



Nestor  
Healthcare  
Group plc

# PRIMECARE INFECTION PREVENTION AND CONTROL POLICY

## GUIDANCE FOR ALL STAFF

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## INTRODUCTION

Infection Prevention and control is of utmost importance to Primecare.

As Independent providers of regulated healthcare activities Primecare will be required to comply with the full set of requirements under The Health and Social Care Act 2008: Code of Practice for health and adult social care on the prevention and control of infections and related guidance (DH, 2009) dated 16 Dec 2009.

We consider infection prevention and control (IP&C) as essential to the safety of our patients, their families, carers and all our employees. It is an important Organisational Clinical Governance Assurance Standard.

Appropriate infection prevention and control measures will ensure that the organisation can both identify and minimise risks to patients and staff and the purpose of this guidance is to serve as an aid and reference to our workforce.

Primecare aims to ensure that all our procedures are compliant with the extensive agenda of legislation and regulations governing safe practice

It is intended that the contents of this guidance document will provide a basis for clinical audit and that it should be regarded as a guide to best practice.

These guidelines apply to all staff working for Primecare.

The aim is to support staff to fulfil their legal responsibilities and their professional obligations in terms of controlling the spread of communicable disease, infection prevention and infection control and to identify and minimise risks to patients and colleagues in the working environment.

This guidance will set in place policies, procedures and guidelines which will support staff in the provision of patient care, promoting safe places for treatment and safe places to work.

## POLICY STATEMENT

**This guidance emphasises the key roles that all staff have in helping to reduce the prevalence and incidence of health care associated infections.**

**It is the policy of Primecare that all staff groups will be educated to understand the principles and practice of effective infection prevention and control. All staff are responsible for the prevention and control of infection. The Infection Prevention and Control Lead will act as an advisor and facilitator to all staff when necessary.**

## SCOPE

This document applies to all staff including agency, locum and bank staff.

NB: In relation to IP&C Staff should ensure that they familiarise themselves with and follow local IP&C policies when working in non-Primecare premises

The purpose of this document is to outline the Basic Principles of Infection Prevention and Control;

Infection Prevention and control is based on the use of practices and procedures that prevent, or reduce, the risk of infection being transmitted from a source of infection (e.g. a person, contaminated body fluids, equipment, environment etc.) to a susceptible individual.

## GENERAL PRINCIPLES OF INFECTION PREVENTION AND CONTROL (STANDARD PRECAUTIONS)

As it is not always possible to identify individuals who are infected or colonised from those who are not. **Basic infection prevention and control principles and procedures must be adopted when caring for every individual.** The aim of standard precautions is to protect both healthcare staff and every individual in their care from the transmission of infection during health care procedures whether the risk is known or unknown.

These precautions ensure maximum protection without the need to ascertain or divulge information on infection status that may be considered confidential.

Standard precautions underpin routine safe practice, protecting both staff and clients from infection. By applying standard precautions at all times and to all patients, best practice becomes second nature and the risks of infection are minimised. The safe practices include:

1. Achieving optimum hand hygiene
2. Using personal protective equipment
3. Safe handling and disposal of sharps
4. Safe handling and disposal of clinical waste
5. Managing blood and bodily fluids
6. Decontaminating equipment
7. Achieving and maintaining a clean clinical environment
8. Managing accidents
9. Good communication – with other health care workers, patients and visitors
10. Training/education.

### Risk assessment

As a registered provider of health care services for and on behalf of the NHS this document illustrates how Primecare ensures that we have made suitable and sufficient assessment of the risks to the person receiving care with respect to the prevention and control of infection.

This guidance outlines the procedures which we will implement to reduce and control those risks and describes how we will monitor and report upon infection prevention and control procedures across our business.

It sets out our objectives in order to meet the needs of the organisation and to ensure the safety of our service users and specifies priorities for action.

Primecare's Quality and Safety Central team are responsible for the organisations infection prevention and control management infrastructure.

The team Quality and Safety Central team oversee regional offices control of infection policies and their satisfactory implementation. The team will ensure through inspection and audit that

regular reporting of standard and recognised infection prevention and control procedures to Operational Directors is assured;  
The Quality and Safety team have the authority to challenge inappropriate practice;  
To assess the impact of all existing and new policies on infections and to make recommendations for change;

**Assurance:** The Quality and Safety Central team will regularly report infection prevention and control compliance to the Senior Management Team (SMT) at quarterly Quality Assurance meetings.

This report will include a review of statistics on incidence of alert organisms and conditions, details of the audit process and a trend analysis on outbreaks or incidents of infection. Serious untoward incidents (SUI) and Root Cause Analysis (RCA) reports will incorporate evidence of appropriate actions which have been taken locally and regionally following occurrences of infection. SUIs and RCAs must be performed for all cases of MRSA Bacteraemia and deaths where *Clostridium difficile* is cited as a cause of death under section 1 or 2 of the death certificate.

These assurance processes are integral features of Primecare's governance and therefore contributes to service user safety. Reports on regional infection prevention and control are available to all stakeholders on request.

## HAND HYGIENE

**Hand hygiene is widely acknowledged to be the single most important activity for reducing the spread of disease, yet evidence suggests that many health care professionals do not decontaminate their hands as often as they need to or use the correct technique which means that areas of the hands can be missed.**

### HANDWASHING

Primecare actively promotes effective hand hygiene procedures. We will actively encourage, monitor and manage all staff in clinical areas to ensure that they adhere to the following principles:

### ROUTINE HAND DECONTAMINATION

The aim of routine hand washing is to remove the dirt and most transient micro-organisms found on the hands and it is carried out:

- Before starting work
- Before eating and handling food
- Before and after giving any direct care to each patient
- Before administering medications - other than injections (see below)
- After any activity that contaminates the hands
- After using the toilet

- After sneezing/blowing the nose
- After cleaning activities
- Before going home
- And any other occasions when hands are thought to have been contaminated
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## HAND WASHING FACILITIES

Hand washing can be improved by the provision of adequate and conveniently located facilities. Basins must be provided where hand washing is required and in all areas where client consultations may take place. Clinical hand-wash basins should not have a plug or overflow, and should have elbow, or foot-operated mixer taps. A separate sink should be available for other cleaning purposes, such as cleaning instruments. Wall mounted liquid soap/ alcohol gel dispensers with disposable soap/gel cartridges are recommended. Dispensers must be kept clean and cartridges replenished regularly. Disposable paper towels must be conveniently sited next to the basins. Soft paper towels will help to avoid skin abrasions. Foot operated pedal bins must also be positioned near the hand wash basin and be of the appropriate size.

