Infection Prevention and Control (IPC) in General Practice:

Practice Accreditation Guidelines

Practice Name:

Endorsed by Clinical Director (signed):
Acknowledgements:

This resource was initially developed by Ben Harris and Kelly Robertson (RN). There are no statements of preference. It is not intended to compel or unduly influence independent clinical practice. Any person accessing any clinical documents must exercise their own clinical judgment on the validity and applicability of the information in the current environment. This resource remains the intellectual property of Canterbury Southern Community Laboratories and Pegasus Health. This material is not able to be redelivered, on sold to any individual or organisation, or made publicly available on any website or in any publication outside of the ownership or control of Pegasus Health or Canterbury Southern Community Laboratories without their expressed written permission.

A further review and update was completed in February 2016 by Ben Harris, Infection Prevention & Control, Canterbury Southern Community Laboratories.

Staff Engagement:

I have read and understood the Infection Prevention & Control Manual

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Introduction
Infection control procedures as outlined in this guideline include:

- Hand hygiene
- Standard and Transmission Based Precautions
- Personal protective equipment
- Actions to be taken following body fluid exposure, or bite
- A clean environment and equipment
- Cleaning, Disinfection and Sterilisation
- Waste Management
- Staff Immunity
- Maintaining IPC in the event of a pandemic or outbreak or organism of concern
- Linen, toys and other specific policies related to IPC

Quality Standards
These guidelines set out a framework for general practice to support the development of their individual standards and in compliance with the RNZCGP Cornerstone and Foundation Standard requirements.

CORNERSTONE™ (full document available online)
Indicator 16 - The practice ensures effective infection control to protect the safety of patients and team members

Foundation Standard (full document available online)
Indicator 15 - The practice ensures effective infection control to protect the safety of patients and team members. (See Appendix Two)

A RNZCGP Infection Control Checklist developed for CORNERSTONE™ may help give some guidance for both Cornerstone and Foundation Standard requirements. This is available online or in the Appendix (three) of this document

Policy Development
Your Infection Prevention & Control programme should have written auditable criteria for your IPC System including:

- **Governance** structure – clinical leadership endorsement, reporting & time lines, accountability, monitoring, documentation, review times
- **IPC team** - designated members with IPC skills, information, results access, surveillance, resource backup, limits of authority
- **Policies and Procedures** – adhere to IPC principles, regulatory requirements, all documented and reviewed. Include IPC on agenda/minutes of each staff meeting
- **Education** – staff IPC overview sessions, hand hygiene, Standard Precautions, key IPC issues, policies and guidelines
- **Surveillance** – use specific criteria for evaluation, feedback and discussion towards continuous improvement (less items done well is best e.g. wound surveillance, hand hygiene, cleaning audit, antibiotic use)
- **Antimicrobial Usage statement** – facility supports prudent use of antibiotics, and follows specific good practice clinical guidelines e.g. BPAC
Infection Control Officer

Each practice team should have an infection control officer(s) – who must have attended a cleaning/disinfection/sterilization workshop by an approved provider e.g. local Community Laboratories at least once every three years. When possible it is recommended that more than one person from the practice attends this training.

Key IPC Principles include:

A. All blood and body fluid substances are potentially infectious
   (whether from patients, visitors or staff and whether or not the infectious disease status of the individual is known)

B. Antibiotic Restraint:
   Our microbiome is our ‘healthy pasture’. Everyone lives in harmony with a vast ‘microbiome’ of organisms as part of their normal microbial flora (i.e. colonisation of skin, mucosa and GI tract). This microbial microbiome is likely made up of at least ten times as many microorganisms as our own tissue cells - perhaps 90 trillion bacteria versus 10 trillion tissue cells. We are only beginning to understand aspects of the ecology of this vast microbiome which normally helps ensure our good health, but can also be associated and/or causal of many other adverse health conditions including obesity, irritable bowel syndrome/disease, allergic disorders, Clostridium difficile diarrhoea, MDRO’s, our moods, etc. Whenever antibiotics are used the susceptible flora (pathogens and commensals) is treated/removed, leaving a more resistant microbiome in its place, which we share with others – touch, communal surfaces, waiting rooms, etc. The more we have contact with people or places who have used antibiotics most, the more likely we are to share and carry some of their resistant microbiome ourselves. ‘My bugs are your bugs concept’.

Reduced antibiotic use and excellent ongoing hand hygiene, cough etiquette plus good environmental cleaning, help prevent/reduce sharing and spread of this increasingly resistant communally shared microbiome.

All and every antibiotic usage selects for resistance, ‘collateral damage’, in individuals and cumulatively adds to the increasing antibiotic resistance in the greater community

C. Standard Precautions

By applying Standard Precautions at all times and to all patients, good practice becomes second nature and the risk of infection/microbial spread is minimised

Standard Precautions include:

- Achieving optimum hand hygiene
- Using personal protective equipment (PPE) when required (e.g. gloves, gown, mask)
- Safe Injection practices, handling and disposal of sharps
- Environmental controls/cleaning
- Reprocessing usable medical equipment and instruments appropriately
- Respiratory hygiene and cough etiquette
- Health waste management
This ensures:

- Consistent quality of care for patients and the community
- Prevention of cross infection
- Ethical and legal standards are achieved
- Medico-legal protection for staff and the practice

Transmission Based Precautions

Contact, Droplet and Airborne Precautions are complementary and in addition to Standard Precautions dependent on the specific clinical diagnosis or known risk factors.

- **Contact Precautions** for potential pathogens that spread through direct contact with the patient or the patient’s environment e.g. contact with fluid secretions, wounds, multi-drug resistant organism

  **Use Standard Precautions plus**
  - Gloves, gown, hand hygiene

- **Droplet Precautions** help prevent pathogen spread through larger droplets, which may spread over short distances (up to one metre) e.g. influenza, pertussis, mumps. Think of anyone with a cough as potentially infectious e.g. around 30-40% of those with influenza have a cough and are not febrile

  **Use Standard Precautions plus**
  - Separate room or cohort with patients with same infection (e.g. Long term care facility)
  - Wear a mask if within 1m of patient, preferably patient to wear a mask also
  - Consider goggles/face shield and gown
  - Hand hygiene pre and post glove removal

- **Airborne Precautions** – to help prevent spread through small droplet nuclei, which remain suspended in the air and may spread over longer distances e.g. whole of room air a risk, as with measles, TB

  **Use Standard Precautions plus**
  - Isolate patient in separate room with door shut, internal windows closed
  - Masks for carer and patient if possible (preferably N95 mask if fit tested)
  - Consider opening external window (air dilution effect)
  - Use gowns, gloves, face shield/goggles
  - Wash hands pre entry and pre and post glove removal

As the infectious risk category increases (i.e. airborne is highest risk), consider appropriate detection awareness and control processes. e.g. when a patient with cough, fever and muscle aches phones for an appointment during an influenza outbreak, can this be detected/noted by the receptionist, have they been trained for this and have appropriate designated authority to act – if the patient has presented to the surgery or will present, how will this patient be managed on arrival to minimise the cross infection risk? e.g. patient required to wear a mask, isolated to one end of waiting room, attended to as quickly as possible. Alternatively can they be seen at home or by phone consultation, or outside the surgery.
Similarly processes for rashes (e.g. measles), vomiting and diarrhoea (especially if Norovirus season or known outbreaks), pertussis, the febrile, etc. Patients with these conditions increase cross infection risk to others, especially when non immune or otherwise immunocompromised e.g. pregnancy.

**Health and Safety**

Health and Safety legislation directs employers to minimise workplace hazards for their employees. Furthermore, the employer shall take all reasonable steps to minimise workplace hazards. This includes the provision of safety equipment e.g. personal protective equipment (PPE) such as gloves, gowns, masks, sharps containers etc, and the education of personnel in the correct use of this safety equipment. In addition, safety equipment shall be accessible at all times to all personnel and employees have a responsibility to ensure that safety equipment or PPE is worn.

**STAFF IMMUNITY**

Appropriate Staff vaccinations should be encouraged to minimise infection risk. When new staff are employed they should be offered advice regarding vaccinations. As a good employer consider offering blood tests to determine their immunity to at least Hepatitis B and Rubella if they are uncertain of their vaccination record or immune status.

Vaccinations for staff may include but are not limited to:

- **Hepatitis B** strongly recommended – once vaccinated, immunity is likely lifelong unless immunocompromised or renal disease present.

- **Influenza** although most healthcare workers are not considered to be at high risk of complications themselves (unless pregnant), influenza can be a serious illness in anyone and annual vaccination is recommended to not only protect themselves but also their much more vulnerable patients/clients. Viral shedding starts a day before symptoms. HCW’s have a better immune response to this vaccine (?? average year 60-70% protection, compared to the vaccinated elderly ?? only 25% protection).

- **Pertussis** each 5-10 years recommended especially if caring for pregnant women, babies or considering pregnancy.

**Mumps, Measles and Rubella (MMR)**

These highly infectious viruses can have relatively high, serious complications for adults including and especially for mother and baby, and in the case of rubella cause foetal abnormalities. Outbreaks occur (e.g. measles, though actually now relatively rare incidence in NZ). Note, future overseas travel may be an increased risk factor depending on country.

Most, but not all, New Zealanders at least will have been vaccinated as children, or the infection and be immune depending on their age. A past history of clinical measles and /or rubella is unreliable, rashes can have many causes. Past infection or partial vaccination is not a contraindication to vaccination.

**Recommend vaccination for those without documented full vaccination.**

HealthPathways should be consulted for up to date information supporting staff immunisation - [http://www.healthpathways.org.nz/](http://www.healthpathways.org.nz/)
http://www.medsafe.govt.nz/profs/datasheet/m/MMRIIinj.pdf:

"Staff who have patient contact (including receptionists) should, if they were born after 1968 have their immunisation status checked (have a record of receiving two doses of MMR) or have their antibody status checked especially for measles/rubella and offered MMR if not immune.

People born pre 1969 are considered immune to measles (wild strains regularly circulating at that time)."

- Tetanus (note date of last booster, consider updating)
- Diphtheria
- Polio
- Varicella
- Hepatitis A

Other vaccine preventable infections/diseases
There are an increasing number of other vaccine preventable infections/diseases also available. In addition, vaccination is increasingly becoming an ongoing prevention intervention required at different ages and stages of life. Recommend discussing these with your GP.

