

# Infection Prevention and Control Policy

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## Policy Summary Overview

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (DH 2015) requires all registered providers of health and social care to have in place appropriate policies in relation to prevention, reducing and controlling risks of infection.

Every individual working for CSH has a responsibility to maintain and improve infection control standards to ensure patient, public and staff safety at all times. The purpose of this policy is to define the individual responsibility and accountability of every member of staff to prevent and control infection.

## 2. INTRODUCTION

CSH/CFHS Surrey must comply with diverse Laws; Regulations; Approved Codes of Practice (ACOPS); Department of Health rules and guidance. CSH Surrey interpret and apply the requirements of these documents so that all employees know what their roles and responsibilities are to ensure their own safety and wellbeing and that all CSH employees provide the best possible care and safe environment to all the patients and clients they deal with.

CSH Surrey is a social enterprise providing nursing and therapy services to the communities of Surrey. CSH aims to ensure appropriate policies, procedures and guidelines are developed, implemented and reviewed to enable ongoing delivery of safe effective quality care services.

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (DH 2015) requires all registered providers of health and social care to have in place appropriate policies in relation to prevention, reducing and controlling risks of infection.

### 2.1 Purpose/Scope

Every individual working for CSH has a responsibility to maintain and improve infection control standards to ensure patient, public and staff safety at all times. The purpose of this policy is to define the individual responsibility and accountability of every member of staff to prevent and control infection.

This Policy is an overarching umbrella document supported with a number of Infection Prevention and Control (IPC) Appendices which set out the actions required for specific activities in each Appendix which must be read in conjunction with the IPC Policy.

### 2.2 Definitions

All definitions are contained within the body of the text of this document.

## 3.0 RESPONSIBILITIES

### 3.1 The Chief Executive

Has overall responsibility for the provision of infection prevention and control within CSH. Must be aware of and comply with legal duties eg Health and Social Care Act, Code of Practice (DH 2015) to identify, assess and control risks of infection in the workplace.

### 3.2 CSH Board

- Is responsible for ensuring the strategic context of this policy is appropriate and meets the need of The Organisation.
- Ensures that the IPC Team is appropriately resourced and fit for purpose.
- Ensures there are clear lines of accountability between risk management, clinical governance, infection control and senior management.
- Ensures adequate additional funding is available as required for the local

management of local, national and international outbreaks.

- Allocates budgets with due attention to infection control and cleanliness ensuring all contracts meet the minimum NHS standards.

### **3.3 The Director of Infection Prevention and Control ( Director of Quality and Governance):**

- Is the lead Executive for Infection Prevention and Control and report directly to the Chief Executive and Board.
- Provides oversight and assurance on infection prevention (including cleanliness) to the CSH board or equivalent.
- Reports directly to the Chief Executive if they have any concerns regarding the implementation of this policy.
- Has overall responsibility for the strategic and operational management of the IPC team, but will delegate the daily management of IPC to the IPC team.
- Ensures evidence based policies and appendices are developed, implemented and monitored.
- Has the authority to challenge inappropriate practice and inappropriate antimicrobial prescribing.
- Has the authority to set and challenge standards of cleanliness
- Assesses the impact of plans/policies on infection control and make recommendations for change.
- Produces an annual report on the state of healthcare associated infections in the organisation.

### **3.4 Service Managers /Hub Managers etc.**

- Must actively manage staff to ensure all staff implement and adhere to infection control policy and procedures.
- Must ensure resources are available to meet infection control standards / requirements.
- Must actively manage their staff to ensure they receive appropriate infection control training as per training needs analysis (TNA) for induction and mandatory training and also any additional IPC training required to ensure they can undertake their role effectively.
- Must ensure Infection Control Link Representatives have appropriate support, education and dedicated time to ensure they can carry out their role effectively.
- Must ensure staff report outbreaks / incidents in accordance with the Organisation process for reporting incidents
- Are responsible for leading and driving a culture of cleanliness in clinical areas.
- Are responsible for setting and monitoring standards of cleanliness in conjunction with others.
- Must ensure equipment decontamination is performed in line with local, national and manufacturer's guidance, this includes the provision of adequate training, equipment and environmental standards for staff to safely decontaminate equipment.
- Must review the patient journey for emergency and planned patients in order to reduce the risk of transmission of infection by minimising the movement of potentially infected patients.
- Are responsible for promoting best IPC practice and challenging poor practice,

particularly if managing staff who have direct contact with service users.

