NHS
South Yorkshire
Integrated Care Board

INFECTION PREVENTION & CONTROL PRIMARY CARE GENERAL PRACTICE POLICIES AND SAFE PRACTICE GUIDANCE

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Name of originator / author:	**Christine Fisher**
Name of responsible committee/ individual:	**Quality & Patient Safety Committee**
Name of executive lead:	**Cathy Winfield: Executive Chief Nurse, South Yorkshire ICB**
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1. INFECTION PREVENTION AND CONTROL PRIMARY CARE GENERAL PRACTICE POLICIES AND SAFE PRACTICE GUIDANCE

1.1. Introduction

The Health and Social Care Act 2008: code of practice on the prevention and control of infections was updated in 2022, to reflect the changes in legislation. The Health and Social Care Act 2022 find good infection prevention and control (IPC), including cleanliness and prudent antimicrobial stewardship (AMS), is essential to ensure that people who use health and social care services receive safe and effective care.

Effective prevention of infection must be part of everyday practice and be applied consistently by everyone. It is also a component of good antimicrobial stewardship, as preventing infections helps to reduce the need for antimicrobials. Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are established and maintained.

1.2. Purpose

The purpose of IPC is to limit the acquisition and spread of pathogenic micro-organisms, by using scientifically based knowledge and through planning, surveillance, education and research as part of the overall policy of achieving high quality health and social care services.

It is the responsibility of the GP Practice to encourage every member of staff to participate in preventing and controlling infections and to comply with Health and Safety, COSHH and other legislation and regulations applying to the safe provision of health and social care.

This policy and guidance apply to all members of staff employed in the practice and includes agency, locum and bank workers as well as volunteers.

All adjustments to infection prevention and control arrangements and policy must be approved and assessed by the IPC lead.

1.3. The risks of not having this policy in place

Failure to comply with this policy may result in the following risks arising:

- The SYICB may not achieve its statutory obligations.
- The ICB may be unable to demonstrate that safe and effective Infection Prevention and Control Standards are in place wherever the ICB commissions.
- Risk of cross infection or contamination due to lack of clarity around measures staff should take to minimise the risk of infection to themselves and their clients.

1.4. Definitions

Included under section 5 is a list and description of the meaning of the terms used in the context of the policy, procedures and guidance.

1.5. Principles

Infection prevention and control has a key role to play in the clinical governance framework of any health and care organisation. This comprehensive range of guidance documents have been developed to help with CQC requirements and to achieve compliance with the Health and Social Care Act 2008: Code of Practice on the prevention

and control of infections and related guidance.

1.6. Roles and responsibilities

Chief Nurse, SYICB – Lead Officer
Assistant Director IPC – Operational For review in new contract.

1.7. Procedures

Training

Infection prevention and control training is a mandatory requirement at induction for all staff groups and as part of mandatory updates for all staff involved in service users' care. Training attendance records must be maintained and reported through internal governance frameworks. All training delivered should be evaluated by delegates.

All IPC leads, or nominated persons are invited to attend the IPC Champion forum. These meeting presently are running quarterly via Microsoft teams/face to face. All care homes and GP practices are contacted with dates of the meetings, alternatively please contact IPCT to be invited to the forums.

Governance

Infection prevention and control has a key role to play in the clinical governance framework of any health and care organisation.

The following activities should be considered an essential element of local IPC activity:

- Development of annual IPC programme and annual statement
- the implementation and monitoring of policies
- the education of all staff
- surveillance and reporting of occurrences of infection

Practices are required to have a nominated Infection Prevention & Control Lead who will outline activities required to be undertaken to provide assurance under the Code of Practice.

The IPC lead may be the registered manager. If someone else takes this lead role they should report directly to the registered manager in this regard and produce an annual statement outlining the IPC arrangements and activities including policy compliance information.

Specialist advice on IPC should be available to all staff. This may be through the infection prevention and control team (IPCT) or other providers of expertise e.g. United Kingdom Health Security Agency (UKHSA).

Information sharing

The Code of Practice requires primary care medical practices to share information on IPC activities and outcomes with patients. Involvement of patient liaison groups is recommended.

Practices are also required to share patient information as appropriate with other health and care providers having due regard to patient confidentiality requirements.

Uniform and Dress code

The GP Practice should ensure that staff clothing should be such that it minimises risks of the transmission of infection. It is a requirement of the Code of Practice that all organisations have a written uniform and dress code policy. Compliance with this policy should form part of the annual audit programme.

In particular clothing must facilitate good hand hygiene practice. Staff must adhere to Bare Below the Elbow (BBE). Stoned rings and wrist jewellery should not be worn when performing clinical tasks. Nails should be short and nail polish and nail extensions should not be worn. Long sleeves, if worn, should be rolled to the elbow for hand washing and clinical tasks.

1.8. Monitoring the compliance and effectiveness of this policy

The Lead Officer is responsible for ensuring the compliance and effectiveness of the policy.

Contract monitoring is undertaken quarterly.

A rolling audit programme is prepared annually by the IPC team with clear timescales for completion and progress and is monitored through governance frameworks

The Infection Prevention Society audit tool in an electronic format is used by the community IPC team to audit GP practices and care homes.

The process for reviewing results and ensuring improvements is undertaken by the SYICB and BMBC.

The monitoring of key performance indicators is undertaken by Contract monitoring.

Surveillance and data collection are a requirement of the Code of Practice but a specific policy on this is not required in primary care. However, it is recommended that a local system for monitoring infections is implemented. In particular post procedure surgical site surveillance is strongly recommended where minor operative procedures are undertaken.

Mandatory reporting of infections to UKHSA is a requirement for MRSA bacteraemia, *Clostridioides difficile* toxin, MSSA bacteraemia and Gram-negative bacteraemia. Annual trajectories are set by the Department of Health to reduce the number of cases of the organisms above.

All NHS Trusts and also (since 2011/12) for all Primary Care Organisations and for SYICB.breaching trajectories carries financial penalties for the organisations concerned. Providers of primary health care services may be involved in the review of individual cases of these infections as part of the mandatory processes expected to be undertaken. Reviews are the responsibility of the acute Trust or SYICB (depending on timing of positive specimen) and GPs / Practice Managers responsible for individual patients' will be informed if their participation is required on a case by case basis.

Monitoring of mandatory reporting for key infections is routinely undertaken by local commissioners of health care.

1.9. Reference

The references in relation to this policy will be reviewed three yearly in line with the policy or if there are substantial changes in guidance, or regulations.

1.10. Review of policy

The review will be three years from the date of approval of this policy.

Individual processes and guidelines will be updated as required, in response to new evidence, expert guidance or regulation.

2. POLICIES

2.1. Notifiable diseases

Notifiable diseases

Some infectious diseases may spread easily in a community or may cause serious diseases in individuals. The requirement to notify some infectious diseases is contained within the Public Health (Control of Disease) Act 1984, amended 2020. Additional guidance and the list of notifiable diseases are contained in the Health Protection Legislation (England) Guidance 2024.

It is the responsibility of Registered Medical Practitioners (RMPs) to notify any suspected or confirmed instance of notifiable disease to the local authority and / or local health protection teams (local arrangements will vary).

Additionally, RMPs are required to notify instances of infection which, in the view of the clinician presents, or could present, significant risk to human health and this should include new or emerging infections.

Notifiable diseases and causative organisms and how to report can be found on:

https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

Notification of clusters of infection

Although not notifiable; clusters of infection (even single cases) can have significant public health implications. Such infections should be reported to the local Health Protection team or proper officer (local authority) promptly.

List of notifiable organisms (causative agents)

Causative agents notifiable to UKHSA under the Health Protection (Notification) Regulations 2010: can be found at https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

This is also available in a poster format ,UKHSA Notifiable diseases poster

2.2. Recognition and management of an outbreak infection

INTRODUCTION

An outbreak of communicable disease/infection can be defined as the incidence of disease above that normally expected. Usually this means that there are two or more linked cases with the same illness/symptoms. In some instances, only one case may be sufficient to instigate investigation as an Incident, e.g. meningococcal meningitis. Outbreaks in community care settings where primary care medical practices may be involved will be similar to those experienced in acute hospital settings e.g. viral gastro-

enteritis, respiratory viruses, e.g. influenza, COVID -19, parasitic infections etc.

Outbreaks of infection may vary in extent and severity, ranging from a few cases of infestation to a large number of food poisoning cases, affecting hundreds of people. Recognition of an outbreak in the early stages may be difficult, therefore medical and nursing/care staff must remain vigilant.

The Consultant in Communicable Disease Control (CCDC) at the UKHSA has overall responsibility for outbreaks of infection in all health and social care provider settings (both NHS and independent sector) and the designated infection control advisor / senior manager on call in the provider setting must inform the UKHSA of any suspected outbreak of infection. An on-call service is provided by UKHSA out-of-hours and at weekends.

STAFF RESPONSIBILITIES
Primary care medical practice staff should be able to recognise a potential outbreak of infection or food poisoning.

Outbreaks in community residential settings should be managed by the organisation providing the care with advice and support from the IPCT and/or UKHSA/HPT. It is recommended that primary care medical practice staff responsible for an individual's care within that setting assure themselves that outbreaks are reported to IPCT and that processes to manage the outbreak are in place.

Practice staff should be aware of contact telephone numbers for IPCT and UKHSA; and of local arrangements for managing outbreaks in community settings. Management of an outbreak of viral gastro-intestinal illness in residential/nursing homes

This guidance is provided for information to GPs to assist them when providing support and guidance to care home managers and staff.

The management of outbreaks of viral gastro-enteritis in primary care settings can be a significant challenge to staff. General Practitioners play an important role in supporting managers and staff during such outbreaks whilst also maintaining responsibility for those residents that are registered with their practice. In addition, the role of the IPCT for Community and UKHSA in advising in the early detection and management of infective diarrhoea/norovirus outbreaks is crucial to the success of local control measures.

Prompt identification of possible cases of infective diarrhoea/ norovirus is crucial so that early interventions aimed at limiting spread can be implemented.

Norovirus is responsible for causing a high incidence of viral gastro-intestinal illness.

Norovirus is a highly contagious gastro-intestinal virus that can be spread by a number of different routes:

- By direct contact with an affected individual.
- By aerosol droplets of virus particles in faces; and in particular when vomiting occurs.
- By aerosol droplets (from vomit/faeces) landing onto surfaces and equipment and then being transferred onto hands and then into the mouth.
- Food-borne either from contaminated food or water or by food handlers that are symptomatic;

Norovirus causes a short illness (24 – 48 hours) associated with nausea, profuse vomiting – often projectile, diarrhoea and abdominal pain. Infection is self-limiting but can cause dehydration and deterioration in the very young and elderly.

CRITERIA FOR SUSPECTING NOROVIRUS OUTBREAK

- Vomiting in > 50% of cases (although sometimes diarrhoea is the prominent symptom)
- Duration of illness 24 - 48hrs
- Patients and staff affected (this is a critical criteria)
- Cases often occur in clusters up to 48 hours apart due to incubation period of 24– 48 hours.

REPORTING / RECORDING AN OUTBREAK OF VIRAL GASTRO-ENTERITIS

As soon as an outbreak is suspected, it is essential to report cases through the local incident reporting mechanism. The IPCT should be contacted to log the details of the outbreak and provide further guidance. In addition, clinicians including GPs must be made aware. It is essential that the local UKHSA and Environmental Health (if a food source is suspected) is notified of the existence of a gastro-enteritis outbreak, irrespective of whether this is deemed to be trivial. UKHSA have a responsibility to be notified of all outbreaks of infection in the independent sector and to be actively involved in outbreaks occurring in the NHS. UKHSA provide 24hr cover over the weekend and Bank holidays if urgent advice is required.

It is essential that the IPCT are involved at the earliest opportunity so that they can communicate promptly and effectively with other healthcare providers (and ambulance personnel) to minimise the risk of spread and service disruption.

DOCUMENTATION

It is advised that Care home staff accurately complete a daily outbreak record sheet which is included in the outbreak pack sent by IPC, to assist in managing the outbreak and for documentation purposes. It is essential to include sick staff details on the record sheets as well as service users. An outbreak toolkit can be found at the end of this section and can be modified and photocopied for local use. A Bristol stool chart is also included.

INVESTIGATION OF SPECIMENS

Faecal specimens should be taken from symptomatic service users as soon as possible after symptoms develop. Assess the normal stool type of a resident and whether there are any further reasons for loose stools prior to sending samples, e.g. change in medications, commencement of antibiotics, regular laxatives. An increased incidence of type 5-7 stools with no underlying reason, should be suspected as infectious diarrhoea. The IPCN will visit to support staff to manage a suspected outbreak. Specimens can be sent via the GP or hand delivered directly to Pathology at Barnsley Hospital, under IPCT/Microbiology arrangements. Further samples if required should be sent via UKHSA. Ideally, staff should also submit faecal samples via their own GP. Only a small sample is required, but ensure the pot is ¾ full to ensure all enteric infections can be tested. Formed stools may not be tested as it is unlikely to be an infected diarrhoea if the stool is formed. It is acceptable to obtain a specimen from a bedpan that also contains urine, as this will not affect results. Request forms should be sent for both C&S **and** virology, and must include Norovirus testing. Microbiology labs will not routinely test for Norovirus unless

there is an increased incidence. Forms should be marked “outbreak”. Remember to send specimens PROMPTLY for investigation as virus particles deteriorate rapidly leading to difficulty in detection. Samples of vomit should not be sent for testing.

OUTBREAK MANAGEMENT

In order for an outbreak to be managed well an outbreak should be recognised, and reported in a timely manner. Standard infection control precautions should be maintained and transmission-based infection precautions should be implemented for symptomatic patients/residents.

Please note early recognition of an outbreak by sending samples as soon as an outbreak is suspected, facilitates appropriate management of the outbreak and can often result in a prompt return to normal service.

Information on standard infection control precautions and transmission based precautions can be found in the National IPC Manual for England

NHS England » National infection prevention and control manual (NIPCM) for England

3. SAFE PRACTICE GUIDANCE: GENERAL

3.1. Infection Control Principles

The spread of infection

The spread of infection requires three elements:

- a source of infecting organisms (bacteria, viruses, fungi)
- a susceptible host
- a route of transmission of the organism from one person / site to another.

Source

The source may be service users, staff or visitors and may include persons with an obvious/ unobvious symptomatic illness, or those who are asymptomatic or colonised by the infectious agent. Another source may be the service user’s own microbial flora. Other potential sources are objects within the environment that have become contaminated, including health care equipment.

Susceptible Host (the individual service user, staff member, visitor)

It is important to remember that it is not only service users that may be susceptible to infection but also staff members and visitors to the facility.