NZ references about vaccines include:
  http://www.healthpathways.org.nz/
Addressing+misconceptions+about+immunisation

From time to time there may be cause to offer employees specific outbreak associated vaccinations for new or emerging infections and dependent on their type or place of work and associated risk category.
PROCEDURES:

Hand Hygiene

Hand hygiene is the single most important procedure for preventing the spread of infections

- All staff must accept responsibility for their skin integrity prior to the commencement of work. All cuts, abrasions and broken skin (e.g. eczema) must be occluded with a waterproof dressing and/or gloves (because of both increased risk to patient from high potential pathogen colonisation rates on HCW, also increased risk to staff member (HCW) from easier pathogen entry to their body from an infected patient)
- Hands and other skin surfaces must be washed immediately with liquid soap and water if they become contaminated with body substances
- Hand washing and alcohol hand rub facilities should be located close to the work area in sufficient numbers to meet staff needs

A single-use hand drying facility e.g. mounted towel dispenser or paper towels is required.

Hand hygiene is mandatory for:

- All staff who have patient contact (before and after contact and before/between procedures)
- All staff who handle anything that has been involved in patient care
- All staff, if their hands become contaminated with blood/body substances.
- Before eating, after toileting

WHO 5 Moments for Hand Hygiene

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<tbody>
<tr>
<td>1</td>
<td>BEFORE TOUCHING A PATIENT</td>
<td>WHEN: Clean your hands before touching a patient and their immediate surroundings WHY? To protect the patient against acquiring harmful germs from the hands of the HCW</td>
</tr>
<tr>
<td>2</td>
<td>BEFORE A PROCEDURE</td>
<td>WHEN: Clean your hands immediately before a procedure WHY? To protect the patient from harmful germs (including their own) from entering their body during a procedure</td>
</tr>
<tr>
<td>3</td>
<td>AFTER A PROCEDURE OR BODY FLUID EXPOSURE RISK</td>
<td>WHEN: Clean your hands immediately after a procedure or body fluid exposure risk WHY? To protect the HCW and the health surroundings from harmful patient germs</td>
</tr>
<tr>
<td>4</td>
<td>AFTER TOUCHING A PATIENT</td>
<td>WHEN: Clean your hands after touching a patient and their immediate surroundings WHY? To protect the HCW and the health surroundings from harmful patient germs</td>
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<tr>
<td>5</td>
<td>AFTER TOUCHING A PATIENTS SURROUNDINGS</td>
<td>WHEN: Clean your hands after touching any objects in a patients immediate surroundings when the patient has not been touched WHY? To protect the HCW and the healthcare surroundings from harmful germs</td>
</tr>
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</table>
Types of Soap:

- **Liquid Soap** is effective in mechanically removing any newly arrived to the skin organisms/pathogens, resistant or not e.g. by touch, if the procedure is performed correctly

- *Liquid soap dispensers must not be topped up. They should be used until empty and then washed, dried and refilled or disposed of.* **Disposable containers with replaceable cartridges are preferred.**

- **Alcohol Hand Rubs** are a recommended alternative and facilitate compliance.
  - Do not use if hands visibly soiled
  - **Do not use post gastroenteritis contact.** Norovirus is likely only partially inactivated by alcohol and *Clostridium difficile* (‘post antibiotic diarrhoea’) spores are not inactivated at all by alcohol

Dermatitic Skin

Health care workers who have dermatitis, eczema, paronychia or any other skin lesion may pose an increased risk to patients and other health care workers because:

- Dermatitic skin is more likely to be colonised with large numbers of potentially pathogenic organisms (e.g. *Staph aureus*)
- Hand washing of dermatitic skin does not appreciably reduce the large skin bacterial load counts
- Personnel with dermatitic skin tend to avoid hand washing because it can aggravate the condition

It is possible to alleviate the above problems by:

- Excluding such staff from direct patient contact whilst condition persists
- Rinsing and drying hands correctly (including dabbing dry not wiping)
- Using individual hand creams (N.B. Contaminated hand creams have been associated with outbreaks of nosocomial infections.)
- Alternating hand hygiene products
- Wearing gloves

**NB:** Wearing some glove types may exacerbate dermatitic conditions (especially latex gloves). Most studies show for most people, not all, water wash hygiene causes significantly more skin integrity issues than alcohol hand rubs. However the first month of first ongoing alcohol rub use may cause more skin problems than liquid soap and water, then alcohol rubs on average cause less skin problems.
Personal Protective Equipment (PPE):

<table>
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<tr>
<th>Correct Sequence for Donning Personal Protective Equipment (PPE)</th>
<th>Correct Sequence for Removing Personal Protective Equipment (PPE)</th>
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<tbody>
<tr>
<td><strong>1. GOWN / APRON</strong></td>
<td><strong>1. GLOVES</strong></td>
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<tr>
<td>Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back</td>
<td>Outside of gloves are contaminated—DO NOT TOUCH!</td>
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<tr>
<td>Fasten in back of neck and waist</td>
<td>Grasp outside of glove with opposite gloved hand; peel off</td>
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<tr>
<td><strong>2. MASK OR RESPIRATOR</strong></td>
<td>Hold removed glove in gloved hand</td>
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<tr>
<td>Secure ties or elastic bands at middle of head and neck</td>
<td>Slide fingers of ungloved hand under remaining glove at wrist</td>
</tr>
<tr>
<td>Fit flexible band to nose bridge</td>
<td>Peel glove off over first glove</td>
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<tr>
<td>Fit snug to face and below chin</td>
<td>Discard gloves in waste container</td>
</tr>
<tr>
<td>Fit-check respirator</td>
<td>Clean and dry your hands thoroughly</td>
</tr>
<tr>
<td><strong>3. GOGGLES OR FACE SHIELD</strong></td>
<td><strong>2. GOGGLES OR FACE SHIELD</strong></td>
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<tr>
<td>If you wear glasses put them on.</td>
<td>Outside of gogglies or face shield are contaminated—DO NOT TOUCH!</td>
</tr>
<tr>
<td>Place goggles or face shield over face and eyes and adjust to fit</td>
<td>To remove, handle by head band or ear pieces</td>
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<tr>
<td><strong>4. GLOVES</strong></td>
<td>Place in designated receptacle for reprocessing or in waste container</td>
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<tr>
<td>Extend to cover wrist</td>
<td>Clean and dry your hands thoroughly</td>
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<tr>
<td><strong>GOWN / APRON</strong></td>
<td><strong>GOWN / APRON</strong></td>
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<tr>
<td>Gown front and sleeves are contaminated—DO NOT TOUCH!</td>
<td>Unfasten ties</td>
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<tr>
<td><strong>MASK OR RESPIRATOR</strong></td>
<td>Pull away from neck and shoulders, touching inside of gown only</td>
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<td>Front of mask/respirator is contaminated—DO NOT TOUCH!</td>
<td>Turn gown inside out</td>
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<tr>
<td>Grasp bottom, then top ties or elastics and remove</td>
<td>Fold or roll into a bundle and discard</td>
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<tr>
<td>Discard in waste container</td>
<td>Clean and dry your hands thoroughly</td>
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The aim of PPE is to protect yourself and your patient from risk of cross infection and is dependent on the level of patient contact and knowledge of the “infectious status” of the patient. There are varying levels and types of PPE and this depends on the level of exposure, the risk of transmission and the nature of the disease.
PPE - protective measures include:
  - Hand hygiene (including before and after glove removal, many gloves have small holes – microbe entry, including capillary action when fluid present)
  - Cough and sneeze etiquette
  - Social distancing through to isolation
  - Masks, Eye Protection
  - Gowns/aprons
  - Gloves

Remember when using PPE
  - Clean hands pre and post use
  - Keep hands (including gloved) away from face
  - Avoid touching or adjusting PPE once in place
  - Remove gloves if they become torn, wash hands before donning new gloves
  - Limit surfaces and items touched
  - Take extreme care on removing PPE, any item may well be significantly contaminated (note several Ebola deaths of HCW associated with PPE removal process)

Gloves:

Should be powder free as this reduces dermatitis risk.

Gloves are worn to:
  - Provide a protective barrier to the hands of healthcare professionals when touching body fluids
  - Reduce the transmission of microorganisms from staff hands to patient during patient care procedures that involve touching their mucous membranes and non-intact skin
  - Reduce the possible cross infection carriage of microorganisms between patients via the hands of staff

Gloves are to be worn when in contact with:
  - blood or body fluids
  - mucous membranes
  - non-intact skin of all patients
- surfaces soiled with blood or body fluids
- Gloves should be used for invasive procedures
- Gloves must be changed after contact with each patient and hands washed immediately after gloves are removed
- Gloves do not replace hand hygiene procedures
- Do not wash disposable gloves

**Disposable Plastic Aprons**
Plastic aprons are to be worn when it is likely that blood or body fluids will come in contact with or splash clothing

**Masks, Eyeglasses, Faceshields**
Masks and eyeglasses are to be worn if there is the potential for blood or body fluids to splash or aerosol into the eyes, mouth or nose e.g. when incising wounds, cysts, abscesses, injecting local anaesthetic or cleaning contaminated medical equipment.

NB Once put on, it is important to **treat masks as very infectious** because if they have done what they were designed for, millions of infectious particles may be in/on the mask!

**How** a mask is fitted (snugly) and used (not touched during use) is likely as significant, if not more so, as the type of mask used (e.g. surgical or N95).

If an N95 or other particulate respirator is used, ensure that it is ‘fit checked’ i.e. airtight fit so no infectious particles can bypass the mask to your respiratory tract.

**Directions for mask fit checking:**
To ensure Filter Respirators and Surgical Masks are providing the intended level of protection, they MUST be ‘Fit Checked’ every time they are worn.

