Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Standard Infection Prevention and Control Precautions Policy

This procedural document supersedes: PAT/IC 19 v.7 – Standard Infection Prevention and Control Precautions Policy

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Executive Sponsor(s):	David Purdue, Director of Nursing, Midwifery and Allied Health Professionals
Author/reviewer: (this version)	Beverley Bacon – Infection Prevention and Control Practitioner
Date revised:	31 October 2020
Approved by (Committee/Group):	Infection Prevention and Control Committee
Date of approval:	17 December 2020
Date issued:	25 January 2021
Next review date:	February 2024
Target audience:	All staff, Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 8	25 January 2021	• Content page updated • Duties and Responsibilities updated • Statement regarding Patients Lacking Capacity added • Section on Aprons/ Gowns updated to include Aerosol Generating Procedures CoVID –19 • Section on FFP Respirators update. • Data Protection section added PLEASE NOTE: **When caring for a Suspected or Confirmed case of CoVID-19 please see latest guidance available on the Trust HIVE**	B Bacon Infection Prevention & Control Practitioner
Version 7	9 February 2018	• Examples of Aerosol Generated Procedures included in section 4.2.c • Appendix Added, 'When to use a Surgical Face Mask or a FFP3 Respirator' • References updated	B Bacon Infection Prevention & Control Practitioner
Version 6	12 March 2015	• Policy updated in line with new Trust format • Change of Policy title • Added 4.8 section on Last Offices • Added Appendix 1 Risk assessment guide for selection of PPE • Added Appendix 2 Safe order for "Donning" or "Doffing" of PPE • Added Appendix 3 Equality Impact Assessment • References updated	B Bacon Infection Prevention & Control Practitioner
Version 5	March 2012	• Page 4 - Section added on "Equality Impact Assessment" • Paragraphs re-named and re-numbered in line with (CORP/COMM 1)	B Bacon Lead Nurse IPC

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1. INTRODUCTION

Standard precautions are the practices that must be adopted by all healthcare workers (HCWs) when potentially coming into contact with any patient's blood, tissue or body fluid. They are based on a set of principles designed to minimise exposure to and transmission of a wide variety of micro-organisms. Since every patient is a potential infection risk it is essential that standard precautions are used for all patients all of the time. It is not possible to know who is, and who is not, infected with a potentially transmissible disease or infection. Thus all body fluids should be regarded and dealt with, as if they were a potential source of infection.

There are a number of key elements to standard control precautions, all of which when appropriately implemented are designed to reduce the risk of transmission of micro-organisms.

The application of transmission based precautions when patients are managed with known infections will support the prevention of the spread of healthcare associated infections.

2. PURPOSE

To implement safe working practices within the healthcare setting to protect staff from the potential risks involved in handling blood, body fluids, the patient, materials or equipment contaminated with micro-organisms.

3. DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff, this includes:

- Employees
- Agency/Locum/Bank Staff/all other contracted workers
- Occupational Health if Staff require treatment

Each individual member of staff, volunteer or contracted worker within the Trust is responsible for complying with the standards set out in this Policy. They need to be aware of their personal responsibilities in preventing the spread of infection. It is the responsibility of Directors and Managers to ensure compliance with this standard.

All staff working on Trust premises, outreach clinics and community settings, including Trust employed staff, agency and locum staff is responsible for adhering to this policy, and for reporting breaches of this policy to the person in charge and to their line manager.

Board of Directors: is responsible for ensuring the implementation of a Board to Ward culture and to support a Zero Tolerance approach to Health Care Associated Infections.

Division Directors, Associate Medical Directors and Assistant Directors of Nursing
Each Divisional management team is responsible for ensuring the policy is adhered to and for ensuring action is taken if staff fails to comply with the policy.

Consultant Medical Staff: are responsible for ensuring their team read and understand this policy, and adhere to the principles contained in it at all times.

Director of Infection Prevention and Control: is responsible for implementing infection and prevention and control strategies throughout the Trust

The Infection Prevention and Control Team: is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

Matrons: are responsible for ensuring dissemination of policy within their allocated areas of responsibility. Policy implementation assurance will be checked when applied on the ward.

