NHS
Somerset
Clinical Commissioning Group

INFECTION PREVENTION AND CONTROL (IP&C) GOOD PRACTICE GUIDE

A SUMMARY OF NATIONAL GUIDANCE INCLUDING THE NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE (NICE) GUIDANCE FOR PRIMARY CARE ORGANISATIONS

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INFECTION PREVENTION AND CONTROL (IP&C) GOOD PRACTICE GUIDE

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1	January 2020	Document sent to stakeholders for comment - Local Medical Council Nursing Advisor and IP&C trainer, Symphony Healthcare Services Head of Nursing and Quality, French Weir Health Centre, Frome Medical Centre, Ryalls Park Medical Centre, Lyngford Park Surgery and Tawstock Medical Centre. Somerset Clinical Commissioning Group – Associate Clinical Director of Primary Care, Patient Safety and Quality Assurance Committee, Director of Nursing, Deputy Director of Nursing, IP&C Lead, Primary Care and Care Home IP&C Nurse, Associate Director of Primary Care and Head of Quality for Primary Care.
2	February 2020	Changes made from comments gained.
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6	May 2020	Final approval
7.1	May 2021	References and links to further information updated and checked. Content updated regarding cleaning cloths and use of mop heads for environmental cleaning, references added. Information on National Standards of Healthcare Cleanliness 2021 added.

Sponsoring Director: **Editor(s):**		Sandra Corry, Director of Quality & Nursing /Infection Prevention & Control Julia Bloomfield, Infection Prevention & Control Nurse.

CONFIRMATION OF EQUALITY IMPACT ASSESSMENT FOR SOMERSET CLINICAL COMMISSIONING GROUP DOCUMENTS/POLICIES/STRATEGIES AND SERVICE REVIEWS

Main aim of the document:

All primary care organisations must comply with the Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infections, and Care Quality Commission (CQC) registration requirements. The aim of this document is to give primary care staff the national evidence based information to hand which will enable them to be complaint with the Code of Practice and to maintain public, patient and staff safety in terms of infection prevention and control which in turn will prevent the spread of infection. This document is a summary of national guidance which includes the National Institute for Health and Care Excellence (NICE) Healthcare Associated Infections Scenario (NICE 2019) located in the Clinical Knowledge Summaries aimed at primary care and general practice. This document is not a policy document nor does it replace primary care organizational policy documents, it is a good practice guide with useful links to guide primary care to national IP&C guidance.

Outcome of the Equality Impact Assessment Process:

No adverse impact identified

If relevant, outcome of the full impact assessment:

None for impact of HCAI for ethnicity, age, gender and 9 protected groups specified under equality and diversity legislation.

Actions taken and planned as a result of the equality impact assessment, with details of action plan with timescales/review dates as applicable:

All commissioned services registered to provide NHS care with the Care Quality Commission are required to adhere to the *Code of practice on the prevention and control of infections and related guidance* (2008) (Updated July 2015) and CQC Guidance for providers on meeting the regulations 2014 (Updated March 2015) and applicable from 1 April 2015 to ensure that staff remain up to date.

Groups/individuals consulted with as part of the impact assessment:

Development of this guide has been in collaboration with the Somerset Clinical Commissioning Group, Symphony Healthcare Services, a number of GP practices and the Local Medical Committee.

INFECTION PREVENTION AND CONTROL GOOD PRACTICE GUIDE FOR PRIMARY CARE

1 INTRODUCTION

1.1 The information in this document has been collated by the Infection Prevention and Control (IP&C) Team at Somerset Clinical Commissioning Group. Information has been gained from the **Clinical Knowledge Summaries commissioned and funded by National Institute for Health and Care Excellence (NICE 2019)** which is aimed at primary care organisations. The document is a tool kit and collection of information gained from the NICE website (NICE 2019) and links to other national IP&C guidelines, policies and resources from the Department of Health and Social Care, Public Health England and NHS England and Improvement.

1.2 This guide is not a policy document nor does it replace organisational IP&C policy in primary care settings. It provides links to national IP&C guidance and national IP&C policy for the use and information of primary care staff. This guide should be used alongside any existing organisational IP&C policy.

1.3 Healthcare associated infections (HCAI) can be acquired following any healthcare intervention within any healthcare setting including primary care (NICE 2019). HCAI can affect individuals of all ages. Healthcare workers, family members and carers are also at risk of acquiring infections.

1.4 It is estimated that 300,000 people a year in England acquire a healthcare associated infection as a result of National Health Service (NHS) care (NICE 2019).

1.5 The most common types of HCAI are respiratory infections (including pneumonia and infections of the lower respiratory tract; 22.8%), urinary tract infections (17.2%) and surgical site infections (15.7%) (NICE 2014, NICE 2017). The majority of morbidity and mortality associated with HCAI is considered preventable.

1.6 Standard Precautions (previously known as Universal Precautions) are infection control practices that when used consistently reduce the transmission of pathogenic micro-organisms. Implementation of standard precautions results in significant decrease in the number of HCAI, ultimately protecting patients, staff and visitors.

1.7 All primary healthcare staff are individually responsible for applying standard precautions in their own practice to reduce the risk of infection to patients/service users, colleagues and themselves.

1.8 HCAIs are those which are directly attributed to an episode of healthcare or a specific intervention. However, it is recognised that some infections arising in the community, such as Coronavirus, Influenza and Norovirus can significantly impact on the delivery of healthcare services and should be considered as a risk to the wider healthcare economy.

1.9 This guide will;

- provide clear guidance on IP&C standard precautions required in general practice to minimise acquisition of HCAI and protect the workforce.

- provide a reference to national evidenced based practice guidelines, national policy and associated policies with regards infection prevention and control, public health, health protection, estates management and health and wellbeing to ensure a comprehensive and collaborative approach to the prevention and control of infections.

- assist IP&C leads in general practice how to comply with the Health and Social Care Act 2008: Code of Practice for the prevention and control of healthcare associated infections (DH 2015) and Care Quality Commission (CQC) registration requirements.

