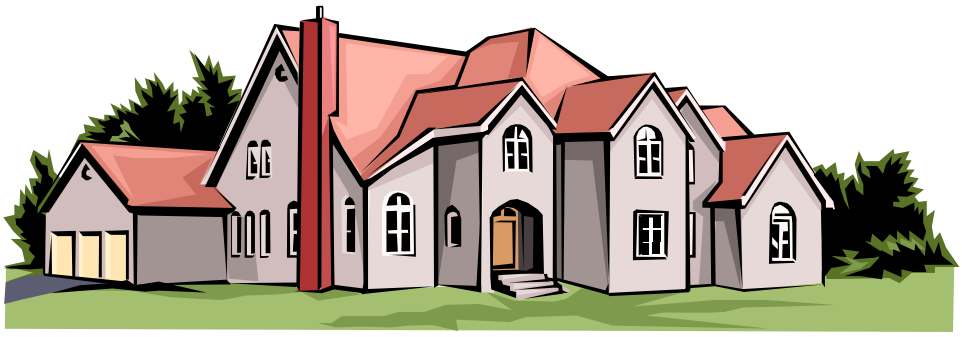
# ESSEX HEALTH PROTECTION UNIT

# INFECTION CONTROL GUIDELINES

# CARE HOMES



Issued January 2004
Revised April 2006

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION A – INTRODUCTION AND CONTACTS

### 1. Introduction

These guidelines have been written for proprietors, managers and carers working within the care home. They replace all previous infection control guidance from the Essex Health Protection Unit (EHPU).

Infection control is an important part of an effective risk management programme to improve the quality of residential care and the occupational health of staff.

### 2. Responsibility

The philosophy of this manual is to encourage individual responsibility by **every** member of staff.

The proprietors and registered manager are responsible for ensuring that there are effective arrangements in place for the control of infections.

### 3. Contacts

Infection Control advice can be obtained from the Essex Health Protection Unit,
8 Collingwood Road, Witham, Essex CM8 2TT.

**The main office telephone number is: 01376 302282**. The CCDCs and Communicable Disease Control Nurses are contactable via this number.

Advice is also available on the EHPU website www.Essexhpa.org.uk.

Users are encouraged to ensure they have access to this site as it has advice and information on a wide range of local communicable disease issues, and during incidents will be updated at least daily with the current state of affairs.

Out of working hours – for **URGENT** communicable disease enquiries:

Contact: 01245 444417, and ask them to page the on-call Public Health Person.
Any policies published prior to March 2005 will contain an old telephone number.

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## SECTION B – INFECTION, ITS CAUSES AND SPREAD

### 1. The Causes of Infection

Micro-organisms that cause infections are known as pathogens. They may be classified as follows:

**Bacteria** are minute organisms about one-thousandth to five-thousandth of a millimetre in diameter. They are susceptible to a greater or lesser extent to antibiotics.

**Viruses** are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

**Pathogenic Fungi** can be either moulds or yeasts. For example, a mould which causes infections in humans is *Trichophtyon rubrum* which is one cause of ringworm and it may also infect nails. A common yeast infection is thrush caused by *Candida albicans*.

**Protozoa** are microscopic organisms, but larger than bacteria. Free-living and non-pathogenic protozoa include amoebae and paramecium. Examples of medical importance include: *Giardia lamblia* which can cause an enteritis (symptoms of diarrhoea).

**Parasites**

Worms are not always microscopic in size but pathogenic worms do cause infection and some can spread from person to person. Examples include: threadworm and tapeworm.

Ectoparasites i.e. headlice and scabies.

**Prions** are infectious protein particles. Example: the prion causing (New) Variant Creutzfeldt-Jakob Disease (vCJD).

## 2. The Spread of Infection

One feature that distinguishes infection from all other disease is that it can be spread, i.e. one person can 'catch' it from another or via a vector (e.g. crawling or flying insects).

It is convenient to classify the modes of spread of infection as follows:

**Direct Contact**
Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. Chickenpox, Tuberculosis, sexually transmitted infections etc.).

**Indirect Contact**
Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens e.g. fomite or vector.

> A fomite is defined as an object, which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person. Examples of potential fomites are bedpans, urinals, thermometers, oxygen masks or practically any inanimate article.
>
> Crawling and flying insects are obvious examples of vectors and need to be controlled.

**Hands**
The hands of health and social care workers are probably the most important vehicles of cross-infection. The hands of residents can also carry microbes to other body sites, equipment and staff.

**Inhalation**
Inhalation spread occurs when pathogens exhaled or discharged into the atmosphere by an infected person are inhaled by and infect another person. The common cold and influenza are often cited as examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses.

**Ingestion**
Infection can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal/oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, Salmonella, Campylobacter.

**Inoculation**
Inoculation infection can occur following a "sharps" injury when blood contaminated with, for example, Hepatitis B virus, is directly inoculated into the blood stream of the victim, thereby causing an infection. Human and animal bites can also spread infection by the inoculation mode.

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## SECTION C - NOTIFICATION OF INFECTIOUS DISEASES

## 1. Introduction

This guideline sets out the procedures for staff to follow in respect of communicable disease control.

## 2. Responsibilities

**Managers**

To report relevant notifiable diseases and outbreaks by telephone, and then by utilising the documentation provided in this document.

**Clinical and healthcare staff**

(a) All staff have an important role in the prevention and control of infection which is an integral quality issue in the care and management of residents and the health and safety of staff.

(b) All staff need to follow all guidelines and participate in their audit.

(c) All staff need to bring infection control issues to the attention of Senior Managers.

All staff need to maintain a high standard of infection control as a matter of good practice.

## 3. Reporting & Documentation of Illness - Suspected/Confirmed Outbreak

Any **registered medical practitioner** (i.e. doctor) who becomes aware or suspects that a patient (s)he is attending is suffering from a notifiable disease is required by law (Public Health Control of Disease Act 1984) to send a notification form to the local authority Proper Officer forthwith.

Although the GP is legally responsible for the formal notification of a number of infectious diseases, any suspicion of an outbreak of communicable disease in the care

home or the community should be reported to the EHPU by the Home (Team) Manager immediately for further investigation, and management as appropriate.

The EHPU should be contacted if:

- There are two or more individuals with vomiting and/or diarrhoea (amongst residents or staff) or sudden onset of coughing with raised temperature

- There are two or more individuals suffering from the same infectious illness

- There is a high sickness rate amongst staff who appear to be suffering from the same infectious disease.

If a residential establishment is affected the following guidance should be followed:

- Care home managers should contact the EHPU without delay if they suspect there may be an outbreak of infection in a home

- The local Environmental Health Department and the CSCI must also be informed

- Senior management must be informed and requested to ensure adequate staffing to cope with the extra demands of managing an outbreak. Staff working in the home should not work in other care establishments until the outbreak is declared over by the EHPU

- List all residents and staff affected, including age, area/unit where resident/ working, onset of symptoms, symptoms suffered, duration of illness, GP and whether a sample has been taken. (Proforma attached for information).

In the event of an outbreak of diarrhoea (with or without vomiting), it is essential to obtain stool samples as soon as possible. The sooner the sample is obtained the higher the chance of identifying the organism causing the outbreak.

To speed the collection of stool samples we recommend that an ‘outbreak’ kit is kept and replenished after use. The kit should contain:

- Stool sample post x 6
- Plastic transport bags x 6
- Laboratory forms (to be completed once sample is obtained) x 6.

The above can be obtained from your GP, District Nurse or Environmental Health Officer.

All staff should be aware of the location of the kit.

Samples should be taken as soon as possible after diarrhoea has started, and kept safely at room temperature. Contact the Communicable Disease Control Nurse for further advice re the completion of the laboratory form etc.,

**Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting**

Isolate symptomatic residents in their own rooms with their own toilet facilities, or a designated commode if en-suite facilities are not available.

Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support handrails and unit kitchens. For the duration of the outbreak, environmental cleaning should be performed using detergent and hot water followed by a chlorine-releasing solution (1 part household bleach to 10 parts water).

Where chlorine-releasing tablets are used follow the manufacturer's dilution instructions, to give a solution of 1000ppm.

All staff handwashing areas and the rooms of symptomatic residents should have an antibacterial liquid dispensed soap (or an alcohol handrub following handwashing with a regular liquid soap) for the duration of the outbreak, then normal liquid dispensed soap should be used after the outbreak.

Residents should be encouraged to wash their hands after using the toilet or commode, and before eating.

Staff should pay attention to all infection control practices, particularly the washing of hands and wearing of protective clothing. A new pair of healthcare approved gloves and a plastic apron should be worn for each resident.

Faecal samples should be obtained from residents and staff if they have symptoms. The microbiology form accompanying the sample should clearly state it is part of an outbreak, as this will determine which specific tests are carried out in the laboratory. (Samples of vomit are not required.)

The home should be closed to admissions until 48 hours after the last symptomatic resident has recovered.

Symptomatic staff must go off duty, a faecal sample must be taken and they must remain off work until symptom free for 48 hours.

Visitors should be informed of the outbreak and unnecessary visits should be discouraged. Those who choose to visit should wash their hands as they enter and leave the home and comply with all other hygiene practices in place.

Residents should only be discharged 48 hours after their last symptom and with the full consent of anyone who may be required to care for them in the community.

If any resident requires admission to hospital the receiving unit must be informed of the outbreak so that they can institute appropriate measures.

The rooms of each resident that has been ill must be terminally cleaned **(refer Section H - 8 Decontamination)** before the home reopens to admissions.

## Specific Guidance for residents with *Clostridium difficile*

### What is *Clostridium difficile?*

*Clostridium difficile* is a bacterium of the intestine, which can be found in both healthy and ill people. There are millions of different types of bacteria in the body which are important for health. These protective bacteria help to break down and digest food and also help to ward off many harmful or foreign bacteria. In a healthy person all the bacteria live in a state of balance with one another.

### What is *Clostridium difficile* colitis?

When there is an imbalance of bacteria and *Clostridium difficile* takes over, it produces two toxins that affect the body and give the symptoms of the disease. The symptoms may include diarrhoea and cramping pain at first, and in the later stages, flu-like symptoms, nausea, vomiting and blood in the stool/faeces.

### How is *Clostridium difficile* colitis diagnosed?

The disease is suspected if a person has been taking, or is currently taking, antibiotics and is suffering with abdominal cramps and diarrhoea. A diagnosis is made by a laboratory test using a stool sample to confirm whether or not the toxin is present in the intestine. The results are usually available within 24 hours. Some patients may have *Clostridium difficile* in their stool but without the symptoms of diarrhoea. It is unlikely that they have *Clostridium difficile* colitis.

### Hospital Transfer

- Symptomatic patients (with diarrhoea) should not be accepted from Acute hospitals. Ideally they should be 48 hours free from symptoms. Seek advice from an EHPU nurse

- Patient should be isolated in their own room for a further 48 hours until bowel habit is established – if diarrhoea returns inform the doctors. The patient must remain in isolation until 48 hours free from symptoms, and normal bowel action has been established

- Faecal samples are not required for clearance

- If symptoms persist, seek advice from GP – further antibiotic treatment may be required.

### Newly diagnosed cases

- Isolate patient

- On lab confirmation of a case of *Clostridium difficile* inform the GP – if the patient is still symptomatic commence antibiotics

- Ensure completion of antibiotics

- If symptoms cease – no further treatment is required. Once diarrhoeal symptoms have ceased for 48 hours the room and toilet facilities should be thoroughly cleaned using the guidance in ' **Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting'**

- If symptoms persist, seek advice from GP.

## 4. Proforma Documents for reporting of Outbreaks of Diarrhoea & Vomiting

**RECORD OF OUTBREAK (Residents)**

**Type: Diarrhoea/Vomiting/Chest Infection/……..**

**Name of Home:** _____

**Record started by:** _____ **Date:**

**Address:** _____

**Reported to: EHPU/EHO/CSCI**

_____

**Total number of residents in home:** _____

**Tel:** _____

**Total number of residents affected:** _____

| Name of Resident | DOB | Area/Unit where Resident | Date Symptoms Started | Symptoms | Duration of Symptoms | GP | | Faecal Sample | |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | Name | Date Seen | Sent | Result |
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**RECORD OF OUTBREAK (Staff)** **Type: Diarrhoea/Vomiting/Chest Infection/……**

**Name of Home:** _____ **Record started by:** _____ **Date:**

**Address:** _____ **Reported to: EHPU/EHO/CSCI**

_____ **Total number of staff in home:** _____

**Tel:** _____ **Total number of staff affected:** _____

| Name of Staff | DOB | Area/Unit where Resident | Date Symptoms Started | Symptoms | Duration of Symptoms | GP Name | GP Date Seen | Faecal Sample Sent | Faecal Sample Result |
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**RECORD OF OUTBREAK OF SCABIES (Residents)**

**Name of Home:** _____ **Record started by:** _____ **Date:** _____

**Address:** _____ **Reported to: EHPU/EHO/CSCI**

_____ **Total number of residents in home:** _____

**Tel:** _____ **Total number of residents affected:** _____

| Name of Resident | DOB | Area/Unit where Resident | Date Symptoms Started | Diagnosed by | | Treatment Date | |
|---|---|---|---|---|---|---|---|
| | | | | GP | EHPU | 1st | 2nd |
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**RECORD OF OUTBREAK OF SCABIES (Staff)**

**Name of Home:** _____ **Record started by:** _____ **Date:**_____

**Address:** _____ **Reported to: EHPU/EHO/CSCI**

_____ **Total number of members of staff in home:** _____

**Tel:** _____ **Total number of members of staff affected:** _____

| Name of Staff Member | DOB | Area/Unit where Resident | Date Symptoms Started | Diagnosed by | | Treatment Date | |
|---|---|---|---|---|---|---|---|
| | | | | GP | EHPU | 1st | 2nd |
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## SECTION D – STANDARD PRINCIPLES OF INFECTION CONTROL

### 1. Standard Principles of Infection Control

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called **Standard Principles of Infection Control.**

Standard Principles of Infection Control include:

Hand decontamination and skin care
Protective clothing
Safe handling of sharps (including sharps injury management)
Spillage Management

All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them.

Everyone involved in providing care in the community should know and apply the standard principles. Each member of staff is accountable for his/her actions and must follow safe practices.

Facilities must be available to promote the compliance to Standard Principles of Infection Control e.g. Personnel protective clothing, and handwashing facilities.

### 2. Hand Decontamination and Skin Care

There are two methods of hand decontamination, which are handwashing, using soap and water, and handrubs, using alcohol or non-alcohol preparations.

Hand decontamination is recognised as the single most effective method of controlling infection.

Hands must be decontaminated:

- Before and after each work shift or work break. (Remove jewellery (rings) prior to handwashing)
- Before and after physical contact with each resident
- After handling contaminated items such as dressings, bedpans, urinals and urine drainage bags

- Before putting on, and after removing, protective clothing, including gloves
- After using the toilet, blowing your nose or covering a sneeze
- Whenever hands become visibly soiled
- Before preparing or serving food
- Before eating, drinking or handling food, and before and after smoking.

**How to Wash Your Hands**

Hands that are visibly soiled, or potentially grossly contaminated with dirt or organic material, must be washed with liquid soap and water. Bars of soap not recommended.

| | **Method** | **Solution** | **Task** |
|---|---|---|---|
| 1 | Social | Liquid soap | For all routine tasks |
| 2 | Hygienic hand disinfection (15-30 secs) | Antiseptics, e.g. Chlorhexidine, povidone-iodine or alcohol hand-rub after social clean | In high-risk areas and during outbreaks |
| **3** | Surgical scrub (2 mins) | Antiseptics, e.g. Chlorhexidine and povidone-iodine | Prior to surgical and other invasive procedures |

An effective handwashing technique involves three stages:

**(a) Preparation**

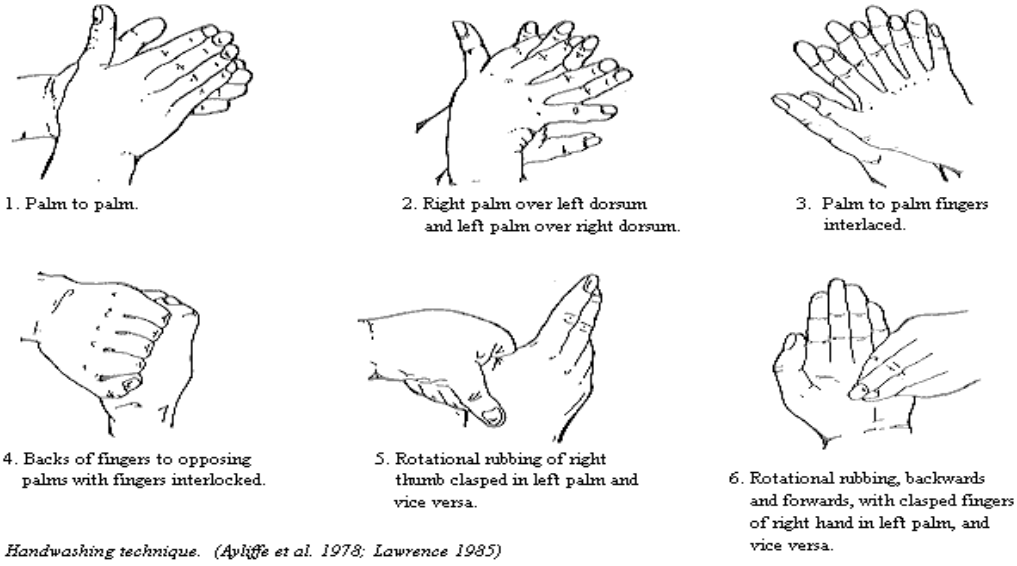
Before washing hands, all wrist, and ideally hand, jewellery should be removed. Cuts and abrasions must be covered with waterproof dressings. Fingernails should be kept short, clean and free from nail polish or nail extensions. Wet hands under warm running water before applying liquid soap or an antimicrobial preparation, ideally from a wall-mounted dispenser.

