

POLICY FOR HEALTH, SAFETY AND WELFARE

PART C ARRANGEMENTS

Section 17

Infection Control

PART C
SECTION 17
INFECTION CONTROL

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1.0 INTRODUCTION

- 1.1 Under the Health and Safety at Work Etc. Act 1974, the London Borough of Barnet (the council) has a duty to ensure, so far as is reasonably practicable, the health, safety and welfare of staff. The council also has a duty to ensure, so far as is reasonably practicable, other persons are not placed at risk by its undertakings.
- 1.2 As part of the above duties, the council will, so far as is reasonably practicable, minimise any risk of infection to staff and others by ensuring sound infection control practices.
- 1.3 This section outlines the arrangements which are to be made throughout the council to reduce cross infection. These arrangements are to form the basis for service safe working procedures.

2.0 RESPONSIBILITIES

2.1 Directors

Directors must ensure that the requirements of this arrangement are implemented throughout their services and that monitoring arrangements are put in place to ensure the risks are being managed and reviewed

2.2 Heads of Service

Heads of Service have a duty to ensure that there are appropriate Infection Control Procedures, to ensure compliance with Health and Safety legislation and this section.

Services must be able to demonstrate, via Risk Assessment and/or Control of Substances Hazardous to Health Assessments, that where there is a risk of cross infection, systems and procedures have been introduced to remove or, where this is not possible, minimise the risk of cross infection.

Services must ensure staff are made aware of relevant cross infection assessments and receive appropriate information, instruction, training and supervision to enable them to work safely.

Directors must establish monitoring systems to ensure services Infection Control Procedures continue to function correctly. When drafting Specific Infection Control Procedures, managers should consider:-

- (i) Provision and maintenance of protective clothing and equipment.
- (ii) Provision and maintenance of suitable handwashing facilities which are separate from waste disposal and food preparation facilities.
- (iii) Appropriate waste disposal equipment.
- (iv) Facilities/equipment to deal with spillage.

- (v) Establishing Safe Systems for the collection, disposal and storage of clinical waste.
- (vi) Provision and maintenance of cleaning and disinfection equipment.
- (viii) Establishing systems for hazard reporting.

2.2 Staff

Employees have a duty to take reasonable care of themselves and others who may be affected by their acts or omissions.

They are required to comply with this policy local arrangements and procedures on Infection Control.

Employees are also required to report to their Line Manager any health and safety hazards or deficiencies in the Infection Control Arrangements they may have identified.

3.0 **GENERAL PRECAUTIONS TO PREVENT/CONTROL THE RISK OF INFECTION.**

3.1 Instructing Employees on Modes of Transfer

Knowledge of the different routes of transmission of infection enables sensible precautions to be taken to prevent cross infection.

Modes of Transmission are:

- Direct Contact

Direct physical contact with a source of infection i.e. contact with infected blood/body fluids or infected individuals.

- Indirect Contact

Indirect contact may take place via a third party for example when carer's hands are dirty. Other media are inanimate objects such as contaminated clothing, linen, seats and air-rings.

- Airborne

Aerosol droplets. Coughing, sneezing, talking and certain respiratory treatment may generate droplets.

- Inoculation

Direct inoculation of bacteria into cuts or grazes or inoculation of blood/body fluids on sharp instruments or needles.

- Vector-Borne

Infection spread by animals or insects e.g. rabies, malaria and leptospirosis.

- Oral

Consumption of contaminated food and drink. Alternatively contaminated hands or objects being placed into the mouth e.g. sucking fingers, pens, etc.

3.2 Universal Precautions

The following universal precautions can reduce the risk of infection. It is not necessary for an employee to know the infection of others for these precautions to be effective.

3.2.1. Apply good basic hygiene practices with regular handwashing.

Hands should be thoroughly washed:

- (i) On arrival on duty and end of a span of duty.
- (ii) After using the toilet or administering first aid.
- (iii) Before handling food and drink or smoking.
- (iv) Before and after performing personal care tasks.
- (v) After handling soiled or contaminated equipment, linen or rubbish.
- (vi) Before and after routine use of gloves.
- (vii) After any potential contact with body secretions or infected materials.

3.2.2. Cover existing wounds or skin lesions with waterproof dressings.

3.2.3. Avoid invasive procedures if suffering from chronic skin lesions on hands.

3.2.4. Avoid contamination by appropriate use of protective clothing.

3.2.5. Protect eyes, mouth and nose from blood where a risk of splashing has been identified.

3.2.6. Prevent puncture wounds, cuts and abrasions in the presence of body fluids.

3.2.7. Avoid usage of sharps wherever possible.

3.2.8. Institute procedures for sterilisation and disinfection of instruments and equipment.

3.2.9. Clear any spillage of blood or other body fluids promptly, and disinfect surfaces.

3.2.10. Institute a procedure for the safe disposal of contaminated waste.

3.3 Handwashing

Hands are commonly involved in the transfer of bacteria. Thorough handwashing is the single most important message in infection control. If hands are properly washed soon after picking up potentially infective bacteria, these transient bacteria will be easily removed.

