**Infection Prevention Control Policy (England)**

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|  |  |  |  |  |

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# Introduction

## Policy statement

The purpose of this document is to ensure that Sheerwater Health Centre remains committed to infection prevention and control (IPC) in the workplace and that patient safety is the utmost priority. The Care Quality Commission (CQC) [regulations](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents) require that healthcare premises are safe, the equipment used is also safe and that there are systems in place to manage the control of infection. Furthermore, the organisation is to be clean, secure, suitable and used properly and ensure that it maintains standards of hygiene appropriate to the purposes for which they are being used.

This policy incorporates the NHS England [National Standards for Healthcare Cleanliness](https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf) dated April 2021. It should be noted that these standards apply to all healthcare settings, including GP surgeries regardless of the way cleaning services are provided.

This policy should be read in conjunction with the **Cleaning Standards and Schedule Policy** and also the following CQC Mythbusters:

* [GP Mythbuster 6: Guidance about Privacy Curtains](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-6-guidance-about-privacy-curtains)
* [GP Mythbuster 99: Infection Prevention and Control in General Practice](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-99-infection-prevention-control-general-practice)

Good IPC is essential to ensure that people who use primary care services receive safe and effective care. Sheerwater Health Centre is committed to providing effective IPC procedures to minimise the risk of infection and to ensure the safety of patients, visitors and staff alike.

## Status

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the [Equality Act 2010](https://www.legislation.gov.uk/ukpga/2010/15/contents). Consideration has been given to the impact this policy might have with regard to the individual protected characteristics of those to whom it applies.

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

# Management of IPC

## Lead responsibilities

At Sheerwater Health Centre, the IPC lead is Wendy Mayne (practice Nurse) and this is detailed within their job description.

The IPC lead is responsible for promoting good infection control practice within Sheerwater Health Centre. Promoting these high standards and then providing evidence of the organisation’s compliance is essential for reputational purposes coupled with the need to maintain high levels of both patient and staff safety.

They are to ensure that:

* They provide timely advice to colleagues, service users and relatives (where applicable)
* Training is provided regarding the standard principles of IPC, specifically training in hand decontamination, the use of PPE and the safe use of and disposal of sharps (this list is not exhaustive)
* Appropriate supplies of sharps containers, PPE and materials for hand decontamination are available

Staff at Sheerwater Health Centre are to support the IPC lead in maintaining high standards of infection prevention and cleanliness.

The IPC team contact for Surrey Heartlands ICB – Monday – Friday 9am – 5pm IPC Trust team. Telephone number 01372 206200 (M) 07825 20917. Out of hours support – via switchboard at St Peter’s Hospital Tel: 01932 872000 & ask for on-call Consultant Microbiologist. The organisation lead is to ensure that any specialist advice is sought as required and this may include oversight of IPC processes including audit to ensure compliance.

Whilst the IPC audit can be completed locally, this organisation would ordinarily liaise with

the local IPC lead to request an external audit. To assist in preparing for an audit, templates are available online although it should be noted that any audit should contain reference to both pandemic planning and the updated national cleaning standards.

[Annex B](#_Annex_B_–) provides a checklist, although the following IPC audit templates may also be used:

* [East and North Herts CCG](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiSgZzP6tn3AhXGRcAKHbNhB5QQFnoECAgQAQ&url=https%3A%2F%2Fwww.enhertsccg.nhs.uk%2Fsites%2Fdefault%2Ffiles%2FHertfordshire-PC-IPC-Self-Assessment-Tool-Mar17.docx&usg=AOvVaw1y85YCl_pZyPAbtPCvNDdc)
* [Mid Notts Pathway](https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwiSgZzP6tn3AhXGRcAKHbNhB5QQFnoECAgQAQ&url=https%3A%2F%2Fwww.enhertsccg.nhs.uk%2Fsites%2Fdefault%2Ffiles%2FHertfordshire-PC-IPC-Self-Assessment-Tool-Mar17.docx&usg=AOvVaw1y85YCl_pZyPAbtPCvNDdc)

Following any IPC audit, the IPC lead in conjunction with the organisational leaders will ensure that any action points are addressed and within an appropriate timescale. Should any actions need a lengthy process to resolve, a risk assessment will be conducted with any outstanding actions added to the organisation’s risk register.

# Policy

## Policy incorporation

This policy incorporates the following protocols (as annexes):

* **Clinical Waste Management Protocol**
* **Disposable (Single-Use) Instruments Protocol**
* **Infection Control Biological Substances Protocol**
* **Infection Control Inspection Checklist**
* **Example Infection Control Annual Statement Report**
* **Isolation of Patients Protocol**
* **Needle-Stick Injuries Protocol**
* **Notifiable diseases**
* **Safe use and disposal of sharps**
* **Sample Handling Protocol**
* **Staff exclusion from work**
* **Sterilisation and Decontamination Protocol**
* **Toys in reception/waiting areas**
* PPE protocol

## Compliance

Sheerwater Health Centre ensures compliance with the [Health and Social Care Act 2008 Code of Practice](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf) criteria which are:

1. Systems in place to manage and monitor the prevention and control of infection
2. To provide and maintain a clean and appropriate environment in managed premises which facilitates the prevention and control of infections
3. To ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance
4. To provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion
5. To ensure the prompt identification of people who have, or are at risk of developing, an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people
6. Systems in place to ensure that all staff (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection
7. Systems in place to ensure that all staff have access to occupational health services and have been immunised according to PHE [Green Book](https://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book).
8. To provide or secure adequate isolation facilities
9. To secure adequate access to laboratory support as appropriate
10. Have and adhere to policies that are designed for the individual’s care and provider organisations that will help to prevent and control infections
11. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

## Annual IPC statement

The annual IPC statement details the risk assessments undertaken and subsequent recommendations regarding IPC. In addition, the statement also details IPC-related significant events and audits completed.

The [Health and Social Care Act 2008 - Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf) on the prevention and control of infections and related guidance (Appendix D) states that the IPC lead is to prepare an annual statement *“for anyone who wishes to see it, including patients and regulatory authorities.”*

This short review should include the following:

* Known infection transmission event and actions arising from this
* Audits undertaken and subsequent actions
* Risk assessments undertaken for the prevention and control of infection
* Education and training received by staff
* Review and update of policies, procedures and guidance

In addition to this, it is considered that this report should include any actions relating to any significant event that has occurred during the reporting period.

To meet the above HSCA directive of “anyone who wishes to see it”, this statement is to be placed on the organisation website. An example IPC statement template can be found at [Annex Q – Example infection control annual statement report](#_Annex_Q_–).

# IPC and COVID-19

New recommendations for primary and community healthcare providers in England relating to COVID-19 can be sought [here](https://www.gov.uk/guidance/covid-19-information-and-advice-for-health-and-care-professionals). Specifically, the recommendations state:

* Healthcare staff should continue to wear facemasks as part of PPE when working in COVID-19/respiratory pathways or where COVID-19 is suspected. In all other areas, universal masking should be applied when there is a known or suspected outbreak
* Universal masking should be considered where patients are at higher risk, e.g., immunocompromised
* Healthcare staff are not required to wear masks in non-clinical areas unless this is their personal preference
* Patients attending with respiratory symptoms should wear a facemask/covering, if tolerated, and be offered one on arrival

Further support on assessing risks can be sought from the [COVID-19 risk assessment - an aide memoire](https://practiceindex.co.uk/gp/forum/resources/covid-19-risk-assessment-an-aide-memoire.1518/).

# IPC and minor surgery

## Overview

Given the increasingly wide variety of interventions now delivered in primary care, staff at Sheerwater Health Centre are to use this guidance for the prevention of healthcare acquired infections (HCAI).

Patient safety is imperative and the prevention of healthcare-associated infections is a priority for Sheerwater Health Centre. Advice can be sought from the publication, [Community Infection Prevention and Control Guidance for General Practice: MRSA](https://www.infectionpreventioncontrol.co.uk/content/uploads/2018/12/GP-13-MRSA-December-2017-Version-1.00-1.pdf).

NICE guidance [CG139](https://www.nice.org.uk/guidance/cg139) reports that an estimated 300,000 patients a year in England acquire an HCAI as a result of care within the NHS. HCAI are often carried by the patients themselves and the use of invasive devices or procedures allow these pathogens to take advantage of a route into the body. HCAI can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life.

## MRSA

In 2007, *methicillin-resistant* staphylococcus aureus (MRSA) bloodstream infections and Clostridium difficile infections were recorded as the underlying cause of, or a contributory factor in, approximately 9,000 deaths in hospital and primary care in England.

MRSA is to be found on the skin or in the nose of up to 33% of the population and generally does not cause an infection. However, certain patients are at risk of infection from MRSA including patients who:

* Are elderly
* Have an underlying or chronic illness
* Are in intensive care
* Have had major surgery
* Are fitted with invasive devices such as urinary devices

Extra care is to be taken when dealing with these at-risk patients to avoid them becoming infected with MRSA.

## Minor surgery and other high-risk procedures

As a result of the complex care increasingly being delivered in primary care settings, standards for the care of patients and the management of devices to prevent related infections are needed that will also reinforce the principles of asepsis.

The Health and Social Care Act 2008 [Code of practice on the prevention and control of infection and related guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf) assumes that all providers of healthcare in primary care settings are compliant with this code. The guideline aims to help to build on advice given in the code and elsewhere to improve the quality of care and practice in these areas over and above current standards.

At Sheerwater Health Centre, the high-risk procedures include:

* Therapeutic injections used in a variety of conditions such as:
	+ Injections into joints (steroids)
	+ Aspiration of joints
	+ Injection of tennis and golfer's elbow, or carpal tunnel injection
	+ Injection of varicose veins and piles
* Excisions
* Incisions
* Other procedures which the organisation is deemed competent to carry out, e.g., skin biopsy (punch and shave), endometrial sampling, removal of toenails, insertion and removal of contraceptive implants

In conjunction with NICE guidance CG139, the areas as detailed within the [primary care HCAI pathway](https://pathways.nice.org.uk/pathways/prevention-and-control-of-healthcare-associated-infections#path=view%3A/pathways/prevention-and-control-of-healthcare-associated-infections/prevention-and-control-of-healthcare-associated-infections-in-primary-and-community-care.xml&content=view-index) and the appropriate infection control measures are to be robustly adhered to. These areas are:

* Availability of equipment
* Hand decontamination
* Personal protective equipment
* Waste disposal
* Safe use and disposal of sharps

## Equipment and rooms

At Sheerwater Health Centre, the dedicated treatment room is to be used wherever possible for invasive procedures. However, should this not be available, then a normal consultation room can be used provided that there is adequate lighting and space.

Any medical equipment should be fit for purpose, be of adequate specification, single use and disposable wherever possible. Should there be any uncertainty about the adequacy of equipment, the Clinical Governance team at Surrey Heartlands ICB will be able to provide advice and guidance.

