Balaam St Surgery
NHS
Same Day Personal Care

Infection Control Policy **Next reviewed on 18/6/2025**

Introduction

The purpose of an infection control policy is to stop and prevent spread of infection within the surgery. This document is based on Public Health Guidance embedded below. The Infection Control Lead for the practice is Dr Barry Sullman.

ICP Guidance.pdf

This documents also adopts and localizes policies from

- https://www.niinfectioncontrolmanual.net/
- https://www.infectionpreventioncontrol.co.uk/gp-practices/
- https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html

Standard infection control Precautions are a set of activities designed to prevent the transmission of organisms between patients/staff and in turn, prevent Healthcare Associated Infections.

We do not always know which patients/clients have organisms that can cause infection. Therefore standard precautions are used in the care of ALL patients/clients in EVERY healthcare setting.

Transmission Based Precautions are used IN ADDITION to Standard Precautions, where a patient is known (or suspected) to have a transmissible infectious organism/disease. These precautions target the three means of transmission (contact, droplet and airborne).

Infection Control Policy Contents	
Standard infection control Precautions	1. Hand Hygiene 2. PPE 3. Safe disposal of waste 4. Safe management of blood and body fluids 5. Safe management of care equipment 6. Safe management of linen (including uniforms and workwear) 7. Safe management of sharps and inoculation injuries 8. Safe management of the care environment
Transmission Based Precautions	9. Isolation, Patient placement and Assessment for Infection Risk 10. Aseptic Technique 11. Contact Precautions 12. Droplet Precautions 13. Airborne Precautions
Specific Infection Control Situations	14. Specimen Collection 15. Blood Borne Viruses

16. MRSA
17. Clostridium Difficile
18. PVL-SA (Panton-Valentien Leukocidin Staphylococcus Aureus)
19. Multi-Drug Resistant Organisms
20. Viral Gastroenteritis/Norovirus
21. Notifiable Diseases
22. SARS CoV2

1. Hand Hygiene

1.1 Hand Hygiene Introduction

The aim of this guidance is to promote good hand hygiene amongst all staff, to prevent the risk of patients acquiring a healthcare associated infection.

All staff will have training on hand hygiene from the Practice Infection Control Lead. This will be delivered on a regular basis annually and recorded in the Infection Control Log.

Hand hygiene is one of the most important procedures for preventing the spread of disease. It is essential that everyone takes responsibility to ensure that the care provided is carried out in a safe manner.

The transmission of microorganisms, such as bacteria and viruses, from one patient to another via staff's hands, or from hands that have become contaminated from the environment, can result in adverse outcomes.

1.2 Involving Patients and the Public in Infection Prevention and Control

Staff should encourage the involvement of patients and the public in infection prevention and control.

In order to facilitate compliance, the following facilities have been introduced:

- Provision of alcohol handrub at several points in reception, waiting area and in the consultation rooms.
- Notices encouraging hand hygiene are displayed throughout the building.

1.3 Microbiology of the Hands

The skin on our hands harbour two types of microorganisms:

Transient microorganisms

Transient microorganisms include bacteria and fungi, and are located on the superficial layers of the skin. They are termed 'transient' as they do not stay long, 'hitching a ride' on the surface of hands where they are easily transferred to other people, for example, contact with a patient's wound, care equipment, and the environment. Transient microorganisms are easily transmitted from staff hands to vulnerable patient sites. However, unlike resident bacteria, they are easily removed by routine handwashing with liquid soap and warm running water or the use of an alcohol handrub

Resident microorganisms (commensal or normal flora)

Resident microorganisms, e.g. Staphylococcus epidermidis, diphtheroids and occasionally Staphylococcus aureus, reside under the superficial cells of the stratum corneum - in skin crevices, hair follicles, sweat glands and under finger nails. Their primary function is defensive in that they protect the skin from invasion by more harmful microorganisms. They do not readily cause infections, but can, however, cause infection, e.g. if they enter the body through broken skin, a person is immunocompromised. They are not easily removed with routine handwashing alone. Either an antimicrobial solution should be used or routine (social) handwash followed by an application of alcohol handrub.

1.4 Good Hand Hygiene Practice

To facilitate effective hand hygiene when delivering direct care, clinical staff must ensure that they:

Cover cuts and abrasions with waterproof dressings

Are 'Bare Below the Elbows', which entails:

- Wearing short sleeved clothing
- Removing wrist and hand jewellery. Rings with jewels, stones, ridges or grooves, should not be worn as these may harbour bacteria and also prevent good hand hygiene. A plain band ring may be worn, but ensure the area under the ring is included when hands are washed or alcohol handrub applied
- Not having dermal piercings on the arms or wrists
- Keeping nails clean and short (fingertip length), as long finger nails will allow a build-up of dirt and bacteria under the nails and impede effective handwashing
- Keeping nails free from nail polish/gel as flakes of polish/gel may contaminate a wound and broken edges can harbour microorganisms
- Keeping nails free from acrylic/artificial nails, nail art/accessories, as these can harbour microorganisms, become chipped or detached

A poster detailing this is displayed in all consulting rooms. The poster is embedded below:

Bare Below Elbows.pdf

1.5 When to clean your hands

Before touching a patient

Clean your hands before touching a patient when approaching him/her. To protect the patient against harmful germs carried on your hands.

Before clean/aseptic procedure

To protect the patient against harmful germs, including the patient's own, from entering his/her body.

After body fluid exposure risk

Clean your hands immediately after glove removal following exposure risk to body fluids. This protects you and the health-care environment from harmful patient germs.

After touching a patient

Clean your hands after touching a patient and her/his immediate surroundings, when leaving the patient's side. This protects you and the health-care environment from harmful patient germs.

After touching patients surroundings

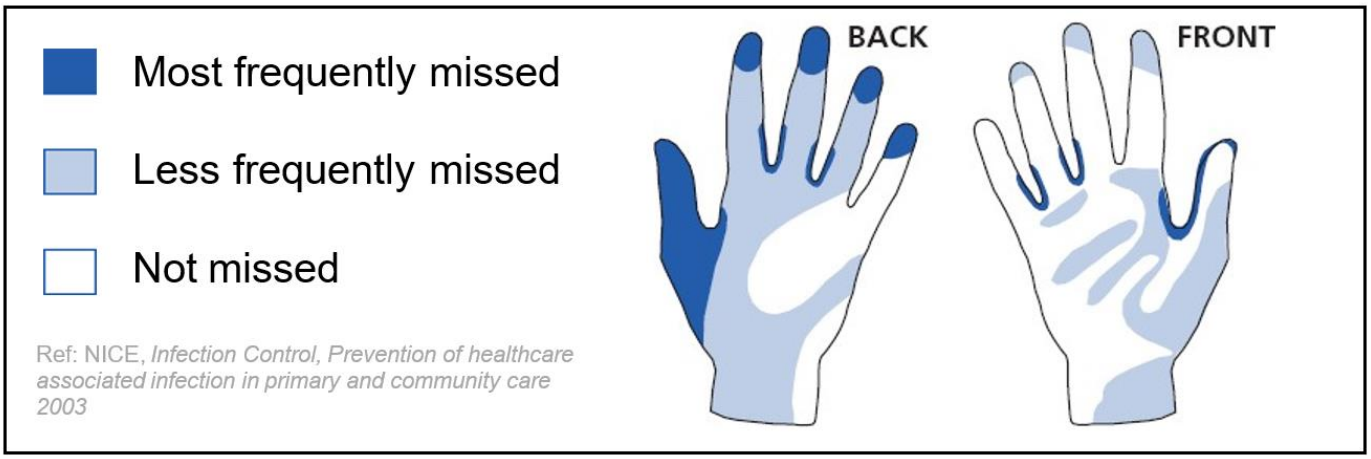
Clean your hands after touching any object or furniture in the patient's immediate surroundings, when leaving – even if the patient has not been touched. This protects you and the health-care environment from harmful patient germs.

A poster detailing this is displayed in all consulting rooms.
The poster is embedded here:

Your_5_Moments_For_Hand_Hygiene_Post

1.6 Most commonly missed areas

It is important to pay particular attention to the following areas which have beenshown to be those most commonly missed during handwashing:



1.7 Hand Hygiene Products

The Practice provides all clinical staff with:

- Antibacterial Handwash in a wall mounted dispenser. This is used for routine cleaning with water.
- Moisturizer. Hand care is important to prevent damage from repeated cleaning. (Also provided to all administrative staff).
- Alcohol Handrub with minimum 60% alcohol. This is to be used when it is not possible to wash the hands. (also provided to all administrative staff).

Each member of staff should put their name on their product to reduce the risk of cross contamination.

Hand hygiene facilities are present in all the consulting rooms:

- Handwash basins should not be used for any other purpose, e.g. disposing of urine, washing cups, decontamination of equipment, due to the risk of cross-contamination
- Bar soap should not be used as it can harbour microorganisms
- Use the wall mounted liquid soap dispensers with disposable soap cartridges. The practice does not use refillable soap dispensers as there is a risk of contamination of the liquid soap and the dispenser
- Fabric hand towels must not be used. Paper towels are provided and should be used in clinical areas and staff toilets as they are the most effective way of removing microorganisms. Wall mounted towel dispensers have been positioned next to the basin, but not so close as to risk contamination of the dispenser or towels. The Practice is using Soft Tork towels as these are constructed from soft paper towels which helps to prevent skin abrasion.
- Keep all dispenser surfaces, inside, outside and underneath, clean and replenished.
- A foot operated lidded lined waste bin, should be positioned near the handwash basin.
- Nail brushes are not used routinely in the practice as they can cause skin damage and harbour bacteria. If nail brushes are used, they should be single use and disposed of after use.

1.8 Hand Cleaning Methods

Handwashing is probably the most important method of protecting the patient. There are three levels of hand hygiene:

Routine (social) hand hygiene

Using liquid soap and warm running water removes dirt, organic matter, e.g. blood, faeces, and most transient organisms, acquired through direct contact with a patient or the environment. The use of a liquid soap containing a moisturiser is recommended to prevent drying of the skin. Handwashing process should take 15-30 seconds.

- Ensure you are 'Bare Below the Elbows'.
- Wet hands first under warm running water.
- Apply liquid soap.
- Rub all parts of the hands for at least 10-15 seconds ensuring that all surfaces of the hands and wrists are covered with soap.
- When caring for patients with confirmed or suspected COVID-19 or any other new emerging infections, rub all parts of the hands and in addition, using steps 2-8 shown in 1.14, rub exposed forearms as these may have been exposed to respiratory droplets.
- Rinse hands thoroughly under warm running water to remove residual soap/solution.
- Dry hands thoroughly using paper towels.
- Alternatively, alcohol handrub can be used instead of liquid soap and warm water, but only if hands are visibly clean.

Antiseptic hand hygiene

Using an antimicrobial solution or liquid soap and warm running water followed by an application of alcohol handrub disinfects the hands by removing transient organisms and reducing the number of resident organisms. This type of hand hygiene should be carried out prior to invasive procedures.

- Ensure you are 'Bare Below the Elbows'.
- Wet hands under warm running water.
- Apply antimicrobial solution or liquid soap.
- Rub all parts of the hands for at least 10-15 seconds as detailed in 1.14 ensuring that all surfaces of the hands and wrists are covered with soap/solution.
- Rinse hands under warm running water to remove residual soap/solution.
- Dry hands thoroughly using paper towels.
- If hands are washed with liquid soap, dry hands thoroughly and apply alcohol handrub after washing, ensuring all surfaces of the hands and wrists are covered with the product until the solution has dried.

Surgical hand hygiene

Using an antimicrobial solution removes transient organisms and a substantial number of resident organisms. The solution will bind to the skin forming an effective barrier that will keep killing bacteria for up to 6 hours after application. This type of handwashing is only required before more invasive surgical procedures, e.g. vasectomy.

- Procedure for using an antimicrobial solution
- Ensure you are 'Bare Below the Elbows'.
- Thoroughly wash the hands for 2 minutes following the technique in 1.14.
- Wash each arm from the wrist to the elbow for 1 minute, keeping the hand higher than the elbow at all times.
- Rinse hands and arms thoroughly from fingertips to elbow, keeping the hands above the elbows at all times.
- Dry hands thoroughly with a sterile paper towel.

1.9 Alcohol Handrub

Alcohol handrub containing a minimum of 60% isopropyl alcohol is an effective alternative to handwashing and is useful when there is a need for rapid hand disinfection. It should be applied to all areas of the hands using the steps 2-8 as shown in the hand hygiene poster in section 1.12

As shown in 1.11, ensuring that all surfaces of the hands and wrists are covered, until the solution dries.