An individual’s resistance to pathogenic micro-organisms can vary greatly. Some individuals may be immune to or able to resist colonisation by an infectious agent, others may simply be colonised and become asymptomatic carriers, whereas others will develop a clinical disease. Persons with underlying disease such as diabetes, lymphoma, leukaemia, etc. or treated with certain antimicrobial agents, corticosteroids, irradiation or immunosuppressive agents are particularly prone to infection. Extremes of age, chronic debilitating disease, shock, coma, traumatic injury or surgical procedures and the presence of invasive devices can also make an individual more susceptible to infection.

Transmission

Micro-organisms can be transmitted by a variety of routes and the same micro- organism may be transmitted by more than one route. For example, the *Varicella zoster* virus which

causes chickenpox can spread via the airborne route as well as by direct contact and gastro-intestinal infections e.g. norovirus can spread by both indirect contact (with contaminated equipment and surfaces e.g. commodes and horizontal surfaces) as well as via the airborne route where virus particles are propelled through the air (and inhaled) and then drop onto surfaces where they contaminate hands and are then ingested.

There are four main routes of transmission:

- contact
- droplet/airborne
- infected food and water
- vectors

Contact transmission:
The most important and frequent means of transmission of infection can be divided into two main subgroups:

- **Direct contact:** Involves direct physical transfer of the micro-organism from person to person e.g. sexually transmitted diseases or from one site to another in the same individual e.g. bowel flora contaminating the urinary tract.
- **Indirect contact:** This is the most significant route of spread in health and social care and involves contact with a contaminated object such as bed linen, instruments, equipment, dressings, etc. It is also the route by which the hands of health and social care workers transmit micro-organisms during service user care.

Airborne /droplet transmission:

- **Droplet transmission:** by large droplets during coughing, sneezing, talking and during procedures which may generate droplets such as suctioning. The droplets are propelled only a short distance through the air.
- **Airborne transmission:** caused by dispersal of smaller micro- organisms, e.g. viruses, contaminated water particles or airborne dust particles containing the infectious agent. These organisms can be widely dispersed by air currents before being inhaled or deposited on the susceptible host; by aerosolisation of water particles which are then inhaled e.g. in shower heads and in the case of dust particles, by airborne spread onto horizontal surfaces, equipment etc.

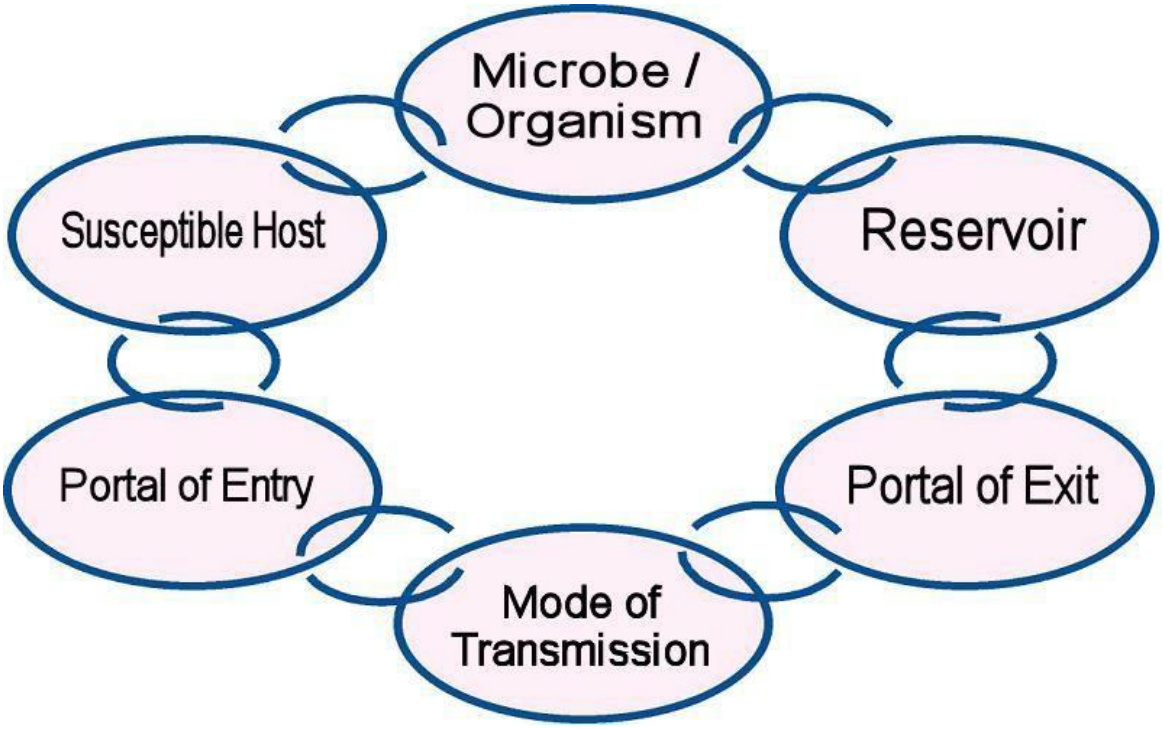
Food and water transmission:
Infection can occur via contaminated food or water supplies. Organisms can be transmitted via the food chain e.g. salmonella in eggs or by inappropriate handling of contaminated raw food or inadequate cooking. Secondary spread (cross- infection) can then occur if surfaces are contaminated by food-stuff e.g. chopping board used to cut contaminated poultry then used to chop salad vegetables. Additionally, infected food handlers can transfer micro-organisms on their hands to food.

Water provides an ideal breeding ground for some micro- organisms, which can then be colonised if the water supply has not been appropriately treated. In the case of *Legionella pneumophila* the bacteria form a biofilm in pipes / shower-heads etc. and can then be dispersed in water particles and inhaled.

Vector borne transmission:
This occurs when vectors such as flies, mosquitoes, rats and other pests transmit infection. This route of transmission is rare in healthcare in the UK although it is a route

of spread requiring containment in food preparation areas.

Breaking the chain of infection
The spread of micro-organisms from their source to a susceptible host is frequently referred to as the chain of infection.



The principles of infection control relate to the implementation of a series of basic control measures whose aim is to break the links in the chain thus reducing the likelihood of spread. These control measures are referred to as standard infection control precautions.

In the prevention of spread via the **direct or indirect contact** route, the following measures apply:

- Effective hand hygiene is the single most important measure in the prevention of the spread of infection.
- Healthcare staff should wear suitable gloves, aprons and other protective clothing whenever there is any possibility of direct contact with infected blood, body fluids or contaminated material.
- Strict adherence to the principles of aseptic technique will minimise the likelihood of contamination during the insertion and management of invasive devices and other clinical procedures such as wound care.
- Effective environmental cleaning and good housekeeping techniques together with appropriate cleaning, disinfection and sterilisation of medical equipment.
- Appropriate segregation and disposal of healthcare waste and contaminated laundry.

In the prevention of infection by **food and water** the following additional measures are important:

- Provision of adequate hand washing facilities, especially when handling or preparing food.
- Strict adherence to food hygiene regulations. All staff who handle food should have undertaken food hygiene training.
- Healthcare environments are subject to strict flushing regime controls to minimise the risk of *Legionella pneumophila.*
- Food handlers suffering from septic conditions of the skin or gastro-intestinal infections MUST be excluded from work until proven to be microbiologically free from infection.

In the prevention of spread of infection by the **airborne** route the following additional measures are important:

- Adequate un-crowded housing
- Segregation of infected service users to minimise the risk of cross-infection. This is usually achieved by either physical segregation in a single room or by measures such as keeping affected service users together (cohort nursing)
- Vaccination/immunization programmes where appropriate.

In the prevention of infection by **vectors** the following information is relevant.

Whilst most people readily associate rats and mice with risks to health, the part played by cockroaches, flies and other insects is not always appreciated. They have been implicated in the transmission of infection in food stores and food preparation areas as well as in medical supplies and in the home.

3.2 Standard Infection Control Precautions

There is often no way of knowing which service users / clients are contaminated or infected with a transmissible micro-organism. It is essential that Standard Infection Control Precautions (SICPs) are used by all staff in all care settings at all times for all patients.

To support the sustainability agenda and gloves off campaign a risk assessment is available to staff on the appropriate use of gloves.
Glove awareness | Campaigns | Royal College of Nursing (rcn.org.uk)

In many instances, pathogenic (disease-producing) organisms have already spread prior to the confirmation of a diagnosis. Furthermore, pathogenic organisms are frequently carried by individuals in their blood or body fluids or on the skin without signs of clinical infection – known as “colonisation”. Therefore, it is important to apply appropriate precautions at all times, for all service users, rather than wait for confirmation of a diagnosis when it may be too late to prevent the spread of infection.

SICPs apply to the care of all service users regardless of diagnosis or presumed infection status, where there is possible contact with:

- blood
- all other body fluids
- secretions and excretions except sweat
- non-intact skin

- mucous membranes (conjunctivae, mouth, nose, vagina, rectum)

SIPC's include:

- Patient placement for infection risk
- Hand hygiene
- Respiratory and cough hygiene
- Personal protective equipment
- Safe management of care equipment
- Safe management of the care environment
- Safe management of linen
- Safe management of blood and bodily fluid spillages
- Safe disposal of waste
- Occupational safety: prevention of exposure including sharps injuries

Details of the implementation of the above precautions and management can be found in NHS England » Chapter 1: Standard infection control precautions (SICPs)

WHO 5 moments for Hand Hygiene.

5 Moments	**Examples of care activity**
1 Before touching a patient	• Before any **direct** contact with the patient
2 Before clean / aseptic procedure	• Before applying disposable gloves • Before examining a patient • Before undertaking an aseptic or clean wound dressing • Before handling / inserting an invasive device • If moving from a contaminated body site to another body site during examination / treatment of the same patient
3 After body fluid exposure risk	• After contact with body fluids, excretions, mucous membrane, non-intact skin or wound dressings • If moving from a contaminated body site to another body site during examination / treatment of the same patient • After removing gloves
4 After touching a patient	• After any **direct** contact with the patient • After removing gloves
5 After touching patient surroundings	• After contact with inanimate surfaces and medical equipment in the immediate vicinity of the patient • i.e. within patient zone

As these examples show, hand hygiene is required both **before** and **after** contact or procedure. Decontaminating hands **before** contact or procedure, will protect the patient. Decontaminating hands **after** contact or procedure will protect the HCW and subsequent contamination of the healthcare environment.

Hand hygiene should be performed before putting gloves on and after removing them.

3.3 Safe use and disposal of sharps

See also section 3.6 – Management of Healthcare Waste.

Many sharps injuries are preventable providing staff are informed of the appropriate procedures which will minimise the risks associated with handling sharps. Safety devices should be used as much as possible to limit the risk of injuries.

Non-compliance with these guidelines may carry medico-legal or health and safety implications.

ASSEMBLY and Storage OF SHARPS CONTAINERS

Only approved sharps containers must be used which comply with current standards. (BS 7320:1990, UN 3292)

Ensure that the sharps container is correctly assembled and that the lid is securely fitted. Follow the manufacturer's recommendations for assembly, as all containers differ. Label the sharps container with the date of assembly, the name of the member of staff who assembled it and location e.g. GP practice name.

All sharps containers must be stored out of the reach of children and others who may be at risk.

When full to the "fill" line the permanent locking mechanism should be activated and the container then labelled with the date, name of the person disposing of the full container and the location details e.g. GP practice name. The closure of the bin at 3 months has been removed in updated guidance.
Update information | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Full sharps containers should be kept in a dedicated, lockable, area. Full containers must NOT be placed inside clinical waste bags.

HSE Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. Guidance for employers and employees)
https://www.hse.gov.uk/pubns/hsis7.pdf

SERVICE USERS OWN SHARPS

Many service users self-administer medications e.g. diabetics. A variety of administration and monitoring systems are available including pens as well as needles, lancets and syringes. All systems involving the use of sharps have the potential to cause injury if handled inappropriately.

Service users self-administering medication must be supervised and trained in safe practices prior to being allowed to self-medicate.

Appropriate equipment must be provided for the service user either by their GP or hospital consultant / nurse specialist (now on prescription). Small portable sharps boxes

complying with relevant standards should be used. These must be returned to the service user's GP practice / pharmacy if distributed from there for disposal as hazardous waste or arrangements for collection should be made by the GP responsible for the patient. Care must be taken to ensure returned sharps boxes are transported appropriately by the service user to minimise risk to the individual and members of the public.

Service user's own sharps must never be disposed of into the household waste stream. This includes lancets used for blood glucose analysis.

TRANSPORTING SHARPS CONTAINERS
Healthcare workers producing sharps waste in non-NHS environments e.g. in the patients' own home may be required to transport the sharps waste back to base in some circumstances (e.g. where such interventions are temporary and the householder does not have a waste collection arrangement in place).

PPE for Venopuncture
Venopuncture is a process of entering the vein to take a sample of blood for diagnostic purposes. Standard infection control precautions should be taken and transmission-based precautions where appropriate

See National IPC Manual for England

NHS England » National infection prevention and control

3.4 Management of Healthcare waste

Health Technical Memorandum 07/01: Safe and sustainable management of healthcare waste
https://www.england.nhs.uk/publication/management-and-disposal-of-healthcare-waste-htm-07-01/
Provides a framework for best practice waste management for health care organisations including primary care providers and since its last update also identifies best practice in sustainable management of waste and supports the NHS drive to be net zero. The guidance has been developed to facilitate the safe compliant management of healthcare waste and targets individuals who have a responsibility for managing waste in organisations providing NHS services.

3.5 Environmental Cleaning

INTRODUCTION
All staff have a responsibility to promote and safeguard the wellbeing and interests of service user/patients. Cleaning is necessary to maintain the appearance, structure and efficient function of the environment and equipment. It is also required to control the microbial population and to prevent the transfer of certain micro-organisms. Cleaning, when performed effectively and regularly may be found to minimise the risk of HCAI's.

Standards of environmental cleaning services should be audited monthly to ensure compliance with local schedules and processes as laid down in the *National Standards of Healthcare Cleanliness 2021* .Where environmental cleaning services are out-sourced to a third-party contractor, local arrangements for regular audit against the contract should be undertaken by the healthcare provider. Where primary care services are undertaken in third party shared/ rented premises i.e. within health centres the Practice should satisfy

itself that appropriate standards are being maintained in accordance with relevant national specifications.
NHS England » National Standards of Healthcare Cleanliness 2021.
The considerations for effective cleaning with particular relevance to infection prevention and control can be found in section 6.

- *Classification of infection risk*
- *National colour coding scheme*
- *Employer responsibilities*
- *Disposable plastic aprons (colour coded)*
- *Protective gloves*
- *Hand hygiene*
- *Accidental exposure to blood or substances*
- *Spillages of bodily fluids*
- *Uniforms and jewellery*
- *Waste management (HTM 01/07 identified above)*

B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk)

3.6 Pest Control

Pest control and management is essential for safe and hygienic health care premises.
All Organisations must have appropriate pest control measures in place to avoid unacceptable risks to patients, staff and visitors. Specialist contractors should be procured to support pest control.
Further advice and considerations for pest control can be found in the following document.

