Shropshire Community Health
NHS Trust

Document Details	
Title	Standard Infection control Precautions (SICP) Policy
Trust Ref No	1081-81987
Local Ref (optional)	
Main points the document covers	Guidance for staff on the implementation of Standard Infection Control Precautions including hand hygiene, PPE to minimise the risk of transmission of infection between patients, staff, and visitors
Who is the document aimed at?	All SCHT staff
Author	Associate Director of Infection Prevention and Control
Approval process	
Who has been consulted in the development of this policy?	This policy has been developed by the IPC team in consultation with appropriate senior Operations and Quality managers, Locality Clinical Managers, Specialist Nurses, Medicines Management and Public Health England
Approved by (Committee/Director)	Infection Prevention and Control Committee
Approval Date	27 April 2023
Initial Equality Impact Screening	Yes
Full Equality Impact Assessment	N/A
Lead Director	Director of Nursing and Allied Health Professionals Director for Infection Prevention and Control
Category	Clinical
Sub Category	Infection Prevention and Control
Review date	April 2026
Distribution	
Who the policy will be distributed to	IPC Operational Group Meeting Members
Method	Electronically to IPC Operational Group Meeting Members and available to all staff via the Trust website
Document Links	
Required by CQC	Yes
Keywords	Standard Precautions, hand hygiene, gloves, gloving, gowning, surgical scrubbing, personal protective equipment, PPE

Amendments History		
No	Date	Amendment
1	December 2021	Updates on PPE: use of gowns, aprons, surgical masks and eye protection. Added flowchart for management of blood and body fluid spills
2	April 2023	Updated policy following V2.3 and V2.4 updates to National IPC manual for England

Contents

1 Introduction

Standard Infection Prevention and Control Precautions (SICP) are the basic infection prevention practices that when used consistently reduce the transmission of potentially pathogenic organisms from both recognised and unrecognised sources. Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

Implementation of these precautions results in a reduction in prevalence of Healthcare Associated infections; ultimately protecting patients, staff and visitors.

Shropshire Community Healthcare NHS Trust delivers healthcare in a variety of inpatient and community locations and this policy provides information for all staff on the practices they must use to achieve safe carer regardless of the setting.

2 Purpose

The purpose of this policy is to provide all staff employed by the trust with the guidance use of SICPs to prevent healthcare associated infections by thus protecting patients, staff and visitors.

3 Scope

The contents of this policy apply to any setting where clinical care is provided including inpatient settings, clinics and people's homes.

4 Definitions

Term / Abbreviation	Explanation / Definition
ABHR	Alcohol based hand rub
Body fluids	Any fluid found in, produced by, or excreted from the human body which includes blood, blood-stained fluid, urine, faeces, saliva, tears, breast milk, cerebrospinal fluid (CSF), semen, vaginal fluid, amniotic fluid, peritoneal fluid, bile, digestive juices, vomit, pus, other infected discharges and serous fluid.
EN	European Committee for Standardisation
IPC	Infection Prevention and Control
MRSA	Meticillin Resistant *Staphylococcus aureus*
PPE	Personal Protective Equipment. Equipment that must be worn by all Heath Care staff, including gloves, aprons and face protection, to protect patients and themselves from the risk of infections and transfer of micro-organisms
RCA	Root Cause Analysis
SICPs	Standard infection control precautions
UKHSA	UK Health Security Agency
WHO	World Health Organisation

5 Duties

5.1 Responsibility for Infection Prevention and Control (IPC) outside the immediate scope of this policy

For duties and responsibilities for IPC practices outside the specific scope of this policy, please refer to the IPC Arrangements and Responsibilities Policy on the Staff Zone SCHT Staff Zone (shropcom.nhs.uk).

5.2 IPC Duties specific to this policy

Clinical staff responsible for assessing of patient on admission / commencement of care.