Alcohol handrub should not be used:

- When caring for patients with Clostridioides difficile or other diarrhoeal illness, due to being ineffective against spores and Norovirus
- On hands that have come into contact with body fluids
- After cleaning an area or care equipment where a patient has diarrhoea and/or vomiting

Alcohol handrub:

- Should only be applied to visibly clean skin
- May be less effective if used immediately after the application of a hand cream/moisturiser

Technique for using alcohol handrub

- Ensure you are 'Bare Below the Elbows'
- Dispense the manufacturer's recommended amount of alcohol product on to hands, ensuring it covers all surfaces of the hand and wrist.
- Rub hands, using the steps 2-8 shown in 1.14, ensuring that all surfaces of the hands and wrists are covered with the product until the solution has dried (about 20 seconds).

Alcohol handrub have been provided throughout the surgery:

- At the entrance to the building or reception desk, following a risk assessment
- At the point of care:
- Free standing bottle on the consulting room desk

Alcohol handrub must not be applied to gloved hands as this may affect the integrity of the glove material.

1.10 Skin Care

To minimise the risk of skin damage, wet hands under warm running water before applying liquid soap or antiseptic solution.

Rinse hands well to remove residual soap and dry thoroughly to prevent chapping.

Always cover cuts and abrasions with a waterproof dressing.

Seek GP advice if you have a skin irritation.

The use of hand cream or lotion will help prevent skin problems and irritation, therefore, promoting compliance with hand hygiene.

For maximum benefit, hand cream or moisturiser should be used 3 times daily.

Moisturizer has been provided as individual personal units to each member of staff. These should not be shared because of the risk of cross contamination.

1.11 Hand Hygiene Technique for Staff Poster

A poster detailing the correct technique is fixed in each consulting room.
It is embedded here:

Hand Hygiene.pdf

2 PPE (Personal Protective Equipment)

2.1 Introduction

All clinical staff must be trained in the correct use and removal of personal protective equipment (PPE).

Before undertaking any task, staff should assess the risks associated with the patient interaction or task to be undertaken and wear PPE that protects adequately when:

- Dealing with a patient who has a confirmed or suspected infection
- There is likely exposure to blood and/or body fluids, non-intact skin or mucous membranes
- Decontaminating the environment or care equipment
- In contact with substances hazardous to health, e.g. cleaning/disinfecting products

Hands should be cleaned before putting on PPE. All PPE should be changed between tasks and disposed of as soon as the task is complete.

Contaminated/infectious PPE should be discarded into the clinical infectious waste stream, non-contaminated/non-infectious PPE should be discarded into the offensive waste stream. Always perform hand hygiene appropriately after removing and disposing of PPE. When caring for patients in relation to COVID-19, perform hand hygiene after removing and disposing of each item of PPE, e.g. pair of gloves, apron, mask, facial protection.

2.2 Gloves

If contact with blood and/or body fluids, substances hazardous to health, e.g. cleaning/disinfecting products, non-intact skin or mucous membranes, is anticipated or the patient has a confirmed or suspected infection, disposable gloves should be worn that are appropriate for the task.

Disposable gloves are single use only. The practice only uses Nitrile gloves. A detailed discussion of all the different glove types can be found at https://www.westlab.com/blog/2017/08/17/nitrile-vs-latex-vs-vinyl-gloves.

The wearing of gloves has been shown to reduce the volume of blood transferred in a needlestick injury by 52% compared with not wearing gloves, which can help reduce the risk of acquiring an infection if you sustain a needlestick injury.

Sterile gloves are also available in Room 7 and should be worn for an aseptic technique.

Hands must be washed with liquid soap and warm running water or alcohol handrub applied immediately before putting on and after removing gloves. Please note, alcohol handrub should not be used if hands are dirty, visibly soiled or dealing with a patient with Clostridioides difficile or other diarrhoeal illness, e.g. Norovirus.

2.3 Aprons

Disposable aprons are impermeable to bacteria and fluids and protect the areas of maximum potential contamination on the front of the body.

A disposable apron is single use and should be worn when:

- There is a risk of exposure to blood and/or body fluids, non-intact skin, mucous membranes
- Undertaking a procedure on a patient with a confirmed or suspected infection

- There is a risk of splashing or soiling to the front of the uniform or workwear
- Undertaking an aseptic technique
- Decontaminating care equipment or the care environment

Never wear an apron for a dirty task and then move onto a clean task without changing it.

Disposable aprons should be removed after each task.

Contaminated/infectious aprons should be discarded into the clinical infectious waste stream.

Hand hygiene should be performed after disposing of an apron.

2.4 Facial Protection

Appropriate facial protection should be worn if there is a risk of splashing of either blood and/or body fluids or substances hazardous to health, e.g. cleaning/disinfecting products, to the face; or the patient has a confirmed or suspected infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles.

Eye and face protection should not be impeded by accessories, e.g. false eyelashes, facial piercings.

The face shields are in Room 7 and the goggles are in the doctors cabinets

2.5 Eye protection

Goggles/safety glasses or a visor should be worn:

- When there is a risk of splashing of blood and/or body fluids or hazardous substances to the eyes
- If the patient has a suspected or confirmed infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles.

Prescription spectacles are not considered eye protection. Eye protection should be removed after each task, cleaned with detergent (yellow wipe) and then decontaminated (green wipe).

The face shields are in Room 7 and the goggles are in the doctors cabinets

2.6 Masks

The Practice has FFP3 and type IIR (fluid resistant) surgical masks. The FFP3 masks are located in the doctors equipment cabinets. The type IIR(fluid resistant) surgical masks are located in Room 7.

A type IIR (fluid resistant) surgical mask should be worn:

- When there is a risk of splashing of either blood and/or body fluids or substances hazardous to health, e.g. cleaning/disinfecting products, to the face
- If the patient has a suspected or confirmed infection transmitted by the droplet or airborne route, e.g. Pulmonary TB, rubella, measles (for COVID- 19, pandemic influenza, refer to the latest national IPC guidance)

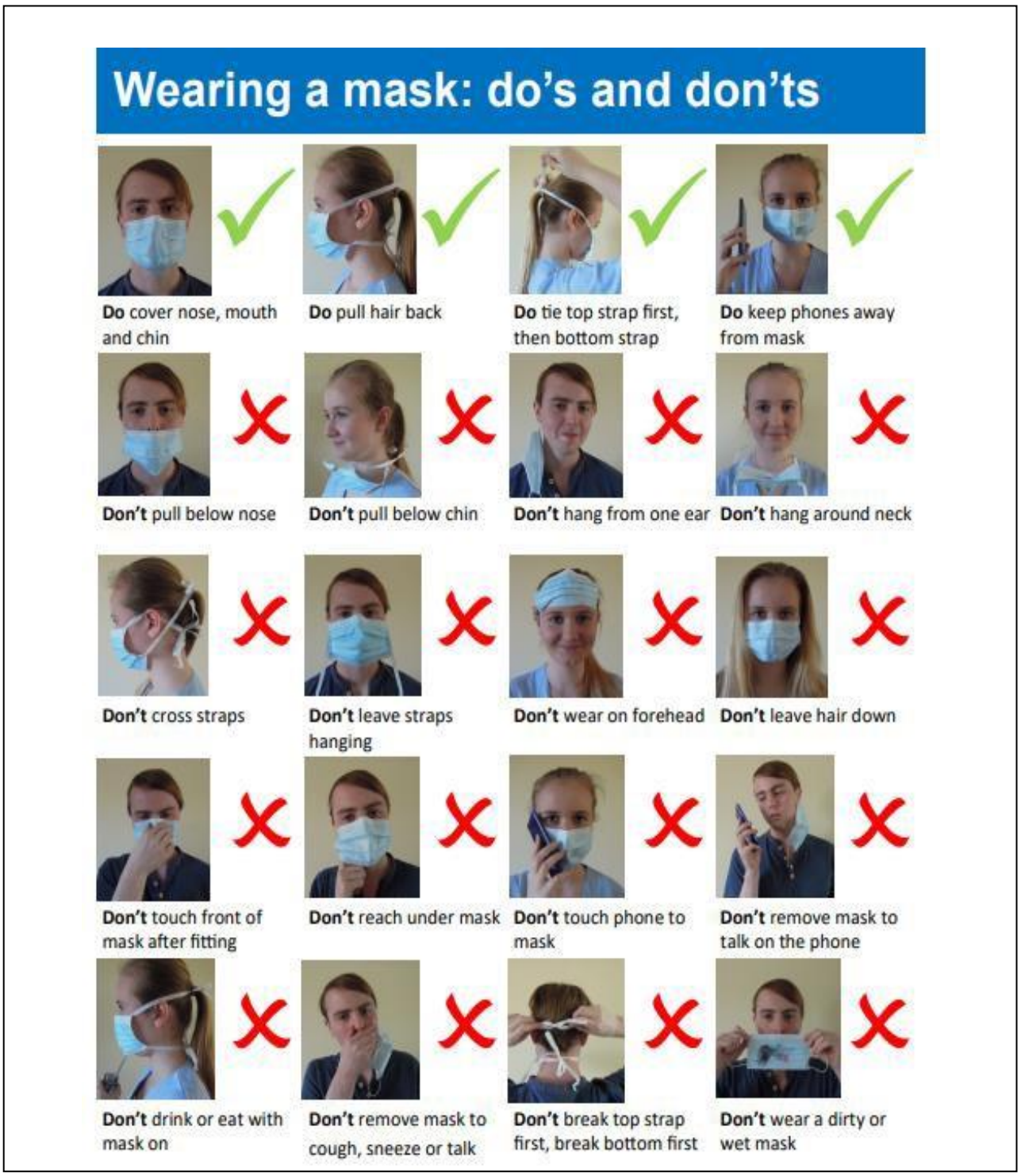
A FFP3 mask (respirator) should be worn where:

- There is a high risk of airborne infection

Surgical masks and FFP3 masks should be removed and disposed of appropriately after each task. They should only be worn once. Contaminated/infectious disposable respirators or masks should be discarded into the clinical infectious waste stream.

Hand hygiene should be performed after disposing of the mask.

Correct Wearing of a Surgical Mask



Disposable respirators are only effective when there is a good seal between the edges of the respirator and your face. If the seal is poor, protection is compromised as contaminated air can leak in through any gaps.

These fitting instructions must be followed each time a 3M™ Aura™ 9300+ Series respirator is worn.

Make sure that your face is clean shaven. Respirators should not be worn with stubble, beards or other facial hair under the area of the face seal as these can prevent a good seal to the face.

Make sure that long hair is tied back and jewellery is removed so that it does not interfere with the seal to the face.

1. With the reverse side up and using the tab, separate the top and bottom panels of the respirator to form a cup shape. Bend slightly at the centre of the noseclip.

2. Ensure that both panels are fully unfolded.

3a. Cup the respirator in one hand with the open side towards your face.

3b. Take both straps in your other hand. Hold the respirator under your chin, with the nosepiece facing upwards and pull the straps over your head.

4. Locate the upper strap across the crown of the head and the lower strap below your ears. The straps must not be twisted. Adjust the top and bottom panels for a comfortable fit, ensuring that the panels and tab are not folded in.

5. Using both hands, mould the noseclip to the shape of the nose to ensure a close fit and a good seal.

▲ **The respirator may not fit as well if you pinch the noseclip using one hand. Use two hands.**

6. Perform a fit-check by covering the front of the respirator with both hands taking care not to disturb its fit.

If you're using an unvalved respirator, **exhale** sharply.
If you're using a valved respirator, **inhale** sharply.

If air leaks around the nose, readjust the noseclip to eliminate leakage then repeat the fit check. If air leaks at the respirator edges, work the straps back along the sides of the head to eliminate leakage then repeat the fit check. **If you cannot achieve a proper fit, DO NOT enter the hazardous area. Consult your supervisor.**

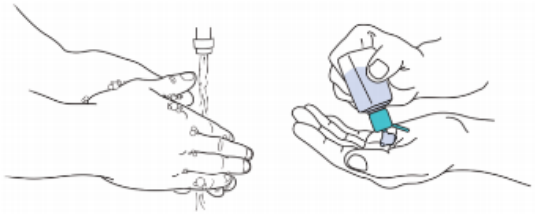
Users of 3M Aura 9300+ should be fit tested. Call the 3M Safety Services Coordinator on 0845 601 3457 or visit the website for further information.

