## Version history

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V1.0</td>
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<td>First version of document</td>
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<tr>
<td>V1.1</td>
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<td>Testing and admission information updated Providing care for residents during pandemic section updated</td>
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</tr>
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</tr>
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</tr>
</tbody>
</table>
| V1.52   | 15/06/2020    | Updated “stay at home” link from PHE to SG throughout
<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of changes</th>
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<td></td>
<td>Changed all mention of physical (social) distancing to physical distancing throughout</td>
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<tr>
<td></td>
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<td>16 Personal or work travel and physical distancing: addition of Transport Scotland face coverings information</td>
</tr>
<tr>
<td>V1.6</td>
<td>04/08/2020</td>
<td>1 Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness: shielding advice and physical distancing sections updated with phase 3 information</td>
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<tr>
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<td>16 Personal or work travel and physical distancing: updated with Phase 3 information.</td>
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<td></td>
<td>17 Link to revised SG visiting guidance</td>
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<tr>
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<td></td>
<td>Annex 1: shielding advice updated, link for staying safe advice updated to phase 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appendix 1: Health Protection Teams email addresses added</td>
</tr>
</tbody>
</table>
Contents

Scope of the guidance ........................................................................................................................................... 5
Introduction ............................................................................................................................................................. 6

1. Measures to prevent spread of COVID-19 and protect people at increased risk of severe illness ......................................................... 6
   1.1 Symptoms of COVID-19 for residents in care homes ............................................................... 7
   1.2 Spread of COVID-19 in care homes ......................................................................................... 7

2. Preventing spread of infection in Care Home Settings................................................................................. 8

3. Providing care for residents during COVID-19 pandemic ........................................................................ 9

4. Measures to protect residents in the shielding category ........................................................................... 10

5. Measures for residents exposed to a case of COVID-19 ........................................................................... 10

6. Admission of individuals to the care home facility ................................................................................. 11

7. Testing in the care home ......................................................................................................................... 12

8. Resident placement ................................................................................................................................... 13

9. Personal Protective Equipment (PPE) .................................................................................................... 14
   9.1 Personal Protective Equipment (PPE) ...................................................................................... 14
   9.2 Access to personal protective equipment (PPE) ..................................................................... 16

10. Care Equipment .......................................................................................................................................... 16

11. Environmental decontamination (cleaning and disinfection) ............................................................. 16

12. Waste ....................................................................................................................................................... 17

13. Safe Management of Linen ................................................................................................................... 18

14. Staff Uniforms .......................................................................................................................................... 18

15. Staffing ...................................................................................................................................................... 18
   15.1 Staff Cohorting (working in dedicated teams) ........................................................................ 18
   15.2 Minimise external staff ............................................................................................................... 18
   15.3 Ensure staff are enabled to follow key measures described in this guidance to prevent spread ................................................................................................................................. 18
   15.4 Staff who have contact with a case of COVID-19 at work ..................................................... 19
   15.5 Staff who have recovered from COVID-19 ............................................................................ 19

16. Personal or work travel and physical distancing ................................................................................. 19

17. Visiting care homes ............................................................................................................................... 20

18. Caring for someone who has died ....................................................................................................... 21

19. Death Certification during COVID-19 pandemic .................................................................................... 21

Annex: 1: Organisational and workplace arrangements during COVID-19 ............................................. 22
1. Physical distancing and stay at home guidance ............................................22
2. Shielding of extremely high risk individuals ......................................................23
3. Stay at home guidance for people who have symptoms or have a COVID-19
diagnosis and their household members (household isolation) ...............................23
4. Test and Protect .................................................................................................23
5. Infection prevention and control (hygiene measures) ..........................................24
Appendix 1 - Contact details for local Health Protection Teams ..................................25
Appendix 2 - Best Practice How to Hand Wash .........................................................27
Appendix 3 - Putting on and removing Personal Protective Equipment (PPE)..................29
Appendix 4 - Routine decontamination of reusable non-invasive patient care equipment .....30
Appendix 5: Decontamination and cleaning processes for facilities with possible or confirmed
cases of COVID-19 .................................................................................................31
Appendix 6: PPE Table 2 ..........................................................................................33
Appendix 7: PPE Table 4 ..........................................................................................34
**Scope of the guidance**
This guidance is to support those working in care home settings to give advice to their staff and users of their services about COVID-19. It should be used for care home settings including nursing homes and residential care where appropriate.

This guidance is based on what is currently known about COVID-19. Health Protection Scotland (HPS) (now part of Public Health Scotland) will update this guidance as needed and as additional information becomes available.
Introduction
The disease COVID-19 is caused by a new strain of coronavirus which was first identified in Wuhan City, China in December 2019. Symptoms range from mild to moderate respiratory illness to pneumonia or severe acute respiratory infection requiring hospital care. COVID-19 was declared a pandemic by the World Health Organisation on 12 March 2020. We now have spread of COVID-19 within communities across Scotland.

1. 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 or a COVID-19 diagnosis (whether or not they have symptoms) and their household contacts to reduce the community spread of COVID-19. This means that anyone who has symptoms of COVID-19 or a COVID-19 diagnosis (whether or not they have symptoms) and anyone else living in the same household should follow ‘stay at home’ advice on NHS Inform.

**Test and protect** is a public health measure designed to break chains of transmission of COVID-19 in the community. This approach operates by identifying cases of COVID-19, tracing the people who may have become infected by spending time in close contact with them, and then supporting those close contacts to self-isolate, so that if they have the disease they are less likely to transmit it to others. Further details can be found on the Scottish Government website and NHS Inform.

**Physical distancing** measures should be followed by everyone in line with the Scottish Government advice to stay safe (physical distancing). Guidelines vary by age group – for up to date information see the Scottish Government website. The aim of physical distancing measures is to reduce the transmission of COVID-19. People who are at increased risk of severe illness from coronavirus should strictly follow physical distancing measures (this includes those with certain medical conditions, pregnant or aged 70 or older). Up to date information can be found on the NHS Inform website. This also includes additional detail on how to adapt physical distancing for those with additional needs.
Shielding is a measure to protect people, including children, who are extremely clinically vulnerable to severe illness from COVID-19 because of certain underlying health conditions. See NHS Inform website for further information.

