<table>
<thead>
<tr>
<th>Policy name: THE PREVENTION AND MANAGEMENT OF RESPIRATORY INFECTIONS</th>
<th>Policy number: C12.38</th>
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<tbody>
<tr>
<td>Originated by: Policy Group</td>
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<tr>
<td>Approved by: Giles Williams</td>
<td>Signature:</td>
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**Compliance:**
NICE Quality Standard 61 Infection Prevention and Control April 2014
NHS England & NHS Improvement, National Standards of Healthcare Cleanliness 2021
The Medical Devices Regulations 2002
Personal Protective Equipment at Work Regulations 1992
The Personal Protective Equipment Regulations 2002
Control of Substances Hazardous to Health Regulations 2002
Management of Health and Safety at Work Regulations 1999
 Provision and use of Work Equipment Regulations 1998
The Health and Safety at Work Act 1974
Public Health (Control of Diseases) Act 1984
Personal Protective Equipment (Enforcement) Regulations 2016
The Workplace (Health, Safety and Welfare) Regulations 1992
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POLICY STATEMENT
Pendleside Hospice recognises its responsibility to maintain a safe and healthy environment for patients, visitors, staff and volunteers.

This policy has been written in order to ensure that all staff provide the correct care and support to patients to those who have, or are suspected of having, a respiratory infection, in accordance with national guidance and legislation.

Under the provisions of the Health and Safety at Work Act 1974 and the Workplace (Health, Safety and Welfare) Regulations 1992 it is the duty of all employees to work safely without risk to themselves or those who may be affected by their work.

SCOPE
This policy is relevant to all staff and volunteers with direct or indirect contact with patients. It gives instructions on preventing the transmission of respiratory infections to vulnerable patients and the prevention of transmission from infected staff and patients. There is a separate policy (C12.17) for patients with suspected or confirmed tuberculosis.

RESPONSIBILITY / ACCOUNTABILITY
The Chair of the Board of Trustees, as the nominated individual for the Registered Provider, is ultimately accountable for the implementation of the policy.

The Clinical Services Manager, and Clinical Department Managers have first-line responsibility for the practical implementation of the policy.

All Hospice employees and volunteers are required to follow the policy and its procedures insofar as they may be affected by them.

RELATED HOSPICE DOCUMENTS, POLICIES AND PROCEDURES
- C11 Oxygen
- C12 Infection Prevention and Control Policy Statement
- C12.1 Hand Hygiene
- C12.2 Choice and Use of Disposable Gloves
- C12.3 Standard Precautions and Personal Protective Equipment
- C12.4 Isolation and Procedure for Notifiable Diseases
- C12.9 Cleaning and Disinfection
- C12.11 Handling of Laundry, Waterproof Duvets and Pillows
- C12.13 Categories and Disposal of Waste
- C12.14 Major Outbreak Plan
- C12.17 The Management of Patient with Tuberculosis
- C12.24 Antimicrobial Guidelines
- C12.28 Decontamination of Medical Devices
- G17 Transport and Driving
- HR4 Uniforms and Personal Protective Equipment
- HR19 Managing Sickness and Absence
- HR26 Health Screening and Vaccination
- Mandatory Training Information and Guidance
STAFF TRAINING REQUIREMENTS
All clinical staff will undertake infection prevention and control training at induction and as an annual refresher. Volunteers undertake infection prevention and control training every two years. All staff should be trained in the proper use of all PPE that they may be required to wear.

MONITORING, REVIEW AND AUDIT
The policy will be monitored in line with the Hospices’ audit schedule and reviewed three-yearly, or as change in legislation or national guidelines dictate. Audits of hand hygiene, personal protective equipment and environmental cleanliness are included in the audit schedule.

RESPIRATORY AND COUGH HYGIENE – “CATCH IT, BIN IT, KILL IT”
Patients, staff and visitors should be encouraged to minimise potential transmission through good respiratory hygiene measures:

- Disposable, single-use tissues should be used to cover the nose and mouth when sneezing, coughing or wiping and blowing the nose. Used tissues should be disposed of promptly in the nearest waste bin.
- Tissues, waste bins (lined and foot operated) and hand hygiene facilities should be available for patients, visitors and staff.
- Hands should be cleaned after coughing, sneezing, using tissues or any other contact with respiratory secretions and contaminated objects.
- Encourage patients to keep hands away from eyes, nose and mouth.
- Some patients may need assistance with containment of respiratory secretions; those who are immobile will need a container (e.g. plastic bag) readily at hand for immediate disposal of tissues.
- In common waiting areas or during transport symptomatic patients may choose to wear a fluid resistant face mask to minimise the dispersal of secretions and reduce environmental contamination.