The Power to Protect Your World℠

2.7 Correct order for putting on and removing PPE

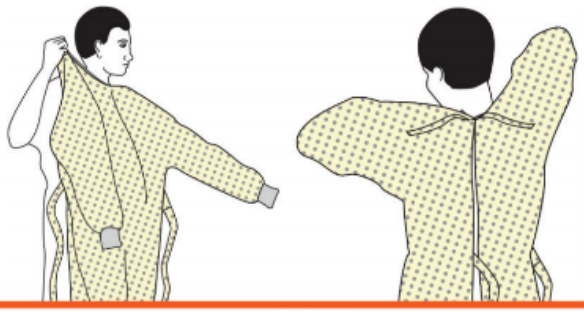
How to PUT ON personal protective equipment (PPE)

1 WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITISER IMMEDIATELY BEFORE PUTTING ON ALL PPE



2 GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back.
- Fasten at back of neck and waist.



3 SURGICAL MASK

- Secure ties or elastic bands at middle of head and neck.
- Fit flexible band to nose bridge.
- Fit snug to face and below chin.

4 EYE PROTECTION

- Place over eyes and adjust to fit.

5 GLOVES

- Extend to cover wrist of gown.

USE SAFE WORK PRACTICES TO PROTECT YOURSELF AND LIMIT THE SPREAD OF CONTAMINATION

- Keep hands away from face.
- Change gloves when torn or heavily contaminated.
- Limit surfaces touched.
- Perform hand hygiene.

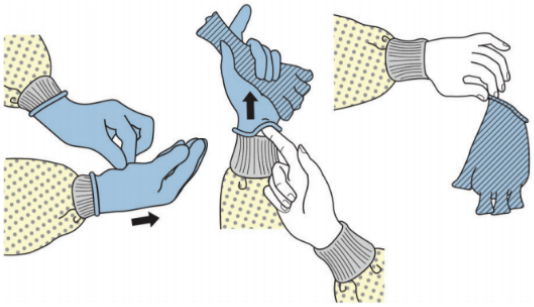
Content: Department of Health & Human Services, USA and Centres for Disease Control & Prevention

How to safely REMOVE personal protective equipment (PPE)

Move away from the patient as far as possible before removing PPE.

1 GLOVES

- The outside of your gloves are contaminated! If your hands get contaminated during glove removal, immediately wash them or use an alcohol-based hand sanitiser.
- Use one gloved hand to grasp the palm area of the other gloved hand. Peel off first glove.
- Hold removed glove in gloved hand.
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove.
- Discard gloves in a clinical waste container.
- Perform hand hygiene.



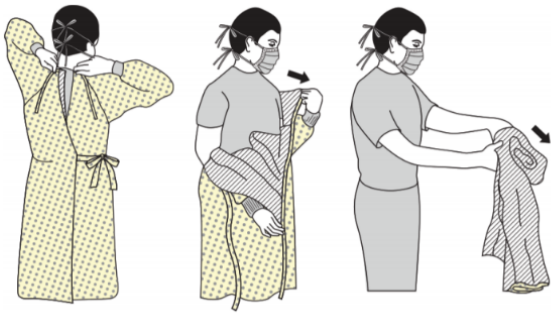
2 EYE PROTECTION*

- The outside of your eye protection is contaminated! If your hands get contaminated during removal, immediately wash them or use an alcohol-based hand sanitiser.
- Remove eye protection from the back by lifting ear pieces.
- If the eye protection is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a clinical waste container.

** If using integrated mask/eye protection, skip step 2.*

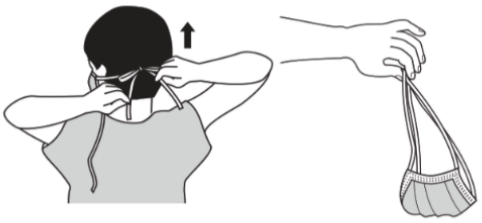
3 GOWN

- The outside of your gown front and sleeves are contaminated! If your hands get contaminated during gown removal, immediately wash them or use an alcohol-based hand sanitiser.
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties.
- Pull gown away from neck and shoulders, touching inside of gown only.
- Turn gown inside out.
- Fold or roll into a bundle and discard in a clinical waste container.
- Perform hand hygiene.



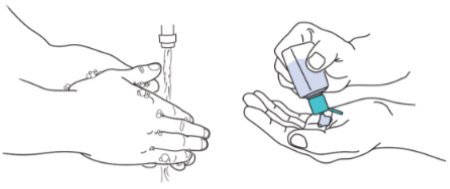
4 SURGICAL MASK

- The front of your mask is contaminated — **DO NOT TOUCH!** If your hands get contaminated during mask/respirator removal, immediately wash them or use an alcohol-based hand sanitiser.
- Grasp bottom ties or elastics of the mask, then the ones at the top, and remove without touching the front.
- Discard in a clinical waste container.



5 WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITISER IMMEDIATELY AFTER REMOVING ALL PPE

- Perform hand hygiene between steps if hands become contaminated and immediately after removing all PPE.



6 DISINFECTION OF ROOM

- Leave room closed and vacant after patient has left.
- Wear gown and gloves and wipe down all hard surfaces with virucidal disinfectant.
- Reusable eye protection should be cleaned with virucidal disinfectant.
- Medical equipment that has touched the patient must be wiped down with a virucidal disinfectant.
- Dispose of wiping agent in clinical waste container. Perform hand hygiene.

2.8 Footwear

Footwear must be well maintained, visibly clean, non-slip and support and cover the entire foot to avoid contamination with blood or body fluids or potential injury from sharps.

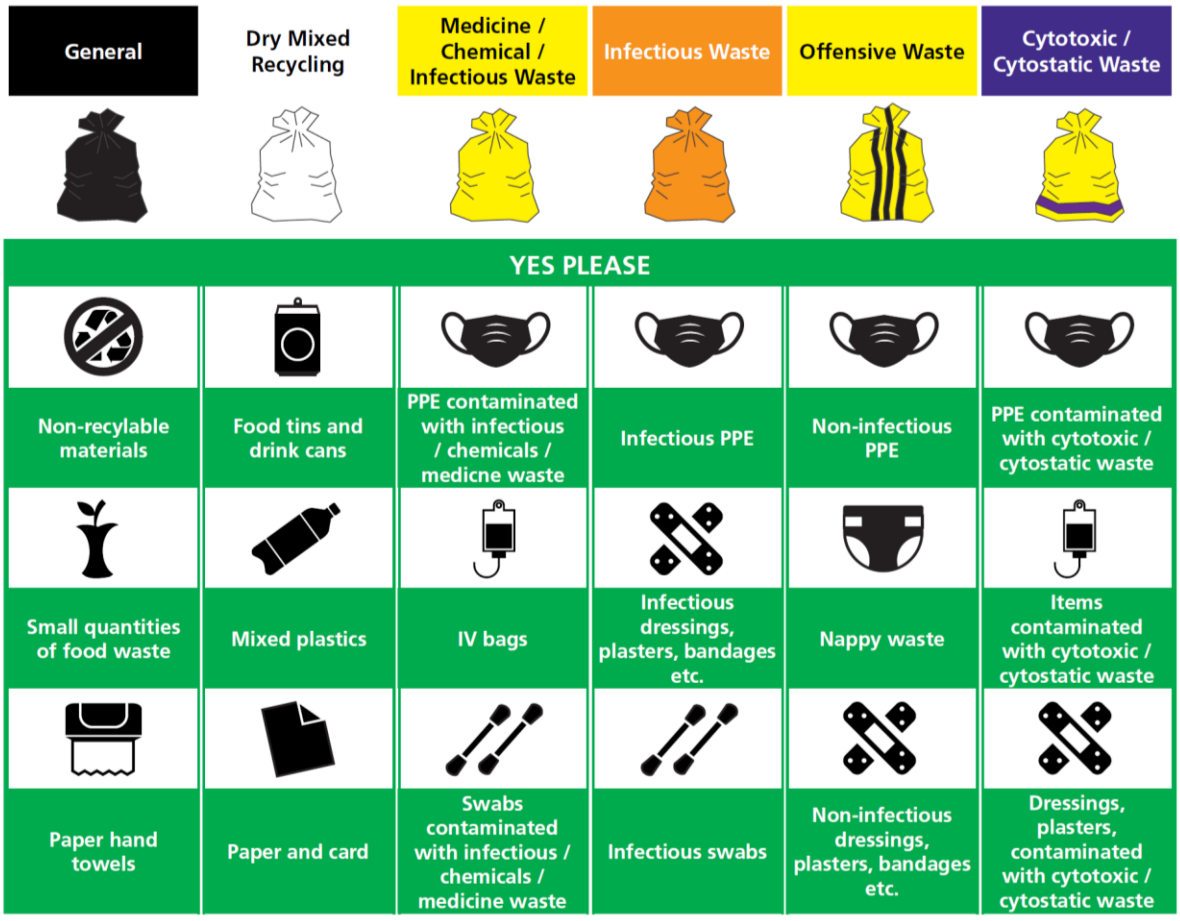
3 Safe Disposal of Waste

3.1 Introduction

All staff are responsible for the safe management and disposal of waste and should understand how waste should be segregated and stored prior to collection or disposal. This is driven by the need to reduce environ mental impact, comply with waste regulations and other national guidance such as The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance, and reduce costs associated with waste management.

3.2 Responsibilities

All staff are responsible to ensure that waste is put into the correct colour bin. This is illustrated in the chart below:



When handling waste, appropriate personal protective equipment (PPE) should be worn, and hands cleaned after removing PPE.

All waste bags should be no more than 3/4 full. This allows enough space for the bag to be tied using a suitable plastic zip tie or secure knot.

NHS Property Services are responsible for disposal of waste.

Useful media is at https://www.property.nhs.uk/news-insight/insights/how-to-dispose-of-waste-correctly/

4 Safe Management of Blood and Body Fluids

4.1 Introduction

4.2 Dealing with blood and body fluid spillages

4.3 Splashes of blood or body fluids

4.1 Introduction

Blood and body fluids, e.g. urine and faeces, may contain a large number of microorganisms, such as bacteria and viruses.

Staff who may have contact with blood or blood stained body fluids, or are exposed to sharps or other inoculation risks, should attend their GP for hepatitis B vaccination and antibody testing to check for their response.

Contamination or spillages with blood or body fluids should be dealt with immediately, as this may expose staff and others to infection. Blood and body fluid spillages should be managed by staff trained in the correct procedure.

4.2 Dealing with blood and body fluid spillages

Clean up blood and body fluids promptly to reduce the risk of infection to other people.

Appropriate personal protective equipment (PPE) should be worn and standard infection control precautions followed.

The spillage kit is located in Room 7.

Dispose of waste and PPE as infectious waste. All cloths used must be single use and disposed of after use. After cleaning the spillage, wash hands with liquid soap and warm running water.

4.3 Splashes of blood or body fluids

Splashes of blood or body fluids to the eyes, nose or mouth must be treated as potential exposure to a blood-borne virus, refer to the Blood Borne Virus section of this policy. For appropriate management of percutaneous exposures (sharps/splash injuries), refer to the 'Safe management of sharps and inoculation injuries' section of this policy.

Any spillages or splashes should be cleaned by the Biohazard spill kit illustrated below. A spill kit is in every room located on the apron holder. A stock of spill kits are in Room 7.

A training video showing how the spill kit works can be found at https://www.youtube.com/watch?v=eIu1uSWt5WQ

5 Safe Management of Care Equipment

In order to ensure safe systems of work and to prevent transmission of infection, it is essential that decontamination of reusable medical devices and care equipment after use on a patient is undertaken to prevent the transmission of infection. This is in accordance with the requirements of The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance.

DAILY

All Clinical Staff are responsible for cleaning their reusable equipment on a daily basis. To facilitate this, the equipment has been placed into organized units which is sealed to maintain cleanliness. At the start of the day all the reusable equipment should be cleaned with a disinfectant wipe (Green wipe). Reusable equipment includes

- Stethoscope
- Blood pressure cuff
- Blood pressure machine
- Otoscope/Opthalmoscope
- Thermometer
- Peak Flow Meter

After disinfection an 'I am clean' GREEN sticker is attached to the box or cabinet. The label will give details of the date of cleaning and signed by the clinician who performed the decontamination.

After every use of the equipment it should be decontaminated (yellow wipe) and disinfected (green wipe).

