The Royal Wolverhampton NHS Trust

Policy Number
IP 12

Title of Policy
Standard Precautions

Contents

Standard Precautions

1.0 Policy Statement (Purpose / Objectives of the policy)

Although not all healthcare associated infections (HCAIs) are avoidable, a significant proportion can be prevented by the adoption of evidence-based infection prevention and control standards, which must be practiced consistently by all staff, in all care settings, at all times, for all patients.

These principles of infection prevention and control are required to prevent exposure of staff to infectious agents, including blood and body fluids and also to protect patients from cross infection.

The Health and Social Care Act (2015): Code of practice for health and social care on the prevention and control of infections and related guidance states:

'Organisations must ensure that, so far as is reasonably practicable, patients, staff and other persons are protected against the risks of acquiring a HCAI, through the provision of appropriate care in suitable facilities consistent with good clinical practice'.

National guidance including: The Prevention of Healthcare Associated Infections in Primary and Community Care (NICE 2012) and Epic 3: National evidence-based guidelines for preventing healthcare associated infections in NHS hospitals in England2014) provide the evidence base for the elements of clinical practice that are essential for the prevention and control of infections. These measures are referred to as Standard Infection Control Precautions (SICPs). They include:

- Hand hygiene,
- The safe use and disposal of sharps,
- The use of personal protective equipment,
- Blood and body fluid management,
- Decontamination of environment and care equipment,
- Waste management, and
- Occupational exposure prevention.

All staff must understand the importance of the standard Infection Control Precautions and apply these standards in order to minimise the risk of cross contamination/ infection to patients, as well as to protect themselves and their colleagues from exposure to infectious agents.

2.0 Definitions

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agents from both recognised and unrecognised sources.

Sources include blood and other bodily fluids, secretions and excretions (excluding sweat), intact or non-intact skin or mucous membranes, and any equipment or items in the care environment.

Transmission Based Precautions (TBPs): TBPs are applied when SICPs alone are insufficient to prevent cross contamination of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent.

Contact precautions: used to prevent and control infection transmission via direct contact or indirectly from equipment or the environment.

Droplet precautions: used to prevent and control infection transmission over short distances via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

Airborne precautions: used to prevent and control infection transmission via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Refer to IP10, Isolation Policy for Infectious Diseases for further advice and guidance.

Hand hygiene: decontamination of the hands by hand washing using liquid soap and water and / or using an alcohol-based hand rub.

Blood and body fluids: includes secretions and excretions - blood, urine, faeces, saliva, tears, breast milk, semen, vaginal fluid, effusions, serous fluid, mucus, cerebrospinal fluid, bile, vomit, and pus and other infected discharges.

Personal protective equipment (PPE): equipment that is worn or held by a person to protect them from risks to their health and safety while at work. Examples include gloves, aprons, fluid repellent gowns/coveralls, and eye and face protection.

Pathogenic microorganisms: microorganisms capable of causing disease or infection.

Linen

Soiled and foul linen is any linen that is, or may be, contaminated with blood, body fluids and / or excreta (HSG (95) 18). This includes linen that has been used by a patient who has a known infectious disease.

Used linen is any linen that has been used, but is not contaminated with blood,

body fluids, excretions, and has not been used by a patient who has a known infectious disease.

Heat labile linen are fabrics that will be damaged by the normal heat disinfection process.

Infected linen specifically applies to linen that has been used by a patient who is known or suspected to be carrying potentially pathogenic microorganisms.

Decontamination
The care setting in particular contains a diverse population of microorganisms, and this must be considered when providing care, particularly for those who are susceptible to infection. Although potentially pathogenic microorganisms are found in air, water and on fomites, determining their role in any infection can be difficult. Appropriate decontamination of care equipment is fundamental to reducing their potential contribution to healthcare associated infections (HCAIs). For the purpose of this policy, care equipment includes items that are non-invasive and are re-usable, and further guidance can be located in the Trust Decontamination of Medical Devices Policy (HS12).

Medical Sharp
An object or instrument necessary for the exercise of specific healthcare activities, which is able to pierce intact tissues.

Safer Sharp
A medical sharp that is designed and constructed to incorporate a feature or mechanism which prevents or minimises the risk of accidental injury from cutting or pricking/piercing the skin.

3.0 Accountabilities

3.1 Trust Board

The Health and Safety at Work Act 1974 exists to protect the health, safety and welfare of all employees. It places a legal responsibility upon every employer so far as is reasonably practicable to provide all employees with a safe working environment, safe systems of work, and safe equipment. This act is supported by a number of companion regulations: The Management of Health and Safety at Work Regulations (1999), Personal Protective Equipment at Work Regulations (1992), The Control of Substances Hazardous to Health Regulations (1994 & 2002), Reporting of Injuries, Disease and Dangerous Occurrences Regulations (1996). Additionally, employers are obliged under the Disability Discrimination Act (1995 & 2013). to take reasonable steps to accommodate employees who have a disability or have developed physically impairing conditions which may have a bearing on their ability to work such as natural Rubber Latex (NRL) sensitivity.

3.2 Senior Sisters/Charge Nurses/Departmental Managers

A selection of PPE, which conforms to the European Community Standards (EC) for safety and performance and is acceptable to the individual practitioners must be provided for staff to use following a risk assessment. Managers are responsible for ensuring that local risk assessments are carried out where necessary, i.e. to identify the use of appropriate PPE, to ensure adherence to safe practices, to ensure immunisation programmes are offered appropriately, and to ensure appropriate training is provided.

3.3 Staff Members

Every employee has a duty to protect health and safety, not only of themselves but also their fellow employees, the patients, and any others entering the service location. All staff members are responsible for preventing and controlling the spread of infection, and must adopt the standard principles of infection prevention and control in their everyday activities appropriate to their role.

Any incidents resulting from a failure to implement the standard principles of infection prevention and control, or from problems with products being used, must be reported. A Datix must be generated, in line with the Trust policy. This is important, particularly in relation to incidents that are related to suppliers or facilities, in order to ensure that lessons are learnt to reduce the risk of incidents recurrence.

3.4 Infection Prevention Team

The Infection Prevention Team (IPT) has the responsibility for auditing this policy at least two-yearly, facilitating education to support the implementation of this policy, and updating the policy to ensure that it reflects current legislation and guidance.

4.0 Policy Detail

All staff involved with the provision of care of patients or who have direct contact with either the patient or their environment must use standard precautions.

4.1 Hand Hygiene

Hands are the most common way in which microorganisms are transferred from one source to another, with the potential to cause infection, especially to those who are at increased risk of infection. In order to reduce the risk of transferring microorganisms, hand hygiene must be performed at all appropriate opportunities, using the correct technique. (For more detail see the Hand Hygiene Policy IP01.)

The hand hygiene procedure undertaken must consider the actual hazards that have been or might be encountered, the subsequent potential and / or actual contamination of hands, and the risk which may present as a result. The nature of the work and any patient interaction will often determine this.

