Infection Prevention & Control Guidance for COVID-19 Community Assessment Hubs

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Note: If you have any queries on this guidance please contact the AMRIC team at hcai.amrteam@hse.ie

Version	Date	Changes from previous version	Drafted by
3.4	**19.04.2021**	• Update period of presumed immunity from 12 weeks to 6 months in line with NPHET recommendation • Updated with recommendation that surgical masks are worn rather than cloth face coverings by those with symptoms suggestive of COVID-19	AMRIC Team
3.3	24.02.2021	• Statement that vaccination does not change the requirement for precautions • Changes to the section of Transmission to reflect recent experience and emergence of new variants • Updated to include NPHET recommendation for implementation of day 5 and day 10 testing for HCWs designated as close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' • Include 12-week exclusion from surveillance testing after confirmed infection • Updated to align with recommendation regarding FFP2 mask availability for HCW caring for suspected or confirmed COVID19 patients • Removal of reference to shortage of PPE as a reason to consider extended use of PPE • Updated to include NPHET recommendation for implementation of day 0 and day 10 testing for close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' and if asymptomatic. • Preliminary deleted from the title	AMRIC Team
3.2	17.09.2020	Updated duration of self-isolation for community cases of COVID-19	AMRIC Team
3.1	03.09.2020	Changes from previous version include: Inclusion of Purpose, Scope and of background material on the virus and the disease in the introduction Updated links to IPC guidance on HPSC Reference to the Interim Guidance on Infection Prevention and Control for the Health Service Executive 2020 Updated information on the main symptoms of COVID-19. Clarification that a healthcare worker can return to work elsewhere after working in assessment hub. Removal of reference to considerations regarding potential shortage of PPE Statement that items of PPE intended for single use should not be reprocessed	AMRIC Team
3.0	12.04.2020	Updated with respect to IPC based broader consultation with GPs. Changes from previous version include: Clarification on extended use of PPE. Clarification on workflow in the Assessment Hub. Clarification that a healthcare worker can return to work elsewhere after working in assessment hub. Clarification on access to and use of computer keyboards.	AMRIC Team

Infection Prevention & Control Guidance for COVID-19 Community Assessment Hubs

Purpose

The purpose of this document is to provide guidance related to the operation of COVID-19 community-based assessment hubs.

Scope

This guidance document is intended to support those responsible for planning, organizing, managing or working in a COVID-19 community-based assessment hub. This guidance outlines an approach to achieve a basic level of infection prevention and control in these settings.

COVID-19 community assessment hubs are intended for clinical assessment of patients with clinical features suggestive of COVID-19. These facilities are likely to serve a significant number of patients with COVID-19 and as well as those without COVID-19. Therefore, a high standard of infection prevention and control is needed to ensure that infection is not transmitted from those who are infected to those who do not have infection.

Introduction

The virus, which causes COVID-19 infection, is called SARS-CoV-2 and belongs to the broad family of viruses known as coronaviruses. It was first identified in the Wuhan province in China in December 2019 and a global pandemic event was declared in March 2020.

Transmission

Like other respiratory viruses, the transmission of SARS-CoV-2 occurs mainly through respiratory droplets generated from the mouth and nose of an infected person during activities such as coughing, sneezing, talking or laughing. The droplets may carry virus directly to the mouth, nose and eyes of person standing nearby or may land on a nearby surface. A recent scientific brief from the World Health Organization (09 July 2020) entitled Transmission of SARS-CoV-2: implications for infection prevention precautions – outlines new scientific evidence available on the virus that causes COVID-19. The conclusion of this report is that the virus is primarily spread through contact and respiratory droplets, but that under certain circumstances airborne transmission may occur (such as when aerosol generating procedures are conducted in health care settings or potentially, in indoor

crowded poorly ventilated settings elsewhere). However, concern regarding the potential for airborne transmission has increased since the recent emergence of new variants. There is particular concern regarding risk of transmission from infectious patients receiving respiratory support with high flow oxygen devices.

