INFECTION PREVENTION, CONTROL & DECONTAMINATION POLICY and PROCEDURES

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| **Ratifying committee/group:** | Patient Safety Group                                         |
| **Date of ratification:** | 12<sup>th</sup> July 2018                                    |
| **Date of Issue:**    | 16<sup>th</sup> July 2018                                    |
| **Review due by:**    | 15<sup>th</sup> July 2021                                     |
| **Version:**          | 2.0                                                            |
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1. **Introduction**

This Policy and its associated procedures have been developed from the Association of Ambulance Chief Executives (AACE) National Policy and Strategy Framework and the Department of Health’s guidance document “Reducing infection through effective practice in the pre-hospital environment” June 2008 and recognition and thanks is hereby extended to those who contributed to the production of this document.

The Trust is committed to minimising all risks associated with infection control and reducing the impact of healthcare associated infection on patients staff and the organisation overall. The Trust encourages the open reporting of infection incidents and risks as part of its adverse incident reporting procedures.

High standards of care are expected throughout the Health Service. Care should be based upon national standards, where they exist and monitored through the framework of Clinical Governance. Standards may be related to policy, procedures and outcomes, and include the provision of high quality facilities and standards of practice.

Although the subject of Infection Prevention Control & Decontamination is broad and complex, it will be seen that the new procedures largely simplify our approach to this key area. Staff should be reassured that all changes reflect current ‘best practice’ in today’s modern health profession, and are subsequently endorsed by Department of Health.

The Health Act 2008 (Part 2 – Prevention and Control of Health Care Associated Infections) provides a code of practice which is designed to:

“Make such provision as the Secretary of State considers appropriate for the purpose of safeguarding individuals (whether receiving health care or otherwise) from the risk, or any increased risk, of being exposed to health care associated infections or of being made susceptible, or more susceptible, to them.”

The Act defines a Health Care Associated Infection as:

“All infection to which an individual may be exposed or made susceptible (or more susceptible) in circumstances where –

a) Health care is being, or has been, provided to that or any other individual, and

b) The risk of exposure to the infection, or of susceptibility (or increased susceptibility) to it, is directly or indirectly attributable to the provision of the health care”.

2. **Scope**

This policy applies to all who work for or carry out work for the Trust, including volunteers and work placement students. It also applies to all patients within the care and control of the Trust and any visitors to the Trust.

3. **Aim**

The prevention and control of infection in healthcare settings can cover a wide range of aspects and activities. It is intended that this document will provide a generic framework of best practice for the control of infection across all sectors of the Trusts activities, but recognises that there will be a requirement for additional local procedures in some areas. Such local procedures should build on rather than replace the guidelines contained within this document.
This Policy will cover all the aspects of infection control and decontamination that are required to protect all staff, patients and third parties, and those issues and procedures raised by Assurance framework or required for statutory purposes.

It is intended that this document should be the central source of reference on matters relating to the management of Infection Prevention and Control. It is essential that all staff read and fully familiarise themselves with this document.

The South Central Ambulance Service NHS Foundation Trust, Infection Prevention Control & Decontamination Policy is intended to provide the Trust board with assurance that the highest standards of infection control within the Ambulance Service are met considering the expectations of the patient for a clean, modern environment, safe working conditions and following best practice by all staff employed within and on behalf of the South Central Ambulance Service NHS Foundation Trust (SCAS).

The risk of transfer of infection to staff and patients, through Ambulance activity, is generally perceived as low, but there is little research to substantiate this, it is therefore possible that the risks are higher than are currently recognised. There are however activities undertaken where the risks to staff are greatly increased such as when disposing of used sharps.

4. Roles and Responsibilities

4.1 Trust Board

The Trust Board will ensure that there are suitable and sufficient arrangements and adequate resources, controls and procedures for the effective implementation of this policy to minimise the risks of infection to staff and patients.

4.2 Chief Executive

The Chief Executive is ultimately responsible for ensuring that the Infection Prevention Control & Decontamination Policy and Procedures are implemented. This is delegated through the Board to the Director of Patient Care (Director of Infection Prevention and Control (DIPC)). The Chief Executive has overall accountability for ensuring that the Trust maintains adequate and appropriate controls and procedures to minimise the risks of infection to staff and patients. The Chief Executive will designate the prevention and control of healthcare associated infections (HCAI) as a core part of the organisations Governance and patient safety programmes.

4.3 Executive Director

In accordance with Department of Health Guidance ‘Winning Ways’ (December 2003) the Director of Patient Care has been designated as the Trusts Director of Infection Prevention and Control and will:

- Report directly to the Chief Executive and Board
- Assess the impact of existing and new policies and plans and make recommendations for change
- Ensure that the Trust provides adequate resources to secure effective prevention and control of healthcare acquired infections
- Oversee control of infection policies and their implementation
- Be responsible for the Infection, Prevention Control and Decontamination Group within SCAS
- Have the authority to challenge inappropriate clinical hygiene practice
- Be an integral member of the Trust’s Quality and Safety Committee
- Chair the Patient Safety Group
- Produce an annual report on the state of healthcare associated infection in the organisation and release this publicly

4.4 The Chief Operating Officer, Divisional Directors and Non-Emergency Directors

The Chief Operating Officer, Divisional Directors and Non-Emergency Director are responsible for the provision, application and monitoring of infection control measures within their directorates.

4.5 All Managers and Line Managers

All Managers must ensure that infection prevention and control is treated as an integral part of their everyday role as stated in the Management of Health and Safety at Work regulations 1999. They are responsible for implementing the Trust’s Control of Infection Policies & Procedures, which includes:

- Ensuring that a copy of the SCAS Infection Prevention Control and Decontamination policy readily available to staff (An electronic version is available on the Trust Intranet and website).
- Providing support to ensure continuous infection prevention and control audits can be undertaken and action plans implemented where required.
- Information on infection prevention and control related matters is disseminated to all staff.
- Provide leadership and supervision to ensure control of infection procedures, including safe systems of work, are fully adopted and applied by all staff.
- Investigate, document and report all accidents, incidents and risks, in accordance with Trust procedures and recommend means of preventing reoccurrence.
- Ensure good housekeeping standards are applied.
- Operational/Departmental Managers will be responsible for overseeing the policy with regard to personal medical details and sickness absence.

First Line Managers have the responsibility to provide leadership and to promote responsible attitudes towards the control of infection. They will set a good example to all staff and act as a role model.

Through work based training, assessment and supervision they will be responsible for ensuring that all employees are competent in applying infection control procedures relevant to their job role, and are aware and adopt all safe systems of work.

All accidents, incidents or risks must be reported immediately and fully documented using the Trust’s reporting procedures.

4.6 All Staff

In accordance with their statutory obligations under Health & Safety legislation all employees must:

- Take reasonable care for the Health & Safety of themselves and any other persons who may be affected by their acts or omissions at work. This duty also includes taking positive steps to understand the hazards in the workplace, to comply with safety rules and procedures and to ensure that nothing they do or fail to do places others at risk.
Co-operate so far as is necessary, with his/her employer, to ensure that all relevant statutory regulations, policies, codes of practice and departmental procedures are adhered to.

Inform the Trust, through the Trust Risk/Accident Reporting Procedure of:

a) Any non-compliance with the Trust's Control of Infection Procedures.
b) Any matter that the employee would reasonably consider represented a shortcoming in the employers' protection arrangements for Health & Safety.
c) All needle stick injuries
d) Contamination injuries i.e. bite or splash.
e) Any near miss events with the potential to cause harm

Particular regard must be paid to:

- Wearing the appropriate protective clothing and safety equipment and the use of appropriate safety devices where applicable.
- Complying with all safe-working procedures.
- Reporting all faults, hazards, accidents, dangerous occurrences, regardless of whether persons are injured in accordance with Trust Policy.
- Staff must pay extra attention to their own safety and the safety of others when working on a task which involves, or involved prior to their attendance, the use of a sharp. Examples of this could be a patient who has used their own Epipen or other medical Professionals who have used a sharp, as they may not have taken the correct and safe action to dispose of their sharp. Proceed with caution until you are sure the sharp has been disposed of appropriately.

**Staff Illness and Reporting**

It is important that staff remember that infection can be passed in either direction, i.e. patients to staff or staff to patients and staff to staff through direct contact or via fomites, e.g. desks or IT equipment.

Staff should inform their Line Manager, if they develop any of the following diseases, and should not report for duty unless advised to do so:

- Skin infection or exposed areas of infestation
- Severe respiratory infection (e.g. pneumonia, TB - Not self-limiting viral infections or the common cold)
- **Unexplained** or **Severe** diarrhoea and / or vomiting
- Jaundice
- Hepatitis
- Infectious diseases, such as chicken pox, measles, mumps, rubella or scarlet fever
- Any other infectious disease (E.g. HIV)

Line Managers will be responsible for advising Human Resources and the Infection Control Lead or Assistant Director of Patient Care of all illnesses reported in this way. All such reporting will be treated in the strictest confidence.

Unexplained or severe diarrhoea and / or vomiting should only be notified to HR and the Infection Control Lead, where three or more cases occur simultaneously on Resource Centres or department in their charge.
Infection Prevention Control and Decontamination Policy

The Infection Control Lead will liaise with Occupational Health and HR if there is concern that a work acquired infection or other infection control issue is apparent.

Infecting agents responsible for gastroenteritis or skin conditions/infections can differ and may include viral, bacterial or fungal pathogens. The infectivity and incubation of these can vary depending on the cause therefore the return to work process would vary depending on the cause.

4.7 Partnership Working

In order to effectively manage risks associated with infection control it is essential that close working relationships are developed with other NHS Trusts and agencies to ensure a smooth transfer through the patients’ care pathway. Sharing of information regarding patients’ clinical conditions and the presence of any known infectious disease will assist in reducing the risk of cross infection and improve patient care overall.

The Trust reports any patient safety incidents through the National Reporting and Learning System to the National Patient Safety Agency (NPSA). Liaison will be via the Trusts Corporate Affairs Department.

The Trust will involve patients and the public on its control of infection procedures through the Patient Involvement Panel and ensure that information such as the Trust’s policy, handbook, annual report and minutes are is available on the Trust’s website.

4.8 Quality and Safety Committee

The Trust Board has delegated responsibility to the Quality and Safety Committee for developing and monitoring effective Policies, Procedures and best practices with regards to the control of infection as part of its overall risk management remit. This will be completed in association with the Patient Safety Group

4.9 Patient Safety Group

This sub-group of the Quality and Safety Committee are responsible for reviewing and recommending changes to Policy and practice. The purpose of the Group is to provide the Trust with an objective and structured approach to implementing effective management of infection control and decontamination across all facilities and services provided by the Trust, with the primary aim of providing a safe environment to all patients, visitors and staff.

4.10 Specialist Infection Control Advice

SCAS will commission, under a Service Level Agreement, external specialist advice. This will be provided by an expert in Infection Control matters and may be a Nurse or Doctor with specialist training in this field. This facility may be purchased centrally or by operational area.

4.11 Occupational Health

The Trust provides an Occupational Health (OH) Service to all employees; this service is available during both normal working hours and outside of normal working hours to provide advice and counselling in relation to needle stick or contamination injuries (See 7.7.6). Further advice can be sought from the appropriate Emergency Department and Duty Supervisor/Officer or the Microbiology team at Queen Alexandra Hospital, Portsmouth under the Trusts service level agreement.
Staff may obtain contact details for the Occupational Health Service from the Human Resources Department or from their Line Manager.

The Occupational Health Service will provide a pre-employment health assessment, which should include:

- Completion of a confidential health questionnaire
- Occupational history with details of previous exposure to infection risk
- Skin examination to evaluate risk from chronic skin disease
- Previous occupational health problems
- Vaccination and immunisation history
  - Check for evidence of BCG or undertake a Mantoux test or T-spot test
  - Check for immunity to measles, mumps or rubella (MMR)
  - Provide polio booster if more than ten years since last booster
  - Document last date of tetanus booster
  - Give advice and vaccination for Hepatitis B.
  - Signpost to GP for Polio or Tetanus if required.

5. Definitions

Cleaning - The physical removal of foreign material (e.g. dust, soil, organic material such as blood, secretions, excretions and microorganisms). Cleaning physically removes rather than kills micro-organisms.

Clinical waste - Is defined in the Controlled Waste Regulations 1992 as:

(a) Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, medicines or other pharmaceutical products, swabs or dressings, or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it; and

(b) Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

Communicable - Capable of being transmitted from one person to another; synonymous with ‘infectious’ and ‘contagious’.

Contamination - The presence of microorganisms on inanimate objects (e.g. clothing, surgical instruments) or microorganisms on body surfaces such as hands, or in substances (e.g. water, food).

Colonization - When micro-organisms are present on or in a person but not currently causing any harm, that person is said to be colonized with those organisms. For example, human beings are normally colonized with huge numbers of several different species of bacteria.

Cross-infection - Cross-infection is one term given to the transmission of infectious agents between patients within the healthcare setting. It may be direct transmission from one person to another, or indirect, for example via an incorrectly cleaned piece of equipment.
Decontamination - The removal of disease-producing microorganisms to leave an item safe for further handling.

Disease - Clinical expression of infection; signs and/or symptoms are produced.

Disinfection - The process of destroying pathogenic organisms or rendering them inert and thereby incapable of causing infection.

Hand Hygiene - A process for the removal or destruction microorganisms on hands.

Healthcare-associated infection (HCAI) - Any infection acquired as a result of a healthcare-related intervention or an infection acquired during the course of healthcare that the patient may reasonably expect to be protected from. For example, a person may acquire viral gastroenteritis in many circumstances but if they acquire it in hospital from another patient, it should be regarded as healthcare associated. This has replaced the term “hospital-acquired infection”.

Healthcare provider - Any person working in a medical setting including physicians, nurses, allied health care professionals, clerical and support staff.

Infection - The entry of an infectious agent in the tissues resulting in clinical signs and symptoms (disease).

Infection prevention and control - Is concerned with preventing healthcare-associated infection within the health-care setting, whether this be patient-to- patient, from patients to staff and from staff to patients, or among-staff.

Infectious agent - Anything that may be transmitted from one person to another, or from the environment to a person, and subsequently cause an infection or parasitic infestation. Infectious agents are most often micro-organisms such as bacteria or viruses.

Outbreak - An excess over the expected incidence of disease within a geographic area during a specified time period, synonymous with epidemic.

Personal protective equipment (PPE) - Specialized clothing or equipment worn by a health care professional for protection against an infectious hazard (e.g. gloves, masks, protective eyewear, gowns). General work clothes (e.g. uniforms, trousers, shirts or blouses) are not intended to function as protection against a hazard and are not considered personal protective equipment.

Pathogen - A micro-organism that is capable of causing infection. Many micro-organisms are opportunistic pathogens; that is, they will cause infection in vulnerable individuals but not, normally, in healthy adults.

Sharps - Needles, syringes, blades, glass vials or other objects capable of causing punctures or cuts.

Sterilisation - The destruction of all forms of microbial life including bacteria, viruses, spores and fungi. Items must be cleaned thoroughly before effective sterilization can take place.

Universal precautions - Correctly called universal blood and body fluid precautions, these are the precautions that are taken with all blood and ‘high-risk’ body fluids. They are
Infection Prevention Control and Decontamination Policy

based on the principle that any individual may be infected with a blood borne virus, such as HIV or hepatitis B, and so pose a risk of infection; no individual can be regarded as completely ‘risk free’

**Standard precautions** - The phrase ‘standard precautions’ is sometimes used interchangeably with ‘universal precautions’ and is used to describe the actions that should be taken in every care situation to protect patients and others from infection, regardless of what is known of the patient’s status with respect to infection, and includes:

- Hand hygiene at the ‘5 moments’ described by the WHO (2009), including before and after each patient contact;
- Care in the use and disposal of sharps;
- Correct use of personal protective equipment for contact with all blood, body fluids, secretions and excretions;
- Providing care in a suitably clean environment with adequately decontaminated equipment;
- Safe disposal of waste;
- Safe management of used linen.

6. **Abbreviations**

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<tr>
<th>Abbreviation</th>
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<tr>
<td>DIPC</td>
<td>Director of Infection Prevention and Control</td>
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<td>NPSA</td>
<td>National Patient Safety Agency</td>
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<tr>
<td>HCAI</td>
<td>Health Care Associated Infection</td>
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<td>AACE</td>
<td>Association of Ambulance Chief Executives</td>
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<td>IPC</td>
<td>Infection Prevention and Control</td>
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<tr>
<td>BCG</td>
<td>Bacillus Calmette-Guérin (Tuberculosis Immunisation Vaccine)</td>
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<td>ANTT</td>
<td>Aseptic Non-Touch Technique</td>
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<tr>
<td>COSHH</td>
<td>Control of Substances Hazardous to Health</td>
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<tr>
<td>ePR</td>
<td>Electronic Patient Record</td>
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<tr>
<td>E&amp;UC</td>
<td>Emergency &amp; Urgent Care</td>
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<tr>
<td>NEPTS</td>
<td>Non-Emergency Patient Transport Services</td>
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<tr>
<td>BBE</td>
<td>Bare Below the Elbows</td>
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<tr>
<td>CCC</td>
<td>Clinical Co-ordination Centre</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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7. **Infection Prevention Control and Decontamination Policy Guidelines**

7.1 **Immunisation Guidance**

Ambulance staff should be vaccinated against the following:
- Tetanus
- Hepatitis B
- Rubella
- Poliomyelitis
- Diphtheria
- Tuberculosis (BCG)
- Measles, Mumps and Rubella (MMR)
- Varicella (Chickenpox)

The majority of staff should have had lifelong immunity conferred by their normal childhood vaccination programmes. These include diphtheria, tetanus, and BCG. If there is any doubt then staff should discuss their vaccination status with Occupational Health or their GP.

Advice on the need for immunisation including booster doses is available from GPs or through the Occupation Health Service provided through the Trust.

The Trust recognises the importance of the annual Influenza vaccination programme and encourages all staff to take up this option. It must be remembered that out breaks of Influenza can have an adverse effect on how we respond to service user and patient care.

7.1.1 **Staff who cannot gain immunity**

If you have to deal with a patient who has a known disease from which you know you are not immune:
- Inform Control and ask if another crew can carry out detail.
- If not, drive whilst patient is aboard.
- Carry from behind the patient.
- Avoid close contact with patient.
- Inform Occupational Health via Control as soon as possible afterwards.
- Complete adverse incident report form record.

7.1.1 **Hepatitis B Vaccination**

The South Central Ambulance Service NHS Foundation Trust is aware of the potential risk to staff caused by the exposure to Hepatitis B and recognises its responsibility to staff to ensure that adequate immunisation is available. It is also vital that patients are protected, e.g., from transmission of the virus from a member of staff who is a carrier.

The source of Hepatitis B is blood and other body fluids. It is transmitted through direct contact.

Some patients, who have had Hepatitis B, can develop a “Carrier Status” whereby they carry the virus and can transmit it long after they have recovered from their own episode of Hepatitis. Although carriers of Hepatitis B seem healthy they can remain infectious for many years.

Contamination can occur by any of the following methods:
- Injected (for instance by needle stick injury).
- Conjunctiva contamination.
- Allowed to contaminate a recent (less than 24 hours old) cut or abrasion.
Vaccination is the most effective and safest method of protection. Hepatitis B vaccination is recommended for all staff who work in contact with patients or who may become exposed to blood or body fluids. This includes:

- A&E (including A&E Support).
- NEPTS.
- Operational Managers.
- Fleet maintenance staff.
- Medical Loans staff, who deal with used loan equipment
- Staff and Community Responders.
- Divisional Medical Directors
- Any staff used by SCAS in a patient care capacity (e.g. St John Ambulance) must have had Hepatitis B vaccinations prior to commencement of duty on behalf of SCAS.
- Vehicle maintenance by external contractors must receive notification of potential risk associated with Ambulance Trust vehicles.

The Hepatitis B vaccine is administered on three occasions. Following the initial inoculation offered at the Occupational Health appointment (pre-employment screening), the 2nd vaccine is administered 4 weeks later (28 days) and the 3rd, 6 months after the initial vaccine. These are followed by a blood test at 6 – 8 weeks later to confirm immunity. An accelerated course may be offered if deemed necessary / appropriate.