**(b) Washing and Rinsing**

The liquid soap solution must come into contact with all of the surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 10-15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly.

**Hygienic Hand Disinfection for Outbreak Control**

This can either be achieved by using antiseptic liquid soap, or by routine handwashing, followed by 5mls of an alcohol handrub.




*Handwashing technique. (Ayliffe et al. 1978; Lawrence 1985)*

**(c) Drying**

This is an essential part of hand hygiene. Dry hands thoroughly using good quality paper towels. In clinical settings, disposable paper towels are the method of choice because communal towels are a source of cross-contamination. Store paper towels in a wall-mounted dispenser next to the washbasin, and throw them away in a pedal-operated domestic waste bin. Do not use your hands to lift the lid or they will become re-contaminated.

Hot air dryers are not recommended in clinical settings. However if they are used in other areas, they must be regularly serviced and users must dry hands completely before moving away.

**(d) Handrubs/Alcohol Gels**

Hands should be free from dirt and organic material. The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

**Emollient Hand Creams**

An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination. If a particular soap, antimicrobial handwash or alcohol product causes skin irritation, an Occupational Health team or GP should be consulted.

**Handwashing Facilities**

Facilities should be adequate and conveniently located. Hand washbasins must be placed in areas where needed e.g. residents' bedrooms, bathrooms, toilets, sluice, laundry and kitchen areas within the home. They should have elbow or foot-operated mixer taps. In sluice, laundry and kitchen areas the handwashing sink must be designated for this purpose.

A separate sink should be available for other cleaning purposes:

- Use wall-mounted liquid soap dispensers with disposable soap cartridges - keep them clean and replenished
- Dispensers should be dismantled and washed regularly with particular attention to the nozzle
- Place disposable paper towels in wall-mounted dispensers next to the basins - soft towels will help to avoid skin abrasions
- Position foot-operated pedal bins near the hand washbasin - make sure they are the right size.

## 3. Protective Clothing

**Selection of protective equipment must be based on an assessment of the risk of transmission of infection between the resident and the risk of contamination of the healthcare workers' clothing and skin by resident blood and body fluids.**

**Assessment of Risk**

**WHAT TO WEAR WHEN**

| No exposure to blood/body fluids anticipated | Exposure to blood/body fluids anticipated, but low risk of splashing | Exposure to blood/body fluids anticipated - high risk of splashing to face |
|---|---|---|
| ↓ | ↓ | ↓ |
| No protective clothing | Wear gloves and a plastic apron | Wear gloves, plastic apron and eye/mouth/nose protection |

## Types of Protective Clothing

### Disposable Gloves

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and they should also be worn during all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments.

Gloves that are acceptable to healthcare personnel and that conform to European Community (CE) standards must be available.

**DO NOT USE** powdered gloves or polythene gloves in healthcare activities.

Gloves must be worn as single-use items. They must be put on immediately before an episode of resident contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different residents, and between different care or treatment activities for the same resident and do not substitute for handwashing.

Gloves must be disposed of as clinical waste and hands decontaminated after the gloves have been removed.

Sensitivity to natural rubber latex in residents, carers and healthcare personnel must be documented. Alternatives to natural rubber latex gloves must be available.

To prevent transmission of infection, gloves must be discarded after each procedure. Gloves should **not** be washed between residents as the gloves may be damaged by the soap solution and, if punctured unknowingly, may cause body fluid to remain in direct contact with skin for prolonged periods.

Hands **must** be washed on removal of gloves.

### Non-Sterile Gloves

Should be used when hands may come into contact with body fluids or equipment contaminated with body fluids. National evidence suggests that Nitrile gloves are better in stress conditions than latex and vinyl gloves.

### Sterile Gloves

Should be used when the hand is likely to come into contact with normally sterile areas or during any surgical procedure.

### General-purpose Utility Gloves

General-purpose utility gloves e.g. rubber household gloves, should be used for cleaning. Ideally, colour coding of such gloves should be used e.g. blue for the kitchen, yellow for general environmental cleaning and red for 'dirty' clinical duties. This will help prevent cross-infection from one area of work to another. The gloves should be washed with general-purpose detergent (GPD) and hot water and dried between use. They should be discarded weekly, or more frequently if the gloves become damaged.

### Polyurethane/Polythene Gloves (Non-Sterile and Sterile)

Polyurethane/polythene gloves do not act as a barrier to infection. They do not meet the Health and Safety Commission regulations and they do not have a place in clinical application. **DO NOT USE.**

### Disposable Plastic Aprons

Should be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.

Plastic aprons should be worn as single-use items for one procedure or episode of resident care and then discarded and disposed of as clinical waste.

Full-body fluid-repellent gowns must be worn where there is a risk of extensive splashing of blood or body fluids onto the skin or clothing of healthcare practitioners.

### Face Masks and Eye Protection

There are few occasions when facemasks are necessary in the care home environment. However when there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes e.g. cleaning of commode pots, full face protection should be worn. Face/eye protection e.g. full face visor, or face masks and goggles should be worn if manual decontamination of equipment is undertaken.

### Respiratory Protective Equipment

When clinically indicated, a particulate filter mask must be used i.e. Pulmonary Tuberculosis.

## 4. Safe Handling of Sharps

All staff should be fully immunised according to national policy. For staff who are at greater risk of contact with fresh blood, it is recommended that they have a course of Hepatitis B vaccine. A record of Hepatitis B antibody response should be kept, obtained after completion of the vaccination course.

Care should be taken to avoid accidental needlestick injury, as exposure to contaminated blood, and blood-stained body fluids may be associated with transmission of blood-borne viruses.

Sharps include needles, lancets, scalpels, stitch cutters, glass ampoules, sharp instruments and broken crockery and glass. Sharps must be handled and disposed of safely to reduce the risk of exposure to blood-borne viruses. Always take extreme care when using and disposing of sharps.

Avoid using sharps whenever possible:

- Clinical sharps should be single-use only
- Sharps must not be passed directly from hand-to-hand and handling should be kept to a minimum
- Needles must not be re-capped, bent, broken or disassembled before use of disposal
- Needle safety devices must be used where there are clear indications that they will provide safer systems of working for healthcare personnel
- Sharps containers must conform to UN3291 or BS7320 standards
- Assemble sharps containers by following the manufacturer's instructions
- Label sharps containers with the source details
- Used sharps must be discarded into a sharps container at the point of use by the user
- Sharps containers must not be filled above the mark indicated on the container
- Close the aperture to the sharps container when carrying or, if left unsupervised, to prevent spillage or tampering
- Carry sharps containers by the handle - do not hold them close to the body
- Never leave sharps lying around
- Do not try to retrieve items from a sharps container
- Do not try to press sharps down in the sharps box to make more room
- Lock the container when it is ¾ full using the closure mechanism
- Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place sharps inside a yellow clinical waste bag
- Containers in public areas must be located in a safe position, and must not be placed on the floor.

**Giving Injections**

Always wash hands thoroughly prior to giving an injection.

If visibly dirty, skin should be cleaned with an individually packed swab soaked in 70% isopropyl alcohol and left to dry. If skin is clean, this step is not necessary.

Venepuncture and injections should be carried out only by staff who are adequately trained and experienced.

**(For occupationally acquired sharps injuries refer to Section E – Management of Sharps Injuries).**

## 5. Spillage Management

Deal with blood and body fluid spills quickly and effectively.

Commercially available spillage kits are available. Ensure that kits remain in date, and that the contents of the kit are replenished immediately after use.

For spillage of high-risk body fluids such as blood, method 1 is recommended.
For low-risk body fluids such as non-blood containing excreta, use method 2.

### 1. Hypochlorite/Sodium Dichloroisocyanurates (NaDCC) Method

- Prevent access to the area containing the spillage until it has been safely dealt with
- Open the windows to ventilate the room if possible
- Wear protective clothing
- Soak up excess fluid using disposable paper towels and/or absorbent powder e.g. Vernagel
- Cover area with NaDCC granules (e.g. Presept, Sanichlor)

Or

- Cover area with paper towels soaked in 10,000 parts per million of available chlorine (1% hypochlorite solution = 1 part household bleach to 10 parts water) e.g. household bleach or Milton, and leave for at least two minutes or follow the instructions provided in the kit)
- Remove organic matter using the towels and discard as clinical waste
- Clean area with detergent and hot water and dry thoroughly
- Clean the bucket/bowl in fresh soapy water and dry
- Discard protective clothing as clinical waste

- Wash hands.

**2. Detergent and Water Method**

- Prevent access to the area until spillage has been safely dealt with
- Wear protective clothing
- Mop up organic matter with paper towels or disposable cloths and/or absorbent powder e.g. Vernagel
- Clean surface thoroughly using a solution of detergent and hot water and paper towels or disposable cloths
- Rinse the surface and dry thoroughly
- Dispose of materials as clinical waste
- Clean the bucket/bowl in fresh hot, soapy water and dry
- Discard protective clothing as clinical waste
- Wash hands
- Ideally, once dry, go over area with a mechanical cleaner.

**N.B. – For spills on carpets and upholstery with or without visible blood**

- Wear protective clothing
- Mop up organic matter with paper towels or disposable cloths and/or absorbent Powder e.g. vernagel
- Clean area with cold water
- Clean area thoroughly with detergent and hot water
- Allow to dry
- Discard protective clothing
- Wash hands
- Ideally, once dry, go over area with a mechanical cleaner.

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## SECTION E – MANAGEMENT OF SHARPS INJURIES

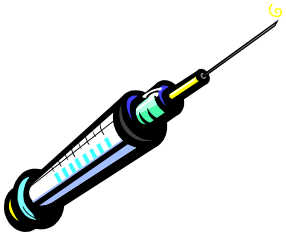
### 1. Occupational Injuries

In the event of a sharp injury/contamination incident these guidelines should be followed.

A sharp injury/contamination incident includes:

- Inoculation of blood by a needle or other 'sharp'
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes or mouth
- Swallowing a person's blood e.g. after mouth-to-mouth resuscitation
- Contamination where clothes have been soaked by blood
- Human bites.

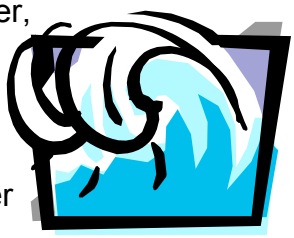
## What to do after a……



# SHARPS INJURY

**Directions for the management of needle-sticks,
and cuts and penetrating wounds**

Wash cuts thoroughly with soap and warm water,
then gently encourage to bleed.
Apply a dressing if necessary.



Splashes to the eyes or mouth
should be thoroughly rinsed with running water

Report incident to your manager immediately (if applicable)

Your medical advisor should: -

a) Take a history and make a risk assessment
b) Review your Hepatitis B vaccine status
c) Take 10ml clotted blood from you and,
if possible, the 'source' (with informed consent)
d) Send the samples to the microbiology department marked
'needle-stick Injury'

Complete an accident form

Insert your local arrangements

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Please Note

If the source is known to have, or at risk of having HIV, the injured person should contact either Accident & Emergency or the Genito Urinary Medicine Clinic, and attend if possible within the hour

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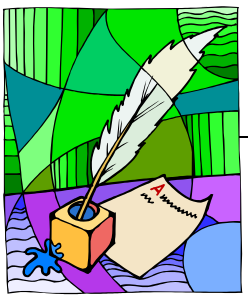

Remember
Be prepared – If you are at risk of exposure –
get immunised against Hepatitis B Virus

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Tel: In hours:- Your GP or Occupational Health Dept

Tel: Out of Hours:- Your local A&E Department

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION F – MANAGEMENT OF INFECTIOUS DISEASES

### 1. Introduction

This section includes a list of fact sheets produced by the EHPU.

The fact sheets include information on incubation periods, method of spread, period of infectivity, exclusion periods and where appropriate the management of contacts.

The fact sheets can be photocopied and passed to members of the public.

In addition, there is extended text on MRSA.

### 2. Fact Sheets

Fact sheets on the following are available on www.essexhpa.org.uk. and www.hpa.org.uk.

- Biting Bugs
- Blood-borne viruses
- Chlamydia
- Conjunctivitis
- Cytomegalovirus
- Chickenpox
- Cryptosporidium
- Diarrhoea and Vomiting
- ESBLs
- Farm & Zoo Visits
- Glandular Fever
- Group A Streptococci
- Hand, Foot and Mouth
- Headlice
- Hepatitis A
- Hepatitis B
- Hepatitis C
- Herpes
- Impetigo
- Influenza
- Legionnaire's Disease
- Leptospirosis

- Listeria
- Lyme Disease
- Measles
- Meningitis
- Molluscum Contagiosum
- MRSA
- Mumps
- Parvovirus
- Polio
- Rabies
- Rashes
- Ringworm
- Rubella
- Scabies
- Shingles
- Threadworms
- Toxoplasmosis
- Tuberculosis (TB)
- Verrucas

## 3. Guidelines for the Management of MRSA in the Community

**What is MRSA?**

MRSA stands for **Methicillin Resistant *Staphylococcus Aureus***

It occurs when the common bacterium of *Staphylococcus aureus* becomes resistant to treatment with the more common antibiotics such as penicillin.

Generally the worst scenario for an individual with MRSA in the community environment is that they have an infection in a wound, which is then slow to heal.

**Why is it known as a Hospital Acquired Disease?**

MRSA will spread more readily in the acute hospital setting, due to the increased vulnerability that patients with an acute illness will have to infection.

When an individual suffers an acute illness, their immunity will be vastly reduced (making them vulnerable to infection). As that individual recovers, so will their immunity.

If an individual makes a complete recovery, their immune system generally makes a full recovery.

If an individual goes on to develop a chronic illness, their immune system may not make a complete recovery. However this deficit in their immune system will be far less than if they were still suffering from an acute illness.

This is why patients who were hospitalised with an acute illness, and then acquire MRSA, are discharged as soon as they have recovered from their acute episode - meaning they do not stay in a high-risk environment for longer than necessary.

**What is the difference between Colonisation and Infection?**

**Colonisation -** means the MRSA is living on the skin (usually nose, throat, axilla or groin), causing no problem to the individual.

**Infection** - means that the MRSA is causing an active infection i.e. the wound is red, hot, inflamed and there may be a discharge and pain.

**Why is the Management of MRSA different in the Community?**

In the community, you will not find the acutely ill patients in the vast numbers that you would in the acute hospital. Therefore the increased vulnerability of patients does not exist to the same extent.

**What Precautions do you Need to Take?**

**No** special precautions are necessary.

Standard principles of infection control (especially handwashing) are all that are necessary.

However MRSA does act as an opportunity to remind us of the good practices that should **already** be in place.

Patients are **not** barrier nursed in the community setting. Ideally they are in a single room, or share a room with someone who does not have an open wound or invasive device e.g. urinary catheter, intravenous device.

**They can mix with other patients socially and at mealtimes**

Laundry or china and cutlery does **not** need to be handled separately. Again, as long as good practices are already in place, there is no need for additional precautions.

Waste should be handled as with any other patient - if the patient is known to have an infection, **and** that infection is producing a discharge, then the waste should be handled as clinical waste and arrangements should be made for a clinical waste collection **(Refer to Section H – 10 Waste Management**).

**Protocol for Treatment and Screening**

Do not screen unless there is clinical evidence to do so.

The state of the wound should be assessed and documented by a nurse trained in wound assessment:

- Size, depth
- Condition of wound
- Does it look infected (is it red, hot, inflamed or has a discharge?)

If the patient is colonised with MRSA of the nose, throat, axilla or groin, do not routinely swab. Should such a patient then develop any wounds:

- Observe for signs of infection
- Swab if there is any sign of infection in a new wound.

