BrisDoc Patient care by people who care

NHS

Notifiable & High Consequence Infectious Diseases Operational, PPE and Cleaning

Version:	Owner:	Created:
2.1	Lucy Grinnell/Renuka Suriyaarachchi (Head of IUC/Head of Nursing/AHPs)	16/02/2024
Published:	**Approving Director:**	**Next Review**
06/06/2025	Rhys Hancock (Director of Nursing, AHPs, and Governance)	06/06/2026

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Purpose

The purpose of this document is to describe the Standard Operating Procedure and IPC measures required for managing patients with Notifiable or High Consequence Infectious Diseases (HCID).

High Consequence Infectious Diseases are listed here: https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#list-of-high-consequence-infectious-diseases

High consequence infectious disease: country specific risk: https://www.gov.uk/guidance/high-consequence-infectious-disease-country-specific-risk

More Notifiable Diseases are added to the list as of **06/04/2025** which is listed here: https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#list-of-notifiable-organisms-causative-agents

This SoP must be used for all people with suspected/confirmed cases of either of these groups of diseases. The table below offers specifics on currently prevalent diseases.

Inclusion Criteria

Disease	Unlikely	Suspected/Likely	Confirmed
Pertussis (Whooping Cough)		Suspect pertussis infection if someone presents with an acute cough lasting for 14 days or more without an apparent cause plus one or more of the following: • paroxysms of coughing, • post-tussive vomiting, • inspiratory whoop, • undiagnosed apnoeic attacks in young infants **Or** someone presents with signs and symptoms consistent with pertussis who has been in contact with a confirmed case in the previous 21 days **Or** someone who is known to be part of any ongoing outbreak investigation in a specific group of people. For example, children attending the same school or nursery where pertussis is known to be been circulating	Advice on testing should be obtained from your local Health Protection Team. • less than 2 weeks from cough onset: PCR and/or culture • between 2 and 3 weeks from cough onset: PCR and/or culture **and/or** **either** oral fluid kit (if aged 2 to less than 17 years) **or** serology • more than 3 weeks from cough onset: **either** oral fluid kit (if aged 2 to less than 17 years) **or** serology

Notifiable and High Consequence Infectious Disease Operational PPE and Cleaning guidance

Measles	Case does not meet the definition of a suspected case (either because it is not clinically classical or the epidemiological features are not present) If there have been no confirmed recent cases, despite adequate surveillance, in the area and the index case has not visited an area where cases are occurring, (either in the UK or internationally) during the incubation period, most cases can be assumed to be unlikely.	**Clinical features** Clinical symptoms of classical primary measles (generally very unwell and considered measles until proven otherwise). • Fever ≥ 39 in the absence of antipyretic, AND • Generalised maculopapular rash, AND • One or more of: • Conjunctivitis • Cough • Coryza AND Epidemiological risk factors (These are a better predictor of measles than clinical features). Increased risk associated with: • Epidemiological link to a confirmed case • Known local outbreaks • Incomplete vaccination/ lack of immunity (including babies not yet due to have completed the full vaccination schedule) • Likelihood of suspected case being confirmed is higher amongst adolescent and young adults. Differentials are common in infants and toddlers. • Membership of community known to be more susceptible (e.g. Orthodox Jewish, traveller, local community with low MMR coverage) • Visited local or international area where measles is circulating • Attendance at large international mass gathering event with substantial mixing and individuals potentially travelling from area where measles is circulating (e.g. festival)	Either laboratory or epidemiologically confirmed Suspected case with laboratory confirmation of acute infection Epidemiologically confirmed (by HPT) Confirmed case in the absence of laboratory evidence with •combination of classical clinical features present AND a direct epidemiological link to a confirmed case (where onset happened within 7-21 days of exposure) •OR clinically classical case AND related to another epidemiologically confirmed case (eg outbreak)
Chickenpox		**Clinical features:** • A prodrome that includes nausea, myalgia, anorexia, and headache (particularly adolescents and adults). • General malaise, loss of appetite, and feeding problems. • Rash. • Small, erythematous macules appear on the scalp, face, trunk, and proximal limbs, which progress over 12–14 hours to papules, clear vesicles (which are intensely itchy), and pustules. • Vesicles can also occur on the palms and soles, and mucous membranes can also be affected, with painful and shallow oral or genital ulcers. • Vesicles appear in crops; stages of development of the rash can therefore differ on different areas of the body.Crusting occurs usually within 5 days of the onset of the rash, and crusts fall off after 1–2 weeks	Laboratory tests can be used for confirmation, but are rarely required in primary care. Confirmation of infection may be required, for example, where there are implications for vulnerable contacts — discuss with a specialist if unsure
MPOX	Cases does not meet the definition of a suspected case either it does not meet the clinical features or include epidemiological risk factors.	**Clinical features:** The illness begins with: • fever • headache • muscle aches • backache	• A person with an orthopox virus PCR-positive result where mpox remains the most likely diagnosis.