## Minor surgery compliance

When undertaking minor surgery, the table below is a check-off guide to ensure that this organisation remains compliant when undertaking surgical procedures:

|  |  |
| --- | --- |
| **Requirement** | **Expected standard** |
| Facilities | * Appropriate equipment for procedures undertaken
* Appropriate premises
 |
| Clinical support | * Appropriately trained and competent
* Professionally accountable to their professional body
 |
| Sterilisation and infection control compliance  | * Appropriate standards
 |
| Clinical waste disposal | * Appropriate standards
 |
| Consent | * Appropriate standards
 |
| Patient information | * Proper written record
* Inform own GP in writing if not registered with the organisation
 |
| Clinician has the necessary skills to conduct the contracted procedures and includes: | * Regular update of skills
* Ability to demonstrate a continuing and sustained level of activity
* Conducting regular audits
* Participation in appraisal of minor surgery activity
* Participation in supportive educational activities
 |
| Pathology  | * All specimens to be sent for histology
 |
| Audit | * Conducted
 |
| Appropriate training for all those involved in procedures | * Appropriately trained
 |

# IPC and community interventions

## Overview

A wide range of interventions are carried out in the community setting. Infections can occur in otherwise healthy individuals, particularly during invasive procedures or where medical devices are used. Specific care will be taken for the following three procedures identified by NICE as the [three most likely sites for HCAI](https://www.nice.org.uk/guidance/cg139/chapter/Introduction) in the community:

* Urinary catheters
* Enteral feeding sites
* Vascular access devices

Specific guidance relating to the above can be found in [Annexes S - U](#_Annex_S_–).

# Summary

All staff undertake IPC training and are committed to maintaining high standards of infection prevention and cleanliness within Sheerwater Health Centre.

Regular training, audit and reviews are key to the prevention of healthcare-associated infection.

# Annex A – Infection Control Biological Substances Protocol

**Introduction**

A biological agent is defined as a micro-organism, cell culture or human endoparasite, whether or not genetically modified, that may cause infection, allergy, toxicity or otherwise create a hazard to human health.[[1]](#footnote-1)

**Overview**

Healthcare workers will encounter a number of sources of infection, be it directly or indirectly, such as:

* Blood and bodily fluids
* Faeces, urine, and vomit
* Direct skin contact
* Respiratory secretions and excretions

Staff must ensure that they adhere to the guidelines given in this document as well as regional and national guidelines. All staff at Sheerwater Health Centre are given training in IPC at induction and will also receive annual refresher training.

**Spillages**

There may be occasions when exposure occurs despite careful attention to the correct procedures. If such incidents occur within the organisation, a spill kit should be used. At Sheerwater Health Centre, the spill kit is stored within the treatment room. Only personnel trained in the use of this kit are authorised to use it.

**Immediate actions**

In the event of a spillage, the following actions are to be taken:

1. The spillage should be dealt with as soon as possible
2. Staff, patients, and visitors must be kept away from the spillage and if possible, a warning sign shown while preparation is made to manage the spill
3. Personal protective equipment (PPE), e.g., eye protection, long-cuffed disposable nitrile gloves and a disposable apron, should be used. If the spillage is extensive, disposable plastic overshoes or rubber boots may be necessary.

**Management of spills**

•   Small blood spills onto hard surfaces: Wearing gloves, clean with universal/detergent wipes and dispose as clinical waste.

•   Large blood spills, e.g., spills onto floor (except urine): Wearing gloves and apron, use the blood spillage wipe and follow the instructions on the packet. Wash area with detergent and water.

•   Very large blood spills including smears to walls etc.: Wearing gloves and apron, use spill wipes and leave to absorb for 30 seconds. Wipe, allowing the rest of the spill to be absorbed (if a larger spill), use the wipe contained within the pack to clean the area, place back into the bag, seal and dispose of in clinical waste.

•   Blood-stained urine spills – DO NOT USE blood spillage kit: Wearing gloves and aprons, soak up urine with paper towels then wash areas with detergent followed by chlorine dioxide solution (Tristel).

•   Urine/vomit spills: Wearing gloves and an apron, use the urine/vomit spillage kit and follow the instructions on the packet. Wash with detergent and water. If urine/vomit spillage kit is not available, soak up urine/vomit with disposable towels then wash area with detergent.

•   Spills onto carpets or soft furnishings: Wearing gloves and apron, soak up spillage with paper towels then clean with detergent and water. Then, for carpets, steam clean or, for soft furnishings, launder or dry clean. If item remains soiled it must be disposed of.

**Further actions and guidance**

All incidents are to be reported to Nine Taylor (Practice Manager) in the first instance. Further guidance and information can be sought by contacting IPC Trust team.

A poster detailing instructions for using spill wipes can be [downloaded here](https://gama.getbynder.com/m/5f87bf977b179bb3/original/Spill-Wipes-Poster-Australia.pdf).

# Annex B – Infection Control Inspection Checklist

**Introduction**

The purpose of this document is to enable Sheerwater Health Centre to assess how it meets the standards for a managed environment that minimises the risk of infection to patients, staff, and relatives.

These standards reflect current legislation, national guidelines, and good practice regarding infection control within a healthcare environment.

**Usage**

The checklist overleaf should be used as a guide and in conjunction with national guidelines. Each consulting room/treatment area, etc. should have an independent assessment completed and annotated on a separate form.

**Summary**

This checklist is not exhaustive and will need to be adapted to reflect building modifications, changes in practices, etc. The nominated IPC lead at Sheerwater Health Centre will review this document annually to ensure accuracy and relevance.

**Infection Prevention Control Checklist (see Annex V – Infection control audit)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Management of IPC** | **Yes** | **No** | **N/A** | **Comments** |
| Is there a named lead person responsible for infection prevention and control?  |  |  |  |  |
| Are these responsibilities detailed in the individual’s job description? |  |  |  |  |
| Are infection prevention and control-related topics agenda items at organisation meetings?  |  |  |  |  |
| Is there evidence of a process for reporting incidents in relation to IPC?  |  |  |  |  |
| Are there up-to-date local contact telephone numbers available from which to obtain advice pertaining to IPC? |  |  |  |  |
| Is there evidence that audits have been undertaken and practice changed regarding IPC?  |  |  |  |  |
| Are there local risk assessments held relating to IPC?  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staff training pertaining to IPC** | **Yes** | **No** | **N/A** | **Comments** |
| Is IPC included in all staff induction programmes?  |  |  |  |  |
| Have staff received mandatory training in IPC? |  |  |  |  |
| Is there a process in place to ensure that all non-attendees at mandatory training are followed up?  |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IPC policy and protocols** | **Yes** | **No** | **N/A** | **Comments** |
| Are policies and protocols available to all staff? |  |  |  |  |
| Are cleaning schedules in place and displayed in all areas? |  |  |  |  |
| Are SLAs monitored and reviewed? |  |  |  |  |
| Is there evidence of reviews of policies and protocols? |  |  |  |  |
| Are audits regularly undertaken to review standards and procedures? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **General IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Is furniture made of impermeable and washable materials?  |  |  |  |  |
| Are all furnishings and fittings visibly clean and in a good state of repair? |  |  |  |  |
| Is the floor visibly clean and in a good state of repair? |  |  |  |  |
| Is the environment generally free from clutter? |  |  |  |  |
| Are items such as telephones and IT equipment clean and in a good state of repair? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Toilet IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Are the toilet environments visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean and in a good state of repair? |  |  |  |  |
| Are all dispensers clean and in a good state of repair?  |  |  |  |  |
| Are paper towels available from an enclosed dispenser?  |  |  |  |  |
| Is there a promotional hand hygiene poster displayed?  |  |  |  |  |
| Is there a hands-free domestic waste bin available, and is it in a good state of repair, clean and labelled appropriately?  |  |  |  |  |
| Are there appropriate facilities for the disposal of sanitary waste? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Baby-changing facilities IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials? |  |  |  |  |
| Is there a dedicated basin for hand washing, and is it clean and in a good state of repair? |  |  |  |  |
| Are all dispensers clean and in a good state of repair?  |  |  |  |  |
| Are paper towels available from an enclosed dispenser?  |  |  |  |  |
| Is there a promotional hand hygiene poster displayed?  |  |  |  |  |
| Is there a hands-free domestic waste bin available, and is it in a good state of repair, clean and labelled appropriately?  |  |  |  |  |
| Is there a hands-free waste bin available for the disposal of nappies, and is it in a good state of repair, clean and labelled appropriately? |  |  |  |  |
| Are there instructions for parents displayed on how to clean the facilities after use and are cleaning materials available? |  |  |  |  |
| Are the changing mats in a good state of repair, intact and clean? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Treatment and consulting room IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |
| Is there a dedicated basin for hand washing, and is it clean and in a good state of repair? |  |  |  |  |
| Are sensor or elbow taps available? |  |  |  |  |
| Are all dispensers clean and in a good state of repair?  |  |  |  |  |
| Are paper towels available from an enclosed dispenser?  |  |  |  |  |
| Is there a promotional hand hygiene poster displayed?  |  |  |  |  |
| Is there a hands-free domestic waste bin available for paper towels, and is it in a good state of repair, clean and labelled appropriately?  |  |  |  |  |
| Are alcohol-based hand-rub bottles wall-mounted in treatment rooms?  |  |  |  |  |
| Is there a designated work surface/trolley for clinical procedures, and is it clean and in a good state of repair?  |  |  |  |  |
| Are all items stored above floor level and are there appropriate storage facilities? |  |  |  |  |
| Are all areas visibly clean (shelving, cupboards, drawers, etc.)? |  |  |  |  |
| Are patient examination couches/chairs clean and in a good state of repair? |  |  |  |  |
| Is the paper roll on couches replaced between patients? |  |  |  |  |
| Are disposable privacy curtains in date and marked with an expiry date? |  |  |  |  |
| Are non-disposable privacy curtains clean and laundered in line with the schedule?  |  |  |  |  |
| Is there a hands-free clinical waste bin available, and is it clean, free from damage and labelled appropriately? |  |  |  |  |
| Is the drug fridge only used for the storage of drugs? |  |  |  |  |
| Is there PPE readily available in the treatment/consulting rooms? |  |  |  |  |
| Are sharps containers correctly assembled, labelled with a date, location and signed? |  |  |  |  |
| Are all sharps bins free from protruding sharps, with contents below the ‘fill’ line? |  |  |  |  |
| Are the lids closed between usage and bins out of the reach of vulnerable patients? |  |  |  |  |
| Are sharps disposed of safely and not resheathed?  |  |  |  |  |
| Are full/locked sharps bins stored appropriately, away from public access until collected for disposal? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Storeroom IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |
| Are all items stored appropriately and off the floor? |  |  |  |  |
| Is the environment tidy and free from clutter? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Domestic/cleaning cupboard IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |
| Are all items stored appropriately and off the floor? |  |  |  |  |
| Is the environment tidy and free from clutter? |  |  |  |  |
| Is there a dedicated basin for hand washing, and is it clean and in a good state of repair? |  |  |  |  |
| Are sensor or elbow taps available? |  |  |  |  |
| Are all dispensers clean and in a good state of repair?  |  |  |  |  |
| Are paper towels available from an enclosed dispenser?  |  |  |  |  |
| Is there a promotional hand hygiene poster displayed?  |  |  |  |  |
| Is there a hands-free domestic waste bin available for paper towels, and is it in a good state of repair, clean and labelled appropriately?  |  |  |  |  |
| Is there a disposal facility for dirty water available, and is it visibly clean, free from damage and in a good state of repair? |  |  |  |  |
| Are mops and buckets stored appropriately and are they clean and dry? |  |  |  |  |
| Is there a colour-coding system in place for cleaning equipment? |  |  |  |  |
| Are all items stored correctly and in accordance with current regulations, i.e., COSHH? |  |  |  |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Staffroom/kitchen IPC standards** | **Yes** | **No** | **N/A** | **Comments** |
| Is the environment visibly clean and free from any damage? |  |  |  |  |
| Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials? |  |  |  |  |
| Is the flooring in a good state of repair, clean and impervious to moisture? |  |  |  |  |
| Are all items stored appropriately and off the floor? |  |  |  |  |
| Is the environment tidy and free from clutter? |  |  |  |  |
| Is staff food placed in the fridge, correctly labelled with names and dates, and with expiry dates? |  |  |  |  |
| Is the fridge free from medicines/drugs? |  |  |  |  |

Date inspection completed: [Insert date]

Inspection completed by: Wendy Mayne (Practice Nurse)

This document should be retained as it can be used as evidence in an IPC audit.