The Trusts Occupational Health Provider will maintain a database of all staff vaccinations. Occupational Health will notify staff of due vaccination dates. It must be stressed that it is every employee’s responsibility to ensure that they receive their inoculations by the due date. This is particularly important in the case of the Hepatitis B vaccination programme.

There are those who cannot gain immunity from Hepatitis B and some who may not wish to be inoculated through choice. Both these cohorts of staff will be counselled by the Occupational Health provider. Those staff that declined the vaccination can then make an informed decision on having or declining the vaccination programme. In the case of a staff member unable to gain immunity or having declined the vaccine, the Occupational Health provider will ensure that a disclaimer in signed by these staff groups so as to relieve the Trust of any responsibility should they contract Hepatitis B, or other infection through their working practices.

Staff who are not immunised against Hepatitis B, who come into contact with the virus, including those who cannot gain immunity, will be offered a Hepatitis B vaccine / immunoglobulin, via normal channels, if it is required.

Operational and observation shifts will be allowed after the first inoculation or in the case of those who cannot gain immunity, or have declined the vaccination, when a disclaimer has been signed through the Occupational Health provider.

7.2 Audit and Inspection

The Trust should be active in ensuring that the appropriate policies and procedures required ensuring a safe environment for patients, staff and visitors are in place and implemented. To this end infection prevention and control environmental audits should be performed throughout the trust.

All SCAS locations and vehicles will be subject to regular audit and inspection as detailed in this infection prevention control and decontamination policy and in line with the Health and Social Care Act 2008, and the DH Essential Steps, safe, clean care.

The Trusts IPC audit tool has been developed to look at key performance (Clinical Safety) indicators including:
The general hygiene of Ambulance premises cooking and washing facilities and food storage.
- The storage and disposal of clinical waste and sharps
- The storage of used linens
- The decontamination and cleanliness of Ambulance vehicles and equipment
- The decontamination and cleanliness of medical equipment
- The decontamination and cleanliness of work stations and equipment
- The knowledge and competency of all staff on IPC matters

The Infection Control Lead will also have responsibility for auditing and reporting of:

- The Trust adverse events reports for IPC
- Reporting of all needle stick injuries
- Audit exception reporting

Audits will be undertaken for premises and vehicles spread over the year period April to March and reported to the Patient Safety Group. Random Station and vehicle auditing by the Infection Control Lead will be at least on a quarterly basis. Audit results will be reported to the Trust Board via the Quality and Safety Committee. This will ensure that any non-compliance is identified and actioned appropriately and quickly.

Station and observational audits should be undertaken by first line managers but can be undertaken by any staff member trained in the Trust auditing processes. The line manager will have overall responsibility for the completion of the audits, ensuring they are inputted onto the web based reporting tool within a 24 hour period and be responsible for any action plans associated with the audit within their remit. The online audit system is access at https://www.auditonline.co.uk/scas

The Head of Operations and Clinical Operations Managers will have overall responsibility to ensure all auditing is carried out to the time scales set out below and action plans are completed in a timely manner and as soon as practicably possible.

- Station audits will be undertaken every other month. This time scale can be altered/amended at the discretion of the Director of Infection Prevention and Control.
- Clinical Co-ordination Centres (CCC) will be audited on a 6 monthly basis along with office areas or quarterly where there are patient facing clinicians / responders.
- Audits for vehicles that have been deep cleaned should also be undertaken and every patient carrying vehicle must be audited at least every 6 months. Vehicle audits can be conducted by any person trained in the Trust auditing process.
- Individual Hygiene Observation audits will be carried out by line managers and will include every member of patient facing staff, including all Operational Managers, at least once annually.

Random auditing of vehicles and stations may also be undertaken by senior managers across the Trust. These audits will be undertaken by managers from any Director, who may be on Trust business on resource centres or other Trust premises. Audit results will be forwarded to the Patient Safety Group via the infection Control Lead for further review, auditing, and appropriate action.

Further IPC audits may be requested by the Patient Safety Group or the Clinical Review Group as appropriate. This may include sharps injuries, Hand Hygiene audits, work acquired infections, work related injuries etc. as part of Key performance indicator work.
The Human Resources department will make available, to the Infection Prevention, Control & Decontamination inspection team an anonymised list of work related infections, acquired by staff at any locality that is to be visited for inspection purposes. It will be the responsibility of the team leader to acquire this list from the Human Resources Department, which will be extracted from records held in HR.

Infection control issues identified during inspections will also be separately reported to the Quality and Safety Committee.

Operational/Departmental Managers will carry out ad hoc inspections of stations and vehicles, on a quarterly basis, to ensure that the principles of this policy are being followed. The result of these inspections will be routinely reported to Quality and Safety Committee if any discrepancies are noted and reported as risks in accordance with the Trusts Risk Management Policy.

7.3 Monitoring

Key Performance Indicators will be monitored by the Infection Control Lead and Assistant Director of Patient Care every six months, these will include:

- Responsibilities of staff will be monitored through development of reports and the appraisal process.
- Number and percentage of staff completing mandatory and induction training in year.
- Number of incidents reported through the Risk Management Process
- Information provided/obtained from the annual Hand Hygiene Audit
- Number of incidents and complaints reported from members of public and external agencies/healthcare providers.
- Contract Monitoring with vehicle cleaning agencies
- Number of inoculation incidents reported and carryout a review of the Trust management, support of staff, reporting arrangements and training.

All of the KPI’s are monitored by the Patient Safety Group who will also specifically

- Monitor progress and outcomes of Clinical investigations, patient involvement and subsequent action plans, and report to the Quality and Safety Committee
- Quality and Safety Committee monitor all of the above and in particular the Trust Monitoring of Action Plans which includes high level investigations
- Annual review of Job Descriptions and Responsibilities.

7.4 Background Information

7.1.1 Basic Microbiology

Micro-organisms and their Properties

The term micro-organism, or microbe, is used to describe any organism, which is too small to be seen with the naked eye. Many micro-organisms live independently of man and those that are dependent exist in a host-organism relationship that is generally harmless and may even be mutually beneficial. Of the vast array of organisms, only about 50 or so species do, in fact, cause harm to humans.

Micro-organisms capable of causing disease are referred to as Pathogens. Infection is a pathological process, which involves the damaging of body tissues by pathogens, or by the toxic substances produced by these pathogens. They generally thrive and multiply in darkness, warmth and moisture, and infection is usually accompanied by signs and symptoms in the
patient, E.g. pain, swelling and/or fever. Pathogenic micro-organisms may be classified as follows:

**Bacteria** are minute organisms about one-thousandth to five-thousandths of a millimetre across. They are susceptible to a greater or lesser extent to antibiotics.

**Viruses** are much smaller than bacteria and although they may survive outside the body for a time, they can only grow inside body cells. Viruses are not susceptible to antibiotics, but there are a few anti-viral medicines available which are active against a limited number of viruses.

**Pathogenic fungi** can be either moulds or yeasts. An example of a mould that causes infection in humans is ringworm, which can also infect nails. A common yeast infection is thrush, caused by an organism *Candida albicans*. Immunosuppressed individuals may develop systemic infections affecting the whole body; one example is aspergillus, which is usually an opportunistic organism taking advantage of the persons lowered immune response.

**Protozoa** are microscopic organisms, but are larger than bacteria. Those that cause disease in humans include *Cryptosporidium parvum*, which causes diarrhoeal illness, and the malaria parasite.

**Worms** are not always microscopic in size, but pathogenic worms do cause infection and some can spread from person to person. Examples include threadworm and tapeworm.

**Prions** are thought to be found in the central nervous system and also in other tissues such as the lymph glands particularly the tonsils. Intensive research into prions continues: they are thought to be the cause of transmissible spongiform encephalopathies (TSE). During the 1980’s new types of prion evolved in the UK, including bovine spongiform encephalopathy (BSE) in cattle and variant Creutzfeldt-Jakob disease (vCJD) in humans.

### 7.4.2 The Transmission of Infection

#### The Chain of Infection

Transmission of infection occurs when the *infectious agent* leaves its *reservoir* or host through a *portal of exit* and is conveyed by some mode of *transmission* and enters through an appropriate *portal of entry* to infect a *susceptible host*. This is the *chain of infection*.

For any given infection, understanding the chain of infection allows appropriate control measures to be recommended.

#### The Reservoir of Infection

The reservoir of an infectious agent is any person, animal, arthropod, plant, soil or substance (or combination of these) in which the infectious agent normally lives and multiplies. It is dependent on the reservoir for survival and it produces itself there in such a way that it can be transmitted to a susceptible host.

#### The Portal of Exit

The portal of exit is the path by which an agent leaves the source host, which usually corresponds with the site at which the agent is localized, for example, respiratory tract, genito-urinary system, gastrointestinal system, skin or blood.

#### The Portal of Entry

The portal of entry is the route by which an agent enters a susceptible host. This provides access to tissues in which the agent can multiply or a toxin can act.

The main portals of entry are:
- The Respiratory Tract: Through inhalation of organisms. (E.g. tuberculosis, diphtheria and mumps)
- The Alimentary Tract: Through ingestion of contaminated food or water. (E.g. salmonellosis and dysentery)
- The Skin and Mucosa: Either by the passage of organisms through damaged skin, (infected wounds), or by the inoculation of organisms. (E.g. Hepatitis B transferred from contaminated needles)
- The Placenta: Via transfer of organisms from the maternal circulation to the foetal circulation (E.g. rubella, cytomegalovirus and syphilis)

Chain of Infection
Sources of infection are:
- Infected patients,
- Colonised patients (who may show no signs of infection),
- People incubating an infectious disease,
- Healthy carriers.

Infection is spread:
- By contact E.g. with contaminated hands, instruments, fomites, (objects) food and water,
- Or through the air via respiratory droplets, dust or skin scales carrying micro-organisms.

Infection can be acquired by:
- Inhalation,
- Ingestion,
- Percutaneous inoculation e.g. via wounds or injections,
- Sexual contact

The risk of transmitting infection to patients or staff can be minimised by adopting simple infection control measures including the following processes and procedures.

- Standard Precautions
- Work Areas, Vehicle and Equipment Cleaning
- Management of Sharps
- Management of Linen
- Procedures for Station and Premises Cleaning

7.5 Standard Precautions

7.5.1 Standard infection prevention and control precautions aim to prevent the transmission of micro-organisms by direct or indirect contact. The transmission of the majority of infectious
Infection Prevention Control and Decontamination Policy

diseases and Blood Borne Viruses that the Ambulance Service comes into contact with can be reduced by the use of these standard precautions. Some communicable diseases require additional precautions and a summary of these can be found in the Communicable Disease Policy.

Infection prevention and control is a fundamental requirement to ensure safe practice where exposure to potential pathogenic micro-organisms can occur, this can affect SCAS personnel, patients or public.

The general principles of these precautions are divided into the following categories:

- Hand hygiene
- Aseptic Non-Touch Technique (ANTT)
- Personal Protective Clothing and equipment
- Prevention and management of inoculation injury including exposure to blood and body fluids
- Cleaning and Decontamination procedures
- Waste management
- Linen and Uniform

Standard precautions are based around treating every patient as if they are potentially infectious. As an Ambulance Service we will not know with the vast majority of patients if there is an infection risk, it is because of this that all SCAS operational staff, as “best practice”, must routinely apply appropriate barrier methods as part of their daily duties including when dealing with deceased persons (to prevent contamination by blood and body fluids and transmission of other infections). These precautions will minimise the risk of infection.

7.5.2 Body Fluids (which may contain the organisms of HIV or Hepatitis B/C) to which Standard Precautions apply:

- Blood
- Body fluids containing visible blood
- Other body fluids including:
  - Seminal fluids
  - Vaginal secretions
  - Cerebral Spinal fluid (CSF)
  - Synovial fluid
  - Amniotic fluid
  - Pleural fluid
  - Peritoneal fluid
  - Pericardial fluid
  - Breast Milk

Other body fluids which may contain pathogenic micro-organisms to which Standard Precautions apply:

- Faeces
- Urine
- Vomit
- Sputum.

7.5.3 Precautions needed

The staff should assess each situation when determining the precautions necessary. The staff member’s individual skills, the facilities available and the likelihood of coming into direct contact with body substances must form the basis of the assessment. Inappropriate and over
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zealous precautions are to be discouraged as overuse of personal protective equipment can cause a wider spread of infection than if it is not used at all. It can also inadvertently be considered as dehumanising to patients. The use of these precautions will:

- Prevent staff skin and clothing becoming contaminated with pathogenic microorganisms which may subsequently be transferred to other patients in their care.
- Prevent staffs’ clothing becoming soiled, wet or stained where there is a risk of exposure to body fluids during the course of the day.
- Prevent contamination of the surrounding patient environment
- Prevent staffs acquiring infection from a patient.

7.5.4 Resources needed

All healthcare facilities (including workshops) should have the following available:

- Powder free disposable gloves (Nitrile) which conform to British and EN standards and be CE marked
- Disposable plastic aprons
- Sleeve protectors
- Shoe Protector Overshoes
- Sharps containers
- Clinical waste bags
- Domestic waste bags
- Eye protection (goggles/visors)
- Face masks (surgical and FFP3)
- Cleaning agents for staff to use when appropriate.
- Linen bags (red alginate and clear plastic) where appropriate

7.5.5 Measures to prevent transmission of infection

- Apply good basic infection prevention and control/hygiene practices, including regular hand hygiene.
- Use clean gloves as and when needed.
- Apply aseptic techniques where appropriate.
- Cover existing wounds or skin lesions with impermeable waterproof dressings.
- Avoid contamination of self and patient by appropriate use of PPE.
- Protect mucous membrane of eyes, mouth and nose from blood and body fluid splashes when appropriate.
- Avoid the use of sharps wherever possible.
- Institute safe procedures for the handling and disposal of needles and other sharps.
- Clear up spillages of blood and other body fluids promptly using the body fluid spill kits provided on Ambulance vehicles and disinfect surfaces to the approved recommendations and standards.
- Institute a procedure for the safe disposal of contaminated waste from its inception to its final disposal.
- Ensure all staff have access to the necessary cleaning materials and know what to do in the event of exposure to blood / bodily fluids or sharps injury.
- Ensure single-use items remain in their packaging until the point of use and dispose of appropriately immediately after use
- Never use re-usable tourniquets.

7.5.6 Personal Hygiene
Cleanliness and high standards of personal hygiene are of paramount importance in minimising the risk of cross infection.

The public image of SCAS stems directly from the appearance and conduct of operational members of staff. They should always:

- Be dressed smartly
- Have hair under control and never loose
- Wear one plain band (wedding) ring only. Stoned rings must not be worn
- Keep fingernails short and smooth. Do not wear any form of nail varnish, clear or otherwise. Acrylic or other false nails must not be worn.
- Ensure uniform is clean, tidy and in good repair.

Please refer to SCAS Uniform Policy for further information

Before a shift begins, all hand jewellery should be removed. (It is accepted that a plain wedding ring may be worn, however all ‘stoned’ rings must be removed.)

SCAS has adopted a ‘bare below the elbows’ clothing policy for all (clinical) staff in uniform who should not wear wrist watches and wrist bands must be removed. This aims to prevent the spread of infection from contaminated sleeves and to aid effective hand-hygiene procedures. However, the Trust will accept wrist watches that are fully washable to be worn. The straps should be of plastic type material and no linked straps must be worn as bacteria reside within these areas.

When ambulance staff need to wear long sleeved uniform, or when high-visibility jackets are required, the following steps should be taken:

- Be aware of any possible contaminants.
- Whenever possible remove long sleeved clothing or wear sleeve protectors.
- Always remove long-sleeved coats to wash hands effectively.

7.5.7 Hand Care

Existing wounds, skin lesions and all breaks in exposed skin must be covered with waterproof dressings at the commencement of duty and checked regularly to ensure integrity. Ambulance staff with dermatitis may be at increased risk of exposure to blood-borne viruses during skin contact with blood or body fluids due to loss of skin integrity. Any member of staff with excessive skin problems must seek advice from SCAS Occupational Health Department.

7.5.8 Hand Hygiene

Good and efficient hand hygiene is the single most important factor in the prevention of and spread of infection.

Effective hand hygiene results in significant reductions in the carriage of potential pathogens on the hands.

Hand washing, using the liquid soap available must be utilised wherever possible. Liquid soap is available in toilets and washrooms of all ambulance premises. When it is not possible to access liquid soap, alcohol rub must be utilised. Alcohol rub is available on every ambulance vehicle.

Hand hygiene must be carried out on all of the following occasions following the World Health Organisations five moments of care approach:
The ‘5 moments of hand hygiene at the point of care’ is a NPSA campaign to promote effective hand hygiene. The five moments are:

- **Before patient contact** – When: Clean your hands before touching a patient when approaching him/her. Why: to protect the patient against harmful germs carried on your hands.

- **Before an aseptic task** – When: Clean your hands immediately before any aseptic task. Why: to protect the patient against harmful germs, including the patient’s own from entering his/her body.

- **After body fluid exposure risk** – When: Clean your hands immediately after an exposure risk to body fluids (and after glove removal). Why: to protect yourself and the healthcare environment from harmful patient germs.

- **After patient contact** – When: Clean your hands after touching a patient and his/her immediate surroundings when leaving the patient’s side. Why: to protect yourself and the healthcare environment from harmful patient germs.

- **After contact with patient surroundings** – When: Clean your hands after touching any object or furniture in the patient’s immediate surroundings when leaving—even if the patient hasn’t been touched. Why: to protect yourself and the healthcare environment from harmful patient germs.

Wherever possible, **soap and water** should be used to clean hands.

If soap and water are not available, hands can be cleaned with detergent wipes first, followed by thorough drying either with paper towels or by air drying, and then alcohol rub can used.

Alcohol rub should be used to decontaminate visibly clean hands, as it can be ineffective if hands are soiled.

Alcohol rub should ideally be used between different care activities for one patient, and between caring for different patients at a scene.

Hand washing must also be carried out:
- At the commencement and finish of each shift
- Prior to eating, drinking and smoking
- After carrying out a cleaning procedure

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Infection Prevention Control and Decontamination Policy
- After using the toilet.
- When hands are visibly dirty
- Before and after each patient contact (including after handling their linen, belongings or equipment).
- Before and after performing any invasive procedure.
- After removing gloves.
- After handling contaminated laundry and waste.

N.B when dealing with patients with faecal matter hand gelling will not neutralise or remove Clostridium Difficile.

7.5.8.1 Use of Gloves

The use of gloves as a method of barrier protection reduces the risk of contamination but does not eliminate it altogether. It is therefore imperative that regular hand hygiene takes place prior to and after the wearing of gloves. Be aware that bacteria already on hands multiply while gloves are being worn and also the integrity of gloves cannot be taken for granted e.g. punctured during use. Only wear gloves when necessary i.e. when conducting aseptic or invasive procedures or when there is a risk of exposure to body fluids or secretions.

7.5.8.2 Hand washing Technique

Effective hand washing technique involves three stages:

Preparation - This requires wetting hands under tepid running water before applying liquid soap or an anti-microbial preparation.

Washing and rinsing - The hand wash solution must come into contact with all the surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 10-15 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly prior to drying with paper towels.

Drying - Ensure that hands are dried thoroughly using paper towels - a key factor in the maintenance of skin integrity are that hands are dried completely.

SCAS has adopted the World Health Organisation (WHO) World Alliance guidance for effective handwashing techniques. See appendix 8

7.5.8.3 Alcohol Gel or Foam

Alcohol is an effective alternative when water and disposable towels are not readily available or when rapid hand disinfection is required. 70% alcohol based solution is the optimum concentration for hand disinfectants.

All staff should apply alcohol rub to their hands, prior to donning gloves in preparation to perform any invasive procedure; time will be needed for rub to dry before attempting to put on gloves. The use of alcohol disinfectants offers temporary protection only, and therefore hand washing with soap and water must be completed as soon as is practicable. Alcohol disinfectant is intended for use on visibly clean hands, therefore the need for regular hand washing cannot be over-emphasised. There is no limit to the number of time alcohol rub
can be used between hand washing, unless hands become visibly soiled. It is important to note that the efficacy of alcohol reduces with every application. SCAS has adopted the World Health Organisation (WHO) World Alliance guidance for effective alcohol hand rub techniques. See appendix 9

7.5.8.4 Application of Alcohol Hand Rub

Apply 3 - 5ml. The alcohol rub must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

Due to the flammability of the alcohol content in the rub – it is prohibited to smoke or use the rub in an area of potential ignition. (Refer to COSHH assessment).

