Policy Document Control Sheet

County Durham and Darlington NHS Foundation Trust

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Table of Revisions

Date	Section	Revision	Author
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2014	Full	To update guidance on PPE and full review	Infection Control Team
2017	Full	To merge this policy with POL/ICC/0025 Collection of Specimens and POL/ICC/0003 Common Infections. Three yearly review	Infection Control Team
2020	Full	Three yearly review	Infection Control Team

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1 Introduction

This policy provides a basic overview of Infection Control; some items are dealt with in depth within other policies.

Standard Infection Control Precautions (previously known as Universal Precautions) represent the standard of care and precautions that should be used in order to minimise exposure to and transmission of, potentially pathogenic micro-organisms from both recognised and unrecognised sources. These precautions should be used by all staff, in all care settings, at all times, for all patients whether an infection risk is known to be present or not.

The key to using these precautions is risk assessment to establish the possible exposure to infectious agents.

The key principles of standard precautions include:

- Assessment of infection risk and patient placement
- Use of effective hand hygiene
- Personal protective equipment use
- Management of care equipment
- Management of care environment
- Management of linen
- Management of blood and body fluid spillages
- Management of sharps
- Management of waste

Further details regarding specific infectious agents can be found in the Trust infection control policies accessible via the Trust Intranet (Staffnet): Infection Control Policies

Advice is also available for the public seeking advice and/or guidance on infection control issues from the Infection Control Department or via the Trust internet site: www.cddft.nhs.uk

The Trust will provide staff with access to Trust documents that reflect the requirements of the Health and Social Care Act 2008 and other associated key national policies.

Health and social care act

Antimicrobial Prescribing Guidelines can be accessed via: Antibiotic Formulary

Aseptic Technique Policy can be accessed via: Aseptic Technique Policy

2 Purpose

The purpose of this policy is to ensure that basic infection control precautions are practiced within the Trust and to minimise the risk of the spread of infections/infectious diseases through the correct employment of isolation precautions.

3 Scope

This Policy applies to all health care workers within County Durham and Darlington NHS Foundation Trust.

This policy/procedure also applies to persons who, although not employed by The Trust, have authorised access to the Internet through the computers owned or managed by The Trust. This includes staff working for any affiliated organisations and includes County Durham and Darlington NHS Services (CDD NHS Services

4 Definitions

This policy is a statement of corporate intent which members of staff, Trustwide, must follow in order to minimise exposure to and transmission of, potentially pathogenic micro-organisms from both recognised and unrecognised sources.

5 Duties

This policy applies to all CDDFT staff working within the Trust.

Trust Board
The Board, via the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manages the risks associated with Infection Control.

Day to day operational responsibility in relation to Infection Control will be that of the Director of Infection Prevention & Control (DIPC). The DIPC will provide assurance to the board that effective systems are in place. The DIPC will be a member of the ICC.

Infection Control Committee (ICC)
The ICC is responsible for the development and approval of all IC related policies within the organisation.

Consultant Microbiologists/Infection Control Doctors
The Consultant Microbiologists are responsible for professional advice to the Infection Control Committee on the use of antibiotic policy, content of Infection Control policies and liaison with Clinicians on clinical microbiology

Senior Infection Control Nurse (SICN)
The SICN is responsible for advising the ICC appropriately, attending Matrons Meetings to advise, and ensuring that all staff can access IC policies as approved by the ICC.

Infection Control Team (ICT)
The ICT are responsible for ensuring all staff are aware of all IC policies (as appropriate to their role) and educating/advising staff on IC issues.

All staff
All staff are responsible for ensuring that they follow all IC policies as approved by the ICC relevant to their job.

6 Main Content of Policy

6.1 Assessment of Patient Infection Risk and Patient Placement including Isolation

The common means of transmission of infection are by:

- Airborne/Droplet route
- Faecal-oral transmission
- Direct contact
- Blood borne

And the degree of infectivity risk depends on:

- Site of infection
- Organisms involved/transmission route
- The patient

The potential for transmission of infection of infectious agents should be assessed on patients' admission and continually reviewed whilst they remain as inpatient. Where this assessment identifies the patient as a cross-infection risk, appropriate management may involve isolation.

All staff need to check patient information systems for infection control alerts as soon as possible, for all patients, on arrival, to enable appropriate management and care of the patient. Alert organisms listed are MRSA, MRSA bacteraemia, C. Diff, CPE and VRE. If patients know that they have been previously positive for any of these organisms at other Trusts, staff should inform the ICT who will investigate and update our systems if necessary.

Patients should be managed on symptoms rather than awaiting laboratory confirmation, and this must continue until asymptomatic or following a clinical decision that the patient is no longer infectious.

6.1.1 Communication with ICT/PHE

It is essential that a member of the ICT is contacted if it is suspected or confirmed that a patient is suffering from a communicable disease in order to ensure that the correct infection control procedures are carried out.

Some infectious diseases (e.g. meningococcal meningitis, diphtheria, polio, Viral Haemorrhagic Fever also require immediate notification to PHE, by telephone, in the first instance. See Guidelines for the Reporting of Suspected/Confirmed Cases of Notifiable Diseases: Policy for Reporting of Suspected/Confirmed Cases of Notifiable Diseases

In the event of a suspected outbreak of infection, the Infection Control Doctor should liaise with Public Health England. See Policy for the Control of an Outbreak of Infection in Hospitals (including Hospital Response to Major Outbreaks of Infection in the Community): Control of outbreaks of infectious diseases

6.1.2 Categories of Isolation

There are two categories of isolation:

Protective isolation: used to minimise the exposure to infectious agents of patients who are particularly at risk of exogenous infection (cross infection from other people or the environment) such as patients who have compromised immune systems due to disease or therapy e.g. neutropenic patients.

