Southern Hampshire
PRIMARY CARE ALLIANCE

Infection Control Policy

1.5

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1.3	29/04/2022	L Busher	Formatting changes / Removal of names / Version control added / Sharps Injury update
1.4	27/06/2022	S Ma	Updated guidance added
1.5	21/07/2022	L Busher	Formatting update and review

CONTENTS

INTRODUCTION

This document sets out the SHPCA policy on infection control and should be used with reference to the principles outlined in the Infection Control (Biological Substances) Protocol and the Infection Control Inspection Checklist. This policy is aligned with the FGSEH IPC policy across the locality.

H&S Infection Prevention & Control

POLICY STATEMENT

SHPCA is committed to the control of infection within the buildings that it leases and in relation to the clinical procedures carried out within them. The owners of the premises will maintain the premises, equipment, drugs and procedures to their own standards detailed within their own Infection Control Inspection Checklist and will provide facilities and the financial resources to ensure that all reasonable steps are taken to reduce or remove all infection risk. SHPCA employees have a duty to understand their policies and to ensure adherence to them. This policy provides an overarching practical approach to ensure compliance.

Wherever possible or practicable, the premises we use will seek to use washable or disposable materials for items such as soft furnishings and consumables, e.g. seating materials, wall coverings including paint, bedding, couch rolls, modesty sheets, bed curtains, floor coverings, towels etc., and ensure that these are laundered, cleaned or changed frequently to minimise risk of infection. It is our responsibility to ensure that we notify the appropriate person if we feel that any items are not fit for purpose or cleaned in an acceptable manner. Appendix 3 contains our Infection Control Annual Statement

RESPONSIBILITY FOR THE MANAGEMENT OF INFECTION RISK

The responsibility for controlling infection and cross-contamination ultimately rests with all staff however specific tasks are allocated as follows:

- The clinician with overall responsibility for Infection Control is Dr Stefanie Ma (Head of Clinical Services)
- The non-clinician responsible for leading on Infection Control is Lee Busher (Head of Governance, Quality & Safety)

The staff member responsible for training and the annual audit of Infection Control is also Dr Stefanie Ma.

Patient placement/assessment for infection risk

Due to the decommissioning of the red hubs, there will be potential for transmission of infection when entering care area. The patient is to be triaged by clinician to assess risk and need for a face-to-face consultation. See appendix 5 for flow chart. Infective risk are those with undiagnosed respiratory illness where coughing and sneezing are significant features or in the context of known widespread respiratory virus activity in the community or a suspected or confirmed outbreak of a respiratory illness in a closed or semi closed setting.

The Chain of Infection

The illustration shows the link in how infection develops, to reduce the risk we must 'break the chain'. **Every link in the chain of infection is necessary for infection to spread. Remove just one**

link and the infection cannot happen.

GENERAL PRINCIPLES

- Follow the World Health Organisation (WHO) 5 Moments for Hand Hygiene
  1. Before direct patient contact.
  2. Before clean/aseptic procedure.
  3. After handling body fluids.
  4. After touching a patient.
  5. After contact within the immediate vicinity of the patient.
- Soap and water is the preferred method for hand hygiene.
- Soap and water must always be used for hand hygiene when hands are visibly soiled, following handling of blood or body fluids or when caring for patients with suspected or confirmed *Clostridium difficile* or diarrhoea of unknown cause.
- Alcohol gel/hand rub can be used when hands are visibly clean.
- Clinical staff must adhere be 'bare below the elbows' when undertaking clinical care to enable effective hand hygiene (see below).
- Cover any cuts/sores or lesions with a waterproof plaster.
- Hands must always be cleaned following removal of Personal Protective Equipment (PPE).
- Protect skin integrity - use moisturiser when appropriate and seek medical advice if skin problems develop.

Annual hand washing training is recommended for all clinical staff

STANDARD PRECAUTIONS

Standard infection control precautions (SICPs) are to be used by all staff in all care settings, at all times, for all patients whether infection is known to be present or not to ensure safety of those being cared for, staff and visitors in care environment

We will continue to be implementing, monitoring and ensure compliance of the 10 elements of SICPs:

1. Patient Placement

2. Hand hygiene

3. Respiratory and cough hygiene

4. Personal Protective Equipment

5. Personal protective Equipment

6. Safe Management of care equipment

7. Safe management of healthcare linen (if applicable)

8. Safe management of blood body fluids

9. Safe disposal of waste (including sharps)

10. Occupational safety / Managing prevention of exposure

The above will be evidenced and audited on a regular basis as per the audit schedule that is in our MS Teams Auditing schedule and evidence file.

ELEMENT 1: HAND WASHING

One of the easiest and most effective ways to break the chain is with good hand washing

Research has shown that hands play a major role in the spread of infection. Bacteria can get in to the body through breaks in the skin. People receiving health care may be more vulnerable, older person and young children. Medication and illnesses affect the body's ability to fight infection

Micro-organisms on hands are either resident flora or transient flora. Resident flora are usually of low virulence. Transient flora may contain many different pathogenic microorganisms, picked up in the course of duty. They are not firmly attached to the skin and can easily be removed by correct hand hygiene.

The purpose of hand hygiene (both washing and drying) is to remove transient flora.

Dedicated hand wash basins should be available in all clinical areas. These should have elbow or wrist operated taps and should not have a plug or an overflow. Water should be offset so that it does not run directly over the waste outlet. They must not be used for the purpose of hand hygiene only and not for the disposal of other any other fluids.

The most frequently missed parts of the hand in hand washing are shown in the picture below:

Staff involved in clinical tasks will always be 'bare below the elbow' and follow the NICE guidelines

below.

