



**STRATEGY FOR THE  
MANAGEMENT OF HEALTH &  
SOCIAL CARE ASSOCIATED  
INFECTION IN THE  
NORTH EAST OF ENGLAND**

“To ensure that all Health & Social Care organisations, patients, service users, carers, families and staff work together to minimise the risk of acquiring Health & Social Care Associated Infection”



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Organisations involved in the development of this strategy document have been:

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Tyne & Wear Care Alliance

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# ////EXECUTIVE SUMMARY

This Strategy for the prevention control and management of Care Acquired Infections is intended to assist the development of appropriate policy to meet a variety of regulative requirements in health and social care organisations, direct payment recipients and to provide guidance to unpaid carers, volunteers, patients and service users across the North-East of England.

The Strategy provides a worksheet to support all new staff working in a Care setting to achieve an acceptable level of practical infection control knowledge on their first day at work. It also sets out clearly the personal responsibilities that everyone of us must accept to ensure that the highest standards of infection control are maintained in care homes and domiciliary care settings.

A critical recommendation contained in this Strategy is the development of a new role of Infection Control Champion. They will have a key role in helping to assist in the allocation of appropriate resources to provide comprehensive services to prevent health and social care associated infection services and to identify gaps and bring these to the attention of the appropriate organisations.

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**STRATEGY**  
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**The strategy for  
the management of  
health & social care  
associated infection**

## **01 Introduction to the Strategy**

- 1.1 The Strategy for the prevention control and management of Care Acquired Infections is intended to assist the development of appropriate policy to meet a variety of regulative requirements in health and social care organisations, direct payment recipients and to provide guidance to unpaid carers, volunteers, patients and service users across the North East of England.

## **02 The Aims of the Strategy**

- 2.1 To provide appropriate policies and best practice that focuses on the needs of patients and service users, their families and carers, and reflects the quality standards that are outlined in the National Service Framework for Older People and the National Minimum Care Standards.
- 2.2 Assist in the standardisation of infection control policies and practices of health and social care providers across the North East of England.
- 2.3 To promote & maintain independence, within the community, by advising patients and service users on safe management of their own care in relation to infection control.
- 2.4 To develop a strategic approach across all agencies in the provision of appropriately structured programmes of education and learning in the area of health and social care associated infection for care workers.
- 2.5 To ensure that patients and service users who are at risk of acquiring health and social care associated infection are identified by standardised risk assessment and that the care then provided is appropriate, safe and suitably recorded and monitored.
- 2.6 To ensure that appropriate action is taken following a serious health and social care associated infection incident and that any learning is implemented.
- 2.7 To ensure that appropriate infection control reporting mechanisms are in place and any relevant audits are undertaken to provide assurance of compliance with policies and practice.
- 2.8 To assist in the allocation of appropriate resources to provide comprehensive services to prevent health and social care associated infections and to identify gaps and bring these to the attention of the appropriate organisations.

## **03. National Policy**

- 3.1 The Health & Social Care Act 2008 contains a full section entitled “Code of practice relating to health care associated infections (section 17)”. It covers both health & social care for the management of health & social care associated infection. It will place the same requirements upon Social Care as required of NHS bodies.
- 3.2 In June 2006 the Department of Health produced infection control guidance Infection Control for Care Homes which should be read in conjunction with this strategy.
- 3.3 The most recent key document in the new Act is the Code of Practice for the Prevention and Control of Healthcare Associated Infections, which was a part of the Health Act 2006. The purpose of the Act and the forthcoming Code is to help Health and Social Care organisations to plan and implement preventive and control processes to avoid incidents of health and social care associated infection.
- 3.4 The Department of Health has also produced a toolkit called Essential Steps to Safe Clean Care. This toolkit enables organisations to systematically undertake self-assessment and improvement. This systematic approach is very useful in assisting organisations to meet the requirements of the Codes of Practice and has assisted the development of this strategy.

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## 04. Strategy will therefore:

- 4.1 Assist in the production of a local policy in line with current guidance which can be adopted by all social care providers.
- 4.2 Provide guidance as to the required level of training for carers and their line managers to implement the local policy.
- 4.3 Identify training needs for carers and their employers and map these against currently available training to identify any shortfall in training provision (see appendix 3).
- 4.4 Address any shortfall in training provision by liaising with training providers and sector skills councils to create a competent workforce instead of a trained workforce.
- 4.5 Agree an implementation plan to explore co-resourcing from existing funding agencies.

## 05. Legal background

- 5.1 The Health and Social Care Act 2008 empowers the Secretary of State to issue regulations and produce a Code of Practice for the control health care associated infection.
- 5.2 By 2010/11 a full registration system will be rolled out across the NHS and to private and voluntary healthcare and social care providers under aligned regulations to be made under the 2008 Act.

## 06. Reference to Standards and Guidance

- 6.1 This strategy has been based on standards and guidance current at the time of its production (November 2008). It will be reviewed in the light of updated guidance and standards.

### **Health and Social Care Bill 2007-2008**

<http://www.publications.parliament.uk/pa/cm200708/cmbills/009/2008009.pdf>

### **Current National Minimum Standards for Domiciliary Care**

<http://www.dh.gov.uk/assetRoot/04/01/86/71/04018671.pdf>

### **Domiciliary Care Agencies Regulations 2002**

<http://www.opsi.gov.uk/si/si2002/20023214.htm>

### **Current National Minimum Standards for Care Homes**

<http://www.dh.gov.uk/assetRoot/04/13/54/03/04135403.pdf>

### **Current National Minimum Standards for Domiciliary Care**

[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/documents/digitalasset/dh\\_4018671.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4018671.pdf)

### **Care Homes Regulations 2001**

<http://www.opsi.gov.uk/si/si2001/20013965.htm>

### **National Service Framework for Older People**

<http://www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/OlderpeoplesNSFstandards/index.htm>

### **Infection Control Guidance for Care Homes (June 2006)**

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_4136381](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4136381)

## 07. Development of a Training Framework

7.1 The Strategy sets out a framework for the content of a suitable and appropriate programme of learning. These programmes should include learning on:

1. Communicable Diseases
2. Hand Hygiene
3. Personal Protective Clothing
4. Disposal of hazardous and non hazardous waste
5. Spillages of blood and body fluids
6. Blood borne viruses
7. Safe disposal of sharps
8. Management of inoculation injury.

More detail on each of these areas can be found in Appendix 3

## 08. Organisational Approaches

### 8.1 Induction Requirements

8.1.1 To ensure the safety of patients and service users it is essential that all members of staff that are new to the organisation are inducted as soon as possible. To support the induction process a checklist has been developed in the form of an A5 booklet to accompany this document.

8.1.2 Use of the checklist:

1. Induction should be delivered wherever possible on the first day of employment
2. The checklist should be fully completed by both the supervisor and the employee
3. The checklist should be used in conjunction with the Current Good Practice Guidelines and Standards which can be found in Appendix 1
4. The new member of staff should have outlined to them their personal responsibilities in relation to Infection Control processes and procedures.

### 8.2 Personal Responsibilities

8.2.1 Every member of staff has personal responsibility for prevention management and control of health and social care associated infection. These are:

1. To undertake all learning and development provided to them by their employer
2. To achieve appropriate learning and qualifications where required
3. To apply all learning and development provided to them by their employer
4. To report all incidents related to the management and control of health and social care associated infection
5. To gain an understanding of all policies and procedures, their application and be accountable for their own actions in assisting the reduction of health and social care associated infection.

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## 8.3 Champions

8.3.1 It is imperative that the role of the Champion is supported by their employer whether directly or via line management structures. This is a new role and those undertaking the role will need time and support in developing their role and acquiring and maintaining the necessary skills and competences.

8.3.2 In June 2006 the Department of Health published Infection Control Guidance for Care Homes. This guidance recommends that the person in charge of each care home should identify a senior nurse or other responsible person who will take a particular interest in infection control and who will act as the control of infection person. In addition it recommends that this person should undertake specific training in infection control to enable them to recognise problems as they occur and seek specialist advice (see appendix 3). The Royal College of Nursing in July 2008 published a report "Hand Hygiene alone will not reduce healthcare associated infections". This report suggested "that infection rates appear to be lower where there is strong leadership... and where workloads are manageable." In order to meet these guidelines and recommendations we recommend that each care home or domiciliary team should appoint someone who is directly responsible for infection control in other words a 'Champion'.