Detergent Wipes
Highly effective, ultra-low smear multi-surface wipes for cleaning prior to disinfecting.
Use to clean

Green Disinfectant Wipe
Combined detergent and disinfectant. Leave to air dry.
Use to kill bacteria

"I am clean sticker"
Clear, highly-visible indicators which show whether or not a room, surface/equipment is clean.
Use to demonstrate cleaning

After the clinician completes the clean at the start of the day, this should be logged into the room cleaning log.

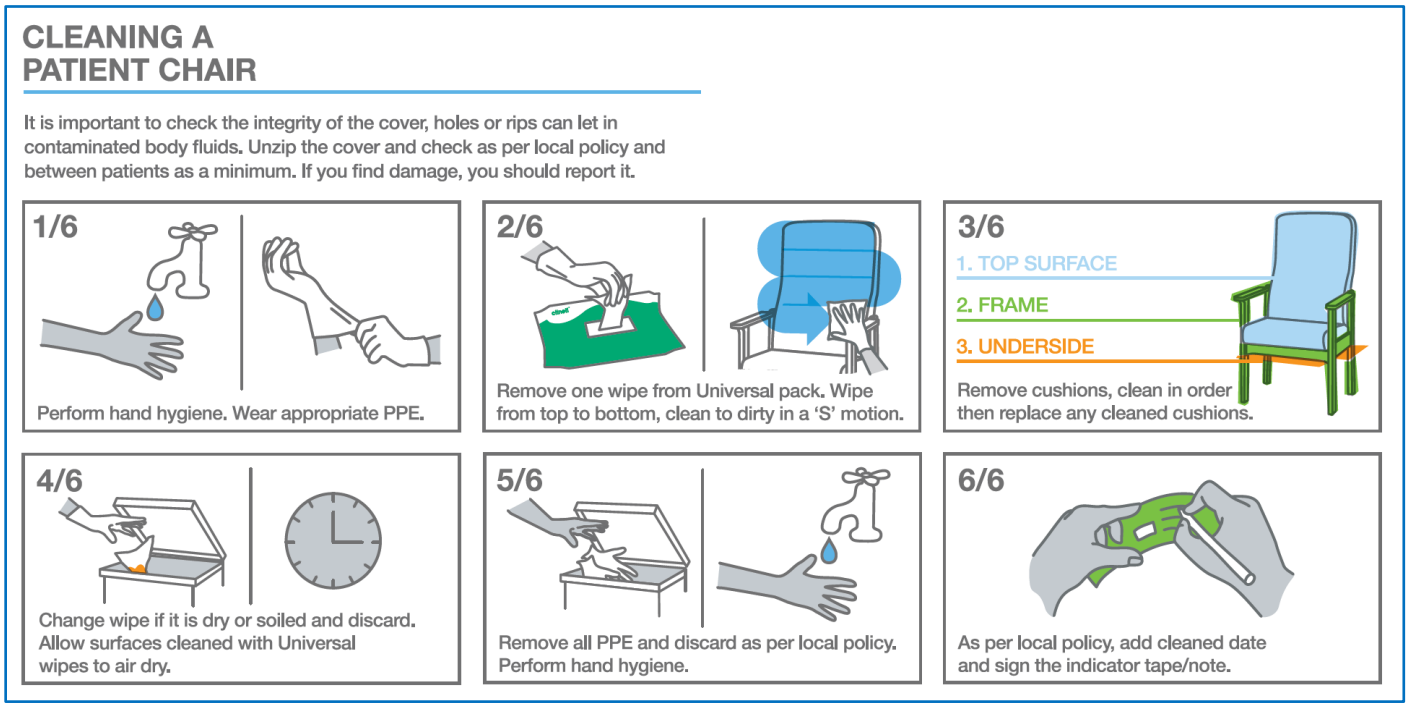
MONTHLY

Once a month, the equipment and storage cabinet are cleaned by Infection Control Lead who also notes the condition of the room. This is recorded in the Room Cleaning Log.

All blood pressure cuffs are washed on a monthly basis by the Infection Control Lead at the Practice in line with Manufacturer Guidance. This is recorded in the Infection Control Log. This guidance is embedded here.

Omron-Cleaning-Procedure.pdf

These principles are demonstrated in this video https://www.youtube.com/watch?v=CiUHkNEcNQI



6 Safe Management of Linen Including Uniforms and Workwear

Blinds, curtains and screens

All practice curtains and screens (disposable or fabric) should be visibly clean with no blood, bodily substances, dust, dirt, debris stains or spillages.

Window blinds curtains are included in the monthly clean and recorded in the Room Cleaning Log

Disposable curtains are used in the practice and are changed on a 6 monthly basis

Uniforms/Workwear

Workwear should be:

- Clean, fit for purpose and support good hand hygiene (bare below elbows for clinical staff).
- Changed immediately if visibly soiled or contaminated.
- Laundered on a cycle of ten minutes at 60°C, which removes almost all microorganisms, or at the highest temperature that the fabric will tolerate
- Laundered separately from other clothing if heavily soiled
- Dried thoroughly. Tumble drying or ironing will further reduce the small number of microorganisms present after washing
- It is not permitted to wear neckties (other than bow ties) or lanyards during direct patient contact. Ties are rarely laundered and have been shown to become contaminated with pathogens, and can accidentally come into contact with patients.
- Footwear must be well maintained, visibly clean, non-slip and support and cover the entire foot to avoid contamination with blood or body fluids or potential injury from sharps.

7 Safe Management of Sharps and Inoculation Injuries

7.1 Handling and Disposing of Sharps

Sharps include needles, cannulas, stitch cutters, scalpels, razor blades, broken glass, medical instruments, e.g. scissors, and other sharp objects.

Handling Sharps

- Avoid unnecessary use of sharps.
- Sharps should only be used where they are required
- Request assistance when using sharps with reluctant or confused patients.
- Do not carry sharps in the hand. Sharps containers should be available at the point of use, i.e. where the sharp is used.
- Do not pass sharps from hand to hand.
- Do not recap needles.
- Dispose of needle and syringes as one unit into a sharps container.
- If it is necessary to detach the needle, great care must be taken, preferably using the device on the sharps container.
- Always carry sharps containers away from the body, ensuring the temporary closure mechanism is closed.

Sharps Disposal

Sharps containers should be:

- Situated in a safe and secure place and not accessible to patients or visitors.
- The sharps container should be close to its place of use. It should never be placed on the floor.
- Sharps should be placed into the correct colour coded sharps container:
    - Orange lid - sharps not contaminated with medicines, e.g. venepuncture
    - Yellow lid - sharps contaminated with medicines
- Always assemble sharps containers correctly, with the lid securely fastened to the base.
- Sharps containers must be labelled with the date and a signature when assembled.
- Sharps containers should not be used for any other purpose than the disposal of sharps.
- Sharps should be placed into the sharps container by the person using them.
- Never press down the contents to make more room or attempt to retrieve an item from the sharps container.

After disposing of a sharp into the sharps container, the aperture should be moved into the temporary closure 'closed' position.

Sharps containers must not be filled above the 'fill line' as this could result in sharps protruding through the aperture. Sharps containers should be disposed of when the fill line has been reached or when the container has been in use for three months, whichever is first. They must be locked and labelled with the source details. The aperture must be 'locked' prior to disposal.

Sharps containers must not be placed inside waste bags prior to disposal. They should be given to Hevin Henry for disposal. These are then put into a clinical steel container for sharps. This is cleared every Thursday.

7.2 Preventing inoculation incidents

An inoculation incident is where the blood/body fluid of one person could gain entry into another person's body, such as:

- A sharps/needlestick injury with a used instrument or needle
- Spillage of blood or body fluid onto damaged skin, e.g. graze, cut, burn
- Splash of blood or blood stained body fluid into the eye, nose or mouth
- Human bite causing skin to be broken

Some accidental exposures to blood and body fluids are not classed as inoculation incidents, e.g. splashes onto intact skin. In these circumstances, washing the contaminated area thoroughly with liquid soap and warm running water is all that is required. Exposure to vomit, faeces and urine (unless visibly blood stained) and to sterile sharps are also not considered as inoculation injuries.

Compliance with the above guidance on good practice in sharps management should reduce the risk of a contaminated sharps injury.

In addition:

- All staff should protect their skin, as skin is an effective barrier to microorganisms. Any cuts or abrasions should be covered with an impermeable dressing to provide a barrier, refer to the 'Hand hygiene Policy for General Practice'
- The use of disposable gloves provides additional protection.
- Facial personal protective equipment should be worn when there is a risk of blood splashing to the mucous membranes, e.g. eyes, nose, mouth, refer to the 'PPE' section of this policy.

Following a specific exposure, the risk of infection will vary depending on the nature of any pathogens in the patient's blood, the type of inoculation and the amount of virus in the patient's blood or body fluid at the time of exposure.

Surveillance studies indicate that the risk of seroconversion following exposure to blood from HIV infected patients is approximately 1 in 300 for percutaneous (needlestick) injury and 1 in 1,000 for mucous membrane exposure.

The risk of acquiring hepatitis B virus from a hepatitis B antigen positive source is approximately 1 in 3, for an unvaccinated individual. Vaccination is protective.

The risk of acquiring hepatitis C through inoculation with a hepatitis C positive source is approximately 1 in 30.

7.3 Action to be taken following an inoculation incident

Immediate management of inoculation injuries

1. **Bleed it** - if there has been a puncture wound, encourage bleeding of the wound by squeezing it under running water (do not suck the wound).
2. **Wash it** - the injured area or damaged skin should be washed thoroughly with liquid soap and warm running water and dried. Blood or body fluid splashes to the eyes, nose or mouth should be irrigated copiously with water.
3. **Cover it** - cover the wound with a waterproof dressing.
4. **Report it** - report the injury to your manager immediately and complete an incident form.
5. **Seek advice** - seek urgent clinical advice immediately, e.g. from your GP. Out of normal office/surgery hours, attend Newham General Hospital Emergency Department.

A poster describing this is displayed in all the clinical rooms. This poster is on the next page and is embedded below.

Sharps Injury.pdf

Balaam St Surgery
Same Day Personal Care

NHS

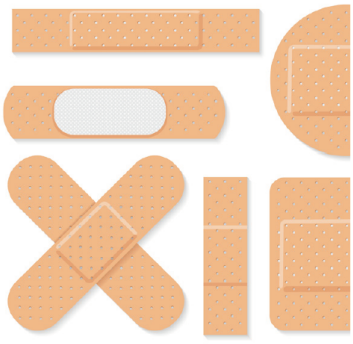
Sharps injury

BLEED IT

Squeeze the wound to encourage bleeding

WASH IT

With liquid soap, under warm running water



COVER IT

With a waterproof dressing

REPORT IT

Immediately to your manager

Sulaymaan Khan

7.4 Management of significant exposures

The term ‘source’ is used for the patient whose blood or body fluids were involved, and the term ‘recipient’ for the member of staff who has been exposed or injured.

A risk assessment should be made based on the significance of the exposure, the recipients’ prior immunity to hepatitis B and the confirmed or suspected status of the source for blood-borne viruses.

If the source patient is known, every attempt should be made to obtain a blood specimen for testing for blood-borne viruses. To avoid discrimination, it is standard practice for the source patient to be offered tests for the three main blood-borne viruses, hepatitis B, hepatitis C and HIV. Appropriate pre-test counselling and informed consent is a prerequisite of testing the source patient.

Bloods from the recipient will also be required for serum save. The taking of blood specimens and the approach to the source patient for permission to test should be managed by the recipients GP.

Reducing the risk of hepatitis B transmission

- Hepatitis B vaccination is effective in preventing hepatitis B transmission.
- All staff (including receptionists and cleaners) who may have direct contact with patient’s blood or blood stained body fluids, are exposed to sharps or other inoculation risks should have had the opportunity for hepatitis B vaccination and antibody status check for their response.
- All staff likely to be in contact with sharps or inoculation risks should be aware of their immunisation status regarding hepatitis B.
- Depending on the circumstances of the exposure and the immune status of the recipient, the recipient may be advised to have immediate additional vaccine dose or to receive hepatitis B immunoglobulin (HBIG).

Seeking early advice is the key to successful intervention to prevent transmission.

Reducing the risk of hepatitis C transmission

No specific post exposure prophylactic measures are advised beyond basic first aid. In the event of a source proving to be hepatitis C positive, specific advice on subsequent testing and management will be provided through the recipients GP including advice on preventing onward transmission.