Ward and Department Managers: are responsible for ensuring all staff have read the policy and implement this when required within their area.

Housekeeping responsibility: routinely maintain a clean environment to reduce level of environmental contamination.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA 2005).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.
- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.
- Further information can be found in the MCA policy, and the Code of Practice, both available on the Extranet.

There is no single definition of Best Interest. Best Interest is determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.

4. STANDARD PRECAUTIONS

4.1 Hand Hygiene

Effective hand hygiene will reduce the risk of transmission of micro-organisms from or via the hands of staff**.** Hands must be decontaminated between caring for different patients or between different care activities for the same patient.
The most important times during care delivery and daily routines when this should occur are described in **'Your 5 moments for Hand Hygiene'**.

Five Moments uses the concept of the 'patient zone' which includes the patient and their immediate surroundings, and sets out when hand hygiene should occur.

Patient hand washing should not be forgotten. All patients should be reminded about good hand washing practices and help should be offered if their physical or health condition makes it difficult for them to wash their hands. Non ambulant patients must be offered means of decontaminating their hands before eating and after using toilet facilities. Hand cleansing wipes are suitable for this purpose and should be stocked on all wards.

PLEASE NOTE

- The Infection Prevention and Control Team along with other colleagues will continue to observe and challenge staff if they do not conform to the **WHO 5 moments** for hand hygiene with a zero tolerance stance.
- Use safe working practices for ALL patients. Decontaminate hands before and after all procedures/contact with patients and after removing gloves.
- Cover ALL cuts and breaks to the skin. Skin conditions should be reported to the Health and Well Being Department

4. 2 Use of Personal Protective Equipment (PPE)

Personal Protective Equipment is used for two reasons: -

1. To protect staff from blood/body fluid contamination.
2. To reduce the risk of cross infection through the reduction in contamination and transferring of micro-organisms to other patients, staff, visitors and the environment.

The selection of protective equipment should be based on an assessment of the risk of contamination of the staff members clothing or skin by patient's blood, body fluids, secretions and excretions and the risk of transmission of micro-organisms from the staff member to patients.

Protective clothing (e.g. disposable plastic apron and disposable gloves) must be worn when there is a danger of exposure to blood, body fluids or cleaning chemicals. If there is a danger of aerosols to the face, (e.g. Respiratory Virus Infections), facial protection must be worn. e.g. visor or goggles

Visiting staff, for example Site Services, must be provided with appropriate protective clothing when visiting wards/departments.

See Appendix 1 Risk Assessment Guide for Selection of Personal Protective Equipment based on risk of Exposure to Blood or Body Fluids

See Appendix 2 Correct order for donning and doffing of Personal Protective Equipment**.**

4.2 a Guidelines for the Correct Use of Disposable Gloves

The use of gloves can reduce the risk of acquiring infection through direct skin contact between HCW and patients (WHO, 2009). Gloves should not be worn unnecessarily or as a substitute for hand decontamination as prolonged and indiscriminate use may cause adverse reactions and skin sensitivity.

- Gloves are a single use item
- Gloves can reduce the likelihood of contact dermatitis in staff exposed to chemical agent

- Gloves must be worn when direct contact with blood, body fluids, non-intact skin or mucus-membranes is anticipated
- Gloves must be changed between patients and different procedures on the same patient
- Gloves **must not** be worn when using computer keyboards, answering the phone, writing in patient's care records or serving meals
- Gloves must be disposed of in Healthcare waste bin in accordance with Trust Waste Disposal Policy and Manual
- Hands must be decontaminated with either soap and water or alcohol hand rub immediately on removal of gloves

Indications for wearing gloves:

- Venepuncture
- Wound inspection
- Cannula insertion
- Aseptic Non Touch Technique
- Emptying urinary catheter bags/stoma bags
- Cleaning soiled equipment
- Cleaning the clinical environment
- Invasive procedures
- Contact with body fluids
- Surgical procedures – use sterile gloves

This is not an exhaustive list.