The screening of staff is **very** rarely required - and should only take place in consultation with the Communicable Disease Control Nurse.

**Suggested Treatment Protocol for Patients with MRSA Infected Wounds**

Consider systemic antibiotic therapy.

**Admission and Care to Residential/Nursing Home**

No home is allowed to refuse admission of a patient/resident/client because they happen to have MRSA. The resident identified with MRSA (either colonisation or infection) should receive the same care as the other residents.

All staff should adhere to the Standard Principles of Infection Control **(refer to Section – D)**. The residents should:

a) Be in a single room

If not,

b) Be in a shared room, but the other resident must not have an open wound or a urinary catheter, or any other invasive device.

In addition to the precautions on previous page:

i) Environmental cleaning should be re-enforced to help prevent further spread

ii) After patient is discharged the room should be thoroughly cleaned and curtains removed for laundering.

**Further Advice**

Please seek further advice from the Essex Health Protection Unit if required.

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION G – INFESTATIONS

### 1.1. Prevention and Control of Headlice in the Community

**Introduction**

These guidelines are written to enable healthcare staff and staff working in care homes to access information about headlice when required.

Headlice are transferred by direct person-to-person (head-to-head) contact lasting around one minute.

Half the people with headlice in the community are adults or pre-school children. Residents frequently have significant close contact with family members who may pass headlice to them. Many infected adults and some newly infected children do not itch and are unaware they have headlice.

In the care home it is the responsibility of the staff to check residents' heads regularly, and treat when headlice are found. With the correct treatment and proper contact tracing, lice can be controlled in the community. Where there are any concerns, the staff can contact the GP, Pharmacist, or Communicable Disease Control Nurse.

### 1.2. Some Facts about Headlice and Nits (Pediculus humanus capitis)

The headlouse is a small insect which feeds by sucking blood and likes to stay close to the scalp for warmth.

The head of a head louse bears two five-jointed antennae. At the top of each is a dish-shaped depression containing heat sensitive hairs, called papillae. If the tip of either antennae registers a temperature of less than 31$^{o}$C, then the insect turns toward the warmer side. This keeps the lice tight against the skin, near to their only food source - blood.

Headlice, therefore, have an invisible territorial boundary, the 31$^{o}$C contour, outside which they will not voluntarily go. All their eggs are glued onto hair close to the scalp within this warm zone, which means that nearly all are laid at the base of hair shafts. Within their warm zone, the insects spread out over the scalp quite evenly. They only seek each other in order to mate.

The human louse cannot live on any other animal. It moves by crawling on hair and can neither jump nor fly. It grows to full size (a little smaller than a match head) in about 10 days, with a life span of perhaps 2 weeks. Whilst growing it changes its skin three times. Cast

skins and louse faeces (which look like black dust) may be found on the pillows of infected people.

The female lays 5 to 8 flesh coloured eggs glued to the base of the hair each night. These take 5 to 7 days to hatch. The empty eggshells, called nits, grow out with the hair at about one centimetre per month.

Lice move fast and can easily be missed when a head is inspected. They have no particular preference for hair colour, length or state of cleanliness. Short hair allows easy transfer from one head to another.

Headlice are injured by vigorous combing. An injured louse cannot grip onto the hair and can easily be combed out.

Re-infection may occur rapidly between intimate contacts.

## 1.3. Prevention

All staff should observe the condition of residents' hair and scalp whilst undertaking personal care and grooming. Occasionally staff may notice a resident scratching their head persistently, or find a fine black dust on pillowcases. If these signs are noticed, a detector (fine-toothed) comb should be used to exclude the possibility of head louse infestation.

When one resident has been found to have headlice, all other residents must be carefully checked using the detection comb.

## 1.4. Treatment - for when Lice are Found

Only treat those with a proven headlice infection, that is the presence of live, crawling lice.

There are two options for the treatment of headlice:

### a) Wet Combing

This method requires perseverance, but may be preferable to using a chemical product on the resident's head. However if treatment continually fails then treatment with insecticides may still be required.

- Wash the hair in the normal way with an ordinary shampoo
- Make sure the teeth of the comb slot into the hair at the roots with every stroke. This should be done over a pale surface, such as a paper towel or the bath
- Clear the comb of lice between each stroke
- Wet lice find it difficult to escape, so removal with the comb is easier

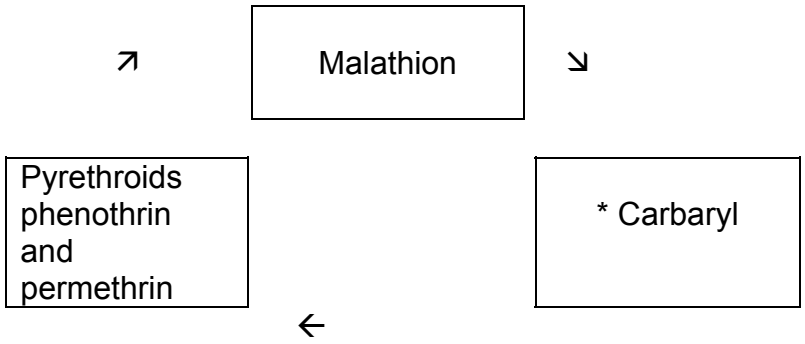
- This routine should be repeated every day for 2 weeks, so that any lice emerging from the eggs are removed before they can mature, mate and lay more eggs.

b) **Insecticides**

The EHPU supports a Mosaic policy for the use of insecticides. This means that no single insecticide is promoted at any given point in time.

There are three main chemicals used.

All must be used according to manufacturer's guidance.




* Carbaryl can only be prescribed by a healthcare professional (e.g. GP and some nurses), the other two chemicals can be bought over the counter.

For individuals that suffer from asthma, eczema, etc., alcohol-based products should be avoided. Aqueous (water) based products are safe to use.

The following table indicates which products are aqueous and alcohol based:

| | **PYRETHROIDS** | **MALATHION** | **CARBARYL** |
|---|---|---|---|
| Aqueous (water) based | Fullmarks liquid<br>Fullmarks mousse | Derbac M<br>Quellada M | Derbac C<br>Carylderm liquid |
| Alcohol based | Fullmarks | Prioderm<br>Suleo M | Suleo C<br>Carylderm lotion |

Insecticides should *ONLY* be used if live lice are found.

Insecticides must not be used more than once a week, and not for more than 3 consecutive weeks.

Headlice shampoos and cream rinses are not recommended as they are poor at killing headlice and do not kill eggs. They should not be used to get rid of lice, nor as a preventative measure.

After treatment, ensuring manufacturer's guidance has been followed and the lotion has been in contact with the hair for the recommended amount of time, shampoo and condition the hair. Whilst the conditioner is still on the hair, use a fine-toothed comb to remove dead lice and nits. It could take up to 24 hours for lice to die, so do not assume the treatment has not worked.

To ensure the treatment has been successful, detection combing on wet hair should be carried out on all treated persons 3 times during the next 7 days.

Re-treat on the 7$^{th}$ day whether or not live headlice are found. This is to ensure that lice hatching from any viable eggs are killed before reaching maturity.

If very small lice are found, this could be due to eggs having survived treatment and re-application with the recommended product should be carried out 7 days after the initial treatment.

If large lice are found, re-infection from an outside source is likely. A repeat treatment should take place and careful contact tracing is required to identify the source of re-infestation.

**Contact Tracing**

Contact tracing, screening and treating is a vital part of the control of headlice.

The person with lice will have caught them from another person who already had headlice and with whom they had head-to-head contact. That person will be someone who has close physical head-to-head contact with the resident, and may not themselves be aware they have lice.

A list should be formulated by each person with headlice of every person they have had head-to-head contact with lasting one minute or more in the past month. This list will be fairly short, but, if the list is complete, the original donor of the headlice can be identified.

Every person on the list should then be told that they have been in contact with a person who has had headlice and that they should have their own hair checked.

## Alternative Therapies

### Aromatherapy/Essential Oils

Many products are now available on the market. Advice from the Insect Research Centre is that these products should not be recommended as a method of treatment and/or prevention of headlice as:

- There is no scientific evidence to support their effectiveness against headlice
- Misuse in the application of such oils can easily occur and there have been reports of children acquiring superficial burns as a result of oils not being correctly diluted
- Some of the oils used in “headlice preparations” may aggravate medical conditions, for example eucalyptus oil should be avoided by people who suffer from epilepsy and asthma. To date no such warnings have appeared on these preparations
- It is the physical act of combing that actually removes lice from the hair.

# HEADLICE MANAGEMENT CHART

**Comb wet hair using a fine-toothed detector comb at least once a week**

**Check family and friends for headlice**

**If LIVE LICE are found**

**If NO live lice NO ACTION**

**Treatment Option One: WET COMBING**

- Wash the hair in the normal way with an ordinary shampoo
- While the hair is very wet, comb through the hair from the roots with a fine-toothed comb
- Make sure the teeth of the comb slot into the hair at the roots with every stroke.
- This should be done over a pale surface, such as a paper towel or the bath
- Repeat this routine every day for two weeks, so that any lice emerging from the eggs are removed they can be spread

**Treatment Option Two: INSECTICIDES**

- Check with your pharmacist, GP or School Nurse which preparations are recommended
- Follow the manufacturer's instructions carefully
- After treatment and whilst the hair is still wet, a fine-toothed comb may be used to remove dead lice
- It could take up to 24 hours for lice to die, so do not assume the treatment has not worked
- To ensure treatment has been successful, detection combing on wet hair should be carried out on all treated persons three times over the next seven days
- REPEAT treatment on the SEVENTH DAY whether or not lice are found
- Small lice means that the eggs were not affected by the first treatment. A repeat treatment will kill the baby lice before they can lay more eggs
- Large lice means that the head has been re-infested – so contact tracing and the treatment cycle will have to be restarted

**AFTER SUCCESSFUL TREATMENT:**

Comb wet hair using a fine-toothed comb at least Once a week

**IF TREATMENT NOT SUCCESSFULFUL**

IF LARGE LICE FOUND:
Check family and friends for Headlice

ACTION:
Repeat treatments

- If treatment Option One used previously use Treatment Option Two
- If treatment Option Two used previously use Treatment Option One

IF SMALL LICE FOUND:
Use Treatment One

## 2. Prevention and Control of Scabies in the Community

### Introduction

Scabies is an allergic response to an infestation of the skin by the mite ***Sarcoptes scabiei*.** The mites penetrate through the skin and excavate burrows at the epidermal/dermal junction. The female mite lays eggs which hatch after 3-4 days. Newly hatched larvae exit the burrows and appear on the surface of the skin before forming their own tunnels. The burden of mites can range from 10-20 to several thousand in people who are severely immuno-compromised. Scabies is distributed worldwide and is endemic in many developing countries.

### Recognition of Symptoms

The most frequent symptom is itching which may affect all parts of the body and is particularly severe at night. There may be no sign of infection for 2-6 weeks after exposure.

Occasionally small vesicles may be visible along the areas where the mites have burrowed. A papular rash may be visible in areas such as around the waist, inside the thighs, lower buttocks, lower legs, ankles and wrists. Firm nodules may develop on the front folds of the axillae and around the naval and in males around the groin. Pale burrows described as a "greyish line resembling a pencil mark" may be present in the skin between the fingers, but are less commonly seen than textbooks suggest.

Failure to find burrows does *not* exclude scabies as a diagnosis.

It should be emphasised that scabies may be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation. Also scabies can look atypical in anyone with immature or impaired immunity such as very young children, those with Down's Syndrome, alcoholics or the very elderly. In immunosuppressed people, such as those with AIDS or those on immunosuppressive therapy, a more severe hyperkeratotic form may develop (Norwegian Scabies).

### Mode of Transmission

Scabies mites are generally not capable of surviving off the host long enough to establish a new infection as they quickly become too dehydrated and weak.

Mites are passed directly from the skin of one person to another. The likelihood of transmission increases with the duration and frequency of skin-to-skin contact.

Fomites (inanimate objects) and animals are not implicated in transmission.

## Incubation

The incubation period is 2-6 weeks before onset of the symptoms in those affected for the first time. Symptoms may occur 1-4 days after the exposure if there is a history of previous infection.

## Outbreaks

Outbreaks occur particularly in care homes, mental health care establishments, long stay hospital wards and pre-school nurseries.

Advice will be given on the need to treat, and the treatment programme, by the EHPU.

## Treatment in a Residential Establishment (Care Home)

When a single suspected case of Scabies occurs in a residential establishment the EHPU should be alerted promptly to investigate. It may be necessary to treat all residents and anyone with whom they have had close contact.

If this action is required, it is important that all staff who have come into direct contact with residents also treat themselves because they may be incubating the disease without showing any symptoms. Family members of asymptomatic staff need not be treated routinely but asked to report any later symptoms.

As far as possible all staff members should receive the treatment on the same day that their unit is treated. Staff should not work in any other area until treatments have been completed throughout the home.

If Scabies is left untreated for a long period of time it can have an immunodepressive effect and cause a more severe form to develop.

Symptomatic people should be treated using 2 applications of insecticidal cream at 7-day intervals. The EHPU will make an individual assessment and advise.

## Following Treatment

It is not uncommon for a person to have itching for up to 4 weeks after successful treatment. Antihistamines may be helpful.

NB **Treatment of babies, young children under 2 years and pregnant women should be supervised by a GP. The recommended treatment is Lyclear dermal cream for which there are no contraindications in these groups.**

## LYCLEAR DERMAL CREAM IS THE TREATMENT OF CHOICE

Lyclear dermal cream is suitable for use by adults, including the elderly and children over 2 months old. Children between 2 months and 2 years should be treated under medical supervision. Pregnant women should seek medical advice.

Carefully follow the instructions enclosed with the cream:

- **Ensure that the entire surface of the body is covered from the hairline on the head to the soles of the feet.** This should include the area behind the ears and the face, avoiding the area around the eyes, otherwise the treatment may not be effective**. If the person to be treated has little or no hair the scalp should also be included**

- Areas of skin normally covered by extensive dressings should be exposed, and Lyclear cream applied onto the intact skin up to and around the wound. The dressing may then be replaced

- Apply the cream to clean, dry and cool skin. Do not apply following a bath or shower

- Pay particular attention to the areas behind the ears, between the fingers and toes, wrists, under the arms, external genitalia, buttocks and under finger and toenails

- The whole body should be washed thoroughly 8-12 hours after treatment

- Be sure to reapply any lotion washed off during the treatment period e.g. after handwashing, or cleaning of the skin

- Directly after treatment, change bed linen and wear freshly laundered clothes

- Lyclear Dermal Cream disappears when rubbed gently into the skin

- Where possible, the cream is best applied by someone other than the person receiving treatment. This makes it easier to get to difficult to reach parts of the body.

It may be necessary to prescribe two tubes of cream per application to ensure all areas of the body are covered thoroughly bearing in mind very dry areas of skin will absorb more of the cream.

