
Report To:	Policy and Resources Committee	Date:	3 February 2015
Report By:	Head of Organisational Development, Human Resources and Communications	Report No:	HR/40/14/BMcQ
Contact Officer:	Pauline Ramsay Health and Safety Team Leader	Contact No:	01475 714723
Subject:	Infection Control Policy		

1.0 PURPOSE

- 1.1 To ask the Committee to approve a reviewed Infection Control Policy for the Council. (Appendix 1)

2.0 SUMMARY

- 2.1 The Control of Substances Hazardous to Health (COSHH) Regulations 2002 place a duty on employers to carry out assessments of the risk to employees and others from various substances. These can include chemicals, infectious agents such as blood borne viruses and bacteria etc.; and to undertake appropriate preventative action where necessary. This policy formalises these requirements into a corporate policy.
- 2.2 The Health and Safety at Work etc. Act places a duty on employers to prepare a written statement of their general policy and as part of that policy to have in place arrangements for the implementation of Health and Safety. The Infection Control Policy will form part of the Council's arrangements for Health and Safety.
- 2.3 The policy sets out how the Council will control the risk from infection in line with the relevant legislation and HSE guidance documentation.
- 2.4 The Organisational Development Strategy was approved by the Policy and Resources Committee in March 2013. This particular proposal is contained within Theme 2 - *Leadership, Succession Planning and Skills Development (Employees our Most Valuable Resource)* and Theme 3 - *Employer of Choice (Continuous Improvement)* in that it focuses on the health, safety and welfare of our workforce.

3.0 RECOMMENDATIONS

- 3.1 The Committee is recommended to approve the Infection Control Policy.
- 3.2 The Committee is asked to support this policy by active promotion of Health and Safety.

Steven McNab
Head of Organisational Development,
Human Resources and Communications

4.0 BACKGROUND

- 4.1 Inverclyde Council is required to ensure that the risks to employee, from the risk of exposure the infection are assessed in line with its legal duties as defined by the COSHH Regulations 2002 (as amended), the Management of Health and Safety at Work regulations 1999 and the Health and Safety at Work etc. Act 1974.
- 4.2 By law (Health and Safety at Work etc. Act 1974 section 2(3)) if you employ five or more people you must have a written health and safety policy. This contains a statement of general policy on health and safety at work and the organisation and arrangements in place for putting that policy into practice. The Infection Control Policy details the arrangements the Council has in place for managing the risks to employee from hazardous substances at work.
- 4.3 The infection Control Policy sets a clear direction for the Council to follow; it will contribute to all aspects of business performance as part of a demonstrable commitment to continuous improvement. It will demonstrate a shared common understanding of the Council's vision, values and beliefs. A positive Health and Safety culture is fostered by the visible and active leadership of senior managers. This is reflected within the policy.
- 4.4 The policy consists of the following main sections:
- Statement of Policy
 - Roles and Responsibilities
 - How the Policy should be implemented
 - Management Requirements
 - Information and Training Requirements
- 4.5 This policy replaces the Council's Blood Borne Virus Policy 1998 which has been withdrawn. It has been updated to include risks from all infections including, but not limited to, BBV's and to bring the policy into line with current guidance on Standard Infection Control Precautions and treatment for needle stick injuries.

5.0 PROPOSALS

- 5.1 The Infection Control Policy be adopted by Inverclyde Council and used as a framework to further enhance the safety of employees and those affected by the work of the Council.

6.0 IMPLICATIONS

Finance

- 6.1 There are no financial implications for this report.

Financial Implications:

One off Costs

Cost Centre	Budget Heading	Budget Years	Proposed Spend this Report £000	Virement From	Other Comments
N/A					

Annually Recurring Costs/ (Savings)

Cost Centre	Budget Heading	With Effect from	Annual Net Impact £000	Virement From (if Applicable)	Other Comments
N/A					

Legal

- 6.2 Legal: Failure to have a robust policy in place and to implement it could result in enforcement action being taken against the Council.

Human Resources

- 6.3 There are no Human Resources implications.

Equalities

- 6.4 ☒ YES
- ☐ NO - This report does not introduce a new policy, function or strategy or recommend a change to an existing policy, function or strategy. Therefore, no Equality Impact Assessment is required.

Repopulation

- 6.5 There are no repopulation issues within this report

7.0 CONSULTATIONS

- 7.1 The Infection Control Policy has been coordinated through the Corporate Health and Safety Committee with Health and Safety seeking the views of both union and management colleagues. The Trades Unions have agreed the Policy.

8.0 LIST OF BACKGROUND PAPERS

- 8.1 Appendix 1 – Infection Control Policy

OD, HR & Comms

Infection Control Policy

Version 2.0

Produced by:
Health and Safety OD, HR & Comms

Inverclyde Council
Municipal Buildings
GREENOCK
PA15 1LX

February 2015



INVERCLYDE COUNCIL IS AN EQUAL OPPORTUNITIES EMPLOYER

THIS POLICY BOOKLET IS AVAILABLE ON REQUEST, IN LARGE PRINT, BRAILLE, ON AUDIOTAPE, OR CD.

DOCUMENT CONTROL

Document Responsibility		
Name	Title	Service
Pauline Ramsay	Health and Safety Team Leader	OD, HR & Comms

Change History		
Version	Date	Comments
1.0	October 1998	Original Interim Document (Withdrawn)
2.0	February 2015	Updated to Infection Control and BBV

Distribution		
Name	Date	Designation
CMT and Extended Management Team		
Union Representatives		
Stuart Graham		UNITE
Billy Matthews		UNISON
Barbara Gillan		GMB
Tom Tracey		EIS
David Magee		SSTA
Noreen McMillan		NAWUWT

Distribution may be made to others on request

Policy Review		
Review Date	Person Responsible	Service
February 2016	Health and Safety Team Leader	OD, HR & Comms

Copyright

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted in any form or by any means, electronic, mechanical, photocopying or otherwise without the prior permission of Inverclyde Council.

CONTENTS

DOCUMENT CONTROL	2
1 INTRODUCTION	5
2 POLICY STATEMENT	5
3 SCOPE	6
4 CONSULTATION & IMPACT ASSESSMENT.....	6
5 ROLES & RESPONSIBILITIES	6
5.1 Corporate Directors.....	7
5.2 Heads of Service.....	7
5.3 Managers/Team Leaders/Supervisors.....	7
5.4 Employee Responsibilities	7
5.5 Health and Safety Team Leader	8
5.6 Corporate Health and Safety Committee	8
6 ARRANGEMENTS	8
6.1 Risk Assessment.....	8
6.2 Immunisation	8
6.3 Standard Infection Control Precautions	9
6.3.1 Assessment of Infection Risk.....	9
6.3.2 Hand Hygiene	10
6.3.3 Respiratory and Cough Hygiene.....	11
6.3.4 Personal Protective Equipment (PPE).....	11
6.3.5 Safe Management of Care Equipment	12
6.3.6 Safe Management of the Workplace Environment	13
6.3.7 Safe Management of Linen.....	13
6.3.8 Safe Management of Blood and Body Fluid Spillages	14
6.3.9 Safe Disposal of Waste (including sharps)	14
6.3.10 Occupational Safety: prevention and exposure management (including sharps)	15
6.4 Special Considerations for First Aiders.....	16
6.5 Vulnerable Employees	17
6.5.1 New or Expectant Mothers	17
6.5.2 Those with lowered immune system (immunocompromised).....	17
6.6 Confidentiality.....	17
7 INFORMATION AND TRAINING	17

7.1	Information	17
7.2	Training	17
7.3	Communication of the Policy	18
8	MONITORING, EVALUATION & REVIEW	18
	APPENDIX 1 – INFECTION CONTROL/RISK ASSESSMENT PROFORMA	19
	APPENDIX 2 – HAND HYGIENE	25
	APPENDIX 3 – REMOVING GLOVES.....	27
	APPENDIX 4 – DECONTAMINATION OF REUSABLE NON-INVASIVE CARE EQUIPMENT	29
	APPENDIX 5 – WATER SOLUBLE LAUNDRY BAGS.....	31
	APPENDIX 6 – MANAGEMENT OF BLOOD AND BODY FLUID SPILLAGES.....	32
	APPENDIX 7 – MANAGEMENT OF HYGIENE WASTE PRODUCED AS A RESULT OF PERSONAL CARE	34
	APPENDIX 8 – BBV: SHARP/NEEDLE UPLIFT AWARENESS	35
	APPENDIX 9 – MANAGEMENT OF OCCUPATIONAL EXPOSURE INCIDENTS	38
	APPENDIX 10 – GUIDANCE ON OTHER INFECTIONS	41

1 INTRODUCTION

- 1.1 The Control Of Substances Hazardous to Health Regulations 2002 require the Council to ensure that employees are protected from chemicals including biological hazards and to protect its employees and others from acquiring blood borne viruses or other infections as a result of their work activities.
- 1.2 Infections at work are those created by exposure to harmful micro-organisms such as bacteria, fungi, viruses and internal parasites.
- 1.3 Micro-organisms which can cause infection in the workplace are generally spread by one of four main routes.
 - Airborne Transmission - In this route, micro-organisms spread by aerosol droplets through the air e.g. respiratory discharges such as coughs and sneezes, or contaminated dust.
 - Faecal-Oral Transmission - This route is spread by hand to mouth e.g. going to the toilet, not washing hands then transferring micro-organisms to food which is then eaten.
 - Direct Contact Transmission - This can either be directly from person to person, from animal to person or indirectly via things such as inanimate objects.
 - Blood and Body Fluid Transmission - This includes a skin penetrating injury e.g. via a contaminated needle or other sharp object or through a bite caused by challenging behaviour or by an infected animal or insect.
- 1.4 Some of the key areas where employees may be exposed to infectious organisms are:
 - Those providing personal care to service users¹ or others.
 - Those in contact with service users with additional support needs who are known to scratch or bite or be subject to unpredictable behaviours.
 - Working in the presence of or finding discarded/used needles.
 - Cleaning up of blood or body fluid spillages.