Staff must ensure that the appropriate type of glove is selected for each particular procedure and purpose. (See Glove Use Policy CORP/HSFS 13).

Inappropriate use of gloves increases the wearer's exposure to the chemicals and accelerants in the glove material, which can result in skin sensitisation.
Gloves should be discarded after a period of care or task. Also, disposable gloves must not be washed between use as damage may go undetected.

4.2 b Aprons/Gowns

Disposable aprons should be worn when there is a risk that clothing may become exposed to blood, body fluids and excretions with the exception of sweat or when close contact may lead to contamination by microbes from the patient, materials or equipment. Disposable aprons should be worn as single use items for one procedure or episode of patient care and then disposed of in accordance with Trust waste policy. Full body fluid repellent gowns should be worn where there is a risk of EXTENSIVE splashing of blood, body fluids, secretions and excretions, onto the skin of health care practitioners.

Disposable coveralls (Long Sleeved Gowns)
Disposable Long Sleeved Gowns may be used if there is a risk of contamination from chemicals or when providing care for a patient with possible/confirmed

- viral haemorrhagic fever,
- long sleeved gowns must be worn when giving care to patients' suspected/confirmed of having Carbapenamase Resistant Enterobacteriacae (CPE).
- undertaking Aerosol Generating Procedures (AGP) for a patient with suspected or confirmed CoVID-19.
- In accordance with the management of Scabies staff must also wear long sleeved gown when applying treatment to patients diagnosed with scabies.

Careful attention must be paid when donning and doffing coveralls as there is a risk that the clothing beneath the suit may become contaminated.

4.2 c Face Mask/Eye Protection

PLEASE NOTE:

When caring for a Suspected or Confirmed case of CoVID-19 please see latest guidance available on the HIVE

Relevant face masks must be worn for infectious reason e.g. Pulmonary tuberculosis, Influenza and eye protection or a full face visor should be worn where there is a risk of blood, body fluids, secretions and excretions splashing into face and eyes.

Surgical Fluid Repellent Masks - They help protect the wearer from splashes of blood or other potentially infectious substances. They are not necessarily designed for filtration efficiency, or to seal tightly to the face.

Respirators - are intended to help reduce the wearer's exposure to airborne particles
When worn correctly, they seal firmly to the face, thus reducing the risk of leakage.

Respirators FFP3 mask **must be worn** there is a risk of aerosolisation of respiratory secretions e.g. when carrying out potentially infectious aerosol generating procedures where a patient is known/suspected to have an infection spread via the aerosol route. It is a legal requirement that anybody who might be required to wear an FFP3 respirator be **fit tested** in order to check that an adequate seal can be achieved with each specific model. It is also important that the user carries out a **fit check** each time an FFP3 respirator is worn. It continues to be a requirement of the Health and Safety Executive any member of staff who will utilise FFP3 mask for clinical procedure must be assessed annually. Matrons in "High Priority Areas" must ensure that their staff receive training Attendance will be captured by the via Oracle Learning Management (OLM) and Electronic Staff Record (ESR) systems.

The following **are classified** as Respiratory Aerosol Generated Procedures (AGP) by the World Health Organization (2009):

- Intubation, extubation and related procedures, e.g. manual ventilation, open suction of any part of the respiratory tract.
- Respiratory and airway suctioning (including tracheostomy care and open suctioning with invasive ventilation)
- Non-invasive ventilation (NIV) including continuous positive airway pressure (CPAP)
- Cardiopulmonary resuscitation
- Bronchoscopy
- Upper gastro-intestinal endoscopy involving open suctioning
- Collection of lower respiratory tract specimens (e.g. bronchial and tracheal aspirates)
- Some dental procedures involving high speed drilling
- Post mortem procedures
- High-flow nasal oxygen (HFNO)*
- Induction of sputum*

* The evidence for these AGPS is acknowledged to be weak.