IPC Team to provide advice on:

- assessment of infection or transmission risk
- applying IPC precautions in the context of the care environment
- support training in standard precautions

6 Content

The Policy of this Trust is to follow the guidance for SICP outlined in the national infection Prevention and Control Manual for England: NHS England » Chapter 1: Standard infection control precautions (SICPs)

SICP consist of ten key elements including:

1. patient placement/assessment of infection risk
2. hand hygiene
3. respiratory and cough hygiene
4. personal protective equipment
5. safe management of the care environment
6. safe management of care equipment
7. safe management of healthcare linen
8. safe management of blood and body fluids
9. safe disposal of waste (including sharps)
10. occupational safety/managing prevention of exposure (including sharps)

Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

The application of SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To protect effectively against infection risks, the following SICPs must be used consistently by all staff.

7 The Ten Elements of SICPs

7.1 Patient placement and the assessment of risk

Patients must be promptly assessed for infection risk on arrival at the care area, in both inpatient and outpatient settings using the trusts assessment documentation.

If an inpatient, the assessment should be continuously reviewed and documented.

This assessment informs where the patient is to be placed (e.g.in a single room or bay).

If a patient presents:

- with diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms

- known to have been previously positive with a multi-drug resistant organism (MDRO), e.g. MRSA, CPE
- or are a known epidemiological link to a carrier of CPE or other significant or recent transmissible condition or organism

there is a risk of cross infection, and the patient is likely to require placement within a single room. If advice is required, contact the IPC Team.

7.2 Hand hygiene

Hand hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause healthcare associated infections (HAIs).

Clinical hand-wash basins must:

- be used for that purpose only and not used for the disposal of other liquids
- have mixer taps, no overflow or plug and be in a good state of repair
- have wall mounted liquid soap and paper towel dispensers.

Hand hygiene facilities should include instructional posters.

7.2.1 Before performing hand hygiene:

- expose forearms (bare below the elbow)
- remove all hand and wrist jewellery. The wearing of a single, plain metal finger ring, e.g. a wedding band, is permitted but should be removed (or moved up the finger to allow the skin under the ring to be cleaned) during hand hygiene. A religious bangle can be worn but should be moved up the forearm during hand hygiene and secured during patient care activities
- ensure fingernails are clean and short, and do not wear artificial nails or nail products
- cover all cuts or abrasions with a waterproof dressing.

7.2.2 To perform hand hygiene:

Wash hands with non-antimicrobial liquid soap and water if:

- hands are visibly soiled or dirty
- caring for patients with vomiting or diarrhoeal illnesses
- caring for a patient with a suspected or known gastrointestinal infection, e.g. norovirus or a spore-forming organism such as *Clostridioides difficile*.

In all other circumstances, use alcohol-based handrubs (ABHRs) for routine hand hygiene during care.

ABHRs must be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used, e.g. within the community, domiciliary care, mental health units etc.

Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

7.2.3 Perform hand hygiene:

- before touching a patient
- before clean or aseptic procedures
- after body fluid exposure risk
- after touching a patient; and

- after touching a patient's immediate surroundings.

Always perform hand hygiene before putting on and after removing gloves.

For how to wash hands, see the step-by-step guide in appendix 1 of this document.

For how to hand rub, see the step-by-step guide in appendix 2 of this document.

For when to clean your hands see "your 5 moments" in appendix 3 of this document.

7.2.4 Skin care

- dry hands thoroughly after hand washing, using disposable paper towels
- use an emollient hand cream regularly e.g. during breaks and when off duty
- do not use or provide communal tubs of hand cream in the care setting
- staff with skin problems should seek advice from occupational health or their GP and depending on their skin condition and the severity may require additional interventions or reporting.

7.2.5 Surgical hand antisepsis

Surgical scrubbing/rubbing (this applies to those undertaking surgical and some invasive procedures):

- perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, e.g. before inserting central vascular access devices
- remove all hand and wrist jewellery (including wedding band)
- single-use nail brushes must only be used for decontaminating nails. Nail picks can be used if nails are visibly dirty
- use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label)
- ABHR can be used between surgical procedures if licensed for this use.

For surgical scrubbing (not rubbing), follow the step-by-step guide in 4 of this document.

For surgical rubbing (not scrubbing), follow the step-by-step guide in 5 of this document.

