Homerton University Hospital NHS
NHS Foundation Trust

Clinical Practice Guideline

Standard infection control precautions policy

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2.0 Summary

.1. The goal of reducing the risk of transmission of micro-organisms within the hospital setting can be assisted by the use of a set of basic principles that are used by all staff in all occasions. These are known as Standard Infection Control Precautions (SICP).

.2. SICPs are derived form Universal Precautions (UPs) that were devised in the 1980's to assist in protecting staff from the risk of contracting HIV. Over time, these have been expanded upon to help protect against contact transmitted organisms as well as blood borne and to protect all persons in the clinical setting.

.3. The spread of micro-organisms within a hospital requires three elements:
- source of the organism
- a susceptible host
- a means of transmission of the organism from one place to another

.4. Sources of organisms include all patients, staff and visitors within the hospital, both people who do and do not have an infection. Other sources can be the environment or equipment that has become contaminated.

.5. A susceptible host is a person who, if exposed to a particular micro-organism in the right circumstances, could develop an infection.

.6. Micro-organisms can transmit in a number of ways which include: contact, blood borne, airborne, droplet, water borne, food borne, faecal-oral route, sexual, vertical (mother to foetus), although the ones that are specifically addressed with SICPs are:
- Contact – This can be direct contact or through a third person or a contaminated article (vector).
- Blood borne – Blood borne viruses can be detected in a number of body fluids, therefore they should all be considered potentially infectious.

.7. Micro-organisms can transmit in one or more of these ways. For example, MRSA can transmit by; contact, air borne, droplet and food borne routes, but tuberculosis only transmits via the droplet route.

3.0 Introduction

The guidelines were developed using the available literature and input from the relevant expert sources and are required as part of compliance for the Hygiene Code 2006. The guidelines were developed by the Infection Control Team and then distributed to all members of the Infection Control Committee and Lead Clinicians for comment (Appendix 1) and then sent to Clinical Governance for final ratification.

4.0 Scope

This policy applies to all employee of the Trust in all locations including temporary, locum and contracted staff.

5.0 Roles and responsibilities

Infection Control Team
To provide training on infection control procedures to all staff on formal induction programmes, refresher training courses and during hand hygiene awareness training sessions.
Medical Staffing and Education Team
To ensure that all appropriate training incorporates infection control and prevention training which includes isolation procedures. To organise, maintain records and follow up on non-attendance for induction of all staff.
Dept/team Managers
To ensure that all staff have infection control as part of the personal development plan and attend trust induction and refresher training on isolation and incidents of non compliance are reported via the Trust incident reporting system..
Clinical staff
To attend the Trust induction which includes infection control procedures and then annual refresher infection control sessions. To comply with standard infection control precautions at all times.

6.0 Standard Infection Control Precautions

ICPs consist of a number of activities which include:

- Hand hygiene (See Hand Hygiene policy)
- Personal protective equipment (see protection of health care workers against BBV)
- Waste management (See Waste Management policy)
- Sharps safety (see protection of health care workers against BBV)
- Decontamination (See Decontamination policy)
- Linen handling (See Linen policy)

A number of these are covered in more detail within their individual policies, but they are touched upon within this policy and the infection control aspects reiterated.

6.1 Hand Hygiene

- It is important that all staff cover any breaks in the skin, especially on the hands, with a waterproof dressing before commencing clinical work. If the dressing becomes loose during the working day, then it should be replaced.
- Keep fingernails clean and short. Do not wear varnish or decorations on the nails.
- No jewellery should be worn on the wrist and only a plain band ring should be worn.
- Hands must be decontaminated immediately before each and every episode of patient contact/care and after any activity that potentially results in hands becoming contaminated
- Hands should be washed with mild soap if soiled or after the removal of gloves.
- Hands can be decontaminated with alcohol hand rub if they are visibly clean (except for patients with diarrhoea). Alcohol must come into contact with all surfaces of the hands and rubbed until dry.
- Ensure an appropriate technique is used whenever decontaminating the hands. See the full hand hygiene policy for details.
- Use an emollient hand cream regularly to protect skin form drying action of decontamination.

