# Standard Infection Control Procedures and Policy
(including Hand Hygiene)

<table>
<thead>
<tr>
<th>Post holder responsible for Procedural Document</th>
<th>Judy Potter, Lead Nurse for Infection Prevention &amp; Control</th>
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<tbody>
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<td>Division/ Department responsible for Procedural Document</td>
<td>Specialist Services, Infection Prevention &amp; Control</td>
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<td>Contact details</td>
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<tr>
<th>Monitoring Information</th>
<th>Strategic Directions – Key Milestones</th>
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<td>Patient Experience</td>
<td>Maintain Operational Service Delivery</td>
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<td>Assurance Framework</td>
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<td>Monitor/Finance/Performance</td>
<td>Develop Acute services</td>
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<td>CQC Fundamental Standards - Regulation: 8</td>
<td>Infection Control                                         ✓</td>
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**Note:** This document has been assessed for any equality, diversity or human rights implications

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**Controlled document**

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### Full History

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<th>Version</th>
<th>Date</th>
<th>Author (Title not name)</th>
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<tr>
<td>1.0</td>
<td>1997</td>
<td>Lead Nurse</td>
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<td>Routine Revision</td>
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<tr>
<td>8.0</td>
<td>Nov 2016</td>
<td>Lead Nurse</td>
<td>Amalgamation of two previous documents, namely Hand Hygiene Policy and Standard Infection Control Procedures and harmonised with community services requirements</td>
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### Associated Trust Policies/ procedural documents:

- Cleaning Policy
- Clinical Guideline for Aseptic Technique
- Decontamination Policy & Procedures
- Inoculation Injury Policy
- Linen Policy
- Source Isolation Policy
- Uniform and Workwear Policy
- Waste Management Policy

### In consultation with and date:

- Infection Control Operational Group: 14th November 2016
- Community Professional Leads, Senior Nurses and Matrons: 19th December 2016
- Infection Control & Decontamination Operational Group: 24th January 2017
- Policy Expert Panel: 1st February 2017

### Contact for Review:

- Lead Nurse/Director of Infection Prevention & Control

### Executive Lead Signature:

*Medical Director*
1. INTRODUCTION

1.1 Standard infection control procedures underpin safe practice, reducing the risk to staff and patients from healthcare related infections (Loveday et al. 2014). Since examination and medical history alone cannot reliably identify all patients colonised or infected with transmissible pathogens standard infection control procedures represent the standard of care to be used routinely for all patients regardless of perceived or known infection risk factors.

1.2 Effective hand hygiene is a critical component of standard infection control procedures and when used as part of a bundle of measures, correctly implemented, will minimise the spread of infectious organisms and reduce healthcare acquired infection.

1.3 For standard precautions to be effective, high levels of compliance must be achieved by all healthcare staff involved in patient care. Experience shows that achieving high levels of appropriate hand hygiene compliance, in particular, can be difficult. Continuous commitment is required throughout the Royal Devon and Exeter NHS Foundation Trust (hereafter referred to as the Trust), championed by senior management and by clinicians at Board level and in each division.

1.4 Failure to comply with this policy could result in disciplinary action.

2. PURPOSE

2.1 To demonstrate that the Trust has a strong commitment to effective implementation of standard infection control procedures, including hand hygiene

2.2 To identify clear responsibilities from ward to board to enable the application of standard infection control procedures as a routine part of clinical practice as outlined in Criterion 9 of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection (DH, 2015)

2.3 To provide a framework through which a high level of hand hygiene compliance is achieved (minimum of 85% using a validated observational audit tool).

2.4 To ensure that a minimum of 90% of relevant staff undertake annual update training

3. DEFINITIONS

3.1 Standard infection control precautions/procedures - A minimum standard of care applied to all patients regardless of perceived or known infection risk factors.

3.2 Hand hygiene – Removal or destruction of microorganisms on the hands. It includes; hand washing with soap and water, hand disinfection using alcohol hand rub and surgical hand antisepsis with an approved antiseptic product.

3.3 Personal Protective Equipment - any equipment used to reduce the risk of the wearer or patient from acquiring a health care associated infection

3.4 A ‘sharp’ is any object, which can puncture the skin. Examples include: hypodermic needles, suture needles, scalpels blades, pieces of bone, teeth splinters, glass ampoules, and pathological specimens.
3.5 **Inoculation injury** – When one person is exposed to the blood or body fluid of another person. This includes:

- penetrating injuries from a sharp object contaminated with blood/body fluid
- contamination of a broken skin surface (e.g. cuts, grazes)
- splashes into the mouth or eyes

4. **DUTIES AND RESPONSIBILITIES OF STAFF**

4.1 The **Board of Directors** are responsible for supporting and encouraging compliance with policy through delegation to the Joint Directors of Infection Prevention and Control.

