PRT04
Respiratory Illnesses Protocol

1.0 Procedure Statement (Purpose / Objectives of the Procedure)

Respiratory viruses include seasonal, avian, and pandemic influenza, respiratory syncytial virus (RSV) and severe acute respiratory syndromes (SARS).

COVID-19, a form of SARS, along with many other respiratory infections such as influenza (flu), can spread easily and cause serious illness in some people. You may be infected with a respiratory virus such as COVID-19 and not have any symptoms but still pass infection onto others.

The common respiratory viruses are seasonal influenza and RSV. They can infect any age group although the severe complications of such infection are often restricted to children and the elderly. These viruses are most commonly transmitted by airborne droplets or nasal secretions and can lead to a wide spectrum of illness. In the UK many of these viruses are seasonal in their activity and tend to circulate at higher levels during the winter months.

The risk of catching or passing on a respiratory illness is greatest when someone who is infected is physically close to or sharing an enclosed and/or poorly ventilated space with other people. When someone with a respiratory viral infection such as COVID-19 breathes, speaks, coughs or sneezes, they release small particles that contain the virus which causes the infection. These particles can be breathed in or can come into contact with the eyes, nose, or mouth. The particles can also land on surfaces and be passed from person to person via touch.

2.0 Accountabilities

As stated in the National infection prevention and control manual for England C1691

Chief Executive/Executive Board are responsible for

- ensuring systems and resources are available to implement compliance with infection prevention and control
- culture that encourages safe working practices for everyone
- safe systems of work, including managing the risk associated with infectious agents through completion of risk assessments and approved through local governance procedures

Chief Operating Officers (COOs) are responsible for

- directing the conduct of operational activities in relation to this protocol
- providing leadership, support, direction and assurance

Director of Infection Prevention and Control (DIPC) is responsible for ensuring

- adoption and implementation of this protocol in accordance with local governance processes

Matrons/Managers/Senior Sisters/Charge Nurses of all services must ensure that staff

- are aware of and have access to this protocol, including measures required to protect themselves and other staff from infection risk
- have adequate support and resources to implement, monitor and take corrective action to comply with this protocol

All staff providing care must

- show their understanding by applying the infection prevention and control principles in this protocol
- communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality
- report to line managers, document and action any deficits in knowledge, resources, equipment an facilities or incidents that may result in transmitting infection including near misses
- not provide care while at risk of transmitting infectious agents to others; if in doubt consult line manager, occupational health and wellbeing or the infection prevention team (IPT)
- inform the IPT of any outbreaks or serious incidents relating to this protocol

Infection Prevention Team must

- inform RWT, NHS England, Midlands Region and UK Health Security Agency (UKHSA) and Black Country integrated care board of any outbreaks or serious incidents

3.0 Procedure/Guidelines Detail / Actions

COVID-19 treatment guidance can be located in the adult medical guidelines section on the Royal Wolverhampton Trust (RWT) Intranet – sub section of COVID-19 treatment guidelines
COVID-19_Treatment_Guidelines_v_2.21.pdf

Treatment_pathway_for_the_management_of_acute_COVID-19_v5.pdf

Adult Medical Guidelines

PPE guidance can be located in the National Infection Prevention Manual or IP09 and IP12 on the RWT Intranet

Flowchart for admissions through Emergency Department and Same Day Emergency Care (SDEC) is available to follow – Appendix 1

For patients who require Critical Care admission guidance is available on isolation – Appendix 2

Symptoms of a respiratory tract infection, including COVID-19 – Appendix 3

Poster available informing staff of when you need to wear a face mask – Appendix 4

List of Aerosol Generating Procedures (AGPs) –Appendix 5

Guidance for Influenza contact patients –Appendix 6

Action card for the stepdown of PCR positive COVID-19 patients or clinically diagnosed COVID-19 to resolved –Appendix 7

Action card for stepdown of Influenza positive patients to resolved – Appendix 8

Poster available for which clean do you require on discharge –Appendix 9

Requisition for powered air-purifying Respirator (PAPR) –Appendix 10

Mask Fit testers are available in most clinical areas. If a new fit tester is required, please contact: rwh-tr.clinicalskillsdepartment@nhs.net

Respiratory Hoods can be obtained from the Medical Equipment Library

Tuberculosis (TB) Guidelines:
DPROC_RESP12_tuberculosis-guidelines.pdf (xrwh.nhs.uk)

4.0 Equipment Required

Appropriate personal protective equipment, please refer to IP12 Standard Precautions

5.0 Training

No training required

Disclaimer:
Our recommendations are based on current national guidelines and relevant evidence-base. This guideline helps inform clinicians clinical judgement. However, clinicians will consider the trade-off between the benefits and harms of an intervention before making a clinical decision.