Higher levels of virus have been detected in patients with severe illness compared to mild cases. Like influenza, peak levels of virus are found around the time of symptom onset. People can be infectious before they develop symptoms (pre-symptomatic spread) and that some people who never notice symptoms may be infectious (asymptomatic spread). The overall importance of spread of infection from pre-symptomatic and asymptomatic people in driving the pandemic remains uncertain.

For hospitalised patients, the infectious period is generally 14 days with no fever for the last five days of that period. This also applies to residents of long-term residential care facilities (LTRCF) and or patients who may intend to transfer to LTRCF.

People in the community with COVID-19 are now asked to self-isolate for 10 days from the date of onset of symptoms, with no fever for the last five days of that period.

In the case of an asymptomatic COVID-19 infection in a person in the community (for example, a person, tested as a close contact of a case or as an outpatient prior to a scheduled procedure), the person should self-isolate for 10 days from the day the test was performed, with no fever for the last five days of that period.

Transmission in the Healthcare Setting

The spread of COVID-19 in the healthcare setting is a specific concern. Experience in Ireland and elsewhere indicates that transmission in acute hospitals and other healthcare settings can occurs readily when the virus is introduced from the community into the hospital. Transmission typically occurs when an unrecognised infectious person (patient staff or visitor) enters the hospital. Control of entry to minimise risk of unrecognised introduction is therefore a key priority in preventing outbreaks. This requires a particular focus when rates of infection in the community served are high.

Outbreaks of infection involving both patients and healthcare workers (HCW) have been frequent in acute hospitals during the recent major community surge in COVID-19. The control of spread in acute hospitals in this context has been very challenging even with extensive measures in place and the number of hospital acquired cases (probable and definite combined) has been very high. The increase in hospital acquired cases may be

related in part to the emergence of SARS-CoV-2 variants with higher transmissibility. Spread of infection from patients who are incubating infection on admission but who are asymptomatic and have undetectable virus on admission has been identified as one source of hospital outbreaks. Infectious healthcare workers who do not realise that they are infectious may also be a source of outbreaks.

Where cases of COVID-19 are detected promptly and transmission-based IPC precautions, including appropriate use of PPE are implemented fully, the risk of spread can be reduced. It is therefore important that acute hospital settings/community assessment hubs have systems in place to ensure that, to the greatest extent possible, patients with COVID-19 are rapidly identified at presentation and after admission are cared for with appropriate transmission-based IPC precautions. A self-assessment checklist of measures that have been found useful in controlling and responding to hospital transmission of COVID-19 is https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/Acute%20Hospital%20Checklist%20for%20COVID-19%20Control%20Measures.pdf

Processes for identification of patients presenting with COVID-19 must take account of the growing experience that a significant number of patients do not have respiratory symptoms on presentation and some may not have any specific clinical features that point to a diagnosis of COVID-19.

Survival in the environment

The SARS-CoV-2 virus has an outer coating called a lipid envelope. The presence of the lipid envelope means that virus is likely to survive for shorter periods outside the human body compared to a non-enveloped virus like Norovirus (Winter-vomiting virus).

The virus is easily killed by common household cleaning products, including bleach and disinfectants.

Survival on environmental surfaces depends on the type of surface and the environmental conditions. One study using a SARS-CoV-2 strain showed that it can survive on plastic for up to 72 hours, for 48 hours on stainless steel and up to eight hours on copper when no cleaning is performed. However, the levels of virus declined very quickly over the time period.

Duration of Infectivity and Isolation Period

People may be infectious for up to two days before they develop symptoms (pre-symptomatic transmission).