	Identifying mpox can be difficult as other infections and conditions can look similar. It is important to distinguish mpox from chickenpox, measles, bacterial skin infections, scabies, herpes, syphilis, other sexually transmissible infections, and medication-associated allergies. Someone with mpox may also have another sexually transmissible infection such as herpes	• swollen lymph nodes • chills • exhaustion • joint pain Within 1 to 5 days after the appearance of fever, a rash develops and the rash changes and goes through different stages before finally forming scabs which eventually fall off. The possibility of mpox should be considered in the following scenarios: **1.** a prodrome (fever, chills, headache, exhaustion, myalgia, arthralgia, backache, lymphadenopathy), and where there is known prior contact with a confirmed or suspected case of mpox in the 21 days before symptom onset Or: 2. an mpox-compatible rash anywhere on the skin (face, limbs, extremities, torso), mucosae (including oral, genital, anal), or symptoms of proctitis, and at least one of the following in the 21 days before symptom onset: ▪ recent new sexual partner ▪ contact with known or suspected case of mpox ▪ a travel history to a country where mpox is currently common ▪ link to an infected animal or meat	• A person with a laboratory-confirmed mpox infection (mpox virus PCR-positive).

Clinical guidance for the management of these cases is out of scope of this document but is available on the BrisDoc Clinical Toolkit. This includes background clinical information, Health Protection Team (HPT) notification, and national and local guidance.Infection Prevention Control

Clinicians are responsible for ensuring that the correct PPE is worn for face-to-face assessment of a patient with suspected notifiable or HCID, and the subsequent cleaning of equipment as set out in this section of the SOP.

IPC measures

	PPE	Cleaning requirements	Ventilation of room	Fallow time
Measles	• Powered respiratory equipment (PRE) this is a respiratory hood* • Apron • Gloves	• Actichlor chlorine-based solution to be used on all high frequency touch points including floors - please see guidance below. • Respiratory hood system to be Cleaned in sluice with clinell wipes. • Mopping required	• Open window at all times.	• Refer to Appendix 5 for fallow time • Close the isolation room door and use signage provided. Please write the time cleaned and the time the room can be used again.

Notifiable and High Consequence Infectious Disease Operational PPE and Cleaning guidance

Pertussis (Whooping Cough)	• Goggles • Surgical mask • Apron • Gloves	• Actichlor chlorine-based solution to be used on all high frequency touch points - please see guidance below • No mopping of floor required.	• Open window at all times.	• None required
MPOX	• Powered respiratory equipment (PRE) this is a respiratory hood* • Apron • Gloves	• Actichlor chlorine-based solution to be used on all high frequency touch points including floors - please see guidance below. • Respiratory hood system to be Cleaned in sluice with clinell wipes. • Mopping required	• Open window at all times.	• Refer to Appendix 5 for fallow time • Close the isolation room door and use signage provided. Please write the time cleaned and the time the room can be used again.
Chickenpox	• Powered respiratory equipment (PRE) this is a respiratory hood* • Apron • Gloves	• Actichlor chlorine-based solution to be used on all high frequency touch points including floors - please see guidance below. • Respiratory hood system to be Cleaned in sluice with clinell wipes. • Mopping required	• Open window at all times.	• Refer to Appendix 5 for fallow time • Close the isolation room door and use signage provided. Please write the time cleaned and the time the room can be used again.

** Note that the respiratory hood affords a higher level of protection than the nationally recommended FFP3 masks. We are using these because individual fitting is not required, and they are reusable.*

Handwashing

Please follow guidance on National Cleaning Standards.

Donning and Doffing PPE

The correct way to put on PPE and remove PPE can be found in the UK Health Security Agency guidance.

