



Infection Prevention and Control Policy

Re-Pat Ltd

Infection Prevention and Control Policy

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Date Policy Completed	January 2025
Previous Review Dates	1/26
Review Date	January 2027 (or when updates are required)
Applicable to	All staff and contractors
Policy Signed By	RICHARD DRAKEFORD

1.Scope

1.1 The Infection Prevention and Control Policy has been developed, as part of Re-Pat Ltd's ongoing commitment to promoting optimal standards of Infection Prevention and Control (IPC) within the organisation.

1.2 Prevention and control of infections are essential cornerstones of ensuring patient and staff safety in care settings.

1.3 This policy encompasses evidence based best practice and has been specifically designed to support staff in minimising the risks associated with the control of infection. It must be emphasised that every member of staff has a responsibility to reduce IPC risks.

1.4 The subject of IPC is broad and complex. This policy is supported by guidance and legislation in-line with the Health and Social Care Act, World Health Organisation guidelines, Department of Health documents, Public Health England recommendations, National Reporting and Learning System guidance and the National Institute for Care Excellence recommendations.

1.5 This policy provides Standard IPC Precautions as the template for its structured format. It is designed to deliver relevant information and guidance to enable staff to follow and understand the underlying principles of IPC.

2. Responsibilities

2.1 All staff have a responsibility to protect themselves, as well as making all reasonable efforts to safeguard the welfare of their patients and all other persons encountered in their daily duties. Adherence to the guidance and procedures within the IPC policy will significantly assist staff in achieving this goal.

2.1.2 All accidents, incidents or risks must be reported immediately and fully documented using the company's incident reporting systems (please refer to the **Accident and Incident Policy** for further guidance).

The Registered Manager has overall accountability for ensuring that Re-Pat Ltd maintains adequate and appropriate controls and procedures to minimise the risks of infection to patients, members of

the public and staff in accordance with the Health and Social Care Act 2008.

The Registered Manager is responsible for the provision, application and monitoring of IPC measures that fall within their area of responsibility.

They are responsible for the following:

- Following all IPC processes within the service, including contact with clients, vehicles, stores and procurement, waste management and cleaning schedules
- Ensuring that staff follow effective IPC processes during all face-to-face client interactions
- Ensuring that all staff are competent in applying IPC procedures relevant to their job role
- Carrying out thorough investigations of IPC related incidents including root cause analysis and learning outcomes.

Infection Control Lead

The **Registered Manager** is also the Infection Control Lead and is responsible for defining the IPC strategy of the service, ensuring patient safety and maintaining quality of care. The Infection Control Lead will be able to deputise areas of their role (where appropriate) to ensure the delivery of safe, evidence-based IPC practices, based on current legislation and guidance.

The Infection Control Lead is responsible for:

- Identifying priorities for the delivery of safe, evidence-based infection control practice based on current legislation and guidance.
- Acting as an ambassador and expert for all aspects of IPC as appropriate. This may include liaising with the Department of Health, National Reporting and Learning System, Public Health England, NHS services, Environmental Health Services, Clinical Commissioning Groups, Social Services and other parties encouraging collaborative working to improve service performance.
- Reporting to the Company Director any serious IPC concerns or incidents which require escalation.

Company Director/Nominated Individual

The Company Director/Nominated Individual will be responsible for maintaining oversight and monitoring IPC processes, protocols and policies and will provide leadership and supervision to ensure compliance.

They are also responsible for providing leadership and promoting responsible attitudes and practices towards IPC.

All Staff

All staff will ensure that they perform their duties in a manner that maintains and promotes the principles and practice of IPC in compliance with national standards, Re-Pat Ltd internal processes, guidelines, procedures in accordance with this policy.

3. Basic Microbiology

Microorganisms

The term microorganism, or microbe, is used to describe any organism which is too small to be seen with the naked eye.

Many microorganisms live independently of humans and those that are dependent exist in a host-organism relationship that is generally harmless and may even be mutually beneficial.

Microorganisms perform many useful functions in the ecological chain, being responsible for the breakdown of dead matter from plants and animals. They are also used in the production of beer, wine, yoghurt, cheese, and bread.

Microorganisms capable of causing disease are referred to as pathogenic organisms. These include viruses, bacteria, fungi, protozoa and Prions. Infection is a pathological process which involves the damaging of body tissues by pathogens, or by the toxic substances produced by these pathogens.

They generally thrive and multiply in darkness, warmth and moisture, and infection is usually accompanied by signs and symptoms in the localised area of the patient, e.g. pain, swelling and/or fever.

Pathogenic microorganisms may be classified as follows:

Viruses are different to other organisms in that they consist of a core of one type of nucleic acid, either deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) surrounded by a protein shell called a capsid. The purpose of the capsid is to protect the virus and to help it to attach to the target host cell. When inside the human cell, the virus takes over the nuclear control of the cell and alters the cellular metabolism so that it makes new virions.

Viruses are usually fragile and do not survive for long outside a living cell, like rhinoviruses, that can survive for short periods and are responsible for colds, more commonly spreading on hands and by direct contact than through the air by coughs and sneezes. Viruses are smaller than bacteria and not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

Bacteria are usually unicellular organisms, with a typical cell being able to carry out many different metabolic activities to increase in size and reproduce. A single bacterium can convert itself overnight into a colony with a population of millions.

Some bacteria form spores when environmental conditions are not suitable and can survive for a long time in the environment. *Clostridium difficile* is one example, which is responsible for antibiotic-associated infections. Bacteria are susceptible to a greater or lesser extent to anti-biotics, but through the mechanism of changing their genetic composition, drug resistance can occur.

Fungi (Pathogenic) are plants that lack the green pigment, chlorophyll that plants use for photosynthesis. Depending on how they grow, fungi are described as mould or yeasts. Fungal diseases are referred to as mycoses and are divided into those that affect the skin, such as ringworm, athlete's foot, and deep infections that affect the whole body causing systemic infections, such as aspergillus. A common yeast infection is thrush, caused by an organism called Candida Albicans.

Prions are infectious agents, smaller than viruses. Unlike other pathogens, prions contain no DNA or RNA. Their only known component is a protein with an abnormal constituent protein in the brain. Thought of as being the cause of the transient spongiform encephalopathies (TSE), for which there is no evidence of a conventional infectious agent, they are thought to be found in the central nervous system (CNS) and in other tissues such as the lymph glands and tonsils.

A new type of prion is thought to have evolved to cause bovine spongiform encephalopathy (BSE) in cattle and resulting in variant Creutzfeldt-Jakob disease (vCJD) in humans. Prion disease is a fatal, infectious, neurodegenerative disorders with no known immunisation or treatment.

Worms are not always microscopic in size but are larger than bacteria. Pathogenic worms do cause infection, and some spread from person to person. Examples include threadworm, tapeworm, hookworms and roundworms. Prevention often relies upon personal hygiene, clean water supplies, quality of food and adequate cooking.

Protozoa are microscopic single-celled microorganisms, larger and more complex than bacteria and some can be pathogenic. Protozoa include paramecium and amoebae, which can be pathogenic. They have a tough outer cell membrane instead of a cell wall and ingest solid particles of food to obtain nutrients. They are the lowest form of animal life and have lifecycles involving only the functions of movement, nutrition, excretion, respiration and reproduction.

Examples of medical importance include Giardia Lamblia, which cause enteritis, and the malaria parasite. Protozoa, like malaria, have lifecycles that include sexual and asexual phases.

4. Spread of Infection

Direct Contact occurs when one person infects the next person, i.e. via the skin, mucous membranes, or personal contact with contaminated body secretions/excretions. Sexually transmitted diseases are also of this mode of spread. Physical contact with an infected site, such as contact with discharge from wounds or skin lesions e.g. shingles, impetigo.