Scottish Government advise:
“People who have been advised to shield because of COVID-19, will no longer have to do so from 1 August and will be asked to follow general safety guidance, as well as follow stringent physical distancing and hygiene measures”.

There are some exceptions to this including those living in residential care or nursing homes. Further information including exceptions can be found on the Scottish Government 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. A risk assessment should be undertaken as it may not be appropriate for them to work on-site at all. 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.

1.1 Symptoms of COVID-19 for residents in care homes
The most common symptoms of COVID-19 are:
• New continuous cough
  or
• Fever
  or
• Loss of/ change in sense of smell or taste.

Elderly residents may present with atypical or non-specific symptoms. See Scottish Government’s COVID-19: clinical guidance for nursing home and residential care residents for more details on clinical presentation.

1.2 Spread of COVID-19 in care homes
COVID-19 is spread through respiratory droplets produced when an infected person coughs or sneezes. This is thought to be the main way the infection is transmitted between people and is most likely to happen when there is close contact (within 2 metres) with an infected person who is symptomatic. It is likely that the risk of infection transmission increases the longer someone has close contact with an infected person.
There are two routes by which COVID-19 can be spread:

- **Directly:** from close contact with an infected person (within 2 metres) where respiratory secretions can enter the eyes, mouth, nose or airways. This risk increases the longer someone has close contact with an infected person.
- **Indirectly:** by touching a surface, object or the hand of an infected person that has been contaminated with respiratory secretions and then touching own mouth, nose or eyes.

Further HPS guidance for other settings, including **Social, Community and Residential Care** and **Domiciliary Care**, is available on the **HPS website**.

### 2. Preventing spread of infection in Care Home Settings

**National Infection Prevention and Control Manual** (NIPCM) provides information and evidence on Standard Infection Control Precautions and Transmission Based precautions which should be applied for COVID-19 disease.

**Hand hygiene**

Hand hygiene is essential to reduce the transmission of infection in health and other care settings. All staff, residents and visitors should decontaminate their hands with soap and water or alcohol-based hand rub (ABHR) when entering and leaving areas where patient care is being delivered. See **Appendix 2** for best practice on hand washing.

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling.

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

If wearing an apron rather than a gown (bare below the elbows), and it is known or possible that forearms 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.

Staff should support any residents with hand hygiene regularly where required.
Respiratory and cough hygiene – ‘Catch it, bin it, kill it’
Residents, staff and visitors should be encouraged to minimise potential COVID-19 transmission through good respiratory hygiene measures which are:

- disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose – used tissues should be disposed of promptly in the nearest waste bin
- tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients, visitors and staff
- hands should be cleaned (using soap and water if possible, otherwise using ABHR) after coughing, sneezing, using tissues or after any contact with respiratory secretions and contaminated objects
- encourage patients to keep hands away from the eyes, mouth and nose

Some patients (such as the elderly and children) may need assistance with containment of respiratory secretions; those who are immobile will need a container (for example a plastic bag) readily at hand for immediate disposal of tissues.

3. Providing care for residents during COVID-19 pandemic
Ensure daily monitoring of all individuals for COVID-19 symptoms, or other signs of illness.
Residents with cognitive impairment may be less able to report symptoms. Elderly or frail residents with co-morbidities may also present with atypical and non-specific signs of illness.
Further information can accessed here. If a resident becomes unwell contact the GP for clinical advice.

- If it is an emergency and you need to call an ambulance, dial 999 and inform the call handler or operator that the unwell person may have coronavirus (COVID-19).

A single case of infection should prompt contact with your local HPT as it may also signal the start of a possible outbreak. An outbreak is normally defined as two linked cases of a disease. For care homes specifically, with respect to COVID-19, an outbreak should be suspected when there is a single new case with symptoms consistent with COVID-19 infection arising in the care home, likely to be due to spread of the virus within the care home. Assessment of resident cases when considering any potential outbreak should also include symptomatic cases who have either been transferred from the facility to hospital as a result of infection or a suspected COVID-19 individual who has died within the same time period. These criteria may apply to other residential settings if there are groups of clinically vulnerable individuals or extremely vulnerable individuals living in group settings. This will need to be considered on an individual basis.

On identification of a new suspected COVID-19 case, you must contact your local HPT without delay who will advise on the need for testing of residents and staff as well as other IPC measures to help limit further spread of the virus and control the outbreak.
If the facility is closed to admissions, then the criteria for reopening is as follows. As a minimum there should be no new symptomatic or confirmed cases for a period of 14 days from last possible exposure to a case, whether in a resident or staff, as this is the criteria for declaring that an outbreak is over. Existing cases should be isolated/coholed and symptoms should be resolving, and there should be sufficient staff to enable the facility to operate safely.

Care Homes are required to report to their regulator, the Care Inspectorate, issues of concern (e.g. COVID-19 cases, COVID-19 deaths, any outbreaks).

4. Measures to protect residents in the shielding category
To help reduce the spread of COVID-19 and to protect people at increased risk of severe illness, i.e. in the shielding category, the following measures should be followed for patients in this category:

- Residents
  - Should have their own single room with en-suite facilities or provided with a dedicated commode where possible
  - Residents who are shielding must not be placed in cohorts

- Staff
  - Must minimise interaction to essential purposes only
  - Must wear PPE when entering their room and within 2m of the resident

5. Measures for residents exposed to a case of COVID-19
Where an individual has developed symptoms or has been diagnosed with COVID-19 (whether they have symptoms or not) within a care home, an assessment of risk should be undertaken to establish the nature and duration of exposure and contact with others. This should be discussed with your HPT.

Where possible, contacts should be isolated individually in single rooms for 14 days after last exposure to a possible or confirmed case. This should be the preferred option whenever possible. Where all single occupancy rooms are occupied, cohorting of exposed residents may be considered. Residents who are undergoing shielding should never be placed in a cohort. Cohorting of patients should be discussed with your HPT.

These contacts should be carefully monitored for any symptoms of COVID-19 during the 14 day period from last exposure.

If symptoms or signs consistent with COVID-19 occur in the 14 days after last exposure then relevant diagnostic tests, including for SARS-CoV-2, should be performed. If they have been cohorted with other individuals, the other residents’ follow-up period recomences from the date of last exposure.

