



Public Health
England

Infection Control Guidelines Care Homes

Essex Health Protection Team

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About Public Health England

Public Health England's mission is to protect and improve the nation's health and to address inequalities through working with national and local government, the NHS, industry and the voluntary and community sector. PHE is an operationally autonomous executive agency of the Department of Health.

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SECTION A – INTRODUCTION AND CONTACTS

A1. Introduction

These guidelines have been written for proprietors, managers and carers working in care homes. They replace all previous infection control guidance from the Essex Health Protection Team (EHPT).

Infection control is an important part of an effective risk management programme to improve the quality of residential care and the occupational health of staff.

These guidelines should be read in conjunction with the Infection Control Guidance for Care Homes (DoH 2006).

A2. Responsibility

The philosophy of this manual is to encourage individual responsibility by **every** member of staff. The proprietors and registered managers are responsible for ensuring that there are effective arrangements in place for the control of infections.

A3. Contacts

Infection Control advice can be obtained from:

Essex Health Protection Team (EHPT)
8 Collingwood Road
Witham
Essex
CM8 2TT

Tel: 0345 155 0069
Fax: 01376 302278

The Consultants in Communicable Disease Control and Communicable Disease Control Nurses are contactable via this number.

Advice is also available on the Internet at www.gov.uk/phe

Out of office hours – for URGENT communicable disease enquiries:

Contact 01245 444417, and ask for the on-call Public Health Person to be paged.

SECTION B – INFECTION, ITS CAUSES AND SPREAD

B1. The Causes of Infection

An understanding of commonly encountered micro-organisms is essential for good infection control practice. Micro-organisms that cause disease are referred to as pathogenic organisms. 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 it may 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 can cause an enteritis (symptoms of diarrhoea).

Parasites

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.

Ectoparasites i.e. head lice and scabies.

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

B2. The Spread of Infection

One feature that distinguishes infection from all other disease is that it can be spread, i.e. one person can 'catch' it from another or via a vector (e.g. crawling or flying insects). There are various means by which micro-organisms can be transferred from a reservoir to susceptible individuals.

The modes of spread of infection can be classified as:

Direct Contact

Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. Chickenpox, Tuberculosis, sexually transmitted infections etc.).

Indirect Contact

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 in areas where malaria carrying mosquitoes live.

Hands

The hands of health and social care workers are probably the most important vehicles of cross-infection. The hands of residents 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 gastro-intestinal 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. Human, animal and insect bites can also spread infection by the inoculation mode.

SECTION C - NOTIFICATION OF INFECTIOUS DISEASES

C1. Introduction

This guideline sets out the procedures for staff to follow in respect of communicable disease control.

C2. Responsibilities

Managers

Managers have a responsibility to report relevant notifiable diseases and outbreaks by telephone, and then by utilising the documentation provided in this document.

Clinical and Healthcare Staff

- (a) All staff have an important role in the prevention and control of infection which is an integral quality issue in the care and management of residents and the health and safety of staff.
- (b) All staff need to follow all guidelines and participate in their audit.
- (c) All staff need to bring infection control issues to the attention of Senior Managers.
- (d) All staff need to maintain a high standard of infection control as a matter of good practice.

C3. Reporting & Documentation of Illness - Suspected/Confirmed Outbreak

Any **registered medical practitioner** (i.e. doctor) who becomes aware or suspects that a patient they are/ attending is suffering from a notifiable disease is required by law (Public Health Regulations 2010) to send a notification form to the local authority Proper Officer forthwith.

While laboratories may report, this does not absolve clinicians from their responsibility to do so. Although the GP is legally responsible for the formal notification of a number of infectious diseases, any suspicion of an outbreak of communicable disease in the care home or the community should be reported to the EHPT by the Home (Team) Manager immediately for further investigation, and management as appropriate.

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

C3.1 Which diseases are notifiable?

List of Notifiable Diseases

Acute Encephalitis	Malaria
Acute Meningitis	Measles
Acute Poliomyelitis	Meningococcal Septicaemia
Acute Infectious Hepatitis	Mumps
Anthrax	Plague
Botulism	Rabies
Brucellosis	Rubella
Cholera	Severe Acute Respiratory Syndrome
Diphtheria	Smallpox
Enteric Fever (Typhoid or Paratyphoid Fever)	Tetanus
Food Poisoning*	Tuberculosis
Hemolytic Uremic Syndrome (HUS)	Typhus
Infectious Bloody Diarrhoea	Viral Haemorrhagic Fever (VHF)
Invasive Group A Streptococcal Disease	Whooping Cough
Legionnaires Disease	Yellow Fever
Leprosy	

*** This category includes any infection which could be food or water-borne e.g. *Campylobacter*, *Salmonella*, *Cryptosporidiosis*, *Giardia*.**

In addition, Registered Medical Practitioners must notify the Proper Officer of the relevant local authority where there are reasonable grounds for suspecting that a patient who is being attended has an infection that presents, or could present, significant harm to human health. The operator of a diagnostic laboratory must notify the Health Protection Agency where causative agents, as set out in Schedule 2 of the Public Health Regulations 2010, are identified in a human sample.

In Essex, the Consultants in Communicable Disease Control (CCDC) act as Proper Officers to local authorities.

The EHPT should be contacted if:

- There are two or more individuals with vomiting and/or diarrhoea (amongst residents or staff) or sudden onset of coughing with raised temperature;
- There are two or more individuals suffering from the same infectious illness;
- There is a high sickness rate amongst staff who appear to be suffering from the same infectious disease.

If a residential establishment is affected the following guidance should be followed:

- Care home managers should contact the EHPT without delay if they suspect there may be an outbreak of infection in a home;
- The local Environmental Health Department and the Care Quality Commission (CQC) may also be informed;
- Senior management must be informed and requested to ensure adequate staffing to cope with the extra demands of managing an outbreak. Staff working in the home should not work in other care establishments until the outbreak is declared over by the EHPT;
- List all residents and staff affected, including age, area/unit where resident/working, onset of symptoms, symptoms suffered, duration of illness, GP and whether a sample has been taken (proforma attached for information in section 4).

In the event of an outbreak of diarrhoea (with or without vomiting), it is essential to obtain stool samples as soon as possible. The sooner the sample is obtained the higher the chance of identifying the organism causing the outbreak.

To reduce the delay in collection of stool samples we recommend that an 'outbreak' kit is kept and replenished after use. The kit should contain:

- Stool sample pots x 6
- Plastic transport bags x 6
- Laboratory forms (to be completed once sample is obtained) x 6

The above can be obtained from your GP, District Nurse or Environmental Health Officer.

All staff should be aware of the location of the kit.

Samples should be taken as soon as possible after diarrhoea has started, and kept safely at room temperature (please see Bristol Stool Form Scale and note that only stool samples of types 6 and 7 of the Scale will usually be processed by the microbiological laboratories). Further details on the tests to request can be found in section 4.

Please ensure sample pots are securely closed, labeled and sent to the laboratory in the correct packaging.

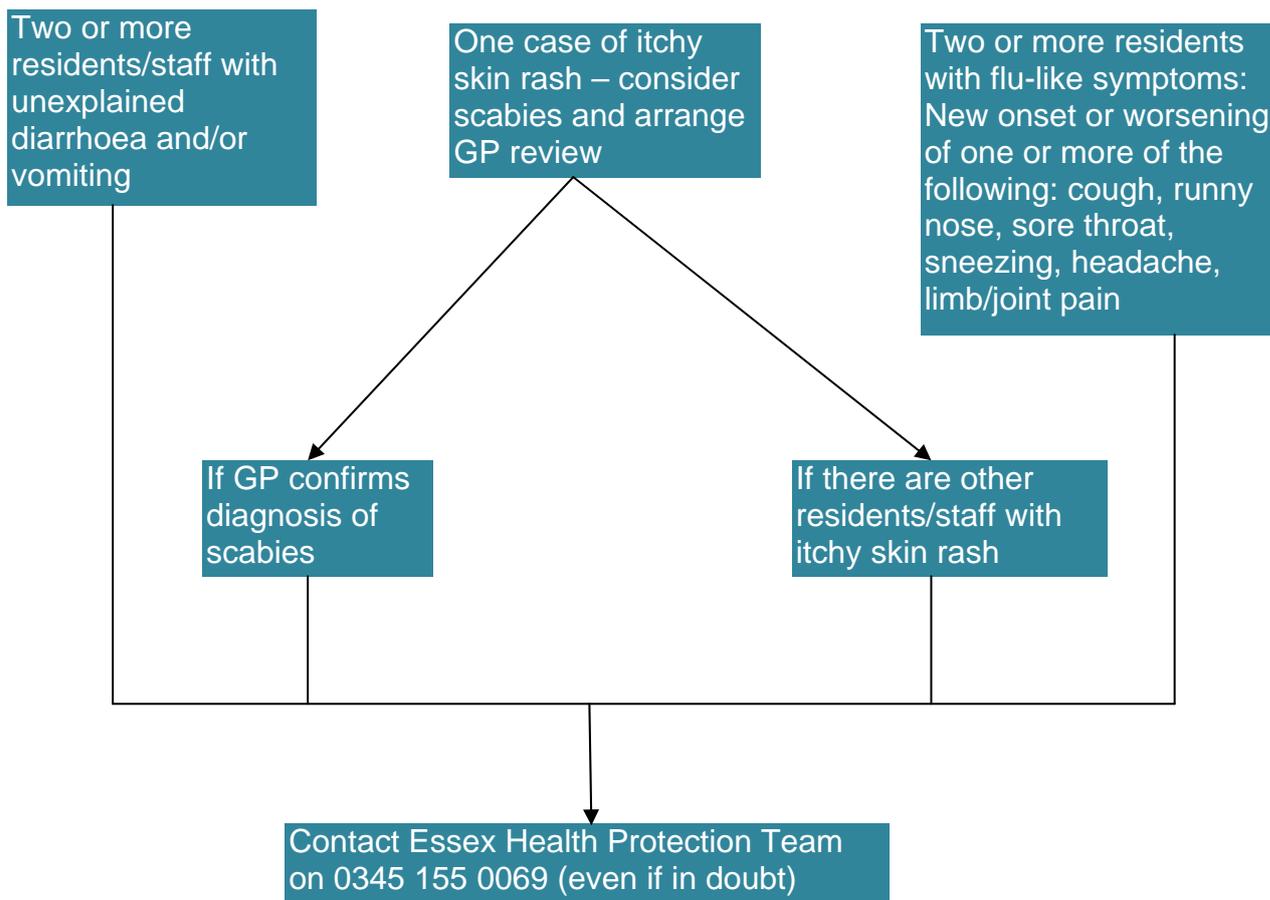
Outbreaks are initially managed based on symptoms and suspicion of what may be responsible for them. Laboratory confirmation of the infection may result in adapting control measures.

Bristol Stool Chart

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 the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid

Reporting Suspect Outbreaks of Infection

Residential care settings have a duty to report suspected outbreaks of infection to their local Health Protection Team



Issued by Essex Health Protection Team, 8 Collingwood Road, Witham, Essex CM8 2TT
Tel: 0345 155 0069 Fax: 01376 302278

C4. Specific Guidance for Common Outbreaks

C4.1. Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting

- Isolate symptomatic residents 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 kitchen units. For the duration of the outbreak, environmental cleaning should be performed using detergent and hot water followed by a 1000 parts per million available chlorine **or** Sodium Dichloroisocyanurate (NaDCC) e.g. Precept, Haztabs diluted as per manufacturer's guidance, **or** a proprietary brand that combines detergent and chlorine agent i.e. Actichlor Plus and Chlorclean);
- All staff handwashing areas and the rooms of symptomatic residents should have liquid dispensed soap and good quality paper towels for optimal hand hygiene;
- Residents 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. A new pair of disposable gloves and a plastic apron should be worn for each resident or procedure if multiple procedures are being performed on the same patient;
- Faecal samples should be obtained from residents and staff if they have symptoms. The microbiology form accompanying the sample should clearly state it is part of an outbreak and request microbiology and virology screening. as these will determine which specific tests are carried out in the laboratory (samples of vomit will not be processed by the lab). Please note the name of the care home on the request form;
- The home should be closed to admissions until 48 hours after the last new symptomatic patient;
- Symptomatic staff must go off duty, a faecal sample must ideally be taken and they must remain off work until 48 hours symptom free;

- 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 home and comply with all other hygiene practices in place. Visitors should not visit their loved ones while symptomatic and can resume normal visits after 48 hours free of symptoms;
- Residents should only be discharged 48 hours after their last symptom and with the full consent of anyone who may be required to care for them in the community;
- At the end of the outbreak terminal cleaning of the care home, including carpets and curtains, should be performed prior to resuming normal activities.

C4.2. Specific Guidance for Outbreaks of Respiratory Infections

Respiratory Infections in Care Homes

Respiratory infections often affect the elderly in residential settings. For most people the illness is mild, but in the elderly it can cause serious illnesses such as pneumonia and even death, because they may have underlying chest problems and compromised immunity.

Between October and March every year respiratory illnesses including influenza circulate. Whenever there is a cluster of cases of new respiratory illnesses the EHPT should be contacted to assess the situation.

Signs and Symptoms

An influenza-like illness (ILI) will present with some or all of the following signs and symptoms:

- Sudden onset of fever
- Headache
- Myalgia
- Prostration
- Coryza (cold or runny nose)
- Sore throat
- Cough

Elderly patients may however not have a fever, and may present with unusual signs and symptoms such as loss of appetite or change in mental state.

An outbreak is defined as two or more cases in a care home within a 3-day period. When influenza is known to be circulating in the community, treatment and prophylaxis will be required for outbreaks in care settings (where evidence of influenza circulating is not clear, laboratory confirmation may be sensible before treatment and prophylaxis are considered).

Control Measures when Viral Respiratory Illness is Suspected

1. Notify EHPT when two or more residents are affected as soon as possible;
2. Isolate ill residents in their rooms or nurse them together on the affected unit until 5 days after the onset of illness;
3. Separate symptomatic residents from asymptomatic residents during activities to prevent further spread or re-infection;
4. Encourage residents to wash their hands frequently, and where they are unable, they should be assisted to wash them. Detergent hand wipes may be used;
5. Offer vaccination to unvaccinated residents;
6. Keep a record of onset dates and the presenting signs and symptoms such as fever, cough etc. (record sheets can be found on page 19);
7. Staff on duty should pay attention to all infection control practices. They should wear gloves and apron when attending to symptomatic residents and wash hands after each contact. The use of masks is based on risk assessment or situations requiring close contact when aerosol-generating procedures are being carried out, such as suctioning;
8. Ill staff must not work until 5 days after the onset of their illness;
9. Unvaccinated staff should be offered vaccination and repeated yearly to protect staff and residents in their care;
10. Environmental cleaning should be stepped up, paying particular attention to door handles, handrails and wheelchair arms using detergent and hot water, followed by 1000 ppm of available chlorine;
11. Nose and throat swabs (maximum 6 of the most recent acute cases). The microbiology form accompanying the sample should clearly state it is part of an outbreak, noting the name of the care/residential home and request a full respiratory virus screen;
12. Used or contaminated paper tissues should be disposed of as infectious waste;
13. The home should be closed to admissions and discharges until the outbreak is declared over. The length of closure is based on isolation of the affecting virus (see table below). Where swabbing is not done there will be an assumption that Respiratory Syncytial Virus (RSV) is likely to be circulating in the home and the length of closure will be 8 days as per lab confirmed RSV.

Virus	Length of Closure
Influenza (irrespective of type), Adenovirus, Para-influenza, Coronavirus, Coxsackie virus, Echovirus	7 days inclusive of terminal cleaning before resuming normal activities.
Respiratory Syncytial Virus (RSV)	10 days inclusive of terminal cleaning before resuming normal activities.
Rhinovirus (without any co-circulating respiratory virus)	No closure required. Terminal cleaning before resuming normal activities.

14. Visitors should be informed of the outbreak and unnecessary visits should be discouraged;
15. Ill visitors should be discouraged from visiting the home;
16. At the end of the outbreak terminal clean the care setting (including the carpets and curtains) before resuming normal activities.

Prevention/Control

People at risk, such as those over 65 years, people with chronic respiratory and cardiovascular diseases, chronic renal diseases, diabetics and immunocompromised are entitled to free yearly seasonal influenza vaccinations.

Therefore it is strongly recommended that all residents in a care home who fall into these groups should be vaccinated to prevent any serious respiratory infection.

Staff should also be vaccinated as part of an employer's Occupational Health programme.

For specific guidance for residents with *Clostridium difficile* refer to Section F4 Management of Infectious Diseases.

For specific guidance for residents with Scabies refer to Section G4 Infestations.

RECORD OF OUTBREAK (Staff)

Type: Diarrhoea/Vomiting/Chest Infection/.....