Indirect Contact occurs when an intermediate carrier is involved in the spread of pathogenic microbes from the source of infection to another person. Examples includes aerosols, fomites, hands, ingestion, inoculation, and vectors:

Aerosols

Droplet spread of infection produced by sneezing and coughing can be spread through the air and infect others by inhalation e.g. chicken pox, measles and mumps. The common cold and influenza are often cited as examples but are more likely spread by hands. Dispersal of skin scales may be associated with the transfer of potentially harmful microbes, but may not be via droplet infection, e.g. it could also be contamination of adjoining surfaces and equipment.

Fomites

Defined as any object which becomes contaminated with organisms from a patient or member of staff which can potentially transmit them to another person e.g. aspirators, splints, resuscitation equipment, linen or practically any inanimate object. The object could be used directly on another patient or could contaminate the hands of healthcare workers.

Hands

Organisms require a mode of transport, and hands are known to be the main source of cross infection and contamination. The hands of patients can also be effective in carrying microbes to other body sites and equipment. Bacterial contamination without apparent soiling of the hands has been shown during contact with patients. Dirty activities such as dealing with body secretion/excretions result in much heavier contamination of the hands, even when gloves are worn.

Ingestion

Infection by ingestion can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are defaecated by infected person, faecal-oral spread may occur. Organisms can be carried by fomites or hands, or in food and drink, e.g. Hepatitis A, Campylobacter, and Salmonella are some of the pathogens passed on by poor hygiene practices.

Inoculation

Infection can occur following a sharps injury, when blood contaminated with a Blood Borne Virus (BBV) is inoculated into the blood stream or where there has been blood or body fluid splash to broken areas of skin or exposed mucous membranes.

Bites

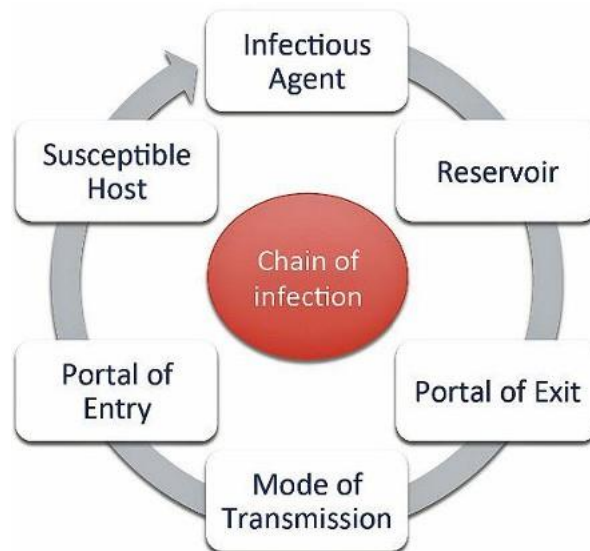
Human bites can cause infection and rabies can be spread from infected animal bites.

Vectors

Animals or insects that passively transmit pathogenic microbes. In the UK, the common house fly is the most prevalent. Exotic species, such as iguana or snakes are a problem with transmitting salmonella to people who come into contact with the animal's skin. Reptiles may also excrete potentially harmful microbes. There is a risk of infection if a person is in contact with faeces and then does not wash their hands. Further examples include mosquitos and malaria, tick bites and Leptospirosis from rats.

5.Chain of Infection

This refers to the process by which infection spreads from one susceptible host to another and is a continuous chain (see diagram below). Each link must be present for infection or colonisation to proceed and breaking any of the links can prevent the infection.



The infectious agent can be a primary pathogen, or a commensal, given the right opportunity. To break the chain of infection, we must destroy or render harmless the causative organisms. In the ambulance setting, many IPC measures aim at removing this link, e.g. effective hand hygiene, the use of disposable equipment, good personal hygiene and maintaining effective decontamination procedures.

Reservoir

The places where the organism causing the infection can be found.

This can include:

- Patients
- Staff
- Equipment
- The environment
- Animals/insects
- Food/water

The role and responsibility of care providers in minimising risks to both patients and staff is crucial to the process of risk reduction. Hazards are associated with IPC practices as well as exposure to microorganisms within care settings.

Staff must always be aware of the level of risk when undertaking their day-to-day practice, especially being aware of potential disease-producing microorganisms present in blood, body fluids, secretions and excretions of seemingly healthy and undiagnosed person. The best accepted advice is that standard universal IPC precautions should be followed.

Ambulance transport environments and equipment can become contaminated with chemical residue, debris, dust, organic matter and potentially infectious organisms. A safe environment can be achieved by removing or destroying contamination and thereby preventing microorganisms or other contaminants reaching a susceptible site in enough quantities to initiate infection.

Animals, like humans, can be host for a wide variety of organisms that are potential pathogens (Zoonoses) for people and other animals. Zoonoses can be transmitted from animals to humans either directly or indirectly by bites, scratches, ectoparasites, accidental ingestion via contact with contaminated soil, food, water or unpasteurised milk.

Portals of Exit and Entry

The routes by which a pathogen leaves its host and enters another. Interventions such as insertion of invasive devices such as urinary catheters and intravenous lines etc. can provide portals of exit and entry.

The main portals of entry are:

- **The respiratory tract** – through inhalation of organisms. (e.g. respiratory tuberculosis, chicken pox, mumps and diphtheria).
- **The alimentary tract** – through ingestion of contaminated food or water (e.g. salmonellosis and dysentery).
- **The skin and mucosa** – either by the passage of organisms through damaged skin, as with infected wounds, or by the inoculation of organisms (e.g. Hepatitis B, Hepatitis C transferred via contaminated needles).
- **The placenta** – via transfer of organisms from maternal circulation to foetal circulation (e.g. HIV, rubella, cytomegalovirus and syphilis).

There are several routes by which infectious agents can leave their host. The exit route may be the same as that of entry, e.g. the respiratory tract in tuberculosis, or salmonella infections, where the route of entry is usually via the mouth and the exit route is through faeces.

Susceptible Host

For an infection to occur once an organism has reached its target, the host must be susceptible. The competence of the body's innate and acquired defence mechanisms will affect whether illness occurs, and the chain of infection may be broken at this point. In infectious diseases, the outcome can depend as much, if not more, on the susceptibility of the person as on factors relating to the microorganism itself.

Some people are at an increased risk of infection:

- Very young children and the elderly
- People who are immunocompromised
- People suffering from chronic illness, e.g. sickle cell anaemia, rheumatoid arthritis or Diabetes
- Receiving certain medications e.g. steroids or cytotoxic medication for cancer or connective tissue disease
- Any person with a break in the body's defences e.g. surgical wounds, skin lesions, indwelling devices such as intravenous lines or catheters

Host Defence Mechanisms

Non-specific defence mechanisms are natural barriers which protect against invasion by pathogens.

The main barriers are:

- The skin - a physical barrier that stops pathogens
- Sebaceous and sweat glands - produce chemicals that kill bacteria
- Lysozyme - found in saliva and the tear glands
- Mucous membranes - these secrete mucus which lines many body parts, traps pathogens and prevents them from entering the body
- Nasal hairs - remove suspended micro-organisms from the air
- Cilia - small hairs which force mucus to the pharynx for swallowing to the stomach. Coughing helps in this process
- Hydrochloric acid - found in the stomach and kills microorganisms.

6. Rationale for Standard IPC Precautions

The aim is to embed effective IPC processes into everyday practice, which are applied consistently by staff.

There are three high risk areas for the transfer of infection to patients:

- Direct or indirect transfer
- Direct contact transmission involves skin-to-skin contact and physical transfer of microbes from an infected or colonised patient to susceptible host. Direct contact may also occur between patients by means of healthcare workers' hands. Indirect contact transmission occurs when there is exposure to a contaminated object (fomite) such as a blanket, splint or stretcher by a susceptible host.
- Invasive devices e.g. I.V cannulas and urinary catheters.

In addition, exposure to a patient's blood or body fluids by ambulance staff puts them at risk from blood borne viral (BBV) infections. The most likely means of transmission of these viruses to ambulance staff is by accidental inoculation incidents such as sharps injury, bites or by blood splashing onto broken skin or mucous membranes.

