



Registered Charity: 1092333

Hart First Response

Infection Prevention and Control Policy

Title: Infection Prevention and Control Policy
Filename: infection control_iss6
Pages: 21
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Approved by: HFR Executive Committee
Issue 3: 23/01/05; Issue 4: 04/06/06; Issue 5: 01/08/10; Issue 6: 01/04/11
Review Date: 01/04/14

1. Introduction

The aims of this policy are:

- 1.1. To minimise and prevent infection and ensure compliance with The Health and Social Care Act 2008, Code of Practice on the prevention and control of infections and related guidance, updated in 2010 with interpretation for independent sector ambulance providers.
- 1.2. To provide an infection prevention and control programme which includes procedures, advice, information, training and appropriate supervision for HFR volunteers (and others where relevant), particularly when providing care to patients, or other interactions with the public.
- 1.3. To provide an audit programme that ensures that key policies and practices are being implemented appropriately.
- 1.4. To provide policy on information sharing when referring, admitting, transferring, discharging and moving service users within and between health and adult social care facilities.

2. Responsibilities

- 2.1. The HFR **lead for infection prevention and control (IPCL)** is the Honorary Secretary, who is responsible for implementation of this policy. The IPCL's role is to:
 - 2.1.1. Be responsible for the HFR's infection prevention and control management and structure;
 - 2.1.2. Oversee local prevention and control of infection policies and their implementation for delivering a safe and clean care environment;
 - 2.1.3. Report directly to the HFR Executive Committee;
 - 2.1.4. Report, when appropriate to the local health protection unit of any outbreaks or serious incidents relating to infection.
 - 2.1.5. Have the authority to challenge inappropriate practice;
 - 2.1.6. Assess the impact of all existing and new policies on infections and make recommendations for change;
 - 2.1.7. Be an integral member of HFR's Executive Committee; and
 - 2.1.8. Produce an annual statement with regard to compliance with good practice on infection prevention and control (including: audits undertaken and actions, risk assessments, training and policy review) and make it available on request to the Care Quality Commission.
- 2.2. External Support and contact will be made initially to Fleet Medical Centre (01252 613327) for referral to NHS Hampshire and Hampshire County Council's Director of Public Health Dr Ruth Milton, or NHS Direct on 0845 4647 for advice. Emergency enquiries will be made directly to the Health Protection Agency: Infectious Disease: 020 8200 4400 or 020 8200 6868.
- 2.3. The **Officer In Charge (OIC)** at events is responsible for:
 - 2.3.1. Monitoring/observing HFR volunteers to ensure best practice is followed.



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- 2.3.2. Deciding if it is appropriate at an event to contact external organisations, whose contact details will be listed on the event sheet.
- 2.3.3. Providing, when required information on infection to other healthcare providers.
- 2.4. **HFR volunteers** must ensure that they follow this policy at all times, to ensure that they:
 - 2.4.1. Undertake their annual mandatory training on infection prevention and control.
 - 2.4.2. Carry and use the appropriate personal protective equipment, to protect them from any hazards they may encounter.
 - 2.4.3. Wash their hands before and after contact with patients. In preference with soap and hot/cold running water. If soap and water are not available, single-use towelettes (with detergent) may be used before an alcoholic handrub. Hands should then be washed with soap and running water at the first opportunity.
 - 2.4.4. Carefully check any equipment before and after use for any soiling, or damage and report it as soon as possible to the IPCL.
 - 2.4.5. Clean equipment appropriately after personal contact where relevant.
 - 2.4.6. Comply with "Bare Below the Elbows" as set out in this policy
 - 2.4.7. Use aseptic technique as appropriate
 - 2.4.8. Communicate with patients in an appropriate manner that ensures understanding and discussion of infectious issues and allows the sharing of relevant information to other healthcare providers when necessary.
 - 2.4.9. Dispose of clinical waste in an appropriate manner, according to local health and safety regulations.
 - 2.4.10. Ensure their Hepatitis B vaccinations are up-to-date and that the HFR Exec has an accurate record of this.
 - 2.4.11. Ensure that if they are part of the first crew of the month, they undertake the monthly ambulance dusting and complete the check-list.
 - 2.4.12. Remember: "If its wet and not yours, don't touch it!"

3. Prevention of Infection

There are a number of infectious diseases that are associated with healthcare (see appendix 3). Many infectious diseases are most transmissible as or just before symptoms start. Hand washing is a critically important measure that is often neglected by adults and children alike: in addition the use of a handkerchief or tissue to stop spread of respiratory secretions (coughing and sneezing) should be emphasised.

4. Diarrhoea and Vomiting

Any HFR volunteer who has had diarrhoea or vomiting in the last 48 hours must not attend training or any other HFR event in case they have norovirus.

5. Hand Washing

5.1. Hand washing is the single most effective means of reducing the spread of infection. Good hand washing should, therefore, be encouraged and practised by everyone.