High frequency Touch Points

The definition of high frequency touch points are all surfaces or items that have had the most frequent contact with many hands. These areas require more cleaning and disinfecting as they pose a significant risk for the spread of infectious diseases. High frequency touchpoints include all patient facing reusable equipment, all surfaces, all furniture including chairs and couch, doorknobs, or handles.

If the surface is visibly unclean use Clinell wipes first and then the disposable cloth with Actichlor to disinfect surfaces by wiping down. Let the equipment dry naturally

High Consequence of Infectious Disease (HCID) Cleaning Box

This box will be available in the Isolation Room. There will be a mixing bottle for actichlor, actichlor tablets and disposable J-clothes. When an assessment of a notifiable/HCID case is performed, the clinician will mix the solution up using tap water. Instructions will be in the box (appendix four). Actichlor is a disinfectant and to be used for high frequency touch points. Once cleaning is completed the clinician will dispose of the cloth and take the actichlor with them to the sluice to be disposed of.

Imported Fever Service for Mpox

Note that as of March 2025, all mpox clades have been derogated and are no longer classified as high consequence infectious diseases (HCIDs), however it remains as a notifiable disease. Patients with a travel or exposure history indicating possible HCID mpox should be discussed with the Rare and Imported Pathogens Laboratory (RIPL) clinical team as soon as possible via the 24/7 Imported Fever Service helpline (0844 778 8990). See guidance on diagnostic testing for information on how to submit samples for testing.

Notifying the Health Protection Team (HPT)

Notifiable or HCID cases must be reported to HPT by the consulting clinician. Details of how to contact HPT are on the notifiable disease page on the Clinical Toolkit (https://www.clinicaltoolkit.co.uk/knowledgebase/notification-of-infectious-diseases-to-public-health-2/). Clinicians should provide HPT with the SevernSide Professional Line number, 0117 244 9283, to enable them to contact us if they need any further information.

Vaccination requests

The Health Protection Team may recommend vaccination for unvaccinated contacts of confirmed or likely cases. SevernSide does not stock or have access to vaccines, so it would rely on the HPT to provide the vaccine and ensure that staff are trained to administer it. For practice services, if this should be agreed, please ensure to follow the face to face/ PPE/ cleaning guidance, and the Green Book provides details about administration.

SevernSide Guidance

Roles and responsibilities

The below describes the responsibilities of the operational team in addition to their usual duties to safely manage patient with a notifiable or HCID during face-to-face appointments in SevernSide IUC.

WaCCs

- When adding the consultation finish times to a case in the non-clinical queue, please also highlight if the advice clinician has selected 'yes' to the suspected notifiable/HCID question. This will ensure the Clinical Co-Ordinator (CC) picks this up appropriately
- If after the CC review a patient requiring an appointment is a notifiable/HCID case, when booking the appointment please ensure:
    - You ask the patient to wear a face mask on entering the building and throughout the consultation
    - You ask the patient to attend the appointment alone. If this is not possible, for example the patient is a child, please ask accompanying people to also where a face mask
    - Advise the patient due to their symptoms the clinician may need to wear high level PPE, this will involve a respiratory hood
    - Add '? Notifiable/HCID Isolation room' tag
- Advise the Shift Manager a Notifiable/HCID appointment has been booked
- Advise the Host a Notifiable/HCID appointment has been booked at their base
- Do not book an appointment in the isolation room for the required shut down period after the notifiable/HCID appointment (please refer **Appendix 5**)

If a person with a notifiable/HCID requires a home visit, the Respiratory Hood will need to be collected from the nearest base.

Hosts

- To ensure Isolation room clinical box is placed in the Isolation Room at the beginning of the shift
- Ensure HCID cleaning box is in the Isolation Room at the beginning of the shift
- Open all windows in the Isolation Room at the beginning of the shift
- Be vigilant for notifiable/HCID appointments being booked
- Flag notifiable/HCID appointments to the base clinician as soon as they are booked
- Advise the Shift Manager immediately if a clinician informs you they are unable to see any notifiable/HCID patients
- Ensure the patient and anyone accompanying them wear a fluid resistant surgical face (FRSM) mask on entry to the building
- Ensure you wear a face mask (FRSM) when directing the patient to the isolation room
- Please note you are unable to chaperone a notifiable/HCID patient as we only have one respiratory hood at each base
- Ensure the isolation room door is closed throughout and after the consultation

