Infection Prevention and Control

Strategy, policy, guidance and procedures for managing healthcare associated infections and control of serious communicable diseases

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Title of originator/author: Fataha Sultan-Petty, Infection Prevention and Control Manager
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Trust Policy Foreword

SWASFT has a number of specific corporate responsibilities relating to patient and staff safety and wellbeing which should be included within all Trust policy and strategy, as a foreword inside the front cover:

Code of Conduct and Conflict of Interest Policy - The Trust Code of Conduct for Staff and its Conflict of Interest and Anti-Bribery policies set out the expectations of the Trust in respect of staff behaviour. SWASFT employees are expected to observe the principles of the Code of Conduct and these policies by declaring any gifts received or potential conflicts of interest in a timely manner, and upholding the Trust zero-tolerance to bribery.

Compassion in Practice – SWASFT will promote the values and behaviours within the Compassion in Practice model which provide an easily understood way to explain our role as professionals and care staff and to hold ourselves to account for the care and services that we provide. These values and behaviours reflect the Trust’s commitment to developing an outstanding service through the conduct and actions of all staff. SWASFT will encourage staff to demonstrate an ongoing commitment to apply the core competencies of Care, Compassion, Competence, Communication, Courage, and Commitment to ensure our patients experience compassionate care.

Duty of Candour – SWASFT will, as far as is reasonably practicable, apply the statutory Duty of Candour to all reported incidents where the Trust believes it has caused moderate or severe harm or death to a patient. This entails providing the affected patient or next of kin (within strict timescales) with: all information known to date; an apology; an explanation about any investigation; written follow-up; reasonable support; and the outcome fed back in person (unless they do not want it). The only exception is where making contact could have a negative impact upon the next of kin. SWASFT employees are expected to support this process by highlighting (early) any incident where they believe harm may have been caused.

Equality Act 2010 and the Public Sector Equality Duty - SWASFT will act in accordance with the Equality Act 2010, which bans unfair treatment and helps achieve equal opportunities in the workplace. The Equality Duty has three aims, requiring public bodies to have due regard to: eliminating unlawful discrimination, harassment, victimization and any other conduct prohibited by the Act; advancing equality of opportunity between people who share a protected characteristic and people who do not share it; and fostering good relations between people who share a protected characteristic and people who do not share it. SWASFT employees are expected to observe Trust policy and the maintenance of a fair and equitable workplace.

Fit and Proper Persons – SWASFT has a statutory duty not to appoint a person or allow a person to continue to be an executive director or equivalent or a non-executive director under given circumstances. They must be: of good character; have the necessary qualifications, skills and experience; able to perform the work they are employed for (with reasonable adjustments); able to provide information required under Schedule 3 (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The definition of good character is not the test of having no criminal convictions but instead rests upon judgement as to whether the person’s character is such that they can be relied upon to do the right thing under all circumstances. This implies discretion for boards in reaching a decision and allows that people can change over time.

Health and Safety - SWASFT will, so far as is reasonably practicable, act in accordance with the Health and Safety at Work etc. Act 1974, the Management of Health and Safety at Work Regulations 1999 and associated legislation and approved codes of practice. It will provide and maintain, so far as is reasonable, a working environment for employees which is safe, without risks to health, with adequate facilities and arrangements for health at work. SWASFT employees are expected to observe Trust policy and support the maintenance of a safe and healthy workplace.

Information Governance - SWASFT recognises that its records and information must managed, handled and protected in accordance with the requirements of the Data Protection Act 1998 and other legislation, not only to serve its business needs, but also to support the provision of highest quality patient care and ensure individual’s rights in respect of their personal data are observed. SWASFT employees are expected to respect their contact with personal or sensitive information and protect it in line with Trust policy.

NHS Constitution - SWASFT will adhere to the principles within the NHS Constitution including: the rights to which patients, public and staff are entitled; the pledges which the NHS is committed to uphold; and the duties which public, patients and staff owe to one another to ensure the NHS operates fairly and effectively. SWASFT employees are expected to uphold the duties set out in the Constitution.

Risk Management - SWASFT will maintain good risk management arrangements by all managers and staff by encouraging the active identification of risks, and eliminating those risks or reducing them to the lowest level that is reasonably practicable through appropriate control mechanisms. This is to ensure harm, damage and potential losses are avoided or minimized, and the continuing provision of high quality services to patients, stakeholders, employees and the public. SWASFT employees are expected to support the identification of risk by reporting adverse incidents or near misses through the Trust web-based incident reporting system.
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Strategy

Strategic Statement

There is a national drive for improved infection prevention and control (IPC) within the NHS, with the Department of Health, Public Health England and the National Institute for Health and Clinical Excellence (NICE) promoting evidence based guidelines and frameworks for assessment. Greater emphasis is being placed on encouraging better use of infection control to prevent infections, rather than relying on antibiotics when infections occur. Every day, HCAIs result in prolonged hospital stays, long-term disability, increased resistance of microorganisms to antimicrobials, massive additional costs for health systems, high costs for patients and their family, and unnecessary deaths. It is estimated that healthcare acquired infections kill around 5,000-20,000 people a year. Around 100,000 people acquire a healthcare associated infection each year, with 30% of these being preventable.

As a member of the healthcare community, the South Western Ambulance Service NHS Foundation Trust (the Trust), is committed to the NHS pledge to improve and drive down the incidence of preventable health care associated infections. Best practice linked with infection prevention and control measures will always remain a high priority.

This Trust is committed to the delivery of the Care Quality Commission Essential Standards of Quality and Safety, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The intention of this regulation is to prevent people from receiving unsafe care and treatment and prevent avoidable harm or risk of harm.

The Trust will aim to assess the risks to people’s health and safety during any care or treatment and make sure that staff have the qualifications, competence, skills and experience to keep people safe.

The Trust seeks to make sure that the premises and any equipment used is safe and where applicable, available in sufficient quantities. Medicines will be supplied in sufficient quantities, managed safely and administered appropriately to make sure people are safe.

The Trust intends on preventing and controlling the spread of infection. Where the responsibility for care and treatment is shared, care planning must be timely to maintain people’s health, safety and welfare.
Cleanliness and Infection Control

Regulation 12 requires the Trust, so far as reasonably practicable, to ensure that patients and their families/carers, persons employed for the purpose of the carrying on of the regulated activity and others who may be at risk of exposure to a health care associated infection arising from the carrying on of the regulated activity, are protected against identifiable risks of acquiring such an infection by the means specified below:

- The effective operation of systems designed to assess the risk of and to prevent, detect and control the spread of a health care associated infection;
- Where applicable, the provision of appropriate treatment for those who are affected by a health care associated infection; and the maintenance of appropriate standards of cleanliness and hygiene in relation to:
  - Premises occupied for the purpose of carrying on the regulated activity,
  - Equipment and reusable medical devices used for the purpose of carrying on the regulated activity, and
  - Materials to be used in the treatment of service users where such materials are at risk of being contaminated with a health care associated infection.

Policy Statement

The Trust is committed to creating robust systems of infection prevention and control, based on a comprehensive infection prevent and control policy. This policy is a live document and is subject to constant review based upon identified risks.

Continual infection control audit allows areas of good practice to be promoted, whilst systematically identifying areas where improvements are necessary. The infection control work is underpinned by robust and comprehensive infection prevention and control processes and procedures. An annual infection prevention and control programme is developed for each financial year to set a programme of work for that year.

An annual infection control update is presented to the Quality Committee to report on progress made and to provide assurance of continued compliance with the Health and Social Care Act 2008, code of practice on the prevention and control of infections and related guidance (updated 2015).

Ken Wenman
Chief Executive

Jennifer Winslade
Executive Director of Quality and Clinical Care
Director of Infection Prevention and Control

This statement is reviewed and updated as required and during the general review of this policy and its procedures.
1. Introduction

1.1 The Trust’s Guidance and Procedures for Infection Prevention and Control Policy sets out the strategic and policy approach to the prevention and control of infection, and describes the organisational infrastructure in place including key accountabilities.

1.2 The document has been developed by the Medical Directorate, based on the requirements set out in the Care Quality Commission Essential Standards of Quality and Safety, Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, the Health and Social Care Act (2008): Code of practice on the prevention and control of infections and related guidance (updated July 2015) and other relevant guidance. It is agreed by the Infection Prevention and Control Group and agreed by the Quality Committee.

1.3 The Infection Prevention and Control document is made available to the public through the Trust’s internet site.

2. Purpose

2.1 The Trust is committed to the provision of a clean safe environment for the delivery of healthcare, patients, employees and the public.

2.2 This document is for the use of all staff and volunteers working on behalf of South Western Ambulance Service NHS Foundation Trust.

2.3 This document, and the requirements within it, are intended to provide the Trust Board with assurance that the standards of infection prevention and control are met, by respecting the patient’s right to a clean, safe environment and by our staff’s right to safe working conditions by following evidence based, best practice guidance.

2.4 The principles which govern the management of a clean safe environment must be applied to all healthcare and associated activities.

2.5 The key principles are:

- Compliance with current legislation.
- Adherence to best practice guidance issued by the Department of Health, Public Health England and other national guidance.
- Provision of person-centred care focused to meet the needs of the individual;
- Management of the risks to patients and employees arising from preventable infections.
- Evidence-based clinical practice.
- Cost effective procurement.
- The use of systems that make the best use of the skills and capacity of clinical staff to ensure effective working practices.
3. **Scope**

3.1 This document has been designed to clearly identify the line of accountability for infection prevention and control from the Chief Executive to all staff. It sets the standards expected and the monitoring and educational requirements necessary for their achievement. In conjunction with supporting policies and the infection prevention and control intranet area, the document provides a source of procedural advice and guidance for clinical and non-clinical staff.

3.2 In order to provide staff with comprehensive and practical guidance, this document incorporates the following procedures:

- Procedure 1: Infection Control Advice
- Procedure 2: Chain of Infection
- Procedure 3: Hand Decontamination
- Procedure 4: Personal Protective Equipment
- Procedure 5: Infection Control Communication
- Procedure 6: Sharps Safety and Management of Inoculation Injuries
- Procedure 7: Management of Clinical Waste
- Procedure 8: Management of Linen
- Procedure 9: Cleaning and Decontamination
- Procedure 10: Principles of Aseptic Non-Touch Technique
- Procedure 11: Facilitated Stand-by Points/Spoke stations
- Procedure 12: Transporting Patients from Closed Wards
- Procedure 13: Employee Protection from Blood-Borne Viruses
- Procedure 14: Care of the Deceased
- Procedure 15: Major Outbreaks and Public Health England
- Procedure 16: Food Transportation on Vehicles

4. **Definitions**

4.1 Cleaning: The physical removal of foreign material (e.g. dust, soil, organic material such as blood, secretions, excretions and microorganisms). Cleaning physically removes rather than kills microorganisms.

4.2 Clinical waste: Is defined in the Controlled Waste Regulations 1992 as:

- (a) Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove 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 person coming into contact with it.
4.3 Communicable: Capable of being transmitted from one person to another; synonymous with ‘infectious’ and ‘contagious’.

4.4 Contamination: The presence of microorganisms on inanimate objects (e.g. clothing, surgical instruments) or microorganisms on body surfaces such as hands, or in substances (e.g. water, food).

4.5 Colonisation: When micro-organisms are present on or in a person but not currently causing any harm, that person is said to be colonised with those organisms. For example, human beings are normally colonised with huge numbers of several different species of bacteria.

4.6 Cross-infection: Cross-infection is one term given to the transmission of infectious agents between patients within the healthcare setting. It may be direct transmission from one person to another, or indirect, for example via an incorrectly cleaned piece of equipment.

4.7 Decontamination: The removal of disease-producing microorganisms to leave an item safe for further handling.

4.8 Disease: Clinical expression of infection; signs and/or symptoms are produced.

4.9 Disinfection: The process of destroying pathogenic organisms or rendering them inert and thereby incapable of causing infection.

4.10 Hand Hygiene: A process for the removal or destruction microorganisms on hands.

4.11 Healthcare-associated infection (HCAI): Any infection acquired as a result of a healthcare-related intervention or an infection acquired during the course of healthcare that the patient may reasonably expect to be protected from. For example, a person may acquire viral gastroenteritis in many circumstances but if they acquire it in hospital from another patient, it should be regarded as healthcare associated. This has replaced the term ‘hospital-acquired infection’.

4.12 Health care provider: Any person working in a medical setting including physicians, nurses, allied health care professionals, clerical and support staff.

4.13 Infection: The entry of an infectious agent in the tissues resulting in clinical signs and symptoms (disease).

4.14 Infection prevention and control: Is concerned with preventing healthcare-associated infection within the health-care setting, whether this be patient-to-patient, from patients to staff and from staff to patients, or among-staff.

4.15 Infectious agent: Anything that may be transmitted from one person to another, or from the environment to a person, and subsequently cause an infection or parasitic infestation. Infectious agents are most often micro-organisms such as bacteria or viruses.

4.16 Outbreak: An excess over the expected incidence of disease within a geographic area during a specified time period, synonymous with epidemic.
4.17 Personal protective equipment (PPE): Specialized clothing or equipment worn by a health care professional for protection against an infectious hazard (e.g. gloves, masks, protective eyewear, gowns). General work clothes (e.g. uniforms, trousers, shirts or blouses) are not intended to function as protection against a hazard and are not considered personal protective equipment.

4.18 Pathogen: A micro-organism that is capable of causing infection. Many micro-organisms are opportunistic pathogens; that is, they will cause infection in vulnerable individuals but not, normally, in healthy adults.

4.19 Sharps: Needles, syringes, blades, glass vials or other objects capable of causing punctures or cuts.

4.20 Sterilisation: The destruction of all forms of microbial life including bacteria, viruses, spores and fungi. Items must be cleaned thoroughly before effective sterilization can take place.

4.21 Universal precautions: Correctly called universal blood and body fluid precautions, these are the precautions that are taken with all blood and ‘high-risk’ body fluids. They are based on the principle that any individual may be infected with a blood borne virus, such as HIV or hepatitis B, and so pose a risk of infection; no individual can be regarded as completely ‘risk free’.

4.22 The phrase ‘standard precautions’ is sometimes used interchangeably with universal precautions and is used to describe the actions that should be taken in every care situation to protect patients and others from infection, regardless of what is known of the patient’s status with respect to infection, and includes:

- Hand hygiene;
- Care in the use and disposal of sharps;
- Correct use of personal protective equipment for contact with all blood, body fluids, secretions and excretions;
- Providing care in a suitably clean environment with adequately decontaminated equipment;
- Safe disposal of waste;
- Safe management of used linen.

5. Duties, Responsibilities and Reporting

5.1 The Board

5.1.1 Board members are collectively responsible for providing leadership and direction on health and safety matters. Members will have a full understanding of the risks, systems in place for managing the risks and appreciation of the causes of any failures. The Board are responsible for monitoring the effectiveness of infection control measures through the annual infection audit and report.
5.2 **Chief Executive**

5.2.1 The Chief Executive has a key role in ensuring that systems are in place and being adhered to, to manage any significant risks facing the organisation and ensure compliance with the Health and Social Care Act (2008). The Chief Executive is ultimately responsible for infection control measures, a responsibility which is delegated to the Executive Director of Nursing and Governance. The Chief Executive is responsible for ensuring compliance with the Trust’s policy which includes standard (universal) infection control precautions, cleaning, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients, disinfection and the reporting HCAIs to Public Health England.

5.3 **Director of Infection Prevention and Control**

5.3.1 The role of Director of Infection Prevention and Control is assigned to the Executive Director of Quality and Clinical Care, who is nominated by the Board to have executive responsibility for infection control and cleaning within the Trust. The post holder has responsibility for overseeing the Infection Control Group, Infection Control Policy and Annual Programme, and is an integral member of the Quality Committee, reporting directly to the Chief Executive.

5.3.2 They are responsible for monitoring and managing the risks associated with infection prevention and control, in accordance with the Trust’s Risk Management Strategy to ensure compliance with the Health and Social Care Act (2008). They have the authority to challenge inappropriate clinical hygiene practice.

