Liverpool Heart and Chest Hospital NHS
NHS Foundation Trust

Reference Number: FOI2021/529
From: Other

Date: 30 March 2022

Subject: Local Guidelines for Covid Treatment and Infection Control

We are looking for guidance regarding patient management. Including the overall management guidelines for any patients who present with covid symptoms, and the infection control process related to them.

Could you please provide a copy of your hospital's full local guidelines on the following topics?

Q1 Current local guidelines for the treatment and management of Covid 19.

A1 Please see the attached document; Respiratory Virus Policy v1.0

Q2 Current local infection control guidelines regarding testing and quarantining/isolation of Covid positive patients

A2 Please see the attached document; Respiratory Virus Policy v1.0

Respiratory Virus Policy

For completion by Author			
Author(s) Name and Title:	Nicola Best, Infection Prevention Nurse		
Scope:	Trust Wide	Classification:	Clinical
Version Number:	1.0	Review Date:	31/03/2023
Replaces:	Pandemic Influenza policy, COVID -19 Infection Prevention and control Policy		
To be read in conjunction with the following documents:	Infection Prevention and Control Standard Precautions, Isolation Policy		
Document for public display:	Yes		
Executive Lead	Dr Raph Perry		

For completion by Approving Committee				
Equality Impact Analysis Completed:			Yes	
Endorsement Completed:		Yes	Record of Changes	N/A
Authorised by:	Emergency planning Committee		Authorisation date:	09/03/2022

For completion by Document Control					
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Officer responsible for Archive:	IG and Document Control Facilitator				

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Document Statement

Acute respiratory tract infection (RTI) is an acute infectious process affecting the upper and/or lower airways. They are commonly caused by viruses including influenza, respiratory syncytial virus (RSV) and more recently SARSCoV2. Symptoms can include any of the following: fever, rhinorrhoea (runny nose), sore throat, cough, limb or joint pain, headache, lethargy, chest pain, loss of taste/smell and breathing difficulties.

Avoiding transmission of acute respiratory infections in healthcare settings can prevent considerable mortality, morbidity, healthcare costs and disruption to services.

Preventing infection requires the consistent application of control measures and maximising coverage of vaccination for influenza and COVID.

This policy details recommendations for the prevention and control of acute RTI in patients and staff.

1. Roles and Responsibilities

The Director of Infection prevention & control is responsible for the implementation of this policy.

The Gold Command group will make strategic decisions and provide oversight regarding management and control measures. They are responsible for ensuring that resources are in place to implement strategies, prioritising competing organisational demands and for the communication and dissemination of information across the Trust. They are responsible for liason with the relevant command structures regionally and nationally.

The Silver Command group is responsible for reviewing all relevant guidance and updating policies and protocols as necessary. They are responsible for operational decisions regarding infection prevention measures, placement of patients, management of testing for staff and patients and self-isolation strategies. They are responsible for monitoring the control measures across the organisation.

The Bronze command group are responsible for the dissemination of information and ensuring that control measures are adhered to within their individual departments.

The infection prevention team are responsible for carrying out surveillance related to respiratory viruses, review of positive patients, co-ordinating outbreak information and participating in monitoring and audit programmes. They are integral members of the Silver Command operational group.

The staff screening team are responsible for staff screening and testing programmes and risk assessment of staff who are infected with, or have been exposed to, respiratory viruses.

The education team are responsible for education and training of staff on PPE (personal protective equipment) and for the fit test programme for respiratory protective equipment.

The supplies department are responsible for the procurement and supply of PPE and all items required to enable effective IPC measures and for their delivery to the relevant wards.

All Liverpool Heart and Chest Hospital Trust Staff are responsible for co-operating with the development and implementation of this policy as part of their normal duties and responsibilities and participating in any investigation or root cause analysis as required.

Temporary or Agency Staff, students or others will be expected to comply with the requirements of all Trust policies applicable to their area of operation.

