Version Control	Date Published	Review Status
V001.1	August 2021	August 2022
V2	Sep 2022	Sep 2023

The Wellington Practice

INFECTION PREVENTION CONTROL POLICY (ENGLAND)

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1 Introduction

1.1 Policy statement

The purpose of this document is to ensure that The Wellington Practice remains committed to the prevention of healthcare-associated infection and that patient safety is the utmost priority. Regulation 15 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 requires that healthcare premises are clean, secure, suitable and used properly and that a provider maintains standards of hygiene appropriate to the purposes for which they are being used.

This policy incorporates the NHS England National Standards for Healthcare Cleanliness dated April 2021. It should be noted that these standards apply to all healthcare settings, including GP surgeries regardless of the way cleaning services are provided.

This policy should be read in conjunction with the Cleaning Standards and Schedule Policy where audits of cleanliness to support infection control can be found. Furthermore, CQC GP Mythbuster 6: Guidance about Privacy Curtains and GP Mythbuster 99: Infection Prevention and Control in General Practice should also be consulted to ensure compliance.

1.2 Status

This document and any procedures contained within it are non-contractual and may be modified or withdrawn at any time. For the avoidance of doubt, it does not form part of your contract of employment.

1.3 KLOE (England only)

The Care Quality Commission would expect any primary care organisation to have a policy to support this process and this should be used as evidence of compliance against CQC Key Lines of Enquiry (KLOE).[1]

Specifically, The Wellington Practice will need to answer the CQC key questions on “Safe” and “Responsive”.

The following is the CQC definition of Safe:

By safe, we mean people are protected from abuse and avoidable harm. *Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse*.

CQC KLOE S1	How do systems, processes and practices keep people safe and safeguarded from abuse?

The following is the CQC definition of Responsive:

By responsive, we mean that services meet people’s needs.

CQC KLOE R1	How do people receive personalised care that is responsive to their needs?

1.4 Training and support

Guidance and support to help those to whom it applies to understand their rights and responsibilities under this policy is available. Additional support will be provided to managers and supervisors to enable them to deal more effectively with matters arising from this policy.

2 Scope

2.1 Who it applies to

This document applies to all employees of the organisation and other individuals performing functions in relation to the organisation such as agency workers, locums and contractors.

Furthermore, it applies to clinicians who may or may not be employed by the organisation but who are working under the Additional Roles Reimbursement Scheme (ARRS).[1]

2.2 Why and how it applies to them

The organisation aims to design and implement policies and procedures that meet the diverse needs of our service and workforce, ensuring that none are placed at a disadvantage over others, in accordance with the Equality Act 2010. Consideration has been given to the impact this policy might have with regard to the individual protected characteristics of those to whom it applies.

Good infection prevention and control (IPC) is essential to ensure that people who use primary care services receive safe and effective care. The Wellington Practice is committed to providing effective IPC procedures to minimise the risk of infection and to ensure the safety of patients, visitors and staff alike.

2.3 IPC and COVID-19

New recommendations for primary and community healthcare providers in England relating to COVID-19 can be sought here. Specifically, the recommendations state:

- Providers of primary and community health services should ensure that measures are in place so that all settings are, where practicable, COVID-secure, using social distancing, optimal hand hygiene, frequent surface decontamination, ventilation and other measures where appropriate

- Where a setting cannot be delivered as COVID-19 secure through all other means, a local assessment may conclude that primary and community healthcare staff (both in clinical and non-clinical roles), when not otherwise required to use personal protective equipment, should wear a face mask, worn to prevent the spread of infection from the wearer

- Where a COVID-19 secure environment cannot be maintained, patients and members of the public entering primary and community healthcare premises should be advised to use face coverings in line with government advice

Further support on assessing risks can be sought from the COVID-19 risk assessment - An aide memoire.

2.4 IPC lead

At The Wellington Practice, the IPC lead is the Lead Practice Nurse and this is detailed within their job description.

The IPC lead is responsible for promoting good infection control practice within The Wellington Practice. They are to ensure that:

- They provide timely advice to colleagues, service users and relatives (where applicable)
- Training is provided regarding the standard principles of infection prevention control, specifically training in hand decontamination, the use of PPE and the safe use of and disposal of sharps (this list is not exhaustive)
- Appropriate supplies of sharps containers, PPE and materials for hand decontamination are available

Staff at The Wellington Practice are to support the IPC lead in maintaining high standards of infection prevention and cleanliness.

Promoting these high standards and then providing evidence of the organisation's compliance is essential for reputational purposes coupled with the need to maintain high levels of both patient and staff safety.

The CCG IPC lead at Frimley CCG is
Vivienne O'Connor
LEAD for INFECTION PREVENTION & CONTROL and PRIMARY CARE QUALITY
DEPUTY DIRECTOR OF INFECTION PREVENTION AND CONTROL

For any specialist advice is sought as required.

2.5 Guidance documentation and policies

The Wellington Practice refers to the following guidance documentation and policies which are related to infection prevention and control:

- Accident reporting policy
- Cleaning standards and schedule policy
- Clinical audit policy
- Health and safety policy
- Safe water policy
- Staff immunisation policy
- Staff occupational health policy
- Workplace fans and COVID-19 risk assessment

2.6 Further supporting information

In addition to the guidance detailed within the annexes of this policy, the following should also be used as reference material when referring to IPC:

- COVID-19: Infection Prevention and Control Guidance

- GOV.UK – Managing common infections: Guidance for primary care
- GOV.UK Healthcare waste
- (HTM 07-01) Management and disposal of healthcare waste.
- GP Mythbuster 99 – Infection prevention control in primary care
- GP Mythbuster 6 – guidance about privacy curtains
- Health and Social Care Act 2008
- Health and Social Care Act Code of Practice
- Health and Social Care Act (Regulated Activities) Regulations 2014
- HSE – Sharps injuries
- Medical Protection Society – Risk alert: Infection control
- MRSA Community Infection and Control Guidance for General Practice
- NHS – Best way to wash your hands
- NHS – What should I do if I injure myself with a used needle
- NICE Guidance – Healthcare-associated Infections [CG139]
- NICE Guidance – Infection Prevention and Control: Quality Standard 61
- National Standards of Healthcare Cleanliness 2021
- National Standards of Healthcare Cleanliness 2021: Appendices
- PHE – Legionella: Detection in healthcare premises
- PHE – IPC guidance – Appendix 1
- PHE – IPC COVID-19 guidance – Appendix 2*

*Note, posters are available within Appendix 2 although similar posters are available within this document at Annex A – Infection Control Biological Substances Protocol and Annex K – Handwashing.

3 Minor surgery and healthcare associated infections

3.1 Overview

Given the increasingly wide variety of healthcare which is delivered in primary care, staff at The Wellington Practice are to use this guidance for the prevention of healthcare acquired infections.

Patient safety is an imperative of care and preventing healthcare-associated infections is a priority for The Wellington Practice. Advice can be sought from the publication, Community Infection Prevention and Control Guidance for General Practice: MRSA.

NICE guidance CG139 reports that an estimated that 300,000 patients a year in England acquire a healthcare related infection as a result of care within the NHS. Healthcare acquired infections (HCAI) are often carried by the patients themselves and the pathogens causing these infections will take advantage of a route into the body provided by an invasive device or procedure. HCAI can exacerbate existing or underlying conditions, delay recovery and adversely affect quality of life.

To assist the IPC lead, the Royal College of Nursing (RCN) have provided this comprehensive document titled, Methicillin-resistant Staphylococcus aureus (MRSA) - Guidance for nursing staff.

3.2 MRSA

In 2007, *methicillin-resistant staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of, or a contributory factor in, approximately 9,000 deaths in hospital and primary care in England.

MRSA is to be found on the skin or in the nose of up to 33% of the population and generally does not cause an infection. However certain patients are at risk of infection from MRSA including patients who:

- Are elderly
- Have an underlying or chronic illness
- Are in intensive care
- Have had major surgery
- Are fitted with invasive devices such as urinary devices

Extra care is to be taken when dealing with these at-risk patients to avoid them becoming infected with MRSA.

3.3 Minor surgery and other high-risk procedures

As a result of complex care increasingly being delivered in primary care settings, standards for the care of patients and the management of devices to prevent related infections are needed that will also reinforce the principles of asepsis.

The Health and Social Care Act 2008 Code of practice on the prevention and control of infection and related guidance assumes that all providers of healthcare in primary care settings are compliant with this code. The guideline aims to help to build on advice given in the code and elsewhere to improve the quality of care and practice in these areas over and above current standards.

At The Wellington Practice, the high-risk procedures include:

- Therapeutic injections used in a variety of conditions such as:
  - Injections into joints (steroids)
  - Aspiration of joints
  - Injection of tennis and golfer's elbow, or carpal tunnel injection
- Excisions
- Incisions
- Other procedures which the practice is deemed competent to carry out - e.g.insertion and removal of contraceptive implants

In conjunction with NICE guidance CG139, the areas as detailed within the primary care HCAI pathway and the appropriate infection control measures are to be robustly adhered to. These areas are:

- Availability of equipment
- Hand decontamination
- Personal protective equipment
- Waste disposal
- Safe use and disposal of sharps

3.4 Equipment and rooms

At The Wellington Practice, the dedicated treatment room is 2/GP/9 (the Minor Surgery Suite) which is to be used wherever possible for invasive procedures. However, should this not be available, then a normal consultation room can be used provided that there is adequate lighting and space.

Any medical equipment should be fit for purpose, be of adequate specification, single use and disposable wherever possible. Should there be any uncertainty about the adequacy of equipment, the Clinical

3.5 Minor surgery compliance

When undertaking minor surgery, the table below is a check-off guide to ensure that this organisation remains compliant when undertaking surgical procedures:

Requirement	Expected standard
Facilities	• Appropriate equipment for procedures undertaken • Appropriate premises
Clinical support	• Appropriately trained and competent • Professionally accountable to their professional body
Sterilisation and infection control compliance	• Appropriate standards
Clinical waste disposal	• Appropriate standards
Consent	• Appropriate standards
Patient information	• Proper written record • Inform own GP in writing if not registered with the practice
Clinician has the necessary skills to conduct the contracted procedures and includes:	• Regular update of skills • Ability to demonstrate a continuing and sustained level of activity • Conducting regular audits • Participation in appraisal of minor surgery activity • Participation in supportive educational activities
Pathology	• All specimens to be sent for histology
Audit	• Conducted
Appropriate training for all those involved in procedures	• Appropriately trained

4 Guidance

4.1 Policy incorporation

This policy incorporates the following protocols (as annexes):

- Clinical Waste Management Protocol
- Disposable (Single-Use) Instruments Protocol
- Infection Control Biological Substances Protocol
- Infection Control Inspection Checklist
- Example Infection Control Annual Statement Report
- Isolation of Patients Protocol
- Needle-Stick Injuries Protocol
- Notifiable diseases
- Safe use and disposal of sharps
- Sample Handling Protocol
- Staff exclusion from work
- Sterilisation and Decontamination Protocol

- Toys in reception/waiting areas

4.2 Compliance

The Wellington Practice ensures compliance with the Health and Social Care Act 2008 Code of Practice criteria which are:

1. Systems to manage and monitor the prevention and control of infection

2. Provide and maintain a clean and appropriate environment in managed premises which facilitates the prevention and control of infections

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

4. Provide suitable, accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

5. Ensure prompt identification of people who have, or are at risk of developing, an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

7. Provide or secure adequate isolation facilities

8. Secure adequate access to laboratory support as appropriate

9. Have and adhere to policies that are designed for the individual's care and provider organisations that will help to prevent and control infections

10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection

4.3 Annual IPC statement

The annual IPC statement details the risk assessments undertaken and subsequent recommendations regarding IPC. In addition, the statement also details IPC-related significant events and audits completed.

