D01b

Infection prevention and control procedure for managers

This document is provided to Crossroads Care Hertfordshire North (now referred to as 'the organisation') as a Network Partner of Carers Trust.

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1.0 SCOPE

1.1 See policy D01a for details.

1.2 In this procedure:

- 'service user' refers to carers as well as to people of all ages with care needs
- 'care worker' refers to staff directly involved in the provision of regulated personal care and support to people with care needs
- 'staff' includes volunteers.

2.0 GENERAL RESPONSIBILITIES

2.1 Everyone has a role to play in preventing the spread of infections and the varying levels of responsibility are set out below.

2.2 Senior managers are responsible for:

- ensuring there are appropriate management controls in place regarding infection prevention and control and that checks and monitoring are taking place
- assessing the fitness or their staff to work (including immunisation requirements, as appropriate)

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- the management of all training records as they pertain to their workforce
- assessing the amount and level of training required for staff involved in food handling, including those involved in providing or selling food at public events.

2.3 Managers and assessors (including care planners) are required to:
- consider infection control hazards
- risk assess and promote good personal, environmental and food hygiene measures
- monitor these measures (during inspections) and other indicators such as staff sickness due to infections.

2.4 All staff have a responsibility to:
- maintain personal hygiene and cleanliness
- comply with local infection control procedures
- notify management of infection control concerns.

2.5 Infection prevention and control lead (IPC lead)

2.5.1 Organisations providing regulated care and support services are required to appoint an infection prevention and control lead (IPC lead) who has the relevant qualifications to undertake infection control risk assessment and to develop / implement local controls to manage hazards in relation to the services being offered.

2.5.2 The IPC lead will ensure the necessary resources are available for the safe and effective management of infection control and outbreaks[1] of infectious diseases.

2.5.3 The IPC lead will oversee training in infection prevention and control, ensuring that staff:
- receive the level of instruction relevant to their role at induction, including a working knowledge of the standard infection control precautions (see D01e and 4.0 below)
- are given regular training updates
- receive the necessary information, support and supervision.

2.5.4 The IPC lead will:
- maintain a list of names and contact details of local health practitioners who can provide advice and support in relation to infection prevention and control issues when needed
- act as point of contact with the relevant enforcement bodies should an outbreak occur.

2.5.5 The IPC lead will provide effective audit, monitoring and quality assurance of infection control and produce an annual statement (available for inspection at any time), that covers:
- any known infection transmission event/s within the organisation
- audits undertaken and subsequent actions and risk mitigation
- risk assessments carried out
- staff training
- update / review of infection prevention and control policy documents where applicable.

2.5.6 Managers are advised to familiarise themselves with the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance 2015.

[1] The definition of 'outbreak 'commonly used in infection control: 'two or more people experiencing a similar illness are linked in time or place (regardless of the organism)'.

3.0 RISK ASSESSMENT

3.1 Where there is a likelihood of infections being contracted in the work setting, a risk assessment must be completed and appropriate control measures put in place.

3.2 The assessor will consider risks from suspected or confirmed infections or communicable diseases with the potential of onward transmission to others. Examples include, but are not restricted to:

- hepatitis B and C
- Tuberculosis
- HIV
- MRSA
- sickness and diarrhoea (including Norovirus and C Difficile).

See DT11 (infectious diseases) for further details.

3.3 Assessors are required to ensure all necessary precautions are identified and control measures in place before services begin. Appendix 1 outlines the Hepatitis B risk assessment process.

3.4 If the assessor is concerned or unsure about a particular infection, they will refer the matter to their line manager or, where delivering regulated care and support services, to the IPC lead who will seek advice from one of the local health practitioners as necessary (see 2.2 above). Any advice received will be documented and communicated to relevant staff.

3.5 Where services are being provided in a service user's home, environmental cleanliness will be included as a routine part of the assessment. If the home is assessed as posing unacceptable risks to the health and safety of staff, the action required to reduce those risks to an acceptable level will need to be taken prior to services commencing.

3.6 If food is to be prepared, cooked, served, stored or transported as a part of service provision, the available food preparation and storage facilities will need to be fully assessed.

