York Teaching Hospital NHS
NHS Foundation Trust

Infection Prevention Policy

Standard Precautions Policy

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Target audience:	All Trust staff
Relevant Regulations and Standards	

Executive Summary

This policy aims to provide all trust staff with the relevant information about control measures required to reduce the risk of exposure from blood/body fluids from any source by encouraging safe working practices i.e standard precautions.

Version History Log

Version	Date Approved	Version Author	Status & location	Details of significant changes
5		Lynn Stokes (Infection Prevention Nurse)	IPT	Re-formatted; update on glove use and environmental decontamination

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1 Introduction & Scope

It is not possible to identify all of those who are colonized or infected with pathogens, for example Methicillin Resistant Staphylococcus Aureus (MRSA), Human Immunodeficiency Virus (HIV), hepatitis virus or others. It is necessary therefore that all patients should be considered potentially infectious.

A minimum standard of hygiene and protection must be applied by all health care workers throughout their working day in the clinical environment. Precautions must be used to minimise the risk of contamination or infection by blood/body fluids, regardless of the presence of clinical disease or diagnosis. This means that safe practice must not be based on diagnosis of disease or infection, but on the degree of risk of exposure to blood/body fluids from any patient.

2 Definitions

Standard Precautions - the term denotes the basic minimum standard of hygiene to be applied throughout all contact with blood or body fluids from any patient or source regardless of diagnosis or infection status.

Personal Protective Equipment (PPE)-refers to the clothing i.e aprons, gloves, masks and eye protection that are worn to protect the wearer from potential contamination of body fluids or hazardous substances. They also protect the patient from cross contamination.

Health Care Workers (HCW) - all staff who have regular clinical or social contact with patients or clinical specimens.

Infection Prevention Team (IPT)-a group of staff who work as a team to help prevent Healthcare Associated Infections (HCAI) and ensure policies are complied with.

Health Care Associated Infections (HCAI) - HCAI are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase the risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence.

3 Policy Statement

Standard precautions are required for the care and treatment of all patients, regardless of their perceived or confirmed infectious status, and in the handling of:

Blood (including dried blood);

All other body fluids, secretions and excretions (excluding sweat), regardless of whether they contain visible blood;

Non intact skin and mucous membranes.

The use of standard precautions is the essential primary risk based approach required to minimise transmission of health care associated infection because:

Infectious patients may not show any signs or symptoms of infection that may be detected in a routine history and medical assessment.

A patient's infectious status is often determined by laboratory tests that may not be completed in time to provide specific isolation practices.

Patients may be infectious before laboratory tests are positive or symptoms of disease are recognised.

People may be placed at risk of infection from those who are asymptomatic but still infectious.

The implementation of standard precautions minimises the risk of transmission of infection from person to person, even in high-risk situations**. Standard precautions should be practised during clinical practice for all patients.**

It is important to remember that bacteria and other micro-organisms are identified as substances hazardous to health under the Control of Substances Hazardous to Health regulations 2002.

4 Equality Impact Assessment

The Trust' statement on Equality is available in the Policy for Development and Management of Policies at Section 3.3.4.

A copy of the Equality Impact Assessment for this policy is at appendix A

5 Accountability

Corporate accountabilities are detailed in the **Policy for Development and Management of Policies** at section 5.

All healthcare professionals and volunteers are responsible and accountable to the Chief Executive for the correct implementation of this policy.

Professional staff are accountable according to their professional code of conduct. Medical staff are professionally accountable through the General Medical Council, and nurses are professionally accountable to the Nursing and Midwifery Council.

6 Consultation, Assurance and Approval Process

Consultation, assurance and approval process is detailed in section 6 of the **Policy for the Development and Management of Policies.**

The Stakeholder is the Hospital Infection Prevention Committee

7 Review and Revision Arrangements

The date of review is given on the front coversheet.

Persons or group responsible for review is the Hospital Infection Prevention Committee

The Compliance Unit will notify the author of the policy of the need for its review six months before the date of expiry.

On reviewing this policy, all stakeholders identified in section 6 will be consulted as per the Trust's Stakeholder policy. Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the appropriate committee as determined by the **Policy for Development and Management of Policies.**

8 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of relevant staff as per the **Policy for Development and Management of Policies**, section 8 and Appendix C Plan for Dissemination.

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

8.2 Implementation of Policies

The Policy will be disseminated through Consultants; Clinical Directors; Directorate Manager; Matrons; and Ward Managers via emails and meetings. Implementation of this policy will be managed by the IPT, matrons and ward managers.