The Health and Social Care Act 2008 - Code of Practice on the prevention and control of infections and related guidance (Appendix D) states that the IPC lead is to prepare an annual statement *"for anyone who wishes to see it, including patients and regulatory authorities."*

This short review should include the following:

- Known infection transmission event and actions arising from this
- Audits undertaken and subsequent actions
- Risk assessments undertaken for the prevention and control of infection
- Education and training received by staff
- Review and update of policies, procedures and guidance

In addition to this, it is considered that this report should include any actions relating to any significant event that has occurred during the reporting period.

To meet the above HSCA directive of “anyone who wishes to see it”, this statement is to be placed on the organisation website.

4.4 Summary

All staff undertake infection prevention and control training and are committed to maintaining high standards of infection prevention and cleanliness within The Wellington Practice.

Regular training, audit and reviews are key to the prevention of healthcare-associated infection.

5 Personal protective equipment

5.1 General

Whilst there has always been a need to provide robust PPE measures in primary care to support infection control principles, during the pandemic there has been a significant emphasis on having greater protection from COVID-19.

Public Health England suggests that *“those most at risk within the UK are professionals working in health and social care sectors. This is because these sectors are responsible for providing essential treatment and care for those who are confirmed to have COVID-19, are symptomatic or are highly vulnerable. They are in prolonged close contact with individuals who are symptomatic or particularly vulnerable to infection”.*

The UK government and devolved administrations have published clear guidance on appropriate PPE for health and social care workers and this has been written and reviewed by all four UK public health bodies and informed by NHS infection prevention control experts.

Governmental information is consistent with World Health Organization (WHO) guidance for protecting health and social care workers from COVID-19 and can be found here. The joint Public Health England and NHS England document titled COVID-19: Infection prevention and control (IPC) provides comprehensive IPC guidance including risk management pathways in the support of COVID-19.

Further reading can be found at COVID-19 risk assessment – an aide memoire.

5.2 Legal

The regulations require that where the health and safety risks cannot be controlled by other means, PPE is required to be correctly selected and used.

If PPE is required then it will be provided free of charge by the organisation.

5.3 PPE requirements

In accordance with the COSHH Regulations, the hierarchy of controls that should be applied when assessing the risks are:

- Eliminate
- Substitute
- Segregate
- Ventilate including local exhaust ventilation
- Personal protective equipment

However, it is recognised that in certain situations and environments not all of these controls can be suitably considered such as infection control between person to person.

Employees who have been provided with PPE must ensure it is used and worn in accordance with the instructions provided.

RCGP advises that basic PPE protection includes:

- Disposable aprons
- Disposable gloves
- Fluid resistant face mask
- Eye protection. This should be worn when there is a risk of contamination to the eyes from splashing of secretions (including respiratory secretions), blood body fluids or excretions

Face masks for general patient assessment only need to be of a fluid resistant, surgical mask types. Once worn, masks should not be touched and should be changed if they become damp or damaged.

An individual risk assessment should be carried out prior to/at the time of providing care. Eye/face protection can be achieved by the use of any one of the following:

- Surgical mask with integrated visor
- Full face shield/visor
- Polycarbonate safety spectacles or equivalent

Cambridge Hospitals NHS Trust has provided this YouTube clip detailing PPE requirements and procedures within primary care.

Further reading can be sought from HSE.

5.4 Risk assessment and selection of PPE

The completion of a risk assessment will identify if there is a requirement for PPE, such as when preparing COSHH assessments that identify the requirement for gloves when using certain substances.

When selecting the suitability of PPE, the following will be taken into account:

- It is appropriate for the risks involved and the extent of exposure
- It will be used to prevent or adequately control the risks without increasing the overall risk
- It will be adjustable and meet the needs of the user in order to fit correctly and comfortably
- The health and wellbeing of employees required to use it
- The length of time that it is to be worn and the requirements for visibility and communication
- The compatibility when using more than one item of PPE

It is essential that the right type and standard of PPE is identified and provided. Additionally, all new PPE will be "CE" marked to demonstrate certain basic/minimum safety requirements.

Further reading on risk management and risk assessing can be found in both the Risk and issue guidance document and the Risk assessment guidance document.

5.5 Information, instruction and training

The organisation will ensure that, where PPE is provided, the provision of adequate information, instruction and training on its use are also included. This will cover:

- The types of risk exposure and why PPE is required
- The operation, performance and limitations of the equipment
- Correct methods for usage and storage
- Any testing requirements before use
- User maintenance including hygiene and cleaning procedures
- Factors that may affect the equipment
- How to identify defects in PPE and the methods of reporting them
- Arrangements for PPE replacement

Refresher training will be provided when required.

5.6 Maintenance and storage

Maintenance schedules provided with the PPE from the manufacturer are designed to ensure the equipment continues to give the degree of protection for the required purpose. These schedules can also include recommended replacement periods and expiry dates. When issued with PPE, it is important to follow the procedures with regard to cleaning, examination, replacement, repair and testing of any equipment supplied.

Any costs incurred for the maintenance of PPE will be the responsibility of the organisation and adequate storage facilities for PPE in order to protect it from contamination, damage, damp or sunlight when not in use will be provided.

5.7 Duties of employees regarding PPE

PPE is a fundamental element of safe practice in primary care. At The Wellington Practice, staff must be aware of the requirements for PPE and infection control requirements and associated policies.

The Personal Protective Equipment at Work Regulations place duties on employees to take reasonable steps to ensure that the PPE provided is properly used.

Other requirements include:

- PPE must be worn and used in accordance with the instructions given
- Employees must take all reasonable steps to ensure that PPE is stored correctly and safely when not in use
- PPE must be examined before use
- Any loss or obvious defect must be immediately reported

- Employees must take reasonable care of any PPE provided and not carry out any maintenance unless trained to do so

Furthermore, in accordance with HTM 07-01,[2] the following details the specification for PPE:

- COSHH requires that risks to health be eliminated, prevented or, where this is not reasonably practicable, reduced.

  Although the use of PPE should be considered as additional to other control measures, it is likely that even after all reasonably practicable precautions have been taken to reduce the exposure of staff who handle, transfer, transport, treat or dispose of healthcare waste, some PPE will still be required. In such cases, employers must ensure that these items are provided, used and maintained.

  They must also make appropriate arrangements for storage and cleaning whilst employees must cooperate with employers to ensure that their legal duties are met.

  The COSHH risk assessment guidance document can be used to support the organisation of the management of COSHH.

Risk assessments might identify the need for PPE, such as:

- Suitable heavy-duty gloves when handling healthcare waste receptacles

  Safety shoes to protect the feet against the risk of receptacles being accidentally dropped. The soles of such shoes or boots may also need to provide additional protection against slippery floors and sharps

  An industrial apron or leg protectors if receptacle handling creates a risk of bodily contact

- Protective face visors, helmets and strong industrial gloves where incinerators or other machines are charged manually

Emergency situations, such as spillages, should also be addressed in any risk assessments. This might include the need for protective equipment to prevent exposure via routes such as skin contact (for example single-use aprons and gloves) or inhalation (for example respiratory protection and/or face visors).

Basic personal hygiene is important in reducing the risk from handling healthcare waste. Employers need to ensure that washing facilities are conveniently located for people handling healthcare waste; this is particularly important at storage and incineration facilities.

5.8 Duties of employees regarding personal clothing

All personnel at this organisation are to ensure that their own clothing is clean and ‘fit for purpose'. Further reading with regard to staff obligations including uniform requirements that support PPE can be found in the Uniform, dress and appearance policy.

5.9 Guide to donning and doffing PPE

[2] DoH Environment and sustainability HTM 07-01

See

UK Health Security Agency

Guide to donning and doffing PPE: Droplet Precautions

for health and social care settings

Donning or putting on PPE

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

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

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

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

4. Put on non-sterile nitrile gloves.

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

Doffing or taking off PPE

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

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

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

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

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

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

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

6. Remove surgical mask.

7. Now wash your hands with soap and water.

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

overleaf UKHSA poster that can be used as a guide to donning and doffing PPE:

Source: UK Health Security Agency (UKHSA)

PPE is to be disposed of as infectious clinical waste (orange bag).

Annex A – Infection Control Biological Substances Protocol

Introduction

A biological agent is defined as a micro-organism, cell culture or human endoparasite, whether or not genetically modified, that may cause infection, allergy, toxicity or otherwise create a hazard to human health.[3]

Overview

Healthcare workers will come into contact with a number of sources of infection, be it directly or indirectly, such as:

- Blood and bodily fluids
- Faeces, urine and vomit
- Direct skin contact
- Respiratory secretions and excretions

Staff must ensure that they adhere to the guidelines given in this document as well as regional and national guidelines. All staff at The Wellington Practice are given training in IPC at induction and will also receive annual refresher training.

Spillages

There may be occasions when exposure occurs despite careful attention to the correct procedures. If such incidents occur within the organisation, a spill kit should be used. At The Wellington Practice, the spill kit is stored in the emergency trolly. Only personnel trained in the use of this kit are authorised to use it.

Immediate actions

In the event of a spillage, the following actions are to be taken:

1. The spillage should be dealt with as soon as possible

2. Staff, patients and visitors must be kept away from the spillage and if possible a warning sign shown while preparation is made to manage the spill

3. Personal protective equipment (PPE), e.g., eye protection, long-cuffed disposable nitrile gloves and a disposable apron, should be used. If the spillage is extensive, disposable plastic overshoes or rubber boots may be necessary.

[3] COSHH 2002

Management of spills

- Small blood spills onto hard surfaces: Wearing gloves, clean with universal/detergent wipes and dispose as clinical waste.

- Large blood spills, e.g., spills onto floor (except urine): Wearing gloves and apron, use the blood spillage wipe and follow the instructions on the packet. Wash area with detergent and water.

- Very large blood spills including smears to walls etc.: Wearing gloves and apron, use spill wipes and leave to absorb for 30 seconds. Wipe, allowing the rest of the spill to be absorbed (if a larger spill), use the wipe contained within the pack to clean the area, place back into the bag, seal and dispose of in clinical waste.

- Blood-stained urine spills – DO NOT USE blood spillage kit: Wearing gloves and aprons, soak up urine with paper towels then wash areas with detergent followed by chlorine dioxide solution (Tristel).

- Urine/vomit spills: Wearing gloves and an apron, use the urine/vomit spillage kit and follow the instructions on the packet. Wash with detergent and water. If urine/vomit spillage kit is not available, soak up urine/vomit with disposable towels then wash area with detergent.

- Spills onto carpets or soft furnishings: Wearing gloves and apron, soak up spillage with paper towels then clean with detergent and water. Then, for carpets, steam clean or, for soft furnishings, launder or dry clean. If item remains soiled it must be disposed of.

Further actions and guidance

All incidents are to be reported to the Practice Manager in the first instance. Further guidance and information can be sought by contacting the Lead Practice Nurse.

Instructions for using spill wipes are shown overleaf.

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SOAKS UP SPILLS SAFELY, IN SECONDS

Clinell Spill Wipes are specifically developed to deal with bodily fluid spills quickly and efficiently. For use on blood spills, body fluid spills and urine.

Clinell Spill Wipes - (NHSSC: VJT268 / Order Code: CSW1)

Tear open the pack.

Remove wipes.

Place the active side (A) face down onto the spill. Leave to absorb for 30 sec.

Push down on plastic backed side (B) and wipe until spill is fully absorbed.

Remove a disinfectant wipe from the sachet.

Clean the spill area in an 'S' shaped motion, from clean to dirty.

Put soiled wipes and empty sachet back into the pack.

If required repeat steps 5-7 with the remaining wipe and reseal.

