The North Thoresby Practice

Infection Prevention and Control Policy

The North Thoresby Practice recognises the importance of working within an environment that promotes good effective infection control measures.

Wherever possible staff should use the guidance and information supplied by the Health Protection Agency (HPA). This will be available when HSCN take over the N3 connection from BT in the Lincolnshire practices as the link will be available to access on all computers to all staff.

Contents:

Infection Control Contact Details

1. Introduction
2. Purpose and Scope
3. Duties and Responsibilities
4. Approval Ratification and Review Process
5. Monitoring compliance and effectiveness
6. Stand Precautions
   1. Hand Hygiene
   2. PPE (Personal Protective Equipment)
   3. Safe use and Disposal of Sharps
      1. *Immediate action for Sharps injury*
   4. Managing spills
   5. Specimen Handling
   6. Waste Management
   7. Cleaning of Medical Equipment and environment
   8. Decontamination of Equipment
7. Storage of Sterile Instruments
8. Aseptic Technique
9. Management of Chronic Wounds
   1. Wound swabbing
10. Minor Surgery Room/ Treatment Room

Infection Control Contact Details

**Surgery Leads and facilitator**:

Jane Hickinson ANP/Nurse Manager

Lyndsey Evans; practice link nurse

Mary Sutton HCA – facilitator

**CCG Contact**

Health Protection

Cross O’Cliff Court

Bracebridge Heath

LINCOLN

LN4 2HN

Switchboard: 01522 513355

**Health Protection Agency – local area**

PHE East Midlands Health Protection Team

Public Health England

Seaton House City Link

NOTTINGHAM

NG2 4LA

Tel: 0344 2254 524 (opt 1)

OOH: 0344 2254 524 (opt 1)

**HPA** [www.hpa.org.uk](http://www.hpa.org.uk)

1. **Introduction**

Healthcare association infections (HCAI) are infections that are acquired following admission to hospitals or as a result of healthcare interventions in other healthcare facilities. There are a wide range of pathogens and communicable diseases besides Methicillin Resistant Staphylococcus Aureus (MRSA) and Clostridium difficile (CDI). Much of the morbidity and mortality associated with HCAI is preventable, and there is ongoing public and political interest in ensuring that the risks or preventable infections are minimised. Infection control is also an indicator of broader clinical governance and quality issues in every establishment.

Healthcare workers may also acquire infections related to exposure to micro-organisms at their workplace. The guidelines produce necessary guidance to identify and minimise the risk of infections and diseases. Extensive research has shown that cleanliness contributes to infection control and a clean environment is the vest platform to tackle healthcare associated infections. The Department of Health recommend the implementation of good infection control techniques and regular auditing to make sure standards are kept and updated as the need requires.

1. **Purpose and Scope**

This document is set out to provide guidelines on infection prevention and control within the practice in order to reduce HCAI and to reduce transmission of infections to healthcare professionals and patients.

1. **Duties and Responsibilities**

Every member of staff has a duty of care to prevent healthcare associated infection and all arrangements in the practices should comply with the following legislations.

The Health and Safety at Work Act (1974) ensures that employers provide, when possible, a safe environment not only for employees but all those visiting the working area, it also requires the employees to be responsible for their own safety and that of others.

Health and Safety at Work Regulations (1999) ensures that the employers to risk assess anything that may be detrimental to the employees’ health and put control measures in place. In relation to infection control, the employers have a responsibility to ensure that staff is protected from exposure to infectious hazards through safer systems of work. These include; personal protective equipment, hand washing facilities, safe disposal of waste and safe handling, storage and carriage of specimens.

The Control of Substances Hazardous to Health (COSHH) Regulations (2002 offers

Guidance regarding the protection against hazardous substances, including chemical and biological agents in the workplace. In order to make sure this is adhered to the employer needs to make sure that there are policies and guidance in place and they are implemented, regularly reviewed and updated.