9 Document Control including Archiving

The register and archiving arrangements for policies will be managed by the Compliance Unit. To retrieve a former version of this policy the Compliance Unit should be contacted.

10 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

10.1 Process for Monitoring Compliance and Effectiveness

Evidence	Monitoring /Who by	Frequency
a. Accountability	Training profiles and training attendance logs. Directorate Leads	Annual
b. Hand hygiene	Hand hygiene audits completed by ward/	Monthly

	department staff Saving Lives High Impact Interventions 1-8	
c. Use of Personal Protective Equipment	Saving Lives High Impact Interventions 1- 8 – completed by ward /department clinical leads e.g. matrons, ward/dept manager	Monthly
d. Decontamination equipment	Saving Lives High Impact Interventions 1- 8 – completed by ward/ department staff Matron Environment Audits completed by ward/dept clinical leads e.g. matrons, ward managers	Monthly
e. Decontamination environment	Monit audits completed by Domestic Team Leads PEAT inspections completed by PEAT teams	According to risk category for each ward/ department
f. Isolation	IPT documentation records. CPD whiteboard records by IPT	For individual patient cases
g. Aseptic Non Touch Technique	Peer review audits by ward and department staff.	Annual peer review
h. Sharps management	AIRs reports, Saving Lives HII 1, 3 - completed by ward/	AIRs as occur, Monthly Saving

	department staff	Lives
i. Data	CPD data, laboratory database surveillance by IPT	Monthly

10.2 Standards/Key Performance Indicators

Saving Lives High Impact Interventions

Hand Hygiene compliance data

IPT performance reports

IPT Clinical Support visit database

11 Training

See section 11 of the **Policy for Development and Management of Policies** for details of the statutory and mandatory training arrangements.

12 Trust Associated Documentation

YHFT [Version 5] Policy for the Development and Management of Policies CORP.RL10

YHFT [Version 1] Infection Prevention Policy for the Decontamination of Reusable Medical Devices and the Environment CLIN.IC19

YHFT [Version 8] Infection Prevention Policy for Effective Hand Hygiene CLIN.IC12

YHFT [Version2] Infection Prevention Isolation Policy CLIN.IC8

YHFT [Version 3] Laundry Policy CLIN.IC9

YHFT [Version 2] Save Use, Handling and Disposal of Sharps

13 External References –

1. EPIC 2 – The EPIC 2: Updated guidelines for Preventing Healthcare Associated Infections in NHS Hospitals 2007.

2. Infection Control Nurses Association (ICNA) 2003, "Preventing *Healthcare Associated Infection"*. www.ips.uk.net

3. Saving Lives – Delivering Clean Safe Care (2007)

4. WHO Guidelines on Hand Hygiene in Health Care. First Global Patient Safety Challenge Clean Care is Safer Care. 2009.

14 Appendices

Appendix A	Applicable body fluids
Appendix B	Standard Precautions
Appendix C	Standard Precautions Door notice
Appendix D	Equality Impact Assessment Tool
Appendix E	Checklist for the Review and Approval
Appendix F	Plan for the Dissemination of the Policy

Appendix A - Body fluids to which the basic minimum standards of hygiene must apply