Ensure that residents who have had no contact with COVID-19 cases are separated from residents with symptoms of COVID-19 or a diagnosis of COVID-19.
6. Admission of individuals to the care home facility

The Health Secretary’s statement on 21st April stated that the following groups should be tested:

- All COVID-19 patients in hospital who are to be admitted to a care home
- All other admissions to care homes

The presumption should be that all residents being admitted to a care home should have a negative test before admission, unless it is in the clinical interests of the person to be moved and then only after a full risk assessment.

For adults without the capacity to consent to a test, see COVID-19: clinical guidance for nursing home and residential care residents for further information.

Admission of COVID-19 recovered patients from hospital

Patients should always be isolated for a minimum of 14 days from symptom onset (or first positive test if symptoms onset undetermined) and absence of fever for 48 hours (without use of antipyretics). They do not require to spend the 14 days in hospital but should ideally have 2 negative tests before discharge from hospital (testing can be commenced on day 8). Tests should have been taken at least 24 hours apart and preferably within 48 hours of discharge.

Where testing is not possible (e.g. patient doesn’t consent or it would cause distress) and following risk assessment for discharge to care home within the 14 day isolation period, then there must be an agreed care plan for the remaining period of isolation up to 14 days in the home.

Further details can be found in Guidance for stepdown of infection control precautions and discharging COVID-19 patients from hospital to residential settings.

Admission of non-COVID-19 patients from hospital

Testing should be done within 48 hours prior to discharge from hospital. A single test is sufficient. A negative result should be available before discharge. The exception is where patient is considered to suffer detrimental clinical consequence or distress if they were not able to be discharged to a care home. In these cases, a patient may be discharged to the care home prior to the test result being available. All patients being discharged from hospital should be isolated for 14 days from the date of discharge from hospital. Risk assessment prior to discharge from hospital should be undertaken in conjunction with the care home.

Note: an admission to hospital is considered to include only those patients who are admitted to a ward. An attendance at A&E or other assessment unit that didn’t result in an admission would not constitute an admission.

Further details on testing requirements can be found in Guidance for Sampling and Laboratory Investigations.
Admissions from the community
All other admissions from the community should have at least one test performed before or on admission, and be isolated on admission for 14 days. Risk assessment prior to admission should be undertaken to ensure that appropriate isolation facilities are available, taking into account requirements for the individual’s care. Where testing is not possible (e.g. individual doesn’t consent or it would cause distress) then there must be an agreed care plan for the 14 days of isolation in the care home.

Residents who leave the premises
Residents who leave the facility to attend an essential non-hospital or hospital day visit, e.g. attending a funeral or hospital appointment, do not require the same measures as a new admission. The guidance outlined on NHS Inform on physical distancing, shielding and household isolation must be followed during day visits. Any concerns about potential exposure to COVID-19 during a day visit may require a local risk assessment to determine whether additional measures are needed.

7. Testing in the care home
Currently all care home residents and staff who develop symptoms should be clinically assessed and where appropriate offered testing for COVID-19.

The First Minister announced changes to testing of residents and staff in care homes on 1 May 2020.

“We now intend to undertake enhanced outbreak investigation in all care homes where there are any cases of COVID - this will involve testing, subject to individuals’ consent, all residents and staff, whether or not they have symptoms. In addition, where a care home with an outbreak is part of a group or chain and staff might still be moving between homes, we will also carry out urgent testing in any linked homes. We will also begin sampling testing in care homes where there are no cases. By definition this will also include testing residents and staff who are not symptomatic. This is a significant expansion and we do not underestimate the logistical and workforce requirements. Now we have the increasing testing capacity, we will make it happen as swiftly as practicable.”

Further details can be found on the Scottish Government website.

New admissions should be considered for retesting after admission if they become symptomatic, including changes in the resident’s condition if indicated after a clinical assessment. The 14 day isolation period that started on admission should be completed even if a COVID-19 test result comes back negative.
For additional information on testing in care home settings, see Interim guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff.

8. Resident placement
All symptomatic or COVID-19 diagnosed residents in the facility should be isolated immediately for 14 days from the date of symptom onset (or date of first positive test if symptom onset undetermined). The individual should be placed in a single room with en-suite facilities, where possible. The door should be kept closed to the room. Where this is not possible, ensure the bed is moved to the furthest safe point in the room to achieve a 2 metre physical distance to the open door. Clearly sign the rooms by placing IPC signs, indicating droplet precautions, at the entrance of the room or area. Confidentiality must be maintained.

If an en-suite is not available, designate a commode that only that individual will use if possible. If a commode is used and cannot be dedicated to the resident, ensure it is cleaned as per Appendix 4.

Only essential staff should enter the individuals room, wearing appropriate PPE as per section 9. All necessary procedures and care should be carried out within the individual’s room. Entry and exit from the room should be minimised during care, especially when care procedures produce aerosols or respiratory droplets.

If a transfer from the facility to hospital is required, the ambulance service should be informed if the individual is a suspected or confirmed COVID-19. Staff in the receiving ward/department should also be notified of this in advance of any transfer and informed of the requirement for isolation on arrival.

Infection Prevention and Control measures can be discontinued once the 14-day isolation period is complete and there has been an absence of fever for 48 hours (without the use of antipyretics). Before IPC measures are stepped down for COVID-19, ensure you consider any additional ongoing IPC measures which may be required for loose stools or any other infectious organisms.

Cohorting of symptomatic individuals:
Cohorting in care homes should be avoided where possible. Individuals who are shielding (extremely high risk) must not be placed in cohorts and should be prioritised for single occupancy rooms. Where all single isolation room facilities are occupied and cohorting is unavoidable, then cohorting can be arranged so that

- Confirmed COVID-19 individuals are placed in multi-occupancy rooms together.
- Suspected COVID-19 individuals are placed in multi occupancy rooms together.
- Confirmed and suspected cases should not be cohorted together.
9. Personal Protective Equipment (PPE)

9.1 Personal Protective Equipment (PPE)

A PPE statement was issued by the Scottish Government with COSLA and SJC Unions – it can be accessed [here](#) and states that social and home workers can wear a fluid resistant surgical mask (FRSM) along with other appropriate PPE where the person they are visiting or otherwise attending to is neither confirmed nor suspected of having COVID-19, if they consider doing so is necessary to their own and the individuals safety.

Table 2 is contained within the [COVID-19 – Infection Prevention and Control guidance](#) and describes the PPE applicable to the facilities described in this guidance when caring for suspected or confirmed cases – also available in [Appendix 6](#).