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

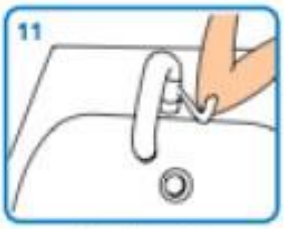
Rub with back of fingers to opposing palms with fingers interlocked

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

Hand washing should take 15–30 seconds

cleanyourhands campaign

NHS National Patient Safety Agency

NHS/DoH

Bare Below the Elbow Standards & Rationale	
Standard	**Rationale**
Keep fingernails short and clean	Microbes can thrive beneath finger nails
Do not wear false nails or nail polish	False nails and nail polish discourage thorough hand washing Micro-organisms thrive in nail glue and in cracked nail polish
Do not wear, bracelets or rings with stones and ridges. One plain band is permitted.	High numbers of bacteria can be found on skin under rings and bracelets. Wearing these discourages effective hand washing.
Sleeves must be short or rolled up to facilitate effective hand decontamination.	Hand decontamination cannot effectively take place, putting patients at risk
Any breached skin - cuts, dermatitis or abrasions - must be covered with a waterproof dressing.	To reduce the risk of cross contamination
Wrist watches MUST be removed prior to procedures requiring hand hygiene	High numbers of bacteria can be found under wrist watches and straps

ELEMENT 2 – DECONTAMINATION

Skin decontamination

When carrying out invasive procedures such as minor surgery, joint injections and inserting contraceptive implants the patient's skin should be cleaned with a 2% chlorhexidine gluconate in 70% isopropyl alcohol wipe (unless allergic). Cleaning should cover the whole area, ensuring that the skin area is in contact with the disinfectant for at least 15-30 seconds. The area should then be allowed to dry.

This is a summary based on infection prevention best practice produced by the West Hampshire Clinical Commissioning Group based on guidance provided in the World Health Organisation (WHO) guidelines on drawing blood: best practices in phlebotomy 2010.

Best Practice DO's	**Best Practice DO NOT's**
DO carry out hand hygiene (use soap and water or alcohol rub) before and after each patient procedure	DO NOT forget to clean your hands
DO use one pair of non-sterile gloves per procedure or patient	DO NOT use the same pair of gloves for more than one patient. DO NOT wash gloves for re-use
DO use a single-use device for blood sampling	DO NOT use a needle, lancet or vacutainer for more than one patient
DO use a new disposable tourniquet for each patient	DO NOT use a visibly dirty or unprocessed tourniquet between patients
DO disinfect the skin at the venepuncture site*	DO NOT touch the puncture site after disinfecting it
DO use a closed vacuum system for blood sampling	DO NOT use needles and syringes to take blood or inject blood into laboratory sample tubes unless local risk assessment advocates a needle and syringe method is the better option for the patient in some circumstances
DO discard the used device (a needle and vacutainer as a single unit) immediately into a sharps container	DO NOT leave an unprotected needle lying outside the sharps container or dismantle sharps
DO seal the sharps container with temporary closure if appropriate	DO NOT overfill or decant a sharps container
DO immediately report any incident or accident linked to a sharp injury, and seek assistance	DO NOT delay seeking assistance after exposure to potentially contaminated material; beyond 72 hours, post exposure prophylaxis is NOT effective

Recommended products should contain 70% Isopropyl + Chlorhexidine 0.5% (unless allergy)

Decontamination of Medical Equipment

Where practicable single use disposable equipment should be used for high risk or invasive procedures.

Reusable instruments (if used) that must maintain sterility i.e. for wound or minor surgery must undergo high level disinfection and sterilisation according to manufacturer's instruction to protect service users and staff.

Single use items must never be reused.

Single patient use items must be securely retained for one named patient for a period of time which is usually determined by the manufacturer.

A decontamination certificate (*Appendix 4*) should be completed and attached to any item of equipment being sent for repair or being moved to another place.

Low risk equipment such as blood pressure cuffs, worktops and couches can be effectively and safely decontaminated with detergent wipes followed by drying.

If heavy contamination caused by body fluid occurs a high level disinfectant wipe or hypochlorite solution may be used with caution. If in doubt contact IPT for advice.

Correct storage of sterile instruments

All packages / boxes must be stored off of the floor to avoid contamination and facilitate effective cleaning.

All sterile packages should be stored in cupboards with doors or enclosed drawers. Do not store under a sink.

Sterile packages that become wet are no longer sterile and must not be used.

Before use examine external packaging for damp or damage, check the sterile indicator strip if reprocessed items and expiry date. Any item failing these must be considered unsterile and reprocessed or disposed of as applicable.

Decontaminaton of Environment

General everyday cleaning provided by a contractor should be monitored regularly against a specified cleaning schedule.

Cleaning of the environment should be carried out in accordance with guidance stated in National Specifications for Cleanliness: Primary medical and dental practices (2010-08.02 | v1).

Contracted cleaning should be carried out in accordance with the NHS cleaning standards as described in National Specifications for Cleanliness: Primary medical and dental practices (2010-08.02 | v1).

Records of cleaning and related audits should be maintained locally.

All cleaning using detergent requires drying as part of the process.

Clinical areas must be cleaned daily and specific areas cleaned more often as required i.e. counter tops, examination couches.

Within treatment rooms cleaning schedules should be in place for medical equipment and kept up to date by clinical staff.

The general fabric of the building can impact upon the ability to clean effectively i.e. broken tiles, cracks to plasterwork and should be maintained appropriately.

Enhanced cleaning must be undertaken following recognised infection risk or contamination with blood or body fluids.

Areas of cleaning responsibilities should be clearly defined within the practice.

Privacy curtains and window curtains/blinds within treatment areas need to be cleaned six monthly unless visibly soiled in the interim.

Ventilation grills, radiators and light fittings should be included within a pre-planned schedule of cleaning at least annually.

