



Morecambe Bay



Primary Care Collaborative

Infection Prevention and Control Policy

Document Reference	POL025
Purpose	The purpose of this policy is to outline the duty and responsibility of staff working on behalf of the organisation in relation to Infection Prevention and Control.
Author	Graeme Redshaw Chief Operating Officer
Application/Scope	Organisation-wide
Approval Date	17/05/2022
Review Date (N.B: Review dates may alter if any significant changes are made)	17/05/2024
Version	V1.0
Status	Approved

MBPCC Infection Control Lead	
Name	
Contact Detail	



Pages	Policy No	Title	Version	Date
3		Introduction	1.00	05/05/2022
4-8	01	SICPs and TBPs (Standard infection control precautions and transmission based precautions)	1.00	05/05/2022
9-16	02	Safe management of the care environment	1.00	05/05/2022
17-23	03	Safe management of care equipment	1.00	05/05/2022
24-33	04	PPE (Personal protective equipment)	1.00	05/05/2022
34-44	05	Hand hygiene	1.00	05/05/2022
45-46	06	Notifiable diseases	1.00	05/05/2022
47-52	07	Safe disposal of waste	1.00	05/05/2022
53-54	08	Safe management of blood and body fluids	1.00	05/05/2022
55-59	09	Respiratory and cough hygiene	1.00	05/05/2022
60-62	10	Safe management of linen (including uniforms and work wear)	1.00	05/05/2022
63-70	11	Safe management of sharps and inoculation injuries	1.00	05/05/2022
71-74	12	Invasive devices	1.00	05/05/2022
75-81	13	Aseptic technique	1.00	05/05/2022
82-89	14	BBVs (Blood-borne viruses)	1.00	05/05/2022



	Introduction to the MBPCC IPC Policies
--	---

MBPCC Infection Prevention and Control Policies are created from current research DOH policies and guidance. The policies are in place to assist people who work in the primary Care service and also for People who use the Primary Care services.

The aim of the policy is to work in conjunction with General Practices within the Morecambe Bay Area and assist in maintaining safe, clean environments to prevent infectious outbreaks.

Each section sets out the evidence, processes and information on how to work to prevent infections as individuals and as a whole team approach.

The Policies are designed to be implemented for all environments. MBPCC provide services in multiple areas including offices, General Practices and Home Visiting Services. The policies are appropriate for all settings.

The IPC policies are provide to all colleagues to ensure each person understands and applies the policies.

The policies will be reviewed annually or as changes occur and will align with an annual IPC audit.

The policies are devised from Standard Infection Control Precautions and Transmission based Precautions.



01	SICPs and TBPs (Standard infection control precautions and transmission based precautions)
-----------	---

1. Introduction
2. Hand hygiene
3. Patient placement and assessment for infection risk
4. Personal protective equipment
5. Respiratory and cough hygiene
6. Safe disposal of waste
7. Safe management of blood and body fluids
8. Safe management of care equipment
9. Safe management of linen (including uniforms and workwear)
10. Safe management of sharps and inoculation injuries
11. Safe management of the care environment
12. Transmission based precautions
13. References

1 Introduction

There are a number of 'Standard infection control precautions' (SICPs) referred to by NHS England and NHS Improvement.

All staff in all situations involving the care of patients or contact with their environment must use standard infection control precautions (SICPs). SICPs may be insufficient to prevent cross transmission of specific infectious agents. Therefore, additional transmission based precautions (TBPs) are required to be used by staff when caring for patients with a confirmed or suspected infection or colonisation.

SICPs and TBPs underpin routine safe practice and break the chain of infection which protects patients and staff. There is often no way of knowing who is infected, so by applying SICPs and TBPs to all people at all times, best practice becomes second nature and the risk of infection is minimised.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.



Hand hygiene is the single most important way to prevent the spread of infection. Good hand hygiene should be undertaken by all staff and patients.

2 Hand Hygiene

Refer to the 'Hand hygiene Policy for General Practice'.

3 Patient Placement and assessment for Infection Risk

Prior to a patient's transfer to another health or social care facility, an assessment for infection risk must be undertaken. This ensures appropriate placement of the patient.

Refer to the 'Patient placement and assessment for infection risk Policy for General Practice'.

4 Personal Protective Equipment

Before undertaking any task, staff should assess any likely exposure to infectious patients, blood and/or body fluids, non-intact skin or mucous membranes or substances hazardous to health, e.g. cleaning/disinfecting products, and wear personal protective equipment (PPE) that protects adequately against the risks associated with the exposure.

Refer to the 'Personal protective equipment Policy for General Practice'.

5 Respiratory and Cough Hygiene

Respiratory and cough hygiene can help reduce the risk of spreading respiratory infections, protecting patients, visitors and staff.

Staff should adopt good respiratory and cough hygiene practices themselves and promote them to patients.

Refer to the 'Respiratory and cough hygiene Policy'.

6 Disposal of Waste

All staff are responsible for the safe management and disposal of waste.

Refer to the 'Safe disposal of waste Policy'.



7 Safe Management of Blood and Body Fluids

All spillages of blood and body fluids must be dealt with promptly.

Refer to the 'Safe management of blood and body fluids Policy.

8 Safe Management of Care Equipment

Cleaning, disinfection and sterilisation is known as decontamination. Safe decontamination of care equipment after use on a patient is an essential part of routine infection control to prevent the spread of infection.

Refer to the 'Safe management of care equipment Policy.

The use of linen such as blankets, pillowcases, fabric hand towels, in General Practice is not recommended as it is not practical to launder items between each patient. Best practice is to use disposable paper products, e.g. paper towels, couch roll.

All fabric blinds, curtains and screens should be visibly clean with no blood, bodily substances, dust, dirt, debris stains or spillages.

Refer to the 'Safe management of linen (including uniforms and workwear) Policy.

10 Safe Management of Sharps and Inoculation Injuries

This is referred to as 'Occupational safety/managing prevention of exposure (including sharps)' by NHS England and NHS Improvement.

Sharps are items that could cause cuts or puncture wounds and include needles and sharp instruments. It is the responsibility of the user to dispose of sharps safely into a sharps container.

Refer to the 'Safe management of sharps and inoculation injuries Policy



11 Safe Management of the Care Environment

Code of Practice on the prevention and control of infections and related guidance requires that registered providers of health and social care 'Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections'.

Refer to the 'Safe management of the care environment Policy

12 Transmission Precautions

SICPs may be insufficient to prevent transmission of specific infections. Therefore, additional TBPs may need to be taken by staff when caring for patients with a confirmed or suspected infection or colonisation.

Decisions on the need for TBPs must be based on the:

- Confirmed or suspected infectious agent
- Severity of the illness caused
- Transmission route of the infectious agent
- Procedures undertaken

TBPs are categorised by the route of transmission of the infection (some infections can be transmitted by more than one route). Application of TBPs may differ depending on the confirmed or suspected infection.

Contact precautions

These are utilised to prevent and control infections which are spread via direct contact with the patient, or indirectly from the patient's immediate care environment and care equipment. This is the most common route of infection transmission.

Droplet precautions

Airborne precautions

These are utilised to prevent and control infections which are spread without necessarily having close patient contact via aerosols (less than or equal to 5 µm, i.e. 0.005 mm) from the respiratory tract of one individual directly onto a mucosal surface, e.g. eyes, nose, mouth, of another individual. Aerosols can travel deeper in to the respiratory system than droplets, to the endpoint (alveoli).



14 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*

NHS Scotland (2012) *National Infection Prevention and Control Manual*



02 Safe management of the care environment

1. Introduction
2. Definitions
3. Standards of healthcare cleanliness
4. Methods of decontamination
5. Equipment used for cleaning
6. Choice of cleaning product
7. Cleaning and disinfecting procedure
8. Blood and body fluid spillages
9. Furniture, fixtures, fittings and toys
10. Colour coding of cleaning equipment
12. References

1 Introduction

Code of Practice on the prevention and control of infections and related guidance requires that registered providers of health and social care 'Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections' and must adequately resource local provision of cleaning services.

- There should be a designated lead for cleaning and disinfection of the environment, who may be the same person as the lead for infection prevention.
- A clean environment reduces the cumulative risk of transmission of infection posed by microorganisms, such as bacteria and viruses, in that environment.
- Outbreaks of infection have been associated with environmental contamination.
- Most microorganisms are found in dust and dirt, so cleaning or vacuuming alone can often cause significant reductions in the amount of organisms in the environment.
- Some microorganisms, e.g. *Clostridioides difficile* spores, are adept at surviving in the environment for long periods and, therefore, enhanced cleaning with disinfection is required when a patient has a confirmed or suspected infection.
- Hands regularly come into contact with surfaces. If hands are not decontaminated, they will transfer any organisms present. This risk is always present, but will increase if environmental cleaning is neglected.



- Numerous agents and cleaning solutions are mentioned within this guidance. As with all substances, COSHH (Care of Substances Hazardous to Health) guidance and manufacturer's instructions must be followed in order to achieve safe practice.
- Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.
- When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

2 Definitions

Contamination:	The soiling of an object with organic matter (dirt, debris, blood, vomit, faeces, etc.) and/or microorganisms, such as bacteria and viruses
Decontamination:	A combination of cleaning, disinfection and sterilisation processes that removes, or reduces, contamination
Cleaning:	A process to remove contamination using 'fluid', usually detergent with warm water, and 'friction' - either mechanical or physical, leaving the surface or care equipment visibly clean. Cleaning must precede disinfection for the process to be effective
Disinfection:	A process to remove or reduce pathogenic (harmful) microorganisms using a disinfecting agent. The ability to kill spores is dependent on the type of disinfectant used. Some disinfectants are deactivated by organic matter. Cleaning must precede disinfection for the process to be effective, either using separate cleaning and disinfecting agents in a two-step process or a combined '2 in 1' product that cleans and disinfects in one step

3 Standards of Healthcare cleanliness

Each General Practice premises should have a cleaning plan with clear cleaning schedules and frequencies, so patients, staff and the public, know what they can expect.

If the Practice contracts cleaning services, the standards and auditing process should be written into the contract.



The *National Standards of Healthcare Cleanliness* provides advice and guidance on:

- What cleaning is required
- How the Practice can demonstrate cleaning services meet these standards

The standards will support:

- The basis for the Practice to develop service level agreements or local procedures
- A benchmark against which to compare services
- Establishing optimum levels of resource to deliver safe cleaning standards
- Part of an ongoing performance management process
- A framework for auditing and monitoring
- As a tool for improving patient and visitor satisfaction

This document will assist Practices in:

- Assigning cleaning responsibilities
- Developing safe cleaning frequencies
- Identifying and risk assessing functional areas to determine cleaning frequencies and levels of auditing and monitoring
- Governance
- Auditing processes

Where cleaning (regular, periodic or 'one off') is provided by external contractors, cleaning plans should also set out the management arrangements in place to ensure the provider delivers against the contract. Contracting out cleaning services does not mean contracting out responsibility, there should be suitable arrangements in place to monitor standards of cleaning and to deal with poor or unsatisfactory performance. Training, including the use of the Practices cleaning and disinfecting products, and hand hygiene, should be provided to all cleaning staff and other staff who undertake cleaning tasks. They should be clear about their roles, responsibilities and understand the importance of thorough cleaning.

Staff who undertake cleaning tasks should be 'Bare Below the Elbows' and follow the Practices 'Uniform Policy', refer to the 'Hand hygiene Policy for General Practice' and the 'Safe management of linen (including uniforms and workwear) Policy for General Practice'.

Waste generated from cleaning tasks should be disposed of appropriately, refer to the 'Safe disposal of waste Policy for General Practice'.



4 Methods of Decontamination

There are 2 levels of environmental decontamination - cleaning and disinfection.

The method recommended will depend on the manufacturer's instructions for the item, a risk assessment of the procedure and the item being used, in accordance with Control of Substances Hazardous to Health (COSHH) Regulations.

5 Equipment for Cleaning

- Use colour coded equipment (see section 10) for cleaning different areas.
- Cleaning cloths should be single use.
- Cleaning equipment should be stored clean and dry after use in a designated area.
- Disposable mop heads should be discarded after use.
- Reusable mop heads should be washed in the bucket in detergent and warm water after use, rinsed and stored upright to dry. Reusable mop heads should be discarded if visibly stained and replaced regularly depending on the frequency of use.
- Equipment, e.g. mops, should not be stored overnight in disinfectants or disinfectant solutions. If disinfection is required, the mop head should be washed in detergent and warm water, rinsed and then soaked for 30 minutes in a chlorine-based disinfectant solution at 1,000 ppm, rinsed and then stored upright to dry.
- Mop buckets should be washed with detergent and warm water and dried with paper towels or stored upside down to air dry on a suitable surface to allow drainage. If disinfection is required, buckets should also be wiped with a chlorine-based disinfectant at 1,000 parts per million and stored upside down to air dry.
- Floor scrubbing machines, steam cleaners and carpet shampoo machines, should be designed to enable tanks to be emptied, cleaned and dried.
- Cleaning products should be stored in a designated lockable area.
- Toilet brushes should be cleaned thoroughly after use in the toilet pan. Place the toilet brush head beneath the water level and flush the toilet.



- Each toilet should have its own toilet brush and holder. Best practice is to use toilet brushes that are stored suspended in their holder, to allow them to air dry and avoid them sitting in stagnant water in the bottom of the holder.

6 Choice of Cleaning Product

- Limit the number of products used to avoid inappropriate use.
- Always check manufacturers' instructions.
- Products should be stored and used in accordance with Control of Substances Hazardous to Health (COSHH) Regulations.

Detergents

Detergent wipes or pH neutral detergent, e.g. Hospec, and warm water, and single use disposable cloths are recommended.

Disinfectants

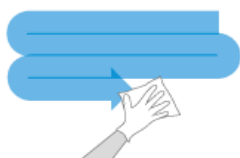
Disinfectants are not required for routine cleaning. Disinfection should be performed following a consultation/treatment with a patient who has a confirmed or suspected infection. It should also be used following contamination with blood or body fluids, refer to the 'Safe management of blood and body fluids Policy for General Practice'.

