Adult Social Care

Infection Prevention and Control

Version 3

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If you would like to make any comments, amendments, additions etc. please email ASCH.AdultCare.Policy@derbyshire.gov.uk

Policy Statement

Derbyshire County Council (DCC) will comply with the following legislation and best practices as described in:

- The Care Act 2014
- The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance (Department of Health, July 2015) (The Code).
- NICE Clinical guideline [CG139]
- CQC: Guidance for Providers on meeting the regulations
- The Health and Safety at Work Act 1974
- Management of Health and Safety at Work Regulations (as amended) 1999
- Control of Substances Hazardous to Health 2002
- Medicines Act 1968
- Infection prevention and control: resource for adult social care

This policy sets out how DCC will comply with the above code of practice. The code of practice sets out the ten criteria against which a registered provider will be assessed on how it complies with the infection prevention and control (including cleanliness) requirements. The general principals contained within this policy should be applied by all staff working within DCC.

It is a requirement that all direct care services including contracted providers produce and maintain a policy which sets out how these standards are to be met. Employees working for, or on behalf of DCC, will comply and maintain high standards of personal hygiene when caring for all service users, whether it is known they suffer from, or carry an infectious disease or not.

There is a requirement to produce an annual statement that must be available upon request providing information on Infection Prevention and Control policies, staff training and outbreaks within the service. See Infection Control Annual Report Appendix 1.

The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance.

Part 2 of the code of practice states

Compliance criterion	What the registered provider will need to demonstrate
1	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them.
2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
3	Ensure appropriate antimicrobial use to optimise resident 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 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, 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.

Useful Contacts

Derbyshire County Council Health Protection Team
ASCH.Health.Protection@derbyshire.gov.uk

United Kingdom Health Security Agency (UKHSA) (East Midlands)
UKHSA.crc.eastmidlands@phe.gov.uk

Roles and Responsibilities

Directors of service will:

- ensure systems are in place to effectively manage infectious diseases within all areas of their service
- appoint a lead officer with responsibility for producing and maintaining the Infection Control Management System for the department who will work in conjunction with Health, Safety and Wellbeing and the Health Protection Team
- maintain their knowledge of infection prevention and control to a level commensurate with their responsibilities
- set a good personal example

Group manager will:

- ensure that the departmental procedures for preventing and managing infections or infectious diseases are implemented throughout their area of control
- monitor the performance of their service and sections within their service, with regards to the control of infectious diseases and compliance with the policy
- delegate actions to the appropriate managers within their service to ensure compliance with the policy
- maintain their knowledge of infection prevention and control to a level commensurate with their responsibilities
- set a good personal example

Service managers will:

- verify the information gathered by the manager on a bi-monthly basis part of the Quality Assurance Framework and appropriate observations of practice carried out
- assist in the development of infection prevention and control action plans and monitor their progress
- maintain their infection prevention and control knowledge to a level commensurate with their responsibilities
- services managers in all divisions must escalate any concerns they have

following audits regarding the standard of Infection Prevention and Control within an environment in which care is provided

- set a good personal example

Establishment managers will:

- have overall responsibility and be accountable for infection prevention and control within their establishment
- ensure tasks and duties with regards to infection prevention and control are carried out as required. Tasks can be delegated to other managers and staff as agreed with regards to their specific service
- carry out risk assessments as necessary to ensure effective measures to control infection are put in place within the establishment(s) for which they are responsible
- ensure the provision of equipment and facilities to enable staff compliance with standard infection prevention and control precautions e.g., provision of personal protective equipment (PPE), hand hygiene facilities, equipment that is easily cleaned and in a good state of repair
- monitor the performance of the establishment for which they have responsibility with regards to the prevention and control of infection, by carrying out infection prevention and control audits and observations of practice in accordance with departmental policy and ensure any actions are completed
- maintain knowledge of infection prevention and control to a level equivalent to their responsibilities by completing training programs and attending update briefings
- observe and monitor staff performance in relation to infection prevention & control
- have a clear plan for cleaning in accordance with departmental policy and procedure
- set a good personal example

Managers overseeing care provided in the community:

- carry out risk assessments as necessary to ensure effective measures to control infection are put in place within the environments for which they are responsible.
- ensure the provision of equipment and facilities to enable staff compliance with standard infection prevention and control precautions e.g., provision of personal protective equipment, hand hygiene facilities, equipment that is easily cleaned and in a good state of repair.
- ensure tasks and duties with regards to infection prevention and control are carried out as required and any departmental audits (where applicable) and observations of practice are completed.

- set a good personal example

Staff working within services will:

- follow the requirements of the Infection Prevention and Control Policy in relation to their role
- maintain knowledge of infection prevention and control to a level equivalent to their responsibilities by completing training programs and attending update briefings as directed by their manager
- adhere to any measures to prevent and control infection as identified in the
- personal support plan and risk assessments in place, including the following of standard infection prevention and control precautions
- report any infection prevention and control concerns to their manager

1. Standard Precautions

All staff in all situations involving the care of people must use infection prevention and control 'standard precautions' (SICPs). These underpin routine safe practice and break the chain of infection which protects people using and visiting the services and colleagues providing support. There is often no way of knowing who is carrying an infection, so by applying standard precautions to all people at all times, best practice becomes second nature, and the risk of infections are minimised.

SICPs may be insufficient to prevent cross-transmission of specific infectious agents. Therefore, additional 'Transmission based precautions' (TBPs) are required when caring for residents with a confirmed or suspected infection.

This policy reflects the 'Standard infection control precautions: national hand hygiene and personal protective equipment policy' published by NHS England and NHS Improvement (April 2022).

1.1 The chain of infection

A series of events must happen to enable germs (for example, bacteria, fungi, and viruses) to cause infections in a person. This is called the 'Chain of Infection.' Each part of the process is a separate 'link' in the chain and the link must be broken at any part of the chain, to stop infection arising.

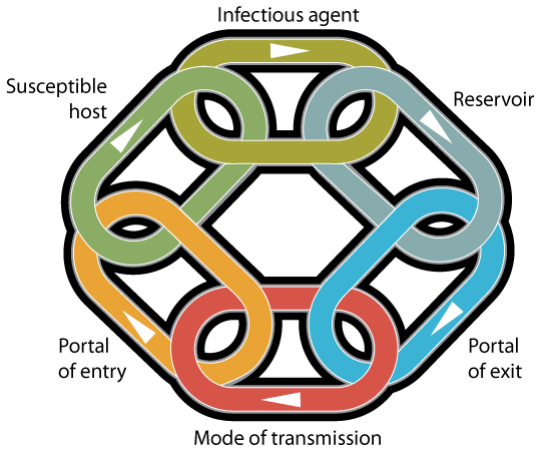


Figure 1 The Chain of Infection
(Source: RCN Chain of Infection: First Steps. accessed Nov. 2020)

1.2.1 The reservoir

The reservoir can be a place where germs can live and multiply. The ‘place’ can be a person, but it can also be any part of the surrounding area of a setting, furnishings, and the equipment we use in care.

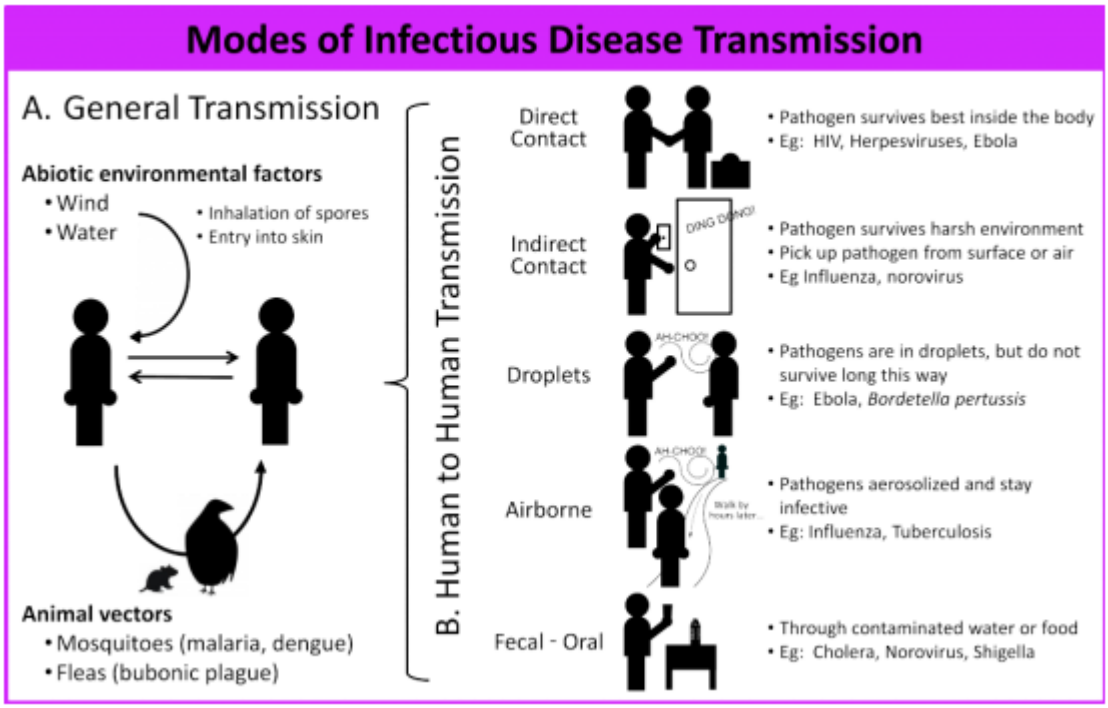
1.2.2 The portal of exit from the reservoir

The ‘portal of exit’ is how the germ can escape from the reservoir. For instance, think about some germs (the infectious agent) sitting on top of a used commode (the reservoir). If a staff member touches the commode, and some of the germs move onto the hands then the staff member’s hands are now the ‘portal of exit’ – the means by which the germs are able to move from the commode to another place. Other ‘portals’ can be people’s normal excretions (stools, vomit), body fluids (blood, saliva) and the air they breathe from their lungs, especially when they cough. The portal can vary from one infection to another (for example diarrheal infections are usually passed on via the person's faeces). Germs can even be spread around on the tiny flecks of skin that peel off our bodies throughout the day and which form part of the dust that settles on all kinds of surfaces. Non-human portals of exit for germs include items of equipment that have not been properly cleaned, such as commodes, bed mattresses, pillows, and reusable equipment.

1.2.1 The mode of transmission

This is how the germs move, or spread, from one place to another. This can happen in a number of ways, such as staff members’ hands touching dirty equipment or contaminated medical instruments, or through the air (coughs, sneezes).

Figure 2 – Mode of Transmission (Source Arval, 2019)



Source: An Introduction to Infectious Disease (Harvard University)

Airborne transmission is different from transmission by respiratory droplets. Respiratory droplets are large enough to fall to the ground rapidly after being produced, as opposed to the smaller particles that can spread airborne infections, although some diseases can be spread by both routes.

1.2.2 The portal of entry into the 'host'

This means the germs that have been moved from the reservoir now invade the person (the 'host'). They can do this by entering wounds and cuts, being swallowed, and being breathed in.

People who are having treatments that involve cutting the skin or placing medical instruments inside the body, such as a catheter being placed into the bladder or a feeding tube being passed down the throat, are also at risk of infection. Another example is people who inject drugs with used needles.

1.2.3 The susceptible host

Healthy people have their own defences which help them fight infection. This means that even if some harmful germs enter the body, the person can fight them off and stay well. The ability of the body to defend itself against infection is called 'immunity.' Some people, however, cannot fight infection effectively.

These include very young children, older people, people who are ill or who are receiving medicines that reduce their immunity, people with long-term health conditions like diabetes and those who are physically weak due to, for instance, malnutrition or dehydration.

People such as these are 'susceptible hosts' – meaning they are vulnerable to developing infection when their bodies are invaded by germs.

1.2.6 The infectious agent

The infectious agent is simply the germ causing the infection. Germs are all around us and within us, and many play very important roles in keeping us healthy. The problem comes when a germ leaves its normal place to go elsewhere in the body – the germs that sit on your skin and which usually cause no harm, for instance, getting into a cut. The germ could then cause infection. There are also many germs that are not helpful to health, and which cause disease. Entry of any of these germs into the body is likely to cause problems.

2. Reducing Risk

The Health and Safety Executive (HSE) outlines the hierarchy of controls, a system that reduces the risks at work. Further information can be found on the HSE website and Infection Prevention and Control: Resource for Adult Social Care.

The hierarchy of control principles can be broadly interpreted for social care settings under the following headings:

- reducing the hazard
- changing what we do
- changing where we work
- changing how we work
- use of PPE

These controls are ranked in the order of effectiveness. PPE is the last control in the hierarchy, used when all other controls have not reduced the risks sufficiently.

3. Hand Hygiene

Hand hygiene is the single most important way to prevent the spread of infection. Good hand hygiene must be undertaken by all staff, residents/service users and visitors.

All staff must have training on hand hygiene and their practice observed. This is provided on a regular basis, e.g., annually. It is essential that everyone takes responsibility to ensure the care provided is carried out in a safe manner.

The transmission of micro-organisms from one person to another via hands can result in adverse outcomes. Micro- organisms, including bacteria, viruses, and fungi, can be introduced onto the

skin or into susceptible sites, such PEG sites, or urinary catheter drainage systems by the hands of staff, other healthcare workers, residents/service users and visitors.

Micro-organisms on the hands are divided into two categories – transient and resident. Transient germs are found on the outer layers of the skin and are fairly easily removed by good hand hygiene. These transient germs are the most likely to cause infections. Resident germs are more deeply attached to the skin and are harder to remove. However, these are less likely to cause infection and can sometimes be protective to the skin.