Staff – disposable single use plastic aprons should be worn for all clinical procedures to provide a protective barrier that will minimise the risk of transmission of micro organisms to the patient. Non sterile gloves must be worn for contact with body fluids as per standard precautions.

Visitors – coats and jackets should be removed before entering the room. A disposable plastic apron should be worn. Visitors must be advised of the importance of hand hygiene before entering the isolation room.

The requirement for protective isolation will be made by the patient's clinician on an individual basis.

Source isolation: used for patients infected or colonised by infectious agents that require additional precautions over and above the standard precautions used for every patient. It minimises the risk of transmission to other vulnerable patients or staff and its use is dependent on the route of transmission of the infectious agent.

Isolation is designed to prevent the spread of pathogens from an infected/potentially infected patient (source) to other patients, hospital personnel, environment and visitors. This has been previously known as barrier nursing. The need for isolation is determined by the way the organism or disease is transmitted and can be achieved by placing patients in a single room on a general ward and wearing the appropriate personal protective equipment.

High Security Isolation Units treat patients with highly communicable disease e.g. viral haemorrhagic fevers, multi drug-resistant tuberculosis, SARS etc. The regional High Security Infectious Diseases Unit (HSIDU) is located at Newcastle Hospital Trust.

6.1.3 Effective Source Isolation

In order to promote effective isolation it is the responsibility of the nurse in charge to ensure that the following are in place:

- Standard IC precautions
- All patients are assessed for the use of cubicles using the Isolation Risk Assessment Tool from the Infection Control intranet page: Risk Assessment Tool
- Single room accommodation, preferably with ensuite, if no ensuite, then dedicated toilet/commode
- Yellow ***"Please see nursing staff before entering this room"*** door sign. Room door should be closed, however a risk assessment must be carried out for each patient to decide if for clinical reasons the door needs to be kept open. This rationale must be recorded in the nursing notes.

- Wearing appropriate personal protective equipment (PPE) for patient care Hand hygiene/PPE policy
- PPE to be kept outside the room.
- Removal of **all** unnecessary items from room prior to use. Any items such as dressings, linen not used, must be disposed of appropriately when the patient is discharged/ transferred.
- Reusable equipment to be left in room for duration of patients stay. Where this is not possible thorough cleaning and disinfection with chlorine releasing agent away from the infected area and before being used on another patient.
- Daily cleaning of room with chlorine releasing agent – including all equipment. The nurse in charge must ensure that domestic staff are aware of the risk of infection and the importance of daily, thorough cleaning of the room using a chlorine releasing agent and must give a daily cleaning sheet identifying infectious patients to domestic staff to ensure appropriate cleaning procedures are followed.
- Separate cleaning equipment must be reserved for isolation rooms. Nursing staff are responsible for the standard of hygiene in isolation rooms and for the decontamination of blood and body fluid spillages in clinical areas.
- Used linen to be disposed of as 'infected'
- Waste to be disposed of as 'clinical'
- Cutlery and crockery items should be processed through the central dishwasher.
- Patient records to be kept outside of room
- Terminal clean of room on transfer/discharge
- Communication with the patient. Isolation may be a traumatic experience and to remain isolated for prolonged periods can be distressing. Every effort should be made to explain the reason for isolation and where possible when it will be discontinued.
- Infection Control contacted for advice.
- Ambulant patients may use the toilet, shower and bath if their condition allows. It must however be ensured that the area is cleaned thoroughly following use.

6.1.4 Patients Requiring Source Isolation

Patients requiring source isolation may include the following:

- Patients with a known transmissible infection including those transmitted by the droplet/airborne route e.g. pertussis (whooping cough), measles and influenza
- Patients with diarrhoeal illness of suspected infectious cause
- Patients who are known or may be colonised with a multi-drug resistant organism e.g.

MRSA (Meticillin Resistant Staphylococcal Aureus) - in high risk areas.
GRE/VRE (Glycopeptide/Vancomycin Resistant Enterococci)
ESBL (Extended Spectrum β-Lactamase Producing)
CPE (Carbapenemase-Producing Enterobacteriaceae) - coliforms and *Acinetobacter* species)
MRO (Multi Resistant Organism)

In order to ensure that the correct IC policies and procedures are being followed, the ICT must be informed of any patient known/suspected of having a communicable disease on the ward (whether isolated or otherwise)

6.1.5 Constraints to Effective Isolation

It is acknowledged that there are constraints to placing every patient who is either colonised with a pathogen or who is showing clinical signs of transmissible disease into a side room, therefore a Risk Assessment must be carried out to prioritise the side-rooms. To assist staff with this assessment follow link Isolation Risk Assessment Tool and inform infection control.

Where a side-room is not available for a patient requiring source isolation but deemed of lower priority e.g. MRSA risk patient, isolation requirements described above should be followed, within the patient bed space within a bay. Under these circumstances it is imperative that Healthcare Workers (HCW) attending the patient are aware of their infection/colonisation status and follow source isolation measures.

