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: | David Partlow, Clinical Development Manager (East)
                          | Fataha Sultan-Petty, Infection Prevention and Control Lead |
| Name of responsible director: | Executive Director of Nursing and Governance |
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Trust Policy Foreword

South Western Ambulance Service NHS Foundation Trust (SWASFT) has a number of specific corporate responsibilities and obligations relating to patient safety and staff wellbeing. All Trust policies need to appropriately include these.

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.

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 minimised, 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.

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, victimisation 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.

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 understand and uphold the duties set out in the Constitution.

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.

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.
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Strategy

Strategic Statement

There is a national drive for improved infection prevention and control 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, HCAI results 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).

**Regulation**

The Health Act 2006 introduced a statutory duty on NHS organisations to observe the provisions of the Code of Practice on Healthcare Associated Infections (the Hygiene Code). The Care Quality Commission (CQC) assumed responsibility for the regulation of health and adult social care on the 1st April 2009. From 2009/10 NHS providers are now required to comply with new regulations issued under the Health and Social Care Act 2008 Act that oblige them to protect patients, staff and others from identifiable risks of HCAI in order to maintain their registration with the Care Quality Commission.

The Hygiene Code has been replaced by Code of Practice, which forms the basis for monitoring compliance with the regulations.

**Sustaining Progress**

The Trusts will continue with the comprehensive infection prevention and control initiative which commenced with the Cleaner Care campaign, to ensure that all staff are aware of the impact of preventable health care associated infections and the mechanisms by which the strategic aims can be achieved.

Ken Wenman  
Chief Executive  

Jennifer Winslade  
Executive Director of Nursing and Governance  
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 approved by the Infection Prevention and Control Group or Clinical Effectiveness Group and ratified 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 contracted agencies 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 A separate action plan exists for the infection prevention and control annual programme and to ensure compliance with the Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance.

3.3 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 Colonization: When micro-organisms are present on or in a person but not currently causing any harm, that person is said to be colonized with those organisms. For example, human beings are normally colonized 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 at the ‘5 moments’ described by the WHO (2009), including before and after each patient contact;
- 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 Nursing and Governance, 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 responsibility is delegated to the Deputy Clinical Director.
5.4 **Executive Director of Nursing and Governance**

5.4.1 The Executive Director of Nursing and Governance is responsible for ensuring the effective implementation and monitoring of infection prevention and control across the UCS Service Line. They are ultimately responsible for ensuring that UCS vehicles and equipment in vehicles and treatment centres 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.

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

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

5.5.2 The Deputy 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 Clinical Development Manager (East). They have the authority to challenge inappropriate clinical hygiene practices and poor infection prevention and control measures.

5.6 **Clinical Development Manager (East)**

5.6.1 The Clinical Development Manager (East) is responsible for the day to day management of infection control, maintaining the Infection Control 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.

5.6.2 The Clinical Development Manager (East) 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.

5.7 **Infection Prevention and Control Lead**

5.7.1 The Infection Prevention and Control Lead is responsible for monitoring completion of the infection prevention and control action 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.

5.7.2 The Infection Prevention and Control Lead maintains a high clinical profile within the Trust, the health community and at national meetings and facilitates the infection prevention and control audit programme and undertake regular audits. 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.
5.7.3 The Infection Prevention and Control Lead 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.

5.8 Director of Operations

5.8.1 The 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.

5.9 The Executive Director of Human Resources and Occupational Development

5.9.1 The Executive Director of Human Resources and Occupational Development 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 Trusts Occupational Health Policy.

5.10 Head of Education and Professional Development

5.10.1 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.

5.10.2 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.

5.11 Pharmaceutical Advisor

5.11.1 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 Urgent Care Service GPs are provided with an 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.
5.12 Head of Logistics

5.12.1 The Head of Logistics 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.

5.12.2 The Head of Logistics is responsible for the cleaning and decontamination of vehicles and medical equipment during the vehicle deep cleaning process.

5.13 Estates Manager

5.13.1 The Estates Manager 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, and non-Trust owned and/or maintained premises comply with Trust standards.

5.13.2 The Estates Manager is responsible for working with the Procurement Manager to appropriately contract and manage cleaning services within Trust HQ and any other nominated building.

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

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

5.14 Domestic Cleaning

5.14.1 Externally procured domestic cleaning services are to deliver on site cleaning according to the principles contained within the Cleaning Strategy and contractual instructions. 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 the Trust any situation that could potentially compromise achievement of the appropriate cleaning standards.

5.14.2 Externally procured domestic cleaning services to monitor compliance with Key Performance Indicators (KPIs) as required within contractual agreements.

5.14.3 Staff should feel empowered to challenge and report poor practice with respect to infection prevention and control.
5.15 Make Ready Operatives

5.15.1 Deliver vehicle cleaning according to the principles contained within the Cleaning Strategy and cleaning schedules. 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.

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

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

5.16 Head of Operations, Operational Managers and Urgent Care Service Managers

5.16.1 The Head of Operations, Operational Managers and UCS Managers 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 audits as requested by the Deputy Clinical Director.

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

5.16.3 They are responsible for ensuring that ambulance vehicles, treatment centres and equipment are cleaned appropriately and documented according to the principles within the Vehicle and Premises Cleaning Schedules and achieve the Trusts high standard of cleanliness through a visible presence, monthly station reviews and support of their Operational Officers. Head of Operations and Operational Managers are designated as the responsible manager for the routine decontamination of equipment within their area.

5.17 Line Managers

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

5.17.2 Managers are responsible for including infection prevention and control within the managerial job descriptions and appraisals of all staff under their line management. Operational Officers are responsible for ensuring the cleaning and decontamination of vehicles and equipment according to the Policy and for the management of operational staff in compliance with appropriate infection prevention and control.

5.17.3 Managers are responsible for challenging poor practice and for ensuring compliance with infection prevention and control policies, procedures and guidance.
5.18 Trust Staff and Clinicians

5.18.1 Responsibility for infection prevention and control is devolved to all staff and clinicians within the Trust. All staff have a responsibility to attend 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.

5.18.2 All staff 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.

5.18.3 The Trust empowers staff to challenge and report poor practice with respect to infection prevention and control.

5.19 Organisational Framework

5.19.1 Infection prevention and control performance is monitored and led by the Infection Prevention and Control Group which reports to the Board through the Clinical Effectiveness Group and the Quality Committee. The group provides feedback and advice to the Clinical Effectiveness Group, Vehicle, Equipment and Uniform Working Group and Board as requested. The group advises the Head of Education of any identified training needs to ensure that learning from experience is incorporated into practice.

5.19.2 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. The Equipment Selection and Procurement Checklist must be completed in all instances.

5.19.3 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 Trusts Infection Prevention and Control Risk Assessment. All staff receive training in risk management and risk assessment during their induction, and a risk assessment tool is available on the Trusts intranet site.
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.

The assessment will consider the following:

- Frequency and scale of contact with blood or other body fluids;
- Number of different person’s blood/body 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.

Healthcare associated infection risk assessments will be owned by the Clinical Effectiveness Group who will monitor the action plans. The Clinical Development Manager (East) 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.

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.

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.

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

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 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.
6.3.2 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 Deputy Clinical Director. The Executive Director of Nursing and Governance/Deputy 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.

6.3.3 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 breech in standards.

6.3.4 Following any immediate action required to reduce the risk of the breech, the following senior staff are authorized to issue an Improvement Order:

- Chief Executive;
- Executive Medical Director;
- Executive Director of Nursing and Governance;
- Director of Operations;
- Deputy Clinical Director;
- Clinical Development Managers;
- Health and Safety Manager;
- Infection Prevention and Control Lead.

6.3.5 The Improvement Order will be issued to the appropriate line manager for urgent action within a period of 24, 48 or 72 hours, 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 monthly 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).

6.4.2 Animals are not permitted onto vehicles, with the exception of assistance animals (e.g. guide dogs). This is only if all other options have been exhausted and the patient’s condition indicates immediate transfer.
7. Antimicrobial Prescribing Procedure

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

- Monitoring and evaluating antimicrobial prescribing and the supply of antimicrobials using PGDs and ensuring it complies with the Public Health England and National Institute for Health and Care Excellence guidance on antimicrobial use.
- Providing feedback to prescribers about their antimicrobial prescribing and any patient safety incidents related to antimicrobial use.
- Providing education and training to clinicians about antimicrobial stewardship and antimicrobial resistance.
- Auditing antimicrobial use within quality improvement programmes.