SCREENING
Patients must be assessed for respiratory symptoms prior to admission to the inpatient unit where possible, by telephone or as part of the referral form. If a patient on the inpatient unit has relevant symptoms on admission or develops them during admission, COVID-19 testing should be done and, where appropriate, sputum samples should be sent.

Current recommendations for patient COVID-19 testing are:

- Patients with a scheduled date of admission to a hospice as an inpatient from the community or a care setting will be eligible for a PCR test 72 hours before admission (if appropriate) and an LFD test on the day of admission.
- If inpatients cannot be tested with a PCR test (for example, unplanned or urgent admissions, or if they have tested positive in the last 90 days) then an LFD test on admission is sufficient.
- Patients admitted to a hospice setting from an NHS hospital will be given a PCR test by the NHS hospital on discharge.

1 https://www.gov.uk/guidance/coronavirus-covid-19-testing-for-hospices
Patients of the Family Centre, Outpatients or Health, Wellbeing & Rehabilitation should be screened by phone and advised to stay away if they have symptoms. Telephone support should be offered as an alternative.

Hospice at Home patients should be screened by telephone and PPE worn by staff if patients or others in the household are symptomatic.

In all healthcare settings, patients with respiratory symptoms should be segregated from non-symptomatic patients as promptly as possible.

HAND HYGIENE
Refer to C12.1 Hand Hygiene for details.

Hand hygiene is essential to reduce the transmission of infection in health and care settings and is a critical element of standard infection control precautions. All staff, patients and visitors should decontaminate their hands with alcohol based hand rub when entering and leaving areas where care is being delivered.

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

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 free from artificial nails or nail products
- Cover all cuts or abrasions with a waterproof dressing.

Hand hygiene includes the use of alcohol based hand rub for routine hand hygiene and hand washing with soap and water, including thorough drying, if hands are visibly soiled or dirty
- The technique for hand washing must be carried out thoroughly for a time sufficient to inactivate the virus i.e. 20 to 30 seconds.

Where no running water is available or hand hygiene facilities are lacking, such as in a patient’s home, staff may use hand wipes followed by alcohol hand rub and should wash their hands at the first opportunity.

TRANSMISSION BASED PRECAUTIONS (TBP)
These are precautions required when caring for a patient with a known or suspected respiratory infection that are used in addition to standard precautions, when standard precautions may not be sufficient. They must be continued until the resolution of the patient’s fever and respiratory symptoms.
Patients should remain in isolation (avoiding communal areas) until the resolution of fever and respiratory symptoms. The decision to modify or “stand down” TBP should be made by the clinical team managing the patient(s) based on symptoms.

Interrupting transmission requires droplet and contact precautions. If aerosol generating procedures are being undertaken then airborne precautions are also required. Airborne precautions are used to prevent the direct transmission of droplets onto the mucosal surface or conjunctivae of another individual.

Types of TBP depend on the suspected or known infections agent, severity of illness caused, transmission route and the procedures being undertaken. Support can be sought from the local infection control team.

There is no need to use disposable plates or cutlery. It can be washed by hand or in a dishwasher using household detergent.

**Contact Precautions**
Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient’s immediate care environment (including care equipment). This is the most common route of cross-infection transmission.

**Droplet precautions**
Measures used to prevent, and control infections spread over short distances (at least 1 metre) via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Droplets penetrate the respiratory system to above the alveolar level.

**Airborne Precautions**
Measures used to prevent, and control infection spread without necessarily having close patient contact via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols can penetrate the respiratory system to the alveolar level.

**AEROSOL GENERATING PROCEDURES**
The following procedures produce potentially infectious aerosols in an infected patient:

- Intubation, extubation and related procedures;
- Tracheostomy procedures;
- Manual ventilation;
- Cardiopulmonary resuscitation;
- Open suctioning;
- Non-invasive or high frequency oscillating ventilation (e.g. BiPAP / CPAP)
- High-flow nasal oxygen
- Induction of sputum

These should only be carried out when essential, in a single room with the doors shut. Only those healthcare staff needed to perform the procedure should be present. A
disposable, fluid repellant surgical gown, gloves, eye protection and FFP3 respirator should be worn by all those in the room.