Five Moments for Hand Hygiene has emerged from the World Health Organization (WHO) Guidelines on Hand Hygiene in Health Care (2009). It defines the key moments for hand hygiene, overcoming misleading language and complicated descriptions (see Table below).

All cuts and abrasions on the hands and forearms must be covered with an occlusive, waterproof dressing. Rashes or eczema on the hands and forearms must always be reported to the Ward / Departmental Manager. Staff must seek advice for persistent skin irritation from Occupational Health and Wellbeing.

Staff must care for their hands to prevent dry, cracked skin conditions developing, which are often caused by failure to wet hands before applying soap, not rinsing off the soap thoroughly, or not drying the hands thoroughly. Regular use of a hand cream is recommended to help protect the skin, and the cream must be presented in individual single use or pump action dispensers. The use of communal pots or containers is not appropriate as they harbour bacteria.

The importance of good hand hygiene must be raised with the patients we care for, as this may be a factor in healthcare associated infections. It is essential that appropriate facilities are made available. Patients must be reminded and helped to wash their hands, especially if their mental or physical condition makes it difficult for them to wash their hands themselves.

Five moments	**When?**	**Why?**
Before patient contact	Clean your hands before touching a patient when approaching him or her	To protect the patient against harmful germs carried on your hands
Before an aseptic task	Clean your hands immediately before any aseptic task	To protect the patient against harmful germs, including the patient's own germs, entering his or her body
After body fluid exposure risk	Clean your hands immediately after an exposure risk to body fluids (and after glove removal)	To protect yourself and the healthcare environment from harmful patient germs
After patient contact	Clean your hands after touching a patient and his or her immediate surrounding when leaving	To protect yourself and the healthcare environment form harmful patient germs

After contact with a patient's surroundings	Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving – even if you haven't touched the patient	To protect yourself and the healthcare environment from harmful patient germs

4.1.1 Bare below the elbows

The impact of healthcare associated infection (HCAI) on patients in terms of morbidity and mortality cannot be understated, and the safety of patients in relation to HCAI is a clear priority for the Trust (HR 22: Staff Dress Code and Uniform Policy).

- Good hand hygiene is the single most effective way of reducing the risk of spreading infection.

- Staff in a clinical environment must keep their hands and wrists free of clothing and non-essential jewellery to facilitate proper hand hygiene.

- Wear short sleeves or ensure that their long sleeves are securely rolled up.

- Remove wrist watches and wrist jewellery (exceptions may be made for certain items of jewellery of religious significance, or medical alert bracelets, which can be moved up the arm away from the wrist when decontaminating hands and undertaking clinical care – specific guidance on this is available from the Infection Prevention Team).

- Limit finger jewellery to one plain band.
- Fingernails must be kept clean and short.
- nail varnish and nail extensions must not be worn.

4.1.2 Ties and other dangling devices

Ties and other dangling devices (e.g., lanyards) can as a vector for the transmission of HCAIs so they must be tucked in or removed prior to patient contact.

4.2 Personal Protective Equipment (PPE)

PPE prevents the transmission of microorganisms between patient and staff (NICE 2012). The need to wear PPE will depend upon the potential risk associated with the planned task, procedure or situation, depending on what the wearer may be exposed to, for instance blood and body fluids. It is the member of staff's responsibility to assess the risk for each procedure undertaken and decide upon the necessary PPE as appropriate.

All blood and body fluids (secretions or excretions) are potentially infectious; therefore, all staff must take reasonable precautions against exposure to these as well as hazardous chemicals and some pharmaceuticals (NICE 2012, Health

and Safety Executive 1999).

PPE includes items such as gloves, aprons, masks, goggles or visors; in certain situations, such as theatre and procedure rooms it includes hats and footwear.

4.2.1 Gloves

Disposable gloves are single use items and must be worn for any invasive procedures, contact with sterile sites and non-intact skin or mucous membranes (NICE 2003), including all activities when in contact with blood and body fluids, or sharp or contaminated instruments or when dealing with chemicals or hazardous substances is anticipated (NICE 2012). They must not be worn unnecessarily, as their prolonged and indiscriminate use can cause adverse reactions and skin sensitivity or allergy.

Gloves are an essential requisite of PPE and have two primary functions:

- Protecting the operator and
- Protecting the patient.

They must be fit for purpose and well-fitting to avoid interference with dexterity, friction, excessive sweating, and finger and hand muscle fatigue. If gloves are required, they must be put on immediately before the episode of patient contact or treatment and removed as soon as the activity is completed, they must be changed between caring for different patients, and between different care or treatment activities for the same patient in order to prevent the transmission of microorganisms to other sites in that individual or to other patients (NICE 2012).

Gloves are to be disposed of according to the use of the glove:

- Household waste (kitchen duties) or
- Infectious waste (used as part of clinical/ cleaning duties).

4.2.2 Aprons

The purposes of wearing disposable plastic aprons are to protect the patients who may be susceptible to infection, to protect the wearer from contamination, and to keep the uniform worn under the apron clean and dry.

Since the front of the body is the most frequently contaminated area, plastic disposable aprons provide adequate protection in most circumstances.
They must be worn when there is a risk that clothing may be exposed to blood and body fluids (except sweat) (NICE 2012). They must also be worn when coming into contact with skin or bed linen of patients who are being cared for using source isolation precautions. In addition, aprons must be worn when close contact with the patient, materials or equipment is anticipated and when there is a risk that clothing may become contaminated with pathogenic micro-organisms, blood or body fluids (except perspiration).

Apron colours

Green	Catering departments, ward kitchen and patient food service at ward level
Blue	General areas including wards, departments, offices and basins in public areas
Red	Bathrooms, washrooms, showers, toilets, basins and bathroom floors
Yellow	Isolation's areas

Long sleeved fluid repellent gowns

Long sleeved, fluid-repellent gowns must be worn where there is a risk of extensive splashing of blood, body fluids, secretions or excretions (with the exception of sweat), onto the skin or clothing of healthcare staff, such as in highly exudative wounds or when assisting with childbirth, when providing personal care for patients known or suspected to be CPE positive, and when undertaking aerosol generating procedures.

Sterile long sleeved, fluid repellent gowns must be worn by operating theatre scrub staff; they must be single-use, waterproof, disposable gowns.

Aprons and gowns must be disposed according use.

- Household waste (kitchen duties) or
- Infectious waste (used as part of clinical/ cleaning duties)

4.2.3 Eye and Face Protection

Protective eyewear and facial protection must be made available for staff to use if the planned procedure is likely to cause splashing of blood, body fluids or drugs (especially cytotoxic), fine particles or contaminated debris into the eyes, mouth or face, or there is a risk of exposure of hazardous substances to the eyes.
It is the member of staff's responsibility to assess the risk for each procedure undertaken and decide upon the necessary PPE as appropriate.

There are a variety of masks available, and staff must ensure that they select the most appropriate mask for the level of protection required.