1. *This policy will be reviewed every 2 years or sooner if any relevant guidelines contradict the contents of this policy.*
2. **Monitoring compliance and effectiveness**

*Monitoring Group in the practice*

The ANP and link nurse are the infection control leads and the HCA is also involved in the monitoring of the service. The partners have overall responsibility in ensuring effective infection control practices in the practice. Other practice staff, such as receptionists and dispensary staff are encouraged to attend relevant training as identified by the practice and/or kept up to date at their own department meetings as well as reading minutes from nurse meetings.

Infection control should be a standing item on nurse meeting agendas and any infection control issues discussed and actions agreed to improve infection control reported on.

The practice should aim to provide assurance that the risks of healthcare associated infections are minimised and that services are delivered in a safe and clean environment.

The practice should ensure development and implementation of action plans from ongoing assessments and audits submitted by the practice

The practice also has the responsibility to

* Ensure that the practice is compliant with the Code of Practice for The Health & Social Cre Act 2008
* Ensure that the practice is compliant with the required staff immunisation programme; and that records of immunisation are kept for the Care Quality Commission (CQC) inspection.
* Ensure that all clinical staff have a yearly mandatory training update on infection control and that records are kept for CQC inspection.

5.1 **Infection Control Link (IC link) within the practice**

One member of the senior staff should be appointed as IC Link. This person will have gone through a basic training course on infection control to take on the lead on infection control. He/she can attain further inputs on current practices in infection control through attending seminars and/or conferences on infection control. This should be part of the staff CPD.

The IC link is Lyndsey Evans. Attendance at the quarterly CCG link meetings and minutes will be made available.

1. **Standard precautions**

Standard precautions were formally known as Universal Precautions and were developed in the 1980’s during the HIV/Aid’s epidemic. They were developed in order to protect healthcare workers from blood borne viruses. These have since been adapted and renamed Standard precautions so they are used within normal practice.

Standard precautions consist of nine elements based on the use of practices and procedures to prevent or reduce the likelihood of an infection being transmitted:

* Handy hygiene
* Personal Protective Equipment (PPE)
* Safe use and disposal of sharps
* Safe handling and disposal of waste
* Maintenance of a clean clinical environment
* Decontamination of equipment
* Storage of sterile equipment

6.1 **Hand Hygiene**

Hand washing is the single most important means of controlling the spread f infection. The micro-organisms on the hands are grouped into two categories – resident and transient flora. Resident flora are usually of low virulence and rarely cause infections except when introduced onto the body through introduction of a urinary catheter or an open wound. Transient flora may consist of any different pathogenic micro-organisms. They are not firmly attached to the skin and can usually be removed quickly and effectively with soap and water.

Hand should be decontaminated either by washing or using an alcohol hand gel after every patient contact. If hands are visibly dirty and have been in contact with blood or body fluids, the choice for hand hygiene should be handwashing.

Alcoholic hand gel, if used, should be rubbed into hands using the “six stages of Handwashing Technique (see 6.1.2)

The purpose of hand hygiene with adequate drying is to remove transient microbial contamination that has been acquired during contact. The hands should ve dried properly after washing because this reduces the number of organisms subsequently released from the hands.

Dedicated hand washing basins should be available in all clinical areas including consultation room, treatment room, and other clinical rooms. They should be fitted with elbow operated mixer taps.

Yearly hand hygiene training for all staff in the practice and records of training should be available at all times.

Examples when hand washing should take place are:

* Before preparing, handling or eating food
* After visiting the toilet
* Whenever hands are visibly dirty
* After removing gloves
* Before wearing sterile gloves
* Before and after examining patients
* Before and after administering medications
* After any possible action that may have resulted in microbial contamination
* Before and after handling wounds, catheters, intravenous lines etc
* Before and after handling urine specimen samples
* Before caring for those patients who are immune-compromised
* Before starting work and after you have finished
* After handling contaminated waste and/or laundry

**Hand Washing Agents**

Hand Washing Agents Instructions for Use

Liquid Soap Disposable paper towels should be used for

hand drying and dispensed from a wall mounted

dispenser

Chlorhexidine (eg Hibiscrub) or These preparations should be used prior to minor

Providine 7.5% (surgical scrub eg surgery,

Betadine) NOT for routine use. Wet hands and forearms, apply

Solution and wash for 2 minutes. Ensure individual fingers

And thumbs are washed. Rinse. Dry hands thoroughly using

Sterile paper towels before putting on sterile gloves

6.1.1 **Hand washing technique**

An appropriate technique for handwashing will ensure that hands are cleaned effectively. What follows is a good, basic technique that should be followed every time hands are washed in the clinical environment.

