IP12
Standard and Transmission-Based Precautions

Contents

1.0 Policy Statement (Purpose / Objectives of the policy)

Good infection prevention control (IPC), including cleanliness and prudent antimicrobial stewardship (AMS), is essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention of infection must be part of everyday practice and be applied consistently by everyone.
Good management and organisational processes are crucial to make sure that high standards of IPC (including cleanliness) are set up and maintained (Department of Health & Social Care 2022).

Although not all healthcare associated infections (HCAIs) are avoidable; a significant proportion can be prevented by the adoption of evidence-based infection prevention and control standards The purpose of this policy is to inform staff of the standard and transmission based infection control precautions that are required to reduce the risk of patients developing a healthcare associated infection but also to protect themselves and their colleagues from exposure to infectious agents.

2.0 Definitions

Airborne precautions: used to prevent and control infection transmission via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Refer to IP10 for further advice and guidance.

Blood and body fluids: Includes secretions and excretions - blood, urine, faeces, saliva, tears, breast milk, semen, vaginal fluid, effusions, serous fluid, mucus, cerebro-spinal fluid, bile, vomit, pus and other infected discharges.

Contact precautions: used to prevent and control infection transmission via direct contact or indirectly from equipment or environment.

Decontamination: the process of removing or destroying infectious agents to prevent the spread of disease. It can include cleaning, disinfection and sterilisation.
The care setting contains a diverse population of microorganisms, and this must be considered when providing care, particularly for those who are susceptible to infection. Although potentially pathogenic microorganisms are found in air, water and on fomites, determining their role in any infection can be difficult. Appropriate decontamination of care equipment is fundamental to reducing their potential contribution to HCAIs. For the purpose of this policy, care equipment includes items that are non-invasive and are re-usable, and further guidance can be located in the following policies HS11 Management of Medical Devices and HS12 Decontamination of Re-usable Medical Devices.

Droplet precautions: used to prevent and control infection transmission over short distances via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

FFP3 mask: Filtering facepiece type of respiratory mask that provides the highest level of protection against airborne particles.

Hand hygiene: decontamination of the hands by hand washing using liquid soap and water and / or using an alcohol-based hand rub.

Heat labile linen: fabrics that will be damaged by the normal heat disinfection process.

Infected linen: linen that has been used by a patient who is known or suspected to be carrying potentially pathogenic microorganisms.

Medical Sharp: an object or instrument necessary for the exercise of specific healthcare activities, which can pierce intact tissues.

Personal protective equipment (PPE): equipment that is worn or held by a person to protect them from risks to their health and safety while at work. Examples include gloves, aprons, fluid repellent gowns/coveralls, and eye and face protection.

Pathogenic microorganisms: microorganisms capable of causing disease or infection body fluids and / or excreta. This includes linen that has been used by a patient who has a known infectious disease.

Safer Sharp: a medical sharp that is designed and constructed to incorporate a feature or mechanism which prevents or minimises the risk of accidental injury from cutting or pricking/piercing the skin.

Standard Infection Control Precautions (SICPs): basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agents from both recognised and recognised sources.

Sources include blood and other bodily fluids, secretions and excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment.

Transmission Based Precautions (TBPs): TBPs are applied when SICPs alone are insufficient to prevent cross contamination of an infectious agent. TBPs are additional infection control precautions required when caring for a patient with a known or suspected infectious agent. TBPs are categorised by the route of transmission of the infectious agent:

Type IIR (FRSM): a fluid-resistant surgical mask that meets standards EN14683 and designed to protect against respiratory droplets, body fluids and particulate matter.

Used linen: any linen that has been used, but is not contaminated with blood, body fluids, excretions, or used by a patient who has a known infectious disease.

3.0 Accountabilities

All registered care providers must demonstrate compliance with the Health and Social Care Act 2008: Code of practice on the prevention and control of infections and related guidance.

3.1 Chief Executive Officers/Executive Board

Are responsible for ensuring:

- Systems and resources are available to implement and monitor compliance with infection prevention and control
- There is a culture that promotes incident reporting, including near misses, while focusing on improving systemic failures and encouraging safe working practices
- Safe systems of work, including managing the risk associated with infectious agents through the completion of risk assessments outlined in Control of Substances Hazardous to Health (COSSH) regulations and approved through local governance procedures. This is for the protection of all healthcare workers, patients, and visitors.

3.2 Chief Operating Officers (COOs) are responsible for:

- Directing the conduct of operational activities in relation to this policy
- Providing leadership, support, direction and assistance

3.3 Directors of infection prevention and control (DIPC) are responsible for ensuring:

- Adoption and implementation of this policy in accordance with local governance processes
- A workforce that is competent in infection prevention and control practice as per criteria 6 of the Health and Social Care Act Code of Practice

3.4 Managers/employers of all services must ensure that staff:

- Are aware of and have access to this policy, including the measures require to protect themselves and their employees from infection risk
- Have had education on infection prevention and control by attending mandatory training as per criteria 1 and 9 of the Health and Social Care Act Code of Practice
- Have adequate support and resources to implement, monitor and take corrective action to comply with this policy
- Who may be at high risk of complications from infection (including pregnancy) have an individual risk assessment
- Who have had an occupational exposure are referred promptly to the relevant agency e.g. GP, occupation health or accident and emergency, and understand immediate actions e.g. first aid, following an occupational exposure including process for reporting
- Have had the required health checks, immunisations and clearance

undertaken by occupational health (including those undertaking exposure prone procedures
- Include infection prevention and control as an objective in their personal development plans
- Refer to infection prevention and control in all job descriptions

3.5 All staff must

- Show their understanding by consistently applying the infection prevention and control principles in this policy
- Protect the health and safety of themselves and their colleagues, patients, relatives and visitors
- Maintain competence, skills and knowledge in infection prevention and control by completing mandatory training as required
- Communicate the infection prevention and control practices to be carried out by colleagues, those being cared for, relatives and visitors, without breaching confidentiality
- Have up-to-date occupational immunisations, health checks and clearance requirements as appropriate
- Report to line managers, document and action any deficits in knowledge, resources, equipment and facilities or incidents that may result in transmitting infection including near misses
- Apply the principles of good practice for uniform and workwear e.g. bare below the elbow and comply with HR22 Staff Dress Code and Uniform Policy
- Not provide care while at risk of transmitting infectious agents to others; if in doubt, they must contact their line manager, occupational health department and or the Infection Prevention team (IPT)
- Inform the IPT of any outbreaks or serious incident relating to an outbreak in a timely manner and in accordance with local policies and procedures

3.6 Infection Prevention Team must:

- Engage with staff to develop systems and processes that leads to sustainable and reliable improvements in applying infection prevention and control practices
- Provide expert advice on applying infection prevention and control in all care settings and on individual risk assessments, ensuring action is taken as required
- Maintain competence, knowledge and skills in infection prevention and control practices
- Have epidemiological/surveillance systems capable of identifying patient case(s) requiring investigation and control
- Review this policy in line with current legislation and guidance and update accordingly
- Facilitate training and education to support the implementation of this policy

4.0 Policy Detail

Standard Infection Control Precautions (SICPS)

Standard infection control precautions (SICPs) are to be used **by all** staff, **in all** care settings, **at all** times, **for all** patients whether infection is known to be present or not, to ensure the safety of those being cared for, staff and visitors in the care environment.

SICPs are the basic infection prevention and control measures necessary to reduce the risk of transmitting infectious agents from both recognised and unrecognised sources of infection.
Sources of (potential) infection include blood and other body fluids, secretions or excretions (excluding sweat), non-intact skin or mucous membranes and any equipment or items in the care environment that could have become contaminated.

The application of SICPs during care delivery is determined by assessing risk to and from individuals. This includes the task, level of interaction and/or the anticipated level of exposure to blood and/or other body fluids.
To protect effectively against infection risks, SICPs must be used consistently by all staff. SICPs implementation monitoring must also be ongoing to ensure compliance with safe practices and to demonstrate ongoing commitment to patient, staff and visitor safety as required by the Health and Safety Executive and the care regulators, the Care Quality Commission.

There are 10 elements of SICPs:

- patient placement/assessment of infection risk
- hand hygiene
- respiratory and cough hygiene
- personal protective equipment
- safe management of the care environment
- safe management of care equipment
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety/managing prevention of exposure (including sharps)

4.1 Patient placement/assessment for infection risk

Patients must be promptly assessed for infection risk on arrival at the care area, (if possible, prior to accepting a patient from another care area) and should be continuously reviewed throughout their stay.
This assessment should influence placement decisions in accordance with clinical/care need(s).
Patients who may present a cross-infection risk include those:

- with diarrhoea, vomiting, an unexplained rash, fever or respiratory

symptoms
- known to have been previously positive with a multi-drug-resistant organism (MDRO), e.g. Meticillin Resistant *Staphylococcus aureus* (MRSA), Carbapenamase-Producing Enterobacterales (CPE)
- who have been an inpatient in any hospital in the UK or abroad or are a known epidemiological link to a carrier of CPE.

Refer to policy IP03 Prevention and Control of MRSA, Vancomycin Resistant Enterococci and other Antibiotic-Resistant Organisms, IP06 Prevention, Control and Management of Clostridium difficile, IP10 Isolation policy for Infectious Diseases for further information and advice.

4.2 Hand hygiene

Hand hygiene is considered one of the most important ways to reduce the transmission of infectious agents that cause HCAIs.

Clinical hand-wash basins must:

- be used for that purpose only and not used for the disposal of other liquids
- have mixer taps, no overflow or plug and be in a good state of repair
- have wall mounted liquid soap and paper towel dispensers.
- Hand hygiene facilities should include instructional posters.

Before performing hand hygiene:

- Expose forearms (bare below the elbow). If disposable over-sleeves are worn for religious reasons, these must be removed and disposed of before performing hand hygiene, then replaced with a new pair*
- Staff in a clinical environment must keep their hands and wrists free of clothing and non-essential jewellery to facilitate effective hand hygiene. The wearing of a single, plain metal finger ring, e.g. a wedding band, is permitted but should be removed (or moved up) during hand hygiene. A religious bangle can be worn but should be moved up the forearm during hand hygiene and secured during patient care activities
- Ensure fingernails are clean and short, and do not wear artificial nails or nail products
- Cover all cuts or abrasions with a waterproof dressing.

For more information refer to HR22 Staff Dress Code and Uniform Policy

To perform hand hygiene:

Wash hands with liquid soap and water if:

- Hands are visibly soiled or dirty
- Caring for patients with vomiting or diarrhoeal illnesses
- Caring for a patient with a suspected or known gastrointestinal

infection, e.g. norovirus or a spore-forming organism such as clostridioides difficile.

In all other circumstances, use alcohol-based handrubs (ABHRs) for routine hand hygiene during care.
ABHRs must be available for staff as near to the point of care as possible. Where this is not practical, personal ABHR dispensers should be used, e.g. within the community, domiciliary care, mental health units etc.
Where running water is unavailable, or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first opportunity.

Perform hand hygiene:

- Before touching a patient.
- Before clean or aseptic procedures.
- After body fluid exposure risk
- After touching a patient; and
- After touching a patient's immediate surroundings.

Always perform hand hygiene before putting on and after removing gloves.

