### PROCEDURE SUMMARY

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called standard/universal precautions and apply to all trust staff, agency/bank staff and contractors. Standard Precautions include:

- Hand-washing and skin care
- Protective clothing – personal protective equipment
- Safe handling of sharps (including sharps injury management)
- Spillage management

These guidelines outline, in detail what these precautions are, and when and how to apply them.

The Trust monitors the implementation of and compliance with this procedure in the following ways:

The responsibility for monitoring and reviewing this Procedural Guideline lies with the Director responsible for Infection Prevention and Control. Compliance with this policy and the supporting procedural guidelines will be audited annually using evidence and guidance based approved audit tools. Audit results will be presented to the Infection Prevention and Control Group. Uptake of Infection prevention and Control Training will be monitored as outlined in ICP1 - The Infection Control Policy - section 7.0.

<table>
<thead>
<tr>
<th>Services</th>
<th>Applicable</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustwide</td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>

The Director responsible for monitoring and reviewing this procedure is The Executive Nurse.
SECTION 2: STANDARD PRECAUTIONS OF INFECTION PREVENTION & CONTROL

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SECTION 2: STANDARD PRECAUTIONS OF INFECTION PREVENTION & CONTROL

1.0 INTRODUCTION

1.1 It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called standard/universal precautions and apply to all trust staff, agency/bank staff and contractors.

1.2 Standard Precautions include:

- Hand-washing and skin care
- Protective clothing – personal protective equipment
- Safe handling of sharps (including sharps injury management)
- Spillage management
- Waste management
- Laundry management

1.3 All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. A disposable apron and vinyl gloves should always be worn when dealing with excreta, blood and body fluids.

1.4 Everyone involved in providing care in the clinical environment should know and apply the standard precautions of hand decontamination, the use of protective clothing, the safe disposal of sharps and body fluid spillages.

1.5 Each member of staff is accountable for his/her actions and must follow safe practices.

1.6 Any person entering any Trust inpatient premises or staff canteen/dining room must decontaminate their hands by applying the hand sanitiser available from the wall-mounted dispenser at the entrance to the area.

1.7 Any member of staff who is letting people enter a ward is expected to direct them to, and prompt the use of, the hand sanitiser dispenser.

1.8 Any member of staff involved in direct patient care is to wear/carry a personal hand sanitiser dispenser.

2.0 HAND HYGIENE AND SKIN CARE

2.1 The Hand Hygiene Procedural Guideline is intended to minimise risk and maximise best practice in hand decontamination. Each part of the document forms an important part of clinical effectiveness and development and is therefore part of the Clinical Governance requirements.
2.2 **Scope**
The guidelines refer to ICP1 – Infection Prevention and Control Policy and have been written for use by all Trust staff including inpatient services staff, outpatient staff, support services and those working in and from community clinics, and all staff caring for patients in their own homes.

2.3 **Responsibility and Accountability**
All Healthcare Workers working for the Essex Partnership University NHS Foundation Trust (from here-on-in referred to as “EPUT” or “the Trust”) must adhere to these Procedural Guidelines. The organisational accountability structure for Infection Prevention and Control is clearly demonstrated in the Infection Prevention and Control Policy and Assurance Framework.

2.4 **The Aim of Hand Decontamination**
Hand decontamination has a dual role to protect both the patient and the Healthcare Worker (HCW) from acquiring micro-organisms which may cause them harm. Healthcare Workers have the greatest potential to spread micro-organisms that cause infection by:

- transfer from one patient to another/staff to patient/patient to staff;
- transfer from the environment to patient; and
- transfer from equipment to patient.

2.5 **Indications for hand hygiene**

**A.** Wash hands with soap and water when visibly dirty or visibly soiled with blood or other body fluids or after using the toilet.

**B.** If exposure to potential spore-forming pathogens is strongly suspected or proven, including outbreaks of C. difficile, hand washing with soap and water is the preferred means.