4.2 On behalf of the Board of Directors, the **Joint Directors for Infection Prevention and Control** are responsible for ensuring that processes are in place for:

4.2.1 Embedding routine hand hygiene as an integral part of Trust ‘culture’, i.e. something that is expected of all staff who work within the Trust as a matter of clinical governance.

4.2.2 Regarding lapses in standard infection control procedures as a serious clinical issue.

4.2.3 Supporting mandatory hand hygiene and infection control education at induction for all staff and appropriate updates for staff involved in direct patient contact.

4.2.4 Ensuring all new Trust employees are provided with written information on hand hygiene and other standard infection control procedures on employment.

4.2.5 Ensuring all necessary facilities and products are provided throughout the Trust, e.g. suitable hand wash basins, soaps, quality paper towels and conveniently sited alcohol hand gel, personal protective equipment and safer sharps devices.

4.2.6 Involving the Infection Prevention and Control Team in the planning process for new construction and refurbishment work so that advice can be given on appropriate facilities to support hand hygiene and other standard infection control procedures as emphasised by Health Building Note 00-09: Infection control in the built environment, and the Health and Social Care Act 2008- Code of Practice updated 2015.

4.3 **Divisional Management Teams** are responsible for:

4.3.1 Actively encouraging compliance with the Policy by all staff groups as outlined below.

4.3.2 Senior clinical staff, e.g. Consultants and Matrons within each division must act as ‘role models’ of good hand hygiene practice and encourage better compliance by example.

4.3.3 Cluster managers will be responsible for ensuring that all relevant staff, including junior medical staff, undertake and complete infection control training and annual updates as per ESR.

4.3.4 Ensuring that the facilities and equipment required are in place so that staff have convenient access.
4.4 **The Occupational Health Department** is responsible for:
Advising staff who develop allergy or intolerance to specific hand hygiene products or personal protective equipment on the alternatives available, in cooperation with the infection prevention and control department.

4.5 **Infection Prevention and Control Team (IPCT)** are responsible for:

4.5.1 Promoting hand hygiene and other standard infection control procedures as a routine part of practice in all staff but particularly for those involved in delivering direct patient care.

4.5.2 Advising the Trust on current best practice.

4.5.3 Advising the Trust on current best practice in planning construction or refurbishment work to ensure compliance with hand hygiene and other standard infection control procedures.

4.5.4 Planning and facilitating delivery of a programme of infection control education to be included in:
- All induction sessions
- A programme of regular updates.
- On other occasions both formal and informal
- Link Nurse Programmes

4.5.5 Monitoring compliance with the policy through infection control audit and routine observation of practice.

4.5.6 Supporting the divisions in delivering hand hygiene audit by developing a system of ward/department specific audits carried out by link nurses at monthly intervals throughout the year. The IPCT will assist with audit design, collation of results and feedback to wards/departments.

4.5.7 Presenting audit results to the Infection Control and Decontamination Assurance Group and included in the Director of Infection Prevention & Control’s Annual Report.

4.5.8 Providing results of hand hygiene audits for inclusion in the ward to board reports.

4.5.9 Ensuring the implementation of effective national campaigns and innovations, e.g. **WHO five moments for hand hygiene**.

4.5.10 Promoting patient empowerment in respect to hand hygiene practice through appropriate forums, and other media.

4.6 **Individual employees are responsible for:**
Complying with best practice in the prevention of infection and following this policy and associated procedures, including hand hygiene.
4.7 **Infection Control and Decontamination Assurance Group (ICDAG)** is responsible for:

4.7.1 Ratifying the policy and procedures.

4.7.2 Using hand hygiene audit data to review performance and identify areas for improvement.

4.7.3 Escalating issues or concerns to the Health and Safety Committee.

4.7.4 Reviewing the policy every three years and making any necessary revisions in light of national evidence-based guidance.

5. **TRAINING**

5.1 All staff working within the Trust must be trained in standard infection control procedures including hand hygiene. This will be delivered to all staff and volunteers, both clinical and non-clinical as part of induction training in accordance with the [Corporate and Local Induction Policy](#).

5.2 All staff who have direct or indirect contact with patients and/or blood and other body fluids will must receive regular updates in accordance with the [Employee Training, Education and Development Policy](#).

