# Infection Control Policy Manual

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**Type:** Clinical Policy  
**Policy applies to:** All services within SCH  

**Policy applies to (staff groups):** All staff

**Policy Compliance:** This policy must be complied with fully at all times by the appropriate staff. Where it is found that this policy cannot be complied with fully, this must be notified immediately to the owner through the waiver process.

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<th>Director of Nursing, Therapies &amp; Governance</th>
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<tr>
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## AGREED POLICY REVIEW / RATIFICATION / ADOPTION PATH:

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**Date:** April 2014 | **Agreed by:** Clinical Policy Group  
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1 Introduction to Infection Prevention & Control in Suffolk Community Healthcare

1.1 The Health & Social Care Act 2008 amended 2010 to include the Code of Practice for the Prevention and Control of Healthcare Associated Infections requires that all healthcare providers have systems in place that are sufficient to minimise the risk of Healthcare Associated Infections (HCAI) to patients, staff and visitors.

1.1.1 Infection Control is an important part of an organisation’s effective risk management programme to improve the quality of patient care and the occupational health of staff.

1.1.2 These policies should be read in conjunction with all other relevant current policies and guidelines including COSHH and Health & Safety regulations.

1.2 Aim

This Policy Manual has been written for health care workers within the community of Suffolk. Its aim is to provide clear, concise guidance on infection control, though it is recognised that individual areas may require their own individual guidelines developed in consultation with the Infection Prevention & Control Lead in order to implement some of these policies.

1.3 Scope of this Policy Manual

This policy manual encompasses the care given in all areas of health care services as provided by Suffolk Community Healthcare. It is acknowledged that some users of this document work in premises over which they have little or no control (e.g. client’s own homes); therefore in some instances users will have to use their own judgement in the interpretation of these policies. If required, further advice is available from the Infection Prevention & Control Lead.

1.4 Responsibilities

1.4.1 The general responsibilities set out in the section relate to all of the policies within this manual. However in some specific policies which require duties of particular organisational positions these will be stated as required.

1.4.2 Suffolk Community Healthcare operates a Board to Ward system for the implementation of Infection Prevention & Control practice and standards. All staff are required to participate in the prevention and control of the spread of infection between hospitals and community settings. All policies in this manual are to be implemented in line with the specific infection control responsibilities of each staff member.

1.4.3 The Contract Director is responsible for ensuring that there are effective arrangements in place for the control of infection.

1.4.4 The Director of Infection Prevention and Control (DIPC) will support the Infection Prevention & Control Lead and the Infection Control Committee in the fulfilment of the annual Infection Control work programme and the production of the Infection Control Annual Report. The DIPC will report directly and through no other officer to the Contract Director.

1.4.5 The Infection Control Committee exists to ensure that Infection Control policies, procedures and guidance are endorsed and that any action plans resulting from issues identified are actioned and completed within the stated timeframe.

1.4.6 The Infection Control Link Worker Group exists to support and enhance best infection control practice amongst their peers. This will involve the completion of monthly practice audits and provision of local training sessions as identified by audit results.
1.4.7 The role of the Infection Prevention & Control Lead is to provide an expert service relating to Infection Prevention and Control and associated clinical risk management. They are to ensure that the service provided matches the needs of the workforce and the local population; is evidence-based and promotes best practice.

1.4.8 Each staff member will have their responsibilities for the prevention and control of infection reflected in their job description and in any personal development plan or appraisal.

1.5 Advisory Contacts

1.5.1 Infection Control advice can be obtained from the Infection Prevention & Control Lead based at 86 Sandy Hill Lane, Ipswich, IP3 0NA.

Telephone number: 07985416276

1.5.2 Advice on microbiological sampling, results of microbiological investigations and therapeutic guidance should be requested from the investigating laboratory’s Consultant Microbiologists. Contact details will be given on the Investigation request form or on the microbiological report form.

1.5.3 Information is also available from the Public Health England website https://www.gov.uk/government/organisations/public-health-england
2 Policy for the Notification of Infectious Diseases

2.1 Introduction

Doctors in England and Wales have a statutory duty to notify a 'Proper Officer' of the Local Authority or local Health Protection Unit (HPU) of confirmed or suspected cases of certain infectious diseases listed below.

2.1.1 Prompt notification and reporting of disease is essential.

2.1.2 The objectives of notification are:
   a. To collect accurate and complete epidemiological information on the disease
   b. To ensure prompt and appropriate control measures to prevent the spread of infection

2.1.3 Any doctor who considers that a patient is suffering from a Notifiable disease must notify the Proper Officer of the local authority using the standard notification procedure.

2.1.4 It is not necessary to wait for laboratory/microbiological confirmation of a diagnosis.

2.1.5 While laboratories may report, this does not absolve clinicians from their responsibility to do so.

2.2 List of Diseases Notifiable (to Local Authority Proper Officers) Under the Health Protection (Notification) Regulations 2010

| Acute encephalitis           | Malaria          |
| Acute infectious hepatitis   | Measles          |
| Acute meningitis             | Meningococcal septicaemia |
| Acute poliomyelitis          | Mumps            |
| Anthrax                      | Plague           |
| Botulism                     | Rabies           |
| Brucellosis                  | Rubella          |
| Cholera                      | SARS             |
| Diphtheria                   | Scarlet fever    |
| Enteric fever (typhoid or paratyphoid fever) | Smallpox |
| Food poisoning*              | Tetanus          |
| Haemolytic uraemic syndrome (HUS) | Tuberculosis    |
| Infectious bloody diarrhoea  | Typhus           |
| Invasive group A streptococcal disease | Viral haemorrhagic fever (VHF) |
| Legionnaires’ Disease        | Whooping cough   |
| Leprosy                      | Yellow fever     |

*Food poisoning:* This category includes any infection which could be food or water-borne e.g. campylobacter, salmonella, cryptosporidiosis, giardia.

2.2.1 Although the following diseases are not Notifiable, the Consultant in Communicable Disease Control should be informed of their occurrence:

- Listeriosis
- Psittacosis
- New Variant Creutzfeldt-Jakob disease (vCJD)
- Novel Coronavirus
2.3 Notification Contact Details

The contact details for use in the event of a suspected notifiable infectious disease occurring in Suffolk are:

Anglia Health Protection Team
Thetford Community Healthy Living Centre
Croxton Road
Thetford
IP24 1JD

Tel: 0844 225 3546

Out of Hours Contact

01603 481221

2.4 References

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3 Infection Control Principles and Standard Precautions Policy

3.1 Introduction

3.1.1 ‘Universal Precautions’ were first recommended in 1985, by the Centers for Disease Control in America, in response to the risk of transmission of HIV to health care workers from patients whose infection status was unknown. Initially they dealt only with body fluids capable of containing blood borne viruses. In the late 1980’s the UK adopted universal precautions but they were expanded to include all routes of transmission and all body fluids/substances capable of containing pathogenic microorganisms, which could potentially lead to cross infection between patients. This expanded version is known as ‘Universal Infection Control Precautions.’ Some healthcare providers use the term Universal Infection Control Precautions (UICP) and others use the term Standard Precautions. The terms are now interchangeable.

3.1.2 It is generally recognised that many patients who are not obviously ill may be carrying viruses such as HIV in their blood/body fluids or pathogens such as MRSA on their skin. These organisms present an infection hazard to other patients and all healthcare workers who come into contact with them. In order to protect patients and staff we must consider all blood and body fluids from all patients to be infected and incorporate measures to minimise the risk of exposure into everyday routine practices. Standard Precautions are therefore an important component of a risk management strategy and clinical governance and must become part of the organisations culture of patient safety.

3.2 Standard Precautions include:

- Hand washing & skincare
- Protective clothing
- Safe handling of sharps (including injury management)
- Dealing with spillages
- Waste & laundry management
- Decontamination of Equipment
- Environmental Hygiene

3.2.1 All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. A disposable apron and either Nitrile or Vinyl gloves should always be worn when dealing with excreta, blood and body fluids.

3.2.2 Everyone involved in providing care in the community must know and apply the Standard Precautions at all times when exposed to body fluid spillages. Each member of staff is accountable for his/her actions and must follow safe practices.
4 Hand Hygiene and Skin Care Policy

4.1 Introduction

4.1.1 Hand hygiene is recognised as the single most effective method of preventing the transmission of infection. The ability of transient microorganisms to transfer to and from hands with ease results in hands being extremely efficient vectors of infection. Thorough hand washing will reduce the risk of cross-infection immediately.

4.1.2 Transient organisms are those that are not usually part of the normal flora. They are picked up during contact with individuals and the immediate environment and are located on the surface of the skin and beneath the superficial cells of the stratum corneum. Any damaged skin, moisture or ring wearing will increase the possibility of colonization. A social hand wash will usually remove most of these transient bacteria.

4.1.3 Resident floras are commonly termed commensals. They are bacteria usually found deep in the epidermis, in skin crevices, hair follicles, sweat glands and beneath fingernails. The numbers of these organisms are only reduced during a surgical scrub process.

4.2 When Hands Must be Decontaminated:

4.2.1 Suffolk Community Healthcare will ensure that hands are decontaminated in line with the recommendations of the World Health Organisations “5 Moments for Hand Hygiene” campaign (Appendix 1).

<table>
<thead>
<tr>
<th>Moment</th>
<th>Indication</th>
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<tbody>
<tr>
<td>1</td>
<td>Before Patient Contact</td>
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<tr>
<td>2</td>
<td>Before an Aseptic Procedure</td>
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<tr>
<td>3</td>
<td>After Contact with bodily fluids</td>
</tr>
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<td>4</td>
<td>After Contact with a Patient</td>
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<tr>
<td>5</td>
<td>After Contact with a Patient’s Environment</td>
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</tbody>
</table>

4.3 Which Hand Wash Solution?

4.3.1 Liquid soap is the preferred option for hand hygiene in Suffolk Community Healthcare and will remove most transient organisms. Emollients are now standard in the majority of hand wash agents to reduce skin dryness.

4.3.2 Alcohol gels: Alcohol is an effective decontamination agent but should only be used on visibly clean hands. It will destroy transient bacteria and is suitable for use when other facilities are inadequate or when hand disinfection is required.

4.3.3 Antiseptic solutions are soap solutions with an antiseptic added (e.g. chlorhexidine, povidone-iodine). They will reduce the resident microorganisms as well as remove the transient. They are harsh on the skin and should be reserved for surgical hand washing.

4.4 How To Wash Your Hands

Hands that are soiled, or potentially contaminated with dirt or organic material, must be washed with liquid soap and water.

<table>
<thead>
<tr>
<th>Type of decontamination</th>
<th>Indication</th>
<th>Agent</th>
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<tbody>
<tr>
<td>Routine /social</td>
<td>When hands are visibly soiled</td>
<td>Soap and water</td>
</tr>
<tr>
<td></td>
<td>When hands are visibly clean</td>
<td>Soap and water or alcohol gel</td>
</tr>
<tr>
<td>Hygienic /antiseptic hand disinfection</td>
<td>Before an aseptic technique</td>
<td>Alcohol gel</td>
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<td></td>
<td>Before donning sterile gloves</td>
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4.4.1 Preparation

The efficacy of hand decontamination is improved if the following principles are adhered to:

- Keep nails short and pay attention to them when washing hands – most microbes on the hands come from beneath the fingernails
- Avoid wearing rings with ridges or stones – total bacterial counts, particularly of Gram-negative bacteria, are higher when rings are worn
- Do not wear artificial nails or nail polish as they discourage vigorous hand washing. Nail polish can flake and itself become a source of contamination
- Remove wrist jewellery e.g. watches and bracelets.
- Wear short sleeve clothing in a clinical environment or roll up long sleeves or remove long sleeved clothing prior to hand washing
- Cuts or abrasions must be covered with occlusive waterproof dressings. Cuts can provide a breeding environment for microorganisms and also provides an entry site for infective organisms

4.4.2 Hand decontamination technique

Using soap & water

- Use liquid soap
- Use running water
- Avoid splashing
- Wet the hands under running water
- Apply the soap and rub hands together vigorously to produce a visible lather
- Cover all areas of the hands including fingertips, webs of finders, thumbs, palms and backs of hands and wrists, the 6 stage technique is recommended for this (Appendix 2)
- Wash for at least 20-30 seconds
- Rinse under running water
- Dry thoroughly with paper towels using a ‘blotting’ action
- Do not re contaminate hands on taps or bin lids

Using alcohol gel

- Apply alcohol gel to clean dry hands; rub over all surfaces of hands and wrists
- Rub hands together covering all surfaces until hands are dry. Pay particular attention to fingertips and palms of hands

4.4.3 Surgical hand washing

Surgical hand washing destroys transient organisms and reduces resident flora before surgical or invasive procedures. An aqueous antiseptic solution is applied for two minutes. Preparations currently available are 4% chlorhexidine-detergent and 0.75% povidone /iodine solution-detergent. This is required before minor surgery and invasive procedures.

4.4.4 Alternative hand preparation for minor surgery and invasive investigations using alcohol hand rub:
For areas where minor surgery or invasive procedures are performed and scrub sinks are not available, the following hand disinfection technique must be used:

1. Ensure nails are clean. Wash hands and wrists with non-medicated liquid soap from the dispenser; rinse under running water and dry thoroughly using paper towels.

2. Apply one application of alcohol gel and rub over all surfaces of hands and wrists paying particular attention to fingertips and palms of hands until the solution evaporates to dryness. This should take at least 20 seconds but it is more important that there is enough gel initially to cover all skin surfaces.

3. Repeat step 2.

For subsequent procedures in the same session, it is only necessary to perform step 2 unless hands become physically contaminated. The rationale for this process is that whilst alcohol gel is an excellent bactericidal agent, it only works on socially clean hands. Washing with soap and water first removes dirt and transient bacteria.

4.5 Hand Creams

4.5.1 Apply an emollient cream regularly to protect skin from the drying effects of regular hand decontamination (Pratt et al; 2007). However, communal pots of hand cream are not recommended as they can become contaminated. Wall or work top mounted dispensers which require a pump action can be used, as can individual issue bottles.

4.5.2 Provision of hand creams is the responsibility of the Team / Locality Managers. Not all hand creams are suitable and compatibility with the hand cleanser should be ensured, advice can be sought from the Infection Prevention & Control Lead.

Notes

Skin lesions – If staff members have lesions or skin problems on their hands, the Occupational Health Department should be consulted for advice.

Use of scrub brushes – Scrub brushes should not be used for routine hand washing as they may abrade the skin and can become reservoirs for bacteria. Brushes in sterile packs can be supplied to areas where a surgical scrub may be necessary.

4.5.3 Skin care summary

- Wet hands before applying the soap
- Use preparations containing emollients
- Always rinse hands and dry thoroughly
- Apply hand cream 3-4 times per shift
- Wear powder-free latex gloves low in extractable proteins and residual accelerators for protection against blood-borne viruses
- Seek professional advice for skin problems
- Wear non-NRL synthetic gloves if sensitised to NRL problems or patient has been identified as sensitised (risk assessment)

4.6 Hand Washing Facilities

4.6.1 Facilities should be adequate and conveniently located. Hand wash basins must be placed in areas where needed and where patient treatments or consultations take place. They must have elbow or wrist operated or sensor operated mixer taps. If required a separate sink must be available for other cleaning purposes – such as cleaning instruments:

- Use wall-mounted liquid soap dispensers with disposable soap cartridges – keep them clean and replenished
- Place disposable paper towels next to the basins – soft paper towels will help to avoid skin abrasions
- Position foot-operated pedal bins near the hand wash basin – make sure they are the right size
- Paper towels may be disposed of as household waste
- Alcohol gel dispensers must be available at the point of care, either by having dispensers near the bed or staff have individual “tottles” with them at all times.

4.6.2 Project managers for capital build or refurbishments must ensure that the Infection Prevention & Control is consulted about the requirements and relevant regulations with regard to the proposed siting and design of hand washing facilities within all healthcare premises.

4.7 Hand Washing In Individual’s Homes

4.7.1 Hands should be washed prior to any procedure in the patient’s home and before departure. It is not recommended that staff routinely use patient provided equipment for hand hygiene, however it is appreciated that a refusal may cause offense or be detrimental to the care relationship as such in all situations it is important to perform a risk assessment of the hand washing facilities available. If these are not adequate then alcohol gel may be used to disinfect visibly clean hands. It is not expected that patients will have elbow or wrist operated taps, as such if the general facilities are suitable, use a hand towel to turn the tap off once completed. It is not consider good practice to use cloth towels provided by the patient or their relatives.

4.7.2 It is recommended that all staff that are required to visit patients in their own homes are provided with the following hand hygiene equipment which is available in pack form:

- Liquid soap
- Alcohol gel
- Soft paper towels
- Moisturiser
- Disposable wet wipes

4.8 Audit of Practice

4.8.1 All hand hygiene practices undertaken by staff will be regularly audited to ensure a consistency in quality and compliance with this policy.

4.8.2 In the community hospitals this will be undertaken through the use of the Lewisham Hand Hygiene Audit tool on a monthly basis.

4.8.3 In community / residential settings this will be undertaken on a quarterly basis through the use of a random selection of patient questionnaires on staff practice.

4.9 Training

All patient facing staff will receive annual training in hand hygiene from the link personnel in the locations. The 5 Moments for Hand hygiene will also be discussed in the annual infection control training and the induction training for staff.

4.10 References


Appendix 1

World Health Organisation 5 Moments for Hand Hygiene

Your 5 Moments for Hand Hygiene

1. BEFORE TOUCHING A PATIENT
   WHEN? Clear your hands before touching a patient when approaching him/her.
   WHY? To protect the patient against harmful germs carried on your hands.

2. BEFORE CLEAN/ASEPTIC PROCEDURE
   WHEN? Clear your hands immediately before performing a clean/aseptic procedure.
   WHY? To protect the patient against harmful germs, including the patient’s own, from entering his/her body.

3. AFTER BODY FLUID EXPOSURE RISK
   WHEN? Clear your hands immediately after an exposure risk to body fluids (and after glove removal).
   WHY? To protect yourself and the health-care environment from harmful patient germs.

4. AFTER TOUCHING A PATIENT
   WHEN? Clear your hands after touching a patient and her/his immediate surroundings, when leaving the patient’s side.
   WHY? To protect yourself and the health-care environment from harmful patient germs.

5. AFTER TOUCHING PATIENT SURROUNDINGS
   WHEN? Clear your hands after touching any object or furniture in the patient’s immediate surroundings, when leaving – even if the patient has not been touched.
   WHY? To protect yourself and the health-care environment from harmful patient germs.

World Health Organization
Patient Safety
A World Alliance for Safer Healthcare
SAVE LIVES
Clean Your Hands

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May 2009

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Appendix 2

The 6 Stage Technique for Hand Hygiene

Six stage handwashing technique

1. Palm to palm
2. Backs of hands
3. Interdigital spaces
4. Fingertips
5. Thumbs and wrists
6. Nails

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Use of Personal Protective Equipment Policy

5.1 Introduction

The selection of protective equipment must be on the basis of an assessment of the risk of transmission of micro-organisms to the patient and the risk of contamination of healthcare practitioners' skin and clothing by blood, body fluids, secretions, and excretions, either by direct or indirect contact with the patient and/or their immediate environment.

5.2 Gloves

5.2.1 Gloves must not be worn unnecessarily as their prolonged and indiscriminate use may cause adverse reactions and skin sensitivity. A risk assessment should be carried out to assess the need for gloves and the appropriate type. Particular consideration must be given to confirmed cases of staff or patient sensitivity to latex, or where highly invasive procedures are undertaken which could result in a latex sensitivity reaction (e.g. for internal examinations or minor surgical procedures).

5.2.2 Sensitivity to natural rubber latex in patients, carers and healthcare workers is becoming more prevalent and to conform to the Health and Safety at Work Act (1974). As such Suffolk Community Healthcare have implemented as a matter of policy the provision of latex free items including gloves. No latex containing items are to be provided for or worn by staff.

5.2.3 Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes and for all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments. Gloves that are acceptable to healthcare workers and that conform to European Community (CE) standards must be available.

5.2.4 **DO NOT USE** powdered gloves or polythene gloves in healthcare activities.

5.2.5 Gloves must be worn as single-use items. They must be put on immediately before an episode of patient contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different patients and between different care or treatment activities for the same patient and must not be used as a substitute for hand washing.

5.2.6 Gloves must be disposed of as clinical waste if contaminated with blood or body fluid and hands decontaminated after the gloves have been removed.

5.2.7 Gloves must not be washed between patients as the gloves may be damaged by the soap solution and, if punctured unknowingly, may cause body fluid to remain in direct contact with skin for prolonged periods.

5.2.8 **Non-sterile gloves** Must be used when hands may come into contact with body fluids or equipment contaminated with body fluids.

5.2.9 **Sterile gloves** Must be used when the hands are likely to come into contact with normally sterile areas or during any surgical procedure.

5.2.10 **General purpose utility gloves**

General purpose utility gloves e.g. rubber household gloves, can be used for cleaning instruments prior to sterilisation, or when coming into contact with possible contaminated surfaces or items. Ideally, colour coding of such gloves must be used e.g. Green for kitchen, Blue for general environmental cleaning and red for ‘dirty’ duties e.g. toilets. This will help prevent cross-infection from one area of work to another. The gloves should be washed with general purpose detergent and hot water, and dried between uses. They should be discarded weekly or more frequently if the gloves become damaged.
5.2.11 Polyurethane /polythene gloves (Non sterile and sterile)

Polyurethane /polythene gloves do not act as a barrier to infection. They do not meet the Health & Safety Commission regulations and they do not have a place in clinical application. Do not use.

5.3 Disposable Plastic Aprons

5.3.1 Must be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat. They should also be worn for giving close physical care and for bed making. Plastic aprons must be worn as single-use items for one procedure or episode of patient care, then discarded and disposed of as either clinical or offensive waste depending on the level of risk of infection with the task.

5.3.2 Disposable plastic aprons should be colour coded depending on the area in which they are worn:

- **Green** for catering
- **Yellow** for isolation areas
- **Red** for toilets and bathrooms
- **Blue** for general cleaning
- White or clear for general patient care

5.4 Face Masks And Eye Protection

These must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes. Areas where this type of incident may be anticipated could be during exposure-prone procedures encountered in dentistry, surgery, podiatry and in the cleaning of instruments.

5.5 Respiratory Protective Equipment

There are very few occasions when the wearing of masks is required in the community. Masks are generally only recommended when there is a risk to staff or patients from airborne spread of infection, most commonly for close contact e.g. chest physiotherapy; with patients who are known or strongly suspected to have Pulmonary Tuberculosis. These staff should receive fit-testing for masks from the Infection Prevention & Control Lead. If a mask is to be worn, a good quality filter type must be used. It must fit the face closely and be changed if it becomes wet.

5.6 Audit of Practice

5.6.1 The provision and availability of PPE will be audited through the isolation room audits and by the Infection Prevention & Control on an annual basis.

5.6.2 Staffs knowledge of the correct use of PPE will be assessed by the Infection Prevention & Control Lead during the annual audits.

5.6.3 The results of all audits will be reported to the infection control committee.

5.6.4 This policy will be monitored annually to ensure it meets current national guidance and formally reviewed every three years.

5.7 Training

All staff will receive training in the appropriate selection and use of PPE as part of their Infection Prevention & Control training.
5.8 References:

15. Infection Control Nurses’ Association (September 1999) ‘Glove Usage Guidelines’ London


   www.mrha.gov.uk/home/idcplg?ldcService=GET_FILE&dDocName=CON007368&RevisionSelectionMethod=Latest


6 Sharps Safety and the Management of Sharps Injuries Policy

6.1 Introduction

6.1.1 Suffolk Community Healthcare recognises its legal obligation to provide a safe work environment and that the risk of injury from sharp implements requires specific management and control. Needle stick injuries and other exposures to blood and body fluids may result in the transmission of blood borne viruses such as HIV, Hepatitis B and Hepatitis C.

6.1.2 Most cases of occupationally acquired HIV have arisen through percutaneous exposure to HIV contaminated materials. However, transmission can occur through contamination of the mucous membranes of the eyes, nose and mouth. The risk of transmitting blood borne viruses from patient to staff is greater than from staff to patients. Many of these incidents result from failure to comply with recommended procedures and all such incidents should be carefully reviewed to identify how recurrence might be prevented.

6.2 Definitions

6.2.1 Sharps Needlestick/Inoculation Injury - Includes, syringes, needles, scalpels, razor blades, broken glass or any other sharp implement with the potential to cause a penetrating injury if not handled in a safe manner.

6.2.2 Percutaneous Injury – When a needle or contaminated sharp object causes injury. This may also occur from a bite causing visible bleeding, or other visible skin puncture. Contact of broken skin e.g. cuts, abrasions, and eczema with blood or bodily fluids will also lead to this type of injury.

