

**Joint Policy for Cumbria Partnership Foundation Trust & North Cumbria
University Hospital NHS Trust**

**Policy Title: Infection Prevention & Control
Standard Precautions Policy**

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Policy On A Page

SUMMARY & AIM

This policy defines the arrangements in place for preventing Healthcare Associated Infections (HCAI). Implementation of this policy into routine clinical practice will enhance patient safety and reduce the risk of patients and visitors acquiring a Health Care Infection; staff will also reduce their risk of developing infection whilst delivering care to patients

TARGET AUDIENCE:

Nurses, Midwives, AHPs, Consultants, Clinical Directors, Matrons, FY1 & FY2 doctors, Registrars, Divisional Associate Medical Directors Associate Chief Operating Officer , General Managers, Business Managers, Departmental and Corporate Managers, Executive, Non-executive Directors .

TRAINING:

On employment all staff receive infection prevention and control (IPC) induction which includes the standard precautions for minimising infection.

Infection Prevention and Control mandatory training is undertaken every 2 years via workbook/e-learning as indicated in the Trust Training Needs Analysis for all staff:

IPC Workbook/e-learning. Level 1 261 Infection Prevention and Control for Non Clinical Staff and Level 2 261 for all Trained Staff.

Hand Hygiene face to face training for all staff every 2 years.

KEY REQUIREMENTS

1. Personal protective equipment (PPE) includes
 - Gloves
 - Disposable plastic aprons or gowns
 - Face, mouth/eye protection e.g. masks/goggles
2. It is the personal responsibility of the individual using a sharp to dispose of it safely.
3. PPE and waste must be disposed of in a safe and secure manner in line with both Trust Waste.
4. The principles of Aseptic Non Touch Technique (ANTT) must be applied when completing any clinical procedure.
5. Staff must decontaminate their hands with soap and water OR use hand sanitizer before and after every episode of patient care in line with the Trust Hand Hygiene Policy

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1. INTRODUCTION

- 1.1 In order to reduce the risk of transmission of HCAI it is important that all staff have clear and concise guidance on how they can be prevented. This policy contains the necessary information to help reduce the risk of acquisition of HCAI and prevent transmission.

2. PURPOSE

- 2.1 To provide staff working within the clinical and community settings clear guidance on the required infection prevention and control measures to ensure safe working practice for patients/clients and staff.

3. POLICY DETAILS -

3.1 Standard Infection Control Precautions (SICP)

SICP are designed to prevent cross transmission from recognised and unrecognised sources of infection. These sources of (potential) infection include blood and other body fluids secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment which are likely to become contaminated. They are necessary to ensure the safety of patients/clients and health care worker (HCW) who visit the environment.

SICP must be implemented at all times within the Trust and community settings. The application of SICP during delivery of care is determined by:

- The level of interaction between the HCW and the patient/client
- The anticipated level of exposure to blood and or body fluids

3.2 Transmission routes of disease

The main transmission routes of disease are listed below. Some infections may be transmitted by more than one route.

3.2.1 Contact

This is the most common route of transmission. Transmission can be divided into two routes:

- Direct contact. This is when an infectious agent is transferred directly from one person to another, through direct body contact without involvement of inanimate objects or other people i.e. skin to skin contact, or the transfer of an infectious agent from an open wound to the mucous membranes or skin break in another susceptible individual. Faecal pathogens are also spread through this route.
- Indirect contact. This is when an infectious agent is transferred to an individual from an object and/or another person. This can occur in a number

of ways e.g. hands of a HCW become contaminated from a patients/clients environment, or equipment etc.

3.2.2 Airborne

The spread of organisms by droplet nuclei (aerosol) or dust through the air and enters a person through the respiratory tract.

This is spread by inhalation of organisms. Droplet spread by close contact involving direct inhalation of droplets, e.g. upper respiratory tract infection, streptococcal sore throat, Pertussis, Influenza, Meningococcal infections etc.

Some organisms remain suspended in the air for prolonged periods and transmission may occur without close contact e.g. Tuberculosis, Varicella, and Measles etc.

3.2.3 Parenteral

This is the spread by inoculation of blood or other body fluids e.g. amniotic, chest drainage etc. Significant exposures for HCW's including needle stick injuries, cuts from scalpel blades and blood splashes to non-intact skin and mucous membranes.

Other examples of parenteral spread are: -

- Sexual intercourse
- Transfusion of infected blood
- Mother-to-baby ("vertical") transmission
- Sharing of injecting equipment
- Acupuncture and tattooing

Contaminated food and or water may act as a common source of infection.

NB. Intravenous fluids or parenteral feeds may become contaminated and act as source of infection. Splashes of blood to intact skin are not thought to be a risk.

3.2.4 Faecal Oral

This is the transmission of diseases when pathogens in faecal particles are transmitted from one host to another. Causes are food and water that has become contaminated through people not decontaminating their hands when preparing food, after toileting etc. and untreated sewage entering drinking water supplies. This allows for the transmission of diseases e.g. Salmonella, Cryptosporidium, Hepatitis A etc.

3.3 Personal Protective Equipment (PPE)

3.3.1 Introduction

The use of PPE is essential for health and safety. The use of PPE is considered standard in certain situations i.e. contact with blood/other body fluids, non-intact

skin, mucous membranes and when undertaking cleaning and decontamination procedures.

The benefit of wearing PPE is twofold, offering protection to both patients/clients and those caring for them. A risk assessment may be required in order to decide which PPE is most appropriate to prevent the transmission of micro-organisms to the patient and to the HCW.

For the purpose of this policy, the PPE described includes:

- Gloves
- Disposable plastic aprons or gowns
- Face, mouth/eye protection e.g. masks, goggles etc.

This policy does not contain details of theatre apparel which is often more comprehensive due to the risks encountered, therefore, a Trust theatre standard operating procedure is available on the Trust Internet providing detailed information.

3.3.2 Gloves Guidelines for Selection

The purpose of gloves is a two way protection for staff and patients from blood and body fluids during clinical procedures, protection for the patient from staff's resident and transient hand flora during procedures, protection for immuno-compromised patients and protection from direct exposure to chemicals e.g. cytotoxics, disinfectants etc. Information on type of gloves, when to wear and situations for use can be found in the glove selection policy.