6.0 Financial Risk Assessment

1	Does the implementation of this document require any additional Capital resources	No
2	Does the implementation of this document require additional revenue resources	No
3	Does the implementation of this document require additional manpower	No
4	Does the implementation of this document release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programs or allocated training times for staff.	No
	Other comments	

7.0 Equality Impact Assessment

An equality analysis has been carried out and it indicates that:

Tick	Options
√	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include: • • •

8.0 Maintenance

This protocol will be reviewed at least annually by the Senior Matron Infection Prevention or following any national guidance.

9.0 Communication and Training

The protocol will be disseminated to all Trust staff via e mail and it will also be available on the Intranet.

Disclaimer:
Our recommendations are based on current national guidelines and relevant evidence-base. This guideline helps inform clinicians clinical judgement. However, clinicians will consider the trade-off between the benefits and harms of an intervention before making a clinical decision.

10.0 Audit Process

There will be no formal audits related to this protocol but numbers of cases are reported externally and the team daily monitor compliance with isolation and compliance with any treatments.

Compliance will be monitored through IPCG following outbreaks or serious incidents

Criterion	Lead	Monitoring method	Frequency	Evaluation
Number of outbreaks or serious incidents recorded relating to respiratory illnesses	Senior Matron Infection Prevention	Outbreak reporting	Monthly	Infection Prevention and Control Group

11.0 References

- IP01 Hand Hygiene
- IP12 Standard Precautions
- Living safely with respiratory infections - Living safely with respiratory infections, including COVID-19 - GOV.UK (www.gov.uk) Last updated June 2022
- COVID-19: information and advice from health and care professionals - COVID-19: information and advice for health and care professionals - GOV.UK (www.gov.uk) Last updated March 2023
- National Infection Prevention and Control Manual
- national-infection-prevention-control-manual-England-version-2.10.pdf
- Tuberculosis (TB) Guidelines
- Tuberculosis diagnosis, screening, management and data
- Tuberculosis (TB): diagnosis, screening, management and data - GOV.UK

Part A - Document Control

Procedure/ Guidelines number and version PRT04 Version 3.0	**Title of Procedure/Guidelines** Respiratory Illnesses Protocol	**Status:** **Final**		**Author:** **Senior Matron Infection Prevention** **For Trust-wide Procedures and Guidelines Chief Officer Sponsor: Chief Nursing Officer**
Version / Amendment History	Version	Date	Author	Reason
	1	Dec 2022	Kim Corbett Senior Matron Infection Prevention	This is a new protocol for all RWT staff to follow in relation to respiratory illnesses
	1.1	July 2023	Senior Matron Infection Prevention	Hyperlink updated within section 3.0 for sub section of COVID-19 treatment guidelines and inclusion of hyperlink for Treatment Pathways for the inpatient management of acute COVID-19
	1.2	July 2023	Senior Matron Infection Prevention	Updates and revisions made to appendices associated with protocol
	2.0	Feb 2024	Matron Infection Prevention	Annual Review
	3.0	November 2024	Matron Infection Prevention	Annual Review
Intended Recipients: All staff groups				
Consultation Group / Role Titles and Date: Infection Prevention and Control Group Consultant Microbiologists, Consultant Respiratory Physicians, Infection Prevention Governance.				
Name and date of group where reviewed		Trust Policy Group – April 2025		
Name and date of final approval committee (if trust-wide document)/ Directorate or other locally approved committee (if local document)		Trust Policy Group – April 2025		
Date of Procedure/Guidelines issue		April 2025		

Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	February 2026 (At least annually or following any national guidance update)

Training and Dissemination: The protocol will be disseminated to all RWT staff and will be available for reference on the Intranet

To be read in conjunction with: IP01 Hand Hygiene IP12 Standard Precautions

Initial Equality Impact Assessment: Completed Yes Full Equality Impact assessment (as required): Completed NA If you require this document in an alternative format e.g., larger print please contact Policy Management Officer 85887 for Trust- wide documents or your line manager or Divisional Management office for Local documents.