- Must actively manage staff that do not adhere to infection control policy and procedures to ensure compliance with CSH infection control standards.

### **3.5 The Infection Control Team**

- Provide expert reactive and proactive information and advice to all staff, patients and relatives about the management of healthcare associated infection (HCAI).
- Work in collaboration with CSH staff at all levels, clinical and non-clinical.
- Will be approachable, informed, adaptable and understanding to the needs of CSH staff.
- Ensure the effective auditing of infection control practices throughout the organisation through monitoring and implementation.
- Are responsible for promoting best IPC practice and challenging poor practice.
- Review the status, in collaboration with others, of the built environment and the effectiveness of the facilities management services, including cleaning, in order to provide a safe and clean environment for patient care.
- Produce and review all infection control policies and appendices in line with national guidance and current evidence base.
- Contribute to the annual infection control plan.
- Develop priorities for targeted surveillance at local level in line with national and local requirements and ensure there is appropriate dissemination of surveillance results.
- Provide expert infection control support to the Strategic Infection Control Group (SIPC)
- Provide a comprehensive infection prevention and control education programme incorporating induction and mandatory training as per TNA.
- To develop new strategies to improve infection control education across the whole of CSH
- Provide expert management of infection outbreaks / incidents including the rapid detection and management of outbreaks.
- Provide expert infection prevention and control advice on all rebuilds and reconfigurations.
- Advise on aspects of decontamination, including all levels of equipment decontamination and cleaning.
- Facilitate an identified and trained group of Infection Control Link Representatives staff, ensuring they work within defined roles and are empowered to raise standards.
- Review and respond appropriately to adverse incident reports relating to infection prevention and control.
- Provide information to patients and the public to ensure they are aware of how they can assist with the prevention of healthcare associated infections.
- Identify corporate learning and development requirements relating to IPC providing recommendations to the learning and development leads.

### **3.6 Infection Prevention and Control Link Representatives**

- IPC Link Representatives are nominated locally by their line managers.
- IPC Link Representatives help to improve the quality of patients/service user's care within their area by developing a core knowledge base in IPC, which has

been negotiated and agreed by the IPC team, and sharing this with their own teams..

- Are responsible for promoting best IPC practice and challenging poor practice, particularly if their team has direct contact with service users.
- Are responsible for raising any IPC issues of concern to the IPC Team.

### **3.7 All Healthcare Workers including clinical staff**

- Must adopt national evidence based practice in order to ensure patients are treated according to best practice
- Must work to the standards set out in this IPC policy and the supporting Appendices
- Challenge poor infection control practice and seek support from the IPC team as required.
- Obtain advice from Occupational Health if they are concerned over risks to self or others

### **3.8 All CSH Employees**

- Are responsible for ensuring they comply with this policy to ensure the safety of all patients, staff, contracted staff and visitors to this Organisation
- Must ensure they have received appropriate IPC training as per TNA.
- Must never knowingly place a patient, member of staff or visitor at risk from an infection.

## **4.0 INFECTION PREVENTION AND CONTROL**

CSH and its entire staff employed or contracted has a responsibility to eliminate or mitigate risks associated with infection

Infection Prevention and Control risks are populated on the risk register as part of the organisation's risk assessment and evaluation process. The strategic and corporate management of significant risks associated with IPC will be recorded in the organisation's Assurance Framework.

Quality assurance process must be in place to monitor levels of risk against national and local infection control standards. Activities in place that demonstrate this include:

- a) IPC audit programme
- b) Access for all staff to IPC training (mandatory)
- c) Quarterly reporting to CSH Board of IPC incidents
- d) Review of quarterly IPC reports at SIPC
- f) Infection Prevention and Control Annual Report
- g) IPC representation at key meeting eg Medical Devices, Patient Environment, Cleanliness contract meetings, Water Safety Group etc.

Non compliance against defined standards identified by audit, must be addressed safely and efficiently locally by the service and Hub Managers.

Infection control management of significant risks on the risk register must be reviewed at least quarterly via the SIPC Group

If compliance cannot be achieved following all appropriate actions then residual risks must be recorded in the Organisations risk register as per the CSH Risk Management Policy.