7.5.8.5 Hand Cream

The regular application of an emollient hand cream protects the skin from the drying effects of regular hand decontamination. Staff are advised to use hand cream on a regular basis in order to help prevent dry skin, which in turn will reduce the risk of lesions developing.

If a particular soap or alcohol product causes skin irritation, advice must be sought from SCAS Occupational Health Department.

7.5.9 Aseptic Non-Touch Technique (ANTT)

Asepsis is defined as the absence of pathogenic organisms. ANTT is a phrase used to describe defined clinical procedures developed to prevent the contamination of wounds and other susceptible body sites through the use of sterile equipment and fluids during invasive medical procedures and by avoiding the contamination of equipment by adopting a ‘non-touch’ technique.

ANTT is designed to keep procedures as free from organisms as possible. The principles of ANTT play a pivotal role in preventing the transmission of infection, regardless of the surrounding environment.

Key principles;
- Keep exposure of susceptible sites to a minimum
- Appropriate hand decontamination prior to the procedure
- Use of gloves (sterile or non-sterile, depending on the nature of the susceptible site e.g. suturing or urinary catheter management)
- Ensure all fluids and materials used are sterile
- Check integrity of packaging
- Ensure contaminated and non-sterile items are kept away from the sterile field
- Not reusing single use items
- Reduce staff / bystander activity (where possible) in the immediate vicinity in which the procedure is to be performed.

It is the responsibility of each staff member to read these principles and incorporate them into every day practice. See http://aace.org.uk/wp-content/uploads/2011/11/New-DH-Guidelines-Reducing-HCAIs.pdf for further details

Intravenous cannulation
Intravenous cannulation should only be carried out on patients who need immediate treatment with medicines or fluid should be cannulated before arrival at a hospital site. The member of staff should insert the cannula aseptically whenever it is physically possible to do so. Good practice from Saving Lives High Impact Intervention No. 2 on peripheral intravenous cannula care recommends:

1. Apply the tourniquet (single use and disposable).
2. Palpate the vein.
3. Decontaminate your hands.
4. Make a sterile field – for example using a sterile cannula dressing pack.
5. Clean the site for venepuncture using 2% chlorhexidine gluconate in 70% Isopropyl alcohol - Do not re-palpate the vein.
6. Leave skin to dry for 30 seconds.
7. Choose a cannula, open the pack and place the cannula aseptically in the sterile field.
8. Decontaminate your hands and don gloves.
9. Insert the cannula according to IHCD guidelines, ensuring that the insertion site is not touched. If insertion attempt is not successful, the same cannula should not be used again.
10. Use a sterile, semi-permeable, transparent dressing to secure the cannula.
11. Record the date and time of insertion on an ‘ambulance’ label.
12. Place the label on the dressing at the furthest point from the insertion site.
13. Dispose of any items used in the appropriate waste receptacles.
15. Record the date and time of insertion on the electronic patient record (ePR) or patient report form.

Always ensure that the giving set and any syringes used for administering medicines through the cannula are handled aseptically. For certain procedures, for example administering diazemuls slowly, titrated to response, or atropine for symptomatic bradycardia (following Joint Royal Colleges Ambulance Liaison Committee guidelines), retain the sterile field to hold the syringe(s) between doses.

In the event that ANTT cannot be applied when cannulating due to the nature of the emergency, it must be recorded on the ePR as an emergency inserted cannula, and included in the patient handover to staff at the receiving unit. All cannulation attempts (including gauge and site) should be recorded on the ePR, whether successful or not. Successful cannulas must have the time and date of cannulation recorded on the cannula securing dressing and the ePR.

All emergency inserted cannulas will be replaced aseptically as soon as is practicable by the receiving unit usually within 24 hours in line with National Guidelines.

7.5.10 PERSONAL PROTECTIVE EQUIPMENT (PPE)

7.5.10.1 Occupational Exposure and Risks

The Ambulance Service is aware that if you work in a situation where you come into contact with blood and body fluid and infectious diseases you could be at risk. It is for this reason that staff should avoid contamination of person and clothing. To avoid contamination staff should always use appropriate protective clothing in any situation when contact is possible. All staff must wear protective eyewear and other appropriate personal protective equipment when dealing with a patient where there is a risk of contamination from blood or other body fluids.
The Control of Substances Hazardous to Health (COSHH) Regulations 2002 requires employees to undertake their own risk assessment and to bring into effect measures necessary to protect workers and others who may be exposed, as far as is reasonably practicable.

All vehicles must be equipped with adequate supplies of gloves, sleeve protectors, aprons, surgical masks, safety spectacles, FFP3 respirator masks and Tyvex suits. It is not sufficient to rely upon helmet visors to protect staff from fluids and droplet spray.

7.5.10.2 Protective Personal Equipment (Inc. Clothing)

Protective clothing and equipment should be selected on the basis of an assessment of the risk of transmission of micro-organisms to the patient, the risk of contamination of health care practitioners’ clothing and skin by patient’s blood, body fluids, secretions and excretions.

Many clinical activities involve no direct contact with body fluid and do not require the use of protective clothing, for example, taking a pulse or blood pressure. Invasive techniques however should always be performed using appropriate PPE.

<table>
<thead>
<tr>
<th>Circumstance/Activity</th>
<th>Appropriate PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No exposure to blood/ body fluids anticipated.</td>
<td>Good hand hygiene (5 moments of hand hygiene).</td>
</tr>
<tr>
<td>Exposure to blood/body fluids anticipated, but low risk of splashing.</td>
<td>Wear gloves, sleeve protectors and plastic apron.</td>
</tr>
<tr>
<td>Exposure to blood/body fluids anticipated and high risk of splashing.</td>
<td>Wear gloves, sleeve protectors, plastic apron and eye/ mouth/ nose protection.</td>
</tr>
</tbody>
</table>

7.5.10.3 Gloves

Within the Ambulance Service the wearing of gloves plays a dual role as a barrier for personal protection and the prevention of the transmission of infection. Second to hand hygiene, consistent use of barrier methods, especially wearing gloves when appropriate to do so, is the most important step in preventing cross-contamination of staff and patients.

When Gloves must be worn

Gloves must be worn for:
- Any aseptic procedure
- Invasive procedures.
- Contact with sterile sites and non-intact skin, mucous membranes.
- All activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions and excretions.
- When handling sharp or contaminated instruments.
- When cleaning equipment prior to disinfection, when handling chemical disinfectant and when cleaning up spillages.

Gloves must be worn as single use items and disposed of as clinical waste or if there is no contamination then disposed of in domestic waste. They must be put on immediately before an episode of patient contact or treatment and removed as soon as the activity is completed. (follow the five moments procedure). Gloves must be changed when handling different patients, or between different care/treatment activities for the same patient, and hand hygiene must be performed between each task.
Gloves should not be worn:

- Whilst driving.
- Normal Patient care, if there is no risk of contamination.

The integrity of gloves cannot be taken for granted and additionally, hands may become contaminated during the removal of gloves. Therefore, the use of gloves as a method of barrier protection reduces the risk of contamination but does not eliminate it.

Hands must be decontaminated with alcohol rub before putting on gloves and in all cases be thoroughly washed with liquid soap and water as soon as the gloves have been removed (a temporary measure of using the alcohol rub can be used if normal hand washing facilities are not readily available).

Size of Gloves - When choosing an appropriate size of glove the following should be considered:

- Gloves that are too large may present an increased risk of a compromise in grip and/or puncture.
- Gloves that are too small may become restrictive.

The choice in selecting the most appropriate size should be based on a comfortable fit.

7.5.10.4 Sleeve protectors

Cross-contamination can occur when long-sleeved uniform is worn to lift numerous different patients. As washing clothes between lifts is not possible, sleeve protectors can be used.

Sleeve protectors can be worn to protect uniform from the wrist to the elbow. They are designed for use over gloves, and can be worn over coat sleeves or on the skin. They are used to reduce the risk of contamination from body fluids or skin cells.

Sleeve protectors are;

- For single patient use
- Worn over the top of gloves
- Disposed of as domestic waste unless contaminated then healthcare waste

7.5.10.5 Aprons

Disposable plastic aprons must always be worn whenever contamination of clothing with blood or body fluid is anticipated. Aprons are to be used because it is the front of the body that is most frequently contaminated. The single-use plastic apron is deemed to provide adequate protection for staff in most instances.

In circumstances in which the risk of uniform contamination or soiling is considered to be beyond the scope of an apron then Tyvex suits must be utilised.

Plastic aprons should also be worn when undertaking any cleaning procedures, or on any occasions where the front of the uniform is at risk of being soiled, and when performing invasive techniques. After use, aprons must be placed in the healthcare waste for disposal and hand hygiene must be performed.
7.5.10.6 Face Masks

Surgical Masks

The main purpose of a surgical mask is to assist in preventing respiratory droplets being expelled into the environment by the wearer e.g. healthcare in the ambulance environment or by an infectious patient. Masks are partially resistant to fluids, and help protect the wearer from splashes of blood and other potentially infectious substances. They are not designed for filtration efficiency, or to seal tightly to the face. The effectiveness of surgical masks is therefore limited but should be worn if there is a risk of blood, body fluids, secretions and excretions splashing into the mouth, or if the patient is prone to episodes of coughing or sneezing.

Respirators

Respirators are intended to help reduce the wearer’s exposure to airborne particles when dealing with highly infectious diseases. This is classed as additional PPE which may require individual fitting and training. Some resemble surgical face masks and are made to defined national standards which define the performance required of the respirator, including filtration efficiency. When worn correctly, they seal firmly to the face, thus reducing the risk of leakage.

SCAS supply FFP3 respirator masks when required and are of the highest filtration efficiency and conform to European standards.

Use of masks/respirators

- Must be fitted correctly.
- Should be changed if they become wet.
- Must not be taken off, handled and then re-applied.
- Are single use and should be disposed of as clinical waste.

7.5.10.7 Tyvex Suits

Tyvex suits are waterproof, disposable gowns which are impervious to micro-organisms. They help protect individuals from contamination which may give rise to cross infection.

Tyvex suits should be worn in the following cases:

- In circumstances where a plastic apron is unsuitable.
- When caring for a patient grossly contaminated with excreta, lice etc. blood or body fluids
- When dealing with highly infectious diseases. (VHF grab boxes are available)

Tyvex suits are single use only and must be disposed of as domestic waste unless contaminated then disposed of as clinical waste followed by hand washing. Further information can be found in the SCAS Special Communicable Diseases Policy.

7.5.10.8 Eye Protection

Protective eyewear i.e. splash goggles, help to prevent splashes of infected material entering the eyes and subsequent absorption of pathogens through mucous membranes.

Use of eye protection
Goggles must be used when there is a recognised danger of blood splashes. Goggles are single use only and must be disposed of as healthcare waste and hand hygiene should be completed immediately after the procedure.

7.6 Procedures for Work Areas, Vehicle and Equipment Cleaning

7.6.1 Work Areas and Vehicle Cleaning

All staff have an individual responsibility to keep their work area or ambulances clean and thus to reduce the risk of cross infection to themselves, their colleagues and their patients. This can best be achieved by all staff members participating in frequent and routine cleaning activities.

All equipment must be cleaned with detergent wipes or disinfectant wipes after every patient use, whether they appear contaminated or not.

Work stations and desks must be wiped down with detergent wipes (Clinell) prior starting and when finishing duties.

7.6.2 General Information

High standards of hygiene both externally and internally of ambulance vehicles and on work surfaces such as desks, are vital for the control of infection. Ambulance vehicles are exposed to a vast array of potential infection sources on a daily basis. Environmental cleanliness also promotes patient confidence and perception of safety.

Micro-organisms that cause infection thrive in soiled, moist and dusty environments. The risk of cross-infection is therefore increased if work areas or the interior of the ambulance are not maintained in a clean, hygienic manner (particularly if invasive procedures are to be performed in this environment). Particular attention should be paid to non-visible areas i.e.; between and behind seats and stretcher locking mechanism etc.

The primary cause for the spread of infection comes from contact with blood and body fluids. The potential risks from such contact can be successfully minimised by paying specific attention to the actual areas that have become contaminated and cleaning them following every patient contact.

To ensure effective disinfection of vehicles and equipment, a range of detergent products are available for use and a three phase approach should be adopted; Acute Cleaning, Routine Cleaning and Deep Cleaning (see 7.6.4).

7.6.3 Cleaning Agents

Under the Control of Substances Hazardous to Health Regulations 2002 (COSHH), employers have to ensure that the exposure of employees to hazardous substances is prevented or if this is not reasonably practicable, adequately controlled. Therefore SCAS have introduced Universal Disinfectant Wipes to complement the low level detergent / disinfectant chemical products:

Universal Sanitising Wipes should be used for acute cleaning of surface areas and most equipment, followed by, where necessary;

Clean using an ‘S’ shaped pattern and allow to air dry. Store packs with wipes in an upright position to allow equal distribution of active solution.
**Low Level Detergent** for stage one cleaning.

**High Level Disinfectant** should be used for disinfection after cleaning of blood and body spillages and in circumstances of known infection **ONLY**.

Spill kits should be used to absorb large spills (>5ml) of blood and body fluid spillages and disposed of as clinical waste. Current product details are available through procurement / stores and normal ordering procedures apply.

**CAUTION;** Under **NO** circumstances should large spills of blood and/or body fluids be sluiced out of the ambulance with copious amounts of water. This is not good infection prevention and control practice as it poses an environmental risk, in all instances spill wipes **MUST** be used.

### 7.6.4 Mops and Buckets

Colour coded buckets and mops are provided for use in specific areas.

- **Green** = Kitchen and Food Preparation Areas
- **Red** = Toilets and Washrooms
- **Yellow** = Vehicle Interiors/Ambulance
- **Blue** = General Station Areas

Mops and their corresponding colour coded buckets must not be interchanged. A fresh water/detergent solution should be prepared each time that the mop is used. After use, the bucket should be emptied, rinsed and the mops should be wrung out as dry as possible before being hung head up. Mop heads should be changed on a weekly basis as a minimum.

**If any mop becomes contaminated with blood or body fluids, then the head should be discarded as clinical waste and a replacement fitted.**
7.6.5 Acute Cleaning

Phase 1 – Patient contact

Please remember that any re-useable equipment (including patient transportation devices) and/or areas of ambulance vehicles used must be cleaned following every patient contact. This includes wiping down areas of the ambulance vehicle (i.e. ambulance vehicle seats and/or stretchers) with universal disinfectant wipes.

Phase 2 – Risk of contamination

This phase of cleaning will be adopted as and when required i.e. when there is blood or body fluid spillages or when there is a potential risk of contamination following the transportation of an infectious patient. The correct management of spillages of blood and body fluid is a vital step in successful control of infection. Exposure to blood and body fluid presents a risk to the health of all persons involved with the working environment of the ambulance service. The conscientious applications of cleaning and disinfection policies are of the utmost importance in the prevention of cross-infection. The risks associated with this can be dramatically reduced with the adoption of ‘standard precautions’ together with following the cleaning and disinfectant procedures contained within this section.

If blood is spilled – the spillage must be dealt with as soon as possible and staff that deal with the spillage must wear appropriate protective clothing. This will include gloves, disposable aprons and eye protection.

Acute cleaning MUST take place immediately or if the ambulance and/or equipment is heavily contaminated with blood/body fluids or you have transported a potentially infectious patient. A request should be made via the Clinical Coordination Centre to return to the nearest ambulance resource centre to undertake the cleaning.

Procedure for Acute Cleaning:
To be performed at the NEAREST available ambulance resource centre or nearest cleaning area.

- Wash your hands
- Contact Clinical Coordination Centre and inform them of the need to decontaminate the vehicle, with an estimated time of completion.
- Open the vehicle doors and windows to ensure adequate ventilation.
- Wear PPE to remove stretcher linen and dispose of as per the linen procedure. (section 5)
- If a spillage of blood or body fluids has occurred follow standard procedures for spillages.
- Ensure that any used disposable clothing, equipment or clinical waste is placed into a yellow clinical waste bag. (All clinical waste must be marked with the station of origin, dated and sealed securely.)
- Wipe over the stretcher mattresses with detergent solution to remove visible soil before wiping with a disinfectant wipe.
- Wash the floor and all surfaces of the ambulance with detergent to remove visible soil before washing with chlorine-based disinfectant and warm water.
- Remove gloves and rewash hands.
- As soon as all surfaces are dry, the ambulance can be put back into service, informing Clinical Coordination Centre of your availability.

7.6.6 Blood and Body Fluid Spillages

For a small spill of blood and/or body fluid (<5ml) the area should be cleaned with (blue roll) tissue and low level detergent wipe to remove visible soil and disinfected using the recommended disinfectant.

For a large spill of blood and/or body fluid (>5ml) spill kits should be used to soak up any spill. The area must then be cleaned with low level detergent to remove all visible soil and then disinfected using the appropriate disinfectant.

In both cases PPE must be worn and all waste (including worn PPE) disposed of as HC or Clinical waste. Good ventilation must be ensured at all times.
7.6.7 Routine Cleaning

This is the cleaning of your work station or vehicle and equipment that takes place to maintain a good standard of cleanliness and hygiene. It is expected that the following is undertaken **once per shift**:

- All visible surfaces to be wiped over with low level detergent.
- Ambulance saloon floor to be mopped with low level detergent.
- Vehicle cab floor to be mopped with low level detergent.
- Particular attention should be paid to door handles, horizontal surfaces, including work monitors, control levers, switches and the steering wheel.

Note: All equipment must be cleaned with low level detergent after every patient use, whether they appear contaminated or not.

7.6.8 Deep Clean

Deep Cleaning involves the cleaning of all the vehicle interiors and equipment comprising of stretchers, mattresses, carry chairs, wheelchairs, spinal boards and scoops thoroughly over and above the general routine cleaning.

This will take place on all vehicles as part of a deep clean twelve week cleaning programme by SCAS contracted Make Ready Teams.

Resource Centres and HQs will receive a deep clean of the premises every 6 months as a minimum.

7.6.9 Equipment Levels

Equipment can be classified under three levels:

**Single patient use (disposable)** i.e. laryngoscope blades, Magills forceps, BVMs and hand suction units. This equipment should be disposed of immediately after usage in
clinical waste/ blades in sharps bin. Under NO circumstances should this equipment be cleaned and re-used.

**Minimal/Limited Usage** i.e. Head Immobilisation System, BP cuffs, Peak flow meters (used with Single patient use Mouth piece)
This equipment can be re-used but if becomes contaminated heavily with blood and/or body fluids should be disposed of as clinical waste and replaced. This equipment must be cleaned with universal disinfectant wipes after every patient use.

**Re-usable medical devices** i.e. Splints, Spinal Board, Carry Chair.
This equipment is re-usable and must be cleaned with the appropriate cleaning agent in line with the three phase approach outlined below. It is imperative that all re-usable medical devices are maintained to good standards of cleanliness and hygiene

**All re-useable medical devices must be cleaned after every patient use.**

**7.6.10 The Decontamination of Re-usable Medical Devices**

The decontamination of re-usable medical devices is a combination of processes, which if not correctly undertaken, individually or collectively, may increase the likelihood of infectious agents being transferred to individuals or the environment.

The term re-usable medical device applies to all such devices whether owned by SCAS, rented, on loan or acquired by any other means.

The decontamination process is required to make medical devices:

- Safe for users to handle
- Safe for use on the patient

**7.6.11 Cleaning of Equipment**

The cleaning of equipment is described in the same three phase approach as for vehicles:

**Acute cleaning**
(i) - this is where equipment and vehicle areas used are cleaned following every patient use

(ii) - this is where equipment is contaminated with blood and/or body fluids and cleaning should be undertaken immediately with low level detergent prior to disinfecting it with the appropriate disinfectant wipe.

**Routine Cleaning**
This should be done as a minimum every week to ensure that all equipment is maintained to good standards of cleanliness and hygiene. Low level detergent should be used.

**Special Cleaning**
This should be carried out on a piece of equipment prior to sending it for inspection, service or repair. Low level detergent should normally be used unless there are obvious signs of blood / body fluids where this should be cleaned using disinfectant wipes.

**Decontamination certificate should be produced** by the forwarding responsible person and should accompany any equipment prior to being sent off for repairs.