7.3 Respiratory and cough hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of known or suspected respiratory illness (pathogens):

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose, if unavailable use the crook of the arm
- dispose of all used tissues promptly into a waste bin
- wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions
- where there is no running water available or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first available opportunity
- keep contaminated hands away from the eyes nose and mouth.

Staff should promote respiratory and cough hygiene helping those (e.g. elderly, children) who need assistance with this, e.g. providing patients with tissues, plastic bags for used tissues and hand hygiene facilities as necessary.

7.4 Personal protective equipment (PPE)

Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear personal protective equipment (PPE) that protects adequately against the risks associated with the procedure. The principles of PPE use set out below are important to ensure that PPE is used correctly to ensure patient and staff safety. Avoiding overuse or inappropriate use of PPE is a key principle that ensures this is risk-based and minimizes its environmental impact. Where appropriate, consideration should be given to the environmental impact of sustainable or reusable PPE options versus single-use PPE while adhering to the principles below.

See appendix 4 as a guide to what PPE is required

See appendix 5 How to put on and remove PPE

7.4.1 All PPE

must be:

- located close to the point of use. PPE for healthcare professionals providing care in the community and domiciliary care providers must be transported in a clean receptacle
- stored to prevent contamination in a clean, dry area until required (expiry dates must be adhered to)
- single-use only unless specified by the manufacturer
- changed immediately after each patient and/or after completing a procedure or task
- disposed of after use into the correct waste stream, e.g. domestic waste, offensive (non-infectious) or clinical waste
- discarded if damaged or contaminated.

NB Reusable PPE such as non-disposable goggles/face shields/visors, must be decontaminated after each use according to manufacturer's instruction.

7.4.2 Gloves

must be:

- worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- changed immediately after each patient and/or after completing a procedure/task even on the same patient
- changed if a perforation or puncture is suspected
- appropriate for use, fit for purpose and well-fitting
- never decontaminated with ABHR or soap between use.
- sterile when worn in operating theatres and for insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of pulmonary artery catheters and spinal, epidural and caudal procedures
- low risk of causing sensitisation to the wearer
- appropriate for the tasks being undertaken, taking into account the substances being handled, type and duration of contact, size and comfort of the gloves, and the task and requirement for glove robustness and sensitivity.

NB Double gloving is **NOT** recommended for routine clinical care.

Gloves are **NOT** required to undertake near patient administrative tasks, e.g. when using the telephone, using a computer or tablet, writing in the patient chart, giving oral medications, distributing or collecting patient dietary trays.

7.4.3 Aprons

must be:

- worn to protect uniform or clothes when contamination is anticipated or likely, e.g. when in direct care contact with a patient.
- changed between patients and/or after completing a procedure or task.
- Green aprons should be worn for food handlers

7.4.4 Full body gowns or fluid-resistant coveralls

must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids,
- worn when a disposable apron provides inadequate cover for the procedure or task being performed
- changed between patients and removed immediately after completing a procedure or task
- sterile when worn in operating theatres and for insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of
- pulmonary artery catheters and spinal, epidural and caudal procedures.

7.4.5 Eye or face protection (including full-face visors)

must be:

- worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely and always during aerosol generating procedures; regular corrective spectacles are not considered eye protection
- not be impeded by accessories such as piercings or false eyelashes
- not be touched when being worn.

7.4.6 Fluid resistant surgical face masks (FRSM):

Surgical face masks are required:

- as a means of source control, e.g. to protect the patient from the wearer during pandemics of respiratory infection
- to protect the wearer when there is a risk splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa.

FRSM must be:

- worn (with eye protection) if a full-face visor is not available and spraying or splashing of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely (Type IIR)
- worn to protect patients from the operator as a source of infection, e.g. when performing surgical procedures or epidurals or inserting a central vascular catheter (CVC) (Type II (not classed as an FRSM) or Type IIR)
- well-fitting and fit for purpose, fully covering the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection)
- removed or changed:
    - at the end of a procedure/task
    - if the mask's integrity is breached, e.g. from moisture build-up after extended use or from gross contamination with blood or body fluids
    - in accordance with manufacturers' specific instructions.