Name of Home: _____

Record started by: _____ **Date:** _____

Address: _____

Reported to: EHPT / EHO / CSCI

Total number of staff in home: _____

Tel: _____

Total number of staff affected: _____

Name of Staff	DOB	Area/Unit where Resident	Date Symptoms Started	Symptoms	Duration of Symptoms	GP		Faecal Sample Sent	Result
						Name	Date Seen		

RECORD OF INFLUENZA-LIKE ILLNESS (Residents)

Name of Home: _____

Record started by: _____ Date: _____

Address _____

Reported to: EHPT / EHO / CSA

Total number of residents in home: _____

Tel: _____

Total number of residents affected: _____

Name of Resident	DOB	Area/Unit where resident	Onset of symptoms	Symptoms Sudden onset of fever, Headache, Myalgia, Prostration, Coryza (cold or runny nose), Sore throat, Cough.	Duration of symptoms	GP		Throat swab	
						Name	Seen	Sent	Result

RECORD OF INFLUENZA-LIKE ILLNESS (Staff)

Name of Home: _____

Record started by: _____ Date: _____

Address _____

Reported to: EHPT / EHO / CSA

Total number of staff in home: _____

Tel: _____

Total number of staff affected: _____

Name of Staff	DOB	Area/Unit where resident	Onset of symptoms	Symptoms Sudden onset of fever, Headache, Myalgia, Prostration, Coryza (cold or runny nose), Sore throat, Cough.	Duration of symptoms	GP		Throat Swab	
						Name	Seen	Sent	Result

SECTION D – STANDARD PRINCIPLES OF INFECTION CONTROL

D1. Standard Principles of Infection Control (Universal Precautions)

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 the **Standard Principles of Infection Control** sometimes referred to as **Universal Precautions**.

The recommendations on Standard Principles provide guidance on Infection Control Precautions that should be applied by all healthcare personnel and other carers, to the care of patients in the community and primary care settings.

Standard Principles of Infection Control include:

- Hand Hygiene and Skin Care
- Protective Clothing
- Safe Handling of Sharps (including Sharps Injury Management)
- Spillage Management
- Linen Management
- Waste Management
- Contamination

All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. Disposable apron and gloves should always be worn for direct patient care and when dealing with excretions, secretions, blood and body fluids.

Everyone involved in providing care in the community should know and apply the standard principles. Each member of staff is accountable for his/her actions and must follow safe practices.

Facilities must be available to promote the compliance to Standard Principles of Infection Control e.g. Personnel protective clothing, and handwashing facilities.

D2. Hand Hygiene and Skin Care

There are two methods of hand decontamination which are handwashing and the use of handrubs, both alcohol and non-alcohol based.

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

Hands must be decontaminated:

- Before and after each treatment session. Remove jewellery (rings);
- Before and after physical contact with each client;
- 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;
- After contact with body fluids;
- Before eating, drinking or handling food, and before and after smoking.

Note that alcoholic handrubs are only effective for visibly clean hands.

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.

An effective handwashing technique involves three stages:

1. Preparation

- Before washing hands, all wrist and, ideally, hand jewellery should be removed;
- Cuts and abrasions must be covered with waterproof dressings;
- Fingernails should be kept short, clean and free from nail polish;
- Hands should be wet under warm running water before applying liquid soap or an antimicrobial preparation.

2. Washing and Rinsing

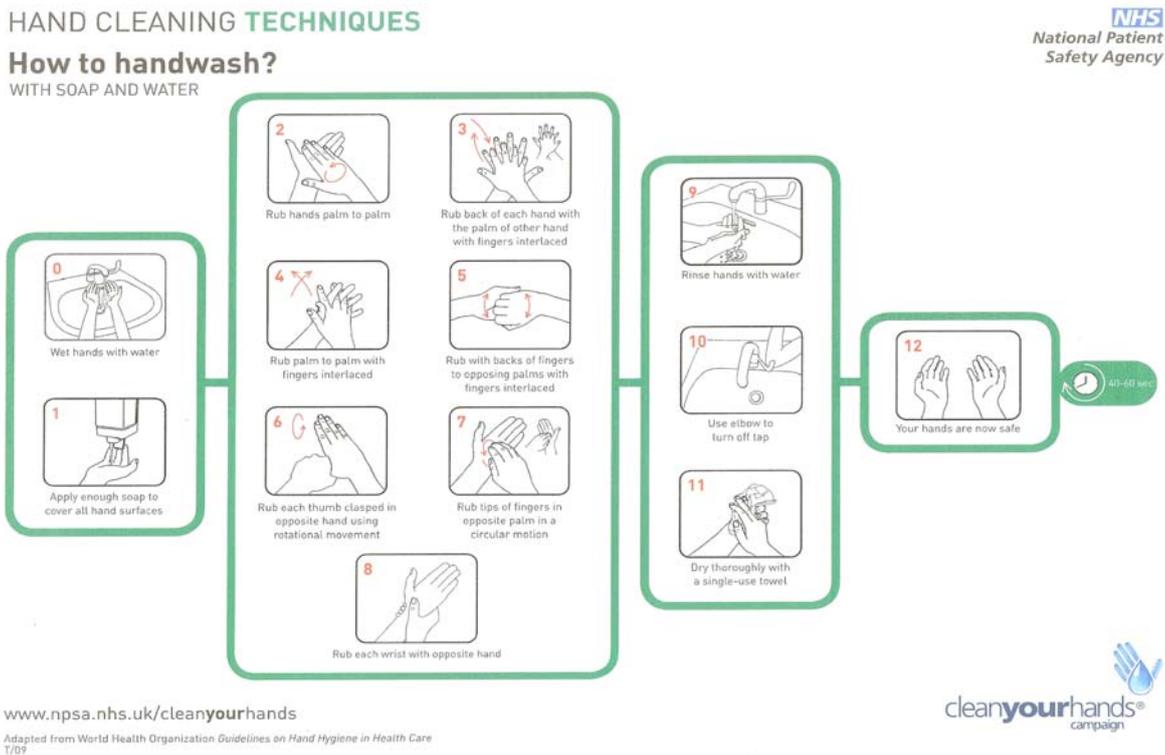
- The handwash solution must come into contact with all of the surfaces of the hand;
- Hands must be rubbed together vigorously for a minimum of 15-30 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers (see figure 1);

- Hands should be rinsed thoroughly.

Hygienic Hand Disinfection

This can either be achieved by using antiseptic liquid soap, or by routine handwashing as demonstrated below, followed by application of an alcohol handrub as recommended by the manufacturer.

Figure 1



3. Drying

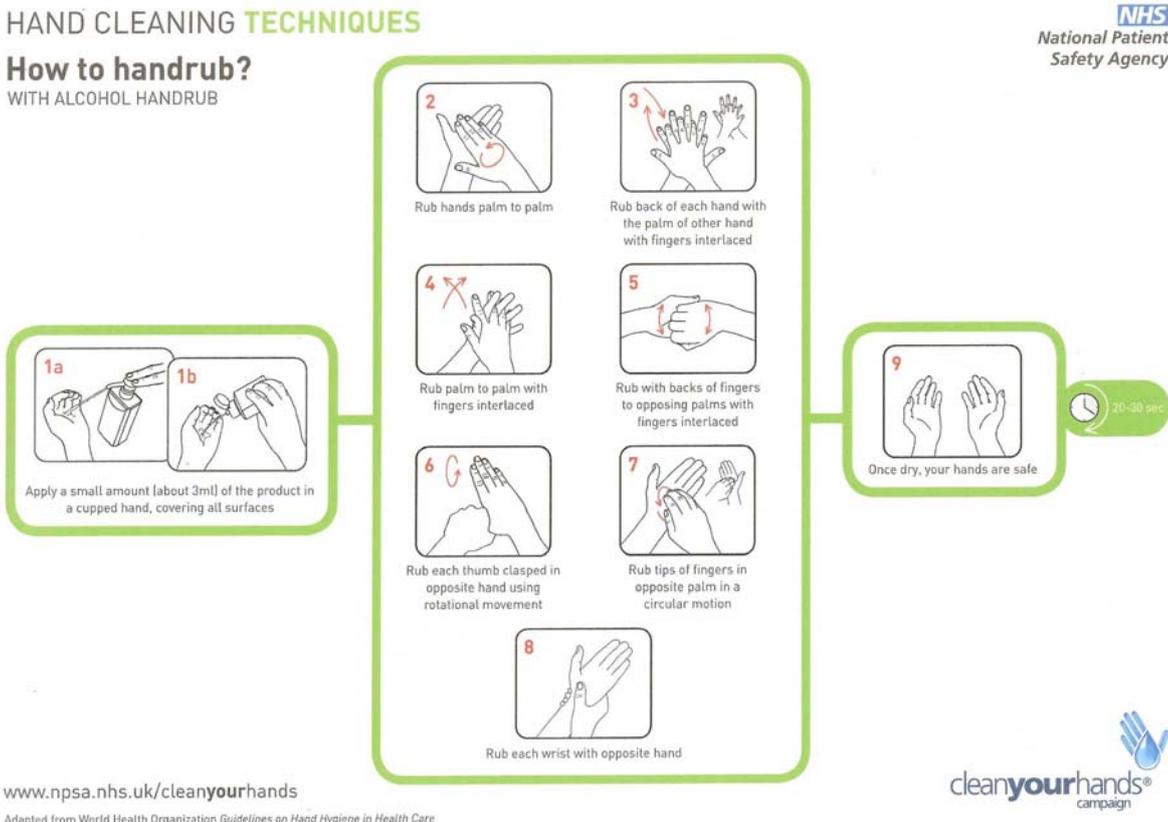
- Dry hands thoroughly using good quality paper towels;
- Disposable paper towels are the method of choice because communal towels can be a source of cross-contamination;
- Store paper towels in a wall-mounted dispenser next to the washbasin, and throw them away in a pedal-operated domestic waste bin;
- Do not use your hands to lift the lid or they will become re-contaminated.

Hot air dryers are not recommended, however, if they are used they must be regularly serviced and users must dry hands completely before moving away.

Alcohol Handrubs/Gels

Hands should be free from dirt and organic material. The handrub solution must come into contact with all surfaces of the hands. They should be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and finger webs until the solution has evaporated and the hands are dry, as described in Figure 2.

Figure 2



This may be used for general decontamination of hands with alcohol gel or liquid.

Hand Creams

An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination.

If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation, the General Practitioner (GP) should be consulted.

Hand Decontamination Facilities

Hand Washing

Facilities should be adequate, free of obstructions and conveniently located. Ideally, handwashing facilities must be available in the room where client consultations and procedures take place. Alternatively, facilities to do so should be a short distance away. They should have elbow or foot-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;
- Dispensers should be dismantled and washed regularly with particular attention to the nozzle;
- Place disposable paper towel dispensers next to the basins - soft towels will help to avoid skin abrasions;
- Position foot-operated pedal bins near the hand washbasin - ensure they are the right size for the amount of waste generated (note: Health & Safety regulations recommend a metal, fireproof bin).

Location of Alcohol Handrubs/Gels

- Dispensers should be wall-mounted outside all treatment rooms ;
- Wall-mounted or free-standing in all examination areas;
- Wall-mounted at the entry and exits to clinical areas.

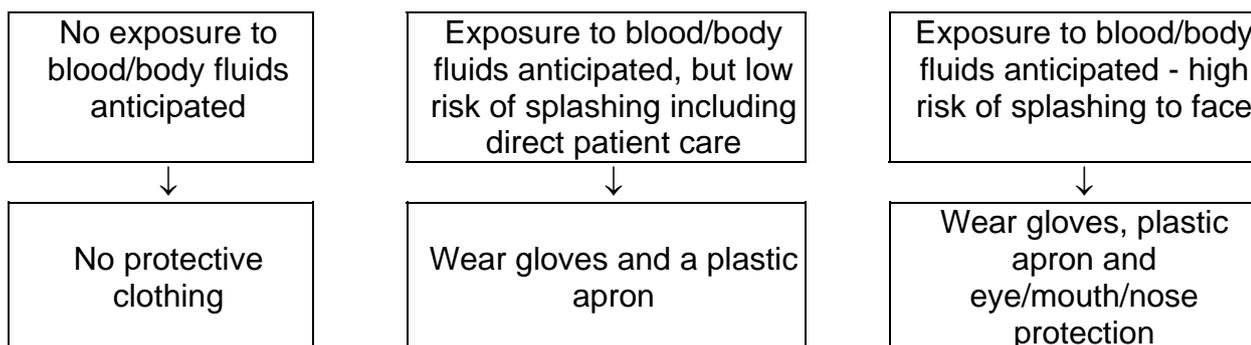
Note that there are instances where a risk assessment is required for placement of alcoholic rub dispenser, particularly where monitoring of its use is difficult.

D3. Protective Clothing

Selection of protective equipment must be based on an assessment of the risk of transmission of infection between the resident and the risk of contamination of the healthcare workers' clothing and skin by resident blood and body fluids.

Assessment of Risk

WHAT TO WEAR WHEN



Types of Protective Clothing

Disposable Gloves

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and they should also be worn during 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 resident contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different residents, and between different care or treatment activities for the same resident. **Gloves are not a substitute for handwashing.**

Following risk assessment for infectious hazard, gloves should be disposed of via the offensive, non hazardous route, or infectious hazardous route, (**Refer Waste Management Section H9**) and hands must be decontaminated after gloves have been removed.

Sensitivity to natural rubber latex in residents, carers and healthcare personnel must be documented. Alternatives to natural rubber latex gloves must be available.

To prevent transmission of infection, gloves must be discarded after each procedure. Gloves should **not** be washed between residents 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.

Hands **must** be washed on removal of gloves.

1. Non Sterile Gloves

Should be used when hands may come into contact with blood and body fluids, or equipment contaminated with blood and body fluids.

2. Sterile Gloves

Should be used when hands are likely to come into contact with normally sterile areas, when inserting invasive devices or during any surgical/aseptic procedure.

3. General-purpose Utility Gloves

General-purpose utility gloves e.g. rubber household gloves should be used when coming into contact with possible contaminated surfaces or items. Colour-coding of such gloves should be used e.g. green for the kitchen, blue for general environmental cleaning, and red for 'dirty' clinical duties. This will help prevent cross-infection from one area of work to another. The gloves should be washed with GPD and hot water, and dried between uses. They should be discarded weekly, or more frequently if the gloves become damaged.

4. 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.**

The Infection Control Nurses Association – now known as the IPS (Infection Prevention Society (2002) recommends that gloves should be kept in their original box, and taken from it as and when required. They must not be decanted into an open container, and they must not be put in uniform pockets. They must not be stored on windowsills or on top of waste bins.

Disposable Plastic Aprons

Should be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.

Plastic aprons should be worn as single-use items, for one procedure or episode of patient care, and then discarded and disposed of by the appropriate waste route (**Refer Waste Management Section H12**).

Full-body fluid-repellent gowns must be worn where there is a risk of extensive splashing of blood or body fluids onto the skin or clothing of healthcare practitioners.

Face Masks and Eye Protection

There are few occasions when facemasks are necessary in the care home environment. However when there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes e.g. manual cleaning of commode pots (not recommended), full face protection should be worn. Face/eye protection e.g. full face visor, or face masks and goggles should be worn if manual decontamination of equipment is undertaken.

Respiratory Protective Equipment

In certain Clinical settings, other protective equipment maybe indicated on clinical needs following thorough risk assessment. Examples maybe SARS, pandemic influenza or open pulmonary TB. Decisions to use these types of respiratory equipment may need to be discussed with EHPT.

D4. Safe Handling of Sharps

All staff should be fully immunised according to national policy. For staff who are at greater risk of contact with fresh blood, it is recommended that they have a course of Hepatitis B vaccine. A record of Hepatitis B antibody response should be kept, obtained after completion of the vaccination course.

Care should be taken to avoid accidental needlestick injury, as exposure to contaminated blood, and blood-stained body fluids may be associated with transmission of blood-borne viruses.

Sharps include needles, lancets, 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 blood-borne viruses. Always take extreme care when using and disposing of sharps. Whenever possible avoid using sharps.

- Clinical sharps should be single-use only.
- Sharps must not be passed directly from hand-to-hand and handling should be kept to a minimum.
- Needles must not be re-capped, bent, broken or disassembled before use of disposal.
- Needle safety devices must be used where there are clear indications that they will provide safer systems of working for healthcare personnel.
- Sharps containers must conform to UN3291 or BS7320 standards.
- Assemble sharps containers by following the manufacturer's instructions.
- Label sharps containers with the source details.

- Used sharps must be discarded into a sharps container at the point of use by the user.
- Sharps containers must not be filled above the mark indicated on the container.
- Close the aperture to the sharps container when carrying or, if left unsupervised, to prevent spillage or tampering.
- Place sharps container on a level stable surface.
- 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 in the sharps box to make more room.
- Lock the container when it is $\frac{3}{4}$ full using the closure mechanism.
- Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place sharps inside a waste bag.
- Containers in public areas must be located in a safe position, and must not be placed on the floor.

Giving Injections

Always wash hands thoroughly prior to giving an injection.

If visibly dirty, skin should be cleaned with an individually packed swab soaked in 70% isopropyl alcohol and left to dry. If skin is clean, this step is not necessary.

Venepuncture and injections should be carried out only by staff who are adequately trained and experienced.

(For occupationally acquired sharps injuries refer to Section E – Management of Sharps Injuries).

D5. Spillage Management

Deal with blood and body fluid spills quickly and effectively.