People with a positive COVID-19 test should self-isolate for 10 days from the date of onset of symptoms, the last 5 days of which there must be no fever. If the person had no symptoms of COVID-19 and the test result was positive, then the person should self-isolate for 10 days from the day the test was performed, the last 5 days of which should be fever free also. Note, however, that if the person requires hospitalisation or is in a residential care facility or a nursing home, then the period of isolation is 14 days with no fever for the last 5 days of that period. HCWs who have tested positive for COVID-19 and who are medically well can return to work 10 days after symptom onset (or date of test if no symptoms) AND 5 days with no fever.

All close contacts including healthcare workers- in line with advice from NPHET there will be day 0 and day 10 testing for close contacts, with exit from restricted movements if the Day 10 test is reported as 'not detected' and if asymptomatic. The requirement for restricted movement and testing does not apply to HCWS in the 6 months after they have had COVID-19 or if fully vaccinated.

Repeat testing at the end of the isolation period is generally not appropriate though exceptions may arise in the context of discussion with Microbiology, Infectious Disease or Public Health. We know that some patients who have COVID-19 may have positive (SARS CoV2 Detected) for weeks or months after the 10-day infectious period is over. However, this does not mean that they can pass on the infection to others.

Testing for SARS-CoV-2 RNA in a person diagnosed with COVID-19 is generally not appropriate in order to declare that the infectious period is over. This assessment is generally based on clinical criteria as above. Certain exceptions apply for example in some acute hospital settings.

Testing for SARS-CoV-2 RNA in an asymptomatic patient previously diagnosed with COVID-19 is generally not appropriate before scheduling treatment (surgery or other treatment) until six months have elapsed since their primary infection.

Vaccination

Vaccination for COVID-19 began in Ireland in late December 2020. Almost all frontline healthcare

workers have now been offered vaccination and most are vaccinated. The impact of vaccination is already apparent in a dramatic reduction in the number of new diagnoses of COVID-19 in healthcare workers since mid-January. It is clear however that the protection afforded to healthcare workers by vaccination is not absolute; therefore, it remains prudent to avoid intense exposure as much as possible. Although there is growing evidence that vaccination also reduces asymptomatic infection and reduces viral load and therefore risk of spread of infection from vaccinated people, it may not prevent transmission of SARS-CoV-2 from healthcare worker to patient in all settings and there a risk that variants that evade vaccine induced protection may emerge. Therefore, at present it is recommended that partially or fully vaccinated healthcare workers when caring for patients should adhere to all IPC measures in this guideline in the same way as they did prior to vaccination. This advice will be reviewed regularly on the basis of emerging evidence and experience. Given the dramatic effect of vaccination in reducing the number of infections in healthcare workers, similar benefits can be expected for many patients once vaccinated.

- The following definition of fully vaccinated has been used in "*Guidance on vaccinated individuals visiting other vaccinated individuals in a household setting*" and is followed in this document.

  Individuals are considered fully vaccinated for COVID-19 as follows and as set out here

  15 days after the second AstraZeneca dose

  7 days after the second Pfizer-BioNTech dose

  14 days after the second Moderna dose

Comprehensive Infection Prevention and Control Guidance

Detailed Infection Prevention and Control guidance for the healthcare services is available in Interim Guidance on Infection Prevention and Control for the Health Service Executive. IPC guidance for the healthcare system is not directly applicable in this non-healthcare setting however many of the principles are relevant and the document may be a useful point of reference.

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/hseinfectionpreventionandcontrolguidanceandframework/

Key principles for preventing the spread of COVID-19

Healthcare workers should be encouraged to accept vaccination as one of the most effective measures to protect themselves and to protect others.

Adherence to **Standard Precautions** with all individuals at all times.