Contact for Review	Senior Matron Infection Prevention
Monitoring arrangements	Monthly outbreak/serious incident data at IPCG

Document summary/key issues covered. Respiratory viruses include seasonal, avian, and pandemic influenza, respiratory syncytial virus (RSV) and severe acute respiratory syndromes (SARS). COVID-19, along with many other respiratory infections such as influenza (flu), can spread easily and cause serious illness in some people. You may be infected with a respiratory virus such as COVID-19 and not have any symptoms but still pass infection onto others.
The common respiratory viruses are seasonal influenza and RSV. They can infect any age group although the severe complications of such infection are often restricted to children and the elderly. These viruses are most commonly transmitted by airborne droplets or nasal secretions and can lead to a wide spectrum of illness. In the UK many of these viruses are seasonal in their activity and tend to circulate at higher levels during the winter months.
The risk of catching or passing on COVID-19 is greatest when someone who is infected is physically close to or sharing an enclosed and/or poorly ventilated space with other people. When someone with a respiratory viral infection such as COVID-19 breathes, speaks, coughs or sneezes, they release small particles that contain the virus which causes the infection. These particles can be breathed in or can come into contact with the eyes, nose, or mouth. The particles can also land on surfaces and be passed from person to person via touch.

Key words for intranet searching purposes	PRT04, Respiratory Illnesses, Respiratory Illness, Infection, Respiratory, COVID, Covid-19, Infection Prevention, Respiratory Tract, clinically extremely vulnerable, Infection, Respiratory Viruses, Influenza, SARS, RSV

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Flowchart for admissions through ED and SDEC

Has the patient got signs and symptoms of a respiratory illness?

Yes

Perform a Point of Care test (POCT) for COVID. When activity increases a FLU POCT must also be completed.

COVID Positive result

Admit to a side room or cohort bay

Flu Positive result

Admit to a side room or cohort bay

Both COVID / Flu Positive result

Admit to a standalone side room

COVID / Flu Negative result

Admit to AMU or a base ward

No

Admit to AMU or a base ward

RSV Positive

RSV positive patients **MUST** be isolated on **NNU, Maternity/Paediatrics, B11 and C35.**

Isolate positive RSV patients on C14/C26 (respiratory) and ICCU if there is a side room available. If no side room is available a risk assessment of other patients in the bay is required, identifying any that may be clinically vulnerable.

RSV positive patients on NNU, paeds/maternity, B11 and C35 should remain isolated/ cohorted until discharge.

Appendix 2

ICCU Respiratory Guidance

A patient must be accepted on clinical need and not await an appropriate bed.

Therefore, for RSV, Flu A and B and COVID, the following principles may help when deciding where to place patients on ICCU.

1. For a patient with a respiratory virus, ideally, they should be in a side room, if one is available.
2. If there are insufficient side rooms, then patients with RSV can be nursed in the bay (whether intubated or not). They should be at least a bed space away from any patients who are more vulnerable e.g., on immunosuppression, or chronic respiratory disease.
3. If there are still insufficient side-rooms, then any patient with influenza (A or B) who is intubated and ventilated, can be moved into a bay with other non-flu patients. NB if they are to be extubated, they should either be moved into a side-room or should be resolved (see below).
4. Patients with COVID should be nursed in a side-room unless they are in a cohort COVID bay. While it may not make much logical/scientific sense to treat this virus differently to flu, the ongoing external scrutiny of this virus means that, for now at least, we will not put COVID patients in a bay with non-covid patients, even if intubated and ventilated.
5. Patients with Flu A who are not intubated but still deemed infectious, can be cohorted with other Flu A patients, but not with flu B patients (or patients who are dually infected with COVID and flu). A similar principle applies to Flu B patients.
6. Flu resolved patients: – a minimum of 5 days after symptom onset with no fever for 24 hours and/either asymptomatic or improving symptoms
7. The same cleaning (amber clean) is required for all of the viruses.