2 POLICY STATEMENT

- 2.1 It is the policy of Inverclyde Council to take all reasonably practicable steps to safeguard the health, safety and welfare at work of all of its employees. The council will comply with all aspects and provisions of the Health & Safety at Work etc. Act 1974; The Control of Substances Hazardous to Health Regulations 2002; The Management of Health and safety at Work Regulations 1999 and all other relevant statutory obligations. This includes the organisation and arrangements required to ensure the risks from infection are adequately controlled for employees and others who may be affected by our undertakings.

A high standard of health and safety performance is recognised as an integral part of the council's service delivery. Therefore, sufficient resources will be allocated to meet the requirements of the council's Infection Control Policy.

¹ Service Users can be anyone receiving personal care within the Council, i.e. pupils in educational establishments, people receiving homecare, those attending residential accommodation, anyone receiving first aid.

2.2 This standard will be achieved by Inverclyde Council:-

- Providing managers with sufficient information to identify work activities and persons at risk from the transmission of infections including blood borne diseases
- Providing managers with information about the transmission of blood borne diseases and management standards for identifying the risk of exposure.
- Offering immunisation at no financial or time cost to those employees who undertake activities which puts them at risk of infection and where an immunisation programme would reduce the risk.
- Monitor immunisation programmes and maintain details of vaccinations including boosters.

2.3 Provide managers with information and training in respect of :-

- Identifying high risk activities where transmission of infection or blood borne diseases is likely to be a hazard.
- Advising whether immunisation may be an appropriate control measure
- The suitability of workplaces, safe working practices, personal protective equipment and equipment used by employees.

2.4 The aim of this policy is to minimise the risk of exposure to harmful micro-organisms and prevent the risk of infection.

2.5 This policy should be read in conjunction with the Council's Occupational Health Policy.

3 SCOPE

3.1 This policy applies equally to all employees regardless of grade, experience or role within the organisation. The policy also applies to contracted staff as far as is reasonably practicable and to pupils, service users or members of the public who have access to Council premises.

4 CONSULTATION & IMPACT ASSESSMENT

4.1 Inverclyde Council recognises the importance of employee consultation and is committed to involving all employees in the development of policies and procedures. The following groups are formally consulted:

- Trade Union Representatives through the Corporate Health and Safety Committee.
- All Chief Officers.
- Employees via the Council Intranet.

4.2 An Equalities Impact Assessment was carried out using the Council's Equalities Impact Assessment Template.

5 ROLES & RESPONSIBILITIES

In addition to the responsibilities laid out in the Corporate Health and Safety Policy the following responsibilities are specific to this Policy.

5.1 Corporate Directors

Corporate Directors have a collective and individual responsibility to employees in providing Health and Safety Leadership within Inverclyde Council, they should ensure that their Directorate has:-

- As far as is practicable, the adequate provision of financial resources to meet the foreseeable expenditure for Personal Protective Equipment and training to deal with BBV's and other infections.

5.2 Heads of Service

Heads of Service will have a pivotal role in the effective implementation of the Infection Control Policy. They shall be responsible for ensuring:

- That this policy is implemented within those areas under their control or influence.
- That there is a system to monitor that their Managers are complying with this policy.
- That where two or more Services are located within a building to liaise with other Heads of Service to co-ordinate infection control arrangements.
- That adequate equipment or facilities are provided and maintained and;
- That suitable notices are displayed informing employees of the arrangements for infection control.

5.3 Managers/Team Leaders/Supervisors

Any person who has a managerial/supervisory responsibility for other employees, whatever title they are given has the responsibility to ensure:

- Assess the risks of transmission of infection or Blood Borne Disease to employees and others, and to establish appropriate procedures.
- Refer employees in areas of known risk of infection to Occupational Health via HR to have their immune status confirmed. If an employee does not have immunity and immunisation is identified as an appropriate control measure for an individual employee they will be offered a course of vaccinations in work time and at no cost to the employee; or their work activities will be changed to reduce their exposure risk.
- Inform employees of the level of risk in their workplace.
- That infection control training is provided where required and retraining carried out every three years.
- Provide employees with guidance and information to minimise the risk of needle stick injuries and the action they should take in the event of a contamination injury.
- That infection control PPE and other materials or equipment are checked and stocks maintained.
- That suitable notices are displayed informing employees of the arrangements for first aid provision.
- Provide employees with guidance on standard infection control procedures to reduce the risk of transmission of blood borne diseases.

5.4 Employee Responsibilities

All employees have a responsibility to ensure that they are complying with the health and safety procedures and requirements appropriate to their job. To achieve this, in relation to this Policy, employees should:

- Where designated as a responsible person ensure that checks on equipment or facilities are checked and maintained.
- Inform their line manager immediately if there are any concerns about safety in relation to infection control.
- Inform their line manager if they require immunisation.
- Report any incidents where there is a risk of infection or contact with Blood Borne Viruses.

5.5 Health and Safety Team Leader

The Council Health and Safety Team Leader shall ensure that the Infection Control Policy is monitored for effectiveness, is subject to regular review, and is revised when necessary. This shall be done in conjunction with Heads of Service and Trades Union safety representatives.

5.6 Corporate Health and Safety Committee

The Corporate Health and Safety Committee will perform a pivotal role in ensuring that this policy is implemented.

The safety committee will oversee monitoring of the effectiveness of the policy and other measures to reduce risks and promote workplace health and safety.

6 ARRANGEMENTS

These arrangements outline the Council's intentions regarding infection control.

6.1 Risk Assessment

The risks from infection at work can be dealt with in the same way as any other health and safety issue - through carrying out a risk assessment. In line with the corporate policy on Hazardous Substances, a risk assessment must be carried out for all work activities where employees may come into contact with infectious micro-organisms at work.

Various factors need to be considered in assessing the risk. The key points are:

- Where the organism may be present e.g. in an animal, person or environment.
- How employees may be exposed e.g. direct skin contact and/or inhalation.
- What effects it may have e.g. infection, cause allergies.
- Exposure i.e. frequency of contact taking into account the systems of work and protective measures in place.
- Who is at risk e.g. employees, visitors, service users.
- Identify employees who may be at greater risk e.g. vulnerable staff.

The aim of the assessment is to enable decisions to be made about the actions needed to prevent or control the risk. This includes the setting up of practical control measures, providing information and training, monitoring exposure and carrying out immunisation and/or health surveillance where the assessment shows that these are required.

An Infection Control/BBV Risk Assessment proforma is available in Appendix 1.

6.2 Immunisation

The need for staff to be immunised is determined by the risk assessment process. Immunisation is a supplement to reinforce other control measures. Staff groups identified by

the risk assessment process as requiring immunisation will have vaccines made available to them free of charge. The line manager should refer the employee to Occupational Health by completing a Health and Safety Occupational Health referral form (See Occupational Health Policy) and sending it to the Health and Safety Team Leader at:

3rd Floor
Municipal Buildings
Clyde Square
Greenock
PA15 1LY
Or emailing it to: health.safety@inverclyde.gov.uk

Post exposure treatments are available for some diseases. Advice on post exposure treatments is available from the Council's occupational health provider. Enquiries should be emailed to health.safety@inverclyde.gov.uk or call (71)4720.

6.3 Standard Infection Control Precautions

Standard Infection Control Precautions (SICP's) are to be used by all employees in all settings where care is being provided at all times for all Service Users, whether infection is known to be present or not, to ensure the safety of those being cared for, including employees and visitors to the Council.

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agent 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 or establishment that could have become contaminated.

The application of SICPs during service delivery is determined by an assessment of risk to and from individuals and includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.

To be effective in protecting against infection risks, SICPs must be used continuously by all employees. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to service user and visitor safety.

There are 10 elements of SICP's

6.3.1 Assessment of Infection Risk

Service users must be assessed for infection risk prior to care being given and this should be continuously reviewed while they are under the care of the Council. This assessment will influence any decisions in regard to the care needs.

Service users who may present a cross-infection risk include those:

- With diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms.
- Known to have been previously positive with a Multi-drug Resistant Organism e.g. MRSA, CPE.
- Who have been hospitalised outside Scotland in the last 12 months.

6.3.2 Hand Hygiene

Hand washing is widely acknowledged to be one of the most important ways of controlling the spread of infection. Employees may think that they know how to wash their hands but evidence suggests that many people do not use the correct technique. This means that areas of the hands can be missed.

The diagrams in Appendix 2 demonstrate the hand hygiene procedure that should be followed when washing with soap and water or using alcohol hand gel or rub.

Hands should be cleaned:

- Before and after personal contact with service users
- Following cleaning activities
- Before handling food
- Before eating, drinking or smoking
- Before taking medication or giving it to someone else
- Before inserting contact lenses
- After contact with body fluids
- After removing gloves
- Whenever hands are visibly dirty
- After any activity or contact that contaminates the hands including using the toilet, coughing, sneezing, handling waste etc. even if gloves have been worn.

Alcohol/antibacterial hand gels and rubs are a practical alternative to soap and water where employees do not have immediate access to suitable washing facilities. However, hands that are visibly dirty or potentially grossly contaminated should wherever possible be washed with soap and water and dried thoroughly.

