NHS
Humber Teaching
NHS Foundation Trust

# STANDARD OPERATING PROCEDURE STANDARD INFECTION CONTROL PRECAUTIONS (SICPS)

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**VALIDITY – All local SOPS should be accessed via the Trust intranet**

**CHANGE RECORD**

| Version | Date | Change details |
|---|---|---|
| *1.0* | *Feb.2023* | *New Standard Operating Procedure. Approved at HAIG (21 February 2023).* |
| *1.1* | *Feb 2024* | *Scheduled annual review for a new SOP. Minor changes made, references reviewed and updated to intranet / web pages. Approved at HAIG (26 February 2024).* |
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## 1. INTRODUCTION

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control (IPC) practices that when used consistently and diligently reduce the transmission of potentially pathogenic organisms from both recognised and unrecognised sources. Implementation of SICPs results in a reduction in prevalence of Healthcare Associated Infections (HCAIs); ultimately protecting patients, staff and visitors.

To reduce the level of variation and inconsistencies in IPC practice delivery across the country the National Infection Prevention and Control Manual (NIPCM) was developed and published in April 2022 outlining the standards of practice which should be delivered as a mandatory requirement by all those involved in care provision in England.

This Standard Operating Procedure (SOP) supplements the contents of the manual by describing the additional operational and clinical processes that all staff within Humber Teaching NHS Foundation Trust are also expected to follow to ensure that all the necessary 10 elements of SICPs are embedded within all care delivery in accordance with both national and the Trust's regulatory requirements.

## 2. SCOPE

This SOP applies to all healthcare workers employed by Humber Teaching NHS Foundation Trust (including contractors, agency/locum staff, students and visiting/honorary consultants/clinicians) who have direct or indirect contact with patients and their environment. They equally apply to both uniform and non-uniform wearing staff.

## 3. DUTIES AND RESPONSIBILITIES

**The Chief Executive**
The Chief Executive will ensure that there are effective and adequately resourced arrangements for infection prevention and control within the organisation.

**Director of Infection Prevention and Control (DIPC)**
The Director of Infection Prevention and Control (DIPC) has delegated responsibility for ensuring the implementation of this SOP and monitoring the impact. As an Executive member of the Trust Board any serious concerns or incidents will be escalated directly to the Chief Executive and the Trust Board.

**Divisional Leads**
Divisional Leads have responsibility to ensure that all staff within the division are aware of this SOP and understand their individual responsibility to follow it at all times. They are responsible for monitoring the implementation of this SOP and for ensuring action is taken when staff fail to comply. They are also responsible for ensuring that the facilities and equipment required are provided to facilitate effective and safe practice.

**Modern Matrons/Clinical Leads**
Matrons are responsible for leading and driving a culture of adherence to effective IPC in their respective clinical areas and for monitoring, recording and reporting compliance with standards. They will support the monitoring of SICP practice as part of the Trust agreed infection prevention and control audit programme and will ensure any areas of non-compliance are addressed.

**The Infection Prevention and Control Team**
The Infection Prevention and Control Team (IPCT) is responsible for providing expert advice in accordance with this SOP and for supporting staff in its implementation. This includes the delivery of an educational programme which includes the use of SICPs as a core component. They are responsible for ensuring this SOP remains consistent with the contents of the NIPCM.

**Ward / Team Managers / Clinical Leads**
It is the responsibility of Ward / Team Managers / Clinical Leads to ensure that this SOP is implemented in their area and for ensuring all staff always adhere to the principles. They are responsible for addressing any issues of non-compliance within their clinical areas of responsibility.

They will also ensure that:
- They take a leading role, personally acting as positive role models of effective infection prevention and control practice.
- All clinical staff within their designated area of responsibility have completed a Hand Hygiene and Personal Protective Equipment (PPE) Clinical Skill Competency assessment in accordance with this SOP. Any individual who does not achieve the necessary competency level is managed in accordance with the Trust approved processes.
- All facilities, equipment and stock are in place and are functional to enable effective IPC practice.
- The Trust approved IPC audit schedule requirements are completed and actions addressed.
- Any staff who experience problems with the skin on their hands at any time are referred to the Occupational Health department for further assessment.