When single rooms are not available and several patients with the same confirmed organism have been identified, these patients may be nursed together in a bay or ward. This is called **Cohort nursing** and the decision to implement this will be taken by the ICT and advice given as necessary. When patients are in cohort isolation the same principles for source isolation must apply, to include; changing apron and gloves and washing hands **between patient contacts** and disinfecting equipment between patients. For effective cohort nursing, bays should have doors that can be closed to provide physical separation from other patients.

Further advice is available from the following policies:

Control of Outbreaks of Infectious Diseases including the Trust response to Community Outbreaks of Infectious Disease in the North East (POL/ICC/0013)

Management of Diarrhoea and Vomiting (Norovirus) (POL/ICC/0023)

http://intranet/sites/policiesandprocedures/pages/default.aspx

If a patient requiring isolation, cannot be isolated for clinical reasons e.g. due to falls risk, this MUST be documented in the nursing notes, reviewed on a daily basis and discussed with ICT.

Where isolation is not possible or practical, this should be discussed with ICT, Patient Flow and reported on Safeguard.

6.1.6 Length of Isolation

The length of isolation required is variable and depends on a number of factors e.g. type of infection, period of communicability, condition of patient and effectiveness of available treatment.

For further advice please contact Infection Control

UHND base	Ext 32190
DMH base	Ext 43024 or 43015

6.1.7 Effects of Isolation

Patients who are placed into a single room may suffer psychological effects. The individual needs of a patient should be balanced against the recognised modes of transmission of organisms; therefore, a risk assessment should be undertaken for each patient. The Infection Control Nurses are available to talk to patients, relatives and staff.

6.1.8 Visitors

The nurse in charge should inform visitors of the precautions required. Visitors, unless involved in direct patient care or if the patient is immuno-compromised, do not need protective clothing but should be encouraged to wash their hands before leaving the room. There may be restrictions for new visitors if the patient has an infectious disease. Advice can be given by the Infection Control Team on an individual basis if required.

6.1.9 Transportation of Infectious Patients

Infectious patients may need to visit other departments for treatment or investigations. A risk assessment should be undertaken and the receiving department must be informed of any risk and the appropriate action to be taken. To prevent airborne transmission of organisms e.g. open case of pulmonary tuberculosis, it may be necessary for the patient to wear a fluid repellent surgical face mask when being transported. Specific advice should be obtained from the clinician in charge.

If a patient is to be transported to another hospital please ensure the ambulance service is given adequate information.

Highly infectious patients may need to be transferred in special transport. Advice should be sought from the Consultant Microbiologist on an individual basis.

6.1.10 Death of Patients with Known or Suspected Infectious Disease

Some patients remain capable of transmitting infection even after death. There are special precautions for this category of patient. (Please see Appendix C).

6.2 Hands and Hand Hygiene

Hand hygiene is the single most important measure in the prevention of cross infection.

All healthcare workers must decontaminate their hands before and after each patient contact and following contact with the patients' environment as directed in the WHO Your 5 Moments for Hand Hygiene as per Trust Policy for Hand Hygiene: hand hygiene/PPE policy

All clinical staff are required to perform a hand wash assessment every 3 years and this will be recorded on your ESR.

6.3 Personal Protective Equipment (PPE)

The use of PPE by HCW serves two purposes the HCW acquiring potentially serious infection and secondly prevents transmission of infection to other patients/visitors.

The choice of PPE is identified through appropriate risk assessment taking into account the infectious agent, route of transmission, the task and degree/time of exposure.

All PPE should be disposed of as clinical waste. Follow link to PPE policy Hand Hygiene/PPE policy

6.3.1 Face Masks

Please see above link for face mask information.

High Filter FFP3 masks/respirator must be worn by staff carrying out aerosol generating procedures (AGP) on patients with certain respiratory infections including seasonal/pandemic influenza, measles and sputum positive pulmonary TB. (See Appendix B for further relevant respiratory infections and AGP information)

Any member of staff required to wear a High Filter FFP3 mask must have been trained and fit-tested **(this is a legal requirement)** and use the appropriate mask that they passed the test with.

On each occasion, after putting on a High Filter FFP3 mask, staff must carry out a fit check.

Staff with facial hair will not be able to be fit-tested and therefore should seek help and advice re appropriate respiratory protection.

Each care group must keep records and update staff every two years.

6.4 Management of Care Equipment

Staff handling used medical devices and equipment should always assume that they are contaminated and must take suitable precautions to reduce the risk to themselves and others. The use of appropriate personal protective equipment (PPE) is therefore mandatory. All decontamination activities should be carried out in dedicated facilities, and in accordance with the manufacturer's instructions. The choice and method of decontamination of equipment is dependent on many factors, but initial choices should be based on likely infection risks to patients.

Equipment presents an infection risk if damaged, so repairs must be made when necessary. Before items are sent for repair/servicing, items should be cleaned and decontaminated whenever necessary and the appropriate form completed to indicate if decontamination has been carried out prior to repair.

6.5 Management of Care Environment

Achieving and maintaining high standards of cleanliness and ensuring that all equipment and furniture is in a good state of repair helps to reduce the bio burden in clinical areas and is an important aspect in managing the care environment. As a general principal an environment that is clean, dust and clutter free with well-

maintained equipment and furniture is less likely to become a reservoir for transient pathogenic organisms.

Therefore, all furniture, fittings and flooring in clinical areas must be in a good state of repair, be made from materials that are impermeable, easy to clean and decontaminate and if contaminated with blood and body fluids be able to withstand chlorine releasing agents at 10,000PPM.

