1. Introduction

1.1 Purpose

This guidance has been developed by Health Protection Scotland in conjunction with an expert working group to standardise the ‘Infection Prevention and Control’ guidance within NHS and non-NHS Primary and Community Care settings in NHSScotland. The content of this guidance is based on current scientific evidence; a complete literature strategy and review which are available at http://www.hps.scot.nhs.uk/haiic/ic/publicationsdetail.aspx?id=42153. This literature base is consistent with the content of Health Protection Scotland’s National Model Policies on Standard Infection Control Precautions. In addition a wider consultation process was used to ensure that expert opinion within the wider NHS and non-NHS has been considered. This guidance was produced on behalf of the Scottish Government Health Directorate as part of the Healthcare Associated Infection (HAI) Task Force (HAITF) Action Plan August 2008.

This guidance will provide practitioners with infection prevention and control measures that should be applied at all times by all practitioners throughout Scotland when delivering healthcare within NHS and non-NHS Community and Primary Care settings. As infection prevention and control is an integral component of clinical governance, this guidance can be used to assist practitioners to quality assure their infection control practices and policies, ultimately improving patient, staff and public safety.

1.2 Use of the guidance

This guidance is intended for use by all those involved in infection prevention and control in order to minimise the risk of HAI within NHS and non NHS Community and Primary Care settings in NHSScotland. Sector specific guidance (where this exists) should be considered in conjunction with this guidance.

This will include: Chief Executives/Senior Managers, Infection Control /Health Protection Teams, General Medical Practitioners, General Dental Practitioners (and the dental team), Public Health Nurses, Community Nursing Teams, Practice Nurses, Consultant Medical Microbiologists, Consultants in Public Health Medicine, Antimicrobial Management Teams, Podiatrists, Community Pharmacists, Optometrists and all other allied health professionals: all Healthcare Workers or Independent Contractors providing care in the NHS and non NHS community and primary care setting.

1.3 Scope

This guidance defines the principles of Standard Infection Control Precautions (SICPs) which are a set of measures to be applied at all times within a healthcare setting or where healthcare is being provided e.g. in a patients own home or doctors surgery. These principles should be applied for both recognised and unrecognised sources of infection and are intended to protect the patient, the healthcare worker and any visitors/carers. The principles outlined in this guidance can also be applied as good practice measures within other independent care settings such as care homes.
The application of SICPs is determined by the level of interaction between the patient and the healthcare worker and the extent of anticipated exposure to blood and body fluids or infectious agent (e.g. for venepuncture only hand hygiene and gloves may be necessary). This requires a risk assessment by the healthcare worker undertaking the procedure.

SICPs must underpin all healthcare activities and should be applied at all times, when exposure to blood, other body fluid secretions or excretions (except sweat), non intact skin or mucous membranes may occur. The principles also apply to equipment or items in the patient environment that may have become contaminated.

There are ten elements to SICPs which are defined in this guidance. These principles do not prevent cross transmission of all infectious agents and additional Transmission Based Precautions may be required.

### 1.4 Legislation

There is a wide variety of legislation around infection prevention and control. The main components are contained within the Health & Safety at Work Act and Regulations and are based on the **assessment of risk to patients, healthcare staff and the public**. This underpins every aspect of this guidance.

The key legislation includes the following:

- **The Health & Safety at Work Act 1974** requires an employer to provide as far as possible a safe working environment. This Act also ensures that employees take reasonable precautions to ensure they undertake safe working practices.

- **The Health & Safety at Work Regulations 1992** requires employers to assess the risk to their employees and put in place control measures. In regard to infection control this includes Personal Protective Equipment (PPE), hand hygiene facilities and safe disposal of waste.

- **The Control of Substances Hazardous to Health Regulations 2002**, requires protection in the workplace against hazardous substances, including chemical and biological agents.

### 1.5 Rationale

This guidance has been developed as part of the Scottish Government’s strategy to prevent and control Healthcare Associated Infection (HAI).

HAIa are defined as ‘infections which are not present at the time the patient’s healthcare journey begins, but which arise afterwards (HPS, 2007)’. This can occur anywhere healthcare is delivered such as in an in-patient area, community setting or even a patient’s own home.

HAIa costs NHSScotland an estimated £183 million per year and are among the most frequent and costly adverse events in healthcare (HPS, 2007; Rigby et al, 1999). There is also evidence from several countries that many HAIa are avoidable by the application of infection control policies and guidance (HPS, 2007).
The ‘National HAI Prevalence Survey’ (2007) identified an overall HAI prevalence for non-acute hospitals of 7.3%. The actual prevalence of other community and primary care settings is not known but is expected to be as great as in-patient areas (Chambers, 2005; Penn, 2005; NHS QIS, 2004).

1.6 Aims and Objectives

Main aim:

- To provide users with a set of infection prevention and control measures which are designed specifically to assist in preventing and controlling infection from recognised and unrecognised sources of infection during care delivery in NHS and non-NHS Community and Primary Care Settings.

Objectives:

- To describe the ten elements of SICPs.
- To assist practitioners to apply SICPs taking into account the needs of the individual receiving care, the setting, the intervention/procedures/activities being undertaken and the exposure to blood/body fluids.
- To provide a standardised, consistent approach, to infection prevention and control within NHS and non-NHS Community and Primary Care settings.
- To be used in conjunction with other guidance, initiatives and activities already underway in many local and national settings.
- To act as reference material to assist healthcare staff directly involved in communication with patients and the general public in relation to HAI.

This guidance does not include:

- clinical procedures;
- local implementation strategies; and
- infection prevention and control measures that require additional Transmission Based Precautions (TBPs) when infectious agents are known or suspected e.g. Clostridium difficile, Mycobacterium Tuberculosis.

This and other relevant information can be found using the following links:

http://www.hps.scot.nhs.uk/haiic/ic/modelinfectioncontrolpolicies.aspx
http://www.hps.scot.nhs.uk/haiic/ic/bundles.aspx
2. Responsibilities for the implementation of the guidance

NHS Scotland Boards must:

• Ensure that systems and resources are in place to facilitate implementation and compliance monitoring with this guidance and the related legislation amongst all NHS staff and these issues have been addressed within contracts with independent contractors/providers.

Managers (or Practice Principal) of all services providing healthcare must ensure that staff:

• Are aware of and have access to this guidance.
• Have instruction/education on this guidance.
• Have adequate support and resources available to implement and monitor compliance with this guidance.
• Undertake risk assessments to assist in implementation of this guidance, commensurate with work activities in the various settings and to comply with legislation.
• Raise any health concerns e.g. diarrhoea and vomiting, or occupational exposure injury e.g. needlestick injury, to the relevant agency e.g. General Medical Practitioner or Occupational Health Department.
• Undertaking Exposure Prone Procedures (EPP) have undergone the required health checks/clearance.
• Ensure that Infection Prevention and Control is included as an objective in Personal Development Plans (or equivalent).

Healthcare workers providing healthcare must ensure that they:

• Apply the principles of SICPs outlined in this guidance.
• Undertake risk assessments when assessing the infection prevention and control requirements to individual situations.
• Communicate the infection prevention and control measures to be taken, dependant on activities, to other colleagues, the patient and relatives/carers without breaching confidentiality.
• Ensure occupational immunisations/health checks/clearance requirements are up to date (if applicable).
• Report to line managers and document (using adverse management systems) any deficits in knowledge, resources and compliance in relation to SICPs, facilities/equipment or incidents that may result in transmission of HAI.
• Attend any mandatory or updates in infection prevention and control education.
• Report any illness or condition which may potentially put others at risk of contracting an HAI to their line manager and Occupational Health Department (if applicable).
• Not provide direct patient care while at risk of potentially transmitting infectious agents to others e.g. suffering from diarrhoea. If in any doubt consult with their manager, General Medical Practitioner, Occupational Health Department or the local Infection Control/Health Protection Team.