# Annex C – Clinical Waste Management Protocol

**Introduction**

NHS England’s framework agreement sets out consistent standards for the collection and disposal of clinical waste from organisations. The framework identifies several benefits including quality standards, consistency, management of contracts and value for money. Clinical waste can be defined as any waste produced by, and as a consequence of, healthcare activities[[2]](#footnote-2).

At Sheerwater Health Centre the approved contractor is Initial.

**Overview**

Under the [Environmental Protection Act 1990](http://www.legislation.gov.uk/ukpga/1990/43/contents) it is unlawful to deposit, recover or dispose of controlled (including clinical) waste without a waste management licence, contrary to the conditions of a licence or the terms of an exemption, or in a way that causes pollution of the environment or harm to human health[[3]](#footnote-3).

Hazardous healthcare waste is subject to the requirements of the [Hazardous Waste Regulations 2005](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/218704/haz-waste-regs-guide.pdf).

**Aim**

The aim of this protocol is to minimise the risks associated with clinical waste, particularly handling and disposal at Sheerwater Health Centre. Throughout this protocol, the term clinical waste refers to “hazardous waste” generated by organisations.

This protocol is to be read in conjunction with the references in the footnotes and hyperlinks within the document.

**Waste segregation**

Segregation on-site is vital to ensure that waste is stored, transported, and ultimately disposed of in the correct manner to maintain compliance with extant regulations. Clinical waste must be segregated as detailed overleaf.

Refer to the NHS Property Services [poster](https://www.property.nhs.uk/media/2906/disposing-of-clinical-and-non-clinical-waste.pdf) and useful [webinar](https://attendee.gotowebinar.com/recording/1206784791883571983) that further explains the correct disposal of clinical and non-clinical waste and advice upon the following:

* Infectious clinical waste including COVID-19 PPE

You should use the ORANGE bags for infectious clinical waste only. This includes COVID-19 waste and other infectious PPE, dressings, and bandages etc.

These orange clinical waste bags should not be placed in non-clinical areas such as corridors, entrances, staff rooms, kitchens and offices etc. so please only place them in infectious clinical waste areas.

* Infectious clinical waste that is also contaminated by medicines and/or chemicals

You must only put waste items that are both infectious and chemically contaminated (for example some samples and diagnostic kits) in the YELLOW bags.

* Non-infectious clinical waste, including face masks in non-infectious areas

The YELLOW and BLACK striped bags should be used for non-infectious clinical waste, e.g., PPE, couch roll, dressings, plasters, bandages, nappies, feminine hygiene products etc.

* General waste and recycling

Paper hand towels, packaging, cardboard, plastic bottles, tins, and any other waste items that are not clinical or infectious must be disposed of in the BLACK bags (general waste) or CLEAR bags (recycling).

Using the incorrect bag is causing huge issues for the clinical waste industry, resulting in missed collections, and costing the NHS substantial amounts of money. Sending waste for incineration is 45% more expensive than sending waste to be recycled.

**Medicines waste**

[CQC GP Mythbuster 99](https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-99-infection-prevention-control-general-practice) advises that following in regard to medicines waste:

* Medicines waste should be stored in a designated bin and collected regularly by an appropriate waste contractor
* Purple topped bins, including sharps bins must be available. This is for the disposal of cytotoxic medicines (which include hormones)
* Staff should be aware which medicines should be disposed of in each bin
* Denaturing kits must be available for the disposal of controlled drugs. There should be a written procedure to govern the process and evidence that dispensary stock-controlled drugs are only disposed of in the presence of an authorised witness
* Labels, prescriptions, and other patient identifiable documents must be treated as confidential waste

Further reading on waste, including segregation can be sought from NHS Property Services [here](https://www.property.nhs.uk/media/3543/nhsps-waste-segregation-update_summer-2021.pdf). Waste segregation posters can be [downloaded here](https://www.property.nhs.uk/media/2689/waste-segregation-posters.pdf).

**Handling of waste**

Clinical waste is classed as hazardous material and must therefore be handled and disposed of in a safe manner, to ensure that personnel are not injured or exposed to contamination.

All personnel, when involved in the handling of clinical waste, should use the correct PPE; it is essential that staff have received IPC training before handling clinical waste. The minimum PPE requirements when handling clinical waste are gloves and an apron. Clinical waste bins must be emptied daily, and bags must not be filled more than three quarters full.

Waste must be taken to the designated area and placed in the correct receptacle whilst awaiting collection from Initial. Access to this area is for authorised personnel only; all staff must ensure that they secure the area when leaving. If this area is inaccessible, Nine Taylor, the Practice Manager is to be informed and alternative arrangements made for the safe storage of the clinical waste.

**Collection**

All clinical waste will be collected by Initial weekly and is to be supported with a [Waste Transfer Note](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/311081/LIT_7932.pdf) (WTN). Copies are to be retained by the Nine Taylor, the Practice Manager to evidence the correct and authorised removal of waste from the site. Hazardous waste requires a [consignment note](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/512167/LIT_6872.pdf) (provided by the contractor) which must be retained for audit purposes.

**Summary**

All staff have a duty of care to ensure that waste is correctly segregated. Compliance with this protocol and the references within it will ensure the safe and effective management of waste at Sheerwater Health Centre. Any questions relating to this protocol are to be directed to Wendy Mayne (Practice Nurse) or Nine Taylor (Practice Manager).

# Annex D – Disposable (Single-Use) Instruments Protocol

**Introduction**

This protocol details the management of single-use items at Sheerwater Health Centre. Single-use items are those items that are to be used on one patient, for a single procedure and then disposed of correctly. Reusing a single-use item could expose both staff and patients to unnecessary risks.

**Overview**

Single-use items are commonly used within the primary care environment. Whilst items held will vary depending on individual preferences, the management of such items remains the same. At Sheerwater Health Centre, Nine Taylor (Practice Manager) is responsible for the ordering of medical stores, including single-use items.

**Identifying single-use items**

Single-use items have an identifier that clearly shows they are single-use only. This symbol is usually on the packaging of the item and may not be on the item itself. If there is any doubt, contact the manufacturer for further guidance.

The symbol that indicates single use is shown below:



Any item that displays this symbol can only be used on one individual, for a single procedure. Once used, the item must be disposed of correctly, following Sheerwater Health Centre’s clinical waste protocol.

**Safety implications**

There are a number of [safety implications](https://www.gov.uk/government/publications/single-use-medical-devices-implications-and-consequences-of-re-use) regarding the reuse of single-use items that clearly explain the risks of reusing an item intended for single use.

 Such implications are:

* Reprocessing single-use devices may compromise their intended function
* Single-use devices may not be designed to allow thorough decontamination and (if applicable) re-serialisation processes
* Reprocessing a single-use device may alter its characteristics so that it no longer complies with the original manufacturer’s specifications and therefore the performance may be compromised
* Single-use devices have not undergone extensive testing, validation, and documentation to ensure the devices are safe to reuse

**Responsibility**

Any individual who reuses an item identified for single use only bears full responsibility for the safety and effectiveness of its function; such actions are against the guidance of the Medicines and Healthcare Products Regulatory Agency (MHRA).

**Summary**

Single-use items are specifically manufactured for the purpose of being used once. The risks associated with reusing such items clearly outweigh the benefits. Reusing items exposes patients and staff to the risk of infection and transfers the responsibility from the manufacturer to the individual.

At Sheerwater Health Centre, training is delivered on a regular basis to ensure that all staff are aware of this protocol and adhere to the single-use policy.

# Annex E – Privacy Curtains Protocol

**Introduction**

The [Health and Social Care Act 2008: Code of practice on the prevention and control of infections](https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance) and related guidance sets out compliance in order to provide and maintain a clean environment in premises that ensures the prevention and control of infection. This includes the statement that “The environmental cleaning and decontamination policy should specify how to clean all areas, fixtures and fittings”.

**Overview**

The Code of Practice references the [national specifications for cleanliness in the NHS](https://www.england.nhs.uk/wp-content/uploads/2021/04/B0271-national-standards-of-healthcare-cleanliness-2021.pdf) and states that “Curtains/blinds should be visibly clean with no blood or body substances, dust, dirt, debris, stains or spillages.”

The national specifications for cleanliness in the NHS suggest cleaning frequencies as a guide and the CQC expects that providers risk assess the required cleaning frequency for their premises and follow their own protocols. The frequency is a decreed within the Cleaning standards and schedule policy. This policy should be used for further information and guidance, be agreed with the cleaning team and be to the same high standards as that which would be expected of the general public and includes:

* Curtains in rooms used for other purposes
* Window coverings such as blinds and curtains in treatment rooms

**Privacy curtains in practice**

Curtains around examination couches may either be:

* Disposable (paper) or
* Re-usable

This organisation has a programme to change privacy curtains every six months although in some cases annually may be sufficient dependant on the location. However, any privacy curtain will be changed immediately if visibly dirty, soiled or stained.

Curtains must extend fully around examination couches, giving full privacy and dignity and window coverings, which may be either curtains or blinds, should cover the whole of the window, giving full privacy and dignity.

**Management and compliance**

Cleaning at Sheerwater Health Centre is managed and overseen by Jamila Arif with records being kept. All administration staff and clinicians are fully trained and responsible for identifying and reporting areas of concern regarding infection control and cleanliness.

# Annex F – Carpets and Soft Furnishings Protocol

**Introduction**

At Sheerwater Health Centre, no clinical space that includes a room or area is carpeted. Areas that do have a carpet are included within the cleaning schedule for cleaning, be this routine vacuuming or a scheduled full carpet clean

**Minimising risk**

A periodic clean has been agreed and will occur periodically, or sooner should there be a requirement.

**Management of contaminated carpets or soft furnishings**

Should any carpets or soft furnishings be contaminated with body fluids or spillages then the following process is to be adhered to:

* Always deal with a spillage immediately
* Wear disposable gloves and apron or gown. If risk of splashing, wear eye protection
* Gather equipment as required. This may include clinical or offensive waste bags, paper towels etc.
* Carefully remove bulk of spillage i.e., vomit/faeces etc. using paper towel or scoop then dispose of directly into waste bag
* If the item can be removed i.e., cushions, then place these items in appropriate bag for soiled items, secure and label
* If the item cannot be removed i.e., furniture or carpet, clean the area thoroughly with general detergent solution and warm water
* Ensure that any contamination of surrounding surfaces is appropriately dealt with
* Staff must request a professional clean of the item or area and this item or area must remain out of use or cordoned off until fully cleaned and dried

# Annex G – Needle-Stick Injury Protocol

**Introduction**

Sharps injuries are a well-known risk to workers in healthcare and, for those who receive them, they can cause anxiety and distress. For the purpose of this protocol, sharps injuries are defined as injuries sustained from needles, scalpels and other instruments that can cause injury by cutting or pricking the skin. This protocol gives detailed guidance for the management of sharps injuries at Sheerwater Health Centre.

**Overview**

Anyone working at Sheerwater Health Centre is at risk from a sharps injury; this includes healthcare workers or clinicians but also non-clinical members of staff who may be at risk if sharps are not stored or disposed of correctly. All employers are required under existing [health and safety law](https://www.hse.gov.uk/pubns/hsis7.pdf) to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.