8.3.3 This Strategy identifies a number of aims and some of these are applicable for a Champion to meet. These are assisting in the standardisation of associated infection control policies and practices of Health and Care Providers across the North East of England. Ensuring that patients and service users who are at risk of acquiring health and care associated infection are identified by standardised risk assessment and that the assistance then provided is appropriate, safe and suitably recorded and monitored. Ensuring that appropriate action is taken following a serious health & social care associated infection incident and that any learning is implemented and disseminated ensuring that appropriate reporting mechanisms are in place to ensure all relevant audits are undertaken to provide assurance of compliance with the policies and practice outcomes.

8.3.4 The Champion will also have a key role in helping to assist in the allocation of appropriate resources to provide comprehensive services to prevent health and social care associated infection and to identify gaps and bring these to the attention of the appropriate organisations.

8.3.5 In order for the Champion to be truly effective and have real credibility the role must be underpinned by a clearly recognisable, transferable set of skills, competences and knowledge. We identified that the Champion would need to be able to deliver the following functions:

- a. Leadership
- b. Maintaining up to date Knowledge and Skills
- c. Maintaining up to date knowledge of parallel activities through networks/briefings
- d. Support Learning and Good Practice in the workplace
- e. Monitoring compliance
- f. Recording compliance and reporting issues
- g. Take corrective action when required
- h. Maintaining quality standards
- i. Liaise and communicate with relevant representatives
- j. Support risk assessment
- k. Cascade information
- l. Support Continuous Professional Development
- m. Auditing skills
- n. Change management.

- 8.3.6 We have mapped these functions against potentially relevant qualifications that are already being delivered. A copy of this mapping is available at Appendix 4. We identified that the most suitable qualification is NVQ L3 Management. We recommend that the Champion will need:
- a. Level 2 qualification that contains elements of competence, assessed in the workplace, in infection prevention and control (see appendix 3)
  - b. Be currently competent and recently updated in infection prevention and control
  - c. Be in a supervisory role
  - d. Have or be working towards an NVQ L3 Management that contained the recommended unit profile of:
    - 4 Mandatory Units plus
    - i. D7 - Provide Learning Opportunities for Colleagues
    - ii. D8 - Help Team Members Address Problems Affecting their Performance
    - iii. Either C2 - Encourage Innovation in your Area of Responsibility or D9 - Build and Manage Teams.
- They will also need bespoke training in:
- i. the use of the Essential Steps Toolkit
  - ii. Acting as the named link with the Infection Control Team within the local PCT
  - iii. Updating current practice.

## 8.4 Manager's Role

- 8.4.1 Registered Managers have personal responsibility for the management and control of health and social care associated infection. These are:
1. To undertake all learning and development provided to them by their employer
  2. To achieve appropriate learning and qualifications where required
  3. To apply all learning and development provided to them by their employer
  4. To report all incidents related to the management and control of health and social care associated infection
  5. To gain an understanding of all policies and procedures, their application and be accountable for their own actions in assisting the reduction of health and social care associated infection
  6. To manage staff in line with policy and procedure
  7. To regularly audit, in line with local policy, all health and social care associated infection organisational or establishment processes
  8. To quality assure the above processes and the practice of their staff to ensure due diligence is being observed
  9. To notify the Health Protection Unit of any occurrence of notifiable diseases or outbreaks of infection
  10. It is the responsibility of the Registered Manager to nominate a senior nurse or other responsible person (Champion) who will take a particular interest in infection control and will act as the infection control liaison.

## 8.5 Development of Procedures specific to Residential and Day Care Establishments

- 8.5.1 This Strategy requires that appropriate procedures are developed to ensure adherence to local policy and will provide an audit trail that demonstrates that standards are being maintained. These procedures will cover the following areas:
1. Isolation
  2. Record Keeping
  3. Safe handling of laundry
  4. Hydrotherapy Pools
  5. Cleaning and disinfection of equipment and the environment
  6. Emotional Care and Confidentiality
  7. Immunisation of Staff

More detail on each of these areas can be found in Appendix 2.

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**APPENDIX 1**  
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**Current good practice  
guidelines & standards**

# APPENDIX 1

## Current Good Practice Guidelines and Standards

The following guidelines and standards have been imported from the Infection Control Guidance for Care Homes - Department of Health, June 2006

It is intended that the guidelines and standards in this appendix are applicable for all care staff whether working in a residential or domiciliary care setting.

### 01. Communicable diseases

All care home staff should be aware of the National Minimum Standards, which sets out the standards that apply to all care homes providing accommodation and nursing or personal care for older people. Those responsible for the day-to-day organisation of the home must have the knowledge and skills to manage and ensure good hygiene standards as laid out in the guidance

(Department of Health, 2003).

### 02. Hand hygiene

Also refer to Prevention of health-care associated infection in primary and community care (NICE, 2003).

Hand hygiene is widely acknowledged to be the single most important activity for reducing the spread of infection. Yet evidence suggests that many healthcare workers do not decontaminate their hands when they need to nor use the correct technique. Hand hygiene must be performed immediately before each and every episode of direct patient contact and after any activity or contact that could potentially result in hands becoming contaminated. Staff should be trained in the use of liquid soap and water, and alcohol hand rub for hand decontamination, and must understand how and when this should be done. Alcohol hand rubs should be used at the point of care. Alcohol hand rubs are not suitable for use on hands that are contaminated with organic matter (eg. faeces, secretions) or during outbreaks of diarrhoeal illness amongst residents caused by *Clostridium difficile* when washing hands with soap and water is necessary. Hand hygiene facilities comprising a hand wash basin, supplied with hot and cold water and disposable paper towels, must be available and easily accessible and not used for any other purpose than hand hygiene. A lack of or inappropriate facilities must be brought to the attention of the manager or owner of the home who has a duty of care to ensure that there are adequate materials and facilities to prevent cross infection in the home.

### 03. Personal protective equipment

Also refer to Prevention of health-care associated infection in primary and community care (NICE, 2003).

Selection of personal protective equipment (PPE) must be based on an assessment of the risk of transmission of micro-organisms to the resident, and the risk of contamination of a healthcare worker's clothing and skin by the resident's blood, other body fluids, secretions or excretions. Disposable gloves and aprons are used to protect both the healthcare worker and the resident from the risks of cross infection. In certain circumstances it may be necessary to wear other PPE, such as a mask and/or goggles/visor. These should be worn when recommended by infection control personnel.

#### Disposable gloves

As with all items of PPE, the need for gloves and the selection of appropriate materials must be subject to careful assessment of the task to be carried out and its related risks to the resident and the healthcare worker. The assessment should include:

1. Who is at risk and whether sterile or non-sterile gloves are required
2. What the risk is, ie. the potential for exposure to blood, body fluids, secretions or excretions where the risk is, ie. contact with non-intact skin or mucous membranes during general care and any invasive procedures.

Gloves are required when contact with blood or body fluids or non-intact skin is anticipated. They should be single use and well-fitting. Sensitivity to natural rubber latex in patients, carers and healthcare personnel must be documented, and alternatives to natural rubber latex gloves must be available, eg. nitrile gloves.

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Gloves are not a substitute for hand hygiene. Gloves must be discarded after each care activity for which they were worn in order to prevent the transmission of micro-organisms to other sites in that individual or to other residents. Washing gloves rather than changing them is not safe and therefore not recommended. Hands should always be decontaminated following removal of gloves.

#### **Disposable plastic aprons**

These should be worn whenever there is a risk of contaminating clothing with blood or other body fluids, or when a resident has a known infection. A disposable plastic apron should also be worn during direct patient care, bed-making, or when decontaminating equipment. The apron should be worn as a single-use item, for one procedure or episode of patient care, and then discarded as clinical waste as soon as the intended task is completed. Hands should be washed following this activity. Aprons must be stored so that they do not accumulate dust that can act as a reservoir for infection.

