Novel coronavirus (COVID-19) standard operating procedure

FM Service Guidance

**This guidance is correct at the time of publishing. However, as it is subject to updates, please use the hyperlinks to confirm the information you are disseminating to the public is accurate.**

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1. Introduction and statutory Compliance

This document is intended to provide guidance during the COVID-19 pandemic to provide information and guidance to organisations that will form the basis of a local risk assessed approach to service delivery, Compliance and Auditing within FM services where there is a suspected, or, confirmed case of COVID-19 within the environment

The SOP’s are regularly updated in line with IPC and PHE guidance, the current update is Version 1 Covid-19 Guidance for the remobilisation of services within health & care settings dated 20 August 2020

The IPC measures recommended are underpinned by the National Infection Prevention and Control Manual practice guide and associated literature reviews <http://www.nipcm.hps.scot.nhs.uk/>

All Statutory Compliance must be carried out unless local agreements are made due to COVID- 19 stopping the work to be carried out. Enhanced non-intrusive inspections should be carried out where possible if statutory maintenance cannot be carried out.

There are areas of the services that are statutory and may require an enhanced service or a continuation of service during the pandemic, these are included with the service guidance documentation:

1. Associated guidance

This is additional guidance around COVID -19 and is not intended to change procedures within other areas of the healthcare setting that does not have suspected of confirmed COVID-19 patients and that is consistent with the standards the organisation currently follows.

The Document should be used in conjunction with the following PHE guidance documents:

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/reducing-the-risk-of-transmission-of-covid-19-in-the-hospital-setting>

<https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/886668/COVID-19_Infection_prevention_and_control_guidance_complete.pdf>

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/new-government-recommendations-for-england-nhs-hospital-trusts-and-private-hospital-providers>

**CEM/CMO/2020/043 letter dated 24.12.2020 with updated guidance relating to Social Distancing training and additional cleaning of communal toilets in inpatient areas as well as details around the South African variant.**

1. NHSE/I FM service SOP’s

Reference to SOP’s include the following documents This document should be used alongside the associated Standard Operating Procedures which can be found on the NHS E&F Collaboration hub (NHS providers only) or your companies intranet:

1. Cleaning Process COVID 19 within 2 metres of patient

2. Cleaning Process COVID 19 High risk area where AGPs are being conducted

3. Cleaning Process COVID 19 Not within 2 metres of patient

4. Portering Process COVID 19 within 2 metres of patient

5. Portering Process COVID 19 High risk area where AGPs are being conducted

6. Portering Process COVID 19 Not within 2 metres of patient

7. Catering Process COVID 19 within 2 metres of patient

8. Catering Process COVID 19 High risk area where AGPs are being conducted

9. Catering Process COVID 19 Not within 2 metres of patient

10. Estates Maintenance Process COVID 19 within 2 metres of patient

11. Estates Maintenance Process COVID 19 High risk area where AGPs are being conducted

12. Estates Maintenance Process COVID 19 Not within 2 metres of patient

13. Linen and Laundry Process COVID 19 within 2 metres of patient

14. Linen and Laundry Process COVID 19 High risk area where AGPs are being conducted

15. Linen and Laundry Process COVID 19 Not within 2 metres of patient

16 Security Process COVID 19 all scenarios

COVID-19 linen and laundry policy

COVID -19 Mental Health guidance document

COVID -19 Primary care guidance

COVID -19 Service guidance document

CO611- COVID-19- Waste-Management-Guidance-SOP-V3

4.COVID-19 Infection Prevention and Control Guidance – all services

* 1. Version 1 New Guidance 20.08.2020 including new instructions dated 24.12.2020

The following guidance is incorporating updated guidance issued on 20/08/2020 and relates solely to considerations of PPE and represents one section of infection, prevention and control for COVID-19 infections and should be used in conjunction with local policies. Trusts will implement safe protocols and follow risk assessment controls to reduce risk. PPE will depend on level of risk and may be different across a healthcare setting.

* 1. Minimise close contact between staff

Review practice to minimise close contact between groups of staff over prolonged periods; for example, avoid congregation at the central nurses station, when clocking in and out, in porters lodges, helpdesks and other areas where teams regularly congregate, restrict number of staff on ward rounds, conduct handover sessions in a setting where there is space for social distancing, consider staggering staff breaks to limit the density of healthcare workers in specific areas.