5.3.3 They are designated as the Decontamination Lead as per the Health and Social Care Act (2008) and the responsible Director for the routine decontamination of equipment.

5.3.4 The authority to challenge inappropriate antibiotic prescribing decisions is delegated to the Executive Medical Director.

5.3.5 Day to day leadership responsibility is delegated to the Clinical Director.

5.4 **Deputy Director for Infection Prevention and Control (Clinical Director)**

5.4.1 The Clinical Director is designated as the Deputy Director for Infection Prevention and Control.

5.4.2 The Clinical Director is responsible for working with Directors, Deputy Directors and heads of department to identify and manage the risks associated with infection prevention and control and to monitor compliance with internal and external assurance frameworks in conjunction with the Executive Director of Nursing and Governance and the Senior Clinical Lead (East). They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures.
5.5 Infection Prevention and Control Manager

5.5.1 The Infection Prevention and Control Manager is responsible for the day to day management of IPC, maintaining the IPC Policy, and implementing good practice within the Trust. They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures. The IPC Manager is also responsible for monitoring completion of the infection prevention and control annual programme and for monitoring compliance with relevant legislation. They provide advice and support to clinical and non-clinical staff to help ensure patients are cared for in a clean, safe environment. They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures.

5.5.2 The Infection Prevention and Control Manager maintains a high clinical profile within the Trust, the health community and at national meetings and facilitates the infection prevention and control workplace review programme and undertakes regular station and vehicle reviews. They are responsible for the communication of infection prevention and control best practice and current research throughout the Trust, also to encourage implementation and ensure Trust literature, policy and procedures are up to date.

5.5.3 The Infection Prevention and Control Manager is responsible working with operational and non-operational managers and clinicians to ensure compliance with good infection prevention and control procedures and for the development of clinical practice which supports and enhances the provision of infection prevention and control.

5.5.4 The Infection Prevention and Control Manager will review infection prevention and control related incidents and escalate issues and disseminate lessons learnt as appropriate. They are responsible for the production of and support for infection prevention and control training sessions, for use in the corporate and mandatory education programmes and review relevant sessions to ensure compliance with current IPC practices.

5.6 Infection Prevention and Control Support Officer

5.6.1 The Infection Prevention and Control Support Officer is responsible for supporting the Infection Prevention and Control Manager with the day to day management of IPC, maintaining the IPC Policy, and implementing good practice within the Trust. They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures. The IPC Support Officer is also responsible for supporting the completion of the infection prevention and control annual programme and for monitoring compliance with relevant legislation. They support clinical and non-clinical staff within their remit to help ensure patients are cared for in a clean, safe environment. They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures.

5.6.2 The Infection Prevention and Control Support Officer assists with facilitating the infection prevention and control workplace review programme and undertakes regular station and vehicle reviews and undertakes any relevant reporting associated with this. They provide support with the communication of infection
prevention and control best practice and current research throughout the Trust, also to encourage implementation and ensure Trust literature, policy and procedures are up to date.

5.6.3 The Infection Prevention and Control Support Officer supports working relationships with operational and non-operational managers and clinicians to ensure compliance with good infection prevention and control procedures and for the development of clinical practice which supports and enhances the provision of infection prevention and control.

5.7 Executive Director of Operations

5.7.1 The Executive Director of Operations is responsible for ensuring the effective implementation and monitoring of infection prevention and control across the Trust within the A&E Service Line. They are ultimately responsible for ensuring that ambulance vehicles and equipment are cleaned appropriately in accordance with the procedures laid down in the Trust’s Guidance and Procedures for Infection Prevention and Control Policy and Strategy.

5.8 The Executive Director of People and Culture

5.8.1 The Executive Director of People and Culture maintains contracts with external Occupational Health provider(s) to ensure the effective screening of new staff and to provide expert support and services for staff in accordance with the Trust's Occupational Health Policy.

5.9 Head of Education and Professional Development

5.9.1 The Head of Education and Professional Development is responsible for ensuring that all staff (clinical and non-clinical), including contractors receive education, information and training in infection prevention and control appropriate to their job role. They are responsible for ensuring that all staff have a working knowledge of Infection Prevention and Control Guidance and Procedures detailed within Trust documents.

5.9.2 The post holder is responsible for developing and updating the Trust’s training needs analysis to ensure it reflects the requirements of national guidance with regards to standard (universal) precautions, cleaning, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients and disinfection. Infection Prevention and Control must be included as appropriate in training development plans, learner outcome plans and be robustly recorded through an effective and accessible training records system.

5.10 Pharmaceutical Advisor

5.10.1 The Pharmaceutical Advisor is responsible for providing expert guidance to ensure prudent and appropriate prescribing according to national guidelines and recommendations. The Advisor is responsible for ensuring that all Trusts antibiotic PGDs comply with national antibiotic prescribing guidance and that prescribers are provided with evidence based formulary. The Pharmaceutical Advisor is responsible for maintaining the Trust’s antimicrobial prescribing
guidance in accordance with the Trust’s Medicines Management Policy.

5.11 Director of Operational Services

5.11.1 The Director of Operational Services is responsible for ensuring that all ambulance vehicles and equipment have received approval from the Vehicle, Equipment and Uniform Working Group (VEUWG), including an infection prevention and control evaluation prior to purchase.

5.11.2 The Director of Operational Services is responsible for the cleaning and decontamination of vehicles and medical equipment during the vehicle deep cleaning process.

5.12 Head of Estates

5.12.1 The Head of Estates is responsible for ensuring that environmental, estate and waste management policies are compliant with infection prevention and control best practice. They are responsible, in alignment with the allocated budget, for ensuring that all premises are fit for purpose and maintained in good physical repair and condition to support good infection prevention and control practice. The Head of Estates must also ensure that all non-Trust owned premises comply with Trust IPC standards.

5.12.2 The Head of Estates is responsible for working with Procurement to appropriately contract and manage cleaning services within the Trust.

5.12.3 The Head of Estates will ensure that timely and effective communication systems are in place to alert the IPC Manager to any planned or possible developments and refurbishments and at all stages of construction, including the final commissioning of new or upgraded facilities.

5.12.4 The Head of Estates is responsible for the management of external estates contracts to ensure compliance with effective waste collection in compliance with the Waste Management Policy.

5.13 Make Ready Operatives

5.13.1 Deliver vehicle cleaning according to the principles contained within the Make Ready Operating Manual. Follow specific cleaning schedule/s as agreed and in accordance to Trust guidance. Monitor all areas to ensure the highest levels of cleanliness are being continually achieved and bring to the attention of Make Ready Manager any situation that could potentially compromise achievement of the appropriate cleaning standards.

5.13.2 Deliver additional emergency deep cleans as per SOP C23 - Emergency Deep Clean Protocol and Escalation Procedure.

5.13.3 Post holders should feel empowered to challenge and report poor practice with respect to infection prevention and control.

5.14 County Commanders, Head of Integrated Urgent Care Services and Tiverton Manager
5.14.1 The County Commanders, Head of Integrated UCS and the Tiverton Manager are responsible for infection prevention and control in all activities within their area of responsibility. They are responsible for ensuring the effective implementation and monitoring of infection prevention and control, including undertaking infection prevention and control reviews as requested by the Clinical Director.

5.14.2 Responsible for challenging poor practice and non-compliance with infection prevention and control policies, procedures and guidance.

5.14.3 They are responsible for ensuring that ambulance premises, ambulance vehicles, treatment centres and equipment are cleaned appropriately according to the principles within the IPC Policy and achieve the Trust’s high standard of cleanliness through a visible presence, monthly station reviews and support of their Operational Officers. County Commanders and Head of Integrated UCS are designated as the responsible manager for the routine decontamination of equipment within their area.

5.15 **Line Managers**

5.15.1 All line managers are required to oversee the implementation of infection prevention and control policies within their area of responsibility and to actively participate in the management of IPC related incidents and risks.

5.15.2 Managers are responsible for including infection prevention and control within the managerial job descriptions and appraisals of all staff under their line management. Operations Officers are responsible for ensuring the cleaning and decontamination of vehicles and equipment is taking place according to the IPC Policy and reiterating the importance of IPC to frontline staff.

5.15.3 All managers are responsible for challenging poor practice and for ensuring compliance with infection prevention and control policies, procedures and guidance.

5.16 **Trust Staff and Volunteers**

5.16.1 All staff and volunteers within the Trust are responsible for maintaining best practice for infection prevention and control. All staff have a responsibility to undertake infection control training and to ensure that infection control policies are effectively implemented in their area of work; which must meet the Trust’s high standard of cleanliness at all times.

5.16.2 All staff and volunteers are responsible for ensuring the continued compliance with the Health and Social Care Act (2008) including following Trust Policy and guidance on standard (universal) infection control precautions, aseptic technique, safe handling and disposal of sharps, prevention of occupational exposure to blood-borne viruses, isolation of patients and disinfection.

5.16.3 The Trust empowers staff to challenge and report poor practice with respect to infection prevention and control.
5.17 Organisational Framework

5.17.1 Infection prevention and control performance is monitored and led by the Infection Prevention and Control Group which reports to the Board through the Quality Committee. The group provides feedback and advice to the Clinical Effectiveness Group, Vehicle, Equipment and Uniform Working Group and Board as requested.

5.17.2 The Vehicle Uniform and Equipment Working Group (VEUWG) is responsible for ensuring that infection prevention and control is fully considered during the selection of consumables and medical equipment.

5.17.3 Adverse incidents relating to infection control must be reported using the incident reporting procedure detailed in the Incident Reporting Policy. Incidents will be reviewed at every Infection Prevention and Control Group, according to the Terms of Reference. Chemical, biological, radiological and nuclear incidents are dealt with separately in the Major Incident Plan.

6. Risks, Incidents and Improvement Orders

6.1 Risk Assessment

6.1.1 Risk assessments must be carried out in accordance with the Trust’s Risk Management Strategy and associated documentation. Risks in respect of healthcare associated infection and serious communicable diseases may be identified on an on-going basis via incident reporting procedures, complaints, claims, infection control audits and risk assessments. These processes are monitored to ensure that any risks are identified and acted upon in a timely manner. Incidents and change in risk ratings are reported to the Infection Prevention and Control Group, for revision of the Trust’s Infection Prevention and Control Risk Assessment. All staff should receive training in risk management and a risk assessment tool is available on the Trust’s intranet site.

6.1.2 Staff undertake dynamic risk assessments as part of their working practice and the Trust will undertake an organisational risk assessment as part of the rolling risk assessment program. The organisational risk assessment will identify any specific roles within the organisation that are at higher risk, and a specific risk assessment will be carried out for these. The organisational risk assessment will assess how likely it is that blood borne viruses or other communicable diseases (e.g. respiratory or gastrointestinal infectious diseases) could cause ill health and decide if existing precautions are adequate.

6.1.3 The assessment will consider the following:

- Frequency and scale of contact with blood or other body fluids;
- Number of different person’s blood/bodily fluids with which contact is made;
- Existing information on injuries/ill health reported in the workplace;
- Impact on the organisation of multiple casualties within staff resources in the event of an outbreak;
- Quality of control measures.

6.1.4 Healthcare associated infection risk assessments will be owned by the IPC
Group who will monitor the action plans. The IPC Team will co-ordinate the risk assessments and monitor progress with reviews. Staff will be made aware of any specific risks via the weekly Bulletin, Operational Notices or Clinical Notices, Clinical Guidelines and publication on the Infection Prevention and Control section of the Trust’s intranet.

6.2 Risk Management

621 It is fundamental to the Trust’s risk management system that all clinical and non-clinical adverse incidents, hazards and near misses are identified, recorded, analysed with the lessons learnt implemented and controls put in place to avoid their future re-occurrence.

622 All incidents regarding infection prevention and control, including reported outbreaks of healthcare acquired infections, must be reported and investigated according to the Incident Reporting Policy. The Infection Prevention and Control Group reviews all related incidents according to their Terms of Reference. Root cause analysis should be applied according to national patient safety guidelines. In the case of suspected outbreaks, the Trust will co-operate fully with relevant partners within the health community during any investigation.

623 The Serious Incident Policy must be followed for any incident that meets the current definition of an SI.

6.3 Internal Improvement Orders

631 The Trust strives to ensure that all estates and vehicles are maintained to a high standard of cleanliness, compliant with the expectations of the Health and Social Care Act (2008). Should staff (outside of the IPC Team) find any area of the estate or vehicle/s be found to fall below the standards specified within the policy or other associated documentation (e.g. cleaning schedules), an incident report must be submitted.

632 Routine concern not immediately affecting the health and/or safety of patients or staff. In the first instance the concern should be discussed with the responsible line manager, with a clear deadline agreed for completing the actions. Should resolution not occur within the agreed period, the incident must be reported to the Executive Director of Nursing and Governance or Clinical Director. The Executive Director of Nursing and Governance/Clinical Director will liaise with the appropriate Executive Director to ensure rapid completion of any outstanding actions. Examples of routine concerns include non-performance of cleaning staff or estates issues which compromise the achievement of infection prevention and control standards.

633 Urgent concern potentially affecting the health and/or safety of patients or staff. Where a concern is raised regarding the standards of infection control which poses a potential threat to the health and/or safety of patients or staff, the Trust must respond quickly to address the breach in standards.

634 Following any immediate action required to reduce the risk of the breach, the following senior staff are authorised to issue an Improvement Order:
• Chief Executive.
• Executive Medical Director.
• Executive Director of Nursing and Governance.
• Executive Director of Operations.
• Clinical Director.
• Head of Integrated Urgent Care Services.
• Head of Operational Services.
• Head of Clinical Hubs.
• Senior Clinical Leads.
• Health, Safety and Security Manager.
• Infection Prevention and Control Manager.

6.3.5 The Improvement Order will be issued to the appropriate line manager for urgent action within a time period as deemed appropriate by the issuing Director/Manager. The Improvement Order may authorise the removal of any vehicle from service or the closure of premises. Any failure to achieve compliance will be escalated to the Chief Executive. All improvement notices will be reported to the Board within the standard Quarterly Infection Prevention and Control Report.

6.4 Animals on Stations and in Vehicles

6.4.1 Animals, including pets, are not permitted in any ambulance building, including Headquarters, administrative hubs, ambulance stations, treatment centres and air ambulance bases, with the exception of assistance animals (e.g. guide dogs) or therapy animals (appropriate risk assessments need to be in place).

6.4.2 Animals are not permitted on any Trust vehicles, with the exception of assistance animals (e.g. guide dogs) if all other options have been exhausted and the patient’s condition indicates immediate transfer.

6.4.3 If an animal has been in contact with stations or vehicles, appropriate cleaning must be completed.

7. Antimicrobial Stewardship

7.1 The Trust supports the judicious use of antimicrobials and aims to develop good antimicrobial stewardship by:

• Monitoring and evaluating antimicrobial prescribing and ensuring it complies with the Public Health England and National Institute for Health and Care Excellence antimicrobial prescribing guidance – managing common infections.
• Providing feedback to prescribers about their antimicrobial prescribing and any patient safety incidents related to antimicrobial use.
• Using PGDs which reflect the Public Health England and National Institute for Health and Care Excellence antimicrobial prescribing guidance – managing common infections.
• Providing education and training to clinicians about antimicrobial stewardship and antimicrobial resistance.
• Encouraging trust clinicians to promote antimicrobial stewardship and to become ‘Antibiotic Guardians’.

7.5 Consultation skills are encouraged that improve antimicrobial stewardship. During the consultation Trust Clinicians should take time to discuss with the patient and/or their family members or carers (as appropriate):

• The likely nature of the condition;
• Why prescribing an antimicrobial may not be the best option;
• Alternative options to prescribing an antimicrobial;
• Their views on antimicrobials, taking into account their priorities or concerns for their current illness and whether they want or expect an antimicrobial;
• The benefits and harms of immediate antimicrobial prescribing;
• What they should do if their condition deteriorates (safety netting advice) or they have problems as a result of treatment;
• Whether they need any written information about their medicines and any possible outcomes.

7.6 Trust Clinicians will not issue an immediate prescription or supply antimicrobials from stock to a patient who is likely to have a self-limiting condition.