Commercially available spillage kits are available. Ensure that kits remain in date, and that the contents of the kit are replenished immediately after use.

For spillage of high-risk body fluids such as blood, method 1 is recommended.
For low-risk body fluids such as non-blood containing excreta, use method 2.

Method 1. Hypochlorite/Sodium Dichloroisocyanurates (NaDCC) Method

- Prevent access to the area containing the spillage until it has been safely dealt with.
- Open the windows to ventilate the room if possible.
- Wear protective clothing.
- Soak up excess fluid using disposable paper towels and/or absorbent powder e.g. Vernagel.
- Cover area with NaDCC granules (e.g. Presept, Sanichlor).

Or

- Cover area with paper towels soaked in 10,000 parts per million of available chlorine and leave for at least two minutes or follow the instructions provided in the kit).
- Remove organic matter using the towels and discard as infectious waste.
- Clean area with detergent and hot water and dry thoroughly.
- Clean the bucket/bowl in fresh soapy water and dry.
- Discard protective clothing appropriately based on risk assessment.
- Wash hands.

Method 2. Detergent and Water Method

- 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.
- Discard protective clothing as appropriate.
- Wash hands.
- Ideally, once dry, go over area with a mechanical cleaner.

N.B. – For spills on carpets and upholstery with or without visible blood

- Wear protective clothing.
- Mop up organic matter with paper towels or disposable cloths and/or absorbent powder e.g. Vernagel.
- Clean area with cold water.
- Clean area thoroughly with detergent and hot water.
- Allow to dry.
- Discard protective clothing.
- Wash hands.
- Ideally, once dry, go over area with a mechanical cleaner.
- Follow the carpet/upholstery manufacturer's instructions to decontaminate the area affected.

SECTION E – MANAGEMENT OF SHARPS INJURIES

E1. Occupational Injuries

In the event of a sharp injury/contamination incident these 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 the individual has an open wound, and clothes have been soaked by blood.
- Bites (where the skin is broken).

When a sharp injury/contamination incident occurs:

1. Encourage bleeding from the wound.
2. Wash the wound in soap and warm running water (do not scrub).
3. Cover the wound with a dressing.
4. Skin, eyes or mouth, wash in plenty of water.
5. Ensure the sharp is disposed of safely i.e. using a non-touch method into a sharps container.
6. Report the incident to immediate supervisor. An incident form should be completed as soon as the recipient of the injury is able.
7. The incident should be reported to the Occupational Health department and GP (**Refer to Sharps Injury poster on Page 33**).
8. Attempt to identify source of the needle/sharp. Depending on the degree of exposure and the knowledge of the source patient/client it may be necessary to take further immediate action, see below.

E2. Control Measures

Any staff, working in a healthcare facility, who handle sharps or hazardous infectious waste should receive a full course of Hepatitis B vaccine and have their antibody level checked to establish immunity.

New staff or any existing staff who know they are not already protected should contact their occupational health department or equivalent for a risk assessment to determine if vaccination is required. Arrange accordingly.

Generally staff in the community do not perform Exposure Prone Procedures (EPPs) with the exception of dental and some podiatrist practices; i.e. where the part of the hands or fingers are out of sight and there is a potential for exposure to blood or body fluids. EPPs are invasive procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the healthcare worker.

However, all staff who do perform EPPs need to be aware of their obligations (see statements by the General Medical Council in Serious Communicable Diseases, 1997; [General Dental Council in Maintaining Standards Guidance 1997;] United Kingdom Central Council for Nursing, Midwifery and Health Visiting Registrar's letter 4/1994 Annex 1) i.e. to declare it if they know themselves to have been at risk of exposure to a blood-borne virus infection (Hepatitis B, C or HIV).

Screening

Existing staff that undertake EPPs should be screened for Hepatitis B.

New employees who undertake EPPs must be screened for both Hepatitis B and Hepatitis C prior to commencing work.

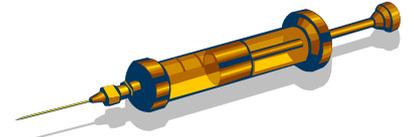
What to do after a SHARPS INJURY

Directions for the management of needlestick injuries, cuts and penetrating wounds, contaminated with blood or blood-stained body fluids



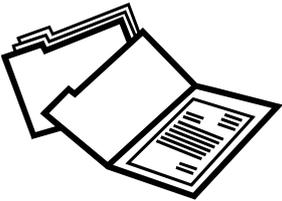
Wash cuts thoroughly with soap and warm water,
then gently encourage to bleed
Apply a dressing if necessary

Splashes to the eyes or mouth
should be thoroughly rinsed with running water



Report incident to your manager immediately (if applicable)

Your medical advisor should: -



- Take a history and make a risk assessment
- Review your Hepatitis B vaccine status
- Take 10ml clotted blood from the recipient and, if possible, the 'source' (with informed consent)
- Send the samples to the microbiology department marked 'needlestick Injury'
- Ensure appropriate follow-up

Complete an accident form

Further advice speak to Essex Health Protection Team
Tel: 0345 155 0069 or OOH 01245 444417 (ask for Public Health On-call Person to be contacted)

Please Note

If the source is known or a risk of having HIV the injured person should contact Accident & Emergency, and attend if possible within the hour

Remember

Be prepared – If you are at risk of exposure –
get immunised against Hepatitis B Virus



Tel: In hours:- Your GP or Occupational Health Dept

Tel: Out of Hours:- Your local A&E Department



SECTION F – MANAGEMENT OF INFECTIOUS DISEASES

F1. Introduction

The Health Protection Agency (HPA) produced a series of factsheets, which are available from the website, www.gov.uk/phe, under Topics A-Z, factsheets, and some are still available on the EHPT website accessible at

The factsheets include information on incubation periods, method of spread, period of infectivity, exclusion periods and where appropriate the management of contacts.

The factsheets can be photocopied and passed to members of the public.

In addition, there is extended text in this document on Meningococcal Disease, MRSA and PVL, Clostridium Difficile and CJD (**Refer to Section G - Infestations, for further information on Scabies and Head lice**).

F2. Guidelines for the Management of MRSA in the Community

What is MRSA?

There are lots of micro-organisms (germs) on our skin and in the air that we breathe, the water that we drink and the food that we eat. Most of them are harmless, some are beneficial and a very small proportion can cause harm. ***Staphylococcus aureus*** is a common germ that is found on the skin and in the nostrils of about a third of healthy people. It can cause harm if it enters the body, for example through cuts and sores.

MRSA stands for ***Meticillin*** (previously known as ***Meticillin Resistant Staphylococcus aureus***). MRSA are types of ***Staphylococcus aureus*** that have developed resistance to Meticillin and some other antibiotics used to treat common infections. Strains of MRSA were first found in the 1960s following the widespread use of antibiotics.

MRSA and other multi-resistant microorganisms can cause problems in hospitals as complicated medical treatments including operations and placement of invasive lines provide opportunities for them to enter the body. Infections can range from skin infections such as boils to more serious infections in wounds, bones, lungs and blood (blood stream infections).

What is the difference between colonisation and infection?

Some people carry MRSA on their skin, throat or in their nostrils quite harmlessly and they have no symptoms of infection. This is called colonisation.

Patients who have an infection will develop signs and symptoms such as temperature or a red, sore or discharging wound.

What precautions do you need to take in the residential care/intermediate care setting?

No special precautions are necessary.

Standard principles of infection control (especially handwashing) are all that are necessary.

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

They can mix with other patients socially and at mealtimes.

Laundry or china and cutlery does **NOT** need to be handled separately. Again, as long as they have good practices already in place, there is no need for additional precautions.

Waste should be handled as with any other patient - if the patient is known to have an infection, **and** that infection is producing a discharge then a risk assessment of infection status should be completed. Colonised patients waste should be disposed of in the offensive waste stream. Infected patient waste should be disposed of in infectious hazardous waste stream (orange bag) (**Refer to Waste Management Section I -9**).

Maintaining a clean environment will help to reduce the transmission of the bacteria. The daily removal of dust and body substances is crucial. Cleaning protocols should also include regular cleaning of high surfaces, curtains, carpets, extractor fans and the removal of radiator covers to clean radiators.

Screening for patients with MRSA

Generally, residents should not be screened unless there is clinical evidence to do so. The NHS Operating Framework for 2008/2009 places Cleanliness and Health Care Acquired Infections (HCAIs) as one of the five national priorities that require particular and sustained attention from Primary Care Trusts (PCTs) and every organisation that provides care to NHS patients. As a result, MRSA Screening has been introduced for all elective and emergency admissions to acute and community hospitals. In some cases such as high risk surgeries, pre-screening is also well established.

Those carrying MRSA who are inpatients will be managed according to established protocols. At times, some people with MRSA will be in care homes. Those who are known to be colonised may be advised by the PCT via their GPs to undergo a decolonisation protocol. In cases where the patient is receiving any clinical input by District Nurses or have an invasive device, an Integrated Care Pathway will be started to reduce unnecessary variations in patient care and outcomes. Where assessment of the resident/service user suggests that MRSA is causing an infection, the GP should be involved with appropriate treatment in addition to the decolonisation protocol.

Typically, decolonisation is done through the use of Octenisan wash for 5-7 days (including two hair washes during the decolonisation period) and Bactroban ointment in the nostrils 3 times a day for 5-7 days. However, there may be local variations and advice should be sought from the Infection Control Nurse in the PCT or the local Acute Hospital.

It is also important to communicate relevant information on infections or colonisation with MRSA when transferring residents/service users to another care setting. A suggested Transfer Form (Inter-Healthcare Infection Control Transfer Form) is available in the Essential Steps to Safe, Clean Care Pack available from the Department of Health.

The screening of staff is very rarely required and should only take place in consultation with the Infection Control Nurse at the PCT or the Communicable Disease Control Nurse at the EHPT.

Admission and care to Residential/Nursing Home

MRSA is not a contraindication for admission to a care home or a reason to exclude an affected person from the life of a home. However, if a resident does have MRSA (either colonisation or infection) that resident should:

- Be in a single room; or
- Not be in a shared room with someone who has an open wound or a urinary catheter, or any other invasive device.

In addition to the precautions on previous page:

- Environmental cleaning should be reinforced to help prevent further spread;
- After patient is discharged the room should be thoroughly cleaned and curtains removed for laundering. (Note that this should be applicable to all other residents).

F3. Specific Guidance for Residents with *Clostridium difficile*

What is *Clostridium difficile*?

Clostridium difficile (also known as 'C. difficile' or 'C. diff') infection is the most important cause of hospital-acquired diarrhoea. *Clostridium difficile* is a bacterium that is present in the gut of up to 3% of healthy adults and 66% of infants. However, *Clostridium difficile* rarely causes problems in children or healthy adults, as it is kept in check by the normal bacterial population of intestine.

What is *Clostridium difficile* infection?

When certain antibiotics disturb the balance of bacteria in the gut, *Clostridium difficile* can multiply rapidly and produce toxins which cause illness.

Clostridium difficile infection ranges from mild to severe diarrhoea to, more unusually, severe inflammation of the bowel (known as pseudomembranous colitis). People who have been treated with broad spectrum antibiotics (those that affect a wide range of bacteria), people with serious underlying illnesses and the elderly are at greatest risk – over 80% of *Clostridium difficile* infections reported are in people aged over 65 years.

Clostridium difficile infection is usually spread on the hands of healthcare staff and other people who come into contact with infected patients or with environmental surfaces (e.g. floors, bedpans, toilets) contaminated with the bacteria or its spores. Spores are produced when *Clostridium difficile* bacteria encounter unfavourable conditions such as being outside the body. They are very hardy and can survive on clothes and environmental surfaces for long periods.

In most patients the treatment for *Clostridium difficile* infection is antibiotic therapy.

How is *Clostridium difficile* colitis diagnosed?

A diagnosis is made by a laboratory test using a stool sample to confirm whether or not the toxin is present in the intestine. The results are usually available within 24 hours. Some patients may have *Clostridium difficile* in their stool but without the symptoms of diarrhoea.

Infection Control Measures to reduce risk of spread of *Clostridium Difficile*

To prevent the spread of the disease requires the implementation of infection control measures:

- Residents with the infection should be cared for in single rooms.
- All residents should be encouraged to wash hands after visiting the toilet and before eating food.
- Staff should wear disposable gloves and aprons when caring for a patient with the infection and wash their hands after contact.
- Visitors should be encouraged to wash hands before leaving the ward.
- Maintain a high standard of cleaning in the care home.

Hospital Transfer

- Ideally patients should be 48 hours free from symptoms before discharge/transfer to a care home setting.
- Patient should be isolated in their own room for a further 48 hours until bowel habit is established.
- Faecal samples are not required for clearance as *Clostridium difficile* may persist in stool specimens for weeks.
- If symptoms persist, seek advice from GP – further antibiotic treatment may be required.

Newly diagnosed cases

- Isolate patient.
- On lab confirmation of a case of *Clostridium difficile* inform the GP – if the patient is still symptomatic commence antibiotics.
- Ensure completion of antibiotics.
- If symptoms cease – no further treatment is required. Once diarrhoea symptoms have ceased for 48 hours the room and toilet facilities should be thoroughly cleaned using the guidance in '**Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting**'.

If symptoms persist, seek advice from GP.

SECTION G – INFESTATIONS

G1. Prevention and Control of Head Lice in the Community

Introduction

Head lice can be found on adults and children. They are transferred from person-to-person wherever head-to-head contact occurs. This is generally at social gatherings or within a household environment.

Treat when head lice are found. The Pharmacist or GP should offer advice and assistance to carers when required. Information on head lice can be found on the HPA website.

Information on head lice can be found on the HPA website www.gov.uk/phe.uk.

G2. Some Facts about Head Lice and Nits (*Pediculus humanus capitis*)

What are head lice (*Pediculus humanus capitis*)?

Head lice are parasitic insects and only live on the heads of people.

The type of louse which affects the head is particularly common and anyone can catch them, although they favour clean, mid-length hair and female heads.

There are three stages of head lice:

- **Nits** are head lice eggs. The eggs or nits are glued to the hair and only become easily visible when they have hatched. Nits remain in the hair until it falls out, which may take up to two years.
- **Nymphs** hatch from the nits. The baby lice look like the adults, but are smaller. They take about 7 days to mature to adults and feed on blood to survive.
- **Adults** are about the size of a sesame seed. They have six legs and are tan to greyish-white. The legs have hook-like claws to hold onto the hair with. Adults can live up to 30 days and feed on blood.

Head lice cannot jump, hop or swim.

Who catches head lice?

Anyone can catch head lice, but preschool children, primary school children and their families are most at risk.

How do you catch head lice?

Head lice are transmitted through direct, prolonged head-to-head contact with an infested person. This is especially common during play or sport at school and with close contacts at home.

Transmission is possible through infected clothes, combs, brushes or towels, but extremely unlikely. The lifespan of a louse is very short once detached from the hair so fumigation is not necessary.

What is having head lice like?

The head lice are most commonly found behind the ears and at the back of the neck. It is rare to find them on the body, eyelashes or eyebrows.

A person with head lice may feel a tickling or itching feeling of something moving in the hair. Most people only realise that they have head lice after the itch has developed which can take from one week to 2-3 months after initial infection. The first time lice are acquired it may take 4 to 8 weeks for allergy to the bites to develop and itching to begin.

Sores can develop due to scratching and can become infected.

Can you prevent head lice?

Head lice are a mild disease. Some schools used to have routine screening, followed by the exclusion of those affected. It was ineffective in preventing spread and the practice has been discontinued.

The best way to stop infection is for people to learn how to check their heads for lice.

Good hair care only helps to control lice in as much as it will help to spot and treat lice early.

G3. Treatment - for when Lice are Found

Chemical treatments are available but **only** treat those where a living, moving louse is found.

There are three options for the treatment of head lice:

1. Wet Combing

This method does require perseverance. However, if this treatment appears to continually fail, treatment with insecticides may still be required.

- Wash the hair in the normal way with an ordinary shampoo;
- Make sure the teeth of the comb slot into the hair at the roots with every stroke. This should be done over a pale surface, such as a paper towel or the bath;
- Clear the comb of lice between each stroke;

- Wet lice find it difficult to escape, so removal with the comb is easier;
- This routine should be repeated every day for 2 weeks, so that any lice emerging from the eggs are removed before they can mature, mate and lay more eggs.

2. Insecticides (pesticides)

There are three chemical insecticides available. However, there is evidence that some head lice have become resistant to particular insecticides. This may lead to problems of eradicating head lice from an individual's head.

Insecticides should *ONLY* be used if live lice are found.

The insecticides are **Malathion, Pyrethroids (Phenothrin and Permethrin)** and **Carbaryl**. Carbaryl can only be prescribed by a healthcare professional (e.g. GP and some nurses), the other two chemicals can be purchased from a pharmacy.

All products must be used according to manufacturer's guidance. Insecticides are not effective on eggs therefore a second application is required a week later to kill the newly hatched lice. Fine comb the hair every 3-4 days between applications and for at least a further 2 weeks after the final application is recommended.

