

INFECTION PREVENTION AND CONTROL POLICY

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DOCUMENT CONTROL

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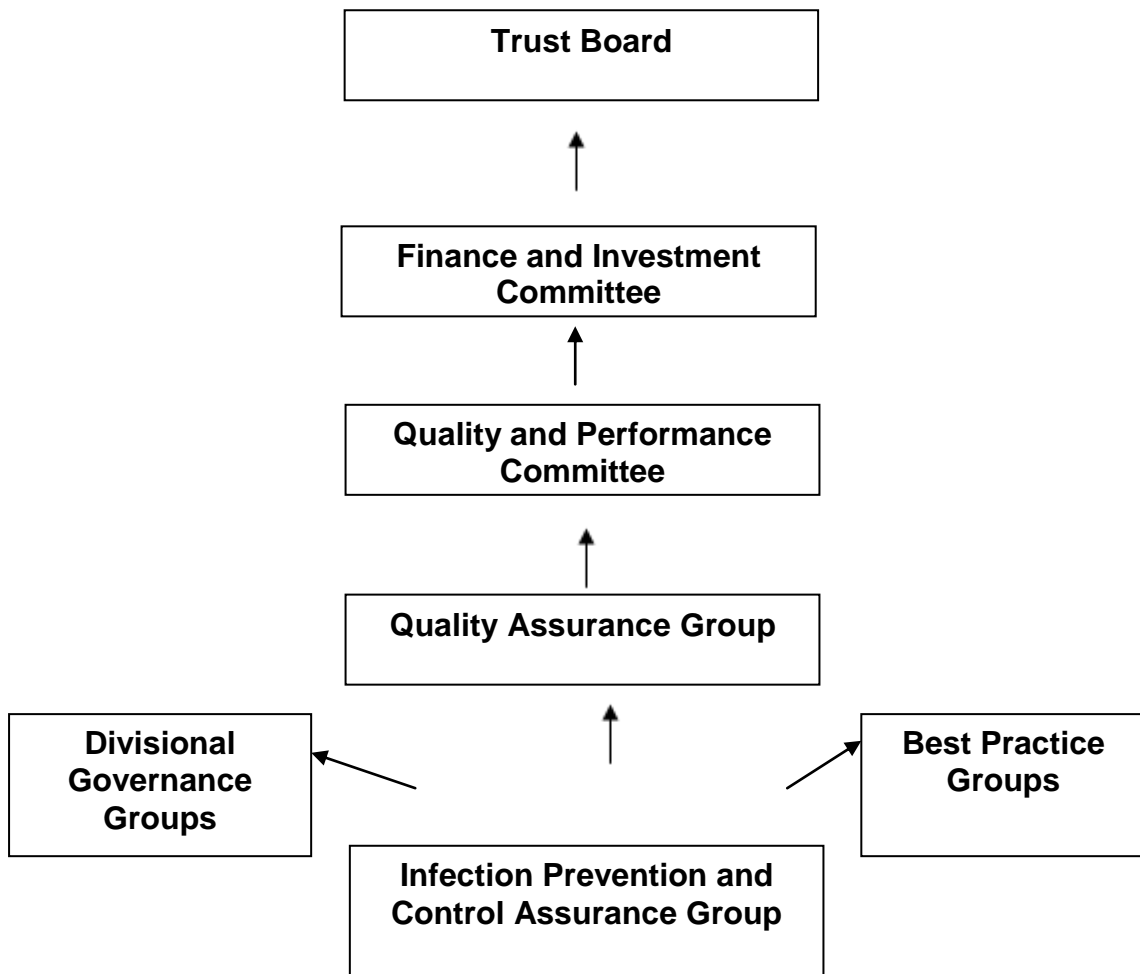
1. INTRODUCTION

- 1.1 Infection Prevention and Control is a core part of an effective risk management programme, aiming to improve the quality of patient care and the occupational health of staff. In addition to the clinical need to prevent the spread of health care associated infection, there are legal requirements to protect patients, staff and visitors from harm.
- 1.2 As per the requirements of the Health and Social Care Act; The Code of Practice for health and adult social care on the prevention and Control of Infections and related guidance (Department of Health, 2008, updated 2015) requires all healthcare Trusts to have clear arrangements for the effective prevention, detection and control of healthcare associated infection, including the procedures to be taken in the event of an outbreak of infection.
- 1.3 Previous arrangements outlined in a series of national guidance documents and reports (Department of Health (DH)/ Public Health laboratory Service (PHLS), 1995; DH, 2002; DH, 2003; DH, 2004a; DH, 2005; DH, 2006) have formed the basis for 'the Code' and are also reflected in this policy document.

2. PURPOSE AND SCOPE

- 2.1 This policy applies to all Trust staff and in particular staff working in inpatient wards with direct patient contact.
- 2.2 This policy will ensure that:
- responsibility for infection prevention and control is embedded at all levels of the organisation.
 - effective arrangements are in place for the provision of a full infection prevention and control service including policy production, surveillance, education and training, and audit led by an Infection Control Team.
 - infection prevention and control advice is provided by a suitably qualified and resourced team, which includes an Infection prevention and Control Doctor and Infection Prevention and Control Nurses, with administrative and information technology support.
 - the Infection Prevention and Control Team is supported by an adequately resourced and staffed microbiology laboratory capable of promptly processing and reporting results on specimens sent for investigation.
 - a multi-professional Infection Prevention and Control Assurance Group is in place to advise and support the Infection prevention and Control Team.
 - all healthcare personnel working within the scope of this policy are aware of the rationale and responsibility to maintain high standards of infection control at all times.

3. Organisational Structure and Framework



4. DUTIES AND RESPONSIBILITIES

4.1 Trust Board and Chief Executive

The Trust Board, via the Chief Executive will:

- ensure there are effective and adequately resourced arrangements for infection prevention and control within the Trust.
- identify a Board level lead for Infection Prevention and Control.
- ensure that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2008, updated 2015).
- approve the Infection Prevention and Control Annual Programme, receiving the Infection Control Annual Report and any other reports regarding the state of infection prevention and control within the organisation.
- ensure that appropriate systems are in place for:
 - reviewing reports and statistics on the incidence of alert organisms (e.g. MRSA, *Clostridium difficile*) and conditions, outbreaks and Serious Incidents Requiring Review.