7.7 When an antimicrobial is a treatment option, Trust Clinicians must document the reason for prescribing, or not prescribing, an antimicrobial in the patient’s clinical record. They must document the plan of care as discussed with the patient, their family member or carer, including the planned duration of any treatment.

7.8 If antimicrobial prescribing is not the most appropriate option Trust Clinicians must discuss other options with the patient, their family member or carer. Options might include self-care with over-the-counter preparations, delayed prescribing or non-pharmacological interventions.

7.9 PGDs for the supply of antimicrobials that have been implicated in the increase in prevalence of clostridium difficile infection will include recent advice on reducing the risk of infection issued by the Department of Health.

7.10 All antimicrobials will be supplied to patients for the minimum recommended period of time. Any use of parenteral antimicrobials will be guided by national advice which is now incorporated into the guidance produced by the National Institute for Health and Care Excellence in partnership with Public Health England.

8. Training Requirements

8.1 All new employees are required to fulfil pre-employment health checks before commencing operational duties and all members of clinical staff must complete appropriate infection prevention and control induction training. Induction training programmes for new staff incorporate the principles and practice of infection prevention and control, awareness of policy and guidance documents, hand hygiene, safe handling and disposal of sharps, management of inoculation incidents, feedback of audit results, examples of good practice and action needed to correct deficiencies.
8.2 Infection prevention and control training is incorporated in the annual development day programme, as detailed in the Trust’s Training Needs Analysis. Compliance with training will be monitored as part of the annual personal appraisal process. All members of staff have a personal training record, which is monitored using the Trust’s Electronic Staff Record (ESR). The frequency of training for all members of staff including non-clinical will be in accordance with the Training Needs Analysis.

8.3 Line Managers are responsible for monitoring compliance with the Infection Prevention and Control Policy on a daily basis and challenging inappropriate practice. The results of IPC reviews, external assessments and incidents reported to the Infection Prevention and Control Group will be used to ensure that the training programme provides effective, focused training. Specific root cause analysis training is delivered to Officers and Managers as required.

9. Monitoring

9.1 The Chief Executive and the Board are responsible for monitoring the effectiveness of the Infection Prevention and Control Policy. The Board and Quality Committee will receive an annual Infection Prevention and Control Report presented by the Executive Director of Nursing & Governance and Clinical Director.

9.2 The annual Infection Prevention and Control Report will be the Trust’s infection control assurance framework and will include:-

- Detailed progress against the annual infection prevention and control annual programme.
- Ratification of the following year’s annual infection prevention and control annual programme.
- Effectiveness of the policy through the presentation of audit findings from station reviews, identifying improvements in infection control standards.
- Assurance of continued compliance with the Health and Social Care Act (2008).
- Assurance of compliance with Care Quality Commission Essential standards.
- Assurance of compliance with the NHS Litigation Authority standards.
- Information from the Head of Education to reflect that the standards of training for non-clinical and clinical staff identified within the training needs analysis are being met.
- A summary of reported incidents reviewed by the Infection Prevention and Control Group and any resulting changes to practice.
- The reduction of infection control risks and their subsequent downgrading on the Risk Register.
- Information from the Health, Safety and Security Manager regarding the number of inoculation incidents reported, confirmation that the immediate management of the injury recorded was appropriate and that support services were provided as appropriate.
- Assurance from the Pharmaceutical Advisor that Trust PGDs and prescribing continues to comply with national antibiotic prescribing guidance.
- A summary of work undertaken by the key individuals responsible for infection prevention and control detailed in section 5, demonstrating that they are fulfilling their identified duties.
• Information about the Trust’s processes and arrangements for preventing and controlling health care acquired infections’ have been and continue to be available to patients and the public through publication of the Guidance and Procedures for Infection Prevention and Control document on the Trusts internet site.

9.3 The Board will receive an update on compliance with infection prevention and control key performance indicators through the Quarterly IPC Report. The Executive Director of Nursing and Governance will present an exceptions report should any serious incidents be reported, any deviations from the policy occur, or an Improvement Notice is issued. The Board may also gain assurance from the Risk Manager through the presentation of information regarding submitted incident reports.

9.4 Monthly station and vehicle reviews should be completed for all Trust ambulance stations by a member of the operations team. The review assesses compliance with infection prevention and control measures throughout the Trust, ensuring that all aspects of the policy are implemented, and cleaning standards are maintained. Each month the County Business Manager must ensure the infection prevention and control review is completed. The results are analysed and compared with the IPC Workplace Review results on a quarterly basis and fed back to the IPC Group for information and appropriate action. The responsibility of completing the actions lies with Operations.

10. Associated Documents

10.1 A comprehensive range of resources can be access through the Trusts intranet site within the Infection Control and Prevention section; this will give access to relevant internal and external publications.
Procedure 1 - Infection Prevention and Control Advice

1. Internal Advice and Guidance

1.1. Infection prevention and control advice is available to staff at all times.

1.2. In hours and routine requests for advice should be directed to the Infection Prevention and Control Manager via telephone 07788565457 or email to fataha.sultan-petty@swast.nhs.uk.

1.3. Requests for time critical advice or any advice during the out of hours period must be made via the Clinical Hub, who will contact the Senior Clinical Advisor on-call.

1.4. The infection prevention and control intranet page provides a comprehensive source of procedural advice and guidance for clinical staff and should be consulted in the first instance. The Infection Prevention and Control A-Z, which can be found in the advice section on the intranet page is a quick glance guide for staff on infectious diseases, what precautions to take if staff have come into contact with a potential infectious disease and vehicle cleaning requirements.

1.5. The Public Health England provide specialist advice, with their website (https://www.gov.uk/topic/health-protection/infectious-diseases) providing a particularly useful and authoritative source of information.

1.6. The needle stick and sharps injury helpline must be contacted following any such injury on 0345 0944021 option 2.

1.7. Staff should report all needle stick, sharps and contamination injuries to the Trust via the incident reporting system.

2. Additional Advice

2.1. Out-of-hours advice is also available by calling the relevant hospital switchboard and asking for the on-call Microbiologist.

2.2. Contact for Public Health England for specialist support:

- **PHE South West**
  Professor Debra Lapthorne, Centre Director
  2 Rivergate
  Temple Quay
  Bristol
  BS1 6EH
  Tel: 0300 303 8162
Procedure 2 - Chain of Infection and Preventing the Spread

1. Purpose

1.1 A clear understanding of the chain of infection is essential in order to implement appropriate transmission based precautions and prevent the spread of infection.

1.2 This procedure is set out to provide an overview of the chain of infection to enable crews to recognise how to break the chain and protect themselves and their patients.

2. Definitions

2.1 The chain of infection refers to the process by which infection can be spread from one susceptible host to another.

2.2 A primary pathogen is any disease producing microorganism.

2.3 A commensal is an organism that generally resides on the human body without causing harm. Otherwise known as colonisation.

3. The Chain of Infection

3.1 Figure 1 - Chain of Infection
4. **Infectious Agents**

4.1 An infectious agent can be a primary pathogen or a commensal given the right opportunity.

4.2 The greater the organisms virulence (ability to grow and multiply), invasiveness (ability to enter the host) and pathogenicity (ability to cause disease) the greater the possibility of that microorganism causing an infection.

4.3 Microorganisms can be split into the following groups:

- **Bacteria** - minute organisms that are, to a greater or lesser extent, susceptible to antibiotics.
- **Viruses** - smaller than bacteria and known to survive outside the body but can only grow within cells, not susceptible to antibiotics.
- **Fungi** - can be either moulds or yeasts, not all are infectious.
- **Protozoa** - single celled organisms that commonly show characteristics associated with animals, they are motile and able to survive in the environment.
- **Parasites** - organisms that live on or in a host and get their food at the expense of the host.
- **Prions** - infectious agents primarily composed of proteins.

5. **Reservoirs**

5.1 A reservoir is somewhere microorganisms can thrive and reproduce. Reservoirs are those which have been proven by epidemiological and microbiological investigations to be the origin of infection.

5.2 Reservoirs can include:

- Patients;
- Staff;
- Equipment and Vehicles;
- Environment including soil and dust;
- Animals and Insects;
- Food and Water.

6. **Portal of Exit and Portal of Entry**

6.1 In order to cause disease a pathogen must have a way to enter the body – a portal of entry.

6.2 To transmit to another host the microorganism must be able to leave the body – a portal of exit.

6.3 The route of exit and entry may be different such as in enteric infections which enter via the mouth and leave via the rectum in faeces.

6.4 The route of exit and entry may be the same such as in respiratory infections where droplets are exhaled by the infectious host and then inhaled by the susceptible host.
6.5 Interventions which breach mucous membranes such as insertion of invasive devices (intravenous cannulation) can also provide portals of entry and exit.

6.6 Different microorganisms can use one or different routes to find new hosts:

- Respiratory Tract – through the inhalation of organisms, including Legionnaire’s disease (Legionella) Open Tuberculosis, Chicken pox and Influenza.
- Alimentary Tract – through ingestion of contaminated food or water including Norovirus, Salmonella, and Clostridium Difficile.
- Skin and Mucosa – through damaged skin or by inoculation including the transmission of Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C.

7. Mode of Transmission

7.1 The one feature which distinguishes infection from all other disease is that it can be spread, one person can catch it from another or via a vector; they can also be caused from the environment.

7.2 Infections can be transmitted by:

- Direct contact.
- Indirect contact.
- Aerosols.
- Ingestion.
- Inoculation.
- Absorption.
- Vectors.

7.3 Direct contact is physical contact with the infectious site, for example contact with discharge from wounds or skin lesions.

7.4 Indirect contact through coughing or sneezing or when an immediate carrier is involved in the spread of pathogenic microbes from one source of infection to another person, for example on the hands of healthcare workers or any equipment which becomes contaminated and is then used on another patient without being decontaminated.

7.5 Aerosols produced by sneezing or in the dispersal of skin scales can spread through the air and infect other such as in chickenpox, measles and mumps.

7.6 Ingestion infection can occur when organisms capable of infecting the gastrointestinal tract are ingested. When these organisms are excreted faecally by an infected person faecal-oral spread is said to occur.

7.7 Inoculation infections occur when microorganisms are inoculated directly into the blood stream. Inoculation injuries include; bites and scratches that break the skin, splashes of blood or body fluids to the eyes, nose or mouth as well as needle stick injuries.
7.8 Vectors are any intermediate agent which can carry an infection between humans/animal for example; mosquitoes.

7.9 Absorption is a route of entry for a few tropical diseases.

8. **Susceptible Host**

8.1 A susceptible host is a person who cannot resist a microorganism invading the body, multiplying and resulting in an infection.

8.2 The host is susceptible to the disease, lacking immunity or physical resistance to overcome the invasion by the pathogenic microorganism.

8.3 Susceptible hosts come in all shapes and sizes and are not always easy to identify. They can be:

- Very young;
- Frail and elderly;
- Those patients on steroids, dialysis or chemotherapy and with pre-existing conditions;
- Patients with severe shock and trauma, this could be physical or psychological, both will have an adverse impact on the patients susceptibility to infection.

9. **Preventing the Spread of Infection**

9.1 In order to prevent the spread of infection the chain of infection must be broken. This can be done at any point in the chain. The most effective way to do this is by employing appropriate standard precautions.

9.2 Standard precautions is an umbrella term used to encompass eight key elements that, when implemented appropriately, will prevent the spread of infection. This includes:

- Hand hygiene (Procedure 3);
- Personal Protective Equipment (Procedure 4);
- Sharps disposal (Procedure 6);
- Waste disposal (Procedure 7);
- Management of clean and soiled linen (Procedure 8);
- Management of blood and body fluid spills (Procedure 9);
- Decontamination of equipment and the environment (Procedure 9).

9.3 Performing hand hygiene at the right time and in the most appropriate way for the situation as this is the single most effective measure to prevent the spread of infection.

9.4 Using appropriate personal protective equipment as indicated by risk assessment to protect the skin from contamination, soiling, splashing and potential harmful microorganisms.
9.5 Managing blood and bodily fluid spillages appropriately to protect all those in the surrounding environment from exposure to microorganisms that could cause harm.

9.6 Managing cross contamination of equipment by preventing the reuse of single use equipment and preventing the reuse of single patient use equipment on other patients. Ensuring decontamination of reusable equipment between patients and preventing any associated environmental contamination. This will reduce the risk of equipment being a factor in the spread of infection.

9.7 Controlling environmental factors by ensuring that cleaning and responsibilities are clear and that the care setting, including fixtures and fittings, are adequately decontaminated and maintained to prevent cross contamination through the environment.

9.8 Safe disposal of clinical and general waste by ensuring that employees are aware of the correct guidance for the disposal of waste and sharps to prevent the risk of inappropriate placement of clinical waste that could potentially cause harm.

9.9 Other fundamental issues that are required to prevent the spread of infection include, but are not limited to:

- Education of employees, clinical and non-clinical;
- Immunisation of healthcare workers;
- Monitoring the implementation of Infection Prevention and Control Policy and procedures;
- Appropriate communication of infection risk between healthcare workers and services (Procedure 5).

9.10 Staff who have experienced diarrhoea and/or vomiting must not return to work until they have been symptom free for at least 48 hours. Staff involved in the handling of food e.g. catering and filling vending machines, must not undertake those activities until they have been symptom free for at least 72 hours.

10. Infestations

10.1 Protective Measures

10.1.1 Standard precautions must be taken if there is any suspicion of infestation, especially hand decontamination and the use of PPE such as gloves and aprons. All items of linen must be red bagged and laundered appropriately (Procedure 8).

10.1.2 With regards to cleaning, staff must to pay close attention to the area immediately occupied by the patient. The trolley, adjacent walls and floor must be cleaned with disinfectant wipes. In cases where there is visible infestation such as fleas, crews must follow the SOP for Flea Infestation found here:

10.1.3 Staff also may wish to request a return to base to change clothing. Any member of staff who suspects they may have become infested should contact the Occupational Health Department or visit their GP for further advice.

10.1.4 For further information on types of infestations, please look at the A-Z of infectious diseases guide found on the IPC intranet page under advice.
Procedure 3 - Hand Decontamination

1. **Purpose**

1.1 Hand decontamination is widely recognised as the single most effective measure for preventing the spread of infection and is vital for ensuring clean safe care.

1.2 This procedure is set out to provide standards for hand decontamination.

1.3 This procedure will provide guidelines to support staff to reduce the transmission of pathogenic micro-organisms between patients and healthcare workers.

2. **Definitions**

2.1 Hand decontamination is a general term referring to any action of hand cleansing that reduces or inhibits the growth of micro-organisms.

2.2 Hand washing is defined as washing hands using plain or antibacterial soap and water.

2.3 Alcohol based hand rub refers to the use of alcohol containing preparations designed for application to the hands in order to inactivate micro-organisms and/or temporarily suppress their growth.

2.4 Hand wipes refer to a piece of pre wetted fabric or paper that is impregnated with antibacterial properties to remove soiling as well as inactivate and/or remove micro-organisms. These wipes are always used in conjunction with alcohol based hand rub when there is no access to soap and water.

2.5 Bare below the elbows refers to Lord Professor Dari’s initiative (2008) which looks to remove the barriers to hand hygiene. This includes the removal of:

- Wrist watches (only allowed for specialist EPRR operations when additional and extensive PPE is required);
- Fitness devices worn on wrists;
- Bracelets;
- Rings with stones;
- Long nails (nails should be short and clean);
- Nail varnish;
- Nail extensions;
- Long sleeves (by shortening sleeves or wearing sleeve protectors).

2.6 This applies to all staff wearing operational uniform and any other staff who are involved in direct patient care, e.g. out of hours GPs.

2.7 Hand hygiene opportunities are defined using the 5 moments of hand hygiene developed by the World Health Organisation. The five moments are defined as the key moments that health care workers should decontaminate their hands to prevent the spread of infection (Figure 2).
3 Personal Practice

3.1 The following standards are the minimum requirement for effective hand hygiene and to reduce the contamination of frequently handled equipment. All staff, including logistics must be bare below the elbows whilst in operational uniform. This includes the removal of wrist watches, stoned rings, bracelets, long sleeves, long nails, nail extensions and nail varnish (clear or coloured). These items are all capable of harbouring pathogens even after hand hygiene has been performed. The only exception to this is when long sleeves are required as part of personal protective equipment (PPE), such as wearing high visibility jackets, air ambulance suits or other Trust issue PPE. Sleeve protectors should be worn, where appropriate, in these situations.