3.7 Hand washing facilities need to be available at all places of work. If adequate facilities are not available (for example in a service user's home), managers will provide staff with liquid soap and paper towels and / or a hand sanitiser as appropriate. Staff need to be made aware, however, that hand sanitisers are **not**:

- an effective method for cleansing hands that are visibly soiled
- for use where the person receiving a service has infectious diarrhoea (for example Norovirus or C Difficile)
- a suitable permanent substitute for hand washing
- to be routinely used in food preparation areas as a substitute for soap and water.

4.0 STANDARD INFECTION CONTROL PRECAUTIONS

4.1 These are a set of practices used to prevent onward transmission of suspected / confirmed infections or communicable diseases (see 3.2 above) that can be acquired by contact with blood, body fluids, non-intact skin and mucous membranes.

4.2. It is important that everyone carries out infection control precautions at all times, regardless of whether infection is present or suspected. The precautions are set out in full in a separate document (Hand hygiene and standard infection control precautions - D01e) for distribution to

staff as appropriate, but a selection of them are discussed briefly below from a management perspective.

4.3 Hand hygiene

4.3.1 Effective hand hygiene is **the** most important method of preventing spread of infections and it is imperative that staff are trained how to execute it correctly. See D01e for details.

4.4 Food hygiene standards

4.4.1 All foods are potentially hazardous and strict hygiene measures need to be applied when it is being transported, handled, stored, prepared, cooked or served.

4.4.2 Assessors need to be aware and comply with the relevant legislation (D01a), and risk assessments need to consider:

- the provision of safe drinking water
- appropriate arrangements for reheating / cooking foods as required
- suitable waste disposal
- hand washing and washing up facilities
- environmental cleanliness or work surfaces and equipment
- the level of training required.

4.4.3 When services involving food are being provided in a service user's home, the assessor is required to check that food preparation and storage areas are free from external sources of contamination. These could include for example:

- pet bowls and litter trays
- pests such as mice, cockroaches
- pest control chemicals or poisons located near food preparation surfaces, equipment or utensils.

Where any such contaminants are identified, the assessor will raise the matter with the service user or their family to seek to resolve the issues.

4.4.4 When meals are being provided to a person with care needs, the assessor will discuss at initial assessment whether they have any food allergies / intolerances or special religious / cultural requirements. These will be documented in the person's care and support plan and staff will be provided with additional instruction / training as necessary

4.5 Personal Protective Equipment (PPE)

4.5.1 PPE should be considered a last resort in managing infection hazards and the risk assessment and resultant controls should mitigate risk through the standard precautions.

4.5.2 Where PPE is required, it must be appropriate for the hazard type, readily available and stored correctly. Managers and the IPC lead are responsible for ensuring that staff are appropriately and sufficiently trained in the requirement, use, replacement and disposal of PPE (and that there is a documented training record to evidence this).

4.5.3 Disposable single use gloves need to:

- be non-latex, such as vinyl or nitrile
- conform to current EU legislation- CE marked as 'medical gloves for single use only'

4.5.4 Disposable gloves and disposable single-use aprons need to be available to staff who:

- provide personal care and support

- may come into contact with blood or body fluids
- carry out domestic tasks, including food handling and waste disposal.

Please note: staff will **not** wear disposable aprons when cooking food over a direct source of heat, as the aprons pose a fire hazard in such circumstances.

4.5.5 Staff footwear needs to be sturdy, non-slip, have flat heels, enclosed back or strap and enclosed toes to reduce the risk of injury from sharps and potential exposure to body fluids.

4.6 Disposal of waste and spillages
4.6.1 Legislation requires procedures to be in place for waste minimisation, handling, storage and collection. Assessors will address the safe disposal of waste and ensure staff are instructed in the processes appropriate to their work environment.

4.6.2 Where regulated care and support services are being provided, the care planner / assessor will:

- identify situations in which care workers may be required to handle / dispose of offensive or clinical waste (see Appendix 2)
- ensure the necessary arrangements and personal protective equipment are in place for care workers to handle the waste safely, in compliance with regulatory requirements
- contact the person's doctor, nurse or the local authority / environment agency if unsure of local requirements
- ensure staff who are required to handle / dispose of offensive or clinical waste are adequately trained (including how to deal with spillages)
- document all necessary information in the person's care and support plan.