7.2 The Trust promotes optimal antimicrobial use and uses the guidance on managing common infections issued by Public Health England as its antimicrobial formulary. The Pharmaceutical Advisor ensures that all Trust antibiotic PGDs comply with the Public Health England and National Institute for Health and Care Excellence guidance on antimicrobial use.

7.3 The Trust will be represented at local antimicrobial group meetings to communicate information and share learning on antimicrobial prescribing, antimicrobial resistance and patient safety incidents.

7.4 Trust Clinicians will be encouraged to promote antimicrobial stewardship and to become 'Antibiotic Guardians'.

7.5 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 or administration 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. Intravenous antimicrobials will be reserved for the management of sepsis. The choice of antimicrobial will be guided by advice from local and national microbiologists.

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 programs 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 program, 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 Trusts 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 Operational Officers are responsible for monitoring compliance with the Infection Control Policy on a daily basis and challenging inappropriate practice. The results of infection control audits, 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 Strategy and Policy. The Board and Quality Committee will receive an annual Infection Prevention and Control Report from the Executive Director of Nursing & Governance and Deputy Clinical Director.

9.2 The annual Infection Prevention and Control Report will be the Trusts infection control assurance framework and will include:

- Detailed progress against the annual infection prevention and control annual programme;
- Request ratification of the following year’s annual infection prevention and control annual programme;
- Demonstrate the effectiveness of the policy through the presentation of audit findings from station reviews, identifying improvements in infection control standards;
- Assure continued compliance with the Health and Social Care Act (2008);
• Assure compliance with Care Quality Commission Essential standards;
• Assure compliance with the NHS Litigation Authority standards;
• Contain 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;
• Contain a summary of reported incidents reviewed by the Infection Prevention and Control Group and any resulting changes to practice;
• Demonstrate the reduction of infection control risks and their subsequent downgrading on the Risk Register;
• Contain 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;
• Provide 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;
• Confirm that 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 monthly performance report. The Executive Director of Nursing and Governance will present an exceptions report should any serious incidents by 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 audit returns are received from all Trust premises, including ambulance stations and social dispatch facilities. The audit assesses compliance with infection control measures throughout the Trust, ensures that all aspects of the policy are implemented, and standards are maintained. Each month the senior clinician or designated manager must complete the online infection prevention and control audit. The results are analysed on a monthly basis, with reports being fed to the Medical and Operational Directorate for information and appropriate action. The Heads of Operations will be informed if a premises review is not returned with 7 days of the month end, to ensure that prompt action can be taken to achieve a full review.

10. Associated Documents

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

- Institute of Health and Care Development. (2007). Ambulance Service Basic Training, Ambulance Staff Training to National Standard, Section 17.3 – 17.5. IHCD. Available at: www.edexcel.com;
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 Lead 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 area 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 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 (www.gov.uk/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 08448 260308.

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**
  Devon, Cornwall, Somerset, Avon, Gloucestershire and Wiltshire
  Tel 0300 303 8162

- **PHE Wessex**
  Dorset, Hampshire & Isle of Wight
  Tel: 0344 225 3861- Option 1 followed by option 4
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.

5.2 Reservoirs are those which have been proven by epidemiological and microbiological investigations to be the origin of infection.

5.3 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. Means 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 form 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 (Spill Management, Procedure 8);
- 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 Manage blood and body fluid spillages appropriately to protect all those in the surrounding environment from exposure to microorganisms that could cause harm.
9.6 Manage care 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 Control of environment ensuring that cleaning and maintenance schedules 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 waste by ensuring that employees are aware of the correct guidance for the disposal of clinical waste and sharps to prevent the risk of inappropriate placement of clinical waste that could 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 (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, 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 washing and the use of PPE such as gloves and apron. All items of linen must be red bagged and laundered appropriately (Procedure 8).

10.1.2 In general, no specific cleaning of the vehicle is necessary, other than close attention to the area immediately occupied by the patient. The trolley, adjacent walls and floor must be cleaned with detergent wipes. In cases where there is visible infestation with fleas, crews 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.

10.2 Scabies

10.2.1 Sarcoptes scabie is a human mite which penetrates the outer layer of the skin. The body’s immune system reacts to the mite’s droppings and saliva resulting in an immune reaction which causes intense itching. The incubation period is up to 8 weeks after contact with an infected person and it may take up to 2 weeks before symptoms present.
10.2.2 Lesions occur mainly on the hands, finger webs, wrists, inside of arms, abdomen, waist, groin and under buttocks. Scabies is spread from person to person by prolonged direct skin-to-skin contact, including sexual contact. Mites do not survive away from their host, as the environment is too cold outside of the skin. Scabies presents a low risk for contraction to ambulance crews providing standard precautions are observed, especially hand hygiene.

10.3 Lice

10.3.1 Lice are wingless insects, which are found worldwide as ectoparasites of mammals. They feed by sucking blood from their host.

10.3.2 Head lice - The female louse lives for 2-4 weeks and can lay 5-8 eggs per day. The eggs are enclosed in tiny sacs, which are attached to the base of the hair and hatch after 7 days. The empty egg cases are called „nits“. The louse takes 10 days to become mature and in turn then able to lay eggs. These lice are only found on the head and transmission is via head-to-head contact. They cannot jump, fly or swim. Head lice found on clothing or furniture are either dead or dying.

10.3.3 Clothing / Body Lice - These lice live in the seams of clothing rather than on the skin of the host. They will live for 13-30 days if they are able to feed. If unable to feed they will die of starvation in 5 days. Infestations usually affect people with poor personal hygiene, who do not regularly change their clothing.

10.3.4 Pubic Lice / Crab Lice - This louse will infest all coarse body hair. Living on pubic hair, axillary hair, beard, eyebrows and eyelashes. The eggs take 6-8 days to incubate and the life cycle is about 3 weeks.

10.4 Fleas

10.4.1 Human fleas are rarely encountered. Animal fleas are host specific, requiring a specific host animal e.g. cat or dog, to breed and complete their life cycle, however animal fleas will feed from any warm-blooded animal. In the UK, fleas are generally not responsible for the transmission of disease. Cat and dog fleas account for 95% of flea problems in the UK. Although they will not remain on a human, the fleas have the ability to jump on to a person and bite before jumping off again.

11. Classifications of Infectious Diseases

11.1 Infectious diseases are classified into two categories according to the infection control precautions required. The previous classification of Category 1 and 2 are now combined and referred to as cases requiring standard (universal) precautions. Further information can be obtained from the Public Health England: [www.gov.uk/health-protection/infectious-diseases](http://www.gov.uk/health-protection/infectious-diseases). Additional information is available on the intranet under the Infection Prevention and Control section, covering the transport of patients with Norovirus and ESBL, MRSA and C. Diff within the A to Z of disease specific precautions.

11.2 Standard (Universal) Precautions

11.2.1 No special precautions are required when transporting patients with these diseases, but standard (universal) infection control precautions must be applied as normal practice, unless advised otherwise by the hospital Consultant.
11.3 Category 3:

11.3.1 The transportation of a patient with a Category 3 infectious disease requires special precautions and procedures which are detailed in the A to Z of disease specific precautions and on the PHE web site. In the UK, most patients who could have a Category 3 disease are likely to present to an Emergency Department either directly or via their GP. The patient will present with pyrexia (fever) of unknown origin (PUO) shortly after having returned from abroad but these early symptoms could indicate any number of far less serious conditions and a positive diagnosis can only be made following extensive tests.

11.3.2 It is likely that A&E staff will already have had contact with such patients before their illness is formally diagnosed. The Advisory Committee on Dangerous Pathogens (ACDP) have issued guidance that most pre-diagnosis Category 3 patients can be safely managed by following the Standard Infection Control Precautions and the safe disposal of clinical waste. If the patient requires ventilation, this must be conducted using either a bag-valve-mask or ventilator. Under no circumstances should any form of direct oral resuscitation be carried out.

11.3.3 However, should a Category 3 disease be subsequently diagnosed, the attending ambulance crew will be required to undergo surveillance for a period of 21 days from the last possible date of exposure to infection.

11.3.4 There need be no restriction on work or movement within the UK, surveillance will simply be the daily monitoring of body temperature and the reporting of any suspicious symptoms. During surveillance those suffering any rise of temperature above 38°C will be kept under surveillance at home and, if fever persists for more than 24 hours, advice sought from a consultant in infectious or tropical diseases.