1.10 The Health and Social Care Act 2008: Code of practice for the prevention and control of HCAIs applies to NHS bodies and providers of independent healthcare and adult social care in England, including primary dental care, independent sector ambulance providers and primary medical care providers. The code reflects the changes required to meet The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the role of infection prevention (including cleanliness) in optimising antimicrobial use and reducing antimicrobial resistance.

1.11 The law states that the code must be taken into account by the Care Quality Commission when it makes decisions about registration and that providers must have regard to the code when deciding how they will meet the regulations. However, the code is not mandatory, so registered providers do not by law have to comply with the code. A registered provider may be able to demonstrate that it meets the regulations in a different way (equivalent or better) from that described in this document. The Code of Practice on the prevention and control of infections and related guidance sets out 10 core duties against which the Care Quality Commission (CQC) will judge a registered provider for compliance.

https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

TABLE 1. HEALTH AND SOCIAL CARE ACT 2008: CODE OF PRACTICE FOR THE PREVENTION AND CONTROL OF HEALTHCARE ASSOCIATED INFECTIONS

Compliance criterion	What needs to be demonstrated
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion.
5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.
6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7	Provide or secure adequate isolation facilities.
8	Secure adequate access to laboratory support as appropriate.
9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

2 ANTIMICROBIAL STEWARDSHIP (AMR)

2.1 Antimicrobials, particularly antibiotics, have saved millions of lives since they were first discovered. Our generation, and that of our parents, has benefited enormously from these important medicines.

2.2 No new classes of antibiotic have been discovered since the 1980s. This, together with the increased and inappropriate use of the drugs we already have, means we are heading rapidly towards a world in which our antibiotics no longer work. We need to act, and act now, to make sure that our children and future generations continue to benefit from these life-saving medicines.

2.3 The UK's five-year national action plan 2019-2024 was published in January 19 and sets out to tackle AMR within and beyond our own borders. It focuses on three key ways to tackling AMR:

- Reducing need for, and unintentional exposure to, antimicrobials
- Optimising use of antimicrobials; and
- Investing in innovation, supply and access.

2.4 For further information see (HM Government 2019)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/784894/UK_AMR_5_year_national_action_plan.pdf

3 EDUCATION AND TRAINING

3.1 All staff involved in providing healthcare should be educated about the standard principles of infection prevention and control at induction and on a regular basis. They should be trained in hand decontamination, the use of personal protective equipment and the safe use and disposal of sharps.

3.2 Staff should educate individuals and their carers about, the benefits of effective hand decontamination, the correct techniques and timing of hand decontamination, when it is appropriate to use liquid soap and water or hand rub and respiratory and cough hygiene (NICE 2019).

3.3 For further information and guidance which can be used for education purposes see the Healthcare-associated infections: prevention and control in primary and community care (NICE 2017). The guideline covers preventing and controlling healthcare-associated infections in children, young people and adults in primary and community care settings. It provides a blueprint for the infection prevention and control precautions that should be applied by everyone involved in delivering NHS care and treatment. https://www.nice.org.uk/Guidance/CG139

4 STANDARD PRECAUTIONS

The following elements of practice form the basis of Infection Prevention Standard Precautions

- Assessment of the risk to and from individuals
- Hand hygiene
- Decontamination
- Safe handling and disposal of waste
- Safe use and disposal of sharps

- Personal Protective Equipment (PPE)
- Safe handling of blood and body fluid spillage
- Laundry
- Respiratory and cough hygiene
- Asepsis

5 ASSESSMENT OF THE RISK TO AND FROM INDIVIDUALS

5.1 Assess the risk to and from individuals promptly on arrival at the General Practice to ensure the prevention of cross contamination between individuals and the environment (NICE 2019).

- Ensure a nominated space has been identified for isolation purposes.

5.2 Standard infection control procedures may be insufficient to prevent cross transmission of specific airborne and droplet infections therefore additional transmission based precautions may be necessary depending on clinical judgement and the transmission route of the infectious agent. Facial protection including surgical masks and eye protection may be required for some infectious agents.

5.3 People who may require isolation include those:

- Who have diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms such as Influenza.
- Known to have positive multi-drug resistant organism (MDRO) e.g. meticillin-resistant *Staphylococcus aureus* (MRSA).
- Who have been hospitalised outside the UK in the last 12 months.

5.4 Prioritise people with suspected, known colonisation or infection and schedule appointments at the end of the clinic session.

5.5 Infectious people should be segregated from others while awaiting consultation and during care management.

5.6 For further information see NICE 2019; https://cks.nice.org.uk/healthcare-associated-infections#!scenarioRecommendation

6 HAND HYGIENE

6.1 Hand hygiene is recognised as one of the most effective methods to prevent the transmission of pathogens and is a central component of standard precautions.

6.2 Micro-organisms on hands are either resident flora or transient flora. Resident flora is usually of low virulence. Transient flora may contain many different pathogenic micro-organisms, picked up in the course of duty. They are not firmly attached to the skin and can easily be removed by correct hand hygiene.

6.3 The purpose of hand hygiene (both washing and drying) is to remove transient flora.

6.4 Dedicated hand wash basins should be available in all clinical areas. These should have elbow or wrist operated taps and should not have a plug or an overflow. Water should be offset so that it does not run directly over the waste outlet. They must be used for the purpose of hand hygiene only and not for the disposal of other any other fluids (DH 2013).

- For further information see the Health Building Note (HBN) 00-09: Infection Control in the built environment on the facilities required to prevent infection spreading (DH 2013).

  https://www.gov.uk/government/publications/guidance-for-infection-control-in-the-built-environment

6.5 NICE (2019) recommends to decontaminate hands immediately:

- Before every episode of direct contact with a person or care, including aseptic procedures.
- After every episode of direct contact with a person or care immediately after any exposure to body fluids, mucous membranes, non-intact skin or wound dressings.
- After any other activity or contact with a person's surroundings that could potentially result in hands becoming contaminated.
- After removal of gloves.

6.6 Also decontaminate hands:

- Before handling an invasive device regardless (whether gloves are used or not).
- If moving from a contaminated body site to another body site during care of the same person.