**Occupational Health Department will:**
- Provide advice to employees who are susceptible to, or who are experiencing problems with the wearing of PPE e.g. The condition of the skin on their hands.
- Provide advice to managers on any restrictions to the duties of employee's who are experiencing any associated problems.
- Provide advice to managers and staff about the use of alternative products for individual members of staff to use on a temporary or permanent basis.
- Liaise with the Infection Prevention and Control Team when clusters of staff in an area report skin problems.

**Infection Prevention and Control Link Practitioner will:**
- Act as a liaison between the clinical area and the IPC Team on all matters pertaining to this policy.
- Cascade all information shared at the link practitioner meetings and ensure documented evidence of this action.
- Act as an assessor for the completion of the Hand Hygiene and PPE Clinical Skill Competency assessments in their respective clinical areas.
- Undertake covert observations of all elements of the SICPs practice in accordance with the Trust agreed IPC audit schedule for their respective area.

**All staff who deliver direct patient care**
It is the responsibility of all staff to ensure that they adhere to evidence based best practice. All staff must take responsibility for their own IPC practice and should act as an advocate for all their patients/clients and others to ensure that everyone demonstrates effective IPC practice and adherence to SICP.
They will ensure that:
- They adhere to the Bare Below the Elbow principles.
- They successfully complete a Hand Hygiene and PPE Clinical Skill Competency assessment if they undertake any clinical duties as part of their job role.
- They inform their line manager if they identify any barriers to the implementation of safe IPC practice in their area of work e.g., lack of hand hygiene facilities or PPE.
- They remain up to date with all mandatory infection prevention and control training requirements as outlined within the Trust Mandatory Training matrix. Each member of staff will complete an annual appraisal, on which all mandatory training is to be identified and attendance recorded.

## 4. PROCEDURES

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control measures that must be adopted to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.

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.

There are 10 elements identified as being essential in the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.

The Trust recognises the importance of implementing these elements into all clinical practice and as such expects all staff to adhere to both the contents of the National IPC Manual and additional supportive information and guidance documents outlined below.

**Standard Infection Control Precautions (SICPs):**

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 equipment
6. Safe management of care environment
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)

### 4.1. Patient Placement/Assessment of Infection Risk

All patients admitted within the Trust must be promptly assessed for infection risk ideally prior to or on arrival at the care area, e.g. inpatient/outpatient/care home, and any patient identified with a potential or actual infection risk should be nursed in an appropriate location and managed in accordance with both the national transmission based precautions section within both the national IPC manual, the Trust disease specific policies/operational guidance Infection Prevention and Control Policies (humber.nhs.uk) and the Trust IPC Guidance at a Glance on the Document store via the IPC intranet page

The Trust approved Infection Prevention and Control Initial Risk Assessment document must be completed for each inpatient admission to provide a record of the assessment but also to sign post the staff member to the subsequent actions that are required to manage the patient. The document is available within all the Humber Teaching NHS Foundation Trust electronic patient record systems.

A care plan for the management of the patient with any commonly encountered nosocomial infections requires completion and is available within electronic patient record systems.
Staff must notify the IPC team of any patient or patients suspected or confirmed with a communicable disease on hnf-tr.ipc@nhs.net. If two or more patients/staff are affected referral and actions must be taken in accordance with the Outbreak of Communicable Infection Policy.

### 4.2. Hand Hygiene

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

Hands must be washed 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.

For details of how to wash hands effectively please refer to the NIPCM Appendix 1: Best practice – How to hand wash, step-by-step images

Where running water is unavailable, or hand hygiene facilities are lacking, staff may also use hand wipes followed by alcohol-based handrub (ABHR) and then wash their hands at the first opportunity

In all other circumstances, ABHR may be utilised for routine hand hygiene during care. For details of how to use hand rub effectively please refer to the NIPCM Appendix 2: Best practice – How to hand rub, step-by-step images

ABHRs must be available for staff as near to the point of care as possible. Where this is not practical or poses a safety issue due to the patient group, personal ABHR dispensers should be used, e.g. within the community, domiciliary care, mental health units etc. This should be attached to the belt or pocket based on risk assessment.