**Minimising risk**

Everyone has a duty of care to minimise the risk of exposure to sharps injuries at Sheerwater Health Centre. The following actions, [recommended by HSE](https://www.hse.gov.uk/healthservices/needlesticks/prevention-management-sharps-injuries.pdf), will further reduce the risk of exposure:

* No needle recapping or re-sheathing
* Availability of portable sharps containers
* Adequate number and placing of sharps containers within arm’s reach
* Disposing of sharps immediately at the point of use in designated sharps containers
* Sealing and discarding sharps containers when they are three quarters full
* Establishing means for the safe handling and disposal of sharps devices before the beginning of a procedure

Training also reduces the risk of exposure, and at Sheerwater Health Centre training pertaining to sharps injuries is covered on e-learning platform, Blue Stream Academy.

**Management of sharps injuries**

All staff need to be familiar with the immediate management procedure, both for themselves if they become injured and for assisting injured colleagues. The management of sharps injuries is shown in the infographic overleaf.

* [NHS – What should I do if I injure myself with a used needle](https://www.nhs.uk/common-health-questions/accidents-first-aid-and-treatments/what-should-i-do-if-i-injure-myself-with-a-used-needle/)
* [HSE – Sharps injuries](http://www.hse.gov.uk/healthservices/needlesticks/)

A poster detailing the process to effectively manage sharps injuries is [accessible here](https://www.bmj.com/content/bmj/suppl/2015/07/29/bmj.h3733.DC1/sharps_infographic_web_sm3.pdf).

Source: [The BMJ](http://www.bmj.com/content/bmj/suppl/2015/07/29/bmj.h3733.DC1/sharps_infographic_web_sm3.pdf)

**Reporting sharps injuries**

At Sheerwater Health Centre, all sharps injuries are to be reported to Nine Taylor, Practice Manager. In addition, report the incident to the duty doctor. It may be necessary to gain further advice from Occupational Health who can be contacted on 01372 205760 (9.30am – 4pm). Out of hours, weekends / Bank Holidays -go to the nearest Accident and Emergency Department.

Sharps injuries must be [reported to HSE](http://www.hse.gov.uk/riddor/report.htm)[[4]](#footnote-4) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) if:

* An employee is injured by a sharp known to be contaminated with a blood-borne virus (BBV), e.g., hepatitis B or C or HIV. This is reportable as a dangerous occurrence
* The employee receives a sharps injury and a BBV acquired by this route seroconverts. This is reportable as a disease
* The injury itself is so severe that it must be reported

If the sharp is not contaminated with a BBV, or the source of the sharps injury cannot be traced, it is not reportable to HSE unless the injury itself causes an over-seven-day injury. If the employee develops a disease attributable to the injury, then it must be reported.

**Recording of sharps injuries at Sheerwater Health Centre**

All sharps injuries sustained at Sheerwater Health Centre must be recorded as a significant event and discussed at practice meetings. As part of the SEA, the outcome may be to conduct an audit to ensure that the safest systems are being adopted, training may be one of the outcomes that needs to be considered.

It is the responsibility of the person suffering a sharps injury to ensure that it is reported/recorded appropriately.

If they are unsure, they should discuss the incident with the Practice Manager.

**Summary**

Sharps injuries are not uncommon within primary care. Due diligence and adherence to guidance and legislation will reduce the risk to all staff. Regular access to training is available at Sheerwater Health Centre to maintain an awareness of the significance of the safe management of sharps.

# Annex H – Safe use and disposal of sharps

**Introduction**

Many sharps’ injuries can be avoided by adhering to the principles of safe organisation at [Sheerwater Health Centre. The incidence of sharps injuries in primary care is surprisingly high. Care is to be always taken to ensure the safe use and disposal of sharps.

**Legislation**

There are several legislative acts and laws governing the safe use and disposal of sharps:

* C[ontrol of Substances Hazardous to Health (COSHH) 2002](http://www.legislation.gov.uk/uksi/2002/2677/pdfs/uksi_20022677_en.pdf)
* [Management of Health and Safety at Work Regulations 1999](http://www.legislation.gov.uk/uksi/1999/3242/contents/made)
* [The Provision and Use of Work Equipment Regulations 1998](http://www.hse.gov.uk/work-equipment-machinery/puwer.htm)
* [Reporting of Diseases, Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR)](http://www.hse.gov.uk/riddor/)
* [The Personal Protective Equipment Regulations 1992](http://www.hse.gov.uk/pubns/indg174.pdf)
* [Health and Safety (First Aid) Regulations 1981](http://www.hse.gov.uk/firstaid/legislation.htm)
* [Safety Representatives and Safety Committee Regulations 1977](https://www.hse.gov.uk/pUbns/priced/l146.pdf)
* [The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013](https://www.hse.gov.uk/pubns/hsis7.htm)

Healthcare workers should adhere to the information detailed in these regulations when searching for guidance/information.

**Safe use principles**

The following principles should be followed at Sheerwater Health Centre:

* Never pass sharps from person to person by hand – use a safe area or receptacle to place them in
* Never walk around the room/organisation with an exposed sharp in your hand
* Never leave sharps lying around – dispose of them appropriately
* Dispose of syringes and needles as a single unit – do not remove the needle first
* Never re-sheathe a needle
* If you are administering care to a confused patient, have help present to minimise the risk of injury to the patient and yourself

**Disposal**

In addition to the above, the safe use of sharps bins is also essential to reduce the risk of exposure. The Sharps Regulations require that clearly marked and secure containers be placed close to the area where sharps are used. Instructions for staff on safe disposal of sharps must also be placed in those areas.[[5]](#footnote-5)

To comply with the regulations, the following guidance is to be adhered to:

* Ensure that sharps bins are of an appropriate size for the clinical activity
* Sharps bins should be available at the point of use of the sharp
* Sharps bins should be located at approximately waist height but out of the reach of children or confused adults
* Between usages, the temporary closure device should be used to prevent accidental exposure if the bin is knocked over
* Only fill the bin to the ‘fill line’
* Used/full sharps bins must be placed in a locked, segregated cupboard or clinical waste bin provided for such a purpose

A poster detailing the correct use of sharps bins is [accessible here](https://www.property.nhs.uk/media/2689/waste-segregation-posters.pdf).

**Correct use of sharps bins**

**Sharps bin management is the responsibility of the clinician using the bin not the cleaning team**

When assembling sharps bins, staff must ensure the following:

* The bin lid and label are a colour match and the bin is of the correct size
* The lid is fully secured and ‘clicked’ into place
* The label is completed legibly, with the name of the individual assembling the bin, the date assembled and the location of the bin

Do ensure that when not in use, the lid window is “temporarily” closed.

Do replace the bin one month after the date of assembly (unless ¾ full prior to this date).

Do not overfill the bin! Once the bin is ¾ full, close the lid securely.

When closing sharps bins, staff are to ensure:

* The lid window is clicked into the closed position
* The date of closure is annotated on the label and signed by the member of staff
* The bin is taken to the clinical waste area

**Summary**

The safe use of sharps and their subsequent safe disposal will reduce the risk of injury to all staff and patients at Sheerwater Health Centre. Any queries relating to safe sharps management and disposal should be directed to Nine Taylor (the Practice Manager) in the first instance.

Supplementary guidance can be found by accessing the hyperlinks within this document or the references at the footnotes.

# Annex I – Sample Handling Protocol

**Introduction**

Staff at Sheerwater Health Centre may at times be expected to handle specimens/samples from patients. This protocol details the guidance for the safe handling of specimens for all staff, including non-clinical members\*.

**Overview**

Clinical specimens are often referred to as samples by patients. A clinical specimen can be defined as any substance (solid or liquid) taken from the patient for the purpose of analysis. All staff at Sheerwater Health Centre have received the required training to ensure that specimens are handled safely. It remains the responsibility of all staff to ensure that they adhere to best practice and the guidance provided.

**Handling**

Specimens, if not handled correctly, are a risk of infection to all personnel involved including healthcare workers, transport staff and laboratory personnel. Specimens that are unlabelled, without a completed request form, in incorrect containers or leaking are unlikely to be processed by the laboratory. If in doubt, speak to Nine Taylor (Practice Manager).

All staff are to ensure the following:

* They are wearing the appropriate PPE, i.e., gloves
* The correct pathology request form has been used
* The correct specimen containers have been used
* The request form and container(s) have been labelled correctly, accurately, and legibly
* There is a match between patient, form, and container
* The above items are placed into the standard packaging for that container
* The package is placed into the transportation container
* PPE is disposed of, and hands are washed
* The receipt of the specimen is annotated in the specimen log

\* [MPS recommend](https://www.medicalprotection.org/ireland/resources-training/articles/view/infection-prevention-and-control-mitigating-the-key-risks) that reception staff do not touch patient specimens. Instead, a box should be placed at reception for patients to leave their samples which can then be passed to the clinical team for processing.

**Collection and transportation**

At Sheerwater Health Centre, specimens are collected on daily around 1pm by a courier for onward transfer to a laboratory. If the courier fails to arrive, inform the Practice Manager immediately.

The packaging of specimens must consist of three components to comply with [UN 3373](https://www.un3373.com/enveloppeninfo/regulations) regulations:

1. A primary receptacle – the specimen tube/pot
2. Secondary packaging – the plastic specimen bag
3. An outer packaging – the Verspak bag used to transport specimens to the laboratory

Example of a Verspak bag:



**Compromised specimens**

There may be occasions when concerns are raised either at Sheerwater Health Centre or the laboratory regarding the integrity of the sample. In such instances, there may be a requirement to raise an incident report, particularly if the specimen has leaked in a public area. However, communication will be maintained between both locations to determine (where possible) the cause.

Any incidents regarding specimens should be recorded as a significant event and discussed at the next organisation meeting. Repeated incidents should indicate the requirement for an audit aimed at improving practice in the future.

**Summary**

It is the responsibility of the sender to collect and package specimens as per the guidance given in this protocol and the associated references. Staff must collect specimens safely and effectively as any undue delay may have a detrimental effect on patient care.

# Annex J – Sterilisation and Decontamination Protocol

**N/A to Sheerwater Health Centre**

**Introduction**

Within the primary care environment, most organisations are opting for single-use items; however, there are some items that are reusable and therefore require sterilisation.

At Sheerwater Health Centre the following items are used which require sterilisation:

This protocol details the procedure for the sterilisation of instruments at Sheerwater Health Centre whilst also detailing the general cleaning and disinfecting of items within the organisation.

**Overview**

The careful sterilisation of equipment used in primary care is essential to the effective delivery of patient care. This policy will provide guidance that conforms to national and local directives. The effective decontamination of equipment between uses is a fundamental element of infection control practices.

**Decontamination process**

The decontamination process, which ultimately leads to sterilisation, is a multi-faceted process consisting of three separate functions:

* **Cleaning** involves the removal of dirt, debris, body fluids, etc. from the equipment. Cleaning precedes the disinfection process
* **Disinfecting** reduces the number of micro-organisms but is not a fail-safe method to ensure that all spores are removed; this stage alone consists of many factors:
	+ Prior cleaning must be effective
	+ The use of the appropriate disinfectant and in the correct strength
	+ The disinfectant must be used correctly as per the manufacturer’s instructions
* **Sterilising** is the only process that removes all micro-organisms.

**Sterilisation**

Reusable items that require sterilisation. No reusable items are being used at Sheerwater Health Centre.

Any questions relating to the sterilisation process are to be directed to the practice nurse in the first instance.