SAFE MANAGEMENT OF PATIENT CARE EQUIPMENT IN AN ISOLATION ROOM

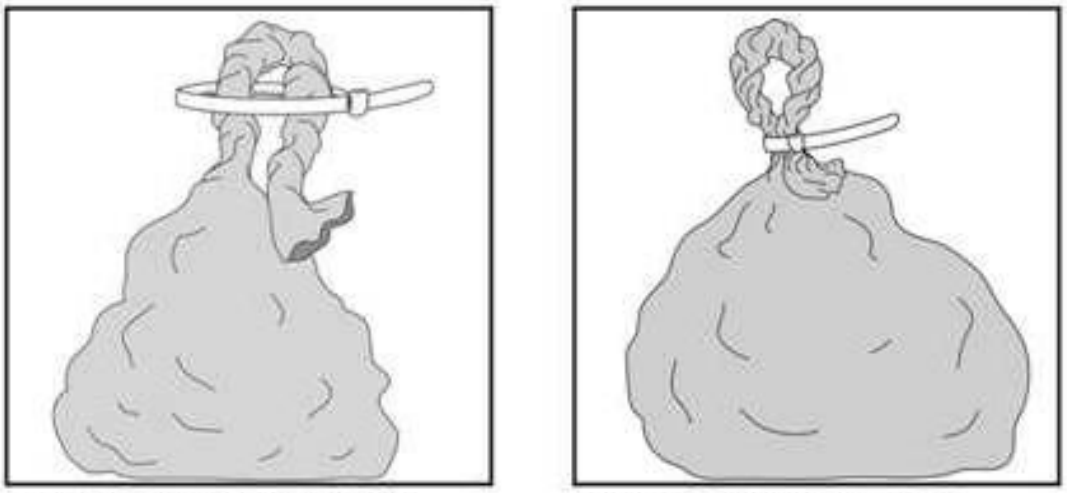
In all 4 sites, there will be a single room designated to be the room used as the isolation room for those deemed to be of infective risk. Reusable non-invasive equipment will be dedicated to the isolation room and is to be decontaminated by the clinician when consultation is finished after every use of the room. For decontamination of the reusable equipment, see appendix 4. These must be cleaned immediately after patient use and between each patient. The isolation room along with other rooms will be visibly clean, free from non-essential items and equipment to facilitate effective cleaning.

ELEMENT 3: SAFE HANDLING AND DISPOSAL OF HEALTHCARE WASTE

Healthcare waste has the potential to be toxic, hazardous and/or infectious. All staff have a duty of care to ensure that waste is segregated, handled, transported and disposed of in an appropriate manner to ensure it does not harm colleagues, patients/service users, the public or the environment.

General Principles

- Waste should be disposed of at the point of care in the nearest appropriate bin. Soiled dressings should be placed in small bags immediately they are removed before being taken to a larger clinical waste bin.
- Waste bags must be changed before ¾ full, and at least daily.
- Waste bags must be swan necked or secured with a plastic tie to produce a fluid tight seal when closed.



Holding waste bags slightly away from the body will reduce risk of contamination or injury if accidentally containing sharp object.

The waste bag must be clearly labelled or tagged with the generators ID as per local protocol.

Waste bags must be stored in an appropriate container, which must always be locked or within a locked compound.

The waste storage/collection area should be inaccessible to animals and the public with waste being stored in locked bins provided by the waste contractor.

SITE SPECIFIC INFORMATION FOR DISPOSAL OF WASTE

Portchester

Clinical waste bins are kept just outside the back door in the car park (not secured). The key to unlock the bins are kept in the cleaner's cupboard by the back door (this is kept unlocked). IPCAS to inform Doug Kershaw (Practice Manager) re bins if over flowing

Forton

Clinical waste bins are kept next door to Rowlands Pharmacy, these are locked behind a wooden fence (to the right as your drive in). The keys for both the gates and the clinical waste bins are hung on a key hook in the Admin room in the Red Hub

Swan

Clinical waste bins are kept in the Doctor's car park at Swan (not secured) and are shared with Boots Pharmacy. These bins are kept locked and the key can be found in shed door (located next to bins) and the code is 2810.

WHC

The clinical waste bins are kept to left of the building (Vine Medical side). The bins are locked away behind wooden fencing. The keys for the bins are kept in the Admin room for Red Hub and the padlock key is kept in the Cleaners cupboard (Vine Medical side). This door is generally kept unlocked

SHARPS SAFETY

Injuries from sharp devices used in healthcare pose a significant risk to the physical and mental health of staff, cost healthcare organisations time and resources and have the potential to result in costly litigation. An inoculation injury is when a person has had exposure to blood or bodily fluids from another person.

A percutaneous injury refers to exposure involving a needle, sharp object used on another person or a human bite or scratch that has broken th skin.

A mucocutaneous injury refers to exposure involving the mucous membranes i.e. mouth, nose, eyes or non intact skin that have been contaminated by blood or body fluids from another person.

General principles

- All staff are responsible for the safe use and disposal of every sharp they generate.
- A plethora of statutes, regulations, and national guidelines require that employers protect staff, patients and visitors through safer systems of work inclusive of substituting traditional unprotected medical sharps with safer alternative devices.
- Sharps must be handled with care and respected as potentially dangerous items.
- Sharps containers must be correctly assembled, tagged and labelled.
- Do not over fill the sharps container, dispose of when 2/3 full as indicated by the fill line.
- Containers must be stored in an appropriate position and at an appropriate height, off the floor and out of reach of children and vulnerable adults.
- The temporary closure should be in place when not in use.
- Never re-sheath needles.
- Dispose of needles and syringes as one complete unit- do not disconnect the needle.
- Insure container is sealed appropriately when full or has been open for three months, labelled, tagged (depending on local protocol) and signed.
- Place sealed containers in a secure location inaccessible by the public to await collection.
- Use the appropriate colour bin as per table below.

