daily
Toys, books, and games/ I-pads	Daily – with disinfectant wipe		

Appendix 9- Patient Information leaflet on COVID-19

1. You have been identified as being a contact of a patient who has tested positive for COVID 19. What is COVID 19?

Coronavirus (COVID-19) is the illness caused by a new strain of coronavirus first identified in Wuhan City, China, It can cause a cough and or a fever/high temperature.
Coronavirus can cause more severe symptoms in people with weakened immune systems, older people and those with long term conditions like diabetes, cancer and chronic lung disease**.**

2. What are the symptoms of COVID 19?

The most common symptoms of COVID-19 are:

- a new continuous cough
- and/or a fever/high temperature (37.8 C or greater).
- You may feel warm, cold or shivery.
- Some people will have more serious symptoms, including pneumonia or difficulty breathing which might require admission to hospital.

3. How does it spread?

Because it's a new illness, we don't know exactly how the virus spreads from person to person. Similar viruses spread by droplets in coughs and sneezes.

4. How can I prevent other people from getting COVID-19?

- You can reduce spreading the infection by:
- Avoiding direct hand contact with your eyes, nose and mouth
- Maintaining good hand washing
- Avoiding direct contact with other patients or sharing personal items such as mobile phones
- Covering your nose and mouth when coughing or sneezing with disposable tissues and disposing of them in the nearest waste bin after use

5. Wash your hands regularly

Wash your hands with soap and water/ disinfectant wipe before eating and drinking, and after coughing, sneezing and going to the toilet.

6. How is it treated?

Currently, there's no vaccine and no specific treatment for the virus.

7. What happens if you are a contact of a patient diagnosed with COVID 19 while in hospital?

You will be monitored for any symptoms of COVID 19 for 14 days while you are in hospital

8. What happens if I am discharged before the 14 days are over?

You need to continue to monitor for symptoms (see symptoms section above) until the 14 days are up. You should be told when that will be by the ward staff on your discharge.

.

9. What about visitors? Are friends and family at risk?

It is recommended that you keep visitors to a minimum and discourage any family members who may be at risk due to underlying health conditions from visiting you.

Appendix 10 -Process for Healthcare acquired COVID-19 Outbreaks and Service Disruption due to Test and Trace related Staff Absences

1. Notification and update of Covid-19 outbreaks and Service Disruption related to Test and Trace

- Routinely, when a suspected outbreak / Test and Trace incident is first identified you should, as usual, contact your local PHE Health Protection Team to inform them with details of the first outbreak control group / incident meeting.
- In addition, and at the same time, providers should also report to their Integrated Care System (ICS) through the COVID-19 Incident Co-ordination Centres (ICCs) using the IIMARCH form.
- As COVID-19 is a category 4 national incident, each region is required to maintain and share with the national incident coordination centre a daily status update of all regional outbreaks and service impact related to Test and Trace. ICS's are therefore required to notify and provide updates to NHS England and NHS Improvement through a designated mailbox england.london-covid19outbreaks@nhs.net

2. Management of Covid-19 outbreaks

Outbreak management to be followed in line with IPC policy manual. In addition, there is an expectation that:

- A post infection review or root cause analysis is completed on patients where a transmission has occurred / is suspected.
- Staff contacts will be identified and managed in line with Trust occupational health and PHE Test and Trace processes.
- There is evidence that the Infection Prevention and Control Board Assurance Framework is completed; https://www.england.nhs.uk/coronavirus/wpcontent/uploads/sites/52/2020/04/C0542-IPC-Board-Assurance-Framework-v1-2.pdf
- There is evidence that the Infection Prevention and Control COVID-19 Management Checklist, version 1.2 has been used in conjunction with an incident investigation tool; https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0542-IPC-Management-checklist-v1-2.pdf
- Evidence of completed actions are recorded on action plan template, with identified action owners and dates of completion
- Lessons learned are collated and disseminated within the organisation and regionally.