- Ensure the door sign (**appendix one**) is added to the door once the clinician has finished cleaning the room
    - Include the time the room has been cleaned and the time the room can be back in use (please refer **Appendix 5** for fallow time for each base)

Shift Managers

- Be vigilant for notifiable/HCID appointments being booked
- Ensure the WaCCs and Hosts are aware of the above
- Ensure the base clinician is aware of and has access to this SOP guidance including cleaning procedures and clinical guidance on the Clinical Toolkit
- Plan for how isolation room patients booked within any required shut down period will be managed (please refer **Appendix 5** for fallow time for each base), this can be one of the following ways:
    - If there is an empty F2F room at the base this can been ringfenced as the isolation room
    - Redirect patients to an alternative base or later appointment
    - Offer another remote assessment either on the phone or video
- Send out the following message to all staff throughout the shift to identify clinicians who are unable to see notifiable/HCID patients

"If you are not able to see patients with notifiable/HCID because you are immunosuppressed, pregnant, or do not have full vaccination/ immunity, please ensure that the rota team are aware of this and/ or flag to the shift manager at the start of your shift"

SevernSide Clinical Coordinator Role

The Clinical Coordinators play a key role in providing clinical support and advice to IUC telephone and F2F clinicians, and to the Shift Manager. This includes minimising the risk of avoidable exposure to notifiable and HCIDs. We ask you to proactively:

- Familiarise yourself with this IUC guidance, including the specific definitions of notifiable and HCID as well as others which may require this specific response (clinical and epidemiological)
- Support clinicians to manage patients with potential notifiable/HCIDs wherever it is clinically safe and reasonable to do so
- Be vigilant for notifiable/HCID when reviewing F2F requests. This will include cases which have been flagged as having notifiable/HCID by the triaging clinician AND cases where the criteria are met but have not been flagged by the triaging clinician.
- Have a low threshold for speaking to the triaging clinician about F2F requests for notifiable/HCID to ensure that all options for remote management have been considered, and/ or to confirm whether the notifiable or HCID is indeed suspected as per national definitions
- Select the correct notifiable/HCID F2F drop down if approving the F2F for a person with a notifiable/HCID, to ensure that the operational processes are implemented and the F2F clinician knows that additional PPE (potentially including the hood) is required.
- Please note that it will not be possible to chaperone a patient with a notifiable/HCID (there is only one hood at each Treatment Centre) so please bear this in mind
- Provide clinical advice/ support to the shift manager if required

Clinicians

- Be familiar with the HCID SOP and adhere to the IPC measures before, during, and after seeing a patient with suspected HCID.
- Ensure all windows in the isolation room are kept open.
- Before seeing the patient, confirm that you have all necessary equipment to assess the patient, including the clinical and cleaning boxes.
- Wear the appropriate Personal Protective Equipment (PPE) as outlined in this SOP before seeing the patient. Each base is equipped with one respiratory hood, which should be ready for use. Please refer to **Appendix 3** for instructions on how to use the respiratory hood.
- Ensure the powered ventilator is switched on before seeing the patient. Powered ventilators are available at Greenway and 168 Medical. Please note that fallow time at these bases may differ. Refer to **Appendix 5** and **Appendix 6** for detailed information.
- Minimize the time spent with the patient to no more than 15 minutes.
- Clean the isolation room after seeing the patient according to the guidelines in **Appendix 4**. It is the clinician's responsibility to ensure the room is cleaned.
- Chaperones are not permitted for notifiable/HCID patients, as only one respiratory hood is available per base.
- Ensure the isolation room door remains closed throughout the consultation and after it concludes.

Overview of patient appointment journey

The flow chart in appendix two gives an overview of a notifiable/HCID patient journey to an appointment including the roles of each person.

Notifiable and High Consequence Infectious Disease Operational PPE and Cleaning guidance

Charlotte Keel Medical Practice

At Charlotte Keel Medical practice – Room 30 is the isolation room.

The Process followed for notifiable/HCID patients is:

Pt presents at desk and is unable to go home as too unwell.

- Pt to be given a mask to wear and directed immediately to the isolation room.

Pt booked into face-to-face appointment in isolation room.