2. Controlled Document Standards

Staff are expected to adhere to the standards detailed in guidance from UK Health Security Agency (see references)

3. Infection Prevention & Control

3.1 Standard Precautions

Standard infection control precautions (must be used at all times for all patients (see separate policy for additional details) and are required across all pathways. These precautions include:

- hand hygiene
- respiratory and cough hygiene
- PPE
- safe management of the care environment
- safe management of care equipment
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management

Universal masking with face coverings or surgical masks (Type II or IIR) to prevent the transmission of SARS-CoV-2 and other respiratory infectious agents in health and care settings, as a source control measure, should continue to be applied for all staff, patients and visitors.

Patients with suspected or confirmed respiratory infection should be provided with a surgical facemask (Type II or Type IIR) to be worn in multi-bedded bays and communal areas if this can be tolerated. Surgical facemasks are not required to be worn by patients in single rooms unless another person enters, or the room door is required to remain open. All patients transferring to another care area should wear a surgical facemask (if tolerated) to minimise the dispersal of respiratory secretions and reduce environmental contamination. Patients should be provided with a new surgical mask at least daily or when soiled or damaged. The requirement for patients to wear a surgical facemask must never compromise their clinical care, such as when oxygen therapy is required.

3.2 Admission and Triage

Patients must be assessed for symptoms of respiratory viral infection prior to admission or on admission and this should be documented in the electronic patient record

3.3 Screening

Patents must be screened for SARSCoV2 prior to admission to the hospital (within 72 hours of admission) or upon admission if an urgent or emergency admission. They should then be screened at regular intervals during their hospital stay (see separate COVID screening protocol for details) and additional they should be screened if they develop any new symptoms
Testing for SARSCoV2 with lateral flow devices will also be performed for surgical patients on the day of surgery and for patients admitted as emergencies from the community.

Testing for other respiratory viruses e.g. Influenza must be undertaken if the patient develops symptoms but will not be undertaken routinely.

3.4 Patient placement

Patients who have been assessed and have no clinical signs of respiratory infection and have tested negative for SARSCoV2 as per testing protocol can be cared for with standard infection control precautions (SICPs) and can be admitted to the most suitable area depending on their clinical condition or any other infection risks identified.

Patient who are identified as close contacts of another person with SARSCoV2 should be placed in a single room or in a cohorted area with other designated contact patients.

If a patient displays any signs or symptoms of respiratory viral infection they should, wherever possible, be placed in a single room, ideally with en-suite facilities, whilst awaiting test results.. A specialised isolation suite/room is not necessary but where available should be used for patients undergoing aerosol generating procedures (AGPs). The transfer of patients outside of their rooms should be limited to medically necessary activities wherever possible.

Patients with a confirmed respiratory infection must be placed in a designated ensuite sideroom or a designated cohorted area. These areas will be clearly identified with appropriate signage.

3.5 Transmission-based precautions

This section describes specific actions that should be taken when applying TBPs. TBPs are applied when SICPs alone are insufficient to prevent transmission of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a suspected or confirmed infectious agent. TBPs are categorised by the route of transmission of the infectious agent.

3.5.1 Physical distancing

In health and care settings physical distancing is the recommended distance that should be maintained between staff, patients and visitors unless mitigations are in place such as the use of PPE. WHO continues to advise that a physical distance of at least 1 metre should be maintained between and among patients, staff, and all other persons in healthcare settings. This distance should be increased wherever feasible, especially in indoor settings. Physical distancing is recommended to remain at 2 metres where infectious respiratory patients are cared for.

3.5.2 Safe management of care equipment and the care environment

The care environment must be kept visibly clean, well maintained and in a good state of repair. The care environment must be free from non-essential items and equipment to facilitate effective decontamination. All care equipment must be clean and well maintained. Reusable non-invasive equipment should be allocated to the individual patient or cohort of patients where possible.

Decontamination of reusable patient care equipment and the care environment must be performed using either: a combined detergent/disinfectant solution at a dilution of 1,000 parts per million (ppm) available chlorine (av.cl); or a suitable disinfectant wipe.