3.1 Involving people using services and the public in infection prevention and control

To comply with *The Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance*, staff should encourage the involvement of people using services and the public in infection prevention and control. To facilitate compliance, the following good practice listed below should be followed:

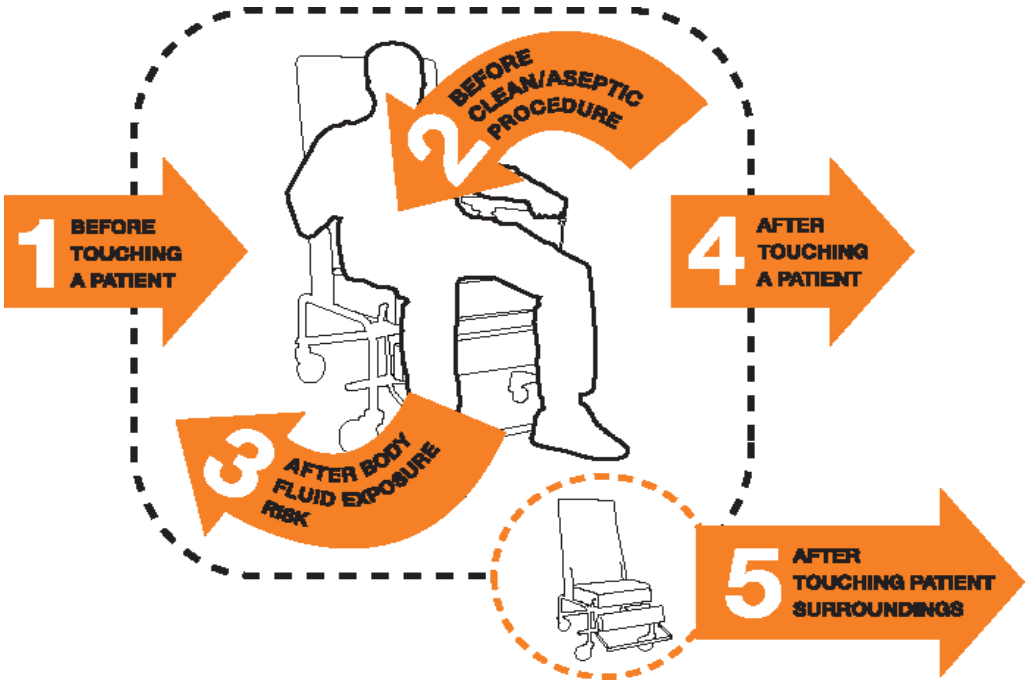
- provide alcohol hand-rub at the care home entrance for visitors to use. Using wall mounted dispensers which use disposable cartridges i.e., not refillable
- hand hygiene posters should be displayed to attract the attention of residents and visitors regarding hand hygiene - see Appendix 2
- hand hygiene information leaflets should be available during outbreaks of infection e.g. viral gastroenteritis - see Appendix 3
- residents/individuals should be encouraged to wash hands after using the toilet and before eating and drinking, or if they are unable to access hand washing facilities, use moist (non-alcohol) skin wipes
- if a resident/individual has an infection, they should use a separate towel to dry their hands, and this should not be used by other people. The towel should be washed daily, and their visitors should wash their hands before leaving

3.2 Good hand hygiene practice

To facilitate effective hand hygiene when delivering care staff should ensure that they:

- cover wounds, cuts, and abrasions with waterproof dressings
- remove wrist and hand jewellery including wristwatches, ‘Fitbit,’ bracelets and some rings. Rings with jewels, stones, ridges, or grooves must not be worn a plain band ring may be worn, but ensure the area under the ring is included when hands are washed, or alcohol hand-rub applied
- are ‘bare below the elbows,’ remove dermal piercings on the hands, arms, or wrists
- refer to Workwear in Direct Care Services Policy

3.3 When to clean your hands



Your 5 moments for hand hygiene at the point of care.

1	**BEFORE RESIDENT/INDIVIDUAL CONTACT**	**WHEN? Clean your hands before touching a resident/individual when approaching them.** **WHY? To protect them against harmful germs carried on your hands.**
2	**BEFORE CLEAN/ASEPTIC PROCEDUREAS**	**WHEN? Clean your hands immediately before any clean/aseptic procedure.** **WHY? To protect the resident/individual against harmful germs, including their own, from entering thei body.**
3	**AFTER BODY FLUID EXPOSURE/RISK**	**WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal).** **WHY? To protect yourself and the health and social care environment.**
4	**AFTER RESIDENT/INDIVIDUAL CONTACT**	**WHEN? Clean your hands after touching a resident/individual and their immediate surroundings, when leaving a resident/individual's side.** **WHY? To protect yourself and the health and social care environment from germs.**

5	**AFTER CONTACT WITH RESIDENTS' / INDIVIDUALS' SURROUNDINGS**	**WHEN? Clean hands after touching any object or furniture in the resident/individuals immediate surroundings when leaving, even if the resident/individual has not been touched.** **WHY? To protect yourself and the health and social care environment from harmful germs.**

Hand decontamination

Having clean hands is the most effective way of preventing infection from spreading. There are five important moments when you should clean your hands:

- just before you provide care to a resident
- as soon as you have finished providing care to a resident
- straight after you have been exposed to any body fluids
- straight after touching the person's surroundings (such as chair, door handle) if this may have contaminated your hands
- as soon as you take off protective gloves.

(Source: NICE - A quick guide for managers and staff in care homes)

Other examples of when hand hygiene should be performed:

- on arrival at work, between each task and before you go home
- whenever hands are visibly dirty
- before putting on and after removal of personal protective equipment (PPE) or domestic gloves (wearing gloves should not be a substitute for handwashing)
- after coughing, sneezing, or blowing your nose
- after using the toilet
- before and after having a coffee/tea/meal break

While micro-organisms such as bacteria and viruses, are not likely to survive for long periods of time on outdoor surfaces in sunlight, some can live for more than 24 hours in indoor environments. Washing your hands with soap and water for at least 20 seconds, or using hand sanitizer, regularly throughout the day will reduce the risk of catching or passing on this virus, or other micro-organisms that are contaminating the skin.

3.4 Most commonly missed areas

Ref: NICE, *Infection Control, Prevention of healthcare associated infection in primary and community care 2003*

3.5 Hand hygiene products

Research and evidence suggest:

- soap and water are as effective as antibacterial handwashing preparations for decontaminating hands and removing transient micro-organisms
- alcohol hand-rubs are not effective in removing physical dirt or soiling and should only be used on visibly clean skin
- alcohol hand-rubs are effective in destroying most transient micro-organisms; however, they are not effective against *Clostridioides difficile* and Norovirus (viral gastroenteritis)

3.6 Hand hygiene facilities

Hand hygiene facilities must be available and not compromise standards by being dirty or in a poor condition.

- in care homes, hand-wash facilities should be available for staff to use in each of the resident's rooms
- bar soap should not be used as it can harbour micro-organisms (germs)
- in care homes, use wall mounted liquid soap dispensers with disposable soap cartridges. Do not use refillable soap dispensers as there is a risk of contamination of the liquid soap and the dispenser
- in care homes, paper towels should be in a wall mounted dispenser next to the hand-wash basin, but not so close as to risk contamination of the dispenser or towels
- keep all dispensers clean and replenished
- nailbrushes should not be used routinely as they can cause skin damage and harbour bacteria. If used, they should be for the individual's use only
- a foot operated lidded bin, lined with a disposable plastic bag must be positioned near the hand-wash basin
- hand-wash basins in clinical areas should have a lever which does not run directly into the drain aperture, with no plug or overflow. If a lever is not provided, use a paper towel to turn off the tap to avoid contaminating the

hands.

- clinical hand-wash basins should not be used for any other purpose e.g., decontamination of equipment, due to the risk of cross-contamination
- in areas where a sink is used for other cleaning purposes e.g., emptying buckets of water in the cleaner's room, there should also be a separate dedicated hand-wash basin
- communal fabric hand towels must not be used
- domiciliary care workers who have concerns about the suitability/ availability of handwashing facilities in service users' homes should discuss this with their line manager, who must arrange for liquid soap and paper towels to be available for the care worker to take on their visits

3.7 Hand hygiene technique

3.7.1 Routine (social) handwashing

Handwashing is the most important method of protecting the resident/service user and yourself from infection. It removes dirt, organic matter, and most transient micro-organisms (germs) acquired through direct contact with a person and from the environment. Liquid soap and warm running water are adequate for this procedure. A twenty second hand-wash using liquid soap is acceptable.

3.7.2 Technique for handwashing

Ensure you are 'bare below the elbows'

- wet hands under warm running water
- apply liquid soap
- vigorously rub all parts of the hands for at least 20 seconds using the steps shown in Appendix 2, ensuring all surfaces of the hands and wrists are covered with soap
- rinse hands thoroughly under warm running water
- dry hands thoroughly using disposable paper towels. Wet hands are more likely to transfer micro-organisms than dry hands, also the friction of the paper towels also helps to further remove micro-organisms on the hands

3.8 Alcohol hand rub

- alcohol hand rub containing a minimum of 60% isopropyl alcohol is an effective alternative to handwashing and is useful when there is a need for rapid hand decontamination
- alcohol hand rub should only be applied to visibly clean skin
- alcohol hand rub should not be used when caring for residents/service users with diarrheal illness, due to being ineffective against *clostridioides difficile*

spores and norovirus

- alcohol hand rub may be less effective if used immediately after the application of a hand cream/moisturizer

3.8.1 Technique for using alcohol hand rub

- ensure you are 'bare below the elbows'
- dispense manufacturer's recommended amount of alcohol solution on to hands
- ensure the solution will cover all the hand and wrist surfaces
- rub using the steps shown in Appendix 2, ensuring all surfaces of the hands and wrists are covered with the product until the solution has dried (about 20 seconds)

Alcohol hand rub must not be applied to gloved hands as this may affect the integrity of the glove material.

3.8.2 Availability of alcohol hand rub

A documented risk assessment should be carried out before siting alcohol hand rub dispensers. If wall mounted dispensers or free-standing pump dispensers are not appropriate, e.g., for domiciliary care workers, staff should be issued with personal dispensers which can be clipped to clothing.

3.9 Skin care

To minimise the risk of skin damage, wet hands under warm running water before applying liquid soap. Rinse hands well to remove residual soap and dry thoroughly to prevent chapping. Always cover cuts and abrasions with a waterproof dressing. Seek Occupational Health or GP advice if you have a skin irritation.

The use of hand cream or lotion will help prevent skin problems and irritation, therefore, promoting compliance with hand hygiene. For maximum benefit, hand cream or lotion should be used three times daily. Communal pots of hand cream (where fingers are placed in the container) should not be used as the contents can become contaminated.

4. Personal Protective Equipment (PPE)

Before undertaking any procedure, staff should assess any likely exposure to blood and/or body fluids, non-intact skin, or mucous membranes and wear PPE that protects adequately when:

- dealing with a resident who has a confirmed or suspected infection
- there is likely exposure to blood and/or body fluids, non-intact skin, or mucous membranes
- decontaminating the environment or care equipment

- in contact with substances hazardous to health, e.g., cleaning/disinfecting products

Hands must be cleaned before putting on PPE. All PPE must be changed between tasks and disposed of as soon as the task is completed. Always perform hand hygiene appropriately after removing and disposing of each item of PPE e.g., pair of gloves, apron, mask, and facial protection. It is best practice in care homes to store PPE in dispensers to reduce the risk of PPE becoming contaminated. It should be stored in a clean dry area until ready for use, e.g., do not store boxes of gloves on top of toilet cisterns or hang aprons behind doors, or in sluice rooms. In all settings, supplies of PPE should be readily available at the point of use and within their expiry date. Any concerns about residents tampering with PPE supplies should be risk assessed locally.

See Appendix 4 for the correct order for putting on and removing PPE.

PPE must be removed in the recommended sequence to minimise the risk of cross/self-contamination.

It is recommended for assurance purposes that annual audits to assess the standard of staff technique are carried out. This is carried out during annual observations of colleagues.

4.1 Gloves

Disposable gloves are single use only.

If contact with blood and/or body fluids, non-intact skin, or mucous membranes is anticipated, or the person using services has a suspected or known infection then disposable gloves should be worn that are appropriate for the task (see below).

Gloves must comply with European Standard EN 455 Medical Gloves for single use (Parts 1-4) and be CE marked for single use. The Medical Devices Agency recommends that only powder-free gloves are purchased due to latex allergy/sensitivity.

Studies have shown that when a contaminated needle pierces a glove, the material of the glove wipes off 86% of the blood from the needle before it passes into the skin.

Hands must be washed with liquid soap and warm running water, or alcohol hand rub applied immediately before putting on and after removing each pair of gloves.

Gloves available from manufacturers can be latex, nitrile or vinyl material. Employers may advise against the use of latex following a risk assessment as it can cause skin sensitivity and allergies. Currently, DCC advocates the use of Nitrile gloves. A risk assessment will be carried out for staff who have sensitivities or allergies to ensure the correct selection of gloves.

Glove selection should be based on risk assessment of:

- sensitivity to latex
- nature of the task

- risk of contamination
- sterile gloves for aseptic technique, e.g., urinary catheterisation, wound care

Gloves should be:

- changed if a perforation or puncture is suspected
- disposed of after each task or care activity e.g., handling used, soiled, or infected linen and clothing
- changed between different tasks on the same resident
- appropriate for use, fit for purpose and well-fitting

The reuse of gloves is not acceptable for the following reasons:

- glove integrity can be damaged if in contact with substances such as isopropanol, ethanol, oils, and disinfectants
- many gloves will develop micro-punctures very quickly and will no longer perform their barrier function
- there is a risk of transmission of infection
- washing of gloved hands or using an alcohol hand rub on gloves is considered unsafe practice

Gloves are not required for making beds with clean linen but should be worn when making beds with used linen. All used gloves should be disposed of appropriately – refer to the DCC's Waste Management Policy for further information.

4.2 Aprons

Disposable aprons are impermeable to bacteria and body fluids and protect the areas of maximum potential contamination on the front of the body.

A disposable apron is single use and should be worn when:

- there is a risk of exposure to blood and/or body fluids, non-intact skin, mucous membranes, or other sources of contamination e.g., the resident has a known or suspected infection
- there is a risk of soiling to the front of uniforms or clothing
- providing direct 'hands on' care to a resident and changed between each task
- decontaminating equipment or the environment

A disposable apron must be removed and disposed of after each task. Hand hygiene must be performed after removing the apron. Appendix 4 putting on and taking off PPE.

4.3 Facial protection including masks

If there is a risk of splashing of blood and/or body fluids to the face then goggles or a visor and a mask should be worn to protect the eyes, nose, or mouth. In addition, when a resident has an infection spread by respiratory secretions, e.g., COVID-19, pulmonary TB, influenza, rubella, measles, a type IIR fluid resistant face mask and eye protection must be worn.

Prescription spectacles are not considered adequate eye protection.

Hand hygiene must be performed after removing each item of facial protection. Eye and face protection must not be impeded by accessories, e.g., false eyelashes, facial piercings.

If you are provided with goggles or a visor that is reusable, clean with running water and mild soap. Rinse with clean water, shake off excess water, and let air dry.

If eye protection is labelled for single use it should be used for a single task (that is, a single episode of an individual resident's personal care) and should then be disposed of after removal in accordance with the relevant DCC Waste Management policy.

Surgical masks must:

- be fluid resistant
- cover both the nose and mouth and not be allowed to dangle around the neck after use
- not be touched once put on
- be changed when they become moist be worn once and discarded as offensive waste

See Appendix 5 showing how to wear your face mask properly.

4.4 FFP3 disposable respirator

A disposable respirator providing a high protection factor is less frequently required in residential care homes. The fit of respiratory masks is critically important, and every user must be fit tested and trained in the use of the respirator. Additionally, a seal fit check should be carried out each time a respirator is worn.

5. Occupational Safety/Managing Prevention of Exposure (Including Sharps)

Sharps are items that could cause cuts or puncture wounds and include needles and sharp instruments. It is the responsibility of the user to dispose of sharps safely into a sharps container. Sharps which are handled inappropriately or not disposed of correctly are dangerous.

Employers, their contractors, and employees have legal obligations under the *Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 (the Sharps Regulations)*. All employers are required to ensure that risks from sharps injuries are adequately assessed, and appropriate control

measures are in place.

Where it is practicable to do so, support from a healthcare professional should be sought in order to substitute traditional unprotected sharps with a 'safer sharp' (medical sharps that incorporate features or a mechanism to prevent or minimise the risk of accidental injury).