- Pt must be informed not to come into health centre via main entrance.
  - Pt to access entrance at GP carpark by pressing the bell to alert Health Nav manager.
  - Direct the pt to isolation room (Health Nav manager to surgical face wear mask)

Clinical Assessment

- Clinician must Don PPE before assessing the patient.
  (PPE and Hood is kept in a box in treatment room)

Post Assessment

- Clinician to make up chlor-clean solution and wipe any touch points.
- Doff gloves and apron and wash hands.
- Open window/door to outside and leave the isolation room.
- Doff respirator hood.
- Don gloves and apron, turn off respiratory hood, clean hood, and associated equipment with clinell wipes.
- Return hood to box and take it back to the Treatment room.
- Inform Ops manager.
- Ops Manager will add "Room Closed" sign to door with shut down time, then remove sign after time has elapsed.

Broadmead Medical Centre

At Broadmead Medical Centre – Room 5 is the isolation room but with current room capacity, is likely to already be in use for existing clinics. Due to our total triage system, it is unlikely that a patient will arrive at reception without a formal appointment.

The Process followed for notifiable/HCID patients is:

Pt presents at desk unexpectedly

Pt to be given a mask to wear and directed to return home and await call from triage clinician. If unable to return home, they are directed either to a spare room or, if necessary, outside the building (via stairs) whilst Room 5 is urgently prepared/vacated.

The majority of potential cases will be identified through remote triage.

- The triaging clinician will access the "clinical management" policy on the Brisdoc clinical toolkit and if a suspected measles case, to call the Health Protection Team for advice.

- If F2F is needed, triaging clinician to conduct majority of assessment remotely in order to minimise time in proximity with suspected case.

Triaging clinician to make an assessment as to the location of the assessment (whether the patient needs to attend Room 5 or to have a home visit) and to identify which clinician will be designated to see the patient .

This will depend on room availability and clinician availability/location. This could be the "triaging clinician" if on site, the "visiting GP" if still capacity or the Room 5 clinician, in which case existing patients for Room 5 will need to be rescheduled .

If patient booked into face-to-face appointment in isolation room.

Patient to wait outside and call the clinician on the practice bypass number (0117 9549825) on arrival.

GP to collect patient and go directly to Room 5 using the stairs (Wearing a surgical face mask)

Division between Room 4 and 5 to be closed.

N.B. Patients pre-booked into Room 5 around the time of appointment need to be rescheduled or moved to a different clinician to enable the notifiable/HCID case to be seen and cleaning to occur afterwards.

Clinical Assessment

Clinician must Don PPE before assessing the patient.

Post Assessment

Clinician to make up chlor-clean solution and wipe any touch points.

Doff gloves and apron and wash hands.

Leave the isolation room.

Doff respirator hood.

Don gloves and apron, turn off respiratory hood, clean hood, and associated equipment with clinell wipes.

Return hood to box.

Add "Room Closed" sign to door with shut down wait time, then remove sign after time has elapsed

Homeless Health Service

At The Homeless Health Service – The Red room is the isolation room.

The Process followed for notifiable/HCID patients is:

Pt presents at desk and is unable to go home as too unwell.

- Pt to be given a mask to wear and directed immediately to the isolation room.

Pt booked into face-to-face appointment in isolation room.

- Patient to wait outside and ring the buzzer on arrival.
- Patient to be asked to go to the rear of the building and to wait by the back door.
  - GP to collect patient and take the patient directly to the 'Red room' (Wearing a surgical face mask).

N.B. the patient should not come into the rest of the Compass Centre.

Clinical Assessment

- Clinician must Don PPE before assessing the patient.

Post Assessment

- Clinician to make up chlor-clean solution and wipe any touch points.
- Doff gloves and apron and wash hands.
- Open window/door to outside and leave the isolation room.
- Doff respirator hood.
- Don gloves and apron, turn off respiratory hood, clean hood, and associated equipment with clinell wipes.

- Return hood to box.
- Add "Room Closed" sign to door with shut down wait time, then remove sign after time has elapsed.