#### **Masks, visors and eye protection**

These should be worn when a procedure is likely to cause splashes with blood or body fluids into the eyes, face or mouth or when it is recommended by infection control personnel when a communicable disease is suspected. It is rare that such protection is necessary in a care home. However, such protective equipment should be stored in the home in case of an emergency.

#### **04. Safe handling and disposal of sharps**

Also refer to Prevention of health-care associated infection in primary and community care (NICE, 2003).

Staff should be trained in the safe handling and disposal of sharps. Venepuncture and injections should only be carried out by staff who are trained and competent in these procedures.

#### **05. Management of blood exposure incidents and post-exposure prophylaxis**

It is important that incidents in which staff are exposed to blood and certain body fluids are managed and followed up correctly, with the provision of post-exposure prophylaxis if necessary, as there is a risk of blood-borne virus transmission (Human Immunodeficiency Virus (HIV), hepatitis B and hepatitis C).

The risk to care workers of hepatitis B, hepatitis C and HIV infection is proportionate to the prevalence of that infection in the population served, the infectious status of the individual source patient, which may or may not be known, and the risk of a significant occupational exposure occurring during the procedures undertaken. In the healthcare setting, occupational blood-borne virus transmission most commonly occurs after percutaneous (ie. through the skin) exposure to a patient's blood by 'sharps' or 'needlestick' injury.

The risk of transmission to a healthcare worker from an infected patient following such an injury has been shown to be around one in three when a source patient is infected with hepatitis B and is 'e' antigen positive (a marker of high infectivity) around one in 30 when the patient is infected with hepatitis C, and around one in 300 when the patient is infected with HIV.

Staff who may have direct contact with patients' blood or blood-stained body fluids or with patients' body tissues should be immunised against hepatitis B. There are currently no vaccines to protect against hepatitis C or HIV.

It is recommended that employers draw up a policy on how such incidents should be handled in conjunction with their CICN. Unless an employer has access to an occupational health service, it is likely that the assessment and follow-up of such incidents will need to be undertaken by their local accident and emergency department. In drawing up local policy, employers should clarify and confirm who will be able to provide such a service.

## 06. Managing spillages of blood or other body fluids

Blood and body fluids may contain a high concentration of micro-organisms, which must be made safe as soon as possible after the spillage has occurred. Clearing blood or body fluid spillages may expose the healthcare worker to pathogenic organisms and every care must be taken to ensure the member of staff is protected by the appropriate use of protective clothing.

The home should have a spillage kit available for use in clearing spills, and staff should be aware of the contents of the kit and trained in its use and in the proper management of biohazard and body fluid spillages. If the incident involves a spillage of blood, a chlorine-based disinfectant, such as sodium dichloroisocyanurate (NaDCC), should be used. Chlorine-releasing agents such as this are corrosive to metal and will bleach soft furnishings.

The spillage kit should contain a disposable scoop for clearing any spillages of needles or any other sharp items that may have spilled out of their container. Gloved hands should not be used to pick up used needles.

**Do not discard sharp items into yellow clinical waste bags and never throw biohazardous waste into the general domestic waste stream.**

## 07. General cleaning

Care homes should be cleaned and kept clean to the highest possible standards simply because care home residents and the public expect, and have a right to, the highest standards of cleanliness. Care providers should be aware that standards of cleanliness are often seen as an outward and visible sign of the overall quality of care provided. Individuals are likely to have significant concerns about the quality of care available in premises that are not kept clean.

A key component of providing consistently high quality cleaning is the presence of a clear plan setting out all aspects of the cleaning service and defining clearly the roles and responsibilities of all those involved, from managers through care staff to domestics. Where cleaning services are provided by private contractors this plan should also set out management arrangements to ensure the provider delivers against the contract. Contracting out the cleaning service does not mean contracting out responsibility, and managers will need to ensure there are suitable arrangements in place to monitor the standards being achieved and to deal with poor or unsatisfactory performance.

A range of advice and guidance has been provided to the NHS in the area of cleanliness, both in terms of providing cleaning services and in monitoring the standards being achieved. While this has in general been designed with NHS hospitals in mind, most of it can equally well be applied to care homes with little or no adjustment. The following source documents will be of particular interest.



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## 08. National specifications for cleanliness

These specifications, contained within the document Guidance on contracting for cleaning, set out in clear and simple terms the standard expected across 49 'elements', which taken together cover all the important aspects of cleanliness encountered in keeping premises clean, from equipment to fixtures and fittings. In addition, it provides a simple auditing / monitoring process which allows care providers to check on how they are performing against the standards.

## 09. Healthcare facilities cleaning manual

This is a detailed, easy to follow, step-by-step manual demonstrating the correct way to clean and detailing the cleaning materials and equipment (and maintenance of equipment) needed to help achieve the highest possible standards of cleanliness. It includes sections covering the prevention and control of infection, health and safety, and detailed methods for general cleaning (furniture, fixtures and fittings and walls), floors, kitchens, washrooms and sanitary areas. There is also advice covering specialist areas (including cleaning of isolation rooms) and patient equipment.

## 10. Minimum cleaning frequencies

Having clearly defined schedules of cleaning tasks is crucial in ensuring that they are carried out at the appropriate frequency. They also help to determine precisely what cleaning resource is needed. If cleaning frequencies are clearly displayed, this can help reassure residents and their family/visitors that cleanliness is seen as an important issue. An example of a minimum cleaning frequency schedule is contained within Guidance on contracting for cleaning.

## 11. Colour coding

Ensuring the risks from cross contamination through inappropriate cleaning practices are kept to the absolute minimum will be aided by the presence of a clear system for the coding of cleaning equipment. A cleaning industry standard designed by the British Institute of Cleaning Science exists and is recommended to all care homes.



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## 12. Environmental assessment

Since 2000, all NHS hospitals have been undertaking annual environmental assessments. These look at the whole range of non-clinical factors involved in the provision of care, including the physical condition of building, fixtures and fittings as well as cleanliness issues. These assessments can be helpful in identifying where additional resources may be required and in allowing care providers to develop plans to ensure that shortfalls are addressed in a practical and prioritised way. It is also considered good practice to include an independent representative during the assessment process, either from among the residents or from elsewhere within the local community, in order that the results of such assessments can be seen to be fair and reliable.

## 13. Decontamination

Within care settings, decontamination of patient equipment, medical devices and the environment occurs frequently. It is extremely unlikely that sterilisation of reusable medical devices occurs. Indeed, if this level of decontamination is required it should be sought from an accredited Sterile Services Department, or single-use disposable instruments should be used.



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## 14. Decontamination processes

Decontamination can be achieved by a number of methods, which fall into the following three categories:

**Cleaning** physically removes contamination but does not necessarily destroy microorganisms. It removes micro-organisms and the organic matter on which they thrive. Cleaning is a necessary prerequisite to effective disinfection or sterilisation. This will be the most common choice of decontamination method within the care home setting.

**Disinfection** reduces the number of viable micro-organisms but may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores.

**Sterilisation** renders an object free from viable micro-organisms including viruses and bacterial spores.

The choice of decontamination method depends on the risk of infection to the patient coming into contact with equipment or medical devices. Such items can be categorised into three risk groups:

**High risk** items are those used to penetrate skin or mucous membrane; or enter the vascular system or sterile spaces. They need to be sterilised if reusable, but single-use items are preferred.

**Intermediate risk** items are those which come into contact with intact mucous membranes or may be contaminated with particularly virulent or readily transmittable organisms. Such items require cleaning followed by disinfection or sterilisation.

**Low risk** items are those which come into contact with intact skin or do not contact the patient. They require cleaning.

## 15. Single-use instruments

As an alternative to sterilising reusable medical instruments, the use of single-use disposable equipment is becoming increasingly popular. Although many items, such as syringes and needles, have been available for many years, the cost, quality and availability of other equipment and instruments have resulted in a significant increase in single-use devices. Any device designated as single use must never be reused under any circumstances.