**C.** It is acceptable to use a sanitiser hand rub as the preferred means for routine hand antisepsis in all other clinical situations described in items D(a) to D(f) listed below, if hands are not visibly soiled.

**D.** Perform hand hygiene:

a) before and after touching the patient
b) before handling an invasive device for patient care, regardless of whether or not gloves are used
c) after contact with body fluids or excretions, mucous membranes, non-intact skin, or wound dressings
d) if moving from a contaminated body site to another body site during care of the same patient
e) after contact with inanimate surfaces and objects (including medical equipment) in the immediate vicinity of the patient
f) after removing sterile or non-sterile gloves
E. Before handling medication or preparing food perform hand hygiene using an sanitiser hand rub or wash hands with either plain or antimicrobial soap and water.

*World Health Organisation (WHO) (2009).*

**Within EPUT hand hygiene guidelines follow the WHO 5 moments for hand hygiene:**

- before patient contact;
- before an aseptic task;
- after body fluid exposure risk;
- after patient contact; and
- after contact with patient surroundings.

(WHO, World Health Alliance for patient safety, 2006; 5 moments of hand hygiene) (*see Appendix 1*).

2.6 A risk assessment of the activity intended or performed will determine the appropriate decontamination process (hand wash or hand rub) and choice of product (e.g. soap, alcohol or antiseptic preparation).

2.7 **Hand Washing**

Hand washing is widely acknowledged to be the single most important activity for reducing the spread of infection.

2.8 Hands that are visibly dirty or potentially grossly contaminated must be washed using evidence based technique for 15-30 seconds, and then rinsed thoroughly (*see appendices 2a & 2b*).

2.9 Single use patient hand wipes must be available for those patients who are unable to access liquid soap and water for hand washing e.g. before meals etc.

2.10 Hand washing facilities must be made available for patients after using the toilet.

2.11 Facilities for staff hand hygiene i.e. hand wipes, bottle of liquid soap, bottles of sanitiser hand rub must be available for community staff if environmental risk assessment identifies working conditions where liquid soap and water are not always available.

2.12 **Surgical Hand Washing**

Surgical hand washing destroys transient organisms (which are easily acquired on the hands) and reduces resident flora before surgical or invasive procedures.
2.13 An aqueous antiseptic solution is applied for 2 minutes. Preparations currently available are 4% Chlorhexidine-detergent and 0.75% Povidone/iodine solution-detergent.

2.14 **Surgical scrub using a skin disinfectant solution**

<table>
<thead>
<tr>
<th>Key steps before starting surgical hand preparation</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Keep nails short and pay attention to them when washing your hands – most microbes on hands come from beneath fingernails</td>
</tr>
<tr>
<td>• Do not wear artificial nails or nail polish</td>
</tr>
<tr>
<td>• Remove all jewellery (rings watches and bracelets)</td>
</tr>
<tr>
<td>• Wash hands and arms with plain soap and water before entering operating room</td>
</tr>
<tr>
<td>• Clean subungual areas with a nail file. Nail brushes should not be used as they may damage the skin and encourage shedding of cells</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Protocol for surgical scrub using a skin disinfectant</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Turn on the taps of the handwash basin, ensure the water is the correct temperature</td>
</tr>
<tr>
<td>• Wet hands and apply a measure of the chosen skin disinfectant</td>
</tr>
<tr>
<td>• Wash each side of each finger, between the fingers and the back and front of one hand for 30 seconds</td>
</tr>
<tr>
<td>• Proceed to wash the arms, keeping the hand higher than the arm at all times. This helps to avoid recontamination of the hands by water from the elbows and prevents bacteria-laden soap and water from contaminating the hands</td>
</tr>
<tr>
<td>• Wash each side of the arm from wrist to elbow for 30 seconds</td>
</tr>
<tr>
<td>• Repeat the process on the other hand and arm, keeping the hands above the elbows at all times</td>
</tr>
<tr>
<td>• Rinse hands and arms by passing then through the water in one direction only, from fingertips to elbow. Do not move the arms back and forth through the water</td>
</tr>
<tr>
<td>• Enter the operating area holding hands above the elbows</td>
</tr>
<tr>
<td>• Dry hands and arms on a sterile towel from fingertips to elbows before donning gown and gloves in an aseptic manner</td>
</tr>
</tbody>
</table>
2.15 **Procedure for surgical hand preparation using alcohol based products**

The handrubbing technique for surgical hand preparation must be performed on perfectly clean, dry hands. On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water. After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).