11.3.5 Patients with a confirmed diagnosis of a Category 3 disease will only be transported by the London Ambulance Service or North East Ambulance Service. In extraordinary circumstances, the Consultant at the Royal Free Hospital may determine that the patient should be transported in an isolator. Although this situation has never arisen before in the UK, crews involved will receive special training and instructions at the time by members of the hospital staff.

12. References


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 antimicrobial 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 detergent and antiseptic to remove soiling and 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 HART operations when additional and extensive PPE is required);
- Bracelets;
- Rings with stones;
- Long nails;
- Nail varnish;
- Nail extensions;
- Long sleeves (by shortening sleeves or wearing sleeve protectors).

2.6 This applies to all staff wearing operational uniform and 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 suit or other Trust issue PPE. Sleeve protectors should be worn as appropriate in these situations.

3.2 Long sleeved jackets will easily become contaminated, impede access to wrist 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 wear/carry portable hand gel for use during domiciliary care.

3.4 Use the hand gel at the entrance to hospital departments and ask those with you to do the same. This will reduce the number of contaminates on your hands and sets the example for colleagues and relatives accompanying your patient.

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 procedures.

3.7 Gloves must not be worn whilst bringing a patient into the Emergency Department; the only permitted exceptions are:

- If the clinician is in contact with blood or body fluids;
- Time critical admissions.

3.8 Crews must be particularly mindful to remove gloves and perform effective hand hygiene prior to engaging with any hospital based equipment including patient monitoring equipment and handover screens/IT equipment.

3.9 Wash your hands before you leave a hospital department and when you have access to a hand wash basin.

3.10 Hand washing will remove any soiling; this 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 are described as the fundamental reference points for healthcare workers in a time-space framework that designates the moments when hand decontamination is required to effectively interrupt microbial transmission during care.

4.2 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.

4.3 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).

4.4 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 The Trust currently has three options for hand decontamination:

- Hand Washing;
- Alcohol Based Hand Rub;
- Hand Wipes (clinell universal sanitising 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 on return to station and in hospital departments. Hands should be washed as shown in the hand decontamination technique as shown below in the next section. If there is access to hand wash facilities these should be utilised when hands are visibly soiled.

5.3 Alcohol based hand rubs 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 The Alcohol based hand rub in use in the Trust is a rub with virucidal properties. This means that it has some effect against norovirus, however, alcohol hand rub is not recommended when there is an outbreak of norovirus, *Clostridium difficile* or other diarrhoeal illnesses- if hand washing facilities are unavailable use disinfectant wipes prior applying alcohol rub.

5.5 5 - 10 mls of alcohol based hand rubs should be applied to visibly clean hands and rubbed in as shown in the hand decontamination technique in Figure 3. Alcohol based hand rubs should be rubbed in until the solution has evaporated and the hands are dry.

5.6 The disinfectant wipes used within the Trust are also suitable for hand decontamination. When staff do not have ready access to hand washing facilities, they can be used to remove as much of the contamination as possible and always be followed by alcohol hand rub. They must also be used prior to alcohol hand rub in the situations detailed in para 5.4.
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 healthcare.
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;
- Water from the taps must not be situated directly above the plug hole;
- 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 committed to meeting the requirements of 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 (or hand drier in non-clinical areas);
- Foot operated, lidded domestic waste bin that is clean internally and externally and in good working order;
- Hand washing technique poster displayed clearly.

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 Any member of staff with excessive skin lesions should consult with occupational health.

7.4 Hands should be moisturised regularly after hand cleaning to reduce the risk of dry skin. 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.

8. References

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) 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;
- 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, and the risk of contamination of the healthcare practitioners clothing and/or skin by patients’ blood, body fluids, secretions and excretions.

3.2 Many clinical activities do not involve direct contact with body 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.
3.4 All vehicles used to respond to patients are required to carry a stock of PPE for use by staff, as detailed in the Standard Vehicle Equipment Policy. Infection Control Bags kept on vehicles must be sealed and the contents checked on a monthly basis or when any contents are used.

Contents list:
- 1 x Clinell Spill wipe;
- 3 x Surgical facemasks with visors;
- 3 x FFP3 facemasks;
- 2 x Infectious waste (orange) bags;
- 2 x Offensive waste (tiger) bags;
- 2 x Staff laundry bags;
- 1 x Red alginate bag;
- 2 x Absorbent gel sachets;
- 2 x Goggles;
- 4 x Aprons;
- 1 x Alcohol hand gel tottle;
- 3 x Sleeve protectors (pairs).

In addition the following items should be available on each operational vehicle:
- 4 x Overboots;
- 8 x Disposable protective suits kept separately in DCA (4 x Medium, 4 x Large);
- 4 x Disposable protective suits kept separately in RRV (2 x Medium, 2 x Large);
- The XL and XXL must be made available on station and 2 x kept by those individuals who require this size.

3.5 More information regarding disease specific precautions can be found in the A to Z of disease specific precautions.

3.6 The following body 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 Clinicians are required to use their judgment when determining the type and level of PPE required for each case, this is dependent on the anticipated risk of exposure to body fluids during particular activities. The guidance provided in Figures 4 and 5 will assist staff in using determining the level of PPE required.

4.2 *Figure 4 - 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>
4.3 Figure 5 - Risk Assessment Approach for Selecting PPE

Assess actual and potential risk of blood or body fluid exposure in task being undertaken

No blood/body fluid contact
- No PPE required
- Decontaminate hands before and after contact
- Dispose of used linen
- Decontaminate equipment between patients
- Dispose of waste appropriately
- Decontaminate hands after contact with patient surroundings, equipment, waste disposal, handling linen and at the end of every call

Potential exposure to blood/body fluid. High risk of splash
- Wear gloves
- Wear apron as above and if splash to clothing likely
- Wear mask/eye protection if appropriate
- Dispose of grossly soiled linen as infected i.e. red alginate bag then red plastic bag
- Dispose of soiled waste in clinical waste bags
- Decontaminate equipment with appropriate method
- Wash hands after contact and removal of gloves and other protective equipment

Exposure to blood/body fluid.
- Wear gloves
- Wear apron
- Wash hands before and after patient contact and on removal of gloves
- Use IPC kit bag
- Wear mask if appropriate
- Wear eye protection if appropriate
- Dispose of soiled linen as infected
- Dispose of soiled waste in clinical waste bags
- Decontaminate equipment appropriately
- Wash hands after contact and removal of gloves and other protective equipment

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 refer to the Health and Safety Team for further advice.
5.3 Non-Sterile, nitrile examination gloves must be worn for contact with skin that is not intact, mucous membranes, all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions and excretions and when handling sharp or contaminated instruments.

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

5.5 Gloves should not be worn unnecessarily; there should be a dynamic risk assessment of the task to be carried out before the decision is made to wear gloves.

5.6 Gloves should be put on immediately before an episode of patient treatment or contact with blood or body 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 for driving vehicles or pushing wheelchairs.

5.9 Gloves must be worn as single use items and disposed of as offensive waste. Heavily contaminated gloves or gloves that have been used with 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).

6. Disposable Apron/Suit

6.1 Disposable plastic aprons must be worn when close contact with the patient, materials or equipment are anticipated and when there is a risk that clothing may become contaminated with pathogenic microorganisms or blood, body fluids, secretions or excretions, with the exception of perspiration, or when cleaning the ambulance and equipment.

6.2 Disposable suits are not required routinely except where there is a risk of extensive splashing of blood, body fluids, secretions or excretions, with the exception of perspiration, onto the skin or clothing of healthcare personnel (for example when assisting with childbirth) or when dealing with infections caused by more hazardous organisms or chemical spills.

6.3 Disposable suits must be worn as single-use items, for one procedure or episode of patient care, and then discarded and disposed of as offensive clinical waste.

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 body fluids, particularly blood or tissue, into the eyes or face.

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 as offensive waste.

8. **Face Masks**

8.1 **Theatre Style Masks**

8.1.1 Masks offer protection against splashing of the mouth and face. Use of theatre style face masks and goggles/visor is recommended during procedures when there is likely to be splash of blood or tissue into the mouth, or if the patient is prone to episodes of coughing or sneezing, or during intubation of patients who are suspected to have meningococcal disease, and in cases of suspected pulmonary tuberculosis (TB).

8.1.2 Where patients have an uncontrolled productive cough (cannot cough into a tissue), consideration should be given to encouraging the patient to also wear a theatre style face mask.

8.1.3 Theatre style masks offer suitable protection for the majority of care delivered to patients suffering from Severe Acute Respiratory Syndrome (SARS) or Swine Flu.

