WILLEN HOSPICE & WILLEN HOSPICE VENTURES

HS012a Infection Control Procedures

Approved By:	Council of Management (JH)
Date of Approval	February 2005
Amended By	P Ball MKGH ICT
Revision Number	003
Revision Due By	February 2008

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HS012a Infection Control Procedures

1.0 Explanation of terms

For the purposes of this document the term 'the Hospice' relates to Willen Hospice and Willen hospice Ventures and the term staff relates to employees and volunteers.

2.0 Introduction & Philosophy

The purpose of this document is to advise hospice staff on the correct methods of infection control. The hospice will have appropriate infection control measures in place, which minimize patients, staff and visitors acquiring a health care associated infection.

All members of staff will abide by the safe practices outlined and attend infection control training to ensure they keep up to date with current practice.

Willen hospice has links with the Infection Control team at Milton Keynes General Hospital (MKGH) who supply information and guidance as required by the hospice.

Statutory Requirements

- National Care Standards Commission Core Standard Infection Control (C25)
- Standards for Specialist Palliative Care from NICE & National Council for Hospices 2002 (H6)

The policy must be used in conjunction with

- Milton Keynes General NHS Trust Control of Infection Manual for disease specific policies (if not listed in Contents above)
- NMC Code of Conduct for Nurses & Midwives
- Hospice policies on Waste management, Enteral feeding, Wound Management, Health & Safety, Risk Management, Latex Allergy.

- As changes are made revised sections will be sent to each relevant department. The new sections should be inserted into this policy and the old section(s) destroyed.
- This policy is based on information in the Control of Infection manual written by MKGH NHS Trust. The information is amended where necessary to reflect conditions at Willen Hospice. It relates to situations where there is a known or suspected risk of infection. It is not, nor can be, definitive. If there are any queries arising from this document, staff should seek advice from the Infection Control team at MKGH or the Chief Executive, Director of Nursing & Patient Services, Inpatient Unit Nurse Manager or Unit Sister(s).

Always contact the Infection Control Team (ICT) at MKGH if:

- You suspect an outbreak of any infection
- There are two or more cases of nausea/vomiting/diarrhoea in the hospice felt to be infective in origin
- You admit, or are asked to care for a patient with, or at risk from MRSA
- You have a patient with or suspected of having bacterial meningitis
- You have a patient with or suspected of having open pulmonary tuberculosis

MKGH contacts: Clinical Nurse Specialist 660033 Ext.: 3545 Bleep: 1182
Consultant Microbiologist 660033 Ext.: 3105 Bleep: 1147

3:0 Responsibility & Accountability

Ultimate Responsibility: The Registered Manager [1]

First Line Responsibility: The Inpatient Unit Nurse Manager who is responsible for developing the links with the infection control team at MKGH and in co-operation with the designated infection control nurse, sharing information with the Sisters of the Inpatient unit and other departments of the hospice as appropriate. This role will involve –

- Providing guidance & information on a day-to-day basis on infection control issues
- Be a link nurse member of MKGH Infection Control Team
- Provide training to hospice staff as appropriate
- Seek guidance from MKGH Infection control team as required

All Heads of Department – to ensure staff are aware of and comply with the policy and procedure.

General Responsibility – All staff are to be aware of the standards expected by the NMC, the Care Standards Commission and any other body concerned directly with infection control with regard to their practice overall.

The hospice will ensure provision of training in infection control for staff whose role requires this.

[1] Chief Executive or Director of Nursing & Patient Services

4:0 Principles of Infection Control

4.1 Universal precautions are set out below (see 5.2). These guidelines set out in greater detail the procedures to follow to prevent the spread of infection and to protect patients staff and visitors.

Isolation

The aim of isolation is to interrupt the spread of a specific micro-organism in order to contain it and prevent cross-infection. The spread of infection requires:

- A source – usually the human body
- A mode of transmission – contact, airborne, vehicle (via contaminated items), across the placenta
- A susceptible host – serious underlying illness and immunosuppression through disease or drug therapy increase the susceptibility of the host.

Appropriate isolation precautions must be taken for the micro-organism concerned with reference to it's virulence, mode of spread and effect on others.

Types of Isolation

There are two types of isolation, source and protective.

SOURCE isolation will be required for:

a) Patients who are a source of pathogenic micro-organisms, which may spread from, time to time to infect others.

b) Non immune inpatient contacts of certain infectious diseases, e.g. childhood infectious diseases, during their infectious period.

c) Patients from a ward or home with an outbreak of infection until known to be non-infective after microbiological testing.

NB: A single room is not always necessary, unless the infection is spread by the airborne route, or contamination of the environment by the infecting organism is likely, patients maybe nursed on the ward observing laid down procedures. A blank yellow sign can be displayed on the bed head warning staff at risk.