6.7 Decontaminate hands preferably with a handrub conforming to current British standards, except in the following circumstances, when liquid soap and water must be used:

- When hands are visibly soiled or potentially contaminated with body fluids.
- In clinical situations where there is potential for the spread of alcohol-resistant organisms (such as *Clostridium difficile* or other organisms that cause diarrhoeal illness).
- Detergent hand wipes can be used when it is not possible to perform handwashing.

6.8 For further information see the World Health Organisation (WHO 2021) 5 Moments for Hand Hygiene link below which provides posters and leaflets.

WHO | Five moments for hand hygiene

6.9 Ensure hands can be decontaminated throughout the duration of clinical work:

- Keep arms bare below the elbow when delivering direct care. (See 6.18)
- Remove wrist and hand jewellery.
- Make sure that fingernails are short, clean and free of nail polish.
- Cover cuts and abrasions with waterproof dressings.

6.10 Use wall mounted liquid soap dispensers with disposable soap cartridges.

- Use a good quality liquid soap.
- Do not use refillable soap dispensers.
- Do not use bar soap.

6.11 Use wall mounted alcohol handrub dispensers with disposable cartridges or free-standing pump dispensers — the alcohol handrub should contain a minimum of 60% isopropyl alcohol.

6.12 Use an antimicrobial solution prior to an invasive procedure (for example, 4% chlorhexidine gluconate skin cleanser, 7.5% povidone iodine, 2% triclosan skin cleanser, or 70% isopropanol plus 0.5% chlorhexidine gluconate solution).

6.13 Use paper towels in clinical areas and staff toilets — good quality soft paper towels will help to prevent skin abrasion.

- Do not use fabric hand towels.

6.14 Do not routinely use nail brushes.

- If nail brushes are used, they should be single use and disposed of after use.

6.15 An effective handwashing technique involves three stages: preparation, washing and rinsing, and drying, and should take around 30–60 seconds.

- Wet the hands under tepid running water (avoid using hot water, as repeated exposure to hot water may increase the risk of dermatitis) before applying liquid soap or an antimicrobial preparation.
- Ensure the handwash solution comes into contact with all of the surfaces of the hand. Rub the hands together vigorously for a minimum

of 10–15 seconds, and pay particular attention to the tips of the fingers, the thumbs and the areas between the fingers.

- Rinse hands thoroughly then dry with good quality paper towels.
- Turn tap off using wrist or elbow lever – if twist taps in situ use a clean paper towel to turn off taps
- For how to wash hands, see this step-by-step guide (NSS 2019).

  http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-1-best-practice-how-to-hand-wash/

6.16 Decontaminating hands using an alcohol handrub should take around 20–30 seconds.

- Ensure hands are free from dirt and organic material.
- Ensure the handrub solution comes into contact with all surfaces of the hand. Rub the hands together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.
- For how to hand rub, see this step-by-step guide (NSS 2019).

  http://www.nipcm.hps.scot.nhs.uk/appendices/appendix-2-best-practice-how-to-hand-rub/

6.17 Apply an emollient hand cream 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 an occupational health team should be consulted.

- For further information about contact dermatitis see information from the Health and Safety Executive (HSE 2019).

  http://www.hse.gov.uk/skin/employ/dermatitis.htm

6.18 **Bare Below the Elbows**

- Bare Below the Elbows (BBE) is a strategy that has been in effect in the UK since 2008. In order to adhere to BBE a person must have sleeves above the elbow, not be wearing a watch or bracelet (medical alert bracelet an exception), have short finger nails, no false nails, no nail varnish and may wear only one plain wedding band. The rationale for this is that it facilitates more effective hand washing thus reducing the transmission of healthcare associated infections. BBE must be adhered to by all staff in contact with patients and their environment to enable them to effectively decontaminate their hands and wrists

between each episode of patient care or contact. It is not possible to do this effectively wearing a wristwatch, jewellery or fitness bracelets.

6.19 For further information refer to the national hand hygiene and personal protective equipment policy, which was published in March 2019 by NHS Improvement (NHSI 2019). This national policy is a practice guide for NHS healthcare staff of all disciplines in all care settings including primary care.

NHS England » Standard infection control precautions: national hand hygiene and personal protective equipment policy

7 DECONTAMINATION OF EQUIPMENT

7.1 NICE (2019) states that safe and effective decontamination of equipment and the environment between patients is a crucial part of standard precautions.

- Decontaminate all equipment after use — the method used depends on the manufacturer's instructions, a risk assessment of the procedure, and the item being used in accordance with Control of Substances Hazardous to Health (COSHH) Regulations.
- Some equipment will have specific instructions which should be followed.
- Single use items must be disposed of in line with local waste procedures.

7.2 There are three levels of decontamination

7.3 Cleaning — clean equipment before disinfection or sterilisation is carried out. A disinfectant will not be effective if there is dirt or visible soiling present (for example, urine, or blood):

- Use detergent wipes or detergent, warm water and single use cloths.
- Dry all equipment that has been cleaned thoroughly before storage.

7.4 Disinfection — disinfect any equipment:

- contaminated with splashes of blood — the disinfectant should have virucidal properties effective against hepatitis B, hepatitis C and HIV.
- That has been in contact with a person with a known or suspected infection, non-intact skin, mucous membranes or body fluids.

7.5 Sterilisation — this is a specialist means of decontaminating equipment. Re-usable items requiring sterilisation must be sent to an accredited decontamination services facility:

- The use of bench top steam sterilisers (autoclaves) is not recommended.

7.6 Disinfectants are available in a variety of formats: wipes, chlorine releasing tablets, liquids or granules — if the disinfectant does not contain a detergent clean the equipment before a disinfectant is used.

7.7 Ensure the correct amount of disinfectant and water are used — if a chlorine-based solution is used it should be at a dilution of 1,000 ppm.

- As diluted chlorine-based disinfectant solutions are unstable and become less effective after 24 hours, a new solution should be made each day.

7.8 Always wear disposable gloves, an apron and if indicated, eye protection.

8 ENVIRONMENTAL CLEANLINESS

8.1 Micro-organisms will always be present in the environment and all primary care staff have a responsibility to be aware of methods to prevent their transmission within healthcare. The choice of decontamination method depends on a number of factors, which include the type of material to be treated, the organisms involved, the time available for decontamination and the risks to staff and patients. Decontamination of equipment and the environment is a key infection prevention measure.