Type of mask	Protection provided	Indication for use
Surgical face mask with fluid shield Type II fluid repellent surgical mask	Direct fluid repellence	Surgical scrub team during procedures outside of the operating theatre where fluid exposure is anticipated Surgical scrub team where glasses are worn As per COVID-19 PPE requirements
Surgical mask with fluid shield and integral visor	Fluid repellence Eye protection	Surgical scrub team (with the exception of those who wear glasses) Dirty room in CSSD Dental decontamination
Respiratory type masks (FFP3)	High level of protection for aerosol transmission by airborne particles	Respiratory isolation and/or aerosol generating procedures
Facial protection (visor, goggles, mask)	Eye protection Facial protection	Where this is an anticipated risk of splash injury As per COVID PPE guidelines

For COVID-19 PPE requirements and a list of aerosol generating procedures please follow the link below:
An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract when treating someone who is suspected or confirmed to be suffering from an infectious agent transmitted by the airborne or droplet route. Only staff who are needed to undertake the procedure should be present, wearing airborne PPE/RPE precautions.

COVID-19 personal protective equipment (PPE) - GOV.UK.

FFP3 masks
The use of FFP3 masks is only recommended for infections transmitted by aerosolised respiratory droplets, for example tuberculosis, and when undertaking aerosol generating procedures. These masks must contain a particulate filter, i.e., FFP3, referred to as respiratory type masks. In accordance with Health and Safety Regulations, staff must be 'fit' tested for the type of FFP3 mask to be used, which will be recorded on ESR and these records kept. Staff must be refitted if a different type of FFP3 mask is to be used or if the face

shape were to change, such as following significant weight loss or gain.

At least one person in each specialty must be trained as a fit tester to then test others in their areas to wear them. All staff who have been mask fitted must be added to the training database to ensure compliance.

Please refer to HS05 Ionising Radiation Safety Policy and
HS06 Laser and UV Therapy Safety Policy:
for specific guidance on Class 4 Personal Protective Equipment requirements.
If a staff member has failed the fit test for FFP3 masks, then personal air purified respirators (PARP) are available – see Appendix 5

4.2.4 Removal of PPE

In a Ward or Department setting, PPE must be removed in the following sequence to minimize the risk of cross-contamination:

- Gloves; gown or apron; eye-protection; fluid repellent surgical mask or FFP3 mask or respirator (see Appendix 1).

In a theatre setting, PPE must be removed in the following sequence to minimize the risk of cross-contamination:

- Gloves and gown must be removed as a single unit or remove the gown with gloved hands and then remove the gloves. NEVER remove soiled gowns with ungloved hands.

4.3 Safe use and disposal of sharps

Medical sharps must conform to the requirements in the Health and Safety (Sharp instruments in healthcare) Regulations 2013 which require healthcare employers to avoid unnecessary use of sharps. Where it is not practical to avoid the use of sharps the following must be applied:

- Use safer sharps if possible,
- Risk assess any use of non-safe sharps and regularly review, and
- Reinforce messages around not recapping sharps and their safe disposal.

The Trust supports the use of safer sharp products, and they must be the first choice for clinical practice. Non-safe sharps must only be used where there is approved clinical justification to do so, and this needs to be supported in a risk assessment and be consistent with other practices.

Use of non-safe sharp devices and the associated risk assessment must be approved through the Inoculation Injury Prevention Group.

When handling sharp objects, they must not be passed directly from hand to hand, and handling must be kept to a minimum. The safe disposal of sharps is the responsibility of the user. Each member of staff is personally responsible for the safe disposal of any sharps used - do not rely on others

to do this for you.

Sharps include hypodermic needles, scalpel blades, razor blades, stitch cutters, clip removers, glass ampoules, cannulae and sharp instruments which are used for clinical care. Whether or not they are contaminated with blood or body fluids, they must be disposed of into a sharps container.

There are several makes of sharps containers currently available, but to be used in RWT they must conform to British Standard Specification for Sharps Containers – BS EN ISO 23907:2012. No other type of disposal container or other method of disposal is legally acceptable. All sharps containers must be lidded and be of sufficient size to accommodate the contents.

The temporary closure mechanisms in the lid of the sharps container must be used when it is not in use (not locked). They must be kept secure and out of reach of patients and visitors.

4.3.1 Disposal

It is the responsibility of the clinical staff to ensure that the sharps container is safe for collection, i.e., the label has been completed and the closure mechanism has been activated. The sharps container must be disposed of when it is two-thirds full (under the thick black line on the sharps container). Do not attempt to press down on the sharps container or shake it to make more room.

Used sharps containers must not be allowed to accumulate, and the removal of the containers must be carried out as frequently as it is required to prevent this occurring. The collector must not remove or handle any sharps containers which are not completely intact, or correctly locked, tagged or labelled. All staff must handle sharps containers with extreme care; containers must only be carried by their handle and held away from the body. They must never be thrown during removal or transportation.

If a sharps container is damaged, place it into a larger container, lock and label the sharp container prior to disposal.

4.3.2 Segregation and colour coding

Yellow sharps containers with an orange lid are used for the disposal of sharps excluding those contaminated with medicinal products and their residues.

Yellow sharp containers with a yellow lid are used for the disposal of sharps including those contaminated with medicinal products and their residues including:

- Sharps waste contaminated with resistant microorganisms from

patients known to be infected with resistant microorganisms, including MRSA or VRE;

- Sharps waste contaminated with a blood-borne virus, from patients infected with blood-borne viruses, including HIV, Hepatitis B, Hepatitis C and Hepatitis D;

- Sharps waste contaminated with respiratory discharges from patients diagnosed or suspected of having open tuberculosis;

- Sharps waste contaminated with discharges from patients with symptoms of diarrhoea and, or vomiting, and those diagnosed with or suspected to be infected with viral or bacterial enteric infections, including norovirus and E. coli 0157, Hepatitis A, Hepatitis E or Clostridium difficile;

- Sharps waste contaminated with any other highly contagious microorganisms, from a patient diagnosed or highly suspected to be carrying the organisms including Neisseria meningitidis, SARS etc.;

- Fully and partially discharged syringes which contained medication which is not classified as cytotoxic or cytostatic.

Yellow sharp containers with a purple lid, are used for the following items:

- Drugs classified as cytotoxic or cytostatic and
- Sharps contaminated with these drugs, including fully and partially discharged syringes.

4.3.3 Spillage of sharps

If an accidental spillage of sharps occurs from a used sharps container during removal the following procedure must be followed:

- Put a hazard warning notice in place,

- Wear heavy duty gloves,

- Do not attempt to pick up any of the sharps by hand, use a disposable scoop (you may need to use forceps),

- Dispose of the used sharps into a large sharps container,

- Dispose of the scoop in the sharps container,

- Lock the sharps container securely, and

- Identify the tag number from the original sharps container and report the incident. Where blood or body fluid spillage has also occurred from the container, carry out the appropriate procedure for blood and, or body fluid spillage management.