Reducing the risk of HIV transmission

In the case of a significant exposure to a confirmed or suspected HIV infected source, or if there is evidence of AIDS related illness, then HIV post exposure prophylaxis (PEP) should be taken. HIV post exposure prophylaxis is most effective if started within one hour of exposure, but not recommended beyond 72 hours post exposure.

PEP treatment is usually only available from an ED, so if the patient is confirmed or suspected to be HIV positive, go straight to ED and inform them of your status to avoid any delay.

Exposure incidents in the community

Occasionally, members of the public will present to GPs following a community exposure, typically an injury with a discarded needle and syringe. In this instance, where the source is unknown, an accelerated course of hepatitis B vaccine is recommended. Community prevalence of HIV and hepatitis C remain low and no specific action in respect of these viruses is indicated.

The incident should be reported to the Health Protection Team.

Persons subject to penetrating human bites should also be offered a course of hepatitis B vaccination and should have their wound medically assessed because of the risk of bacterial infection.

8 Safe Management of the Care Environment

A clean environment reduces the cumulative risk of transmission of infection posed by microorganisms, such as bacteria and viruses, in that environment. Outbreaks of infection have been associated with environmental contamination.

Most microorganisms are found in dust and dirt, so cleaning or vacuuming alone can often cause significant reductions in the amount of organisms in the environment.

Some microorganisms, e.g. Clostridioides difficile spores, are adept at surviving in the environment for long periods and, therefore, enhanced cleaning with disinfection is required when a patient has a confirmed or suspected infection.

Hands regularly come into contact with surfaces. If hands are not decontaminated, they will transfer any organisms present. This risk is always present, but will increase if environmental cleaning is neglected.

Standard Cleaning Procedure

The practice is based in NHSPS premises which is cleaned daily by NHSPS in accordance with NHS regulations.

A cleaning plan is displayed in the Reception Area

Administrative staff clean the reception on a daily basis using a Detergent (Yellow) followed by a 2 in 1 (Green - Detergent and Antimicrobial) product to wipe down all surfaces. An "I am clean" sticker is then applied to the worksurface. The "I am clean" label will give details of the date of cleaning and signed by the administrator who performed the decontamination. This is also recorded into a cleaning log displayed in the Reception Area.

The practice has moved all cables off worksurfaces to create a clutter free environment. Staff will maintain a clutter free workspace and ensure a clean open area.

Detergent Wipes
Highly effective, ultra-low smear multi-surface wipes for cleaning prior to disinfecting.
Use to clean

Green Disinfectant Wipe
Combined detergent and disinfectant. Leave to air dry.
Use to kill bacteria

"I am clean sticker"
Clear, highly-visible indicators which show whether or not a room, surface/equipment is clean.
Use to demonstrate cleaning

Administrative Staff will clean all waiting room chairs using detergent wipes (yellow) followed by Antimicrobial (Green) at the start of the morning session at 0800 and at the start of the afternoon session at 1400.

Patient Flow and Waiting Area

The practice has a one way flow system to reduce the risk of cross infection between patients.

Patients enter the practice through a one-way cordoned queue system. Along the one way queue, markers have been placed on the ground to ensure social distancing in the queue. Along the one way queue, there are 2 hand sanitizing stations and patients are encouraged to the use them.

The queue system leads to a waiting area where seating is arranged in a socially distanced arrangement.

When patients are called to their appointment they go to the consulting room along a one way corridor ; and after the consultation they leave the building along the one-way corridor, exiting the building through the back door.

This one way system and socially distanced seating ensures reduced risk of any cross infection.

Administrative Staff will clean all waiting room chairs using detergent wipes (yellow) followed by Antimicrobial (Green) at the start of the morning session at 0800 and at the start of the afternoon session at 1400. This is recorded in a cleaning log displayed in the reception area.

The practice has a clear cleaning plan and displays this to patients.

Clinical staff clean their room before starting working by wiping down all surfaces with a 2 in 1 product. Clinical staff also wipe down all surfaces and equipment which has been in contact with a patient, straight after the consultation. This is recorded into the cleaning log displayed in the waiting area.

General Room Cleaning

The practice is based in an NHS Property Services maintained building.

The Infection Control Team (Clinical Lead, Practice Nurse, Practice Manager) will hold a multidisciplinary cleaning meeting with the Building Manager and Cleaner on a quarterly basis. During the meeting, logs and cleaning policies are reviewed.

9 Isolation, Patient Placement and Assessment for infection risk

9.1 Introduction

Isolation precautions are essential infection prevention and control practices to prevent the spread of communicable disease within General Practice. The type of isolation used is known as 'Source Isolation'.

Source Isolation is used to minimise the risks of micro-organisms being transferred from an affected person to other patients, staff and visitors. It is important to recognise that it is the micro-organism, which is being isolated, e.g. source, rather than the patient.

Room 1 is the isolation room in the practice. Room 1 has a two-way video link to Room 2. This video link should be used to minimize contact with the patient. This is shown in the photo below.

INSERT PHOTO HERE

9.2 Isolation

Triage

When triaging a patient for a face to face consultation who needs to be seen in the isolation room, use the slot type "Isolation room". This will make it clear to the reception to take the patient straight to the Isolation Room.

Arrival

On arrival at the Practice, the patient should be taken immediately to the isolation room (Room 1). When the patient is in the room, the door should remain closed. The camera should be turned on. The video screen should be turned on. Using the speakerphone, a call is made to Room 2.

Consultation

The clinician should ensure the patient has a complete understanding of why they are being isolated and the precautions required.

When the clinician attends the isolation room to do a physical examination, they should wear appropriate personal protective equipment (PPE) should be worn following a risk assessment.

The practice has the following PPE available

- Full face respirator x2
- Half face respirator x4
- Face shields multiple
- 3M FFP3 Face masks
- Surgical face masks

- Gloves
- Aprons
- Long sleeve gowns

PPE should be donned before entry into the room. Eye protection is only required if there is a possibility of splashing of body fluids to the eyes.

The Isolation Room has:

- A notice should be displayed on the door stating 'Isolation room – Danger – Biohazard – Do not enter'.
- The room should be free from clutter and, where possible, equipment not required for the consultation should be removed from the room before the patient enters.
- A foot operated lidded waste bin should be available and waste disposed of as infectious waste.
- The Isolation Room has its own dedicated equipment.

After the consultation - Decontamination

The isolation room or area used for isolation should be decontaminated after use. Use the detergent (Yellow) wipes first, followed by bactericidal (Green) wipes to clean all surfaces. If the room cannot be decontaminated immediately, a notice should be displayed stating 'Isolation area – awaiting deep clean'.

Wearing appropriate PPE, e.g. disposable apron and gloves, the immediate environment and equipment, such as couch, chair, work surfaces, stethoscope, should be cleaned with a detergent wipe and then disinfected with a green wipe.

All waste should be disposed of as infectious waste.

9.3 Patient transfer between health and social care settings

To help reduce the risk of healthcare associated infection:

Standard infection prevention and control precautions should be followed whenever transferring a patient, whether they have a known infection or not. Additional precautions may be required for some known infections e.g. the wearing of masks for Pulmonary TB and Pandemic Influenza.

Ensure that equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with this policy.

10 Aseptic Technique

10.1 Introduction

An aseptic technique is used to carry out a procedure in a way that minimises the risk of contaminating an invasive device, e.g. urinary catheter, or a susceptible body site such as the bladder or a wound.

10.2 When should an aseptic technique be used

The following are some examples of when an aseptic technique should be used, but is not an exhaustive list:

- When dressing wounds less than 48 hours old
- When dressing wounds healing by primary intention, e.g. surgical wounds
- When dressing deep wounds that lead to a cavity or sinus
- When dressing burn wounds
- If the patient is immunosuppressed, diabetic or at high risk of infection

10.3 Who should undertake an aseptic technique

Only staff educated, trained and assessed in aseptic technique should undertake this procedure. Adherence to the principles of asepsis (as described below) plays a vital role in preventing the transmission of infection in any environment. It is the responsibility of each member of staff who undertakes an aseptic technique to understand the meaning of these principles and to incorporate them into their everyday practice.

It is a requirement to undertake annual peer audits to monitor competency of the technique and a record of training and audit should be available.

Staff undertaking an aseptic technique should be free from infection, e.g. colds, sore throats, septic lesions.

10.4 The principles of asepsis/aseptic technique

Asepsis is defined as the absence of pathogenic (harmful) microorganisms, such as bacteria and viruses. The principles of asepsis/aseptic technique are:

- Reducing activity in the immediate vicinity of the area in which the procedure is to be performed
- Keeping the exposure of a susceptible site to a minimum
- Checking all sterile packs to be used are in date and there is no evidence of damaged packaging or moisture penetration
- Ensuring all fluids to be used are in date
- Not reusing single use items
- Ensuring contaminated/non-sterile items are not placed in the sterile field

- Ensuring appropriate hand decontamination prior to, during and after the procedure

10.5 Procedure for dressing a wound with aseptic technique

- The person undertaking the procedure is 'Bare Below the Elbows' and any cuts/grazes are covered with a waterproof dressing.
- Ensure that all windows are closed and any fans in the area are turned off. Avoid exposing or dressing wounds or performing an aseptic procedure for at least 30 minutes after room cleaning to allow any dust particles to settle.
- Check that all items required for the procedure are available, packaging is intact and sterile items are within the expiry date.
- Introduce yourself to the patient and prior to gaining verbal consent from them explain and discuss the procedure.
- Clean hands using the correct technique, with liquid soap and warm running water and dried with paper towels 1.12 or an alcohol handrub is used and allowed to dry (using steps 2-8 on 1.12).
- Clean the dressing trolley with pH neutral detergent, e.g. Hospec and water or detergent wipes, from top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shaped pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice. This cleaning motion reduces the amount of microorganisms, such as bacteria and viruses, that may be transferred from a dirty area to a clean area. Dry with paper towels. If disinfection is also required, use disposable wipes saturated with 70% isopropyl alcohol and allow to air dry.
- Place the items required for the procedure on the lower shelf of the trolley.
- The patient is positioned comfortably for the procedure so that the wound is easily accessible without exposing the patient unduly.
- Clean hands using the correct technique, with liquid soap and warm running water and dried with paper towels or an alcohol handrub is used and allowed to dry.
- Put on a disposable apron.
- If an existing dressing is in place, loosen the adhesive or tape to aid its removal later.
- Hands are decontaminated, using the correct technique, with liquid soap and warm running water and dried with paper towels or an alcohol handrub is used and allowed to dry.
- The outer packaging of the sterile pack is opened and contents removed using a sliding action onto the cleaned surface, ensuring that the inner pack is not touched.
- The sterile pack inner wrap is opened, using only the corners of the paper and to create a sterile field.
- Open any other items required, and gently tip onto the centre of the sterile field.
- Clean hands with an alcohol handrub.
- Carefully use the open end of the disposable waste bag to lift it from the sterile field. Then hold the bag by one edge and place the other hand inside to cover the hand like a sterile 'glove' to arrange the items on the sterile field. If there is a previous dressing in place, remove and invert the bag with the dressing inside.
- The waste bag is then positioned so that contamination of the sterile field does not occur during the procedure.
- If required, sterile solutions are opened and poured into the gallipot or solutions section of the dressing tray.
- Clean hands with an alcohol handrub and don sterile gloves.
- Apply the principle of 'a clean hand and a dirty hand'.
- The procedure is carried out, including cleaning of the skin where applicable, maintaining a sterile field throughout the procedure.
- The patient is left in a comfortable position, maintaining dignity.
- Waste is then disposed of in the appropriate coloured waste stream bag
- Remove PPE and dispose of in the appropriate coloured waste stream bag - gloves off first, dispose, then remove and dispose of apron and clean hands.

- Clean, and if the patient has a confirmed or suspected infection, disinfect the trolley using disposable wipes saturated with 70% isopropyl alcohol and allow to air dry.
- Clean hands with liquid soap and warm running water and dry with paper towels or apply alcohol handrub and allow to dry.
- Ensure the procedure is documented and any tracking labels provided are added in the patient's records.