The following procedures **are not** classified as aerosol generated procedures:

- Nasogastric tube insertion
- Chest Drains
- Mechanical ventilation or respiratory therapy treatment unless an AGP is being performed on an open system

- Closed suctioning with invasive ventilation
- Nasopharyngeal aspiration
- Nebulisation
- Supraglottic airway insertion (including laryngeal mask airways)

Chest physiotherapy is **not** considered an AGP but a surgical mask should be worn by the patient if tolerated and Health Care Workers should wear PPE as recommended for routine care (surgical mask) during the procedure.
See Appendix 3 for more information when to use a Surgical Face Mask or FFP3 Respirator.

4.3 Safe Use and Disposal of Sharps

Great care must be taken when using needles (PAT/IC 8): An injection tray with an integral sharps box or mobile sharps trolley should be used when a healthcare worker has to walk some distance to the point of use. Always dispose of sharps immediately after use and at the point of use. Used sharps must never be carried around by hand or in receivers, trays or other receptacles other than sharps containers as outlined above.

1. Disposable non-sterile gloves must be worn when taking blood samples.
2. **DO NOT** re-sheath needles.
3. **DO NOT** disassemble needles from syringes or other devices wherever possible. If disassembly is required, the needle should be removed using an approved device NOT fingers. Wherever possible dispose of as a single unit.
4. Place used needles directly into sharps container for disposal.
5. Patients who self administer medication or undertake blood glucose recording example diabetic patients must be provided with an appropriate sharps containers.
6. **DO NOT** overfill disposable sharps container. Full containers should be sealed for incineration and labelled with ward or department of origin.

If **any** injury occurs:

1. **ENCOURAGE** bleeding
2. **WASH** the injured area
3. **COVER** affected area with a fully occlusive waterproof dressing
4. **REPORT** the incident and follow the procedure stated in policy PAT/IC 14 if a sharps injury occurs, ensuring an incident form is completed.
5. **CONTACT** the Occupational Health Department for advice or the A&E department if out-of-hours.

4.4 Safe Handling of Specimens

Extreme care should be taken at all times with all specimens. For further information refer to policy PAT/IC 11.

4.5 Waste Disposal

All waste must be handled, segregated and disposed of in accordance with the 'Waste Disposal Policy' (CORP/HSFS 17).

4.6 Disinfection of Equipment

Any equipment used by patients should be cleaned and decontaminated between each use and when soiled, using an appropriate cleaning agent.

In the event of spillage of blood and/or body fluids, decontaminate in accordance with Spillages of Blood and Other Body Fluids - PAT/IC 18.

Reusable equipment can be a potential source of infection if not appropriately decontaminated after each use.

Cleaning is an essential stage in the decontamination process and must always precede disinfection and /or sterilization. Selection of the appropriate decontamination method will ensure that the equipment is clean and fit for purpose. Check manufacturer's instructions for use of suitable cleaning agents.

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).

The user must sign and date the appropriate labels to confirm that cleaning has taken place. During decontamination, the user must check clinical equipment for signs of damage and send for repair or disposal if appropriate.

A completed label must accompany each piece of equipment sent for repair.
Suitable personal protective equipment 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.

Refer to Cleaning and Disinfection of Ward Based Equipment - PAT/IC 24 for detailed guidance of suitable methods of decontamination.

4.7 Linen

Linen must be handled correctly to reduce the risk of cross-infection to healthcare staff.
Used 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. See Laundry Policy- Bagging Procedure for Linen and in particular Appendix A which details the way in which used linen should be sorted and categorised. The procedure design is such as to reasonably ensure that laundry staff do not manually open bags containing infectious linen and are protected from infectious agents.

4.8 Last Offices

When carrying out the last offices the following should be implemented.

- Wear PPE; gloves and apron
- Remove all drains, catheters and intravenous lines except where a post mortem is required
- Contain leakage from wounds and line sited by ensuring they are covered with a waterproof dressing

After carrying out last offices a body bag must be used in the following circumstances:
When a body is leaking body fluids or there is gross external contamination with blood.
Staff must ensure that mortuary staff are aware of the reason for using a body bag.
When a patient has or is strongly suspected of having one of the following biohazard conditions:

- Anthrax
- Classic or variant Creutzfeldt-Jakob disease (CJD)
- CoVID-19
- Diphtheria
- Hepatitis B, C
- HIV
- Meningococcal septicaemia / meningitis if death occurs before 48 hours of appropriate antibiotic therapy being completed
- Rabies virus
- Invasive β-haemolytic Streptococcus Group A disease if death occurs before 48 hours of appropriate antibiotic therapy being completed
- Tuberculosis
- Typhoid/ Paratyphoid
- Viral Haemorrhagic fever

When relatives are collecting patients' property, any soiled patient's clothing must be placed in a water-soluble clothing bag which must be secured and placed inside a property bag. An itemised list of contents must be attached.

