

# ESSEX HEALTH PROTECTION UNIT

## PRISON INFECTION CONTROL GUIDELINES



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# ALL STAFF AND PRISONERS

## SECTION A - INTRODUCTION AND CONTACTS

### 1. Introduction

This document has been written as a general guide to the most common problems prison staff may encounter. The document is not intended as an exhaustive guide to infectious diseases, and should be read in conjunction with the Essex Health Protection Unit (EHPU) Community Infection Control Guidelines, which contains an Environment Audit Tool for healthcare units, which is available from [www.hpa.org.uk/essex/](http://www.hpa.org.uk/essex/).

This document is intended for use by Healthcare staff, Allied prison staff (i.e. probation Officers) and Prison Officers. Most of the action required represents common sense and follows basic principles. In cases where there is still uncertainty medical advice is available from:

1. The Chief Medical Officer (the General Practitioner employed by the Prison Service) will be able to give advice for the healthcare of prisoners
2. Staff members' own General Practitioners for their personal health advice
3. Primary Care Organisations' Infection Control Nurses
4. If the answer is still unclear the EHPU will give advice about infectious diseases. Contact numbers can be found in the Contacts section of this publication.

It should be recognised that we are exposed to potentially harmful organisms all the time. Adults do not often become ill because they have already developed immunity. However, because infections can be passed on, even though someone appears well, it is important that high standards of basic hygiene are always maintained. Adults living in a residential environment are more likely to transmit infection to one another.

### 2. Scope

This document gives guidance for those working in the Prison and Young Persons Institution (YOI) environment. These guidelines are not intended as a basis for advice to the general public. Certain disease specific information sheets are available from the Health Protection Agency website: [www.hpa.org.uk/Essex/Policies](http://www.hpa.org.uk/Essex/Policies).

If any further infection control advice or follow-up is required for prisoners or their families please contact a member of the EHPU.

### **3. Responsibility**

The philosophy of this manual is to encourage responsibility by every member of staff. All should participate in the prevention and control of infection.

Under the current Health and Safety at Work legislation (inter alia), it is the clear legal responsibility of HM prisons to ensure that effective arrangements are in place for the management and control of infection and communicable diseases amongst inmates, staff (including volunteers) and visitors.

Each prison should have nominated an appropriately experienced and qualified person and alternative(s), who have overall responsibility for the day-to-day control of infection and communicable disease in the prison setting.

All arrangements should comply with the Health and Safety at Work Act (1974) and the relevant associated legislation. This will involve the Prison Governor ensuring the following in relation to infection and communicable disease control:

- Measures for the protection of members of staff, inmates and all others coming into contact with the workings of the prison
- The provision and maintenance of equipment and systems of work, which are practicable, safe, and without risk to health, along with the provision of information, training and supervision, as appropriate for the prevailing circumstances. If necessary, health surveillance may also need to be undertaken.

It is recommended that staff should have ready access to an Occupational Health (OH) Service. All staff should be aware of their health-related obligations, and ensure that their own routine immunisations are up-to-date (including BCG and Hepatitis B).

### **4. Contacts**

Infection Control advice can be obtained from the PCO infection control nurses:

- Mid Essex                    01245 398770
- North East Essex        01206 288500
- South East Essex        01702 224600
- South West Essex        01268 705000
- West Essex                01279 694747.

The Essex Health Protection Unit is based at:

Essex Health Protection Unit  
8 Collingwood Road  
Witham  
Essex  
CM8 2TT

**The main office telephone number is: 0845 1550069.** The Consultants in Communicable Disease Control (CCDCs) and Communicable Disease Control Nurses (CDCNs) are contactable via this number. The fax number is 01376 302278.

Advice is also available on the HPA website [www.hpa.org.uk/Essex](http://www.hpa.org.uk/Essex). Users are encouraged to ensure they have access to this site, as it has advice and information on a wide range of local communicable disease issues, and during incidents will be updated at least daily with the current state of affairs

Out of working hours – for **URGENT** communicable disease enquiries contact 01245 444417, and ask operator to contact the on-call Public Health Person.

## SECTION B - STAFF HEALTH

### 1. Immunisation

Immunisation protects against serious illnesses. Modern vaccines are safe and effective, and every effort should be made to ensure that staff are protected. A risk assessment should be undertaken by the Prison Service to ensure all employees who require it are immunised against Hepatitis B. The Department of Health (Immunisation Against Infectious Diseases Aug 2006) advises that all staff should have their immunisation status established before starting work. This should be done by the OH Department.

All employees should have been fully immunised against polio, tetanus, diphtheria and tuberculosis (BCG). If they are unsure whether they are up-to-date with all their immunisations, they should consult their own GP.

Immunisation Against Infectious Diseases 'The Green Book' Chapter 18 states immunisation is recommended for all prison staff in regular contact with prisoners.

It is recommended that prison staff working directly with prisoners that are unvaccinated, tuberculin-negative, and aged under 35 years should receive BCG.

Hepatitis B vaccination is recommended for all prison service staff in regular contact with prisoners.

All female employees of child-bearing age should have had rubella or MMR vaccine before starting work.

Pregnant women should seek medical advice promptly if they come into direct contact with:

- A suspected case of rubella (German measles)
- A case of chickenpox or shingles, especially if they do not have a definite history of infection themselves
- A case of parvovirus B19 (slapped cheek syndrome)
- Anyone with an undiagnosed generalised rash.

## SECTION C - INFECTION, ITS CAUSES AND SPREAD

### 1. The Causes of Infection

Micro-organisms are integral to infections, and a basic insight into the characteristics of commonly encountered micro-organisms is essential for good infection control practice. Micro-organisms that cause disease are referred to as pathogenic organisms. They may be classified as follows:

**Bacteria** are minute organisms about one-thousandth to five-thousandth of a millimetre in diameter. They are susceptible to a greater or lesser extent to antibiotics.