Sustained transmission of COVID-19 is occurring within Scotland. Table 4 provides additional PPE considerations where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen – also available in [Appendix 7](#).

[Appendix 3](#) describes the procedures for putting on and removing PPE. All staff must be trained on how to use PPE appropriate for their role to limit the spread of COVID-19.

Table 2 also describes the additional PPE required if undertaking an Aerosol Generating Procedure (AGP) – Table 2 can be accessed [here](#) and in [Appendix 6](#). The local Health Protection Team can advise on this. AGPs should be avoided where possible.

The following procedures are considered AGPs:

- Respiratory tract suctioning
- Bronchoscopy
- Dental procedures (using high speed devices such as ultrasonic scalers and high speed drills)
- High Flow Nasal Oxygen (HFNO)
- High Frequency Oscillatory Ventilation (HFOV)
- High speed cutting in surgery/post mortem procedures if this involves the respiratory tract or paranasal sinuses
- Induction of sputum using nebulised saline
- Manual ventilation
- Non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- Tracheal intubation and extubation
- Tracheotomy or tracheostomy procedures (insertion or removal)
- Upper ENT airway procedures that involve suctioning
- Upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract

*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.

Certain other procedures/equipment may generate an aerosol from material other than an individual’s secretions but are not considered to represent a significant infection risk and do not require AGP PPE. Procedures in this category include:

- administration of 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.

For individuals with suspected/confirmed COVID-19, any of the potentially infectious AGPs listed above should only be carried out when essential. The required PPE for AGPs should be worn by those undertaking the procedure and those in the room, as detailed above. Where possible, these procedures should be carried out in a single room with the doors shut. Only those staff who are needed to undertake the procedure should be present.

It is the responsibility of care home providers to ensure that all staff have been fit tested for FFP3 respirators where appropriate. If you do not anticipate the need for FFP respirators and are not caring for anyone currently receiving AGPs such as CPAP, these should not be ordered or stockpiled and any surplus stock should be returned.

**PPE used for sessional use**

Aprons and gloves are subject to single use as per Standard Infection Control Precautions (SICPs), and must be changed between residents. Respirators, fluid-resistant (Type IIR) surgical masks (FRSM), eye protection and disposable fluid repellent coveralls or long-sleeved disposable fluid repellent gowns can be subject to sessional use in circumstances outlined in the PPE tables.

A single session refers to a period of time where health and care staff are undertaking duties in a specific setting within the facility e.g. providing direct care for individuals. Staff can go between residents in sessional PPE. A session ends when the health and care worker leaves the specific setting within the facility, for example the COVID-19 cohort area.

Sessional use should always be risk assessed and considered where there are high rates of cases. PPE should be disposed of after each session or earlier if damaged, soiled, or uncomfortable.
9.2 Access to personal protective equipment (PPE)
All services who are registered with the Care Inspectorate that are providing health and care support and have an urgent need for PPE after having fully explored local supply routes/discussions with NHS Board colleagues, can contact a triage centre run by NHS National Services for Scotland (NHS NSS).

Please note that in the first instance, this helpline is to be used only in cases where there is an urgent supply shortage after “business as usual” routes have been exhausted.

The following contact details will direct providers to the NHS NSS triage centre for social care PPE: Email: support@socialcare-nhs.info Phone: 0300 303 3020. The helpline will be open (8am - 8pm) 7 days a week.

10. Care Equipment
Where possible use single-use equipment and dispose of after use.

Where single use is not possible, use dedicated care equipment in the individual’s room. This should not be shared with other individuals receiving care. If it is not possible to dedicate pieces of equipment to the individual, such as commodes or moving aides, these must be decontaminated immediately after use and before use of any other individual following the guidance in Appendix 4.

Do not use fans that re-circulate the air and open windows for ventilation if it is safe to do so.

Try to keep the room clutter-free and avoid storing any unnecessary equipment or soft furnishings in individuals’ own rooms to prevent unnecessary contamination of items.

11. Environmental decontamination (cleaning and disinfection)
Those carrying out the cleaning must be familiar with the required environmental and equipment decontamination processes, be trained in these accordingly and ensure they are wearing the appropriate PPE. People responsible for cleaning should be advised to clean the COVID-19 areas and isolation room(s) after all other unaffected areas of the facility have been cleaned.

COVID-19 affected areas should be cleaned at least twice daily paying particular attention to common touch surfaces such as door handles, tablets, mobile phones, light switches, remote controls and bed rails.
Coronaviruses are readily inactivated by commonly available disinfectants such as alcohol (70% ethanol) and chlorine-releasing agents (sodium hypochlorite at 1,000 ppm av. cl.).

Therefore, decontamination of the environment should be performed as per Appendix 5 using either

- A combined detergent disinfectant solution at a dilution of 1000 parts per million available chlorine (ppm available chlorine (av.cl.));

  or

- A detergent clean followed by disinfection (1000ppm av.cl.).

In the event of a blood or body fluid spillage, keep people away from the area. Use a spill-kit if available, using the PPE within the kit or PPE provided by the employer/organisation and follow the instructions provided with the spill-kit.

**Environmental decontamination where the suspected or confirmed case is no longer in the room/ environment**

The immediate area occupied by the individual and any equipment used by the individual, should be cleaned using the methods described above. Once this process has been completed, the area can be put back into use.

Any public areas where a symptomatic or a COVID-19 diagnosed individual has only passed through (spent minimal time in), e.g. corridors, and which are not visibly contaminated with any body fluids, do not need to be further decontaminated beyond routine cleaning processes.

Decontamination of soft furnishings may require to be discussed with the local Health Protection Team. If the furnishing is heavily contaminated, you may have to discard it. If it is safe to clean with standard detergent and disinfectant alone then follow appropriate procedure. If it is not safe to clean the item should be discarded.

In situations where belongings of the deceased are being removed, the belongings should first be cleaned with a general household detergent active against viruses and bacteria.

### 12. Waste

If the care home has a clinical waste contract, all waste belonging to the affected individual can be placed in the clinical waste and disposed of immediately. There is no need to hold waste for 72 hours where a clinical waste stream is available.

