Limiting transmission of COVID-19 in the healthcare setting requires a range of infection prevention and control measures and interventions.

PHE suggests that Infection control advice is based on the reasonable assumption that the transmission characteristics of COVID-19 are similar to those of the 2003 SARS-CoV outbreak. The initial phylogenetic and immunologic similarities between COVID-19 and SARS-CoV can be extrapolated to gain insight into some of the epidemiological characteristics.

The guidance below is based on the combination of the following national guidance-please keep referring to the national sites for any updates:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876577/Infection_prevention_and_control_guidance_for_pandemic_coronavirus.pdf
(27/03/2020).
https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/gp-preparedness-update-letter-27-march-2020-.pdf
(27/03/2020)
https://www.gov.uk/government/publications/wn-cov-guidance-for-primary-care/wn-cov-interim-guidance-for-primary-care
(13/03/2020)

- As transmission is due to droplet and touch transmission all patients should be encouraged to wash their hands as part of their appointment process and prior to visiting a health site whilst having the opportunity to wash their hands or use hand sanitizer on arrival prior to entering the consulting room. Hand hygiene is essential to reduce the transmission of infection in health care settings and is a critical element of standard infection control precautions (SICPs). All staff, patients and visitors should decontaminate their hands with alcohol based hand rub (ABHR) when entering and leaving areas where care for –suspected and confirmed COVID-19 patients.

- If a suspected case spent time in a communal area, for example, a waiting area or toilet facilities, then these areas should be cleaned with detergent and disinfectant as soon as practicably possible, unless there has been a blood or body fluid spill which should be dealt with immediately. Once cleaning and disinfection have been completed, the area can be put back in use. Rational is that COVID-19 can be transmitted to objects and surfaces and exist for 72 hrs or more.

Primary care

In primary care settings (e.g. General Practitioner (GP) practices) suspected COVID-19 patients should be segregated in place or time from other patients, this may be achieved by:

- Creating a separate area within the facility for care of suspected patients, including separate waiting and reception areas if possible. The area should be separated from non-segregated areas by closed doors. To control entry, signage should be displayed warning of the segregated area.

- All areas including the consulting/treatment rooms to be used have all non-essential equipment, leaflets, kit removed from surfaces so as to aid effective cleaning at the end of the surgery shift.

- Alternatively, suspected patients should be seen at a different time from other patients, with disinfection of shared areas taking place between different clinics.

- GP practices may make arrangements for distinct COVID-19 and non-COVID-19 clinics. (Non-essential GP clinics may need to be cancelled to enable this.

- Primary care staff should, wherever possible be allocated to either COVID-19 or other patients.

- Consulting Rooms where a possible COVID-19 case is identified requires cleaning before the next patient following section 4 of the guidance for primary care referenced above

Staff working within the assessment sites should have adequate and correct PPE provision. Fluid-resistant (Type IIR) surgical mask (FRSM) is recommended; all general ward staff, community, ambulance and social care staff should wear an FRSM for close patient contact (within 1 metre), unless performing an AGP, when a filtering face piece (class 3) (FFP3) respirator, eye protection, a disposable long sleeved gown and gloves should be worn.

Disposable gloves

Disposable gloves must be worn when providing direct patient care and when exposure to blood and/or other body fluids is anticipated/likely, including during equipment and environmental decontamination. Gloves must be changed immediately following the care episode or the task undertaken.

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. An individual risk assessment should be carried out prior to/at the time of providing care.

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

Regular corrective spectacles are not considered adequate eye protection.

A FRSM must be worn when working in close contact (within 1 metre) of a patient with COVID-19 symptoms. This provides a physical barrier to minimise contamination of the mucosa of the mouth and nose.

A FRSM for COVID-19 should:

- be well fitted covering both nose and mouth;
- not be allowed to dangle around the neck of the wearer after or between each use;
- not be touched once put on;
- be changed when they become moist or damaged;

PHE Guidance on cleaning and waste management suggests;

The use of disposable cloths or paper roll or disposable mop heads, to clean and disinfect all hard surfaces or floor or chairs or door handles or reusable non-invasive care equipment or 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.)
- or 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

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

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 when used in isolation/cohort areas.

- 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. Consideration is required to establish if equipment such as tympanic thermometers, pulse oximetery equipment and cleanable BP cuffs are in use.

- Clean all reusable equipment systematically from the top or furthest away point.

- Management of healthcare (including clinical) and non-clinical waste Large volumes of waste may be generated by frequent use of PPE; advice from the local waste management team should be sought prospectively on how to manage this. Dispose of all waste as clinical waste.

- Waste from a possible or a confirmed case must be disposed of as Category B waste. The transport of Category B waste is described in Health Technical

Memorandum 07-01: Safe management of healthcare waste. Disposal of all waste related to possible or confirmed cases should be classified as infectious clinical waste suitable for alternative treatment, unless the waste has other properties that would require it to be incinerated.

- clean, dry and store re-usable parts of cleaning equipment, such as mop handles
- remove and discard PPE as clinical waste
- perform hand hygiene

Only cleaning (detergent) and disinfectant products must be prepared and used according to the manufacturers' instructions and recommended product "contact times" must be followed.