3.3.1. The following items are necessary to ensure adequate handwashing:

- (i) Accessible hand wash sink separate from sinks used for cleaning equipment or food preparation.
- (ii) Elbow or foot operated taps are desirable.
- (iii) Liquid soap (bar soaps harbour bacteria if left damp).
- (iv) Disposable hand paper towels or warm air hand dryers (re-usable towels become contaminated).
- (v) Handwash posters indicating the correct handwashing technique are helpful to both teach and remind each individual of its importance.

(Please see Appendix E for Handwashing Procedure)

3.4 Personal Protective Clothing and Clinical Waste

All members of staff should wear appropriate "CE marked" protective clothing when handling body fluids or potentially contaminated materials.

Adequate supplies of the following may be required depending on risk assessment:

Non sterile latex/vinyl gloves

Sterile latex gloves

General household gloves for cleaning equipment

Single use disposable plastic aprons

Plastic protective goggles, spectacles or visors

3.4.1. Disposable Gloves

Disposable Gloves should be worn when there is a risk of infection, particularly when dealing with body fluids. Cross contamination between staff or others is minimised by wearing gloves.

Sterile latex/vinyl gloves should be used when there is a risk of transmitting infections through open wounds or broken skin e.g. cleaning or dressing abrasions etc.

- 3.4.2 Non-sterile latex/vinyl gloves should be used for procedures involving contact with body fluids e.g. washing or changing incontinent clients or changing urine drainage bags.

Disposable Gloves must be discarded after:-

- (i) every single use. (Disposable Gloves must not be washed and reused).
- (ii) direct contact with a person's body fluids.

3.5 Disposable Plastic Aprons

- 3.5.1. Disposable plastic aprons should be worn when:-

- (i) taking care of clients, if clothes or bed linen are likely to be soiled.
- (ii) there is a risk of splashing of body fluids.

Aprons must be disposed of after every single use.

3.6 Eye and Face Protection

Goggles or spectacles are only necessary when there is a risk of splashing body fluids.

3.7 Maintenance and Replacement of Personal Protective Equipment

Disposable Personal Protective Equipment (PPE) must be disposed of after use, but for reusable PPE:

- (i) An effective system of maintenance is essential to make sure the equipment continues to provide the degree of protection for which it was designed. Maintenance is required under the Personal Protective Equipment Regulations and includes, where appropriate, cleaning, disinfection, examination, replacement, repair and testing. Service Areas are responsible for ensuring that maintenance is carried out, and those written maintenance procedures are produced, in accordance with advice from PPE manufacturers. These procedures, together with any records of tests and examinations, should be kept in a safe location.
- (ii) In addition, the Heads of Service should arrange for all relevant staff to be provided with a copy of the maintenance procedures, and instruct them to check their PPE before it is worn.
- (iii) All damaged PPE must be immediately disposed of and new PPE issued.

4.0 CONTROL OF BODY FLUID SPILLAGES

4.1 Wash hands before and after dealing with body fluid spillages.
(See Appendix E for instructions on hand washing).

4.2 Body Fluid Spillage: General Requirements

4.2.1. The following protective clothing and equipment must be available for staff use:

- A Disposable latex sterile and non-sterile latex gloves
- B Disposable plastic aprons
- C Eye and face protection when necessary
- D Hypochlorite or neat Milton
- E Paper towels
- F Yellow plastic bags

4.2.2. General Housekeeping

- A Wear disposable gloves and plastic aprons.
- B Clean up immediately.
- C Ventilate the area.
- D Splashes on skin or clothing should be washed off immediately with soap and water.
- E Because disinfectant and sodium hypochlorite may discolour carpets, spillage should be cleaned with warm soapy water or a germ killing carpet cleaner and dried.
- F If there is contaminated broken glass, use a scoop and dispose of in a sharps box.
- G Discard gloves, plastic aprons, and any disposable towels used for mopping up into a yellow bag and/ or a clinical waste bin.

4.3 Spillage of Body Fluids not visibly contaminated with blood

e.g. faeces, vomit, urine, sputum

- A Always wear disposable gloves and plastic disposable apron.
- B Use paper towels to soak up the spill, discard directly into a clinical waste bin or bag.
- C Clean contaminated area with Hypochlorite solution or hot water mixed with disinfectant, and dry thoroughly.

D Carpets and fabrics should be cleared with carpet cleaner and dried.

4.4 Blood Spills

A Wear disposable gloves and disposable plastic aprons.

B Ventilate by opening nearby windows completely. Cover spill with hypochlorite solution and leave for at least 2 minutes. If the spill is urine, and visibly contaminated with blood, use paper towels to soak up the liquid, then neat Milton or other suitable disinfectant.

C Clear up spillage with paper towels, or plastic scoop if available, and discard directly into a yellow bag or clinical waste bin.

