Novel coronavirus (COVID-19) Guidance for Primary Care
Management of patients presenting to primary care
Version 10.5

Publication date
02 April 2020

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Before use check the HPS COVID-19 page to verify this is the current version
### Version History

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<th>Date</th>
<th>Summary of changes</th>
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<td>V1.0</td>
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<td>V2.0</td>
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<td>- Algorithm for suspect case of WN-Cov in primary care</td>
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<td>V3.0</td>
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<td>- Section 4 – environmental cleaning following possible case in primary care</td>
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<td>- Appendix 3 – putting on and removing PPE in primary care</td>
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<td>31/01/20</td>
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<td>Refined definition of contacts with a case (page 3).</td>
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<td>Small amendment to contact definition</td>
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<td>V8.0</td>
<td>12/02/2020</td>
<td>Text and algorithm amended to include action re symptomatic contact of possible case Algorithm amended to clarify that travel includes transit through a risk area Addition of:</td>
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<td>- section on further information</td>
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<td>Waste guidance amended to reflect management as Category B Appendix 3: Removed reference to double glove. Version history has been moved to page 1.</td>
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<td>Reference to coronavirus (2019n-CoV) changed to COVID-19</td>
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<td>26/02/2020</td>
<td>Included links to PPE instructional videos</td>
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<td>28/02/2020</td>
<td>Phone numbers corrected in appendix 2</td>
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<td>V8.4</td>
<td>05/03/2020</td>
<td>Phone numbers corrected in appendix 2</td>
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<tr>
<td>V8.5</td>
<td>12/03/2020</td>
<td>Update to</td>
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<td>- Management section (including PPE)</td>
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<td>- Test result section</td>
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<td>V 9.0</td>
<td>13/03/2020</td>
<td>Updated to reflect move from containment to delay</td>
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<td>14/03/20</td>
<td>Update to: Reporting to HPT &lt;br&gt;Addition of AGPS and advice</td>
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<td>V10</td>
<td>16/03/20</td>
<td>Update: stay at home advice &lt;br&gt;Handling deceased</td>
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<td>V 10.1</td>
<td>19/03/20</td>
<td>Update: Removal of avian influenza reference &lt;br&gt;CPR IPC information added</td>
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<td>V 10.2</td>
<td>20/03/20</td>
<td>Clarification: statement on triage of patients</td>
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<tr>
<td>V10.3</td>
<td>24/03/20</td>
<td>Update to triage of patients &lt;br&gt;Addition of the section on “Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness”</td>
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<td>V10.4</td>
<td>27/03/20</td>
<td>Update to case definition &lt;br&gt;Addition of “Testing for COVID-19 infection to enable key workers to return to work”</td>
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<td>Addition of “Death Certification during the COVID-19 Pandemic”. &lt;br&gt;Revision in Personal Protective Equipment within Infection Prevention and Control section</td>
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1. Introduction

The disease COVID-19 is caused by a new strain of coronavirus which was first identified in Wuhan, China. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. COVID-19 was declared a pandemic by the World Health Organisation on 12/3/2020. We now have spread of COVID-19 within communities in the UK.

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

There is currently no vaccine to prevent COVID-19.

The following measures are recommended to help reduce the spread of COVID-19 and to protect people at increased risk of severe illness:

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

Social distancing measures should be followed by everyone, including children, in line with the government advice to stay at home. The aim of social distancing measures is to reduce the transmission of COVID-19. Up to date information can be found on the NHS Inform website. Note that shielding advice should be followed by individuals at risk of severe infection.

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

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

The case definition being used across the UK reflects our current understanding from the epidemiology available and will likely be subject to change as new information emerges. For most people COVID-19 will be a mild, self-limiting infection and will not require admission to hospital. People in the community who fit the definition should self-isolate.

Clinicians should test patients who meet the case definition for individuals requiring hospital admission. Clinicians should also consider testing any patient in hospital (whether a new admission or existing patient) with new respiratory symptoms, fever or worsening of a pre-existing respiratory condition. Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised. Inpatients must be assessed for bacterial sepsis or other causes of symptoms as appropriate.

3.1. Case definition for individuals in the community

People with the following symptoms are advised to self-isolate for 7 days and COVID-19 testing is not required.

Recent onset (within the last 7 days):

- New continuous cough
  and/or
- High temperature.

3.2. Case definition for individuals requiring hospital admission

- Clinical or radiological evidence of pneumonia
  or
- Acute respiratory distress syndrome
  or
- Influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing)

4. Triage of Patients

From 0800 Monday 23 March, people who are unwell and worried about COVID-19 will be directed to consult NHS inform and phone NHS 24 (call 111) as the first point of contact, not their GP. NHS inform and NHS 24 will form the first point of contact for all COVID-19 related symptoms during both in and out of hours. NHS inform have developed posters
which can be printed and shared. It can be found at the NHS inform - Advice for professionals under communication toolkits.