8.2 NICE (2019) states all staff should know and understand the importance of thorough cleaning — a clean environment reduces the cumulative risk of transmission of infection posed by micro-organisms.

8.3 **Ensure a cleaning plan is in place** — this should include:

- The standards to be achieved.
- Clear allocation of responsibility for cleaning of all areas and items and a designated person to lead on cleaning and decontamination.
- Cleaning schedules and frequencies and the names of people responsible for cleaning.
- Systems to measure outcomes, the reports required and who should receive them.
- Operational and training policies and procedures and risk assessment protocols.
- How cleaning services, operations and controls dovetail with arrangements for infection control, including training for all cleaning staff in infection control policies and procedures.
- A documented record of cleaning undertaken.
- The management arrangements in place to ensure external cleaning contractors (if used) deliver against the contract. Suitable arrangements should be in place to monitor standards of cleaning and to deal with poor or unsatisfactory performance.

8.4 **Ensure blood and body fluid spillages are dealt with promptly.**

8.5 Limit the number of cleaning products to avoid inappropriate use.

8.6 **Detergents**

- Select and use a good quality neutral detergent or detergent wipe.
- Liquid detergents classed as anionic and non-ionic have the best detergent activity.

8.7 **Disinfectants**

- Use spillage kits for disinfecting surfaces following a blood or body fluid spillage.
- Use disinfectants which are virucidal and bactericidal for disinfecting surfaces after dealing with a person with a known infection.
- Alcohol wipes can be used, but as they do not contain a cleaning agent, surfaces should first be wiped with a detergent wipe or solution of neutral detergent and warm water. Alcohol is effective against meticillin-resistant *Staphylococcus aureus* (MRSA) and multi-resistant gram negative bacteria (MRGNB), but is not effective against Norovirus and *Clostridium difficile*.
- Make up disinfectant solutions according to the manufacturer's instructions.

8.8 **Use colour coding for cleaning equipment used for cleaning different areas** — this ensures that these items are not used in multiple areas, therefore, reducing the risk of transmission of infection from one area to another, (for example, toilet to kitchen).

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

8.9 **Measures for reducing the risk of transmission of infection from cleaning equipment include:**

- Use single-use disposable cloths and mop heads where industrial washing machine facilities are unavailable to launder re-useable microfiber cloths and mop heads.
- Store equipment clean and dry after use in a designated area.
- Store products in a designated lockable area.

- Wash re-usable cloths & mop heads after use in an industrial washing machine at the highest temperature possible, as according to manufacturer's guidance. Replace re-usable mop heads regularly depending on the frequency of use.

- Do not store equipment, (for example, mops) overnight in disinfectants or disinfectant solutions. If disinfection is required, wash the mop head in detergent and warm water, rinse and soak for 30 minutes in a hypochlorite solution at 1,000 ppm, rinse and then store upright to dry.

- Floor scrubbing machines, steam cleaners and carpet shampoo machines, should be designed to enable tanks to be emptied, cleaned and dried.

- Ensure each toilet has its own toilet brush and holder.

- Place the toilet brush head beneath the water level and flush the toilet, and clean thoroughly after use.

8.10 **Measures for reducing the risk of transmission of infection from furniture, fixtures, fittings, and toys include ensuring that:**

- Surfaces are smooth, wipe able and non-impervious to facilitate effective cleaning.

- Damaged surfaces are repaired or replaced.

- When purchasing new furniture, fixtures and fittings the item can be easily cleaned.

- Toys are wipe able and in good condition, and that they are cleaned on a regular basis (for example weekly, with detergent and warm water) and included in the cleaning schedule. **Note:** magazines are allowed in waiting rooms.

- Carpets are not recommended in clinical areas because of the risk of body fluid spills. Where carpets are in place there should be a risk assessment, procedures or contracts for regular steam cleaning and dealing with spillages.

8.11 The NHS National Standards of Healthcare Cleanliness 2021 were published in April 2021. The National standards of healthcare cleanliness 2021 apply to all healthcare environments and replace the National specifications for cleanliness in the NHS 2007 (and amendments) published by the National Patient Safety Agency. To encourage continuous improvement they combine mandates, guidance, recommendations and good practice.

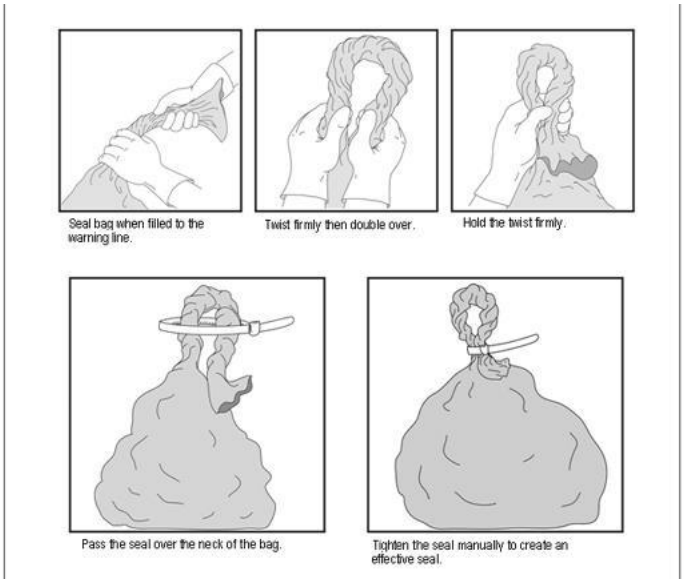
8.12 The standards and supporting documents can be found on the NHSE&I website at NHS England » NHS Premises Assurance Model & NHS England » National Standards of Healthcare Cleanliness 2021: Supporting documents

9 SAFE HANDLING AND DISPOSAL OF HEALTHCARE WASTE

9.1 Healthcare waste has the potential to be toxic, hazardous and/or infectious. All staff have a duty of care to ensure that waste is segregated, handled, transported and disposed of in an appropriate manner to ensure it does not harm colleagues, patients/service users, the public or the environment.