• Adhere to any exclusion periods as directed by Infection Control/Health Protection Team.

**Staff with infection control/health protection responsibilities must provide the following according to their area of expertise:**

• Assist with the implementation of this guidance.

• Expert advice.

• Advice on individual risk assessments as required.

• Recommendations for improvements to practice where appropriate.
3. General principles of Standard Infection Control Precautions in NHS and non-NHS Community and Primary Care Settings

3.1 Hand Hygiene

Hands should be cleaned frequently in order to prevent Healthcare Associated Infection (HAI). The most important opportunities occur during care delivery.

'Your 5 moments for Hand Hygiene' should be followed:

- Before touching a patient.
- Before a clean/aseptic task.
- After body fluid exposure.
- After touching a patient.
- After touching patient surroundings.

By following the approved hand hygiene technique (Appendix 1) pathogenic microorganisms will be removed and therefore the spread of infectious agents will be reduced, particularly those that may cause HAI.

Practice points:

- Ensure equipment is available such as hand wash basin, disposable towels, liquid soap and/or alternatively alcohol based hand rub if hands are physically clean (if outwith the clinical area, such as visiting patient at home, it is advisable to carry liquid soap, paper towels and/or alcohol based hand rub).
- Alcohol based hand rub should not be used alone when providing healthcare for people with norovirus and/or Clostridium difficile (Appendix 1 & Appendix 2).

Hand washing

- In clinical or personal care situations ensure the hand wash basin is free from extraneous items, e.g. equipment, cups, nail brushes.
- Ensure jackets/coats/wristwatches are removed.
- Work wear/clothing that does not go past the elbow is required to expose wrists and forearms, termed ‘bare to the elbows’.
- Jewellery should be removed (a plain band is acceptable providing these can be moved up to clean underneath).
- Ensure nails are short, clean and free of nail polish (false nails must not be worn when providing healthcare).
- The water temperature, should be warm (mixer taps are preferable in clinical areas).
- Always wet hands before applying the liquid or antimicrobial soap (if required).
- Apply the appropriate volume of soap, usually a dispensed amount (3mls).
Cover all areas of the hands and wrists using the defined technique in Appendix 1. This should take at least 15 seconds.

Hands and wrists should then be rinsed well under the running water without touching the taps or sink.

Pat hands dry ensuring thoroughly dried.

Taps should be turned off using a ‘hands-free’ technique, e.g. elbows or wrists. Where ‘hands-free’ lever taps are not in place, paper towels can be used.

Dispose of the paper towels into the domestic/household waste without touching the waste receptacle.

Hand rub

Alcohol based hand rub is used as an alternative to hand washing and is the recommended product for ensuring effective hand hygiene in all patient care situations except when:

- Hands are visibly soiled;
- The patient has diarrhoea and/or vomiting;
- There is direct hand contact with any body fluids;
- There is an outbreak of diarrhoeal illness e.g. norovirus and Clostridium difficile.

To apply alcohol based hand rub cover all areas of the hands using the defined technique in Appendix 2. It should take at least 20 seconds to complete the procedure.

There is currently no scientific evidence available to detail the amount of times alcohol based hand rub can be used before hand washing is required. This differs depending on the product and activities undertaken.

In optometry settings alcohol based hand rub should be used with caution as the residual effect achieved from these products can cause irritation to the patient e.g. when demonstrating the fitting of contact lenses.

General

- A surgical scrub may be required for example during surgical or invasive procedures defined at a local level. This is a defined technique including hands and forearms (to the elbow). This procedure takes 2 minutes.

- It is important to protect the skin on hands from drying and cracking where bacteria, in particular, may harbour, and to protect broken areas from becoming contaminated particularly when exposed to blood and body fluids.

- Hand creams can be applied to care for the skin on hands, however, only individual tubes of hand cream should be used or hand cream from wall mounted dispensers.

- Creams used should not affect the action of hand cleaning solutions being used or the integrity of gloves.
3.2 Respiratory Hygiene/Coughing and Sneezing Etiquette

Hand hygiene plays an important part in the control of respiratory hygiene/coughing and sneezing etiquette. This information was previously included in the hand hygiene element. However due to the current and continuing threat from Pandemic influenza this now forms a separate element.

**Practice Points**

- Cover nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses.
- Dispose of used tissues in the nearest waste receptacle.
- Wash hands after coughing, sneezing, using tissues, or after contact with respiratory secretions and contaminated objects.
- Keep hands away from the mucous membranes of the eyes and nose. Certain patient/clients (e.g. the elderly, children) may need assistance with containment of respiratory secretions. Those who are immobile will need a receptacle (e.g. a plastic bag) readily at hand for the immediate disposal of used tissues and be offered hand hygiene facilities.
- Within certain healthcare settings e.g. in waiting rooms (particularly during Pandemic influenza) if the healthcare worker is in close contact (3 feet) it may be pertinent for symptomatic patients to wear a surgical mask as a precautionary measure. This guidance is available on [http://www.hps.scot.nhs.uk/resp/influenza.aspx?subjectid=95](http://www.hps.scot.nhs.uk/resp/influenza.aspx?subjectid=95)

3.3 Personal Protective Equipment (PPE)

**Practice Points - Gloves**

- Gloves must be appropriate for use, fit for purpose and well fitting to avoid interference with dexterity, friction, excessive sweating, finger and hand muscle fatigue. The criteria for glove selection are contained in Appendix 3.
- Disposable gloves should be donned prior to commencement of any procedure where exposure/contamination might occur by holding the wrist end of the glove open with one hand, which allows the other hand to enter easily (do not wear jewellery under gloves).
- A double gloving strategy may be considered in particularly high risk situations and requires local risk assessment e.g. Exposure Prone Procedures (EPP).
- The use of gauntlet style (long arm) gloves to cover forearms may be necessary in certain situations where a risk assessment identifies the need e.g. when there is a risk of a significant exposure.
- **Gloves should be changed between patients/clients/procedures.**
- It may also be necessary to change gloves between tasks on the same patient to prevent further cross-contamination.
- Disposable gloves must NEVER be washed or alcohol based hand rubs applied to gloves during or after use.
- Never re-use single use disposable gloves.
• Remove gloves that have been used for a procedure, immediately after the task is finished.

• **Gloves are not a substitute for employing good hand hygiene. This should be performed each time gloves are removed.**

• Torn, punctured or otherwise damaged gloves should not be used and should be removed immediately (safety permitting) if this occurs during a procedure.

**Practice points - aprons/gowns**

• Aprons/gowns should be appropriate for use, fit for purpose, and avoid any interference during procedures.

• Disposable, single-use plastic aprons are preferred when exposure to blood and other body fluids might occur, particularly in healthcare settings. Never reuse/wash single-use disposable aprons/gowns.

• An impermeable gown should be worn when there is a risk of significant splashing of body fluids rather than a plastic apron, e.g. in theatre type settings during minor surgery such as insertion of dental implants/during invasive procedures/local decontamination rooms.

• The main use of aprons/gowns is to protect the user’s workwear/uniform which is not considered as PPE.

**Practice points - face, mouth/eye protection, e.g. surgical masks/goggles, visors**

• Face, mouth/eye protection (face shields/visors) should be worn when splashing/aerosolisation/contamination from blood/other body fluids might occur.

• Some disciplines e.g. dentistry/midwives (during delivery), may be required to wear face mask/visor and/or goggles routinely due to the risk of splashing.

• Surgical masks are not routinely advised for blood and body fluid protection. If used these should always fit comfortably, covering the mouth and nose. When not in use for protection, they should be removed and not worn around the neck.