Patients and visitors to the Organisation must be provided with appropriate information to allay concerns about infection or how to manage infection. This information can be provided in the form of leaflets, web based information, media messages and any other form of media deemed appropriate.

#### 4.1 Infection Prevention and Control Incidents

In line with the IPC Annual Plan, mandatory reporting will continue for the following organisms:

- MRSA, MSSA & E coli bacteraemia
- *Clostridium difficile* or MRSA deaths
- *Clostridium difficile* positive results (48hrs after admission).
- New MRSA positive results post 48hrs of admission in inpatient settings
- Glycopeptide Resistant Enterococci (GRE) bacteraemia
- Ward closures due to infection / Outbreaks of infection
- Other significant IPC incidents

In addition the IPC team will be alert to the emergence of new health threats e.g. carbapenemase-producing Enterobacteriaceae and implement strategies where required to minimise risk within the organisation and wider health economy.

#### 4.2 Standard Infection Prevention and Control Precautions

Infection is a common but often avoidable complication of healthcare which has a major impact on the patient and the healthcare service. Practices to prevent patients acquiring infection and to minimise the risk of transmission should be incorporated into routine practice and not just implemented for patients known to have infections (Wilson 2006).

These routine precautions are called 'standard precautions'. All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. This includes injury by sharp objects and bites.

Infection control procedures are also important to protect staff from infection. All staff should demonstrate good infection control and hygiene practice. (The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance 2015).

Everyone involved in providing care should be educated about standard principles and trained in the use of personal protective equipment (PPE)

Key principles include:

- Hand Hygiene
- Personal Protective Equipment (PPE)
- Respiratory Hygiene



- Sharps and Inoculation Injuries
- Safe handling of blood and body fluids spillages
- Cleaning and decontamination
- Aseptic technique
- Safe handling and disposal of linen and waste
- Safe handling of laboratory specimens

Standard Precautions must be applied by all care staff in the care of all patients/service users and are applicable in all care settings including hospitals, clinics, surgeries' or in the patients own home/place of residence (Ayliffe 2009).

Wherever care is delivered, healthcare workers must have access to supplies of:

- Materials for hand decontamination
- Sharps containers
- Personal protective equipment

See Appendix 14 Standard Precautions, Appendix 13 Management of Linen and Appendix 8 Management and Collection of Specimens.

### 4.3 Hand Hygiene

Hand hygiene is a term that incorporates the decontamination of hands by methods including routine hand washing, surgical hand washing and the use of alcohol hand rubs (Uniform and Workwear Guidance DH 2010). Contaminated or dirty hands are closely associated with the transmission of healthcare associated infection (HCAI). Hand hygiene is considered to be the single most important means of preventing the spread of infection and is therefore an essential practice for patient safety.

Adequate facilities must be provided to enable staff to wash and dry their hands regularly and appropriately, to use alcohol hand rub if applicable, to use clinell wipes if applicable and to protect their skin using moisturisers. Each inpatient and clinical area must have the following equipment near to the point of care of the service user to ensure adequate hand hygiene:

A dedicated hand wash basin, which is easily accessible, with no plug or overflow. This must be separate from a dedicated sink for cleaning equipment.

- Elbow operated mixer taps
- Wall mounted liquid soap dispenser with adequate supply of liquid soap
- Wall mounted disposable paper towels
- Hand hygiene posters displaying the correct technique
- New builds and refurbishments should include hand washing sinks which conform to national standards
- If a clinical hand wash basin is not available e.g. in some childhealth settings, alcohol hand rub must be available at the point of care.
- All community based staff must be provided with facilities for hand hygiene such as alcohol hand rub

Please see Appendix 1 Hand Hygiene

#### 4.4 Aseptic Technique

Aseptic technique can be defined as a means of preventing or minimising the risk of introducing harmful micro-organisms into sterile/key sites of the body when undertaking clinical procedures. The Organisation provides a standardised approach to aseptic technique with additional training for staff undertaking these procedures. Staff undertaking any aseptic technique must be 'competent' before performing these tasks, and must ensure their practice complies with the Aseptic Technique procedure.

Equipment and training must be provided to enable staff to undertake aseptic technique as per the Aseptic Technique procedure.

