1 Introduction

Healthcare Associated Infections (HCAI) are a major concern in both acute and community settings.

Not all HCAIs are avoidable but a significant proportion can be prevented by the application of evidenced-based practice. Using preventative measures that are evidence based are core components of an effective strategy designed to prevent patients from acquiring infections and their associated risks.

To ensure consistency of Infection Prevention and Control (IPC) practices this policy is based upon the recommendations as identified in NCGC (2012) and Epic 3 guidance (2014).

2 Policy Scope

This policy applies to all healthcare professionals providing care in acute and community services within Newcastle Upon Tyne Hospitals NHS Foundation Trust (NuTH). This includes medical staff, nurses, allied health professionals, students, agency and locum staff.

3 Policy Aim

The aim of this policy is to minimise risk and transmission of potentially pathogenic microorganisms. This policy covers the standard principles which are a mandatory requirement in all healthcare settings and any other environment where health care is provided.

4 Duties (Roles and Responsibilities)

- The Chief Executive has overall responsibility for the implementation, monitoring and review of this policy
- This responsibility is delegated to the Director of Infection Prevention and Control (DIPC) who is an executive board member
- The Infection Prevention and Control Committee (IPCC) will review the policy and any new evidence base within the time frame set out in the policy
- It is the responsibility of the Trust to ensure that policies, procedures, education and training are in place to minimize the risk of infection to both staff and patients
• It is the responsibility of the Trust/line managers and service leads to ensure that all policies, procedures, education and training are available to all staff
• It is the responsibility of all staff to ensure that they understand and implement this policy and attend education and training sessions as required by their role
• Staff requiring support to comply with Standard Precautions should discuss this with their line manager

5 Definitions

• IPC - Infection Prevention and Control
• DIPC - Director of Infection Prevention and Control
• NCGC - National Clinical Guideline Centre
• Epic3 - National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England
• HCW - Healthcare worker
• HCAI - Healthcare Associated Infection
• PPE - Personal Protective Equipment
• BBE - Bare Below the Elbow
• CAT - Clinical Assurance Tool
• IPCC - Infection Prevention and Control Committee
• CGARD - Clinical Governance and Risk Department

6 Standard Precautions

6.1 Effective Hand Hygiene

The most simple and effective way to prevent HCAIs is by undertaking timely, effective hand hygiene. The Trust recommends that hands are decontaminated in accordance with the ‘5 Moments for Hand Hygiene’. Refer to Hand Hygiene Policy.

Basic hand hygiene principles, which include the following, should be applied in every setting:

- Hands must be decontaminated:
  - Immediately before and after each and every episode of direct patient contact or care
  - Before aseptic procedures using an anti-microbial solution. In some community environments for example patients’ homes where these may not be available staff must decontaminate their hands with soap and water followed by alcohol based hand rub prior to undertaking procedure
  - After any activity or contact that could potentially result in hands becoming contaminated
  - Immediately after any exposure to body fluids
  - Immediately after contact or other activity within a patient’s surroundings that could potentially result in hands becoming contaminated
  - Immediately after removal of PPE
  - Hands that are visibly soiled or potentially contaminated must be washed with liquid soap and water
• Staff must be compliant with hand hygiene decontamination technique as per Hand Hygiene Policy
• All staff involved in patient care must be compliant with Bare Below the Elbow (BBE); there should be no sleeves or garments below the elbow, no wrist watches or wrist jewellery. Only a plain wedding band (i.e. without stones) is acceptable in clinical areas and before clinical contact. Fingernails must be short, clean and free of nail polish and false nails should not be worn
• Alcohol-based hand rubs must not be used with patients identified/suspected to be infected/colonised with Clostridium difficile

6.2 Patients should be offered an opportunity to wash hands as i.e. before meals, after using the toilet and at other times as appropriate

6.3 Skin Integrity

Skin is impermeable to microorganisms if intact. However, if the skin is broken, then microorganisms may enter a body site and cause infection.

It is essential therefore that if there are any breaks in the integrity of skin, that they are covered with a waterproof dressing to prevent exposure of these areas to microorganisms.