- Cleaning is **essential** before disinfection is carried out. A disinfectant will not be effective if contamination with organic matter, e.g. dirt, debris, blood, vomit, faeces, and/or microorganisms, such as bacteria and viruses, is present. Therefore, if the disinfectant is not a '2 in 1' detergent and disinfectant product, e.g. Clinell Universal Wipes, Chlor-Clean tablets, the environment should be cleaned before a disinfectant is used.
- When using disinfectant products, always wear PPE, e.g. disposable gloves, apron, and risk assess the need for facial protection.
- No disinfectant acts instantly - to ensure efficacy, always follow the manufacturer's guidance on contact time (how long the product needs to be left on the surface), and whether the product should be left to air dry or wiped/rinsed off. Be aware that a products contact time will vary, depending on the confirmed/suspected pathogenic microorganism(s) present. Some disinfectants and '2 in 1' detergent and disinfectant wipes/fluids can damage surfaces if they are not compatible with the surface material.
- Do not use chlorine-based disinfectant solutions on wooden or fabric surfaces.
- Disinfectants which are virucidal and bactericidal should be used for disinfecting surfaces after dealing with a patient with a confirmed



infection, e.g. MDRO, MRSA, or suspected viral infection. A dual acting product, e.g. Chlor-Clean, Actichlor plus, made into a solution at a dilution of 1,000 parts per million (ppm), or the use of a wipe, such as Clinell Universal, will be effective in decontaminating the surfaces adequately.

- If a chlorine-based disinfectant solution is used, it should be at a dilution of 1,000 ppm, unless the item is contaminated with blood and/or blood stained body fluids when a dilution of 10,000 ppm should be used.
- A sporicidal product should be used if the patient is confirmed or suspected to have an infection caused by spores, e.g. *C. difficile*, refer to the '*Clostridioides difficile* Policy for General Practice' for further information.
- Alcohol wipes can be used, but as they do not contain a cleaning agent, surfaces should first be wiped with a detergent wipe or solution of pH neutral detergent and warm water. Alcohol is effective against MRSA and MDRO, but is not effective against Norovirus and *Clostridioides difficile*.
- To ensure efficacy, disinfectant solutions must be made up to the manufacturer's instructions, i.e. measure the product and water accurately, no guesses. The date and time the solution was made up should be documented.
- Discard solutions as per manufacturer's instructions, e.g. chlorine-based disinfectant solutions should be disposed of 24 hours after making up.
- Cleaning is **essential** before disinfection is carried out, unless a one step '2-in-1' cleaning and disinfecting product, e.g. Clinell Universal Wipes, Chlor-Clean tablets, is used.
- The correct personal protective equipment (PPE) must be worn, and hands cleaned after removing and disposing of PPE.
- When cleaning and disinfecting, clean top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shaped pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice. This cleaning motion reduces the amount of microorganisms, such as bacteria and viruses that may be transferred from a dirty area to a clean area.





- Flooring should be decontaminated last, using the technique above. In the event that the flooring is carpeted, it should be shampooed or steam cleaned.
- Detailed guidance on how to perform common cleaning tasks can be found in the National Patient Safety Agency (NPSA) *The Revised Healthcare Cleaning Manual*.

7 Blood and Body Fluids Spillage

Refer to the 'Management of blood and body fluids Policy for General Practice'.

8 Furniture, Fixtures and Fittings

- Surfaces should be smooth, wipe-able and non-impervious to facilitate effective cleaning.
- Damaged surfaces should be repaired or replaced.
- When purchasing new furniture, fixtures and fittings, ensure that the item can be easily cleaned (in accordance with the manufacturer's instructions).
- The provision of magazines and toys for patients, e.g. in waiting areas, should be risk assessed. If toys are provided, they should be wipeable and in good condition, these should be decontaminated on a regular basis.

9 Colour coded equipment

Colour coding of cleaning materials and equipment ensures that these items are not used in multiple areas, therefore, reducing the risk of transmission of infection from one area to another, e.g. toilet to kitchen.

In accordance with the National Patient Safety Agency, all cleaning materials and equipment, e.g. disposable cloths, mops, buckets, aprons and gloves, should be colour coded.

Cleaning products such as detergent, bleach and other disinfectants do not need to be colour coded.



A relevant National Patient Safety Agency colour coded chart should be displayed in the cleaner's room, see Table 1 below.

National colour coding scheme - for cleaning materials and equipment in primary care medical and dental premises	
All GP Practices are recommended to adopt the national colour code for cleaning materials (see below). All cleaning items, e.g. disposable cloths, mops, buckets, aprons and gloves, should be colour coded.	
RED	Sanitary areas, including sinks in sanitary areas
BLUE	General areas, e.g. waiting rooms and consulting rooms, including sinks in general areas
GREEN	Kitchens
YELLOW	Treatment and minor operation rooms

6 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

National Patient Safety Agency (2009) *The Revised Healthcare Cleaning Manual* www.nrls.npsa.nhs.uk/resources/?EntryId45=61830

NHS England and NHS Improvement (2021) *National Standards of Healthcare Cleanliness 2021*

NHS England and NHS Improvement (2021) *National Standards of Healthcare Cleanliness 2021: Supporting documents*
www.england.nhs.uk/publication/national-standards-of-healthcare-cleanliness2021-supporting-documents/#heading-4

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*



03 Safe management of care equipment

1. Introduction
2. Definitions
3. Methods of decontamination
4. Cleaning procedure
5. Cleaning
6. Disinfection
7. Sterilisation
8. Classification of care equipment
9. Reusable personal protective equipment
10. References

1 Introduction

Management systems should ensure adequate supplies of reusable medical devices. Decontamination of equipment includes reusable medical devices and care equipment. Medical devices and care equipment are essential for safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease.

In order to ensure safe systems of work and to prevent transmission of infection, it is essential that decontamination of reusable medical devices and care equipment after use on a patient is undertaken to prevent the transmission of infection.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.



2 Definitions

Contamination:	The soiling of an object with organic matter (dirt, debris, blood, vomit, faeces, etc.) and/or microorganisms, such as bacteria and viruses
Decontamination:	A combination of cleaning, disinfection and sterilisation processes that removes, or reduces, contamination
Cleaning:	A process to remove contamination using 'fluid', usually detergent with warm water, and 'friction' - either mechanical or physical, leaving the surface or care equipment visibly clean. Cleaning must precede disinfection for the process to be effective.

3 Methods of Decontamination

Disinfection:	A process to remove or reduce pathogenic (harmful) microorganisms using a disinfecting agent. The ability to kill spores is dependent on the type of disinfectant used. Some disinfectants are deactivated by organic matter. Cleaning must precede disinfection for the process to be effective, either using separate cleaning and disinfecting agents in a two-step process or a combined '2 in 1' product that cleans and disinfects in one step
Sterilisation:	A process that removes or destroys all viable organisms including spores. Prions will not be effectively destroyed by this process

There are 3 levels of decontamination - cleaning, disinfection and sterilisation. All reusable medical devices and care equipment should be adequately decontaminated after use on a patient before storing or use on another patient.

Those performing decontamination should be aware that disinfectants and '2 in 1' detergent and disinfectant wipes/fluids can damage plastic surfaces of medical devices and care equipment if they are not compatible with the surface material. Reports describe damage to devices, such as tympanic thermometers, patient monitors. This damage may compromise the ability to decontaminate the device adequately or affect the function of the device. Check manufacturer's instructions to ensure cleaning products are compatible with the item.

The method recommended will depend on the manufacturer's instructions, a risk assessment of the procedure and the item being used in accordance with Control of Substances Hazardous to Health (COSHH) Regulations.



4 Cleaning Procedure

- The correct personal protective equipment (PPE) must be worn.
- When cleaning and disinfecting, clean top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shaped pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice. This cleaning motion reduces the amount of microorganisms, such as bacteria and viruses that may be transferred from a dirty area to a clean area.
- Detailed guidance on how to perform common cleaning tasks can be found in the National Patient Safety Agency (NPSA) *The Revised Healthcare Cleaning Manual*.

Cleaning;

- When using cleaning products, always wear PPE, e.g. disposable gloves, apron, and risk assess the need for facial protection.
- Detergent wipes or pH neutral detergent, e.g. Hospec, and warm water and single use disposable cloths are recommended.
- Cleaning is **essential** before disinfection or sterilisation is carried out.
- All reusable medical devices and care equipment that has been cleaned must be dried thoroughly before storage.

5 Cleaning

- When using cleaning products, always wear PPE, e.g. disposable gloves, apron, and risk assess the need for facial protection.
- Detergent wipes or pH neutral detergent, e.g. Hospec, and warm water and single use disposable cloths are recommended.
- Cleaning is **essential** before disinfection or sterilisation is carried out.
- All reusable medical devices and care equipment that has been cleaned must be dried thoroughly before storage.

6 Disinfection

- When using disinfectant products, always wear PPE, e.g. disposable gloves, apron, and risk assess the need for facial protection.
- A disinfectant should be used for reusable medical devices or care equipment that has been in contact with non-intact skin, mucous membranes, body fluids or a patient with a confirmed or suspected infection.



- Disinfectants can be in the form of a wipe, e.g. Azo wipes, or as chlorine releasing tablets or liquids, such as Haztabs, Presept.
- Some disinfectant products are '2 in 1', which contain both a detergent and a disinfectant, e.g. Clinell Universal Wipes, Chlor-Clean tablets.
- A disinfectant will not be effective if contamination with organic matter (dirt, debris, blood, vomit, faeces, etc.) and/or microorganisms, such as bacteria and viruses, is present. Therefore, if the disinfectant is not a '2 in 1' detergent and disinfectant product, reusable medical devices or care equipment should be cleaned before a disinfectant is used.
- Some disinfectants and '2 in 1' detergent and disinfectant wipes/fluids can damage plastic surfaces of medical devices and care equipment if they are not compatible with the surface material.
- At minimum, the disinfectant product should be bactericidal and virucidal. Sporocidal disinfectants should be used when a patient is confirmed or suspected to have diarrhoea due to *Clostridioides difficile*, refer to the '*Clostridioides difficile* Policy for General Practice' for further information.
- When disinfecting reusable medical devices or care equipment, always follow the manufacturer's instructions, some items will have specific instructions which should be followed, e.g. Propulse machine, spirometry devices.
- A disinfectant should be used for care equipment:
 - Contaminated with splashes of blood - the appropriate disinfectant should have virucidal properties effective against hepatitis B, hepatitis C and HIV, and be used at the correct concentration advised by the manufacturer
 - That has been in contact with a patient with a confirmed or suspected infection, non-intact skin, mucous membranes or body fluids
- To ensure a disinfectant solution works effectively, it is important that the correct amount of disinfectant and water are used. If a weaker solution is used, the microorganisms will not be killed, too strong, and care equipment or surfaces can be damaged.
- No disinfectant acts instantly - to ensure efficacy, always follow the manufacturer's guidance on contact time (how long the product needs to be left on the surface), and whether the product should be left to air dry or wiped/rinsed off. Be aware that a products contact time will vary, depending on the confirmed/suspected pathogenic microorganism(s) present.
- Do not use chlorine-based disinfectant solutions on wooden or fabric surfaces.



- If a chlorine-based disinfectant solution is used, it should be at a dilution of 1,000 parts per million (ppm), unless the item is contaminated with blood and/or blood stained body fluids, when a dilution of 10,000 ppm should be used.
- As diluted chlorine-based disinfectant solutions are unstable and become less effective after 24 hours, a new solution should be made each day and the date and time documented.
- Numerous agents and cleaning solutions are mentioned within this guidance. As with all substances, COSHH (Care of Substances Hazardous to Health) guidance and manufacturer's instructions must be followed in order to achieve safe practice.


7 Sterilisation

The use of bench top steam sterilisers (autoclaves) is not recommended. Sterilisation is a specialist means of decontamination of care equipment. Reusable items requiring sterilisation after use must be sent to an accredited Decontamination Services Facility.

Alternatively, single use disposable care equipment should be used.

8 Classification of care equipment

Single use

Items intended for single use are packaged with this symbol  or are labelled 'single use'.

Items labelled or marked for single use, e.g. disposable forceps, auroscope ear piece, must not be used again as they are designed to be used only once.

Single patient use

Items intended for single patient use, e.g. nebuliser, mask, spacers, can be decontaminated after each use and reused on the same patient, but cannot be used on another patient. It will be indicated on the packaging 'single patient use'. If spacers are required for reversibility testing, disposable single use spacers can be used.

GP Practices who disregard this information and prepare single use devices for further use, may be transferring legal liability for the safe performance of the product from the manufacturer to themselves, or the organisation that employs them.



Reusable non-invasive care equipment

Reusable non-invasive equipment, e.g. blood pressure cuffs, thermometers, wheelchairs, are reused on more than one patient following decontamination.

Use of reusable non-invasive care equipment must comply with manufacturer's instructions and decontamination must be undertaken:

- Between each use
- After contamination with blood or body fluids
- Before inspection, servicing or repair

For any queries regarding reprocessing of care equipment, advice should be sought from the manufacturer or your local Community Infection Prevention and Control or Health Protection Team.

9 Reusable Personal Protective Equipment

After use, reusable personal protective equipment (PPE) e.g. safety glasses, face visor, should be decontaminated and stored appropriately.

If worn when a patient **does not** have a confirmed or suspected infection or the PPE is **not** visibly soiled with blood or body fluids, cleaning is sufficient see sections 5.

If worn when a patient has a confirmed or suspected infection, or the PPE is visibly soiled with blood or body fluids, it should be cleaned and disinfected, see sections 5 and 6.

Decontaminated reusable PPE should then be stored appropriately, e.g. in a clean lidded wipeable container or plastic bag. Do not store on open surfaces where it may become contaminated.

Face visors can be reused and replaced whenever required. Please add your name to your face visor. Follow the correct procedure below for decontamination.



10 References

- Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* Department of Health (2006) *Essential steps to safe, clean care*
- Health and Safety Executive (2002) *Control of Substances Hazardous to Health (COSHH) Regulations*
- Loveday et al (2014) *epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospital in England*
- Medicines and Healthcare Products Regulatory Agency (2018) *Single-use medical devices: implications and consequences of reuse*
- Medicines and Healthcare Products Regulatory Agency (2014) *Managing Medical Devices Guidance for healthcare and social services organisations*
- Medicines and Healthcare Products Regulatory Agency (2013) *Detergent and disinfectant wipes used on reusable medical devices with plastic surfaces – risk of degrading plastic surfaces MDA/2013/019*
- National Patient Safety Agency (2009) *The Revised Healthcare Cleaning Manual*
- NHS England and NHS Improvement (2021) *National Standards of Healthcare Cleanliness 2021*



04 PPE (Personal protective equipment)

- 1 Introduction
- 2 Gloves
- 3 Aprons
- 4 Facial protection
- 5 Correct order for putting on and removing PPE
- 6 Footwear
- 7 References

1 Introduction

All staff must be trained in the correct use and removal of personal protective equipment (PPE).