Insecticides are available in alcohol and aqueous-based preparations. Individuals that suffer from asthma, eczema etc should avoid alcohol based products. Please check the suitability of the product with the pharmacist.

Insecticides must not be used more than once a week, and not for more than 3 consecutive weeks.

3. Non-pesticide Lotion

Non pesticide lotion – Dimeticone compound (proprietary name Hedrin) - coats head lice and smothers them. There is no resistance to this lotion. However careful application is required for effective killing of the lice. It is important to follow the instructions on the pack, ensuring that the lotion is applied evenly and is combed throughout the length of the hair.

Two applications, one week apart, are required to kill lice and hatching lice. To check effectiveness use a detector comb 24 hours after the second treatment. Further applications can be used if head lice remain present after the 2nd course of treatment.

4. Contact Tracing

Contact tracing is an important part of the control of head lice infestation. Contacts will be other individuals who have had head-to-head contact lasting approximately one minute or more in the past month.

These social contacts outside of the home may include family members, friends from and other social groups.

A contact list should be formulated by each person with head lice. This list will be fairly short. Every person on the list should then be told that they have been in contact with a person who has had head lice and that they should have their own hair checked.

G4. Prevention and Control of Scabies in the Community

Introduction

The condition commonly known as 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 immuno-compromised (Norwegian Scabies). Scabies is distributed worldwide 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. There may be no sign of infection for 2-6 weeks after exposure.

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 navel 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 textbooks 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 (Norwegian 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 with prolonged contact. 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 2–6 weeks before onset of symptoms in those infected for the first time. Symptoms may occur 1–4 days after re-exposure.

Outbreaks

Outbreaks occur particularly in residential/nursing homes, mental healthcare establishments, long-stay hospital wards and pre-school nurseries.

Advice will be given on the need to treat and the treatment programme by the EHPT.

Treatment in a Residential Establishment (Care Home or Intermediate Care)

When a single suspected case of Scabies occurs in a residential establishment the EHPT (or Infection Control Team if the residential setting is owned by the PCT) should be alerted promptly to investigate. It may be necessary to treat all residents and anyone with whom they have had close contact.

If this action is required, it is important that all staff who have come into direct contact with residents also treat themselves because they may be incubating the disease without showing any symptoms. Family members of symptomatic staff will require one application of treatment. If family members are symptomatic they will require 2 applications of treatment. Family members of asymptomatic staff need not be treated routinely but asked to report any symptoms that develop later.

As far as possible all staff members should receive the treatment on the same day that their unit is treated. Staff should not work in any other area until treatments have been completed throughout the home.

Symptomatic people should be treated using 2 applications of insecticidal cream 5 – 7 days apart. The EHPT will make an individual assessment and advise.

Following Treatment

It is not uncommon for a person to have itching for up to 4 weeks after successful treatment. It is not necessarily as a result of treatment failure. It can take up to that length of time for the body to absorb the material associated with the Scabies infestation such as dead mites, egg casing etc.

Antihistamines may be helpful to control the itching. In residents with dry skin conditions emollient cream will moisturise the skin.

Lyclear Dermal Cream is The Treatment of Choice

Lyclear dermal cream is suitable for use by adults, including the elderly and children over 2 months old. Children between 2 months and 2 years should be treated under medical supervision. Pregnant women should seek medical advice.

- Ensure that the entire surface of the body is covered from the hairline on the head to the soles of the feet. This should include the area behind the ears and the face, avoiding the area around the eyes, otherwise the treatment may not be effective. If the person to be treated has little or no hair the scalp should also be included;
- Areas of skin normally covered by extensive dressings should be exposed, and Lyclear cream applied onto the intact skin up to and around the wound. The dressing may then be replaced;
- Apply the cream to clean, dry and cool skin. Do not apply following a bath or shower;
- Pay particular attention to the areas behind the ears, between the fingers and toes, wrists, under the arms, external genitalia, buttocks and under finger and toe nails;
- The whole body should be washed thoroughly 8 - 12 hours after treatment, with warm water or as indicated by the manufacturer;
- Be sure to reapply any lotion washed off during the treatment period e.g. after handwashing, or cleaning of the skin;
- Directly after treatment, change bed linen and wear freshly laundered clothes;
- Lyclear Dermal Cream disappears when rubbed gently into the skin. It is not necessary to apply the cream until it remains detectable on the surface;
- Where possible, the cream is best applied by someone other than the person receiving treatment. This makes it easier to get to difficult to reach parts of the body.

It may be necessary to prescribe two tubes of cream to ensure all areas of the body are covered thoroughly bearing in mind very dry areas of skin will absorb more of the cream.

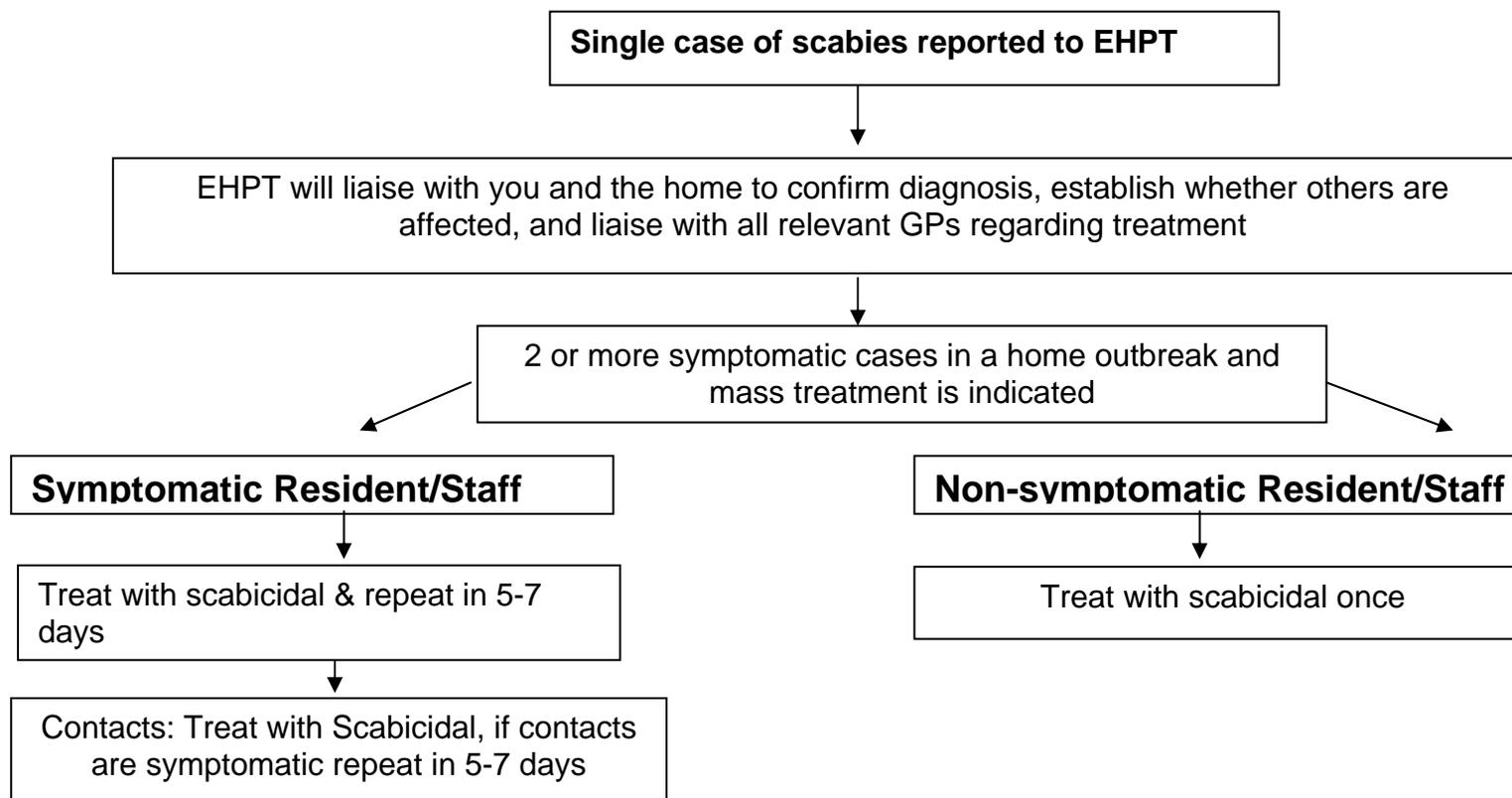
The following table shows the approximate amount of cream to be used as a **single** application:

Adults and children over 12 years	1 tube, but large people may require up to 2 tubes but no more than 2 tubes
Children aged 5 to 12 years	Up to half a tube
Children aged 1 to 5 years	Up to one quarter of a tube
Children aged 2 months to 1 year	Up to one eighth of a tube

NB Following discussions with the Medical Entomology Centre in Cambridge, (Insect Research and Development Ltd) it is now recommended to apply scabicial lotions/creams to the face avoiding the area around the eyes.

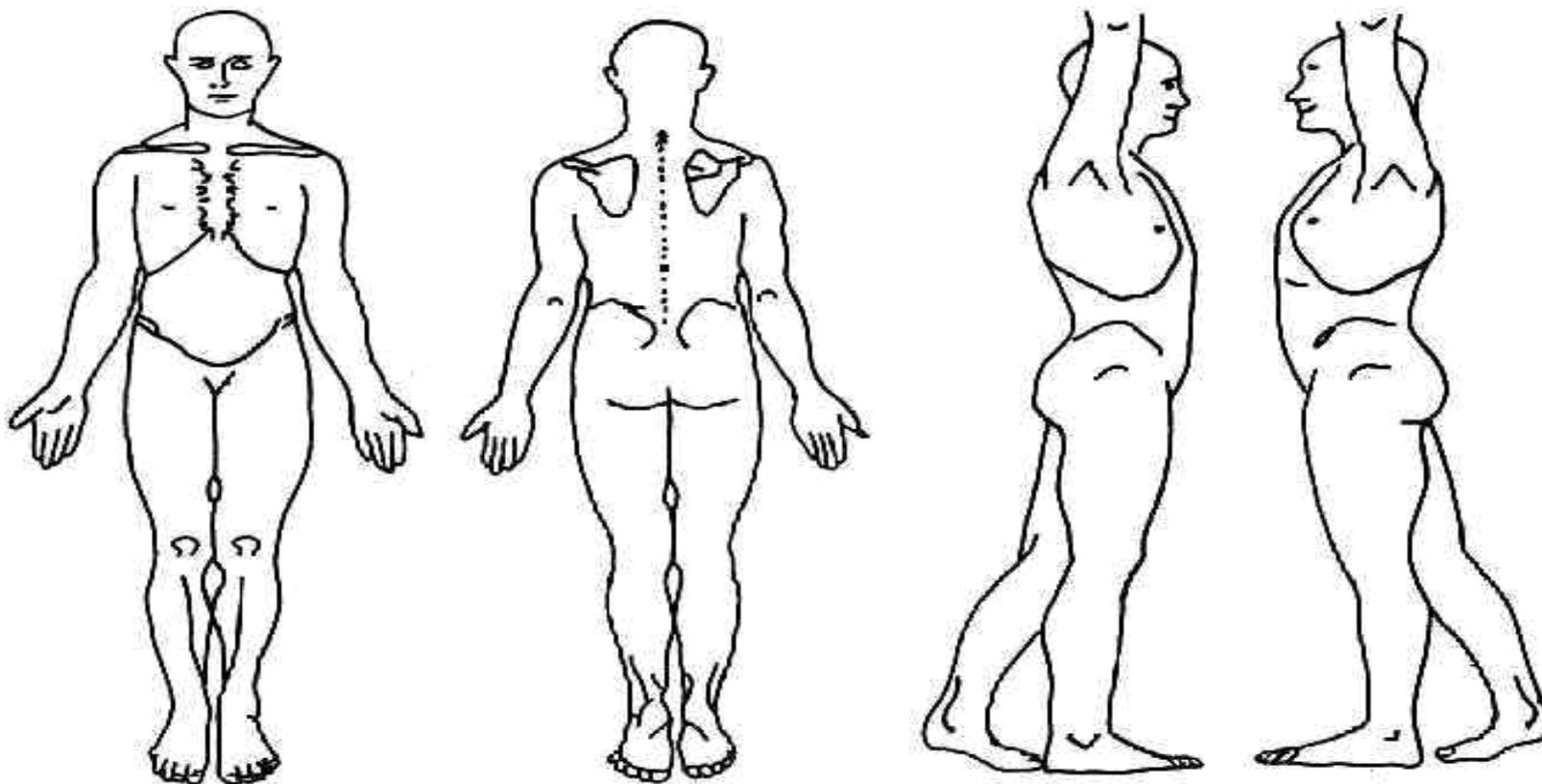
This may conflict with some manufacturers' guidance. However, there is increasing evidence that scabies may also affect the face and failure to treat this area could result in an incomplete and therefore unsuccessful treatment.

ACTION TO TAKE WHEN A SINGLE CASE OF SCABIES OCCURS IN A RESIDENTIAL CARE SETTING



Action for Essex Health Protection Team

- Plan treatment programme
- Coordinate with care setting to inform residents' GPs and request treatments
- Encourage care setting to acquire and distribute treatment to staff instead of organising with their GPs as this may lead to a higher risk of treatment failure.
- Arrange staff education sessions on treatment and management as required
- Provide printed information
- Establish surveillance procedure post mass treatment for up to 8 weeks following successful treatment



Please document the position of any rash on the Body Chart for monitoring the progress/deterioration of symptoms. This should be kept in the patient's notes and available for review.

RECORD OF OUTBREAK OF SCABIES (Staff)

Name of Home: _____

Record started by: _____ Date: _____

Address _____

Reported to: EHPT/EHO/CSCI

Total number of members of staff in home: _____

Tel: _____

Total number of members of staff affected: _____

Name of Staff Member	DOB	Area/Unit where resident	Date Symptoms started	Diagnosed by		Treatment Date	
				GP	EHPT	1 st	2 nd

SECTION H – CLINICAL PRACTICE

- Aseptic Technique
- Care of Patients with known Infectious Disease - Source Isolation (Barrier Nursing)
- Management of Non-Infectious and Infectious Deceased Clients
- Decontamination
- Laundry Management
- Enteral Feeding
- Prevention and Control of Infection Associated with Urinary Catheter Care
- Safe Handling of Specimens
- Waste Management

H1. 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 the patient to staff or other patients.

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 (this list is not exhaustive):

- Dressing wounds;
- Removal of sutures or clips;
- Dressing peripheral or centrally sited intravenous lines;
- Removal of drains;
- Endotracheal suction;
- Dressing tracheostomy site.

However the procedure is undertaken either with forceps or sterile gloved hands. The important principles are that the susceptible site should not come into contact with any item that is not sterile.

Any items that have been in contact with the wound will be contaminated and should be disposed of safely, or decontaminated.

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 and hot water, and then dried to ensure that pathogens are removed.

This process should be undertaken after each separate patient episode.

Wound Swabbing

Swabbing should only be undertaken if wound/site of invasive device exhibits signs of infection. They should not be taken routinely, or if wound/site is healing.

H2. Care of Patients with known Infectious Diseases – Source Isolation (Barrier Nursing)

In Residential Settings

Within the home setting, traditional barrier nursing is not often recommended. 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.

H2.1 Diseases

More detailed information about diseases can be found in the relevant Section of these guidelines, and on the HPA website www.gov.uk/phe.uk.

The following communicable diseases may require isolation nursing precautions to be initiated.

DISEASE	HOW LONG THE DISEASE REMAINS INFECTIOUS
Beta-haemolytic streptococci Group A	Infectious until: (a) Clearance of organism is demonstrated or (b) 24 hours after the start of appropriate antibiotic therapy
Chickenpox	Infectious until vesicles are dry (usually about 5 days)
<i>Clostridium difficile</i> (Pseudomembranous colitis)	Infectious until diarrhoea has ceased for 48 hours
Gastro-enteritis	Infectious until symptom free for 48 hours
Hepatitis A	Infectious until 7 days after the onset of jaundice

Hepatitis B and C	Blood and body fluids should be assumed to be infectious
HIV	As above
Impetigo	Infectious until lesions are crusted or healed. However infectivity will be reduced following 24 hours of appropriate antibiotics
Meningococcal Meningitis	Infectious for 24 hours after start of appropriate antibiotic therapy

Mumps	Infectious for 5 days after onset of swelling in salivary glands
Rubella	Infectious for 4 days from onset of rash. Non-immune pregnant staff should not nurse these patients
Scabies	Infectious until one application of a scabicial treatment has been completed
Shigella	Infectious until diarrhoea has ceased for 48 hours
Shingles	Infectious to a person who has not had chickenpox by direct contact with vesicles. The contact will develop chickenpox
Pulmonary Tuberculosis (Open)	Infectious until the first two weeks of appropriate antibiotic therapy have been given. The infectious period may be prolonged for Multi-Drug Resistant TB (MDRTB)

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

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

H2.2 Care of Patients with Known Infectious Diseases

Standard Principles of Infection Control should be strictly adhered to at all times (Refer to Section C)

Once a diagnosis has been made, the patient (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

Hand hygiene (**as described in Section D2**) should be practiced before and after every patient contact.