Face masks (fluid repellent surgical mask) should be worn in all areas unless in an office on own. Masks should be worn to and from rest area/restaurant and can be removed when eating and drinking.

All staff and other care workers must maintain social/physical distancing of 2 metres where possible (unless providing clinical or personal care and where the Risk Assessment has listed correct PPE and the PPE is being worn). Review your local guidance in relation to the instructions dated 24.12.2020 to ensure compliance

* 1. Ventilation

Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room. In an isolation room with 10-12 air changes per hour (ACH), a minimum of 20 minutes is considered pragmatic. In a single room with 6 ACH this would be approximately one hour.

Airborne precautions are NOT required for AGPs on patients/individuals in the low risk COVID-19 pathway, providing the patient has no other infectious agent transmitted via the droplet or airborne route. Always seek advice from the local IPC team to confirm presence of any airborne infections. This information can change daily.

* 1. Operational guidance

Parts of the advice set out in the guidance may need operational liaison locally, but the principles must be adhered to.

Patients/Individuals treatment, care and support are to be managed in 3 COVID-19 pathways each trust will identify each areas risk pathway examples are note that these areas may change regularly;

**High risk**: Any care facility where untriaged individuals present for assessment or treatment (symptoms unknown) and waiting for test result. Confirmed COVID-19 positive individuals are cared for and symptomatic or suspected COVID-19 individuals including those with a history of contact with a COVID-19 case.

Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

* Designated areas within Emergency/Resuscitation Departments
* GP surgeries/walk in centres
* Facilities where confirmed or suspected/symptomatic COVID-19 individuals are cared, for example:
  + Emergency admissions to in-patient areas (adult and children)
  + Mental health
  + Maternity
  + Critical Care Units
  + Renal dialysis units

**Medium risk**: This includes patients/individuals who have no symptoms of COVID-19 but do not have a COVID-19 test result.

Examples of patient (individual) groups/facilities within these pathways: these lists are not exhaustive

* Designated areas within Emergency/Resuscitation, GP surgeries and walk-in centres
* Non elective admissions
* Primary care facilities, for example general dental and general practice
* Facilities where individuals are cared, for example in-patients; adult and children, Mental health, Maternity, Critical Care Units
* Outpatient depts. including Diagnostics and Endoscopy
* Care homes\*
* Prisons

\*This guidance does NOT apply to Adult Social Care settings in England.

**Low risk**: Patients/individuals with no symptoms and a negative COVID-19 test who have self-isolated for at least 72 hours prior to admission

Examples of the patient (individual) groups/facilities within these pathways: these lists are not exhaustive

* Planned/elective surgical procedures including day cases
* Oncology/chemotherapy patients and/or facilities
* Planned in -patient admissions (adult and children), Mental health, Maternity
* Outpatients including Diagnostics/Endoscopy
* Care homes\*
* Prisons

\*This guidance does NOT apply to Adult Social Care settings in England.

* Establish separation of patient pathways and staff flow.
* The risk pathways will be segregated, and risk areas may be colour coded, subject to local Trust protocols and subject to change.
* Increase frequency of cleaning of environmental surfaces, personal and communal electronic devices to at least twice daily and undertaken by both users and domestics.
* Key areas such as emergency departments, outpatients, triage, reception desks, and specialist departments will need to have plans in place to manage/separate patients with suspected or confirmed COVID-19 from those who do not. Areas/zones within pathways can be designated into a combination of any of the three pathways.
* The use of face masks (for staff) or face coverings 1 (England and Scotland) is recommended in addition to social distancing and hand hygiene for staff, patients/individuals and visitors in both clinical and non-clinical areas to further reduce the risk of transmission
* Staff arrangements should be considered for social distancing and use of rest rooms, break out areas, training areas, locker rooms and restaurants. Liaise with all stakeholders to plan segregation, donning/doffing, table cleaning etc. including policy for catering operation.
* Refer to: Keeping workers and customers safe during Covid-19 published 23.06.2020 for guidance.