**Viruses** are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

**Pathogenic Fungi** can be either moulds or yeasts. For example, a mould which causes infections in humans is *Trichophyton rubrum* which is one cause of ringworm and which can also infect nails. A common yeast infection is thrush caused by *Candida albicans*.

**Protozoa** are microscopic organisms, but larger than bacteria. Free-living and non-pathogenic protozoa include amoebae and paramecium. Examples of medical importance include *Giardia lamblia*, which causes an enteritis (symptoms of diarrhoea).

**Worms** are not always microscopic in size but pathogenic worms do cause infection and some can spread from person to person. Examples include threadworm and tapeworm.

**Prions** are infectious protein particles. For example the prion causing (New) Variant Creutzfeldt-Jakob Disease (vCJD).

### 2. The Spread of Infection

There are various means by which micro-organisms can be transferred from their reservoir to susceptible individuals. These are:

**Direct Contact.** Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. chickenpox, tuberculosis, sexually transmitted infections etc.).

**Indirect Contact.** Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens e.g. fomite or vector.

A **fomite** is defined as an object, which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person. Examples of potential fomites are instruments, impression trays and suction tips or practically any inanimate article.

Crawling and flying insects are obvious examples of **vectors** and need to be controlled. Insect bites may cause infections such as malaria in areas where malaria carrying mosquitoes live.

**Hands.** The hands of healthcare workers are probably the most important vehicles of cross-infection. The hands of patients can also carry microbes to other body sites, equipment and staff.

**Inhalation.** Inhalation spread occurs when pathogens exhaled or discharged into the atmosphere by an infected person are inhaled by and infect another person. The common cold and influenza are often cited as examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses.

**Ingestion.** Infection can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal-oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, *Salmonella*, *Campylobacter*.

**Inoculation.** Inoculation infection can occur following a “sharps” injury when blood contaminated with, for example, Hepatitis B virus is directly inoculated into the blood stream of the victim, thereby causing an infection. Bites from humans can also spread infection by the inoculation mode.

## SECTION D - ROUTINE PROCEDURES FOR THE CONTROL OF INFECTION

### 1. Standard Principles/Universal Precautions

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called **Standard Principles of Infection Control (or Universal Precautions)**.

The recommendations on standard principles provide guidance on infection control precautions that should be applied by all healthcare personnel, and other carers, to the care of patients in community and primary care settings.

Standard Principles of Infection Control include:

- Hand Hygiene and Skin Care
- Protective Clothing
- Safe Handling of Sharps (including Sharps Injury Management).

All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them.

Everyone involved in providing care in the prison should know and apply the standard principles of hand decontamination, the use of protective clothing and the safe disposal of sharps. Each member of staff is accountable for his/her actions and must follow safe practices.

### 2. Hand Hygiene and Skin Care

There are two methods of hand decontamination which are handwashing and handrubs, both alcohol and non-alcohol-based.

Hand decontamination is recognised as the single most effective method of controlling infection.

Hands must be decontaminated:

- Before and after each work shift or work break. Remove jewellery (rings)
- Before and after physical contact with each client
- After handling contaminated items such as dressings, bedpans, urinals and urine drainage bags

- Before putting on, and after removing protective clothing, including gloves
- After using the toilet, blowing your nose or covering a sneeze
- Whenever hands become visibly soiled
- Before preparing or serving food
- Before eating, drinking or handling food and before and after smoking.

## How to Wash Your Hands

Hands that are visibly soiled, or potentially grossly contaminated with dirt or organic material, must be washed with liquid soap and water.

	Method	Solution	Task
1	Social (15-30 seconds)	Liquid soap	For all routine tasks
2	Hygienic hand disinfection (15-30 seconds)	Antiseptics, e.g. chlorhexidine, povidone-iodine or alcohol hand-rub after social clean	In high-risk areas and during outbreaks
3	Surgical scrub (2 mins)	Antiseptics, e.g. chlorhexidine, povidone-iodine, thorough and careful. Dry on sterile towels	Prior to surgical and other invasive procedures. Bars of soap not recommended

An effective handwashing technique involves three stages:

### 1. Preparation

Before washing hands, all wrist and, ideally, hand jewellery should be removed. Cuts and abrasions must be covered with waterproof dressings. Fingernails should be kept short, clean and free from nail polish. Hands should be made wet by placing them under tepid running water before applying liquid soap or an antimicrobial preparation.

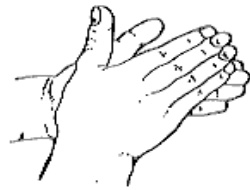
### 2. Washing and Rinsing

The handwash solution must come into contact with all of the surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 15-30 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly. When decontaminating hands use an alcohol handrub, hands should be free from dirt and organic material. The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers until the solution has evaporated and the hands are dry.

## Surgical Handwashing

Surgical handwashing destroys transient organisms and reduces resident flora before surgical or invasive procedures. An aqueous antiseptic solution is applied for two minutes. Preparations currently available are 4% chlorhexidine-detergent and 0.75% povidone/iodine solution-detergent.

This is required before minor surgery and invasive procedures.