Check manufacturer's instructions for suitability of cleaning products especially when dealing with electronic equipment. If the item cannot withstand chlorine releasing agents consult the manufacturer's instructions for a suitable alternative to use following or combined with detergent cleaning. Manufacturer's guidance/instructions and recommended product 'contact time' must be followed for all cleaning/disinfectant solutions/products.

3.5.3 Frequency of decontamination of reusable patient care equipment

Reusable (communal) non-invasive care equipment must be decontaminated:

- between each patient and after patient use
- after blood and body fluid contamination
- at regular intervals as part of scheduled, routine equipment cleaning

An increased frequency of decontamination should be considered for reusable patient care equipment when used in isolation/cohort areas.

3.5.4 Frequency of decontamination of the care environment

An increased frequency should be incorporated into the environmental decontamination schedules for patient isolation rooms and cohort areas. Decontamination of inpatient rooms (isolation rooms and cohort areas) must be carried out at least twice daily. Surfaces where there may be higher environmental contamination rates, including toilets/commodes (particularly if patients have diarrhoea), and frequently touched surfaces such as nurse call buttons, medical equipment, door/toilet handles and locker tops, over-bed tables and bed rails should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Inpatient rooms must also be terminally cleaned:

- following resolutions of symptoms and removal of precautions
- when vacated following discharge or transfer (this includes removal and disposal or laundering of all curtains and bed screens)
- following an AGP if the room is vacated. Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room.

Inpatient rooms where possible will have an additional decontamination process with UV_C.

In outpatient departments and primary care settings the extent of decontamination between patients will depend on the duration of the consultation/assessment, the patient's presenting symptoms and any visible environmental contamination

3.5.5 Personal protective equipment

Before undertaking any procedure, staff should assess any likely blood and body fluid exposure risk and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

All PPE should be:

- compliant with the relevant BS/EN standards (technical standards as adopted in the UK post-Brexit)
- located close to the point of use
- stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to)
- single-use only, unless specified by the manufacturer
- changed immediately after each patient and/or following completion of a procedure or task
- disposed of after use into the correct waste stream of healthcare waste

Hand hygiene must be performed after removal of PPE.

Any reusable PPE/RPE must have a decontamination and maintenance process in place and responsibility assigned.

3.5.6 Disposable gloves

Gloves are not an alternative to hand hygiene. Inappropriate use of gloves, including not changing them as recommended above, risks the gloves contributing to the transfer of infectious agents and cross infection.

Gloves are not required unless exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely. Gloves are not required when undertaking administrative tasks (for example using the telephone, using a computer or tablet), writing in the patient chart, giving oral medications or vaccinations, distributing or collecting patient dietary trays. The unnecessary use of gloves generates excessive waste.

Disposable gloves must:

- be changed immediately after each patient and/or after completing a procedure/task even on the same patient
- be put on immediately before performing an invasive procedure and removed on completion
- be changed if damaged or punctured
- not be decontaminated with alcohol based hand rub (ABHR) or soap between use

3.5.7 Aprons and gowns

Disposable plastic aprons must be worn to protect staff uniform or clothes from contamination when providing direct patient care for patients with suspected or confirmed respiratory infection and during environmental and equipment decontamination.

Aprons are not required when: undertaking administrative tasks, (for example using the telephone, using a computer or tablet), writing in the patient chart, giving oral medications or vaccinations, distributing or collecting patient dietary trays. The unnecessary use of aprons generates excessive waste.

Fluid-resistant gowns must be worn:

- when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure/task being performed
- when performing AGPs on patients with a suspected or confirmed respiratory infection
- when there is a risk of extensive splashing of blood and/or other body fluids for example during AGPs

Disposable aprons and gowns must be changed between patients and immediately after completion of a procedure or task.

3.5.8 Eye and face protection

Eye or face protection (including full-face visors or goggles) must:

- be worn if blood or body fluid contamination to the eyes or face is anticipated or likely
- be worn by staff when caring for patients with a suspected or confirmed infection spread by the droplet or airborne route as deemed necessary by a risk assessment
- be worn during AGPs
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn

Regular corrective spectacles are not considered as eye protection.