6.2 Personal Protective Equipment

PPE consists of a number of items:

- Gloves

- Apron
- Facial protection

PPE should be selected and worn on the basis of the risk of transmission of organisms to the patient and the risk of contamination of the staff member's clothing and skin by the patient's blood, body fluids, secretions and excretions or chemicals used for decontamination.

Gloves

Gloves must be worn for:

- Invasive procedures
- Contact with sterile sites, non-intact skin and mucous membranes
- All activities that carry a risk of exposure to blood, body fluids, secretions and excretions
- When handling sharp or contaminated items
- When dealing with chemicals which may have adverse reactions with skin

- Gloves are single use items and must be put on at the appropriate time in procedures and removed as soon as the activity is completed
- Gloves must be changed between caring for different patients or for performing different tasks with the same patient.
- Gloves can be made from three different materials and staff should consider the following when making a glove choice:

  Vinyl – an all-purpose glove. May not be useful for procedures that require fine movements, i.e. dressings, but can be used for general cleaning.

  Latex – A very good glove that is useful for fine movements, i.e. dressings. Be aware of possible and confirmed latex allergies in both staff and patients.

  Non-latex (Nitrile) – A similar glove to latex, but reduced risk of allergic reaction.

  Plastic gloves must not be worn for clinical practice as there is too high a risk of damage to the glove when it is removed from its paper backing.

  Powdered gloves must not be worn as it has been shown they can create allergies to latex as well as adhesions during surgical procedures.

  Another choice to make is whether the glove is sterile or non sterile:

  - Non-sterile – The choice for most occasions including general cleaning.
  - Sterile should only be used for sterile/aseptic procedures e.g, dressings and wound management. Surgery, where a break in the glove is likely to expose a sterile area to the organisms on the hands.

  Staff should be aware of their glove size and only wear their appropriate size. If the glove is too big, it may slip and if too small, there is a much higher risk of splitting.

  After removal of gloves hands must be washed.

Aprons and Gowns

- Disposable plastic aprons should be worn when there is a risk that clothing or uniform may become exposed to blood, body fluids, secretions and excretions.
- Full body, fluid repellent gowns should be worn where there is a risk of extensive splashing of blood, body fluids, secretions and excretions onto the skin of health care practitioners.
- Aprons and gowns are single use only and must be changed between patients and different tasks with the same patient.
- Aprons and gowns must be disposed of as clinical waste.

Facial Protection

- There is a risk to health care staff if the mucous membranes of the face are contaminated with blood borne virus containing body fluids. Although this risk is lower than an inoculation injury, it is still a risk that should be avoided.

- Facial protection should be worn where there is a risk of blood, body fluids, secretions and excretions or chemicals splashing into the face and eyes.
- Facial protection should consist of :
    - Mask and goggles (Waterproof, theatre-style mask)
    - Full face visor
- If a mask is worn it is single use only and must be disposed of as clinical waste after use.
- All re-usable facial protection must be decontaminated after use. This will normally consist of neutral detergent and water or detergent wipes, although manufacturer's instructions must be complied with.

6.3 Waste Management

- **Domestic Waste**

Domestic waste includes items that are not contaminated with blood or body fluids. This can include: newspapers, flowers, wrapping and packaging, paper towels used for drying hands, etc.

Domestic waste should be disposed of into transparent bags.

- **Sharps**

Sharps include needles, blades, cannulae, broken glass, etc. Intact glass vials should also be disposed of in the sharps bin.

Sharps must not be passed from hand to hand and handling should be kept to a minimum

Needles must not be removed from syringes or vacutainers by hand prior to disposal. In preference, they should be disposed of as one unit.

Needles should not be recapped by hand.

Sharps bins must be assembled appropriately. They must be signed and dated when assembled.

Used sharps must be disposed of into a sharps bin at point of use. Do not take sharps to a bin; take the bin to the sharps.

Sharps bins must not be filled over the indicator mark.

If safety devices are available (venepuncture), they should be used to reduce the risk of sharps injury.

6.4 Decontamination

Please refer to the main decontamination of re-usable equipment policy for details on the appropriate use of chemicals and methods of decontamination.

- Decontamination must not be performed on single use equipment. All single use equipment will be labelled 'single use only' or have the single use symbol.
- All single use equipment must be disposed of after one use. Any attempt at decontamination or re-use may have serious consequences.