1. Palm to palm.



2. Right palm over left dorsum and left palm over right dorsum.



3. Palm to palm fingers interlaced.



4. Backs of fingers to opposing palms with fingers interlocked.



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



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

*Handwashing technique. (Ayliffe et al. 1978; Lawrence 1985)*

### 3. Drying


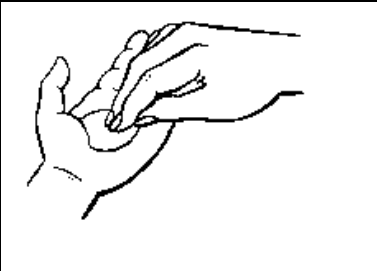
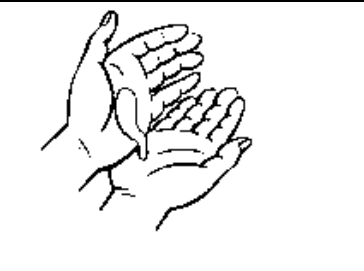



This is an essential part of hand hygiene. Dry hands thoroughly using good quality paper towels. In clinical settings, disposable paper towels are the method of choice because communal towels are a source of cross-contamination. Store paper towels in a wall-mounted dispenser next to the washbasin, and throw them away in a pedal operated domestic waste bin. Do not use your hands to lift the lid or they will become re-contaminated.

Hot air dryers are not recommended in clinical settings. However if they are used in other areas, they must be regularly serviced and users must dry hands completely before moving away.

### Handrubs/Alcohol Gels

Hands should be free from dirt and organic material. The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and hands are dry

## How to Apply:

		
<b>1. Apply alcohol decontaminant to the palm of one hand</b>	<b>2. Press fingertips of other hand to the palm</b>	<b>3. Tip the remaining alcohol from one palm to the other</b>
		
<b>4. Press fingertips of the other hand to the palm</b>	<b>5. Quickly spread alcohol onto all surfaces of both hands</b>	<b>6. Continue spreading the alcohol until it dries</b>

This may be used for general decontamination of hands with alcohol gel or liquid. This method has been developed by Ecolab.

## Hand Cream

An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination. If a particular soap, antimicrobial handwash or alcohol product causes skin irritation, an OH department should be consulted.

## Hand Decontamination Facilities

### Handwashing

Handwash facilities should be adequate and conveniently located. Handwash basins must be placed in areas where needed and where client consultations take place. They should have elbow or foot-operated mixer taps. A separate sink should be available for other cleaning purposes - such as cleaning instruments:

- Use wall-mounted liquid soap dispensers with disposable soap cartridges - keep them clean and replenished
- Place wall-mounted disposable paper towels next to the basins - soft towels will help to avoid skin abrasions
- Position foot-operated pedal bins near the handwash basin - make sure they are the right size for the amount of waste generated.

## Location of Alcohol Handrubs/Gels

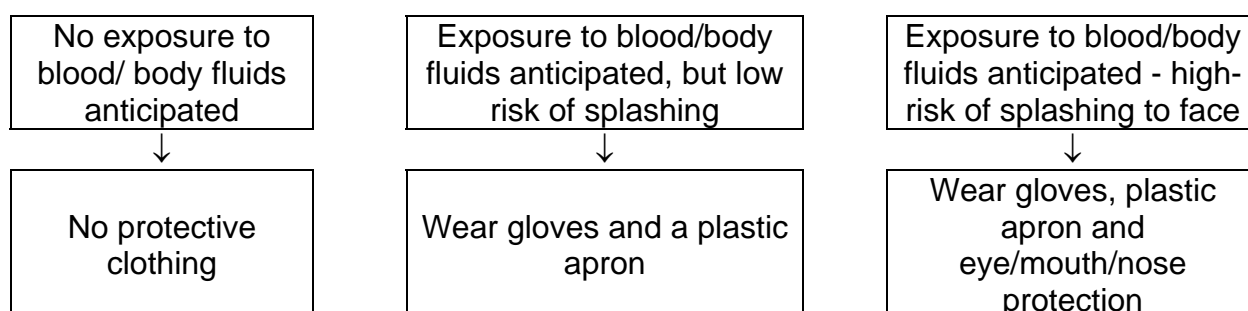
- Dispensers should be wall-mounted outside all patient rooms in healthcare
- Wall-mounted or free-standing in all examination areas
- Wall-mounted at the entry and exits to clinical areas
- Individual staff pocket alcohol gel should be available for all Prison Healthcare workers
- It is recommended that a wall-mounted alcohol dispenser is placed at all staff points on prisoner wings.

## 3. Protective Clothing

Selection of protective equipment must be based on an assessment of the risk of transmission of infection between the patient and carer.

### Assessment of Risk

#### WHAT TO WEAR WHEN



### Types of Protective Clothing

#### Disposable Gloves

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments.

Gloves that are acceptable to prison officers and healthcare personnel and that conform to European Community (CE) standards must be available.

**DO NOT USE** powdered gloves or polythene gloves in healthcare activities.

Gloves must be worn as single-use items. They must be put on immediately before an episode of patient contact or treatment and removed as soon as the

activity is completed. Gloves must be changed between caring for different patients, and between different care or treatment activities for the same patient. Gloves do not substitute for handwashing.

Gloves must be disposed of as clinical waste and hands decontaminated after the gloves have been removed.

Sensitivity to natural rubber latex must be documented and alternatives to natural rubber latex gloves must be available.

To prevent transmission of infection, gloves must be discarded after each procedure. Gloves should **not** be washed between patients as the gloves may be damaged by the soap solution and, if punctured unknowingly, may cause body fluid to remain in direct contact with skin for prolonged periods.

### **1. Non Sterile Gloves**

Should be used when hands may come into contact with blood and body fluids, or equipment contaminated with blood and body fluids.

### **2. Sterile Gloves**

Should be used when the hand is likely to come into contact with normally sterile areas or during any surgical procedure.