If the care home does not have a clinical waste contract, ensure all waste items that have been in contact with the individual (e.g. used tissues and disposable cleaning cloths) are disposed of securely within disposable bags. When full, the plastic bag should then be placed in a second bin bag and tied. These bags should be stored in a secure location for 72 hours before being put out for collection.
13. Safe Management of Linen
Any towels or other laundry used by the individual should be treated as infectious and placed in a bag before removing from the isolation room and placing directly into the laundry hamper/bag. Take the laundry hamper as close to the point of use as possible, do not take inside the isolation room. When handling linen do not:
- Rinse, shake or sort linen on removal from beds
- Place used/infectious linen on the floor or any other surface e.g. table top
- Re-handle used/infectious linen when bagged
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle.

14. Staff Uniforms
If available, laundry services should be used to launder staff uniforms. If this is not available uniforms should be transported home in a disposable plastic bag. Uniforms should be laundered daily, and:
- separately from other household linen
- in a load not more than half the machine capacity
- at the maximum temperature the fabric can tolerate, then ironed or tumble dried.

15. Staffing
15.1 Staff Cohorting (working in dedicated teams)
Assigning a dedicated team of staff to care for individuals with COVID-19 is an additional IPC measure which can help prevent onward spread of infection. This should be implemented whenever there are sufficient levels of staff available (so as not to have a negative impact on non-affected individual care).

15.2 Minimise external staff
- The use of bank or agency staff should be minimised. Where used then they should only work for one facility where possible.
- Contractors on site should be kept to a minimum and only essential work carried out.

15.3 Ensure staff are enabled to follow key measures described in this guidance to prevent spread
- Ensure that all individuals in the facility are aware of the requirement to self-isolate if they or their household members develop symptoms of COVID-19 or are diagnosed with COVID-19 and support them in doing so.
- Follow Test and Protect advice on NHS Inform where appropriate
- Consider the additional demands that will be placed on people by requirements for household isolation and put in place resilience planning to support this.
15.4 Staff who have contact with a case of COVID-19 at work
Staff who come into contact with a COVID-19 individual at the workplace while not wearing PPE can remain at work, using PPE appropriately. This is because in most instances this will be a short-lived exposure, unlike exposure in a household setting that is ongoing. These are guiding principles and there should be an individual risk assessment based on staff circumstances and the exposure.

All staff should be vigilant for COVID-19 symptoms during the incubation period following exposure (up to 14 days). If staff develop symptoms they should stay at home and seek advice from NHS Inform or occupational health department as per the local policy.

For additional advice for staff – see Scottish Government’s COVID-19: clinical guidance for nursing home and residential care residents.

Staff Testing
Information on testing staff and their symptomatic household members can be found on NHS Inform. The Scottish Government’s advice on COVID-19 testing can also be found here. There is also Interim guidance on COVID-19 PCR testing in care homes and the management of COVID-19 PCR test positive residents and staff available.

15.5 Staff who have recovered from COVID-19
Staff who have had confirmed COVID-19 and have since recovered must continue to follow the IPC measures as for all other staff including PPE.

16. Personal or work travel and physical distancing
Physical distancing and staying safe advice is in place for all. When using public transport (buses/trams/subways/trains) and private/commercial vehicles, aim to maintain a 2 metre physical distance whenever possible. Where people from different households are sharing a private vehicle (car, taxi, minibus, lorries) then consideration should be given to how physical distancing can be applied within the vehicle, where possible. If you can adhere to physical distancing whilst travelling, then do so. Where this is not possible and you are travelling with non-household members, limit the number of passengers and space out as much as possible.

The Scottish Government have the following advice for Phase 3:

“In enclosed spaces, where physical distancing is more difficult and where there is a risk of close contact with multiple people who are not members of your household, you should wear a face covering.”

People must wear a face covering in shops and on public transport and public transport premises such as railway and bus stations and airports. This applies to open-air railway platforms, but not to bus stops.
There is no evidence to suggest there might be a benefit outdoors from wearing a face covering unless in a crowded situation.

Physical distancing, hand hygiene and respiratory hygiene are the most important and effective things we can all do to prevent the spread of coronavirus. The wearing of face coverings must not be used as an alternative to any of these other precautions.”

Additional information, including specific exemptions are outlined also.

Household members can travel together in larger numbers in a private vehicle. People who are in the higher risk category should consider carefully how they can apply physical distancing advice stringently.

The following general infection prevention and control measures should be followed:

- **Hand hygiene** - use handwashing facilities (or where this is not available, alcohol based hand rub) before and after journeys.
- **Catch coughs and sneezes in tissues or cover mouth and nose with sleeve or elbow (not hands); dispose of the tissue into a bin and wash hands immediately.**
- **Practice physical distancing, for example, sit or stand approximately 2 metres from other passengers, travel in larger vehicles where possible or use vehicles with cab screens, if available.**
- **If using public transport, try to avoid busier times of travel to maximise practising physical distancing.**
- **Clean vehicles between different drivers or passengers, as appropriate.**
- **See Transport Scotland’s [advice on how to travel safely](https://www.transportscotland.gov.uk/travel-safely) for further information.**
- **Do not attend work or use public transport if displaying any COVID-19 symptoms.**

17. **Visiting care homes**

The Scottish Government has produced [COVID-19: adult care homes visiting guidance](https://www.gov.scot/publications/covid-19-adult-care-homes-visiting-guidance/) which outlines a staged approach to the re-introduction of extended visiting to adult care homes. Facilities must review their visiting policy in light of this. The guidance outlined on [NHS Inform](https://www.nhsinform.scot) on physical distancing, shielding and household isolation must be followed by visitors. This advice will significantly limit face-to-face interaction with friends and family in residential settings.

Particular efforts should be made to allow loved ones of a resident receiving end of life care to visit. All visitors must be informed of and adhere to IPC measures in place.

Local risk assessment should ensure a pragmatic and proportionate response, including the consideration of whether there is a requirement for visitors to wear PPE. A log of all visitors should be kept. Visiting may be suspended if considered appropriate by the facility. Consider alternative measures of communication including phoning or face-time.
18. Caring for someone who has died
The IPC measures described in this document continue to apply whilst the individual who has died remains 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 individuals. 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. Body bags may be used for other practical reasons such as maintaining dignity or preventing leakage.

For further information, please see the following guidance produced by Scottish Government Coronavirus (COVID-19): guidance for funeral directors on managing infection risks when handling the deceased and funeral services.