Disposal of Potentially Infected Items

Contaminated dressings and all disposable items should be disposed of as hazardous waste (**Refer to Section H9 Waste Management**).

Urinals and Bedpans

Manual cleaning is not good practice, and **must not** be undertaken, when dealing with potentially or known infectious body fluids.

Either use disposed pans, or if reusable pans are used, they must be cleaned in a washer/disinfector.

If reusable pans are used, they must be decontaminated in a bedpan washer/disinfector. An automated process should achieve a temperature of at least 80°C for 1 minute. If disposable pans are used they must be disposed of via a macerator.

A service contract for these machines must be in place, and provision made for the prompt replacement or repair in the event of malfunction.

If the automated system is temporarily unavailable disposable pans must be utilised, and disposed of via the hazardous waste disposal route (orange bag). Note that some waste contractors are still electing to provide yellow bags.

Linen

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

Should be segregated into dissolvable laundry bags thereby minimising any risk to staff.

Crockery and Cutlery

Disposable items are not required. A dishwasher capable of achieving a temperature of at least 80°C for at least 1 minute is recommended. A service contract for these machines must be in place, and provision made for the prompt replacement or repair of the machine in the event of malfunction.

If a dishwasher is not available items can be washed in the kitchen sink using GPD, and water as hot as can be tolerated.

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. Ambulance control should be informed when booking transport or when infectious status is known.

Personal Protective Equipment (PPE)

A risk assessment must be made for each patient contact episode in order that the correct protective clothing is worn. If the staff member is not planning to have any direct contact with the patient or the immediate surroundings, protective clothing may not need to be worn.

Supplies of disposable gloves, aprons and masks (if necessary) should be accessible outside the isolation room and donned prior to entering the room. Hands must be sanitised prior to the wearing of protective clothing.

Disposal of Potentially Infected Items

Contaminated dressings and all disposable items and protective clothing should be disposed of as infectious hazardous waste. The orange bag must be situated inside the isolation room, and hands must always be washed inside the room after protective clothing is removed. Hands should also be sanitised immediately after leaving the room.

Medical Equipment

Disposable equipment should be used whenever possible. Non-disposable equipment such as sphygmomanometers, stethoscopes etc. should remain in the room and be terminally cleaned once the patient is discharged.

Daily Cleaning of Isolation Rooms

All rooms must be cleaned at least daily using freshly prepared General Purpose Detergent (GPD) solution. Horizontal surfaces should be kept dust free and any spillages cleaned immediately. Isolation rooms should be cleaned after the other areas of the ward and all equipment such as cloths and mops should be disposable or laundered after each use.

Terminal Cleaning of Isolation Rooms

Disinfection is not generally required although the Infection Control Team for specific situations may recommend it.

H3 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. Dispose as clinical waste.
- (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 from where all other care equipment is requested.

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
Cholera	Psittacosis
Diphtheria	Pyrexia of unknown origin
Food Poisoning (if faecal matter is leaking)	Q fever
Hepatitis B	Rabies
Hepatitis C	Smallpox
HIV/AIDS	Tuberculosis (infective)
Leprosy	Viral Haemorrhagic fever
Meningococcal Septicaemia (with or without meningitis)	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 may not be opened e.g. if the patient suffered from Anthrax, Plague, Rabies, Smallpox or Viral Haemorrhagic Fever.

Further advice on specific infectious diseases can be found in the Infection Control Guidelines for Funeral Directors, following the link – www.gov.uk/phe.uk or advice can be sought from the EHPT calling 0345 155 0069.

H4. Decontamination

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

The Medical and Healthcare Products Regulatory Agency (MHRA) defines the following terms:

- **Cleaning** 'is a process which physically removes contamination but does not necessarily destroy microorganisms'. 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.

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

- **Disinfection** 'is a process used to reduce the number of viable microorganisms, 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

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 skin or mucous membranes, are classified as high-risk and must be sterile before use.

Classification of Infection Risk Associated with the Decontamination of Medical Devices

Risk	Application of Item	Minimum Standard
High	In close contact with broken skin or broken skin or broken mucous membrane Introduced into sterile body areas	Cleaning followed by sterilisation
Medium	In contact with mucous membranes Contaminated with particularly virulent or readily transmissible organisms Before use on immunocompromised patients	Cleaning followed by sterilisation or disinfection NB: Where sterilisation will damage equipment, cleaning followed by high level disinfection may be used as an alternative
Low	In contact with healthy skin Not in contact with patient	Cleaning

MHRA DB2006 (05) November 2006

Within the care home environment the majority of equipment to be decontaminated will require cleaning, or cleaning and disinfection. Sterile items should be purchased sterile and pre-packed, and require disposal after single-use. Items that require decontamination should follow a process recommended by the manufacturer.

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.

Thorough cleaning with detergent and warm water and clean non-shedding cloths, followed by rinsing and thorough drying.

H4.1. Disinfection Method

Disinfection methods apply to handwashing, skin preparation and 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	wide range of bacterial, virucidal, sporicidal and fungicidal activity rapid action non-toxic in low concentrations can be used in food preparation cheap	inactivated by organic matter corrosive to metals diluted solutions can be unstable needs to be freshly prepared does not penetrate organic matter bleaches fabrics need ventilation	can be used on surfaces and for body fluid spills
Sodium Dichloroisocyanurates (NaDCC) e.g. Presept, Haz- Tab, Sanichlor	slightly more resistant to inactivation by organic matter slightly less corrosive more convenient long shelf-life	as above	as above
Alcohol 70% e.g. isopropanol	good bactericidal, fungicidal and virucidal activity rapid action leaves surfaces dry non-corrosive	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	most useful as disinfectants for skin good fungicidal activity low toxicity and irritancy	limited activity against viruses no activity against bacterial spores inactivated by organic matter	For skin and hand decontamination

Training

Training of personnel to use the equipment correctly is an essential part of ensuring a safe procedure. No staff should be expected to use such equipment, or be involved in the sterilisation procedure unless a clear understanding is first ensured.

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.

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

The MDA (1995) guidance suggests that reprocessing and re-using such items may pose hazards for patients and staff, if the reprocessing method has not been validated. Therefore re-use of single-use products is not advisable unless the outcomes have been taken into account. The Consumer Protection Act 1987 will hold a person liable if a single-use item is reused against the manufacturer's recommendations.

H4.2. Decontamination of Equipment

DECONTAMINATION OF THE CLINICAL ENVIRONMENT

Environmental Cleaning

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

National initiatives such as The Health Act 2006, Essential steps to Safe Clean Care (2006), Towards cleaner hospitals and lower rates of infection (2004), and NHS Estates Healthcare Facilities Cleaning Manual (2009) all promote the importance of cleanliness in the healthcare environment, to assist in tackling the problem of healthcare acquired infections.

- 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. All surfaces should be kept clear of unnecessary equipment or clutter to ensure regular and thorough cleaning can occur. The most important component of an effective cleaning programme is the regular removal of dust from all horizontal surfaces.

- GPD and water should be used for all environmental cleaning – follow the manufacturer’s instructions. Disinfectant such as a chlorine releasing solution, should only be used to decontaminate spills of body fluids, or for “terminal” cleaning of an area after a known case or outbreak of infection.
- 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, these should be cleaned with vacuum cleaner with filters daily or contracts for regular steam cleaning and dealing with spills (suggested frequency of steam cleaning in waiting rooms yearly).
- Walls require spot cleaning to remove splashes/marks.
- Difficult to reach/clean areas should have contracts arranged for regular planned preventive maintenance and cleaning e.g. behind radiator guards, fans, ventilation units/grills etc.
- All cleaning equipment should be colour-coded for different areas of use, as per National colour-coding guide (see further on. e.g. buckets, mop handles, aprons, gloves and disposable cloths etc.).
- The water used for cleaning, in buckets, must be changed frequently and disposed in a sluice sink/hopper. Clean the mop handle and bucket after use. Dry and store bucket inverted.
- Mop heads should be removed after each use for laundering in a hot wash and then stored dry but if heavily soiled to be discarded. Single-use mop heads should be used if industrial washing machine laundering facilities are not available.
- Single-use, non-shedding cloths or paper roll should be used for cleaning and drying.
- Equipment and materials used for general cleaning should be kept separate from those used for dealing with body fluids.
- All equipment used for cleaning including vacuums and floor polishers should be clean and maintained properly.

H4.3. A-Z of Equipment and the Decontamination Method

Dilution Chart

Uses of hypochlorite and strengths of solutions

USE	DILUTION OF SOLUTION	AVAILABLE CHLORINE	
		%	Parts per million (ppm)
	Undiluted	10*	100,000*
Blood and blood stained fluids spills	1 in 10	1.0	10,000
Environmental disinfection	1 in 100	0.1	1,000
Disinfection of clean instruments	1 in 200	0.05	500
Feeding utensils, catering surfaces and equipment	1 in 800	0.0125	125

**Approximate values of some brands of Thick Bleach. Concentrations may vary. Always follow the manufacturers instructions to make-up the concentration required. Same applies where tablets are used.*

- Always follow the manufacturer's instructions when using a hypochlorite (bleach) solution.
- Hypochlorite should not be poured over urine as a harmful gas can be released.
- It is not advisable to use hypochlorite on carpets and soft furnishings. Follow manufacturer's instructions when decontamination is required.
- When using hypochlorite, always ensure that the area is well ventilated.

EQUIPMENT	CLEANING METHOD
Baths	To be cleaned between users. With gloved hand, clean bath surface, grab rails and taps with hot water, GPD and paper towels, or GPD wipes. Rinse.
Bedpans	Disposable pans are recommended to be disposed of in a Macerator. Reusable Pans to be decontaminated in Washer Disinfector. Manual cleaning is not advised.
Beds, backrests, bed cradles and mattresses	To be included in the regular cleaning regime, but to be cleaned between users with hot water and GPD, or GPD 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 hot water and GPD, or GPD wipes, using disposable paper towels and gloved hand and then flush.
Bucket (plastic)	Empty contents down toilet or slop hopper. Wash with GPD and dry.
Bowls – patient washing	Clean between each use with hot water and GPD, or GPD wipes, using disposal paper towels. Rinse and store dry on the shelf of a cupboard.
Commode armrests and seats	If no soiling is evident, clean with hot water and GPD, 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, clean with hot water and GPD, or GPD wipes followed by 1000 ppm available chlorine solution. Use separate wipes for armrests and seats.
Curtains	Launder 6 monthly or at once if visibly soiled or after an outbreak of infection as part of the terminal clean Disposable curtains are available and are recommended where a laundry service is not available.
Floors	Dust control – dry mop. Wet cleaning – wet mop, wash with hot water and GPD. If known contamination – follow with 1,000 ppm available chlorine.
Furniture and Fittings	Damp dust with hot water and detergent. If known contamination – follow with 1,000 ppm available chlorine.
Hoists and slings	Residents/'patients' slings should be allocated to each individual, and kept at their side ready for use. On discharge, or if the sling becomes soiled, the sling should be washed in an industrial washing machine on as hot a wash as the fabric will tolerate as per manufacturers guidance. The slings should be dried and then stored in a designated area. Alternatively, single patient slings can be used and disposed of once the patient no longer requires it.
Lavatory Brushes	Rinse in flushing water and store dry.
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 hot water and GPD followed by 1000 ppm available chlorine solution.

Mop (wet)	Disposable recommended. Dispose after single task or for periods not exceeding three hours. Reusable, heat disinfect in washing machine and dry thoroughly daily, or more frequently if necessary. Store dry.
Mop (dry)	Single-use covers – dispose of after use.
Nail brushes	Single-use only.
Nebulisers	<p>Single patient use nebuliser and tubing recommended. Clients should have their own nebuliser units, which should be washed with hot water and GPD between use. Store dry. On completion of treatment, dispose of nebuliser. Follow manufacturer’s instructions.</p> <p>Nebulisers which are used in the surgery or loaned to clients must be thoroughly decontaminated between patient uses. All tubing, mask, and filters should be disposed of after use, and replaced with new, disposable components before the item is used by another client.</p> <p>Staff must maintain a register of use (giving patient details and date of use) for each nebuliser including a record of the decontamination process detailing the date, time, cleaning method used, items replaced, and the signature and name of the member of staff responsible.</p>
Showers	Should be clean and maintained. Launder curtains 3 monthly. Shower heads should be de-scaled when necessary. If not in use – shower should be run for 5 mins weekly (potential Legionella risk).
Stethoscopes	Clean with GPD wipe after each use.
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 in the appropriate waste.(See Waste Section H (Subsection 9).</p> <p>Non-disposable bottles – recommend change to disposable.</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	Single-use recommended.

Trolleys (dressing trolleys)	Clean top and all surfaces with hot water and GPD, or GPD wipes daily. Dry thoroughly. If trolley becomes contaminated between patient use, wash with GPD and hot water again.
Toys	Soft toys should be washable via an industrial washing machine. Plastic toys to be washed in hot water and GPD. Wooden toys are not suitable.
Urinals	Single-use recommended. Non disposable urinals should be mechanically cleaned as described for bedpans. Non-disposable urinals in an individual's own home - wear disposable plastic apron and gloves, empty urine into the toilet, clean thoroughly using paper towels, hot water and GPD. Rinse, dry and store inverted.
Urine jugs	Single-use recommended. Reusable - Wearing gloves and apron, a separate clean jug should be used for each urine collection. Empty the contents into the toilet and rinse. Clean thoroughly with hot water and GPD using disposable paper towels. Rinse and dry. Store inverted. Allocate a jug per individual resident/patient.
Walking frames, wheelchairs etc.	Clean with GPD and hot water, or GPD wipes and dry. In residential environment clean weekly, daily during outbreaks and immediately after contamination with body fluids.
Walls and Ceilings	Not an infection problem. When visibly soiled use hot water and detergent. Splashes of blood, urine or known contaminated material should be cleaned promptly with 1,000 ppm available chlorine.
Weighing scales	Wash scales with GPD and hot water, or GPD wipes after each use
Work surfaces	General Cleaning Use GPD and hot water, or GPD wipes. Contaminated Surfaces Clean with GPD and hot water, or GPD wipes, and then wipe with a 1,000 ppm available chlorine solution

H4.4. Colour-Code for Hygiene

Based on the Safer Practice Notice – Colour-coding hospital cleaning materials and equipment, published by the National Patient Safety Agency.

National Colour Coding Scheme



THE GOLDEN RULE: WORK FROM THE CLEANEST AREA TOWARD THE DIRTIEST AREA. THIS GREATLY REDUCES THE RISK OF CROSS-CONTAMINATION.

1. The aim of a colour-coding system is to prevent cross-contamination.
2. It is vital that such a system forms part of any employee induction or continuous training programme.
3. A minority of people are colour-blind in one or more colours. Some individuals may not know this and colour identification testing should form part of any induction training.
4. Always use two colours within the washroom/sanitary area.
5. The colour-coding system must relate to all cleaning equipment, cloths and gloves.

Monitoring of the system and control of colour-coded disposable items against new stock release is extremely important.