D Wash contaminated area with hot water and detergent.

E Aprons, gloves, paper towels, etc., must be put into a yellow plastic bag/clinical waste bin for incineration.

4.5 Urine Spillage

A Do not use any chlorine releasing agents, e.g. Domestos, Titan, because chlorine gas may be released.

B If not visibly contaminated with blood, follow guidelines in 4.3.

C If visibly contaminated with blood, follow guidelines in 4.4.

5.0 **PREVENTION OF CROSS INFECTION IN THE WORKING ENVIRONMENT**

5.1 Requirements

All toilet and changing areas must be ventilated, adequately lit and specifically designed to facilitate cleaning.

5.1.1 For general hygiene purposes, separate gloves and cloths should be used for toilet, bathroom and kitchen cleaning. Colour coding these items will help to reduce the risk of accidental contamination.

5.2 Colour Coding

Blue or pink rubber gloves and cloths when working in the bathroom/toilets.

Yellow rubber gloves and cloths when working in the kitchen. Another colour should be used for general cleaning.

Rubber household gloves should be washed in hot soapy water after use and dried in a ventilated area. Gloves should be examined before use to ensure they remain in good condition. If punctured, torn or showing signs of deterioration, gloves must be discarded.

5.3 Daily Cleaning

Service areas must ensure that each building has an effective specification for daily cleaning. The specification should be designed to control dust and minimise the risk of cross infection.

6.0 **CLINICAL WASTE DISPOSAL**

6.1 The Disposal of Clinical Waste is governed by a number of pieces of legislation.

6.2 Clinical Waste is defined as:-

- (a) any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs and other pharmaceutical products, swabs or dressings, or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove to be hazardous to any person coming into contact with it; and
- (b) any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

Clinical waste is categorised by the Health and Safety Executive as follows:-

Group A

- (a) All human tissue, including blood, (whether infected or not), animal carcasses and tissue from veterinary centres, hospitals or laboratories, and all related swabs and dressings.
- (b) Waste materials, where the assessment indicates a risk to staff handling them, for example from infectious disease cases.
- (c) Soiled surgical dressings, swabs and all other soiled waste from treatment areas.

Group B

Discarded syringe needles, cartridges, broken glass and any other contaminated disposable sharp instruments or items.

Group C

Microbiological cultures and potentially infected waste from pathology departments (laboratory and post-mortem rooms) and other clinical or research laboratories.

Group D

Certain pharmaceutical and chemical wastes.

Group E

Items used to dispose of urine, faeces and other bodily secretions or excretions assessed as not falling within Group A. This includes used disposable bedpans or bedpan liners, incontinence pads, stoma bags and urine containers. It will be apparent that Group E contains items, which will usually present a low level of risk. However, as the actual risk cannot be readily demonstrated, items within this Group should be treated as clinical waste taking into account local circumstance. It should be recognised that while the risk from Group E items may be low, they will often be of an offensive nature and adequate steps should be taken, in line with the general duties under Health and Safety at Work etc. Act, for proper handling and disposal arrangements.

Other Group E items, not mentioned specifically are sanitary towels, tampons and nappies.

6.2.2. Disposal Of Group A Wastes

These wastes should be placed in a suitable yellow clinical waste storage bag, or clinical waste bin if only small quantities are generated.

Yellow storage bags should be suspended in pedal operated lidded holders and removed at least daily, or when three quarters full. Bags should be securely tied before removal, and deposited into a clinical waste storage container for collection by a Licensed Waste Operator.

Group A Wastes must be incinerated at an authorised site.

Yellow bag holders must be:-

- (a) suitable for size of bag.
- (b) fitted with a close fitting, foot pedal operated lid.
- (c) designed to facilitate easy cleaning, with smooth surfaces.
- (d) impermeable, and disinfected regularly inside and out.

Waste Storage Containers should be impervious, facilitate disinfection, pest resistant, and prevent unauthorised access.

THE CONTENTS OF A YELLOW BAG MUST NEVER BE EMPTIED LOOSE INTO THE CONTAINERS.

Clinical waste bins, like sanitary waste bins, are made of a ridged plastic but, unlike sanitary waste bins, they must be yellow and fitted with a foot pedal operated lid.

Waste Storage Containers should be emptied weekly and clinical waste bins collected every 30 days.

6.2.3 Disposal Of Group B Wastes

(e.g. discarded needles, body fluid contaminated broken glass etc)

Discarded sharps should be placed in a purpose designed container conforming to British Standard 7320 (1990). Sharps containers should be of a capacity adequate to hold items of all shapes and sizes arising, and should be sealed when three quarters full, or at intervals of one week, whichever comes sooner. DO NOT PRESS DOWN SHARPS IN A BOX TO CREATE MORE ROOM.

An anti-social development in recent years has been the casual discarding of syringes in Council void properties and public places. Service Areas who identify staff who may encounter syringe needles must produce a risk assessment that is communicated to the staff.