For how to wash hands, see the step-by-step guide in **Appendix 1**

For how to hand rub, see the step-by-step guide in **Appendix 2**

Skin care

- Dry hands thoroughly after hand washing, using disposable paper towels
- Use an emollient hand cream regularly e.g. during breaks and when off duty
- Do not use or provide communal tubs of hand cream in the care setting
- Staff with skin problems should seek advice from occupational health or their GP and depending on their skin condition and the severity may require additional interventions or reporting.

Surgical hand antisepsis

Surgical scrubbing/rubbing (this applies to those undertaking surgical and some invasive procedures):

- Perform surgical scrubbing/rubbing before donning sterile theatre garments or at other times, e.g. before inserting central vascular access devices
- Remove all hand and wrist jewellery (including wedding band)
- Nail brushes should not be used for surgical hand antisepsis
- Nail picks (single use) can be used if nails are visibly dirty

- Soft, non-abrasive, sterile (single use) sponges may be used to apply antimicrobial liquid soap to the skin if licensed for this purpose
- Use an antimicrobial liquid soap licensed for surgical scrubbing or an ABHR licensed for surgical rubbing (as specified on the product label)
- ABHR can be used between surgical procedures if licensed for this use or between glove changes if hands are not visibly soiled.

For surgical scrubbing (not rubbing), follow the step-by-step guide in **Appendix 3**

For surgical rubbing (not scrubbing), follow the step-by-step guide in **Appendix 4**

4.3 Respiratory and cough hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of known or suspected respiratory illness (pathogens):

- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose, if unavailable use the crook of the arm
- Dispose of all used tissues promptly into a waste bin
- Wash hands with non-antimicrobial liquid soap and warm water after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions
- Where there is no running water available or hand hygiene facilities are lacking, staff may use hand wipes followed by ABHR and should wash their hands at the first available opportunity
- Keep contaminated hands away from the eyes nose and mouth.

Staff should promote respiratory and cough hygiene helping those (e.g., elderly, children) who need assistance with this, e.g. providing patients with tissues, a dedicated receptacle i.e. waste bag for used tissues and hand hygiene facilities as necessary.

4.4 Personal protective equipment (PPE)

Before undertaking any procedure, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin or mucous membranes and wear personal protective equipment (PPE) that protects adequately against the risks associated with the procedure. The principles of PPE use set out below are important to ensure that PPE is used correctly to ensure patient and staff safety. Avoiding overuse or inappropriate use of PPE is a key principle that ensures this is risk-based and minimizes its environmental impact. Where appropriate, consideration should be given to the environmental impact of sustainable or reusable PPE options versus single-use PPE while adhering to the principles below. Refer to **Appendix 5a** for Personal protective equipment (PPE) required when applying standard infection control

precautions (SICPs) and **Appendix 5b** for PPE required when applying transmission-based precautions (TBPs) discussed later in this policy.

To minimise the risk of cross contamination PPE should be put on and removed in a certain order. For the recommended method of putting on (donning) and removing PPE (doffing) refer to **Appendix 6**

All PPE must be:

- Located close to the point of use. PPE for healthcare professionals providing care in the community and domiciliary care providers must be transported in a clean receptacle
- Stored to prevent contamination in a clean, dry area until required (expiry dates must be adhered to)
- Single use only unless specified by the manufacturer
- Changed immediately after each patient and/or after completing a procedure or task
- Disposed of after use into the correct waste stream, e.g. domestic waste, offensive (non-infectious) or clinical waste
- Discarded if damaged or contaminated.

NB Reusable PPE such as goggles/face shields/visors, must be decontaminated after each use according to manufacturer's instruction.

Gloves must be:

- Worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely
- Changed immediately after each patient and/or after completing a procedure/task even on the same patient, and hand hygiene performed
- Changed if a perforation or puncture is suspected
- Appropriate for use, fit for purpose and well-fitting
- Never decontaminated with ABHR or soap between use
- Low risk of causing sensitisation to the wearer
- Appropriate for the tasks being undertaken, taking into account the substances being handled, type and duration of contact, size and comfort of the gloves, and the task and requirement for glove robustness and sensitivity.

Sterile gloves must be worn:

- When sterility is required in an operating theatre, and
- For some aseptic techniques e.g. insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of pulmonary artery catheters and spinal, epidural and caudal procedures

NB Double gloving is **NOT** recommended for routine clinical care. However, it may be required for some exposure prone procedures, e.g. orthopaedic and gynaecological operations, when attending major trauma

incidents or as part of additional precautions for high consequence infectious disease management.

Gloves are **NOT** required to carry out near patient administrative tasks, e.g., when using the telephone, using a computer or tablet, writing in the patient chart; giving oral medications; distributing or collecting patient dietary trays.

If worn, oversleeves must be:

- Changed immediately after each patient and/or after completing a procedure/task even on the same patient, and hand hygiene performed.
- Removed and disposed of if visibly contaminated or soiled.

Aprons must be:

- Worn to protect uniform or clothes when contamination is anticipated or likely.
- Changed between patients and/or after completing a procedure or task.

Apron colours:

Green	Catering departments, ward kitchen and patient food service at ward level
Blue	General areas including wards, departments, offices and basins in public areas
Red	Bathrooms, washrooms, showers, toilets, basins and bathroom floors
Yellow	Isolation areas

Full body gowns or fluid-resistant coveralls must be:

- Worn when there is a risk of extensive splashing of blood and/or body fluids, e.g. operating theatre, Critical Care.
- Worn when a disposable apron provides inadequate cover for the procedure or task being performed.
- Changed between patients and removed immediately after completing a procedure or task.
- Sterile when sterility is required in an operating theatre and for some aseptic techniques e.g. for insertion of central venous catheters, insertion of peripherally inserted central catheters, insertion of pulmonary artery catheters and spinal, epidural and caudal procedures.

Eye or face protection (including full-face visors) must:

- Be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely, e.g. by members of the surgical theatre team and always during aerosol generating procedures; regular corrective spectacles are not considered eye protection
- Not be impeded by accessories such as piercings or false eyelashes
- Not be touched when being worn.

Fluid resistant surgical face masks (FRSM):

Surgical face masks are required:

- As a means of source control, e.g. to protect the patient from the wearer during sterile procedures such as surgery, and
- To protect the wearer when there is a risk splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa.
- As an element of PPE for droplet precautions.

FRSM must be:

- Worn (with eye protection) if a full-face visor is not available and spraying or splashing of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely (Type IIR).
- Worn to protect patients from the operator as a source of infection, e.g. when performing surgical procedures or epidurals or inserting a central vascular catheter (CVC) (Type IIR).
- Well-fitting and fit for purpose, fully covering the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection).
- Removed or changed:
  – at the end of a procedure/task
  – if the mask's integrity is breached, e.g. from moisture build-up after extended use or from gross contamination with blood or body fluids
  – in accordance with manufacturers' specific instructions.

Footwear must be:

- Visibly clean, non-slip and well-maintained, and support and cover the entire foot to avoid contamination with blood or other body fluids or potential injury from sharps.
- Removed before leaving a care area where dedicated footwear is used, e.g. theatre; these areas must have a decontamination schedule with responsibility assigned.

Headwear

Headwear is not routinely required in clinical areas unless part of theatre

attire or to prevent contamination of the environment such as in clean rooms.

Headwear must be:

- Worn in theatre settings and clean rooms, e.g. central decontamination unit.
- Well-fitting and completely cover the hair.
- Changed or disposed of between clinical procedures/lists or tasks and if contaminated with blood and/or body fluids.
- Removed before leaving the theatre or clean room.
- Individuals with facial hair must also cover this in areas where headwear is required, e.g. wear a snood.

NB Headwear worn for religious reasons such as turbans, kippot veils, headscarves must not compromise patient care and safety. These must be washed and/or changed daily or immediately if contaminated and comply with additional attire requirements, for example, in theatres.

4.5 Safe management of care equipment

Care equipment is easily contaminated with blood, other body fluids, secretions, excretions and infectious agents. Consequently, it is easy to transfer infectious agents from communal care equipment during care delivery.

Care equipment is classified as either:

- Single use: equipment which is used once on a single patient then discarded. This equipment must never be re-used. The packaging will carry the symbol of the number two in a circle with a diagonal cross.
- Single patient use: equipment which can be reused on the same patient and may require decontamination in-between use such as nebuliser masks.
- Reusable invasive equipment: used once then decontaminated, e.g. surgical instruments and solid-state reusable equipment, such as, flexible endoscopes and transducers.
- Reusable non-invasive equipment: (often referred to as communal equipment) – reused on more than one patient following decontamination between each use, e.g. commode, patient transfer trolley.

NB Needles and syringes are single use devices, they should never be used more than once or reused to draw up additional medication. Never administer medications from a single-dose vial or intravenous (IV) bag to multiple patients.

Before using any sterile equipment check that:

- The packaging is intact.

- There are no obvious signs of packaging contamination.
- The expiry date remains valid.
- Any sterility indicators are consistent with the process being completed successfully.

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

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

If providing domiciliary care, equipment should be transported safely and decontaminated as above before leaving the patient's home.
Always adhere to Control of Substances Hazardous to Health (COSHH) risk assessments and manufacturers' guidance for use and decontamination of all care equipment.

- All reusable non-invasive care equipment must be decontaminated between patients/clients using either approved detergent wipes or detergent solution, in line with manufacturers' instructions, before being stored clean and dry.
- Decontamination protocols must include responsibility for; frequency of; and method of environmental decontamination.
- An equipment decontamination status certificate will be required if any item of equipment is being sent to a third party, e.g. for inspection, servicing or repair.
- Guidance should be sought from the infection, prevention and control team prior to procuring, trialling or lending any reusable non-invasive equipment.
- Medical devices and other care equipment must have evidence of planned preventative maintenance programmes.

Further information can be found in HS11 Management of Medical Devices Policy and HS12 Decontamination of Re-Usable Medical Devices

4.6 Safe management of the care environment

The care environment must be:

- Visibly clean, free from non-essential items and equipment to facilitate effective cleaning.
- Well maintained, in a good state of repair and with adequate ventilation for the clinical specialty.

Always adhere to COSHH risk assessments for product use and processes for decontamination of the care environment.

Routine cleaning

- The environment should be routinely cleaned in accordance with the National Cleaning Standards.
- Use of detergent wipes is acceptable for cleaning surfaces/frequently touched sites within the care area.
- A fresh solution of general-purpose neutral detergent in warm water is recommended for routine cleaning unless a chlorine-based product is recommended by the IPT or consultant microbiologist in response to a rise in infections. This should be changed when dirty or when changing tasks.
- Routine disinfection of the environment is not recommended unless advised by Infection Prevention team or consultant microbiologist, however, 1,000ppm available chlorine should be used routinely on sanitary fittings.
- Staff groups should be aware of their environmental cleaning schedules for their area and clear on their specific responsibilities.
- Cleaning protocols should include responsibility for, frequency of, and method of environmental decontamination.

Refer to Cleaning Delivery Plan for further information

4.7 Safe management of linen

Healthcare laundry must be managed and segregated in accordance with HTM 01-04 Decontamination of Linen for Health and Social Care: management and provision

Healthcare linen is categorised as:

- **Clean linen** – linen washed and ready to be used.
- **Used (soiled and fouled) linen** – used linen, irrespective of state, which on occasion may be contaminated by blood or body fluids, and
- **Infectious linen** – linen that has been used by a patient who is known or suspected to be infectious.