- ensuring that clinical responsibility for infection prevention and control is effectively devolved to:
 - all professional clinical groups in the Trust Senior Managers, Ward Managers and clinical staff

4.2 **Director of Infection Prevention and Control (DIPC) will:**

- have executive responsibility to the Trust Board for infection prevention and control, including outbreak management;
- report directly to the Trust Chief Executive and through Governance arrangements to the Trust Board;
- oversee local control of infection prevention and control policies and their implementation;
- be responsible for the Infection Prevention and Control Assurance Group within the Trust.
- has the authority to challenge inappropriate clinical practice as well as antibiotic prescribing decisions.

4.3 **The Infection Prevention and Control Assurance Group**

The purpose of the Trust Infection Prevention and Control Assurance Group is to ensure that;

- The Trust can demonstrate ongoing compliance with the Hygiene Code of Practice (DH, 2008, updated 2015).
- Infection Prevention and Control policies, procedures and additional guidance are endorsed, implemented, reviewed and audited on a rolling programme basis.
- Relevant national guidance is reviewed/implemented and assessment completed as indicated.
- Documents relevant to Infection Prevention and Control are received, discussed interpreted and disseminated across the Trust.
- The Trust Assurance Framework, as it relates to Infection Prevention and Control, is implemented and monitoring of action work plans.
- The Chief Executive and the Quality Assurance Group are alerted to any serious risks, problems or hazards relating to Infection Control Prevention and Control and make recommendations.
- Review reports on Healthcare Associated Infection and other infection prevention and control issues.
- Review all relevant audit reports, agree and monitor any associated action plans.
- Commission and approve policies for all aspects of Infection Prevention and Control and review their implementation.
- Produce and monitor the annual work programme for the Infection Prevention and Control Team for approval by the Trust Board.
- Advise on the most effective use of available resources for the implementation of the Infection Prevention and Control programme.
- Recommend amendments to local policies and procedures to ensure compliance with all relevant legislation, Health Service guidelines etc.

- Promote best practice in infection prevention and control within the Trust.
- Produce an Annual Report to the Trust Board.
- Monitor all SIRI's relating to Infection Prevention and Control quarterly, including risks for inclusion onto the Trust risk register and lessons learned.
- Provide a twice yearly report to the Quality Assurance Group.
- Action plans (local and Trustwide) relating to Infection Prevention and Control are monitored to ensure completion.

4.4 Head of Infection Prevention and Control will;

- Co-ordinate the provision of expert Infection Prevention and Control advice across the Trust during normal office hours.
- Attend the Quality and Performance Meeting as required to provide Board level assurance.
- Lead and co-ordinate the management of outbreaks of infection, including respiratory outbreaks, diarrhea and vomiting, MRSA and *Clostridium difficile*. Ensure the completion of individual outbreak reports and their dissemination to local teams.
- Ensure that all relevant legislation, Health Service guidelines etc are reviewed and that appropriate amendments/ additions are made to local policies and procedures.
- Ensure that Infection Prevention and Control procedures are continually reviewed and improved within the Trust and that changes to practice and/or procedures are disseminated to staff via local reporting mechanisms.
- Monitor compliance against infection prevention and control best practice and procedures, policy implementation, national and local objectives and statutory requirements. Non-compliance will be monitored through action plans, local or Trustwide, responsibility for completion and sharing local action plans remain with the relevant team.
- Manage the Infection Prevention and Control group's audit plan, report findings back to the Infection Prevention and Control Assurance Group and co-ordinate the reporting of audit results to relevant best practice groups and individual teams for local dissemination.
- Manage the Infection Prevention and Control Assurance Group's annual work plan and update the group quarterly.
- Co-ordinate the Infection Prevention and Control Team's response to inappropriate infection prevention and control practice and ensure findings are reported directly to local teams.
- Collate monthly outbreak of infection metrics for the Trust Board;
- Co-ordinate the Infection Prevention and Control Team's response in support of Trust staff during the assimilation of RCA data in relation to MRSA bacteraemias, PIR (Post Infection Review) and cases/ outbreaks of *Clostridium difficile* as per national guidance. Ensure results of these investigations are reported to outside agencies, at Trust level and locally.

- Co-ordinate the reporting of notifiable diseases to outside agencies as per national requirement.
- Co-ordinate the provision of infection prevention and control training and co ordinate cascade training for hand hygiene.
- Review all Infection Prevention and Control related Datix reports, co-ordinate any subsequent investigations and report findings, via Datix, to area leads for local dissemination and the original reporter.
- Co-ordinate thematic reviews as indicated through Datix and ensure findings are reported at all organisational levels, including to local teams.
- Formalise links with the Trust Antimicrobial Stewardship (AMS) Lead;
- Feedback any AMS issues identified as part of infection control remit to the AMS lead.

4.5 Healthcare Personnel

- all healthcare staff have a duty to act on and report at the earliest opportunity conditions or incidents that may be deemed infectious to others, e.g. communicable/notifiable diseases and resistant organisms (using the Datix on-line Untoward Event Reporting form accessible to all staff on the Trust Intranet).
- all healthcare staff are required to adhere to the policies, guidelines and procedures pertaining to the prevention and control of healthcare associated infection which provide a framework for safe and best practice.
- these guidelines are based on the recommendations of recognised national organisations/bodies including:
 - Department of Health (DH)
 - Infection Prevention Society (IPS)
 - NHS Estates
 - Public Health England (PHE)
 - Clinical Quality Commission (CQC)
 - Royal College of Nursing (RCN)
 - Health & Safety Executive (HSE)
 - Hospital Infection Society (HIS)
 - National Audit Office (NAO)
 - Medicines & Healthcare Products Regulatory Agency (MHRA)

5. DEFINITIONS

- **Infection** - The invasion and multiplication of microorganisms such as bacteria, viruses, and parasites that are not normally present within the body.
- **Control** - system of measures to manage an activity.
- **Transmission** (of infection) – the passing of a pathogen causing communicable disease from an infected host individual or group to a particular individual or group, regardless of whether the other individual was previously infected, via a direct or indirect route.

- **SIRI** – Serious Incident requiring Review. A SIRI can be identified as an incident where one or more patients, staff members, visitors or member of the public experience serious or permanent harm, alleged abuse or a service provision is threatened.

