Infection Control and Prevention Policy

Introduction

Quality statements are the commitments that providers, commissioners and system leaders should live up to. Expressed as ‘we statements’, they show what is needed to deliver high-quality, person-centred care.

When they refer to 'people' we mean people who use services, their families, friends and unpaid carers. This includes:

- people with protected equality characteristics
- those most likely to have a poorer experience of care or experience inequalities.

Elizabeth Finn Homes (EFH) will commit to the following quality statements for: Infection Control and Prevention

Learning culture

We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

Safe systems, pathways and transitions

We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services.

Safe environments

We detect and control potential risks in the care environment. We make sure that the equipment, facilities and technology support the delivery of safe care.

Safe and effective staffing

We make sure there are enough qualified, skilled and experienced people, who receive effective support, supervision and development. They work together effectively to provide safe care that meets people’s individual needs.

Involving people to manage risks

We work with people to understand and manage risks by thinking holistically so that care meets their needs in a way that is safe and supportive and enables them to do the things that matter to them.

Infection prevention and control

We assess and manage the risk of infection. We detect and control the risk of it spreading and share any concerns with appropriate agencies promptly.

Assessing needs

We maximise the effectiveness of people’s care and treatment by assessing and reviewing their health, care, wellbeing and communication needs with them.

Delivering Evidence Based Care and Treatment

We plan and deliver people’s care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards.

How staff, teams and services work together

We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services.

Monitoring and improving outcomes

We routinely monitor people's care and treatment to continuously improve it. We ensure that outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves.

Consent to care and treatment

We tell people about their rights around consent and respect these when we deliver person-centred care and treatment.

Kindness, compassion and dignity

We always treat people with kindness, empathy and compassion and we respect their privacy and dignity. We treat colleagues from other organisations with kindness and respect.

Treating people as individuals

We treat people as individuals and make sure their care, support and treatment meets their needs and preferences. We take account of their strengths, abilities, aspirations, culture and unique backgrounds and protected characteristics.

Responding to people's immediate needs

We listen to and understand people's needs, views and wishes. We respond to these in that moment and will act to minimise any discomfort, concern or distress.

Person-centred care

We make sure people are at the centre of their care and treatment choices and we decide, in partnership with them, how to respond to any relevant changes in their needs.

Care provision, integration, and continuity

We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity.

Listening to and involving people

We make it easy for people to share feedback and ideas or raise complaints about their care, treatment and support. We involve them in decisions about their care and tell them what's changed as a result.

Partnerships and communities

We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.

Learning, improvement and innovation

We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.

Scope

EFH will deliver services, in line with current guidance and best practice, for the prevention and control of the spread of infection among staff, residents, family, professionals and the local community.

EFH will use a number of strategies to prevent and control the spread of infections, including following the latest guidance, regulations and legislation, as well as policies and procedures, clear assignment of responsibility and training for staff/managers.

This policy and procedure are provided for the regulated activity of accommodation for people requiring nursing or personal care.

Equality Statement

EFH is committed to equal rights and the promotion of choice, person-centred care and the promotion of independence. This policy demonstrates our commitment to creating a positive culture of respect for all individuals. The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the nine named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to reflect the Human Rights Act 1998 to promote positive practice and value the diversity of all individuals.

Policy Statement

As a responsible employer Elizabeth Finn Homes (EFH) has prepared this statement to discharge those duties under the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

EFH understands infection control to be the name given to a wide range of policies, procedures and techniques intended to prevent the spread of infectious diseases amongst staff, residents and their communities.

This policy statement and the policies within will be reviewed and revised at regular intervals and any changes will be brought to the notice of all EFH employees.

The aim of our homes is to ensure that residents, their families and staff are as safe as possible from acquiring infections at the home and all staff are aware of and put into practice the standard infection control precautions. A designated IC lead and or Clinical Training Co-ordinator and cleaning/decontamination lead must be identified for each home (these may be but do not have to be, the same individual). An Infection Control Champion should be assigned for each Home / Unit/ Floor within the home, they will work closely with the Infection Control Lead to promote & monitor best practice in their work areas.

EFH policies aim to be compliant with current guidance and regulations on the prevention and control of infections that are likely to affect residents. The homes policies comply with Regulation 12, Cleanliness and Infection Control of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Department of Health Guidance, the Health and Social Care Act 2008 Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance) NICE Guidelines Infection prevention and control December 2020.

Legal Considerations and Statutory Guidance

The home will adhere to the following infection control legislation.

The Health & Safety at work Act etc1974 and the Public Health Infectious Diseases Regulations 1988 which place a duty on the home to prevent the spread of infections.