6.2.3 Mucocutaneous Injury – When splashes occur into the mouth, nose or conjunctiva.

6.2.4 Source – is the patient (or rarely a HCW) whose blood or other body fluid has been transmitted by an exposure incident. The source may be tested for the presence of a BBV only with informed consent.

6.2.5 Recipient – is the HCW (or rarely a patient) who is contaminated with infected or potentially infected blood or other body fluids as a consequence of an exposure incident.

6.2.6 Seroconversion – occurs when the blood of the recipient to an exposure incident changes from negative to positive for a BBV. This may take up to six months but usually occurs within three months

6.3 Duties

6.3.1 Suffolk Community Healthcare will put in place arrangements to reduce the risk of exposure to blood borne viruses by implementing appropriate control measures such as management of clinical waste, provision of appropriate Personal Protective Equipment (PPE) engineering controlled needle systems, training in the management of violence and aggression and hand hygiene training.

6.3.2 Infection Prevention and Control advice and Occupational Health Services will be available to all staff.

6.3.3 The organisation has a responsibility to make staff aware of these services through induction training.

6.3.4 Line managers must make all staff aware of the arrangements for these services above by using available resources such as posters and the BBV procedure within this policy.
6.3.5 Line managers will undertake general risk assessments to identify suitable control measures for the protection of staff against BBVs.

6.3.6 Line managers will also undertake a specific risk assessment following an accidental occupational exposure to a member of staff to a blood borne virus.

6.3.7 Occupational Health is responsible for providing guidelines on immunisation against infectious diseases for employees of Suffolk Community Healthcare. It will also provide advice to healthcare workers who believe they may have acquired a BBV, either occupationally or in other circumstances or those known to have acquired a BBV. It will provide on-going support to the HCW following an accidental occupational exposure of a member of staff to a blood borne virus.

6.3.8 Employees must follow guidance issued by their Professional Bodies and the organisation in respect of BBV’s and to undertake clinical procedures in accordance with guidelines or established practice.

6.4 Legislative Framework for Sharps Safety

6.4.1 The Health and Safety at Work Act (1974) places a legal responsibility upon employers to provide a safe working environment, safe systems of work and safe equipment. Employees also have a duty to comply with the Act and with safe systems of work. The Act is supported by a number of companion Regulations. These are:

- Personal Protective Equipment at Work Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013.
- The Management of Health and Safety at Work Regulations 1999
- The Control of Substances Hazardous to Health Regulations (COSHH) 2002 (amended 2004).
- Health and Safety (Sharps Instruments in Healthcare) Regulations 2013

6.5 The Provision of Sharps Containers

Only UN approved standard bins should be purchased. It is recommended that the Daniels range of Sharps bins are used as they conform to BS7230: 1990, UN3291, AFNOR NFX 30-500 and ISO 9002. There is a large range of Sharps bins available from 0.5L to 22L capacity.

6.6 The Assembly and Management of Sharps Containers

- Always assemble sharps containers correctly.
- Press the lid down around the rim of the container and ensure you have heard the click of the lid as it snaps onto the bottom of the bin.
- It is the responsibility of the person assembling the bin to complete the details on the label of the bin. This is to enable traceability of bins in case of an incident.
- Sharps containers should never be over filled.
- Bins should be disposed of when they reach the fill line
- Always activate the temporary closure mechanism when the bin is not in use or is being transported from one location to another.
- Always secure sharps bins to walls or trollies with correctly fitted brackets
- Do not place sharps containers on the floor, window sills or above shoulder height
- Label sharps containers with the source details prior to disposal
- Place damaged sharps containers inside a larger sharps container – lock and label prior to disposal. Do not place inside a clinical waste bag
6.7 For Community Staff Transporting Used Sharps Boxes In Their Cars;

- Sharps must only be carried by staff if there is no alternative for safe disposal
- The container must be carried in a secure area of the car (e.g. the boot) to prevent tipping
- The container must be carried out of sight (e.g. the boot)
- The temporary closure must be used whilst transporting /carrying
- As the volume of sharp clinical waste is small in these circumstances, there is no requirement for the member of staff to display a ‘Hazard’ notice on their car
- Staff must take sealed sharps containers to their employers’ lockable clinical waste storage collection point as soon as possible to ensure their safe storage prior to disposal

6.8 Safe Practice In The Use Of Sharp Devices

- Avoid the use of sharps whenever possible and where the use of a sharp is essential, exercise particular care in the handling and disposal.
- Gloves must be worn when performing venepuncture and intravenous therapy care.
- Assistance should be sought to handle confused patients, babies or young children.
- Use intravenous devices with a safety feature whenever possible.
- Do not guide a needle with a finger.
- Sharps should never be passed from hand to hand.
- Do not re-sheath sharps after use.

6.9 Safe Disposal Of Sharps

- All sharps must be disposed of immediately after use in the correct container (Appendix 3).
- It is the responsibility of the person using them to do so.
- A sharps bin must be taken to the point of use, and a tray to carry a secured sharps bin and equipment should be used.
- The disposal of a used sharp must never be delegated.
- Syringes and needles should be disposed of as a single unit. It is not appropriate to disconnect the needle from the syringe before disposal.
- Only dispose of sharps in a sharps bin.
- Never dispose of sharps with other clinical waste.
- Do not try to retrieve items from a sharps container
- Never overfill a sharps bin

6.10 Sharps Spillage

- Always wear gloves.
- Have a correctly assembled sharps bin to hand. (See Appendix 4 – Correct use of sharps containers.
- Pick up dropped needle & syringe from the plunger end.
- Dispose of into the sharps bin.

6.11 Safety Devices

6.11.1 In order to comply with the Health & Safety (Sharps Instruments in Healthcare) Regulations 2013 the organisation will be sourcing safety devices. A safety device is one that incorporates a built in safety feature in its design, which is intended to reduce the risk of a sharp or needle stick injury before, during or after use. Devices that eliminate the unnecessary use of needles and devices with safety features can reduce the number of sharps injuries that have occurred. Safety devices must conform to the Medicines and Healthcare products Regulatory Agency (MRHA) and therefore carry the CE mark. The device must not compromise the safety of the user or patient, or increase the risks associated with the procedure being undertaken.

6.11.2 Any safety device product must:
- Provide a barrier between the hand and needle.
- Allow and/or require the users' hands to remain behind the needle at all times.
- Have safety features that are an integral part of the device.
- Have safety features that cannot be deactivated and remain protective throughout disposal to protect staff.
- Be simple and self-evident to operate and require little or no training for effective use.
- Be appropriate to the procedure to be undertaken and should be chosen following a risk assessment.

6.12 Diabetic Sharps

6.12.1 All used diabetic sharps must be disposed of in a regulation sharps container (this includes lancets and BD needle clippers).

6.12.2 Sharps containers are available for diabetics from all GP surgeries. General Practitioners should ensure that the patient is aware of the correct method of disposal of the filled sharps container. The Environment Agency (as the enforcing body) has agreed that legally, sharps containers can be returned to the surgery for disposal under exemption 39(2) of the Waste Management Licensing Regulations 1994 (as amended). The Local Authority also has a duty to collect clinical waste including sharps from households. The householder may be charged by the Local Authority for this service. **Whichever route is used, the patient must be made aware that it must not be disposed of in the household waste system under any circumstances.**

6.13 Management Of Sharps Injuries

6.13.1 Suffolk Community Healthcare will provide its entire staff with access to a full immunisation programme that will reflect current national policy. As part of this programme all those staff who will be handling sharps or who face exposure to blood or bodily fluids will receive a course of hepatitis B vaccine. This is a one off course of vaccinations and as such a records check will suffice for new employees moving from a previous healthcare provider. A record of the hepatitis B antibody response will be kept by Occupational Health for all clinical staff involved in ‘exposure prone procedures’ or where regular exposure to blood/blood stained body fluids occurs. The Occupational Health Department can advise staff regarding their need for immunisation and any necessary boosters.

In the event of a sharp injury/ contamination incident, these guidelines must be followed:

**A sharp injury/ contamination incident includes:**
- Inoculation of blood by a needle or other ‘sharp’
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes, mouth
- Contamination where clothes have been soaked by blood
- Bites

6.13.2 Immediate First Aid Following Exposure to Blood/Body Fluids (Appendix 5)

- **DO NOT SUCK THE WOUND!**
- Encourage the injury to bleed, under running water.
- Wash injury with soap and water but avoid scrubbing. Dry well and cover with a waterproof dressing.
- Contaminated skin whether broken or intact, conjunctivae or mucous membranes should be irrigated copiously with water. If contact lenses are worn, eye irrigation should take place carefully before and after removing the lenses.
- Note the name of the source patient, if known.
- Report the accident immediately to your manager/ supervisor and follow the organisations Incident Reporting Procedure.
- Contact the Occupational Health Department as soon as possible after the injury for advice about risk assessment and prophylaxis.
- Out of hours advice should be obtained from the nearest NHS Accident & Emergency Department.
- All adverse events/near misses involving sharps or splashes, whether there has been an injury or not, must be reported by staff by completion of a sentinel incident form.
- Managers are responsible for investigating the incident and agreeing on any preventative actions to be taken to prevent recurrence.

A sharps injury first aid poster should be on display in clinical areas (Appendix 6)

6.13.3 Risk Assessment

If the source is known to be positive or likely to be positive for a BBV and the exposure incident has been significant and the recipient is not immune or already infected with HBV, HCV or HIV then the incident will be deemed to be high risk.

6.13.4 Serum Save

A blood sample will be taken from the employee with informed consent and sent to the microbiology department as a baseline sample for storage for two years. This blood sample will only be tested if tests on the source are positive for a BBV or likely to be positive. The blood sample may also be used to test for immunity to HBV.

6.13.5 Is The Employee Immune To Hepatitis B?

After a significant exposure incident, a booster dose of Hep B vaccine will need to be given. If the employee is not immune to Hepatitis B or immunity to HBV is incomplete, vaccination will need to be given in a standard regimen (0, 1, and 6 months with a titre check 2 months after the last dose) or an accelerated regimen (0, 1, 2 months with a titre check two months after the third dose and then a booster at 12 months) according to the risk assessment.

6.13.6 Source Risk Assessment

As part of the risk assessment the Occupational Health nurse or doctor will need to know about the current and past health of the source, in particular whether the source is known to be, or likely to be, infected with HBV, HCV or HIV. Such a judgement may involve a clinician studying the medical records. If despite this the status of the source is still uncertain then the source should be asked to give consent to a blood sample being taken for testing for one or more of these viruses. The team working with or looking after the source (but not the injured person) should counsel the source about the incident and the need for testing. This is usually the most senior clinical person available. If testing is undertaken the source will need to be given the results of the tests.

N.B If the Designated Doctor wishes they may contact the “UK Advisory Panel For Health Care Workers Infected With BBV” for advice. Department of Health 2006.

6.13.7 Source Is Known To Be HIV Positive

If the source is HIV positive or likely to be positive and the exposure is likely to have been significant then this will be judged to be a high-risk incident for seroconversion. Post-Exposure Prophylaxis (PEP) should be offered to the recipient. Ideally this should be started within 1-2 hours of the injury, but can be given up to 72 hours post incident and should be taken for four weeks. Recipient follow-up by Occupational Health at 6, 12 and 24 months will be recommended to check for seroconversion.
Current Advice For PEP

Truvada (tenofovir 300 mg and emtricitabine 200mg) one tablet daily plus Kaletra (lopinavir 200mg and ritonavir 50mg) two tablets twice daily is currently the national recommended regimen. Recipients should be aware that side effects from this medication are common and prescription is ‘off label’.

6.13.8 Source Is Known To Be Hepatitis B Positive

If the source is HBV positive or likely to be positive and the exposure is likely to have been significant, and the recipient’s immunity is uncertain, or they are unvaccinated against HBV, then this will be judged to be a high-risk incident for seroconversion. Hepatitis B Immunoglobulin (HBIG) and an accelerated course of HBV vaccination will be recommended to protect the recipient. Recipient follow-up by Occupational Health will be recommended at 6, 12 and 24 weeks to check for seroconversion. If the recipient is immune to HBV then risk of seroconversion is very low and follow-up will not be required.

6.13.9 Source Is Known To Be Hepatitis C Positive

If the source is HCV positive, or likely to be positive, and the exposure has been significant then this will be judged to be a high-risk incident for seroconversion. There is currently no vaccination or prophylaxis in this situation. Recipient follow-up in Occupational Health will be recommended at 6, 12 and 24 weeks to check for seroconversion.

6.13.10 Reverse Needlestick Procedure

These incidents are very rare, with only 3 reported cases globally of transmission of a BBV from a healthcare worker to a patient. However, in the event that a patient is accidentally exposed to the blood or bodily fluids this policy should be followed with the patient being treated as the recipient and the staff member as the source.

6.13.11 Exposure Prone Procedures

Generally staff in the community do not perform Exposure Prone Procedures (EPPs) with the exception of dental practices and within some podiatric surgery. However, all staff who do perform EPPs need to be aware of their obligations (see statements by the GMC in Maintaining Standards Guidance 1997; United Kingdom Central Council for Nursing, Midwifery and Health Visiting Registrar’s letter 4/1994 Annex 1). Any staff that is infected with a BBV will be able to undertake EPPs in line with the recommendations of the United Kingdom Advisory Panel for Healthcare Workers Infected with Blood Borne Viruses (UKAP).

6.14 References

22. RCN Epinet available from www.needlestickforum.netv


Appendix 3
Correct Sharps Bin Selection

1. **AM I A SHARP?**
   - **NO**: Refer to your waste policy for disposal instructions.
   - **YES**: Proceed to the next step.

2. **Have I been contaminated with Cytotoxic or Cytostatic medicines?**
   - **NO**: Proceed to the next step.
   - **YES**: Proceed to the next step.

3. **Have I been contaminated with medicines?**
   - **NO**: Dispose in a purple lidded sharps container.
   - **YES**: Proceed to the next step.

4. **Dispose in a yellow lidded sharps container.**

5. **Dispose in an orange lidded sharps container.**
Appendix 4
CORRECT USE OF SHARPS CONTAINERS

Assemble correctly... snap lid on all round and fill in label details

Place on bracket, securely fitted to wall or trolley
OR take to point of use in a SHARPSGUARD® tray

Ensure container door is in the open position before use

Close temporary closure when not in use

Lock door when contents reach fill line

Complete label and tag it

Remove container and dispose of according to local policy

REMEMBER!
Always dispose of sharps at the point of use
Appendix 5
INOCULATION INJURY CHECKLIST

- Was the puncture sight encouraged to bleed gently, under warm running water?
- Was the area washed with soap and water?
- If it was a mucocutaneous splash, was it irrigated with water?
- Was the incident reported to the immediate line manager?
- Was the incident reported through the Company accident procedures?
- Did the injured person inform Occupational Health or attend the nearest A&E?
- Was the source patient identifiable?
- Has the incident been risk assessed for acquiring a BBV?
- If indicated was blood taken from the source patient?
- Does the injured person know their Hepatitis B immunity status?
- Is Post Exposure Prophylaxis required?
- If yes has this been prescribed and commenced?
- Are further tests for potential seroconversion required?
Appendix 6
WHAT TO DO IF YOU HAVE A SHARPS/NEEDLESTICK/INOCULATION INJURY

BLEED IT - Squeeze wound to encourage bleeding

WASH IT - with soap, under running water

COVER IT - with a waterproof dressing

REPORT IT
7. Management of Blood or Bodily Fluid Spillages Policy

7.1 Introduction

It is vital that any spillage must be attended to as soon as possible. Under the Control of Substances Hazardous to Health Regulations 1994 (COSHH) assessment of hazards and associated risks to health must be undertaken to ensure the health and safety of employees, patients and other visitors to the health care premises.

7.2 Responsibilities for Spillage Management

7.2.1 Modern Matrons/CHT Team Leaders: are responsible for ensuring that staff are appropriately trained and understand their responsibilities with regard to cleaning of blood or bodily fluid spillages.

7.2.2 Clinical staff: are responsible for undertaking a prompt and appropriate clean of blood or bodily fluids stained with blood.

7.2.3 Domestic cleaning staff: are responsible for the prompt and appropriate clean of non-blood stained bodily fluids as required.

7.2.4 Domestic Supervisors: are responsible for ensuring that there are adequate supplies of suitable cleaning materials in the localities in which they operate.

7.3 Blood /Body Fluid Spillage Management Guidelines (Not Suitable For Urine Spills)

7.3.1 Hypochlorite /Sodium Dichloroisocyanurates (NaDCC) method – To be used ONLY where the surface will tolerate chlorine-releasing (bleach) disinfectant e.g. flooring, non-upholstered furniture.

- Prevent access to the area containing the spillage until it has been safely dealt with
- Open the windows to ventilate the area if possible
- Wear protective clothing (disposable gloves and apron)

Either:
Cover the area with NaDCC absorbent granules or 1% solution (e.g. Presept™, Actichlor™); leave for 2 minutes and clean up with disposable towels.

Or for large spills with danger of high fume levels:
Mop up organic matter with paper towels or disposable cloths and /or absorbent powder e.g. Vernagel™ and then wash surface with a solution containing 10,000 parts per million of available chlorine (1% hypochlorite solution = 1 part household bleach to 10 parts water) and leave for 2 minutes.

- Disposable towels should be disposed of as clinical waste
- Clean the area with detergent and hot water and dry thoroughly
- Clean the bucket /bowl in fresh soapy water and dry
- Discard protective clothing as clinical waste
- Wash and dry hands

7.3.2 Detergent and water method – To be used when the surface is unsuitable for contact with hypochlorite disinfectant e.g. soft furnishings, carpets.

- Prevent access to the area until the spillage has been safely dealt with
- Wear protective clothing
- Mop up organic matter with paper towels or disposable cloths and /or absorbent powder e.g. Vernagel™
- Clean surface thoroughly using a solution of general purpose detergent and hot water and paper towels or disposable cloths
Rinse the surface and dry thoroughly
Dispose of materials as clinical waste
Clean the bucket/bowl with fresh hot, soapy water and dry
Remove protective clothing and discard as clinical waste
Wash and dry hands
Ideally, once dry; go over area with a mechanical cleaner

7.3.3 On soiled carpets, upholstery and soft furnishings, a steam cleaner may be used after excess fluid has been removed with paper towel.

7.4 References:

30. Control of Substances Hazardous to Health (COSHH) Regulations 1994
32. HSE Environmental Hygiene Guidance Note Number 17
34. Substances Hazardous to Health Emergency Spillage Guide, Croner Publications
8 Clinical Waste Management Policy

8.1 Introduction

8.1.1 Suffolk Community Healthcare have a legal responsibility to ensure that waste generated by employed staff is disposed of safely, ensuring no harm is caused either to staff, patients, members of the public or the environment. This responsibility begins when waste is generated and ends with its final disposal, even where properly authorised agents are used. This policy relates to waste generated during clinical activity and does not constitute the whole waste management policy for Suffolk Community Healthcare.

8.1.2 It is essential that persons handling waste exercise care to prevent injury or transmission of infection to themselves or others. This is to fulfil their responsibilities under the current legislation.

8.2 Legislative Framework

The management of waste in the healthcare environment is governed by the current legislative acts:
- Health & Safety at Work Act (1974)
- Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance
- Control of Pollution Act (1974)
- Control of Pollution (Amendment) Act (1989)
- Environment Protection Act (1990)
- Environment Protection (Duty of Care) Regulations (1991)
- Controlled Waste Regulations (1992)
- The Special Waste Regulations (1996)
- Health Care Waste Management and Minimisation (2007)
- The Misuse of Drugs Act 2001
- The Lists of Wastes Regulations 2005

8.3 Definition Of Clinical Waste

8.3.1 Clinical waste is:

a. Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, secretions, drugs or other pharmaceutical products. Soiled swabs or dressings, or syringes, needles or other sharp instruments, being waste which, unless rendered safe, may prove to be hazardous to any person coming into contact with it; and

b. Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any other person coming into contact with it (Controlled Waste Regulations 1992)

8.3.2 Waste is coded according to the European Waste Framework Directive (2008/98 EC) to produce common terminology throughout Europe. The following waste codes apply to the waste produced by Suffolk Community Healthcare and its dependent services:
### 8.4 Segregation Of Waste Produced Within Health Care Premises

The key to the safe disposal of waste is for all staff to conform to the system of segregation shown in appendix 7. This system enables clear identification of the different types of waste encountered and indicates the disposal procedures that apply to each category.

### 8.5 Handling and disposal of waste

- Waste must be segregated at the point of origin
- Personal protective equipment must be worn when handling waste (e.g. apron & gloves)

**8.5.1 Clinical waste should be:**

- Correctly bagged in clinical waste bags (as supplied centrally by Procurement) to prevent spillage
- Kept in a rigid-sided holder or container with a foot operated lid and so far as is reasonable and practicable – out of the reach of children
- Double bagged where:
  - The exterior of the bag is contaminated
  - The original bag is split, damaged or leaking
- Only filled to ¾ full
- Securely sealed and labelled at the point of use to identify their source

**8.5.2 Clinical waste bags should never be:**

- Decanted into other bags, regardless of volume
- Contaminated on the outside
- Contain sharps or sharps containers

### 8.6 Disposal Of Sharps Containing Medical Waste

8.6.1 Sharps are items which could cause cuts or puncture wound, including needles, syringes with needles attached, broken glass ampoules, scalpels and other blades.

8.6.2 Medicinal waste is classified in two categories:

- Cytotoxic and cytostatic medicines = hazardous waste
- Medicines other than those classified cytotoxic or cytostatic
8.6.3 Used sharps and/or fully discharged syringes may still contain or be contaminated with medicinal waste. Sharps and syringes contaminated with residual medicines (other than cytotoxic or cytostatic medicines) must be disposed of in a YELLOW topped approved sharps container for incineration. Sharps contaminated with cytotoxic or cytostatic medicines must be disposed of in a PURPLE topped approved sharps container for incineration. Medicines not contained in a syringe which require incineration should be disposed of in a BLUE topped container.

8.7 Storage Of Clinical Waste

8.7.1 Clinical waste must be removed from the point of generation as frequently as circumstances demand, and at least weekly.

8.7.2 Between collections, waste must be:

- Stored in correctly coded bags with bags of each colour code kept separate
- Situated in a centrally designated area of adequate size related to the frequency of collection
- Sited on a well-drained, impervious hard standing floor, which is provided with wash-down facilities
- Kept secure from unauthorised persons, entry by animals and free from infestations (e.g. in a lockable bin/area)
- Accessible to collection vehicles

8.8 Management Of Clinical Waste Produced In Non-Healthcare Managed Environments

8.8.1 (e.g. private households) – this does not include private residential care establishments: A householder has no legal duty of care to dispose of clinical waste in the way described above. However, a health or social care worker who provides care in a private household does, e.g. NHS organisation, Social Services, care agency staff.

8.8.2 Sharps in Patients Homes

In situations where a patient may have a potential need to use a sharps box between visits by healthcare professional e.g. diabetic patients, they are to be provided with a suitable colour coded sharps bin to meet their requirements. It is permissible for community staff to transport these in their vehicles in a safe manner as described above for disposal. Patients must be informed of the safety recommendations for keeping these boxes particularly in households with children.

8.8.3 Clinical Waste

The assessable health risk of most waste from patients’ homes is very low; however, changes to EU Waste Regulations now make it illegal for local authorities to accept infectious waste on to surface landfill sites. As such there is a requirement for healthcare professionals to risk assess all waste they produce for its’ known or suspected infectious nature. Once it is established that the waste is infectious a separate infectious waste stream must be utilised.

All waste that is assessed as non-infectious is classified as offensive waste. This can in small quantities (less than a bin liner per week) be placed into the householders waste collection stream. For larger amounts than this the healthcare professional can book collections with an approved waste contractor through the Facilities Management administrator.

It is no longer permissible for known or suspected infectious swabs and dressings to be double-wrapped and placed in the patient’s normal household waste collection.