8.2 **High efficiency FFP3 Masks**

8.2.1 High efficiency masks or respirators with filtering efficiency of the European Standard CEN FFP3 are recommended when caring for patients suspected to be suffering from severe respiratory infections (SARS, MERs), suspected Viral Haemorrhagic Fever (Ebola, Lassa Fever) or Swine Flu when you will be within 1m of the patient whilst aerosol producing procedures are being carried out.

8.2.2 Use of high efficiency masks requires specific training and fit testing under COSHH regulations. Individuals who have a beard or large moustache may not benefit from the full protection offered by these masks (or anything that interferes with the fit).

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 infectious 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 body fluids.

9.2 Sleeve protectors are single patient use and can be worn over the top of gloves. They must be disposed of as offensive waste.

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, i.e. when high visibility jackets cannot be removed. Arms can be washed or cleaned between patients, sleeves cannot.

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 masks, as shown in Figure 6.
Applying and Removing L1A PPE

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

1. Apron (or Gown)
   - Hand hygiene;
   - Pull over head and fasten at back of waist.

2. Mask
   - Secure ties or elastic bands at middle of head and neck;
   - Fit flexible band to nose bridge;
   - Fit snug to face and below chin;
   - If RPP3 Frischcheck respirator.

3. Eye Protection (Goggles/Face Shield)
   - Place over face and eyes and adjust to fit.

4. Gloves
   - Extend to cover wrist.

PPE must be removed in the following order: gloves, apron, eye protection, then mask as shown in the diagram below.

1. Gloves
   - Grasp the outside of the glove with the opposite gloved hand - peel off;
   - Hold the removed glove in the gloved hand;
   - Slide the fingers of the ungloved hand under the remaining glove at the wrist then peel the second glove off over the first glove;
   - Hand hygiene.

2. Apron (or Gown)
   - Unfasten or break ties at neck;
   - Fold down, pull apron away from neck and shoulders, touching inside only. Do not lift over head;
   - Brake ties behind back. Fold in or roll into a bundle;
   - Hand hygiene.

3. Eye Protection (Goggles/Face Shield)
   - Handle only by the headband or the sides;
   - Hand hygiene.

4. Mask
   - Unfasten the ties - first the bottom, then the top;
   - Pull away from the face;
   - Hand hygiene.

Please note: The hand hygiene instructions that are referenced above should be completed as shown in the picture to the left.
11. References

- HCAI and Cleanliness Division (2008) Reducing Infection through effective practice in the pre hospital environment Department of Health;
- Personal Protective Equipment at Work Regulations 1992 HMSO;
- MDA safety/Hazard notice MDA SN2001 Safe use and disposal of sharps;
- Protective clothing – Principles and Guidance. Infection Control Nurses Association 2002;
- A comprehensive glove choice – Infection Control Nurses Association 2002;
- HIV and other blood borne viruses – guidance for anaesthetists Association of Anaesthetists 1992;
- Health & Safety Executive, Control of Substance Hazardous to Health (COSHH) Regulations 2002.
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 infection control status and risks will enable suitable measures to be put in place to minimise the infection risks to both employees and patients. This is vital to ensure that any risks associated with the transmission of infection to the service user and others 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;
- 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 patient care record.

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 PTS Control**

3.1 When booking patients for transport PTS 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 (or patient) must be asked if the patient has any medical conditions that may cause a significant risk of cross infection to another person.

3.3 Infection control risks and status will be recorded on the work sheet to inform crews prior to transportation.

3.4 Patients that pose a significant infection control risk must be transported individually; this will need to be factored into the work plan for the shift.

4. Procedure for PTS Staff

4.1 Before accepting a 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.

4.2 If any information regarding a patient’s medical condition is communicated to the PTS crew this will need to be communicated to an appropriate person in the receiving department.

4.3 When collecting a patient from transportation, if the patient communicates any symptoms of diarrhoea and/or vomiting to the PTS crew this should be discussed with the nurse in charge and PTS control, this patient will be unable to travel with other patients.

4.4 If there is any query as to whether a patient requires single transportation this should be discussed with PTS control in the first instance. Additional advice may be sought via the Infection Prevention and Control Lead or the Senior Clinical Advisor.

4.5 If a patient has symptoms of diarrhoea and/or vomiting on route to the receiving destination, ideally, the crew should notify the receiving department on route so appropriate arrangements can be made. Where this is not possible, upon arriving at the destination one crew member should remain on the vehicle with the patient while the other notifies the receiving department. If neither of these options is practical then the crew must notify the receiving department upon arrival in the unit.

5. Urgent Care Service

5.1 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 if they arrive on scene before the departure of the UCS clinician.

5.2 If a patient is being admitted to a hospital the information will need to be communicated to the relevant department, this should be also be communicated through the Single Point of Access (SPoA) where available.
6. Notification of Hospital Departments

6.1 Communicable infectious diseases may give rise to an outbreak of infection amongst patient, visitors and healthcare staff.

6.2 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.

6.3 In order to ensure that this information is communicated in a timely fashion to Emergency Departments clinicians are encouraged to pre-alert hospital departments if they are transporting a patient with symptoms of diarrhoea and/or vomiting according to the guidance provided in Figure 7. Further guidance can be found in Clinical Guideline (CG10) Diarrhoea and Vomiting.

6.4 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.
6.5 Figure 7 - Diarrhoea and Vomiting Hospital Liaison Guidance

**Patient presents with sudden onset of diarrhoea and/or vomiting and their clinical condition requires conveyance to an acute facility?**

If yes, proceed with the following: If no, go to next page.

**Does the patient present with any of the following:**

- Unexpected onset of diarrhoea and/or vomiting? E.g. cannot be explained by other presenting conditions. Examples may include, but are not limited to - recent prescription of medication which may cause D&V, patient vomiting but appears under the influence of alcohol, overdose, recent bowel surgery, heart attack?
- Reported contact with someone with diarrhoea and/or vomiting within the previous 48 hours?
- Resides, works at or visits an institution with a known infectious outbreak?
- Taken antibiotics within the previous 14 days?
- Alternative method of feeding present e.g. PEG, naso-gastric tube?

**Is the patient vomiting or actively experiencing diarrhoea following arrival of ambulance clinician?**

If yes, proceed with the following: If no, go to next page.

**Does the patient’s clinical condition require them to be transported directly to an Emergency Department Resuscitation Room?**

- Yes
  - Transport patient directly to the ED resuscitation room.*
  - State ‘patient likely to require isolation’ during the hospital pre-alert
  - Enter department immediately on arrival at hospital.
- No
  - Transport patient to normal destination.
  - Place a hospital pre-alert specifically to state patient likely to require isolation’
  - On arrival attendant to remain with patient, whilst driver discusses case with senior nurse on duty before patient enters department.

**Transport patient to normal destination.**

- No specific pre-alert regarding infectious status required.
  - If patient’s clinical condition permits, attendant to remain with patient on arrival, whilst driver discusses case with senior nurse on duty before patient enters department.
- Yes
  - Transport patient to normal destination.
  - On arrival convey patient into department.
  - Discuss any issues regarding diarrhoea and/or vomiting with nurse during routine handover.

* May also include transport to catheter laboratory for primary angioplasty, or other condition specific bypasses.

Guidance must be applied to all patients presenting with diarrhoea and/or vomiting whose clinical condition makes conveyance necessary.
Procedure 6 - Safe Sharps Management and the Management of Inoculation Injuries

1. Purpose

1.1 This procedure is set out to provide a 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 (Safer needle network, 2012), 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, pinches, 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%. There are 40,000 injuries reported yearly in the UK, it is suspected that at least 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 the 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, sharps are less likely to injure the person using them, it will be much more likely for the sharps injury to occur to the make ready staff or the next crew to use the vehicle.

4.4 Other contributing factors include:

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

5. Preventing Sharps Injuries

5.1 The Trust are 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 and single use lancets (for blood glucose monitoring).

5.2 Clinical sharps must where possible be single use only and must be stored in their designated containers on the vehicles and in the appropriate bags when not in use.

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 clinician using the sharp to dispose of it safely.

6.3 Sharps bins must be compliant with UN 3291 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 8 - Sharp Bin Label Completion

6.8 The temporary closure mechanism should be in use when the sharps bin is not in use and the bin should be locked when 2/3rds 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 it isn’t 2/3"d full.

7. Safe Management of Sharps

7.1 All clinicians should attend appropriate training and refresher sessions and only use devices if they have been trained to do so. Needle safe devices should be used where available and if trained to do so.