3.2 Long sleeved jackets will easily become contaminated, impede access to wrists and prevent thorough hand washing. Long sleeved jackets must be removed or sleeves shortened to mid forearm for hand washing.

3.3 All staff in operational uniform must carry a portable hand sanitiser for use during domiciliary care and care delivered outside of a clinical setting.

3.4 Hand gel at the entrances to hospital departments should be used by all staff, especially when entering and leaving.

3.5 Gloves must not be worn continually and must be changed between ‘clean’ and ‘dirty’ procedures.

3.6 Only freshly donned gloves may be worn during aseptic/clean procedures.

3.7 Unless contact with blood or bodily fluids is likely, gloves must not be worn whilst conveying a patient.

3.8 Staff must be particularly mindful to remove gloves and perform effective hand hygiene prior to touching any hospital equipment including patient monitoring equipment and handover screens/IT equipment. This is to prevent cross contamination and break the chain of infection.

3.9 Hands should be washed with soap and water before leaving any hospital department.

3.10 Hand washing is the most basic and effective standard precaution and will remove any soiling. It will also get rid of the build-up of alcohol gel and make subsequent use of the gel more effective.

4 Opportunities for Hand Decontamination

4.1 The opportunities for hand decontamination (hand hygiene) used by the Trust were established by the World Health Organisation in 2005 and have been integrated into more than 400 hospitals worldwide.

4.2 These “5 moments” aim to offer healthcare workers clear advice on how to integrate hand hygiene in the complex task of care. The “5 moments” for hand
decontamination can most easily be represented by Figure 2 (Trust Hand Washing Technique posters are available and must be placed wherever hand washing facilities are available).

4.3 Figure 2- WHO Five Moments

4.5 In addition to those opportunities listed in Figure 2, other opportunities to decontaminate hands include (but are not exclusive to):

- Before preparing, eating, drinking or handling food;
- Before and after going to the toilet;
- Before and after smoking;
- Before starting work and after finishing work;
- Before putting on and after the removal of personal protective equipment;
- After handling dirty linen or waste;
- After cleaning equipment or environment;
- After handling contaminated items, including dressings, bedpans, urine drainage bags.
5. **Decontamination Options**

5.1 There are currently three options for hand decontamination:

- Hand washing;
- Alcohol hand sanitiser;
- Hand wipes.

5.2 Hand washing with soap and water is the gold standard for infection prevention and control and must be undertaken on a regular basis. In the pre hospital care environment it should be undertaken when there is access to appropriate hand wash facilities such as, in hospital departments and on return to station. Hands should be washed as shown in the hand decontamination technique which is illustrated below in the next section. If there is access to hand wash facilities these should be utilised.

5.3 Alcohol based hand sanitisers inactivate microorganisms and/or temporarily suppress their growth; they are only effective on physically clean hands as they are unable to penetrate through physical soiling.

5.4 All clinical staff must carry alcohol handrub when in uniform.

5.5 Personal issue moisturiser is available to all staff, and should be used as required after the use of alcohol handrub. If staff experience any form of localised skin reaction or dermatitis (see section 7 Skin Care) following the use of alcohol handrub, they should seek treatment through their GP and request referral to the occupational health service. The Trust provides an alternative handrub on the product catalogue, for staff who require a more sensitive product.

5.6 Approximately 3mls of alcohol based hand sanitiser should be applied to visibly clean hands and rubbed in as shown in the hand decontamination technique in Figure 3. Hand sanitiser should be rubbed in until the solution has evaporated and the hands are dry.
Hand-washing technique with soap and water

1. Wet hands with running water
2. Apply enough soap to cover all hand surfaces
3. Rub hands palm to palm to create lather
4. Rub back of each hand with palm of other hand with fingers interlaced
5. Rub palm to palm with fingers interlaced
6. Rub with back of fingers to opposing palms with fingers interlocked
7. Rub each thumb clasped in opposite hand using a rotational movement
8. Rub tips of fingers in opposite palm in a circular motion
9. Rub each wrist with opposite hand
10. Rinse hands with running water
11. Use elbow or paper towel to turn off tap
12. Dry thoroughly with a single-use towel
13. Hand washing should take 15–30 seconds

Adapted from world health organization guidelines on hand hygiene in health care.
6. **Hand Washing Facilities**

6.1 Hand wash basins should be dedicated for hand washing only.

6.2 Health Technical Memorandum (HTM) 64. Requires hand washing facilities in clinical areas to be equipped as follows:

- No plug;
- No overflow;
- Taps should not discharge directly into the drain aperture as this might generate aerosols;
- Elbow operated or non-touch taps.

6.3 Whilst the Trust does not provide clinical areas for the assessment and management of patients within Trust premises it is guided by Health Technical Memorandum (HTM) 64.

6.4 All hand wash basins within the Trust must be equipped with the following:

- Liquid soap;
- Disposable paper towels;
- Pedal operated (or hands free), lidded domestic waste bin that is clean internally and externally and in good working order;
- Hand washing technique poster displayed clearly.

6.5 Discrepancies may be found in shared premises such as tri-service sites and very small ambulance stations where space is limited.

7. **Skin Care**

7.1 Healthy, intact skin provides an effective barrier against infection. It is important to keep the skin in good condition by using the correct hand washing method, drying hands thoroughly and regularly using hand moisturising cream.

7.2 Cuts and abrasions must be covered with waterproof dressings whilst on clinical duty. These must be checked regularly and replaced as necessary whilst on duty.

7.3 Hands should be moisturised regularly after hand decontaminating to reduce the risk of dryness. Dry skin is more susceptible to cracks and lesions. The Trust supplies pocket sized moisturisers for staff, this can be ordered and kept with the supplies of alcohol gel.

7.4 Healthcare workers are at a higher risk of developing dermatitis on their hands. This is generally because of regular hand washing and can also occur with prolonged glove use. It is important to follow good hand hygiene techniques, ensuring soap is fully rinsed off and hands are dried properly, particularly in between fingers. Dermatitis can cause skin to become red, inflamed (irritated), blistered, dry, thickened and cracked.
7.6 If staff experience any form of localised skin reaction or dermatitis, they should seek treatment through their GP and request referral to the occupational health service. Further information can be found here. The Trust provides alternative handrub and alternative gloves where required.
Procedure 4 - Personal Protective Equipment (PPE)

1. Purpose

1.1 Employees have a responsibility to wear PPE that has been provided by the Trust and to co-operate with management on matters of health and safety.

1.2 The Personal Protective Equipment at Work Regulations 1992 (amended 2018) requires that PPE is to be supplied and used at work wherever there are risks to health and safety that cannot be controlled in other ways.

1.3 The PPE Regulations are concerned with protecting workers, however in the health service PPE is used to also protect the health and safety of patients as well as staff.

1.4 These regulations also require that PPE is:

- Properly assessed before use to ensure it is suitable.
- Fit tested if applicable as required by HSE.
- Maintained and stored properly.
- Provided with instructions on how to use it safely.
- Used correctly by employees.

2. Definition

2.1 For the purposes of this procedure clinical personal protective equipment (PPE) is defined as being all equipment that is intended to be worn or held by a person at work in order to protect them against the transmission of micro-organisms and blood-borne viruses.

3. Selection of Clinical PPE

3.1 Selection of appropriate protective equipment must be based on an assessment of the risk of transmission of micro-organisms to the patient or the carer. As well as the risk of contamination of the healthcare worker’s clothing and/or skin by patients’ blood, bodily fluids, secretions and excretions.

3.2 Many clinical activities do not involve direct contact with bodily fluids and consequently do not require the use of personal protective equipment. For example: pushing a wheelchair, taking observations including blood pressure, pulse and temperature.

3.3 PPE includes but is not limited to:

- Gloves - sterile and non-sterile.
- Aprons.
- Sleeve protectors.
- Protective suits.
- Face masks.
- Eye protection/goggles.
All vehicles used to respond to patients are required to carry a stock of PPE for use by staff. IPC bags kept on vehicles must be checked regularly and when any contents are used. The contents is detailed with the Standard Vehicle and Equipment Policy.

3.4 The following bodily fluids may pose a transmission risk and should be handled with the same precautions as blood:

- Cerebrospinal fluid.
- Peritoneal fluid.
- Pleural fluid.
- Pericardial fluid.
- Synovial fluid.
- Amniotic fluid.
- Semen.
- Vaginal secretions.
- Breast milk.
- Vomit.
- Urine.
- Any other body fluid, including saliva when in association with dentistry.
- Unfixed tissues and organs.

4. **Determining Level of PPE Required**

4.1 Patient facing staff are required to use their judgement when determining the type and level of PPE required for each case, this is dependent on the anticipated risk of exposure to bodily fluids during particular activities. The guidance provided in Figure 5 will assist staff in using determining the level of PPE required.

4.2 **Figure 5 - Selecting PPE**

<table>
<thead>
<tr>
<th>No exposure to blood, body fluids, secretions or excretions anticipated</th>
<th>No protective clothing required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to blood or body fluids anticipated but LOW risk of splashing</td>
<td>Gloves and Aprons required</td>
</tr>
<tr>
<td>Exposure to blood or body fluids anticipated but HIGH risk of splashing</td>
<td>Gloves, aprons and eye/mouth/nose protection.</td>
</tr>
</tbody>
</table>
5. **Gloves**

5.1 It is important to note that the Trust is a latex free organisation and consequently all gloves used within the Trust must be latex free. Vinyl gloves are not adequate for use in healthcare due to the porous nature of the material. Nitrile gloves are the glove material of choice.

5.2 Persons who feel they may be allergic to Nitrile gloves should be referred to the Occupational Health Team for further advice and assessment. If staff experience any form of localised skin reaction or dermatitis (see Section 7 Skin Care), they should seek treatment through their GP and request referral to the occupational health service. Further information can be found here. The Trust provides alternative gloves where required.

5.3 Non-Sterile, nitrile examination gloves must be worn for contact with skin that is not intact, mucous membranes, exposure to blood, bodily fluids, secretions and excretions as well as when handling sharps or contaminated instruments.

5.4 Sterile, nitrile gloves must be worn for aseptic/clean procedures and contact with sterile/clean sites.

5.5 Gloves must not be worn unnecessarily and staff should assess each individual task before the decision is made to wear gloves.

5.6 Gloves should be put on immediately before patient treatment if there is potential contact with blood or bodily fluids and removed as soon as the activity is completed.

5.7 Gloves need to be changed between caring for different patients or between different care/treatment activities for the same patient.

5.8 Gloves must not be worn whilst driving vehicles or pushing wheelchairs/stretchers.

5.9 Gloves must be worn as single use items and disposed of in the offensive waste stream. Gloves that have been used treating a patient with a known or suspected infection should be disposed of in the infectious waste stream.

5.10 Hand decontamination should accompany the disposal of gloves and in between glove changes. (See Procedure 3 - Hand Decontamination).

5.11 For further information see the ‘Do you love your gloves?’ section on the Trust’s IPC intranet page.

6. **Disposable Apron/Suit**

6.1 Disposable plastic aprons must be worn when there is a risk that clothing may become contaminated with blood, bodily fluids, secretions or excretions, or when cleaning the ambulance and equipment.

6.2 Disposable suits are only required where there is a risk of extensive splashing of blood, bodily fluids, secretions or excretions or when dealing with infections caused by more hazardous organisms or chemical spills.
6.3 Disposable suits must be worn as single-use items, and then disposed of in the appropriate clinical waste stream.
6.4 Staff must always ensure they have at least one complete spare uniform available for occasions when uniform contamination has occurred.

7. **Visors/Eye Protection**

7.1 Eye protection/visors are required to be worn when a particular procedure is likely to cause splashing of bodily fluids, particularly blood or tissue, into the eyes or face. Eye/face protection is also recommended when managing an airway as there may be risk of contamination e.g. if the patient coughed/vomited during the procedure.

7.2 Eye protection is also recommended when caring for patients suspected to be suffering from Severe Acute Respiratory Syndrome (SARS) or pandemic influenza.

7.3 Visors and eye protection are single use items and consequently following use should be disposed of in the appropriate clinical waste stream.

8. **Face Masks**

8.1 **Surgical Face Masks**

8.1.1 Masks offer protection against splashing of the mouth and face. Use of surgical face masks and eye protection is recommended during procedures when there is likely to be splashing of bodily fluids into the mouth. It is also recommended if the patient is prone to episodes of coughing or sneezing, or during intubation of patients who are suspected to have an infectious respiratory disease.

8.1.2 Where patients have an uncontrolled cough, staff should consider encouraging the patient to also wear a surgical face mask.

8.1.3 Facemasks are single use and should be disposed of into an appropriate waste stream following use.

8.2 **High efficiency FFP3 Masks**

8.2.1 High efficiency masks or respirators with filtering efficiency of the European Standard EN 149:2001 FFP3 are recommended when caring for patients thought to be suffering from severe respiratory illnesses.

8.2.2 Use of high efficiency masks requires specific training and fit testing under COSHH regulations.

8.2.3 Face masks should fit correctly with no gaps at the side and should not be pulled up and down.

8.2.4 Face masks are single-use only and should be disposed of in the appropriate waste stream.
9. **Sleeve Protectors**

9.1 Sleeve protectors can be worn to protect the wearers’ uniform from the wrist to the elbow when there is a risk of contamination from bodily fluids.

9.2 Sleeve protectors are single patient use and can be worn over the top of gloves. They must be disposed of in the appropriate clinical waste stream.

9.3 They are not a replacement for removing or rolling up long sleeves during clinical activities but can be used during situations where it is not possible to remove sleeves, for example when wearing a high visibility jacket at a road traffic collision.

10. **Applying and Removing PPE**

10.1 PPE must be put on in the following order; apron, mask, eye protection then gloves, as shown in the diagram below.

10.2 PPE must be removed in such a way to limit the potential for cross contamination. Hands should be decontaminated after the removal and disposal of each piece of PPE. The order for removing PPE is gloves, aprons, eye protection and face mask.
Procedure 5 - Infection Control Communication

1. **Purpose**

1.1 This procedure is set out to provide best practice guidelines for communicating infection control risks and/or status.

1.2 The effective communication of an infection status and risks will enable suitable measures to be put in place to minimise the infection risks to both healthcare workers and patients. This is vital to ensure that any risks associated with the transmission of infection is minimised.

1.3 The Trust has a duty to ensure that it provides suitable and sufficient information on each patient’s infection status whenever a patient is to be moved from one organisation to another, where this is known.

1.4 Any information regarding a patient’s infectious status should be treated as confidential information and should only be shared with individuals involved in that patients care.

2. **Procedure for Emergency Care**

2.1 The information regarding a patient’s infection status may be obtained in the following ways:

- Patient provided;
- Medical history provided by others such as family or household members;
- Patient history provided by other health care professional/organisation;
- Clinical assessment of patient:
  - Respiratory - productive cough
  - Gastrointestinal - diarrhoea and/or vomiting
  - Circulatory - Signs of sepsis / raised temperature
  - Presence of a rash / cellulitis
  - Clinically infected wound / indwelling device
  - Recent foreign travel

2.2 Any information gained regarding a patient’s infectious status, along with the source of this information, must be documented on the electronic patient care record (ePCR).

2.3 Any information regarding a patient’s infection status must be verbally communicated to the receiving healthcare professional.

2.4 It may be necessary to notify the receiving department in advance if it is anticipated that the patient may require isolation.
3. **Procedure for Patient Transfers**

3.1 When booking patients for transfers control will ask the person booking the patient if the patient has any specific infections that the crew will need to be aware when transporting the patient.

3.2 Before booking the patient for transportation the initiating establishment must be asked if the patient has any medical conditions that may cause a significant risk of cross infection to another person.