6.3.2.1 Hand Preparation

Preparation of the hands increases the effectiveness of cleaning. Employees identified as at risk from infection and/or deliver personal care should:

- Expose their forearms.
- Keep nails short, clean and free of polish or artificial nails.
- Avoid wearing jewellery, such as wristwatches, bracelets and especially rings with ridges or stones. A plain metal finger ring is acceptable but it should be moved up or removed during hand hygiene.
- Cover all cuts and abrasions with a waterproof dressing.

6.3.2.2 Hand Washing Facilities

In premises, adequate hand washing facilities must be available and easily accessible. Designated hand washing facilities must be provided in treatment rooms, laundries and kitchens. Designated hand washing facilities must have basins provided with liquid soap dispensers, paper towels and foot-operated waste bins. Where hand washing facilities are not readily available for example when working at outside locations employees should have access to alternatives i.e. alcohol/antibacterial hand gels and rubs.

6.3.2.3 Hand Drying/Skin Care

Improper drying can contaminate hands that have been washed. Wet surfaces transfer organisms more effectively than dry ones and inadequately dried hands are prone to skin damage.

- Dry hands thoroughly after hand washing using disposable paper hand towels.
- Use an emollient hand cream during work breaks and when not working.
- Do not use or provide communal tubs of hand cream in settings where personal care is being provided.

6.3.3 Respiratory and Cough Hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross-transmission of respiratory illness:

- Cover the nose and mouth with a disposable tissue when sneezing, coughing wiping and blowing the nose.
- Dispose of all tissues promptly into a waste bin.
- Wash hands with a non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions.
- Keep contaminated hands away from the eyes, nose and mouth.

Employees should promote respiratory and cough hygiene helping those (e.g. elderly, children or those with additional support needs) who need assistance with this e.g. providing Service Users with tissues, plastic bags for used tissues and hand hygiene facilities as necessary.

6.3.4 Personal Protective Equipment (PPE)

Personal protective equipment is used to protect both staff and service users from the risk of cross-infection. It may also be required for contact with animals, hazardous chemicals and some pharmaceuticals. PPE includes items such as gloves, aprons, masks, goggles or visors. In certain situations it may also include hats and footwear.

All PPE should be:

- Located close to the point of use
- Stored to prevent contamination in a clean/dry area until required for use (expiry dates must be adhered to.)
- Be single use only items where possible
- Disposed of correctly i.e. contaminated waste or domestic waste.

Reusable PPE items i.e. non disposable goggles or face shields must have a decontamination schedule with responsibility assigned.

6.3.4.1 Disposable Gloves

Gloves must be:

- worn where there might be contact with body fluids and or blood,
- changed immediately after each Service user and/or following completion of a procedure or task;
- changed if a perforation or puncture is suspected and appropriate for use, fit for purpose and well fitting.

Gloves are not a substitute for hand washing. Disposable gloves are for single use only and they must be removed and discarded appropriately as soon as the task is completed. Hands must always be washed following their removal. The disposable gloves provided

must be either powder free vinyl or nitrile. Latex gloves must not be issued to staff due to the risk of sensitivity and allergic reaction associated with latex.

The correct procedure for the safe removal of re-usable and single use gloves is shown in Appendix 3.

6.3.4.2 Disposable Plastics Aprons

These should be worn whenever there is a risk of contaminating clothing with body fluids and when a service user has a known infection. Employees should dispose of them appropriately once the task is completed and/or changed between Service users.

6.3.4.3 Masks, Visors and Eye protection

These should be worn when a work activity is likely to cause body fluids or substances to splash into the eyes, face or mouth. Masks may also be necessary if infection is spread through the airborne route – for example, severe acute respiratory syndrome (SARS). Staff should ensure that this equipment fits correctly, is handled as little as possible, and changed between service users or tasks. Masks should be disposed of appropriately immediately after use.

6.3.5 Safe Management of Care Equipment

Care equipment is easily contaminated with blood or other body fluids, secretions, excretions and infectious agents. Consequently it is easy to transfer infectious agents from communal equipment. Care equipment is classified as either:

- Single-use – equipment which is used once on a single service user and then discarded. It must never be reused even on the same person. The packaging carries this symbol.
 - o Needles and syringes are single use devices.
 - o Never administer medications from a single dose vial to multiple service users.
- Single Service User use – equipment which can be reused on the same Service User.
- Reusable invasive equipment – used once then decontaminated. (It is unlikely that Inverclyde Council will deal with this equipment stream.)
- Reusable non-invasive equipment – or communal equipment. Reused on more than one service user following decontamination between each use.



Before using any sterile equipment check that:

- The packaging is intact
- There are no obvious signs of packaging contamination; and
- The expiry date remains valid.

Decontamination of reusable non-invasive care equipment must be undertaken:

- Between each use
- After blood and/or body fluid contamination;
- At regular predefined intervals as part of an equipment cleaning protocol; and
- Before inspection, servicing and repair.

Follow manufacturers' guidance for use and decontamination of all care equipment.

All reusable non-invasive care equipment must be rinsed and dried following decontamination then stored clean and dry.

Decontamination protocols should include responsibility for; frequency of and method of environmental decontamination.

For guidance on how to decontaminate non-invasive care equipment see Information Sheet 58, Appendix 4.

6.3.6 Safe Management of the Workplace Environment

The cleanliness of the environment where a service user is being cared for is important to prevent the spread of infection. The person responsible for maintaining this environment must be identified and a clear reporting mechanism in place to ensure that any deficiencies are notified so that they can be acted upon.

The environment must be:

- Visibly clean, free from non-essential items and equipment to facilitate effective cleaning;
- Well maintained and in a good state of repair; and routinely cleaned in accordance with an agreed cleaning schedule.
- A fresh solution of general purpose neutral detergent in warm water is recommended for routine cleaning. This should be changed when dirty or at 15 minute intervals when changing tasks.
- Routine disinfection of the environment is not recommended. However, 1,000ppm available chlorine should be used routinely on sanitary fittings.

Employee groups should be aware of their environmental cleaning schedules and clear on their specific responsibilities. Cleaning protocols should include responsibility for; frequency of; and method of environmental decontamination.

6.3.7 Safe Management of Linen

Clean linen should be stored in a clean, designated area, preferably an enclosed cupboard. If it is not stored in a cupboard then the area it is stored must be designated for that purpose and the linen covered with an impervious cover able to withstand decontamination.

For all used linen:

- Ensure a laundry receptacle is available as close as possible to the point of use.

Do not:

- Rinse shake or sort linen on removal from any beds etc.;
- Place used linen on the floor or any other surfaces, i.e. tables;
- Re-handle used linen once bagged;
- Overfill laundry receptacles; or
- Place inappropriate items in the laundry receptacle i.e. used equipment/needles.

For all infectious linen i.e. linen or clothing that has been used by a service user who is known or suspected to be infectious and/or linen that is contaminated with blood and/or other body fluids e.g. faeces:

- Place directly into a water-soluble/alginage bag (Appendix 5) and secure; then place into a plastic bag e.g. clear bag before placing in a laundry receptacle or returning to the Service User. This applies to any items heavily soiled and unlikely to be fit for reuse.

6.3.8 Safe Management of Blood and Body Fluid Spillages

Spillages of blood or other body fluids may transmit blood borne viruses. Spillages must be decontaminated immediately by staff trained to undertake this safely. Responsibilities for the decontamination of blood and body fluid spillages should be clear within each area.

For management of blood and body fluid spillages see Appendix 6 Information Sheet 57.

6.3.9 Safe Disposal of Waste (including sharps)

There are various classifications of waste:

- Domestic Waste
 - o Recyclates (glass, paper and plastics, metals, cardboard)
 - o Residual waste (any other domestic waste that cannot be recycled)
- Clinical Waste
 - o Generally is produced as a result of healthcare activities e.g. soiled dressings, sharps. Or waste which may contain infectious materials, i.e. blood or body fluid contamination.
- Hygiene Waste
 - o See SEPA guidance on this type of waste. Appendix 7

Clinical waste should be put into clinical waste yellow bags, clearly identified as clinical waste. These bags must be removed and incinerated by an approved waste management provider, and should not be disposed of in any other manner.

6.3.9.1 Clinical Waste Deposit Area

To comply with the "Waste Management Licensing Regulations" Inverclyde Council have made available a central clinical waste collection point.

A clinical waste skip (yellow in colour) is located at the Pottery Street Waste Depot adjacent to the port-a-cabin at the weighbridge.

This facility is available to allow the safe deposit of clinical waste that may be collected by Inverclyde Council employees during the course of their duties.

The clinical waste skip will be controlled by Transport and Waste employees operating from the garage office. The key for the skip and the "Clinical Waste Deposit Register" will be held and controlled from this location.

Employees wishing to deposit clinical waste should report to the garage office and give the appropriate information to employees controlling the waste collection point.

If no employees are present efforts should be made to locate them or a return visit made.

- Clinical waste should not be deposited in this area if no employees are present to provide access to the skip.
- Clinical waste being deposited must be in either a sharps container or clinical waste yellow bag.
- Clinical waste must always be properly bagged; it must never be deposited loose.

Sharps boxes must:

- Have a dedicated handle.
- Have a temporary closure mechanism, which must be employed when the box is not in use.

- Be disposed of when the manufacturers' fill line is reached; and be labelled with the point of origin and the date of closure.

Information Sheet 49 – BBV: Sharp/needle uplift awareness provides further information on the correct method of uplifting needles. Appendix 8

6.3.10 Occupational Safety: prevention and exposure management (including sharps)

A sharp is defined as any item that is capable of penetrating the skin and may be contaminated with blood or other body fluids. Sharps include needles, glass, metal and knives. The main hazards of a sharps injury are Hepatitis B, Hepatitis C and HIV. Sharps handling must be assessed kept to a minimum and eliminated is possible with the use of approved safety devices. Manufacturers' instructions for safe use and disposal must be followed.