H4.5. Decontamination of Equipment Prior to Inspection, Service, Repair or Loan

Figure 3 Decontamination flow chart for devices being sent for investigation/repair or service

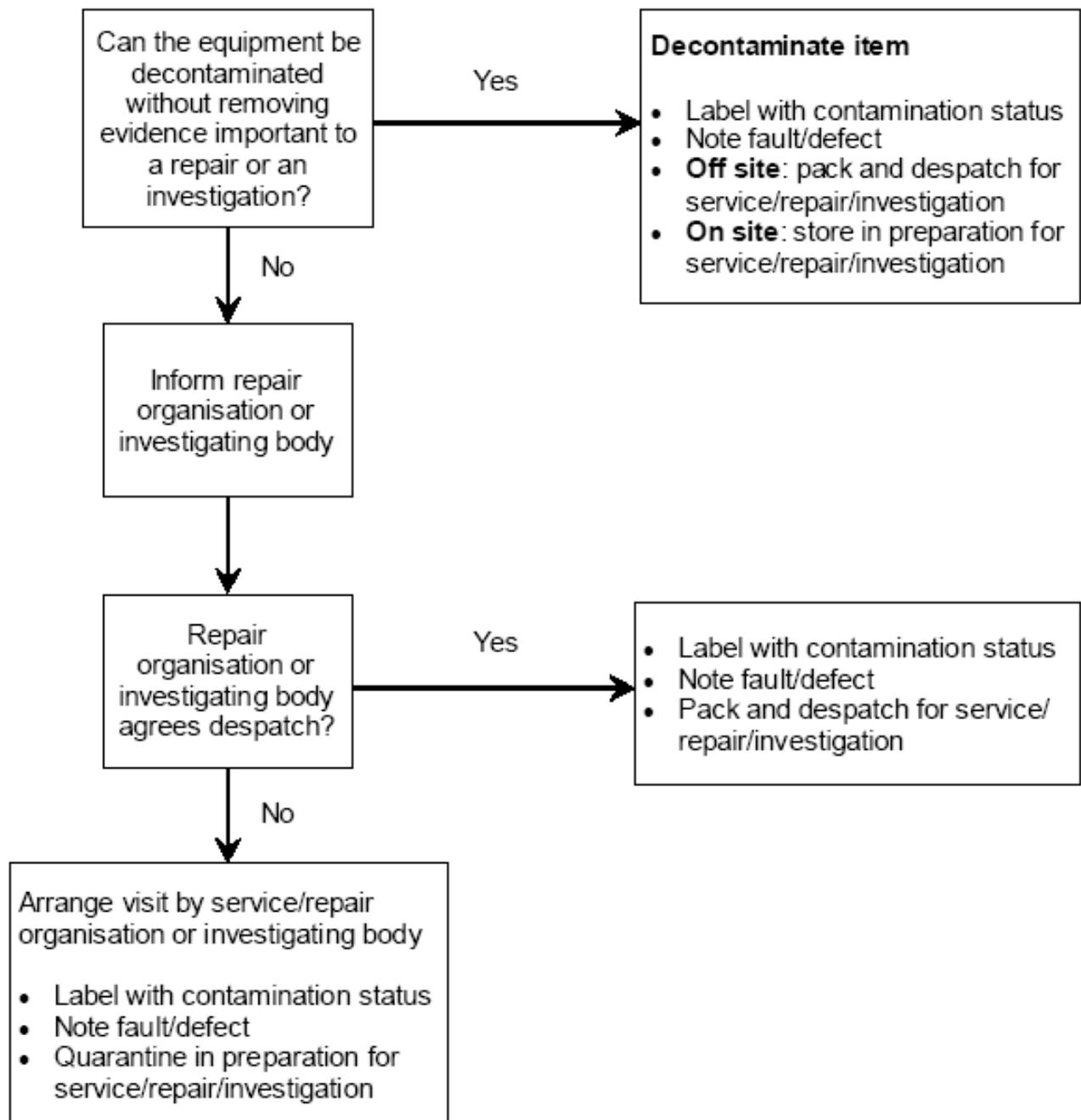


Figure 4 Sample form – declaration of contamination status

From (consignor): _____ Address _____ _____ _____ Reference _____ Emergency tel _____	To (consignee): _____ Address _____ _____ _____ Reference _____
---	--

Type of equipment _____ Manufacturer _____
 Description of equipment _____
 Other identifying marks _____
 Model No. _____ Serial No. _____
 Fault _____

Is the item contaminated?	Yes* <input type="checkbox"/>	No <input type="checkbox"/>	Don't know <input type="checkbox"/>
* State type of contamination: blood, body fluids, respired gases, pathological samples, chemicals (including cytotoxic drugs), radioactive material or any other hazard _____			
Has the item been decontaminated?	Yes† <input type="checkbox"/>	No‡ <input type="checkbox"/>	Don't know <input type="checkbox"/>
† What method of decontamination has been used? Please provide details			
Cleaning _____			
Disinfection _____			
Sterilization _____			
‡ Please explain why the item has not been decontaminated? _____ _____			

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

This item has been prepared to ensure safe handling and transportation:	
Name _____	Position _____
Signature _____	
Date _____	Tel _____

H5. Laundry Management

Laundry facilities:

- The laundry must be sited so that soiled articles are not carried through areas where food is stored, prepared, cooked or eaten.
- The laundry should have a flow of 'dirty to clean'. Clean items should not pass back through the 'dirty' area of the laundry.
- Soiled laundry must be stored in a designated area within the laundry, separate from the area where clean laundry is handled.
- The laundry floor must be of a smooth, impermeable and easily cleanable material.
- The laundry room should be ventilated with appropriate extraction devices.
- Domestic staff should have a clear programme for cleaning the laundry environment. All horizontal surfaces should be damp-dusted on a daily basis.
- Any body fluid contamination must be cleaned immediately according to the spillage policy.
- Walls must be in sound condition and easily cleaned as necessary.
- All machinery must be maintained in a clean dust-free condition and must be covered by a service agreement which supports prompt repair or replacement of the machine in case of breakdown. Records of maintenance/service should be kept.
- Staff must have use of a designated handwash facility with liquid soap and paper towels within the laundry.
- Washing machines should have programming ability to meet disinfection standards:
 - A 'sluice' cycle to pre-wash heavily contaminated laundry.
 - Machine should reach 65°C for a minimum of 10 minutes or 71°C for 3 minutes in order to achieve disinfection.
 - Laundry staff should have training and be competent in the use of the equipment.

- Washing powders and other substances must be kept in a locked storage cupboard. Material Safety Data Sheets for any potentially hazardous substances must be obtained and be available for reference.

Laundry practices:

- Laundry staff should always wear gloves and a disposable apron whilst handling laundry.
- Hands must be washed after removal of protective clothing.
- Soiled laundry must be removed to the designated laundry area for processing as soon as possible after it has been produced.
- Soiled laundry must be transported around the home only whilst contained within designated linen bags.
- Linen contaminated with blood or body fluids must be contained within a water-soluble or soluble-stitched bag prior to being placed in a normal linen bag. This enables contaminated laundry to be placed into the machine (on a 'sluice' cycle) whilst in the soluble bag thereby reducing the risks of body fluid contamination, and potential infection risk, to the staff member.
- Heat labile clothing must be washed at the highest temperature possible according to the item's fabric care instructions. Where indicated disinfection can be achieved by adding sodium hypochlorite in 150ppm concentration to the wash during the rinse cycle.
- There is no need to segregate laundry from residents who are colonised with MRSA unless the linen is soiled with body-fluids, or as advised by the EHPT. Good hygiene practices will suffice.
- Tumble-drying and ironing are also heat disinfection processes.

Curtains/blinds:

- These should be washed at least twice a year, or when there is visible contamination, and after outbreaks, or following the discharge or death of a resident with an infection. If in doubt please contact EHPT for advice.

Sending Laundry to a Commercial Laundry

A commercial laundry service may stipulate a colour coding system for the management of soiled linen.

Usually laundry bags are colour coded in the following way:

- Used linen - a white bag;
- Foul linen and/or infected linen – placed in a red water-soluble bag, into a red outer bag.

If resident's laundry is sent to a commercial laundry, by collection or delivery, it should be checked whether they have any special instructions regarding the colour-coding system.

Staff Uniforms or Work Clothes

Staff who are at risk of contaminating their clothes by body fluids should always change into 'home' clothes - 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. Cardigans/jumpers should be washed at least weekly.

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.

Shoes should be cleaned immediately if contaminated with body fluids, using GPD and hot water - disposable gloves should be worn.

H6. Enteral Feeding

Preparation and Storage of Feeds

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

Wherever possible pre-packed, 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 to the enteral feeding tube.

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

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

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

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.

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.

In some areas, single patient use syringes are used to administer drugs. Check the packaging to ensure it is **single patient** use, and, if it is, follow the manufacturer's instructions on decontamination between uses.

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 fresh tap 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.

H7. Prevention and Control of Infection in Urinary Catheter Care

Routes of Entry for Infection

Urinary catheters are inserted to provide urinary drainage. They may be introduced via the urethra or into the bladder through a supra-pubic procedure.

Comprehensive information, advice and support is available from the continence advisors.

Bacteria may enter the bladder of the catheterised patient in one of four ways:

- Introduced with the catheter at the time of insertion;
- Travel along the outside of the catheter;
- Travel along the inside lumen of the catheter;
- Through a break in the closed system.

Assessment for Catheter Equipment

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

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

Catheter insertion, changes and care should be documented.

Following assessment, the best approach to catheterisation that takes account of the clinical need, anticipated duration of the 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 supra-pubic catheters, the choice of catheter material and gauge will depend on an assessment of the patient's individual characteristics, and predisposition to blockage.

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

There are a variety of types of urinary catheters. When the assessment for the need for catheterisation is made the catheter material and expected usage should be recorded. In the community, medium (up to 28 days) or long-term (up to 12 weeks) catheters are recommended.

The retaining balloon should be filled with sterile water to the volume indicated by the manufacturer (usually 10mls for adults and 3-5 mls in children).

Catheter Insertion

Catheterisation is an aseptic technique.

Ensure that healthcare workers are trained and competent to carry out catheter insertion.

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

The urethral meatus should be cleaned before insertion of the catheter, with sterile normal saline prior to insertion.

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

Documentation

The following details must be documented in the patient records e.g. amount of urine drained, problems encountered, patient discomfort, reason for catheterisation, date of insertion, catheter size, type, length, balloon size, batch number, expiry date.

Catheter Maintenance

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

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 their gloves.

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

A link system should be used to facilitate overnight drainage, to keep the original system intact. Drainage bag should be **single-use**.

The meatus should be washed daily with soap and water.

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

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

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

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 standard principles of infection control.

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

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

Each patient should have an individual care regimen designed to minimise 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 infections.

Antibiotic prophylaxis when changing catheters should only be used for patients with a history of catheter-associated urinary tract infection following catheter change, or as indicated by the local Antibiotic Policy.

H8. 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 of Infection Control** (i.e. wearing of appropriate gloves, disposable plastic apron and washing and drying of hands before and after the procedure).
- Appropriate container should always be used, and follow instructions as to how to collect the specimen.
- 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.
- 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 “Outbreak in (add name of care home). Stool specimens should be sent as soon as an outbreak is suspected e.g. the second loose stool in 24 hours.

H9. Waste Management

The management of Healthcare Waste has changed in line with the new Hazardous Waste Regulations.

The new Department of Health document is entitled: **Environment and Sustainability – Health Technical Memorandum 07-01: Safe Management of Healthcare Waste**. This guidance has been produced to provide a framework for best practice in waste disposal. The guidance is designed to help healthcare organisations and other producers of waste to meet their legislative requirements.

HTM 07-01 is available from the Stationary Office or it may be electronically downloaded from DH website www.dh.gov.uk/publications.

It is strongly recommended that the organisation/healthcare businesses also consult the HTM 07-01 and discuss waste disposal with the management or advisors of the waste collection contractor.

All healthcare organisations should have a waste policy that provides clearly written instructions on the way waste should be managed. The roles and responsibility of the waste management chain from “cradle to grave” still applies. Producers of waste are advised to carry out regular audit of their waste management systems to ensure that they complying with best practice.

Example of Waste produced in the Healthcare Sector

Hazardous Waste

Infectious Waste
Fluorescent Waste
Laboratory Chemicals
Cleaning Chemicals
Photo Chemicals
Oils
Batteries
Waste Electronics
Asbestos
Paints
Solvents
Contaminated Land

All waste products will have European waste codes.

Non-Hazardous Waste

Domestic Waste (black-bag or municipal waste)
Food Waste
Offensive/Hygiene Waste
Packaging Waste
Recyclates (paper, glass, aluminium etc)
Furniture
Construction and Demolition Waste
Grounds Waste

Note: Adapted from Welsh Health Estates 'Healthcare waste strategy for Wales' guidance document.

All healthcare organisations have a legal responsibility to dispose of waste safely, ensuring no harm is caused either to staff, members of the public or the environment. The healthcare organisations' 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).

H9.1. Definitions

Clinical Waste

- 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 regulations subdivide healthcare clinical waste into:

1. Waste that poses a risk of infection (infectious waste)
2. Medicinal waste.

Infectious Waste

The Hazardous Waste Regulations define this as:

H9 Infectious: Substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in man or other living organisms. (Traditionally known as “**clinical waste**”.)

Medicinal Waste

Classified into two categories:

- (a) Cytotoxic and cytostatic medicines (classified as Hazardous Waste)
- (b) Medicines other than cytotoxic and cytostatic.

Failure to segregate cytotoxic and/or cytostatic medicines from other medicines will mean that the entire medicinal waste stream will need to be classified as hazardous.

Cytotoxic and cytostatic classifications can be found in the NIOSH Alert or the BNF.

Offensive/Hygiene Waste

Non-infectious (human waste and sanpro (sanitary protection) waste such as nappies, incontinence pads etc.), which does not require specialist treatment or disposal, but which may cause offence to those coming into contact with it.

H9.2. Segregation Of Waste

The new regulations focus on the correct segregation at the point of generation, correct identification of the waste and the safe disposal via the appropriate route.

The European Waste Code (EWC) coding for correct labelling is illustrated in the following table:

Table 1 EWC Coding for the Types of Healthcare Waste

EWC Code	Colour of Text	Description of Waste
18 01 XX	Black	Waste from natal care, diagnosis, treatment or prevention of disease in humans
18 01 01	Black	Sharps except 18 01 03*
18 01 02	Black	Body parts and organs including blood bags and blood preserves (except 18 01 03*)
18 01 03**	Red	Waste whose collection and disposal is subject to special requirements in order to prevent infection
18 01 04	Black	Waste whose collection and disposal is subject to special requirements in order to prevent infection e.g. dressings, plaster casts, linen, disposable clothing
18 01 06*	Blue	Chemicals consisting of dangerous substances
18 01 07	Black	Chemicals other than those listed in 18 01 06*
18 01 08**	Red	Cytotoxic and cytostatic medicines
18 01 09	Black	Medicines other than those mentioned in 18 01 08*
18 01 10**	Red	Amalgam waste from dental care

*Hazardous Waste list entries

Hazardous wastes are absolute entries (in which case they are always hazardous – highlighted red** in the table) or mirror entries (which can be either hazardous or non-hazardous depending on their properties – highlighted blue* in the table).

A national colour-coding system has been developed. Most infectious clinical waste generated in community settings will be disposed of in the orange package stream.

Non-infectious waste and incontinence waste is considered to be offensive. It can be disposed of in yellow bags with black strips (refer to figures 4 and 5 on the following pages).

The assessment for whether waste is hazardous because of infection will be made at the point of generation i.e. the site of healthcare provision.

An assessment is required to ascertain the correct type of packaging i.e. if there is a risk of an item piercing a waste bag a rigid container should be used.

Colour-coding key to segregation system

Colour	Description
 Yellow	Waste which requires disposal by incineration Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility
 Orange	Waste which may be “treated” Indicative treatments/disposal required to be “rendered safe” in a suitable permitted or licensed facility. <i>Usually alternative treatment plants (APT’s) However this waste may also be disposed of by incineration</i>
 Purple	Cytotoxic and Cytostatic Waste Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility
 Yellow & Black	Offensive/Hygiene Waste Indicative treatments/disposal required is landfill in a suitable permitted or licensed site. This waste should not be compacted in unlicensed facilities
 Black	Domestic (Municipal) Waste Minimum treatments/disposal required is landfill in a suitable permitted or licensed site. Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste
	Amalgam Waste For recovery

Table from HTM07-01: Safe management of healthcare waste. Figure 4

The use of yellow/black for offensive/hygiene waste was chosen as these colours have historically been universally used for the sanitary/offensive/ hygiene waste stream.

Waste Packaging and Colour-coding

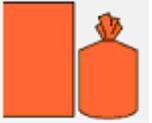
Waste receptacle	Waste Types	Example contents	Indicative treatment/disposal
 Yellow body/ Purple lid	Sharps contained with cytotoxic and cytostatic medicinal products	Sharps used to administer cytotoxic products	Incineration
 Yellow lid and body	Infectious and other waste requiring incineration including anatomical waste, diagnostic specimens, reagent or test vials, and kits containing chemicals	Anatomical waste from theatres	Incineration
 Receptacle must be UN-approved for liquids Yellow	Partially discharged sharps not contaminated with cyto products	Syringe body with residue medicinal product	Incineration
 Yellow	Medicines in original packing	Waste in original packaging with original closures	Incineration
 Yellow	Medicines NOT in original packing	Waste tablets not in foil pack or bottle	Hazardous waste incineration
 Orange	Infectious waste, potentially infectious waste and autoclaved laboratory waste	Soiled dressings	Licensed/permitted treatment facility
 Yellow body/orange lid	(i) Sharps not contaminated with medicinal products or (ii) Fully discharged sharps contaminated with medicinal products other than cytotoxic and cytostatic medicines	Sharps from phlebotomy	Suitably authorised incineration or alternative treatment facility
 Yellow/black	Offensive/hygiene waste	Human hygiene waste and non-infectious disposable equipment, bedding and plaster casts	Deep landfill

Figure 5

Assessment of Hazard

Generally in primary healthcare the waste generated is less of an infectious hazard.

Infectious waste is waste that has been generated from a person with signs and symptoms of infection and will be considered infectious or potentially infectious and should be disposed of in orange waste streams. Non-infectious but offensive waste should be disposed of in a yellow bag with black stripe. There will be occasions when offensive/hygiene waste is potentially infectious e.g. patients/residents with gastroenteritis, in which case the correct waste-stream is orange.

Healthcare workers working in the community and in the household environment need to assess the waste they are producing for the hazardous properties it may contain, most notably 'infectious'.

H9.3. Handling of Waste

- Waste should be segregated at the point of origin;
- Personal protective clothing should be worn when handling waste;
- Waste should be:
 - Correctly bagged in the appropriate coloured bag of 225 gauge to prevent spillage;
 - Double bagged where:
 - The exterior of the bag is contaminated;
 - The original bag is split, damaged or leaking.
 - Kept in a rigid-sided holder or container with a foot-operated lid, and, so far as is reasonably practicable, out of the reach of children;
 - Only filled to $\frac{3}{4}$ full;
 - Securely sealed and labelled with coded tags at the point of use to identify their source.
- Waste should not:
 - Be decanted into other bags, regardless of volume
 - Be contaminating the outside of the bag
 - Sharps must be disposed of into appropriate colour-coded sharps containers that meet BS7320/UN3291
 - Sharps container should **NEVER** be placed into a waste bag.