Storage and handling of clean linen:

- Hand hygiene should be performed prior to handling clean linen.
- Clean linen should be removed from plastic bags before storage to prevent the growth of *Bacillus cereus*.
- Clean linen should be stored above floor level in a designated area, preferably an enclosed cupboard that is clean, dry and cool.
- If clean linen is not stored in a cupboard, then the trolley used for storage must be designated for this purpose and completely covered with an impervious covering/or door that is able to withstand decontamination.
- Clean linen storage areas should be dedicated for the purpose and appropriately designed to prevent damage to linen and to

allow for the rotation of stocks.
- Clean linen should be physically separated from used/infectious linen when in storage and during transport.

Storage and handling of used and infectious linen:

- Staff handling used and/or infectious linen must wear appropriate PPE
- Hand hygiene must be performed after handling used and/or infectious linen.
- Ensure a laundry receptacle is available as close as possible to the point of use for immediate linen deposit.
- Used items of linen should be removed one by one and placed in the used linen hamper/stream.
- do not:
    - rinse, shake or sort linen on removal from beds/trolleys
    - place used linen on the floor or any other surfaces e.g. a locker/tabletop
    - re-handle used linen once bagged
    - overfill laundry receptacles (not more than 2/3 full); or
    - place inappropriate items in the laundry receptacle e.g. used equipment/needles
- Infectious linen must not be sorted but should be rolled together and sealed in a water-soluble bag (entirely water soluble 'alginate' bag or impermeable bag with soluble seams), which is then placed in an impermeable bag immediately on removal from the bed and secured before leaving a clinical area.
- Linen should be placed in an impermeable bag immediately on removal from the bed or before leaving a clinical department
- Linen bags/receptacles must be tagged (e.g., hospital ward/care area) and dated
- Store all used/infectious linen in a designated, safe, lockable area while awaiting collection. Collection schedules must be acceptable to the care area and there should be no build-up of linen receptacles
- All linen that is deemed unfit for re-use, e.g., torn or heavily contaminated, should be categorised at the point of use and returned to the laundry for assessment and disposal.

Linen used during patient transfer, e.g., blankets, should be categorised at the point of destination.

Clean linen that is rejected, ripped or stained should go in pink bags and returned

Linen from patients infected with, or at high risk of having, Hazard Group 4 organisms (haemorrhagic fever viruses such as Lassa Fever) should be disposed of at the point of use as Category A waste and must not be returned to a laundry. For more information refer to IP07 High Consequence Infectious Disease policy

For how to manage linen at care area level see **Appendix 9**

4.8 Safe management of blood and body fluid spillages

Spillages of blood and other body fluids may transmit blood borne viruses.
Spillages must be treated immediately by staff trained to undertake this safely.
Responsibilities for the management of blood/body fluid spills must be clear within each area/care setting.

For management of blood and body fluid spillages see **Appendix 7** and **Appendix 8**

If an organisation locally approves a product for use in the management of blood and body fluid spills, the organisation is responsible for ensuring safe systems of work, including the completion of a risk assessment approved through local governance procedures. Organisations must confirm the efficacy and suitability of the product (i.e., that it conforms with the relevant standards and is appropriate for the intended use) with the product manufacturer.

A locally approved product which conforms to: **EN17126, EN13727, EN14348, EN14476, EN13697, EN14885, EN13706, EN1650, EN1276** and **EN13624** may be used for the management of blood and body fluid spills.

Healthcare providers should ensure that any polymer gel for non-patient use (e.g. spill kits, controlled drug destruction, use by cleaning staff) is kept secure and away from patients. See National Patient Safety Alert – National Patient Safety Alert – Superabsorbent polymer gel granules (2019) NatPSA/2019/002/NHSPS.

4.9 Safe disposal of waste (including sharps)

Health Technical Memorandum (HTM 07-01) contains the regulatory waste management guidance for all health and care settings (NHS and non-NHS) in England and Wales including waste classification, segregation, storage, packaging, transport, treatment and disposal.
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to the safe disposal of sharps.

Definitions of Healthcare (including clinical) waste:

Clinical waste means waste from a healthcare activity (including veterinary healthcare) that:

- Contains viable micro-organisms or their toxins which are known or reliably believed to cause disease in humans or other living organisms. For example, if a patient is known or suspected to be infected, or colonised, by an infectious agent. Clinical judgement should be applied in the assessment of waste and should consider the

infection status of a patient, and the item of waste produced.

- Contains or is contaminated with a medicine that contains a biologically active pharmaceutical agent, or
- Is a sharp, or a body fluid or other biological material (including human and animal tissue) containing or contaminated with a dangerous substance within the meaning of Regulation (EC) No 1272/2008 of the European Parliament and of the Council on classification, labelling and packaging of substances and mixtures, as amended from time to time.

Offensive waste is waste that:

- Is not clinical waste,
- Is not infectious, but may contains body fluids, secretions or excretions,
- Is non-hazardous, and
- Falls within waste codes 18 01 04 if from healthcare, or 20 01 99 if from municipal sources.

Table 1: Categories of waste and segregation at source

Category	Segregation	Treatment/disposal
Offensive (non-infectious)	Yellow bag with black stripe (tiger) bag	Energy from waste, landfill or other permitted processes
Clinical waste (infectious only)	UN approved orange bag, UN approved box or sharps container	For alternative treatment
Healthcare waste contaminated with non-hazardous pharmaceuticals or chemicals)	UN approved yellow bag, UN approved box or sharps container	For incineration or other permitted process
Waste contaminated with cytotoxic or cytostatic medication	UN approved purple bag, UN approved box or sharps container	For incineration
Non-hazardous pharmaceuticals (no sharps)	Blue box/container	For incineration or other permitted process
Anatomical waste/full blood bag and blood preserves	UN approved red lidded container	For incineration only
Domestic	Black/clear bags	Energy from waste, recovery or landfill
Recycling	Clear, green or other colour bag	Recycling

Safe waste disposal at care area level:

Always dispose of waste:

- Immediately and as close to the point of use as possible; and
- Into the correct segregated colour coded rigid container or sharps box if a sharp
- Liquid waste, e.g., suction canisters, must be rendered safe by adding a polymer gel or compound to the container prior to placing in an orange lidded leak proof bin or yellow lidded leak proof bin if contaminated by pharmaceuticals.
- Waste bags must be no more than 2/3 full and no more than the UN approved weight and must be securely tied using a plastic tie or secure knot using a ‘swan neck’ to close. Waste must be traceable back to ward/care area or department, this may be achieved by writing on bags (prior to use), attaching sticky labels or uniquely numbered tags with the post code on them.

- Store all waste in a designated, safe, lockable area while awaiting collection.
- Collection schedules must be acceptable to the care area and there should be no build-up of waste receptacles.
- Local guidance on management of waste at care level, e.g., domiciliary settings should be followed.

Sharps containers (for safety devices, refer to section 4.10)

Sharps containers must:

- Have a handle (small community boxes do not require a handle) and temporary closure mechanism, employed when box is not in use
- Be disposed of when the manufacturers' fill line is reached
- Be labelled with point of origin and date of assembly and disposal. Where re-usable sharps containers are used, organisations must have a protocol in place to assure themselves of safe use and reprocessing.

Further information can be found in the Health Technical Memorandum (HTM 07-01).

4.10 Occupational safety: prevention of exposure (including sharps injuries)

The Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 outline the regulatory requirements for employers and contractors in the healthcare sector in relation to: arrangements for the safe use and disposal of sharps; provision of information and training to employees; investigations and actions required in response to work related sharps injuries.
There is a potential risk of transmission of a BBV (blood bourne virus) from a significant occupational exposure and staff must understand the actions they should take when a significant occupational exposure incident takes place. **There is a legal requirement to report all sharps injuries and near misses to line managers/employers.**

A significant occupational exposure is:

- A percutaneous injury e.g. injuries from needles, instruments, bone fragments, or bites which break the skin; and/or
- Exposure of broken skin (abrasions, cuts, eczema, etc); and/or
- Exposure of mucous membranes including the eye from splashing of blood or other high risk body fluids.

For the management of an occupational exposure incident refer to HS03 Sharps Safety Policy (including Splash Injury and Post Exposure Prophylaxis PEP).

Safety devices

Health and Safety (Sharp Instruments in Healthcare) Regulations 2013 are concerned with reducing and eliminating the number of 'sharps' related injuries which occur within healthcare. Its basic guidance is:

- Avoid unnecessary use of sharps.

- If use of medical sharps cannot be avoided, source and use a 'safer sharp' device.
- If a safer sharp device is not available then safe procedures for working with and disposal must be in place e.g. sticky mats, sharps bins, safety procedures and training.

Sharps handling must be assessed, kept to a minimum and eliminated, if possible, with the use of approved safety devices.

- Manufacturers' instructions for safe use and disposal must be followed.
- Needles must not be re-sheathed/recapped or disassembled after use.
- Sharps must not be passed directly hand to hand.
- Used sharps must be discarded at the point of use by the person generating the waste.
- Always dispose of needles and syringes as 1 unit
- If a safety device is being used safety mechanisms must be deployed before disposal.

When transporting sharps boxes for community use these must be transported safely with the use of temporary closures.

5.0 Transmission Based Precautions (TBPs)

Standard infection control precautions may be insufficient to prevent cross transmission of specific infectious agents and additional precautions called "transmission-based precautions" (TBP) may be required when caring for patients with known / suspected infection or colonisation.
Transmission based precautions are categorised by the route of transmission of infectious agents (some infectious agents can be transmitted by more than one route).
Clinical judgement and decisions should be made by staff on what additional precautions are required and this will be based on:

- suspected/known infectious agent
- severity of the illness caused
- transmission route of the infectious agent
- care setting and procedures undertaken.

5.1 Type of precautions:

5.1.1 Contact precautions:

Used to prevent and control infections that spread via direct contact with the patient or indirectly from the patient's immediate care environment (including care equipment). This is the most common route of cross-infection transmission.

5.1.2 Droplet precautions:

Measures used to prevent, and control infections spread over short distances (at least 1 metre)* via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.

*During the COVID-19 pandemic increased physical distancing (2 metres) was introduced as an additional IPC measure. This has now decreased to pre-pandemic physical distancing (1 metre) in all areas.

5.1.3 Airborne precautions:

Measures used to prevent, and control infection spread without necessarily having close patient contact via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual.
The traditional modes of transmission for respiratory infectious agents as defined before the COVID-19 pandemic are unlikely to be as delineated as is described in the scientific literature, i.e. droplet or airborne transmission and the application of TBPs may differ depending on the setting and the known or suspected infectious agent. Applications of TBPs should be considered within the framework of the hierarchy of controls. Setting-specific risk assessment tools are available to support organisations in applying the hierarchy of controls (HoC).

For information about the type of precautions, optimal patient placement, isolation requirement and respiratory precautions required refer to IP10 Isolation Policy

5.2 Patient placement/assessment of infection risk
The potential for transmission of infection must be assessed when a patient enters a care area. If hospitalised/in a care home setting, this should be continuously reviewed throughout the stay/period of care. The assessment should influence patient placement decisions in line with clinical/care need(s).