5.2. When to encourage hand washing:

- Before and after: preparing, serving or eating food.
- After: going to the toilet.
- Before and after dealing with any patient.
- Handling sick people's clothing.
- Handling, stroking or being licked by animals.
- Contact with animal excreta.
- Cleaning pets' living and sleeping areas.
- After sneezing or coughing
- Contact with body fluid substances (urine, faeces, vomit, sputum, or blood).

5.3. How to encourage hand washing:



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- 5.3.1. Ideally warm water, soap and disposable towels should be available in all toilets.
- 5.3.2. At events cold water, soap and disposable towels should be available in all toilets.
- 5.3.3. All first aid kits and ambulances must have appropriate hand gel for "dry" handwashing. This will be a surgical hand gel, follow instructions on the bottle.

5.4. Effective Hand washing (see appendix 2)

- 5.4.1. Hands should be wet under running water before applying soap
- 5.4.2. Hands should be washed vigorously for 15-30 seconds (or the time it takes to sing the nursery rhyme 'Jack and Jill').
- 5.4.3. Particular attention should be paid to thumbs, finger nails and between fingers.
- 5.4.4. Hands should be dried thoroughly after washing.
- 5.4.5. Don't use excess soap as this can cause sore skin.
- 5.4.6. Don't use excessively hot or cold (if possible) water.
- 5.4.7. Don't wash for longer than 1 minute.
- 5.4.8. Volunteers are encouraged to apply an emollient hand cream regularly to protect skin from the drying effects of regular hand decontamination.

5.5. Five Moments of hand hygiene at the point of care (National Patient Safety Agency - NPSA)

- 5.5.1. Before patient contact
- 5.5.2. Before a clean/aseptic procedure
- 5.5.3. After body fluid exposure risk
- 5.5.4. After patient contact
- 5.5.5. After contact with patient surroundings (bedding, clothing, uniform, ambulance)

6. Modified Aseptic (Clean) Technique

- 6.1. Aseptic technique must be used for any medical invasive procedure that breaches the skin or mucous membranes.
- 6.2. A modified aseptic, clean technique will be used for procedures such as wound cleaning and dressing.
- 6.3. Volunteers will be trained and demonstrate proficiency (against the competencies in appendix) before being allowed to undertake these procedures independently.
- 6.4. The modified aseptic, clean technique should be performed as follows:
- 6.5. Ensure that all equipment required is ready and that a clean area on which to place it is available.
- 6.6. Explain the procedure to the patient and obtain their verbal consent.
- 6.7. Position the patient so that the procedure can be performed easily
- 6.8. Position the clinical waste bag so that it is easily accessible
- 6.9. Wash hands and disinfect with alcohol handgel
- 6.10. If direct contact with blood or body fluid is anticipated, gloves must be worn
- 6.11. Use sterile swabs and saline to clean the site and apply a sterile dressing
- 6.12. It is acceptable to use non sterile gloves and tap water (suitable for drinking) for irrigation of traumatic wounds.
- 6.13. Avoid touching any clean area whilst performing the procedure.
- 6.14. On completion of the procedure, all clinical waste must be disposed of into a clinical waste bag. This includes gloves and aprons
- 6.15. Effective hand hygiene must be implemented.

7. Blood Borne Viruses (BBVs) prevention and management of exposure

- 7.1. Hepatitis B, Hepatitis C and HIV infections are among the important viral infections that can be spread by blood in the UK.
- 7.2. It is important to think about the mechanism of transmission of these diseases when considering activities and the risk of disease spread. Normal activities DO NOT pose risks. Examples of normal activities are drinking cups of tea, practising bandaging.



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7.3. Volunteers infected with hepatitis B or C or HIV are required to inform the IPCL at the earliest opportunity. The IPCL will take advice about fitness for work in line with Department of Health guidance by liaising with the UK Advisory Panel for Healthcare Workers Infected with Blood-borne Viruses when advice is needed on procedures that may be carried out by BBV-infected care workers.

7.4. Volunteer Ambulance aider applicants that are BBV positive

7.4.1. In line with Health clearance for tuberculosis, hepatitis B, hepatitis C and HIV: New healthcare workers (2007). The HFR Exec have agreed that for new ambulance aiders who may perform similar exposure-prone procedures (EPPs) to paramedics, ie may be required to provide treatment to open fractures which provide a risk of laceration to the healthcare provider when in close contact with the patient's body fluids, additional health clearance should also be undertaken. Additional health clearance means being non-infectious for HIV (antibody negative), hepatitis B (surface antigen negative or, if positive, e-antigen negative with a viral load of 10^3 genome equivalents/ml or less) and hepatitis C (antibody negative or, if positive, negative for hepatitis C RNA).

7.4.2. Before confirmation of ambulance aider status, the volunteer will be asked to sign a declaration of their BBV (Hep B, C, HIV) status. If the volunteer is positive for BBV, they will be asked to undertake the additional health clearance listed above and if found to be infectious, they will be ineligible to continue in the ambulance aider role.