It is essential that each ward/department completes a risk assessment prior to the siting of any ABHR dispenser within the clinical area and they should only be placed in a position which allows the staff to monitor that it is being used appropriately and not open to misuse.

The nozzle on the ABHR dispenser must be cleaned daily by a designated individual to prevent blocking and squirting in to the eyes or clothing.

Accidental splashes should be managed by irrigation to the affected eye/eyes in the first instance. Staff members should then contact the Occupational Health Department for further advice.

If a significant ingestion occurs medical advice needs to be sought urgently. The National Poisons Information Service must also be contacted (TOXBASE telephone number 0344 892 0111) to give further advice. Any incidents must be reported to the line manager and a DATIX must be completed in accordance with the Trust  Incident Reporting Policy N-038 found on the Report an Incident intranet page.

Skin Care

Contact dermatitis and dry skin is often reported by healthcare workers following contact with hand washing products. Hand washing products contain surfactants which remove dirt from the surface of the skin however they can also compromise the lipid barrier of the skin leading to dryness, redness and irritation.

The skin irritation may also be associated with poor hand hygiene technique and the failure to wet hands prior to applying soap, the incomplete rinsing of hands or inadequate drying. The use of a non-perfumed moisturiser also helps to prevent skin from becoming dry. This should be applied regularly to protect the hands from the drying effects of the hand hygiene products. It should be noted that staff must not use communal tubs or pots of hand cream as they can become a potential source of infection. Please refer to the Trust Skincare Leaflet via the Occupational Health intranet page.

Cultural Considerations

The Trust recognises and values the diversity of cultures, religions and disabilities of its employees however there may be circumstances in which there are genuine occupational reasons as to why the wearing of certain articles and/or clothing is not permissible and priority will be given to health and safety and infection prevention and control. There may be circumstances where being bare below the elbows may cause difficulties to individual members of staff on grounds of disability,

religious beliefs or other personal reasons. This should be discussed with the member of staff's line manager who should seek advice from Human Resources and the Infection Prevention and Control Team.

Wearing of Medical Alert Bracelets
A medical alert bracelet is worn to alert first responders and medical personnel to give information around medical conditions and allergies. If medic alert jewellery needs to be worn, this should not be made of fabric material and worn ideally off the wrist (necklace or anklet) rather than as a bracelet when possible. The Medic Alert Foundation has a wide selection of alternative jewellery available, and wearers should consider purchasing a suitable alternative when their current jewellery needs replacing or updating.

### 4.3. Respiratory and Cough Hygiene

Respiratory and cough hygiene etiquette is designed to minimise the risk of cross transmission of known or suspected respiratory illness and to minimise the risk.

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose
- 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.

It is essential that staff must assist those (e.g. elderly, children) who may need assistance with this, e.g. providing patients with tissues, plastic bags for used tissues and hand hygiene wipes as necessary.

### 4.4. The Use of Personal Protective Equipment (PPE)

All blood and body fluids pose a potential risk of transmitting infection therefore it is important that a risk assessment is completed to assess any likely exposure and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken. The Trust will supply appropriate PPE to all employees who may be exposed to risks of contamination at work and any shortages or concerns about the quality of any must be immediately reported to the line manager.

PPE **must** be worn in all instances when in direct contact with blood or body fluids or when cleaning with chemicals.

Unless specified by the manufacturer, all items of PPE must be worn as single use for one procedure or episode of patient care and then discarded and disposed of as clinical waste, before washing and drying hands

The use of full body, fluid repellent gowns or coveralls should be carefully considered when there is a risk of extensive splashing of any of body fluids, when dealing with high risk pathogens or when dealing with heavily contaminated environments with body fluids.

**All PPE ideally should be removed before leaving the area in which it was used unless it is deemed to pose a clinical risk to the patient by doing so e.g. bedroom, clinical room and hands must be decontaminated after removal.**

The routine use of PPE by visitors will be determined according to the organism involved however, disposable plastic aprons should be worn when direct patient care is undertaken by a

relative/significant other or when there is potential for the individuals clothing to become contaminated or the areas is experiencing an outbreak.