All staff handling waste should receive appropriate training to carry out the procedure safely.

H9.4. Disposal of Waste

The bag should be removed and securely fastened at least once a day or when $\frac{3}{4}$ full, labelled with its place of origin (e.g. home details) and placed in the designated waste collection point.

Disposal of Sharps

A risk assessment is required to identify the correct waste stream required.

Syringes, needles, lancets, razors, ampoules and other sharps should always be placed in the correct sharps container (see Waste-packaging and colour-coding). These items should never be placed in a waste bag of any kind.

Care should be taken to ensure that sharps containers are correctly assembled according to the manufacturer's instructions.

Use the appropriately-sized sharps container to prevent used sharps being stored for long periods of time.

It is the responsibility of the person who uses a sharp to dispose of it safely.

Always place sharps in the sharps container as soon as possible, at point of use.

Sharps containers must be sealed, labelled with the point of origin and placed in the designated waste collection point when $\frac{3}{4}$ full.

Sharps containers should conform to BS 7230/UN 3291.

Sharps containers should be kept in a safe location (on a flat surface, below eye level but not on the floor). This will reduce the risk of injury to patients, visitors and staff.

Disposal of Pharmaceutical Waste - Medicinal Waste

Pharmaceutical waste includes all part-used and out-of-date medicines, cream and ointment tubes and aerosols. Other associated waste e.g. empty blister packs and alcohol wipe containers can be disposed of in the domestic waste stream (black bag).

All pharmaceutical waste should be placed directly into the pharmaceutical waste container, or returned to the local chemist for them to place into their pharmaceutical waste container.

Ensure that the container is clearly labelled, and that all associated documentation is signed off at the time of collection.

H9.5. Storage Of Hazardous/Non-Hazardous Healthcare Waste

Infectious waste should be removed from the 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;
- Accessible to collection vehicles.

H9.6. Management of Clinical Waste in Care Homes

The above guidance should be followed in full.

Each health and social care employer is responsible for ensuring that contracts are in place to collect clinical waste from their premises. They are also responsible for monitoring the performance of their staff and waste contractors.

Community healthcare workers generating waste in health and social care establishments are responsible for ensuring the waste that they generate is managed correctly, this is part of their duty of care.

The waste should be stored in a suitable place to which children, pets, pests etc. do not have access.

This 'cradle to grave' responsibility will include the correct storage of waste whilst awaiting collection by an authorised collector.

Risk Assessment

A risk assessment should be undertaken to determine whether the waste generated by the healthcare worker is a hazard because it has a known or potential risk of infection. This should be a professional assessment based on clinical signs and symptoms and prior knowledge of the patient.

Infectious Waste

The table below is based on the Delphi process for identifying wound infection (European Wound Management Association 2005) and can be used to assist in the risk assessment.

Potentially infectious healthcare waste like dressings, blood and body fluids based on a risk assessment must be disposed of in an orange bag.

However the healthcare worker may have further information that would indicate that the waste is potentially infectious. Infectious waste must be disposed of in an orange bag.

Non-infectious Waste

Non-infectious healthcare waste generated by a healthcare worker should be disposed of via the offensive waste stream (yellow with black strip waste bag).

H9.7. Current Legislation

- Health & Safety at Work etc Act 1974
- Control of Pollution Act 1974
- Collection and Disposal of Waste Regulations 1988
- Control of Pollution (Amendment) Act 1989
- Environmental Protection Act 1990
- Environmental Protection (Duty of Care) Regulations 1991
- Controlled Waste Regulations 1992
- The Special Waste Regulations 1996
- HTM Environment and Sustainability 07-01 Safe Management of Healthcare Waste Department of Health 2006
- Health Care Waste Management and Minimisation 2000.

In Summary

It is the responsibility of the home to ensure that they are using the correct waste containers and the correct EWC codes.

Residential Care Homes

- Sharps bins – are prescribed for individual residents i.e. a diabetic resident if required. Liaise with District Nurse Team or GP – sharps boxes should be returned for disposal to GP surgery or pharmacy according to local arrangements.

- Orange bags for soiled dressings and other “infectious waste” labelled with the EWC code 18 01.02 at disposal. Depending on the volume of waste generated (small amounts of waste i.e. dressings no larger than 130mm x 220mm can be disposed of as domestic waste).
- Yellow and black striped bags for incontinence waste labelled with EWC code 18 01 04 at disposal.
- Black bags for domestic waste.
- Pharmacy waste should be returned to dispensing pharmacy for disposal.

Nursing Homes

- Sharps bins – Yellow lidded sharps bins for partially discharged sharps not containing chemo or cytostatic medicines with EWC code 18 01 01.
- If required - Purple lidded sharps bins for Chemotherapy and Cytostatic waste with EWC code 18 01 08.
- Orange bags for soiled dressings and other “infectious waste” labelled with the EWC code 18 01 03 at disposal. Depending on the volume of waste generated.
- Yellow and black striped bags for incontinence waste labelled with EWC code 18 01 04 at disposal.
- Black bags for domestic waste.
- Pharmacy waste – Yellow lidded ridged container - discuss with dispensing pharmacy with EWC code 18 01 09.

The assessment of whether waste is hazardous because of infection will be made at the point of generation i.e. the site of healthcare provision.

SECTION I – FOOD HYGIENE

I1. Introduction

This guideline sets out the procedures for staff to follow for food hygiene in Care homes.

I2. Legislation

All individuals who handle food should follow basic food hygiene practices to ensure contamination and subsequent disease does not occur.

All staff involved in the handling of food should be aware of the legislation relevant to food management. The main legislation is the Food Safety Act 1990 and its related regulations (General Food Hygiene Regulations (1995) and The Food Safety (Temperature Control) Regulations (1995)).

I3. Basic Requirements for Food Safety

The Local Authority Environmental Health Officers will advise on Food Safety and Kitchen Hygiene in the care home setting.

The following basic principles should be observed:

- It should be ensured that the food purchased is of good and wholesome quality and is subsequently stored, prepared, cooked and served in hygienic conditions;
- Check “use by” dates. Use food within recommended times;
- Do not provide/eat food containing uncooked eggs. Keep eggs in the fridge;
- **Food Preparation Areas.** All food preparation surfaces should be cleaned before use with hot water and GPD;
- **Pets.** Keep pets away from food, and preparation areas;
- **Cross Contamination.** Care must be taken not to contaminate cooked foods with raw foods. Ideally there should be a separate chopping board and utensils for each type of food (e.g. raw meat, cooked meat and raw and cooked perishables);

- **Hands and Hand-washing.** Hands **must** be washed thoroughly following any cleaning session, after toilet visits, before handling food and between handling different food types e.g. raw and cooked meats;
- **Refrigerators.** All fridges should be defrosted and cleaned regularly. Should a spillage occur or food become stale the whole interior of the fridge should be cleaned with hot water and GPD and dried thoroughly;
- **Food.** Food should be stored at the correct temperature. The fridge should be kept at 5° C or lower. The freezer should be kept at minus 18°C or below. In the care home, it is essential that a record of daily temperature recordings is kept;
- **Storage.** Store raw meat and fish at the bottom of the fridge ensuring juices do not drip on to salads and vegetables. Raw meat and defrosting foods should be stored in covered dishes, or boxes which can catch drips. All sealed dry foods should be stored on shelves or in cupboards. Food should not be stored on the floor. Open packs of food should be stored in containers or packaging sealed to inhibit the entry of animals. Open bottles, such as squash, sauces and jams may require storage in the refrigerator. Follow manufacturer's guidelines;
- **Defrosting.** All foods should be defrosted in the fridge or microwave, not at room temperature (unless specified on the packaging). Do not re-freeze uncooked food. Cook before you freeze again;
- **Cooking.** Always follow cooking times on the labels and in cookbooks. Cook food thoroughly so that the temperature reaches 70° C for at least 2 minutes. Ideally food should be eaten as soon as it is cooked or prepared. Never re-heat food;
- **Leftovers.** These should not be left out unnecessarily. Cold food should be covered and put directly into the fridge. Hot food should be cooled for one hour at room temperature and then placed in the fridge. All leftovers should be eaten within 2 days;
- **Crockery and Cutlery.** A mechanical dishwasher incorporating a hot drying cycle should be used if possible. If a dishwashing machine is not available, hot water and GPD should be used for washing. Wherever possible, dry with disposable heavy-duty paper towel. If used, tea towels are to be changed daily and laundered at least 65° C;

- **Dishcloths.** Should be changed daily and laundered at least 65°C.

SECTION J – STAFF HEALTH

J1. Occupational Health Service

The Code of Practice in the Health and Social Care Act 2008 requires that employees

‘Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in prevention and control of infection associated with the provision of health and social care’.

Registered providers should ensure that policies and procedures are in place in relation to the prevention and control of infection such that:

- all staff can access occupational health services or access appropriate occupational health advice;
- occupational health policies on the prevention and management of communicable infections in care workers are in place;
- decisions on offering immunisation should be made on the basis of a local risk assessment as described in ‘Immunisation against infectious disease (The Green Book)’. Employers should make vaccines available free of charge to employees if a risk assessment indicates that it is needed (COSHH Regulations 2002);
- there is a record of relevant immunisations;
- the principles and practice of prevention and control of infection are included in induction and training programmes for new staff. The principles include ensuring that policies are up-to-date, feedback from audit results, examples of good practice and action needed to correct poor practice;
- there is appropriate ongoing education for existing staff (including support staff, volunteers, agency/locum staff and staff employed by contractors), which should incorporate the principles and practice of prevention and control of infection;
- there is a record of training and updates for all staff;
- the responsibilities of each member of staff for the prevention and control of infection are reflected in their job description and in any personal development plan or appraisal.

J2. Principles of Staff Health in Care Homes

Care home staff are not in general at increased risk of acquiring communicable diseases. However, it is wise to take some basic precautions:

- Keep a record of staff immunisation histories, to facilitate action should an incident occur;
- Consider the need to vaccinate staff who have not completed a primary course of the following routine childhood vaccine:
 - Diphtheria;
 - Tetanus;
 - Polio;
 - MMR for those 35 and under (2 doses 3 months apart);
 - Meningitis C vaccine for those 25 and under (1 dose).
- The Control of Substances Hazardous to Health (COSHH) Regulations 1994 require employers to undertake a risk assessment of their environment and to bring into effect measures necessary to protect their workers who may be exposed to Hepatitis B (Green Book);
- Employers are expected to organise and pay for vaccination of any workers who are considered to be at risk. They are also expected to keep records of who has been vaccinated;
- Staff who regularly handle sharps e.g. needles, cannulae, lancets etc., which may be contaminated with the blood of others, should have a full course of Hepatitis B vaccine, including measurement of antibody levels. (Blood test 2 months after final dose of vaccine);
- Details of the schedules are available in the DOH document “Immunisation Against Infectious Disease 2006” The Green Book found at www.dh.gov.uk . Staff should be aware of “sharps injury” procedure (**Refer Section E – Management of Sharps**);

- Staff from countries with high incidence of TB should be assessed on employment and on an annual basis for symptoms suggestive of tuberculosis e.g. persistent cough, weight loss, night fevers etc. The review should be on an individual basis with a face-to-face interview

A list of countries classified as high risk defined as a rate of TB equal to or more than 40 per 100,000 population can be found at the end of this section and is also available from the HPA website (www.gov.uk/phe.uk by entering into estimates of TB in the search engine);

- Consider BCG vaccination for staff under 35 years old whose parents or grandparents were born in a TB high prevalence country;
- Influenza Immunisation – the DOH recommend that social care employers (especially nursing and care homes where older people are cared for) should offer yearly immunisation to their staff. This is a very important measure to protect the residents of care homes, in whom vaccination is less effective than in younger age groups.

SECTION K – PETS and PESTS

K1. Introduction

This guideline sets out the procedures for staff to follow for pets.

Management and staff in a care home have the responsibility for the care and management of pets, if there are any, in the home.

K2. Pets

Pets can often enhance the quality of life for the ageing and the ill. However, many types of animal often kept as pets can be the source of human infection, including exotic species such as reptiles, fish or birds. Sensible precautions can reduce any infection risk to an acceptable level.

All animals should be regularly groomed and checked for signs of infection, flea infestation, or other illness. If pets become ill, diagnosis and treatment by a vet should be sought. All animals should have received relevant inoculations. Dogs and cats should be wormed regularly, as directed by a vet, and be subject to a regular programme of flea prevention.

Hands should be washed following any contact with animals, their bedding or litter.

Pets should not be fed in the kitchen or other food preparation areas and their dishes and utensils should be washed separately from other household articles.

Once opened, pet food containers should be kept separate from food for human consumption.

Food not consumed in one hour should be taken away or covered to prevent attracting pests.

K3. Litter Box Care

Take particular care if you are pregnant.

Always wear a protective apron and gloves when cleaning the litter box.

Always wash hands immediately after removing protective clothing.

If possible, fit a disposable liner to the box for easy cleaning.

Soiled litter should be changed daily.

Litter should be sealed in a plastic bag and disposed of in household waste.

The litter box should not be sited near food preparation, storage or eating areas.

The litter box should be disinfected whenever the litter is changed by being filled with boiling water which is allowed to stand for at least 5 minutes in order to kill toxoplasmosis eggs and other organisms.

K4. Pests

Pests may be found in any property but with sensible precautions will not present an infection risk to residents and staff.

These include:

- **Insects** ants, flies, cockroaches, fleas, silverfish
- **Rodents** rats and mice
- **Birds** pigeons, magpies, sparrows, etc.

Feral cats and foxes

Kitchen and food stores provide ideal conditions for pests. Not only do they eat the food but also they contaminate and spoil a lot more.

Control measures should include the following:

- Stop pests getting in by fly screens, well-fitting doors, covered drains and bird netting;
- Look out for droppings, nests, chew-marks on wood or cables;
- Discard any foodstuffs or other articles affected by pests, including milk from bottles, the tops of which have been pecked by birds;
- Clean up any spillage and decaying food immediately. Carry out regular inspection and rotate any stock. Use rodent-proof containers with well-fitting lids. Store food off the ground.

If any pests are found the local Environmental Health office should be contacted.

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SECTION M – CARE HOME AUDIT TOOL

AREA _____

DATE _____

TIME _____

CARE HOME ADDRESS _____

NAME OF C.D.C.N. _____

CARE HOME REPRESENTATIVE _____

Infection Control Audit Tool Guidance

How to use the audit tool

This tool is to be used by Infection Control Nurses and others interested in infection control (i.e. Infection Control Link Practitioners etc.) to assess infection control practices within their establishment. It includes criterion that determines whether the organisation or the area being audited has comprehensive policies, procedures and structures in place to ensure appropriate infection control practices.

Planning the audit programme

The tool is meant for conducting infection control audit and producing audit reports. To minimize disruption of activities in the area to be audited and to ensure that locations are accessible, relevant information, documentation and personnel are available, adequate planning should take place with the relevant personnel from the area to be audited.

Time required

Different areas will require more time to audit than others but generally adequate time is needed so that things are not rushed through without getting the necessary information.

Scoring

All criteria should be marked either 'Yes' for achieved, 'No' for not achieved and 'N/A' for not applicable. It is not acceptable to enter an 'N/A' response where a national standard must be achieved.

Example 1:

	Hand hygiene	Yes	No	N/A	Comments
	The organisation has comprehensive procedures and policy for hand hygiene				

In example 1 above it is not appropriate to mark 'N/A' because it is a national standard to have a hand hygiene policy. If it is not available a 'No' score must be entered. The action plan will then reflect that change in practice required. If a standard is not achievable because a facility is absent or a practice not undertaken the use of 'N/A' is acceptable.

Comments should be written on the form for each of the criteria at the time of the audit, clearly identifying any issues of concern and areas of good practice. They should also include reasons for achieving, or not achieving, the criterion and specific training needs. These comments can then be incorporated into the final report.

Whilst it is not essential to issue scores to managers, it is useful for them to be recorded for annual comparison of compliance to policies. Comments made can indicate where some compliance has been observed e.g. eight out of ten sharps boxes are labelled.

Scoring should be carried out as follows:-

Add the total number of 'Yes' answers and divide by the total number of questions answered (including all 'Yes' and 'No' answers) excluding the 'N/A' and then multiply by 100 to get the percentage.

Formula:-

$$\frac{\text{Total number of yes answers}}{\text{Total number of yes and no responses}} \times 100 = \%$$

Example 2:

	Hand hygiene	Yes	No	N/A	Comments
2	Hand hygiene is integral part of induction for all staff		✓		Hand hygiene is not integral part of induction for new staff
3	Staff have received training in hand hygiene procedures (ask a staff member)	✓			
4	Clinical staff nails are short clean and free from nail extensions and varnish	✓			

In example 2, using the formula, the responses should be calculated as follows:

$$\frac{2}{3} \times 100 = 66.6 = 67\%$$

Where more than one audit tool has been used in an individual ward or department, like the kitchen environment and hand hygiene, each score from each audit tool should be added and then divided by the number of audit tools used. This will give an overall audit percentage score for the department or unit.