7.4.3. EPPs are those invasive procedures where there is a risk that injury to the worker may result in exposure of the patient's open tissues to the blood of the worker. These include procedures where the worker's gloved hands may be in contact with sharp instruments, needle tips or sharp tissues (eg spicules of bone or teeth) inside a patient's open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. Such procedures occur mainly in surgery, obstetrics and gynaecology, dentistry and some aspects of midwifery. Most nursing duties do not involve EPPs; exceptions include accident and emergency and theatre nursing.

7.4.4. By contrast to other emergency workers, a paramedic's primary function is to provide care to patients. Paramedics do not normally perform EPPs. However, paramedics who would be restricted from performing EPPs should not provide pre-hospital trauma care.

7.4.5. According to the 2007 guidance, staff involved in direct patient care include: paramedics and ambulance drivers, students and trainees and volunteers who have regular clinical contact with patients and who are directly involved in patient care.

7.5. Common Sense BBV Precautions

7.5.1. Wear gloves and use other PPE as appropriate

7.5.2. Always wash hands thoroughly following contact with body substances (urine, faeces, sputum, and vomit).

7.5.3. Cover skin abrasions with a waterproof dressing.

7.6. Occupational health guidance

7.6.1. Occupational health advice can be obtained from the IPCL or from the volunteer's own General Practitioner.

7.7. Routine vaccination

7.7.1. All first aiders should undergo a course of Hepatitis B vaccinations and keep their immunisation up-to-date. Hepatitis B vaccination is recommended for those who may have direct contact with patients' blood or blood-stained body fluids. This includes any who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten by patients. Antibody levels for hepatitis B should be checked one to four months after the completion of a primary course of vaccine. Such



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information allows appropriate decisions to be made concerning post-exposure prophylaxis following known or suspected exposure to the virus.

- 7.7.2. Ensuring Hepatitis B immunity is the responsibility of the individual and must be reported to the HFR Hon. Sec. so that it can be logged on the database. If necessary HFR will pay for the vaccination. All volunteers should be up to date with their routine immunisations, e.g. tetanus, diphtheria, polio and MMR. MMR vaccine is especially important in the context of the ability of volunteers to transmit measles or rubella infections to vulnerable groups.

8. Body Fluid Spillages

9. Urine, Vomit & Faeces

- 9.1. All spillages of body fluids (urine, vomit or faeces) should be dealt with immediately.
- 9.2. Disposable gloves should be worn and as much of the spillage as possible should be mopped up with absorbent toilet tissue or paper towels: this can be disposed of into a yellow plastic clinical waste sack.
- 9.3. For spillages indoors (in vehicles), clean the area using either a disinfectant spray (such as Bioguard), or the Biohazard Kit (depending on size or type of spillage).
- 9.4. For spillages outside sluice the area with water. Do not forget to wash your hands after you have taken your gloves off.

10. Blood

- 10.1. Blood spillages should be dealt with immediately. All blood should be treated as though it were infected. The blood from anyone who is known to be HIV or hepatitis B infected does not need to be treated any differently from blood spillage from anyone else.
- 10.2. Wear gloves as detailed previously. Indoors, cover the spillage with hypochlorite granules, e.g. 'Sanitiser' powder - 'Sanitiser' is a bleach product that will render the blood spillage safe from potential infection. Scoop up the powder with a paper towel and dispose of it in a yellow plastic clinical waste sack. Clean the area with a neutral detergent, e.g. washing up liquid and hot water, rinse and dry.
- 10.3. In the unlikely event of a very large spillage of blood where there is widespread contamination and it would be impractical or unsafe to spread large amounts of 'Sanitiser' powder, clean the area thoroughly with detergent and hot water, rinse and dry.
- 10.4. Small spillages of blood outside do not pose a recognisable risk and do not need to be cleaned away. Do not forget to wash your hands after you have taken the gloves off.
- 10.5. Carpets - Blood, or other body fluid spillage on carpets and upholstery should be cleaned with warm soapy water or a proprietary liquid carpet shampoo since the use of hypochlorite granules may discolour fabrics.

11. Notifiable Diseases

- 11.1. These are listed under the Public Health (Control of Disease Act) 1984 and the Public Health (Infectious Diseases) Regulations 1968.

12. Contamination incidents

13. Needle stick injury

- 13.1. Every needle stick-type injury must be reported to the IPCL and an incident report form completed. The name and address of the person whose fluids were involved in the incident must be recorded if possible.
- 13.2. The object should be placed as soon as possible carefully into a sharps box.
- 13.3. The wound should be encouraged to bleed by gentle pressure around it.
- 13.4. The wound should be cleaned with soap and water, and a medi-wipe and covered with a plaster.
- 13.5. The patient should seek medical advice at the first available opportunity.
- 13.6. The sharps box should be disposed of as clinical waste as soon as possible after use.
- 13.7. The lancets used for BM testing incorporate a sharps protection system.