### **3. General-purpose Utility Gloves**

General-purpose utility gloves e.g. rubber household gloves, can be used for cleaning instruments prior to sterilisation, or when coming into contact with possible contaminated surfaces or items. Ideally, colour-coding of such gloves should be used e.g. blue for the kitchen, yellow for general environmental cleaning, and red for 'dirty' clinical duties. This will help prevent cross-infection from one area of work to another. The gloves should be washed with general-purpose detergent and hot water, and dried between use. They should be discarded weekly, or more frequently if the gloves become damaged.

### **4. Polyurethane/polythene Gloves (Non Sterile and Sterile)**

Polyurethane/polythene gloves do not act as a barrier to infection. They do not meet the Health and Safety Commission regulations and they do not have a place in clinical application. **DO NOT USE.**

### **Disposable Plastic Aprons**

Should be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.

Plastic aprons should be worn as single-use items, for one procedure or episode of patient care, and then discarded and disposed of as clinical waste.

## Face Masks and Eye Protection

Must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face, mouth and eyes.

## Respiratory Protective Equipment

For example, a particulate filter mask, must be used when clinically indicated for pulmonary tuberculosis.

## 4. Safe Handling of Sharps

All staff should be fully immunised according to national policy. In addition, all those handling sharps should have had a course of Hepatitis B vaccine. A record of Hepatitis B antibody response should be kept for all clinical staff involved in 'exposure prone procedures' or where regular exposure to blood/blood-stained body fluids occurs.

Care should be taken to avoid accidental needlestick injury, as exposure to contaminated blood may be associated with transmission of blood-borne viruses (BBVs).

Sharps include needles, scalpels, stitch cutters, glass ampoules, sharp instruments and broken crockery and glass. Sharps must be handled and disposed of safely to reduce the risk of exposure to blood-borne viruses. Always take extreme care when using and disposing of sharps. Avoid using sharps whenever possible.

- Clinical sharps should be single-use only
- Do not re-sheath a used needle - if this is necessary a safe method, i.e. a re-sheathing device, must be used
- Discard sharps directly into a sharps container immediately after use and at the point of use
- Sharps containers should be available at each location where sharps are used
- Sharps containers must comply with UN 3921 and BS7320 standards
- Close the aperture to the sharps container when carrying or if left unsupervised to prevent spillage or tampering
- Place sharps containers on a level stable surface
- Do not place sharps containers on the floor, window sills or above shoulder height - use wall or trolley brackets

- Assemble sharps containers by following the manufacturer's instructions
- Carry sharps containers by the handle - do not hold them close to the body
- Never leave sharps lying around
- Do not try to retrieve items from a sharps container
- Do not try to press sharps down to make more room
- Lock the container when it is three-quarters full using the closure mechanism
- Label sharps containers with the source details prior to disposal
- Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place inside yellow clinical waste bag.

### **Giving Injections**

Always wash hands thoroughly prior to giving an injection.

If the patient's skin is visibly dirty, it should be cleaned with an individually packed swab soaked in 70% isopropyl alcohol and left to dry. If skin is clean, this step is not necessary.

Venepuncture and injections should be carried out only by staff who are adequately trained and experienced.

**For occupationally acquired sharps injuries refer to Section E.**

<h2><b>5. Spillage Management</b></h2>
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Deal with blood and body fluid spills quickly and effectively.

Commercially available spillage kits should be readily available to deal with blood and body fluid spillages.

The kits should be kept in a designated place (depending on the size of the establishment more than one kit should be available).

Ensure that kits remain in date and that kits are replaced immediately after use.

## **SECTION E - MANAGEMENT OF SHARPS INJURIES**

### **1. Occupational Injuries**

In the event of a sharp injury/contamination incident these guidelines should be followed:

A sharp injury/contamination incident includes:

- Inoculation of blood by a needle or other 'sharp'
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes or mouth
- Swallowing a person's blood e.g. after mouth-to-mouth resuscitation
- Contamination where the individual has an open wound, and clothes have been soaked by blood
- Bites (where the skin is broken).

When a sharp injury/contamination incident occurs:

1. Encourage bleeding from the wound
2. Wash the wound in soap and warm running water (do not scrub)
3. Cover the wound with a dressing
4. Skin, eyes or mouth, wash in plenty of water
5. Ensure the sharp is disposed of safely i.e. using a non-touch method into a sharps container
6. Report the incident to immediate supervisor. An incident form should be completed as soon as the recipient of the injury is able
7. The incident should be reported to the health department
8. Attempt to identify source of the needle/sharp. Depending on the degree of exposure and the knowledge of the source patient/client it may be necessary to take further immediate action, see below.

### **2. Control Measures**

Any staff working in a prison who have regular contact with prisoners should receive a full course of Hepatitis B vaccine and have their antibody level checked (see staff health Section B).

New staff or any existing staff who know they are not already protected should contact their OH department to arrange vaccination and testing without delay.

Generally staff in the prison do not perform Exposure Prone Procedures (EPPs) with the exception of the dental department.

However, all staff who do perform EPPs need to be aware of their obligations (see statements by the General Medical Council in Serious Communicable Diseases, 1997; General Dental Council in Maintaining Standards Guidance 1997; United Kingdom Central Council for Nursing, Midwifery and Health Visiting Registrar's letter 4/1994 Annex 1) i.e. to declare it if they know themselves to have been at risk of exposure to a blood-borne virus infection (Hepatitis B, C or HIV).

### **Post-Exposure Prophylaxis for the Recipient**

Those who have received an injury as defined above should seek urgent medical advice from the nearest A&E Department. Should prophylaxis for HIV be required this is best started within 60 minutes.

