

INFECTION CONTROL POLICIES

(Please refer to separate yellow folder)

Assurance Statement

This policy aims to ensure that Suffolk Mental Health Partnership NHS Trust has in place mechanisms to ensure that the risk of infection to service users, staff and visitors are minimised.

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Governance Committee	Clinical & Service Governance
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INFECTION CONTROL MANUAL

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SECTION 1 INTRODUCTION AND CONTACTS

1.1 Introduction

Infection control is an important part of the Trust's effective risk management strategy to improve the quality of patient care and the occupational health of staff.

This manual has been written for Suffolk Mental Health Partnership NHS Trust (SMHPT) staff and approved by the Trust's Infection Control Committee.

Its aim is to provide clear, concise policies and guidance on the management of infection control.

This manual should be read in conjunction with all other relevant current policies and guidelines including COSHH and Health and Safety regulations.

1.2 Scope

The Manual includes policies and guidance on health and social care as provided by the Trust.

It is acknowledged that some staff work in premises where they have little or no control (e.g. client's own homes). Therefore in some instances staff will have to use their own judgement in the interpretation of the guidelines. If required, further advice is available from the Trust's Infection Control Nurse.

1.3 Responsibility

The philosophy of this manual is to encourage individual responsibility by **every** member of staff.

All staff should participate in the prevention and control of infection ensuring a seamless infection control service between hospitals and the community.

The **Chief Executive** is responsible for ensuring that there are effective arrangements in place for the control of infections.

The designated **Director of Infection Prevention and Control (DIPC)** is the **Director of N.S.G.**

The **DIPC** has delegated responsibility for managing and monitoring the effectiveness of existing infection control processes.

They will support the Infection Control Team and the Infection Control Committee in their fulfilment of the annual Infection Control Service Programme and the production of the Infection Control annual report.

The Infection Control Committee exists to ensure that Infection Control policies, procedures and guidance are endorsed.

The role of the Infection Control Nurse is to provide an expert service relating to Infection Control and associated clinical risk management. It is to ensure that the service provided matches the needs of the workforce and the local population, is evidence based and promotes best practice.

1.4 Notifiable Diseases

Statutory Notification. The attending doctor has a statutory duty to notify infectious diseases listed below, whether confirmed or suspected, to the **local authority of the patient's residence**.

Prompt notification and reporting of disease is essential

The objectives of notification are:

1. To collect accurate and complete epidemiological information on the disease
2. To ensure prompt and appropriate control measures to prevent the spread of infection

Any Doctor who considers that a patient is suffering from a Notifiable disease has a statutory duty to notify the Proper Officer of the local authority using the standard notification procedure.

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

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

List of diseases notifiable under the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1988.

Anthrax	Plague
Cholera	Poliomyelitis
Diphtheria	Rabies
Dysentery (Amoebic or Bacillary)	Relapsing Fever
Encephalitis	Rubella
Food Poisoning*	Scarlet Fever
Leprosy	Smallpox
Leptospirosis	Tuberculosis
Malaria	Typhoid Fever
Measles	Typhus
Meningitis (all types)	Viral Haemorrhagic Fever
Meningococcal Septicaemia (without meningitis)	Viral Hepatitis
Mumps	Whooping Cough
Ophthalmia Neonatorum	Yellow Fever
Paratyphoid Fever	

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

Although the following diseases are not Notifiable, the Consultant in Communicable Disease (contactable at the Suffolk Health Protection Unit) should be informed of their occurrence:

- Legionnaires' Disease
- Listeriosis
- Psittacosis
- New variant Creutzfeldt-Jakob disease (vCJD)
- Severe acute respiratory syndrome (SARS)

SECTION 2 INFECTION, ITS CAUSES AND SPREAD

2.1 The Causes of Infection

Micro organisms that cause infections are known as pathogens. They may be classified as follows:

Bacteria are minute organisms about one-thousandth to five thousandth of a millimetre in diameter. They are susceptible to a greater or lesser extent to antibiotics.

Viruses are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

Pathogenic Fungi can be either moulds or yeasts. For example, a mould which causes infections in humans is *Trichophyton rubrum* which is one cause of ringworm and which can also infect nails. A common yeast infection is thrush caused by *Candida albicans*.

Protozoa are microscopic organisms, but larger than bacteria. Free-living and non-pathogenic protozoa include amoebae and paramecium. Examples of medical importance include: *Giardia lamblia*, which causes enteritis (symptoms of diarrhoea).

Worms are not always microscopic in size but pathogenic worms do cause infection and some can spread from person to person. Examples include: threadworm and tapeworm.

Prions are infectious protein particles. Example: the prion causing (New) Variant Creutzfeldt - Jakob disease.

2.2 The Spread of Infection

A feature that distinguishes infection from all other disease is that it can be spread from one person to another.

It is convenient to classify the modes of spread of infection as follows:

Direct Contact: Direct spread of infection occurs when one person infects the next by direct person to person contact (e.g. chicken pox, tuberculosis, sexually transmitted infections etc.).

Indirect: Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens e.g. fomite or vector.

A fomite is defined as an object, which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person.

Examples of potential fomites are bedpans, urinals, thermometers, oxygen masks or practically any inanimate article.

Crawling and flying insects are obvious examples of vectors and need to be controlled. Insect bites may cause infections such as malaria.

Hands: The hands of health and social care workers are probably the most important vehicles of cross-infection. The hands of patients can also carry microbes to other body sites, equipment and staff.

Inhalation: Inhalation spread occurs when pathogens exhaled or discharged into the atmosphere by an infected person are inhaled by and infect another person. The common cold and influenza are often cited as examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses.

Ingestion: Infection can occur when organisms capable of infecting the gastrointestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal-oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, salmonella, campylobacter.

Inoculation: Inoculation infection can occur following a “sharps” injury when blood contaminated with, for example, Hepatitis B virus, is directly inoculated into the blood stream of the victim, thereby causing an infection. Bites from humans can also spread infection by the inoculation mode.

Splash Injury: Infection may occur through splashing of blood, body fluids, secretions or excretions into the face and eyes.

SECTION 3

STANDARD PRINCIPLES for the Prevention and Control of Infection (previously known as UNIVERSAL PRECAUTIONS)

3.1 Standard Principles

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called **Standard Principles**.

STANDARD PRINCIPLES include:

- Handwashing and skin care
- Protective clothing
- Safe handling of sharps (including sharps injury management)
- Dealing with spillages
- Waste and laundry management
- Decontamination

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

Everyone involved in providing care in the community should know and apply the standard principles of hand decontamination, the use of protective clothing, the safe disposal of sharps and body fluid spillages. Each member of staff is accountable for his/her actions and must follow safe practices.

3.2 Hand Hygiene and Skin Care

Hand hygiene is recognised as the single most effective method of controlling infection.

The ability of transient microorganisms to transfer to, and from, hands with ease results in hands being extremely efficient vectors of infection. Thorough hand washing will reduce the risk of cross infection immediately.

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

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

Hands must be decontaminated:

- Before and after each work shift or work break. Remove jewellery (only plain band wedding rings are exempt and it must be possible to move and clean under them).
- Before and after physical contact with each client.
- After handling contaminated items such as dressings, bedpans, urinals and urine drainage bags.
- Before putting on, and after removing protective clothing, including gloves.
- After using the toilet, blowing your nose or covering a sneeze.
- Whenever hands become visibly soiled.
- Before preparing or serving food.
- Before eating, drinking or handling food and before and after smoking.

Which hand wash solution?

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

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

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

How to wash your hands

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

Type of Decontamination	Indication	Agent
Routine / social	When hands are visibly soiled When hands are visibly clean	Soap & water Soap & water or Alcohol gel
Hygienic / antiseptic hand disinfection	Before an aseptic technique Before donning sterile gloves After providing care to a patient with a resistant organism	Alcohol gel
Surgical hand disinfection	Prior to all surgical and other highly invasive procedures	Antiseptic solutions or alcohol gel

Preparation

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

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

Hand decontamination technique

Using Soap and Water

- Use liquid soap
- Use running water
- Avoid splashing
- Wet the hands under running water
- Apply the soap and rub hands together vigorously to produce a visible lather
- Cover all areas of the hands including fingertips, webs of fingers, thumbs, palms and backs of hands
- Wash for at least 20-30 seconds
- Rinse under running water
- Dry thoroughly with paper towels using a “blotting” action
- Do not re contaminate hands on taps or bin lids

Using alcohol gel

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

Surgical Hand Washing

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

This is required before minor surgery and invasive procedures.

Alternative hand preparation for minor surgery and invasive investigations using alcohol hand rub

For areas where minor surgery or invasive procedures are performed and scrub sinks are not available, the following hand disinfection technique may be used:

1. Ensure nails are clean. Wash hands and wrists with non-medicated liquid soap from the dispenser, rinse under running water and dry thoroughly using paper towels
2. Apply one application of alcohol gel and rub over all surfaces of hands and wrists paying particular attention to fingertips and palms of hands until the solution evaporates to dryness. This should take at least 20 seconds but it is more important that there is enough gel initially to cover all skin surfaces
3. Repeat Step 2

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

Notes

Use of hand creams – Communal pots of hand cream should not be used as these can become contaminated and a source of cross infection. Individual tubes or lotions with an integral pump dispenser are preferred.

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

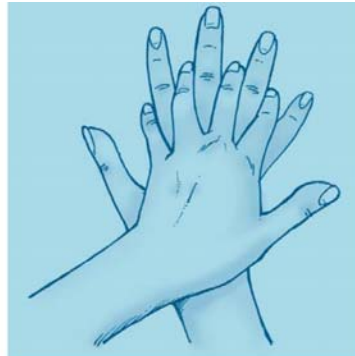
Use of scrub brushes – Scrub brushes should not be used for routine hand washing as they may abrade the skin and can become reservoirs for bacteria. Brushes in sterile packs are supplied by HSDU to areas where a surgical scrub may be necessary.

Skin care summary

- Wet hands before applying soap
- Use preparations containing emollients
- Always rinse hands and dry thoroughly
- Apply hand cream regularly
- Wear powder-free latex gloves low in extractable proteins and residual accelerators for protection against blood borne viruses
- Seek professional advice for skin problems
- Wear non-NRL synthetic gloves if sensitised to natural rubber latex proteins



1. Palm to palm



2. Right palm over left dorsum and left palm over right dorsum



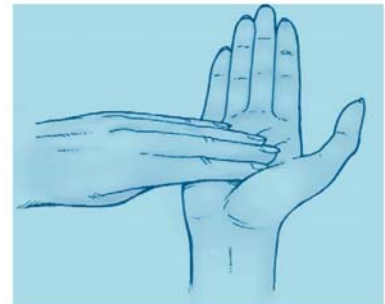
3. Palm to palm fingers interlaced



4. Backs of fingers to opposing palms with fingers interlocked



5. Rotational rubbing of right thumb clasped in left palm and vice versa



6. Rotational rubbing, backwards and forwards with clasped fingers

Hand washing facilities

Facilities should be adequate and conveniently located. Hand wash basins must be placed in areas where needed and where client consultations take place. They should have elbow-operated or sensor-operated mixer taps. A separate sink should be available for other cleaning purposes - such as cleaning instruments.

- Use wall-mounted liquid soap dispensers with disposable soap cartridges - keep them clean and replenished.
- Place disposable paper towels next to the basins - soft paper towels will help to avoid skin abrasions.

- Position foot-operated pedal bins near the hand wash basin – make sure they are the right size.
- Paper towels may be disposed of as household waste.

Project Managers involved in redesign or new facilities must ensure that the infection control nurse is consulted about the requirements and relevant regulations with regard to the **proposed siting and design of handwashing facilities** within all healthcare premises.

Handwashing in patients' homes

Hands should be washed prior to any procedure in the patient's home and before departure.

It is important to do a risk assessment of handwashing facilities available. If these are not adequate then alcohol gel may be used to disinfect visibly clean hands. Disposable wipes could be used on soiled hands followed by alcohol gel.

References

Babb JR (1996). 'Application of Disinfectants in Hospitals and other Healthcare Establishments.' Infection Control. March, p4-12.

Infection Control Nurses Association (ICNA) (2002).Hand Decontamination Guidelines. London.

NICE Guidelines, Prevention and Control of Healthcare Associated Infection in Primary and Community Care – June 2003.

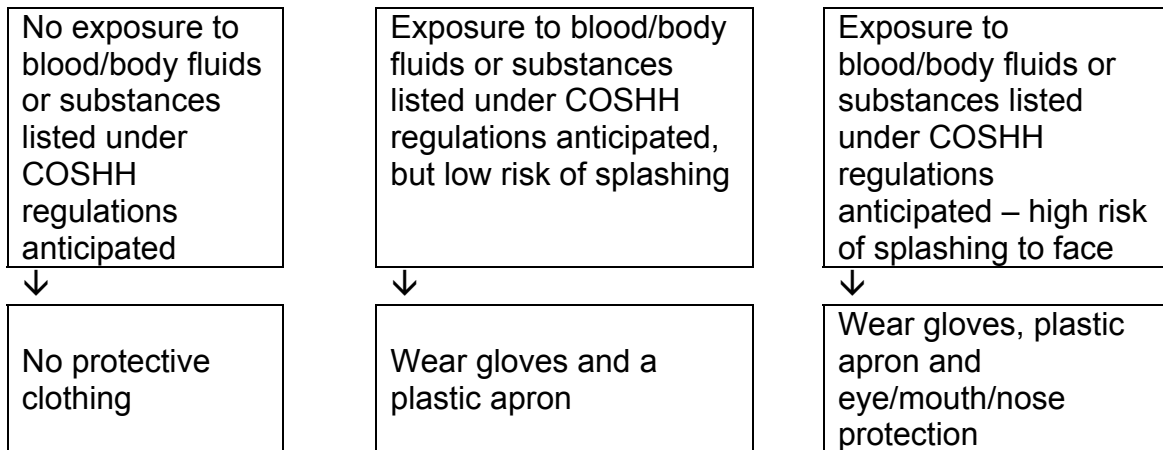
RCN (2004). Good practice in infection control – Guidance for nursing staff. Royal College of Nursing. London.