Dispose of pack as hazardous waste.

DISPOSE OF IN HAZARDOUS WASTE. DO NOT FLUSH OR MACERATE.

For more information, please contact the Infection Prevention and Control Team.

Annex B – Infection Control Inspection Checklist

Introduction

The purpose of this document is to enable The Wellington Practice to assess how it meets the standards for a managed environment that minimises the risk of infection to patients, staff and relatives. These standards reflect current legislation, national guidelines and good practice regarding infection control within a healthcare environment.

Usage

The checklist overleaf should be used as a guide and in conjunction with national guidelines. Each consulting room/treatment area, etc. should have an independent assessment completed and annotated on a separate form.

Summary

This checklist is not exhaustive and will need to be adapted to reflect building modifications, changes in practices, etc. The nominated IPC lead at The Wellington Practice will review this document annually to ensure accuracy and relevance.

Infection Prevention Control Checklist

Management of IPC	Yes	No	N/A	Comments
Is there a named lead person responsible for infection prevention and control?				
Are these responsibilities detailed in the individual's job description?				
Are infection prevention and control-related topics agenda items at organisation meetings?				
Is there evidence of a process for reporting incidents in relation to IPC?				
Are there up-to-date local contact telephone numbers available from which to obtain advice pertaining to IPC?				
Is there evidence that audits have been undertaken and practice changed regarding IPC?				
Are there local risk assessments held relating to IPC?				

Staff training pertaining to IPC	Yes	No	N/A	Comments
Is IPC included in all staff induction programmes?				
Have staff received mandatory training in IPC?				
Is there a process in place to ensure that all non-attendees at mandatory training are followed up?				

IPC policy and protocols	Yes	No	N/A	Comments
Are policies and protocols available to all staff?				
Are cleaning schedules in place and displayed in all areas?				
Are SLAs monitored and reviewed?				
Is there evidence of reviews of policies and protocols?				

Are audits regularly undertaken to review standards and procedures?				

General IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				
Is furniture made of impermeable and washable materials?				
Are all furnishings and fittings visibly clean and in a good state of repair?				
Is the floor visibly clean and in a good state of repair?				
Is the environment generally free from clutter?				
Are items such as telephones and IT equipment clean and in a good state of repair?				

Toilet IPC standards	Yes	No	N/A	Comments
Are the toilet environments visibly clean and free from any damage?				
Are all furnishings and fittings visibly clean and in a good state of repair?				
Are all dispensers clean and in a good state of repair?				
Are paper towels available from an enclosed dispenser?				
Is there a promotional hand hygiene poster displayed?				
Is there a hands-free domestic waste bin available, and is it in a good state of repair, clean and labelled appropriately?				
Are there appropriate facilities for the disposal of sanitary waste?				
Is the flooring in a good state of repair, clean and impervious to moisture?				

Baby-changing facilities IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				

Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials?				
Is there a dedicated basin for hand washing, and is it clean and in a good state of repair?				
Are all dispensers clean and in a good state of repair?				
Are paper towels available from an enclosed dispenser?				
Is there a promotional hand hygiene poster displayed?				
Is there a hands-free domestic waste bin available, and is it in a good state of repair, clean and labelled appropriately?				
Is there a hands-free waste bin available for the disposal of nappies, and is it in a good state of repair, clean and labelled appropriately?				
Are there instructions for parents displayed on how to clean the facilities after use and are cleaning materials available?				
Are the changing mats in a good state of repair, intact and clean?				
Is the flooring in a good state of repair, clean and impervious to moisture?				

Treatment & consulting room IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				
Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials?				
Is the flooring in a good state of repair, clean and impervious to moisture?				
Is there a dedicated basin for hand washing, and is it clean and in a good state of repair?				
Are sensor or elbow taps available?				

Are all dispensers clean and in a good state of repair?				
Are paper towels available from an enclosed dispenser?				
Is there a promotional hand hygiene poster displayed?				
Is there a hands-free domestic waste bin available for paper towels, and is it in a good state of repair, clean and labelled appropriately?				
Are alcohol-based hand-rub bottles wall-mounted in treatment rooms?				
Is there a designated work surface/trolley for clinical procedures, and is it clean and in a good state of repair?				
Are all items stored above floor level and are there appropriate storage facilities?				
Are all areas visibly clean (shelving, cupboards, drawers, etc.)?				
Are patient examination couches/chairs clean and in a good state of repair?				
Is the paper roll on couches replaced between patients?				
Are disposable privacy curtains in date and marked with an expiry date?				
Are non-disposable privacy curtains clean and laundered in line with the schedule?				
Is there a hands-free clinical waste bin available, and is it clean, free from damage and labelled appropriately?				
Is the drug fridge only used for the storage of drugs?				
Is there PPE readily available in the treatment/consulting rooms?				
Are sharps containers correctly assembled, labelled with a date, location and signed?				
Are all sharps bins free from protruding sharps, with contents below the ‘fill’ line?				

Are the lids closed between usage and bins out of the reach of vulnerable patients?				
Are sharps disposed of safely and not resheathed?				
Are full/locked sharps bins stored appropriately, away from public access until collected for disposal?				

Storeroom IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				
Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials?				
Is the flooring in a good state of repair, clean and impervious to moisture?				
Are all items stored appropriately and off the floor?				
Is the environment tidy and free from clutter?				

Domestic/cleaning cupboard IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				
Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials?				
Is the flooring in a good state of repair, clean and impervious to moisture?				
Are all items stored appropriately and off the floor?				
Is the environment tidy and free from clutter?				
Is there a dedicated basin for hand washing, and is it clean and in a good state of repair?				
Are sensor or elbow taps available?				

Are all dispensers clean and in a good state of repair?				
Are paper towels available from an enclosed dispenser?				
Is there a promotional hand hygiene poster displayed?				
Is there a hands-free domestic waste bin available for paper towels, and is it in a good state of repair, clean and labelled appropriately?				
Is there a disposal facility for dirty water available, and is it visibly clean, free from damage and in a good state of repair?				
Are mops and buckets stored appropriately and are they clean and dry?				
Is there a colour-coding system in place for cleaning equipment?				
Are all items stored correctly and in accordance with current regulations, i.e. COSHH?				

Staffroom/kitchen IPC standards	Yes	No	N/A	Comments
Is the environment visibly clean and free from any damage?				
Are all furnishings and fittings visibly clean, in a good state of repair and made from impermeable, washable materials?				
Is the flooring in a good state of repair, clean and impervious to moisture?				
Are all items stored appropriately and off the floor?				
Is the environment tidy and free from clutter?				
Is staff food placed in the fridge, correctly labelled with names and dates, and with expiry dates?				
Is the fridge free from medicines/drugs?				

Date inspection completed: [Insert date]

Inspection completed by: [Insert name and position]

This document should be retained as it can be used as evidence in an IPC audit.

Annex C – Clinical Waste Management Protocol

Introduction

NHS England's framework agreement sets out consistent standards for the collection and disposal of clinical waste from organisations. The framework identifies a number of benefits including quality standards, consistency, management of contracts and value for money. Clinical waste can be defined as any waste produced by, and as a consequence of, healthcare activities[4].

At The Wellington Practice the approved contractor is SRCL via Facilities Management.

Overview

Under the Environmental Protection Act 1990 it is unlawful to deposit, recover or dispose of controlled (including clinical) waste without a waste management licence, contrary to the conditions of a licence or the terms of an exemption, or in a way that causes pollution of the environment or harm to human health[5].

Hazardous healthcare waste is subject to the requirements of the Hazardous Waste Regulations 2005.

Aim

The aim of this protocol is to minimise the risks associated with clinical waste, particularly handling and disposal at The Wellington Practice. Throughout this protocol, the term clinical waste refers to "hazardous waste" generated by organisations.

This protocol is to be read in conjunction with the references in the footnotes and hyperlinks within the document.

Waste segregation

Segregation on-site is vital to ensure that waste is stored, transported and ultimately disposed of in the correct manner to maintain compliance with extant regulations. Clinical waste must be segregated as detailed overleaf.

Refer to the NHS Property Services poster and useful webinar that further explains the correct disposal of clinical and non-clinical waste and advice upon the following:

- Infectious clinical waste including COVID-19 PPE

  You should use the ORANGE bags for infectious clinical waste only. This includes COVID-19 waste and other infectious PPE, dressings and bandages etc.

  These orange clinical waste bags should not be placed in non-clinical areas such as corridors, entrances, staff rooms, kitchens and offices etc. so please only place them in infectious clinical waste areas.

[4] NICE Guidance

[5] Guidance on the correct disposal of potentially hazardous clinical waste

- Infectious clinical waste that is also contaminated by medicines and/or chemicals

  You must only put waste items that are both infectious and chemically contaminated (for example some samples and diagnostic kits) in the YELLOW bags.

- Non-infectious clinical waste, including face masks in non-infectious areas

  The recommended national guidance for YELLOW and BLACK striped bags should be used for non-infectious clinical waste, e.g., PPE, couch roll, dressings, plasters, bandages, nappies, feminine hygiene products etc. (*Note local Health Centre clinical waste does not provide for these bags)*

- General waste and recycling

  Paper hand towels, packaging, cardboard, plastic bottles, tins and any other waste items that are not clinical or infectious must be disposed of in the BLACK bags (general waste) or CLEAR bags (recycling).

Using the incorrect bag is causing huge issues for the clinical waste industry, resulting in missed collections and costing the NHS substantial amounts of money. Sending waste for incineration is 45% more expensive than sending waste to be recycled.

Further reading can be sought from NHS Property Services here.

Waste Type	Classification	Colour Coding	Description & Disposal Method
Infectious	Hazardous	YELLOW	Infectious waste which requires disposal by incineration.
Infectious	Hazardous	ORANGE	Infectious waste which may be treated to render safe prior to disposal or alternatively it can be incinerated.
Cytotoxic / Cytostatic	Hazardous	PURPLE	Waste consisting of, or contaminated with, cytotoxic and/or cytostatic products which requires disposal by incineration.
Offensive	Non-Hazardous	YELLOW & BLACK	Non-infectious, offensive/hygiene waste which may be recycled, incinerated or deep landfilled.
Anatomical	Hazardous	RED	Anatomical waste which requires disposal by incineration.
Medicinal	Non-Hazardous	BLUE	Waste medicines, out of date medicines, denatured drugs, which requires disposal by incineration.
Dental	Hazardous	WHITE	Dental amalgam & mercury including spent and out of date capsules, excess mixed amalgam & contents of amalgam separators which requires disposal by recovery or recycling.
Domestic	Non-Hazardous	BLACK	This waste should not contain any infectious materials, sharps or medicinal products, and requires disposal by landfill.

DISPOSING OF CLINICAL AND NON-CLINICAL WASTE

NHS Property Services

General	Dry Mixed Recycling	Medicine / Chemical / Infectious Waste	Infectious Waste	Offensive Waste	Cytotoxic / Cytostatic Waste
					
YES PLEASE					
					
Non-recylable materials	Food tins and drink cans	PPE contaminated with infectious / chemicals / medicne waste	Infectious PPE	Non-infectious PPE	PPE contaminated with cytotoxic / cytostatic waste
					
Small quantities of food waste	Mixed plastics	IV bags	Infectious dressings, plasters, bandages etc.	Nappy waste	Items contaminated with cytotoxic / cytostatic waste
					
Paper hand towels	Paper and card	Swabs contaminated with infectious / chemicals / medicine waste	Infectious swabs	Non-infectious dressings, plasters, bandages etc.	Dressings, plasters, contaminated with cytotoxic / cytostatic waste
NO THANKS					
					
Recycling waste	General	Paper hand towels	Paper hand towels	Paper hand towels	Paper hand towels
					
Clinical and sharps waste	Food	General and packaging	General and packaging	General and packaging	General and packaging
					
Liquids	Glass	Sharps	Medicines and sharps	Sharps	Sharps

Handling of waste

Clinical waste is classed as hazardous material and must therefore be handled and disposed of in a safe manner to ensure that personnel are not injured or exposed to contamination.