5. TRAINING AND SUPPORT

The training requirements of staff will be identified through a training needs analysis. Role specific education will be delivered by the service lead or nominated person.

Infection prevention and control must be included in individual Annual Professional Development Appraisal and any training needs for infection prevention and control addressed.

It is an expectation for all clinical staff to attend IPC training as per local Training Needs Analysis, which will be captured by the Training and Education Department via OLM and ESR systems.

6. MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Monitoring	Who	Frequency	How Reviewed
The policy will be reviewed in the following circumstances:-	APD Process Group IPCT	Every three years routinely, unless: • When new national or international guidance are received. • When newly published evidence demonstrates need	Approved Procedural Document (APD) database Policy will be approved and ratified by the Infection Prevention and Control Committee

		for change to current practice. • Action required from Root Cause Analysis Serious Incident Investigation Report	
Compliance with policy to negate cross-infection	The Infection Prevention and Control Practitioners	Weekly	"Alert organism review" to monitor adherence with the policy.
Training needs for infection prevention and control	Ward and Department Managers Training and Education Department	Annually	Staffs Professional Development Appraisal Attendance will be captured by the via OLM system

7. DEFINITIONS

Standard Precautions underpin all infection prevention and control practice. The precautions must be used for all patients whether they are known to have an infection or not. Universal/ standard precautions are a collection of essential practices that when used together will reduce the risk of patients, visitors and staff from developing transmissible infections.
Personal protective equipment (PPE) is the equipment that must be worn by HCWs to protect patients and staff against the risk of infection.
"Donning" Putting on
"Doffing" Removal of.

FFP3 respirator – Filter Face Piece Respirator Mask

AGP – Aerosol Generating Procedures

8. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are disadvantaged over others. Our objectives and responsibilities relating to equality and diversity are outlined within our equality schemes. When considering the needs and assessing the impact of a procedural document any discriminatory factors must be identified.

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 4)

9. ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy should be read in conjunction with other Trust Policies and protocols for the prevention and control of HCAI in line with the Health and Social Care Action 2008. In particularly:

- Cleaning and Disinfection of Ward Based Equipment – PAT/IC 24
- Care after Death and Bereavement Policy: Operational Policy for Staff to follow in the event of a Patient Death - PAT/T 60
- Glove Use Policy (Latex) – CORP/HSFS 13
- Hand Hygiene – PAT/IC 5
- Hazard Group 4 Viral Haemorrhagic Fevers - PAT/IC 32
- Laundry Policy – Bagging Procedure for Linen PAT/IC 21
- Management of Respiratory Type Viruses - PAT/IC 10
- Mental Capacity Act 2005 - Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) - PAT/PA 19
- Pathology Specimens - Collection and Handling of Pathology Specimens – PAT/IC 11
- Privacy and Dignity Policy – PAT/PA 28
- Scabies – Guidance on Management – PAT/IC 7
- Sharps Policy - Safe Use and Disposal – PAT/IC 8
- Management of sharps injuries and blood and body fluid exposure incidents – PAT/IC 14
- Spillages of Blood and Other Body Fluids – PAT/IC 18
- Tuberculosis – Care of the Patient Pulmonary or Laryngeal Tuberculosis in Hospital – PAT/IC 23
- Waste Disposal Policy and Manual - CORP/HSFS 17
- Fair Treatment for All - CORP/EMP 4
- Equality Analysis Policy – CORP/EMP 27

10. DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website:
https://www.dbth.nhs.uk/about-us/our-publications/information-governance/