PROTECTIVE isolation will be required for patients who are immunocompromised due to disease or therapy. These patients are highly susceptible to infection. The sign stating "Please see nursing staff before entering" must be used as available on each room door.

5:0 General Policies

5.1 Definitions & Surveillance

- Hospital acquired infection (HAI) Currently defined as an “infection appearing 72 hours or more after admission”. A patient readmitted with an infection resulting from a previous admission is also regarded as having an HAI.

- Community acquired infection (CAI) A community-acquired infection is defined as an infection found to be active (or under active treatment) at the time of survey, which was present or incubating on admission to hospital.

- Surveillance – MKGH ICT will provide quarterly surveillance reports on the incidence of MRSA and Clostridium Difficile (C. Diff) occurring at Willen Hospice. The ICT will also alert the hospice by telephone immediately any infection that posses a risk to the patient or staff is identified.

5.2 Universal Precautions

- It is the policy of Willen Hospice that disposable gloves and disposable aprons are worn when contact with body fluids is likely. This contact may be during direct patient care or when handling items used by or for patients. **Wearing gloves does not remove the need for thorough hand washing once gloves have been removed.**

- Patients with, or suspected of having, airborne infections or infections which may lead to contamination of the environment, e.g. MRSA, infectious diarrhoea, must be nursed in a single side room whilst in the hospice. A sign isolation procedures are in force must be displayed on the door as detailed in the current policy.

- Both in the hospice and the community it is the responsibility of the person in charge of the patient’s care to warn others of the risk of infection and the required protective clothing. Patient’s diagnoses must be disclosed. This responsibility may be delegated to the nurse in charge of the unit or responsible for the patient’s care.

5.3 Hand washing

Hand washing is the single most effective method of preventing the spread of infection.

- Hands are important sites for contamination by transient organisms, and have resident organisms deep seated in the epidermis.

- The purpose of hand washing is to remove soilage and loose skin scales, to remove or destroy transient organisms, and, in the case of an antiseptic hand wash, to reduce the number of resident organisms.

- A social hand wash, using liquid soap and water will effectively remove transient organisms. Using soap and water, wash hands for 30-45 seconds, thoroughly rinse and then dry hands. This is required before
    - Handling or eating food
    - Having contact (other than social contact) with a patient
    - Prior to non-aseptic procedure (even if gloves are to be worn).
- It is required after
    - Using the toilet or helping a patient use the toilet
    - Completing a procedure (even if gloves were worn)
    - Alcohol hand gel is a very effective solution for decontamination of *clean* hands. It is not a substitute for soap and water in removing soilage, and can be used frequently between social contact with patients if hand washing is not carried out.
    - Resident florae are not easily removed by a single hand wash and require hygienic hand washing.
    - Hygienic hand washing. Using an antiseptic detergent or alcohol hand rub, (Hibiscrub/Betadine). Wet hands and apply solution, wash hands and wrists for 1-3 minutes. Thoroughly rinse and dry hands. Special care must be given to include tips of fingers, and thumb, usually neglected in the hand washing procedure. This will remove transient organisms and some resident organisms. This is required:
        - Where there is a high probability of microbial contamination e.g. after contact with a patient in isolation
    - Surgical hand washing/cleansing using an antiseptic detergent or an alcohol rub (Hibiscrub/Betadine), washing thoroughly (up to the elbows) for up to 2 minutes, using a sterile nail brush to remove stubborn ingrained dirt, rinsing thoroughly and drying on a sterile paper towel, is required Prior to any aseptic procedure, e.g. chest aspiration or drainage of ascites
        - Prior to any aseptic procedure e.g. a dressing

5.4 Hand Care

- Nails must be short clean and smooth. No nail varnish or false nails are to be worn. (See Uniform/Dress at work policy)

- Jewellery, apart from one plain ring (e.g. wedding bands) and stud earrings should not be worn. (See Uniform/Dress at work policy)
- Cracked skin may become colonised with potentially pathogenic organisms, so sore chapped skin, eczema or psoriasis must be treated.
- Cuts and abrasions must be covered with a waterproof dressing of appropriate colour.
- Hand cream, preferably water based should be used to avoid drying and cracking of skin. This should not be shared between staff.
- Gloves – disposable, single use powdered/non powdered sterile/non-sterile latex free, are available and must be used when indicated.

Hands must be washed:

- **Before performing invasive procedures**
- **Before caring for susceptible patients**
- **Before and after touching wounds**
- **After situations where microbial contamination of hands is likely to have occurred**
- **After touching inanimate sources that are likely to be contaminated**
- **After taking care of an infected patient**
- **Between contacts with different patients in high risk units**
- **Before handling food or feeding a patient**
- **As soon as they are soiled**
- **After using the lavatory**
- **Before a meal**

5.4.1 Community Guidelines for routine hand decontamination

Aqueous antiseptic solutions or alcohol hand rubs/gels may be used as an alternative in place of soap and water if the hands are visibly clean. They are particularly useful when hand washing may eb inconvenient, e.g. opening dressing packs, in the midst routine care and when in patients homes.