NHS England » National Standards of Healthcare Cleanliness 2021: Pest control

Treatment with insecticides and rodenticides, by themselves, is rarely enough and it is essential that attention be paid to good general hygiene and structural maintenance.

3.7 Estates and facilities management

Increases in the incidence of healthcare associated infections, and public concern, has highlighted the importance of appropriate management of healthcare environments.

Research has consistently shown that the environment can be a secondary reservoir for organisms with the potential for infecting patients. Good standards of basic hygiene, cleaning and regular planned maintenance can assist in preventing healthcare associated infections. This is more easily achieved if the built environment supports best practice.

More information to support primary and community care services can be found in found in Health building note 11-01.
Https://www.england.nhs.uk/wp-content/uploads/2021/05/HBN_11-01_Final.pdf
Matters to take into consideration in the primary and community health care environment are listed below

- Cleaning services
- Building and refurbishment, including air handling system
- Waste management
- Laundry arrangements for used and infected linen

- Planned preventative maintenance
- Pest control
- Management of drinkable (potable) and non-drinkable (non-potable) water supplies
- Minimising the risk of Legionella by adhering to national guidance
- Food services, including food hygiene and food brought into the care setting by service users, staff and visitors."
- Ventilation

Building & Refurbishment works

Technical guidance is produced by the Department of Health for healthcare building projects covering a range of health and social care provision. These include Health Building Notes (HBNs) and Health Technical Memoranda (HTMs).
A key document covering IPC aspects of buildings is HBN 00-09, *Infection Control in the Built Environment* (2013). Health Building Note 00-09: Infection control in the built environment (england.nhs.uk)

When planning builds or refurbishment of primary care facilities, or when planning additional clinical services, the appropriate guidance must be consulted and IPC advice sought.

Areas or rooms where clinical activities are to be undertaken (e.g. wound dressings, insertion of urinary catheters, or other invasive procedures) or where medical consumables are to be stored should incorporate IPC requirements. If the disposal of blood and body fluids is likely to be undertaken in primary care then a dirty utility facility (sluice), is required. Consideration should be given to providing a suitable area for the testing and disposal of urine samples. Samples should never be disposed of into a hand wash sink. Ventilation requirements should also be taken into consideration, particularly in high use areas e.g. waiting rooms and in rooms where respiratory investigations are undertaken.

Carpets are not acceptable in areas where clinical procedures are undertaken.

If enhanced services are provided consideration must be given to the suitability of the environment in which these will be conducted. Local Commissioners policies detailing this must be sourced and followed. If no such policy is available advice should be sought from IPC specialists. Details of requirements will depend on what type, or levels of procedures are to be undertaken. Minimal Access Interventions (MAIs) and ophthalmic procedures for example require mechanical ventilation systems whilst minor procedures can be conducted in a naturally ventilated room. Windows, if opened, must be protected with mesh screens.

Clinical services may be provided in sites managed by other organisations. In such situations the organisation must assure itself that the environment is appropriate for the care being delivered and is managed in accordance with the principles outlined in this policy and with published guidance.

Water Safety

The maintenance, construction and installation of hot and cold-water supply systems are vital for public health. Healthcare premises are dependent upon water to maintain hygiene and a clean comfortable environment for patients and staff and for treatment and

diagnostic purposes.

Comprehensive guidance on measures to control waterborne pathogens including s *Pseudomonas aeruginosa, Stenotrophomonas maltophilia,* Mycobacteria as well as legionella, can be found in the following documents which advocates that a water safety group and a water safety plan should be in place to ensure adherence and to protect the safety of the healthcare organisations users.

HTM 04-01 and the Health & Safety Commission Approved Code of Practice (L8) give detail on the required management arrangements to reduce this risk.

Health Technical Memorandum 04-01: Safe water in healthcare premises. Part A: Design, installation and commissioning (england.nhs.uk)

HSE Approved Code of Practice (ACOP) L8 & HSG274 (legionellacontrol.com)

Planned Preventative Maintenance (PPM)
Most equipment used in health and social care carries PPM requirements as recommended by manufacturers. Good equipment management can prolong the life of the equipment, prevent costly breakdown, and ensure the equipment is fit for purpose. Failure of some equipment in healthcare may pose IPC risks. This would include, but is not limited to: -

- Bed Pan Washers/macerators
- Laundry equipment e.g. washers/dryers
- Vaccine/specimen Fridges
- Catering equipment e.g. fridges/dishwashers
- ICE making machines

Policies or processes should be in place to ensure this equipment is maintained in line with manufacturer's instructions and this maintenance should be documented.

4 SAFE PRACTICE GUIDANCE - CLINICAL

4.1 Safe management and decontamination of medical equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery. Categories of care equipment and their classification can be found in National IPC manual for England
NHS England » Chapter 1: Standard infection control precautions (SICPs)

Decontamination requires the implementation of a number of processes, from purchasing equipment through to delivery and use, cleaning and disinfecting, packing, sterilising, repair and disposal. To be effective it needs standards to be set for all elements of the device life cycle.

It is the responsibility of healthcare staff to ensure that all medical devices used in patient care are appropriately decontaminated and fit for purpose.

The national standards of healthcare cleanliness 2021 appendices include guideline for cleaning equipment see below

https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021-appen

Please refer to the table below, if local guidelines are suggested.

A to Z and decontamination of patient equipment and medical devices

Device	Cleaning method	Method for contaminated/infected equipment	Frequency
Airways	Single use only	N/A	N/A
Arm rests	Wash with neutral detergent, rinse and dry	Wash with chlorine-based product or approved disinfectant, rinse and dry	On discharge of if visibly soiled
Audiometer headphones	Wipe with neutral detergent and dry		After each use
Auroscope and ear pieces	Wash ear pieces with neutral detergent. Wipe scope with detergent wipe	Consider disposal or wash with chlorine approved disinfectant Ensure ear piece is free of wax, particularly down the lumen. Do not immerse the auroscope.	After each use
Baby changing mats	Wipe with neutral detergent, rinse and dry.	Wash with chlorine-based product or approved disinfectant	After each use
Baby Scales	Wipe with neutral detergent, rinse and dry	Wash with chlorine-based product or approved disinfectant rinse and dry	After each use
Blood pressure cuffs	Clean with a detergent wipe	Single patient use cuff for infectious patients	After each use
Blood pressure machine	Clean with detergent wipe	If not able to use dedicated equipment for infectious patients, clean after each use with chlorine-based product or appropriate detergent	
Crockery and cutlery	Dishwasher or hand wash using hot water and detergent	Dishwasher only	After each use.
Dressing trolley	Clean with neutral detergent and dry. Clean from top to bottom using an 'S' shape motion.		Before and after each use
Electronic devices e.g. IPad	Clean with a disinfectant wipe, or use commercial wipes for electronic equipment. Keyboards – cover with wipeable cover or use soap and water. Dry with a paper towel.		After each use
Examination couch	Clean with neutral detergent, rinse and dry. Use paper couch roll and change between each patient use.	Wash with chlorine-based product or appropriate disinfectant, rinse and dry	Daily or if visibly dirty
Fans	Clean with neutral detergent.	Wipe with chlorine-based product or appropriate disinfectant rinse and dry	After each use or if visibly dirty
Furniture and fittings	Damp dust with detergent solution	Clean where possible with chlorine-based product	

Device	Cleaning method	Method for contaminated/infected equipment	Frequency
Hair brushes	Single resident/client use	N/A	N/A
Medicine Pots	Single use/reusable	N/A/Cleaned in a dishwasher	N/A
Medicine trolley/cupboard	Clean with neutral detergent, rinse and dry		Weekly or if visibly soiled
Mops	Disposable mops Reusable	N/A Laundered	After each use After each use
Nebuliser compressor	Clean with a universal detergent/2 in 1 wipe		After each use
Oxygen masks	Single patient use.	N/A	Weekly or if soiled
PCs, printers and keyboards	Wipe with detergent wipe		Daily
Peak flow meters	Wipe with detergent wipe. Mouth pieces single use.	Wipe with disinfectant wipe	After each use
Pillows	Cover with impermeable cover	Decontaminate after use	After each use
Pulse oximeter units	Wipe with detergent wipe	Wipe with chlorine-based product or approved disinfectant	After each use
Pulse oximeter probes	Wipe with detergent wipe	Wipe with chlorine-based product or approved disinfectant	After each use
Shaving brushes	Residents own. Not to be used for clinical shaving	N/A	N/A
Resuscitation trolley	Clean with neutral detergent, rinse and dry.	Clean with chlorine-based product or appropriate disinfectant rinse and dry	Weekly or if visibly soiled
Sputum container	Disposable only	N/A	N/A
Stethoscopes	Wipe with detergent wipe	Wipe with chlorine-based product or approved disinfectant	After each use
Suction equipment	Clean and dry containers with neutral detergent. Use disposable liners	Clean with wipe with chlorine-based product or approved disinfectant or approved disinfectant rinse and dry	After each use
Therapy equipment	Wipe with detergent wipe	Clean with wipe with chlorine-based product or approved disinfectant or approved disinfectant	After each use
Thermometers	Use disposable probe cover Wipe monitor with detergent wipe	Clean monitor with disinfectant wipe	After each use
Tympanic thermometers	Use disposable ear piece Wipe monitor with detergent wipe	Clean monitor with disinfectant wipe	After each use
Toys and play equipment	Wash with neutral detergent, rinse and dry. Do not soak soft toys.	Clean with wipe with chlorine-based product or approved disinfectant or approved disinfectant. Heavily contaminated soft toys may have to be destroyed.	After each use
Walking aids	Wash with neutral detergent, rinse and dry	Clean with wipe with chlorine-based product or approved disinfectant or appropriate disinfectant, rinse and dry	After each use

Device	Cleaning method	Method for contaminated/infected equipment	Frequency
Wheel chairs	Clean with neutral detergent	Clean with chlorine-based product or approved disinfectant rinse and dry or use disinfectant wipe	After each use
Weighing scales	Clean with neutral detergent or use detergent wipe	Clean with wipe with chlorine-based product or approved disinfectant, rinse and dry or use disinfectant wipe	After each use
Bed pans, commode pans, urinals	Disposable or clean in washer/disinfector		After each use
Bed pan shells (holders for disposable bed pans	Wash in warm detergent and water, rinse and dry with paper towels		After each use
Buckets (used to soak dressings)	Ideally use disposable liner and change after each patient. Always wash after removal of liner.	Wash with neutral detergent and warm water, rinse and dry thoroughly. Store inverted and separated	

This list contains common use equipment only and is not exhaustive.

4.2 Aseptic Technique: care of invasive devices

INTRODUCTION

The following section provides guidance for the most commonly performed nursing procedures and clinical practices in relation to the control of infection. The following advice reflects current expert opinion and guidance incorporating relevant research and best practice recommendations.

Expert advice should always be sought should staff require it. Further guidance can be obtained from the following specialists:

- Nutritional Support Team
- Tissue Viability/Wound Management Nurse Specialist
- Respiratory Nurse Specialist
- Continence Advisor

PRINCIPLES OF ASEPSIS

Asepsis means “without micro-organisms” thus an aseptic technique is a method used to prevent contamination of wounds and other susceptible body sites or invasive device insertion sites by potentially pathogenic organisms which may lead to infection. This can be achieved by ensuring that clinical staff understand the principles, follow the recommended practices and that only sterile equipment is used during invasive procedures.

All staff performing invasive procedures or managing wounds should receive appropriate training.

INFECTION RISKS IN IMMUNOCOMPROMISED PATIENTS

Infection is caused by micro-organisms which invade the host's immunological defence mechanisms, although susceptibility to infection may vary from person to person. The risk of infection is increased if the patient is immunocompromised by:

- Age – neonates and the elderly are more at risk due to less efficient immune systems
- Underlying disease – for example those patients with a severe debilitating or malignant disease or conditions such as diabetes
- Prior drug therapy – for example immunosuppressive drugs, steroids or broad-spectrum antimicrobials
- Patients undergoing surgery

In addition, the following factors should be considered when undertaking aseptic procedures on immunocompromised patients:

- Classic signs and symptoms of infection are often absent
- Untreated infection may disseminate rapidly
- Infections may be caused by unusual organisms or organisms which, in most circumstances are non-pathogenic i.e. do not cause disease
- Some antibiotics are less effective in immunocompromised patients
- Repeated infections may be caused by the same organism

WHEN TO USE AN ASEPTIC/NON-TOUCH (ANTT) TECHNIQUE

An aseptic technique should be used during any invasive procedure which breaches the body's natural defences e.g. the skin, mucous membranes, or when handling equipment which will enter a normally sterile area. The principles of asepsis should be applied to:

- Wound dressings
- Insertion *and manipulation* of invasive devices e.g. urinary catheters, all intravenous devices, PEG tubes etc**.**

THE PRINCIPLES OF ASEPSIS

Action	Rationale
Hand hygiene	Hand washing is the single most important procedure for preventing cross infection. Transient bacteria can be almost completely removed by effective hand hygiene techniques. In addition, resident bacteria (which can cause infections following highly invasive procedures) can be reduced by the use of an antiseptic detergent or the application of an alcohol hand gel following a social handwash. Hands should always be washed before and after contact with susceptible sites. Hand Hygiene may be required several times during a procedure.
Gloves	Gloves should be worn for all potential contact with blood or bodily fluids. Sterile gloves should be worn for the insertion of invasive devices and minor surgical procedures. Clean, non-sterile gloves are acceptable for

	most wound care procedures and on-going device-related care.
Protective clothing	Water repellent plastic aprons will need to be worn to prevent staff clothing from becoming contaminated with bacteria from wounds or invasive devices. It will also protect the wound/invasive device from bacteria that may be present on staff uniform/clothing. Sterile impermeable gowns may be required for some minor surgical procedures.
Non-touch technique	The susceptible site should not come into contact with any item that is not sterile.
Equipment	All instruments, fluids and materials that come into contact with a wound, surgical site or during the insertion/manipulation of an invasive device, must be sterile to reduce the risk of contamination. This includes not only products used during the procedure but any final dressing (s). The sterility of the device/fluids/materials must be protected from contamination.
Dressing trolley	The trolley should be cleaned with detergent and water if it becomes physically contaminated. Alcohol wipes may be used between uses if necessary. The sterile field will normally protect the trolley from contamination. Ensure sticky tape residues are removed from the trolley rails. (Ideally these trolleys should not be used for other purposes). Alternatively, for some procedures, plastic trays may be used. These must be cleaned before and after each use.

Wound management

Both chronic and acute wounds may be infected or colonised with micro-organisms, including MRSA. Chronic wounds colonised with MRSA are at increased risk for both wound infection and systemic infection (especially blood stream Early referral of patients with chronic wounds to specialist health professionals e.g. tissue viability teams and, in the case of diabetic foot ulcers, urgent referral to a multidisciplinary foot care team, is indicated to promote healing and reduce the risk of infection.