7.2 Clinical sharps must be single use only and be stored in their designated cupboard on the vehicle or in the appropriate bags when not required.

7.3 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 clinicians should always dispose of their own sharps and never expect anyone else to dispose of them on their behalf.

7.4 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 commercial devices should be used for this purpose.

7.5 Needles and cannula 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.

7.6 All clinical staff should be extra vigilant during emergency procedures as there is an increase in risk of inoculation injury in this situation.

7.7 Clinicians should always ask for assistance when cannulating, giving injections or setting up fluid therapy if the patient is uncooperative, although the assisting clinician should never hold the sharps bin this must be placed on a stable surface.

7.8 All grades of 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.

7.9 It is important that employees do not underestimate the implications of sharps injuries. All inoculation injuries must be managed according to this policy.

8. Management of Inoculation Injuries

8.1 An inoculation injury is defined as:

- Inoculation of blood by a needle or other sharp;
- Contamination of broken skin with blood;
- Blood splashes to mucous membrane e.g. eyes or mouth;
- Swallowing a person’s blood e.g. after mouth-to-mouth resuscitation;
- Contamination where clothes have been soaked by blood;
- Body 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 the process detailed in Figure 9.

8.3 The first aid required following an inoculation injury is:

- Do not suck the wound;
- Wash the wound with warm running water and soap;
- Encourage bleeding gently;
- 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 Staff should then attend the nearest / receiving emergency department or minor injury unit where this is available and appropriate, to be risk assessed to ascertain if post exposure prophylaxis is required and to have blood samples taken.

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

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 08448 260308.

8.8 Occupational health will provide staff with the appropriate follow up.
ACTION TO BE TAKEN IN THE EVENT OF A CONTAMINATION INJURY TO SWAST EMPLOYEES

**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**

**NO**

**IMMEDIATE ACTION IS NEEDED.**

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

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 the helpline:

08448 260308
As soon as possible (Helpline is manned 9-5 Mon-Fri, if OOH leave message on answerphone)

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

**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

March 2016
9. References

- MDA safety/Hazard notice MDA SN2001 Safe use and disposal of sharps;
Procedure 7 - Management Clinical Waste

1. Purpose

1.1 The Trust has adopted 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 9 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. No other waste streams should be used within the organisation; information regarding the full range of options is included to ensure that staff are familiar with the options available at hospital facilities.

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 tiger 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 have no visible contamination can be disposed of as household waste into the black-bag waste stream.

2.4.2 Updated vehicle specification provides two bins, these should allow for a Tiger stripe waste stream and Domestic waste stream.
2.5 **Offensive (Yellow Bag with Black Stripe)**

2.5.1 The Trust has adopted the offensive waste category for use on all ambulance vehicles, as the standard route for disposing of the majority of items that would have traditionally been put into the infectious orange bag waste stream.

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 bag 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 a yellow and black 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.

2.7 **Figure 10 - Waste Segregation:**

[Image of waste segregation diagram]
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. 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 or is split or leaking;
- 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 receiving hospitals.

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

4.3 All clinical waste must be stored in a locked bin or approved storage container, to which the public have no access. Small ambulance clinical waste bags should be disposed of at any Emergency Department, or at any ambulance station.

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 an incident report 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 a tiger yellow/black bag may be placed within the infectious (orange) 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 Management Policy.

5.2  Controlled drugs must be managed in accordance with the Trusts Medicines Management Policy.
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 the majority of 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 split 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;
- Hi 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 tops and trousers to wear 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 wherever 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 removed.
3.3 Visibly soiled uniforms present an infection risk and can be disconcerting for patients; clean uniforms present a professional appearance.

3.4 Although best avoided, if you do wear your long sleeved jacket during clinical care please take all measures to avoid contamination, including the use of sleeve protectors and wash your jackets regularly.

3.5 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).

3.6 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.

3.7 In order to avoid overloading your machine, wash your uniforms separately to other clothing.

3.8 Uniforms should then 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. Uniforms are placed into the bag, which should then be sealed with the pink tape, thus eliminating any unnecessary handling of soiled garments. The uniform bag is 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 the domestic waste. These easy to follow instructions are printed onto each bag.

3.10 Do not use the pink/red hospital-style linen bags, these are not designed for use in a domestic washing machine and will not dissolve effectively, which may result in damage to the machine.

3.11 *Figure 11 - Laundry Bags*

3.12 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. The clothing bags are provided as an option for staff and are not obligatory.

3.13 If your uniform is heavily soiled with body fluid the most appropriate course of action would be to dispose of it as clinical waste.
4. Soiled Linen Management

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 12

<table>
<thead>
<tr>
<th></th>
<th>Used (soiled &amp; foul) linen</th>
<th>Infectious / Infested linen</th>
</tr>
</thead>
<tbody>
<tr>
<td>White plastic / linen sac</td>
<td>All used linen, irrespective of state, but on occasions contaminated with blood or body fluids</td>
<td></td>
</tr>
<tr>
<td>Red alginate bag within a red linen / plastic sac</td>
<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 for laundry service collection it should not be handled again.
5. Clean Linen

5.1 Clean linen should be stored in the linen cupboard on the vehicle and where available on stations in a closed cupboard.

5.2 If there is any risk of contamination from dust or damp, store clean linen in clear polythene bags and move cupboard away from direct exposure.

5.3 Local practices may include provision to exchange linen at the receiving hospital and in line with local arrangements on a one for one basis.

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

6. Patients 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.

7. References

- Further information regarding laundry practice (for commercial processes) HSG 95(18) Hospital laundry arrangements for used and infected linen NHS executive (1995);
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 and thus reduce the risk of cross infection the themselves, their colleagues and their patients.

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 microorganism – 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 13 apply to all PPE, mops and buckets in use within these areas.

3.2 Figure 13 - 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 All cleaning items, for example cloths (re-useable and disposable), mops, and buckets must be colour coded. In any event mops cloths and buckets must not be transferred between different areas.

3.4 Cleaning equipment must be stored clean and dry between uses. Single use cloths and mop heads should be in use. Mops, cloths and brushes must not be stored in disinfectant or cleaning solutions.
4. Cleaning- Using Detergent

4.1 Cleaning is a prerequisite of decontamination to ensure that effective disinfection or sterilisation can be carried out.

4.2 Cleaning with hot water and detergent will remove soil, organic material, microorganisms and bacterial spores.

4.3 After cleaning all surfaces they should be thoroughly dried with either disposable cloths or blue paper roll. If using disinfectant wipes, area should be left to air dry.

4.4 When cleaning by hand, a sink is needed which is deep enough to completely immerse items to be cleaned – precautions should be taken to prevent injury or splash. Scrubbing can generate aerosols which may convey infective agents, if scrubbing is required it must be carried out with the equipment and brush below the surface of the water and wear appropriate PPE.

5. Cleaning-Using Disinfectant

5.1 If required disinfection should only be carried out after a detergent clean.

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

5.3 Disinfection processes can inactivate blood borne viruses but do not destroy bacterial spores e.g. tetanus. 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.

5.4 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 detergent.</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. Defibrillators</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>
5.7 Special Precautions when Cleaning-Using Chlor Clean

5.7.1 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 and correctly prepared give an accurate strength.

5.7.2 Once Chlor-Clean has been made up it will start to lose its strength, therefore all solutions must be discarded after 24 hours. A fresh batch of disinfectant should be made at the commencement of each shift and any unused solution disposed of. Further guidance is provided in Figure 11.

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

5.7.4 Appropriate precautions should be taken in line with the relevant COSHH 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 Lead 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.
5.7.5  Figure 14 - 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

Further information is available within the Infection and Control Policy

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

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

6.2 Sterile instruments can be obtained by:

- Purchasing pre-sterilised single use items. These avoid the need for re-sterilisation and are a practical and safe method. They must be stored using a stock rotation system in accordance with manufacturer’s recommendations;
- Using a sterile supplies department (SSD). Sterilisation can only be undertaken by specialist Sterile Supplies services. There needs to be a specific contract specifying the responsibilities of both parties.

6.3 Sterilised equipment should be kept in their wrapping until the moment of use. Excessive handling should be avoided before application. If the outer wrapping is damaged, do not use; as the sterility will be compromised.

7. Blood and Body Fluid Spillage

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

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

7.3 In general, the volumes of most blood or body fluid spills that occur are not excessive, e.g. blood smeared on a sharps box. They can be managed by wiping with a disinfectant wipe.

7.4 Clinel 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 consist of chlorine tablets and granules, diluters and scoopers.