Gloves are not a substitute for hand hygiene and hands must be decontaminated after gloves are removed.

3.3.3 Disposable Aprons or Gowns

Disposable apron or gown must be worn by HCW's when in close contact with the patient, materials or equipment as this may lead to contamination of uniforms or other clothing with microorganisms or, when there is a risk of contamination with blood, body fluids, secretions, or excretions (with the exception of perspiration) or when preparing/using chemicals. [Appendix 1](#) provides guidance on when to wear and disposal.

3.3.4 Facial/Respiratory Protection

HCW may have to wear facial protection to prevent respiratory droplets from patients mouth and nose expelled into the environment being inhaled and to protect mucous membranes e.g. eyes, nose etc. from exposure to blood and or body fluids when splashing occurs.

Respiratory hygiene incorporates covering nose and mouth with disposable single use tissues when sneezing, coughing, wiping and blowing nose. Keep contaminated hands away from mucous membranes i.e. eyes and nose.

A risk assessment must be carried out to identify the type of protection required taking into account the suspected or confirmed diagnosis of the patient.

Appendix 2 provides guidance on type, situation and process for use and disposal.

3.4 Removal of PPE

PPE must be removed in the following sequence to minimise the risk of cross/self-contamination:

- Gloves;
- Apron;
- Eye protection (when worn); and
- Mask/respirator (when worn).

Aprons and gloves worn for routine cleaning and bed making in the clinical area can be disposed of into household waste bags. Disposal of PPE must be in accordance with Trust and community waste regulations refer to Trust waste policy. Hands must be decontaminated following the removal of PPE.

3.5 Safe Use and Disposal of Sharps

All HCW's must be aware of their responsibility in avoiding needle stick or sharps injuries. It is the personal responsibility of the individual using a sharp to dispose of it safely. There is a risk that injuries sustained to staff and patients through the use of sharps contaminated with blood or other body fluids e.g. amniotic, chest drainage etc. may transmit blood-borne infections e.g. Hepatitis C, HIV etc.

All sharps injuries must be reported immediately according to the Trust Inoculation Injury Policy to ensure that the appropriate action can be taken. It is the duty of every employee, under the Health and Safety at Work Act to report such incidents and document them properly.

Sharps are (this is not an exhaustive list):

- needles
- syringes
- razors
- stitch cutters
- scalpel blades
- trocars
- cannulae
- used ampoules

See Appendix 3 on safe handling, use of sharps boxes and disposal procedures

3.6 Aseptic Non Touch Technique (ANTT)

Aseptic technique is a clinical practice aimed to protect patients from contamination or infection during a wide range of clinical procedures. ANTT theory and practise framework provides a logical and standardised set of rules and principles that staffs

require in order to safely apply an aseptic technique. It is essential that HCW are properly educated and trained in ANTT.

The principles of ANTT must be applied when completing any clinical procedure. The following lists of procedures are all covered within ANTT:

- Cannulation
- Urinary catheter
- Venepuncture
- Wound dressing
- IV device management/administration
- Blood culture

Full guidance on ANTT can be found in the Trust Aseptic Policy Incorporating Aseptic Non Touch Technique (ANTT) for clinical procedures Policy.

3.7 Waste Management

PPE must be disposed of in a safe and secure manner to protect patients, staff, visitors and others, as well as the general community from the harmful effects of hazardous waste and to care for the general environment.

Please refer to the Trust Waste Management policy available on the intranet for detailed guidance on safe systems of work for the storage, handling, transportation and disposal of general, clinical and hazardous wastes generated within the Trust and community setting.

3.8 Notifiable Diseases and Organisms

All notifiable conditions must be reported to Public Health England. The responsibility for this reporting is:

- Notifiable diseases – responsible clinicians report
- Notifiable organisms – lab/microbiologist will report

The following link explains the process:

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

PHE Notification form must be used:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/324450/Notifiable_disease_form.pdf

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

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis

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

3.9 Transmissible Conditions

In order to reduce the risk of healthcare associated infections (HCAI), it is critical that all Trust staff have access to guidance on management of transmissible infections which can impact on healthcare.

Knowledge of the organism, the route of transmission and infection control measures can reduce the potential for cross infection. [Appendix 4](#) and [6](#) give staff information on diseases/infective agents and an aid to diagnosing gastroenteritis.

The NCUH transmissible conditions fact sheets can be accessed via the staff intranet at the Infection prevention page.

<http://nww.staffweb.cumbria.nhs.uk/services-and-departments/infection-prevention-and-control/policies-guidelines-protocols/Home.aspx>

There are dedicated fact sheets for a variety of transmissible conditions which provide staff with up to date infection prevention information and guidance for the most common infectious conditions which are considered a risk within a healthcare setting.

The fact sheets for the following transmissible conditions can be found via the intranet:

1. Bed Bugs
2. Campylobacter
3. Chicken Pox
4. Cryptosporidiosis
5. Cytomegalovirus (CMV)
6. E. coli 0157
7. Fleas
8. Giardia
9. Head Lice
10. Hepatitis A Virus (HAV)
11. Hepatitis B Virus (HBV)
12. Hepatitis C Virus (HCV)
13. Hepatitis D
14. Hepatitis E
15. HIV
16. Measles
17. Meningitis – Bacterial
18. Meningitis - Viral
19. Mumps
20. Parvovirus
21. Pneumocystis Jiroveci Pneumonia (PCP)
22. Rubella (German measles)
23. Salmonella
24. Scabies
25. Shigella
26. Shingles
27. Slapped Cheek
28. Stenoptrophamonas
29. Zika Virus

3.10 Isolation

Isolation is an important factor in the prevention of transmission of infection. Guidance on the three types of isolation; source, protective and strict can be found in [appendix 5](#).

4. TRAINING AND SUPPORT

It is the responsibility of the managers to ensure that their staff are appropriately trained to ensure that SICP are implemented.

On employment all staff receives IPC induction including guidance on standard infection control precautions for minimising infection at mandatory corporate induction.

Infection Prevention and Control mandatory training incorporating standard precautions for minimising infection is undertaken every 2 years via workbook/e-learning as indicated in the Trust mandatory TNA for all staff.

IPC Workbook/e-learning. Level 1 261 Infection Prevention and Control for Non Clinical Staff and Level 2 261 for all Trained Staff.