10.6 Clean Technique

This is a modified aseptic technique, the principles being, in essence, the same as that for performing an aseptic technique. The main difference is the wound can be irrigated with or immersed in non-sterile fluids, e.g. tap water of drinkable quality, and non-sterile gloves can be worn. A clean technique is used for dressing most wounds healing by secondary intention such as:

- Pressure ulcers
- Leg ulcers, dehisced wounds
- Dry wounds, simple grazes
- Removing sutures

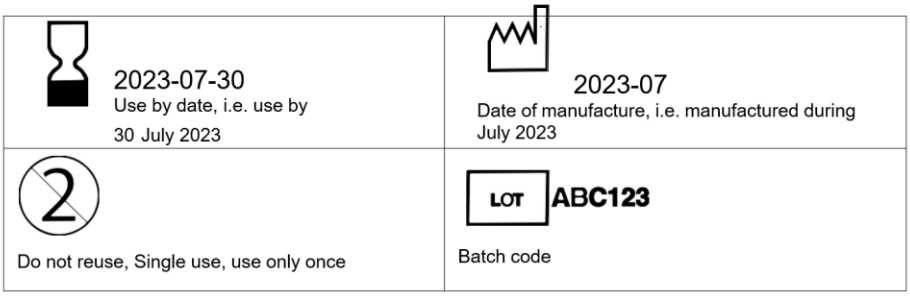
A clean technique should not be used to dress significant wounds that are less than 48 hours old, diabetic foot wounds, cavity wounds, e.g. with a sinus, or wounds of patients who are immunosuppressed.

10.7 Summary Table

Summary for wound dressings		
Description	**Aseptic technique**	**Clean technique**
Gloves	Sterile	Non-sterile
Dressings	Sterile	Sterile
Cleansing solution	Sterile water/saline/ antiseptic	Tap water

Technique for commonly performed procedures		
Procedure	**Technique**	**Comments**
Surgical wound dressing	Aseptic	Expose the wound for minimal time
Catheter removal	Clean	Clean meatus with soap and water
Cervical smear	Clean	Use a sterile disposable (single use) speculum or a reusable onethat has been sterilised by an accredited Decontamination Services Department
IUD insertion	Aseptic	

10.8 Symbols and their Meanings



11 Contact Precautions

Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission.

Ensure appropriate patient placement in the isolation room.

Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens.

Limit transport and movement of patients outside of the room to medically-necessary purposes. When transport or movement is necessary, cover or contain the infected or colonized areas of the patient's body. Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. Don clean PPE to handle the patient at the transport location.

Use disposable patient-care equipment. For non disposable equipment, clean and disinfect after use.

12 Droplet Precautions

Use Droplet Precautions for patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking.

Source control: put a mask on the patient.

Ensure appropriate patient placement in the isolation room.

Use personal protective equipment (PPE) appropriately. Don mask upon entry into the patient room or patient space.

Limit transport and movement of patients outside of the room to medically-necessary purposes. If transport or movement outside of the room is necessary, instruct patient to wear a mask and follow Respiratory Hygiene/Cough Etiquette:

- Cover your mouth and nose with a tissue when coughing or sneezing;
- Use in the nearest waste receptacle to dispose of the tissue after use;
- Perform hand hygiene (e.g., hand washing with non-antimicrobial soap and water, alcohol-based hand rub, or antiseptic handwash) after having contact with respiratory secretions and contaminated objects/materials.

13 Airborne Precautions

Use Airborne Precautions for patients known or suspected to be infected with pathogens transmitted by the airborne route (e.g., tuberculosis, measles, chickenpox, disseminated herpes zoster).

Source control: put a mask on the patient.

Ensure appropriate patient placement in the isolation room.

Restrict susceptible healthcare personnel from entering the room of patients known or suspected to have measles, chickenpox, disseminated zoster, or smallpox if other immune healthcare personnel are available.

Use personal protective equipment (PPE) appropriately.

Immunize susceptible persons as soon as possible following unprotected contact with vaccine-preventable infections (e.g., measles, varicella or smallpox).

14 Specimen Collection

All specimens are a potential infection risk, therefore, all specimens must be collected using standard infection control precautions, and where required, transmission based precautions.

Procedure for specimens brought into the Practice by Patients

- Patients are given plastic bags and asked to seal the sample in the plastic bag.
- Staff should apply standard infection control precautions when handling specimens and appropriate personal protective equipment (PPE) is worn. Gloves should be worn when handling the plastic bag.
- Staff should ensure the container is appropriate for the purpose. If there is leakage or an inappropriate container is used, the specimen should be rejected as it will not be processed by the laboratory due to the infection risk.
- The lid is securely closed
- There is no external contamination of the outer container by the contents
- Specimens should be labelled.
- The transport bag should be sealed using the integral sealing strip (not stapled, etc)
- Specimens received from patients should be placed in a rigid wipeable container. This should be cleaned on a regular basis with a disinfectant wipe
- Samples are not stored. Patients are asked to bring samples before 9am so that they can be sent off in the same day transport which typically arrives 9 to 10am. If patients bring a samples after transport has gone, you should ask the patient to take the sample directly to pathology.

15 Blood Borne Viruses

15.1 Introduction

Blood-borne virus (BBV) infections are spread by direct contact with the blood of an infected person. The main blood-borne viruses of concern are:

- Human immunodeficiency virus (HIV), which causes acquired immune deficiency syndrome (AIDS)
- Hepatitis B virus (HBV) and hepatitis C virus (HCV) which cause hepatitis

These three viruses are considered together because infection control requirements are similar due to similarities in their transmission routes.

15.2 Transmission Mechanisms

HIV

HIV infection is spread by direct contact with an infected person's cell containing body fluids, e.g. blood, semen, vaginal secretions, breast milk, amniotic fluid, pleural effusions, and cerebrospinal fluid.

Routes of transmission:

- Sexual transmission - vaginal, anal, or oral sex (especially in the presence of oral disease such as ulceration or gingivitis)
- Mother to baby - during pregnancy, childbirth, or through breastfeeding
- Inoculation from:
- A contaminated needle, e.g. sharps injury

- Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment
- Unsterile tattooing, body piercing or acupuncture equipment
- A contaminated instrument
- Transfusion of contaminated blood or blood product in a country where blood donations are not screened for HIV
- Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors
- A contaminated human bite that breaks the skin

HIV is not transmitted by:

- Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing
- Insects such as mosquitoes and lice
- Food or water

Hepatitis B

Hepatitis B infection is spread by direct contact with an infected person's blood or blood stained body fluids. 95% of chronic hepatitis B infections in the UK occur in migrant populations, having been acquired perinatally in the country of birth.

Routes of transmission:

- Sexual transmission - occurs during sex via mucous membranes, e.g. vaginal, anal, and oral. People having unprotected sex or having multiple partners are at greatest risk
- Mother to baby - during pregnancy, childbirth, or through breastfeeding if nipples are cracked or bleeding
- Inoculation from:
    - A contaminated needle, e.g. sharps injury
    - Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment
    - Unsterile tattooing, body piercing or acupuncture equipment
    - A contaminated instrument
- Transfusion of contaminated blood or blood product in a country where blood donations are not screened for hepatitis B
- Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors
- A contaminated human bite that breaks the skin

Hepatitis B is not transmitted by:

- Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing
- Insects such as mosquitoes and lice
- Food or water

Hepatitis C

Hepatitis C is spread by contact with an infected person's blood.

Routes of transmission:

- Currently, the majority of cases in the UK are caused by sharing contaminated drug injecting equipment, less common routes are:
- Sexual transmission - occurs infrequently in heterosexual relationships. The risk is increased in people with multiple partners or those at risk for sexually transmitted infections (STIs), in HIV-positive people (particularly in men who have sex with men), and with risky sexual practices (for example anal sex)
- Mother to baby - during pregnancy, childbirth, or through breastfeeding if nipples are cracked or bleeding

- Inoculation from:
    - A contaminated needle, e.g. sharps injury
    - Shared items contaminated with blood from an infected person, e.g. needles or other drug injecting equipment
    - Unsterile tattooing, body piercing or acupuncture equipment
    - A contaminated instrument
- Transfusion of contaminated blood or blood product in a country where blood donations are not screened for Hepatitis C
- Direct exposure of mucous membranes or an open wound to infected blood or blood stained body fluids, e.g. splashing on to broken skin, eyes or mouth, sharing toothbrushes or razors
- A contaminated human bite that breaks the skin

Hepatitis C is not transmitted by:

- Sharing eating utensils or bathroom facilities, hugging, kissing, hand holding, coughing, or sneezing
- Insects such as mosquitoes and lice
- Food or water

15.3 Precautions to reduce the risk of transmission of Blood Borne Viruses

Prevention strategies focus on minimising lifestyle risks, early recognition of cases to facilitate early treatment and advice for cases, screening in pregnancy for the reduction of vertical transmission of HIV and hepatitis B.

As a result of the lack of early symptoms in some infected people and the ability of the viruses to persist as chronic infections, many people who carry these blood-borne viruses may not be aware they are infected. Assigning risk on the basis of declared high risk activity in a patient is potentially discriminatory and highly unreliable.

Staff who may have contact with blood or blood stained body fluids, or are exposed to sharps or other inoculation risks, should have had the opportunity for hepatitis B vaccination and antibody testing to check for their response.

Precautions to prevent inoculation of blood and certain body fluids will prevent transmission of these viruses.

In the practice setting these include:

Sharps and inoculation injuries:

As always, care should be taken with sharps - use safety sharps where assessment indicates they will provide safe systems of working for staff, refer to section 7 of this policy.

Appropriate management of percutaneous exposures (sharps/splash injuries), refer to section 7 of this policy.

Always:

- Keep cuts or broken skin covered with waterproof dressings
- Protect eyes, nose and mouth from blood splashes where there is a risk of splashing
- Avoid direct skin contact with blood and blood stained body fluids (if blood/blood stained body fluids are splashed on to the skin, wash off with liquid soap and warm running water)
- Wear Nitryl gloves. The practice does not use latex or vinyl gloves
- Always clean hands before and after giving first aid

Spillages of blood or body fluids

Urine, faeces, sputum, tears, sweat and vomit are not considered to pose a risk of blood borne virus infection unless they are contaminated with blood.

Contain and promptly clean and disinfect surfaces contaminated by spillages of blood and blood stained body fluids. Refer to this policy for advice on cleaning spillages of blood and/or blood stained body fluid.

A spillage kit is located in Room 7.

Spillage kits may contain solidifying polymer granules. A National Patient Safety Alert issued in 2017, following a number of deaths and incidents related to patients ingesting the product, advises a risk assessment and procedures in place to ensure supplies are securely stored away from the general public.

Disposal of waste
Waste contaminated with blood and/or blood stained body fluids from a person with a confirmed or suspected blood-borne virus, should be disposed of into the appropriate infectious waste stream. Refer to section 11 of this policy.

Specimen collection
Refer to section 14 of this policy.

Specimens and request forms from patients confirmed to be or suspected of being infected with blood-borne viruses should be labelled with a 'Danger of Infection' and marked as hazardous on the request form.

15.4 Referral or transfer to another health or social care provider

If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of

- The patient's blood borne viruses status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate infection prevention and control measures to be taken, e.g. transported without other patients, isolated on admission.
- Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated in accordance with this policy.

16 Methicillin Resistant Staph Aureus MRSA

16.1 Introduction

Staphylococcus aureus is a common bacteria that is frequently found on the skin or in the nose of healthy people without causing an infection.

If the bacteria invades the skin or deeper tissues, and multiplies, an infection can develop. This can be minor, such as pimples, boils, or serious, such as wound infections, pneumonia or bacteraemia.

Methicillin is an antibiotic that was commonly used to treat Staphylococcus aureus, until some strains of the bacteria

developed resistance to it. These resistant bacteria are called Methicillin Resistant Staphylococcus aureus (MRSA). Strains identified as methicillin resistant in the laboratory will not be susceptible to flucloxacillin - the standard treatment for many staphylococcal infections. These strains may also be resistant to a range of other antibiotics.

MRSA is not usually a risk to healthy people. Research has shown that healthcare workers, who become colonised, have acquired the bacteria through their work, but the MRSA colonisation is usually present for a short time only.

Information for patients and carers is at https://www.nhs.uk/conditions/mrsa/

16.2 Colonisation and infection

Colonisation means that MRSA is present on or in the body without causing an infection.

Up to 33% of the general population at any one time are colonised with Staphylococcus aureus (including MRSA) on areas of their body, e.g. nose, skin, axilla, groin. It can live on a healthy person without causing harm and most people who are colonised do not go on to develop infection. Less than 5% of colonising strains in the healthy population who have not been in hospital are Methicillin resistant, but it is more common in vulnerable people who are in contact with the health and social care system.

Infection means that the MRSA is present on or in the body and is multiplying causing clinical signs of infection, such as in the case of septicaemia or pneumonia, or for example, in a wound causing redness, swelling, pain and or discharge.