While alcohol hand gels and rubs are a practical alternative to soap and water, alcohol is not a cleaning agent. Some micro-organisms are inherently resistant to alcohol, e.g. *Clostridium difficile* and Norovirus, in presence of these organisms hands must be washed with soap and water. Hands that are visibly dirty or potentially grossly contaminated must be washed with soap and water and dried thoroughly. Hand preparation increases the effectiveness of decontamination. You should:

- 1 Keep nails short, clean and polish free
- 2 Not wear wrist watches and jewellery, especially rings with ridges or stones when giving care.
- 3 Not wear artificial nails or nails 'jewels'.
- 4 Keep any cuts and abrasions covered with a waterproof dressing.
- 5 Remove your wristwatch, any bracelets and rings and roll up long sleeves before washing your hands (and wrists). In addition, bear in mind the following points:

### **The technique is more important than the solution used.**

A 10-15 second hand wash using liquid soap is adequate for the purpose of routine washing and decontamination.

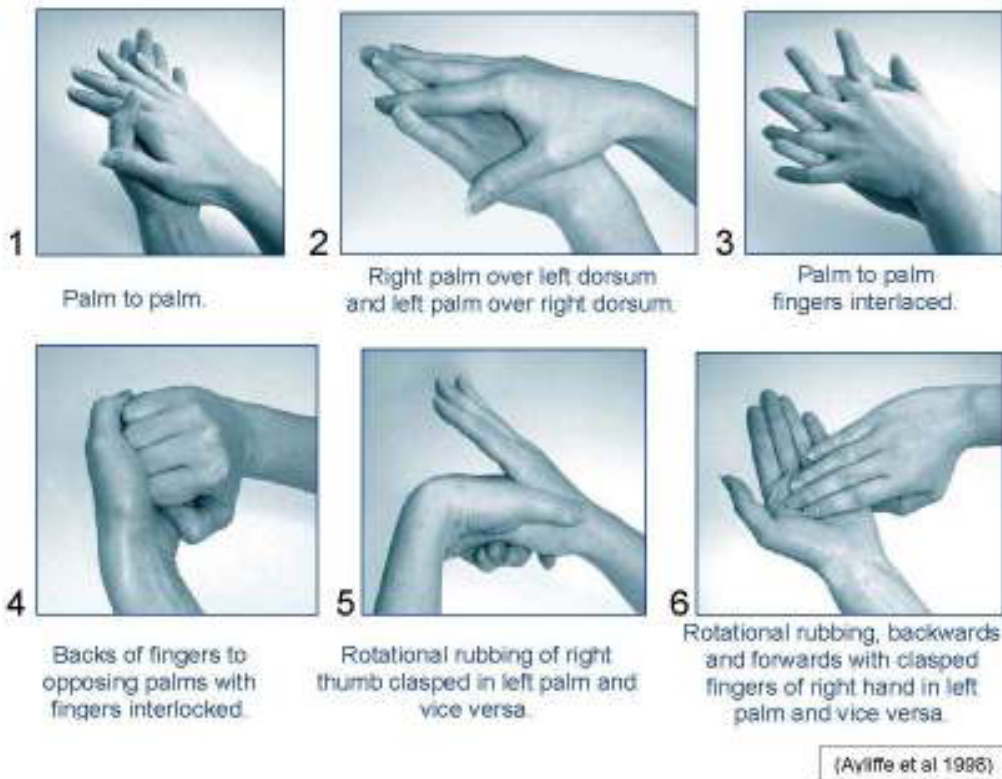
Expose the wrists and forearms. All parts of the hands must be included in the process.

Wet hands under running warm water before applying soap.

Apply liquid soap or aqueous antiseptic solution in the recommended product volume

Rub all parts of the hands vigorously, without applying more water, using the six-step technique

**Six Step Hand washing Technique**



Rinse hands under running water

Liquid soap is to be used because bar soap can become contaminated.

Disposable, cartridge-type system should be used to contain liquid soap, rather than a top-up system.

Aqueous antiseptic solutions or alcohol hand rubs/gels may be used as an alternative in place of soap and water if the hands are visibly clean but they are not a replacement for hand washing. Hands should be washed whenever time and resources permit. It is advisable to wash with soap and water as soon as practical after using alcohol gel.

Alcohol hand gel must be available in each clinical area and to all staff working in clinical areas. They are particularly useful when hand washing may be inconvenient, e.g. opening dressing packs, in the midst of routine care and when in patients' homes.

Conditions in some homes may prevent adequate decontamination. Hand rubbing with alcohol-based solution can be at least as effective as hand washing with either unmedicated soap or antiseptic agent, providing hands are visibly clean.

Alcohol gels should be rubbed in until completely evaporated. These gels have emollients incorporated thus reducing the viscosity of the alcoholic solution meaning the gel will spread easily over the surface of the hands.

**SURGICAL HAND WASHING**

The aim of surgical hand washing is the destruction of transient organisms and a reduction of resident microbes on the hands as well as to remove or destroy transient microbes. Surgical

hand washing provides a higher level of decontamination than routine hand washing. It is also used when caring for patients who are particularly vulnerable to acquiring infections, such as those in high risk areas like intensive care units. You can use the same aqueous antiseptic solutions and alcohol-based products that you use for routine hand washing (ensure follow local policy). The main differences are that you need to decontaminate your wrists and forearms and increase the time taken.