Staff should be aware of the potentially damaging effects of hand decontamination products. To protect skin from the drying effects of regular hand decontamination an approved emollient should be provided and applied regularly.

If staff develop persistent skin problems they should seek advice from the Occupational Health Service as soon as possible.

6.4 Appropriate Use of Personal Protective Equipment (PPE)

The main purpose of PPE is to protect staff and reduce the risk of exposure / transmission of microorganisms from staff to patient and vice versa.

The use of PPE must be based on an assessment of the level of risk associated with a specific procedure / care activity. Also refer to:-

• Personal Protective Equipment Policy
• Isolation Policy

Adequate supplies of PPE must be readily available for staff use in all areas.

6.4.1 Gloves

• Appropriate gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes and all activities that have been assessed as carrying a risk of exposure to blood, body
fluids, secretions or excretions, or when handling sharp or contaminated instruments. This includes the cleaning of equipment

- Gloves must conform to current EU legislation, be worn as a single use item and be disposed of as Trust Waste Policy once the task is complete
- Gloves must be changed between care activities on the same patient and between each patient
- Gloves must never be cleaned with alcohol based hand rub
- Hands must ALWAYS be decontaminated after gloves are removed

6.4.2 Aprons

- Disposable plastic aprons must be worn to protect HCWs clothing from blood and body fluids but also for close contact with patients to prevent the spread of pathogenic microorganisms.
- In some circumstances long sleeved fluid repellent gowns or aprons may be required if there is risk of extensive splashing of blood or body fluids or when performing aerosol generating procedures on patients with certain respiratory infections e.g. Mycobacterium tuberculosis and Influenza
- Aprons must be single use

6.4.3 Masks/Goggles/Face Visors

- Must be worn if there is a risk of exposure to the mucous membranes of the face from splashing of blood or body fluids
- If equipment is single use, must be disposed of as clinical waste
- If reusable (goggles/visor) must be decontaminated appropriately after each use. Refer to the Cleaning and Disinfection Procedure
- Appropriate respiratory protective equipment must be selected according to risk assessment that takes into account the infective microorganism, the anticipated activity and the duration of exposure. e.g. Influenza and Mycobacterium tuberculosis. Refer to: Guidelines for the Management of Patients with Influenza, Isolation Policy and Prevention and Control of Tuberculosis

6.5 Disposal of Waste

6.5.1 Safe Use and Disposal of Sharps (e.g. needles, trochars, glass ampoules, etc.)

Staff must be aware of their responsibility in preventing needlestick injuries.

PHE (2014) reported that seven in ten (71%) of exposures involve a percutaneous needlestick injury, the majority of which involved a hollow bore needle. Other devices which can cause injury include scalpels, stitch cutters, glass ampoules and sharp instruments.
To prevent occupational injuries from sharps it is vital that they are used and handled safely. Refer to Appendix F Policy for the Prevention and Management of Needlestick Injuries and Blood Borne Virus Exposures.

If a needlestick injury is sustained refer to Policy for the Prevention and Management of Needlestick Injuries and Blood Borne Virus Exposures.

6.5.2 Safe Disposal of Waste

This Trust produces many types of waste which by Law must be disposed of via different routes. This segregation also reduces the risk of exposure of contaminated material to staff, patients, visitors and the general public. It is essential that staff are aware of how to dispose of all types of waste. Refer to Waste Management Policy.

6.6 Safe Disposal of Used Laundry

Used linen is a potential source of infection, as it may be contaminated with potentially pathogenic microorganisms. Appropriate PPE must be worn when handling used linen to prevent contamination of staff uniforms. Refer to Laundry Management Policy.

6.7 Management of Blood and Body Fluid Spillages

When there are spillages of blood and body fluids it is essential that these are managed correctly to prevent the risk of infection. All blood and body fluids must be regarded as” high risk”. Refer to Waste Management Policy.

6.8 Decontamination of Equipment

Healthcare equipment can become contaminated therefore it is vital that ALL equipment is kept clean and decontaminated after each patient use. Refer to Cleaning and Disinfection Procedure and Decontamination of Healthcare Equipment following Patient Use and Prior to Service or Repair.