Patients who may present a cross-infection risk in any setting includes those:

- with diarrhoea, vomiting, an unexplained rash, fever or respiratory symptoms
- known to have been previously positive with MDRO e.g., methicillin-resistant staphylococcus aureus (MRSA), carbapenemase-producing enterobacterales (CPE)
- who have been an inpatient in any hospital in the UK or abroad or are a known epidemiological link to a carrier of CPE
- who have a known or suspected infection or colonisation.

Isolation facilities should be prioritised depending on the known/suspected infectious agent (refer to IP10 Isolation policy).
All patient placement decisions and assessment of infection risk (including isolation requirements) must be clearly documented in the patient notes and provided in patient handovers with other healthcare/care providers.
The clinical judgement and expertise of the staff involved in a patient's management and the IPT should be sought, particularly for the application of TBPs, e.g., isolation prioritization, when single rooms are in short supply.

5.2.1 Single room isolation in hospital settings:

- isolation of infectious patients can be in specialised isolation facilities, single room isolation, cohorting of infectious patients where appropriate,

ensuring that they are separated by at least 3 feet (1 metre) with the door closed.

- isolation room doors should remain closed, if this is not possible, e.g., paediatrics, there should be a documented risk assessment.
- signage should be used on doors/areas to communicate isolation requirements and prevent entry of unnecessary visitors, and non-essential staff. Patient confidentiality must be maintained.
- if single rooms are limited, infectious patients who have conditions that could increase the risk of transmission of infection to other patients, such as, excessive cough or an MDRO should be prioritised for placement in a single room.
- single room prioritisation should be reviewed daily and the clinical judgement and expertise of the staff involved in a patient's management and the IPT should be sought particularly for the application of TBPs.
- infectious patients should only be transferred to other departments if clinically necessary. If the patient has an infectious agent transmitted by the airborne/droplet route, then if possible/tolerated the patient should wear a surgical face mask in communal areas during.
- receiving department/hospital and transporting staff must be aware of the necessary precautions.

5.2.2 Cohorting in hospital settings:

Cohorting of infectious patients can be considered when:

- Single rooms are in short supply and if there are two or more patients (a cohort) with the same confirmed infection.
- There are situations of service pressure e.g., winter, and patients may have different or multiple infections.

Infectious patients who must not be cohorted with others with different or multiple infections include:

- Those at increased risk of acquisition and adverse outcomes resulting from infection (e.g., immunosuppression).
- Individuals who are unlikely to comply with TBPs.

5.2.3 Before discontinuing isolation:

Individual patient risk factors should be considered (e.g., there may be prolonged shedding of certain microorganisms in immunocompromised patients).

5.3 Safe management of patient care equipment in an isolation room/cohort area

- Use single-use items if possible.
- Reusable non-invasive care equipment should be dedicated to the isolation room/cohort area and decontaminated prior to use on another patient.
- An increased frequency of decontamination should be considered for reusable non-invasive care equipment when used in isolation/cohort areas.

5.4 Safe management of the care environment

The care environment must be:

- visibly clean, free from non-essential items and equipment to facilitate effective cleaning
- well maintained, in a good state of repair and with adequate ventilation for the clinical specialty.

Equipment used for environmental decontamination must be either single-use or dedicated to the affected area then decontaminated or disposed of following use e.g., cloths, mop heads.

5.5 Environmental decontamination: enhanced cleaning

Refer to the National Cleaning Standards for enhanced cleaning in different settings.

5.5.1 Inpatient settings:

Patient isolation/cohort rooms/area must be decontaminated **at least daily**, this may be increased on the advice of IPCTs/. These areas must be decontaminated using either:

- a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
- a general-purpose neutral detergent in warm water followed by solution of 1,000ppm av cl.
-

Alternative cleaning agents/disinfectant products may be used with agreement of the local IPC team.

Employers must ensure that cleaning products and protocols are managed and risk assessed in accordance with the COSHH regulations – Control of substances hazardous to health (COSHH) – health and safety topics in cleaning.

Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfection solutions.
Increased frequency of decontamination/cleaning schedules should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates, e.g.:

- Toilets/commodes particularly if patients have diarrhoea; and
- "Frequently touched" surfaces e.g., door/toilet handles, locker tops, over bed tables and bed rails.

Vacated rooms should also be decontaminated following an Aerosol Generating Procedure (AGP) (see additional information in section 5.9). Clearance of infectious particles after an AGP is dependent on the ventilation and air change within the room. This is a minimum of 20 minutes in hospital settings where most of these procedures occur. In general wards and single rooms there should be a

minimum of 6 air changes per hour, in negative-pressure isolation rooms there should be a minimum of 10 air changes per hour. Advice should be sought from the IPCT.

5.5.2 Primary care/outpatient settings:
The extent of decontamination between patients will depend on the duration of the consultation/assessment, the patients presenting symptoms and any visible environmental contamination.

5.6 Terminal decontamination
Following patient transfer, discharge, or once the patient is no longer considered infectious, remove from the vacated isolation room/cohort area, all:

- healthcare waste and any other disposable items (bagged before removal from the room)
- bedding/bed screens/curtains – manage as infectious linen (bagged before removal from the room) https://www.england.nhs.uk/publication/decontamination-of-linen-for-health-and-social-care-htm-01-04/
- reusable non-invasive care equipment (decontaminated in the room prior to removal)

The room should be decontaminated using either:

- a combined detergent disinfectant solution at a dilution (1,000ppm av.cl.); or
- a general-purpose neutral detergent in warm water followed by a solution of 1,000ppm av.cl. (or alternative locally agreed cleaning product).

Rooms must be cleaned from highest to lowest points and from least to most contaminated points.
Organisations can consider using hydrogen peroxide vapour disinfection or ultraviolet light technology for specific pathogens. Manufacturers' guidance and recommended product "contact time" must be followed for all cleaning/disinfection solutions.
Terminal cleaning of outpatient/theatre recovery areas should be in accordance with local policy as advised by the local IPCT.

5.7 Personal protective equipment (PPE): fluid-resistant surgical masks (FRSM) and respiratory protective equipment (RPE)

Personal protective equipment (PPE) must still be used in accordance with standard infection control precautions (SICPs) when using respiratory protective equipment (RPE).
Where it is not reasonably practicable to prevent exposure to a substance hazardous to health (as may be the case where healthcare workers are caring for patients with suspected or known airborne pathogens), the hazard must be adequately controlled by applying protection measures appropriate to the activity and consistent with the assessment of risk in accordance with the hierarchy of controls.

If the hazard is unknown the clinical judgement and expertise of IPC staff is crucial, and the precautionary principle should apply.

5.7.1 Fluid-resistant surgical masks

Source control:

Inpatients with suspected or confirmed respiratory infection should be asked to wear a facemask (FRSM) unless isolated in a single room. FRSM should be worn in multi-bedded bays, communal areas, e.g., waiting areas for diagnostics, and during transfer if this can be tolerated and is deemed safe for the patient.
Outpatients (including urgent and emergency care (UEC) and primary care) and patients in pre-hospital settings, e.g. ambulance, with respiratory symptoms should be asked to wear a facemask/covering if this can be tolerated and is deemed safe for the patient. Outpatients without respiratory symptoms are not required to wear a facemask unless this is a personal preference.

The request for patients to wear a facemask **must never compromise their clinical care**, such as when oxygen therapy is required or where it causes distress, e.g., paediatric/mental health settings.
Visitors and individuals accompanying patients to inpatient, outpatient appointments or the emergency department are not required to wear a facemask unless this is a personal preference.

If cluster transmission of a respiratory pathogen is known or suspected, consider extending the use of FRSM as source control to health and care staff in the affected clinical areas(s). This should be guided by local risk assessment.

5.7.2 FRSM for droplet precautions:

FRSM must be worn by staff when providing care within 1 metre of a patient when droplet precautions are applied. **Appendix 5b** details additional PPE required.

5.8 Respiratory protective equipment

Respiratory protective equipment (RPE), i.e., a filtering face piece (FFP) must be considered when a patient is admitted with a known/suspected infectious agent/disease spread wholly or partly by the airborne route and when carrying out AGPs on patients with a known/suspected infectious agent spread wholly or partly by the airborne or droplet route.
The decision to wear an FFP3 respirator should be based on clinical risk assessment, e.g., task being undertaken, the presenting symptoms, the infectious state of the patient, risk of acquisition and the availability of treatment for the infectious agent.
For a list of organisms spread wholly or partly by the airborne (aerosol) or droplet routes refer to IP10 Isolation Policy

National priority risk categorisation for fit testing with FFP3 respirators
The following risk categorisation is the minimum requirement for staff groups that require FFP3 respirator fit testing. Healthcare organisations can add to this, for example, where there are high risk units. This categorisation is inclusive of out of

hours services.

Level 1 – Preparedness for business as usual
Staff in clinical areas most likely to provide care to patients who present at healthcare facilities with an infectious pathogen spread by the airborne route; and/or undertake aerosol generating procedures (AGPs) i.e., A&E, intensive care unit, paediatrics, respiratory, infectious diseases, anaesthesia, theatres, chest physiotherapists, A&E, ambulance staff, bronchoscopy staff, resuscitation teams, mortuary staff.

Level 2 – Preparedness in the event of emerging threat
Staff in clinical settings likely to provide care to patients admitted to hospital in the event of an emerging threat e.g., medical receiving, surgical, midwifery and specialty wards, all ambulance staff. In the event of an '**epidemic/pandemic**' local assessment as per organizations preparedness plans apply.

FFP3 respirator or powered respirator hood:

- May be considered for use by visitors if there has been no previous exposure to the infected person or infectious agent; **but**
- Must never be worn by an infectious patient(s) due to the nature of the respirator filtration of incoming air not expelled air.
- Powered respirator hoods are an alternative to tight-fitting FFP3 respirators for example when fit testing cannot be achieved.
- Powered hoods can be single use (disposable) or reusable (with a decontamination schedule, see note) and must be fluid resistant; the filter must be enclosed with the exterior and the belt able to withstand disinfection with 10,000ppm av.cl.
- Respirators and powered respirator hoods with exhalation vales are ineffective for source control. These should not be worn by a healthcare worker/operator when sterility directly over the surgical field is required e.g., in theatres/surgical settings or when undertaking a sterile procedure (see National Patient Safety Alert).

All tight-fitting RPE, i.e., FFP3 respirators, must be:

- Single-use (disposable) or reusable, and worn with a full-face visor if not classed as fluid-resistant by the manufacturer (EN149).
- Fit tested on all healthcare staff who may be required to wear a respirator to ensure an adequate seal/fit according to the manufacturers' guidance.
- Fit checked (according to the manufacturers' guidance) every time a respirator is donned to ensure an adequate seal has been achieved.
- Compatible with other facial protection used i.e. protective eyewear so that this does not interfere with the seal of the respiratory protection. Regular corrective spectacles are not considered adequate eye protection.

For any facial hair, the hair must not cross or interfere with the respirator sealing surface. If the respirator has an exhalation valve, hair within the sealed mask area should not impinge upon or contact the valve. Staff must pass a face fit test for any tight-fitting respiratory protective equipment that they need to use for work activities.

Please note: Any respirator, including reusable respirators/powered respirator hoods must comply with HSE guidance (HSG53) and be adequate and suitable for their intended use. Reusable respirators must have a decontamination schedule in place and be maintained according to manufacturer's instructions.