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Appendices

Appendix 1 – Room closure sign

ROOM CLOSED
DO NOT USE

Date Room Cleaned	
Time room cleaned	

Date Room next available	
Time room next available	

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Appendix 2 – SevernSide Process for seeing notifiable/HCID patients F2F

Triaging clinician requests F2F and selects 'yes' to Notifiable/HCID case question

WaCC notes 'Notifiable/HCID suspected/likely' on case in non-clinical queue

CC suggests alternative management of patient liaising with triaging clinician

CC approves F2F and confirms 'potential notifiable/HCID case' in line with CC guidance

WaCC books appointment and gives the patient the following additional information:

- Patient and anyone accompanying them to wear a face mask on entry to the building
- Advise due to patient symptoms higher level PPE will be worn by the clinician which includes a respiratory hood

WaCC adds '?Notifiable/HCID – Isolation Room' tag to the appointment

WaCC advises Shift Manager and Host of appointment

Host advises clinician of appointment

Patient arrives at base. Host advises patient to stay in car until room and clinician available

Host to don face mask and invite patient into building. Patient and accompanying people to wear face mask

Host directs patient straight to Isolation Room and ensures the door is closed

Clinician to don appropriate level of PPE before entering the Isolation Room. Enters the room and closes the door

Clinician assessment, aiming for patient/ contacts to spend < 15 minutes with clinician, even if further discussion required by phone after the F2F. Patient Leaves immediately.

Clinician makes up antichlor solution, cleans the room as per the cleaning guidance. Doff gloves and apron. Wash hands. Leave the Isolation Room, closing the door behind them and go straight to the sluice

Clinician don gloves and apron. Turn off and remove respiratory hood. Clean hood and associated equipment with Clinell wipes. Return the hood to the Respiratory hood box

Host to complete and add 'Room Closed' sign to door

After shut down time, Host to remove 'Room Closed' sign and inform clinicians Isolation Room is available

Appendix 3 - Clinicians Guide to using and cleaning the respiratory hoods

The Facilities Team have responsibility for the maintenance of the respiratory hood system and making sure it is ready for use.

Using respiratory hood systems

The system consists of a wipeable hood, an air tube, and air pump with integrated filter. Step by step laminated instructions (appendix three) on how to use the equipment are in the Respiratory hood box.

Fresh filtered air is pumped into the hood and the exhaled air is removed through positive pressure from the bottom of the hood, like a balloon.

Cleaning the respiratory hood

The hood, air tube and air pump will be cleaned by the clinicians with Clinell wipes using standard infection precautions. The clinician will leave the isolation room (see below section on cleaning the isolation room) wearing respiratory hood and go directly to the sluice. The clinician will don gloves and an apron, turn off and remove the respiratory hood then clean the hood, tube and pump.

Using Clinell wipes, clean the inside and outside of the hood, the outer air tube and the respirator. Doff PPE. Take the respiratory equipment and place it back in the respiratory equipment box.

There will be PPE and Clinell wipes in the sluice to facilitate cleaning.

Where is it stored & what is in the Respiratory hood box

The Respiratory hood will be stored in a plastic box on the Personal Protective Equipment Trolley.

Testing and changing the battery/filter of the Respiratory hood system

The filter and battery of the airflow unit will be changed if the air flow is not adequate, the filter is 75% full, or annually, or as indicated by the light on the Respiratory hood system, whichever is sooner. This will be checked weekly by facilities and the battery and filter changed/charged as required. Fully charged there is enough charge for 11 hours. This will be done by facilities every week.