Blood

Urine

Faeces

Vomit

Cerebrospinal Fluid

Pleural Fluid

Pericardial Fluid

Synovial Fluid

Amniotic Fluid

Semen

Vaginal Secretions

Breast milk

Saliva in association with dentistry

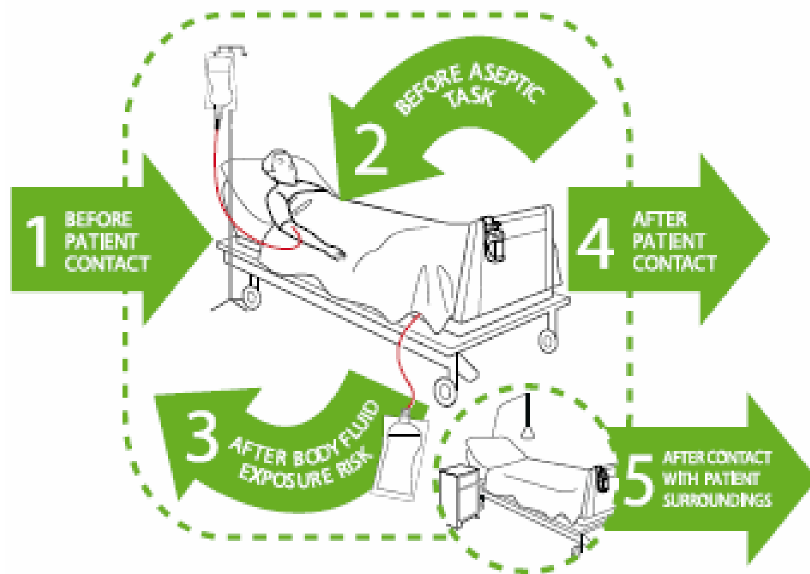
Unfixed tissues and organs

Any other body fluid containing visible blood

Appendix B – Standard precautions

Hand Hygiene - For detailed advice refer to the Infection Prevention Policy for Effective Hand Hygiene York Hospitals NHS Foundation Trust

WHO-5 moments for hand hygiene



Level of hand decontamination and preparation required

Disinfectant hand gel is recognised as the most convenient and effective method of hand decontamination where hands are not visibly soiled.

Effective hand washing with a liquid soap will remove transient micro organisms and render hands *socially clean*. This level of decontamination is sufficient for general social contact and most clinical care activities.

Disinfectant-based hand rubs are not effective in removing dirt, soiling, or *Clostridium difficile* spores, therefore hands *must* be washed with soap and water to remove visible dirt/soiling and when caring for patients with *Clostridium difficile* and diarrhoeal/vomiting illness ***before*** disinfectant gel is applied.

Whichever solution is chosen, it must be acceptable to the user in terms of care of application, time, access and dermatological effects.

Personal Protective Equipment (PPE)

The aim of PPE is to protect staff and patients and reduce opportunities for transmission of micro organisms.

The decision by the HCW to wear PPE must be based on

a) The degree of risk of exposure to blood/body fluids from *any* patient.

b) The risk to the patient of transmission of microorganisms.

c) The risk to the health care worker of contamination of clothing and skin by patient's blood or bodily fluids

Gloves - Gloves are required for:

- Exposure to blood and body fluids from any patient
- Exposure of non intact skin
- Exposure to chemicals or hazardous substances (COSHH)

Staff with dermatological concerns must be referred to Occupational Health

Sharps disposal

It is the users' responsibility to dispose of sharps safely into an approved sharps container that is secured into a sharps tray/holder at the point of use (see Safe Handling and Disposal of Sharps Policy)

Sharps injuries

Refer to the Needlestick, Sharps and Splash injuries Policy and procedure)

Isolation

Isolation is required when infection is suspected or proven and there is a risk of spread to other patients.

Isolation is also required to protect the immunocompromised that are at risk from environmental organisms and those carried by staff and visitors.