4.4 Linen

The provision of an adequate laundry service is a fundamental requirement of direct patient care. Although soiled linen may be contaminated with microorganisms, the risk of disease transmission is negligible if it is handled, transported and laundered in a manner that avoids dispersal (Damani 2003).

4.4.1 General principles to prevent infection

The average person can shed approximately 10,000,000 skin cells a day and 10% of those will have microorganisms on them which may be pathogenic. The laundry process begins at the bedside when used linen is removed and sent off to the laundry. Standard infection control precautions must be adhered to, to minimise the risk of infection. Key elements for the provision of safe linen are:

- Change bedding carefully,
- Bag used linen at the bedside, into the appropriate colour bag (See Linen Policy IP05),
- Place potentially contaminated linen into a dissolvable liner and secure tightly,
- Wear PPE for handling contaminated linen i.e., apron; gloves are not necessary for handling used linen unless it is soiled, fouled or infected,
- Hands must be decontaminated following handling used linen, and
- Never place linen – soiled, used or clean - on the floor.

4.4.2 Colour coding

The category of linen inside a laundry container must be clearly indicated on the outside. The following colour coding must be in place (Appendix 2):

- White – all linen, including soiled as long as it is not regarded as infected;
- Red soluble bag inside a white polythene bag – all used and soiled linen which is infected or potentially infected.

4.5 Waste

All waste must be handled, segregated and disposed of in accordance with the Trust Waste Disposal Policy (HS 10). All waste such as soiled dressings, gloves and aprons must be disposed into an Orange Infectious waste bag in a foot operated bin.

5.0 Financial Risk Assessment

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

If the response to any of the above is **'Yes'** please complete a standard business case report which is signed by your Divisional Accountant and Directorate Manager for consideration by the Divisional Management Team before progressing to your specialist committee for approval. **Please retain all yes content in the final policy.**

6.0 Equality Impact Assessment

Employers are obliged under the Disability Discrimination Act (1995) to take reasonable steps to accommodate employees who have a disability or have developed physically impairing conditions which may have a bearing on their ability to work such as natural Rubber Latex (NRL) sensitivity. There are no other equality or diversity issues arising from this policy.

7.0 Maintenance

The Infection Prevention Team will inform the Infection Prevention and Control Group and through this the Trust Management Committee of any necessary amendment to this policy.

8.0 Communication and Training

8.1 Aspects of this policy will be included in the Trust induction and mandatory infection prevention training sessions.

8.2 Revisions to and launch of this policy will be facilitated by the Infection Prevention Team and carried out through the Divisional Leads communication network to include the Infection Prevention Links and Divisional Matrons.

9.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee / Group
Compliance with PPE usage	Nurse Manager Infection Prevention	Trust-wide Audit	Monthly	Infection Prevention and Control Group
Compliance with PPE usage	HoN Corporate Support Services	PPE audit which incorporates PPE compliance	Monthly	Environment Group Exception report to PSIG
Compliance with Sharp instruments in healthcare Regulations 2013	HoN Corporate Support Services /Occupational Health and Wellbeing	Inoculation injury data and associated claims data Procurement data on the ordering of devices posing a risk of inoculation injury Analysis of sharps/splash related injuries	Monthly Monthly	Staff Sharps/Splash Injury Group Actions agreed via Health and Safety Committee
Fit testing trainer in each clinical specialty	Matron Infection Prevention/ Education and Training	Training Database	Monthly	Infection Prevention and Control Group

10.0 References - Legal, professional or national guidelines

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Part A - Document Control

Policy number and Policy version: IP12 V6	**Policy Title** Standard Precautions	**Status:** Final		**Author:** Infection Prevention Team **Director Sponsor:** Chief Nurse
Version / Amendment History	Version	Date	Author	Reason
	V1	May 2008	Infection Prevention Team	Reached stated review date
	V2	Dec 2010	Infection Prevention Team	Reached stated review date
	V3	Feb 2014	Infection Prevention Team	Reached stated review date
	V4	May 2016	Infection Prevention Team	Following HSE inspection on compliance with Safer Sharps Regulations 2013
	V4.1	May 2018	Infection Prevention Team	Addition of Appendix 4 Protocol for FIT testing training and Mask fitting
	V5	April 2019	Infection Prevention Team	Full review
	V5.1	July 2020	Infection Prevention Team	COVID-19 Pandemic
	V6	March 2022	Infection Prevention Team	Full review
Intended Recipients: Trust Wide				
Consultation Group / Role Titles and Date: Infection Prevention and Control Group				

Name and date of Trust level group where reviewed	IPCG January 2022 Trust Policy Group – April 2022
Name and date of final approval committee	Trust Management Committee – April 2022
Date of Policy issue	May 2022
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated)	April 2025 Every 3 years

Training and Dissemination: The approved policy can be found on the Trust Intranet system Managers and Matrons will be informed of the launch and any revisions to the policy Basic Training will be provided on induction through the local induction process. Further training will be arranged in response to audit findings
To be read in conjunction with: Hand Hygiene Policy IP01 Linen Policy IP05 Glove Policy IP09 Isolation IP10 Waste Management Policy HS10 Staff Dress Code and Uniform Policy HR22 Sharps Safety Policy HS03 Decontamination of Medical Devices Policy HS12
Initial Equality Impact Assessment (all policies): Completed Yes **Full Equality** **Impact assessment (as required): Completed Yes**

Monitoring arrangements and Committee	Trust wide audit feedback to IPCG

Document summary/key issues covered.

Principles of infection prevention and control are required to prevent exposure of staff to infectious agents, including blood and body fluids and also protecting patients from cross infection.

The Health and Social Care Act (2015): Code of practice for health and social care on the prevention and control of infections and related guidance states:

'Organization's must ensure, so far as is reasonably practicable, patients, staff and other persons are protected against the risks of acquiring a HCAI, through the provision of appropriate care in suitable facilities consistent with good clinical practice'.

National guidance including: The Prevention of Healthcare Associated Infections in Primary and Community Care (NICE 2012) and Epic 3: National evidence-based guidelines for preventing healthcare associated infections in NHS hospitals in England (2014), provide the evidence base for the elements of clinical practice that are essential for the prevention and control of infections. These measures are referred to as Standard Infection Control Precautions (SICPs).

Key words for intranet searching purposes	
High Risk Policy? **Definition:**	**No**

Part B **Ratification Assurance Statement**

Name of document: IP12 Standard Precautions

Name of author: Danielle Dain Job Title: Senior Infection Prevention Nurse

I the above named author confirm that:

- The Strategy/Policy/Procedure/Guidelines (please delete) presented for ratification meet all legislative, best practice and other guidance issued and known to me at the time of development of the said document.

- I am not aware of any omissions to the said document, and I will bring to the attention of the Executive Director any information which may affect the validity of the document presented as soon as this becomes known.

- The document meets the requirements as outlined in the document entitled Governance of Trust- wide Strategy/Policy/Procedure/Guidelines and Local Procedure and Guidelines(OP01).