In all of the above phases the following should be adhered to:
1. Ensure the wearing of Personal Protective Equipment i.e. gloves, aprons and splash goggles.
2. Where possible remove any gross soiling under running water
3. Ensure that whatever cleaning product is used after application the equipment is thoroughly rinsed with water and allowed to dry

7.6.12 Sterile Equipment and Consumables

All sterile equipment and consumables provided by the Trust are for **single use only**. They must be appropriately disposed of immediately following use.

- Do not use sterile items if the outer pack is damaged or it is wet
- Use the equipment as soon as possible after opening
- Handle with care and avoid contamination
- Open packets must be appropriately disposed of following use
- Check the expiry date and do not use items beyond stated expiry date

7.6.13 Ambulance Exteriors

The exterior of all SCAS vehicles (including door recesses) should be maintained in a clean and hygienic condition. They must be thoroughly cleaned when visibly dirty. Vehicle wash bays and associated vehicle washing equipment are available on SCAS ambulance resource centres, and should be utilised when necessary.

**Prioritising Exterior Cleaning**

The **washing of an ambulance must never delay the response to an emergency call**. Ambulance personnel are therefore required to use their judgement in the planning and appropriate timing of any ambulance cleaning procedure. On the occasions in which there is not enough time to complete a full exterior cleaning routine, then the following items should be cleaned as priority in order to comply with the safety and legal requirements. This should include

- Windscreen
- Windows
- Lights
- Indicators
- Reflectors
- Mirrors
- Number plates

**Note:** staff should pay particular attention to the cleaning of areas where dirt is likely to be transferred to the crew's hands and thus create a route for cross infection e.g. door handles.

7.6.14 Cleaning of Vehicles and Equipment prior to Inspection, Service or Repair

The failure to ensure that vehicles and equipment are free from blood and body fluids prior to inspection, service, repair, disposal or refurbishment puts members of staff at risk from exposure to hazardous substances. SCAS has a duty to its employees or other third parties, who may come into contact with contaminated equipment or articles, to prevent exposure or to provide sufficient information to allow the person exposed to take all reasonable steps to control their exposure.
Infection Prevention Control and Decontamination Policy

Failure to appropriately clean equipment or vehicles represents a significant risk to those who are required to carry out the repairs or servicing.

7.6.15 Decontamination Certification

Equipment

All equipment and articles for inspection, maintenance, repair and disposal must be accompanied by appropriate documentation (Equipment Decontamination Certificate) signed by an appropriate person i.e. line manager or Make ready Supervisor.

If the equipment is to leave the premises, a copy of the certificate is required to be securely attached to the item

Note - It is illegal to send contaminated equipment through the post.

Ambulances

When sending an ambulance to workshops for any engineering work, you should ensure that the vehicle is not contaminated.

Any equipment to be left on the vehicle for servicing e.g. stretcher, carry chair must likewise ensure that it is not contaminated.

It is also important to ensure that vehicles going for maintenance or repair are sent to workshops, including external contractors, in a state which is safe for non-clinical staff to work in. All healthcare waste should be removed and the sharps box should either be removed or placed in the closed position. The interior and equipment should be checked for sharps and contamination, and cleaned if necessary.

7.6.16 Cleaning Materials Options Chart

<table>
<thead>
<tr>
<th>CHEMICAL</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
<th>USES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chlorine based Hypochlorite (E.g. Domestos, Milton) Diluted to 10,000 parts per million. For blood spills/100,000 parts per million</td>
<td>Wide range of bacterial, virucidal, sporidical and fungicidal activity - Rapid action - Non-toxic in low concentrations - Can be used in food preparation areas - Cheap</td>
<td>- Inactivated by organic matter - Corrosive to metals - Diluted solutions can be unstable - Need to be freshly prepared - Does not penetrate organic matter - Bleaches fabrics - Need ventilation</td>
<td>Can be used on surfaces and for body fluid spills. Under no circumstances with urine as this will produce ammonia gas.</td>
</tr>
<tr>
<td>Sodium Dichloroisocyanurates NaDCC (E.g. Precept, HazTab, Sanichlor)</td>
<td>- Slightly more resistant to inactivation by organic matter - Slightly less corrosive - More convenient, long shelf-life and easy to make up</td>
<td>As above</td>
<td>Can be used on surfaces and for body fluid spills.</td>
</tr>
<tr>
<td>Alcohol 70% E.g. ethanol / isopropyl skin cleansing swab</td>
<td>- Good bactericidal, fungicidal and virucidal activity - Rapid action - Leaves surfaces dry - Non-corrosive</td>
<td>- Non-sporidical - Flammable - Does not penetrate organic matter - Requires evaporation time</td>
<td>Can be used on surfaces or for skin/hand decontamination</td>
</tr>
<tr>
<td>Product</td>
<td>Description</td>
<td>PPE Requirements</td>
<td>Use</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chlorhexidine E.g. hibiscrub,</td>
<td>- Most useful as disinfectants for skin</td>
<td>None</td>
<td>For skin / hand decontamination</td>
</tr>
<tr>
<td>Chlorhexidine Gluconate /</td>
<td>- Good fungicidal activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Isopropyl Alcohol Skin</td>
<td>- Low toxicity and irritancy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preparation Wipes</td>
<td>- Limited against viruses</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- No activity against bacterial spores</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Inactivated by organic matter</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinell Wipes (Green Packet)</td>
<td>Universal sanitising wipe. Actively kills 99.999% of all germs including</td>
<td>None</td>
<td>Can be used on skin and hard surfaces</td>
</tr>
<tr>
<td></td>
<td>MRSA, Acinetobacter, VRE, Pseudomonas, Norovirus and many more.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinell spill Wipes (orange</td>
<td>Soaks up spillages up to 1.5 litres. Generates peracetic acid effective</td>
<td>PPE to be worn</td>
<td>For use on blood, vomit or urine spillages</td>
</tr>
<tr>
<td>packet)</td>
<td>against all known micro-organisms associated with BBVs, including Hepatitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>B &amp; C, norovirus and C.Diff</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
7.6.17 Equipment Cleaning Guide

**Detergent Clean = 1**
**Disinfectant Clean = 2**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>INFORMATION</th>
<th>CLEANING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Observation Equipment</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Peak Flow meter | Remove disposable mouthpiece                                                 | - Mouthpiece – Single patient use  
- Main Body – 1 & 2                                                           |
| Stethoscope    | Remove Diaphragm/bell unit from tubing  
Unscrew bezel to diaphragm  
Unscrew earpieces from headset | - Diaphragm/Bell – Disinfectant wipe (Do not immerse)  
- Diaphragm – Disinfectant wipe  
- Headset – Disinfectant wipe  
- Tubing – Disinfectant wipe  
- Ear Pieces – 1 & 2                                                                 |
| Sphygmomanometer |                                                                               | - Inflatable Cuff – Disinfectant wipe  
- Pressure Gauge – Disinfectant wipe  
- Carry Case – Disinfectant wipe  |
| BM Kit         | Remove from case                                                             | - Body – Disinfectant wipe  
- Case – Disinfectant wipe  
- Lancets – Single Patient Use *(Discard as per sharps procedure)* |
| Hand held suction |                                                                               | - Replace unit if contaminated                                             |
| Thermometer    |                                                                               | - Disinfectant wipe – acute  
- 1 and 2 at Deep Clean                                                        |

**Radios & Phones**

<table>
<thead>
<tr>
<th>DESCRIPTION</th>
<th>INFORMATION</th>
<th>CLEANING</th>
</tr>
</thead>
</table>
| Mobile Phone   | Do not immerse unit in water or any other solution, or allow liquid to penetrate the outer casing | - Disinfectant wipe – acute  
- 1 and 2 at Deep Clean                                                      |
| Hand held radio |                                                                               | - Disinfectant wipe – acute  
- 1 and 2 at Deep Clean                                                      |
| Vehicle Based Radio |                                                                               | - Disinfectant wipe – acute  
- 1 and 2 at Deep Clean                                                      |
## Electrical Monitoring Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifepak 12</td>
<td>Do not immerse unit in water or any other solution, or allow liquid to penetrate the outer casing</td>
</tr>
</tbody>
</table>
| Marquette Responder 3000 | - Disinfectant wipe immediately after use then;  
- Unit - 1 & 2  
- Cable & Leads – 1 & 2  
- Electrodes – Single Patient Use  
- Defib pads – Single Patient Use  
- Razor – Single Patient Use |
| Zoll Defibrillator | - Casing – 1 & 2  
- All other items = Single Patient Use |
| Pulse Oximetry    | - Disinfectant wipe – acute  
- Unit and cables 1 and 2 at Deep Clean |
| Vehicle based suction | - Casing – 1 & 2  
- All other items = Single Patient Use |
| ePR Unit          | - Disinfectant wipe – acute  
- Unit 1 and 2 at Deep Clean |

## Immobilisation Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| K.E.D./ED 2000    | - Disinfectant wipe immediately after use then;  
- Unit – 1 & 2  
- Straps- Any removable straps can be washed at 40°C if available at the time |
| Trac-3/Sagar Splint| - Disinfectant wipe immediately after use then;  
- Unit – 1 & 2  
- Straps- Any removable straps can be washed at 40°C if available at the time |
| Spinal Board & Straps | Remove Head huggers/Straps  
May be re-used if no signs of bodily fluids present, otherwise = Disposable |
| Cervical Collars  | - Disinfectant wipe immediately after use then;  
- Unit – 1 & 2  
- Straps- Any removable straps can be washed at 40°C if available at the time |
| Frac-Pacs         | - Disinfectant wipe immediately after use then;  
- 1 & 2 at Deep Clean |

## Manual Handling and Moving Equipment

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Instructions</th>
</tr>
</thead>
</table>
| Stretcher & straps | - Disinfectant wipe immediately after use then;  
- 1 & 2 at Deep Clean |
| Carry chair & straps | - Disinfectant wipe immediately after use then;  
- 1 & 2 at Deep Clean |
| Scoop Straps      | - Disinfectant wipe immediately after use then;  
- 1 & 2 at Deep Clean |
| Sliding board (banana) | - Disinfectant wipe immediately after use then;  
- 1 & 2 at Deep Clean |

---

Infection Prevention Control and Decontamination Policy
<table>
<thead>
<tr>
<th>Item</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transfer belt</td>
<td>- Disinfectant wipe immediately after use then;</td>
</tr>
<tr>
<td></td>
<td>- 1 &amp; 2 at Deep Clean</td>
</tr>
<tr>
<td>Soft transfer disc</td>
<td>- 1 &amp; 2</td>
</tr>
<tr>
<td>Sliding sheet (small/large)</td>
<td>- Disinfectant wipe immediately after use then;</td>
</tr>
<tr>
<td></td>
<td>- 1 &amp; 2 at Deep Clean</td>
</tr>
<tr>
<td>Linen</td>
<td></td>
</tr>
<tr>
<td>Blankets</td>
<td>If soiled, place in red alginate bag – label with</td>
</tr>
<tr>
<td></td>
<td>what soiled by and place in dirty laundry at</td>
</tr>
<tr>
<td></td>
<td>Hospital or station laundry facilities</td>
</tr>
<tr>
<td>Canvas (incl. Carry Canvas)</td>
<td>- Place in laundry at Hospital or station laundry</td>
</tr>
<tr>
<td></td>
<td>facilities</td>
</tr>
<tr>
<td>Draw sheet</td>
<td>- Place in laundry at Hospital or station laundry</td>
</tr>
<tr>
<td></td>
<td>facilities</td>
</tr>
<tr>
<td>Pillow (if not single use)</td>
<td>Must have plastic casing</td>
</tr>
<tr>
<td></td>
<td>- Disinfectant wipe immediately after use then;</td>
</tr>
<tr>
<td></td>
<td>- 1 &amp; 2 at Deep Clean</td>
</tr>
<tr>
<td>Pillow Case</td>
<td>- Place in laundry at Hospital or station laundry</td>
</tr>
<tr>
<td></td>
<td>facilities</td>
</tr>
<tr>
<td>Space blanket</td>
<td>- Single Patient Use</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td></td>
</tr>
<tr>
<td>Oxygen Flow meters</td>
<td>Remove from vehicle</td>
</tr>
<tr>
<td></td>
<td>- Disinfectant wipe immediately after use then;</td>
</tr>
<tr>
<td></td>
<td>- 1 &amp; 2 at Deep Clean</td>
</tr>
<tr>
<td>Uniform and PPE</td>
<td></td>
</tr>
<tr>
<td>Uniform</td>
<td>Spare should be kept on Station</td>
</tr>
<tr>
<td></td>
<td>- Machine wash @ 60° C – If severely soiled –</td>
</tr>
<tr>
<td></td>
<td>Dispose &amp; Replace</td>
</tr>
<tr>
<td>Footwear</td>
<td>- Disinfectant wipe</td>
</tr>
<tr>
<td>Hard Hat/helmet</td>
<td>- Disinfectant wipe</td>
</tr>
</tbody>
</table>
High Visibility Jacket H/W
- Machine wash according to instructions on Jacket

High Visibility Jacket L/W
- Machine wash according to instructions on Jacket

## Bags and Pouches

<table>
<thead>
<tr>
<th>Item</th>
<th>Action Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Response Bags</td>
<td>Remove items inside bag – If very soiled, clean as required/place consumables in Clinical Waste (if contaminated)</td>
</tr>
<tr>
<td>Oxygen bag</td>
<td>Hand wash @ 40° C with detergent (light Soil)</td>
</tr>
<tr>
<td>Entonox bag</td>
<td></td>
</tr>
<tr>
<td>Medicines pouches</td>
<td></td>
</tr>
<tr>
<td>Paediatric bag</td>
<td></td>
</tr>
</tbody>
</table>

### 7.7 Procedure for Management of Sharps

#### 7.7.1 General Information

The safe handling and disposal of needles and other sharp instruments, form part of an overall strategy of clinical waste disposal to protect staff, patients and third parties from exposure to blood borne pathogens. Inoculation injuries arising from exposure to contaminated sharps represent the most likely route of infection spread, and subsequent risk to SCAS staff. Many percutaneous injuries are preventable and therefore with the implementation of the procedures for the safe handling and disposal of sharps this will reduce the risks of exposure to sharps injuries.

In May 2013, the European Council Directive 2010/32/EU (the Sharps Directive) was made regulation. This states that:

All employers are required under existing health and safety law to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.

- Avoid the unnecessary use of sharps
- Where it is not reasonably practicable to avoid the use of medical sharps, the Sharps Regulations require employers to:
  - Use safer sharps (incorporating protection mechanisms)
  - Activated the needle shield after a procedure is completed
  - Prevent the recapping of needles
  - Place secure containers and instructions for safe disposal of medical sharps close to the work area
7.7.2 Definition of Sharps

A 'sharp' is defined as an article that can cut or puncture the skin by having a fine edge or point. For example:

- Needles
- Cannula
- Medicine Ampoules/containers
- Razors
- Scalpels/blades
- Sharp bones

7.7.3 Avoiding Inoculation Injury

- Ensure you are organised before beginning a procedure.
- Cannulation and other procedures involving the use of sharps should, where possible, not be attempted in a moving vehicle. Attempting cannulation in a moving ambulance is challenging and the risks of needle stick injury are high. The decision to carry out a procedure using sharps or needles should be determined on a case by case basis by the ambulance clinician whilst factoring the clinical needs of the patient.
- All sharps are single use only and must always be stored in their designated areas within the ambulance.
- Sharps must not be passed directly from hand to hand and handling should be kept to a minimum – i.e. the needle should only be removed from its sheath once the patient has been prepared, and only then just prior to the intended use of the item.
- Needles must not be bent or broken prior to use or disposal.
- Activate any sharpsafe device when the procedure is complete prior to disposal
- Needles must not be re-sheathed at any time, especially during disposal.
- Staff must not leave sharps for other personnel to dispose of.
- Under no circumstances must unsheathed sharps be carried in hands or pockets.
- Needles and syringes must not be disassembled by hand prior to disposal – needles and syringes must be disposed of as one unit into a designated ‘sharps’ container.
- Extreme care must be taken when attempting invasive procedures on patients who are restless, agitated or unconscious.
- Ampoule breakers must be used when drawing up medicines from an ampoule.
- All procedures involving the use of sharps must be undertaken by staff who are qualified and trained in the use of sharps and therefore are authorised to complete the required procedures.

7.7.4 Safe Disposal of Sharps

When using sharps it is the personal responsibility of staff using those sharps to dispose of them safely in the sharps containers which SCAS provide – the containers conform to BS7320:1990/UN3291 standards.

- Ensure careful, unhurried handling of sharps at all times
- Staff should ensure that they are familiar with the assembly instructions of the sharps containers and their associated locking devices.
- All used sharps e.g. needles, must be disposed of immediately after use, and placed directly into a sharps container by the person who has used the item.
- The placing of paper / other packaging into a sharps containers reduces its capacity and therefore the sharps containers must not be utilised for these items.
• When disposing of sharps into the sharp container, care must be taken to prevent the outside of the sharps container from becoming contaminated.
• Do not over fill sharps containers, they must be replaced when: 2/3rds full
• When the sharps will no longer drop cleanly through the flap.
• In any event, on a monthly basis

• Sharps containers must be sealed and routinely disposed of on a monthly basis, even if the two-thirds mark has not been reached. The date of expiry, vehicle call sign and station of origin must be entered on each container as well as being signed as soon as it is put into use.
• When full, sharps containers should be placed in the designated receptacle on station where they will be collected by licensed transporters of clinical waste. This should be the only method by which any sharps containers used by the Trust should be disposed of.

Note – under no circumstances should items be forced through the flap of sharps containers, and fingers must be kept out of the containers at all times

7.7.5 Sharps/Blood Splash Injuries

Incidents involving the risk of blood-borne infection include:

• Inoculation of blood by a needle, or other sharp
• Contamination of broken skin with blood/body fluids
• Contamination of broken skin with blood/body fluid soaked clothing or linen
• Blood/body fluid splashes to mucous membranes, e.g. eyes or mouth
• Human bites or scratches (where the skin is broken)

The use of Standard Precautions ensures that all blood and body fluids are regarded as infectious. It is therefore highly important that any inoculation incident that involves contact with blood or body fluids are treated as a matter of urgency and the following procedure must be adopted.

7.7.6 Sharps/ Splash Injury Procedure

The following action must be taken in the event of sustaining a sharps injury from a sharp that has been used on a patient or body fluid splash to mucous membrane or broken skin (See appendix 5):

• Remove the object from the skin ensuring that the sharp is disposed of into a sharps container.
• Immediately encourage the site of the injury to bleed by applying gentle pressure, do not squeeze. The wound must not be sucked.
• Flush wound under running water for two minutes, wash the site with soap and water and cover with a plaster. It must be remembered not to ‘scrub’ the injury site or pat the area dry.
• If blood or body fluid splashes into the eyes, then irrigate with water or saline.
• If blood or body fluid splashes into the mouth, rinse the mouth with copious amounts of water then wash the face thoroughly with soap and water.
• Inform Control of the incident who will then arrange for staff’s immediate attendance at the nearest Casualty or Emergency Department.

• Identify and document the patient from whom the needle stick injury originated, i.e. DONOR, and inform your local manager or duty Bronze immediately.
Your local manager or duty Bronze must refer you to SCAS Occupational Health Department (via the contact phone number) as soon as possible, to have a risk assessment (The risk assessment may be done by the hospital medical team).

The hospital will require details of the incident including:
- How the incident occurred
- Information of the source patient

If the sharps /splash injury where either the source of the contamination is not known or when the patient involved refuses to travel, the A/E department will complete a risk assessment to ascertain the degree of risk posed.

Once discharged from the A/E department staff must return to station to complete an Incident Report Form (Datix).

7.7.7 Risk Assessment Issues

7.7.7.1 Hepatitis B risk assessment

If source patient is HB antigen positive (a carrier of infection) or high risk, the need for Hepatitis B prophylaxis will be considered by the Occupational Health Department or ED with follow up appointments at local GUM clinics.

7.7.7.2 Hepatitis C risk assessment

If source patient is hepatitis C positive, Occupational Health / ED / GUM Clinic will arrange appropriate advice to employee and arrange follow up.