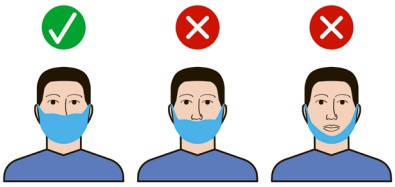
Appendix 3:

Symptoms of a respiratory tract infection, including COVID-19 can include:

Symptoms of COVID-19, flu and common respiratory infections include:

- continuous cough
- high temperature, fever or chills
- loss of, or change in, your normal sense of taste or smell
- shortness of breath
- unexplained tiredness, lack of energy
- muscle aches or pains that are not due to exercise
- not wanting to eat or not feeling hungry
- headache that is unusual or longer lasting than usual
- sore throat, stuffy or runny nose
- diarrhoea, feeling sick or being sick

People with symptoms of a respiratory infection including COVID-19 - GOV.UK (www.gov.uk)



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When you need to wear a fluid resistant surgical face mask

(This applies to all areas including **inpatients, outpatients and community settings**)

When caring for a patient who is suspected or confirmed of having an active respiratory infection caused by a droplet transmissible pathogen to protect staff from exposure

On personal risk assessment.

If a patient or colleague requests you to wear a mask.

When caring for patients in outbreak situations involving an infection spread via droplet route.

Emergency Portals. When assessing for symptoms of respiratory tract infections.* including ED, SDEC of all specialties, PAU, Cardiology, Maternity triage, UTC, Phoenix.

Cohort bay of patients with infection spread via droplets, then sessional mask is advised

When not to wear a fluid resistant surgical mask

Office areas.

Hospital corridors.

Inpatient areas
(Unless specified above masks are not routinely required in other inpatient areas.).

Training environments and meetings.

Outpatients.

Emergency portals. Following assessment and confirmed having no respiratory tract symptoms.

***Examples of infections transmitted via droplets: SARS-CoV-2 (COVID-19), Influenza A/B, Respiratory Syncytial Virus (RSV), Bacterial Meningitis, Diphtheria, Mumps.**

Refer to IP10 Isolation Policy for Infectious Diseases and IP12 Standard Precautions.

Safe & Effective | Kind & Caring | Exceeding Expectation

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Appendix 5:
List of aerosol generating procedures

Aerosol generating procedures (AGPs) are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection).

The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

- **awake* bronchoscopy** (including awake tracheal intubation)
- **awake* ear, nose, and throat** (ENT) airway procedures that involve respiratory suctioning
- **awake* upper gastro-intestinal endoscopy**
- **dental procedures** (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
- **induction of sputum**
- **respiratory tract suctioning****
- **surgery or post-mortem procedures** (like high speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses
- **tracheostomy procedures** (insertion or removal).

*Awake including ‘conscious’ sedation (excluding anaesthetised patients with secured airway).

** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current AGP list. Only open suctioning beyond the oro-pharynx is currently considered an AGP. Oral/pharyngeal suctioning is **not** considered an AGP.

Appendix 6

Flu Contacts in AMU

- Temporarily close the bay to new admissions.

- Assess all patients who have been in contact with a confirmed flu case in the bay and prescribe prophylactic dose of Tamiflu, once daily for 10 days following a medical assessment. Patient should have recent LFTs, U&Es and weight.

- Contacts can be moved to bays in other wards if required as part of their care or discharged once assessed for Tamiflu. Prophylactic Tamiflu should continue for 10 days. Note, **patients returning to their own home or care home must take Tamiflu with TTOs.**

- A confirmed case must be moved to a side room with ensuite facilities or a flu cohort bay following advice from the Infection Prevention Team or Microbiology.

- **Do not cohort Flu A, Flu B and COVID-19 positive patients together. Each virus must be cohorted separately**

- Bed spaces must be cleaned with a hypochlorite solution and the curtains changed.

- The bay can then reopen.

Flu Contacts in other wards

- Temporarily close the bay to new admissions.

- Move positive flu patient to a side room with ensuite facilities or a cohort flu bay following advice from Infection Prevention or Microbiology.

- **Do not cohort Flu A, Flu B and COVID-19 contact patients together. Contacts for each virus must be cohorted separately**

- Assess all patients who have been in contact with a confirmed flu case in the bay and prescribe prophylactic Tamiflu once daily for 10 days following a medical assessment. Patient should have recent LFTs, U&Es and weight.

- All contacts to be isolated for 72 hours to observe for signs/symptoms of flu.

- Send a Flu swab if a contact patient develops any signs/symptoms of flu.

- Contacts require 72 hours in isolation or a cohort bay and be asymptomatic before considering moving the patient from isolation or a cohort bay. Prophylactic Tamiflu should continue for 10 days.

- If no further cases are identified after 72 hours and patients are asymptomatic no additional screening is required, and the bay can re-open.