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), which place a duty on the home to report certain outbreaks of diseases as well as accidents such as needle stick injuries.

The Control of Substances Hazardous to Health Regulations 2002 (COSHH) which place a duty on the home to ensure that potentially infectious materials within the home are identified as hazards and dealt with accordingly.

The Hazardous Waste Regulations 2005 which make it the responsibility of the home to dispose of clinical waste safely.

The Food Safety Act 1990 which place a duty on a home to ensure compliance with the Environmental Health Regulations.

Health Protection (Notification) Regulation 2010 places a duty on a home to report certain outbreaks of diseases.

The Policy

Standard Infection Control Precautions (SICPs)

Standard infection control precautions (SICPs) are the basic infection prevention and control measures necessary 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 (excluding sweat), non-intact skin or mucus membranes and any equipment or items in the home that could have become contaminated
.
The application of SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To protect effectively against infection risks, SICPs must be used consistently by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to residents, staff and visitors.

There are 10 elements of SICPs:

1. Resident assessment for infection risk
2. Hand hygiene
3. Respiratory hygiene and cough etiquette
4. Personal protective equipment (PPE)
5. Safe management of care equipment
6. Control of the environment
7. Safe management of 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)

Prevention and control of infection is an important part of maintaining residents' safety and wellbeing. There is increased public awareness of healthcare associated infections (HCAI) through Government and NHS initiatives and media reports.

EFH, in accordance with the Fundamental Standards set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, is committed to ensuring that all residents, staff and visitors are protected against identifiable risks of acquiring a healthcare associated infection.

Audit

The Infection Control Lead for the home is responsible for completing a quarterly whole home audit and a regular audit of infection control outbreaks whilst ensuring that evidence-based policies and procedures in relation to the control of infection are developed and their implementation is monitored.

The Infection Control Lead will monitor carefully any incident reports relating to infection control matters in order to identify any trends or patterns. The Clinical Lead will carry out a monthly analysis of routine infections that have been treated each month to identify any areas of practice where further training or improvements are required.

Basic Infection Prevention and Control Practice:

Hand Hygiene

Please refer to EFH Hand Hygiene Policy

Hand hygiene is widely acknowledged to be the most effective methods to prevent the transmission of pathogens and is a central component of standard precautions.

Refer to NHS Standard Infection Control Precautions; national hand hygiene and personal protective equipment policy- March 2019 for hand washing guidance, PPE selection and use and Management of occupational exposure incidents

https://improvement.nhs.uk/resources/national-hand-hygiene-and-personal-protective-equipment-policy/

Hands should be washed with soap from dispensers and dried thoroughly with disposable paper towels as per guidelines. Staff must be shown correct procedure during their induction. Hand hygiene is to be monitored by Infection Control Lead & Champions.

Alcohol gel is an effective agent in the prevention of cross infection, but must not be used as an alternative to hand washing. Alcohol hand gel should be located at the point of care.

Wounds or infectious skin conditions must be covered with a waterproof protective dressing.

For activities that might involve contact with body fluids and dressing wounds, gloves must be worn. Thorough hand washing should precede and follow each individual procedure.

All care staff should adhere to the 'bare below the elbow' philosophy (i.e. no sleeves, jewellery (a single plain metal finger ring is permitted but should be rotated during hand hygiene) artificial nails or nail products are not permitted. Nails should be short and clean.

The Storage, Preparation and Serving of Food

Refer to the EFH policy on food preparation and handling.

Any storage or handling of food raises a potential risk of poisoning so the highest standards of hygiene must be observed by all staff at all times. All food brought into the home by staff should be stored in the food fridge in the staff room and lunch boxes removed at the end of their shift. Any outdated food should be disposed of. Staff should follow all food storage recommendations and observe sell by dates scrupulously. Any staff suffering from food poisoning, diarrhoea or vomiting should report this to the home, be symptom free for 48 hours before returning to their duties.

HACCP (Hazard Analysis Critical Care Point) – refer to EFHL HACCP policy

Personal Protective Equipment (PPE)

Please refer to Elizabeth Finn Homes Ltd PPE policy (HSP16)

Personal Protective Equipment such as gloves & aprons are disposable and designed for single use only.
Carers PPE should be changed between each resident and procedure.
Commonly used PPE items include gloves and aprons.
Less commonly used items, but essential in certain infectious conditions are face masks, gowns and eye goggles.