Body fluids which could possibly contain bacterial and/or viral pathogens are:

- Faeces
- Urine
- Vomit
- Sputum

The following may also contain the organisms of HIV or Hepatitis B/C:

- Blood
- Blood-stained body fluids
- Body tissues
- CSF, amniotic, pericardial, pleural fluids etc.
- Exudate or other tissue fluid from burns or skin lesions

6.1.1 Most blood/body fluid exposures in care settings are preventable. Standard infection prevention and control precautions are a simple set of effective practices designed to protect staff and patients from infection. As it is not always feasible to identify those infected with bacterial and/or viral pathogens and take precautions only with them, use these practices when caring for all

patients.

6.1.2 All blood and body fluids are potentially infectious and standard IPC precautions are necessary to prevent exposure to them. Decisions regarding the level of precautions to use should be proportionate to the possible risk based on the nature of the procedure to be undertaken, and not on the actual or assumed infection status of the patient.

6.1.3 Staff should cover any breaks in the skin, cuts or abrasions with a latex free waterproof dressing as these can provide an entry for pathogenic organisms.

Infection risk assessment

Re-Pat Ltd will regularly risk assess patients and staff members and their risk of acquiring an infection and provide them with the information required to ensure their safety.

Where staff are aware that they will be supporting patients with suspected or diagnosed COVID-19 or any other new emerging infections, staff should refer to national infection prevention and control guidance for advice on the PPE to be worn and the risk assessment process to follow.

The process of risk assessment will contribute to planning and will determine whether any extra IPC precautions are required when transporting the patient, such as whether staff need to wear additional personal protective equipment (PPE).

The assessment will include all factors which place the patient at a higher risk of acquiring or spreading an infection and may include:

Symptoms:

- history of current diarrhoea or vomiting
- unexplained rash
- fever or temperature
- respiratory symptoms, such as coughing or sneezing

Contact:

- previous infection with a multi-drug resistant pathogen (where known)
- recent travel outside the UK where there are known risks of infection
- contact with people with a known infection

Clinical risk factors:

- vaccination status which will assist assessment of their susceptibility to infection and allow protective actions to be taken when necessary
- wounds or breaks in the skin
- invasive devices such as urinary catheters
- conditions or medicines that weaken the immune system

Environmental risk factors, such as poor ventilation

7. Personal Hygiene

One of the key principles of operating effective standard IPC precautions is the need for every staff member to practice good standards of personal hygiene.

It is essential that a high standard of personal hygiene and appearance is maintained by all staff. Patients and the public expect staff to have a neat and clean appearance, this in the first instance involves close and constant attention to personal hygiene standards, which if maintained will help minimise the risk from cross-infection.

8. Hand Hygiene

Hands are the most common way in which microorganisms, particularly bacteria and viruses, are transported and subsequently cause infection, especially to those who are most susceptible to infection. In order to prevent the spread of microorganisms to those who might develop serious infections through this route while receiving care, adequate hand hygiene must be performed. This is the single most important practice in reducing the transmission of infectious agents, including HCAs, during delivery of care.

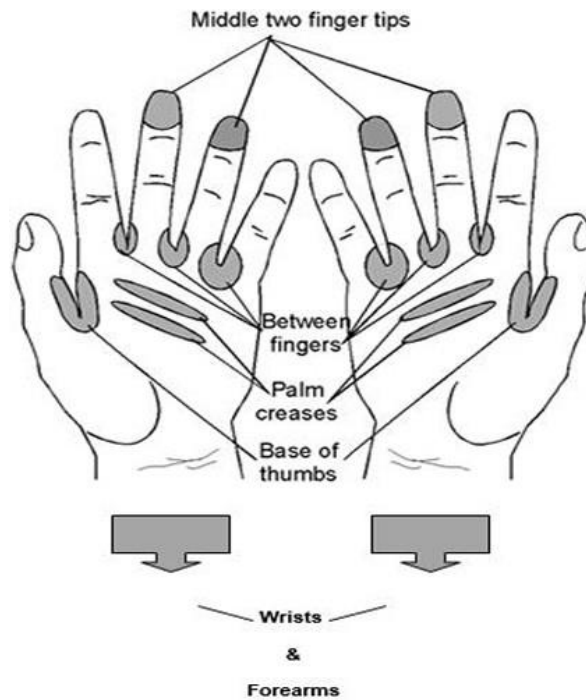
The hand hygiene procedure being undertaken should consider the potential/actual hazards that have or might be encountered, the subsequent potential/actual contamination of hands, and any risks that may present as a result.

Healthy, intact skin provides an effective barrier against infection. Therefore, it is essential that all cuts, abrasions, open lesions etc. are covered with a waterproof dressing. Any member of staff who becomes affected with skin conditions such as extensive skin lesions, dermatitis or psoriasis must seek medical advice from their GP and may need to be removed from direct duties until the current condition resolves.

Over-wearing of gloves can cause irritation or sensitivity, leading to dermatitis or allergic reactions. This can be minimised by early intervention by contacting a medical professional for advice.

It cannot be over emphasised that regular hand hygiene is one of the most crucial interventions in the prevention of cross-infection in care settings.

The diagram below shows the areas of skin that are commonly missed during poor hand hygiene.



Reducing the possibility of poor hand hygiene:

- Correct PPE and IPC processes are to be adopted by all staff in the course of their duties
- Ensure fingernails are clean and short, with no artificial nails or nail products
- Wearing one plain band only (wedding ring style), with no stones, ridges or grooves
- Watches are not to be worn on the wrist. Bracelets or bands are not permitted unless they are the approved “medic-alert” type or are worn for medical or cultural reasons. These should be removed prior to performing hand hygiene practices.

Hand Care

To protect the skin on hands from drying and cracking, where bacteria may thrive, and to protect broken areas from becoming contaminated particularly when exposed to blood and body fluids, follow these instructions:

- Cover all cuts and abrasions with a latex free waterproof dressing.
- Where skin lesions, cuts or grazes cannot be adequately covered, staff should contact Occupational Health or their GP for further advice and guidance
- Hand creams should be applied regularly to care for the skin. Only individual tubes of hand cream should be used or hand cream from wall mounted dispensers
- Creams used should not affect the action of hand cleaning solutions being used or the integrity of gloves
- Antibacterial soaps, perfumed soaps, or other solutions might cause skin problems for some staff members if used frequently
- Staff should report any continuing skin problems to the Registered Manager or their GP for further advice and/or treatment.

When to Perform Hand Hygiene

In order to maintain effective IPC processes and daily routines, the ‘Three Rs of Hand Hygiene’ should be followed.

The 'Three Rs' procedure aims to prevent infections moving between the community and from different environments.



REMOVE

Decontaminate hands immediately before patient contact. This moment is equally important to everyone who works in healthcare. Germs are on everyone's hands regardless of what our job is. If you are going to be in contact with a patient for any reason, for example to help them stand up or sit down, or to help them to move from an area, you must clean your hands to stop any germs that are on your hands moving onto the patient.

REDUCE the risk of introducing infection by thoroughly washing hands immediately before and after all patient interactions.

RE-CLEANING of hands when leaving the patient or their surroundings to remove any pathogens or microorganisms staff may have acquired. This will reduce cross-contamination and protect patients, yourself and your colleagues. Gloves do not replace the need for hand hygiene.

9. Personal Protective Equipment (PPE)

9.1. The Control of Substances Hazardous to Health (COSHH) Regulations 2002 (as amended in 2004) requires employers to undertake their own risk assessment, and to bring into effect measures necessary to protect workers and others who may be exposed, as far as is reasonably practicable.

9.2. For the purposes of this policy, Personal Protective Equipment (PPE) is defined as being all equipment that is intended to be worn or held by a person at work, which protects them against the transmission of micro-organisms. Re-Pat Ltd refers to this type of PPE as Infection Prevention Kit (IP Kit).

9.3. Employees have a responsibility to wear IP Kit when there is a risk of exposure to pathogens. Staff should only wear IP Kit that has been provided by the company.

9.4. Re-Pat Ltd is responsible for ensuring the IP Kit is:

- properly assessed before use to ensure it is suitable

- maintained and stored properly away from potential contamination
- staff are provided with instructions on how to use it safely.