Definitions.

Flu contact: a person who has close contact with another person with infectious influenza e.g., shared the same bay

Tamiflu: flu prophylaxis.

Confirmed case: a patient with laboratory confirmed influenza from a nose or throat swab.

Appendix 7:

SARS-CoV-2 Step down criteria

ACTION CARD	Stepdown of PCR positive COVID-19 patients or clinically diagnosed COVID-19 to resolved
OFFICERS TO UNDERTAKE THIS ROLE	Capacity managers, medical and senior nursing staff

PROMPT: Patients previously positive or diagnosed clinically COVID-19 positive meeting stepdown criteria outlined below

	Patient must meet **ALL** of the following criteria
1.	Midnight at the end of Day 5 days since symptom onset or positive swab
2.	Afebrile for >48hrs without the use of antipyretics
3.	Absence of immunosuppression* ***Severe immunosuppression**: Acute or chronic leukaemia/lymphoma/myeloma/immunosuppression due to HIV/AIDS. Cellular immune deficiencies; allogenic/autologous stem cell transplant < 24 months; chemotherapy/radiotherapy < 6 months; monoclonal biologics <12 months; significant immunosuppressed therapy <3 months
4.	Clinical improvement
5.	Absence of hypoxia (i.e., SpO2 has returned to patients own baseline)

Note: post viral cough can persist for several weeks and is not a reason, on its own, to continue enhanced precautions.

Patients requiring AGP procedures must be nursed in side rooms or designated bay

Previously COVID-19 PCR positive patients who meet this criteria do not need rescreening for 90 days from first positive result. Should a patient who meets this criteria inadvertently be re-tested then this result can be disregarded unless any of the above criteria applies

NUMBER	ACTION
1	Assessment of COVID-19 positive patients to stepdown as a resolved case at midnight on Day 5 must be completed by medical/nursing staff.
2	If patient can be classed as resolved, patient may move to a COVID or non-COVID area
3	Teletracking must be updated to resolved to ensure Capacity team are aware of progress and also prior to transferring to West Park or Cannock Chase Hospital
4	If patient is still symptomatic, then clinician to review the patient on a daily basis

Appendix 7:

SARS-CoV-2 Step down criteria

5	Do not rescreen patients unless new symptoms develop within 90 days of first positive result

Appendix 8:

Influenza Step down criteria

The Royal Wolverhampton NHS Trust

ACTION CARD	Stepdown of Influenza patients to resolved
OFFICERS TO UNDERTAKE THIS ROLE	Capacity managers, medical and senior nursing staff

PROMPT: Patients previously positive meeting stepdown criteria outlined below

	Patient must meet **ALL** of the following criteria
1.	Midnight at the end of Day 5 since symptom onset or positive swab regardless of how may doses of Tamiflu have been administered
2.	Afebrile for >48hrs without the use of antipyretics
3.	Absence of immunosuppression* ***Severe immunosuppression**: Acute or chronic leukaemia/lymphoma/myeloma/immunosuppression due to HIV/AIDS. Cellular immune deficiencies; allogenic/autologous stem cell transplant < 24 months; chemotherapy/radiotherapy < 6 months; monoclonal biologics <12 months; significant immunosuppressed therapy <3 months
4.	Clinical improvement
5.	Absence of hypoxia (i.e., SpO2 has returned to patients own baseline)

Note: post viral cough can persist for several weeks and is not a reason, on its own, to continue enhanced precautions.

Patients requiring AGP procedures must be nursed in side rooms or designated bay

NUMBER	ACTION
1	Assessment of Influenza positive patients to stepdown as a resolved case at midnight on Day 5 must be completed by medical/nursing staff.
2	If patient can be classed as resolved, patient may move to a Flu cohort area or a green ward
3	Teletracking must be updated to resolved to ensure Capacity team are aware of progress and also prior to transferring to West Park or Cannock Chase Hospital
4	If patient is still symptomatic, then clinician to review the patient on a daily basis
5	Do not rescreen patients unless new symptoms develop within 90 days of first positive result

Which clean do you require on discharge?