5.3 Attendance at infection control training will be monitored through the Infection Control and Decontamination Assurance Group and/or Safety and Risk Committee as applicable.

5.4 Divisional Infection Control Leads and Heads of Department in the Facilities, Diagnostics and Professional Services Clusters are responsible for reporting attendance rates to the group and are also responsible for ensuring that any staff who fail to attend training are contacted and alternative training dates planned.

5.5 **Training Needs Analysis (TNA)**

Staff requiring training will have their ESR records mapped to the appropriate e-learning.

6. **STANDARD INFECTION CONTROL PROCEDURES**

Standard infection control procedures include:

- Effective hand hygiene procedures (Refer [Appendix 1 ‘Hand Hygiene’](#))
- Maintenance of skin integrity and protection of open wounds/skin lesions (Refer [Appendix 1 ‘Skincare’](#))
- Use of appropriate personal protective equipment (Refer [Appendix 2 ‘PPE’](#))
- Avoidance of inoculation injury through safe use and disposal of sharps (Refer [Appendix 3 ‘Sharps’](#))
- Aseptic technique (Refer [Clinical Guideline for Aseptic Technique](#))
- Appropriate decontamination of instruments and equipment, including safe management of blood spillage (Refer [Decontamination Policy and procedures](#))
- Maintaining a clean hospital environment (Refer [Cleaning Policy, Source Isolation Policy](#) and [Decontamination Policy and procedures](#)).
- Safe disposal of waste (Refer [Waste Management Policy](#))
• Safe handling and laundering of used linen (Refer Linen Policy)

6.2 Standard procedures form the basis for safe care but may need to be supplemented with transmission based precautions as described in the Source Isolation Policy when a known or suspected transmissible infection risk exists.

7. ARCHIVING ARRANGEMENTS
The original of this procedure will remain with the Lead Nurse/Director for Infection Prevention and Control. An electronic copy will be maintained on the Trust Intranet (A-Z), P – Policies – S – Standard. Archived copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy, where one exists, will be held for 10 years.

8. PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE PROCEDURES

8.1 In order to monitor compliance with this policy, the auditable standards will be monitored as follows:

<table>
<thead>
<tr>
<th>No</th>
<th>Minimum Requirements</th>
<th>Evidenced by</th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Compliance with this policy and procedures will be monitored by the Infection Prevention and Control Team when they make routine visits to clinical areas. Any lapses in compliance will be raised with the nurse in charge of the ward/unit or the Matron who will be expected to rectify.</td>
<td>Datix reports</td>
</tr>
<tr>
<td>2.</td>
<td>Sharps will be disposed into approved sharps containers</td>
<td>Waste audits, Datix reports</td>
</tr>
<tr>
<td>3.</td>
<td>Trust wide hand hygiene compliance of 85% will be the minimum standard</td>
<td>Infection Control dashboard</td>
</tr>
<tr>
<td>4.</td>
<td>Trustwide training attendance will be 90% of relevant staff</td>
<td>Infection Control Operational Group Minutes</td>
</tr>
</tbody>
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8.2 Frequency
In each financial year, the Lead Nurse/Director of Infection Prevention and Control will ensure that results of the auditable standards are included in the annual report of the Joint Directors of Infection Control which is presented to the Board of Directors.

8.3 Undertaken by
Lead Nurse/Director of Infection Prevention and Control

8.4 Dissemination of Results
Results from reporting will be discussed at Infection Control and Decontamination Assurance group meetings, through Divisional Governance Group meetings and escalated to the Infection Control and Decontamination Assurance Group if compliance with the minimum standards not achieved.
8.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Infection Control and Decontamination Assurance Group, which meets quarterly.

8.6 Any barriers to implementation will be risk-assessed and added to the risk register.

8.7 Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system. Compliance with these procedures will be monitored by the Infection Prevention and Control Team when they make routine visits to clinical areas. Any lapses in compliance will be raised with the nurse in charge of the ward/unit or the Matron who will be expected to rectify.

9. **REFERENCES**


APPENDIX 1: HAND HYGIENE PROCEDURES

1. BACKGROUND INFORMATION

1.1 Microbes on the hands can be classified as either transient or resident.

- **Transient micro-organisms** are found on the surface of the skin. Direct contact with other people or equipment can result in the transfer of 'transients' to or from the hands with ease. As such they are an important cause of cross infection. However, they are also easily removed by routine hand hygiene practice.

- **Resident micro-organisms** are more deeply seated in the epidermis. As a result they are difficult to remove and are not usually implicated in cross infection. However, during surgery and other major invasive procedures they may enter deep tissues and cause infection. Thus there is a need for more extensive hand hygiene prior to such procedures (4.5.2 refers).