- The document meets the requirements of the NHSLA Risk Management Standards to achieve as a minimum level 2 compliance, where applicable.

- I have undertaken appropriate and thorough consultation on this document and I have detailed the names of those individuals who responded as part of the consultation within the document. I have also fed back to responders to the consultation on the changes made to the document following consultation.

- I will send the document and signed ratification checklist to the Policy Administrator for publication at my earliest opportunity following ratification.

- I will keep this document under review and ensure that it is reviewed prior to the review date.

Signature of Author: Danielle Dain

Date: February 2022

Name of Person Ratifying this document (Director or Nominee):
Job Title:
Signature:

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Please ensure this page has been completed correctly, then print, sign and email this page only to: The Policy Management Officer

IMPLEMENTATION PLAN

Policy number and policy version 12 V6	**Policy Title**	Standard Precautions	
Reviewing Group	Infection Prevention and Control Group		**Date reviewed:** January 2022
Implementation lead: Infection Prevention Team			
Implementation Issue to be considered (add additional issues where necessary)		**Action Summary**	**Action lead/s (Timescale for completion)**
Strategy; **Consider** (if appropriate) 1. Development of a pocket guide of strategy aims for staff 2. Include responsibilities of staff in relation to strategy in pocket guide.		Policy awareness delivered as part of online IP Trust induction session	IP Team agreement of online training - completed
Training; Consider 1. Mandatory training approval process 2. Completion of mandatory training form		Policy awareness included as part of online IP Trust induction session and mandatory training	IP Team agreement of online training - completed
Development of Forms, leaflets etc; Consider 1. Any forms developed for use and retention within the clinical record **MUST** be approved by Health Records Group prior to roll out. 2. Type, quantity required, where they will be kept / accessed/stored when completed		Not required	
Strategy / Policy / Procedure communication; Consider		IPCG / Senior Managers Operational Group meetings Trust Intranet in	Head of Nursing – Corporate Support Services Senior Matron – Infection Prevention

1. Key communication messages from the policy / procedure, who to and how?	Infection Prevention Policy suite Staff Team Meetings for local launch and implementation Staff Bulletin	
Financial cost impleme ntation Consider Business case develop ment	None identified	
Other specific Policy issues / actions as required **e.g. Risks of failure to implement, gaps or barriers to implementation**	PPE available for staff to use as required	

Appendix 1

Putting on PPE for non AGPs (Donning)

[COVID-19: personal protective equipment use for aerosol generating procedures - GOV.UK]

[COVID-19: personal protective equipment use for non-aerosol generating procedures - GOV.UK]

Public Health England

Putting on personal protective equipment (PPE)

for non-aerosol generating procedures (AGPs)*

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

Pre-donning instructions:

- **Ensure healthcare worker hydrated**
- **Tie hair back**
- **Remove jewellery**
- **Check PPE in the correct size is available**

1. Perform hand hygiene before putting on PPE.

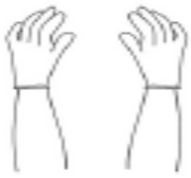
2. Put on apron and tie at waist.

3. Put on facemask – position upper straps on the crown of your head, lower strap at nape of neck.

4. With both hands, mould the metal strap over the bridge of your nose.

5. Don eye protection if required.

6. Put on gloves.



*For the PPE guide for AGPS please see:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Taking off PPE for Non AGPs (Doffing)

Public Health England

Taking off personal protective equipment (PPE)

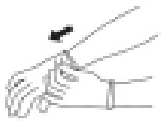
for non-aerosol generating procedures (AGPs)*

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

- **PPE should be removed in an order that minimises the risk of self-contamination**
- **Gloves, aprons (and eye protection if used) should be taken off in the patient's room or cohort area**

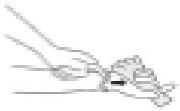
1 Remove gloves. Grasp the outside of glove with the opposite gloved hand; peel off.

Hold the removed glove in the remaining gloved hand.



Slide the fingers of the un-gloved hand under the remaining glove at the wrist.

Peel the remaining glove off over the first glove and discard.

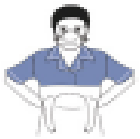


2 Clean hands.

3 Apron.

Unfasten or break apron ties at the neck and let the apron fold down on itself.

Break ties at waist and fold apron in on itself – do not touch the outside – **this will be contaminated.** Discard.



4 Remove eye protection if worn.

Use both hands to handle the straps by pulling away from face and discard.

5 Clean hands.

6 Remove facemask once your clinical work is completed.

Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only. Lean forward slightly. Discard. DO NOT reuse once removed.

7 Clean hands with soap and water.

*For the PPE guide for AGPS please see:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-aerosol-generating-procedures

Applying PPE for AGPs (Donning)

Public Health England

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs) – Gown version

Use safe work practices to protect yourself and limit the spread of infection

- keep hands away from face and PPE being worn
- change gloves when torn or heavily contaminated
- limit surfaces touched in the patient environment
- regularly perform hand hygiene
- always clean hands after removing gloves

Pre-donning instructions

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

Putting on personal protective equipment (PPE). The order for putting on is gown, respirator, eye protection and gloves. This is undertaken outside the patient's room.

Perform hand hygiene before putting on PPE

1 **Put on the long-sleeved fluid repellent disposable gown** - fasten neck ties and waist ties.

2 **Respirator.**
Note: this must be the respirator that you have been fit tested to use. Where goggles or safety spectacles are to be worn with the respirator, these must be worn during the fit test to ensure compatibility

Position the upper straps on the crown of your head, above the ears and the lower strap at the nape of the neck. Ensure that the respirator is flat against your cheeks. With both hands mould the nose piece from the bridge of the nose firmly pressing down both sides of the nose with your fingers until you have a good facial fit. If a good fit cannot be achieved **DO NOT PROCEED**

Perform a fit check. The technique for this will differ between different makes of respirator. Instructions for the correct technique are provided by manufacturers and should be followed for fit checking

3 **Eye protection** - Place over face and eyes and adjust the headband to fit

4 **Gloves** - select according to hand size. Ensure cuff of gown covered is covered by the cuff of the glove.

Removing PPE for AGPs (Doffing)

Public Health England

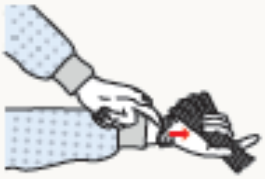
Quick guide – gown version

Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination.

The order of removal of PPE is as follows:

1 **Gloves –** the outsides of the gloves are contaminated


Clean hands with alcohol gel

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



3 **Eye protection -** the outside will be contaminated

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

5 Wash hands with soap and water

Applying/Removing Coveralls (Donning/Doffing)

Public Health England

Putting on (donning) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

Use safe work practices to protect yourself and limit the spread of infection

- keep hands away from face and PPE being worn
- change gloves when torn or heavily contaminated
- limit surfaces touched in the patient environment
- regularly perform hand hygiene
- always clean hands after removing gloves

Pre-donning instructions

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

Putting on personal protective equipment (PPE). The order for putting on is coverall, respirator, eye protection and gloves. This is undertaken outside the patient's room.