All personnel, when involved in the handling of clinical waste, should use the correct PPE; it is essential that staff have received IPC training before handling clinical waste. The minimum PPE requirements when handling clinical waste are gloves and an apron.

Clinical waste bins must be emptied on a daily basis and bags must not be filled more than three quarters full. Waste is removed daily by the Facilities Management Contracted cleaning service.

Collection

All clinical waste arangements ae via Facilities Management using SRCL and they are responsbile to retain all evidence regarding the correct and authorised removal of waste from the site. Hazardous waste requires a consignment note[6] (provided by the contractor) which must be retained for audit purposes.

Summary

All staff have a duty of care to ensure that waste is correctly segregated. Compliance with this protocol and the references within it will ensure the safe and effective management of waste at The Wellington Practice. Any questions relating to this protocol are to be directed to the Lead Practice Nurse in the first instance.

[6] Example of a Consignment Note

Annex D – Disposable (Single-Use) Instruments Protocol

Introduction

This protocol details the management of single-use items at The Wellington Practice. Single-use items are those items that are to be used on one patient, for a single procedure and then disposed of correctly. Reusing a single-use item could expose both staff and patients to unnecessary risks.

Overview

Single-use items are commonly used within the primary care environment. Whilst items held will vary depending on individual preferences, the management of such items remains the same. At The Wellington Practice, the nursing team is responsible for the ordering of medical stores, including single-use items.

Identifying single-use items

Single-use items have an identifier that clearly shows they are single-use only. This symbol is usually on the packaging of the item and may not be on the item itself. If there is any doubt, contact the manufacturer for further guidance.

The symbol that indicates single use is shown below:

Any item that displays this symbol can only be used on one individual, for a single procedure. Once used, the item must be disposed of correctly, following The Wellington Practice's clinical waste protocol.

Safety implications

There are a number of safety implications[7] regarding the reuse of single-use items that clearly explain the risks of reusing an item intended for single use.

Such implications are:

[7] Single-use medical items: implications and consequences of reuse

- Reprocessing single-use devices may compromise their intended function
- Single-use devices may not be designed to allow thorough decontamination and (if applicable) re-serialisation processes
- Reprocessing a single-use device may alter its characteristics so that it no longer complies with the original manufacturer's specifications and therefore the performance may be compromised
- Single-use devices have not undergone extensive testing, validation and documentation to ensure the devices are safe to reuse

Responsibility

Any individual who reuses an item identified for single use only bears full responsibility for the safety and effectiveness of its function; such actions are against the guidance of the Medicines and Healthcare Products Regulatory Agency (MHRA).

Summary

Single-use items are specifically manufactured for the purpose of being used once. The risks associated with reusing such items clearly outweigh the benefits. Reusing items exposes patients and staff to the risk of infection and transfers the responsibility from the manufacturer to the individual.

At The Wellington Practice, training is delivered on a regular basis to ensure that all staff are aware of this protocol and adhere to the single-use policy.

Annex E – Privacy Curtains Protocol

Introduction

The Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance sets out compliance in order to provide and maintain a clean environment in premises that ensures the prevention and control of infection. This includes the statement that "The environmental cleaning and decontamination policy should specify how to clean all areas, fixtures and fittings".

Overview

The Code of Practice references the national specifications for cleanliness in the NHS and states that "Curtains/blinds should be visibly clean with no blood or body substances, dust, dirt, debris, stains or spillages."

The national specifications for cleanliness in the NHS suggest cleaning frequencies as a guide and the CQC expects that providers risk assess the required cleaning frequency for their premises and follow their own protocols. The frequency is a decreed within the Cleaning standards and schedule policy. This policy should be used for further information and guidance, be agreed with the cleaning team and be to the same high standards as that which would be expected of the general public and includes:

- Curtains in rooms used for other purposes
- Window coverings such as blinds and curtains in treatment rooms

Privacy curtains in practice

Curtains around examination couches may either be:

- Disposable (paper) or
- Re-usable

This organisation has a programme to replace privacy curtains every 12 months. However, any privacy curtain will be changed immediately if visibly dirty, soiled or stained.

Curtains must extend fully around examination couches, giving full privacy and dignity and window coverings, which may be either curtains or blinds, should cover the whole of the window, giving full privacy and dignity.

Management and compliance

Cleaning at The Wellington Practice is managed and overseen by the NHS Property Services Facilities Management Service. All administration staff and clinicians are fully trained and responsible for identifying and reporting areas of concern regarding infection control and cleanliness.

Annex F – Carpets and Soft Furnishings Protocol

Introduction

At The Wellington Practice, no clinical space that includes a room or area is carpeted. Areas that do have a carpet are included within the cleaning schedule for cleaning, be this routine vacuuming or a scheduled full carpet clean

Minimising risk

A periodic clean has been agreed and will occur every 6 months, or sooner should there be a requirement.

Management of contaminated carpets or soft furnishings

Should any carpets or soft furnishings be contaminated with body fluids or spillages then the following process is to be adhered to:

- Always deal with a spillage immediately
- Wear disposable gloves and apron or gown. If risk of splashing, wear eye protection
- Gather equipment as required. This may include clinical or offensive waste bags, paper towels etc.
- Carefully remove bulk of spillage i.e., vomit/faeces etc. using paper towel or scoop then dispose of directly into waste bag
- If the item can be removed i.e., curtains or cushions, then place these items in appropriate bag for soiled items, secure and label
- If the item cannot be removed i.e., furniture or carpet, clean the area thoroughly with general detergent solution and warm water
- Ensure that any contamination of surrounding surfaces is appropriately dealt with
- Staff must request a professional clean via Facilities Management of the item or area and this item or area must remain out of use or cordoned off until fully cleaned and dried

Annex G – Needle-Stick Injury Protocol

Introduction

Sharps injuries are a well-known risk to workers in healthcare and, for those who receive them, they can cause anxiety and distress. For the purpose of this protocol, sharps injuries are defined as injuries sustained from needles, scalpels and other instruments that can cause injury by cutting or pricking the skin. This protocol gives detailed guidance for the management of sharps injuries at The Wellington Practice.

Overview

Anyone working at The Wellington Practice is at risk from a sharps injury; this includes healthcare workers or clinicians but also non-clinical members of staff who may be at risk if sharps are not stored or disposed of correctly. All employers are required under existing health and safety law to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.[8]

Minimising risk

Everyone has a duty of care to minimise the risk of exposure to sharps injuries at The Wellington Practice. The following actions will further reduce the risk of exposure[9]:

- No needle recapping or resheathing
- Availability of portable sharps containers
- Adequate number and placing of sharps containers within arm's reach
- Disposing of sharps immediately at the point of use in designated sharps containers
- Sealing and discarding sharps containers when they are three quarters full
- Establishing means for the safe handling and disposal of sharps devices before the beginning of a procedure

Training also reduces the risk of exposure, and at The Wellington Practice training pertaining to sharps injuries is delivered annually.

Management of sharps injuries

All staff need to be familiar with the immediate management procedure, both for themselves if they become injured and for assisting injured colleagues. The management of sharps injuries is shown in the infographic overleaf.

[8] Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

[9] Prevention and management of sharps injuries: Inspection of NHS Organisations (HSE 2016)

Managing sharps injuries

by **Will Stahl-Timmins**
illustrations by **Katie Jessop**

27th July 2015

1 First aid

2 Assess incident risk

Incident risk:	High	Low	Minimal
Injury	Deep	Superficial	No skin breach
Needle use	Intravascular	Suturing/ Subcutaneous	Not used on patient
Age of sharps	Recently used	Old, discarded	Contact with low risk fluids: Saliva, Urine, Vomit, Faeces
Blood on sharps	Visible	Not visible	

3 Assess source patient

for blood borne viruses. HIV, Hepatitis B (HBV) and hepatitis C (HCV) are the most common.

Post-exposure prophylaxis (PEP) and/or follow up treatment may be required.

Is the source patient known to be infected with one or more **blood borne viruses?**

Yes / No

No further action required

Viral load

Detectable / Unknown / Fully suppressed

Treatment status

Untreated / advanced infection / Unknown / Long term treatment, good adherence

Do risk factors apply?
e.g. Injecting drug users, men who have sex with men, sex workers

Yes / No

Recent blood test
negative for HIV, HBV & HCV

No / Yes

High risk exposure

HIV
Begin immediate PEP with antiretroviral agents
See table 2

HBV
Check vaccine status
See table 3

HCV
Follow up and treat if necessary
See table 4

Low risk exposure

No further action required

The full BMJ clinical review on sharps injuries is available at: **http://bmj.co/sharps**

Source: The BMJ

Reporting sharps injuries

At The Wellington Practice, all sharps injuries are to be reported to the Lead Practice Nurse or Duty GP if nurse absent.

Sharps injuries must be reported to HSE[10] under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) if:

- An employee is injured by a sharp known to be contaminated with a blood-borne virus (BBV), e.g., hepatitis B or C or HIV. This is reportable as a dangerous occurrence

- The employee receives a sharps injury and a BBV acquired by this route seroconverts. This is reportable as a disease

- The injury itself is so severe that it must be reported

If the sharp is not contaminated with a BBV, or the source of the sharps injury cannot be traced, it is not reportable to HSE unless the injury itself causes an over-seven-day injury. If the employee develops a disease attributable to the injury, then it must be reported.

Recording of sharps injuries at The Wellington Practice

All sharps injuries sustained at The Wellington Practice must be recorded as a significant event and discussed at practice meetings. As part of the SEA, the outcome may be to conduct an audit to ensure that the safest systems are being adopted, training may be one of the outcomes that needs to be considered.

It is the responsibility of the person suffering a sharps injury to ensure that it is reported/recorded appropriately.

If they are unsure, they should discuss the incident with the Practice Manager or Duty GP.

Summary

Sharps injuries are not uncommon within primary care. Due diligence and adherence to guidance and legislation will reduce the risk to all staff. Annual training is delivered at The Wellington Practice via eLearning to maintain an awareness of the significance of the safe management of sharps.