- To ‘Fit Check’ a respirator, the wearer should forcefully inhale and exhale several times
- The respirator should collapse slightly upon inhaling and expand upon exhaling
- The wearer should not feel any air leaking between his/her face and the respirator
- This is the sign of a good facial fit and a successful ‘Fit Check’
- If the respirator does not collapse and expand OR if air is leaking out between the wearers face and the respirator, then this is NOT a good facial fit
- The wearer should adjust the respirator until the leakage is corrected and he/she is able to successfully ‘Fit Check’ the respirator, or try another brand if good fit not achievable

**Tips for Achieving a Good Fit:**

A. Use a mirror while adjusting the respirator
B. Ask someone to look for hair or earrings that might be caught in the seal
C. Make sure the headbands are positioned properly. It is especially important that the top headband is on the crown of your head, as it is designed to hold the bottom of the respirator snug against your chin

It is important to stress to the wearer that

- The respirator must be ‘Fit Checked’ each and every time it is donned, and
- He/she should not proceed with activities until a successful Fit Check has been completed
# Personal Protection Measures

(MOH Guidelines 2006)

<table>
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<tr>
<th>Risk level</th>
<th>Hand Hygiene</th>
<th>Social distance</th>
<th>Cough and sneeze etiquette</th>
<th>Adequate ventilation</th>
<th>Masks</th>
<th>Gloves</th>
<th>Gown Or Apron</th>
<th>Eye protection</th>
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<td>Lower to Medium</td>
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For people who can maintain more than one meter from those potentially infected

For those who may be unable to maintain over a 1 meter distance from those potentially infected

For those who cannot maintain at least 1 meter distance for those potentially infected

For those who cannot maintain at least 1 meter distance AND are performing high risk procedures (suctioning)

Hand Hygiene: Social distance: Cough and sneeze etiquette: Adequate ventilation: Masks: Gloves: Gown Or Apron: Eye protection:

- Lower to Medium Risk level: Hand Hygiene: Social distance: Cough and sneeze etiquette: Adequate ventilation: Masks: Gloves: Gown Or Apron: Eye protection:

- Medium Risk level: Hand Hygiene: Social distance: Cough and sneeze etiquette: Adequate ventilation: Masks: Gloves: Gown Or Apron: Eye protection:

- Medium to High Risk level: Hand Hygiene: Social distance: Cough and sneeze etiquette: Adequate ventilation: Masks: Gloves: Gown Or Apron: Eye protection:

- High Risk level: Hand Hygiene: Social distance: Cough and sneeze etiquette: Adequate ventilation: Masks: Gloves: Gown Or Apron: Eye protection:
Action to be taken following sharps injury, blood body fluid exposure (BBFE), splash or bite

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
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<tbody>
<tr>
<td>Bleed it</td>
<td>encourage bleeding</td>
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<tr>
<td>Wash it</td>
<td>Under running water</td>
</tr>
<tr>
<td>Cover it</td>
<td>with a waterproof dressing</td>
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<tr>
<td>Report it</td>
<td>to the senior member of staff/GP on duty or visit A&amp;E or your own GP immediately if high risk HIV</td>
</tr>
<tr>
<td>Record it</td>
<td>in the incident book</td>
</tr>
<tr>
<td>Assess</td>
<td>risk of hepatitis B &amp; C or HIV</td>
</tr>
<tr>
<td>Obtain</td>
<td>relevant blood samples from Source and the injured person if informed consent given and send to lab without delay stating BBFE and clearly notating Source (if available) and injured samples</td>
</tr>
</tbody>
</table>

**Your Medical Practitioner will consider**
The need for post-exposure prophylaxis (PEP) or follow-up testing for Hepatitis B & C or HIV

**Factors to consider:**
- Can source be identified?
- Is source likely/known to be infected with hepatitis B, C or HIV?
- Is Injured person(or Source) known to have been vaccinated to HBV
- Can a sample be obtained from Source with informed consent?
- Was it a high-risk injury, eg much fluid exposure or source ill/terminal with high viral load?
- Was a high-risk body fluid inoculated eg blood?
- How much time has elapsed between injury and follow-up?
- Would side effects of any prophylaxis outweigh the possible benefit?
- Observe wound/BBFE site for signs of infection and inflammation

Forms and a process available to follow: [http://www.canterburyscl.co.nz/](http://www.canterburyscl.co.nz/) under Infection Control tab at top of page and on HealthPathways
A CLEAN ENVIRONMENT

Cleaning of the Practice
It is essential to have a planned, documented and monitored cleaning schedule adjusted in proportion to practice throughput and patient type, and also for any contracted cleaners

- Daily
- Weekly
- Monthly
- Annually

Areas to be considered:
- Consulting
- Treatment areas
- Service areas
- Administration areas
- Waiting area
- Other

Daily:
- All horizontal surfaces damp dusted daily and spot cleaned as necessary
- Hard floors mopped daily and spot cleaned as necessary
- Carpeted floors vacuumed daily and spot cleaned as necessary
- Toilets and basins cleaned daily and spot cleaned as necessary
- Chairs in waiting room damp dusted and spot cleaned as necessary
- Any area/surface that is touched routinely (e.g. door handles, reception counter, chair arms) – increase the cleaning frequency when known outbreaks of concern in the community and after known high infectious risk patients

Weekly:
- Telephone and keyboards damp dusted weekly
- Maintenance of cleaning equipment – mops, buckets, cleaning rags, filters on vacuum cleaners

Monthly:
- Light fittings damp dusted regularly
- Windows and glass partitions cleaned regularly and spot cleaned as necessary

Annually:
- Walls and ceilings cleaned annually and spot cleaned as necessary

Decontamination and Disinfection of Communal Children’s Toys
- Many children who are ill may also be infectious and use or share toys. The potential for transmitting infections and MDRO’s is obvious
- Encourage caregivers to bring a toy, book or pictures for colouring in with their own crayons etc to further minimise cross infection risk
If toys are supplied, they should be kept to a minimum in the waiting room – if used, it is recommended having 2 toy boxes available to change daily/weekly.

Select play toys that can be easily cleaned and disinfected. Toys that are unable to be put in mouths, do not permit use of stuffed furry toys. Soft, cuddly toys should not be used as they require washing and drying, which is much more difficult than toys made of impervious materials.

Toys are to be cleaned and disinfected at least weekly and when visibly soiled. Cleaning may be required more often, when children with infectious colds or conditions are seen using toys.

Toys with broken surfaces are to be discarded, as their cleanliness cannot be maintained.

Clean and disinfect large stationary toys (e.g., climbing equipment) at least weekly and whenever visibly soiled.

When a toy requires cleaning and disinfection after a known likely infectious contamination, do so immediately or store in a designated labelled container separate from toys that are clean and ready for use.

If play equipment is on lease to the practice, it is the practice responsibility to ensure the supplier has a cleaning program included in the lease, if not the practice must take responsibility for cleaning the items.

Consider removal of toys during outbreaks of concern.

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**Cleaning, Disinfection and Sterilisation**

**Summary:**

**CLEANING**

It is critical do cleaning well. When performed properly cleaning can remove up to 95% organic material and so 95% microorganisms. Enzymes and detergents can help this process (e.g. Enzoclean, Clinidet). Standard sterilisation and disinfection are not very effective against infectious prions (e.g. ‘mad cow disease’), another reason thorough cleaning is so important.

**DISINFECTION**

Only disinfect thoroughly cleaned items, with

1. the right specific disinfectant (check with manufacturer for specifically what it will cover, e.g. TB, virus, spores, bacteria, fungi) e.g. Presept (NOT Clinidet)
2. at the specified concentration for that task
3. for the specified contact time to achieve disinfection
4. re made up fresh as per manufacturer’s stated requirement

If the above is followed strictly, then $10^{-5}$ log of organisms should be killed/inactivated by the disinfectant – so the more organisms that were cleaned off prior to disinfection the more effective the disinfection process.

Items for sterilisation do not require prior disinfection.
STERILISATION
When performed properly on well cleaned items in an appropriately accredited, calibrated validated autoclave then $10^{-6}$ log of organisms will be killed/inactivated – the more organisms that were cleaned off prior to sterilisation the more successful the sterilisation process will be.

Suitable for items used in invasive procedures.

Always follow any specific manufacturers instructions for each piece of equipment or item.

Spaulding’s Criteria (modified) for cleaning, disinfection and sterilisation of patient-care items and equipment

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Application</th>
<th>Process</th>
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<tbody>
<tr>
<td>Critical</td>
<td>Entry or penetration into sterile tissue, cavity or bloodstream</td>
<td>Sterility required</td>
</tr>
<tr>
<td>Semi-critical</td>
<td>Contact with intact non sterile mucosa or non intact skin</td>
<td>Sterilisation preferred where possible. If sterilisation not possible, then high level chemical disinfection required</td>
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<tr>
<td>Non-critical</td>
<td>Contact with intact skin</td>
<td>Clean as necessary with detergent and water</td>
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</tbody>
</table>

Single Use Items
NB in general if a manufacturer says an item is ‘single use’, it is advisable not to reuse or reprocess the item due to liability risk in the event of a cross infection or adverse event

CLEANING OF EQUIPMENT
Cleaning is critical to be done well and involves the removal of visible dirt, organic matter or other foreign material from an item. Cleaning reduces the bacterial load to very low levels, so items that have been cleaned well can usually be considered safe for intact skin contact. All items should have debris removed and be thoroughly cleaned prior to autoclaving or disinfecting.

Both disinfectant and steam penetrate organic material poorly or not at all. After cleaning & drying consider using a magnifying glass routinely to better evaluate the cleaning thoroughness e.g. forcep serrated edges.

Disinfection and Sterilisation processes are significantly compromised on items that have not been thoroughly cleaned.
It is important to wear protective clothing when cleaning all instruments e.g. gloves, apron, and eyeglasses. Cleaning instruments under water surface prevents splashes.

If in doubt about how to appropriately clean a specific piece of equipment always check with the manufacturer for specific instructions – these may be available on the internet also.

**Blood Glucose Meters:**
- Clean as per manufacturer's instructions

**Ear Syringing Equipment:**
- The metal nozzles should be cleaned, soaked in an appropriate disinfecting solution, rinsed, dried and autoclaved. **Use disposables where possible.**
- The barrel of the syringe should be completely emptied of water, dismantle if possible, clean, with an appropriate disinfecting solution and leave to dry overnight. (Please check manufacturers' guidelines as, equipment will vary from surgery to surgery).
- Tubing should be washed out with disinfecting solution then rinsed with plenty of fresh water and **stored vertically to allow water to drain and tubing to dry.** Replace tubing monthly or more frequently if obvious signs of contamination or cracking.

**Ear Pieces:**
- For example - tympanometer, auroscopes / otoscopes – ideally, single use only but if re-use required then wash well in warm water then soak in disinfecting solution e.g. Presept for the recommended time, remove and dry.

**Finger Prick Devices:**
- These vary; preferably use “Glucolets” with disposable needles.

**Glass Thermometers:**
- After use, wipe with a paper towel to remove saliva and then cleaned with an appropriate medical detergent solution prior to soaking.
• Soak in an appropriate disinfectant e.g. Presept for recommended time e.g. at least 30 minutes.
• Rinse in water and dry with clean paper towel or gauze.
• Store dry in a container.