2. WHEN TO DECONTAMINATE HANDS

2.1 Hands must be decontaminated in accordance with the World Health Organisation (WHO) ‘5 Moments for hand hygiene’ (see Figure 1)

2.2 The dotted line in figure 1 identifies the concept of the ‘patient zone’ as opposed to the area out with which is referred to as the health care environment. The ‘patient zone’ will be contaminated with many of the same microbes that are shed by the patient. The healthcare environment is contaminated with a wider range of microbes but is non-specific to any individual person. The 5 moments reduces transmission of microbes within the patient zone and aims to prevent it between the patient zone and the wider environment.

![WHO 5 moments for hand hygiene](Diagram)

2.3 There are other occasions when you must wash your hands and these include:

- Before handling or serving food
- After going to the toilet
- After handling specimens
- After handling waste, used laundry or contaminated equipment

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Standard Infection Control Procedures and Policy (Including Hand Hygiene)
Ratified by: Infection Control & Decontamination Assurance Group: 24th January 2017
Review date: June 2021
3. LEVELS AND METHODS OF HAND HYGIENE

3.1 Routine Hand Hygiene:

Hand washing with soap and water will remove transient micro-organisms and visible dirt/soiling. Liquid soap and running water is required for this level of hand hygiene. Bar soap is not permitted for staff handwashing in health care premises.

**Method**

Wet hands thoroughly under running water
Apply liquid soap for 10-15 seconds using an effective technique (Refer Fig 1a).
Rinse thoroughly under running water.
Dry thoroughly with paper towels.

3.1.1 Use of alcohol hand rub

Generally, alcohol hand rub is an effective alternative to routine handwashing if the hands are visibly clean. It is useful when soap and water are not readily available/pragmatic. It facilitates timely hand hygiene and must be available either in dispensers at the point of care or carried by staff.

**Method**

Apply enough alcohol hand rub to thoroughly cover your hands, using the technique outlined in Figure 1b, rub hands together briskly until dry.

3.1.2 For any patient suffering from Diarrhoea and/or Vomiting, soap and water should be used to perform hand hygiene. This is because some of the causative organisms are resistant to alcohol gel e.g. *Clostridium difficile*.

**Method**

Apply enough alcohol hand rub to thoroughly cover your hands, using the technique outlined in Figure 1b, rub hands together briskly until dry.
HAND CLEANING TECHNIQUES
How to handwash?
WITH SOAP AND WATER

1. Wet hands with water
2. Rub backs of palms
3. Rub back of each hand with the palm of the other hand with fingers interlaced
4. Swivel hand to expose all sides of both hands
5. Rub palm of one hand with fingers of the other hand
6. Rub each hand with soap and scrub
7. Rub tops of fingers in a spiral motion
8. Rub each wrist with soap and scrub
9. Rinse hands
10. Turn off taps
11. Dry hands with paper towel
12. Use air dryer

Figure 1a

HAND CLEANING TECHNIQUES
How to handrub?
WITH ALCOHOL HANDRUB

1a. Apply a small amount of liquid or a sufficient volume of alcohol rub
1b. Rub palms against fingers
2. Rub hands palm to palm
3. Rub back of each hand with the palm of the other hand with fingers interlaced
4. Swivel hands to expose all sides of both hands
5. Rub palm of one hand with fingers of the other hand
6. Rub each thumb in the opposite hand using a rotational movement
7. Rub top of fingers and tips of fingers in a spiral motion
8. Rub each wrist with the opposite hand
9. Dry hands and remove excess

Figure 1b
3.2 Surgical Hand Hygiene

3.2.1 Surgical Hand washing (also described a surgical scrub)

Pre-operative surgical hand washing will remove or destroy transient micro-organisms and significantly reduce detachable resident micro-organisms. Antiseptic detergent solutions are required for this level of hand hygiene eg povidone iodine detergent or 4% chlorhexidine detergent Refer to Theatre Guidelines section 4.

3.2.2 Use of alcohol hand rub/gel

This method can be used between cases if the hands are visibly clean. A surgical hand wash must be undertaken at start of list. The alcohol hand rub/gel used must be suitable for preoperative hand disinfection - check manufacturers recommendations

Method
Two separate applications of suitable alcohol hand rub must be rubbed into hands and forearms until dry in accordance with the conditions outlined in 3.2.1

4. OTHER ASPECTS OF HAND HYGIENE FOR STAFF WHO HAVE DIRECT PATIENT CONTACT

4.1 Finger Nails

4.1.1 Finger nails must be kept clean and short ie not visible beyond the finger tip, when viewed from the palm side. Nail varnish and false finger nails/tips must not be worn.