6.9 Maintenance of a Clean Clinical Environment

The environment can become contaminated with microorganisms that are responsible for HCAIs. Therefore good standards of environmental cleanliness are integral and important components of any environmental strategy. Refer to Decontamination of the Patient Environment (including terminal and deep cleaning) Policy.

7 Education and Training

All Trust employed staff, including agency and locum staff are responsible for accessing and adhering to IPC policies.
Education and training on Standard Precautions is integral with the Trust’s induction and mandatory e-learning programmes. It is the responsibility of the departmental/service lead to ensure that education and training is successfully completed by all staff.

8  **Equality and Diversity**

The Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds. This policy has been appropriately assessed.

9  **Monitoring**

Compliance to this policy for acute services is monitored on a monthly basis via the CAT scorecard; a monthly report is submitted to IPCC and Trust Board.

Compliance to this policy for community services is monitored monthly via Community CAT and the Essential Steps audit tool on a quarterly basis.

Results are submitted in monthly report for Community CAT and via quarterly Essential Steps report to the IPCC and Trust board.

<table>
<thead>
<tr>
<th><strong>Standard / process / issue</strong></th>
<th><strong>Monitoring and audit</strong></th>
<th><strong>By</strong></th>
<th><strong>Committee</strong></th>
<th><strong>Frequency</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute setting</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene and Bare Below the Elbow (BBE); Personal Protective Equipment; Isolation; Cleaning and Disinfection; Decontamination of Patient Environment</td>
<td>Within the framework of the Clinical Assurance Tool (CAT)</td>
<td>IPC Link Staff, Ward/Service Managers</td>
<td>IPCC</td>
<td>Monthly</td>
</tr>
<tr>
<td>Laundry Management</td>
<td>Audit</td>
<td>IPC Link Staff</td>
<td>IPCC</td>
<td>Annually</td>
</tr>
<tr>
<td><strong>Community setting (nursing)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene and BBE; Personal Protective Equipment</td>
<td>Within the framework of the Community CAT</td>
<td>IPC Link Staff with support from IPC Team if required</td>
<td>IPCC</td>
<td>Monthly</td>
</tr>
<tr>
<td>Cleaning and Disinfection; Decontamination of</td>
<td>Community Environment Action Team</td>
<td>Community IPC Team</td>
<td>IPCC</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Patient Environment</td>
<td>(CEAT)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>--------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community setting (other staff groups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hand Hygiene and BBE; Personal Protective Equipment</td>
<td>Within the framework of Essential Steps Audit Tool</td>
<td>IPC Link Staff with support from IPC Team if required</td>
<td>IPCC</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Waste/Sharps Management</td>
<td>Summary pre-acceptance clinical waste audit for each site</td>
<td>Trust Waste Officer</td>
<td>Trust Waste Management Group and Estates Senior Management Team</td>
<td>5 yearly</td>
</tr>
<tr>
<td>Cleaning and Disinfection; Decontamination of Patient Environment</td>
<td>Community Environment Action Team (CEAT)</td>
<td>Community IPC Team</td>
<td>IPCC</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Management of Patients with Influenza</td>
<td>Periodic audit</td>
<td>IPC Team</td>
<td>IPCC</td>
<td>Over winter season</td>
</tr>
<tr>
<td>Prevention and Control of Tuberculosis</td>
<td>Individual case by case</td>
<td>IPC Team</td>
<td>IPCC</td>
<td>Tri-annually</td>
</tr>
<tr>
<td>Reporting of Needlestick Incidence</td>
<td>Individual case by case (Datix and OH Reporting Data)</td>
<td>Health &amp; Safety and Occupational Health Service</td>
<td>Health and Safety Committee</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Decontamination of Healthcare Equipment</td>
<td>Audit</td>
<td>Medical Electronic Department</td>
<td>Trust Decontamination Group</td>
<td>Annually</td>
</tr>
</tbody>
</table>

10 Consultation and Review

Consultation of this policy was undertaken by members of the IPCC and IPC nurses. This policy will be reviewed every three years by the IPCC or as and when significant changes make earlier review necessary.