Cytotoxic & cytostatic medicinal sharps	**Non medicinal sharps (e.g. bloods)**	**Medicinal Sharps**
Dispose in purple lidded container	Dispose in orange lidded container	Dispose in yellow lidded container

NEEDLESTICK/ INOCULATION INJURY

SHPCA are fortunate enough to be able to utilise Solent Occupational Health Service: https://www.occupationalhealth.solent.nhs.uk/

NEEDLESTICK INJURY CALL 0300 123 3392

First Aid

Allow puncture site to bleed, ideally under running water (do not squeeze)

Wash wound/exposed area with soap and water, do not scrub and cover with a waterproof dressing.

Irrigate eyes with copious water (before and after contact lenses removal)

In Hours - Report to line manager and the Occupational Health Provider on 0300 123 3392 (9am-5pm)

Out of hours - attend local Emergency Department

Complete incident form.

ELEMENT 5: PERSONAL PROTECTIVE EQUIPMENT (PPE)

All staff that are in direct contact with patients who have infection risk, should wear a surgical facemask (type II or Type IIR). Patient with infective risk should be wearing a mask prior to entrance to the site. For confirmed airborne high conseqeuence infectious diseases which includes COVID-19 or suspected of COVID-19, a surgical mask, plastic gown and eye protection and gloves is required. Surgical face masks should be removed and disposed of inside the patient room once the clinician patient has left consultation room (See Appendix 1.3 for donning and doffing of PPE).

UKHSA advice indicates that health and care staff should continue to wear facemasks as part of personal equipment required for transmission-based precautions when in direct contact with those of infective risk. This is to include settings where untriaged patients may present to. In all other clinical care areas, universal masking should be applied when there is known or suspected cluster transmission of SARS-CoV-2 for example.

Patients with respiratory symptoms who are required to attend for out of hours or extended access should wear a facemask/covering. All other patients are not required to wear a facemask unless this is a personal preference.

For visitors or carers of patients, in settings or situations where there is a high risk of infection, visitors may be asked to wear a facemask. Visitors or individuals accompanying

patients will not be required to wear a facemask unless this is a personal preference, although they will be encouraged to do so.

Assess the risk:

No Blood or body fluid No known infection	Blood or Body Fluids But low risk of splashing	Blood or Body Fluid with high risk of splashing
No PPE Except aprons for bed making	Non sterile gloves & aprons	Non sterile gloves & Apron or gown & eye and face protection

AEROSOL GENERATING PROCEDURES

The following procedures if done through the hub, need to be done in the isolation room: induction of sputum, respiratory tract suctioning and awake ear, nose and throat airway procedures that involve respiratory suctioning.

The minimum items of PPE that must be readily available for all clinical staff in each clinical room are:

- Plastic aprons.
- Gloves- non sterile for general use and sterile for aseptic procedures.
- Eye and face protection – fluid / splash repellent standard.

Aprons and gloves should be stored in an appropriate wall mounted dispenser or similar so that the potential for contamination of these items is kept to a minimum prior to use, this also maximises workspace within the treatment room.

See Appendices 1 for standard guidance on Donning PPE, and Appendix 3 for Covid-19 Specific Guidance.

PPE General principles

Aprons

- Aprons are inexpensive yet effective at reducing contamination to the front of clothing where most contamination occurs.
- Aprons are single use items and must be changed between patients.
- Aprons must be changed between dirty and clean procedures on the same patient.
- Long sleeved water impervious gowns may be used if the risk of contamination is excessive e.g. large blood or body fluid spillage or when skin to skin contact should be avoided i.e. untreated scabies.

Gloves

- Gloves are NOT 100% impervious and hand washing after removal is essential.
- Gloves must be worn if contact with blood, body fluids, secretions, excretions or hazardous substances is expected.
- Disposable gloves are single use items and must be discarded after each procedure.
- Gloves must be changed between dirty and clean procedures on the same patient.
- Gloves used in healthcare must conform to current BN standards (BS EN 455) and marked with the CE logo.

Masks, spectacles or visors

- Eye protection (visor or goggles) and/ or surgical masks should be worn for any activity where there is a risk of body fluid splashing into the face or eyes.
- Specialist FFP2 and FFP3 masks should only be used when indicated by Public Health England or the IPT i.e. during an influenza pandemic or particular infectious diseases such as multi drug resistant tuberculosis (MDRTB)

Remember - Staff will be less likely to wear PPE if it is not easily accessible.

REMOVAL OF PPE

PPE should be removed in a specific order to minimise the potential for cross-contamination. This is gloves, apron, eye and face protection (if worn).

Gloves

- Grasp the outside of the opposite gloved handpeel off holding the removed glove in the gloved hand.
- Slide the fingers of the un-gloved hand under the glove at the wrist, peel forward.
- Discard both gloves in clinical waste stream.

Hand hygiene must follow removal of the final item of PPE.

https://www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

ELEMENT 6: SAFE HANDLING OF BLOOD AND BODY FLUIDS

Blood and body fluids can contain blood borne viruses (BBV) or other pathogens. Therefore, dealing with spills of blood or body fluid may expose the healthcare worker to contamination from potential pathogens and therefore spills must be dealt with swiftly, safely and effectively.

General Principles

- Deal with spill quickly and effectively
- Commercial spillage kits are available and must be stored away from children and vulnerable adults.
- Ensure the spill kit selected is suitable for the body fluid to be cleaned.
- Manufacturer's instructions must be followed when using spillage kits.

ELEMENT 7: RESPIRATORY AND COUGH ETIQUETTE

Correct respiratory hygiene and cough etiquette is effective in decreasing the risk of transmission of pathogens contained in large respiratory droplets e.g. influenza virus. Particularly during COVID, this has never been so apparent.

Such droplets land on surfaces and as the viruses survive well can easily be transferred from one person to another.

General Principles

- Cover mouth and nose when coughing or sneezing.
- Dispose of tissues immediately into appropriate waste bin.
- Perform hand hygiene frequently.