Suggested decontamination methods for commonly used equipment can be found in the table on pages 18 and 19 of the Department of Health's Infection Control Guidance for Care Homes

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## 16. Manufacturers' responsibilities

Manufacturers of reusable medical devices are required by the Medical Devices Directive (93/42/EEC) to supply clear written decontamination instructions, which should include appropriate cleaning, disinfection or sterilisation methods.

Certain fabrics or materials can be difficult to decontaminate. It is therefore advisable, prior to purchasing equipment, to assess carefully that the recommended decontamination methods are practical, safe and reliable.

## 17. General principles for cleaning

An automated or mechanical process must always be used in preference to a manual process. However, in many instances this is not possible. When using automated methods, for example washing machines, this is normally followed by disinfection, which is achieved by high temperatures (thermal disinfection) within the wash cycle as opposed to the use of chemicals such as bleach.

## 18. General principles for chemical disinfection

Chemical agents should only be used where:

Sterilisation is not required it is impossible to disinfect using heat cleaning alone is insufficient.

Disinfectants should not be used routinely as cleaning agents or deodorants.

Disinfectants must not be used for the storage of equipment (eg. mops).

Organic debris (eg. faeces, secretions) may inactivate some disinfectants. Items should be clean prior to chemical disinfection.

Disinfectants must be used at the recommended dilution.

Disinfectants must be stored and discarded in accordance with the manufacturers' instructions.

Disinfectants must not be used unless agreed by the occupational health and safety department and the infection control team.

COSHH regulations must be adhered to.

A timing device with an audible signal must be used to ensure immersion for the correct time period.



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## 19. Waste

Due to legislative changes that include the Hazardous Waste (England and Wales) Regulations 2005 and the Lists of Waste Regulations 2005 (which introduce the European Waste Catalogue Codes), there have been substantial changes in the way that waste is defined. Clinical waste is still defined in the Controlled Waste Regulations 1992; however, as a consequence of the Hazardous Waste Regulations 2005, any waste that is deemed to be infectious or hazardous is considered to be hazardous waste and must be consigned for disposal at suitably licensed facilities. The Hazardous Waste Regulations 2005 define infectious waste as “substances containing viable micro-organisms or their toxins which are known or reliably believed to cause infection in man or other living organisms”.

New guidance on the disposal of waste produced by healthcare providers is in development. The following information about waste disposal is an interim guide. Guidance on local policy should be sought from the CIGN or EHO.

This following information aims to ensure the safe and efficient collection, handling and disposal of all waste, and in particular clinical waste/hazardous waste.

## 20. Responsibilities

The responsibility for the day-to-day management of clinical/hazardous waste rests with the person in charge. All those working in areas where clinical/hazardous and general waste arise must adopt safe working practices, since failure to do so may result in the establishment being in breach of its statutory obligations as regulated by the Environment Agency under the Environmental Protection Act, section 34 Duty of Care requirements.

The person in charge has a duty to ensure that all clinical/hazardous waste is correctly bagged, sealed, tagged and stored before collection for incineration/alternative treatment as appropriate. Collection of waste should be arranged through a licensed disposal contractor - using licensed carriers to transport the waste to licensed treatment/disposal plants only.

## 21. Staff training

Management has the responsibility for ensuring that all staff and volunteers are trained by a competent waste manager and that records are maintained.

Those responsible for staff training must ensure that staff use appropriate protective clothing and equipment.



## 22. Segregation of waste

**All waste should be secured in an approved way and identified with a coded tie or label.**

Areas where clinical/hazardous waste is produced should have foot-operated bag holders.

There should be a wall chart showing the correct bags to be used according to the type of waste.



# APPENDIX 1

## 23. Categories of waste

### A. Clinical waste

The following must be disposed of in yellow bags:

1. Soiled surgical dressings, swabs and all other contaminated waste from treatment areas
2. Material other than linen from cases of infectious disease
3. All human tissues (whether infected or not) and tissues from laboratories, and all related swabs and dressings
4. Tampons and used sanitary towels; where possible, these should be disposed of separately in dedicated bins.

The following should be disposed of in a macerator; if not, they must be disposed of in yellow / orange bags depending on treatment route:

1. Incontinence pads, including those from non-infected residents
2. Used disposable bedpan liners, urine containers, incontinence aids and stoma bags, even from non-infected residents. Water authorities are now expecting that healthcare providers seek authorisation before flushing away disposable bedpan liners as they are known to block up pumps and drains.

Managers are responsible for ensuring that there is an effective procedure for dealing with an accidental spillage (see section on managing spillages). This procedure must include staff training. A named person (head of department/supervisor) and deputy must be designated. There must be proper cleansing of the affected area and any tools or protective clothing used should be correctly dealt with.

**Note:** Non-infected waste can go to landfill in tiger bags - yellow bag with black stripe.

### B. Sharps

**The following must be disposed of in a sharps container:** discarded syringes, needles, cartridges, small items of broken glass and any other sharp instruments.

Sharps contaminated with pharmaceutical medication, especially cytotoxic and cytostatic medication, must be disposed of by incineration.

### C. Non-clinical waste or domestic waste

Other general waste (food waste, non-contaminated paper and household materials) should be disposed of in black bags.

The Hazardous Waste Regulations 2005 do not allow mixing; this includes mis-segregation of domestic-type waste into the clinical or hazardous waste stream.

### D. Bulk storage of waste

Specific areas (stillages) must be designated. Storage should be in a well-drained area, with impervious hard standing and wash-down facilities. The area should be kept secure from unauthorised persons. Storage areas should not be accessible to scavenging animals.

**Clinical/hazardous waste in orange or yellow bags must be kept separate from general waste in black bags** to minimise the risk of accidental cross contamination. All accidental spillages in the bulk storage areas must be cleaned up immediately (see section on general cleaning). The area should be fully cleansed at least weekly with an appropriate disinfectant; it should not be hosed down as this may cause the formation of aerosols.

### E. Disposal of pharmaceutical products

Unused drugs and other pharmaceutical products should be returned to the pharmacist; they must not be administered to any resident other than the resident for whom they were dispensed.



# APPENDIX 1

## 24. Immunisation

Presented below is a summary of some of the important diseases that may be relevant in a care home setting. For a full and comprehensive guide on all matters relating to vaccine preventable diseases refer to Immunisation against infectious disease 1996 - The Green Book. This is the Department of Health publication that reflects national policy on matters relating to immunisation. Copies can be accessed on the Department of Health website ([www.dh.gov.uk/greenbook](http://www.dh.gov.uk/greenbook)). Information and advice related to vaccine-preventable diseases can also be obtained from your local HPU.

COSHH requires that if a risk assessment shows there to be a risk of exposure to biological agents for which vaccines exist, then these should be offered if the employee is not already immune. The pros and cons of immunisation/non-immunisation should be explained when making the offer. The Health and Safety at Work Act 1974 requires that employees are not charged for protective measures such as immunisation.

For further information, refer to Biological agents: managing the risks in laboratories and healthcare premises

(Health and Safety Executive, 2005).

## 25. Influenza - residents and staff

Influenza is an acute viral infection of the respiratory tract. There are three types of influenza virus: A, B and C. Influenza A and B are responsible for most clinical illness. Influenza is highly infectious with an incubation period of between one and three days.

Influenza causes acute respiratory illness among people of all ages every winter. Those most severely affected are older people and people who already have a chronic medical condition such as heart or respiratory disease. Influenza is estimated to cause about 12,000 deaths in the UK in an average year and can put considerable strain on health services.

Annual influenza immunisation is recommended for all those living in long-stay care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality. Immunisation is also recommended for all those over the age of 65 years and all those aged over six months with serious chest, heart, liver, kidney disease or diabetes requiring insulin or oral hypoglycaemic drugs and those who are immunosuppressed by disease or treatment.

Influenza immunisation is highly effective in preventing influenza in working-age adults. Influenza immunisation is recommended for health and social care staff directly involved in patient care, especially for staff in nursing and care homes who look after older people. Influenza immunisation of staff may reduce the transmission of influenza to vulnerable patients, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves.