Appendix 10 – IIMARCH Form for Notification of Outbreak / Incident / Service

Disruption due to Test and Trace related staff absence:

Element	Key questions and considerations	Action
I	Information What, where, when, how, how many, so what, what might? Timeline and history (if applicable), key facts reported using M/ETHANE	
I	Intent Why we are here, what are our strategic objectives are to address? Strategic aim and objectives, joint working strategy	
M	Method How are we going to do it? Command, control and co-ordination arrangements, tactical and operational policy and plans, contingency plans	
A	Administration What is required for effective, efficient and safe implementation? Identification of commanders, tasking, timing, decision logs, equipment, dress code, PPE, welfare, food, logistics	
R	Risk assessment What are the relevant risks, and what measures are required to mitigate them? Risk assessments (dynamic and analytical) should be shared to establish a joint understanding of risk. Risks should be reduced to the lowest reasonably practicable level by taking preventative measures, in order of priority. Consider the hierarchy of controls. Consider Decision Controls	
C	Communications How are we going to initiate and maintain communications with all partners and interested parties? Radio call signs, other means of communication, understanding of interagency communications, information assessment, media handling and joint media strategy	

H	Humanitarian issues What humanitarian assistance and human rights issues arise or may arise from this event and the response to it? Requirement for humanitarian assistance, information sharing and disclosure, potential impacts on individuals' human rights	

Appendix 11- COVID-19 Contact tracing- Factsheet

1. What is contract tracing?

Contact tracing attempts to find all contacts of a confirmed case, in order to test or monitor them for infection. The goal is to stop the spread of a disease by finding and isolating cases.

Contact tracing is a core public health intervention that plays an important role in the control of COVID-19 infection. The aim of contact tracing is to rapidly identify potentially newly infected persons who may have come into contact with existing cases, in order to reduce further onward transmission.

2. How does contact tracing work?

Contact tracing consists of three steps:

- Contact identification: to identify persons who may have been exposed to SARS-CoV-2 virus as a result of being in contact with an infected person.
- Contact listing: to trace and communicate with the identified contacts, and to provide information about suitable infection control measures, symptom monitoring and other precautionary measures such as the need for self-isolation.
- Contact follow-up: to monitor the contacts regularly for symptoms.

3. What the process of contact tracing?

A clinician will speak to suspected individual, to gather details of places they visited and the people they've been in contact with since they became unwell. This information is used to build up a detailed picture of the people we need to get in touch with, such as colleagues and patients.

Contact tracing for patients/ services users is provided by the Infection Prevention and Control department

Contact tracing for healthcare staff is provided by Occupational Health Department –Team Prevent.

4. What is a close contact?

When we talk about "close contact" it's important to point out that we're not looking for people the person may have passed in a building, as the risk in these situations is very low. A close contact involves either face to face contact or spending more than 15 minutes within 2 metres of an infected person.

Once we have recorded the close contacts, we can categorise them into high or low risk, then contact them to provide advice on what they should do.

5. What's the difference between a high risk exposure and a low risk exposure?

High-risk exposure contacts who have spent 15 minutes or more in close proximity to (2 metres or less) or in a closed environment with a case, and low-risk exposure contacts who are still at risk but who have not been exposed to a case for as long.

6. I am a staff member and have been contact by NHS test and trace, as a contact whilst at work, what should I do?

If you have been contacted by the NHS test and trace service, and identified as a contact, whilst at work please contact the Infection Prevention and Control department as soon as possible – elft.infectioncontrol@nhs.net. A risk assessment would be required to ascertain if personal protective equipment was worn or if there were any breeches in personal protective equipment use. Advice will then be provided on whether to self-isolate or continue working.

7. I am a staff member and have been contact by NHS test and trace, as a contact whilst not at work, what should I do?

Staff who have been notified through the NHS test and trace service that they are a contact of a confirmed case of COVID-19 in the community (outside their place of work) they should inform their line manager and self-isolate for 14 days, in line with the NHS Test and Trace guidance.

This advice should be followed regardless of the results of any SARS-CoV-2 antibody testing. A positive antibody result signifies previous exposure, but it is currently unknown whether this correlates with immunity, including protection against future infections.