4.7 Linen management or laundry facilities
4.7.1 Where regulated care and support services are being provided, the care planner / assessor will provide details in the person's care and support plan of how to deal with contaminated laundry (for example washing at highest temperature for the article concerned).

4.7.2 Consideration also needs to be given to suitable cleaning arrangements for non-clothing items such as hoists and slings.

4.8 Inoculation injuries (sharps, bites, splash injuries)
4.8.1 A **sharps injury** occurs following a puncture wound or cut to the skin, usually from a needle of other sharp object (percutaneous exposure). If the sharp is contaminated with blood, there is risk of transmission of infectious agents such as hepatitis B, hepatitis C or HIV.

4.8.2 **Bites** can also puncture the skin and introduce infective agents and human bites are prone to infection due to the bacteria present in salvia.

4.8.3 A **splash injury** occurs if blood or other body fluid comes into contact with the eyes, or the inside of the mouth or nose (mucocutaneous exposure).

4.8.4 D01e details the action staff need to follow if they sustain an inoculation injury.

4.9 Safe use and disposal of sharps
4.9.1 Where possible care planners / assessors will seek, through risk assessment, to reduce or eliminate the need for staff to handle sharps.

4.9.2 Where the need for staff to handle sharps is unavoidable, managers will ensure the service is set up to meet regulatory requirements in accordance with the European Directive 2010/32/EU. See D01e for details.

5.0 STAFF ILLNESS AND EXCLUSION

5.1 Staff who have an infection (for example a cold or sore throat) that could be transmitted to others, need to consider whether to attend work in view of the potential effect of their illness on others (especially vulnerable groups) and to inform their line manager.

5.2 Staff will be informed that:

- if they have nausea, vomiting, diarrhoea or stomach cramps they are required to refrain from work and not return until 48 hours after the last episode of vomiting or diarrhoea
- if they experience symptoms while at work, they are required to inform their line manager / person on call immediately so that arrangements can be made to relieve them.

5.3 Staff will be advised that if they are diagnosed with an infectious disease, it is recommended that they inform their line manager, though they are not obliged to do so. It needs to be made clear, however, that such information will enable their manager to support them, to ensure their safety and to amend their duties as necessary.

5.4 Care workers who have conditions such as MRSA, eczema, dermatitis and psoriasis need to be managed on an individual basis. Onward referral to their doctor (GP) or occupational health may be appropriate

5.5 Staff need to be informed that if they suspect that a service user has an infection or communicable disease they are required to inform their line manager.

6.0 FITNESS FOR WORK AND IMMUNISATION STATUS

6.1 Organisations providing regulated care and support services need to consider the immunisation status of any staff member who has direct contact with service users. It is strongly recommended that these staff are immunised against measles, mumps and rubella, chickenpox, hepatitis B, tuberculosis and influenza.

- The IPC lead will advise care workers of the benefits of immunisation (namely to minimise the risks to themselves and others).

- Where a care worker states they have already been vaccinated, the IPC lead will obtain documentary evidence of dates and the degree of immunity gained.

- A record will be kept in the care worker's personal file of advice given, vaccinations uptake and immunisation status or refusal.

6.2 **Hepatitis B** is a virus that can infect the liver. Pre-exposure vaccination is strongly recommended for staff who may come into contact with blood or body fluids as part of their work and are at risk of being occupationally exposed.

- A higher prevalence of hepatitis B has been found among certain groups of people with learning disabilities than in the general population. Close contact and behavioural issues (such as biting or scratching) may lead to increased risk of infection.

- Managers will advise care workers who choose not to be immunised for hepatitis B or who have a poor antibody response, to seek further advice and support (for example from occupational health or their GP) in order to establish the action they should take in the event of exposure to blood or body fluids.

6.3 **Tuberculosis (TB)** is a bacterial infection spread through inhaling tiny droplets from the coughs and sneezes of an infected person. TB that affects the lungs is the only contagious form (active pulmonary TB) and usually spreads after prolonged exposure to someone with the illness.