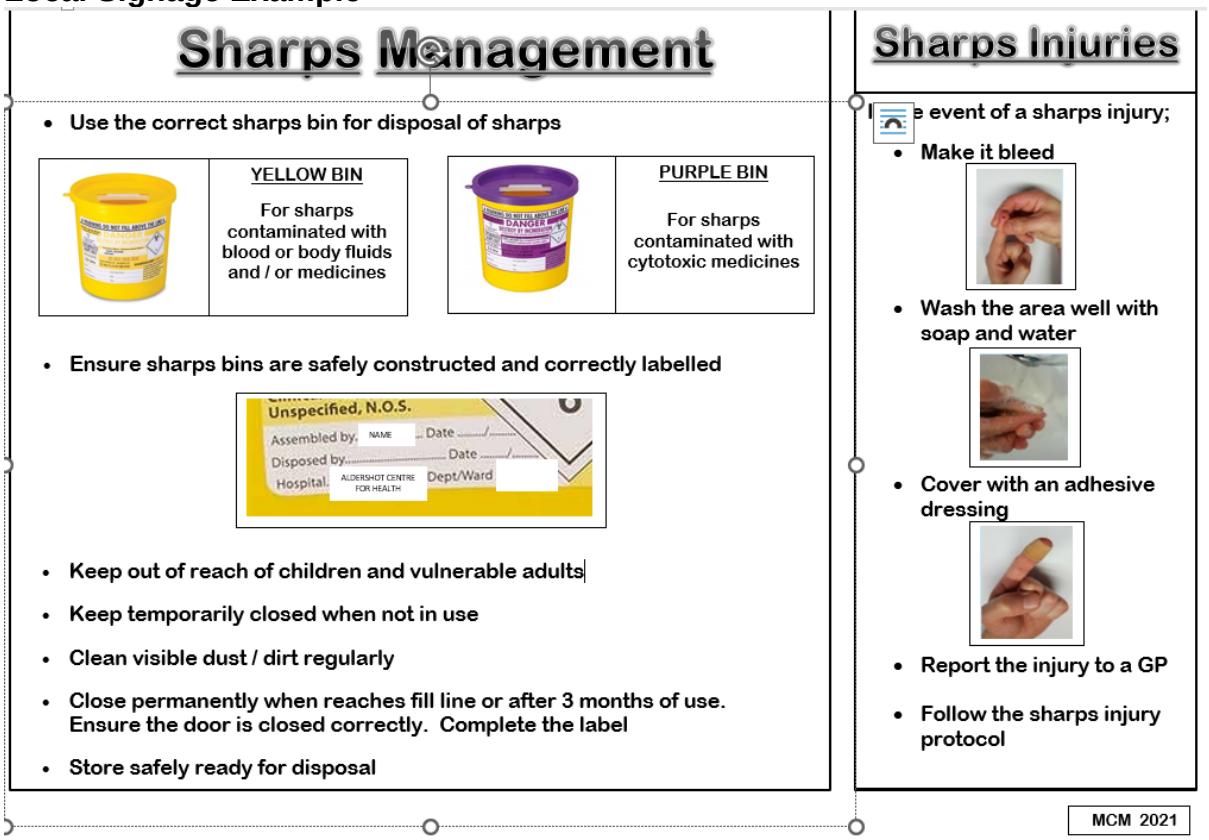
[10] HSE Sharps injuries – What you need to do

Annex H – Safe use and disposal of sharps

Introduction

Many sharps' injuries can be avoided by adhering to the principles of safe organisation at The Wellington Practice. The incidence of sharps injuries in primary care is surprisingly high. Care is to be taken at all times to ensure the safe use and disposal of sharps.

Local Signage Example



Legislation

There are a number of legislative acts and laws governing the safe use and disposal of sharps:

- Control of Substances Hazardous to Health (COSHH) 2002
- Management of Health and Safety at Work Regulations 1999
- The Provision and Use of Work Equipment Regulations 1998
- Reporting of Diseases, Injuries and Dangerous Occurrences Regulations 2013 (RIDDOR)
- The Personal Protective Equipment Regulations 1992
- Health and Safety (First Aid) Regulations 1981
- Safety Representatives and Safety Committee Regulations 1977
- The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

Healthcare workers should adhere to the information detailed in these regulations when searching for guidance/information.

Safe use principles

The following principles should be followed at The Wellington Practice:

- Never pass sharps from person to person by hand – use a safe area or receptacle to place them in
- Never walk around the room/organisation with an exposed sharp in your hand
- Never leave sharps lying around – dispose of them appropriately
- Dispose of syringes and needles as a single unit – do not remove the needle first
- Never re-sheathe a needle
- If you are administering care to a confused patient, have help present to minimise the risk of injury to the patient and yourself

Disposal

In addition to the above, the safe use of sharps bins is also essential to reduce the risk of exposure. The Sharps Regulations require that clearly marked and secure containers be placed close to the area where sharps are used. Instructions for staff on safe disposal of sharps must also be placed in those areas.[11]

To comply with the regulations, the following guidance is to be adhered to:

- Ensure that sharps bins are of an appropriate size for the clinical activity
- Sharps bins should be available at the point of use of the sharp
- Sharps bins should be located at approximately waist height but out of the reach of children or confused adults
- Between usages, the temporary closure device should be used to prevent accidental exposure if the bin is knocked over
- Only fill the bin to the 'fill line'
- Used/full sharps bins must be placed in a locked, segregated cupboard or clinical waste bin provided for such a purpose

See overleaf for an image regarding the safe use of sharps bins.

[11] HSE Health Services Information

Correct use of sharps bins

Sharps bin management is the responsibility of the clinician using the bin not the cleaning team

When assembling sharps bins, staff must ensure the following:

- The bin lid and label are a colour match and the bin is of the correct size
- The lid is fully secured and 'clicked' into place
- The label is completed legibly, with the name of the individual assembling the bin, the date assembled and the location of the bin

Do ensure that when not in use, the lid window is "temporarily" closed.

Do replace the bin one month after the date of assembly (unless ¾ full prior to this date).

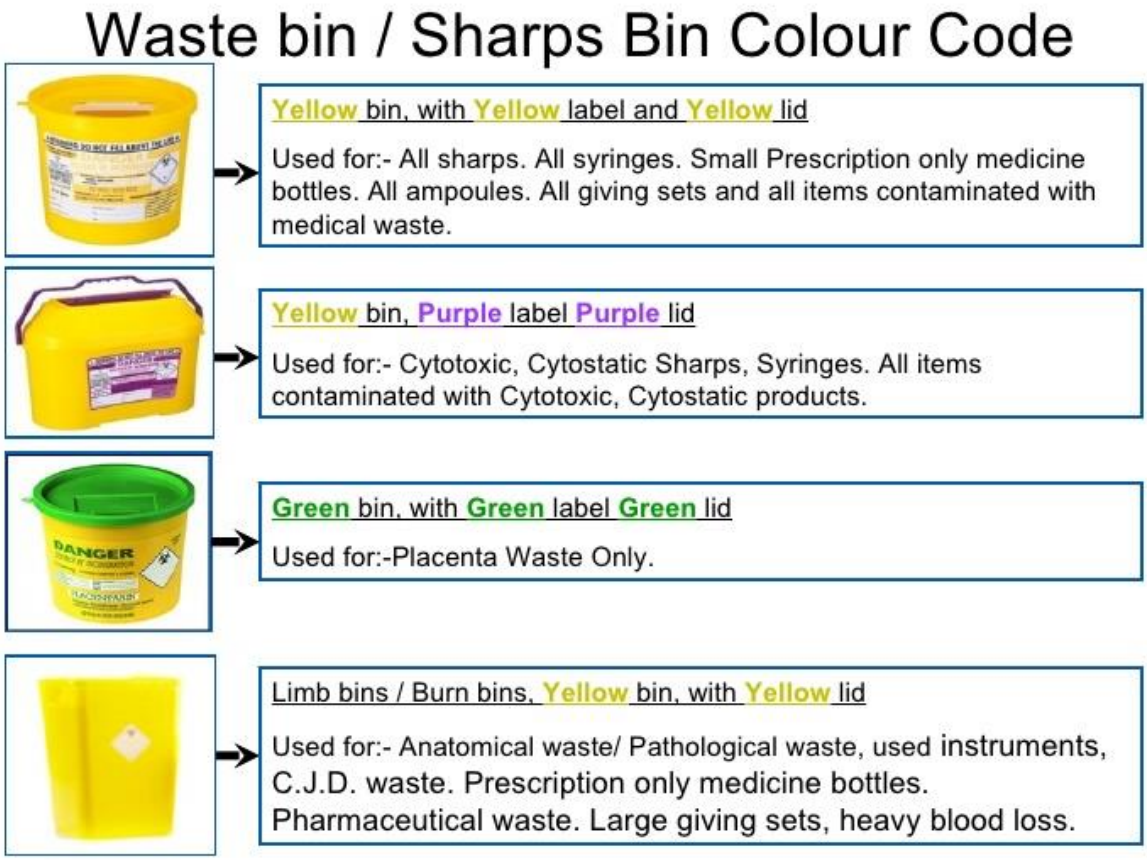
Do not overfill the bin! Once the bin is ¾ full, close the lid securely.

When closing sharps bins, staff are to ensure:

- The lid window is clicked into the closed position
- The date of closure is annotated on the label and signed by the member of staff
- The bin is taken to the clinical waste area

Colour-coded sharps bins

The image below illustrates the uses and colours of sharps bins:



Summary

The safe use of sharps and their subsequent safe disposal will reduce the risk of injury to all staff and patients at The Wellington Practice. Any queries relating to safe sharps management and disposal should be directed to the Lead Practice Nurse in the first instance.

Supplementary guidance can be found by accessing the hyperlinks within this document or the references at the footnotes.

Annex I – Sample Handling Protocol

Introduction

Staff at The Wellington Practice may at times be expected to handle specimens/samples from patients. This protocol details the guidance for the safe handling of specimens for all staff, including non-clinical members*.

Overview

Clinical specimens are often referred to as samples by patients. A clinical specimen can be defined as any substance (solid or liquid) taken from the patient for the purpose of analysis. All staff at The Wellington Practice have received the required training to ensure that specimens are handled safely. It remains the responsibility of all staff to ensure that they adhere to best practice and the guidance provided.

Handling

Specimens, if not handled correctly, are a risk of infection to all personnel involved including healthcare workers, transport staff and laboratory personnel. Specimens that are unlabelled, without a completed request form, in incorrect containers or leaking will not be processed by the laboratory.

All staff are to ensure the following:

- They are wearing the appropriate PPE, i.e., gloves
- The correct pathology request form has been used
- The correct specimen containers have been used
- The request form and container(s) have been labelled correctly, accurately and legibly
- There is a match between patient, form and container
- The above items are placed into the standard packaging for that container
- The package is placed into the transportation container
- PPE is disposed of and hands are washed
- The receipt of the specimen is annotated in the specimen log

* MPS[12] recommend that reception staff do not touch patient specimens. Instead, a box should be placed at reception for patients to leave their samples which can then be passed to the clinical team for processing.

[12] Medical Protection Society Specimen Handling

Collection and transportation

At The Wellington Practice, specimens are collected regularly throughout the day via the Frimley CCG pathology lab courier service. If the courier fails to arrive, inform the pathology lab as this may affect the viability of the specimens.

The packaging of specimens must consist of three components to comply with UN 3373 regulations[13]:

A. A primary receptacle – the specimen tube/pot

B. Secondary packaging – the plastic specimen bag

C. An outer packaging – the Verspak bag used to transport specimens to the laboratory

Example of a Verspak bag:

Compromised specimens

There may be occasions when concerns are raised either at The Wellington Practice or the laboratory regarding the integrity of the sample. In such instances, there may be a requirement to raise a significant event incident report, particularly if the specimen has leaked in a public area. However, communication will be maintained between both locations to determine (where possible) the cause.

Any incidents regarding specimens should be recorded as a significant event and discussed at the next organisation meeting. Repeated incidents should indicate the requirement for an audit aimed at improving practice in the future.

Summary

It is the responsibility of the sender to collect and package specimens as per the guidance given in this protocol and the associated references. Staff must collect specimens safely and effectively as any undue delay may have a detrimental effect on patient care.

[13] UN3373 Regulations

Annex J – Sterilisation and Decontamination Protocol

Introduction

Within the primary care environment, the majority of organisations are opting for single-use items; however there are some items that are reusable and therefore require sterilisation. At The Wellington Practice the following items are used which require sterilisation:

- None used as single use disposable items used

This protocol details the procedure for the sterilisation of instruments at The Wellington Practice whilst also detailing the general cleaning and disinfecting of items within the organisation.

Overview

The careful sterilisation of equipment used in primary care is essential to the effective delivery of patient care. This policy will provide guidance that conforms to national and local directives. The effective decontamination of equipment between uses is a fundamental element of infection control practices.