• Goggles should provide adequate protection when the risk of splashing is present, e.g. those used must ‘wrap around’ the eye area to ensure side areas are protected.

• Face shields/visors may be considered, in place of a surgical mask and/or goggles, where there is a higher risk of splattering/aerosolisation of blood/other body fluids.

• Personal glasses are not a form of eye protection

**Put on** PPE in the following order – apron (or gown), surgical mask, eye protection, gloves.

**Remove** PPE in the following order – gloves, apron, gown, eye protection, surgical mask.

• Care should be taken on removal of PPE to avoid cross contamination.
3.4 Control of the Environment

The environment where community and primary care is delivered is diverse. Clinical/personal care areas/items/equipment shared by different patients, relatives or carers (e.g. toilets) can become contaminated with blood, other body fluids, secretions and excretions containing potentially pathogenic microorganisms. The generic types of disinfectants and detergents for environmental cleaning in a clinical setting is summarised in Appendix 4.

The physical environment where clinical procedures are undertaken for example general practice, dentistry or podiatry, require the following:

- The room should be of a sufficient size to contain the minimum amount of equipment to allow staff to work unhindered.
- The work surfaces should be smooth, impervious, waterproof and able to withstand cleaning and/or disinfection.
- A hand wash basin with lever-operated mixer taps, no plug or overflow (with taps that do not discharge directly over the drain), wall mounted liquid soap, antiseptic hand solution, and disposable towels.
- A pedal foot operated lined bin.
- Alcohol based hand rub should be available at the point of care e.g. bed/couch/chair side.
- The room should have adequate storage facilities.
- The furniture, fixtures and fittings should be clean, washable, moveable and in a good state of repair.
- If privacy screens are used around examination couches these should be laundered at least twice yearly or when visibly contaminated.
- The clinical/personal care area should be such that the areas for clean and dirty procedures are clearly defined (zoned) and arranged to reduce the risk of cross contamination.
- The floors should be intact and seam free with coved edges. The covering should be able to withstand cleaning and disinfection such as vinyl.
- The walls and ceilings should be smooth, impervious and washable, and able to withstand cleaning and/or disinfection.
- The lights should be sufficiently bright and of a suitable construction that allows easy cleaning.
- Ventilation should meet standards required for the procedures to be carried out. If required mechanical ventilation should be used.
- Fixtures and fittings (including radiators) must be in good condition and easily cleaned.
- Window curtains should be avoided.
- If curtains are used these should be laundered yearly. Washable blinds are more appropriate and these should be removed and cleaned yearly and/or when visibly soiled. Blinds should be suction cleaned monthly.
• Disposable paper sheeting should be used for examination and operating couches.
• A routine cleaning schedule must be available in the clinical/surgery/personal care area. This will detail the level and frequency of cleaning required and should be based on a local risk assessment and reflect local infection control guidance/policy to ensure that the environment is clean at all times. The schedules should specify the item(s) to be decontaminated, frequencies and the methods used. Guidance can be found in ‘NHSScotland Cleaning Specification’ (2009).
• Within NHSScotland premises, the ‘NHSScotland Cleaning Specification and Colour Coding of Hospital Cleaning Materials’ should be complied with in in-patient areas.
• In non-NHS settings, the principles outlined in Section G of the NHSScotland National Cleaning Specifications should apply as a good practice principal.

Practice points:
• Always wear PPE e.g. gloves and apron, and dispose of this immediately following use between patients and/or interventions by referring to local infection control policies.
• Gather all relevant equipment and ensure that equipment/receptacles are clean before use. Cloths used for cleaning must be single use and disposable.
• The choice of cleaning agent (detergent) is important.
  o General purpose neutral detergent is suitable for routine environmental cleaning of non clinical surfaces (antimicrobial agents must not be used e.g. chlorhexidine) local infection control policies must be followed.
  o Alcohol wipes should not be used for routine cleaning of the environment (these are only suitable for disinfection of stainless steel e.g. dental bracket tables following cleaning).
  o In the absence of appropriate cleaning agents and facilities, detergent wipes may be a suitable alternative for routine cleaning of the environment e.g. clinics within non-healthcare settings.
• Follow manufacturers’ instructions provided on cleaning agents in regard to dilutions, expiry dates and storage.
• Use warm (hand hot) water with general purpose neutral detergent applied with disposable cloths.
• Disinfectants should not be used for routine cleaning with the exception of items such as toilets and wash hand basins. If required for other areas/items due to infection or the presence of organic matter such as blood splatter, the disinfectant should be a chlorine releasing agent. N.B. Chlorine releasing agents cannot be used on stainless steel. Manufacturer’s instructions on dilution and contact times should be followed.
• ‘Damp dusting’ with a general purpose neutral detergent and warm water is the recommended method for routine cleaning of the environment.
• Ensure all areas are thoroughly cleaned and free from dust and grime, paying particular attention to harder to reach areas, e.g. corners, edges, underneath of couches, etc.
• Air-drying following washing is generally acceptable, however, if areas are particularly wet these should be dried with clean, preferably disposable, cloths.

• Soft furnishings, such as carpets, should be vacuumed and can also be wet-vacuumed when necessary. Carpets should not be fitted in places where clinical interventions are carried out. Furniture should be free of dust and staining.

• In the healthcare setting vacuums are required to be fitted with a HEPA filter which should be changed following manufacturer’s guidance. This is also a recommendation for non-NHS community and primary care premises.

• Items should be checked while cleaning for any damage and these reported and removed/replaced/repaired as appropriate.

• Any additional information on cleaning/disinfecting agents to be used at specific times should be discussed with Infection Control/and or Health Protection staff.

• If a spillage of blood or other body fluids occurs, this must be managed by following section 3.5 Management of Blood and Body fluid Spillages.

Additional considerations (home setting):

• The healthcare worker should be satisfied that the environment where they are delivering care is safe for both the patient and themselves. Healthcare workers should risk assess the patients requirements and their environment and apply the measures advised in this guidance to ensure optimum patient care.

3.5 Management of Blood and Body Fluid Spillages

Occupational exposure to blood, other body fluids, secretions and excretions through spillages poses a potential risk of infection, particularly to those who may be exposed while providing health or personal care. The safe and effective management of such spillages is, therefore, essential in order to prevent transmission of infection via this route, and to comply with Health and Safety Legislation.

Practice points:

• Personal protective equipment e.g. disposable gloves and aprons are essential. Goggles/face protection/visor may be required if there is a risk of splashing to eyes/mouth e.g. if exposure to splashing or aerosols is likely to occur.

• Check the correct waste bag is available particularly in clinical/surgery/personal care settings, e.g. orange for healthcare waste (this may depend on external contracts).

• Within a patient’s own home a risk assessment is required prior to the disposal of waste generated as a result of healthcare. If waste is considered hazardous healthcare waste then a special waste uplift is required. Otherwise dispose of as domestic waste.

• Containment of spillages may be necessary in the first instance prior to management.

• In the clinical setting granules that absorb the spill should be used if available. The manufacturer’s instructions should be followed. Please note that if non chlorine granules are used then the area must be disinfected following disposal of the granules.

• If granules are not available spillages should be absorbed using disposable towels.
• In the home setting, spillages should be absorbed using disposable paper towels however if these are not available hand towels, kitchen roll and products supplied by the home owner can be used to ensure no damage occurs. Care must be taken to avoid splashing during this time.

*Hard surfaces (clinical areas only):*

• Do not apply chlorine releasing agents directly onto large urine spills as this may result in the release of chlorine gas.

• Apply the approved disinfectant to the spillage containing a solution or granules of a chlorine releasing agent, with a concentration of 10,000ppm available chlorine (av) for blood and 1000ppm av for body fluids. Ensure the spillage is completely covered with the solution/granules as this inactivates blood borne viruses.