PREVENTING CONTAMINATION AND CROSS INFECTION

Wound care should only be carried out by those who are deemed competent to do so and have received training in the principles of asepsis and appropriate wound management. The principles of asepsis should be applied to all wounds irrespective of causation or type e.g. surgical wound, trauma wound, chronic wound etc.

Dressing changes should be performed in a treatment room which has a designated hand hygiene sink and is subject enhanced cleaning.

Further wound care guidance can be found at

https://www.nice.org.uk/advice/esmpb2/resources/chronic-wounds-advanced-wound-dressings-and-antimicrobial-dressing

URINARY CATHETER MANAGEMENT – long-term urinary catheters

Over 90 000 of the adult population in the UK are thought to have a urinary cateter,24% of these individuals are like to develop a catheter associated urinary tract infection CAUTI (BMJ 2019)

Further guidance for both medical professionals and patients can be found at

Long-term use of urinary catheters | Information for the public | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

Reducing catheter-associated urinary tract infections - GOV.UK (www.gov.uk)

MANAGEMENT OF VASCULAR ACCESS DEVICES

Vascular access devices may be one of the main causes of healthcare associated bacteraemia's strict protocols are required to keep patients safe and reduce the risk of infection. See attached guideline.

Quality statement 5: Vascular access devices | Infection prevention and control | Quality standards | NICE

A quick reference guide poster from the Infection prevention and control society can be found at;

VAD Pathway_May2022.pdf (dripp.org.uk)

MANAGEMENT OF RESPIRATORY EQUIPMENT

Respiratory equipment such as nebulisers and humidifiers may act as potential sources of infection. Bacteria may colonise respiratory equipment and deliver contaminated air directly into the lungs leading to respiratory tract infection or may be transmitted to other patients on the hands of health care workers.

All respiratory equipment including nebulisers and humidifiers should be used as per manufactures instructions to reduce this risk.

Staff dealing with this equipment should adhere to standard infection control precautions, unless the patient is known to be infectious, then transmission-based precautions should be implemented

MANAGEMENT OF ENTERAL FEEDING

Health care workers should receive training prior to dealing with any enteral feeding and management of the system for administration. Enteral feeding of patients in the community should be managed by a multi-disciplinary team which includes the patients GP. Further guidance including the management to reduce the risk of infection can be found at
Key priorities for implementation | Healthcare-associated infections: prevention and control in primary and community care | Guidance | NICE

SURGICAL PROCEDURES

INTRODUCTION

This section has been written using the professional guidance issued by the Association for Perioperative Practice and contained in: Standards and Recommendations for Surgery in

Primary Care AFPP 2016

Reference should be made to the general principles of aseptic technique listed in page 3 of section A (Aseptic Technique and Care of Invasive Devices). These principles, correctly applied, will help prevent contamination of an open wound (during surgical procedures) or sterile body cavity (e.g. for Joint Injections).

The basic principles of aseptic technique prevent contamination of the open wound, isolate the operative site from the surrounding non-sterile physical environment and create, maintain and promote a sterile field so that surgery can be performed safely.

This section is not intended to provide comprehensive guidance on minor surgical procedures. Its purpose is to highlight those practices that have an impact on the prevention and control of the development of post-operative wound infection.

Guidance on the minor surgery environment is available in section 14 Estates and Facilities Management.

GENERAL CONSIDERATIONS

All staff involved in the preparation and performance of surgical procedures must receive competency assessed training in aseptic surgical techniques. This should include surgical hand scrub and gown/glove donning procedures. The management and use of sterile instruments should also be taught and assessed, all information should be document and up to date.

Staff with infected lesions of the skin or bacterial infections of the upper respiratory tract should not participate in any aseptic technique.

The environment and all working surfaces must be cleaned in accordance with local policies prior to the commencement of any aseptic procedures.

If asepsis is compromised immediate action is required. Contaminated items should be removed and discarded. If the sterile field is compromised then a new field is required. Re-gloving and re- gowning may also be required.

Things to remember when setting up a sterile field:
Do not place sterile items near open windows or doors, only place sterile items and equipment within your aseptic field. Do not contaminate sterile items when opening, dispensing, or transferring them. When touching key parts ensure sterile gloves are being worn.

EQUIPMENT AND MEDICAL DEVICES

All pre-sterilised articles must be checked for evidence of sterilisation, damage, integrity of packaging and expiry date prior to use. Any packs found to be in an unsatisfactory condition must be discarded.

Single use medical devices are preferred. If reusable medical devices are used, then decontamination must take place in a fully compliant accredited Sterile Services Department (SSD).

<u>Symbols and their meanings</u> –

2023-07-30. Use by date, i.e. use by 30 July 2023.
2023-07. Date of manufacture, i.e. manufactured during July 2023.

Items used within a sterile field *must be sterile*. Any items that fall into an area of questionable cleanliness must be considered non-sterile. This is of particular importance where medical devices contain more than one component part which may involve a disposable element and a re-usable element e.g. diathermy forceps.

In procedures involving 'knife to skin' a sterile drape is required. This should be handled by the edges only, and applied from surgical site to periphery. Once in situ these should not be rearranged.

Sterile drapes should conform to EN 13795 (European Committee for Standardization 2002) and be used correctly to establish a sterile field.

Sterile drapes should be handled as little as possible. The drapes should be applied from the surgical site to the periphery, avoiding reaching over non-sterile areas. Once placed, drapes should not be repositioned in order to avoid contamination of the sterile field.

SCRUBBED PERSONNEL
Sterile gloves should be worn for all invasive procedures by the clinician undertaking the procedure and any scrub assistant who manipulates the sterile field or instruments.

Sterile gowns should be worn for all 'knife to skin' procedures. These should comply with standard EN 13795. Care should be taken when donning gowns to avoid contaminating the front of the gown.

Scrubbed personnel should remain close to the sterile field and not leave the immediate area. If personnel leave the sterile field and exit the minor surgery area they must re-scrub before returning to the sterile field. Leaving the sterile field increases the risk for potential contamination.

Personnel participating in sterile procedures must stay within the sterile boundaries; a wide margin of safety should be given between scrubbed and non-scrubbed personnel.

When changing positions or moving between sterile areas, scrub personnel should turn back to back or face to face to avoid contamination.

Scrubbed personnel must keep their arms and hands within the sterile field at all times. Contamination may occur if hands are moved below the level of the sterile field.

Scrubbed personnel should only be seated when the operative procedure is to be performed at that level.

Circulating personnel should not walk between sterile fields (e.g. between a prepared patient and the instrument trolley) and should be aware of keeping an adequate distance from the sterile field.

SPECIAL CONSIDERATIONS
Dressings must be removed carefully from the wound to prevent scattering of micro-

organisms into the air; it is recommended that this is carried out by an assistant wearing gloves and not a member of the scrubbed team. Used and soiled dressings should be discarded immediately and in accordance with local policy. To reduce the risk of airborne cross infection, talking, movement, opening and closing doors, exposure of wounds, disturbance of clothing and linen and number of personnel in the minor surgery area should be kept to a minimum. Special consideration must be taken to maintain the integrity of the sterile field at all times.

The sterile field should be constantly monitored and maintained, as sterility cannot be assured without direct observation. Any break in sterility must be reported and acted on to ensure patient safety.

Sterile fields should be prepared as close as possible to the time of use.

PROCEDURE TROLLEY

A designated area, which affords sufficient space to open packs whilst maintaining a sterile field, should be identified for this procedure. There should be minimal movement of personnel within this area during the preparation of the trolley.

A trolley of appropriate size is required for sterile instrumentation and products and this may be influenced by the type of procedure / surgery being carried out. This area, along with the wound site, comprises the sterile field. Fields should be protected from contamination by unsterile items or by non-scrubbed staff. Care must be taken when opening items onto the sterile field e.g. additional instruments/dressings/fluids, to ensure the field is not compromised.

All trolleys should adhere to the Medical Devices Directive 93/42/ EEC (incorporated into UK law in 2002) and be stable and robust enough for the intended job and in good condition (surfaces and trolley tops should be intact, seamless, easily washable and all joints must be sealed free of surface abrasions) and in sound working order. Ease of cleaning should be taken in to account when making product choice as should ease of movement and height. Trolleys should be included in a planned prevention maintenance programme. Particular attention to wheel mechanisms is required in order to allow free and smooth movement. Trolleys, mayo stands and bowl stands should be made of aluminium, stainless steel or mild steel covered in nylon.

Work surfaces should be designated according to clean or dirty tasks being performed.

Preparation of sterile trolleys in advance, with the use of sterile sheets to cover them, is not recommended. The trolleys are subject to contamination over time and removal of sheets without contamination cannot be guaranteed. In addition, unless trolleys are continuously monitored, there is a potential for sterility to be compromised.

Scrubbed personnel should move draped sterile trolleys by placing hands on the horizontal surfaces only.

To maintain asepsis, it is essential that all staff are aware of the correct method of opening different sterile packages to avoid the contamination of contents. Circulating practitioners should open wrapped sterile supplies by opening the wrapper flap furthest away from them first. The nearest wrapper should be opened last. Outer wrappers should be secured when presenting sterile items, to avoid contamination. The scrubbed person opens packs towards

themselves first and then away, to avoid contamination of the sterile item.

Sterile items should be presented to the operating or scrubbed practitioner or placed securely on a specific area of the sterile field identified and managed by the operating or scrubbed practitioner. Items should not be tossed onto a sterile field as they may roll off or cause other items to be displaced.

Sharps and heavy items must be presented to avoid penetration of the sterile field. Sharps should be opened into a container to avoid sharps injury and damage to the sterile field. Needles and scalpel blades may pose a risk to staff during procedures if safe practices are not followed. Sharps items should never be passed from hand to hand, whether used or not. A 'neutral zone' should be identified.

If re-usable blade handles are used, the blade should be removed using a dedicated device to prevent injury to the operator.

When dispensing solutions, the solution vessel should be placed near the trolley edge or held by the operating or scrubbed practitioner. The solution should be poured slowly to avoid splashing which could cause strike-through and compromise the sterile field.

The edge of a container is considered contaminated after the cap is removed and therefore the sterility of its contents cannot be guaranteed if the cap is replaced.

Preparation of sterile trolleys in advance, with the use of sterile sheets to cover them, is not recommended. The trolleys are subject to contamination over time and removal of sheets without contamination cannot be guaranteed. In addition, unless trolleys are continuously monitored, there is a potential for sterility to be compromised.

Trolleys should be positioned close together to ensure that there are no breaks in the sterile field.

The disposal of all equipment, drapes and sharps must be carried out in accordance with local and national guidelines. The scrub person should be considered the person of choice to dispose of all contaminated materials whilst still gowned and gloved.

PATIENT SKIN PREPARATION IN THE REDUCTION OF SURGICAL SITE INFECTION

Skin preparation is the process by which the skin is cleansed to reduce the number of transient and resident skin bacteria before surgical incision. Transient bacteria do not normally colonise the skin and are easily removed, whereas resident bacteria grown on normal skin and are difficult to remove. Most wound infections are associated with the patient's own skin flora and thus skin must be prepared to reduce the risk of surgical site infection.

The purpose of skin preparation is to remove dirt and debris from the skin, reduce the number of micro-organisms, inhibit the re-growth of further micro-organisms and reduce the number of micro-organisms entering the wound site, thus reducing the potential for surgical site infection.

Skin preparation should not cause irritation to the skin.
A decision tool for surgical skin prep can be found here- surgical-skin-prep-decision-tool-

2022.pdf (afpp.org.uk)

HAIR REMOVAL

Hair removal is often a routine part of pre-operative preparation but staff and patients need to be aware of the evidence and rationale for this practice as research has shown that removal of hair is not always necessary and should only be undertaken after assessment of the individual patient. The removal of hair is only necessary if it will directly interfere with access to the incision site or if there is a risk it will contaminate the wound site. Systematic review (Tanner et al 2006) has shown no difference in surgical site infection rates among patients who have had hair removal prior to surgery and those who have not.

If hair removal is undertaken the following is recommended:

- Patient consent must be obtained with a full explanation of the method to be used and why it is necessary
- Method of hair removal should be decided between the patient and the clinician performing the procedure
- Patients should be advised not to shave themselves prior to surgery as shaving may increase their risk of developing an SSI
- Hair removal should take place as close to the time of surgery as possible to minimise the risk of bacterial contamination of the skin surface
- Hair removal should be carried out by an experienced practitioner in a clean area of the surgical suite with good lighting, affording patient privacy at all times
- Details including who performed the hair removal, the area from where the hair was removed and the method used should be documented.

METHODS OF HAIR REMOVAL

Depilatory creams also do not abrade the skin but are less practical as they need to be left in place for several minutes and have the potential to cause allergic reactions.

Clipping – using an electric or battery-powered clipper with a disposable or re- usable head (that can be disinfected) – cut the hair close to the skin without the blade actually touching it is a simple and less irritating method than shaving. they are also associated with the lowest risk of causing abrasions

Wet shaving causes the most trauma to skin and carries the highest risk of postoperative wound infection. Wet shaving should not be used unless other methods are not suitable.

SOLUTIONS USED FOR SKIN PREPARATION

Antiseptics have to be effective against transient and resident micro-organisms. They should have a broad spectrum of microbial activity with a fast and lasting effect against Gram negative and Gram-positive bacteria, as well as viruses and fungi. They should be resistant to inactivation by organic matter, be non-toxic and acceptable cosmetically.

Antiseptics should be supplied in ready-to-use, single use containers or sachets as sterility is not guaranteed once open and there is a risk of contamination from using multi-use containers.

Solutions must be licensed as a preparation suitable for skin disinfection prior to a surgical procedure. Skin preparation solutions should not be used past their expiry date.

Skin preparation fluid should not be kept on the sterile trolley following skin preparation. This supports good infection prevention principles and patient safety. Only solutions that are in labelled containers should remain on the sterile trolley (NHS England 2015).
Types of skin preparation include:

- Povidone-iodine alcoholic solution
- Povidone-iodine aqueous solution
- Chlorhexidine 0.5% in 70% industrial methylated spirit (IMS)
- Iodine 1% in IMS
- 70% iodine in spirit
- Chlorhexidine gluconate 0.015% and cetrimide solution
- 70% IMS

Alcohol solutions are deemed to be more efficient than aqueous solutions

Decisions regarding the preparation to be used should be influenced by the area which requires preparation, the condition of the skin and patient allergies.

Delicate areas, such as eyes and ears may require special or diluted solutions. Chlorhexidine is not recommended for facial prep and iodine may cause corneal damage if introduced into the eye. If solutions enter the inner ear they may cause sensorineural deafness. Chlorhexidine gluconate and alcohol or alcohol-based solutions should also be avoided on mucous membranes.

When using an alcohol-based solution, it is imperative that skin is allowed to dry completely after each application and before applying electrocautery or laser treatment. Spontaneous combustion can occur when flammable solutions are exposed to an ignition source when oxygen is present.