9.5. The selection of the IP Kit must be based on an assessment of the risk of transmission of micro-organisms to the patient or to the staff member, and the risk of contamination of the staff members' clothing and skin by patient's blood/body fluids, secretions or excretions.

9.6. The IP Kit should consist of the following:

- disposable medical gloves
- disposable plastic aprons
- disposable plastic overshoes
- disposable fluid repellent suits including boots
- disposable surgical face masks
- disposable FFP3 mask
- appropriate eye protection.

9.8 The choice of protective equipment selected depends on the anticipated risk of exposure to body fluid during the activity. Many general activities involve no direct contact with blood or body fluid and do not require the use of protective clothing, including gloves.

9.9 Staff must use their judgement in determining the likely requirements in each case using the following flowchart:



10. Gloves

The use of gloves as a method of barrier protection reduces the risk of contamination but does not eliminate this entirely.

It is recommended that staff should only wear gloves for two main reasons:

- To prevent pathogenic organisms from being transmitted to patients and from one patient to another by the staff members' hands.
- To reduce the risk of the staff member themselves acquiring an infection through contact with blood/body fluids, non-intact skin or mucous membranes.

Staff should familiarise themselves with the sizes available. Their choice in selecting the most appropriate size should be based on a comfortable fit that is not too tight to become restrictive, but equally not too loose as to compromise grip and/or increase the risk of puncture.

Provided gloves are correctly used, they can perform the following functions:

- Provide a protective barrier and prevent gross contamination of the hands when in contact with blood and body fluids, secretions, excreta, mucous membranes and non-intact skin.
- Reduce the likelihood that organisms from the hands of personnel will be transmitted to patients during invasive or other patient care procedures that involve touching mucous membranes and non-intact skin.
- Reduce the likelihood that hands of personnel contaminated with organisms from a patient or fomite can transmit these organisms to another patient.
- Protect the skin against certain hazardous substances, e.g. cleaning chemicals, petrol, diesel, oil.
- Staff should be aware that the inappropriate or overuse of gloves can be a hazard and has been associated with cross infection/contamination.
- The unnecessary wearing of gloves may also result in missed opportunities for hand hygiene and increase the risks for cross contamination.
- Defects in gloves may be present and hands could be potentially contaminated during their removal. Therefore, it is important that hands should always be decontaminated after using gloves.
- The use of gloves should never be viewed as a substitute for appropriate hand washing.

Key Information for Glove Use

- Gloves are effective in reducing the contamination of hands and help limit possible transmission of pathogens
- Gloves do not provide complete protection against hand contamination
- Staff should remember that failing to remove gloves may contribute to the transmission of organisms
- Staff should plan the sequence of procedures in a rational manner which limits the use of gloves and to use non-touch techniques as much as possible during care. The emphasis should be on minimising the need for glove use and more on using alcohol hand rub and soap and water
- Use of petroleum-based hand lotions or creams may adversely affect the integrity of latex gloves
- At no time must gloves be washed or alcohol gel applied to save changing or removing gloves.

Recommendations on Glove Use

- The use of gloves does not replace the need for hand cleansing by either alcohol hand rub or hand washing with soap and water
- Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, or other non-intact skin will occur
- Remove gloves immediately after completing a patient procedure or task

- Staff should not wear the same pair of gloves to support more than one patient.

When wearing gloves, staff should change or remove gloves in the following situations:

- During patient care if moving from contaminated body site to a clean body site on the same patient
- After touching a patient, before moving onto other tasks
- After touching a contaminated site and before touching a clean site or the environment.

Note: Emergency treatment should never be withheld in the absence of wearing gloves, however, ensure hands are thoroughly washed at the earliest opportunity.

Note: Any member of staff who develops a skin irritation on their hands should complete a Re-Pat Ltd Incident Reporting Form in addition to seeking advice from the Registered Manager.

Glove Donning Technique

There is no specific technique for use of non-sterile gloves. Staff should pull-on gloves on in a convenient manner, interlock fingers after the gloves are in place to ensure a comfortable fit and free movement.

Recommended Glove Removal Technique

- Grasp the palm of the first glove just below the wrist
- Roll the glove towards the fingertips so that it turns inside out
- Hold the removed glove by the fingertips of the remaining gloved hand
- Place two fingers of the bare hand inside the cuff of the remaining glove
- Roll the second glove towards the fingertips with the bare hand until the first glove is inside the second glove
- Continue to remove until both gloves are inside out
- Dispose of used glove into a clinical waste bag
- Decontaminate hands using alcohol hand rub or wash and dry hands thoroughly.

Note: It is the outside of the glove which is in contact with potentially infected material, and the possibility of exposure to unprotected skin is at its greatest when the gloves are removed.

Aprons

Single use disposable plastic aprons are recommended for general use and should be worn when there is a risk that clothing, or uniforms may become exposed to blood/body fluids, secretions and excretions or other organic substances. Plastic aprons should only be worn as a single use item for one procedure or episode of patient care.

The front of the body is the part most frequently contaminated, therefore, single-use plastic aprons are deemed to provide adequate protection for staff in most instances. Plastic aprons should also be worn during any cleaning activity or on any occasion where the front of the uniform is at risk of being soiled.

Aprons should be removed immediately after use by:

- Tearing the neck strap first and then the waist ties
- Folding/rolling into a ball, only touching the inside of the apron, and discard as clinical waste.
- Hand hygiene must be performed immediately after disposing of the apron.

11. Face Masks

In order to minimise the possibility of cross contamination, under Standard Infection Prevention and Control Precautions, disposable masks may be necessary as an additional precaution.

The use of disposable face masks is not required routinely, as they would normally only be worn for illnesses caused by more hazardous organisms. However, they should be worn if there is a risk of blood or body fluid being splashed into the mouth, or if the patient has been diagnosed with a respiratory infection or virus.

In this situation, the patient should also be encouraged to wear a face mask to help to contain the spread of any infection. These can be found in the IP Kit.

If undertaking CPR, staff should wear a disposable facemask and eye protection, particularly for confirmed or suspected cases including (but not limited to):

- Respiratory Infections
- Influenza
- Sepsis
- Meningitis
- Pulmonary Tuberculosis

Mask removal and disposal:

- Remove away from the face, and place into clinical waste.
- Disposable face masks are for single use only.

High efficiency masks or respirators

High efficiency masks or respirators with filtering efficiency of the European Standard CEN P2/FFP2 or FFP3 are recommended when supporting patients suspected to be suffering from Severe Acute Respiratory Syndrome (SARS), Covid-19 or during a pandemic flu outbreak. Use of high efficiency masks requires specific training and fit testing under COSHH regulations 2002.

Disposable high efficiency masks or respirators must not be touched unnecessarily and must be discarded when wet. They must not be pulled up and down to keep away from the face but renewed after each episode of use. They are a single use item and must be disposed of as clinical waste.

Disposable Safety Eyewear

Safety eyewear must be worn on any occasion where there is a risk of blood or body fluids slashing into the eyes, or when similar risks arise from activities such as vehicle or equipment cleaning.

Eyewear can be cleaned with universal wipes or soap and water unless heavily contaminated. In this case they should be disposed of into clinical waste.

12. Sharps Management and Safe Disposal

Employer Responsibilities

Section 2 of the Health and Safety at Work Act (1974) states, 'It shall be the duty of every employer to ensure, so far as reasonably practicable, the health, safety and welfare at work of all employees'.

The employer is required to provide appropriate information and instruction, together with appropriate safety equipment, training and supervision to ensure their employees are protected at work.

In healthcare settings, all employers should provide a safe working environment in which safe equipment is available and where staff are appropriately trained in the hazards posed by handling sharps and body fluids.

Employee Responsibilities

Employees have duties under sections 7 and 8 of the Health and Safety at Work Act (1974) and Reg.14 of the Management of Health and Safety at Work regulations (1999).

Employees must comply with any safety policies or procedures put in place to protect their health. Employees must also protect their own health and safety by using any protective clothing issued to them. Employees also have a duty to ensure that their actions do not harm the health and safety of others.