3.3 Protective Clothing

Selection of protective equipment must be based on an assessment of the risk of transmission of microorganisms to the patient, and the risk of contamination of the healthcare practitioners' clothing and skin by patients' blood, body fluids, secretions or excretions.

Assessment of Risk

WHAT TO WEAR WHEN



Types of Protective Clothing

Gloves

Gloves should not be worn unnecessarily as their prolonged and indiscriminate use may cause adverse reactions and skin sensitivity.

A risk assessment should be carried out to assess the need for gloves and the appropriate type.

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments.

Gloves that are acceptable to healthcare personnel and that conform to European Community (CE) standards must be available.

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

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

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

Sensitivity to natural rubber latex in patients, carers and healthcare personnel must be documented. Alternatives to natural rubber latex gloves must be available. (See Latex Allergy Policy).

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

Non sterile gloves

These must be used when hands may come into contact with body fluids or equipment contaminated with body fluids.

These must be used when the hand is likely to come into contact with normally sterile areas or during any surgical procedure.

General purpose utility gloves

General purpose utility gloves e.g. rubber household gloves, can be used for cleaning instruments prior to sterilisation, or when coming into contact with possible contaminated surfaces or items. Colour coding of such gloves should be used e.g.

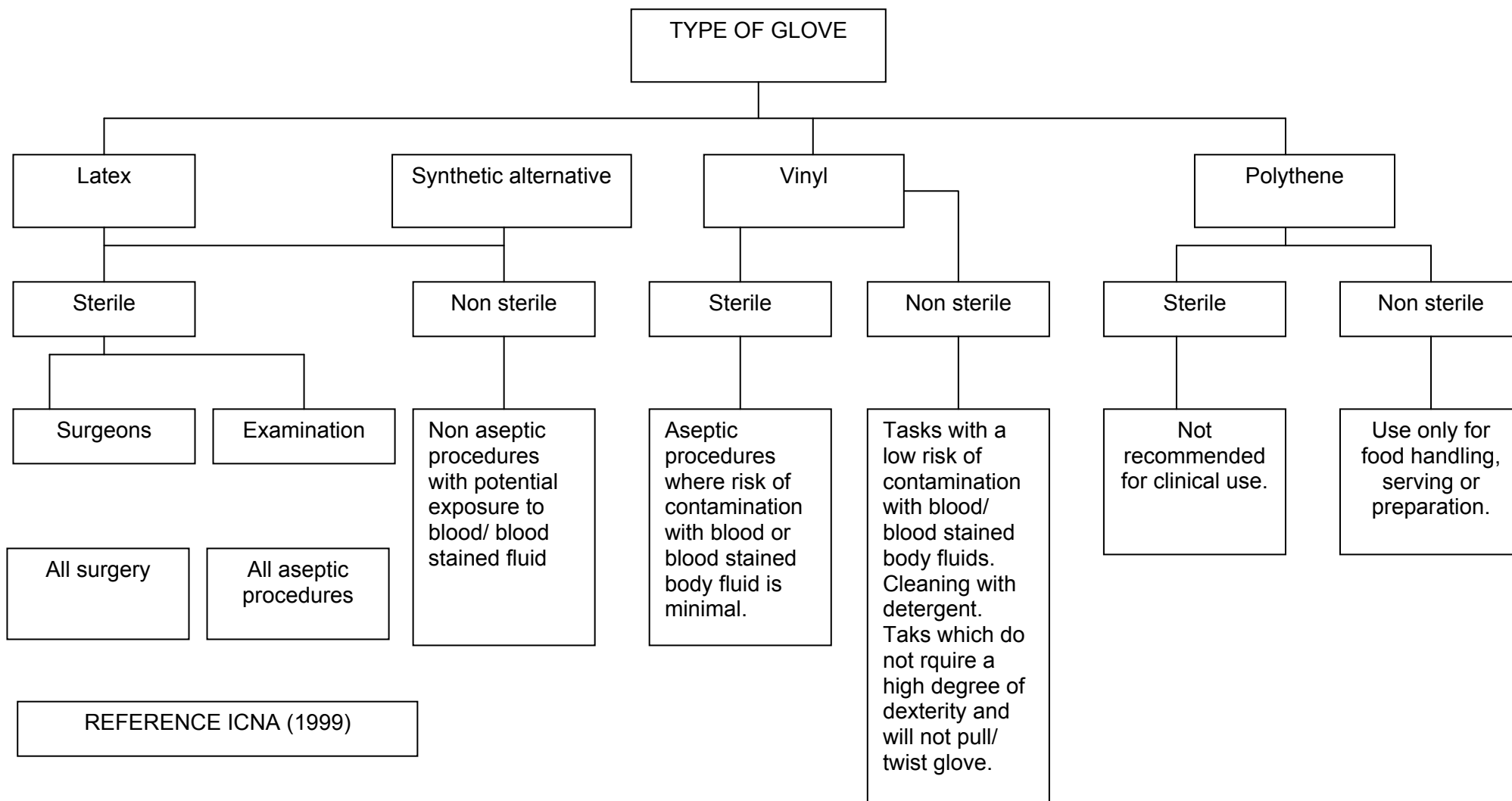
- blue for the kitchen
- yellow for general environmental cleaning
- red for 'dirty' clinical duties.

This will help prevent cross-infection from one area of work to another. The gloves should be washed with general purpose detergent and hot water, and dried between use. They should be discarded weekly or more frequently if the gloves become damaged.

Polyurethane/polythene gloves (non sterile and sterile)

Polyurethane/polythene gloves do not act as a barrier to infection. They do not meet the Health and Safety Commission regulations and they do not have a place in **clinical** application. **DO NOT USE**.

GLOVE USAGE GUIDELINES



All gloves should be powder free and have the lowest possible levels of extractable proteins and chemical accelerators

Disposable plastic aprons

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

Face masks and eye protection

Must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes.

Respiratory protective equipment

There are very few occasions when the wearing of masks is required in the community.

If a mask is to be worn, a good quality filter type should be used. It must fit the face closely and be changed if it becomes wet.

References

Infection Control Nurses Association (September 1999) 'Glove Usage Guidelines', London.

Infection Control Nurses Association (2002). Protective Clothing; Principles and Guidance. London.

Medical Devices Agency (April 1996) 'Latex Sensitisation in the Health Care Setting (Use of Latex Gloves)'. London.

NICE Guidelines (June 2003). Prevention & Control of Healthcare Associated Infections in Primary & Community Care. London

3.4 Safe Handling of Sharps

All staff should be fully immunised according to national policy. In addition, all those handling sharps should have had a course of hepatitis B vaccine. A record of hepatitis B antibody response should be kept by occupation health for all clinical staff involved in 'exposure prone procedures' or where regular exposure so blood/blood stained body fluids occurs. The Occupational Health department can advise staff regarding their need for immunisation and any necessary boosters.

Care should be taken to avoid accidental needlestick injury, as exposure to contaminated blood may be associated with transmission of Blood Borne Viruses.

The average risk of transmission of bloodborne viruses following a single percutaneous exposure with blood known to contain a bloodborne virus has been estimated to be:

- | | | |
|--------------------------------------|-------|------------|
| • Hepatitis B (HBV) | 33.3% | (1 in 3) |
| • Hepatitis C virus (HCV) | 3.3% | (1 in 30) |
| • Human Immunodeficiency virus (HIV) | 0.31% | (1 in 319) |

Sharps include needles, scalpels, stitch cutters, glass ampoules, sharp instruments and broken crockery and glass. Sharps must be handled and disposed of safely to reduce the risk of exposure to bloodborne viruses. Always take extreme care when using and disposing of sharps. Avoid using sharps whenever possible;

- clinical sharps should be single use only
- do not re-sheath a used needle - if this is necessary, a safe method – for example, a re-sheathing device - must be used
- discard sharps directly into a sharps container immediately after use and at the point of use
- sharps containers should be available at each location where sharps are used
- sharps containers must comply with UN 3921 and BS7320 standards
- close the aperture (temporary closure) to the sharps container when carrying or if left unsupervised to prevent spillage or tampering
- place sharps containers on a level stable surface in a safe and secure area
- do not place sharps containers on the floor, window sills or above shoulder height - use wall or trolley brackets
- assemble sharps containers by following the manufacturer's instructions
- carry sharps containers by the handle - do not hold them close to the body
- never leave sharps lying around
- do not try to retrieve items from a sharps container
- do not try to press sharps down to make more room
- lock the container when it is three-quarters full using the closure mechanism
- label sharps containers with the source details prior to disposal
- place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place inside a clinical waste bag.

For community staff carrying sharps boxes in their cars:

- sharps should only be carried by staff if there is no alternative for safe disposal
- the container should be carried in a secure area of the car to prevent tipping over whilst driving
- the container should be carried out of sight
- the temporary closure should be used whilst transporting/carrying
- as the volume of sharp clinical waste is small in these circumstances, there is no requirement for the member of staff to display a 'Hazard' notice on their car
- staff must take sealed sharps boxes to their employer's lockable clinical waste storage and collection point as soon as possible to ensure their safe storage prior to disposal.

Diabetic Sharps

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

Sharps containers are available for diabetics from all general practice surgeries. General Practitioners should ensure that the patient is aware of the correct method of disposal of the filled sharps bin. The Environment Agency (as the enforcing body) has agreed that, legally, sharps bins can be returned to the surgery for disposal under exemption 39(2) of the *Waste Management Licensing Regulations 1994* (as amended). The Local Authority also has a duty to collect clinical waste including sharps from households. The householder may be charged by the local authority for this service.

Whichever route is used, the patient must be made aware that it must not be disposed of in the household waste system under any circumstances.

References

British Medical Association (1990, Reprinted 1993) 'A Code of Practice for the Safe Use and Disposal of Sharps'. BMA House, London.

British Standards Institute BS7320 (1990) 'Specification for Sharps Containers. London.

Health Service Advisory Committee (1992). 'Safe Disposal of Clinical Waste'

NICE Guidelines (June 2003). Prevention & Control of Healthcare Associated Infections in Primary & Community Care. London.

United Nations Standard 3291 (1997). Clinical Waste/Infectious Substances Unspecified.

3.5 Dealing with Spillages

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

Responsibilities

Managers are responsible for the implementation of a policy that deals with spillages. Should exposure occur, they are also required to ensure that any risks to staff, patients and visitors are minimised.

All staff have responsibility for ensuring that they adhere to any policies and procedures to minimize the hazards resulting from any spillage.

All staff involved in the clinical care of patients or the safe handling of waste must be aware of how to deal safely with any spillage should it occur.

Blood/body fluid spillage management guidelines (not suitable for urine spills)

1. **Hypochlorite / Sodium Dichloroisocyanurates (NaDCC) Method – to be used ONLY where surface will tolerate chlorine releasing (bleach) disinfectant i.e. flooring, non-upholstered furniture.**

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

Either:

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

or, for large spills with danger of high fume levels:

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

- disposable towels should be disposed of as clinical waste
- clean area with detergent and hot water, and dry thoroughly
- clean the bucket/ bowl in fresh soapy water and dry
- discard protective clothing as clinical waste
- Wash and dry hands.

2. **Detergent and water method – to be used when the surface is unsuitable for contact with hypochlorite disinfectant i.e. soft furnishings, carpets.**

- Prevent access to the area until spillage has been safely dealt with
- wear protective clothing
- mop up organic matter with paper towels or disposable cloths and/or absorbent powder e.g. vernagel™
- clean surface thoroughly using a solution of detergent and hot water and paper towels or disposable cloths
- rinse the surface and dry thoroughly
- dispose of materials as clinical waste
- clean the bucket/ bowl in fresh hot, soapy water and dry
- remove protective clothing and discard as clinical waste
- wash and dry hands
- ideally, once dry; go over area with a mechanical cleaner.

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

References

Control of Substances Hazardous to Health regulations 2002

Health and Safety at Work Act (1974)

HSE Environmental Hygiene Guidance Note Number 17

RCN (2004). Good Practice in Infection Control – Guidance for Nursing Staff. Royal College of Nursing, London.

Substances Hazardous to Health Emergency Spillage Guide – Croner Publications

3.6 Waste Management

Guidelines for the safe handling and management of clinical waste

SMHPT have a legal responsibility to ensure that waste generated by staff employed by the organisation is disposed of safely, ensuring no harm is caused either to staff, members of the public or the environment. This responsibility begins when waste is generated and ends with its final disposal; even where properly authorised agents are used.

It is essential that persons handling waste exercise care to prevent injury or transmission of infection to themselves or others. This is to fulfil their responsibilities under the current legislation (for list see end of this section).

Definition of clinical waste

Clinical waste is:

- a) any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, soiled swabs or dressings, or syringes, needles or other sharp instruments, being waste which, unless rendered safe, may prove to be hazardous to any person coming into contact with it; and
- b) any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any other person coming into contact with it.

