EXE EAR CARE

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POLICY TITLE – Infection prevention and control policy (IPC)
POLICY NUMBER – 004

Date authored – 23/07/2024 Next review - 22/07/2025

REFERENCE

A. NHS England. National infection prevention and control manual (NIPCM)
B. Health and Social Care Act 2008: Code of practice on the prevention and control of infections.
C. NICE. Hearing loss in adults: Assessment and Management.
D. GOV.UK. Classify different types of waste.

GENERAL

1. The CEO, Mr R Toon, is nominated as the IPC lead. They are responsible for all IPC policy decisions and adjustments where the environment favours a change.

2. The purpose of this policy is to safeguard provision of evidence-based practices and ensure uniformity of approach, therein reducing the incidence of healthcare associated infection (HCAI).

3. Delivered therapy must follow the National Institute of Clinical Excellence (NICE) guidance on Hearing loss in adults: Assessment and Management as this provides the most contemporaneous and evidence-based recommendations on safety and IPC precautions.

4. Where the clinician is demonstrating symptoms of a communicable illness, providing clinical services that day is not permitted. This precaution recognises that the majority of service user are elderly and as such, contracting an illness will likely have more serious implications.

5. Following consultation, every service user is to be given post therapy care instructions that empower them to reduce the risk of infection. This information is to be provided in a medium suitable to their information needs (verbal, patient information leaflet, video link etc)

6. Clinical staff are to undertake relevant annual IPC training.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

7. There is no compelling evidence that ear wax can harbour communicable diseases. However, the clinician has a small risk of encountering the blood and serous fluid of the service user. Therefore, appropriate PPE measures are to be observed.

8. Clinicians are to have received and completed, as a minimum, immunisation schedules for;

    a. Hepatitis A.
    b. Hepatitis B.
    c. Measles, mumps and rubella.
    d. Varicella

9. The following, single use PPE is to be used and discarded for every clinical engagement;

    a. Apron.
    b. Gloves.
    c. Eye protection.
    d. Fluid resistant surgical mask.

EQUIPMENT CARE

10. All consumables are single use. Single use means that they can be used on one service user then MUST be discarded. No single use item is to be reused. Examples of single use consumables are;

    a. Suction and irrigation tips.
    b. Ear specula.
    c. Jobson Horne probes.
    d. All PPE.

11. Daily serviceability checks and IPC actions are to occur and be recorded in 3CDE for clinical equipment, as per manufacture instructions. Examples of equipment included;

    a. Electronic irrigator.
    b. Suction machine.
    c. Digital otoscope.

WASTE

12. All waste is to be categorised, separated and disposed of appropriately. The common categories are;

    a. *Healthcare offensive waste* – Including disposed PPE, disposed consumables, soiled outer dressings. The waste status is **NON-HAZARDOUS.** EWC Code 18-01-04.
    b. *Mixed municipal waste* – Non sensitive paperwork, packaging materials. The waste status is **NON-HAZARDOUS.** EWC Code 20-03-01.

13. Healthcare offensive waste is to be stored it the nominated secure location in the correctly nominated receptacle, protected from the elements.

14. A contractor is employed to collect and dispose of stored healthcare offensive waste. Every collection is to have a waste transfer note that is stored for a minimum of 2 years.

MANAGEMENT OF INFECTION

15. Some groups of service user are more prone to infection than others. When delivering care to these sub-groups (immunocompromised, diabetic, systemic steroid use / DMARDS, elderly etc) the clinician is consider this risk and employ appropriate mitigation and extra advice to the service user. Where the risk of infection is too high, not providing therapy may be the correct decision.

16. Re-acidification (Acetic acid spray) can restore some of the ears natural resistance to infection and is a useful tool in reducing infection likelihood post irrigation, especially in the suspectable population.

17. Irrigation for a client that is clearly already suffering from *otitis externa* is NOT to be performed. The process will leave them susceptible to worsening of their infection and not provide relief. The only exception to this is if the causative organism is of a fungal nature. Irrigation in this instance will be beneficial.

18. Microsuction for service users presenting with a diagnosed *otitis externa,* especially chronic is beneficial. Suctioning away of the debris and puss breaks down the biofilm so their antibiotic drops can have their intended effect without obstruction.

19. Simple and clear advice should always be given to the service user of what to do if after consultation they begin to experience the signs and symptoms of infection, in a manor that meets the *Accessible information standard.*

20. Where a service user may benefit from antimicrobial use, they are to be directed to their GP for assessment, with a referral letter summarising their therapy, to enable diagnosis and treatment.

REVIEW

21. This policy is to be reviewed annually as per the date in the header. It may be appropriate to review sooner if there is significant change in regulation.

AUTHORITY

22. This policy was written today the *23rd July 2024* and is enacted with immediate effect. All directors and employees of Exe Ear Care are to follow the guidance and direction within.

R. J. Toon
CEO.