7.5 It consists of a super absorbent pad, measuring 40x40cm, containing a special 2 layered non-woven covered with a plastic backing. This pad will absorb up to a litre of fluid and once absorbed the fluid will trigger an oxidative reaction within the pad itself which will neutralise all the pathogens within the spill. It also comes with two individually wrapped disinfectant wipes to complete the clean and allow any staining from the original spill to be removed.

7.6 The following method should be used to clean a body fluid spillage:

- In the treatment centre/office environment 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 completed absorbed;
- Place wipe back in original wrapper bag;
- Use the disinfectant wipe in the packet to further clean the area, using an S
shaped motion to entirely cover the surface;
- Dispose of wipes in appropriate 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;

8 Ambulance Station/Environmental Cleaning

8.1 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 contracted external cleaning contractors to provide station cleaning.

8.2 A written cleaning schedule must be developed and available for inspection for all premises. Template schedules for premises are available on the infection prevention and control intranet page. The schedule must specify the persons responsible for cleaning, the frequency of cleaning, methods to be used and expected outcomes. An annual deep clean will be considered for all sites, where required.

8.3 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.

8.4 Keep mops and buckets clean, dry and stored appropriately. Mop heads should be single use and not stored attached to mop handles.

8.5 Provide single use, non-shredding cloth or paper roll for cleaning.

8.6 Keep equipment and materials used for general cleaning separate from those used for cleaning up bodily fluids.

8.7 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.

8.8 Use general purpose detergent for all environmental cleaning (following the manufacturers’ instructions) even when subsequent disinfection is required.

8.9 When replacing paper hand towels, these must be put into the holder, and not placed on top. Paper towel and liquid soap dispensers of the cartridge type must be cleaned regularly.

8.10 Vacuum cleaner bags and filters must be changed as necessary and the brush cleaned of hair and fluff before storage.

8.11 Crockery and cutlery should be washed immediately after use in hot water and general-purpose detergent. Wherever possible, leave to air-dry or, if necessary, dry with disposable heavy-duty paper towel. Kitchens and hand washing areas should not have tea towels or reusable towels. Single use paper towels should be
8.12 It is usually sufficient to clean floors by removing dust with a properly maintained filtered vacuum cleaner. They can then be cleaned by washing with hot water and general purpose detergent, using mops or suitable scrubbing machine.

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

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

8.15 Refrigerators should be defrosted and cleaned regularly in accordance with manufacturer's instructions. Should a spillage occur or food become stale, the whole interior of the fridge should be cleaned with hot water and general purpose detergent and dried thoroughly.

8.16 Anti-slip shower mats must be washed with hot water and general-purpose detergent and hung in a clean dry place when not in use. (Cork type shower mats are not to be used).

8.17 Shower rooms and hand basins must be cleaned regularly with a cream cleanser, using a piece of disposable cloth which can be discarded of into a black waste sack.

8.18 Toilets should be cleaned with a toilet brush, using a toilet de-scaling liquid. Toilet brushes should be cleaned by flushing the cistern and rotating the brush as the clean water comes through; tap on the edge of the toilet to remove excess water, air-dry and store dry in brush holder.

8.19 Waste bins must be cleaned at least weekly inside and outside with hot water and general purpose detergent.

8.20 Sack holders should also be cleaned regularly as above.

9. Vehicle Cleaning

9.1 Cleaning schedules for each vehicle type are available on the infection prevention and control intranet page, and must be applied for all cleaning. The schedule must specify the persons' responsible for cleaning, the frequency of cleaning, methods to be used and expected outcomes. All vehicle deep cleans must be recorded in the Vehicle Log Book.

9.2 It is important to maintain high standards of hygiene within the ambulance 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.
9.3 All staff have an individual responsibility to keep the ambulance 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 individual clinicians must maintain vehicles in a state of readiness, it is appreciated that on occasion’s excessive exposure to body fluids or other infection risks require that the vehicle receive an immediate deep clean and that the vehicle is removed from operational use until such time as that deep clean has been completed. The process which must be followed on such occasions is shown below is detailed in the Emergency Deep Clean SOP. This can be found on the IPC page along with the Emergency deep clean request form. [http://intranet.swast.nhs.uk/station-and-vehicle-cleaning.htm](http://intranet.swast.nhs.uk/station-and-vehicle-cleaning.htm)

9.4 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 attend to vehicle and equipment cleaning 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 saloon 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 required to transport the patient. This type of incident should occur extremely infrequently, and must be reported through the incident reporting system.

9.5 An incident report must be completed for all vehicles that are found not to be in a satisfactory condition. The vehicle must then be cleaned, or removed from service until a clean can be conducted.

9.6 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.
9.7 **Figure 15 - Unsatisfactory Vehicle Procedure**

Trust vehicle associated Infection control incident reported via DATIX

- **Vehicle number and date identified on DATIX**
  - Station and crew identified and Service Delivery Manager contacted
  - Service Delivery Manager to discuss with clinicians why the vehicle was left in unsafe manner
  - Outcome of discussion to be recorded in investigation section of DATIX and update e-mailed to infection control for review.
  - If further incidents occur with same clinician
    - Practice issues to be discussed with clinician – further support from Infection Prevention and Control Lead if required
  - If further incidents occur with same vehicle
    - Vehicle to be reviewed by Infection Prevention and Control Lead or appointed manager

- **Vehicle number and date NOT identified on DATIX**
  - Request made to reporter for more information
  - Vehicle number and date identified on DATIX
  - No further information available
  - Request for information to be documented on all further incidents reported
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 The use of PPE should also be considered whenever it is deemed necessary. This would ordinarily include eye protection and disposable aprons, particularly when using manually operated vehicle wash systems. Hand protection is important and rubber household gloves, or heavy-duty gloves should be worn.

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 cleaning should pay particular attention to any areas where dirt is likely to be transferred to the crew’s hands e.g. door handles.

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 body 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 yellow clinical waste bag.

11. Vehicle Interior Cleaning After Each Patient Journey

11.1 Vehicle and equipment cleaning must take place after each patient episode. It is standard practice to use detergent wipes in order to clean all surfaces that may have been contaminated, including stretcher handles, any equipment used and clinical surfaces. This need only take a few minutes.

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

11.3 Where an ambulance has become contaminated with blood or body fluid, 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 products carried by on all vehicles. Cleaning at an ambulance station should only be required for larger spills or gross contamination with body fluids.

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 saloon surfaces with detergent wipes;
- Brush any floor debris from the vehicle salon;
- Mop the floor with Chlor-clean;
- Note clean in vehicle log book.
12.2 At the end of each shift, the following procedure must be followed:

- Remove all personal bags and items;
- Remove waste bags;
- Check that all saloon surfaces are clean - if not clean with detergent wipes;
- Check for discarded sharps on the floor;
- Brush any floor debris from the vehicle salon;
- Mop the floor with Chlor-clean;
- Note clean in vehicle log book.

12.3 If it is not possible to complete the procedure detailed in Para 12.2 at the commencement of a shift, the remaining elements must be completed at the earliest opportunity. Vehicle should not complete a shift without the full procedure being applied.

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 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 aircraft should follow the protocols adopted throughout this guidance for the cleaning of road ambulances. 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. Spillage kits used on any aircraft should not contain any bleach solution as this could damage metals / wiring.

14.3 For routine cleaning general purpose detergents and hot water, or detergent wipes should be acceptable. For disinfection, an approved alcohol wipe or spray should be used following cleaning.

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 manufacturer:

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

15.3 The Consumer Protection Act 1987 will hold a person liable if a single use item is re-used against the manufacturer’s recommendations.
15.4 Any equipment supplied within sealed packaging designed to keep the item sterile or clean must remained stored within the packaging. Items must not be removed from packaging for storage in response bags etc.

15.5 Re-useable equipment, including vehicles, should be appropriately decontaminated between each patient using a risk assessment model detailed in Table 2.

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

15.7 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.