Before undertaking any task, staff should assess the risks associated with the patient interaction or task to be undertaken and wear PPE that protects adequately when:

- Dealing with a patient who has a confirmed or suspected infection
- There is likely exposure to blood and/or body fluids, non-intact skin or mucous membranes
- Decontaminating the environment or care equipment
- In contact with substances hazardous to health, e.g. cleaning/disinfecting products
- Hands should be cleaned before putting on PPE. All PPE should be changed between tasks and disposed of as soon as the task is complete.
- Contaminated/infectious PPE should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious PPE should be discarded into the offensive waste stream. Always perform hand hygiene appropriately after removing and disposing of PPE. When caring for patients in relation to COVID-19, perform hand hygiene after removing and disposing of each item of PPE, e.g. pair of gloves, apron, mask, facial protection.



Best practice is to use a PPE dispenser to reduce the risk of the PPE becoming contaminated. PPE should be readily available at the point of use and within the expiry date. Stored PPE should be located in a clean dry area until ready for use.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance for advice on the PPE to be worn.

2 Gloves

If contact with blood and/or body fluids, substances hazardous to health, e.g. cleaning/disinfecting products, non-intact skin or mucous membranes, is anticipated or the patient has a confirmed or suspected infection, disposable gloves should be worn that are appropriate for the task (see 'Glove selection guide').

Disposable gloves are single use only.

Disposable gloves must comply with European Standard EN 455 Medical Gloves for single use (Parts 1-4) and be CE marked for single use. The Medical Devices Agency recommends that only powder-free gloves are purchased due to latex allergy/sensitivity.

The wearing of gloves has been shown to reduce the volume of blood transferred in a needlestick injury by 52% compared with not wearing gloves, which can help reduce the risk of acquiring an infection if you sustain a needlestick injury.

Sterile gloves must be available and worn for an aseptic technique.

Hands must be washed with liquid soap and warm running water or alcohol handrub applied immediately before putting on and after removing gloves. Please note, alcohol handrub should **not** be used if hands are dirty, visibly soiled or dealing with a patient with *Clostridioides difficile* or other diarrhoeal illness, e.g. Norovirus.



Gloves can be latex, nitrile or vinyl material. Employers may advise against the use of latex following a risk assessment as it can cause skin sensitivity and allergies.

Staff who develop any irritation or dermatitis on their hands should report to their Occupational Health Provider/GP and seek clinical advice.

Glove selection should be based on risk assessment of:

- Sensitivity to latex
- Nature of the task
- Risk of contamination
- Need for sterile gloves

The following table provides a list of procedures and glove choice as a guide.

Glove selection guide	Sterile		Non-sterile			
	La tex	Nitrile	Latex	Nitrile	Vinyl	Domestic
Procedure and type of contact Ticks indicate which glove to use for the procedures listed and if they should be sterile or non-sterile. Please note that this is not an exhaustive list.						
Aseptic technique	✓	✓				
Blood/blood stained body fluids contact			✓	✓		
Body fluids contact			✓	✓	✓	
Clean technique			✓	✓		
Decontamination of care equipment			✓	✓	✓	
Domestic tasks						✓
IUCD insertion	✓	✓				
Minor surgery	✓	✓				
Rectal examination			✓	✓		
Short and non-manipulative tasks					✓	
Urinary catheterisation	✓	✓				
Vaginal examination			✓	✓		
Venepuncture/Phlebotomy			✓	✓		



Glove type	Description
Latex gloves	Are made from natural rubber and due to their elasticity provide a better fit. Latex gloves can cause skin sensitivity and following risk assessment some employers are using alternative products such as nitrile
Nitrile gloves	Are a synthetic alternative to latex gloves. They are suitable to be worn when in contact with blood and blood stained body fluids and if a patient or member of staff is latex sensitive
Vinyl gloves	Are looser fitting than nitrile or latex gloves, less durable for procedures involving twisting and more likely to tear. They are not recommended for contact with blood and blood stained body fluids. Therefore, they should only be worn when there is no risk of exposure to blood or blood stained body fluids and if tasks are short and non-manipulative. They are not associated with skin irritation
Polythene gloves	Are not recommended for clinical use
Domestic gloves	Are suitable for household cleaning. Due to their rubber content, they are not suitable for use when a staff member has a sensitivity to latex (see Latex gloves above). In such cases, nitrile gloves can be worn, although the user should be aware that nitrile gloves are not as durable (strong) as domestic gloves

Gloves should be:

- Stored in a clean area in their original box/packaging away from sunlight, heat sources and liquids (including chemicals)
- Checked before use for any damage such as pin holes and changed if a perforation or puncture is suspected
- Changed before the manufacturer's recommended breakthrough time* is exceeded - more than one pair may be required for a prolonged task. * 'Breakthrough time' is the time a chemical takes to permeate through the glove material and reach the inside. Permeation is a process by which a chemical can pass through a material without going through pinholes or pores or other visible openings. This breakthrough time informs you how long you can use a glove for
- Disposable gloves should be:
 - o Disposed of after each procedure or activity
 - o Changed between different procedures on the same patient
 - o Worn



when decontaminating care equipment or the care environment o Appropriate for use, fit for purpose and well-fitting

The reuse of disposable gloves is not recommended for the following reasons:

- Glove integrity can be damaged if in contact with substances such as isopropanol, ethanol, oils and disinfectants
- Many gloves will develop micropunctures very quickly and will no longer perform their barrier function
- There is a risk of transmission of infection
- Washing your hands whilst wearing disposable gloves, or using an alcohol handrub on disposable or domestic gloves, is considered unsafe practice

Contaminated/infectious gloves should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious gloves should be discarded into the offensive waste stream, refer to the 'Safe disposal of waste Policy for General Practice' for further information.

Hand hygiene should be performed after disposing of gloves.

To reduce the risk of transmission of infection between different areas, it is recommended that for cleaning activities, coloured domestic gloves in line with the National Colour Coding Scheme for cleaning materials and equipment in primary medical care and dental premises, should be worn:

- Red for sanitary areas, including sinks in sanitary areas
- Blue for general areas, e.g. waiting rooms and consulting rooms (including sinks in general areas)
- Green for kitchens
- Yellow for treatment and minor operation rooms

3 Aprons

Disposable aprons are impermeable to bacteria and fluids and protect the areas of maximum potential contamination on the front of the body.

A disposable apron is single use and should be worn when:

- There is a risk of exposure to blood and/or body fluids, non-intact skin, mucous membranes
- Undertaking a procedure on a patient with a confirmed or suspected infection
- There is a risk of splashing or soiling to the front of the uniform or workwear
- Undertaking an aseptic technique
- Decontaminating care equipment or the care environment



Never wear an apron for a dirty task and then move onto a clean task without changing it.

Disposable aprons should be removed after each task.

Contaminated/infectious aprons should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious aprons should be discarded into the offensive waste stream, refer to the 'Safe disposal of waste Policy for General Practice' for further information.

Hand hygiene should be performed after disposing of an apron.

Colour coding of aprons

Clinical duties

- White aprons should be worn for clinical duties, e.g. wound dressing.

Cleaning activities

To limit the likelihood of the same apron being worn in different risk areas, reducing the risk of transmission of infection, coloured aprons in line with the National Colour Coding Scheme for cleaning materials and equipment in primary medical care and dental premises, should be worn:

- Red for sanitary areas, including sinks in sanitary areas
- Blue for general areas, e.g. waiting rooms and consulting rooms (including sinks in general areas)
- Green for kitchens
- Yellow for treatment and minor operation rooms

4. Facial protection

Appropriate facial protection should be worn if there is a risk of splashing of either blood and/or body fluids or substances hazardous to health, e.g. cleaning/disinfecting products, to the face, or the patient has a confirmed or suspected infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles (for COVID-19, pandemic influenza, refer to the latest national infection prevention and control guidance).

Eye and face protection should not be impeded by accessories, e.g. false eyelashes, facial piercings.

Eye protection



Goggles/safety glasses or a visor should be worn:

- When there is a risk of splashing of blood and/or body fluids or hazardous substances to the eyes
- If the patient has a suspected or confirmed infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles (for COVID-19, pandemic influenza, refer to the latest national IPC guidance)

Prescription spectacles are not considered eye protection.

Eye protection should be removed after each task.

Contaminated/infectious disposable eye protection should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious eye protection should be discarded into the offensive waste stream, refer to the 'Safe disposal of waste Policy for General Practice' for further information.

Hand hygiene should be performed after disposing of disposable eye protection.

Reusable eye protection should be appropriately decontaminated and stored following each use, e.g. in a clean lidded wipeable container or plastic bag, refer to the 'Safe management of care equipment Policy for General Practice' for further information.

Hand hygiene should be performed after decontamination of reusable eye protection.

Masks

A type IIR (fluid resistant) surgical mask should be worn:

- When there is a risk of splashing of either blood and/or body fluids or substances hazardous to health, e.g. cleaning/disinfecting products, to the face
- If the patient has a suspected or confirmed infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles (for COVID-19, pandemic influenza, refer to the latest national IPC guidance)
- Surgical masks should be worn once











- Contaminated/infectious masks should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious masks should be discarded into the offensive waste stream, refer to the 'Safe disposal of waste Policy for General Practice' for further information
- Hand hygiene should be performed after disposing of masks





5 Correct Procedure For Donning and Doffing PPE

	<p>Ensure you are 'Bare Below the Elbows' and hair is tied back. Clean your hands. Pull apron over your head and tie at back of your waist.</p>		<p>Grasp the outside of the glove with opposite gloved hand, peel off, holding the removed glove in the gloved hand. Slide the fingers of the un-gloved hand under the remaining glove at the wrist and peel off. Discard. Clean hands.</p>
	<p>Elasticated masks: Position loops behind ears. Tied masks: Position upper straps on the crown of your head, lower straps at the nape of your neck. For both masks: With both hands, mould the flexible band over the bridge of your nose.</p>		<p>Break apron strap at the neck, allow the apron to fold down on itself. Break waste straps at your back and fold apron in on itself. Fold or roll into a bundle taking care not to touch the outside surface. Discard. Clean hands.</p>

	<p>Holding the eye protection by the sides, place over your eyes.</p>		<p>Handle eye protection only by the headband or the sides. Discard disposable eye protection. Reusable eye protection must be decontaminated. See note below. Clean hands.</p>
	<p>Put on gloves and extend to cover your wrists.</p>		<p>Elasticated masks: Pull loops over ears. Tied masks: Untie or break lower straps followed by upper straps. Both masks: Holding only by the loops or straps, discard. Clean hands.</p>



6 References

- Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*
- Department of Health (2013) *Choice Framework for local Policy and Procedures (CFPP) 01-04 Decontamination of linen for health and social care: Social care*
- Department of Health (2007) *Transport of Infectious Substances best practice guidance for microbiology laboratories*
- Department of Health (2006) *Essential steps to safe, clean care*
- Health and Safety Executive *Respiratory protection equipment: Fit testing basics* www.hse.gov.uk/respiratory-protective-equipment/fit-testing-basics.htm [Accessed June 2021]
- Health and Safety Executive *Choosing the right gloves to protect skin: A guide for employers* www.hse.gov.uk/skin/employ/gloves.htm [Accessed May 2021]
- Health and Safety Executive (2013) *Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations)*. HSE Information sheet www.hse.gov.uk/pubns/hsis7.pdf
- Health and Safety Executive (2009) *The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations (CDG 2009)* www.legislation.gov.uk/ukxi/2009/1348/contents/made
- Health and Safety Executive (1974) *Health and Safety at Work, etc. Act 1974* London
- Loveday HP, et al, epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England *Journal of Hospital Infection* 86S1 (2014) S1-S70
- National Institute for Health and Care Excellence (2012, updated February 2017) *Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139*
- NHS England and NHS Improvement (2021) *National Standards of Healthcare Cleanliness 2021*
- NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*



05 Hand hygiene

1. Introduction
2. Involving patients and the public in infection prevention and control
3. Microbiology of the hands
4. Good hand hygiene practice
5. When to clean your hands
6. Most commonly missed areas
7. Hand hygiene products
8. Hand hygiene facilities
9. Hand cleaning methods
10. Alcohol handrub
11. Skin care
12. Hand cream or lotion
13. References
14. Appendix 1: Hand Hygiene Technique for Staff

1 Introduction

The aim of this guidance is to promote good hand hygiene amongst all staff, to prevent the risk of patients acquiring a healthcare associated infection.

All staff should have training on hand hygiene, it is best practice that this is provided on a regular basis, e.g. annually. The Practice should minimise the risk of poor hand hygiene and have processes in place to prevent this occurring. Hand hygiene is one of the most important procedures for preventing the spread of disease. It is essential that everyone takes responsibility to ensure that the care provided is carried out in a safe manner.

The transmission of microorganisms, such as bacteria and viruses, from one patient to another via staff's hands, or from hands that have become contaminated from the environment, can result in adverse outcomes.

Two routes of infection exist: microorganisms can be introduced into susceptible sites, such as surgical wounds, by direct contamination or potential pathogenic (harmful) organisms can be transmitted by hands and establish themselves as temporary or permanent colonisers of the patient and subsequently cause infection at susceptible sites.



Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

2 Involving patients and the public in infection prevention and control

Staff should encourage the involvement of patients and the public in infection prevention and control.