9.2 Healthcare waste must be

- Disposed of at the point of care in the nearest appropriate bin. Soiled dressings should be placed in small bags immediately they are removed before being taken to a larger clinical waste bin
- Bags must be changed before 2/3 full, and at least daily
- Bags should be swan necked or secured with a plastic tie to produce a fluid tight seal when closed.



9.3 Wear personal protective equipment when handling waste.

9.4 Hold waste bags by the neck and keep at arm's length to reduce the risk of a sharp injury in case a sharp item has been inappropriately disposed of in the bag.

9.5 Healthcare waste must be segregated immediately by the person generating the waste into appropriate colour-coded storage or waste disposal bags or containers which are compliant with current national legislation and local policies.

- Orange — infectious waste (e.g. contaminated gloves or dressings).
- Yellow and black striped — offensive/hygiene waste (e.g. stoma or catheter bags where no infection is suspected).
- Purple — cytotoxic or cytostatic medicine waste (e.g. medicine containers with residue).
- Blue — medicinal waste (e.g. empty medicine bottles).
- Black — domestic waste (e.g. paper towels, food waste).

9.6 Healthcare waste must be labelled appropriately with the address and date prior to collection by the waste contractor (some waste contractors may undertake this) to ensure traceability if an incident occurs.

9.7 Healthcare waste must be packaged for transportation — waste bags should be no more than 2/3 full. This allows enough space for the bag to be tied using a suitable plastic zip tie or secure knot. If a waste bag awaiting collection is torn, the torn bag and contents should be placed inside a new waste bag.

9.8 Healthcare waste must be stored in a secure place away from public access which is inaccessible to animals. Waste bags must be stored in an appropriate container provided by the waste contractor, which must always be locked or within a locked compound.

9.9 Healthcare waste must be transported and disposed of in accordance with current national legislation and local policies. The Management and Disposal of Healthcare Waste (HTM 07-01) (DH 2013) details the environmental benefits of the safe management and disposal of healthcare waste. It also presents opportunities for cost savings, safer working practices and reducing carbon emissions related to the management of waste. For further information see https://www.gov.uk/government/publications/guidance-on-the-safe-management-of-healthcare-waste

9.10 Further information can be found in the COVID 19 waste management standard operating procedure at Coronavirus » COVID-19 waste management standard operating procedure (england.nhs.uk)

10 SAFE USE AND DISPOSAL OF SHARPS

10.1 Injuries from sharp devices used in healthcare pose a significant risk to the health of staff, and can be costly in terms of time and resources to healthcare organisations. It can also have the potential to result in costly litigation.

10.2 An inoculation injury is when a person has had exposure to blood or bodily fluids from another person.

10.3 A percutaneous injury refers to exposure involving a needle, sharp object used on another person or a human bite or scratch that has broken the skin.

10.4 A mucocutaneous injury refers to exposure involving the mucous membranes i.e. mouth, nose, eyes or non-intact skin that have been contaminated by blood or body fluids from another person.

10.5 Sharps include needles, cannulas, stitch cutters, scalpels, razor blades, broken glass, and medical instruments (for example, scissors, and other sharp objects).

10.6 General principles of safe practice include

- Training and assessment of all users in good practice in sharps management — this should cover the correct use and disposal of sharps and sharps safety devices, and what to do in the event of an injury.

- All staff are responsible for the safe use and disposal of every sharp they generate.

- Never re-sheath needles.

- Do not pass sharps directly from hand to hand — keep handling to a minimum.

- Do not bend or break used standard needles before disposal.

- Discard used sharps immediately (dispose of the needle and syringe as one unit) into the correct colour coded sharps container, which must conform to current standards — this should be done by the person generating the sharps waste.

- Purple lid — cytostatic or cytotoxic medicines.
- Orange lid — not contaminated with medicines.
- Yellow lid — contaminated with medicines.

10.7 Sharps containers:

- Must be located in a safe position (not on the floor) that avoids spillage, at a height that allows the safe disposal of sharps, and is away from public access areas and out of the reach of children.

- Must not be used for any other purpose than the disposal of sharps.

- Must not be filled above the fill line.

- Must be disposed of when the fill line is reached and labelled with the date, source prior to disposal and a signature when assembled, locked and disposed of.

- Should be temporarily closed when not in use.

- Should be disposed of every 3 months even if not full, by the licensed route in accordance with local policy.

10.8 Use sharps safety devices if a risk assessment has indicated that they will provide safer systems of working for healthcare workers, carers and patients.

10.9 Further information can be found in the Essential Practice for Infection Prevention and Control (RCN 2017)

https://www.rcn.org.uk/professional-development/publications/pub-005940

10.10 Further guidance can be found in the Managing the risks of sharps injuries (NHS Employers 2015)

https://www.nhsemployers.org/-/media/Employers/Documents/Retain-and-improve/Health-and-wellbeing/Managing-the-risks-of-sharps-injuries-v7.pdf

11 VENEPUNCTURE

11.1 Prior to the venepuncture procedure:

- Decontaminate hands with liquid soap and warm running water or use alcohol hand rub
- Put on a disposable apron
- clean hands again after applying cleanable and wipe able tourniquet and palpating the vein
- Put on disposable gloves.
- Clean the individuals skin with 70% isopropyl alcohol skin wipes for 30 seconds and allow the skin to dry.

11.2 **Once the venepuncture procedure is complete:**

- Release the tourniquet and place a low linting sterile gauze over the puncture site.
- Once the needle is removed discard sharps in a sharps container.
- Apply pressure and use an additional piece of sterile gauze if necessary.
- Inspect the puncture point for bleeding.
- Apply a sterile adhesive plaster or hypoallergenic tape.
- Remove and dispose of gloves and apron.
- Decontaminate hands with liquid soap and warm running water or use alcohol hand rub.

12 ASEPTIC TECHNIQUE

12.1 Aseptic technique minimises the risk of contaminating an invasive device or contaminating a vulnerable area, such as a wound when introduction of micro-organisms may increase the risk of infection. Aseptic Technique guidance for general practice can be found in the Infection Prevention and Control Website.

https://www.infectionpreventioncontrol.co.uk/resources/aseptic-technique-general-practice/

13 MINOR SURGERY

Guidelines for performing minor surgery in primary care can be found in the link below.