(Controlled Waste Regulations 1992)

The coding of waste is determined by the List of Wastes (England) Regulations 2005:

18 01 01	Sharps (except 18 01 03)
18 01 02	Body parts and organs including blood bags and blood preserves (except 18 01 03)
18 01 03	Wastes whose collection and disposal is subject to special requirements in order to prevent infection
18 01 04	Wastes whose collection and disposal is not subject to special requirements in order to prevent infection
18 01 06	Chemicals consisting of or containing dangerous substances
18 01 07	Chemicals other than those mentioned in 18 01 06
18 01 08	Cytotoxic and cytostatic medicines
18 01 09	Medicines other than those mentioned in 18 01 08
18 01 10	Amalgam waste from dental care

Segregation of waste produced within healthcare premises

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

CATEGORY OF WASTE	RECEPTACLE
<p>General (domestic type) Waste</p> <p>Paper, flowers, kitchen waste, bottles, aerosols.</p> <p>Gloves that have not been in contact with blood or body fluids.</p>	<p>Black Plastic Bags</p> <p>Within solid-sided, pedal-operated, lidded bins.</p> <p>Never place clinical waste in these bins</p>
<p>Clinical Waste</p> <p>All waste that has been in contact with blood or body fluids e.g. gloves, dressings, catheter bags, incontinence aids, nappies.</p> <p>Empty maceratable products in event of macerator malfunction</p>	<p>Orange Plastic Bags (225 gauge)</p> <p>Within solid-sided, pedal operated, lidded bins.</p>
<p>Sharps</p> <p>Needles, blades etc.</p>	<p>BS 7320/UN 3291 Approved Sharps Container</p>
<p>Special Clinical / Pharmaceutical Waste</p>	<p>Advice must be sought from Pharmacist and/or Facilities Manager</p>

Handling and disposal of waste

- waste should be segregated at the point of origin
- personal protective clothing should be worn when handling waste

Clinical waste should be:

- correctly bagged in orange bags of 225 gauge to prevent spillage
- kept in a rigid-sided holder or container with a foot-operated lid, and so far as is reasonable practicable, out of the reach of children
- double bagged where:
 - the exterior of the bag is contaminated
 - the original bag is split, damaged or leaking
 - only filled to $\frac{3}{4}$ full
 - securely sealed and labelled with coded tags at the point of use to identify their source.
- clinical waste bags should never be:
 - decanted into other bags, regardless of volume
 - contaminated on the outside

- sharps must be disposed of into approved sharps containers that meet BS7320/UN3291
- sharps containers should **NEVER** be placed into a orange clinical waste bag. Refer to section 3.4

Disposal of sharps containing medicinal waste

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

Medicinal waste is classified into two categories:

- cytotoxic and cytostatic medicines = hazardous waste
- medicines other than those classified as cytotoxic or cytostatic

Used Sharps and/or fully discharged syringes may still contain or be contaminated with medicinal waste.

Sharps and syringes contaminated with residual medicines (other than cytotoxic or cytostatic medicines) must be disposed of in a **yellow** topped UN approved sharps bin for incineration.

Sharps contaminated with cytotoxic and cytostatic medicines must be disposed of in **purple** lidded sharps bins for incineration.

Storage of clinical waste

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

Between collections, waste should be:

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

Management of clinical waste produced in non-healthcare managed environments i.e. private households.

(this does **NOT** include private residential care establishments).

A householder has no legal duty of care to dispose of clinical waste in the way described above. However, a health or social care worker who provides care in a private household does e.g. NHS Trust, Social Services, care agency staff. The assessable health risk of most waste from patient's homes is very small

and in most instances used swabs and dressings can be double wrapped and placed in the patient's normal household collection.

A risk assessment should be undertaken to determine whether there is an increased risk of transmission of infection due to;

- The risk of potential exposure to waste to a third party. For example; waste placed in the household waste stream is collected and crushed/compacted in a collection vehicle. If body fluids within the waste are crushed, these may then spread over an area and possibly contaminate the collection operative.
- The waste is saturated with body fluids such that if lightly compressed, free-flowing blood and/or body fluids would result.
- The waste is a used sharp e.g. needle and/or syringe, lancet. Sharps must be discarded into a sharps container (BS 7320, UN 3291).

In these instances a clinical waste collection should be arranged.

A clinical waste collection can be arranged by ringing the Facilities Manager for Suffolk Support Services. See Appendix 1 for contact details

The following information will be required:

- Client's name
- Full address (including post code)
- Telephone number for client
- How often the waste needs collecting
- What type of waste it is e.g. soft waste in bags, sharps, pharmaceutical.
- Contact details of the person making the referral

For waste that does not constitute high risk, but is defined as clinical waste, the following action should be carried out:

The following table is a guide to help staff to assess the correct disposal route for clinical waste items.

ITEM	ADDITIONAL INFO	DISPOSAL
Soiled dressings	Less than one 20 litre bag per week	Double wrapped in plastic bags and disposed of in household waste stream (black bag/bin)
Wound drains and tubing – drainable. Urinary catheters and bags. Stoma bags - drainable		Empty collection reservoir into toilet and dispose of empty item in household waste stream after double wrapping as above

Drainage bags which are not able to be emptied safely		Discuss clinical waste collection with Facilities Manager
Large quantities of heavily soiled dressings or other waste	More than one 20 litre bag per week	Discuss clinical waste collection with Facilities Manager
Diabetic sharps	Sharps bin prescribed by GP	Patient to take bin to GP practice for disposal
Sharps		Clinical waste collection will need to be arranged with Facilities Manager

New regulations in force since 01.01.2002 state that all health care risk wastes (clinical waste) must be contained in UN approved rigid packaging when transported on the road.

Staff working in the community must not carry clinical waste in their cars (except sharps containers which are already rigid).

Current legislation

- Health & Safety at Work etc Act 1974
- Control of Pollution Act 1974
- Collection and Disposal of Waste Regulations 2005
- Control of Pollution (Amendment) Act 1989
- Environment Protection Act 1990
- Environment Protection (Duty of Care) Regulations 1991
- Controlled Waster Regulations 1992
- The Special Waste Regulations 1996
- The Safe Disposal of Clinical Waste 1999
- Health Care Waste Management and Minimisation 2007
- ADR 2003 (Carriage of Dangerous Goods by Road)

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SMHPT Waste Management policy.

3.7 Laundry Management

Linen must be kept to a minimum in community based clinic areas unless laundry services are contracted. If laundry services are contracted, the service provider's guidelines must be followed.

Areas, which do not use a contracted laundry service, should use disposable pillowcases, sheets and towels as appropriate.

Examination couches

Examination couches and pillows if used, must be covered with a disposable paper towel, which must be changed between patients

Pillows are not considered essential, as all couches should have head-tilts. However, if pillows are used, they should be sealed within a plastic impermeable cover. Disposable pillowcases should then be used. These should be discarded once weekly or more frequently if they become soiled. If standard pillowcases are used, they must be washed weekly or more frequently if they become soiled

Blankets/sheets are not considered essential. For modesty, a length of disposable paper towel should be used to cover exposed parts of the body.

Curtains

- At windows, it is recommended that vertical blinds are used
- Around couches, curtains should only be used if required to protect patient's modesty
- There should be an environmental cleaning schedule which should include cleaning blinds and bed curtains twice yearly

When linen is used

- Linen must be changed at least weekly, or more frequently if soiled
- Place linen soiled with body fluids in a leak-proof, water soluble bag and arrange prompt laundering
- Used linen must be laundered at 71⁰C for 3 minutes or 65⁰C for 10 minutes. For staff health reasons and quality control issues (as domestic washing machines are not generally designed to comply with this standard), it is not acceptable for linen to be laundered by any member of staff using their own personal facilities i.e. at home

In the patient's own home

Staff caring for clients in their own homes or in group homes may be involved in the laundering of client's clothes or linen. The following principles should be noted:

The microorganisms in most soiled and fouled linen are unlikely to cause infection in healthy workers provided that care is taken. But to further minimize the risk

- Wear a waterproof apron and gloves when dealing with used laundry
- Ensure that adequate hand washing facilities are available
- Remove any protective clothing and wash hands before returning to other duties
- Do not smoke or eat while dealing with laundry
- Cover cuts and abrasions with waterproof dressing

In a client's own home, a domestic washing machine may be used. Soiled and fouled linen should be pre-washed and then washed at the highest temperature that the material will withstand. Soiled or fouled linen should not be washed by hand.

Staff uniforms or work clothes

SMHPT Dress code policy HR26/2/05 must be complied with at all times. The majority of bacteria and viruses will not survive away from the host and would not present a high risk of infection on clothing. However, within a mass of body fluid, organisms would survive longer.

Staff who are at risk of contaminating their clothes by body fluids should always change into 'home' clothes as soon as possible – preferably before leaving the work place or as soon as home is reached.

Uniforms or work clothes should be washed as soon as possible on as hot a wash as the fabric will tolerate. This must be at least 40 °C and ideally 60 °C. Cardigans/jumpers should be washed at least weekly.

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

References

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3.8 Decontamination of equipment

The aim of decontaminating equipment is to prevent potentially pathogenic organisms reaching a susceptible host in sufficient numbers to cause infection.

Those involved in the purchase of equipment should consider how it will be cleaned prior to purchasing.

SINGLE USE EQUIPMENT

Single use means that the manufacturer:

- Intends the item to be used once, then thrown away.
- Considers the item unsuitable for use on more than one occasion.
- Has insufficient evidence to confirm that re-use would be safe.

The Medicines and Healthcare Regulations Authority guidance advises that reprocessing and re-using such items may pose hazards for patients and staff, if the reprocessing method has not been validated.

The Consumer Protection Act 1987 will hold a person liable if a single use item is reused against the manufacturer's recommendations. Liability under this legislation continues for 10 years.

Single patient use means that the item can be reused if re-processed using an appropriate method and is used on the **same patient only**. The manufacturer will provide details of the appropriate method of decontamination of the device in this instance.

The duration of use is dependant upon undertaking a risk assessment of individual risk factors.

The Medical and Healthcare products Regulations Agency (MHRA) defines the following terms:

Cleaning is an essential prerequisite of equipment decontamination to ensure effective disinfection or sterilisation can subsequently be carried out.

- Cleaning is a process which physically removes contamination but does not necessarily destroy micro-organisms. The reduction of microbial contamination cannot be defined and will depend upon many factors including the efficiency of the cleaning process and the initial bio-burden.
- Disinfection is a process used to reduce the number of viable micro-organisms, which may not necessarily inactivate some viruses and bacterial spores. Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation.
- Sterilisation is a process used to render the object free from viable micro-organisms, including spores and viruses.

RISK ASSESSMENT

Re-usable equipment should be appropriately decontaminated between each patient using a risk assessment model. Use only the decontamination method advised by the manufacturer - using any other process may invalidate warranties and transfer liability from the manufacturer to the person using or authorising the process.

Medical equipment is categorised according to the risk that particular procedures pose to patients - by assessing the microbial status of the body area being manipulated during the procedure. For example, items that come into contact with intact mucous membranes are classified as intermediate risk and require disinfection between each use as a minimum standard. Items that enter normally sterile body areas, or come into contact with broken mucous membranes, are classified as high risk and must be sterile before use.

Risk Assessment for Decontamination of Equipment

Risk	Application of Item	Suitable method
Low	<ul style="list-style-type: none">in contact with healthy skin e.g. stethoscopes, washing bowls,ornot in contact with patient e.g. furniture, mattresses, surfaces, commodes	Cleaning and drying
Intermediate	<ul style="list-style-type: none">in contact with intact mucous membranesorcontaminated with virulent or readily transmissible organisms (body fluids)orprior to use on immuno-compromised patients e.g. thermometers, auroscope earpieces.	Cleaning followed by disinfection or single use
High	<ul style="list-style-type: none">in contact with a break in the skin or mucous membraneorfor introduction into sterile body areas for example uterine sounds, instruments used for surgical/ operative procedures	Sterile at point of use, or single use

Cleaning methods

Cleaning is the first step in the decontamination process. It must be carried out before disinfection and sterilisation to make these processes effective. Thorough cleaning is extremely important in reducing the possible transmission of all microorganisms, including the abnormal prion protein that causes variant Creutzfeldt-Jacob Disease (vCJD).

Staff must wear the appropriate personal protective clothing whilst handling and cleaning used medical devices or equipment. Refer to section 3.3

Thorough cleaning with general purpose detergent (GPD) (i.e. Hospec™) and warm water - maximum temperature 35°C - will remove many micro-organisms.

Hot water should not be used as it will coagulate protein making it more difficult to remove from the equipment.

The concentration of the detergent solution must be as advised by the manufacturer. This requires that a measured amount of detergent is added to a known volume of water.

All equipment must be thoroughly rinsed in clean water and dried using a non-shedding disposable cloth prior to use or further processing.

Manual cleaning of small items and surgical instruments must be undertaken in a designated sink, which is deep enough to completely immerse the items to be cleaned.

Scrubbing can generate aerosols, which may convey infective agents. Therefore if scrubbing is necessary it must be carried out with the brush and item beneath the surface of the water.

Personal protective equipment, including aprons, gloves and goggles or visors, must be readily available for staff undertaking the manual cleaning of equipment.

Cleaning equipment - such as brushes must be stored clean and dry between uses.

Disinfection methods

Disinfection methods apply to handwashing, pre-operative skin preparation and the disinfection of medical devices or equipment.

Disinfection of equipment should be limited and, where possible, disposable or autoclavable equipment used instead. If disinfection is required, use the method recommended by the manufacturer.

Chemical	Advantages	Disadvantages	Uses
Chlorine-based: Hypochlorites (e.g. Domestos™, Milton™) NB Undiluted commercial hypochlorite contains approx. 100,000ppm available chlorine	<ul style="list-style-type: none"> • wide range of bacterial, virucidal, sporicidal and fungicidal activity • rapid action • non-toxic in low concentrations • can be used in food preparation • cheap 	<ul style="list-style-type: none"> • inactivated by organic matter • corrosive to metals • diluted solutions can be unstable • need to be freshly prepared • does not penetrate organic matter • bleaches fabrics • need ventilation 	<p>can be used on surfaces and for body fluid spills – minimum contact time 2 mins.</p> <p>(0.1% (1000 ppm) solution for disinfecting surfaces and equipment, 1% (10,000 ppm) solution for disinfecting blood spillages)</p>

Sodium Dichloroisocyanurates (NaDCC) e.g. Presept, Actichlor – available in liquid, tablet and granule form	<ul style="list-style-type: none"> • slightly more resistant to inactivation by organic matter • slightly less corrosive • more convenient • long shelf-life 	<ul style="list-style-type: none"> • as above 	as above The correct dilutions are better achieved using NaDCC tablets
Alcohol 70% e.g. isopropanol	<ul style="list-style-type: none"> • good bactericidal, fungicidal and virucidal activity • rapid action • leaves surfaces dry • non-corrosive 	<ul style="list-style-type: none"> • non-sporicidal • flammable • does not penetrate organic matter • requires evaporation time 	can be used on surfaces, or for skin and hand decontamination
Chlorhexidine e.g. Hibiscrub™, chlorhexidine wound cleaning sachets	<ul style="list-style-type: none"> • most useful as disinfectants for skin • good fungicidal activity • low toxicity and irritancy 	<ul style="list-style-type: none"> • limited activity against viruses • no activity against bacterial spores • inactivated by organic matter 	for skin and hand decontamination

Sterile instruments may be obtained by purchasing pre-sterilised single use items. These avoid the need for re-sterilisation and are a practical and safe method. You must store items using a stock rotation system according to manufacturer's instructions.