- Key elements of Standard Precautions in this context are hand hygiene, promotion of respiratory hygiene and cough etiquette and environmental cleaning. Additional details on Standard Precautions are available in the Interim Guidance on Infection Prevention and Control for the Health Service Executive 2021.
- Early identification of potential cases of COVID-19 and rapid implementation of Contact and Droplet Precautions pending diagnosis. Additional details on Contact and Droplet Precautions are available in the Interim Guidance on Infection Prevention and Control for the Health Service Executive 2021.
- Avoiding unnecessary direct physical contact (such as undertaking a physical examination) with suspect or confirmed cases.
  - Maintain physical distancing between all individuals at all times where possible.
  - Liaison with Public Health Specialist as required.
- Provision of up to date information about the virus (basic information as above and additional information available from www.hpsc.ie).

Infection Prevention and Control Training of Staff

Training of staff should at a minimum require familiarising themselves with good infection prevention and control practice for example by reading relevant guidance at www.hpsc.ie and watching relevant videos at https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/

Hand hygiene training should be delivered directly by a hand hygiene trainer who has already completed the National Hand Hygiene Train the Trainer programme or equivalent training. Training should take into consideration physical distancing.

Note it may be possible to deliver training remotely by video link. Hand hygiene performance should be assessed and be noted to be satisfactory.

If directly delivered training is not available training in performing hand hygiene should be completed and assessed on www.hseland.ie.

Staff working in the Assessment Hub should be trained in the correct procedure for donning and doffing PPE. Donning and doffing PPE should be assessed and documented as satisfactory. Refer to https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/videoresources/acutehealthsettingcovid-19videoresources/

Please refer to the link below further information re training.

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/employersemployeesguidance/#d.en.20122

Staff working in Assessment Hubs should be aware of the main symptoms of COVID-19. They should inform their manager and not attend for work if they develop fever, cough, shortness of breath, loss or change to sense of smell or taste, or have other symptoms of acute viral infection.

Managers should confirm with staff at that start of each shift that they are free of the key symptoms of fever, cough, shortness of breath, loss or change to sense of smell or taste and have no other symptoms of acute viral infection.

Staff who develop symptoms of fever, cough, shortness of breath loss or change to sense of smell or taste, or other symptoms of acute viral infection at work should inform their manager promptly and should not continue to work.
Occupational health guidelines for staff are available on the HPSC website:
https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/

Staff Uniforms/Personal Clothes

There is no persuasive evidence that uniforms/personal clothing pose a significant hazard in terms of spreading infection. Normal household laundry practices can be expected to inactivate the COVID-19 virus and most other common pathogens. A ten-minute wash at 60 degrees Celsius is sufficient to remove most microorganisms. Using detergents means that many organisms can be removed from fabrics at lower temperatures however; it is recommended that uniforms are washed at the hottest temperature suitable for the fabric.

It is important that healthcare workers are bare below the elbows providing patient care. Staff should change immediately if uniform or clothes become visibly soiled or

contaminated.

An increasing number of healthcare services provide laundered work clothes such as scrubs that staff can change into on arrival for work. This may be of value in terms of comfort and in supporting “bare below the elbows” however, it is important to emphasise that scrubs are not personal protective equipment and are not essential to achieve good infection prevention and control practice.

Healthcare Workers providing care in the Assessment Hub

All healthcare workers can return to their normal work place after completion of work in an assessment hub subject to the following:

- They have adhered to recommended Infection Prevention and Control Practice at all times with all individuals in the assessment hub.
- They do not have fever, cough, shortness of breath, loss or change to sense of smell or taste or other symptoms of viral infection.
- They adhere to recommended Infection Prevention and Control Practice in their primary workplace.
- Routine testing of asymptomatic healthcare workers for COVID-19 after completion of work in an assessment hub and before returning to their normal workplace is not required. However, the requirement to complete a COVID-19 Healthcare Worker Relocation Self Risk Assessment does apply in cases where the healthcare worker is reassigned from one healthcare facility to another. Testing should be performed, if required, based on the outcome of that Self Risk Assessment. The Self Risk Assessment form is available at the link below.

https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance/covid-19-testing-protocol-for-healthcare-workers-moving-to-a-different-service.pdf

Healthcare workers should complete this self-assessment on an ongoing basis to identify the need for testing.