Surgical procedures may be carried out one after the other without the need for handwashing, provided that the handrubbing technique for surgical hand preparation is followed (Images 1 to 17).

1. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the dispenser
2. Dip the fingertips of your right hand in the handrub to decontaminate under the nails (5 seconds)
3. Images 3–7: Smear the handrub on the right forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds)
4. See legend for Image 3
5. See legend for Image 3
6. See legend for Image 3
7. See legend for Image 3
8. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your right hand, using the elbow of your other arm to operate the dispenser
9. Dip the fingertips of your left hand in the handrub to decontaminate under the nails (5 seconds)
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10. Smear the handrub on the left forearm up to the elbow. Ensure that the whole skin area is covered by using circular movements around the forearm until the handrub has fully evaporated (10-15 seconds).

11. Put approximately 5ml (3 doses) of alcohol-based handrub in the palm of your left hand, using the elbow of your other arm to operate the distributor. Rub both hands at the same time up to the wrists, and ensure that all the steps represented in images 12-17 are followed (20-30 seconds).

12. Cover the whole surface of the hands up to the wrist with alcohol-based handrub, rubbing palm against palm with a rotating movement.

13. Rub the back of the left hand, including the wrist, moving the right palm back and forth, and vice-versa.


15. Rub the back of the fingers by holding them in the palm of the other hand with a sideways back and forth movement.

16. Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa.

17. When the hands are dry, sterile surgical clothing and gloves can be donned.

Repeat the above-illustrated sequence (average duration, 60 sec) according to the number of times corresponding to the total duration recommended by the manufacturer for surgical hand preparation with an alcohol-based handrub.
2.15 **How to Wash Your Hands**  
See hand Cleaning Techniques in Appendix 2a &2b.

2.16 Effective hand washing technique involves three stages: Preparation, washing, rinsing and drying.

2.17 **Preparation**  
Staff should not wear hand or wrist jewellery, including wrist watches (a plain metal band i.e. wedding ring is acceptable).

2.18 Fingernails should be kept short, clean and free from nail polish. No false/gel overlay nails or nail jewellery should be worn.

2.19 Cuts and abrasions must be covered with waterproof dressings.

2.20 Arms must be bare below the elbows to facilitate lathering with soap or the application of sanitiser hand rub over the base of the hands, wrists and lower arms as required.

2.21 Hands should be wet under tepid running water before applying liquid soap or an antimicrobial preparation.

2.22 **Washing and Rinsing**  
When washing hands apply enough soap to cover all hand surfaces to ensure that the hands are well lathered.

2.23 The hands must be rubbed together thoroughly for a minimum of 10-15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands must be rinsed thoroughly.

2.24 **Hand Drying**  
This is an essential part of hand hygiene. Hands must be dried thoroughly using good quality paper towels.

2.25 In clinical settings disposable paper towels must be used, as communal towels are a source of cross-contamination.

2.26 Store towels in a wall mounted dispenser next to the washbasin, and dispose of in a pedal operated domestic (black bag) waste bin.

2.27 Do not use your hands to lift the lid or they will become re-contaminated.

2.28 Hot air dryers are not recommended in clinical settings. However, if they are used in other areas, they must be regularly serviced and users must dry hands completely before moving away.