- It is recommended that care workers are vaccinated, following risk assessment, due to the increased risk of contracting TB while working.
- It is important that managers are aware of their workforce's immunisation status in relation to TB before allocating staff to work with a person who is suspected of having active pulmonary TB.

6.3.1 In cases where a person receiving care and support is known to have active pulmonary TB, managers and the IPC lead will:

- follow up-to-date guidance from their local Infection Prevention and Control Team (or equivalent), ensuring all guidance received is fully documented
- ensure staff are informed of additional precautions required (for example airborne droplet precautions), as directed by the Infection Prevention and Control Team or other health professionals and that these are documented in the person's care and support plan
- provide the appropriate Personal Protective Equipment (PPE)
- ensure that where aerosol generating procedures are conducted in the home or if multi-drug resistance is suspected, allocated care workers are fit tested for FFP3 masks and provided with the appropriate PPE.

6.3.2 Examples of airborne / contact precautions relating to active pulmonary TB are documented in the accompanying guidance documents (D01c, D01d).

6.4 It is recommended that care workers are vaccinated annually against influenza.

7.0 OUTBREAKS AND REPORTING

7.1 In compliance with RIDDOR (2013), all incidents of staff acquiring a notifiable disease linked to work activities must be reported to the Health and Safety Executive (HSE).

- Notifiable diseases include: food poisoning, enteric disease, measles, meningitis, mumps, rabies, rubella, tetanus, typhoid fever, hepatitis, HIV / AIDS, whooping cough and tuberculosis.

- For the full list of notifiable diseases and how to report them, go to: https://www.gov.uk/guidance/notifiable-diseases-and-causative-organisms-how-to-report

- For organisations providing regulated care and support services and with access to the care practice Operational Policy Framework (OPF), details of reporting requirements are provided in the operational health and safety procedure (F01b).

- In addition, managers will fulfil the reporting requirements of their organisation's insurers[2].

7.2 Suspected outbreaks of an infectious disease or food-related illness must be reported immediately to the local Infection Prevention and Control Team, Health Protection Unit or Environmental Health Department as appropriate.

8.0 CONFIDENTIALITY

8.1 Managers will not respond to third party requests for information about a service user unless they have first obtained written permission from the individual concerned. Please refer to your organisation's confidentiality and disclosure policy for further details. (Providers of regulated care and support services see D11b). Any breach of confidentiality may be treated as a disciplinary matter.

8.2 Providers of regulated care and support

- Care workers will routinely be informed of the diagnosis of the person with care needs to inform the work they do. This information will not be disclosed to others, apart from on a 'need to know' basis in relation to the person's direct care and support.

- In exceptional circumstances, the person with care needs and / or their carer may request that their diagnosis (for example their HIV or hepatitis status) be withheld from allocated care workers. Assessors will only agree to such a request following consultation with their IPC lead who may seek advice from a relevant healthcare professional as necessary and may conclude it is unsafe for staff to provide care and support under such circumstances.

9.0 LEARNING AND DEVELOPMENT

9.1 Managers are responsible for assessing the roles undertaken by:

- staff **not** directly involved in the provision of care and support to people with care needs
- volunteers within their organisation

to determine the level of briefing / induction / training they require in relation to infection prevention and control.

9.2 For staff who are involved in the provision of regulated care and support services, general learning and development requirements relating to infection prevention and control are contained in the learning and development policy documents (E13).

9.3 Managers will assess whether staff working with people who have a suspected / confirmed infection or communicable disease (for example those listed in 7.1 above) require additional information, instruction or training and how frequently this needs to be updated

10.0 ACCEPTANCE

10.1 The organisation's IPC lead, managers, assessors (including care planners) and staff involved in the implementation of this procedure are required to evidence that they have received, read and understood its contents. Evidence required:

- title and reference number of the document

[2] Organisations insured by Ecclesiastical Insurance will report incidents relating to this procedure (for example, inoculation injuries) to Watson Laurie insurance brokers using the incident report form (DT03)

- name and signature of the staff member
- job title
- date.

10.2 Responsibility for following this procedure rests with the individual staff member. Failure to do so may result in disciplinary proceedings.