In some circumstances an application of alcohol hand rub, rubbed in until evaporated, will help to remove any potential pathogens that might be left after hand washing. These include:

- Before giving injections
- After contact with known or suspected infected body fluids

Although emollients are now standard ingredients in most liquids soaps and alcohol rubs, some individuals continue to experience soreness or sensitisation. Rinsing of the hands before and after washing will reduce this, and the use of hand cream may help to protect the skin.

Communal containers (pots & tubes) must not be used because the contents become contaminated; use pump-action container or individual tube. Hand creams must be compatible with the hand washing agent.

5.5 Disinfection & Sterilization*

The risk to the patient should be assessed and each item used should be categorised as below. The appropriate method of disinfection or sterilisation* should then be applied.

Risk to patient/client	Application	Recommendation
HIGH	Items in close contact with break in the skin or mucous membranes or introduced into a sterile body area, e.g. surgical instruments, needles	Sterilise*
INTERMEDIATE	Items in contact with intact skin, mucous membranes or body fluids, particularly after use on infected patients or prior to use for highly susceptible patients e.g. ear piece from auroscope	Sterilise* or disinfect
LOW	Items in contact with healthy skin or mucous membranes or not in contact with patient, e.g. wash bowl	Clean

*Sterilization is by heat or chemicals is not available at Willen Hospice. Contact HSDU at MKGH for advice before embarking on any procedure where this may subsequently be required.

- Before buying new equipment for patient care, check the methods for cleaning, sterilising or disinfecting with supplier or manufacturer. If necessary seek advice from the MKGH infection control team.

- If an item requires decontamination before service and repair, then this must be carried out appropriately and signed certificate must accompany the item. These are available from the IPUNM [2]

- Items that cannot be decontaminated prior to service or repair must be labelled as such and the department/company contacted.

- Single Use Items - Items that are labelled as single use disposable items **must** be disposed of after use. Items that are labelled as single use patient use may be used on the same patient providing they have been adequately decontaminated as defined above between uses. Such items have a limited life span and should be disposed of according to manufacturer's instructions.

Methods of Disinfection

Disinfection is a treatment causing reduction in the numbers of micro-organisms (usually excluding spores) to a safe or relatively safe level. Heat, cleaning or chemicals can achieve this.

HEAT*	Preferable method e.g. pasteurisation or boiling
CLEANING	Removes a high proportion of contaminating micro-organisms if done correctly. **The value of cleaning in disinfection is generally underestimated.**
CHEMIICAL SOLUTIONS#	Requires careful monitoring. Different disinfectants kill different groups of micro-organisms. Organic matter inactivates most. Some interact with either disinfectants or detergents e.g. soap inactivates chlorhexidine. Some may sensitise skin (Clearsol); others will corrode metals (Precept).

*Heat is not available at Willen Hospice. Seek advice from HSDU or Infection control team at MKGH.
#Chemical solutions – limited range for use at Willen; follow COSHH guidelines.

[2] In Patient unit Nurse Manager

5.5 Exit cleaning of Infected room or environment

Final cleaning of a room and or environment once a patient has been discharged or transferred.

1. Nursing staff will clear room of debris and bag all linen within the room according to hospice policy
2. Hospice Housekeeping staff to take down curtains and arrange for cleaning
3. Housekeeping staff will perform a high clean and a low clean wearing gloves, apron and goggles

High Clean

The high clean includes all surfaces that cannot be reached from standing on the floor. The following should be cleaned with hot water and neutral detergent:-

- Window and door frames
- All ledges & tops of cupboards
- Curtain tracking

Wall washing not necessary is not necessary unless obviously contaminated.

Low Clean

As soon as the high clean has been done, proceed with a low clean using hot water and neutral detergent. This will include:-

- All lower surfaces
- Windowsills
- Radiators
- Lower horizontal surfaces
- Bed base and mattress – the mattress should be cleaned both sides plus the complete bed frame
- Locker
- Chair

As soon as the above are clean and dry, the high clean and low clean need repeating using a chlorinated disinfectant, e.g. Actichlor.
Chlorinated disinfectants are skin irritant – wear protection for skin, clothes and eyes
Dilute as per instructions –See COSHH warnings
On completion, the following should be done inside the room:
Put plastic apron and gloves into a yellow clinical waste bag; wash and dry hands; place used hand towels in yellow clinical waste bag; secure waste bag; leave room and dispose of yellow clinical waste bag; wash and dry hands.
Once dry the room can be used.

5.7 Safe handling of laundry

- Used laundry such as sheets and pillow cases (not hospice property) that are not fouled or from an isolated patient are put into white terylene bags and sent off site via the hospice laundry on the lower floor. Bags must not be over filled.