• Follow manufacturer’s instructions to ensure the correct contact time is achieved - this is usually 2-5 minutes.

• Clear towels/disinfectant from the area, place disposable towels immediately into a healthcare waste receptacle.

• Clean the area using fresh disposable towels and a solution of water and general purpose neutral detergent and dry.

• Dispose of all remaining items into a healthcare waste receptacle.

• Dispose of personal protective equipment into the healthcare waste.

• Perform hand hygiene.

• In the home setting, discuss with the patient/home owner the cleaning/disinfection agents that they use. Never apply chlorine realising agent or bleaching agents as this may cause damage.

*Soft furnishings:*

• Avoid purchasing soft furnishings for use in clinical areas as they may become contaminated.

• If spillage has occurred on an area of carpet or soft furnishing which may be damaged as a result of the process, a solution of general purpose neutral detergent and water may be used as these items may be damaged.

• Soft furnishings can also be wet vacuumed/steam cleaned.

• Following cleaning of soft furnishings, every effort must be made to air the room to allow drying in order that the furnishing/carpet is dry before reuse.

• If a chlorine releasing agent is used then ensure the soft furnishing can withstand this product. Refer to manufacturer’s guidance.

• Alcohol solutions must not be used to decontaminate spillages.
3.6 Management of Care Equipment

Care equipment used for patients/clients can become contaminated with blood, other body fluids, secretions and excretions during the delivery of care. Therefore, they must be managed appropriately in order to limit the risk of potentially pathogenic microorganisms being transmitted.

Patient care equipment is classified as:

**Single use**: The expression ‘single-use’ means that the medical device is intended to be used on an individual patient during a single procedure and then discarded. It is not intended to be reprocessed and used on another patient. The symbol below is used on medical device packaging indicating ‘do not reuse’ and may replace any wording. Some single-use devices are marketed as non-sterile which require processing to make them sterile and ready for use. The manufacturer of the device will include appropriate processing instructions to make it ready for use.

![Single-use symbol](image)

**Single-patient use** means the medical device may be used for more than one episode of use on **one patient only**; the device may undergo some form of reprocessing between each use.

**Reusable**: A medical device designated by its manufacturer as suitable for multiple episodes of use; either for a defined maximum number of use cycles or until inspection reveals wear or damage to the extent that the device must be repaired or replaced.

The Spaulding Classification is a system (Table 1) used to assess the level of decontamination required for instruments and items used in patient care based on the potential risk of infection transmission.

**Table 1. Spaulding Classification**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Type of Procedure</th>
<th>Level of Decontamination Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>Invasive devices that enter tissue that is usually sterile or enters the vascular system; e.g., artery forceps, probes, biopsy forceps, dental extraction forceps/elevators</td>
<td>Requires sterilization</td>
</tr>
<tr>
<td>Semi-critical</td>
<td>Device contacts intact mucous membrane but does not penetrate sterile tissue; e.g., flexible endoscopes, dental mirrors, vaginal specula</td>
<td>Requires high level disinfection* (Sterilization preferred where practicable **)</td>
</tr>
<tr>
<td>Non-critical</td>
<td>Device only contacts intact skin; e.g., stethoscope, sphygmomanometer cuff</td>
<td>Can be processed by cleaning (and low level disinfection where necessary)</td>
</tr>
</tbody>
</table>

* High level disinfection is a process designed to kill vegetative microorganisms, mycobacteria, viruses, fungal spores and some, but not all, bacterial spores.

** See Safety Action Notice (SAN(Sc)03/23) Re-usable Stainless Steel Vaginal Specula etc: Risk of Cross Infection

The majority of care equipment items include non-invasive, reusable items such as stethoscopes, thermometers, blood pressure monitors etc. which fall into the non-critical Spaulding classification.
In addition the ‘Glennie Framework’ is a classification system used in Scotland to set the technical and operational requirements for decontamination of invasive reusable surgical instruments/medical devices based on the CJD transmission risk of the tissue with which they have been in contact (refer to Section 4.2).

Practice points:

- Put on PPE prior to cleaning care equipment and dispose of this immediately following use e.g. gloves and disposable aprons.
- Hand hygiene should be performed prior to donning and removal of gloves.
- Gather all relevant equipment and ensure equipment/receptacles used to decontaminate care equipment are clean before use. Single use items, such as disposable cloths must be used at all times in healthcare settings.
- Follow equipment/device manufacturer’s instruction for the recommended cleaning method and cleaning agent compatibility and the cleaning agent’s manufacturer’s instruction regarding amount to be used, dilution and contact time. Ensure solutions are made up freshly and stored within a receptacle which must be clearly labelled with the name of the solution and preparation date and disposed of e.g. on a 24-hour basis.
- Use a cleaning agent that best meets the overall needs.
- General purpose neutral detergent is generally suitable for all care equipment and should be used unless otherwise indicated by local infection control policy (antimicrobial agents are not routinely recommended).
- Do not use chlorhexidine, e.g. Hibiscrub or any other hand hygiene agents, for cleaning of equipment.
- Alcohol wipes must not be used for routine cleaning of equipment however can be used on stainless steel equipment such as bracket tables or trolleys. Alcohol must not be used where soilage has occurred, e.g. blood splatter.
- The use of detergent wipes may be useful for small items such as stethoscopes, blood pressure cuffs.
- The use of warm (hand hot) water with general purpose neutral detergent is preferable.
- If the equipment/reusable item cannot be fully immersed then wipe with a detergent wipe or disposable cloth and detergent solution if appropriate.
- Ensure all areas are thoroughly cleaned, free from dust and grime.
- Air-drying following washing of large surfaces is generally acceptable, however, on smaller areas or areas that are particularly wet, these should be dried with disposable cloths/paper towels.
- For reusable invasive equipment that requires processing (at a central or local decontamination unit) pre cleaning is not usually required. Such equipment should be securely contained, labelled and transported in accordance with the requirements of the Carriage of Dangerous Goods Regulations (2004) where appropriate.
- Care equipment/reusable items should be fully immersed for cleaning in a designated sink (preferably stainless steel).
Cleaning of equipment should take place immediately while fully immersed under the water to avoid potential aerosolisation when rubbing equipment surfaces. The item should then be rinsed and dried.

- If care equipment/reusable items are taken to a central area for cleaning, it should be transported clearly indicating that it requires decontamination. The area/room itself should be clean, fit for purpose and free from extraneous items before and after procedures.
- Care equipment/reusable items should be checked while cleaning for state of repair. Couches, chairs etc should be checked regularly for permeability and signs of wear and tear such as staining or tearing and repaired/replaced as necessary.
- If possible, utilise laundry facilities for items such as cleaning equipment, e.g. mop heads. Clean mop heads and other equipment should always be stored in a clean dry area. Within NHSScotland Hospitals the ‘NHSScotland National Colour Coding for Hospital Cleaning Materials and Equipment’ (HFS, 2008) should apply. In non-NHS settings the principles outlined in ‘NHSScotland National Colour Coding for Hospital Cleaning Materials and Equipment’ (HFS 2009) should apply.
- Patient care equipment or medical equipment such as infusion pumps which are loaned to patients cared for within domestic settings should be checked for cleanliness prior to use by the healthcare worker.
- Any patient care equipment or medical equipment no longer required by the patient within their home setting should be appropriately decontaminated and/or certificated by the healthcare worker prior to returning to home loan services or medical physics/estates (refer to local Infection Control Policies).

Any additional information on cleaning/disinfecting agents e.g. the use of chlorine releasing agent, to be used at specific times should be discussed with Infection Control and/or Health Protection staff.