Decontamination process

The decontamination process, which ultimately leads to sterilisation, is a multi-faceted process consisting of three separate functions:

- **Cleaning** involves the removal of dirt, debris, body fluids, etc. from the equipment. Cleaning precedes the disinfection process

- **Disinfecting** reduces the number of micro-organisms but is not a fail-safe method to ensure that all spores are removed; this stage alone consists of many factors:

    - Prior cleaning must be effective
    - The use of the appropriate disinfectant and in the correct strength
    - The disinfectant must be used correctly as per the manufacturer's instructions

- **Sterilising** is the only process that removes all micro-organisms.

Sterilisation

No sterilisation takes place within the practice.

General decontamination

The table below details the equipment/items held and used within The Wellington Practice and the associated decontamination requirements:

Equipment	Decontamination method
Airways	Single use
Ambu bags	Single use/clean with detergent followed by appropriate disinfectant
Auroscope ear pieces	Single use
Baby-changing mat	Cover with disposable paper between babies. Clean with detergent at end of the session. If contaminated with blood/body fluids, clean then disinfect before next baby in line with policy
Baby weighing scales	Cover with disposable paper between babies. Clean with detergent at end of the session. If contaminated with blood/body fluids, clean then disinfect before next baby in line with policy
Bowls (used for cleaning purposes)	Empty, rinse with clear water and store inverted to dry
Blood pressure equipment	Wipe cuff and monitor with detergent/detergent wipe, pat dry with paper towel between patient uses. Do not immerse cuff in water. Disposable single-use cuff/cuff cover for use when a patient has a multi-resistant organism
Doppler ultrasound probe	Remove gel, clean with detergent/detergent wipe. Do not immerse in water
Ear syringe – Propulse	Follow disinfection procedure in Ear Care Procedure
ECG equipment: Electrodes Straps/leads/machine	Single use Clean with detergent/detergent wipe. Do not immerse in water
Examination couches	Cover with disposable paper towel between patients. Clean with detergent at the end of the session. Clean and disinfect with NaDCC if contaminated with blood/blood-stained body fluid
Minor surgical instruments	Disposable, single use
Nebulisers	Wash mask and chamber with detergent, rinse and leave to dry on disposable paper. Do not wash tubing
Peak flow meters/spirometry	Follow manufacturer's guidance Disposable single-use mouthpieces with one-way valve or filter (change filter as directed by manufacturer) Clean machine weekly with detergent/detergent wipe
Pelvic stimulator electrodes	Single patient use Clean with detergent/detergent wipe to remove any residues Wrap in paper roll and replace in carry case

	Return to patient for cleaning at home, following manufacturer's instructions
Pillows	All pillows should be protected with plastic (sealed) or vapour-permeable cover Wipe with detergent/detergent wipe in between patients and at end of session Disinfect with NaDCC if contaminated with blood/blood-stained body fluid
Physiotherapy equipment	Clean weekly with detergent/detergent wipe, or disinfect with NaDCC if contaminated with blood/blood-stained body fluid
Pulse oximeter	Clean weekly with detergent/detergent wipe and between patients
Scissors	Single use NB: Bandage/dressing scissors – clean between patients with detergent/detergent wipe, and disinfect if required
Stethoscope	Clean between each patient use, with detergent wipe
Sticks/frames/crutches	Clean with detergent/detergent wipe between users
Stitch/staple removers	Single use
Suction machines	Follow manufacturer's guidance. Contact CES if further advice required
Thermometer	Disposable sheath for each patient Clean handpiece weekly with detergent/detergent wipes Do not immerse in water
Tourniquet	Wipe with detergent/detergent wipe, pat dry with paper towel between patient use or: Disposable single patient use if appropriate in specific services. If reusable tourniquet grossly contaminated – dispose of. Ensure adequate supply available
Treatment chairs	Clean daily with detergent/detergent wipes
Trolleys	Clean with detergent/detergent wipe prior to/following use
Toys: Hard	Clean weekly with detergent/detergent wipe or after use if used as part of treatment/assessment All hard toys must be made of suitable material to withstand disinfection if required
Soft	Not suitable for healthcare facilities
Weighing scales	Clean weekly with detergent/detergent wipe
Work surfaces	Clean with detergent/detergent wipe at the end of each session
Vacutainer needle holder	Single use
Vaginal speculum	Disposable, single use

Vaginal ultrasound probes	Cover with condom during use, clean with detergent/detergent wipes after removal Do not immerse in water

Summary

The effective decontamination of equipment and the appropriate use of single-use items are essential to reducing the risk of infection. The clinical environment must be maintained appropriately for the delivery of safe, clean care.

All staff at The Wellington Practice have a duty of care to ensure they follow IPC policy and protocols at all times.

Annex K – Isolation of Patients Protocol

Introduction

Control of infection is one of the key elements of safe care in general practice. There may be on occasion a requirement to isolate patients and it is essential that The Wellington Practice is prepared to deal with such occurrences. This protocol will explain the procedure for patient isolation at The Wellington Practice.

Overview

Isolation in healthcare is defined as the voluntary or compulsory separation and confinement of those known or suspected to be infected with a contagious disease (whether ill or not) to prevent further infections. The kind of isolation required will depend on the type of disease. All staff must ensure that they understand the isolation protocol at The Wellington Practice.

In accordance with The Code of Practice detailed in the Health and Social Care Act 2008, adequate isolation facilities must be provided to minimise the spread of infection to both patients and staff.

The isolation of patients must be based on the infection risk. The Lead Practice Nurse or Duty GP must be consulted if there is concern regarding an infectious patient. Where doubt exists, caution should be taken and further advice sought from the local trust IPC team.

Recognising the requirement for isolation

Staff should remain vigilant and if they suspect a patient is contagious and presents with any of the following, they must inform a clinician immediately:

- Cough and/or fever might indicate influenza
- Diarrhoea and/or vomiting might indicate Clostridium difficile, norovirus or food poisoning
- Skin lesion/rash might indicate scabies, chicken pox or measles

This list is not exhaustive but merely indicative of examples of the ways in which an infectious patient may present. Further conditions will be discussed during staff training. It is acknowledged that it may not always be possible for staff to recognise a patient with a contagious illness.

Isolation protocol

Sensitivity is key when dealing with patients who may be contagious whilst also considering other patients within the immediate vicinity. Transferring the patient to a single room, which can be decontaminated appropriately before being used again, is an effective way of reducing the spread of infection.

Transferring the patient from the waiting area to isolation should be done in such a manner as to limit movement thereby reducing the spread of infection.

The clinician must:

- Ask the patient to follow them to room 9 (NHS Property Service ID 2/GP/41)

- Explain to the patient why they have been asked to move

- Ensure that the door to the room is closed to further reduce the spread of infection

- Update the team, ensuring that they are aware of the potential risks associated with the infection

- Update the patient's individual health record

Assessment of the patient by additional clinicians must be limited to minimise the transmission of infection. All staff involved in the care of a patient suspected of being contagious must ensure that they adhere strictly to the IPC protocols detailed in this policy.

Equipment used in the care of the infectious patient should, where practicable, be single use. However, where this is not possible the subsequent decontamination process should follow the guidance detailed in Appendix H of this policy.

Effective IPC precautions will further reduce the risk of transmission. Procedures such as the use of PPE, correct hand hygiene measures and decontamination will greatly reduce the risk of patients and staff becoming infected.

Room decontamination must also follow the guidance detailed in Appendix H. The room must not be used until it has been decontaminated. It is advised that the room used for isolation is routinely free from clutter, has appropriate PPE and a clinical waste bin for the disposal of PPE and is easily accessible for all patient groups.

Further guidance

The following information is aimed at promoting the risk of transmission. See overleaf for posters on the following:

- Prevent the spread of flu
- Norovirus
- Pandemic management policy
- Current Gov.uk guidance on Infection Control*

*Note, due to the regular updating of isolation guidance, including that for COVID-19, no link has been provided. However, the latest information can be sought by searching "Infection control isolation" on the Gov.uk website.

Prevent the spread of flu

Catch it

Cover your nose and mouth with a clean tissue when you cough or sneeze

Bin it

Dispose of used tissue in your nearest bin

Kill it

Washing your hands and cleaning surfaces prevents the spread of germs

Summary

Isolating a patient who is suspected of having or has a proven contagious disease is the most effective way of minimising the spread of the disease to staff and patients at The Wellington Practice.

Staff must ensure that they adhere to the guidance detailed in this policy and, where they have cause for concern, they are to contact the Lead Practice Nurse and/or Duty GP. Regular training and compliance will ensure that the risk is minimised at The Wellington Practice.

Annex L – Handwashing

Each year the World Health Organization's **SAVE LIVES: Clean Your Hands** campaign aims to progress the goal of maintaining a global profile on the importance of hand hygiene in healthcare.

Whilst alcohol hand rub is a quick and easy way to clean your hands, especially when a sink is not easily accessible, there are times when you must wash your hands with soap and water.

These are:

- When hands are visibly soiled. This is because alcohol hand rub kills germs on clean hands but, because it is not soap, it cannot dissolve grease or oil so, if hands are soiled, they need to be washed.

- Hands that have come into contact with body fluids. This is because the mechanical action of washing is important in removing any body fluid material that may be on the hands.

- Cleaning in an area where a patient has diarrhoea and/or vomiting. This is because alcohol hand rub does not kill some of the germs that cause diarrhoea and vomiting.

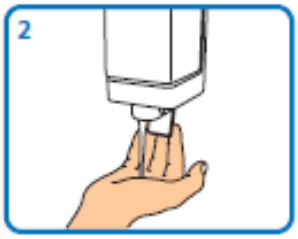
It should be noted that gloves can move organisms around just as well as hands. Wearing gloves does not replace the need for hand hygiene.

Hand and wrist jewellery can harbour micro-organisms and reduce compliance with hand hygiene. Wristwatches and jewellery should be removed prior to commencing cleaning duties.

An NHS handwashing video clip can be found here.

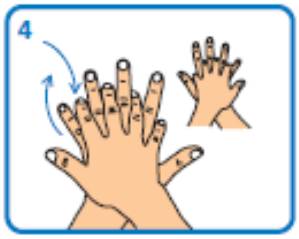
Hand-washing technique with soap and water

Wet hands with water



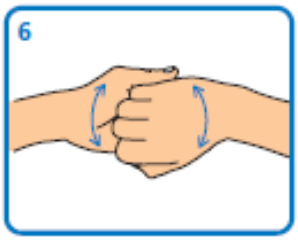
Apply enough soap to cover all hand surfaces

Rub hands palm to palm

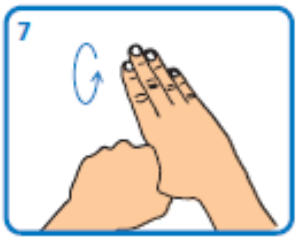


Rub back of each hand with palm of other hand with fingers interlaced

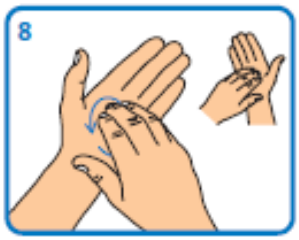
Rub palm to palm with fingers interlaced



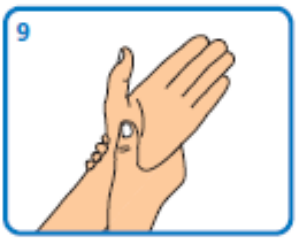
Rub with back of fingers to opposing palms with fingers interlocked