- Decontamination of re-usable equipment must be performed as recommended by the manufacturer of the item using the appropriate procedure and chemicals. Inappropriate use may cause damage to the item.
- All decontamination should be performed in the appropriate area of the ward department to reduce the risk of contamination of the environment.
- Appropriate PPE should be worn to protect staff during decontamination.

6.5 Linen Handling

- Used linen and clean linen should be kept separate and not transported on the same trolley.
- Used linen must be segregated appropriately to protect the linen staff into the categories in the table below:

PLASTIC BAG COLOUR	CONTENTS	PROCEDURE
White bag	Routine used linen, towels etc	Must **not** include infected linen or linen contaminated with blood or body fluids. Must be checked for miscellaneous items e.g. dentures, spectacles, incontinence pads, bedpans or any sharps or other instruments. Do not overfill. Seal securely.
Red Alginate Water-Soluble bag (soluble inner bag)	All infected or infested linen and linen contaminated with blood or body fluids. Pathology Coats.	Check for miscellaneous items. Do not overfill bags. Seal securely before **double bagging into a Red bag.**
Red bag	Red alginate water-soluble bag containing all infected or infested linen and linen contaminated with blood or body fluids.	Contents must first be placed in a red alginate water-soluble bag and securely sealed, then placed in the red bag.
Purple bag	Trust-owned items eg curtains, slide sheets, white coats	Contents must be properly labelled. If infected, infected or contaminated with blood or body fluids, contents must first be placed in a red alginate water-soluble bag and securely sealed.
Green bag	Theatre Green Linen and Scrub suits	If blood stained, use **red alginate bag** first and then double-bag into a **red plastic bag**. Check for miscellaneous items. Do not overfill. Seal securely.
Brown bag	Reject linen eg. torn, excessively stained, badly creased	Bags obtained from Linen Services

- Whenever making beds or dealing with used linen, staff should wear a plastic apron to protect their uniform. If they are dealing with foul, infected or infested linen, they should wear a plastic apron and gloves and remove them after completion.
- Linen bags should be taken to the bedside by using a linen skip.

7. Monitoring, audit and education

All staff receive infection prevention and control training as part of the Corporate induction programme or medical staff induction and standard infection control precautions are covered in these sessions. It is mandatory for all staff to attend and attendance is monitored by the education and medical staffing team.
All clinical staff must attend an infection control update annually and standard infection control precautions are included in these sessions.

References/Bibliography

Pratt RJ, Pellowe CM, Wilson JA, Loveday P, Harper PJ, Jones SRLG, McDougall C, Wilcox MH. Epic 2 National Evidence Based Guidance for preventing HCAI in NHS hospitals in England. Journal of Hospiatl Infection. Feb 2007. 65S: S1-S64**.**

http://www.epic.tvu.ac.uk/PDF%20Files/epic2/epic2-final.pdf

Wilson J. (2001*). Infection Control in Clinical Practice*. Second edition. London: Balliere Tindall

Appendix 1

List of all staff consulted as part of guideline development

First Consultation
Daniel Krahe (Acting DIPC)
Monique Laberinto (ICN)
Gema Martinez-Garcia (ICN)
Nancy Hallett (Chief Executive)
John Coakley (Medical Director)
Pauline Brown (Chief Nurse)
Chris Griffiths (NED)
Andrew Panniker (Director of Environment and HR)
Lorraine Tinker (Divisional Senior Nurse CWS)
Louise Olley (Divisional Senior nurse GEM)
Jennie Negus (Acting Divisional Senior nurse DSO)
Sarah Addiman (Health Protection Team representative)

Equalities Impact Assessment

This checklist should be completed for all new Corporate Policies and procedures to understand their potential impact on equalities and assure equality in service delivery and employment.