Clean each hand and forearm using rotational rubbing. Hold your hands higher than your elbows while you do this, so that water and debris drip away from your hands into the sink. You may use sterile disposable nailbrushes to clean the fingernails (refer to your local policy). However, you do not need to scrub your skin. There are a number of accepted methods. Three examples are outlined below.

1. Wash your hands and forearms with an aqueous antiseptic solution for 3 to 5 minutes and dry your hands and forearms completely.
2. Wash your visibly clean hands and forearms with an alcohol-based product for three minutes.
3. Use an antiseptic hand wash for three minutes, dry your hands and forearms completely and then apply an alcohol rub or gel for 4 to 5 minutes (Community Practitioners and Health Visitors Association 2007)

## HAND DRYING

**Dry hands thoroughly.** Improper drying can re-contaminate hands that have been washed. Conversely correct drying can further reduce the micro-organisms remaining on the hands after washing. Wet surfaces transfer organisms more effectively than dry ones and inadequately dried hands are prone to skin damage. Disposable paper hand towels of good quality should be used to ensure hands are dried thoroughly. Hand towels should be conveniently placed in wall mounted dispensers close to hand washing facilities.

## EMOLLIENTS

Although emollients are now standard ingredients in most liquid soaps and alcohol rubs, some individuals continue to experience soreness or sensitisation. Rinsing of the hands before and after washing will reduce this, and the use of hand cream may help to protect the skin. Communal pots must not be used because the contents become contaminated; use a pump-action container or individual tube. Hand creams must be compatible with the hand-washing agent as hand creams with an anionic emulsifying agent reduce the residual antibacterial effect of chlorhexidine. If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation the occupational health team should be consulted.

**Copies of the hand hygiene standards and laminated hand washing posters are available on request from the Central Clinical Governance Team**

More information about hand hygiene is available from the National Patient Safety Agency at <http://www.npsa.nhs.uk/cleanyourhands/>

## USING PERSONAL PROTECTIVE EQUIPMENT

### Personal protective equipment

- Staff should wear personal protective equipment (PPE) if there is a risk of exposure to blood or bodily fluids.
- These include gloves, aprons, masks and goggles/visors.
- Glove, aprons and masks should be used as single use items.
- Hands should be washed before and after using gloves.

**The wearing of gloves is not an alternative to hand washing**

## SAFE HANDLING AND DISPOSAL OF SHARPS

The term 'Sharps' encompasses needles, scalpels, stitch cutters, glass ampoules and any sharp instrument. The main hazards of a sharps injury are hepatitis B, hepatitis C and HIV. To reduce the risk of injury and exposure to blood borne viruses, it is vital that sharps are used safely and disposed of carefully.

**A sharps container should be available at the point of use and whomever uses the sharp is responsible for its safe disposal**

**Label sharps boxes as per local policy**

### MANAGEMENT OF CLINICAL SHARPS

- 1 Sharps are stored safely away from the public and out of reach of children
- 2 The user must discard sharps immediately after use directly into a sharps container.
- 3 Sharps must never be carried or passed in the hand, or be left lying around
- 4 Clinical sharps should be single-use only
- 5 Needles are never re-sheathed
- 6 Handling is kept to a minimum
- 7 Needles are not broken or bent before use or disposal
- 8 Syringes or needles are not dismantled by hand and are disposed of as a single unit
- 9 Sharps are disposed of at the point of use
- 10 Staffs take personal responsibility for any sharps they use and dispose of them in a designated container at the point of use. The container should conform to UN standard 3291 and British Standard 7320
- 11 Sharps containers are not filled by more than two thirds and are stored in an area away from the public
- 12 When carrying the container or when it is left unsupervised, close the aperture to prevent spillage, or tampering
- 13 Do not attempt to retrieve items from a sharps container
- 14 Do not attempt to press down upon sharps to make more room
- 15 Carry them by the handle; do not hold them close to the body

- 16 If sharps are spilled from a container use a safe technique to retrieve them, e.g. a dustpan and brush, and place carefully in a container
- 17 Do not place sharps containers on the floor, or above shoulder height; use wall or trolley brackets. Sharps containers should be placed out of direct sunlight
- 18 Sharps boxes are signed on assembly, final closure/locking and disposal
- 19 Staff should ensure they are aware of inoculation injury policy.
- 20 All staff injuries should be reported to the relevant Manager on shift and the injured person must report to Occupational Health Department or out of hours to A&E. Staff should familiarise themselves with local procedures for dealing with inoculation injury.

**If you notice that any of the above procedures are not being followed properly by colleagues you should inform your line manager and fill out an ACI form. Dispose of sharps boxes as per local policy.**

## MANAGING BLOOD AND BODILY FLUIDS

### SPILLAGES

To prevention and control infection it is important to minimise, reduce and eliminate potential environmental contamination. Standard precautions indicate that ALL blood and body fluids are potentially infectious. A written cleaning schedule, based on a Control of Substances Hazardous to Health (COSHH) (HSE, 2005) risk assessment should be followed when managing spillages of blood and body fluids.

All staff must ensure that any spillage of blood or body fluid is dealt with immediately. Staff must have access to the necessary equipment and procedural information. Correct procedure must be followed and any problems identified when dealing with the spillage must be reported to their line manager.

### PROCEDURE

- All body fluid spillage must be cleaned up immediately and effectively.
- Wear disposable gloves and an apron and ensure adequate ventilation.  
If there is risk of splashing a face visor or goggles and mask should be worn.
- Body fluid spillages of urine or vomit must be cleaned up using disposable spillage kits and discarded into a clinical waste bag. When carrying out this procedure protective clothing must be worn. Once the urine or vomit, which is not bloodstained, has been cleaned up, decontaminate the area with a chlorine preparation solution – 1,000 ppm chlorine (or Bleach based Product). If fabric will not tolerate the chlorine preparation, use warm water and detergent.
- If there is visible blood or blood stained body fluid present, (1% Sodium hypochlorite solution 10,000 Parts Per Million ppm) (Bleach based product) apply to cover the area and follow the manufacturer's instructions.
- Chlorine-releasing agents can be a hazardous especially if used in large volumes in confined spaces, or mixed with other chemicals or urine. A risk assessment and COSHH assessment must be carried out if using these chemicals.