Hub Environment

In all community assessment hubs, it is necessary to consider the layout of the facility that has been allocated for this purpose. It is recognised that facilities will vary. Taking this into consideration the following principles are outlined with a flow of work going from clean area to contaminated zone/area.

The facility should be secure so that it provides a contained environment for healthcare workers and patients and so that healthcare risk waste can be protected until disposed of safely. Principles of management of clinical waste are as per Interim Guidance on Infection Prevention and Control for the HSE apply.

The facility should be uncluttered and free of any unnecessary objects.

The space and configuration should ensure that anyone waiting for assessment can remain in a separate room from other patients and staff except when being physically examined or if this is not possible that they remain at least 1 metre away from other patients and from staff when in a controlled clinical space and 2 metres away from other people if waiting in a place other than a controlled clinical space.

Areas/zones need to be clearly demarcated as clean or contaminated

To the greatest extent possible, the facility should be such as to allow all surfaces, particularly all contact surfaces to be readily cleaned and disinfected.

There should be minimum equipment in the clinical room to allow for all horizontal surfaces to be cleaned/disinfected easily between each patient. Rooms may be cleaned immediately after a patient leaves and re-used once surfaces are dry unless Aerosol Generating Procedures (AGPs) associated with an increased risk of infection are performed. Performance of AGPs in a COVID-19 assessment hub is likely to be a very exceptional event. For details on AGPs associated with increased risk of infection, see https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/aerosolgeneratingprocedures/

Computer keyboards should be available in contaminated zone/area and clean zone/area if possible. The computer in the clinical examination room should be at the furthest point from the patient. This keyboard should have an impermeable and cleanable cover to facilitate cleaning and disinfection between each patient.

If it is necessary to record written information as an aide memoire in the clinical zone to aid making a record (for example observations for the INEWS score) this should be recorded on an impermeable surface in non-permanent ink so that the surface can be cleaned and reused.

If the operational model involves healthcare workers in PPE moving between rooms the hallway/corridor area within which movement between rooms in PPE is permitted is a contaminated zone and should be away from the clean zone /area (entrance and break rooms) and be clearly demarcated from other zones. Staff who do not need to be in the contaminated zone should not enter the zone.

Alcohol hand rub should be provided at the entrance and exit to clean and contaminated areas /zones and both patients and staff are required to perform hand hygiene on entry and before exit.

Assessment Hub Operation

There should be effective supervision at all times to ensure that guidance is implemented. Staff should not eat, drink or smoke/vape in the contaminated clinical zone/area and should minimise social interaction.

Dining/break facilities should be separate from the clinical contaminated zone/ area and social distancing maintained.

Staff should follow good infection prevention and control practice in particular careful attention to hand hygiene, respiratory hygiene and cough etiquette and should use appropriate Personal Protective Equipment (PPE) as per national guidelines (please see link below).
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

NPHET guidance on the use of surgical masks by healthcare workers should be followed by all staff at all times.

People attending for assessment should be by appointment to avoid people congregating while waiting for assessment.

Where possible people who drive to the assessment hub by private car should remain in their car until called for assessment.

Signage should indicate that people waiting for assessment should not eat, drink or

smoke/vape and should not have contact with or speak with others awaiting assessment and should leave promptly after being seen.

Where possible patient flow should avoid patient overlap between patients arriving for assessment and those leaving (to avoid social interaction).