2.29 **Decontamination of Hands Using sanitiser hand rub /gels**  
A risk assessment must be undertaken when the easy availability of sanitiser hand rub /gels is considered unsafe, e.g. on a mental health inpatient unit.
2.30 Hands should be free from dirt and organic material. Sanitiser hand rub must be applied to hands using an evidence-based technique until both hands are dry (see Appendices 2a & 2b).

2.31 When cleaning hands, 1 pump from the dispenser of sanitiser hand rub will provide a 3ml dose, which is sufficient for covering all surfaces of the hands and wrists.

2.32 Alcohol-based hand rubs/gels must come into contact with all the surfaces of the hand. The hands must be rubbed together thoroughly, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

2.33 Individually carried dispensers must be available for all staff to wear, particularly in inpatient units and for community staff.

2.34 Any person entering any Trust inpatient premises or staff canteen/dining room must decontaminate their hands by applying the hand sanitiser available from the wall-mounted dispenser at the entrance to the area.

2.35 Any member of staff who is letting people enter a ward is expected to direct them to, and prompt the use of, the hand sanitiser dispenser.

2.36 All hand hygiene products must be approved by the Infection Prevention and Control Team.

2.37 **In-Patient Areas**

All Healthcare Workers will “risk assess” their choice of hand cleaning technique based on whether their hands are visibly soiled or not.

2.38 When caring for patients with *Clostridium difficile* and Norovirus (gastrointestinal upsets), sanitiser hand rub may not be effective, therefore hand washing must be adopted as it is the most effective method, and will physically remove spores, or viral particles.

2.39 Anti-viral sanitiser hand rub /gels can be used in addition to soap and water.

2.40 **For Community Staff**

All Community Healthcare Workers should “risk assess” their choice of hand cleaning technique based on whether their hands are visibly soiled or not and their access to hand wash sinks.

If adequate hand wash facilities are not available, sanitizing wipes suitable for use on hands should be used to remove any organic debris. Hand decontamination products including wipes, individual bottles of liquid soap, sanitiser hand rub and soft white paper towels must be carried by all community staff working in conditions where liquid soap and water is not always available.
2.41 If hands are visibly clean sanitiser hand rub /gel can be used.

2.42 Dermatitis / unusual skin reaction
If an unexplained skin reaction/rash occurs on a healthcare worker’s hands or elsewhere on the body, they must be referred to Occupational Health for further assessment and testing. Assumptions should not be made with regards what may be causing it until a diagnosis is received. If the skin is broken and exposed and the area is too large to cover with a waterproof dressing, they may need to refrain from clinical duties until healed, and their duties no longer pose an infection risk to their health.

3.0 TYPES OF HAND WASHING/HAND DECONTAMINATION

3.1 The Table below illustrates different methods of hand washing and should be part of the hand hygiene risk assessment process.

<table>
<thead>
<tr>
<th>Method</th>
<th>Solution</th>
<th>Task</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hand washing</td>
<td>Liquid soap</td>
<td>For all routine tasks</td>
</tr>
<tr>
<td>2. Sanitiser hand rub – hand disinfectants</td>
<td>Hand disinfection e.g. Purell, Cutan, Byotrol</td>
<td>Rapid decontamination for hands not visibly soiled (recommended by WHO 5 Moments of Care) Please refer to manufacturer’s instructions</td>
</tr>
</tbody>
</table>

4.0 HAND CREAMS

4.1 Emollient hand creams are provided by EPUT for Healthcare Workers to protect skin from the drying effects of regular hand decontamination. If skin irritation occurs, an occupational health referral should be made.

5.0 HAND WASHING FACILITIES

5.1 Facilities should be adequate and conveniently located. Clinical hand wash basins must comply with the requirements HBN 00-10 Element 4 (sanitary ware assemblies). This specifies that they must be placed in areas where needed and where client consultations take place. They should have automatic, sensor, elbow or wrist operated taps. Water temperatures should be thermostatically controlled & delivered via mixer taps. If a base-fitted drainage outlet is in situ the water flow should not be directed into the drain but be offset to reduce contaminated splashback. Taps should be wall mounted to eliminate ‘swan necks’ which may become reservoirs for Legionella. A separate sink should be available for other cleaning purposes.
5.2 Use wall-mounted liquid soap dispensers with disposable soap cartridges; these should be kept clean and replenished.