- Never use mops to clear up body fluid spillages

Splashes of blood or body fluid on to the skin should be washed off immediately with soap and water.

Broken glass should never be picked up by hand, even if wearing gloves.

Disposable forceps, or a paper or plastic scoop should be used, and glass disposed of in the sharps box.

**N.B. Please ensure that local policies are adhered to in non-Primecare premises**

## **ACHIEVING AND MAINTAINING A CLEAN CLINICAL ENVIRONMENT**

A dirty clinical environment is one of the factors that may contribute towards infection rates. Conversely, high standards of cleanliness will help to reduce the risk of cross-infection. Good design in buildings, fixtures and fittings is also important to allow efficient cleaning.

Cleaning removes contaminants, including dust and soil, large numbers of microorganisms and the organic matter that may shield them, for example, faeces, blood and other bodily fluids.

All staff who work in a clinical setting should have a regular planned, written and monitored cleaning schedule that details the items and environments to be cleaned and the frequency of cleaning of each area and each item of equipment:

Before and after each clinic session

Daily

Weekly

Monthly

Annually

Additionally, cleaning equipment such as vacuums, floor scrubbing machines and polishers should be cleaned and properly maintained.

Contracted cleaning staff may not clean certain items of medical equipment. It will be the responsibility of the users of the equipment to clean it in these circumstances. Staff should be aware of which equipment they are required to clean, what to clean it with and how often such equipment needs cleaning.

## **PROCEDURES & GUIDANCE FOR OCCUPATIONAL EXPOSURE TO POTENTIAL BLOOD BORNE VIRUSES**

The aim of this guidance is to set out a framework to ensure that any exposure to blood borne viruses (BBVs), for example needlestick injuries, can be dealt with as quickly and as effectively as possible by all members of staff. The policy will concentrate specifically on Hepatitis B, Hepatitis C and HIV although the procedures and guidelines are relevant to other blood borne viruses.

Primecare takes its Health and Safety responsibilities very seriously with regard to BBVs and

recognises that staff individually have a responsibility to ensure they work safely and contribute to a safe working environment. However Primecare recognises that in some situations, despite good clinical practice cross-infection of BBVs may occur. This document also aims to give clear guidance on what to do in these circumstances.

Blood borne virus's (BBVs) which present the most significant hazards to health care staff are those associated with a carrier state with persistent replication of the virus in the human host and persistent viraemia (See references section on Blood-borne Virus). BBVs can be transmitted sexually or by direct exposure to infected blood or other body fluids contaminated with infected blood. In the workplace, direct exposure can happen through accidental contamination by a sharp instrument, such as a needle or broken glass. Infected blood may also spread through contamination of open wounds, skin abrasions, skin damaged due to a condition such as eczema, or through splashes to the eyes, nose or mouth.

All staff at risk of exposure to blood-borne viruses must be vaccinated against Hepatitis B. Managers should ensure staff have access to immunisation via Occupational Health.

A health care worker must follow standard precautions at all times when handling all body fluids – not just blood. The following body fluids can all pose a significant risk to the health care worker. It is worth remembering that members of staff are at risk from their patients as the patients are from staff. Many infected patients can be a symptomatic and may not know they are carriers of a blood borne virus.

Cerebrospinal fluid

Unfixed tissues and organs

Amniotic fluid

Exudates or other tissue fluid from burns or skin lesions

Peritoneal fluid

Semen

Pleural fluid

Vaginal secretions

Pericardial fluid

Breast Milk

Synovial fluid

Any other body fluid containing visible blood, including saliva in association with dentistry.

Healthcare workers may be at increased risk of exposure to blood borne viruses when performing Exposure Prone Procedures (EPPs). Exposure Prone Procedures are those procedures where there is a risk that injury to the worker may result in the exposure of the patient's open tissues to the blood of the worker. These include procedures where the health care worker's gloved hands come into contact with sharp instruments, needle tips or sharp tissues (e.g. spicules of bone or teeth) inside an open body cavity, wound or confined anatomical space where the hands or fingertips may not be completely visible at all times. However, other situations can present a risk, such as pre-hospital trauma care and care of patients where the risk of biting is regular and predictable.

If a health care worker is known to have or strongly suspects they may have a BBV, this does

not necessarily mean a change of job however the staff member must inform the Occupational Health department for their own and others safety. All professionally regulated staff are obliged, under their code of conduct, to inform their employers (Occupational Health Providers) if they believe they have a condition that could be a risk to their patients or colleagues. Health care workers with BBVs may be directed to refrain from Exposure Prone Procedures, which could put others at risk and cause them further illness; this would be a decision of the Occupational Health Consultant.

***Staff should consider the following precautions to reduce risk:***

- Prevent puncture wounds, cuts and abrasions, especially in the presence of
- blood and body fluids;
- When possible avoid use of, or exposure to, sharps such as needles, glass, metal etc, or if unavoidable take care in handling and disposal;
- Cover all breaks in exposed skin by using waterproof dressings and suitable gloves;
- Use good basic hygiene practices, such as hand washing;

**EXPOSURE TO BLOOD BORNE VIRUSES**

**(1) FIRST AID:**

**SHARPS INJURY:** Wash under running water. Encourage bleeding by gently squeezing.

**MUCOSAL EXPOSURE:** Irrigate with copious amounts of water. If eyes and wearing contact lenses irrigate before and after removing them.