The following table shows the approximate amount of cream to be used as a single application:

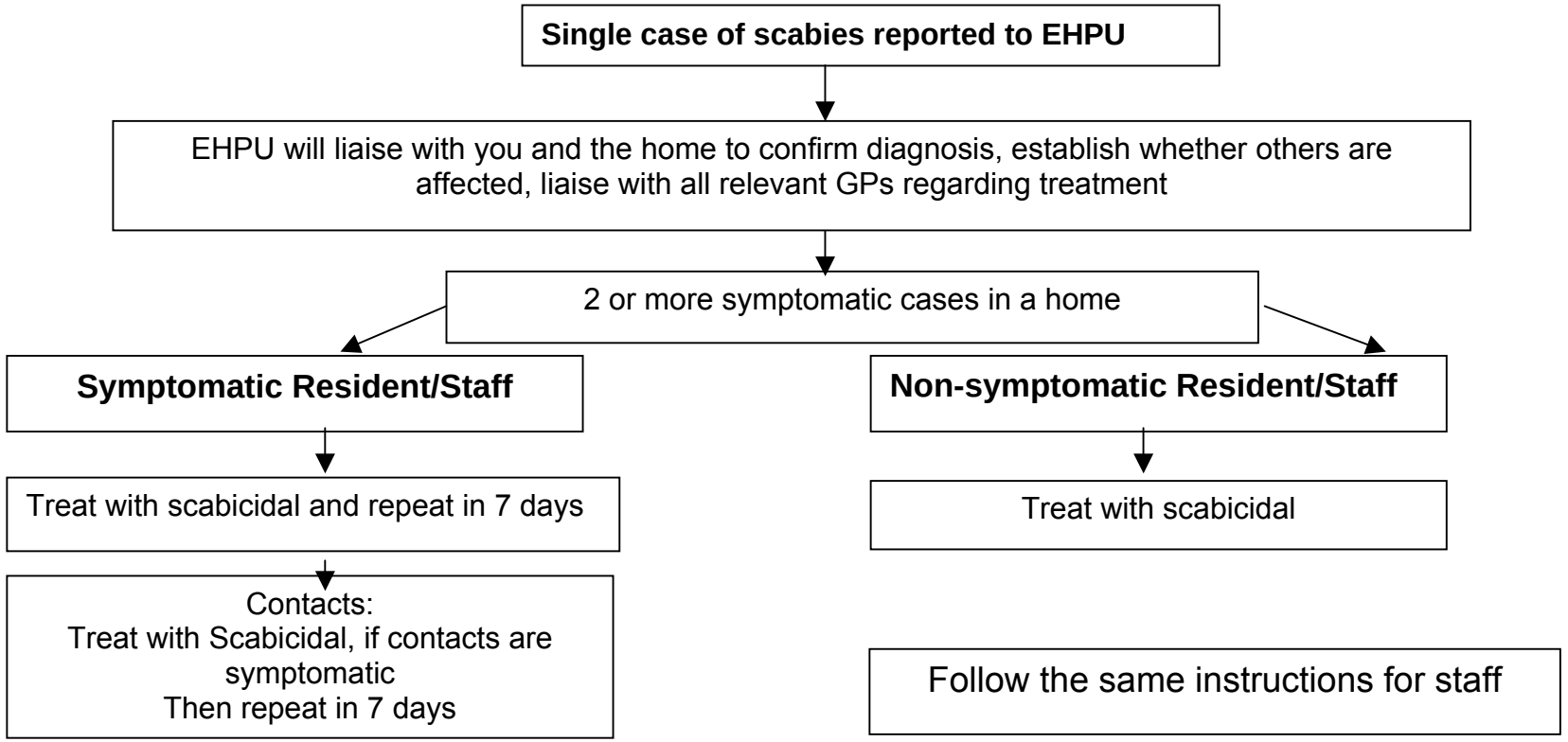
| | |
|---|---|
| Adults and children over 12 years | Up to 1 tube, may require up to 2 tubes but no more than 2 tubes |
| Children aged 5 to 12 years | Up to half a tube |
| Children aged 1 to 5 years | Up to one quarter of a tube |
| Children aged 2 months to 1 year | Up to one eighth of a tube |

Following discussions with the Insect Research Centre in Cambridge it is now recommended to apply scabicide lotions/creams to the face avoiding the area around the eyes.

This may conflict with some manufacturers' guidance. However, there is increasing evidence that scabies may also affect the face and failure to apply the cream to this area could make it an incomplete, and therefore unsuccessful treatment.

Benzyl Benzoate has been shown to be less effective compared to other scabicides. The British National Formulary (BNF) caution that it is an irritant to skin, and therefore not recommended for children, elderly and sensitive skins.

## ACTION TO TAKE WHEN A SINGLE CASE OF SCABIES OCCURS IN A RESIDENTIAL CARE SETTING




**Action for Essex Health Protection Unit**

- Plan treatment programme
- Inform residents' GPs and request treatments
- Inform staff members' GPs
- Arrange staff education sessions on treatment and management
- Provide printed information
- Establish surveillance procedure post mass treatment

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION H – CLINICAL PRACTICE

The Clinical Practices included in the section are**:**

1. Aseptic Technique
2. Enteral Feeding
3. Central Venous Catheters
4. Urinary Catheter Care
5. Isolation Precautions (Barrier Nursing)
6. Safe Handling of Specimens
7. Management of Infectious Deceased Residents
8. Decontamination of Equipment
9. Laundry Management
10. Waste Management

## 1. Aseptic Technique

Aseptic technique is the term used to describe the methods used to prevent contamination of wounds and other susceptible sites by organisms that could cause infection (Marsden Manual of Clinical Nursing Procedures).

The aims of aseptic technique are:

- To prevent the introduction of pathogens to the site
- To prevent the transfer of pathogens from one person to another.

**An aseptic technique should be implemented during any invasive procedure that bypasses the body's natural defences.**

An aseptic technique should also be adopted when undertaking the following procedures:

Dressing wounds
Removal of sutures or clips
Dressing peripheral or centrally sited intravenous lines
Removal of drains
Endotracheal suction
Dressing tracheostomy site.

Forceps have traditionally been used for the procedure. However, forceps are cumbersome to use and do not have additional advantages over using sterile-gloved hands.

The procedure can be performed more easily holding sterile swabs in the sterile-gloved hand. Hands should be washed before and after the technique.

Any items that have been in contact with the wound will be contaminated and should be disposed of safely, or decontaminated, if appropriate.

Many aseptic techniques include a ritualistic practice of cleaning trolleys with alcohol between residents. It is now felt that this serves no useful purpose, and that an area cleaned by detergent and hot water is sufficient, as the sterile field will be created by the sterile towel contained within the dressing pack.

Bacteria acquired on the healthcare workers' clothing during the procedure may be transferred into the wound of another resident, therefore a clean disposable apron should be used for each dressing procedure.

## Management of Chronic Wounds

If dressings are removed by soaking, a plastic impermeable liner/bag should be placed in the bucket/bowl before filling with water.

After the wound has been washed the water should be disposed of in a sluice or a sink which is separate from the handwash sink.

The plastic liner should be disposed of and the bath/bowl should be thoroughly cleaned with detergent solution and then dried to ensure that pathogens are removed.

This process should be undertaken after each separate resident episode.

## Wound Swabbing

Swabbing should only be undertaken if the wound/site of the invasive device exhibits signs of infection. Swabs should not be taken routinely, or if the wound/site is healing.

## 2. Enteral Feeding

### PREPARATION AND STORAGE OF FEEDS

Wherever possible pre-packed, ready-to-use feeds should be used in preference to feeds requiring decanting, reconstitution or dilution.

The system selected should require minimal handling to assemble and be compatible with the resident's enteral feeding tube.

Effective hand decontamination must be achieved prior to feed preparation.

When decanting, reconstituting or diluting feeds, a clean working area should be prepared and equipment dedicated for enteral feed use only should be used.

Feeds should be mixed using cooled boiled water or freshly opened sterile water and a no-touch technique.

Feeds should be stored according to the manufacturer's instructions and, where applicable, food hygiene legislation.

Where ready-to-use feeds are not available, feeds may be prepared in advance, stored in a refrigerator and used within 24 hours.

### ADMINISTRATION OF FEEDS

Minimal handling and an aseptic no-touch technique should be adopted to connect the administration system to the enteral feeding tube.

Ready-to-use feeds may be given for a whole administration session, up to a maximum of 24 hours.

Administration sets and feed containers are for single-use and must be discarded after each feeding session.

### CARE OF INSERTION SITE AND ENTERAL FEEDING TUBE

The stoma should be washed at least daily with water and dried thoroughly.

To prevent blockage, the enteral feeding tube should be flushed with fresh tap water before and after feeding or administering medications. Enteral feeding tubes for residents who are immunosuppressed should be flushed with either cooled freshly boiled water or sterile water from a freshly opened container.

## 3. Central Venous Catheters

The incidence of Central Venous Catheter (CVC) related infections is 4-20%. Staphylococci are implicated in 50% of episodes. Other pathogens include Candida, E. coli, Klebsiella and Pseudomonas.

Catheter-related sepsis causes significant morbidity and mortality.

These recommendations apply to the care in the community of all adults and children with CVCs that are being used for the administration of fluids, medications, blood components and/or total parenteral nutrition. They should be used in conjunction with the recommendations on **Standard Principles of Infection Control (refer to Section D).**

These recommendations do not specifically address the more technical aspects of the care of the patients receiving haemodialysis, who will generally have their CVCs managed in dialysis centres.

These recommendations are divided into four intervention categories:

- Education of patients, their carers, and healthcare personnel
- General asepsis
- Catheter site care
- Standard principles of catheter management.

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

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

Community healthcare personnel caring for a patient with a CVC should be trained, and assessed as competent, in using and consistently adhering to the infection prevention practices described in this guideline.

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

**General asepsis**

An aseptic technique must be used for catheter site care and for accessing the system.

Before accessing or dressing CVCs, hands must be decontaminated either by washing with an antimicrobial liquid soap and water or by using an alcohol handrub.

Hands that are visibly soiled or contaminated with dirt or organic material must be washed with soap and water before using an alcohol handrub. Following hand decontamination, clean gloves and a no-touch technique or sterile gloves should be used when changing the insertion site dressing.

## INTRAVENOUS CANULATION AND THERAPY

Factors influencing development of sepsis include:

- Immuno-compromised resident
- Initial skin preparation
- Care of the insertion site
- Type and number of connector
- Skin microflora and type of dressing
- Care and maintenance of line
- Contamination of fluids administered.

## RECOGNISING CATHETER ASSOCIATED INFECTIONS

**Localised** effects may occur at the insertion site or along the track of a tunnelled device. These include:

- Thrombophlebitis
- Exudate formation
- Heat at site
- Oedema
- Pain
- Irritation
- Erythema.

**Systemic** effects include:

- Pyrexia
- Elevated white cell count.

## ACTION TO TAKE IN THE EVENT OF AN INFECTION OCCURRING

As soon as the problem is identified contact the Doctor in charge of the resident's care.

The doctor may recommend a number of investigations to identify the cause and site of any infection.

## EXTRAVASATION

Occurs when a peripherally inserted intravenous cannula becomes dislodged from the vein and the fluid accumulates in the surrounding tissues. **As soon**

**as the problem is identified stop infusion and contact the Doctor in charge of the resident's care.**

Possible signs are:

- Swelling
- Discomfort
- Burning
- Pain.

Action:

- Ensure line is turned off
- Do not use intravenous line
- Inform Doctor in charge of the resident's care
- Elevate the limb to promote venous drainage
- Monitor vital signs if the cannula was being used to administer fluids to prevent dehydration or correct hypovolaemia.

**Catheter Site care**

Preferably, a sterile transparent, semi-permeable polyurethane dressing should be used to cover the catheter site.

If a patient has profuse perspiration, or if the insertion site is bleeding or oozing, a sterile gauze dressing is preferable to a transparent, semi-permeable dressing.

Gauze dressings should be changed when they become damp, loosened or soiled, and the need for a gauze dressing should be assessed daily. A gauze dressing should be replaced by a transparent dressing as soon as possible. Transparent dressings should be changed every 7 days, or sooner if they are no longer intact or moisture collects under the dressing.

Dressings used on tunnelled or implanted CVC sites should be replaced every 7 days until the insertion site has healed, unless there is an indication to change them sooner.

An alcoholic chlorhexidine gluconate solution should be used to clean the catheter site during dressing changes, and allowed to dry. An aqueous solution of chlorhexidine gluconate should be used if the manufacturer's recommendations prohibit the use of alcohol with the product.

Individual sachets of antiseptic solution or individual packages of antiseptic-impregnated swabs or wipes should be used to disinfect the dressing site.

Healthcare personnel should ensure that catheter-site care is compatible with catheter materials (tubing, hubs, injection ports, luer connectors and extensions) and carefully check compatibility with the manufacturer's recommendations.

**General principles for catheter management**

The injection port or catheter hub should be decontaminated using either alcohol or an alcoholic solution of chlorhexidine gluconate before and after it has been used to access the system.

In-line filters should not be used routinely for infection prevention.

Antibiotic lock solutions should not be used routinely to prevent catheter-related bloodstream infections (CRBSI).

Systemic antimicrobial prophylaxis should not be used routinely to prevent catheter colonisation or CRBSI either before insertion or during the use of a CVC.

Preferably, a single lumen catheter should be used to administer parenteral nutrition. If a multilumen catheter is used, one port must be used exclusively dedicated for total parental nutrition and all lumens must be handled with the same meticulous attention to aseptic technique.

Preferably, a sterile 0.9 percent sodium chloride injection should be used to flush and lock catheter lumens.

When recommended by the manufacturer, implanted ports or open-ended catheter lumens should be flushed and locked with heparin sodium flush solutions.

Systemic anticoagulants should not be used routinely to prevent CRBSI.

If needle-less devices are used, the manufacturer's recommendations for changing the needle-less components should be followed.

When needle-less devices are used, the risk of contamination should be minimised by decontaminating the access port with either alcohol or an alcoholic solution of chlorhexidine gluconate before and after using it to access the system.

When needle-less devices are used, healthcare personnel should ensure that all components of the system are compatible and secured, to minimise leaks and breaks in the system.

In general, administration sets in continuous use need not be replaced more frequently than at 72 hour intervals unless they become disconnected or a catheter-related infection is suspected or documented.

Administration sets for blood and blood components should be changed every 12 hours, or according to the manufacturer's recommendations.

Administration sets used for total parenteral nutrition infusions should generally be changed every 24 hours. If the solution contains only glucose and amino acids, administration sets in continuous use do not need to be replaced more frequently than every 72 hours.

## TOTAL PARENTERAL NUTRITION

- Total Parenteral Nutrition (TPN) is the administration of nutrient solutions via a central or peripheral vein. It is most commonly administered through a peripherally inserted CVC into the superior vena cava and it is used when the resident's gastro-intestinal tract is non-functional.

- Preferably a single lumen catheter should be used to administer TPN.

- Strict asepsis is required when dealing with parenteral nutrition procedures.

- Administration sets should be changed every 24 hours.

- Residents are generally self-caring with advice and support from the Nutrition Support Team.

- The Nutrition Nurse Specialist team is available 24 hours a day via your local hospital.

# 4. Urinary Catheter Care

## ROUTES OF ENTRY FOR INFECTION

Urinary catheters are inserted to provide urinary drainage. They may be introduced into the bladder or via the urethra through the abdominal wall – supra-pubic.

Comprehensive information, advice and support is available from the continence advisors. They can be contacted on:

| | |
|---|---|
| **Mid Essex** | **01245 318518** |
| **South** | **01268 448505 or 01375 394968** |
| **West** | **01279 698901** |
| **East (Colchester)** | **01206 747723** |

**or from the District Nursing Service**

Bacteria may enter the bladder of the catheterised resident in one of four ways:

- Introduced with the catheter at the time of insertion
- Travel along the outside of the catheter
- Travel along the inside lumen of the catheter
- Through a break in the closed system.

## ASSESSMENT FOR CATHETER EQUIPMENT

Once the decision to insert a urinary catheter has been made an individual assessment needs to be completed by the nurse or continence advisor for:

- Size, length and type of catheter
- Appropriate drainage and securing system.

The catheter size should be the smallest that is capable of providing adequate drainage. Catheters are available in paediatric, female and male (standard) lengths. In some instances it may be more appropriate to use a male length for a female resident.

### Assessing the need for catheterisation

Indwelling urinary catheters should be used only after alternative methods of management have been considered.

The patient's clinical need for catheterisation should be reviewed regularly and the urinary catheter removed as soon as possible.

Catheter insertion, changes and care should be documented.

**Catheter Drainage Options**

Following assessment, the best approach to catheterisation that takes account of the clinical need, anticipated duration of the catheterisation, patient preference and risk of infection should be selected.

Intermittent catheterisation should be used in preference to an indwelling catheter if it is clinically appropriate and a practical option for the patient.

For urethral and supra-pubic catheters, the choice of catheter material and gauge will depend on an assessment of the patient's individual characteristics and predisposition to blockage.

In general, the catheter balloon should be inflated with 10ml of sterile water in adults and 3-5ml in children.

In patients for whom it is appropriate, a catheter valve may be used as an alternative to a drainage bag.

**Catheter Insertion**

All catheterisations carried out by healthcare personnel should be aseptic procedures. After training, healthcare personnel should be assessed for their competence to carry out these types of procedures.

Intermittent self-catheterisation is a clean procedure. A lubricant for single patient use is required for non-lubricated catheters.

For urethral catheterisation, the meatus should be cleaned before insertion of the catheter, in accordance with local guidelines/policy.

An appropriate lubricant from a single use container should be used during catheter insertion to minimise urethral trauma and infection.

**Catheter Maintenance**

Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve.

Healthcare personnel should ensure that the connection between the catheter and the urinary system is not broken except for good clinical reasons (for example changing the bag in line with the manufacturer's recommendations).

Healthcare personnel must decontaminate their hands and wear a new pair of clean, non-sterile gloves before manipulating a patient's catheter and must decontaminate their hands after removing their gloves.

Carers and patients managing their own catheters must wash their hands before and after manipulation of the catheter, in accordance with the recommendations in the standard principles of infection control.
Urine samples must be obtained from a sampling port using aseptic technique.

Urinary drainage bags should be positioned below the level of the bladder and should not be in contact with the floor.

A link system should be used to facilitate overnight drainage to keep the original system intact. Drainage bag should be single use.

However if non-drainable bags are used, they should be emptied by snipping the bottom corner of the bag and emptying the contents down the toilet or sluice.

The urinary drainage bag should be emptied frequently enough to maintain urine flow and prevent reflux and should be changed when clinically indicated.

The meatus should be washed daily with soap and water.