5.1 Good practice in sharps management needle management

- avoid unnecessary use of sharps
- request assistance when using sharps with reluctant or confused resident.
- do not carry sharps in the hand - sharps containers should be available at the point of use, i.e., where the sharp is used
- always use a sharps tray with an integrated sharps container
- do not pass sharps from hand to hand and keep handling to a minimum
- do not re-cap, bend or break needles before disposal
- dispose of needle and syringes as one unit into a sharps container
- always carry sharps containers away from the body, ensuring the temporary closure mechanism is closed

Ensuring safe use

- all staff should be educated in the safe use and disposal of sharps and the action to take in the event of an injury
- sharps containers must be situated in a safe and secure place and not accessible to residents or visitors
- at no time should a sharps container be placed on the floor
- sharps containers must comply with the UN3291 and British standard BS7320
- the correct size of the sharps container to be used should be determined according to the volume of sharps generated
- sharps should be placed into the correct colour coded sharps container:
    - Orange label/lid – sharps not contaminated with medicines
    - Yellow label/lid – sharps contaminated with medicines
    - Purple label/lid – sharps contaminated with cytostatic or cytotoxic medicines

See Appendix 6 - Sharps Segregation poster

- sharps containers must be correctly assembled, with the lid securely fastened to the base and dated, signed and location recorded when assembled
- sharps containers must not be used for any other purpose than the disposal of sharps
- sharps must be placed into the sharps container by the person using the sharp

- never press down the contents to make more room or attempt to retrieve an item from the sharp's container
- after disposing of a sharp into the sharp's container, the aperture must be moved into the temporary closure 'closed' position
- sharps containers must not be filled above the 'fill line' as this could result in sharps protruding through the aperture
- the aperture must be 'locked' prior to disposal
- sharps containers must not be placed inside waste bags prior to disposal
- sharps containers must be dated and signed when locked and disposed of

Sharps containers must be disposed of when the fill line has been reached or when the container has been in use for three months **even if not full**. Failure to do so is in contravention of Health Technical Memorandum 07-01: Safe management of healthcare waste (Department of Health 2013).

5.2 Prevention of sharps injuries

An inoculation incident is where the blood/body fluid of one person could gain entry into another person's body, such as:

- an injury with a used instrument or needle
- spillage of blood or body fluid onto damaged skin, e.g., graze, cut, rash, burn
- splash of blood or blood stained body fluid into the eye, mouth, or nose
- human bite causing skin to be broken

Many accidental exposures to blood and body fluids are not classed as exposure incidents e.g., splashes onto intact skin. In these circumstances, washing the contaminated area thoroughly with liquid soap and warm running water is all that is required. Exposure to vomit, faeces, and urine (unless visibly blood stained) and to sterile sharps are also not considered as sharps injuries.

In addition:

- all staff must protect their skin, as skin is an effective barrier to micro-organisms
- any cuts or abrasions should be covered with impermeable dressings to provide a barrier
- disposable gloves must be worn when there is a risk of exposure to blood or body fluids

Always:

- use standard infection control precautions (SICPs), which includes the use of face mask
- dispose of single-use items after one use

- dispose of waste as per policy

5.3 Risk of infection from sharps injuries

Following a specific exposure, the risk of infection will vary depending on the type of micro-organisms in the resident's/service user's blood, the type of injury and the amount of organism in the resident's/service user's blood or body fluid at the time of injury.

5.4 Action to be taken following a sharps injury

In the event of a splash injury to eyes, nose, or mouth

Rinse affected area thoroughly with copious amounts of running water.

In the event of a bite or skin contamination

Wash affected area with liquid soap and warm running water, dry and cover with a waterproof dressing.

In the event of a needle-stick/sharps injury

- encourage bleeding of the wound by squeezing under running water (do not suck thewound)
- wash the wound with liquid soap and warm running water and dry (do not scrub)
- cover the wound with a waterproof dressing

In all cases

Report the injury to your manager immediately

If the injury is caused by a used sharp or sharp of unknown origin, splash to non-intact skin or mucous membrane or a bite has broken the skin:

- immediately contact your GP or Occupational Health department
- out of normal office hours, attend the nearest Accident and Emergency (A&E) department
- if you have had a needle-stick or sharps injury from an item which has been used on a someone (source), the doctor in charge of their care may take a blood sample from the source to test for hepatitis B, hepatitis C and HIV (following counselling and agreement of the resident/service user) or their representative

5.5 Reducing the risk of hepatitis B transmission

Hepatitis B vaccination is effective in preventing hepatitis B transmission.

All staff exposed to sharps or other inoculation risks should have had the opportunity for hepatitis B vaccination and antibody measurement to check for their response.

All staff likely to be in contact with sharps or inoculation risks should be aware of their immunisation status regarding hepatitis B.

Depending on the circumstances of the exposure and the immune status of the recipient, the recipient may be advised to have immediate additional vaccine doses or to receive hepatitis B immunoglobulin.

Seeking early advice is the key to successful intervention to prevent transmission. A referral to Occupational Health should made for those identified as being at high risk of hepatitis B.

5.6 Reducing the risk of hepatitis C transmission

No specific post exposure prophylactic measures are advised beyond basic first aid. In the event of a source proving to be hepatitis C positive, specific advice on subsequent testing and management will be provided through your GP or Occupational Health provider including advice on preventing spreading the infection further.

5.7 Reducing the risk of HIV transmission

In the case of a significant exposure to a known or suspected HIV infected source, or if there is evidence of AIDS related illness, then HIV post exposure prophylaxis (PEP) may be offered. HIV post exposure prophylaxis is most effective if started within one hour of exposure and is not recommended beyond 72 hours post exposure. Advice must be sought from your Occupational Health provider/GP or A&E, who will perform a risk assessment, and advise on therapy.
PEP treatment is usually only available from an A&E department, so if the resident/service user is known or suspected to be HIV positive then go straight to A&E.

5.8 Immunisation of residents

Permanent residents must have a record of their immunisation status and eligibility is regularly reviewed in line with the ‘Immunisation against infectious disease’ (the ‘Green Book’). Following this review residents may be offered further immunisation as needed.

Safe Management of Blood and Body Fluids

Blood and body fluids, e.g., urine and faeces, may contain a large number of micro-organisms, such as bacteria, viruses, and fungi. Contamination or spillages with blood or body fluids should be dealt with immediately, as this may expose staff and others to infection. Bodily fluid spillages should be managed by staff trained in the correct procedure. See Appendix 7

6.1 Dealing with blood/blood-stained body fluid spillages

Items contaminated with blood, or any body fluids stained with blood must be disinfected promptly and then the affected area cleaned (see table below) to reduce the risk of infection to other people. Appropriate PPE must be worn, and standard infection control precautions followed. Where a cleaning system is purchased by a department any relevant task cards should be followed.

Action for blood and/or blood-stained body fluid spillages ***Dilution of 10,000 parts per million (ppm) available chlorine***
Preparation of a chlorine based solution: dilution of 1 in 10, e.g., 10 ml of chlorine based in 100 ml of water.
1. Clean hands and put on disposable apron and gloves (wear facial protection if there is a risk of splashing).
2. Ventilate the area, e.g., open windows/doors, as fumes will be released from the chlorine.
3. Place solution or granules directly onto the spillage. Leave for the required contact time which is specified by the manufacturer.
4. Clear away the spillage and dispose of as infectious waste.
5. With detergent wipes or general purpose neutral detergent and warm water and disposable cloth, clean the area, then leave to air dry or dry with paper towels.
6. Dispose of cloth and paper towels as infectious waste.
7. Remove and dispose of PPE as infectious waste
8. Wash hands with liquid soap and warm running water, rinse, and dry hands thoroughly to prevent the transmission of infection.

6.2 Dealing with body fluid spillages (not blood/ blood stained)

Clean up body fluids, such as urine, faeces, and vomit, promptly. The affected area should be cleaned and then disinfected to reduce the risk of infection to other people (see table below).

Best practice is to use a body fluid spillage kit, which should be used following the manufacturer's guidance and within expiry date.

Action for body fluid spillages (NOT blood and/or blood stained) ***Dilution of 1,000 parts per million (ppm) available chlorine***
Preparation of a chlorine solution: dilution of 1,000 parts per million (ppm) available chlorine. Do not use a solution containing chlorine directly on to urine as toxic fumes will be released.
1. Clean hands and put on disposable apron and gloves (wear facial protection if there is a risk of splashing).
2. Ventilate the area, e.g., open windows/doors, as fumes will be released from the chlorine.
3. Soak up any excess liquid or clean up any solid material using paper towels, if it is a urine spillage, a gelling agent can be used. Place solution or granules directly onto the spillage. Leave for the required contact time as specified by the manufacturer.
4. Clear away the spillage and dispose of as infectious or offensive waste.
5. With detergent wipes or general purpose neutral detergent and warm water and disposable cloth, then leave to dry or dry with paper towels.
6. Dispose of cloth and paper as infectious or offensive waste.
7. Remove and dispose of PPE as infectious or offensive waste.
8. Wash hands with liquid soap and warm running water, rinse, and dry hands thoroughly to prevent the transmission of infection.

6.3 Use of chlorine-based disinfectants:

- always use the appropriate PPE, e.g., disposable apron and gloves, and wear facial protection if there is a risk of splashing to the face
- some disinfectants supplied as tablets must be added to the specified amount of water to achieve the correction concentration
- always use cold water when diluting chlorine-based disinfectants
- do not use spray bottles
- if the dilution of the chlorine-based disinfectant is incorrect and a weak solution is used, any blood-borne virus, e.g., Hepatitis B, hepatitis C and HIV, will not be killed. If the dilution is too strong, the equipment or surfaces may be damaged
- diluted chlorine-based disinfectant solutions become less effective after 24 hours
- when a solution is made, the date and time must be recorded, and the solution disposed of after 24 hours.
- to ensure that micro-organisms, such as bacteria, viruses, and fungi, are killed, always leave chlorine-based disinfectant solutions for 5-10 minutes

contact time or as specified on the container

- do not use a chlorine-based disinfectant solution directly on urine as toxic fumes will be released
- chlorine-based disinfectants should not be used on soft furnishings, untreated wood, and carpets as it will cause 'whitening/bleaching.' Therefore, only general purpose neutral detergent and warm water, a carpet shampoo machine or steam cleaner, should be used
- if soft furnishings or other items are heavily contaminated with blood or body fluids that cannot be adequately decontaminated, they should be disposed of
- rooms where cleaning is occurring should be well ventilated

Refer to the Residential Domestic and Cleaning Policy

7. Aseptic Non-Touch Technique (ANTT)

ANTT is used to carry out a procedure in a way that minimises the risk of contaminating an invasive device, e.g., urinary catheter, or a susceptible body site such as the bladder or a wound.

7.1 When should ANTT be used?

The following are some examples of when ANTT technique must be used, but is not an exhaustive list:

- when inserting an invasive device, e.g., urinary catheter
- when dressing wounds less than 48 hours old
- when dressing wounds healing by **primary intention**, e.g., surgical wounds
- when dressing deep wounds that lead to a cavity or sinus
- when dressing burn wounds
- if the resident is immunosuppressed, diabetic or at high risk of infection
- when connecting an enteral feeding tube to the feed administration system (PEG)

7.2 Who should undertake ANTT?

Personal care givers looking after residents with indwelling devices, e.g., urinary catheter, PEG tube, are not responsible for giving clinical care, but need to have knowledge of asepsis and understanding of the importance of not introducing contamination to these devices.

Only staff trained and assessed in aseptic technique should undertake this procedure. The processes for competency sign off by trained health professionals and observation requirements in place these should be followed as per the relevant management of medication and health related activities procedure.

Adherence to the principles of asepsis plays a vital role in preventing the transmission of infection in any environment. It is the responsibility of each member of staff who undertakes an aseptic technique to understand the meaning of these principles and to incorporate them into their everyday practice.

8. Urinary Catheter Care

A urinary catheter is a thin flexible hollow tube that drains urine from the bladder into a drainage bag and is a closed system. The catheter is inserted into the bladder either through the urethra (genital area) or through a small hole made in the abdomen (suprapubic). The catheter is held in place by a small balloon filled with sterile water. Each time a break is made in the closed system, e.g., changing a catheter bag, it is an opportunity for infection to be introduced. Good infection control practices are essential to prevent infection.

All staff providing care for people with a catheter need to understand the importance of the correct management of these devices and must receive training to do so. Please see relevant medication policy for details around training and competency requirements.

8.1 Urinary tract infections

All people with a urinary catheter are at increased risk of acquiring a UTI and the longer a catheter is in place, the greater the risk. The need for a urinary catheter will be reviewed on a regular basis by a practitioner, e.g., District Nurse, GP.

The risk of getting a catheter associated UTI (CAUTI) is associated with the:

- method of catheterisation
- length of time the catheter has been in place
- quality of catheter care
- residents'/service users' susceptibility to infection
- unnecessary emptying of catheter drainage bags
- unnecessary changing of catheter drainage bags
- unnecessary taking of urine samples

8.2 Signs and symptoms of UTI

In someone **with** a urinary catheter, a CAUTI is likely if the person has one or more of the following symptoms:

- shivering, chills, or a temperature less than 36°C or above 38°C
- new pain or tenderness in the flanks or lower back
- new or worsening confusion, agitation, drowsiness
- offensive smelling or cloudy urine is not a symptom of CAUTI

8.3 Catheter hygiene:

Routine personal hygiene for individuals, such as a daily bath or shower, is important to maintain catheter hygiene. For individuals who are unable to bathe or shower, staff should wash the genital area and the external catheter tube, in a direction away from the body, daily with soap and warm water. For female residents it is important to wash the genital area from front to back to prevent contamination from the anal area (back passage).

The genital area and external catheter tube should also be washed, rinsed and dried following any incontinent bowel movement.

Towels used to dry the genital area and catheter tube should be laundered after each use.

8.4 Catheter care

- use a catheter anchoring device and two leg straps to prevent pulling and damage to the urethra.
- move the catheter anchoring device daily, from leg to leg, to avoid pressure damage to the skin and bladder opening.
- inspect the urethral opening daily for signs of pressure damage. If damage noted, record in the individuals records, and inform the resident's GP.
- do not change catheters unnecessarily, but if the catheter is frequently blocking, bypassing, etc., discuss with your local continence nurse specialist or the individuals GP

8.5 Catheter bag

- catheter drainage bags may be body-worn, i.e., leg bag, or free standing for mobile residents, a leg bag should always be used, held in place with an anchoring device and two leg straps to reduce the risk of damage to the urethra/bladder by the catheter/catheter drainage bag being pulled
- position the urine drainage bag below the level of the bladder to allow good drainage - incorrect positioning, even for a short time, is linked to back flow (urine in the tube or bag flowing back into the bladder) and higher rates of infection
- body worn (leg bag) systems should be changed weekly (or in line with manufacturer's instructions) - each change should be documented in the individuals notes
- when opening the closed system to fit a new bag, a rigorous non-touch clean technique is essential - the tip of the new drainage tube must not be touched before inserting into the catheter
- catheter valves are sometimes used for residents with urological conditions as an alternative to a leg bag - they need to be changed every 5-7 days as per manufacturer's instructions, using a rigorous non-touch clean technique
- unnecessary emptying, changing, or taking urine samples, increases the risk

of CAUTI and inappropriate antibiotic prescribing and should be avoided

- maintenance of a closed system is essential to prevent infection
- single use two litre night bags should be added for overnight drainage in residents with body worn (leg bag) systems, using a non-touch clean technique
- catheter bags must be kept off the floor (attach to a stand/hanger)

8.6 Bag emptying

- where possible, educate and encourage the individual to empty their own drainage bag, using a clean technique and effective hand hygiene
- a rigorous non-touch clean technique is required for this procedure. See Section 7 aseptic non-touch technique (ANTT)
- the bag should be emptied before it becomes completely full, e.g., 2/3 full, to avoid backflow
- a separate single use clean container should be used for each individual to empty the urine into, which is then emptied and disposed of appropriately
- always avoid contact between the urine drainage bag tap and the container

8.7 Catheter specimen of urine

Where a specimen is required for an individual who has a catheter health input should be sought.