"Full" sharp boxes must be incinerated at a licensed site.

Control measures to be considered include:

- training staff in procedures identified by risk assessment, and to be vigilant.
- wearing of suitable heavy-duty gloves.
- use of disposable tongs
- use of sharps box.
- instructing staff on first aid treatment for needle stick injuries (Ref 7.0).

6.2.4 Disposal Of Group C Wastes

The Authority's Mortuary should comply with the Health Service Advisory Committee's publication "Safe Working and the Prevention of Infection in the Mortuary and Post-Mortem Room".

Schools should follow the advice issued by CLEAPSS School Science Service on the disposal of microorganisms, cultures and the cleaning of associated equipment.

6.2.5 Disposal of Group E Wastes

(i.e. items used to dispose of urine, faeces, other body secretions not contaminated with blood, for example, nappies and incontinence pads).

Urine, faeces and other bodily secretions or excretions should be discharged to sewer via the sluice, WC or a suitable disposal unit. If their containers are made totally from paper pulp then they can be macerated and discharged to sewer at the same time as their contents. If made of some other substances then they should be placed in a clinical waste bag or clinical waste bin (See Group A Wastes for details of clinical waste bag or bin systems).#

6.3 HANDLING A CLINICAL WASTE BAG OR BIN

6.3.1 Labelling

Each bag/bin should carry a clear label stating place of origin and contents.

6.3.2 Assessment

The Head of Service should ensure that a Manual Handling Assessment is made where there is a risk of an injury when handling a clinical waste bag or bin.

Where possible, yellow bags and clinical waste bins should be conveyed by a trolley designated for the purpose. The trolley should be designed to facilitate easy cleaning, with smooth surfaces, and be impermeable. There should be no harbourage for insects. The trolley should be disinfected at the end of each working day.

If staff are required to move clinical waste bags or bins by hand, they should be trained to:-

- a) wear appropriate protective clothing.
- b) check that storage bags are effectively sealed and/or lids secured at both the beginning and end of the movement.
- c) handle bags by the neck only.
- d) never throw or drop the bin or bag.
- e) keep the bag or bins away from the member of staff's truck. (The Manual Handling Regulations 1992 should be considered).
- f) know the procedures in case of accidental spillage and reporting hazards/accidents.
- g) ensure origin of waste is clearly marked on bag or bin.
- h) understand the problems relating to sharps and aerosol disposal. (Aerosol must not be incinerated).

6.4 STORAGE GENERAL REQUIREMENTS

6.4.1 Clinical waste should be stored in a designated area, prior to collection (e.g. Container). Signs should be considered.

6.4.2 Clinical waste must be kept separate from domestic waste at all times.

Colour coding should be adopted for waste:

- Black or grey bags/bins for normal household waste
- Yellow bags/bins for clinical waste

- Red plastic bags for infected linen
- Clear plastic for non-infected linen

6.4.3 Clinical waste storage containers/areas should be locked and inaccessible to unauthorised persons, and vermin.

6.4.4 A clinical waste storage container/area should be able to be disinfected, and sited on a well drained and impervious hard standing.

6.4.5 Clinical waste storage areas must not be near food preparation areas, and should be adequately lit.

6.5 TRANSFER OF WASTE BY CONTRACTOR TO SITE LICENSED TO RECEIVE CLINICAL WASTE

Heads of Service who are responsible for establishments "producing" clinical waste, which is transferred to an incineration site, must establish procedures to ensure:-

- that the waste is packed safely and securely so that there is no possibility of it escaping.
- where clinical waste is transported by a contractor, that the carrier of waste is registered, or is exempt from the requirement to register.
- the relevant establishment manager issues a transfer note and a description of the waste to the contractor.
- copies of the transfer note and description of waste are kept for a period of two years.
- that the incineration facility is licensed or authorised for receipt of the type of clinical waste.

7.0 **SHARPS INJURY GUIDELINES**

7.1 First Aid.

- A. Stop what you are doing and attend to the injury.
- B. Encourage bleeding.
- C. Wash well with soap and warm running water.
- D. Cover with waterproof dressing.

7.2 Report incident to Line Manager.

7.3 Seek medical advice as soon as possible if a puncture injury has occurred.

7.4 Complete accident/incident form. Include names of all those involved.

7.5 Even if the staff member has been immunised against Hepatitis B, these guidelines must be followed.

7.6 Further advice can be obtained from the Occupational Health service

8.0 **LAUNDRY AND HANDLING OF SOILED CLOTHING/LINEN**

8.1 Requirements - to prevent cross infection:-

- Designated laundry area with ventilation directly into the atmosphere.
- Designated storage area for soiled laundry, which must be secure, cool, dry and free from pests.
- Industrial washing machine with both sluice and hot wash cycles, professionally installed, with precautions to prevent contamination by creating an aerosol.
- Maintenance programme established for washing machine and laundry area.
- Handwash facilities - please see 3.3.
- Supply of waterproof aprons and gloves.
- Waterproof laundry bags.