All items must be stored off the floor. Waste and soiled linen should be removed from the clinical area on a regular basis. Faults/damage to the care environment should be reported promptly and actively followed up.

The treatment room must not be used as an additional cubicle.

6.6 Management of Linen

Clean linen should be stored off the floor in a designated cupboard. Used linen should be handled carefully, for example, do not shake bed linen when re-making or stripping beds as this causes airborne contamination with micro-organisms and skin scales.

Soiled linen must be placed directly into a **white plastic bag**. Linen should be bagged at the point of use and not discarded onto the floor or patient's bed table.

Infected linen/fouled linen must be discarded into a **red alginate bag** then a white plastic bag. All used linen should be bagged appropriately and stored separately from clean linen preferably in sluice area for collection.

6.7 Management of Blood and Body Fluid Spillage

It is the responsibility of clinical staff to deal with blood spills immediately with chlorine releasing agent at the appropriate strength (10,000 parts per million).

If available, collect the blood spillage kit and follow the instructions provided. Disposable gloves and apron should be worn – use eye protection if required. Ensure adequate ventilation. Wear face mask when using granules.

If broken glass or any other sharp is included in the spill it can be picked up using forceps and disposed of in a sharps container before the chlorine releasing agent is used.

6.8 Management of Sharps

Safe, efficient and immediate disposal of sharps is essential. Follow link Policy for safe use and disposal of sharps

All needlestick injuries must be:

- Risk assessed and managed as per BBV policy BBV Exposure Policy
- Reported on Safeguard
- Reported to Staff Health & Wellbeing with the risk assessment.

6.9 Management of Waste

It is most important that waste is correctly segregated and disposed of into the correct bag or containers.

Clinical waste, for example infected dressings and all waste used with infectious patients should be disposed of in orange bags.

Offensive waste, such as incontinence pads or nappies should be disposed of in yellow and black striped bags (tiger bags).

Domestic waste, such as paper towels (except where there is a known infection risk), wrappings from dressings and other medical equipment should be disposed of in the clear plastic bags.

For further guidance please refer to local Trust policy and procedures regarding waste management which are available via the intranet, Policy for Waste Procedures

6.10 Other Considerations

Patient Hygiene
Good patient hygiene is essential in preventing infection as it reduces the number of organisms found on the patient's skin. Daily showering or bathing is preferred, however if this is not possible bed bathing is acceptable. Disposable wash bowls should be used, and the dirty water should be discarded in the dirty utility and not disposed of down a hand hygiene sink.

Patients must have their own towel, flannel and other toiletries, disposable cloths are preferred to flannels. Toiletries should be single patient use. Communal cleansing foams, towels etc. should not be used.

Patients should be offered hand hygiene before meals.

After using the toilet, bed pan or commode, patients should be offered and encouraged to use hand washing facilities. Patients should also be encouraged to clean the toilet seat with a cleansing wipe before and after use. Staff should assist if necessary.

Following use a commode or bedpan should be cleaned by a member of staff with a chlorine-releasing agent. After cleaning, all commodes/bedpans should have a signed and dated tape placed from side to side to indicate that the cleaning has taken place. This tape should not be reused.

Ointments and Creams
All ointments and creams should be supplied for individual use only. They should be left with the patient and used within the expiry date. A pump dispenser is preferred, however, if this is not available, a clean gloved hand or a wooden spatula should be used to remove cream from the container.

6.11 Patient Communication

Appropriate provision must be made available for disabled patients and patients with dementia to ensure effective communication. Where relevant patients must be given information leaflets about the appropriate organism if they are available. Information leaflets must be printed double sided and in colour. Leaflets can be translated as necessary by contacting the Patient Experience Team. Patient Information Leaflets available via the intranet Infection Control Patient Information Leaflets

6.12 Assessment of Diarrhoea

In acute diarrhoea the initial assessment should focus on establishing if this is new onset diarrhoea. It could be that this is a usual pattern of elimination for the patient. It is also important to understand exactly what the patient means by 'diarrhoea' as this may not represent the medical definition of diarrhoea at all. Patients should also be asked about incontinence and urgency; nursing staff should be aware that a person may consider they have diarrhoea when they really have a disorder of continence. Patients may be reluctant to talk about incontinence and so it is important to ask the question within the assessment accessible via the following link Isolation Risk Assessment Tool

It is essential that thorough risk assessment takes place as to the potential cause of a new onset of acute diarrhoea. Specimens should be obtained if no non-infectious cause is identified or infection is suspected.

Faecal specimens should not be taken 'just in case' or on a repeat basis unless advised by Infection Control Team.

Medicines that can produce diarrhoea

Diarrhoea is a common adverse drug reaction (ADR) with many medicines. Antimicrobials account for about 25% of drug-induced diarrhoea though most cases are benign (Lee, 2006).
While diarrhoea has been seen with most medicines, some medicines are more commonly implicated than others

Alternative diagnoses for the diarrhoea are important; therefore, careful attention should be paid to the temporal relationship between the time that the medicine is first taken and when the diarrhoea first appears.

Further information on adverse effects is available from local medicines information
Centres.

6.13 Collection of Specimens

Successful laboratory diagnosis depends on the collection of specimens at the appropriate time, using the correct technique and equipment and transporting them to the designated laboratory safely and without delay. For this to be achieved, good liaison is essential between medical, nursing, portering and laboratory staff.