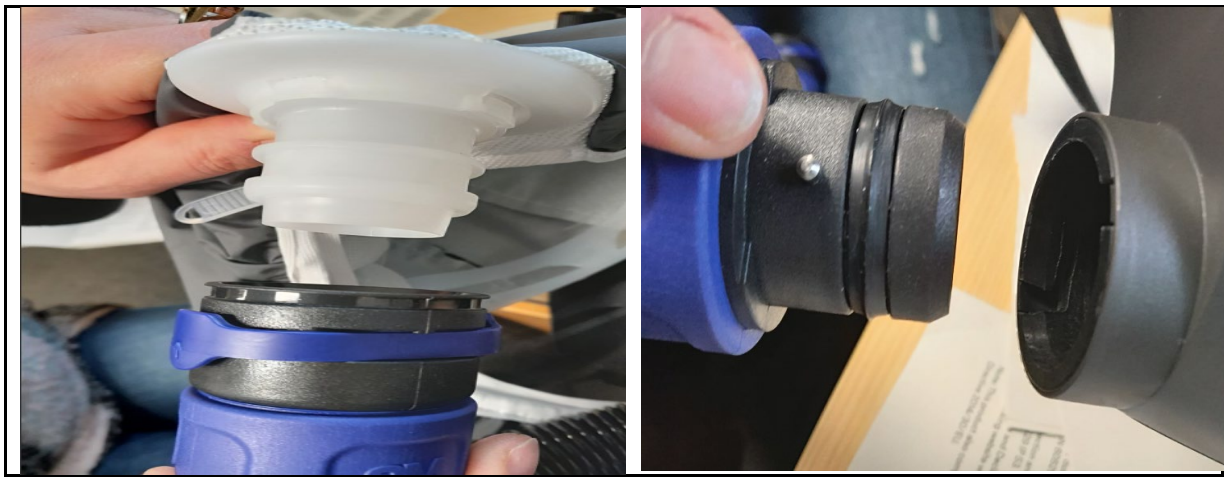
Operating Instructions for Clinicians

1. Clip the Versaflo Respirator to your waist by using the belt and adjust as necessary. https://www.youtube.com/watch?v=VRDKTsJqhgo – **Please watch this video for how to use the respiratory hood (Versaflo respirator).**

2.Connect the larger end of the air tube to the hood and click it into place.

3. Place the hood over the head, ensure the head band is against your forehead. The hood must be placed in front of your ears and around your chin, ensuring there is a good seal. The hood headband can be adjusted for a tighter fit. The respirator must be in use before entering the isolation room, do not remove the hood & respirator until you are in the sluice.

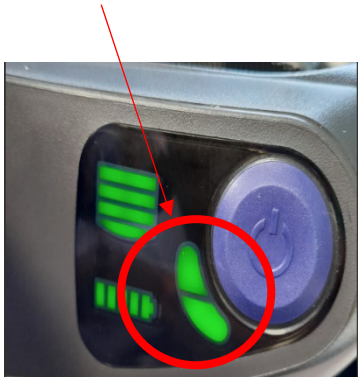
4. Fit the smaller end of the air tube to the Versaflo Respirator, ensuring the 2 metal clips are in-line and twist to lock.



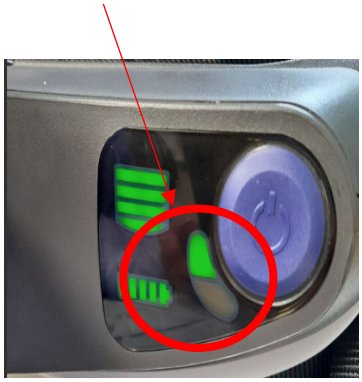
Adjusting flow

Once fitted to your waist, press the blue button and air flow will commence, the unit will power up and it will start with a standard flow, this is indicated by 1 green light next to the blue button. If the blue button is pressed again, hi flow will commence, this is indicated by 2 green lights next to the blue button. To take it back to standard flow, press the blue button twice.

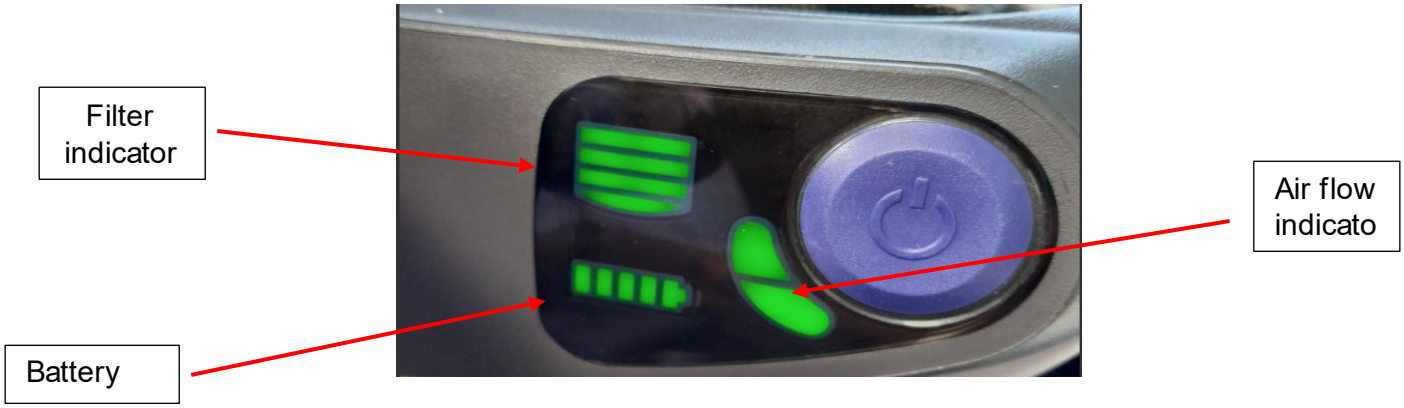
Hi flow



Standard flow



Lights on the Versaflo Respirator



After a few seconds, the filter light & the battery light will go out and only the air flow indicator light will show.