Please refer to Elizabeth Finn Homes Ltd Coronavirus policy (HSP09)

Disposable Gloves must be worn when contact with body fluids or non-intact skin is anticipated.
Gloves reduce, but do not eliminate, the risk of contamination; hand hygiene is therefore essential following removal of gloves.
An alternative to latex (e.g. Nitrile) gloves must be available for staff known to have a confirmed sensitivity to latex.

Nitrile Gloves are to be worn when there is risk of contamination by bodily fluids

Please refer to Elizabeth Finn Homes Ltd PPE policy (HSP16)

Disposable aprons must be worn when there is a risk of clothing being contaminated with blood or body fluids. As with gloves, aprons should be disposed of following each single procedure.
Gloves and aprons must be readily available to staff; PPE should be well stocked and located throughout the home, at the main points of care.

White Aprons: Used for daily personal care / non infected clinical care e.g. dressings
Red Aprons: Used for infected personal care / infected clinical care
Blue Aprons: Catering use

Face masks and eye protection should only be worn on the advice of the local Infection Prevention and Control team.

(Refer to NHS Standard infection control precautions: national hand hygiene and personal protective equipment policy- March 2019)

Management of Sharp Instruments

Sharps include such items as:

- Hypodermic needles (including those attached to syringes)
- Stitch cutters
- Used razor blades (separate sharps bin should be used)
- All sharps containers must be purpose designed and colour coded
- Bins must be signed and dated on assembly.
- After use, hypodermic needles should not be replaced in needle sheaths and, as with all other single use sharp objects, should not be replaced in their packaging,
- The containers should be sealed when approximately ¾ full, and dated.
- Containers should be stored in the locked clinical room and out of reach of residents and visitors
- The safety aperture should be kept in the closed position (but not sealed) when not in use
- Homes must ensure that used/sealed sharps containers are collected by the corporate provider of clinical waste collection.
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Reusable Medical Devices

The Registered Manager will ensure the suitability of equipment under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Maintenance, Servicing and cleaning records are to be kept of all devices in use. Cleaning should be carried out as per manufactures instructions.
Medical devices can describe equipment which is usually used for providing healthcare interventions such as:

Equipment used in diagnosis or healthcare monitoring, such as thermometers and blood pressure monitors, blood sugar glucometers

Equipment used in the provision of therapy or treatment, such as syringes, needles, infusion pumps, catheters
Bed rails, hoists and slings, wheelchairs

Single-use Equipment

A single-use device is defined as one that should only be used on one person during a single procedure then discarded. It should not be reprocessed and used again, even on the same person. This should not be confused with ‘single patient’ use devices, which may be used more than once on the same person and can undergo reprocessing.

Devices designed for single use must not be reused except in emergency circumstances where there is no alternative. Such exceptional usage should be made only after a suitable risk assessment and should be reported as an untoward incident. Disposable scissors should be discarded in sharps box after use.

Equipment Failure

The home has in place clear arrangements for adverse events, incidents, errors and near-miss reporting that relates to the use of medical devices. The Registered Manager should ensure that these arrangements are robustly and fully implemented and that all such equipment failures are recorded as an untoward incident and an investigation held to look at possible ramifications, pointers for the future and lessons for procurement.

All medical devices that are suspected to be defective must be removed from use immediately and the circumstances of the failure fully investigated. Equipment should be referred for repair or replacement as required and where necessary retained for further investigation by an appropriate agency such as the Medicine and Healthcare products Regulation Agency (MHRA). All MHRA warning notices should be circulated to all relevant staff.

Risk Assessments

As the first line of responsibility, Registered Managers will maintain links and seek advice or guidance from their Local Health Trust Infection Control Team as necessary.

A designated Infection Control Lead / Clinical Training Co-ordinator must be identified for each home. An Infection Control Champion should be assigned for each Unit/ Floor within the home, they will work closely with the Infection Control Lead to promote & monitor best practice in their work areas.

Each Home will be individually responsible for the assessment of risk and to prevent, detect and control the spread of healthcare associated infection within their premises. An appropriate standard of cleanliness and hygiene in relation to environment, equipment and materials at risk of contamination must be maintained, in compliance with Outcome 8, Regulation 12, with regard to “The Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance”, Department of Health, 2015. Risk assessments should be readily available along with records of cleaning schedules for all areas and equipment. Refer to EFH Policies for Housekeeping.