RED CLEAN

ProXcide® HPV System
(Suitable for use in VACANT rooms only)

Required following discharge of patients infected with:
- Clostridioides difficile
- Norovirus
- Multi-resistant Acinetobacter
- Vancomycin resistant enterococci (VRE) – (CHU only)
- CPE
- Any area following sewage leaks/spills

Any other infection/areas requested by Infection Prevention

AMBER CLEAN

Chlorine-based agent

Required following discharge of patients infected with:
- MRSA
- RSV
- ESBL producing organisms
- VRE
- FLU
- COVID -19
- Measles
- Condition-related Diarrhoea
- Tuberculosis

Any other infection/areas requested by Infection Prevention

GREEN CLEAN

Detergent solution/wipe

Required following discharge of patients with no known infections

NURSING RESPONSIBILITIES

Pre Cleaning Process
- Strip bed and remove all linen and towels into a red soluble bag
- Check patient locker is empty and dispose of any remaining items including patient consumables and any medication
- Clean mattress and check for strike-through
- Ensure air mattresses are inflated
- Clean air mattress
- Remove all crockery, jugs and glasses
- Clean the patient suction unit
- Clean white board
- Clean clinical equipment and leave in the room
- Dispose of sharps box
- Call details at bottom of poster to request a Red Clean

Pre Cleaning Process
- Strip bed and remove all linen and towels into a red soluble bag
- Check patient locker is empty and dispose of any remaining items including patient consumables and any medication
- Clean mattress (for air mattresses attach decontamination certificate ,deflate mattress, bag and remove from room) and check for strike-through
- Remove all crockery, jugs and glasses
- Clean the patient suction unit
- Clean white board
- Clean clinical equipment and leave in the room
- Dispose of sharps box
- Call contact details at bottom of poster to request an Amber Clean

Pre Cleaning Process
- Strip bed and remove all linen and towels into white laundry bag
- Dispose of any remaining patient consumables
- Check patient locker is empty and dispose of any remaining items including patient consumables and any medication
- Remove all crockery, jugs and glasses
- Clean white board
- Dispose of sharps box
- Clean patient locker, bed table, entertainment system

Between hours of 8:00pm and 11:00am Monday - Friday and 7:00pm - 2:00pm Saturday - Sunday nurses to:
- Clean mattress and check for strike-through
- Clean the patient suction unit
- Clean clinical equipment
- Call contact details at bottom of poster to request a Green Clean

Post Process
- Re stock consumables
- Put room back to normal

DOMESTIC CLEANING RESPONSIBILITIES

Pre Process: Detergent and chlorine solution & HPV
- Fully extend and wipe curtains
- Empty hand towel dispensers and remove exposed toilet roll - Fully enclosed toilet roll may remain in the room
- Clean the patient bed frame and mattress (air mattresses are nursing responsibility as above)
- Clean all high and low surfaces
- Clean patient locker (inside and out), bed table, chair, entertainment system
- Clean all sockets and switches
- Remove all waste and tag, clean waste receptacle
- Wall wash to hand height
- Wipe Blinds
- Clean all areas of the en-suite
- Mop floor
- Ensure locker cupboard and drawer is open
- Turn all mattresses on their side
- Commence HPV Decontamination

Post Process
- Re stock consumables
- Put room back to normal

Pre Process: Detergent and chlorine solution
- Remove and dispose of curtains
- Remove any exposed paper products e.g. hand towels
- Clean the patient bed frame
- Clean all high and low surfaces
- Clean patient locker(inside and out), bed table, chair, entertainment system
- Clean all sockets and switches
- Remove all waste and tag, clean waste receptacle
- Clean all areas of the en-suite
- Mop floor

Post Process
- Re stock consumables
- Hang and date new curtains and put room back to normal

Pre Process: Detergent

Monday - Friday between hours of 11:00am - 8:00pm Domestics to:

Saturday - Sunday between hours of 2:00pm - 7:00pm bed team to:
- Clean the patient suction unit
- Clean clinical equipment
- Clean patient locker, bed table, entertainment system
- Clean all sockets and switches
- Remove all waste and tag, clean waste receptacle
- Clean all areas of the en-suite, wipe over sanitary ware
- Mop floor

Post Process
- Re stock consumables
- Put room back to normal

CLEANING TIME SCALES (ON WARD)

3-4 hours	1 hour	30 minutes

IMPORTANT: ANY DE-ESCALATION OF A CLEAN MUST BE AUTHORISED BY THE INFECTION PREVENTION TEAM OR ON-CALL MICROBIOLOGIST

TO REQUEST A RED OR AMBER CLEAN, PLEASE CONTACT:
DOMESTIC SERVICES ON EXT. 5029 ON-CALL SUPERVISORS (MON – FRI BETWEEN 9PM – 7AM AND AT WEEKENDS) ON BLEEP 7762