8.2 Handling Linen

Apron and gloves should be worn when dealing with laundry. Soiled sheets and clothing should be placed in a water soluble red laundry bag and must not be allowed to touch the floors of bedrooms, living rooms or any other surface.

Avoid creating dust when removing linen from resident's bed, and place in the appropriate laundry bag at the bedside.

Red laundry bags should be sealed and immediately transported to the defined storage area.

9.0 **ASSESSMENT OF RISK FOR MICROBIOLOGICAL HAZARDS**

9.1 Service management are required, by the Corporate Safety Policy Arrangement for the Control of Substances Hazardous to Health (COSHH), to carry out an assessment of the risk to staff from biological agents they may encounter in the course of their work.

9.2 The COSHH Assessment should consider the following points:-

Hazard: (Something with the potential to cause harm).

- The bacteria that may be present.

- The disease they may cause.
- How and where they are present.
- How they are transmitted.

9.2.2. Risk:- the likelihood that the harm from a particular hazard is realised.

9.2.3. Risk Management - Where a significant risk from Microbiological hazard is identified the following must be considered.

- The control measures to be applied.
- The need for monitoring procedures.
- The need for Health Surveillance procedures.
- The range of instruction and training to be given to staff. Periods between refresher training should also be identified.

Please note that Control Measures will vary according to the specific route of infection and mode of transmission. For control measures relating to specific diseases please see Appendix C.

10.0 **IMMUNISATION**

10.1 Immunisation is recommended where Services have identified the need in their risk assessments that an individual may be at risk. Service managers should keep records of all their staff vaccinations and immune status. However, immunisation is not an alternative to good infection control practices and cannot be enforced.

10.2 Employees should contact their General Practitioner to carry out any necessary vaccinations. In certain cases the General Practitioner may levy a charge, and this cost should be borne by the responsible service.

APPENDIX A

HANDWASHING PROCEDURE

- A Remove rings where possible (keep safe). If rings cannot be removed move up and down to allow the skin under to be washed.
- B Turn on taps.
- C Wet hands up to the forearms, apply soap/cleaner.
- D Smooth soap/cleanser evenly all over your hands for 10-15 seconds, lather well.
- E Hold hands down so that water from finger tips drains into sink.
- F Avoid splashing clothing or floor.
- G Rub hands together vigorously, use friction on all surfaces i.e. between fingers, under rings etc.
- H Rinse hands thoroughly holding hands down.
- I Ensure taps are clean, by washing them in soap and rinse, if necessary, (this is particularly necessary where hands were used for turning on taps).
- J Dry hands thoroughly, taking special care between fingers.
- K Paper towels or hand dryer should be used for drying. To ensure hands are completely dry more than one paper towel may be needed.

APPENDIX B**BIOLOGICAL RISK CHART BY OCCUPATION/TYPE OF WORK**

Occupation	Tetanus	Polio	Tuberculosis	Hepatitis A	Hepatitis B	Hepatitis C
Asylum seekers	low	low	high	low	low	low
Building Control Officers	high	low	low	low	low	low
Care workers	mod	low	low	mod	mod	low
Cemetery & Crematorium	high	low	low	low	low	low
Children & Family Centres	mod	low	high	mod	mod	low
Civil Engineering & Sewer Operatives	high	high	low	high	high	high
Day Centre Staff	mod	low	mod	mod	mod	low
Environmental Health Officers	high	low	low	low	low	low
Escorts	high	low	mod	low	low	low
First Aiders	low	low	low	low	mod	low
Grounds Maintenance	high	low	low	mod	mod	low
Home Care	low	low	mod	mod	mod	low
Homeless Person Officers	low	low	high	low	low	low
Mortuary Officers	high	high	high	high	high	high
Neighbourhood Wardens	high	low	low	low	low	low
Nursery school	low	mod	high	mod	mod	low
Park & Countryside Rangers	high	low	low	low	low	low
PE Teachers & outdoor pursuit staff	mod	low	low	low	mod	low
Pest Controllers Needle stick collection	high	low	low	low	low high	low high
Play co-ordinators	low	low	low	low	low	low
Refuse & Cleaning	high	low	low	low	low	low
Residential Care	mod	low	mod	mod	mod	low
Sewer Construction	high	high	low	high	high	high
Social workers	low	low	high	low	low	low
Social workers and family support	low	low	high	mod	mod	low
Special educational needs	mod	mod	low	mod	mod	low
Swimming pools	high	low	low	low	low	low
Team /project workers	low	low	high	low	low	low
Trading Standards	high	low	low	low	low	low
Vehicle Maintenance	high	low	low	low	high	low
Void Property Staff	high	high	low	high	high	low

IMMUNISATION INFORMATION

For all immunisation medical advice should be sought when

- Pregnant.
- Suffering from acute febrile illness (except in the presence of a tetanus-prone wound).
- The individual has experienced a severe reaction to a previous dose.