Skin solutions should be kept in a locked cupboard and particular attention should be paid to storage of flammable solutions according to the control of substances hazardous to health (COSHH) regulations 2002.

4.4 Isolation of infectious patients in general practice

INTRODUCTION

The aim of isolation is to contain and prevent the spread of potential or known pathogenic or epidemiologically important organisms in order to reduce the risk of transmission of infection to and from patients, visitors or staff.

Identifying patients with suspected infections in General Practice can be a challenge as many patients visiting the surgery will not be aware of their potentially infectious status or may not communicate this is advance to staff.

Patients visiting the practice with known infections (or colonisation with transmissible organisms such as MRSA) provide less of a challenge but consideration is still required to ensure that risks are reduced / avoided during their practice visit.

Patients being visited in their own homes (or in other community environments, such as care homes) also pose a risk to staff attending to provide care.

INDICATIONS FOR ISOLATION IN GENERAL PRACTICE

There are a number of circumstances in which suspected or known infections may present in general practice. These include (but are not limited to):

- Diarrhoea and / or vomiting e.g. norovirus; *C. difficile* diarrhoea; bacterial food-poisoning
- Suspected or clinically proven infection which may be transmitted through the respiratory / airborne route e.g. influenza, Covid, chickenpox, measles, TB, Group A streptococcal sore throat, etc.
- Suspected or clinical proven infection which may be transmitted via the contact route e.g. MRSA, Group A streptococcal infection in wounds

COMMUNICATION

Informing patients of their responsibilities to limit the spread of infection is difficult. Posters and other visual means of identifying risks (including translation into local languages) can help to inform patients of the need to communicate symptoms when they attend the practice.

Reception staff should be trained (at induction and during mandatory IPC training) to identify those symptoms which may indicate transmissible infections e.g. rash, diarrhoea, vomiting etc. when receiving calls from patients requesting appointments or visits. Reception staff are NOT expected to take any other action other than to notify medical or nursing staff if they are concerned about patients' symptoms so that effective arrangements can be put in place e.g. being placed in (and examined / treated) in a separate room.
At this time, it may be deemed necessary for the patient to have a virtual consultation with a medical practitioner to ascertain the level of infection risk, particularly where a high consequence infectious disease is suspected (HCID)

Medical and nursing staff visiting patients in their own home or in residential care environments should be trained (as part of professional update training) to identify risks that may require additional precautions to be taken e.g. single room isolation in a care home for a resident with diarrhoea/vomiting).

All professional staff attending patients with suspected / known infections should be familiar with the route of spread (of infection) and standard infection prevention and control precautions to be used whilst providing care. Staff should also be familiar with additional interventions such as enhanced cleaning of equipment and the environment which may be required following care (and which may require additional time to undertake).

SEGREGATION OF PATIENTS IN GENERAL PRACTICE WHILST AWAITING APPOINTMENT

Patients with suspected / known infections *spread by the respiratory / airborne route* should be segregated whilst awaiting their appointment and ideally should be examined in the same room to minimise the risk of environmental spread to other clinical areas. A separate consulting room is ideal. A chlorine based clean or product of equivalent efficacy is required after the consultation to reduce the risk to other patients.

Patients with diarrhoea / vomiting should ideally not attend surgery. However, in such circumstance's patients should also be segregated as above. In addition, *where possible,* a separate toilet should be made available together with items such as disposable bowls

and wipes. Patients should be examined at the earliest opportunity. Any toilet facilities used by symptomatic patients should be cleaned with chlorine-based product prior to being used by other patients.

Patients with suspected / known infections *spread by the contact route* e.g. those with colonised or infected wounds requiring dressing can wait in general waiting areas. Usually these patients will be returning for regular wound care. In such cases, nursing/ medical staff should be encouraged to provide appointments at the end of clinics to allow for additional cleaning of equipment / environment following care.

INTERVENTIONS TO REDUCE RISK

Standard infection prevention control precautions should be used at all times with all patients. Strict attention to these precautions is necessary whilst examining/ treating patients with suspected / known infections in general practice:

- Strict Hand Hygiene.
- Appropriate use of PPE as per guidance.
- Disposal of infectious waste into orange bags.
- Thorough cleaning of ALL medical devices / equipment used.
- Use of single use, disposable medical devices where appropriate.
- Cleaning of all environmental surfaces in contact with the patient and their immediate environment – chair, couch, trolley, desk, horizontal surfaces etc.
- Ideally, non-essential items of equipment / furniture should be removed from the immediate environment during procedures such as wound dressings to minimise environmental contamination. This is of particular importance with wounds colonised / infected with MRSA which is spread by both contact and airborne route on skin scales as well as contaminated dressings.
- Prompt cleaning of any spillage of body fluids.

TRANSPORT OF SERVICE USERS TO OTHER HEALTHCARE ENVIRONMENTS

On occasions, general practice staff may be required to refer a patient for additional healthcare to another provider e.g. for admission to hospital.

Receiving hospital staff must be informed of the potential infection risks prior to the transfer. This should be done at the time of making the referral. Ambulance service staff must be informed of potential / known infection risks so that they can make appropriate arrangements for transportation. All infection risks should be documented in handover documentation.

4.5 Collection of microbiological specimens

Please read in conjunction with the Transport of specimens to the laboratory:
Transport of Specimens to the Laboratory - Pathology (barnsleyhospital.nhs.uk)

COLLECTION OF SPECIMENS – REFERENCE GUIDE (MARSDEN MANUAL OF CLINICAL NURSING PROCEDURES 10TH EDITION)

SITE	ACTION
Nose (anterior nares)	Relates to specimens for MRSA carriage. Prior to taking swabs from the nose, moisten with sterile water. One swab should be rotated around just inside both nostrils (do not swab further back into the nose).
Throat	One swab should contact one tonsil (or tonsillar fossa). The service user should stick out their tongue whilst the swab is guided down the side of the throat to contact the tonsil. A tongue depressor may be required. Do not contact any other area of mouth or tongue as this may cause contamination with other organisms.
Perineum	One swab should be rolled over the area between the genitalia and the anus (from front to back). Hygienic cleaning of the area should be undertaken if required prior to swabbing.
Groin	One swab should be rolled along the area of skin on the inner part of the thighs closest to the genitalia. Moisten with sterile saline beforehand.
Eye swabs	The exudate from the eye can be swabbed to identify some bacteria but others need to be identified by conjunctival scrapings which should be taken in an eye clinic. Hold swab parallel to the cornea and gently rub the conjunctiva in the lower eyelid from the nasal side outwards. If both eyes are to be swabbed a separate swab must be used for each eye.
Ear swabs	Ensure no antibiotics or other therapeutic drops have been used in the aural region 3 hours before taking the swab, Place the swab at the entrance of the auditory meatus. Rotate gently once.
Wounds/skin lesions	One swab should be rolled over the area. The wound may be irrigated with saline to remove surface debris before taking the swab if remnants of dressing remain. For large wounds, roll swab in a zig-zag motion to include all wound surface. If the wound is dry, moisten with 0.9% sodium chloride.
Catheter specimen of urine (CSU) 5-10 mls is required	Clamp tubing below rubber cuff (of catheter) to allow urine to collect. Urine specimens should only be taken from the sampling port using a sterile syringe +/- sterile needle (most manufacturers provide needle-less ports). Please note, using a needle increases the risk of sharps injury. Needles should not be used if it is a needle less port. Swab with 70% alcohol and allow to air dry prior to sampling. Aspirate the required amount of urine and remove the needle/syringe. Urine specimens must not be taken from the catheter bag as misleading results will be obtained due to bacteria having multiplied in the previously drained urine.
Mid-stream specimen of urine (MSU) 5-10 mls is required	Male - clean skin around prepuce (after retracting) with soap/water or normal saline. Female – part labia and clean with soap/water or normal saline (from front to back). Use separate swab for each wipe. The first and last part of the urine stream should be discarded and the mid-stream specimen collected into a sterile receiver and poured into a sterile container.
Stool/faecal specimens	Using the integrated spoon, scoop enough faecal matter to fill 2 thirds of the specimen container. Stool specimens can be obtained from a bedpan containing urine. This does not affect results. Only liquid stools (Bristol Stool Chart 6/7) will be examined for *C. difficile* toxins.
Vaginal Swabs	A sterile vaginal speculum must be used in order to separate the vaginal walls. The swab must be taken from as high in the vagina as possible.
Indwelling devices e.g. PEG site	One swab to be rolled over the area of skin surrounding the device. Pre- moisten swab with sterile water if necessary.
Pus	Pus may be collected using a sterile syringe and transferred into a sterile specimen container.

Transportation of Specimens

Specific requirements for Barnsley Community services` are outlined in the following

documents

Transport of Specimens to the Laboratory - Pathology (barnsleyhospital.nhs.uk)
Sample-Transport-Procedures-for-the-Community (5).doc

4.6 Infection with specific alert organisms

INTRODUCTION
This section is designed for professional staff including. GPs who may provide healthcare to service users in residential care settings as well as in their own home and in local general practice facilities.

Safe Infection control practice requires knowledge of micro-organisms, the diseases they cause and how they spread between people.

To assist staff, the following list provides basic information on common infectious diseases; causative organism; mode of transmission and specific information relating to clinical care.

Staff should consult the following list to determine the risk posed to others and how to manage service users safely.

Some infections are caused by an individual's own micro-organisms. This is called Endogenous Infection.

Cross infection where micro-organisms have been transmitted between individuals are called Exogenous Infections.

Advice may be sought from the local IPC Team / clinician / GP / UKHSA on the management of service users or service users' household contacts with these infections.

NOTIFICATION OF INFECTIOUS DISEASES
UKHSA regulations require statutory notification of certain infectious diseases. Notification is the responsibility of a Registered Medical Practitioner. See section IPC Management Policy

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INFECTIOUS (COMMUNICABLE) DISEASES - Standard Infection Control Precautions (SICP)

Disease	Mode of Transmission	Comments and Precautions
Candidiasis (thrush)	Endogenous spread	SICP. May indicate immunosuppression or recent antibiotic therapy.
Chickenpox (Varicella)	Respiratory droplets and direct contact with vesicle fluid	Incubation period 14 – 16 days Highly infectious until lesions are dry. Potentially harmful to non-immune pregnant women and the immunocompromised. Suspicion of Chicken Pox *in a member of staff* must be reported immediately to the CCDC (at local HPU) even at weekends. Respiratory isolation.
Chlamydiosis	Sexual transmission	No restrictions
Cholera	Ingestion of contaminated food or water	Incubation period 1- 3 days SICP
Clostridioides difficile See separate section	Faecal-Oral. This bacterium produces spores which can live in the environment for months or years and requires chlorine releasing disinfectants to destroy	Enteric Isolation (own toilet facilities) Environmental cleaning with chlorine releasing disinfectants. Do NOT use alcohol hand rub as less effective than soap and water. Service users with active *Clostridioides difficile* associated disease may be cared for in hospital but may present in general practice
Cold sores	Contact with vesicle fluid, saliva, sexual contact	SICP especially hand hygiene and glove use
Common cold	Respiratory droplets and contact spread	Incubation period 1-3-day SCIP
Covid-19	Droplet/Airborne spread	SICP, Respiratory precautions. PPE required. See link for latest guidance https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals

Disease	Mode of Transmission	Comments and Precautions
Cryptosporidiosis	Faecal-oral route	SICP
Cytomegalovirus	Direct contact,	SICP
Diarrhoea	Faecal-oral route, contact spread	SICP. Soap and water for hand hygiene (NOT alcohol rub). Environmental cleaning of toilet facilities after use with chlorine releasing disinfectant
Fifth disease (Erythema infectiosum)	Respiratory secretions (saliva, mucus) Also from infected blood	AIso known as Slapped Cheek Syndrome Incubation period 4 – 21 days Infectious before rash appears Women in first trimester at risk of serious complication; also, those with sickle cell disease and the immunocompromised
Glandular fever (Infectious mononucleosis)	Contact spread with saliva	Incubation period 28 – 42 days Infection may be transmitted on hands of staff if contaminated with saliva. Good hand hygiene essential
Hand foot & mouth disease (Coxsackie A/ Enterovirus 71)	Direct contact with nose and throat secretions; faeces	Incubation period 3 – 7 days Strict attention to hand hygiene Immunocompromised at risk. Severe complications uncommon (neurological mainly) Outbreaks common in nurseries / schools
Hepatitis A	Faecal-oral route	SICP
Hepatitis B *See sub-section on Blood Borne Viruses (BBV)*	Direct contact with infected blood, sexually transmitted	SICP when in contact with blood- or blood-stained body fluids. Safe spillage management. Safe sharps management Immunization of all staff in contact with blood.
Hepatitis C *See sub-section on Blood Borne Viruses (BBV)*	As above	SICP when in contact with blood- or blood-stained body fluids Safe spillage management Safe sharps management Avoid contact with lesions
HIV Human Immunodeficiency Virus *See sub-section on Blood Borne Viruses (BBV)*	By direct contact with infected blood, sexual transmission and vertical transmission (mother to baby)	SICP when in contact with blood- or blood-stained body fluids. Safe spillage management Safe sharps management

Disease	Mode of Transmission	Comments and Precautions
Impetigo	Direct contact with lesions	Young children often highly susceptible Attention to hand hygiene essential Avoid contact with lesions
Infestations *See Sub Section below*	Body Lice, Hair Lice, Scabies	SICP
Influenza	Respiratory (droplet) and contact transmission	Incubation period is 1-4 days. Transmission risk continues for 3-7 days or until the patient is asymptomatic. At risk patient groups should be immunised according to published guidance – see separate vaccination section. Influenza can cause outbreaks in residential care settings, the HPA may request swabbing of affected residents and ant-viral treatment/prophylaxis. Advice should be sought from HPA. May cause mild self-limiting disease however unvaccinated at-risk patients may experience severe disease.
Legionnaires' disease	Inhalation of contaminated aerosols	Not spread from person-to-person.
Measles	Respiratory droplets	Incubation period 9 – 12 days Potentially hazardous to the very young (under 1 year), immune-compromised people or non-immune pregnant women. Respiratory isolation.
Mpox	Respiratory/contact	Clade I HCID The components are: filtering face piece 3 (FFP3) respirator hood longer-length visor long rear-fastening fluid-resistant surgical gown tied to the side

Disease	Mode of Transmission	Comments and Precautions
		medium thickness apron inner gloves middle gloves taped to the gown with microporous tape outer gloves wellington boots Clade II SICP - Fluid resistant surgical mask NHS England » Clade I mpox (MPXV) pathway actions: patients self-presenting in general practice Monkeypox information for primary care
MRSA *See sub-section on MRSA*	Contact spread	SICP, strict attention to hand hygiene and principles of asepsis when caring for invasive devices or wounds.
Mumps (pertussis)	Respiratory droplets, direct contact with saliva	Incubation period 7 – 14 days Infectious prior to onset of illness. SICP Respiratory isolation.
Norovirus	Spread via airborne and contact routes in vomit and faeces	Incubation period 1 – 2 days Usually self-limiting but can cause severe dehydration in infants / elderly Enteric / contact isolation SICPs
Poliomyelitis	Faecal-oral route, direct contact with nasal or oral secretions	Incubation period 7 – 14 days Strict attention to hand hygiene.
PVL *Staphylococcus aureus*	Contact transmission	Some strains of *Staphylococcus aureus* (both Meticillin resistant and sensitive) produce Panton Valentine Leukocidin, a toxin which is a virulence factor. Strains can cause skin and soft tissue infections which commonly recur. Rarely this causes severe invasive disease e.g. necrotising haemorrhagic pneumonia. PVL should be suspected in patients presenting with recurrent skin

Disease	Mode of Transmission	Comments and Precautions
		infections e.g. boils. Swabs should be taken and PVL suspicion noted on the request. Positive results should be notified to HPA. who will advise on contact tracing and
Resistant Organisms e.g. VRE, ESBLs/Gram negative enterococci	Many bacteria are developing resistance to antibiotics in addition to MRSA. These include some strains of normal gut flora which can be spread by direct or indirect contact	SICP and application of principles of asepsis.
Rubella (German measles)	Direct contact with respiratory secretions or droplets.	Incubation period 14 – 21 days Potentially hazardous to the very young (under 1 year), immune-compromised people or non-immune pregnant women. Respiratory isolation.
Salmonella	Food-borne – ingestion of contaminated food. Faecal-oral transmission.	Transmission can occur via food handling by infected individual. Enteric precautions (own toilet facilities).
Scabies See sub-section on Parasite infections	Prolonged skin-to-skin contact	Crusted or Norwegian scabies highly infectious. Dermatology diagnosis recommended. SICP apply. Staff contacts may need treatment.
Shingles (Varicella Zoster)	Direct contact with lesion exudate	Shingles can occur in people who have had chicken pox when the virus reactivates in sensory nerve cells. People not immune to chicken pox can acquire this from individuals with shingles Keep lesions covered. Strict attention to hand hygiene and glove use when in contact with lesions. Infectious until lesions dry.