See Appendix 2

ELEMENT 8: ASEPSIS

Aseptic technique is the term used to describe the actions taken to prevent contamination of wounds and other susceptible sites by organisms that could cause infection. Aseptic technique can be applied in any clinical setting. Procedures requiring asepsis should be carried out in a designated treatment room which is suitable for the task.

Full asepsis using a sterile field, sterile equipment and sterile gloves or an Aseptic Non Touch Technique ANTT) aim to achieve the same objectives – DO not contaminate key parts.

Asepsis must be maintained during any procedure that bypasses the body's natural defenses i.e. wound dressings, removal of sutures, endotracheal suctioning, dressing tracheotomy sites, urinary catheter change and the administration of Intravenous Medications.

Components of Asepsis include

- Hand Decontamination
- Personal Protective Equipment
- Preparing the patient for a clinical procedure
- Creating & maintaining an aseptic field
- Use of a safe operative technique
- Safe disposal of sharps & waste

TAKING A WOUND SWAB

Infection is a clinical diagnosis and microbiological sampling can only determine the presence of organisms and their sensitivities.

Therefore wound swabs should only be undertaken if antibiotics are indicated and not routinely to check an infection has cleared for example.

Wherever possible microbiological sampling SHOULD be taken prior to the commencement of antibiotics, however if a wound continues to deteriorate whilst on therapy ensure clinical details contain current/recent antibiotic therapy, dose and start date.

Signs & Symptoms suggestive of infection

- Increased pain
- Erythema
- Deteriorating wound
- Increased exudates
- Unpleasant odour
- Cellulitis
- Pyrexia
- Patient generally unwell

How to Swab

- Use the swab in its dry state on the wound and then place into the transport medium and charcoal to aid the survival of fastidious organisms.
- Clean the wound first to remove the surface contaminants.
- Swab viable tissue displaying signs of infection, rotating the swab gently to increase pick up whilst avoiding trauma to wound bed.
- Microbiology request form must include three points of patient identification OR it will not be tested.

Include good quality data on the request form such as:

- Site swabbed
- Description of wound
- Current/recent treatment
- Other signs of infection such as pyrexia

Ensure transport to the laboratory as soon as possible to aid survival of fastidious organisms. Samples may be placed in a designated refrigerator but should not remain there for more than 24 hours, therefore this needs taking into account when obtaining a sample prior to a weekend for example.

The clinician generating the swab is responsible for checking the results so that correct treatment is commenced or changed if required.

Remember infection is a clinical diagnosis and the presence of an organism without signs of infection will not usually require treatment.

CRITERIA FOR SOURCE ISOLATION

It is rare to isolate patients within primary care however on occasion the risks to vulnerable patients within close proximity of a waiting area may mean timely isolation is required.

Source isolation is designed to prevent the spread of pathogens from an infected patient to other patients, staff and visitors. The need for isolation is determined by the way the organism or disease is transmitted.

Patients attending any SHPCA clinical site with the following symptoms must be isolated in a suitable room and not wait in the general waiting area:

- Known or suspected communicable infection /disease e.g. Measles, Pulmonary Tuberculosis, Chicken Pox or unexplained rash if considered to be of an infectious cause
- Diarrhoea and/or vomiting
- Patients reporting symptoms suggestive of influenza.

REVIEW

This policy may be reviewed at any time at the request of the Clinical Commissioning Group (CCG) and it will automatically be reviewed twelve months from initial approval and then on a three yearly basis unless organisational changes, legislation guidance or non-compliance prompt earlier review.

The following general precautions will apply:

Infection Control Training will take place for all staff on an annual basis and will include training on hand decontamination, handwashing procedures, the use of Personal Protective Equipment (PPE) and the safe use and disposal of sharps (as appropriate).

Random and unannounced Infection Control Inspections will take place to ensure compliance

REFERENCES

Ayliffe,G.A.J. Babb,J. R. Taylor, L. J. (2001) 3rd Ed. *Hospital-Acquired Infection Principles and Prevention*. Arnold London.

Council Directive 2010/32/EU (2010) Implementing the framework agreement on prevention from sharps injuries in the hospital and health care sector. Official Journal of European Union.

Department of Health (1998). Guidance for Clinical Healthcare Workers: protection against Infection with Blood Borne Viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. Department of Health: London.

Department of Health (2007). Clean, safe care. Reducing infections and saving lives. Department of Health: London.

Department of Health and Health Protection Agency (2010). Pandemic (H1N1) 2009 Influenza. A summary of guidance for infection control in healthcare settings. Department of Health: London.

Garner, JS. (1996) Hospital Infection Control Practices Advisory Committee. Guideline for isolation precautions in hospitals. *Infection Control and Hospital Epidemiology.*17(1):54-80.

Health and Safety Executive Advisory Committee on dangerous Pathogens (1995). Protection Against Blood Borne Infections in the workplace: HIV and Hepatitis. HMSO, London.

Health and Safety Executive (1992) Personal Protective Equipment at work. Guidance on regulations. L25. London, Health and Safety Executive. The Personal Protective.

Lawrence ,J., May, D. (2003). *Infection Control in the Community* Churchill Livingstone Guidance for Clinical Healthcare Workers: Protection Against Infection with Blood Borne Viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. 1998 Department of Health, London.

Loveday.HP et al (2014) Epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. The Journal of Hospital Infection. 8651, s1-s70

National Specifications for Cleanliness: Primary medical and dental practices (2010-08.02 | v1).

The Health and Social Care Act (2010). Code of Practice for health and adult social care on the prevention and control of infections and related guidance. Department of Health: London.