1. TETANUS

Tetanus spores are present in soil and may be introduced into the body during injury, causing an acute disease characterised by muscular rigidity.

1.1 Vaccination (inactivated)

- A. Primary Course: 3 doses at 4 weekly intervals of 0.5ml absorbed tetanus vaccine. Primary immunisation is usually given during infancy.
- B. Reinforcing Doses: at 10-yearly intervals.
Common reactions may include some localised pain, redness and swelling.

1.2 Special Comments

Although the duration of immunity is thought to be 10 years, an adult who has received five doses of tetanus absorbed vaccine, either in childhood or as an adult, does not require further boosters other than at the time of injury.

2. POLIO

The polio virus is transmitted from person to person via the gastro-intestinal tract, causing poliomyelitis, which may cause paralysis.

2.1 Vaccination (live)

- A. Primary Course: 3 doses each of 3 drops at 4 weekly intervals.
Primary immunisation is usually given during infancy.
- B. Reinforcing Doses: necessary every 10 years only if in "high risk" group.
- C. As the vaccine strain poliomyelitis virus may be present in the faeces of recently immunised persons, strict personal hygiene following contact with faeces is necessary.

3. **TYPHOID**

Typhoid fever is caused by salmonella typhi, which is acquired mainly through food and drink that has been contaminated with the excreta of an infected person.

3.1 **Vaccination**

There are now 3 types of typhoid vaccine available. Two are given by injection and a third is given by mouth.

The new injection type is "Typhim VI" which is an inactivated vaccine.

Dose: A single dose, 0.5ml, repeated every 3 years for those at risk.

4. **HEPATITIS A**

Hepatitis A Virus (HAV), is transmitted person to person, by contaminated food and water.

Occupational groups at risk are:

- Institution and healthcare personnel
- Sewage workers
- Nursery workers
- Food handlers
- Travellers to endemic areas

4.1 **Vaccination**

Dose: One dose followed by a booster at 6 -12 months.

5. **HEPATITIS B**

Transmission of Hepatitis B Virus (HBV) is commonly as a result of blood/body fluid to blood/body fluid contact, including injury with a contaminated sharp instrument,

Occupations at risk include:-

- Medical waste handlers
- Laundry workers processing contaminated linen
- Refuse handlers
- Void housing clearance staff
- First aiders

- Emergency services employees
- Residential/day care staff
- Special School/ Special Unit Staff

5.1 **Vaccination** (inactivated)

A. Dose: Three doses given at 0, 4 and 24 weeks, and a post-vaccine screen one month after the third dose of vaccine, and thereafter a single dose booster every 3-5 years.

B. Accelerated Course:

Used when rapid immunisation is required, e.g., following exposure to Hepatitis B virus (HBV). It involves 3 doses at 0, 4 and 8 weeks with a booster after 1 year and thereafter a booster every 3 - 5 years. The dose is as above.

REDUCING THE RISKS OF VIRAL HEPATITIS / AIDS

HEPATITIS

Hepatitis means inflammation of the liver. It may be caused by viral infections and drugs, of which the most common is alcohol. Although hepatitis viruses range from A – G, the most common are hepatitis A, B (the more serious) and C.

HEPATITIS A VIRUS (HAV)

Hepatitis A Virus (HAV) is an enterically transmitted acute infection of the liver.

Transmission: faeco-orally from other humans

Through contaminated water and food. e.g. shellfish from sewage contaminated waters.

PREVENTION STRATEGY

- **Follow standard practice (Universal Precautions)**
- Good personal hygiene, especially toilet hygiene in nurseries and schools
- Exclude infected food handlers from work
- Health education
- Immunisation procedure for staff at risk

HEPATITIS B VIRUS (HBV)

At work, HBV is transmitted through infected body fluids, accidental needle stick injury or getting cut or grazed with a contaminated item.

Transmission

Person to person by a number of blood borne routes, e.g., horizontal transmission via skin inoculation, contamination of mucous membranes or damaged skin, or by sexual transmission. Vertical transmission (mother to baby) may occur intrauterine or perinatally.

PREVENTION STRATEGY

- Comprehensive health education
- Immunisation procedure for staff at risk
- Availability of advice and counselling

- Adherence to infection control policy
- Follow standard practice (Universal Precautions)

HEPATITIS C VIRUS (HCV)

Hepatitis C virus (HCV) is a major public health concern.

Transmission is the same as HBV, except for sexual transmission, which is uncommon.

Recent studies and outbreaks have proven that the existing pool of hepatitis C infections is among injecting drug abusers. Occupational exposure, e.g. needle stick accidents and tattooing practices, account for small proportions of the pool.

Although Hepatitis C is frequently asymptomatic, over half of those with acute infection may develop chronic hepatitis.

PREVENTION STRATEGY

As for HBV (except there is no HCV vaccine).

HIV and AIDS

Human Immunodeficiency virus (HIV) is the cause of HIV related illnesses including AIDS. People can have HIV without being ill with AIDS, but their body fluids remain infectious.