Disease	Mode of Transmission	Comments and Precautions
Tuberculosis *See sub-section on TB*	Inhalation of airborne droplets	Pulmonary disease infectious until after 2 weeks of treatment. Infections at other sites are not normally infectious. Respiratory isolation for first two weeks of treatment.

MRSA PATHWAY FOR COMMUNITY SERVICES

Meticillin Resistant *Staphylococcus aureus* (MRSA) is a *S. aureus* bacterium that has developed resistance to all beta-lactams, penicillin's, cephalosporins and imipenem. It may colonise without any adverse effects or can cause various degrees of infection ranging from mild to life threatening, MRSA is known to be prevalent in hospitals, residential and nursing homes. Early identification of patients who are colonised with MRSA and appropriate management of these patients has shown to reduce the risk of transmission and infection including MRSA bacteraemia within the community.

People who live in the community may live quite normally with MRSA colonisation and may not have any signs and symptoms. However, people who fit in a high-risk criterion may be more susceptible to severe infection or/ and bacteraemia:

- A person with an Indwelling device, e. g. urinary catheter, PEG, PICC, or cannula.
- A person who is diabetic and had venous ulcers or deep wounds.
- A person who misuses IV drugs
- Patient who have long term chronic illnesses conditions
- Patients who are immunocompromised
- Patients with open wounds.
- Patient who has a Vac dressing.

COLONISATION VERSES INFECTION

Colonisation – means that MRSA is present on or in the body without causing an infection.
Infection – This can occur when the MRSA invades an opening or wound on the body and can then multiply causing clinical symptoms, e.g., fever, inflammation, confusion, rigors, redness, exudate to the wound.

Bacteraemia -If an infection is left untreated the patient may develop a blood stream infection which could lead to multi-organ failure and /or death. The Department of Health sets annual targets to reduce incidence of MRSA Bacteraemia.

MANAGEMENT OF PATIENTS WITHIN THE COMMUNITY SETTING

Swabbing

MRSA Swabbing
Please note:
Bacterial swabs in the charcoal transport medium must be used.
The tip of the swab should be moistened with 0.9% sodium chloride (sterile saline) when taking nose and skin swabs.

Specimens to be taken:
It is important that patients do not do their own swabs as poor technique may give a false negative result.

Nose: use one swab for both nostrils (moisten swab with sterile saline).
Groin: Use one swab for both sides (moisten swab with sterile saline).
Skin lesions/wound swab: one swab for each site. Sites should be clearly identified. Swab

should be moistened with sterile saline and rubbed into the area.
CSU: In catheterised patients. Ensure correct technique is used and the sample is not taken from the drainage bag.
All manipulated sites e.g. IV-line site, tracheostomies, peg site etc.
Sputum depending on clinical presentation for example a productive cough

Decolonisation
All adult first isolate MRSA positive patients should be prescribed the following decolonisation regime in an attempt to eradicate or a least temporarily suppress MRSA.

For a first isolate decolonisation treatment should be given for all sites regardless of where positive, for example nasal treatment and body decolonisation should be given for a wound swab along with octenillin wound irrigation and a review for systemic antibiotics. If any subsequent decolonisation is required treat the positive site only.

Procedure	**Product**	**Directions**	**Duration**
Nasal Clearance	Mupirocin cream 2% (Bactroban R) Naseptin® (Chlorhexidine dihydrochloride 0.1%w/w/ Neomycin sulphite 0.5%w/w) nasal cream. **Caution** Naseptin is contra indicated if the patient has a peanut allergy Octenisan® nasal gel Apply BD (Water based gel, can be used with nasal oxygen cannulae)	Apply to both nostrils 3 times day Apply to both nostrils 4 times day Apply to both nostrils twice daily	**5 days** **10 days** **5 days**
Daily shower/bath	4% chlorhexidine wash **This is considered 1st line treatment, please assess skin integrity of patient prior to prescribing this treatment** Octenisan® solution 2%	moisten the skin, apply the wash, and leave for 1-3min After each wash, clean clothing, bedding and towels should be used. Thoroughly apply product directly on to wet skin covering all areas, paying particular	**5 days** **5 days**

		attention to the axilla, groin and perineal area; allow 1minute contact time then rinse. After each wash, clean clothing, bedding and towels should be used.	
Hair wash	4% chlorhexidine wash **1st line** Octenisan® solution 2%	Wash hair with the product twice during this period Wash hair with the product twice during this period	**5 days** **5 days**
If throat positive	Chlorhexidine spray (Corsodyl®) Three times daily	Three times daily	**5 days**
If wound swab positive	Octenilin® wound irrigation	If infected systemic antibiotics may be required	**Based on wound assessment may continue for the duration of systemic antibiotics**

Following completion of the above treatment please assess if a re screen for MRSA is required, generally this is not considered necessary for colonisation. If a re screen is deemed necessary leave 2-3 days before repeating swabs. Nose, groin, wound, urine if catheterised, any manipulated site, any other previously positive site and throat swab for those with dentures, must be sent. If found to positive again repeat the decolonisation regime. If still positive after second decolonisation contact Community IPCT or the medical microbiologist for further advice.

Please note it is now not considered necessary to swab patients in the community until 3 negative screens are obtained, however treatment should consider any risk factors, for example indwelling devices that may put the patient at higher risk of developing an MRSA bacteraemia.

This information is also available on the BEST website

4.7 Blood Borne Viruses

INTRODUCTION

Viruses transmitted by blood and blood-stained body fluids are of particular importance to healthcare workers who may be at risk of acquiring infection during the course of their work. The most significant route of spread (in occupational exposure) is via contaminated sharps.

The most important blood borne viruses are:

- Hepatitis B
- Hepatitis C
- HIV

This should be read in conjunction with other policies within this manual:

- Safe handling and disposal of sharps
- Management of Occupational Exposure to Blood Borne Viruses
- Decontamination of Medical Equipment
- Spillages of blood and body fluids

HEPATITIS B (HBV)

Is a liver infection that can be spread to others via blood, vaginal fluid and semen. Vaccinations are available for hepatitis B. Standard infection precautions are required.
Please see link for further information-Hepatitis B - NHS

HEPATITIS C (HCV)

Hepatitis C is a virus that can affect the liver and may cause potentially life-threatening damage if left untreated. Standard infection precautions are required.

Please see link for further information-Hepatitis C - NHS

HUMAN IMMUNODEFICIENCY VIRUS (HIV)

Damages cells in the immune system this weakens a person's ability to fight infection and disease. Standard infection precautions are required.
Please see link for further information-HIV and AIDS - NHS

Occupational transmission of HIV

Please see link for further information-Guidance on management of potential exposure to blood-borne viruses in emergency workers

REDUCING THE RISK OF OCCUPATIONAL EXPOSURE

Injury with a contaminated sharp device / instrument is the most likely route of transmission to a care worker, therefore all staff should be aware of safe working practices when handling and disposing of used sharp instruments.

Staff should be made aware of the action to be followed in the event of accidental sharps injury or splash incidents. Staff are advised to Wash it, Bleed it, Cover it and Report it.

MANAGING SERVICE USERS WITH BLOOD-BORNE VIRUSES

Staff should adopt standard infection control precautions for all service users regardless of the perceived risk of infection. Protective clothing is necessary only for direct contact with

blood or body fluid. Specimens should be labelled as 'high risk' as per specimen collection policy.

4.8 Transmissible spongiform encephalopathies

Transmissible spongiform encephalopathies (TSEs), also known as prion diseases, are a group of rare degenerative brain disorders.

Creutzfeldt-Jakob disease (CJD) is the most well-known of the human TSEs symptoms diagnosis, treatment of CJD can be found at the following link- Creutzfeldt-Jakob disease - NHS

4.9 Tuberculosis introduction

INTRODUCTION

Tuberculosis (TB) is an infectious disease caused by *Mycobacterium tuberculosis complex.* To minimise the risk of infection patients who have suspected infectious pulmonary TB should be seen at places away from other patients.

For information on prevalence diagnosis and treatment-| NICEOverview | Tuberculosis| Guidance | NICE
https://www.gov.uk/guidance/tuberculosis-screening

Patients confirmed positive for TB should be referred to the Barnsley Community TB service. Contact details 01226 731686/ 07884493506 (Health Integration Team) or email HealthIntegrationTeam@swyt.nhs.uk

STAFF PROTECTION / CONTACT TRACING

Staff that are caring for service users with open pulmonary TB within the first two weeks of treatment are required to wear, FFP3 masks.

All close staff contacts of sputum smear positive (AFB positive) service users will be checked and followed up by the TB nurse specialist as appropriate. A contact list will be compiled in conjunction with the local Trust Infection Control Advisor and the local Health Protection Team

Any employee of the organisation who develops an illness suggestive of tuberculosis should seek medical advice from their own GP as soon as possible.

MULTI-DRUG RESISTANT TUBERCULOSIS (MDRTB)

There are now increasing numbers of service users being identified with a tuberculosis infection which is resistant to more than one of the usually prescribed drugs used for treatment. Once identified these service users are usually cared for in hospital until they are no longer infectious. However, it is possible that general practice staff may have had regular contact with the service user prior to admission. In such cases, guidance will be provided by the UKHSA Health Protection Team in collaboration with the local Chest Physician / TB team

and Trust Infection Control Advisor.

4.10 Lice ectoparasites

HEAD LICE, BODY LICE, PUBIC LICE AND THE SCABIES MITE

Lice live on the skin or inner layers of clothing. Once parted from their host, they soon die, although the nits or eggs may remain viable for long periods. Transmission is by contact either with the hair (head or pubic lice) or clothing (body lice) of the host.

HEAD LICE (PEDICULUS HUMANUS CAPITAS)

The adult louse is approximately 3mm long and lives for about 20 days. The female head louse produces on average 56 eggs after a single insemination, at the rate of approximately six eggs per day. It feeds on human blood. Bites cannot be felt but repeated bites lead to sensitisation and irritation (itching) of the scalp. Irritation to the scalp is also due to an allergic reaction to louse faeces. Once the infected person is sensitised to the bites the itch is continuous. The eggs, which are difficult to see, are glued to individual hairs just above the roots and are tear shaped and approximately 1mm long. They hatch after 7- 11 days and reach adult stage within 6-12 days. The empty egg shells (nits) are white and shiny and are harmless. As the hair grows the empty egg shells can be found further along the hair shaft.

Diagnosis and treatment please see link-

Head lice and nits - NHS

BODY LICE

The adult body louse is larger than the head louse and also feeds on human blood. It is associated with poor living conditions, lack of cleanliness and lack of adequate nutrition. The presenting signs are pinpoint lesions, excoriation and pigmentation of the skin. Eggs are laid on the clothing of the host, in the lining, seams and underwear and occasionally on the body hairs. The body louse may be transferred by direct contact, but more often by wearing infested clothing or sleeping in infested bedding.

Treatment

Treatment does not usually require pesticides.

Body lice are seldom found on the skin after clothing has been removed. The louse only transfers in the dark therefore remove clothing in a well-lit room.

It is recommended that staff wear gloves and a plastic apron while assisting service users. Collect clothing and bed linen in water-soluble linen bags.

Clothes should be turned inside out and tumbled dried at 50^0 C for 30 minutes. This will be sufficient to kill both lice and eggs. Clothes can then be washed in the usual way.
No special environmental measures are required.

CRAB LOUSE

The crab louse is generally found in the pubic and perineal region, but may also be in the armpits, hairy chests, beard, eyebrows and eyelashes. It is more firmly attached and less likely to transfer to healthcare staff. It is normally acquired by intimate contact. It feeds on human blood and can be seen as a dark red spot. Bites cannot be felt but irritation occurs and blue/grey skin lesions can be seen.

Treatment
Treatment is with Malathion or Carbaryl lotions or shampoo.
Clothing should be washed and ironed.

Staff should wear gloves if required to carry out the treatment.

Sexual partners should be treated simultaneously whether infection is confirmed with them or not.

For further information see-

Pubic lice | Health topics A to Z | CKS | NICE

4.11 Scabies

Infection with the scabies mite is currently increasing and there have been a number of cases of resistance to the usual treatments. Extended direct contact (i.e. skin to skin for 3-5 minutes) is required for transmission of the mite.

Scabies is an infestation of the skin by the microscopic mite *Sarcoptes scabei,* which burrows into the skin. These burrows are often visible as a discoloured, raised line, which may be straight, tortuous or dotted on the wrists, back of the hands and between the fingers.

Infection with scabies presents with intense itching caused by an allergic reaction to the faeces of the mite. The burrowing itself may also cause itching. The mite tends to burrow into warm skin creases so elbows, armpits, beneath the breasts, waist, groin, genitalia, buttocks, knees and ankles are often affected.