Staff should also be aware of and pay extra attention to their safety when working on a task which involves, or involved prior to their attendance, the use of a sharp. Examples of this could be where a medical professional who has used a sharp and may not have taken the correct and safe action to dispose of it. Proceed with caution until you are sure the sharp has been disposed of appropriately.

General

The safe handling of sharps is a critical factor in the successful control of infection. Inoculation injuries arising from exposure to contaminated sharps represent a recognised route of infection spread, and subsequent risk to staff. It is therefore imperative that all staff adhere closely to the following precautions and procedures in order to minimise the risks associated with the use of sharps.

The term 'sharps' applies to a wide range of individual ambulance and hospital equipment. However, these may be more broadly classified as:

- Needles
- Lancets
- Syringes with an integral needle
- Cannulas
- Drug ampoules/containers
- Razors
- Scalpels/blades

- Bone fragments (including teeth)
- Single use laryngoscope blades, Magill forceps and spikes from giving sets (which can tear through a clinical waste bag).

All sharps are for single patient use only and must always be correctly stored in their original packaging and in their designated containers and/or storage compartment in the vehicle or r

Re-Pat Ltd provides several sizes of sharps containers, both for cupboard use in an ambulance, and smaller variations for insertion in the Response Bag.

It is important that staff should only replace sharps containers approved and supplied by Re-Pat Ltd.

Staff should not use sharps containers for any other purpose other than for the disposal of sharps i.e. pen holders and small equipment storage. This poor practice can lead to needlestick injuries due to misinterpreting the use of containers.

Staff should familiarise themselves with the assembly instructions and locking devices on each of the sharps containers provided by the company.

The start date should be entered on each container as soon as it is put into use, together with its point of origin, i.e. vehicle number and/or bag number.

All used needles and sharps must be disposed of immediately after use and placed directly into a sharps container by the person who has used the item. It is vital that sharps are never disposed of into waste bins, plastic bags, blankets or anywhere other than in a recognised sharps container.

The use of safety devices such as safety cannula and safety lancets does not alter the need to safely dispose of used sharps.

The company's reporting procedures must be used for any near miss incidents such as needles incorrectly disposed of.

Paper or plastic packaging must not be placed into sharps containers, as this reduces their capacity. However, should removal of the packaging present any risk of subsequent injury, then the packaging and the sharps should be disposed of together.

Needles and syringes must always be disposed of as one unit. Staff should never attempt to re-sheath or separate a needle from its syringe.

Sharps containers should be changed when it becomes two thirds full (up to the black full line), or when the sharps will no longer drop cleanly through the flap. This must take place as soon as practicable, after either of these events has occurred.

Under no circumstances should items be forced through the opening. Fingers must always be kept out of the container.

Staff must never attempt to transfer the contents from one container to another, e.g. from a small to a large sharps box.

Sharps containers must be sealed with the date of locking and by whom. They should be routinely

collected of on a two-monthly basis, even if the two thirds mark has not been reached.

Used sharps containers which become damaged must be placed into a larger secure container with the outer compartment appropriately labelled.

The openings of sharps boxes must be closed and secured, prior to placing in the clinical waste bin on station. Sharps boxes must never be placed into a clinical waste bag.

Incidents where adequate and appropriate measures have not been taken to dispose of sharps, thereby putting others at risk of injury, must be regarded as adverse incidents and reported using the company's incident reporting procedures.

13. Accidental Inoculation Injuries

According to Standard Infection Control precautions, all blood and body fluids must be regarded as infectious. Therefore, any exposure should be viewed as a potential hazard to staff. It is therefore imperative that any accidental inoculation incident that involves contact with blood or body fluids is treated with the utmost care, and with close attention to the following procedure.

Incidents involving risk of blood-borne infection may include:

- Needle stick or other sharp injury
- Contamination of broken skin with blood/body fluids
- Contamination of broken skin with blood/body fluid-soaked clothing or linen
- Blood/body fluid splashes to mucous membranes, e.g. eyes or mouth
- Oral contact with a person's blood, vomit or mucous, e.g. after performing direct mouth-to-mouth resuscitation; and
- Human/animal bites or scratches (where the skin is broken).

Post Exposure Action (see Appendix for further details)

The following course of action must be taken if any of the above incidents occur:

- Ensure the sharp, if present, is disposed of safely into a sharps container
- Encourage bleeding from the wound, but do not suck
- Wash the site immediately with soap and water or apply alcohol disinfectant for five minutes if unable to access conventional hand washing facilities
- For both methods, do not scrub the area as you may make the wound larger by breaking down the edges
- Wash the wound thoroughly with soap and water at the earliest opportunity, and cover with an impermeable waterproof dressing
- Treat blood or body fluid splashes to the eyes with ample irrigation of water or saline
- Splashes to the mouth should be washed with copious amounts of water. Wash the face thoroughly with soap and water
- Arrange immediate attendance at the nearest A&E department. The hospital will require details of how the incident occurred, as well as all information relating to the source patient
- The potential exists for staff to sustain sharps or splash injuries when either the source of the contamination is not known, or when the patient involved refuses to travel. In each of these cases, it is still essential that the staff member reports immediately to their nearest A&E department, for the degree of risk to be assessed.

Further actions

It is likely that blood samples will be sought from the member of staff, as well as the source patient if present, though the patient has the right to refuse. The source patient should be provided with appropriate information about the implications of these tests and appropriate time to consider and discuss them.

Information relating to the member's Hepatitis B, and Tetanus immunisation status would also be helpful in this situation, so staff should maintain a current awareness of their vaccination record.

On completion of the risk assessment, the assessing practitioner may offer a course of prophylactic treatment. This will be fully discussed with the individual member of staff and may be commenced before all investigations have been completed.

Prophylactic treatment may be halted before completion if tests later come back to show there was no risk.

Reporting Procedure

Staff must complete an untoward incident report form as soon as possible. The Registered Manager should ensure the injured person receives the appropriate and immediate assistance from their GP and/or A&E Department and that all relevant details are documented.

The affected staff member should be offered psychological support and/or counselling. The Registered Manager should encourage the staff member to access support via their GP in the first instance.

When is Post Exposure Prophylaxis (PEP) considered?

PEP should only be considered when there has been exposure to blood or other high-risk body fluids known to be or strongly suspected to be infected with HIV.

Strongly suspected includes individuals with clinical symptoms highly suggestive of HIV disease or individuals from countries where HIV is highly prevalent who may not yet have had a blood test.

Strongly suspected does not include an injury from an unknown source e.g. an inappropriately discarded needle in the healthcare setting or in a public place, nor an individual with a single life-style factor e.g. IV drug abuser.

PEP should not be considered following contact through any route with low-risk materials e.g. urine, vomit, saliva, faeces, unless they are visibly blood stained.

If PEP is indicated, it should be commenced as soon as possible after the incident, ideally within one hour of the exposure incident. The Department of Health recommends considering PEP even if one to two weeks have elapsed since the incident.

Ongoing advice regarding return to work can be obtained from Occupational Health or the individuals' GP.

All injuries involving exposures to HIV and Hepatitis B must be reported to the Health & Safety Executive under the Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR)

Regulations (1995).

Public Health England recommendations:

- Blood samples should be taken from the affected staff member
- Initial baseline blood sample on first attendance (for archiving by Virology Department)
- At six months, the staff member may wish to be tested for one or more of the three BBVs
- If the source is known or highly suspected to be a BBV carrier then testing can be offered at six weeks, three months and six months thereafter.
- Where there is evidence of an acute infection, the staff member should be referred for specialist management e.g. possible combination therapy for HCV.
- If the source patient has not been tested and the risk is assessed as significant, testing should take place as follows:

Time	Hepatitis C	Hepatitis B	HIV
10ml clotted sample for archiving at time of incident			
6 Weeks	PCR	Surface Antigen	Antigen/Antibody combined test
3 Months	PCR & Antibody	Surface Antigen	Antigen/Antibody combined test
6 Months	Antibody	Surface Antigen Surface Antibody	Antigen/Antibody combined test

14. Blood and Body Fluid Spillage Management

The effective management of blood and body fluid spillage is a crucial factor in the successful control of infection. Exposure to any such fluid presents a risk to the health of all persons involved within their working environment. However, these risks are easily minimised by following the principles of Standard Infection Control Precautions, in addition to maintaining a routine approach to simple cleaning and disinfection procedures.