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14. Mucous Membrane contamination

- 14.1. Every mucous membrane contamination incident must be reported to the IPCL and an incident report form completed. The name and address of the patient/person whose fluids were involved in the incident must be recorded if possible.
- 14.2. Mucous membranes include eyes, nose and mouth.
- 14.3. PPE eg goggles and face masks are available and must be used when appropriate.
- 14.4. Mucous membrane contamination should be followed by flushing the area with copious amounts of running water.
- 14.5. Review of exposure risk
- 14.6. The IPCL will review whether the exposure is significant ie whether there is a high risk body fluid and significant route.
- 14.7. High risk body fluids do not include urine, vomit, faeces or saliva unless visibly contaminated with blood.
- 14.8. Significant routes include: sharps injuries, exposure of broken skin, exposure of mucous membranes.
- 14.9. If the exposure is significant the IPCL will advise the volunteer to attend the nearest Emergency Department and will contact the source patient/person to ask their consent for a blood sample for testing.

15. Resuscitation

- 15.1. There is evidence that TB and SARS have been contracted from mouth to mouth ventilations on people. The Resuscitation Council (UK) recommends the use of a pocket mask when delivering cardio-pulmonary resuscitation. Pocket masks incorporate a filter and are single-use. Therefore, all volunteers should use barrier methods for giving ventilations e.g. bag valve mask or pocket mask.
- 15.2. Resuscitation performed wearing appropriate protective equipment does not constitute an EPP.

16. Care of the deceased

- 16.1. HFR will only recognise life extinct in accordance with the ROLE definitions in JRCALC.
- 16.2. If a patient dies at an event the OIC will inform the police and the body will be left in situ, and covered with a blanket.
- 16.3. If a patient arrests within the ambulance, they should be treated appropriately and conveyed to the nearest Emergency Department.
- 16.4. The routine equipment cleaning procedure should be used, unless there is reason to suspect a notifiable disease.
- 16.5. If a notifiable disease is suspected the IPCL will contact the HPA for appropriate advice.

17. Equipment

- 17.1. HFR is responsible for providing personal protective equipment (PPE) and HFR volunteers should carry and use it when exposure to blood and body substances may occur. PPE includes aprons, gloves, face shields, shoe protectors, face masks and safety goggles. This list is not exhaustive and other items may be added/available.
- 17.2. All other equipment should be inspected before and after use for any soiling. Any equipment that has been in direct contact with a patient (or a simulating patient) should be wiped clean and disinfected using an alcohol or Biohazard wipe, or soaked in dilute Milton's solution for 30 minutes. This includes stethoscope diaphragms, BP cuffs, cervical collars, frac pacs, trolley cot and long boards. All parts of any equipment should be dismantled, where possible, to allow physical removal of all particulate and biological matter. Equipment should be cleaned with detergent and water and dried thoroughly.



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17.3. HFR volunteers are issued with individual stethoscopes to decrease the risk of ear infections. HFR volunteers are individually responsible for maintaining their own stethoscopes in a clean and serviceable manner.

18. Gloves

- 18.1. Gloves should only be worn: if there is a risk of contact with blood and/ or body fluids; when sharp or contaminated instruments are being handled; and/or if there is likely to be contact with non-intact skin or mucous membranes during general care or an invasive procedure.
- 18.2. Gloves can also be worn to protect the wearer's hands from organic contamination, but they should be changed for clean gloves before any invasive technique is performed on a patient.
- 18.3. Gloves should not be worn unnecessarily; there should be an assessment of the task to be carried out and of the risks to both the patient and the healthcare worker before the decision is made to wear gloves.
- 18.4. Gloves should also: only be put on immediately before patient contact; be changed between each patient task; be changed between caring for different patients; be changed as soon as they are contaminated; and be discarded as clinical waste.
- 18.5. Gloves must not be worn: when driving to and from a scene; or for longer than necessary.
- 18.6. Hand hygiene rules should be adhered to before putting on gloves and after removing them – washing with soap and water whenever possible, or using detergent wipes and alcohol gel if no washing facilities are available.

19. Aprons

- 19.1. Aprons should be worn: if there is a risk of contamination of the wearer's uniform from blood or body fluids; when carrying out any cleaning procedure that may cause contamination of the uniform; and when transporting known infectious patients.
- 19.2. Aprons should be disposed of: after a single use; as clinical waste; by unfastening or breaking ties; by pulling apron away from the neck and shoulders touching the inside of the apron only; by turning the apron inside out, folding or pulling into a bundle and discarding.

20. Airway maintenance

- 20.1. Equipment used for airway maintenance – for example endotracheal tubes and laryngeal masks – should remain in sterile packaging until the point of use.
- 20.2. These items should be removed from the packaging and inserted immediately. They must not come into contact with other items before use.

21. Resusci Annie

- 21.1. These should be cleaned and maintained according to the Laerdal guidelines which state that:
- 21.2. During class between students the same face may be used, but must be disinfected using a manikin wipe. This should be wiped over the manikin's face, wrapped snugly over the mouth and nose and left for 30 seconds. The manikin's face should then be dried with a paper towel. Alternatively, the students may be issued with individual face shields.
- 21.3. After class the airway should be disposed of and replaced with a new one (the date of replacement will be written on the new airway in biro). Also the manikin face should be removed, washed in warm soapy water, rinsed, disinfected using dilute Milton's solution for at least 30 minutes, rinsed again and then thoroughly dried before replacing on the manikin.
- 21.4. There is evidence that Herpes simplex (cold sores), Meningococcus, and Hepatitis B have been transmitted to trainees via resuscitation manikins. Any trainee that appears to have cold sores should be asked to use a face shield to practice mouth to mouth



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ventilations. If they refuse, then on the grounds of health and safety any HFR volunteer may refuse to allow them to practice.