Other procedures may generate aerosol from material other than secretions and are not a significant infection risk such as administration of pressurized humidified oxygen or medication via nebulization.

PERSONAL PROTECTIVE EQUIPMENT (PPE)
PPE is used where it is not reasonably practicable to completely prevent exposure to a substance hazardous to health.

Respiratory Protective Equipment (RPE) must be considered when a patient is cared for who has a known or suspected infectious agent spread wholly or partly by the airborne route, and when carrying out aerosol generating procedures (AGPs) on patients with a known or suspected infectious agent spread wholly or partly by the airborne or droplet route. The same should be worn when a patient is vomiting and an infectious cause is suspected (e.g. gastroenteritis, hepatitis A or norovirus).

<table>
<thead>
<tr>
<th>PPE Item</th>
<th>Enter the patient’s room</th>
<th>Aerosol generating procedures</th>
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<tbody>
<tr>
<td>Disposable Gloves</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disposable Plastic Apron</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Disposable Gown</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Fluid-resistant (type IIR) surgical mask (FRSM)</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Filtering face piece (class 3) (FFP3) respirator</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Disposable Eye Protection</td>
<td>Risk assessment</td>
<td>Yes</td>
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Staff are permitted to exceed the level of precautions described if there are sufficient stocks of PPE and this will not cause distress or alarm to the patient.

When undertaking any procedure staff should assess any likely exposure and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

All staff should be trained in the proper use of all PPE that they may be required to wear.

All PPE should be:
- Compliant with the relevant BS/EN standards;
- Located close to the point of use;
- Stored to prevent contamination in a clean/dry area until required;
- Expiry dates must be adhered to;
- Single-use only;
- Changed immediately after each patient and/or following completion of a procedure or task; and disposed of after use in the correct waste stream

If samples have been taken and the infectious agent is known then some precautions may be stepped down sooner refer to the National Infection Prevention and Control Manual for England, appendix 11a.
DISPOSABLE GLOVES
See C12.2 Choice and Use of Disposable Gloves.

Disposable gloves must be worn when providing direct patient care and when exposure to body fluids (except sweat) is anticipated, including during equipment and environmental decontamination. Gloves must be changed immediately following the care episode or task.

DISPOSABLE APRON / GOWN
Disposable plastic aprons must be worn to protect staff uniforms and clothes from contamination when providing direct patient care and during environmental and equipment decontamination.

Fluid-resistant gowns must be worn when a disposable plastic apron provides inadequate cover of the uniform or clothes for the procedure being performed e.g. aerosol generating procedures. If non fluid-resistant gowns are used a disposable plastic apron should be worn underneath.

They should be changed between patients and immediately after completion of a procedure / task.

EYE PROTECTION / FACE VISOR
Eye / face protection should be worn when there is a risk of contamination to the eyes from splashing of secretions (including respiratory secretions), blood, body fluids or excretions from an infected patient. Regular corrective spectacles are not considered to be eye protection.

Disposable, single-use eye/face protection is recommended. Protection can be achieved by use of any one of the following:
- Surgical mask with integrated visor;
- Full face shield/visor;
- Polycarbonate safety spectacles or equivalent;

RESPIRATORY PROTECTIVE EQUIPMENT (RPE)
FLUID RESISTANT SURGICAL MASKS (Type IIR) (FRSM)
Fluid resistant type surgical masks are worn to protect the wearer from the transmission by respiratory droplets they must be worn when:
- Working within 2 metres of a patient with symptoms.
- There may be occasions when rates of infection are high, that masks may be required at all times.