Hand Hygiene training is also an integral part of complying with the requirements of this policy, face to face training is provided at induction and all staff must complete further face to face sessions on a 2 yearly basis thereafter.

5. PROCESS FOR MONITORING COMPLIANCE

The process for monitoring compliance with the effectiveness of this policy is as follows:

Aspect being monitored	Monitoring Methodology	Reporting	Committee	Frequency
		Presented by		
Monitoring of Standard Infection Control Precautions	Cannulation, wound, urinary catheterization, central line management, hand hygiene, peripheral line management audits	Clinical wards and depts.	Infection Prevention and Control Committee	Quarterly
		Infection Prevention and Control		Operational Cleaning and Quality Meeting
Monitoring of Inoculation Injuries	Inoculation Injury Reporting	Occupational Health Manager	Infection Prevention and Control Committee	Quarterly

Wherever the above monitoring has identified deficiencies, the following must be in place:

- Action plan
- Progress of action plan monitored by the Infection Prevention and Control Committee minutes
- Risks will be considered for inclusion in the appropriate risk registers

6. REFERENCES:

- epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2014) Loveday H.P, Wilson J.A, Pratt R.J, et al. Journal Hospital Infection 86 (supp):S1-S70
- epic 2 National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England (2007) Pratt RJ, Pellowe CM, Wilson JA et al. Journal of Hospital Infection 65 (supp 1)
- Garner JS, Hospital infection control practices advisory committee. Guidelines for isolation precautions in hospital. Infection Control Epidemiology 1996; 17:53-80.
- Health Protection Agency (2014) Factsheets – Infectious Diseases. Available from <http://www.hpa.org/uk/Publications/InfectiousDiseases/Factsheets/>
- The Control of Substances Hazardous To Health Regulation 2002 (COSHH)
- Sharps Injury in Healthcare (2013) Available from: <http://www.hse.gov.uk/healthservices/needlesticks/eu-directive.htm>

7. ASSOCIATED DOCUMENTATION:

NCUH Aseptic Technique Policy

[http://cptportal.cumbria.nhs.uk/SiteDirectory/InfectionPrevention/Pages1/Policy%200Chapters%202017/B-%20Aseptic%20Non-Touch%20Technique%20\(ANTT\).pdf](http://cptportal.cumbria.nhs.uk/SiteDirectory/InfectionPrevention/Pages1/Policy%200Chapters%202017/B-%20Aseptic%20Non-Touch%20Technique%20(ANTT).pdf)

NCUH Hand Hygiene Policy

<http://nww.staffweb.cumbria.nhs.uk/policies/categories/infection-prevention/hand-hygiene.pdf>

<http://cptportal.cumbria.nhs.uk/SiteDirectory/InfectionPrevention/Pages1/Policy%200Chapters%202017/Hand%20Hygiene.pdf>

NCUH Clostridium difficile

<http://nww.staffweb.cumbria.nhs.uk/policies/categories/infection-prevention/clostridium-difficile-policy.pdf>

<http://cptportal.cumbria.nhs.uk/SiteDirectory/InfectionPrevention/Pages1/Policy%200Chapters%202017/N-%20Management%20of%20Clostridium%20difficile%20infection.pdf>

Health and Safety Policy

<http://nww.staffweb.cumbria.nhs.uk/policies/categories/security-health-and-safety/health-and-safety-policy.pdf>

Glove

<http://nww.staffweb.cumbria.nhs.uk/policies/categories/security-health-and-safety/glove-selection-clinical-policy.pdf>

NCUH Fact sheets

<http://nww.staffweb.cumbria.nhs.uk/services-and-departments/infection-prevention-and-control/policies-guidelines-protocols/Home.aspx>

8. DUTIES (ROLES & RESPONSIBILITIES):

8.1 Chief Executive / Trust Board Responsibilities:

The Chief Executive and Trust Board jointly have overall responsibility for the strategic and operational management of the Trust, including ensuring that Trust policies comply with all legal, statutory and good practice requirements.

8.2 Executive Director Responsibilities: Director of Nursing

All policies have a designated Executive Director and it is their responsibility to be involved in the development and sign off of the policies, this should ensure that Trust policies meet statutory legislation and guidance where appropriate. They must ensure the policies are kept up to date by the relevant author and approved at the appropriate committee.

8.3 Managers Responsibilities:

Managers are responsible for ensuring adequate dissemination and implementation of policies relevant to the staff in their areas. Managers are also responsible for making sure staff can access policies on the Intranet

8.4 Staff Responsibilities:

All staff are responsible for co-operating with the development and implementation of Trust policies as part of their normal duties and responsibilities. All staff must complete Infection Prevention and Control eLearning module. They are responsible for ensuring that they maintain up to date awareness of corporate and local policies with regard to their own and their staff roles and responsibilities. As part of ongoing professional development all staff are expected to keep themselves updated regarding infection prevention and control

8.5 Infection Prevention and Control Committee Responsibilities:

The Chair of the above committee will ensure the policy approval is documented in the final section of the Checklist for Policy Changes. The committee will agree the approval of the final draft of the policy.

9. ABBREVIATIONS / DEFINITION OF TERMS USED

ABBREVIATION	DEFINITION
ANTT	Aseptic Non Touch Technique
CCDC	Consultant in Communicable Disease Control
COSHH	Care of Substances Hazardous to Health
DIPC	Director of Infection Prevention and Control
HCAI	Healthcare Associated Infection
HCW	Healthcare Workers
HPV	Hydrogen Peroxide Vapour
HIV	Human Immunodeficiency virus
IPC	Infection Prevention and Control
IPCC	Infection Prevention and Control Committee
IPCT	Infection Prevention and Control Team
MDRTB	Multidrug Resistant Tuberculosis
OH	Occupational Health
PHE	Public Health England
PPE	Personal Protective Equipment
TB	Tuberculosis
VRE	Vancomycin Resistant Enterococcus

TERM USED	DEFINITION
Isolation	The use of infection control precautions aimed at controlling and preventing the spread of infection.
Source Isolation (Barrier Nursing)	Isolation of a patient who is the source of the infection.