- Other items for laundry such as towels wash cloths, and duvet covers are laundered on site. These are placed in the blue linen bags and taken to the hospice laundry on the lower floor.

- For fouled laundry – (sheets and pillowcases) place in red soluble bag and then into red outer laundry bag for dispatch to outside laundry; hospice items should be placed in a red soluble bag and taken direct to the hospice laundry for washing. Patient's own items where fouled should also be sent to hospice laundry labelled with name and in a red soluble bag.

5.8 Safe handling of body fluid spills

- Use the body spill kit kept in Treatment Room 1. Disposable aprons and gloves must always be used when handling blood and body fluids. The use of goggles is advised.

- Spills in ward/patient rooms are the responsibility of the member of staff caring for the patient at that time. They must arrange for the prompt decontamination and clearing of the spill.

- In the event of a spill being discovered in other areas the person in charge must be informed and they will be responsible for arranging the prompt decontamination and clearing of the spill.

- Details for decontamination of a spill are available in the MKGH infection control policy.

- When skin contamination has occurred immediately wash blood or body fluids off using running water and soap. Dry well. Complete critical incident form and Report incident to manager. A waterproof dressing must cover all cuts and abrasions.

- See section 5.7 regarding care of fouled linen.

- Reusable equipment such as slings for hoists should decontaminated according to manufacturers instructions. Disposable items should be used wherever possible.

Pressure relieving mattresses must be washed with hot water and detergent, rinsed and dried. If further decontamination is required Use manufacturer's instructions or seek advice from the infection control team at MKGH.

5.9 Disposal of clinical waste

- Clinical waste is disposed of by removal off-site by contract with MKGH. The two yellow portable bins are kept beside the administration block. The filled bins are removed and replaced three times per week.

- Clinical waste is segregated from ordinary waste by being put in yellow plastic bags that include the makings "For incineration". The nursing staff is responsible for putting filled bags into the portable bins.

- Clinical waste from the hospice includes:
    - soiled surgical dressings
    - swabs and all other contaminated waste from clinical areas
    - material from cases of infectious diseases
    - discarded syringes, needles, cartridges broken glass and any other sharp instruments (see section 5.9 for details of safe handling and disposal)
    - used disposable bed pan liners, urine containers, incontinence pads and stoma bags, suction liners

        - Ordinary waste is put into black plastic bags that are dealt with by the hospice housekeeping team.
        - The contents of disposable bed pan liners, urine containers, and stoma bags can be disposed of via the sluices or purpose built disposal units into the sewer system.
        - Drainage bags and incontinence pads must not be put down sluices or toilets; they must be disposed of via yellow clinical waste bags; patients will need to be informed of this where they manage their own stomas for example.
        - All clinical waste should be placed in yellow bags at point of generation, and bags sealed when no more than ¾ full.
        - The appropriate plastic ties must be used to seal each bag before transfer to the portable bin.
        - Further information is available from the infection control nurse at the hospice, the MKGH infection control policy or the MKGH Infection control team.

5.9 5.10 Safe use and Disposal of Sharps

All healthcare workers are responsible for the safe disposal of the sharps they use. Sharps boxes used must be approved, conforming to DoH specification UN3291

- Sharps boxes must be conveniently located to preclude injury to patients visitors and healthcare workers e.g. the sluice and clinical room
- In cases of isolation Individual sharps boxes must be available in patient's rooms.
- Sharps boxes must be correctly assembled according to manufacturers instructions.
- Sharps boxes must be disposed of when ¾ full or at least every seven days.
- Before disposal sharps boxes must be closed and locked and labelled with hospice details.
- In cases of know infectious patients sharps boxes must be disposed of daily.
- Sharps boxes made ready for disposal must be placed in the portable clinical waste bins ready for removal.
- “Sharps” must be carried in a tray or container that prevents injury to the carrier
- Used sharps must not be carried about unnecessarily
- Needles must not be resheathed by hand, bent or broken prior to disposal
- Used needles must not be removed from the syringe unless absolutely necessary, e.g. when decanting blood into a specimen bottle. The syringe and needle must be disposed of as one unit. Do not use the needle-removing device fitted to some sharps boxes.
- Other sharps such as scalpel blades and suture needles can be placed on or into designated disarmers prior to disposal into a sharps bin
- All used sharps must be discarded avoiding direct hand contact with the contaminated part.
- Inoculation injury – if an injury results from a used sharp, bleeding must be encouraged, the area washed under running water and a waterproof dressing applied. The injury must be reported to the departmental manager and occupational health department; an accident form for staff must also be completed. (See section 7.1)

5.11 Food handling at ward level

- This guidance refers to food provided by the hospice for patient consumption. The Hospice cannot accept responsibility for the safety of food purchased or brought in by patients, relatives or visitors.
- Perishable foods should be stored in the refrigerator.
- Keep food covered
- Food preparation by nursing staff should be confined to preparation of toast or microwave food, prepared by staff that has attended appropriate food handling training.
- Hands must always be washed before handling food
- Protective clothing must be changed, e.g. use a pink plastic apron when handling food
- Protective clothing provided, e.g. gloves must be worn.
- Food must not be disposed of at bedside level. It should be returned to the kitchen for disposal via waste disposal system.
- Members of staff with the following conditions must not handle or prepare food – Diarrhoea and /or vomiting, obvious skin infections, boils, etc.