- On completion of the risk assessment, the doctor may offer a course of prophylactic treatment. This will be fully discussed with the individual member of staff, and may be started before all investigations have been completed.
- It is likely that a blood sample will be taken from the member of staff, as well as the patient. Staff should be aware of their own immunisation record including their Hepatitis B and Tetanus immunisation status.
- If the sharp or body fluid is from an identified donor, the donor will be counselled and their consent obtained in writing for a blood sample to be taken.

Note - The patient has the right to refuse to give a sample. There are also restrictions within the consent e.g. if a patient has had an impaired conscious level, under the age of 16yrs, deceased or if the patient is not capable of understanding fully the implications of giving the consent. In these circumstances the consent will not be allowed to be obtained.

- Clinical Coordination Centre staff (Control), on staff’s reporting of a sharp / splash incident, will inform the member of staff’s Local Manager or Duty Bronze and stand the crew down for a reasonable period until the necessary actions are taken. An incident report form (Datix) must be completed on return to the resource centre and submitted.

7.7.8 HIV Post Exposure Prophylaxis (PEP)

7.7.8.1 The Source Patient

If initial assessment indicates that an exposure has been high/medium risk – that is with the potential for HIV transmission – consideration should then be given to the HIV status of the patient. A doctor will make arrangements to approach a source patient whose HIV status is not known and ask for their informed consent to HIV testing. This approach should not be undertaken by the exposed worker.
HIV PEP is likely to be more effective if started within the hour therefore it may be beneficial to start the PEP until further information is available about the source patient. Changes can be made to the PEP regimen including cessation if required.

7.7.8.2 What is HIV PEP?

Antiretroviral agents from three classes of medicines are currently licensed for first line treatment of HIV infection, namely:

- Nucleoside analogue reverse transcriptase inhibitors (NRTIs)
- Non-nucleoside reverse transcriptase inhibitors (NNRTIs)
- Protease inhibitors (PIs)

7.7.8.3 PEP Side Effects

All of the antiretroviral agents have been associated with side effects. Many of these can be named symptomatically:

- Gastrointestinal
- Malaise
- Fatigue
- Headache

If symptoms believed to arise from PEP are distressing, cannot be managed symptomatically and the healthcare worker feels unable to continue to adhere to the regimen, expert advice should be sought about suitable substitution.

7.7.8.4 Risk of acquiring HIV

The risk of acquiring HIV infection following occupational exposure to HIV-infected blood is low. (Approx. 3 per 1,000 injuries). However staff should be aware of the appropriate action to take and what treatment to expect.

7.7.8.5 Immediate Action

Immediately following ANY exposure – whether or not the source is known to pose a risk of infection – the site of the exposure e.g. wound or intact skin should be washed liberally with soap and water but without scrubbing. Free bleeding of puncture wounds should be encouraged gently but wounds should not be sucked. Eyes should be irrigated with copious amounts with water, before and after removing any contact lenses.

Inform Control of the incident and that immediate attendance at the nearest Casualty Department is required. Identify and document the source of the exposure and complete and submit an Incident Report Form immediately.

The hospital will require details of the incident including:

- How the incident occurred.
- Information of the source of the patient.

7.7.8.6 Incident Reporting
It is vital that an Incident Report Form (Datix) is completed and submitted to your Line Manager immediately. Such incidents of exposure to HIV are required to be reported to the Health and Safety Executive (HSE) under the RIDDOR Regulations 1995; this will be carried out by the Risk department once the incident is reported.

7.7.8 Action To Be Taken By The Local Manager

- Direct the injured member of staff to attend, together with the DONOR to the Accident and Emergency department of the nearest hospital without delay.
- Advise the injured member of staff to request the doctor on duty, or sister in charge, to obtain:
  - Consent from DONOR to take sample of clotted blood for hepatitis B, hepatitis C & HIV serology
  - Sample of clotted blood from the injured ambulance personnel for storage only at Virology Department.
- Ensure the injured member of staff completes an Incident Report Form on their return to the Station.
- Report the incident to the Occupational Health Department as soon as possible and ensure that copies of the results are sent to the department.

7.8 Management of Linen

7.8.1 General Information

The definition of linen, in the context of SCAS, is any article that requires laundering. Soiled linen is the source of a large number of pathogenic organisms but, if handled and managed properly, will pose little or no risk to ambulance service personnel.

The use of blankets within SCAS poses a risk, albeit a small risk there is still a potential for cross infection and therefore particular stringent attention should focus on these items along with stretcher bedding and pillowcases.

7.8.2 Management of Linen

Micro-organisms in most soiled and fouled linen are unlikely to cause infection in healthy workers provided that care is taken. To further minimise the risk:

- Maintain standard principles of infection prevention and control
- Wear an apron and gloves (and sleeve protectors if wearing long sleeved coat) when dealing with contaminated laundry
- Remove any personal protective clothing and dispose of these items into the clinical waste. Ensure you wash your hands thoroughly before returning to other duties
- Cover cuts and abrasions with waterproof dressings

7.8.3 Disposable Linen

Single patient use (disposable) linen, once used all items are placed into the domestic waste bags unless it is contaminated then it should be placed in clinical waste bags.

7.8.4 Categories of Linen

Used Linen
Linen that has been used and has become dirty by general use and **NOT** therefore contaminated with blood or body fluid.

**Contaminated Linen**
- Linen that has become contaminated with blood or body fluids
- Linen that has been used with patients with infectious diseases
- Linen that has been used where patients are known or suspected to have infestations

### 7.8.5 Handling of Soiled Linens

If members of staff follow standard precautions in handling all contaminated linens, the chance of disease transmission will be almost non-existent. A break in safety techniques can be the cause of healthcare workers getting infected through the handling of contaminated linens.

The following standard precautions must be applied when handling all soiled or contaminated linen, in order to eliminate the opportunity for the transmission of disease.

- Hand washing should be performed after having contact with all soiled linen.
- Protective barrier apparel (PPE) should be used as follows:
  - Gloves should be worn for actual or potential contact with soiled linen or contaminated with blood or body substances.
  - Aprons should be worn for the management of soiled or contaminated linen if contamination of the clothing is likely to occur.
- Hand hygiene should be completed ensuring efficient hand washing is completed after dealing with soiled linen. This should include the use of waterproof dressings to cover all breaks in the skin. (All soiled linen must be bagged at the location where it is used.
- Soiled or contaminated linen should be handled as little as possible and with minimum agitation.
- Caution must be exercised to prevent laundry bags from being overfilled; they should not exceed ½ full.
- Linen must be used on an individual patient basis only i.e. blankets, sheets and pillowcases (contaminated linen must be placed in a red alginate bag and placed in the laundry bin.)
- If occupational exposure to blood borne viruses occurs, ensure that the procedure for inoculation injuries is followed as a matter of urgency.
- Whenever contaminated laundry is wet and presents a reasonable likelihood of leakage from the bag, the laundry should be transported 'double bagged' in order to prevent soak-through and/or leakage of fluids to the exterior.

### 7.8.6 Disposal of Used Linen

Within the ambulance environment it would be normal practice for linen in use by a patient to be transferred with the patient. Any used linen left on a vehicle should be placed in a clear plastic bag and stored in a safe position within the rear of the vehicle. On returning to station the used linen and bag must be placed into the laundry bin.

### 7.8.7 Disposal of Contaminated Linen

Contaminated linen must be placed in a ‘red alginate’ bag and sealed prior to storing in a safe position in the rear of the vehicle. Red alginate bags are biodegradable and therefore disintegrate during a wash cycle. The bags must not be filled over ½ full as the bags are fragile in nature. The bag should be tagged detailing the nature of the contaminant.
On returning to station the red bag must be placed in the laundry bin.

Note: Hand washing must be performed after having contact with all soiled linen. Any PPE used must be placed in the appropriate clinical waste.

7.8.8 Hazards

It is vital that the procedure for the safe use of sharps and their disposal is rigorously followed. Care should be taken when handling used laundry, as articles of clinical waste have been found i.e. sharps and incontinence sheets can be discovered in blankets.

If any sharps are found within used blankets, careful extrication should take place, the article disposed of safely via clinical waste procedures and an Incident Report Form should be completed and submitted to your line manager.

7.8.9 Station Linen

Linen drying towels fall within the used linen category and therefore should be placed in clear plastic bags, sealed and subsequently placed into the laundry bins.

Towels for showers must be single use and placed in the laundry bin once used.

Tea towels and towels for hand drying must not be used, Paper towels must be provided in kitchen and bathroom areas.

7.8.10 Operational Staff Uniform

All operational SCAS staff are provided with a uniform and are expected to ensure that it is clean and maintained to a high standard. This, in addition to the portrayal of a professional image, reduces the risk of cross infection from patients to staff and vice versa. A clean uniform should be worn on a daily basis.

A spare uniform should be stored in staff lockers where provided or readily available should the staff member need to change due to contamination or other reason.

It is the responsibility of staff to ensure their uniform is laundered, taking into account the laundry instructions attached to the various items of uniform.

7.8.11 Used Uniform

Generally, ambulance uniform will fall into this category and should be washed in accordance with normal household laundry arrangements. It is recommended that it is washed at 60°C with normal laundry detergent.

7.8.12 Contaminated Uniform

There will be occasions where contamination of uniform with blood and/or body fluid is unavoidable. In these cases, Control must be informed and arrangements for the changing into a clean uniform should be made as soon as possible.

Note: where possible a spare set of uniform should be kept within an individual’s locker.
The Department of Health details a procedure for thermal disinfection in the cases of contaminated uniform which states that disinfection is achieved when using wash temperatures of 60°C for 10 minutes. This is recommended guidance and wash care recommendations of garments and own washing facilities should be taken into account.

The overloading of washing machines should be avoided and other items of household laundry or contaminated linen should not be placed in with the contaminated uniform. If washing by hand is unavoidable, household rubber gloves should be worn.

Note: heavily contaminated uniform should be written off by a Manager before being discarded in healthcare waste and a replacement authorised by a line manager.

7.8.13 The Storage of Clean Linen

Clean linen should be stored by methods that will ensure its cleanliness. Rooms that are used to store clean linen should follow the following criteria:

- Area shall be properly ventilated to prevent the accumulation of dust and lint
- Shelves used for storing linen shall be placed approximately 1-2 inches from the wall for accessible cleaning; the bottom shelf shall be 6-8 inches from the floor; the top shelf shall be 12-18 inches below the ceiling
- Schedule of cleaning of the ‘clean linen’ room/store should be written which includes floors and shelves
- Only clean linens must be stored in this area
- The door should remain closed at all times
- When storing clean linen on the vehicles they should be stored in a cupboard with a clean interior and not stored where it can be contaminated by other items.

7.9 Procedures for Station and Premises Cleaning

7.9.1 General information

Dust, dirt and moisture are the three factors that are responsible for the survival and growth of micro-organisms. To ensure that microbes die rapidly areas must be kept clean and dry.

Cleaning techniques are important as ‘dry dusting’ and sweeping only succeeds in the re-distribution of the dust and dirt. As a minimum hot water and detergent should be used. This is suitable for the routine domestic cleaning activities in and around the station / department.

Ensuring that surfaces are dry is an important factor in the reduction of micro-organisms. Surfaces or items cleaned should be allowed to dry as thoroughly as possible, before being reused.

Whilst undertaking cleaning duties, consideration must be given to using appropriate PPE to ensure adequate protection. Providing no contact has been made with blood or body fluids, disposable cleaning items can be discarded as domestic waste.

Contract cleaners attend all SCAS stations and premises to undertake daily cleaning. Staff are still required to clear up after themselves, particularly following dining.

With regard to Health and Safety, hazard warning signs must be used to indicate wet floors or for any other hazard that may be present during cleaning duties.
All Ambulance premises should have a cleaning schedule which will state what should be cleaned and the frequency of the clean. Sub-contractors should refer to their local policies once agreed by Procurement, Estates and the Infection Control Lead.

7.9.2 Mops and Buckets

Colour coded buckets and mops are provided for use in specific areas:

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Green</td>
<td>Kitchen and Food Preparation Areas</td>
</tr>
<tr>
<td>Red</td>
<td>Toilets and Washrooms</td>
</tr>
<tr>
<td>Yellow</td>
<td>Vehicle Interiors/Ambulance</td>
</tr>
<tr>
<td>Blue</td>
<td>General Areas</td>
</tr>
</tbody>
</table>

Mops and their corresponding colour coded buckets must not be interchanged. A fresh water/detergent solution should be prepared each time that the mop is used. After use, the bucket should be emptied, rinsed and stored inverted and the mops should be wrung out as dry as possible before being stored inverted. Mop heads must be changed at least on a weekly basis and when visibly dirty.

If any mop becomes contaminated with blood or body fluids, then the head should be discarded as clinical waste and a replacement fitted.

7.9.3 Paper Towels

When replenishing paper hand towels these must always be placed into the dispenser and never left on top. Paper towel and liquid soap dispensers must be cleaned on a regular basis.

7.9.4 Vacuum Cleaners

Bags or chambers must be changed or emptied when necessary with general cleanliness ensured before putting away for storage.

7.9.5 Crockery and Cutlery

Hot water and general purpose detergent should be used and the items dried with paper towels.

7.9.6 Floors

Properly maintained vacuum cleaners should be used to clean carpeted floors. Dust from non-carpeted floors should also be removed with a vacuum cleaner and the surface then mopped using detergent and hot water.

7.9.7 Kitchens

All food preparation surfaces must be cleaned regularly with hot water and general purpose detergent as a minimum. Any defects in these areas must be reported to ensure they are kept in good repair. Surfaces should not be allowed to become cluttered with non-kitchen items. Waste bins should be cleaned both inside and out in accordance with the schedule. Black bin liners must be used in all general waste bins and separate bins bags used for recyclable material waste bins. When full they should be safely secured and subsequently
removed for disposal. Cookers, microwaves and other kitchen appliances must be cleaned on a regular basis and after each use.

7.9.8 Fridge and Freezers

These must be defrosted and cleaned on a regular basis with hot water and detergent. Cleaning should be completed when a food item has been spilled or has become stale. Items stored in the fridge/freezer must be labelled with the date and the owner’s name, and fresh food should not be left in the fridge over 24 hours unless they have a specific sell by date on them. All fridges should be temperature checked on a regular basis to meet health and safety food hygiene standards.

7.9.9 Showers and Hand Basins

Shower rooms and hand basins must be cleaned regularly with a single use cloth and detergent cleaner then disposed of into a black waste sack. Shower curtains and anti-slip mats should be free from stains, smudges, odours and mould. Liquid soap must be available at all sinks, with hand hygiene signage present. Bars of soap and nail brushes must not be used. Paper towels are provided for hand drying. Personal towels for showering must be brought in and taken home on a daily basis and will no longer be supplied by the Trust.

7.9.10 Toilets

Toilet brushes should be cleaned in the dedicated station or premises cleaning area after use in hot water and detergent and then stored to dry in the brush holder.

8. Training

All operational Ambulance staff, out of hours, Non-Emergency Services, Clinical Co-ordination Centre staff and any staff who work on or with SCAS vehicles or potentially contaminable equipment will have effective induction and continuous education in control of infection and decontamination. This must include training in:

- Basic microbiology and routes of transmissions
  - “The chain of infection”
  - Communicable diseases
  - Group 2 (previous Category III diseases) and their control
- Relevant staff immunisations (what is required and where to get them)
- Standard Precautions.
- Management of sharps and sharps injuries (where relevant)
- General hygiene and the storage and preparation of food

All staff must understand their responsibilities under this policy before commencement of duties.

Operational performance with regard to the use of Standard Precautions is the responsibility of each individual member of staff. First Line Managers and The Education Department will be responsible for assessing “Operational” compliance with this policy whenever they carry out operational assessments of staff. They should ensure that these matters are referred to when writing their assessment reports.

The Head of Education will ensure that control of infection is included in all Induction and relevant continuing education programmes. In particular all staff should be made aware of the risks from blood and body fluids, including the appropriate consideration of gloves and management of sharps as part of their induction and basic training.
All staff must complete a mandatory e-learning refresher training module using the NHS competency framework. This can be accessed either via a trust computer or by using the external web portal on a personal home network.

1. Patient facing clinical staff must complete a Level 2 module annually
2. All other staff must complete a Level 1 module every 3 years

9. **Equality and Diversity**

An equality and diversity impact assessment has been completed for this policy and can be found in Appendix 3. and Appendix 4:

10. **Monitoring**

All policies must have a monitoring section to outline how you will monitor that the processes described within the policy are being followed as well as the outcomes. The following table must be completed to explain how this.

It is also good practice to include in the appendices an audit proforma to carry out the monitoring (if appropriate) as this will ensure that results will be comparable.

<table>
<thead>
<tr>
<th>Standard / process / issue</th>
<th>Monitoring and audit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Method</td>
</tr>
<tr>
<td>All E&amp;UC vehicles are contracted to be made ready once every 24 hours by our external contractor, Churchill. The contract requires that equipment is checked and the vehicle undergoes a daily clean. The contract requires all E&amp;UC vehicles to undergo a 12 weekly deep clean and PTS vehicles every 6 weeks, where all equipment and consumables are removed and a thorough cleaning programme takes place before the vehicle is re-equipped and put back into service. There is no daily make ready contract for PTS vehicles and the staff are required to clean their vehicles at the end of their shift.</td>
<td>All EU&amp;C and NEPTS vehicles are audited against NHS standards on a bi-annual basis. Any standard that does not pass an audit question develops an action plan for that non-compliance and can be tracked to give assurance that the issue is being rectified or awaiting approval for completion.</td>
</tr>
<tr>
<td>All Resource Centres and stand-by points (ASAPs), are audited against NHS standards on a bi-monthly basis and Northern and Southern House HQ’s and CCCs, bi-annually. Any standard that does not pass an audit question develops an action plan for that non-compliance and can be</td>
<td></td>
</tr>
</tbody>
</table>
11. **Consultation and Review**

11.1 A consultation exercise on the policy will be carried out with the stakeholders listed below.

11.2 This policy will be reviewed every three years or sooner if there are any relevant changes to Legislation, guidance or best practice.

11.3 A list of the persons or groups from whom comments have been invited are included in the table below.

<table>
<thead>
<tr>
<th>Stakeholder or Group Title</th>
<th>Consultation Period (From-to)</th>
<th>Comments received (Yes/No)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Safety Group</td>
<td>11th June 2018 to 12th July 2018</td>
<td>Yes</td>
</tr>
</tbody>
</table>

12. **Implementation (including raising awareness)**

The policy will be implemented and communicated to managers and staff within the Trust via the weekly newsletter, Staff Matters. Emails will also be sent to senior managers and area managers asking them to bring the existence of the policy to their staff.

13. **References**


Department of Health (2013) Health Building Note 00-09: Infection control in the built environment. Crown Copyright 2013


Infection Prevention, Decontamination and Control Policy. SCAS (September 2015)


NICE (2014). Infection prevention and control: Quality standard (QS61)


Pre-Employment Check Procedure, SCAS (June 2014)

Provision and Use of Work Equipment Regulations 1998

Sickness Management Policy, SCAS (February 2017).

Waste Management Policy & Procedure, SCAS (June 2016)

14. **Associated documentation**

The following SCAS Policies and Procedures have been cross referenced and should be use for further guidance when utilising and referring to this policy.