In these instances a clinical waste collection should be arranged, by telephoning the Facilities Management administrator for Suffolk Community Healthcare on 01473 3278969
The following information will be required:

- Patient /client’s name
- Full address including postcode
- Telephone number for patient /client
- How often the waste is to be collected
- What type of waste e.g. soft waste in bags, sharps, pharmaceutical
- Contact details of the person making the referral

8.8.4 Clinical waste must be contained within an approved rigid packaging when transported on the road. Staff working in the community must not carry clinical waste in their cars (except approved sharps containers which are already rigid and should be carried out of sight and in as stable an area as possible e.g. in the boot of the car)

8.9 References


### Appendix 7
Colour Coding for Waste Segregation

<table>
<thead>
<tr>
<th>Waste Colour Code</th>
<th>Waste Stream</th>
<th>Examples of Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow</td>
<td>Infectious and clinical waste that must be incinerated</td>
<td>Known infectious waste and medicinally contaminated sharps</td>
</tr>
<tr>
<td>Orange</td>
<td>Clinical Waste that can be treated and sent to land fill or be incinerated</td>
<td>Clinical items that have been in contact with blood or bodily fluids e.g. blood soaked dressings, saliva covered tongue depressors. Non-medicinally contaminated sharps</td>
</tr>
<tr>
<td>Red</td>
<td>Anatomical parts which must be incinerated</td>
<td>All anatomical body parts except non amalgam filled teeth which can go into an orange topped sharps bin</td>
</tr>
<tr>
<td>Purple</td>
<td>Medicinal waste that contains Cytotoxic or Cytostatic elements</td>
<td>All medicines and their associated equipment which have been in contact cytotoxic or cytostatic elements. Will also include urinary catheters and bags for uro-oncology patients</td>
</tr>
<tr>
<td>Teal</td>
<td>Medicinal waste that doesn’t contain Cytotoxic or Cytostatic elements</td>
<td>All medicines except Cytostatic or Cytotoxic</td>
</tr>
<tr>
<td>Black</td>
<td>Domestic Waste</td>
<td>All household style waste e.g. flowers, food cartons, newspapers.</td>
</tr>
<tr>
<td>Yellow</td>
<td>Offensive Hygiene Waste</td>
<td>Non- infectious items that have been used for the active management of a patient e.g. Nappies, incontinence pads, sanitary pads, non-contaminated disposable gloves and aprons, non-medicine containing IV bags and lines.</td>
</tr>
<tr>
<td>Black</td>
<td>Amalgam waste for recovery</td>
<td>Teeth with amalgam fillings for amalgam recovery</td>
</tr>
</tbody>
</table>
9 Laundry Policy

9.1 Introduction

9.1.1 Suffolk Community Healthcare at all times and in accordance with Health and Safety Legislation, must ensure that steps are taken to prevent infection during the handling and laundering of linen. The provision of clean linen is a fundamental requirement for patient care. Linen used in health care can become soiled with, blood, excreta or other body fluids containing numbers of pathogenic micro-organisms. Handling or processing of soiled linen can present an infection risk to staff, patients and external laundry contractors.

9.1.2 When laundry services are contracted, it is essential that the contractor is able to comply with the requirements of this policy.

9.1.3 It is strongly recommended that linen is kept to a minimum in community based outpatient and clinic areas unless laundry services are contracted. Areas which do not use a contracted laundry service should use disposable pillowcases, sheets and towels as appropriate.

9.2 Categorisation of Laundry

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
<th>Handling Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Used</td>
<td>Routine patient linen or clothing</td>
<td>White nylon or plastic bags</td>
</tr>
<tr>
<td>Soiled</td>
<td>Linen that is wet or faecally contaminated</td>
<td>Red nylon bag with a soluble alginate bag inside. If a relative wishes to take laundry home use a soluble bag inside a waterproof bag.</td>
</tr>
<tr>
<td>Infected</td>
<td>Linen from Patients with a known infection e.g. C diff, Salmonella, MRSA</td>
<td>Red soluble alginate bag then placed inside a red nylon or red plastic bag</td>
</tr>
<tr>
<td>Heat labile</td>
<td>Fabric damaged by Thermal disinfection e.g. Wool, synthetics</td>
<td>Send to laundry in bags depending on the category above</td>
</tr>
</tbody>
</table>

9.3 Laundry Management

9.3.1 All staff handling soiled linen must adhere to the standard precautions policy and wear gloves and aprons. Hands must be washed following any handling procedure. Linen should be held away from the body to prevent contamination of clothing.

9.3.2 Used linen must be placed into the appropriate colour coded container as soon as possible after removal.
9.3.3 Care must be taken to remove any extraneous items from dirty linen before it is placed in laundry bags. Soiled linen storage and processing areas must be separate from clean linen storage, patient care areas, food preparation areas, and clean equipment storage areas.

9.3.4 Linen bags must never be more than two thirds full, and must be secured before removal.

9.3.5 Pillows, duvets, mattress overlays – these must be protected by heat-sealed waterproof covers which are cleaned with detergent & water between patients. Alcohol wipes MUST not be used as these items contain alcohol which damages the cover and may then allow fluids to pass through to the mattress foam thus reducing the life of the mattress and its ability to protect patients from cross infection is then reduced. If the cover is damaged or punctured and the article itself is contaminated it must be condemned and disposed of as clinical waste.

9.3.6 Patient handling aids e.g. slings, slide sheets etc... – All handling aids should be standardised for each patient. This may be achieved by use of single patient disposable products or washable fabric aids. If washable, then they must be laundered at 65°C for 10 minutes or 71°C for 3 minutes. Washable items must be placed in red alginate bags then a red plastic bag.

**NB**, if a fabric sling contains plastic reinforcing struts then these must be removed prior to the sling being sent for laundering.

9.3.7 Manual soaking/washing of soiled items must never be carried out. A sluice cycle or cold pre-wash must be used for all soiled items.

9.3.8 Linen should be bagged at the bedside never shaken or allowed to touch the floor.

9.4 Use of On Site Washing Machines

9.4.1 The use of on-site washing machines must not be used for the laundering of bedding or curtains. They are permissible for the cleaning of patient handling aids in line with the requirements stated above and in extreme cases the laundering of patients clothing if there is no other option available for this.

9.4.2 In situations that require the cleaning of patients clothing this must be done separately from other items, and the washing machine must have a full cycle run through afterwards to remove any potential residual soil remaining from the clothes.

9.5 Temperatures For Mechanical Washing

<table>
<thead>
<tr>
<th>Items</th>
<th>Recommended Temperature</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Linen (infected items must be washed separately)</td>
<td>65°C for not less than 10 minutes</td>
<td>Daily or Weekly minimum</td>
</tr>
<tr>
<td></td>
<td>Or 71°C for not less than 3 minutes</td>
<td></td>
</tr>
<tr>
<td>Tea towels</td>
<td></td>
<td>Daily</td>
</tr>
<tr>
<td>Face Cloths</td>
<td></td>
<td>Weekly minimum</td>
</tr>
<tr>
<td>Personal Towels</td>
<td></td>
<td>Weekly minimum</td>
</tr>
<tr>
<td>Item</td>
<td>Washing Temperature</td>
<td>Frequency</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Uniforms (must be washed separately)</td>
<td>65°C for a minimum of 10 minutes</td>
<td>Daily</td>
</tr>
<tr>
<td>Mop head Clinical area (can be disposable)</td>
<td>65°C for not less than 10 minutes or 71°C for not less than 3 minutes</td>
<td>Daily</td>
</tr>
<tr>
<td>Mop head non-Clinical (can be disposable)</td>
<td></td>
<td>Daily</td>
</tr>
<tr>
<td>Curtains</td>
<td>As per manufacturer's instructions</td>
<td>Every 6 months</td>
</tr>
<tr>
<td>Soft Furnishings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Duvets</td>
<td>Dry Clean, Wipe clean with hard surface.</td>
<td>Every 6 months, Between each patient use</td>
</tr>
<tr>
<td>Patient Clothing</td>
<td>As per manufacturer's instructions</td>
<td>As required</td>
</tr>
<tr>
<td>Patient Handling Slings</td>
<td>As per manufacturer's instructions or 65°C for 10 minutes if suitable.</td>
<td>After each patient admission episode or if soiled.</td>
</tr>
</tbody>
</table>

9.6 **Considerations When Contracting An Off Site – Laundry**

9.6.1 The frequency of collection will depend on the volume of laundry and the agreed schedule between the SCH facility and the laundry provider.

9.6.2 The provider is responsible for cleaning and disinfection of the container/vehicles in order to prevent contamination of clean linen at the following times:

- After any spillage
- After transportation of dirty laundry if it is to be used for clean laundry next
- At least weekly.

9.6.3 There must be no contact between clean and soiled/fouled linen at any time. If soiled and fouled linen are to be transported in the vehicle at the same time there must be a waterproof barrier or a rigid container for the used linen.

9.6.4 The provider must comply with all aspects of the carriage of dangerous goods acts. The majority of laundry consignments are not classified as dangerous for transport. However there may be occasions when soiled linen will need to be classified as dangerous for transport due to it containing pathogens which prove a significant risk of spreading disease and the load is heavily soiled to the extent that the potential for exposure and infection is high. In these instances linen should be classified as infectious i.e. clinical waste and be disposed of.

9.7 **Return Of Clean Laundry**

9.7.1 Contamination of clean linen must be prevented by

- Ensuring roll cages are adequately covered and cleaned on a regular basis
- Storage in a clean, dry area or cage.
- Transport in a clean dry container/vehicle which is cleaned and disinfected prior to loading with clean linen.

9.7.2 Linen which is (or is considered to be) contaminated must be returned to the laundry for processing.

9.7.3 Fire access points must not be obstructed by returned linen.

9.8 **Using Disposable Coverings for Couches**

- The surface of all couches must be of a washable impermeable fabric.
- The condition of the surface of all couches should be regularly checked (minimum once monthly) to ensure the fabric remains intact.
- The couch should be covered with a disposable paper towel, which must be changed between patients.
- If the paper towel becomes soiled and the soiling seeps through to the surface of the couch, the couch must be decontaminated before use by another patient. If contaminated with blood clean with detergent wipes, followed by a sodium dichloroisocyanurate compound (NaDCC) (e.g. Actichlor).
- If the contaminant is another body-fluid, general-purpose detergent and warm water, or detergent wipe is sufficient to decontaminate the surface of the couch.
- Pillows are not considered essential as all couches should have head-tilts. However, if pillows are used, they should be sealed within a plastic impermeable cover. Disposable pillowcases should then be used. These should be discarded once weekly or more frequently if they become soiled. If standard pillow cases are used, they must be washed weekly or more frequently if they become soiled.
- Blankets/sheets are not considered essential. For modesty, a length of disposable paper towel should be used to cover exposed parts of the body.

9.9 **Curtains**

- At windows, it is recommended that washable blinds are used.
- Around couches, curtains should only be used if required to protect patient’s modesty. These should be disposable wherever possible.
- There must be an environmental cleaning schedule which must include window and bed curtains to be laundered or changed twice yearly, or when contaminated.

9.10 **Terry Towels**

- Terry towels must not be used in Suffolk Community Healthcare premises. Hands should be dried on disposable paper towels.
- If used to protect the patient each patient should be provided with a clean towel (or disposable paper towel).

9.11 **Staff Uniforms Or Work Clothes**

9.11.1 The Dress Code & Uniform Policy must be complied with at all times.

9.11.2 The majority of bacteria and viruses will not survive away from the host and would not present a high risk of infection on clothing. However, within a mass of body fluid, organisms would survive longer.
9.11.3 Staff who are at risk of contaminating their clothes by body fluids should always change into ‘home’ clothes as soon as possible – preferably before leaving the work place or as soon as home is reached. Uniforms or work clothes should be washed as soon as possible on as hot a wash as the fabric will tolerate. This must be at least 40°C and ideally 60°C. Cardigans /jumpers should be washed at least weekly.

9.11.4 Shoes should be cleaned immediately if contaminated with body fluids, using general purpose detergent and hot water; disposable gloves should be worn.

9.12 Monitoring of Policy

9.12.1 Arrangements and practice for the management of laundry will be audited on an annual basis in all inpatient facilities by the IPC lead.

9.12.2 On site laundry facilities will be audited as part of the environmental audit programme by the enabling services department

9.13 References


10 Decontamination of Re-Usable Medical Equipment Policy

10.1 Introduction

10.1.1 The protection of both patients and staff from the transmission of infection from medical devices and other equipment which come into contact with patients or their body fluids requires the adoption of safe systems of work. The Health & Social Care Act (2008) Code of Practice for the Prevention and Control of Healthcare Associated Infection Section 10, paragraph (i), places a legal requirement for health care organisations to have these systems in place and set out in a core Decontamination & Disinfection Policy.

10.1.2 It is a regulatory requirement of the Care Quality Commission to ensure that facilities that use equipment should do so in a manner that keeps people safe from harm from unsafe or unsuitable equipment.

10.2 Aim

10.2.1.1 The aim of this section of the policy manual is to prevent and control the spread of infection by the provision of sound decontamination principles and to link together the existing documents relating to decontamination, for the safety of both staff and patients. This policy will describe the requirements of decontamination for all staff in the following areas:

- The Principles of Decontamination
- Responsibility for Decontamination
- Decontamination of Equipment for Investigation, Inspection, Service or Repair and Declaration of Status
- Medical Devices supplied for Single-use
- General Principles for Cleaning Equipment
- Use of Disinfectants and Antiseptics
- Suspected Contamination with Prions
- Disinfectants and their uses

10.2.2 To ensure that decontamination policies and procedures:

- Are in line with organisational governance
- Meet organisational and clinical standards
- Minimise risk
- Involve safe systems of work
- Are monitored and reviewed in a structured way

10.2.3 Where possible, single use items of medical equipment are used rather than reusable, especially where a reusable item is found to be difficult to clean effectively

10.3 Definitions

10.3.1 Medical device - defined by the European Union as “any instrument, apparatus, appliance, material or other article whether used alone or in combination, intended by the manufacturer to be used for human beings for the purpose of: control of conception; diagnosis, prevention, monitoring, treatment or alleviation of disease; diagnosis, monitoring, treatment, alleviation of or compensation for an injury or handicap; investigation, replacement or modification of the anatomy or physiological process. Surgical instruments are medical devices. (Council Directive 93/42/EEC). Therefore medical devices include, for example, commode chairs, drip stands, dressing trolleys, BP cuffs, bedpans as well as surgical instruments.

10.3.2 Decontamination - is the process of rendering an article safe to handle, by cleaning with or without disinfection or sterilisation. There are three levels of decontamination categorised as follows:
a. **Cleaning** - Cleaning is the removal of dirt and organic matter. Cleaning removes up to 80% of micro-organisms and is an essential part of an infection control programme. Given that organic matter will inactivate disinfectants, all items must be cleaned before disinfection or sterilisation can be achieved.

b. **Disinfection** - Disinfection is the removal or destruction of adequate numbers of potentially harmful micro-organisms to allow the item to be handled or used safely. The most effective method of disinfection is heat disinfection. However, the most common method used is with liquid chemicals, for example alcohol. It should be noted that organisms that form spores, for example Clostridium difficile are not destroyed by disinfection alone.

c. **Sterilisation** - Sterilisation is the total destruction and removal of all micro-organisms including spores.

10.3.3 **Surgical instruments** – any instrument that comes into contact with mucous membranes, penetrates intact skin into a body area or is in contact with non-intact skin

10.3.4 **Prions** – Transmissible Spongiform Encephalopathy’s (TSE)

10.3.5 **Risk** - The Microbiology Advisory Committee to the Department of Health (MAC Manual), Sterilization, Disinfection, and Cleaning of Medical Equipment: Guidance on Decontamination, classifies the risk of infection associated with the decontamination of medical devices as:

a. **High risk** - In close contact with a break in the skin or mucous membrane or introduced into sterile body areas. Equipment used in this situation should be sterilised when reprocessed e.g. surgical instruments, endoscopes and implants

b. **Intermediate risk** - In contact with mucous membranes; contaminated with particularly virulent or readily transmissible organisms; or prior to use on immune compromised patients. Equipment used in this situation requires disinfection or sterilisation e.g. respiratory/anaesthetic equipment, bedpans

c. **Low risk** - In contact with healthy skin or not in contact with the patient. Equipment used where there is no contact with the patient should be cleaned. But if the equipment is in contact with healthy skin, cleaning may not be sufficient in some cases.

10.3.6 In Suffolk Community Healthcare with the exception of the Foot & Ankle podiatry and Community Dental Dependent Services all of the equipment will fall into the low or intermediate risk classifications. The majority of the specialist equipment used by the two specific services mentioned above will predominantly fall into the intermediate to high risk classifications.

10.4 **Principles Of Decontamination**

10.4.1 The principles of decontamination are:

- To remove organic matter e.g. body fluids, tissue, food or soil which may contain or support the growth of pathogenic organisms.
- May be required to remove chemical hazards (specialist advice may need to be sought from experts outside the organisation).

10.5 **Responsibilities For Decontamination**

10.5.1 **The Ward/Departmental or Team Managers**: have overall responsibility for the decontamination of equipment in their area. The Ward/Departmental or Team Manager should nominate a person who is responsible for cleaning equipment. Cleaning schedules must be drawn up and an adequate system must be in place for the recording and monitoring of schedules and standards. All staff involved with decontamination should have adequate and suitable training.
10.5.2 **Purchase Procedure** It is the responsibility of the budget holders to seek advice from appropriate specialist staff to ensure that infection risks are addressed at the purchasing stage in compliance with MDA DB9801, Medical Equipment and Devices: Management for Hospital and Community based Organisations. Equipment purchased must take account of good design that allows easy decontamination and be constructed with durable materials that support easy cleaning and disinfection. Pre-purchase questionnaire (PPQ) forms obtained from the supplier will indicate recommended cleaning and disinfection processes.

10.6 **Condition Monitoring**

The on-going condition of all medical equipment needs to be monitored to ensure that infection risks can be managed effectively. When the equipment condition has deteriorated to the extent that effective cleaning is no longer achieved easily, the equipment must be disposed of safely in accordance with the Waste Management Policy.

10.7 **Supplies**

There should always be available supplies of clean equipment to ensure that the re-use of potentially contaminated or single-use equipment does not happen.

10.8 **Scheduled Cleaning**

All re-usable clinical equipment in Suffolk Community Healthcare will be subject to a cleaning schedule which will detail both the cleaning frequency and cleaning procedure, as well as the agents to be used and the staff responsible. There are procedures common to all cleaning schedules, but certain items of equipment require particular actions (e.g. the finish or design of an item of equipment may require special attention to ensure that it is effectively cleaned).

10.9 **Training Of Staff**

All staff need to understand the importance of the measures in place to reduce the infection risk from healthcare equipment. Appropriate on-going training must be provided to ensure that staff implement the measures required. The effectiveness of training should be monitored regularly as part of their performance appraisal.

10.10 **Equipment Disposal Or Repair**

Equipment that requires disposal or repairs must be decontaminated if it has been in contact with blood or body fluids. Equipment that cannot be cleaned effectively and therefore remains contaminated should be disposed of as clinical waste. Large or specialist pieces of equipment will need special arrangements and further support should be sought from the Suffolk Community Healthcare Waste Manager, the equipment manufacturer or the Environment Agency.

10.11 **Choice Of Decontamination Method**

10.11.1 All equipment will require cleaning. Some equipment will also require disinfecting or sterilising. Decontamination will work less efficiently on equipment that is difficult to clean, and/or in a poor condition. Compatibility of equipment with the chosen method of decontamination will be determined from information supplied by the manufacturer. Manufacturers of medical devices are required to provide decontamination guidance for reusable products. The choice of method also depends on the purpose of the equipment and other risk factors as follows:
<table>
<thead>
<tr>
<th>Category</th>
<th>Indication</th>
<th>Examples</th>
<th>Level of Decontamination</th>
<th>Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>High Risk</td>
<td>Items that penetrate skin or mucous membranes, or that enter sterile body areas</td>
<td>Surgical instrument, needles, *Vaginal speculum.</td>
<td>Sterilise</td>
<td>Autoclave and use sterile</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single use - disposable</td>
</tr>
<tr>
<td>Medium Risk</td>
<td>Items that have contact with mucous membranes or are contaminated by microbes that are easily transmitted</td>
<td>Bedpans. Commodes Thermometers Tongue Depressors</td>
<td>Disinfect or sterilize</td>
<td>Autoclave or disinfect by heat (80°C – 1min)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Chemical disinfection may be appropriate for certain heat labile items, e.g. commodes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single use disposable</td>
</tr>
<tr>
<td>Low Risk</td>
<td>Items used on intact skin</td>
<td>Washbowls mattresses</td>
<td>Clean</td>
<td>Wash with hot water and detergent and dry thoroughly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Single use disposable</td>
</tr>
</tbody>
</table>

*Vaginal speculum must be single use or sterilised after use but do not need to be sterile at point of use, unless used during a sterile procedure

10.11.2 Cleaning

- All items must be cleaned according to manufacturer’s instructions.
- Cleaning is essential before disinfection or sterilisation is carried out.
- Neutral detergent in water and single use cloths are recommended or detergent wipes may be used.
- All equipment must be cleaned in a dedicated sink (not hand wash basin) or bowl in which the water can be deep enough not to cause splashes or aerosols.
- All equipment with narrow lumens must be not be manually cleaned. They must be cleaned in a washer disinfector or similar automated device.
- Always wear protective gloves and aprons and if splash or aerosol is considered likely face and eye protection as per the Standard Precautions Policy.
- All cleaned equipment must be dried thoroughly before storage.

10.11.3 Disinfection

- All chemical disinfectants must be correctly selected and used according to manufacturers’ instructions. They must be diluted as instructed and discarded when the shelf life expires.
- The CoSHH regulations must be adhered to at all times.
- Always wear disposable gloves, apron and eye protection, when using disinfectants.
- Rinse equipment with clean water after disinfection if indicated.
- Discard disinfectant solution after use, clean container and store dry.
- Glutaraldehyde is no longer recommended for disinfection.
10.11.4 Sterilisation

- A centralised sterilisation service department (CSSD) must be used for this method of decontamination.
- Instruments used in high risk procedures must be sterile at the point of use.
- Sterile autoclaved equipment returned from CSSD must be stored correctly in an area that is clean, well ventilated and secure, and away from sources of contamination from dust and splashes. All sterile items must be stored off the floor.
- Saturated steam under pressure delivered at the highest temperature compatible with the product is the preferred method for the sterilisation of most instruments and this takes place in the porous-load sterilisers within CSSD. Items must reach the required temperature for the specified time period. In order to demonstrate that the re-processed items have been sterilised, indicator labelling will be used which demonstrates that the instruments have been heated to 134oc for the full 3.5 minutes required staff must check this for the required colour change before using the item.

NB. Benchtop steam sterilisers must not be used

10.12 Availability Of Disinfectants

The products listed below are available within Suffolk Community Healthcare:

<table>
<thead>
<tr>
<th>Product</th>
<th>Comments on Usage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ALCOHOL</strong></td>
<td></td>
</tr>
<tr>
<td>Isopropyl Alcohol 70% impregnated swabs</td>
<td>Skin cleanser prior to injection</td>
</tr>
<tr>
<td>Industrial methylated spirit 70% (IMS 70%) spray</td>
<td>Hard Surface disinfectant</td>
</tr>
<tr>
<td>Alcoholic handrub (62%) – Spirogel</td>
<td>Hand decontamination – provided hands are clean</td>
</tr>
<tr>
<td>Hydrex DS Spray (Chlorhexidine in Ethanol 65-75%)</td>
<td>Skin disinfectant</td>
</tr>
<tr>
<td>Hydrex Surgical Scrub Chloraprep 2%</td>
<td>Skin disinfectant</td>
</tr>
<tr>
<td><strong>Disinfectant wipes</strong> (70% Isopropyl alcohol)</td>
<td>Hard Surface disinfectant</td>
</tr>
<tr>
<td>e.g. Azowipes, Cliniwipe IPA 100, Tuffie wipes</td>
<td></td>
</tr>
<tr>
<td>Detergent wipes e.g. Cutan, Tuffie detergent wipes</td>
<td>Hard surface impregnated wipes.</td>
</tr>
<tr>
<td>Hospex liquid detergent</td>
<td>Use diluted as recommended</td>
</tr>
<tr>
<td><strong>AMMONIUM CHLORIDE</strong></td>
<td></td>
</tr>
<tr>
<td>T SPRAY II 60ml bottle</td>
<td>Available to specific areas only for intra-cavity probes such as vaginal probes. The active ingredient is user activated by adding water to the fill line indicated on the bottle</td>
</tr>
<tr>
<td>250ml bottle</td>
<td></td>
</tr>
<tr>
<td><strong>CHLORHEXIDINE</strong></td>
<td></td>
</tr>
<tr>
<td>1 in 25 (4%) Surgical scrub</td>
<td>Hand disinfection/surgical scrub, available in specific areas</td>
</tr>
<tr>
<td>Chloraprep</td>
<td>Pre-operative skin preparation particularly prior to</td>
</tr>
<tr>
<td>Product Description</td>
<td>Use</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chlorhexidine aqueous solution (0.5%) – Unisept 1% Chlorhexidine Gluconate Centramide (Savlon)</td>
<td>cannulation, available in specific areas Has historically been used as skin disinfection and for wound cleaning but is of little clinical value</td>
</tr>
<tr>
<td><strong>CHLORINE PREPARATIONS (made from Actichlor tablets)</strong></td>
<td></td>
</tr>
<tr>
<td>Hypochlorite solution 10,000 ppm available Chlorine</td>
<td>For cleaning and decontaminating spillages of blood/blood stained body fluids</td>
</tr>
<tr>
<td>Hypochlorite solution 1000 ppm</td>
<td>Environmental decontamination of hard surfaces management of blood spills</td>
</tr>
<tr>
<td>Chlorclean (combined Chlorine releasing agent and detergent)</td>
<td>Environmental decontamination of hard surfaces, as advised by the ICT during outbreak situations</td>
</tr>
<tr>
<td>Hypochlorite solution 125ppm (0.012%) e.g. diluted Milton solution</td>
<td>Infant feeding utensils</td>
</tr>
<tr>
<td>Titan Sanitiser</td>
<td>To clean bathtubs after each patient use, patient bowls after discharge.</td>
</tr>
<tr>
<td><strong>POVIDONE IODINE</strong></td>
<td></td>
</tr>
<tr>
<td>Antiseptic solution 10%</td>
<td>Skin disinfection</td>
</tr>
<tr>
<td>Dry powder spray</td>
<td>Skin disinfectant. Use only on advice of medical staff</td>
</tr>
<tr>
<td>Povidone Iodine Surgical Scrub</td>
<td>Hand disinfection. Available to specific areas only</td>
</tr>
<tr>
<td>Povidone Iodine in alcoholic base</td>
<td>Skin disinfection</td>
</tr>
<tr>
<td><strong>TRICLOSAN PREPARATIONS</strong></td>
<td></td>
</tr>
<tr>
<td>Octanisin</td>
<td>As part of the decontamination protocol for patients with MRSA. Use only when advised by ICT.</td>
</tr>
<tr>
<td>Triclosan (0.5%) – Manusept</td>
<td>Hand decontamination, sometimes used in MRSA decolonisation protocol</td>
</tr>
<tr>
<td><strong>TRISTEL</strong></td>
<td></td>
</tr>
<tr>
<td>1 Day, 1Day concentrate, multishot</td>
<td>Available to specific areas only. For sterilisation of thermo labile instruments, training required prior to use.</td>
</tr>
<tr>
<td>Tristel sterilising wipes</td>
<td>For use on hard surfaces. Available to specific areas only. Training required prior to use.</td>
</tr>
</tbody>
</table>
10.13 Decontamination Of Equipment For Investigation, Inspection, Service Or Repair

10.13.1 The Health and Safety at Work Act (1974) requires that safe systems of work should be implemented to protect all staff including persons who are not employed by the company. The Medicines and Healthcare Products Regulatory Agency (MHRA 2003) outlines the need to prevent the transmission of infection from medical equipment whether laboratory, consumables or material used in the treatment, diagnosis or care of patients, and other equipment which comes into contact with body fluids. The process to follow when sending equipment for investigation, inspection, service or repair is outlined in Appendix 8 of this policy manual.