**General decontamination**

The table below details the equipment/items held and used within Sheerwater Health Centre and the associated decontamination requirements:

|  |  |
| --- | --- |
| **Equipment** | **Decontamination method** |
| Airways  | Single use  |
| Ambu bags  | Single use/clean with detergent followed by appropriate disinfectant  |
| Auroscope earpieces  | Single use  |
| Baby-changing mat  | Cover with disposable paper between babies. Clean with detergent at end of the session. If contaminated with blood/body fluids, clean then disinfect before next baby in line with policy  |
| Baby weighing scales  | Cover with disposable paper between babies. Clean with detergent at end of the session. If contaminated with blood/body fluids, clean then disinfect before next baby in line with policy  |
| Bowls (used for cleaning purposes)  | Empty, rinse with clear water and store inverted to dry  |
| Blood pressure equipment  | Wipe cuff and monitor with detergent/detergent wipe, pat dry with paper towel between patient uses. Do not immerse cuff in water. Disposable single-use cuff/cuff cover for use when a patient has a multi-resistant organism  |
| Doppler ultrasound probe  | Remove gel, clean with detergent/detergent wipe. Do not immerse in water  |
| Ear syringe – Propulse  | Follow disinfection procedure in Ear Care Procedure  |
| ECG equipment: Electrodes Straps/leads/machine  | Single useClean with detergent/detergent wipe. Do not immerse in water  |
| Examination couches  | Cover with disposable paper towel between patients. Clean with detergent at the end of the session. Clean and disinfect with NaDCC if contaminated with blood/blood-stained body fluid  |
| Minor surgical instruments  | Disposable, single use  |
| Nebulisers  | Wash mask and chamber with detergent, rinse and leave to dry on disposable paper. Do not wash tubing  |
| Peak flow meters/spirometry  | Follow manufacturer’s guidanceDisposable single-use mouthpieces with one-way valve or filter (change filter as directed by manufacturer) Clean machine weekly with detergent/detergent wipe  |
| Pelvic stimulator electrodes  | Single patient useClean with detergent/detergent wipe to remove any residuesWrap in paper roll and replace in carry caseReturn to patient for cleaning at home, following manufacturer’s instructions  |
| Pillows  | All pillows should be protected with plastic (sealed) or vapour-permeable coverWipe with detergent/detergent wipe in between patients and at end of session Disinfect with NaDCC if contaminated with blood/blood-stained body fluid  |
| Physiotherapy equipment  | Clean weekly with detergent/detergent wipe, or disinfect with NaDCC if contaminated with blood/blood-stained body fluid  |
| Pulse oximeter  | Clean weekly with detergent/detergent wipe and between patients  |
| Scissors | Single use NB: Bandage/dressing scissors – clean between patients with detergent/detergent wipe, and disinfect if required  |
| Stethoscope  | Clean between each patient use, with detergent wipe  |
| Sticks/frames/crutches  | Clean with detergent/detergent wipe between users  |
| Stitch/staple removers  | Single use  |
| Suction machines  | Follow manufacturer’s guidance. Contact CES if further advice required  |
| Thermometer  | Disposable sheath for each patientClean handpiece weekly with detergent/detergent wipes Do not immerse in water  |
| Tourniquet  | Wipe with detergent/detergent wipe, pat dry with paper towel between patient useor:Disposable single patient use if appropriate in specific services. If reusable tourniquet grossly contaminated – dispose of. Ensure adequate supply available  |
| Treatment chairs  | Clean daily with detergent/detergent wipes  |
| Trolleys  | Clean with detergent/detergent wipe prior to/following use  |
| Toys: Hard  | Clean weekly with detergent/detergent wipe or after use if used as part of treatment/assessmentAll hard toys must be made of suitable material to withstand disinfection if required  |
| Soft  | Not suitable for healthcare facilities  |
| Weighing scales  | Clean weekly with detergent/detergent wipe  |
| Work surfaces  | Clean with detergent/detergent wipe at the end of each session  |
| Vacutainer needle holder  | Single use  |
| Vaginal speculum  | Disposable, single use  |
| Vaginal ultrasound probes  | Cover with condom during use, clean with detergent/detergent wipes after removal Do not immerse in water  |

**Summary**

The effective decontamination of equipment and the appropriate use of single-use items are essential to reducing the risk of infection. The clinical environment must be maintained appropriately for the delivery of safe, clean care.

All staff at Sheerwater Health Centre have a duty of care to ensure they always follow IPC policy and protocols.

# Annex K – Isolation of Patients Protocol

**Introduction**

Control of infection is one of the key elements of safe care in general practice. There may be on occasion a requirement to isolate patients and it is essential that Sheerwater Health Centre is prepared to deal with such occurrences. This protocol will explain the procedure for patient isolation at Sheerwater Health Centre.

**Overview**

Isolation in healthcare is defined as the voluntary or compulsory separation and confinement of those known or suspected to be infected with a contagious disease (whether ill or not) to prevent further infections. The kind of isolation required will depend on the type of disease. All staff must ensure that they understand the isolation protocol at Sheerwater Health Centre.

In accordance with [The Code of Practice](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf) detailed in the Health and Social Care Act 2008, adequate isolation facilities must be provided to minimise the spread of infection to both patients and staff.

The isolation of patients must be based on the infection risk. At Sheerwater Health Centre, the lead for IPC is Wendy Mayne, the Practice Nurse and they must be consulted if there is concern regarding an infectious patient. Where doubt exists, caution should be taken, and further advice sought from the local trust IPC team and can be contacted on 01372 206200 or 01483 443592 (Monday to Friday 9am to 5pm) Out of hours support via the switchboard at St Peter’s Hospital 01932 872000 and ask for on-call Consultant Microbiologist.

**Recognising the requirement for isolation**

Staff should remain vigilant and if they suspect a patient is contagious and presents with any of the following, they must inform a clinician immediately:

* Cough and/or fever might indicate influenza
* Diarrhoea and/or vomiting might indicate Clostridium difficile, norovirus or food poisoning
* Skin lesion/rash might indicate scabies, chicken pox or measles

This list is not exhaustive but merely indicative of examples of the ways in which an infectious patient may present. Further conditions will be discussed during staff training. It is acknowledged that it may not always be possible for staff to recognise a patient with a contagious illness.

**Isolation protocol**

Sensitivity is key when dealing with patients who may be contagious whilst also considering other patients within the immediate vicinity. Transferring the patient to a single room, which can be decontaminated appropriately before being used again, is an effective way of reducing the spread of infection.

**Transferring the patient** from the waiting area to isolation should be done in such a manner as to limit movement thereby reducing the spread of infection.

The clinician must:

* Ask the patient to follow them to the small room at the end of the corridor leading to the treatment room
* Explain to the patient why they have been asked to move
* Ensure that the door to the room is closed to further reduce the spread of infection
* Update the team, ensuring that they are aware of the potential risks associated with the infection
* Update the patient’s individual health record

**Assessment** of the patient by additional clinicians must be limited to minimise the transmission of infection. All staff involved in the care of a patient suspected of being contagious must ensure that they adhere strictly to the IPC protocols detailed in this policy.

**Equipment** used in the care of the infectious patient should, where practicable, be single use. However, where this is not possible the subsequent decontamination process should follow the guidance detailed in Appendix H of this policy.

**Effective** IPC precautions will further reduce the risk of transmission. Procedures such as the use of PPE, correct hand hygiene measures and decontamination will greatly reduce the risk of patients and staff becoming infected.

**Room** decontamination must also follow the guidance detailed in Appendix H. The room must not be used until it has been decontaminated. It is advised that the room used for isolation is routinely free from clutter, has appropriate PPE and a clinical waste bin for the disposal of PPE and is easily accessible for all patient groups.

**Summary**

Isolating a patient who is suspected of having or has a proven contagious disease is the most effective way of minimising the spread of the disease to staff and patients at Sheerwater Health Centre.

Staff must ensure that they adhere to the guidance detailed in this policy and, where they have cause for concern, they are to contact the Practice Manager. Regular training and compliance will ensure that the risk is minimised at Sheerwater Health Centre.

# Annex L – Handwashing

Each year the World Health Organization’s **SAVE LIVES: Clean Your Hands** campaign aims to progress the goal of maintaining a global profile on the importance of hand hygiene in healthcare.

Whilst alcohol hand rub is a quick and easy way to clean your hands, especially when a sink is not easily accessible, there are times when you must wash your hands with soap and water.

These are:

* When hands are visibly soiled. This is because alcohol hand rub kills germs on clean hands but, because it is not soap, it cannot dissolve grease or oil so, if hands are soiled, they need to be washed.
* Hands that have come into contact with body fluids. This is because the mechanical action of washing is important in removing any body fluid material that may be on the hands.
* Cleaning in an area where a patient has diarrhoea and/or vomiting. This is because alcohol hand rub does not kill some of the germs that cause diarrhoea and vomiting.

It should be noted that gloves can move organisms around just as well as hands. Wearing gloves does not replace the need for hand hygiene.

Hand and wrist jewellery can harbour micro-organisms and reduce compliance with hand hygiene. Wristwatches and jewellery should be removed prior to commencing cleaning duties.

An NHS handwashing video clip can be found [here](https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/) . A hand-washing technique poster can be [downloaded here](https://www.berkshirehealthcare.nhs.uk/media/33429304/nhs-hand-wasing-technique.pdf) and an alcohol handrub hand hygiene technique poster can be [downloaded here](https://www.sthelensccg.nhs.uk/media/1641/hands-with-gel.pdf).

# Annex M – Hand hygiene audit

**Introduction**

This annex explains when hand washing should occur in general practice and provides a useful audit tool to enable Sheerwater Health Centre to conduct hand hygiene audits.

**When to decontaminate hands**

[NICE](https://www.nice.org.uk/guidance/cg139/chapter/1-Guidance#standard-principles) states there are five occasions when staff should wash their hands:

1. Immediately before every episode of direct patient contact or care including aseptic procedures
2. Immediately after every episode of direct patient contact or care
3. Immediately after any exposure to body fluids
4. Immediately after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated
5. Immediately after removal of gloves

Decontaminate hands, preferably with a hand rub conforming to current British standards (at the time of publication of the recommendations (March 2012): BS EN 1500:1997) except in the following circumstances when liquid soap and water must be used:

* When hands are visibly soiled or potentially contaminated with body fluids **or**
* In clinical situations where there is potential for the spread of alcohol-resistant organisms (such as Clostridium difficile or other organisms that cause diarrhoeal illness)

**Good practice**

To facilitate good hand hygiene in a clinical environment, staff should be “bare below the elbows” when delivering direct patient care:

* Where practical, staff should not wear long sleeves. If they do, then sleeves should be rolled up to the elbow
* Watches, wrist bands and other jewellery should be removed (wedding rings are permitted if it is a plain band)
* Fingernails should be kept short and clean
* False nails, gel nails, nail jewellery and nail polish is not to be worn
* Any minor cuts or abrasions are to be covered with a waterproof dressing

**Audit**

The audit tool overleaf can be used to determine compliance with hand hygiene within Sheerwater Health Centre. Where non-compliance is identified, risk assessments and action plans should be produced, and audits repeated until a satisfactory level of compliance is achieved.