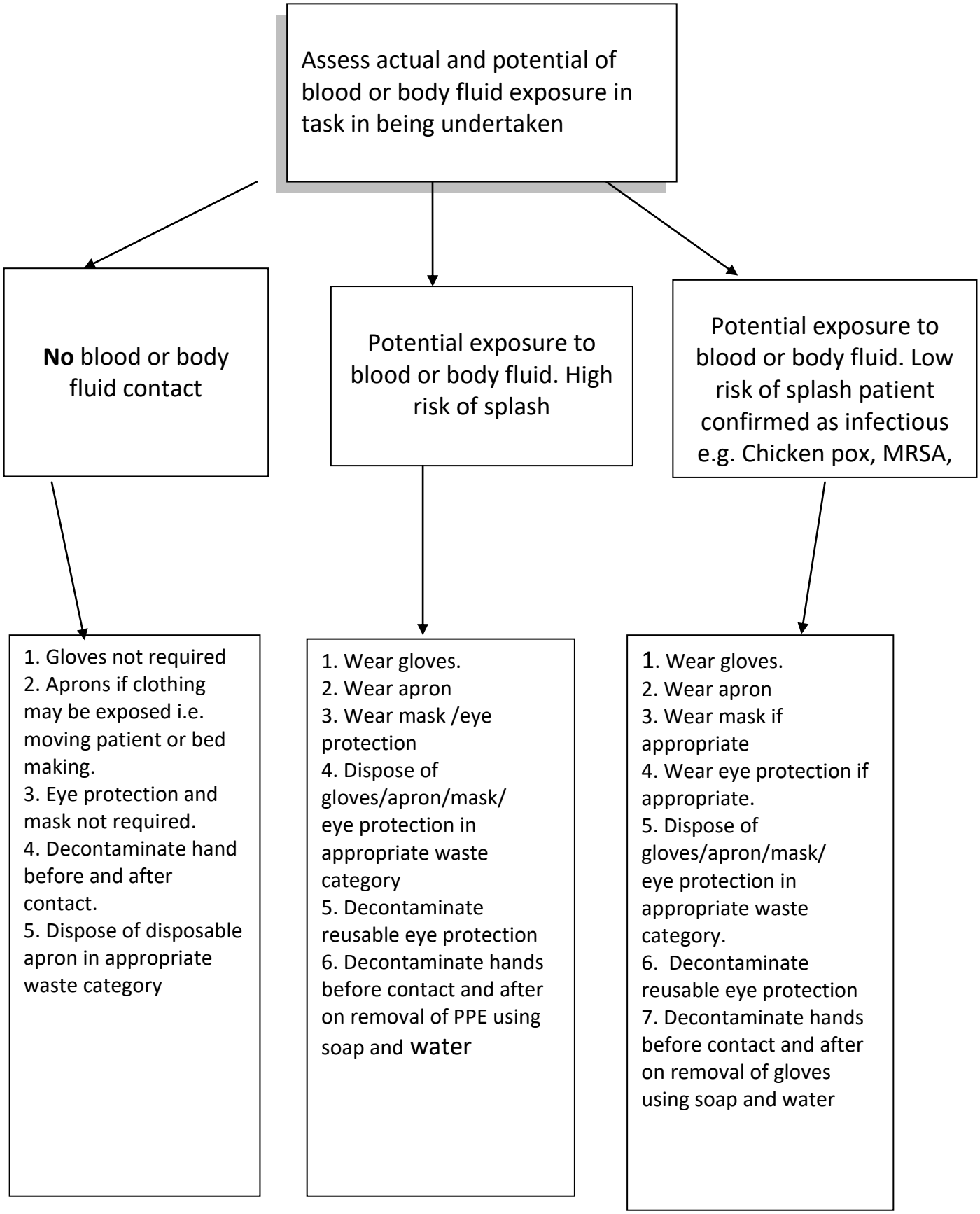
11. REFERENCES

1) The Health and Social Care Act 2008. Department of Health.

2) EPIC3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection Jan 2014 volume 86 supplement 1 pages S1 – S70.