10.13.2 Equipment must be decontaminated prior to repair, service or inspection following the general principles for cleaning. Disinfection will be required for equipment contaminated with blood or body fluids.

10.13.3 Equipment which can be autoclaved should be dismantled and sent to the Sterile Services Department. Consult either the Decontamination Manager or the Infection Prevention & Control Lead before sending. It may be necessary to use a water soluble bag for transportation.

10.13.4 For equipment which cannot be decontaminated without being dismantled by the engineer, advice should be sought from the Medical Engineering Company and the equipment should be cleaned and then sealed in a clear plastic bag and should have an infection risk sticker attached.

10.13.5 If the equipment is the subject of a complaint or investigation, decontamination may prevent a full investigation. In these circumstances the investigation body must be consulted.

10.13.6 All equipment must be packed and dispatched with a declaration of contamination status. This certification must conform to the standards required in MHRA DB 2006 (05) A copy of a suitable decontamination declaration certificate is in Appendix 9.

10.14 Single Use Medical Devices

10.14.1 Single use means that the medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient.

10.14.2 Devices that are labelled by the manufacturer for ‘single use only’ must not be reused (Medical Devices Agency (2000)).

10.15 Record Keeping And Traceability

10.15.1 All practitioners undertaking the decontamination of re-usable medical equipment are required under HSC 2000/032 – Decontamination of Medical Devices and HSC 1999/178 variant Creutzfeld Jakob Disease, Minimising the Risk of Transmission to ensure that a system is in place that can trace the use of a reusable medical device to individual patients.

10.15.2 These records must be kept for 11 years.

10.15.3 Where possible records of equipment used and sterilisation processes undertaken should be placed in the patients permanent records.

10.15.4 If this is not practicable a central record of the devices used and decontamination methods can be utilised.

10.16 Monitoring

This policy will be monitored through the regular audit of the decontamination of equipment in the in-patient units and the podiatry services.
10.17 References

42. Sterilization, Decontamination & Cleaning of Medical Equipment: Guidance on Decontamination from the Microbiology Advisory Committee to Department of Health, Medicines and Healthcare products Regulatory Agency. Revised Part 2 Protocols 2005


47. HSC 1999/178 Variant Creutzfeldt Jakob Disease (vCJD): Minimising the risk of transmission, Department of Health, 1999

48. HSC 1999/179 Controls Assurance in Infection Control: Decontamination of Medical Devices, Department of Health, 1999

49. HSC 2000/032 Decontamination of Medical Devices, Department of Health, 2000


51. MDA Safety Notice SN 9619 Compatibility of Medical Devices and their Accessories and Reprocessing Units with Cleaning, Disinfecting and Sterilizing Agents, Medical Devices Agency, 1996

52. Health and Safety at Work Act 1974. HMSO; 1974

53. HTM 01-01 Decontamination of re-usable medical devices - Part A NHS Estates 2007

54. ADCP/SEAC Transmissible spongiform encephalopathy agents: safe working and the prevention of infection, Department of Health, 2001


57. MHRA DB2003 (2003) Management of Medical Devices prior to repair, service or investigation.


61. MHRA DB 2006 (05) Managing Medical Devices.

Appendix 8
Handling of equipment prior to inspection, service, repair, return to lending organisation or investigation of adverse incident

Note: it is illegal to send contaminated items through the post

Is it possible to decontaminate the equipment without removing evidence important to the investigation or repair?

Yes

Decontaminate Equipment
- Label with contamination status
- Note fault or defect

Offsite: pack and despatch for service/repair/investigation
Onsite: Arrange suitable storage for service/repair/investigation

No

Inform the repair organisation or investigating body

Repair organisation or investigating body agrees despatch

Yes

- Label with contamination status
- Note fault/defect
- Pack and dispatch for service/repair/investigation

No

Arrange Visit by service/repair organisation or investigating body.
- Label with contamination status
- Note fault/defect
- Quarantine in preparation for service/repair/investigation
Appendix 9
Declaration of Contamination Certificate

From (consignor): _____________________
To (consignee): _____________________
Address ____________________________________________
_____________________________________________________
_____________________________________________________
Reference ____________________________________________
Emergency tel __________________________

Type of equipment ____________________________
Manufacturer _______________________________________
Description of equipment _________________________________________
Other identifying marks _________________________________________
Model no. ____________________________ Serial No. ____________________________
Fault _________________________________________

Is the item contaminated?  Yes*  No  Don’t know
*State type of contamination, blood, body fluids, respired gases, pathological samples, chemicals (including cytotoxic
drugs), radioactive material of any other hazard

Has the item been decontaminated? Yes†  No‡  Don’t know
† What method of decontamination has been used? Please provide details
Cleaning _________________________________________
Disinfection _________________________________________
Sterilisation _________________________________________
‡ Please explain why this item has not been decontaminated?
_____________________________________________________________________________________
_____________________________________________________________________________________

Contaminated items should not be returned without prior agreement of the recipient.

This item has been prepared to ensure safe handling & transportation:
Name ____________________________ Position ____________________________
Signature __________________________
Date ____________________________ Tel ____________________________
11 Environmental Cleaning Policy

11.1 Introduction

11.1.1 Ensuring our facilities are clean and safe is an essential component in the provision of effective healthcare. A clean and tidy environment is an outward manifestation of the health of the organisation and provides the right setting for good patient care practice. It is fundamental in assisting patients to recover and helps in the prevention and control of the spread of healthcare associated infections.

11.1.2 Cleanliness and infection control are closely linked in the public mind, however there are important distinctions to be made; whilst cleanliness contributes to infection control, preventing infections requires more than simple cleanliness.

11.1.3 There are numerous publications to assist health care providers in ensuring that their cleaning programmes are properly focussed, effectively resourced and that they consistently deliver high quality services that are well regarded by patients. This policy will reflect these requirements.

11.2 Purpose

11.2.1 The purpose of this policy is to achieve the following outcomes:

a. Taking Cleanliness Seriously
   - Ensure high standards of cleanliness are maintained across all facilities.
   - Through partnership working between managers of facilities and Enabling Services to develop cleaning schedules for their individual areas of activity.
   - Setting clear local standards (reflecting national Standards of Cleanliness guidance) and policies.
   - Keeping cleanliness high on the Suffolk Community Healthcare agenda

b. Listening to Patients
   - Develop patient feedback surveys and act on feedback
   - Ensure patients receive treatment in an environment that is clean safe and welcoming

c. Infection Control
   - Through the development, implementation and monitoring of cleaning standards by a partnership of Enabling Services the Infection Prevention & Control Lead, facility managers and link workers.

d. Education and Development
   - Ensure that staff responsible for cleanliness has the ability and support to do a good job through:
     - Induction training
     - On-the-job support
     - Customer service training
     - Supervisory, managerial and leadership development training
     - Certificated competence of operatives (NVQ)

e. Monitoring
   - Ensure that high standards of cleanliness are maintained and that any reduction is recognised and corrected through:
     - Working to national targets that measure performance over a range of factors
     - Establish a management system that supports continuous improvement and
     - Senior Nurses and Departmental Managers to be involved in maintaining and monitoring cleanliness standards

11.3 Definitions

11.3.1 Cleaning - is the removal of dirt and organic matter. Cleaning removes up to 80% of microorganisms and is an essential part of an infection control programme.
11.3.2 **Routine Cleaning** – is the day to day cleaning that is maintained through a schedule in order to prevent the undue accumulation of debris and detritus in the environment.

11.3.3 **Terminal Cleaning** – is a higher level of cleaning that is normally undertaken once a patient with a known infection has been discharged. This is usually around the patient’s immediate bed area or isolation room. It will normally include changing curtains and cleaning surfaces with disinfectant solutions.

11.3.4 **Deep Clean** – is a programmed system for annual cleans of patient care areas which requires the cleaning of all areas in the department including the walls, ceilings, ducting and air vents. It is advisable to link this with the annual maintenance programme for the sites that have operating theatres to reduce the amount of downtime for the department.

11.4 **Duties**

11.4.1 The Chief Executive has overall responsibility for ensuring that the environments in which patients receive care are clean.

11.4.2 The Executive Director for Enabling Services is responsible for ensuring that effective cleaning systems are provided.

11.4.3 The Head of Hotel Services is responsible for the provision and management of on-site cleaning services.

11.4.4 The Facilities Management Team Are Responsible For Monitoring Hygiene Standards Through Monthly Audits.

11.4.5 Domestic supervisors are responsible for ensuring that all facilities are cleaned in line with the schedules and keeping the records of cleaning activities.

11.4.6 Team Leads & Modern Matrons are responsible for ensuring that day to day cleaning standards are maintained and raising issues regarding environmental hygiene with the hotel services.

11.4.7 All staff have a responsibility to ensure that the environment is clean and that issues regarding cleaning are raised with the appropriate people.

11.5 **Cleaning Schedules**

All clinical facilities will have their own written comprehensive cleaning schedule.

- The schedule will specify the persons responsible for cleaning, the frequency of cleaning, the methods to be used and which items were required e.g. Electro-Medical equipment are to be cleaned by designated staff groups. A recommended cleaning schedule with responsibilities is in Appendix 10
- In addition there should be a schedule to ensure all cleaning equipment is cleaned and maintained properly.
- Cleaning schedules should be monitored on a 6 monthly basis by the Facilities Officer and Domestic Supervisors. Changes to cleaning schedules and timings should be notified through the infection control committee.

11.6 **Colour Coding For Hygiene**

All equipment used for cleaning must be colour coded in order to prevent cross contamination from one area to another. The National Colour Coding Scheme for Hospitals must be observed.
### Table 1 National Colour Coding

| SANITARY APPLIANCES AND WASHROOM FLOORS (Bathrooms, washrooms, showers, toilet, basins and bathrooms) | GENERAL AREAS (inc Wards, departments, offices and communication areas) |
| KITCHENS (inc catering departments) | ISOLATION |

#### 11.7 Storage Of Cleaning Materials

- All cleaning materials must only be stored in dedicated rooms and cupboards.
- All chemical used for cleaning must be risk assessed and stored in line with CoSHH regulations.
- All cleaning materials must be cleaned and dried after use.
- Segregate colour coded cleaning equipment, such as mop heads, gloves and cloths for toilets, kitchens, clinical areas and isolation areas.
- All cleaning equipment that has a tank for liquids must have these drained and left open at the end of each shift.

### Table 2 Cleaning Equipment Maintenance & Storage

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Frequency of Cleaning</th>
<th>Method of Cleaning</th>
<th>Method of Storage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mops Handles</td>
<td>Daily</td>
<td>Hard Surface Wipe or Hot Water and Neutral Detergent</td>
<td>In a storage rack</td>
</tr>
<tr>
<td>Mop Heads</td>
<td>Daily</td>
<td>Launder</td>
<td>Invert in a storage rack if stored between use</td>
</tr>
<tr>
<td>Mop Buckets</td>
<td>After each use</td>
<td>Wash &amp; Dry</td>
<td>Inverted</td>
</tr>
<tr>
<td>Clothes</td>
<td>Disposable or Daily if Microfibre</td>
<td>Launder if Microfibre</td>
<td>Shelf or Cupboard</td>
</tr>
<tr>
<td>Dusters</td>
<td>Disposable or Daily if Microfibre</td>
<td>Launder if Microfibre</td>
<td>Shelf or Cupboard</td>
</tr>
<tr>
<td>Floor Scrubber Pads</td>
<td>After each use</td>
<td>Hot Water &amp; Neutral Detergent</td>
<td>Hang to allow air drying</td>
</tr>
<tr>
<td>Floor Scrubber</td>
<td>After each use</td>
<td>Hard Surface Wipe or Hot Water and Neutral Detergent</td>
<td>In Cleaners Cupboard</td>
</tr>
<tr>
<td>Floor Polishers</td>
<td>After each use</td>
<td>Hard Surface Wipe or Hot Water and Neutral Detergent</td>
<td>In Cleaners Cupboard</td>
</tr>
<tr>
<td>Vacuum Cleaner</td>
<td>Daily</td>
<td>Empty bag or Cylinder</td>
<td>In Cleaners Cupboard</td>
</tr>
</tbody>
</table>

#### 11.8 Frequency Of Cleaning

The cleaning of the environment is based on the level of risk associated with the nature of the use of these areas. These levels of risk and minimum cleaning frequencies are set by National Standards (see table 3).
Table 3  Areas in Suffolk Community Healthcare by Level of Risk

<table>
<thead>
<tr>
<th>Very High Risk</th>
<th>High Risk</th>
<th>Significant Risk</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Operating Theatres</td>
<td>Patient Rooms</td>
<td>Outpatients</td>
<td>Offices</td>
</tr>
<tr>
<td>Wards</td>
<td>Dirty Utilities</td>
<td>Chaplaincy Rooms</td>
<td></td>
</tr>
<tr>
<td>Sterile Store Rooms</td>
<td>Waiting Rooms</td>
<td>Retail Outlets</td>
<td></td>
</tr>
<tr>
<td>Clean Utilities</td>
<td></td>
<td>Meeting Rooms</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Store Rooms</td>
<td></td>
<td>Training Rooms</td>
<td></td>
</tr>
<tr>
<td>Treatment Rooms</td>
<td></td>
<td>General Store Rooms</td>
<td></td>
</tr>
<tr>
<td>In Patient Day Rooms</td>
<td></td>
<td>CES Equipment</td>
<td>Storage Areas</td>
</tr>
<tr>
<td>Public Thoroughfares and toilets</td>
<td></td>
<td>Reception Desks</td>
<td></td>
</tr>
<tr>
<td>CES Cleaning Areas</td>
<td></td>
<td>Records Stores</td>
<td></td>
</tr>
</tbody>
</table>

The recommended frequency of cleaning is included in Appendix 10

11.9  Cleaning In The Event Of An Outbreak Of Infection

11.9.1 An increase in the frequency and standard of cleaning is a major contributor to the control of an outbreak of infection. A review of the frequency of cleaning must be conducted as soon as an outbreak of infection is suspected or confirmed. Recommended additional cleaning in the event of an outbreak is in Appendix 2.

11.9.2 This review will be undertaken by the senior nurse and cleaning manager with advice from the Infection Prevention & Control Lead.

11.9.3 The cleaning standards in the event of an outbreak must be monitored and reported on daily to the outbreak control team.

11.10  Terminal Cleaning

11.10.1 All patients’ rooms that have been used for the care of infectious patients must undergo a thorough or terminal clean once a patient has been discharged in readiness for the next patient. A recommended terminal clean is in Appendix 3.

11.10.2 In the event of a confirmed Clostridium difficile outbreak the Terminal Clean may include the use of Hydrogen Peroxide vapour. This can be arranged through the Infection Prevention & Control Lead.

11.11  Use Of Microfibre

The use of Mirco fibre technology has proven benefits in the ease of use, storage of chemicals, long term costs and time in the routine cleaning of hospitals. However, it is less effective against spore forming organisms such as Clostridium difficile in the event of outbreaks, in which more conventional cleaning with Hypochlorites will be required. Facilities can use Micro fibre but must have the ability to clean areas affected in an outbreak with more conventional methods.

11.12  Patient Satisfaction

11.12.1 The cleanliness of a hospital or other health facility is linked to good standards of infection control and safety by patients. The overriding issue for them will be the standard of cleanliness in order for them to consider themselves in safe care.

11.12.2 Regular patient satisfaction surveys relating to cleanliness must be conducted and the results passed to the infection control committee.
11.13 Staff Training

11.13.1 All staff involved in the cleaning of the environment should be appropriately trained, including NVQ certification were required.

11.13.2 This training must include relevant input on:

- Methods of cleaning,
- CoSHH regulations,
- Use of Personal Protective Equipment
- Health & Safety.
- Infection Control
- Standards to be achieved.

11.14 Monitoring Audit And Review

11.14.1 It is the responsibility of the local cleaning supervisor to monitor cleaning standards on a daily basis.

11.14.2 The cleanliness of the facilities will be audited by the enabling services team. The frequency of audit will reflect the level of risk associated with it as per the national standards.

Table 4. Frequency of Hygiene Audit

<table>
<thead>
<tr>
<th>Very High Risk Area</th>
<th>High Risk Area</th>
<th>Significant Risk Area</th>
<th>Low Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>Monthly</td>
<td>Two Monthly</td>
<td>Quarterly</td>
</tr>
</tbody>
</table>

11.14.3 Enabling services will provide a regular report to the infection control committee on the state of cleanliness of the facilities.

11.14.4 The cleanliness standards of all facilities will be reported on in the Annual Infection Prevention & Control Report prepared by the DIPC for the Board.

11.14.5 In Patient satisfaction surveys must include items on cleanliness standards and allow recommendations to be made.

11.14.6 Given the high volume of auditing this policy will entail, it is recommended that an electronic reporting system be utilised in order to accommodate this volume and provide real time reports to enable prompt action.

11.15 References

63. Revised Guidance on Contracting for Cleaning (December 2004)
64. The National Specifications for Cleanliness in the NHS: a Framework for Setting and Measuring Performance Outcomes (NPSA, April 2007)
65. An Integrated Approach to Hospital Cleaning: Microfibre Cloth and Steam Cleaning Technology (May 2007) Department of Health
67. The Matrons Charter 2004
68. Colour Coding of Hospital Cleaning Materials and Equipment. Safer Practice Notice 15. NPSA. January 2007
70. Towards Cleaner Hospitals and Lower Rates of Infection (July 2004) Dept. of Health


73. Care Quality Commission, Essential Standards of Quality and Safety, March 2010
### Appendix 10

**Recommended Cleaning Schedule and Responsibility**

<table>
<thead>
<tr>
<th>Cleaning Task</th>
<th>Schedule</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commodes</td>
<td>1 full clean daily and between each patient use</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>Weighing scales, manual handling equipment</td>
<td>1 full clean daily and contact points between each patient use.</td>
<td>Nursing staff after use</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Domestic services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>when in storage</td>
</tr>
<tr>
<td>Medical equipment, e.g. intravenous infusion pumps, drip stand, pulse oximeters etc.</td>
<td>1 full clean daily and between patient use.</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>CONNECTED TO A PATIENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical equipment, e.g. intravenous infusion pumps, drip stand, pulse oximeters etc.</td>
<td>1 full clean weekly and between each patient use.</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>NOT CONNECTED TO A PATIENT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient wash bowls</td>
<td>1 full clean daily and between each patient use. Can use macerator disposable</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>Bedside oxygen and suction connectors, earpieces for beside entertainment system.</td>
<td>1 full clean daily and between each patient use.</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>Patient fans</td>
<td>Case clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>1 full clean weekly</td>
<td></td>
</tr>
<tr>
<td>Alcohol gel and hand wash containers, clipboards and notice boards.</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Notes and drugs trolley</td>
<td>1 full clean weekly. Drugs trolley to be wiped clean of spillages at the end of each round</td>
<td>Nursing Staff</td>
</tr>
<tr>
<td>Linen trolley</td>
<td>Contact points daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>1 full clean weekly</td>
<td></td>
</tr>
<tr>
<td>Entrance/Exit</td>
<td>Dust removal and wet mop with 2 full cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>Machine clean weekly</td>
<td></td>
</tr>
<tr>
<td>Stairs (internal and external)</td>
<td>Dust removal and wet mop with 2 full cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>Machine clean weekly</td>
<td></td>
</tr>
<tr>
<td>External areas</td>
<td>1 full clean weekly</td>
<td>NHS Property Services</td>
</tr>
<tr>
<td>Switches/Sockets /Data Points</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Area</td>
<td>Task Details</td>
<td>Responsible Party</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Walls</td>
<td>Check clean daily, Dust weekly, Washing yearly</td>
<td>Domestic Services, NHS Property Services for Wall Washing</td>
</tr>
<tr>
<td>Ceilings</td>
<td>Dust monthly, Washing yearly</td>
<td>NHS Property Services</td>
</tr>
<tr>
<td>All Doors</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>All Glazing inc partitions - Internal</td>
<td>1 check clean daily, 1 full clean weekly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Mirror</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Bedside Patient TV</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Radiators</td>
<td>1 full clean daily of covers and exposed pipework, Annual clean of internal heating element</td>
<td>Domestic Services, NHS Property Services</td>
</tr>
<tr>
<td>Low level Ventilation grilles extract and inlets</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>High Level Ventilation grilles</td>
<td>Full Clean Monthly</td>
<td>NHS property Services</td>
</tr>
<tr>
<td>Floor - Polished</td>
<td>Dust removal and wet mop 1 full clean daily, Machine clean weekly, Strip &amp; re-seal yearly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Floor - Non-slip</td>
<td>Dust removal and wet mop 1 full cleans daily, Machine clean weekly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Soft floor</td>
<td>1 full clean weekly, Shampoo 12 monthly and as necessary in between</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Pest Control Devices</td>
<td>Dust removal &amp; 1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Electrical Items</td>
<td>Dust removal 1 full clean weekly</td>
<td>Clinical- Nursing Staff, Non Clinical – Domestic Services</td>
</tr>
<tr>
<td>Cleaning Equipment</td>
<td>Full clean after each use</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Low Surfaces</td>
<td>1 full clean daily &amp; 1 check clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>High Surfaces</td>
<td>1 full cleans weekly &amp; 1 check clean weekly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Chairs</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Beds</td>
<td>Frame daily, Under bed weekly, Whole bed on discharge</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Area</td>
<td>Cleaning Schedule</td>
<td>Responsible Department</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Lockers &amp; Wardrobes</td>
<td>1 full clean daily and 1 check clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Tables</td>
<td>1 full clean daily and 1 check clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>All dispensers and holders</td>
<td>Daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Waste Receptacle</td>
<td>1 Full clean daily + 1 check clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>Deep clean weekly</td>
<td></td>
</tr>
<tr>
<td>Curtains</td>
<td>Clean, change or replace yearly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>Bed Curtains 6 monthly</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Between patients if infected case</td>
<td></td>
</tr>
<tr>
<td>Blinds</td>
<td>Dust &amp; Full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Dishwasher</td>
<td>1 full clean daily + 2 check cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Fridge/Freezer</td>
<td>3 check cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>1 full clean weekly (remove all contents to clean)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Defrost freezer monthly</td>
<td></td>
</tr>
<tr>
<td>Ice Machine and Hot Water Boiler</td>
<td>Daily check clean</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>1 full clean weekly</td>
<td></td>
</tr>
<tr>
<td>Kitchen Cupboards</td>
<td>1 full clean weekly</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Microwave</td>
<td>1 full clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Shower</td>
<td>1 full clean daily + 1 check clean daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Toilets</td>
<td>2 full cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td></td>
<td>Spot cleaning as required</td>
<td></td>
</tr>
<tr>
<td>Replenishment</td>
<td>2 times daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Sinks</td>
<td>2 full cleans daily</td>
<td>Domestic Services</td>
</tr>
<tr>
<td>Bath</td>
<td>1 full clean daily &amp; between use</td>
<td>Domestic Services</td>
</tr>
</tbody>
</table>
Appendix 11

Cleaning in the Event of an Outbreak

The nurse in charge will notify the Domestic Services Supervisor when special cleaning in the event of an outbreak is required.