# APPENDIX 1



## 26. Pneumococcal infections

*Streptococcus pneumoniae* (also called pneumococcus) can cause severe chest infection, blood poisoning and meningitis, especially in the very young, elderly people, or in anyone with reduced immunity. Pneumococcal immunisation is recommended for all those 65 years and over and those under 65 years of age who are at an increased risk from pneumococcal infection.

These medical risk groups include people who have a heart condition, chronic lung disease, chronic liver disease, diabetes mellitus, a weakened immune system, a damaged spleen or no spleen.

A single dose of pneumococcal polysaccharide vaccine is recommended for those 65 years and over or over two years of age and in a medical risk group. Revaccination with pneumococcal vaccine is not recommended except for people whose antibody levels are likely to decline more rapidly, eg. people with no spleen or who have a problem with their spleen or people with chronic renal disease.

Ideally, pneumococcal vaccine should be given four to six weeks before elective splenectomy or chemotherapy. Where this is not possible, it should be given up to two weeks before.

## 27. Hepatitis B - staff

Hepatitis B vaccination is recommended for the following groups considered at increased risk:

1. Healthcare workers who may have direct contact with patients' blood or blood-stained body fluids or with patients' tissues; this includes any staff who are at risk of injury from blood-contaminated sharp instruments or being deliberately injured or bitten by patients
2. Staff of care homes and other accommodation for those with learning difficulties
3. Individuals in residential accommodation for those with learning difficulties
4. Individuals receiving regular blood or blood products and their carers
5. Patients with chronic renal failure
6. Patients with chronic liver disease.

The objective of the immunisation programmes is to provide a minimum of three doses of hepatitis B vaccine for individuals at high risk of exposure to the virus or complications of the disease.

# APPENDIX 1

## 28. Schedule

1. Nought, one and six months
2. Nought, one and two months in groups at high risk and for post-exposure prophylaxis. A fourth dose is given at 12 months

In those at risk of occupational exposure, particularly healthcare workers, antibody titres should be checked one to four months after the completion of a primary course of vaccine. It is preferable to achieve antibody titre (anti-HBs) above 100 mIU/ml.

## 29. Tuberculosis and BCG vaccine - staff

Human tuberculosis (TB) is caused by *Mycobacterium tuberculosis* and may affect any part of the body. The most common form of TB is pulmonary (lung) TB, which accounts for almost 60% of all TB cases in the UK. The symptoms are varied and depend on the site of infection. General symptoms may include fever, loss of appetite, weight loss, night sweats and lassitude. Pulmonary TB typically causes a persistent productive cough, which may be accompanied by blood-streaked sputum. Almost all cases of TB in the UK are acquired by the respiratory route through breathing in infected respiratory droplets from a person with infectious respiratory TB. Transmission is most likely when the index case has sputum that is smear positive for the bacillus on microscopy and often after prolonged close contact, such as living in the same household.

Not all healthcare workers are at an equal risk of TB. There are likely to be categories of healthcare workers who are at particular risk of TB and this should be part of the clinical risk assessment when the use of BCG is being considered for a healthcare worker, eg. contact with possible TB patients or clinical material. BCG vaccine should be offered to unvaccinated individuals aged under-35 years that are found to be tuberculin negative following Mantoux testing. There are no data on the protection afforded by BCG vaccine when it is given to adults aged 35 years and over.

# APPENDIX 1

## 30. Tetanus (lockjaw) - residents and staff

Tetanus can be caught through any wound contaminated by soil, including, for example, puncture wounds such as those inflicted by a rose thorn contaminated with manure. Most staff should have had a primary course of immunisation in childhood and adequate booster doses, including one on leaving school. Older staff and residents, however, may not have had either a primary course or adequate booster doses. Cases of tetanus have a high fatality rate, and it is recommended that the immunisation status of all staff and residents is checked and appropriate action taken.

## 31. Rubella (German measles) - staff

All seronegative women of childbearing age should be protected against rubella. Any nursing home which is likely to deal with women of childbearing age should require evidence from staff in the form of the result of an appropriate blood antibody test to show that they are immune to rubella (German measles). Although the disease is not much more than a mild fever and rash, it can have devastating effects on the developing foetus, especially during the first three months of a pregnancy. A history of the infection as a child or adult but without an antibody test is unreliable. There are many similar fleeting rashes that are not due to rubella and do not give immunity to it. Satisfactory evidence of protection would include documentation of:

1. Having received two doses of a rubella-containing vaccine, or
2. A positive antibody test for rubella.

Staff and female residents of childbearing age who are not immune should be immunised with two doses of mumps, measles and rubella (MMR) vaccine, the second dose given one month after the first.

[www.dh.gov.uk/  
assetRoot/04/13/43/33/04134333.pdf](http://www.dh.gov.uk/assetRoot/04/13/43/33/04134333.pdf)





### 32. Measles - staff

Measles is caused by a highly infectious virus of the paramyxovirus family that produces a rash and fever. It can result in complications such as convulsions, pneumonia, inflammation of the brain and even death.

Measles is spread by airborne or droplet transmission. Individuals are infectious from when the first symptoms occur to four days after the appearance of the rash.

MMR vaccine can be given to individuals of any age. The decision on whether or not to vaccinate adults needs to take into consideration the past vaccination history, the likelihood of an individual remaining susceptible and the future risk of exposure and disease. Individuals born before 1970 are likely to have had all three natural infections and are less likely to be susceptible. It is important that healthcare workers are protected against measles so that they do not transmit the virus to vulnerable groups.

Satisfactory evidence of protection would include documentation of:

1. Having received two doses of MMR vaccine,
- or
2. Positive antibody tests for measles.

MMR vaccine is recommended when protection against measles, mumps and/or rubella is required. It can be given irrespective of a history of measles, mumps or rubella infection or vaccination. There are no ill effects from immunising such individuals because they have pre-existing immunity that inhibits replication of the vaccine viruses.

### 33. Poliomyelitis - staff

Poliomyelitis is an acute illness that follows invasion through the gastrointestinal tract by one of three serotypes of polio virus (serotypes 1, 2 and 3). Transmission is through contact with the faeces or pharyngeal secretions of an infected person. Oral polio vaccine (OPV) was used for routine immunisation in the UK because of the risk of importation of wild virus until 2004, at which time it was replaced by inactivated polio vaccine (IPV). Both OPV and IPV provide excellent individual immunity.

# //////////////////APPENDIX 1

## 34. Varicella - staff

Varicella (chickenpox) is an acute, highly infectious disease caused by the varicella zoster virus. The illness usually starts with one to two days of fever and malaise although this may be absent, particularly in young children. Vesicles begin to appear on the face and scalp, spreading to the trunk and abdomen and eventually to the limbs. After three or four days, vesicles dry with a granular scab and are usually followed by further crops. Vesicles may be so few as to be missed or so numerous that they become confluent, covering most of the body.

Herpes zoster (shingles) is caused by the reactivation of the patient's varicella virus. Virus from lesions can be transmitted to susceptible individuals to cause chickenpox but there is no evidence that herpes zoster can be acquired from another individual with chickenpox.

Varicella immunisation is recommended for non-immune healthcare workers who have direct patient contact. Healthcare workers who have no previous history of chickenpox or shingles infection will need to have a blood test to check their immunity. Those who are seronegative should be recommended the vaccine.

# //////////////////APPENDIX 1



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**APPENDIX 2**  
**//////**

**General guidelines  
on the management  
of infections**

# APPENDIX 2

## General guidelines on the management of infections

This appendix is **not** intended to be applicable for staff working in a domiciliary care setting

### 1. Introduction

In this section, advice is given on how to prevent the spread of infection if individual cases occur in residents. Most of the diseases listed will have been diagnosed by a doctor (usually the resident's general practitioner), who should be the source of advice on treatment of the individual's illness.

Care homes are expected to meet the requirements laid down in the Care Standards Act 2000. In addition, Regulation 37 of the Care Homes Regulations 2001 states that:

"The registered person shall give notice to the Commission without delay of the occurrence of the outbreak of any infectious disease which in the opinion of any registered medical practitioner attending persons in the care home is sufficiently serious to be so notified."