5.3 In areas where it has been assessed as too great a risk to install wall-mounted soap dispensers i.e. patient en-suite bathrooms, free standing pump bottles of soap should be provided for both patient and staff use (when staff are carrying out clinical procedures in patient bedrooms)

5.4 Place disposable paper towel dispensers next to the basins (soft paper towels will help to avoid skin abrasions).

5.5 Position foot-operated pedal bins near the hand wash basin, and make sure they are the right size. If the bin is to be used solely for paper hand towels, a domestic waste bag should be used.

6.0 SIGNAGE

6.1 Signage explaining the importance of hand hygiene compliance must be visible on entry to all inpatient health care facilities.

6.2 There must be clearly signposted hand hygiene facilities on entry and exit from inpatient/clinical areas.

6.3 Staff, patients and visitors should be encouraged to comply with requests for hand hygiene through the use of easily visible and clear signage, information leaflets and posters.

7.0 REPLACEMENT AND MAINTENANCE OF HAND HYGIENE PRODUCTS

7.1 Under The Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance – Criteria 2, 5 and 9, it is the responsibility of:

- All Healthcare Workers to alert their line manager/link practitioners if hand washing facilities are broken/faulty or stocks of soap/hand rub or paper towels have run out.

- All infection prevention and control link practitioners to monitor hand washing techniques and use of these products.

- Service Line Managers & Matrons to ensure that adequate stocks of hand hygiene products and hand washing facilities are available where required.
8.0 HAND HYGIENE COMPLIANCE AUDITS

8.1 Please see Appendices 3, 4 and 5 for the relevant sections on hand hygiene audit pertaining to service areas

8.2 Appendix 3 – Hand Hygiene Audits – Mental Health and Community inpatient services in West and South East Essex, and Bedfordshire.

8.3 Appendix 4 – Hand Hygiene Audits – Community services in West and South East Essex and Bedfordshire.

8.4 Appendix 5 - Hand Hygiene Audits – Mental Health services in Mid and North Essex

9.0 PERSONAL PROTECTIVE EQUIPMENT (PPE)

9.1 Selection of protective equipment must be based on an assessment of the risk of transmission of infection between the patient and health care practitioner.

WHAT TO WEAR WHEN

<table>
<thead>
<tr>
<th>No exposure to blood/ body fluids anticipated</th>
<th>Exposure to blood/body fluids anticipated, but low risk of splashing</th>
<th>Exposure to blood/body fluids anticipated - high risk of splashing to face</th>
</tr>
</thead>
<tbody>
<tr>
<td>No protective clothing</td>
<td>Wear gloves and a plastic apron</td>
<td>Wear gloves, plastic apron and eye/mouth/nose protection</td>
</tr>
</tbody>
</table>

9.2 Types of Protective Clothing

9.2.1 Disposable Gloves
Nitrile/Vinyl gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments.

9.2.2 Gloves that are acceptable to healthcare personnel and that conform to European Community (CE) standards must be available.

9.2.3 DO NOT USE powdered, latex or polythene gloves in healthcare activities.
9.2.4 Gloves must be worn as single-use items. They must be put on immediately before an episode of patient contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different patients, and between different care or treatment activities for the same patient, and do not substitute for hand-washing.

9.2.5 Gloves must be disposed of as clinical waste and hands must be decontaminated before putting on and after removing gloves.

9.2.6 To prevent transmission of infection, gloves must be discarded after each procedure. Gloves should not be washed between patients as the gloves may be damaged by the soap solution and, if punctured unknowingly, may cause body fluid to remain in direct contact with skin for prolonged periods.

9.2.7 **Non Sterile Gloves**
- Should be used when hands may come into contact with body fluids or equipment contaminated with body fluids.