3.3 IPC risks and status should be communicated to inform crews prior to transfer.

3.4 Patients that pose a significant IPC risk must be transported separately.

4. **Urgent Care Service**

4.1 If the Urgent Care Service requires transport for any potentially infectious patient, this information must be communicated to the Clinical Hub at the time of booking the transport and communicated to the crews.

4.2 If a patient is being admitted to a hospital the information will need to be communicated to the relevant department.

5. **Pre-alerting Hospital Departments**

5.1 Communicable infectious diseases may increase the risk of an outbreak amongst patient, visitors and healthcare staff.

5.2 Outbreaks exist when there are more cases than expected in a given area or among a specific group of people over a particular time period. Outbreaks of infectious diarrhoea and vomiting, for example, can lead to widespread closures of wards and life limiting symptoms in the most vulnerable patient. It is therefore vital that any potential communicable infection is communicated to the receiving area.

5.3 In order to ensure that this information is communicated in a timely fashion to Emergency Departments and hospital wards, clinicians are encouraged to pre-alert hospital departments if they are transporting a patient with symptoms of diarrhoea and/or vomiting. Further guidance is provided in Clinical Guideline CG10 Diarrhoea and Vomiting.

5.4 If the infection status history indicates to the crew that isolation may be required the crew are to pre-alert the receiving department using the existing processes.
Procedure 6 - Safe Sharps Management and the Management of Inoculation Injuries

1. **Purpose**

1.1 This procedure is set out to provide best practice guidelines for the safe management of sharps.

1.2 The procedure will also provide guidance on dealing with needle stick injuries and contain details for the referral process.

1.3 Sharps injuries are second only to back injuries as a cause of occupational injury, this procedure therefore aims to inform practice to reduce the occurrence of needle stick injuries within our service.

2. **Definitions**

2.1 Sharps injuries are any injury where a needle or other sharp object, penetrates via a percutaneous route (through the skin). This includes cuts, scratches, nicks and gashes which break the skin. In a healthcare setting or situation, sharps can be potentially contaminated with bodily fluids.

2.2 Blood and body fluids include:

- Cerebrospinal fluid.
- Peritoneal fluid.
- Pleural fluid.
- Pericardial fluid.
- Synovial fluid.
- Amniotic fluid.
- Semen.
- Vaginal secretions.
- Breast milk.
- Vomit.
- Urine.
- Any other body fluid.

2.3 Sharps include:

- Needles.
- Scalpels.
- Stitch cutters.
- Glass ampoules.
- Sharp instruments.
- Razors.
- Any article that can cut or puncture the skin by having a fine edge or point.
3. **Background Information**

3.1 Sharps injuries account for 17% of reported accidents to NHS Staff and are the second most common cause of injury, behind moving and handling at 18%. It is estimated around 40,000 sharps related injuries are reported yearly in the UK, however it is suspected that the true figure could be double that as many go unreported. Needle stick and sharps injuries are a significant issue.

3.2 Contaminated needles can transmit more than 20 dangerous blood-borne pathogens including hepatitis B, hepatitis C and Human Immuno-deficiency Virus (HIV). The effects can be devastating for the injured party and their family.

4. **Causes of sharps injuries**

4.1 The device that is most likely to cause a needle stick injury in the ambulance service is an intra-venous cannula.

4.2 The risk of injury increases when a sharps bin is not available, is too far away or is overfull.

4.3 Inappropriate disposal of sharps presents a significant risk for others in the environment.

4.4 Other contributing factors include:

- Complacency.
- Healthcare workers that are working in areas unfamiliar to them.
- Healthcare dealing with uncooperative or restless patients.
- The time of day, with more sharps injuries occurring post lunch and in the evening.
- Tiredness.
- Poor practice.

5. **Preventing Sharps Injuries**

5.1 The Trust is committed to reducing the number of inoculation injuries to staff and recognises that exposure prevention is the primary strategy to reduce these injuries. In keeping with this the Trust has introduced needle-safe cannula, sharps safe IM needles, plastic boxes to store razors and single use lancets (for blood glucose monitoring).

5.2 Clinical sharps should be single use only and must be stored in their designated containers and/or appropriate bags when not in use. They should also be kept in sealed packaging to reduce the risk of cross contamination.
6 Safe Use of Sharps Bins

6.1 Sharps must only be disposed of in sharps bins.

6.2 It is the responsibility of the person using the sharp to dispose of it safely.

6.3 Sharps bins must be compliant with UN3291 and BS7320 standards.

6.4 Sharps bins must always be assembled correctly and checked before they are used for the first time.

6.5 Sharps bins should be secured to an appropriate bracket in the vehicle which is below shoulder height. These bins should never be hung by their handle or placed in clinical waste bags.

6.6 Sharps bins must always be labelled when they are assembled, when they are closed and when they are disposed of, as indicated on the label. The hospital should be filled in as SWAST and area/dept./ward should be filled in with the station e.g. Bristol.

6.7 Figure 6 - Sharp Bin Label Completion (design of label may vary)

6.8 The temporary closure mechanism should be in position when the sharps bin is not in use and the bin should be locked when two thirds full and disposed of as per the Waste Management Policy.

6.9 Sharps bins should not be used for more than three months and should be disposed of when it has reached 3 months even if they aren’t two thirds full.
7. **Safe Management of Sharps**

7.1 All staff and volunteers should attend appropriate training and only use devices if they have been trained to do so. Sharps safe devices should be used where available.

7.2 Sharps must be disposed of immediately after use and not passed hand to hand. Handling must be kept to a minimum and the sharps bins should be positioned to promote this practice. Sharps should only be handled by one person at a time and healthcare workers should always dispose of their own sharps and never expect anyone else to dispose of them on their behalf.

7.3 All devices should be assembled with care and disposed of as a single unit, needles should never be cut, bent or broken prior to use or before disposal. If disassembling devices is unavoidable the utmost care should be taken when disposing of the sharps.

7.4 Needles and cannulas must never be re-sheathed and the needles should only be removed from their sheaths when the patient has been prepared and the needle is ready to be used.

7.5 All staff should be extra vigilant during emergency procedures as there is an increase in risk of inoculation injury in these situations.

7.6 Healthcare workers should always ask for assistance when cannulating, giving injections or setting up fluid therapy if the patient is uncooperative. The assisting HCW should never hold the sharps bin this must be placed on a suitable surface or securely attached to the wall.

7.7 All employees should report any inoculation injuries, as well as near misses and examples of bad practice (regardless of whether they resulted in an injury) using the Trust incident reporting system. Poor practice should be challenged appropriately and escalated if required.

7.8 It is important that any sharps injury is managed in accordance with this policy.

8. **Management of Inoculation and Contamination Injuries**

8.1 An inoculation/contamination injury can be:

- Breaking of skin by a needle or other sharp.
- Contamination of broken skin with bodily fluids.
- Blood or bodily fluid splashes to mucous membrane e.g. eyes or mouth.
- Accidental swallowing of bodily fluids.
- Contamination where clothes have been soaked by bodily fluids.
- Exudates or secretions through a wound or sore.
- Bites or scratches.
8.2 The immediate priority following an inoculation injury is first aid, this will reduce the risk of transmission of blood borne viruses. Any inoculation injury should be managed in accordance with the process detailed in Figure 7.

8.3 The first aid required following an inoculation injury is:

- Wash the wound with warm running water and soap (do not suck the wound);
- Encourage bleeding gently (if possible)
- Cover wound with a dressing.

8.4 Following a contamination or splash injury, irrigate the area with copious amounts of tap water or saline solution.

8.5 If uniform is heavily contaminated, staff must remove safely (polo shirts must be cut off) and disposed of in the correct waste stream. Staff should shower and change into spare uniform.

8.6 Staff should then attend the nearest emergency department to be risk assessed and to have blood samples taken in accordance with the contamination injury process (Figure 7). The risk assessment should ascertain if post exposure prophylaxis (PEP) is required.

8.7 Bloods should be requested from the source patient (where known and available) and taken by a third party (someone not directly involved in the incident). The patient must give informed consent prior to having blood samples taken to establish if they have any blood borne viruses. The patient has the right to decline having blood samples taken.

8.7 All inoculation injuries must be reported to occupational health as soon as possible after the incident. This is reported through the needle stick and sharps helpline on 03450 944021 Option 2.

8.8 Occupational health will provide staff with the appropriate follow up.

8.9 Staff should then report the injury to the Trust via the incident reporting system.
Recipient = Injured health care worker
Donor = patient involved in the contamination injury. Donors who refuse testing should be treated as high risk.

(*) Advice taken from Department of Health Immunisation against infectious disease. Hepatitis B chapter

8.9 Figure 7 - Contamination Injury Process

Contaminated needlestick, sharps injury, bite or scratch

+ First Aid - Encourage bleeding & wash under running water / sterile water /0.9% sodium chloride and cover with a waterproof plaster.

Blood or body fluid splash in eyes or mouth or nose

+ First Aid - Irrigate under running water / sterile water /0.9% sodium chloride (before & after removing contact lenses if worn)

Blood or body fluid splash on broken skin

+ First Aid - Wash under running water / sterile water /0.9% sodium chloride and cover with a waterproof plaster.

Report incident to manager at earliest opportunity but do not delay follow up

Refer to SWAST Needlestick and Contamination Injury section in the Infection Prevention and Control Policy. Complete incident report form as soon as possible

Is donor considered high risk, for example HIV, Hep B positive? (Discuss with source patient’s doctor/medical team)

YES

IMMEDIATE ACTION IS NEEDED.
Immediately go to nearest Accident and Emergency (A & E) department. Inform manager

If PEP is required, A & E doctor should refer client on to local Genito-Urinary Medicine Department for further assessment and ongoing prescription of PEP and appropriate follow up within 72 hours.

Inform Optima Health of all incidents on 03450 944021 Select Option 2 as soon as possible (out of hours leave a message with recipient name, date of birth and contact number).

Optima Health follow up results, advise of any other action required and offer serial testing for injuries from unknown donors, donors who aren’t tested or donors who are infected with HIV, Hepatitis B and or Hepatitis C. They can also give further advice and support when needed

Manager to review the incident. How could it have been prevented?
ENSURE AN INCIDENT REPORT (DATIX) IS COMPLETED WITHIN 24HRS

NO

Go nearest A & E as soon as possible (within 24 hours of injury). A 6ml clotted blood sample is taken from staff member for “save serum” to be sent to local microbiology.

Is Donor known and able to give informed consent?

YES

If recipient is immune to Hepatitis B then a booster of vaccine may be needed if it is over one year since last dose. If recipient is non responder to Hepatitis B vaccine then HIGG may be indicated. If incomplete or no previous Hepatitis B vaccine course then accelerated course of Hepatitis B vaccine needed (*). Serial testing will be required which is organised by Optima Health.

If donor is in A & E, Donor’s medical team will explain issue and obtain INFORMED CONSENT from donor

If donor is Hepatitis B surface antigen positive then recipient may require a Hepatitis B booster (HIGG for non-responders or those who have had less than 2 doses of Hepatitis B vaccine) within 24 to 48 hours of injury.

If donor is in A & E, contact SWAST Infection Prevention & Control Lead who will chase. (07788565457)

6ml clotted blood sample is collected from donor for Hep B surface antigen, Hep C antibodies and HIV antibodies. Send to nearest microbiology. If donor not in A & E, contact SWAST Infection Prevention & Control Lead who will chase.

If donor is known and able to give informed consent?

NO

See A & E doctor immediately for risk assessment. PEP if indicated should be commenced as soon as possible (ideally within one hour of the injury). Ensure blood is taken for storage from recipient and potential exposure to hepatitis C and B is also considered. A Hepatitis B booster /HIGG may be required within 24 to 48 hours (see opposite boxes).

If PEP is required, A & E doctor should refer client on to local Genito-Urinary Medicine Department for further assessment and ongoing prescription of PEP and appropriate follow up within 72 hours.

Inform Optima Health of all incidents on 03450 944021 Select Option 2 as soon as possible (out of hours leave a message with recipient name, date of birth and contact number).

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Manager to review the incident. How could it have been prevented?
ENSURE AN INCIDENT REPORT (DATIX) IS COMPLETED WITHIN 24HRS

(*) Advice taken from Department of Health Immunisation against infectious disease. Hepatitis B chapter

January 2019

Recipient = Injured health care worker
Donor = patient involved in the contamination injury. Donors who refuse testing should be treated as high risk.
Procedure 7 - Management Clinical Waste

1. **Purpose**

   1.1 The Trust applies Health Technical Memorandum 07-01: Safe Management of Healthcare Waste. The memorandum details the new national unified approach to waste management. The handling, segregation and transport of waste generated both internally and from external organisations through the Medical Transport Service must comply with all guidance provided by Health Technical Memorandum 07-01.

   1.2 The Trust has contracted out the services for the provision of clinical waste disposal. All contracts with NHS providers and external suppliers are subject to the NHS Conditions of Contract for the Supply of Services. All clinical waste is handled in accordance with the Controlled Waste Regulations 1991 and the Control of Pollution Act 1989.

2. **Segregation of Waste**

   2.1 Segregation of waste at the point of production into suitable colour-coded packaging is vital to good waste management and ensuring compliance with current regulations. The colour-coded segregation system outlined in this procedure identifies and segregates waste on the basis of waste classification and suitability of treatment/disposal options. Health and safety, carriage and waste regulations require that waste is handled, transported and disposed of in a safe and effective manner.

   2.2 Figure 8 identifies the range of waste classification applicable under the national unified approach to waste management. Following an assessment of waste streams, the Trust has introduced waste segregation facilities for the categories detailed in the following paragraphs. The Trust also has a recycling waste stream; more information on this can be found in the Waste Management Policy.

   2.3 Trust premises must provide the required waste streams appropriate to the function of the building, where waste can be segregated at source. All clinical areas must have facilities to segregate waste into the streams detailed. Whilst it is acknowledged that some older ambulance vehicles do not have provisions to segregate waste, all new vehicles are supplied with separate domestic and offensive waste bins. Waste must be segregated where facilities exist.

2.4 **Domestic Waste (Black Bag)**

   2.4.1 Domestic waste is waste similar in nature and composition to waste generated at home. Domestic waste must not contain any contaminated or infectious materials, sharps or medicinal products. Domestic waste must be placed in black bags for disposal. Gloves that are not contaminated can be disposed of as household waste into the domestic waste stream.

   2.4.2 The vehicle specification provides two bins, one for offensive waste stream and the other for domestic waste.
2.5 **Offensive (Yellow Bag with Black Stripe)**

2.5.1 The Trust has an offensive waste category for use on all ambulance vehicles, as the standard route for disposing of the majority of clinical waste generated when treating a patient.

2.5.2 In order to maintain appropriate segregation of waste, all ambulances should utilise the yellow and black striped ‘tiger’ bags in the clinical waste bin next to the stretcher (or alternative location for older vehicles) and domestic waste bags in the second bin. Only potentially infectious waste should be placed in orange infectious waste bags. Orange bags must continue to be available on all vehicles and in the IPC kit bags for this purpose. Where only a single waste bin is available on ambulances, the bin must contain an offensive waste bag as the main waste stream and additional black domestic waste bags should be available as required.

2.5.3 Acceptable items that should be disposed of in offensive waste include: soiled gloves, inco-pads, used vomit bowls and dressings. Items which have the potential to be infectious must be disposed of in the infectious orange bag waste stream.

2.6 **Infectious Waste (Orange Bag)**

2.6.1 All Trust vehicles must keep a stock of orange waste bags to be used for the disposal of any infectious or potentially infectious waste.

2.6.2 Infectious waste constitutes of any waste that has been in contact with a patient who is either infectious or potentially infectious. E.g. a patient with symptoms of acute diarrhoea and vomiting should be treated as potentially infectious.

2.6.3 **Figure 8 - Waste Segregation:**
3. **Handling of Waste**

3.1 When handling clinical waste all staff must use personal protective equipment, (PPE) the minimum being gloves. Aprons must be considered if leakage is anticipated or there has been heavy contamination. All items of disposable PPE become clinical waste once used.

3.2 Staff are expected to make every effort to ensure that any waste arising from their activities, clinical and non-clinical is disposed of properly. Where this has not been possible and waste is left in a public place or private dwelling they must contact the Clinical Hubs, and arrange for collection.