* Get water to correct temperature, not too hot or too cold
* Wet your hands before putting liquid soap on
* One squirt of liquid soap
* Perform six stage handwashing technique for 1—20 seconds of rubbing see 6.1.2), remember to include the wrists
* Rinse hands thoroughly – remove all traces of soap
* Dry hands with paper towels – especially between fingers
* Dispose of paper towels into foot-operated domestic waste bin
* Turn taps off – with elbows if elbow operated taps or with a clean, dry paper towel.

6.1.2 **Six Stages Hand Washing Technique**

Rinse the hands under running water and apply soap



The hands should then be placed underneath running water to ensure all soap is off the hands, any soap left on the hands may result in skin irritation. Hands should be thoroughly dried with hand towels. An alcohol based gel can be used when hands are physically clean i.e. have no visible dirt and the technique used to wash hands can be rub the alcohol gel until dry, It the patient has or is suspected to have Clostridium Diffcille (C Diff) the alcohol gel alone is not efficient enough in killing the spores. Therefore, the hands should be thoroughly washed and followed by alcohol gel. A moisturising lotion should also be made available to help prevent the skin from drying out following frequent hand washing.

**Requirements**

In order to carry out this washing technique the following things need to be in place:

* Easy accessible sinks
* Hot and cold mixer taps
* Elbow or wrist operating taps to reduce the risk of hand contamination
* Liquid soap with disposable cartridges, soap bars are not suitable for the clinical setting as they can colonise bacteria which therefore make them a source of cress-infection.
* Wall mounted paper towel dispensers. Reusable towels are not suitable within the clinical setting as they may be contaminated with micro-organisms and, therefore, a source of cross-infection.
* Nail brushes should not be used within the clinical setting
* Alcohol hand rub should be made available to disinfect hands when they are already physically clean (have no visible dirt)

6.2 **Personal Protective Equipment (PPE)**

The Personal Protective Equipment Regulations (1992) require the assessment of where personal protective equipment (PPE) needs to be used. The equipment needs to be suitable and sufficient for the task and to comply with CE or BS standards.

Protective clothing aims to prevent the transmission of micro-organisms between patients and heath care staff. The need to wear protective clothing will depend upon the potential risk associated with the planned task. It is the healthcare worker’s responsibility to assess this risk and decide upon the necessary clothing as appropriate.

6.2.1 **Disposable plastic aprons**

Disposable plastic aprons should be worn when contamination of clothing with blood and body fluids is anticipated. Plastic aprons should be discarded after each procedure and between patients and disposed of any clinical waste.

6.2.2 **Mouth and nose masks**

Masks should be available for use for procedures where blood or bodily fluids are likely to splash onto the face. The masks are disposable and should be thrown away following use.

6.2.3 **Gloves**

Disposable gloves should be worn when contact with blood/body fluids is anticipated, during direct contact with non-intact skin or mucous membranes or when dealing with the chemicals/hazardous substances.

Increased awareness of the need to use gloves as part of standard precautions has resulted in a significant usage. It is important to note that gloves are an additional precaution and should not be solely relied upon as a barrier to infection.

* Risk assessment must be made for each patient contact with known infectious disease. eg Methicillin Resistant Staphylococcus Aureus (MRSA) that the correct protective clothing is worn.
* Supplies of disposable gloves, aprons and masks (if necessary) should be accessible in clinical rooms and treatment rooms.