9.2.8 **Sterile Gloves**
- Should be used when hands are likely to come into contact with normally sterile areas or during any aseptic procedure.

9.2.9 **General Purpose Utility Gloves**
- General purpose utility gloves e.g. rubber gloves, can be used when doing general cleaning of surfaces or items. Colour coding of such gloves should be used. This will help prevent cross-infection from one area of work to another.

9.2.10 **Disposable Plastic Aprons**
- Should be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.

9.2.11 Plastic aprons should be worn as single-use items, for one procedure or episode of patient care, and then discarded and disposed of as clinical waste. Colour coded according to local arrangements.

9.2.12 **Face Masks and Eye Protection**
- Face masks may be worn for a number of reasons:
  - to provide a barrier against potential splashes of blood / body fluids reaching the nose and mouth
  - protect vulnerable individuals from the respiratory droplets of the wearer
  - to provide protection against aerosolised organisms in the case of certain infections e.g. Influenza
9.2.13 All face masks will provide a barrier to blood splashes, but should be removed / replaced if they become soiled or wet to ensure continued protection.

9.2.14 Surgical face masks prevent droplets being expelled into the environment by the wearer, but must only be worn for the duration specified by the manufacturer.

9.2.15 Respirator masks are required for some infections / procedures. These are tight fitting ‘FFP3’ masks that do not allow air leaks from the sides and in order to work effectively each individual should be ‘fit-tested’ to identify the make of mask suitable for that person. The need for these masks in EPUT community environments is rare. However they would be used in the event of a pandemic influenza outbreak for procedures that create aerosols, such as bronchoscopy. See link for fitting instructions: http://www.england.nhs.uk/wp-content/uploads/2013/12/how-to-ffp3-poster-v2.pdf

9.2.16 Torn or damaged face protection should not be used and should be removed immediately if this occurs during a procedure.

9.2.17 Supplies should be stored in a clean dry place. Face masks should not be stored out of the original box to ensure the expiry date / batch number is known and the integrity is maintained.

9.2.18 The eyes, nose and mouth will require protection from blood and body fluid splashes during certain procedures. This can be achieved by wearing goggles and clinical face mask or a full length visor.

9.2.19 Some goggles and visors are reusable and should be decontaminated according to manufacturer’s instructions after each use.

9.2.20 Disposable or ‘single use’ versions must be discarded after each patient use.

9.2.21 **Respiratory Protective Equipment**

For example, a particulate filter mask must be used when clinically indicated for pulmonary tuberculosis or Influenza. The Infection Prevention and Control Team will advise when this is necessary.

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**10.0 SAFE HANDLING AND DISPOSAL OF SHARPS**

10.1 All staff should be fully immunised according to national policy. In addition, all those handling sharps should have had a course of hepatitis B vaccine. A record of hepatitis B antibody response should be kept for all clinical staff involved in ‘exposure prone procedures’ or where regular exposure to blood/blood stained body fluids occurs. This record will normally be held by the Occupational Health department, but each health care practitioner has a responsibility to be aware of their vaccination status.
10.2 Care should be taken to avoid accidental needle stick injury as exposure to contaminated blood may be associated with transmission of Blood Borne Viruses.

10.3 Sharps include needles, scalpels, stitch cutters, glass ampoules, sharp instruments, razors, teeth and nails, as well as blood-stained broken glass and crockery. Sharps must be handled and disposed of safely to reduce the risk of exposure to blood borne viruses. Always take extreme care when using and disposing of sharps.

10.4 Sharp safe devices e.g. Vanishpoint, Securegard must be used where available when performing any invasive procedure i.e. administering intravenous or injectable medication, when performing phlebotomy or using finger prick lancets.

10.5 Clinical sharps are single use only.

10.6 Do not re-sheath, bend, break or disassemble a used needle - if this is necessary a safe method - for example, a re-sheathing device – must be used.