TERM USED	DEFINITION
Protective Isolation (Reverse Barrier Nursing)	The physical separation of a patient at high risk from common organisms carried by others. The patient requires protection i.e. they are immuno-compromised.
Strict Isolation	Used for the isolation of highly communicable diseases such as Viral Haemorrhagic Fever. Patients requiring this level of isolation must be transferred to an Infectious Diseases Unit as soon as possible.

APPENDIX 1 – DISPOSABLE APRONS OR GOWNS

Use and disposal of disposable apron or gowns within clinical areas as follows:

- worn as a single-use item, for one procedure or episode of patient care
- fluid-repellent gowns must be worn where is a risk of extensive splashing of blood, body fluids, secretions or excretions with the exception of perspiration e.g. childbirth, theatres etc.
- risk of clothing contamination with blood, body fluids
- bed making
- cases of suspected or confirmed infection e.g. MRSA
- cleaning of the environment or equipment
- preparation of chemicals
- Dispose into the orange waste stream with the exception if worn when bed making when disposal can go into the household waste stream.

APPENDIX 2 - FACIAL/RESPIRATORY PROTECTION

Masks must always fit comfortably, covering the mouth and nose. When not in use, they must be removed, disposed of into the orange waste stream and must not be worn around the neck, reusable items e.g. respirator masks etc. must have a decontamination schedule and this must be carried out immediately after use.

The following equipment is recommended for use within clinical areas, detailed guidance is contained within appendix 5 A-Z modes of transmission.

- Standard surgical masks for use during routine operating procedures, suspected confirmed meningococcal infection etc.
- Standard surgical masks with eye visors when there is a risk that eyes may become contaminated with blood/body fluids during operations, suctioning etc.
- Filter masks with a filtration rate of >95% for nuclei of 1-5 microns when there are minute airborne respiratory particles present must be worn when carry out aerosol generating procedures in cases of suspected TB, influenza etc. and during confirmed multi drug resistant tuberculosis (MDRTB) cases etc. Refer to the Trust TB and Influenza policy for more guidance. Clinical areas must ensure they have sufficient stocks of masks through the normal purchasing route.
- Eye protection e.g. goggles or shield, can be used in conjunction with surgical mask and these must be used when risk of blood and or body fluid contamination may occur.
- Respirator masks for use when caring for patients with MDRTB, SARS, pandemic flu etc. It is vital that staff undertake education and training on using these masks before use to ensure the mask fits correctly.

When to change face protection:

- Face protection must be changed between patients/clients procedures.
- Change between tasks on the same patient/client to prevent unnecessary cross-contamination.
- Remove immediately you have finished the task
- If the mask becomes wet or soiled it must be changed immediately in order to ensure continued protection.

Unused masks must be stored away from possible sources of contamination.

N.B. There is no evidence that HCW's wearing surgical facemasks protects patients from HCAI during routine ward procedures e.g. wound dressings etc.

APPENDIX 3 - SAFE USE AND DISPOSAL OF SHARPS

Safe handling of Sharps

- Use of sharps must be avoided wherever possible
- Needles must not be recapped, bent/broken or disassembled after use.
- Needle free devices must be implemented to reduce risk of inoculation injury
- Sharps must not be passed directly from hand to hand and handling must be kept to a minimum.
- Sharps must not be carried by hand; ideally they should be carried on a purpose made sharps tray with integral sharps bin.
- Vacutainers must be used for phlebotomy wherever possible.
- Needles and syringes must be discarded as a single unit.

Safe disposal of Sharps

- Sharps must be disposed of into a sharps container at the point of use.
- The user must ensure that the size of the sharps bin is appropriate for the clinical activity and size of the equipment being disposed.
- Sharps boxes must not be filled above the maximum fill line.
- It is the responsibility of the user to dispose of their own sharps at point of use.
- Between uses, the temporary closure device must be activated to prevent accidental spillage from the sharps bin.

Safe use of the sharps bins

- Sharps bins must conform to UN 3291 and BS 7320 standards (NB: yellow bins with purple lids must be used for disposal of cytotoxic waste)
- Sharps bins with open aperture facility must be used for the disposal of intravenous giving sets and these bins must be stored away from main patient areas i.e. clean utilities.
- Sharps bins must be located in a position that is out of reach of children.
- Sharps bins must not be stored on the floor or above shoulder height; they should where possible be wall or trolley mounted.
- Sharps bins can be positioned on shelving at an appropriate height to allow disposal of items in a safe manner.

Safe disposal of Sharps bins

- When the maximum fill line is reached, sharps bins must be closed, locked and the label completed by the person doing this.
- Locked boxes must be stored in an appropriate facility i.e. ward sluice whilst waiting for the collection.

APPENDIX 4 - A-Z OF ROUTES OF SPREAD OF INFECTION

DISEASE & OR INFECTIVE AGENT	INCUBATION PERIOD	PERIOD OF INFECTIVITY TO OTHERS	MAIN MODE/ ROUTE OF SPREAD	ISOLATION REQUIRED	COMMENTS/ IMPORTANT PRECAUTIONS
ANTHRAX (Cutaneous lesions or pulmonary infection)	1-7 days (Occasionally up to 8 weeks)	Not applicable	Contact with infected animals or animal products. No person-person spread except from direct contact with skin lesions	NO	Possible agent for bio terrorism. Contact IPCT urgently if suspected case. Standard precautions. Wear gloves if in contact with skin lesions. Label lab samples as high risk
ATYPICAL MYCOBACTERIA	Not applicable	Not applicable	No person-person spread	NO	Standard precautions
BRONCHIOLITIS Respiratory Syncytial Virus (RSV)	1-10 days	While respiratory symptoms persist	1. Airborne, inhalation of aerosols 2. Hand contact with respiratory secretions or contaminated surfaces	YES Single room with door closed	Highly infectious. Wear apron and gloves while in single room. May cause serious infections in babies with underlying lung or cardiac problems.
BRUCELLOSIS	Variable	Not applicable	Contact with infected animals, ingestion raw milk	NO	Standard precautions
CHOLERA	2-3 days	While patient has diarrhoea	1. Ingestion contaminated food/water 2. Faecal-oral	YES	Enteric precautions. Hand hygiene of major importance to prevent person-to-person spread.
CONJUNCTIVITIS	Variable depending on pathogen	While symptoms persist	Direct contact	Not routinely	Discuss individual cases with IPCT.
DIPHTHERIA Corynebacterium diphtheriae	2-5 days	Until throat swabs negative	Airborne - close personal contact	YES Single room with door closed	Notify ICT and Public Health England (PHE) immediately. Standard precautions. Contact tracing and screening essential. Erythromycin for contacts.
ENTERIC FEVER i.e. Typhoid fever, (Salmonella typhi or paratyphi)	8-14 days (Range 3-30 days)	While organism in stools/urine	Ingestion of contaminated food/water	YES	Enteric precautions. Acute cases rarely infect others by direct contact. Carriers may infect food.