* 1. Moving and transferring patients
* Patients must be taken straight to and returned from clinical departments and according to the correct pathway/risk. Follow local protocols and stay within care pathway/risk. Areas may change use during course of day due to inpatient admissions.

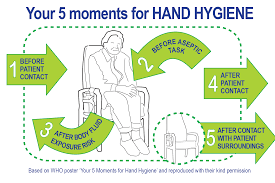
* 1. Hand hygiene

Hand hygiene should extend to include washing of exposed forearms, hand-washing advice has been updated to include washing of forearms, when forearms have been exposed or may have been exposed to respiratory droplets or other body fluids

Hand hygiene must be performed immediately before every episode of direct patient care and after any activity/task or contact that potentially results in hands becoming contaminated, including the removal of personal protective equipment (PPE), equipment decontamination and waste handling. Refer to 5 moments for hand hygiene.

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.



* 1. Wearing of facemasks and face coverings
* Hospitals should ensure that measures are in place and communicated widely, so that all settings are, where practicable, COVID-secure, using:
  + Social distancing,
  + Optimal hand hygiene,
  + Frequent surface decontamination,
  + Ventilation
  + And other measures where appropriate (as advised)
* in all settings that are unable to be delivered as COVID-19 secure, all hospital staff (both in clinical and non-clinical roles), when not otherwise required to use personal protective equipment, should wear a fluid resistant surgical mask; worn to prevent the spread of infection from the wearer. For example, to and from breaks, to and from workplace, break out areas and public areas.
* visitors and outpatients to hospital settings should wear a form of face covering for the same reason, to prevent the spread of infection from the wearer
* The recommendation is for Type II Fluid Resistant Surgical Mask (FRSM) worn to prevent the spread of infection from the wearer. If Type IIR facemasks are more readily available, and there are no local supply issues for their use as personal protective equipment, then these can be used as an alternative to Type I or Type II masks. In the event of shortages of any face mask an alternative will be advised, always refer to local IPC.
* The extended use of face masks does not remove the need for other key bundles of measures to reduce the risk of transmission of SARS-CoV-2, including social/physical distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate. Reliance on individual (as opposed to bundles of) measures to reduce the risk of virus transmission is not enough.
  1. Environmental cleaning and decontamination

There is evidence for other coronaviruses of the potential for widespread contamination of patient rooms or environments, so effective cleaning and decontamination is vital. The frequency of cleaning the care environment in designated COVID-19 care areas should be for, single rooms, cohort areas and clinical rooms must be decontaminated (using a combined detergent chlorine solution at 1000ppm) at least twice daily. A suitable alternative can be used in agreement with IPC lead, this may vary regionally/nationally.

Rooms/areas where PPE is removed must be decontaminated, ideally timed to coincide with periods immediately after PPE removal by groups of staff (at least twice daily).

* the increased frequency of decontamination/cleaning should be incorporated into the environmental decontamination schedules (using a combined detergent chlorine solution at 1000ppm) for all areas, including where there may be higher environmental contamination rates.
* Communal toilets in in-patient areas must be cleaned after each use.
* Cleaning means a clean of all touch points and a full clean of any visibly soiled items
* Consideration needs to be given on implementing this practice, some examples of how this can be achieved are detailed below:
  + An assessment of additional labour requirements to clean communal toilets in in-patient wards after each use.24/7 subject to the availability of funding
  + Additional cleaning colleagues employed dedicated to the additional toilet cleans required, or a mix of dedicated cleaning teams and clinical colleagues who support patients during toileting
  + Reallocation of resources from other parts of the estate to provide the additional cleans
  + Cleaning wipes provided for self-cleaning of communal toilets in staff areas
  + Clinical or ward housekeeping colleagues to provide the additional cleaning frequency
  + Use of tape to identify areas that have been cleaned / require cleaning to ensure compliance to the additional cleaning requirement
  + Any mixture of the above suggestions
* Opportunities for cleaning of frequently touched surfaces multiple times (more than twice a day wherever possible) should be taken, including for example:
* surfaces such as medical equipment, door/toilet handles and locker tops, patient call bells, over bed tables and bed rails must be cleaned at least twice daily, and when known to be contaminated with secretions, excretions or body fluids;
* touch points in public areas such as lifts and corridor handrails; and
* electronic equipment, including mobile phones, desk phones and other communication devices, tablets, desktops, and keyboards (particularly where these are used by many people), should be decontaminated at least twice daily with 70% ethyl alcohol or product as specified by the manufacturer
  1. While the patient is in the room

### Cleaning and decontamination should only be performed by staff trained in the use of the appropriate PPE; in some instances, this may need to be trained clinical staff rather than domestic staff, in which case, clinical staff may require additional training on standards and order of cleaning.