Calls will be triaged through NHS24 to a local (non-patient facing) hub staffed with clinicians drawn from across both primary and secondary care. People who need to be seen will be offered appointments at dedicated local assessment centres, staffed and equipped to deal with COVID-19 related presentation.

Primary Care should make every effort to triage all patients by telephone to avoid the patient presenting at the practice or department unnecessarily and to minimise any contact with patients with respiratory symptoms.

5. Management of patients identified through telephone consultation who do not require clinical assessment and meet the possible case definition for COVID-19

Advise the patient to self-isolate at home. Direct the patient to “stay at home” advice which can be found on NHS Inform. “Stay at home” advice differs depending on whether the patient lives alone or in a household with other people.

Provide the patient with worsening advice and direct them to phone NHS 24 (call 111) if their symptoms deteriorate. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

6. Management of patients requiring clinical assessment

For patients who should be self-isolating but who require clinical assessment for non-Covid19 matters the following precautions should be taken.

6.1. Infection Prevention and Control


For all consultations with patients presenting with symptoms in keeping with the case definitions described in section 3, appropriate Personal Protective Equipment (PPE) must be worn as per Table 2 of the guidance which can be accessed here.

Table 4 provides additional considerations for PPE where there is sustained transmission of COVID-19 taking into account individual risk assessment for this new and emerging pathogen and can be accessed here.

Ensure that staff are:

- familiar with all PPE required including provision of adequate supplies, safe donning and doffing procedures, where stored and how it should be used
- aware of what actions to take if an individual meeting the case definition presents
An FFP respirator is only required if undertaking an Aerosol Generating Procedure (AGP) which should be avoided in the Primary Care setting for this group of patients. The following procedures are considered AGPs:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning of the respiratory tract (including the upper respiratory tract) *
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy and upper ENT airway procedures that involve suctioning
- Upper Gastro-intestinal Endoscopy where there is open suctioning of the upper respiratory tract
- Surgery and post mortem procedures involving high-speed devices
- Some dental procedures (e.g. high-speed drilling)
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP) **
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- High flow nasal oxygen (HFNO) ***

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

** CPAP and BiPAP are considered Aerosol Generating Procedures (AGPs). Long Term Oxygen Therapy is not. The current recommended advice is as follows:

- Primary care staff should avoid visiting patients who have respiratory symptoms and are on CPAP/BiPAP at home.
- Consider phone consultations in the first instance to assess whether the patient requires a home visit. If it is safe to postpone the visit until symptoms have resolved, then do so.
- If you must carry out a home visit, phone ahead and establish what times of the day the patient is on their CPAP/BiPAP. Primary care staff should ensure they visit at least 1 hour after the CPAP/BiPAP was switched off which will provide adequate time for the aerosols to dissipate (based on 3 Air Changes per Hour (ACH))
- If the clinical condition is such that the CPAP/BiPAP cannot be turned off for a full hour before the visit then the patient should, if possible, move to another room before the practitioner enters their home and the door of the room where the CPAP/BiPAP takes place should be closed. The practitioner can then enter the patient’s home to assess their condition.
- If the patients clinical condition is such that neither of these is possible and there are no appropriate primary care practitioners available who have been face fit tested or there no access to FFP respirator masks, then the patient will require transfer to hospital for clinical assessment.
- Alert the ambulance that the patient is a suspected COVID-19 requiring CPCP/BiPAP

***Note: High Flow Nasal Oxygen, sometimes referred to as High Flow Nasal Cannula Therapy, is the process by which warmed and humidified respiratory gases are delivered to a patient through a nasal cannula via a specifically designed nasal cannula interface. These devices can be set to deliver oxygen at specific concentrations and flow rates (typically 40-60L/min-1 for adults). This is different from standard home oxygen delivered through a nasal cannula which is not an AGP.
For patients with suspected/confirmed COVID-19, any of these potentially infectious AGPs should only be carried out when essential. Where possible, these procedures should be carried out in a single room with the doors shut. Only those healthcare staff who are needed to undertake the procedure should be present and are required to wear PPE in line with Table 2: performing an AGP.