21.5. Each manikin will have an "Annie Servicing Record" (see appendix 1) which will be completed after each session of use.

22. Training bandages

22.1. These should be issued individually during training. After use they should be disposed of or washed at 60 deg C as appropriate, and dried before re-use.

23. Food hygiene

23.1. Only those volunteers with a food hygiene certificate will prepare food supplied by HFR at any event eg pre-hospital provision or training.

23.2. Food supplied by volunteers for their own consumption must be of a variety that is suitable for storage at the temperature maintained within the ambulance during the event.

24. Uniform

24.1. There should be sufficient uniforms available so freshly laundered clothing can be worn for each event (or each day if the event last multiple days).

24.2. HFR will provide a limited supply of spare clothing in the ambulance if volunteer's clothing items become contaminated (for example, splashed with blood and/or body fluids).

24.3. HFR volunteers must change out of their uniform promptly at the end of a shift i.e. uniform is only to be worn on recognised first aid / training events.

24.4. HFR volunteers must presume some degree of contamination, even on clothing which is not visibly soiled i.e. hands must be washed and dried after handling fabric.

24.5. Uniforms must be carried separately from other items - clean and dirty uniforms must not be transported together.

24.6. HFR volunteers must follow HFR's volunteer guidance on the wearing and decontamination of uniforms.

24.7. HFR volunteers must practice "Bare Below the Elbows" (BBE) during patient care activity involving direct contact with patients and their close environment. This includes activity that involves examining patients and wound care and activity in the healthcare setting such as in an Ambulance.

24.8. BBE should be practised at an event at all other times as much as is reasonably practicable, depending on the environmental climate. When HFR Volunteers need to wear long-sleeved clothing, such as high-visibility jackets, the following steps should be taken:

- Be aware of any possible contaminants
- Roll up or pull back sleeves
- Always remove long-sleeved coats and/or roll up shirt sleeves to wash (or alcohol gel) hands effectively
- Wear sleeve protectors when necessary.

24.9. HFR volunteers at events must have removed jewellery on hands and wrists, this includes rings, wrist-watches, bracelets, medic-alert type bracelets (the only exception to this are plain band wedding rings).

24.10. HFR volunteers at events must have ensured that fingernails are short and free of nail varnish (false nails must not be worn).

24.11. HFR volunteers at events must have ensured that hair is worn neatly in a style that is off the collar and does not require frequent re-adjustment.

24.12. Identification badges should be clearly displayed, but along with pens, scissors or other sharp or hard objects should not be placed in positions such as outside breast pockets, where they may cause injury or discomfort to patients during care activity. These items should be carried inside clothing, in hip pockets or a waist/hip level.

24.13. Laundry recommendations for used or contaminated clothing/bedding

24.14. Hand washing clothing items is ineffective and unacceptable.



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- 24.15. Used clothing will be washed at 40 deg C and dried thoroughly before use.
- 24.16. Used bedding will be washed at 60 deg C and dried thoroughly before use.
- 24.17. Grossly contaminated clothing/bedding will be packaged and disposed of as clinical waste.

25. Clinical Waste

- 25.1. The HFR waste disposal policy must be followed, this is inline with Local authority regulations. Attempts should be made to segregate wastes at the point of generation. Hazards arise when handling, storing, transporting and disposing of waste.
- 25.2. Blood and body substances should be disposed of directly into the sewer system where possible.
- 25.3. Heavily contaminated wound dressings should be contained in a leak-proof bag and double bagged before disposal.
- 25.4. Care must be taken in the handling and disposal of sharps.
- 25.5. All PPE should be disposed of as clinical waste.

26. HFR Storage Environment

- 26.1. All parts of the premises from which HFR provides storage will be suitable for the purpose, kept clean and maintained in good physical repair and condition.

27. Ambulance Cleaning

28. Exterior

- 28.1. The exterior of vehicles should be kept clean, for the health and safety of staff and patients and also of other road users

29. Interior

- 29.1. Ambulance interiors should be thoroughly cleaned (including inside cupboards, walls and equipment), as specified in the National Patient Safety Agency's cleaning specification (see appendix for cleaning schedule)
- 29.2. Ambulance interiors will be cleaned using blue utensils (in line with NPSA colour coding) for General areas including wards, departments, offices and basins in public areas
- 29.3. Extra attention to cleaning is required immediately after the transport of any patient with diarrhoea, as the infection status of the patient may not be known. The vehicle interior, including the walls and floors and all items used to treat the patient, must first be cleaned with soap and water and then with chlorine-based fluid, to ensure that any infected matter is removed – as, for example, Clostridium difficile spores are only removed by thorough cleaning and chlorine disinfection.