Please see Appendix 10 Aseptic Non Touch Technique(ANTT)

#### 4.5 Sharps and Inoculation Injuries

The Organisation has a duty to protect, so far as is reasonably practical, healthcare workers from exposure to communicable infections during the course of their work. Measures must therefore be in place to protect all organisation staff from blood borne viruses such as Hepatitis B and C and HIV. These include:

- Immunisation of staff as set out in the Immunisations against infectious disease (DH)
- To address the requirements of the EU Council Directive 2010/32/EU to provide a safe working environment for healthcare staff through the prevention of sharps injuries
- Access to equipment e.g. PPE and UN compliant Sharps bins
- A clear process in place following occupational exposure
- Provision of devices that incorporate sharps protection mechanisms to provide safer systems
- Ensure there is in place a protocol for the safe handling and disposal of sharps.
- Provision of education in the prevention and management of sharps injuries
- Facilities must be available for employees in their area of work to ensure they are able to comply with the Sharps and Inoculation procedure.

All healthcare workers must be aware of their responsibility in avoiding needlestick / sharps injuries.

Please see Appendix 5 Sharps and Inoculation Management and CSH Waste Policy.

#### 4.6 Decontamination of Medical Devices

All re-usable medical devices must be effectively decontaminated to protect patients, visitors and staff from the risks of infection. The Health Technical Memorandum 01- 01: Management and decontamination of surgical instruments (medical devices) used in acute care, Parts A-E (DH 2016), outlines the principles of decontamination which must be applied to re-usable medical devices. The CHS Decontamination Policy is based on this guidance.

All medical devices must be purchased in line with CSH Decontamination of Medical Devices policy.

All staff must be able to differentiate between single use, single patient use and re-usable medical devices. Devices designated for single use must not be re-used under any circumstances. Anyone who reprocesses or reuses a device intended by the manufacturer for a single use occasion bears the full responsibility for its safety and effectiveness.

All staff must be aware of the process to follow to effectively decontaminate medical devices (when appropriate) or when applicable the process for sending medical devices away for reprocessing.

Funding and resources must be available for additional staff training and to ensure decontamination facilities comply with HTM 01-01.

Please see Appendices – Decontamination of Medical Devices and Single Use Procedures.

#### **4.7 MRSA (Meticillin-resistant Staphylococcus aureus)**

*Staphylococcus aureus* is a gram negative bacterium which can be present in the normal flora of the nose of about 30% of the population, usually without causing harm. It is an organism that colonises the skin and is found in moist sites such as the nose, axillae, skin folds and perineum, and in certain circumstances where there are cuts, sores or wounds on the skin, it may cause boils, wound infections and blood stream infections. MRSA (Meticillin Resistant Staphylococcal Aureus) is a variant of *Staphylococcus aureus* which has developed resistance to commonly used antibiotics and may be more difficult to treat because of limited treatment options. Antibiotic resistant pathogens constitute an important and growing threat to public health. Hospital inpatients can become susceptible for colonisation by resistant microbes because antibiotics given for prophylaxis and treatment kill their natural skin flora. Often service users will have wounds or invasive devices such as urinary catheters which act as a reservoir and route of entry into the body.

All healthcare staff must be aware of their individual responsibility to effectively manage MRSA and ensure service users who are confirmed as having MRSA are managed safely and appropriately and receive adequate information about their condition.

All inpatient areas that undertake MRSA admission screening must have a clear process in place to record the MRSA screen and action the results from the screen in a timely way as outlined in the MRSA procedure

Resources and facilities must be available to ensure that the process for the effective management of MRSA can be adhered to.

Please see Appendix 2. MRSA and Other Antibiotic Resistant Organisms

#### **4.8 Clostridium difficile**

*Clostridium difficile* infection (CDI) causes serious illness and outbreaks among hospital inpatients. The elderly and those who have received prior broad spectrum antibiotics are particularly at risk. Environmental contamination with *Clostridium difficile* spores contributes

to the risk of a patient acquiring CDI. Service users from a non-inpatient setting can also develop *Clostridium difficile* associated diarrhoea.