### **Testing the Source Patient**

In some instances it will not be possible to identify the source patient. However, if the source is identifiable and available for testing, a blood specimen should be obtained with consent, and sent to the microbiology laboratory (an appropriately trained person should discuss the implication of the blood test and results, prior to obtaining consent from the source patient). This can be done on an urgent basis, in consultation with the laboratory. All donors should be tested for Hepatitis B and C, and HIV if appropriate. Additional advice on risk assessment can be obtained from the prison service OH department

### **Investigation of the Person Receiving the Injury**

Blood should be obtained from the exposed person and stored in a secure archive at 20°C or below for at least 2 years.

### **Hepatitis B Prophylaxis**

All those receiving a sharps injury or mucous membrane blood splash should be offered vaccination if not known to be immune.

### **Hepatitis C Virus**

There is no post-exposure prophylaxis for Hepatitis C.

The risk of acquiring Hepatitis C from a single percutaneous exposure is 0.5-1.8%.

In the event that the source patient cannot be tested, management of the injured person should be based upon a risk assessment.

## Human Immunodeficiency Virus (HIV)

- The risk of acquiring HIV from a single percutaneous exposure is small and on average is estimated to be 0.3%.
- The risk of acquiring HIV through mucous membranes exposure is less than 0.1%.

Studies have suggested that taking zidovudine (AZT) as soon as possible after occupational exposure may reduce the risk.

### When to Consider Post-Exposure Prophylaxis (PEP)

Post-exposure prophylaxis should be considered **only** when there has been exposure to blood or other high-risk body fluids **known to be** or **strongly suspected** to be infected with HIV (These fluids include: amniotic fluid, vaginal secretions, semen, human breast milk, CSF, peritoneal fluid, pericardial fluid, pleural fluid, synovial fluid, saliva in association with dentistry, unfixed organs and tissues).

“Strongly suspected” includes individuals with clinical symptoms highly suggestive of HIV disease or individuals from countries where HIV is highly prevalent who may not yet have had a blood test.

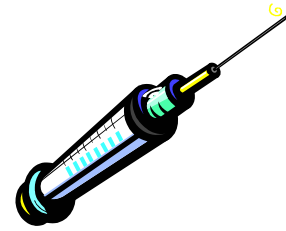
**Strongly suspected does not include an injury from an unknown source, nor an individual with a single lifestyle factor e.g. intravenous drug abuser.**

Post-exposure prophylaxis should **not** be considered following contact through any route with **low risk** materials e.g. urine, vomit, saliva, faeces, unless they are visibly blood-stained.

If post-exposure prophylaxis is indicated it should be started **as soon as possible** after the incident and ideally **within the hour**. (However Department of Health recommends it may be worth considering PEP even if 1-2 weeks have elapsed since the incident).

The individual should attend the nearest A&E department without delay.

What to do after a.....



# SHARPS INJURY

**Directions for the management of needlestick injuries, and cuts and penetrating wounds, contaminated with blood or blood-stained body fluids**



Wash wounds thoroughly with soap and warm water, then gently encourage to bleed. Apply a dressing if necessary.

Splashes to the eyes or mouth should be thoroughly rinsed with running water.



Report the incident to your manager immediately.



Your medical advisor should: -

- Take a history and make a risk assessment
- Review the recipients Hepatitis B vaccine status
- Arrange for 10ml clotted blood to be taken from the recipient and,
  - If possible the 'source' (with informed consent)
- Send the sample to the microbiology department marked 'Needlestick injury'
  - Ensure appropriate follow-up.

Complete an accident form.

Insert your local arrangements.

## Please Note

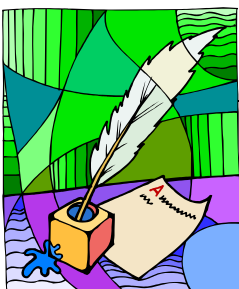
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If the source is known or is at risk of having HIV the injured person should contact Accident & Emergency, and attend within the hour

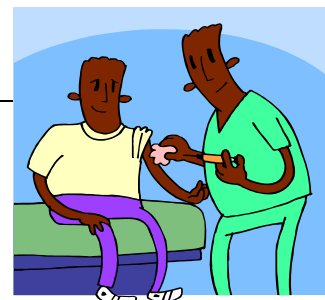
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## Remember

Be prepared – if you are at risk of exposure to BBVs – get immunised against the Hepatitis B Virus



For risk assessment and possible treatment  
In hours:- Your GP or OH Department  
Out of Hours:- Your local A&E Department



# SECTION F - FOOD HYGIENE

## 1. Introduction

This guideline sets out the procedures for staff to follow for food hygiene.

## 2. Legislation

All individuals who handle food should follow basic food hygiene practices to ensure contamination and subsequent disease does not occur.

All staff involved in the handling of food should be aware of the legislation relevant to food management. The main legislation is the Food Safety Act 1990 and its related regulations (General Food Hygiene Regulations (1995), The Food Safety (Temperature Control) Regulations (1995), and prison Service Guidance.

## 3. Basic Requirements for Food Safety

### Facilities and equipment

- There should be adequate and suitable premises, facilities and kitchen equipment for the storage, preparation, cooking and serving of food, taking into account the volume of meals produced
- Persons handling food should be provided with suitable and hygienic protective over-clothing.

### Systems and Training

- Food served in the establishment should be of a good nutritional and wholesome quality. It is the responsibility of the prison management to ensure that high standards of hygiene prevail throughout all the processes of food storage, preparation, cooking and serving
- A Food Hazard Analysis Critical Control Point (HACCP) System, or similar, must be in place based on a thorough risk assessment. The Local Authority Environmental Health Department will be happy to advise on this
- All staff and inmates involved with food handling must have adequate training and competence in food hygiene and food safety. This would include the Basic Food Hygiene Certificate, issued by the Local Authority Environmental Health Department.