3.5.9 Surgical face masks

In addition to universal masking, a fluid-resistant surgical mask (Type IIR) must be worn by staff when caring for patients with a suspected or confirmed infection spread by the droplet route.

Surgical masks must:

- be well fitted covering both nose and mouth
- not be allowed to dangle around the neck at any time
- not be touched once put on
- be changed when they become moist or damaged
- be worn once and then discarded in line with country-specific guidance or policy (hand hygiene must always be performed after disposal)
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3.5.10 Respiratory protective equipment (RPE)/FFP3 (filtering face piece) or powered air purifying respirator (PAPR) hood

A respirator with an assigned protection factor (APF) 20, that is, an FFP3 respirator (or equivalent), must be worn by staff when:

- caring for patients with a suspected or confirmed infection spread by the airborne route (during the infectious period)
- when performing AGPs on a patient with a suspected or confirmed infection spread by the droplet or airborne route

Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

An FFP3 respirator or powered respirator hood must never be worn by an infectious patient.

Respirators can be single use or sessional use (disposable or reusable).

All tight fitting RPE, that is, FFP3 respirators must:

- be fluid-resistant
- be fit tested on all health and care staff who may be required to wear a respirator to ensure an adequate seal/fit according to the manufacturer's guidance*
- be fit checked (according to the manufacturer's guidance) every time a respirator is donned to ensure an adequate seal has been achieved
- be compatible with other facial protection used (protective eyewear) so that this does not interfere with the seal of the respiratory protection
- be disposed of and replaced if breathing becomes difficult, the respirator is damaged or distorted, the respirator becomes obviously contaminated by respiratory secretions or other body fluids, or if a proper face fit cannot be maintained
- not be touched once put on, if adjustments are needed ensure hand hygiene is undertaken
- be removed outside the patient's room or cohort area

In the absence of an anteroom/lobby, remove RPE and eye protection in a safe area (for example outside the isolation/cohort room/area). All other PPE should be removed in the patient care area. Perform hand hygiene after removing and disposing of RPE.

*Where fit testing fails, suitable alternative equipment must be provided. Reusable respirators can be used by individuals if they comply with HSE recommendations and should be decontaminated and maintained according to the manufacturer's instructions, this may be country specific.

Further information regarding fitting and fit checking of respirators can be found on the Health and Safety Executive website.

Respirators with exhalation valves are not fluid-resistant unless they are also ‘shrouded’. Valved non-shrouded respirators should be worn with a full-face shield if blood or body fluid splashing is anticipated.

Respirators and powered respirator hoods with exhalation valves are ineffective for source control. These should not be worn by a healthcare worker/operator when sterility directly over the surgical field is required, for example in theatres/surgical settings or when undertaking a sterile procedure, as the exhaled breath is unfiltered.

3.5.11 Summary of PPE required for direct care of patients with suspected or confirmed respiratory infection

If there is no direct contact with the patient or their environment, gloves and aprons/gowns are not required.

Refer to guidance on donning (putting on) and doffing (removing) PPE for droplet and airborne precautions.

Table 1: PPE required while providing direct care for patients with suspected or confirmed respiratory infection

PPE required by type of transmission/exposure	Disposable gloves	Disposable/reusable fluid-resistant apron/gown	FRSM/RPE	Eye/face protection (goggles or visor)
Droplet PPE	Single use	Single use apron or fluid-resistant gown if risk of extensive spraying/splashing	Single use FRSM Type IIR for direct patient care (1)	Single use or reusable (1)
Airborne PPE (When undertaking or if AGPs are likely) (3) Or if an unacceptable risk of transmission remains following rigorous application of the hierarchy of controls (4)	Single use	Single use fluid-resistant gown	Single use FFP3 (2) or reusable respirator/powered respirator hood (RPE)	Single use or reusable (2)

(1) FRSM can be worn sessionally (includes eye/face protection) if providing care for cohorted patients. All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(2) RPE can be worn sessionally (includes eye/face protection) in high risk areas where AGPs are undertaken for cohorted patients (see footnote 4). All other items of PPE (gloves/gown) must be changed between patients and/or after completing a procedure or task.