**(2) REPORT:**

Complete CIF and report to Line Manager

Line manager to contact Occupational Health in hours and A&E out of hours

**THE PREVENTION AND CONTROL OF CLOSTRIDIUM DIFFICILE**

## WHAT IS CLOSTRIDIUM DIFFICILE?

*Clostridium difficile* (*C. diff*) is a micro-organism (any organism too small to be viewed by the unaided eye, such as bacteria) that causes diarrhoea and can lead to serious illnesses even death. It more commonly infects the elderly and the frail. *Clostridium difficile* is an anaerobic bacterium that can cause infection in the gut. The bacterium produces toxins, (A toxin is a poisonous substance, especially a protein, that is produced by living cells or organisms and is capable of causing disease when introduced into the body tissues) which damage the gut, causing illnesses of varying severity. Some people carry the bacteria without symptoms, many develop diarrhoea, in severe cases this can lead to colitis, (inflammation of the colon), and can cause death. *Clostridium difficile* can form spores; developing a thick protective capsule and slowing its metabolism. Spores are able to survive for prolonged periods of time in the environment, they are resistant to extremes in temperature, and desiccation, but when conditions become favourable again they germinate and multiply.

## CLINICAL SYMPTOMS

Diarrhoea is a stool that takes up the shape of its container; it is entirely watery with no solid pieces.

*Clostridium difficile* causes a range of symptoms from mild diarrhoea to life threatening colitis with ulceration and bleeding. The symptoms associated with *Clostridium difficile* can be life threatening. Management of the patient must include accurate monitoring of fluid and nutritional intake and staff must be alert to signs of dehydration and colitis. *Clostridium difficile* is transmitted from patients who are symptomatic. Spread does not occur from an asymptomatic carrier in the absence of diarrhoea. *Clostridium difficile* bacteria and spores are excreted in large numbers in liquid and often explosive diarrhoea. Diarrhoea is considered significant when a patient has more than 3 episodes in 24 hours. Symptoms of *Clostridium difficile* include:

- Mild to moderate diarrhoea (*Clostridium difficile* diarrhoea has a distinctive odour)
- Stomach cramps/tenderness
- Fever
- Loss of appetite
- Nausea

*Clostridium difficile* colitis is used to describe anyone who has an infection of the colon caused by *Clostridium difficile*. Colitis means inflammation of the colon, although in some cases the symptoms may be more severe resulting in toxic mega-colon and death.

## Spread of *C. diff*

Person to person spread is possible because those suffering from *C. diff* shed millions of the bacteria in their faeces. The spores can then survive for a long time in the environment and can be transported on the hands of the health care personnel who have contact with infected patients or with environmental surfaces (floors, bedpans, toilets, commodes) contaminated with *C. diff*. Stool samples received from hospital in-patients are most often routinely tested for this bacterium. However, as this may not be the case, all suspected cases should be investigated by sending a diarrhoeal faecal specimen to the microbiology department for detection of *C. diff* toxins. The problem of cross infection only exists when diarrhoea is present, especially if it is

severe or accompanied by incontinence.

Following are patients/clients who are at the greatest risk of infection:

- Elderly patients
- Long length of stay in healthcare settings
- Antibiotic exposure.
- Post-gastrointestinal surgery/manipulation.
- Immunocompromised medical conditions

## TREATMENT AND PREVENTING SPREAD OF C diff

Treat as per local protocols for minimising the spread of infection; this should include strict adherence to Primecare's and local antibiotic prescribing protocols.

***\* Antibiotics such as co-amoxiclav, cephalosporins and quinolones have been proven to increase the incidence of MRSA, C. diff and antibiotic resistant UTIs. As a company Primecare suggest that prescribers only use these in necessary circumstances and refer to local guidance for further information on antibiotic prescribing.***

All infected patients/clients should be segregated from non-affected patients/clients. Strict hand washing before and after patient contact remains the most effective control measure in preventing person-to-person spread of this infection. Alcohol gel should not be used on its own, as it is not effective against C diff infection. Hands should be washed with soap and warm water.

Wear non-sterile single use disposable gloves and plastic aprons when handling excreta.

The Health Protection Agency website provides some easy access information on *Clostridium difficile*: [http://www.hpa.org.uk/infections/topics\\_az/clostridium\\_difficile/c\\_diff\\_faqs.htm](http://www.hpa.org.uk/infections/topics_az/clostridium_difficile/c_diff_faqs.htm)

## CONTROL OF METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA) POLICY

### INTRODUCTION

Staphylococcus aureus is a common skin bacterium and around 30% of the healthy population carry it on their skin or in their nose at any one time, without causing harm. Several strains of Meticillin Resistant Staphylococcus Aureus (MRSA) have emerged that are resistant to many antibiotics, including meticillin. The risk of infection is increased in vulnerable groups that include newborn infants, the elderly, problem drug users and those who are admitted to hospital. The consequences of developing a serious infection with MRSA can be life threatening. Evidence to date strongly implicates MRSA as a significant cause of Healthcare Associated Infection (HCAI) resulting in increased morbidity and mortality in addition to increased healthcare costs. Until the early 1990s MRSA accounted for less than 5% of all staphylococcal bloodstream infections (bacteraemias). MRSA as a proportion of all *Staphylococcus aureus* bacteraemia has levelled out, over the years 2001 - 2006, at around 40%. Since 2006 there has

been a reduction in cases of MRSA bacteraemia but it remains a condition with high morbidity and mortality.

It is the responsibility of all staff to :

- Ensure that adequate infection prevention and control measures are taken
- Reduce the risks of transmission of MRSA, to ensure that correct procedures are followed and
- Ensure that any problems encountered when treating patients with or trying to control MRSA are reported to their line manager.

*Antibiotics such as co-amoxiclav, cephalosporins and quinolones have been proven to increase the incidence of MRSA, C. diff and antibiotic resistant UTIs. As a company Primecare suggest that prescribers only use these in necessary circumstances and refer to local guidance for further information on antibiotic prescribing.*

## INFECTION RISKS

The risk of transmission of MRSA within a domiciliary setting is generally low. However prevalence in residential care homes is increasing and healthcare associated infection or colonisation is become more common in such settings.