## **Storage and Use of Food**

- An extant system should be in place so that food is used in 'date order'
- Food should always be discarded when past it's 'use by' date
- In order to prevent the growth of harmful pathogens in foodstuffs, the correct temperatures must be maintained at various stages of storage and food preparations
- Freezer temperatures should be maintained between minus 12°C and minus 18°C
- Refrigerator temperatures should be kept at, or below, 5°C. Max/min thermometers are recommended. Regular readings should be logged.

## **Separation of Raw and Cooked Food**

- Particular care should be taken that raw meat, poultry and fish are always kept quite separate from food which is to be eaten without further cooking. This should pertain at all stages of food storage and handling. The majority of food poisoning outbreaks are the result of lapses in this area
- Adequate facilities should be available for the physical separation of raw meats and foodstuffs which are to be eaten without further cooking
- There should be separate (colour-coded) knives and chopping boards for preparing raw meats and other foodstuffs.

## **Temperature Control of Foodstuffs**

- Sanitised food thermometers should be used to monitor temperature at critical points:
  - During cooking at 75°C
  - At 'hot holding' at above 63°C
  - At serving at above 63°C.
- Temperature recordings should take place at every meal preparation and the results should be logged, dated, signed and retained for inspection.

#### **4. Food Handlers Fitness for Work**

Food handlers should have appropriate training in food safety leading to a basic knowledge and understanding of the underlying principles of the avoidance of food-borne illness. These aspects would need to be commensurate with the responsibilities and activities undertaken.

It is the legal responsibility of the prison Medical Officer attending a case of Notifiable Disease, including suspected food poisoning, to formally notify the proper officer of the Local Authority.

Each person suffering from acute diarrhoea (three or more loose motions in 24 hours) should have a single faeces specimen taken at an early stage in the illness. This should routinely be sent to the local microbiology laboratory for examination, to help establish a diagnosis.

Individuals with:

- Diarrhoea and vomiting must not handle food until 48hrs symptom free. However some diarrhoeal micro-organisms may require microbiological clearance i.e *Salmonella Typhi*
- Cuts and grazes should be covered with a blue waterproof dressing. The dressing should be changed prior to commencing the shift
- Healthcare staff must assess infected wounds to determine the individual's fitness for work.

## SECTION G - PESTS

### 1. Introduction

Pests may be found in any property but with sensible precautions will not present an infection risk to prisoners or staff. There should be a contract to control rodent and insect populations with a reputable Pest Control Contractor.

These include:

- **Insects**  
Ants, flies, cockroaches, fleas, silverfish
- **Rodents**  
Rats and mice
- **Birds**  
Pigeons, magpies, sparrows, etc.
- **Feral cats and foxes**

Kitchen and food stores provide ideal conditions for pests. Not only do they eat the food but they also contaminate and spoil a lot more.

### 2. Control Measures

Control measures should include the following:

- Stop pests getting in by fly screens, well-fitting doors, covered drains and bird netting
- Look out for droppings, nests, chew-marks on wood or cables
- Discard any foodstuffs or other articles affected by pests, including milk from bottles, the tops of which have been pecked by birds
- Clean up any spillage and decaying food immediately. Carry out regular inspection and rotate any stock. Use rodent-proof containers with well-fitting lids. Store food off the ground
- Ensure external waste bins are kept in a secure pest-free area
- Ensure internal and external waste bins are cleaned regularly, both the inside and outside of the bin.

# HEALTHCARE UNIT

## SECTION H - NOTIFICATION OF INFECTIOUS DISEASES

### 1. Introduction

This guideline sets out the procedures for staff to follow in respect of communicable disease control. It includes the reporting, documentation and notification procedures.

### 2. Accountability

The Governor should ensure the application of recommendations within the prison.

Healthcare Managers should support clinical and support staff in the implementation of the guidelines.

#### **Clinical Staff, Prison Officers and Support Staff**

- All staff have an important role in the prevention and control of infection which is an integral quality issue in the care and management of prisoners and the health and safety of staff
- All staff need to follow all guidelines
- All staff need to bring infection control issues to the attention of Senior Managers
- All staff need to maintain a high standard of infection prevention and control as a matter of good practice.

### 3. Notification Procedures

#### **Explanatory note**

Any registered medical practitioner who becomes aware or suspects that a patient (s)he is attending is suffering from a notifiable disease is required by law (Public Health Control of Disease Act 1984) to send a notification form to the local authority Proper Officer forthwith.

**It is not necessary to wait for laboratory/microbiological confirmation of a diagnosis.**

While laboratories may report, this does not absolve clinicians from their responsibility to do so.

## Which diseases are notifiable?

### List of Notifiable Diseases

Anthrax	Paratyphoid Fever
Cholera	Plague
Diphtheria	Poliomyelitis
Dysentery (Amoebic or Bacillary)	Rabies
Encephalitis	Relapsing Fever
Food Poisoning*	Rubella
Leprosy	Scarlet Fever
Leptospirosis	Smallpox
Malaria	Tuberculosis
Measles	Typhoid Fever
Meningitis (all types)	Typhus
Meningococcal Septicaemia (without meningitis)	Viral Haemorrhagic Fever
Mumps	Viral Hepatitis
Ophthalmia Neonatorum	Whooping Cough
	Yellow Fever

\* This category includes any infection which could be food or water-borne e.g. *campylobacter*, *salmonella*, *cryptosporidiosis*, *giardia*.

### How quickly should I notify?

The law specifies that notification should be “forthwith” i.e. without any delay. Please send out notification forms on the same day the patient is seen and make sure they are not being “batched”.

Single cases of certain communicable diseases may have significant public health implications in the prison setting.

