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Which Principles of the NHS Constitution Apply? Please list from principles 1-7 which apply 3,4,5 Principles	Which Staff Pledges of the NHS Constitution Apply? Please list from staff pledges 1-7 which apply 1,2,3,4 Staff Pledges
Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? Yes	
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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations ‘at a glance’

Introduce yourself with #hello my name is... 	Value the contribution of everyone	Share learning with others
Be friendly and welcoming	Team working across all areas	Recognise diversity and celebrate this
Respect shown to everyone	Seek out and act on feedback	Ensure all our actions contribute to safe care and a safe working environment
Put patients at the centre of all we do	Be open and honest	For those who supervise / manage teams: ensure consistency and fairness in your approach
Show support to both staff and patients	Communicate effectively: listen to others and seek clarity when needed	Be proud of the role you do and how this contributes to patient care

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1. SUMMARY

In the absence of effective drugs or a vaccine, control of this disease relies on the appropriate management of cases, (including isolation of confirmed cases) and their close contacts. Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under certain circumstances, airborne transmission is thought to have occurred from aerosolised respiratory secretions and faecal material. Personal protective equipment and good infection prevention precautions are extremely useful in preventing spread but can never completely eliminate risk as they are user dependent.

2. PURPOSE

This procedure describes the infection prevention precautions required when caring for patients with possible, probable or confirmed middle east respiratory syndrome coronavirus (MERS-CoV).

This procedure is based on the following Public Health England guidance:

- Infection Control Advice – Middle East Respiratory Syndrome Coronavirus (MERS-CoV) June 2013¹
- Infection Control Precautions to Minimise Transmission of Respiratory Tract Infections (RTIs) in the Healthcare Setting²
- MERS-CoV Case Algorithm Version case v27 13 January 2016³

3. SCOPE

All clinical staff especially those working in A+E departments, admissions units and intensive care settings are to follow this procedure.

4. PROCEDURE

INFECTION CONTROL ADVICE – POSSIBLE OR CONFIRMED MERS-CoV CASES

4.1 'Possible' Case Definition

Any person with severe acute respiratory infection requiring admission to hospital:

- With symptoms of fever ($\geq 38^{\circ}\text{C}$) or history of fever, and cough

AND

- With evidence of pulmonary parenchymal disease (eg clinical or radiological evidence of pneumonia or acute respiratory distress syndrome (ARDS))

AND

- Not explained by any other infection or aetiology

AND AT LEAST ONE OF

- History of travel to, or residence in an area where infection with MERS-CoV could

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have been acquired in the 14 days before symptom onset

OR

- Close contact* during the 14 days before onset of illness with a confirmed case of MERS-CoV infection while the case was symptomatic

OR

- Healthcare worker based in ICU caring for patients with severe acute respiratory infection, regardless of history of travel or use of PPE

OR

- Part of a cluster of two or more epidemiologically linked cases within a two-week period requiring ICU admission, regardless of history of travel.

***Close contact** is defined as:

- Prolonged face-to-face contact (>15 minutes) with a symptomatic confirmed case in a household or other closed setting **OR**
- Healthcare or social care worker who provided direct clinical or personal care or examination of a symptomatic confirmed case, or within close vicinity of an aerosol generating procedure **AND** who was not wearing full PPE at the time

Possible case management algorithm (see appendix 1)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491902/Algorithm_case_v27-13January2016.pdf³

4.2 Transmission-based precautions

Droplet, contact and enteric precautions must be followed. For all Aerosol Generating Procedures include **airborne precautions**.

- **Droplet precautions** are designed to minimise transmission of respiratory pathogens from infected patients via droplets to susceptible persons. Droplets stay in the air short time, travel 1–2 m, droplets come into contact with mucous membranes of eyes, nose and mouth and transmit infection.
- **Contact precautions** are designed to prevent transmission of infection by contact with the patient or the patient's environment; transmission may be direct or indirect.
- **Airborne precautions** are designed to prevent transmission of infectious agents via particles which remain suspended in the air. It is not an important mode of transmission of RTI in the absence of aerosol generating procedures.