Community Acquired Infections

Healthcare and/or community acquired infections that are likely to affect EFH residents are:

- Influenza (COVID-19)
- MRSA
- Clostridium Difficile
- Norovirus
- ESBL (Extended Spectrum Beta-Lactamases- enzymes produced by bacteria such as Escherichia coli (E.coli) and Klebsiella. These bacteria are found in the human bowel but can cause serious illness)
- Scabies

On confirmation of a resident colonising or being affected with such an infection, the relevant risk assessment and care pathway should be followed and a care plan implemented as applicable.
Standard infection control precautions must be adhered to and isolation management must only be practised where the risk of cross infection is high.

NOTE: Colonisation of MRSA and ESBL do not require routine isolation. Likewise, localised infections i.e. wounds or stomas that can be kept fully covered do not pose a cross-infection risk to other residents and isolation is therefore not necessary.

MRSA

MRSA (Methicillin Resistant Staphylococcus Aureus) is a potentially dangerous bacterium that is resistant to certain antibiotics.

The staphylococcus aureus organism commonly colonises in the skin (particularly skin folds, hairlines, and perineum) without causing infection. A person becomes clinically infected if the organism invades the skin or deeper tissues and multiplies to cause a localised response e.g. wound infection or systemic response e.g. septicaemia.

Colonisation of MRSA

Healthy people can be colonised by MRSA without any personal risk to their own health.
Common sites for colonisation of MRSA:

- Nose
- Groin
- Armpit

Skin, nose and throat swabs from these sites will often be taken during a hospital admission.
Topical anti-bacterial preparations will be prescribed to treat any person identified as colonising MRSA – this treatment is known as decolonisation.

MRSA skin/wound infections

As with most skin infections, signs and symptoms might include the affected area to be:

- Red
- Inflamed
- Painful
- Hot to the touch
- Oozing exudate
- In addition to the above localised physical signs, a person may have a high temperature.

Any suspected wound infection should be swabbed and sent for microbiology screening.
Infected and/or discharging wounds must be kept covered at all times.

(NOTE: District Nurses are responsible for the management of wound care in homes providing residential care – good verbal communications and written documentations between home staff and DN's is therefore vital)

The consequence of developing a serious infection with MRSA can be severe and the range of antibiotic treatment is limited. It is therefore vital to take the appropriate precautions to prevent transmission, but especially where client groups are susceptible to infection.

On confirmation of MRSA or any wound infection, a care plan must always be implemented.

Managing Outbreaks of Diarrhoea and/or Vomiting

Mild cases of diarrhoea in elderly people are relatively common and do not always have an infective origin. However, any case of diarrhoea or vomiting in an elderly community, such as a care home, is a cause for concern as it may, if caused by an infectious agent such as Clostridium difficile. This can be spread to other residents if urgent steps are not taken to prevent this. The spread of such an infection can easily lead to an outbreak, which may have serious implications for the health of all residents and staff.

In the case of two or more unexpected cases of diarrhoea and/or vomiting occurring at the home within a few days of each other, this will be considered an outbreak and should be treated as such in order to ensure that any cases of diarrhoea occurring within the home are appropriately managed and that effective precautions are taken to minimise the risks of cross-infection. Refer to Public Health England Guidance & Information

Indicators

The home recognises key indicators of a viral outbreak as being:

1. Sudden onset of vomiting or diarrhoea
2. A rapidly rising attack rate
3. A high attack rate also affecting staff

Procedures

All cases of diarrhoea will be viewed as infectious until advised otherwise and the following actions taken:

While a resident has diarrhoea their contact with other residents should be restricted. They should be cared for in their own room and designated a specific commode or toilet for their exclusive use.

A designated clinical waste bin should be placed in en suite bathrooms of those residents affected & yellow bags removed daily being taken directly to the Yellow Clinical Waste skip outside.

Faecal samples should be obtained from symptomatic residents and the microbiology form accompanying the sample should clearly state it is part of an outbreak.

Staff should wear disposable gloves and aprons when caring for residents with diarrhoea and the need to observe careful hand washing practice should be stressed. Antibacterial alcohol gels should be used routinely during an outbreak by healthcare staff between attending to residents but hands must always be washed very thoroughly with soap and water before attending to a resident. Red bags should be provided for staff to take worn uniforms home in order to avoid cross contamination in their own homes.

Housekeepers should be informed which residents/areas are affected to ensure that environmental cleaning is increased and particular attention should be paid to toilets, bathrooms, door handles, commodes and support handrails. For the duration of the outbreak, environmental cleaning should be performed using detergent and hot water followed by a chlorine-releasing solution at concentrations of 1000ppm. Tech care products need to be used on surfaces and floors in accordance with manufacturer's instructions to ensure that the spread of infection is controlled.