6.2.4 **Essentials of glove usage**

* Glove usage should be decided following a risk assessment of the planned task e.g. consideration of: who is at risk (patient or healthcare worker and whether sterile/non sterile gloves are needed; the potential for exposure to blood, body fluids, secretions and excretions; contact with non-intact skin or mucous membranes during general care and invasive procedures.
* Gloves must be worn for invasive membranes and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions or sharp/contaminated instruments.
* Gloves should not be worn as an alternative to hand washing. It is vital that good hand hygiene is maintained
* Hands should be washed before and after glove use.
* Gloves should be changed after each procedure and between patients
* Never re-use disposable gloves
* Reports of latex allergy are increasing. Therefore, prolonged, unnecessary usage should be avoided.
* Non-powdered latex gloves must be used as standard. Evidence suggests that powdered gloves increase the risk of developing a latex allergy.
* Individuals sensitised to latex gloves must be supplied with appropriate alternatives (e.g. nitrile/synthetic vinyl (CE approved) gloves)
* Sterile gloves are indicated for aseptic or surgical procedures, especially where sterile materials are handled.

6.2.5 **Which Glove?**

Employers must provide gloves that conform to European Community Standards (CE) for safety and performance and need to provide those which are acceptable to practitioners. Disposable gloves are manufactured in variety of materials. The following is a selection of glove materials currently available.

Natural rubber latex (NRL) have been in use for over 100 years and remain the preferred material for glove manufacture and protection against blood borne viruses (BBVs) NRL gloves are close fitting, do not impair dexterity and are not prone to splitting and because of this, they are the gloves of choice when contact with blood and body fluids is anticipated.

NRL gloves can be sterile/non-sterile, depending on the task to be performed. The problem of healthcare worker/patient sensitivity to NRL proteins must be considered when deciding on glove materials.

**Nitrile/polychloroprene**

Offers a good synthetic alternative to latex but is more expensive. They can be used during procedures where dexterity is required and also when contact with blood/body fluids is anticipated. However, nitrile gloves have the chemical range as NRL and may also lead to sensitivity problems.

**Vinyl**

Vinyl gloves are inexpensive and may be suitable for use in areas where there is a low bio-hazard risk. In the past they have been considered to be rigid, inflexible and prone to break or leak when in use. They were, therefore, not considered suitable for use when dealing with blood/body fluids or when manual dexterity was required. However, in 2000, standards for the manufacturing of medical gloves for single use were devised and implemented. All gloves were then required to perform to the same standard regardless of material. It is now considered that vinyl gloves made to European Community (CE) standards provide the same level of protection NRL.

**Polythene**

Polythene gloves are not recommended for use in the clinical setting. They are ill-fitted, predisposed to splitting/tearing and providing limited protection. They must not be used when contact with blood and body fluids is anticipated.

**Sterile vs. non-sterile glove**

Sterile gloves should be worn during all surgical procedures, during aseptic invasive procedures with potential exposure with blood/body fluids and during sterile pharmaceutical.

Non-sterile gloves are required during procedures when hands are likely to become contaminated with organic matter and micro-organisms (e.g. removing dressings, venepuncture, cleaning blood/body fluids spills)

6.2.6 **Latex Sensitivity**

As the use of latex gloves has increased, reports of latex sensitivity amongst health care workers and patients have risen. The risk of allergic reaction is not only related to gloves but can involve other latex based devises. Reactions are classified as:

* Delayed hypersensitivity (type IV) resulting in contact dermatitis. This is the most common hypersensitivity reaction to NRL. Response occurs between 6-48 hours after exposure.
* Immediate hypersensitivity (type I) – Anaphylactic shock/collapse. Response occurs 5-30 minutes after exposure. Individuals with history of anaphylaxis caused by latex must avoid the use of latex gloves and devices.

6.2.7 **High risk populations**

The following groups appear to have an increased risk of developing a latex allergy:

* Individuals with frequent occupational exposure
* Atopic individuals – those with a predisposition to allergic reactions (e.e. hay fever, asthma)
* Individuals with food allergies (e.g. bananas, avocado, tomato and kiwi fruit)
* Frequent healthcare interventions, particularly where latex decived are used (e.g. spina bifida, congenital urological abnormalities or any conditions required repeated surgical intervention)

Seek specialist advice if latex sensitivity is suspected. If the individual is sensitised, then all notes should be clearly marked (including dental and hospital notest). In type I reactions, the individual should wear a Medic Alert bracelet.