8.8 Suprapubic catheters

Suprapubic catheters are urinary catheters inserted directly into the bladder through a small hole made in the abdomen, instead of the urethra.

Catheter management

The main principles of care and management of the suprapubic catheter are similar to for those of the urethral catheter. Prevention of infection is the primary aim.

- aseptic technique should be used when cleaning the insertion site until the site has healed (7-10 days). This will be performed by the district nurse
- a sterile dry dressing may be required for the first 24/48 hours after initial insertion
- when the insertion site has healed, the site and catheter can be cleaned daily using a clean cloth, soap, and warm water
- the catheter, as it emerges, must be supported at right angles to the abdomen. Clothing must, therefore, not be too tight

8.9 Drainage system

As for urethral catheter, although a holster appliance may be more comfortable.

9. Specimen Collection

A specimen is a sample of body fluid, e.g., urine, faeces. All specimens are a potential infection risk; therefore, all specimens must be collected using standard infection control precautions. Specimens should be transported in a rigid container in accordance with the *Carriage of Dangerous Goods and Use of Transportable Pressure Equipment (2009).*

Taking routine specimens should be avoided to help reduce inappropriate prescribing of antibiotic treatment. Specimens should only be taken if there are indications of a clinical infection.

9.1 Specimen containers and transport bags

The person who obtains the specimen must ensure:

- the container is appropriate for the purpose and is CE marked. If there is leakage or an inappropriate container is used, the specimen will not be processed by the laboratory due to the infection risk
- the lid is securely closed
- there is no external contamination of the outer container by the contents
- specimens are placed inside the plastic transport bag attached to the request form after they have been labelled
- the transport bag should be sealed using the integral sealing strip (not stapled etc.)
- for large specimens, e.g., 24 hour urine, specimens may be enclosed in individual clear plastic bags tied at the neck
- the request form must not be placed in the bag but securely tied to the neck of the bag
- specimens received from residents should be transported to GP surgeries in a rigid wipe- able container - this should be disinfected after each usage
- in domiciliary care, if a specimen bag has not been provided by the GP Practice, the specimen container should be placed in a rigid container with a lid, e.g., ice cream or margarine tub, to transport it to the GP Practice. This can then be washed after use or disposed of

9.2 Collection of specimens

Sample	Key information	Indication	Container
Faeces	Open bowel into a receptacle, e.g., commode. In domiciliary care, a clean, dry container e.g. ice cream container, carrier bag positioned under the toilet seat may be used. Scoop a sample of faeces into the specimen container using the container spoon provided. NB: Fecal specimens can be taken even if contaminated with urine.	Diarrhea, increase in frequency, presence of blood, abdominal pain.	Stool specimen container (at least 1/4 full) 
	If the resident/service user has had antibiotic treatment in the past 12 weeks, request *Clostridioides difficile* testing.		
Nasal swabs	Gently rotate the swab ensuring it is touching the inside of the nostril. Repeat the process using the same swab for the other nostril.	Advised to provide an MRSA screen	Sterile cotton swab in transport medium. Charcoal medium increases survival of bacteria during transportation. If the wound is dry, moisten the swab with sterile 0.9% sodium chloride or sterile water
Sputum	Sputum should be coughed up directly into a sterile container. Early morning specimens taken before eating provide the best results.	Productive cough (green or yellow) or presence of blood in sputum	Plain universal container 
Urine: Catheter specimen of urine (CSU)	See Section 8.4 Catheter specimen of urine		

Urine: Mid-stream sample of urine (male)	Retract foreskin and clean area with soap and warm water. Ask the service user to urinate, passing the first part into the toilet, collecting the middle part of the flow into the sample pot and pass the remainder into the toilet. Replace foreskin.	Pain on passing urine, increase in frequency, fever, new urinary incontinence, new or worsening confusion, pain in the sides or lower abdomen.	Universal container with boric acid preservative (red top) which prevents bacteria from multiplying in the container. If sample is less than 5ml, a white top universal container must be used as the preservative in the red topped bottle will be too potent for a urine sample of less than 5ml and may kill off any micro-organisms.
Urine: Mid-stream sample of urine (female)	Clean the genital area with soap and warm water, wiping from front to back. Ask the service user to urinate, passing the first part into the toilet, collecting the middle part of the flow into the sample pot and pass the remainder into the toilet. In domiciliary care, a clean, dry container e.g., ice cream container, may be used.	Pain on passing urine, increase in frequency, fever, new urinary incontinence, new or worsening confusion, pain in the sides or lower abdomen.	Universal container with boric acid preservative (red top) which prevents bacteria from multiplying in the container. If sample is less than 5ml, a white top universal container must be used as the preservative in the red topped bottle will be too potent for a urine sample of less than 5ml and may kill off any micro-organisms.
Wound swab This type of specimen must only be obtained by someone adequately trained in the procedure.	A sample of drained pus, using a needle and syringe, is preferred to a swab. However, if there is not enough pus to provide a sample, take a swab of any pus or leaking fluid present. If the swab is to be taken from an ulcer, clean away any scabbed area with saline before taking the swab. Swabbing of dry crusted areas is unlikely to be helpful. When necessary to take a swab from a dry wound, moisten the swab with normal saline first.	Swelling, redness, heat, a yellow or green discharge, increased discharge of fluid, wound deterioration, fever.	Sterile cotton swab in transport medium. Charcoal medium increases survival of bacteria during transportation. If the wound is dry, moisten the swab with sterile 0.9% sodium chloride or sterile water

10. Safe Disposal of Waste (Including Sharps)

Must be read in conjunction with relevant DCC Waste Management Policy

11. Safe Management of Linen

In residential services, an adequate laundry service must be available to provide care that is both safe for staff and residents. Linen used in all care settings can become soiled with blood, faeces and other body fluids containing micro- organisms. Therefore, when handling used, soiled, fouled, and infected linen, it is essential that care is taken to prevent the spread of infection. Refer to Laundry procedure and Workwear in Direct Care Services.

12. Safe Management of Care Equipment

Decontamination of equipment includes reusable medical devices and equipment. Medical devices and equipment are essential for safe and effective prevention, diagnosis, treatment and rehabilitation of illness and disease. Equipment requiring decontamination also includes resident equipment such as wheelchairs, commodes, walking frames, walking sticks, rotundas, hoists, pressure relieving cushions and mattresses.

To ensure safe systems of work and to prevent transmission of infection, it is essential that decontamination of reusable medical devices and equipment after use on a resident is undertaken to prevent the transmission of infection. This is 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 guidanc*e.

In the event of an incident/outbreak of high risk infectious disease please see Residential Domestic and Cleaning Policy

12.1 Definitions

Equipment: Equipment used in residential/domiciliary care includes aids to daily living, e.g., wheelchairs, walking frames, commodes, raised toilet seats, shower chairs, pressure relieving mattresses and cushions

Contamination: The soiling of an object with harmful, potentially infectious, or unwanted matter.

Decontamination: A combination of processes that removes or destroys contamination.

Cleaning: A process that will physically remove contamination (blood, vomit, faeces, etc.) and many microorganisms using detergent wipes or neutral liquid detergent and warm water.

Disinfection: A process to remove or kill pathogenic (disease causing) micro-organisms using an antimicrobial agent. The ability to kill spores is dependent on the type of disinfectant used.

Sterilisation: A process that removes or destroys all organisms including spores.

12.2 Classification of care equipment

12.2.1 Single use

Items intended for single use are packaged with this ② symbol or are labelled 'single use.' Items labelled or marked for single use, e.g., disposable scissors, tympanic (ear) thermometer covers, some medicine pots, must not be used again as they are designed to be used only once.

12.2.2 Single resident use

Items intended for single resident use will be labelled with 'single use,' e.g., oxygen mask. These can be decontaminated after each use and reused on the same resident but cannot be used on another resident.

Hoist slings should be single resident use, e.g., labelled for use by a named resident and should not be used by any other person. They should be laundered regularly and whenever visibly soiled.

To disregard this information and prepare single-use devices for further use, may be transferring legal liability for the safe performance of the product from the manufacturer to the Council.

12.3 Methods of decontamination

There are three levels of decontamination, cleaning, disinfection, and sterilisation. All reusable medical devices and equipment should be adequately decontaminated after use on a resident.

Those performing decontamination should be aware that detergent and disinfectant can damage plastic surfaces of medical devices if they are not compatible with the surface material. Reports describe damage to devices such as tympanic thermometers, patient monitors, infusion pumps. This damage may compromise the ability to decontaminate the device adequately or affect the function of the device.

The method of decontamination to be applied will depend on the manufacturer's instructions, a risk assessment of the procedure and the item being used in accordance with Control of Substances Hazardous to Health (COSHH) Regulations.

12.4 Cleaning

Cleaning is a process that removes contaminants including dust, soil, large numbers of micro-organisms and the organic matter that shields them, such as faeces, blood, pus, urine, and other body fluids. To ensure effective cleaning, both the equipment used and the item to be cleaned must be in a good state of repair.

- detergent wipes or neutral liquid detergent and water and single use cloths are recommended
- cleaning is essential before disinfection or sterilisation is carried out

- when cleaning and disinfecting, clean all surfaces using an 's' shaped pattern from clean to dirty, top to bottom, taking care not to go over the same area twice
- this cleaning motion reduces the number of micro-organisms, such as bacteria, viruses, and fungi, which may be transferred from a dirty area to a clean area
- all equipment that has been cleaned must be dried thoroughly before storage

12.5 Disinfection

Disinfection is a process that reduces the number of micro-organisms to a level at which they are less harmful and is only effective if the equipment or surface is thoroughly cleaned with detergent wipes or a neutral liquid detergent and warm water beforehand. Some disinfectant products contain both a detergent and a disinfectant. This means equipment does not need to be cleaned before disinfection.

- chlorine-based disinfectant should be used for equipment that has been in contact with a resident with a known or suspected infection, non-intact skin, mucous membranes, or body fluids
- at minimum, the disinfectant product should be bactericidal and virucidal
- follow the Adult Social Care Task Card Cleaning System which provides guidance around disinfection and the solutions required. See also the Residential Cleaning and Domestic Policy
- COSHH regulations must be adhered to at all times

12.6 Sterilisation

Reusable items requiring sterilisation after use must be sent to an accredited Decontamination Services Facility. Alternatively, single use disposable equipment should be used.

12.7 Evidence of decontamination

Monthly audits to assess the standard of cleanliness of equipment should be carried out. Refer to Residential Domestic and Cleaning Policy - Environmental Cleanliness Audit

12.8 Decontamination of equipment prior to inspection, service, repair, or disposal

When equipment requires servicing or repair, documentation should accompany the equipment stating if the item has or has not been decontaminated (see Appendix 9 'Declaration of contamination status'). It is illegal to send contaminated items through the post.

Equipment for disposal should be cleaned prior to disposal.

Equipment that is known or thought to be infected, e.g., been in contact with non-intact skin, mucous membranes, body fluids or a resident with a known or suspected infection, or heavily soiled, should be cleaned and disinfected prior to disposal as infectious waste. The items must be

suitably bagged, securely sealed, and labelled as biohazard. Removal must be sought via an approved contractor. Prior to removal, they should be stored in a secure area. Please refer to relevant DCC Waste Management Policy.

12.9 Infection risks and categories

Risk category	Level of decontamination	Method	Examples
Low risk Items in contact with intact skin	Cleaning	Clean using detergent wipes or general purpose neutral detergent and warm water	• Mattresses • Toilet raisers • Walking frames • Pressure relieving cushions • Blood pressure cuffs • Reusable PPE
Medium risk Items in contact with intact mucous membranes, or contaminated with blood/body fluids or in contact with a resident with a known or suspected infection	Disinfection (cleaning should be undertaken before disinfection)	Disinfect using disinfectant wipes or a chlorine-based disinfectant • The use of single use items • Items sterilised by an accredited Decontamination Services Facility	Equipment contaminated with body fluids • Reusable PPE
High risk Items in contact with a break in the skin or mucous membrane or introduced into a sterile body area	Sterilisation	• Single use • Items sterilised by an accredited Decontamination Services Facility	• Needles/syringes • PEG tubes • Urinary catheters

13. Mattresses and Pressure Relieving Cushions

Poor maintenance of mattresses, pressure relieving cushions and their covers may lead to staining of the foam or inner surfaces. This damage can promote the growth of micro-organisms, which are a potential cause of transmission of infection. Proper care, maintenance and cleaning is, therefore, essential.

13.1 Ordering of new equipment

Always ensure that appropriate standards are met before ordering new equipment.
Mattresses and pressure relieving cushions should be of an appropriate thickness and covered with a waterproof cover, preferably with an integral zip fastener for easy inspection of the underside of the cover and the contents.

The covers should be able to withstand cleaning with detergent wipes or neutral liquid detergent and warm water and disinfecting with products effective against bacteria, viruses and spores as required.

13.2 Care and maintenance

The following guidance should be followed:

All mattresses and pressure relieving cushions should be enclosed in a waterproof cover. Mattresses, pressure relieving cushions and their covers should be dated and numbered when put into use and replaced to a pre-determined schedule according to manufacturers' instructions. It may not be possible to label some mattresses, pressure relieving cushions or covers, i.e., special mattresses. An appropriate system must be put in place to identify these.

Mattress covers should be cleaned regularly and whenever visibly soiled with detergent wipes or neutral liquid detergent and warm water when required, disinfected with appropriate products, e.g., bactericidal, virucidal, and sporicidal.

All covers, zip fasteners and contents must be **regularly** inspected for damage. Monthly checks are undertaken during the cleaning process and additionally when a room is vacated prior to a new occupier. See Residential Domestic and Cleaning Policy for the cleaning schedules. If a cover is stained, worn, or torn, the contents must be examined, and the damaged cover should be replaced immediately.

If the mattress is wet or stained, the cover and mattress should be disposed of.

Special mattresses and pressure relieving cushions, including those with hinged sections/air cells, should be maintained and cared for in accordance with manufacturers' instructions.

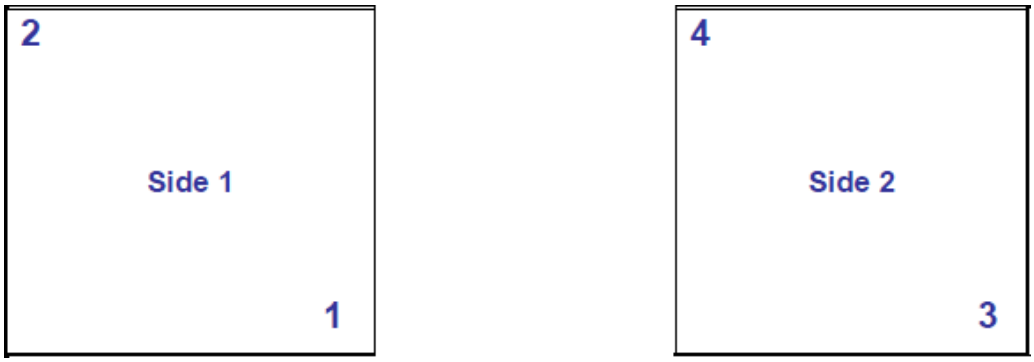
See Section 12: Safe Management of Care Equipment

13.3 Mattress turning

Some mattresses do not require turning, so always refer to manufacturer's instructions. Those mattresses that do require turning to extend the life and efficacy of the mattress should be turned as per the manufacturer's instructions.