Instruments:
• Rinse under running warm water (low pressure) to remove visible contamination
• Dismantle or open all items for cleaning prior to placement in solution containing cleaning agent e.g. Enzoclean, or Clinidet for recommended time
• Check instruments individually, scrub with a bristled, autoclaveable, brush if debris is adhered to surfaces under water to reduce splashing
• Wash all surfaces of the items with detergent, including lumens and valves. Remove stubborn staining/debris by using a non-abrasive scouring pad
• Remove, rinse and dry with a lint-free cloth. Drying reduces the risk of contamination as residual moisture may impede the sterilisation process and can damage instruments
• Visually inspect the cleanliness and condition of all items
• (See section re autoclaving)

Oxygen Masks, Nebuliser Bowls and Mouthpieces: If reusing on a different patient is allowable by the manufacturer, follow their instructions, otherwise the following is advised:
• Wash in warm water with detergent and soak in disinfecting solution. e.g. Presept.
• Rinse three times after removal from disinfecting solution
• Some nebuliser bowls and mouthpieces can be autoclaved (check with manufactures’ instructions)

Oxygen Tubing:
• This should be dated and discarded monthly

Spacers:
• Normal use involves priming a spacer, e.g. wash device in warm water and dishwashing detergent, do not rinse, and stand to dry naturally. This device can then be taken home for patients’ individual use.

The process outlined below is for use in surgeries when spacers are not issued to patients to take home after use. Follow manufacturers instructions.
• Spacers must be washed in warm water with a detergent.
• Soak in disinfectant e.g. Presept, then rinse 3 times.
• Wash again in warm soapy water to reprime, and allow drying naturally.
• Do not dry with a towel as this increases electrostatic charging.
• Reassemble after drying.

Sphygmomanometer:
• It is recommended that the cuff be washed or wiped if contaminated.
Stethoscopes:
- The earpieces should be removed and washed in warm soapy water when contaminated.
- The diaphragm should be wiped with a clean, damp cloth or an alcohol wipe.

Vacutainer Needle Holders:
- Remove any blood with medical detergent
- After each use, rinse under running water and soak in disinfecting solution e.g. Presept.
<table>
<thead>
<tr>
<th>Management of blood or body substance Spills</th>
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<tbody>
<tr>
<td><strong>Spot cleaning</strong></td>
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<tr>
<td>Wipe up spot immediately with a damp cloth or paper towel.</td>
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<tr>
<td>Wipe with disinfectant</td>
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<tr>
<td>Discard contaminated materials (paper towelling, ) in accordance with waste management regulations</td>
</tr>
<tr>
<td>Dry the site to prevent slipping</td>
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<td>Wash hands</td>
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Spills kit to include the following:
- plastic scoops (large and small)
- plastic supermarket bags,
- paper towels,
- disposable gloves,
- plastic apron,
- alcohol hand gel
- VIRACLEAN disinfectant

NB Where fabric or carpet may be damaged by chlorine/disinfectant – after removal of visible soiling with paper towels/water, etc, finally steam clean or use of boiling water can be a suitable alternative.

**DISINFECTION:**

**Chemical Disinfectants:**
- Chemical disinfectants can be expensive and misuse can lead to the development of bacterial resistance. All disinfectants require more than a few seconds of exposure to be effective and they are not active when dry. **Always check manufacturers’ instructions**
- To achieve disinfection requires more than just exposure of the object to the agent. The object must be ***thoroughly clean*** and free of soap, detergent or any other substance that may neutralize the disinfectant. Chemical disinfectants do not penetrate through dense organic material
- The **appropriate disinfectant** must be made up at the **appropriate concentration** for the task and given the **recommended time** to act on the surfaces being disinfected
- Written proof from the manufacturer of the appropriateness of any disinfectant for the task should be retained at the practice e.g. place manufacturers written information sheets in Practice Resource folder with Infection Control Resource. Documentation of any change in use of chemical disinfectants is recommended.

The process of disinfection is commonly divided into three levels - low, intermediate and high. The first step in the process is to thoroughly clean the item. Disinfectants will not work in the presence of debris, therefore clean, disinfect and dry. Foreign material will inactivate or limit the penetration and effectiveness of both chemical and physical agents.

The purpose for which an instrument is to be used dictates the level of disinfection required. For objects that contact intact skin but do not penetrate, the lowest level of disinfection is satisfactory.

**Low Level Disinfection:**
- **Definition:** Items on contact with normal and intact skin
- **Examples:** Stethoscopes, blood pressure cuffs
- **Suitable method:** Cleaning and drying usually adequate, sometimes low level disinfection required

**Intermediate Level Disinfection:**
- **Definition:** Items in contact with mucous membranes or other items contaminated with particularly virulent or readily transmissible organisms, or items to be used on highly susceptible patients
- **Examples:** Respiratory equipment, gastroscopes
• Suitable method: Sterilisation preferable otherwise high level disinfection required

If heat sensitive, intermediate or high-level chemical disinfection is recommended.

High Level Disinfection:
• Definition: Items in close contact with mucous membrane or broken skin or introduced into a normally sterile body area.
• Examples: Surgical instruments, syringes, needles, intrauterine devices and associated equipment, dressings, urinary and other catheters.
• Suitable method: Sterilisation required. High level disinfection may sometimes be acceptable if sterilisation is not possible or practicable.

STERILISATION:

Sterilisation is essential for all items that penetrate intact skin or mucous membranes and is effective against spores and all microorganisms that can be tested. The two methods of sterilisation available for use in general practice are dry heat or steam under pressure (autoclaving).

• Autoclave 121°C for 15 minutes, or as per the recommendation on the manufacturers’ instructions.
• ‘Flash’ steriliser 134°C for 3 minutes, or 132°C for 4 mins holding time Dry Heat Hot Air Oven 160°C for 120 mins minimum holding time, plus penetration time. Used for anhydrous items and items sealed within impermeable containers which cannot be sterilised by steam under pressure. Not to be used for sterilising liquids.
• Times stated for autoclaves are the holding times (at that specified temperature and pressure) and do not allow for the time taken for heat to penetrate the articles
• Standard sterilisation may not be effective against some agents e.g. prions as in BSE (mad cows’ disease) – neural tissue contamination is an increased risk for this

THE AUTOCLAVE:

Operating Your Autoclave:
Always follow manufacturers’ instructions. If your manual is lost it is important you obtain a new copy or obtain one from someone with the same model or the internet.

All items should have debris removed and be thoroughly cleaned prior to autoclaving for effective sterilisation to occur.

Non-Packaged Items:
Items that are not packaged are sterilised between uses, and once removed from the autoclave do not remain sterile but are surgically clean only if used ‘immediately’. To store instruments between uses ensure a clean, dry container is used – this container must be cleaned/autoclaved regularly.
Packaged Items:
Autoclaved instruments not required for immediate use can be stored if they are appropriately packaged. Approved autoclave bags should be double folded and sealed with autoclave tape or steripeel.

Always date and label items. Packaged items remain sterile for at least 6 months if packages remain unopened and undamaged and stored correctly. Only use white-board water based pens on packages. Do not use ball point pens which may penetrate the package integrity and these and vivid type oil based markers may damage the autoclave.

Never use staples.

Placing Items in Autoclaves:
- Correct loading of the autoclave is critical to proper sterilisation
- Ensure items are spaced adequately to allow air removal and allow steam to penetrate
- Place bowls and kidney dishes on their sides, or upside down to facilitate air egress and allow steam penetration, not stacked over the top of each other as this restricts air removal and steam penetration

Removal of Sterilised Items:
- Allow all instruments and containers to cool
- Check the electronic monitor and/or chemical indicators on bags/tape to ensure correct colour change (reprocess items if results are not acceptable, and document this)
- If items are packaged, ensure packaging is intact and completely dry (reprocess contents if they are not)

Once sterilised all instruments should be stored:
- In a dry area e.g. closed drawer or cupboard
- Out of sunlight
- Loosely packed together to maintain the integrity of the packaging
- Ensure that stock is rotated

Quality Control of Autoclaves:

Accurate documentation is important for audit and medico-legal protection. Practices should be able to provide documentation for every autoclave load, including controls and in the event of an autoclave failure all remedial measures undertaken. Documentation should be retained for a minimum of 10 years ideally, and for every load.

Where:
- Visual/electronic printer/reader used - Ideally and strongly recommended. In addition each load (and package) should have some form of indicator (e.g. class 1 temperature strip colour or tape change) to show the package or basket has in fact been through the autoclave and is not about to go through (‘has this basket on the bench been through or is it about to be autoclaved’ scenario).

The ‘pass’ electronic measure then assures the key sterilisation parameters required.

- Where no electronic readout or printer present
  Use higher level Chemical indicators – e.g. class 4, 5, or 6 temperature and time detecting indicators (e.g. ‘integrator strips’) required where no electronic monitoring is available to help assure the key sterilisation parameters have been met. – keep a
date/time/initial record of these results for each load (i.e. PASS/FAIL) NB: Biological indicators – spore strips are no longer routinely required. These will be tested at annual validation.

**Monitoring Frequency:**
Every load

**Other Monitoring Parameters**
Depending on the type of autoclave, the type of instruments (e.g. hollow bore needles or lumens, tubing) and whether wrapped or not - other monitoring measures may also be required – check manufacturer’s instructions/recommendations carefully. e.g.:
- **daily air removal and steam penetration test** for wrapped instruments (Bowie-Dick Test requires placing a small, disposable test pack into the autoclave/wrapped item)
- **leak rate vacuum test** on sterilisers that utilise a vacuum stage for air removal .....performed daily in the absence of an air detector or weekly if an air detector is fitted

**Failure:**

**Failure of indicators or process means unsterile loads and items should be treated as non-sterile and no instruments will be issued.**

**Document this in writing** ‘No instruments issued’ in the Manual and your QC sheets when it occurs, date/initial!

Next Steps: Check steriliser plug, water level etc, repeat load with new indicator or control again and if repeat ‘fails’, again document ‘No instruments issued’, date/initial and have autoclave serviced.

**Autoclaves should be calibrated and validated at least annually.**

Validation of autoclaving can be a complex area to follow every last detail. In practice most surgeries have their autoclave installed and commissioned by an external body (e.g. accredited installers) who also do Performance Qualification (PQ) testing at that time – e.g. you specify what type of things you will be autoclaving (e.g. disassembled instruments, are there lumens or hollow needles to be sterilised, what is their bore diameter compared to length ratio) and how they will be packaged (if wrapped) and specify how loaded (space around all to allow the steam contact with all surfaces). The testers then make sure that the cycle you are using is still working in those places that the steam has most trouble penetrating e.g. one part of a fully loaded autoclave, with wrapped items including a long hollow bore needle will take longest to sterilise. Thus many autoclaves would not be able to sterilise these items, and they should not be attempted if yours has not been validated for these specifically named items.