19. Death Certification during COVID-19 pandemic
According to the CMO letter dated 20th May 2020 “Updated Guidance to Medical Practitioners for Death Certification during the COVID-19 Pandemic” from 21 May 2020,

“any death due to COVID-19 or presumed COVID-19 (a) where the deceased was resident in a care home (this includes residential homes for adults, the elderly and children) when the virus was contracted or (b) where to the best of the certifying doctor’s knowledge, there are reasonable grounds to suspect that the deceased may have contracted the virus in the course of their employment or occupation” should be reported to the Procurator Fiscal under section 3(g) of the Reporting deaths to the Procurator Fiscal guidance. It remains that medical practitioners do not need to report all deaths as a result of COVID-19 disease or presumed COVID-19 disease to the Procurator Fiscal where this would have otherwise been required under 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.”
Annex: 1: Organisational and workplace arrangements during COVID-19

This annex contains general advice for workplaces and applies to a range of settings, therefore may be relevant to care homes. For further information, see the non-healthcare settings guidance.

All organisations and individuals must ensure that they adhere to up to date guidance on recommended public health measures from Scottish Government. Consider which groups of people (e.g. staff, contractors, volunteers, service users and visitors) need to be included in applying guidance to your setting. Consider which of the services or activities provided in your setting are essential.

The key public health measures to reduce the spread of infection and preventing infection in vulnerable people are described in detail on NHS Inform.

- **Physical distancing** and **staying safe** guidance.
- **Shielding** of very high risk individuals.
- Stay at home guidance for people who have symptoms or have a COVID-19 diagnosis (whether they have symptoms or not), and their household members (**household isolation**).
- **Test and Protect**
- **Infection prevention and control** (hygiene measures) and PPE.

1. **Physical distancing and stay at home guidance**

   Ensure that all members of the organisation are aware of the requirement to follow physical distancing and stay at home guidance and support them in doing this. Consider the additional demands that will be placed on people and your organisation by following advice on physical distancing and put in place resilience planning to support this.

   Stay at home guidance is in place for everyone. Work that can be done remotely should be done from home. Where the work cannot be done from home then physical distancing must be followed. Individuals who are at increased risk of infection (but not in the shielding category) are advised to follow the physical distancing advice stringently and this must be taken into consideration. Note individuals following shielding or isolation guidance must not attend the workplace.

   It is essential that the clear recommendation of the 2m rule outlined in the physical distancing guidance is adhered to. For work designated as essential, there are however circumstances where the 2 m rule cannot be followed despite all possible steps being taken to try to maintain this; in those circumstances a risk based approach should be used. A risk assessment should be conducted that considers the following aspects and the outcome should be documented:
Is it an essential role (see key worker guidance)?
Is the task being done essential?
Is it essential that the task is done now or can it be deferred?
Can the task be done in a different way so that 2m distance can be maintained?
  - Yes – do this and document a justification that describes why the process has changed from usual practice, make sure your usual Health and Safety considerations are applied.
  - No – then adapt the task to ensure physical distancing is adhered to as far as possible and document this.
    - **Minimise the time** spent at less than 2m
    - **Maintain 2m distance for** breaks and lunch
    - **Maximise the distance**, where the 2m distance cannot be kept, always ensure the greatest distance between people is maintained
  - Apply **environmental changes** to minimise contact such as physical barriers, markings or changing placement of equipment or seating (e.g. a screen between staff and customers, or tape markings on the floor to show the 2 metre distance required).
  - Consider **changes in working practices** (stagger times at which work is done or breaks are taken; restructure work flows to allow for physical distancing to be implemented).
  - Ensure that good hygiene practices and all **infection prevention and control measures** are implemented fully.

2. **Shielding of extremely high risk individuals**

See the information on shielding in section 1 of this guidance. Further information on shielding is available in the Scottish Government COVID-19: shielding support and contacts guidance and NHS Inform.

3. **Stay at home guidance for people who have symptoms or have a COVID-19 diagnosis and their household members (household isolation)**

Organisations must ensure that all members of the organisation are aware that they must stay at home if they or a household member develop symptoms of COVID-19 or have a COVID-19 diagnosis and they should support them in doing this. Further details are available on NHS Inform.

4. **Test and Protect**

Organisations should be aware of up to date advice on the test, trace, isolate, support approach, and support their members to follow this. More information is available from the Scottish Government website and NHS Inform.
5. Infection prevention and control (hygiene measures)

Organisations should:

- Promote good hand hygiene for all staff, volunteers, contractors, service users and visitors.
- Ensure that adequate facilities are available for hand hygiene, including handwashing facilities that are adequately stocked or alcohol based hand rub at key areas (e.g. entry and exit points).
- Ensure workers are aware they must not attend work with COVID-19 symptoms or if they have a COVID-19 diagnosis (whether they have symptoms or not). They must also not attend work if they are required to self-isolate (through household isolation or test and protect measures).
- Ensure that everyone knows what to do if someone becomes symptomatic whilst at work.
- Ensure regular detergent cleaning schedules and procedures are in place using a product which is active against bacteria and viruses.
  - Twice daily cleaning and disinfection of frequently touched objects and surfaces (e.g. telephones, keyboards, door handles, desks and tables).
  - Ensure that where possible movement of individuals between work stations is minimised and where work spaces are shared there is cleaning between use (e.g. avoid hot desking and instead each individual has a designated desk).
  - Clean work vehicles, between different passengers or shifts as appropriate.
- Ensure any crockery and cutlery in shared kitchen areas is cleaned with warm general purpose detergent and dried thoroughly before being stored for re-use.
- Ensure good ventilation (e.g. keep windows open where appropriate).
- Ensure that individuals are aware of and able to follow the hygiene advice.
- Ensure that individuals follow the “personal or work travel and physical distancing” guidance.
## Appendix 1 - Contact details for local Health Protection Teams