A significant occupational exposure is:

- An injury which breaks the skin, e.g. injuries from needles, bites etc.
- 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.

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

Accidents can occur at any stage and to reduce the risk of injury and exposure to blood-borne transmissible diseases. To avoid injury employees should ensure that:

- Sharps are not passed directly from hand to hand.
- Handling is kept to a minimum.
- Needles are not broken or bent before use or disposal.
- Syringes or needles are not dismantled by hand before disposal.
- Needles are never re-sheathed.
- They plan for the safe handling and disposal of sharps before they are used.
- Used sharps are placed in a special container at the point of use, by the user and not a third party. This should conform to UN Standard 3291 and British Standard 7320.
- Service users who self-medicate must be encouraged to dispose of sharps themselves directly into a sharps container at the point of use.
- Where needles are regularly used consideration should be given to the use of retractable needles.
- Sharps containers must be kept in a secure place away from unauthorised people.

Employees who are identified at risk from injury by discarded needles should be provided with puncture resistant gloves and suitable equipment for safe handling and disposal.

Premises or locations that identify a risk from discarded sharps such as syringes must have suitable equipment available/accessible to remove the sharps. Out of hours, they can liaise with the Community Wardens to make arrangements for the area to be made safe.

For information on the management of an occupational exposure incident see Appendix 9

6.3.10.1 Managing Accidents

Accidental exposure to body fluids can occur by:

- Injury penetrating the skin – for example, from needles, instruments, bone fragments or significant bites that break the skin.
- Exposure of broken skin – for example, abrasions, cuts or eczema.
- Exposure of mucous membranes, including the eyes and the mouth.

The action that should be taken immediately following accidental exposure to body fluids, including blood is given below and illustrated in Appendix 9.

Action to be taken by the person exposed:

- Immediately stop what you are doing and attend the injury.
- Encourage bleeding of the wound by applying gentle pressure – do not suck. Wash well under running water, dry and apply a waterproof dressing as necessary. If body fluids splash into eyes, irrigate with cold water. If body fluids splash into your mouth, do not swallow. Rinse out several times with cold water. Report the incident to your manager and complete an online Accident Form and the Accident Book
- If line manager is not available contact Health and Safety on ext. 4720.
- Go to A&E

Action to be taken by the line manager:

- Initiate an investigation into the cause of the incident.
- If the Service User involved in the incident is known gain information from the Care Plan about medical history.
- Assess the degree of risk to the employee. Incident that will normally be regarded as high risk are:
 - o Needlestick injuries
 - o Bites – that break the skin
 - o Any incident resulting in the skin being broken
- Contact the Health & Safety Team for follow up action/treatment as necessary.
- Inform Health and Safety of all relevant information about the incident.
- Ensure an accident form is completed.
- Complete/review risk assessment.
- Following an incident, exposed staff should be given time to talk about their concerns, provided with information about the risks arising from the exposure, and informed of the support available from the staff counselling service.

Action to be taken by Occupational Health

- Check the immune status of the exposed employee if known, and discuss their immune status with the employee.
- Dependent on best practice, offer the employee the chance to have their blood tested.

6.4 Special Considerations for First Aiders

The risk of being infected whilst carrying out first aid duties is small. The following precautions can be taken to reduce the risk of infection:

- Cover any cuts or grazes on your skin with a waterproof dressing.
- Wear disposable gloves when dealing with blood or any other body fluid.
- Use suitable eye protection and a disposable plastic apron where splashing is possible.
- Use devices such as a resuscitator when giving mouth-to-mouth resuscitation, but only if you have been trained to use them.
- Wash hands after the procedure.

6.5 Vulnerable Employees

If there is a known infectious risk, managers must consider if any of the staff exposed would be at increased risk due to their own health. Guidance on other infections is available in Appendix 10.

6.5.1 New or Expectant Mothers

Some infections in pregnancy may cause damage to the developing baby and pregnant staff should not work with these infectious hazards. (Advice must be sought from the Health and Safety Team or Occupational Health Service, on individual cases when appropriate.)

Main risks are from chicken pox, rubella, measles like rashes, slapped cheek and certain zoonosis such as toxoplasmosis and psittacosis. All pregnant staff must have a risk assessment completed as soon as their pregnancy is known.

6.5.2 Those with lowered immune system (immunocompromised)

This would include those being treated with radiotherapy and chemotherapy for cancer, and high doses of steroids or illness that affects immunity such as Leukaemia, HIV. These individuals are more likely to develop some infections and these may be more severe. Advice must be sought from the Occupational Health Unit on an individual case basis and an individual risk assessment carried out.

6.6 Confidentiality

Confidentiality must be maintained at all times. Services should actively safeguard and protect confidentiality about the medical status of all staff and service users. When the medical status of a staff member or service user is known, either through recorded information or verbally, the indisputable “need to know” is the criteria for disclosure not “want to know”.

Deliberate breaches of confidentiality will be considered a disciplinary matter. An individual who wishes his/her medical status to remain confidential should have his/her wishes respected. For information to be shared the informed consent of the individual should be obtained. Before an individual gives consent, it is vital that she/he should be aware of the implications of agreeing to disclosure of information. The Council's Data Protection Policy and Data Protection Protocols must always be followed.

7 INFORMATION AND TRAINING

7.1 Information

Inverclyde Council recognises the need to provide staff with relevant information on the how to deal with the risk of infection and exposure to BBV's. Employee awareness will help with the implementation of this policy. Information on the infection control will be made available on the Council's Intranet System ICON, and on Information Sheets. The information will be updated on a regular basis.

7.2 Training

The Council recognises that training of employees is important to ensure that all relevant employees have the necessary skills to carry out the requirements of this policy. Employees identified as at risk from infection and/or deliver personal care must receive information and

training on the Infection Control Policy and standard precautions on induction. This must be reviewed on a regular basis and the training recorded.

7.3 Communication of the Policy

The Council recognises the importance of communicating the policy to all employees. This policy will be communicated to staff via the Corporate Health and Safety Committee, the Council's team briefing system and a copy will be placed on the Council's Intranet system ICON.

8 MONITORING, EVALUATION & REVIEW

This reviewed policy was ratified by the Council's Policy and Resources Committee on 09 February 2015 and implemented immediately thereafter.

Regular monitoring and review are necessary to measure the effectiveness of the policy and to ensure it remains relevant to the needs of the Council. This policy will be subject to monitoring and review on a regular basis by the Corporate Health and Safety Section via the Corporate Health and Safety Committee.

The policy will be reviewed 12 months from implementation and every three years thereafter unless there is significant change in legislative requirements or risk assessment identifies a need for review. Measuring the effectiveness of the policy will include the auditing of compliance with this policy, and monitoring of incidents.

APPENDIX 1 – INFECTION CONTROL/RISK ASSESSMENT PROFORMA

Risk Assessment – Infection Control including Blood Borne Viruses (BBV's)

Reference No:				Service:			
Please see guidance at Appendix 1 on how to complete this Risk Assessment on behalf of Individuals / Groups potentially exposed to BBV's. This risk assessment should be regularly reviewed as change in work activity / equipment / personnel / systems or industry standards dictate. If no other changes occur then the activity should be re-assessed after a period of 3 years. N.B Continue on blank paper if required.							
1. Provide Detail of Work Activity:				2. Person(s) at Risk:			
3. Hazard:				4. Types of Loss / Injury /Ill health: e.g. infection/disease/psychological harm			
5. Existing Control Measures:							
6. Risk Rating Number (RRN) with Existing Control Measures:					X		=
				Severity		Likelihood	
HIGH:			MEDIUM:			LOW:	
High =20 to 36			Med = 9 to 18			Low = 1 to 8	
7. Is vaccination available for control of this risk?							
8. Could vaccination significantly reduce the risk to this individual or group?							
9. After explanation has the individual or group expressed a willingness to consider this option?							
If the above control measures are NOT considered adequate to reduce the risk of exposure to a tolerable level, additional control measures must be implemented. These could include vaccination, which should only be considered if responses to the following questions are 'yes'							
10. Additional Recommended Control Measures:				Action by:	Completion Date:		
11. RRN after implementation of additional control measures: Repeat RRN from above if no additional measure recommended					X		=
				Severity		Likelihood	
Assessed by:				Date:			
Designation:							
Person Responsible for ensuring the above is Implemented:							
Signature:				Issue Date:			
Designation:				Review Date:			
12. Occupational Health Referral:				Date:			
Comments: If assessing for one individual please include employee signature and date							

Guidance on Completion of Form

Introduction: - This Risk Assessment ProForma should be used when considering the level of risk of contracting an infection i.e. TB or a Blood Borne Virus (BBV) to which an individual or group may be exposed.

Detailed guidance and current best practice in terms of risk of BBV's and other Infection control issues can be found in the associated standard.