Wilson J (2006). Infection Control

National Institute for Health and Care Excellence (NICE) Guidelines:

Healthcare-Associated infections - Prevention and control in Primary and Community Care

www.nice.org.uk/guidance/cg139/chapter/1-Guidance

Guidance on Infection Control July 2015 (Dept of Health)

Legionella guidance (HSE) - http://www.hse.gov.uk/legionnaires

Care Quality Commission - http://www.cqc.org.uk/content/guidance-providers and http://www.cqc.org.uk/guidance-providers/gps/nigels-surgery-full-list-tips-mythbusters-latest-update

Health Building Note 11-01: Facilities for primary and community care services 2013 (DoH)

Essential practice for infection prevention and control - Guidance for nursing staff, Royal College of Nursing 2012

https://www.infectionpreventioncontrol.co.uk/

APPENDIX 1 – DONNING PPE – STANDARD GUIDANCE

Public Health England

Putting on personal protective equipment (PPE)

Standard Infection Control Precautions

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

Pre-donning instructions:

- **Ensure healthcare worker hydrated**
- **Tie hair back**
- **Remove jewellery**
- **Check PPE in the correct size is available**

1. Perform hand hygiene before putting on PPE.

2. Put on apron and tie at waist.

3. Put on facemask – position upper straps on the crown of your head, lower strap at nape of neck.

4. With both hands, mould the metal strap over the bridge of your nose.

5. Don eye protection if required.

6. Put on gloves.

APPENDIX 2 DOFFING PEE – STANDARD GUIDANCE

Public Health England

Taking off personal protective equipment (PPE)

Standard Infection Control Precautions

Please see donning and doffing video to support this guidance: https://youtu.be/-GncQ_ed-9w

- **PPE should be removed in an order that minimises the risk of self-contamination**
- **Gloves, aprons (and eye protection if used) should be taken off in the patient's room or cohort area**

1 Remove gloves. Grasp the outside of glove with the opposite gloved hand; peel off.

Hold the removed glove in the remaining gloved hand.

Slide the fingers of the un-gloved hand under the remaining glove at the wrist.

Peel the remaining glove off over the first glove and discard.

2 Clean hands.

3 Apron.

Unfasten or break apron ties at the neck and let the apron fold down on itself.

Break ties at waist and fold apron in on itself – do not touch the outside – **this will be contaminated**. Discard.

4 Remove eye protection if worn.

Use both hands to handle the straps by pulling away from face and discard.

5 Clean hands.

6 Remove facemask once your clinical work is completed.

Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only. Lean forward slightly. Discard. DO NOT reuse once removed.

7 Clean hands with soap and water.

APPENDIX 2 DONNING & DOFFING GUIDANCE –COVID-19 GUIDANCE

Public Health England

Guide to donning and doffing PPE: Droplet Precautions

for health and social care settings

Donning or putting on PPE

Before putting on the PPE, perform hand hygiene. Use alcohol handrub or gel or soap and water. Make sure you are hydrated and are not wearing any jewellery, bracelets, watches or stoned rings.

1. Put on your plastic apron, making sure it is tied securely at the back.

2. Put on your surgical face mask, if tied, make sure securely tied at crown and nape of neck. Once it covers the nose, make sure it is extended to cover your mouth and chin.

3. Put on your eye protection if there is a risk of splashing.

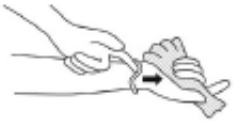
4. Put on non-sterile nitrile gloves.

5. You are now ready to enter the patient area.

Doffing or taking off PPE

Surgical masks are single session use, gloves and apron should be changed between patients.

1. Remove gloves, grasp the outside of the cuff of the glove and peel off, holding the glove in the gloved hand, insert the finger underneath and peel off second glove.



2. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

3. Snap or unfasten apron ties the neck and allow to fall forward.

Snap waist ties and fold apron in on itself, not handling the outside as it is contaminated, and put into clinical waste.

4. Once outside the patient room. Remove eye protection.

5. Perform hand hygiene using alcohol hand gel or rub, or soap and water.

6. Remove surgical mask.

7. Now wash your hands with soap and water.

Please refer to the PHE standard PPE video in the COVID-19 guidance collection:
www.gov.uk/government/publications/covid-19-personal-protective-equipment-use-for-non-aerosol-generating-procedures

APPENDIX 3 IPC ANNUAL STATEMENT

Purpose

This annual statement will be generated each year in June in accordance with the requirements of The Health and Social Care Act 2008 *Code of Practice on the prevention and control of infections and related guidance*. It details:

- Any infection transmission incidents and any action taken (these will have been reported in accordance with our Significant Event procedure)
- Details of any infection control audits undertaken and actions undertaken
- Details of any risk assessments undertaken for prevention and control of infection
- Details of staff training
- Any review and update of policies, procedures and guidelines

Infection Prevention and Control (IPC) Lead

Southern Hampshire Primary Care Alliance has 2 Leads for Infection Prevention and Control:

- The Medical IPC lead for SHPCA is: Dr S Ma
- The Nursing IPC lead is: L Busher

Infection transmission incidents (Significant Events)

Significant events (which may involve examples of good practice as well as challenging events) are investigated in detail to see what can be learnt and to indicate changes that might lead to future improvements. All significant events are reviewed monthly with the Medical and Nursing Lead with learning cascaded to all relevant staff.

In the past year there has been a significant event of Covid-19. Response – All staff to follow Government guidance of social distancing, hand washing, face masks and training on use of PPE, ensured adequate supplies, Practice zoning, staggered breaks/restricted numbers, triage of all patients, patient screening at door entrance, broad messaging to patients about Covid-19 and use of surgery.

Infection Prevention Audit and Actions

The Annual Infection Prevention and Control audit was completed by Dr Stef Ma in June 2022.