4.3 Hand hygiene

- As per Hand Hygiene procedure and WHO Five Moments of Hand Hygiene⁴
- This is essential before and after all patient contact, contact with the patient's environment, after removal of protective clothing and after cleaning of the environment.
- Use soap and water or use alcohol hand rub if hands are socially clean
- All staff must be 'Bare Below the Elbows'⁵

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4.4 Isolation

- Patients requiring assessment and investigation should be assessed in an isolation room or at home if this is possible.
- Patients requiring admission should be admitted directly to isolation room with en-suite facilities.
- Room doors should be kept closed.
- On critical care units, the patient should be nursed in a neutral-pressure side room (with closed ventilator circuit if required)
- Staff should wear protective clothing as detailed below.
- Rooms should have enhanced daily cleaning with ChlorClean and Green Universal Clinell wipes for equipment that cannot be cleaned with ChlorClean
- Isolation notices must be placed on the door
- Only essential staff should enter the room.
- A record should be kept of all staff in contact with a possible/confirmed case.

4.5 Staff

- Staff must comply with all infection control procedures as detailed above
- A record must be maintained of all staff involved in the assessment, care and management of the patient.
- The record sheet should be placed at the door and all staff entering must complete this.
- The use of bank or agency staff should be avoided wherever possible.
- All staff should be vigilant for any respiratory symptoms in the 14 days following last exposure to a case and should not come to work if they have a fever or cough. They should seek advice from the Consultant Microbiologist and Occupational Health department
- The Consultant Microbiologist will advise on where they should be medically assessed. During this period, symptomatic staff should avoid close contact with people both in the hospital and in the general community.

4.6 Visitors

- The number of visitors should be restricted.
- Visitors entering the isolation room must wear PPE.
- Visitors must be trained in the appropriate use of protective clothing, mask fit tested and hand hygiene.
- A log of all visitors must be kept.

4.7 Protective Clothing / Personal Protective Equipment (PPE)

- **PPE To be worn by all staff and visitors entering the room as detailed below**
- Ensure that staff who are likely to be caring for possible or confirmed cases are familiar with an FFP3 respirator conforming to EN149:2001⁶, and that fit testing has been undertaken before using this equipment
- Long sleeved, fluid-repellent disposable gown to be worn by ALL staff and visitors entering the room – if staff wore scrubs underneath this would obviate problems with

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laundering of uniforms and other clothing.

- Non-sterile surgical gloves.
- Fit testing must be undertaken before using this equipment and a respirator should be fit-checked every time it is used.
- Eye protection (prescription glasses do not provide adequate protection against droplets, sprays and splashes) Goggles or visors to be worn

4.8 Aerosol Generating procedures (AGP)

- Procedures that produce aerosols of respiratory secretions (AGP) are:
 - cardiopulmonary resuscitation
 - bronchoscopy (unless carried out through a closed circuit ventilation system)
 - surgery and post mortem procedures in which high-speed devices are used
 - dental procedures
 - non-invasive ventilation (NIV) eg bilevel positive airway pressure ventilation (BiPAP)
 - continuous positive airway pressure ventilation (CPAP)
 - high frequency oscillatory ventilation (HFOV)
 - induction of sputum
- **The following are NOT considered to be aerosol generating procedures (AGP) for the purpose of respiratory infections**
 - **administration of pressurised humidified O₂**
 - **administration of medication via nebulisation**
 - **obtaining diagnostic nose and throat swabs**
- Where these procedures are medically necessary, they should be undertaken in the isolation room with the door shut
- The minimum number of required staff should be present and they must wear personal protective equipment (PPE) as described above
- Entry and exit from the room should be minimised during the procedure
- If a room is used for a procedure it should be left for 20 minutes, cleaned and is then ready for re-use. This is because the large particles will fall out within seconds and the small aerosol particles will behave almost as a gas.

4.9 Equipment

- Use dedicated equipment in the isolation room.
- Dispose of single use equipment as clinical waste inside room.
- Re-useable equipment should be avoided if possible. If used, disinfect according to the manufacturer's instructions.
- Ventilators should be protected with a high efficient filter, e.g. BS EN ISO 23328-1:2008⁷, and standard decontamination procedures followed.
- Closed system suction should be used
- Use of equipment that re-circulates air (e.g. fans) should not be used as this has the potential to turn a negative-pressure room into a positive-pressure room.
- Crockery should be washed in a dishwasher.