Decontamination of equipment prior to inspection, service, repair or loan.
Do not send contaminated equipment elsewhere without decontaminating first.

All external surfaces must be cleaned using general purpose detergent (GPD), and dried. If there is visible body fluid contamination the exterior surface should also be wiped with an alcohol or hypochlorite solution.

Before dispatch, complete and attach a certificate (see Appendix 2), which states the method of decontamination used, or the reason why it was not possible (NHS Management Executive 1993). Service and maintenance engineering contractors may provide identification tags, which must be attached to the item in addition to the decontamination certificate.

Purchasing equipment

When considering purchasing an item of equipment, consideration should be given to ease and method of cleaning. Cleaning instructions should be available with the item and these should be kept and incorporated into local cleaning guidelines.

A-Z OF EQUIPMENT AND THE DECONTAMINATION METHOD

EQUIPMENT	CLEANING METHOD
Babies feeding bottles and teats Dummies and feeding equipment	Disposables preferred. Non-disposables – as dummies and feeding equipment (see below). Single use preferred. Communal sterilising tanks must <u>not</u> be used. Single person use sterilising tanks should be cleaned thoroughly with GPD solution and rinsed before use. Ensure total immersion of equipment in Milton (or similar) solution. Tank must be cleaned daily and fresh solution prepared. Electric steam steriliser should be used as per manufacturer's guidance.
Baby changing mats	Cover with paper towel and change between each baby. Clean between each baby and at end of session with detergent wipes. Store dry.
Baths, Bath hoists	To be cleaned between users. With gloved hand, clean bath surface, grab rails and taps with warm water, GPD and paper towels. Rinse.
Bath water additives	There are no antiseptic solutions that should be added to the bath. When antiseptic bathing is prescribed, the agent should be applied directly to the skin instead of soap.
Bedpans and urinals (non-disposable)	Wearing disposable plastic apron and gloves, flush away contents and clean thoroughly using paper towels and GPD solution. Rinse, dry and store inverted. Disinfection using sodium hypochlorite solution 1000ppm (0.1%) will be required if the client has enteric symptoms.
Bedpan washers/ macerators	These should be used, cleaned and serviced according to manufacturer's guidance.
Beds, backrests, bed cradles and mattresses	To be cleaned between users with GPD solution or detergent wipes. If soiling is evident then immediately clean as above and then wipe over with chlorine-releasing compound.
Bidets	To be cleaned after each use. Clean surface of pan and taps with GPD solution, using disposable paper towels and gloved hand and then flush.
Blood pressure cuff	Wipe with detergent wipe. If heavily contaminated, will need laundering
Bowls, buckets – patient washing	Clean between each use with GPD solution, using disposal paper towels. Rinse and store dry.

Commode armrests and seats	If no soiling is evident, clean with GPD solution or detergent wipes, and dry using paper disposable towels. If soiling is evident, or there is an outbreak of diarrhoea, or the previous user had a loose stool, follow by wiping over with a 0.1% chlorine-releasing solution (eg Presept, Actichlor). Use separate wipes for armrests and seats.
Curtains	Wash or dry clean as appropriate if contaminated. (Normal change every 6 months)
Damp dusting (all surfaces)	GPD solution or detergent wipe. If known contamination or resistant organism, follow with 0.1% Hypochlorite solution.
Ear pieces from auroscopes	Disposable are now available. Clean thoroughly with GPD solution, using thin brushes to clean inside. Rinse and dry thoroughly before storage.
ECG/ECT Equipment <ul style="list-style-type: none"> • Electrodes • Straps • Machine 	<ul style="list-style-type: none"> • Use disposable • Wash well with warm water • Wipe over with damp cloth (detergent wipe), keep covered when not in use
Examination couches	Surface must be in good repair, clean with GPD solution or detergent wipes at start and finish of each session or if becomes soiled. Cover with disposable paper roll and change between each client use.
Nurse's scissors and bandage scissors	Wipe with detergent wipe before and after use
Razors – safety or electric	Use disposable or patients own. Do not allow sharing
Stethoscopes	Clean with detergent wipes.
Suction equipment	<p>Disposable suction units are recommended. After each use (or 24 hours if in frequent use) the disposable components should be disposed of as clinical waste.</p> <p>Non-disposable bottles – ensuring appropriate staff protection, empty the contents into the toilet, rinse with cold water. Clean using GPD solution. Store dry.</p> <p>Tubing should be disposable.</p> <p>Filters – these should be replaced when wet and at appropriate intervals in keeping with the manufacturer's instructions.</p>

Thermometers	Disposable or tympanic thermometers are preferred For traditional thermometers, use disposable sheaths and wipe between uses with alcohol wipe. Do not soak in any solution
Tourniquets	Wipe with detergent wipe
Toys	Toys must be cleaned with GPD solution at least weekly. Soft toys are not recommended.
Urine jugs (non disposable)	The use of disposable jugs is advised. Wearing disposable plastic apron and gloves a separate clean jug should be used for each urine collection. Empty contents into the toilet and rinse. Clean thoroughly using GPD solution and paper towels,. Rinse, dry and store inverted.
Weighing scales	Line with disposable paper towel. Clean with detergent wipes before next baby is weighted and at the end of each clinic session. Store dry.
Work surfaces	General Cleaning Use GPD solution or detergent wipes. Contaminated Surfaces Clean with GPD solution or detergent wipes and then wipe with 0.1% sodium hypochlorite solution.

NB In many instances, detergent wipes may be substituted for GPD solution.

For specialist equipment, refer to manufacturer's instructions in the first instance.

ENVIRONMENTAL CLEANING

The environment plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk and should be kept to a minimum by regular cleaning and by good design features in buildings, fittings and fixtures.

A written cleaning schedule should be devised specifying the persons responsible for cleaning, the frequency of cleaning and methods to be used and the expected outcomes:

- Work surfaces and floors should be smooth-finished, intact, durable of good quality, washable and should not allow pooling of liquids and be impervious to fluids
- Carpets are not recommended in treatment rooms or areas where clinical procedures will take place because of the risk of body fluid spills

- Where carpets are in place, there should be procedures or contracts for regular steam cleaning and dealing with spills
- Keep mops and buckets clean, dry and store inverted
- Mop head should be removable for frequent laundering, or single use if this is not possible
- Provide single use, non-shedding cloths or paper roll for cleaning
- Colour code cleaning equipment, such as mop heads, gloves and cloths for toilets, kitchens and clinical areas. Use different colours for each area, see NHS Estates cleaning manual.
- General purpose detergent is sufficient for most environmental cleaning - follow the manufacturer's instructions.

DOMESTIC	CLEANING
Bucket (plastic)	Empty contents down toilet or slop hopper. Wash inside and outside of bucket with detergent solution (eg Hospec), rinse, and dry prior to storage.
Mop (wet)	Rinse, dry and store head up after use; heat disinfect in washing machine and dry thoroughly weekly
Mop (dry)	Vacuum after each use
Lavatory brushes	Rinse in flushing water and store dry
Suggested colour coding of cleaning equipment	Red: toilet bathroom/sluite Blue: kitchen/pantry Yellow: all other areas
Floors	Dust control – dry mop Wet cleaning – wet mop, wash with GPD solution. If known contamination follow with hypochlorite 1000ppm
Furniture and fittings	Damp dust with GPD solution. If known contamination follow with hypochlorite 1000ppm (0.1% solution) if fabric will tolerate.
Lavatory seat and handle	If soiling is evident, or there is an outbreak of diarrhoea, or the previous user had a loose stool, clean with GPD solution followed by chlorine-releasing compound (i.e. Prescept, Actichlor) 1000ppm
Showers	Should be clean and maintained. Launder curtains 3 monthly. Shower heads should be de-scaled when necessary
Walls and ceilings	When visibly soiled use GPD solution. Splashes of blood should be cleaned promptly with 1.0% hypochlorite solution.

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SECTION 4 MANAGEMENT OF SHARPS INJURIES

In the event of a sharp injury/contamination incident the following guidelines should be followed:

A sharp injury/contamination incident includes:

- inoculation of blood by a needle or other 'sharp'
- contamination of broken skin with blood
- blood splashes to mucous membrane e.g. eyes or mouth
- swallowing a person's blood e.g. after mouth to mouth resuscitation
- contamination where clothes have been soaked by blood
- human bites resulting in significant wound

Any staff working in a healthcare facility who handle sharps or clinical waste should receive a full course of hepatitis B vaccine and have their antibody level checked on appointment.

Managers should ensure that new staff, or any existing staff who know they are not already protected, visit their occupational health department to arrange vaccination without delay.

Blood and body fluids may contain a variety of microorganisms that are transmissible to healthcare staff. The most important of these are **Hepatitis B, Hepatitis C, and HIV**. Although Hepatitis B and HIV infection are very uncommon in people who have lived exclusively in this region, they are increasingly seen in those who have travelled from other parts of the world. For example, Hepatitis B is particularly common in South East Asia, and HIV in sub-Saharan Africa. Hepatitis C is known to be common in injecting drug users in the UK.

The **risk of transmission** from a positive source depends on the **nature of the injury** and on **the volume of blood transferred**. Thus, splashes to mucous membranes including the conjunctivae are regarded as being lower risk than percutaneous injuries such as needlesticks, of which **deep injuries involving hollow-bore needles** removed from a blood vessel represent the greatest hazard.

For percutaneous injuries, the risk of transmission is thought to be in the order of:

- 1 in 300 for HIV,
- 1 in 30 for Hepatitis C, and up to
- 1 in 3 for a Hepatitis B e antigen positive source.

However, the risk of transmission may be reduced if appropriate action is taken without delay.

Healthcare staff must avoid exposure to blood and body fluids wherever possible by adopting safe handling techniques and correct disposal of needles, syringes and sharp instruments, and by using gloves and eye protection where

appropriate. If an exposure does occur however, the procedures described in this policy should be followed.

4.1 Summary of actions

First Aid The exposed healthcare worker should thoroughly wash the site of exposure with soap and water without scrubbing, or irrigate mucous membranes (including conjunctivae) copiously with water, after removing contact lenses if present. Puncture wounds should be gently encouraged to bleed. The wound should then be covered with a waterproof dressing.

Report promptly to line manager, who will ensure that the exposed health care worker contacts occupational health immediately for further advice and that the staff member follows this advice. Out of office hours, attend the A&E department within one hour where the risk assessment will be performed. In accordance with the Incident Policy the individual must complete an incident form.

When the source patient is known to be HIV It is helpful if someone telephones ahead to inform A&E and also alerts Occupational Health so that appropriate records can be made available.

The exposed healthcare worker will be seen by a practitioner in the A&E Department as a priority case who will:

- Assess the incident: was it a significant exposure to blood or a high risk body fluid?
- If so, contact the doctor responsible for the source patient who will find out if the source patient is known to carry a blood borne virus, and if not known, make an assessment of the likelihood that the source patient is a carrier.
- Assess the vaccination status of the exposed healthcare worker to Hepatitis B and give a dose of vaccine (and in some circumstances Hepatitis B immunoglobulin) if required.
- If the source patient is known or strongly suspected to be HIV positive, recommend a course of post-exposure prophylaxis to the exposed healthcare worker. Dispense a starter pack after appropriate discussion and obtaining consent. Further specialist advice will be obtained from Occupational Health.
- Obtain a serum sample from the exposed healthcare worker (with permission) for long term storage.
- Arrange follow-up for the exposed healthcare worker with the Occupational Health Department if required.

Assessment of the source patient

An initial assessment of the source patient will be made by a suitable professional responsible for the patient (but not the exposed healthcare worker). The relevant person will ascertain from the medical notes or by direct questioning whether the patient is known or strongly suspected to be HIV seropositive, or positive for Hepatitis B or C. This information will be communicated to the A & E doctor for the immediate management of the exposed healthcare worker. At this or a later stage, a request will be made of

the patient, after appropriate discussion and obtaining consent, to be tested for markers of Hepatitis B, Hepatitis C and HIV infection. The patient will be informed of the test results, and if required, may receive counselling from the Department of Sexual Health.

Follow-up by occupational health

The Occupational Health Department will document the nature and circumstances of the exposure, and will coordinate the follow-up of the exposed healthcare worker after the incident in the following ways.

- Provide counselling and support as required.
- Ensure that a course of hepatitis B vaccination is completed, if necessary.
- If a course of HIV post-exposure prophylaxis has been started, monitor compliance and adverse effects. Discontinue the course if further assessment of the source patient indicates that he or she is unlikely to be HIV positive.
- Carry out follow-up serological tests (with the healthcare worker's consent) at the relevant times for Hepatitis B antibody, Hepatitis C RNA and/or antibody and HIV antigen/antibody.
- Refer to specialists in other fields, for example sexual health, gastroenterology, or obstetrics for further advice or treatment if required.
- If the source patient is known to carry a blood borne virus, the exposure and its outcome should be reported in confidence to the national surveillance scheme coordinated by the Communicable Disease Surveillance Centre, Colindale.

References

British Medical Association. A code of Practice for the Safe Use and Disposal of Sharps. BMA, London. 1990.