5.12Clinical Decontamination

- Appropriate protective clothing must be worn to prevent contamination of person or clothing. This includes wearing gloves and aprons or gowns and masks appropriate to the task.
- Bed frames, chair and other furniture surfaces should be washed with detergent and warm water.
- Plastic mattress and pillow covers to be washed with detergent and warm water.
- Commode surfaces to be washed with detergent and warm water, rinsed and dried when soiled and inspected weekly to ensure they are clean.
- Blood and body fluid splashes on floors and walls should be cleaned off immediately using disposable cloth, hot water and detergent, and the cleaning cloth disposed of via a yellow clinical waste bag.

5.13 Collection, packaging, handling & delivery of laboratory specimens

- Specimens must be collected using universal precautions as outlined in section 5.2.
- The person collecting the specimen, who must also complete the appropriate forms, must complete the patient details on containers for specimens.
- The specimens must be put into the appropriate plastic bag and sealed as per instructions.
- Where there is a potential or known risk of infection use should be made of “Danger of Infection” stickers to alert hospice and laboratory staff.
- The specimens should be transported to MKGH as quickly as possible after they are collected. Ideally this should be done in the mornings.
- Specimens for transport must be carried in the hospice box identified for this purpose.
- The hospice driver should not be expected to handle the specimens themselves until opening the box at MKGH and giving the specimens to the pathology receptionist.

5.14Antimicrobial prescribing

This must be done following local guidance on use of antibiotics and other antimicrobial agents.

Where advice is required contact the Consultant Microbiologist on call at MKGH.

6:0 Disease specific policies

If detailed advice is not given here consult the MKGH Infection Control policy or contact the MKGH Infection Control team for advice in specific cases.

6.1 **MRSA (Methicillin Resistant Staphylococcus Aureus)** Staphylococcus aureus is one of the most commonly isolated bacterial pathogens. 20-30% of individuals carries Staphylococcus aureus in their nose and on moist areas of the skin particularly the perineal area. Multiple antibiotic resistances may occur both in hospital and the community. MKGH infection control team regard Willen Hospice as a 'low risk' area.

6.1.1 Normal skin and mucous membrane from an effective mechanical barrier against local tissue infection. MRSA may be spread by skin scale dispersal by airborne route, indirectly on equipment, or by direct person-to –person contact. The primary cause of spread is by **UNWASHED HANDS.**

6.1.2 Known carriers should avoid contact with people with open cuts or wounds

6.1.3 Universal infection control precautions must be taken at all times by staff.

6.1.4 Day Hospice patients need not be restricted or isolated.

6.1.5 Hospice in-patients should be preferably be nursed in a single room.

6.1.6 Patients to be transferred into the hospice from MKGH or another hospital must have been swabbed for MRSA before transfer. Where results are not know prior to transfer the patients will be nursed in side room and isolated until the results of the swabs are confirmed.

6.1.7 **Management principles for MRSA**

6.1.8 Patients who have a MRSA wound infection should be treated and the wound covered securely with an occlusive dressing. Any procedure that might result in increased skin scale dispersal should be performed away from other patients, e.g. washing, dressing, wound management. Inpatient's dressings should be changed in their own room. The patient should be isolated if they feel unwell.

6.1.9 Patients with MRSA should be encouraged to maintain good personal hygiene. Baths used by these patients must be thoroughly cleaned after use with normal cleaning fluid. Commodes must be cleaned after each use by an MRSA patient. If the patient has open lesions consider allocating one commode for use only by this patient.

6.1.10 A single room is the preferred place for nursing an MRSA patient. Plastic apron and gloves must be worn, and hands washed using a chlorhexidine or povidone iodine liquid. Alcohol hand rub can also be used. Visitors only need protective clothing if they are going to be directly participating in delivering care, otherwise hand washing only on leaving. Equipment such as lifting slings should be allocated to that patient only and thoroughly cleaned after use has ceased. Bed linen can be changed and treated as normal linen. Clinical waste is disposed of in a yellow bag as usual. General cleaning can be via a daily damp dust and mop or vacuum of the floor as appropriate. Terminal cleaning of the room must involve a change of curtains and a thorough clean by the hospice housekeeping team. No special precautions are required in the event of the death of an MRSA patient.