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4.10 Cleaning

- Domestic staff to wear protective clothing as indicated above, and they must be made aware of the need for additional precautions and be trained in these.
- Daily cleaning should be carried out with more frequent cleaning of commonly used hand-touched surfaces.
- The isolation area should be cleaned after the rest of the ward area.
- Dedicated or disposable equipment must be used for cleaning.
- Cleaning equipment must be decontaminated following use.

4.11 Linen

- Bag linen inside single room - do not carry through ward/department.
- Linen should be bagged in accordance with procedures for infected linen and the laundry informed of the high-risk nature.

4.12 Waste

- Dispose of all waste as clinical waste (Infectious); in particular, ensure the appropriate disposal of faeces and urine.

4.13 Specimens

All specimens must be treated as biohazard:

- Label with biohazard label
- Mark request form accordingly
- Double bag for confirmed cases. All specimens will be handled at Containment Level 3.
- Transportation of samples between laboratories should be by enhanced category B (category A packaging and category B courier). For further advice discuss with Consultant Microbiologist or Lab Manager

4.14 Critical care

- All respiratory equipment must be protected with a high efficiency filter e.g. BS EN ISO 23328-1:2008⁷.
- Disposable respiratory equipment should be used wherever possible.
- Re-usable equipment must, as a minimum, be disinfected in accordance with the manufacturer's instructions.
- The ventilator circuit should not be broken unless absolutely necessary
- Ventilators must be placed on standby when carrying out bagging.
- Protective clothing detailed above must be worn. The use of non-invasive positive-pressure ventilation equipment carries with it an increased risk of transmission of infection.
- Water humidification should be avoided and a heat and moisture exchanger should be used if possible
- Only essential staff should be in the patient's room when AGPs are being carried out.

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4.15 Theatres

- Theatres must be informed in advance.
- The patient should be transported directly to the operating theatre and should wear a surgical mask if it can be tolerated.
- The patient should be anaesthetised and recovered in the theatre.
- Staff should wear protective clothing as detailed above.
- Disposable anaesthetic equipment should be used wherever possible.
- Re-usable anaesthetic equipment should be decontaminated in line with the manufacturer's instructions.
- The anaesthetic machine must be protected by a filter with viral efficiency to 99.99%.
- Instruments and devices should be decontaminated in the normal manner. Instruments must be transported safely.
- The theatre should be cleaned as per Trust theatre decontamination procedure
- Theatres should not be used for 15 minutes after the patient leaves if conventionally ventilated, or 5 minutes if ultraclean ventilation is used.

4.16 Transfers to other departments

- Where possible, all procedures and investigations should be carried out in the single room with a minimal number of staff present during any procedures. Only if clinical need dictates, and in conjunction with the infection control team, should patients be transferred to other departments; the following procedures then apply:
 - The department must be informed in advance.
 - The patient must be taken straight to and from the investigation/treatment room, and must not wait in a communal area.
 - To allow appropriate decontamination after any procedure, patients should be at the end of a list.
 - The patient should wear a 'surgical' mask if this can be tolerated - this will prevent large droplets being expelled into the environment by the wearer.
 - The treatment/procedure room, trolley/chair and all equipment should be cleaned with a suitable agent after use.
 - Staff carrying out procedures must wear the protective clothing indicated above.
 - It is possible that the virus can survive in the environment for at least 48 hrs, so environmental decontamination is vital

4.17 Transfer to other institutions

- Transfer of cases to another hospital should be avoided unless it is necessary for medical care.
- Patients should not be transferred solely for the purpose of accommodation in a negative-pressure room.
- If transfer is essential, the Infection Prevention Team at the receiving hospital and the ambulance staff must be advised in advance of the special circumstances of the transfer

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4.18 Handling dead bodies

- The act of moving a recently deceased body onto a hospital trolley for transportation to the morgue might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk.
- A body bag must be used for transferring the body
- Once in the hospital mortuary it would be acceptable to open the body bag in order to view the body.
- Washing or preparing the body is acceptable if those carrying out the task wear long-sleeved gowns and gloves which should then be discarded. Facial protection may be considered against splashing and should be guided by a risk assessment.
- Mortuary staff and funeral directors must be advised of the biohazard risk.
- Embalming is not recommended because of the potential presence of virus in blood.
- If a post mortem is required then it needs to be undertaken using safe working techniques (e.g. manual rather than power tools) and wearing full PPE, as per pandemic influenza, in the event that power tools are used. High security post mortem suites are available if needed.