MRSA infections usually occur in health and social care settings and, in particular, vulnerable patients. Clinical infection with MRSA occurs either from

the patient's own resident MRSA (if they are colonised) or by transmission of infection from another person who could be an asymptomatic carrier or have a clinical infection. Staphylococcus aureus infects a range of tissues and body systems causing symptoms that may be common to different infections caused by other bacteria.

16.3 Patients at risk of infection from MRSA

- Patients with an underlying illness.
- Older people - particularly if they have a chronic illness.
- The very ill - patients in intensive care.
- Those with open wounds or who have had major surgery.
- Patients with invasive devices such as urinary catheters.

16.4 Routes of transmission

- Direct spread via hands of staff or patients.
- Care equipment that has not been appropriately decontaminated.
- Environmental contamination (Staphylococci that spread into the environment may survive for long periods in dust).

16.5 Treatment

Any treatment required will be on an individual patient basis. Patients who are colonised with MRSA, i.e. no clinical signs of infection, do not usually require antibiotic treatment.

Antibiotic treatment should only be prescribed if there are clinical signs of infection:

- If the person has suspected or confirmed MRSA and:
- Clinical features of severe or complicated infection (for example sepsis, endocarditis, pneumonia, osteomyelitis, joint infection, immunocompromised, multiple comorbidities or at extremes of age)

- Has an abscess requiring surgical intervention Urgent assessment in secondary care should be arranged.

If the person has an uncomplicated skin/soft tissue or urinary tract infection without systemic features and MRSA is suspected or confirmed:

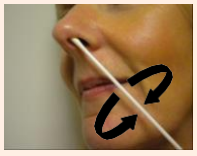
- Discuss treatment (such as antibiotics and wound care) with a Microbiologist
- Do not routinely treat with oral or topical antibiotics, unless directed by microbiology
- Arrange follow up (after 48 hours, or sooner if worsening) to monitor for signs of complications (such as sepsis, cellulitis, pneumonia or osteomyelitis) and to ensure infection is resolving

16.6 Suppression treatment and screening

Suppression treatment is not routinely required for a positive MRSA swab result. A risk assessment should be undertaken to determine if the patient has any risk factors, e.g. wound, invasive device, resident in a care home. If risk factors are identified, suppression treatment may be indicated to reduce the incidence of an MRSA bacteraemia.

Screening swabs following suppression treatment are not required for patients in the community. Screening swabs for MRSA may be undertaken by the hospital for specific planned admissions to hospitals. However, if you are requested to take a nasal swab for MRSA, follow the instructions below on 'How to take a nasal swab for MRSA screening'.

How to take a nasal swab for MRSA screening

How to take a nasal swab for MRSA screening	
	• Wash hands and apply apron and non-sterile gloves. • Place a few drops of either sterile 0.9% sodium chloride or sterile water onto the swab taking care notto contaminate the swab.
	• Place the tip of the swab inside the nostril at the angleshown. • It is not necessary to insert the swab too far into thenostril.
	• Gently rotate the swab ensuring it is touching theinside of the nostril. • Repeat the process using the same swab for the othernostril.
	• Place the swab into the container. • Remove and dispose of gloves and apron and cleanhands. • Complete patient details on the container and specimen form. Request 'MRSA screening' underclinical details on the form.

If a MRSA positive result is diagnosed after a patient has been discharged from hospital, the GP will be informed, and, if appropriate, suppression treatment should be prescribed.

Screening swabs following suppression treatment are not required for patients in the community.
Suppression treatment consists of two separate treatments :

Body and hair treatment
An antibacterial solution for body and hair treatment, e.g. Chlorhexidine 4%, Octenisan or Prontoderm Foam, daily for 5 days, following the manufacturer's instructions.
For dermatology patients, the use of Chlorhexidine 4% is not advised, therefore, use Octenisan or Prontoderm Foam, daily for 5 days, following the manufacturer's instructions.

Nasal treatment
Nasal Mupirocin 2% ointment, e.g. Bactroban nasal, 3 times a day for 5 days, following the manufacturer's instructions.
For patients who have a resistance to Mupirocin, Naseptin nasal ointment should be used 4 times a day for 10 days, following the manufacturer's instructions.

Compliance with the above programme is important and once commenced should be completed to prevent resistance to Mupirocin. Both skin, hair and nasal treatment should be started on the same day.
Clean towels, bedding and clothing, should be used each day during the treatment. After completion of the treatment, further screening or treatment is not required unless advised by the microbiologist or local HP Team.

MRSA suppression treatment instructions for patients on Octenisan, Prontoderm and Bactroban, are available to download at www.infectionpreventioncontrol.co.uk.

16.7 Precautions for MRSA

Colonisation with MRSA may be long term. MRSA does not present a risk to other healthy individuals and carriers should, therefore, continue to live a normal life without restriction.

Standard infection control precautions and, where required, transmission based precautions should be followed by all staff at all times, to reduce the risk of transmission of infection.

- No specific precautions are required for patients attending for a routine GP consultation.
- Patients attending for a procedure, e.g. wound dressing, where possible, should be scheduled at the end of the session.
- Prior to any examination or treatment, a risk assessment to determine the personal protective equipment (PPE) required should be undertaken refer to the PPE section of this policy.
- Hand hygiene is essential before and after direct contact with a patient using liquid soap and warm running water or alcohol handrub.
- PPE should be disposed of after each procedure and hands cleaned.
- Waste should be disposed of as infectious waste, refer to the safe disposal of waste section of this policy.

16.8 Environmental and care equipment cleaning

If a patient has attended for an examination or procedure, reusable medical devices, care equipment, the treatment couch and immediate area should be cleaned and disinfected, refer section 13 of this policy.

17 Clostridium Difficile

17.1 Introduction

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

Clostridioides difficile (C. difficile) is present harmlessly in the gut (bowel) of up to 3-5% of healthy people and 66% of babies as part of their normal gut flora. However, when antibiotics disturb the balance of bacteria in the gut, C. difficile can multiply rapidly producing toxins causing diarrhoea or colitis.

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

17.2 C. difficile conditions

There are two types of C. difficile conditions:

C. difficile colonisation means that the bacteria are present in the bowel, but not producing toxins. Symptoms, if present, are usually very mild and antibiotic treatment is not usually required. People who are colonised are often known as 'carriers'. Patients who are colonised are at high risk of progressing to infection

C. difficile infection (CDI) means that the bacteria are present and producing toxins, causing symptoms which can be mild to severe, including life-threatening pseudomembranous colitis, toxic megacolon and even perforation of the bowel.

C. difficile is usually associated with, and triggered by, the prior use of antibiotics prescribed as treatment for, or to prevent infection (prophylaxis).

17.3 Risk factors for C. difficile

The risk factors associated with acquiring C. difficile are:

- Age - incidence is much higher in those aged over 65 years
- Underlying disease - those with chronic renal disease, underlying gastrointestinal conditions and oncology patients
- Antibiotic therapy - patients who are receiving or who have recently received antibiotic treatment (within 3 months), especially broad-spectrum antibiotics such as cephalosporins, e.g. cefuroxime, quinolones, such as, ciprofloxacin, co-amoxiclav or clindamycin. C. difficile has been associated with oral, intramuscular and intravenous routes of administration of antibiotics
- Recent hospital stay - patients who are frequently in hospital or who have had a lengthy stay in hospital
- Bowel surgery - those who have had bowel surgery
- Other medication - patients receiving anti-ulcer medications, including antacids and proton pump inhibitors (PPIs), e.g. omeprazole, which are used for treating reflux (heartburn and indigestion)
- Previous history of colonisation or infection with C. difficile - patients are at greater risk of developing C. difficile infection (CDI)

17.4 Routes of transmission

C. difficile produces invisible to the naked eye, hard to kill, microscopic spores, which are passed in the diarrhoea. The spores are resistant to air, drying and heat, and can survive in the environment for months and even years.

The main routes of transmission of C. difficile spores are:

- Contaminated hands of staff and patients
- Contact with contaminated surfaces or equipment, e.g. toilet flush handles, toilet assistance rails

17.5 Infection prevention and control measures

Hand hygiene

- Clinical Staff should be 'Bare Below the Elbows' whilst on duty.
- Alcohol handrubs do not kill spores, therefore, should not be used.
- Hands should be washed with liquid soap and warm running water and dried with paper towels after contact with each patient (and their environment if a home visit is undertaken, including immediately prior to leaving).

Personal protective equipment

- All staff should wear disposable gloves and aprons for all contact with the patient.
- Gloves and apron should be changed between tasks, removed in the room, disposed of as infectious waste and hands washed with liquid soap and warm running water after removing PPE.

Cleaning and disinfection

- C. difficile spores can survive in the environment for months or possibly years if not adequately cleaned. If a patient who is confirmed to have C. difficile and has either had diarrhoea in the last 48 hours, or whilst in the Practice, the immediate environment, e.g. couch, work surfaces, toilet, should be decontaminated.
- Cleaning with detergent wipes or pH neutral detergent and warm water alone is insufficient to destroy C. difficile spores. Antibacterial surface sprays, including Milton and Flash with bleach, are not effective against C. difficile spores
- Following cleaning, surfaces must be disinfected with a sporicidal product. The practice has invested in Clinell Sporicidal wipes. Each consulting room has a pack of sporicidal wipes. These should be used to kill the spores.

Using the Sporicidal Wipes

The practice has placed a pack of sporicidal wipes in each room.
These need to be activated with water as illustrated below.

Wear recommended PPE.

Remove one wipe from the pack.

To activate, wet the wipe with water under a tap or dip into a bucket.

Squeeze out the wipe to remove excess water.

Working from clean to dirty, wipe in an 'S' shaped pattern, taking care not to go over the same area twice.

Change the wipe if it becomes dry or soiled □and discard in the clinical waste bin. Let the surface air dry.

A training video is at https://www.youtube.com/watch?v=V7iqlHky5Nk

18 PVL-SA (Panton-Valentien Leukocidin Staphylococcus Aureus)

18.1 Introduction

Staphylococcus aureus (SA) is a common bacterium that approximately one in three people carry on their skin or in their nose without causing an infection. Some types of SA produce a toxin called Panton-Valentine Leukocidin (PVL) and they are known as PVL-SA.

PVL-SA predominantly causes recurrent skin and soft tissue infections (SSTIs), but can also cause severe invasive infections, including necrotising haemorrhagic pneumonia in otherwise healthy young people in the community.

In the UK, the genes encoding for PVL are carried by approximately 2% of clinical isolates of SA submitted to the National Reference Laboratory, whether methicillin-sensitive (MSSA) or methicillin-resistant (MRSA). Most PVL- SA strains in the UK are MSSA, with MRSA being less common accounting for 0.8% of all isolates.

18.2 Clinical features of PVL-SA

PVL-SA can cause harm if it enters the body, for example through a cut or a graze.

Skin and soft tissue infections:

- Boils (furunculosis), carbuncles, folliculitis, cellulitis, purulent eyelid infections
- Cutaneous lesion ≥5cm in diameter
- Pain and erythema out of proportion to severity of cutaneous findings
- Necrosis

Invasive infections:

- Necrotising pneumonia - often after a flu-like illness
- Necrotising fasciitis
- Osteomyelitis, septic arthritis and pyomyositis
- Purpura fulminans

The epidemiology of PVL-SA differs from that of other SA. Cases tend to be younger and, in the UK, associated with community settings rather than hospital.

Risk factors for PVL related infection - the 5 ‘C’s:

- Contaminated shared items, e.g. towels
- Close contact, including contact sports, e.g. wrestling, rugby, judo
- Crowding, e.g. closed communities, military training camps
- Cleanliness
- Cuts and other compromised skin integrity, chronic skin conditions, e.g. eczema, psoriasis

Risk groups are often young and healthy people. Outbreaks or clusters can occur in the community.

18.3 Routes of transmission

- Direct spread, i.e. skin-to-skin contact with someone who is already infected.
- Equipment that has not been appropriately decontaminated.
- Environmental contamination.

18.4 Primary Care Precautions for PVL-SA

Standard infection control precautions and, where required, transmission based precautions should be followed by all staff at all times, to reduce the risk of transmission of infection.

- Patients attending for a procedure, e.g. wound dressing, where possible, should be scheduled at the end of the session.
- No specific precautions are required for patients attending for a routine GP consultation.
- Prior to any examination or treatment, a risk assessment to determine the personal protective equipment (PPE) required should be undertaken.
- Hand hygiene is essential before and after direct contact with a patient using liquid soap and warm running water or alcohol handrub.
- PPE should be disposed of after each procedure and hands cleaned after disposing of personal protective equipment (PPE).
- Waste should be disposed of as infectious waste.