DISEASE & OR INFECTIVE AGENT	INCUBATION PERIOD	PERIOD OF INFECTIVITY TO OTHERS	MAIN MODE/ ROUTE OF SPREAD	ISOLATION REQUIRED	COMMENTS/ IMPORTANT PRECAUTIONS
FUNGAL SKIN INFECTIONS e.g. Ringworm	1-2 weeks	While lesions present	Direct contact with lesions Indirect contact with contaminated surfaces	NO	Standard precautions
GAS GANGRENE Cl. perfringens	Not applicable	Not applicable	No person to person spread	NO	Standard precautions. Infection from patient's own faecal flora or contamination of wound with soil
GLANDULAR FEVER	4-6 weeks	May be prolonged	Person to person spread by close contact with saliva	NO	Standard precautions
HAND, FOOT & MOUTH DISEASE Coxsackie virus	3-5 days	While clinical symptoms persist	Person to person spread by contact with respiratory secretions & faecal-oral route	NO	Enteric precautions (virus excreted in stools)
HERPES SIMPLEX I & II a) Cold sores, herpetic whitlows	2-12 days	Until lesions dry & crusted	Direct/close contact with lesions	Not routinely	Standard precautions. Wear gloves if contact with lesions. Avoid contact with patients with immunosuppression, burns or eczema. Cover whitlows
b) Genital	As above	While lesions active	Sexual contact	Not routinely	As above - special risk to neonates
c) Neonatal	As above	Consider as potentially infectious while in hospital	Mother-to-baby at delivery	YES	Separate from other babies & mothers. Mother & baby's secretions to be handled as infected.
LEPTOSPIROSIS	1-3 weeks	Not applicable	Contact with contaminated water or soil. Direct contact with infected animals	NO	Standard precautions
LISTERIOSIS L. monocytogenes	Variable	Products of conception highly	In hospital may be spread by direct contact with products of	Mother & baby only	Enteric precautions, main risk is to immuno-compromised or pregnant women and neonates.

DISEASE & OR INFECTIVE AGENT	INCUBATION PERIOD	PERIOD OF INFECTIVITY TO OTHERS	MAIN MODE/ ROUTE OF SPREAD	ISOLATION REQUIRED	COMMENTS/ IMPORTANT PRECAUTIONS
		infectious to neonates	conception or infected neonates		
MALARIA	1-4 weeks, may be longer for P. vivax	Not applicable	Mosquito bites, & rarely parenteral spread via inoculation injuries	NO	Standard precautions
Haemophilus influenzae (Hib)	2-5 days	As above	Close personal contact	YES For first 24 hrs of antibiotic therapy.	Standard precautions. No risk to adult contacts, children under 5 may be susceptible.
Pneumococcal	Unknown	Not applicable	Infection from patients own upper respiratory flora	Not essential	Standard precautions
Viral e.g. Coxsackie, Echovirus	Variable	For 7 days after onset	Faecal-oral route, virus excreted in stools	Not routinely	Enteric precautions. Isolation for some patients e.g. babies and younger children. Discuss individual cases with ICT
NECROTISING FASCIITIS	Not applicable	Not applicable	Usually from patient's own flora	Not routinely unless caused by Streptococcus Group A until 24hrs of antibiotics	Standard precautions
PLAGUE Yersinia pestis	1-7 days	Until completing 72 hrs of effective antibiotics	Bites of infected fleas. Person to person spread by respiratory droplets if pneumonic plague	YES Single room with door closed	Possible agent for bio terrorism. Contact ICT urgently if suspected case. Standard precautions with filter type masks & eye protection if pneumonic plague

DISEASE & OR INFECTIVE AGENT	INCUBATION PERIOD	PERIOD OF INFECTIVITY TO OTHERS	MAIN MODE/ ROUTE OF SPREAD	ISOLATION REQUIRED	COMMENTS/ IMPORTANT PRECAUTIONS
RABIES	2-8 weeks (May be longer)	Not applicable	Bites or scratches from infected animals e.g. dogs No person to person spread	NO	Standard precautions, wear protective clothing when handling all body fluids & secretions
SCARLET FEVER	See streptococci infections				
SMALLPOX	12 days (Range 7-17)	From onset fever until crusts shed from skin lesions	Airborne spread by respiratory droplets. Contact with skin lesions or contaminated laundry or waste	YES Single room with door closed	Possible agent for bio terrorism. Contact ICT urgently if suspected case. Full protective clothing for non-immune staff. Limit staff access. Probable/confirmed cases transferred to high security Infectious Disease unit
STAPHYLOCOCCAL INFECTIONS S. Aureus, e.g. wound infection, boils abscesses, impetigo		While organism present (carriers may transmit infection)	1. Direct/indirect contact. 2. Airborne	Only if antibiotic resistant, or extensive lesions present	Standard precautions.
STREPTOCOCCAL INFECTIONS e.g. cellulitis, impetigo, scarlet fever, pharyngitis,		During acute infection	Airborne & direct contact	YES For first 24 hours antibiotic therapy.	Standard precautions. May cause life-threatening invasive infections
TETANUS	3-21 days	Not applicable	Contamination of wounds with spores in soil	NO	Standard precautions.
Tuberculosis (TB)	See TB Policy				
TOXOPLASMOSIS	1-3 weeks	Not applicable	Ingestion of contaminated meat, or	NO	Standard precautions. Not spread from person to person.