1. Describe the work activity undertaken by the individual or group. (Some relevant examples are listed in Infection Control or BBV Standard)
2. Consider who may be at risk Include all those who may be affected
e.g., clients, service users, contractors, members of public etc. where relevant
3. Consider the Hazards associated with this Work Activity i.e. what has the potential to cause harm? The following list of work areas / job types may be of use but is not exhaustive;

Waste Management	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Property Maintenance	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Play Equipment	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Inspections	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Cleaners	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Caretakers/Janitors	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Social Care Workers	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Ground Maintenance	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Hostel Officers	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus
Housing Inspectors	Contact / piercing of Skin from hidden contaminated sharps / needles / exposure to bacteria/virus

- Blood Transfer through Violence / Assault
- Blood / Body Fluid Transfer through Personal Care Activities
- Blood / Body Fluid Transfer through Cleaning Activities
- Blood / Body Fluid Transfer through delivery of First Aid
- Body Fluid transfer through skin puncturing in the form of human bites
- Close sustained contact with an infected person

4. Detail potential Loss / Ill-Health / Disease or other Harm

Consider the various forms of Hepatitis, HIV or other known BBV's. Don't exclude psychological harm to which individuals may be exposed when contracting a needlestick injury and / or knowingly absorbing blood / body fluid products. While risk of contamination is still extremely low, it can be 6 months before an individual receives the 'all-clear' in this respect.

5. Existing Control Measures

Provide a detailed explanation of what is already in place to reduce the risk associated with the work activity. The following list of options may be helpful, but are not exhaustive;

- Provision of Information on Council Policy and Guidance
- Provision of Instruction and / or Training in:
 - o BBV's, Infection Control, Sharps Handling, Blood and Body Fluid Spillages, Blood and Body Fluid Clean Up Procedures, Good Hygiene Standards, Use of Sharps Kits, COSHH Awareness etc.
- Use of Safe Systems of Work –
- Good Personal Hygiene / Hand washing Practices.
- Safe Handling and Disposal of Sharps
- Issue of Sharps Collection Kits
- Issue of Blood / Body Fluid Clean Up Kits
- Knowledge of 'Action to be Taken in the Event of a Sharps Injury' protocols
- Awareness of Incident / Accident reporting Procedures
- Adequately covered cuts and wounds.
- Use correct tools for job e.g. lifting hooks, devices, tongs, remote pickers
- Use of Personal Protective Equipment – e.g. various gloves – needle retardant or disposable gloves, disposable aprons, rubber boots, disposable overshoes, eye shields, face masks, waterproof clothing, disposable suits.
- (PPE should be seen as a last resort, and where used, suitably stored, inspected, maintained, cleaned etc. as required).

6. Assess the level of Risk with existing Control Measures.

See Appendix 2 for further assistance.

7, 8, 9 Vaccination

If the Control Measures are NOT considered adequate to reduce the risk of exposure to a tolerable level, additional control measures must be implemented. These could include vaccination, but this should only be considered if responses to the questions 8, 9, and 10, are 'yes'.

If this is the case, vaccination should be entered as an additional control measure (11) and the individual (or group) should be referred to Occupational Health for further 'person specific' guidance. When this process is complete the Risk Assessment should be updated.

10. Additional Control Measures

This is the opportunity to reduce the risk even further. In this section, you may include vaccination, (if the conditions of 7, 8, 9. are satisfied), or any of the wide range of Control Measures not previously implemented at 5, which might help to reduce the risk further.

11. Risk Rating (Following Implementation of Further Control Measures)

Assess the level of Risk with the Additional Control measures, using the same method as before.

12. Occupational Health Referral

Where it has been decided to pursue vaccination as an additional control measure – please record this here, with a note of appointment date.

Conclusion

Now simply ensure the assessment is signed and dated by the appropriate individuals and copied to the Health and Safety Team Leader, Municipal Building, Clyde Square Greenock.

This risk assessment should be regularly reviewed as change in work activity / equipment / personnel / systems or industry standards dictate. If no other changes occur then the activity should be re-assessed after a period of 3 years

Comments: If risk assessing exclusively for one individual, please include employee signature and date in this box.

13 General Risk Assessment Guidance

Hazard - Hazard is an event or situation, which has the potential to cause harm (loss, damage, injury, ill-health, psychological harm, industrial disease or death)

Risk - Risk is the chance, or likelihood, that the harm will occur from a particular hazard.

Examples

- (i) A discarded needle is a hazard, which could result in the risk of infection, ill-health or psychological damage.
- (ii) Exposure to body fluids is a hazard, which could result in risk of infection or ill health.

We require to estimate how likely a risk is to materialise and how severe the consequences might be, in order to prioritise the necessary preventative action.

Quantification of Risk

- Estimation of severity - The severity column should be used to estimate the severity of impact, should the risk arise.
- Estimation of Likelihood - The likelihood column should be used to estimate the chance of the risk occurring.

Severity		Likelihood	
1	Negligible	1	Remote
2	Minor	2	Very unlikely
3	Moderate	3	Possible
4	Major	4	Likely
5	Critical	5	Very Likely
6	Catastrophic	6	Almost Certain

When selecting the “severity”, we need to consider how the risk would impact in terms of level of loss, injury or ill-health. We need to consider what is most probable, rather than what is possible.

When selecting the “likelihood”, we need to consider the exposure frequency, e.g. disposing of a hypodermic needle, as a ‘one off’, is less likely to have an impact than undertaking needle sweeps on a daily basis.

Risk Rating = Severity x Likelihood

The Risk Rating Matrix outlined below is a tool with which the risk rating can be classified, and is accepted as a means of analysing Inverclyde Council's Health and Safety Risk and whether this is considered to be HIGH, MEDIUM or LOW. Risks rated at 9 or above require to be addressed, in order that they can be reduced to the lowest level reasonably practicable. Those below 9 should be continually monitored, (and addressed where resources permit).

Risk Rating Matrix

36	30	24	18	12	6
30	25	20	15	10	5
24	20	16	12	8	4
18	15	12	9	6	3
12	10	8	6	4	2
6	5	4	3	2	1

High	20 to 36	Risks not acceptable under any circumstances. Immediate risk reduction required.
Med	9 to 18	Risk reduction measures required.
Low	1 to 8	Address where resources permit and continue to monitor regularly, as risks can increase over time.

APPENDIX 2 – HAND HYGIENE

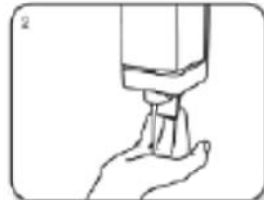
How to handwash step by step images.

Steps 3 – 8 should take at least 15 seconds

Source: World Health Organisation



Wet hands with water



Apply enough soap to cover all hand surfaces



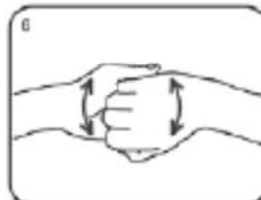
Rub hands palm to palm



Right palm over the back of the other hand with interlaced fingers and vice versa



Palm to palm with fingers interlaced



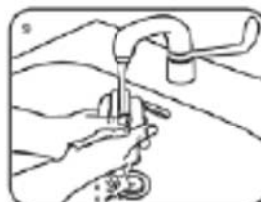
Backs of fingers to opposing palms with fingers interlocked



Rotational rubbing of left thumb clasped in right palm and vice versa



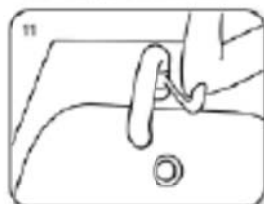
Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa



Rinse hands with water



Dry thoroughly with towel



Use elbow to turn off tap or turn off using the towel



...and your hands are safe



Adapted from the World Health Organization



Germs. Wash your hands of them.

How to hand rub, step by step images.

How to handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS ONLY WHEN VISIBLY SOILED!



Duration of the entire procedure: **20-30 sec.**



Apply a palmful of the product in a cupped hand and cover all surfaces.



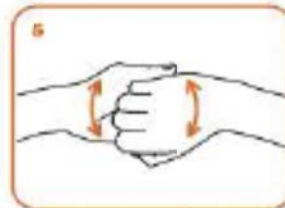
Rub hands palm to palm



right palm over left dorsum with interlaced fingers and vice versa



palm to palm with fingers interlaced



backs of fingers to opposing palms with fingers interlocked



rotational rubbing of left thumb clasped in right palm and vice versa



rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa



...once dry, your hands are safe.



Adapted from the World Health Organization



Germ. Wash your hands of them.

APPENDIX 3 – REMOVING GLOVES

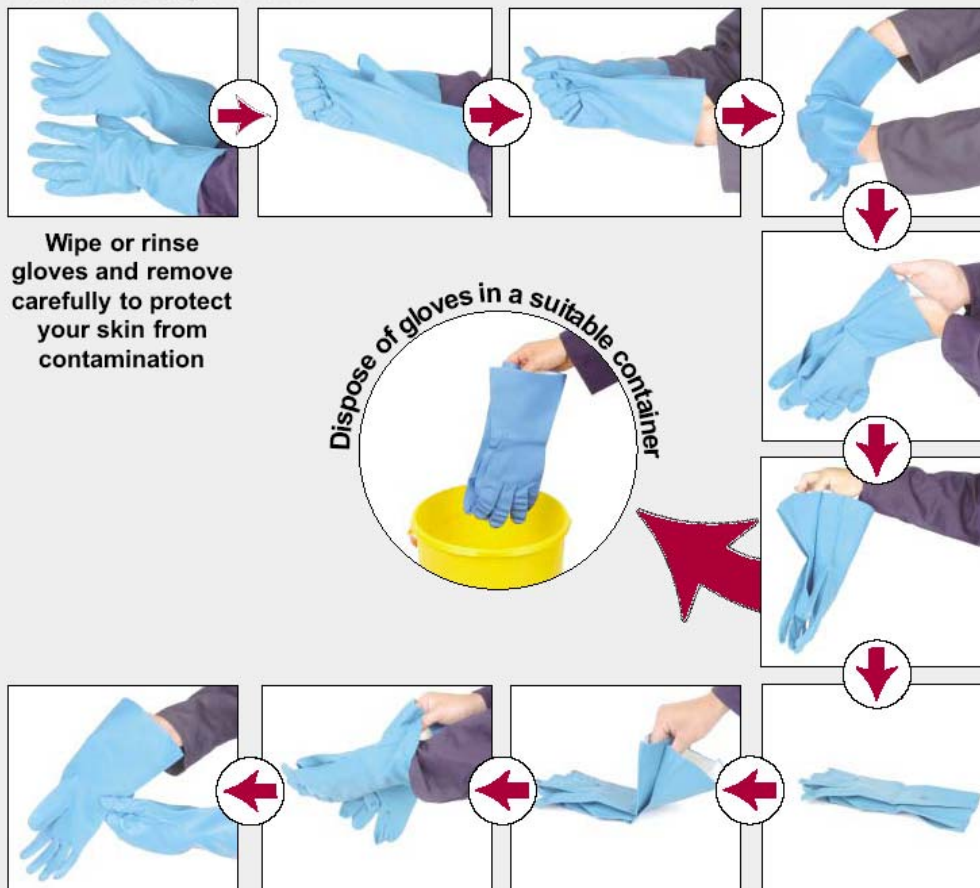


Health and Safety
Executive

Correct removal of gloves

Reusable gloves (chemically resistant)