30. Equipment – decontamination and cleaning

- 30.1. All equipment used for patient treatment – for example monitors, carry chairs, longboards, scoop stretchers and all other items used for the movement of patients – should be cleaned using detergent wipes or soap and water then either air-dried or wiped with clean paper towels after every patient use. (see appendix for cleaning schedule)
- 30.2. All items of linen (blankets, pillow cases, canvases) must be changed after every patient, and the linen placed into plastic bags for washing.
- 30.3. The stretcher must be wiped over with detergent wipes or soapy water and a clean cloth then air-dried or wiped dry with clean paper towels after every patient use.
- 30.4. If the stretcher has been soiled with blood or body fluids, it should also be wiped with chlorine-based fluid to decontaminate it after it has been cleaned with detergent.
- 30.5. Pillows are fully sealed in plastic and will be covered with a single use disposable pillow case. Between patients, the pillow will be wiped with a detergent wipe before a clean pillowcase is fitted.
- 30.6. Under no circumstances should linen be used for more than one patient.
- 30.7. All single-use equipment must be disposed of in the appropriate waste packaging. Single-use equipment must only be used on one patient.



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- 30.8. All drinkable water will be provided as sealed and dated commercially bottled water. Each bottle will be single patient use.
- 30.9. Where water is supplied on the ambulance for hand washing the risk of Legionella (bacterial growth is supported at 20-45 deg C) will be minimised by adhering to national guidance (HSE 2000). This entails:
- 30.10. Draining and leaving to dry and water supply on the ambulance at the end of an event.
- 30.11. Six-monthly cleaning of all associated water bottles and piping by soaking in Milton (according to manufacturer's instruction).
- 30.12. The risk of Legionella in the water in the ambulances screen washer will be minimised by ensuring that commercial screen wash is added as required.

31. Staff training and support

- 31.1. On induction HFR volunteers will receive training on infection prevention and control.
- 31.2. HFR volunteers will receive infection prevention and control practical training by demonstration and skills-based supervision on the ambulances.
- 31.3. All HFR volunteers will receive annual mandatory training on infection prevention and control
- 31.4. HFR volunteers will be made aware of this updated policy by members of the HFR Executive as appropriate.

32. Policy Consultation

- 32.1. This policy has been circulated to the HFR Executive and Medical Advisor for consultation.
- 32.2. The policy will be approved by the HFR Executive with future reviews and updates tabled for approval at Exec meetings.

33. Dissemination

- 33.1. Once the policy has been approved a summary of relevant changes (and a link) will be disseminated via email to the HFR volunteers, and a pdf copy of the policy placed by a member of the Exec on the member's section of the website: www.hartresponse.org.uk
- 33.2. Monitoring of Compliance and Effectiveness
- 33.3. Monitoring of the policy will be the responsibility of the HFR Executive.
- 33.4. This will be through incidents reported on the HFR database, weekly patient review and annual audits. Actions and lessons learned will be monitored through the HFR Executive. Where any omissions or deficits have been noted results and action plans will be monitored through the HFR Executive.
- 33.5. Lessons learned will be disseminated to the HFR volunteers through email briefings or via weekly training sessions.

34. Implementation

- 34.1. The HFR Executive are responsible for communicating this information to HFR volunteers and ensuring that the procedures are followed.

35. Archive Statement

- 35.1. The Honorary Secretary is responsible for archiving all previous versions and supporting evidence of approval for this policy.

36. Associated Policies

- 36.1. Waste Management policy



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36.2. Reporting Adverse Incidents policy

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Appendix: Competencies in Modified Aseptic Technique

Candidate	
Assessor	
Date	
Decision	

Use of modified aseptic technique

The trainee will be able to demonstrate safe, cleaning and dressing of a wound using a modified aseptic technique.

Knowledge

- Describes how pathogens may be introduced to a wound
- Identifies which equipment should be sterile vs. non-sterile
- Explains the importance of hand hygiene
- Describes how to prevent contamination of other equipment eg first aid kit

Performance

The candidate will demonstrate the modified aseptic technique on a simulating patient with a traumatic wound.

Performance criteria

The trainee demonstrates the following actions correctly:

	Observed (tick)
Ensure that all equipment required is ready and that a clean area on which to place it is available.	
Explain the procedure to the patient and obtain their verbal consent	
Position the patient so that the procedure can be performed easily	
Position the clinical waste bag so that it is easily accessible	
Wash hands / disinfect with alcohol handgel	
Put on gloves	
Examine wound site	
Use sterile swabs and saline (or mediwipes) to clean the wound site	
Use clean swabs/mediwipes for each cleaning stroke (from the centre outwards)	
Apply a sterile dressing	
Avoid touching any clean area/first aid kit whilst performing the procedure	
Dispose of clinical waste into a clinical waste bag	
Remove gloves (dispose of correctly)	
Give appropriate advice and offer cuts and grazes advice card	

Range: External minor bleeding, dirty graze	Feedback
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Issue 1

Created: April 2011



Registered Charity: 1092333

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Appendix 2: Effective handwashing

FIGHT GERMS BY WASHING YOUR HANDS!