3.3 Waste must not be decanted into other bags, regardless of volume and sharps containers must never be placed into a clinical waste bag. Any spillage or contamination resulting from the movement of clinical waste must be thoroughly cleaned at the earliest opportunity (see Spillage Management, Procedure 8).

3.4 Clinical waste must be:

   - Correctly bagged to prevent spillage.
   - Double bagged where the exterior of the bag is contaminated, split or leaking.
   - Disposed of in a pedal operated bin until it is transferred to the larger clinical waste bins for collection by the waste contractor.
   - Kept in a rigid-sided holder or container, and, so far as is reasonably practicable, kept out of reach of children.
   - Only filled to ¾ full.
   - Sharps bins need to be correctly labelled and dated.

4. **Disposal of Clinical Waste**

4.1 Where possible and practicable all clinical waste should be disposed of at the receiving hospitals.

4.2 The Trust has a contract in place with an external approved provider to manage the collection of clinical waste at stations.

4.3 All clinical waste must be stored in a secure area or approved storage container, to which the public have no access. If this is not possible and large collection bins are outside where the public may have access, all bins must be locked.

4.4 Prior to departure from an incident, crews must make every effort to ensure that no items of waste are left on the scene. Where sharps are used away from the vehicle, the sharps boxes carried in the response bag must be utilised.

4.5 Under no circumstances should any item of clinical waste be placed in domestic waste bins or abandoned outside designated containers at hospitals, on station, or in the rear of ambulances. Incidents where adequate and appropriate measures have not been taken to dispose of clinical waste or sharps, thereby putting others at risk of injury and cross-contamination, must be regarded as adverse incidents
and reported using the incident reporting form.

4.6 Where waste requires disposal on arrival at hospital and appropriately segregated waste bins are not available, it is acceptable to dispose of the waste within a higher category. For example an offensive waste bag may be placed within the infectious waste stream.

5. **Pharmaceutical Waste**

5.1 Medicines that have been opened and not used or, only part used, must be disposed of in an approved yellow sharps container. Unused drugs must be managed in accordance with the Trust’s Medicines Governance Policy.

5.2 Controlled drugs must be managed in accordance with the Trust’s Controlled Drugs Policy.

5.3 Cytotoxic/cytostatic (carbetocin and chloramphenicol) must be disposed of in a cytotoxic sharps bin (identified with a purple top). As these are not used within the Trust, syringes used to administer carbetocin must be disposed of at the receiving unit. Expired stock of these drugs should be returned to Central Store, Exeter.

6. **Clinical Waste on RRVs**

6.1 On occasion, an attending clinician may generate waste that is not immediately possible to contain or dispose of appropriately. This may be more evident when the patient is attended by a Rapid Response Vehicle (RRV) and especially so if a Specialist Paramedic or SWAMP Paramedic has attended and provided a form of wound closure.

6.2 Where appropriate, much of the waste generated may be disposed of through the patient’s own normal household waste stream e.g. packaging, non-contaminated gloves. However, where items require disposal as offensive or infectious waste, a clinical waste container should be utilised as appropriate to hold any clinical waste where onward transfer is required in an RRV.

6.3 All RRVs should carry these containers and any clinical waste generated should be initially placed inside the correct waste bag. That bag should then be placed inside the cardboard container for transfer in the vehicle boot.

6.4 The bins are intended as once use only and should be disposed of within the appropriate waste stream in its entirety. If the box is used for the carriage of infectious waste, then it should be placed in the infectious waste stream. If used for the carriage of offensive waste, then the box should be placed in the offensive waste stream.
Procedure 8 - Management of Linen

1. Purpose

1.1 This procedure is set out to provide requirements for minimising the risk of cross infection by ensuring appropriate management of uniforms, linen and patient clothing.

1.2 The Trust has contracted out some services for the provision of linen. All contracts with NHS providers and external suppliers are subject to the NHS Conditions of Contract for the Supply of Laundry Services and the NHS Conditions of Contract for the Supply of Services. All contracts must comply with Health Service Guidance HSG (95) 18, Hospital laundry Arrangements for Used and Infected Linen.

2. Definitions

2.1 For the purposes of this procedure linen is spilt into four categories:

- Uniforms.
- Clean Linen.
- Soiled linen.
- Transporting patients clothing.

2.2 Uniforms are defined as those items that are provided by the Trust:

- Trousers/skirts.
- Shirts.
- T-Shirts.
- Jackets.
- High visibility jackets and trousers.
- Specialist suits - Air ambulance, BASICs, HART.

2.3 Linen is defined as the items used with the patient and include, but are not limited to:

- Blankets.
- Sheets.
- Pillow cases.

2.4 Patients clothing includes any items that are taken with the patient into hospital or moved with the patient during transfer and/or discharge.

3. Management and Care of Uniform

3.1 All staff should have sufficient uniform to allow clean clothing each shift and at least one spare set of uniform on station in case the uniform becomes contaminated during the shift.

3.2 When there is a reasonable likelihood that they may be delivering patient care during their shift, clinically qualified responding managers should always wear uniform where possible. When responding to an incident without being in full uniform, managers must wear high visibility jacket and if the jacket is left open, ties must be
3.3 Long hair (shoulder length and longer) should be tied back and kept off the collar to reduce the risk of contamination.

3.4 Visibly soiled uniform presents an infection risk and can be disconcerting for patients; clean uniform presents a professional appearance.

3.5 Although best avoided, staff wearing long sleeved jackets during clinical care must take all appropriate measures to avoid contamination, including the use of sleeve protectors and regular washing of jackets.

3.6 It is good practice to wash your uniform at the hottest temperature suitable for the fabric; in tests a wash for ten minutes at 60°C removes almost all micro-organisms, only 0.1% of any Clostridium difficile spores remain, microbiologists advise that this is too few to carry any cause for concern. Washing with detergent at 30°C removed all gram positive micro-organisms including Methicillin Resistant Staphylococcus Aureus (MRSA).

3.7 Keeping washing machines (and tumble dryers) clean and well maintained will protect the machines washing efficiency. Dirty or underperforming machines can result in poor wash cycles.

3.8 Uniforms should be steam ironed to further reduce the levels of microorganisms, and stored in a manner that reduces the risk of contamination.

3.9 Uniform bags (white with blue stripe) are available to all staff taking uniforms home for washing with the aim of eliminating any unnecessary handling of soiled garments. These are provided as an option for staff and their use is not mandatory.

3.10 Easy to follow instructions are printed onto each bag. Uniform should be placed into the bag, which should then be sealed with the pink tape. The uniform bag should be placed unopened into the washing machine. During the wash cycle the soluble membrane and tie tape will dissolve releasing the contents of the bag for washing. Once the cycle is complete the bag should be removed and discarded into domestic waste.

3.11 Staff should not use the pink/red hospital-style linen bags, as these are not designed for use in a domestic washing machine and will not dissolve effectively which may result in damage to the machine.
3.12 Figure 9- Laundry Bags

3.13 Providing the guidance is adhered to there is no evidence that uniforms (or other work clothes) pose a significant hazard in terms of spreading infection.

3.14 If uniform is heavily soiled with body fluid the most appropriate course of action would be to dispose of it as clinical waste. In such cases, contaminated T shirts or polo shirts should be cut off and not removed over the head.

4. Management of Soiled Linen

4.1 When handling soiled linen:

- Cover cuts and abrasions with waterproof dressings;
- Wear an apron and gloves;
- Dispose of used linen promptly into the appropriate linen bag;
- Do not put soiled linen onto a clean surface or onto clean equipment;
- Remove personal protective equipment (PPE) and wash hands after use and before returning to other duties.

4.2 For laundry purposes linen must be segregated into one of the following groups (in accordance with HSG (95) 18 - Hospital Laundry Arrangements for Used and Infected Linen).

4.3 Figure 10 – Laundry bags

<table>
<thead>
<tr>
<th>Used (soiled &amp; foul) linen</th>
<th>Infectious / Infested linen</th>
</tr>
</thead>
<tbody>
<tr>
<td>White plastic / linen sac</td>
<td>Red alginate bag within a red linen / plastic sac</td>
</tr>
<tr>
<td>All used linen, irrespective of state, but on occasions contaminated with blood or body fluids</td>
<td></td>
</tr>
<tr>
<td>Used linen from a patient with a known or suspected infectious condition (i.e. MRSA, C.diff) Used linen from patients with an infestation (i.e. scabies, lice, fleas)</td>
<td></td>
</tr>
</tbody>
</table>
4.4 Ambulance staff must make themselves familiar with local procedures to ensure correct segregation.

4.5 Particular care should be exercised when handling linen in case clinical waste or sharps have been accidentally concealed within.

4.6 Items other than linen must not be placed in these bags – sharps are a hazard to laundry workers and other items can cause damage to the linen and washing machines.

4.7 Once linen has been placed in the bag it should be disposed of at the nearest Hospital.

5. **Management of Clean Linen**

5.1 Operational crews should exchange linen at receiving hospitals on a one for one basis.

5.2 Clean linen should only be stored in the linen cupboard on a front line vehicle. Clean linen should not be stored on ambulance stations.

5.3 Hospital linen is not permitted for personal staff use on station and is for patient use only.

6. **Management Patient’s Linen and Clothing**

6.1 Any patient’s linen or clothing (not including those items that are being worn) should be transported in an appropriate bag or suitcase.

6.2 If staff need to access patient’s clothing bags appropriate Personal Protective Equipment should be worn and hands decontaminated appropriately afterwards.
Procedure 9 - Cleaning and Decontamination

1. **Purpose**

   1.1 This procedure is set out to provide the requirements for minimising the risk of cross infection by ensuring that staff are aware of the expected standards for cleaning and decontamination of the environment and equipment.

   1.2 The maintenance of high standards of cleanliness on all surfaces and equipment is a crucial factor in the prevention and control of infection.

   1.3 All staff have a responsibility to keep the ambulance, station and equipment clean, therefore reducing the risk of cross contamination.

2. **Definitions**

   2.1 Cleaning is defined as the process of physically removing dirt and contamination from surfaces but does not necessarily destroy the microorganisms.

   2.2 Disinfection is defined as a process to reduce the number of viable microorganisms on a surface.

   2.3 Sterilisation is defined as the process used to render objects free from viable microorganisms – this includes viruses and spores but not prions.

3. **Colour Coding**

   3.1 The national colour coding for ambulance services aims to prevent cross infection and to reduce the risk of cross contamination. The colours detailed in Figure 11 apply to all cleaning cloths, mops and buckets in use within these areas. **Mops cloths and buckets must not be transferred between different areas.**

   3.2 **Figure 11 - National Colour Codes**

<table>
<thead>
<tr>
<th>Red</th>
<th>Blue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Showers and toilets</td>
<td>General areas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Green</th>
<th>Yellow</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kitchen and dining areas</td>
<td>Ambulance interiors</td>
</tr>
</tbody>
</table>

   3.3 Cleaning equipment must be stored clean and dry between uses. All mop heads and cloths must be single use only. Mops, cloths and brushes must not be stored in disinfectant or cleaning solutions.
4. **Cleaning-Using Disinfectant**

4.1 Disinfection is a process used to reduce the number of viable microorganisms and can apply to hand washing, skin preparation and cleaning equipment. Harmful micro-organisms can be destroyed by chemicals such as a chlorine releasing agent or by immersion in hot water e.g. 70-80°C.

4.2 Disinfection processes can inactivate blood borne viruses but do not destroy bacterial spores e.g. C-Diff. Disinfection of equipment should be limited and, where possible, single use equipment should be used instead. Chemicals used for disinfection are detailed in Table 1.

4.3 *Table 1 - Disinfection Options*

<table>
<thead>
<tr>
<th>Product</th>
<th>Details</th>
<th>Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlor-Clean Tablets</td>
<td>Tablets containing the disinfectant NaDCC (1,000ppm) together with an anionic</td>
<td>Routine vehicle floor cleaning and disinfecting.</td>
</tr>
<tr>
<td>Surface Wipes</td>
<td>Clinell Universal Sanitising Wipes - Surface wipes.</td>
<td>Cleaning of equipment where NaDCC and water cannot be used e.g.</td>
</tr>
<tr>
<td>Single Use Spill Wipes</td>
<td>Single use spill wipes</td>
<td>Dealing with body fluid spills.</td>
</tr>
</tbody>
</table>
4.4 Special Precautions when Cleaning Using Chlor-Clean

4.4.1 Sodium Dichloroisocyanurate (NaDCC) is a broad spectrum anti-microbial agent which is effective against bacteria (including MRSA, E Coli and Pseudomonas), fungi, viruses (including HIV and Hepatitis). It is more stable and therefore more effective than liquid forms of Sodium Hypochlorite. Tablets have a longer shelf life and are more convenient to use.

4.4.2 Once Chlor-Clean has been made up it will start to lose its strength, therefore all solutions must be discarded after 24 hours. This must be managed at local level. Further guidance is provided in Figure 12.

4.4.3 Chlor-Clean disinfectant solution is made up by placing one tablet in 1 litre of cold water.

4.4.4 Appropriate precautions should be taken in line with the relevant COSSH assessment:

- Always ensure manufacturer’s decontamination advice is compatible with the disinfectant intended to be used. If in doubt contact the Infection Prevention and Control Team or Health and Safety Team;
- Wherever possible ensure good ventilation when using any chlorine based product;
- Never mix disinfectants with other disinfectants or detergents. Disinfectants may react causing a chemical reaction and detergents may reduce the strength of the available chlorine. Only use pre prepared combination products where this is necessary (Chlor-Clean) as these are manufactured to be compatible;
- Always wear appropriate PPE for the task performed;
- Store Chlor-Clean in its original container, in a dry, cool, well-ventilated area. As stated in COSHH guidelines.
4.4.5 Figure 12 - Making Up a Disinfectant Solution

**How to use Chlor-Clean**

**Always wear appropriate PPE:** Gloves, apron, eye protection and suitable coveralls to avoid exposure to the skin.

**Before you start**
- Always wear protective gloves and an apron
- Ensure good ventilation
- Refer to CoSHH note on product label and check expiry date

**To make up Chlor-Clean**
- For any bodily fluid spills, please use spill wipes.
- Use one tablet for every litre of water from the cold tap
- Use 2 tablets for 2 litres of water
- **=1,000 p.p.m** available Chlorine
- Use 1 tablet for 1 litre of water

Chlor-Clean is only effective for 24 hours.
- Please ensure Chlor-Clean is not left in diluter bottle for more than 24 hours.

**DOs**
- Always make a fresh solution each day/shift;
- Always use in a well ventilated area;
- Store in accordance with CoSHH regulations;
- Use water from the cold tap.

**DON’Ts**
- Do not shake the container to mix;
- Do not use directly on blood, urine or vomit.
- NEVER mix with any other cleaning agent or any chemical;
- Never make up with hot water;
- Never use in a spray bottle.

Use with a mop to clean floor. Discard any remaining solution.

Further information is available within the Infection and Control Policy.
5 Sterilisation

5.1 All clinical instruments and equipment used to surgically penetrate, or may come into contact with breaks in the skin or mucosa must be sterile.

5.2 The Trust’s sterile equipment is obtained by purchasing pre-sterilised single use items. These avoid the need for re-sterilisation. They must be stored using a stock rotation system in accordance with manufacturer’s recommendations.

5.3 Sterilised equipment should be kept in its packaging until the moment of use. Excessive handling should be avoided before application and if the outer wrapping is damaged, it should not be used as the sterility will be compromised.

6 Blood and Bodily Fluid Spillage

6.1 Effective management of blood and bodily fluid spillage is a crucial factor in controlling the spread of infection.

6.2 Exposure to any such fluid constitutes a risk to all staff and others within the immediate environment. These risks can be minimised by promptly dealing with the spillage and appropriate cleaning and disinfection.

6.3 Clinell Spill Wipes have been specifically developed to deal with bodily fluid spills in a quick and efficient manner. They are a direct replacement for previous blood spill kits which consisted of chlorine tablets and granules, diluters and scoopers.