APPENDIX 1
Hepatitis B: Risk assessment process for providers of regulated care and support services

When carrying out an assessment prior to allocating care and support work, the assessor will consider the risk level of both the person with care needs and the member of staff in relation to hepatitis B. Suitable risk assessment will lead to an identification of the hazards, an understanding of the associated risks and the necessary precautions for a safe system of work.

1.0 Person with care needs
The risk assessment will seek to identify those who could present a high risk to staff of transference of hepatitis B through the staff member coming into contact with their blood or body fluids containing blood (for example urine, faeces, saliva, vomit) via an inoculation injury or through splashes of blood or body fluids to broken skin / eyes / nose / mouth. This includes people with care needs who:

- are known to have hepatitis B
- may bite, scratch or otherwise draw blood
- are injecting drug users
- are incontinent of urine and / or faeces
- are breast feeding
- have visited high risk countries and may have come in contact with infected blood or body fluids.

The government Green Book (chapter 18 Hepatitis B) states that 'all healthcare workers who may have direct contact with patients' blood, blood-stained body fluids or tissues, require vaccination. This includes any staff who are at risk of injury from blood-contaminated sharp instruments, or of being deliberately injured or bitten.'

2.0 Staff
2.1The staff risk assessment will seek to identify those who are at high risk of contracting hepatitis B. This includes staff members who:

- are non-responders to the hepatitis B vaccine
- have declined to have the hepatitis B vaccine
- are immuno-compromised (for example taking steroids, undergoing chemotherapy / radiation therapy for cancer or are HIV positive)
- have eczema, psoriasis or dermatitis on their face, hands or lower arms.

2.2 In situations where a staff member fails to gain sufficient immunity or falls into one of the categories listed at 2.1 above, managers will recommend that they seek further advice (for example from occupational health or their GP) about any actions or restrictions that may be required in the event of an exposure to blood of body fluid.

2.3 It is also recommended that staff who are non-responders seek further advice from either occupational health or their GP to determine whether they are carriers of hepatitis B.

3.0 Tasks that are considered to be at low to medium risk of transference of hepatitis

- Domiciliary tasks.
- The provision of personal care to people assessed as being at low risk of transferring hepatitis B, who do not fall into any of the categories listed in 1.0 above.

4.0 Tasks that are at higher risk of transference of hepatitis

- The provision of personal care to those listed in 1.0 above.
- Handling sharps.

APPENDIX 2
SAFE DISPOSAL OF WASTE IN SERVICE USERS' HOMES

Where regulated care and support is being provided to a person with care needs in their own home, care workers may be required to handle and dispose of small amounts of offensive or clinical waste in addition to general household waste.

Offensive waste (also referred to as hygiene waste)
Offensive waste is waste produced from a non-infections source.

It consists of such items as incontinence pads, nappies, sanitary waste, catheter / stoma bags, paper towels used to clean spillages, used disposable gloves and aprons.

It may be offensive in appearance and may smell, but is not classed as hazardous under environmental legislation.

Offensive waste, such as that listed above, needs to be double- bagged before being placed in with domestic waste. It should never be placed into dustbins loose.

Clinical waste
Clinical waste consists of waste that may pose a threat to public health. It is a category of hazardous waste and has to be collected and disposed of under tightly controlled conditions that are legally enforced by strict government regulations.

Examples of domestic clinical waste

- Any waste containing blood, bodily fluids, excrement or excretions generated by a person with an infection that may be transmitted to others (such as MRSA, HIV, TB, hepatitis, C. Difficile).
- Contaminated swabs and dressings.
- Syringes, needles, lancets and other sharp instruments.
- Any other healthcare related waste that may cause infection to a person coming into contact with it.

Where waste has been identified as clinical, this needs to be clearly recorded in the person's care and support plan and staff informed of the action they are required to take.

Disposal of domestic clinical waste
Clinical waste must not be mixed in with general household waste or placed in standard domestic waste bags or bins. It must be placed in the appropriate bag / container in compliance with local authority requirements and collected separately by a suitable waste carrier service organised by them.

Syringes, needles and other sharp instruments must be disposed of in a British Standards sharps container (obtained on an FP10 prescription).

For information concerning the disposal of unwanted drugs and other pharmaceutical products 9also classed as clinical waste), see the medication procedure for managers (B02b).