6.1.11 The nurse responsible for arranging the discharge of a patient with MRSA must alert all healthcare professionals who will visit the patient at home. The ambulance service will also need alerting if they are providing transport. Patients being transferred to the hospital must be warned that they might be swabbed for MRSA at the hospital. Where a patient is due to transfer to a nursing home, the home must be informed that the patient has MRSA.

6.1.12 Advice on the treatment of MRSA and action to take when staff is found to have MRSA is available from the MKGH Infection control manual or MKGH infection control team.

6.2 General management of HIV positive patients

6.2.1 Risk of infection – HIV is found in most body fluids, but blood, semen, vaginal fluid and breast milk are known to be sources of the virus.

6.2.2 In the healthcare setting the virus can gain entry through no intact skin, e.g. cuts, abrasions and exfoliative conditions, through mucous membranes and as a result of inoculation injury.

6.2.3 It is the responsibility of the admitting physician to ensure that members of staff involved in the care, investigation or treatment of the patient are aware of the risk of infection.

6.2.4 For healthcare workers the most likely route of exposure to HIV is from inoculation injuries such as needlestick, contamination of an abrasion, spillage into the eye or mouth with blood or other body fluids likely to contain the virus. Special care should be taken to avoid such accidents.

6.2.5 In the event of such an accident, the site should be washed immediately and thoroughly with soap and water while encouraging bleeding. The Head of Department and MKGH Occupational Heath dept be informed. An

accident form should be completed and a record entered in the accident book. Consult MKGH Infection Control team for further information.

6.2.6 Infection control precautions – in line with hospice policy protective clothing e.g. latex free gloves, and disposable aprons must be worn when handling body fluids and items contaminated with such fluids.

6.2.7 Staff should ensure all cuts abrasions, etc are covered with an appropriately coloured waterproof dressing.

6.2.8 Isolation – only necessary under these circumstances –

Uncontrolled bleeding/diarrhoea
Concomitant communicable infections e.g. open pulmonary TB
To prevent opportunistic infection (protective isolation)
To help management of seriously ill patient
If the patient requests or requires privacy, isolation in a single room with own toilet/bathroom facilities is preferred.

6.2.9 Clinical waste –

Waste contaminated by body fluids should be disposed of via yellow clinical waste sacks

Patient should have their own sharps box kept safely in their room

Only linen contaminated with body fluids need to be placed in a red soluble bag and then a red terylene bag.

All other linen may be treated as soiled linen (placed into white terylene bags)

6.2.10 Crockery & cutlery –

Do not spread infection, unless there is contamination with blood, and should be washed by the normal kitchen routine.

6.3 Tuberculosis

6.3.1 Tuberculosis is caused by Mycobacterium tuberculosis. There are many other atypical mycobacterium, which while causing infection are not communicable. It is not possible to identify the species when detecting acid fast bacilli. Cultures of mycobacterium can take weeks therefore precise identification of the bacterium can take up to two months.

6.3.2 In all cases of acid fast bacilli present in sputum (smear positive) it is assumed to be Mycobacterium tuberculosis until proven otherwise. Isolation of the patient will therefore, be instigated.

6.3.3 Patients who are smear positive that is with enough organisms in the sputum to be seen on direct examination are infectious.

6.3.4 These patients are considered non-infectious after two weeks of appropriate anti-biotic therapy and show signs of clinical improvement. They remain so if continuing regular chemotherapy. Organisms may still be present in the sputum during this time.

6.3.5 Those who smear negative for three sputum samples are not infectious.

6.3.6 Patients with tuberculosis disease in sites other than lungs are not infectious.

6.3.7 Hospice patients who are smear positive must be nursed in a side room for at least two weeks from the onset of treatment. Staff whose TB immunity has been assessed as adequate by Occupational Health at MKGH should care for these patients.

6.3.8 Staff do not need to wear masks for most patients with TB. There are dust/mite masks available in the hospice and from NHS supplies for staff to use in case of suspected multi-drug resistant TB and cases where sputum inducing procedures increases risk of contact with the organism.

6.3.9 Normal crockery and cutlery can be used and cleaned as usual.

6.3.10 No special precautions are required for bed linen unless contaminated with sputum and this must then be treated as infectious linen (see 5.6).

6.3.11 Disposal of infected material e.g. sputum pots and tissues must be via a yellow clinical waste bag (see 5.8).

6.3.12 The hospice expects gloves and aprons to be worn whenever contact with body fluids is likely.

6.3.13 Visitors and relatives do not normally need to take special precautions though they must be made aware of the risk. Visitors who have had no contact in the preceding 12 weeks should be advised against visiting to limit contacts.

6.3.14 Infectious patients suspected or know to have Multi Drug Resistant Tuberculosis (MDR-TB) are more serious because of the complexities of the required treatment regimens.