Copies of the audits are to be retained as evidence for CQC and local IPC inspections.

|  |  |  |  |
| --- | --- | --- | --- |
| **Date of audit** |  | **Auditor name and role** |  |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Observation** | **Staff group i.e., nurse/ paramedic/ GP etc.** | **Did the individual wash their hands at every “moment”?** | **Are those delivering direct patient care “bare below the elbows”?** | **Did the staff member use the correct hand washing techniques?** | **Were any cuts and abrasions covered with an appropriate dressing?** | **Were paper towels disposed of correctly and without hand contact on the bin?** |
| 1 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 2 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 3 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 4 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 5 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 6 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 7 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 8 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 9 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 10 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 11 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 12 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 13 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 14 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 15 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 16 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 17 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 18 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 19 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |
| 20 |  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  | Yes No N/A  |

|  |
| --- |
| **Findings** |
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|  |
| --- |
| **Recommendations** |
|  |

|  |
| --- |
| **Actions required (and by whom)** |
|  |

|  |
| --- |
| **Review plan (including date)** |
|  |

# Annex N – Notifiable diseases: Infectious disease in patients

**Introduction**

Clinicians at Sheerwater Health Centre have a statutory duty to notify the ‘proper officer’ at their local council or local Health Protection Team (HPT) of suspected cases of certain infectious diseases. Details of the local HPT can be found [here](https://www.gov.uk/health-protection-team).

**Notifiable diseases infections or contamination**

The following are notifiable under the [Health Protection (Notification) Regulations 2010](https://www.legislation.gov.uk/uksi/2010/659/contents/made)

* Acute encephalitis
* Acute infectious hepatitis
* Acute meningitis
* Acute poliomyelitis
* Anthrax
* Botulism
* Brucellosis
* Cholera
* COVID-19
* Diphtheria
* Enteric fever (typhoid or paratyphoid fever)
* Food poisoning
* Haemolytic uraemic syndrome (HUS)
* Infectious bloody diarrhoea
* Invasive group A streptococcal disease
* Legionnaires’ disease
* Leprosy
* Malaria
* Measles
* Meningococcal septicaemia
* Mumps
* Plague
* Rabies
* Rubella
* Severe Acute Respiratory Syndrome (SARS)
* Scarlet fever
* Smallpox
* Tetanus
* Tuberculosis
* Typhus
* Viral haemorrhagic fever (VHF)
* Whooping cough
* Yellow fever

Further reading can be found at the Gov.uk document titled [Notifiable diseases and causative organisms: how to report](https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report#list-of-notifiable-diseases)

<https://www.gov.uk/government/publications/notifiable-diseases-poster-for-registered-medical-practitioners>

Although the CQC is responsible for monitoring compliance with the requirements of the [Health and Care Act 2008 (Regulated Activities) Regulations 2014](https://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents), it is not required to be notified about any [outbreaks of infection](https://www.cqc.org.uk/sites/default/files/20150331_100501_v6_00_guidance_on_statutory_notifications_ASC_%20IH_PDC_PA_Reg_Persons.pdf). However, UKHSA (formally known as PHE) does need to be informed about certain infection outbreaks and incidents through the local HPT by following the reporting procedure outlined below.

The Health and Social Care Act 2008 code of practice for the prevention and control of infections requires that NHS providers report cases and outbreaks of certain infections including, but not necessarily exclusively:

* Clostridium difficile
* Blood stream infections caused by methicillin resistant staphylococcus aureus (MRSA) and glycopeptide resistant enterococci (GRE)
* Surgical site infections (SSI) following orthopaedic surgery.

Certain infections or conditions are also notifiable to the Office of National Statistics by law. These notifications are submitted by any doctor in clinical practice.

**Reporting procedure**

GPs are to use the [registered medical practitioner notification form](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/533776/RegisteredMedicalPractitionerForm.docx) shown at Appendix 1 to Section A: Notification Regulations to inform the local HPT about suspected notifiable disease cases.

**Summary**

It is essential that clinicians ensure that the notification form is completed and submitted to the proper officer within three days or in the event of urgent cases, within 24 hours by telephone.

Where doubt exists, guidance can be sought from Surrey and Sussex Health Protection Unit at Horesham on 0845 894294.

# Annex O – Toys in reception/waiting areas

**Introduction**

Contrary to popular misconception, toys are permitted in the reception and waiting areas at Sheerwater Health Centre and, just like all areas within the organisation, are to be cleaned in accordance with the information given in the [HSCA 2008](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf).

**CQC requirements**

The CQC no longer has any specific guidance that focuses on toys in GP organisations. [Annex O](#_Annex_K_–) of this policy will satisfy CQC requirements.

**Summary**

It is essential that Sheerwater Health Centre conforms to the guidance detailed in the HSCA 2008 to ensure that we “Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections” and all toys should be added to the cleaning schedule.

Refer to the **Cleaning standards and schedule policy.**

# Annex P – Staff exclusion from work

**Introduction**

Control of infection is one of the key elements of safe care in general practice. There may be on occasion a requirement to exclude staff from work and it is essential that Sheerwater Health Centre is prepared to deal with such occurrences.

**Recognising the requirement for exclusion**

Staff must fully understand that there may be occasions when they are not able to work due to illness.

It is essential that they advise their line manager if they are suffering from the conditions listed in the table below and adhere to the timescales for exclusion; this will minimise the risk of other staff and patients being exposed to the condition.

|  |  |
| --- | --- |
| **Condition** | **Recommendations** |
| Chickenpox | Exclude staff member until lesions are dry or lesions have scabbed over |
| Conjunctivitis | Seek advice on appropriateness of work, this will depend uponclinical specialty, number of cases presenting, extent ofconjunctivitis, likely cause, potential for spread and treatmentplan |
| COVID-19 contacts | Refer to current UK HSA advice |
| COVID-19 | Refer to current UK HSA advice |
| Dermatitis | If infected or discharging skin lesions, exclude staff member from clinical duties until the lesions have healedOH to be consulted for advice |
| Diarrhoea and vomiting (or either condition on its own) | If considered to be infectious in nature, staff should be 48-hoursymptom free prior to returning to work In the event of an outbreak advice will be issued and will be dependent upon the source organism |
| Head lice | No exclusion, treatment or wet combing must be undertaken to eradicate colonisation |
| Hepatitis A | Restrict from patient contact, contact with patients’ environment and food handling until 7 days after onset of jaundiceIn an outbreak situation UK HSA will advise on management |
| Hepatitis BHealthcare worker who does not perform EPP | No restrictionsStandard precautions should always be appliedThis is a blood borne virus that is not infectious through normal casual contact |
| Hepatitis BHealthcare worker who does perform EPP | Do not perform exposure prone invasive procedures Seek advice from Occupational Health who will review andrecommend procedures |
| Hepatitis C | Do not perform exposure prone invasive proceduresSeek advice from Occupational Health who will review andrecommend procedures |
| Herpes SimplexHands (Herpatic Whitlow) | Staff members with facial Herpes Simplex are to be excluded from giving eye and neonatal care until lesions have healedRestrict from patient contact and contact with theenvironment until lesion has healedSeek advice from Occupational Health. This will be based on clinical tasks being undertaken |
| HIV infection | Do not perform exposure prone invasive proceduresOH must be consulted for advice |
| Impetigo | Staff should be excluded until lesions are crusted/healed or for 48 hours after starting antibiotic treatmentAntibiotic treatment speeds up healing and reduces the infectious period |
| Influenza contacts | Contacts of someone with influenza who remainsasymptomatic may continue to workAll staff should follow standard precautions to prevent spread of infection |
| Influenza and Influenza Like Illness (ILI) | Staff with probable/suspected flu or flu like symptoms, (feverof >38°C or history of fever plus two or more symptoms ofcough or other respiratory symptoms, chills, sore throat,headache, muscle aches) should stay away from work andinform their manager of symptom presentationIf influenza is suspected linked to healthcare contact or confirmed swab results staff should remain off work for a minimum of five days from symptom onset and should stay away from work until they feel well |
| Measles | Staff with Measles must be excluded for four days from onsetof rash and return to work only when feeling well. Measles ispreventable by vaccination (2 doses of MMR) which should beoffered to agreed staff groupsPregnant staff who are contacts should seek prompt advice from their GP or midwife |
| MRSA | Occupational Health to be consulted  |
| Mumps | Staff with Mumps must be excluded for five days from onset ofswelling and must feel well before returning to work. Mumpsis preventable by vaccination (2 doses of MMR) which shouldbe offered to agreed staff groupsStaff who are contacts should seek prompt advice from Occupational Health |
| Pandemic | Refer to current governmental advice |
| Ringworm | Treatment will usually be provided from GP and member ofstaff if completing healthcare tasks will need to keep affectedarea coveredFor staff with ringworm on their face/scalp further advice should be sought |
| Salmonellosis | Exclude staff member until they are symptom free for a period of 48 hours |
| Scabies | Exclude staff member until they have had their first treatmentIf crusted scabies, further treatments may be necessary prior to returning to work and advice from the Infection Prevention and Control Team and/or Occupational Health Department should be sought |
| Shingles | If rash is dry, or covered with an occlusive dressing as long asthe individual is medically well they are fit for workCare should be taken if Shingles rash is sited on a face and further advice is required from Infection Control and/or Occupational Health in this situation. |
| Streptococcal Group Ainfection (Strep pyogenes) | If infection is identified a course of antibiotic treatment isrequired. Staff may return to unrestricted duties after 48hours treatmentIf a member of staff is a household contact of someoneidentified with a Group A Streptococcal infection, the memberof staff must be aware of need to be vigilant for any signs andsymptoms of infection presenting in the 30 days from time ofcontactIf asymptomatic no further actions are required |
| Pulmonary Tuberculosis | Exclude from work until proven non-infectious |
| Whooping Cough(Bordetella pertussis) | Ensure Public Health England guidance on health managementof pertussis in healthcare settings is followed up |

In instances where the organisation manager is not the line manager for the staff member concerned, the organisation manager is to be informed of the absence at the earliest opportunity (or the deputy organisation manager in their absence).

Where absence affects clinical delivery or service delivery, the organisation manager is to be informed immediately in line with the organisation’s **Sickness absence management policy**.

Should doubt exist regarding the exclusion period, advice from the occupational health (OH) department must be sought. Occupational health can be contacted on 01372 205760 Monday to Friday 9.30am – 4pm. Out of hours, weekends and bank holidays – Accidnet and Emergency Department.

NB: The table above is not exhaustive.

Reference: [Worcestershire Health and Care NHS Trust](https://www.worcestershirehealth.nhs.uk/EasySiteWeb/GatewayLink.aspx?alId=181178)

# Annex Q – Example IPC Annual Statement Report

Sheerwater Health Centre

[Insert date]

**Purpose**

This annual statement will be generated each year in [enter month] in accordance with the requirements of the [Health and Social Care Act 2008 Code of Practice](https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance) on the prevention and control of infections and related guidance. The report will be published on the practice website and will include the following summary:

* Any infection transmission incidents and any action taken (these will have been reported in accordance with our significant event procedure)
* Details of any infection control audits undertaken, and actions undertaken
* Details of any risk assessments undertaken for the prevention and control of infection
* Details of staff training
* Any review and update of policies, procedures, and guidelines

**Infection Prevention and Control (IPC) lead**

The lead for infection prevention and control at Sheerwater Health Centre is [insert name and role].

The IPC lead is supported by [insert name and role].

**a. Infection transmission incidents (significant events)**

Significant events involve examples of good practice as well as challenging events.

Positive events are discussed at meetings to allow all staff to be appraised of areas of best practice.

Negative events are managed by the staff member who either identified or was advised of any potential shortcoming. This person will complete a Significant Event Analysis (SEA) form that commences an investigation process to establish what can be learnt and to indicate changes that might lead to future improvements.