The Royal Wolverhampton NHS Trust operates a FFP3 Train the Trainer model of fit testing. Further information can be found on the Kite site FFP3 Mask Information

5.8.2 Removal (doffing) of PPE

- In the absence of an anteroom/lobby remove FFP3 respirators and eye/face protection in a safe area (e.g., outside the isolation/cohort room/area).
- All other PPE should be removed in the patient care area.

For the recommended method of putting on and removing PPE, see UK Health and Safety Agency guides.

5.9 Aerosol generating procedures

AGPs are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection).
The list of medical procedures that are considered to be aerosol generating and associated with an increased risk of respiratory transmission is:

awake* bronchoscopy (including awake tracheal intubation)
awake* ear, nose, and throat (ENT) airway procedures that involve respiratory suctioning
awake* upper gastro-intestinal endoscopy
dental procedures (using high speed or high frequency devices, for example ultrasonic scalers/high speed drills)
induction of sputum
respiratory tract suctioning**
surgery or post-mortem procedures (like high-speed cutting / drilling) likely to produce aerosol from the respiratory tract (upper or lower) or sinuses
tracheostomy procedures (insertion or removal).

*Awake including 'conscious' sedation (excluding anaesthetised patients with secured airway).
** The available evidence relating to respiratory tract suctioning is associated with ventilation. In line with a precautionary approach, open suctioning of the respiratory tract regardless of association with ventilation has been incorporated into the current AGP list. Only open suctioning beyond the oro-pharynx is currently considered an AGP. Oral/pharyngeal suctioning is **not** considered an AGP.

5.10 Infection prevention and control when caring for the deceased

The principles of SICPs and TBPs continue to apply while deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients.

Staff should advise relatives of the precautions following viewing and/or physical contact with the deceased and also when this should be avoided.

Washing and/or dressing of the deceased should be avoided if the deceased is known or suspected to have an invasive streptococcal infection, viral haemorrhagic fevers or other hazard group 4 infectious agents.

Deceased individuals known or suspected to have a hazard group 4 infectious agent should be placed in a sealed double plastic body bag with absorbent material placed between each bag. The surface of the outer bag should be disinfected with 1000ppm av.cl before being placed in a robust sealed coffin.

Post-mortem examination should not be performed on a deceased individual known or suspected to have hazard group 4 infectious agents. Blood sampling can be undertaken in the mortuary by a competent person to confirm or exclude this diagnosis.

Refer to **Appendix 12** for further information

6.0 Financial Risk Assessment

1	Does the implementation of this policy require any additional Capital resources	No
2	Does the implementation revenue resources of this policy require additional	No
3	DoeIPs the implementation of this policy require additional manpower	No
4	Does the implementation of this policy release any manpower costs through a change in practice	No
5	Are there additional staff training costs associated with implementing this policy which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments	

7.0 Equality Impact Assessment

An equality analysis has been conducted, and it indicates that:

Tick	Options
√	A. There is no impact in relation to Personal Protected Characteristics as defined by the Equality Act 2010.
	B. There is some likely impact as identified in the equality analysis. Examples of issues identified, and the proposed actions include:

8.0 Maintenance

The IPT will inform the Infection Prevention and Control Group (IPCG) and through this the Trust Management Committee of any necessary amendment to this policy.

9.0 Communication and Training

9.1 Aspects of this policy will be included in the Trust induction and mandatory infection prevention training sessions.

9.2 Revisions to and launch of this policy will be facilitated by the Infection Prevention Team and carried out through the Divisional Leads communication network to include the Infection Prevention Links and Divisional Matrons.

10.0 Audit Process

Criterion	Lead	Monitoring method	Frequency	Committee
Compliance with PPE usage	HoN Corporate Support Services	Environmental audit which incorporates PPE compliance	Quarterly	Environment Group Exception report to PSIG
	Ward and department managers	Environmental audit which incorporates PPE compliance	Monthly	Environment Group IPCG
Compliance with Hand Hygiene	Ward and department managers	Observation audit	Monthly	IPCG

Compliance with Sharp instruments in healthcare Regulations 2013	HoN Corporate Support Services	Inoculation injury data and associated claims data Procurement data on the ordering of devices posing a risk of inoculation injury	Quarterly Monthly	Inoculation Injury Prevention Group
Compliance with Sharp instruments in healthcare Regulations 2013	Occupational Health and Wellbeing	Analysis of sharps related injuries	Monthly	Inoculation Injury Prevention Group Actions agreed via Health and Safety Committee
Compliance with waste management	Departmental Manager/ Waste Manager HoN Corporate Support Services	Using the HTM 07 01 protocol as set out in HS10 Waste Management policy Environmental audit which incorporates waste compliance IPS annual audit which incorporates waste compliance	Annually Quarterly Annually	Environment Group Environment Group Environment Group
Compliance with safe management of care equipment	Decontamination Lead Medical Physics	Lead Surgical Instruments – SSD Endoscopy instruments via AWD process Manager database system. Maintenance records	Quarterly Quarterly Annual	Medical Equipment Group Medical Equipment Group

Compliance with safe management of care environment	Hotel Services	Technical audits	Weekly/Monthly dependant on functional risk rating	Environment Group IPCG
Compliance with linen guidance as per HRM 01-04	Hotel services/Infection Prevention team	Linen audits	Annually	Environment group Linen group IPCG

11.0 References - Legal, professional or national guidelines must underpin policies and be referenced here. Where appropriate cross references must be made to other policies.

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Department of Health (2015). The Health and Social Care Act (2008). Code of practice for the NHS on the prevention and control of health care associated infections and related guidance. London: Department of Health; 2009.

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15. (2007). National Patient Safety Agency.

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Part A - Document Control

Policy number and Policy version: IP12 V7.0	**Policy Title** Standard and Transmission-Based Precautions	**Status:** Final		**Author: Matron Infection Prevention** **Chief Officer Sponsor: Chief Nursing Officer**
Version / Amendment History	Version	Date	Author	Reason
	V1	May 2008	Infection Prevention Team	Reached stated review date
	V2	Dec 2010	Infection Prevention Team	Reached stated review date
	V3	Feb 2014	Infection Prevention Team	Reached stated review date
	V4	May 2016	Infection Prevention Team	Following HSE inspection on compliance with Safer Sharps Regulations 2013
	V4.1	May 2018	Infection Prevention Team	Addition of Appendix 4 Protocol for FIT testing training and Mask fitting
	V5	April 2019	Infection Prevention Team	Full review
	V5.1	July 2020	Infection Prevention Team	COVID-19 Pandemic
	V6	March 2022	Infection Prevention Team	Full review
	V7.0	March 2025	Matron Infection Prevention	3 yearly policy review and to incorporate standard and transmission-based precautions information from recently created National Infection Prevention and Control Manual for England
Intended Recipients: All staff				
Consultation Group / Role Titles and Date: February 2025 Infection Prevention Team, Microbiologists, Hotel Services, Waste manager, Medical Physics, Occupational Health & Wellbeing				

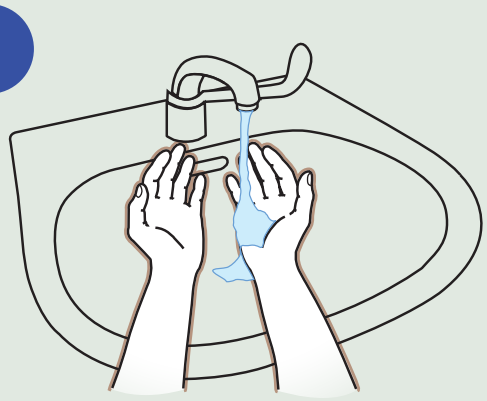
Name and date of Trust level group where reviewed	Infection Prevention & Control Group (IPCG) - February 2025 Trust Policy Group – June 2025
Name and date of final approval committee	Trust Policy Group – June 2025
Date of Policy issue	June 2025
Review Date and Frequency (standard review frequency is 3 yearly unless otherwise indicated – see section 3.8.1 of Attachment 1)	June 2028, 3 yearly
Training and Dissemination: Policy will be available for staff to refer to on the Trust intranet. Content will be included in Trust Induction and mandatory training	
To be read in conjunction with: Hand Hygiene policy IP01, Linen policy IP05, Glove policy IP09, Isolation policy IP10, Waste management policy HS10, Staff Dress Code and Uniform policy HR22, Sharps Safety policy HS03, Decontamination of Medical Devices policies HS11 & HS12	
Initial Equality Impact Assessment (all policies): Completed Yes **Impact assessment (as required): Completed NA**	
Monitoring arrangements and Committee	IPCG
Document summary/key issues covered. The purpose of this policy is to inform staff of the standard and transmission-based infection control precautions that are required to reduce the risk of patients developing a healthcare associated infection but also to protect themselves and their colleagues from exposure to infectious agents.	
Key words for intranet searching purposes	Standard precautions, transmission-based precautions

UK Health Security Agency

Best Practice: How to hand wash step by step images

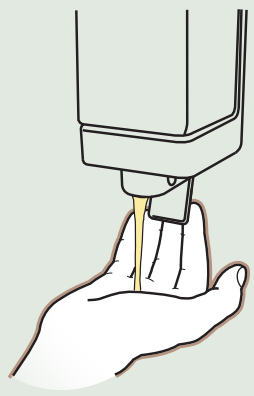
Steps 3-8 should take at least 15 seconds.

1



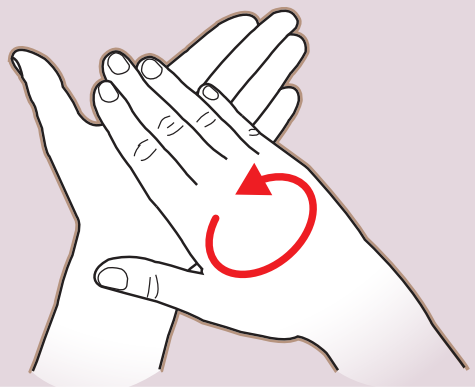
Wet hands with water.

2



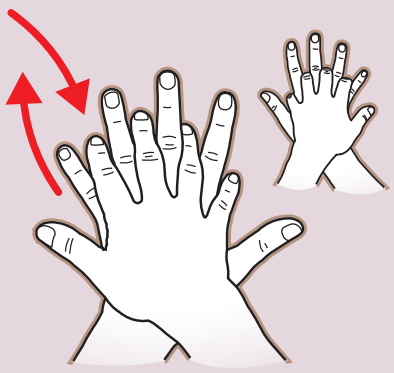
Apply enough soap to cover all hand surfaces.

3



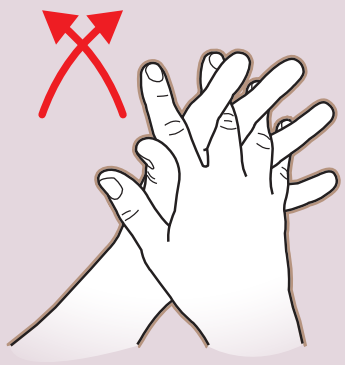
Rub hands palm to palm.