ICNA (2003) Reducing Sharps Injury – Prevention and Risk Management. London

Health Services Advisory Committee. Safe Disposal of Clinical Waste. Sheffield: HSE 1999

Health and Safety Commission. Control of Substances Hazardous to Health Regulations 1999. Approved Codes of Practice. HSE Books 1999.

Medical Devices Agency (2001a) MDA SN 2001(19). Safe Use and Disposal of Sharps. London, Department of Health.

RCN Epinet available from www.needlestickforum.net

RJ Kent, (May 2004). 'Management of Blood and Body Fluid Exposure Incidents in Healthcare Staff'

SECTION 5

SPECIFIC ORGANISM RELATED INFORMATION

5.1 Guidelines for the Management of Meticillin Resistant Staphylococcus Aureus - MRSA

Staphylococcus aureus is a type of bacterium carried in the nose and on the skin of about 20-40% of the population, usually without causing any harm. However, it is the most common cause of simple, uncomplicated skin and wound infections. It may be responsible for more serious infections and those most at risk are hospital patients undergoing major surgery or those who require intensive care.

Some strains of Staphylococcus aureus have become resistant to Meticillin (a once commonly used antibiotic), as well as to other antibiotics. MRSA behaves in the same way as ordinary Staphylococcus aureus and does not cause more severe or different infections. However MRSA is harder to treat as there are fewer antibiotics with which to treat it, and some of these antibiotics may have to be given by injection or infusion. They may also have unpleasant side effects. MRSA rarely causes infection in healthy people, such as healthcare staff and their families, and does not normally spread easily outside of hospital or other healthcare settings.

Outside acute hospital units people may carry MRSA without it causing harm to themselves or others. They are said to be MRSA carriers or to be colonised with MRSA. Although attempts are made to eradicate colonisation in acute hospitals, this is not always necessary for patients in low-risk clinical areas of the hospital, or in the community.

Why is it known as a hospital acquired disease?

MRSA will spread more readily in the acute hospital setting, due to the increased vulnerability that patients with an acute illness will have to infection.

When an individual suffers an acute illness, their immunity will be vastly reduced (making them vulnerable to infection). As that individual recovers, so will their immunity.

If an individual makes a complete recovery, their immune system generally makes a full recovery.

If an individual goes on to develop a chronic illness, their immune system may not make a complete recovery. However this deficit in their immune system will be far less than if they were still suffering from an acute illness.

What is the difference between colonisation and infection?

Colonisation - means the organism (in this case MRSA) is living on the skin (usually nose, throat, axilla or groin), causing no problem to the individual.

Infection - means that the organism (in this case MRSA) is causing harm i.e. there are symptoms of an active disease.

Why is the management of MRSA different in the community?

In the community, there are not the large numbers of acutely ill patients that there are in the acute hospital. Therefore the increased vulnerability of patients does not exist to the same extent.

What precautions need to be taken?

No special precautions are necessary.

Standard Principles, especially handwashing, are all that are necessary.

However MRSA does act as an opportunity to remind us of the **good practices** that should be in place.

Patients do **not** require barrier nursing in the community setting. Ideally they are in a single room, or share a room with someone who does not have an open wound or invasive device e.g. urinary catheter, intravenous device.

They can mix with other patients socially and at mealtimes.

Laundry, china and cutlery do **not** need to be handled separately. Again, as long as good practices are already in place, there is no need for additional precautions.

In patient's own homes, waste should be handled as with any other patient (refer to waste section, 3.6).

Screening

Routine screening of patients in the community is not necessary.

Screening swabs may be requested by the hospital prior to a surgical procedure. The hospital will usually specify the screening required but it is likely to be nose, groin and any wounds.

Depending on the results, MRSA eradication treatment may be necessary immediately prior to the patient's/clients admission to hospital.

The screening of **staff is very rarely required** - and should only take place in consultation with the Infection Control Nurse.

MRSA wound swabbing

Do not swab unless there is clinical evidence to do so.

The state of the wound should be assessed and documented by a registered nurse with necessary skills in wound assessment:

- size, depth
- condition of wound
- does it look infected (is it red, hot, inflamed or has a discharge?)

The wound should be monitored to assess if it is healing:

- if the wound is healing - do not swab

If the patient is colonised with MRSA of the nose and/or groin, do not routinely swab. Should such a patient then develop any wounds:

- observe for signs of infection
- swab if there is any sign of infection in a new wound.

Always treat the wound and not the swab result.

Apply the **dressing that is clinically indicated** to promote the correct environment for wound healing and to control exudate.

Some wounds may benefit from using dressings containing silver or iodine but when there is significant local cellulitic infection, systemic treatment should be considered. General Practitioners should refer to the antibiotic policy. Alternatively, advice may be sought from a microbiologist.

Admission to a care facility,

No inpatient facility or home is allowed to refuse admission of a patient/resident/client because they happen to have MRSA. However, if a resident does have MRSA (either colonisation or infection) that resident should:

- be in a single room. **OR**
- be in a shared room, but the other resident must not have an open wound or a urinary catheter, or any other invasive device.

In addition to the above precautions:

- environmental cleaning should be reinforced to help prevent further spread
- after patient is discharged the room should be thoroughly cleaned

Further Advice

Please seek further advice from the Infection Control Nurse if required.

References

Department of Health (1996). MRSA: What Nursing and Residential Homes need to know? HMSO, London.

Royal College of Nursing (2000). Meticillin Resistant Staphylococcus aureus (MRSA); Guidance for Nurses. RCN, London.

Joint BSAC/HIS/ICNA Working Party Report on MRSA (2006). Guidelines for the Control and prevention of Meticillin resistant Staphylococcus aureus(MRSA) in healthcare facilities. Journal of Hospital Infection, 63, Supplement 1 May 2006).

5.2 Guidelines for the management of patients with diarrhoea caused by *Clostridium difficile*

Clostridium difficile is a Gram-positive, anaerobic spore forming bacillus which can be found in the gut. Some strains of the bacterium produce two toxins which cause fluid loss from the bowel mucosa and cellular damage.

The spores, which are resistant to heat, drying and some disinfectants, can survive in the environment for several months.

It is the most common cause of antibiotic associated diarrhoea and hospital-acquired infectious diarrhoea.

Gastrointestinal symptoms may be mild but in extreme cases can lead to pseudomembranous colitis (PMC), which can be life-threatening.

The symptom is mainly diarrhoea, which usually starts 10-15 days (range from a few days to 2 months) after commencing antibiotics, in particular the cephalosporins.

Spread occurs by direct patient to patient contact, the hands of health care workers and contact with the contaminated environment.

Those at greatest risk of *Clostridium difficile* infection are the elderly, those on antibiotic therapy and post surgical patients.

Prevention

The key measure in preventing the development of *Clostridium difficile* is control of antibiotic usage:

- Short courses of only 5-7 days are preferable to longer courses
- Narrow spectrum antibiotics are preferable to broad spectrum agents or combinations
- Avoid high risk antibiotics for patients aged 60 years or more. High risk antibiotics are clindamycin, cefixime, cefotaxime, ceftriaxone and to a lesser extent, cefuroxime.

For further information refer to the Suffolk PCT GP Antibiotic Policy.

Rapid improvement from the symptoms usually occurs following stopping the antibiotic(s) together with fluid replacement. Treatment is with oral metronidazole. If this is not effective, oral vancomycin should be prescribed.

Infection control precautions

- All staff must **wash** their hands after each contact with the patient – alcohol gel is not effective against *Clostridium difficile* spores.
- All patients must be able to wash their hands after a bowel motion
- Beds, surfaces, lavatories and commodes must be thoroughly cleaned each day or after use with detergent and water followed by disinfection with 0.1% hypochlorite solution.
- All equipment that comes in contact with the patient must be disinfected/sterilized according to the instructions relating to that item. Refer to section 3.8
- Disposable equipment should be used whenever possible.

- Patients' clothing and linen should be washed according to the section for dealing with infected linen.

It is important to communicate to any relevant practitioner about previously infected patients who are being transferred to them in view of the significant proportion who may relapse and the fact that further antibiotic treatment may increase the risk of relapse.

NB. Clearance stool samples are not required in any circumstances.

Information leaflets on Clostridium difficile are available for both staff and patients on SMHPT intranet site under Infection Control

Contact the Infection Control Nurse as soon as there is a suspected case of Clostridium difficile for discussion and guidance.

All confirmed cases of Clostridium difficile will undergo a local root cause analysis (RCA) to ascertain the likely cause and to produce an action plan to address any identified areas of concern.

References

National Clostridium difficile Standards Group (June 2003). Report to the Department of Health. DoH, London.

Suffolk Primary Care Trust ' GP antibiotic Formulary 2008.

www.suffolkpct.nhs.uk/ProfessionalResources/PharmacyMedicinesManagement/MedicinesManagement/tabid/908/Default.aspx

5.3 Guidelines for the management of patients with Vancomycin-resistant enterococci (VRE) or Organisms producing extended spectrum beta-lactamase (ESBLs)

- Enterococci are part of the normal flora of the intestinal tract and they are sometimes also isolated from other non-sterile sites including the vagina, skin and mouth.
- They are usually organisms of low virulence, but in some situations may cause infection, including infection of the urinary tract, abdominal wounds, biliary tract or intravenous catheters. Debilitated and immunocompromised patients are at a higher risk of infection.
- Enterococci are intrinsically resistant to many antibiotics. Traditionally, amoxoxillin or glycopeptide antibiotics (Vancomycin and teicoplanin) have been used to treat significant infections. However, in recent years, Vancomycin resistance has become more common, especially in *Enterococci faecium*. These strains (VRE) are not more likely to cause disease than susceptible ones, but they are a lot harder to treat when they do.
- Enterococci are able to survive on environmental surfaces for long periods, and they are also relatively resistant to heat. VRE are readily transferred from patient to patient unless a high standard of cleaning and excellent infection control practice are observed.

Organisms producing extended spectrum beta-lactamase (ESBLs)

- Some strains of 'coliform' bacteria, especially *Klebsiella* and *Enterobacter*, are known to carry plasmids containing genes for enzymes that break down a wide variety of antibiotics. These organisms are resistant to all but a few reserve (and expensive) intravenous antibiotics such as meropenem.
- ESBL-producing organisms may be carried without symptoms in the gut, but they are also responsible for infection, for example of the urinary tract. Locally, these are occurring more frequently, even from patients in the community.
- High standards of infection control practice are required to prevent spread of these organisms between patients.

Infection control management of these resistant organisms

- Ensure meticulous hand hygiene after contact with patient and/or the environment.
- Use gloves for handling all body fluids.
- Avoid contaminating the environment when disposing of body fluids.
- Pay particular attention to cleaning the environment, especially wet areas such as sluices or bathrooms where body fluids are emptied.
- Ensure thorough cleaning of equipment used by the patient.

Contact the Infection Control Nurse to discuss care and treatment of a patient identified with one of these organisms.

SECTION 6 OUTBREAK CONTROL

Definition - An outbreak may be defined as two or more linked cases, as assessed by an Infection Control Nurse (ICN), of an infection or an increase in the number of infections that would normally be expected.

A single case of some diseases eg Diphtheria, in any setting would also be considered an outbreak.

It is important to recognize potential outbreaks promptly to enable control measures to be implemented as soon as possible to prevent further cases.

All healthcare staff should be aware of possible signs of infection (fever, diarrhoea, vomiting) and should report these to the manager of the area at the time. This information should then be reported to ICN immediately for further management advice. Out of hours, contact the service manager on-call.

The following should always be reported:

- an increased incidence of vomiting and/or diarrhoea occurring either over a short or extended period amongst patients/clients and/or staff
- several cases of a similar infection (based on clinical diagnosis) in patients/clients and staff who have had close contact with each other eg respiratory symptoms
- an unusually high number of absences amongst staff
- an incident involving a member of staff should also be reported to Occupational Health

If an inpatient day and treatment facility is affected the incident should be treated as a Serious Untoward Incident and the following guidance should be followed:

- The person in charge should contact the ICN without delay if they suspect there may be an outbreak of infection (out of hours, the on call service manager)
- Senior manager must be informed to ensure adequate staffing to cope with extra demands of managing an outbreak. Staff working in the area should not work in other care establishments until the outbreak is declared over
- Senior manager to complete an Infection Control Outbreak Summary Report Form (see Appendix 3)
- Senior manager to contact Centre for Service Excellence and follow SUI policy

When **influenza** is diagnosed, the ICN or the Director on call should immediately contact the Health Protection Unit in hours, or the on call Public Health clinician out of hours, for advice to ensure that the correct procedure is followed for the administration of prophylaxis/treatment if deemed appropriate.

There is an **Outbreak Control Plan for Suffolk** which will be activated by the Health Protection Unit following criteria defined within the plan.

6.1 Specific guidance for outbreaks of diarrhoea and/or vomiting

It is important when assessing patient's symptoms that previous history is taken into consideration to ensure accurate case-finding and reporting. NB the Bristol stool chart is attached for reference.

- Inform ICN and complete an incident report form
- Isolate symptomatic patients wherever possible in their own rooms with their own toilet facilities or a designated commode if en-suite facilities are not available.
- Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support hand rails and unit kitchens. For the duration of the outbreak, environmental cleaning should be performed using detergent and hot water followed by a chlorine releasing solution (eg 0.1% Actichlor solution).
- All staff handwashing areas and the rooms of symptomatic patients should have an alcohol hand rub available for the duration of the outbreak. NB. Handwashing with soap and water continues to be an effective procedure in preventing cross-infection. **If norovirus is suspected, soap and water hand hygiene is essential as soap and water does not deactivate this virus.**
- Patients should be encouraged to wash their hands after using the toilet and before eating.
- Staff should pay attention to all infection control practices, particularly the washing of hands and wearing protective clothing.
- Faecal samples should be obtained from patients and staff if they have symptoms. The microbiology form accompanying the sample should clearly state it is part of an outbreak, as this will determine which specific tests are carried out in the laboratory. (Samples of vomit are not required.)
- **On the advice of the Infection Control Nurse and service manager**, the area may need to be closed to admissions until a further risk assessment deems the area safe for reopening. This action is considered a Serious untoward Incident and the Centre for Service Excellence should be notified immediately.
- Symptomatic staff must go off duty, a faecal sample must be taken and they must remain off work until they have been symptom free for 48 hours (see Staff Health Policies, Section K).
- Visitors should be informed of the outbreak and unnecessary visits should be discouraged. Those who choose to visit should wash their hands as they enter and leave the area and comply with all other hygiene practices in place.