Guidelines on the facilities required for minor surgical procedures and minimal access interventions - Journal of Hospital Infection

14 PERSONAL PROTECTIVE EQUIPMENT (PPE)

14.1 Base the selection of protective equipment on the risk of:

- Transmission of the microorganism(s).
- Contamination of clothing and skin by blood, body fluids, secretions or excretions.

14.2 Equipment which may be appropriate to use includes:

14.3 Gloves — wear these for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments. Use of gloves does not replace the need for hand hygiene measures.

14.4 Gloves used for direct care must:

- Be changed between caring for different people, and between different care or treatment activities for the same person.
- Be worn as single-use items — they must be put on immediately before an episode of contact or treatment and removed as soon as the activity is completed. They must then be disposed of correctly in accordance with current national legislation or local policies.
- Be appropriate for the task.
- Conform to current EU legislation (CE marked as medical gloves for single use). Alternatives to natural rubber latex gloves must be available for people who have a documented sensitivity to natural rubber latex. Do not use polythene gloves for clinical interventions.
- For further information see Royal College of Nursing's Tools of the Trade: Guidance for Health Care Staff on Glove Use and the Prevention of work-related Dermatitis (RCN 2021). Tools of the trade| Royal College of Nursing (rcn.org.uk)

14.5 Disposable plastic apron — wear this if there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions.

- Wear a long-sleeved fluid-repellent gown if there is a risk of extensive splashing of blood, body fluids, secretions or excretions onto skin or clothing.

- Disposable plastic aprons or gowns must be worn as single-use items, for one procedure or one episode of direct care. They must be disposed of correctly in accordance with current national legislation or local policies.

14.6 Face masks and eye protection — wear these if there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes.

15 BLOOD AND BODY FLUID SPILLAGE

15.1 Blood and body fluids can contain blood borne viruses (BBV) or other pathogens. Therefore, dealing with spills of blood or body fluid may expose the healthcare worker to contamination from potential pathogens and therefore spills must be dealt with swiftly, safely and effectively.

15.2 Use an appropriate blood spillage kit when dealing with blood/blood stained body fluid and follow the manufacturer's instructions. NICE (2019) recommends

- Wear PPE.

- Dispose of the spillage and contents of the pack as infectious waste.

- Use detergent and warm water alone on carpets or soft furnishings (or a carpet cleaning machine or steam cleaner if practicable).

- Chlorine-based disinfectant solution or granules may cause damage when dealing with a spillage on carpets or soft furnishings.

15.3 Deal with body fluid spillages (for example, urine, or vomit) promptly.

- Use an appropriate spillage kit when dealing with non-blood stained body fluids and follow the manufacturer's instructions.

- Do not place a chlorine-based product directly on urine as toxic fumes are released.
- Wear PPE.

- Dispose of the spillage and contents of the pack as infectious or offensive waste.

- Use detergent and warm water alone on carpets or soft furnishings (or a carpet cleaning machine or steam cleaner if practicable).

- Chlorine-based disinfectant solution or granules may cause damage when dealing with a spillage on carpets or soft furnishings.

16 LAUNDRY

16.1 **NICE (2019) states to use disposable paper products** (for example, paper towels, couch roll).

16.2 Do not use linen such as blankets, pillowcases, fabric hand towels — it is not practical to launder items between each consultation.

16.3 **Fabric curtains and screens** — these should be laundered by a professional laundry service on a documented planned schedule (for example, 6-monthly or laundered immediately if visibly soiled).

16.4 Change disposable curtains, if used, every 6 months or immediately if visibly soiled. The date the curtain is put up should be documented.

16.5 Seal pillows and blankets in a wipe able cover with no tears and clean with a detergent wipe after use.

- Disposable couch roll should be used to cover the pillow or maintain the patient's modesty for procedures where this is required and disposed of after use.

16.6 Wear personal protective equipment (for example, a disposable apron) to prevent contamination of uniform and workwear.

16.7 Ensure uniforms and workwear are:

- Fit for purpose and support good hand hygiene.
- Laundered separately from other clothing on a hot wash cycle at the highest temperature that the fabric will tolerate.
- Garments should be dried thoroughly. Tumble drying or ironing will further reduce the small number of micro-organisms present after washing.

16.8 Neckties/lanyards and direct care activity. Ties have been shown to be contaminated by pathogens, can accidentally come into contact with people and are rarely laundered. For this reason it is recommended that they are not worn whilst undertaking direct care activities.

16.9 For further information see (NHSE&I) Uniforms and workwear: Guidance on uniform and workwear policies for NHS employers

https://www.england.nhs.uk/wp-content/uploads/2020/04/Uniforms-and-Workwear-Guidance-2-April-2020.pdf

17 RESPIRATORY AND COUGH HYGIENE

17.1 NICE (2019) states to minimise the risk of cross-contamination from respiratory illness:

- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose.

- Dispose of all used tissues promptly into a waste bin.
- Wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions.
- Where there is no running water available or hand hygiene facilities are lacking, use hand wipes followed by alcohol based hand rub and wash hands as soon as possible.
- Keep contaminated hands away from the eyes nose and mouth.

18 WHAT PRECAUTIONS SHOULD BE TAKEN FOR SPECIFIC INFECTIONS?

18.1 NICE (2019) states in addition to standard precautions, transmission based precautions (TBPs) may be necessary, depending on the:

- Suspected/known infectious agent.
- Severity of the illness caused.
- Transmission route of the infectious agent.
- Care setting and procedures undertaken.

18.2 TBPs are categorised by the route of transmission (some infections can be transmitted by more than one route).

- Contact — used to prevent and control infections that spread via direct contact with the person or indirectly from their immediate care environment (including care equipment). This is the most common route of cross-infection transmission.
- Droplet — used to prevent and control infections spread over short distances (at least 1 metre) via droplets (>5μm) from the respiratory tract of one person onto a mucosal surface or conjunctivae of another. Droplets penetrate the respiratory system to above the alveolar level.
- Airborne — used to prevent and control infections spread without necessarily having close patient contact via aerosols (≤5μm) from the respiratory tract of person onto a mucosal surface or conjunctivae of another. Aerosols penetrate the respiratory system to the alveolar level.