The first step in the accurate diagnosis of infectious disease is to obtain adequate specimens for microbiological examination.

General Points (including other related policies, procedures, guidelines)

All specimens should be collected using **universal/standard precautions**

- Always wash hands before and after obtaining and handling specimens. Cover cuts and lesions with a waterproof dressing.
- Wear disposable gloves and plastic aprons if there is any likelihood of contact with blood or body fluids.

- Do not use specimen containers for any other purpose and close tops securely. Take care not to contaminate the outside of the container with blood or other material.
- Discard needles and syringes safely into sharps boxes at point of use.
- All staff who take blood samples or deal with specimen transport should be familiar with the Blood Borne Virus Policy. Identification of Specimen

6.14 Identification of Specimen

Please refer to the Pathology Handbook for current advice on labelling, request forms, specimens and minimum identification criteria Pathology Handbook.
Pathology Handbook

Request Form

Routine samples
- Clinical details
- Full name or other unique coded identifier
- Date of birth
- Hospital Number of NHS Number
- Address for GP samples
- Source of request
- Consultant / Requesters code for OPD or Clinic requests
- Date and time of collection

For confidential samples
- Unique coded identifier
- Source of request
- Date and time of collection

Sample:
Identification required (which matches those on the request form) is full name or other unique coded identifier plus one other from:

- Hospital number
- NHS number
- Date of Birth

Date and time of collection are vital for interpretation of certain tests

Transfusion and HLA/tissue typing specimens to be hand written and must include Name, Hospital Number and Date of Birth

6.15 Blood Cultures

Please refer to the policy for taking blood cultures POL/N&Q/0044 click link:
Blood Culture

Number and Timing
The timing of blood cultures in the continuous bacteraemia of endocarditis is not important, but in many cases the bacteraemia is intermittent and is related to fever and rigors which normally follow the appearance of organisms in the blood by some 30 - 60 minutes. Blood cultures should be taken as near to the onset of a spike of fever as possible. Whenever possible, one or two sets should be taken prior to antibiotic treatment being commenced.

In endocarditis only a small number of sets are needed to isolate the organism. However three sets should be taken prior to antibiotic treatment commencing if possible. If the first few cultures are negative do not persist as further samples are unlikely to be rewarding.

The diagnosis of other conditions may be helped by repeated cultures but again three sets taken not less than one hour apart will give the best compromise on recovery of the organism. Single sets may be adequate for neonates in whom the density of bacteraemia is usually higher.

6.16 Maintaining the Quality of Specimens

Please refer to the Pathology Handbook for current advice on labelling, request forms, specimens and minimum identification criteria

6.17 Precautions for High Risk Specimens

Please refer to the Pathology Handbook for current advice on labelling, request forms, specimens and minimum identification criteria. Use link above

Also refer to ACDP (HSE) for current list of:

Hazard group 4
The main organisms in group 4 are the viruses causing the viral haemorrhagic fevers e.g. Lassa and Ebola viruses. For further advice contact Pathology Services or Infection Control.

Hazard group 3
Group 3 organisms include:

- Bacillus anthracis (anthrax)
- Brucella species (brucellosis)
- Chlamydia psittaci (psittacosis)
- Escherichial coli 0 157 (E coli 0 157)
- Shigella dysenteriae (dysentery)
- Salmonella typhi and parathypi (typhoid and para-typhoid)
- Mycobacterium tuberculosis and other mycobacteria (tuberculosis)
- Human immunodeficiency virus (HIV)
- Hepatitis B & C
- Plasmodium falciparum (falciparum malaria)
- Rabies virus
- The prions causing all forms of Creutzfeldt-Jakob disease
- SARS virus

All specimens from patients with known or suspected group 3 infections for **all laboratory departments** must be designated as **high risk** initially. Precautions may be modified, on the advice of the Infection Control Team, when more information becomes available. Only competent/experienced healthcare workers should attempt to carry out procedures where there is a risk of needlestick injury e.g. venepuncture/cannulation.

'Danger of Infection' labelling
Please refer to POL/ICC/0005 Categorisation of Biological Agents and Transport of Specimens
'Categorisation of Biological Agents and Transport of Specimens'

6.18 Obtaining High Risk Specimens

Sputum and other samples in tuberculosis: - For suspected pulmonary tuberculosis three sputum samples should be collected, preferably taken on waking. The request form should be marked 'acid-fast bacilli' (AFB) and a 'Danger of Infection' sticker affixed to the form and the container. Gloves should be worn for handling sputum. For investigation of tuberculosis at other sites pus or tissue in a sterile universal container or 2 universal containers full of urine or 3 consecutive days (early morning samples) are required.

Other specimens: - Generally procedures for obtaining urine, swabs, and faeces samples are the same as for routine specimens. 'Danger of Infection' stickers must be affixed to request forms and containers for faeces samples when typhoid, dysentery or E coli 0157 are suspected, as these samples are highly infectious to laboratory staff. The Infection Control
Team will advise.

6.19 Process for Specimen Collection and Transportation

Hazard of infection may occur to staff and patients during the process of specimen collection and transportation to the laboratory. It is therefore essential that:

a) Appropriate PPE should be worn when collecting specimens

b) Specimens are collected in appropriate containers.

c) Specimen containers are filled carefully to avoid contamination of the outer surface.

d) Specimens that may present an infection risk should be placed in the appropriate plastic bag, sealed and marked 'danger of infection'

e) Request forms and labels must be filled in **accurately** and **completely**.

f) All specimens must be sent to the laboratory as soon as possible or stored appropriately.

g) Specimens e.g. catheter specimens of urine must be taken as per recommended clinical nursing procedure to prevent contamination of the specimen. Processing contaminated specimens is expensive, preventable and causes an unnecessary delay in commencing any required treatment for the patient.