6. BACKGROUND AND GENERAL PRINCIPLES

- 6.1 This policy sets out how the Trust will aspire to reduce healthcare associated infection by providing the highest possible standards of infection prevention and control management within the limitations of available resources.
- 6.2 The Trust will provide locally adapted guidelines as statements of good practice based on systematic review of research and other evidence.
- 6.3 The Trust will generate infection surveillance data and feedback results to relevant parties in order to improve the quality of care.
- 6.4 The Trust will audit practice in relation to infection prevention and control policies and protocols and disseminate findings to appropriate groups.
- 6.5 The Trust will ensure an ongoing education programme, tailored to meet the needs of the service.
- 6.6 Leaflets and posters are available to service users and the public regarding the Trust's Infection Control arrangements and procedures, (see Appendices B, C & D).
- 6.7 The Trust recognises and respects the cultural and other differences between people and these will be taken into account when implementing this policy

7. CONTACT DETAILS

Head of Infection Prevention and Control
Somerset Partnership NHS Foundation Trust
Direct Dial: 01278 432132

8. TRAINING REQUIREMENTS

- 8.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- Staff Induction (e-learning Package) – Standard Infection Control Precautions
 - Hand Hygiene Training
 - Medical Devices

- Food Hygiene
- Infection Control e-learning package accessible on the Trust Intranet
- Untoward Event Reporting

9. MONITORING COMPLIANCE AND EFFECTIVENESS

9.1 Monitoring arrangements for compliance and effectiveness

- The Infection Prevention and Control Assurance Group reports directly to the Quality Assurance Group on a twice yearly basis.
- The chair of the Quality Assurance Group provides a quarterly report to the Quality and Performance Committee (a sub group of the Trust Board) and the Trust Lead for Infection Prevention and Control attends as required.
- Overall performance is monitored by the Finance and Investment Committee (a sub group of the Trust Board).
- Key surveillance and outbreak figures are reviewed by the Trust Board on a two monthly basis.
- The Director of Infection Prevention and Control provides an overarching annual Infection Prevention and Control report to the Trust Board.

9.2 Responsibilities for conducting the monitoring

- The Chair of the Quality Assurance Group will ensure required feedback reports from the Infection Control Assurance Group are timetabled within the Quality Assurance Group reporting schedule and present on appropriate agenda.
- The Chair of the Quality and Performance Committee will ensure required feedback reports from the Quality Assurance Group are timetabled within the Quality and Performance Committee reporting schedule and present on appropriate agenda. They will also request attendance of the Trust Lead for Infection Prevention and Control as required.
- The Chair of the Finance and Investment Committee will ensure required feedback reports from the Associate Directorate of Performance are timetabled within the Finance and Performance Group reporting schedule and present on appropriate agenda.
- The Head of Infection Prevention and Control will ensure the secretary to the Trust Board has the required key Infection Prevention and Control surveillance and outbreak figures for two monthly review by the Trust Board.

9.3 Methodology to be used for monitoring

- In line with the Terms of Reference the Infection Prevention and Control Assurance Group will produce an annual work plan and report progress to the Quality Assurance Group twice yearly.

- Key surveillance and performance indicators are discussed as Standing Agenda Items at each quarterly Infection Prevention and Control Assurance Group meeting and action plans for any issues of concern are monitored.
- The Group will regularly discuss and monitor the measures within the CQC registration standards, measures in relation to PLACE, new national guidance or relevant changes to best practice.
- Infection prevention and control related Patient Safety Alerts from CAS, SABS, Public Health Alert, MRSA and Medical Devices will be discussed and recorded within the Minutes of each quarterly meeting with detail of any action taken.
- New SIRI's, Significant Risks and Lessons Learnt relating to infection prevention and control will be discussed at each quarterly meeting and forwarded reported to the Quality Assurance Group.
- The Infection Prevention and Control Assurance Group will review this policy at least every three years, in accordance with any National Guidance or update legislation.
- Infection Prevention and Control will form part of the Trust Annual Audit Plan, results of relevant internal and external audits will be reviewed by the Infection Prevention and Control Assurance Group, internal audits include:
 - Isolation Practice
 - Peripheral Venous Cannula Care
 - Legionella Monitoring
 - Hand Hygiene
 - Disposal of Sharps
 - PPE
 - Ward Cleanliness
- external auditor investigations and reports will include:
 - PLACE Scores
 - Environmental Health Visit
- The Infection Prevention and Control Assurance Group will be responsible for agreeing and monitoring resulting action plans.
- The Infection Prevention and Control Team are responsible for ensuring all relevant audit results are reported to the associated best practice groups and to teams for local dissemination.
- Untoward incidents are reported via the Datix system, all Infection Prevention and Control related Datix reports are reviewed by the Trust Head of Infection Prevention and Control. The Datix system will be used to ensure the individual responsible for the reporting area, and the original reporter, are informed of the results of this review, including any subsequent investigation.
- Thematic reviews will be undertaken by the Infection Prevention and Control Team if indicated through untoward incident reporting. These would be reported locally, to relevant best practice groups and to the Infection Prevention and Control Assurance Group. Any resulting

action plans will be monitored through the Infection Prevention and Control Assurance Group.

- Specific monitoring and surveillance data is also reported to the Trust Commissioner to provide overall assurance with regard to Infection Prevention and Control.

9.4 **Frequency of monitoring**

- The Infection Prevention and Assurance Control Group will regularly monitor progress of the Annual Work programme by discussing at each quarterly meeting.
- progress report to the Quality Assurance Group twice yearly:
- new infection prevention and control SIRI's, Significant Risks and Lessons Learnt will be discussed as a Standing Agenda item at each quarterly meeting and reported to the Quality Assurance Group
- monthly key surveillance and outbreak of infection figures will be forwarded to the Chief Executive for inclusion into the summary report
- RCA/PIR and outbreak reports will be forwarded following outbreaks of infection to the Chief Executive for inclusion alongside the monthly metrics and will be reviewed quarterly by the Infection Control Assurance Group for Lessons Learnt
- the DIPC will report quarterly to the Trust Board on Infection Prevention and Control

9.5 **Process for reviewing results and ensuring improvements in performance occur.**

- Audit results will be presented to the Infection Prevention and Control Assurance Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring broad dissemination at all levels within the Trust and improvements, where necessary, are implemented.
- Action plans resulting from investigations relating to Infection Prevention and Control will be monitored through the Infection Prevention and Control Assurance Group. This group is responsible for disseminating findings at all levels of the organisation.
- Untoward incidents relating to infection Prevention and Control are reported and processed through the Datix system, responses are directed to the individual with responsibility for the area and the original reporter.
- Staff awareness is raised through the Trust newsletter, local dissemination and Best Practice and Special Interest Groups.

10. REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS

10.1 References

- DH (2003) Winning ways. Working together to reduce Healthcare Associated Infection in England. Report from the Chief Medical officer. London. DH.
- DH (2004a). Towards cleaner hospitals and lower rates of infection: A summary of action. London: DH.
- DH (2004b). Competencies for Directors of Infection Prevention and Control. London: DH.
- DH (2005). Saving lives: a delivery programme for reducing healthcare associated infection (HCAI) including MRSA. London: DH.
- DH (2006). Essential Steps to Safe, Clean Care: Reducing health care associated infection. London: DH.
- DH (2002) Getting ahead of the curve. A strategy for combating infectious diseases (including other aspects of health protection). London: DH.
- DH (2008, UPDATED 2015) The Health and Social Care Act 2008. Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance. London DH.
- DH/PHLS (1995) Hospital infection control: guidance on the control of infection in hospitals. HSG (95) 10. London. Department of Health.

10.2 Cross reference to other procedural documents

- Blood Borne Viruses Policy
- Cleaning and Decontamination of Equipment Policy
- Datix Risk Register Guidance
- Decontamination of Flexible Endoscopic Equipment Policy
- Dress Code (Uniform) Policy
- Hand Hygiene Policy
- Health and Safety Policy
- Induction (Corporate & Local) Policy
- Isolation Policy
- Laundry Policy
- Learning Development and Mandatory Training Policy
- Medical Devices Policy
- Medicines Policy
- Needlestick and Contamination Injury Policy
- Outbreak Management Policy
- Risk Management Policy and Procedure
- Serious Incident Requiring Investigation (SIRI) Policy
- Staff Training Matrix (Training Needs Analysis)
- Untoward Event Reporting Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

11. APPENDICES

11.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such.

Appendix A - Notice to all Visitors

Appendix B- Reducing the Risk of Infection in Hospital

Appendix C - Infection Control Assurance Framework Flowchart

Appendix D- Standard Operating Procedure for Infection Control

Appendix E - Standard Operating Procedure for Infection Control in Dental Settings

Notice to all Visitors

You can help prevent the spread of the diarrhoea and vomiting virus this winter

Please help us protect everyone in this ward:



Do not continue with your visit if you feel unwell or have recently had symptoms of diarrhoea and vomiting.

Stay at home if you have had diarrhoea and vomiting. Please do not visit the ward for at least two days after you have recovered.



Always clean your hands before entering the ward and after your visit.

If you are unsure or have any queries, then please see the Nurse in charge.

REDUCING THE RISK OF INFECTION IN HOSPITAL

What YOU can do to help

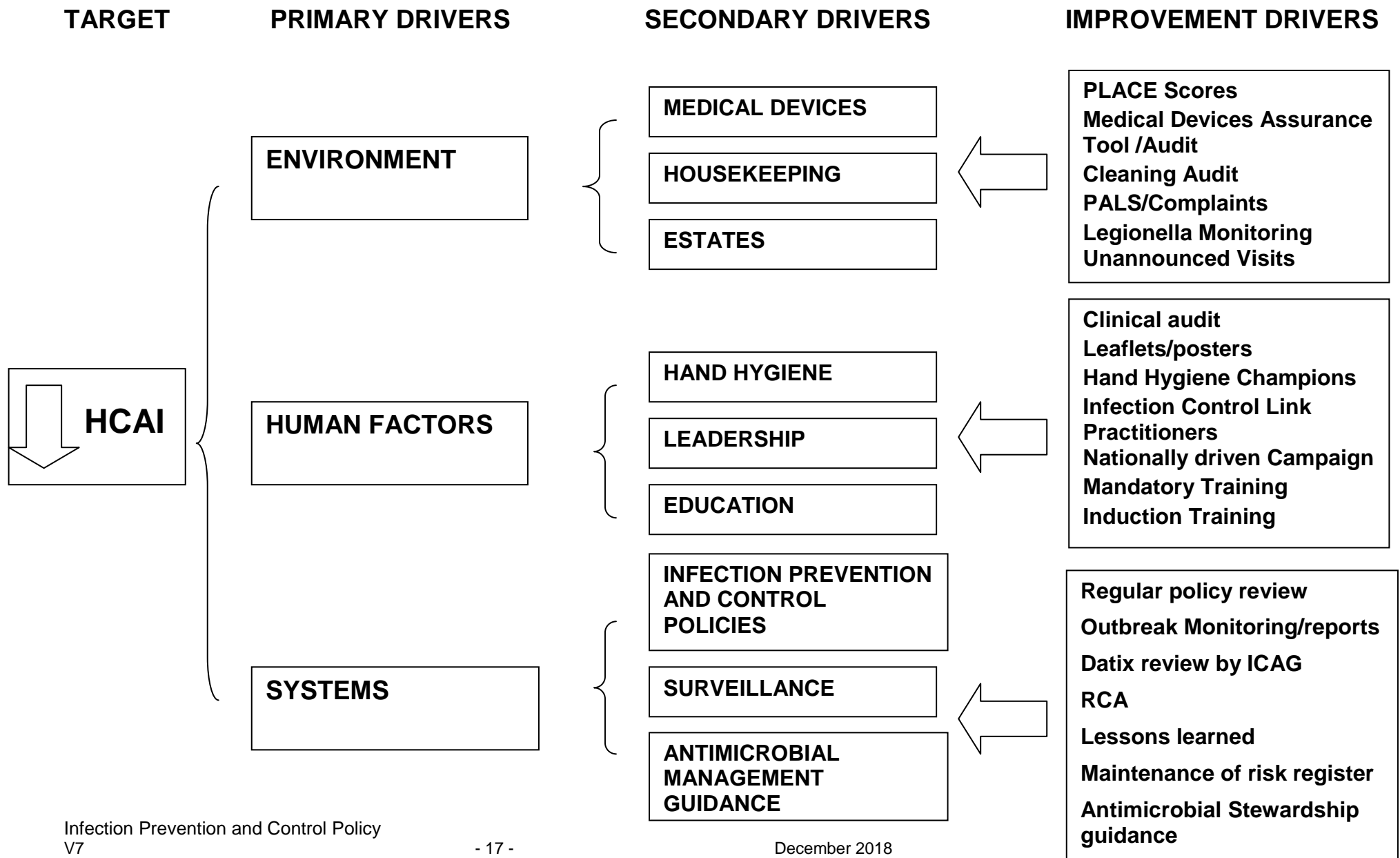
The publicity about hospital acquired infection (HCAI's) has caused a great deal of concern across the country; however the risk of acquiring an infection whilst in hospital remains low. As a patient, you can further help us to reduce the risk by following the advice we give in this leaflet which you will find is also relevant to your visitors.