### 3.7 Occupational Exposure (Including Sharps)

Sharps injuries are one of the most common types of injury to be reported to Occupational Health Services by healthcare staff. The greatest occupational risk for transmitting a Blood Borne Virus (BBV) is through parenteral exposure, e.g. a needlestick injury, especially from needles with hollow bores where blood may reside. Risks can also exist from splashes of blood/body fluids/excretions/secretions particularly to mucous membranes; however, this risk is considered to be smaller. There is currently no evidence that BBVs can be transmitted through intact skin, inhalation or through the faecal oral route. However precautions are important to protect all who may be exposed, particularly when treatment for certain BBVs is not readily available.

**A significant exposure is:**

- percutaneous injury (from needles, instruments, bone fragments, significant bites which break the skin);
  and/or
- exposure of broken skin (abrasions, cuts, eczema, etc);
  and/or
• exposure of mucous membranes including the eye.

**Practice Points**

• Practitioners who undertake Exposure Prone Procedures e.g. dentists - and have reason to believe that they may be infected with a blood borne virus have an ethical responsibility to obtain medical advice, which can include any required testing. If the practitioner is identified as infected with a blood borne virus then changes in clinical practice may be necessary, which may include restrictions in practice. If an employee is identified then the employer must undertake a risk assessment of their duties to determine potential risk to patients/visitors.

• The use of approved safety devices should be considered for sharps safety management when there is the potential for contamination with a patient’s blood or body fluid.

• If providing domiciliary care extra care should be taken when using sharps in homes when there may be issues with available work space and poor lighting or storing sharps equipment.

• If storing sharps containers in the home care should be taken to ensure this is stored safely with the temporary closure in place particularly when there may be young children in the home.

• Used needles must never be re-sheathed (with the exception of local anaesthetic syringe and needle used in dental practice where a safe system for re-sheathing must be used).

• Single use disposable blades should be used. Where these are not available a needle/blade removal device should be used.

• PPE must be worn as required to minimise the risk of exposure.

• Approved sharps containers should be assembled correctly and should never be over-filled, i.e. above the manufacturer’s fill line on the container/more than ¾ full. Local IP&C Policy will advise on the renewal of the sharps container if less than ¾ full e.g. weekly/monthly

• Sharps containers should be UN approved and should be safely and appropriately sealed in accordance with manufacturer’s instructions, and should be disposed of once filled to the ‘Full line’.
  o Items should never be removed from sharps containers. The temporary closure mechanism on sharps containers should be used in between use for safety.
  o The label on the sharps containers must be completed upon commencement of use and again once sealed to facilitate tracing if required.
  o Any exposure incident that occurs must be reported to the line manager and managed appropriately via Occupational Health or Accident & Emergency Departments.
  o Sharps containers should be stored/positioned safely and available at the point of use e.g. within a tray device with room for an integral container or wall mounted if in a clinic below shoulder height. They should never be placed on the floor.
  o The safe carriage of sharp items is also essential, e.g. if sharps containers are being used by district nurses, general medical practitioners, general dental
practitioners or podiatrists they must be secured safely when being transported, for example, in the boot of their car in a safe, secure container with the temporary closure in use.

- Blood or other body fluids that have spilled or have contaminated items should be cleaned up appropriately and timeously using a chlorine releasing agent.

- Control of Substances Hazardous to Health (COSHH) sheets and product data sheets should be referred to at times when an exposure incident occurs and when steps/products are required to manage these.

**Procedure for an occupational exposure**

If an exposure incident should occur, the following steps should be taken to minimise the risk of harm from the exposure:

- Perform first aid to the exposed area immediately.

- Skin/tissues should be encouraged to bleed. Do not suck the area.

- Then wash/irrigate with warm running water and antiseptic or liquid soap. Do not scrub the area.

- The area should then be covered using a waterproof dressing.

- Eyes and mouth should be rinsed/irrigated with copious amounts of water. A washout kit may be available in clinical areas. If contact lenses are worn, irrigation should be performed before and after removing these.

- Do not swallow the water which has been used for mouth rinsing following mucocutaneous exposure.

- Report/document the incident as per local procedures immediately, e.g. to managers/Occupational Health department/Accident and Emergency department. Urgency is important in these situations as post exposure prophylaxis for HIV or other treatments are required (i.e. it is recommended that this is commenced within 1 hour of the incident having taken place but not advised if exposure time exceeds 72 hours).

- Near misses should also be clearly reported/documented.

- Ensure that the item that caused the injury is disposed of safely to ensure that a further incident is avoided, i.e. into an approved sharps container

### 3.8 Management of Linen

The main categories of linen within NHSScotland premises are:

- **Used linen** – this refers to all used linen, irrespective of state, except linen from infectious (or isolated) patients/clients or those suspected of being infectious.

- **Infected linen** – this specifically applies to linen that has been used by a patient who is known or suspected to be carrying an infectious agent.

- **Heat labile linen** – refers to items which need to be washed at lower temperatures, e.g. 40° C, to avoid shrinkage.
• **Radioactive linen** – is linen contaminated with radioactive material and is not covered under SICPs.

• **Soiled/foul linen** – this is an additional term used in practice and refers to linen contaminated with blood or other body fluids, e.g. faeces. Local policy will determine into which category this linen will be placed e.g. used or infected.

It is important that the appropriate precautions are taken to ensure contamination to/from linen does not occur to people or to the environment potentially causing infection. Such important precautions apply to all stages of linen management: storage, handling, bagging, transporting and laundering.

**Practice points:**

• A disposable plastic apron should always be worn when handling ‘used linen, soiled/foul or infected linen’ (and disposable gloves where linen is soiled/foul or infected).

• Always hold ‘used linen, soiled/foul or infected linen’ away from yourself to avoid contamination of clothing from linen.

• Ensure appropriate, clean bags/receptacles, are available as close to the point of use as possible for disposal.

• Do not sort/separate ‘used linen’. Place each item directly into the designated bag/receptacle.

• ‘Soiled/foul’ (if designated as infected) and ‘infected linen’ should be placed into an alginate bag then into an outer e.g. clear bag.

• Staff should avoid shaking linen as this may result in the dispersal of potentially pathogenic microorganisms and/or skin scales into the environment.

• Never place/drop linen on the floor or on other surfaces which may be touched frequently as this could lead to contamination, especially during care delivery.

• ‘Soiled/foul’ (if bagged as infected) or ‘infected linen’ should not be re-handled.

• ‘Used, soiled/foul or infected linen’ bags/receptacles should never be overfilled.

• ‘Soiled/foul’ (if designated as infected) and ‘infected linen’ should be appropriately tagged for identification.

• After handling linen, staff should ensure they dispose of any PPE appropriately.

• Hand hygiene should be performed following handling of used linen, soiled/foul or infected linen’ and removal of PPE.

• If linen is used in community or primary care setting this must be changed/laundered between patients or alternatively disposables used e.g. paper roll on examination couches.

• Privacy screens around examination couches should be laundered at least twice yearly and when visibly contaminated.

• Window curtains (if used) should be laundered at least yearly

• A risk assessment by all NHSScotland Boards in regard to workwear and uniform for all categories of staff should be undertaken.
• Clean linen should always be stored in a clean, designated area, preferably a (purpose built) cupboard, away from the floor to prevent contamination with dust and/or aerosols.

• Ideally, linen should not be decanted onto different trolleys/shelves or stored in corridors when delivered as this may result in contamination.

Additional considerations (home setting):

Patients or their carers may seek advice on home laundering. Explain the principles of SICP particularly hand hygiene and advise that the HPS ‘Washing Clothes at Home’ leaflet is available at [http://www.documents.hps.scot.nhs.uk/hai/infection-control/publications/washing-clothes-home.pdf](http://www.documents.hps.scot.nhs.uk/hai/infection-control/publications/washing-clothes-home.pdf)

• Alginate bags (special dissolvable red washing bags designed for central laundry use) must never be placed within a domestic washing machine.