An audit on hand washing was undertaken in June 2022. SHPCA plan to undertake the following audits in 2022/2023:

- Annual Infection Prevention and Control audit
- Domestic Cleaning audit
- Hand hygiene audit
- Sharps

Risk Assessments

Risk assessments are carried out so that best practice can be established and then followed. In the last year the following risk assessments were carried out / reviewed:

Legionella (Water) Risk Assessment: SHPCA has conducted/reviewed its water safety risk assessment to ensure that the water supply does not pose a risk to patients, visitors or staff. This is managed via the estates and facilities teams.

Immunisation: SHPCA ensure all staff are up to date with their Hepatitis B immunisations and offered any occupational health vaccinations applicable to their role (i.e. MMR, Seasonal Flu, Covid-19)

Other examples:

Privacy Curtains: The NHS Cleaning Specifications state the curtains should be cleaned or if using disposable privacy curtains, replaced every 6 months. To this effect we use disposable privacy curtains and ensure they are changed every 6 months. The privacy modesty curtains although handled by clinicians are never handled by patients and clinicians have been reminded to always remove gloves and clean hands after an examination and before touching the curtains. All curtains are regularly reviewed and changed if visibly soiled.

Cleaning specifications, frequencies and cleanliness: We have a cleaning specification and frequency procedure which our cleaners and staff work to. An assessment of cleanliness is conducted by the HCA team and logged. This includes all aspects in SHPCA including cleanliness of equipment.

Hand washing sinks: SHPCA has clinical hand washing sinks in every room for staff to use, which meet the latest standards. We have also replaced our liquid soap with wall mounted soap dispensers to ensure cleanliness.

Training

All staff receives annual online training in infection prevention and control.

Hand Hygiene training and audit is carried out annually by our Lead Nurse.

Policies

All Infection Prevention and Control related policies are in date for this year.

Policies relating to Infection Prevention and Control are available to all staff and are reviewed and updated annually. All are amended on an on-going basis as current advice, guidance and legislation changes. The Infection Control policy is uploaded onto the TeamsNet once reviewed with notification sent to staff.

Responsibility

It is the responsibility of each individual to be familiar with this Statement and their roles and responsibilities under this.