Acquired Immune Deficiency Syndrome (AIDS) is a severe life threatening clinical condition that causes the body's normal defences to fail and, therefore, be unable to protect itself from illness and infection.

Transmission: in the workplace, same as hepatitis B, i.e.:

- Accidental inoculation by infected needles, instruments or glass.
- Contamination of cuts, abrasions or eyes etc, by infected body fluids.

NB: HIV is not easily transmittable because you would normally require a very large amount of bodily fluid to become infected. i.e. a large volume of infected blood has to be inoculated before seroconverting, whereas infection with HBV is possible by only a small dose.

USEFUL CONTACTS

Colindale Public Health Laboratory 020 8200 4400

Hepatitis "Virus Laboratory" - Ext 3204

Hepatitis A test - Ext 4471
Vaccination - Ext 4405

Hepatitis B test
Vaccination

- Ext 4542
- Ext 4542

British Liver Trust

01473 276326

Tuberculosis

Tuberculosis (TB) is a serious infectious disease, caused by mycobacterium tuberculosis. If untreated, it may become life threatening. The disease most commonly affects the lungs (Pulmonary Tuberculosis) but may also affect other organs, including kidneys, spine, brain and bone. TB is a notifiable disease, under the Public Health (Control of Disease) Act 1984.

Transmission Inhalation of infected droplet nuclei spread predominantly by coughing, sneezing, singing and prolonged talking.

Aerosol spread (through physiotherapy treatment).

By infected milk from non tuberculin tested cows. NB: all UK milk producing cows must be tuberculin tested.

The incubation period is defined by tuberculin test reaction and is usually 3 - 8 weeks (but can be up to 12 weeks), the latent period being decades. Infectivity remains for as long as there are viable bacteria in the sputum.

Symptoms:

In the first months of the infection (primary stage), the individual may only experience a flu like illness including fever, loss of appetite, weight loss, fatigue, night sweats.

As the disease progresses to the second stage, (this is when the bacteria can spread to others), symptoms present depend on the part of the body affected. Pulmonary tuberculosis is usually associated with a dry cough that becomes productive, with sputum that may be blood stained. There may also be chest pain and shortness of breath.

TB is a two stage disease. A newly infected person is considered to have latent tuberculosis. At this stage clinical evidence is not always present, and the disease cannot be transmitted to others.

In the second stage the infection progresses to active disease, clinical features will manifest and TB may be transmitted to others.

Who is at risk?

Anyone who has not developed natural immunity to TB, and the immunocompromised, or those having specific therapy e.g. steroid or chemotherapy.

Anyone who has not been vaccinated against TB.

People living in over crowded and poorly lit conditions, and the undernourished.

Occupational risks include:

- Post mortem attendants.
- Staff in close contact with and delivering personal care to residential clients.

- Staff in close contact with asylum seekers from countries known to have a particularly high incidence of TB
- Staff in close contact with persons known to have been rough sleepers.

Most healthy and well nourished people are at low risk.

Safe Working Practices

Exposure to droplet infection is impossible to avoid, so the best protection is vaccination.

Within the care sector:

- Wear mask (only for the first two weeks of the individual's treatment, thereafter it is not necessary).
- Avoid unnecessary dust when removing linen from a resident's bed. Place in the appropriate laundry bag at the bedside.

Vaccination BCG (Bacillus Calmette-Guerin)

In the UK, most children are skin tested and vaccinated if necessary. This occurs in early teens, which should provide lifelong immunity. The BCG vaccination normally leaves a permanent lumpy scar in the skin, which may confirm that vaccination has been performed.

TB Contact

Visit your GP to determine if you are protected or not:

- if you have had contact with a person with active TB. Inform your manager.
- if in your job you are in constant contact with people from countries with a high incidence of TB.

MENINGITIS

Meningitis is inflammation of the membrane lining (meninges) of the brain and the spinal cord.

There are many different types of bacteria and viruses that can cause meningitis. Generally, untreated bacterial meningitis can be fatal, whereas if viral, the condition is less severe and subsides without treatment.

About 10% of people have the bacteria in their throats without harm to anyone. People at risk are young children (one to five years), teenagers and young adults.

Bacterial Meningitis is an acute infection, caused by a species of the *Neisseria meningococcus* (of which type A, B and C are important). Groups B and C are most common in the UK. Early detection and treatment is vital for full recovery. The condition is notifiable to the Proper Officer Consultant in Communicable Disease Control, and the Environmental Health Authority (EHA) for contact tracing.

Transmission:

- Person to person through respiratory droplets.
- Direct contact with nose and throat secretions, (prolonged contact usually occurs in a household setting, and through wet mouth kissing).

Incubation:

3 to 4 days - up to 7 days.

Symptoms

Commence with a sore throat or headache and may progress rapidly within several hours to drowsiness and signs of meningitis such as fever, vomiting, headache, stiff neck, photophobia, joint pain and fitting.