6.4 Clinell spill wipe packs consist of one super absorbent pad, which will absorb up to a litre of fluid. The pack also comes with two individually wrapped disinfectant wipes to complete the clean.

6.5 The following method should be used to clean a bodily fluid spill:

- Section off the area containing the spillage until it has been safely dealt with;
- Apply appropriate PPE (gloves, apron as required);
- Ventilate area if possible;
- Place the active side of the wipe on the spill, and leave to absorb fluid for 30 seconds. If it is a large area, use more than one spill wipe;
- Push down on plastic backed side until spill is completely absorbed;
- Dispose of the wipe in the appropriate clinical waste stream;
- Use the disinfectant wipe in the packet to further clean the area, using an S shaped motion to entirely cover the surface;
- Dispose of disinfectant wipes in appropriate clinical waste stream;
- If the spill involves a floor, mop at the earliest opportunity with Chlor-Clean solution;
- If the spill is on a vehicle and there is an infection risk e.g. the patient conveyed has symptoms of C-diff, the vehicle must be taken off the road to be deep cleaned;
7 Ambulance Station/Environmental Cleaning (Trust staff)

7.1 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 equipment, fittings and fixtures. The Trust has external cleaning contractors to provide station cleaning; however it is staff’s responsibility to clean up after themselves e.g. washing dishes, cups etc.

7.2 Work surfaces and floors should be smooth-finished, intact, durable, washable and should not allow pooling of liquids or/and be impervious to liquids. Estates should be contacted if station is not compliant.

7.3 Mops and buckets should be kept clean, dry and stored appropriately. Mop buckets should be stored inverted and mop heads should be single use and not stored attached to mop handles.

7.4 Single use, non-shredding cloth or paper roll should be used for cleaning.

7.5 Cleaning equipment, such as mop handles, cloths & buckets must be colour coded for designated areas and have signs clearly displayed in all areas, indicating the colour coding system, to aid compliance.

7.6 Staff should use universal cleaning wipes for general cleaning and wiping down equipment, (this includes IT equipment).

7.7 When replacing paper hand towels, these must be put into the holder, and not placed on top or side.

7.8 Crockery and cutlery should be washed immediately after use. Kitchens and hand washing areas should not have tea towels or reusable towels. Single use paper towels should be available.

7.9 Food preparation surfaces should be cleaned regularly with hot water and general-purpose detergent or universal wipes. These areas should be kept in good repair to facilitate cleaning. Ovens and microwaves must be cleaned after use.

7.10 Hands must be washed thoroughly following any cleaning session. Nailbrushes must not be used.

7.11 Refrigerators should be defrosted and cleaned regularly in accordance with manufacturer’s instructions. Should a spillage occur or any contamination, the whole interior of the fridge should be cleaned with hot water and general purpose detergent and dried thoroughly. See the Utilisation of Trust Fridges SOP for further guidance.

7.12 Staff must take responsibility for cleaning up after themselves; this includes washing up, cleaning surfaces and toilets after use. This is not the responsibility of the cleaning company.

7.13 Additional cleaning tasks should be undertaken as per the advice from the IPC Team.
8 Social Dispatch Points (SDPs)

8.1 This procedure is set out to provide the requirements for minimising the risk of cross infection by ensuring appropriate management of facilitated social dispatch points (SDPs).

8.2 SDPs are those areas which should provide crews with:

- Comfortable seating that is in good condition and clean.
- The provision of hot/cold drinks.
- Toilet access.
- A place to eat meals and take breaks.
- An area away from the public.
- An area with restricted access.

8.3 SDPs do not have any cleaning provisions therefore; it is the responsibility of the staff using them to ensure it is left in a clean and appropriate state.

9 Vehicle Cleaning

9.1 It is important to maintain high standards of hygiene within ambulances and RRVs to prevent the spread of infection. Steam cleaners are provided for Make Ready Operatives to use when deep cleaning a vehicle. Caution should be used when applying steam in the vicinity of any electronic devices, lights or medical device brackets. The Trauma wall must not be steamed. All vehicle deep cleans must be recorded in the Vehicle Log Book.

9.2 All staff have an individual responsibility to keep Trust vehicles clean, to reduce the risk of cross infection to themselves, their colleagues and their patients. This can best be achieved by all crew members participating in frequent and routine cleaning activities - most importantly between each patient. Whilst individuals must maintain vehicles in a state of readiness, it is appreciated that sometimes excessive exposure to bodily fluids or other infection risks require that the vehicle receive an emergency deep clean and that the vehicle is removed from operational use until such time as that deep clean has been completed. On these occasions the process detailed in the Emergency Deep Clean SOP must be followed.

9.3 Emergency calls should not be delayed as a result of a vehicle being routinely washed or cleaned. Crews must use their judgement in determining the most appropriate time to clean the vehicle and equipment, in order to avoid any disruption to the vehicles' deployment. The required interior cleaning must be completed prior to booking clear. In exceptional cases, a DCA may be tasked to an emergency call, when the ambulance is not in a suitable condition to transport a patient. In these cases the crew should respond to the call, but request back-up if conveyance is required. This type of incident should occur extremely infrequently, and must be reported through the incident reporting system.

9.4 An incident report must be completed for all vehicles that are found in an unsatisfactory condition. The vehicle must be removed from service until a clean is carried out.
9.5 It is the responsibility of the crew to leave the vehicle visibly clean, removing sharps bins and waste before sending it for a deep clean. If the crew has overrun and do not have time to complete a clean, this should be handed over to the Duty Commander.

10 The Vehicle Exterior

10.1 The exterior surfaces of all ambulance service vehicles should be maintained in a consistently clean condition. Vehicle wash facilities on stations should be utilised as necessary. Careful attention should be paid to all aspects of safety, including adherence to any locally applied instructions.

10.2 PPE should be worn at all times when cleaning a vehicle. This would ordinarily include eye protection and disposable aprons, particularly when using manually operated vehicle wash systems. Hand protection is important and the use of gloves should be considered – changing regularly and decontaminating hands as appropriate.

10.3 If pressures of operational requirements prevent a thorough cleaning of the vehicle exterior, attention should be prioritised to the relevant safety and legal requirements e.g. windscreen, windows, lights, indicators, reflectors, mirrors and number plates. In addition, any areas where dirt is likely to be transferred to the crew’s hands e.g. door handles should also be paid particular attention to.

10.4 The usual detergent based cleaning agents are satisfactory for general exterior vehicle cleaning; however, if the exterior has become contaminated with blood or bodily fluids, the detergent clean should be followed by disinfection to eradicate the potential source of infection. PPE (disposable gloves and apron) should be worn in this case and these items must be disposed of into the appropriate clinical waste stream.

11 Vehicle Interior Cleaning After Each Patient Journey

11.1 Vehicle and equipment cleaning must take place after each patient. It is standard practice to use disinfectant wipes in order to clean all surfaces that may have been contaminated. Crews must pay particular attention to high risk areas which include but are not limited to pulse oximeters, steering wheels and stretcher handles. This should only take a few minutes.

11.2 Blankets, pillow cases, sheets etc. must be changed between patients if used.

11.3 Any waste generated must be removed after each patient, due to potential cross contamination.

11.4 Where an ambulance has become contaminated with blood or bodily fluids, cleaning must take place following handover of the patient at their destination and prior to booking clear. Small spillages can be dealt with using the spill wipes carried on all vehicles.
12 The Vehicle Interior - Daily Clean

12.1 At the commencement of each shift, the following procedure must be followed:

- Check that a new appropriate waste bag is present inside the bin/s;
- Clean all surfaces with disinfectant wipes;
- Brush any debris from the vehicle floor;
- Mop the floor with Chlor-Clean;
- Document clean has been completed.

12.2 At the end of each shift, the following procedures must be followed:

- Remove all personal bags and items;
- Remove any waste generated;
- Check that all vehicle surfaces are clean- if not clean with disinfectant wipes;
- Brush any debris from the vehicle floor;
- Mop the floor with Chlor-Clean;
- Document clean has been completed.

12.3 If it is not possible to complete the procedure detailed in Para 12.1 at the commencement of a shift, the remaining elements must be completed at the earliest opportunity. Operational demand is appreciated however; crews must ensure the above is completed at least once during a clinical shift.

13 Vehicle Interior Deep Cleaning

13.1 All ambulance interiors must be subjected to a comprehensive clean in accordance with the relevant cleaning schedule for the vehicle type. This is co-ordinated by the Logistics Department using dedicated Make Ready Operatives. Frontline vehicles are maintained and deep cleaned on a 42 day cycle.

14 Aircraft Cleaning

14.1 The cleaning of aircrafts should be guided by this policy but adapted for aircrafts. Care should be taken on the different floor covering of aircraft and any other issues where the use of water or other cleaning agents may require special care.

14.2 All cleaning chemicals used within an aircraft need to be approved by the Aviation Authority.

15 Decontamination of Medical Devices and Consumables

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

15.2 Certain items of equipment are classified as “single-use only”, single use means that the item is to be used once and then discarded.
15.3 The Consumer Act 1987 will hold a person liable if a single use item is re-used against the manufacturer's recommendations.

15.4 Single patient use means; the medical device may be used for more than one episode of use on one patient only. E.g. Oxygen masks.

15.5 Single use means; the medical device is intended to be used on an individual patient during a single procedure and then discarded. E.g. Cannulation.

15.6 Any equipment supplied within sealed packaging designed to keep the item sterile or clean must remained stored within the packaging. For example, items such as airways must not be removed from its original packaging for storage in response bags.

15.7 Any consumables in damaged or broken packaging must be discarded of and replaced.

15.8 Re-useable equipment should be appropriately decontaminated between each patient.

15.9 Heavily contaminated medical devices need to be cleaned thoroughly with disinfectant wipes.

15.10 If unsure the medical device is thoroughly cleaned, e.g. concerns bodily fluids may have entered the crevices of the device or gone inside the piece of equipment. Double bag and send back to medical devices with an attached note explaining the circumstances.

15.11 A decontamination certificate must be attached to the piece of equipment before sending it back to logistics and this states the method of decontamination used, or the reason why it was not possible. [Link](http://intranet.swast.nhs.uk/Downloads/SWASFT%20downloads/Logistics/CertificateDecontamination.pdf)

15.12 All reusable medical devices must be decontaminated in accordance with manufacturer's instructions as well as legislative and best practice requirements.

16 Cleaning of Vehicles Prior to Service or Repair

16.1 Vehicles requiring repair or servicing must be cleaned of all organic material, by the last ambulance crew to use the vehicle.

16.2 It is also important to ensure that vehicles going for maintenance or repair are sent to workshops (including external contractors), in a state which is safe for non-clinical staff to work in.

16.3 All clinical waste and sharps bins must be removed and the sharps box must be removed. **This is the crew's responsibility.**

16.4 If cleaning and checking of the vehicle has not been possible, workshops must be notified of the risk and any precautions that are necessary must be discussed and agreed with them.
Procedure 10 - Principles of Aseptic Non-Touch Technique

1. Purpose

1.1 This procedure is set out to provide the requirements of minimising the risk of cross infection by ensuring that an aseptic non-touch technique is applied where possible, and when undertaking invasive procedures that bypass the body’s natural defences.

2. Definitions

2.1 Asepsis is defined as the absence of pathogenic organisms.

2.2 Aseptic non-touch technique is a clinical procedure developed to prevent the contamination of wounds or other susceptible body sites by using sterile equipment and fluids during invasive medical procedures and by avoiding the contamination of the equipment by adopting a non-touch technique.

3. Principles of Aseptic Non-touch Technique

3.1 The principles of aseptic non-touch technique play a vital role in preventing the transmission of infection in any environment. It is the responsibility of staff to understand these principles and incorporate them into everyday practice.

3.2 The principles of aseptic non-touch technique are:

- Keeping the exposure of susceptible sites to a minimum.
- Ensuring appropriate hand decontamination prior to the procedure.
- Using gloves – sterile or non-sterile gloves depending on nature of susceptible site.
- Ensuring that all fluids and materials used are sterile.
- Checking that all packs used are sterile and show no signs/evidence of damage.
- Ensuring that contaminated and non-sterile items are not placed on the sterile field.
- Not reusing single use items.
- Reducing staff and/or bystander activity (whenever possible) in the immediate vicinity of the where the procedure is performed.

3.3 If aseptic non-touch technique cannot be applied, because of the nature of the emergency or environmental factors then this must be handed over to the staff at the receiving hospital and clearly documented on the ePCR.

3.4 The indications for using aseptic non-touch technique are:

- Routine insertion of an intravenous cannula;
- Urinary catheterisation;
- Traumatic or surgical wounds including suturing or gluing;
- Trauma wounds;
- Any other invasive medical procedure.
4. **Intravenous Cannulation**

4.1 Peripheral intravenous cannulation is a commonly performed procedure and has an associated risk of infection because of the potential for direct microbial entry to the blood stream.

4.2 Due to the increased risk of infection with pre-hospital cannulation, patients should only be cannulated when there is a clinical need. Unjustified prophylactic cannulation and cannulation purely on the basis that it has come to be expected by the hospital must not occur.

4.3 As a general guide, cannulation would be considered appropriate where a drug or fluid is likely to or needs to be administered en-route to hospital or where the patient’s condition is unstable and likely to deteriorate.

4.4 The choice of cannula must reflect the size of the vein and the maximum flow rate required. Inserting a cannula which is too large for the size of the vein increases endothelial damage, leading to an increased risk of phlebitis. Venous return cannot take place because the vein itself is actually occluded by the cannula (known as the haemodilution effect). Therefore using the smallest suitable cannula, that will deliver the required flow rate, not only reduces the risk of phlebitis, but increases the uptake of drug.

4.5 Intravenous cannulation must be carried out aseptically whenever the patients’ clinical condition allows a routine insertion, such as stable patients requiring the administration of IV pain relief. Good practice from the Saving Lives - High Impact Intervention on peripheral intravenous cannulation recommends:

- Apply a single use disposable tourniquet.
- Palpate the vein.
- Decontaminate hands.
- Clean the site using 2% Chlorhexidine gluconate in 70% isopropyl alcohol.
- Leave the skin to dry for 30 seconds.
- Choose cannula, open pack and place cannula aseptically in the sterile field - if this is not possible another HCW should open the cannula packaging and present the cannula so it can be grasped by the cannulating clinician without touching the outer packaging.
- Decontaminate hands and don gloves.
- Insert cannula, ensuring that the site is not touched.
- Use a sterile, semi-permeable transparent dressing to secure the cannula;
- Record date and time of insertion on cannula dressing.
- Dispose of any used items in the appropriate waste receptacles;
- Decontaminate hands.
- Record the date and time of insertion on the ePCR.
4.6 If any of the above steps cannot be performed due to circumstances, such as life threatening emergencies or environmental conditions, the inserted device must be classified as **EMERGENCY INSERTED**. This must be recorded on the ePCR and handed over to the receiving hospital staff.

4.7 Always ensure that giving sets and syringes are handled aseptically. For certain procedures, a sterile field should be retained to hold the syringes between doses. Syringes should not be stored in pockets or on the patient’s lap between the administration of doses.

5. **Catheterisation**

5.1 Urinary tract infections are the second largest group of healthcare associated infections in the UK, amounting to 17.2% of all hospital acquired infections, with 43-56% of these infections attributed to the presence of an indwelling catheter.

5.2 All staff carrying out catheterisation must have received formal training and be competent in catheter insertion, replacement and maintenance.

5.3 Urinary catheter insertion and care must be completed using sterile equipment, including sterile catheter packs and sterile gloves and aprons.

5.4 The key principles of aseptic non-touch technique must be applied throughout the procedure.

5.5 Where possible hands should be washed with liquid soap and paper towels prior to catheterisation. Hands must be cleaned before putting gloves on and on removal.

5.6 The choice of catheter material and gauge for urethral and suprapubic catheterisation will depend on an assessment of the patients’ needs, individual characteristics and predisposition to blockage.

5.7 For urethral catheterisation:

- The urethral meatus must be cleaned, this can be cleaned using soap and water or saline solution – depending on what is available;
- Appropriate lubricant from a single use container must be used during catheterisation to minimise urethral trauma and infection;
- The catheter balloon should be inflated, after insertion, with 10mls of sterile water in adults and 3-5mls in children.