- Patients should only be discharged/transferred when/if they are symptom free (48 hours symptom free is required in those groups with a high risk of spreading gastro-intestinal infection. For SMHPT purposes these are adults who may find it difficult to implement good standards of personal hygiene). Areas receiving discharged/transferred patients should be aware of the situation.

6.2 Prevention and Control of Scabies

Introduction

Scabies is an allergic response to an infestation of the skin by the mite ***Sarcoptes scabiei***. The mites penetrate through the skin and excavate burrows at the epidermal/dermal junction. The female mite lays eggs which hatch after 3-4 days. Newly hatched larvae exit the burrows and appear on the surface of the skin before forming their own tunnels. The burden of mites can range from 10-20 to several thousand in people who are severely immunocompromised. Scabies is distributed world-wide and is endemic in many developing countries.

Recognition of Symptoms

The most frequent symptom is itching which may affect all parts of the body and is particularly severe at night.

Occasionally small vesicles may be visible along the areas where the mites have burrowed. A papular rash may be visible in areas such as around the waist, inside the thighs, lower buttocks, lower legs, ankles and wrists. Firm nodules may develop on the front folds of the axillae and around the naval and in males around the groin. Pale burrows described as a “greyish line resembling a pencil mark” may be present in the skin between the fingers, but are less commonly seen than text books suggest.

Failure to find burrows does *not* exclude scabies as a diagnosis.

It should be emphasised that scabies may be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation. Also scabies can look atypical in anyone with immature or impaired immunity such as very young children, those with Down’s Syndrome, alcoholics or the very elderly. In immunosuppressed people, such as those with AIDS or those on immunosuppressive therapy, a more severe hyperkeratotic form may develop known as Norwegian or crusted scabies

Mode of Transmission

Scabies mites are generally not capable of surviving off the host long enough to establish a new infection as they quickly become too dehydrated and weak.

Mites are passed directly from the skin of one person to another. The likelihood of transmission increases with the duration and frequency of skin to skin contact.

Fomites and animals are not implicated in transmission.

Incubation

The incubation period is up to 8 weeks after contact with an affected person.

Diagnosis

The definitive diagnosis of scabies is made by microscopic identification of the mites, eggs or mite faeces from skin scrapings.

Outbreaks

Outbreaks occur particularly in long-stay healthcare establishments.

Advice

For NHS establishments advice will be given on the need to treat and the treatment programme by the Community Infection Control Nurse following **confirmed diagnosis** by a competent practitioner. The Scabies outbreak policy (separate document) will be followed and all information required by staff, patients, relatives etc will be supplied to the area manager at the time.

References

Applying treatment for scabies. Leaflet produced by North West (Liverpool) Regional Drug Information Centre.

British National Formulary BNF 43, March 2002.

Burgess I, Cohen J. Treating Lice and Scabies. Prescriber, pages 99 –105, 19 November 2000

Roberts DT (Editor). Lice & Scabies - A Health Professionals Guide to Epidemiology and Treatment. Public Health Laboratory Service, London 2000.

The Management of Scabies and Threadworms. National Prescribing Centre - Prescribing Nurses Bulletin Volume 1, November 3, 1999.

6.3 Guidelines for the Management of Head lice

Head lice are flat greyish-brown insects about the size of a grain of rice, which live in the hair. They like to stay close to the scalp for warmth and feed by biting the scalp. The female louse lays eggs each night and glues them on to the base of individual hairs.

Lice are spread from head to head. The lice crawl over from one person to another when heads are touching. They are not spread by using someone else's hat, scarf etc.

Lice are common in both adults and children and as such are a family problem. People may have head lice and not know that they have. It is important that everyone checks their hair regularly for lice and if they find them, treat them correctly and tell all their contacts.

The best way to control head lice is by detection, treatment and contact-tracing.

Detection involves looking for live lice by combing with a lice detection comb on wet and conditioned hair:

Part the hair into small sections and comb through with the lice detection comb, from scalp to the ends of the hair, section by section.

After each stroke, wipe the comb on a tissue and check for live lice.

The whole head needs to be checked. If lice cannot be found, treatment is not necessary.

If live lice are found, **treatment** and contact tracing should be undertaken. Lyclear is currently the recommended treatment. Alternatively, Derbac M or Quellada M may be used. The manufacturer's instructions should be carefully followed.

Alternatively, head lice may be cleared over a period of 2 weeks by '**wet combing**'. Between 15 and 30 minutes are needed to undertake this procedure and it needs to be repeated every 3 days for 2 weeks:

Wash hair as normal and rub in some conditioner. Comb with the conditioner still in the hair.

Divide into sections.

Put comb into the hair as flat as possible and comb each section of hair down to the ends.

Do this for every part of the hair.

After each stroke, wash comb under the tap to remove lice.

Contact tracing is a vital part of head lice treatment. If infected individuals are not identified they may pass head lice on. Examples of contacts include household members, grandparents, cousins, best friends, school friends and social contacts.

Reference

Aston R, Duggal H, Simpson J. Head lice. Report for Consultants in Communicable Disease Control, Public Health Medicine Environmental Group 1998.

Burgess I, Cohen J. Treating Lice and Scabies. Prescriber, pages 99 –105, 19 November 2000

Roberts DT (Editor). Lice & Scabies - A Health Professionals Guide to Epidemiology and Treatment. Public Health Laboratory Service, London 2000.

SECTION 7 CLINICAL PRACTICE

7.1 Aseptic Technique

Aseptic technique is the term used to describe the methods used to prevent contamination of wounds and other susceptible sites by organisms that could cause infection (Marsden Manual of Clinical Nursing Procedures).

The aims of aseptic technique are:

- To prevent the introduction of pathogens to the site.
- To prevent the transfer of pathogens from one patient to another.

An aseptic technique should be implemented during any invasive procedure that bypasses the body's natural defences.

An aseptic technique should also be adopted when undertaking the following procedures:

- Dressing wounds
- Endotracheal suction
- Dressing tracheostomy site

Hands should be washed before and after the technique. A clean pair of latex gloves should be donned prior to commencing the technique.

Many aseptic techniques include a ritualistic practice of cleaning trolleys with alcohol between patients. It is now felt that this serves no useful purpose, and that an area cleaned by detergent and hot water is sufficient, as the sterile field will be created by the sterile towel contained within the dressing pack.

Bacteria acquired on the clothing during the procedure may be transferred into the wound of another patient, therefore a clean disposable apron should be used for each dressing procedure.

Management of Chronic Wounds

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

After the wound has been washed then water should be disposed of in a sluice or a sink which is separate from the handwash sink.

The plastic liner should be disposed of and the bath or bowl should be thoroughly cleaned with detergent solution and then dried to ensure that pathogens are removed.

This process should be undertaken after each separate patient episode.

7.2 Care of Clients with Known Infectious Diseases

It should be recognised that staff caring for clients in their own homes do not have to fully implement the traditionally recognised methods of barrier nursing. This is because there are generally no other vulnerable clients who need to be protected from cross infection, apart from staff and other people who live in the house, for whom the practice of universal precautions will suffice.

However it is important for staff to appreciate that when they are caring for someone with a known or suspected infectious disease, there is the potential for cross-infection if basic infection control principles are not followed.

DISEASES

More detailed information about certain organisms can be found in section 5 of this manual.

Refer to Appendix 4 for a table of communicable diseases.

Precautions should also be taken with clients suffering from the following symptoms, until a diagnosis is confirmed:

- (a) Diarrhoea of unexplained origin
- (b) Pyrexia of unknown origin
- (c) Excessive bleeding
- (d) Rashes of unknown aetiology
- (e) Excessive vomiting

PROCEDURES

Standard Principles should be strictly adhered to at all times refer to Section 3

Once a diagnosis has been made, the client (and family) must have their infectious disease carefully explained, the mode of spread and its significance if any, for the patient's condition.

Hand Hygiene

Alcohol hand rub should be used after normal handwashing, or an antibacterial soap should be used to wash hands.

Disposal of Potentially Infected Items

Contaminated dressings and all disposable items should be disposed of as clinical waste. A designated collection from the client's home may be necessary if there is a large quantity (see section on Waste Management – refer to section 3.6).

Urinals and Bedpans

It is recommended that disposable products are used. If these are not available, following the safe disposal of the contents, care should be taken when cleaning the urinal or bedpan to avoid splashing. A plastic apron and non-sterile latex or vinyl gloves should be worn. The item should be cleaned with General Purpose Detergent and hot water prior to disinfection with a sodium hypochlorite solution (strength 10,000 ppm, (1 part household bleach to 10 parts water) and left for 10 minutes). The bedpan/urinal should be dried and stored inverted.

Linen

Linen should be washed on as hot a wash as the fabric will tolerate, as promptly as possible.

Crockery and Cutlery

Disposable items are not required. General purpose detergent and water as hot as can be tolerated is sufficient. A dishwasher may be used if available.

Transporting Clients

Clients should only be sent to other department/premises (i.e. care homes, hospital Out-patient or In-patient departments) when it is essential. Staff involved in the direct care of the client should be informed of the risk, so that relevant control measures can be implemented.

7.3 Care during Enteral Feeding (NICE Guidelines)

These guidelines apply to adults and children and should be used in conjunction with the guidance on Universal Precautions (Standard Principles).

They should be considered when developing related policies.

The recommendations are divided into four distinct interventions:

- Education of patients, their carers and healthcare personnel
- Preparation and storage of feeds
- Administration of feeds
- Care of insertion site and enteral feeding tube

Education of patients, their carers and healthcare personnel

Patients and carers should be educated about and trained in the techniques of hand decontamination, enteral feeding and the management of the administration system before being discharged from hospital.

Community staff should be trained in enteral feeding and management of the administration system.

Follow-up training and ongoing support of patients and carers should be available for the duration of home enteral tube feeding.

Preparation and storage of feeds

Wherever possible pre-packaged, ready-to-use feeds should be used in preference to feeds requiring decanting, reconstitution or dilution.

The system selected should require minimal handling to assemble, and be compatible with the patient's enteral feeding tube.

Effective hand decontamination must be carried out before starting feed preparation.

When decanting, reconstituting or diluting feeds, a clean working area should be prepared and equipment dedicated for enteral feed use only should be used.

Feeds should be mixed using cooled boiled water or freshly opened sterile water and a no-touch technique.

Feeds should be stored according to the manufacturer's instructions and, where applicable, food hygiene legislation.

Where ready-to-use feeds are not available, feeds may be prepared in advance, stored in a refrigerator, and used within 24 hours.

Administration of feeds

Minimal handling and an aseptic no-touch technique should be used to connect the administration system to the enteral feeding tube.

Ready-to-use feeds may be given for a whole administration session, up to a maximum of 24 hours. Reconstituted feeds should be administered over a maximum 4-hour period.

Administration sets and feed containers are for single use and must be discarded after each feeding session.

Care of insertion site and enteral feeding tube

The stoma should be washed daily with water and dried thoroughly.

To prevent blockage, the enteral feeding tube should be flushed with water before and after feeding or administering medications. Enteral feeding tubes for patients who are immunosuppressed should be flushed with either cooled freshly boiled water or sterile water from a freshly opened container.

Reference

National Institute of Clinical Excellence (NICE), (2003). Prevention of healthcare associated infection in primary and community care. Care during enteral feeding. London.

7.4 Care of patients with long-term urinary catheters (NICE Guidelines)

These guidelines apply to the care in the community of all adults and children and should be used in conjunction with the recommendations on universal precautions (standard principles). These guidelines focus on preventing infection. However, because infection has a complex interrelationship with encrustation and blockage, these aspects of catheter management are also addressed.

The recommendations are divided into five distinct interventions:

- Education of patients, their carers and healthcare personnel
- Assessing the need for catheterisation
- Selection of catheter drainage options
- Catheter insertion
- Catheter maintenance

Education of patients, their carers and healthcare personnel

Patients and carers should be educated about and trained in techniques of hand decontamination, insertion of intermittent catheters where applicable, and catheter management before discharge from hospital.

Employees must be trained in catheter insertion. Follow-up training and ongoing support of patients should be available for the duration of long-term catheterisation.

Assessing the need for catheterisation

Indwelling urinary catheter should be used only after alternative methods of management have been considered.

The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible. Catheter insertion, changes and care should be documented.

Selection of catheter drainage options

Following assessment, the best approach to catheterisation that takes account of clinical need, anticipated duration of catheterisation, patient preference and risk of infection should be selected.

Intermittent catheterisation should be used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient.

For urethral and suprapubic catheters, the choice of catheter material will depend on an assessment of the patient's individual characteristics and predisposition to blockage.

In general, the catheter balloon should be inflated with 10ml of sterile water in adults and 3-5ml in children.

In patients for whom it is appropriate, a catheter valve may be used as an alternative to a drainage bag.

Catheter insertion

All catheterisations carried out by healthcare personnel should be aseptic procedures. After training, healthcare personnel should be assessed for their competence to carry out these types of procedures.

Intermittent self-catheterisation is a clean procedure. A lubricant for single-patient use is required for non-lubricated catheters.

For urethral catheterisation, the meatus should be cleaned before insertion of the catheter, in accordance with Trusts/policy.

An appropriate lubricant from a single-use container should be used during catheter insertion to minimize urethral trauma and infection.