Table 2. Transmission based precautions (TBPs) required for infectious agents.

Suspected or confirmed pathogen	Disease	Type of TBP required
Adenovirus	Upper/lower respiratory tract	Droplet

	infection	
Adenovirus	Conjunctivitis, gastroenteritis	Contact
Bordetella pertussis	Whooping cough	Droplet
Clostridium difficile	*Clostridium difficile* infection	Contact
Salmonella spp	Gastroenteritis	Contact
Hepatitis A	Hepatitis, gastroenteritis	Contact
Herpes zoster	Shingles (vesicle sack)	Contact
Influenza virus	Influenza	Droplet
Measles virus	Measles	Droplet/airborne
Meticillin-resistant *Staphylococcus aureus* (MRSA)	Colonisation, skin and wound infections, endocarditis, pneumonia, osteomyelitis, urinary tract infections and bacteraemia	Contact
Mumps virus	Mumps	Droplet
Norovirus	Winter vomiting disease	Contact
Panton-Valentine Leukocidin *Staphylococcus aureus* (PVL-SA)	Skin and soft tissues infection, necrotising pneumonia, necrotising fasciitis, osteomyelitis, septic arthritis and pyomyositis, purpura fulminans	Contact

(NICE 2019)

19 HIGH CONSEQUENCE INFECTIOUS DISEASES (HCID)

19.1 In the UK, a high consequence infectious disease (HCID) is defined by PHE (2020) according to the following criteria:

- acute infectious disease
- typically has a high case-fatality rate
- may not have effective prophylaxis or treatment
- often difficult to recognise and detect rapidly
- ability to spread in the community and within healthcare settings
- requires an enhanced individual, population and system response to ensure it is managed effectively, efficiently and safely

19.2 Guidance and information about high consequence infectious diseases and their management in England can be found at Public Health England (PHE 2021). For further information see

https://www.gov.uk/guidance/high-consequence-infectious-diseases-hcid#classification-of-hcids

Contact HCID	Airborne HCID
Argentine haemorrhagic fever (Junin virus)	Andes virus infection (hantavirus)
Bolivian haemorrhagic fever (Machupo virus)	Avian influenza A H7N9 and H5N1
Crimean Congo haemorrhagic fever (CCHF)	Avian influenza A H5N6 and H7N7
Ebola virus disease (EVD)	Middle East respiratory syndrome (MERS)
Lassa fever	Monkeypox
Lujo virus disease	Nipah virus infection
Marburg virus disease (MVD)	Pneumonic plague (Yersinia pestis)
Severe fever with thrombocytopaenia syndrome (SFTS)	Severe acute respiratory syndrome (SARS)*

20 CORONAVIRUS – COVID-19

20.1 Coronaviruses are a large family of viruses with some causing less-severe disease, such as the common cold, and others causing more severe disease such as COVID-19, Middle East respiratory syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) coronaviruses (PHE 2020).

20.2 Information on COVID-19, including guidance for the management of possible or confirmed cases can be found at COVID 19: guidance for health professional - https://www.gov.uk/government/collections/wuhan-novel-coronavirus

20.3 COVID 19 IP&C guidance can be found on the PHE website found at https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

21 BLOOD-BORNE VIRUSES

21.1 NICE (2019) states that Blood borne-viruses (BBVs) include:

- Human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS).
- Hepatitis B virus (HBV).
- Hepatitis C virus (HCV).

21.2 Precautions to prevent inoculation with BBVs include:

- Standard precautions — used appropriately these should be sufficient to ensure that no extra precautions are required for people known to carry these viruses.

- Blood and body fluid spillage — urine, faeces, sputum, tears, sweat and vomit are not considered to pose a risk unless they are contaminated with blood.

- Waste disposal.

- Venepuncture and sharps disposal — specimens and request forms from people known to be or suspected of being infected with blood-borne viruses should be labelled with a 'Danger of Infection' or 'hazard' sticker.

- Use of safety sharps where appropriate.

- Appropriate management of percutaneous exposures (sharps/splash injuries).

- Protection of clinical and other staff with hepatitis B vaccination.

21.3 Standard infection prevention and control precautions for reducing the risk of transmission of BBVs include:

- Keep cuts or broken skin covered with waterproof dressings.

- Protect eyes, mouth and nose from blood splashes where there is a risk of splashing.

- Avoid direct skin contact with blood and blood stained body fluids

- If blood/blood stained body fluids are splashed on to the skin, wash off with liquid soap and warm running water.

- Wear disposable latex/nitrile gloves when contact with blood or body fluids is likely.

- Always clean hands after removing gloves.

- Always clean hands before and after giving first aid.

- Contain and promptly disinfect surfaces contaminated by spillages of blood and body fluids.

22 CLOSTRIDIUM DIFFICILE

22.1 **NICE (2019) states to follow standard procedures, including.**

- Hand hygiene — use liquid soap and warm running water. Do not use alcohol hand rubs as these do not kill spores.

- Personal protective equipment — wear disposable gloves and an apron. Remove these (gloves first then apron) and dispose of appropriately.

22.2 **Advise symptomatic people to:**

- Wash hands thoroughly with liquid soap and warm running water, especially after going to the toilet and before preparing or eating food.
- Use a separate towel to dry hands and to wash it daily. This should not be used by other members of the household or visitors.
- Close the toilet seat lid before flushing after an episode of diarrhoea — this will reduce spread onto surrounding surfaces.
- Clean hard surfaces in toilets/bathrooms (for example, taps, toilet flush, door handles, soap dispenser) at least daily using household bleach.
- Wash soiled clothing and bedding as soon as possible — these should be washed separately from other people's laundry at the highest temperature the fabric will tolerate.
- Have a shower or bath every day if possible, as *C. difficile* can be present on other areas of the body.
- Stay at home until free from diarrhoea for 48 hours to prevent spreading it to other people, if possible.
- Drink plenty of fluids to prevent dehydration.
- Not to take medicines to stop diarrhoea (unless prescribed by a healthcare professional), as this will stop *C. difficile* being cleared from the body.
- That visitors, including pregnant women and children, are not at risk if they are healthy.
- That once recovered, there is no risk to other people.