Certain other procedures/equipment may generate an aerosol from material other than patient secretions but are not considered to represent a significant infectious risk. Procedures in this category include:

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

**Note:** During nebulisation, the aerosol derives from a non-patient source (the fluid in the nebuliser chamber) and does not carry patient-derived viral particles. If a particle in the aerosol coalesces with a contaminated mucous membrane, it will cease to be airborne and therefore will not be part of an aerosol. Staff should use appropriate hand hygiene when helping patients to remove nebulisers and oxygen masks.

NB: **Table 2** also provides details of recommended PPE to be worn by staff providing direct care or visiting patients at home where the patient or someone in the household is within the extremely vulnerable group undergoing shielding.

### 6.2. Face to face clinical assessment

Where possible consider practical approaches to facilitate infection prevention and control measures for this group of patients. This could include:

- Designated area or rooms for seeing patient with respiratory symptoms
- Seeing such patients at a specific time of day (e.g. end of a list or separate clinic)
- Rooms used for assessment of these patients should be kept clutter free with equipment kept in closed cupboards to minimise potential for contamination. Soft furnishings should be avoided where possible. Tie back examination curtains to avoid contamination. The practice should have a regular laundering regime in place for curtains
- Segregation of patients with respiratory symptoms from other patients e.g. using separate entrances, separate waiting areas, dedicated staff for respiratory patients
- All non-essential items including toys, books and magazines should be removed from receptions, waiting areas, consulting and treatment rooms

### 6.3. Clinical assessment at home visit

If carrying out a home visit, follow infection prevention and control advice as per 6.1 above. Practitioners should carry a waste bag to dispose of PPE following the visit.
Following the patient consultation, PPE should be removed as per appendix 2. This should be placed in a disposable plastic bag, tied and held for 72 hours before being placed in patients own domestic waste bin.

**6.4. Management of patients following clinical assessment**

If the patient does not require referral to secondary care and they meet the case definition for a possible case of COVID-19 they and their household members should be advised to self-isolate. Direct the patient to “stay at home” advice which can be found at [NHS Inform](https://www.nhsinform.scot/). Provide the patient with worsening advice and direct them to phone NHS24 if their symptoms deteriorate. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

If the patient does require referral to secondary care this should be done via existing mechanisms for hospital referral – phone ahead, do not advise the patient to self-present at A&E or minor injury unit.

**6.5. Transport to hospital**

Patients must not use public transport or taxis to get to hospital. Transport options include:

- Patients can be taken to hospital by an accompanying friend or family member if they have already had significant exposure to the patient and are aware of the possible COVID-19 diagnosis.
  
  The patient should sit in the rear of the car and wear a surgical face mask if available. The car should be well ventilated with an open window. They should be given clear instructions on what to do when they get to the hospital to minimise risk of exposure to staff, patients and visitors.

  OR

- If the patient is clinically well enough to drive themselves to the hospital, then they can do so. They should be given clear instructions on what to do when they get to the hospital to minimise risk of exposure to staff, patients and visitors.

  OR

- Arrange transfer by Scottish Ambulance Service (ensuring that you inform the ambulance call handler of the concerns about COVID-19) and proceed with management as follows:
  
  - Staff should withdraw from the room if the patient is clinically well enough to be left unattended.
  - Close the door to the room.
  - Wash your hands with soap and water.
  - If required, identify suitable toilet facilities that only the patient will use.
  - If required to re-enter the room, Table 2
7. Self-isolation

Patients self-isolating should be advised to follow the “stay at home” advice on NHS Inform. Stay at home advice differs depending on whether the patient lives alone or in a household with other people. Isolation notes are available by following the NHS Inform Symptom Checker for all categories of self-isolation.

8. Social distancing and shielding

Practices should familiarise themselves with the advice on social distancing and shielding (see introduction). Practices will need to consider how best to deliver their services in light of these recommendations.

9. Reporting to Local Health Protection Team

Individual suspected cases in community or social or residential care settings do not need to be reported to local HPTs.

The local Health Protection Team (HPT) she be informed of clusters or outbreaks in:

- A long-term care facility
- A prison or place of detention or other closed setting
- Any other group residential setting such as boarding schools

An outbreak of COVID-19 is defined as 2 or more cases in the same setting where nosocomial infection and ongoing transmission is suspected.

Please check appendix 1 for contact details of local HPTs.

10. Testing for COVID-19 infection to enable key workers to return to work

The Scottish Government have produced guidance for NHS Boards in relation to the testing of key health and social care workers for COVID-19 infection to enable them to return to work. Further information can be found here.