7.4.7 Footwear

must be wipeable and:

- visibly clean, non-slip and well-maintained, and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps
- removed before leaving a care area where dedicated footwear is used, e.g. theatre or day surgery. These areas must have a footwear decontamination schedule with responsibility assigned.

7.5 Safe management of care equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery.

Care equipment is classified as either:

- single use: equipment which is used once on a single patient then discarded. This equipment must never be re-used. The packaging will carry the symbol of the number two in a circle with a diagonal cross

- single patient use: equipment which can be reused on the same patient and may require decontamination in-between use such as nebuliser masks
- reusable invasive equipment: used once then decontaminated, e.g. surgical instruments
- reusable non-invasive equipment: (often referred to as communal equipment) – reused on more than one patient following decontamination between each use, e.g. commode, patient transfer trolley.

NB Needles and syringes are single use devices, they should never be used more than once or reused to draw up additional medication. Never administer medications from a single-dose vial or intravenous (IV) bag to multiple patients.

Before using any sterile equipment check that:

- the packaging is intact
- there are no obvious signs of packaging contamination
- the expiry date remains valid
- any sterility indicators are consistent with the process being completed successfully.

Decontamination of reusable non-invasive care equipment must be undertaken:

- between each use/between patients
- after blood and/or body fluid contamination
- at regular predefined intervals as part of an equipment cleaning protocol
- before inspection, servicing or repair.

If providing domiciliary care, equipment should be transported safely and decontaminated as above before leaving the patient's home.

Always adhere to Control of Substances Hazardous to Health (COSHH) risk assessments and manufacturers' guidance for use and decontamination of all care equipment.

- all reusable non-invasive care equipment must be decontaminated between patients/clients using the Trust approved detergent wipes

- decontamination protocols must include responsibility for; frequency of; and method of environmental decontamination (see cleaning and disinfection policy).
- an equipment decontamination status certificate will be required if any item of equipment is being sent to a third party, e.g. for inspection, servicing or repair
- guidance should be sought from the Medical Devices Group and infection prevention and control team prior to procuring, trialling or lending any reusable non-invasive equipment
- medical devices and other care equipment must have evidence of planned preventative maintenance programmes. This is the responsibility of the Medical Device Asset (budget) Owner.

For decontamination of surgical instruments see HTM01-01 decontamination of surgical instruments.

7.6 Safe management of the care environment

The care environment must be:

- visibly clean, free from non-essential items and equipment to facilitate effective cleaning
- well maintained, in a good state of repair and with adequate ventilation.

Always adhere to COSHH risk assessments for product use and Trust processes for decontamination of the care environment in line with the National Standards of Healthcare Cleanliness 2021 B0271-national-standards-of-healthcare-cleanliness-2021.pdf (england.nhs.uk).

7.6.1 Routine cleaning

- the environment should be routinely cleaned in accordance with the National Cleaning Standards
- use of detergent wipes are acceptable for cleaning surfaces/frequently touched sites within the care area, unless during an outbreak. Trust Cleaning policy and the National Cleaning Standards on cleaning and disinfection during an Outbreak must be followed.
- a fresh solution of general-purpose neutral detergent in warm water is recommended for routine cleaning. This should be changed when dirty or when changing tasks
- routine disinfection of the environment is not recommended however, 1,000ppm available chlorine should be used **routinely** on sanitary fittings
- staff groups should be aware of their environmental cleaning schedules for their area and clear on their specific responsibilities
- cleaning protocols include responsibility for, frequency of, and method of environmental decontamination. This includes clinical staff who are responsible for patient care equipment and/or areas as well as domestic or hotel service staff.

See Cleaning policy - https://staffzone.shropcom.nhs.uk/smii/doclib/10286.pdf

7.7 Clean linen

See Trust's linen policy - https://staffzone.shropcom.nhs.uk/smii/doclib/10446.pdf

- should be stored in a clean, designated area, preferably an enclosed cupboard
- if clean linen is not stored in a cupboard, then the trolley used for storage must be designated solely for this purpose and completely covered with an impervious covering/or door that is able to withstand decontamination

- do not:
    - rinse, shake or sort linen on removal from beds/trolleys
    - place used linen on the floor or any other surfaces e.g. a locker/table top
    - re-handle used linen once bagged
    - overfill laundry receptacles (not more than two-thirds full); or
    - place inappropriate items in the laundry receptacle e.g. used equipment/needles.