It is essential that all blood and body fluid spillages are cleaned and disinfected as soon as is practicable.

In general, the volume of most blood or body fluid spillages that occur daily are not excessive. They can be safely managed by the wearing of PPE, normally gloves and apron as a minimum.

However, for the occasions when these provisions are considered insufficient, the use of the body fluid disposal spill kits should be utilised as detailed below.

Blood/Body Fluid Disposal Kits

All Re-Pat Ltd vehicles must carry the means to enable staff to successfully manage blood and body fluid spills. Therefore, spill kits will be available on all Re-Pat Ltd vehicles. The design and purpose of these kits take account of the risk of exposure to blood and body fluid spills in vehicles.

Method of Application (Spill Kits)

Appropriate items of PPE, e.g. gloves and apron should be worn.



Once the fluid has been absorbed, the bulk of the spill can be removed. The contaminant must then be placed into a clinical waste bag.

The area should be thoroughly cleaned using the vehicle issued disinfectant wipes.

All the remaining items from the kit should be placed into a clinical waste bag, along with the disposable items of PPE.

15. Waste Management

All staff have a legal responsibility for the safe and proper disposal of waste. It is crucial that staff recognise and understand their individual responsibilities in complying with the waste disposal procedures and seek advice and guidance if any area of uncertainty should arise. This means that the health and safety of staff, patients and any other persons with whom staff come into contact, can be suitably protected.

Types of Waste:

Domestic Waste includes all household waste, glass, aerosols and batteries, but excluding any item generated from a clinically related activity.

Clinical waste is any used disposable item which comprises of, or contains any human tissue, blood or other body fluid, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharp instruments, and any other waste arising from any clinical intervention, which may prove to be hazardous or cause infection to any persons coming into contact with it.

Clinical waste bags should be identifiable by tagging the bag with Re-Pat Ltd, date and vehicle number.

(See Appendix for further details)

Infectious waste regulations require that the hazardous properties of all waste are assessed. The

Hazardous Waste Directive (HWD) identifies 14 properties in waste that are deemed to be hazardous. Hazard H9 refers to:

- Infectious substances containing viable microorganisms or their toxins, which are known or reliably believed to cause disease in man or other living organisms.
- Infectious waste is defined by the Hazardous Waste Directive in H9 Infectious as: 'Substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in man or other living organisms'.
- HWD acknowledges that many waste streams contain pathogens, but where there is a low-level present or the concentration is at a naturally occurring level, or where the infectious part has been removed by specific segregation at source, the waste would not be considered hazardous according to H9.

Segregation of Waste

Different types of waste require different procedures to ensure their safe and appropriate disposal. It is therefore essential that waste is correctly identified and segregated at source, in order to remove all avoidable risk during subsequent handling, storage and transportation.

Similarly, care must be exercised in segregating items of non-disposable equipment and linen from clinical waste, prior to adopting the relevant cleaning and decontamination process.

Safe and effective waste segregation requires the use of colour coded storage bags and containers, appropriate to the waste type.

All items of clinical waste must be placed in the appropriate receptacle at source, as soon as is reasonably practicable. This should always be performed by the staff member immediately involved in the generation of the waste, particularly where the use of sharps is concerned.

Under no circumstances should any item of clinical waste be placed in any domestic waste bin, or left abandoned outside designated containers, e.g. in the rear of ambulances, etc.

Untoward waste incidents are incidents where inadequate and inappropriate measures involving the disposal of clinical waste, sharps, or pharmaceutical waste thereby putting others at risk of injury and cross-contamination, must be regarded as adverse incidents and reported using the company's incident report system.

Linen Management

The term 'linen' refers to all materials that require laundering. As most linen has the potential to harbour microorganisms, it is important that all service linens are appropriately managed in order to minimise any risk from cross contamination.

Although the risks of cross infection from linen are small, attention should be directed at those items utilised in the direct care of patients. Ambulance blankets are naturally the main items of linen used in this respect, along with supplementary articles such as canvasses and carry sheets.

Segregation of Linen

For laundry purposes, linen must be segregated into one of the following groups:

- **Used Linen:** Linen which has been in general use but has not been contaminated by blood or body fluids
- **Contaminated Linen:** Linen which has become contaminated by blood or body fluids, or which has been used in the care of a patient with a known infectious disease or infestation.

The importance of hand hygiene is again emphasised, together with the need for staff to apply an impermeable waterproof dressing to any cuts or abrasions during any period of duty.

Staff must exercise all due care when preparing items for laundering. Disposable gloves and aprons must always be worn as a minimum, particularly when handling contaminated linen. Items of linen should always be held away from the body to reduce the risks of contact with uniform.

Safe and effective linen segregation calls for the use of colour coded storage bags, appropriate to local arrangements and laundry type. All items requiring laundry must be bagged at source, after ensuring that any item of equipment etc. has firstly been removed.

16. Staff Uniform

Most bacteria and viruses will not survive away from the host and would not present a high risk of infection transmission on clothing during general wearing whilst on duty.

However, visible soiling or contamination where there are a greater number of organisms might be an infection risk and is likely to affect patient confidence. Staff should change into a clean uniform at the start of each shift.

Once off duty, staff should always change into 'home' clothes as soon as possible – preferably before leaving the workplace.

The uniform itself is not IP Kit, and so staff should wear IP Kit in any situation where there is danger or potential danger to the individual from blood/body fluid splashing etc.

In general, the responsibility for uniform laundering currently rests with the individual member of staff. Staff should wash uniforms or other work clothes as soon as possible and in accordance with the care label instructions – preferably on as hot a wash as the fabric will tolerate. Tumble-drying and ironing are part of the heat process.

Where necessary in order to avoid overloading, uniforms should be washed separately from other clothes. There is no evidence of cross contamination but overloading the machine will reduce wash efficiency.

In most cases, staff uniform can and should be included as part of the general domestic washing arrangements undertaken by each member of staff. All the components of the laundry process contribute to the removal or killing of microorganisms on fabric. There is no conclusive evidence of a difference in effectiveness between commercial and domestic laundering in removing microorganisms.

On occasions, there may be exposure to splashes of blood or body fluids. On these occasions, staff should use the disposable aprons in the IP Kit. These are also available in the Primary Response Bag. For cases where extensive soiling or contamination is foreseeable, staff should wear a disposable suit as an outer garment, in addition to any other necessary IP Kit items. After use, the apron or suit should be disposed of as clinical waste and the uniform checked for any contamination.

If, despite all efforts, heavy contamination of the uniform occurs with either blood or body fluids soaking through to the skin, arrangements should be made for staff to return to base for a shower to remove any skin contamination and a uniform change. Operational staff are expected to keep at least one complete spare uniform in their station locker or the boot of their car.

Heavily contaminated uniform with blood or body fluids or from a known or suspected infectious patient, should be disposed of as clinical waste.

17. Colour Coding for Cleaning

Re-Pat Ltd follow a colour-coding system, which is based on hospital colours and should always be followed by staff undertaking cleaning activities.

If there is a shortage of colour-coded materials or equipment, the Registered Manager should be informed immediately, an Incident Report Form completed, and any items replenished.

RED	Washroom floors, showers, sinks, toilets.
BLUE	Ambulance vehicles, offices and public areas.
GREEN	Kitchen, food & drink preparation areas.
YELLOW	Isolation areas.

Ambulance Area/Environmental Cleaning

Dust, dirt and liquid residues will increase the risk of transmitting infection. They should be kept to a minimum by regular cleaning and by good design features in all equipment, 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 expected outcomes.

Work surfaces and floors should be smooth-finished, intact, durable, washable and should not allow pooling of liquids or/and be impervious to liquids. Hands must be washed thoroughly following any cleaning session. Communal nailbrushes must not be used.