Compliance level

Using the compliance categories, as below, percentage scores can be allocated a level of compliance as follows:

Compliant	85% or above
Partial compliance	75 to 84%
Minimal compliance	74% or below

Allocation of compliance level for more than one audit score (overall rating)

Compliance level can be allocated to an individual clinical area, like a ward, based on the overall scores of the several audit tools used or to a standard across a Trust or Company, for instance sharps management standards.

It must be noted that the overall level of compliance in these instances can only be compliant **if all overall scores are 85% or more**.

Consider the overall compliance level or overall rating in the tables below:

Ward A: Audit of general infection control standards	
Environment	86%
Waste	91%
Sharps	80%
Linen	87%
Hand hygiene	91%
Total	435 divided by 5 = 87%

The overall rating will be **Partial Compliance** because one standard (Sharps) is below 85%, this being the minimum score compliant.

Audit of sharps standards across surgical directorate	
Ward A	85%
Ward B	91%
Ward C	90%
Ward D	96%
Ward E	98%
Total	460 divided by 5 = 92%

The overall rating will be **Compliant** because all the areas scored above 85%.

Feedback of information and report findings

Before leaving it is advisable that the auditor should give a verbal report about any areas of concern and of good practice to the person in charge of the area audited. This should be followed by a written report that clearly identifies areas requiring action by the auditor, to the relevant manager for action.

Where there are concerns or minimal compliance observed it may be necessary to re-audit the area. A system of feedback between the unit and the infection control

team must be in place to monitor the action taken and progress being made. This may involve feedback meetings or the return of completed action plans.

Feedback form samples/templates

To help facilitate report writing after auditing, sample forms or templates have been provided at the end of this document. Auditors are free to use them as a guide when writing their report.

M1. Environment

M1.1. General Environment

Standard Statement: The environment will be maintained appropriately to reduce the risk of cross-infection.

		Yes	No	N/A	Comments
1	Is there a cleaning schedule available for inspection (evidence of a used tick sheet)				
2	Overall appearance of the environment is tidy and uncluttered with only appropriate, clean and well-maintained furniture is being used				
3	Fabric of the environment and equipment smells clean, fresh and pleasant				
4	Rooms allocated for clinical practice are fit for the purpose and not carpeted				
5	Floor coverings are washable and impervious to moisture and are sealed regularly				
6	Floors, including edges and corners, are visibly clean with no visible body substances, dust, dirt or debris				
7	Furniture, fixtures and fittings should be visibly clean with no body substances, dust, dirt, debris or adhesive tape				

		Yes	No	N/A	Comments
8	Furniture (chairs and couches) in communal client/patient areas are made of impermeable and washable materials				
9	Furniture is free from rips and tears				
10	Medical equipment, e.g. lifting aids, is cleaned, maintained and stored appropriately				
11	Hoist slings are allocated to one resident only				
12	Pillows are covered with washable and impervious materials				
13	There is a procedure in place to regularly decontaminate curtains and blinds, minimum yearly, but also when contaminated with body fluids and following an outbreak of Diarrhoea and Vomiting				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M1.2. Surfaces

		Yes	No	N/A	Comments
1	Carpets vacuumed daily				
2	Carpets deep cleaned 6 monthly (see cleaning record)				
3	Hard floors vacuumed daily				
4	Hard floors damp mopped daily				
5	Hard floors washed/scrubbed weekly				
6	Mops stored dry/inverted				
7	Mop heads machine-washed weekly in GPD				
8	Flat surfaces damp dusted daily				
9	Correct dilution of disinfectants used				
10	Dilution chart accessible				
12	Disinfectants stored in a locked cupboard (COSHH)				
13	Carpets are cleaned after spillages of body fluids				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M1.3. Kitchens

		Yes	No	N/A	Comments
1	Kitchen is regularly inspected by Environmental Health Department				
2	Separate handwash basin available				
3	Liquid soap available				
4	Paper towels available				
5	Foot-operated and labelled waste bin available				
6	No evidence of infestation or animals in the kitchen				
7	Floor visibly clean, free of dust, grit, litter, water or other liquids				
8	Cleaning materials accessible, and away from food				
9	Cleaning equipment colour coded (green), and stored separately from other cleaning materials				
10	Drying cloths are disposable (paper roll)				
11	Opened foods are labelled with name and date of opening and in pest-proof containers				
12	Bread is stored in a clean bread bin				
13	Milk stored in fridge				
14	Food within expiry date				

		Yes	No	N/A	Comments
15	Microwave and toaster are visibly clean				
16	All cooking appliances are visibly clean				
17	Kitchen trolley is clean and in good state of repair				
18	Kitchen free from left-over food				
19	There is a satisfactory system for cleaning crockery and cutlery e.g. dishwasher with a planned maintenance programme				
20	Water coolers are visibly clean and on a planned maintenance scheme				
21	Fridge/freezers are clean and free of ice build-up				
22	Fridge/freezers have thermometers, temperatures taken daily and appropriate action is taken if standards are not met i.e. fridge temperature less than 5° C and freezer less than -18°C				
23	Fridge free from specimens and drugs				
24	Hands washed prior to the handling of food				
25	Staff aware of policy regarding sickness				
26	There are no inappropriate items or equipment in the kitchen				

		Yes	No	N/A	Comments
27	Fly screens are in place where required				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M1.4. Bedrooms

		Yes	No	N/A	Comments
The following areas are all clean and free from stains and dust:					
1	Beds				
2	Mattresses and covers in good condition (select a bed at random and undertake a mattress test ¹)				
3	Lockers and wardrobes				
4	Bedside tables and chairs				
5	Floor including edges and corners				
6	Curtains and blinds				
7	Handwash basins clean				
8	Clients have individual towels/toiletries				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

¹ Mattress Test: examine the mattress – there should be no staining visible and the mattress should be impermeable to fluids (Place paper beneath the cover and press down for 10 seconds. Pour 30mls of water onto area and press for 30 seconds. Remove an examine paper towel for signs of leakage beneath cover).

M1.5. Bathrooms and Toilets

		Yes	No	N/A	Comments
1	Baths and bath mats are cleaned after each client use				
2	Appropriate cleaning materials are available for staff use				
3	Cleaning materials available and stored correctly				
4	There is evidence that baths, sinks, taps and showers not in use are run through at least weekly				
5	Handwash basin in each bathroom/toilet is visibly clean				
6	Paper towels and liquid soap are available				
7	Waste bins are foot-operated				
8	Shower curtains and bath mats are free from mould, clean and dry				
9	Walls tiles and wall fixtures are clean, intact and free from mould				
10	Floors, including edges are free of dust and grit				
11	Hoists are cleaned after use				
12	Nothing stored on edges of baths/basins				
13	Toilets are clean and free from organic matter even under the toilet seat				
14	Clients have their own toiletries				

		Yes	No	N/A	Comments
15	There is evidence that Jet type baths are serviced and cleaned according to the manufacturer's instructions				
16	There is evidence that the Jet type baths are operated weekly when not regularly used by the service user				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M1.6. Sluice Areas

		Yes	No	N/A	Comments
1	There is a separate area for cleaning sanichairs etc				
2	Appropriate facilities are available and in working order to ensure correct disposal (or disinfection) of bedpans and urinals e.g. washer disinfector or macerator				
3	Washer disinfector/macerators are used according to the manufacturer's instructions				
4	There is a regular maintenance plan in place for washer disinfector/macerators				
5	Manual cleaning is not the recommended procedure but where there is no other facilities the correct procedure is used				
6	Sanichairs/bedpans/urinals stored clean and dry, on racks (urinals inverted)				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M2. Infection Control Practice

Standard Statement: The premises are kept clean, hygienic and free from offensive odours throughout, and systems are in place to control the spread of infection, in accordance with relevant legislation and published guidance.

		Yes	No	N/A	Comments
1	Check supplies of: Latex/vinyl gloves, plastic aprons, soap/paper towels, appropriate waste bags and Alginate laundry bags.				
2	Current Infection Control policy accessible to all staff				
3	Outbreak plan readily available				
4	Clients can be segregated in the event of an outbreak				
5	Staff education programme in place				
6	Staff report communicable disease i.e. Scabies or gastroenteritis, to manager				
7	Managers report and document outbreaks to EHPT, CQC and EHOs as appropriate				
8	Staff remain off sick until treated/clinically well				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

Standard Statement: Hands will be decontaminated correctly and in a timely manner using a cleansing agent to reduce risk of cross-infection.

		Yes	No	N/A	Comments
1	The hand hygiene policy/procedural guidance is available to all staff				
2	Staff have received training in hand hygiene procedures (ask staff)				
3	Hand hygiene is an integral part of induction for all staff				
4	Handwashing sinks in clients' bedrooms are accessible with functional liquid soap and paper towel dispensers				
5	Liquid soap is available at all handwashing sinks				
6	Liquid soap must be single-use cartridge dispensers				
7	Wall-mounted or pump dispenser hand cream is available for use				
8	There are no plugs or overflows or water from taps passing directly into the plug hole of handwashing basins				
9	Soap and alcoholic handrub dispenser nozzles are visibly clean				
10	Soft absorbent paper towels are available at all handwashing sinks				
11	Handwashing sinks are free from used and inappropriate items				
12	Clinical staff nails are short, clean and free from nail extensions and varnish				

		Yes	No	N/A	Comments
13	No wrist watches, stoned rings or other wrist jewellery are worn during clinical procedures				
14	There are no nail-brushes on handwashing sinks				
15	Bar soaps are not present on sinks				
16	Elbow/mixer taps are available in all handwashing sinks				
17	Handwashing sinks are visibly clean				
18	Alcohol handrub is available for hand disinfection *				
19	Handwashing sinks are located in all areas where clinical practice takes place				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

*Provided correct handwashing facilities are available (see 16), alcohol handrubs are not necessary, and this category may be marked N/A.

M2.2. Personal Protective Equipment (PPE)

Standard statement: Personal protective equipment is available and is used appropriately to reduce the risk of cross-infection.

		Yes	No	N/A	Comments
1	There is a comprehensive policies/procedures manual that includes the appropriate use of PPE				
2	The staff are trained in the use of PPE as part of their induction				
3	Sterile and non-sterile non-powdered latex/vinyl/nitrile based gloves are available in all clinical areas				
4	Alternatives to natural rubber latex (NRL) are available for use by staff who are sensitive to NRL				
5	Gloves are available in a range of sizes				
6	Gloves are used as single-use items for each clinical procedure or patient episode				
7	Gloves are stored appropriately				
8	Hands are decontaminated following the removal of gloves (observe 2 or 3 healthcare workers)				
9	Disposable plastic colour-coded aprons are available				
10	Disposable plastic aprons are used by staff when there is the risk of clothing or uniform contamination				

		Yes	No	N/A	Comments
11	Disposable plastic aprons are used as single-use items for each clinical activity of patient care				
12	Plastic goggles and face masks or visors are used when there is a risk of body fluid splashing into the face and eyes				
13	Used protective clothing is disposed of appropriately				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M2.3. Spillages

Standard Statement: The healthcare worker will demonstrate safe handling and disposal of all body fluids.

		Yes	No	N/A	Comments
1	Staff are familiar with the policy for dealing with spills of body fluids				
2	Appropriate disinfectants are available for cleaning all body fluid spillages such as Sodium hypochlorite solution in the strength 1:10,000ppm				
3	The procedure for clearing away spillages is followed as per Essex Health Protection Team (EHPT) Infection Control Guidelines				
4	A spillage kit is available				
5	Furniture that has been contaminated with body substances and cannot be cleaned is condemned				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				
	Status				%
	Date of next audit				

M2.4. Laundry Management

Standard Statement: Linen is managed and handled appropriately to prevent cross-infection.

		Yes	No	N/A	Comments
1	Clean linen is stored away from dirty linen and in a dust-free environment				
2	Soiled linen is washed immediately				
3	Soluble/Alginate bags are used for foul and/or infected linen				
4	Linen washed at 65°C for not less than 10 minutes or as high as the manufacturers' recommended temperature				
5	Linen is ironed before use				
6	Personal linen is designated for each client's use				
7	The washing machine (industrial) is operated according to the manufacturers' guidance and is regularly maintained (see service record)				
8	The tumble dryer (industrial) is operated according to the manufacturers' guidance and is regularly maintained				
9	Handwashing facilities are available within the laundry room				
	Totals				
	Over all scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M2.5. Waste Disposal

Standard Statement: All waste from healthcare premises is segregated and identified at source, transported and disposed of safely without risk of contamination, infection or injury to healthcare staff and the general public, and in accordance with legislation.

		Yes	No	N/A	Comments
1	There is a comprehensive policy/procedure in place including waste disposal				
2	There is evidence that the home is registered with a licensed waste contractor (check records)				
3	Staff have attended training sessions about correct and safe disposal of healthcare waste (check training records)				
4	Waste is correctly segregated (according to regulation in force) into clinical and household waste				
5	Correctly colour-coded waste bins/bags are used				
6	Waste bags are no more than 2/3rds full, secured and labelled prior to disposal				
7	Waste bins are visibly clean inside and out				
8	There is a dedicated area for the storage of healthcare waste, which is under cover from the elements, free from vermin and pests and the area locked and inaccessible to animals and the public				

		Yes	No	N/A	Comments
9	All waste is collected on a regular basis by a licensed contractor, at least once a week				
10	Consignment notes kept and up to date				
11	The producer of the waste realises their duty of care to ensure waste is incinerated				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M2.6. Handling of Sharps

Standard statement: Sharps/needlestick injuries, bites and splashes involving blood or other body fluids are managed in a way that reduces the risk of injury or infection.

		Yes	No	N/A	Comments
1	Sharps container used conforms to BS 7320/UN 3291, and is assembled correctly				
2	Bins are stored safely and off the floor away from the public and out of reach of children				
3	Sharps containers are available for use and located within easy reach				
4	The box is not filled beyond the indicator mark i.e. less than 2/3rds full and there are no protruding sharps				
5	Sharps are disposed of directly at the point of use				
6	All sharp bins are labelled and signed according to policy				
7	Full sharps bins are locked, sealed and kept in a locked area prior to collection				
8	All staff are aware of what action should be taken following a sharps injury (question a member of staff)				

		Yes	No	N/A	Comments
9	Staff who are involved with clinical practice such as giving injections, obtaining blood samples and dealing with blood spillages are vaccinated against Hepatitis B and there is documented proof of this e.g. blood glucose monitoring				
10	Syringes with a residue of Prescribed Only Medication are disposed of according to current legislation				
11	The temporary closure mechanism is used when the bin is not in use				
12	Full sharps containers are sealed only with the integral lock and tape or stickers are not used				
13	Sharps containers are not placed in waste bags prior to disposal				
14	Sharps containers are visibly clean with no body substances, dust, dirt or debris				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M2.7. Guidelines, Policies and Standards

Standard Statement: There are written policies and procedures that demonstrate infection prevention and control for all client care.

		Yes	No	N/A	Comments
1	Current infection control policy is available				
2	Infection control policy is easily accessible to all staff				
3	There are at least 2 members of staff aware of the content of the policy				
4	Staff are aware of the notification procedure for notifiable infectious diseases				
	Totals				
	Overall scoring				
	Potential total				
	Percentage				%
	Status				
	Date of next audit				

M3. Feedback Forms

AUDIT OF INFECTION CONTROL STANDARDS

Summary Feedback Report

Sheet One

Clinical Setting		Date	
Location		Auditor(s)	
Audit Tool		% score for compliance	
Compliance Rating			
Evidence of quality care and best practice			
Summary of areas of non-compliance			

INFECTION CONTROL AUDIT

Feedback Report to Departmental Staff

Sheet Two

Date			
Location			
Compliance Rating			
Audit Tool			
Area of non-compliance. The following criteria were not met and a score was recorded	Target date for review	Action taken	Signed

INFECTION CONTROL AUDIT

Audit Summary Report

Date			
Location			
Compliance Rating			
Audit Tool			
Question	Result	Positive Comments	Negative Comments

REPORT TEMPLATE

Single audit tool report for several areas

1. Introduction

The audit tool was used over the following areas

The date range selected for this report was from _____ to _____

2. Overall score and level of compliance for the audits undertaken

A total of audits were undertaken using the.....

The overall score was % with a compliance rating of

Figure 1: Overall compliance to the standard per location/clinical area

3. Percentage compliance to each of the criteria scoring or above

4. Percentage compliance to each of the criteria scoring below

5. Main findings

6. Recommendation for action

7. Conclusions

REPORT TEMPLATE

All audits completed in a given time period

1. Introduction

This report covers the period from _____ to _____

2. Overall score and compliance rating for each of the audit tools used

3. Main Findings

4. Recommendations for action

5. Conclusions

REPORT TEMPLATE

Annual report making comparisons with previous years data

1. Introduction

This report covers the period from _____ to _____

2. Overall score and compliance rating for each of the audit tools used

3. Main Findings

4. Recommendations for action

5. Conclusions