- Personal hygiene is very important when you are in hospital. It is necessary to bring in with you all your personal toiletries including soap and facecloth.
- Always wash your hands after using the toilet and before meal times.
- Try to keep your bed space/room area free from clutter. This will allow the service assistants/housekeeping staff to clean your room properly.
- Your bed space/room should be cleaned regularly. If you or your visitors notice something, which has been missed during cleaning, report it immediately and request that it is cleaned.
- If you visit the bathroom or toilet and it does not look clean, report this immediately to the nurse in charge of the ward and use an alternative in the meantime.
- Staff can protect you by washing their hands or cleaning them with an alcohol hand rub.
- If a member of staff needs to examine you or perform a procedure do not be afraid to remind them to clean their hands, if you are worried they may have forgotten **it's OK to ask!**
- Encourage your visitors to wash their hands or use the alcohol hand rub before entering and leaving the ward. They should also be advised to cover up any open wounds, such as a cut finger, with a suitable dressing.
- If your visitors have symptoms such as diarrhoea or vomiting or infections such as chickenpox, **they must not visit.** Please discuss this with the nurse in charge of the ward.

Further information

If you have any further question, please ask your nurse, who can contact the Infection Control Team, if necessary.

Infection Control Assurance Framework Flowchart



STANDARD OPERATING PROCEDURE FOR INFECTION PREVENTION AND CONTROL ADVICE

All healthcare staff have a duty to act on and report at the earliest opportunity conditions or incidents that may be deemed infectious to others, e.g. communicable/notifiable diseases and resistant organisms.

All healthcare staff are required to adhere to the policies, guidelines and procedures pertaining to the prevention and control of healthcare associated infection, which provide a framework for safe and best practice.

In the event that staff identify or suspect conditions or incidents that may be deemed infectious to others, e.g. communicable/notifiable diseases and resistant organisms they **must** take the following actions:

During Office Hours (09.00-17.00) inform the Trust Infection Prevention and Control Team as follows:

- Land line/Answerphone: 01278 432132
- Senior Infection Prevention and Control Nurse (Interim Lead): 07825 656426
- Infection Prevention and Control Nurse: 07824 864947
- Infection Prevention and Control Nurse: 07795 841259

Out of Hours: staff must contact the on call Senior Manager who can contact the Taunton and Somerset NHS Foundation Trust Consultant Microbiology Team for any guidance required.

Standard Operating Procedure for Infection Control in Dental Settings

1. INTRODUCTION

- 1.1 The implementation of robust infection prevention and control practices is vital across the Somerset Primary Care Dental Service (PCDS).
- 1.2 The following protocol describes the local clinical processes which will mitigate the risk of cross infection for the Somerset PCDS, to be followed at all times and in each Dental Access Centre (DAC). If there is any aspect that is not clear, please firstly ask your Infection Prevention and Control Link Practitioner. Remember, any patients might ask you about the protocol so make sure you understand it.

2. PURPOSE AND SCOPE

- 2.1 This protocol aims to ensure and assist complete compliance with Department of Health (DOH) Hygiene Code of Practice (2008, updated 2015) and the Health Technical Memorandum 01-05 and CQC Outcome 8, Cleanliness & Infection Control.
- 2.2 This protocol applies to all staff working with the Somerset PCDS including Temporary, Locum, Bank and Contracted staff.

3. DUTIES AND RESPONSIBILITIES

- 3.1 Good infection prevention and control practice is the responsibility of every member of staff with in the Somerset PCDS.
- 3.2 Infection Prevention and Control Link Practitioners are appointed in each of the Somerset Partnership managed Dental Access Centres to assist in the provision of locally based infection prevention and control knowledge and support to other members of the dental teams.
- 3.3 Somerset Partnership NHS Foundation Trust has a dedicated/qualified Infection Prevention and Control Team. The team provide advice on general infection prevention and control issues and visit PCDS DAC sites to provide training, ensure minimum standards are adhered to and generally support staff in maintaining as safe an environment as possible in relation to Infection Prevention and Control. For details of this team, further relevant guidance, policies and procedures, please refer to the Somerset Partnership staff intranet, Infection Prevention and Control Policies and Protocols.

4. DEFINITIONS

- 4.1 Decontamination - a process which removes or destroys microorganisms to render an object safe for use. It includes cleaning, disinfection and sterilisation.
- 4.2 Cleaning - a process that removes foreign material (e.g. soil, organic material, micro-organisms) from an object.
- 4.3 Disinfection - is a process that reduces the number of pathogenic microorganisms, but not necessarily bacterial spores, from inanimate objects or skin, to a level which is not harmful to health.
- 4.4 Sterilisation - is a process that destroys all microorganisms including bacterial spores.

5. DECONTAMINATION OF INSTRUMENTS AND EQUIPMENT

- 5.1 Please refer to the trust Cleaning and Decontamination of Equipment Policy via the Intranet site.
- 5.2 Gloves and eye protection must be worn when handling and cleaning used instruments.
- 5.3 All re-usable instruments must be decontaminated/sterilized after use.
- 5.4 Single use instruments and equipment must be identified and disposed of safely, never reused. These items include all items which bear the single use symbol and, although not an exhaustive list, include: salivary ejectors, matrix bands, aspirator tips, stainless steel burs, polishing cups/brushes, any tepees or other brushes used on patients and endodontic files.
- 5.5 Before being used, all new dental instruments must be decontaminated fully according to the manufacturer's instructions.
- 5.6 The service will purchase instruments that can withstand automated pre sterilisation cleaning processes (via a washer-disinfector) and a vacuum autoclave sterilisation process.
- 5.7 At the end of each patient treatment, instruments should be transferred to the decontamination area for processing in the appropriate lidded containers. Transport containers should be cleaned with detergent wipes and left to dry after each use.
- 5.8 Staff will be appropriately trained as per the requirements of HTM 01-05 to ensure they are competent to decontaminate existing and new reusable dental instruments. Records of this training are kept.

6. CLEANING

- 6.1 Cements must be wiped off instruments before hardening.

- 6.2 Used instruments must be cleaned using the washer-disinfector following the manufacturer's instructions for use.
- 6.3 In the emergency event where all available washer-disinfectors are out of service please refer to Manual Cleaning Protocol.
- 6.4 When placing instruments in the washer-disinfector:
- Open instrument hinges and joints fully and disassemble where appropriate
 - avoid overloading instrument carriers or overlapping instruments
- 6.5 Staff at each base clinic have been trained to run routine tests (weekly protein detection test and daily soil test) to ensure washer disinfectors are running effectively. Data from each cycle is kept as proof of compliance. Please refer to appliance testing protocol for more information.
- 6.6 If a cycle of the washer disinfector fails on two consecutive attempts, the Senior Dental Nurse must be informed, the fault recorded in the faults log and an engineer called.
- 6.7 Washer Disinfectors are validated at installation, and are regularly serviced. All documentation for service records is filed and stored.