6.3.15 Where MDR-TB is suspected contact the Infection Control Team and Consultant Microbiologist at MKGH as they require specialised accommodation treatment and care.

6.3.16 Where MDR-TB is known prior to admission the patient must not be transferred here until deemed safe by the local Infection Control Team and the hospice medical director.

6.3.17 Follow up and contact tracing is performed in Milton Keynes by Health Visitor TB liaison; contact via MKGH infection control team or MK PCT.

6.3.18 Following the death of a patient with tuberculosis the body must be treated as infectious and placed in a cadaver bag. The undertakers must be informed in advance of the risk.

6.4 Risks with Human Transmissable Spongiform Encephalopathy (TSE) including New Variant Creutzfeldt Jacob Disease (nvCJD)

6.4.1 Human Transmissible Spongiform Encephalopathy (TSE) is a group of neuro-degenerative diseases resulting in dementia, incapacitation and death. Creutzfeldt-Jacob (CJD) and new variant Creutzfeldt-Jacob (nvCJD) are part of this group.

6.4.2 TSE is a familial disease that can also be transmitted through iatrogenic routes, contaminated medical instruments, and inoculation via skin and mucous membranes and exceptionally through ingestion. Patients who have received human dura mater and human pituitary hormones such as human growth hormone are at risk. Cases have also been reported in patients following corneal implants.

6.4.3 Information regarding TSE is constantly being updated and this guidance should be followed whilst bearing in mind that a risk assessment on each patient know, suspected or at risk of TSE should be carried out in line with the most up to date information available before treatment is carried out.

6.4.4 Patients may be nursed in open wards with no added precautions to those in use for clinical waste, laundry and protective clothing for dealing with body fluids.

6.4.5 No added precautions are necessary for non-invasive investigations or treatment in other departments.

6.4.6 The hospice does not expect to carry out any invasive procedures on patients' known, suspected or at risk of TSE. If such procedures are required they must be carried out in theatres ideally so the patient will require transfer to MKGH or other hospital.

6.4.7 Disposable equipment should be used for procedures and disposed of via incineration in the clinical waste system.

6.4.8 In the case of death the body must be placed in a cadaver bag and the undertakers informed of the risk of infection. Currently the individual may be buried or cremated as they wish.

6.4.9 All other enquiries relating to TSE should be directed to MKGH infection control team in the first instance.

7:0 Staff Policies

7.1 Staff Health

- All staff and volunteers have responsibility for their own health. If an employee becomes concerned about a health matter at work they must inform their line manager.

7.2 Sharps/Needlestick injury

- Protective clothing must be worn for clinical procedures in line with the policy on universal precautions (5.2).
- Never re-sheath needles
- Always dispose of sharps carefully and as soon as possible
- Treat all blood and body fluid spills as potentially infectious. Contact Occupational Health at MKGH if skin problems arise.

Action following a bite or a sharp/needlestick injury –

- Squeeze the injured site to promote bleeding and to remove contaminated substances. Wash the injury in warm soapy water, dry well and apply a waterproof dressing to protect the wound. If the injury is on the hands and the site difficult to cover adequately gloves should be worn.

7.3 Staff Immunization

- All clinical staff must ensure their immunisations against Hepatitis B tetanus and BCG are up to date and produce written evidence to verify this or sign a written disclaimer.

- All volunteers working in the clinical area are encouraged to be currently immunised against Hepatitis B and tetanus especially those performing clinical tasks.

7.4 Staff exclusion in cases of infectious diseases

- Any staff member who contracts or knows they have been in contact with a significant infectious disease including those listed in Appendix 1 must inform their line manager and remain off work, if necessary as advised by their own GP

7.5 Notification of infectious and other diseases

All medical practitioners are legally obliged to notify the Consultant in Communicable Disease Control in every case of the following diseases:

- Acute Encephalitis
- Acute Poliomyelitis*
- Anthrax*
- Cholera*
- Diphtheria*
- Dysentery (Amoebic or Bacillary)*
- Food poisoning or suspected food poisoning
- Leprosy
- Leptospirosis
- Malaria
- Measles
- Meningitis*
- Meningococcal Septicaemia (without meningitis)*
- Mumps
- Opthalmia Neonatorum
- Paratyphoid Fever*
- Plague*
- Rabies*
- Relapsing Fever*
- Rubella
- Scarlet Fever
- Smallpox*
- Tetanus
- Tuberculosis (All forms)
- Typhoid Fever*
- Typhus

- Viral Haemorrhagic Fever*
- Viral Hepatitis
- Whooping Cough
- Yellow Fever

* Urgent Notification (by telephone if necessary)

- Other diseases with possible public health significance e.g. legionella, must also be notified by telephone as soon as possible.