4.2 Jewellery

4.2.1 Staff must remove rings (other than a plain band), bracelets and wristwatches prior to clinical patient contact to facilitate effective hand washing. Staff who have on-going clinical contact e.g. doctors, nurses, physiotherapists should remove such jewellery at the start of their shift as it is impractical to do this prior to every patient contact.

4.2.2 Although a plain band ring is permitted during most clinical practice it is preferable to remove it for surgical procedures.

4.3 Skin Care

4.3.1 Bacterial counts increase when the skin is damaged therefore care must be taken to maintain skin integrity:-

- Always wet hands thoroughly prior to application of liquid soap or antiseptic detergent.
- Rinse hands thoroughly to remove soap or antiseptic detergent.
- Dry hands carefully.
- Apply good quality non ionic hand cream at the end of a shift (avoid communal pots of hand cream).
- Always cleanse hands after removing gloves.
4.3.2 Any staff who develop eczema, dermatitis or any other skin condition must seek advice from the Occupational Health Department as soon as possible.

- Any member of staff unable to use the recommended hand cleansing agents due to a skin condition/allergy must seek advice from the Occupational Health Department.
- Cuts and abrasions must be covered with a waterproof dressing.

5. **HAND HYGIENE AWARENESS FOR PATIENTS AND HOSPITAL VISITORS**

5.1 Hand cleansing wipes can be obtained from NHS Supply Chain and must be offered to patients who are unable to access hand washing facilities.

5.2 Patients will be encouraged to clean their hands after using the toilet and prior to eating meals. For patients who are not independent hand wipes or bowls of water and soap will be provided.

5.3 Visitors are invited to use the hand gel located in the bed space area, if they wish.

5.4 Visitors who are involved in providing care to a patient should be advised on appropriate hand hygiene techniques by the clinical staff.

6. **COMPLIANCE**

6.1 Hands are the principle route by which cross infection occurs in health care settings. Hand hygiene is, therefore, the single most important means of reducing the spread of infection. All healthcare workers are required to comply with these procedures.

6.2 Compliance will be encouraged by:

- Ensuring easy access to appropriate hand hygiene products at the point of care.
- Increasing awareness of the importance of hand hygiene amongst healthcare workers using multiple strategies including; training (upon induction, in clinical areas and annual updates), posters and positive role modelling.
- Ensuring that uniforms and other clothing worn for direct contact with patients or the clinical environment allow the arm to be bare below the elbow.
- Providing information for patients about the importance of hand hygiene.
- Inviting patients to prompt staff to clean their hands if they think they have forgotten.

6.2.2 Compliance will be monitored through regular audit of hand hygiene practice in clinical areas using a validated Hand Hygiene Audit tool. Observational audits must be undertaken by the link nurse or other trained auditor.

- Feedback to individual staff can be provided by the auditor whilst collective feedback will be delivered to the ward/department through the ‘spotlight posters’ displayed in the clinical area. Monthly compliance rates will be included as a run chart on ‘ward to board’ reports. The target compliance rate will be reviewed by the Infection Control and Decontamination Assurance Group when the Hand Hygiene Policy is reviewed.
• Feedback to staff will be provided at the end of the observation audit by the auditor and the result entered on the ward/dept ‘Spotlight’ poster. This will highlight good practice and aid communication where actions are required.

6.2.3 In care settings where observational audit described above is not appropriate such as community nursing and outpatient settings feedback from patients will be sought on hand hygiene practice before and after examination. Managers of areas who wish to use this method must seek the approval of the Infection Prevention and Control Team.

6.2.4 Results of audits and patient feedback will be included in Ward to Board Reports and on the Infection Control Performance Dashboard and reviewed quarterly.
APPENDIX 2: PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. SELECTION OF PPE

1.1 Selection of appropriate protective clothing should follow a risk assessment of the procedure to be performed. Figure 2 identifies the types of PPE available for clinical and support staff. The following factors should be considered:

- The risk of contamination of health care workers clothing and skin
- The risk of transmission to the patient
- In addition, in relation to gloves, patient/user latex allergy must be considered.

1.2 The use of protective clothing does not negate the need to wear a freshly laundered uniform/clothing for each shift. Furthermore, uniforms/clothing must be changed if contaminated during the course of a shift.