In order to facilitate compliance, the following should be introduced:

- Provide alcohol handrub at the entrance to the building or reception area for the use of patients and visitors (see section 10)
- Notices and hand hygiene posters should be displayed regarding hand hygiene to attract the attention of patients and visitors
- Hand hygiene information leaflets should be available to patients (where appropriate) suffering from alert organisms, e.g. *E. coli* 0157, *Clostridioides difficile* and MRSA infection. A 'Hand hygiene: Information leaflet for community service users and relatives' is available to download at www.infectionpreventioncontrol.co.uk

3 Microbiology of the hands

The skin on our hands harbour two types of microorganisms:

- **Transient microorganisms**
Transient microorganisms include bacteria and fungi, and are located on the superficial layers of the skin. They are termed 'transient' as they do not stay long, 'hitching a ride' on the surface of hands where they are easily transferred to other people, for example, contact with a patient's wound, care equipment, and the environment. Transient microorganisms are easily transmitted from staff hands to vulnerable patient sites. However, unlike **resident** bacteria, they are easily removed by routine handwashing with liquid soap and warm running water or the use of an alcohol handrub



- **Resident microorganisms (commensal or normal flora)**

Resident microorganisms, e.g. *Staphylococcus epidermidis*, diphtheroids and occasionally *Staphylococcus aureus*, reside under the superficial cells of the stratum corneum - in skin crevices, hair follicles, sweat glands and under finger nails. Their primary function is defensive in that they protect the skin from invasion by more harmful microorganisms. They do not readily cause infections, but can, however, cause infection, e.g. if they enter the body through broken skin, a person is immunocompromised. They are not easily removed with routine handwashing alone. Either an antimicrobial solution should be used or routine (social) handwash followed by an application of alcohol handrub

4 Good Hand Hygiene

To facilitate effective hand hygiene when delivering direct care, staff must ensure that they:

- Cover cuts and abrasions with waterproof dressings
- Are 'Bare Below the Elbows', which entails:
 - Wearing short sleeved clothing or rolling sleeves up to the elbows
 - Removing wrist and hand jewellery. Rings with jewels, stones, ridges or grooves, should not be worn as these may harbour bacteria and also prevent good hand hygiene. A plain band ring may be worn, but ensure the area under the ring is included when hands are washed or alcohol handrub applied
 - Not having dermal piercings on the arms or wrists
 - Keeping nails clean and short (fingertip length), as long finger nails will allow a build-up of dirt and bacteria under the nails and impede effective handwashing
 - Keeping nails free from nail polish/gel as flakes of polish/gel may contaminate a wound and broken edges can harbour microorganisms
 - Keeping nails free from acrylic/artificial nails, nail art/accessories, as these can harbour microorganisms, become chipped or detached.



5 When to Clean Your Hands

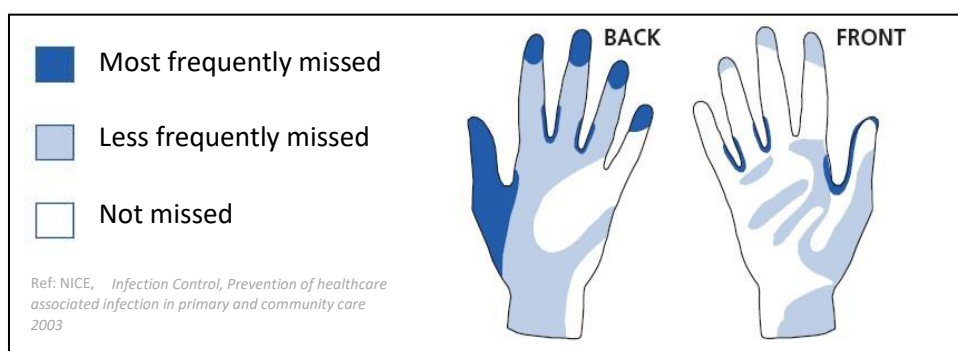
1 BEFORE PATIENT CONTACT	<p>WHEN? Clean your hands before touching a patient when approaching him/her.</p> <p>WHY? To protect the patient against harmful germs carried on your hands.</p>
2 BEFORE A CLEAN/ASEPTIC PROCEDURE	<p>WHEN? Clean your hands immediately before any clean/aseptic procedure.</p> <p>WHY? To protect the patient against harmful germs, including the patient's own, from entering his/her body.</p>
3 AFTER BODY FLUID EXPOSURE RISK	<p>WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal).</p> <p>WHY? To protect yourself and the health and social care environment from harmful patient germs.</p>
4 AFTER PATIENT CONTACT	<p>WHEN? Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side.</p> <p>WHY? To protect yourself and the health and social care environment from harmful patient germs.</p>
5 AFTER CONTACT WITH PATIENT SURROUNDINGS	<p>WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched.</p> <p>WHY? To protect yourself and the health and social care environment from harmful patient germs.</p>

Other examples of when hand hygiene should be performed:

- **Whenever** hands are visibly dirty or soiled
- **Before** the start of your shift, **between** each task and **before** you go home
- **Before** putting on and **after** removal of personal protective equipment, (wearing gloves should not be a substitute for handwashing)
- **Before** and **after** having a coffee/tea/meal break
- **After** coughing, sneezing or blowing your nose
- **After** using the toilet

6 Most Commonly Missed Areas

It is important to pay particular attention to the following areas which have been shown to be those most commonly missed during handwashing.





7 Hand Hygiene Products

The product should be deemed suitable for its intended use by the manufacturer and comply with European Standards. When choosing products, consideration should be given to the risk of dermatological side effects.

- Ensure products are within the expiry date.
- A good quality liquid soap with a moisturiser is recommended for routine (social) hand hygiene. The liquid soap should be in a disposable cartridge in a wall mounted dispenser.
- An alcohol handrub may be used for routine (social) hand hygiene. The alcohol handrub should contain a minimum of 60% isopropyl alcohol (see section 10).
- When it is not possible to perform handwashing, e.g. in the event of loss of the water supply, non-alcohol skin wipes, e.g. baby wipes, can be used for hand hygiene. Hands should be rubbed vigorously, then apply alcohol handrub, if available, using the steps 2- 8 shown in Appendix 1, ensuring

that all surfaces of the hands and wrists are covered with the product until the solution has dried

An antimicrobial solution should be used prior to an invasive procedure. Types of antimicrobial solutions include:

- 4% Chlorhexidine gluconate skin cleanser, e.g. Hibiscrub

- 7.5% Povidone iodine
- 2% Triclosan skin cleanser
- 70% Isopropanol plus 0.5% Chlorhexidine gluconate solution, e.g. Hibi Liquid Handrub+ solution.

8 Hand hygiene Facilities

Hand hygiene facilities should be available within a GP Practice and not compromise standards by being dirty or in a poor condition:

Facilities should be adequate and conveniently located

Handwash basins must be available in areas where needed and where patient care or consultations take place

Handwash basins in clinical areas should have a single lever or sensor mixer tap which does not run directly into the drain aperture, with no plug or overflow



If a lever or sensor mixer tap is not provided, use a paper towel to turn off the tap to avoid contaminating the hands

Handwash basins should not be used for any other purpose, e.g. disposing of urine, washing cups, decontamination of equipment, due to the risk of cross-contamination

In areas where a sink is used for other cleaning purposes, e.g. emptying buckets of water in the cleaner's room, there should also be a separate dedicated handwash basin.

Bar soap should not be used as it can harbour microorganisms

Use wall mounted liquid soap dispensers with disposable soap cartridges. Do not use refillable soap dispensers as there is a risk of contamination of the liquid soap and the dispenser

Fabric hand towels must not be used

Paper towels should be used in clinical areas and staff toilets as they are the most effective way of removing microorganisms. Wall mounted dispensers should be positioned next to the basin, but not so close as to risk contamination of the dispenser or towels. Good quality soft paper towels will help to prevent skin abrasion

Keep all dispenser surfaces, inside, outside and underneath, clean and replenished

- A foot operated lidded lined waste bin, should be positioned near the handwash basin
- Hot air driers are not suitable for clinical areas, but can be used in nonclinical areas
- Nail brushes should not be used routinely as they can cause skin damage and harbour bacteria. If nail brushes are used, they should be single use and disposed of after use.

9 Hand cleaning Methods

Handwashing is probably the most important method of protecting the patient. There are three levels of hand hygiene:

Routine (social) hand hygiene

Using liquid soap and warm running water removes dirt, organic matter, e.g. blood, faeces, and most transient organisms, acquired through direct contact with a patient or the environment. The use of a liquid soap containing a moisturiser is recommended to prevent drying of the skin. Handwashing process should take 15-30 seconds.

- Ensure you are 'Bare Below the Elbows'.
- Wet hands first under warm running water.
- Apply liquid soap.



- Rub all parts of the hands for at least 10-15 seconds (see Appendix 1), ensuring that all surfaces of the hands and wrists are covered with soap.
- When caring for patients with confirmed or suspected COVID-19 or any other new emerging infections, rub all parts of the hands and in addition, using steps 2-8 shown in Appendix 1, rub exposed forearms as these may have been exposed to respiratory droplets.
- Rinse hands thoroughly under warm running water to remove residual soap/solution.
- Dry hands thoroughly using paper towels.
- Alternatively, alcohol handrub can be used instead of liquid soap and warm water if hands are visibly clean.

Antiseptic hand hygiene

Using an antimicrobial solution or liquid soap and warm running water followed by an application of alcohol handrub disinfects the hands by removing transient organisms and reducing the number of resident organisms. This type of hand hygiene should be carried out prior to invasive procedures.

- Ensure you are 'Bare Below the Elbows'.
- Wet hands under warm running water.

Apply antimicrobial solution or liquid soap.

Rub all parts of the hands for at least 10-15 seconds (see Appendix 1), ensuring that all surfaces of the hands and wrists are covered with soap/solution.

Rinse hands under warm running water to remove residual soap/solution.

Dry hands thoroughly using paper towels.

If hands are washed with liquid soap, dry hands thoroughly and apply alcohol handrub after washing, ensuring all surfaces of the hands and wrists are covered with the product until the solution has dried.

Surgical hand hygiene

Using an antimicrobial solution removes transient organisms and a substantial number of resident organisms. The solution will bind to the skin forming an effective barrier that will keep killing bacteria for up to 6 hours after application. This type of handwashing is only required before more invasive surgical procedures, e.g. vasectomy.

Procedure for using an antimicrobial solution Ensure you are 'Bare Below the Elbows'.



Thoroughly wash the hands for 2 minutes following the technique in Appendix 1.

Wash each arm from the wrist to the elbow for 1 minute, keeping the hand higher than the elbow at all times.

Rinse hands and arms thoroughly from fingertips to elbow, keeping the hands above the elbows at all times.

Dry hands thoroughly with a sterile paper towel.

Procedure for using 70% Isopropanol plus 0.5% Chlorhexidine gluconate

This has been found to be as effective as the aqueous antimicrobial skin disinfectant products. If using this type of product: Ensure you are 'Bare Below the Elbows'

Dispense at least 5 mls of alcohol disinfectant solution, e.g. Hibisol, into the cupped palm and rub all skin surfaces of the hands and forearms
Rub vigorously for four minutes, ensuring that all surfaces of the hands, wrists and forearms, are covered with the product until the solution has dried

Alcohol handrub containing a minimum of 60% isopropyl alcohol is an effective alternative to handwashing and is useful when there is a need for rapid hand disinfection. It should be applied to all areas of the hands using the steps 2-8 shown in Appendix 1, ensuring that all surfaces of the hands and wrists are covered, until the solution dries.

10 Alcohol Handrub

Alcohol Handrub **should not be used:**

- When caring for patients with *Clostridioides difficile* or other diarrhoeal illness, due to being ineffective against spores and Norovirus
- On hands that have come into contact with body fluids
- After cleaning an area or care equipment where a patient has diarrhoea and/or vomiting

Alcohol handrub:

- Should only be applied to visibly clean skin
- May be less effective if used immediately after the application of a hand cream/moisturiser



Technique for using alcohol handrub

- Ensure you are 'Bare Below the Elbows' (see Section 4).
- Dispense the manufacturer's recommended amount of alcohol product on to hands, ensuring it covers all surfaces of the hand and wrist.
- Rub hands, using the steps 2-8 shown in Appendix 1, ensuring that all surfaces of the hands and wrists are covered with the product until the solution has dried (about 20 seconds).

Alcohol handrub can be used between cases on a surgical list provided a surgical handwash is undertaken initially and hands are visibly clean.

Availability of alcohol handrubs

The availability of alcohol handrub at the point of patient contact was recommended by the National Patient Safety Agency (NPSA) as part of their 'cleanyourhands' campaign in 2005. Although initially implemented only in the acute setting, this was later promoted nationally for use in community settings. To reduce the risk of misuse, e.g. ingestion, a risk assessment should be undertaken before siting alcohol handrub.

Alcohol handrub should be available in wall mounted alcohol handrub dispensers with disposable cartridges or free-standing pump dispensers:

- At the entrance to the building or reception desk, following a risk assessment
- At the point of care:
 - Wall mounted adjacent to the examination couch inside the curtain area
 - Wall mounted adjacent to the consulting room desk/chair
 - Free standing bottle on the consulting room desk
 - Personal dispenser clipped onto the healthcare workers clothing

Alcohol handrub must not be applied to gloved hands as this may affect the integrity of the glove material.

11 Skin Care

To minimise the risk of skin damage, wet hands under warm running water before applying liquid soap or antiseptic solution.

Rinse hands well to remove residual soap and dry thoroughly to prevent chapping.

Always cover cuts and abrasions with a waterproof dressing.

Seek Occupational Health or GP advice if you have a skin irritation.



12 Hand Cream or Lotion

The use of hand cream or lotion will help prevent skin problems and irritation, therefore, promoting compliance with hand hygiene.

For maximum benefit, hand cream or moisturiser should be used 3 times daily.

It is good practice to provide hand cream or moisturiser in a wall mounted dispenser. All should be in a single use cartridge or container.

Communal pots of hand cream (where fingers are placed in the container) should not be used as the contents can become contaminated.

13 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (2007) *Essential Steps to safe, clean care* Loveday HP

et al (2014) *epic3: National Evidence-Based Guidelines for*

Preventing Healthcare Associated Infections in NHS Hospitals in England Journal of Hospital Infection 86S1 S1-S70

www.his.org.uk/files/3113/8693/4808/epic3_National_Evidence-Based_Guidelines_for_Preventing_HCAI_in_NHSE.pdf

National Institute for Health and Care Excellence (2012, updated February 2017) *Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139*

National Institute for Health and Care Excellence (2019) *Clinical Knowledge Summary Healthcare-associated infections: Scenario: Prevention and control of healthcare associated infections (Hand hygiene – use of paper towels in clinical areas and staff toilets)* <https://cks.nice.org.uk/topics/healthcare-associatedinfections/management/management/#hand-hygiene>

National Patient Safety Agency (2011) *Clean Your Hands Campaign 5 Moments for hand hygiene*

NHS England and NHS Improvement (April 2021) *National Standards of Healthcare Cleanliness 2021*


NHS England and NHS Improvement (April 2020) *Uniforms and workwear: guidance for NHS employers*

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy* Royal Marsden NHS Foundation Trust (2020) *The Royal Marsden Hospital Manual of Clinical and Cancer Nursing Procedures 10th Edition*

WHO (2009) *WHO Guidelines on Hand Hygiene in Health Care: First Global Service User Safety Challenge. Clean Care is Safer Care.* World Health Organization, Geneva whqlibdoc.who.int/publications/2009/9789241597906_eng.pdf



14 Appendix 1: Hand Hygiene Technique for Staff



HAND HYGIENE TECHNIQUE FOR STAFF

- If using liquid soap and warm water, use all steps.
- If using alcohol handrub, use steps 2-8.