### Domestic/portering/catering/audit staff should be assigned to areas within care pathways/risks and avoid entering other areas if possible and agreed locally.

### The main patient isolation room should be cleaned at least twice daily. Body fluid spills should be decontaminated (using chlorine-based spill kits) promptly.

### It is strongly recommended that cleaning of isolation areas is undertaken separately to the cleaning of other clinical areas.

* 1. Cleaning the room once the patient has been discharged or left the room

Follow the SOP for the specific areas

If a risk assessment indicates that a higher level of contamination may be present or there is visible contamination with body fluids, the need for additional PPE should be considered.

Particular attention is needed in cleaning of toilets/bathrooms as COVID-19 has been frequently found to contaminate surfaces in these areas.

Dedicated or disposable equipment (such as mop heads, cloths) must be used for environmental decontamination and disposed of as infectious clinical waste.

Reusable equipment (such as mop handles, buckets) must be decontaminated after use.

Communal cleaning trollies should not enter the room.

* 1. Management of equipment and the care environment

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

Cleaning equipment should be segregated to areas according to pathway/risk. Colour coding for equipment should always follow the National Cleaning Standards 2020 and not to be mistaken with coloured risk pathways.

Only cleaning (detergent) and disinfectant products supplied by employers are to be used. Products must be prepared and used according to the manufacturers’ instructions and recommended product ‘contact times’ must be followed. If alternative cleaning agents/disinfectants are to be used, they should only on the advice of the IPCT and conform to EN standard 14476 for viricidal activity.

In the low risk COVID-19 pathway organisations may choose to revert to general purpose detergents for cleaning, as opposed to widespread use of disinfectants (with the exception of blood and body fluids, where a chlorine releasing agent (or a suitable alternative) solution should be used.

Within the low risk COVID-19 pathway, standard theatre cleaning and time for air changes provides appropriate levels of IPC and there is no requirement for additional cleaning or theatre down time unless the patient has another infectious agent that requires additional IPC measures.

* 1. Equipment

### Patient care equipment should be single-use items if possible, i.e. patient washbowls. Reusable (communal) i.e. commodes 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

### 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.

### Avoid the use of fans that re-circulate the air.

* 1. Environment

### Patient isolation rooms, cohort areas and clinical rooms must be decontaminated at least daily, plus multi user touch points cleaned twice per day.

### Clinical rooms should also be decontaminated after clinical sessions for patients with possible/known pandemic COVID-19 In addition, patient isolation rooms must be cleaned using terminal/isolation clean protocol.

### Following resolution of symptoms,

### Discharge or transfer (this includes removal and laundering of all curtains and bed screens) once vacated by staff following an AGP

### Domestic/cleaning staff performing environmental decontamination should:

### ideally be allocated to specific area(s) and not be moved between pathways COVID-19 and non-COVID-19 care areas. To be trained in personal protective equipment (PPE) to use and the correct methods of wearing, removing and disposing of PPE

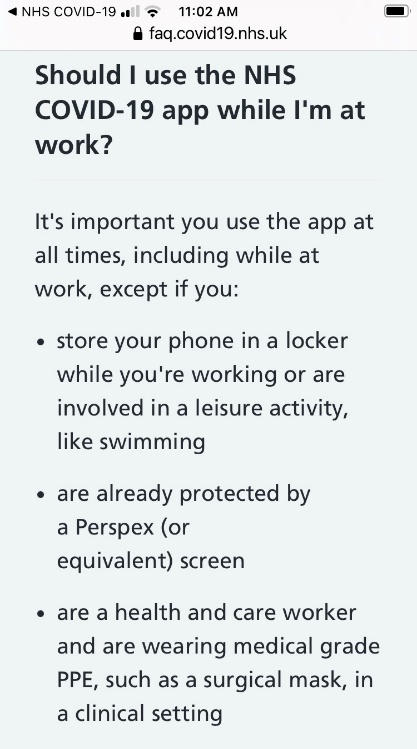
* 1. Test and Trace for England and associated risks.