Suggested turning procedure:

- mark mattress cover on 'side 1' as shown
- turn over and mark 'side 2' as shown
- turn mattresses regularly using a pre-determined pattern from 1-4



13.4 Disposal of used/soiled/infected items

Used mattress, covers and pressure relieving cushions do not normally need to be disposed of as infectious waste. They must be socially clean, i.e. cleaned with detergent and warm water and have a decontamination certificate attached (see Appendix 9), prior to being disposed of as household waste.

Any item that is known, thought to be infected, or heavily soiled, should be cleaned and disinfected prior to disposal as infectious waste. The items must be suitably bagged, securely sealed, and labelled as biohazard. Removal must be sought via an approved contractor. Prior to removal, they should be stored in a secure area. DCC Waste Management Policy should be followed.

13.5 Items to be returned following a loan period

Where special mattresses and pressure relieving cushions have been used on a loan basis and are required to be returned, the items must be decontaminated according to manufacturer's instructions prior to return and be accompanied by a completed decontamination certificate (see Appendix 14). The item must then be stored in a clean area awaiting collection.

14. Safe Management of Care Environment

The *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* requires that registered providers of health and social care "Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections".

- all staff must know and understand the importance of thorough cleaning
- a clean environment reduces the risk of transmission of infection posed by micro-organisms in that environment
- outbreaks of infection have been associated with environmental contamination
- most micro-organisms are found in dust and dirt, so cleaning or vacuuming alone can often cause significant reductions in the number of organisms in the environment
- some micro-organisms, e.g., *Clostridioides difficile* spores, can survive in the environment for long periods and, therefore, enhanced cleaning with a chlorine based solution is required when a resident has a known or suspected *Clostridioides difficile* colonisation or infection
- hands regularly come into contact with surfaces. If hands are not effectively decontaminated, they will transfer any organisms present. This risk is always present but will increase if environmental cleaning is neglected.

Each care home should have a cleaning plan in place as per the Residential Domestic and Cleaning Policy, this sets out:

- the clear allocation of responsibility for cleaning of all areas of, and items within, the premises
- the person in overall charge of cleaning (usually the registered manager)
- cleaning schedules and frequencies
- the systems to be used to measure outcomes
- operational and training policies and procedures which include how the care home will ensure all staff receive appropriate training prior to being allocated specific cleaning tasks.
- the risk assessment requirements

15. Outbreaks/Isolation

This section must be read in conjunction with relevant departmental cleaning policy. This guidance is designed to support and promote good practice in the investigation, management and control of infectious disease outbreaks or incidents which may have significant public health implications.

Each control problem will be unique, requiring specific measures to deal with individual circumstances. For these reasons, this guidance should be regarded as a template for action, describing key principles and good practice in the management and control of communicable disease.

15.1 Key personnel

Any member of staff working in a care environment has a duty to notify their line manager if they suspect a person using services has an infection. The person should then be assessed by their GP as soon as possible.

In a residential care setting, the manager must inform, where required, the United Kingdom Health Security Agency (UKHSA) local Health Protection Team (HPT) if they suspect that there may be an outbreak of an infection or infectious disease - that is two or more linked cases with the same symptoms of an infection. Prompt reporting of cases of infectious disease to UKHSA is essential for the monitoring of infection and allows for early investigation and prompt control of its spread.

15.2 Recognising the problem

Effective control depends on early recognition and timely intervention. Staff must be aware of symptoms **amongst both residents and staff,** which may indicate a possible outbreak, for example:

- cough and/or fever may represent influenza and COVID-19
- diarrhea and/or vomiting may indicate Norovirus or food poisoning
- skin lesions/rash may indicate scabies

If there is cause to suspect a problem, contact your local UKHSA team, who will then inform the Community IPC team.

Other infections which need to be recognised and reported include:

- notifiable diseases at https://www.gov.uk/guidance/notifiable-diseases-and-causative- organisms-how-to-report
- serious and unusual infections, e.g., Diphtheria, Polio, etc.

15.3 Definition of an outbreak

- two or more cases of residents or staff with the same infection or symptoms linked in time or place
- a greater than expected rate of infection compared with usual background levels for the place and time where the outbreak has occurred.
- a suspected, anticipated, or actual event involving microbial or chemical contamination of food or water.

Suspected outbreaks must be notified, where appropriate, to the local UKHSA team at the earliest opportunity.

Monitoring of cases of reported cases in residential establishments must be recorded on the Outbreak Monitoring Form, Appendix 8. The information recorded on the outbreak form will be used to populate the annual statement. When an outbreak has been confirmed the Quality and Compliance Team must be alerted.

15.4 Isolation (residential settings)

The terms ‘isolation’ and ‘isolation nursing’ are used in preference to ‘barrier nursing.’ The reason for isolating residents for infection prevention and control purposes is to protect other residents, this is known as ‘source isolation.’

Source isolation is used to minimise the risks of micro-organisms being transferred from an affected person.

Residents and their visitors should be informed of the reason for isolation and the infection prevention and control measures required to prevent the spread of infection.

Managers and staff who are using isolation as a control measure should bear in mind that if a resident is deemed not to have capacity, the Mental Capacity Act 2005 Deprivation of Liberty Safeguards (DoLS) applies. If residents are to be confined to particular parts of the establishment as an infection control measure, advice should be taken from a senior manager as to whether specific action might need to be taken under the Mental Capacity Act or use of the Deprivation of Liberty Safeguards.

15.5 Protective isolation

Residents who are particularly susceptible to infection, such as those with reduced immunity due to medication or a condition, may require isolation nursing to prevent them acquiring an infection from people or the environment.

It is unlikely that a resident in a care home setting would have a level of susceptibility that would require protective isolation. Further advice on protective isolation can be obtained from your local UKHSA team or Community Infection Prevention and Control (IPC) team.

15.6 Risk assessment

The decision to isolate a resident should not be taken lightly and should always be taken after assessing the risk to the individual, other residents and staff and the decision documented in care plans and made in accordance with the principles of the Mental Capacity Act 2005 (and updating legislation) and human rights law.

Advice should be sought from your UKHSA team or local Community IPC team on the appropriateness of isolating a resident. The following should be taken into consideration:

- how the infection is spread, e.g., air-borne, fecal-oral route
- the environment
- the susceptibility of others to the infection
- the resident's clinical condition, e.g., mental health
- evidence-based practice

If an outbreak of diarrhea and/or vomiting is suspected, residents with symptoms of diarrhea and/or vomiting should be considered as infectious and isolated where possible until 48 hours symptom free.

15.7 Standard precautions during outbreaks of infection

See Section 1 Standard Precautions

Whilst additional precautions may need to be taken with some communicable diseases, e.g., *Clostridioides difficile*, pulmonary TB, influenza or COVID-19, the use of standard precautions is usually all that is required for the majority of infections.

Refer to the Government Guidance Infection prevention and control: resource for adult social care

For residents who are isolated, all staff providing hands on care in the room must wear the appropriate PPE.

Apron and gloves should be changed between tasks, removed in the room, disposed of as infectious waste and hands washed with liquid soap and warm running water.

15.8 Requirements for isolation

The most effective form of isolation of an affected resident is in a single room with en-suite facilities. The requirements for isolation include:

- a notice for the door with advice to see the person in charge before entering. This may be omitted if it can be assured that all relatives/visitors are made aware of the actions they need to take whilst visiting the resident and when leaving the room
- a designated toilet/commode must be identified for the affected resident if en-suite facilities are not available. If a urinal or commode is used, it must be kept in the resident's room for their sole use and a disposable cover or reusable lid should be used when transporting the urinal/pan for emptying/cleaning in a sluice room
- disposable aprons and gloves
- eye protection is only required if there is a possibility of splashing of body fluids to the eyes
- face masks are not required routinely and should only be worn if there is a risk of splashing of body fluids to the face/mouth. Refer to Guidance Infection prevention and control in adult social care: COVID-19 supplement
- see Adult Care Laundry Procedure
- waste bin pedal operated with a lid and lined with appropriate waste bag for infected waste, e.g., orange - this may depend on your waste contractor

15.9 Control measures

- where possible designated staff should be allocated to care for only affected residents
- to reduce the risk of spreading the virus within the care home, if there is a floor

level, e.g., ground floor, unaffected by the outbreak with no affected residents, where possible staff working on this floor should not work on or visit affected floors. Residents should also not be allowed to visit other floors

- staff with vomiting and/or diarrhea must stay off work until they are symptom free for 48 hours. If staff become unwell with symptoms of vomiting and/or diarrhea whilst at work, they should be sent home immediately, and the affected area should be cleaned appropriately
- all staff, including agency and bank staff, should be discouraged from working in other health and social care settings whilst the outbreak is in progress. If unavoidable, they should have 48 hours off duty before working in another establishment and wear freshly laundered uniforms/clothing
- where possible the door to the room should be kept closed. If this is not possible, a documented risk assessment should be recorded in the resident's records
- when entering the room of an isolated resident, disposable apron and gloves should be worn if there is physical contact with the resident or their environment e.g., helping a resident get out of bed, help with feeding or cleaning of the room, or as advised by care home staff
- if there is no physical contact with the resident, e.g., taking a cup of tea into the room, disposable apron and gloves are not required unless the resident has Clostridioides difficile
- on completion of the episode of care, apron, gloves and masks, where used, should be removed in the resident's room, gloves should be removed first, (see Appendix 4) and disposed of in the room as infectious waste in a foot operated lidded waste bin
- hands should be washed in the resident's room with liquid soap and warm running water and dried with paper towels immediately before leaving the room. After exiting the room, hands should be washed again or an alcohol hand rub can be used, unless the resident is isolated due to diarrhea, then hands must be washed
- where possible, medical equipment used in the room should be disposable. If reusable equipment is used, it should be appropriately decontaminated on removal from the room before use on another resident
- increased touch point cleaning must be instigated. Refer to Residential Domestic and Cleaning Policy

15.10 Precautions for visitors

In most cases, visitors do not need to wear PPE e.g., apron and gloves, when visiting an infected resident except:

- if they are providing/assisting in the physical care of a resident
- if they are visiting a resident with *Clostridioides difficile* and providing personal care or advised by care home staff

To prevent the spread of infection, visitors who are unwell should be advised not to visit and those with a history of diarrhea and/or vomiting should be advised not to visit until they are symptom free for 48 hours.

- it is recommended that non-essential visits are re-scheduled, e.g., hairdresser, until the outbreak has been declared over
- planned functions/events, e.g., BBQ, Christmas party, should be cancelled and re- scheduled for when the care home has re-opened

In relation to COVID-19, appropriate national guidance should be followed.

15.11 Disposal of faeces/urine

Where bed/commode pans or urinals are to be taken to the sluice, the following procedure should be followed:

- hands should be washed with liquid soap and warm running water and gloves and apron worn
- cover the bed/commode pan or urinal with paper or a lid before leaving the room
- on entering the sluice, dispose of the contents carefully to avoid splashing in either a slop hopper or bed pan washer/disinfector
- dispose of the paper cover as infectious waste or clean and disinfect the lid appropriately
- if a bedpan washer disinfector is not available, clean the urinal or pan using detergent wipes or a disposable cloth and neutral liquid detergent, and warm water, and then disinfected by wiping with disinfectant wipes effective against bacteria and viruses or a chlorine-based disinfectant solution at a dilution of 1,000 parts per million. If the resident has *Clostridioides difficile* and disinfectant wipes are used, they should be effective against *clostridioides difficile* spores. See Section 12
- remove gloves then apron and dispose of as infectious waste
- wash hands with liquid soap and warm running water and dry with paper towels before leaving the room

Commodes should be left in the resident's room for their use only, and the frame (including all underneath surfaces) be cleaned after each use, using detergent wipes or a disposable cloth and neutral liquid detergent and warm water, and then disinfected by wiping with disinfectant wipes effective against bacteria and viruses or a chlorine-based disinfectant solution at a dilution of 1,000 parts per million

15.12 Disposal of waste

See DCC Waste Management Policy.

15.13 Environmental cleaning during an outbreak

Infection prevention and control recommendations and the Residential Domestic and Cleaning Policy must be followed.

15.14 Crockery and cutlery

There are no specific precautions for crockery and cutlery. Used crockery and cutlery should be washed as usual in the dishwasher; there is no need to wash them separately from crockery and cutlery used by other residents.

Water jugs and drinking glasses should also be washed in a dishwasher.

15.15 Linen

Refer to the Adult Care Laundry Procedure

15.16 Declaring Outbreak Over

Outbreak is declared over at different times, depending on the original infection. Refer to relevant section of this policy or Government Guidance Infection prevention and control: resource for adult social care.

The Quality and Compliance Team must also be notified.

16. Inter-Health and Social Care Infection Control Transfer

It is a requirement of the *Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance* that accurate information on the infection status of a resident is communicated when transferring them to another health or social care provider to prevent the spread of healthcare associated infection (HCAI).

Prior to a resident's transfer to and/or from another health and social care facility, an assessment for infection risk must be undertaken. This ensures appropriate placement of the resident.

A Health and Social Care Infection Control Transfer Form (see Appendix 10) must be completed for all transfers, internal or external and whether the resident presents an infection risk or not.

A 'confirmed risk' resident is one who has been confirmed by a laboratory test or clinical diagnosis, e.g., Methicillin resistant *Staphylococcus aureus* (MRSA), Multi-Resistant Gram-Negative Bacteria (MRGNB), Pulmonary Tuberculosis (TB), scabies, seasonal influenza, and enteric infections (diarrhea and/or vomiting) including *Clostridioides Difficile*.

A 'suspected risk' resident includes one who is awaiting laboratory test or clinical diagnosis results to identify infections/organisms or those who have been in recent contact/close proximity to an infected person. Residents at suspected risk include those with diarrhea, vomiting, an unexplained rash, fever, or respiratory symptoms.

A ‘no known risk’ resident does not meet either of the criteria above.

The completed form should be supplied to the receiving provider and a copy kept by the care home in the resident’s records.

16.1 Duties & responsibilities

Care home staff with responsibility for arranging a resident’s transfer should complete the Health and Social Care Infection Control Transfer Form (see Appendix 10) for the resident to be transferred, whether they have a confirmed, suspected or no known infection.

If the resident is in the ‘suspected or confirmed infection risk’ group, the person completing the transfer form is responsible for advanced communication, e.g., by telephone, to the transport service at the time of booking and the receiving health or social care facility prior to the transfer, to enable them to make appropriate arrangements.

16.2 Application

All admissions, transfers and discharges to all health and social care facilities including:

- admissions to hospital
- transfers from or to another care home

Attendance for treatment or support in another health or adult social care setting for admissions from hospital to a care home or home care, the hospital should provide this information prior to transfer.