4



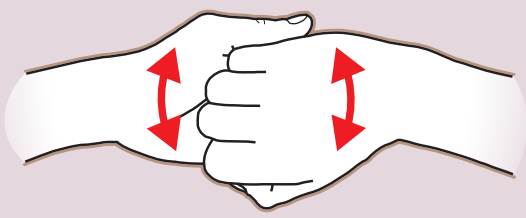
Right palm over the back of the other hand with interlaced fingers and vice versa.

5



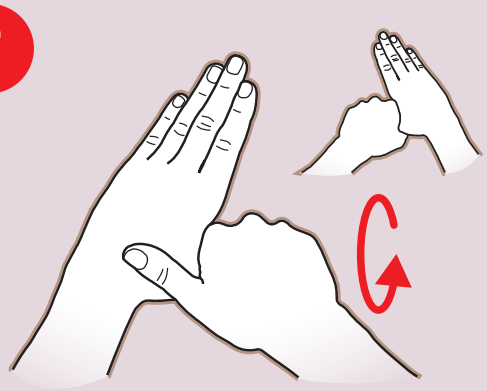
Palm to palm with fingers interlaced.

6



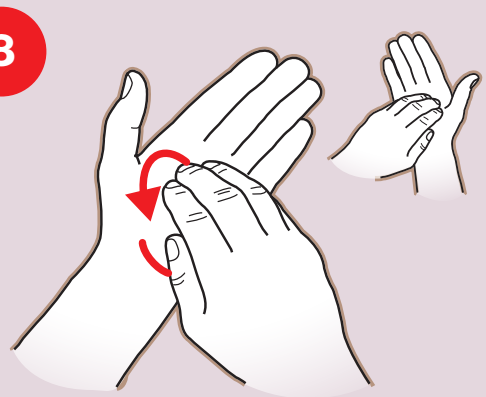
Backs of fingers to opposing palms with fingers interlocked.

7



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

8



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

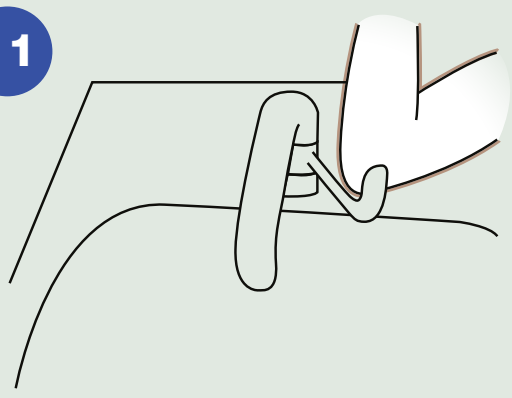
9

Rinse hands with water.

10

Dry thoroughly with towel.

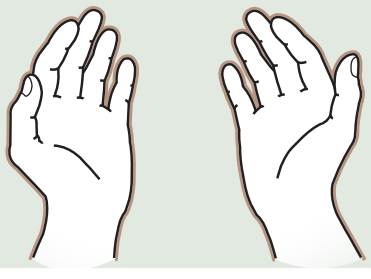
11



Use elbow to turn off tap.

12

Steps 3-8 should take at least 15 seconds.



... and your hands are safe*.

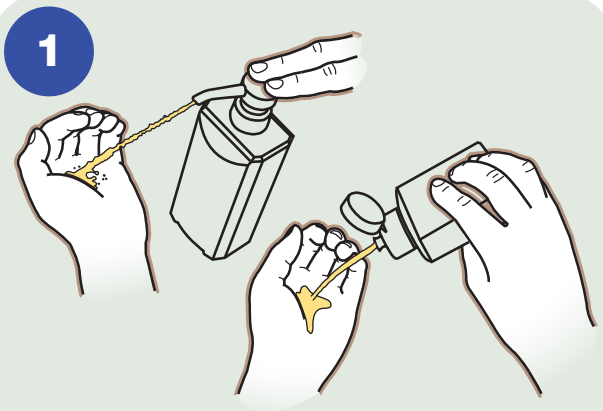
Adapted from the World Health Organization/Health Protection Scotland

*Any skin complaints should be referred to local occupational health or GP.

UK Health Security Agency

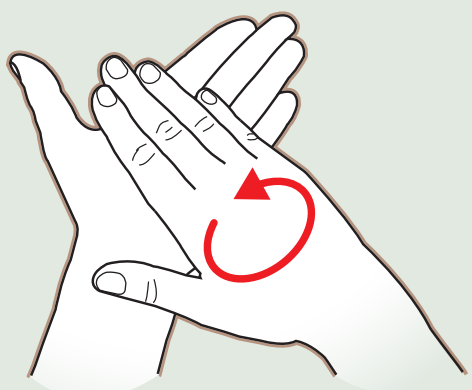
Best Practice: How to handrub step by step images

1



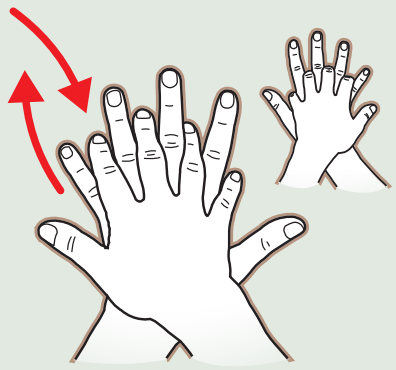
Apply a palmful of the product in a cupped hand and cover all surfaces.

2



Rub hands palm to palm.

3

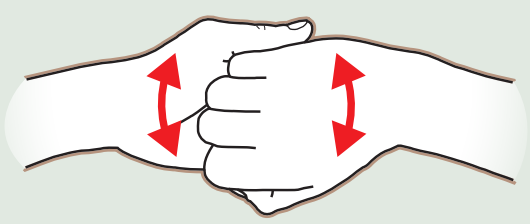


Right palm over the back of the other hand with interlaced fingers and vice versa.

4

Palm to palm with fingers interlaced.

5

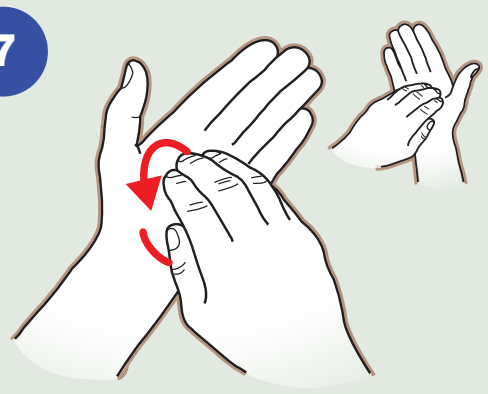


Backs of fingers to opposing palms with fingers interlocked.

6

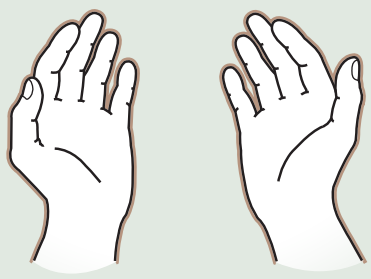
Rotational rubbing of left thumb clasped in right palm and vice versa.

7



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

8



Once dry, your hands are safe.

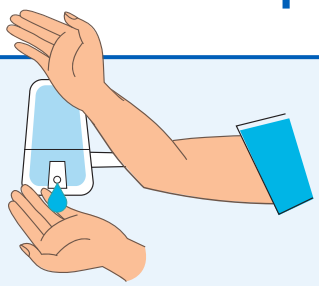
Adapted from the World Health Organization/Health Protection Scotland

Appendix 3: Best practice - surgical hand antisepsis using antimicrobial soap

1

Wet hands and forearms.*

2

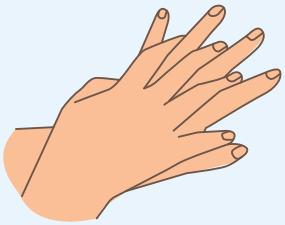


Put antimicrobial liquid soap onto the palm of each hand/arm using the elbow of your other arm to operate the dispenser.

3

Rub hands palm to palm. Steps 3-8 should take a minimum of 2 minutes.

4

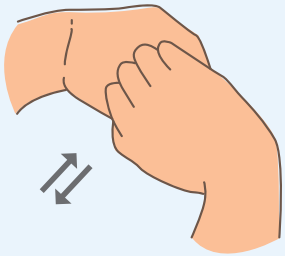


Right palm over the back of the other hand with interlaced fingers and vice versa.

5

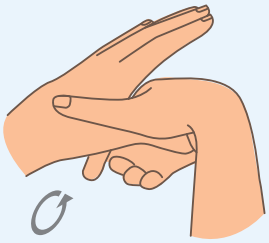
Palm to palm with fingers interlaced.

6



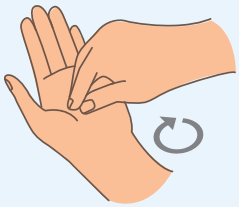
Backs of fingers to opposing palms with fingers interlaced.

7



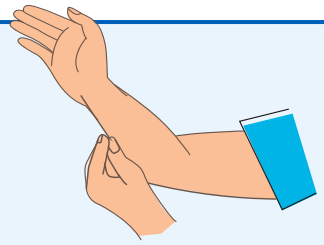
Rotational rubbing of left thumb clasped in right palm and vice versa.

8



Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa. Rinse hands between steps 8-9, passing them through the water in one direction only.

9



Put antimicrobial liquid soap onto the palm of your left hand using elbow of your other arm to operate the dispenser. Use this to scrub the right arm for 1 minute using a rotational method keeping the hand higher than the arm at all times.

10

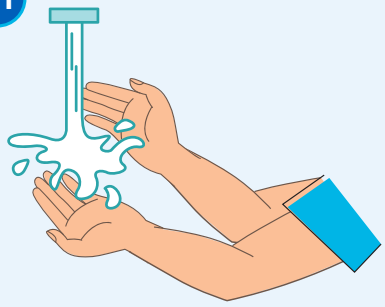
Repeat the process for the other hand and arm keeping hands above elbows at all times.

If the hand touches anything at any time, the scrub must be lengthened by 1 minute for the area that has been contaminated.

*Nails should be cleaned before the first scrub of the day, or if visibly dirty, e.g. using a nail pick (single-use). Any skin complaints should be referred to local occupational health or GP.

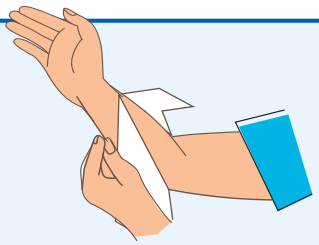
Local policy may recommend repeating steps 1-11 to the mid-forearms only.

11



Rinse hands and arms by passing them through the water in one direction only, from fingertips to elbow. Do not move the arm back and forth through the water.

12

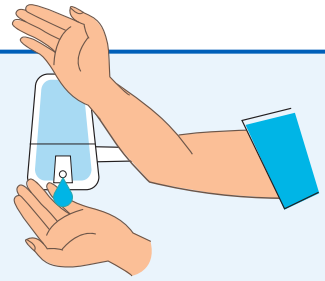


Hold hands above the elbow. Use one sterile, disposable towel per hand and arm. Blot the skin of the hand, then use a corkscrew movement to dry from the hand to the elbow. The towel must not be returned to the hand once the arm has been dried and must be discarded immediately.