The aim of notification is to ensure public health action is taken promptly. The EHPU should be telephoned on the day of diagnosis on Tel: **0845 1550069** on strong clinical suspicion for **all** except:

- Isolated cases and household contacts with dysentery
- Isolated cases and household contacts with food poisoning (we would like to be telephoned about any *E coli* 0157, *Listeria* and Hepatitis A)
- Chronic Hepatitis B and C

- Leptospirosis
- Malaria
- Ophthalmia neonatorum
- Scarlet fever
- Cases of tuberculosis already under the care of a chest physician.

These may be notified by post utilising the usual notification forms.

#### **Where do I obtain notification forms?**

These are available on application to the EHPU, who supply them on behalf of the Essex Local Authorities; we can post or email a blank template.

#### **We would also like to know about cases of:**

- Legionella
- Suspected outbreaks of any infection i.e. D&V
- One or more cases of scabies in a prison
- Young persons found during screening prior to BCG to have a strongly positive skin test.

### **4. Outbreak of Infection – Reporting and Documentation of a Suspected or Confirmed Illness**

#### **Recognising Outbreaks of Infection**

Any suspicion of an outbreak of communicable disease in the Prison/YOI should be reported to the EHPU immediately for further investigation, and management advice as appropriate.

The EHPU should be contacted if:

- There are two or more individuals with vomiting and/or diarrhoea (amongst prisoners or staff)
- There are two or more individuals suffering from the same infectious illness
- There is a high sickness rate amongst staff, who appear to be suffering from the same infectious disease.

If the Prison/YOI is affected (whether the member of staff is directly employed by the establishment or not) the following guidance should be followed:

- Healthcare staff should contact the EHPU without delay if they suspect there may be an outbreak of infection in the prison
- They must also inform their local Environmental Health Department
- Senior management must be informed and requested to ensure adequate staffing to cope with extra demands of managing an outbreak. Staff working in the Prison/YOI should not work in other care establishments until the outbreak is declared over by the EHPU
- List all prisoners and staff affected, including age, area/unit where resident/working, onset of symptoms, symptoms suffered, duration of illness, GP and whether a sample has been taken (copies are attached for information).

### **Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting**

- Isolate symptomatic prisoners in their own cells or own room within the healthcare unit. Their own toilet facilities, or a designated commode if en-suite facilities are not available are required
- Cohorting of prisoners may be necessary
- Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support hand rails and kitchen units. For the duration of the outbreak, environmental cleaning should be performed using detergent and hot water followed by a 1 in 1000 parts per million available chlorine-releasing solution that is 0.1% hypochlorite solution, 1 part household bleach in 10 parts of water or Sodium Dichloroisocyanurate (NaDCC) e.g. Precept, Haztabs diluted as per manufacturer's guidance, or a proprietary brand that combines detergent and chlorine agent i.e. Actichlor Plus  
NB Alcohol Gel alone will not destroy Norovirus or *Cl. Difficile*.
- All staff handwashing areas and the rooms of symptomatic prisoners should have an antibacterial liquid dispensed soap (or an alcohol handrub following handwashing with a regular liquid soap) for the duration of the outbreak, then normal liquid dispensed soap should be used
- Prisoners should be encouraged to wash their hands after using the toilet and before eating
- Staff should pay attention to all infection control practices, particularly the washing of hands and wearing protective clothing. A new pair of latex or nitrile gloves and a plastic apron should be worn for each prisoner

- Faecal samples should be obtained from prisoners and staff if they have symptoms. The microbiology form accompanying the sample should clearly state it is 'part of an outbreak', as this will determine which specific tests are carried out in the laboratory (samples of vomit are not required)
- It may be necessary to close the Wing to admissions until 48 hours after the last symptomatic patient has recovered. This will be decided in consultation with the EHPU
- Symptomatic staff must go off duty, a faecal sample must be taken and they must remain off work until 48 hours symptom free
- Prisoners should only be transferred 48 hours after their last symptom, and the receiving facility should be informed of the prisoners condition
- Soiled/infected linen must be transferred to the laundry in a sealed soluble bag within a red laundry bag.

Please photocopy the proforma (following pages) in the event of an outbreak of Diarrhoea & Vomiting or Scabies.

**RECORD OF OUTBREAK OF DIARRHOEA AND/OR VOMITING (Prisoners)**

Name of Prison/Wing: \_\_\_\_\_

Record started by: \_\_\_\_\_

Date: \_\_\_\_\_

Address \_\_\_\_\_

Reported to: EHPU/EHO

\_\_\_\_\_

Total number of prisoners in Prison: \_\_\_\_\_

Tel: \_\_\_\_\_

Total number of prisoners affected: \_\_\_\_\_

Name of Prisoner	DOB	Area/Unit where resident	Date of Onset of symptoms	Symptoms				Duration of symptoms	GP		Faecal Sample	
				D	V	D&V	Other		Name	Date Seen	Date Sent	Result

**RECORD OF OUTBREAK OF DIARRHOEA AND/OR VOMITING (Staff)**

Name of Prison/Wing: \_\_\_\_\_

Record started by: \_\_\_\_\_

Date: \_\_\_\_\_

Address \_\_\_\_\_

Reported to: EHPU/EHO

\_\_\_\_\_

Total number of staff in Prison: \_\_\_\_\_

Tel: \_\_\_\_\_

Total number of staff affected: \_\_\_\_\_

Name of Staff	DOB	Area/Unit where resident	Date of Onset of symptoms	Symptoms				Duration of symptoms	GP		Faecal Sample	
				D	V	D&V	Other		Name	Date Seen	Date Sent	Result



**RECORD OF OUTBREAK OF SCABIES (Prisoners)**

Name of Prison/Wing: \_\_\_\_\_

Record started by: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

Reported to: EHPU/EHO

\_\_\_\_\_

Total number of prisoners in Prison: \_\_\_\_\_

Tel: \_\_\_\_\_

Total number of prisoners affected: \_\_\_\_\_

Name of Prisoner	DOB	Area/Unit	Date of onset of symptoms	Diagnosed by		Treatment Date	
				Medical Officer	EHPU	1 <sup>st</sup>	2 <sup>nd</sup>