10.7 Sharps should never be passed from hand to hand and should be disposed of by the user.

10.8 Discard sharps directly into an appropriately colour coded sharps container immediately after use and at the point of use.

10.9 Sharps containers should be available at all locations where sharps are used.

10.10 Sharps containers must comply with UN 3921 and BS7320 standards;

10.11 Close the temporary closing mechanism of the sharps container when carrying or if left unsupervised to prevent spillage or tampering.

10.12 Place sharps containers on a level, stable surface;

10.13 Do not place sharps containers on the floor, windowsills or above shoulder height - use wall or trolley brackets.

10.14 Assemble sharps containers by following the manufacturer’s instructions; date and sign the box indicating when it was assembled, and by whom.

10.15 Carry sharps containers by the handle - do not hold them close to the body

10.16 Never leave sharps lying around.

10.17 Do not try to retrieve items from a sharps container.

10.18 Do not try to press sharps down to make more room.
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10.19 Lock the container when it is three-quarters full using the closure mechanism.

10.20 Label sharps containers with the source details prior to disposal; Audit tag the box.

10.21 Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place inside yellow clinical waste bag.

10.22 **Giving Injections**
Always wash hands thoroughly prior to giving an injection.

10.23 If visibly dirty, skin should be cleaned with an individually packed swab soaked in 2% Chlorhexidine and 70% isopropyl alcohol and left to dry. If skin is clean, this step is not necessary.

10.24 Venepuncture and injections should be carried out only by staff who are adequately trained and experienced.

10.25 **PLEASE NOTE**
For occupationally acquired sharps injuries and the management thereof, see ICPG1 - Section 9.

11.0 **SPILLAGE MANAGEMENT**

11.1 All spillage of blood and body fluids should be dealt with immediately.

11.2 **For Mental Health staff:** Body fluid spillage kits should be available and easily accessible in all Departments.

11.3 **For community staff working in inpatient premises** (e.g. clinics, general practices, intermediate care wards), a ‘grab bucket’ containing all the relevant equipment, or a commercially packed kit/absorbant pad should be readily available to deal with a spillage of body fluids.

11.4 The kit should be kept in a designated place (depending on the size of the establishment there may be more than one kit. Commercially produced spillage kits are available e.g. Biohazard Spill Kit or Clinell spill wipe, Response kit.

11.5 **If no blood visible in spillage:**

1. Keep people away from the area. Collect spillage kit in bucket.
2. Wear appropriate disposable gloves and a disposable apron.
3. Cover spillage with disposable towels or absorbent powder and allow to soak into towel or powder, thereby removing excess of spillage.
4. Wipe surface with general purpose detergent and hot water.
5. Dispose of used disposable towels and cloths into clinical waste sack.
6. Dispose of protective clothing.
7. Wash hands.
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11.6 **For blood or blood stained body fluids.**

Before stage 4 as above:

- Open door and any windows to provide adequate ventilation.
- Apply sufficient hypochlorite solution or Haz Tabs, Presept, Sanichlor, to cover spillage and leave for at least 2 minutes.

11.7 **For spills on carpets and upholstery with or without blood visible.**

1. Collect spillage kit in bucket.
2. Wear appropriate disposable gloves and disposable apron.
3. Clear away excess with disposable paper towels and dispose of as clinical waste.
4. Clean area with cold water.
5. Clean area thoroughly with detergent and hot water. Do not use a hypochlorite solution as it will bleach carpets or fabric.
6. Allow to dry thoroughly. It is then no longer an infection risk to others.
7. Once dry, go over area with a mechanical cleaner.
8. Clean and dry bucket and restock all used equipment. Store dry.

### 12.0 REFERENCES - SECTION 2


Royal College of Nursing (RCN) (2012), Tools of the Trade – RCN guidance for healthcare staff on glove use and the prevention of contact dermatitis, London.


WHO Guidelines on Hand Hygiene in Health Care (2009), First Global Patient Safety Challenge Clean Care is Safer Care, WHO Library Cataloguing-in-Publication Data.

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