You should have/ keep a written copy and updated list of what instruments the autoclave was validated to sterilise and on what (temperature/time) cycle at the time of commissioning and the serial number of the autoclave. The rationale being when it was set up (say 10 years ago) only scissors and forceps may have been sterilised, now packaged items and long hollow lumens are required – these require different sterilisation parameters because steam cannot penetrate these as easily, so the original validation would not cover these more recently added items.
That having been said, after the initial set up validation, **most surgeries rely on the annual external service check (includes biological controls) and ongoing monitoring of every load by electronic chart recorder and/or class 4, 5 or 6 indicator strips (measure two parameters e.g. time and temp).** There is no requirement for ongoing biological testing any more (except in large institutions/hospitals), primarily because the results are not ready for a few days and the more important thing is to be assured that ‘when the autoclave door is opened at the end of the cycle do I have reasonable assurance that the items in this load have been sterilised?’ And if not (failed process) what is my **written process** to follow e.g. ‘issue no instruments from this load’, check any visible parameters e.g. water for steam, try re sterilise cycle again, if still fails, call in external accredited service team, document all this.

The actual formal parts of calibration and validation are structured as:

**Validation**

**Installation Qualification (IQ)** (i.e. the steriliser and the area it is installed in comply with manufacturer recommendations)

**Operational or commissioning Qualification (OQ)** (i.e. steriliser operates within stated limits when used in accordance with operational procedures)

**Performance Qualification (PQ)** (i.e. both initial description of loads to be tested, how loaded, which cycle etc, compliance then and ongoing)
- Physical qualification
- Microbiological qualification

Effective sterilisation includes many aspects including education, training, documentation and encompasses
- Cleaning
- Inspection
- Assembly
- Packaging
- Loading
- Sterilisation cycle
- Unloading
- Storage
- Distribution
- Performance testing, routine monitoring and recording
- Calibration and maintenance
- Validation of the whole process (includes IQ, OQ, PQ)

In summary the internal validation is largely encompassed by you knowing (documentation) that staff have been trained in cleaning, loading, etc and understand the whole process including what items are able and are not able (validated) to be processed. The indicator validation strips and/or electronic monitoring are only of this process wider assurance process.
## Autoclave Monitoring

√ – Pass  
x – Fail  

**NB:** Document remedial action taken in the event of sterilisation failure

<table>
<thead>
<tr>
<th>Week beginning</th>
<th>Mon</th>
<th>Tues</th>
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Linen use and Laundering

- If using material linen on consulting room beds, a good practice often used is to either use a paper roll to cover the linen, including the pillow, and this is changed between patients
- If no paper roll is available impervious disposable paper sheet under the patient should be used, and a disposable paper towel to cover the pillow. These should be changed between patients
- Soiled linen should be soaked and then placed in a separate bag awaiting transfer to the laundry

Although linen and laundering has a low incidence of association with cause of infection, well documented cases have occurred.

These are mainly from multiple uses of the same laundry – either visibly soiled or ‘visibly clean’ but contaminated e.g. transfer of MDRO’s, scabies, etc. as with used examination bed sheets or from multiple use gowns.

The laundry washing process itself will essentially render the item a non infectious risk by water dilution, heat, detergent/bleach and (heat) drying. Use common sense because each of these factors will play a part.

Linen heavily contaminated with blood or other body fluids should be bagged and transported in a manner that will prevent leakage. Gloves and other appropriate protective apparel should be worn when handling/sorting soiled linen.

However used linen should be bagged, laundered, transported and stored in a manner that minimises exposure by cross-contamination which may occur anywhere in the cycle including ‘dirty’ linen contacting clean linen.

Breaches in the processing including recontamination by shaking used linen/sheets on removal rather than folding inwards, transport and bag cross contamination of dirty/clean linen, lack of hand hygiene when handling clean linen, linen left uncovered, doors to storage areas left open, and open access to linen.

- Wash hands before handling clean linen
- Keep linens on shelving units/storage covered or door closed
- The linen storage area should only be accessible to appropriate personnel
- Do not carry clean or soiled textiles against your clothes/uniform
- Take linen directly from storage to the site/bed with no stops on the way

If using a non-accredited linen laundry service (e.g. home washing), this processing is harder to validate/verify, ensure no cross contamination in the laundry floor area, or during transport to/from the medical centre. In practice any ‘hot cycle’ will be sufficient, and dependent on detergent/bleach and drying process, even ‘cold wash’ cycles may be acceptable.

Commercial accredited laundry services often use water temperatures of at least 60-70C and 50-150 ppm of chlorine bleach to remove significant quantities of microorganisms from grossly contaminated linen.
The majority of medical centre rubbish/waste can be disposed of by:

- recycling
- ‘ordinary’ rubbish (no human organic material)
- compostable waste (e.g., fruit, vegetables)
- sharps

The remainder will be Hazardous or Controlled waste and needs to be segregated and disposed of separately because of the infectious risk.

The universal medical dictum is

“All human blood and body fluids are to be treated as potentially infectious”

To help mitigate risks from waste handling and disposal both within the medical centre, and to the collection, disposal and treating companies staff, this (potentially infectious) human organic waste is best disposed of in either of two ways, either

A. ‘Controlled Waste’ – when the contaminated waste cannot leak or drip including on compaction by an authorised waste removal truck for this category. This human waste category contains human organic material so should be thought of as infectious still
- e.g. emptied urine bags, IV tubing (no needle) and bags, catheter tubing, syringes (without needles), emptied drainage collectors (e.g. colostomy, minivacs), used dressings, gauze, etc, used and emptied specimen containers, used PPE equipment

- Potential leaking items on compaction can usually be prevented by first adding a potentially leaking item into a plastic bag with enough absorbent material, e.g. paper towels, to absorb any fluid present before adding to the ‘controlled waste’ container

- Medical centres should aim to separate off and have all their human contaminated material in this category because disposal is safer and cheaper by weight:

B. ‘Infectious Waste’ - any material containing human blood and body fluids that can leak/drip on storage, transport or compaction

- disposal is likely to be much more expensive per kg and should be avoided where practicable

- dispose of body fluids into the sewage system, including via sluice sink where practicable

The above ‘infectious waste’ should be a small component, if any, of the total waste/rubbish from the medical centre. It is good practice for a registered waste company to collect/dispose of this ‘controlled waste’ (and ‘infectious waste’ if any) where possible, as per NZS 4304:2002 and the Foundation Standard, however a local authority may not specifically require this.

Other special waste categories include:
radioactive waste, cytotoxic waste, pharmaceutical waste - special conditions are required for each

“NB. All clinical areas should have appropriate, labelled, segregated waste bins.

Paper for shredding should be deposited in the agreed bin for shredding or collection by a commercial shredding operation.

Sharps containers should also be present in each clinical area, out of reach of children.

- Ensure the Sharps container top is firmly locked into place when assembling
- Do not overfill Sharps above maximum limit line, and only use for sharp items
- Ensure full containers lid is firmly locked/secured into place before leaving for removal/disposal

Sharps containers are available in a variety of sizes: Most common are 1 litre (this sits neatly in a blood tray) and 7.6 litres.

Sharp containers are ordered through local Medical Laboratory at no cost if the general practice is using the services of this Laboratory. The Laboratory will usually collect the full containers for disposal where practicable”.
### Waste Segregation Categories

<table>
<thead>
<tr>
<th>Waste Category</th>
<th>Colour Code</th>
<th>Items</th>
<th>Disposal process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-hazardous Waste</strong></td>
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</tr>
<tr>
<td>Recycling</td>
<td>(yellow recycling bin in Chch)</td>
<td>Clean paper, magazines, cardboard, plastics, unbroken glass, aluminium cans, tin, metal, aerosols</td>
<td>Local authority kerbside</td>
</tr>
<tr>
<td>Organic</td>
<td>(green recycling bin in Chch)</td>
<td>Food scraps, paper towels, coffee grinds, tea bags, bread/pastry, fruit, vegetables, flowers, garden waste</td>
<td>Local authority kerbside</td>
</tr>
<tr>
<td>Other Waste</td>
<td>(Red wheelie bin in Chch)</td>
<td>Most of the rest of the waste (no blood, body fluids)</td>
<td>Local authority kerbside</td>
</tr>
<tr>
<td>Confidential Waste</td>
<td></td>
<td>All confidential health information for shredding</td>
<td>Company contract collection for shredding or recycling if already shredded</td>
</tr>
<tr>
<td><strong>Hazardous Waste</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharps</td>
<td>Yellow Sharps Containers</td>
<td>All sharps including needles, scalpels, glass ampoules broken open, any object having sharp points capable of causing a penetrating injury</td>
<td>Generally collected and disposed of by community labs or accredited waste company</td>
</tr>
<tr>
<td>Cytotoxic</td>
<td>Purple container specified</td>
<td></td>
<td>Incineration or other as per local authority</td>
</tr>
<tr>
<td><strong>Controlled Waste</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Controlled waste</td>
<td>“potentially infectious ……no expressible liquid”</td>
<td>“…potentially infectious human body fluids which shall not be expressible under compaction”</td>
<td>Good practice to have removed by accredited company for disposal</td>
</tr>
<tr>
<td><strong>Infectious Waste</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infectious Waste</td>
<td>Yellow biohazard container specified</td>
<td>“…waste containing expressible body fluids”</td>
<td>Good practice to have removed by accredited company for disposal</td>
</tr>
<tr>
<td>Vaccine waste</td>
<td></td>
<td>If vaccines are expired or the cold chain has been breached these vaccines should be returned to e.g. Zuellig Pharma Ltd (check address on order forms)</td>
<td></td>
</tr>
<tr>
<td>Pharmaceutical</td>
<td>Return to Pharmacist for disposal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Body Substance Injury/Exposure

Recording and notification of accidents and serious harm is a requirement of the Health and Safety in Employment Act 1992.

Definitions:

Recipient The person exposed to blood or body substance
Source The person whose blood or body substance the recipient was exposed to. The source may be unknown.

Types of contact to be reported:
- Injury resulting from contact with used needles or sharp objects (e.g. scalpel blades) that have been contaminated with blood or body substance.
- Splashing of blood or body substance onto mucous membrane (e.g. eyes, nose or mouth) or onto a cut, burn or broken skin (e.g. dermatitis).
- Human bites where the skin surface is broken.