7. INSPECTION

- 7.1 After going through the washer disinfector all instruments should be dry.
- 7.2 Instruments are examined, using an illuminated magnifying glass, to make sure there is no sign of any rust or surface contaminants. If surface contaminants are seen the instrument is put through the washer disinfector again. If rust is found, or if the surface contaminant cannot be removed the instrument is disposed of as sharps waste.
- 7.3 If the instrument appears clean when examined under a good light (and magnification) they are ready to be pouched for the sterilisation process.
- 7.4 Dry handpieces must be lubricated before sterilisation but after cleaning.

8. STERILISATION

- 8.1 A vacuum (Type B) autoclave is used at all sites.
- 8.2 T1, T2 test cycles must be completed on each autoclave at the start of each week. A T3 (steam penetration) test cycle must be carried out prior to using the autoclave each day. Results of these tests must be documented and filed on the appropriate proforma. Please refer to appliance testing protocol for more information.
- 8.3 Instruments are to be pouched prior to being sterilised. Pouches must be stamped with the date they were processed before sterilisation.

- 8.4 Pouches should be folded along the perforated line and sealed once instruments placed within.
- 8.5 Pouches must be rotated with-in drawers. Storage of these instruments must not exceed 12 months, after this, instruments must be reprocessed.
- 8.6 Any instruments that are blunt, bent, damaged or show signs of corrosion should be disposed of as per the Healthcare Clinical Waste Policy.
- 8.7 All cycle data must be downloaded and checked and the relevant information recorded in the Eschmann log books by a trained and competent person.
- 8.8 If a cycle of either the washer disinfecter or autoclave fails on two consecutive attempts, the Senior Dental Nurse must be informed, the fault recorded in the faults log and an engineer called.
- 8.9 All water reservoirs must be drained at the end of each day and left to dry overnight.

9. WORK SURFACES AND EQUIPMENT

- 9.1 Clean and dirty area zoning should be in place at all times.
- 9.2 Between patient treatments, the local working area (work surfaces) and items of equipment must be cleaned using the Trust approved universal wipes. Alcohol free products should be used.
- 9.3 Items of equipment to be cleaned include the dental chair, inspection light and handles, hand controls, clinician operating unit (including bracket table, connectors and leads of handpieces, 3-in-1), spittoons, aspirator unit (including suction tubing) and, if used, x-ray units and controls and/or inhalation sedation unit. Other equipment that may have become contaminated must also be cleaned (e.g. Curing light, amalgamator).
- 9.4 The head rest cover and barrier shields, in appropriate locations, must be changed between each patient.
- 9.5 Suction tubing must be decontaminated at the end of each day using a suitable detergent e.g. Pull-Jet. Approximately one litre of prepared Pull-Jet solution must be used. Suction filters must also be thoroughly cleaned at this time.
- 9.6 In addition, cupboard doors and other exposed surfaces (including x-ray viewing box, clinician's stools, keyboards and computers) within the surgery should be cleaned daily with detergent wipes.
- 9.7 Cleaning under and behind washer-disinfectors and sterilizers must be completed regularly using the easy reach brushes provided. Thorough cleaning of these areas must also be completed whenever these items are moved for servicing.

10. IMPRESSIONS AND LABORATORY WORK

- 10.1 Dental impressions must be rinsed until visibly clean and disinfected by immersion using perform ID or classic impression disinfectant (as recommended by the manufacturer) and labelled as 'disinfected' on the laboratory docket.
- 10.2 Technical work being returned to or received from the laboratory must also be disinfected.

11. DENTAL EQUIPMENT FOR INSPECTION OR REPAIR

- 11.1 All equipment that comes into contact with blood or other bodily fluids will require decontamination/sterilisation prior to inspection or repair by an engineer or manufacturer.
- 11.2 Cleaning & autoclaving is the method of choice. For larger items (e.g. dental chair, dental operating unit, X-ray equipment) where this is not possible, chemical agents (detergent wipes) should be used.
- 11.3 A written certificate must be completed to confirm decontamination has been carried out. These are available in the Decontamination of Equipment policy.

12. HAND HYGIENE

- 12.1 The Somerset Partnership policy on hand hygiene must be followed routinely. The full policy can be found on the intranet.
- 12.2 Dedicated clinical hand wash sinks are available in every surgery and elbow taps are installed.
- 12.3 Nails must be short and clean and free of nail art, permanent or temporary enhancements (false nails), Gel polish or nail varnish. Arms must be bare below the elbow and staff must not wear watches or rings with stones. Any cuts in skin should be covered by a water proof plaster.
- 12.4 Wash hands using liquid soap between each patient treatment before donning and after removal of gloves. Follow the hand-washing techniques displayed at each hand wash sink.
- 12.5 Scrub or nail brushes must not be used; they can cause abrasion of the skin where microorganisms can reside. Ensure that paper towels and drying techniques do not damage the skin.
- 12.6 Alcohol based hand-rubs/gels can be used instead of hand-washing between patients during surgery sessions if the hands appear visibly clean. It should be applied using the same techniques as for hand-washing. There are no product recommendations for the maximum number of applications. If hands become “sticky”, then it is recommended that soap and water be used.

- 12.7 At the end of each session and following hand-washing, apply the hand cream provided to counteract dryness. Do not use hand cream under gloves; it can encourage the growth of microorganisms.