Rub each thumb clasped in opposite hand using a rotational movement

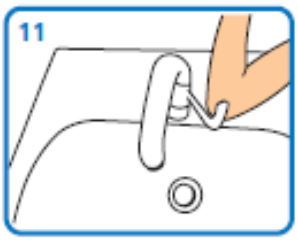


Rub tips of fingers in opposite palm in a circular motion



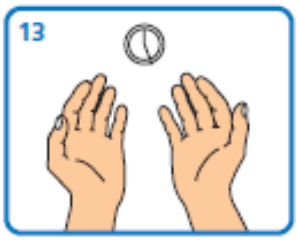
Rub each wrist with opposite hand

Rinse hands with water



Use elbow to turn off tap

Dry thoroughly with a single-use towel

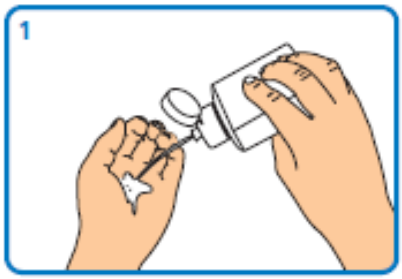


Hand washing should take 15–30 seconds

cleanyourhands campaign

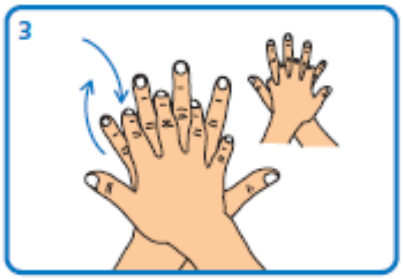
NHS National Patient Safety Agency

Alcohol handrub hand hygiene technique – for visibly clean hands

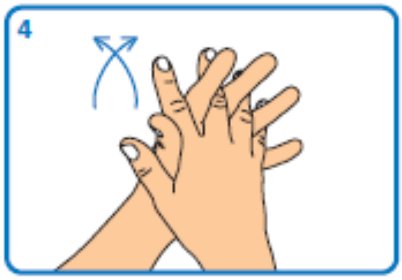


Apply a small amount (about 3 ml) of the product in a cupped hand

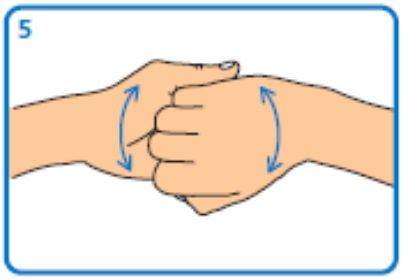
Rub hands together palm to palm, spreading the handrub over the hands



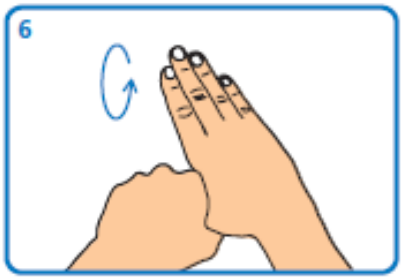
Rub back of each hand with palm of other hand with fingers interlaced



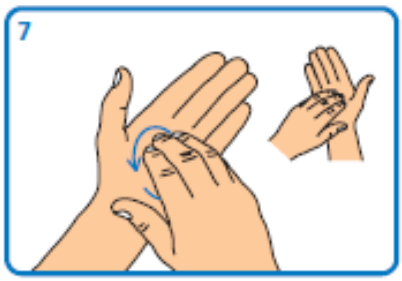
Rub palm to palm with fingers interlaced



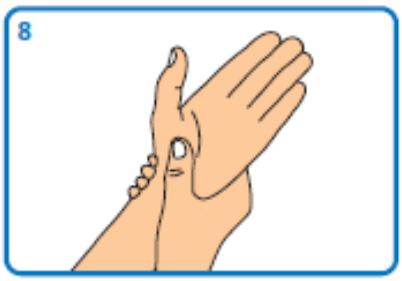
Rub back of fingers to opposing palms with fingers interlocked



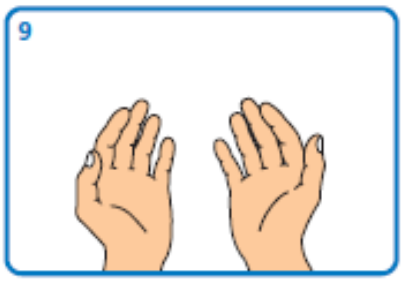
Rub each thumb clasped in opposite hand using a rotational movement



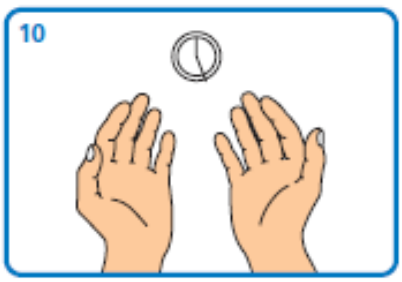
Rub tips of fingers in opposite palm in a circular motion



Rub each wrist with opposite hand



Wait until product has evaporated and hands are dry (do not use paper towels)



The process should take 15–30 seconds

cleanyourhands campaign

NHS National Patient Safety Agency

Annex M – Hand hygiene audit

Introduction

This annex explains when hand washing should occur in general practice and provides a useful audit tool to enable The Wellington Practice to conduct hand hygiene audits.

When to decontaminate hands

There are five moments (or occasions) when staff should wash their hands:[14]

1. Immediately before every episode of direct patient contact or care including aseptic procedures

2. Immediately after every episode of direct patient contact or care

3. Immediately after any exposure to body fluids

4. Immediately after any other activity or contact with a patient's surroundings that could potentially result in hands becoming contaminated

5. Immediately after removal of gloves

Decontaminate hands, preferably with a hand rub conforming to current British standards (at the time of publication of the recommendations (March 2012): BS EN 1500:1997) except in the following circumstances when liquid soap and water must be used:

- When hands are visibly soiled or potentially contaminated with body fluids **or**

- In clinical situations where there is potential for the spread of alcohol-resistant organisms (such as *Clostridium difficile* or other organisms that cause diarrhoeal illness)

Good practice

In order to facilitate good hand hygiene in a clinical environment, staff should be “bare below the elbows” when delivering direct patient care:

- Where practical, staff should not wear long sleeves. If they do, then sleeves should be rolled up to the elbow

- Watches, wrist bands and other jewellery should be removed (wedding rings are permitted as long as it is a plain band)

- Finger nails should be kept short and clean

- False nails, gel nails, nail jewellery and nail polish is not to be worn

[14] NICE Prevention and control of healthcare associated infections in primary care

- Any minor cuts or abrasions are to be covered with a waterproof dressing

Audit

The audit tool overleaf can be used to determine compliance with hand hygiene within The Wellington Practice. Where non-compliance is identified, risk assessments and action plans should be produced and audits repeated until a satisfactory level of compliance is achieved.

Copies of the audits are to be retained as evidence for CQC and local IPC inspections.

Date of audit		Auditor name and role	

Observation	Staff group i.e., nurse/ paramedic/ GP etc.	Did the individual wash their hands at every "moment"?	Are those delivering direct patient care "bare below the elbows"?	Did the staff member use the correct hand washing techniques?	Were any cuts and abrasions covered with an appropriate dressing?	Were paper towels disposed of correctly and without hand contact on the bin?
1		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
2		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
3		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
4		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
5		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
6		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
7		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
8		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
9		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
10		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
11		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
12		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
13		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
14		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
15		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
16		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
17		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
18		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
19		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐
20		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐ N/A ☐

Findings

Recommendations

Actions required (and by whom)

Review plan (including date)

Annex N – Notifiable diseases: Infections or contamination in patients

Introduction

Clinicians at The Wellington Practice have a statutory duty to notify the 'proper officer' at their local council or local Health Protection Team (HPT) of suspected cases of certain infectious diseases. Details of the local HPT can be found here.

Notifiable diseases infections or contamination

The following are notifiable under the Health Protection (Notification) Regulations 2010

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- COVID-19
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires' disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

Further reading can be found at the Gov.uk document titled Notifiable diseases and causative organisms: how to report

Although the CQC is responsible for monitoring compliance with the requirements of the Health and Care Act 2008 (Regulated Activities) Regulations 2014, it is not required to be notified about any outbreaks of infection. However, UKHSA (formally known as PHE) does need to be informed about

certain infection outbreaks and incidents through the local HPT by following the reporting procedure outlined below.

The Health and Social Care Act 2008 code of practice for the prevention and control of infections requires that NHS providers report cases and outbreaks of certain infections including, but not necessarily exclusively:

- Clostridium difficile
- Blood stream infections caused by meticillin resistant staphylococcus aureus (MRSA) and glycopeptide resistant enterococci (GRE)
- Surgical site infections (SSI) following orthopaedic surgery.

Certain infections or conditions are also notifiable to the Office of National Statistics by law. These notifications are submitted by any doctor in clinical practice.

Reporting procedure

GPs are to use the registered medical practitioner notification form shown at Appendix 1 to Section A: Notification Regulations to inform the local HPT about suspected notifiable disease cases.

Summary

It is essential that clinicians ensure that the notification form is completed and submitted to the proper officer within three days or in the event of urgent cases, within 24 hours by telephone.

Where doubt exists, guidance can be sought from Frimley CCG Lead IPC designated person.

Annex O – Toys in reception/waiting areas

Introduction

Contrary to popular misconception, toys are permitted in the reception and waiting areas at The Wellington Practice and, just like all areas within the organisation, are to be cleaned in accordance with the information given in the HSCA 2008.

However there are no toys in the Aldershot Centre for Health in which the practice is situated.

CQC requirements

The CQC no longer has any specific guidance that focuses on toys in GP organisations. Annex O of this policy will satisfy CQC requirements.

Summary

It is essential that The Wellington Practice conforms to the guidance detailed in the HSCA 2008 to ensure that we “Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections” and all toys should be added to the cleaning schedule.

Refer to the Cleaning standards and schedule policy.

Annex P – Staff exclusion from work

Introduction

Control of infection is one of the key elements of safe care in general practice. There may be on occasion a requirement to exclude staff from work and it is essential that The Wellington Practice is prepared to deal with such occurrences.

Recognising the requirement for exclusion

Staff must fully understand that there may be occasions when they are not able to work due to illness.

It is essential that they advise their line manager if they are suffering from the conditions listed in the table below and adhere to the timescales for exclusion; this will minimise the risk of other staff and patients being exposed to the condition.