15.7 Table 2 - Risk Assessment for Decontamination of Equipment

<table>
<thead>
<tr>
<th>RISK</th>
<th>APPLICATION OF ITEM</th>
<th>MINIMUM STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINIMAL</td>
<td>Items / surfaces not in contact with the patient e.g. floors, walls</td>
<td>Clean and dry</td>
</tr>
<tr>
<td>LOW</td>
<td>Items / surfaces that come into contact with healthy skin e.g. mattresses, rails,</td>
<td>Clean and dry <strong>but</strong>, if contaminated with blood,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>body fluids or suspected transmissible organisms -</td>
</tr>
<tr>
<td></td>
<td></td>
<td>disinfect</td>
</tr>
<tr>
<td>MEDIUM</td>
<td>In contact with intact mucous membranes, or if contaminated with virulent or readily transmissible organisms e.g. respiratory equipment, earpieces, thermometers</td>
<td>Disinfect or single use</td>
</tr>
<tr>
<td>HIGH</td>
<td>In contact with a break in the skin or mucous membrane, or for introduction into normally sterile body areas e.g. forceps, cannula, dressings</td>
<td>Sterilise or single use</td>
</tr>
</tbody>
</table>

16 Cleaning of Vehicles and Equipment Prior to Inspection, Service or Repair

16.1 Equipment requiring repair or servicing must be cleaned of all organic material, by the last ambulance clinician to use the vehicle, before it is sent away.

16.2 A decontamination certificate must be attached to the equipment on dispatch, which states the method of decontamination used, or the reason why it was not possible. [http://intranet.swast.nhs.uk/Downloads/SWASFT%20downloads/Logistics/CertificateOfDecontamination.pdf](http://intranet.swast.nhs.uk/Downloads/SWASFT%20downloads/Logistics/CertificateOfDecontamination.pdf)

16.3 All reusable medical devices must be decontaminated in accordance with manufacturer’s instructions as well as legislative and best practice requirements.
16.4 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.

16.5 All clinical waste should be removed and the sharps box must either be removed or placed in the closed position. The interior and equipment must be checked for sharps and contamination, and cleaned if necessary. **This is the crew’s responsibility.**

16.6 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.

17 Reference

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, 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 the 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.

3.1 Principles of Aseptic Non-touch Technique

3.2 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 each employee to understand these principles and incorporate them into everyday practice.

3.3 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.

3.4 If aseptic non touch technique cannot be applied, because of the nature of the emergency or environmental factors for example, this must be handed over to the staff at the receiving hospital and clearly documented on the patient care record.

3.5 The indications for using aseptic non touch technique are:

- Routine insertion of intravenous cannula;
- Urinary catheterisation;
- Wounds healing by primary intention (before the skin has healed) e.g. traumatic or surgical wounds including suturing or gluing;
- Trauma wounds;
- Any other invasive medical procedure.
4.1 Intravenous Cannulation

4.2 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 bloodstream.

4.3 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.

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

4.5 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 into the circulation.

4.6 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 clinician 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 Patient Care Record.
4.7 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 PCR and handed over to the receiving hospital staff.

4.8 Always ensure that giving sets and syringes and handled aseptically. For certain procedures, such as when titration of medication is required a sterile field should be retained to hold the syringes between doses. Syringes should not be stored in pockets or on the patients 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 19.7% of all hospital acquired infections, with 60% of these infections attributed to the presence and length of duration of an indwelling catheter.

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

5.3 Urinary catheter insertion and care must be undertaken 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. Where this is not possible a detergent wipe must be used prior to using alcohol based hand rub. Hands must be cleaned before putting gloves on and after removing them.

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 3-5 mls 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 (detailed in 3.1) 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 detergent wipe must be used prior to using alcohol based hand rub. Hands must be cleaned before putting gloves on and after removing them.

6.4 Hand hygiene must be performed following wound care.

7. References

- Royal college of nursing IV Therapy Forum Standards for infusion therapy. July 2003;
Procedure 11 - Facilitated Stand-by Points/Spoke Stations

1. Purpose

1.1 This procedure is set out to provide the requirements for minimising the risk of cross infection by ensuring appropriate management of facilitated stand by points and spoke stations.

2. Definitions

2.1 For the purpose of this procedure a spoke station is a fully facilitated stand by point where crews start and finish their shift.

2.2 Facilitated stand by points are those areas which provide crews with:

- Comfortable seating that can be wiped clean and is free from tears and stains;
- Television (where practicable);
- The provision of hot drinks;
- Toilet access;
- A place away from the public gaze;
- Ability to make cold drinks.

2.3 A fully facilitated standby point is defined as a facilitated stand by point which also provides crews with:

- Cooking facility (microwave and oven/grill);
- Dining tables and chairs;
- Cutlery/crockery/utensil and the ability to wash these;
- Refrigerator;
- Access to e-mail and internet;
- Landline facility.

3. Vehicle Cleaning

3.1 It is essential that vehicles are maintained and that a clean and safe working environment is provided, vehicle cleaning schedules are provided on the Trust Intranet covering both standard and deep cleans.

3.2 If the spoke station or facilitated stand by point has dedicated facilities for cleaning, such as a sluice facility or a dedicated area in a cleaning cupboard for the disposal of used water, simple vehicles cleans may be undertaken on site.

3.3 A simple mop out and surface wipe may be undertaken at the site if cleaning facilities are available. If facilities are not available then all surfaces must be wiped with disinfectant cloths and the vehicle mopped out during a visit to an ambulance station or acute Trust site.

3.4 All deep cleans must be undertaken at the nearest ambulance station where Make Ready operatives are available, or Make Ready site.

3.5 Any contamination with blood or bodily fluids must be cleaned either at an acute hospital site or at the nearest ambulance station.
3.6 Spill wipes must be available on all vehicles.

3.7 All used water must be disposed of down dedicated facilities in a sluice area or down a drain and not hand wash basins or kitchen sinks.

4. **Waste Disposal**

4.1 Facilitated stand by points and spoke stations only have a domestic waste stream available on site.

4.2 All offensive and infectious waste must be disposed of at an acute site or ambulance station in appropriate waste stream.

4.3 Mop heads and any cloths used for cleaning at the facilitated stand by point or spoke station can be disposed of as domestic waste, as they should not have been contaminated with blood or body fluids.

4.4 Sharps bins must not be left on a spoke station or facilitated stand by point, they must remain on the vehicle until they can be disposed of at the nearest ambulance station with appropriate sharps disposal process in place.

5. **Stores - Equipment and Consumables**

5.1 If there is room for the storage of consumables these must be stored in a dedicated facility (cupboard or room) which is lockable, doors must be shut at all times.

5.2 Stock levels must be kept to a minimum and a stock list should be drawn up with the Operational Locality Manager for each spoke station or facilitated stand by point with storage facilities to manage this appropriately.

5.3 Stores must be kept in the cupboard and not be stored on the floor in these areas – excess stock should be removed from the station as soon as feasibly possible.

5.4 Vehicles may be stocked from the spoke station or stand by point but any used medical equipment must be disposed of in an appropriate manner.

5.5 Storage areas should be cleaned on a regular basis to ensure stock does not become contaminated.

6. **Race Meeting Days at Cheltenham Racecourse**

6.1 All teams are to be based at an alternative location during race meetings.

6.2 Following meetings a deep clean is to be carried out by the cleaning company contracted by the racecourse management.

6.3 Any non-compliance with infection prevention and control standards should be followed up with an incident form and, where possible, supported with photographic evidence.
Procedure 12 - Transporting Patients from Closed Wards

1. Purpose

1.1 This procedure is set out to provide ambulance clinicians with best practice guidelines when moving patients from a ward closed due to infection 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/client, especially those with diarrhoea or vomiting, should be avoided unless for essential medical or psychological intervention. 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 to the patient and others from infection may be minimised.

2.2 The infection status of patients is defined as either no risk, suspected risk or confirmed risk. For example, a confirmed risk patient/client has been confirmed as being colonised with Methicillin-resistant Staphylococcus aureus (MRSA).

2.3 A suspected risk patient/client is 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 Control Teams to ensure that the risks of cross infection are assessed and minimised prior to planning suspected or confirmed infectious patients’ discharge or inter-healthcare Transfer.
- Informing the Infection Control Team at the receiving facility of any infectious conditions (during working hours) 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 clinicians with a full verbal handover, and a completed Transfer Form (according to local policy).

2.5 The Trust is responsible for:

- Ensuring Clinical Hub staff inform the attending ambulance clinicians of the patient’s infection control status (where this is known).
- Following infection and control guidance to minimise the spread of infection.
- Informing the receiving staff of any confirmed or suspected risk patient during the clinical handover.
- Safely conveying patient notes and the Transfer Form (where provided).
2.6 In many cases the patient's infection status will not be known; staff must follow standard precautions for all patients. Further guidance on transporting patients with MRSA, C. Diff, ESBL and Norovirus can be found in the Frequently Asked Question sheets on the Infection Prevention and Control intranet page.