6.2.8 **Minimising the risk**

Healthcare staff

* Only use latex gloves when required. Powdered gloves are not recommended due to the increase allergy (although some form of glove should be used)
* Wash and dry hands before and after glove use
* Ensure that staff are aware of the risk of latex sensitivity and the methods to reduce it

Patients

* Ask patients about history of latex allergy. If latex allergy is known, document in notes and seek specialist advice.
* Remind patients with known allergy to inform medical professionals before any form of treatment commences.

**6.3** **Safe use and disposal of sharps**

Needlestick injuries are instrumental in the transmission of blood borne viruses. Most of these injuries occur due to mishandling of sharps. All staff should be aware of their health-related obligations and ensure that their own routine immunisations are up-to-date (including BCG, chicken pox, MMR and Hepatitis B)

Sharps include needles, scalpels, broken glass, teeth, stitch cutters, glass ampoules and any other items that may cause skin puncture or laceration. The safe handling and disposal of sharps is essential in reducing the risk of exposure to blood borne viruses. The risk of injury can be minimised by adhering to accepted good practice.

6.3.1 **Sharps, needle stick and splashing incidents**

In the event of one of the following incidents:

* Inoculation of a staff member with a patient’s blood/body fluids by a needle or other sharp item previously used on a patient
* NOT urine or faeces (unless they contain blood)
* Contamination of **broken** skin with bloody/body fluid
* Bloody/body fluid splashes in the eye, nose or mouth
* Contamination with a patient’s blood/body fluid to such a degree that a change of clothing is needed.
* Contamination or oral mucosa with blood/body fluid

**PLEASE ALSO SEE SEPARATE HEALTH & SAFETY POLICY**

**The immediate action to be taken flowing a needle stick injury is available at the practice in all clinical areas**

6.3.2 **Safe methods of work**:

* Never re-sheath contaminated needle manually
* All sharps used should conform to European standards
* Sharps should be disposed of immediately after use
* Sharps should be placed directly into an approved container by the user
* Never leave sharps to be disposed of by someone else
* Dispose of syringe and needle as one unit directly into sharp containers wherever possible
* Containers should be conveniently placed for staff use. Where appropriate, take the container to the point of use.
* Ensure that the bin is correctly assembled and that the lid is securely fastened before commencing use
* Sharps containers should not be placed on the floor, on an unstable surface or above shoulder height. They should be inaccessible to children and unauthorised persons
* Containers should be sealed and disposed of when three-quarters full (do not attempt to press down on container to make more room)  
  never attempt to retrieve any item from a sharp container
* Containers must not be placed into yellow bags prior to disposal
* If a sharps container is damaged, placed into a larger container, lock and label prior to disposal

Immediate action following an inoculation accident or accidental exposure to blood or body fluids

**IMMEDIATE ACTION**

**STOP WHAT YOU ARE DOING AND ATTEND THE INJURY**

* Encourage Bleeding of the wound by applying gentle pressure
* Do not suck
* Wash well under running water
* Dry and apply a waterproof dressing, as necessary

**If body fluids splash into eyes If body fluids splash into mouth**

**Irrigate with cold water do not swallow, rinse out**

**Several times with cold water**

* Report incident to your manager
* Complete accident form

**Initiate investigation as to the cause of the incident and risk management**

**Injury from clean/unused Injury from used needle or instrument**

**Instrument or needle - Risk assessment by GP on duty or**

**No further action likely A & E doctor**

6.3.3 **Sharps Containers**

There are several types of sharps bins currently on the market but all must conform to British Standard BS7320. 1990. When the bin is three quarters full close securely and change. The bin should be labelled with Surgery name, address and date before disposal (collection); sealed bins should not be placed in yellow bag prior to disposal. Ensure that sealed bins awaiting collection are housed in a locked area which is inaccessible to unauthorised persons. The sharps bins should be placed in the Sluice room with staff only access.