1 Don the coveralls

- Step into coveralls
- Pull up over waist
- Insert arms into sleeves, if thumb hoops available then hoop these over your thumbs, ensure sleeves cover end of gloves so no skin is visible
- Pull up over the shoulders
- Fasten zip all the way to the top

Do not apply the hood of the coverall as there is no requirement for airborne transmission.

Steps 2 to 4 overleaf >

Putting on (donning) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

2 Respirator

Note: this must be the respirator that you have been fit tested to use. Eye protection always be worn with a respirator. Where goggles or safety spectacles are to be worn with the respirator, these must be worn during the fit test to ensure compatibility.

Position the upper straps on the crown of your head, above the ears and the lower strap at the nape of the neck.

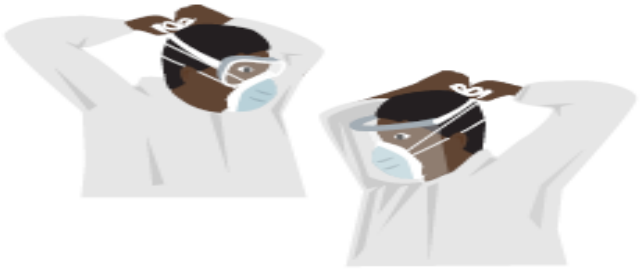
Ensure that the respirator is flat against your cheeks. With both hands mould the nose piece from the bridge of the nose firmly pressing down both sides of the nose with your fingers until you have a good facial fit.

If a good fit cannot be achieved DO NOT PROCEED. Perform a fit check.

The technique for this will differ between different makes of respirator. Instructions for the correct technique are provided by manufacturers and should be followed for fit checking.

3 Eye protection

Place over face and eyes and adjust the headband to fit



4 Gloves

- Select according to hand size
- ensure cuff of coverall is covered by the cuff of the glove

Public Health England

Removal of (doffing) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination. PPE is to be removed carefully in a systematic way before leaving the patient's room i.e. gloves, then gown/coverall and then eye protection.

The FFP2/3 respirator must always be removed outside the patient's room. Where possible in a dedicated isolation room with ante room or at least 2m away from the patient area.

This is to reduce the risk of the healthcare worker removing PPE and inadvertently contaminating themselves or the patient while doffing.

The FFP2/3 respirator should be removed in the anteroom/lobby. In the absence of an anteroom/lobby, remove FFP2/3 respirator in a safe area (e.g., outside the isolation room). All PPE must be disposed of as infectious clinical waste.

1 Firstly, grasp the outside of the outside of the glove with the opposite gloved hand; peel off

Hold the removed glove in gloved hand

Then, slide the fingers of the ungloved hand under the remaining glove at the wrist

Peel the remaining glove off over the first glove and discard

Clean hands with alcohol hand gel or rub

Steps 2 to 6 overleaf >

Removal of (doffing) personal protective equipment (PPE) including coveralls for aerosol generating procedures (AGPc)

2 **Remove coveralls**

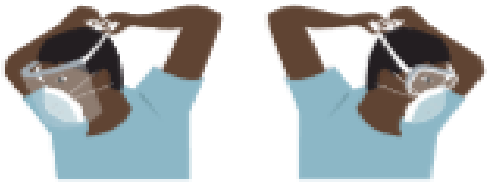
- Tilt head back and with one hand pull the coveralls away from your body
- With other hand run your hand up the zip until you reach the top and unzip the coveralls completely without touching any skin, clothes or uniform following the guidance of your buddy
- Remove coveralls from top to bottom. After freeing shoulders, pull arms out of the sleeves
- Roll the coverall, from the waist down and from the inside of the coverall, down to the top of the shoes taking care to only touch the inside of the coveralls
- Use one shoe covered foot to pull off the coverall from the other leg and repeat for second leg. Then step away from the coverall and dispose of it as infectious waste

3 **Clean hands with alcohol hand gel or rub**

4 **Eye protection**

(preferably a full face visor – goggles can be used as an alternative) – the outside will be contaminated

To remove, use both hands to handle the restraining straps by pulling away from behind and discard



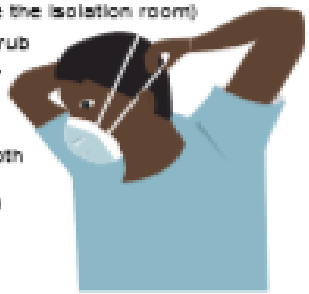
5 **Respirator**

In the absence of an anteroom/lobby remove FFP2/3 respirators in a safe area (e.g., outside the isolation room)

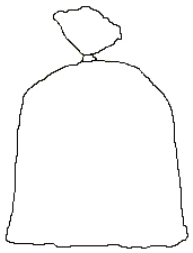
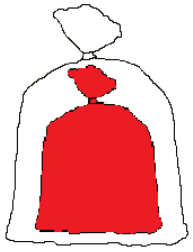
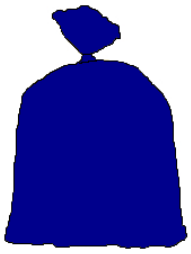
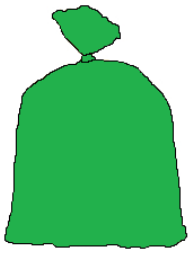
Clean hands with alcohol hand gel or rub

Do not touch the front of the respirator as it will be contaminated

- lean forward slightly
- reach to the back of the head with both hands to find the bottom restraining straps and bring it up to the top strap
- lift straps over the top of the head
- let the respirator fall away from your face and place in bin



6 **Clean hands with soap and water**

	CATEGORY	DESCRIPTION	SPECIAL NOTES	COLOUR	PICTURE
A	**Used and soiled linen**	All used and soiled linen (including patient wear) for example nightwear, patient gowns etc.	Place into a white polythene bag; this now includes linen and patient wear that is soiled with blood, faeces, vomit and urine. **Do not place soiled linen in white bags if it's known as infected linen.**	**White Polythene Bags**	
B	**Infected linen**	All used and soiled linen including patient wear from patients with known infections or suspected infectious.	Put in to a red soluble (alginate) bag and tie, then into a **WHITE** polythene bag. **The outer bag must be tied and attach tape round the neck of the bag which indicates 'Infected linen'**	Red Soluble Bag *Inside a* **White Polythene Bag**	
C	**Return to Sender items (RTS)**	Items owned by the Trust / Hospital / ward, for example uniforms, glide sheets, baby sleeping bags etc.	All items must be labeled, with Dept, Hospital name. Any items sent not labeled may not be returned. If you have any Return to Sender items that are infected, follow instruction B	**Navy Blue Polythene Bag**	
D	**Rejected clean linen (unused)**	Any clean linen which is found to be unusable (i.e. torn, stained, etc. not fit for purpose)	All rejected linen must be placed in a green polythene bag for returned through the specific process agreed with the Trust.	**Green Polythene Bag**	