DISEASE & OR INFECTIVE AGENT	INCUBATION PERIOD	PERIOD OF INFECTIVITY TO OTHERS	MAIN MODE/ ROUTE OF SPREAD	ISOLATION REQUIRED	COMMENTS/ IMPORTANT PRECAUTIONS
			via contact with cat faeces		
TYPHOID FEVER	See Enteric fever				
Viral Haemorrhagic Fever (VHF)	See VHF Policy				
WORM INFESTATION Threadworms Roundworm, Hookworm, Whipworm	Variable Depends on species	While infestation persists	Person to person spread - faecal-oral route. Contact with soil contaminated with faeces	Not routinely	Standard precautions
YELLOW FEVER	3-6 days	First 3-5 days of clinical illness	Mosquito bites, no person to person spread	No	Standard precautions.

APPENDIX 5 - ISOLATION

	Where to isolate	Room Rules	Precautions		
			Contact	Enteric	Respiratory
SOURCE ISOLATION	<p>A single room is preferred, but not always required for this level of isolation.</p> <p>Cohorting within a multi bedded area may be considered for patients who have the same pathogen</p>	<p>A standard precautions sign must be placed at the entrance to the room where it is visible to all staff.</p> <p>Visitors and members of staff from other departments must report to the Nurse-in charge before entering the room.</p> <p>The door of the room (if fitted) must be kept closed at all times unless the clinical need of the patient dictates otherwise.</p> <p>Patients must not leave the room / ward area to attend other departments without prior arrangement / notification of the receiving department.</p>	<p>Gloves must be worn for all direct contact with the patient and their immediate environment and if there is any risk from contamination with blood and body and/or body fluids.</p> <p>Plastic aprons must be worn for all direct contact with the patient and their immediate environment and when soiling of the uniform is likely.</p> <p>Masks are not required unless there is the additional risk of airborne spread.</p> <p>Full face protection e.g. visor or goggles, must be worn if there is a risk of splashing from blood or body fluids and secretions into the face.</p>	<p>A patient who has unexplained or suspected/confirmed infectious diarrhoea, a single room must be used. (If more than 1 patient has enteric symptoms then notify the IPCT and refer to the Norovirus policy)</p> <p>If confirmed Clostridium difficile move the patient into a single room (with en-suite facilities if possible) immediately and no later than 2 hours from the notification of the result. A dedicated commode must be allocated for the patient's use.</p> <p>Send a stool specimen following the Should I Send a Stool Specimen guidance.</p> <p>Complete the initial actions at onset of</p>	<p>A blue square sign must also be displayed at the entrance to the room to notify staff that respiratory precautions are required. This notifies staff that there are infection prevention precautions in place.</p> <p>The IPCT must be contacted for advice regarding use of surgical or respirator masks.</p> <p>Visitors and members of staff from other departments must report to the Nurse-in-Charge before entering the room.</p> <p>Patients must not leave the room to attend other departments without prior arrangements.</p>
PROTECTIVE ISOLATION	<p>The patient must be nursed in a single room preferably with</p>	<p>The isolation room door must be closed at all times, apart from</p>			

	<p>en-suite facilities if available.</p>	<p>the necessary entrances and exits.</p> <p>All staff entering the room must wash their hands with soap and water or use the hand rub if appropriate.</p> <p>Aprons and gloves must be worn by all staff when entering the room.</p> <p>Limit the number of staff entering the isolation room. Reducing the number of staff who come into contact with the patient will further reduce the risk of cross infection.</p> <p>Staff who are nursing patients with infections should avoid nursing patients in protective isolation during the same span of duty.</p> <p>Staff with infections must not be working within the clinical environment.</p>	<p>Hands must be washed with soap and water or disinfected with hand rub before entering and exiting the room, after patient contact, after contact with potentially infected materials, and after removal of disposable gloves.</p>	<p>diarrhoea pathway and maintain the bowel diary.</p> <p>A standard precaution sign must be placed at the entrance to the room where it is visible to all staff. This notifies staff that there are infection prevention precautions in place.</p> <p>Visitors and members of staff from other departments must report to the Nurse-in-Charge before entering the room.</p> <p>The door of the room must be kept closed at all times unless the clinical need of the patient dictates otherwise.</p> <p>Patients must not leave the room / ward area to attend other departments without prior arrangement / notification of the receiving department.</p>	<p>The door of the room must be kept closed at all times unless the clinical need of the patient dictates otherwise.</p> <p>Gloves must be worn for all direct contact with the patient and their immediate environment and if there is any risk from contamination with blood and body fluids.</p> <p>Plastic aprons must be worn for all direct contact with the patient and their immediate environment and when soiling of the uniform is likely.</p> <p>Full face protection e.g. visor or goggles should be worn if there is a risk of splashing from blood or body fluids and secretions.</p> <p>Hands must be washed with soap and water and then disinfected with hand</p>
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		<p>Ensure all staff are aware of the necessary precautions.</p> <p>All equipment must be cleaned before being taken into the isolation room and again after use.</p> <p>The vacated room must be cleaned thoroughly before it can be reoccupied.</p> <p>Visitors do not need to wear plastic aprons or gloves for routine social visiting but they must wash their hands before and after visiting.</p> <p>Most single rooms do not have specific ventilation in place. There are a small number of rooms on both sites that have either positive, negative or switchable ventilation. It is important for staff in those areas to be familiar with the</p>		<p>Gloves must be worn for all direct contact with the patient and their immediate environment and if there is any risk from contamination with blood and/or body fluids.</p> <p>Plastic disposable aprons must be worn for all direct contact with the patient and their immediate environment and when soiling of the uniform is likely.</p> <p>Hands must be washed with soap and water before entering the room, after patient contact, after contact with potentially infected materials, and after removal of disposable gloves. PPE must be disposed of through the orange waste stream.</p>	<p>rub before entering the room, after patient contact, after contact with potentially infected materials, and after removal and disposal of gloves.</p>
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		ventilation arrangements and the patients that it is safe to isolate in those rooms.			
STRICT ISOLATION	This method is used for the isolation of highly communicable diseases such as Viral Haemorrhagic Fever. Patients requiring this level of isolation must be transferred to an Infectious Diseases Unit as soon as possible.				