Follow the steps shown



- Always select the correct size gloves
- Use gloves for no longer than one day

www.hse.gov.uk

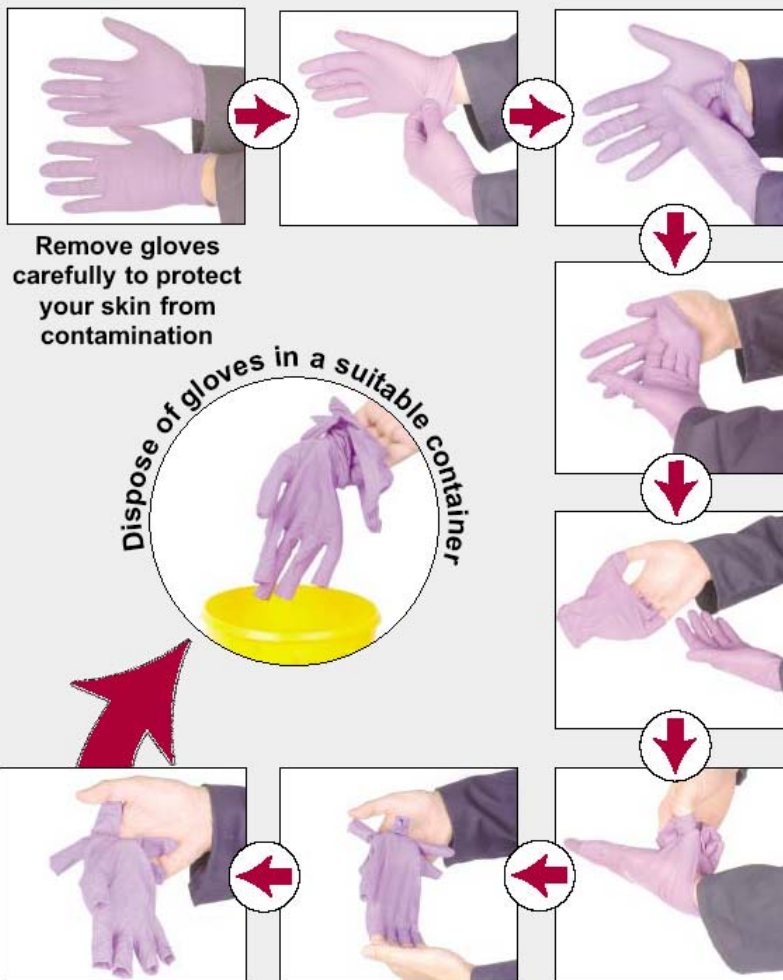


Health and Safety
Executive

Correct removal of gloves

Single use gloves (splash resistant)

Follow the steps shown



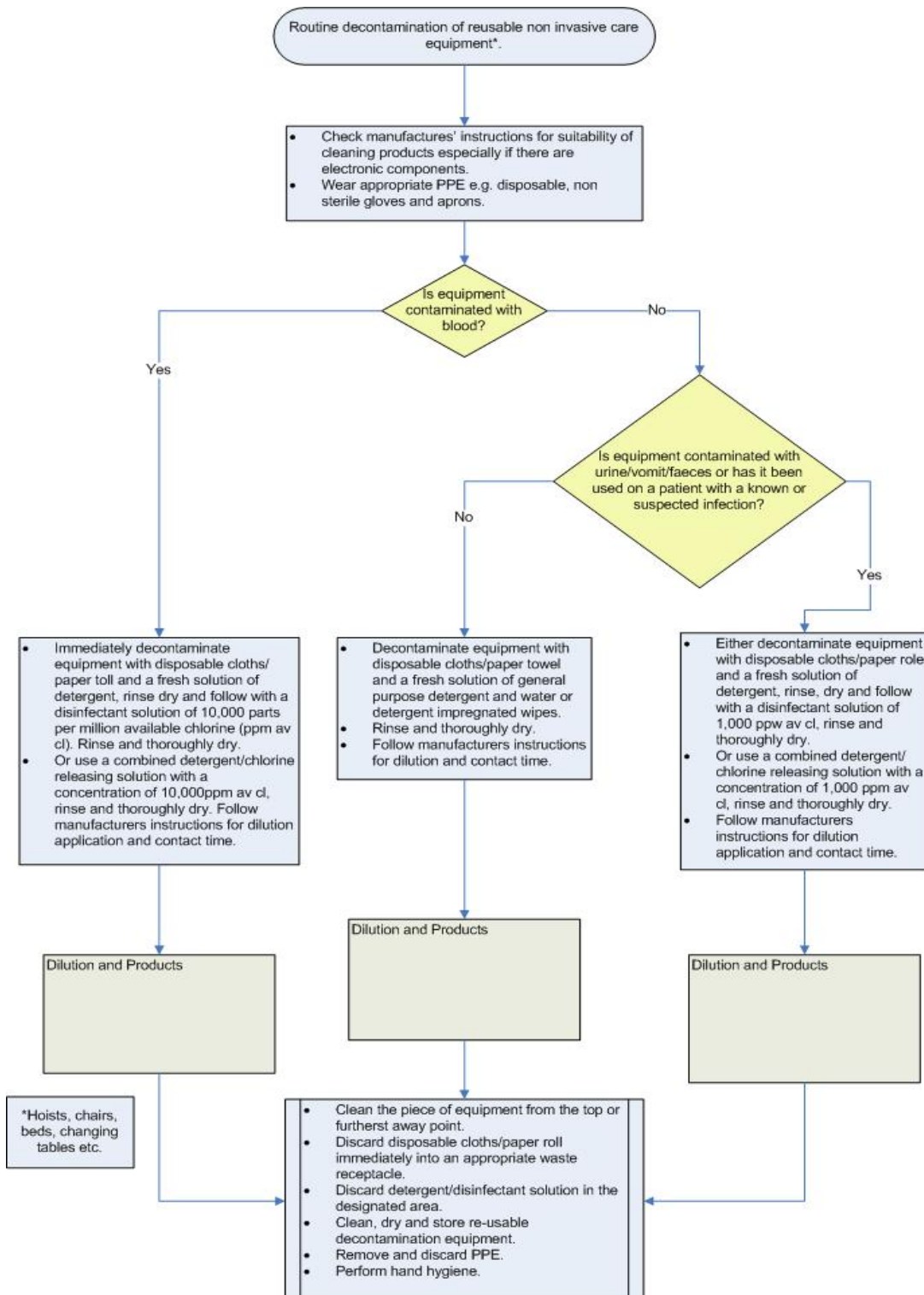
www.hse.gov.uk

APPENDIX 4 – DECONTAMINATION OF REUSABLE NON-INVASIVE CARE EQUIPMENT

Information Sheet No. 58

Decontamination of reusable non-invasive care equipment

The following procedure should be followed for decontamination of reusable non-invasive care equipment. Within boxes A and B the local chemicals and dilution rates should be added. This information sheet should be made freely available on noticeboards and to employees who may be responsible or required to deal with decontamination of reusable non-invasive care equipment.



APPENDIX 5 – WATER SOLUBLE LAUNDRY BAGS

Water soluble laundry bags are used to avoid the spread of infection and contamination, and to control environmental pollution.

Infected materials are placed and sealed into the bag at the source of infection and are then transferred to the washing machine still inside the bag. The soluble strip then dissolves to allow the bag to split and the infected item to be washed. This process prevents any employees coming into contact with the affected material.