(3) Consideration may need to be given to the application of airborne precautions where the number of cases of respiratory infections requiring AGPs increases and patients cannot be managed in single or isolation rooms.

(4) Where a risk assessment indicates it, RPE should be available to all relevant staff. The risk assessment should include evaluation of the ventilation in the area, operational capacity, and prevalence of infection/new SARS-CoV-2 variants of concern in the local area. The hierarchy of controls can be used to inform the risk assessment. Staff should be provided with training on correct use.

3.5.12 Aerosol generating procedures

An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or confirmed to be suffering from an infectious agent transmitted by the airborne or droplet route. Only staff who are needed to undertake the procedure should be present, wearing airborne PPE/RPE precautions.

The list of medical procedures that are considered to be aerosol generating or associated with an increased risk of respiratory transmission is:

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

*The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current (COVID-19) AGP list. It is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, that is oral/pharyngeal suctioning is not an AGP.

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

Airborne precautions are not required for AGPs on patients/individuals if screening, triaging and testing have confirmed the absence of respiratory infection.

3.6 Duration of precautions

In general, patients should remain in isolation or cohorted, and TBPs should be applied until resolution of fever and respiratory symptoms, or until they are established on or have completed an appropriate course of treatment. This will be dependent on the infectious agent.

Some patients with more severe illness or underlying immune problems may remain infectious for a longer period. The duration of TBPs may require modification based on available pathogen-specific guidance and patient information.

TBPs should only be discontinued in consultation with clinicians (including microbiology/IPC team) and should take into consideration the infectious agent, individual's test results (if available) and resolution of clinical symptoms.

For in-patients with COVID-19, isolation should continue until 10 days after the onset of symptoms (or their first positive COVID-19 test if they do not have any symptoms), provided the clinical criteria below have been met.

Clinical criteria:

- clinical improvement with at least some respiratory recovery
- absence of fever (temperature greater than 37.8°C) for 48 hours without the use of medication
- no underlying severe immunosuppression

Patients do not routinely need to be re-tested by PCR test before stepping down isolation. Inpatients will be tested with LFD on day 11 before stepping down. If this remains positive testing will continue daily until a negative result is obtained if a patient is still positive on day 14 advice should be sought from the microbiologist/virologist.

A cough or a loss of, or change in, normal sense of smell or taste (anosmia), may persist in some individuals for several weeks, and are not considered an indication of ongoing infection when other symptoms have resolved.

This guidance does not apply if there are any additional indications for ongoing isolation and transmission based precautions (for example MRSA carriage, C.difficile infection, diarrhoea).

For clinically suspected COVID-19 patients who have tested negative and whose condition is severe enough to require hospitalisation, the isolation period should be measured from the day of admission.

3.7 Severely immunocompromised patients

It is possible for severely immunocompromised patients to remain infectious for prolonged periods, even if they do not display any symptoms. The isolation period for these patients whilst in hospital should be at least 14 days.

In severely immunocompromised patients resolution of symptoms should not be used as a marker of decreased infectiousness and these patients should be isolated in side rooms, cubicles or cohorted until they return a negative PCR test. Staff should strictly adhere to recommended IPC measures throughout the inpatient stay.

Severely immunocompromised patients can end their isolation after a single negative PCR test result taken no earlier than 14 days after the onset of symptoms or first positive test.

Inpatients who are considered contacts of SARS-CoV-2 cases should isolate for 10 days from the date of exposure (unless symptoms occur, or positive test result).

3.8 Care of the deceased

The principles of SICPs and TBPs continue to apply when caring for the deceased. This is due to the ongoing risk of transmission although the risk is usually lower than for living patients. Organism-specific requirements for use of body bags, viewing, hygienic preparations, post-mortem examinations and embalming are described by the Health and Safety Executive. Additional guidance on the COVID-19: guidance for care of the deceased is available.