Healthcare laundry must be managed and segregated in accordance with HTM 01-04 which categorises laundry as follows:

7.7.1 Used linen (previously known as soiled/fouled linen):

- ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit
- should be placed in an impermeable bag immediately on removal from the bed or before leaving a clinical department.

7.7.2 Infectious linen (this mainly applies to healthcare linen)

Infectious linen includes linen that has been used by a patient who is known or suspected to be infectious and/or linen that is contaminated with blood and/or other body fluids, e.g. faeces:

- linen in this category must not be sorted but should be sealed in a water soluble bag (entirely water soluble 'alginate' bag or impermeable bag with soluble seams), which is then placed in an impermeable bag immediately on removal from the bed and secured before leaving a clinical area
- infectious linen bags/receptacles must be tagged (e.g. hospital ward/care area) and dated
- store all used/infectious linen in a designated, safe, lockable area while awaiting uplift. Uplift schedules must be acceptable to the care area and there should be no build-up of linen receptacles
- all linen that is deemed unfit for re-use, e.g. torn or heavily contaminated, should be categorised at the point of use and returned to the laundry for assessment and disposal.

Linen used during patient transfer, e.g. blankets, should be categorised at the point of destination.

7.8 Safe management of blood and body fluid spillages

Spillages of blood and other body fluids may transmit blood borne viruses.

Spillages must be treated immediately by staff trained to undertake this safely.

Responsibilities for the treatment of blood/body fluid spills must be clear within each area/care setting.

For management of blood and body fluid spillages see Appendix 6.

7.9 Safe disposal of waste (including sharps)

See Trust policy for Waste - https://staffzone.shropcom.nhs.uk/smii/doclib/10636.pdf

Waste must be managed in the appropriate waste stream (see below)

Table identifying waste streams

Offensive (non-infectious)	Yellow bag with black stripe (tiger) bag
Clinical waste (infection only)	UN approved orange bag, UN approved box or sharps container
Healthcare waste contaminated with non-hazardous pharmaceuticals or chemicals)	UN approved yellow bag, UN approved box or sharps container
Waste contaminated with cytotoxic or cytostatic medication	UN approved purple bag, UN approved box or sharps container
Non-hazardous pharmaceuticals (no sharps)	Blue box/container
Anatomical waste/full blood bag and blood preserves	UN approved red lidded container
Domestic	Black/clear bags
Recycling	Clear, green or other colour bag

7.9.1 Safe waste disposal at care area level:

Always dispose of waste:

- immediately and as close to the point of use as possible; and
- into the correct segregated colour coded UN 3291 approved waste bag or container (rigid container or sharps box if sharp)
- In exceptional cases, if a large quantity of liquid waste, for example blood from a surgical theatre is to be disposed of, it must be rendered safe by adding a polymer gel or compound before placing in an orange lidded leak proof bin.
- waste bags must be no more than 3/4 full and no more than the UN approved weight; and use a ratchet tag/or tape (for healthcare waste bags only) using a ‘swan neck’ to close.
- store all waste in a designated, safe, lockable area while awaiting uplift. Uplift schedules must be acceptable to the care area and there should be no build-up of waste receptacles.
- local guidance on management of waste at care level, e.g. domiciliary settings should be followed.

7.9.2 Sharps containers (for safety devices, refer to section 7.10)

Sharps containers must:

- have a handle (small community boxes do not require a handle) and temporary closure mechanism, employed when box is not in use
- be disposed of when the manufacturers’ fill line is reached
- be labelled with point of origin and date of assembly and disposal.