13. WATER SOURCES AND LINES

- 13.1 The constant use of a 1% concentration of Alpron in your Clean Water system is required to prevent Biofilm problems in the waterlines.
- 13.2 Use the Alpron Storage Canister to make up 5 litres of ready to use Alpron as per the manufacturer's instructions.
- 13.3 This ready to use Alpron solution needs to be changed/refreshed at a maximum interval of 4 weeks; this includes the Alpron on the spittoon and on the dental unit in each surgery. There should be a log sheet in each surgery to mark when this has been done and when the next change is due.
- 13.4 At the start of each session flush each dental line for 2 minutes and always flush between patients for 20-30 seconds. This is to ensure no oral bacteria are transferred between patients, as anti-retraction valves have been shown to fail on a regular basis.
- 13.5 A water dip test needs to be done every 3 months on samples of water from the 3 in 1 from both the dental chair and spittoon (if uses bottled system). This will normally be completed by the IPC link practitioner. Please refer to the manufactures guidelines (Quality Water Specialist LLP) for full details. This should then be recorded in the log provided. Securely label the culture and leave red side up in a suitable location to incubate for 7 days. Count any dots that appear on the slide and alert your senior dental nurse immediately should any sample fail the test.
- 13.6 Alpron certification is completed on an annual basis by the manufacturer.
- 13.7 For all water sources please refer to the Somerset Partnership: Guidelines for the prevention of legionella in healthcare premises – the flushing of infrequently used water outlets; this is available on the intranet. All outlets (including dental units with bottled water) must be assessed on a weekly basis and any that have been used less than three times in the week must be identified. All identified outlets must be flushed through as per the Somerset Partnership NHS Foundation Trust procedure guidelines. Log sheets must be completed on a weekly basis.

14. CLINICAL WASTE DISPOSAL

- 14.1 Please see the Somerset Partnership Healthcare Waste (Clinical Waste) Policy for further information and the Blood Borne Viruses Policy. Waste contaminated with blood saliva or other bodily fluids is regarded as clinical waste.
- 14.2 All domestic waste (including paper hand towels used to dry clean hands) is disposed of in black plastic bags.

- 14.3 Identified soft clinical healthcare waste is stored in orange sacks for collection. Clinical waste sacks must be no more than three-quarters full, have the air gently squeezed out to avoid bursting when handled by others and tied at the neck, not knotted. Orange sacks must be labelled with the date, postcode of DAC and according to the type of waste.
- 14.4 Sharps waste (anything that has the potential to puncture the orange bags, including needles, LA cartridges, scalpel blades, 3 in 1 tips, aspirator tips, steel burs, matrix bands, files and reamers etc.) must be disposed of in yellow UN type approved puncture-proof containers (BS 7320), and labelled to indicate the type of waste. Sharps containers must be disposed of when no more than two-thirds full.
- 14.5 Dental amalgam (including spent capsules, separated waste amalgam, and extracted teeth containing amalgam) and developer/fixer solutions must be disposed of as hazardous waste by the registered waste carrier appointed by the practice.
- 14.6 Clinical waste and sharps waste must be stored securely in the areas provided before collection for final disposal by the registered waste carrier appointed by the Trust. The waste carrier holds a certificate of registration with the Environment Agency.
- 14.7 At each collection of waste, the waste carrier issues a consignment note, which is retained by Somerset Partnership for 3 years.
- 14.8 All relevant staff will be trained in the handling, segregation, and storage of all healthcare waste generated in the practice. All staff who are involved in handling clinical waste or are exposed to body fluids should be vaccinated against hepatitis B.

15. PERSONAL PROTECTIVE EQUIPMENT (PPE)

- 15.1 Training in the correct use of PPE is included in the staff induction programme. All staff must receive updates in its use and when new PPE is introduced into the practice.
- 15.2 PPE includes protective clothing, disposable clinical gloves, plastic disposable aprons, face-masks, and eye protection.
- 15.3 Footwear must be fully enclosed and in good order.

16. GLOVES

- 16.1 The disposable clinical gloves used in the practice are CE-marked, latex-free and powder-free.
- 16.2 Anyone developing a reaction to protective gloves or a chemical must inform their Senior Dental Nurse immediately and referral to the Trust Staff Occupational Health Service must be undertaken.

- 16.3 Clinical gloves are single-use items and must be disposed of as clinical waste.
- 16.4 Long or false nails may damage clinical gloves, so nails should be kept short. False nails/gel overlays, Gel polish and nail polish are not permitted as per the Trust Hand Hygiene Policy.
- 16.5 Alcohol rubs/gels must not be used on gloved hands, nor should gloves be washed.
- 16.6 Gloves are worn for all clinical procedures and when handling contaminated objects.

17. PLASTIC APRONS

- 17.1 Plastic aprons should be worn during decontamination processes, when staff member may be exposed to splashes of body fluid/ contaminated fluids, and when changing X-ray chemicals. Aprons are single use and should be disposed of as clinical waste. Plastic aprons are removed by breaking the neck straps and gathering the apron together by touching the inside surfaces only.

18. FACE AND EYE PROTECTION

- 18.1 Face and eye protection must be worn during all operative and decontamination procedures. Face masks are single use items and must be disposed of as clinical waste.
- 18.2 A visor or face shield should be worn to protect the eyes; spectacles do not provide sufficient protection. Eye protection should be cleaned according to the manufacturer's instructions, when it becomes visibly dirty, and/or at the end of each session. Disposable visors should be used where possible.
- 18.3 Staff should wear eye protection when engaged in any procedure where aerosol or particles might be created (including washing instruments, changing solutions, and trimming dentures).

19. PROTECTIVE CLOTHING

- 19.1 Staff are provided with uniforms to be worn in clinical areas (see Somerset Partnership Intranet: Uniform Policy for all Somerset Partnership Staff).
- 19.2 Protective clothing becomes contaminated during operative and decontamination procedures.
- 19.3 Surgery clothing should be clean at all times and freshly laundered clothing worn every day. Visibly contaminated uniform should be changed immediately.
- 19.4 Machine washing at 60C° with a suitable detergent is advised.

19.5 Clinical uniforms are not to be worn outside the clinic except when attending a domiciliary patient.

20. DOMICILIARY VISITS

20.1 All infection prevention and control procedures as documented in the rest of this protocol must be followed where ever possible during domiciliary visits, including zoning of clean and dirty areas.

20.2 Where hand wash sinks are not available, alcohol gel can be used as an alternative. Please see item number 9.6 above.

20.3 Medical instruments to be packaged and transported in an appropriate container, both prior to and following use of, until decontamination facilities available at base clinic.

20.4 All medical instruments requiring cleaning and sterilisation are to be kept moist using an enzymatic spray, and put into a separate lidded plastic container, **of appropriate size**, to ensure that clean and dirty equipment are kept separated.

20.5 Please refer to Somerset Partnership: Protocol for Handling of District Nursing and Domiciliary Clinical Waste. Where the clinical waste arises from a patient that is not known or not suspected to have a disease caused by a micro-organism or its toxin and waste fits into a white care bag, with the patient's consent, this can be disposed of in the patient household waste bin. This is inclusive of gloves, aprons, gauzes etc.

20.6 Orange bags are not routinely used, unless risk assessment deems patient is high risk. If used, they must be left in a safe place in the home and arrangements made with the County Council for clinical waste collection from that site.