CDI affects the colon and results in a wide spectrum of disease. Service users may experience abdominal pain with explosive watery foul smelling diarrhoea. Some have fever and a raised white cell count (leucocytosis). Pseudomembranous colitis (PMC), toxic megacolon and perforation are life threatening complications. Occasionally severe disease such as PMC can occur without diarrhoea and other diagnostic procedures such as colonoscopy may be required. CDI infection can be diagnosed by stool culture, toxin detection or using molecular methods.

All healthcare staff must be aware of the actions needed when a person presents with diarrhoea and give consideration that it may have an infectious cause. Service users with suspected potentially infectious diarrhoea should be isolated, following a risk assessment, to prevent the spread of infection.

Resources and facilities must be available to ensure the effective management of suspected or confirmed cases of *Clostridium difficile*.

Please see Appendix 11. *Clostridium difficile* Management

#### **4.9 Carbapenemase Producing Enterobacteriaceae**

Enterobacteriaceae are a family of bacteria that usually live harmlessly in the gut of humans. If this bacteria spreads it can cause infections of the bladder, bloodstream and chest. Carbapenemase-producing Enterobacteriaceae (CPE) are a type of bacteria which have become resistant to carbapenem antibiotics, this resistance is helped by enzymes (chemicals) called carbapenemases found in some strains of bacteria which can destroy carbapenem antibiotics. The spread of these resistant CPE bacteria can cause problems to vulnerable service users' in hospital or other care settings, because there are limited antibiotics to treat the infections they cause.

In 2013 PHE published an acute trust toolkit for the early detection, management and control of CPE and in June 2015 a toolkit for non-acute and community settings was published to provide practical advice for health and social care staff and information for the service user and their family.

Please see Appendix 18 The Management of Carbapenemase Producing Enterobacteriaceae (CPE) and Carbapenem Resistant Organisms.

#### **4.10 Diarrhoea and Vomiting**

The two main causes of an outbreak of diarrhoea and/or vomiting in a healthcare setting are either *Clostridium difficile* and/or gastroenteritis due to small round structured viruses such as Norovirus. Service users presenting with symptoms of diarrhoea and/or vomiting must be appropriately managed in order to reduce the risk of cross transmission whilst also maintaining their clinical needs and the needs of any other service users.

All staff must be able to recognise when a potential outbreak may be starting and the actions they must take if they suspect the beginnings of an outbreak in their area of work.

Resources and facilities must be available to ensure that outbreaks are managed effectively

and appropriately and in a timely manner eg the provision of enhanced cleaning when required.

See Appendix 3 Management of Diarrhoea and Vomiting

#### 4.11 Isolation

The spread of infection between patients in hospital can be reduced by the physical isolation of either; patients at increased risk of infection (protective isolation) or those patients who pose an infection risk to others (source isolation). Methods of physical isolation include:

- Source isolation in dedicated side rooms – preferably with own ensuite facilities. Patients must be risk assessed prior to placing in source isolation to ensure their safety is not compromised.
- Segregation of a group of patients with a disease or infection from patients who do not harbour the disease or infection - this is referred to as cohort nursing in an open ward / clinic area).
- Facilities and/or equipment must be available to ensure compliance with the Isolation Procedure. This will include the provision of PPE and arrangements for enhanced levels of cleaning.

See Appendix 4 Isolation Management

#### 4.12 Reporting Notifiable Diseases

**It is a statutory requirement for the Consultant Microbiologist or the Medical practitioner to inform the Consultant in Communicable Diseases, Surrey and Sussex Health Protection Unit at Horsham on 0845 8942944 of any reportable notifiable diseases.**

**The IPC Team should be informed immediately of any infections suspected or diagnosed.**

Please see Appendix 4 Isolation Management for list of reportable notifiable diseases.

#### 4.13 Outbreak of Infection/Major Outbreak

The rapid recognition of an outbreak is one of the most important objectives of routine surveillance. All staff must be vigilant at all times and must report any concerns to the IPC team by day or the on call manager at weekends, bank holidays or out of office hours. Outbreaks will be graded as either an outbreak / incident or major outbreak depending upon the severity or number of cases involved. outbreak control measures will depend on individual needs of each location within the organisation.

Equipment and/or facilities must be provided/available to ensure the organisation can comply with the Outbreak of Infection procedure. The provision of additional funding may be required to effectively manage an outbreak.