0 Wet hands under warm running water

1 Apply enough liquid soap to cover all hand surfaces

2 Rub hands palm to palm in a circular action

3 Rub back of each hand with the palm of other hand with fingers interlaced

4 Rub palm to palm with fingers interlaced

5 Rub backs of fingers to opposing palms with fingers interlocked

6 Rub each thumb clasped in opposite hand using a rotational action

7 Rub tips of fingers in opposite palm in a circular action

8 Rub each wrist with opposite hand

9 Rinse hands under warm running water

10 Use elbow or paper towel to turn off tap

11 Dry thoroughly with paper towels

12 Your hands are now safe



06 Notifiable Diseases

1. Introduction
2. List of notifiable diseases
3. References

1 Introduction

Diseases that are notifiable to the Local Authority Proper Officers under the Health Protection (Notification) Regulations 2010 are listed below.

Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local Council or Health Protection (HP) Team of suspected cases of certain infectious diseases.

2 List of Notifiable Diseases

Diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010:

Disease	Whether likely to be routine or urgent
Acute encephalitis	Routine
Acute infectious hepatitis (A, B, C)	Urgent if suspected bacterial infection, otherwise routine
Acute meningitis	Urgent
Acute poliomyelitis	Urgent
Anthrax	Urgent
Botulism	Urgent
Brucellosis	Routine: urgent if UK acquired
Cholera	Urgent
COVID-19	Urgent
Diphtheria	Urgent
Enteric fever (typhoid or paratyphoid)	Urgent
Food poisoning	Routine: urgent, if as part of a cluster or outbreak
Haemolytic uraemic syndrome (HUS)	Urgent
Infectious bloody diarrhoea	Urgent
Invasive group A streptococcal disease	Urgent



Legionnaires' disease	Urgent
Leprosy	Routine
Malaria	Routine: urgent if UK acquired
Measles	Urgent
Meningococcal septicaemia	Urgent
Mumps	Routine
Plague	Urgent
Rabies	Urgent
Rubella	Routine
Severe Acute Respiratory Syndrome (SARS)	Urgent
Scarlet fever	Routine
Smallpox	Urgent
Tetanus	Routine: urgent if associated with injecting drug use
Tuberculosis	Routine: urgent if healthcare worker or suspected cluster or multidrug-resistant
Typhus	Routine
Viral haemorrhagic fever (VHF)	Urgent
Whooping cough	Urgent if diagnosed in acute phase: routine if later diagnosis
Yellow fever	Routine: urgent if UK acquired

This list is not exhaustive. If in doubt, please telephone your local HP Team.

Report other diseases that may present significant risk to human health under the category 'other significant disease'.

3 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (May 2010, updated October 2020) *Notifiable diseases and causative organisms: how to report*

Department of Health (March 2010) *Health Protection Legislation (England) Guidance*

Public Health England (May 2010) *Statutory notification by registered medical practitioners* of all hazards: infections, chemicals & radiation*

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820133/PHE_Notifiable_diseases_poster_HPT.pdf



07 Safe disposal of waste

1. Introduction
2. Responsibilities
3. Disposal of waste
4. Assessing waste for segregation
5. References

1 Introduction

The management of healthcare waste is an essential part of ensuring that General Practice activities do not pose a risk or potential risk of infection and are appropriately managed. Waste is potentially hazardous and if not disposed of correctly can result in injury or infection.

All staff are responsible for the safe management and disposal of waste and should understand how waste should be segregated and stored prior to collection or disposal. This is driven by the need to reduce environmental impact, comply with waste regulations and other national guidance such as *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*, and reduce costs associated with waste management.

Contingency plans and emergency procedures should be in place in the event of contamination from waste.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SCIPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance on the disposal of waste.

2 Responsibilities

Staff in General Practice have a responsibility for ensuring that waste is dealt with appropriately from the point of generation to the point of final disposal. All staff should be trained and aware of waste procedures. It remains the legal responsibility of the General Practice, not the waste contractor, to ensure full compliance with environmental waste regulations. Waste should be:



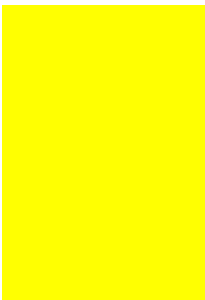

- Correctly segregated
- Appropriately labelled
- Packaged appropriately for transportation
- Stored safely and in a secure place away from areas of public access within the premise
- Described accurately and fully on the accompanying documentation when removed from the premise
- Recorded and copies of the waste documentation retained, including record keeping
- Transferred to an authorised waste contractor for transport to an authorised waste disposal site
- Monitored, audited and the way in which waste arrangements work, should be reviewed

3 Disposal of Waste

- All waste should be segregated correctly (see Section 4) as per your local policy and in accordance with your waste contractor.
- When handling waste, appropriate personal protective equipment (PPE) should be worn, and hands cleaned after removing PPE.
- All waste bags should be no more than 3/4 full. This allows enough space for the bag to be tied using a suitable plastic zip tie or secure knot.
- Waste bags should be labelled with the address and date prior to collection by the waste contractor (some waste contractors may undertake this) to ensure traceability if an incident occurs.
- When handling tied waste bags, only hold the bag by the neck and keep at arm's length to reduce the risk of injury in case a sharp item has been inappropriately disposed of in the bag.
- If a waste bag awaiting collection is torn, the torn bag and contents should be placed inside a new waste bag.
- Waste bins in clinical areas and toilets should be lined and foot pedal operated with a lid. Always use the foot operated mechanism to open the lid to prevent hand contamination.
- Waste bins in other areas, e.g. office, should have a liner, but do not need to have a lid.



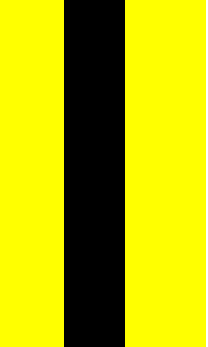
Assessing Waste for Segregation

<p>Clinical infectious waste Waste from a patient with a confirmed or suspected infection which poses a potential infection risk and there are also medicines or chemicals present.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Anatomical wastes and tissue samples preserved in hazardous chemicals • Medicines, medicinally contaminated syringe bodies, medicated dressings • Contaminated dressings that contains an active pharmaceutical, e.g. ibuprofen • Diagnostic kits contaminated with potentially infectious body fluids and chemical reagents (this does not include sticks from dip tests) <p>Domestic and offensive waste must not be placed in this waste stream</p>	<p>Yellow: Yellow bag or yellow lidded sharps container</p> 	<p>For incineration in a suitably permitted or licensed facility (must not be sent for alternative treatment)</p>
<p>Clinical infectious waste Waste from a patient with a confirmed or suspected infection, but not contaminated with medicines or chemicals.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Contaminated PPE, e.g. gloves, aprons • Contaminated dressings that do not contain an active pharmaceutical • Very small pieces of tissue • Syringe bodies contaminated with body fluids, but not medicines <p>Domestic and offensive waste must not be placed in this waste stream</p>	<p>Orange: Orange bag or orange lidded sharps container</p> 	<p>Can be sent for treatment to render it safe prior to disposal or incinerated in a permitted or licensed facility</p>

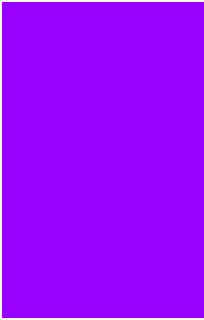
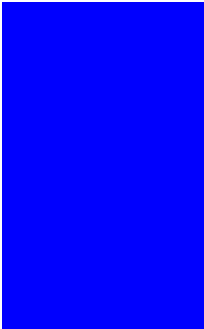
Waste should be assessed by the member of staff at the time the waste is produced and segregated in the correct colour waste stream identified below. Further information can be



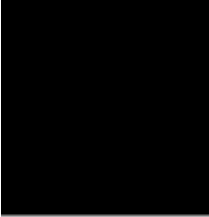
found in the *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste.*

<p>Offensive/hygiene waste General Practices will generate two different offensive waste streams which should be segregated.</p> <p>Domestic-type waste <i>Note: if the total quantity in a collection interval is less than 7kg, this waste can be placed in the black bag (municipal/domestic) waste stream.</i></p> <p>Examples are:</p> <ul style="list-style-type: none"> • Feminine hygiene wastes from toilets • Nappies from otherwise healthy children, etc <p>Healthcare-type waste Waste from patients with no confirmed or suspected infection which may be contaminated with body fluids.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Gloves, aprons • Uncontaminated dressings • Empty non-medicated infusion bags • Stoma or catheter bags* • Cardboard vomit/urine bowls* • Incontinence pads • Female hygiene waste, nappies <p><i>*Note: Liquids, e.g. urine, faeces, vomit, should not be placed in this waste stream and may need to be discarded to foul sewer before containers are discarded</i></p> <p>Mixing of waste is prohibited - offensive waste must be separated from the clinical waste stream</p>	<p>Yellow and black striped: Yellow and black striped bag</p> 	<p>May be landfilled in a permitted or licenced waste facility</p>
--	--	--



<p>Cytotoxic or cytostatic medicine waste Waste classified as hazardous consisting of, or contaminated with, cytotoxic and/or cytostatic medicines.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Medicine containers with residues of cytotoxic or cytostatic medicines (bottles, infusion bags or syringe barrels) • Items contaminated with cytotoxic or cytostatic medicines, e.g. swabs <p>Used sharps from treatment using cytotoxic or cytostatic medicines</p>	<p>Purple: Purple bag or yellow and purple striped bag. Purple lidded sharps container</p> 	<p>Must be sent for incineration in a permitted or licenced waste facility</p>
<p>Medicinal waste classed as non-hazardous Non-infectious, non-cytotoxic or cytostatic.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Unused medicines in original packages • Part empty containers containing residues of medicines • Empty medicine bottles • Medicated, e.g. antibiotic, infusion bags <p>Medicines in aerosol form, e.g. betadine iodine, cryogenic sprays, asthma medication, must be segregated from other medicines, or their presence identified on the accompanying waste documentation</p>	<p>Blue: Blue lidded sharps container</p> 	<p>For incineration in a permitted or licenced waste facility</p>



<p>Municipal/domestic waste Non-hazardous paper, includes items normally found in household waste.</p> <p>Examples are:</p> <ul style="list-style-type: none"> • Newspapers • Food waste • Paper towels from handwashing • Uncontaminated couch roll • Packaging 	<p>Black: Black bag (clear or opaque bags may be used)</p> 	<p>For landfill at a suitable permitted facility</p>
--	---	--

5 References

Department of Health (2015) *The Health and Social Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (2013) *Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste*

Department of Health (2011) *Safe management of healthcare waste Version 2.0: England*

Royal College of Nursing (2014) *The management of waste from health, social and personal care RCN guidance*



08 Safe management of blood and body fluids

1. Introduction
2. Dealing with blood and body fluid spillages
3. Splashes of blood or body fluids
4. References

1 Introduction

Blood and body fluids, e.g. urine and faeces, may contain a large number of microorganisms, such as bacteria and viruses.

Staff who may have contact with blood or blood stained body fluids, or are exposed to sharps or other inoculation risks, should have had the opportunity for hepatitis B vaccination and antibody testing to check for their response.

Contamination or spillages with blood or body fluids should be dealt with immediately, as this may expose staff and others to infection. Blood and body fluid spillages should be managed by staff trained in the correct procedure.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

GP Practices should ensure regular audits to monitor compliance with the Policy are undertaken and to provide assurance.

2 Dealing with blood and body fluid spillages

Clean up blood and body fluids promptly to reduce the risk of infection to other people.

Appropriate personal protective equipment (PPE) should be worn and standard infection control precautions followed.

Best practice is to use a spillage kit appropriate to the type of spillage, e.g. blood/blood stained body fluids or non-blood body fluids, which should be used following the manufacturer's guidance and within its expiry date.



Spillage kits may contain solidifying polymer granules. A National Patient Safety Alert issued in 2017, following a number of deaths and incidents related to patients ingesting the product, advises a risk assessment and procedures in place to ensure supplies are securely stored away from the general public.

- If the spillage kit is unsuitable for use on soft furnishings, untreated wood and carpets, clean the surface using a pH neutral detergent and warm water, a carpet shampoo machine or steam cleaner.
- If soft furnishings or other items are heavily contaminated with blood or body fluids that cannot be adequately decontaminated, they should be disposed of appropriately.
- Dispose of waste and PPE as infectious waste.
- Wash hands with liquid soap and warm running water.
- If a mop and bucket are used, they should be in accordance with the national colour coding, refer to the 'Safe management of the care environment Policy for General Practice'. After use, the mop head should be disposed of immediately as infectious waste and the bucket washed with detergent and warm water and dried with paper towels, and then wiped with a chlorine-based disinfectant at 1,000 parts per million and stored upside down to air dry.
- All cloths used must be single use and disposed of after use.

3 Splashes of blood or body fluids

Splashes of blood or body fluids to the eyes, nose or mouth must be treated as potential exposure to a blood-borne virus, refer to the 'BBVs Policy for General Practice'.

- For appropriate management of percutaneous exposures (sharps/splash injuries), refer to the 'Safe management of sharps and inoculation injuries Policy for General Practice'.

4 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Health and Safety Executive *How to deal with an exposure incident*

www.hse.gov.uk/biosafety/blood-borne-viruses/how-deal-exposureincident.htm#immediate [Accessed May 2021]

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*

NHS England (2017) *Risk of death and severe harm from ingesting superabsorbent polymer gel granules* NatPSA/2019/002/NHSPS www.england.nhs.uk/wp-content/uploads/2020/02/PS_Alert_Polymer_28_Nov_2019_FINAL.pdf



09 Respiratory and Cough Hygiene

1. Introduction
2. What are respiratory tract infections?
3. How are respiratory secretions infections spread?
4. Good respiratory and cough hygiene
5. References

1 Introduction

Respiratory and cough hygiene can help reduce the risk of spreading respiratory infections, protecting those in contact with the infected person, e.g. patients and staff.