Soiled linen should be bagged and dealt with separately as potentially infectious according to care home policies and practices. Laundering of soiled bed linen or clothing should be on a hot cycle of the washing machine (at 71ºC for thirty minutes or more where possible).

Residents should be encouraged to wash their hands after using the toilet or commode and before eating.

Where required the residents GP should be called and any prescribed treatment administered as per their instructions.

Visitors should be informed of the outbreak and unnecessary visits should be discouraged. Those who choose to visit should wash their hands as they enter and leave the home and comply with all other hygiene practices in place. In the event of a serious outbreak all visitors should be discouraged.

The local infection control team should be contacted and any advice acted upon without delay.

The Registered Manager will inform the Care Quality Commission of any outbreak using the relevant notification form.

A Daily Outbreak Meeting should be held to ensure good communication throughout the home.

The home should be closed to admissions until 48 hours after the last symptomatic resident has recovered.

Symptomatic staff should go off duty immediately and go to see their GP. They should have a faecal sample taken and should remain off work until symptom-free for 48 hours.

If any infected resident requires admission to hospital the receiving unit should be informed of the outbreak so that they can institute appropriate measures.

The home recognises that confirming the diagnosis as early as possible is essential in outbreak management. Stool samples should therefore be taken early in the course of illness as soon as possible after residents develop symptoms. A supply of stool specimen pots should be kept readily accessible for use in emergencies. Samples should be appropriately labelled as “outbreak” to ensure it will be tested for viruses.

Clostridium Difficile

Clostridium difficile (C Diff) is a bacteria which produces spores that are difficult to destroy and can survive for a long time in the environment.

C diff is a major cause of diarrhoea in hospitals and long-term care facilities. Susceptibility to infection is increased in the elderly, by the use of certain drugs which alter the normal gut flora, stool softeners, enemas and drugs that affect gut motility.

Infection with C diff can lead to symptoms ranging from mild watery diarrhoea (often explosive) to severe frequent diarrhoea.

Alcohol based cleaning products are not affective in destroying C diff spores. Thorough hand washing with soap and water and strict adherence to universal precautions is paramount in controlling spread. Environmental cleaning must be regular with disinfectant. EFHL currently uses Tech Care cleaning products.

If two or more people are experiencing symptoms, residents or staff, will be treated as an outbreak. Records must be kept of the name of the person affected, when their symptoms started, what treatments have been given, when the symptoms ended. Suspected or confirmed cases of C diff must be isolated with strict adherence to the company’s policy and procedure. The C diff risk assessment and care pathway documentation should be completed Stool samples should be sent to microbiology – suspected C diff must be clearly stated on the form.

Isolation must continue until 48 hours following last symptoms.

Following a period of 48 hours clear of symptoms, a thorough deep clean of the environment must be completed – all hard surfaces, including undersides of bed frames, toilets, chairs need to be washed with disinfectant (Tech Care) and all soft furnishings will require to be steam cleaned. Opened disposable items (conti-wipes, tissues etc.) should be thrown away.

Refer to Public Health England guidance for posters, information & record charts

https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2017/09/phe-sw-ipc-in-care-homes-outbreak-pack-sept-18.pdf

COVID-19 Statement

Currently there are no COVID-19 rules or restrictions in the UK, though this could change if there is another major outbreak.

It is the responsibility of the Registered Manager and organisation to monitor the English Government guidelines for any changes to the guidance and law. See 'Adult social care: guidance.'

In addition, there is guidance in place from NHS England, the UK Government and Health and Safety Executive on how care settings should minimise risk to both care workers and residents.

This advice should be incorporated into the risk management and health and safety policies, procedures, and systems of work where appropriate.

Please see:

- COVID-19 restrictions replaced by public health advice, HSE
- Infection prevention and control in adult social care: acute respiratory infection

Specific additional ACS Guidance (used in conjunction with 'Infection prevention and control in adult social care: acute respiratory infection'):

https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings

https://www.infectionpreventioncontrol.co.uk/content/uploads/2021/05/CH-10-Isolation-July-2020-Version-2.01.pdf

Training

Care staff are provided with training regarding Infection Control Procedures at all suitable stages of their employment from induction onwards.

Seeking Feedback about

EFH will seek feedback from people, families, staff, involved professionals and volunteers about their experiences of Infection Control where it is appropriate to do so. We will seek feedback in person during conversations and via surveys and meetings. We will respond to feedback and tell people about changes and improvements we make as a result of their feedback.

References

https://www.cqc.org.uk/guidance-providers/residential-adult-social-care/infection-prevention-control-care-homes

Review date	Next Review Date
May 2024	May 2027