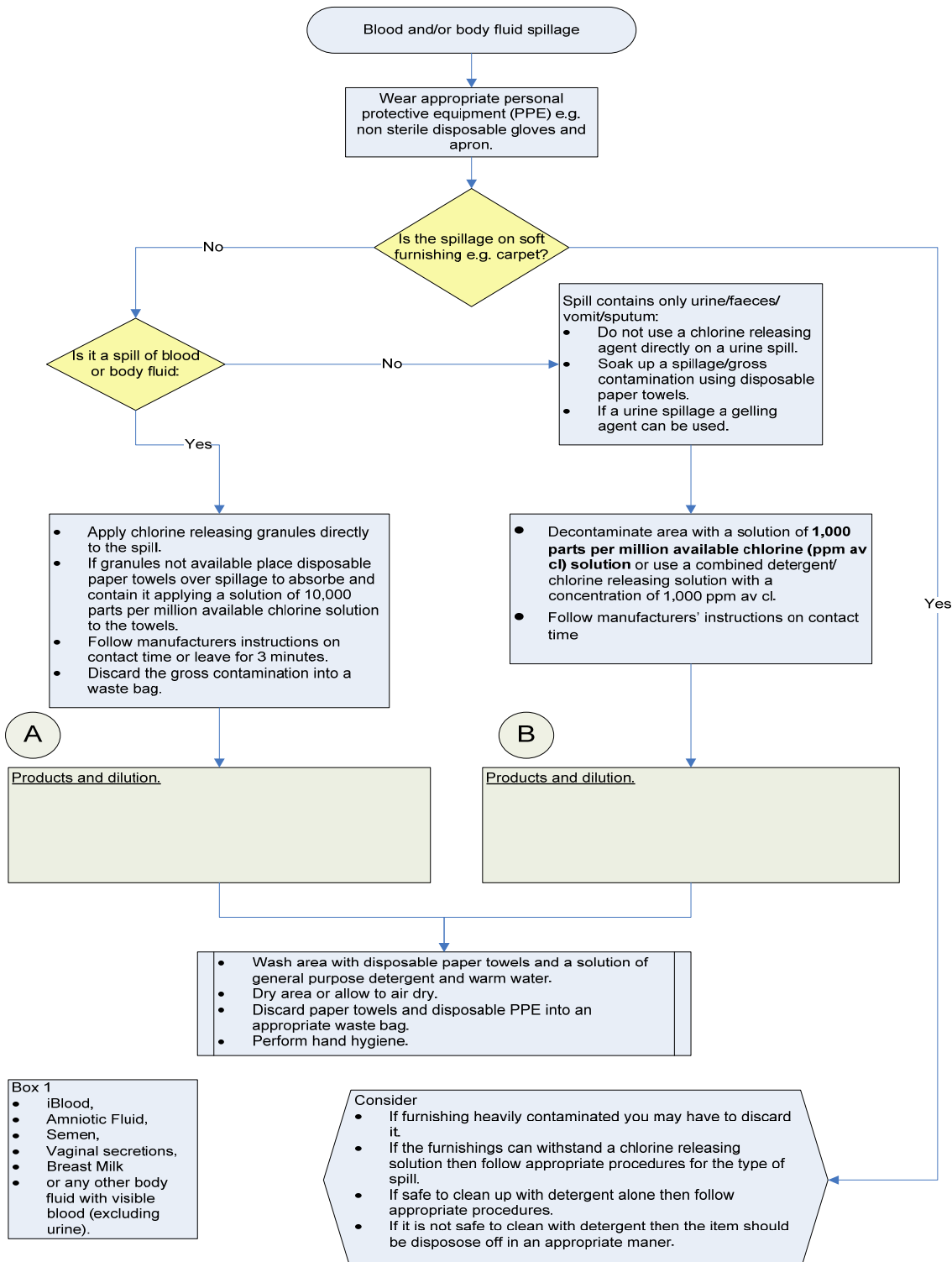


APPENDIX 6 – MANAGEMENT OF BLOOD AND BODY FLUID SPILLAGES

Information Sheet No. 57

Management of Blood and Body Fluid Spillages

The following procedure should be followed for blood and body fluid spillages. Within boxes A and B the local chemicals and dilution rates should be added. This information sheet should be made freely available on notices and to employees who may be responsible or required to deal with blood and body fluid spillages.



APPENDIX 7 – MANAGEMENT OF HYGIENE WASTE PRODUCED AS A RESULT OF PERSONAL CARE



Background

The provision of 'personal care' is carried out in a number of settings such as care homes, day centres, nurseries, sheltered housing and housing support. Such activities produce varying quantities of 'hygiene waste' such as nappies, incontinence products and feminine hygiene products.

This guidance has been produced in co-operation with the Care Inspectorate and provides guidance on the management and disposal of hygiene waste as a result of personal care.

What is hygiene waste?

Hygiene waste can be defined as 'waste that is produced from human or animal hygiene activities that:

- may cause offence due to the presence of recognisable healthcare waste items or body fluids;
- does not meet the definition of an infectious waste;
- does not possess any hazardous properties;
- is not identified by the producer, or holder, as needing disinfection, or any other treatment, to reduce the number of microorganisms present.'

In general, hygiene waste will include:

- sanitary towels and tampons;
- panty liners;
- feminine wipes;
- incontinence products and nappies;
- catheter and stoma bags;
- animal faeces and animal bedding etc.

Please note: The term hygiene waste has all but replaced the historical terms 'SANPRO' and 'Group E' wastes. Hygiene waste is also commonly referred to as 'offensive' waste and both terms are interchangeable for the purposes of this guidance.

When is hygiene waste infectious or hazardous?

It is generally assumed that hygiene waste won't be infectious or hazardous.

Where 'client' knowledge or diagnosis by a medical practitioner suggests that there is a possibility of infection, such as the gastrointestinal infection *E-coli*, you should undertake a risk assessment to enable a proper classification of the waste.

Where the assessment proves that there is a risk of infection, the waste should be classified as hazardous and segregated from non-infectious hygiene waste.

APPENDIX 8 – BBV: SHARP/NEEDLE UPLIFT AWARENESS

Information Sheet No. 49

Blood Borne Virus: Sharp/ Needle Uplift Awareness

On discovering needles/ sharps

- Where practicable, make the area safe and get help.
- **Always** take the “**sharps box**” and selected kit items to the needle/ sharp; never the other way round!
- Sharp boxes are available in different sizes ranging from a small hand held (for minimal needles found) to large free standing ones (for larger amounts found on a regular basis).
- Choose a box that suits your needs.
- Your kit should include tweezers, gloves, disinfectant, plasters, dressings, etc.
- Always select the required items **before** lifting any sharp/needle

Uplifting needles / sharps

- Assess the situation/ location of the discovered sharp/ needle.
- If the sharp/needle is surrounded by body fluid/blood, is there any possibility of any blood/ fluid getting underneath your gloves, onto your hands and then into your own blood system.
- Check your hands for cuts prior to lifting sharp/needle in fluid. Before you put on any suitable item of PPE (e.g. Gloves) apply plasters to such cuts.
- Wear suitable PPE:- gloves, safety foot wear, apron, etc. as required and depending on your job.
- Use tweezers or litter pickers to uplift the sharps/ needles and place in the sharps box through the opening.
- Always lift needles individually, never more than one at a time as this increases the possibility of receiving a needle stick injury
- Never put your hands into any area you cannot see in to.

Use of a small hand held sharps box

- As a rule of thumb, always hold the sharps box at point/side where the handle is located (or side opposite the **disposal** opening)
- This ensures the designated disposal opening is as far away from your hand as possible as you could be distracted when disposing of a sharp/ needle, and your hand may slip and miss the opening. If so, you will minimise the possibility of sustaining a needle stick injury.
- The chances of obtaining a needle stick injury increases if the sharps box is held in any other way.

Use of a larger sharps box:

- As before, carry the **box** to the location of the sharp/ needle. Set the box down beside sharp/ needle on a solid level surface where possible.
- Pick up sharp/ needle with tweezers and drop into the box through the flap at the top.
- **NEVER** place your fingers inside box to hold the flap open when discarding sharps/ needles.

Dispose of material

- All “**soft**” material i.e. clothing, wound dressings etc, should be disposed of in suitable yellow bags clearly labelled as “**contaminated waste**” .
- **Never** place sharps/ needles in these yellow bags. These are only for soft material such as disposable gloves, light weight plastic aprons, soiled bandages, soft cloths used to soak up blood/ fluids, etc.
- Dispose of all contaminated waste in accordance with your service guidelines.
- Uplift may be arranged with an external contractor; or
- Disposal may have been agreed with Pottery Street depot, for the use of their clinical waste skip.
- Always take due care and attention when disposing of any sharp/needle.

Needle/ sharp removal from....

- If a needle is located outside in a public place such as in a park, Environmental Services will generally arrange to have the needle uplifted.
- If the needle is located within a social housing environment the relevant housing association would be responsible for its removal from site.
- If a private house then the owner/occupier is responsible for uplifting the sharp/needle.
- If further clarification is required contact your supervisor/line manager first. If advice is still required, contact Health and Safety.

Remember

- Assess the situation
- Wear appropriate PPE as required
- Always take the sharps box to the needle/ sharp
- If care and attention is taken at all times there is a minimal chance of receiving a needle stick injury
- The chances of contracting a Blood Borne Virus from a needle stick injury is **LOW!**

APPENDIX 9 – MANAGEMENT OF OCCUPATIONAL EXPOSURE INCIDENTS

Information Sheet No. 59

Management of Occupational Exposure Incidents

Needlestick Injuries

Injuries from needles used in medical procedures are sometimes called needlestick or sharps injuries. Sharps can include other medical supplies, such as syringes, scalpels and lancets and glass from broken equipment.

Once someone has used a needle, viruses in their blood such as hepatitis B, hepatitis C, HIV, may contaminate it. This includes needles used to inject illegal drugs. Blood can also contaminate sharps.

Blood/Body Fluid Exposure

Any incident involving contamination of eyes, mouth or open wounds with blood or body fluids which may or are likely to contain blood or are visibly blood stained.

Assessing your Exposure

The healthcare professional treating you will assess the risks to your health and ask about your exposure, for example, how and when it happened, who had used the needle, whose blood or body fluid you were exposed to.

Samples of your blood may need to be tested for hepatitis B and C or HIV.