3) Public Health England "A guide to the FFP respirator" – HHS England Gateway Reference 00349 August 2013.

APPENDIX 1 – RISK ASSESSMENT GUIDE FOR SELECTION OF PPE BASED ON THE RISK OF EXPOSURE OF BLOOD OR BLODY FLUID

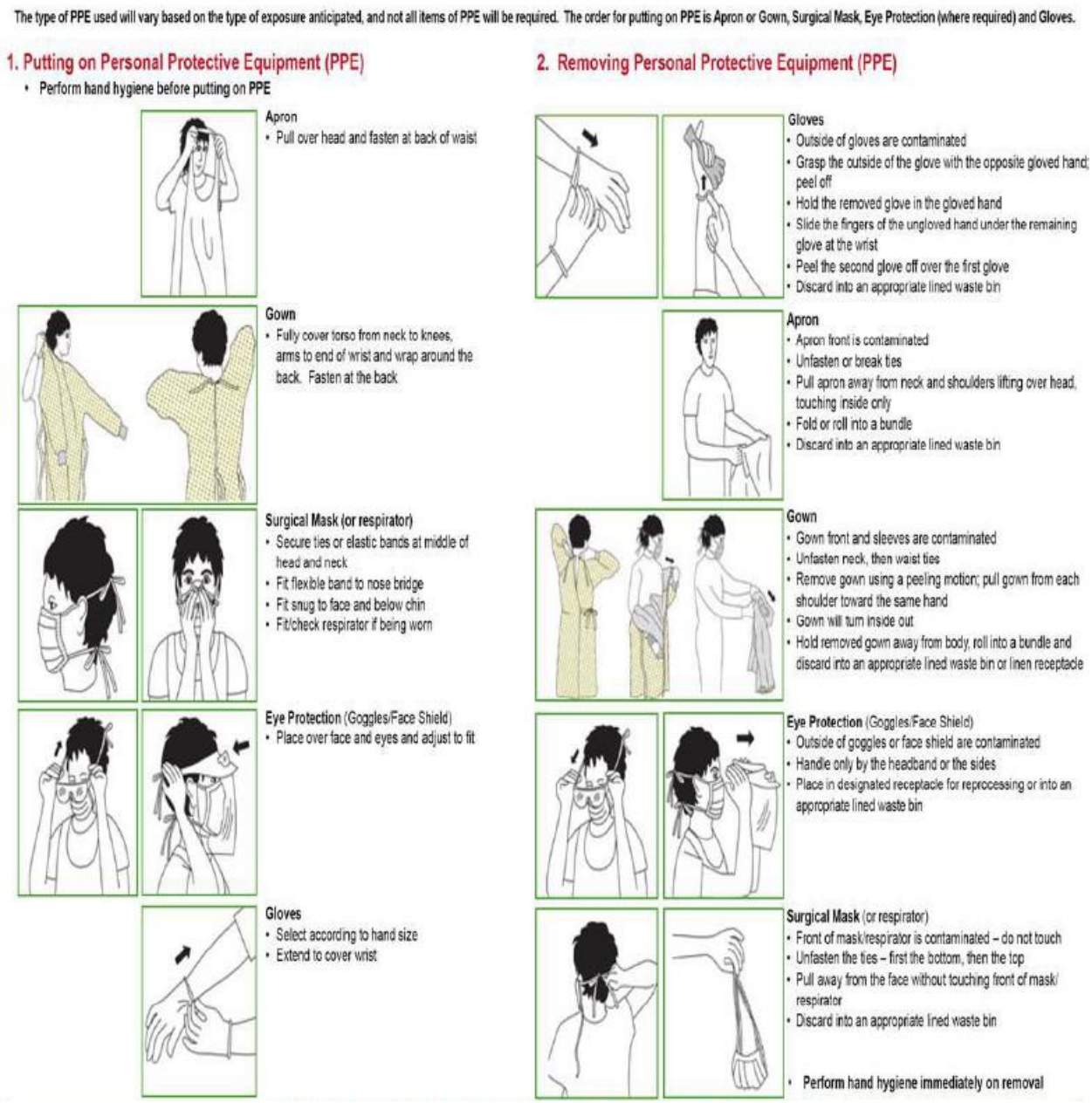


APPENDIX 2 – SAFE ORDER OF "DONNING" OR "DOFFING" PERSONAL PROTECTIVE EQUIPMENT

PLEASE REMEMBER!