All PPE should be:

- Located close to the point of use. PPE for healthcare professionals providing care in the community must be transported in a clean receptacle.
- Stored in a clean/dry area to prevent contamination until required for use (expiry dates must be adhered to).
- Single-use only items unless specified by the manufacturer; and disposed of after use into the correct waste stream i.e. healthcare waste or domestic waste.
- Changed immediately after each patient and/or after completing a procedure or task.
- In a safe, secure location particularly in the mental health, forensic and children units.

All clinical staff are required to demonstrate they can wear PPE in accordance with the perceived and actual risks that the exposure poses. This includes the ability to don (put on) and doff effectively staff to refer to the NICM Appendix 6: Putting on and removing personal protective equipment (PPE)

The use of Fluid resistant surgical mask (FRSM) within the Trust

Staff must read section 1.4 of the NIPCM (PPE) but also refer to the latest Trust Communication and the IPC team for specific guidance on when FRSM must be used in their setting dependent upon the local prevalence of respiratory infection.

Consideration must be given to service users with communication difficulties, such as an individual who relies on lip reading or a person with autism who needs to see the whole of the staff members face to interpret meaning from the interactions they have with staff.

### 4.5. Safe Management of Care Equipment

Equipment used in the care environment can become easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. It is important the equipment used within our services are well maintained, used in accordance with the manufacturers' recommendations and decontaminated at the correct moment.

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 is the Trust preferred option when appropriate and available.

Reusable equipment can be a potential source of infection if not appropriately decontaminated. Any reusable equipment used by patients should be cleaned and decontaminated between each use and when soiled. Please refer to Appendix 11 in the Medical and Non-medical Devices Policy N-042.

If utilising reusable equipment the user of the device is responsible for ensuring that it is visibly clean and free from contamination with blood/body fluids following each procedure and prior to re-use or prior to sending for repair (internally/externally).

Suitable PPE must be worn during decontamination procedures to protect the healthcare worker from exposure to microorganisms or infectious agents, where the risk of splash is anticipated.

Standardised cleaning checklists have been developed to ensure a standardised template is in use throughout the Trust by all clinical teams for reusable items of patient equipment and these can be

found in the document store. Guidance regarding the cleaning requirement for all equipment and toys can be found on the Document store IPC Document Store (humber.nhs.uk).

Routine cleaning is fundamental in the safe management of the care environment. The Trust Commitment to Cleanliness Charters reflects the implementation of the National Standards of Healthcare Cleanliness 2021 for all its cleaning and monitoring arrangements and all staff should familiarise themselves with the cleaning charter/schedule and the auditing processes that are required within their respective areas of work.

A charter setting out the commitment to ensure a consistently high standard of cleanliness is required in each area within the Trust and this should be prominently displayed within the ward/area.

### 4.6. Safe Management of Healthcare Linen

All healthcare linen must be managed in accordance with HTM 01-04 Decontamination of linen for health and social care and as stipulated within section 1.7 of the NIPCM. Within the Trust we currently have two contracts in place to manage our healthcare linen within the clinical settings and the processes and management of the linen varies slightly between our sites.

The bagging procedure poster for the management of healthcare linen at Malton and Whitby Hospital can be found via the IPC Document Store (humber.nhs.uk).

The bagging procedure poster for the management of healthcare linen in all other Trust inpatient settings can be found via the IPC Document Store (humber.nhs.uk).

All used bed linen may be contaminated with potential pathogens therefore should be removed from the bed with care and placed immediately into the appropriate bag at the bedside and not on the floor or carried through the ward/department. Although linen may be contaminated with body fluids, which may carry disease, there is little risk if the correct bagging procedure is followed.