Keep mops and buckets clean and dry with the mop head resting in the wring cone section of the bucket. Mop heads should be removed for disposal when they have become either visibly dirty or contaminated with blood or body fluids.

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

Use general purpose detergent for all environmental cleaning (following the manufacturers' instructions) even when subsequent disinfection is required.

When replacing paper hand towels, these must be put into the holder, and not placed on top. Paper towel and liquid soap dispensers of the cartridge type must be cleaned regularly.

Vacuum cleaner bags and filters must be changed as necessary and the brush cleaned of hair and

fluff before storage.

Crockery and cutlery should be washed immediately after use in hot water and general-purpose detergent. Wherever possible, leave to air-dry or, if necessary, dry with disposable heavy-duty paper towel.

Staff should remove dust with a properly maintained filtered vacuum cleaner. This should be cleaned by washing with hot water and general-purpose detergent, using mops or a suitable scrubbing machine.

Food preparation surfaces should be cleaned regularly with hot water and general-purpose detergent. These areas should be kept in good repair to facilitate cleaning. Staff must clean any kitchen equipment that they have used such as oven, microwave or toaster.

Refrigerators should be defrosted and cleaned regularly in accordance with manufacturer's instructions. Should a spillage occur, or food become stale, the whole interior of the fridge should be cleaned with hot water and general-purpose detergent and dried thoroughly.

Anti-slip shower mats must be washed with hot water and general-purpose detergent and hung in a clean dry place when not in use. (Cork type shower mats are not to be used).

Shower rooms and hand basins must be cleaned regularly with a cream cleanser, using a disposable cloth which can be discarded into a black waste sack.

Toilets should be cleaned with a toilet brush if soiled, using a toilet de-scaling liquid if required.

Toilet brushes should be cleaned by flushing the cistern and rotating the brush as the clean water comes through; tap on the edge of the toilet to remove excess water, air-dry and store dry in brush holder.

Waste bins must be cleaned at least weekly inside and outside with hot water and general-purpose detergent. Sack holders should also be cleaned regularly as above.

Vehicle and Equipment Cleaning

The relevance of maintaining high standards of hygiene and cleanliness has an even greater significance to the interiors of ambulance vehicles and the equipment carried. Interior surfaces are prone to becoming dirty and dusty during normal everyday activity. This can lead to a rapid build-up of contamination, which if left unchallenged, potentially creates an ideal breeding ground for infectious organisms to grow and multiply.

All items of equipment can potentially become a source of cross infection. It is important that close attention is given to their respective cleaning and disinfection procedures.

It is therefore imperative that all staff meet their individual responsibilities in keeping the vehicle and equipment clean, and thus help to reduce the risks of cross infection/contamination to themselves, their colleagues and their patients.

This can best be achieved by all staff participating in frequent and routine cleaning activities - most importantly between each patient.

Under the principles of standard IPC, it is important that ambulance equipment is always maintained in a clean and hygienic condition. This highlights the need to regularly check and clean equipment, with any shortfalls being addressed as soon as operational demands allow. It is vital that any equipment contaminated with either blood or body fluids is cleaned and disinfected at the earliest opportunity.

All decontamination procedures should be carried out as soon as possible. A cleaning schedule for the vehicle should be used and completed by staff. The Registered Manager is responsible for the monitoring of cleaning schedules.

Vehicle Interior and Equipment Cleaning - After Each Patient Journey

Vehicle and equipment cleaning should take place after each patient interaction by staff. It is best practice to use detergent wipes in order to clean all items that may have become contaminated.

Staff should assess if the spillage can be dealt with using paper towels, universal wipes or spillage kits carried in all vehicles. These are all disposable and should be placed in a clinical waste bag and removed.

18. Decontamination of Equipment

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

Certain items of equipment are classified as 'single-use only': do not re-use. A single-use device is used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used again, even on the same patient.

The symbol below is used on medical device packaging indicating 'do not re-use' and may replace any wording.



Re-useable equipment and devices e.g. stretchers and wheelchairs should be appropriately decontaminated between each patient. The same procedures should be applied to all detachable items removed from the vehicle.

It is recommended as best practice that where possible, equipment used for patient care should be for single patient use and disposable. The Consumer Protection Act (1987) will hold a person liable if a single use item is re-used against the manufacturer's recommendations.

19. Staff Immunisation

Immunisation is not available against all infections and neither is it guaranteed to be 100% effective. Therefore, immunisation should not be regarded as an alternative to practicing high standards of Infection Prevention and Control.

The primary aim of vaccination is to protect the individual who receives the vaccine, but particularly important for care staff, vaccinated individuals are also less likely to be a source of infection to others. This reduces the risk of immunocompromised and unvaccinated individuals being exposed to infection. This means that individuals that cannot be vaccinated will still benefit from a routine vaccination programme.

Re-Pat Ltd will encourage all staff to remain up to date with recommended vaccinations including booster and seasonal doses, in order to help reduce risk from these infections. Re-Pat Ltd will keep a record of staff vaccination status and undertake risk assessments in relation to this to ensure the safety of staff and service users wherever possible.

Re-Pat Ltd regularly access the Green Book for the latest information on vaccines and vaccination procedures for vaccine preventable infectious diseases in the UK.

20. Training

All staff working for Re-Pat Ltd will receive IPC training as part of their induction and annually thereafter as part of the mandatory training programme (please refer to the **Training and Development Policy**). All training will comply with the criteria in The Health and Social Care Act 2008 Code of Practice and CQC requirements.

21. Monitoring

Compliance with this policy will be monitored by the IPC Lead/Registered Manager through regular auditing and the examination of incident reports. Lessons learned will be discussed at individual staff supervision, management and team meetings.

Related Policies

Accident and Incident Policy
Training and Development Policy
Recruitment Policy
Health and Safety Policy
Quality, Governance and Risk Policy
Medication Policy
Equality and Diversity Policy