Transmission is related to direct contact with an infected or colonised individual, usually via the hands of health care workers, or indirect contact with the organism in dust or body fluids via contaminated equipment and surfaces. Infection prevention and control efforts should be concentrated on a good hand hygiene technique, particularly after contact with a person known to have MRSA, and ensuring that the environment is clean and dry. Alcohol hand gel must be available to all health care personnel working in clinical areas.

Good hand hygiene techniques and high standards of practice and environmental hygiene are important factors for reducing transmission of MRSA. Gloves and aprons should be worn when giving care to infected or colonised patients or where risk of contamination of clothing is likely.

MRSA will not normally infect a healthy person. Although it is possible for people outside healthcare to become infected most cases are among people in the following at risk groups.

### **At risk groups:**

Previous long term, recent or multiple courses of antibiotics

Previous admission to healthcare, particularly hospitals.

Patients over the age of 65 years

Having invasive medical devices or chronic skin conditions

Patients who have a weakened immune system

Patients having undergone surgery recently

Patients with open wounds, chronic wounds may be colonised.

### **COMMUNITY ASSOCIATED MRSA:**

While most cases of MRSA have the risk factors as mentioned above in recent years Community **Associated** strains of MRSA have been identified. These should be distinguished from Community **Acquired** MRSA, which may be a strain of MRSA which is either associated with

Hospital or the Community. Community associated MRSA strains may be genetically different from healthcare associated strains and can occur in people who do not have any of the risk factors mentioned above.

Community Associated MRSA is more likely to be found in the following groups of people: Injecting drug users; patients who have skin infections, lacerations and boils and carbuncles, infestation bites (fleas lice and scabies); patients who share equipment e.g. razors and clothing; patients who have poor standards of personal hygiene due to homelessness or living in hostels; those with a history of prison incarceration.

### MANAGEMENT OF MRSA IN COMMUNITY SETTINGS

Treatment to eradicate **MRSA colonisation** is not routinely recommended. Each case should be individually assessed; a patient who has **skin infections** e.g. boils and other skin lesions should be referred to a General Practitioner for investigation and treatment. If the patient requires antimicrobial therapy for their MRSA or other infections this should be prescribed with care and in accordance with the local antimicrobial prescribing guidelines. Advice on antimicrobial prescribing can be sought from the local area Consultant Microbiologist

- In their own home MRSA carriers are of no risk to healthy family, friends, and staff should give advice on good domestic hygiene including the washing of clothing and bed linen and cleaning of the environment. Clothing and bed linen should be washed on the hottest temperature the fabric can tolerate and tumble dried if possible. Crockery and cutlery can be managed in the normal way
- There should be no restrictions for patients attending social events or using public transport
- Patients with MRSA infection or colonisation attending hospital clinics or travelling by ambulance should notify the hospital and ambulance staff of their MRSA status. Carers are not at risk providing that good hygiene and the standard infection prevention and control precautions and guidelines are adhered to.

Additional information for those affected by MRSA, C diff and other HCAs is available at <http://www.clean-safe-care.nhs.uk/>

### EDUCATION & TRAINING:

Managers must ensure that a training needs analysis is conducted for all staff for which they are responsible. Regular training and updates will be conducted at the point of Induction and thereafter annually. The Infection prevention and control updates will include hand hygiene and all staff must access the update programme on a rolling 11 months turnaround. A log of all attendees will be automatically generated and for any staffs who do not register there Line Manager will be immediately notified. A central record will be kept and this will be subject to annual audit inspection.

## REFERENCES AND BIBLIOGRAPHY

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## Appendix 1 INFECTION CONTROL INSPECTION CHECKLIST

### Introduction

The purpose of this document is to provide the practice, centre, PCC with a tool with which to inspect the premises for infection prevention and control purposes. Refer also to the Infection Control Policy <sup>[\*]</sup>. Please complete all relevant fields.

### Section 1 – Practice/PCC Details:

#### Address of Premises:

**Date of Audit**

**Name / Designation of  
Person Completing Audit**

**Name / designation of  
additional person  
completing audit**

**Name / designation of  
additional person  
completing audit**

**Named person responsible  
for Infection Prevention  
and control within the  
Practice**

**Practice Manager**

**Senior Practice Nurse**

**Number of waiting rooms  
/ reception rooms**

**Number of consulting  
rooms**

**Number of treatment  
rooms**

**Number of "Dirty" utility  
rooms**

**Number of public toilets**

**Number of staff toilets**

**Other Areas**

Is minor surgery performed? Y / N

If Yes, Indicate which types

**Section 2 - Documentation and Environmental Issues:**

	Yes	No	Comments
Is there a daily and weekly cleaning specification written down?			
Do the cleaner / contractor follow it?			
Is the specification reviewed on a regular basis and is evidence of the review available?			
Are curtains and blinds cleaned as part of the specification?			
Is there a waste and a clinical waste disposal contract in operation?			
Are Waste Consignment notes provided at each collection and are they available for inspection?			
Is waste collected at least once per week?			
Do all external waste bins / skips have lockable lids, and are they locked?			
Is there a written infection prevention and control policy?			
Is the policy dated and is there evidence of review on at least an annual basis?			
Is the policy accessible to staff?			
Are there written instructions available relating to:			
Hand Hygiene <i>See Hand washing guidelines [*]</i>			
Use of protective Clothing			
Sharps			

Decontamination of equipment  
 Body Fluid spillage  
 Waste handling  
 Sterilisation and equipment cleaning  
 Handling of Specimens  
 Fridge cleaning and defrosting  
 Acceptance / purchase of toys  
 Cleaning of toys  
 Needle Stick Injury  
 Is there evidence of review of these within the last 12 months?  
  
 Is the Medical Device Agency (MDA) DB 9605 document, or the MDA DB 2000 (O5) document available – Purchase Operation and maintenance of (vacuum) Bench Top Steam Sterilisers (if appropriate)?  
  