Staff should adopt good respiratory and cough hygiene practices themselves and promote them to patients.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

GP Practices should ensure regular audits to monitor compliance with the Policy are undertaken and to provide assurance.

2 What are respiratory tract infections?

Respiratory tract infections (RTIs) are mainly caused by viruses and can affect the upper respiratory tract or the lower respiratory tract.

Upper respiratory tract infections (URTIs), e.g. sore throat, Rhinovirus (common cold), sinusitis, involve the throat, nose or sinuses.

Lower respiratory tract infections (LRTIs), e.g. pneumonia, bronchitis, tuberculosis, involve the large airways in the lungs.

RTIs caused by a virus, e.g. the common cold, usually get better without any treatment.



RTIs caused by bacteria, e.g. pneumonia, tuberculosis, usually require antibiotic treatment and in some cases, admission to hospital.

Symptoms of an RTI include:

- A sore throat
- Sneezing
- A cough - which may bring up mucus
- A stuffy or runny nose
- Headaches
- Muscle aches
- Tight chest, wheezing or breathlessness
- Fever
- General unwell feeling

3 How are respiratory secretions infections spread?

When a person with a respiratory infection coughs or sneezes, millions of viral or bacterial particles are released from the mouth or nose in respiratory droplets. These droplets travel in the air, contaminating people and surfaces in their path.

Infection is then spread either:

- Person-to-person, e.g. the droplets land directly on the mucous membranes of a person's eyes, nose or mouth, and the infection then enters their body
- Indirectly, e.g. the droplets land on surfaces such as care equipment, desk or person. Hands that then come into contact with that surface become contaminated. If the hands are not cleaned and the person touches their eyes, nose or mouth, they can become infected

Bacteria and viruses can survive in the environment from hours to months, e.g. influenza virus up to 24 hours, COVID-19 up to 72 hours.

For advice on influenza management, please contact your local Community Infection Prevention and Control (IPC) or Health Protection (HP) Team.

Other illnesses caused by viruses, e.g. chicken pox, measles, can also be spread by inhaling droplets of the respiratory secretions from an infected person's cough or sneeze, or from touching surfaces contaminated when they coughed or sneezed.

Those most at risk of developing complications of infections spread by respiratory secretions include:

- Children under 5 years of age
- Adults aged 65 years and over



- People age 6 months to 65 years and over who have chronic diseases or lowered immunity levels
- Pregnant women
 - Adults aged 65 years and over
 - People age 6 months to 65 years and over who have chronic diseases or lowered immunity levels
 - Pregnant women

4 Good respiratory and cough hygiene

To reduce the risk of spreading infections when coughing, sneezing, wiping or blowing the nose, staff and patients should:

- Have access to and use disposable tissues (not cloth handkerchiefs)
- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose
- Dispose of used tissues into a waste bin or bag immediately after use
 - Clean hands with either:
 - Liquid soap and warm running water; or
 - Skin wipes or alcohol handrub

For further details, refer to the 'Hand hygiene Policy for General Practice'.

Staff may need to help patients to ensure that:

- Disposable tissues are available
- There is a waste bin within easy reach for them to dispose of used tissues
- They are able to or are assisted to clean their hands

Do not:

- Use cloth handkerchiefs
- Touch the eyes, nose and mouth until hands have been cleaned after contact with respiratory secretions or items contaminated with them, e.g. tissues, surfaces
- Use skin wipes if suitable handwashing facilities are available
- Contaminate surfaces and pockets of uniform or clothing with used tissues



If no disposable tissue is available, cough or sneeze into your elbow or upper arm, not your hand and not into the air. Although this won't stop all the respiratory secretions spreading, it can reduce the distance they travel.



Respiratory and cough hygiene



- Cough or sneeze into a clean tissue, not into your hands.



- Dispose of the tissue immediately into the nearest waste bin.



- If you do not have a tissue, cough or sneeze into your upper sleeve.



- Always clean your hands after coughing or sneezing, either using soap and warm running water, alcohol handrub or hand wipes.

These steps will help prevent the spread of colds, flu and other respiratory infections



5 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

<https://fitfortraveltest.scot.nhs.uk/advice/disease-prevention-advice/respiratoryhygiene-and-infections#Respiratory> [Accessed May 2021]



10	Safe management of linen (including uniforms and work wear)
-----------	--

1. Introduction
2. Curtains
3. Pillows and blankets
4. Staff uniforms and workwear
5. References

1 Introduction

The use of linen, such as blankets, pillowcases, fabric hand towels, in General Practice is not recommended as it is not practical to launder items between each patient. Best practice is to use disposable paper products, e.g. paper towels, couch roll.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

GP Practices should ensure regular audits to monitor compliance with the Policy are undertaken and to provide assurance.

2 Blinds, Curtains and Screens

All blinds, curtains and screens (disposable or fabric) should be visibly clean with no blood, bodily substances, dust, dirt, debris stains or spillages.

Blinds, curtains and screens should be included on cleaning schedules and records should be maintained for evidence/assurance.

The frequency of changing/cleaning is determined by assessing each functional area containing window blinds, curtains and screens, assessing and assigning the area to one of the six functional risk (F1-6) categories. In addition, any blinds, curtains or screens that are visibly soiled should be



changed/cleaned immediately. Refer to the *National Standards of Healthcare Cleanliness 2021* for further information.

All fabric curtains and screens should be laundered by a professional laundry service. The washing process should have a disinfection cycle in which the temperature of the load is either maintained at 65°C for not less than ten minutes or 71°C for at least 3 minutes.

3 Pillows

Pillows should be in a sealed wipeable cover with no tears and should be decontaminated appropriately with a detergent or detergent and disinfectant wipe after use. Damaged or stained wipeable covers and/or pillows should be replaced.

Fabric pillow cases, couch sheets and 'modesty' blankets are not recommended as it is not practical to launder them after each patient use. Disposable couch roll should be used to cover the couch, pillow, or maintain the patient's modesty for procedures where this is required and disposed of after each use. The pillow/couch should then be decontaminated appropriately with a detergent or detergent and disinfectant wipe.

4 Staff Uniforms and Workwear

Code of Practice on the prevention and control of infections and related guidance recommends that clothing/uniform and workwear policies ensure that clothing worn by staff when carrying out their duties should be clean and fit for purpose. Particular consideration should be given to items of attire that may inadvertently come into contact with the patient.

- Always:
 - Change in and out of uniform at work, or completely cover uniform when travelling to and from work
 - Wear a clean uniform at the start of each shift and have enough uniforms to facilitate this
 - Use personal protective equipment, e.g. disposable apron, to prevent contamination of uniform and workwear □ Uniforms and workwear should be:
 - Clean, fit for purpose and support good hand hygiene
 - Changed immediately if visibly soiled or contaminated
 - Laundered on a cycle of ten minutes at 60°C, which removes almost all microorganisms, or at the highest temperature that the fabric will tolerate



- Laundered separately from other clothing if heavily soiled ○
Dried thoroughly. Tumble drying or ironing will further reduce the small number of microorganisms present after washing
- It is not good practice to wear neckties (other than bow ties) or lanyards during direct patient contact. Ties are rarely laundered and have been shown to become contaminated with pathogens, and can accidentally come into contact with patients.
- Footwear must be well maintained, visibly clean, non-slip and support and cover the entire foot to avoid contamination with blood or body fluids or potential injury from sharps.

6 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (2016) *Health Technical Memorandum: 01-04 Decontamination of linen for health and social care: Management and provision*

NHS England and NHS Improvement (April 2021) *National Standards of Healthcare Cleanliness 2021*

NHS England and NHS Improvement (April 2020) *Uniforms and workwear: guidance for NHS employers*

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*



11 Safe management of sharps and inoculation injuries

1. Introduction
2. Good practice in sharps management
3. Prevention of inoculation incidents
4. Risk of infection from inoculation incidents
5. Action to be taken following an inoculation incident
6. Management of significant exposures
7. Reducing the risk of hepatitis B transmission
8. Reducing the risk of hepatitis C transmission
9. Reducing the risk of HIV transmission
10. Exposure incidents in the community
11. References

1 Introduction

This Policy is one of the 'Standard infection control precautions' (SICPs) referred to as 'Occupational safety/managing prevention of exposure (including sharps) by NHS England and NHS Improvement.

Sharps

Sharps include needles, cannulas, stitch cutters, scalpels, razor blades, broken glass, medical instruments, e.g. scissors, and other sharp objects.

Sharps which are handled inappropriately or not disposed of correctly are dangerous.

Health and Safety

Healthcare employers, their contractors and employees have legal obligations under the *Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations)*. All employers are required to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.



When caring for patients in relation to COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance.

GP Practices should ensure regular audits to monitor compliance with the Policy are undertaken and to provide assurance.

2 Good Practice in Sharps Management

Needle management

- Avoid unnecessary use of sharps.
- Where it is not reasonably practicable to avoid using sharps, safer sharps incorporating protection mechanisms should be used if possible.
- For certain procedures, needle free equipment is available and must be used.
- Sharps should only be used where they are required, e.g. not for collection of urine samples from catheter bags.

Request assistance when using sharps with reluctant or confused patients.

- Do not carry sharps in the hand. Sharps containers should be available at the point of use, i.e. where the sharp is used.
- Use a sharps tray with an integrated sharps container.
- Do not pass sharps from hand to hand.
- Do not recap needles.
- Dispose of needle and syringes as one unit into a sharps container.
- If it is necessary to detach the needle, great care must be taken, preferably using the device on the sharps container.
- Always carry sharps containers away from the body, ensuring the temporary closure mechanism is closed.

Ensuring safe use

- All staff (clinical and non-clinical) should be educated in the safe use and disposal of sharps and the action to take in the event of an injury.
- Sharps containers should be situated in a safe and secure place and not accessible to patients or visitors.
- In rooms or areas where sharps containers do not need to be moved, they should be wall-mounted near the point of use, i.e. where the sharp is used.



- A sharps container should never be placed on the floor.
- Sharps containers should comply with the UN3291 and British Standard BS7320.
- The correct size sharps container to be used should be determined according to the volume of sharps generated.
- Sharps should be placed into the correct colour coded sharps container:
 - Purple lid - sharps contaminated with cytostatic or cytotoxic medicines
 - Orange lid - sharps not contaminated with medicines, e.g. venepuncture
 - Yellow lid - sharps contaminated with medicines
- Always assemble sharps containers correctly, with the lid securely fastened to the base.
- Sharps containers must be labelled with the date and a signature when assembled.
- Sharps containers should not be used for any other purpose than the disposal of sharps.
- Sharps should be placed into the sharps container by the person using them.
- Never press down the contents to make more room or attempt to retrieve an item from the sharps container.
- After disposing of a sharp into the sharps container, the aperture should be moved into the temporary closure 'closed' position.
- The aperture must be 'locked' prior to disposal.
- Sharps containers must not be filled above the 'fill line' as this could result in sharps protruding through the aperture.
- Sharps containers should be disposed of when the fill line has been reached or when the container has been in use for three months, whichever is first. They must be locked and labelled with the source details.
- Sharps containers must not be placed inside waste bags prior to disposal.

3 Prevention of inoculation incidents

An inoculation incident is where the blood/body fluid of one person could gain entry into another person's body, such as:

- A sharps/needlestick injury with a used instrument or needle
- Spillage of blood or body fluid onto damaged skin, e.g. graze, cut, burn
- Splash of blood or blood stained body fluid into the eye, nose or mouth



- Human bite causing skin to be broken

Some accidental exposures to blood and body fluids are not classed as inoculation incidents, e.g. splashes onto intact skin. In these circumstances, washing the contaminated area thoroughly with liquid soap and warm running water is all that is required. Exposure to vomit, faeces and urine (unless visibly blood stained) and to sterile sharps are also not considered as inoculation injuries.

Compliance with the above guidance on good practice in sharps management should reduce the risk of a contaminated sharps injury.

In addition:

- All staff should protect their skin, as skin is an effective barrier to microorganisms. Any cuts or abrasions should be covered with an impermeable dressing to provide a barrier, refer to the 'Hand hygiene Policy for General Practice'
- The use of disposable gloves provides additional protection as long as dexterity is not impeded. New phlebotomists learning the procedure should be taught to undertake venepuncture with gloves, refer to the 'Venepuncture Policy for General Practice'

Disposable gloves should be worn for invasive procedures and when there is a risk of exposure to contaminated sharps

Facial personal protective equipment should be worn when there is a risk of blood splashing to the mucous membranes, e.g. eyes, nose, mouth, refer to the 'PPE Policy for General Practice'

- Use standard infection control precautions.
- Dispose of single use items after one use.
- Dispose of waste appropriately, refer to the 'Safe disposal of waste Policy for General Practice'.

4 Risk of Infection from inoculation incidents

Following a specific exposure, the risk of infection will vary depending on the nature of any pathogens in the patient's blood, the type of inoculation and the amount of virus in the patient's blood or body fluid at the time of exposure.

Surveillance studies indicate that the risk of seroconversion following exposure to blood from HIV infected patients is approximately 1 in 300 for



percutaneous (needlestick) injury and 1 in 1,000 for mucous membrane exposure.

The risk of acquiring hepatitis B virus from a hepatitis B antigen positive source is approximately 1 in 3, for an unvaccinated individual. Vaccination is protective.

The risk of acquiring hepatitis C through inoculation with a hepatitis C positive source is approximately 1 in 30.

Refer to the 'Blood-borne viruses Policy for General Practice'.

6 Action to be taken following an inoculation incident

Immediate management of inoculation injuries

- **Bleed it** - if there has been a puncture wound, encourage bleeding of the wound by squeezing it under running water (do not suck the wound).
- **Wash it** - the injured area or damaged skin should be washed thoroughly with liquid soap and warm running water and dried. Blood or body fluid splashes to the eyes, nose or mouth should be irrigated copiously with water.
- **Cover it** - cover the wound with a waterproof dressing.
- **Report it** - report the injury to your manager immediately and complete an incident form.
- **Seek advice** - seek urgent clinical advice immediately, e.g. from your GP, Advance Nurse Practitioner, Occupational Health provider. Out of normal office/surgery hours, attend the nearest Emergency Department (ED).