They will want to know if you have been immunised against Hepatitis B and what your immunisation status is, have you previously received any doses of HBV vaccine, if so, did you respond to the vaccine? If you have been immunised by the Council's Occupational Health Provider this information will be on record and can be sourced by contacting:

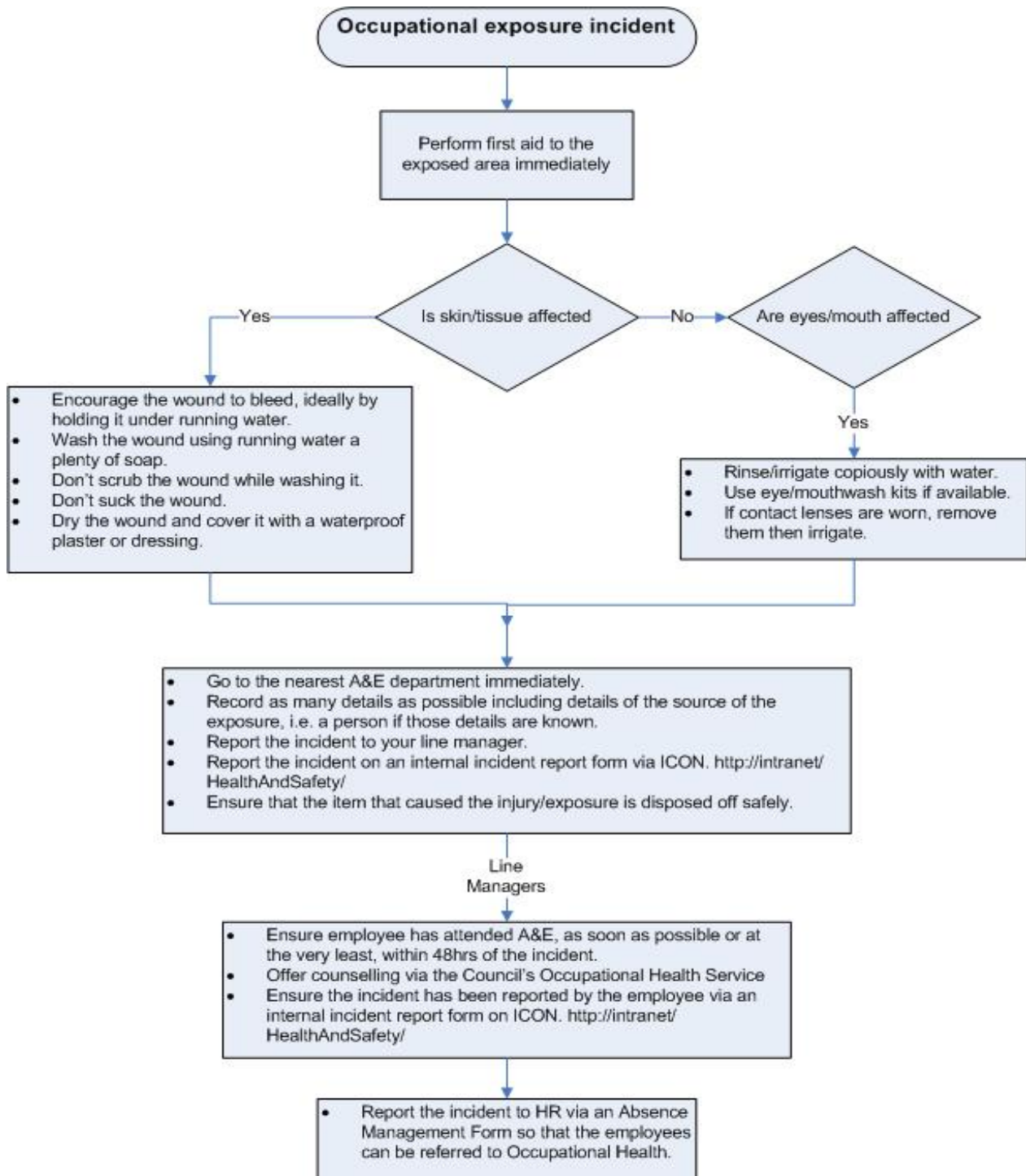
Inverclyde Physiotherapy
19 Union Street
Greenock PA16 8DD
01475 725285

Your healthcare professional may also arrange to test samples of the other person's blood, if they give their consent.

Post Exposure Prophylaxis

All of the above will contribute to any decisions on whether HIV and/or HBV post-exposure prophylaxis, or follow-up for evidence of HCV transmission, is required.

The flowchart below should be followed where there is an exposure to blood or body fluids.



APPENDIX 10 – GUIDANCE ON OTHER INFECTIONS

General Infections

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
CHICKENPOX	15–18 days.	From 1 day before up to 5 days after the appearance of rash.	Exclude for 5 days from onset of rash.	If a vulnerable person or pregnant woman is exposed to chickenpox or shingles they should be informed of the contact and be advised to seek appropriate medical advice.
SHINGLES	Re-activation of Chicken Pox virus.	Infectious only if lesions are exposed.	Only those people who have previously had chicken pox can get shingles.	
CONJUNCTIVITIS (viral or bacterial)	Depends on cause.	Whilst eye is inflamed, spread by contact , sharing towels etc.	Until treatment has begun and Inflammation has started to resolve.	Good personal hygiene can reduce the risk of transmission.
FIFTH DISEASE (Slapped Cheek Syndrome/ Parvovirus)	5-7 days.	Probably from 7 - 14 days after initial contact.	Until clinically well. Rash does not indicate infectivity.	If a pregnant woman is exposed to Parvovirus she should promptly inform her GP.
GERMAN MEASLES (RUBELLA)	14–21 days.	From a few days before to 5 days after onset of rash.	5 days from appearance of rash.	If a pregnant woman is exposed to Rubella she should promptly seek advice from her GP.
GLANDULAR FEVER	33–49 days.	Once symptoms have subsided, risk is small apart from very close contact, e.g. kissing.	Until clinical recovery.	None.

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
HAND, FOOT AND MOUTH DISEASE	3–7 days.	Probably from 1 day before to a few days after onset of symptoms.	Until clinically well. Rash does not indicate infectivity.	None.
HEPATITIS A (Infective Hepatitis)	2-6 weeks.	From 7 - 14 days before to 7 days after onset of symptoms.	7 days from onset of jaundice and when clinically fit with no symptoms.	None.
INFLUENZA	1-5 days.	Probably up to 7 days in young children; 3-5 days in adults.	Until clinically well.	Immunisation is available for certain vulnerable groups.
MEASLES	10–15 days.	A few days before up to 5 days after onset of rash.	5 days from onset of rash.	None.
MENINGOCOCCAL DISEASE MENINGITIS/ SEPTICAEMIA	2-10 days (commonly 2 – 5 days).	Whilst organism is present in naso-pharynx (back of the nose and throat).	Until clinical recovery. Must be with medical advice.	No exclusion for contacts receiving antibiotic prophylaxis.
MENINGITIS not due to meningococcal infection	Varies.	Varies.	Once person is well they can return to school or work.	
MUMPS	12–21 days.	From a few days before onset of symptoms to subsidence of swelling.	Until swelling has subsided or when clinically recovered 5 days from onset of swollen glands.	None.

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
SCARLET FEVER AND OTHER STREPTOCOCCAL INFECTIONS	2–5 days.	Whilst organism is present in the naso pharynx (back of nose and throat) or skin lesion.	5 days after commencing antibiotics.	None.
TONSILITIS	Varies depending on organism.	Varies depending on organism.	Until clinically well.	None.
TUBERCULOSIS	Variable.	Whilst organism is present in sputum.	As per medical advice.	Managers must inform the Health and Safety Team of any cases of Tuberculosis.
WHOOPING COUGH	10–14 days.	7 days after exposure to 21 days after onset of paroxysmal coughing ('the whoop').	5 days after commencing antibiotics.	None.
WORMS	Variable.	Until worms are treated.	Until treated, may return with strict advice on good hand hygiene.	Close contacts, i.e. family members will require treatment.

Skin Infections

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
HEADLICE (PEDICULOSIS)	Lice eggs hatch in a week and reach maturity in 8-10 days.	As long as lice remain alive.	Exclusion is not necessary however, treatment should be administered as soon as possible after detection of live lice – all contacts should be checked.	Examination of family is required and treatment undertaken if live lice are detected. Head lice can only move from one head to another during head to head contact of at least 1 minute.
IMPETIGO (Streptococcus pyogenes and Staphylococcus aureus)	Usually 4-10 days, but can occur several months after colonisation.	Whilst lesion remains moist.	Until the lesions have crusted or healed. Treatment is rapidly effective.	None.
MOLLUSCUM CONTAGIOSUM	19-50 days: 7 days to 6 months.	Unknown, probably as long as lesions persist.	No exclusion necessary.	None.
RINGWORM OF FEET (ATHLETES FOOT)	Unknown.	As long as lesions are present.	Exclusion from school or barefoot exercise not necessary once treatment commenced.	None.
RINGWORM OF SCALP	10-14 days.	As long as active lesions are present.	Exclude until treatment has commenced. Treatment usually lasts several weeks.	None.

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
RINGWORM OF BODY	4-10 days.	As long as lesions are present.	Exclude until treatment has commenced.	None.
ROSEOLA (Sixth Disease)	10 days range 5-15 days.	Unknown.	No exclusion necessary.	None.
SCABIES	2-6 weeks.	Until treated.	Exclusion until the day after the first treatment.	Mites are transferred during prolonged skin to skin contact. Those who have had prolonged skin to skin contact should have simultaneous treatment.
VERRUCAE PLANTARIS (PLANTAR WARTS)	2-3 months.	Unknown, probably as long as lesion visible.	Not generally necessary. PE and swimming may continue providing lesion is covered with a waterproof plaster.	None.