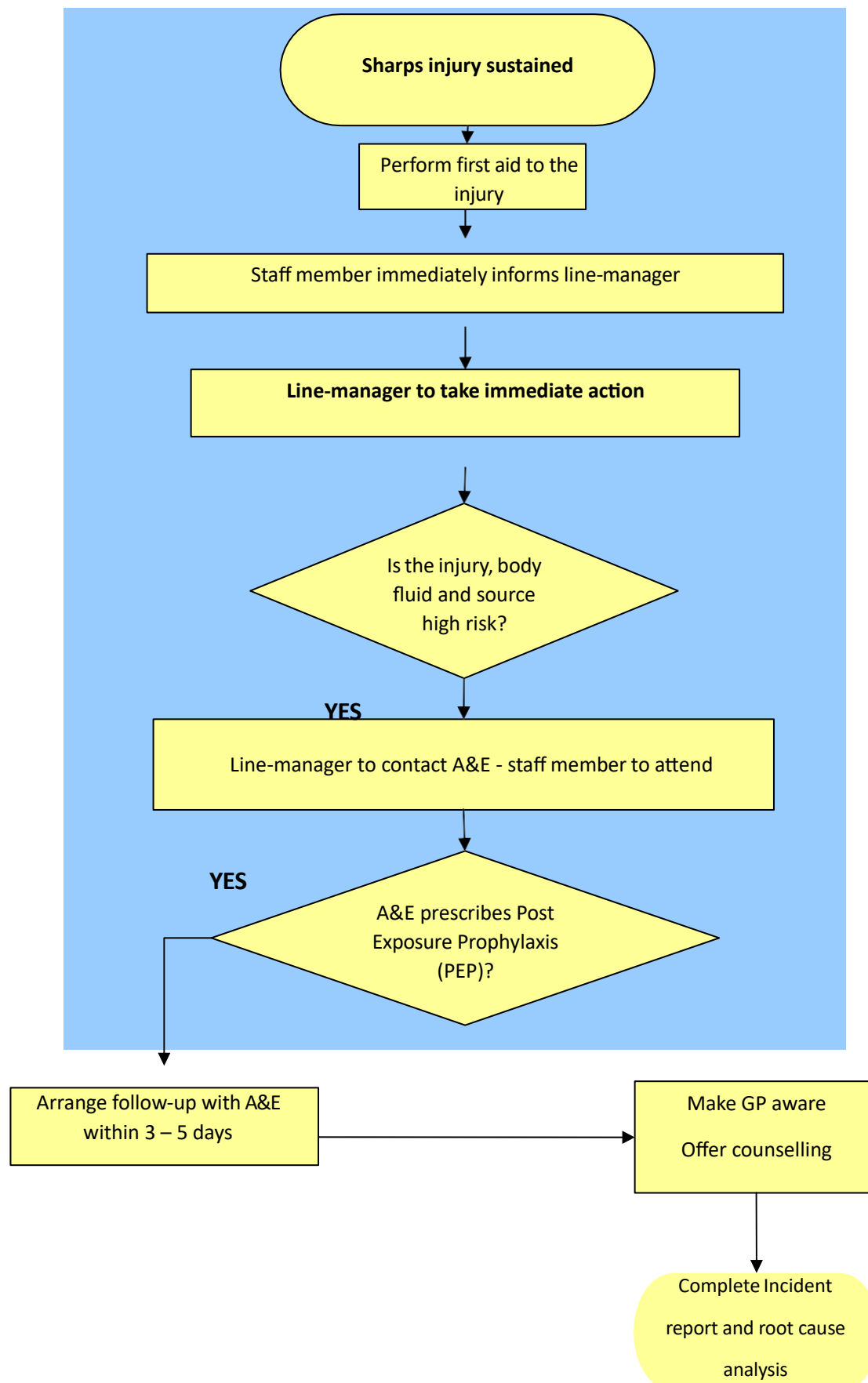
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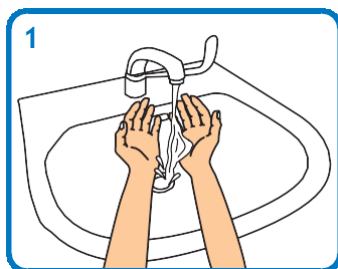
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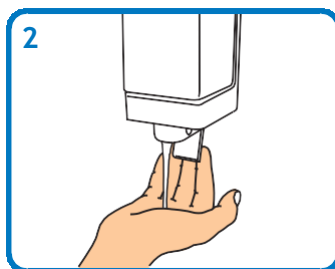
Appendix 1 – Sharps injury flowchart (where there is a risk of BBV transmission)



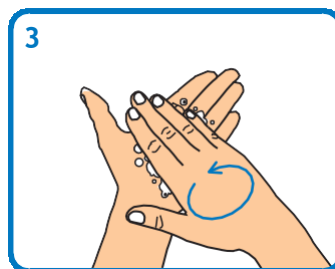
Appendix 2 Hand-washing technique with soap and water



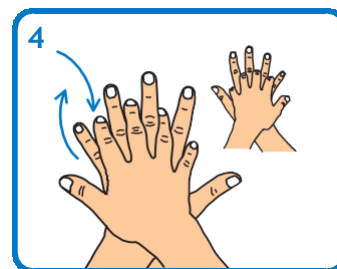
Wet hands with water



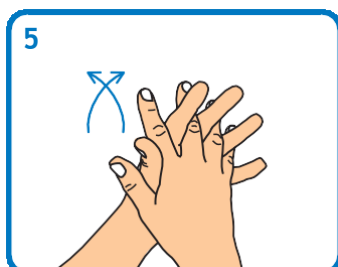
Apply enough soap to cover all hand surfaces



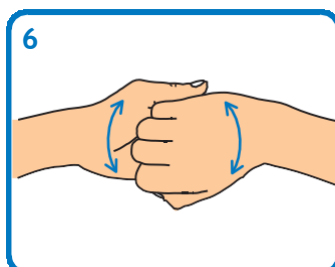
Rub hands palm to palm



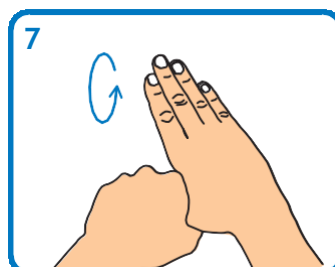
Rub back of each hand with palm of other hand with fingers interlaced



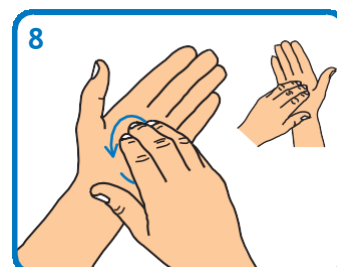
Rub palm to palm with fingers interlaced



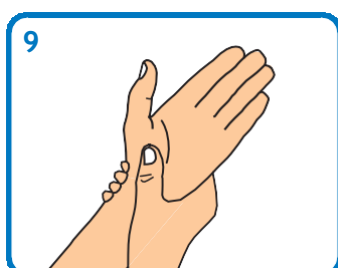
Rub with back of fingers to opposing palms with fingers interlocked



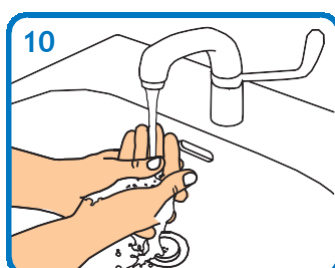
Rub each thumb clasped in opposite hand using a rotational movement



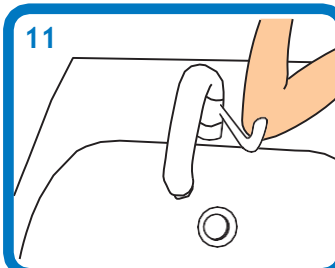
Rub tips of fingers in opposite palm in a circular motion



Rub each wrist with opposite hand



Rinse hands with water



Use elbow to turn off tap



Dry thoroughly with a single-use towel

Appendix 3 – Domestic Waste Guidelines

Domestic (municipal) waste

Minimum treatment/disposal required is landfill in a suitably permitted or licensed site.

Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste.

Examples:

- General waste (plastic cups, newspapers etc.)
- Paper towels (including those used for routine standard universal cleaning)
- Packaging from medication (not contaminated with product or infected body fluids)
- Uncontaminated, gloves and aprons
- Small uncontaminated dressings and bandages

Appendix 4 - Clinical Waste Poster and Guidelines

Clinical Waste Only:



Examples:

- Items known to be contaminated with infectious pathogens e.g. dressings from known infected wounds, and other items that have been in contact with infectious body fluids
- Items used during cleaning after a confirmed suspected infectious incident, dispose of all cleaning equipment used including paper towels, gloves, aprons etc.

Good practice – only use designated clinical waste bins, one for sharps, and a separate one for bags



Bad practice – unlidded bins side by side where general waste is mixing with clinical waste and vice versa



All packaging from medication whether contaminated or not with product or infected body fluids should be disposed of into clinical waste. Where clinical waste requires disposal on station or Make Ready it is Trust policy to use designated clinical waste bins. Sharps bins should be sealed after 2 months of start date or when 3/4 full dated and signed when closed and placed into the large clinical waste bins. They should NEVER be placed inside bags.

It is illegal to dispose of clinical waste in general waste bins. Clinical waste bags should be marked with Re-Pat Ltd, date and vehicle no.

Examples of clinical waste are:

- Items known to be contaminated with infectious pathogens e.g. dressings from known infected wounds, and other items that have been in contact with infectious body fluids
- Items used during cleaning after a confirmed suspected infectious incident (dispose of all cleaning equipment used including paper towels, gloves, aprons etc.)

Clinical Waste Bag Tagging Procedure

It is the responsibility of the Registered Manager to oversee that the procedure is compliant and audited regularly.

All clinical waste bags must be labelled and tagged with the following information:

- Vehicle number
- Company name
- Date

Actions:

1. Complete the label with the information above and slide on to the plastic tag.
2. Lock the tag tightly around the top of the clinical waste bag to close it.
3. Place the bag into the designated clinical waste bin.