### 4.7. Safe Management of Blood and Body Fluids

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

- Staff dealing with a spillage of blood or body fluids should be trained to undertake the task safely, i.e. have received mandatory IPC training.
- Appropriate PPE(e.g. gloves, apron) should be worn when dealing with blood and other body fluid spillages.
- The organic matter (the spillage of either blood or body fluids) should firstly be absorbed and cleared way and all disposed into the clinical waste stream.
- When the spillage has been absorbed / cleared, the surface area to be disinfected using a Trust approved chlorine releasing agent / disinfectant product, i.e., Actichlor Plus, Chlor Clean. Staff must always follow the manufacturers' dilution guidance. Clean and disinfect an area larger than the spill with your disinfectant solution.
- Chlorine releasing agents are inactivated by organic matter. Care is necessary with metals as chlorine is corrosive.

For the management of blood spills please refer to the NIPCM Appendix 9: Best practice – management of blood and body fluid spills.

How to use Actichlor Plus training video can be found here.

### 4.8. Safe Disposal of Waste (including sharps)

Good waste management (including sharps is essential and staff must refer to section 1.9 in the NICM for full guidance. Referral must also be made to the Waste Management Policy F-020.

**For staff caring for patients within nursing homes or premises which are owned and managed by other providers the arrangements for waste disposal may differ from the categories described above and guidance from the local contractors will need to be sought.**

**Waste bags** must be no more than ¾ full and a ratchet tag/or tape (for healthcare waste bags only) must be utilised adopting a 'swan neck' to close with the point of origin and date of closure clearly marked on the tape/tag.

**All waste** to be stored in a designated, safe, lockable area whilst awaiting collection. Collection schedules must reflect the requirements of the service and there should be no excess build-up of waste receptacles.

**Liquid waste**, e.g. blood must be rendered safe by adding a self-setting gel or compound before placing in a healthcare waste bag however this must be kept secure and away from patients. See National Patient Safety Alert – PS_Alert_Polymer_28_Nov_2019_FINAL.pdf (england.nhs.uk)

**Transporting offensive or infectious waste from patients' homes**
Where waste is generated by a healthcare worker for people in their own homes, the healthcare worker is responsible for ensuring that the waste is managed correctly; this is part of their duty of care. All waste must be packaged and labelled correctly and transported for appropriate treatment and disposal. Healthcare organisations and their employees have responsibility for the waste while it is being stored awaiting collection and for arranging that collection.

**Clinical waste can only be left in the patient's home** if the householder consents to the healthcare worker who produced the waste leaving it in the home for later collection by an appropriate organisation (for example a waste contractor acting on behalf of the local authority or healthcare provider). If the householder declines to give consent, the healthcare worker cannot legally leave the waste. This problem should be discussed with the householder and the manager of the healthcare worker in order to explore all options of convenient and safe resolution.

While awaiting collection from the householder's home, the waste should be stored in a suitable place to which children, pets, pests etc. do not have access. It is not appropriate to leave the waste unsupervised on the pavement awaiting collection.

How to correctly assemble a sharps container, please refer to the sharps container assembly poster and the video how to assemble a SHARPSGUARD container.

## 4.9. Occupational Safety/Managing Prevention of Exposure (including sharps)

There is a potential risk of transmission of a Blood Borne Virus (BBV) from a significant occupational exposure and staff must understand the actions they should take when a significant occupational exposure incident takes place.

A significant occupational exposure is defined as:

- 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 information regarding the immediate action to take following an inoculation incident please refer to the Trust Occupational Health Inoculation Accidents intranet page.

Any sharps injuries and near misses must be reported to line manager and a DATIX must be completed in accordance with the Trust Incident Reporting Policy N-038 found on the Report an

Incident intranet page.

### 4.10. Key Standards/Performance Indicators

The Trust utilises a variety of surveillance methods in the measurement of IPC performance to provide assurance that all elements of practice outlined within the NIPCM are being adhered to.

This includes:

- The completion of a Trust approved IPC Audit programme completed by the IPC Link Practitioner, Matron and or the IPCT. All results will be captured by utilising the Trust approved audit system.
- An external Sharps Safety Audit programme
- Review of any learning from exception or incident reports.
- Opportunistic observational visits including Executive, IPCT, Matron walk rounds
- Intelligence obtained from the Trust alert organism data
- Leaning identified from communicable disease outbreaks

The Trust approved IPC audit packages encompass the measurement of both IPC policy knowledge, but also the observation and monitoring of IPC practice focusing on the key elements as described above. A planned timetable is in place for each of the clinical areas however the schedule will be assessed and reviewed according to the results obtained and the associated level of risks posed with any areas of non-conformity. Where non-compliance is identified, support and advice will be provided by the IPC Team to improve performance.