 Are steriliser maintenance documents available for inspection?  
  
 Is there a steriliser pressure testing certificate available dated within the last 12 months?  
  
 Are COSHH assessments available?

### Section 3 – Specially Designated Areas

	Yes	No	Comments
Is there a specially designated toilet for staff use only? Is there a specially designated toilet for patient use only? Is there a specially designated room or area for dirty use – cleaning, linen, waste disposal? Are there specially designated baby changing facilities? Is there a procedure for the disposal of baby changing waste? Is there a specially designated area for minor surgery?			

### Section 4 – Waste Management - general

	Yes	No	Comments
Are external waste bins lockable and locked?			
Are waste bags securely sealed?			
Is disposable protective wear placed within clinical waste?			
Are contaminated instruments utensils or disposables placed on sinks or working surface areas?			
Are clinical waste bins provided in all treatment rooms?			
Are non-clinical waste bins free from contaminates?			
Are clinical and non-clinical waste bins pedal operated?			
Are clinical and non-clinical waste bins fitted with an appropriate disposable liner?			
Are clinical waste bins clean?			
Are clinical waste bins less than 80% full?			
Are all waste bins or bags stored externally in a designated area?			
Does a service contract for sanitary units exist?			
Is waste clearly segregated – clinical, household, hazardous, non-hazardous?			

## Section 5 – Hand Hygiene – general

See *Hand washing guidelines* [\*]

	Yes	No	Comments
Is a gel sterilising solution available in all treatment rooms and staff toilets?			
Is a gel sanitising solution available within doctors' bags?			

**Is a liquid soap available within all treatment rooms?**

**Are wall mounted paper towels available near each sink?**

**Has training in hand hygiene taken place within the last 12 months?**

**Are the premises free from “bar” soap?**

**Are all clinical room taps elbow / wrist operable?**

**Are there posters in appropriate locations demonstrating good hand washing techniques?**

**Are only sterile / single use nail brushes available?**

**Are all clinical sinks free from used nail brushes?**

**Are liquid soaps wall mounted?**

**Are there designated hand- wash basins (not used for other purposes)?**

**Is the hand-wash basin visibly clean?**

**Are clinical staff able to demonstrate good hand-washing techniques?**

## Section 6 – Cleaning Equipment

	Yes	No	Comments
<b>Are mops stored clean and dry?</b>			
<b>Are non-disposable mop heads laundered at least on a weekly basis?</b>			
<b>Are disposable mop heads changed daily?</b>			
<b>Are mop buckets stored clean and dry?</b>			
<b>Are single-use cleaning clothes used, and disposed of after use?</b>			

Are COSHH assessments available for cleaning products?

Are cleaning materials stored in a designated area?

Are hazardous cleaning materials in evidence in non-designated areas?

## Section 7 - Samples

	Yes	No	Comments
Are specimens stored in a specially designated area?			
Is there a designated specimen fridge (not used for other purposes)?			
Is a specimen handling protocol available for safe handling by both clinical and non-clinical staff?			

## Section 8 – Room Inspections

A Section 8 Inspection Report Form should be completed for every room detailed within Section 1 above.

### Waiting Room

	Yes	No	Comments
Is the furniture clean?			
Is the furniture in a good state of repair?			
Is the furniture of a type and material which is easy to clean?			
Is the floor impervious and sealed?			
Is the carpet in a good state of repair?			
Can the carpet be easily cleaned?			
Is the carpet clean and free from stains?			

Is there a “dust trap” at the entry door?

Are any toys provided of a washable type only?

Are the toys clean?

Is there a designated toy storage area?

Is the toy storage area clean

Is there a person responsible for the toy cleaning, and is this on the cleaning specification

Are any flat surfaces clean and free from stains

Are wall surfaces clean and “egg-shell” painted

## Corridors

	Yes	No	Comments
Is any furniture in a good state of repair?			
Is any furniture of a type and material which is easy to clean?			
Is the floor impervious and sealed?			
Is the carpet in a good state of repair?			
Can the carpet be easily cleaned?			
Is the carpet clean and free from stains?			
Any pictures or other wall decorations clean and dust free?			
Are wall surfaces clean and “egg-shell” painted?			

## Kitchen Area

	Yes	No	Comments
Is any furniture in a good state of repair?			

Is any furniture of a type and material which is easy to clean?

Is the floor impervious and sealed?

Is the floor around the cooking / preparation area washable?

Is the carpet in a good state of repair?

Can the carpet be easily cleaned?

Are work surfaces clean?

Is there a designated food fridge?

Is the sink unit visibly clean?

Is liquid soap available?

Are paper towels available?

Is there a foot operated pedal bin for kitchen waste?

Does the waste bin have a waterproof liner?

Is food stored in sealed containers?

Is the fridge visibly clean?

Is the cleaning and defrosting of the fridge within the cleaning specification?

Are wall surfaces clean and "egg-shell" painted?

## Consulting Room or Treatment Room

	Yes	No	Comments
Is any furniture in a good state of repair?			
Is any furniture of a type and material which is easy to clean?			
Is the floor impervious and sealed?			