Further information is available via the Pathology handbook available on the Trust intranet site. Pathology Handbook

Further information on the procedures to follow to collect a microbiological sample is available in the Marsden Guidelines via the Trust Intranet
http://intranet/Directorates/CorporateDirectorates/NursingDirector/nursing

6.20 Guidance on the Transfer of Patients Outside of Speciality

This guidance should read in conjunction with the **POL/OBD/001 Emergency Pressures and Bed Policy (January 2018-2019)**

These have been produced to assist staff with their decision making with regard to **transferring of patients outside of the speciality** taking into account infection control principles.

No patient with a known infection should be boarded

This includes:

Patients known to be MRSA positive or with a history of a previous MRSA positive result **must not** be transferred outside of the speciality from medicine to surgery/orthopaedics

Patients who have not had a negative MRSA screen and MRSA status is not known **must not** be transferred outside of the speciality from medicine to surgery/orthopaedics

Patients with diarrhoeal illness must not be transferred until 48 hours free of symptoms.

Patients with chest infection/pneumonia should not be boarded outside of the speciality, if they have a productive cough with blood stained, muco-purulent or purulent sputum, or if they are on nebuliser therapy.

Patients with cellulitis or acute/chronic skin infection should not be transferred outside of the speciality

If transfer of patients to other specialities **is absolutely** necessary then the following should be observed;

- complete a **risk assessment**
- **full rationale should be documented** in the patient's notes and
- **Incident report** must be raised on Trust safeguard system.

Any breaches of this guidance should be reported on the safeguard system. If in any doubt as to the suitability of infected patients to board please contact:

Infection Control DMH/BAH Ext 43024 or UHND 32190 (8.30am-4.30pm)

Out of hours contact on-call Microbiologist via switchboard.

Calls will only be accepted from the Patient flow

6.21 Food Hygiene

Health care workers involved in the handling, cooking, transportation and serving of food i.e. catering staff, nurses, domestics, porters etc. are classed as food handlers and should be trained in food hygiene to a level appropriate to their job.

For further information refer to the Trust Food Hygiene Policy POL/FM/0018 follow link: FoodPolicy.pdf

The Trust's online Food Hygiene Training package can be accessed via the following link: Lifelong Learning

7 Monitoring

7.1 Compliance and Effectiveness Monitoring

Compliance with this policy will be monitored as outlined in the table below.

7.2 Compliance and Effectiveness Monitoring Table

Monitoring Criterion	Response
Who will perform the monitoring?	Infection Control Team
What are you monitoring?	Compliance with policy
When will the monitoring be performed?	Following incident management reporting
How are you going to monitor?	Follow-up and investigate incident management report
What will happen if any shortfalls are identified?	Formulate action plan, disseminate training and education
Where will the results of the monitoring be reported?	IC Governance, ICC and Health and Safety Committee
How will the resulting action plan be progressed and monitored?	By Care Group
How will learning take place?	Individual one to one, key messages, ward safety huddles and essential training

8 Glossary of Terms

MRSA Meticillin Resistant Staphylococcal Aureus
GRE/VRE Glycopeptide/Vancomycin Resistant Enterococci
ESBL Extended Spectrum β-Lactamase Producing
CPE Carbapenemase-Producing Enterobacteriaceae
ICT Infection Control team
ICC Infection Control Committee
SICN Senior Infection Control Nurse
HCW Healthcare Worker
AGP Aerosol Generating Procedures
MRO Multi Resistant Organisms

9 Associated Documentation

Antimicrobial Prescribing Guidelines

Pathology Handbook

POL/IC/TV/0015	Policy for Aseptic Technique
POL/ICC/0002	Policy for Hand Hygiene/PPE
POL/NG/0007	Uniform Appearance and Dress Code Policy
POL/ICC/0027	Policy for the use of Gloves in a Clinical Setting
POL/ICC/0012	Policy for the Safe Use and Disposal of Sharps
POL/PD/0011	Blood Borne Virus Policy
POL/ICC/0005	Policy for the Categorisation of Biological Agents and Transport of Specimens
POL/FM/0018	Food Hygiene Policy
POL/ICC/0013	Policy for the Control of an Outbreak of Infection in Hospitals (including Hospital Response to Major Outbreaks of Infection in the Community)
POL/ICC/0004	Guidelines for the Reporting of Suspected/Confirmed Cases of Notifiable Diseases
POL/ICC/0003	Policy for Management of Common Infections/Infectious Diseases (including isolation of patients)

Trust online Food Hygiene Training Package

Ayliffe G A et al (2000) Control of Hospital Infection *A practical handbook* 4th edition. London. Arnold

Dancer S J et al (2007) *Epic2: Updating the evidence base for national evidence based guidelines for preventing healthcare associated infections in NHS hospitals in England* Journal of Hospital Infection Vol 65, Supplement 1

Department of Health (2005) *Saving Lives: a delivery programme to reduce health care associated infections (HCAI) including MRSA* London DH, 2005

Department of Health (2008) The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Department of Health (2003) *Winning ways: working together to reduce health care associated infection in England* Report from the Chief medical Officer London DH 2002