3. Definitions

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

4. Outbreaks

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

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

5. Transportation of Patients

5.1 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.

5.2 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.

5.3 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.

5.4 A patient with diarrhoea and/or vomiting who are going to their own home should not travel on emergency ambulance transport. If they are experiencing symptoms of diarrhoea and/or vomiting they may travel on non-emergency Patient Transport Service (PTS) ambulance but should not travel with other patients.

6. Cleaning Vehicles

6.1 If your vehicle is soiled by vomit or faeces from a patient suspected to have norovirus or clostridium difficile the vehicle should be taken off the road so that the crew can clean the vehicle thoroughly before sending it off for a deep clean.

6.2 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: http://intranet.swast.nhs.uk/station-and-vehicle-cleaning.htm

6.3 If there is no soiling by vomit or faeces normal between patient cleaning applies.
7. References

Procedure 13 - 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 the vulnerable 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

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

2.2 For the purpose of this procedure occupational health will be referred to as OH

2.3 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.

2.4 Blood borne viruses will be referred to as BBVs and includes Hepatitis B, Hepatitis C and Human Immuno-deficiency Virus (HIV).

3. Pre-Employment Checks

3.1 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 health care and laboratory staff.

3.2 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

4.1 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.

4.2 New staff or 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 when required.
4.5 If employees are diagnosed with a BBV, they have a duty to inform the Trust and will be referred to OH (via HR). 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 when required.

4.6 If a member of staff is identified as having a BBV the Trust will undertake a review of all patients the staff member has provided care for since their last negative test for BBV. This will be dependent on the results of their baseline blood test, if the baseline blood test is negative for BBV the review will go from the date of the needlestick injury until the date of positive test. If the baseline bloods indicate that the infection was present prior to the needlestick injury this review will go to the last negative BBV result, or commencement of Trust employment if no testing has been carried out, this will be dependent on level of risk and further advice will be sought from UK Advisory Panel on Health Care Workers Infected with Blood Borne Viruses (UKAP) if required.

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

4.8 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 undertaken 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
- Wash the injury (with soap) under running water
- Dress the injury
- Report it to the Duty Officer
- 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 at the most appropriate hospital emergency department to consider the need for PEP.

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 undertaken 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 undertaken 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 body fluids 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 All 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) 1995
7. Staff Support Following Contamination Injury

7.1 The local Operational Commander 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 Six of the Infection Prevention Control Policy.

7.3 During the next working day the appropriate Operational Manager/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.

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:

- 24hr Needle stick Line: 08448260308;
- Occupational Health Tel: 0844826306;
- IPC Lead Fataha Sultan-Petty: 07788565457;
- fataha.sultan-petty@swast.nhs.uk;

8. References

• Department of Health (2002) *Hepatitis C Infected Health Care Worker*
  London: DoH;
Procedure 14 - 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 Policy and Clinical Guideline 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.
Procedure 15 - Major Outbreaks and Public Health England

1. Purpose

1.1 The Local and Regional Services Division of 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 gastrointestinal illness.

2. Food Transportation

2.1 Food is not to be transported in the saloon of an ambulance vehicle and must 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;
- Sealable;
- Washable;
- Leak proof;
- Undamaged.

2.4 Ice blocks 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.

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 hygiene procedures must be undertaken 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.
**Appendix A - Strategic Cleaning Plan**

1 **Introduction**

1.1 The NHS Plan (DH, 2000) identified a need to develop national cleaning standards that would be applicable to all NHS Trusts. It made it a core objective for each Trust to nominate a Board member to take personal responsibility for monitoring hospital cleanliness and that they would report to the board on cleanliness matters.


2 **Accountability**

2.1 Section 5 of this policy/strategy details the responsibility of the Chief Executive, Board, Management team and front line staff with regard to the Cleaning Strategy and Cleaning Operational Policy. The Executive Director of Nursing and Governance in their capacity as the Trusts Director of Infection Prevention and Control is the nominated Board lead for cleaning.

3 **Governance and Risk**

3.1 The governance arrangements for cleaning, infection prevention and control are detailed within section 6 of the Guidance and Procedures for Infection Prevention and Control. The Strategic Cleaning Plan supported by the Operational Cleaning Plan will assist compliance with the Health and Social Care Act (2008), demonstrate due diligence and promote consistent high standards of cleanliness. Cleaning related risks are identified within the Infection Prevention and Control Risk Assessment.

3.2 In line with the revised national specifications for cleanliness, functional areas within the Trust have been grouped into four levels of cleaning intensity based on the risks associated with inadequate cleaning in that functional area; very high, high, significant and low, as detailed in Table 1.
### 3.3 Table 3 - Cleaning Intensity Levels:

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High</td>
<td>Consistently high levels of cleanliness must be maintained. Very high risk areas may include Ambulance vehicles, sterile storage areas.</td>
</tr>
<tr>
<td>High</td>
<td>Outcomes should be maintained by regular and frequent cleaning with „spot“ cleaning in between. High risk areas may include sluice areas, toilets, and kitchens.</td>
</tr>
<tr>
<td>Significant</td>
<td>In these areas high levels of cleanliness are required for both hygiene and aesthetic reasons. Outcomes should be maintained by regular and frequent cleaning with „spot“ cleaning in between. Significant risk areas may include rest rooms, locker rooms offices used by first responders.</td>
</tr>
<tr>
<td>Low</td>
<td>In these areas high levels of cleanliness are required for aesthetic and to a lesser extent hygiene reasons. Outcomes should be maintained by regular and frequent cleaning with „spot“ cleaning in between. Low risk areas may include administrative areas, non-sterile supply areas, record storage and archives.</td>
</tr>
</tbody>
</table>

### 3.4 The clarity of cleanliness standards is of paramount importance. It is essential that the staff have a clear understanding of the standards and task requirements to ensure they are working towards and assessing the same cleanliness outcomes. All cleaning must be part of an agreed cleaning schedule, and carried out according to guidance within this Policy. It is a requirement that all domestic cleaners either employed or contracted by the Trust must also comply with guidance within the NHS Cleaning Manual.

### 4. Process and Delivery

#### 4.1 The delivery of agreed standard based on the National specifications for cleanliness in the NHS: A framework for setting and measuring performance outcomes in ambulance trusts will be supported by the following arrangements:

5 Performance Monitoring

5.1 The implementation of the Strategic Cleaning Plan will be monitored by the Infection Prevention and Control Group through the assurance provided by the short station review and ad-hoc audits and inspections. The group will monitor implementation of the Annual Infection Prevention and Control Program (including cleaning) and the continual achievement of standards within premises and vehicles. The Committee incorporates the role of the Patient Environment Action Group (PEAG) and national standards of cleanliness group recommended by the National Specification for Cleanliness. The Board receive a monthly update.

6 Operational Cleaning Plan

6.1 In order to meet the National Specification for Cleanliness cleaning schedules stating the frequency, method, standard and responsibility have been developed. Trust wide schedules have been adopted for the cleaning of emergency ambulances, PTS ambulances and rapid response vehicles. Generic schedules have been created for premises with an appointed domestic cleaner and for those without. The generic schedules should be adapted by the line manager to meet local circumstances. All premises must display an agreed cleaning schedule.

6.2 For the purposes of the National Specifications for Cleanliness, the Infection Prevention and Control Strategy, policy, guidance and procedures for managing healthcare associated infections and control of serious communicable diseases and associated cleaning schedules, are considered to be the Trusts Operational Cleaning Plan. The document also fulfils the requirements of the National Specifications for Cleanliness eight key objectives.

7 Resources

7.1 Many factors affect the investment needs of a particular area, including age, levels of maintenance, and purpose. Sufficient resources should be allocated for cleaning and investment must recognise this. The Trust Board must also acknowledge that adequate investment is required for additional cleaning if there is an outbreak of infection or contamination. The Executive Medical Director will ensure that business cases for the development of cleaning services are developed and submitted as required.

8 Review

8.1 The Infection Prevention and Control Lead will ensure that the strategic cleaning plan is maintained at all times, reflects the current service requirements and takes into account pending codes of practice or legislation requirements that effect cleaning services.
## Appendix B - Version Control Sheet

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Author</th>
<th>Summary of Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Draft</td>
<td>27/02/13</td>
<td>Clinical Development Manager East</td>
<td>New Policy</td>
</tr>
<tr>
<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>
</tr>
<tr>
<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>
</tr>
<tr>
<td>4</td>
<td>18/05/16</td>
<td>Infection Prevention Control Lead</td>
<td>Complete revision.</td>
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