Any IPC audits or surveillance findings are reported at both Healthcare Associated Infection Group (HAIG) and the divisional governance meetings and are used to inform any performance review and business planning agenda. In the event of an infection control risk being identified following an assessment, audit or inspection, the divisions are responsible for ensuring remedial action is taken, if required, to minimise risk and to ensure that any lessons learnt as a result of any investigations, complaints etc, is embedded into practice to improve care delivered.

For further information please refer to the Infection Prevention and Control Arrangements Policy N-014.

### 4.11. Review of the Policy

This SOP will be reviewed every three years routinely, unless:

- New national or international guidance is received
- Newly published evidence demonstrates the need for change to current practice.
- Action is required from Root Cause Analysis, Serious / Incident Investigation Report

### 4.12. Staff Training Requirements

Infection prevention and control training which includes all element of SICPs practice is delivered as part of the mandatory training requirements for staff as defined in the Trust Mandatory Training Needs analysis.

All Trust staff regardless of their job role are also required to complete theoretical hand hygiene training on induction.

All staff who are required to complete the Infection Prevention and Control Level 2 mandatory training are required to complete the Trust approved Hand Hygiene and PPE Clinical Skill Competency assessment. Once completed the result must be recorded on the ESR system.

Following the competency assessment, if level 3 is not achieved, then an action plan should be agreed between the supervisor and practitioner. This action plan should be documented at the end of the competency assessment addressing any areas for improvement to achieve the required level of competency.

## 5. KEY REFERENCE DOCUMENTS


Department of Health (2022) The Health and Social Care Act 2008: Code of Practice on the Prevention and control of infections and related guidance. [available from] The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (publishing.service.gov.uk)

Department of Health (2016) Health Technical Memorandum 01-04: Decontamination of linen for health and social care https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04

Humber Teaching NHS Foundation Trust. *Infection Prevention and Arrangements Policy* https://Infection Prevention and Control Arrangements Policy N-014

Humber Teaching NHS Foundation Trust. *Admission and Transfer Policy* https://IPC Admission and Transfer Policy N-033

Humber Teaching NHS Foundation Trust *MRSA Policy* https: MRSA Policy N-021.

Humber Teaching NHS Foundation Trust *Medical Devices and Non-Medical Devices and Equipment of High Cost/Volume for use in Patient Areas – Management and Procurement* (N-042) https://intranet. Medical and Non-medical Devices Policy

Humber Teaching NHS Foundation Trust *Isolation Precautions Policy* https://Isolation Precautions Policy

Humber Teaching NHS Foundation Trust *Management and Protection of Health Care Workers exposed or infected with Blood Borne Viruses (HIV, Hepatitis B and C) (N-068)* OH-Blood-borne Virus Policy N-068.pdf

NHS England (2018) The Gloves are off [available from] NHS England » 'The gloves are off' campaign

NHS Scotland (2023) ARHAI Indications and Techniques for Hand Hygiene (scot.nhs.uk) Literature Review

NHS England (2022) National infection prevention and control manual (NIPCM) for England NHS England 2022 National Infection Prevention and Control Manual

Humber Teaching NHS Foundation Trust https://intranet.humber.nhs.uk/report-an-incident.htm

National Patient Safety Alert – Superabsorbent polymer gel granules (2019) NatPSA/2019/002/NHSPS.