20.7 **If it is not possible to dispose of sharps in approved sharps containers belonging to the domiciliary setting (for example a nursing home), sharps waste should be safely secured in a 2 litre (or other appropriately sized) approved yellow sharps bin. The sealed sharps bin should be further secured in the locked domiciliary box before transporting back to base for safe disposal.**

20.8 Following the above advice, it should be impossible for sharps to be displaced into the transporting vehicle, but, it may still be prudent to inform any mechanic working on the vehicle that it has been used for the transportation of sharps.

21. MINIMISING BLOOD-BORNE VIRUS TRANSMISSION AND IMMUNISATION

21.1 Staff identified on appointment as at risk of exposure to blood borne viruses will be required to undergo an occupational health assessment. Records of these assessments will be held securely by the Trust Occupational Health Provider to ensure confidentiality is maintained.

- 21.2 Staff will be required to provide evidence to Occupational Health of being vaccinated against Hepatitis B, Diphtheria, Poliomyelitis, Pertussis, Rubella, Tetanus and TB. All staff to be offered the annual Influenza vaccine.
- 21.3 All clinical staff must be immunised against hepatitis B; records of hepatitis B seroconversion will be held securely by Occupational Health For those who do not seroconvert or cannot be immunised, advice will be sought on the appropriate course of action.
- 21.4 Ultra Safety Plus syringes are supplied for all dental injections in line with the European Directive: Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.
- 21.5 In the event of an inoculation injury, the wound should be allowed to bleed, washed thoroughly under running water and, if required, covered with a waterproof dressing, in accordance with the Somerset Partnership Contamination Injury Poster (displayed in all surgeries and decontamination rooms). All inoculation injuries must be reported to the senior person on duty. Call the Optima Occupational Health needle stick and contamination advice line on **0844 826 0308**. Report on the DATIX system. Confidential records of these injuries will be maintained, as required under current health and safety legislation.

22. BLOOD SPILLAGE PROCEDURE

- 22.1 Please also refer to the Standard IPC Precautions Policy including Blood and Body Fluid Spillage, to be read in conjunction with Healthcare Clinical Waste Policy and Hand Hygiene Policy.
- 22.2 Spillages of blood occur rarely in dentistry, although there might be occasions when a surface becomes grossly contamination with blood or blood/saliva. If blood is spilled – either from a container or as a result of an operative procedure – the spillage should be dealt with as soon as possible using the body fluid spillage kit. The spilled blood should be treated with sodium dichloroisocyanurate granules, producing 10,000 ppm chlorine, and completely covered by disposable towels, Good ventilation is essential. At least 5 minutes must elapse before the towels etc. are cleared and disposed of as clinical waste.
- 22.3 Appropriate protective clothing must be worn when dealing with a spillage of blood: gloves, protective eyewear and a disposable apron. Care should be taken to avoid unnecessary contact with metal fittings, which can corrode in the presence of sodium hypochlorite. The use of alcohol in the same decontamination process should be avoided.

23. ENVIRONMENTAL CLEANING

- 23.1 The non-clinical areas of the practice are cleaned, in line with Somerset Partnership policy and cleaning contracts, by contract cleaners.
- 23.2 The cleaning contract is managed by the Estates and Facilities Management, a multi-disciplinary team lead by the Facilities Manager. Facilities Management can give advice on cleaning and audit schedules as well as any problems identified.
- 23.3 All staff have a responsibility to monitor the cleanliness of the practice and report any concerns to their Senior Dental Nurse for further escalation and action.
- 23.4 Records of cleaning protocols and audits/checks on its efficacy are analysed, actioned and retained.

24. REVIEW

- 24.1 This protocol and the policies referred to within it, will be reviewed at regular intervals to ensure currency and amended as required by changes within the practice and legal and professional requirements.

25. TRAINING REQUIREMENTS

- 25.1 The trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Intranet.
- 25.2 Every member of staff will receive training in all aspects of infection control as part of their induction program and through regular mandatory update training, annually.
- 25.3 Appropriate records of this mandatory training will be maintained for all members of staff.
- 25.4 Clinical members of staff also have a responsibility to keep up to date through Continuing Professional Development requirements as dictated and monitored by the General Dental Council, the statutory professional regulator of dentists and dental clinical professionals

26. MONITORING COMPLIANCE AND EFFECTIVENESS

- 26.1 All staff of the PCDS are responsible for monitoring standards of infection control and prevention across the DACs and ensuring all advice and instruction within this protocol is strictly followed. Any concerns identified should be raised either with their Infection Prevention and Control Link Practitioner or Senior Dental Nurse and escalated using the appropriate channels.

26.2 **Process for Monitoring Compliance**

- Annual HTM 01-05 Compliance Audit undertaken by the Infection Prevention and Control Team
- Interim 6 monthly HTM 01-05 Compliance Audit undertaken by local Dental teams

Non-compliant outcomes investigated, and actions undertaken to mitigate risk.

27. **REFERENCES, ACKNOWLEDGEMENTS AND ASSOCIATED DOCUMENTS**

27.1 **References**

DH (2013) Health Technical Memorandum 07-01 – Safe management of healthcare waste.

DH (2013) Health Technical Memorandum 01-05 - Decontamination in primary care dental practices (2013 Edition).

DH (2008, UPDATED 2015) The Health & Social Care Act 2008. Code of Practice for health and adult social care on the Prevention and Control of Infections and related guidance.

The management of Health and Safety at Work Regulations 1999.

Health and Safety at Work Act 1974.

CQC Registration Standards

European Directive: Health and Safety (Sharps Instruments in Healthcare) Regulations 2013.

27.2 **Cross reference to other procedural documents**

Antimicrobial Prescribing Policy

Blood Borne Viruses Policy

Cleaning and Decontamination of Equipment Policy

Hand Hygiene Policy

Health and Safety Policy

Induction (Corporate & Local) Policy

Infection Control Surveillance Policy

Infection Prevention and Control Policy

Laundry (Handling) Policy

Learning, Development and Mandatory Training Policy

Medical Devices Policy

Needlestick and Contamination Injury Policy

Risk Management Policy and Procedure

Standard IPC Precautions Policy including Blood and Body Fluid Spillage
Uniform Policy for all Somerset Partnership Staff
Untoward Event Reporting Policy
Waste – Healthcare Clinical Waste (including Domiciliary Waste) Policy
Waste – Non Clinical Waste Policy
Water Safety (including Legionella) Policy

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.