ADDITIONAL EQUIPMENT REQUIRED FOR ISOLATION					
All equipment must be cleaned and labelled as such before being taken into the isolation room and again after each use.					
Inside the patient's room/bay	Outside the patients room or entrance to isolation ward/area	Laundry	Waste	Patient charts/notes	Cutlery and Crockery
Stethoscope Disposable single patient use BP cuff Dynamap (blood pressure, pulse, O2 saturations) Thermometer Commode/own toilet facility Waste receptacles	Disposable gloves and aprons dispensers if available Hand rub (unless enteric precautions in place and hand washing with soap and water must be used) Masks (if required)	Linen must be disposed of at the point of use. Used, contaminated linen must be placed into a red alginate (water soluble) then a white plastic outer bag. Advice should be sought from the Laundry Policy if unsure re: type or colour of plastic bags to use	Clinical waste must be placed into an orange waste bag. A bin should be provided inside the room. The bag must be sealed and labelled in the room before removal to the pickup point	Patient's charts / notes must be kept outside of the isolation room / area	The use of disposable cutlery or crockery is not required. These items must be cleaned as normal

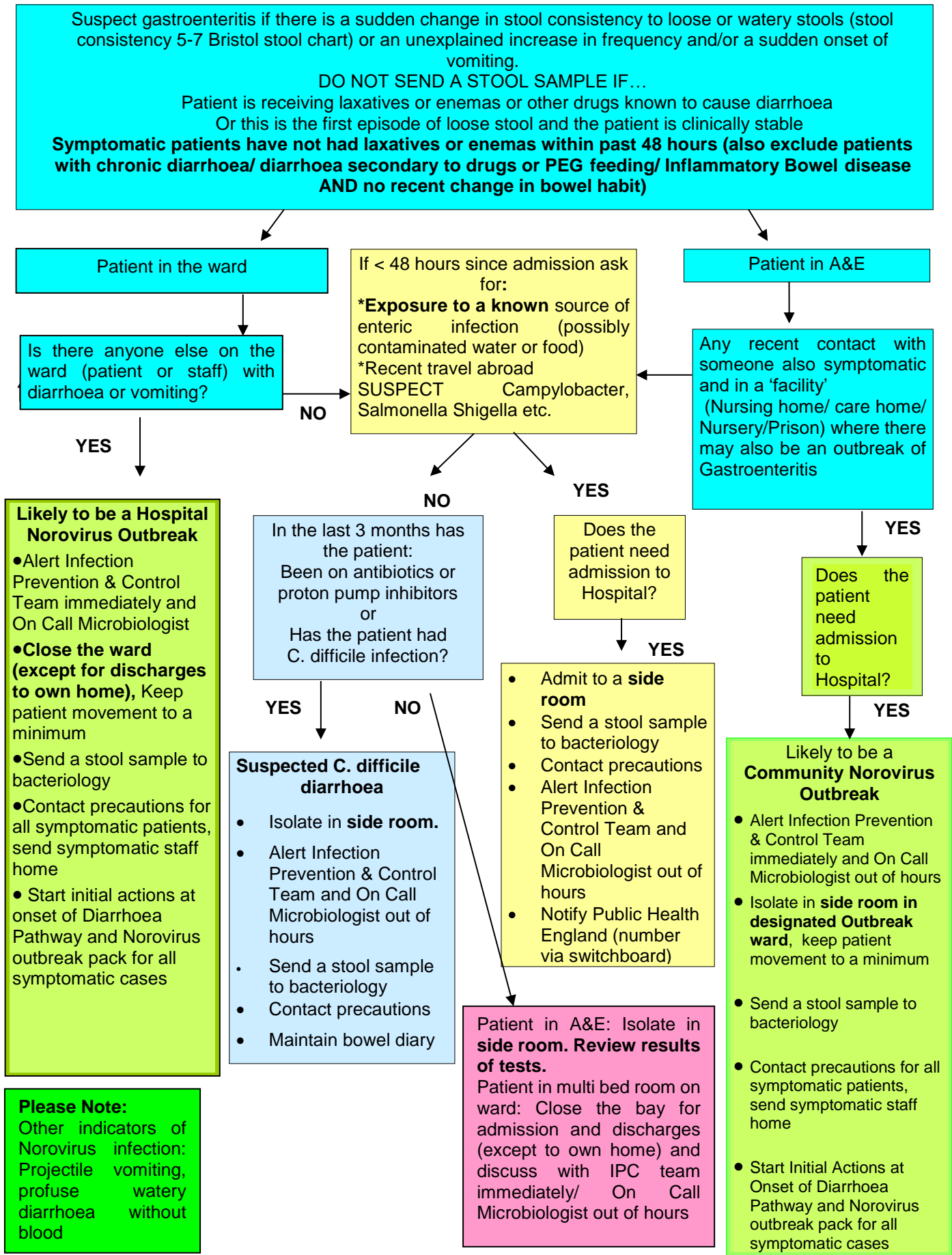
CLEANING OF ROOMS AND ENVIRONMENT
There is specific policies on the Intranet relating to cleaning and decontamination of patient equipment and environment, staff must refer to these to advise them of the necessary products to use, how and frequency.

TRANSFER OF INFECTED/COLONISED PATIENTS				
	Avoid If possible	Urgent	For patient management	Who needs informing of current status
Ward transfers	Yes	Yes	Yes	Receiving Ward Essential
Visits to Departments	Yes	Yes	Yes – patients must not be left in patient waiting areas	Receiving Department AND Portering
Ambulance	Yes	Yes	Yes	Ambulance Control at time of booking and Ambulance Crew
Other Care facilities	Yes	Yes	Kept to minimum	Transferring Ward MUST inform receiving facility of patient status (note in nursing notes who has been informed)

NB. Please refer to the Infection Prevention and Control Guidance for the Admission, Transfer and Discharge of Patients.

http://nww.staffweb.cumbria.nhs.uk/policies/categories/infection-prevention.aspx?InfectionPreventionGenericList_List_GoToPage=1

APPENDIX 6 - AID TO THE DIAGNOSIS OF INFECTIOUS GASTROENTERITIS



APPENDIX 7 - ISOLATION PRIORITISATION AT NCUH NHS TRUST

The use of side rooms must be reviewed daily by Ward Manager

The movement of patients requiring isolation between wards/ hospitals should be kept to a minimum.

If patient transfer is required, clear communication between wards is essential and clearly documented in patient records.