18.5 Environmental and care equipment cleaning

If a patient has attended for an examination or procedure, reusable medical devices, care equipment, the treatment couch and immediate area should be cleaned and disinfected.

18.6 Referral or transfer to another health or social care provider

If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of the patient's PVL-SA status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate infection prevention and control (IPC) measures to be taken, e.g. transported without other patients, isolated on admission.

Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated.

19 Multi-Drug Resistant Organisms (including extended spectrum beta-lactamase and cabapenemase producing organisms)

19.1 Introduction

Multidrug-resistant organisms (MDROs) are microorganisms that have become resistant to the drugs normally used to treat them. Although MDROs include bacteria, fungi, viruses and parasites, this policy will focus on bacteria only.

Antimicrobial resistance is the ability of bacteria to resist the effects of antibiotics normally used to treat them, so the bacteria are not killed, this is known as 'antibiotic resistance'.

Antibiotic resistance makes infections difficult to treat. It may also increase the length of severity of illness, the period of infection, adverse reactions (due to the need to use less safe alternative drugs), length of hospital admission and overall costs.

Numerous bacteria are normally found in the bowel. Not all are resistant to antibiotics and not all will cause serious illness. Species of bacteria commonly found include Escherichia coli (E. Coli), Klebsiella, Proteus, Pseudomonas Enterobacter and Acinetobacter. Collectively these bacteria are referred to as Gram-negative bacilli (GNB). These bacteria, under certain circumstances, can become resistant to antibiotics and may require infection control management. They are referred to as multidrug-resistant organisms (MDROs).

Some MDROs contain beta-lactamases (extended spectrum beta lactamases or ESBL's) which can destroy/inactivate even broad spectrum antibiotics, such as cefuroxime and cefotaxime.

Newer MDROs known as MDRO CPO (carbapenemase-producing organism) have recently been identified. These resistant strains of bacteria produce an enzyme that destroys the powerful group of antibiotics, such as imipenem, which are used in hospitals. Until now, these have been the 'last resort' antibiotics medics have relied on when other antibiotics have failed to treat infections.

Other MDROs include Gram-positive bacteria (for example 'Vancomycin- resistant Enterococcus (VRE), MDRO Tuberculosis (TB), caused by the bacterium Mycobacterium tuberculosis and Meticillin resistant Staphylococcus aureus (MRSA), refer to the section 4 of this policy for MRSA.

The increasing prevalence of antibiotic resistant microorganisms, especially those with multiple resistance, is an international concern. In November 2016, the UK government announced plans to reduce infections across the NHS. This included plans to reduce the number of healthcare associated Gram- negative bloodstream infections by 50%, by financial year 2020 to 2021

19.2 Key Points

Bacteria commonly achieve antibiotic resistance by producing an enzyme, beta-lactamase. This counters the effect of specific antibiotics.

The genes that carry antibiotic resistance can spread to other bacteria and control of MDROs requires comprehensive infection control and antibiotic prescribing policies and stewardship.

Many MDROs are likely to be passed on via the faecal oral route.

MDROs can cause urinary tract infections, pneumonia and surgical site infections. However, the majority of patients with MDROs are colonised which means bacteria are present, but they do not have symptoms of infection. MDROs are usually identified in stool and urine specimens. If the patient does not have active infection, i.e. they are colonised, antibiotic treatment is not required.

Patients who are colonised with a MDRO do not usually pose a risk to healthy people, but may be a risk to those who are vulnerable.

People at increased risk of being colonised or infected with a MDRO are:

- Those who in the last 12 months have:
- Been an inpatient in any hospital, UK or abroad
- Had multiple hospital treatments, e.g. dialysis, or have had cancer chemotherapy
- Been previously identified as CPO positive (includes household and care home contacts of known cases)
- Have had previous exposure to broad-spectrum antibiotic courses, particularly carbapenems in last month
- Are resident in 'Long Term Care Facilities', particularly where higher levels of interventional care are provided, e.g. long-term respiratory ventilation

19.3 Routes of transmission

- Direct spread via hands of staff and patients.
- Care equipment that has not been appropriately decontaminated.
- Environmental contamination.

Although MDROs can be spread via care equipment, the most common route is by contact with an infected or colonised patient. Therefore, the importance of good hand hygiene before and after direct contact with a patient is essential.

19.4 Precautions taken in the practice for MDROs

Standard infection control precautions and, where required, transmission based precautions (TBP) (section) should be used for patients confirmed or suspected to have a MDRO. Colonisation with a MDRO may be long term, therefore transmission based precautions (TBP) should be followed by all staff at all times, to reduce the risk of transmission of infection.

When a patient is confirmed or suspected to have a CPO infection or colonisation, staff should apply contact TBPs on a risk assessment basis, particularly where there is a presence of wound drainage, diarrhoea or faecal incontinence. In these situations, there is increased potential for environmental contamination and subsequent risk of transmission.

For all patients with profuse diarrhoea, appropriate medical management and enhanced cleaning of any toilet facilities used by the patient should be undertaken.

Patients with a MDRO attending for a procedure, e.g. wound dressings, where possible, should be scheduled at the end of the session to allow for environmental cleaning.

Prior to any examination or treatment, a risk assessment to determine the personal protective equipment (PPE) required should be undertaken, e.g. wear disposable gloves and apron when in contact with a patient's body fluids, e.g. wound, urine. These should be disposed of after each procedure and hands cleaned. Refer to the 'PPE Policy for General Practice'.

If a patient is suspected or known to have a CPO infection or colonisation, long sleeved fluid repellent gowns should be worn if there is a risk of extensive splashing of body fluids to the uniform, e.g. dealing with an ileostomy. The Practice stores the long sleeve gowns in Room 7.

Hand hygiene is essential before and after direct contact with a patient using liquid soap and warm running water or alcohol handrub. Detergents and Disinfectants are located in every clinical room.

Waste contaminated with body fluids should be disposed of as infectious waste.

19.5 Environmental and care equipment cleaning

If a patient has attended for an examination or procedure, reusable medical devices, care equipment, the treatment couch and immediate area, should be cleaned and disinfected.

19.6 Referral or transfer to another health or social care provider

If it is necessary to refer or transfer a patient to another health or social care provider, e.g. ambulance service, hospital, they should be informed of the patient's MDROs status prior to the transfer. This will enable a risk assessment to be undertaken to determine the appropriate infection prevention and control (IPC) measures to be taken, e.g. transported without other patients, isolated on admission.

Transmission based procedures should be followed whenever transferring a patient, whether they have a confirmed infection or not.

Ensure that care equipment used to transfer the patient, e.g. wheelchair, is decontaminated.

20 Viral Gastroenteritis/Norovirus

20.1 Procedure during an outbreak of viral gastroenteritis

20.2 Management of a symptomatic patient

20.1 Procedure during an outbreak of viral gastroenteritis:

Admin Staff

Put the Norovirus Stop poster up on all approaches to reception. The poster is embedded here.

norovirus stop.pdf

Clinical Staff

When assessing a patient with suspected viral gastroenteritis, disposable apron and gloves should be worn. Before putting on and after removal of personal protective equipment (PPE), hands should be washed with liquid soap, warm running water and dried with paper towels.

Alcohol handrub should not be used as it is not effective at killing Norovirus.

Patients with symptoms should be encouraged to wash their hands thoroughly with liquid soap and warm running water after an episode of vomiting or diarrhoea, using the toilet and before eating and drinking.

During periods of increased activity with Norovirus, Practice staff should be reminded to wash hands thoroughly rather than using alcohol handrub after patient contact, before their breaks and before eating and drinking.

20.2 Managing a symptomatic patient – Vomit or Diarrhoea

Best practice is to use a spillage kit appropriate to the type of spillage for vomit, this should be used following the manufacturer's guidance and within its expiry date.

Spillage kits may contain solidifying polymer granules. A National Patient Safety Alert issued in 2017, following a number of deaths and incidents related to patients ingesting the product, advises a risk assessment and procedures in place to ensure supplies are securely stored away from the general public.

Due to the highly infectious nature of Norovirus, if a patient vomits or has diarrhoea in the Practice, a qualified member of staff should clean the area using an appropriate spillage kit. If possible, move waiting patients to another waiting room/area until the spillage has been dealt with.

If a patient vomits or has diarrhoea in a toilet, the area should be immediately deemed 'out of order' and signage indicating this put on the door. The toilet area should be cleaned and disinfected promptly before the area is re-opened.

Dispose of waste and PPE as infectious waste.

Wash hands with liquid soap and warm running water.

All cloths used must be single use and disposed of after use.

21 Notifiable Diseases

21.1 Introduction

Diseases that are notifiable to the Local Authority Proper Officers under the Health Protection (Notification) Regulations 2010 are listed below.

Registered medical practitioners (RMPs) have a statutory duty to notify the 'proper officer' at their local Council or Health Protection (HP) Team of suspected cases of certain infectious diseases. Our local office is located at

North East and North Central London HPT

Public Health England, 4th Floor, Wellington House, 133-155 Waterloo Road, London, SE1 8UG

Email necl.team@phe.gov.uk Telephone 020 3837 7084 (option 0, then option 2)

Urgent out of hours advice for health professionals only 0151 434 4319 or 020 3837 7084

Coronavirus Response Cell Telephone: 0300 303 0450 or email: LCRC@phe.gov.uk

Email for PII phe.nenclhpt@nhs.net

21.2 Notification form

Complete a notification form immediately on diagnosis of a suspected notifiable disease. Don't wait for laboratory confirmation of a suspected infection before notification. The form can be found online at www.gov.uk/government/publications/notifiable- diseases-form-for-registered-medical-practitioners .

Send the form to the proper officer within 3 days, or notify them verbally within 24 hours if the case is urgent. You can contact the local HP Team for further guidance.21.3 List of notifiable diseases

Diseases notifiable to local authority proper officers under the Health Protection (Notification) Regulations 2010:

Disease	Whether likely to be routine or urgent
Acute encephalitis	Routine
Acute infectious hepatitis (A, B, C)	Urgent if suspected bacterial infection, otherwise routine
Acute meningitis	Urgent
Acute poliomyelitis	Urgent
Anthrax	Urgent
Botulism	Urgent
Brucellosis	Routine: urgent if UK acquired
Cholera	Urgent
COVID-19	Urgent
Diphtheria	Urgent
Enteric fever (typhoid or paratyphoid)	Urgent
Food poisoning	Routine: urgent, if as part of a cluster or outbreak
Haemolytic uraemic syndrome (HUS)	Urgent
Infectious bloody diarrhoea	Urgent
Invasive group A streptococcal disease	Urgent
Legionnaires' disease	Urgent
Leprosy	Routine
Malaria	Routine: urgent if UK acquired
Measles	Urgent
Meningococcal septicaemia	Urgent
Mumps	Routine
Plague	Urgent
Rabies	Urgent
Rubella	Routine
Severe Acute Respiratory Syndrome (SARS)	Urgent
Scarlet fever	Routine
Smallpox	Urgent
Tetanus	Routine: urgent if associated with injecting drug use
Tuberculosis	Routine: urgent if healthcare worker or suspected cluster or multidrug-resistant
Typhus	Routine
Viral haemorrhagic fever (VHF)	Urgent
Whooping cough	Urgent if diagnosed in acute phase: routine if later diagnosis
Yellow fever	Routine: urgent if UK acquired

Report other diseases that may present significant risk to human health under the category ‘other significant disease’

22 SARS CoV2

22.1 Patient Assessment at Reception

On arrival reception should:

- Check the patients record for a SARS CoV2 test on screen. If it is positive in the last 14 days please advise the GP due to see the patient straightaway.
- Have you been in contact with anyone with Coronavirus infection.
- Have you been in contact with anyone who is self isolating.
- Have you any symptoms, such as fever, cough, sore throat, loss of smell or taste, or shortness of breath.
- Scan a forehead temperature. If it is above 37.5C contact the GP straightaway.

22.2 Patient Flow

Ask patients to sit in the socially distanced seating and ask that they leave the building using the one way system marked on the floor.

22.3 Staff Screening Requirements

All staff are required to be:

- Fully vaccinated and have received the booster vaccination.
- Undertake Lateral Flow Tests onsite Monday and Thursday.

Failure to comply with these conditions will lead to disciplinary action.