5.8 All staff need to be aware of the risk of infection for the patient if catheter bags are not correctly cared for and managed during transportation. Urinary catheter drainage bags must not be placed on the floor and must be kept below the level of the bladder to prevent backflow.

5.9 Hand hygiene should be performed before and after catheter care.
6. **Wound Care (Including Gluing and Suturing)**

6.1 Wound care must be undertaken using sterile equipment, including sterile wound care packs and sterile gloves and aprons. This equipment must be available to all clinicians who are qualified in suturing and gluing.

6.2 The key principles of aseptic non-touch technique must be applied throughout the procedure.

6.3 Where possible hands should be washed with liquid soap and paper towels prior to wound care. Where this is not possible a hand wipe can be used prior to using alcohol based hand rub. Hands must be physically clean before putting on gloves.

6.4 Hand hygiene must be performed following wound care.
Procedure 11 - Transporting Patients from Closed Wards

1. **Purpose**

1.1 This procedure is set out to provide ambulance crews with best practice guidelines when moving patients from a ward closed due to infection prevention and control issues.

2. **Background**

2.1 The Trust frequently transfers patients between two hospital facilities, and to or from care homes. In order to prevent the spread of infectious diseases between facilities, hospitals are responsible for following locally agreed policies and procedures. In general the transfer of an infectious patient, especially those with diarrhoea or vomiting, should be avoided unless intervention is essential. Under the Health and Social Care Act (2008), NHS bodies have a duty to ensure they provide suitable and sufficient information on a patient’s infection status whenever they arrange for a patient to be moved from the care of one organisation to another, so that any risks are minimised.

2.2 The infection status of patients is defined as either no risk, suspected risk or confirmed risk. For example, a patient colonised with Methicillin–Resistant Staphylococcus Aureus (MRSA) is defined as a ‘confirmed risk’ however, a patient with D&V symptoms would be defined as a ‘suspected risk’.

2.3 A suspected risk patient can also be someone awaiting laboratory test results to identify infections/organisms or has been in recent contact or close proximity to an infected patient.

2.4 Transferring facilities are responsible for:

- Liaising with their Infection Prevention and Control Team, this is to ensure that the risk of cross contamination is assessed and minimised;
- Informing the IPC Team at the receiving facility of any infectious conditions before the transfer is carried out.
- Notifying the Ambulance Clinical Hub of any suspected or confirmed risk at the time of requesting transport, including the presence of diarrhoea and/or vomiting.
- Ensuring that any wounds are covered with an appropriate occlusive dressing.
- Providing the attending ambulance crews with a full verbal handover and any relevant documentation.

2.5 The Trust is responsible for:

- Ensuring Clinical Hub staff inform the attending ambulance crews of the patient’s infection status (where this is known).
- Following IPC guidance to minimise the spread of infection.
- Informing the receiving staff of any confirmed or suspected risk during the handover.
- Safely conveying patient notes and any other documents (where provided).
2.6 In many cases the patients’ infection status will not be known. In these instances staff must follow standard precautions for all patients. Further guidance on transporting patients can be found on the Infection Prevention and Control intranet page or by contacting the IPC Team.

3. **Outbreaks**

3.1 Outbreaks of communicable disease/infection can be defined as the incidence of disease above the normally expected level.

3.2 Ward closures for infection prevention and control precautions are generally due to an outbreak of a communicable disease.

3.3 Outbreaks of infection may vary in extent and severity, ranging from a few cases to a large number of cases affecting staff and patients.

4. **Transportation of Patients**

4.1 If a hospital requires transportation for a patient they have a duty to inform us of any infection prevention and control issues but it is always important to ask if this information is not volunteered.

4.2 There are two main types of patients who may require transportation from closed wards, those who require urgent care and those who are going to their own home.

4.3 A patient with diarrhoea and/or vomiting who requires urgent clinical care may need to be moved from a closed ward to a different hospital, for example; from a community hospital to an acute Trust hospital. These patients must travel alone.

5. **Cleaning Vehicles**

5.1 If the vehicle is soiled by vomit or faeces from a patient suspected to have an infectious disease, the vehicle should be taken off the road immediately so that the crew can clean the vehicle thoroughly before sending it off for an emergency deep clean.

5.2 The crew need to fill out a deep clean request form before sending the vehicle to the Make Ready Team. This can be found on the IPC intranet page or by clicking on this URL:

5.3 If there is no soiling, a normal between patient clean is sufficient and there is no need for an emergency deep clean to take place.
Procedure 12 - Employee Protection from Blood Borne Viruses

1. Purpose

1.1 The purpose of this procedure is to define the Trust’s arrangements to prevent avoidable contraction of blood borne viruses for staff and to protect patients from acquiring a blood borne virus from a member of staff.

1.2 The procedure defines the appropriate pre-employment medical screening and management of staff with blood borne viruses including the provision of post exposure prophylaxis following contamination injuries.

2. Definitions

21 For the purpose of this procedure contamination injuries include needle stick injuries, inoculations, splash contamination and bites/scratches that break the skin or breach mucous membranes.

22 For the purpose of this procedure Occupational Health will be referred to as OH.

23 Exposure prone procedures are defined as those invasive procedures where there is a risk that an injury to the worker may result in the exposure of the patients’ open tissue to the blood of the healthcare worker.

24 Blood borne viruses will be referred to as BBVs and includes but are not limited to Hepatitis B, Hepatitis C and Human Immuno-deficiency Virus (HIV).

3. Pre-Employment Checks

31 All new employees are required to undertake pre-employment medical screening, which will include a review of the person’s immunisation status in accordance with the Department of Health recommendations for Immunisation of Healthcare and Laboratory Staff.

32 All staff who perform exposure prone procedures will be screened for blood borne virus infections as part of the pre-employment medical screening. Staff who decline this screening will not be cleared for work involving exposure prone procedures.

4. Control of Infection Measures

41 Any member of staff working in healthcare environments that handle sharps or clinical waste should receive a full course of hepatitis B vaccinations followed by an antibody level check six weeks after the end of the course.

42 Existing staff who know that they are not protected against hepatitis B should contact their line manager immediately to arrange vaccinations without delay.

4.4 If the employee does not develop antibodies following immunisation, OH have a duty to inform the Trust. Each case will be reviewed individually and in accordance with national guidance with specialist advice sought if required.
4.5 If employees are diagnosed with a BBV outside of the Trust, they have a duty to inform the Trust and will be referred to OH. If the employee is diagnosed through OH – OH and the staff member have a duty to inform the Trust. Each case will be reviewed individually and in accordance with national guidance, specialist advice will be sought if required.

4.6 Immunisation is not a substitute for good infection prevention and control practices, as immunisation is not available for all blood borne viruses.

4.7 Personal Protective Equipment (PPE) and effective hand decontamination should be used to minimise the risk of infection, in accordance with the infection prevention and control policy – staff must refer to procedure 4 of the infection prevention and control policy for further information.

5 Exposure Prone Procedure

5.1 Exposure prone procedures are invasive procedures where there is a high risk that the healthcare worker may be at risk of injury whilst exposed to the patients’ open tissue. Including where the workers gloved hands maybe in contact with sharp instruments, needle tips or sharp tissue inside a patients open body cavity, wound or confined anatomical space where the hands or fingertips are not completely visible at all times. This includes situations such as pre-hospital trauma.

5.2 Staff who perform EPP need to be aware of their obligations to declare if they know they have been at risk of exposure to a BBV, this includes situations that fall outside of work as well as during working hours.

5.3 All new starters applying for posts which may involve EPP must have specific screening in accordance with national guidance, this includes testing for BBVs.

5.4 All staff infected with a BBV will need to be reviewed on a case by case basis commencing with a referral to OH. If required, further advice can be obtained from UKAP.

5.5 The final decision about the type of work that may be carried out by a healthcare worker infected with a BBV should be made on an individual basis taking into account the specific working practices of the worker concerned, this decision will be undertaken by the Trust and reviewed in accordance with the restriction of practice policy. Specialist advice will be sought from OH and UKAP as required.
6. **Post Exposure Prophylaxis (PEP)**

6.1 Following inoculation/contamination injuries staff must

- Gently bleed the wound (if applicable).
- Wash the injury/area (with soap) under running water (if applicable).
- Dress the injury (if applicable).
- Report it to the Duty Operations Commander.
- Attend Emergency Department for blood tests.
- Complete an Incident Report.
- Inform Occupational Health.

6.2 Further information on first aid for the management of needle stick, inoculation and splash contamination injuries can be found in Procedure 6.

6.3 For all inoculation or contamination injuries, staff should be assessed and the need for PEP considered at the hospital Emergency Department.

6.4 If the source patient is able to be identified and is able to consent to giving a blood sample, informed consent should be gained and a blood sample sent to the microbiology laboratory to test for hepatitis B, C and HIV. This process must be carried out by a clinician who was not involved in the incident, normally a member of the hospital staff. Occupational Health will then chase the results of the test.

6.5 In the event that the source patient cannot be tested, management of the member of staff should be based on a risk assessment carried out by the emergency department or OH. Clinical information about the incident and the patient will be reviewed to ascertain if the incident is high risk. In the event that the patient and incident are considered ‘high risk’ the healthcare worker should be treated as if the source is known to be positive.

6.6 PEP should be considered when there has been exposure to blood or high risk bodily fluids from an individual known or strongly suspected to be infected with HIV.

6.7 PEP should be considered when an individual is strongly suspected to have a BBV, including individuals with clinical symptoms of HIV, IV drug users or those from countries where HIV is highly endemic who may have not been tested.

6.8 If PEP is indicated it must be started as soon as possible after the incident, ideally within 1 hour but can be commenced within the first 72 hours.

6.9 On-going advice should be obtained through OH in the first instance. Alternatively genitourinary medicine (GUM) clinics are available for advice and case management. In some instances it might be appropriate for the individuals’ GP to manage the case.

6.10 Any injuries involving exposure to HIV and Hepatitis must be reported to the Health and Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) 2013. This is completed by the Health, Safety and Security Team.
7. **Staff Support Following Contamination Injury**

7.1 The local duty officer is responsible for providing support to the member of staff in the first instance, ensuring that appropriate services are accessed and information provided.

7.2 Any member of staff sustaining an inoculation or contamination injury must be managed in accordance with the Safe Sharps Management Procedure 6 of the Infection Prevention and Control Policy.

7.3 During the next working day the appropriate Operations Officer will assume responsibility for ensuring the member of staff is fully supported and that they have accessed the full range of support services identified, including OH and counselling if required. A welfare officer will be agreed at this point, with the Staying Well service being signposted if required.

7.4 Follow up for on-going blood tests and PEP etc. will be organised through OH. For staff requiring PEP this will include weekly liver and renal function tests to monitor the impact of the medication. Dependant on the risk post exposure blood testing for BBVs includes tests at:

- Six weeks – Hepatitis C and Hepatitis B antibodies (if a booster has been given);
- Twelve weeks – HIV and Hepatitis C;
- Twenty-four weeks – Hepatitis C.

7.5 The majority of staff are able to continue working during this period. However, the Trust recognises that PEP for HIV is prone to side effects that may impact an individual’s ability to perform at work. This will be discussed on a case by case basis and lead by the Trust with advice from OH.

7.6 If it is identified that adjustments need to be made to working arrangements whilst the staff member is undertaking PEP and during the follow up period the Trust will review each case on an individual basis and seek advice from OH as and when required.

7.7 **Useful Contacts:**

- Occupational Health/Needle stick line: 03450 944021 Option 2
- IPC Manager Fataha Sultan-Petty: 07788565457; fataha.sultan-petty@swast.nhs.uk;
- IPC Support Officer Helen Chapman-Duke: 07717468257; helen.chapman-duke@swast.nhs.uk;
- Public Health England South West: 0300 303 8162
Procedure 13 - Care of the Deceased

1. Purpose

1.1 Attention must be paid to infection prevention and control procedures in the event of a patient dying in transit, or in the case of a crew needing to confirm death or move a deceased patient. The Resuscitation and Confirmation of Death Policy must be followed to ascertain the circumstances in which resuscitation should/should not be carried out.

2. Handling and Transport

- The body must not be handled unnecessarily;
- Deceased patients being transported by the Trust must be placed in a heavy-duty disposable plastic body bag;
- Consider the use of gloves and apron if contact with body fluids is likely;
- If there is any risk of infection, hospital staff must be warned;
- Upon completion of the incident, the vehicle and all appropriate equipment must be decontaminated according to procedures documented in this policy.
Procedure 14 - Major Outbreaks and Public Health England

1. Purpose

1.1 Public Health England provides specialist support to prevent and reduce the impact of infectious diseases, chemical and radiation hazards, and major emergencies. Additional teams are based within all localities, and our involved in a range of activities, including:

- Local disease surveillance;
- Laboratory services;
- Alert systems;
- Investigation and management of health protection incidents and outbreaks;
- Delivery and monitoring of national action plans for infectious diseases at local level.

1.2 In the case of a major outbreak, PHE will coordinate the response and investigation. Rapid microbiological and epidemiological investigations are essential for effective immediate control and to ensure lessons are learnt for longer term prevention. PHE are responsible for holding and updating national outbreak plans, as well as many disease-specific major incident plans, working with microbiology and clinical colleagues, Local and Regional Services and, for emergencies, with the Centre for Emergency Preparedness and Response.

1.3 In the case of a major outbreak, the Trust will be co-ordinated through the normal command structure, following directions from PHE as the lead body.
Procedure 16 - Food Transportation on Vehicles

1. **Purpose**

1.1 The purpose of this procedure is to minimise the risk of cross contamination of food with potential harmful micro-organisms and to reduce the risk of gastro intestinal illness.

2. **Food Transportation**

2.1 Food is not to be transported in the back of the DCA and must only be transported in the cab area.

2.2 In order to prevent the contamination of food, food containers should be:

- Fit for purpose.
- Lidded.
- Washable.
- Leak proof.
- Liquid proof.
- Labelled.
- Dated.

2.3 Cool bags can be utilised to increase the amount of time that food can remain out of the fridge before cooking or consumption. Cool bags must be:

- Fit for purpose.
- Clean.
- Sealable.
- Washable.
- Leak proof.
- Undamaged.

2.4 Ice packs need to be used in conjunction with the cool bag, these should have been in a freezer for at least 24 hours prior to use and must be the correct size for the bag and amount of food to be kept chilled. This is the staff’s responsibility.

3. **Food Consumption**

3.1 Food and drink must not be consumed whilst driving a moving vehicle.

3.2 Staff must not consume food or drink in the treatment/clinical area of the vehicle and must not consume food or drink whilst undertaking clinical care.
4. Hand Hygiene

4.1 Hand decontamination must be carried out prior to, after handling or consuming food or drink.

4.2 Hand hygiene should be undertaken with soap and water, not alcohol hand gel, prior to eating or drinking. Gloves should never be used as a substitute for appropriate hand hygiene.

References

- Department of Health (2002) Getting Ahead of the Curve: A Strategy for combating infectious diseases (including other aspects of health protection);
### Appendix A - Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
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<td>1</td>
<td>27/02/13</td>
<td>Senior Clinical Lead East</td>
<td>New Policy</td>
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<td>2</td>
<td>26/06/14</td>
<td>Infection Prevention Control Lead</td>
<td>Update to statement Update to section 5 Update to 6.4 Minor amendments to hand decontamination procedure 3.</td>
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<td>3</td>
<td>27/01/14</td>
<td>Infection Prevention Control Lead</td>
<td>Updated procedure 13 agreed at IPCG Updated contact numbers for PHE and OH needlestick injury helpline</td>
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<td>4</td>
<td>18/05/16</td>
<td>Infection Prevention Control Lead</td>
<td>Complete revision.</td>
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<td>04/02/19</td>
<td>Infection prevention and Control Manager</td>
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<td>5.1</td>
<td>29/04/19</td>
<td>Infection prevention and Control Manager</td>
<td>Updated Trust policy foreword. Sections 5 and 7 - Additional information on skin sensitivities, dermatitis and accessing support.</td>
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