• Launder items using as high a temperature as possible as per washing instructions.

• Use normal washing powder/detergent.

• Tumble dry where possible (following manufacturer’s guidance).

• Iron according to manufacturers’ instructions. A hot iron with steam is best if possible.

• Hand hygiene should be performed following handling of items.

• Where hand rinsing of heavily soiled items is absolutely necessary, this should be carried out by fully submerging the items to avoid potential aerosolisation/splashes while rinsing. Ensure splashing is minimised, particularly when discarding used water.

• It is advisable to wash soiled/foul items separately from other laundry.

NB In situations where a particular infection is known or suspected; specific advice should be given by staff/local guidance should be followed, as actions may differ in relation to laundering where high temperatures cannot be achieved. Further information on this can be sought from Infection Control/Health Protection Teams.

3.9 Safe Disposal of Waste

Waste produced through the provision of healthcare activities is generally classified as healthcare waste in the European Waste Catalogue (EWC) ([Appendix 5](#)).

In Scotland, businesses (including NHS Scotland, Local Authorities and Public Sector organisations) have a legal duty to ensure that any waste they produce is handled safely and within the law. This is referred to as “duty of care”. If a business in conducting its services, produces or deals with waste that has hazardous properties, then it must comply with the Special Waste etc Regulations.

In Scotland, Healthcare (including clinical) Waste arises through the provision of NHS Scotland care services (within NHS owned and leased premises and in community settings) and definitions, policy, procedures, the risk based approach and practical guidance is given through NHSScotland Scottish Healthcare Technical Note 3: Waste Management Guidance. (SHTN 3). NB. This Guidance is currently being updated and will be issued as a working draft for consultation.
‘Healthcare (including clinical) Waste’ covers a wide range of arisings and the risk ranges from wastes that pose a potential low or negligible risk such as human hygiene waste, or wastes that pose a potential risk either due to their potentially infectious nature or potential contamination with medicinal/pharmaceutical products.

Healthcare (including clinical) Wastes which may pose a risk of infection and/or are contaminated with certain pharmaceutical products are “Special Waste” and are subject to additional controls as specified in the Special Waste Amendment (Scotland) Regulations 2004 and the Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2007. Such Healthcare (including clinical) Wastes include anatomical, infectious or potentially hazardous substances, such as substances consisting wholly or partly of human or animal tissue, blood or other bodily fluids, excretions, drugs and other pharmaceutical products, swabs or dressings, syringes, needles or other sharps.

The properties of any waste produced (such as a result of any provision of healthcare services) must be risk assessed and transferred/consigned in accordance with the European Waste Catalogue (EWC) and SHTN 3, all in accordance with the requirements set out in NHSScotland ‘Environmental Management Policy Action Plan’ (2008). If formerly assessed as non hazardous this can normally be disposed of as domestic/household waste.

Those (such as NHSScotland and their Contractors, Local Authorities and Public Sector partner organisations) providing healthcare in primary care and community settings (beyond NHS owned or leased premises, where SHTN 3 systems will be in place) must ensure environment, health and safety issues are considered, risk assessed and managed appropriately, following current waste disposal guidance (SHTN 3). This may involve an extended “duty of care” and providing clarity on waste disposal or take back arrangements. This must ensure that any potentially contaminated waste is correctly segregated and correctly packaged to ensure it does not cause subsequent harm. For example those who care for themselves at home and as such generate waste, e.g. self-injecting diabetics or those administering parental medicinal products etc. The extended “duty of care”, must also be a consideration and appropriate support and guidance must be in place locally for those persons in community settings, to ensure waste is safely stored, handled and disposed of correctly.

**General Practice points in Community Settings (see SHTN 3 for Specific Procedures):**

- Risk assess the location for suitability and to ensure the safe storage of medicinal/pharmaceutical products and associated healthcare service equipment and waste storage, handling and disposal arrangements.
- Consider wearing gloves and, where necessary, an apron (a PPE risk assessment may be undertaken in some circumstances when disposing/handling waste).
- Heavy duty gloves may be necessary for those handling large volumes of waste/waste receptacles.
- Ensure the correctly colour coded and labelled waste containers (bags and bins) are readily available, safe to use and in visible places at the point of use/waste generation, e.g. where sharps are being used, including those near-patient systems involving appropriately sized small containers (“sharps boxes”) contained on a tray, must be directly at the point where sharps related waste originates.

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• Avoid contact with the waste container itself where practicable, e.g. the lining or outside of bags/containers, while waste items are being disposed.

• Never overfill or compress waste containers. If a bag or bin/container is full, it should be sealed and a fresh container set up and used.
  o Bags should not be more than ¾ full.
  o Bin/sharps containers/bins should be no more than ¾ full or past the manufacturer’s fill line.

• Items containing fluid e.g. placentas (special containers are available for placentas), particularly those containing blood/other body fluids that have to be disposed of should first have the contents solidified in order that they are safe to transport. This can be achieved by following manufacturer’s instructions, and for example, using solidifying products, e.g. granules. This should be carried out where the wastes present a handling/spillage risk. This practice should not affect clinical management.

• Any used/unused ampoules or medicine cartridges e.g. local anaesthetic cartridges, should be disposed of via sharps containers, which should be treated as special waste e.g. pharmaceutical waste as per EWC.

• Extracted teeth with Amalgam must not be discarded into the sharps box. This requires to be disposed as ‘Special Waste’ according to the EWC coding e.g. into a designated tooth box and handled by a specialist metal recycling company.

• Seal all filled bags/bin containers appropriately before disposal/transporting/processing, in accordance with local guidance (e.g. bag tied, first using a swan neck tie). Staples should never be used for sealing bags. Never drop or throw filled waste containers.

• Store unused, clean waste bags/containers in a clean area until they are required.

• Store filled waste bags/containers in an upright position, in a designated safe area which is easy to clean, lockable, has a roof and is inaccessible to birds, dogs, animal pests and children and is well lit and well ventilated. They should not be stored/held in clean areas such as corridor floors and should never been thrown into storage areas.

• Ensure storage area for Healthcare (including clinical) Waste is also clearly labelled for segregation and secured to prevent unauthorised access.

• Store domestic (black bag) waste separately from Healthcare (including clinical) Wastes.

• Waste storage areas wherever possible should be sited away from clinical, food preparation and general storage areas.

• Any service providers contracted to remove waste must fully comply with all legislation in force at the time of the contract.

• Tagging of waste, particularly in healthcare settings, is essential, e.g. utilisation of recognised codes, such as EWC. The area of origin and date should also be clearly marked on the waste bag/container:
  o Ensure waste containers are kept upright, during use or when full.
  o Never remove items from waste containers. Sealed bags/bin containers should never be reopened.
After dealing with waste, staff should ensure that they dispose of any used PPE appropriately into waste containers.

Hand hygiene should be performed following any waste handling/disposal/removal of PPE.

This section outlines general practice points and should not be read in isolation in relation to waste management but must be considered alongside other national and local waste guidance/policies (such as Local Policy and/or SHTN 3).

3.10 Place of Care - Patient placement

The placement of patients is an important consideration in standard prevention and control of infection particularly in acute healthcare settings but increasingly within primary and community care settings.

- Patient placement as part of SICPs means an individual who could potentially contaminate the environment with blood or body fluids, or suspected to be suffering from an infectious agent, is usually placed within a consulting/single room.

- Single rooms may be unavailable, and patient placement for SICP purposes may have to compete with multiple factors such as the availability of cubicles the diagnosis of the individual/psychological factors/terminal care rather than clinical need.

- Local risk assessments of the individual/group of patients, the environment and the suspected/actual infection before placement will often be required.