8. What is the process of contact tracing for patients?

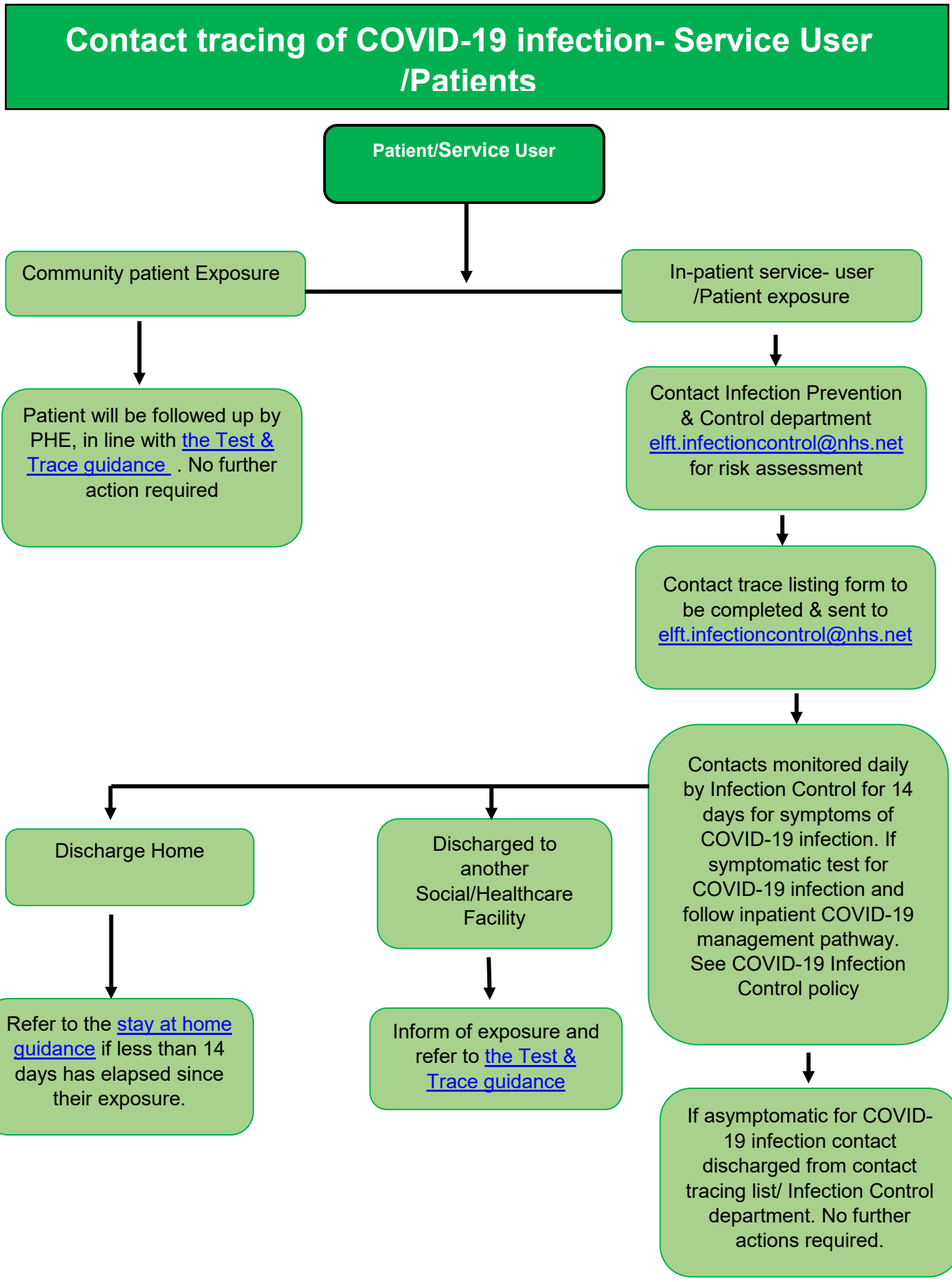
If a patient has been identified as a contact of a confirmed COVID-19 cases, the Infection Prevention and Control department will contact the manager of service/ department and gather further information to risk assess. A contact trace listing form will be sent to the manager of the service/department to complete that would enable easy identification of contacts. This form is completed and sent to the Infection Prevention and Control department– elft.infectioncontrol@nhs.net

The contacts are contacted on a daily basis, for 14 days, to monitor for symptoms and if symptomatic to follow management pathway for covid-19 infection. For further information please refer to COVID-19 IPC policy.

9. How do you know contact tracing works?

Contact tracing is a tried and trusted approach that has been used for many years to prevent the spread of infection and to contain and stop outbreaks. Data from contact tracing can contribute to a better understanding of the epidemiology of COVID-19, providing valuable information on transmission and attack rates, supporting the identification of key settings where transmission is occurring

Appendix 11- Contact tracing of COVID-19 infection- Service User/Patients



Contact tracing of COVID-19 infection- Healthcare workers

Staff notified by NHS Test and Trace services as contact of COVID-19 infection OR has symptoms whilst at place of work

If symptomatic at work, go off duty and self-isolate for 14 days. Contact line manager and Contact Infection Prevention & Control department elft.infectioncontrol@nhs.net for risk assessment.

Risk assessment to include:

- the severity of symptoms
- the length of exposure
- the proximity to the patients
- the activities that took place when the worker was in proximity (such as aerosol-generating procedures (AGPs), monitoring, personal care)
- whether the healthcare worker had their eyes, nose or mouth exposed
- whether Personal protective equipment was worn

Is there a high risk of exposure?