Appendix 4: Best practice - surgical hand rub technique using alcohol based hand rub (ABHR)

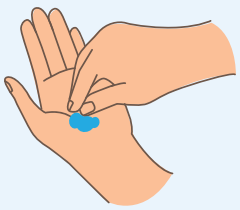
- The hand rubbing technique for surgical hand preparation must be performed on clean, dry hands.
- On arrival in the operating theatre and after having donned theatre clothing (cap/hat/bonnet and mask), hands must be washed with soap and water.
- After the operation when removing gloves, hands must be rubbed with an alcohol-based formulation or washed with soap and water if any residual talc or biological fluids are present (e.g. the glove is punctured).
- Surgical procedures may be carried out one after the other without the need for hand washing, provided that the hand rubbing technique for surgical hand preparation is followed (images 1 to 15).

1



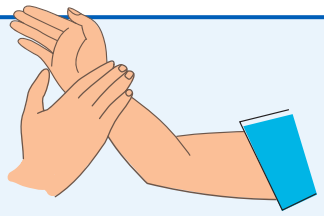
Put approximately 5ml (3 doses) of alcohol-based hand rub in the palm of your hand using the elbow of your other arm to operate the dispenser.

2



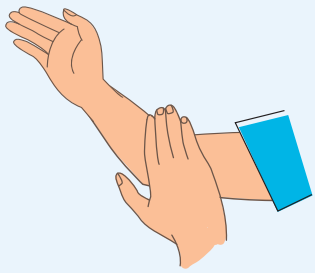
Dip the fingertips of your right hand in the hand rub to decontaminate under the nails (5 seconds).

3

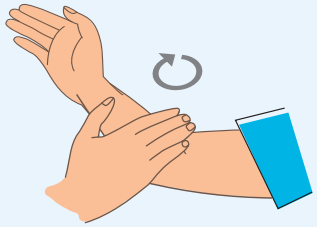


Steps 3-4: Smear the hand rub on the right forearm up to the elbow.

4

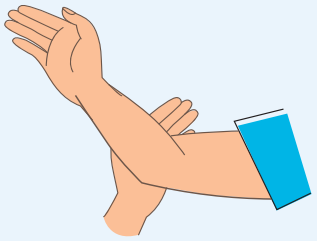


5

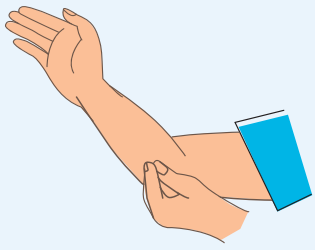


Steps 5-7: Ensure that the whole skin area is covered by using circular movements around the forearm until the rub has fully evaporated (10-15 seconds).

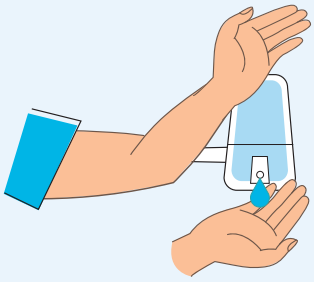
6



7



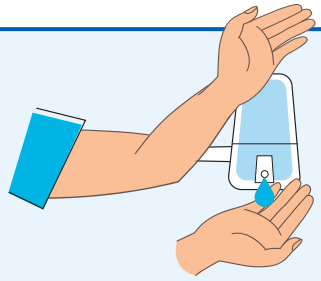
8



Repeat steps 1-7 for the left hand and arm.

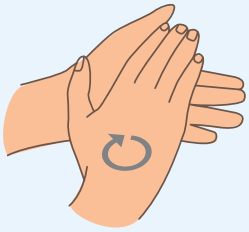
Steps 9-15 are on the next page.

9



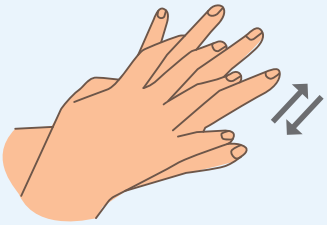
Put approximately 5ml (3 doses) of alcohol-based hand rub in the palm of your hand using the elbow of your other arm to operate the dispenser. Rub both hands at the same time up to the wrists and ensure that all the steps presented in steps 9-14 are followed.

10



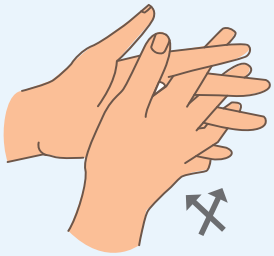
Cover the whole surface of the hands up to the wrist with alcohol-based hand rub, rubbing palm against palm with a rotating movement.

11



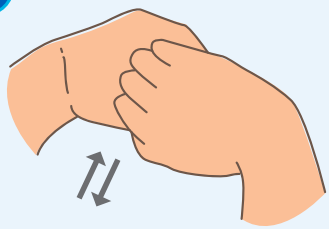
Rub the back of the hands up to the wrist with alcohol-based handrub, rubbing palm over the back of the other hand with interlaced fingers and vice versa.

12



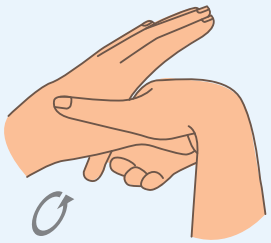
Rub the back of the left hand, including the wrist, moving the right palm back and forth and vice versa

13



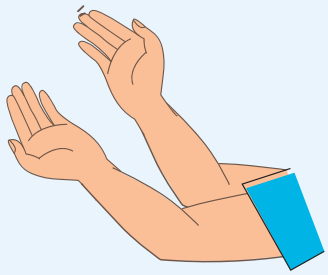
Rub palm against palm back and forth with fingers interlaced.

14



Rub the thumb of the left hand by rotating it in the clasped palm of the right hand and vice versa.

15



When the hands are dry, sterile surgical clothing and gloves can be donned.

Appendix 5a: Personal protective equipment (PPE) when applying standard infection control precautions (SICPs)

Before undertaking any procedure or task, staff should assess any likely exposure to blood and/or other body fluids, non-intact skin, mucous membranes or any equipment or items in the care environment that could be contaminated and wear personal protective equipment (PPE) if required. PPE must protect adequately against the risks associated with the procedure or task.

Hand hygiene must be performed before putting on and after removal of PPE.

SICPs	Gloves	Apron	Gown (ambulance staff use coveralls)	Fluid resistant surgical mask (FRSM)	Eye/face protection
No anticipated exposure to blood or body fluid, mucous membranes, or non-intact skin.	✗	✗	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated but **NO risk of splashing or spraying.**	✓	✓	✗	✗	✗
Exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated **AND risk of spraying or splashing**.	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated.	✓	✓

Where to put on and remove PPE

If required as above, PPE should be put on within the patient room/care area.

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

All PPE must be removed and disposed of before leaving the patient room/care area on completion of care episode.

NB. Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

Appendix 5b: Personal protective equipment (PPE) when applying transmission based precautions (TBPs)

SICPs may be insufficient to prevent cross transmission of specific infectious agents and additional precautions (TBPs) may be required. PPE must protect adequately against the risks associated with the procedure or task. Refer to appendix 11a for additional information.

Hand hygiene must be performed before putting on and after removal of PPE.

TBPs	Gloves	Apron	Gown	Fluid resistant surgical mask (FRSM)	Respiratory Protective Equipment (RPE)	Eye/face protection
Contact precautions	✗ Unless exposure to blood or body fluid, mucous membranes, or non-intact skin is anticipated or footnote 1 applies[1]	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated or footnote 2 applies[2]	✗	✗ Unless risk of splashing or spraying of blood or body fluids is anticipated
Droplet precautions	✓	✓	✗ Unless in place of an apron if extensive spraying or splashing is anticipated	✓	✗	✓
Airborne precautions	✓	✗	✓	✗	✓	✓

Where to put on and remove PPE

Gloves are not an alternative to hand hygiene. Gloves must always be removed after each task on the same patient and hand hygiene performed as per the 5 moments for hand hygiene.

Contact precautions: required PPE should be put on within the patient room/care area immediately **before** direct contact with the patient or their environment and should be removed and disposed of **before** leaving the patient room/care area.

Droplet and airborne precautions: required PPE should be put on **before** entering the patient room/care area. Unless there is a dedicated isolation room with anteroom, gowns, aprons and gloves should be removed and disposed of before leaving the patient room/care area. Eye/face protection and RPE (if worn) must be removed and disposed of **after** leaving the patient room/care area.

1.Clinical risk assessment may also indicate the use of gloves for specific organisms such as scabies, multi-drug resistant organisms or those with increased potential for hand and environmental contamination such as spore forming organisms e.g. *C. difficile*. This list is not exhaustive.
2.Universal masking using FRSM may be indicated as a source control measure during outbreaks of respiratory infectious agents.

PPE requirements for high consequence infectious diseases should be discussed with specialist teams as per appendix 11b.

Appendix 6: Putting on and Removing Personal Protective Equipment (PPE)

Before undertaking any procedure or task, staff should assess the risk of likely exposure to blood and/or other body fluids, non-intact skin, mucous membranes, or any equipment or items in the care environment that could be contaminated, and wear PPE if required. PPE must protect adequately against the risks associated with the procedure or task. The items of PPE worn will vary based on the type of exposure anticipated, and not all items of PPE may be required.

Putting on Personal Protective Equipment (PPE)

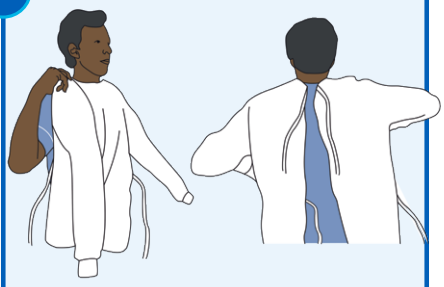
Before beginning, check which items of PPE are required and that these are available in the correct size.

The order for putting on PPE is Apron or Gown, Fluid-Resistant Surgical Mask (FRSM)/ Respiratory Protection Equipment (RPE) (FFP3),[1] Eye Protection, then Gloves.

1

Apron: Pull over head and tie securely at the back.

2



Gown: Fully cover torso neck to knees, arms to end of wrist and wrap around the back. Fasten at the back.

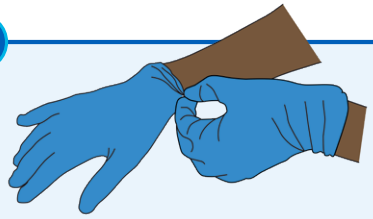
3

FRSM or RPE (FFP3)[1]: Secure ties or elastic bands at middle of head and neck. Fit flexible band to nose bridge. Fit snug to face and below chin. Respirators must be fit checked if being worn.

4

Eye Protection (Goggles/Face Shield): Place over face and eyes and adjust to fit.

5



Gloves: Pull on taking care to minimise contamination of the outer surface by holding gloves at the wrist opening only. Extend to cover wrist (over gown cuffs, if applicable).

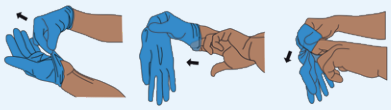
Steps on removing PPE are continued on the next page.

Removing Personal Protective Equipment (PPE)

When removing PPE, the correct technique is essential to avoid touching the most contaminated areas of PPE e.g., the outside of gloves and front of aprons/gowns, eye protection, and FRSM/RPE.

The order for removing PPE is Gloves, Apron or Gown, Eye Protection, then FRSM/RPE (FFP3)[1].