- Initial and ongoing assessment of patient placement is important because patients/clients may not show any signs or symptoms of infection but pose a risk to others via transmission from blood or body fluids.

- Communication between multidisciplinary teams, laboratories and local infection control/health protection teams is key to ensuring patient placement is appropriate.
4. Additional Considerations for Community and Primary Care Settings

4.1 Minor Surgery

- Minor surgery can generally be described as any superficial surgical procedure involving little hazard to the life of the patient and not requiring general anaesthesia.
- This can involve procedures such as removal of skin tags, warts, teeth etc.
- The utilisation of SICPs alone are unlikely to be sufficient precautions to encompass all the aspects of minor surgery.
- Many of the areas that require detailed consideration fall outside the scope of this guidance (e.g. room specifications).
- It is therefore recommended that local risk assessments are carried out by local Infection Control /Health Protection Teams for any minor surgery undertaken. This must consider aspects of; the type of incision, duration of surgery and whether there is a mixture of clean and dirty procedures. The web links below will provide further information regarding minor surgery:

Royal College of Surgeons of Edinburgh - [http://www.rcsed.ac.uk/](http://www.rcsed.ac.uk/)

Health Facilities Scotland - [http://www.hfs.scot.nhs.uk/](http://www.hfs.scot.nhs.uk/)

British Dental Association - [http://www.bda.org/](http://www.bda.org/)


4.2 Reprocessing of Surgical Instruments

The requirements for reprocessing surgical instruments in a community or primary care setting are contained within a variety of documents and are outwith the scope of this document. However as this is a routine component of many independent contractors roles the following information sources will assist clinicians in Scotland if undertaking reprocessing.


4.3 The use of infusion devices

Infusion devices such as peripheral catheters, Hickman type catheters and enteral feeding devices within home settings has substantially increased due to the increase in community based care.

- The insertion and care criteria for these devices is the same as those used in a hospital setting (refer to Local Policy) however additional advice and guidance will need to be given to the patient, family and carers regarding maintenance of the system and contact details should any issues occur.
- The healthcare worker (clinician) should check the insertion site for any signs of infection, such as inflammation and swelling, at each visit and remove (or refer to clinician for removal) the catheter if required.
- Skin should be decontaminated with 70% alcohol/chlorhexidine applied and allowed to dry before injections.
- It is important that any manipulation of the catheter is done using an aseptic non-touch technique in addition to SICPs.
- Maintain a clean dressing at the catheter site. It is recommended that catheter dressings are changed every 7 days or when visibly soiled, damp or loose. When changing a dressing an appropriate antiseptic solution should be used to clean the site.
- Peripheral catheters should be changed at least every 72 hours however central venous catheters do not need to be changed routinely and should only be removed if no longer needed or if infection occurs.
- Administration (giving) sets if used for general purposes do not need to be changed more frequently than 72 hours. This time is reduced to 24 hours if they have been used for products that could promote microbial growth such as total parental nutrition.
- Further guidance is available on [http://www.hps.scot.nhs.uk/haiic/ic/bundles.aspx](http://www.hps.scot.nhs.uk/haiic/ic/bundles.aspx)

4.4 Acupuncture

- Acupuncture is a widely used alternative therapy using solid needles at particular points on the body.
- Single use only acupuncture needles should be used.
- The patient's/client's skin does not require to be disinfected. If the site is dirty, wash with soap and water then dry. Do not touch the shaft of the needle. Do not point the needle towards yourself when inserting. Discard needles into an approved sharps container immediately after the procedure.
Appendix 1 – How to Hand Wash

How to Hand Wash - step by step images

1. Wet hands with water
2. Apply enough soap to cover all hand surfaces
3. Rub hands palm to palm
4. Right palm over the back of the other hand with interlaced fingers and vice versa
5. Palm to palm with fingers interlocked
6. Backs of fingers to opposing palms with fingers interlocked
7. Rotational rubbing of left thumb sloshed in right palm and vice versa
8. Reciprocate rubbing backwards and forwards with clasped fingers of right hand in left palm and vice versa
9. Rinse hands with water
10. Dry thoroughly with towel
11. Use elbow to turn off tap
12. Steps 3-8 should take at least 15 seconds...

...and your hands are safe

Source: World Health Organisation

Adapted from the World Health Organisation

Germs. Wash your hands of them.
Appendix 2 – How to hand rub

How to hand rub?

Steps 2 – 7 should take at least 15 seconds

Duration of the entire procedure: 20-30 sec.

1a. Apply a palmful of the product in a cupped hand and cover all surfaces

1b. Rub hands palm to palm

2. Right palm over left dorsum with interlaced fingers and vice versa

3. Palm to palm with fingers interlaced

4. Backs of fingers to opposing palms with fingers interlocked

5. Rotational rubbing of left thumb clasped in right palm and vice versa

6. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

7. ...once dry, your hands are safe

Adapted from the World Health Organisation
Appendix 3 – Risk Assessment – Glove Usage

Risk Assessment - Glove Usage

ARE GLOVES REALLY NECESSARY?

Gloves are NOT required for procedures where there is minimal risk of cross infection between patients and staff e.g.
- Basic care procedures without contact with blood or bodily fluids
- Transferring food from food trolley to patient bedside
- Making/unscrewing bed/bathing or removing patients’ uncontaminated clothing
- Taking recordings (BP, Temp, Pulse)
- Closed Intestinal Surgery

DON’T WEAR GLOVES

Gloves ARE required for procedures where there is a risk of cross infection between patients and staff and further risk assessment should be carried out

IS THERE A HIGH RISK OF EXPOSURE TO BLOOD AND BODILY FLUIDS?

NO

NON STERILE VINYL

SA STERILE FIELD REQUIRED

YES

NON STERILE STERILE NITRILE OR SYNTHETIC GLOVE WITH EQUIVALENT BARRIER PROPERTIES

THEATRE ENVIRONMENT

- STERILE NITRILE

TOILET ENVIRONMENT

- ELASTOMER
- NITRILE
- NON-PowdRED LOW PROTEIN LATEX
- SYNTHETIC POLYURETHANE
- TACTIRON

Glove Selection - Guidance

ALL GLOVE SELECTION MUST BE PRECEDED BY RISK ASSESSMENT

TypE OF ACTIVITY

Cleaning

Polythene

Gloves where there is a low risk of contamination, non-sterile clinical care, or environmental cleaning e.g.
- Oral care
- Emptying catheter drainage bags
- Emptying urinary/bowel and suction jars
- Handling non-risk specimens
- Clinical cleaning
- Dressing wounds when contact with blood/body fluids is unlikely
- E.g. general surgery
- Endotracheal suction
- Applying creams
- Teaching patients with unknown skin rash/eczema/irritation
- Making beds/changing clothing of patients in isolation

Non Sterile Vinyl

Non Sterile Nitrile

Procedures involving high risk of exposure to BFRs and where high barrier protection is needed e.g.
- Potential exposure to blood/body fluids e.g. blood spitting, nasal mucosa, blood glucose monitoring, administering intravenous/suppositories and rectal examinations
- Handling cytotoxic material
- Handling sharps
- Vaginal examination
- Baseline and specimen collection procedures on patients known or suspected to be high risk of EBV
- Non-surgical obstetric procedures
- Vaginal examination in obstetrics

Sterile Nitrile Examination Gloves

All staff using latex gloves of any type will be required to participate in the OHS skin health surveillance programme.

All Surgery and Theatre Radiological procedures

STERILE STERILE GLOVES

- Vinyl
- Nitrile
- Non powdered low protein latex
- Synthetic polyurethane
- Tactiron

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Appendix 4 Chemical Disinfectants recommended in this guidance. Refer to product guideline before use.