A notice saying “Please see Nurse in Charge before entering” will be displayed at the entrance to the room by nursing staff. This is to advise staff to seek assistance before initial entry into the area.

The Domestic Services Supervisor will ensure that all staff working in the area are aware of the correct procedure to follow and will supply them with separate equipment (held solely for cleaning in the event of an outbreak) to include:

- Yellow Mop and bucket
- Yellow Single use Cloth/disposable paper/nursing wipes
- Paper towels
- Non sterile single use gloves
- Yellow single use apron
- General purpose detergent
- Hypochlorite tablets
- Orange waste bags
- Red Plastic Bags and Water Soluble Linen Bags
- Vac bags and Filter – For carpeted areas

Cleaning will be carried out daily unless specified by the outbreak management group or Infection Prevention & Control Lead

The cleaning procedure will be as follows:-

- Gather equipment
- Don single use apron and gloves before entering the area
- Damp dust all surfaces using single cloth, dedicated bucket and a solution of 1000 parts per million sodium hypochlorite. The process is to be repeated using a solution of neutral detergent and warm water
- Ensure that the door handle is cleaned and dried thoroughly.
- Damp dust blinds
- If floor area is carpeted then clean with a vacuum cleaner fitted with High Efficiency Particle Extraction Filtration. Steam clean soiled areas
- Remove all waste, Clean waste holders
- Whilst still wearing protective clothing remove all waste and equipment to the sluice room
- Dispose of waste and clean and dry all equipment. Mops used should be placed in a water soluble bag, then a red bag and laundered, If used disposable mop heads to be disposed of between cleaning events
- Remove protective clothing and dispose of as clinical waste
- Return equipment to storage area
- Thoroughly wash, rinse and dry hands
- Curtains do not need to be changed unless soiled or at the request of the Infection Prevention & Control Lead until the outbreak is over.

6. The above cleaning regime may need to be repeated several times per day during an outbreak.
Appendix 12
Recommended Terminal Cleaning

The nurse in charge will notify the Domestic Services Supervisor when an infected patient is discharged.

The cleaning services will ensure that they:

a. Damp dust all surfaces using single cloth and a solution of hypochlorite 1000ppm and warm water.
b. Rinse and dry metal surfaces
c. Clean all toilets, showers and sinks.
d. Clean and polish all mirrors and internal windows.
e. Remove all waste, Clean waste holders
f. Clean and dry door handles
g. Change and launder all curtains in the affected room
h. Damp dust blinds
i. Vacuum and mop floors.

In the event of a Clostridium difficile infection this can be forgone in preference for Hydrogen Peroxide Vapour fogging of the room if the room design so permits.
12 Screening of MRSA in the Community Policy

12.1 Introduction

*Staphylococcus Aureus* is the most common source of healthcare acquired infections in the world. A resistant strain of this organism called MRSA which will cause a proportion of these infections has been found to colonise people in the wider community. Following a review of the NHS by Lord Darzi, the NHS Operating Frameworks for 2008/09 and 2009/10 require all health care providers to ensure that all patients are screened for MRSA carriage. In line with government policy Suffolk Community Healthcare will screen all relevant elective and urgent admissions and take the appropriate action to actively treat all MRSA colonised patients.

12.2 Purpose

The purpose of this policy is to ensure all relevant patients admitted to Suffolk Community Healthcare locations are:

- Screened for MRSA carriage
- Provided with suitable information on MRSA carriage and decolonisation
- Receive a suitable and effective decolonisation course of treatment
- Are reviewed for MRSA following the development of signs of infection during an admission.

12.3 Who To Screen

12.3.1 In accordance with DH guidance all patients who are admitted to Suffolk Community Healthcare locations for either elective or urgent care or for surgical procedures with the SEPT Podiatry service will be screened for MRSA carriage. The only DH allowed exceptions to this policy are patients who are admitted for the following types of care:

- Endoscopy of the Gastro Intestinal Tract
- Paediatric patients
- Minor Dermatology procedures e.g. Warts and other liquid nitrogen treatments
- Outpatient appointments
- Ophthalmology
- Dental
- Routine Obstetrics
- Pain management
- STOPs

NB: The majority of patients who are transferred to Suffolk Community Healthcare from an acute sector provider will have been screened for MRSA by that provider and as such will not require screening on transfer unless the patients records demonstrate no screening has occurred.

12.3.2 In line with the DH policy the following patients will require screening by Suffolk Community Healthcare:

- Direct admissions to the Community Hospitals by GP’s
- Admissions to the respite care beds in Blue Bird Lodge
- Patients undergoing foot & ankle surgery
- Any patient transferred from an acute provider with no record of MRSA screening having been completed

12.4 When to Screen Patients

Patients accessing Suffolk Community Healthcare services will be screened at the following times:
- As part of the admission procedure for those being admitted directly to a community hospital or for those not identified as being screened by an acute care provider.
- As part of the pre-operative assessment process for patients undergoing foot and ankle surgery.
- As part of the investigation process for patients who develop wound or device related infections whilst receiving care as either an inpatient of one of the community hospitals or in their own home.

12.5 How to Screen Patients

12.5.1 Ensure all patients who require screening are provided with suitable information on MRSA Screening and Decolonisation

12.5.2 All patients undergoing screening will require a minimum of two swabs to be taken:

- One swab of the nostrils (both nostrils can be swabbed with the same swab)
- One swab from the groin or perineum

12.5.3 In addition depending on the patient’s individual situation swabs will be required from:

- One swab from each invasive device the patient may have, the area to be swabbed is the point at which it enters the patient.
- One swab from each active wound the patient may have.
- If the patient has an active Urinary Tract Infection then a urine specimen will be required.

12.6 Screening Technique

12.6.1 The recommended method to be used when taking swabs is

a. Nasal swabs: moisten swab in sterile normal saline or the gel at the bottom of the swab container, the sample should be taken from the anterior nares, the swab should be inserted into the forward area of the nostril and should be rotated gently. (See picture)

b. Groins or perineum: moisten swab in sterile normal saline or the gel at the bottom of the swab container, wipe over area in a zigzag and rolling motion

c. Wounds and invasive device entry points: If wound is dry then dampen swab with sterile normal saline, wipe swab over area in a zigzag and rolling motion avoiding the wound margins

d. Catheter urine samples: Samples should be taken from the sample port after cleansing area with an alcohol swab. The sample should be taken with a sterile syringe

e. All specimens must be comprehensively labelled as "MRSA screen" and the request card should provide explicit details of the site screened especially if multiple sites are involved.

f. All screening specimens taken should be clearly documented in the patient’s notes, to include sites and date of screening.
12.7 Consideration of Consent

When undertaking any clinical procedure the practitioner responsible for the procedure must ensure that the patient has given informed consent to the procedure, for more information please see Consent Policy. Where the practitioner or anyone involved in caring for the patient has any concerns regarding the capacity of the patient to consent to the procedure, the practitioner should assess the patients capacity to consent, and if appropriate make a Best Interests decision as to whether the patient should undergo the procedure, for more information please see the Mental Capacity Act Policy.

12.8 Decolonisation (See Appendix 13)

12.8.1 All patients who are found to be positive for MRSA will need to be decolonised as part of their continuing care or prior to surgery with the foot and ankle service.

12.8.2 Decolonisation of patients on admission to a community hospital:

- All MRSA positive patients will need to be isolated in single rooms whilst decolonisation is undertaken.
- The initial decolonisation regimen is
  - A 5 day course of topical body washes with an antiseptic solution, the recommended one for Suffolk Community Healthcare is Octenisen.
  - Towels and bedding to be changed daily
  - The hair to be washed twice in the 5 day period with the antiseptic solution.
  - A concurrent 5 day course of Mupiricin nasal ointment TDS to be applied.
  - On completion of the 5 day regimen wait 2 days to allow the skin's normal flora to re-establish itself.
  - Repeat the screen of all previous sites.
- If this screen is negative repeat it twice more at 24hr intervals once 3 negative screens have been received the patient can come out of isolation.
- If any of the screens have a positive MRSA result, repeat the initial decolonisation regimen.
- If decolonisation has not been achieved after 3 attempts the process should stop and the patient be managed as MRSA positive for the remainder of their admission and a record of the decolonisation attempts and outcome must accompany them on discharge or transfer.

12.8.3 Decolonisation of Patients attending for Podiatric Surgery

- The patients should be prescribed a 5 day course of antiseptic body wash and Mupiricin as described for inpatients above.
- Arrangements should be made for repeat screening 7 days after prescribing the decolonisation regimen.
- If the initial screen is negative, repeat the screens at 24-72 hr. periods depending on the ability of patients to re-attend for this.
- If any of the repeat screens are positive repeat the decolonisation regimen, this can be done up to 3 times.
- If the patient fails to become negative for MRSA, surgery can be undertaken following discussion between the clinician and patient with due regard to the risks and benefits of the procedure. In this situation further advice can be provided by the Infection Prevention & Control Lead.

12.9 Decolonisation Of Transfer Patients

If a patient is transferred from an acute provider to a community hospital whilst undergoing decolonisation the patient should be isolated and the original decolonisation regimen continued and then repeat screened as per this policy.
12.10 Monitoring Of Policy

All sites in Suffolk Community Healthcare who are required to screen patients will submit a monthly report detailing:
- The number of patients who meet the criteria for screening
- The number of patients who have been screened
- The number of patients found to be positive for MRSA
- The number of patients who have undergone a course of decolonisation

12.11 Staff Training

All staff will be trained on how to collect an MRSA swab specimen and which information to provide to patients and relatives.

References

80. Department of Health (2010); MRSA screening – Operational Guidance 3; Gateway reference number 13482
Appendix 13
Inpatient Unit MRSA Screening Flowchart

Is the patient a Direct admission?

Yes

Screen within the first 24hrs of arrival

No

Have they been screened by the previous care provider?

Yes

No further action required

No

Initial Screen:
1. Both Nostrils
2. Perineum
3. Any active wounds
4. Any Invasive devices

Is the patient positive?

No

No further action required

Yes

Isolate & Decolonise with a 5 day programme of a topical nasal antibiotic with daily body and two hair washes. Wait for 2 days following the end of the programme

Repeat the Initial Screen

Is the patient positive?

Yes

Repeat the decolonisation programme and initial screen timeline

No

Is the patient positive?

Yes

Repeat the Screen every 24hrs until 3 clear screens achieved. If any subsequent screens are positive repeat the decolonisation programme

No

Attempt final decolonisation regimen

No

Is the patient positive?

Yes

Treat as positive and record decolonisation in the records

No

Repeat the Initial Screen
13 Management of Patients with MRSA Policy

13.1 Introduction

13.1.1 Staphylococcus aureus (S. aureus) can be carried in a number of sites on the body e.g. nose and perineum. These areas are called carriage sites. Up to 30% of the population are nasal carriers at any one time. Staphylococcus aureus is usually a commensal, neither benefiting nor harming the host. However, if it gains access to tissues beneath the skin or mucosa it may cause infections e.g. abscesses, wound/chest infections. It may, rarely, cause severe systemic infections.

13.1.2 MRSA is the name given to strains of S. aureus that are resistant to Meticillin. Meticillin is an antibiotic that is not used clinically but Meticillin Resistant S.aureus is often resistant to other commonly used antibiotics. Like S. aureus, MRSA may colonise or cause an infection. There is no evidence that MRSA causes more severe infections than other strains of S. aureus, but treatment is often more difficult. In an extremely small number of patients, often with severe underlying disease, MRSA may be a contributing factor in their death. Generally the worst scenario for an individual with MRSA in the community environment is that they have an infection in a wound, which is then slow to heal.

13.2 Purpose

Suffolk Community Healthcare is committed to limiting the spread of MRSA within our health care premises and the wider community, by ensuring people with MRSA are managed effectively. This document aims to provide guidance for staff as to the management of patients with MRSA. This guideline will not be detailing screening of patients as this is covered in a separate policy.

13.3 Definitions

13.3.1 Colonisation

MRSA lives harmlessly on the skin, on hair follicles and in the nose of some people. This is described as colonisation, which is more common than infection. Carriage can be transient, but in some cases carriage is persistent. Patients who have Peg tubes for enteric feeding or long term urinary catheters in situ (foreign device) may have extended periods of colonisation which may not resolve until these have been removed. Colonisation is common in chronic wounds e.g. leg ulcers and pressure ulcers. Some can develop infection based on individual risk factors and their immune status. It is not always possible to predict who will go on to develop infections. Certain admissions should be monitored in line with organisations screening policy to detect patients who are colonised and hence at potentially greater risk of developing infection.

13.3.2 MRSA Infection

MRSA infection occurs if the organism invades the skin or deeper tissues and multiplies to cause a local or systemic reaction causing pain, redness swelling cellulites, pus and pyrexia. Infections can range from minor skin lesions to deep abscess, chest infections, pneumonia, and urinary tract infections. MRSA infection should be suspected if wound exudates increases, or if healing is slow and for any infection that is not responding to antibiotics.

13.3.3 MRSA Bacteraemia

MRSA bacteraemia is a blood stream infection. This is a life threatening sepsis that can lead to death if not diagnosed early and treated effectively. Patients who have an MRSA bloodstream infection will need to be managed in a general hospital. Surveillance and reporting of MRSA bloodstream acquisitions is mandatory for all health care providers. Reports must be made to the Dept. of Health through Public Health England (PHE). The likelihood of a patient developing an MRSA Bacteraemia in a community setting is considered low.
13.4  Risk Factors For Acquiring An MRSA Infection

13.4.1 There are many factors that can increase the risk of patients developing infection in hospital. Patient’s resistance to infection can vary depending on their immune status.

13.4.2 Other factors include:

- History of MRSA or spouse is MRSA positive
- Hospitalisation in the past year
- Transfers from hospital abroad
- Recent surgery or trauma
- Recent or frequent antibiotic use or incomplete course of antibiotics
- Patient in long term care institution (care home or hospice)
- Dialysis and end stage renal failure
- Diabetes Mellitus
- Permanent indwelling catheter or medical device that passes through the skin into the body
- Venous ulcers
- Pressure ulcers
- Skin disease: Eczema, psoriasis or dermatitis

13.5  Management Of A Patient With An MRSA Infection

13.5.1 MRSA infection can be suspected in patients who have conditions e.g. chest infections, urinary infections, skin and wound infections that are not responding to antibiotics or for patients who have had incomplete or repeated courses of antibiotics or any of the risk factors above.

13.5.2 Any antibiotic treatment should be carefully assessed and should only be used in accordance with Antimicrobial Prescribing Guidelines. Certain broad-spectrum antibiotics may encourage the growth of MRSA and increase the risk to the patient and health care setting.

13.5.3 Delay in treating infection can increase the risk of severe infections developing. Patients who have confirmed MRSA infection will usually require a course of antibiotics and may also need nasal and skin eradication.

13.5.4 Advice about appropriate blood tests and treatment should be sought from a consultant microbiologist.

13.5.5 The choice of antibiotics will depend on:

- The clinical condition of the patient
- The severity and site of the infection and on the particular strain of MRSA
- The presence of devices e.g. urinary catheters and other risk factors
- The presence of underlying medical conditions

13.5.6 All cases must be closely monitored to detect signs of deterioration. The Infection Prevention & Control Lead must be given regular updates on the patient’s condition. Patients with severe clinical infections may need to be transferred to a general hospital, as they may need to be given intravenous antibiotics e.g. Vancomycin or Teicoplanin, which are toxic. Surgery to debride wounds may also be necessary in some situations.

13.6  Management Of MRSA Bacteraemia

13.6.1 If a bloodstream infection is suspected or detected, the patient must be referred to a general hospital for intravenous antibiotics immediately.

13.6.2 The Infection Prevention & Control Lead must be informed in order that a notification to PHE can be made once a definite confirmation has been made.
13.6.3 A Root Cause Analysis (RCA) needs to be completed for ALL cases of MRSA Bacteraemia. This investigation and analysis and subsequent action plan should be conducted by the staff responsible for and involved in the patient’s care. Advice can be sought from the Infection Prevention & Control Lead or DIPC.

13.6.4 Every case of MRSA bacteraemia MUST be reported as a Serious Untoward Incident (SUI) and be investigated using the RCA, and in the first instance be reported to the Clinical Quality and Safety Group.

13.7 Precautions For MRSA Infected Patients

13.7.1 Hand Decontamination - Effective hand decontamination is the most important infection control measure, which must be undertaken by everyone. Staff and visitors should decontaminate their hands on entering and leaving clinical areas.

- Apply waterproof dressings to cuts, abrasions and lesions especially on the hands
- Maintain strict hand decontamination before and after each patient contact and between different tasks performed for the same patient
- Following contact with body fluid
- Following contact with contaminated items and bed linen
- Prior to application of and on removal of gloves and aprons
- Before handling invasive devices attached to the patient
- Before serving or preparing food

13.7.2 Personal Protective Equipment - Selection of personal protective equipment is based on the assessment of the risk of transmission of microorganisms to the patient and the risk of contamination of healthcare worker’s clothing and skin by patients' blood, body fluid, secretions or excretions.

13.7.3 Appropriate protective clothing, plastic aprons and gloves should be worn for direct patient contact, with infected tissues, contaminated dressings or linen.

13.7.4 No special precautions are necessary if serving food, beverages, or talking to the patient.

13.7.5 Wear sterile gloves for contact with sterile body sites.

13.7.6 Gloves and plastic aprons should be worn when in contact with non-intact skin or mucous membranes, body fluid.

13.7.7 Gloves and aprons are a single use item and must be removed as soon as individual patient care is completed. Hand decontamination must be carried out following removal of gloves as hands can be re-contaminated on removal. Gloves must be changed between different care or treatments on the same patient.

13.8 Waste Disposal

13.8.1 Waste should be disposed of according to the Waste Management Policy. In patient settings clinical waste should be placed in a designated orange bag in the room or by the bedside and secured and tagged when no more than three quarters full.

13.8.2 For patients receiving care in their own homes the waste must be treated as infectious and arrangements must be made for the removal of this waste.

13.9 **Laundry Disposal** - Laundry should be considered infective and disposed of in an alginate bag. Secure the bag, place in an impermeable bag for soiled or infected linen and seal before taking outside of the room or away from the bedside.

13.9.1 MRSA will be destroyed by temperatures over 65 degrees C but can also be eradicated or reduced by dilution or use of bleaching products.

13.9.2 Patient's personal clothing can be taken home in a plastic bag and washed in a domestic washing machine.

13.10 **Environmental Decontamination** - A cleaning schedule should be produced, applied and monitored in all clinical areas.

13.10.1 Maintain a clean environment paying special attention to horizontal surfaces where dust settles.

13.10.2 Cleaning of MRSA isolation areas should be carried out at the end of the ward cleaning schedule using colour coded equipment identified for isolation areas, fresh detergent and/or disinfectant. Further advice can be sought from the Infection Prevention & Control Lead.

13.10.3 Crockery and cutlery may be washed in hot water and detergent with the rest of the ward equipment. Disposable equipment is not necessary.

13.10.4 Nursing staff should clean clinical equipment that is not included in domestic cleaning schedules.

13.10.5 Equipment (e.g. sphygmomanometers, stethoscopes, hoist slings) should be dedicated for MRSA positive patients. Shared equipment should be decontaminated between each patient use. Single use or single patient use items should be used whenever possible.

13.10.6 The bed area must be terminally cleaned after the patient is transferred or discharged as per the Environmental Cleaning Policy. Curtains must be changed and laundered.

13.11 **Communication**

13.11.1 A diagnosis of MRSA can instil fear and anxiety in many patients, their families and their carers. Treatment regimens and isolation, if required, can add to distress and uncertainty. Staff must be sensitive to the impact of MRSA on their patients.

13.11.2 The timely provision of both written and verbal information to patients, their relatives and visitors will mitigate feelings of anxiety. This information should include some detail of the treatments or medications they may receive, whether they are allowed to leave their isolation room and advice on the wearing of protective clothing for visitors.

13.11.3 This information should be repeated as often as necessary to ensure the patient, and their family, are informed and are involved in care decisions.

13.11.4 Patients who are colonised or infected with MRSA should be informed of what this means and if treatment is indicated this should be explained. The MRSA leaflet should be given to them and their family or visitors.

13.11.5 Visitors should be advised of any precautions, which may be necessary, e.g. hand decontamination before leaving the room or cohort area. Protective clothing is not usually necessary for visitors unless they are involved in the care. Any isolation protocols should be explained to patients and visitors by staff.
**13.12 Staff Screening**

Screening of staff is rarely required. The decision to screen staff should only be made in consultation with both the Infection Prevention & Control Lead and the DIPC as part of an outbreak management process. Results of staff screening, and any subsequent treatment, will be dealt with by the Occupational Health Provider.

**13.13 Deceased Patients**

The same Standard Infection Control precautions should be used for the deceased as well as the living. Cadaver bags are NOT necessary.

**13.14 Training**

All clinical staff will receive annual infection control training as a mandatory requirement. Training in all aspects of routine infection control will prepare staff to manage an MRSA infected patient.

**13.15 Monitoring**

13.15.1 Compliance with this guideline will be monitored through the infection control audits undertaken within Suffolk Community Healthcare.

13.15.2 All incidents of MRSA Bacteraemia will be notified by the Infection Prevention & Control Lead to the PHE within 24hrs of occurrence.

13.15.3 All cases of MRSA and management actions will be monitored by the infection control committee and major issues reported to the CG&SG.

**13.16 References**


89. Department of Health. (2003); towards cleaner hospitals and lower rates of infection. A summary of action.


92. Royal College of Nursing (2004); Methicillin resistant staphylococcus aureus (MRSA)-
guidance for nursing staff.
Management of Patients with Clostridium difficile Policy

14.1 Introduction

Clostridium difficile (c.diff) is the most commonly diagnosed bacterial cause of infectious healthcare associated diarrhoea. Causing illness when the balance of the normal gut flora is disturbed by the frequent use of certain antibiotics, e.g. Cephalosporin’s. It accounts for 15-25% of antibiotic associated diarrhoea. Outbreaks of infection are generally prolonged and difficult to control due to the ability for it to spread very easily. The infection causes illness ranging from brief diarrhoea to life-threatening pseudomembranous colitis which in some outbreaks, has led to a number of deaths.

14.2 Purpose

The purpose of this document is to provide guidance primarily for the prevention of Clostridium difficile (C.diff) and secondarily for the management of symptomatic patients and to prevent cross infection to others.

14.3 Definitions

Clostridium difficile: is a bacterium of the Clostridium family, a group of Gram-positive, anaerobic bacilli which is widely found in soil and in the intestinal gut of animals. It is spore forming which enables it to develop into vegetative bacteria and are resistant to drying, heat, stomach acid, alcohol and can survive in the environment for long periods of time. These factors facilitate the transmission of C.difficile spores from infected patients and may contaminate the environment, which allows transmission of infection to vulnerable patients.

14.4 Risk Factors

The following are recognised risk factors for infection
- Elderly (over 65 years)
- Long length of stay in healthcare settings
- Recent use of antibiotics especially broad spectrum e.g. cephalosporin’s, which are harmful to normal gut flora.
- Recent surgery, especially gastro-intestinal surgery
- Serious underlying disease/illness
- Immunocompromising conditions
- Patient having chemotherapy
- Prolonged use of proton pump inhibitors i.e. Omeprazole, Lansorprazole

14.5 Recognition Of Infection

- Toxins produced by C.diff damage the large bowel causing watery, explosive, foul smelling diarrhoea. Ranging from a mild disturbance to a very severe illness.
- Some patients may develop severe pseudomembranous colitis (PMC) with ulceration and bleeding from the colon, toxic megacolon, and, at worst, perforation of the intestine leading to peritonitis, which can be fatal.
- Diarrhoeal stools are typically defined as those that take the shape of the containers i.e. those in the range of type 5 to type 7 on the Bristol Stool Chart, See Appendix 14
- Fever, loss of appetite, nausea and abdominal pain/tenderness may be present.

14.6 Prevention of clostridium difficile

14.6.1 Primary Clostridium difficile infection is nearly always associated with and triggered by, the use of antibiotics, prescribed to treat another condition or given prophylactically. Secondary infection can occur due to ingestion of bacterial spores from the environment. Therefore, prevention of Clostridium difficile infection relies on ensuring that patients do not become susceptible through
disruption of their normal gut flora and on preventing as far as possible their exposure to the
organism.

14.6.2 Regular checks of the history of antibiotics and which if any antibiotics are currently being
administered should be undertaken by clinical staff and pharmacists.