When an individual presents to the Assessment Hub they should be managed as follows:

- The patient attending the Assessment hubs should phone the receptionist ahead and wait in the car until initial clinical/administration details are obtained and advised to enter to the hub.
- All people attending for assessment should be asked to clean their hands with alcohol hand rub on entering and the assessment hub.
- It is now recommended that patients with symptoms suggestive of COVID-19 wear a surgical mask rather than a cloth face covering.
- If the patient cannot tolerate a surgical mask, they should be provided with tissues and be asked to cover their nose and mouth with a tissue particularly if coughing or sneezing.
- If waiting in the Hub they should wait in the designated waiting area.
- If someone has accompanied the person, the accompanying person should wear a surgical mask or cloth face covering. The accompanying person should be asked to avoid contact with other people including staff. Except in very exceptional circumstances, no more than one person should accompany the patient.
- All people attending should be asked to clean their hands with alcohol hand rub before leaving the assessment hub.

Personal protective equipment (PPE) for staff

Good infection prevention and control practice including appropriate use of personal protective equipment (PPE) is vital to ensure the safety of patients and staff during the current COVID-19 emergency.

The choice of PPE worn by staff should be determined by risk assessment of the tasks to be performed. This is clearly outlined in the Health Protection Surveillance Centre's current recommendations for the use of Personal Protective Equipment (PPE) in the management of suspected or confirmed COVID-19.

Healthcare workers in community and hospital settings should have access to a well-fitted respirator mask (FFP2) and eye protection when in contact with possible or confirmed COVID-19 cases and COVID-19 contacts. HPSC/AMRIC guidance has been updated to include this recommendation. In the context of a COVID-19 assessment hub, it is appropriate to consider all patients in the setting as suspected COVID-19 cases.

https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/ppe/

To protect patients and staff to the greatest extent possible it is preferable to avoid risk rather than to mitigate risk through use of PPE.

Avoid risk of exposure as much as possible

The absolute minimum number of staff required to provide care should engage with the patient.

Plan ahead for any person in the clinical contaminated zone to complete as many tasks as possible while in the zone to reduce exposure of others and limit donning and doffing.

In so far as possible a person in the contaminated zone should have ready access to a colleague who can bring additional items to the boundary of the contaminated and clean zones.

If the circumstances are such that adequate physical distance can be maintained from the patient at all times, use of PPE provides no additional risk reduction unless an aerosol generating procedure is being performed in the occupied space.

Extended use of PPE

In the assessment hub setting extended use of PPE for the sole purpose of limiting demand for PPE is not appropriate, as adequate supplies of PPE are available.
It is recognised that in certain circumstances such as when working in a cohort area dedicated to patients with COVID-19, extended use of certain items of PPE when moving between patients may be considered to facilitate working and to reduce potential HCW exposure related to very frequent donning and removal of PPE. Where measures vary from usual practice, it is necessary to ensure the lowest possible risk to patients and HCW.
Extended use means that certain items of PPE (gown, face mask, eye protection) may be

used while attending to a series of patients with COVID-19 in succession in a single period of clinical activity in one ward or unit.

- Gowns should normally be changed between patients and after completion of a procedure or task. However, if necessary to cope with workload and to reduce exposure risk associated with very frequent changes of PPE:
- Extended use of gowns in confirmed COVID-19 cohort areas may be considered for HCW engaged in low contact activities although for these activities, a disposable apron is often appropriate.
- Where HCW are engaged in high contact activities, then gowns should be changed between patients, to minimise risk of cross-transmission of other pathogens commonly encountered in healthcare settings (e.g., antimicrobial resistant organisms, such as CPE, MRSA, VRE or C. difficile).
- If PPE is wet, soiled or torn it must be doffed and disposed of.
- It is not appropriate to continue to wear PPE that was used in care of patients with COVID-19 when moving between wards or units or when moving from a clinical care area to a designated office space or break area on the ward or unit.

Extended use of gloves is not appropriate. Gloves must be changed and hand hygiene performed between patients and sometimes between different care activities on the same patient.

Double-gloving is not appropriate in the context of caring for patients with COVID-19. Cleaning gloves with ABHR is not appropriate. If there is a concern that gloves are contaminated, they must be removed safely, hand hygiene performed and a fresh pair of gloves donned if required to continue that task.