Health & Safety Executive (2003) *Health & Safety Regulation. A Short Guide* London HSE 2003

Health & Safety Executive (2005) *COSHH: a brief guide to the regulations: What you need to know about the Control of Substances Hazardous to Health (COSHH) Regulations 2002* London HSE 2005

Infection Control Nurses Association (2002) *A comprehensive glove choice* ICNA May 2002

Medical Devices Agency (2001) Safety Notice (SN) 2001 (19) *Safe use and disposal of sharps* London MDA

World Health Organisation (2006), 'Your Five Moments for Hand Hygiene' Available at: http://www.who.int/gpsc/5may/background/5moments/en/index.html

Public Health England *Prepare and Protect (Guidance for staff on personal protective equipment) http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1317141193682*

NHS Scotland: National Infection Control Manual (2016)
http://www.nipcm.hps.scot.nhs.uk/

Royal Marsden Manual of Clinical Nursing procedures 9th Edn (2016)
http://www.rmmonline.co.uk/

10 Appendices

Appendix 1 - Procedure Following Death of Patients with Suspected or Known Infections/Infectious ~Diseases

Appendix 2 - Equality Impact Assessment

10.1 Appendix 1 Procedure Following Death of Patients with Suspected or Known Infections/Infectious ~Diseases

PROCEDURE FOLLOWING DEATH OF PATIENTS WITH SUSPECTED OR KNOWN INFECTIONS/INFECTIOUS DISEASES

1. Safe handling and disposal of an infected body is necessary if a deceased patient was presumed or known to be suffering from an infectious disease.

2. For most infections the following protective clothing is required:

   Disposable plastic apron

   Nitrile gloves (non-sterile)

   In the unlikely event of a patient dying from a category 4 pathogen please see POL/ICC/0005 Categorisation of Biological Agents and Transport of Specimens.

   Policy for the Categorisation of Biological Agents and Transport of Specimens

   Additional protective clothing is required:

   Tyvek boiler suit with hood

   Hair covered with theatre cap

   Further advice is available from the Consultant Microbiologist:

UHND Ext 32430/32613/32450	Out of hours via switchboard
DMH Ext 43241	Out of hours via switchboard

   Plastic body bags (cadaver bags) These are required if there is excessive leakage of blood/body fluids and also for certain infections, as follows:

   Guidelines for procedures undertaken following death

Bagging:	Placing the body in a plastic body bag
Viewing:	Allowing the bereaved to see, touch, and spend time with the body before disposal
Embalming:	Injecting chemical preservatives into the body to slow the process of decay. Cosmetic work may be included.
Hygienic preparation:	Cleaning and tidying the body so it presents a suitable appearance for viewing (an alternative to embalming)

Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
Low	Acute encephalitis	No	Yes	Yes	Yes
	Leprosy	No	Yes	Yes	Yes
	Meningitis (except meningococcal)	No	Yes	Yes	Yes
	Mumps	No	Yes	Yes	Yes
	Ophthalmia neonatorum	No	Yes	Yes	Yes
	Rubella	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
	Whooping cough	No	Yes	Yes	Yes
Medium	Relapsing fever	Adv	Yes	Yes	Yes
	Food poisoning	No/Adv	Yes	Yes	Yes
	Hepatitis A	No	Yes	Yes	Yes
	Acute poliomyelitis	No	Yes	Yes*	Yes
	Diphtheria	Adv	Yes	Yes	Yes
	Dysentry	Adv	Yes	Yes	Yes
	Leptospirosis (Weil's disease)	No	Yes	Yes	Yes
	Malaria	No	Yes	Yes	Yes
	Meningococcal septicaemia (with or without meningitis)	Adv	Yes	Yes	Yes
	Paratyphoid fever	Adv	Yes	Yes	Yes
	Cholera	No	Yes	Yes*	Yes
	Scarlet fever	Adv	Yes	Yes	Yes

Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
	Tuberculosis	Adv	Yes	Yes	Yes
	Typhoid fever	Adv	Yes	Yes	Yes
	Typhus	Adv	No	No	No
High	Hepatitis B, C and non-A non-B	Yes	Yes	No	No
High (rare)	Anthrax	Adv	No	No	No
	Plague	Yes	No	No	No
	Rabies	Yes	No	No	No
	Smallpox	Yes	No	No	No
	Viral haemorrhagic fever	Yes	No	No	No
	Yellow fever	Yes	No	No	No

Adv **=** Advisable and may be required by local health regulations. *Requires particular care during embalming.

Guidelines for handling cadavers with some infections that are not notifiable in England and Wales:

Degree of risk	Infection	Bagging	Viewing	Embalming	Hygienic preparation
Low	Chickenpox/shingles	No	Yes	Yes	Yes
	Cryptosporidiosis	No	Yes	Yes	Yes
	Dermatophytosis	No	Yes	Yes	Yes
	Legionellosis	No	Yes	Yes	Yes
	Orf	No	Yes	Yes	Yes
	Psittacosis	No	Yes	Yes	Yes
	Methicillin resistant *Staphylococcus aureus*	No	Yes	Yes	Yes
	Tetanus	No	Yes	Yes	Yes
Medium	HIV/AIDS	Adv	Yes	No	No
	Haemorrhagic fever with renal syndrome	No	Yes	Yes	Yes
	Q fever	No	Yes	Yes	Yes
High	Transmissible spongiform encephalopathies (e.g. CJD)	Yes	No*	No	No
	Invasive group A streptococcal infection	Yes	No	No	No

Adv **=** Advisable and may be required by local health regulations. *If necropsy has been carried out.