22.3 For further information see Clostridioides difficile: guidance, data and analysis - GOV.UK (www.gov.uk)

23 CREUTZFELDT-JAKOB DISEASE

23.1 No special measures over and above standard infection control procedures are required when caring for people with CJD or vCJD, as it is unlikely that a procedure will be undertaken that involves contact with high or medium risk tissues (NICE 2019).

23.2 For further information see Creutzfeldt-Jakob disease (CJD) surveillance: biannual updates - GOV.UK (www.gov.uk)

24 MULTI-RESISTANT GRAM NEGATIVE ORGANISM (MRGNO)

24.1 NICE (2019) states to follow standard infection control precautions and good hand hygiene practice**.**

- Hand hygiene is essential before and after direct contact — use liquid soap and warm running water or alcohol hand rub.

24.2 No specific precautions are required for people attending for a routine GP consultation, however, personal protective equipment should be worn if an examination is undertaken involving contact with body fluids.

- Schedule people attending for a procedure (for example, wound dressing) at the end of the session to allow for environmental cleaning, if possible.

- Wear disposable gloves and apron when in contact with body fluids — dispose of these after each procedure.

- Wear long sleeved fluid-repellent gowns, if there is a risk of extensive splashing of body fluids to the uniform.

- Clean the treatment couch and immediate area with detergent and warm water followed by a hypochlorite solution at a dilution of 1000 ppm, or a disinfectant wipe if the person has attended for a procedure.

- Dispose of waste contaminated with body fluids as infectious waste.

- For further information see the NHSE&I website NHS England » Preventing healthcare associated Gram-negative bloodstream infections (GNBSI)

25 METICILLIN-RESISTANT STAPHYLOCOCCUS AUREUS

25.1 **NICE (2019) states to follow standard infection control precautions** and good **hand hygiene** practice.

- Hand hygiene is essential before and after direct contact — use liquid soap and warm running water or alcohol hand rub.

25.2 No specific precautions are required for people attending for a routine GP consultation, however, personal protective equipment should be worn if an examination is undertaken involving contact with body fluids.

- Schedule people attending for a procedure (for example, wound dressing) at the end of the session to allow for environmental cleaning, if possible.

- Wear disposable gloves and apron when in contact with body fluids — dispose of these after each procedure.

- Wear long sleeved fluid repellent gowns if there is a risk of extensive splashing of body fluids to the uniform.

- Clean the treatment couch and immediate area with detergent and warm water followed by a hypochlorite solution at a dilution of 1000 ppm, or a detergent/disinfectant wipe if the person has attended for a procedure.

- Dispose of waste contaminated with body fluids as infectious waste.

25.3 For further information on MRSA screening Who to screen for MRSA - GOV.UK (www.gov.uk)

26 NOROVIRUS

26.1 **NICE (2019) states to follow standard infection control precautions** and good **hand hygiene** practice.

26.2 When assessing people with suspected norovirus:

- Wash hands with liquid soap, warm running water and dry with paper towels. Alcohol hand rub should not be used as it is not effective at killing norovirus.

- Wear a disposable apron and gloves.

- Wash hands again after removing the apron and gloves.

26.3 Encourage people with symptoms to wash their hands thoroughly with liquid soap and warm running water:

- After an episode of vomiting or diarrhoea,

- After using the toilet.

- Before eating and drinking.

26.4 During periods of increased activity with norovirus:

- Remind practice staff to wash their hands thoroughly (rather than using alcohol hand rub) after patient contact, before their breaks and before eating and drinking.

- Advise people (including staff) with vomiting and/or diarrhoea to stay off work until they are symptom free for 48 hours**.**

- If this occurs at work, send staff home immediately.

26.5 If a person vomits, clear up spillages promptly:

- Wear personal protective equipment (for example, apron and gloves).

- Ventilate the area by opening doors, windows if possible.

- Clean up vomit with paper towels.

- Use an appropriate body fluid spillage kit to clean the affected area.

- Do not use a chlorine-based disinfectant in a carpeted area, clean with detergent and warm water, a carpet cleaning machine or steam cleaner.

- Dispose of waste and personal protective equipment as infectious waste.

- Wash hands with liquid soap and warm running water.

26.6 If a mop and bucket are used, they should be in accordance with the national colour coding. After use, the mop head should be laundered or disposed of immediately as infectious waste and the bucket washed with detergent and warm water and then wiped with a chlorine-based disinfectant at 1,000 parts per million and stored upside down. All cloths used must be single use and disposed of after use.

26.7 For further information see Norovirus: guidance, data and analysis - GOV.UK (www.gov.uk)

27 PANTON-VALENTINE LEUKOCIDIN STAPHYLOCOCCUS AUREUS (PVL-SA)

27.1 Discuss a confirmed diagnosis of PVL-SA with the Public Health England (PHE) team.

27.2 **NICE (2019) states to follow standard infection control precautions** and good **hand hygiene** practice.

- Hand hygiene is essential before and after direct contact — use liquid soap and warm running water or alcohol hand rub.

27.3 No specific precautions are required for people attending for a routine GP consultation; however, personal protective equipment should be worn if an examination is undertaken involving contact with body fluids.

- Schedule people attending for a procedure (for example, wound dressing) at the end of the session to allow for environmental cleaning, if possible.

- Wear disposable gloves and apron when in contact with body fluids — dispose of these after each procedure.

- Wear long sleeved fluid repellent gowns if there is a risk of extensive splashing of body fluids to the uniform.

- Disinfect the treatment couch, surfaces and any medical devices used if the person has attended for a procedure with a detergent and warm water followed by a hypochlorite solution at a dilution of 1000 ppm, or a detergent/disinfectant wipe Dispose of waste contaminated with body fluids as infectious waste.

27.4 For further information PVL-Staphylococcus aureus infections: diagnosis and management - GOV.UK (www.gov.uk)

28 GUIDELINE REVIEW

28.1 This guideline will be reviewed in line with any changes to national guidance or at least two yearly.

29 REFERENCES

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