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Office Hours Telephone Number</th>
<th>Out of Hours Telephone Number</th>
<th>Health Protection Team Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>01292 885858</td>
<td>01563 521 133</td>
<td><a href="mailto:hpteam@aapct.scot.nhs.uk">hpteam@aapct.scot.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crosshouse Hospital switchboard</td>
<td></td>
</tr>
<tr>
<td>Borders</td>
<td>01896 825560</td>
<td>01896 826 000</td>
<td><a href="mailto:Healthprotection@borders.scot.nhs.uk">Healthprotection@borders.scot.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Borders General switchboard</td>
<td></td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>01387 272 724</td>
<td>01387 246 246</td>
<td><a href="mailto:dumf-uhb.hpt@nhs.net">dumf-uhb.hpt@nhs.net</a></td>
</tr>
<tr>
<td>Fife</td>
<td>01592 226435</td>
<td>01592 643355</td>
<td><a href="mailto:hpt.fife@nhs.net">hpt.fife@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Victoria Hospital switchboard</td>
<td></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>
<td><a href="mailto:FV-UHB.healthprotectionteam@nhs.net">FV-UHB.healthprotectionteam@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Grampian</td>
<td>01224 558520</td>
<td>0345 456 600</td>
<td><a href="mailto:grampian.healthprotection@nhs.net">grampian.healthprotection@nhs.net</a></td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>0141 201 4917</td>
<td>0141 211 3600</td>
<td><a href="mailto:phpu@ggc.scot.nhs.uk">phpu@ggc.scot.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gartnavel switchboard</td>
<td></td>
</tr>
<tr>
<td>Highland</td>
<td>01463 704886</td>
<td>01463 704 000</td>
<td><a href="mailto:hpt.highland@nhs.net">hpt.highland@nhs.net</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Raigmore switchboard</td>
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</tr>
<tr>
<td>Lanarkshire</td>
<td>01698 858232 / 858228</td>
<td>01236 748 748</td>
<td><a href="mailto:healthprotection@lanarkshire.scot.nhs.uk">healthprotection@lanarkshire.scot.nhs.uk</a></td>
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<tr>
<td></td>
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<td>Monklands switchboard</td>
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<tr>
<td>Lothian</td>
<td>0131 465 5420/5422</td>
<td>0131 242 1000</td>
<td><a href="mailto:health.protection@nhslothian.scot.nhs.uk">health.protection@nhslothian.scot.nhs.uk</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Edinburgh Royal switchboard</td>
<td></td>
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<tr>
<td>Health Board</td>
<td>Office Hours Telephone Number</td>
<td>Out of Hours Telephone Number Ask for Public Health On Call</td>
<td>Health Protection Team Email</td>
</tr>
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<td>-----------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Orkney</td>
<td>01856 888034</td>
<td>01856 888 000 Balfour Hospital switchboard</td>
<td><a href="mailto:ork-HB.PublicHealth@nhs.net">ork-HB.PublicHealth@nhs.net</a></td>
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<tr>
<td>Shetland</td>
<td>01595 743340</td>
<td>01595 743000 Gilbert Bain switchboard</td>
<td><a href="mailto:shet-hb.PublicHealthShetland@nhs.net">shet-hb.PublicHealthShetland@nhs.net</a></td>
</tr>
<tr>
<td>Tayside</td>
<td>01382 596 976/987</td>
<td>01382 660111 Ninewells switchboard</td>
<td><a href="mailto:healthprotectionteam.tayside@nhs.net">healthprotectionteam.tayside@nhs.net</a></td>
</tr>
<tr>
<td>Western Isles</td>
<td>01851 708 033</td>
<td>01851 704 704</td>
<td><a href="mailto:wihealthprotection@nhs.net">wihealthprotection@nhs.net</a></td>
</tr>
</tbody>
</table>
Appendix 2 - Best Practice How to Hand Wash

Steps 3-8 should take at least 15 seconds.

1. Wet hands with water.
2. Apply enough soap to cover all hand surfaces.
3. Rub hands palm to palm.
4. Right palm over the back of the other hand with interlaced fingers and vice versa.
5. Palm to palm with fingers interlaced.
6. Backs of fingers to opposing palms with fingers interlocked.
7. Rotational rubbing of left thumb clasped in right palm and vice versa.

8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa.

9. Rinse hands with water.

10. Dry thoroughly with towel.

11. Use elbow to turn off tap.

12. Steps 3-8 should take at least 15 seconds.

...and your hands are safe.
Appendix 3 - Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE
PPE should be put on before entering the room.

- Keep hands away from face and PPE being worn
- Change gloves when torn or heavily contaminated
- The order for putting on is apron, surgical mask, eye protection (where required)

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.

Gloves
- Grasp the outside of the glove with the opposite gloved hand; peel off.
- Hold the removed glove in gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the glove off and discard appropriately.

Gown
- Unfasten or break ties.
- Pull gown away from the neck and shoulders, touching the inside of the gown only.
- Turn the gown inside out, fold or roll into a bundle and discard.

Eye Protection
- To remove, handle by headband or earpieces and discard appropriately.

Fluid Resistant Surgical facemask
- Remove after leaving care area.
- Untie or break bottom ties, followed by top ties or elastic and remove by handling the ties only and discard as clinical waste.

To minimise cross-contamination, the order outlined above should be applied even if not all items of PPE have been used.
Perform hand hygiene immediately after removing all PPE.
Appendix 4 - Routine decontamination of reusable non-invasive patient care equipment

- Check manufacturer’s instructions for suitability of cleaning products especially when dealing with electronic equipment.
- Wear appropriate PPE e.g. disposable, non-sterile gloves and aprons.

Is equipment contaminated with blood?

- Is equipment contaminated with urine/vomit/faeces or has it been used on a patient with a known or suspected infection/colonisation?

- Decontaminate equipment with disposable cloths/paper towel and a fresh solution of general-purpose detergent and water or detergent impregnated wipes.
- Rinse and thoroughly dry.
- Disinfect specific items of non-invasive, reusable, communal care equipment if recommended by the manufacturer e.g. 70% isopropyl alcohol on stethoscopes.

- Immediately decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of 1,000 parts per million available chlorine (ppm av cl)*, rinse and thoroughly dry.
- Or use a combined detergent/chlorine releasing solution with a concentration of 1,000 ppm av cl*, rinse and thoroughly dry.
- 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.

- Immediately decontaminate equipment with disposable cloths/paper roll and a fresh solution of detergent, rinse, dry and follow with a disinfectant solution of 10,000 parts per million available chlorine (ppm av cl)*, rinse and thoroughly dry.