All significant events are reviewed and discussed at several meetings each month. Any learning points are cascaded to all relevant staff where an action plan, including audits or policy review, may follow.

In the past year there have been [xx] significant events raised that related to infection control. There have also been [xx] complaints made regarding cleanliness or infection control.

**b. Infection prevention audit and actions**

Detail information about the organisation and any requirements needed following the CQC inspection.

Input any information regarding any external IPC inspections.

List all internal audits that have been conducted within the previous year. Discuss the implementation of any audit requirements or shortcomings and how staff are involved to promote high standards of IPC.

Detail any projected audit reviews and frequency.

**c. Risk assessments**

Risk assessments are carried out so that any risk is minimised to be as low as reasonably practicable. Additionally, a risk assessment that can identify best practice can be established and then followed.

In the last year, the following risk assessments were carried out/reviewed:

[Detail what assessments have been conducted].

A suggested list, but one that is not exhaustive, could contain the following:

* General IPC risks
* Staffing, new joiners and ongoing training
* COSHH
* Cleaning standards
* Privacy curtain cleaning or changes
* Staff vaccinations
* Infrastructure changes
* Sharps
* Water safety
* Toys
* Assistance dogs

In the next year, the following risk assessment will also be reviewed:

[Detail]

**d. Training**

In addition to staff being involved in risk assessments and significant events, at Sheerwater Health Centre all staff and contractors receive IPC induction training on commencing their post. Thereafter, all staff receive refresher training [annually].

Various elements of IPC training in the previous year have been delivered at the following times: [Detail]

**e. Policies and procedures**

The infection prevention and control related policies and procedures that have been written, updated, or reviewed in the last year include, but are not limited, to:

 [Detail]

Policies relating to infection prevention and control are available to all staff and are reviewed and updated annually. Additionally, all policies are amended on an ongoing basis as per current advice, guidance, and legislation changes.

**f. Responsibility**

It is the responsibility of all staff members at Sheerwater Health Centre to be familiar with this statement and their roles and responsibilities under it.

**g. Review**

The IPC lead and [enter name and post] are responsible for reviewing and producing the annual statement.

This annual statement will be updated on or before [enter date].

**Signed by**

[Insert name]

For and on behalf of Sheerwater Health Centre

# Annex R – PPE protocol

**Introduction**

Whilst there has always been a need to provide robust PPE measures in primary care to support infection control principles, during the pandemic there has been a significant emphasis on having greater protection from COVID-19.

Public Health England suggests that *“those most at risk within the UK are professionals working in health and social care sectors. This is because these sectors are responsible for providing essential treatment and care for those who are confirmed to have COVID-19, are symptomatic or are highly vulnerable. They are in prolonged close contact with individuals who are symptomatic or particularly vulnerable to infection”.*

The UK government and devolved administrations have published clear guidance on appropriate PPE for health and social care workers and this has been written and reviewed by all four UK public health bodies and informed by NHS infection prevention and control experts. For guidance relating to COVID-19, see [Chapter 5](#_IPC_and_COVID-19).

Further reading can be found at **COVID-19 risk assessment – an aide memoire**.

**Legal**

The regulations require that where the health and safety risks cannot be controlled by other means, PPE is required to be correctly selected and used.

If PPE is required, then it will be provided free of charge by the organisation.

**PPE requirements**

In accordance with the [COSHH Regulations](http://www.hse.gov.uk/coshh/), the hierarchy of controls that should be applied when assessing the risks are:

* Eliminate
* Substitute
* Segregate
* Ventilate including local exhaust ventilation
* Personal protective equipment

However, it is recognised that in certain situations and environments not all of these controls can be suitably considered such as infection control between person to person.

Employees who have been provided with PPE must ensure it is used and worn in accordance with the instructions provided.

[RCGP](https://www.rcgp.org.uk/about-us/rcgp-blog/covid-19-gp-guide-personal-protective-equipment.aspx) advises that basic PPE protection includes:

* Disposable aprons
* Disposable gloves
* Fluid resistant face mask
* Eye protection. This should be worn when there is a risk of contamination to the eyes from splashing of secretions (including respiratory secretions), blood body fluids or excretions

Face masks for general patient assessment only need to be of a fluid resistant, surgical mask types. Once worn, masks should not be touched and should be changed if they become damp or damaged.

An individual risk assessment should be carried out prior to/at the time of providing care. Eye/face protection can be achieved by the use of any one of the following:

* Surgical mask with integrated visor
* Full face shield/visor
* Polycarbonate safety spectacles or equivalent

Cambridge Hospitals NHS Trust has provided this [YouTube clip](https://youtu.be/j3hfEpjAx0E) detailing PPE requirements and procedures within primary care.

Further reading can be sought from [HSE](https://www.hse.gov.uk/pubns/indg174.pdf).

**Risk assessment and selection of PPE**

The completion of a risk assessment will identify if there is a requirement for PPE, such as when preparing COSHH assessments that identify the requirement for gloves when using certain substances.

When selecting the suitability of PPE, the following will be considered:

* It is appropriate for the risks involved and the extent of exposure
* It will be used to prevent or adequately control the risks without increasing the overall risk
* It will be adjustable and meet the needs of the user to fit correctly and comfortably
* The health and wellbeing of employees required to use it
* The length of time that it is to be worn and the requirements for visibility and communication
* The compatibility when using more than one item of PPE

It is essential that the right type and standard of PPE is identified and provided. Additionally, all new PPE will be ‘CE’ marked to demonstrate certain basic/minimum safety requirements.

Further reading on risk management and risk assessing can be found in both the **Risk and Issue Guidance document** and the **Risk Assessment Guidance document**.

**Information, instruction and training**

The organisation will ensure that, where PPE is provided, the provision of adequate information, instruction and training on its use are also included, including refresher training. This will cover:

* The types of risk exposure and why PPE is required
* The operation, performance and limitations of the equipment
* The correct methods for usage and storage
* Any testing requirements before use
* User maintenance including hygiene and cleaning procedures
* Factors that may affect the equipment
* How to identify defects in PPE and the methods of reporting these
* Arrangements for PPE replacement

**Maintenance and storage**

Maintenance schedules provided with the PPE from the manufacturer are designed to ensure the equipment continues to give the degree of protection for the required purpose. These schedules can also include recommended replacement periods and expiry dates. When issued with PPE, it is important to follow the procedures regarding cleaning, examination, replacement, repair and testing of any equipment supplied.

Any costs incurred for the maintenance of PPE will be the responsibility of the organisation and adequate storage facilities for PPE to protect it from contamination, damage, damp or sunlight when not in use will be provided.

**Duties of employees regarding PPE**

PPE is a fundamental element of safe practice in primary care. At Sheerwater Health Centre, staff must be aware of the requirements for PPE and infection control requirements and associated policies.

The Personal Protective Equipment at Work Regulations place duties on employees to take reasonable steps to ensure that the PPE provided is properly used.

Other requirements include:

* PPE must be worn and used in accordance with the instructions given
* Employees must take all reasonable steps to ensure that PPE is stored correctly and safely when not in use
* PPE must be examined before use
* Any loss or obvious defect must be immediately reported
* Employees must take reasonable care of any PPE provided and not carry out any maintenance unless trained to do so

Furthermore, in accordance with [HTM 07-01](https://www.england.nhs.uk/wp-content/uploads/2021/05/HTM_07-01_Final.pdf), the following details the specification for PPE:

* COSHH requires that risks to health be eliminated, prevented or, where this is not reasonably practicable, reduced.

Although the use of PPE should be considered as additional to other control measures, it is likely that even after all reasonably practicable precautions have been taken to reduce the exposure of staff who handle, transfer, transport, treat or dispose of healthcare waste, some PPE will still be required. In such cases, employers must ensure that these items are provided, used and maintained.

They must also make appropriate arrangements for storage and cleaning whilst employees must cooperate with employers to ensure that their legal duties are met.

The **COSHH Risk Assessment Guidance document** can be used to support the organisation of the management of COSHH.

Risk assessments might identify the need for PPE, such as:

* Suitable heavy-duty gloves when handling healthcare waste receptacles

Safety shoes to protect the feet against the risk of receptacles being accidentally dropped. The soles of such shoes or boots may also need to provide additional protection against slippery floors and sharps

An industrial apron or leg protectors if receptacle handling creates a risk of bodily contact

* Protective face visors, helmets and strong industrial gloves where incinerators or other machines are charged manually

Emergency situations, such as spillages, should also be addressed in any risk assessments. This might include the need for protective equipment to prevent exposure via routes such as skin contact (for example single-use aprons and gloves) or inhalation (for example respiratory protection and/or face visors).

Basic personal hygiene is important in reducing the risk from handling healthcare waste. Employers need to ensure that washing facilities are conveniently located for people handling healthcare waste; this is particularly important at storage and incineration facilities.

**Duties of employees regarding personal clothing**

All personnel at this organisation are to ensure that their own clothing is clean and ‘fit for purpose'.

**Guide to donning and doffing PPE**

The UKHSA Guide to donning and doffing PPE: Droplet Precautions poster can be [downloaded here](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1044504/COVID-19_Non_AGP_Donning_and_doffing_PPE_droplet_precautions.pdf). PPE is to be disposed of as infectious clinical waste (orange bag).

# Annex S – HCAI in the Community – Urinary Catheters

**Introduction**

There are two main types of urinary catheter:

* *Intermittent catheters* which are temporarily inserted into the bladder and removed once the bladder is empty
* *Indwelling catheters* which remain in place for many days or weeks and are held in position by an inflated balloon in the bladder

Many patients prefer to use an indwelling catheter as it is more convenient and avoids the repeated insertions needed with intermittent catheters. However, indwelling catheters are [more likely to cause problems](https://www.nhs.uk/conditions/urinary-catheters/) such as infections.

**Education of patients, their carers and healthcare workers**

In addition to preventative infection control measures, such as handwashing and PPE, patients and carers should, where appropriate, also be educated about and trained in the insertion of intermittent catheters and catheter management before any discharge from hospital.

Additionally, due to the greater collaboration between traditional primary care roles and those within the community setting, PCN staff working within the community must also be trained in catheter insertion. This training is to also include the routine management of suprapubic catheters as the insertion site is considered to be a major infection route.

Follow-up training and ongoing support of patients and carers should be available for the duration of long-term catheterisation.

**Assessing the need for catheterisation**

Indwelling urinary catheters should be used only after alternative methods of management have been considered. The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible.

Catheter insertion, changes and care should be documented.

# Annex T – HCAI in the community – Vascular Access Devices (VADs)

**Introduction**

A vascular access device (VAD) is an indwelling catheter, cannula or other instrument used to obtain venous or arterial access.

VADs are inserted into veins via peripheral or central vessels for diagnostic or therapeutic reasons, such as blood sampling, central venous pressure readings, the administration of medication, fluids, total parenteral nutrition and blood transfusions.

Further information on the types of VADs and their use can be found in the following article:

<https://www.nursingtimes.net/clinical-archive/haematology/make-the-right-choice-of-vascular-access-device-01-06-2004/>

**Education of patients, their carers and healthcare workers**

Before discharge from hospital, patients and their carers should be taught any techniques they may need to use to prevent infection and safely manage a VAD.

Healthcare workers caring for a patient with a VAD should be trained, and assessed as competent, in using and consistently adhering to the infection prevention practices described in this guideline.

Follow-up training and support should be available to patients with a VAD and their carers.

**General asepsis**

Hands must be cleaned and decontaminated (see Art 3.4) before accessing or dressing a VAD.