Before putting on PPE the Health Care Worker should:

- be wearing appropriate uniform and footwear as per uniform policy.
- perform hand hygiene
- ensure that any cuts or abrasions are covered with a waterproof dressing



PLEASE REMEMBER!

PPE should be safely removed, disposed of into designated waste receptacle and hand hygiene performed before leaving the patients room/ or undertaking the next task

APPENDIX 3 – WHEN TO USE A SURGICAL FACE MASK OR FFP3 RESPIRATOR

When caring for patients with **suspected or confirmed infectious respiratory virus**, all healthcare workers need to – prior to any patient interaction – assess the infectious risk posed to themselves and wear the appropriate personal protective equipment (PPE) to minimise that risk.

When to use a surgical face mask

In cohorted area (but no patient contact)	Close patient contact (within one metre)
For example: Cleaning the room, equipment cleaning, discharge patient room cleaning, etc	**For example:** Providing patient care, direct home care visit, diagnostic imaging, phlebotomy services, physiotherapy, etc
PPE to be worn	**PPE to be worn**
• Surgical face mask (along with other designated PPE for cleaning)	• Surgical face mask • Apron • Gloves • Eye protection (if risk of contamination of eyes by splashes or droplets)

When to use an FFP3 respirator

Carrying out potentially infectious aerosol generating procedures

Where a patient is known/suspected to have an infection spread via the aerosol route

When caring for patients known/suspected to be infected with a newly identified respiratory virus

For example:
bronchoscopy, endotracheal intubation, tracheostomy procedures, cardiopulmonary resuscitation, diagnostic sputum induction:

PPE to be worn

- FFP3 respirator
- Gown
- Gloves
- Eye protection

- Fit testing should be carried out by a properly trained competent fit tester.

These images are for illustrative purposes only. Always follow the manufacturer's instructions.

Remember

- PPE should be put on and removed in an order that minimises the potential for cross-contamination.
- The order for PPE removal is gloves, apron or gown, eye protection, surgical face mask or FFP3 respirator.
- Hand hygiene must always be performed following removal of PPE.
- Healthcare workers who have had influenza vaccination, or confirmed infl za intection, are still advised to use the above infection control precautions.

PLEASE NOTE:

When caring for a Suspected or Confirmed case of CoVID-19 please see latest guidance available on the Trust HIVE

APPENDIX 4 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Policy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Standard IP&C Precautions Policy PAT/IC 19 v.8	Corporate Nursing Infection Prevention and Control	Beverley Bacon IPCP	Existing Procedural Document	10th December 2020

1. Who is responsible for this policy? Infection Prevention and Control Team

2. Describe the purpose of the policy? To implement safe working practices within the healthcare setting.

3. Are there any associated objectives? To protect staff from the potential risks involved in handling blood, body fluids, the patient, materials or equipment contaminated with micro-organisms.

4. What factors contribute or detract from achieving intended outcomes? Adequate resources e.g. Gloves/Aprons. Staff will receive instructions and direction regarding infection prevention and control practice

5. Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? No

- **If yes, please describe current or planned activities to address the impact**

6. Is there any scope for new measures which would promote equality? N/A

7. Are any of the following groups adversely affected by the policy?

a. Protected Characteristics	Affected?	Impact
b. Age	No	
c. Disability	No	
d. Gender	No	
e. Gender Reassignment	No	
f. Marriage/Civil Partnership	No	
g. Maternity/Pregnancy	No	
h. Race	No	
i. Religion/Belief	No	
j. Sexual Orientation	No	

8. Provide the Equality Rating of the service/ function/policy /project / strategy

Outcome 1 ✓	Outcome 2	Outcome 3	Outcome 4

9. Date for next review December 2023

Checked by: Carol Scholey **Date: 17th December 2020**