7.10 Occupational safety: prevention of exposure (including sharps injuries)

The policy of the trust is to reduce all exposure to sharps and sharps injuries by abiding by The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013

There is a potential risk of transmission of a blood borne virus from a significant occupational exposure and staff must understand the actions they should take when a

significant occupational exposure incident takes place. **There is a legal requirement to report all sharps injuries and near misses to line managers/employers.**

A significant occupational exposure is:

- a percutaneous injury e.g. injuries from needles, instruments, bone fragments, or bites which break the skin; and/or
- exposure of broken skin (abrasions, cuts, eczema, etc); and/or
- exposure of mucous membranes including the eye from splashing of blood or other high risk body fluids.

For the management of an occupational exposure incident see Appendix 7. For full information see the Blood Borne Viruses Policy - First Aid of Needlestick Injury including management of patients.

7.10.1 Safety devices

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 are concerned with reducing and eliminating the number of 'sharps' related injuries which occur within healthcare. Its basic guidance is:

- avoid unnecessary use of sharps
- if use of medical sharps cannot be avoided, source and use a 'safer sharp' device
- if a safer sharp device is not available then safe procedures for working with and disposal must be in place e.g. sticky mats, sharps bins, safety procedures and training.

Sharps handling must be assessed, kept to a minimum and eliminated, if possible, with the use of approved safety devices.

- manufacturers' instructions for safe use and disposal must be followed
- needles must not be re-sheathed/recapped or disassembled after use
- sharps must not be passed directly hand to hand
- used sharps must be discarded at the point of use by the person generating the waste
- always dispose of needles and syringes as 1 unit
- if a safety device is being used safety mechanisms must be deployed before disposal.

When transporting sharps boxes for community use these must be transported safely with the use of temporary closures.

8 Consultation

This policy has been developed by the IPC team in consultation with appropriate Locality Clinical Managers, advisors/specialists (e.g., Medical Advisor, Specialist Nurses, Medicine Management), UKHSA and IPC Operational Group Meeting members.

A total of three weeks consultation period was allowed and comments incorporated as appropriate.

8.1 Approval Process

The IPC Operational Group Meeting members will review this policy and it will then be tabled at the IPC Committee for approval.

9 Dissemination and Implementation

This policy will be disseminated by the following methods:

- Managers informed via Datix who then confirm they have disseminated to staff as appropriate

- Staff – via Team Brief, digital Staff Noticeboard and IPC newsletters
- Awareness raising by the IPC team
- Published to the Staff Zone of the Trust website

The web version of this policy is the only version that is maintained. Any printed copies should therefore be viewed as 'uncontrolled' and as such, may not necessarily contain the latest updates and amendments. When superseded by another version, it will be archived for evidence in the electronic document library.

9.1 Advice

Individual Services' IPC Link staff act as a resource, role model and are a link between the IPC team and their own clinical area and should be contacted in the first instance if appropriate.

Further advice is readily available from the IPC team or the Consultant Microbiologist.

9.2 Training

Managers and service leads must ensure that all staff are familiar with this policy through IPC induction and update undertaken in their area of practice.

In accordance with the Trust's mandatory training policy and procedure the IPC team will support/deliver training associated with this policy. IPC training detailed in the core mandatory training programme includes Standard Infection Control Precautions and details regarding key IPC policies. Other staff may require additional role specific essential IPC training, as identified between staff, their managers and / or the IPC team as appropriate. The systems for planning, advertising and ensuring staff undertake training are detailed in the Mandatory Training Policy and procedure. Staff who fail to undertake training will be followed up according to the policy.

Further training needs may be identified through other management routes, including Clinical Case Review (CCR), Root Cause Analysis (RCA) and Post Infection review (PIR), following an incident/infection outbreak or following audit findings. Additional ad hoc targeted training sessions may be provided by the IPC team.

10 Monitoring Compliance

Reporting Audits of:

- Hand hygiene
- Decontamination of equipment
- Cleaning audits
- assessment documentation

RCAs and investigations following transmission of infection

11 References

12 Associated Documents

This policy should be read in conjunction with:

13 Appendices

Appendix 1. Best Practice - How to hand wash

Appendix 2. Best Practice - How to handrub

Appendix 3. 5 Moments

Appendix 4. PPE when applying SICPs

Appendix 5 Donning and Doffing PPE

Appendix 6 Management of blood and body fluid spills

Appendix 7 Management of Occupational Exposure to Blood Borne Viruses