NO

Healthcare worker can continue to work as normal. No further action required

YES

If the risk assessment concludes there has been a significant breach or close contact without PPE, the worker should remain off work for 14 days & monitor for symptoms of COVID-19 infection. If symptomatic healthcare worker to get tested for COVID-19 infection

Refer to Occupational Health –Team Prevent for contact tracing and follow-up

EQUALITY ANALYSIS

Equality Analysis Template

Part 1: Equality Analysis Details	
Title of 'Proposal'	COVID -19 Infection Prevention & Control Policy
Name of directorate	Corporate
Name of manager undertaking the Equality Analysis	Rana Begum- Trust-wide Lead Infection Prevention & Control Nurse
Consultation date/s with staff	To be confirmed
Consultation date/s with service users	To be confirmed
Date Equality Analysis Completed	17th June 2020
Review date **(Review at least once every three years)**	The emerging evidence base on COVID-19 is rapidly evolving. Further updates may be made to this policy as new guidance emerges.

Part 2: Proposal Details

1) What are the aims of the proposal? Indicate if this is a new proposal or the review of an existing one?

(The term 'proposal' covers *activities such as such as policy development, policy review, service redesign and internal reorganisation or restructuring processes)*

Part 3: Equality Analysis of Staff		
Protected Groups ▪ Identify the impact or potential impact on each of the following protected groups, with due regard to the three aims of the PSED (public sector equality duty).	**Impact Positive or negative?** **or no impact?**	**Please describe the process of your analysis with reference to the following:** ▪ **Results of consultation** ▪ **Data or research on the protected groups that you have considered** ▪ **Implications for the protected groups**
Age:	No impact	
Disability: (Consider a range of impairments, including - sensory, mental, physical and learning disability)	No impact	
Sex:	No impact	
Religion or Belief: (including no belief)	No impact	
Sexual Orientation:	No impact	
Race: including ethnicity and nationality	No impact	
Gender Reassignment	No impact	
Pregnancy and Maternity	No impact	
Marriage and Civil Partnership	No impact	

Part 4: Equality Analysis of Service Users / Patients		
Protected Groups **(Equality Strands)** ▪ Identify the impact or potential impact on each of the following protected groups, with due regard to the three aims of the PSED (public sector equality duty).	**Impact Positive or negative?** **or** **no impact?**	**Please describe the process of your analysis with reference to the following:** ▪ **Results of consultation** ▪ **Data or research on the protected groups that you have considered** ▪ **Implications for the protected groups**
Age:	No impact	
Disability: (Consider a range of impairments, including - sensory, mental, physical and learning disability)	No impact	
Sex:	No impact	
Religion or Belief: (including no belief)	No impact	
Sexual Orientation:	No impact	
Race: including ethnicity and nationality	No impact	
Gender Reassignment:	No impact	
Pregnancy and Maternity	No impact	
Marriage and Civil Partnership	No impact	

Part 5: Findings from the Equality Analysis
Use this space provided below to elaborate on your decision based on the findings of the equality analysis
1. **Accept the proposal** - no evidence of discrimination; appropriate opportunities have been taken to advance equality and foster good relations. *No impact-Not applicable*
2. **Adjust the proposal** - take steps to remove barriers to advance equality. It may involve introducing actions to mitigate the potential effect or to look at how to deliver the proposal in a different way. It *is* lawful under Equality Law to treat people differently in some circumstances, for instance developing single sex provision where required *No impact-Not applicable*
3. **Continue the proposal** - despite adverse effects or taking opportunities to advance equality provided the proposals do not unlawfully discriminate and can be objectively justified. ***(To identify whether a proposal may unlawfully discriminate due regard should be given to discrimination on the basis of the protected characteristics)*** *No impact-Not applicable*
4. Stop the proposal – the policy shows unlawful discrimination and adverse effects that cannot be mitigated *Not applicable*

Part 6: Equality Analysis Action Plan	
Adverse Impact – Staff	No impact-N/A

Adverse Impact – Service Users	No impact-N/A

This analysis has been checked and approved by:

Name: Rana Begum

Title: Trust-wide Lead Infection Prevention & Control Nurse

Date: 17th June 2020

Once completed the document should be sent to the Trust's Risk & Datix Manager to support the policy development and review process: joanne.sims3@nhs.net.

References

http://www.eastlondon.nhs.uk/about_us/equality_and_diversity.asp Equality Information including examples of Equality Analysis, East London Foundation Trust

www.equalityhumanrights.com Equality and Human Rights Commission

www.stonewall.og.uk Lesbian, Gay & Bisexual Information and Research, Stonewall

www.ndti.org.uk; Achieving Age Equality in Local Mental Health Services, National Mental Health Development Unit