Procedure:
1. Wash injured area under running water, squeeze gently to help area bleed. For eye and mucous membrane exposure, irrigate with water/saline or under running tap water. Cover wound if able with an adhesive waterproof dressing.
2. Seek informed consent from source, if appropriate and known, for screening blood tests for HBV, HCV and HIV (10ml sample of blood in a plain tube)
3. Bloods to be taken from recipient for HBV, HCV and HIV (10ml sample of blood in a plain tube). Seek informed consent first.
4. Time frames for seeking Infectious Disease Specialist input if source is known to be positive for:
   - HIV preferably within 2-4 hours
   - Hepatitis B within 48 hours (if recipient has no immunity)
5. Complete OSH Accident Investigation form, appropriate ACC form to lodge claim with ACC and appropriate laboratory forms.
6. Original copy of OSH Accident investigation form is to be filed in the Practice Incident Book. It is recommended that the recipient retain a copy for their reference
7. Document injury/exposure in recipient/source medical notes as appropriate.
8. Recipient to contact own or nominated GP for follow up of blood results
9. Ensure that the affected person has been appropriately counselled regarding the possibility of transmission of blood borne disease.

NB It is important to retain records of Hepatitis B vaccination

For people vaccinated against Hepatitis B, over 90% will develop measurable immunity (Hepatitis B antibodies, HBsAb), as detectable by laboratory tests, but this measurable immunity wanes with time.

➢ In practice, if the injured person has ever been fully vaccinated to hepatitis B, and if they are not immunocompromised or have renal disease, then the probability
of catching clinically significant hepatitis B are essentially zero, regardless of what the immune status now shows on a blood test and whether or not measurable HBsAb was ever produced/detected. Published papers and time experience show immunity is likely lifelong because of cellular immunity which cannot be detected

- But for extra assurance and to comply with NZ Immunisation Handbook guidelines if the injured person is fully vaccinated and no hepatitis B antibodies are detected in the blood test, usually a vaccination series and/or immunoglobulin will be advised to provide extra certainty of protection to hepatitis B

When hepatitis B immunoglobulin (HBIG) or a hepatitis B vaccine series is given to a non immune injured person who was exposed to a hepatitis B source, their risk of infection is reduced 75%. If this HBIG is combined with initiating a hepatitis B vaccination series, protection is thought to be 85-95%.

Risks can increase in the following situations (i.e. more virus numbers can be introduced), if:

- A deep injury
- Terminal or new viral bloodborne illness in the source patient (both scenarios have higher viral load numbers present)
- Visible blood on the device which caused the injury
- Injury with a needle which had been placed in a source patient's artery or vein

All exposures to non blood contaminated urine, saliva, bites and scratches have significantly reduced infection transmission rates to those noted above.

If Source testing is available and tests are negative for virus then bloodborne viral infection risk is almost zero (but a potential window period post recent Source infection).

Risk also decreases with time if the source of the injury is not direct from a person but via the environment (e.g. needle in a garden) because these viruses become more inactive off people with time. Although hepatitis B can survive the longest, up to about 6 months, most of the initial viral numbers would be inactive by then and unlikely to be enough to cause an infection after this time.

Post single blood exposure risk of acquirement from a positive source if recipient unvaccinated:

- Hepatitis B ↑ 15 - 30% or higher if hepatitis e antigen present (HBeAg)
- Hepatitis C ↑ 5-6%
- HIV 0.3%

Refer HealthPathways and www.canterburyscl.co.nz under ‘Infection Control’ tab for process and forms

Useful References for more information:

Bloodborne Infectious Diseases CDC Management and treatment Guidelines:

HCV Guidance: Recommendations for Testing, Managing, and Treating Hepatitis C (IDSA)
http://www.hcvguidelines.org/
STAFF HEALTH & INFECTIONS

All practices should state clearly what infections are permissible for staff to continue working with. These recommendations will vary between types of practice and on a case by case evaluation.

1. Consider removing from patient contact if:
   - Conjunctivitis
   - Diarrhoea
   - Acute respiratory tract infection
   - Group A streptococcal infections
   - Pyogenic skin lesions
   - MDRO with cross infection risk
   - Scabies
   - Rubella
   - Measles, mumps, chicken pox, whooping cough, severe dermatitis or eczema (especially on the hands).

2: Usually no need to remove from patient contact:
   - HIV
   - HBV, HCV carrier
   - Oral Herpes simplex

**Note:** It is important that HIV positive staff and Hepatitis B and C virus carriers are meticulous regarding compliance with body substance barrier precautions.

### Work Restriction Policies for Health Care Providers

<table>
<thead>
<tr>
<th>Infection</th>
<th>Restriction</th>
<th>Length of Restriction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>Restrict from direct patient care</td>
<td>Until discharge resolved</td>
</tr>
<tr>
<td>Gastroenteritis</td>
<td>Restrict from direct patient care and food preparation</td>
<td>Until symptoms resolve or person is deemed non-contagious (at least 48hrs symptom free post norovirus)</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Restrict from direct patient care and food preparation</td>
<td>Until 1 wk after onset of jaundice</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>None*</td>
<td></td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>None*</td>
<td></td>
</tr>
<tr>
<td>Herpes simplex, orofacial</td>
<td>Restrict from direct care of newborn infants</td>
<td>Until lesions dry</td>
</tr>
<tr>
<td>HIV</td>
<td>None*</td>
<td></td>
</tr>
<tr>
<td>Viral respiratory infections, acute febrile (e.g. Influenza, RSV)</td>
<td>Restrict from direct patient care</td>
<td>Until 5 d after symptom onset or acute symptoms resolve whichever is sooner</td>
</tr>
<tr>
<td>Measles</td>
<td>Exclude from centre</td>
<td>Until 7 d after onset of rash</td>
</tr>
<tr>
<td>Mumps</td>
<td>Exclude from centre</td>
<td>Until 9 d after onset of parotitis</td>
</tr>
<tr>
<td>Pediculosis</td>
<td>Restrict from direct patient contact</td>
<td>Until treated</td>
</tr>
<tr>
<td>Pertussis</td>
<td>Exclude from centre</td>
<td>Until treated for 5 d</td>
</tr>
<tr>
<td>Rubella</td>
<td>Exclude from centre</td>
<td>Until 5 d after onset of rash</td>
</tr>
<tr>
<td>Infection</td>
<td>Restriction</td>
<td>Duration</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Staphylococcal skin infection</td>
<td>Restrict from direct patient care</td>
<td>Until treated for 24 h and well covered</td>
</tr>
<tr>
<td>Streptococcal infection, group A</td>
<td>Restrict from direct patient care</td>
<td>Until treated for 24 h and well covered</td>
</tr>
<tr>
<td>Tuberculosis, active</td>
<td>Exclude from centre</td>
<td>Until proven non infectious</td>
</tr>
<tr>
<td>Varicella (chicken pox)</td>
<td>Exclude from centre</td>
<td>Until lesions crusted</td>
</tr>
<tr>
<td>Zoster (shingles)</td>
<td>If covered, restrict from care of immunocompromised patients If cannot be covered, restrict from patient care</td>
<td>Until lesions crusted</td>
</tr>
</tbody>
</table>

* Health care providers with these infections should be especially careful when performing procedures which could risk transmission of blood from provider to patient

Maintaining Infection Prevention and Control Within General Practice in the event of a Pandemic or Other Special Infectious Situation

Any patient presenting to the practice has the potential to be infectious, and it is usually the unknown or unsuspected infected patient who ends up causing the most concern in retrospect.

For this reason, systems must be set up to protect general practice staff from possible cross infection by patients. This is a Health and Safety requirement.

Standard Precautions underpin safe protection and should be used at all times with every patient. The following checklist is intended as a guide for general practice. Further infection control advice in primary care is available for organisms of concern:

specific organisms or global outbreaks of concern:
www.cdc.gov
http://www.who.int/topics/infectious_diseases/en/

local/NZ outbreaks or organisms of concern:

Surveillance Criteria and Clinical Criteria can be Different

The WHO Severe Acute Respiratory Infection (SARI) case definition is:
“An acute respiratory illness with
• a history of fever or measured fever of ≥38°C, and
• cough, and
• onset within the past 10 days, and
• requiring inpatient hospitalisation”

The NZ Public Health Influenza Surveillance ILI case definition criteria is:
"an acute respiratory tract infection characterized by an abrupt onset of two of the following: fever, chills, headache and myalgia".

NB Surveillance criteria is much stricter (less specific) than clinical infection symptom criteria
In a 3 year retrospective study of 207 hospitalised patients in a large USA hospital, who were subsequently proven to have had influenza on admission – 90% had a cough, but 40% were afebrile regardless of age

Door signs and posters
Display signs alerting patients if they have flu like symptoms to let Reception staff know. Also display signs encouraging hand hygiene and cough etiquette in the waiting room.
Hand Hygiene

Hand hygiene is the single most important step in reducing the spread of infection.

All patients with an infection risk should be asked to use an alcohol-based hand rub when they enter your surgery - this is for other patients’ protection as much as for the protection of general practice staff.

Staff should perform hand hygiene before and after every patient contact.

- When hands are visibly dirty, contaminated, or soiled, wash with liquid soap and water
- If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands

Respiratory Hygiene/Cough Etiquette

- Post signs at entrances and in strategic places (e.g., waiting room, consultation room) with instructions to patients and other persons with symptoms of a respiratory infection to cover their mouths/noses when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after hands have been in contact with respiratory secretions.
- Provide tissues and no-touch receptacles (e.g., foot-pedal operated lid or open, plastic-lined waste basket) for disposal of tissues.

“Streaming” options for seeing patients with ILIs within your practice?

You may wish to consider “streaming” patients who present with flu like symptoms to your practice. These plans will need to be adapted for each practice to suit needs, depending on size of practice, nature of the building, the population of the practice, and staff preferences. Suggestions include:

- Identifying a separate waiting areas
- Different times of clinics for flu/non-flu patients
- Flow of people through the practice – is it possible to arrange this so that people move in one direction rather than coming back past each other?
- Minimise amount of time in waiting area, e.g. flu patients wait in their cars and are phoned/texted when ready to be taken in
- Some non-flu activities redirected to other times/places e.g. blood testing to lab

Personal Protective Equipment (PPE)

There are varying levels and types of PPE and this depends on the level of exposure, the risk of transmission and the nature of the disease.

To ensure correct use of PPE for you and your practice staff please refer to the MOH Guidelines, which clearly outline the appropriate levels of PPE.

Continue to have disposable multi-purpose masks available for patients presenting with respiratory symptoms and ask them to wear these at all times in your practice.

Maintaining a Clean Environment

Ensure your workplace has a regularly planned, written and monitored cleaning schedule, which details both the items and environments to be cleaned and how often this should happen.
The influenza virus can remain viable on hard surfaces for up to 48 hours therefore these surfaces e.g. reception, bench tops, doors, door handles, tills, EFTPOS machines, telephones, computer keyboards, etc should be wiped down regularly throughout the day with an appropriate solution or 70% alcohol based wipes.

70% Alcohol or detergent and water readily inactivates most respiratory viruses.

Gastroenteritis viruses (e.g. norovirus) are more effectively inactivated by cleaning with a clean disposable cloth and a solution of bleach (prepared daily, 1:10 bleach solution). Ensure the spray nozzle is directed for “squirt” not “spray” to avoid the inhalation of potential harmful chemical.

Books and toys should be kept to a minimum or not provided in the waiting room. Although it is difficult to monitor the cleanliness of the toys having 2 toy boxes available to change daily ensures the toys are being cleaned on a regular basis.

Appropriate ventilation with doors and windows and proper maintenance of air conditioning systems is important.

It is also important that all staff understand and follow your workplace’s written policies and procedures on all aspects of infection control.
Useful Websites

http://www.healthpathways.org.nz/

Infectious Diseases

http://www.cdc.gov/az/
http://www.who.int/topics/en/
http://www.hpa.org.uk/Topics/TopicsAZ/

Waste Management

www.sanipakltd.co.nz
http://www.interwaste.co.nz/

Education or Training Course Resources

https://www.healthlearn.ac.nz/
http://www.infectioncontroltoday.com

Guidelines

https://www.rnzcgp.org.nz/assets/documents/CORNERSTONE/InfectionControlCheckList1.1.pdf (a useful checklist for Cornerstone but relevant for Foundation Std)
http://www.cdc.gov/hai/
http://www.moh.govtnz/moh.nsf
APPENDIX One

Foundation Standard Health Care Waste Guide
Indicator 14  1 Nov 2015


INDICATOR 14
There is safe storage and disposal of health care waste

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>14.1 Practice waste is correctly categorised, safely stored, collected and disposed of in accordance with the industry standard NZS 4304:2002.</td>
<td>Waste management policy; and Waste collection units; and Waste storage area; and Method of waste disposal.</td>
</tr>
<tr>
<td>14.2 In all areas where sharps are used, the practice has puncture resistant sharps containers that are out of reach of children, and display a biohazard symbol in accordance with NZS 4304:2002.</td>
<td>Sharps containers located out of reach of children, and marked in accordance with NZS 4304:2002.</td>
</tr>
</tbody>
</table>

Guidance notes

New Zealand Standard NZS 4304:2002 details how health care waste is managed. To ensure compliance, practices should obtain a copy from Standards New Zealand. The essentials are summarised here but the Standard should be consulted for detail. Management of some hazardous waste will require reference to other sources (e.g., National Radiation Laboratory Code or controls under the HSNO Act).

Health care waste refers to all waste generated by a health care facility and includes 'non-hazardous', 'controlled' and hazardous waste. Non-hazardous waste constitutes the bulk of waste generated and is managed in the same way as household waste.

Hazardous waste requires proper handling, storage, transport and disposal to minimise risk to personnel, the public and the environment, and to prevent causing cultural or aesthetic offence.

A fundamental principle of waste management is the minimisation of waste.

Hazardous waste

This is initially classified as either sharps or non-sharps waste.

Sharps waste is categorised as radioactive, cytotoxic or infectious and is subject to controls for both sharps and the appropriate hazardous waste.

Non-sharps waste is categorised as infectious (including body parts), radioactive, cytotoxic or other (e.g., solvents, chemicals, pharmaceuticals).

Controlled waste

This includes waste that is recognisable as coming from a health care facility and that is contaminated with body fluids (that cannot be expressed) or may be aesthetically offensive. It includes intravenous tubing, catheters, cannulas, empty syringes (no needles), disposable sheathing, disposable scopes, used dressings, disposable gloves or other surgical garments.
Non-hazardous waste
Categorised as recyclable (paper, glass, plastics, metal) or general waste (solid or liquid).

Segregation
Waste must be segregated according to its category at the time and place it is generated, and then be bagged, packaged or containerised as appropriate.

Sharps must be placed in sharps containers.

Hazardous waste requiring refrigeration must be stored in a dedicated refrigerator.

Radioactive waste must be segregated and stored in accordance with the National Radiation Laboratory Code of Safe Practice.

Containers and packaging
Figure 2 shows the appropriate containers for packaging different categories of healthcare waste.

**Figure 2. Segregation and packaging process**

**Bags**

Bags for the collection and storage of waste other than sharps must:

- have sufficient strength to contain waste
- comply with NZS 7603 (for plastic bags)
- conform to the colour coding and marking system (in Figure 2)
- be filled to not more than two-thirds of their capacity
- allow for the secure final closure when two-thirds full
- be secured with closure devices that do not have sharp protuberances (e.g., staples).
- Paper bags must not be used for hazardous waste.

**Sharp containers**

These must meet the requirements in AS/NZS 4261 (Reusable containers for the collection of sharp items used in human and animal medical applications).

Sharps containers should be in place in all clinical and treatment areas or where any hazardous waste may be generated such as sluice/sterilising rooms. The disposal of sharps is the responsibility of the person generating the sharps. Used sharps should be disposed of directly after use not left on work surfaces. Needles should never be bent, broken or recapped. Fill containers to the designated level only. When full, securely attach the well-fitting lid and dispose of through a licensed operator. These measures reduce the risk of inadvertent needle stick injuries. Holders for the biohazard containers should preferably be wall mounted at chest height, out of doorways and high traffic areas. Loose biohazard containers (not wall mounted) in current use, should not be left on the floor, on trolley tops, on consultation desks or on any surface within easy reach of children.

**Rigid-walled containers**

Reusable rigid-walled containers (e.g., mobile garbage bins) should be resistant to leakage, impact rupture and corrosion and should be inspected after each use to ensure they are intact.

**Packaging and labelling for transport**

Hazardous and controller waste must be packaged, labelled and documented for transport in accordance with NZS 5433 (Transport of dangerous goods on land).

**Health care waste storage**

Hazardous and controlled waste must be stored in designated areas and must not be left unattended at road-side or other area where the public may have unsupervised access.

The storage areas must be sufficient to maintain segregation of waste and separation from other stored materials. It must:

- be secure
- be vermin-proof and easily cleaned, with walls and floors of impervious material and floors bunded or graded to a valved sewer outlet
- have adequate access and space for movement
- have adequate lighting so it can be effectively cleaned and information on containers and documents easily read
- have adequate ventilation to remove odours and exhaust vents must prevent exhaust entering buildings or public areas
- be identified with signs appropriate to the categories of waste stored
- must have ready access to materials for managing spills, suitable protective clothing and handwashing facilities.

Each regional council will have its own bylaws and regulations with regard to waste disposal, which practices must be cognizant of and comply with.
INDICATOR 15

The practice ensures effective infection control to protect the safety of patients and general practice team members

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Evidence may include</th>
</tr>
</thead>
<tbody>
<tr>
<td>15.1 The practice has infection control policies and procedures that align with the AS/NZS 4815: 2006 Standard.</td>
<td>■ Infection control policy; and</td>
</tr>
<tr>
<td>15.2 General practice team members responsible for managing infection control have received sterilisation and disinfection training, within the last three years.</td>
<td>■ Infection control training records – name of provider, date of delivery, names/certificates or persons attending.</td>
</tr>
<tr>
<td>15.3 The practice can demonstrate how it monitors the effectiveness of each sterilisation cycle.</td>
<td>■ Sterilisation documentation.</td>
</tr>
<tr>
<td></td>
<td>■ Records of effective sterilisation cycles.</td>
</tr>
<tr>
<td>15.4 A current calibration and validation record is available for the steriliser.</td>
<td>■ Calibration and validation records.</td>
</tr>
</tbody>
</table>

Guidance notes

General practices frequently undertake invasive procedures such as minor surgery, and there are emerging antimicrobial resistant organisms and blood-borne viral infections. It is important to provide a safe environment for staff, patients and other people in the practice. To ensure this, all team members should be equipped with the requisite knowledge, skills and attitudes required for good infection control practices.

The infection control policy should include but is not limited to:

- Facilities, equipment, and procedures necessary to implement standard and additional (transmission based) precautions for control of infections.
- Cleaning, disinfecting and reprocessing of reusable equipment.
- Cleaning schedule for the practice premises.
- Waste management.
- Special situations, e.g. influenza epidemics, norovirus, H1N1.
- Staff immunity and infections.
- Hand hygiene.
- Prevention and management of infection by service providers.
- Antimicrobial usage.
- Single-use items.
- Management of occupational exposure to blood and body fluids.
- Cleaning, decontamination, disinfection and sterilisation of instruments and equipment.
- Wound management.
- Linen services.
- Vanepuncture.
- Cryotherapy.
- Cleaning and servicing of the steriliser.
SECTION 2: Practice Environment and Safety

The purpose of this indicator is to ensure infection control practices prevent the spread of infectious organisms to patients and within the practice. Monitoring, validation, maintenance, calibration, cleaning and training are essential to ensure equipment and procedures meet requirements.

In many respects, the principles of infection control such as hand hygiene and standard precautions remains a constant between different parts of the health sector. However the translation of hospital policies and procedures to the office based practice is often not appropriate due to differing risks, equipment and staff factors. Training and competency of the practice team in relation to infection control in an office based setting is essential in ensuring the effectiveness of infection control in a general practice.

The checklist is to provide guidance only and does not constitute a comprehensive or exhaustive tool on the subject matter or method of verifying compliance. It is written as a guide for general practices performing minor surgical procedures. It is not intended as a reference tool for practices undertaking more comprehensive surgical procedures or for day stay facilities.

The text is directed at health professionals who hold a qualification in medicine or healthcare and who are trained and skilled in regard to the prevailing risks of infection. Persons implementing the policies must exercise their own independent skill and judgement or seek appropriate advice as to reliance upon the guide, which may require modification in light of the risk profile of their particular practice or circumstances. The practice must act with due diligence to determine whether their policy meets their needs and that the content aligns with all legal, ethical and moral obligations.

Indicator 15
There is safe storage and disposal of healthcare waste.

Indicator 16
The practice ensures infection control to protect the safety of patients and team members.

<table>
<thead>
<tr>
<th>GUIDE TO INFECTION CONTROL</th>
</tr>
</thead>
<tbody>
<tr>
<td>INFECTION CONTROL CATEGORY</td>
</tr>
<tr>
<td>Cleaning of the practice</td>
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<tr>
<td>Indicator 15</td>
</tr>
<tr>
<td>--------------</td>
</tr>
<tr>
<td>The practice safely stores and disposes of sharps, contaminated material and hazardous material</td>
</tr>
<tr>
<td>Waste Management</td>
</tr>
<tr>
<td>Healthcare waste is categorised by its properties and characteristics rather than the source of the waste, e.g. laboratory, home healthcare, etc NZS 4304.2002</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Special waste</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>How is waste transported and stored within the practice</td>
</tr>
<tr>
<td>How is waste disposed of and by whom:</td>
</tr>
<tr>
<td>• Dangerous goods declarations – retain copy in practice for 10 years</td>
</tr>
<tr>
<td>Hand hygiene</td>
</tr>
<tr>
<td>• Clinical</td>
</tr>
<tr>
<td>• Using what product:</td>
</tr>
<tr>
<td>• Alcohol based hand rub</td>
</tr>
<tr>
<td>Duration of process</td>
</tr>
<tr>
<td>Drying technique:</td>
</tr>
<tr>
<td>-------------------</td>
</tr>
<tr>
<td>• Paper towels</td>
</tr>
<tr>
<td>• Clean section of roller towel</td>
</tr>
<tr>
<td>• Sterile towel</td>
</tr>
</tbody>
</table>

When do hands need to be cleaned

<table>
<thead>
<tr>
<th>WHO recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Place acute febrile respiratory patients at least 1 metre away from others in common waiting areas, if possible</td>
</tr>
<tr>
<td>• Post visual alerts at the entrance to health-care facilities instructing persons with respiratory symptoms to practice respiratory hygiene/cough etiquette</td>
</tr>
<tr>
<td>• Consider making hand hygiene resources, tissues and masks available in common areas, and areas used for the evaluation of patients with respiratory illnesses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>WHO recommendations:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Cough etiquette for persons with respiratory symptoms should apply source control measures:</td>
</tr>
<tr>
<td>• Cover their nose and mouth when coughing/sneezing with tissue or mask,</td>
</tr>
<tr>
<td>• Dispose of used tissues and masks</td>
</tr>
<tr>
<td>• Perform hand hygiene after contact with respiratory secretions</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are standard precautions:</td>
</tr>
<tr>
<td>To include but not limited to:</td>
</tr>
<tr>
<td>• Hand hygiene</td>
</tr>
<tr>
<td>• Personal protective equipment</td>
</tr>
<tr>
<td>• Respiratory hygiene and cough etiquette</td>
</tr>
<tr>
<td>• Aseptic techniques</td>
</tr>
<tr>
<td>• Sharps waste management</td>
</tr>
<tr>
<td>• Cleaning, environmental and spills management</td>
</tr>
<tr>
<td>• Waste disposal, laundry and cleaning services</td>
</tr>
<tr>
<td>• Reprocessing of reusable medical equipment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reprocessing of Reusable Equipment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Categorisation using Spalding Classification</td>
</tr>
<tr>
<td>• Critical (high risk)</td>
</tr>
<tr>
<td>• Semi critical (medium risk)</td>
</tr>
<tr>
<td>• Non critical (low risk)</td>
</tr>
</tbody>
</table>

Definitions of single use items

| Single patient use |
| Single use medical equipment |

<table>
<thead>
<tr>
<th>Layout of reprocessing area</th>
</tr>
</thead>
<tbody>
<tr>
<td>Define the process for decontamination, sterilisation and storage:</td>
</tr>
<tr>
<td>To include but not limited to:</td>
</tr>
<tr>
<td>• Sharps disposal</td>
</tr>
<tr>
<td>• Cleaning</td>
</tr>
<tr>
<td>• Drying</td>
</tr>
<tr>
<td>• Packaging</td>
</tr>
<tr>
<td>• Indicators/integrators</td>
</tr>
<tr>
<td>• Loading of steriliser</td>
</tr>
<tr>
<td>• Unloading</td>
</tr>
<tr>
<td>• Storage of processed equipment</td>
</tr>
<tr>
<td>• Rotation of stock</td>
</tr>
<tr>
<td>• Record keeping</td>
</tr>
<tr>
<td>• Tracking and traceability</td>
</tr>
<tr>
<td>• Steriliser maintenance</td>
</tr>
<tr>
<td>• Calibration and validation records</td>
</tr>
<tr>
<td>• What action to take when cycle fails</td>
</tr>
</tbody>
</table>

How are staff training

| What personal protective equipment is to be used |

**RNZCGP CORNERSTONE General Practice Accreditation Programme 2011**

Pegasus-CSCLab Guide to Infection Control v2a March 2016 (2) 28 Jan 2016

Page 47 of 50
| Steam steriliser | Cycle monitoring for every load:  
Class one chemical indicator on outside of every packaged item  
Class one chemical indicator on tray for unwrapped loads  
Class 4, 5 or 6 chemical indicator on tray or within pack  
Document:  
- Change in colour of Class 1 indicator (tape)  
- Results of Class 4, 5 or 6 indicator - on tray or in pack  
- Correct time/temperature was achieved  
- Condition of packs  
- Load number or time of day  
- Corrective action if faulty process  
- Name of person signing process off  
- Retain record of cycle parameters for 10 years  
Optional:  
- Weekly biological/ enzymatic indicator  

Only sterilisers with a drying cycle are suitable for sterilising wrapped items. Passive drying with a closed or "cracked-door" is not a suitable alternative. Practices with older style sterilisers without an active drying cycle should consider:  
- Purchase of a new steriliser  
- Use prepacked disposable sterile supplies  
- Use off site sterilisation facilities

Best practice but NOT MANDATORY:  
Link pack to a validated process and on to a patient by:  
- Date/cycles number from pack written in patient's notes  
- Label gun - stick peel off data from pack in patient's notes  
- Procedure book – enter patient's name, date and process number of pack

| Steam steriliser | Cycle monitoring:  
Class one chemical indicator on outside of every packaged item  
Class one chemical indicator on tray for unwrapped loads  
Printout of every cycle  
Optional:  
- Annual biological/ enzymatic indicator  

Document as printout fades:  
- Change in colour of Class 1 indicator (tape)  
- Load number  
- Results of printout  
- Corrective action if faulty process  
- Condition of packs  
- Name of person signing process off  
- Retain record of cycle parameters for 10 years

Best practice but NOT MANDATORY:  
Link pack to a validated process and on to a patient by:  
1. Date/cycles number from pack written in patient's notes  
2. Label gun – stick peel off data from pack in patient's notes  
3. Procedure book – enter patient's name, date and process number of pack  
4. Or enter electronic data in the patient's notes

| Disinfection process for items unable to be processed by thermal means. | What items:  
Consider definitions of single use items  
- Single patient use  
- Single use medical equipment  
Using what product:  
- Chlorine releasing disinfectant  
- 70% isopropyl alcohol wipes  
What dilutions:  
Duration of process:  
Disinfection is not a substitute for sterilisation - items used for critical procedures must be sterilised. Items that are not clean cannot be effectively disinfected.

| Loading of steriliser | How to load the steriliser  
Wrapped items:  
- Cellophane side up  
- Use perforated trays  
- Use lead separators, e.g. stainless steel 'toast rack'  
- Dishes on their side |
<table>
<thead>
<tr>
<th><strong>Staff Immunisation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>May include but not limited to:</td>
</tr>
<tr>
<td>• Hepatitis B</td>
</tr>
<tr>
<td>• Tetanus</td>
</tr>
<tr>
<td>• Diphtheria</td>
</tr>
<tr>
<td>• Pertussis</td>
</tr>
<tr>
<td>• Mumps</td>
</tr>
<tr>
<td>• Measles</td>
</tr>
<tr>
<td>• Rubella</td>
</tr>
<tr>
<td>• Polio</td>
</tr>
<tr>
<td>• Varicella</td>
</tr>
<tr>
<td>• Influenza</td>
</tr>
<tr>
<td>• Hepatitis A</td>
</tr>
<tr>
<td>Staff records of immunisation status</td>
</tr>
<tr>
<td>Guidelines to work restrictions and management of staff with an infectious illness:</td>
</tr>
<tr>
<td>• Disease</td>
</tr>
<tr>
<td>• Restrictions on role/work</td>
</tr>
<tr>
<td>• Duration of restriction</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Blood/body fluid exposure policy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the policy to manage exposed person and source after incident:</td>
</tr>
<tr>
<td>Summary:</td>
</tr>
<tr>
<td>• Decontaminate exposed area</td>
</tr>
<tr>
<td>• Define exposure:</td>
</tr>
<tr>
<td>• Doubtful parental exposure</td>
</tr>
<tr>
<td>• Possible parental exposure</td>
</tr>
<tr>
<td>• Definite parental exposure</td>
</tr>
<tr>
<td>• Massive exposure</td>
</tr>
<tr>
<td>• Test</td>
</tr>
<tr>
<td>• Assess risk of transmission of infection</td>
</tr>
<tr>
<td>• Initiate treatment</td>
</tr>
<tr>
<td>• Referral</td>
</tr>
<tr>
<td>• Documentation, notification, ACC</td>
</tr>
<tr>
<td>How have staff been trained to manage a blood/body fluid exposure</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Needle stick injury policy</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>All staff to be familiar with the process</td>
</tr>
<tr>
<td>Act immediately</td>
</tr>
<tr>
<td>DO NOT WAIT FOR BLOOD TEST RESULTS before commencing treatment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Off site sterilisation</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>A documented agreement between the two parties is essential to detail the process and the responsibilities of each party.</td>
</tr>
<tr>
<td>Practice policy to include but not limited to:</td>
</tr>
<tr>
<td>• Health and safety, e.g. sharps disposal, standard precautions</td>
</tr>
<tr>
<td>• Preliminary pre-cleaning</td>
</tr>
<tr>
<td>• Transportation of soiled items</td>
</tr>
<tr>
<td>• Transportation of sterile items</td>
</tr>
<tr>
<td>• Tracking and traceability</td>
</tr>
<tr>
<td>• Record keeping</td>
</tr>
<tr>
<td>Validation and calibration of off-site steriliser – annual documentation</td>
</tr>
</tbody>
</table>

The practice demonstrates its commitment to health and safety in the workplace.
Resources:

Health and Safety in Employment Act 1992
Infection Control for General Practice: Medlab South Limited, January 2006
Standards New Zealand: Office-based health care facilities – Reprocessing of reusable medical and surgical instruments and equipment, and maintenance of the associated environment, AS/NZS 4815:2005
The Royal New Zealand College of General Practitioners: Aiming for Excellence 2009