1 Wet your hands

2 Soap

3 Lather and scrub - 20 sec

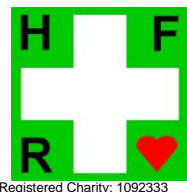
4 Rinse - 10 sec

5 Turn off tap

6 Dry your hands

DONT FORGET TO WASH:

- between your fingers
- under your nails
- the tops of your hands



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Appendix 3: Information on relevant Infections (<http://www.nhsdirect.nhs.uk/>)

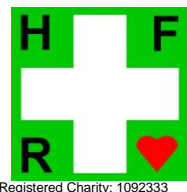
Name	Type	Symptoms	General info	Prevention
MRSA, Methicillin Resistant Staphylococcus aureus	bacteria	If the bacteria get into the body through a break in the skin they can cause infections such as boils, abscesses, or impetigo. If they get into the bloodstream (bacteraemia) they can cause more serious infections.	About 1 in 3 of us carries it on the surface of our skin or in our nose without developing an infection - this is known as being colonised by the bacteria.	If you are prescribed antibiotics you should always make sure that you complete the full course. MRSA is usually passed on by human contact, often from the skin of the hands. You should always wash your hands thoroughly.
Clostridium difficile	bacteria	Mild to severe diarrhoea, blood stained stools, fever, and abdominal cramps. Older people are most at risk from infection, with the majority of cases (80%) occurring in people over the age of 65.	Present naturally in the gut of around 3% of adults and 66% of children. C. diff doesn't cause any problems in healthy people. Some antibiotics that are used to treat other health conditions can interfere with the balance of good bacteria in the gut. When this happens, C. diff bacteria can multiply	Wash your hands with soap and water. Alcohol hand gel should also be used. However, it does not kill the spores so the additional use of water and detergent is essential.
Tetanus	bacteria	Once inside your body, the bacteria release a toxin which then causes tetanus, although the illness can take up to 21 days to develop. Tetanus affects your nerves, and can be fatal.	Bacteria get into your body through a wound/burn eg , a cut while gardening, or an animal bite. You are more at risk of developing tetanus if the wound is deep or if it gets dirty with soil or manure. This is an anaerobic bacterium.	The only way to prevent tetanus is to be immunised. A full course of tetanus immunisation consists of five doses of vaccine.
Hepatitis B	virus	Flu-like symptoms, such as tiredness, general aches and pains, headaches and fever, loss of appetite, nausea or vomiting, and diarrhoea, abdominal pains, and jaundice, this occurs because your inflamed liver is unable to remove bilirubin a substance in the blood that causes your skin and the whites of your eyes to become yellow.	Hepatitis B is spread through the blood and bodily fluids of an infected person. Hepatitis B is 100 times more infectious than HIV. The incubation period is between one and six months.	You will need three injections of hepatitis B vaccine over a period of 4-6 months for full protection. A blood test is then taken one month after the third dose to check that the immunisations have worked. You should then be immune for at least 5 years. A booster injection is usually given 5 years after the initial injection



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Name	Type	Symptoms	General info	Prevention
HIV, Human Immunodeficiency Virus	virus	Flu-like symptoms in the first couple of months which may include: a high temperature and fever, a sore throat, fatigue, a skin rash, muscle aches and pains, headaches, nausea, vomiting, and diarrhoea.	HIV is an infection which develops into Acquired Immunodeficiency Syndrome (AIDS). This is fatal, there is no cure.	Safe sex – use condoms. Do not share needles if you are injecting drugs, and avoid a blood transfusion in any country that does not screen blood for HIV.
Norovirus	virus	most common cause of infectious gastroenteritis (diarrhoea and vomiting) in England and Wales. The illness is generally mild and people usually recover fully within 2-3 days	Aerosols incubation period for norovirus-associated gastroenteritis is 12 to 48 hours, with a median of approximately 33 hours	Norovirus is highly infectious. Particular attention to good hygiene measures should be observed during outbreaks. It is very important to wash your hands with soap and water

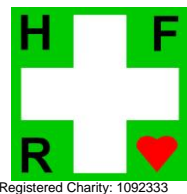


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Appendix 4: Ambulance cleaning schedule – copies with date fields for completion are maintained for each vehicle.