14.6.3 Change from broad spectrum to narrow spectrum antibiotics whenever clinically indicated.

14.6.4 Avoid unnecessary antibiotic usage

14.6.5 Discontinue courses of antibiotics as soon as possible

14.7 Specimen Collection

14.7.1 All patients will be reviewed for potential cause of diarrhoea on every instance of passing a
type 5 to type 7 stool.

14.7.2 If this assessment indicates the potential cause to be C.diff infection a stool specimen
should be sent.

14.7.3 The quantity sent must be at least a ¼ of the specimen pot

14.7.4 The specimen must be type 5, 6 or 7 in consistency.

14.7.5 The specimen request form must state that Microscopy Culture & Sensitivity (MC&S) and
C.diff toxin (CDT) testing is required.

14.7.6 Ensure that all relevant historical and clinical information is included upon therequest form,
e.g. recent travel, recent treatment etc.

14.7.7 There is no requirement to send specimens for C.diff clearance, absence of the infectious
toxin is identified by the absence of diarrhoea.

N.B. Do not send a specimen within 28 days of a previous positive specimen.

14.8 Management of Symptomatic Patients

14.8.1 The patient will be source isolated in a side room within two hours of the confirmed or
suspected diagnosis of infection.

14.8.2 The patient will have either a dedicated en-suite toilet or commode facilities

14.8.3 The patient will be commenced on a strict fluid balance measurement in order to ensure
adequate hydration is maintained.

14.8.4 The current medication will be reviewed within 24hrs of the onset of symptoms with a view
to discontinue were possible current antibiotic treatments and other medications that affect the gut
e.g. PPI’s and Aperients.

14.8.5 A decision to commence Metronidazole treatment for C.diff can be made by the prescribing
clinician and need not be specimen led.

14.8.6 The patient will be provided with an explanation and an information leaflet about their
current condition and the need to isolate them.

14.8.7 All symptomatic patients must be notified to the Infection Prevention & Control Lead within
24hrs.
14.8.8 All confirmed symptomatic cases will be investigated using the Root Cause Analysis methodology.

14.9 Isolation Precautions

14.9.1 Staff will need to ensure the Standard Precautions outlined in the Standard Precautions policies are strictly enforced.

- Hand Hygiene must be soap and water based only, alcohol gels are not to be used.
- Gloves and aprons are to be worn by all staff entering the isolation area to provide care and removed before leaving the room.
- The door must be kept closed and a sign directing visitors to report to the nurse in charge before entering must be displayed upon it.
- All linen must be handled and managed as infected.
- All waste must be considered as infectious.
- The room and all the equipment in it must be cleaned with a 1000ppm hypochlorite solution followed by a general purpose detergent solution daily.
- There is no requirement to have dedicated crockery and cutlery
- The isolation precautions will remain in place until the patient has been asymptomatic for 48hrs.

14.10 Treatment For C.Diff

14.10.1 C.diff falls into 4 distinct categories of infection:

- Mild CDI – typically less than three episodes of diarrhoea (stool type 5-7) in a 24hr period and is not associated with a raised white cell count.
- Moderate CDI – is typically has three to five episodes of diarrhoea (stool type 5-7) in a 24hr period and is associated with a raised white cell count that is <15x10⁹/L.
- Severe CDI – the number of episodes of diarrhoea are not an accurate indicator at this stage. Patients will have a White Cell Count >15x10⁹/L, or an acute rising serum creatinine (>50% increase above baseline), or an acute pyrexia of >38.50C, or evidence of severe colitis either abdominal or radiological signs.
- Life threatening CDI – the number of episodes of diarrhoea are not an accurate indicator at this stage. Patients will have the severe symptoms and may include hypotension, a partial or complete ileus or toxic mega colon or CT evidence of severe disease.

14.10.2 Patients in community settings usually fall into the Mild to Moderate categories and can be treated with antibiotics. Usually this will be Metronidazole 400mg TDS for 10 or 14 days. If patients who do not respond to this treatment or who have recurrent relapses following treatment this may be advanced to Vancomycin 125mg QDS for 10-14 days. It is advisable for GP’s to discuss repeated courses of treatment and the potential need for Vancomycin with the Consultant Microbiologist.

14.10.3 If patients develop signs and symptoms for severe or life threatening CDI they must be transferred to an acute Trust for on-going management, having completed the In Healthcare Transfer form to accompany them (Appendix 15).

14.11 Patients With C.Diff In Their Own Home

The risk of cross infection in the patient’s own home is minimal. However it is possible that symptomatic patients may contaminate their toilet area(s) in their own home and, therefore, should instigate a thorough cleaning regime of those areas.
14.12 Patient Transfers

14.12.1 Patients with confirmed or suspected C.diff **must not** be accepted as a transfer from an acute care provider.

14.12.2 Patients who are scheduled for transfer to another care provider can continue to be transferred so long as the receiving carer is aware of their infectious status, or potential exposure to the infection if they have been cared for in the same bay or ward area as a known infectious patient and is prepared to accept them. In all cases of transfers out which involve active or exposure to known infections an Inter Healthcare Transfer Form must be completed to send with the patient.

14.12.3 A patient with an active Cdiff infection can be transferred/discharged to their own home so long as they can manage their own condition or have the support necessary to enable them to manage it.

14.13 Staff Training

All clinical staff will receive annual refresher training on the identification, management and prevention of C.diff infections as part of their mandatory infection control training.

14.14 Monitoring

14.14.1 All episodes of C.diff and the management actions will be reported to the infection control committee.

14.14.2 All completed Root Cause Analysis investigations will be shared with the infection control committee and the wider organisation for shared learning.

14.14.3 The infection control precautions will be audited during each episode using the Isolation Precautions audit tool.

14.14.4 The compliance with the antibiotic prescribing policy will be audited on a monthly basis and the results passed to the infection control and medicines management committees.

14.15 References


104. High Impact Intervention No.7 (2007) Care Bundle to Reduce the Risk of Clostridium Difficile Infection. DH.


<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3 ![X]</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>4 ![X]</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces ENTIRELY LIQUID</td>
</tr>
</tbody>
</table>
### Appendix 15

Inter-Healthcare Infection Control Transfer Form

<table>
<thead>
<tr>
<th>Patient Details: (insert label if available)</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>GP:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>NHS Number:</td>
<td>Current Patient Location</td>
</tr>
<tr>
<td>Date of Birth:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Receiving Location: Hospital/Ward/Care</th>
<th>Transferring Hospital:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home/district nurse</td>
<td>Contact Number:</td>
</tr>
<tr>
<td>Is the Infection control team or ambulance service aware of transfer? Yes / No</td>
<td>Infection Control Aware of Transfer? Yes / No</td>
</tr>
<tr>
<td>Contact Number:</td>
<td>Is the Patient an Infection Risk?</td>
</tr>
<tr>
<td></td>
<td>Please tick the appropriate box</td>
</tr>
<tr>
<td></td>
<td>☐ Confirmed risk</td>
</tr>
<tr>
<td></td>
<td>☐ Confirmed risk</td>
</tr>
<tr>
<td></td>
<td>☐ Suspected risk</td>
</tr>
<tr>
<td></td>
<td>Organism:</td>
</tr>
</tbody>
</table>

If the patient has diarrhoeal illness please indicate bowel history for the last week  
(Use the Bristol Stool Chart in Appendix 14)

<table>
<thead>
<tr>
<th>Monday</th>
<th>Tuesday</th>
<th>Wednesday</th>
<th>Thursday</th>
<th>Friday</th>
<th>Saturday</th>
<th>Sunday</th>
</tr>
</thead>
</table>

Is the diarrhoea thought to be infectious in nature? Yes / No

Relevant Specimen Results (including MRSA admission screens, glycopeptide resistant enterococcus, C.difficile, multi resistant acinetobacter) treatment and antimicrobials.

<table>
<thead>
<tr>
<th>Specimen</th>
<th>Date</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Treatment:</th>
</tr>
</thead>
</table>

| Other Information: |

<table>
<thead>
<tr>
<th>Is the patient aware of their infection diagnosis?</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient require Isolation Precautions?</td>
<td>Yes/No</td>
</tr>
</tbody>
</table>

If Yes please found the receiving unit in advance

<table>
<thead>
<tr>
<th>Name of Staff Completing the form</th>
</tr>
</thead>
<tbody>
<tr>
<td>Print Name</td>
</tr>
<tr>
<td>Contact Number</td>
</tr>
</tbody>
</table>
15 Outbreak Management Policy

15.1 Introduction

15.1.1 Outbreaks of infection vary greatly in extent and severity, ranging from a few cases of diarrhoea and vomiting, to a larger outbreak of food poisoning involving potentially hundreds of people, to a single case of diphtheria.

15.1.2 This section of the policy manual is concerned primarily with the investigation, management and control of outbreaks of infectious disease in the hospital locations. Outbreaks in the surrounding communities will primarily be managed by the Consultant in Communicable Disease Control (CCDC) for which we as community healthcare providers will need to provide support as required.

15.1.3 The principles of outbreak management are the same in all areas and it is not to be considered unusual for us as community providers to have to collaborate with local acute sector providers and the local Health Protection Unit or local authorities.

15.1.4 Outbreaks cannot be easily defined and the control procedures can be simple or extended according to developing circumstances. The level of response to a possible outbreak will depend upon the agent involved as much as the number of persons affected.

15.2 Purpose

The purpose of this policy is to identify procedures for the management of outbreaks of infectious diseases to prevent further transmission of suspected or confirmed infections.

15.3 Definitions

15.3.1 Suspected Outbreak – suspicion that there may be an outbreak of infection, without confirmation via laboratory results.

15.3.2 Outbreak – Two or more associated cases of a communicable disease or infection. Single cases of severe or potentially highly infectious diseases should be treated as if it were an outbreak.

15.3.3 Acute Outbreak – an outbreak which develops quickly over a few hours e.g. food poisoning caused by toxins.

15.3.4 Non-acute Outbreak – an outbreak which develops over a number of days or weeks e.g. influenza, salmonella.

15.3.5 Major Outbreak – A widespread outbreak or one involving a particularly virulent organism.

15.3.6 Notifiable Diseases - There are certain diseases which are notifiable to the Local Authority Proper Officer under the Health Protection (Notification) Regulations 2010. It is the legal responsibility of the attending Medical Officer to make the notification.

15.4 Recognition

15.4.1 Actual or potential outbreaks of infection may be identified by one or more of the following methods;

- Laboratory surveillance of microbiology reports may show an increase in the number of isolates of a single species.
- Medical or nursing staff may notice an increased incidence of a specific organism or similar symptoms, from the ‘background’ for that clinical area.
- Occupational Health may notice an increased incidence of a specific infection or similar symptoms.
The Consultant in Communicable Disease Control (CCDC), of the local Health Protection Units carry out surveillance of notifications in collaboration with Environmental Health Officers. A rising incidence may suggest the presence of an outbreak.

15.4.2 It is essential that any member of clinical staff report their suspicions to the senior nurse on duty.

15.4.3 The Infection Prevention & Control Lead should be contacted promptly. Out of hours contact the Senior Manager on Call (SMOC) who will contact the Infection Prevention & Control Lead.

15.4.4 The Infection Prevention & Control Lead will notify the Director of Infection Prevention & Control (DIPC) once the initial assessment and actions are put in place to discuss arrangements and consider the need for an outbreak committee to be called.

15.4.5 It does not matter if investigation subsequently shows an outbreak is not occurring. It is important to recognise potential outbreaks promptly to enable control measures to be implemented as soon as possible to prevent further cases.

15.4.6 The following should always be reported to the Infection Prevention & Control Lead, or the Senior Manager On-call out of hours (incidents involving a member of staff should also be reported to Occupational Health):

- An increased evidence of vomiting and/or diarrhoea occurring either over a short or extended period amongst patients or staff
- Several cases of a similar infection (based on clinical diagnosis) in patients/clients and staff who have had close contact with each other (e.g. respiratory symptoms)
- An unusually high number of absences amongst staff

15.4.7 When influenza is diagnosed, the Infection Prevention & Control Lead or the Senior Manager On-Call should immediately contact the Health Protection Unit in office hours, or the on-call Public Health Clinician out of hours for advice, to ensure that the correct procedure is followed for the administration of prophylaxis/treatment if deemed appropriate.

15.5 Initial Investigation

The following information will be required when an outbreak is suspected:

- The number of individuals affected
- The time of the occurrence of symptoms within each individual
- The symptoms of each affected individual
- Suspected source
- This can be recorded on the Outbreak Summary Report form at Appendix 16.

15.6 Formation of the Outbreak Control Group

15.6.1 The decision to call a meeting of the Outbreak Control Group is the responsibility of the Director of Infection Prevention and Control or the most Senior Director available or on call in the absence of the DIPC.

15.6.2 This decision will be made based upon the available evidence and advice from the following:

- The local or On-call CCDC if contacted for advice.
- The Infection Prevention & Control Lead
- The Medical Director

15.6.3 Depending on the nature of the outbreak external invitees to the meetings may be required e.g. local authority Environmental Health Officers if it is a suspected food borne source.
The suggested outbreak control group would comprise the following roles and responsibilities:

<table>
<thead>
<tr>
<th>MEMBERSHIP</th>
<th>RESPONSIBILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DIPC *</td>
<td>Chair Meetings</td>
</tr>
<tr>
<td>CEO or Other Director Level</td>
<td>Ensures appropriate resources are made available &amp; Communications with wider Serco Medical Group</td>
</tr>
<tr>
<td>Representative *</td>
<td>GP and Acute Trust Liaison</td>
</tr>
<tr>
<td>Medical Director *</td>
<td>Infection Prevention and Control Advice</td>
</tr>
<tr>
<td>Infection Prevention &amp; Control Lead</td>
<td>Infection Prevention and Control Advice</td>
</tr>
<tr>
<td>Microbiologist</td>
<td>Microbiology Advice</td>
</tr>
<tr>
<td>Local Area Manager</td>
<td>Wider Locality Actions</td>
</tr>
<tr>
<td>Head of Nursing</td>
<td>Organisational Community Staffing resources</td>
</tr>
<tr>
<td>Senior Modern Matron</td>
<td>Wider Hospital Staffing resources</td>
</tr>
<tr>
<td>Site Modern Matron</td>
<td>Providing current situation information &amp; reports and ensuring measures decided are enforced at site level.</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>Ensuring adequate cleaning services available</td>
</tr>
<tr>
<td>CCC Manager</td>
<td>CCC support and public enquiry management</td>
</tr>
<tr>
<td>Press Officer</td>
<td>Prepare press releases and staff information releases as required</td>
</tr>
<tr>
<td>Admin Staff</td>
<td>Minutes of meetings and records of actions</td>
</tr>
</tbody>
</table>

The following will be invited as the situation requires:

- **CCDC**: Community situation advice, provide links to national support services.
- **EHO**: Will be required to investigate food borne outbreaks.
- **Local Water Company**: May be required if a water based problem is identified.
- **Occupational Health**: If staff health is affected.

The members designated with an * may be required to be the public face of an outbreak control situation.

**NB.** It is not necessary for all staff to meet face to face and conference calls should be utilised when possible. Not all staff are required for all outbreaks or for a whole outbreak and membership will be amended on a situational basis.

### 15.7 Actions Required Of The Outbreak Control Group

#### 15.7.1 Clinical

- A case definition should be made
- At risk groups and contacts must be clearly defined
- The optimal clinical management of cases should be agreed
- The appropriate control measures should be agreed upon
- It should be decided whether contact tracing is applicable/ appropriate

#### 15.7.2 Information

- The group should agree the advice to be given to patients, relatives and visitors
- Clear guidance should be given to all clinical and support staff
- All information should be released in written form
15.7.3 Organisational

- Resource issues should be discussed. These will include staffing, funding, supplies, domestic services etc. Secretarial support will be provided by the CCC.
- It should be decided whether help from outside organisations is necessary.
- Each member of the group should have a clearly defined role and responsibilities for carrying out actions (see responsibilities in the table above).
- The group should also decide when to meet and how frequently to review progress and it may be necessary to identify an ‘incident room’ for the duration of the outbreak.

15.7.4 Communication

- Channels of communication should be utilised within the organisation and wider Serco medical group. It may be appropriate to provide an intermediate report to the group Executive Board.
- Channels of communication should also be set up outside of the organisation with other involved agencies.
- A press release statement should be prepared and a designated person appointed to deal with the media if required.

15.7.5 Closing of the Outbreak

- The OCG must meet and define the end of the outbreak situation.
- A final report must be prepared by the DIPC and disseminated to the CEO, CG&SG, wider Serco medical group as required, the CCG and any other involved agencies.
- There should be a post-outbreak review of the control measures and future recommendations made.

15.8 References

107. Public Health (Control of Diseases) Act 1984
108. Public Health (Infectious Diseases) Regulations 1988
109. HSG (93)56 Public Health: Responsibilities of the NHS and roles of others
114 Health Protection (Notification) Regulations 2010 (SI 2010/659)
115 Health Protection (Local Authority Powers) Regulations 2010 (SI 2010/657)
116 Health Protection (Part 2A Orders) Regulations 2010 (SI 2010/658),
117 CDC Updated Norovirus Outbreak Management and Disease Prevention Guidelines Recommendations and Reports March 4, 2011 / 60(RR03);1-15
Appendix 16

Infection Control Outbreak Summary Report Form

Facility ___________________________ Ward/Dept: ___________________________
Description of illness: ______________________________________________________

Start Date: ___________________________ End Date: _____________________________
Total no. of patients affected: _________________________________________________
No. of patients of ward/unit: _________________________________________________
Total no. of specimens obtained: _______________________________________________
Results: (both positive & negative) _____________________________________________

Total no. of staff affected:
Occupational Health involvement: Yes No
(delete as necessary)
Infection Control involved: Yes No
(delete as necessary)
Brief description of advice given: _____________________________________________

Action taken: __________________________________________________________________

Details of bed closures or restrictions on admission/discharges and transfers:
____________________________________________________________________________

Name: ___________________________ Job Title: ___________________________

1 copy to be sent to Infection Control Nurse
Signature__________________________________________________
Date completed: ___________________________
16 Aseptic Non Touch Technique Policy

16.1 Introduction

Many patients will require an invasive procedure to be undertaken as part of their treatment. It is commonly recognised that these invasive procedures will compromise the body’s natural defence mechanisms against microbial contamination. It is therefore inherent upon health care practitioners to ensure that any invasive procedure is undertaken in a manner that will reduce the level of microbial contamination of potentially vulnerable body sites in order to maintain patient safety.

16.2 Purpose

The purpose of this policy is to detail the acceptable standard required for the undertaking of Aseptic Non Touch Technique (ANTT) procedures through:

- An understanding of the need for aseptic technique
- An understanding of the principles of ANTT
- The use of ANTT when performing an invasive procedure
- The use of ANTT in association with other relevant organisation policies and guidelines.

16.3 Definitions

16.3.1 Aseptic Non Touch Technique

Aseptic non touch technique (ANTT) is a Theoretical Framework developed using research based evidence in order to standardise practice and rationalise the many different techniques currently in use. It is a method that is designed to reduce microbial contamination of a vulnerable body site. This may include such procedures as wound dressings or more invasive procedures such as intravenous cannulation or inserting a urinary catheter. See Appendix 17 for further procedures.

16.3.2 A Clean Technique

This is a modified technique that can used for dressing chronic wounds that are healing by secondary intention e.g. Leg Ulcers, Pressure sore and dehisced wounds that will already be heavily colonised with environmental microorganisms. It can also be used for dressing simple grazes, removing sutures and for endo-tracheal suction. For these procedures clean non sterile gloves and a disposable plastic apron should be worn. In addition chronic wounds may be irrigated or cleansed using potable or drinking water rather than sterile fluids.

16.4 Principles of Asepsis

16.4.1 Prepare the area in which the procedure is to be performed, including decontamination of the work surfaces, trolley or tray to be used with detergent and water or detergent wipes and dry thoroughly. In patients own homes this may need to be modified depending on the surfaces available.

16.4.2 Ensure all hand and wrist jewellery is removed in accordance with the bare below the elbows requirements of the SCH uniform policy.

16.4.3 Perform hand hygiene in accordance with the Hand Hygiene Policy. The level of hand hygiene will depend on the nature of the procedure to be undertaken.

16.4.4 A sterile field should be created through the use of drapes and protective clothing, the size of this field and level of protection will depend on the complexity of the procedure to be undertaken. For example:

- Surgery or central venous catheterisation will require a large area and maximum protective measures.
- A small drape, sterile gloves and plastic apron will be sufficient for a wound dressing.
Clean non sterile gloves and plastic apron should be adequate for phlebotomy or I.V drug administration.

16.4.5 Assemble all appropriate equipment for the procedure. Packaging must be checked for completeness and dates to ensure they have not expired.

16.4.6 When items are opened onto a sterile field this should be done by peeling the package open and allowing the item to fall from a height that will not cause damage or allow it to bounce.

16.4.7 Wherever possible do not expose wounds or undertake aseptic procedures within 30 minutes of an area that has had routine bed making or domestic cleaning performed.

16.4.8 Soiled dressings must be removed carefully to prevent microbial shedding into the air using the inverted waste bag from the dressing pack or gloves to protect hands.

16.4.9 Wounds must be exposed for a minimum amount of time to reduce contamination and maintain temperature.

16.4.10 Change gloves and perform hand hygiene at any time that contamination has occurred. NEVER apply hand hygiene products to gloves.

16.4.11 Perform the procedure including skin preparation in a manner that will not contaminate a sterile or vulnerable site. Always work from the centre to the edge of an area.

16.4.12 Any solutions used to clean or irrigate the area must be sterile.

16.5 Aseptic Non Touch Technique (ANTT)

16.5.1 Principles of ANTT

- Always wash hands effectively
- Never contaminate key parts
- Touch non key parts with confidence
- Take appropriate infection control precautions

16.5.2 When clean, non-sterile gloves are worn rather than sterile gloves a “non touch technique” is required to maintain asepsis. In practice this means avoiding touching key parts of equipment or the patient during the procedure. In general terms the following areas staff should avoid touching:

- Sterile equipment that will be used invasively e.g. needle or catheter tips.
- Sterile products used for preparing solutions e.g. syringe hubs or tips of needles.
- Seals of IV connectors that have been disinfected in preparation for the administration of medicines.
- The surface of sterile dressings that will be in contact with wounds.
- Skin after it has been disinfected prior to cannulation or phlebotomy.
- Open wounds and invasive device sites.

16.6 Essential Steps For All Procedures

16.6.1 The following are required for aseptic, aseptic non touch or clean procedures.

- Dispose of Single Use items after each use.
- Dispose of single patient use items after treatment
- Decontaminate all re usable items in line with local policies and manufacturer’s instructions.
- Store sterile equipment in clean, dry conditions off the floor.
- Dispose of waste as per the waste management policy
16.6.2 Minimise interventions that result in a break in closed systems e.g. IV or urinary catheter manipulation

16.7 Management of chronic wounds

16.7.1 If dressings are removed by soaking, a plastic impermeable liner/bag should be placed in the bucket/bowl before filling with water.

16.7.2 After the wound has been washed, then water should be disposed of in a sluice or a sink which is separate from the hand washing sink. The plastic liner should be disposed of and the bath or bowl should be thoroughly cleaned with detergent solution and then dried to ensure that pathogens are removed. This process should be undertaken after each separate patient episode.

16.8 Staff Training

All newly qualified or appointed clinical staffs who are required to undertake aseptic non touch technique procedures are to be trained and assessed as competent before undertaking them and a record kept in their personal folder. A staff competency assessment form is at Appendix 18.