**6.4 Managing Spillages**

* Deal with blood and body fluid spills quickly and effectively
* Reception have facilities which deal with spillages
* Urine and stool contamination should be treated as an infectious clean, unless they are blood stained
* Blood stained carpet should be replaced.

***How to deal with it:***

Spillage kits at both sites healthcare worker to familiarise with. Then it may require deep cleaning so management need to be informed.

**6.5 Specimen Handling**

Please refer to separate policy

**6.6 Waste Management**

Please see separate policy.

**6.7 Cleaning of Medication Equipment & Environment**

6.7.1 **Cleaning of Medical Equipment**

* Clean medical equipment as per manufacturers’ instructions between patients
* Single use items must be disposed of after each use
* We do not now use re-usable instruments
* Cleaning schedule after use of room to be completed

6.7.2 **General Environmental Cleaning**

Please refer to cleaning schedule. Environmental cleaning is carried out by Alyson Dring and cleaning schedule and audits.

Any concerns about the standard of cleaning should be reported to the Infection Control lead or practice manager.

**6.8 Decontamination of Equipment**

Equipment to be sent for inspection, service or repair

* Equipment which has been contaminated with blood/body fluids, or has been exposed to patients with a known infectious disease should be decontaminated before being sent to third parties for inspection, service or repair and labelled as such

If equipment cannot be decontaminated (e.g. if the device needs to be dismantled by an engineer) a biohazard label should be attached, together with a completed label and the article wrapped in a strong plastic cover.

**7.** **Instruments Storage of Sterile Instruments**

Correct storage of sterile instruments is important in order to protect the integrity of sterilised equipment

* All sterile packages, including sterile fluids, are stored above the ground to avoid contamination and to allow proper cleaning of the floor.
* All sterile packages should be stored away from dirty areas and away from hand basins. Instruments in a wet package are considered non-sterile.
* Store sterile instruments in plastic or other wipeable containers, but not those made from cardboard as it sheds and creates dust and debris.
* Before use, examine wrapping for damage or damp & expiry dates.
* Expired single-use instruments should be disposed of

**8. 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 naturel 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 endotracheal suction
* Dressing tracheostomy site
* Urinary catheter change

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 the wound will be contaminated and should be disposed of safely or decontaminated for reusable instruments.

Cleaning of trolleys with 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.

**9. 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 with is separate from the hand wash sink.

The plastic liner should be disposed of and the bowl should be thoroughly cleaned with detergent and hot water and then dried to ensure that pathogens are removed. Patients should provide their own bowls and have their own bowls.

This process should be undertaken after each separate patient episode. With buckets and liners provided by the patient.

9.1 **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.

A wound should ideally be swabbed if it looks infected before commencing antibiotics.

**10. Minor Surgery Room/Treatment Room**

It is preferable to have a room dedicated for minor surgery. There should be an appropriate changing facility for the patients to respect their privacy & dignity. The general tidiness and cleanliness is not to be compromised with a strict cleaning regime.

***Requirements:***

* A mixer elbow tap hand basin with wall mounted Hibiscrub or Povidine Iodine 7.5% for hand decontamination before minor surgeries.
* The room should be clear from unnecessary storage and clutter to allow for easy cleaning at the end of each session.
* The couch should have good lighting for the procedures
* The couch should be covered with disposable couch paper and to be changed with each patient.
* The couch should be wiped down with Hypochlorite solution after each session of surgery
* Aseptic technique should be used for all minor surgeries and the trolley is to be wiped down in between patients.
* Windows should be closed with no electric fan switched on while minor surgery is in progress to prevent dispersal of dust and thus contamination to the new wound.
* All waste from this room should be treated as clinical waste, except the packaging of products.
* Disposable instruments must be disposed of at the end of each case into the sharps bin or clinical bin, if the instruments have no sharp ends.
* The horizontal surfaces of the minor surgery room must be wiped down by the nursing staff after each session; preferably with 1,000 parts if sodium hypochlorite solution made for healthcare settings (COSHH 1999)
* **Cleaning of the minor surgery room after each session must be recorded and signed by the nurse in a log book**