An [aseptic technique](https://www.healthline.com/health/aseptic-technique) must be used for VAD catheter site care and when accessing the system.

**Further information on VADs**

For further information on VADs, refer to the Vascular Access Device Clinical Protocol and/or [NICE Guidance QS61](https://www.nice.org.uk/guidance/qs61/chapter/quality-statement-5-vascular-access-devices) published April 2014

# Annex U – HCAI in the Community – Enteral feeding

**Introduction**

This is a type of feeding used for people who cannot eat normally where liquid food is given through a tube directly into the gut.

**Education of patients, their carers and healthcare workers**

Before patients leave hospital, they, along with their carers, should have received thorough training and feel confident about managing enteral feeding at home.

The patient should be reassured that there is support available at home from community healthcare staff following discharge.

Avoiding infections such as gastroenteritis is particularly important for people who have enteral feeding.

**Equipment**

The equipment used for giving feeds should be handled as little as possible and an aseptic technique should be used. The feed-giving set and feed containers must be discarded after each feeding session.

The place where the feeding tube enters the body, ‘the peg,’ should be washed daily with water and dried thoroughly.

To prevent blockages, the feeding tube should be flushed with freshly drawn tap water before and after feeding or giving medications, using syringes provided by the patient’s healthcare worker. However, for immunosuppressed patients, either cooled freshly boiled water or sterile water from a freshly opened container should be used to flush the tube.

**Further information on enteral feeding**

For further information on enteral feeding, refer to the Enteral Clinical Protocol and/or [NICE Guidance QS139](https://www.nice.org.uk/guidance/cg139/ifp/chapter/enteral-feeding) Updated February 2017.

# Annex V – Infection control audit

**INFECTION CONTROL AUDIT**

**INFECTION CONTROL AUDIT**

***The following audit tool is taken from ‘Infection Control Guidance for General Practice’ published by Community Infection Control Nurses Network of the Infection Prevention Society in conjunction with the Royal College of General Practitioners.***

**Method of weighting and scoring**

* For each section, answer each question with ‘YES’, ‘NO’, ‘PARTIAL’ or ‘N/A’
* Give each answer the following scores
	+ - YES = 1
		- NO = 0
		- N/A = 1
		- PARTIAL COMPLIANCE - there are three categories:
			* Low = 0.25
			* Medium = 0.5
			* High = 0.75
* Add together the scores for the questions to give a total score for the audit.
* Divide the total score by the total number of questions in the audit.
* Then, multiply by 100% to give an overall compliance score in percentage.

**Overall score = \_\_\_\_\_\_\_Total Final Score\_\_\_\_\_\_\_\_ x 100 = %**

 **Total number of questions (77)**

**Section 1: Management (8 questions)**

**Standard: Infection control management is seen as an integral part of the overall business of the practice**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Infection control related topics are an agenda item at practice business meetings and decisions are recorded | Y | N | P |  |
| Up-to-date records are kept, detailing staff training in infection control related subjects. | Y | N | P |  |
| All staff knows where to find the local contact numbers for the Infection Control Team, Microbiologist and Consultant in Communicable Disease Control. | Y | N | P |  |
| Accurate records are kept of staff immunisation, immune status, and dates of future boosters as appropriate. | Y | N | P |  |
| The practice has documentary evidence of audits undertaken and practice changed to improve infection control. | Y | N | P |  |
| An incident book is kept for reporting all accidents and near misses including those with implications for cross-infection. | Y | N | P |  |
| Staff are immunised in line with current guidelines. | Y | N | P |  |
| Senior member of staff is designated infection control lead role. | Y | N | P |  |

**Section 2: Clinical practices (13 questions)**

**Standard: Clinical practices reflect infection control guidelines.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Staff have access to infection control guidelines | Y | N | P |  |
| The following protective clothing is available to staff:* Latex sterile gloves (non-powdered)
* Vinyl non-sterile gloves
* Plastic disposable aprons
* Eye protection (goggles or visors)
* Face masks
 | Y | N | P | N/A |
| When questioned, staff can state the procedure for dealing with specimens of blood or body fluids. | Y | N | P | N/A |
| There are designated fridges for storage of specimens and pharmaceutical products. | Y | N | P | N/A |
| Appropriate transport containers are available for pathology specimens. | Y | N | P | N/A |
| Suction machines are stored clean and dry. | Y | N | P | N/A |
| All sterile products are stored above floor level. | Y | N | P |  |
| Items of sterile equipment are within their use-by date. (check 2 random items). | Y | N | P |  |
| Single-use paper towelling is used to protect the treatment couches. | Y | N | P |  |
| Blood sampling is undertaken using a single-use vacuum blood collection system to minimise risk. | Y | N | P | N/A |
| Chemical disinfectants are prepared at correct strength and used appropriately in practice. (Look for written policy and procedures with dilution tables.) | Y | N | P |  |
| Data sheets are available for all products (COSHH 1999). | Y | N | P |  |
| Biohazard Spill Kit is available to deal with blood spillage | Y | N | P |  |

**Section 3: Hand washing (16 questions)**

**Standard: Correct facilities are available for staff and patients to decontaminate hands. In addition, staff can demonstrate effective methods of decontaminating hands.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| There is easy access to all hand wash basins. | Y | N | P |  |
| Hand wash basins are designated for this use only. | Y | N | P |  |
| Liquid soap is available in wall –mounted dispensers at all hand wash basins (no bar soap) | Y | N | P |  |
| Hand wash basins are cleaned thoroughly at the end of each day or when visibly soiled. | Y | N | P |  |
| There is an adequate supply of paper towels at each hand wash basin. | Y | N | P |  |
| Paper towels are supply through paper towel dispensers | Y | N | P |  |
| Hand wash basins are free from plugs. | Y | N | P |  |
| Hand wash basins are free from nail brushes. | Y | N | P |  |
| Hand wash basins are free from extraneous items such as cups/drinking glasses. | Y | N | P |  |
| Alcohol-based hand rubs are available for staff use. | Y | N | P |  |
| Staff can describe the correct use of alcohol-based hand rubs. | Y | N | P |  |
| Staff are observed using hand rub or soap and water to decontaminate hands correctly during the audit. Request staff to demonstrate if necessary. | Y | N | P | N/A |
| Clinical staff hands are free of nail art and jewellery (plain bands can be worn). | Y | N | P |  |
| Posters demonstrating good hand washing technique are available at the hand wash basins in clinical areas. | Y | N | P |  |
| Wash hand basins are fitted with mixer valves or elbow/wrist/foot operated mixer taps. | Y | N | P |  |
| Yearly training records of hand hygiene are available  | Y | N | P |  |

**Section 4: Waste disposal (8 questions)**

**Standard: All waste is managed correctly to minimise risk of infection or injury to staff and the public.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| There is a written policy available to all staff on waste disposal. | Y | N | P |  |
| Foot-operated clinical waste bins are easily accessible in the clinical area. | Y | N | P |  |
| Yellow bags are placed in foot-operated bins that are in good working order. | Y | N | P |  |
| Household waste is placed in black bags. | Y | N | P |  |
| Glass and aerosols are disposed of in rigid containers, not placed in bin liners. | Y | N | P | N/A |
| Clinical waste is stored in a designated locked area which is inaccessible to people and animals. | Y | N | P | N/A |
| The storage area for waste is clean. | Y | N | P |  |
| There is documentary evidence to show that all clinical waste (including sharps boxes) is disposed of by a registered waste collection company. | Y | N | P |  |

**Section 5: Clinical equipment (13 questions)**

**Standard: All clinical equipment is decontaminated appropriately and stored correctly.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Single-use items are used once and then discarded | Y | N | P |  |
| Items are stored appropriately to avoid contamination with dust or splashes (e.g. cupboards, drawers, lidded containers). | Y | N | P |  |
| All reusable items are decontaminated by a contracted CSSD service prior to storage. (Check 2 random items), | Y | N | P | N/A |
| All reusable items are examined for wear and tear, e.g. rust on instruments, loose hinges. | Y | N | P | N/A |
| Items found to have faults or damages are taken out of service. | Y | N | P | N/A |
| Dressing trolleys are clean and in a good state of repair. | Y | N | P |  |
| Decontamination certificates/labels are completed and attached to equipment prior to sending for service or repair. | Y | N | P |  |
| Examination specula are disposable.  | Y | N | P | N/A |
| Sterile specula are used for IUCD insertion. | Y | N | P | N/A |
| All instruments required to be sterile at the point of use are available pre-packed and sterile or autoclaved by a contracted CSSD service. | Y | N | P | N/A |
| Nebuliser equipment is designated single patient use and disposed of as a clinical waste. | Y | N | P | N/A |
| Nebuliser machines are cleaned between use with solution of detergent and water. | Y | N | P | N/A |
| All tubing used to connect nebuliser equipment to nebuliser machines are single-use and disposed of as a clinical waste. | Y | N | P | N/A |

**Section 6: Sharps handling and disposal (7 questions)**

**Standard: To avoid the risk of needlestick injuries, sharps are handled and disposed of safely.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| A written policy and procedure for handling and disposal of sharps is available. | Y | N | P |  |
| Sharps boxes are available for use and conform to British Standard BS 7320 and UN Standard (UN 3291). | Y | N | P |  |
| Boxes are discarded when two thirds full to a designated clinical waste collecting area. | Y | N | P |  |
| Sharps boxes are assembled correctly according to manufacturer’s instructions. | Y | N | P |  |
| Sharps boxes are labelled in accordance with legal requirements. | Y | N | P |  |
| Staff knows what action to take in the event of a needlestick injury (randomly question staff members). | Y | N | P |  |
| Sharps boxes are stored above floor level. | Y | N | P |  |

**Section 7: The general environment (12 questions)**

**Standard: Good standards of general hygiene are maintained to ensure the health and safety of patients and staff.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| All areas including clinical areas are visibly clean and free from extraneous items. | Y | N | P |  |
| The sluice area is visibly clean and free from spillages. | Y | N | P | N/A |
| Equipment is visibly clean and in a good state of repair. | Y | N | P |  |
| Mops/buckets are clean, dry and stored inverted. | Y | N | P | N/A |
| Mops are laundered after each use or are disposable. | Y | N | P | N/A |
| Walls are intact and have smooth washable surfaces. | Y | N | P |  |
| Floor coverings are intact and have smooth washable surfaces. | Y | N | P |  |
| Furniture and all horizontal surfaces are cleaned on a regular basis (and cleaning regimes are documented and filed). | Y | N | P |  |
| All horizontal surfaces are accessible and uncluttered for ease of cleaning. | Y | N | P |  |
| Equipment such as computer terminals and keyboards within treatment areas are in a visibly clean state. | Y | N | P |  |
| Curtains are laundered at least 6 monthly | Y | N | P | N/A |
| Curtain rails are free from dust. | Y | N | P | N/A |

1. [COSHH 2002](http://www.hse.gov.uk/coshh/index.htm) [↑](#footnote-ref-1)
2. [NICE Guidance](https://www.nice.org.uk/guidance/cg139/chapter/1-guidance) [↑](#footnote-ref-2)
3. [Guidance on the correct disposal of potentially hazardous clinical waste](https://www.gov.uk/guidance/healthcare-waste) [↑](#footnote-ref-3)
4. [HSE Sharps injuries – What you need to do](http://www.hse.gov.uk/healthservices/needlesticks/actions.htm) [↑](#footnote-ref-4)
5. [HSE Health Services Information](http://www.hse.gov.uk/pubns/hsis7.pdf) [↑](#footnote-ref-5)