Entering the contaminated clinical zone /area:

Healthcare workers should don PPE in a clean donning area outside the contaminated zone/area (ideally have a demarcated donning space /room just outside entrance to contaminated clinical area /zone). Personal phones or devices should not be taken into the contaminated zone. If mobile phones are required in the contaminated zone they should be devices dedicated to use in the contaminated zone.

It is valuable to have a colleague visually check correct donning before entering. Note a chair is required to sit on for donning of a coverall suit. A hard easily cleanable chair should be available.

Individual clinical room

In each clinical room, on completion of examination make a record using the keyboard in the room.

If moving to another room to see the next patient remove gloves, place in healthcare risk waste and perform hand hygiene before leaving the room then move directly to the next room by the shortest practical route in PPE and perform hand hygiene and don a fresh pair of gloves on arrival in the next room.

If staying in the same room to see the next patient remove gloves, place in healthcare risk waste bin and perform hand hygiene before arrival of the next patient.

How to safely exit the contaminated zone /area

On completion of a clinical session and before leaving the contaminated zone for any reason, remove PPE in the designated doffing area/room and dispose of as healthcare risk waste. Note a chair is required to sit on for removal of a coverall suit. A hard, easily cleanable chair should be available and the surface wiped with a detergent/disinfectant wipe before starting doffing.

Reprocessing of PPE

Items of PPE that are intended for single use should not be reused. If re-usable items of PPE are used, they must a clearly defined processes for reprocessing before re use.

General precautions for staff working in COVID-19 Assessment Hubs

- Avoid touching your eyes, nose and mouth, respiratory viruses need access to these body sites in order to cause infection.
- Clean your hands regularly using an alcohol-based hand rub (if hands are not visibly soiled) or by washing with soap and water.
- Keep distance between yourself and others whenever possible.
- Observe respiratory hygiene and cough etiquette for example if coughing and sneezing and you are not wearing a mask, cover your mouth and nose with a tissue. Discard the tissue immediately into a closed bin and clean your hands with alcohol-based hand rub or soap and water. If you do not have a tissue cough into your upper arm or the crook of your elbow - do not cough into your hand.

Cleaning of medical equipment used in the assessment of patients in COVID-19 Assessment Hubs

- Where possible single patient use items are preferred.
- Medical equipment that comes into direct contact with patients should be cleaned between patients and at the end of each clinic session, for example stethoscopes, blood pressure cuffs, tympanic thermometers, electrocardiograph leads and machine surfaces touched by staff during patient examination. Cleaning should conform to manufacturer's instructions. In many cases, this will require wiping with a combined detergent/disinfectant wipe.
- The person assigned to clean equipment should wear gloves (disposable single use nitrile or household gloves) and a disposable plastic apron.
- Cleaning of medical equipment used for the consultation should be carried out after the patient has left the examination room.

Environmental cleaning of clinical areas and communal areas in COVID-19 Assessment Hubs

- The facility should be cleaned and disinfected at least daily and whenever visibly dirty.
- All contact surfaces close to the patient should be wiped clean with a combined detergent/disinfectant wipe after each patient.
- All contact surfaces should be cleaned and disinfected at a minimum of twice per day and more frequently if there is high throughput or any incident that is likely to have contaminated surfaces (for example a patient with violent coughing or sneezing).
- Clinical areas and communal areas such as waiting areas should be cleaned with household detergent followed by a disinfectant (as outlined above) or combined household detergent and disinfectant for example one that contains a hypochlorite (bleach solution) as soon as is practicably possible. Products with these specifications are available in different formats including wipes.
- The person assigned to clean the room should wear gloves (disposable single use nitrile or household gloves) and a disposable apron then physically clean the environment and furniture using a household detergent solution followed by a disinfectant or use a combined household detergent and disinfectant for example one that contains a hypochlorite (bleach solution).
- Cleaning should be carried out when patients are not present.
- Standard cleaning of walls or floors is appropriate.