- Follow manufacturer’s instructions for dilution, application and contact time.
- Clean the piece of equipment from the top or furthest away point
- Discard disposable cloths/paper roll immediately into the healthcare waste receptacle
- Discard detergent/disinfectant solution in the designated area
- Clean, dry and store re-usable decontamination equipment
- Remove and discard PPE
- Perform hand hygiene

* Scottish National Blood Transfusion service and Scottish Ambulance Service use products different from those stated in the National Infection Prevention and Control Manual
Appendix 5: Decontamination and cleaning processes for facilities with possible or confirmed cases of COVID-19

a. In preparation
   - 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 FRSM, disposable plastic apron and gloves.

b. 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.

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

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.

Carpeted flooring and soft furnishings
   - 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.
d. 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.
# Appendix 6: PPE Table

## Recommended PPE for primary, outpatient, community and social care by setting, NHS and independent sector

<table>
<thead>
<tr>
<th>Setting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable fluid-resistant coverall/gown</th>
<th>Surgical mask</th>
<th>Fluid-resistant (Type III) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection&lt;sup&gt;3&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any setting</td>
<td>Performing an aerosol generating procedure&lt;sup&gt;1&lt;/sup&gt; on a possible or confirmed case&lt;sup&gt;2&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Primary care, ambulatory care, and other non-emergency outpatient and other clinical settings e.g. optometry, dental, maternal, mental health</td>
<td>Direct patient care – possible or confirmed case&lt;sup&gt;1&lt;/sup&gt; (within 2 metres)</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>✓ single or sessional use&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Working in reception/communal area with possible or confirmed case&lt;sup&gt;1&lt;/sup&gt; and unable to maintain 2 metres social distance&lt;sup&gt;6&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
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<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Individuals own home (current place of residence)</td>
<td>Direct care to any member of the household where any member of the household is a possible or confirmed case&lt;sup&gt;1&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Direct care or visit to any individual in the extremely vulnerable group where a member of the household is within the extremely vulnerable group undergoing shielding&lt;sup&gt;9&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>Home birth where any member of the household is a possible or confirmed case&lt;sup&gt;7&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Community and social care, care home, mental health inpatients and other overnight care facilities e.g. learning disability, hospices, prison healthcare</td>
<td>Facility with possible or confirmed case&lt;sup&gt;1&lt;/sup&gt; – and direct resident care (within 2 metres)</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td>Any setting</td>
<td>Collection of nasopharyngeal swab&lt;sup&gt;10&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
<td>✓ single use&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

### Table 2

1. This may be single or reusable (facepiece protection, full face or goggles).
2. A list of aerosol generating procedures (AGPs) is included in section 5.1 (https://www.gov.uk/government/publications/equipment-novel-coronavirus-infection-prevention-and-control-guidance-personal-protection-equipment). (Note: AGPs are undergoing further review at present).
4. Single-use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator, after each patient and/or following completion of a procedure, task, or session; dispose of decontaminated reusable items after each patient contact as per Standard Precautions (SPCs).
5. Single use refers to a period of time where health care workers is undertaking duties in a specific care setting based on a maximum exposure risk, e.g. on a ward round, providing imaging care for patients. A session ends when the health care worker leaves the care setting/occupational environment.
6. Seasonal use should always be risk assessed and considered where there are high rates of hospital cases. PPE should be deployed after each session or earlier if damaged, soiled or uncomfortable.
7. A single use should be replaced by using PPE in high risk contexts, e.g. where there are high rates of community cases.
8. Risk assessment is required for utilising PPE when there is an anticipated likely risk of contamination with respiratory droplets or blood or bodily fluids.
10. Suggested use for single use/seasonal use contact, i.e. risk assessment would be required for single use, seasonal use for community care settings.
Appendix 7: PPE Table 4

Additional considerations, in addition to standard infection prevention and control precautions,

where there is sustained transmission of COVID-19, taking into account individual risk assessment for this new and emerging pathogen, NHS and independent sector

<table>
<thead>
<tr>
<th>Setting</th>
<th>Context</th>
<th>Disposable Gloves</th>
<th>Disposable Plastic Apron</th>
<th>Disposable fluid-repellent coverall/gown</th>
<th>Surgical mask</th>
<th>Fluid-resistant (Type III) surgical mask</th>
<th>Filtering face piece respirator</th>
<th>Eye/face protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any setting</td>
<td>Direct patient/resident care assessing an individual that is not currently a possible or confirmed case (within 2 metres)</td>
<td>✓ single use¹</td>
<td>✓ single use³</td>
<td>×</td>
<td>×</td>
<td>✓ risk assessment at first contact¹</td>
<td>x</td>
<td>✓ risk assessment at first contact³</td>
</tr>
<tr>
<td>Any setting</td>
<td>Performing an aerosol generating procedure² on an individual that is not currently a possible or confirmed case²</td>
<td>✓ single use¹</td>
<td>×</td>
<td>✓ single use³</td>
<td>×</td>
<td>×</td>
<td>✓ single use¹</td>
<td>✓ single use¹</td>
</tr>
<tr>
<td>Any setting</td>
<td>Patient transport service driver conveying any individual to essential healthcare appointment, that is not currently a possible or confirmed case in vehicle within 2 metres</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>×</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

Table 4

1. This may be single or reusable face/vacuum protection/1 face visor or goggles.
3. Single use refers to disposal of PPE or decontamination of reusable items e.g., eye protection or respirators, after each patient contact and/or following completion of a procedure, task, or session when decontamination of reusable items is not practical/feasible. Risk assessment to disposal of PPE or decontamination of reusable items in the first instance as per Standard Infection Control Precautions (SICPs).
4. Risk assessment refers to utilization of PPE when there is an anticipated likelihood of exposure to blood or bodily fluids. Where staff consider there is a risk to themselves or the individuals they are caring for they should wear a fluid repellent surgical mask with or without eye protection as determined by the individual staff member for the care episode/session.
5. A single session refers to a period of time where a healthcare worker is undertaking duties in a specific care setting/setting environment e.g., on a ward round, providing ongoing care for inpatients.
6. A session ends when the healthcare worker leaves the care setting/setting environment. Interval use should always be risk assessed and consider the risk of infection to self from patients, residents and health and care workers where COVID-19 is circulating in the community and hospitals. PPE should be disposed of at the end of each session or earlier if damaged, soiled, or uncomfortable.
7. Ambulance staff conveying patients are not required to change or upgrade PPE for the purposes of patient handover.