Each patient should have an individual care regimen designed to minimise the problems of blockage and encrustation. The tendency for catheter blockage should be documented in each newly catheterised patient.

Bladder instillations or washouts must not be used to prevent catheter-associated infections.

Catheters should be changed only when clinically necessary, or according to the manufacturer's current instructions.

Antibiotic prophylaxis when changing catheters should only be used for patients with a history of catheter-associated urinary tract infection following catheter change, or for patients who have a heart valve lesion, septal defect, patent ductus or prosthetic valve.

Reusable intermittent catheters should be cleaned with water and stored dry in accordance with the manufacturer's instructions.

**Straps for day bags**

A catheter should always be securely positioned, usually to the resident's leg to prevent trauma and potential infection. Velcro (MG) straps ***ONLY*** are suitable for this purpose. They are available on GP prescription.

**Documentation**

The following details must be documented in the patient records e.g. amount of urine drained, problems encountered, patient discomfort, reason for catheterisation, date of insertion, catheter size, type, length, balloon size, batch number, expiry date.

## 5. Care of Residents with known Infectious Diseases Isolation Precautions (Barrier Nursing)

Within the care home setting, traditional strict barrier nursing is not often recommended. The GP or EHPU may recommend a modified version for residents who develop acute symptoms of possible infectious disease. It is important for staff to appreciate that when they are caring for someone with a known, or suspected, infectious disease, there is the potential for cross-infection if basic infection control principles are not followed.

**Diseases**

More detailed information about diseases can be found in the relevant Section of these guidelines, and on the EHPU website www.essexhpa.org.uk, or on the HPA website www.hpa.org.uk.

The following communicable diseases may require isolation nursing precautions to be initiated.

| DISEASE | HOW LONG THE DISEASE REMAINS INFECTIOUS |
|---|---|
| Beta-haemolytic streptococci Group A | Infectious until:<br><br>(a) Clearance of organism is demonstrated<br>or<br>(b) 24 hours after the start of appropriate antibiotic therapy |
| Chickenpox | Infectious until vesicles are dry |
| *Clostridium difficile* (Pseudomembranous colitis) | Infectious until diarrhoea has ceased for 48 hours |
| Gastro-enteritis | Infectious until symptom free for 48 hours |
| Hepatitis A | Infectious until 7 days after the onset of jaundice |
| Hepatitis B + C | Blood and body fluids should be assumed to be infectious |

| | |
|---|---|
| HIV | As above |
| Impetigo | Infectious until:<br>a) culture negative, or<br>b) have received at least 24 hours of appropriate antibiotics, or<br>c) clinical improvement |
| Meningococcal Meningitis | Infectious for 24 hours after start of appropriate antibiotic therapy |
| Mumps | Infectious for 9 days after onset of swelling in salivary glands |
| Rubella | Infectious for 4 days from onset of rash. Non-immune pregnant staff should not nurse these patients |
| Scabies | Infectious until one application of a scabicidal treatment has been completed |
| Shigella | Infectious until diarrhoea has ceased for 48 hours |
| Shingles | Infectious to a person who has not had chickenpox by direct contact with vesicles. The contact will develop chickenpox |
| Pulmonary Tuberculosis (Open) | Infectious until the first two weeks of appropriate antibiotic therapy have been given. The infectious period may be prolonged for Multi-Drug Resistant TB (MDRTB) |

Precautions should also be taken with residents suffering from the following symptoms until a diagnosis is confirmed:

(a) Diarrhoea of unexplained origin
(b) Temperature of unknown origin
(c) Excessive bleeding
(d) Rashes of unknown aetiology
(e) Excessive vomiting.

## PROCEDURES

**Standard principles of infection control should be strictly adhered to at all times (refer to Section D – Standard Principles of Infection Control).**

Once a diagnosis has been made, the resident (and family) must have the condition explained to them including the mode of spread and its significance.

### Hand Hygiene

Alcohol handrub should be used after normal handwashing. In some instances i.e. outbreak of Diarrhoea and Vomiting the use of antibacterial soap will be requested by the CDCN.

### Disposal of Potentially Infected Items

Contaminated dressings and all disposable items should be disposed of as clinical waste **(refer to Section H – 10 Waste Management**).

### Urinals and Bedpans

Automated washer/disinfectors are recommended.

If not available, the contents should be emptied down the toilet or sluice and flushed away. Care should be taken when cleaning the urinal or bedpan to avoid splashing. A plastic apron and non-sterile latex or vinyl gloves should be worn. The item should be cleaned with GPD and hot water prior to disinfection with a sodium hypochlorite solution strength 10,000 p.p.m. (1 part household bleach to 10 parts water) and left for 10 minutes. The bedpan/urinal should be dried and stored inverted.

### Linen

Should be washed on as hot a wash as the fabric will tolerate as promptly as possible. Soiled linen should be contained within a soluble alginate bag to minimise the risk of contamination to the environment or to personnel **(refer to Section H - 9 Laundry Management).**

### Crockery and Cutlery

Disposable items are not required. GPD and water as hot as can be tolerated is sufficient, to be washed in the usual kitchen sink or dishwasher.

## Transporting Residents

Residents should only be sent to other department/premises (i.e. care homes, hospital Out-patient or In-patient departments) when it is essential. Staff involved in the direct care of the resident should be informed of risk factors, so that relevant control measures can be implemented.

## Deceased Residents

Standard principles of infection control should be maintained when a patient dies. If the resident had, or was suspected of having, an infectious disease when they died the mortuary/funeral director staff should be informed of the potential infectious risk, but not the exact condition – patient confidentiality continues after death.

## 6. Safe Handling of Specimens

Clinical specimens include any substance, solid or liquid, taken from the resident for the purpose of analysis.

Staff should be trained to handle specimens safely.

**General Principles:**

- All specimens should be collected using **Standard principles of infection control** (i.e. wearing of appropriate gloves, disposable plastic apron and washing and drying of hands before and after the procedure)

- When a resident is asked to provide a specimen, they should be provided with the appropriate container and given instructions as to how to collect the specimen

- Laboratory approved containers must be used labelled with resident identification details, date of specimen and specimen details. The lids should be screwed on tightly. The container with the specimen must be placed in an individual transparent plastic transport bag as soon as it has been labelled

- The transport bag must be sealed. The request form must always accompany the specimen but should not be put inside the bag with the specimen. If a wound swab, state type of wound, where on the body, whether deep or superficial and if antibiotics have been used either topical or systemic

- Specimens must be sent to the laboratory as soon as possible after collection. This will mean planning workload carefully. Whilst awaiting transport, specimens should be stored securely, for as short a time as possible i.e. not overnight and away from food and medicines

- If specimens have to be stored awaiting transport for more than 4 hours, specimens should be stored in an airtight container in a designated fridge - **not a food fridge**

- The laboratory must receive sputum specimens within 24 hours of it being obtained.

**NB. In the event of a suspected outbreak of infection it is important for specimens to be collected promptly and for the request form to be marked as 'Possible Outbreak'. Stool specimens should be sent as soon as an outbreak is suspected e.g. the second loose stool.**

# 7. Management of Non-Infectious and Infectious Deceased Residents

This guideline sets out the procedures for staff to follow for the management of non-infectious and infectious deceased residents.

## MANAGEMENT OF DECEASED RESIDENTS

The deceased should be treated with the due respect and dignity appropriate to their religious and cultural background. Last Offices, which vary according to religious and cultural practices, may be compromised by the need for specific measures if an infectious disease was associated with the death, or co-existed at the time of death. Any problems should be discussed with a member of the EHPU who may wish to consult the appropriate religious authority.

Most bodies are not infectious, however through the natural process of decomposition the body may become a source of potential infection, whether previously infected or not, therefore sensible precautions should be taken routinely:

(a) Disposable gloves and apron should be worn by the person preparing the body

(b) Washing the body with soap and water is adequate

(c) Dressings, drainage tubes, etc. should be removed unless the death occurred within 24 hours of an operation or was unexpected, in which case the advice of the coroner's office should be sought

(d) Clean dressings should be applied to any wounds

(e) Profusely leaking orifices may be packed with gauze or cotton wool.

## ADDITIONAL LAST OFFICES FOR A KNOWN INFECTED BODY

The body of a person who has been suffering from an infectious disease may remain infectious to those who handle it.

If the deceased has died from one of the following infectious diseases listed below, the body will need to be placed in a cadaver bag.

The risk of infection from the deceased and the precautions necessary varies with the disease. See table below.

| Disease / Organism | Cadaver bag | Body Viewing |
|---|---|---|
| Chicken Pox | No | Yes |
| Shingles | No | Yes |
| Food poisoning | No * | Yes |
| Diphtheria | Yes | Yes |
| Hepatitis A | No | Yes |
| Hepatitis B | Yes | Yes |
| Hepatitis C | Yes | Yes |
| HIV | Yes | Yes |
| Meningococcal Disease | No | Yes |
| Tuberculosis (open) | Yes | Yes |
| Influenza (pandemic) | No | Yes |
| MRSA | No | Yes |
| Measles | No | Yes |
| Mumps | No | Yes |
| Rubella | No | Yes |
| Invasive Group A Streptococcus | No | Yes |
| CJD / vCJD | No | Yes |
| Crusting Scabies | Yes | Yes |

**A cadaver bag should be used if large quantities of body leakage present.**

- * unless body fluid leakage
- For a more extensive list refer to EHPU's Infection Control Guidelines for Funeral Directors on www.essexhpa.org.uk

Once the body is sealed in the bag, protective clothing is no longer necessary.

Relatives and friends who wish to view the body should do so as soon after death as possible. The cadaver bag can be opened by a member of staff wearing gloves and apron, but relatives should be told that there is a risk of infection and should be advised to refrain from kissing or hugging the body.

Care home manager should discuss with the GP the risk of infection posed to the funeral director. The funeral directors do not need to be informed of the exact condition of the deceased, only that they pose a risk.

Proforma letter from Care Home to Funeral Director:

> As a precaution against the risk of infection we have placed that body into a cadaver bag.

**Proforma Letter**

To the Funeral Director

**Re:**

Name of deceased:-

Date of Birth of deceased:-

Date and time of death of deceased:-

I wish to inform you that the deceased named above may pose a risk of infection and for this reason they have been placed in a cadaver bag.

Embalming **may**/**may not** be undertaken.

Signed:-

Name in block capitals:-

Contact Address e.g. surgery:-

Date:-

## 8. Decontamination of Equipment

The aim of decontaminating equipment is to prevent potentially pathogenic organisms reaching a susceptible host in sufficient numbers to cause infection.

Certain items are classified as single-use only. These items must never be re-used. If in doubt, refer to the manufacturer's recommendations or contact the EHPU. The symbol below indicates single-use, and will be displayed on the package.


After use these items should be disposed of as clinical waste. Where there is a choice of single-use or re-usable items, the single-use item is recommended.

Re-usable equipment must be appropriately decontaminated between each resident. Use only the method advised by the manufacturer - using any other process might invalidate warranties and transfer liability from the manufacturer to the person using or authorising the process. If you have any doubts about the manufacturer's recommendations, seek further advice.

The Medical and Healthcare products Regulations Agency (MHRA) defines the following terms:

- **Cleaning** 'is a process which physically removes contamination but does not necessarily destroy micro-organisms'. The reduction of microbial contamination cannot be defined and will depend upon many factors including the efficiency of the cleaning process and the initial bio-burden (potential amount of organisms on the item)

  Cleaning is an essential prerequisite of equipment decontamination to ensure effective disinfection or sterilisation can subsequently be carried out

- **Disinfection** 'is a process used to reduce the number of viable micro-organisms, which may not necessarily inactivate some viruses and bacterial spores'. Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation

- **Sterilisation** 'is a process used to render the object free from viable micro-organisms, including spores and viruses'.

## RISK ASSESSMENT

The decision to clean, disinfect or sterilise depends on the risk of the equipment transmitting infection, or acting as a source of infection.

### Risk Assessment for Decontamination of Equipment

| Risk | Application of Item | Minimum Standard |
|---|---|---|
| Low | In contact with healthy skin or<br>Not in contact with resident<br>e.g. furniture, mattresses, surfaces, commodes | Clean |
| Intermediate | In contact with intact mucous membranes or contaminated with virulent or readily transmissible organisms (body fluids) or prior to use on immuno-compromised residents<br>**e.g. thermometers, auroscope earpieces** | Disinfect, or single-use |
| High | In contact with a break in the skin or mucous membrane or<br>For introduction into sterile body areas for example instruments used for surgical/ operative procedures | Sterilise, or single-use |

Adapted from Medical Devices Agency, Part 2 (1996) now MHRA

## CLEANING METHODS

Cleaning is the first step in the decontamination process. It must be carried out before disinfection and sterilisation to make these processes effective. Thorough cleaning is extremely important in reducing the possible transmission of all micro-organisms.

Thorough cleaning with detergent and warm water - maximum temperature $35^0$C - will remove many micro-organisms. Hot water should not be used, as it will coagulate protein making it more difficult to remove from the equipment.

### Commode pots/Bedpans/Urinals

Mechanical cleaning using a washer/disinfector is recommended as these can be validated.

Manual cleaning is not recommended. However if manual cleaning must be undertaken it must be undertaken in a designated sink, which is deep enough

to completely immerse the items to be cleaned. Scrubbing can generate aerosols, which may convey infective agents. Therefore if scrubbing is necessary it must be carried out with the brush and item beneath the surface of the water.

Personal protective equipment, including aprons, gloves and goggles or visors, must be readily available for staff and used as appropriate.

Cleaning equipment, such as mops, brushes, and cloths must be stored clean and dry between uses. Use single-use, non-shedding cloths rather than re-usable cloths. Do not store brushes and mops in disinfectant solutions.

After cleaning and thorough rinsing, the items should be dried using a disposable non-shedding absorbent cloth.

**Bedpan Washer/Disinfectors:**

Guidance from HTM 2030 should be followed:

- Use a detergent solution as recommended by the manufacturer
- Operate and load as recommended by the manufacturer
- Inspect commode pots/bedpans and urinals for residual debris after cleaning, and repeat process if necessary
- Ensure that maintenance, servicing and performance testing is carried out as advised by the manufacturer.

**Note:**

**Compatibility of all materials and items to be processed should be established by reference to the manufacturer's instructions.**

## DISINFECTION METHODS

Disinfection methods apply to handwashing, skin preparation and equipment. Disinfection of equipment should be limited and, where possible, disposable equipment used instead. If disinfection is required, use the method recommended by the manufacturer.

| Chemical | Advantages | Disadvantages | Uses |
|---|---|---|---|
| Chlorine-based: Hypochlorites (e.g. Domestos, Milton) NB Undiluted commercial hypochlorite contains approx. 100,000ppm available chlorine | • wide range of bacterial, virucidal, sporicidal and fungicidal activity<br>• rapid action<br>• non-toxic in low concentrations<br>• can be used in food preparation<br>• cheap | • inactivated by organic matter<br>• corrosive to metals<br>• diluted solutions can be unstable<br>• need to be freshly prepared<br>• does not penetrate organic matter<br>• bleaches fabrics<br>• needs ventilation | • can be used on surfaces and for body fluid spills |
| Sodium Dichloroisocyanurates (NaDCC) e.g. Presept, Haz-Tab, Sanichlor | • slightly more resistant to inactivation by organic matter<br>• slightly less corrosive<br>• more convenient<br>• long shelf-life | • as above | • as above |
| Alcohol 70% e.g. Isopropanol | • good bactericidal, fungicidal and virucidal activity<br>• rapid action<br>• leaves surfaces dry<br>• non-corrosive | • non-sporicidal<br>• flammable<br>• does not penetrate organic matter<br>• requires evaporation time | • can be used on surfaces, or for skin and hand decontamination |
| Chlorhexidine e.g. Hibiscrub, Chlorhexidine wound cleaning sachets | • most useful as disinfectants for skin<br>• good fungicidal activity<br>• low toxicity and irritancy | • limited activity against viruses<br>• no activity against bacterial spores<br>• inactivated by organic matter | • for skin and hand decontamination |

## STERILISATION METHODS

**Sterile instruments can be obtained by:**

**1. Purchasing pre-sterilised single-use items**

These avoid the need for re-sterilisation and are a practical and safe method. Items must be stored using a stock rotation system and according to manufacturer's instructions.

Do not use items after the 'use by' date.

This is the preferred option for care homes requiring sterile items of equipment. It is usual practice for community nursing or medical staff to provide their own sterile items of equipment for use in this setting.

**2. Using a sterile supplies department (SSD)**

SSDs may provide a cost effective and efficient service. There should be a contract specifying the responsibilities of both parties. Since June 1998 SSDs have been bound by the Medical Devices Directive 93/42/EEC, which requires the department to have a quality system of audit and to have been assessed and validated as CE compliant.