Where ED advice has been sought, your Occupational Health provider/GP should be informed to ensure that they are able to:

- a) Follow up and give any on-going support, and
- b) Complete the organisational reporting procedure

7 Management of Significant Exposure

The term 'source' is used for the patient whose blood or body fluids were involved, and the term 'recipient' for the member of staff who has been exposed or injured.



A risk assessment should be made based on the significance of the exposure, the recipients' prior immunity to hepatitis B and the confirmed or suspected status of the source for blood-borne viruses. This should be carried out by your GP, Occupational Health provider or ED.

If the source patient is known, every attempt should be made to obtain a blood specimen for testing for blood-borne viruses. To avoid discrimination, it is standard practice for the source patient to be offered tests for the three main blood-borne viruses, hepatitis B, hepatitis C and HIV. Appropriate pre-test counselling and informed consent is a prerequisite of testing the source patient.

Bloods from the recipient will also be required for serum save. The taking of blood specimens and the approach to the source patient for permission to test should be managed by a third party, i.e. somebody other than the recipient of the injury.

8 Reducing the Risk of Hepatitis B Transmission

Hepatitis B vaccination is effective in preventing hepatitis B transmission.

- All staff (including receptionists and cleaners) who may have direct contact with patient's blood or blood stained body fluids, are exposed to sharps or other inoculation risks should have had the opportunity for hepatitis B vaccination and antibody status check for their response. All staff likely to be in contact with sharps or inoculation risks should be aware of their immunisation status regarding hepatitis B.

Depending on the circumstances of the exposure and the immune status of the recipient, the recipient may be advised to have immediate additional vaccine dose or to receive hepatitis B immunoglobulin (HBIG).

- Seeking early advice is the key to successful intervention to prevent transmission.

9 Reducing the Risk of Hepatitis C Transmission

No specific post exposure prophylactic measures are advised beyond basic first aid. In the event of a source proving to be hepatitis C positive, specific advice on subsequent testing and management will be provided through your Occupational Health provider including advice on preventing onward transmission.



10 Reducing the Risk of HIV Transmission

In the case of a significant exposure to a confirmed or suspected HIV infected source, or if there is evidence of AIDS related illness, then HIV post exposure prophylaxis (PEP) should be offered. HIV post exposure prophylaxis is most effective if started within one hour of exposure, but not recommended beyond 72 hours post exposure. Advice must be sought from your Occupational Health provider/GP or ED, who will perform a risk assessment, and advise on treatment.

PEP treatment is usually only available from an ED, so if the patient is confirmed or suspected to be HIV positive, go straight to ED and inform them of your status to avoid any delay.

11 Exposure Incidents in the Community

Occasionally, members of the public will present to GPs following a community exposure, typically an injury with a discarded needle and syringe. In this instance, where the source is unknown, an accelerated course of hepatitis B vaccine is recommended. Community prevalence of HIV and hepatitis C remain low and no specific action in respect of these viruses is indicated.

The incident should be reported to the Consultant in Communicable Disease Control (CCDC) at your local Health Protection (HP) Team.

If the source is known, a risk assessment is required and further intervention may be advised. GPs should discuss these cases with the CCDC or the local Consultant Microbiologist.



12 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (2013) *Health Technical Memorandum 07-01: Safe management of healthcare waste*

www.gov.uk/government/publications/guidance-on-the-safe-management-ofhealthcare-waste

Department of Health (2008, updated 2013) *HIV Post Exposure Prophylaxis. Guidance from the UK Chief Medical Officers Expert Advisory Group on AIDS*

www.gov.uk/government/uploads/system/uploads/attachment_data/file/203139/HIV_post-exposure_prophylaxis.pdf

Department of Health (2006, updated 2021) *The Green Book Immunisation against infectious diseases* – latest updated versions can be accessed at

www.gov.uk/government/collections/immunisation-against-infectious-diseasethe-green-book



12 Invasive Devices

1. Introduction
2. Definition of an invasive device
3. Examples of invasive devices
4. Period of use
5. Inserting an invasive device
6. Managing an invasive device
7. References

1 Introduction

An invasive device provides an entry point for microorganisms, such as bacteria and viruses, to enter the body and is a potential source for introducing infection.

All staff involved in inserting or managing an invasive device should be educated about the standard principles of infection prevention and control (IPC). Information on this policy should be included in IPC training for all relevant staff groups.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

GP Practices should ensure regular audits to monitor compliance with the Policy are undertaken and to provide assurance.

2 Definition of an Invasive Device

Invasive device

A device which, in whole or in part, penetrates inside the body, either through a body orifice or through the surface of the body.

Surgically invasive device

A device which penetrates inside the body through the surface of the body, with the aid of or in the context of a surgical operation/procedure.

3 Examples of Invasive Devices



Below are some examples of invasive devices, this list is not exhaustive:

- Vascular access devices:
 - Peripheral vascular access device
 - Central venous access device, e.g. peripherally inserted central catheter (PICC), skin-tunnelled catheter, implanted port
- Urinary catheters
- Suprapubic catheters
- Wound drains
- Gastrostomy tubes
- Subdermal contraceptive implants
- Intrauterine devices

4 Period of Use

The length of time an invasive device can be used for is categorised as follows:

- **Transient**
Normally intended for continuous use for less than 60 minutes
- **Short term**
Normally intended for continuous use for not more than 30 days
- **Long term**
Normally intended for continuous use for more than 30 days

5 Inserting an Invasive Device

- Prior to insertion, the need for any invasive device should be evaluated and any alternative methods be considered.
- Only staff trained and deemed competent in aseptic technique, refer to the 'Aseptic technique Policy for General Practice', and the insertion of the type of device being inserted should perform the procedure. An aseptic technique competency and procedure audit tool can be downloaded at www.infectionpreventioncontrol.co.uk.
- The insertion should take place in a clinical environment, e.g. treatment room.
- Ensure all care equipment used for the procedure is sterile, the packaging is intact and equipment within the expiry date.
- Prior to inserting a device through the skin, appropriate skin decontamination should be performed, e.g. 2% Chlorhexidine in 70% alcohol.



- SICPs and TBPs and aseptic technique should be applied during the insertion of the device. Refer to the 'SICPs and TBPs Policy for General Practice' and the 'Aseptic technique Policy for General Practice'.
- Details of the device, reason for insertion and date inserted, should be recorded in the patient's notes.

6 Managing an Invasive Device

Only staff trained and deemed competent in manipulation of the type of device inserted should perform the procedure. If staff are unfamiliar with a particular device, advice and protocols should be obtained from the relevant specialist nurses in secondary care.

The need for an invasive device must be reviewed regularly and the device should be removed as soon as possible.

The principles of care for any invasive device are to:

- Prevent infection
- Maintain a 'closed' system with as few connections as possible to reduce the risk of contamination
- Keep the device patent
- Prevent damage to the device and any attachments

SICPS and TBPs and aseptic technique should be applied when manipulating the device.

Any signs or symptoms of infection associated with the device should be recorded in the patients' notes and applicable action taken. Seek further appropriate advice as required, e.g. Specialist Nurse, Consultant Microbiologist.



7 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* European Commission (July 2010) *Guidelines relating to the application of The Council Directive 93/42/EEC on medical devices*

National Institute for Health and Care Excellence (March 2016) *Quality and Productivity case study*

National Institute for Health and Care Excellence (March 2012, updated February 2017) *Healthcare-associated infections: prevention and control in primary and community care. Clinical Guideline 139*

National Institute for Health and Care Excellence (February 2006, reviewed July 2017) *Nutrition support for adults: oral nutrition support, enteral tube feeding and parental nutrition*

Royal Marsden NHS Foundation Trust (2020) *The Royal Marsden Hospital Manual of Clinical and Cancer Nursing Procedures 10th Edition*



13 Aseptic technique

1. Introduction
2. When should an aseptic technique be used?
3. Who should undertake an aseptic technique?
4. The principles of asepsis/aseptic technique
5. Good Practice
6. Essential equipment
7. The procedure for dressing a wound using an aseptic technique
8. Clean technique
9. Non-touch technique
10. Symbols and their meanings
11. References

1 Introduction

An aseptic technique is used to carry out a procedure in a way that minimises the risk of contaminating an invasive device, e.g. urinary catheter, or a susceptible body site such as the bladder or a wound.

2 When should it be used?

The following are some examples of when an aseptic technique should be used, but is not an exhaustive list:

- When inserting an invasive device
- When dressing wounds less than 48 hours old
- When dressing wounds healing by primary intention, e.g. surgical wounds
- When dressing deep wounds that lead to a cavity or sinus
- When dressing burn wounds
- Minor surgery procedures
- Suturing wounds
- Insertion of intrauterine devices (IUD)
- If the patient is immunosuppressed, diabetic or at high risk of infection



3 Who should undertake an aseptic technique?

- Only staff educated, trained and assessed in aseptic technique should undertake this procedure. Adherence to the principles of asepsis (as described below) plays a vital role in preventing the transmission of infection in any environment. It is the responsibility of each member of staff who undertakes an aseptic technique to understand the meaning of these principles and to incorporate them into their everyday practice.
- It is a requirement to undertake annual peer audits to monitor competency of the technique and a record of training and audit should be available. An assessment record and audit tool are available to download at www.infectionpreventioncontrol.co.uk.
- Staff undertaking an aseptic technique should be free from infection, e.g. colds, sore throats, septic lesions.

4 Principles of Asepsis

Asepsis is defined as the absence of pathogenic (harmful) microorganisms, such as bacteria and viruses.

The principles of asepsis/aseptic technique are:

- Reducing activity in the immediate vicinity of the area in which the procedure is to be performed
- Keeping the exposure of a susceptible site to a minimum
- Checking all sterile packs to be used are in date and there is no evidence of damaged packaging or moisture penetration
- Ensuring all fluids to be used are in date
- Not reusing single use items
- Ensuring contaminated/non-sterile items are not placed in the sterile field
- Ensuring appropriate hand decontamination prior to, during and after the procedure

5 Good Practice

- Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.
- Dispose of single use items after use. Do not reuse.



- Decontaminate single patient use items after each use and dispose of at the end of the course of treatment (single patient use items can be decontaminated and reused again on the same patient, but cannot be used on another patient).
- Store sterile equipment in clean, dry conditions, off the floor and away from potential damage.
- Dispose of waste as per local policy.

6 Essential Equipment

The essential equipment required will vary depending on the procedure being performed.

- Detergent wipes or pH neutral detergent and water for cleaning the surface to be used and paper towels. 70% isopropyl alcohol disinfecting wipes if disinfection is required.
- Personal protective equipment (PPE), e.g. apron, eye or facial protection if there is a risk of splashing on to your face.
- Sterile gloves.
- Sterile dressing pack.
- Fluids for cleaning and/or irrigation - 0.9% sodium chloride is normally appropriate.
- Hypoallergenic tape (if required).
- Appropriate dressing (if required).
- Alcohol handrub: This is an acceptable alternative to hand washing. Handwashing will take more time and may entail leaving the patient; alcohol handrub is the most appropriate method for hand hygiene during a procedure as long as hands are physically clean.
- Any extra equipment that may be needed during the procedure, e.g. sterile scissors.
- Traceability system (sticker or electronic) for any reusable surgical instruments.
- Patient record form.



7 The procedure for dressing a wound using an aseptic technique

1. The person undertaking the procedure is 'Bare Below the Elbows' (BBE), refer to the 'Hand hygiene Policy for General Practice', and any cuts/grazes are covered with a waterproof dressing.
2. Ensure that all windows are closed and any fans in the area are turned off. Avoid exposing or dressing wounds or performing an aseptic procedure for at least 30 minutes after cleaning to allow any dust particles to settle.
3. Check that all items required for the procedure are available, packaging is intact and sterile items are within the expiry date.
4. Introduce yourself to the patient and prior to gaining verbal consent from them explain and discuss the procedure.
5. Clean hands using the correct technique, with liquid soap and warm running water and dried with paper towels (see Appendix 1) or an alcohol handrub is used and allowed to dry (using steps 2-8 on Appendix 1).
6. Clean the dressing trolley with pH neutral detergent, e.g. Hospec and water or detergent wipes, from top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shaped pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice. This cleaning motion reduces the amount of microorganisms, such as bacteria and viruses, that may be transferred from a dirty area to a clean area. Dry with paper towels. If disinfection is also required, use disposable wipes saturated with 70% isopropyl alcohol and allow to air dry.
7. Place the items required for the procedure on the lower shelf of the trolley.
8. The patient is positioned comfortably for the procedure so that the wound is easily accessible without exposing the patient unduly.
9. Clean hands using the correct technique, with liquid soap and warm running water and dried with paper towels or an alcohol handrub is used and allowed to dry.
10. Put on a disposable apron.
11. If an existing dressing is in place, loosen the adhesive or tape to aid its removal later. Hands are decontaminated, using the correct technique, with liquid soap and warm running water and dried with paper towels or an alcohol handrub is used and allowed to dry.
12. The outer packaging of the sterile pack is opened and contents removed using a sliding action onto the cleaned surface, ensuring that the inner pack is not touched.
13. The sterile pack inner wrap is opened, using only the corners of the paper and creates a sterile field.
14. Open any other items required, and gently tip onto the centre of the sterile field.
15. Clean hands with an alcohol handrub.
16. Carefully use the open end of the disposable waste bag to lift it from the sterile field. Then hold the bag by one edge and place the other hand inside to



cover the hand like a sterile 'glove' to arrange the items on the sterile field. If there is a previous dressing in place, remove and invert the bag with the dressing inside.

17. The waste bag is then positioned so that contamination of the sterile field does not occur during the procedure.
 18. If required, sterile solutions are opened and poured into the gallipot or solutions section of the dressing tray.
 19. Clean hands with an alcohol handrub and don sterile gloves.
 20. Apply the principle of 'a clean hand and a dirty hand'.
 21. The procedure is carried out, including cleaning of the skin where applicable, maintaining a sterile field throughout the procedure.
 22. The patient is left in a comfortable position, maintaining dignity.
 23. Waste is then disposed of in the appropriate coloured waste stream bag, refer to the 'Safe disposal of waste Policy for General Practice'.
-
24. Remove PPE and dispose of in the appropriate coloured waste stream bag, refer to the 'Safe disposal of waste Policy for General Practice' - gloves off first, dispose, then remove and dispose of apron and clean hands.
 25. Clean, and if the patient has a confirmed or suspected infection, disinfect the trolley using disposable wipes saturated with 70% isopropyl (see point 6 above) alcohol and allow to air dry.
 26. Clean hands with liquid soap and warm running water and dry with paper towels or apply alcohol handrub and allow to dry.
 27. Ensure the procedure is documented and any tracking labels provided are added in the patient's records.