Turning off the Versaflo Respirator

Do not turn the respirator off unit you have vacated the isolation room and entered the sluice. Press and hold the blue button until the machine stops working, and then let go of the blue button.

Appendix 4 - High Consequence of Infectious Disease (HCID) cleaning box

For use in the Isolation Room only

Contents:

1 x Acticlor Mixing Bottle

1 x Tub of Chlor-Clean Tablets

1 x Box of Disposable Cloths

1x bucket and mop

The clinician will mix the solution up using tap water. Chlor-Clean is a disinfectant and to be used for high frequency touch points.

Instructions for mixing the solution: -

- To make 1000ml solution use 1 litre cold water with 1 tablet Chlor-Clean.
- Fill the empty Actichlor bottle with 1 litre of cold water and add 1 tablet of Chlor-Clean.
- Place the top on the bottle and secure, let the tablet dissolve, and then invert the bottle a few times to ensure mixed thoroughly.

Decontamination

- Cleaning is essential before disinfection is carried out. Please see guidance for Decontamination of reusable non-invasive care equipment.
- When cleaning and disinfecting, clean top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shaped pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice.
- • Flooring should be decontaminated last, using the technique above by using the mop and bucket with chlorine releasing solution.

Storing of the solution: -

- Each bottle of made-up solution should be kept in the Isolation room. Along with the disposable cloths and Chlor-Clean tablets.

Disposing of the cleaning solution and cloths: -

- After the Isolation room has been cleaned, the solution is to be taken to the sluice to be disposed of. Discard all disposable cloths and PPE in the clinical waste bag.

Appendix 5- Fallow time

Base	Powered Ventilator	Ventilation assessment done	Fan speed	Fallow time
Greenway	yes	yes	3	9 minutes
168 Medical	yes	yes	Full speed	59 minutes
Marksbury Rd]	No	Yes	N/A	2 hours
Christchurch	No	No	N/A	2 hours
Clevedon	No	Yes	N/A	2 hours
Broadmead	No	Yes	N/A	2 hours

Charlotte keel	No	Yes	N/A	2 hours
Homeless health	No	Yes	N/A	2 hours

Appendix 6 – Powered Ventilator

168 Medical

Please remember to switch on the powered ventilator an put it on **full speed** before directing the patient to the isolation room by the host. The clinician should switch it off after cleaning the room, once the patient has departed.

Powered Ventilator at Greenway

Please remember to switch on the powered ventilator an put it on **fan speed 3** before directing the patient to the isolation room by the host. The clinician should switch it off after cleaning the room, once the patient has departed.

Version Control

Version	Author	Date	Changes
1.0	Lucy Grinnell	16/02/2024	Initial Document
1.1	Lucy Grinnell	23/02/2024	Addition of Notifying the HPT section
1.2	Rhys Hancock	26/02/2024	Addition of Practice Services
1.3	Rhys Hancock	27/03/2024	Move to Notifiable/HCID SOP for BrisDoc
1.4	Shelly Joseph	23/08/2024	Addition of MPox
1.5	Rhys Hancock	13/09/2024	Update to Mpox sections following new national guidance
1.6	Shelly Joseph	15/10/2024	Change in PPE for MPox and when to consider clade 1 Mpox
1.7	Shelly Joseph	06/12/2024	Change in cleaning standards to measles and MPox
1.8	Rachael Hardaker	21/01/2025	Changed BMC process following location changes.
2.0	Renuka Suriyaarachchi, Linda Meekhums and Shelly Joseph	07/04/2025	Version control of all versions reviewed and all previous versions aligned. This version amalgamates all changes including changes in fallow time, ventilation assessments, clinicians' responsibilities and removal Mpox as it is no longer an HCID. Intellectual property rights added Chickenpox added as it became a notifiable disease as of 06/04/2025
2.1	Shelly Joseph	03/06/25	Added video for how to use the respiratory hood (Versaflo respirator)