Please see Appendix 8 Infection Prevention and Control Outbreak Management and

Procedures, Appendix 6 Seasonal Influenza Management, and Appendix 3 Management of Diarrhoea and Vomiting

#### **4.14 Ward Closure due to suspected or confirmed infection**

During outbreaks of infection it may become necessary to close a ward to contain the spread of infection. The decision to close a ward will be made following consultation with the IPC team or the on call manager out of normal working hours and weekends. This decision will be communicated to key staff by email. A closed ward is unable to accept new admissions or inter ward/hospital transfers. Patients cannot be discharged to other health or social care premises. A closed ward can therefore impact on the delivery of a normal service.

Resources and facilities must be available to ensure effective management during a ward / department closure such as enhanced cleaning arrangements.

See Appendix 8 Infection Prevention and Control Outbreak Management, Appendix 3 Management of Diarrhoea and Vomiting, Appendix 16 Admission/Transfer / Discharge Procedures For The Infected Patient

#### **4.15 Safe Handling Of Food**

Food health and safety legislation places clear responsibility on suppliers of food to ensure that it is fit for consumption. This includes the providers of food for individuals in hospitals, not only in terms of food prepared in the main kitchens, but also its management on the ward and other service areas where public consume food ie. League of Friends..

**Please see** CSH Safe Handling of Food Policy and Procedure.

#### **4.16 Infestation e.g. Scabies**

Scabies is a skin condition caused by a mite *Sarcoptes scabiae* var *hominis*. Infection with the scabies mite can result in an allergic reaction to its saliva and faeces causing an intensely itchy rash – Classical Scabies. There is a rare form of scabies where the itching does not usually occur and mites build up crusted lesions on the skin – Crusted or Norwegian Scabies. These crusts contain many more mites than in classical scabies and as a consequence are much more infectious. The crusts can also survive for some time in the environment protected by the moisture of skin flakes.

The allergic rash can take up to 6 weeks to develop, though it can occur in less than 2 weeks if the person has been sensitised by a previous scabies infection. The rash can last for several weeks after successful treatment.

All healthcare staff must be aware of the actions needed if they suspect a service user may have a scabies infection.

Resources and facilities must be available to ensure the effective management of service users with scabies.

See Appendix 12 Infestation Management

#### **4.17 Transportation of Clinical Specimens**

A specimen is a body substance such as blood, sputum, pus, urine or faeces taken from a person for the purpose of analysis. The aim of the analysis is to identify micro-organisms that cause disease and to inform appropriate treatment. Specimens can also be analysed for diagnostic purposes in identifying underlying medical conditions.

All specimens should be regarded as potentially infected and if they are not handled or transported safely can pose a risk of infection to all people involved including healthcare workers, service users and their carers. Accuracy of laboratory results is dependent on the quality of the specimen received.

All staff involved in the handling or transportation of clinical specimens must be aware of and adhere to the process for their safe management. Standard precautions for IPC must always be followed.

See Appendix 7 The Management and Collection of Specimens

#### **4.18 Care of the Deceased Patient with a known or suspected infection**

Under the Health and Safety at Work Act (1974) (section 6.1.1) all employers have a responsibility for the safety of their employees. Those employees also have a duty of care to inform others of potential risks. Care of the deceased who had a potentially infectious disease fall into this category. Good clear communication regarding the possibility of an infection risk must be maintained between healthcare staff, mortuary attendants and funeral directors at all times.

All staff involved in performing Last Offices should be aware of the actions they must take to reduce the risks of infection to themselves and any other staff who may be involved. Please refer to Appendix 4 Isolation Management and Appendix 2 MRSA and Other Antibiotic Resistant Organisms

#### **4.19 Infection Control In The Built Environment**

The healthcare environment is a secondary reservoir for micro-organisms with a potential for causing infection. It is important that healthcare buildings are designed with appropriate consultation, and the design facilitates good infection prevention and control practices and has the quality and design of finishes and fittings that enable thorough access, cleaning and maintenance to take place. If healthcare associated infection is to be reduced, it is imperative that infection control is considered at all stages of the capital/estates development process, from planning and design through to the completion of the build for both new builds and refurbishment of existing facilities.

See Appendix 19 – Infection Prevention and Control Procedures For Design Construction and Renovation/Refurbishment Projects

#### **4.20 Animals & Pets**

Documented research and evidence support the benefits of elderly, terminally ill, psycho geriatric individuals and people who have learning disabilities, if they wish, being allowed contact with animals.