Catheter maintenance

Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve.

Healthcare personnel should ensure that the connection between the catheter and the urinary drainage system is not broken except for good clinical reasons, (for example changing the bag in line with the manufacturer's recommendations).

Healthcare personnel must decontaminate their hands and wear a new pair of clean, non-sterile gloves before manipulating a patient's catheter, and must decontaminate their hands after removing gloves.

Carers and patients managing their own catheters must wash their hands before and after manipulation of the catheter, in accordance with the recommendations in the universal precautions (standard principles) section.

Urine samples must be obtained from a sampling port using an aseptic technique.

Urinary drainage bags should be positioned below the level of the bladder, and should not be in contact with the floor.

A link system should be used to facilitate overnight drainage, to keep the original system intact.

The urinary drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux, and should be changed when clinically indicated.

The meatus should be washed daily with soap and water.

Each patient should have an individual care regimen designed to minimize the problems of blockage and encrustation. The tendency for catheter blockage should be documented in each newly catheterised patient.

Bladder instillations or washouts must not be used to prevent catheter-associated infection.

Catheters should only be changed when clinically necessary or according to the manufacturer's current recommendations.

Antibiotic prophylaxis when changing catheters should only be used for patients with a history of catheter-associated urinary tract infection following catheter change, or for patients who have a heart valve lesion, septal defect, patent ductus or prosthetic valve.

Reusable intermittent catheters should be cleaned with water and stored dry in accordance with the manufacturer's instructions.

Reference

National Institute of Clinical Excellence (NICE), (2003). Prevention of healthcare associated infection in primary and community care. Care of patients with long-term urinary catheters. London.

7.5 Management of Non Infectious and Infectious Deceased Clients

This guideline sets out the procedures for staff to follow for the management of non infectious and infectious deceased clients.

MANAGEMENT OF DECEASED CLIENTS

The deceased should be treated with the due respect and dignity appropriate to their religious and cultural background. Last Offices, which vary according to religious and cultural practices, may be compromised by the need for specific measures if an infectious disease was associated with the death, or co-existed at the time of death. Any problems should be discussed with the Consultant in Communicable Disease Control who may wish to consult the appropriate priest or religious authority.

Most bodies are not infectious, however through the natural process of decomposition the body may become a source of potential infection whether previously infected or not, therefore sensible precautions should be taken routinely.

- a. Disposable gloves and aprons should be worn when washing and preparing the body.
- b. Washing the body with soap and water is adequate.
- c. Dressings, drainage tubes, etc. should be removed unless the death occurred within 24 hours of an operation or was unexpected in which cases a post-mortem is likely.
- d. Clean dressings should be applied to any wounds.
- e. Profusely leaking orifices may be packed with gauze or cotton wool.

ADDITIONAL LAST OFFICES FOR A KNOWN INFECTED BODY

The body of a person who has been suffering from an infectious disease may remain infectious to those who handle it.

Body bags are available from either the undertaker or the stores centre where all other care equipment is requested from.

The mortuary/funeral director staff should be informed of the potential infectious risk.

If the deceased has died from one of the following infectious diseases listed below, the body will need to be placed in a cadaver bag.

Anthrax	Plague
Brucellosis	Acute poliomyelitis
Chickenpox/shingles	Psittacosis
Cholera	Pyrexia of unknown origin
Diphtheria	Q Fever
Food Poisoning (if faeces is present)	Rabies

Hepatitis B
Hepatitis C
HIV/AIDS
Leprosy
Meningococcal Septicaemia (without meningitis)

Tuberculosis (infective)
Viral Haemorrhagic Fever
Yellow Fever

or if there are large quantities of body fluids present.

A 'Notification of Death' label and a 'Danger of Infection' label should be attached discreetly to the outside of the bag. Neither label should state the diagnosis, which is confidential information. It is the responsibility of the certifying clinician to ensure the funeral directors have sufficient information about the level of risk of infection and stating the type of precautions required. Once the body is sealed in the body bag, protective clothing will no longer be necessary.

Relatives and friends who wish to view the body should do so as soon after death as possible. The bag can be opened by a member of staff wearing gloves and plastic apron, but relatives should be told that there is a risk of infection and should be advised to refrain from kissing or hugging the body. In some rare instances the bag could not be opened e.g. if the patient suffered from Anthrax, Plague, Rabies or Viral Haemorrhagic Fever.

Further advice on specific infectious diseases can be found in the Infection Control Guidelines for Funeral Directors (www.ehpt.nhs.uk/publications/FuneralPolicy.pdf), or advice can be sought from the Infection Control Nurse.

Reference

Infection Control Guidelines for Funeral Directors. Essex Health Protection Unit. July 2004. (www.ehpt.nhs.uk/publications/funeralpolicy.pdf)

7.6 Safe Handling of Specimens

Clinical specimens include any substance, solid or liquid, removed from the patient for the purpose of analysis.

Staff should be trained to handle specimens safely and receive regularly updated immunisation cover.

General Principles

- All specimens should be collected using **Standard Principles** – refer to section 3.1 (i.e. wearing of appropriate gloves, disposable plastic apron and washing and drying of hands before and after the procedure).
- When a patient is asked to provide a specimen, they should be provided with the appropriate container and given instructions as to how to collect the specimen.
- Should a patient bring a specimen in an inappropriate container (i.e. pickle jars, old medicine pots), they should be given the correct container and asked to take their incorrectly presented specimen back home for disposal, as the facility is unlikely to have any safe means of disposal. It may be possible to provide the specimen at the facility to save an extra journey.
- Laboratory approved containers must be labelled with patient identification details, date of specimen and specimen details. The lids should be screwed on tightly. The container with the specimen must be placed in an individual transparent plastic transport bag as soon as it has been labelled.
- The transport bag must be sealed. The request form must always accompany the specimen but should not be put inside the bag with the specimen. If a wound swab, state type of wound, where on the body, whether deep or superficial and if antibiotics have been used either topical or systemic.
- Specimens must be sent to the laboratory as soon as possible after collection. This will mean planning work load carefully. Whilst awaiting transport, specimens should be stored securely, for as short a time as possible i.e. not overnight and away from food and medicines.
- If specimens have to be stored awaiting transport for more than 4 hours, specimens should be stored in an air tight container in a designated fridge - **not a food fridge**.
- Sputum specimens must be received by the laboratory within 24 hours.

NB. In the event of a suspected outbreak of infection it is important for specimens to be collected promptly and for the request form to be marked as 'Possible Outbreak'. Stool specimens should be sent as soon as an outbreak is suspected e.g. the second loose stool.

SECTION 8 STAFF HEALTH

This section of the Manual gives an overview of the guidance for managers and for staff. Each section contains information about the transmission of the disease followed, where applicable, by recommendations about prevention, acute infection, return to work and advice for contacts.

Where advice refers to “health care workers” this applies to all staff in clinical roles or who have routine contact with patients.

Pregnant staff should seek individual advice from Occupational Health about infectious hazards in their work area e.g. chickenpox.

Cross references are made within this manual to other national and local Policies and Guidelines.

The Occupational Health Department will have local operational policies

Blood borne viruses:

For further information on exposure to blood borne viruses, see section 3.4.

- **Hepatitis B**

This viral infection is transmitted by percutaneous and permucosal exposure to infected blood or body fluids for example at work by sharps injury, bites or blood splashes. Transmission rates may be up to 30% in certain circumstances. Immunisation against hepatitis B is recommended for all staff in patient contact or handling blood or body fluids and tissue samples, including domestic and portering staff. Since 1987 the vaccine has been genetically engineered and not made from blood products.

Only a proportion of acute hepatitis B infections may be clinically recognised, the remainder being asymptomatic therefore the diagnosis must be confirmed by blood tests. In accordance with Department of Health Guidelines (HSG 93 (40) and Addendum EL(96)77) carriers of the hepatitis B virus who are known to be e antigen positive, i.e. highly infectious, must not carry out procedures where there is a risk that injury to themselves will result in their blood contaminating a patient’s open tissues (“Exposure Prone Procedures”-EPP's). Therefore all staff expected to perform EPP’s must demonstrate satisfactory immunity or absence of infectivity.

- **Hepatitis C**

This virus has a similar epidemiology to hepatitis B, with a transmission rate of between 3% and 10% following percutaneous exposure. There is no vaccine available and staff exposed to or infected with hepatitis C should seek individual advice from the Occupational Health Department.

- **HIV**

The virus that causes AIDS (Acquired Immuno Deficiency Syndrome) is transmitted in a similar way to hepatitis B virus but the rate of transmission appears to be much lower. Current evidence suggests 0.3%

transmission following percutaneous exposure. There is currently no vaccine available.

Health care workers who are HIV positive must not undertake exposure prone procedures, in accordance with Department of Health Guidance. In the event of an exposure to **known** HIV infected blood, visit the acute hospital A&E department within 1 hour where drug treatment will be made available as post exposure prophylaxis.

Gastro Intestinal Infections

No employee who has symptoms of food poisoning or viral gastro-enteritis, that is diarrhoea and/or vomiting, should be at work.

A single stool sample should be submitted wherever possible. For most common gastro-enteritis (including most Salmonellas) no further samples are necessary. Health care workers and food handlers may return to work 48 hours after they have become symptom free, with emphasis on the importance of hand-washing. (See section 6.1)

For certain unusual infections (Salmonella typhi/paratyphi, Vibrio cholera, Vero toxin producing E coli (VTEC) and Shigella dysenteriae) please consult Occupational Health for advice re return to work. Where there is an outbreak of gastro-intestinal infection which is likely to affect a number of staff, the Infection Control Nurse will alert Occupational Health.

Group A Streptococci

Group A Streptococci cause a variety of diseases most commonly Streptococcal sore throat and skin infections (impetigo, pyoderma). Staff with Group A Streptococcal infection should remain off work until clinically well or until 48 hours after commencement of an appropriate antibiotic.

Hepatitis A

This viral infection is transmitted person to person by the faecal-oral route. A vaccine is available, but is not routinely recommended as prophylaxis for health care workers.

Estate staff whose work involves dealing with raw sewage are offered the vaccine.

Following acute hepatitis A infection, staff should be excluded from work until 7 days after the onset of jaundice or until clinical recovery. Stool samples are unnecessary but wherever possible the diagnosis should be confirmed by a salivary or blood test.

Influenza and Other Respiratory Viruses

This group of viral infections is transmitted by airborne route and direct contact (e.g. from hand to mucus membrane). The common cold is probably infectious from 24 hours before onset of symptoms and for 5 days afterwards. Influenza is probably infectious for 3 - 5 days from clinical onset in adults.

Immunisation against the currently circulating strain of influenza is available for vulnerable individuals and is recommended for key health care workers.

Meningococcal meningitis: prophylaxis for contacts

Prophylaxis for health care workers is only recommended where:

- a) Mouth-to-mouth resuscitation has been undertaken.
- b) Blood or vomit has been splashed on the worker's face.

MRSA

This is a strain of *Staphylococcus aureus* which is resistant to methicillin and often other anti-staphylococcal antibiotics. Hands are the most important source of transmission either directly or indirectly by contact with contaminated surfaces and equipment. Airborne spread may occur via contaminated skin scales.

Transmission and colonisation/infection are similar to other strains of *S. aureus* but treatment of significant infections may be more difficult. MRSA is not, in general, a risk to the health of staff or their families or the pregnant worker.

Screening of staff for MRSA colonisation will only be undertaken on the recommendation of the infection control nurse.

Any staff member found to be colonised with MRSA should be managed directly by the Occupational Health Department (rather than the GP) who will be able to carry out a specialist assessment which will identify the need for any restriction from clinical duties.

Rubella

Rubella is important because of its effects on the developing foetus. To protect pregnant patients and staff all new Health Care Workers should be screened for Rubella antibodies unless they are known to be immune. Those without antibodies should be immunised by Occupational Health.

Tetanus & Polio

Tetanus and Polio immunisation should be kept up-to-date for all staff in patient contact and for all maintenance staff (either by Occupational Health or via the individual's own General Practitioner). Once a member of staff has received 5 doses of tetanus and polio vaccine they are considered immune. Further boosters are not required (unless for a specific injury in the case of Tetanus).

Tuberculosis

Tuberculosis in health care workers may result from occupational exposure and infected workers pose a potential infection risk to susceptible patients. The disease is transmitted by exposure to airborne droplets produced during coughing or sneezing from infectious pulmonary or laryngeal TB cases. In most circumstances extra-pulmonary TB is not infectious.

All staff in contact with patients should have had BCG immunisation. New staff who do not have a characteristic BCG scar are screened by Mantoux testing in the Occupational Health Department, in accordance with NICE guidelines, 2006 (Ref: CG033).

Multiple drug resistant TB (MDRTB) is now appearing in the UK and poses a particular problem. Staff involved with the care of patients with MDRTB must be adequately protected i.e. have a scar or documented positive Heaf/Mantoux test.

Any member of staff with active pulmonary TB should be excluded from work until they have been adequately treated by a respiratory physician to render them non infectious.

Varicella-Zoster Virus (VZV)

VZV is highly infectious by direct and indirect contact with vesicle fluid and respiratory secretions. However, most adults brought up in the United Kingdom will already be immune. All health care workers should be aware of whether or not they are immune i.e. have ever had either Chicken Pox or Shingles. Staff working with immuno-compromised patients who do not have a positive history should have a blood test for Varicella-Zoster antibody to confirm their status.

Any member of staff who develops Chicken Pox, or Shingles on exposed areas of skin, should go off work immediately and inform Occupational Health as soon as possible. They should not return to work for at least 5 days after the rash first appears or until all the skin lesions are fully scabbed.

Non immune contacts of VZV cases should seek advice as soon as possible regarding the use of VZ Immuno Globulin prophylaxis especially if pregnant, taking oral steroids or immuno-compromised.

Further guidance on other common communicable diseases can be found on the 'Guidance on Communicable Diseases' sheet produced by the Health Protection agency. This is attached as Appendix 4.