16.9 Monitoring

16.9.1 A record of staff competence to undertake ANTT procedures will be maintained by all locations.

16.9.2 Failures of staff competency are to be notified to the infection control committee for further action.

16.9.3 The audit of the policy will be through staff questioning on location infection control audits.

16.10 References


# Appendix 17

## Recommended Technique For Routine Clinical Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Technique</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical Smear</td>
<td>Clean</td>
<td>Use a Sterile Speculum</td>
</tr>
<tr>
<td>Indwelling Urinary Catheter Insertion</td>
<td>Aseptic</td>
<td>Routine Hand Hygiene Sterile Gloves and disposable single use apron</td>
</tr>
<tr>
<td>Intermittent Urethral Catheterisation</td>
<td>Aseptic if in a Hospital Clean if in a patients home</td>
<td>Routine Hand Hygiene Sterile Gloves and disposable single use apron if in hospital</td>
</tr>
<tr>
<td>IUD Insertion</td>
<td>Aseptic</td>
<td>Surgical Hand Hygiene</td>
</tr>
<tr>
<td>IV Medication Preparation for Immediate Use and Administration</td>
<td>Aseptic Non Touch Technique</td>
<td>Routine Hand Hygiene Clean Non Sterile Gloves</td>
</tr>
<tr>
<td>Supra Pubic Catheter Insertion</td>
<td>Aseptic</td>
<td>Surgical Hand Hygiene, Full barrier precautions</td>
</tr>
<tr>
<td>Suction – Laryngeal, Endotracheal</td>
<td>Clean</td>
<td>Routine Hand Hygiene Dispose of catheter after each insertion</td>
</tr>
<tr>
<td>Wound dressing of wounds healing by primary intention e.g. Surgical Wound</td>
<td>Aseptic</td>
<td>Routine Hand Hygiene Sterile Gloves and disposable single use apron</td>
</tr>
<tr>
<td>Wound dressing of wounds healing by secondary intention e.g. venous ulcer</td>
<td>Clean</td>
<td>Routine Hand Hygiene Clean Non Sterile Gloves and disposable single use apron</td>
</tr>
</tbody>
</table>
# Aseptic Non Touch Technique Competency Assessment Tool

## Performance Criteria

<table>
<thead>
<tr>
<th>Stage 1 Technical Skills – Set Up</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>1. Prepares the environment (if at a bedside, cleaning and bed making should have ceased 30 minutes beforehand) windows closed and fan turned off.</td>
<td></td>
</tr>
<tr>
<td>2. Decontaminate hands and put on appropriate PPE</td>
<td></td>
</tr>
<tr>
<td>3. Clean the surface on which the sterile field will be formed</td>
<td></td>
</tr>
<tr>
<td>4. Select all dressing materials &amp; equipment</td>
<td></td>
</tr>
<tr>
<td>5. Checks the sterile packs are intact with no evidence of damage or moisture penetration</td>
<td></td>
</tr>
<tr>
<td>6. Checks expiry dates on sterile packs</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 1 Technical Skills – Principles of Asepsis</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>7. Describes the principles of Asepsis</td>
<td></td>
</tr>
<tr>
<td>8. Identifies groups of patients with increased risks of infection</td>
<td></td>
</tr>
<tr>
<td>9. Explains the use of PPE</td>
<td></td>
</tr>
<tr>
<td>10. Explains the significance of environment preparation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2 Clinical Skills - Patient Preparation</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>11. Explains the procedure to the patient and gains consent</td>
<td></td>
</tr>
<tr>
<td>12. Positions the patient in the most appropriate position that remains comfortable for the patient</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2 Clinical Skills – Procedure</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Repeats appropriate hand decontamination</td>
<td></td>
</tr>
<tr>
<td>14. Dons the appropriate PPE</td>
<td></td>
</tr>
<tr>
<td>15. Opens the dressing pack onto the prepared surface ensuring the fold is facing upward and touches the outer upward corners only.</td>
<td></td>
</tr>
<tr>
<td>16. Opens additional sterile items carefully onto the sterile field</td>
<td></td>
</tr>
<tr>
<td>17. Removes the soiled dressing</td>
<td></td>
</tr>
<tr>
<td>18. Removes gloves and decontaminates hands</td>
<td></td>
</tr>
<tr>
<td>19. Clinician decides whether to use sterile of non-sterile gloves. If using non sterile gloves, forceps must be used</td>
<td></td>
</tr>
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<td>20. Positions the sterile towel to maintain the sterile field</td>
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<td>21. Completes the dressing and disposes of all equipment</td>
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<tr>
<td>22. Decontaminates any re-usable items in line with SCH policy and manufacturer’s instructions.</td>
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<tr>
<td>23. Removes PPE and decontaminates hands</td>
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<tr>
<th>Stage 3 – Management</th>
<th>Achieved</th>
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<tr>
<td>Yes</td>
<td>No</td>
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<tr>
<td>24. Understands the importance of wound assessment</td>
<td></td>
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<tr>
<td>25. Understands when and how to seek specialist advice if the wound has deteriorated</td>
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</tr>
<tr>
<td>26. Understands the importance of recording practice in the patients records including the condition of the wound and equipment used</td>
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17 Maintaining the Cold Chain Policy

17.1 Introduction

17.1.1 The efficacy and safety of medicines, including vaccines, requiring storage at controlled low temperature, typically 2-8oC, depends on maintaining this temperature up to the time of administration. Failure to store medicines according to manufacturers' recommendations can invalidate the expiry date and cause manufacturers to disclaim responsibility for any apparent failure of the medicine as the safety and efficacy of such medicines can be significantly compromised.

17.1.2 Although this policy has been written primarily to cover the transport and storage of vaccines, the basic principles also apply to all medicines requiring refrigerated storage.

17.1.3 Current practice should reflect national policy as stated in the current version of Immunisation against infectious disease 2006, Chapter 3, “Storage, distribution and disposal of vaccines” published by the Department of Health, the conditions specified in manufacturer’s product license (SPC) and The Safe And Secure Handling Of Medicines: A Team Approach, Royal Pharmaceutical Society of Great Britain (2005).

17.1.4 Freezing can cause deterioration or increased reactogenicity of some vaccines. It can also cause hairline cracks in the ampoule/vial/pre-filled syringe with the potential for contamination of the contents. Excessive heat speeds up the loss of vaccine potency and, as exposure to UV light also decreases potency, they should be protected from light.

17.1.5 Local and national audit of the cold chain has identified poor storage, monitoring and documentation and a lack of knowledge of how and why it should be maintained. This poses potential risks to patient care.

17.2 Purpose

The purpose of this policy is to set standards of practice to ensure the cold chain is maintained and thereby minimise the risk of compromising the efficacy and safety of refrigerated medicines.

17.3 Definitions

Cold Chain - maintenance of the temperature of medicines, including vaccines, between 2 and 8oC at all times during storage and transport. This includes from the time of delivery up to the time of administration.

17.4 Duties / Responsibilities

17.4.1 Each clinical setting where vaccines and heat sensitive pharmaceutical products are stored must have one trained and designated individual (this may include administrative staff) and one deputy to be responsible and accountable for:

- receipt and storage of vaccines/heat sensitive pharmaceutical products
- monitoring and recording of fridge temperatures
- audit and evaluation of training needs for staff using or involved in use of these products

17.4.2 The designated person and/or their deputy should be easily identifiable by recording the name on fridge monitoring records.

17.4.3 The designated person or deputy (in their absence) is responsible for the following:

- Checking the order and contents of a delivery of vaccines/products for expiry, damage, leakage and correct transportation (i.e. evidence that the cold chain has been maintained)
- Signing to acknowledge correct safe receipt
- Immediate storage of products in the designated storage refrigerator
- Completing a vaccine/product log
- Ensure overstocking does not take place
- Exercising stock rotation to prevent wastage from out of date vaccines and Products
- Removal and safe disposal of expired or damaged stock
- Maintaining accurate and legible records of cold chain monitoring for audit Purposes
- Ensuring immediate action is taken if the fridge thermometer reading is or has been outside the recommended range (between 2°C and 8°C).

17.4.4 17.4.4 Team leads are responsible for ensuring that their staff, particularly new starters, bank, locum and agency staff, adhere to the standards in this policy. They are also responsible for maintaining the cold chain as part of the organisation’s business continuity plans i.e. refrigerator breakdown, loss of electricity supply.

17.5 Receiving refrigerated medicines or vaccines

17.5.1 When expecting a delivery of any vaccine or medicine requiring storage at 2-8°C the designated accountable person or deputy must ensure that whoever accepts the delivery is aware of the need to check the order for leakage, damage and discrepancies.

17.5.2 If there is any concern that a break in the cold chain has occurred prior to delivery, the delivery should not be accepted but reported to the distributor along with the reason for non-acceptance. An incident report should be completed via the Sentinel reporting system.

17.5.3 All deliveries of refrigerated medicines must be unpacked immediately on arrival and placed in a pharmacy/vaccine refrigerator and not left at room temperature. Items must remain in the manufacturer's original packaging to protect them from light.

17.5.4 Delivery notes containing batch numbers and expiry dates of vaccines must be retained for 2 years from date of receipt.

17.6 Storage Conditions

17.6.1 Refrigerators must:
- Be designed specifically for storage of pharmaceuticals or vaccines. Domestic refrigerators are not suitable for this purpose.
- Be of an appropriate size for the quantity of stock to be stored (not more than 50% full to allow adequate air circulation). Order frequency should be increased rather than compromising air flow by filling the refrigerator.
- Be kept locked or in a locked room (with no public access) when not occupied by a member of staff, as all prescription only medicines (POMs) must be stored under locked conditions. This also discourages unnecessary opening of the fridge door. Keys to the refrigerator must be stored securely e.g. in a key safe only accessible to authorized staff.
- Be reserved exclusively for the storage of vaccines and other pharmaceutical products requiring storage between 2°C and 8°C. Do not store food, milk, drink or specimens in the refrigerator.
- Be sited away from external windows and all heat sources e.g. radiators, direct sunlight.
- Be defrosted every 6 to 8 weeks if not self-defrosting or has an automatic defrosting mechanism.
- Be wired into a non-switched fused spur unit to avoid it being switched off accidentally and connected to an essential services electricity supply, if available. If this is not possible, tape over the plug and label with a recommended cautionary notice e.g. “Pharmacy fridge: Do NOT switch off”. Portable Appliance Testing (PAT) will then be required.
- Be serviced according to manufacturer’s instructions to ensure an operating temperature of 2°C to 8°C is maintained at all times whilst storing refrigerated medicines.
- Have its integral thermometer independently calibrated at least annually to ensure readings are true.
- Have a digital maximum and minimum thermometer which also records the current temperature, regardless of the existence of an integral refrigerator thermometer.

17.7 Temperature Monitoring

17.7.1 Refrigerator temperature readings must be regularly monitored by the designated person or deputy using a maximum-minimum thermometer to identify when the temperature may have been outside the recommended range. A recommended temperature recording sheet is at Appendix 1.

17.7.2 If the refrigerator is not in continuous use, it can be switched off when not in use as long as staff ensures the correct operating temperature is achieved before used for storage.

17.7.3 A separate battery-operated maximum-minimum thermometer with a probe should be used for each refrigerator so that it can be read without opening the refrigerator door. The probe should be placed at the centre of the refrigerator in an empty vaccine box or similar container.

17.7.4 The designated person or deputy at each base must read and record the maximum, minimum and current temperature of each refrigerator at the beginning of each working day as a minimum, ideally twice daily (beginning and end of working day), especially if a large quantity of items is regularly stored.

17.7.5 The thermometer must always be reset after recording each reading by following the manufacturer’s instructions.

17.7.6 Any refrigerator temperature reading falling outside the range 2°C to 8°C must be reported to the team lead.

17.7.7 The current refrigerator temperature should also be visually checked before removing any vaccine or the start of an immunisation session.

17.7.8 If there is more than one refrigerator in the same room, each one should be clearly labelled and identified (e.g. Fridge1, Fridge 2 etc.) and cross referenced to the appropriate temperature monitoring sheet and operating manuals.

17.7.9 The recommended temperature recording sheet should be used (see Appendix 19) to record refrigerator temperatures. Records should be maintained for at least 2 years and kept close to the referenced fridge.

17.7.10 The designated person and deputy must have training in the principles of the cold chain, how to read and reset the thermometer and what action to take if the temperatures are outside the correct range.

17.8 Refrigerator Content

17.8.1 All medicines should be stored in the original manufacturer’s packaging as this is printed with the expiry date and batch number, contains a patient information leaflet and administration instructions and protects vaccines from light and damage.

17.8.2 Fridge contents should be evenly distributed to allow air to circulate around items and shelves thus enabling the temperature to remain constant.

17.8.3 Medicines should be stored in the main body of the fridge, not in the bottom drawer or door where the temperature can be higher. Storage adjacent to a freezer compartment or freezer packs should also be avoided.
17.8.4 Stock must be rotated according to expiry date and older stock placed at the front of the fridge to use first to minimise potential for unnecessary medicines waste.

17.8.5 Expired stock must be removed as soon as possible and safely destroyed according to local policy.

17.8.6 Medicines should not occupy more than 50% of the volume of the main body of the fridge i.e. the fridge must not be overfilled so that air flow is not compromised. An overfilled fridge can also create potential for freezing and lead to poor stock rotation.

17.9 Transport

Validated cool boxes should be used for transporting vaccines (see NHS Supply Chain catalogue). The time between removing vaccines from refrigerated storage and administration must be kept to a minimum.

17.10 Domiciliary Visits

17.10.1 Vaccines must be kept in the original packaging and placed in a cool box to ensure vaccine potency is maintained.

17.10.2 If the vaccine is not administered to the patient within one day of being in the cool box it should be disposed of in the appropriate sharps bin and not returned to the stock supply in the fridge. Vaccines can be returned to the fridge up to 72 hours after removal if temperature monitoring indicates they have been kept below 25°C.

17.10.3 Other medicines may only be returned to the fridge if conditions stated in manufacturers’ information are met.

17.10.4 Cool boxes must be transported out of direct sunlight and secured in the employees’ car to ensure vaccines are not damaged and the cold chain is maintained.

17.11 School Immunisation Sessions & Clinic Sessions

17.11.1 Cool boxes should be packed immediately before dispatch to the clinic/school immunisation session.

17.11.2 Vaccines must be kept in the manufacturer’s original packaging, wrapped in bubble wrap or similar insulation material, and placed in a cool box with cool packs at fridge temperature as recommended by the manufacturer’s instructions.

17.11.3 Thermometer probe must be placed at the centre of each cool box and temperature monitored and recorded on arrival at the immunisation site, every two hours thereafter and on arrival back at base. Temperature logs should be filed together with refrigerator monitoring logs from where the vaccine was obtained.

17.11.4 If there is no fridge at a vaccination site, vaccines must be stored in the cool box until used.

17.11.5 Keep vaccines as cool as possible for the duration of a session i.e. cool boxes must be kept away from direct heat sources and the lid kept in place as much as possible.

17.11.6 Replace the lid and cool packs immediately after removing any vaccine from the cool box.

17.11.7 Cool boxes and cool packs used for school immunisation sessions are designed to maintain the cold chain for up to eight hours if the lid is kept in place.
17.11.8 Ideally each vaccine should be taken directly from the cool box for each administration. However, when it is necessary to expedite a mass immunisation session, it may be necessary to remove a given number of doses. These doses should be kept under 25°C until administered.

17.11.9 Any unused vaccine that has maintained the cold chain in cool boxes should be returned to the fridge within 72 hours of the end of a session. Each vaccine must be marked “use first” and marked with the date it was returned to stock.

17.11.10 Marked stock must be the first stock used at the next session. If this marked stock is not used at the next (second) session it must be discarded following local policy.

17.11.11 Frozen ice packs should not be used unless designed to prevent the ice pack from touching the vaccines.

17.11.12 Cool boxes must be transported in the boot of employees’ cars and not on a car passenger seat.

17.12 Cold Chain Incidents

17.12.1 Team managers should have business continuity plans for storing vaccines, in the event of refrigerator breakdown, loss of electricity supply or other disruptions to the cold chain. This should be implemented immediately to prevent loss of stock.

17.12.2 If there is any breach of the cold chain, i.e. any temperature record falling outside 2°C to 8°C such as refrigerator breakdown or interruption of the electricity supply an incident form must be completed after the fridge contents have been safely stored.

17.12.3 If the fridge current temperature is within the range 2°C to 8°C but maximum or minimum readings are outside of this range try to establish how long the temperature may have been outside the acceptable range. Seek advice on further action from either of the sources in section 17.13.

17.12.4 If it is necessary to move stock to alternative cold storage, it should be separated from other stock and clearly marked to indicate it should not be used until confirmed as safe to do so. If immediate transfer is not possible, keep the fridge door closed and regularly monitor temperature up to the time of transfer.

17.12.5 If the electricity supply to the fridge has been disconnected record the current fridge temperature. If this and the maximum/minimum readings are between 2°C to 8°C reconnect the power supply, if possible. No further action is necessary. If any reading is outside this range reconnect the power supply and record the time of reconnection. Try to establish how long the temperature has been outside this range and seek advice from either of the sources in section 17.12.6.

17.12.6 If it is not possible to reconnect the fridge to the power supply consider moving the contents to alternative cold storage as in 17.12.4 above.

17.12.7 If the fridge is faulty contact the facilities management team to correct the fault and use an independent thermometer to verify it is operating correctly before returning any medicines to it.

17.13 Information Sources

17.13.1 The following sources can be consulted in the event of a potential breakage of the cold chain:

a) Health Protection Unit: 0845 055 2022 (vaccines)

b) Medicines Information department of product manufacturer (details in the BNF)
17.14  Training

This is an integral part of the Health Protection Agency’s Core Curriculum for Immunisation Training (Core Topic 8) and should be delivered as part Immunisation training sessions.

17.15  Monitoring Compliance

This policy will be audited annually to verify compliance with this policy and standards therein. The audit tool is at Appendix 20.

17.16  References


125. NPSA Supporting information on Rapid Response Report: Vaccine Cold Storage (January 2010). Available online at: www.nrls.npsa.nhs.uk/alerts/?entryid45=66111&q=0%C2%ACvaccine%C2%AC


Appendix 19
TEMPERATURE MONITORING CHART FOR MEDICINE REFRIGERATORS

Maximum - minimum thermometers should remain in the refrigerator, except when readings are being taken.

Recording the temperature should be performed regularly preferably in the morning before the refrigerator is opened.
Please complete the chart below - complete the date and time before opening the refrigerator

CLINIC/SITE: .......................................................... Month: ........................................

Name of ‘designated person’ ......................

Remember to re-set the thermometer after Reading

If the maximum reading is above 8°C or below 2°C contact your line manager.

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Now</th>
<th>Min</th>
<th>Max</th>
<th>Re-set/Initials</th>
<th>Comments</th>
<th>Action</th>
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</tbody>
</table>
Appendix 20

Vaccination Safety Audit Form

<table>
<thead>
<tr>
<th>Location</th>
<th>Name of Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Name/Service</td>
<td>Auditor</td>
</tr>
<tr>
<td>Date</td>
<td>Contact No</td>
</tr>
</tbody>
</table>

The manager responsible for the monitoring of the refrigerators in each clinic is responsible for ensuring that a regular audit of the operation guidelines is undertaken to ensure maximum effectiveness of the vaccine.

For all audits, standards for compliance are 100%

The following questions must be answered:

<table>
<thead>
<tr>
<th>Qu No</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Is there a designated person responsible for ensuring that the cold chain is maintained?</td>
</tr>
<tr>
<td>2</td>
<td>Staff are aware of the importance of the cold chain being maintained during transport of the vaccine to the clinic/surgery and out of the clinic/surgery to client’s homes or residential homes, and have a validated cool box.</td>
</tr>
<tr>
<td>3</td>
<td>Vaccines are placed immediately into the medicine fridge upon delivery.</td>
</tr>
<tr>
<td>4</td>
<td>The medicine fridge has a minimum and maximum thermometer.</td>
</tr>
<tr>
<td>5</td>
<td>Minimum and maximum temperature checks are performed regularly and are recorded.</td>
</tr>
<tr>
<td>6</td>
<td>Staff are aware of what action to take if the fridge temperature falls outside the safe range (2-8°C) i.e. to contact the electrician and pharmaceutical company.</td>
</tr>
<tr>
<td>7</td>
<td>The fridge is clean, and filled to less than 50% capacity, with vaccines and medicines not touching the sides of the fridge or stored in enclosed compartments.</td>
</tr>
<tr>
<td>8</td>
<td>The vaccines and medicines are stored away from the freezer compartment. Defrosting is carried out at least every 3 months, plus when a build-up of ice is visible.</td>
</tr>
<tr>
<td>9</td>
<td>Staff are aware of the procedure to be undertaken in the event of a spillage of a live vaccine (i.e. use of protective clothing, hand washing and disposal in clinical waste)</td>
</tr>
<tr>
<td>10</td>
<td>All vaccines are used in rotation. All expired vaccines have been returned to the supplier or disposed of in accordance with the cold chain policy; suppliers may not take them back.</td>
</tr>
<tr>
<td>11</td>
<td>Food or clinical specimens are not being stored in the medicines refrigerator.</td>
</tr>
</tbody>
</table>

Date re-audit is due: 

Please return/email completed forms to the Clinical Audit & Effectiveness Officer: christine.roper@suffolkch.nhs.uk or fax to: 01473 276486  Thank you.
18 Management of Norovirus Outbreaks Policy

18.1 Introduction

18.1.1 Norovirus is a major cause of acute gastroenteritis and diarrhoea in children and adults. The cause of illness, Norovirus (previously known as Norwalk-like or Small Round Structured Virus) was described in 1968 in samples from an elementary school in Norwalk, Ohio. The disease is often termed Winter Vomiting Disease because of the increased prevalence in the winter months; however it can be detected throughout the year.

18.1.2 Norovirus is the most common cause of outbreaks of gastro-enteritis in hospitals and can also cause outbreaks in other settings such as schools, nursing homes and cruise ships. Hospital outbreaks often cause major disruption in hospital activity resulting ward closures, cancelled admissions and delayed discharges which can significantly reduce clinical activity for the duration of the outbreak. Failure to observe and comply with Infection Control guidelines/policy can lead to further spread of infection and a delay in the hospital returning to normal activity.

18.1.3 Outbreaks can affect both patients and staff, sometimes with attack rates in excess of 50%. For this reason, staff shortages can be severe, particularly if several wards are involved at the same time. It is therefore essential that cases are detected early and isolated appropriately to prevent spread and major outbreaks.

18.2 Signs and Symptoms of Norovirus

18.2.1 The average incubation period for Norovirus associated gastro-enteritis is 12-48 hours. The illness is characterized by a sudden acute onset of:

- Vomiting (This is the predominant symptom, often projectile, and is seen in 50% of cases, however, clusters can occur where vomiting is infrequent or absent altogether).
- Watery diarrhoea and abdominal cramps
- Nausea

18.2.2 In addition headache, myalgia, fever and malaise are common. Some or all of the above symptoms may be present. Symptoms last between one and three days and recovery is usually rapid. Dehydration is the most common complication and patients may require replacement fluids.

18.3 Transmission

18.3.1 Noroviruses are highly contagious. It is estimated that around 30,000,000 (30 million) viral particles are released during one vomiting incident. However, it only takes around 100 of these particles to cause illness. Noroviruses are transmitted primarily through the faecal –oral route either by person to person spread or via contaminated food or water. In addition Noroviruses can be spread via aerosol dissemination of infected particles following vomiting.

18.3.2 Transmission can also occur through hand transfer of the virus to the oral mucosa following contact with environmental surfaces, fomites and equipment which have been contaminated with either faeces or vomit. Norovirus can survive for up to 12 days on some surfaces.

18.4 Diagnosis

18.4.1 Norovirus may be suspected clinically in patients and staff with a history of vomiting of sudden onset followed by diarrhoea. During an outbreak several people are commonly affected over a short space of time and cases with typical features may be ascribed to norovirus infection without further testing.
18.4.2 Confirmation of norovirus infection depends on a PCR test performed on faecal samples. This is useful in confirming the nature of an outbreak early on. Once Norovirus is identified on a ward, further testing will only be performed in order to determine whether norovirus shedding is occurring in cases of persistent diarrhoea. Norovirus testing may be performed in order to identify atypical or outlying cases. Testing will only be performed after discussion with the Infection Prevention & Control Lead or Microbiologists.

18.5 Patient Treatment

There is no effective treatment for noroviruses. It is a self-limiting illness which will cease within a few days. It is important to ensure prompt fluid replacement to prevent dehydration and its complications. Anti-emetics or anti-motility agents must not be prescribed.

18.6 Outbreak Management

18.6.1 Isolation

- Any patient with symptoms suggestive of Norovirus must be isolated as a priority. The Infection Prevention and Control Lead should be informed at the earliest opportunity of the patient’s condition.
- The priority is to ensure that patient care is not compromised and at the same time prevent the spread of the virus to other susceptible patients and prevent a major outbreak
- Doors to bays/ rooms MUST remain closed
- Symptomatic patients must have dedicated commodes/toilet facilities.
- Symptomatic patients must have dedicated equipment e.g. monitoring equipment. Patient equipment must be cleaned and disinfected with a chlorine based disinfectant between each patient use.
- The allocation of a single room will generally take precedence over all other “alert” organisms with the exception of suspected/confirmed symptomatic Clostridium difficile or, chicken pox,
- If staff are unsure as to whether a patient already in a single room can be de-isolated, the Infection Prevention and Control Lead must be contacted.
- The posters in the unit D&V boxes must be displayed at the entrance of the ward and on the room used to isolate the symptomatic patient/s.
- The requirement for isolation must be reviewed on a daily basis and recorded in the patients records, using the following criteria:
  - Has the patient been asymptomatic for 48hrs
  - Is there a negative specimen result

18.6.2 Ward Closure

Ward closure will be made following a risk assessment of the area where the diarrhoea has occurred. Typically when more than 1 bay is affected, or the symptomatic patient/s cannot be adequately isolated all of the ward should be closed. This decision should be made following discussion with the Infection Prevention & Control Lead and notified to the Operational Management of the Organisation.