Persons in charge are reminded of the need to keep a record of residents suffering from any infectious disease. They are encouraged to remind the doctor of the duty to notify the diseases listed in Appendix 1, and should themselves, immediately contact the local HPU by telephone to alert him or her to the occurrence of a case of any notifiable disease.

Whenever an outbreak of any infectious disease is suspected within a home, the person in charge must contact the local HPU.

Care homes should ensure that they provide suitable and sufficient information on each resident's infection status whenever they are moved from the care of one organisation to another.

### 2. Management of patients in isolation

It is important to remember that the resident in isolation will be both physically and psychologically isolated. When a decision about isolating an infected resident is taken, it is important to take into account the likely effect on the resident. Elderly people may become disorientated and confused by isolation, which should therefore be avoided unless it is really necessary. The local HPU/CICN will advise on the management of individual cases that pose difficulties. Verbal and written information must be given to both the resident and visitors; the local HPU/CICN may have leaflets explaining individual infections which the home can use. The information should include the details and reason for the isolation, the likely duration, precautions required and the ways in which the client's psychological and physical needs will be met, eg. availability of telephone, newspapers and visiting times.

Planning of a client's care must take into account the extra time required for isolation procedures, ie.. donning of protective clothing, psychological support, extra time to take in food and drinks.

# APPENDIX 2

## 3. Diarrhoea and vomiting

Diarrhoea in elderly people is common and does not always have an infective origin. Other possible causes are over-prescription of laxatives, change in diet, underlying bowel disease. Nevertheless, all cases should be taken seriously and presumed to be infectious until advised otherwise.

The resident's GP should be notified. If infection is suspected, the GP may arrange for specimens to be sent to the laboratory. This is particularly important if the diarrhoea follows a course of antibiotic treatment.

If more than two cases, suspected or known to be infectious, occur within a few days, the local HPU should be notified.

Residents who are vomiting should be kept in a single room as long as symptoms persist. Most acute diarrhoeal infection is caused by viruses and is shortlived, but the symptoms and their effect on the elderly person can be severe. There is often little warning of the vomiting and, as the viruses can become airborne, the infection can spread rapidly in a home. It is therefore important that infected residents are isolated until 48 hours after the symptoms have settled. In contrast, although bacterial infections can cause severe diarrhoea, the infection is less often passed from person to person, and it may not be necessary to keep the resident isolated until persistent diarrhoea has resolved. Management should be planned on a careful risk

assessment, which should take into account continence, personal hygiene, overall health, likelihood of physical contact with other residents or their food, the facilities available and the vulnerability of other residents. The local HPU/CICN can advise on this process.

Infected residents should, if possible, have sole use of a designated toilet as long as their symptoms persist. In the case of likely norovirus infection, they should keep a designated toilet facility for 48 hours after their symptoms have settled.

The local health protection team will advise on any special measures necessitated by an outbreak.

If food-borne infection is suspected, the HPU/EHO should be contacted and samples of food and of faeces/vomit should be retained for investigation. Sudden onset of symptoms in several residents and/or staff over 24 - 48 hours may suggest a foodborne problem.

Consideration should be given to the safety of visitors of residents with infections, particularly if the visitors are elderly or very young.

Information for visitors should ask them not to visit if they have had symptoms of diarrhoea or vomiting within the previous 48 hours.

Most residents with diarrhoea or vomiting can be cared for in the home environment, as the symptoms are likely to subside within 48 hours. In the event of hospital assessment/admission being necessary, the receiving hospital must be notified of the possibility of infection before the resident arrives, so that appropriate precautions can be put in place to prevent spread.

If a resident is discharged from hospital within 48 hours of the last symptoms of diarrhoea and vomiting, every effort should be made to care for them in a single room with a dedicated toilet and appropriate precautions until they have been clear of symptoms for 48 hours.

# APPENDIX 2

## 4. Respiratory infections

Respiratory infections are very common and may be serious in elderly or debilitated people. They may be viral or bacterial in origin. The risk of respiratory infections can be reduced by annual influenza vaccination of elderly residents, and younger residents with serious underlying health problems. Influenza immunisation for care staff can also reduce the likelihood of a 'flu outbreak' occurring. Elderly residents should also receive pneumococcal vaccine.

Many of these infections are airborne, so the residents should be nursed in a single room during the acute illness, particularly if they are coughing.

The GP may arrange for sputum specimens/respiratory secretions to be sent to the laboratory.

If an outbreak of respiratory disease in a residential home is suspected, the local HPU should also be contacted. They may arrange for the collection of further specimens, and suggest the use of antiviral medication if indicated.

Consideration should be given to the safety of those visiting residents with infections, particularly elderly and very young visitors.

If residents require admission to hospital during a possible outbreak of respiratory infection, the admitting hospital should be informed of the infection risk before the patient arrives.

Pneumonia, unless associated with a viral influenza-like illness, is unlikely to be infectious to others. Nevertheless, the resident may be very ill and nursing in a single room is desirable



# APPENDIX 2

## 5. Skin infections/infestations

It may be necessary to care for a resident in a single room until treatment of skin infections/infestations is complete, or during the acute/weeping phase of a skin infection.

Residents with infections must be treated with tact and their confidentiality must be protected. Although this applies to all types of infection, some infestations can lead to particular social stigmatisation.

The local HPU/CICN can advise on local policies on the treatment of infestations. They can also advise on how to co-ordinate the treatment of a large group of patients and/or staff and visitors if this is required.

Consideration should be given to the safety of visitors of residents with infections, and they should be provided with information about symptoms and treatment.

Visiting healthcare workers (eg. district nurses or physiotherapists) who have close physical contact with residents must be informed if a resident has a skin infection or infestation.

If a resident with a skin infection, or an active or partially treated infestation, requires admission to hospital, the admitting hospital should be informed of the condition.

## 6. Blood-borne infections

Residents with sudden onset of jaundice should be isolated in a single room, with use of a dedicated toilet, until hepatitis A has been ruled out.

Residents with jaundice due to hepatitis B or C, or those who are carriers of the viruses or have HIV infection, do not need to be isolated.

Standard precautions, including care with sharps disposal, must be strictly observed.

## APPENDIX 2



### 7. Antibiotic-resistant bacteria

Residents may be transferred from hospital while colonised with a variety of antibiotic-resistant bacteria. Examples include MRSA and ESBL-producing *E. coli*. Usually these bacteria will be colonising the skin or gut, without causing harm to the resident, and will not cause harm to healthy people.

Because colonisation can be very long-term, it is not appropriate to isolate residents known to be colonised with antibiotic-resistant bacteria. Good hand hygiene and the use of standard precautions will help minimise the spread of these organisms in a care home environment.

It is not recommended that residents are treated in an attempt to rid them of colonisation with antibiotic-resistant bacteria while in residential care, or that they are sampled repeatedly to monitor the colonisation. Occasionally treatment of colonisation is recommended if a resident is to undergo elective surgery, but this should be discussed directly with the infection control team in the hospital concerned.

If a resident previously known to be colonised with antibiotic-resistant bacteria requires admission to hospital, this information should be added to the referral note.

People affected by MRSA do not present a risk to the community at large and should continue their normal lives without restriction. MRSA is not a contraindication to admission to a home or a reason to exclude an affected person from the life of a home. However, in residential settings where people with open post-operative wounds or intravascular devices are cared for, infection control advice should be followed if a person with MRSA is to be admitted or has been identified amongst residents.

# APPENDIX 2

## 8. Laundry and linen

The provision of clean linen is a fundamental requirement of care. Incorrect handling, laundering and storage of linen can pose an infection hazard.

When setting up a care home, owners should consider whether they are going to have an on-site laundry or make other arrangements. Proper facilities for a laundry are expensive; commercial washing machines, dryers, ongoing costs of maintenance and labour are high. A long-term contract with a commercial laundry or hospital could be a more satisfactory solution.

Infection can be transferred between contaminated and uncontaminated items of clothing, laundry and the environments in which they are stored.