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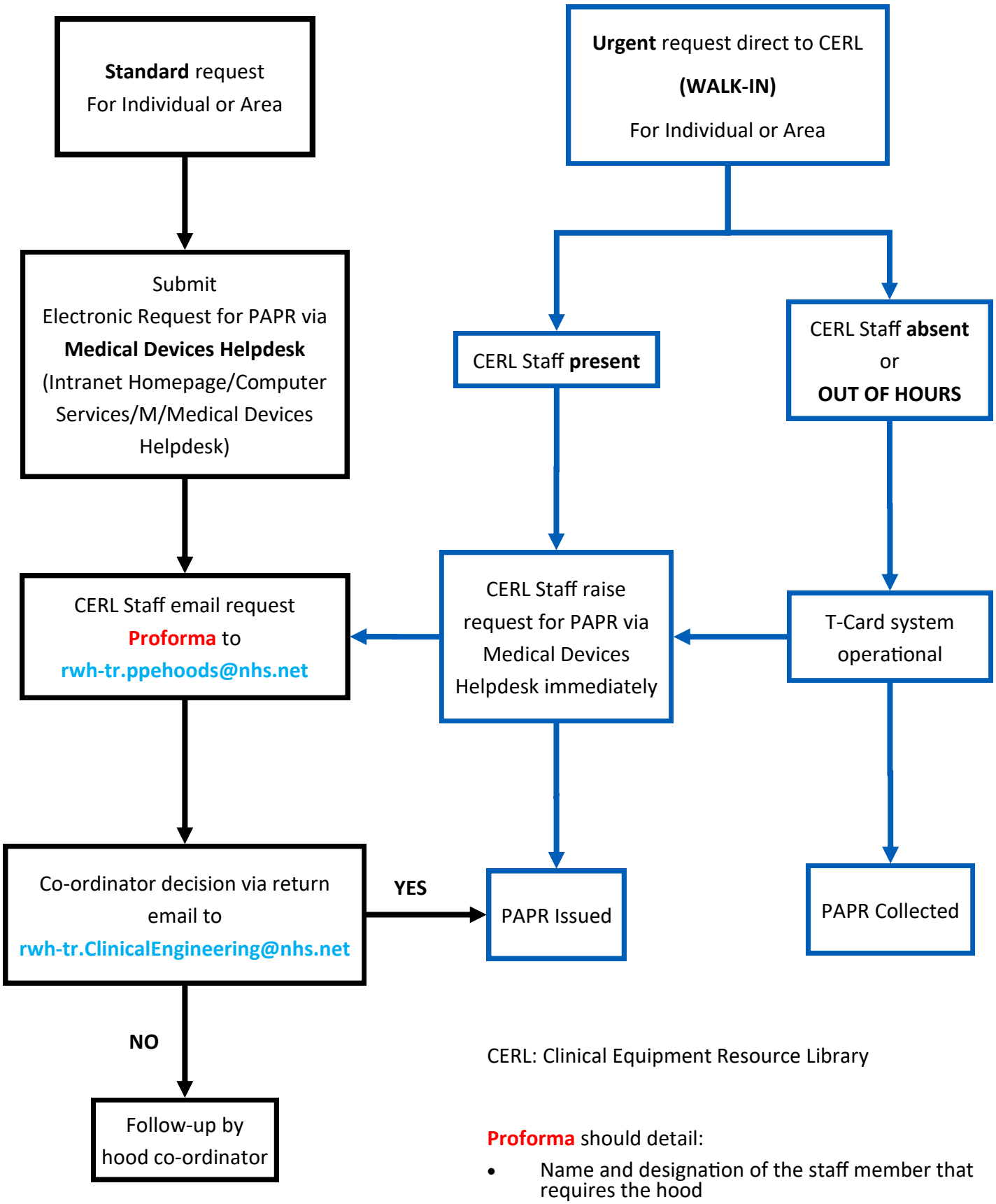
FLOWCHART: REQUISITION FOR POWERED AIR-PURIFIED RESPIRATOR (PAPR)



CERL: Clinical Equipment Resource Library

Proforma should detail:

- Name and designation of the staff member that requires the hood
- Area they are working
- Contact details

AA v1 10/2020