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7.6 Staff Training

- The Hospice will have a nominated member of nursing staff who will be a link nurse with MKGH Infection Control team.
- The Infection Control link nurse will disseminate training and information to hospice staff.
- MKGH Infection Control team will be invited to visit the Hospice to audit practices and give staff advice a minimum of twice per year.
- Training requirements of staff will be identified via the appraisal and risk assessment systems.

8.0 Major Outbreak Plan

- The clinical staff of the hospice must advise the Infection control team at MKGH of any suspected outbreak:

  - Which has caused more than one death

  - Three or more admissions over a 48 hour period with acute infections of a related nature

  - Three or more suspected cases of food poisoning – use questionnaires for patients and staff available on the hospice intranet

  - Or any confirmed case of viral haemorrhagic fever (e.g. Lassa Fever) or Diphtheria.

    - The Hospice Medical Director (or doctor on call in their absence) and Manager on call must be informed immediately.

- The Hospice Medical Director will discuss with the MKGH Infection Control team to see if the outbreak requires institution of the Major Outbreak plan.

    - When an outbreak is declared the hospice will follow the guidance laid down in the MKGH Infection Control policy for management of a major outbreak.

- The Hospice will appoint an Outbreak Control Committee made up of

    - Chief Executive (Chair)
    - Medical Director
    - director of Nursing and Patients Services
    - Inpatient Unit Nurse Manager
    -
    - Members of MKGH Infection Control Team as required
    - Hospice Infection Control link nurse

- The Chair will conduct the meeting of the committee as per the guidance laid down in MKGH Infection Control policy.

- The Hospice will manage the outbreak following the guidance laid down in the MKGH Infection Control policy.

Appendix 1
Staff & Volunteers Exclusion from work

The hospice deals with vulnerable and ill people who need protection from staff who have infectious diseases. This will be done by exclusion of staff based on the guidance in the tables below.

DISEASE	INFECTIVE PERIOD	STAY OFF WORK CASE
Chicken pox	From 2 days before until the last of the lesions are dry	6 days from onset of last spot
Conjunctivitis	While purulent discharge is present	Until discharge stops
Cryptosporidium	Whilst has diarrhoea	Until 48 hours after first normal stool
Erythema Infectiosum (Slapped cheek syndrome)	4 days before until 4 days after onset of rash	Until clinically well
Gastro enteritis (inc. Salmonella & Shigellosis)	As long as organism is present in stools, but mainly while diarrhoea lasts	Until clinically well & 48 hours without diarrhoea or vomiting. CCDC may advise longer period of exclusion.
Glandular Fever	When symptomatic	Until clinically well
Giardia lambia	Whilst has diarrhoea	Until 48 hours after first normal stool
Hand, Foot and Mouth Disease	As long as active ulcers are present	1 week or until open lesions are healed
Hepatitis A	1 week before until 1 week after onset of jaundice	1 week after onset of jaundice
Human Immuno Deficiency Virus (HIV/AIDS)	For life	None
Measles	Up to 4 days before until 4 days after rash appears	4 days from onset of rash
Meningitis	Varies with organism	Until clinical recovery
Mumps	1 week before until 10 days after swelling appears	10 days after onset of rash
Rubella	1 week before until 5 days after onset of rash	5 from onset of rash
Streptococcal sore throat & Scarlet Fever	As long as organism is present in throat, usually up to 48 hours after antibiotic started	Until clinically improved (usually 48 hours after antibiotic started)

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DISEASE	INFECTIVE PERIOD	STAY OFF WORK CASE
Shingles	Until after the last of the lesions are dry	Until all lesions are dry – minimum 6 days from onset of rash
Tuberculosis	Depends on part infected. Patients with open TB usually become non-infectious after two weeks of treatment	IN case of open TB, until cleared by TB clinic. No exclusion necessary in other situations.
Threadworm	As long as case harbours the organism	None though requires treatment and very high standard of hand hygiene
Typhoid Fever	As long as case harbours the organism	Seek advice from the CCDC
Whooping cough	1 week before until 3 weeks after onset of cough (or 5 days after start of antibiotic treatment)	Until clinically well, though check with CCDC

SKIN DISEASES

Impetigo	As long as purulent lesions present	Until skin has healed
Head Lice	As long as lice or live eggs are present	Exclude until treated
Ringworm 1. Tinea Capitis (Head)	As long as active lesions are present	Exclusion not always necessary unless an epidemic is suspected
2. Tinea Corporis (Body)	As long as active lesions are present	None
3. Tinea Pedis (Athletes foot)	As long as active lesions are present	None
Scabies	Until mites and eggs have been destroyed	If a single case until treatment is completed; if whole unit is being treated no sick leave required
Verrucae (Plantar warts)	As long as wart is present	None (warts should be covered with waterproof dressing for swimming and barefoot activities

CCDC = Consultant in Communicable Disease Control