Transfer documentation, e.g. an Inter-health and social care infection control (IHSCIC) transfer form (see Appendix 10) or patient passport, must be completed for all transfers, internal or external and whether the resident presents an infection risk or not.

When transferring a resident who has had diarrhea of any cause in the past 7 days, staff should ensure they include the infection risk, history of type of stool (see Appendix 11) and frequency of bowel movements during the past week. The history should be given in any verbal communication to the ambulance personnel and the receiving unit to ensure that isolation facilities are identified.

During outbreaks of infectious disease, do not transfer anybody to another facility until the outbreak is over unless there is a clinical need.

17. Viral Gastroenteritis/Norovirus

Viral gastroenteritis is usually caused by a virus known as Norovirus which is a non-enveloped virus only affecting people. Norovirus was previously known as Norwalk or SRSVs (small round structured virus).

Other less common causes include Rotavirus and Sapovirus.

The incubation period for viral gastroenteritis is usually 24-48 hours, but cases can occur within 12 hours of exposure. Symptoms include:

- sudden onset of vomiting
- watery non-bloody diarrhea
- abdominal cramps
- nausea
- low grade fever
- headache

The illness is usually of a short duration lasting 24-72 hours with a full recovery. Maintaining good hydration is important. If there is clinical concern about the resident, then the GP should be notified.

Norovirus is highly infectious and is transmitted from person-to-person primarily through the fecal-

oral route, or by direct person-to-person spread. Evidence also exists of transmission due to aerosolisation of vomit which can contaminate surfaces or enters the mouth and is swallowed.

Once an affected person is 48 hours symptom free, they are considered non-infectious.

Immunity to norovirus is of short duration, possibly only a few months.

Outbreak confirmation/notification

See Section 15

In domiciliary care, affected people should be advised stay at home until they have been symptom free for 48 hours to avoid the risk of spreading the infection.

17.3.1 Hand hygiene

Refer to Section 3: Hand hygiene

17.3.2 Environmental cleaning and disinfection

See above and any relevant departmental cleaning guidance.

17.3.3 Specimens

See Section 9

17.2 Visiting during an outbreak

See Section 15

17.3 Declaring the end of the outbreak

Whenever possible, control measures should be maintained for 72 hours after the last episode of vomiting and/or diarrhea in the last known case. A deep clean should be undertaken on all affected resident's rooms and all communal areas prior to re-opening of the care home.

- a deep clean of all communal areas and affected resident's rooms should be undertaken with carpets, curtains and soft furnishings washed, shampooed or steam cleaned
- refer to Section 14 Outbreaks/Isolation

18. Multi-Resistant Bacteria including ESBL and CPE

The increasing prevalence of antibiotic resistant micro-organisms, especially those with multiple resistance, is an international concern.

Antibiotic resistance makes infections difficult to treat. It may also increase the length of severity of illness, the period of infection, adverse reactions (due to the need to use less safe alternative drugs), length of hospital admission and overall costs.

Many bacteria are normally found in the bowel. Not all are resistant to antibiotics and not all will cause serious illness. Species of bacteria commonly found include *Escherichia coli* (*E. Coli*), Klebsiella, Proteus, Pseudomonas Enterobacter, and Acinetobacter. Collectively these bacteria are referred to as Gram- negative bacilli (GNB). These bacteria, under certain circumstances can become resistant to antibiotics and may require infection control management. They are referred to as **Multi-resistant Gram-Negative Bacteria** (MRGNB).

Some MRGNB contain beta-lactamases (**Extended Spectrum Beta Lactamases** or ESBL's) which can destroy/inactivate even broad spectrum antibiotics such as penicillin, trimethoprim, cefuroxime, and cefotaxime.

New MRGNB known as CPE (**carbapenemase-producing Enterobacteriaceae**) have recently been identified. These resistant strains of bacteria carry a carbapenemase enzyme that destroys carbapenem antibiotics, the powerful group of antibiotics such as imipenem which is used in hospitals. Until now, these have been the 'last resort' antibiotics medics have relied on when other antibiotics have failed to treat infections.

18.1 Key points

- Gram-Negative Bacteria (GNB) are commonly found in the gastro-intestinal tract, in water and in soil and can be part of the transient bacteria carried on the hands of staff and on equipment used in care homes
- Multi-Resistant Gram-Negative Bacteria (MRGNB) are found most frequently

in residents/service users who have received broad spectrum antibiotics and those who have diminished immunity

- the bacteria commonly achieve antibiotic resistance by producing an enzyme which can destroy or inactivate broad spectrum antibiotics
- the genes that carry antibiotic resistance can spread to other bacteria and control of MRGNB requires comprehensive infection control and appropriate antibiotic prescribing
- MRGNB are likely to be passed on via the fecal/oral route and are usually identified in stool and urine specimens
- most people with MRGNB are colonised which means bacteria are present, but they do not have symptoms of infection and antibiotic treatment is not required unless they develop symptoms.
- MRGNB can cause urinary tract infections, pneumonia, and surgical site infections
- residents/individuals who are colonised with MRGNB do not usually pose a risk to healthy people but may be a risk to those who are vulnerable.

18.2 Routes of transmission

- direct spread via hands of staff and residents
- equipment that has not been appropriately decontaminated
- environmental contamination

Although MRGNB can be spread via equipment, the most common route is by contact with an infected or colonised person. Therefore, the importance of good hand hygiene before and after direct contact with a resident/service user is essential.

18.3 Treatment

Giving antibiotics to asymptomatic (colonised) residents to clear the organism is not recommended because it is not causing an infection.

Antibiotic treatment should only be given to a resident who has clinical signs of infection.

18.4 Clearance specimens

MRGNB clearance specimens, including fecal samples or swabs for CPE, are not required. Repeat specimens should only be taken if the resident has clinical signs of an infection, e.g., pyrexia, pain on passing urine.

18.5 Precautions for MRGNB

Residents with a MRGNB infection

- residents with a MRGNB active infection should be isolated until no longer symptomatic, unless they have diarrhea, when they should be isolated until 48 hours symptom free – See Section 15 Outbreaks/Isolation
- during isolation, staff must wear appropriate PPE when providing hands on care. See Section 4: Personal Protective Equipment
- hands must be cleaned after removing and disposing of each item of PPE e.g., pair of gloves, apron. See section 3: Hand Hygiene

Residents colonised with MRGNB

- residents colonised with MRGNB do not require isolation
- colonisation with MRGNB may be long term, therefore, good hand hygiene practice and standard infection control precautions should always be followed by all staff to reduce the risk of transmission of infection
- a resident with MRGNB present in their urine who is not catheterised and is continent with no symptoms of a urinary tract infection is very unlikely to present a risk to others
- residents can visit communal areas, e.g., dining room, television room and can mix with other residents
- hand hygiene is essential after direct contact with a resident, or their surroundings, using either liquid soap and warm running water or alcohol hand rub. See section 3: Hand Hygiene
- residents should be encouraged to wash hands or use skin wipes after using the toilet and before meals
- appropriate PPE must be worn when in contact with body fluids
- normal laundry procedures are adequate. However, if laundry is soiled with urine or faeces, it should be treated as infected. Items that are soiled should be washed at the highest temperature the item will withstand – See Section 11: Safe Management of Linen
- staff should ensure if the resident has any wounds, they are covered with an appropriate dressing, as advised by a healthcare professional, e.g., GP, Tissue Viability Nurse, Community Nurse
- no special precautions are required for crockery/cutlery, and they should be dealt with in the normal manner
- waste contaminated with body fluids should be disposed of as infectious waste. See DCC Waste Management Policy

19. MRSA (Methicillin Resistant Staphylococcus Aureus)

Staphylococcus aureus (SA) is a common bacterium that approximately 1/3 of people carry on the skin or in the nose of healthy people without being aware of it. If the bacteria invade the skin or deeper tissues, and multiplies, an infection can develop. This can be minor, such as pimples, boils, or serious, such as wound infections, pneumonia, or bacteremia.

Methicillin is an antibiotic that was commonly used to treat *Staphylococcus aureus*, until some strains of the bacteria developed resistance to it. These resistant bacteria are called **Methicillin resistant *Staphylococcus aureus*** (MRSA). Strains identified as methicillin resistant in the laboratory will not be susceptible to flucloxacillin – the standard treatment for many staphylococcal infections. These strains may also be resistant to a range of other antibiotics.

MRSA is not usually a risk to healthy people. Research has shown that healthcare workers, who become colonised, have acquired the bacteria through their work, but the MRSA is usually present for a short time only.

Panton-Valentine Leukocidin (PVL) is a toxin produced by less than 2% of *Staphylococcus aureus* (SA). It is associated with an increased ability to cause disease. PVL-SA causes recurrent skin and soft tissue infection, but can also cause invasive infections, in otherwise healthy young people in the community. Staff who develop recurrent skin and soft tissue infections should seek medical advice.

19.1 Colonisation and infection

Colonisation means that MRSA is present on or in the body without causing an infection. Up to 33% of the general population at any one time are colonised with *Staphylococcus aureus* (including MRSA) on areas of their body, e.g., nose, skin, armpit, groin. It can live on a healthy body without causing harm and most people who are colonised do not go on to develop infection. Less than 5% of colonising strains in the healthy population who have not been in hospital are methicillin resistant, but it is more common in vulnerable people who are in contact with the health and social care system.

Infection means that the MRSA is present on or in the body causing clinical signs of infection, such as in the case of septicemia or pneumonia, or for example, in a wound causing redness, swelling, pain and/or discharge.

MRSA infections usually occur in health and social care settings and, in particular, vulnerable people. Clinical infection with MRSA occurs either from the resident's own resident MRSA (if they are colonised) or by transmission of infection from another person who could be an asymptomatic carrier or have a clinical infection.

19.2 Who is at risk of infection from MRSA

- residents/individuals with an underlying illness.
- older people – particularly if they have a chronic illness.
- those with open wounds or who have had major surgery.

- residents/individuals with invasive devices, such as urinary catheters or peg feeding tubes.

19.3 Routes of transmission

- direct spread via hands of staff or residents/individuals
- equipment that has not been appropriately decontaminated
- environmental contamination (*Staphylococci* that spread into the environment may survive for long periods in dust)

19.4 Treatment

Any treatment required will be on an individual basis. Antibiotic treatment will only be prescribed if there are **clinical signs of infection**. Residents/service users who are colonised with MRSA, i.e., no clinical signs of infection, do not usually require antibiotic treatment.

19.5 Suppression treatment and screening

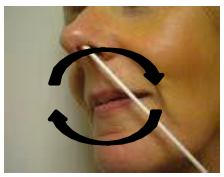
In accordance with Department of Health guidance, screening of some patients is undertaken by hospitals. Screening is not usually required in a care home. However, if the care home is requested to take a nasal swab for MRSA, follow the instructions 'How to take a nasal swab for MRSA screening.'

- suppression treatment may be prescribed for some residents/service users with MRSA in certain conditions, e.g., they are due to be admitted to hospital, have a wound, or an invasive device, such as a urinary catheter, enteral feeding tube
- suppression treatment consists of a 5 day course of both a daily body wash and a nasal ointment. Depending on the product used, the body wash is either applied as a shower gel/shampoo or applied after washing and left on the skin
- to maximise the effectiveness of the suppression treatment, the application instructions provided for the products should be followed. Compliance with the above programme is important and, once commenced, should be completed to prevent antibiotic resistance

If a MRSA positive result is diagnosed after a resident has been discharged from hospital, the GP will be informed, and if appropriate will prescribe suppression treatment.

Screening swabs following suppression treatment are not required for residents/service users in the community.

19.6 How to take a nasal swab for MRSA screening

How to take a nasal swab for MRSA screening	
	• Wash hands and apply apron and non-sterile gloves. • Place a few drops of either sterile 0.9% sodium chloride or sterile water onto the swab taking care not to contaminate the swab.
	• Place the tip of the swab inside the nostril at the angle shown. • It is not necessary to insert the swab too far into the nostril.
	• Gently rotate the swab ensuring it is touching the inside of the nostril. • Repeat the process using the same swab for the other nostril.
	• Place the swab into the container. • Dispose of gloves and apron and clean hands after removing each item of PPE, e.g., pair of gloves, apron. • Complete resident details on the container and specimen form. Request 'MRSA screening' under clinical details on the form.

19.7 Precautions for MRSA

Residents with a MRSA infection

- residents with an active MRSA infection should be isolated until they are symptom free (usually after a course of antibiotics). Refer to the isolation section 14
- any infected wound or skin lesion should be covered with an appropriate dressing as advised a healthcare professional, e.g., GP, Tissue Viability Nurse, Community Nurse. The dressing should be checked frequently for signs of leakage and replaced accordingly until the wound is dry
- during isolation, staff should wear disposable apron and gloves when providing hands on care
- hands should be cleaned after removing and disposing of each item of PPE

e.g., pair of gloves, apron

Residents colonised with MRSA

- colonisation with MRSA may be long term, therefore, good hand hygiene practice and standard infection control precautions should be always followed by all staff, to reduce the risk of transmission of infection
- a resident with colonisation of MRSA in their urine who is not catheterised and is continent with no symptoms of a urinary tract infection is very unlikely to present a risk to others
- residents with MRSA can share a room unless they or the person sharing the room has wounds, catheters, or any other invasive device
- residents with MRSA can visit communal areas, e.g., dining room, television room and can mix with other residents
- hand hygiene is essential after direct contact with a resident or their surroundings using either liquid soap and warm running water or alcohol hand rub
- residents should be encouraged to wash hands or use skin wipes after using the toilet and before meals
- disposable apron and gloves should be worn when in contact with body fluids
- normal laundry procedures are adequate. However, if laundry is soiled with urine or faeces, it should be treated as infected. Items that are soiled should be washed at the highest temperature the item will withstand. See Laundry procedure
- staff should ensure if the resident has any wounds, they are covered with an appropriate dressing, as advised by a healthcare professional, e.g., GP, Tissue Viability Nurse, and Community Nurse
- no special precautions are required for crockery/cutlery, and they should be dealt within the normal manner
- waste contaminated with body fluids should be disposed of as infectious waste – See DCC Waste Management Policy
- hands must be cleaned after removing and disposing of each item of PPE e.g., pair of gloves, apron
- there is no need to restrict visitors, but they should be advised to wash hands or use alcohol hand rub on arriving and leaving
- residents should not be prevented from visiting day centres, etc., and may socialise outside the care home
- if a resident requires hospital admission, the receiving department/hospital staff should be informed of the resident's MRSA status. This will enable a risk assessment to be undertaken to determine whether the resident should be isolated on admission.

20. Clostridioides Difficile (C. difficile)

Clostridioides difficile (formerly known as Clostridium difficile) is a bacterium which produces spores that are resistant to air, drying and heat. The spores survive in the environment and are the main route of spreading the Clostridioides Difficile (C. Difficile).

C. difficile is present harmlessly in the gut (bowel) of 3-5% of healthy adults as part of their normal gut flora. However, when antibiotics are given for an infection, they kill off some of the good bacteria in the gut, which leaves room for C. difficile to multiply rapidly, producing toxins causing diarrhea. The presence or absence of these toxins is detected in the Laboratory as part of the C. difficile testing process.

In the majority of residents, the illness is mild, and a full recovery is usual. Elderly people, often with underlying illnesses may, however, become seriously ill.