Local sterilisation of equipment is not recommended in the care home setting. For further advice please contact the EHPU.

## SINGLE-USE EQUIPMENT

***Single-use*** means that the manufacturer:

- Intends the item to be used once, then thrown away
- Considers the item unsuitable for use on more than one occasion
- Has insufficient evidence to confirm that re-use would be safe.

***Single patient*** use means that the item can be re-used on ***same patient only***. The duration of use is dependant upon undertaking a risk assessment of individual risk factors.

The MDA (1995) guidance suggests that reprocessing and re-using such items may pose hazards for residents and staff if the reprocessing method has not been validated. Therefore re-use of single-use products is not advisable unless the outcomes have been taken into account. The Consumer Protection Act 1987 will hold a person liable if a single-use item is reused against the manufacturer's recommendations.

## A-Z OF EQUIPMENT AND THE DECONTAMINATION METHOD

For all equipment refer to manufacturers instructions for decontamination.

| EQUIPMENT | CLEANING METHOD |
|---|---|
| Baths | Clean between users. With gloved hand, clean bath surface, grab rails and taps with hot water, GPD and paper towels. Rinse. Dry using disposable paper towel.<br>Specialist mechanical baths must be regularly serviced and cleaned according to manufacturer's instructions. **Clear protocols are required to define any categories of resident for whom these baths are contraindicated** |
| Bath water additives | There are no antiseptic solutions that should be added to the bath. When antiseptic bathing is prescribed, the agent should be applied directly to the skin instead of soap on a wet cloth |
| Bedpans (non-disposable) | Wearing disposable plastic apron and gloves, flush away contents and clean thoroughly using paper towels, warm water and GPD. Rinse, dry and store inverted. (**Refer to Disinfection Methods Section H- 8**). Disinfection using **sodium hypochlorite solution** 100ppm (1 part bleach to 10 parts water) will be required if the resident has enteric symptoms, or damaged skin/mucous membranes.<br>Care homes should be upgrading sluice facilities to incorporate mechanised washer/disinfector machines |
| Bedpan washers/ macerators | These should be used, cleaned and serviced according to manufacturer's guidance |
| Beds, backrests, bed cradles and mattresses | To be cleaned between use with hot water and GPD and then dried. If soiling is evident then immediately clean as above and then wipe over with a disinfectant using **sodium hypochlorite solution (as above)** |
| Bidets | To be cleaned after each use. Clean surface of pan and taps with hot water and GPD, using disposable paper towels and gloved hand and then flush |
| Bowls - resident washing | Clean between each use with hot water and GPD, using disposal paper towels. Rinse and store dry |

| | |
|---|---|
| Commode armrests and seats | If no soiling is evident, clean with hot water and GPD and dry using disposable paper towels **after every use**. If soiling is evident, or the user had a loose stool, clean with hot water and GPD. Wipe over with a **sodium hypochlorite solution** (as above). Store dry. **Use separate wipes for armrests and seats and clean armrests first** |
| Ear pieces from auroscopes | Recommend disposable single-use if possible.<br>Clean thoroughly with GPD and hot water, using thin brushes to clean inside. Rinse and dry thoroughly before storage |
| Ear syringe 'Propulse' | Before first use of the day and after each resident use – clean earpieces in GPD and warm water solution. Fill tank with sodium hypochlorite solution (Milton) 125ppm. Run this solution through the tubing ensuring the absence of any air bubbles. Allow at least 10 minutes in order for disinfection to take place. Empty tank and tubing, rinse with sterile water for irrigation, dry with disposable, non-shedding paper towel and try to ensure that tubing is as dry as possible |
| ECG Equipment<br>- Electrodes<br>- Leads/Machine | - Use disposable electrodes<br>- Wipe over with damp cloth, keep covered when not in use. Follow manufacturer's instructions |
| Examination couches | Surface must be in good repair, clean with hot water and GPD at start and finish of each session or if becomes soiled. Cover with disposable paper towel and change between each resident use |
| Hoists and slings | After each resident use, clean thoroughly using hot water and GPD and store dry<br>Slings should be single resident use and regularly laundered<br>Single patient use disposable slings are also available |
| Nail brushes | Single-use only, should not be used as a communal item |

| | |
|---|---|
| Nebulisers | **Nebuliser Units** Follow manufacturer's instructions, or wipe with damp cloth and GPD and hot water after each use<br><br>**Nebuliser (patient end) equipment** i.e. tubing, mask and nebuliser reservoir should be single patient use.<br>Mask and nebuliser reservoir – wash with hot water and GPD, and dry between each use. Store dry<br><br>If the nebuliser unit is being used for several residents the patient end equipment must be removed from the unit at the end of each treatment and stored as above, in a clean container in the residents room<br><br>Nebuliser unit to be decontaminated as above between each patient use<br><br>All single patient use equipment must be disposed of at the end of the residents treatment, or earlier if grossly soiled |
| Suction equipment | Disposable suction jar/liners units are recommended.<br>Suction machine – clean with GPD and hot water and dry<br><br>When in use jars/liners should be disposed of when full, or after 24 hours as clinical waste<br><br>Non-disposable bottles - ensuring appropriate staff protection, empty the contents into the toilet, rinse with cold water.<br>Clean using hot water and GPD, store dry.<br>Tubing should be disposable<br><br>Filters - These should be replaced when wet and at appropriate intervals in keeping with the manufacturer's instructions |
| Thermometers | Use disposable sheaths for single resident use: After **each** use, wipe with GPD wipes and store dry |
| Trolleys (dressing trolleys) | Clean top and all surfaces with hot water and GPD daily. Dry thoroughly. If trolley becomes contaminated between resident use, wash with GPD and hot water again |

| | |
|---|---|
| Urinals (non-disposable) | The use of disposable urine bottles is advised, as manual cleaning is both difficult and unsatisfactory<br><br>Automated washer/disinfectors should be used where possible<br><br>Non-disposable urinals - wearing disposable plastic apron and gloves, empty urine into the toilet/sluice hopper, clean thoroughly using hot water and GPD. Rinse, dry and store inverted.<br><br>Ideally each resident should have a designated urine bottle |
| Urine jugs (non-disposable) | Single-use is recommended<br><br>Re-useable jugs, or single patient use jugs, wearing gloves and apron empty the contents into the toilet/sluice hopper. Clean with hot water and GPD. Rinse and store dry and inverted.<br><br>Note: Jugs must be decontaminated between each use |
| Work surfaces | **General Cleaning** - Use GPD and hot water or multi-surface wipes<br><br>**Contaminated Surfaces** - Clean with GPD and hot water and then wipe with 1% sodium hypochlorite solution |

**ENVIRONMENTAL CLEANING**

The environment plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk. They should be kept to a minimum by regular cleaning and by good design features in buildings, fittings and fixtures.

A written cleaning schedule should be devised specifying the persons responsible for cleaning, the frequency of cleaning and methods to be used and the expected outcomes:

- Work surfaces and floors should be smooth-finished, intact, durable of good quality, washable and should not allow pooling of liquids and be impervious to fluids

- Carpets are not recommended in clinical areas because of the risk of body fluid spills

- Where carpets are in place, there should be procedures or contracts for regular steam cleaning and dealing with spills

- Keep mops and buckets clean, dry and store inverted

- Re-useable mop heads should be removable for frequent laundering, or single-use if this is not possible

- Mop heads should not be used for body fluid spillages

- Provide single-use, non-shedding cloths or paper roll for cleaning

- Keep equipment and materials used for general cleaning separate from those used for cleaning up body fluids

- Colour-code cleaning equipment, such as mop heads, gloves (if reusable) and cloths for toilets, kitchens and clinical areas. Use different colours for each area

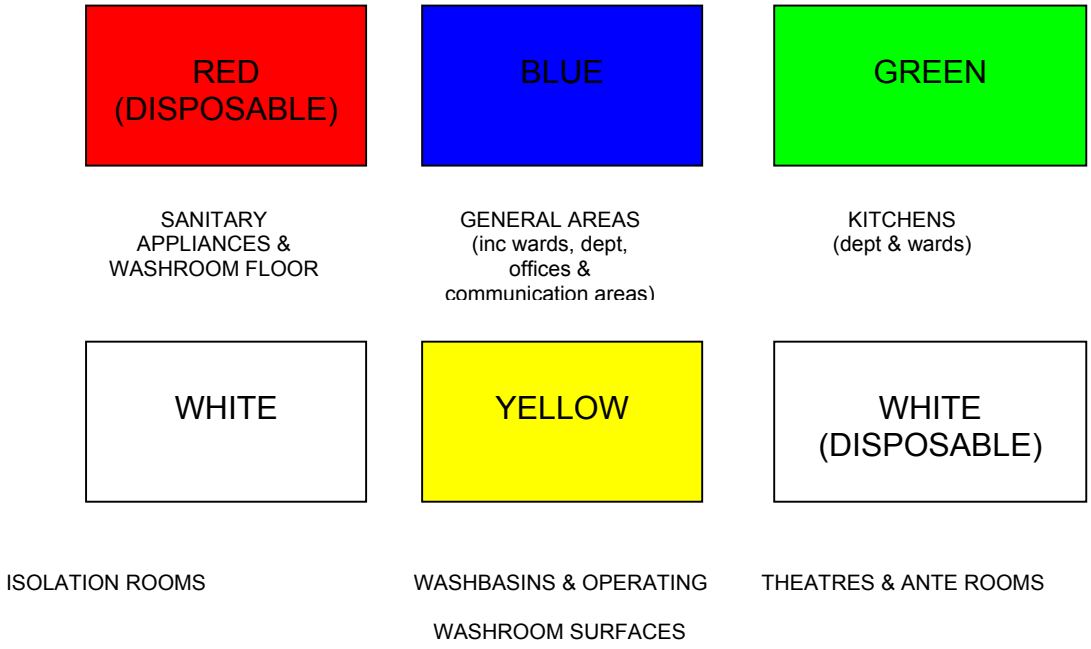
- Use GPD for all environmental cleaning - follow the manufacturer's instructions.

**Colour Code for Hygiene**

The following table is from the NHS Healthcare Cleaning Manual and make recommendations for colour coding the cleaning equipment. These recommendations should be followed.

## Colour Code for Hygiene

Based on the National Colour-coding System for the British Institute of Cleaning Science




THE GOLDEN RULE: WORK FROM THE CLEANEST AREA TOWARD THE DIRTIES AREA. THIS GREATLY REDUCES THE RISK OF CROSS CONTAMINATION.

1. The aim of a colour-coding system is to prevent cross contamination

2. It is vital that such a system forms part of any employee induction or continuous training programme

3. A minority of people are colour blind in one or more colours. Some individuals may not know this and colour identification testing should form part of any induction training

4. Always use two colours within the washroom/sanitary area

5. The colour-coding system must relate to all cleaning equipment, cloths and gloves.

Monitoring of the system and control of colour-coded disposable items against new stock release is extremely important.

**DOMESTIC CLEANING PRACTICE**

| | |
|---|---|
| Bucket (plastic) | Empty contents down toilet or slop hopper<br>Clean with GPD, rinse and store dry, inverted |
| Mop (wet) | Disposable is recommended. Dispose of after single task, or after periods of use not exceeding 3 hours. If reusable, heat-disinfect in washing machine and dry thoroughly, daily, or more frequently if necessary. Store dry |
| Mop (dry) | Vacuum after each use. Replace covers daily or more frequently if necessary |
| Lavatory brushes | Rinse in flushing water and store dry |
| Suggested colour coding of cleaning equipment | See Colour code for hygiene table |
| Floors<br>- (vinyl or equivalent)<br><br>- carpet | Dust control - dry mop<br>Wet cleaning - wet mop - see above<br>If known contamination - refer to Section D - 5 Spillage Management, follow with hypochlorite 1000 ppm<br>Vacuum/ steam clean |
| Furniture and fittings | Damp dust with hot water and GPD<br>If known contamination - follow with hypochlorite 1000 ppm |
| Lavatory seat and handle | If soiling is evident, or there is an outbreak of diarrhoea, or the previous user had a loose stool, clean with hot water and GPD followed by **sodium hypochlorite solution** |
| Showers | Should be clean and maintained. Showerheads should be de-scaled when necessary. If not in regular use showers should be run for 5 minutes weekly as they are a potential Legionella risk. Shower curtains, if present, should be washed frequently to prevent the formation of mould. |
| Walls and ceilings | Not an infection problem. When visibly soiled use hot water and GPD. Splashes of blood, urine or known contaminated material should be cleaned promptly with hot water and GPD, followed by hypochlorite solution 1000ppm – Refer Section D – 5 Spillage Management) |

## DECONTAMINATION EQUIPMENT PRIOR TO INSPECTION, SERVICE, REPAIR OR LOAN

Do not send contaminated equipment elsewhere without decontaminating first. Before dispatch, complete and attach a certificate which states the method of decontamination used, or the reason why decontamination was not possible. Equipment that is impossible to decontaminate is likely to be complex, high-technology and heat-sensitive. Often it cannot be decontaminated without being dismantled by an engineer - in this case attach a bio-hazard label to the item. Complete the clearance certificate (see next page).

**DOCUMENTATION**

A completed clearance certificate must be attached to the equipment prior to work being carried out. A suggested letter is:

From:
---
---
---
---

To:
---
---
---
---

Make and description of equipment item:
---

Model/Serial/Batch Number:
---

Other distinguishing marks:
---

This equipment/ item has not been in contact with blood or other body fluids. It has been cleaned in preparation for inspection, servicing or repair.

This equipment has been decontaminated. The method used was:

---

This equipment could not be decontaminated. The nature of risk, and safety precautions to be adopted are:

---

Signed Date

Position Address

# 9. Laundry Management

## IN THE CARE HOME

### Laundry facilities

The laundry must be sited so that soiled articles are not carried through areas where food is stored, prepared, cooked or eaten.

The laundry should have a flow of 'dirty to clean'. Clean items should not pass back through the 'dirty' area of the laundry.

Soiled laundry must be stored in a designated area within the laundry, separate from the area where clean laundry is handled.

The laundry floor must be of a smooth, impermeable and easily cleanable material.

Domestic staff should have a clear programme for cleaning the laundry environment. All horizontal surfaces should be damp-dusted on a daily basis.

Any body fluid contamination must be cleaned immediately according to the spillage policy.

Walls must be in sound condition and easily cleaned as necessary.

All machinery must be maintained in a clean dust-free condition and must be covered by a service agreement which supports prompt repair or replacement of the machine in case of breakdown. Records of maintenance/service should be kept.

Staff must have use of a designated handwash facility with liquid soap and paper towels within the laundry.

Washing machines should have programming ability to meet disinfection standards:

- A 'sluice' cycle to pre-wash heavily contaminated laundry
- Machine should reach 65$^{o}$C for a minimum of 10 minutes or 71$^{o}$C for 3 minutes in order to achieve disinfection
- Laundry staff should have training and be competent in the use of the equipment.

Washing powders and other substances must be kept in a locked storage cupboard. Material Safety Data Sheets for any potentially hazardous substances must be obtained and be available for reference.

**Laundry practices**

Laundry staff should always wear gloves and a disposable apron whilst handling laundry.

Hands must be washed after removal of protective clothing.

Soiled laundry must be removed to the designated laundry area for processing as soon as possible after it has been produced.

Soiled laundry must be transported around the home only whilst contained within designated linen bags.

Linen contaminated with blood or body fluids must be contained within a water-soluble or soluble-stitched bag prior to being placed in a normal linen bag. This enables contaminated laundry to be placed into the machine (on a 'sluice' cycle) whilst in the soluble bag thereby reducing the risks of body fluid contamination, and potential infection risk, to the staff member.

Heat labile clothing must be washed at the highest temperature possible according to the item's fabric care instructions. Where indicated disinfection can be achieved by adding sodium hypochlorite in 150ppm concentration to the wash during the rinse cycle.

There is no need to segregate laundry from residents who are colonised with MRSA or who have any other infection unless advised by the EHPU. Good hygiene practices will suffice.

Tumble-drying and ironing are also heat disinfection processes.

**Curtains/blinds**

These should be washed at least twice a year, or when there is visible contamination, and after outbreaks, or following the discharge or death of a resident with an infection. If in doubt please contact EHPU for advice.

## SENDING LAUNDRY TO A COMMERCIAL LAUNDRY

A commercial laundry service may stipulate a colour coding system for the management of soiled linen.

Usually laundry bags are colour coded in the following way:

Used linen - a white bag

Foul linen and/or Infected linen – placed in a red water-soluble bag, into a red outer bag.

If residents laundry is sent to a commercial laundry, by collection or delivery, it should be checked whether they have any special instructions regarding the colour coding system.

## STAFF UNIFORMS OR WORK CLOTHES

Staff who are at risk of contaminating their clothes by body fluids should always change into 'home' clothes - preferably before leaving the work place or as soon as home is reached.