5. ATTACHMENTS	
Number	Title
1	MERS-CoV Case Algorithm
2	Procedure on a Page – Middle Eastern Respiratory Virus (MERS)
3	Equality & Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	Title and web links from the document library

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7 SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS	
References in full	
	References
1	Public Health England (PHE) (2013) MERS-CoV: infection control for possible or confirmed cases. [Online] Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361569/MERS-CoV_infection_control.pdf (accessed 30.3.16)
2	Public Health England (PHE) (2015) Infection control precautions to minimise transmission of acute respiratory tract infections in healthcare settings https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/452928/RTI_infection_control_guidance_PHE_v3_FPF_CT_contents2.pdf (accessed 30.3.16)
3	Public Health England (PHE) (2016) MERS-CoV Case Algorithm Version case v27 13 January 2016 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491902/Algorithm_case_v27-13January2016.pdf (accessed 30.3.16)
4	World Health Organisation (WHO) Five moments for hand hygiene. Available at: http://www.who.int/gpsc/tools/Five_moments/en/ (accessed 30.3.16)
5	Loveday, HP et al (2014) epic3: National Evidence-Based Guidelines for Preventing Healthcare-Association Infections in NHS Hospitals in England. Journal of Hospital Infection. 86 Supplement 1 pp.S1-S70. [Online] Available at: http://www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf (accessed 30.3.16.16)
6	The Stationery Office (TSO) (2001) (BS EN 149: 2001) respiratory protective devices. Filtering half masks to protect against particles. Requirements, testing, marking. Available from: http://shop.bsigroup.com/ProductDetail/?pid=00000000030178264 (accessed 30.3.16)
7	The Stationery Office (TSO) (2008) (BS EN ISO 23328-1:2008) Breathing system filters for anaesthetic and respiratory use. Salt test method to assess filtration performance. Available from: http://shop.bsigroup.com/ProductDetail/?pid=00000000030167197 (accessed 30.3.16)
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World Health Organisation (2014) Infection prevention and control of epidemic-and pandemic prone acute respiratory infections in health care. [Online] Available at: http://www.who.int/csr/bioriskreduction/infection_control/publication/en/ (accessed 30.3.16)	

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8. DEFINITIONS / GLOSSARY OF TERMS	
Abbreviation or Term	Definition

9. CONSULTATION WITH STAFF AND PATIENTS		
Enter the names and job titles of staff and stakeholders that have contributed to the document		
Name	Job Title	Date Consulted
Monika Pasztor	Consultant Microbiologist	
Vanda Plecko	Consultant Microbiologist	
Kate Ogah	Consultant Microbiologist	
David Telford	Consultant Microbiologist	

10. DISTRIBUTION PLAN	
Dissemination lead:	IPC Team
Previous document already being used?	Yes
If yes, in what format and where?	SharePoint Document Library
Proposed action to retrieve out-of-date copies of the document:	Archive previous version
To be disseminated to:	
Document Library	
Proposed actions to communicate the document contents to staff:	Cascaded through Matrons at IPOG and IPCC meetings, Senior Nurse and Midwifery Group, Procedural Documents and Information Leaflet Group Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING		
Is training required to be given due to the introduction of this policy? *Yes / No * Please delete as required		
Action by	Action required	Implementation Date

12. AMENDMENT HISTORY				
Version No.	Date of Issue	Page/Selection Changed	Description of Change	Review Date
2	30/03/2016	Throughout	Made more user friendly. Easier to read	01/04/2019
2.1	17/10/2017	Page 3	BSF page added	01/04/2019
2.2	13/02/2019	Page 1	Review Date extended – form 027/2019	01/06/2019