Cadaver bags are available from ITU DMH and ITU UHND.

3. **<u>Viewing the body and advice to relatives</u>** Although relatives may have risked infection from contact with the patient in life, further risk to relatives or attendants must be minimised.

   Relatives should be encouraged to view the body before removal from the ward.

   The body should not be removed from the cadaver bag unless a post-mortem examination is to be carried out.

The relatives should be told that the patient died from an infectious disease. Relatives who are concerned regarding exposure should be referred to the Consultant in charge of the patient.

4. **Transfer of the body to the mortuary** The body should be transferred as soon as possible after viewing.

   Porters transferring the body are not required to wear protective clothing as the cadaver bag acts as a barrier to transmission of infection.

   The mortuary staff and pathologist **must** be forewarned in all cases of the infections highlighted in Point 3.

5. **Organ donation** For certain categories of infection, organs may not be donated even if the patient carried a donor card. Further advice is available from the Transplant Co-ordinator, Freeman Hospital, Newcastle.

10.2 Appendix 2 - Equality Analysis/Impact Assessment (v4/2018)

Division/Department:	Infection Control
Title of policy, procedure, decision, project, function or service:	Policy for Infection Control
Lead person responsible:	Senior Nurse Infection Control
People involved with completing this:	Consultant Microbiologists Infection Control Team

Type of policy, procedure, decision, project, function or service:

Existing	☒
New/proposed	☐
Changed	☐

Date Completed:	January 2020

Step 1 – Scoping your analysis

What is the aim of your policy, procedure, project, decision, function or service and how does it relate to equality?

To ensure that basic infection control precautions are carried out within the Trust and to direct staff to other relevant infection control policies for more detailed information and guidance.

Who is the policy, procedure, project, decision, function or service going to benefit and how?

Staff and patients

What barriers are there to achieving these outcomes?

None

How will you put your policy, procedure, project, decision, function or service into practice?

Policy will be disseminated Trustwide and available on the Trust intranet. Paper copy stored in Corporate Records Office, DMH. Infection Control Newsletter alerts people that the policy has been reviewed. Renewal of policy sent out via Trust bulletin.

Does this policy link, align or conflict with any other policy, procedure, project, decision, function or service?

Hand Hygiene Policy
Policy for the Use of Gloves in Clinical Settings
Policy on the Safe Use and Disposal of Sharps
Blood Borne Virus Policy
Policy for the Categorisation of Biological Agents and Transport of Specimens
Policy for the Control of an Outbreak of Infection in Hospitals (including Hospital Response to Major Outbreaks of Infection in the Community)
Guidelines for the Reporting of Suspected/Confirmed Cases of Notifiable Diseases
Policy for the Management of Common Infections/Infectious Diseases (including isolation of patients)
Food Hygiene Policy
The Trust's online Food Hygiene Training package

Step 2 – Collecting your information

What existing information / data do you have?

The Policy is based on national guidance and is relevant to all groups.

Who have you consulted with?

Consultant Microbiologists Infection Control Team Infection Control Committee

What are the gaps and how do you plan to collect what is missing?

None

Step 3 – What is the impact?

Using the information from Step 2 explain if there is an impact or potential for impact on staff or people in the community with characteristics protected under the Equality Act 2010?

Ethnicity or Race

No impact or potential for impact on any group

Sex/Gender

No impact or potential for impact on any group

Age

No impact or potential for impact on any group

Disability

No impact or potential for impact on any group

Religion or Belief

No impact or potential for impact on any group

Sexual Orientation

No impact or potential for impact on any group

Marriage and Civil Partnership (applies to workforce issues only)

No impact or potential for impact on any group

Pregnancy and Maternity

No impact or potential for impact on any group

Gender Reassignment

No impact or potential for impact on any group

Other socially excluded groups or communities e.g. rural community, socially excluded, carers, areas of deprivation, low literacy skills etc.

No impact or potential for impact on any group

Step 4 – What are the differences?

Are any groups affected in a different way to others as a result of the policy, procedure, project, decision, function or service?

No

Does your policy, procedure, project, decision, function or service discriminate against anyone with characteristics protected under the Equality Act 2010?

Yes ☐ **No** ☒

If yes, explain the justification for this. If it cannot be justified, how are you going to change it to remove or mitigate the affect?

Step 5 – Make a decision based on steps 2 - 4

If you are in a position to introduce the policy, procedure, project, decision, function or service? Clearly show how this has been decided.

After consultation with Consultant Microbiologists and Infection Control Team and Infection Control Committee. Approved at Executive Patient Safety & Experience Committee. Ratified at Integrated Quality & Assurance Committee.

If you are in a position to introduce the policy, procedure, project, decision, function or service, but still have information to collect, changes to make or actions to complete to ensure all people affected have been covered please list:

N/A

How are you going to monitor this policy, procedure, project or service, how often and who will be responsible?

Compliance Monitoring Key Performance Indicators will be submitted on a monthly basis to the Board and ward areas via the intranet and deficits actioned by the Matron for that area. Annual ICNA Environmental Audit is also carried out by the Infection Control Team. **Compliance Measures** Training (as appropriate) will be provided as per the Life Long Learning Directory available on Staffnet. Monitoring of attendance at training will be undertaken by Learning and Development.