If a patient has had symptoms of suspected/confirmed norovirus and they are in a bay with others, the whole bay must be closed in an attempt to contain the spread of infection from both affected and exposed patients. This decision should be made following discussion with the Infection Prevention and Control Lead. If the affected patient is transferred to a single room the remaining patients still need to be isolated as they may be incubating the virus.

There must be no further admissions to the closed bay / ward.

Dedicated nursing staff should be allocated to nurse symptomatic patients.
18.6.3 Personal Protective Equipment (PPE)

PPE e.g.: aprons and gloves must be used appropriately and for each episode of care/treatment/examination on all patients by all staff. These must be changed for each episode of care.

There is currently no evidence to support the wearing of face masks for either patients or staff.

18.6.4 Hand Hygiene

The hands of healthcare staff can provide the vehicle for the transmission of norovirus. It is essential that all staff wash their hands when required using the correct washing technique to help reduce the risk of transmission.

Alcohol gel is not effective against these viruses and therefore hands must be washed with soap and water before and after every patient contact and contact with potentially infectious equipment, furnishings or other fomites. In major outbreaks of Norovirus consideration must be made for the removal of alcohol gels, in order that soap & water can only be used.

Gloves do not obviate the need to wash hands.

Patients must be provided with the opportunity to wash their hands or use hand wipes after each toileting episode and also before each meal.

18.6.5 Patient movement

There must be no transfer of patients to other departments/wards/hospitals from affected bay/ward unless there is an urgent clinical need in which case the receiving department must be informed.

Minimal numbers of staff should attend the patient. Aprons and gloves must be worn. All equipment that the patient has come in contact with must be cleaned with a chlorine based disinfectant e.g. Actichlor plus. The patient must return directly to the ward and must not wait in a waiting area with others.

The movement of affected patients from one bay to another for cohort management is NOT recommended.

Patients from affected bays must not be discharged to Care Home facilities unless they have had the illness and are 48 hours symptom free. Patients can however be discharged to their own homes so long as they have the appropriate support in place.

All receiving hospitals/Care Homes and the ambulance service must be informed of the situation before transfer is made. This may result in discharges using ambulance services being delayed.

18.7 Staff

18.7.1 Non-essential staff must not visit the affected bay/ward. Wherever practicable/possible procedures i.e. venepuncture, ECG’s should be undertaken by ward staff. Where bays only are closed, a team of dedicated staff should be allocated to these bays. Staff (nursing or domestic) who are working on the affected ward must not be moved to work in other parts of the hospital. The use of Bank and Agency staff is only advised when absolutely necessary. They can work elsewhere afterwards, but should not be deployed to other areas during the shift.
18.7.2 Allied Health Professionals (AHP’s) should allocate a nominated individual to the affected bay/ward. If this is not possible, the affected area must be visited last.

18.7.3 Staff who become symptomatic with diarrhoea and /or vomiting must leave the area immediately and must not return to work until 48 hours symptom free. They must inform the person in charge of the area to ensure that any toilet facilities are terminally cleaned. Staff maybe required to submit a sample of faeces to assist with outbreak investigation.

18.8 Ward Management

18.8.1 An outbreak form for symptomatic patients and Staff must be maintained by the ward team. A recommended form is at Appendix 21. This will be reviewed Mon – Fri by the Infection Prevention and Control Lead.

18.8.2 Bristol Stool and fluid balance charts must be maintained on all affected patients.

18.8.3 Ward staff must inform domestic services of the situation and advise the use of Antichlor Plus.

18.8.4 Water jugs must be kept covered to prevent the water from becoming contaminated, Be washed thoroughly each day in a dish washer, and the water changed frequently.

18.8.5 Bowls of fruit and open packets of food, i.e. biscuits, must be removed as they may become contaminated as a result of aerosol contamination.

18.8.6 Eating and drinking in the open ward is not advised for staff.

18.8.7 It is essential that if a ward is affected by norovirus discharge planning is continued to ensure prompt discharge of patients once the ward re-opens.

18.9 Ward Cleaning

Whilst a bay or ward is closed during an outbreak, the area must be cleaned daily with both detergent and chlorine e.g. Actichlor Plus. Frequently used areas such as toilet areas should be cleaned at least three times daily and more frequently should the need arise. A decision regarding the frequency of cleaning must be made by the Outbreak Control Group if there is a requirement to call one.

18.10 Visiting

18.10.1 Visiting should be restricted to close family members and friends only - preferably the same people visiting for the period of the ward/bay closure.

18.10.2 No children to be allowed to visit unless the patient is critically ill.

18.10.3 Visitors must not visit if they have had diarrhoea and vomiting. They must be 48 hours symptom free before they can visit. They should not visit if they have been in contact with anyone with diarrhoea and vomiting until 48 hours after contact.

18.10.4 On entering the ward, visitors must wash their hands with soap and water.

18.10.5 They should visit only the patient they have come to see and not go from bed to bed.

18.10.6 On leaving the ward, visitors should wash their hands with soap and water.

18.10.7 If a visitor to an affected ward needs to visit a non-affected area, this should be discouraged. If however this is essential then the visit to the affected ward should be carried out last.
18.11 Ward re-opening

18.11.1 Rooms, Bays, or the Ward may be terminally cleaned and reopened 48 hours after the (last symptomatic episode), on the instruction of the Infection Prevention & Control Lead or Outbreak Management Group,

18.11.2 Equipment that cannot be decontaminated must be disposed of. Any patients remaining in the bay should be decanted out of the bay to an alternative bed within the ward (do not transfer patients to other wards) to facilitate an effective terminal clean.

18.11.3 The terminal clean must be monitored by either the Ward Sister or Modern Matron. The ward/bay must not be re-opened until approved by nurse in charge.

18.12 Communication

For the duration of any period of closure the Chief Executive, Director of Infection Prevention & Control, Operations Director and relevant Locality Area Manager and any other relevant personnel will be updated by the Infection Prevention and Control Lead on a daily basis who will provide details of which ward/bay, the number of empty beds, number of cases to date the last occurrence and the next review date / time.

18.13 Escalation Procedure

When a bay/ward has been closed with confirmed norovirus, an outbreak control group may be convened by the DIPC. Once convened, the outbreak control group will determine the frequency of future meetings and escalate reports in line with the outbreak management policy.

In situations in which an outbreak control group is not called, the daily situation should be reported by the manager in charge on the daily escalation call.

18.14 Training

Training in the recognition and management of acute diarrhoeal patients will be included in the mandatory infection control training.

18.15 Monitoring

The monitoring of isolation practices will be undertaken during each isolation event using the Isolation Audit Tool on the intranet.

18.16 References

Appendix 21
Ward Daily Monitoring of Diarrhoea & Vomiting

Location…………………………………………… Outbreak Start Date…………………… Current Week Start Date………………………………………………

Infection Control Lead Aware Yes/No

<table>
<thead>
<tr>
<th>Name</th>
<th>Hospital Number</th>
<th>Bed Number</th>
<th>Control Method</th>
<th>Specimen Sent</th>
<th>Symptoms</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td>M</td>
<td>T</td>
</tr>
</tbody>
</table>

Key: Symptoms
D = Diarrhoea  V = Vomiting  N = Nauseous  SC = Stomach Cramps

Control Method
I = Isolated  C = Cohorted

Results
Nor = Norovirus  CDT = C.diff Toxin  +ve = Positive  -ve = Negative
Appendix 22: Communicable Disease in the Community Guidance

Exclusion Guidance for Communicable Diseases in Community settings

August 2010
(Review Date: August 2012)

Membership of the Group includes:
Steve Gee, Ed Kaczmarski, Jeanette Kempster, Lorraine Lighton, Gill Marsh, Ken Mutton, Matthew Olley,
Ruth Phip and Jeff Scott
on behalf of the North West Policy Group

www.hpa-nw.org.uk
### INCUBATION PERIOD, COMMUNICABILITY AND SUGGESTED EXCLUSION CRITERIA FOR COMMUNICABLE DISEASES

<table>
<thead>
<tr>
<th>Disease</th>
<th>Average incubation period (days)</th>
<th>Period of communicability</th>
<th>Minimal Period of Exclusion Cases (subject to clinical recovery)</th>
<th>Contacts</th>
<th>Notifiable Disease</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bacillary Dysentery (Shigella)</td>
<td>1 - 7</td>
<td>Whilst organism is present in the stool, but much more infectious whilst symptomatic</td>
<td>HPU to advise</td>
<td>HPU to advise.</td>
<td>YES</td>
</tr>
<tr>
<td>Campylobacter</td>
<td>1 - 11 (usually 2 - 5 days)</td>
<td>Whilst organism is present in the stool, but much more infectious whilst symptomatic.</td>
<td>Until symptom free for 48 hours</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Chickenpox</td>
<td>10 - 21</td>
<td>1-2 days before rash appears and 5 days after onset of rash</td>
<td>5 days from onset of rash</td>
<td>Pregnant contacts should contact their Occupational Health Dept. / GP / midwife for advice</td>
<td>NO</td>
</tr>
<tr>
<td>Conjunctivitis</td>
<td>Depends on cause</td>
<td>Whilst eye is red and discharging</td>
<td>None unless outbreak / cluster occurs consult local HPU.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Cryptosporidiosis</td>
<td>7 - 10</td>
<td>Variable, usually while diarrhoea present. 2-4 weeks from onset of symptoms.</td>
<td>Until symptom free for 48 hours</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Diphtheria</td>
<td>2 - 5</td>
<td>Whilst the organism is present in nose, throat or skin lesions</td>
<td>HPU to advise</td>
<td>HPU to advise.</td>
<td>YES</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion</td>
<td>Notifiable Disease</td>
<td></td>
</tr>
<tr>
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<td></td>
</tr>
<tr>
<td>E.coli O157</td>
<td>1 - 14</td>
<td>Whilst organism is present in the stool, but much more infectious whilst symptomatic.</td>
<td>HPU or Environmental Health to advise. Exclusion from swimming until test results show that a person is no longer an infection risk to others.</td>
<td>HPU or Environmental Health to advise</td>
<td>YES</td>
</tr>
<tr>
<td>Fifth Disease (Slapped Cheek or Parvovirus B19)</td>
<td>13 - 18</td>
<td>For 7 days before the rash appears and until onset of rash.</td>
<td>None</td>
<td>None BUT pregnant contacts should discuss with their GP or midwife.</td>
<td>NO</td>
</tr>
<tr>
<td>Food Poisoning (non-specific)</td>
<td>Varies according to cause</td>
<td>Varies according to cause</td>
<td>Until symptom free for 48 hours.</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>German Measles (Rubella)</td>
<td>14 - 21</td>
<td>From 7 days before to 4 days after onset of rash.</td>
<td>6 days from onset of rash.</td>
<td>None - BUT pregnant contacts should immediately contact their GP or midwife to check on their Rubella antibody status.</td>
<td>YES</td>
</tr>
<tr>
<td>Glandular Fever (Infectious Mononucleosis)</td>
<td>28 - 42</td>
<td>Varies but spread only by very close contact</td>
<td>None</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Giardia</td>
<td>5 - 25</td>
<td>Varies but more infectious whilst symptomatic.</td>
<td>Until symptom free for 48 hours.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Hand, Foot and Mouth Disease</td>
<td>3 - 5</td>
<td>Children who are ill (have symptoms) are infectious but, they can carry the virus in their faeces for many weeks after recovery, so may continue to pass it on.</td>
<td>None</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion Cases (subject to clinical recovery)</td>
<td>Minimal Period of Exclusion Contacts</td>
<td>Notifiable Disease</td>
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<tr>
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</tr>
<tr>
<td>Headlice* (Pediculosis)</td>
<td></td>
<td>Appropriate treatment is required as soon as possible. Contact tracing essential including family contacts.</td>
<td>None</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>15 - 50 (usually 28 days)</td>
<td>From 14 days before to 7 days after onset of symptoms</td>
<td>7 days from onset of jaundice / symptoms.</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>90 - 180</td>
<td>Variable – person infectious whilst virus is present in the body</td>
<td>None</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>42 - 63</td>
<td>Variable – person infectious whilst virus is present in the body</td>
<td>None</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Herpes Simplex (Cold Sores)</td>
<td></td>
<td>Whilst sore is present. Avoid kissing when sore is present.</td>
<td>None</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Impetigo (Streptococcal Group A skin infection)</td>
<td></td>
<td>Medical treatment is rapidly effective in most cases.</td>
<td>Until 48 hours of antibiotic treatment has been completed &amp;/or lesions have stopped weeping / have crusted over.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion Cases (subject to clinical recovery)</td>
<td>Contacts</td>
<td>Notifiable Disease</td>
</tr>
<tr>
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<td>-------------------</td>
</tr>
<tr>
<td>Influenza (seasonal)</td>
<td>1 - 3 (occasionally 5)</td>
<td>In Adults: One day before and 3 - 5 days after onset of symptoms.</td>
<td>Until clinically well</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In Children: 3 days before and up to 9 days after onset.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>10 - plus a further 2 – 4 days before the rash appears</td>
<td>2-4 days before to 5 days after onset of rash</td>
<td>4 days from onset of rash</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Meningococcal Disease</td>
<td>Usually 3 – 5 days</td>
<td>Whilst organism is present in nasopharynx</td>
<td>Until clinical recovery</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Molluscum Contagiosum</td>
<td>variable</td>
<td>Whilst lesions are present</td>
<td>NONE – but avoid close contact sports whilst lesions are present.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>MRSA (Methicillin resistant <em>Staphylococcus aureus</em>)</td>
<td>Not applicable</td>
<td>Whilst organism is present BUT the risk of transmission to others in a social setting is negligible</td>
<td>NONE – but any wounds should be covered.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Mumps</td>
<td>14 - 21</td>
<td>From 7 days before onset of symptoms to 5 days after</td>
<td>5 days from onset of swollen glands</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Poliomyelitis</td>
<td>3 - 21</td>
<td>Whilst virus is present in stool or nasopharynx</td>
<td>HPU to advise</td>
<td>HPU to advise</td>
<td>YES</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion Cases (subject to clinical recovery)</td>
<td>Contacts</td>
<td>Notifiable Disease</td>
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</tr>
<tr>
<td>Ringworm of feet (Athlete's Foot)</td>
<td></td>
<td>As long as untreated lesion is present</td>
<td>None - exclusion from barefoot activities (including swimming) unnecessary, <strong>but</strong> treatment always advisable.</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Ringworm of the body* (Tinea/Trichophytosis)</td>
<td></td>
<td>As long as untreated lesion is present</td>
<td>Until appropriate treatment has been commenced</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Ringworm of the scalp* (Tinea/Trichophytosis)</td>
<td></td>
<td>As long untreated lesion is present</td>
<td>Until appropriate treatment has been commenced</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Salmonella</td>
<td><strong>12 - 72 Hours</strong></td>
<td>Whilst organism is present in the stool, but much more infectious whilst symptomatic.</td>
<td>Until symptom free for 48 hours</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Scabies*</td>
<td>2 – 4 weeks before itching starts for initial exposure – reduced to 1 - 4 days in re-exposure</td>
<td>Whilst infection is untreated</td>
<td>Until 1st application of treatment has been completed. Significant close contacts (household) will also require treatment</td>
<td>None – but household &amp; significant close contacts need to be treated.</td>
<td>NO</td>
</tr>
<tr>
<td>Shingles</td>
<td>None – reactivation of existing chickenpox virus</td>
<td>5 days from onset of rash and whilst rash is 'wet' and if vesicles are on exposed area of body not covered by clothing e.g. face</td>
<td>Exclude only if rash is weeping and cannot be covered.</td>
<td><strong>Pregnant contacts</strong> should contact their Occupational Health Dept./GP/midwife for advice if they have no known/unsure history of previous Chickenpox infection.</td>
<td>NO</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion Cases (subject to clinical recovery)</td>
<td>Contacts</td>
<td>Notifiable Disease</td>
</tr>
<tr>
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</tr>
<tr>
<td>Scarlet Fever (and some tonsillitis caused by streptococcus)</td>
<td>1 - 4</td>
<td>Whilst organism is present in nasopharynx</td>
<td>24 hours after commencing antibiotic treatment.</td>
<td>None</td>
<td>YES</td>
</tr>
<tr>
<td>Threadworm</td>
<td></td>
<td>Whilst eggs are being produced</td>
<td>None – but treatment required.</td>
<td>Non - but treatment of household contacts recommended.</td>
<td>NO</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Variable – range: 3 - 12 weeks</td>
<td>Whilst living organism is present in sputum of a person with pulmonary (lung) TB infection</td>
<td>HPU to advise</td>
<td>HPU to advise</td>
<td>YES</td>
</tr>
<tr>
<td>Typhoid and Paratyphoid Fever</td>
<td>7 – 14 but can be shorter or longer dependent on how many bacteria are ingested.</td>
<td>Whilst organism is present in stool, but much more infectious whilst symptomatic.</td>
<td>HPU or Environmental Health to advise.</td>
<td>HPU to advise</td>
<td>YES</td>
</tr>
<tr>
<td>Verrucae Plantaris (Plantar Warts)</td>
<td>variable</td>
<td>Whilst warts are visible.</td>
<td>None</td>
<td>None</td>
<td>NO</td>
</tr>
<tr>
<td>Viral Gastroenteritis including Norovirus</td>
<td>Varies according to virus</td>
<td>Varies according to virus</td>
<td>Until symptom free (includes nausea) for 48 hours.</td>
<td>None</td>
<td>NO – BUT if suspect an outbreak then contact PCT/HPU immediately</td>
</tr>
<tr>
<td>Disease</td>
<td>Average incubation period (days)</td>
<td>Period of communicability</td>
<td>Minimal Period of Exclusion Cases (subject to clinical recovery)</td>
<td>Contacts</td>
<td>Notifiable Disease</td>
</tr>
<tr>
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</tr>
<tr>
<td>Whooping Cough (Pertussis)</td>
<td>6 - 20</td>
<td>5 days if treated with antibiotics and 21 days from onset if not treated with antibiotics even if cough persists</td>
<td>5 days if treated with antibiotics and 21 days from onset if not treated with antibiotics even if cough persists.</td>
<td>None</td>
<td>YES</td>
</tr>
</tbody>
</table>

* It is important that the rest of the family are checked for headlice, scabies and ringworm

**References:**

Guidance on Infection Control in School and other Child Care Settings poster, HPA, April 2010.


Health Protection Agency website: [www.hpa.org.uk](http://www.hpa.org.uk)

Immunisation against Infectious Diseases, 2006, DH, TSO (the Stationery Office), London.
Title of Policy: Infection Control Policy Manual

Description: The Suffolk Adult Safeguarding Board (ASB) is a multi-agency partnership that promotes the development of adult safeguarding work throughout the county. The member organisations have committed themselves to implementing this policy, the good practice principles, and the adult safeguarding procedures.

Part 1: Assessment of Impact

a) How will the policy meet the needs of different communities and groups?

- **Age:** It is not considered that the age will have any impact on the application of this policy although this organisation recognises that some age-groups may hold more entrenched and long standing beliefs than others.

- **Religion or Belief:** It is possible that this policy will impact on some families as these behaviours may be influenced by race by religion, belief and faith and it may challenge some assumptions.

- **Disability:** It is not considered that this will have any impact on the application of this policy.

- **Sexual Orientation:** It is considered that this policy should apply equally to all patients whatever their sexual orientation.

- **Ethnicity:** It is possible that this policy could impact on some families as these behaviours may be influenced by race, ethnicity and nationality and it may challenge some assumptions.

- **Socio-economic disadvantage:** The focus of any review should always be on the individuals concerned regardless of socio-economic group. It should not impact to cause any socio-economic disadvantage.

- **Gender (including transgender):** This policy is gender neutral and should meet the needs of all such groups.

- **People living in rural areas:** This policy should be applied equally regardless of place of residence and should not impact on people living in rural areas.

Other: This organisation recognises that some members of society generally have difficulty accessing health and social care services such as people who are homeless, prisoners or street workers. Whilst it is recognised that infection control issues maybe variable in certain cultural and religious groups the guidance for staff is applicable regardless of this. It is expected, therefore that the policy will be applied equally regardless of these factors.

b) Positive Impact: Reducing Inequalities: How is the Policy likely to have a significant positive impact on equality by reducing inequalities that already exist? Explain how it will meet our duty to:

- **Promote equal opportunities:** This policy will ensure that all adults at risk of neglect and abuse have equal right to protection from the professionals and organisations involved in their care.

- **Promote good community relations:** As with other policies and guidelines within the organisation, this one aims to ensure that SCH provides quality services to the community of Suffolk ensuring that the whole community has access to a safe health and social care environment. Fostering good relations with partner organisations will be enhance by the application of this policy.

- **Get rid of discrimination:** If staff continue to work within this policy and within professional guidelines and protocols this should avoid discrimination at any level.

- **Promote positive attitudes towards, encourage participation in and enable more favourable treatment of, disabled people:** This policy applies to all patients equally irrespective of any disability and staff will make all reasonable adjustments to accommodate any disability.

- **Get rid of harassment:** There are policies in place which prevent harassment both within the organisation and between the staff and patients (e.g. Whistle Blowing Policy, Disciplinary Policy, Adverse Incidents, Code of Conduct, Confidentiality, Code of Practice).

- **Promote and protect human rights:** SCH recognises that certain individuals are by definition vulnerable and this policy is designed to ensure their human rights are not affected in any way.
c) Negative Impact – Potential Discrimination: Could the Policy have a significant impact on equality in relation to each of the following groups or characteristics?

- **Age:** It is anticipated that age will not have a negative impact on this policy although some age-groups are more vulnerable than others.
- **Disability:** It is possible that this policy could impact negatively in regard to physical and mental disability as it may challenge the care that has been prescribed.
- **Ethnicity:** It is possible that this policy could impact negatively on some families as views and behaviours are influenced by race, ethnicity and nationality and it may challenge some assumptions.
- **Gender (including transgender):** This policy will be applied equally regardless of gender.
- **Religion or Belief:** It is possible that this policy will impact negatively on some families’ views and behaviours are influenced by religion, belief and faith and it may challenge some assumptions.
- **Sexual Orientation:** This policy will apply equally regardless of sexual orientation and not impact negatively as a result.
- **Socio-economic groups:** The focus of any review should always be individuals concerned, regardless of socio-economic group. The policy should not impact to cause any socio-economic disadvantage.
- **People living in rural areas:** This policy should be applied equally regardless of place of residence and should not impact on people living in rural areas although it is recognised they may have more difficulty accessing certain services.

Other: This organisation recognises that some members of society generally have difficulty accessing health and social care services such as people who are homeless, prisoners or street workers. Whilst it is recognised that infection control issues may be variable in certain cultural and religious groups the guidance for staff is applicable regardless of this. It is expected, therefore that the policy will be applied equally regardless of these factors and there will not be a negative impact.

Part 2: Evidence

What is the evidence for your answers above?

- **Age:** It is the intention and aim of this policy that, in consultation with statutory and non-statutory bodies, reflects current best practice and fulfils current statutory obligations under law.
- **Disability:** It is the intention and aim of this policy that it will reflect best evidence based practice and aim not discriminate based on a physical or mental disability.
- **Ethnicity:** It is the intention and aim of this policy that it shall be applied equally according to best practice and legal obligations and not discriminate unfairly based on ethnicity. However, there is evidence that there will be variations in views and behaviours which may impact on the equal application of this policy based on ethnicity.
- **Gender (including transgender):** It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on gender.
- **Religion or Belief:** It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on religion or belief. However, there is evidence that there will be variations in views and behaviours based on religion, belief and faith which may impact on the equal application of this policy.
- **Sexual Orientation:** It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on sexual orientation.
- **Socio-economic groups:** It is the intention and aim of this policy that it shall be applied equally according to best practice and not discriminate unfairly based on socio-economic status. However, there is evidence that there will be variations in views and behaviours based on socio-economic status which may impact on the equal application of this policy.

Other: This organisation recognises that some members of society generally have difficulty accessing health, social care and other support services such as people who are homeless, prisoners or street workers. As a result there may be further cultural, ethnic and religious variations as a result of this which may affect the equality of impact of the policy.

Part 3: Conclusion

B – A negative impact is possible:
The policy has the clear potential to have a positive impact by on the safety and wellbeing of patients. However, whilst every effort will be made to reduce any negative impact, this organisation recognises that there are a number of internal and external influences on which affect the views of individuals and groups which may impact on the equality of impact of this policy on various groups in society.

Part 4: Next Steps

Action Plan:
To review the operation of the policy as per SCH protocol to ensure there are no changes in its impact.
<table>
<thead>
<tr>
<th>Part 5: For the Record</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name and Title of people who carried out the EIA:</td>
</tr>
<tr>
<td>Sarah Miller, Clinical Effectiveness Manager</td>
</tr>
<tr>
<td>Date EIA completed: May 2014</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Date EIA signed: 21/6/14</td>
</tr>
</tbody>
</table>