6



Gloves: Pinch and lift the outside of the glove in the palm area with the opposite gloved hand; peel off while turning inside out. Hold the removed glove in the gloved hand. Slide two fingers of the ungloved hand under the remaining glove at the wrist. Peel the second glove off over the first glove and discard.

7

Apron: Unfasten or break neck ties and allow apron to fall forward. Unfasten or break waist ties and pull apron away from the body touching the inside only. Fold or roll into a bundle and discard.

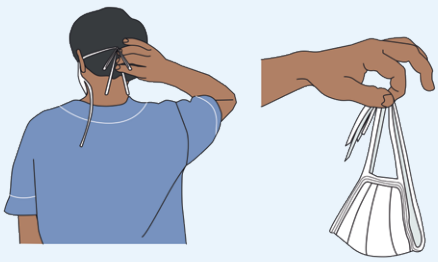
8

Gown: Unfasten neck, then waist ties. Remove using a peeling motion; pull gown from each shoulder towards the same hand turning gown inside out. Hold removed gown away from body, fold or roll into a bundle and discard.

9

Eye Protection (Goggles/Face shield): Handle eye protection only by the headband or the sides. Face shields/glasses should be removed by grasping sides and pulling directly forward, away from face. To remove goggles with an elasticated headband, tilt head forward and grasp the headband with index fingers and thumbs, lift the headband upwards whilst pushing frame away from face, lower goggles away from face and discard.

10



FRSM or RPE (FFP3)[1]: Unfasten the ties - first the bottom, then the top or, if elasticated, pull top and bottom elastics together. Handling the ties/elastics only pull away from the face without touching front of mask/respirator and discard.

- **All PPE should be removed before leaving the care area and immediately disposed of directly into the appropriate waste stream, or a designated receptacle for reusable PPE.**
- **Perform hand hygiene immediately upon removal of PPE.**

1. Reusable RPE including powered hoods may require a different order for putting on and removing, refer to your local policy if applicable.

SoChlor® DST

GV Health
Life. Protected.

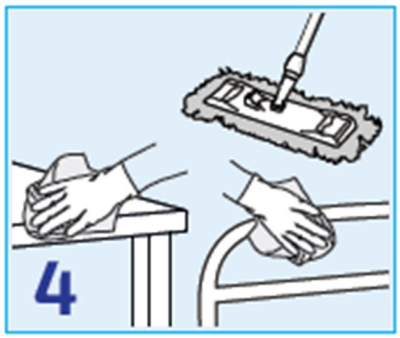
Environmental Hygiene & Disinfection

CLEAN AND DISINFECT IN ONE STEP WITH SOCHLOR DST

Wear disposable gloves and apron.
If risk of splashing wear eye protection.

Remove any gross contamination before applying SoChlor™, including urine & vomit.

Dissolve SoChlor™ tablets (according to dilution instructions below) in water. If solution is older than 24hrs make new solution.



Use solution according to your hospital policy. Once applied, allow surfaces to air dry. (5 min contact time recommended)

Dispose of remaining solution into sluice or drain with running water.

Wash your hands after removing gloves.

Dilution Instructions

Dilution rates for SoChlor DST per 1 litre of water		
Environmental Situation	Required amount of available chlorine	SoChlor DST / 1.7g NaDCC Tablet (MFB256 / MFB294)
Standard disinfection and clean	1,000 ppm	1
Outbreak disinfection	5,000 ppm	5
Disinfection of blood or blood-stained spills	10,000 ppm	10

Safety & Precautions

DON'T take internally, avoid eye and direct skin contact.

DON'T mix directly with acids* or cationic detergents *eg. urine or vomit.

AVOID PROLONGED contact with stainless steel or clothing.

ALWAYS keep out of the reach of children & vulnerable patients.

ALWAYS dispose used materials as clinical waste.

ALWAYS make fresh solution if solution date is not known.

ALWAYS replace lid after use and store in a secure dry place.

WHERE POSSIBLE ensure good ventilation.

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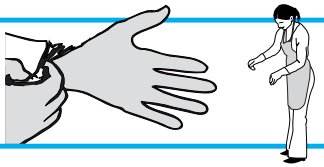
www.gvhealth.com

Urine & Vomit Spillages

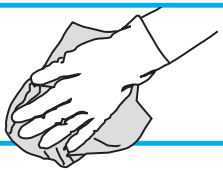
1 Put on protective clothing: Gloves and Apron.



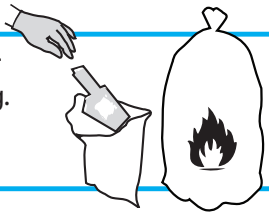
2 Sprinkle all the GV Absorbent Granules over the spill and leave for 30-60 seconds.

3 When the granules have absorbed the spill open bag, collect granules using the scoop and scraper and place in the bag along with used scoop and scraper.

4 Use disinfectant surface wipes to clean the area of the spill and remove any smears. Use paper towels to dry the area.



5 Place used scoop & scraper, surface wipes, paper towels and protective clothing, gloves last in bag. Tie bag top to seal. Place bag into appropriate waste disposal channel.



BAG AND CONTENTS MUST BE DISPOSED OF IN ACCORDANCE WITH LOCAL WASTE DISPOSAL POLICIES.

TEXTILE BAGGING POLICY

This bagging policy ensures compliance to Department of Health HTM 01-04 Decontamination of linen and social care.

HTM 01-04 - COLOUR CODING
TEXTILE BAGGING POLICY

USED LINEN HIRE ITEMS
E.g. Sheets, Pillowcases, Towels, Night Wear etc

White Elis Bag

REJECTED LINEN

Rejected / Return Items Only Pink Elis Bag

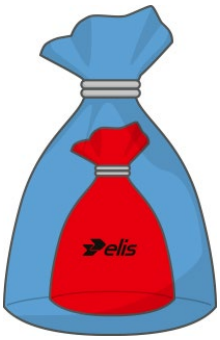
INFECTED LINEN HIRE ITEMS

Dissolvable Red Bag Inside White Elis Bag

HOSPITAL OWNED ITEMS

Blue Elis Bag

INFECTED HOSPITAL OWNED ITEMS



Dissolvable Red Bag Inside Blue Elis Bag

SURGEONS' GOWNS, THEATRE DRAPES

Green Elis Reusable Surgical Bag

INFECTED SURGEONS' GOWNS, THEATRE DRAPES

Inner Dissolvable Red Bag Outer Green Elis Reusable Bag

This supersedes all previous linen bagging policies, in adherence to Department of Health guidelines HTM 01-04

Appendix 12: Transmission based precautions for deceased patients with infection

As per section 2.6 of the NIPCM, the principles of SICPs and TBPs continue to apply while deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. Additional precautions may be required depending on the organism and activities carried out (see table).

Infection	Causative agent	Hazard Group	Is a body bag needed[1]?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Airborne: small particles that can remain airborne with potential for transmission by inhalation							
Plague (Pneumonic and bubonic)	*Yersinia pestis*	3	Yes	Yes	If an appropriate facility is found	Consult specialist advice	Consult specialist advice
Tuberculosis	*Mycobacterium tuberculosis*	3	Yes	Yes	Yes	Yes	Yes
Middle Eastern Respiratory Syndrome (MERS)	MERS coronavirus	3	Yes	Yes	Yes	Yes	Yes
Severe acute respiratory syndromes	eg SARS coronavirus see HSE Handling the deceased with suspected or confirmed COVID-19 - HSE	3	Yes	Yes	Yes	Yes	Yes
Droplet: large particles that do not remain airborne for very long and do not travel far from source with potential for transmission via mucocutaneous routes (ie mouth, nose, or eyes)							
Meningococcal septicaemia (Meningitis)	*Neisseria meningitidis*	2	No	Yes	Yes	Yes	Yes
Non-meningococcal meningitis	Various bacteria including *Haemophilus influenzae* and also viruses	-	No	Yes	Yes	Yes	Yes

Infection	Causative agent	Hazard Group	Is a body bag needed[1]?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Influenza (animal origin)	eg H5 and H7 influenza viruses	3	No	Yes	Yes	Yes	Yes
Diphtheria	*Corynebacterium diphtheriae*	2	No	Yes	Yes	Yes	Yes
Contact: either direct via hands of employees, or indirect via equipment and other contaminated articles where transmission is primarily via an ingestion route							
Invasive streptococcal infection	*Streptococcus pyogenes* (Group A)	2	Yes	Yes	Yes	No	No
Dysentery (shigellosis)	*Shigella dysenteriae (type 1)*	3	Advised	Yes	Yes	Yes	Yes
Methicillin-resistant *Staphylococcus aureus (*MRSA)	Methicillin-resistant *Staphylococcus aureus*	2	No	Yes	Yes	Yes	Yes
Hepatitis A	Hepatitis A virus	2	No	Yes	Yes	Yes	Yes
Hepatitis E	Hepatitis E virus	3	No	Yes	Yes	Yes	Yes
Enteric fever (typhoid/para typhoid)	*Salmonella typhi/paratyphi*	3	Advised	Yes	Yes	Yes	Yes
Brucellosis	*Brucella melitensis, B. arbortus, B. suis*	3	No	Yes	Yes	Yes	Yes
Haemolytic uraemic syndrome	Verocytotoxin/ shiga toxin producing *E.coli* (eg O157:H7)	3	No	Yes	Yes	Yes	Yes
Contact: either direct or indirect contact with blood/other blood containing body fluids via a skin-penetrating injury or via broken skin and through splashes of blood/other blood containing body fluids to eyes, nose and mouth							
Acquired Immune Deficiency Syndrome related illness	Human immune-deficiency virus	3	No	Yes	Yes	Yes	Yes
Anthrax	*Bacillus anthracis*	3	Yes	No	Yes[4]	No	No
Hepatitis B, D and C	Hepatitis B, D and C viruses	3	No	Yes	Yes	Yes	Yes
Rabies	Lyssaviruses	3	No	Yes	No	No	No
Viral haemorrhagic fevers	Various – see UKHSA guidance[6]	4	Yes[5]	No	No	No	No
Contact: either direct or indirect contact with body fluids (eg brain and other neurological tissue) via a skin-penetrating injury or via broken skin							

Infection	Causative agent	Hazard Group	Is a body bag needed[1]?	Can the body be viewed?	Can post mortem be carried out?[2]	Can hygienic treatment be carried out?[3]	Can embalming be carried out?[2]
Transmissible spongiform encephalopathies (eg vCJD)	Various prions	3	Yes	Yes	Yes	Yes	No

Notes

[1] It is advised that a body bag is used for the deceased in all cases where there is (or is likely to be) leakage of bodily fluids.

[2] When carrying out higher risk procedures such as post-mortem or embalming, consideration should be given to the need for additional measures to prevent contamination of equipment and the environment and to prevent staff exposure to infectious material eg through additional PPE and use of safer sharps devices.

[3] Hygienic treatment refers to washing and/or dressing of the deceased.

[4] Where anthrax infection is suspected, before undertaking a post mortem the rationale for the procedure should be carefully considered; particularly where examination may increase the potential for aerosol generation.

[5] A double body bag must be used.

NB Hazard group 4 and HCID will be transported by HART teams (see section 2.6)

[6] UKHSA High consequence infectious diseases (HCID) - GOV.UK (www.gov.uk)