Even during a normal washing cycle a number of micro-organisms can be passed between clothing and linen, and will only be partially removed during the rinse cycles. Thorough drying of the laundry, however, does reduce the levels of contamination to a level that no longer poses a risk.

Within the care home, specific hygiene measures should be taken to reduce these risks, including:

1. Correct handling to prevent the spread of infection
2. Appropriate disinfection of the laundry.

The legal framework that applies to these activities includes the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999), The Control of Substances Hazardous to Health Regulations (2002) and the National Minimum Care Standards (2002).

HSG(95)18 Hospital laundry arrangements for used and infected linen remains extant guidance, although this will be reviewed during 2006/2007. Advice can be sought from the CICN.



# APPENDIX 2

## 9. Requirements for laundering

A laundry area designated for that purpose only, with separate ventilation and a flow through system, so that dirty laundry can arrive through one door and be quickly decontaminated, before drying and removal through a separate exit to a clean storage area.

An industrial washing machine with sluice and hot wash cycles is required. These should be professionally installed and maintained with precautions to prevent contamination by them creating aerosols.

An industrial dryer should be used that is regularly maintained to dry all clothing and linen.

A regular service and maintenance inspection schedule should be maintained for the home's regulating body.

Appropriate personal protective clothing and eye protection should be available for staff.

Hand decontamination facilities, including hand hygiene basin with lever taps and no plug or overflow, liquid soap and disposable paper towels. Hand decontamination solutions, eg. alcoholic hand gel, should be available along with a pedal-operated clinical and domestic waste bin and first aid kit.

Under no circumstances should a manual sluice facility or sluicing basin be used or situated in the laundry.

# APPENDIX 2



## 10. Handling dirty linen

All dirty linen must be handled with care and attention paid to the potential spread of infection. Plastic aprons and suitable gloves should be worn for handling dirty or contaminated clothing and linen. Gloves in the laundry should meet the same standards as gloves used for other caring activities because of the potential exposure to blood and other body fluids. Care should also be taken to reduce the risks of latex sensitisation through the continued need to wear protective gloves - suitable alternatives are available for purchase.

Linen should be removed from a resident's bed with care, avoiding the creation of dust, and placed in the appropriate bag category outside the room. Personal clothing should also be removed with care and placed in the linen bag, not placed upon the floor. Linen should be separated into categories ready for decontamination, negating the need for additional handling within the laundry. Laundry staff should never empty bags of linen onto the floor to sort the linen into categories - this presents an unnecessary risk of infection. Hands should then be decontaminated.

Linen should be divided into three basic categories ready for decontamination; many care homes currently use three water-soluble/alginate bag liners within cotton sacks in a wheeled trolley to aid this separation, keeping linen off the floor before taking the bags to the laundry.

Policy on the management of linen may differ from area to area. The following advice is given as a suggested practical approach to the management of laundry within the care home. Further advice can be sought from your CICN. If linen is sent to an off-site laundry, they should be made aware of its nature and their written guidelines should be followed. You should be satisfied that the laundering of items sent will meet decontamination guidelines.

## 11. Categorisation and segregation of linen

It is the responsibility of the person disposing of the linen to ensure that it is segregated appropriately. Three categories should be used, these can be colour coded.

**Used linen and clothing** - white cotton sack. Soiled linen should be placed into a clear, water-soluble/alginate bag, clothing into a separate water-soluble bag, within a white cotton sack.

**Heavily soiled/infected linen** - red cotton sack. Heavily soiled items should have any solids removed prior to being placed into a red, water-soluble/alginate bag within a red cotton sack. Infected linen includes linen with blood or other body fluids present that could contain pathogenic organisms, eg. viral gastroenteritis or blood where blood-borne viruses could be present.

**Clothing and heat-labile linen** - off white cotton sack. This should be placed into a clear, water-soluble/alginate bag within a cotton sack. Heavily soiled clothing should be placed into a red, water-soluble/alginate bag.

Manual soaking/slucing must never be carried out. The pre-wash/slucing cycle in the washing machine should be used after removing any solids.

# APPENDIX 2

## 12. The laundering process

Many micro-organisms will be physically removed from the linen, by the detergent and water, during the washing cycle. Washing at high temperatures, above the normal domestic 40°C wash, will allow the temperature of the water to disinfect the items.

All linen/clothing should enter the laundry through the dirty entrance, and should not be stored but quickly processed.

The laundry staff should never open the inner water-soluble bags. Instead, the bags should be transferred to the washing machine for decontamination. Machines should not be overloaded.

All items should be processed in a cycle that reaches 71°C for at least three minutes or at 65°C for at least ten minutes. Heavily soiled/infected linen should also have a pre-wash cycle selected. Heat-labile items should be washed at the highest temperature possible for the item. If the item has been heavily soiled or is infected, it should be placed in a red, water-soluble bag and a pre-wash cycle selected, along with an appropriate disinfectant, eg. oxygen-releasing or bleaching agent added to the washing process. Regularly washing items below 65°C without using a bleaching agent may allow biofilms to build up in the machines.

All items should then enter a drying process within an industrial dryer. Once removed they should be stored in a clean area, above floor level and not be kept in the laundry area.

## 13. Advice to staff on laundering of uniforms

The uniforms of staff providing personal care should be changed daily, and the wash temperature should reach the minimum of 65°C for at least ten minutes. This should be followed by thorough drying and hot ironing.

## 14. Hydrotherapy Pools

Where hydrotherapy pools are installed, the following actions should be followed:

1. Pay particular attention to the manufacturer's instructions in relation to the prevention of infection
2. Cleaning, disinfection and chlorination are carried out to a written procedure in accordance with the installers' instructions
3. Regular water testing for bacterial contamination and disinfection levels are carried out, monitored and audited
4. Keep appropriate records of the cleaning, disinfection and water tests and their results

## 15. Emotional Care and Confidentiality

People who are seriously ill and perhaps dying have a right to expect their culture, faith and lifestyle to be respected.

Anti-discriminative practice should be adhered to when supporting people with a communicable disease. People, who are ill, have a right to be treated with dignity and respect.

Service users have the right to absolute discretion and confidentiality.

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# APPENDIX 3



# APPENDIX 3

## Education, Training & Development - Level 2 & 3

It would be good practice for all members of staff to initially undertake training in infection prevention and control that delivers all appropriate underpinning knowledge and have passed all the relevant learning assessment requirements.

To support this, awarding bodies have developed a new qualification - Award in the Prevention and Control of Infection, which is included in the Qualification Credit Framework (QCF) and highlighted below

Learning Aim Ref	Learning aim title	Award Body	Current provision Indicator	NVQ Level	For Review	Hours
50042725	Award in the Prevention and Control of Infection (QCF)	CG	Y	2	12/10	70
50047188	BTEC Award in Prevention and Control of Infection (QCF)	EDEXCEL	Y	2	12/10	70
50043791	Award in the Prevention and Control of Infection (QCF)	EDI	Y	2	12/10	70
50042968	Award in the Prevention and Control of Infection (QCF)	NCFE	Y	2	12/10	70

The qualifications that have been approved for inclusion on the QCF underpin the NOS and are owned by Skills for Health as the lead Sector Skills Council and include an outcome of demonstration of good hand washing technique and correct use of PPE.

### Additional Guidance

A useful publication is the Health & Safety Executive document 'Health & Safety in Care Homes'. This book is available from the HSE website [www.hsebooks.com](http://www.hsebooks.com) ISBN0717620824

### Appropriate Competency based qualification

Although there are many references to infection control and client safety within a variety of NVQ units, there is not one implicit unit specifically for this area. Therefore as part of good practice, anyone undertaking NVQ's within the Health & Social Care sector, should consider giving reference to this as part of their demonstration of competence and good practice whilst undertaking any aspect of their award.

Good practice should be embedded within any organisation whose business is in respect of caring for people, whether within a health or social care setting.

Within this context it is recommended that the Essential Steps to Safe, Clean Care - A good practice guide published by the Department of Health should be adopted. This will formulate effective practices of good hand hygiene within those establishments and should be considered as the minimum best practice benchmark in respect of Infection Prevention and Control.