Figure 2 – Types of PPE, purpose and use

<table>
<thead>
<tr>
<th>ITEM OF PPE</th>
<th>PURPOSE/USE</th>
<th>COMMENTS</th>
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<tbody>
<tr>
<td>GLOVES</td>
<td></td>
<td>Gloves do not replace the need for hand hygiene.</td>
</tr>
<tr>
<td>Sterile, surgeons gloves</td>
<td>Surgery and other major invasive procedures where comfort, dexterity and sensitivity is required.</td>
<td>Double gloving is recommended for orthopaedic and breast implant surgery. The Expert Advisory Group on AIDS and HIV also recommends double gloving as a method of reducing percutaneous exposure during surgical procedures on patients with blood borne pathogens.</td>
</tr>
<tr>
<td>Sterile, examination gloves</td>
<td>Non surgical aseptic procedures</td>
<td></td>
</tr>
<tr>
<td>Non sterile, vinyl examination gloves</td>
<td>Non sterile procedures with potential exposure to blood/blood stained body fluids Non sterile procedures involving used sharps Handling disinfectants (excluding aldehydes)</td>
<td>Gloves must be manufactured to BS EN 455</td>
</tr>
<tr>
<td>Non sterile, nitrile examination gloves</td>
<td>Handling cytotoxic material An alternative to vinyl gloves when vinyl deemed unsuitable by Occupational Health Handling aldehydes</td>
<td></td>
</tr>
</tbody>
</table>
| **Rubber household gloves** | - For domestic and ancillary staff for cleaning duties.  
  - For unavoidable manual cleaning of surgical instruments | Reusable. Gloves should be washed in detergent and warm water after use |
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<tbody>
<tr>
<td><strong>PLASTIC APRONS (Short Sleeved)</strong></td>
<td>- Offers protection to/from clothing at site of greatest exposure/contact during routine patient care activities</td>
<td>Must be changed between clean and dirty tasks</td>
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<tr>
<td><strong>PLASTIC APRONS (Long Sleeved)</strong></td>
<td>- Offers an enhanced level of protection.</td>
<td>Cheaper than a gown but less comfortable for prolonged periods of wear.</td>
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</tbody>
</table>
| **EYE PROTECTION**  
  Glasses, goggles, visors | - To protect eyes from aerosol or splash contamination of body fluids eg from surgery, endoscopy, suctioning | |
| **GOWNS**  
  Waterproof or water repellent, sterile or non sterile | - Offers protection to clothing and skin during procedures where there is the potential for gross exposure to blood and other body fluids.  
  - Reduces skin scale dispersal from the wearer thus reducing risk of infection for the patient during invasive procedures.  
  - Offers greater protection (than aprons) to staff during the care of certain infectious conditions eg Norwegian Scabies | Use mainly restricted to:  
  Theatres  
  Endoscopy units  
  Delivery suite  
  Aseptic drug preparation units  
  Infectious diseases ward  
  Sterile gowns must be used for sterile procedures. |
| **MASKS**  
  Surgical Masks | - Limited reduction of transmission of microorganisms expelled from the mouth and nose of the wearer.  
  - Protects the wearer from blood and other body fluid splashes/aerosols to the lower face and mouth eg surgery, endoscopy, suctioning. | If masks are worn they must cover the nose and mouth  
  Do not handle the mask whilst in place.  
  To remove mask, wash hands, handle mask by tapes only and then wash hands. |
| **Filtering Face Piece respirators (FFP3)** | - Protection against *Mycobacterium tuberculosis* and other infections transmitted by droplet nuclei. | Staff must be fit tested to ensure the brand of mask used is effective. If it is not, alternatives must be provided. |
| **FOOTWEAR**  
  Rubber boots | - Protects feet from body fluids. | Use indicated in:  
  Theatres where blood or body fluid spill likely to be profuse. |
| Overshoes | - Use not recommended. | |

*Standard Infection Control Procedures and Policy (Including Hand Hygiene)*  
Ratified by: Infection Control & Decontamination Assurance Group: 24th January 2017  
Review date: June 2021
APPENDIX 3: SAFE HANDLING AND DISPOSAL OF SHARPS

1. MINIMISING THE RISK OF SHARPS INJURY

1.1 The risk of sharps injury can be minimised through the use of sharps that incorporate features or mechanisms to prevent or minimise the risk of accidental injury, safe handling and correct disposal procedures.

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

1.3 Use safer sharps devices when there is clear indication that they will provide safer systems of work and not compromise patient care (HSE, 2013).