<table>
<thead>
<tr>
<th>Chemical</th>
<th>Mode of Action</th>
<th>Microbicidal Activity</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isopropyl Alcohol or Ethyl Alcohol – 60-80% conc</td>
<td>Denatures proteins</td>
<td>• Potent virucidal and bactericidal properties. • Low sporicidal action</td>
<td>• Hand/skin disinfection • Clean stainless steel surfaces • External surfaces of equipment used on intact skin e.g stethoscopes</td>
</tr>
<tr>
<td>Chlorhexidine gluconate – 4% or 0.5-1% added to alcohol based hand rubs</td>
<td>Attachment and disruption of cytoplasmic membranes</td>
<td>• Good activity against Gram-positive bacteria • Less activity against Gram-negative bacteria and fungi • Minimal activity against mycobacteria • No sporicidal activity • <em>In vitro</em> activity against enveloped viruses but less activity against non-enveloped viruses</td>
<td>• Hand/skin disinfection</td>
</tr>
<tr>
<td>Chlorine and chlorine compounds-</td>
<td>Multiple including</td>
<td>• Broad spectrum biocidal action including virucidal, bactericidal and sporicidal</td>
<td>• General disinfection of the environment at dilutions of 1000 p.p.m. av chlorine and for spillages of blood and other body fluids 10000/1000 p.p.m av chlorine • Not suitable for stainless steel</td>
</tr>
<tr>
<td>• Hypochlorites e.g sodium hypochlorites (12-14% av chlorine)</td>
<td>• Breaks DNA • Decrease Adenosine Triphosphate production • Inhibition of protein synthesis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Household bleach (5.25-6.15% conc 52,500-61,500 ppm available chlorine (av))</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Appendix 5 – EWC Coding

NHSScotland – EWC coding guide for healthcare wastes
Interim SHTN 3 guidance

## C. The Changes in Detail

### Classification

This interim guidance is applicable to the following NHS waste streams.

<table>
<thead>
<tr>
<th>Stream Colour Code</th>
<th>General Description of Waste arising from the delivery of healthcare services</th>
<th>Treatment / Disposal Route</th>
<th>Classification as Special Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td>Household / Domestic waste Stream mixed black bag household / domestic waste from clinical / ward / office and other areas.</td>
<td>Recycling, or landfill or municipal solid waste (MSW) incineration.</td>
<td>NOT Special Waste.</td>
<td></td>
</tr>
<tr>
<td>Orange Stream special waste low risk healthcare (clinical) waste (in bags and bins) arising directly from the delivery of healthcare by clinicians.</td>
<td>Heat treatment</td>
<td>Special Waste.</td>
<td></td>
</tr>
<tr>
<td>Yellow Stream special waste high risk &amp; ethical healthcare (clinical) waste (in bags and bins) arising directly from the delivery of healthcare by clinicians.</td>
<td>Healthcare waste incineration</td>
<td>Special Waste.</td>
<td></td>
</tr>
<tr>
<td>Red Stream special waste particular chemical wastes arising directly from healthcare processes</td>
<td>Recovery</td>
<td>Special Waste.</td>
<td></td>
</tr>
<tr>
<td>Other Healthcare wastes particular wastes produced as a result of healthcare activities</td>
<td>Specialist disposal</td>
<td>Special Waste.</td>
<td></td>
</tr>
<tr>
<td>Other Non-Healthcare wastes particular wastes that are NOT healthcare waste</td>
<td>Recovery or specialist disposal</td>
<td>Certain wastes are Special Waste.</td>
<td></td>
</tr>
</tbody>
</table>

NHS Bodies must ensure that the various wastes they produce are appropriately segregated, classified, described/labelled and disposed of in accordance with the regulations.
Glossary

Blood Borne Viruses - A virus carried in the blood or certain other body fluids that may cause serious disease in specific people and few or no symptoms in others. These viruses can spread from person to person even when no symptoms are apparent. The main bloodborne viruses of interest are; hepatitis B, hepatitis C, and human immunodeficiency virus (HIV).

Community Care Setting – where care is delivered jointly between the NHS, local authorities, and other partners.

Disinfectant – usually a chemical (or physical) agent that destroys pathogenic bacteria but might not kill bacterial spores. It refers to substances applied to inanimate objects.

Enteral Feeding - The insertion of a tube that provides nutrition via the gastrointestinal tract.

Exposure Prone Procedures - An invasive procedure that could possibly result in injury to a healthcare worker and subsequent exposure may occur from the patient’s open tissues to the blood of the healthcare worker. It includes situations where a healthcare worker’s gloved hands may be in contact with sharps/sharp tissues, confined spaces where movement is limited or where the healthcare worker’s fingertips are not visible.

General Purpose Neutral Detergent – A cleaning agent with no proven antimicrobial properties, usually used for routine general cleaning.

HAI Task Force - Following publication of ‘Preventing Infections Acquired While Receiving Healthcare, the Scottish Executive’s Action Plan to reduce their risk to patients, staff and visitors 2002-2005’, the Healthcare Associated Infection (HAI) Task Force set out to develop key identified areas by overseeing existing work in progress and commissioning several new working groups to address the many tasks specified in the HAI Action Plan.

Healthcare Associated Infection (HAI) - Infections that are not present at the time the individual’s care commences, but which arise afterward

Hickman Type Catheter - A specific type of central venous catheter most commonly used for the administration of chemotherapy or other medications, as well as for the withdrawal of blood for analysis. They can be used when long-term intravenous access is needed (e.g. dialysis).

Independent Contractors in Healthcare – examples include dentists, general practitioners, opticians and pharmacists. Refer to http://www.isdscotland.org/isd/755.html?text-size=1 for complete list

Infectious Agent - Any organism, such as a pathogenic virus, parasite, or bacterium, that is capable of invading body tissues, multiplying, and causing disease

Parts Per Million (ppm) Dilutions - A common measurement used to describe the concentration of disinfectant.
Peripheral Vascular Catheter - A frequently used device that is inserted into a peripheral vein to provide medication or fluids (and also take blood).

Post Exposure Prophylaxis - Treatment given after exposure to a potential infectious agent to avoid any infection and subsequent disease from the exposure.

Primary Care Setting - health services that play a central role in the local community: e.g. GPs, pharmacists, dentists and midwives. Primary care providers are usually the first point of contact for a patient. They also follow a patient throughout their care pathway

Recognised Source of Infection – where an infection is known to be present

Risk Assessment - The evaluation of aspects linked with a procedure to establish the amount of precautions necessary.

Standard Infection Control Precautions (SICPs) - These are the minimum precautions necessary to reduce the risk of transmission of microorganisms from both recognised and unrecognised sources of infectious agents that may be present in blood, other body fluids, secretions, excretions, non intact skin and mucous membranes. They must be used by ALL health and social care workers in ALL situations involving the care of patients/clients in order to prevent spread of infectious agents to other non intact skin and/or mucous membranes (this includes sharp injuries). They should be applied when dealing with the immediate patient/client environment which might be contaminated with blood, other body fluids, etc. There are nine elements to SICPs and they are essential in preventing and controlling HAI. These are available on http://www.hps.scot.nhs.uk/haiic/ic/modelinfectioncontrolpolicies.aspx

Transmission Based Precautions - Transmission Based Precautions, in addition to Standard Infection Control Precautions (SICPs), are a set of measures that should be implemented when patients/clients are either suspected or known to be infected with a specific infectious agent, when aiming to prevent and control spread, particularly in relation to healthcare associated infections (HAI). Transmission Based Precautions are categorised according to the route of transmission of the infectious agent such as droplet, contact and/or airborne

Total Parenteral Nutrition - A formula containing a number of different nutritional elements (e.g. salts, glucose, lipids) administered intravenously.

Unrecognised Source of Infection – where an infection is not confirmed but may be present