- Pay special attention to frequently touched sites including door handles, backs of chairs, taps of washbasins, toilet handles and any surfaces that the patient has touched. Once cleaning and disinfection have been completed and all surfaces are completely dry, the area can be put back into use.
- If toilet facilities for patients are provided, they must be cleaned at least twice a day and checked for cleanliness at least 4 times per day. They should be separate from staff toilets.
- Discard waste including used tissues, disposable cleaning cloths) into a healthcare risk waste bag.
- Remove the disposable plastic apron and gloves and discard into a healthcare risk waste bag.
- Healthcare risk waste bags should be not be overfilled. Tie off at about ¾ full.

Appendix 1

11/4/2020 Preliminary Guidance Infection Prevention and Control in Community Assessment Hubs – Training Recommendations.

Pre- training

Materials to become familiar with prior to training/working in community assessment hubs. Important to check regularly for updates on www.hpsc.ie.

Videos

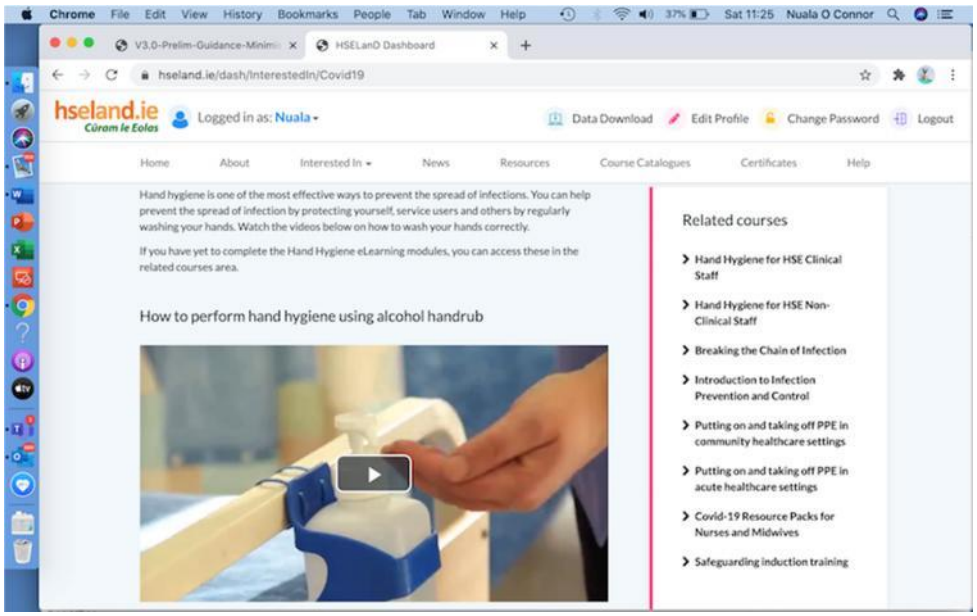
PPE donning and doffing videos training programme
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/primarycareguidance/videoresources/
PPE donning and doffing video
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/videoresources/
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/

Doffing ear looped surgical mask:
https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/videoresources/
https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/videoresourcesforipc/

HSEland infection control modules on hand hygiene, standard precautions, PPE, respiratory hygiene and cough etiquette and 2 reminder videos on the COVID19
https://www.hseland.ie/dash/InterestedIn/Covid19

GPs can register for free using their medical council number when they are asked for

employee number.



Practical onsite learning should include

- Opportunity to be supervised on correct donning and doffing of PPE.
- Observation on completing same three times and signed off as competent in same.
- Practice the buddy system approach which should be part of regular working day on the hub HCW supervise each other's technique regularly to maintain good IPC standards.
- The practical exercise should include what to do if you make a mistake.

It should be delivered by someone with infection control expertise. This may be difficult in light of areas who may not have access to IPCN's so suggest an alternative (go to another site where there may be access to IP&CN).

ENDS