Type IIR masks should:
- Be well fitted, covering both the nose and mouth;
- Not be allowed to dangle around the neck of the wearer after each use;
- Not be touched once put on
- Be changed when they become moist or damaged; and
- Be worn once then discarded as healthcare clinical waste (hand hygiene must be performed after disposal.
- Changed between patients
FILTERED FACE PIECE RESPIRATORS (FFP3)
FFP3 respirators should be considered whenever there is a risk of airborne transmission when a patient has suspected or confirmed infection. The decision to wear an FFP3 respirator/hood should be based on clinical risk assessment e.g. task being undertaken, the presenting symptoms, the infectious state of the patient, risk of acquisition and the availability of treatment. They must be:

- **Single-use** (disposable) and preferably fluid-resistant (if not then a full face visor should also be worn);
- Valved respirators are not fully fluid-resistant unless they are also ‘shrouded’. If a valved, non-shrouded FFP3 respirator is used then eye protection must be worn.
- **Fit tested** on all staff who may be required to wear an FFP3 respirator to ensure an adequate seal/fit;
- **Fit checked** every time one is donned to ensure an adequate seal has been achieved;
- Compatible with other facial protection used i.e. protective eyewear so that this does not interfere with the seal of the respiratory protection (regular corrective spectacles are not considered adequate eye protection).
- Disposed of and replaced if breathing becomes difficult, it is damaged or distorted, obviously contaminated or if the proper fit cannot be maintained;
- After other PPE has been removed inside the room, the FFP3 mask should be removed outside the room and disposed of.
- **Be worn once then discarded** as healthcare clinical waste (hand hygiene must be performed after disposal.

FACIAL HAIR AND FFP3 RESPIRATORS
For any facial hair, the hair must not cross or interfere with the respirator sealing surface. If the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve. Some examples can be found here [https://www.cdc.gov/niosh/npptl/pdfs/facialhairwmask11282017-508.pdf](https://www.cdc.gov/niosh/npptl/pdfs/facialhairwmask11282017-508.pdf)
**QUICK GUIDE TO DONNING AND DOFFING PPE: DROPLET PRECAUTIONS**

### Donning or putting on PPE

- **1.** Put on your plastic apron, making sure it is tied securely at the back.
- **2.** Put on your surgical face mask, if tied, make sure it is secured tightly at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.
- **3.** Put on your eye protection if there is a risk of splashing.
- **4.** Put on non-sterile nitrile gloves.
- **5.** You are now ready to enter the patient area.

### Doffing or taking off PPE

- **1.** Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.
- **2.** Perform hand hygiene using alcohol hand gel or rub, or soap and water.
- **3.** Snap or unfasten apron ties the neck and allow to fall forward.
- **4.** Once outside the patient room. Remove eye protection.
- **5.** Perform hand hygiene using alcohol hand gel or rub, or soap and water.
- **6.** Remove surgical mask.
- **7.** Now wash your hands with soap and water.
How to put on and fit check an FFP3 respirator

1. Hold the respirator in one hand and separate the edges to fully open it with the other hand. Bend the nose wire (where present) at the top of the respirator to form a gentle curve.
2. Turn the respirator upside down to expose the two headbands, and then separate them using your index finger and thumb. Hold the headbands with your index finger and thumb and cup the respirator under your chin.
3. Position the upper headband on the crown of your head, above the ears, not over them. Position the lower strap at the back of your head below your ears.
4. Ensure that the respirator is flat against your cheeks.
5. Mold the nosepiece across the bridge of your nose by firmly pressing down with your fingers until you have a good facial fit. If a good fit cannot be achieved, do not proceed.

Now perform a fit check

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

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

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

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

If a successful fit check cannot be achieved, remove and refit the respirator. If you still cannot obtain a successful fit check, do not enter the work area.

Public Health England 2013 as accessed 11/08/22
DONNING PPE FOR AGPS (GOWN VERSION)

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

1. Put on the long-sleeved fluid repellent disposable gown
2. Respirator
• Perform a fit check.

Perform hand hygiene before putting on PPE

UK Health Security Agency as accessed 11/08/22

DOFFING PPE FOR AGPS (GOWN VERSION)

PPE should be removed in an order that minimises the potential for cross contamination.
The order of removal of PPE is as follows:

1. Gloves –
   • the outsides of the gloves are contaminated
   • Clean hands with alcohol gel

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

3. Eye protection -
   • the outside will be contaminated

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

5. Wash hands with soap and water

UK Health Security Agency as accessed 11/08/22
**ADDITIONAL PRECAUTIONS**

**VENTILATION**
Ventilation is the process of introducing fresh air into indoor spaces whilst removing stale air. This helps remove air containing virus particles. While droplets fall quickly to the ground aerosols containing virus can remain suspended in the air, increasing the risk of spread in poorly ventilated rooms. This risk is increased with the number of infected people in the room and if they are participating in energetic activity, shouting, singing or talking loudly. The more fresh air that is brought inside, the quicker airborne virus will be removed.