## Appendix A - Equality Impact Assessment

**For strategies, policies, procedures, processes, guidelines, protocols, tenders, services**

1. **Document or Process or Service Name:** Standard Infection Control Precautions (SICPS)
2. **EIA Reviewer:** Deborah Davies, Lead Nurse Infection Control ddavies10@nhs.net
3. **Is it a Policy, Strategy, Procedure, Process, Tender, Service or Other?** SOP

| **Main Aims of the Document, Process or Service**<br>To comply with the HCAI code of Practice of the Health and Social Care Act 2008 and the National infection prevention and control manual (NIPCM) for England (2022)<br>Adherence to the Standard Infection Control precautions procedure will ensure risk of healthcare acquired infection is massively reduced. |
|---|
| Please indicate in the table that follows whether the document or process has the potential to impact adversely, intentionally or unwittingly on the equality target groups contained in the pro forma |

| Equality Target Group<br>1. Age<br>2. Disability<br>3. Sex<br>4. Marriage/Civil Partnership<br>5. Pregnancy/Maternity<br>6. Race<br>7. Religion/Belief<br>8. Sexual Orientation<br>9. Gender re-assignment | Is the document or process likely to have a potential or actual differential impact with regards to the equality target groups listed?<br><br>Equality Impact Score<br>Low = Little or No evidence or concern (Green)<br>Medium = some evidence or concern(Amber)<br>High = significant evidence or concern (Red) | How have you arrived at the equality impact score?<br>a) who have you consulted with<br>b) what have they said<br>c) what information or data have you used<br>d) where are the gaps in your analysis<br>e) how will your document/process or service promote equality and diversity good practice |
|---|---|---|

| Equality Target Group | Definitions | Equality Impact Score | Evidence to support Equality Impact Score |
|---|---|---|---|
| **Age** | Including specific ages and age groups:<br><br>Older people<br>Young people<br>Children<br>Early years | Low | This policy is consistent in its approach regardless of age. |
| **Disability** | Where the impairment has a substantial and long term adverse effect on the ability of the person to carry out their day to day activities:<br><br>Sensory<br>Physical<br>Learning<br>Mental health<br><br>(including cancer, HIV, multiple sclerosis) | Low | This policy is consistent in its approach regardless of Disability. Additional time may be required to provide information to patients with limited understanding about why they are isolated and the need for staff usage of Personal Protective equipment for example masks are being worn as they may find this anxiety provoking. For patients with mental health conditions such as depression or anxiety, isolation may prove an additional issue, therefore care needs to be taken to ensure adequate interaction and support is provided.<br><br>Comments received from several individuals (staff and patients) describing the communication difficulties experienced when staff wear facemasks. This was taken into consideration and sources found for alternative facemasks that would protect the wearer and others around them but allow for effective communication when feasible. |
| **Sex** | Men/Male<br>Women/Female | Low | This policy is consistent in its approach regardless of patients sex. |
| **Marriage/Civil Partnership** | | Low | This policy is consistent in its approach regardless of marital status. |

| Equality Target Group | Definitions | Equality Impact Score | Evidence to support Equality Impact Score |
|---|---|---|---|
| **Pregnancy/ Maternity** | | Low | This policy is consistent in its approach regardless of pregnancy/maternal status. |
| **Race** | Colour<br>Nationality<br>Ethnic/national origins | Low | This policy is consistent in its approach regardless of race.it is acknowledged however that for any patient whose first language is not English, as information needs to be provided and understood, staff will follow the trust interpretation policy. |
| **Religion or Belief** | All religions<br>Including lack of religion or belief and where belief includes any religious or philosophical belief | Low | This policy is consistent in its approach regardless of religious belief. |
| **Sexual Orientation** | Lesbian<br>Gay men<br>Bisexual | Low | This policy is consistent in its approach regardless of sexual orientation. |
| **Gender Reassignment** | Where people are proposing to undergo, or have undergone a process (or part of a process) for the purpose of reassigning the person's sex by changing physiological or other attribute of sex | Low | This policy is consistent in its approach. |

**Summary**

| Please describe the main points/actions arising from your assessment that supports your decision above<br><br>None of the equality strands have been identified in the initial impact assessment<br><br>The practices / actions recommended in this policy is based upon the potential for cross-infection of a potentially harmful bacteria from one individual to another. Factors for consideration will include microbiolological data, extent of symptoms and the potential risk of the spread of infection to others in conjunction with other safety risk factors. | |
|---|---|
| EIA Reviewer: Deborah Davies | |
| Date completed: 13.2.24 | Signature: D.Davies |