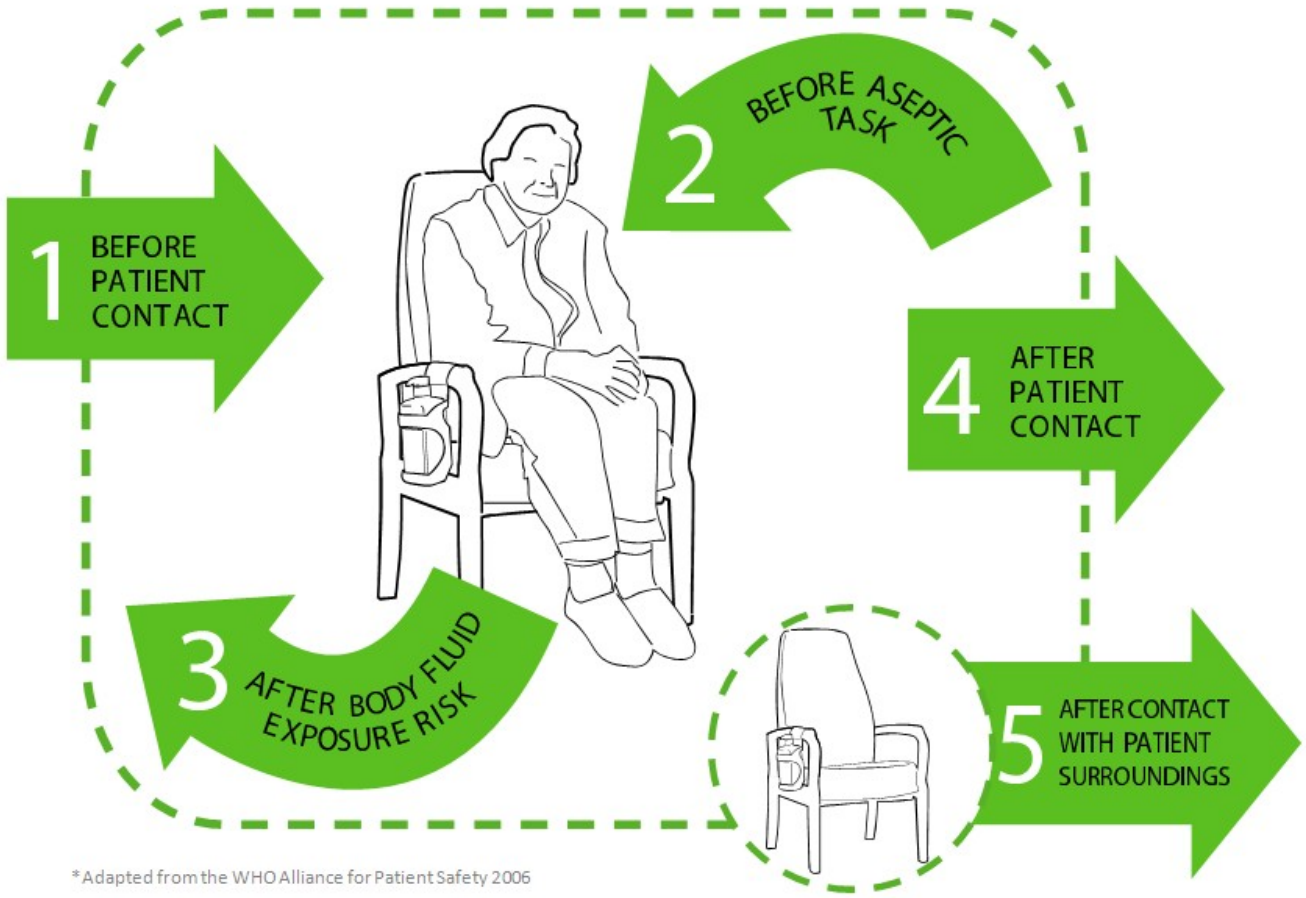
Important Notes

Before fastening any bag, make sure it is no more than **three quarters full,** (bags that are too heavy may not be collected and will cause manual handling issues)

Dirty linen may not be collected if any of the above procedures are breached.

Do not send any other items such as pillows, patient belongings etc. within the soiled linen.

Your 5 moments for hand hygiene at the point of care*



*Adapted from the WHO Alliance for Patient Safety 2006

Wash your hands with soap and water more often for 20 seconds

Palm to palm

The backs of hands

In between the fingers

The back of the fingers

The thumbs

The tips of the fingers

Use a tissue to turn off the tap.
Dry hands thoroughly.

CORONAVIRUS
PROTECT YOURSELF & OTHERS

Protocol for FIT testing training and Mask fitting

In accordance with Health and Safety Regulations, staff must be 'Fit' tested for the type of FFP3 mask to be used, which will be recorded on OLM and these records kept. Staff need to be refitted if a different type of mask is to be used or if the face shape were to change, such as following significant weight loss or gain or facial hair is present).

YES - Has been mask fitted

Staff to wear FFP3 Masks when high level protection for aerosol transmission by airborne particles is required e.g TB and aerosol generating procedures (AGPs)

To be worn for the following procedures

- Care of patient with suspected or proven pulmonary TB (for full indications refer to TB Guidelines)
- Respiratory tract suctioning
- Induction of sputum with nebulised saline
- CPR
- non-invasive ventilation (NIV); Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP)
- Manual ventilation
- Tracheal Intubation and extubation
- Tracheotomy or tracheostomy procedures (insertion/removal)
- Upper ENT airway procedures that require suctioning
- upper gastro-intestinal endoscopy where there is open suctioning of the upper respiratory tract
- Bronchoscopy High frequency oscillatory ventilation (HFOV)
- high speed cutting in surgery/post mortem procedures if this involves the respiratory tract or paranasal sinuses
- dental procedures using high speed devices such as ultrasonic scalers and high speed drills
- high flow nasal oxygen (HFNO

NO – Required mask fitting

Contact Infection Prevention for further advice or seek local trained individual for mask fitting

If identified by Infection Prevention (IP) further trainers are required then IP will contact Clinical Skills to arrange an ad hoc FIT training session

Clinical Skills to arrange FIT tester sessions for the Trust

Matrons/Ward Sisters/Charge Nurses to ensure that each ward/department has FIT testers in their area.

Staff who have received the FIT testers training must ensure that all staff in their area have been mask fitted

Forward names of staff who have been mask fitted to Infection Prevention to ensure that the database is accurate

The Royal Wolverhampton NHS
NHS Trust

Standard Operational Procedure (SOP)

Title:	Requisition for Personal Air Purified Respirator
Intended readers:	Frontline staff who work in AGP environments
Dissemination:	All Directorate management teams
Authors:	PPE GROUP – clinical Representative
Date:	6 October 2020
Review date:	6 October 2022

Introduction

The trust is committed to providing appropriate and effective Personal Protection Equipment (PPE) to all staff who require them to perform their duties as safely as possible. Though different face masks exist within the trust that provide a level of protection when used in conjunction with other PPE and safety practices, there are some individuals working on the frontline, who have failed the fit tests for all available masks or are unable to use the face masks for other reasons. Personal Air Purified Respirators (PAPRs) are an alternative to the high filtration face masks (FFP3), able to provide the requisite level of protection.