- Personal Protective Equipment Policy
- Health and Safety Policy & Procedures
- Recruitment Policy
- Sickness Absence Policy
- Pre-employment Checks Procedure
- Uniform Policy
- Waste Management Policy
- Mandatory Training Policy
- Corporate Induction Policy
## Appendix 1: Review Table

<table>
<thead>
<tr>
<th>Version</th>
<th>Reason for change</th>
<th>Overview of change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Review of policy</td>
<td>Adoption of new policy template. The majority of changes were made to the numbering format of the sections to reflect the new template</td>
</tr>
<tr>
<td>1.0</td>
<td>Removed as no longer current practice guidelines</td>
<td>1.0 - Basic Ambulance Aid Manual produced by the IHCD</td>
</tr>
<tr>
<td>1.0</td>
<td>Included as part of the new policy template</td>
<td>2.0 Scope - Inserted 'Work Experience' exchanged with 'Work Placement'</td>
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<tr>
<td>1.0</td>
<td>Format changed from previous policy to reflect the new policy format</td>
<td>3.0 - Aim - Amended from sections within the previous IPC Policy</td>
</tr>
<tr>
<td>1.0</td>
<td>Included as part of the new policy format</td>
<td>4.0 - Trust Board</td>
</tr>
<tr>
<td>1.0</td>
<td>Moved to Section 7.3 in new policy template</td>
<td>4.2 - 2015 Policy - Re-worded paragraph and fixed grammar - Moved to Section 7.3</td>
</tr>
<tr>
<td>1.0</td>
<td>Moved to Section 8 in the new policy template</td>
<td>5.0 - 2015 Policy - Training section amended due to duplication in introduction and moved to Section 8 in new policy template</td>
</tr>
<tr>
<td>1.0</td>
<td>Wording added</td>
<td>4.5 - added ‘and website’</td>
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<tr>
<td>1.0</td>
<td>Change to reflect exception reporting</td>
<td>4.6 - Text amended - a) Any non-compliance with the Trust's Control of Infection Procedures. e) Any near miss events with the potential to cause harm</td>
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<tr>
<td>1.0</td>
<td>Added bullet point</td>
<td>4.6 - Staff Illness and reporting - Included “Unexplained or” to “Severe diarrhoea and / or vomiting</td>
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<tr>
<td>1.0</td>
<td>Included to cover unexplained source of potentially infected episodes rather than limited to just ‘severe’</td>
<td>4.6 - Staff Illness and reporting - Included “Unexplained or” to “Severe diarrhoea and / or vomiting</td>
</tr>
<tr>
<td>1.0</td>
<td>Recognition of integral role of the member of staffs Line Manager in accordance with sickness reporting procedures</td>
<td>4.11 - Added text “or from their Line Manager”.</td>
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<tr>
<td>1.0</td>
<td>To reflect the updated resource since the previous Policy was published</td>
<td>7.2 - Information added “The online audit system is access at <a href="https://www.auditonline.co.uk/scas%E2%80%9D">https://www.auditonline.co.uk/scas”</a></td>
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<tr>
<td>1.0</td>
<td>Text added for information and guidance</td>
<td>7.5. Sentence added - “It can also inadvertently be considered as dehumanising to patients”.</td>
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<tr>
<td>Section</td>
<td>Changes Made</td>
<td></td>
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<td>---------</td>
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<tr>
<td>1.0</td>
<td>Omitted from previous policy</td>
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<tr>
<td>7.5.2</td>
<td>Added to body fluid list - ‘Breast Milk’</td>
<td></td>
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<tr>
<td>1.0</td>
<td>Text added for Infection Control context</td>
<td></td>
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<tr>
<td>7.5.3</td>
<td>Text added - “where there is a risk of exposure to body fluids”</td>
<td></td>
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<tr>
<td>1.0</td>
<td>Text amended for clarity</td>
<td></td>
</tr>
<tr>
<td>7.5.4</td>
<td>Amended Text - “Powder free disposable gloves (Nitrile) which conform to British and EN standards and be CE marked”</td>
<td></td>
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<td>1.0</td>
<td>Omitted from Previous Policy</td>
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<tr>
<td>7.5.4</td>
<td>Amended text Added “Shoe Protector Overshoes”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Added text for clarity</td>
<td></td>
</tr>
<tr>
<td>7.5.5</td>
<td>Added text “using the body fluid spill kits provided on Ambulance vehicles”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Amended to reference updated policy</td>
<td></td>
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<tr>
<td>7.5.6</td>
<td>Amended text to “Uniform Policy”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Link to guidance in appendix added for clarity</td>
<td></td>
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<tr>
<td>7.5.8.2</td>
<td>Text added with reference to Appendix for Handwashing guidance</td>
<td></td>
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<tr>
<td>1.0</td>
<td>Guidance text added</td>
<td></td>
</tr>
<tr>
<td>7.5.8.2</td>
<td>- Text added “It is important to note that the efficacy of alcohol reduces with every application”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Link to guidance in appendix added for clarity</td>
<td></td>
</tr>
<tr>
<td>Text added with reference to Appendix for alcohol gel hand rub guidance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Amended for awareness of personal choice and differences between peoples hand dryness</td>
<td></td>
</tr>
<tr>
<td>7.5.8.5</td>
<td>Text amended - Replaced “daily” with “regular”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Added text to ensure clarity for using the correct type of glove where appropriate</td>
<td></td>
</tr>
<tr>
<td>7.5.9</td>
<td>Added text to ‘Use of Gloves’ - “(sterile or non-sterile, depending on the nature of the susceptible site e.g. suturing or urinary catheter management)”</td>
<td></td>
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<tr>
<td>Added for clarity</td>
<td>Added reference to text about ANTT with relevant guidelines</td>
<td></td>
</tr>
<tr>
<td>Included text specific to ANTT techniques from relevant guidelines</td>
<td>Included paragraph specific to Intravenous Cannulation</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Included for clarity and guidance</td>
<td></td>
</tr>
<tr>
<td>7.6.3</td>
<td>- Universal sanitising wipes - added text and diagrams</td>
<td></td>
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<tr>
<td>Amended for correctness</td>
<td>- Sentence amended - Spill ‘wipes’ replaced by Spill ‘kits’ and added “and disposed of as clinical waste”</td>
<td></td>
</tr>
<tr>
<td>Paragraph</td>
<td>Change Description</td>
<td>Page Section</td>
</tr>
<tr>
<td>-----------</td>
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<td>-------------</td>
</tr>
<tr>
<td>1.0</td>
<td>Changed to reflect current practice and universal supply of disinfectant wipes across SCAS</td>
<td>7.6.5</td>
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<tr>
<td></td>
<td>- Acute Cleaning - Phase 1 - Patient Contact - Amended low level detergent wipes with “universal disinfectant wipes”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acute Cleaning - Procedure for Acute Cleaning - Changed wording from “disinfectant solution” to “disinfectant wipe”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Added text to bullet point “Rewash hands” - “Remove gloves and”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Included for clarity &amp; guidance</td>
<td>7.6.6</td>
</tr>
<tr>
<td></td>
<td>Diagram included</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Changed to reflect current practice and universal supply of disinfectant wipes across SCAS</td>
<td>7.6.9</td>
</tr>
<tr>
<td></td>
<td>Amended text - “universal disinfectant wipes”</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Added to reflect current practice across SCAS</td>
<td>7.6.16</td>
</tr>
<tr>
<td></td>
<td>Added text to table</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Alcohol 70% - “E.g. ethanol / isopropyl skin cleansing swab”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Chlorhexidine - Chlorhexidine Gluconate / Isopropyl Alcohol Skin Preparation Wipes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Amended “Detergent wipes” to “Disinfectant wipes” throughout table</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Paragraph added to reflect guidelines and for clarity</td>
<td>7.7.1</td>
</tr>
<tr>
<td></td>
<td>In May 2013, the European Council Directive 2010/32/EU (the Sharps Directive) was made regulation. This states that: All employers are required under existing health and safety law to ensure that risks from sharps injuries are adequately assessed and appropriate control measures are in place.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Avoid the unnecessary use of sharps</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Where it is not reasonably practicable to avoid the use of medical sharps, the Sharps Regulations require employers to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Use safer sharps (incorporating protection mechanisms)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Activated the needle shield after a procedure is completed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Prevent the recapping of needles</td>
<td></td>
</tr>
<tr>
<td></td>
<td>▪ Place secure containers and instructions for safe disposal of medical sharps close to the work area</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Sentence added to reflect guidelines and for clarity</td>
<td>7.7.3</td>
</tr>
<tr>
<td></td>
<td>Sentence added - Activate any sharpsafe device when the procedure is complete prior to disposal</td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Amended to reflect the change in policy with handling of sharps following a review of sharps and needle stick injuries across the organisation. Requested by John Black SCAS Medical Director and agreed by the Clinical Review Group, the Health, Safety and Risk Group and the Patient Safety Review Group.</td>
<td></td>
</tr>
<tr>
<td>7.7.3 - Wording changed to “Cannulation and other procedures involving the use of sharps should, where possible, not be attempted in a moving vehicle. Attempting cannulation in a moving ambulance is challenging and the risks of needle stick injury are high. The decision to carry out a procedure using sharps or needles should be determined on a case by case basis by the ambulance clinician whilst factoring the clinical needs of the patient.”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Amended to ensure no contaminated linen or other items are washed with uniform</td>
<td></td>
</tr>
<tr>
<td>7.8.2 - Sentence amended to included “contaminated linen”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Added to clarify the hygienic storage of linen within vehicles to ensure it is not contaminated prior to use</td>
<td></td>
</tr>
<tr>
<td>7.8.13 - Sentence added - “When storing clean linen on the vehicles they should be stored in a cupboard with a clean interior and not stored where it can be contaminated by other items”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>Amended to reflect NHS recycling bags</td>
<td></td>
</tr>
<tr>
<td>7.9.7 - Sentence amended - Black bin liners must be used in all general waste bins and separate bins bags used for recyclable material waste bins.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.0</td>
<td>New paragraph added to included statement reference mandatory e-learning training module</td>
<td></td>
</tr>
<tr>
<td>Section 8 - Paragraph added</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 16. Appendix 2: Responsibility Matrix - Policies, Procedures and Strategies

<table>
<thead>
<tr>
<th>Policy Group</th>
<th>Lead Director / Officer</th>
<th>Working Group</th>
<th>Committee</th>
<th>Board Ratification</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategies</td>
<td>As appropriate</td>
<td>As appropriate</td>
<td>As appropriate</td>
<td>Required</td>
</tr>
<tr>
<td>Standing Orders &amp; Standing Financial Instructions</td>
<td>Chief Executive + Director of Finance</td>
<td>Not applicable</td>
<td>Audit Committee</td>
<td>Required</td>
</tr>
<tr>
<td>Corporate Policies</td>
<td>Chief Executive + Director of Patient Care</td>
<td>As appropriate</td>
<td>Quality and Safety Committee</td>
<td>Required/ Committee decision</td>
</tr>
<tr>
<td>Health and Safety Policies and Procedures</td>
<td>Director of Patient Care</td>
<td>Strategic Health, Safety and Risk Group</td>
<td>Quality and Safety Committee</td>
<td>Health and Safety Policy – Required</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>H&amp;S Appendices – Committee decision</td>
</tr>
<tr>
<td>Control of Infection Policy and Procedures</td>
<td>Director of Patient Care</td>
<td>Clinical Review Group</td>
<td>Quality and Safety Committee</td>
<td>Required</td>
</tr>
<tr>
<td>Personnel Policies and Procedures</td>
<td>HR Director</td>
<td>Staff Consultation Group</td>
<td>Quality and Safety Committee</td>
<td>Required for new policies. Committee decision for revisions</td>
</tr>
<tr>
<td>Financial Policies and Procedures</td>
<td>Director of Finance</td>
<td>Not applicable</td>
<td>Audit Committee</td>
<td>Required for new Policies. Committee decision for procedural changes.</td>
</tr>
<tr>
<td>Operational Policies and Procedures</td>
<td>Director Operations</td>
<td>As appropriate or through Team Meeting</td>
<td>Quality and Safety Committee</td>
<td>Committee decision</td>
</tr>
<tr>
<td>Information and IT Policies and Procedures</td>
<td>Director of IT</td>
<td>Information Governance Steering Group</td>
<td>Quality and Safety Committee</td>
<td>Committee decision</td>
</tr>
<tr>
<td>Emergency Operational Centre Policies and Procedures</td>
<td>Director Operations</td>
<td>As appropriate</td>
<td>Quality and Safety Committee</td>
<td>Committee decision</td>
</tr>
<tr>
<td>Clinical Policies and Procedures</td>
<td>Director of Clinical Services</td>
<td>Clinical Review Group</td>
<td>Quality and Safety Committee</td>
<td>Committee decision</td>
</tr>
</tbody>
</table>
17. **Appendix 3: Equality Impact Assessment Form Section One – Screening**

**Name of Function, Policy or Strategy:** Infection Prevention Control and Decontamination Policy

**Officer completing assessment:** Chris Jackson - Infection Prevention & Control Lead (acting)

**Telephone:** 07342 059967

<table>
<thead>
<tr>
<th>1. What is the main purpose of the strategy, function or policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>To provide the Trust board with an effective approach to ensure the highest standards of infection control within the Ambulance Service are met considering the expectations of the patient to a clean, modern environment, safe working conditions and following best practice by all staff employed within and on behalf of the South Central Ambulance Service NHS Foundation Trust (SCAS).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. List the main activities of the function or policy? (for strategies list the main policy areas)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. To provide and effective framework to ensure best practice for the control of infection across all sectors of the Trusts activities</td>
</tr>
<tr>
<td>2. To provide instructions and guidance with a central source of reference for all staff on how to ensure the control of infection across all sectors of the Trusts activities</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Who will be the main beneficiaries of the strategy/function/policy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff, patients and contractors</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. Use the table overleaf to indicate the following:-</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Where do you think that the strategy/function/policy could have an adverse impact on any equality group, i.e. it could disadvantage them?</td>
</tr>
<tr>
<td>b. Where do you think that there could be a positive impact on any of the groups or contribute to promoting equality, equal opportunities or improving relations within equality target groups?</td>
</tr>
<tr>
<td>Category</td>
</tr>
<tr>
<td>--------------------------</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Disability</strong></td>
</tr>
<tr>
<td><strong>Sexual Orientation</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Religion/Belief</strong></td>
</tr>
</tbody>
</table>
Policy is designed to protect all staff and people who carry out work for or on behalf of the Trust.

Whilst there is some potential impact for staff who wearing certain clothing or are required to maintain facial hair it is considered lawful to expect that the protection of patients and staff from HCAI the is greater than the need to protect the belief of the individual.

<table>
<thead>
<tr>
<th>Equal Opportunities and/or improved relations</th>
<th>✓</th>
<th>N/A</th>
</tr>
</thead>
</table>

Notes: Faith groups cover a wide range of groupings, the most common of which are Muslims, Buddhists, Jews, Christians, Sikhs and Hindus. Consider faith categories individually and collectively when considering positive and negative impacts.

The categories used in the race section refer to those used in the 2001 Census. Consideration should be given to the specific communities within the broad categories such as Bangladeshi people and to the needs of other communities that do not appear as separate categories in the Census, for example, Polish.
5. If you have indicated that there is a negative impact, is that impact:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal (it is not discriminatory under anti-discriminatory law)</td>
<td>☑</td>
</tr>
<tr>
<td>Intended</td>
<td>☑</td>
</tr>
<tr>
<td>Level of Impact</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
</tr>
</tbody>
</table>

If the negative impact is possibly discriminatory and not intended and/or of high impact then please complete a thorough assessment after completing the rest of this form.

6(a). Could you minimise or remove any negative impact that is of low significance? Explain how below:

N/A

6(b). Could you improve the strategy, function or policy positive impact? Explain how below:

N/A

7. If there is no evidence that the strategy, function or policy promotes equality, equal opportunities or improves relations – could it be adopted so it does? How

N/A

Please sign and date this form, keep one copy and send one copy to the Trust's Equality Lead.

Signed: Chris Jackson

Name: Chris Jackson - Infection Prevention and Control Lead (acting)

Date: 7th June 2018
18. Appendix 4: Equality Impact Assessment Form Section Two - Full Assessment

Name of Function, Policy or Strategy: ........................................................................................................

Officer completing assessment: ................................................................................................................

Telephone...........................................................................................................................................................

Part A
Looking back at section one of the EQIA, in what areas are there concerns that the strategy, policy or project could have a negative impact?

<table>
<thead>
<tr>
<th>Category</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>N/A</td>
</tr>
<tr>
<td>Race</td>
<td>N/A</td>
</tr>
<tr>
<td>Disability</td>
<td>N/A</td>
</tr>
<tr>
<td>Sexuality/Transgender</td>
<td>N/A</td>
</tr>
<tr>
<td>Age</td>
<td>N/A</td>
</tr>
<tr>
<td>Faith</td>
<td>N/A</td>
</tr>
</tbody>
</table>

2. Summarise the likely negative impacts:

..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................
..........................................................................................................................................................

3. Using the table below, give a summary of what previous or planned consultation on this topic, policy, function or strategy has or will take place with groups or individuals from the equality target groups and what has this consultation noted about the likely negative impact?

<table>
<thead>
<tr>
<th>Equality Target Groups</th>
<th>Summary of consultation planned or taken place</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td>Sexuality/Transexuality</td>
<td></td>
</tr>
<tr>
<td>Older People</td>
<td></td>
</tr>
</tbody>
</table>
4. What consultation has taken place or is planned with Trust staff including staff that have or will have direct experience of implementing the strategy, policy or function?

...................................................................................................................................................
...................................................................................................................................................
...................................................................................................................................................

5. Check that any research, reports, studies concerning the equality target groups and the likely impact have been used to plan the project and guide or indicate what research you intend to carry out:

<table>
<thead>
<tr>
<th>Equality Target Groups</th>
<th>Title/type of/details of research/report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td></td>
</tr>
<tr>
<td>Disability</td>
<td></td>
</tr>
<tr>
<td>Sexuality/Transexuality</td>
<td></td>
</tr>
<tr>
<td>Older People</td>
<td></td>
</tr>
<tr>
<td>Younger People</td>
<td></td>
</tr>
<tr>
<td>Faith</td>
<td></td>
</tr>
</tbody>
</table>

7. If there are gaps in your previous or planned consultation and research, are there any experts/relevant groups that can be contacted to get further views or evidence on the issues?

☐ Yes (Please list them and explain how you will obtain their views)

...................................................................................................................................................
...................................................................................................................................................

☐ No

**Part B**

Complete this section when consultation and research has been carried out
7a. As a result of this assessment and available evidence collected, including consultation, state whether there will be a need to be any changes made/planned to the policy, strategy or function.

7b. As a result of this assessment and available evidence is it important that the Trust commission specific research on this issue or carry out monitoring/data collection?

(You may want to add this information directly on to the action plan at the end of this assessment form)

...............................................................
...............................................................
...............................................................
...............................................................

8. Will the changes planned ensure that negative impact is:

Legal? (not discriminatory, under anti-discriminatory legislation) □

Intended? □

Low impact? □

9a. Have you set up a monitoring/evaluation/review process to check the successful implementation of the strategy, function or policy?

Yes □ No □

9b. How will this monitoring/evaluation further assess the impact on the equality target groups/ensure that the strategy/policy/function is non-discriminatory?

Details:

...............................................................
...............................................................
...............................................................

Please complete the action plan overleaf, sign the EQIA, retain a copy and send a copy of the full EQIA and Action Plan to the Trust’s Equality Lead.

Signed:.................................................................

Name:.................................................................

Date:.................................................................
## Appendix 5: Ratification Checklist

### Section 1: To be completed by Author prior to submission for ratification

<table>
<thead>
<tr>
<th>Policy Title</th>
<th>Infection Prevention Control and Decontamination Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author’s Name and Job Title</td>
<td>Chris Jackson - Infection Prevention and Control Lead (acting)</td>
</tr>
<tr>
<td>Review Deadline</td>
<td></td>
</tr>
<tr>
<td>Consultation From - To (dates)</td>
<td></td>
</tr>
<tr>
<td>Comments Received? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>All Comments Incorporated? (Y/N)</td>
<td></td>
</tr>
<tr>
<td>If No, please list comments not included along with reasons</td>
<td></td>
</tr>
<tr>
<td>Equality Impact Assessment completed (date)</td>
<td>7th June 2018</td>
</tr>
<tr>
<td>Name of Accountable Group</td>
<td>Patient Safety Group</td>
</tr>
<tr>
<td></td>
<td>Health Safety and Risk Group</td>
</tr>
<tr>
<td>Date of Submission for Ratification</td>
<td></td>
</tr>
</tbody>
</table>

### Section 2: To be completed by Accountable Group

| Template Policy Used (Y/N)                        |                                                        |
| All Sections Completed (Y/N)                      |                                                        |
| Monitoring Section Completed (Y/N)                |                                                        |
| Date of Ratification                              |                                                        |
| Date Policy is Active                             |                                                        |
| Date Next Review Due                              |                                                        |
| Signature of Accountable Group Chair (or Deputy)  |                                                        |
| Name of Accountable Group Chair (or Deputy)       |                                                        |
Infection Prevention Control and Decontamination Policy

20. Appendix 6: Infection Prevention and Control Structures

- Trust Board (includes DIPC)
- Quality and Safety Committee
- Health and Safety Committee
- Patient Safety Group
- Trust Infection Control Lead
- Assistant Director of Quality
- Directors, Assistant Directors and Area Managers
  - EU&C Ops
  - NEPTS
  - Fleet Services
  - CCC
  - Education Team
  - HR
  - Estates
  - Occupational Health Provider
  - External Infection Control Groups
  - NASIPCG
21. Appendix 7 : Six Steps to Hand Hygiene

![Six Steps to Hand Hygiene](image)

**Six Steps to Hand Hygiene**

Wet your hands and apply liquid soap (one squirt) or apply alcohol gel if hand washing facility isn’t available. Then, follow the next six steps using five forward and five backward strokes.