Recurrence of C. difficile occurs in up to 20% of cases after the first episode. This increases to 50-60% after a second episode.

C. difficile has been associated with outbreaks in health and social care settings. It is, therefore, imperative that good infection prevention and control measures are instigated so that transmission does not occur in any health or social care setting.

There are two types of C. difficile conditions:

- C. difficile infection (CDI) This means that the bacteria are present and producing toxins, causing symptoms which can be mild to severe, including life threatening pseudomembranous colitis, toxic megacolon and even perforation of the bowel
- C. difficile colonisation This means that the bacteria are present in the bowel, but not producing toxins. Symptoms, if present, are usually very mild and antibiotic treatment is not usually required. People who are colonised are often known as ‘carriers’
- residents who are colonised are at high risk of progressing to infection
- C. difficile is almost always associated with, and triggered by, the prior use of antibiotics prescribed as treatment for, or to prevent infection (prophylaxis).

20.1 Risk Factors for *C. Difficile*

The risk factors associated with acquiring *C. difficile* are:

- age – incidence is much higher in those aged over 65 years
- underlying disease – those with chronic renal disease, underlying gastrointestinal conditions or have a suppressed immune system
- antibiotic therapy – those who are receiving or who have recently received antibiotic treatment (within 3 months), especially broad-spectrum antibiotics such as cephalosporins, e.g., cefuroxime, quinolones, such as, ciprofloxacin,

co-amoxiclav or clindamycin. C. difficile has been associated with oral, intramuscular, and intravenous routes of administration of antibiotics

- recent hospital stay – those who are frequently in hospital or who have had a lengthy stay in hospital
- other medication – those receiving anti-ulcer medications, including antacids and proton pump inhibitors (PPIs), e.g., omeprazole, which are used for treating reflux (heartburn and indigestion)
- nasogastric tubes – those undergoing treatments requiring nasogastric tubes
- colonisation with *C. difficile* – they are at greater risk of developing *C. difficile* infection (CDI)

20.2 Signs and symptoms

If a resident has diarrhea (types 5-7 on the Bristol Stool Form Scale, see Appendix 11), that is not attributable to underlying causes, e.g. inflammatory colitis, overflow, or therapy, such as, laxatives, enteral feeding, then it is necessary to determine if this is due to *C. difficile* infection.

Symptoms include:

- explosive, foul-smelling watery diarrhea, which may contain blood and or mucous
- abdominal pain and fever due to the toxins causing fluid loss from the gut and cell damage
- dehydration which can be severe due to fluid loss

The symptoms are usually caused by inflammation (swelling and irritation) of the lining of the bowel and can last from a few days to several weeks. Most people develop symptoms whilst taking antibiotics, however, symptoms can appear up to 10 weeks after finishing a course of antibiotics.

In the majority of residents, the illness is mild, and a full recovery is usual. Older residents often with underlying illnesses and CDI may, however, become seriously ill. Occasionally, residents with CDI may develop a severe form of the infection called pseudomembranous colitis which can cause significant damage to the large bowel resulting in perforation, peritonitis, and death.

20.3 Hydration

Fluid loss due to diarrhea can lead to dehydration. Residents/Service users with C. difficile should be encouraged to drink plenty of fluids.

20.4 Diagnosis

It is difficult to diagnose *C. difficile* just by symptoms alone. Therefore, a diarrhea sample must be sent to the microbiology laboratory and tested for the presence of *C. difficile.*

See Section 9 Collection of specimens. THE SPECIMEN REQUEST FORM MUST REQUEST

THAT THE SAMPLE BE TESTED FOR *C. DIFFICILE*

20.5 Routes of transmission

The main routes of transmission of *C. difficile* spores are:

- contaminated hands of staff and residents
- contact with contaminated surfaces or equipment, e.g., commodes, toilet flush handles, toilet assistance rails

20.6 Prevention of C. Difficile

The main methods of preventing and reducing transmission of *C. difficile* are:

- prudent antibiotic prescribing – antibiotics should not be prescribed unless necessary
- prompt isolation of residents with suspected or confirmed *C. difficile* colonisation or infection. In supported living or extra care, the service user should be advised to remain in their accommodation and not to visit communal areas until they are symptom free for 48 hours and passed a formed stool (type 1-4 on the Bristol Stool Form Scale, Appendix 11) or their bowel habit has returned to normal.
- promptly sending a stool sample for *C. difficile* testing
- good hand hygiene practice – See Section 3: Hand Hygiene.
- use of appropriate PPE e.g., disposable apron and gloves
- reducing the number of spores in the environment by thorough cleaning and then disinfecting, see section 6 Safe Management of Blood and Body Fluids
- cleaning with warm water and a general purpose neutral detergent/detergent wipe alone is insufficient to destroy C. difficile spores
- encourage the service user, where possible, to have a shower or bath daily as C. difficile spores may be on other areas of their body

The following mnemonic protocol (SIGHT) should be applied when managing suspected potentially infectious diarrhea.

S	Suspect that a case may be infective where there is no clear alternative cause for diarrhea
I	Isolate the resident in their own room – residential, supported living or extra care only
G	Gloves and aprons must be worn for all contact with the resident and their environment
H	Hand washing with liquid soap and warm running water before and after each contact with the resident and their environment
T	Test the stool for toxin by sending a specimen immediately

20.7 Management and treatment

The resident should be reviewed by their GP promptly.

- antibiotics causing diarrhea should be stopped, if possible, as should other drugs that might cause diarrhea. If it is not appropriate to discontinue antibiotics, it may be possible to substitute agent(s) with a narrower spectrum. Do not discontinue medication without consultation with the resident's GP
- supportive care should be given to CDI cases, including attention to hydration and nutrition. Fluid loss due to diarrhea can lead to dehydration
- residents/individuals with *C. difficile* should be encouraged to drink plenty of fluids
- the course of treatment can be repeated, in consultation with the GP, if symptoms persist

The resident's bowel movements should be recorded on a 'Stool chart record' – See Appendix 11
The severity of illness should be assessed using the following table and documented daily in the resident's records. Share this information with the resident's GP.

Severity of *C. difficile* infection	
1	Mild disease: typically, <3 stools per day type 5-7 (on Bristol Stool Form Scale)
2	Moderate disease: typically, 3-5 stools per day type 5-7
3	Severe disease: A temperature of >38.5C or GP practice reports increasingly abnormal blood test results, or evidence of severe colitis (abdominal symptoms) The number of stools may be less reliable as an indicator of severity
4	Life threatening disease includes low blood pressure

Recurrence of diarrhea following treatment

Recurrence of CDI occurs in up to 20% of cases after the first episode. A proportion of recurrences are re-infections (20-50%) as opposed to relapses due to the same strain. Relapses tend to occur in the 2 weeks after treatment stops. This increases to 50-60% after a second episode.

Studies have suggested that some of these relapses are in fact re-infection due to the person re-infecting themselves from spores in their environment, hence the need for thorough cleaning and disinfection of the environment, see Section 14: Safe Management of the Care Environment. If a resident relapses, a second course of treatment is usually indicated. **The resident's GP must be notified of any relapse.**

20.8 Enhanced resident monitoring

In the event of a resident being suspected or confirmed with *C. difficile* colonisation or infection, the instigation of enhanced monitoring of other residents for symptoms of *C. difficile* with close observation of all residents receiving antibiotic treatment.

Other residents who develop diarrheal stools should be isolated immediately and have a stool

sample sent for *C. difficile* testing. A fluid balance, see Nutrition and Hydration Policy, and stool chart, Appendix 10,should be commenced.

20.9 Referral or transfer from another setting

- transfer to another Domiciliary Care Agency or a Care Home should, where possible, be deferred until the service user is no longer infectious
- an individual is classed as no longer infectious once they have had no diarrhea for 48 hours and passed a formed stool (type 1-4 on the Bristol stool form scale, see Appendix 11) or their bowel habit has returned to their normal type, unless essential investigations or treatment is required
- prior to any transfer, an Inter-health and social care infection control (IHSCIC) transfer form (see Appendix 10), must be completed for all transfers, internal or external and whether the resident presents an infection risk or not

20.10 Death of a resident with C. Difficile infection

No special precautions other than those for a living resident are required for a deceased resident. See Section 25: Care of the Deceased.

20.11 Investigation of C. Difficile cases

A root cause analysis (RCA) should be conducted by your local Community Infection Prevention and Control or UKHSA for each CDI case to identify any lapses in care. The home may be requested to supply relevant information for the RCA investigation. By implementing the lessons learned from the RCA, resident safety can be continuously improved.

21. Scabies

Scabies is a skin infection caused by mites known as Sarcoptes Scabie. Females burrow into the skin, laying about twenty-five eggs and then die. The new mites hatch from the eggs in 10-15 days, tunnel up to the skin surface and grow into adults. The main symptoms of scabies are due to the body's allergic reaction to the mites and their waste. Symptoms include an itchy, widespread rash (often worse at night) which occurs mainly between the fingers, on the waist, armpits, wrists, navel, and elbows. It usually affects both sides of the body alike. The rash does not correspond to where the mites are located on the body.

There are two forms of scabies both caused by the same mite. The most common form of 'classical scabies,' has fewer than twenty mites all over the body. The rarer type of 'crusted (Norwegian) scabies,' which may be seen in immunosuppressed individuals, can have thousands or millions of mites causing a more severe reaction in the skin. It develops due to an insufficient immune response in the host.

Scabies is contagious before symptoms occur which is on average 3-6 weeks following infestation, however, if a person has had scabies in the past, symptoms will develop in 1-4 days.

Untreated scabies is often associated with secondary bacterial infection which may lead to cellulitis

(infection of the deeper layers of the skin), folliculitis (inflammation of a hair follicle), boils or impetigo. Scabies may also exacerbate other pre-existing skin conditions, such as eczema and psoriasis.

21.1 Transmission from an infected person

Direct skin to skin contact with a person who is infected with scabies (approximately 10 minutes uninterrupted skin-to-skin contact).

The mite cannot jump from person to person but can crawl from one individual to another when there is skin to skin contact for a short period of time, e.g., shaking hands.

21.2 Classical scabies

On average, the mites can survive in the environment for 24-36 hours, therefore, can be transmitted from clothing or bedding.

21.3 Crusted (Norwegian) scabies

Crusted (Norwegian) scabies is highly contagious due to the large number of mites.

The mites can survive in the environment for 7 days, therefore, can easily be transmitted from clothing, bedding, and upholstery.

21.4 Diagnosis

Diagnosis of scabies is usually made from the history and examination of the affected person, in addition to the history of their close contacts, up to 8 weeks prior to diagnosis.

Misdiagnosis is common because of its similarity to other itching skin disorders, such as contact dermatitis, insect bites, and psoriasis.

Classical scabies

Diagnosis should be confirmed by a GP or Dermatologist.

Crusted (Norwegian) scabies

A diagnosis by a dermatologist is essential but a GP must be consulted immediately so treatment is not delayed.

Where working within a setting caring with adults, management, and treatment of this form of scabies must be undertaken in association with your local Community Infection Prevention and Control (IPC) or UKHSA Team and Dermatologist.

Staff

Members of staff who are diagnosed as having scabies, or identified as contacts of a case, should

not return to work (in the affected setting or others they may work in) until after their first 24-hour treatment dose is completed. They should co-ordinate their treatment doses to coincide with the care home's treatment dates.

For further information refer to Guidance: UKHSA guidance on the management of scabies cases and outbreaks in long-term care facilities and other closed settings for the latest recommended actions to take.

22. Respiratory/Cough Hygiene

Respiratory tract infections (RTIs) are infections of parts of the body involved in breathing, such as the sinuses, throat, airways, or lungs. RTIs are mainly caused by viruses and can affect the upper respiratory tract or the lower respiratory tract.

Upper respiratory tract infections Upper respiratory tract infections (URTIs) include the common cold, tonsillitis, sinusitis, laryngitis, and flu. The most common symptoms are headache, aching muscles, a blocked/stuffed up or runny nose, sneezing and a sore throat. URTIs caused by a virus, e.g., the common cold, usually get better without any treatment over days to weeks.

Lower respiratory tract infections Lower respiratory tract infections (LRTIs) include bronchitis (an infection of the airways), pneumonia (lung infection), bronchiolitis (an infection of the small airways that affects babies and children) and tuberculosis, a bacterial lung infection. Flu can affect both the upper and lower respiratory tract.

The most common symptom of LRTI is coughing, in severe cases residents cough up mucus and can suffer from breathlessness, wheezing and chest tightness.

RTIs caused by bacteria, e.g., pneumonia, tuberculosis, often require antibiotic treatment and in some cases, admission to hospital. Bacterial infections are not covered in this policy.

When caring for residents in relation to COVID-19 or any other new emerging infections, refer to Guidance People with symptoms of a respiratory infection including COVID-19

22.1 How are respiratory illnesses spread?

When a person with a respiratory spread infection coughs or sneezes, millions of viral or bacterial particles are released from the mouth or nose in respiratory droplets. These droplets travel in the air, contaminating people and surfaces in their path.

Infection is then spread either:

- person-to-person, e.g., the droplets land directly on the mucous membranes of a person's eyes, nose or mouth, and the infection then enters their body
- indirectly, e.g., the droplets land on surfaces such as a bed, table, or person. Hands that then come into contact with that surface become contaminated. If the hands are not cleaned and the person touches their eyes, nose, or mouth they can become infected

Bacteria and viruses can survive in the environment from hours to months, e.g., influenza virus up to 24 hours, COVID-19 up to 72 hours.

For advice on respiratory illness management, please contact your local Community Infection Prevention and Control (IPC) or United Kingdom Health Security Agency (UKHSA) team, where appropriate.

Other illnesses caused by viruses, e.g., chicken pox, measles, can also be spread by inhaling droplets of the respiratory secretions from an infected person's cough or sneeze, or from touching surfaces contaminated when they coughed or sneezed.

Those most at risk of developing complications of infections spread by respiratory secretions include:

- children under 5 years of age
- adults aged 65 years and over
- people aged 6 months to 65 years and over who have chronic diseases or lowered immunity levels
- pregnant women

22.2 Good respiratory and cough hygiene

Ventilation is especially important to reduce the number of microorganisms in the air which will contaminate surfaces. Staff should ensure rooms are well ventilated by opening windows, e.g., 10 minutes every hour.

Staff should adopt and promote good respiratory and cough hygiene by encouraging, assisting, and advising residents to:

- cover their nose and mouth with a disposable tissue when sneezing or coughing and using a disposable tissue for wiping and blowing their nose
- dispose of used tissues promptly into a waste bin or bag provided
- wash hands, use alcohol handrub or hand wipe after coughing, sneezing, wiping, or blowing their nose
- cough or sneeze into the crux of their elbow on any occasion when there is not a tissue available.
- do not cough or sneeze into their hands and not into the air - although this will not stop all the respiratory secretions spreading, it can reduce the distance they travel

For further details, See Section 3 Hand Hygiene

Do not:

- touch the eyes, nose and mouth until hands have been cleaned after contact with respiratory secretions or item contaminated with them, e.g., tissues,

surfaces

- use skin wipes if suitable handwashing facilities are not available
- contaminate surfaces and pockets with used tissues

If no disposable tissue is available, cough or sneeze into your elbow or upper arm, not your hand or into the air. Although this will not stop all the respiratory secretions spreading it can reduce the distance they travel.