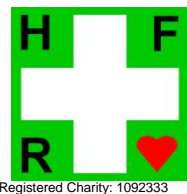
Item	Method	Responsibility	After each use	After each event	Monthly	6-monthly
Blinds and visors	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Cab - footwells	soapy water and sponge	Exec/OIC	None	Check clean	Remove dust	Remove plastic trays from footwells and wash out any mud or debris
Ceiling	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Ceiling lights	soapy water and sponge	Exec/OIC	None	Check clean	Check clean	remove covers and clean insides
Cleaning equipment	soapy water and sponge	Exec/OIC	Full clean after each use	Full clean after each use	Full clean after each use	Full clean after each use
Clipboards & notices.	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Remove dust	Full clean
Dashboard	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Remove all items and clean including air vents
Doors	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Dressing cases	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Remove dust	Full clean
Electrical items eg AED, Suction	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Remove dust	Full clean
Floor – Cab	soapy water and sponge	Exec/OIC	None	Full washing	Remove dust	Remove all items and vacuum under seats, full washing



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Item	Method	Responsibility	After each use	After each event	Monthly	6-monthly
Floor – non-slip	soapy water and sponge	Exec/OIC	None	Dust removal and full clean	Dust removal and full clean	Full washing
Hand hygiene/alcohol rub dispensers	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Full clean	Remove dust	Full clean
High surfaces	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
IV track and clips	Biohaz/detergent wipes	First aider	Clean contact points	Check clean	Remove dust	Full clean
Lockers	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Low surfaces	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Manual handling equipment ie long board, scoop	Biohaz/detergent wipes	First aider	Clean contact points	Check clean	Remove dust	Full clean
Medical equipment non-wetable e.g. pulse oximeters, Blood pressure cuffs.	Biohaz/detergent wipes	First aider	Clean contact points	Check clean	Remove dust	Full clean
Medical equipment wettable e.g. Frac pacs and other splinting	Biohaz/detergent wipes	First aider	Clean contact points	Check clean	Check clean	Full clean
Medical gas equipment: Ventilator, Gas cylinder holders	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Remove dust	Full clean
Outside of vehicle	soapy water and sponge	Exec/OIC	None	Check clean	Full washing	Full washing
Pillows	Biohaz/detergent wipes	First aider	Clean plastic cover, remove and dispose of pillow	Check clean	Check clean	Replace plastic cover

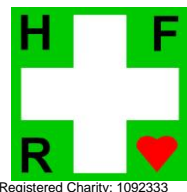


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Item	Method	Responsibility	After each use	After each event	Monthly	6-monthly
			case			
Radios	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Check clean	Full clean
Seats	Biohaz/detergent wipes	First aider	Clean patient contact points	Full clean	Remove dust	Full clean
Sinks	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Full clean	Remove dust	Full washing
Switches, handles (inc door handles)	Detergent wipes	Exec/OIC	None	Full clean	Remove dust	Full clean
Tables (flat surfaces)	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Full clean	Remove dust	Full washing
Trolley cot	Biohaz/detergent wipes	First aider	Clean mattress	Full clean	Remove dust from frame	Full clean
Ventilation/Eberspaker grilles extract and inlets.	Biohaz/detergent wipes	Exec/OIC	None	Check clean	Remove dust	Full washing
Walls	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Waste receptacles	Biohaz/detergent wipes and/or soapy water	Exec/OIC	None	Check clean	Remove dust	Full washing
Water tanks	Milton	Exec/OIC	None	Empty water	Check clean	Full washing and pipe change
Windows and internal glazing including partitions	soapy water and sponge	Exec/OIC	None	Check clean	Remove dust	Full washing



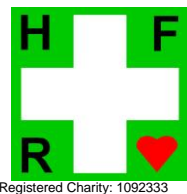
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Appendix 5: Equality Impact Assessment

Impact	Age	Disability	Race	Gender	Religion or Belief	Sexual Orientation
Do different groups have different needs, experiences, issues and priorities in relation to the proposed policy?	N	Y	N	N	Y	N
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups?	N	N	N	N	N	N
Is there potential for or evidence that the proposed policy will affect different population groups differently (including possibly discriminating against certain groups)?	N	N	N	N	N	N
Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups?	N	N	N	N	N	N

Do different groups (age, disability, race, sexual orientation, gender, religion or belief) have different needs, experiences, issues and priorities in relation to the proposed policy?	<p>Bare below the elbows can provide challenges for different religious groups and those wishing to display Medic alerts. Compliance requires that medic alert bracelets are not worn on the wrist but can be worn as a necklace. For Muslims there is no religious requirement to cover the skin, although this is encouraged in certain groups. For Sikhs there is a requirement to wear a silver bangle. These issues have been considered but are not adequate reasons for putting patient's safety at risk; therefore compliance of this policy is required for all HFR volunteers who wish to treat any patient.</p> <p>We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect any of the other groups differently.</p>
Is there potential for or evidence that the proposed policy will not promote equality of opportunity for all and promote good relations between different groups (age, disability, race, sexual orientation, gender, religion or belief)?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will not promote equality of opportunity or good relations between different groups.
Is there potential for or evidence that the proposed policy will affect different population groups (age, disability, race, sexual orientation, gender, religion or belief) differently (including possibly discriminating against certain groups)?	We have no statistical or anecdotal evidence, at this stage, to show that this policy will affect these mentioned groups differently.



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Is there public concern (including media, academic, voluntary or sector specific interest) in potential discrimination against a particular population group or groups (age, disability, race, sexual orientation, gender, religion or belief)?

We have no statistical or anecdotal evidence, at this stage, to show that there is public concern in potential discrimination against the protected groups identified above.

Based on the information set out above the HFR Executive has decided that a full equality impact assessment is not necessary.