Opening windows and doors is the quickest way of increasing ventilation, even for a few minutes. Also ensure that trickle vents (at the top of windows) and other vents are open and not blocked. Respiratory viruses are more common in cold weather because windows tend to remain closed. If someone in a room is unwell with a respiratory infection keeping a window slightly open and the door closed (if safe to do so) will reduce the spread from that room to other parts of the building.

Avoid the use of fans that recirculate the air, where possible.

**VISITORS**
All visitors must be instructed on hand hygiene and the use of face coverings and must not visit any other care area. Signage to support restrictions is critical. Visitors with symptoms must not enter the healthcare facility and should be encouraged to leave. Visitors may be required to wear PPE.

**PATIENT TRANSFERS AND TRANSPORT**
See policy G17 Transport and Driving.
- Staff at the receiving destination must be informed that the patient has or is suspected to have a respiratory infection.
- If transport or movement is necessary, consider offering the patient a fluid-resistant surgical mask to be worn during transportation
- Patients must be taken straight to and returned from clinical departments and not wait in communal areas. Where possible patients should be placed at the end of clinical lists.
- Patients transfer from one healthcare facility to another should be avoided; transfer may be undertaken if medically necessary for specialist care arising out of complications or concurrent medical events.

**SAFE MANAGEMENT OF LINEN**
No special requirement are required. All linen used in the direct care of patients with symptoms should be managed as “infectious” linen. It must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment.
STAFF UNIFORMS AND CLOTHES
See policy HR4 Uniforms and Personal Protective Equipment.
The appropriate use of PPE will protect staff uniform from contamination in most circumstances.

Uniforms should be laundered:
- 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.

It is best practice to change into and out of uniforms at work and not wear them when travelling; this is based on public perception rather than evidence of infection risk. This does not apply to community workers who are required to travel between patients in the same uniform.

MANAGEMENT OF WASTE
- Large volumes of waste may be generated by frequent use of PPE.
- Dispose of all waste as infectious waste.
- Waste from a possible or a confirmed case must be disposed of as Category B waste and should be classified as infectious clinical waste suitable for alternative treatment, unless the waste has other properties that would require it to be incinerated.

MANAGEMENT OF MEDICAL EQUIPMENT
See C12.28 Decontamination of Medical Devices.
Patient care equipment should be single-items if possible. Reusable non-invasive equipment should be avoided as far as possible and be allocated to the individual patient.

Reusable (communal) non-invasive equipment must be decontaminated:
- Between each patient and after patient use
- After blood and body fluid contamination; and
- At regular intervals as part of equipment cleaning. An increased frequency of decontamination should be considered for reusable non-invasive care equipment.

Decontamination of equipment in the care environment must be performed using either:
- A combined detergent / disinfection solution at a dilution of 1,000 parts per million of available chlorine (av. cl.); or
- A general purpose neutral detergent in a solution of warm water followed by a disinfectant solution of 1,000ppm activated chlorine.

Only cleaning (detergent) and disinfectant products supplied by employers are to be used.
ENVIRONMENT
If patients have confirmed or suspected infection their rooms must be decontaminated at least daily. Clinical rooms must also be decontaminated after each clinical session for patients with known / suspected infection. Patient isolation rooms must be terminally cleaned following resolution of symptoms, discharge or transfer.

Where feasible, environmental decontamination should be performed after a room has been ventilated. A minimum of 20 minutes is pragmatic, longer if possible.

Increased frequency of decontamination should be incorporated into the cleaning / decontamination schedules for areas where there may be a higher contamination: Toilets / commodes and frequently touched surfaces such as medical equipment, door and toilet handles, patient call bells, over the bed tables and bed rails should be cleaned at least twice daily and when known to be contaminated with secretions, excretions or body fluids.

Domestic / cleaning staff performing environmental decontamination should be trained in which PPE to use and the correct methods of wearing, removing and disposing of PPE.

HANDLING THE DECEASED
See C12.27 Care After Death for High Risk Persons.
The principles of standard infection control precautions and transmission based precautions continue to apply whilst the deceased person remains in the care environment. This is due to the ongoing risk of infectious transmission, although the risk is usually lower than for living patients. There is no requirement for a body bag and viewing, hygienic preparation, post-mortem and embalming are all permitted.