3.9. Visitors

Visits from patient's relatives and/or carers (formal/informal) should be encouraged and supported. If visitors are attending a care area with infectious patients, they should be made aware of any infection risks and offered appropriate PPE. This would routinely be an FRSM. Gloves and aprons are not routinely required unless providing direct patient care. Visitors should also be instructed on effective hand hygiene.

Visitors should not be present during AGPs on infectious patients unless they are considered essential following a risk assessment, for example carer/parent/guardian.

It may be considered appropriate to restrict visiting because of outbreaks of respiratory infection in health and care settings. This is a local outbreak management team decision.

Visitors with respiratory symptoms should not be permitted to enter a care area. However, if the visit is considered essential for compassionate (end of life) or other care reasons (for example parent/child) a risk assessment should be undertaken, and mitigations put in place to support visiting wherever possible.

3.10 Outbreak

If 2 or more cases of respiratory infection are diagnosed in either patients or staff and there appears to be a common link this must be highlighted and investigated as a potential outbreak. An outbreak meeting should be convened as soon as possible and, if a link established, this should be reported via the national outbreak reporting system.

3.11 Inter Hospital Transfers

Patients should generally not be transferred from one hospital to another for routine care.

However, some patients may require transfer for specialist care.If transfer is essential, this must be arranged by the hospital co-ordinators who will liaise with the transferring hospital and the ambulance service, who must be informed of the patient's full condition in advance. The hospital co-ordinators will inform the relevant ward staff and the infection prevention team

3.12 Intra Hospital Movement of patients

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Patients with respiratory viruses should not leave the segregated area or isolation room except for urgent/critical procedures. If a patient is required to another department within the hospital the following procedures must be followed;

1. Receiving department must be informed in advance
2. Patients must be taken straight to and returned straight from the department and must not wait in communal areas.
3. Patients must be last on the list to allow for full decontamination of the room and equipment.
4. The patient must wear a surgical mask while in transit

In the event that relevant information is not provided by the transferring department an incident form must be completed

3.13 Vaccination

A vaccination programme is instituted annually, commencing September for influenza , this will be co-ordinated by the Risk and Safety lead. All members of staff will be offered the vaccine, including volunteers and students on placement during the relevant time period. Vaccination uptake rates will be reported to Liverpool CCG and Immform monthly during the period of the campaign.

A vaccination programme for SARSCoV2 has been instituted and will be progressed in the future according to the criteria and schedule advised by NHS England.

3.14 Antiviral therapy at LHCH

Antivirals act independently of vaccination and predominantly shorten the duration and severity of illness and length of hospital stay, they will be recommended for specific

respiratory viruses such as influenza..
Antivirals will be prescribed to inpatients for treatment and prophylaxis according to advice from the microbiology and pharmacy departments

4. Policy Implementation Plan

The Emergency Planning Group Committee is responsible for reviewing this policy.
This will be reviewed and updated with any further guidance from the Department of Health or UKHSA (UK Health and Security agency)
All staff can access this policy via the intranet and will be informed as part of local induction.
Updates and new information relevant to the policy will be communicated via Corporate Communications.

5. Monitoring of Compliance

Standard Infection control practices including hand hygiene and decontamination of equipment will be monitored as part on the ongoing infection control audit process
Cleanliness of the environment and of equipment will be monitored by the matrons and by the hygiene supervisors.
Compliance with PPE will be monitored by the infection prevention team, departmental heads and matrons.
Compliance with the fit testing programme will be monitored by the Education department.

This policy will be considered a live working document which may be subject to change at short notice in response to emerging national guidance.

This policy will be tested as part of the Trusts schedule to test all emergency plans and the trust will participate in desktop exercises as required to test this plan at local and regional level.

6. References

https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-guidance-for-maintaining-services-within-health-and-care-settings-infection-prevention-and-control-recommendations

https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf

8. Endorsed By:

Name of Lead Clinician / Manager or Committee Chair	Position of Endorser or Name of Endorsing Committee	Date
Dr Perry	DIPC	
Helen Martin	Emergency Planning Committee	9th March 22

9. Record of Changes

Section No	Version No	Date of Change	Description of Amendment	Description of Deletion	Description of Addition	Reason