1. Rub your hands together, palm to palm.
2. Rub your right palm over the back of your left hand, and then your left palm over the back of your right hand.
3. Rub your hands together, palm to palm, with your fingers interlaced.
4. Rub your left fist in your right palm, and then your right fist in your left palm.
5. Rotate your right thumb in your left palm, and then, your left thumb in your right palm.
6. Rub your right fingers in your left palm, and then, your left fingers in your right palm.

Don't forget to wash your wrists and dry your hands thoroughly.
22. Appendix 8 : How to Hand Wash

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds

0. Wet hands with water;
1. Apply enough soap to cover all hand surfaces;
2. Rub hands palm to palm;
3. Right palm over left dorsum with interlaced fingers and vice versa;
4. Palm to palm with fingers interlaced;
5. Backs of fingers to opposing palms with fingers interlocked;
6. Rotational rubbing of left thumb clasped in right palm and vice versa;
7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
8. Rinse hands with water;
9. Dry hands thoroughly with a single use towel;
10. Use towel to turn off faucet;
11. Your hands are now safe.

World Health Organization | Patient Safety | SAVE LIVES
Clean Your Hands
Appendix 9: How to Hand Rub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a. Apply a palmful of the product in a cupped hand, covering 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.

World Health Organization
Patient Safety
SAVE LIVES
Clean Your Hands

Infection Prevention Control and Decontamination Policy
## Appendix 10 : A-Z of Disease Specific Precaution

<table>
<thead>
<tr>
<th>DISEASE/INFECTION</th>
<th>INCUBATION PERIOD</th>
<th>ROUTE OF SPREAD</th>
<th>PREVENTION OF SPREAD</th>
<th>DURATION OF PRECAUTIONS</th>
<th>VEHICLE CLEANING REQUIREMENTS</th>
</tr>
</thead>
</table>
| **Acinetobacter** | Dependent on infection site | Direct or indirect contact with a colonised or infected person or contaminated equipment/surfaces | Single patient transport for duration of precautions  
Hand decontamination  
Gloves and aprons for patient contact  
Environmental cleanliness | Whilst the patient remains colonised or infected | Normal between patient clean with vehicle based wipes (all surfaces and equipment) and mop the floor with Chlorine based cleaning solution.  
Spill pack must be used on any blood or body fluid spill. |
| **Acquired Immune Deficiency Syndrome AIDS**  
See also HIV. | Variable, although the time from infection to development of detectable antibodies 1-3 months | Blood to blood and per mucosal exposure to infective body fluids | Hand decontamination  
Gloves and aprons for exposure to body fluids.  
Following contamination/needle stick injuries action must be taken immediately. | Life long | Normal between patient clean with vehicle based wipes (all surfaces and equipment) – deep clean if body fluid soiling is extensive  
Spill pack must be used on any blood or body fluid spill. |
<table>
<thead>
<tr>
<th>DISEASE/INFECTION</th>
<th>INCUBATION PERIOD</th>
<th>ROUTE OF SPREAD</th>
<th>PREVENTION OF SPREAD</th>
<th>DURATION OF PRECAUTIONS</th>
<th>VEHICLE CLEANING REQUIREMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adenovirus *Conjunctivitis</td>
<td>Between 5 – 12 days but in many instances this duration is exceeded</td>
<td>Contact with secretions/lesions and contaminated equipment Faecal/oral</td>
<td>Single patient transport for duration of precautions Decontaminate articles contaminated with secretions Gloves must be worn for contact with any secretions/lesions.</td>
<td>For the duration of symptoms</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>Amoebic Dysentery</td>
<td>Variable, from a few days to several months or years; commonly 2-4 weeks</td>
<td>Faecal/oral</td>
<td>Single patient transport for duration of precautions Hand decontamination. Aprons/gloves when handling infective material</td>
<td>Whilst diarrhoea persists</td>
<td><strong>Symptomatic</strong> during conveyance - deep clean required <strong>Non-symptomatic</strong> during conveyance - a normal between patient clean with vehicle based wipes (all surfaces) Spill pack must be used on any blood or body fluid spill.</td>
</tr>
<tr>
<td>DISEASE/ INFECTION</td>
<td>INCUBATION PERIOD</td>
<td>ROUTE OF SPREAD</td>
<td>PREVENTION OF SPREAD</td>
<td>DURATION OF PRECAUTIONS</td>
<td>VEHICLE CLEANING REQUIREMENTS</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
<td>-----------------</td>
<td>----------------------</td>
<td>-------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Anthrax</td>
<td>From 1-7 days</td>
<td>Inhalation, ingestion or direct contact with infected items. Airborne transmission from inhalation of spores. (person to person airborne transmission does not occur) Direct skin to skin contact can cause transmission although this is rare.</td>
<td>No isolation procedures required (unless clothing thought to be contaminated). Personal protective equipment should be used in situations where there is potential for splashes and inoculation injuries. Avoid any powder – wear a mask if necessary. Any incidents should be reported immediately and deliberate release acts should be discussed with HART</td>
<td>For the duration of symptoms</td>
<td>Deep clean using chlorine based disinfectant Spill pack must be used on any blood or body fluid spill.</td>
</tr>
<tr>
<td>Botulism</td>
<td>Usually 12 – 36 hours after exposure to toxin</td>
<td>Ingestion or inhalation of the toxin produced by Clostridium botulinum (spores found in soil)</td>
<td>Hand decontamination. Cover wounds with waterproof dressings Wear gloves if performing any invasive procedures</td>
<td>For the duration of symptoms</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces and equipment) Spill pack must be used on any blood or body fluid spill.</td>
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<tr>
<td>DISEASE/INFECTION</td>
<td>INCUBATION</td>
<td>ROUTE OF SPREAD</td>
<td>PREVENTION OF SPREAD</td>
<td>DURATION OF PRECAUTIONS</td>
<td>VEHICLE CLEANING REQUIREMENTS</td>
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<tr>
<td>Bronchiolitis (Respiratory Syncital Virus)</td>
<td>From 1 to 10 days</td>
<td>Respiratory secretions, airborne, direct contact with infected secretions.</td>
<td>Single patient transport for duration of precautions</td>
<td>For the duration of symptoms</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td>Hand decontamination</td>
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<td>Masks for aerosol generating procedures. Gloves for contact with secretions.</td>
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<td>Encourage patient to cough into a tissue</td>
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<td>Campylobacter</td>
<td>1 – 11 days (usually 2 - 5)</td>
<td>Eating raw or undercooked meat (especially poultry), unpasteurised milk, untreated water and domestic pets with watery diarrhoea If hygiene is poor, person to person spread is possible.</td>
<td>Single patient transport for duration of precautions</td>
<td>For the duration of symptoms</td>
<td>Symptomatic during conveyance - deep clean required Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces) Spill pack must be used on any blood or body fluid spill.</td>
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<td>Hand decontamination</td>
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<td></td>
<td>Gloves and aprons during patient contact, Gloves must be changed regularly and if contaminated.</td>
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<td>DISEASE/INFECTION</td>
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<tr>
<td>Carbapenem Resistance Organisms (CRO/CPE/CRE)</td>
<td>Patient may be infected or colonised</td>
<td>Direct or indirect contact with contaminated items/surfaces or</td>
<td><strong>Single patient transportation</strong>&lt;br&gt; Gloves and apron for patient contact.&lt;br&gt; Hand decontamination</td>
<td>Duration of infection or colonisation</td>
<td><strong>Body fluid soiling of vehicle</strong> during conveyance - deep clean required&lt;br&gt; <strong>Non-symptomatic</strong> during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)&lt;br&gt; Spill pack must be used on any blood or body fluid spill.</td>
</tr>
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<td>DISEASE/INFECTION</td>
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| **Chickenpox**   | 10 -21 days after exposure Infectious 2 days before the lesions appear | Direct person to person contact, airborne and through contact with infected articles (including clothing and bedding) Can be contracted from patients with Shingles. | **Single patient transport for duration of precautions**  
Hand decontamination  
Gloves and apron for patient contact.  
FFP3 facemasks are required if the patient has cold symptoms or if staff immunity is unknown. **Staff not immune to chicken pox must (where possible) avoid contact.** | Usually 7-10 days after rash has appeared until last lesion has crusted over | Normal between patient clean with vehicle based wipes (all surfaces and equipment) |
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<tbody>
<tr>
<td>Cholera Vibrio cholera</td>
<td>Up to 5 days</td>
<td>Contact with faeces – Faecal/oral route</td>
<td>Single patient transport for duration of precautions Hand decontamination Apron and gloves for direct patient contact and disposal of body fluids.</td>
<td>Until bacteriologically clear</td>
<td>Symptomatic during conveyance - deep clean required Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces) Spill pack must be used on any blood or body fluid spill.</td>
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<tr>
<td><strong>Clostridium difficile</strong></td>
<td>Typically between 1 and 10 weeks dependent on strain and the health of the</td>
<td>Faecal/oral route</td>
<td>Ingestion of spores through contact with contaminated surfaces</td>
<td>Hand decontamination with soap and water or vehicle based wipes and alcohol hand gel. Hand gel alone is not sufficient</td>
<td>Isolation precautions can be discontinued once the patient is asymptomatic for 48 hours</td>
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<td>Gloves and aprons for all contact, change gloves between clean and dirty procedures</td>
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<tr>
<td>Disease</td>
<td>Incubation Period</td>
<td>Mode of Transmission</td>
<td>Preventive Measures</td>
<td>Duration of Symptoms</td>
<td>Additional Precautions</td>
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<tr>
<td>Creutzfeldt-Jakob Disease (CJD)</td>
<td>Unknown, likely to be many years or decades</td>
<td>Contact with infected blood and body fluids. Direct contact with infected medical equipment Ingestion of beef/beef products from BSE infected cattle</td>
<td>Apron and gloves for direct contact with body fluids. Eye protection to be worn if risk of splashing Single use items, any metal surgical items should be disposed of in the yellow lidded sharps bin.</td>
<td>Life long</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces and equipment) Spill pack must be used on any blood or body fluid spill.</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>1-28 days Average 7-10 days</td>
<td>Contact with infected animals or person to person spread through the faecal/oral route.</td>
<td>Single patient transport for duration of precautions Hand decontamination Apron and gloves for direct contact with and disposal of body fluids</td>
<td>Duration of symptoms</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces). If symptomatic during transportation as an extra precaution the floor needs to be mopped with a chlorine based solution Spill pack must be used on any blood or body fluid spill.</td>
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<tr>
<td>Cytomegalovirus</td>
<td>3-12 weeks</td>
<td>Contact with blood and bodily fluids</td>
<td>Hand decontamination&lt;br&gt;Apron and gloves for direct contact with and disposal of body fluids</td>
<td>Duration of symptoms</td>
<td>Normal between patient clean with vehicle based wipes (all surfaces and equipment)&lt;br&gt;Spill pack must be used on any blood or body fluid spill.</td>
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<tr>
<td>Dengue Fever</td>
<td>5 to 8 days following mosquito bite</td>
<td>Mosquito borne infection&lt;br&gt;It is not spread from person to person</td>
<td>Hand decontamination&lt;br&gt;Gloves when undertaking any invasive procedure&lt;br&gt;If patient is bleeding – Gloves, aprons, facemasks and eye protection</td>
<td>Duration of symptoms</td>
<td>Not bleeding - Normal between patient clean with vehicle based wipes (all surfaces and equipment)&lt;br&gt;Bleeding – deep clean required&lt;br&gt;Spill pack must be used on any blood or body fluid spill.</td>
</tr>
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<td>DISEASE/INFECTION</td>
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| Diarrhoea infections | Dependant on causative microorganism normally 6 – 48 hours | Faecal / oral route. Can be airborne if patient is projectile vomiting. | Single patient transport for duration of precautions  
Hand decontamination – hand wipes followed by alcohol gel. Soap and water when available. Alcohol hand gel is not effective against diarrhoeal infections  
Apron and gloves for direct contact with and disposal of body fluids. Consider use of sleeve protectors  
Facemasks and eye protection when if patient is actively vomiting (especially during transportation)  
**NB. Staff must be 48 hours symptom free before returning to work** | Until symptoms have ceased or non-infective cause diagnosed by medical staff (i.e. colitis) | **Symptomatic** during conveyance - deep clean required  
**Non-symptomatic** during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)  
Spill pack must be used on any blood or body fluid spill. |
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<tr>
<td>Diphtheria</td>
<td>Up to 10 days. Average 7 days following contact with the bacteria</td>
<td>Respiratory droplets and through direct contact with respiratory secretions. Direct contact with discharge from cutaneous lesion.</td>
<td>Single patient transport for duration of precautions Hand decontamination Attending staff should have been immunized. Those of uncertain status should contact OH. Gloves, for invasive procedures, and an apron. If patient is actively coughing: an FFP3 facemask and eye protection are required.</td>
<td>Until bacteriologically negative, usually after 3 days of antibiotic therapy</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces) Any linen stored within the patient area (and not within the cupboard) should be removed from the vehicle. Spill pack must be used on any blood or body fluid spill. If your uniform is soiled, despite the use of PPE, your uniform will require changing.</td>
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| Ebola             | 3-21 days         | Direct contact with the blood or body fluids from an infected person. | Strict Isolation, Single patient transport for duration of precautions  
Escalate to ROM and NILO immediately.  
Crew briefed regarding levels of risk and PPE required.  
**Inform ED Immediately**  
Transfer to specialist centres are undertaken by the HART team | Whilst virus present in blood and secretions | Deep clean required – see deep clean procedure for Viral Haemorrhagic Disease  
Spill pack must be used on any blood or body fluid spill. |
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<tr>
<td>Escherichia coli</td>
<td>Dependent on the site of infection. Patients could be colonised.</td>
<td>Ingestion of contaminated food or water Faecal/oral route</td>
<td>The patient should be transported singly. Hand decontamination Gloves for invasive procedures and aprons if there are any body fluids.</td>
<td>Duration of infection or colonisation</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces) Any linen stored within the patient area (and not within the cupboard) should be removed from the vehicle. Spill pack must be used on any blood or body fluid spill.</td>
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| ESBL (Extended Spectrum Betalactamase) | Antibiotic resistant strain of bacteria, 
Can cause urinary tract infection, pneumonia or surgical wound infections | Faecal/oral route | The patient should be transported singly if they or any other patient scheduled to travel with them has an open wound, catheter or intravenous cannula. 
Plastic apron and gloves for direct patient contact. 
Hand decontamination | Duration of infection or colonisation | A normal between patient clean with vehicle based wipes (all surfaces and equipment) 
Spill pack must be used on any blood or body fluid spill. |
### Infection Prevention Control and Decontamination Policy

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<tr>
<th>DISEASE/INFECTION</th>
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<tbody>
<tr>
<td>Epstein Barr Virus (Infectious mononucleosis glandular fever)</td>
<td>4-6 weeks</td>
<td>Exchange of oral secretions</td>
<td>Plastic apron and gloves for direct patient contact. Disinfection of articles soiled with nose and throat discharges Hand decontamination</td>
<td>Duration of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
<td>Fleas</td>
<td>Can survive as pupa (eggs) for several months in linens and carpets</td>
<td>Direct contact Indirect contact (environmental) Fleas are able to move and jump</td>
<td>Patients should be transported singly Gloves and aprons for patient contact – consider sleeve protectors or waterproof coverall. Change uniforms post conveyance</td>
<td>Whilst in contact with reservoir</td>
<td>Remove all linen and waste Access specialist cleaning through OSD. Isolate vehicle to contain infestation.</td>
</tr>
<tr>
<td>Disease/Infection</td>
<td>Incubation Period</td>
<td>Route of Spread</td>
<td>Prevention of Spread</td>
<td>Duration of Precautions</td>
<td>Vehicle Cleaning Requirements</td>
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<tr>
<td>Gastroenteritis</td>
<td>S. aureus 30mins-8hrs usually 2-4hrs Salmonella 6-72hrs Campylobacter 2-5 days Shigella 1-3 days E. Coli 0157 2-8 days</td>
<td>Faecal / oral route. Can be airborne if patient is projectile vomiting.</td>
<td>Single patient transport for duration of precautions Hand decontamination – hand wipes followed by alcohol gel. Soap and water when available. Apron and gloves for direct contact with and disposal of body fluids. Consider use of sleeve protectors Facemasks and eye protection when if patient is actively vomiting (especially during transportation) NB. Staff must be 48 hours symptom free before returning to work</td>
<td>Until symptom free for 48 hrs</td>
<td>Symptomatic during conveyance - deep clean required Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces) Spill pack must be used on any blood or body fluid spill.</td>
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</table>
| Gastroenteritis Viral Small round structured viruses (e.g. Norwalk / Norovirus) | 12-72hrs | Faecal/oral | Single patient transport for duration of precautions Hand decontamination – hand wipes followed by alcohol gel. Soap and water when available. Alcohol hand gel is not effective against diarrhoea infections Apron and gloves for direct contact with and disposal of body fluids. Consider use of sleeve protectors Facemasks and eye protection when if patient is actively vomiting (especially during transportation) **NB. Staff must be 48 hours symptom free before returning to work** | From onset of illness until 48hrs after last symptoms | **Symptomatic during conveyance - deep clean required**
| **Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)** | | | | | Spill pack must be used on any blood or body fluid spill. |