Uniforms or work clothes should be washed as soon as possible on as hot a wash as the fabric will tolerate. Cardigans/jumpers should be washed at least weekly.

The majority of bacteria and viruses will not survive away from the host and would not present a high-risk of infection on clothing. However, within a mass of body fluid organisms would survive longer.

**Shoes should be cleaned immediately if contaminated with body fluids, using GPD and hot water - disposable gloves should be worn.**

# 10. Waste Management

**The requirements for managing healthcare waste are about to change owing to the new Hazardous Waste Regulations. We are awaiting further clarification.**

## 1. RESPONSIBILITY

All organisations have a legal responsibility to dispose of waste safely, ensuring no harm is caused either to staff, members of the public or the environment. This responsibility begins when waste is generated and ends with its final disposal, even where properly authorised agents are used.

It is essential that persons handling waste exercise care to prevent injury or transmission of infection to themselves or others. This is to fulfil their responsibilities under the current legislation (for list see end of this Section).

## 2. DEFINITION OF CLINICAL WASTE

Clinical waste is:

a) Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, soiled swabs or dressings, or syringes, needles or other sharp instruments, being waste which, unless rendered safe, may prove to be hazardous to any person coming into contact with it; and

b) Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any other person coming into contact with it.

(Controlled Waste Regulations 1992)

Clinical waste is categorised by the Health and Safety Executive as follows:

## 3. SEGREGATION OF WASTE

The key to the safe disposal of waste is for all staff to conform to the system of segregation shown in the table below. This system enables clear identification of the different types of waste encountered and indicates the disposal procedures that apply to each category.

This is currently being reviewed following the recent Hazardous Waste Regulation (2005). In addition there have been:

1) Changes in Waste Management Regulation, notably Landfill Waste Regulations (2002)

2) Changes in carriage regulations, notably amendments to Carriage of Dangerous Goods and Use of Transport Pressure Equipment Regulations (ADR 2005)

3) Changes in waste segregation – the need to segregate and identify waste destined for different disposal routes.

Therefore new guidance is awaited from the Environment Agency as to the categories of waste according to the European Waste Catalogue and routes of disposal. We currently recommend that you follow the waste contractor's instructions until we get clarity from the Environment Agency.

## 4. HANDLING OF WASTE

Waste should be segregated at the point of origin.

Personal protective clothing should be worn when handling waste.

Clinical waste should be:

- correctly bagged in yellow bags of 225 gauge to prevent spillage
- double bagged where:
    - the exterior of the bag is contaminated
    - the original bag is split, damaged or leaking
- kept in a rigid-sided holder or container with a foot operated lid, and so far as is reasonably practicable, out of the reach of children
- only filled to ¾ full
- securely sealed and labelled with coded tags at the point of use to identify their source.

Clinical waste should not be:

- decanted into other bags, regardless of volume
- contaminated on the outside
- re-used
- Sharps must be disposed of into approved sharps containers that meet BS7320/UN3291
- Sharps container should **NEVER** be placed into a yellow clinical waste bag.

## 5. DISPOSAL OF WASTE

Clinical waste should be placed in a yellow bag (minimum gauge 225mm).

The bag should be removed and securely fastened at least once a day or when ¾ full, labelled with its place of origin and placed in the designated clinical waste storage/collection point.

### Disposal of sharps

Syringes, needles, razors, ampoules and other sharps should always be placed in a sharps container. These items should never be placed in a waste bag of any kind.

Care should be taken to ensure that sharps containers are correctly assembled according to the manufacturer's instructions.

Use the appropriately sized sharps container to prevent used sharps being stored for long periods of time.

It is the responsibility of the person who uses a sharp to dispose of it safely.

Always place sharps in the sharps container as soon as possible.

Sharps containers must be sealed, labelled with the point of origin and placed in the designated clinical waste collection point when ¾ full.

Sharps containers should conform to BS 7230/UN 3291.

Sharps containers should be kept in a safe location (on a flat surface, below eye level but not on the floor). This will reduce the risk of injury to residents, visitors and staff.

### Diabetic Sharps

All diabetic sharps should go into a sharps container (this includes lancets).

General Practitioners can now prescribe sharps boxes on FP10. General Practitioners should ensure that the resident is aware of the correct method for disposal of the filled sharps bin. Alternative approaches may include returning it to the GP Surgery, a local clinic, or local pharmacy.

### Disposal of Aerosol Cans/Glass/Bottles/Broken Crockery/Dry Cell Batteries

These must never be placed in any waste bag, especially a yellow clinical waste bag which is destined to be incinerated.

These items should always be placed in a designated cardboard box, lined with a plastic bag to render it leak-proof. The box should be labelled to indicate its contents and method of disposal.

### Disposal of Pharmaceutical Waste - Special Waste

Pharmaceutical waste includes all part-used and out of date medicines, cream and ointment tubes and aerosols. Other associated waste e.g. empty blister packs and alcohol wipe containers can be disposed of in the domestic waste stream (black bag).

All pharmaceutical waste should be placed directly into the pharmaceutical waste container, or returned to the local chemist for them to place into their pharmaceutical waste container.

When ¾ full, the container must be sealed, labelled to identify its source with contact details and placed in the designated collection point.

**Ensure that the container is clearly labelled, and that all associated documentation is signed off at the time of collection.**

## 6. STORAGE OF CLINICAL WASTE

Clinical waste should be removed from point of generation as frequently as circumstances demand, and at least weekly.

Between collections, waste should be:

- Stored in correctly coded bags, with bags of each colour code kept separate

- Situated in a centrally designated area of adequate size related to the frequency of collection

- Sited on a well-drained, impervious hard standing floor, which is provided with wash down facilities

- Kept secure from unauthorised persons, entry by animals and free from infestations

- Accessible to collection vehicles.

## 7. CURRENT LEGISLATION

- Health & Safety at Work etc Act 1974

- Control of Pollution Act 1974

- Collection and Disposal of Waste Regulations 1988

- Control of Pollution (Amendment) Act 1989

- Environmental Protection Act 1990

- Environmental Protection (Duty of Care) Regulations 1991

- Controlled Waste Regulations 1992

- The Special Waste Regulations 1996

- The Safe Disposal of Clinical Waste 1999

- Health Care Waste Management and Minimisation 2000.

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION I – FOOD HYGIENE

### 1. Introduction

This guideline sets out the procedures for staff to follow for food hygiene in Care homes.

### 2. Legislation

All individuals who handle food should follow basic food hygiene practices to ensure contamination and subsequent disease does not occur.

All staff involved in the handling of food should be aware of the legislation relevant to food management. The main legislation is the Food Safety Act 1990 and its related regulations (General Food Hygiene Regulations (1995) and The Food Safety (Temperature Control) Regulations (1995)).

### 3. Basic Requirements for Food Safety

The Local Authority Environmental Health Officers will advise on Food Safety and Kitchen Hygiene in the care home setting.

The following basic principles should be observed:

- It should be ensured that the food purchased is of good and wholesome quality and is subsequently stored, prepared, cooked and served in hygienic conditions
- Check “use by” dates. Use food within recommended times
- Do not provide/eat food containing uncooked eggs. Keep eggs in the fridge
- **Food Preparation Areas**. All food preparation surfaces should be cleaned before use with hot water and GPD
- **Pets.** Keep pets away from food, and preparation areas

- **Cross Contamination**. Care must be taken not to contaminate cooked foods with raw foods. Ideally there should be a separate chopping board and utensils for each type of food (e.g. raw meat, cooked meat and raw and cooked perishables)

- **Hands and Hand-washing**. Hands **must** be washed thoroughly following any cleaning session, after toilet visits, before handling food and between handling different food types e.g. raw and cooked meats

- **Refrigerators.** All fridges should be defrosted and cleaned regularly. Should a spillage occur or food become stale the whole interior of the fridge should be cleaned with hot water and GPD and dried thoroughly

- **Food**. Food should be stored at the correct temperature. The fridge should be kept at 5$^{o}$ C or lower. The freezer should be kept at minus 18$^{o}$C or below. In the care home, it is essential that a record of daily temperature recordings is kept

- **Storage.** Store raw meat and fish at the bottom of the fridge ensuring juices do not drip on to salads and vegetables. Raw meat and defrosting foods should be stored in covered dishes, or boxes which can catch drips. All sealed dry foods should be stored on shelves or in cupboards. Food should not be stored on the floor. Open packs of food should be stored in containers or packaging sealed to inhibit the entry of animals. Open bottles, such as squash, sauces and jams may require storage in the refrigerator. Follow manufacturer's guidelines

- **Defrosting.** All foods should be defrosted in the fridge or microwave, not at room temperature (unless specified on the packaging). Do not re-freeze uncooked food. Cook before you freeze again

- **Cooking**. Always follow cooking times on the labels and in cookbooks. Cook food thoroughly so that the temperature reaches 70$^{o}$ C for at least 2 minutes. Ideally food should be eaten as soon as it is cooked or prepared. Never re-heat food

- **Leftovers.** These should not be left out unnecessarily. Cold food should be covered and put directly into the fridge. Hot food should be cooled for one hour at room temperature and then placed in the fridge. All leftovers should be eaten within 2 days

- **Crockery and Cutlery**. A mechanical dishwasher incorporating a hot drying cycle should be used if possible. If a dishwashing machine is not available, hot water and GPD should be used for washing. Wherever possible, dry with disposable heavy-duty paper towel. If used, tea towels are to be changed daily and laundered at least 60$^{o}$ C

- **Dishcloths.** Should be changed daily and laundered at least 60ºC.

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION J – STAFF HEALTH

### 1. Occupational Health Service

If you have access to an occupational health service you should refer to any written guidance issued by them.

### 2. Principles of Staff Health in Care Homes

Care home staff are not in general at increased risk of acquiring communicable diseases. However, it is wise to take some basic precautions:

- Keep a record of staff immunisation histories, to facilitate action should an incident occur

- Consider the need to vaccinate staff who have not completed a primary course of the following routine childhood vaccine:

    - Diphtheria
    - Tetanus
    - Polio
    - MMR for those 25 and under (2 doses 3 months apart)
    - Meningitis C vaccine for those 25 and under (1 dose).

As a general public health measure, regular boosters are NOT required, nor should individuals have more than 5 doses of tetanus unless they sustain a high-risk injury.

- The Control of Substances Hazardous to Health (COSHH) Regulations 1994 require employers to undertake a risk assessment of their environment and to bring into effect measures necessary to protect their workers who may be exposed to Hepatitis B (Green Book)

- Employers are expected to organise and pay for vaccination of any workers who are considered to be at risk. They are also expected to keep records of who has been vaccinated.

- Staff who handle sharps e.g. needles, cannulae, lancets etc., which may be contaminated with the blood of others, should have a full course of Hepatitis B vaccine, including measurement of antibody levels. (Blood test 2 months after final dose of vaccine.)

Details of the schedules are available in the DOH document "Immunisation Against Infectious Disease 1996 " (The Green Book) found at www.dh.gov.uk . Staff should be aware of "sharps injury" procedure **(refer Section E – Management of Sharps)**

- Staff from countries with high incidence of TB should be assessed on employment and on an annual basis for symptoms suggestive of tuberculosis e.g. persistent cough, weight loss, night fevers etc. The review should be on an individual basis with a face-to-face interview A list of countries classified as high risk can be found at the end of this section and is also available from www.immunisation.nhs.uk. (the list can be found on the Tuberculosis fact sheet)

- Consider BCG vaccination for staff whose parents or grandparents were born in a TB high prevalence country

- Influenza Immunisation – the DOH recommend that social care employers (especially nursing and care homes where older people are cared for) should offer yearly immunisation to their staff.

## Countries with rates of TB over 40/100,000 of the population

**A**
Afghanistan
Albania
Algeria
American Samoa
Angola
Argentina
Armenia
Azerbaijan

**B**
Bahamas
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia Herzegovina
Botswana
Brazil
Brunei Darussalam
Burma (Myanmar)
Bulgaria
Burkina Faso
Burundi

**C**
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
Colombia
Comoros
Congo
Cook Islands
Côte d'Ivoire
Croatia

**D**
Democratic People's Republic of Korea
Democratic People's Republic of Congo
Djibouti
Dominican Republic

**E**
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Estonia
Ethiopia

**G**
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea Bissau
Guyana

**H**
Haiti
Honduras

**I**
India
Indonesia
Iraq

**J**
Japan

**K**
Kazakhstan
Kenya
Kiribati
Kuwait
Kyrgyzstan
Korea

**L**
Lao People's Democratic Republic
Latvia
Lesotho
Liberia
Lithuania

**M**
Macedonia
Madagascar
Malawi
Malaysia
Mali
Marshall Islands
Mauritania
Mauritius
Mexico
Micronesia (Federated States of)
Moldova
Mongolia
Morocco
Mozambique
Myanmar (Burma)

**N**
Namibia
Nepal
New Caledonia
Nicaragua
Niger
Nigeria
Northern Mariana Islands

**P**
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines

**Q**
Qatar

**R**
Republic of Korea
Republic of Moldova
Romania
Russian Federation
Rwanda

**S**
Samoa
Sao Tome and Principe
Saudi Arabia
Senegal
Serbia and Montenegro
Seychelles
Sierra Leone
Singapore
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Syrian Arab Republic

**T**
Tajikistan
Tanzania
Thailand
Timor Leste
Toga
Tokelau
Tonga
Turkey
Turkmenistan
Tuvalu

**U**
Uganda
Ukraine
United Republic of Tanzania
Uzbekistan

**V**
Vanuatu
Venezuela
Viet Nam

**Y**
Yemen

**Z**
Zambia
Zimbabwe

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION M – PETS AND PESTS

### 1. Introduction

This guideline sets out the procedures for staff to follow for pets.

Management and staff in a care home have the responsibility for the care and management of pets, if there are any, in the home.

### 2. Pets

Pets can often enhance the quality of life for the ageing and the ill. However, many types of animal often kept as pets can be the source of human infection, including exotic species such as reptiles, fish or birds. Sensible precautions can reduce any infection risk to an acceptable level.

All animals should be regularly groomed and checked for signs of infection, flea infestation, or other illness. If pets become ill, diagnosis and treatment by a vet should be sought. All animals should have received relevant inoculations. Dogs and cats should be wormed regularly, as directed by a vet, and be subject to a regular programme of flea prevention.

Hands should be washed following any contact with animals, their bedding or litter.

Pets should not be fed in the kitchen or other food preparation areas and their dishes and utensils should be washed separately from other household articles.

Once opened, pet food containers should be kept separate from food for human consumption.

Food not consumed in one hour should be taken away or covered to prevent attracting pests.

## 3. Litter Box Care

Never deal with a cat's litter box if you are pregnant.

Always wear a protective apron and gloves when cleaning the litter box.

Always wash hands immediately after removing protective clothing.

If possible, fit a disposable liner to the box for easy cleaning.

Soiled litter should be changed daily.

Litter should be sealed in a plastic bag and disposed of in household waste.

The litter box should not be sited near food preparation, storage or eating areas.

The litter box should be disinfected whenever the litter is changed by being filled with boiling water which is allowed to stand for at least 5 minutes in order to kill toxoplasmosis eggs and other organisms.

## 4. Pests

Pests may be found in any property but with sensible precautions will not present an infection risk to residents and staff.

These include:

**Insects** - ants, flies, cockroaches, fleas, silverfish
**Rodents** - rats and mice
**Birds** - pigeons, magpies, sparrows, etc.
**Feral cats and foxes**

Kitchen and food stores provide ideal conditions for pests. Not only do they eat the food but also they contaminate and spoil a lot more.

Control measures should include the following:

- Stop pests getting in by fly screens, well-fitting doors, covered drains and bird netting

- Look out for droppings, nests, chew-marks on wood or cables

- Discard any foodstuffs or other articles affected by pests, including milk from bottles, the tops of which have been pecked by birds

- Clean up any spillage and decaying food immediately. Carry out regular inspection and rotate any stock. Use rodent-proof containers with well-fitting lids. Store food off the ground.

If any pests are found the local Environmental Health office should be contacted.