**Is the floor or carpet clean and free from stains?**

**Is the floor free from clutter and easily accessible for cleaning?**

**Is the carpet in a good state of repair?**

**Can the carpet be easily cleaned?**

**Is equipment accessible for cleaning?**

**Is lighting clean?**

**Are lighting levels good?**

**Are work surfaces clean?**

**Are work surfaces sealed around the edges?**

**Are work surfaces in a good state of repair?**

**Are work surfaces free from clutter?**

**Is there a designated work surface for clinical procedures?**

**Are any trolleys easily cleanable and in a good state of repair?**

**Are paper consumables stored off the floor?**

**Is storage space adequate?**

**Are cupboards well organised and clean?**

**Are drawers well organised and clean?**

**Are items of sterile equipment and supplies in date?**

**Are couches clean?**

**Are couches in a good state of repair?**

**Are couches cleanable by wiping?**

**Are disposable couch covers used?**

**Are couch covers or couch rolls changed**

**after every patient?**

**Are curtains clean?**

**Are sink areas free from contaminates?**

**Is there a pedal operated clinical waste bin?**

**Is there a pedal operated non-clinical waste bin?**

**Is clinical and non-clinical waste properly segregated?**

**Are waste bins less than 80% full?**

**Is there a basin designated for hand-washing only?**

**Is a sharps container available?**

**Is the sharps container full to below the maximum line?**

**Is liquid soap available?**

**Is the liquid soap wall mounted?**

**Is sanitising gel available?**

**Is the room free from bar soap?**

**Is the room free of non-sterile nail brushes?**

**Are paper towels available?**

**Is the tap elbow / wrist operable?**

**Is there a poster demonstrating good hand washing techniques?**

**Are the walls egg-shell painted?**

**Is there a form of mechanical ventilation (extractor fan) (Minor surgery areas only)?**

**Is the ventilation visibly clean and dust-free?**

**Is there a stainless steel trolley available (Minor surgery areas only)?**

**Is cleaning fluid readily available for the stainless steel trolley?**

## **Utility Rooms**

	<b>Yes</b>	<b>No</b>	<b>Comments</b>
<b>Is any furniture in a good state of repair</b>			
<b>Is any furniture of a type and material which is easy to clean?</b>			
<b>Is the floor impervious and sealed?</b>			
<b>Is the floor free from clutter and easily accessible for cleaning?</b>			
<b>Is equipment accessible for cleaning?</b>			
<b>Are work surfaces clean?</b>			
<b>Are work surfaces sealed around the edges?</b>			
<b>Are work surfaces in a good state of repair?</b>			
<b>Are work surfaces free from clutter?</b>			
<b>Is storage space adequate?</b>			
<b>Are cupboards well organised and clean?</b>			
<b>Are drawers well organised and clean</b>			
<b>Are sink areas free from contaminates?</b>			
<b>Is there a pedal operated clinical waste bin?</b>			
<b>Is there a pedal operated non-clinical waste bin?</b>			
<b>Is clinical and non-clinical waste properly segregated?</b>			
<b>Are waste bins less than 80% full?</b>			
<b>Is there a basin designated for hand-</b>			

**washing only?**

**Is liquid soap available?**

**Is the liquid soap wall mounted?**

**Is sanitising gel available?**

**Are paper towels available?**

**Is the tap elbow / wrist operable?**

**Is there a poster demonstrating good hand washing techniques?**

**Are the walls egg-shell painted?**

**Toilet Areas**

	Yes	No	Comments
<b>Are toilets in a good state of repair?</b>			
<b>Are the toilets clean?</b>			
<b>Is the floor impervious and sealed?</b>			
<b>Is the floor free from clutter and easily accessible for cleaning?</b>			
<b>Is there a hand-wash basin?</b>			
<b>Is there a hand washing poster displayed?</b>			
<b>Is there wall-mounted liquid soap?</b>			
<b>Are there paper towels available?</b>			
<b>Are electrical hand driers available?</b>			
<b>Is there a foot-operated pedal bin?</b>			
<b>Does the pedal bin have a disposable liner?</b>			
<b>Is there a mechanical means of ventilation (extractor fan)?</b>			
<b>Is sanitising gel available (staff toilets only)?</b>			

Is the toilet area free from bar soap and non-sterile nail brushes?

Are the walls egg-shell painted?

Is the tap elbow / wrist operable?

Is there an adequate supply of toilet roll available?

## Baby Facilities

	Yes	No	Comments
Is the changing facility clean?			
Is the changing facility easily washable?			
Is there a designated hand wash basin?			
Are paper towels available?			
Is there a foot operated pedal bin available?			
Does the bin have a disposable waterproof liner?			
Are there local instructions to parents visible?			
Are there paper liners available for the table facility?			
Are there instructions available for nappy disposal?			

## Other Areas

### Reception areas, offices, meeting rooms

	Yes	No	Comments
Is any furniture in a good state of repair?			
Is any furniture of a type and material			

which is easy to clean?

Is the floor or carpet clean and free from stains?

Is the floor free from clutter and easily accessible for cleaning?

Is the carpet in a good state of repair?

Can the carpet be easily cleaned?

Is lighting clean?

Are lighting levels good?

Are work surfaces clean?

Are work surfaces free from clutter?

Is storage space adequate?

## VERSION AND DOCUMENT CONTROL

### PREPARATION

Process / Version	Name	Date	Notes
Draft A Drafted by	Stephanie Boland	2007	
Draft B Amended by	Helun Ford	02/01/08	
Draft C Amended by	Stephanie Boland	02/01/08	
Draft D Formatted by	Graham Wellfare	03/01/08	
Draft E Final Review by	Stephanie Boland	07/03/08	

Authorised by Bruce Websdale

20/05/08

Version 1.0 issued

20/05/08

### Updating

Process / Version	Name	Date	Notes
1.0a) Amended by	Alison Carlick	25/08/09	Per CIO SPCT

1.0b) Updated by	Graham Wellfare	03/09/09	
1.0c) Reveiwed by	Iain Chorlton	11/09/09	
1.0d) Amended by	Bruce Websdale	11/09/09	'Hand washing'
1.0e) Amended by	Judy Prescott	16/09/09	
Authorised by	Bruce Websdale	17/09/09	
Issued / 1.1		17/09/09	
1.1a) Amended	Ursula Holt	15/12/2009	'deep review'
1.1b) Proofread	Graham Wellfare	18/12/2009	
1.1c) Final Amendments	Sandi Houghton, Judy Prescott	21/12/2009	
1.1d) Updated to CQC	Ursula Holt	22/01/2010	Adjusted to reflect CQC requirements
1.1e) External Review	Pauline McDonald	01/03/2010	Per SMT request
2.0 Authorised by	David Rose	03/03/2010	
2.0 Issued		04/03/2010	