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Appendix 1: MERS-CoV Case Algorithm

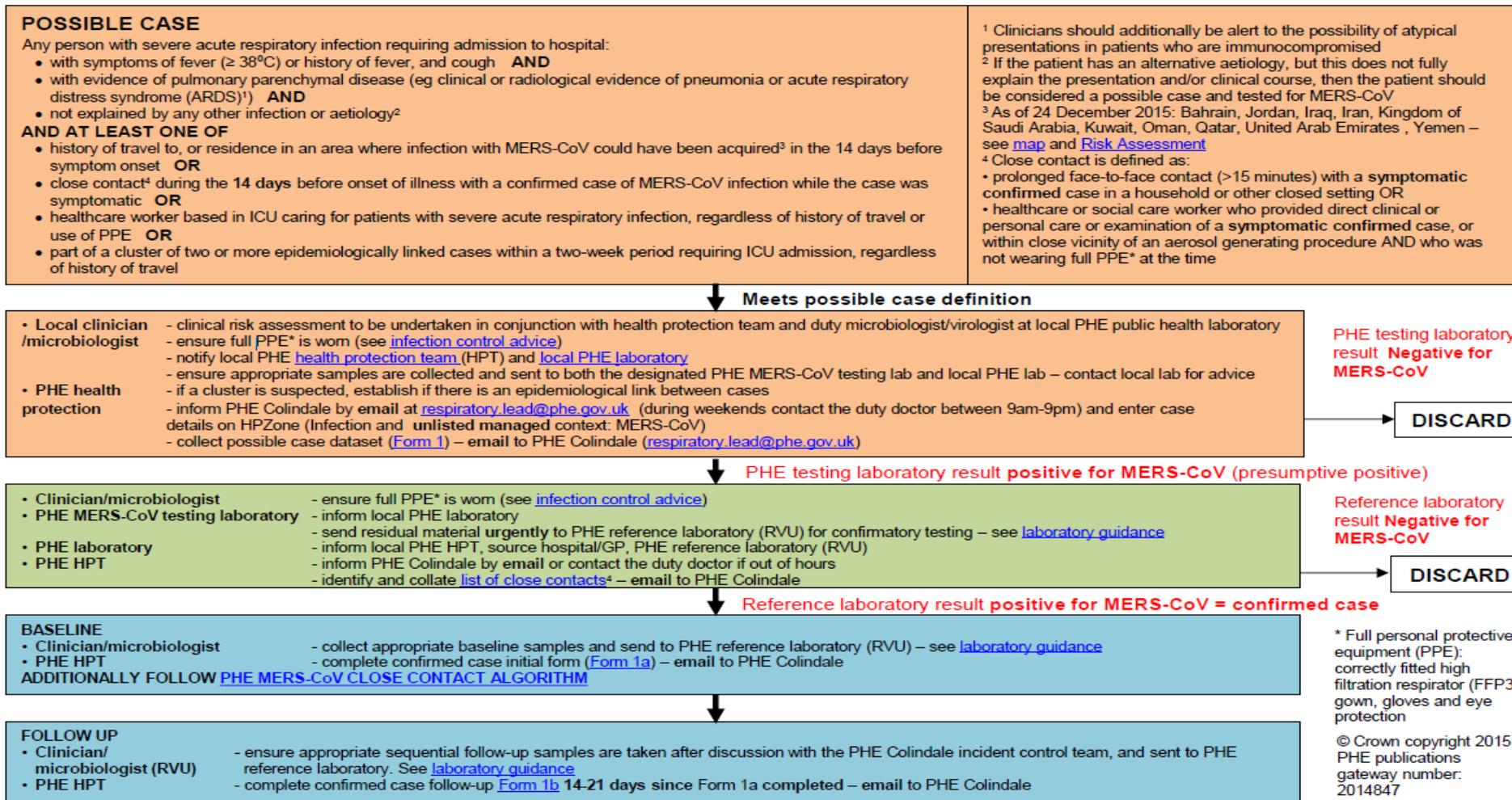


MERS-CoV Case Algorithm

Version case_v27 13 January 2016

Investigation and public health management of possible cases of severe acute respiratory illness associated with Middle East respiratory syndrome coronavirus (MERS-CoV)