See Appendix 13: 'Catch it' poster to be displayed in reception area/notice board

23. Enteral Tube Feeding

Enteral tube feeding is a process where nutrition is delivered into an individual's gastrointestinal tract by 1 of 3 ways:

- through the nose into the stomach by nasogastric feeding tube
- directly into the stomach by gastrostomy or PEG (percutaneous endoscopic gastrostomy) feeding tube
- directly into the small bowel by jejunostomy feeding tube

Only commercially prepared feeds should be used. Residents receiving enteral tube feeding should be supported by the multidisciplinary team (MDT). Enteral tube feeding administration must be undertaken only by suitably trained and competent staff. Initial training and competency should be assessed and monitored by the relevant MDT members.

This policy for safe practice will assist staff to reduce the risk of infection associated with enteral tube feeding. It is recommended that regular audits are undertaken. An audit tool is available to download at www.infectionpreventioncontrol.co.uk.

Refer to the relevant Management of Medication and Health Related Activities Procedure.

23.1 Care of the tube insertion site

Hand hygiene is essential before contact with the resident's enteral feeding tube and/or insertion site. Hands should be washed with liquid soap and warm running water and thoroughly dried using paper towels. Alcohol hand rub can be used if hands are visibly clean.

If there is pain on feeding or external leakage of stomach contents, or fresh bleeding, stop any feed immediately and urgently contact your local Hospital Emergency Department.

Unless advised differently by the enteral tube manufacturers or a healthcare professional, the alternative advice should be documented in the resident's care plan.

- following insertion of an enteral tube, treat the insertion site as a surgical wound using an aseptic technique for the first 48 hours, keeping it clean and dry

- after 48 hours, the insertion site should be washed daily with tap water and dried thoroughly. Avoid water immersion, e.g., bathing in a bath, for 2 weeks and reapply dressing
- when the insertion site has healed, usually 10-12 days, no dressing is required. The site should be inspected and cleaned with soap and water daily

24. Invasive Devices

An invasive device provides an entry point for micro-organisms, such as bacteria, viruses, and fungi, to enter the body and is a potential source for introducing infection.

Standard infection control precautions are essential infection prevention and control practices to prevent the spread of infection within care homes.

All staff involved in inserting or **managing an invasive device** should be educated about the standard principles of infection prevention and control (IPC). Information on this policy should be included in IPC training for all relevant staff groups.

24.1 Definition of an invasive device

Invasive device: A device which, in whole or in part, penetrates inside the body, either through a body opening, e.g., mouth, nostril, or through the surface of the body.

Surgically invasive device: A device which penetrates inside the body through the surface of the body, with the aid of or in the context of a surgical operation/procedure.

24.2 Examples of invasive devices

Below are some examples of invasive devices, this list is not exhaustive:

- urinary catheters – see Section 8: urinary catheter care
- gastrostomy/peg tubes – refer to the ‘enteral tube feeding policy for care home settings’ available from health partners.
- nasogastric tubes
- wound drains
- subcutaneous infusion devices
- vascular access devices:
    - peripheral vascular access device, e.g., IV cannula
    - Central venous access device, e.g., peripherally inserted central catheter (PICC), skin-tunneled catheter, implanted port

Period of use

The length of time an invasive device can be used for is categorised as follows:

- transient: normally intended for continuous use for less than 60 minutes
- short term: normally intended for continuous use for not more than 30 days
- long term: normally intended for continuous use for more than 30 days

Managing an invasive device

Only staff trained and deemed competent in management of the type of device where applicable, its administration system, should perform the procedure. If staff are unfamiliar with a particular device or management system, advice and protocols should be obtained from the relevant specialist nurses in secondary care.

The need for an invasive device must be reviewed regularly and the device should be removed as soon as possible.

The principles of care for any invasive device are to:

- prevent infection
- maintain a 'closed' system with as few connections as possible to reduce the risk of contamination
- keep the device patent
- prevent damage to the device and any attachments

Standard infection control precautions and aseptic technique should be applied when manipulating the device. Any signs or symptoms of infection associated with the devise should be recorded in the resident's notes and applicable action taken. Seek further appropriate advice as required, e.g., GP, advanced nurse practitioner.

25. Care of the Deceased

The aim of this policy is to advise staff on the principles of safe practice to prevent the spread of infection from a deceased resident, whilst ensuring that they are treated at all times in a respectful manner, paying heed to their religious beliefs. In care homes without a registered nurse, it is the registered manager's responsibility to ensure carers are appropriately trained and have the relevant competence for personal care after death.

Refer to Adult Care End of life Procedure

Additional requirements for deceased residents with infectious disease

- disposable apron, fluid resistant face mask and gloves should be worn throughout the procedure, eye and face protection should also be worn if there is a risk of splashing. Masks may be required to be worn on other occasions,

e.g., in the event of pandemic flu and COVID-19

- the personal effects belonging to the resident, such as clothing, should be returned to the relatives with instructions that they should be washed separately at the highest temperature recommended by the manufacturer
- if any clothing is soiled, there should be a sensitive discussion with the family giving them the option of the items being disposed of by the home
- if the deceased resident is known or suspected to have been suffering from a high risk infectious disease, relatives should be discouraged from retrieving personal effects such as clothing. If this is not possible, advice should be given to relatives on the appropriate decontamination of personal effects. Advice given should be documented
- all linen should be treated as infected
- all waste must be disposed of in a plastic bag and tied. The plastic bag should then be placed in a second bin bag and tied before being disposed of as infectious waste as per DCC policy
- other personal effects, such as books, etc., hold very little risk of transmitting infection and, as such, normally require no disinfection process unless visibly contaminated. However, in cases where the deceased resident is known or suspected to have been suffering from a high-risk infectious disease, these must be decontaminated if visibly soiled
- the resident's room should be cleaned and disinfected before it is used for other residents. Refer to Residential Domestic and Cleaning Policy
- staff must dispose of all PPE as infectious waste on completion and wash their hands thoroughly with liquid soap and warm running water followed by an application of alcohol hand rub

25.2 Funeral directors

Funeral directors must be informed of the resident's infection status prior to the transfer of a body.

26. Animals in a Care Home Setting

The presence of pets or visiting animals is widely accepted as a useful way to enhance the quality of life for residents. However, disease can be acquired through contact with animals, especially if a person's immunity is reduced through age, illness, or therapy.

26.1 Infections associated with animals

Animal	Disease
Dogs and cats	Salmonella
	Campylobacter
	Toxocara
	Toxoplasma

Birds	Chlamydia psittaci
Terrapins	Salmonella
Exotic pets, e.g., snakes, lizards, iguanas	Salmonella
Tropical fish	Salmonella
	Streptococcus iniae
	Aeromonas
	Mycobacterium marinum
Ponies, horses, donkeys	Salmonella
	Ringworm

Taking sensible precautions will reduce the risk to an acceptable level.

The manager should ensure a knowledgeable person is responsible for the animal.

There should be a written agreement in the home to ensure full understanding of the:

- types of animals allowed for pet therapy visits - only mature, house trained animals should be allowed
- control and permitted behaviour of pets whilst in the home
- routes of entry, exit and passage for the pet in the home
- areas where pets are not allowed, i.e., food storage, preparation, cooking or serving areas
- insurance liability of owners and handlers

26.2 Exotic & tropical pets

Examples include exotic birds, insects, and reptiles. Many of these animals require very specialist care that is different to caring for common domestic pets. They can suffer from stress, and this damages their immune system, which increases the risk of transmitting opportunistic infections to humans.

These exotic pets are not recommended for purchase within care home premises.

Fish tanks

Fish tanks can pose an infection hazard and need stringent management if purchased.
Tanks should not be sited nor cleaned in areas where immunocompromised residents are cared for.

- tanks must be kept sealed and located in a dayroom or reception area
- wash hands with liquid soap and warm running water before and after handling fish or cleaning aquariums
- if liquid soap and water are not readily available, use alcohol hand rub
- ensure any cuts or wounds on hands are covered with a waterproof dressing

and gloves are worn prior to touching the fish or aquarium water

- residents and visitors must not have direct access to the water as it will be heavily contaminated with micro-organisms, such as bacteria, viruses, and fungi
- fish food is also frequently contaminated with pathogenic micro-organisms, such as Salmonella, therefore, hands must be washed thoroughly after handling fish food
- a maintenance contract with an aquarium maintenance specialist must be established

26.3 Choice of animal

The following factors require consideration for the long-term commitment of owning any animal:

- which member(s) of staff will hold responsibility for the animal?
- what is the residents' preference?
- is the animal suitable for the environment and its restrictions?
- are there any staff/residents with allergies or objections?
- feeding arrangements
- grooming arrangements
- can the animal be kept out of kitchen/food areas?
- veterinary arrangements
- cleaning/disposal of excrement arrangements
- equipment – purchase and cleaning

26.4 Animal care

All animals must be screened by a veterinary practitioner prior to being introduced to the premises. Only introduce pets to residents after the pet has been adequately de-flea'd, wormed and vaccinated.

- animal vaccinations must be up to date
- animals should be regularly wormed
- animals should have their coats brushed and cleaned regularly
- flea treatment should be used on both the animal and its environment as necessary
- animals must be checked annually by a veterinary practitioner
- person responsible must ensure records of the pet worm and flea treatments, along with vaccinations and veterinary care are kept up to date

26.4 Food and feeding

- hygienic practices must be observed at all times, e.g., handwashing
- fresh water should always be available
- feeding areas should be kept clean and pest free
- pet food should be stored in a designated area (not in the refrigerator with resident's/staff member's food)
- commercial pet foods are preferable
- once opened, moist food should be used the same day
- moist food should be removed after 4 hours if not eaten
- feeding dishes and containers must be washed after each feed
- dried pet food must be clearly labelled
- animals must not be fed in the kitchen

26.6 Waste and litter

- do not store the litter tray near food storage, preparation or eating areas
- litter trays and cages should be lined for easy cleaning
- always wear disposable gloves and apron when cleaning and emptying litter trays or cages and handling animal faeces
- litter must be changed daily
- litter trays must be cleaned and disinfected weekly or before if visibly soiled
- take care when disposing of animal faeces. Use a 'poop scoop' and dispose of contents into a disposable bag and place into a designated bin or into the general waste system
- when the task is completed, dispose of gloves and apron and wash hands
- Pregnant women should not undertake any of the tasks listed above because of the risk of toxoplasmosis.

26.7 Staff care

- all staff must be aware of the hygiene considerations following the handling of animals, cleaning, feeding and/or other equipment
- skin lesions/cuts/abrasions must be adequately covered
- hands must be washed thoroughly after feeding/handling animals
- food must not be shared with the animals

26.8 Visiting animals

Various organisations work throughout the UK who arrange to bring pets into hospitals and other health and social care premises for the benefit of the residents, e.g., PAT (Pets as Therapy). All

volunteers must ensure the pets used are registered with the appropriate scheme.

The animals used are usually dogs and the following guidance should apply:

- the dog must be an adult
- must be house trained
- regularly de-wormed
- regularly treated for fleas
- fully vaccinated
- visits should not take place if the dog is unwell
- animals must be kept away from other residents with phobias or allergies
- do not allow the dog to put their paws on a bed, or to climb onto a bed

Hatching Kits can be used by the service if these are used then a risk assessment is required.

26.9 Assistance dogs

The Equality Act 2010 says that reasonable adjustments must be made to avoid discriminating against people with disabilities. These include waiving a ‘no dog policy’ so a disabled person may be accompanied by their recognised assistance dog.

All recognised assistance dog owners carry a card advising that assistance dogs should not be a risk to health and hygiene. It is a requirement that all recognised assistance dogs must be regularly de-flea’d, wormed and vaccinated in accordance with the latest veterinary advice and also receive regular health assessments by vets.

The assistance dog is the responsibility of its user about keeping it under control, discipline, toileting, exercising, provision of water, coping with the dog’s sudden illness, etc. This responsibility is promoted by the assistance dog charities and forms part of the user’s training. In the unlikely event that it is necessary for the dog’s excreta to be cleared up by staff, refer to Section 27.6 Waste and litter. In extreme cases, or if the occurrence happens more than once during the visit, the user should be asked to remove the dog from the premises.

Assistance dogs are working animals, not pets, and through training recognise when they are ‘on duty.’ Distraction may jeopardise the safety of the user, therefore, it is important that assistance dogs are not petted or distracted without the user’s permission.

26.10 General precautions

- animals should not be permitted to lick residents or staff
- after touching animals, staff and residents should wash their hands thoroughly. Alcohol hand rub or skin wipes should be offered to residents that are unable to access handwashing facilities
- cleaning schedules and records should include all aspects of the pet’s eating, drinking and accommodation, e.g., bowls, bottles, bedding, bed, cage, hutch,

aquarium, fishbowl, etc.

- keep bedding and feeding equipment scrupulously clean (machine washable bedding is advised)
- wash feeding or other equipment separate from staff or residents' utensils/equipment in warm soapy water
- seek advice immediately if the animal is unwell

26.11 Bites/scratches

- animal claws should be trimmed to reduce the risk of scratches. If a bite or scratch from an animal occurs, it should be washed with liquid soap and warm running water, dried and covered with a waterproof dressing and the injury reported immediately
- seek medical attention if necessary. Antibiotics and tetanus vaccination may be indicated for flesh penetrating wounds
- animal bites can occasionally cause serious infections, particularly in immunosuppressed people
- medical advice should be sought if in doubt

26.12 Deceased animals

Make all arrangements with the veterinary practitioner who is responsible, and they will advise the correct course of action.

26.13 Feral animals

This refers to animals that are not domesticated and live in the wild. Common examples include wild cats, squirrels, and foxes.

They should not be fed or attracted to care homes as they can become a nuisance or risk to health.

Care must be exercised when dealing with any stray or wild animal, as they may have contracted disease from another wild animal.

26.14 Farm visits

Farm visits can be fun and a useful aid to stimulation, but sensible precautions are recommended and include the following:

- wash and dry hands thoroughly after touching animals
- pregnant women should avoid contact with sheep during the lambing season and for 6 weeks after it has finished
- do not eat or drink while going around the farm, eat and drink only in designated areas and clean hands before eating or drinking

- do not put your face against the animal
- do not put your hands in your mouth after touching the animal
- do not touch any animal droppings
- clean shoes and wheels, e.g., wheelchair, walking frame, when leaving the farm and wash hands thoroughly

27. Infection Prevention and Control Resources, Education, and Training

All essential training regarding Infection Prevention and Control must be completed by staff working within care environments.

28. Other Infectious Diseases

This policy is unable to cover all infections that our services may encounter. When supporting an individual who as an identified infection SICP must be followed. Further information can be found on the NHS website or by contacting the Quality and Compliance team.

Approval and Authorisation History

Approval and authorisation history

Name	Date
Authored by Quality and Compliance/Public Health	March 2022
Authorised by Senior Management Team	March 2022
Approved by Helen Jones	March 2022
Helen Jones Team	March 2014

Change history

Version	Date	Name	Reason
Version 1	March 2022	Quality and Compliance	Creation of new IPC Policy to replace old
Version 2	June 2022	Quality and Compliance	Review. Changes to genericise terms used in document
Version 3	January 2024	Quality and Compliance	Review and update