Avoid re-sheathing used (i.e. those that have been used to administer medication to a patient or draw blood or other body fluids) needles. If re-sheathing is unavoidable use a re-sheathing device or one handed technique.

1.4 Discard needle and syringe as one unit, whenever possible. If disassembly is necessary it must not be done by hand but with the mechanism provided on the sharps bin.

1.5 Dispose of sharps into a sharps container (conforming to UN3291 & BS7320) immediately after use.

1.6 Sharps bins must be easily accessible to staff but at the same time must not be a hazard to patients or visitors. Sharps bins must be placed out of easy reach of unauthorised persons, especially children.

1.7 A sharps bin must be taken to the point of use. Never carry used sharps to a sharps bin.

1.8 Ensure sharps bins are correctly assembled, according to manufacturer's instructions, before use.

1.9 Avoid passing used sharps from person to person by hand eg from surgeon to scrub practitioner - use a receiver.

1.10 Sharps disposal devices, such as adhesive pads, must be available in areas such as theatres.

1.11 Use a vacuum aspiration system for venepuncture whenever possible.

1.12 If using syringe and needle for venepuncture never fill blood tubes using the needle. Remove used needles using the needle removing device on the sharps bin. Unscrew tops of bottles to fill.

1.13 Never overfill sharps bins. When 3/4 full sharps bins must be properly closed and sealed. Do not place bin in a yellow bag.

1.14 Sharps bins must be labelled with the source department/unit and the date of assembly/disposal.

1.15 Staff moving sharps bins must check that the seal remains closed during and after transportation.

1.16 Always carry sharps containers by the handle (where present) and away from the body.
2. **Procedure following Inoculation Injury**

2.1 Exposure to blood or body fluid, from a sharps injury, bite or from splashing into the eyes, mouth or broken skin must be reported and followed up because of the risk of infection with blood borne viruses.

2.2 If you sustain an inoculation injury, the risk of infection is likely to be very low. However, it is important to report it immediately so that appropriate action can be taken. (Refer section 6.2)

2.3 **First Aid**

2.3.1 **Inoculation injury/Spillage on damaged skin/Bite:**

- Encourage bleeding of injury (but not by sucking or squeezing).
- Wash site immediately and thoroughly with soap and water.
- Cover with waterproof dressing.

2.3.2 **Splashes in the eye/mouth**

Irrigate the eye with copious amounts of water using eye wash equipment, rinse mouth with water and spit out.

2.3.3 **Sepsis**

Where the source patient has sepsis eg Group A *Streptococcus*, antibiotic prophylaxis may be indicated for the victim. This should be mentioned when seeking advice.

2.4 **Seek Immediate Advice**

- Injured Staff - phone the Occupational Health Dept - 24 hour - Inoculation Injury Hotline - 01392 405800
- Injured members of the public – Contact nearest Emergency Department.

An assessment will be then be made as to the appropriate action, e.g. need for prophylaxis.

Refer **Inoculation Incident Policy** for further advice.
APPENDIX 4: MANAGEMENT OF ALL STAFF WHO ARE NON-COMPLIANT WITH INFECTION CONTROL PRECAUTIONS

Member of staff observed as being non-compliant either through audit and/or practice

Is the member of staff who is observing non-compliance able to address the issue with non-compliant member of staff?

Yes

Is this the first time non-compliance has been observed?

Yes

Ascertain reason for non-compliance e.g. lack of knowledge, inadequate equipment and rectify

Situation Rectified

No

Further non-compliance

Non-compliance continues

Consider whether behaviour constitutes professional misconduct and, if so, take appropriate action

No

Report to Matron/Senior Matron/Head of Department as appropriate

Report to Lead Nurse or Clinical Director who will deal with in accordance with disciplinary procedures

Situation rectified

Review date: June 2021

Standard Infection Control Procedures and Policy (Including Hand Hygiene)
Ratified by: Infection Control & Decontamination Assurance Group: 24th January 2017
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APPENDIX 5: COMMUNICATION PLAN

The following action plan will be enacted once the document has gone live.