11. Environmental cleaning following a suspected case

Once a suspected case has left premises, the room where the patient was placed/isolated should not be used until adequately decontaminated. The room door should remain shut until it has been cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back into use immediately.
11.1 Preparation

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

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

11.2 On entering the room

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste.
- Provided curtains have been tied back during the examination and no contamination is evident, these can be left in situ. Otherwise, remove any fabric curtains or screens and bag as infectious linen.
- Close any sharps containers, wipe the outer surfaces with either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.) or a neutral purpose detergent followed by disinfection (1000 ppm av.cl.).

11.3 Cleaning process

Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:

1. Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)

or

2. A neutral purpose detergent followed by disinfection (1000 ppm av.cl.):
   - follow manufacturer’s instructions for dilution, application and contact times for all detergents and disinfectants
   - any cloths and mop heads used must be disposed of as single use items
11.4. Cleaning and disinfection of reusable equipment
- clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal
- clean all reusable equipment systematically from the top or furthest away point

11.5. Carpeted flooring and soft furnishings
Ideally the use of examination rooms that are carpeted should be avoided. For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer’s instructions for a suitable alternative to use following, or combined with, detergent cleaning.

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

11.7. Cleaning of communal areas
If a possible case spent time in a communal area used for non-respiratory patients, for example, a waiting area or toilet facilities, then these areas should be cleaned with detergent and disinfectant (as above) unless there has been a blood/body fluid spill which should be dealt with immediately (guidance is available at Appendix 9 of the National Infection Prevention and Control Manual). Once cleaning and disinfection have been completed, these areas can be put back into use immediately.

11.8. Attending deaths
The principles of Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) continue to apply whilst deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

12. Death certification during the COVID-19 pandemic
According to the CMO letter on “Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic” medical practitioners do not need to report deaths as a result of COVID-19 disease or presumed COVID-19 disease to the
Procurator Fiscal where they would otherwise require to be reported in terms of section 3(d) of the Reporting deaths to the Procurator Fiscal guidance. Deaths as a result of presumed COVID-19 disease in the community are not required to be reported to the local health protection team.

DCRS will continue to provide advice via their enquiry line on 03001231898 or dcrs@nhs24.scot.nhs.uk and authorise disposal of repatriations to Scotland.

13. Further information

Further Information for health professionals can be found on the HPS COVID-19 page

Information for the general public NHS Inform.
## Appendix 1: Contact details for local Health Protection Teams

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<th>Organisation</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number</th>
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<tr>
<td>Ayrshire and Arran</td>
<td>01292 885858</td>
<td>01563 521 133 Crosshouse Hospital switchboard</td>
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<tr>
<td>Borders</td>
<td>01896 825560</td>
<td>01896 826 000 Borders General switchboard</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
</tr>
<tr>
<td>Fife</td>
<td>01592 226435</td>
<td>01592 643355 Victoria Hospital switchboard</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>01786 457 283 Ask for CPHM on call</td>
<td>01324 566000 Ask for CPHM on call</td>
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<tr>
<td>Grampian</td>
<td>01224 558520</td>
<td>0345 456 6000</td>
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<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600 Gartnavel switchboard</td>
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<td>Highland</td>
<td>01463 704886</td>
<td>01463 704 000 Raigmore switchboard</td>
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<td>01236 748 748 Monklands switchboard</td>
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<td>0131 465 5420/5422</td>
<td>0131 242 1000 Edinburgh Royal switchboard</td>
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<td>Orkney</td>
<td>01856 888034</td>
<td>01856 888 000 Balfour Hospital switchboard</td>
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<td>01382 660111 Ninewells switchboard</td>
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Appendix 2: Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE
PPE should be put on before entering the room where the patient is. Put PPE on in the following order:

1. Disposable plastic apron
2. A Type IIR (Fluid Resistant Surgical Facemask) FRSM. This should be close fitting and fully cover the nose and mouth. Do not touch the front of the mask when being worn
3. Disposable non-sterile nitrile, latex or neoprene gloves. There is no requirement for double-gloving

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

Removal of PPE
PPE should be removed in an order that minimises the potential for cross-contamination. Before leaving the room where the patient is, gloves, apron and FRSM should be removed (in that order, where worn) and disposed of as clinical waste. Guidance on the order of removal of PPE is as follows:

1. 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.
   - Discard as clinical waste.

2. Apron
   - Unfasten or break apron ties.
   - Pull the apron away from the neck and shoulders, touching the inside of the apron only.
   - Turn the apron inside out, fold or roll into a bundle and discard as clinical waste.
3. Fluid Resistant Surgical Facemask (FRSM)

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

Perform hand hygiene immediately after removing all PPE.

**Instructional video**

An instructional video for the correct order for donning, doffing and disposal of PPE for healthcare workers in a primary care setting has been produced.

You can access this in the following locations:

- [YouTube](#)
- [Vimeo](#)