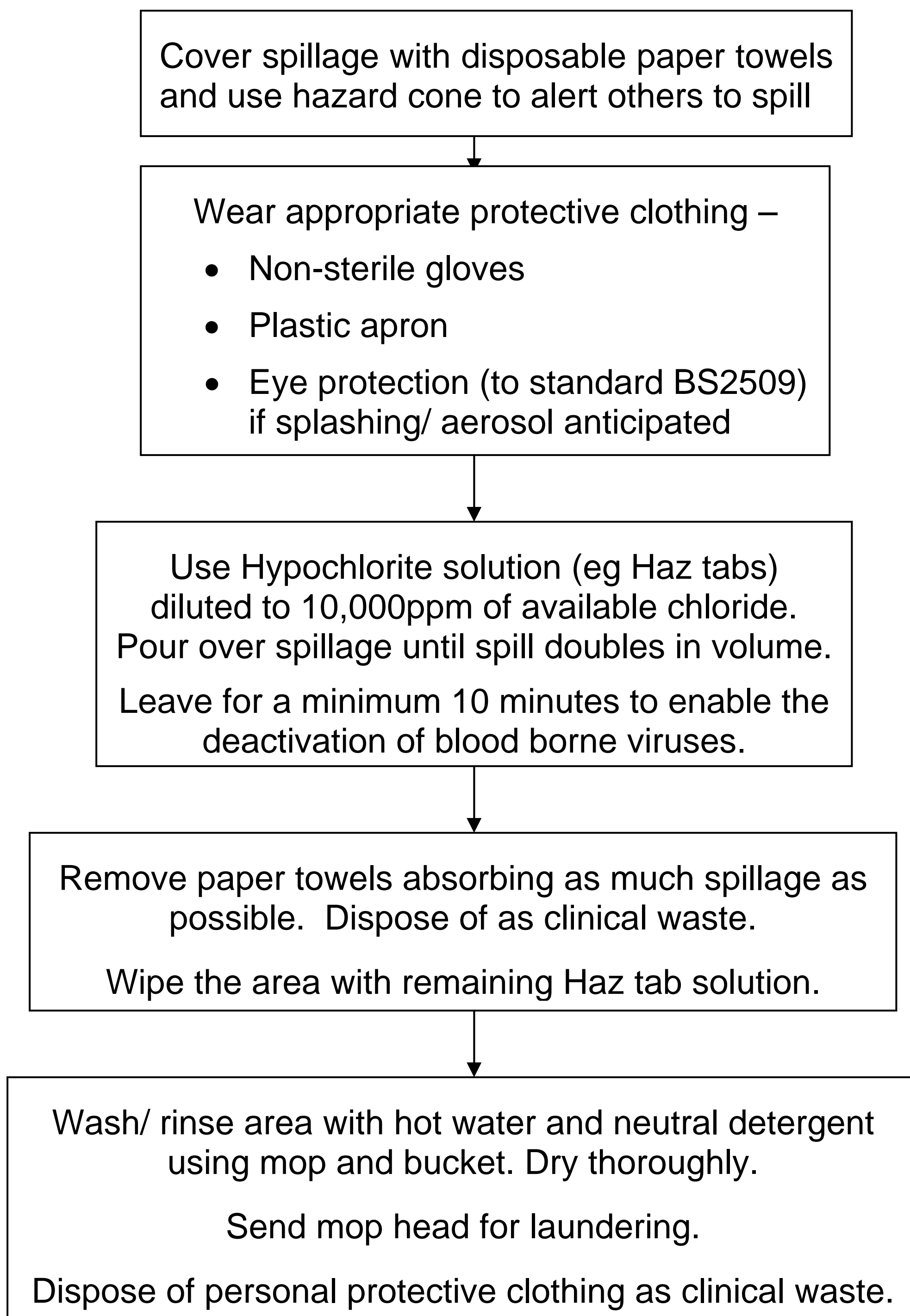
Effective and timely isolation of infected patients (suspected or proven infection) into single rooms is necessary to reduce the spread of the infection. Liaise with bed Managers if single rooms are unavailable.

The appropriate door notice must be displayed that outlines the precautions required specific to the infection being isolated.

Control of Substances Hazardous to Health (COSHH)

Biological agents such as bacteria and other micro-organisms, and chemicals e.g. chlorine, can put people's health at risk. The law requires employers to control exposure to these types of hazardous substances to prevent ill health. They have to protect both employees and others who may be exposed by complying with The Control of Substances Hazardous to Health Regulations 2002 (COSHH). It is the responsibility of all employees to make proper use of control measures and undergo training and instruction as required.

Spillages of Blood/Body Fluids - Procedure for dealing with blood spillages from any patient/ source



In the event of eye or skin contact with hypochlorite solution –

- Wash area with copious amounts of water. Consult Occupational health or Emergency Department

Waste Management

Clinical waste- e.g. dressings, swabs, giving sets - dispose of into orange bag

Anatomical waste- e.g. foetal tissue, limbs, theatre waste- dispose of into yellow bag

General Domestic Waste- e.g. paper towels, plastic cups- dispose of into black bag

Refer to trust waste management policy for further clarification

Laundry

Used linen

Used Linen must be placed into a white plastic bag and tied securely. Bags must not be overfilled to facilitate secure closure.

Soiled and Fouled Linen

Soiled and foul Linen should be placed in a red hot water soluble plastic bag and then into a red outer plastic (non soluble). It should be disposed of as described in above.

Infected Linen

Infected Linen should be placed in a red hot water soluble plastic bag then into a red outer plastic bag (non soluble).

Decontamination of Equipment and Environment

Decontamination and cleaning procedures must be rigorously applied.

(a) The Environment

- MRSA – Micro fibre system (Domestic Services)
- Clostridium difficile – Chlor clean whole ward twice daily. Toilets 4 times daily.
- Norovirus – Chlor clean whole ward daily. Toilets twice daily.

- Rooms must be terminally cleaned before occupation by other patients.

(b) Clinical Equipment

- Where possible should be single patient use.
- MRSA – Clinell wipes.
- Norovirus – Clinell wipes.
- Clostridium difficile – Clinell Sporicidal wipes (available from the IPT) or Chlor clean 1,000ppm for communal clinical equipment – bed pans/commodes

(c) Other Equipment (bed frames, mattresses, lockers, bed tables, chairs, etc.)