### **Infections**

It is well documented that the following list of diseases can be acquired from a variety of normal domestic pets. E.g.

Salmonella  
Campylobacter  
Toxocara  
Toxoplasma  
Yersinia  
Ringworm  
Ticks

**ALL CSH employees who wish to introduce pets into Health Service premises must have the written permission from Senior Service Manager. Pets belonging to CSH employees are not allowed on Health Service Premises.**

## Visiting Animals

### Dogs

Visiting dogs are allowed access to Health Service premises under the following circumstances:

- Dogs visiting their owners
- Guide dogs for the blind and hard of hearing - when owners are attending clinics etc.
- Dogs that are part of a recognised dog visiting scheme.

**N.B.** Pro Dogs Active Therapy (PAT) and Canine Concern England are the only schemes allowed within the Organisation.

## 4.21 Viral Haemorrhagic Fevers ( e.g. Ebola Identification)

VHF's are of particular public health importance because:

- They can spread readily within a hospital setting
- They have a high case-fatality rate
- They are difficult to recognise and detect rapidly
- There is no effective treatment

See Appendix 17 Viral Haemorrhagic Fevers (based on the 'Management of Hazard Group 4 viral haemorrhagic fevers (VHFs) and similar human infectious diseases of high consequence' (DH November 2014).

## 4.22 Financial Impact & Resource Implications

- All staff must have access to hand hygiene facilities at the point of care
- All staff must have access to personal protective equipment in their workplace, as per risk assessment
- All staff must be given time to complete IPC mandatory training as per the TNA
- All new builds / refurbishments must comply with national guidance for IPC
- Resources must be available to deal with outbreaks of infection such as implementing additional cleaning and supplies of PPE.

The Organisation must ensure resources are available to provide an effective IPC infrastructure, including the provision of an IPC team and 24hr access for microbiological advice.



## 5. ASSOCIATED DOCUMENTS AND REFERENCES

### Infection Control Appendices

1. Appendix 1- Hand Hygiene
2. Appendix 2- MRSA and other Antibiotic Resistant Organisms
3. Appendix 3- Management of Diarrhoea and Vomiting
4. Appendix 4- Isolation Management
5. Appendix 5- Sharps and Inoculation Management
6. Appendix 6- Seasonal Influenza Management
7. Appendix 7- The Management and Collection of Specimens
8. Appendix 8- Infection Prevention and Control Outbreak Management
9. Appendix 9- Decontamination of Medical Devices and Single Use
10. Appendix 10- Aseptic Non Touch Technique (ANTT)
11. Appendix 11- *Clostridium difficile* Management
12. Appendix 12- Infestation Management
13. Appendix 13- Management of Linen
14. Appendix 14- Standard Precautions
15. Appendix 15- Tuberculosis Management
16. Appendix 16- Admission/ Transfer/ Discharge Procedures For The Infected Patient
17. Appendix 17- Viral Haemorrhagic Fever Management
18. Appendix 18- The Management of Carbapenemase Producing Enterobacteriaceae (CPE) and Carbapenem Resistant Organisms (CPO)
19. Appendix 19- Infection Prevention and Control Procedures For Design Construction and Renovation/Refurbishment Projects (in preparation)

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**Public Health England. Toolkit for managing carbapenemase-producing Enterobacteriaceae in non-acute and community settings. London: Public Health England, 2015 (June);**

<https://www.gov.uk/government/publications/carbapenemase-producing-enterobacteriaceae-non-acute-and-community-toolkit>) Health Protection Agency. *Standards for Microbiology Investigations. Laboratory Detection and Reporting of bacteria with Carbapenem Hydrolising  $\beta$ -lactamases (Carbapenemases) 2013*

World Health Organisation (2009) *WHO Guidelines on Hand Hygiene in Healthcare - First Global Patient Safety Challenge Clean Care is Safe Care*

National Infection Prevention and Control Manual NHS, National Services Scotland. [www.nipcm.scot.nhs.uk](http://www.nipcm.scot.nhs.uk)

## **6. TRAINING**

All CSH Surrey employees will be provided with suitable training on Infection Prevention and Control, at induction and as part of the mandatory training schedule and ad hoc as required.