For all email contact please use respiratory.lead@phe.gov.uk



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Appendix 2: Procedure on a Page – Middle Eastern Respiratory Virus (MERS)

PROCEDURE ON A PAGE – MIDDLE EASTERN RESPIRATORY VIRUS (MERS)

Middle Eastern respiratory syndrome (MERS) is a viral respiratory disease caused by a novel coronavirus (MERS-CoV) that was first identified in Saudi Arabia in 2012. Typical MERS symptoms include fever, cough and shortness of breath

ROUTES OF TRANSMISSION

The virus does not seem to pass easily from person to person unless there is close contact, such as occurs when providing unprotected care to a patient.

- **Droplet:** Stays in air short time, travel 1–2 m, droplets come into contact with mucous membranes of eyes, nose and mouth and transmit infection.
- **Airborne:** Aerosol generating procedures produce small droplets that remain in the air for longer, go further and transmit infection via mucous membrane or inhalation.
- **Contact:** May be direct or indirect – contact via hands to mucous membranes, can be transferred from hard surface up to 24 hours, and from soft fabrics up to 2 hours.

ISOLATION

- Isolate suspected MERS in an isolation room with en-suite
- Keep door closed at all times
- Isolation notices must be placed on the door
- Only essential staff should enter the room.
- A log of all staff in contact with a possible/confirmed case must be kept

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- PPE To be worn **by all staff and visitors** entering the room as detailed below
- FFP3 respirator to be worn on entrance to room (fit testing should be undertaken before using this equipment.)
- Gloves and long sleeved, fluid-repellent disposable gown to be worn by ALL staff and visitors entering the room (hand hygiene standards to be maintained)
- Eye protection (prescription glasses do not provide adequate protection against droplets, sprays and splashes) Goggles or visors to be worn

Visitors

- The number of visitors should be restricted where possible. A log must be kept.
- Visitors entering the isolation room must wear PPE, and must be trained in the appropriate use of protective clothing, mask fit tested and hand hygiene.

All staff

- **MERS-CoV investigation pack is available in Microbiology on request**
- A record log must be maintained of all staff involved in the assessment, care and management of the patient. It should be kept at the door and completed.
- The use of bank or agency staff should be avoided wherever possible.
- All staff should be aware of respiratory symptoms in the 14 days following last exposure to a case and not work if they have a fever or cough. Seek advice from the Consultant Microbiologist and Occupational Health department
- During this period, symptomatic staff should avoid close contact with people both in the hospital and in the general community.

For further information:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/361569/MERS-CoV_infection_control.pdf

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/491902/Algorithm_case_v27-13January2016.pdf

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Appendix 3: EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Age	No	
	• Disability	No	
	• Race	No	
	• Sex	No	
	• Religious belief – including no belief	No	
	• Sexual Orientation	No	
	• Gender reassignment	No	
	• Marriage and civil partnership	No	
	• Pregnancy and maternity	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?	N/A	
4.	Is the impact of the policy/guidance likely to be negative?	No	
4a	If so can the impact be avoided?		
4b	What alternative are there to achieving the policy/guidance without the impact?		
4c	Can we reduce the impact by taking different action?		

For advice in respect of answering the above questions, and / or if you have identified a potential discriminatory impact of this procedural document, please contact the relevant person (see below), together with any suggestions as to the action required to avoid/reduce this impact.

For Service related procedural documents: Lynne Wyre, Deputy Chief Nurse & Lead for Service Inclusion and Diversity

For Workforce related procedural documents: Karmini McCann, Workforce Business Partner & Lead for Workforce Inclusion and Diversity.

University Hospitals of Morecambe Bay NHS Foundation Trust		ID No. Corp/Proc/052
Version No: 2.2	Next Review Date: 01/06/2019	Title: Management Of Known Or Suspected Middle East Respiratory Syndrome Coronavirus (MERS-CoV)
<i>Do you have the up to date version? See the intranet for the latest version</i>		