References

Benenson AS (Ed). Control of Communicable Disease Manual 16th Edition. American Public Health Association, Florida. 1995.

Department of Health. Food Handlers Fitness to Work. DOH, London. 1995.

DH (1996) Immunisations against Infectious Disease – 'The Green Book'. New February 2006, Chapter 35 – Varicella.

www.dh.gov.uk/assetRoot/04/12/86/09/04128609.pdf

Drug and Therapeutic Bulletin. Preventing Meningococcal Infection. 1990. 28 (9) 34-6

NICE (2006). Tuberculosis (Ref CG003)

www.nice.org.uk/page.aspx?o=CG033NICEguideline

PHLS. Communicable Disease Report. 1993. Vol. 3 No 10.

UK Health Departments. Guidance for Clinical Health Care Workers: Protection against Infection with Bloodborne Viruses. DOH, London. 1998.

SECTION 9

QUALITY ISSUES AND AUDIT

The effective control of preventable infections has always been seen as an indicator of the quality of care a patient may receive. Activities such as standard setting and audit programmes have become essential components of an infection control programme. Clinical governance is as an umbrella term of these programmes. Its broad aim is to reassure people that quality is the essence of healthcare at all levels of the organisation.

Accountability and responsibility for risk assessment and quality of care will be an issue for all health professionals. All staff have a clear responsibility for their risk assessments and the quality of the service they provide.

All practitioners will be expected to follow practices that are clinically safe, effective and evidence based. Particular commitment will be given to following the guidelines and recommended practices introduced by the National Institute for Clinical Excellence (NICE).

Infection control in all healthcare settings is gaining a higher profile. It is essential to maintain public confidence in the services offered by the production, implementation and audit of robust policies and the documentation of activities such as decontamination of equipment.

All action plans should commence with the setting of standards for infection control. An audit tool can be used to monitor infection control practices and provide data on compliance with policies. This data has other uses including the planning of educational needs or evaluating the overall effectiveness of infection control programmes.

Following an audit it is important that all relevant staff are given the opportunity to discuss the findings. Urgent problems identified in the audit would have to be addressed at that time.

A report should be written that recognises and highlights areas of good practice as well as those of concern. There should be an action plan, recommendations and time scales for their adoption.

Re-audit of the area will ensure that recommendations have been accepted.

A wide range of audit tools are available covering all aspects of infection control practice and the environment. The ICNA audit tools can be accessed via the Infection Control section of SMHPT intranet site.

The infection control nurse, members of the Infection Control Link group and the audit team will be able to assist in the selection of an appropriate audit tool where areas wish to initiate their own audit.

Audit will also be carried out as part of an annual programme endorsed by the SMHPT Infection Control Committee.

CONTACTS

Infection Control advice can be obtained from:-

For urgent enquiries please contact the Director of Nursing – mobile number 07534 901923.

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

Information is also available on the Health Protection Agency website www.hpa.org.uk

This site has advice and information on a wide range of infection control issues and links to a number of other useful organisations.

Local infection control advice for non-NHS community organisations can be obtained from the Suffolk Health Protection Unit.

Telephone: 01473 329583

Email: xxxx@xxxx.xxx.xx

Contact details for Occupational Health:

Occupational Health

Direct Line: 01473 329343

A clinical waste collection can be arranged by contacting

Carole Clarke,

Facilities Manager for Suffolk Support Services

Telephone number: 01473 329766

Mobile phone number: 07973156755

e-Email address: xxxxxx.xxxxxx@xxxx.xxx.xx

DECONTAMINATION CERTIFICATE

From:

To:

Make and description of equipment item: _____

Model/Serial/Batch Number: _____

Other distinguishing marks: _____

- This equipment/ item has not been in contact with blood or other body fluids. It has been cleaned in preparation for inspection, servicing or repair.
- This equipment has been decontaminated. The method used was :

- This equipment could not be decontaminated. The nature of risk, and safety precautions to be adopted are:

Signed

Date

Position

Address

Infection Control Outbreak Summary Report Form

Facility _____ Ward/Dept: _____

Description of illness: _____

Start Date: _____ End Date: _____

Total no. of patients affected: _____

No. of patients of ward/unit: _____

Total no. of specimens obtained: _____

Results: *(both positive & negative)* _____

Total no. of staff affected: _____

Occupational Health involvement: *(delete as necessary)* Yes No

Infection Control involved *(delete as necessary)* Yes No

Brief description of advice given: _____








Action taken: _____

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

Name:	Job Title:
-------	------------

1 copy to be sent to Infection Control Nurse
--

Signature: _____
Date completed: _____

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3 ✓		Like a sausage but with cracks on its surface
Type 4 ✓		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID



Guidance on Communicable Diseases (March 2005 Issue)

Produced by: Suffolk Health Protection Unit
PO Box 170, St Clements Hospital, South Building, Foxhall Road, Ipswich IP3 8LS
Tel: 01473-329583; Fax: 01473-329090

GUIDANCE ON COMMUNICABLE DISEASES (MARCH 2005 ISSUE)

DISEASE	INCUBATI ON PERIOD	INFECTIOUS PERIOD MODE OF TRANSMISSION	ADVICE ON RESTRICTIONS & EXCLUSIONS	SCHOOL CONTACTS	NOTES
Athletes' foot	Unknown	Infectious while lesions are present. Spread by direct contact or via contaminated floors, showers etc.	No exclusion required as transmission requires prolonged contact	No action required	Treatment is by drying between toes after bathing and applying fungicidal dusting powder to feet
Chicken pox	2-3 weeks	Infectious from 5 days before to 5 days after appearance of spots. Transmission is mainly respiratory but blisters contain some virus	Exclude for at least 5 days after spots first appear or until they become dry	Pregnant non-immune women in the first 20 weeks of gestation or in the last weeks of gestation need to see their GP as this disease can affect them and their fetus severely	A highly contagious disease which appears to be most infectious around the onset of the rash. Infection confers long immunity and second attacks are rare. N.B. Shingles is a reactivation of the chickenpox virus and, in general, adults do not require exclusion. For advice on individual cases, however, please consult the Suffolk Health Protection Unit (SHPU) – contact details overleaf
Cold sores (Herpes Simplex)	2-12 days	Usually spread by direct contact or saliva. Up to 20% of healthy children are shedding herpes simplex virus at any one time	No exclusion required – or feasible as virus is shed for up to 8 weeks following development of a cold sore	No Action	Once acquired, this virus remains in the body, awakening at intervals to cause recurring cold sores
Conjunctivitis "Pink eye"	24-72 hours	Can be infectious while eye is inflamed. Spread by contact, sharing flannels etc.	Exclusion not usually necessary after medical advice given or treatment started	No Action	Good personal hygiene can reduce the risk of transmission

Gastro-enteritis (Diarrhoea &/or vomiting)	Varies according to cause	Multiple linked cases should be reported at the earliest opportunity to the local environmental health department. Under usual circumstances, all individual cases of gastroenteritis should be excluded until well and free from symptoms for 48 hours.			
Glandular fever	4-6 weeks	Virus may be carried for up to a year after the illness. Spread is usually via kissing	Exclusion is not routine as most transmission is from asymptomatic carriers of the virus.	No Action	
Hand foot & mouth	3-5 days	Respiratory and faecal-oral spread during illness. Faecal-oral spread alone for some weeks thereafter	No exclusion required	No Action	Usually a mild illness causing blisters on palms, soles & mouth. Virus in faeces for some weeks
Headlice	Headlice can only move from one head to another during head to head contact of at least 1 minute		There is no need to exclude a child from school who has headlice but advice should be given to families about checking and treating all infested people. For further guidance please see information sheet on the Health Protection Agency website at www.hpa.org.uk		All <i>infested</i> members of an affected person's family must be treated
Hepatitis A ("Yellow Jaundice")	2-6 weeks	Faecal-oral transmission, mostly in the week before and the week after jaundice appears	Exclusion mandatory until 1 week after jaundice appears. Person may be ill, but non-infectious, for weeks	Advice should be sought from SHPU at an early stage (contact details overleaf)	Scrupulous hygiene after using the lavatory is essential for limiting spread
Influenza	1-5 days	Infectious up to one week after onset	Exclusion for 1 week	No Action	Immunisation is available for certain vulnerable groups
Impetigo	1 – 4 days depending on organism	Infectious usually until lesions healed. The bacteria are usually spread by pus on fingers	Exclusion for 48 hours after treatment commenced unless lesions can be covered	No Action	The three important measures are medical treatment, covering the lesion and personal hygiene
Measles	7-18 days	Infectious from just before illness starts until 3 days after the appearance of the rash	Transmission is unusual after the third day of the rash, so 5 days exclusion is sufficient	No Action (Most children immunised)	Unimmunised persons can usually be vaccinated successfully if within 3 days of contact
Meningitis	Varies according to cause	Advice should be sought at an early stage from SHPU (contact details overleaf)			

Molluscum contagiosum	7days – 6 months	Spread by direct contact or by contaminated materials. Lesions can persist for 2 years	No exclusion required	No action	Most transmission is within families
Mumps	12-25 days	Infectious for 1 week either side of the onset of facial swelling	Exclusion until 1 week after the onset of swelling	No Action	
Ringworm	10-14 days	Spread by direct contact skin to skin or indirect contact via combs, clothing etc.	Exclusion not necessary after treatment has started. Scalp ringworm needs oral treatment	No Action	Pets and farm animals <i>may be</i> a source of infection - but this is not usually so
Roseola infantum		Most transmission is within families	No exclusion required. Most children immune by school age	No Action	Prolonged asymptomatic shedding common in children and adults
Rubella “German Measles”	14-23 days	Infectious for about 1 week before, and for 5 days after, the onset of the rash.	Exclusion for 5 days after onset of rash	Non-immune pregnant women should be made aware so that they can consult their doctor for advice	Virus shedding, and thus transmission, wanes from 2 days after the rash appears
Scabies	2-6 weeks (1-4 days if previously infected)	Infectious until treated. Mites are transferred during skin-to-skin contact. Transmission via bed linen is unusual.	Exclusion until the day after the first treatment	Household members and those who have had prolonged skin-to-skin contact should have simultaneous treatment	The mites make tiny burrows in the skin which itch intensely especially at night. Sites include between fingers, wrists, elbows.
Scarlet fever (Scarlatina)	1-3 days	Infectious until treated with appropriate antibiotic for 48 hours	Exclusion until 48 hours after treatment started	No Action	
Slapped cheek disease (Fifth disease)	4-20 days	Infectious before onset of rash but probably not after rash appears	Exclusion until clinically well. As not all children are ill, this may mean no exclusion at all	Pregnant women should be made aware so that they can consult their doctor for advice.	Rash has a “slapped cheek” appearance followed a day or so later by a lace-like body rash
Threadworms	A few days (the time taken for the worms to transit the gut)	Infectious until treatment. Eggs can be transferred to mouth on fingers if the anus is scratched	None	Contacts and family members should be treated simultaneously	Good hygiene and adequate treatment are essential

Tuberculosis	Highly variable. Minimum 6 weeks	Only infectious if many germs in the sputum.	Smear-positive cases will be excluded for two weeks from the start of treatment.		
Verrucae and Warts	2-3 months	Infectious while visible lesions persist	Neither exclusions nor 'verucca socks' have proved useful in limiting spread	No Action	Usually disappear spontaneously. If there is pain on walking, medical advice can be sought
Whooping Cough (Pertussis)	7-10 days	If untreated, infectious from onset until about 3 weeks later. If antibiotics are used very early, this period is reduced to 5 days	Exclusion for 3 weeks from onset if untreated. If treated with antibiotic can return after 5 days	Unimmunised household contacts under 7 years should be excluded until on antibiotic treatment	During an outbreak children under 5 years should not be admitted to school unless known to be immunised.

Contacts

Environmental Health Departments

<p>Babergh District Council Environmental Health Department Corks Lane Hadleigh, IP7 6SJ Tel: 01473-825890 Fax: 01473-825738</p>	<p>St. Edmundsbury Borough Council Environmental Health & Housing Services Borough Offices, Angel Hill Bury St. Edmunds, IP33 1XB Tel: 01284-757054 Fax: 01284-757039</p>
<p>Forest Heath District Council Environmental Health Department College Heath Road Mildenhall, IP28 7EY Tel: 01638-719284 Fax: 01638-716493</p>	<p>Suffolk Coastal District Council Environmental Health Department Melton Hill Woodbridge, IP12 1AU Tel: 01394-444358 Fax: 01394-444359</p>
<p>Ipswich Borough Council Environmental Health Department Civic Centre Civic Drive Ipswich IP1 2EE Tel: 01473-432000 Fax: 01473 433062</p>	<p>Waveney District Council Environmental Health Department Town Hall High Street Lowestoft, NR32 1HS Tel: 01502-562111 Fax: 01502-523150</p>
<p>Mid-Suffolk District Council Environmental Health Department 131 High Street Needham Market, IP6 8DL Tel: 01449-720711 Fax: 01449-727237</p>	

Primary Care Trusts

<p>Suffolk PCT Rushbrook House Paper Mill Lane, Bramford Ipswich, IP8 4DE Tel. 01473 770000</p>	
<p>Waveney PCT 6 Regent Road Lowestoft, NR32 1PA Tel: 01502-533733 Fax: 01502-512772</p>	

Education Departments

<p><u>Northern area:</u></p> <p>Suffolk County Council Education Department Adrian House Alexandra Road Lowestoft, NR32 1PL Tel: 01502-405000 Fax: 01502-519956</p>	<p><u>Southern area:</u></p> <p>Suffolk County Council St Andrew House County Hall Ipswich, IP4 1LJ Tel: 01473-583000</p>
<p><u>Western area:</u></p> <p>Suffolk County Council Education Department Shire Hall Bury St Edmunds, IP33 1RX Tel: 01284-352000 Fax: 01284-352106</p>	