This is a modified aseptic technique, the principles being, in essence, the same as that for performing an aseptic technique. The main difference is the wound can be irrigated with or immersed in non-sterile fluids, e.g. tap water of drinkable quality, and non-sterile gloves can be worn. A clean technique is used for dressing most wounds healing by secondary intention such as:

- Pressure ulcers
- Leg ulcers, dehisced wounds
- Dry wounds, simple grazes
- Removing sutures

A clean technique should not be used to dress significant wounds that are less than 48 hours old, diabetic foot wounds, cavity wounds, e.g. with a sinus, or wounds of patients who are immunosuppressed.



8 Clean technique

A clean technique should not be used to dress significant wounds that are less than 48 hours old, diabetic foot wounds, cavity wounds, e.g. with a sinus, or wounds of patients who are immunosuppressed.

9 Non-touch technique

A clean technique should not be used to dress significant wounds that are less than 48 hours old, diabetic foot wounds, cavity wounds, e.g. with a sinus, or wounds of patients who are immunosuppressed.

A non-touch technique should be used for both an aseptic technique and a clean technique.




Description	Aseptic technique	Clean technique
Gloves	Sterile	Non-sterile
Dressings	Sterile	Sterile
Cleansing solution	Sterile water/saline/ antiseptic	Tap water

Technique for commonly performed procedures

Procedure	Technique	Comments
Surgical wound dressing	Aseptic	Expose the wound for minimal time
Catheter removal	Clean	Clean meatus with soap and water
Cervical smear	Clean	Use a sterile disposable (single use) speculum or a reusable one that has been sterilised by an accredited Decontamination Services Department
IUD insertion	Aseptic	



10. Symbols and their meanings

 <p>2023-07-30 Use by date, i.e. use by 30 July 2023</p>	 <p>2023-07 Date of manufacture, i.e. manufactured during July 2023</p>
 <p>Do not reuse, Single use, use only once</p>	<div style="border: 1px solid black; display: inline-block; padding: 2px;">LOT</div> ABC123 Batch code

12. References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Loveday HP, et al, epic 3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England *Journal of Hospital Infection* 86S1 (2014) S1-S70

National Institute for Health and Care Excellence (2012, updated February 2017) *Healthcare-associated infections: prevention and control in primary and community care Clinical Guideline 139*

Royal Marsden NHS Foundation Trust (2020) *The Royal Marsden Hospital Manual of Clinical and Cancer Nursing Procedures 10th Edition*



14 BBVs (Blood-borne viruses)

- 1 Introduction
- 2 HIV
- 3 Hepatitis
- 4 Infectivity
- 5 Precautions to reduce the risk of transmission of BBVs
- 6 Referral or transfer to another health or social care provider

1 Introduction

Blood Borne Virus

Blood-borne virus (BBV) infections are spread by direct contact with the blood of an infected person. The main blood-borne viruses of concern are:

Human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS)

Hepatitis B virus (HBV) and hepatitis C virus (HCV) which cause hepatitis

These three viruses are considered together because infection control requirements are similar due to similarities in their transmission routes.

2 HIV

HIV infection damages the immune system increasing the risk of severe infections and certain cancers. There is no cure or vaccine, but treatment includes drugs that have proved very effective at improving the quality of life and extending lifespan. Individuals with HIV may not have any symptoms and may be unaware of their infection.

The figures for HIV cases in the UK in 2019 were:

4,139 people newly diagnosed with HIV - a fall of 34% from a peak of 6,312 reported in 2014

98,552 people were seen for HIV care in the UK

An estimated 105,200 people in the UK were living with HIV

The number of deaths among people with HIV remained stable with 622 deaths

3 Hepatitis



Viral hepatitis is notifiable and cases should be reported to the Consultant in Communicable Diseases Control (CCDC) at your local Health Protection (HP) office. Early discussion of new cases with your local CCDC is recommended, who will coordinate contact tracing and the provision of hepatitis B immunoglobulin (HBIG) and vaccine.

Effective vaccination for hepatitis B is available for high risk individuals and individuals who have been exposed.

Hepatitis B

- Hepatitis B causes an infection of the liver. Acute infection may be asymptomatic or may cause a non-specific illness with nausea, vomiting, loss of appetite and jaundice. Infection without apparent illness is common in children.
- The risk of developing chronic hepatitis B infection depends on the age at which infection is acquired and the risk is increased in those whose immunity is impaired. Most infected adults recover fully and develop lifelong immunity. However, approximately 5% of previously healthy adults may remain infected (chronic carriers) and potentially infectious. Children infected between the ages of 1-5 years have a much higher chance of becoming a chronic carrier (20-50%) and this is particularly the case for babies infected at birth (90%).
- Around 20-25% of individuals with chronic HBV infection worldwide have progressive liver disease, leading to cirrhosis in some patients.

UK estimates for hepatitis B prevalence is low, around 0.3%, but is more common in other parts of the world and among UK residents exposed in those countries.

Hepatitis C

- Hepatitis C is another virus which can damage the liver. Most individuals with hepatitis C have no symptoms and are unaware of their infection. Some may develop a flu-like illness and jaundice. About 1 in 5 people infected with hepatitis C recover completely. The majority become chronically infected, about 10-30% of these will develop severe liver scarring (cirrhosis) in 20 years and annually 1-3% will go on to develop liver cancer.
- Worldwide, over 185 million people are estimated to be infected with the hepatitis C virus. In the UK, about 143,000 people were estimated to be living with chronic hepatitis C in 2018, a 20% decrease on the number from 2015 (which was around 182,400 people).

UK estimates for hepatitis C prevalence are low, around 0.5%, but is more common in other parts of the world and among UK residents exposed in those countries. Prevalence among drug users may be as high as 50-80%.

4 Infectivity



HIV

HIV infection is spread by direct contact with an infected person's cell containing body fluids, e.g. blood, semen, vaginal secretions, breast milk, amniotic fluid, pleural effusions, and cerebrospinal fluid.

Routes of transmission:

Sexual transmission - vaginal, anal, or oral sex (especially in the presence of oral disease such as ulceration or gingivitis)

Mother to baby - during pregnancy, childbirth, or through breastfeeding

Inoculation from:

A contaminated needle, e.g. sharps injury

Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment

Unsterile tattooing, body piercing or acupuncture equipment

A contaminated instrument

Transfusion of contaminated blood or blood product in a country where blood donations are not screened for HIV

Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors

A contaminated human bite that breaks the skin

HIV is not transmitted by:

Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing
Insects such as mosquitoes and lice
Food or water

Hepatitis B

Hepatitis B infection is spread by direct contact with an infected person's blood or blood stained body fluids. 95% of chronic hepatitis B infections in the UK occur in migrant populations, having been acquired perinatally in the country of birth.

Routes of transmission:

Sexual transmission - occurs during sex via mucous membranes, e.g. vaginal, anal, and oral. People having unprotected sex or having multiple partners are at greatest risk

Mother to baby - during pregnancy, childbirth, or through breastfeeding if nipples are cracked or bleeding
Inoculation from:



A contaminated needle, e.g. sharps injury

Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment

Unsterile tattooing, body piercing or acupuncture equipment

A contaminated instrument

- Transfusion of contaminated blood or blood product in a country where blood donations are not screened for hepatitis B
- Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors
- A contaminated human bite that breaks the skin

Hepatitis B is not transmitted by:

- Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing
- Insects such as mosquitoes and lice
- Food or water

Hepatitis C

Hepatitis C is spread by contact with an infected person's blood. About 10% of people with hepatitis C virus infection have no recognised risk factor.

Routes of transmission:

Currently, the majority of cases in the UK are caused by sharing contaminated drug injecting equipment, less common routes are:

- **Sexual transmission** - occurs infrequently in heterosexual relationships. The risk is increased in people with multiple partners or those at risk for sexually transmitted infections (STIs), in HIV-positive people (particularly in men who have sex with men), and with risky sexual practices (for example anal sex)
- **Mother to baby** - during pregnancy, childbirth, or through breastfeeding if nipples are cracked or bleeding □ **Inoculation from:**
 - A contaminated needle, e.g. sharps injury
 - Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment
 - Unsterile tattooing, body piercing or acupuncture equipment
 - A contaminated instrument



- Transfusion of contaminated blood or blood product in a country where blood donations are not screened for Hepatitis C
 - Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors
 - A contaminated human bite that breaks the skin
-
- **Hepatitis C is not transmitted by:**
 - Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing Insects such as mosquitoes and lice
 - Food or water

5 Precautions to reduce the risk of transmission of BBVs

Prevention strategies focus on minimising lifestyle risks, early recognition of cases to facilitate early treatment and advice for cases, screening in pregnancy for the reduction of vertical transmission of HIV and hepatitis B.

As a result of the lack of early symptoms in some infected people and the ability of the viruses to persist as chronic infections, many people who carry these blood-borne viruses may not be aware they are infected.

Assigning risk on the basis of declared high risk activity in a patient is potentially discriminatory and highly unreliable.

Precautions to prevent inoculation of blood and certain body fluids will prevent transmission of these viruses.

Staff who may have contact with blood or blood stained body fluids, or are exposed to sharps or other inoculation risks, should have had the opportunity for hepatitis B vaccination and antibody testing to check for their response.

Always use standard infection control precautions and, where required, transmission based precautions (SICPs and TBPs), refer to the 'SICPs and TBPs Policy for General Practice'.

In a General Practice setting these include:

Sharps and inoculation injuries:



As always, care should be taken with sharps - use safety sharps where assessment indicates they will provide safe systems of working for staff, refer to the 'Safe management of sharps and inoculation injuries Policy for General Practice', which is in line with the Health and Safety Executive guidance

Appropriate management of percutaneous exposures (sharps/splash injuries), refer to the 'Safe management of sharps and inoculation injuries Policy for General Practice'

Keep cuts or broken skin covered with waterproof dressings

- Protect eyes, nose and mouth from blood splashes where there is a risk of splashing
- Avoid direct skin contact with blood and blood stained body fluids (if blood/blood stained body fluids are splashed on to the skin, wash off with liquid soap and warm running water)
- Wear disposable latex or nitrile gloves when contact with blood or blood stained body fluid is likely (vinyl gloves are not recommended for contact with blood)
- Always clean hands before and after giving first aid

Spillages of blood or body fluids

Urine, faeces, sputum, tears, sweat and vomit are not considered to pose a risk of BBV infection unless they are contaminated with blood.

Contain and promptly clean and disinfect surfaces contaminated by spillages of blood and blood stained body fluids. Refer to the 'Safe management of blood and body fluids for General Practice', 'Safe management of the care environment Policy for General Practice' and 'SICPs and TBPs Policy for General Practice' for advice on cleaning spillages of blood and/or blood stained body fluid.

Spillage kits may contain solidifying polymer granules. A National Patient Safety Alert issued in 2017, following a number of deaths and incidents related to patients ingesting the product, advises a risk assessment and procedures in place to ensure supplies are securely stored away from the general public.

Disposal of waste

Waste contaminated with blood and/or blood stained body fluids from a person with a confirmed or suspected blood-borne virus, should be disposed of into the appropriate infectious waste stream. Refer to the 'Safe disposal of waste Policy for General Practice'.



Specimen collection

SICPs and TBPs should be applied when collecting any specimens. Refer to the 'Specimen collection Policy for General Practice' and the 'Venepuncture Policy for General Practice'.

Specimens and request forms from patients confirmed to be or suspected of being infected with blood-borne viruses should be labelled with a 'Danger of Infection' or 'hazard' sticker.

6 Referral or transfer to another health or social care provider

Referral or Transfer to Another Health or Social care Provider

If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of the patient's BBVs status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate infection prevention and control (IPC) measures to be taken, e.g. transported without other patients, and isolated on admission.

Staff preparing to transfer a patient to another health and social care provider should complete the Inter-Health and Social Care Infection Control Transfer Form (see Appendix 1) or patient passport. This should accompany patient. Refer to the 'Patient placement and assessment for infection risk Policy for General Practice'.

SICPs and TBPs should be followed whenever transferring a patient, whether they have a confirmed infection or not.

The completed transfer documentation should be supplied to the receiving health or social care provider and a copy filed in the patient's notes.

Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with the 'Safe management of care'.



7 References

Department of Health (2015) *The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance*

Department of Health (2013, updated 2017) *Immunisations against infections*
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/628602/Greenbook_chapter_18.pdf

European Agency for Safety and Health at Work (2010) *Directive 2010/32/EU – prevention from sharp injuries in the hospital and healthcare sector*

Hawker et al (2019) *Communicable Disease Control and Health Protection Handbook 4th Edition*

Health and Safety Executive (2018) *Managing infection risks when handling the deceased: Guidance for the mortuary, post-mortem room and funeral premises, and during exhumation*

Health and Safety Executive (2013) *Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 Guidance for employers and employees*

National Institute for Health and Care Excellence (2012, updated 2017)
www.nice.org.uk/guidance/cg139/chapter/1-Guidance#standard-principles

National Institute for Health and Care Excellence (Revised May 2021) *Clinical Knowledge Summary Hepatitis B* <https://cks.nice.org.uk/topics/hepatitis-b/>

National Institute for Health and Care Excellence (Revised April 2020) *Clinical Knowledge Summary Hepatitis C* <https://cks.nice.org.uk/topics/hepatitis-c/>

National Institute for Health and Care Excellence (Revised May 2021) *Clinical Knowledge Summary HIV infection and AIDS* <https://cks.nice.org.uk/topics/hivinfection-aids/>

NHS England and NHS Improvement (March 2019) *Standard infection control precautions: national hand hygiene and personal protective equipment policy*

NHS England (2017) *Risk of death and severe harm from ingesting superabsorbent polymer gel granules* NatPSA/2019/002/NHSPS
www.england.nhs.uk/wpcontent/uploads/2020/02/PS_Alert_Polymer_28_Nov_2019_FINAL.pdf



Dissemination/Training

Action by	Action Required	Implementation Date
Liz Stedman	Upload to TeamNet/shared drive/website	17/05/2022

Amendment History

Version No.	Date of Issue	Section/Page changed	Description of change	Review Date
V1.0	17/05/2022	All	Approved by the Board	17/05/2024