Observations of staff hand hygiene practices should be undertaken by the designated, responsible person on at least an annual basis.

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# APPENDIX 4



## Skills Mapping with Current Qualifications

# APPENDIX 4

Best fit	Maps with		SfH NOS Health	SfC NOS Care	M&L Stands 2004	SfH NOS M&L	L2 NVQ H&SC	L3 NVQ H&SC	L4 NVQ H&SC	L2 Team Leading 4 Man 2 Opt	L3 NVQ M'ment 4 Man 3 Opt	L4 NVQ M'ment 5 Man 4 Opt	L4 NVQ RMA	L4 NVQ LMCS
	Essential Skills	Leadership Skills												
Leadership Skills		GEN 33			B5 B6 E7 F1	B5 E7 B6 F1	B5 M			B6 O	B6 O	B6 O	RM1 M A2 O	LMC A1 M
Maintaining up to date Knowledge and Skills	HSC23 HSC33 HSC43	HSC23 HSC33 HSC43			A2	A2		HSC33	HSC43		A2 M	A2 O	RG6 O	LMC A1 M
Maintaining up to date knowledge of parallel activities through networks/briefings	GEN 27 HSC33 HSC43	HSC33 HSC43			F8 A3	A2 A3		HSC33	HSC43			F8 O A3 O	RG6 O SC15 O	LMC D1 O
Support Learning and Good Practice in the workplace	HSC23 HSC43 HSC348	HSC23 HSC43 HSC348			D7 D8	D7	D7 O D8 O	HSC23	HSC43		D7 O D8 O	D7 O	C13 M	
Monitoring compliance	HSC3120	HSC440 HC3120			B8	B8		HSC440	HSC440			B8 O	F6 O	LMC C1 M
Recording compliance and reporting issues	HSC3120	HSC440 HC3120			B8 D6	B8 D6		HSC440	HSC440			B8 O D6 O	F6 O	LMC C1 M
Take corrective action when required	HSC240 HSC3117 HSC430	HSC240 HSC3117 HSC430			C1 C2 B8 E10	C1 C2 B8	C1 O	HSC430	HSC430		C2 O	B8 O C2 M E10 O		
Maintaining quality standards	HSC451 GEN 3	HSC451			D5 D6	D5 D6	D5 O	HSC451	HSC451		D6 M	D6 O	C13 M F3 O	LMC A5 O LMC E3 O
Liaise and communicate with relevant representatives	GEN 27 HSC433	HSC433			D1 A3 D2 F8	D2 A3	D1 M	HSC433	HSC433		D1 O	A3 O D2 M F8 O	SC15 O	LMC D1 O
Support Risk Assessment	HSC240 HSC3117 HSC22 HSC32 HSC42 HSC430	HSC240 HSC3117 HSC22 HSC32 HSC42 HSC430			E5 E6 B10	B10 E5 E6	E5 M	HSC42 HSC430	HSC42 HSC430		E6 M	B10 E6 M	A2 O	LMC C1 M
Cascade Information	HSC26 HSC43 HSC3115	HSC26 HSC43 HSC3115			D7 E11	D7	D7 O	HSC43	HSC43		D7 O E11 O	D7 O		LMC A1 M
Support Continuous Professional Development	HSC23 HSC33 HSC43 GEN 33	HSC23 HSC33 HSC43			D7	D7	D7 O	HSC43	HSC43		D7 O	D7 O	RG6 O OC10 O	LMC A1 M
Auditing skills	HSC3120	HSC3120											F3 O F6 O	
Change Management					C4 C5 C6	C4 C6					C4 O C5 O C6 O	C4 O C5 O C6 O	F3 O	LMC A2 O

# APPENDIX 4

LMCS A1	Manage and develop yourself and your workforce within care services
A2	Manage your own resources and professional development
RMA A2	Manage activities to meet requirements
LMCS A2	Facilitate and manage change within care services through reflective motivating and flexible leadership
A3	Develop your personal networks
LMCS A5	Allocate and monitor the progress and quality of work in your area of responsibility - imported D6
B5	Provide Leadership for your team
B6	Provide Leadership in your area of responsibility
B8	Ensure compliance with legal, regulatory, ethical and social requirements
B10	Manage Risk
C1	Encourage innovation in your team
LMCS C1	Develop and maintain systems, procedures and practice of care services to manage risks and comply with health and safety requirements
C2	Encourage innovation in your area of responsibility
C4	Lead Change
E11	Communicate information and knowledge
LMCS E11	Manage a project - imported F1
F1	Manage a project - imported to LMCS as E11
RMA F3	Manage continuous quality improvement
RMA F6	Monitor compliance with quality systems
F8	Work with others to improve customer services
GEN 3	Maintain health and safety in a clinical/therapeutic environment
GEN 27	Develop, sustain and evaluate collaborative working with other organisations
GEN 33	Enable other individuals to reflect on their own values, priorities, interests and effectiveness
HSC22	Support the health and safety of yourself and individuals (Health and Safety core)
HSC23	Develop your knowledge and practice (Personal and Professional Development, core)
HSC26	Support individuals to access and use information
HSC32	Promote, monitor and maintain health, safety and security in the working environment (Health and Safety, core)
HSC33	Reflect on and develop your practice (Personal and Professional Development, core)
C5	Plan Change
C6	Implement Change
RMA C10	Develop teams and individuals
RMA C13	Manage the performance of teams and individuals
D1	Develop productive working relationships with colleagues
LMCS D1	Lead and manage work for care services with networks, communities, other professionals and organisations
D2	Develop productive working relationships with colleagues and stakeholders
D5	Allocate and check work in your team
D6	Allocate and monitor the progress and quality of work in your area of responsibility - imported to LMCS as A5
D7	Provide Learning Opportunities for colleagues
D8	Help team members address problems affecting their performance
LMCS E3	Monitor and manage the quality of the provision of care services
E5	Ensure your own actions reduce risks to health and safety
E6	Ensure health and safety requirements are met in your area of responsibility
E7	Ensure an effective organisational approach to health and safety
E10	Take effective decisions
HSC42	Contribute to the development and maintenance of health and safe practices in the working environment (Health and Safety core)
HSC43	Take responsibility for the continuing professional development of self and others (Personal and Professional Development, core)
HSC240	Contribute to the identification of the risk of danger to individuals and others
HSC348	Help individuals to access learning, training and development opportunities
HSC430	Support the protection of individuals, key people and others
HSC432	Contribute to the development and maintenance of healthy and safe practices in the working environment (Health and Safety, core)
HSC433	Develop joint working agreements and practices and review their effectiveness
HSC436	Promote and manage a quality provision (Imported Unit - CHILD CARE RESIDENTIAL MANAGER 17)
HSC440	Support effective governance (Imported Unit - DANOS AB5)
HSC451	Lead teams to support a quality provision
HSC3115	Receive, analyse, process, use and store information
HSC3117	Conduct an assessment of risks in the workplace (Imported Unit - ENTO UNIT G)
HSC3120	Support competence achieved in the workplace (Imported Unit - LEARNING AND DEVELOPMENT L20)
RMA RM1	Manage a service which meets the best possible outcomes for the individual
RMA RG6	Take responsibility for your business performance and the continuing development of self and others.
RMA SC15	Develop and sustain arrangements for joint working between workers and agencies



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# //////GLOSSARY OF TERMS

CCDC	Consultant in Community Disease Control
Cdif	Clostridium difficile
CICN	Community Infection Control Nurse
COSHH	Control of Substances hazardous to health
DN	District Nurse
EEC	European Economic Community
EHO	Environmental Health Officer
HDH	Department of Health
HPU	Health Protection Unit
MDC	Metropolitan District Council
MMR	Measles Mumps & Rubella
MRSA	Methicillin-resistant Stephylococcus Aureus
NHS	National Health Service
NICE	National Institute for Health & Clinical Excellence
NOS	National Occupational Standards
NVQ	National Vocational Qualification
PPE	Personal Protective Clothing
PCT	Primary Care Trust
UK	United Kingdom

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