A haemorrhagic rash, (red spots or blotches that do not blanch under glass tumbler pressure), may be present, and this is often associated with septicaemia.

Close Contacts

Are people who have had close prolonged contact with the case in the week before the onset of symptoms. Managers should respond quickly to any reported cases and contact occupational health immediately.

Safe Working Practices

Anyone who has been in close contact with individuals who may have the disease should contact their doctor the same day.

INFECTION CONTROL MONITORING SHEET

Date: _____ Time: _____

Name of Establishment: _____

Manager: _____

Others Present: _____

Please answer each question **yes or no as applicable**

STANDARD 1: Handwashing

Handwashing is the single most important measure in infection control.

- 1. Liquid soap is available at all sinks?

- 2. Paper towels or hand dryers are available near all sinks?

- 3. No re-usable towels in use?

- 4. There are no nail brushes present on sinks (Except in food preparation areas)?

- 5. Staff involved in dealing with body fluids/ clinical waste are not wearing jewellery?

- 6. Skin under jewellery is washed if jewellery cannot be removed?

- 7. No cups or drinking facilities at handwashing sinks?

- 8. Access to handwashing sink is clear e.g. no equipment etc. soaking in the sink?

Comments:

STANDARD 2: Protective Clothing

The use of personal protective clothing and correct clinical practice will help to reduce the risk of cross-infection. Protective clothing should be selected following assessment of the risk.

The following protective clothing is available for staff use:

1. Latex sterile and non-sterile latex gloves?

2. Disposable plastic aprons?

3. Eye and face protection where necessary?

Body fluid spillage:

4. The appropriate disinfectant is available for cleaning up body fluid spillage?

5. All staff are aware of the procedure for dealing with body fluid spillage?

Comments:

STANDARD 3: The Environment

Good maintenance of the environment will help to reduce cross infection

1. All general areas are clean?

2. Changing room, toilets, bathrooms are clean and free from extraneous items?

3. Sluice macerator areas are free from extraneous items?

4. Kitchens are clean and not used for storage of laundry or clinical waste?

5. Toys are wipeable or machine washable and are clean and in good state of repair?

6. Cleaning specification is met?

7. Cover blankets are laundered and changed if contaminated?

8. Foot operational bins are always used for disposal of clinical waste?

Comments:

STANDARD 4: Waste Disposal

Waste must be disposed of in accordance with current guidelines, to reduce the risk of contamination/injury.

1. The clinical waste policy is available and staff are aware of specific procedures?
2. Foot operational bins are in working order?
3. Suitable yellow bags are used for disposal of waste (where yellow bag system operates)?
4. Waste bags are less than 3/4 full and securely tied before they are transported?
5. Household waste is placed in black bags and securely tied?
6. Clinical waste is stored only in designated area prior to disposal?
7. The storage area is locked and inaccessible to unauthorised persons and vermin?
8. Clinical waste and domestic waste is correctly segregated?
9. Storage bin and area cleaned regularly?
10. Bags are labelled to show place of origin?
11. Facilities are available to deal with spillage i.e. dustpan and brush and appropriate 'disinfectant'?
12. Protective Clothing e.g. gloves and aprons are available to staff handling clinical waste?
13. Collection of clinical waste bins and bags is undertaken regularly by a registered company and disposed of by incineration at a licensed site?

Comments:

STANDARD 5: Handling of Sharps

Care must be exercised during the use and disposal of sharps. Needles are not to be resheathed prior to disposal into approved sharps boxes.

1. Sharps boxes are available for use and conform with British Standards BSI 7320 and UN 3H1/Y1/S/98

2. The box is not more than 3/4 full with no protruding sharps?

3. The sharps box is assembled correctly - check lid is secure?

4. The sharp box is labelled with point of origin?

5. Sharps are disposed of directly into sharps box?

6. Staff are aware of sharps injury policy and procedure to take in case of accident?

7. Sharps boxes are stored above floor level and safely out of reach of children?

Comments:

STANDARD 6: Detergents/Disinfectants and Antiseptics

Correct use of detergents/disinfectants and antiseptics will help reduce the risk of infection

1. Disinfectants are used at the correct dilution and appropriately

2. COSHH Assessments are available

Comments

Infection Control Monitoring Sheet Report Form

Date of inspection	Date of proposed follow up audit	Lead person (Print Name)	Staff present at audit (Print name)
AREA	PROBLEM IDENTIFIED	ACTION RECOMMENDED	ACTION TAKEN AND DATE
Standard 1: Hand washing			
Standard 2: Protective Clothing			

AREA	PROBLEM IDENTIFIED	ACTION RECOMMENDED	ACTION TAKEN AND DATE
Standard 3: The Environment			
Standard 4: Waste Disposal			

AREA	PROBLEM IDENTIFIED	ACTION RECOMMENDED	ACTION TAKEN AND DATE
Standard 5: Handling of Sharps			
Standard 6: Chemicals			