Infection with the scabies mite is very difficult to detect until the infested individual becomes allergic to proteins in the excreta of the mite which takes from 2-6 weeks. This causes increasingly intensive itching particularly at night. There are two particular types of scabies to note:

- Classical scabies which presents in otherwise healthy individuals. There are few mites present and few associated complications.
- Crusted scabies which can occur in those with impaired immunity. Infestation is with large numbers of mites, reaching possibly thousands and affecting the entire body. Typical burrows may not be seen and the service user may present with a rash resembling a chronic dermatitis. The classical itch may be absent. This form of scabies is highly infectious and can cause environmental contamination.

Transmission of scabies infection occurs during very close skin-to-skin contact with an infected individual and spreads rapidly under crowded conditions where frequent skin-to-skin contact is unavoidable such as in hospitals, care homes and childcare facilities.

As many elderly people are affected by dry skin it is often extremely difficult to diagnose scabies infestation in the elderly. Referral to a dermatologist for confirmation of diagnosis is often the most effective method of determining an accurate diagnosis particularly if other treatment regimens have failed.

Treatment and management can be found for both care homes and individual cases at the following links.

UKHSA guidance on the management of scabies cases and outbreaks in long-term care facilities and other closed settings - GOV.UK
Scabies: management advice for health professionals - GOV.UK

Seek guidance from UKHSA or IPCT, if there is the likelihood of more than one case of scabies i.e. an outbreak.

4.12 Management of *Clostridioides difficile* (*C.difficile*) diarrhoea

INTRODUCTION

Clostridioides difficile (C. difficile) is a bacterium which produces spores that are resistant to air, drying and heat. The spores survive in the environment and are the main route of transmission of the bacterium.

C. difficile is present harmlessly in the gut (bowel) of up to 3% of healthy adults and 66% of babies as part of their normal gut flora. However, when antibiotics disturb the balance of bacteria in the gut, *C. difficile* can multiply rapidly producing toxins causing diarrhoea or colitis.

C. difficile has been associated with outbreaks, in health and social care settings. It is, therefore, imperative that good infection prevention and control measures are instigated so that transmission does not occur in any health or social care setting.

***C. difficile* Clinical Presentation**

Asymptomatic carriage – specific treatment not indicated.

Simple colitis – mild/moderate watery diarrhoea with lower abdominal colic.

Severe colitis ± pseudo membrane formation – severe diarrhoea with abdominal pain, distension, constitutional upset, leucocytosis or leukopenia.

Fulminant colitis – severely ill with marked systemic upset, distended tender abdomen ± peritonism e.g. clinical picture of toxic mega colon. Diarrhoea may be absent.

Emergency surgery is required for patients with perforation and those who fail to respond to medical treatment. Urgent surgical referral should be considered in cases of severe or fulminant colitis.

Severity assessment

Mild disease: Three or fewer type 5-7 stools on Bristol Stool Chart per day and normal white cell count (WCC). May improve merely by stopping offending antibiotic.

Moderate Disease: Three to Five type 5-7 stool per day and a raised WCC <15,000.

Severe disease: WCC>15,000 or acute rising CRP hypotension or evidence of severe colitis (abdominal and radiological signs). The number of stools may be a less reliable indicator of severity.

SIGNS AND SYMPTOMS OF *Clostridiodes difficile* infection
Two or more episodes of loose stool in a 24- hour time period enough to take the shape of a container or Bristol stool chart types 5-7, not attributable to any other cause.

PATIENT RISK FACTORS FOR *CLOSTRIDIOIDES DIFFICILE* DISEASE
The risk factors associated with acquiring *C. difficile* are:
Age – incidence is much higher in those aged over 65 years
Underlying disease – those with chronic renal disease, underlying gastrointestinal conditions and oncology residents
Antibiotic therapy – those who are receiving or who have recently received antibiotic treatment (within 3 months), especially broad-spectrum antibiotics such as cephalosporins, e.g. cefuroxime, quinolones, such as, ciprofloxacin, co-amoxiclav or clindamycin. *C. difficile* has been associated with oral, intramuscular and intravenous routes of administration of antibiotics
Recent hospital stay – those who are frequently in hospital or who have had a lengthy stay in hospital
Other medication – those receiving anti-ulcer medications, including antacids and proton pump inhibitors (PPIs), e.g. omeprazole, which are used for treating reflux (heartburn and indigestion)
Nasogastric tubes – those undergoing treatments requiring nasogastric tubes

Colonisation with *C. difficile* – they are at greater risk of developing *C. difficile* infection (CDI)

SAMPLING AND DIAGNOSIS
Expert guidance on sampling has been issued: Department of Health (2012)
Updated DH/ARHAI guidance on the diagnosis and reporting of C. difficile
DH Title (publishing.service.gov.uk)

Patients presenting with watery diarrhoea should be assessed for indications of *C. difficile* disease. Normal bowel patterns and alternative causes of diarrhoea should also be considered. Cases may be identified where the bacteria is present as a colonising organism with diarrhoea from alternative causes.

If *C. difficile* disease is suspected a stool sample should be taken and sent to the microbiology laboratory. Only samples of Bristol Stool Grade 5-7 should be sent i.e. stools that take the shape of the container. The request should be for MC&S and *Clostridioides difficile* toxin. Samples contaminated with urine may be sent.

Diagnosis is usually made by detecting the presence of toxins using EIA. Secondary tests (GDH/NAAT/PCR) may also be undertaken.

TREATMENT
Produced with kind permission from *Clostridioides difficle* policy, Barnsley Hospital NHSFT

Treatment	**Antibiotic, dosage and course length**
First-line antibiotic for a first episode of mild, moderate or severe C. difficile infection	Vancomycin: 125 mg orally four times a day for 10 days
Second-line antibiotic for a first episode of mild, moderate or severe C. difficile infection if vancomycin is ineffective	Fidaxomicin: 200 mg orally twice a day for 10 day
C. difficile infection if first and second-line antibiotics are ineffective	Seek advice from microbiologist
Antibiotic for a further episode of C. difficile infection within 12 weeks of symptom resolution (relapse) Recurrent symptoms likely to develop in 15%-20% cases. This most commonly occurs 5 -20 days after primary illness but can occur up to 6 weeks later. Symptoms can be due to re-infection with a different strain of *C. difficile*.	Fidaxomicin: 200 mg orally twice a day for 10 days
Antibiotics for life-threatening C. difficile infection	Seek advice from microbiologist. May advise: Antibiotics that specialists may initially offer are: Vancomycin: 500 mg orally four times a day for 10 days With Metronidazole: 500 mg intravenously three times a day for 10 days

If Fidaxomicin is advised for the patient by the consultant microbiologist please refer to Amber with Guidance (Amber-G) = To be recommended or initiated by a specialist* with follow up prescribing and monitoring by primary care clinicians shared care guideline. Fidaxomicin Amber G Guideline Shared care guideline (barnsleyccg.nhs.uk)

Where diarrhoea is severe and frequent, particularly in the elderly patient, dehydration with electrolyte imbalance may follow. Supportive therapy and blood tests may be required.

Antimotility agents should not be prescribed and patients should be advised not to purchase these over the counter.

The use of PPIs should be reviewed and, if possible, discontinued. Surgical, gastroenterology and nutritional advice may be required.

Wherever possible antibiotics prescribed for other infections should be stopped. Advice may be sought from the Community Medicines Management or Microbiologist if required. Where continuing antibiotic therapy is required this should be assessed on a daily basis. In some cases, stopping antibiotic therapy may lead to cessation of diarrhoea symptoms within 48 hrs.

A flag should be placed on your information system so that you are aware of this result and information whenever the patient has consultation. Once the patient has recovered, follow up samples for clearance are not required.

Antibiotic use is the greatest risk factor for *C. difficile* infection, particularly use of the '4C antibiotics', broad-spectrum agents such as co-amoxiclav, cephalosporins, quinolones (including ciprofloxacin) and clindamycin.
The majority of cases occur in people aged 65 years and over but it can occur in any age group. Infection may manifest whilst on antibiotics, but a significant number of cases occur following cessation of therapy, the incubation period extending to several weeks. Symptoms may include fever, abdominal pain and diarrhoea (with/without blood or mucous.

There is a possibility that the patient could have a relapse of infection, this is generally within 8 weeks of the initial infection; or may suffer re-infection which could happen at any time, especially if antibiotics are given. Please avoid broad spectrum antibiotics. If re-infection occurs, please discuss management and treatment with the consultant microbiologist at Barnsley Hospital. However, some studies have suggested that some of these relapses are in fact re-infection due to the person re-infecting themselves from spores in their environment, hence the need for thorough cleaning and disinfection of the environment,

Future administration of broad-spectrum antibiotics could precipitate a reoccurrence of the infection. Please prescribe antibiotics with caution. If antibiotics are required, a short course of a narrow-spectrum agent is preferable.

Please click the link to access the NICE summary table Antimicrobial prescribing table (rcgp.org.uk)

The Expert Guidance for the Management National Institute for Health and Care Excellence (NICE) guideline on Clostridioides difficile infection (CDI). NICE summary table Antimicrobial prescribing table (rcgp.org.uk) for treatment of Clostridioides difficile infection.

PREVENTION OF SPREAD
Clostridioides difficile spores from diarrhoeal patients will contaminate the environment, equipment and the hands/clothing of healthcare workers. Therefore:

- Hand Hygiene is essential after all contact with the patient and their environment. **Spores are not reliably killed by alcohol gel therefore hands must be washed with soap and water.**
- Aprons should be worn as appropriate to protect clothing. This would include handling of patient's body fluids and contact with the environment.
- Gloves should be worn for contact with patient's body fluids or contaminated equipment. Hands must always be washed after removal of gloves.
- Medical/Nursing equipment having contact with the patient/environment should ideally be decontaminated with a chlorine releasing disinfectant (1,000 parts per million) are recommended for decontamination. (See Decontamination of Medical Equipment). Equipment returned to the Community Loan Store should be decontaminated according to the Loan Store instructions and the accompanying

return form should state this is done.

- Where patients with *C. difficile* disease are cared for in a care home setting, primary care staff should satisfy themselves that staff are familiar with processes designed to prevent cross-infection/contamination. This will include environmental cleaning regimes, isolation requirements and the need for dedicated toilet facilities whilst the patient is symptomatic. Home staff should be reminded of the importance of hand hygiene with liquid soap and water.
- If a patient with known or suspected *C. difficile* disease is transferred to another care setting it is essential that the receiving facility is informed of the diagnosis in advance of transfer. Ambulance transport staff must also be informed when the transport is arranged.
- Carers of patients at home with *C. difficile* infection should be taught to wash their hands with liquid soap and water after contact. The patient should also practice, with help as required, good hand hygiene. Enhanced environmental cleaning of frequent touch point areas (toilets, door handles, light switches) with diluted household bleach should be advocated.

  Once the patient has been asymptomatic for over 48 hours and passed a formed stool they are no longer deemed to be an infection risk

INVESTIGATION OF CASES

Cases of *Clostridiodes difficile* disease from all sources are reported through Public Health England Data Capture system (MESS) as required by DoH Mandatory Surveillance schemes.

Notes of patients diagnosed with *Clostridioides difficile* infection are reviewed as part of System based investigation by acute NHS Trusts and local SYICBs. This may involve requests to GPs for information and, to participate in the process. This activity assists in understanding causation and thus developing programmes to reduce the incidence of this disease. Further review may be required if a patient dies with *Clostridioides difficile* certified as a primary cause of death.

4.13 Multi drug resistant organisms within the community setting

The increase of MDRO within healthcare facilities is of great concern due to the risk of poor outcomes due to limited antimicrobial options and implications for safe placing of patients in health and social care facilities, when further care is required. Increasing spread of resistant organisms could possibly lead to a public health emergency. As patients are having reduced stays in acute care and may require long term care in the health and social care settings or support from Domiciliary care, it is advised that there is an understanding of the epidemiology of these MDRO and how they can be managed safely in the community. Contacts of a confirmed case may require screening. Please contact IPCT for further advice on screening. Further information on antimicrobial resistance can be found – Antimicrobial resistance (AMR) - GOV.UK

CARBAPENEMASE-PRODUCING ENTEROBACTERALES (CPE)

Enterobacterales is a group of bacteria that normally live in the gut of humans and animals. They include species such as *Escherichia coli*, *Klebsiella* spp. and *Enterobacter* spp. However, these organisms are also some of the most common causes of infections, including urinary tract infections, intra-abdominal and bloodstream infections. Carbapenems are necessary and effective antibiotics which are reserved to treat the most serious infections. Carbapenem's are enzymes (chemicals) made by some types of bacteria, which allow them to destroy carbapenem antibiotics and thus become resistant. This makes any infection caused by CPE difficult to treat.

Patients are more at risk of developing CPE if they have been admitted to a hospital abroad, received multiple courses of antibiotics or a hospital in UK which has a high incidence of CPE.

Early detection and screening are vital to reduce the risk of transmission to others. Please see link to UKHSA guidance and contact IPCT /UKHSA for further advice.

CANDIDA AURIS

Candida auris was identified in 2009 as a new strain of candida species that has been associated with infection and outbreaks in health care settings. It has been isolated from a range of body sites including skin and urogenital and respiratory tracts. It may result in invasive infections for example candidemia, pericarditis and pneumonia.

Candida auris has been predominately identified in high dependency areas. It appears highly transmissible between patients and contaminated environments

Candida auris demonstrates reduced sensitivities to the first line antifungal therapy, fluconazole, and variable susceptibility to other antifungal agents. Please seek further advice from Microbiology or clinical pharmacist.

Colonisation of patients has been reported from affected hospitals around the UK. Evidence supports that colonisation is difficult to eradicate and tends to persist, making infection prevention and control strategies particularly important, including after discharge from hospital.

GLYCOPEPTIDE RESISTANT ENTEROCOCCI. (GRE)

Most enterococcal infections are endogenous (patient's own flora) however, in recent years have been shown to cause healthcare associated infection (HCAI).

Resistance to glycopeptides such as vancomycin has emerged, particularly in *Enterococcus faecalis* and *Enterococcus faecium* mainly as a result of heavy use of glycopeptides for the treatment of MRSA, Coagulase negative staphylococcus and *Clostridium difficile* diarrhoea.

Glycopeptide-Resistant Enterococci (GRE) are resistant to glycopeptide antibiotics (vancomycin and teicoplanin). GRE are sometimes also referred to as VRE (Vancomycin – Resistant Enterococci. Resistance to glycopeptides reduces the treatment options for clinical infection.

Patients are more at risk of GRE if they have extended hospital stays, including admissions to critical care, prolonged treatments of antibiotics, contact with a colonised or infected person or and are immunocompromised

INFECTION CONTROL PRECAUTIONS

Patients with carriage of multi resistant organisms can be managed safely in the community, GP practices, and Primary care settings should consider if symptomatic, seeing the patient at the end of the allocated list.