<table>
<thead>
<tr>
<th>Staff groups that need to have knowledge of the document</th>
<th>All staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The key changes if a revised policy/strategy</strong></td>
<td>Amalgamation of Hand Hygiene Policy and Standard Infection Control Procedures into one document. Content remains the same.</td>
</tr>
<tr>
<td><strong>The key objectives</strong></td>
<td>To identify clear responsibilities from ward to board to enable the application of standard infection control procedures as a routine part of clinical practice as outlined in Criterion 9 of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection (DH, 2015)</td>
</tr>
<tr>
<td></td>
<td>To provide a framework through which a high level of hand hygiene compliance is achieved (minimum of 85% using a validated observational audit tool).</td>
</tr>
<tr>
<td></td>
<td>To ensure that a minimum of 90% of relevant staff undertake annual update training</td>
</tr>
<tr>
<td><strong>How new staff will be made aware of the policy and manager action</strong></td>
<td>Induction</td>
</tr>
<tr>
<td><strong>Specific Issues to be raised with staff</strong></td>
<td>No new issues</td>
</tr>
<tr>
<td><strong>Training available to staff</strong></td>
<td>Induction and infection control updates</td>
</tr>
<tr>
<td><strong>Any other requirements</strong></td>
<td>N/A</td>
</tr>
<tr>
<td><strong>Issues following Equality Impact Assessment (if any)</strong></td>
<td>No negative impacts</td>
</tr>
<tr>
<td><strong>Location of hard / electronic copy of the document etc.</strong></td>
<td>Infection Control Team Office and Site Management Office</td>
</tr>
</tbody>
</table>
APPENDIX 6: EQUALITY IMPACT ASSESSMENT TOOL

<table>
<thead>
<tr>
<th>Name of document</th>
<th>Standard Infection Control Procedures Policy and Procedures (including Hand Hygiene)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Division/Directorate and service area</td>
<td>Specialist Services, Infection Control</td>
</tr>
</tbody>
</table>
| Name, job title and contact details of person completing the assessment | Judy Potter  
Lead Nurse/Joint Director for Infection Prevention and Control |
| Date completed: | 20/10/2016 |

The purpose of this tool is to:

- **identify** the equality issues related to a policy, procedure or strategy
- **summarise the work done** during the development of the document to reduce negative impacts or to maximise benefit
- **highlight unresolved issues** with the policy/procedure/strategy which cannot be removed but which will be monitored, and set out how this will be done.

1. **What is the main purpose of this document?**

   To identify clear responsibilities from ward to board to enable the application of standard infection control procedures as a routine part of clinical practice as outlined in Criterion 9 of the Health and Social Care Act 2008, the Code of Practice on the Prevention and Control of Infection (DH, 2015)

   To provide a framework through which a high level of hand hygiene compliance is achieved (minimum of 85% using a validated observational audit tool).

   To ensure that a minimum of 90% of relevant staff undertake annual update training

2. **Who does it mainly affect?** *(Please insert an “x” as appropriate:)*

   Carers ☐  
   Staff X  
   Patients ☐  
   Other (please specify)

3. **Who might the policy have a ‘differential’ effect on, considering the “protected characteristics” below?** *(By differential we mean, for example that a policy may have a noticeably more positive or negative impact on a particular group e.g. it may be more beneficial for women than for men)*

   Please insert an “x” in the appropriate box (x)
### 4. Apart from those with protected characteristics, which other groups in society might this document be particularly relevant to... (e.g. those affected by homelessness, bariatric patients, end of life patients, those with carers etc.)?

N/A

### 5. Do you think the document meets our human rights obligations?  

Feel free to expand on any human rights considerations in question 6 below.

**A quick guide to human rights:**

- **Fairness** – how have you made sure it treats everyone justly?
- **Respect** – how have you made sure it respects everyone as a person?
- **Equality** – how does it give everyone an equal chance to get whatever it is offering?
- **Dignity** – have you made sure it treats everyone with dignity?
- **Autonomy** – Does it enable people to make decisions for themselves?

### 6. Looking back at questions 3, 4 and 5, can you summarise what has been done during the production of this document and your consultation process to support our equality / human rights / inclusion commitments?

The content of this policy is not new but an amalgamation of two existing policies into one document. Previous discussions with the Equality and Diversity Manager did not identify any issues relating to equality, diversity and inclusion commitments. The policy has been circulated to all members of the Infection Control Team which includes Specialist Nurses and Medical Microbiologists for consultation and has been considered by the Infection Control Operational Group which includes widespread representation from clinical, managerial and support staff.
7. If you have noted any ‘missed opportunities’, or perhaps noted that there remains some concern about a potentially negative impact please note this below and how this will be monitored/addressed.

<table>
<thead>
<tr>
<th>“Protected characteristic”:</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Issue:</td>
<td></td>
</tr>
<tr>
<td>How is this going to be monitored/ addressed in the future:</td>
<td></td>
</tr>
<tr>
<td>Group that will be responsible for ensuring this carried out:</td>
<td></td>
</tr>
</tbody>
</table>