There are only a limited number of PAPRs in the trust therefore this SOP is designed to ensure that PAPRs are allocated to right areas and individuals in a consistent, efficient and fair manner. It will provide a triage system to operate alongside the pre-existing medical device request process for acquisition of PARPs.

Process

1. As PAPRs are classified as medical devices, individuals or areas that require them should put in a request utilising the medical devices help desk on the intranet.
2. The request will be picked up by the Clinical Equipment Resource Library (CERL) who will forward it to the PPE hoods generic mailbox for triage at: rwh-tr.ppehoods@nhs.net. **Information forwarded should include name and designation of the staff member that requires the hood, area they are working and contact details.**
3. The central co-ordinator will assess the appropriateness of the request and approve or decline the request by return email to the clinical engineering mailbox to action at - rwh-tr.ClinicalEngineering@nhs.net

Request by Individual

In considering the appropriateness of a request for a PAPR for personal use, the central co-ordinator will consider:-

- What masks the individual has been fit tested for

- Whether the individual has failed all genres of FFP3 masks available in the trust
- What clinical area they work in
- their role/job title
- risk or probability of individual exposure to Aerosol Generating Procedures (AGPs)?
- Any other reason for the request?
- Number of hoods available for individual allocation

Request of PAPR for an Area

There may be clinical areas that require PAPRs for the first time, to replace returned/recalled equipment allocated to the area or replace or stock for emergency or adhoc use. The request would be made by the appropriate person via the medical device helpdesk on the intranet.

- The central co-ordinator will consider:-
- category of clinical activity in the specific area
- risk of AGPs occurring in the area
- How often hoods are required
- Number of hoods required for safety of staff
- Number of staff sharing the hoods
- Number of hoods available for disbursement

Walk-in Requests/Access to PAPRs

During working hours

- The preferred method of requisition for hoods would be through the Medical device electronic request process (Medical Devices Helpdesk) and this should be encouraged and reiterated as often as possible.

- It is however recognised that some urgent requests would be on a walk-in basis.

- If a CERL member of staff is present, a medical device request should be raised at the time by the staff member and the PAPR released for use. An email should be sent to the hoods generic mailbox (with the requisite information on the proforma) for follow up as necessary.

- If No CERL staff member is present – the T-card system should apply with retrospective medical device request and email to PAPR mailbox by a CERL member of staff.

Out of hours

- The pre-existing T-card System should operate as normal and a retrospective request raised for the device by CERL staff. An email should be sent to the PAPR mailbox for follow-up.

This is to ensure that PAPRs are accessible in a timely manner for emergency use at all times without negating the control system in place.

Additional Information

- The clinical co-ordinator for hoods will, as much as possible, endeavour to allocate the limited number of PAPRs to individuals and areas that are deemed at highest risk due to their line of work or nature of clinical activity in the work area and will be given priority over individuals or areas deemed at low risk.
- There may be a need for further interrogation of the request with the originator for clarification in which case the originator will be contacted via telephone or email.
- In some instances, alternatives to hoods such as the half-face respirators may be offered to an individual - if available, suitable and acceptable to the individual.
- PAPRs that are located in clinical areas but do not appear to be required or utilised (via Teletracking and direct contact) will be recalled or retrieved to CERL so they are available for loaning out to individuals or areas that require them to enable them to perform their clinical duties safely.
- If an individual or area allotted a PAPR, no longer requires it, they must return the device to CERL and not pass it on or neglect to return it to CERL.
- All users of allocated PAPRs should have received the requisite training required to safely use the device.
- Servicing and changing of filters at set intervals, battery re-charging or replacement are required to ensure the devices are operating at the required efficiency. Users must comply with recalls for servicing as soon as possible and must not attempt to change filters themselves.
- PAPRs must be cleaned between uses and or users following stipulated trust /manufacturer Infection prevention guidance that relates to the particular device.
- If the designated person/co-ordinator are unavailable to respond to requests forwarded to the hoods generic Mailbox, the Clinical Engineers will authorise the release of a hood unconditionally.
  The request will be retrospectively addressed by the hood co-ordinator as necessary.

If there are any queries, please contact the medical device helpdesk via the intranet or the hoods

Clinical co-ordinator at : rwh-tr.ppehoods@nhs.net

SOP – POWERED RESPIRATORY HOODS – Universal Hood Disinfection

1. Prior to acquiring a Universal Hood all staff must read the training literature and watch the video on the following link and refer to the training instruction material in Appendix 1 **http://kite.xrwh.nhs.uk/clinical-skills-and-resuscitation/ffp3-mask-information/**

2. A Hood should only be used in conjunction with the single-use cowl which will cover the hood helmet and the wearer's shoulders.

3. The Hoods will be located in the Clinical Equipment Resource Library (CERL), location C10. The Hoods are available on an as required basis.

4. During use, if the following alarms battery or filter, occur staff must discontinue using the Hood and return to CERL as points 4-7 onwards. Where a Hood is faulty or suspected to be faulty staff must log a call on the Medical Physics Helpdesk http://rwf22a.xrwh.nhs.uk/Oneview/login.aspx.

5. When a staff member leaves the clinical area for a break and removes their PPE, they must dispose of the single-use cowl and decontaminate the cleanable parts of the Hood. On re-entering the area and putting on PPE again they must put on a pair of gloves to put on the Hood (then remove the gloves) and cowl before putting on a clean pair of gloves for the work they will be undertaking.

   Under no circumstances should staff share the use of the Hood during a session.

6. Following end of the working week the user should:
   - Dispose of the single-use cowl at the point of use. **NOTE – this item must not be returned to the CERL.**
   - Decontaminate the Hood with appropriate cleaning product (Clinell Universal wipe, or detergent clean followed by 1000ppm chlorine, or combined detergent/chlorine product such as SoChlor).
   - Place cleaned Hood in red plastic equipment bag and place completed Decontamination sticker (orange sticker) on the bag.
   - Return the Hood and all other accessories to the CERL Library. This must be done at the end of use. **NOTE – the single-use cowl must not be returned to the CERL.**

7. On arrival at the CERL the user should place the Hood contained in its sealed red bag **ON THE DEDICATED TROLLEY FOR HOOD RETURNS WITHIN CERL.**

8. If the user requires another Hood for the following week this can be obtained from the main Equipment Library room within CERL.

Appendix 1

User Manual for Universal Hood and Visor

User Manual for Universal Hood and V

User Manual for Universal Momentum PAPR System

User Manual for Universal Momentum