In residential care, an asymptomatic, resident should not be required to isolate. Good standard Infection control precautions and strict environmental cleaning are required to reduce risk of transmission to others. Direct the resident away from any residents with open wounds or indwelling devices.

Uncontrolled faecal or Urinary incontinence increases the risk of transmission and a symptomatic resident should receive all cares in a dedicated en-suite room. If an en-suite room is not available, the individual should be placed in a single room with a designated commode with easy access to hand washing facilities. Please contact IPCT for further advice and support.

4.14 Occupational Safety: Prevention of exposure to blood borne viruses

INTRODUCTION

When there is a significant risk of transmission of a blood borne virus staff should understand what actions to undertake if an occupational exposure incident occurs. Training in relation to the management of a needle-stick injury or blood splash must be provided as a mandatory component of Health and Safety / Infection Control induction training and annual training updates.

Further information on significant exposure and Safety devices can be found here NHS England » Chapter 1: Standard infection control precautions (SICPs)

OCCUPATIONAL ACQUISITION OF BBVS

A number of factors are associated with an increased risk of occupationally acquired BBV infection:

- deep injury
- visible blood on the device which caused the injury
- injury with a needle which had been placed in an artery or vein
- high levels of circulating virus in the source – as in late stage AIDS or during sero-conversion in the early stages of infection

These factors will be taken into consideration when assessing the risk of BBV transmission following a sharps injury. Such an assessment will usually be undertaken by either the local Occupational Health provider or local ED / minor injury unit.

MANAGEMENT ARRANGEMENTS FOLLOWING OCCUPATIONAL EXPOSURE TO BBVS

It is essential that a risk assessment is undertaken at the earliest possible opportunity as delay in receiving prophylaxis (if required) could affect outcome i.e. the possibility of sero-conversion. This needs to be undertaken at the time of the injury NOT at the end of the

working day. Current guidance states that HIV prophylaxis should be commenced within one hour of the incident, but can still be given after that time (up to 72 hours post-injury). Risk assessment should be carried out by a qualified and competent health care professional. This is usually either an occupational health professional or staff at local ED or Minor Injury Unit. Local GPs may be assumed to provide this service (as health care professionals) but the registered provider must confirm that this is the case and document that arrangement (see next paragraph).

All registered care providers must have a comprehensive policy in place that details the precise process for staff to follow when sustaining a sharps injury / significant splash with potentially contaminated blood or blood-stained body fluids. The policy should clearly state how staff can access prompt professional risk assessment and treatment. All organisations must have either 24-hour access to an Occupational Health Service and / or a Service Level Agreement in place with a local NHS Trust if local provision of risk assessment and treatment is not available or is only available during working hours i.e. if no out-of-hours occupational health service is available.

For First Aid attending for risk assessment and reporting of an incident please see

Dealing with an exposure incident - Blood borne viruses (BBV)

For post exposure prophalysis

Guidance on management of potential exposure to blood-borne viruses in emergency workers

EAGA guidance on HIV post-exposure prophylaxis - GOV.UK

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APPENDIX A

CHECKLIST FOLLOWING SHARPS/SPLASH INJURY

To be completed by staff member who has sustained the sharps/splash injury and then taken to Emergency Department and/or Occupational Health.

Personal details	
Name:	Date of birth:
Post:	Place of work:
Telephone number: Home: Work:	Manager:
Date:	Time of accident/incident:

Details of the injury
Brief description of the incident. Is the patient known to have a BBV (please tick box if applicable)? **Sharps injury:** Needle/scalpel blade or other sharp instrument Scratch Bite Cut Bone Other **Skin exposure:** Abrasion Eczema Psoriasis Other **Exposure to mucous membrane** Eye Other
Which high risk body substance? Blood Blood stained body fluid Vaginal secretions Saliva (if visibly blood stained e.g. in association with dentistry) Other please specify ……

Local arrangements for risk assessment / management of injury
Occupational Health: During surgery hours please contact:
Accident and Emergency Department: Out of surgery hours please contact: Identify yourself as a Healthcare Worker who has sustained a sharps injury.

4.15 Management of infections in staff

INTRODUCTION

From time to time, health care staff may develop infections which could expose some service users and colleagues to the risk of infection.

Symptoms or signs of infection can appear trivial to staff who are usually fit and well, but can cause severe problems in vulnerable service users.

REPORTING

Early reporting and implementation of suitable control measures can prevent cross-infection and subsequent outbreaks of infection.

Confirmed or suspected transmissible infections in health care staff should be reported by the staff member to the Practice Manager or lead clinician. In addition, advice can be sought from the local IPC team Health protection team and Consultant Medical Microbiologist if there is concern regarding spread to other staff and/or service users.

TREATMENT

If necessary, treatment should only be undertaken by the Occupational Health provider (OH) or the individual's General Practitioner (GP), as appropriate.

EXCLUSION FROM WORK

The necessity for exclusion from work should be discussed with the lead clinician and in liaison with the UKHSA/ Consultant Medical Microbiologist / Environmental Health Officer (EHO) as necessary.

Staff with gastro-intestinal infections who handle or prepare food in the course of their work may be required to stay off work until their stool specimens are free of micro-organisms. Guidance must be sought from Occupational Health or the individual's GP who will make the decision regarding return to work after liaising with a medical microbiologist/CCDC where necessary.

Although not an exhaustive list, the following table summarises the risks to service users from staff with some infectious diseases

INFECTIOUS DISEASES AND ADVICE TO STAFF

INFECTION	SERVICE USER RISKS	ADVICE TO STAFF
BLOOD BORNE VIRUSES (BBV) including Hepatitis B Hepatitis C HIV	The risk of transmission of a blood borne virus from a HCW to a service user is extremely low. Not all staff will be aware of their possible infectious status therefore standard infection control practice should be applied at all times.	Staff should seek confidential advice from their GP or local clinician as soon as possible following diagnosis, or if concerned that they may have been exposed to a BBV. An assessment will be made regarding further clinical management, in consultation with the HPT If a staff member is diagnosed with a BBV some modification of working practices may be necessary in some situations.
INFECTED SKIN LESIONS or skin conditions, i.e. psoriasis, eczema, impetigo etc.	A bacterial infection is the usual cause which can then be spread to service users. Particularly vulnerable service users are those with open lesions, surgical or traumatic wounds, the immuno-compromised or elderly.	Staff suffering with these infections may be required to remain off duty until the infection has resolved unless it can be covered by an occlusive dressing. Antibiotics are often required.
CHICKEN POX (varicella)	Non-immune and immune-suppressed service users may require active protection e.g. immunisation and guidance should be sought from the service users GP immediately exposure is confirmed or suspected.	Non-immune health care staff, i.e. those who have not had the disease or vaccination, should seek immediate medical advice and may be medically suspended from clinical work from day 8-21 post- exposure. Non-immune pregnant staff (particularly < 20 weeks pregnant or in last 3 weeks of pregnancy) must discuss with their Obstetrician urgently. Immune-suppressed staff who have had contact with an infectious case must discuss their exposure with their clinician and / or Occupational Health provider immediately. Immunisation against varicella (chickenpox) is now widely available for non-immune individuals. See section – Vaccination Programme for Staff
COLD SORES and GENITAL HERPES INFECTIONS	Caused by the herpes simplex virus, which may expose some service users who are immuno- compromised, neonates and pregnant women to particular risks. Viral encephalitis may ensue in these susceptible service users.	Depending on working environment staff may need to remain off duty until resolution of symptoms and lesions are dry. Seek medical guidance. Do not touch lesions, wash hands thoroughly.

INFECTION	SERVICE USER RISKS	ADVICE TO STAFF
DIARRHOEA and/or VOMITING	These may be symptoms of food poisoning or viral infection, which can result in cross infection causing outbreaks. Viral outbreaks spread rapidly & vulnerable service users are at particular risk especially babies and the elderly.	Staff must remain off duty until 48 hours after resolution of the symptoms. Notify the Practice Manager / lead clinician if more than 2 staff affected.
Respiratory Viruses **INFLUENZA** **SARS-CoV2**	A viral infection which usually spreads to service users and other staff if prompt action is not taken. It can cause high morbidity and mortality rates, particularly in the elderly. Risk varies depending on a number of factors such as vaccination status, underlying co-morbidities, duration of exposure, immunological status	Staff should remain off duty until resolution of symptoms. Uptake of influenza vaccine is recommended for both care workers and vulnerable service users. Follow current government guidance https://www.gov.uk/coronavirus
MEASLES, MUMPS and RUBELLA	Cases are highly infectious.	Non-immune staff must inform Practice Manager / lead clinician of exposure to an infectious source. Non-immune pregnant staff, i.e. those who have no history of disease and/or no positive antibody test must seek medical guidance especially in the first trimester of pregnancy.
SARS-CoV2	Risk varies depending on a number of factors such as vaccination status, underlying co-morbidities, duration of exposure, immunological status	Follow current government guidance https://www.gov.uk/coronavirus

INFECTION	SERVICE USER RISKS	ADVICE TO STAFF
SCABIES	Staff may be infected by skin to skin contact with service users. Scabies is often difficult to diagnose in the elderly. Service users remain contagious until 24hrs post-treatment. If > 1 service user affected, treatment will need to be undertaken simultaneously.	Staff contacts of infested service users may require treatment but this is unlikely to occur in General Practice. If staff member is affected, family contacts will also require treatment. Contact IPC/HPT for further guidance. .
SORE THROATS	These may have many causes but are usually viral. Bacterial causes e.g. streptococcal infections can cause severe infections in vulnerable service users. simultaneously.	Staff should remain off duty until resolution of symptoms, if unwell and with a severe sore throat associated with pyrexia. Notify the Practice Manager / lead clinician if more than one member of staff is affected.
TUBERCULOSIS	Physical isolation is only required for those who are pulmonary smear positive for AFBs (acid fast bacilli). Isolation should continue until at least 14 days after commencing appropriate anti- tuberculosis therapy and/or until advised by TB specialist/team.	The necessity for exclusion of diagnosed staff members from work will require discussion by the lead clinician in conjunction with the TB specialist team. Contacts will be investigated by the TB nurse specialist and HPT
PARVOVIRUS (FIFTH DISEASE)	Mild, non-febrile viral disease characterized by erythema of cheeks. Most infectious prior to development of rash but not infectious thereafter.	Can cause foetal abnormality. Pregnant staff less than 20 weeks pregnant should seek advice from their obstetrician.

5 DEFINITIONS OF TERMINOLOGY

Asepsis-is recognised as the state of being free from pathogenic microorganisms

Aseptic technique- is defined as a means of preventing or minimising the risk of introducing harmful micro-organisms into sterile/key sites of the body when undertaking clinical procedures

Aseptic Non-Touch Technique (ANTT) is a specific type of aseptic technique. The overriding principle is that key sites e.g. wound, must not come into contact with any item (hand, equipment, solution) that is not sterile. Sterile gloves are not always required for standard ANTT. Each procedure must be risk assessed. Whether sterile or non-sterile gloves are worn depends if you can avoid touching the sterile parts of equipment which will come into contact with the service users' susceptible areas e.g. their wound

Clostridioides difficile **Infection (CDI) –**Anaerobic, gram positive spore forming bacillus. Theses spores are resistant to exposure to air, drying, heat and survive in the environment. Following antibiotic therapy, the intestinal flora is altered which allows any *C. difficile* bacteria to proliferate. The bacteria produce 2 toxins:

Cross infection –The transmission of disease from one person to another because of a breach in barrier.

Decontamination-The process used to remove organic matter and micro-organisms from an item and render it safe for use. There are three levels of decontamination: cleaning, disinfection and sterilisation.

Hand decontamination-The physical removal of blood, body fluids and transient micro-organisms from the hands e.g. hand washing.

Hand Hygiene-A general term that applies to either: hand washing, antiseptic handwash, antiseptic hand rub or surgical antisepsis

Healthcare Associated Infection (HCAI) - Infections that occur as a result of contact with the healthcare system in its widest sense-in community and hospital settings

Health Protection Teams (HPT) – provide specialist public health advice and operational support to NHS, local authorities and other agencies

Healthcare Worker- Any person employed by the health service, social services authority or agency to provide care for sick, disabled or elderly people.

Infection Prevention and Control (IPC) –To reduce to an acceptable minimum the risk of the acquisition of an infection amongst service users, healthcare workers and any others in the healthcare environment.

Infection Prevention and Control Team (IPCT) - A specialist team employed by the organisation to provide expert reactive and proactive information and advice about the management of healthcare associated infections and incidents.

Meticillin Resistant *Staphylococcus aureus* (MRSA) - is a variant of *Staphylococcus aureus* which has developed resistance to commonly used antibiotics and is considered endemic in both hospitals and the community setting and may be more difficult to treat because of limited treatment options.

Personal Protective Equipment (PPE) - All equipment which is intended to be worn or held by a person to protect them from risks to health and safety whilst at work.
Examples of PPE include gloves, aprons and eye and face protection.

Resident Organisms - Micro-organisms that colonise the deeper crevices of the skin and hair follicles as they have adapted to the hostile environment. They are not readily transferred to other people or objects and are not easily removed by the mechanical actions of soap and water, but can be reduced in number with the use of an antiseptic solution.

Risk Assessment – Making a suitable and sufficient assessment of risks-this will involve identifying the hazards (something with the potential to do harm) and evaluating the extent of risks (the likelihood that the harm from a particular hazard is realised) and identifying measures needed to comply with legal requirements.

Sharps injury/ Incident - When intact skin is breached by a sharp object (needle instrument, or bone) This also includes human bites and scratches that break the skin.

Transient Organisms - Micro-organisms acquired on the skin through contact with surfaces. The hostile environment of the skin means that they can usually only survive for a short time, but they are readily transferred to other surfaces touched. They can be removed by washing with soap and water or inactivated by alcohol hand rub.

UKHSA (The **UK Health Security Agency**) is a government agency in the United Kingdom, responsible since April 2021 for UK-wide public health protection and infectious disease capability, and replacing Public Health England. It is an executive agency of the Department of Health and Social Care (DHSC).

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7 DOCUMENT CONTROL

DOCUMENT CONTROL

Version No	Type of Change	Date	Description of change
V1	New Policy	December 2015	
V1.1	3-year review	February 2020	Comprehensive rewrite to clarify purpose and scope of the policy and consider the following: • General Data Protection Regulations 2016 and: • The CCG's Policy on Policies issues in September 2017
V2	2-year review	June 2022	Minor changes to content. Not affecting policy. Addition of links to government websites. Updating of references. Removal of Antibiotic Prescribing Policy. Addition of information regarding risk assessing placement of alcohol-based hand rubs in public areas. Removal of vaccine management guidelines. Inclusion of advice relating to SARS-CoV2
V3	2-year review	Jan 2025	Restructure of the document including change in structure of organisations from CCG to ICBS. Main body of document streamlined with added links to other guidance including National IPC manual for England.