Action	Condition	Notes
1. Side Room MANDATORY	Possible Viral Haemorrhagic Fever (VHF)	Isolate until VHF is excluded.
	Pulmonary Tuberculosis	Confirmed or suspected open pulmonary TB - (negative pressure essential if MDR TB risk). Isolation to cease 2 weeks after start of chemotherapy and at discretion of chest physicians.
	Measles	Isolation until 4 days after the appearance of the rash.
	Chickenpox or Shingles	Isolate until lesions are dry/crusted. In the case of Shingles with lesions on a covered area of the body - risk assess.
	Prolonged neutropenia after bone marrow transplantation or intensive chemotherapy	To remain in side room until neutrophil count above 1.0. Neutropenia regarded as neutrophils <1.0 Severe neutropenia neutrophils <0.5
	Meningococcal Meningitis (and other unknown bacterial Meningitis until diagnosis)	Isolate until 48 hours after start of appropriate antibiotic treatment.
	Avian influenza/SARS (Severe Acute Respiratory Syndrome)	Negative pressure ventilation recommended.
2. Side Room ESSENTIAL	Fever & Rash ?Cause	Isolate until rash has been diagnosed as non-infectious.
	Diarrhoea due to suspected/ confirmed C. difficile	Patients must remain isolated until there has been no diarrhoea (types 5-7) for at least 48 hours and formed stools been achieved (type 1-4). Enteric precautions can end at this time.
	Diarrhoea due to suspected Norovirus	Isolate until free of symptoms for 48 hours. During outbreaks it may be necessary to cohort patients (see outbreak plan for "Aid to diagnosis of Infectious Gastroenteritis").
	Diarrhoeas (e.g. Salmonella, Campylobacter and other suspected infectious Gastroenteritis)	Isolate until free of symptoms for 48 hours. (see outbreak plan for "Aid to diagnosis of Infectious Gastroenteritis").
	Hepatitis A	Isolation not necessary 7 days after onset of Jaundice.
	Influenza	The duration of isolation precautions for hospitalised patients should be continued for 24 hours after the resolution of fever and respiratory symptoms. For prolonged illness with complications Immuno-suppressed patients may remain infectious for a longer time period. The decision to discontinue isolation should be based on assessment of the patient's clinical condition and agreement with the ICT. Wear surgical mask when nursing patients. May not be practicable to isolate in epidemics
	Parainfluenza	Isolation to cease 4 days after start of symptoms if immune-competent and no symptoms. Immuno-compromised patients x 3 negative specimens required.
	Group A Streptococcus	Isolation to cease once patient has had 24 hours of appropriate antibiotics. If extensive infection e.g. Necrotising fasciitis it is prudent to show microbiological clearance of infection.
3. Side Room STRONGLY ADVISED	MRSA †	Risk assess e.g. isolate if MRSA in sputum and very productive or has eczema or in high risk area (ITU, Orthopaedics, SCBU, Haemato-oncolgy). Nasal carriage only and commenced on decolonisation treatment = low risk.
	Palliative care patients	Palliative care patients with severe, uncontrolled pain or other symptoms. Patients that are imminently dying (approx 48 hrs).
	Penicillin resistant Pneumococcus	Isolate if patient is productive of sputum and until they have had 48 hours of appropriate antibiotics.

4. Side Room Recommended	Resistant Coliforms and Pseudomonas (including Acinetobacter, Klebsiella, E.Coli, Enterobacter, - resistant to one or more of: Gentamicin/ Meropenem/ Amikacin) †	Risk assess e.g. isolate if present in sputum and very productive. Use gloves and aprons.
	Febrile neutropenia - other causes	Risk assess the need for protective isolation - desirable if side rooms available.
	Palliative care patients	Palliative care patients with very distressed relatives/large family groups that may be disturbing to other patients on a ward.
	Disruptive patients	Patients who are disruptive may require a side room for the benefit of others.
	VRE	Risk assess e.g. isolate if VRE in sputum and very productive.
5. Side Room Unnecessary	Hepatitis B & C	Isolation only necessary if patient is bleeding profusely.
	Lice and scabies	Isolation not necessary unless patient has crusted scabies until treatment is completed.
	Legionnaire's Disease	Isolation unnecessary.

*This chart is for guidance and where the use of a side room is 'strongly advised or recommended' the final decision must be taken by the ward Sister/Charge Nurse, Infection Prevention and Control and the Site Bed Manager following a risk assessment.

*Out of hours the final decision on the use of a side room rests with the on call Bed/Site Manager who can contact the on call Microbiologist and/or the on call senior manager for advice if required.

*For some outbreaks of infection it will be necessary to cohort patients in bays or areas and again this is a decision that must be taken following a risk assessment and a discussion with the Ward Sister, Infection Prevention and Control and the Bed Management Bed/Site Manager.

DOCUMENT CONTROL

Equality Impact Assessment Date	As per previous policy
Sub-Committee & Approval Date	Trust Infection Prevention and Control Committee 23/7/19

History of previous published versions of this document:

Trust	Version	Ratified Date	Review Date	Date Published
NCUH Trust	6.0	20/9/17	30/09/2020	22/9/17
NCUH Trust	2.0	19/09/2014	31/10/17	8/10/14
CPFT		Aug 2017	31/08/2020	26/09/2017

Statement of changes made from previous version

Version	Date	Section & Description of change
0.1	24/6/19	<ul style="list-style-type: none"> Page 2 PPE abbreviated and used Page 3 duplication of 'Purpose' paragraph removed Page 6, 3.4, altered to reflect reviewing waste policy for disposal Page 7, 3.7, used PPE abbreviation rather than full txt
0.2	10/7/19	<ul style="list-style-type: none"> Sections 2.1, 3.1 included reference to community staff Section 3.3.1 theatre policy changed to reflect its now a SOP
0.3	17/7/19	<ul style="list-style-type: none"> Appendix 1 altered to reflect disposal situation when bed making Section * altered to refer to community waste disposal Appendix 5, product names removed and reference made to cleaning and decontamination policy
0.4	08/08/2019	<ul style="list-style-type: none"> Formatting and spelling amendments

List of Stakeholders who have reviewed the document

Name	Job Title	Date
Alyson Vannet	Infection Prevention and Control Support Nurse	24/6/19
Clare Williamson	Quality & Safety Manager Community Hospitals – North	8/7/19
Mike Judge	Environmental Services Office PCT	12/7/19
Christine Musgrave	Matron NCUH NHS Trust	15/7/19
Debbie McKenna	Health Protection Specialist Cumbria County Council	15/7/19