FM teams should identify any risks associated with staff working together and should they be identified through the track and trace process an assessment should be carried out.

The risk assessment, SOP, work area, contact method and risk pathway combined should provide an outcome whether to isolate or not.

For example; a night porter in correct PPE who walks behind a suspected COVID-19 patient who is wearing a mask, is at a lower exposure risk than a receptionist who has face to face interactions with numerous untriaged patients and visitors, or someone cleaning in a side room housing a confirmed COVID-19 patient

See extract below from the Track and trace app regarding pausing the App when in a healthcare environment



1. KPI’s

Organisations in conjunction with FM partners should consider whether to suspend KPI’s during the COVID-19 pandemic to ensure the services can be flexed dynamically to meet the rapid changes to service provision that will be required during the pandemic, this could include:

* Local agreements during the pandemic must be agreed and recorded by organisations detailing the areas changed to accept patients being treated with COVID-19, whether these are cohort or high risk areas, the cleaning, catering and portering services required to meet these requirements, including enhanced cleaning requirements, catering menus considerations and portering routes patient movements etc..
* Identification of the key critical KPI to remain and how the others will be changed to ensure focus is channeled in the correct areas.
* Areas being closed to patients such as outpatient clinics, offices etc.
* Requirements relating to staff feeding and retail
* Enhanced service requirements

1. PPE process checks – by local arrangement

It is critical that FM teams follow the PPE requirement that is included in both the training documents and SOP’s for each service, the PPE has been taken from the latest and most up to date guidance and is updated and dovetailed to the guidance each time it is changed.

It is also important that guidance on the use of face masks and coverings in hospital settings to prevent COVID-19 transmission are followed

Auditing should include checking the availability of the correct PPE, donning and doffing of PPE and user compliance and should include all FM teams within the areas of the organization where patients are being housed with suspected or confirmed C0VID-19.

Other areas that should be audited are:

* A competency audit of staff ensuring the correct process should be undertaken at random intervals
* Correct storage of PPE should form part of the audit process
* Correct disposal procedures in place
* Complete paperwork outside of environment – (put together simple appendix form)
* Launderable gowns – linen skips available.

1. Legionella and Pseudomonas – tap flushing

Organisations to follow their own procedures for little used water outlets as approved by the water safety group and to be mindful of legionella from aerosolization.

1. For areas that have reduced usage or have been closed water outlets should be run as per the HTM-04-01 guidance
2. With the increase in hand washing requirements in some areas, and some areas being closed and mothballed, a risk assessment needs to be undertaken as to which water outlets need additional flushing
3. If tap flushing is required to support the management of Legionella and Pseudomonas, it is important that this work-continues and increases to cover areas that are usually open and don’t require a daily service, during the pandemic all closed areas need to be identified and a program introduced to flush all water outlets daily for at least 2 minutes. This will also ensure the water tanks turnover at least once daily.
4. Record should be kept detailing all taps flushed with the day and date recorded.
5. In areas where there are suspected or confirmed COVID -19 patients the teams allocated to these areas to carry out daily services should carry out the tap flushing service and keep the appropriate records.
6. Water outlets include but are not limited to:
   1. Wash hand basin taps, including single and mixer taps
   2. Sink taps
   3. Sluice sink taps
   4. Toilets and sluice sinks should be flushed
   5. Drinking water stations plumbed into the water supply should be run
   6. Bath taps and any shower attachments housed inside the bath should be run
   7. Shower heads
   8. External taps
7. It is imperative that all control measures are carried out and if access is difficult in Covid areas then Medical staff must carry out any required flushing and record it.
8. Any areas being converted into ICU spaces need to be confirmed as “Augmented” and a Pseudomonas Risk Assessment needs to be undertaken with the necessary flushing and testing put in place.
9. Any Cleaning and Chlorination of Cold Water Service Tanks need to be co-ordinated with Medical staff to ensure no break in any service occurs.