- MRSA – Micro fibre System.
- Clostridium difficile – Clinell Sporicidal wipes or Chlor clean 1,000ppm.
- Norovirus – Clinell wipes

Appendix C- Door Notice For Standard Precautions

- **Please keep door closed**
- **Effective hand hygiene before and after patient contact**
  - Hands not visibly soiled - disinfectant gel.
  - Hands visibly soiled or nursing patients with enteric illness - wash with soap and water.
- **Disposable gloves and apron**

  Must be worn for contact with blood and body fluids
- **Waste** Dispose of in room as clinical waste.
- **Linen** Dispose of as contaminated/infected linen, by placing in water-soluble bag, and then placed in an outer red plastic bag.
- **Documentation** Keep outside the room
- **Environmental cleaning**

With micro-fibre and neutral detergent. Communal patient equipment i.e. commodes, bed pans etc can be cleaned with Clinell Wipes.

Please clean this room last

Please refer to patients care plan for further details or contact the Infection Prevention Team, ext 5860

Owner: Infection Prevention Team (IPT) Date of Issue: April 2011 Version: 5 Review Date: April 2012 Approved by: IPT

Appendix D Equality Impact Assessment Tool

To be completed when submitted to the appropriate committee for consideration and approval.

Name of Policy:	**Standard Precautions**

1.	**What are the intended outcomes of this work?**	
2	**Who will be affected?** *Patients, staff*	
3	**What evidence have you considered?** *Health Protection Agency guidelines?*	
a	**Disability**	
b	**Sex**	
c	**Race**	
d	**Age**	
e	**Gender Reassignment**	
f	**Sexual Orientation**	
g	**Religion or Belief**	
h	**Pregnancy and Maternity**.	
i	**Carers**	
j	**Other Identified Groups**	
4.	**Engagement and Involvement**	

a.	Was this work subject to consultation?	Yes
b.	How have you engaged stakeholders in constructing the policy	No
c.	If so, how have you engaged stakeholders in constructing the policy	
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs	
5.	**Consultation Outcome** Approved by Hospital Infection Prevention Committee *Now consider and detail below how the proposals impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and promote good relations between groups*	
a	Eliminate discrimination, harassment and victimisation	
b	Advance Equality of Opportunity	
c	Promote Good Relations Between Groups	
d	What is the overall impact?	
	Name of the Person who carried out this assessment:	
	Date Assessment Completed	
	Name of responsible Director	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Equality and Diversity Committee, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix E Checklist for the Review and Approval

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?		
	Is it clear whether the document is a guideline, policy, protocol or procedures?		
2	**Rationale**		
	Are reasons for development of the document stated?		
3	**Development Process**		
	Is the method described in brief?		
	Are individuals involved in the development identified?		
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?		
	Is there evidence of consultation with stakeholders and users?		
	Has an operational, manpower and financial resource assessment been undertaken?		
4	**Content**		
	Is the document linked to a strategy?		
	Is the objective of the document clear?		
	Is the target population clear and		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	unambiguous?		
	Are the intended outcomes described?		
	Are the statements clear and unambiguous?		
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?		
	Are key references cited?		
	Are the references cited in full?		
	Are local/organisational supporting documents referenced?		
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?		
	Has QA been completed and approved?		
6	**Approval**		
	Does the document identify which committee/group will approve it?		
	If appropriate, have the staff side committee (or equivalent) approved the document?		
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?		
	Does the plan include the necessary training/support to ensure compliance?		
8	**Document Control**		
	Does the document identify where it will		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	be held?		
	Have archiving arrangements for superseded documents been addressed?		
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPIs to support monitoring compliance of the document?		
	Is there a plan to review or audit compliance with the document?		
10	**Review Date**		
	Is the review date identified?		
	Is the frequency of review identified? If so, is it acceptable?		
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?		

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for			

<table>
<tr><td colspan="4">maintaining the organisation’s database of approved documents.</td></tr>
<tr><td>Name</td><td></td><td>Date</td><td></td></tr>
<tr><td>Signature</td><td colspan="3"></td></tr>
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Appendix F Plan for dissemination of policy

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	
Date finalised:	
Previous document in use?	
Dissemination lead	
Which Strategy does it relate to?	
If yes, in what format and where?	
Proposed action to retrieve out of date copies of the document:	**Compliance Unit will hold archive**

Dissemination Grid

To be disseminated to:	**1)**	**2)**
Method of dissemination		
Who will do it?		
and when?		
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

Date put on register / library	
Review date	
Disseminated to	
Format (i.e. paper or electronic)	
Date Disseminated	
No. of Copies Sent	
Contact Details / Comments	