11 Implementation of Policy (including raising awareness)

Clinical Directors/Matrons/Sisters/Charge Nurses and Clinical Leads must ensure that staff are aware of this policy.

This policy is available for staff to access via NuTH intranet.

12 References


NuTH Policies:

Cleaning and Disinfection Procedure
Decontamination of Healthcare Equipment following Patient Use and Prior to Service or Repair
Decontamination of the Patient Environment (including terminal and deep cleaning) Policy
Guidelines for the Management of Patients with Influenza
Hand Hygiene Policy
Isolation Policy
Laundry Management Policy
Personal Protective Equipment Policy
Policy for the Prevention and Management of Needlestick Injuries and Blood Borne Virus Exposures
Prevention and Control of Tuberculosis
Waste Management Policy

Author:

Infection Prevention and Control Team
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Equality Analysis  Form A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

PART 1

1. Assessment  Date: 01.06.2015

2. Name of policy / strategy / service:
   Standard Precautions Policy

3. Name and designation of Author:
   Sheila Postlethwaite; Infection Prevention and Control Senior Nurse

4. Names & designations of those involved in the impact analysis screening process:
   Sheila Postlethwaite; Infection Prevention and Control Senior Nurse, Lucy Hall; Equality and Diversity Lead

5. Is this a:  Policy x  Strategy  Service
   Is this:  New  Revised x
   Who is affected  Employees x  Service Users  Wider Community
6. **What are the main aims, objectives of the policy, strategy, or service and the intended outcomes?** *(These can be cut and pasted from your policy)*

The aim of this policy is to minimize risk and transmission of potentially pathogenic microorganisms. This policy covers the standard principles which are a mandatory requirement in all healthcare settings and any other environment where health care is provided.

7. **Does this policy, strategy, or service have any equality implications?**

   Yes  [ ]  No  [x]

These have been incorporated into the policy.

If No, state reasons and the information used to make this decision, please refer to paragraph 2.3 of the Equality Analysis Guidance before providing reasons:
8. **Summary of evidence related to protected characteristics**

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Evidence, i.e. What evidence do you have that the Trust is meeting the needs of people in various protected Groups</th>
<th>Does evidence/engagement highlight areas of direct or indirect discrimination? If yes describe steps to be taken to address <em>(by whom, completion date and review date)</em></th>
<th>Does the evidence highlight any areas to advance opportunities or foster good relations. If yes what steps will be taken? <em>(by whom, completion date and review date)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td>Race / Ethnic origin (including gypsies and travellers)</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sex (male/ female)</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Religion and Belief</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Sexual orientation including lesbian, gay and bisexual people</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Age</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Disability – learning difficulties, physical disability, sensory impairment and mental health. Consider the needs of carers in this section</td>
<td>Reasonable adjustments for disabled staff</td>
<td>Some disabled staff – for example those with learning or physical disability may need additional support to comply with the standard. Add: Any staff requiring support to comply with the precautions should discuss this with their line manager - to staff responsibility. SP June 2015.</td>
<td>No</td>
</tr>
<tr>
<td>Gender Re-assignment</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Marriage and Civil Partnership</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maternity / Pregnancy</td>
<td>None relevant to this policy</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
9. Are there any gaps in the evidence outlined above? If ‘yes’ how will these be rectified?

No

10. Engagement has taken place with people who have protected characteristics and will continue through the Equality Delivery System and the Equality Diversity and Human Rights Group. Please note you may require further engagement in respect of any significant changes to policies, new developments and or changes to service delivery. In such circumstances please contact the Equality and Diversity Lead or the Involvement and Equalities Officer.

Do you require further engagement? Yes No

11. Could the policy, strategy or service have a negative impact on human rights? (E.g. the right to respect for private and family life, the right to a fair hearing and the right to education?)

No

PART 2

Name: Sheila Postlethwaite

Date of completion: 4th June 2015

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified, please refer to the Policy Author identified above, together with any suggestions for action required to avoid/reduce the impact.)