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1. Cleaning chemicals and associated consumable products

During the pandemic, there will be shortages of some products and organisations should be agile about identifying suitable alternative products, this will relate to products such as:

* 70% alcohol-based wipes
* Soap
* Sanitiser
* Waste bags using the UN approved product for infectious waste bags as per the waste policy
* Waste tags
* Chlorine and detergent cleaning chemicals with chlorine releasing agents
* Disposable curtains
* Paper products such as hand towels and toilet rolls
* Cleaning wipes and probe wipes

Also ensuring that appropriate COSHH information and risk assessment are carried out and available for all products

1. Training

Separate training presentations have been produced to support the COVID-19 pandemic, these should be used in conjunction with the SOP’s and relevant guidance documents and updated as and when the guidance is updated.

These training presentations can be found on the NHSE/I website and FM suppliers team page.

Ensure that training records are updated on completion of the initial and updated training and ensure these records are kept up to date and available,

It is important that ALL colleagues have received Infection Control training and that this is refreshed in line with current guidance, level of surge and local policies

This guidance covers ALL colleagues including temporary and agency team members who should receive the same level of training as permanent colleagues with records retained as per local policy.

1. Other consideration -all FM services

During the pandemic considerations should be given to the following items and discussion around flexing the service to accommodate the increased cleaning requirements in the area housing suspected or confirmed COVID-19 and associated areas and tasks

* 1. Organisations are asked to encourage greater enforcement of mask use for patients and FM colleagues should support the organisation in encouraging inpatients to wear a face mask wherever possible
  2. Review the frequency of changing curtains particularly in areas with suspected or confirmed COVID-19 balancing the infection prevention requirements with the availability of stock of disposable curtains with agreement from local IPC teams
  3. Review Programmed Preventative Maintenance PPM and non-urgent works for both hard and soft FM to postpone or defer, where appropriate, to all the resource to be re-allocated to clinical and in-patient areas with agreement from the responsible officer / IPC teams
  4. Review the process of patients hand hygiene practices, particularly in relation to meal and beverage services, to consider what facilities are available for patients to perform effective hand hygiene with local IPC teams
  5. Consider the options of closing non-clinical areas, in line with government advice in relation to working from home where possible, to reduce the pressure on the FM service.
  6. Consider the option of moving non-clinical cleaning to overnight, where applicable and appropriate to do so.
  7. Where available, use centralised waste bins in non-clinical areas and ask staff to empty their own waste bins in non-clinical areas.
  8. Identify areas within organisations that could be self-sustaining, such as laundry facilities and consider asking the teams working in these areas to carry out their own cleaning services.
  9. Where fresh cook facilities are in place look at the impact of fresh food shortages that may occur as the pandemic progresses and the ability to source fresh food is impacted.
  10. NHSE/I have Confirmed that hand driers can continue to be used in public areas of the organisation, in all other areas hand hygiene should be performed using soap and paper hand towels.
  11. Ensuring hand hygiene posters are displayed in public areas
  12. All stakeholders to engage with silver command for daily briefing and status updates. Create communication groups and escalation routes to share information.
  13. Sign off all SOP’s and RA with Trust.

1. Cleaning auditing

As the impact of the Pandemic varies across the country; organisations should risk

assess locally and consider standing down audits as part of local governance/

emergency planning. This will depend on local contractual requirements, reinstating

as the incident resolves.