## **7. MONITORING COMPLIANCE AUDIT & REVIEW**

The Occupational Health Department, in collaboration with the Infection Control Team and the Health and Safety Manager will monitor and review all incident reports of inoculation/sharps and splash injuries within CSH Surrey and address any issues raised. They will also monitor and review trends and provide reports to CSH Surrey's Strategic Infection Prevention and Control Group and The Health and Safety Committee.

## **8. DISSEMINATION AND REVIEW PROCESS**

The policy has been written by the Head of Infection Control. It is approved by the Strategic Infection Control Committee.

The policy will be available on the Intranet and will be reviewed by the SIPC Group every 2 years or sooner if relevant new legislation, guidance or evidence is published.

## 9. VERSION CONTROL

Record of Changes			
Date	Version	Changes / Comments	Approving Forum
?/06/19	1.0	New Policy incorporating IPC Appendices	SIPC

**CSH Surrey Policy and Procedure Ratification Tool**

<b>1.0</b>	<b>Document Title &amp; Reference number</b>	
1.1	Infection Prevention and Control Policy	
1.2	Ref number	IC 01
<b>2.0</b>	<b>Document Author ( Name &amp; Job Title)</b>	
2.1	Name	<b>Mo Farish</b>
2.2	Job title	<b>Head of IPC</b>
<b>3.0</b>	<b>Reason for Development/Review: * Please delete as applicable</b>	
	New format incorporating all guidelines as appendices	
<b>4.0</b>	<b>Does this document replace or supersede an existing policy</b> Yes	
	If yes please provide details: IPC Policy	
<b>5.0</b>	<b>Summary Overview</b>	
	Overarching IPC Policy incorporating all IPC Guidelines	
<b>6.0</b>	<b>Approval process</b>	
6.1	Executive Sponsor	<b>Denise Thiruchelvam – Director of Quality and Nursing</b>
6.2	Approval Forum	<b>SIPC</b>
6.3	Date of Approval:	<b>26<sup>th</sup> July 2019</b>
<b>7.0</b>	<b>Ratification Checklist</b>	
7.1	Lead Author details are clearly stated	Yes
7.2	Author/ Approval demonstrate appropriate qualifications/experience to develop this document	Yes
7.3	The purpose for the document is clear	Yes
7.4	The scope of the document is clear	Yes

7.5	Content supports rationale	Yes
7.6	Content is clear and unambiguous	Yes
7.7	Responsibilities clearly stated	Yes
7.8	Auditable standards or processes of monitoring compliance and implementation are clearly stated	Yes
7.9	Any associated risks have been clearly documented	Yes
7.10	There is an appropriate update evidence base including references / NICE etc	Yes
7.11	External Regulation Requirements ( e.g. CQC/HSE/NHSR/ NHSI) have been reflected	Yes
7.12	Reference to consent requirements is evident if applicable	Yes
7.13	Training and/or competencies requirements are clearly stated	Yes
7.14	There is clear cross reference to related documents/data sources including cross reference to related CSH documents	Yes
7.15	Consultation processes, dates and those involved including co-owners and public where appropriate have been recorded	Yes
7.16	Corporate Image: Pages, entries and sections are clearly numbered. Arial 11 and above has been used	Yes
7.17	Document control – Reference and Version numbering are correct	Yes
7.18	Review date is clearly stated (one/two or three years)	Yes
<b>8.</b>	<b>Ratification</b>	
8.1	Ratification Forum	Policy Working Group
8.2	Ratification Date	10-10-2019

### Equality impact assessment tool

		Yes/No	Comments
<b>1.</b>	<b>Does the document/guidance affect one group less or more favourably than another on the basis of:</b>	No	
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation - Straight, Lesbian, Gay and Bisexual etc	No	
	Age	No	
	Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
<b>2.</b>	<b>Is there any evidence that some groups are affected differently?</b>	No	
<b>3.</b>	<b>If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?</b>	N/A	
<b>4.</b>	<b>Is the impact of the document/guidance likely to be negative?</b>	N/A	
<b>5.</b>	<b>If so, can the impact be avoided?</b>	N/A	
<b>6.</b>	<b>What alternative is there to achieving the document/guidance without the impact?</b>	N/A	
<b>7.</b>	<b>Can we reduce the impact by taking different action?</b>	N/A	