Policy/Service Name:	**Notification of Infectious Diseases Policy**
Author:	**Vickie Longstaff**
Role:	**Nurse consultant**
Directorate:	**DSO**
Date	**18th May 2009**

Equalities Impact Assessment Question	**Yes**	**No**	**Comment**
1. How does the attached policy/service fit into the trusts overall aims?	Yes		Compliance with health and social care act 2009. Code of practice for reducing HCAI in the NHS.
2. How will the policy/service be implemented?			Systems already in place as practices are standard and have not changed.
3. What outcomes are intended by implementing the policy/delivering the service?			Compliance with health and social care act 2009. Code of practice for reducing HCAI in the NHS.
4. How will the above outcomes be measured?			Compliance with health and social care act 2009. Code of practice for reducing HCAI in the NHS.
5. Who are they key stakeholders in respect of this policy/service and how have they been involved?			Infection control committee given opportunity to comment
6. Does this policy/service impact on other policies or services and is that impact understood?		NO	
7. Does this policy/service impact on other agencies and is that impact understood?		No	
8. Is there any data on the policy or service that will help inform the EqIA?		No	
9. Are there are information gaps, and how will they be addressed/what additional information is required?		No	

Equalities Impact Assessment Question	Yes	No	Comment
10. Does the policy or service development have an adverse impact on any particular group?		No	
11. Could the way the policy is carried out have an adverse impact on equality of opportunity or good relations between different groups?		No	
12. Where an adverse impact has been identified can changes be made to minimise it?		N/A	
13. Is the policy directly or indirectly discriminatory, and can the latter be justified?		No	
14. Is the policy intended to increase equality of opportunity by permitting Positive Action or Reasonable Adjustment? If so is this lawful?		N/A	

EQUALITIES IMPACT ASSESSMENT
FOR POLICIES AND PROCEDURES

2. If any of the questions are answered 'yes', then the proposed policy is likely to be relevant to the Trust's responsibilities under the equalities duties. Please provide the ratifying committee with information on why 'yes' answers were given and whether or not this is justifiable for clinical reasons. The author should consult with the Director of HR & Environment to develop a more detailed assessment of the Policy's impact and, where appropriate, design monitoring and reporting systems if there is any uncertainty.

3. A copy of the completed form should be submitted to the ratifying committee when submitting the document for ratification. The Committee will inform you if they perceive the Impact to be sufficient that a more detailed assessment is required. In this instance, the result of this impact assessment and any further work should be summarised in the body of the Policy and support will be given to ensure that the policy promotes equality.

Policy Submission Form

To be completed and attached to any policy or procedure submitted to the Trust Policy Group

1	**Details of policy**	
1.1	Title of Policy:	Standard Infection Control Precautions Policy
1.2	Lead Executive Director	
1.3	Author/Title	Vickie Longstaff (Infection Control Nurse Consultant)
1.4	Lead Sub Committee	Infection control committee
1.5	Reason for Policy	To provide clear information on standard infection control precautions
1.6	Who does policy affect?	All staff involved in patient contact
1.7	Are national guidelines/codes of practice incorporated?	Health and social care act 2009. Code of practice for reducing HCAI in the NHS.
1.8	Has an Equality Impact Assessment been carried out?	Yes
2	**Information Collation**	
2.1	Where was Policy information obtained from?	Epic 2 National Evidence Based Guidance for preventing HCAI in NHS hospitals in England.
3	**Policy Management**	
3.1	Is there a requirement for a new or revised management structure if the policy is implemented?	No
3.2	If YES attach a copy to this form	N/A
3.3	If NO explain why	No change to current practice
4	**Consultation Process**	
4.1	Was there internal/external consultation?	Both – see appendix 1
4.2	List groups/Persons involved	Infection Control Committee – see appendix 1
4.3	Have internal/external comments been duly considered?	Yes
4.4	Date approved by relevant Sub-committee	26th March 2009
4.5	Signature of Sub committee chair	
5	**Implementation**	

5.1	How and to whom will the policy be distributed?	All clinical staff via infection control newsletter and will be posted on intranet
5.2	If there are implementation requirements such as training please detail?	None
5.3	What is the cost of implementation and how will this be funded?	None
6	**Monitoring**	
6.1	List the key performance indicators e.g. core standards	Health and social care act 2008 – Code for reducing HCAI in the NHS
6.2	How will this be monitored and/or audited?	CQC monitor compliance
6.3	Frequency of monitoring/audit	Annually

Date policy approved by Trust Policy Group:

20/5/09

Signature of Trust Board Group chair: