



INFECTION PREVENTION AND CONTROL POLICY

Chew Medical Practice recognises the importance of working within an environment that promotes good effective infection control measures. Wherever possible staff should use the guidance and information supplied by the Health Protections Agency (HPA). All clinical computers will have a direct link to the website from their desktops. Desktops in Dispensary and Reception will also have access as directed by the line managers for those areas.

Infection Control Contact Details

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Useful links

Health Protections Agency www.hpa.org.uk.

Cleaning schedule for Chew Medical Practice

Spillages

1 INTRODUCTION

Healthcare associated infections (HCAI) are infections that are acquired following admission to hospitals or as a result of healthcare interventions in other healthcare facilities. There are a wide range of pathogens and communicable diseases besides *Methicillin Resistant Staphylococcus Aureus* (MRSA) and *Clostridium difficile* (CDI). Much of the morbidity and mortality associated with HCAI is preventable, and there is ongoing public and political interest in ensuring that the risks of preventable infections are minimised. Infection control is also an indicator of broader clinical governance and quality issues in every establishment.

Healthcare workers may also acquire infections related to exposure to micro-organisms at their workplace. The guidelines produce necessary guidance to identify and minimise the risk of infections and diseases. Extensive research has shown that cleanliness contributes to infection control and a clean environment is the best platform to tackle healthcare associated infections. The Department of Health recommend the implementation of good infection control techniques and regular auditing to make sure standards are kept and updated as the need requires.

2 PURPOSE AND SCOPE

This document is set out to provide guidelines on infection prevention and control within the practice in order to reduce HCAI and to reduce transmission of infections to healthcare professionals and patients.

3 DUTIES AND RESPONSIBILITIES

Every member of staff has a duty of care to prevent healthcare associated infection and all arrangements in the practices should comply with the following legislations;

The Health and Safety at Work Act (1974) Ensures that employers provide, when possible, a safe environment not only for the employees but all those visiting the working area, it also requires the employees to be responsible for their own safety and that of others.

Health and Safety at Work Regulations (1999) Ensures that the employers to risk assess anything that may be detrimental to the employees' health and put control measures in place. In relation to infection control, the employers have a responsibility to ensure that staff is protected from exposure to infectious hazards through safer systems of work. These include; personal protective equipment, hand washing facilities, safe disposal of waste and safe handling, storage and carriage of specimens.

The Control of Substances Hazardous to Health (COSHH) Regulations (2002): Offers guidance regarding the protection against hazardous substances, including chemical and biological agents in the workplace. In order to make sure this is adhered to the employer needs to make sure that there are policies and guidance in place and they are implemented, regularly reviewed and updated.

4. This policy will be reviewed every 2 years or sooner if any relevant guidelines contradict the contents of this policy.

5 MONITORING COMPLIANCE AND EFFECTIVENESS

Monitoring Group in the Practice

The Lead nurse is the infection control lead. The partners have overall responsibility in ensuring effective infection control practices in the practice. Other practice staff, such as receptionists and Dispensary staff are encouraged to attend relevant training as identified on the Practice's training matrix, this will enable them to understand the issues involved.

Infection Control should be discussed regularly at group meetings where a report should be made on infection control issues and actions agreed to improve infection control in the practice.

The practice should aim to provide assurance that the risks of healthcare associated infections are minimised and that services are delivered in a safe and clean environment.

The practice should ensure development and implementation of the action plan from the outcome of the Self Audit Tool. Improvements made should be reflected through the subsequent audit submitted by the Practice.

The practice also has the responsibility to:

- Ensure that the Practice is compliant with the Code of Practice for The Health & Social Care Act 2008.
- Ensure that the Practice is compliant with the required staff immunisation programme; and that records of immunisation are kept for the Care Quality Commission (CQC) inspection.
- Ensure that all clinical staff have a yearly mandatory training update on infection control and that records are kept for CQC inspection.
- Register the Practice with the Care Quality Commission when invited to do so.

Infection Control Link (IC Link) within the Practices

One member of the senior staff should be appointed as IC Link. This person will have gone through a basic training course on infection control to take on the lead on infection control. He/she can attain further inputs on current practices in infection control through attending seminars and/ or conferences on infection control. This should be part of the staff CPD.

The IC link is Becky Wych. All minutes of the CCG infection control meetings will be added to Intradoc under the infection control folder under link meetings. A hard copy will also be available on hard copy on the notice boards in the corridor.

6. STANDARD PRECAUTIONS

Standard precautions were formally known as Universal Precautions and were developed in the 1980's during the HIV/Aid's epidemic. They were developed in order to protect healthcare workers from blood Bourne viruses. These have since been adapted and renamed Standard precautions so they are used within normal practice.

Standard precautions consist of nine elements based on the use of practices and procedures to prevent or reduce the likelihood of an infection being transmitted;

- Hand hygiene
- Personal Protective Equipment (PPE)
- Safe use and disposal of sharps
- Safe handling and disposal of waste
- Maintenance of a clean clinical environment
- Decontamination of equipment
- Storage of Sterile Equipment

6.1 Hand Hygiene

Hand washing is the single most important means of controlling the spread of infection. The micro-organisms on the hands are grouped into two categories - resident and transient flora. Resident flora are usually of low virulence and rarely cause infections except when introduced into the body through introduction of a urinary catheter, or an open wound. Transient flora may consist of many different pathogenic micro-organisms. They are not firmly attached to the skin and can usually be removed quickly and effectively with soap and water.

Hands should be decontaminated either by washing or using an alcohol hand gel after every patient contact. If hands are visibly dirty and have been in contact with blood or body fluids, the choice for hand hygiene should be handwashing.

Alcoholic hand gel, if used, should be rubbed into hands using the “Six Stages of Handwashing Technique (see 6.1.2).

The purpose of hand hygiene with adequate drying is to remove transient microbial contamination that has been acquired during contact. The hands should be dried properly after washing because this reduces the number of organisms subsequently released from the hands.

Dedicated hand washing basins should be available in all clinical areas including consultation room, treatment room, chiropody room and children clinic room. They should be fitted with elbow operated mixer taps.

Yearly hand hygiene training for all staff in the practice and records of training should be available at all times.

Examples when hand washing should take place are:

- Before preparing, handling or eating food
- After visiting the toilet
- Whenever hands are visibly dirty
- After removing gloves
- Before wearing sterile gloves
- Before and after examining patients
- Before and after administering medications
- After any possible action that may have resulted in microbial contamination
- Before and after handling wounds, catheters, intravenous lines, peg feeders
- Before and after handling urine specimen samples
- Before caring for those patients immune-compromised
- Before starting work and after you have finished
- After handling contaminated waste and/or laundry

Table 1: Hand washing agents

Hand Washing Agents	Instruction for Use
Liquid Soap	Disposable paper towels should be used for hand drying and dispensed from a wall mounted dispenser.
Chlorhexidine (e.g. Hibiscrub) or Povidine iodine 7.5% (surgical scrub e.g. Betadine)	These preparations should be used prior to minor surgery. Not for routine use. Wet hands and forearms, apply solution and wash for 2 minutes. Ensure individual fingers and thumbs are washed. Rinse. Dry hands thoroughly using sterile paper towels before putting on a pair of sterile gloves.

6.1.1 Hand washing technique

An appropriate technique for handwashing will ensure that hands are cleaned effectively. What follows is a good, basic technique that should be followed every time hands are washed in the clinical environment.

- Get water to correct temperature, not too hot or too cold
- Wet your hands before putting liquid soap on
- One squirt of liquid soap
- Perform six-stage handwashing technique for 10-20 seconds of rubbing (see 6.1.2), remember to include the wrists.
- Rinse hands thoroughly – remove all traces of soap
- Dry hands with paper towels – especially between fingers.
- Dispose of paper towels into foot-operated domestic waste bin.
- Turn taps off – with elbows if elbow operated taps or with a clean, dry paper towel.

6.1.2 Six Stages Hand Washing Technique.

Rinse the hands under running water and apply soap,



Rub hands together palm to palm.



Interlock fingers to reach in between the fingers.



Place one hand on the back of the other and rub, interlock fingers. Change over to do the other hand.



Clean the back of the fingers into the palm of the other hand and rub. Change over to do other hand.



Clean the thumbs by rotational rubbing in the palm of the opposite hand. Change over to do the other hand.



Clean the palm of the hand by a rotational rubbing, backwards and forwards with clasped fingers in to one hand at a time.

The hands should then be placed underneath running water to ensure all soap is off the hands, any soap left on the hands may result in skin irritation. Hands should be thoroughly dried with hand towels. An alcohol based gel can be used when hands are physically clean i.e. have no visible dirt and the technique used to wash hands can be rub in the alcohol gel until dry. If the patient has or is suspected to have Clostridium Difficile (C Diff) the alcohol gel alone is not efficient enough in killing the spores therefore the hands should be thoroughly washed and followed by alcohol gel. A moisturising lotion should also be made available to help prevent the skin from drying out following frequent hand washing.

Requirements

In order to carry out this washing technique the following things need to be in place

- Easy accessible sinks
- Hot and cold mixer taps
- Elbow or wrist operating taps to reduce the risk of hand contamination
- Liquid soap with disposable cartridges, soap bars are not suitable for the clinical setting as they can colonise bacteria which therefore make them source of cross-infection.
- Wall mounted paper towel dispensers. Reusable towels are not suitable within the clinical setting as they may be contaminated with micro-organisms and therefore a source of cross-infection
- Nail brushes should not be used within the clinical setting
- Alcohol hand rub should be made available to disinfect hands when they are already physically clean (have no visible dirty)

6.2 Personal Protective Equipment (PPE):

The Personal Protective Equipment Regulations (1992) require the assessment of where personal protective equipment (PPE) needs to be used. The equipment needs to be suitable and sufficient for the task and to comply with CE or BS standards.

Protective clothing aims to prevent the transmission of micro-organisms between patients and health care staff. The need to wear protective clothing will depend upon the potential risk associated with the planned task. It is the health care worker's responsibility to assess this risk and decide upon the necessary clothing as appropriate.

6.2.1 Disposable plastic aprons

Disposable plastic aprons should be worn when contamination of clothing with blood and body fluids is anticipated. Plastic aprons should be discarded after each procedure and between patients and disposed of any clinical waste.

6.2.2 Mouth and nose masks

Masks should be available for use for procedures where blood or bodily fluids are likely to splash onto the face. The masks are disposable and should be thrown away following use.

6.2.3 Gloves

Disposable gloves should be worn when contact with blood/body fluids is anticipated, during direct contact with non-intact skin or mucous membranes or when dealing with chemicals/hazardous substances.

Increased awareness of the need to use gloves as part of standard precautions has resulted in a significant increase in usage. It is important to note that gloves are an additional precaution and should not be solely relied upon as a barrier to infection.

- Risk assessment must be made for each patient contact with known infectious disease, e.g. Methicillin Resistant Staphylococcus Aureus (MRSA) that the correct protective clothing is worn.
- Supplies of disposable gloves, aprons and masks (if necessary) should be accessible in clinical rooms and treatment rooms.

6.2.4 Essentials of glove usage

- Glove usage should be decided following a risk assessment of the planned task e.g. consideration of: who is at risk (patient or healthcare worker (HCW) and whether sterile/non sterile gloves are needed; the potential for exposure to blood, body fluids, secretions and excretions; contact with non-intact skin or mucous membranes during general care and invasive procedures.
- Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions or sharp/ contaminated instruments.
- Gloves should not be worn as an alternative to hand washing. It is vital that good hand hygiene is maintained.
- Hands should be washed before and after glove use.
- Gloves should be changed after each procedure and between patients.
- Never re-use disposable gloves.
- Reports of latex allergy are increasing. Therefore prolonged, unnecessary usage should be avoided.
- Non-powdered latex gloves must be used as standard. Evidence suggests that powdered gloves increase the risk of developing a latex allergy.
- Individuals sensitised to latex gloves must be supplied with appropriate alternatives (e.g. nitrile/synthetic vinyl (CE approved) gloves)
- Sterile gloves are indicated for aseptic or surgical procedures, especially where sterile materials are handling.

6.2.5 Which glove?

Employers must provide gloves that conform to European Community Standards (CE) for safety and performance and need to provide those which are acceptable to practitioners. Disposable gloves are manufactured in variety of materials. The following is a selection of glove materials currently available.

Natural rubber latex (NRL) have been in use for over 100 years and remain the preferred material for glove manufacture and protection against blood borne viruses (BBVs). NRL gloves are close fitting, do not impair dexterity and are not prone to splitting. Because of this, they are the gloves of choice when contact with blood and body fluids is anticipated.

NRL gloves can be sterile/non-sterile, depending on the task to be performed. The problem of HCW/patient sensitivity to NRL proteins must be considered when deciding on glove materials.

Nitrile/polychloroprene

Offers a good synthetic alternative to latex but is more expensive. They can be used during procedures where dexterity is required and also when contact with blood/body fluids is anticipated. However, nitrile gloves have the chemical range as NRL and may also lead to sensitivity problems.

Vinyl

Vinyl gloves are inexpensive and may be suitable for use in areas where there is a low bio-hazard risk. In the past they have been considered to be rigid, inflexible and prone to break or leak when in use. They were therefore not considered suitable for use when dealing with blood/body fluids or when manual dexterity was required. However, in 2000, standards for the manufacturing of medical gloves for single use were devised and implemented. All gloves were then required to perform to the same standard regardless of material. It is now considered that vinyl gloves made to European Community (CE) standards provide the same level of protection as NRL.

Polythene

Polythene gloves are not recommended for use in the clinical setting. They are ill-fitted, predisposed to splitting/tearing and providing limited protection. They must not be used when contact with blood and body fluids is anticipated.

Sterile vs. non-sterile gloves

Sterile gloves should be worn during all surgical procedures, during aseptic invasive procedures with potential exposure with blood-body fluids and during sterile pharmaceutical.

Non-sterile gloves are required during procedures when hands are likely to become contaminated with organic matter and micro-organisms (e.g. removing dressings, venepuncture, cleaning blood/body fluids spills)

6.2.6 Latex Sensitivity

As the use of latex gloves has increased, reports of latex sensitivity amongst health care workers and patients have risen. The risk of allergic reactions is not only related to gloves but can involve other latex based devices. Reactions are classified as:

- Delayed hypersensitivity (type IV) resulting in contact dermatitis. This is the most common hypersensitivity reaction to NRL. Response occurs between 6-48 hours after exposure.
- Immediate hypersensitivity (type I) – Anaphylactic shock/collapse. Response occurs 5-30 minutes after exposure. Individuals with history of anaphylaxis caused by latex must avoid the use of latex gloves and devices.

6.2.7 High risk populations

The following groups appear to have an increased risk of developing a latex allergy:

- Individuals with frequent occupational exposure.
- Atopic individuals – those with a predisposition to allergic reactions (e.g. hay fever, asthma).
- Individuals with food allergies (e.g. bananas, avocado, tomato and kiwi fruit).
- Frequent healthcare interventions – individuals with conditions which require frequent healthcare interventions, particularly where latex devices are used (e.g. spinal bifida, congenital urological abnormalities or any conditions required repeated surgical intervention).

Seek specialist advice if latex sensitivity is suspected. If the individual is sensitised, then all notes should be clearly marked (included dental and hospital notes). In type I reactions, the individual should wear a Medic Alert bracelet.

6.2.8 Minimising the risk

Healthcare Staff

- Only use latex gloves when required. Powered gloves are not recommended due to the increase allergy (although some form of gloves should be used).
- Wash and dry hands before and after glove use
- Ensure that staff is aware of the risk of latex sensitivity and the methods to reduce it.

Patients

- Ask patients about history of latex allergy. If latex allergy is known, document in notes and seek specialist advice.
- Remind patients with known allergy to inform medical professionals before any form of treatment commences.

6.3 Safe use and disposal of sharps

Needlestick injuries are instrumental in the transmission of bloodborne viruses. Most of these injuries occur due to mishandling of sharps. All staff should be aware of their health-related obligations and ensure that their own routine immunisations are up-to-date (including BCG, chicken pox, MMR and Hepatitis B).

Sharps include needles, scalpels, broken glass, teeth, stitch cutters, glass ampoules and any other items that may cause skin puncture or laceration. The safe handling and disposal of sharps is essential in reducing the risk of exposure to blood borne viruses. The risk of injury can be minimised by adhering to accepted good practice.

6.3.1 Sharps, needlestick and splashing incidents

In the event of one of the following incidents:

- Inoculation of a staff member with a patient's blood/ body fluids by a needle or other sharp item previously used on a patient
- NOT urine or faeces (unless they contain blood)
- Contamination of **broken** skin with bloody/body fluid
- Blood/body fluid splashes in the eye, nose or mouth
- Contamination with a patient's blood/ body fluid to such a degree that a change of clothing is needed
- Contamination of oral mucosa with blood/ body fluid

PLEASE ALSO SEE SEPARATE HEALTH AND SAFETY POLICY

The immediate action to be taken following a needle stick injury is available and on display throughout the practice. These are located in all clinical areas.

6.3.2 Safe methods of work:

- Never re-sheath contaminated needle manually.
- All sharps used should conform to European standards these should be obtained from SPS. (Their details can be located on Intradoc under needles)
- Sharps should be disposed of immediately after use.
- Sharps should be placed directly into an approved container by the user.
- Never leave sharps to be disposed of by someone else.
- Dispose of syringe and needle as one unit directly into sharp containers wherever possible.
- Containers should be conveniently placed for staff use. Where appropriate, take the container to the point of use.
- Ensure that the bin is correctly assembled and that the lid is securely fastened before commencing use.
- Sharps containers should not be placed on the floor, on an unstable surface or above shoulder height. They should be inaccessible to children and unauthorised persons.
- Containers should be sealed and disposed of when three-quarters full (do not attempt to press down on container to make more room)
- Never attempt to retrieve any item from a sharp container.
- Containers must not be placed into yellow bags prior to disposal.
- If a sharps container is damaged, placed into a larger container, lock and label prior to disposal.

Immediate action following an inoculation accident or accidental exposure to blood or body fluids

**IMMEDIATE ACTION
STOP WHAT YOU ARE DOING AND
ATTEND THE INJURY**

Encourage bleeding of the wound
by applying gentle pressure.
Do not suck.



Wash well under running water.



Dry and apply a waterproof dressing, as necessary.



**If body fluids splash
into eyes, irrigate with
cold water.**



**If body fluids splash into
mouth, do not swallow,
rinse out several times
with cold water.**



Report incident to your manager.



Complete accident form.

**Initiate investigation as to the cause of the incident
and risk management.**

Injury from clean/unused
instrument or needle – No
further action likely

Injury from used needle or
instrument – Risk assessment
by General Practitioner on
duty, Occupational Health
or
A&E doctor

6.3.3 Sharps Containers

There are several types of sharps bins currently on the market but all must conform to British Standard BS7320; 1990. When the bin is three quarters full, close securely and change. The bin should be labelled with Surgery name, our address and date before disposal; sealed bins should not be placed in yellow bag prior to disposal. Ensure that sealed bins awaiting collection are housed in a locked area which is inaccessible to unauthorised persons. The sharps bins should be placed in the Sluice room with staff only access.

6.4. Managing Spillages

- Deal with blood and body fluid spills quickly and effectively.
- Reception have facilities which deal with spillages.
- Urine and stool contamination should be treated as an infectious clean, unless they are blood stained.
- Blood stained carpet should be replaced.

How to deal with it:

- ***If the spillage is about an incontinence pad size –***

Spread the NaDCC granules generously over the spillage, leave it for 3-minutes (this allows the granules to kill the bloodborne viruses). Move the yellow clinical bin close to the spillage. Three minutes later, remove the spillage with apron & gloves and dispose of it directly into the clinical bin.

- ***If the spillage is more than an incontinence pad size –***

Put on apron & gloves and soak up the blood & body fluids with absorbent pads or incontinence pads; place them directly into a close-by orange/yellow clinical bin.

PLEASE ENSURE THAT YOU HAVE WRITTEN THIS IN THE CLEANERS BOOK SO THAT THE AREA CAN BE DEEP CLEANED.

6.5 Specimen Handling

Please refer to separate policy

6.6 Waste Management

Please see separate policy. The lead for waste management is Kate Davenport.

6.7 Cleaning of Medical Equipment & Environment

6.7.1 Cleaning of Medical Equipment:

- Clean medical equipment as per manufacturers' instructions between patients.
- Single-use items must be disposed of after each use (**Appendix B**).
- All reusable instruments, if in use, must be sent to the contracted central sterilization department (CSSD) for high level disinfection or sterilisation for instruments which enter into sterile areas like a wound. CSSD has a controlled environment with trained staff to reprocess and sterilize medical instruments.
- A 'Decontamination Certificate' must be affixed to any medical equipment due to be returned to the Equipment Library, for service & repair; showing the date of cleaning and the name and title of the staff who did the cleaning
- There is a cleaning schedule in all treatment rooms located on the back of doors.

6.7.2 General Environmental Cleaning

Please refer to cleaning schedule. Environmental cleaning is carried out by the Cleaning Co-operative and separate policies/ audits are available. If there is any concern about the standard of cleaning this should be reported to the infection control lead or practice manager. There is also a cleaning communication book which can be located in reception.

6.8 Decontamination of Equipment

Equipment to be sent for inspection, service or repair

- Equipment which has been contaminated with blood/body fluids, or has been exposed to patients with a known infectious disease should be decontaminated before being to third parties for inspection, service or repair.

- All equipment to be inspected, serviced or repaired must be labelled indicating that the item either:
 - Has not been in contact with blood or body fluids
 - Has been cleaned and decontaminated
 - Could not be decontaminated

If equipment cannot be decontaminated (e.g. if device needs to be dismantled by an engineer), a biohazard label should be attached, together with a completed label and the article wrapped in a strong plastic cover.

7. Instruments Storage of Sterile Instruments

Correct storage of sterile instruments is important in order to protect the integrity of sterilised equipment.

- All sterile packages, including sterile fluids, are stored above the ground to avoid contamination and to allow proper cleaning of the floor
- All sterile packages should be stored in cupboards or enclosed drawers.
- All sterile packages should be stored away from dirty areas and away from hand basins. Instruments in a wet package are considered non-sterile.
- Store sterile instruments in plastic or other wipeable containers, but not those made from cardboard as it sheds and creates dust and debris.
- Before use, examine wrapping for damage or damp & expiry dates.
- Expired single-use instruments should be disposed of.

8. Aseptic Technique

Aseptic technique is the term used to describe the methods used to prevent contamination of wounds and other susceptible sites by organisms that could cause infection (Marsden Manual of Clinical Nursing Procedures).

The aims of aseptic technique are:

- To prevent the introduction of pathogens to the site
- To prevent the transfer of pathogens from the patient to staff or other patients.

An aseptic technique should be implemented during any invasive procedure that bypasses the body's natural defences.

An aseptic technique should also be adopted when undertaking the following procedures (this list is not exhaustive):

- Dressing wounds
- Removal of sutures or clips
- Endotracheal suction
- Dressing tracheostomy site
- Urinary catheter change

The procedure is undertaken either with forceps or sterile gloved hands. The important principles are that the susceptible site should not come into contact with any item that is not sterile.

Any items that have been in contact with the wound will be contaminated and should be disposed of safely or decontaminated for reusable instruments.

Cleaning of trolleys with detergent and hot water is sufficient, as the sterile field will be created by the sterile towel contained within the dressing pack.

Bacteria acquired on the clothing during the procedure may be transferred into the wound of another patient, therefore a clean disposable apron should be used for each dressing procedure.

9. Management of Chronic Wounds

If dressings are removed by soaking, a plastic impermeable liner/bag should be placed in the bucket/bowl before filling with water.

After the wound has been washed then water should be disposed of in a sluice or a sink which is separate from the hand wash sink.

The plastic liner should be disposed of and the bowl should be thoroughly cleaned with detergent and hot water, and then dried to ensure that pathogens are removed. Patients should provide their own bowls and have their own bowls.

This process should be undertaken after each separate patient episode. With buckets and liners provided by the patient

9.1 Wound Swabbing

Swabbing should only be undertaken if wound/ site of invasive device exhibits signs of infection. They should not be taken routinely, or if wound/ site is healing.

A wound should ideally be swabbed if it looks infected before commencing antibiotics.

10. Minor Surgery Room/ Treatment Room

It is preferable to have a room dedicated for minor surgery. There should be an appropriate changing facility for the patients to respect their privacy & dignity. The general tidiness and cleanliness is not to be compromised with a strict cleaning regime.

Requirements:

- A mixer elbow tap hand basin with wall mounted Hibiscrub or Povidine Iodine 7.5% for hand decontamination before minor surgeries
- The room should be clear from unnecessary storage and clutter to allow for easy cleaning at the end of each session.
- The couch should have good lighting for the procedures
- The couch should be covered with disposable couch paper and to be changed with each patient.
- The couch should be wiped down with Hypochlorite solution (see Table 1) after each session of surgery.
- Aseptic technique should be used for all minor surgeries and the trolley is to be wiped down in between patients.
- Windows should be closed with no electric fan switched on while minor surgery is in progress to prevent dispersal of dust and thus contamination to the new wound.
- All waste from this room should be treated as clinical waste; except the packaging of products.
- Disposable instruments must be disposed of at the end of each case into the sharps bin or clinical bin, if the instruments have no sharp ends.
- The horizontal surfaces of the minor surgery room must be wiped down by the nursing staff after each session; preferably with 1,000 parts of sodium hypochlorite solution made for healthcare settings. (COSHH 1999).
- Cleaning of the minor surgery room after each session must be recorded and signed by the nurse, in a log book.