* Organisations that are now working within a pathways protocol should amend frequency for some or all auditing requirements. This should be agreed with the IPCT team / DIPC and documented as part of that risk assessment and planning. Agree the audit monitoring programme with all stakeholders, standard monitoring in High Risk pathways should not be undertaken in the conventional way, any personnel going into suspected or confirmed patient areas should be limited to essential personnel only.
* It is important to keep records if the tasks and workload for each shift and area and these need to be available should they be required later– particularly around the main clean and touchpoint cleaning schedule. Any unavailability due to access issues must be recorded at the end of shift to ensure compliance of frequency in the area. This is more important during the pandemic in COVID -19 affected areas these should detail end of life care, admission and additional clinical activity, they should be kept in cleaning cupboard and or phone through to operational offices should these be required
* Efficacy audits should be undertaken to ensure the cleaning process is correct and adherence to a predictable safe outcome that is beneficial to ensure the safety of patients, staff and the environment. Example is included appendix 6. Remove PPE and clean hands before moving on to next task

1. Catering consideration and auditing
2. Food safety management system should be adapted for the COVID -19 pandemic, taking into account any fresh food shortages or menu and dietary changes
3. Temp checks and menu should be kept on the ward pantry area and stored in a plastic wallet, if the records are required off the ward the records should be photographed, and the photograph used as evidence.
4. Disposable crockery and cutlery is not required in any of the areas housing suspected or confirmed COVID-19 patients, and crockery and cutlery can be washed in a dishwasher or hand washed as per the food safety requirements.
5. Patient satisfaction surveys on in -patient areas where suspected or confirmed COVID-19 should be suspended during the period of the pandemic
6. Catering teams should understand the three risk pathways and follow segregation protocols as far as practicable. Agree a plan to deliver patient feeding service with IPC. PPE for sessional use should be reviewed in line with the risk assessment.
7. Estates
8. See the COVID-19 Estates Maintenance policies and note that an Aerosol generating Procedure (AGP) can be caused by unblocking toilets, work on Macerators and drains linked to Covid areas. It is imperative the correct PPE is used when carrying out this work and a Permit to Access is created.
9. Estates and sub-contractors should understand the three risk pathways and follow segregation protocols as far as practicable. Agree a plan to deliver essential repairs and compliance with IPC. PPE for sessional use should be reviewed in line with the risk assessment
10. Linen

See the COVID-19 linen and laundry policy for this section. Linen checks to be continued at the central linen area.

1. Ensure that the recommendations within the Linen and Laundry SOP’s is adhered to particularly around clean linen delivery
2. Identify bags that are scrubs using either labels marking the outer bag as containing scrubs or writing on the outside of the bag that the bag contains scrubs, where possible the scrubs should be contained in separate cages to the soiled linen to ensure the laundry team can easily identify the scrubs and priorities these for laundering.
3. Laundering of scrubs / gowns in on site laundries must be completed using the thermal disinfection cycle and conform to HTM-01-04
4. Porters and sub-contractors should understand the three risk pathways and follow segregation protocols as far as practicable. Agree a plan to deliver laundry service and curtain replacement with IPC. PPE for sessional use should be reviewed in line with the risk assessment
5. Security
6. PPE compliance checks need to be undertaken by the local team
7. Operational practices should be as per Local Operating procedures (SOPs)
8. Temporary COVID-19 Amendments to SOPs – to be agreed locally and all security staff fully briefed
9. PPE Compliance checks as per section 5
10. Security and personal bodyguards should understand the three risk pathways and follow segregation protocols as far as practicable. Agree a plan to deliver security service and review risk assessments with IPC. PPE for sessional use should be reviewed in line with the risk assessment.
11. Waste
12. See the separate COVID-19 waste policy available on the NHS estates hub and NHS estates Teams section for NHS suppliers
13. Porters and feminine hygiene waste contractors should understand the three risk pathways and follow segregation protocols as far as practicable. Agree a plan to deliver the bin/waste service and review risk assessments with IPC. PPE for sessional use should be reviewed in line with the risk assessment.
14. Methodologies

Cleaning methodologies have been developed and approved by the cleaning group associated with the development of the new cleaning standards. This approval has been received to use some of these methodologies to support teams during the COVID-19 pandemic. PPE should be issued and worn in accordance with Risk Assessment.

**Reference Documents**

1. Covid 19 guidance for infection prevention and control in heaLthcare settings V 1.1 upDATED PPe GUIDANCE 18th MAY – Now Archived
2. Guidance for the remobilisation of services within health and care settings V1 20TH AUGUST 2020
3. CEM/CMO/2020/043 LETTER DETAILING UPDATES TO CLEANING, TRAINING AND SOCIAL DISTANCING 24.12.2020