Condition	Recommendations
Chickenpox	Exclude staff member until lesions are dry or lesions have scabbed over
Conjunctivitis	Seek advice on appropriateness of work, this will depend upon clinical specialty, number of cases presenting, extent of conjunctivitis, likely cause, potential for spread and treatment plan
COVID-19 contacts	Refer to current UK HSA advice
COVID-19	Refer to current UK HSA advice
Dermatitis	If infected or discharging skin lesions, exclude staff member from clinical duties until the lesions have healed OH to be consulted for advice
Diarrhoea and vomiting (or either condition on its own)	If considered to be infectious in nature, staff should be 48-hour symptom free prior to returning to work In the event of an outbreak advice will be issued and will be dependent upon the source organism
Head lice	No exclusion, treatment or wet combing must be undertaken to eradicate colonisation
Hepatitis A	Restrict from patient contact, contact with patients' environment and food handling until 7 days after onset of jaundice In an outbreak situation UK HSA will advise on management
Hepatitis B	No restrictions Standard precautions should always be applied

Healthcare worker who does not perform EPP	This is a blood borne virus that is not infectious through normal casual contact
Hepatitis B Healthcare worker who does perform EPP	Do not perform exposure prone invasive procedures Seek advice from Occupational Health who will review and recommend procedures
Hepatitis C	Do not perform exposure prone invasive procedures Seek advice from Occupational Health who will review and recommend procedures
Herpes Simplex Hands (Herpatic Whitlow)	Staff members with facial Herpes Simplex are to be excluded from giving eye and neonatal care until lesions have healed Restrict from patient contact and contact with the environment until lesion has healed Seek advice from Occupational Health. This will be based on clinical tasks being undertaken
HIV infection	Do not perform exposure prone invasive procedures OH must be consulted for advice
Impetigo	Staff should be excluded until lesions are crusted/healed or for 48 hours after starting antibiotic treatment Antibiotic treatment speeds up healing and reduces the infectious period
Influenza contacts	Contacts of someone with influenza who remains asymptomatic may continue to work All staff should follow standard precautions to prevent spread of infection
Influenza and Influenza Like Illness (ILI)	Staff with probable/suspected flu or flu like symptoms, (fever of >38°C or history of fever plus two or more symptoms of cough or other respiratory symptoms, chills, sore throat, headache, muscle aches) should stay away from work and inform their manager of symptom presentation If influenza is suspected linked to healthcare contact or confirmed swab results staff should remain off work for a minimum of five days from symptom onset and should stay away from work until they feel well
Measles	Staff with Measles must be excluded for four days from onset of rash and return to work only when feeling well. Measles is preventable by vaccination (2 doses of MMR) which should be

	offered to agreed staff groups Pregnant staff who are contacts should seek prompt advice from their GP or midwife
MRSA	Occupational Health to be consulted
Mumps	Staff with Mumps must be excluded for five days from onset of swelling and must feel well before returning to work. Mumps is preventable by vaccination (2 doses of MMR) which should be offered to agreed staff groups Staff who are contacts should seek prompt advice from Occupational Health
Pandemic	Refer to current governmental advice
Ringworm	Treatment will usually be provided from GP and member of staff if completing healthcare tasks will need to keep affected area covered For staff with ringworm on their face/scalp further advice should be sought
Salmonellosis	Exclude staff member until they are symptom free for a period of 48 hours
Scabies	Exclude staff member until they have had their first treatment If crusted scabies, further treatments may be necessary prior to returning to work and advice from the Infection Prevention and Control Team and/or Occupational Health Department should be sought
Shingles	If rash is dry, or covered with an occlusive dressing as long as the individual is medically well they are fit for work Care should be taken if Shingles rash is sited on a face and further advice is required from Infection Control and/or Occupational Health in this situation.
Streptococcal Group A infection (Strep pyogenes)	If infection is identified a course of antibiotic treatment is required. Staff may return to unrestricted duties after 48 hours treatment If a member of staff is a household contact of someone identified with a Group A Streptococcal infection, the member of staff must be aware of need to be vigilant for any signs and symptoms of infection presenting in the 30 days from time of contact If asymptomatic no further actions are required

Pulmonary Tuberculosis	Exclude from work until proven non-infectious
Whooping Cough (Bordetella pertussis)	Ensure Public Health England guidance on health management of pertussis in healthcare settings is followed up

In instances where the organisation manager is not the line manager for the staff member concerned, the organisation manager is to be informed of the absence at the earliest opportunity (or the deputy organisation manager in their absence).

Where absence affects clinical delivery or service delivery, the organisation manager is to be informed immediately in line with the organisation's Sickness absence management policy.

Should doubt exist regarding the exclusion period, advice from Occupational Health (OH) must be sought.

NB: The table above is not exhaustive

Reference: Worcestershire Health and Care NHS Trust

Annex Q – Example Infection Control Annual Statement Report

Infection Prevention Control (IPC) Annual Statement 2023-2024

Purpose

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

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

Infection Prevention and Control (IPC) Lead

Wellington Practice Lead for Infection Prevention and Control: **Mandy Morgan – Practice nurse**

The IPC Lead is supported by: **Dr Sangeeta Rathor**

Mandy keeps updated on infection prevention practice

Infection transmission incidents (Significant Events)

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

In the past year there have been no significant events raised that related to infection control.

During the current Covid-19 pandemic, we are working closely with local services to continue to provide safe care for all within guidelines in a fast changing situation.

Infection Prevention Audit and Actions

- The Infection Prevention and Control audit is completed every six months by the IPC nurse lead.

- Techniques and best practice are discussed at staff practice meetings.

Wellington Practice plan to continue to undertake the following audits in 2022/2023

- Annual Infection Prevention and Control audit
- Minor Surgery outcomes audit
- Domestic Cleaning audit
- Hand hygiene audit
- MRSA statistics as required
- Medicines management regarding anti-biotics audit

Risk Assessments

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

Legionella (Water) Risk Assessment: The building has a facilities management contract that conducts water safety risk assessment to ensure that the water supply does not pose a risk to patients, visitors or staff.

Curtains: The NHS Cleaning Specifications state the curtains should be cleaned or if using disposable curtains, replaced every 12 months. To this effect we use disposable curtains and ensure they are changed every 12 months or when contaminated. The window blinds are very low risk and therefore do not require a particular cleaning regime other than regular vacuuming to prevent build-up of dust. The modesty curtains although handled by clinicians are never handled by patients and clinicians have been reminded to always remove gloves and clean hands after an examination and before touching the curtains. All curtains are regularly reviewed and changed if visibly soiled.

Toys:
There are no toys in waiting / consultation rooms.

Cleaning specifications, frequencies and cleanliness:

The building is supported by an external cleaning provider instructed by the building's facilities management service and are tasked with a cleaning specification and frequency policy. An

assessment of cleanliness is conducted by the cleaning team and logged. This includes all aspects in the surgery including cleanliness of equipment.

Hand washing sinks: All clinical sinks met the required standards when installed with wall mounted soap dispensers and visual guides for hand washing techniques. Any subsequent replacements will be requested to conform to current standards via NHS Property Services.

Training

All our staff receive annual training in infection prevention and control.

The Lead IP Nurse has attended Infection prevention and control training and key learning facts

were disseminated to the team during in house training sessions. Additionally, there is a lead IP forum attended to share learning and experiences.

Policies

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

Policies relating to Infection Prevention and Control are available to all staff and are reviewed and updated annually, and all are amended on an on-going basis as current advice, guidance and legislation changes.

Responsibility

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

Review date

Jan 2024

Responsibility for Review

The Infection Prevention and Control Lead and the Practice Manager are responsible for reviewing and producing the Annual Statement.

6 Annex B – Audit guidance

Introduction

The purpose of a confidentiality audit is to identify if:

- Any confidentiality issues exist and, if so, to detail what they are
- Systems are at risk through deliberate misuse
- Existing controls are adequate and provide the necessary safeguards

The audit will also review:

- Local controls and processes regarding the access to, and use of, electronic data
- Local controls and processes regarding the access to, and use of, manual records
- Staff knowledge and awareness of their responsibilities and extant legislation regarding confidentiality

The Wellington Practice is to ensure that there are appropriate confidentiality procedures in place in order to monitor access to personal confidential data.

Frequency

Confidentiality audits are to be undertaken through spot checks and questionnaires on a quarterly basis, and reports produced and retained for assurance purposes.

Assurance required

The table overleaf explains the criteria, assurances and evidence required for confidentiality audits. It can be used to assist with ensuring that the organisation and its staff are compliant in data security and protection. It is a useful tool when carrying out an audit of confidentiality as per the Data Security and Protection Toolkit.

Report template

Annex C gives an example of a confidentiality report template.

Level	Criterion for confidentiality audit	Assurance required	Source of assurance or evidence
1	There are documented confidentiality audit procedures in place that include the assignment of responsibility for monitoring and auditing access to confidential personal information. The procedures have been approved by senior management or committee and have been made available throughout the organisation.	Auditors require assurance that: • There are documented confidentiality audit procedures in place which include the assignment of responsibility for monitoring and auditing access to confidential personal information • The procedures have been approved by senior management or committee and have been made available throughout the organisation	• Policy on confidential patient information • Standard procedures for monitoring and auditing access to patient information • Management approval of procedures (e.g., meeting minutes or other papers recording approval) • Documented assignment of responsibilities to job roles • Corresponding job descriptions • Publication of procedures throughout the organisation
2	All staff members with the potential to access confidential personal information have been made aware of the procedures. The procedures have been implemented and appropriate action is taken where confidentiality processes have been breached.	Auditors require assurance that: • The training provided for staff who are conducting audits and investigating alerts is comprehensive, clear and unambiguous about the action to be taken • The written procedures for confidentiality audit and monitoring are implemented in the organisation	As above, plus: • Training records for staff carrying out audits and investigations • Descriptions of training provided • Corporate security and human resources procedures • Incident log of confidentiality alerts

Level	Criterion for confidentiality audit	Assurance required	Source of assurance or evidence
		• Appropriate disciplinary and remedial actions are taken where confidentiality processes have been breached • All staff members with the potential to access confidential patient information are aware of the audit procedures; and • The audit procedures are widely accessible	• Reports of the subsequent disciplinary actions taken • Minutes detailing committee reviewing confidentiality issues and performance • Availability of organisation's confidentiality, security and employment procedures to relevant staff • Methods used to make relevant current staff aware of the confidentiality audit procedures and disciplinary sanctions. This might take many forms, such as awareness sessions, as part of mandatory training, team discussions or distributions to staff • For relevant new joiners, evidence of induction training on confidentiality requirements and audit
3	Access to confidential personal information is regularly reviewed. Where necessary, measures are put in place to reduce or eliminate frequently	Auditors require assurance that: • The procedures for confidentiality audits and monitoring are regularly reviewed for scope and depth	As above, plus: • Reports from reviewing the audit and monitoring process

Level	Criterion for confidentiality audit	Assurance required	Source of assurance or evidence
	encountered confidentiality incidents or events.	• Identified vulnerabilities are recorded, solutions are identified and problems resolved; and • Staff effectiveness in relation to confidentiality audits and monitoring is maintained, e.g., by appropriate ongoing training	• Security incidents and events relating to confidentiality • Risk register including identified confidentiality vulnerabilities • Reports of procedural and/or security changes, resulting from alerts or identified risks • Updated procedures and policy from lessons learned

Staff	Date audited
Spot check that staff understand their responsibility towards data security	
Spot check that staff are aware of data protection policies	
Have staff received training on data protection?	
Have any staff undergone disciplinary action in relation to data protection and security?	
Spot check that staff understand how to report security breaches and near misses	
Physical access to hardcopy records	
Check that the record of which staff have access to areas is up to date	
All offices, files or cabinets which contain confidential information are kept locked when not in use	
Has all confidential waste been disposed of securely and are there destruction certificates? (If applicable)	
Has anyone inappropriately accessed, or attempted to access, confidential records?	
Digital access to records	
Is the allocation of administrator rights restricted?	
Have staff access rights been reviewed?	

Check if there is any evidence of staff sharing access rights	
Screens are locked when not in use and smartcards removed	
Check that the password policy is being followed	
Has anyone inappropriately accessed, or attempted to access, confidential records?	
Have appropriate security measures been applied to all computers, laptops and mobile devices?	
Staff are using computers appropriately, e.g., no personal use, no downloading unapproved software, no social media use etc.	
Sharing data	
Procedures for safely sharing personal information via post are being followed	
Procedures for safely sharing personal information via fax are being followed	
Procedures for safely sharing personal information via secure email are being followed	
Legal checks	
The information asset register has been reviewed and signed off	
The record of processing activities has been reviewed and signed off	
Records of consent are up to date and still applicable	

7 Annex C – Example of an audit report template

[Insert practice name]	Date of audit:	Audit reference no: [01/22] Page [1] of [2]
Summary of audit:		
Name of auditor(s):		
Date audit conducted:		
Date audit closed:		
[Insert practice name]	Date of audit:	Audit reference no: [01/22] Page [2] of [2]

Summary of observations:		
Observation reference:	Description of observation:	
Summary of agreed actions:		
Reference:	Action required:	By whom & date:
Agreed follow-up/review:		
Name & signature of auditor(s):	Date closed:	
Additional comments:		
Name & signature of auditor(s):	Final closure date:	

8 Annex D – Confidentiality poster

Source: Practice Index