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION L – AUDIT TOOL

See Appendix 1

# ESSEX HEALTH PROTECTION UNIT
# INFECTION CONTROL GUIDELINES
# FOR CARE HOMES

## SECTION L – REFERENCES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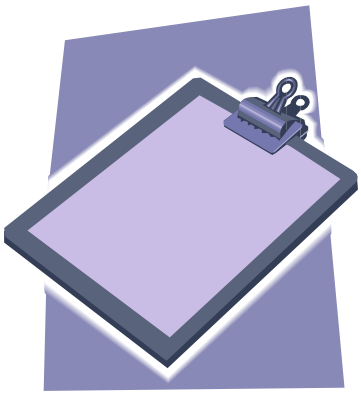
# APPENDIX 1

# Care Home Audit Tool



Issued by Essex Health Protection Unit
January 2006

## INFECTION CONTROL ENVIRONMENTAL AUDIT

This tool is broken down into two distinct parts:

### Environmental Audit

1. Environment
   - a) General
   - b) Surfaces
   - c) Kitchen
   - d) Bedrooms
   - e) Bathrooms and Toilets
   - f) Sluice

### Infection Control Practices

2. Infection Control
   - a) Hand hygiene
   - b) PPE
   - c) Spillages
   - d) Laundry
   - e) Waste disposal
   - f) Handling of sharps
   - g) Guidelines and policies

Throughout the audit form indicate:

| | |
|---|---|
| √ | for **achieved** |
| x | for **not achieved** |
| NA | for **not applicable** |

Additional comments should include:

reasons for not achieved
areas that raise concern
specific training needs

Action Plan based on the findings/failings of the audit with clear lines of responsibility and timescales for action.

Items need to be numbered to assign action against any failing in the subsequent Action Plan.

**Scoring**: The number of positive answers divided by the total number of questions answered, multiplied by 100 = % score.

**AREA** _____

_____

**DATE** _____ **TIME** _____

**CARE HOME ADDRESS** _____

_____

_____

**NAME OF C.D.C.N.** _____

**CARE HOME REPRESENTATIVE** _____

## 1. Environment

## 1a) General Environment

Standard Statement: The environment will be maintained appropriately to reduce the risk of cross-infection.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Is there a cleaning schedule available for inspection (evidence of a used tick sheet) | | | | |
| 2 | Overall appearance of the environment is tidy and uncluttered with only appropriate, clean and well-maintained furniture is being used | | | | |
| 3 | Fabric of the environment and equipment smells clean, fresh and pleasant | | | | |
| 4 | Rooms allocated for clinical practice are fit for the purpose and not carpeted | | | | |
| 5 | Floor coverings are washable and impervious to moisture and are sealed regularly | | | | |
| 6 | Floors, including edges and corners, are visibly clean with no visible body substances, dust, dirt or debris | | | | |
| 7 | Furniture, fixtures and fittings should be visibly clean with no body substances, dust, dirt, debris or adhesive tape | | | | |
| 8 | Furniture (chairs and couches) in communal client/patient areas are made of impermeable and washable materials | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 9 | Furniture is free from rips and tears | | | | |
| 10 | Medical equipment, e.g. lifting aids, is cleaned, maintained and stored appropriately | | | | |
| 11 | Hoist slings are allocated to one resident only | | | | |
| 12 | Pillows are covered with washable and impervious materials | | | | |
| 13 | There is a procedure in place to regularly decontaminate curtains and blinds, minimum yearly, but also when contaminated with body fluids and following an outbreak of Diarrhoea and Vomiting | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 1b) Surfaces

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Carpets vacuumed daily | | | | |
| 2 | Carpets deep cleaned 6 monthly (see cleaning record) | | | | |
| 3 | Hard floors vacuumed daily | | | | |
| 4 | Hard floors damp mopped daily | | | | |
| 5 | Hard floors washed/scrubbed weekly | | | | |
| 6 | Mops stored dry/inverted | | | | |
| 7 | Mop heads machine-washed weekly in GPD | | | | |
| 8 | Flat surfaces damp dusted daily | | | | |
| 9 | Correct dilution of disinfectants used | | | | |
| 10 | Dilution chart accessible | | | | |
| 12 | Disinfectants stored in a locked cupboard (COSHH) | | | | |
| 13 | Carpets are cleaned after spillages of body fluids | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 1c) Kitchens

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Kitchen is regularly inspected by Environmental Health Department | | | | |
| 2 | Separate handwash basin available | | | | |
| 3 | Liquid soap available | | | | |
| 4 | Paper towels available | | | | |
| 5 | Foot-operated and labelled waste bin available | | | | |
| 6 | No evidence of infestation or animals in the kitchen | | | | |
| 7 | Floor visibly clean, free of dust, grit, litter, water or other liquids | | | | |
| 8 | Cleaning materials accessible, and away from food | | | | |
| 9 | Cleaning equipment colour coded (green), and stored separately from other cleaning materials | | | | |
| 10 | Drying cloths are disposable (paper roll) | | | | |
| 11 | Opened foods are labelled with name and date of opening and in pest-proof containers | | | | |
| 12 | Bread is stored in a clean bread bin | | | | |
| 13 | Milk stored in fridge | | | | |
| 14 | Food within expiry date | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 15 | Microwave and toaster are visibly clean | | | | |
| 16 | All cooking appliances are visibly clean | | | | |
| 17 | Kitchen trolley is clean and in good state of repair | | | | |
| 18 | Kitchen free from left-over food | | | | |
| 19 | There is a satisfactory system for cleaning crockery and cutlery e.g. dishwasher with a planned maintenance programme | | | | |
| 20 | Water coolers are visibly clean and on a planned maintenance scheme | | | | |
| 21 | Fridge/freezers are clean and free of ice build-up | | | | |
| 22 | Fridge/freezers have thermometers, temperatures taken daily and appropriate action is taken if standards are not met i.e. fridge temperature less than 5° C and freezer less than -18°C | | | | |
| 23 | Fridge free from specimens and drugs | | | | |
| 24 | Hands washed prior to the handling of food | | | | |
| 25 | Staff aware of policy regarding sickness | | | | |
| 26 | There are no inappropriate items or equipment in the kitchen | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 27 | Fly screens are in place where required | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 1d) Bedrooms

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| The following areas are all clean and free from stains and dust: | | | | | |
| 1 | Beds | | | | |
| 2 | Mattresses and covers in good condition (select a bed at random and undertake a mattress test [1]) | | | | |
| 3 | Lockers and wardrobes | | | | |
| 4 | Bedside tables and chairs | | | | |
| 5 | Floor including edges and corners | | | | |
| 6 | Curtains and blinds | | | | |
| 7 | Handwash basins clean | | | | |
| 8 | Clients have individual towels/toiletries | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

[1] Mattress Test: examine the mattress – there should be no staining visible and the mattress should be impermeable to fluids. (Place paper beneath the cover and press down for 10 seconds. Pour 30mls of water onto area and press for 30 seconds. Remove an examine paper towel for signs of leakage beneath cover.)

## 1e) Bathrooms and Toilets

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Baths and bath mats are cleaned after each client use | | | | |
| 2 | Appropriate cleaning materials are available for staff use | | | | |
| 3 | Cleaning materials available and stored correctly | | | | |
| 4 | There is evidence that baths, sinks, taps and showers not in use are run through at least weekly | | | | |
| 5 | Handwash basin in each bathroom/toilet is visibly clean | | | | |
| 6 | Paper towels and liquid soap are available | | | | |
| 7 | Waste bins are foot-operated | | | | |
| 8 | Shower curtains and bath mats are free from mould, clean and dry | | | | |
| 9 | Walls tiles and wall fixtures are clean, intact and free from mould | | | | |
| 10 | Floors, including edges are free of dust and grit | | | | |
| 11 | Hoists are cleaned after use | | | | |
| 12 | Nothing stored on edges of baths/basins | | | | |
| 13 | Toilets are clean and free from organic matter even under the toilet seat | | | | |
| 14 | Clients have their own toiletries | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 15 | There is evidence that Jet type baths are serviced and cleaned according to the manufacturer's instructions | | | | |
| 16 | There is evidence that the Jet type baths are operated weekly when not regularly used by the service user | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 1f) Sluice Areas

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | There is a separate area for cleaning sanichairs etc | | | | |
| 2 | Appropriate facilities are available and in working order to ensure correct disposal (or disinfection) of bedpans and urinals e.g. washer disinfector or macerator | | | | |
| 3 | Washer disinfector/macerators are used according to the manufacturer's instructions | | | | |
| 4 | There is a regular maintenance plan in place for washer disinfector/macerators | | | | |
| 5 | Manual cleaning is not the recommended procedure but where there is no other facilities the correct procedure is used | | | | |
| 6 | Sanichairs/bedpans/urinals stored clean and dry, on racks (urinals inverted) | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2. Infection Control Practice

Standard Statement: The premises are kept clean, hygienic and free from offensive odours throughout, and systems are in place to control the spread of infection, in accordance with relevant legislation and published guidance.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Check supplies of: Latex/vinyl gloves, plastic aprons, soap/paper towels, clinical waste bags and Alginate laundry bags. | | | | |
| 2 | Current Infection Control policy accessible to all staff | | | | |
| 3 | Outbreak plan readily available | | | | |
| 4 | Clients can be segregated in the event of an outbreak | | | | |
| 5 | Staff education programme in place | | | | |
| 6 | Staff report communicable disease i.e. Scabies or gastroenteritis, to manager | | | | |
| 7 | Managers report and document outbreaks to EHPU, CSCI and EHOs as appropriate | | | | |
| 8 | Staff remain off sick until treated/clinically well | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2a) Hand Hygiene

Standard Statement: Hands will be decontaminated correctly and in a timely manner using a cleansing agent to reduce risk of cross-infection.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | The hand hygiene policy/procedural guidance is available to all staff | | | | |
| 2 | Staff have received training in hand hygiene procedures (ask staff) | | | | |
| 3 | Hand hygiene is an integral part of induction for all staff | | | | |
| 4 | Handwashing sinks in clients' bedrooms are accessible with functional liquid soap and paper towel dispensers | | | | |
| 5 | Liquid soap is available at all handwashing sinks | | | | |
| 6 | Liquid soap must be single-use cartridge dispensers | | | | |
| 7 | Wall-mounted or pump dispenser hand cream is available for use | | | | |
| 8 | There are no plugs or overflows or water from taps passing directly into the plug hole of handwashing basins | | | | |
| 9 | Soap and alcoholic handrub dispenser nozzles are visibly clean | | | | |
| 10 | Soft absorbent paper towels are available at all handwashing sinks | | | | |
| 11 | Handwashing sinks are free from used and inappropriate items | | | | |
| 12 | Clinical staff nails are short, clean and free from nail extensions and varnish | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 13 | No wrist watches, stoned rings or other wrist jewellery are worn during clinical procedures | | | | |
| 14 | There are no nail-brushes on handwashing sinks | | | | |
| 15 | Bar soaps are not present on sinks | | | | |
| 16 | Elbow/mixer taps are available in all handwashing sinks | | | | |
| 17 | Handwashing sinks are visibly clean | | | | |
| 18 | Alcohol handrub is available for hand disinfection * | | | | |
| 19 | Handwashing sinks are located in all areas where clinical practice takes place | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

*Provided correct handwashing facilities are available (see 16), alcohol handrubs are not necessary, and this category may be marked N/A.

## 2b) Personal Protective Equipment (PPE)

Standard statement: Personal protective equipment is available and is used appropriately to reduce the risk of cross-infection.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | There is a comprehensive policies/procedures manual that includes the appropriate use of PPE | | | | |
| 2 | The staff are trained in the use of PPE as part of their induction | | | | |
| 3 | Sterile (for Nursing homes) and non-sterile non-powdered latex/vinyl/nitrile based gloves are available in all clinical areas | | | | |
| 4 | Alternatives to natural rubber latex (NRL) are available for use by staff who are sensitive to NRL | | | | |
| 5 | Gloves are available in a range of sizes | | | | |
| 6 | Gloves are used as single-use items for each clinical procedure or patient episode | | | | |
| 7 | Gloves are stored appropriately | | | | |
| 8 | Hands are decontaminated following the removal of gloves (observe 2 or 3 healthcare workers) | | | | |
| 9 | Disposable plastic colour-coded aprons are available | | | | |
| 10 | Disposable plastic aprons are used by staff when there is the risk of clothing or uniform contamination | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 11 | Disposable plastic aprons are used as single-use items for each clinical activity of patient care | | | | |
| 12 | Plastic goggles and face masks or visors are used when there is a risk of body fluid splashing into the face and eyes | | | | |
| 13 | Used protective clothing is disposed of as clinical waste | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2c) Spillages

Standard Statement: The healthcare worker will demonstrate safe handling and disposal of all body fluids.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Staff are familiar with the policy for dealing with spills of body fluids | | | | |
| 2 | Appropriate disinfectants are available for cleaning all body fluid spillages such as Sodium hypochlorite solution in the strength 1:10,000ppm | | | | |
| 3 | The procedure for clearing away spillages is followed as per Essex Health Protection Unit (EHPU) Infection Control Guidelines | | | | |
| 4 | A spillage kit is available | | | | |
| 5 | Furniture that has been contaminated with body substances and cannot be cleaned is condemned | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | |
| | Status | | | | % |
| | Date of next audit | | | | |

## 2d) Laundry Management

Standard Statement: Linen is managed and handled appropriately to prevent cross-infection.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Clean linen is stored away from dirty linen and in a dust-free environment | | | | |
| 2 | Soiled linen is washed immediately | | | | |
| 3 | Soluble/Alginate bags are used for foul and/or infected linen | | | | |
| 4 | Linen washed at 65◦C for not less than 10 minutes or as high as the manufacturers' recommended temperature | | | | |
| 5 | Linen is ironed before use | | | | |
| 6 | Personal linen is designated for each client's use | | | | |
| 7 | The washing machine (industrial) is operated according to the manufacturers' guidance and is regularly maintained (see service record) | | | | |
| 8 | The tumble dryer (industrial) is operated according to the manufacturers' guidance and is regularly maintained | | | | |
| 9 | Handwashing facilities are available within the laundry room | | | | |
| | Totals | | | | |
| | Over all scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2e) Waste Disposal

Standard Statement: All waste from healthcare premises is segregated and identified at source, transported and disposed of safely without risk of contamination, infection or injury to healthcare staff and the general public, and in accordance with legislation.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | There is a comprehensive policy/procedure in place including waste disposal | | | | |
| 2 | There is evidence that the home is registered with a licensed waste contractor (check records) | | | | |
| 3 | Staff have attended training sessions about correct and safe disposal of clinical waste (check training records) | | | | |
| 4 | Waste is correctly segregated (according to regulation in force) into clinical and household waste | | | | |
| 5 | Correctly colour-coded waste bins/bags are used | | | | |
| 6 | Waste bags are no more than 2/3rds full, secured and labelled prior to disposal | | | | |
| 7 | Waste bins are visibly clean inside and out | | | | |
| 8 | There is a dedicated area for the storage of clinical waste, which is under cover from the elements, free from vermin and pests and the area locked and inaccessible to animals and the public | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 9 | All waste is collected on a regular basis by a licensed contractor, at least once a week | | | | |
| 10 | Consignment notes kept and up to date | | | | |
| 11 | The producer of the clinical waste realises their duty of care to ensure clinical waste is incinerated | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2f) Handling of Sharps

Standard statement: Sharps/needlestick injuries, bites and splashes involving blood or other body fluids are managed in a way that reduces the risk of injury or infection.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Sharps container used conforms to BS 7320/UN 3291, and is assembled correctly | | | | |
| 2 | Bins are stored safely and off the floor away from the public and out of reach of children | | | | |
| 3 | Sharps containers are available for use and located within easy reach | | | | |
| 4 | The box is not filled beyond the indicator mark i.e. less than 2/3rds full and there are no protruding sharps | | | | |
| 5 | Sharps are disposed of directly at the point of use | | | | |
| 6 | All sharp bins are labelled and signed according to policy | | | | |
| 7 | Full sharps bins are locked, sealed and kept in a locked area prior to collection | | | | |
| 8 | All staff are aware of what action should be taken following a sharps injury (question a member of staff) | | | | |

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 9 | Staff who are involved with clinical practice such as giving injections, obtaining blood samples and dealing with blood spillages are vaccinated against Hepatitis B and there is documented proof of this e.g. blood glucose monitoring | | | | |
| 10 | Syringes with a residue of Prescribed Only Medication are disposed of according to current legislation | | | | |
| 11 | The temporary closure mechanism is used when the bin is not in use | | | | |
| 12 | Full sharps containers are sealed only with the integral lock and tape or stickers are not used | | | | |
| 13 | Sharps containers are not placed in waste bags prior to disposal | | | | |
| 14 | Sharps containers are visibly clean with no body substances, dust, dirt or debris | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |

## 2g) Guidelines, Policies and Standards

Standard Statement: There are written policies and procedures that demonstrate infection prevention and control for all client care.

| | | Yes | No | N/A | Comments |
|---|---|---|---|---|---|
| 1 | Current infection control policy is available | | | | |
| 2 | Infection control policy is easily accessible to all staff | | | | |
| 3 | There are at least 2 members of staff aware of the content of the policy | | | | |
| 4 | Staff are aware of the notification procedure for notifiable infectious diseases | | | | |
| | Totals | | | | |
| | Overall scoring | | | | |
| | Potential total | | | | |
| | Percentage | | | | % |
| | Status | | | | |
| | Date of next audit | | | | |