Infection Prevention Control and Decontamination Policy
<table>
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<tr>
<th>Condition</th>
<th>Incubation Period</th>
<th>Mode of Transmission</th>
<th>Precautions</th>
<th>Duration of Infectious Phase</th>
<th>Environmental Cleaning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Giardia enteritis</strong></td>
<td>Usually 3-25 days</td>
<td>Ingestion of contaminated food or water, Faecal/oral route</td>
<td><strong>Single patient transport for duration of precautions</strong>&lt;br&gt;Hand decontamination – hand wipes followed by alcohol gel. Soap and water when available. Alcohol hand gel is not effective against diarrhoeal infections&lt;br&gt;Apron and gloves for direct contact with and disposal of body fluids. Consider use of sleeve protectors</td>
<td>Duration of enteric symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)&lt;br&gt;&lt;br&gt;<strong>If symptomatic</strong> during transportation as an extra precaution the floor needs to be mopped with a chlorine based solution</td>
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<tr>
<td><strong>Gonococcal conjunctivitis (Ophthalmia neonatorum)</strong></td>
<td>Usually 1-5 days</td>
<td>Contact with conjunctival discharge</td>
<td><strong>Isolation for first 24 hrs after administration of effective therapy</strong>&lt;br&gt;Apron and gloves for direct contact with and disposal of body fluids.&lt;br&gt;Hand decontamination</td>
<td>Until 24 hrs of specific treatment</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
<td>Hand, foot and mouth disease (viral)</td>
<td>3-5 days</td>
<td>Respiratory tract secretions and faeces</td>
<td>Apron and gloves for direct contact with and disposal of body fluids. Staff and patient hand washing</td>
<td>10–14 days after onset of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
<td>Hepatitis A</td>
<td>15-50 days Average of 28 days</td>
<td>Faecal/oral Ingestion of contaminated food or water</td>
<td>Single patient transport for duration of precautions Gloves and aprons for contact with blood and body fluids Hand decontamination Vaccination is available for high risk staff (HART) and is offered as travel vaccination to some destinations</td>
<td>Until 1 week after onset of jaundice</td>
<td>If symptomatic during transportation as an extra precaution the floor needs to be mopped with a chlorine based solution</td>
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<td>Hepatitis B and C</td>
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<td>Blood to blood contact and per mucosal exposure to infective body fluids</td>
<td>Follow up inoculation injuries immediately</td>
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<td>Excessive blood soiling of vehicle during conveyance - deep clean required</td>
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<td>Hep B</td>
<td>Vertical transmission from mother to baby</td>
<td>Gloves and aprons for contact with blood and body fluids and when undertaking invasive procedures.</td>
<td>Whilst viral load is high the patient is infective.</td>
<td>Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)</td>
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<td>Usually 45-180 days</td>
<td>Risk of transmission through sexual contact (risk is higher with Hep B)</td>
<td>Hepatitis B vaccination is available to all staff and is strongly encouraged</td>
<td>Regular blood tests are required to monitor viral load</td>
<td>Spill pack must be used on any blood or body fluid spill.</td>
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<td>Hep C.</td>
<td>from 2 weeks – 6 months</td>
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<tr>
<td>Herpes simplex</td>
<td>2-12 days</td>
<td>Contact with saliva and fluid from lesions.</td>
<td>Single patient transport for duration of precautions</td>
<td>Until lesions are dried. Contagious when vesicles are ‘wet’</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td>Personal contact with another.</td>
<td>Gloves and aprons for contact with secretions</td>
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<tr>
<td>Human immuno-deficiency virus (HIV)</td>
<td>Long silent period with no symptoms</td>
<td>Direct contact to blood and body fluids. Inoculation or contamination injuries Sexually transmitted</td>
<td>Gloves and aprons for contact with blood and body fluids and when undertaking invasive procedures. Follow up inoculation injuries immediately.</td>
<td>Lifelong</td>
<td>Excessive blood soiling of vehicle during conveyance - deep clean required</td>
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<td></td>
<td>Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)</td>
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<td>Spill pack must be used on any blood or body fluid spill.</td>
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<tr>
<td>Impetigo</td>
<td>Variable</td>
<td>Direct contact with exudate from skin lesions or indirect contact through contaminated items</td>
<td>Single patient transport for duration of precautions Gloves and aprons for contact with secretions Hand decontamination</td>
<td>Until lesions are dried Healthcare workers can normally return to work 48 hours after they commence treatment</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>DISEASE/INFECTION</td>
<td>INCUBATION PERIOD</td>
<td>ROUTE OF SPREAD</td>
<td>PREVENTION OF SPREAD</td>
<td>DURATION OF PRECAUTIONS</td>
<td>VEHICLE CLEANING REQUIREMENTS</td>
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<tr>
<td>Influenza</td>
<td>24-72 hours</td>
<td>Highly transmissible</td>
<td>Single patient transport for duration of precautions</td>
<td>Duration of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
<td></td>
<td></td>
<td>Respiratory droplets via the airborne route.</td>
<td>Apron and gloves for direct contact with and disposal of body fluids. Consider use of sleeve protectors</td>
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<td></td>
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<td>Indirect contact through contaminated items</td>
<td>Facemasks and eye protection if patient is unable to use a tissue to catch coughs and sneezes. FFP3 mask required for airway management.</td>
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<td></td>
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<td>Can request that patient wears a mask.</td>
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<tr>
<td>Legionnaire's disease</td>
<td>2-19 days Average 6 – 7 days</td>
<td>Inhalation of aerosolised bacteria from a contaminated water source</td>
<td>Apron and gloves for direct contact with and disposal of body fluids.</td>
<td>No evidence of person to person spread</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
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<tr>
<td>Malaria</td>
<td>7 – 30 days although can be years</td>
<td>Parasitic disease – spread via infected female <em>Anopheles</em> mosquito</td>
<td>No direct transmission person to person – transmission by transfusion/inoculation is possible</td>
<td>Duration of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>Middle East Respiratory Syndrome Coronavirus</td>
<td>Up to 14 days</td>
<td>Large respiratory droplets. Detected in blood, faeces and urine. Airborne transmission through aerosol generating procedures</td>
<td><strong>Single patient transport for duration of precautions</strong>&lt;br&gt;Hand decontamination&lt;br&gt;Coveralls, gloves, FFP3 respiratory masks and eye protection required for patient contact.</td>
<td>24 hours after last symptoms</td>
<td>Vehicle should be aired for 20 minutes then vehicle and equipment cleaned with detergent/disinfectant wipe. Vehicle will then require a deep clean with sodium chlorine based cleaning solution.</td>
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</table>
| Measles           | From 7 to 18 days from exposure to onset of symptoms (normally 10 days) usually 14 days until rash appears | Measles virus is highly communicable. Respiratory from airborne droplets or indirect contact from contaminated items. | Single patient transport for duration of precautions
Gloves and apron for patient contact.
FFP3 facemasks are required if the patient has cold symptoms or if staff immunity is unknown.
Request that patient wears a mask if they are unable to catch coughs and sneezes in a tissue
Hand decontamination
**Non-immune Staff contacts should be referred to OH next working day.**
MMR vaccination can be given as post exposure prophylaxis within 72 hours of exposure for non-immune contacts. | On suspicion of measles until at least 4 days after onset of rash | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
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<tbody>
<tr>
<td>Meningitis</td>
<td>2 to 10 days (commonly 3-4 days)</td>
<td>Direct contact with oral/nasal secretions. Large particle respiratory droplets</td>
<td>Single patient transport for duration of precautions&lt;br&gt;Gloves and apron for patient contact.&lt;br&gt;Staff to wear FFP3 facemask for close contact during suctioning or intubation.&lt;br&gt;Eye protection (exposure of eyes to respiratory droplets can cause meningococcal conjunctivitis)&lt;br&gt;Hand decontamination&lt;br&gt;Staff whom have had direct contact with secretions should contact OH for advice regarding antibiotic prophylaxis</td>
<td>Onset of acute illness until 48 hours of appropriate antibiotic treatment given</td>
<td>Extensive body fluid contamination during conveyance - deep clean required&lt;br&gt;No body fluid contamination during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)&lt;br&gt;Spill pack must be used on any blood or body fluid spill.</td>
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**Viral Meningitis**
Can be caused by a variety of viral infections

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<th>VEHICLE CLEANING REQUIREMENTS</th>
</tr>
</thead>
</table>
| Viral Meningitis  | Dependent on the virus concerned | Direct contact with oral/nasal secretions. Large particle respiratory droplets | Single patient transport for duration of precautions  
Gloves and apron for patient contact.  
Staff to wear an FFP3 facemask for close contact during suctioning or intubation.  
Eye protection (exposure of eyes to respiratory droplets can cause meningococcal conjunctivitis)  
Hand decontamination | Onset of acute illness | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
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<tbody>
<tr>
<td>Methicillin Resistant Staphylococcus Aureus (MRSA)</td>
<td>4 – 10 days</td>
<td>Direct and indirect contact</td>
<td>The patient should be transported singly if they or any other patient scheduled to travel with them has an open wound, catheter or intravenous cannula. Plastic apron and gloves for direct patient contact. Hand decontamination</td>
<td>Duration of infection or colonisation</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<tr>
<td>DISEASE/INFECTION</td>
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</table>
| Mumps             | 15-18 days       | Direct contact with saliva or droplets of saliva from an infected person | Single patient transport for duration of precautions  
Gloves and apron for patient contact.  
FFP3 facemasks are required if the patient has cold symptoms or if staff immunity is unknown.  
Request that patient wears a mask if they are unable to catch coughs and sneezes in a tissue  
Hand decontamination  
Non immune staff contacts should be referred to OH | 7 days before until 9 days after onset of parotitis | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
<table>
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<tr>
<td>NDM-1 and carbapenem resistance organisms (CRO/CPE/CRE)</td>
<td>Patient may be infected or colonised</td>
<td>Main infection source: Urine, sputum, wound secretions</td>
<td>The patient should be transported singly if they or any other patient scheduled to travel with them has an open wound, catheter or intravenous cannula. Gloves and apron for patient contact. Hand decontamination</td>
<td>Duration of infection or colonisation</td>
<td>Body fluid soiling of vehicle during conveyance - deep clean required</td>
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<tr>
<td>Antibiotic resistant strain of bacteria</td>
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<td></td>
<td>Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces) Spill pack must be used on any blood or body fluid spill.</td>
</tr>
<tr>
<td>Carbapenems are a powerful group of broad spectrum beta-lactam (penicillin-related) antibiotics which, in many cases, are our last effective defense against multi-resistant bacterial infections.</td>
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<tr>
<td>Necrotising fasciitis may be caused by various bacteria</td>
<td>1 – 5 days</td>
<td>Direct contact with wound exudate or indirect contact through contaminated surfaces</td>
<td>Single patient transport for duration of precautions Gloves and apron for patient contact. Hand decontamination</td>
<td>Infection treated</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>DISEASE/INFECTION</td>
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</table>
| Parvovirus        | 4-20 days         | Direct contact with respiratory secretions | Single patient transport for duration of precautions  
Can be passed from mother to foetus.  
Pregnant staff should seek advice from OH Services  
Gloves and apron for patient contact.  
FFP3 facemasks are required for airway management or a surgical facemask if the patient is unable to contain respiratory secretions in a tissue | Communicability greatest before onset of rash – up to 1 week after onset of symptoms.  
Common in children | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |

'.slapped face' appearance on the cheek is usual.
<table>
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<tr>
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<tbody>
<tr>
<td>Pinworm/Threadworm (Enterobiasis) Peri-anal itching.</td>
<td>As long as eggs are deposited on the perianal skin.</td>
<td>Faecal-oral&lt;br&gt;Direct contact with infective eggs by hand contact.&lt;br&gt;Indirect contact through contaminated clothing and items</td>
<td>Educate patient on good personal hygiene and to Shower every day&lt;br&gt;Eggs can remain infective on bed linen and clothing and need to be decontaminated.&lt;br&gt;Gloves and aprons for patient contact&lt;br&gt;Hand decontamination</td>
<td>Duration of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>Plague</td>
<td>1 to 6 days&lt;br&gt;Normally 1 – 3 days</td>
<td>Bites from infected fleas&lt;br&gt;Direct contact with infected blood or bodily fluids&lt;br&gt;Inhalation of respiratory droplets</td>
<td>Single patient transportation for duration of precautions&lt;br&gt;Gloves and apron for patient contact.&lt;br&gt;FFP3 facemasks are required for airway management or a surgical facemask if the patient is unable to contain respiratory secretions in a tissue</td>
<td>2 days after the fever has subsided</td>
<td>Symptomatic during conveyance - deep clean required&lt;br&gt;Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)&lt;br&gt;Spill pack must be used on any blood or body fluid spill.</td>
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<td>DISEASE/INFECTION</td>
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<tr>
<td>Psittacosis 'parrot fever'</td>
<td>7-28 days</td>
<td>Inhalation of secretions and dust from infected birds.</td>
<td>Single patient transport for duration of precautions&lt;br&gt;&lt;br&gt;Patients with a cough should be requested to cough into a tissue, if they are unable to cough into a tissue, ask the patient if they can wear a facemask. If not consider wearing a facemask&lt;br&gt;&lt;br&gt;Gloves and aprons for patient contact&lt;br&gt;&lt;br&gt;Hand decontamination</td>
<td>Duration of symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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# Infection Prevention Control and Decontamination Policy

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</table>
| Pyrexia of unknown origin associated with recent foreign travel | Various | Inoculation/Pharyngeal secretions | Strict Isolation, Single patient transport for duration of precautions  
No blood and body fluids – gloves and aprons for patient contact.  
Blood and body fluids – waterproof coverall, apron, facemask, eye protection and gloves.  
Hand decontamination  
Inform ED Immediately | Whilst symptoms persist or non-infective diagnosis confirmed | Extensive body fluid contamination during conveyance - deep clean required  
No body fluid contamination during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)  
Spill pack must be used on any blood or body fluid spill. |
| Q (Query) Fever Flu-like illness with fever | 2 – 3 weeks. | Inhalation of infected dust or exposure to amniotic fluid or placenta | No isolation procedures required  
Special obstetric precautions are required for pregnant patients as products of conception may be infectious  
Gloves and aprons for contact with body fluids.  
Hand decontamination | Duration of symptoms | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
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<tbody>
<tr>
<td>Respiratory syncytial virus (RSV)</td>
<td>1-10 days</td>
<td>Direct contact with droplets from respiratory secretions</td>
<td>Single patient transport for duration of precautions</td>
<td>Duration of active symptoms</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td>Patients with a cough should be requested to cough into a tissue, if they are unable to cough into a tissue, ask the patient if they can wear a facemask. If not consider wearing a facemask</td>
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<td></td>
<td>Gloves and aprons for contact with respiratory secretions</td>
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<td>Hand decontamination</td>
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<tr>
<td>Ringworm (Fungal skin or scalp infection - Tinea)</td>
<td>4-10 days</td>
<td>Direct contact with lesions or indirect contact with contaminated equipment</td>
<td>No isolation procedures required.</td>
<td>Until treatment has commenced</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td></td>
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<td></td>
<td>Gloves and aprons for contact with lesions.</td>
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<td>Hand decontamination</td>
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<td>Rubella (German Measles)</td>
<td>14-21 days</td>
<td>Direct contact and respiratory droplet spread</td>
<td>Single patient transport for duration of precautions&lt;br&gt; Gloves and aprons for patient contact.&lt;br&gt; FFP3 facemasks are required if the patient is actively coughing.&lt;br&gt; Hand decontamination.&lt;br&gt; All female staff in contact with patient must be known to be immune; all staff likely to be dealing with pregnant patients should be immune.</td>
<td>For one week before and at least 4 days after onset of rash</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td><strong>Salmonella</strong></td>
<td>6 – 72 hours</td>
<td>Faecal-oral route</td>
<td>Single patient transport for duration of precautions</td>
<td>Until 48 hours symptom free</td>
<td>Symptomatic during conveyance - deep clean required</td>
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<tr>
<td>(Food poisoning / gastroenteritis)</td>
<td></td>
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<td>Gloves and aprons for all contact with patient and body fluids.</td>
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<td>Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)</td>
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<td></td>
<td>Hand decontamination</td>
<td></td>
<td>Spill pack must be used on any blood or body fluid spill.</td>
</tr>
<tr>
<td><strong>Scabies</strong></td>
<td>Up to 8 weeks before onset of itching.</td>
<td>Prolonged skin to skin contact.</td>
<td>Gloves and apron for all contact consider waterproof coverall or sleeve protectors to offer further protection.</td>
<td>Until mites and eggs destroyed by treatment</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
<tr>
<td>Classical / Norwegian</td>
<td>4 days for previously exposed individuals</td>
<td>Indirect contact through contaminated clothing/bed linen</td>
<td>Hand decontamination</td>
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<td>Contact OH / GP if itching up to 6 weeks following contact</td>
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| Scarlet Fever     | Up to 1 week (Average 2 – 5 days) | Droplet spread via respiratory secretions | Single patient transport for duration of precautions  
If patient is coughing request they cough into a tissue, if they are unable to, consider facemask for patient.  
Gloves and aprons for direct patient contact and contact with respiratory secretions.  
Hand decontamination | If treated - 48 hrs  
If untreated - 10-21 days | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
### Shingles (Varicella zoster)

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<td></td>
<td>Can be many years</td>
<td>Contact with vesicle fluid from skin lesions</td>
<td>Single patient transport for duration of precautions</td>
<td>Until lesions are dried.</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
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<td>(it is a reactivation of the chicken pox virus in someone previously infected)</td>
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<td>Gloves and aprons for direct patient contact and contact with lesions.</td>
<td>Usually up to one week</td>
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<td>Hand decontamination</td>
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<td></td>
<td>Staff not immune to chicken pox must avoid contact with infective lesions</td>
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</tbody>
</table>
**DISEASE/INFECTION** | **INCUBATION PERIOD** | **ROUTE OF SPREAD** | **PREVENTION OF SPREAD** | **DURATION OF PRECAUTIONS** | **VEHICLE CLEANING REQUIREMENTS**
--- | --- | --- | --- | --- | ---
Small pox  
Patients to be transferred to centre with specialist isolation facilities. | 7-19 days | Respiratory droplets from oropharyngeal lesions | Single patient transport for duration of precautions  
Inform ED and discuss with command structure immediately.  
Gloves, waterproof coveralls, apron, FFP3 facemask and eye protection/visor are required for any patient contact.  
Transfer of patient to specialist centre should be undertaken by the HART team | From onset of illness to disappearance of all scales | Deep clean required.
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<td>Streptococcus Group A (Necrotising fasciitis, GAS gangrene, impetigo)</td>
<td>1-3 days</td>
<td>Respiratory droplets. Exudate. Direct contact with infected lesions</td>
<td>Single patient transport for duration of precautions&lt;br&gt;Facemask and visor or eye protection required for contact with patient with respiratory symptoms.&lt;br&gt;Gloves and aprons for direct patient contact&lt;br&gt;Hand decontamination</td>
<td>For 48 hrs after commencement of appropriate antibiotics for sore throats.&lt;br&gt;For skin infections – until condition improves or negative swab obtained</td>
<td>Extensive body fluid contamination during conveyance - deep clean required&lt;br&gt;No body fluid contamination during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)&lt;br&gt;Spill pack must be used on any blood or body fluid spill.</td>
</tr>
</tbody>
</table>
### Infection Prevention Control and Decontamination Policy

**TB - Open**

<table>
<thead>
<tr>
<th>DISEASE/INFECTION</th>
<th>INCUBATION PERIOD</th>
<th>ROUTE OF SPREAD</th>
<th>PREVENTION OF SPREAD</th>
<th>DURATION OF PRECAUTIONS</th>
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<tr>
<td>Pulmonary Tuberculosis and Multi Drug Resistant Pulmonary Tuberculosis In the lungs</td>
<td>Variable Normally 2 – 10 weeks</td>
<td>Respiratory droplets, prolonged close contact (more than 8 hours) with an infective case</td>
<td>Single patient transport for duration of precautions, FFP3 facemask for airway management procedures, Request that patient catches coughs in a tissue, patient to wear facemask if in public/patient areas, Gloves and aprons for contact with respiratory secretions, Vaccination is available to staff.</td>
<td>Whilst viable tubercle bacilli are discharged in the sputum or during the first 2 weeks of treatment</td>
</tr>
</tbody>
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**TB - Closed**

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<td>i.e. within a closed body cavity not the lungs</td>
<td>2-10 weeks</td>
<td>Generally not communicable unless cavity is drained</td>
<td>Hand decontamination</td>
<td>A normal between patient clean with vehicle based wipes (all surfaces and equipment)</td>
</tr>
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**Infection Prevention Control and Decontamination Policy**

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**South Central Ambulance Service**

**NHS**

**NHS Foundation Trust**
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| Typhoid           | 7 – 14 days but can be up to 1 month. | Faecal-oral route contaminated food and water | Single patient transport for duration of precautions  
Gloves and aprons for direct contact with body fluids.  
Hand decontamination | Until 3 negative stool specimens taken 48 hours after antibiotics stopped | Symptomatic during conveyance - deep clean required  
Non-symptomatic during conveyance - a normal between patient clean with vehicle based wipes (all surfaces)  
Spill pack must be used on any blood or body fluid spill. |
| Undiagnosed rash  | Various | Dependent on diagnosis | Single patient transport for duration of precautions  
Gloves and apron for direct patient contact.  
Hand decontamination | Whilst symptoms persist or a non-infective diagnosis confirmed | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |
### Infection Prevention Control and Decontamination Policy

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| Viral Haemorrhagic Disease  
Congo Fever  
Lassa Fever  
Ebola | 3-21 days | Direct contact with the blood or body fluids from an infected person. | Strict Isolation, Single patient transport for duration of precautions  
FOLLOW CLINICAL NOTICE  
Escalate to Senior Clinical Advisor On Call and NILO immediately. Crew briefed regarding levels of risk and PPE required.  
Inform ED Immediately  
Transfer to specialist centres are undertaken by the HART team | Whilst virus present in blood and secretions | Deep clean required – see deep clean procedure for Viral Haemorrhagic Disease  
Spill pack must be used on any blood or body fluid spill. |
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| Whooping cough     | 7-20 days         | Direct contact with respiratory secretions | Single patient transport for duration of precautions  
If patient is coughing request they cough into a tissue, if they are unable to, consider facemask for patient.  
Gloves and aprons for direct patient contact and contact with respiratory secretions.  
Hand decontamination  
Vaccination is available; if non immune staff are exposed discuss vaccination or PEP with OH. | If treated - 5 days after onset of appropriate therapy  
If untreated until 3 weeks after onset of catarrhal stage | A normal between patient clean with vehicle based wipes (all surfaces and equipment) |