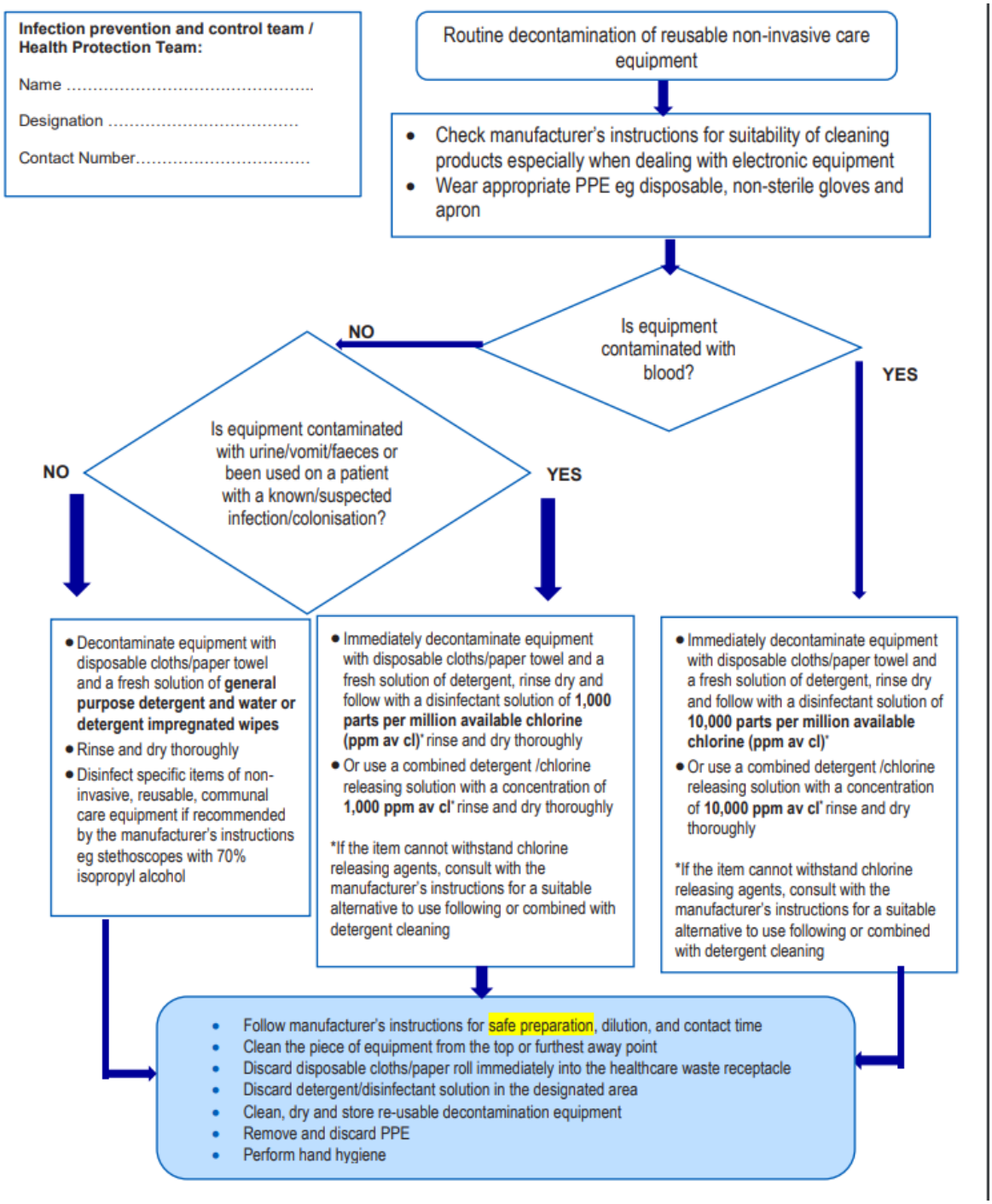
Review date

February 2023

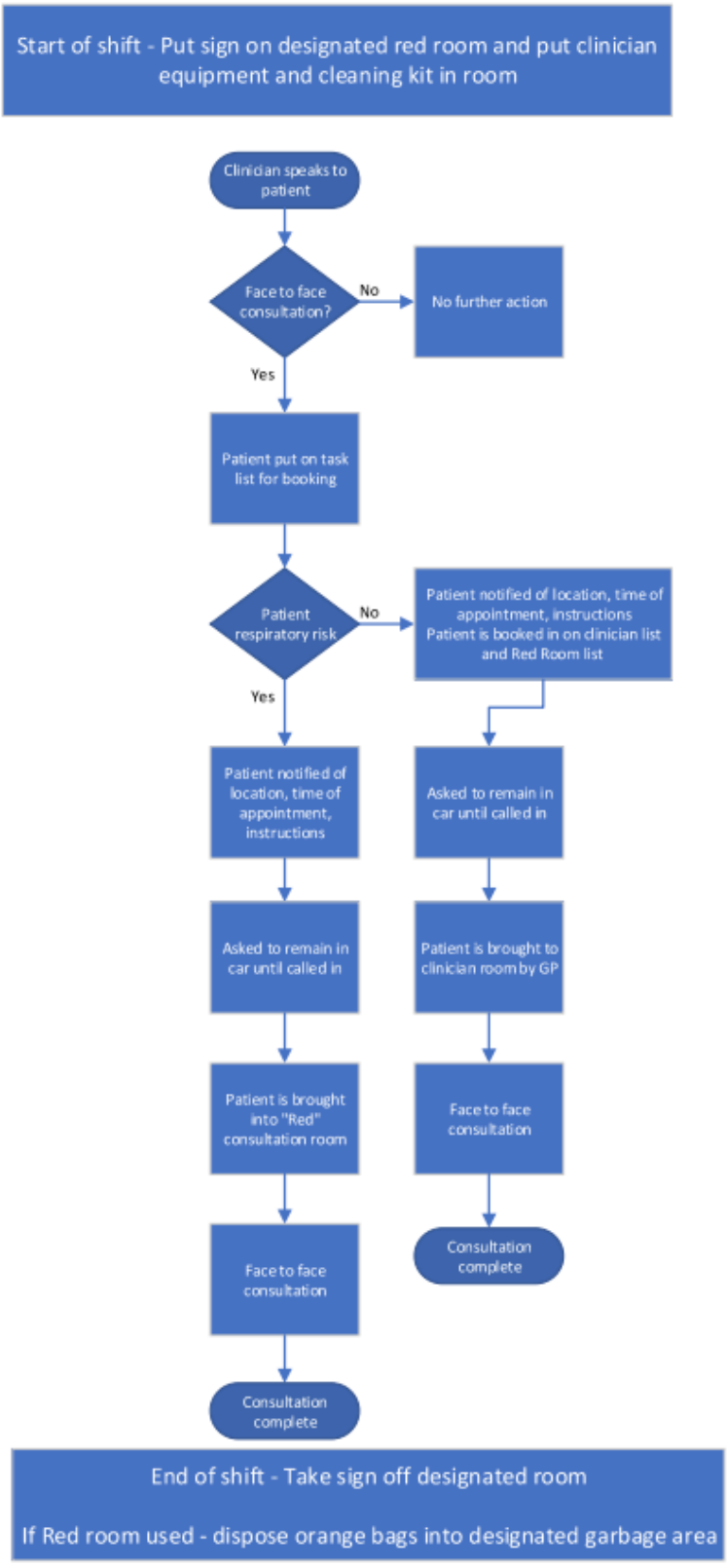
Responsibility for Review

The Infection Prevention and Control Lead Nurse and Medical Lead are responsible for reviewing and producing the Annual Statement.

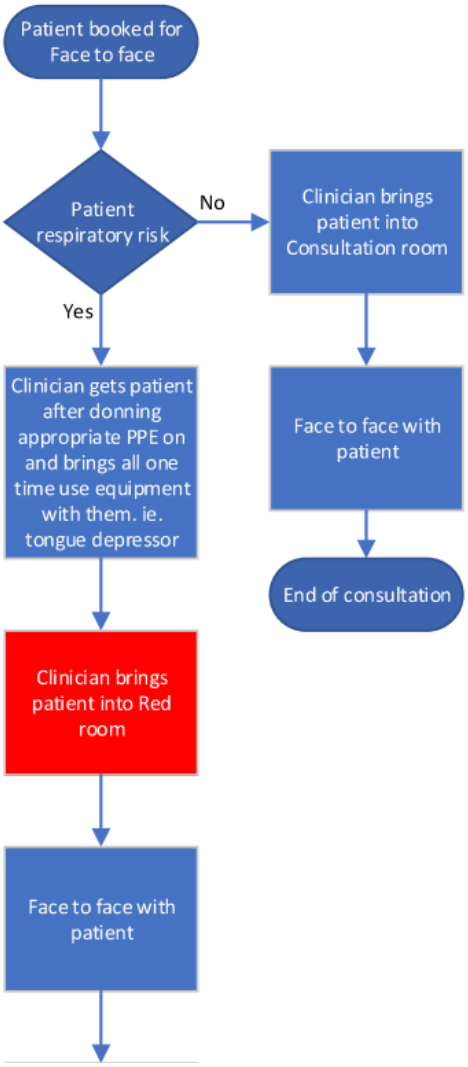
APPENDIX 4: DECONTAMINATION OF EQUIPMENT IN AN ISOLATION ROOM



APPENDIX 5 FLOW CHART FOR PATIENT FLOW FOR FACE-TO-FACE CONSULTATIONS



APPENDIX 5B FLOW CHART FOR PATIENT FLOW FOR FACE-TO-FACE



CONSULTATIONS - DOCTOR ACTION