**RECORD OF OUTBREAK OF SCABIES (Staff)**

Name of Prison/Wing: \_\_\_\_\_

Record started by: \_\_\_\_\_ Date: \_\_\_\_\_

Address \_\_\_\_\_

Reported to: EHPU/EHO

\_\_\_\_\_

Total number of members of staff in Prison: \_\_\_\_\_

Tel: \_\_\_\_\_

Total number of members of staff affected: \_\_\_\_\_

Name of Staff Member	DOB	Area/Unit	Date of onset of symptoms	Diagnosed by		Treatment Date	
				Medical Officer	EHPU	1 <sup>st</sup>	2 <sup>nd</sup>

# SECTION I - NEW ENTRANTS INCLUDING TRANSFERS-IN FROM OTHER CUSTODIAL SITES

## 1. New Arrival Screening

On arrival **all** new entrant or transfer-in prisoners should have a screening interview. However, as prisoners may be transferred from other units at any time of the night and at short notice this may not always be possible. It is important to avoid a situation where the arriving prisoner with an undiagnosed infectious disease, such as unrecognised tuberculosis infection, is placed in a cell with other prisoners. Therefore on arrival, whatever time of the day or night, the healthcare staff should make an enquiry about any symptoms a prisoner may have which indicate an infectious risk to others such as:

- History and appearance of being unwell with a recent/long-term cough, that may or may not be productive. If productive, is it blood-stained?
- History of recent weight loss
- Fever
- Malaise
- Diarrhoea and vomiting
- Skin rash.

In addition to the above advice please consult Section H – Notification.

Once the prisoner has been admitted a member of healthcare staff should undertake a screening interview. Immunisation checks should form part of the routine health screening undertaken when prisoners are accepted into the prison. This should include a check that the following are up-to-date:

- Polio
- Diphtheria
- Tetanus
- BCG (confirmed by presence of scar on deltoid region of the left arm)
- MMR
- Meningitis C (if under 25 years).

Where no history of vaccination exists, or is not known, follow algorithm:  
[www.hpa.org.uk/infection/topics\\_az/vaccination/algorithm\\_2006\\_Sept1.pdf](http://www.hpa.org.uk/infection/topics_az/vaccination/algorithm_2006_Sept1.pdf).

In addition prisoners are at particular risk of blood-borne virus infections. They should therefore also be offered:

- Immunisation against Hepatitis B Recommended for all sentenced prisoners and all new inmates entering prison. This is in agreement with guidance on immunisation of prisoners against Hepatitis B issued by the Director of Health Care to heads of healthcare in HM Prison Service. For prisoners over the age of 18 the 'very rapid' schedule of zero, seven and twenty-one days is recommended. A fourth dose is recommended 12 months after the first dose.

A Chest x-ray should be considered if the prisoner has suspicious symptoms such as a history of a cough lasting longer than three weeks, persistent fever and/or weight loss.

If the HM Prison Service First Reception Health Screen form is used the following additional information listed below is required:

- Record present signs and symptoms of ill health. Be alert to physical signs e.g. a persistent cough. The prisoner may not report such symptoms as a symptom of ill health
- Immunisation history to include Diphtheria, MMR, Hepatitis B and if prisoner is 25 years or under, Meningitis C
- Rashes.

## 2. New Arrival Questionnaire

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Last Place of Residence: \_\_\_\_\_

\_\_\_\_\_

GP Name: \_\_\_\_\_

GP Address: \_\_\_\_\_

\_\_\_\_\_

GP Telephone No: \_\_\_\_\_

Has consent been gained to contact GP? Yes/No

### BACKGROUND HISTORY

Has prisoner had contact with the homeless population or intravenous drug user? Yes/No

If yes – When, Duration and Type of Contact e.g. sharing kit, sexual contact

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### CURRENT HEALTH

Does the prisoner have any of the following symptoms at the moment or in the past week?

Fever Yes/No Recent Weight Loss Yes/No

Diarrhoea Yes/No Vomiting Yes/No

Skin Rash Yes/No Unexplained Malaise Yes/No

Cough Yes/No If yes is it dry and/or productive Yes/No

If productive is it blood-stained Yes No

If yes to any of the above, what action is taken?

Isolation/Referral to GP/Referral to Hospital

**Previous blood tests for:**

**Hepatitis B**                      **Yes/No**                      **Date:** \_\_\_\_\_

**Hepatitis C**                      **Yes/No**                      **Date:** \_\_\_\_\_

**HIV**                                      **Yes/No**                      **Date:** \_\_\_\_\_

**IMMUNISATION HISTORY**

**Has the prisoner had the following immunisations:**

**Polio**                                      **Yes/No**                      **Tetanus**                                      **Yes/No**

**Diphtheria**                              **Yes/No**                      **MMR**                                      **Yes/No**

**BCG**                                      **Yes/No**                      **Hepatitis B**                                      **Yes/No**

**Meningitis C (if under 25 years of age)**                                      **Yes/No**

# SECTION J - MANAGEMENT OF INFECTIOUS DISEASES

## 1. Introduction

Information sheets are available from [www.hpa.org.uk/Essex](http://www.hpa.org.uk/Essex).

The information sheets include information on incubation periods, method of spread, period of infectivity, exclusion periods and where appropriate the management of contacts.

The information sheets can be photocopied and passed to members of the public.

In addition, there is extended text on Meningococcal Disease, MRSA and Tuberculosis.

## 2. Information Sheets

Information sheets on the following can be found on the Essex Health Protection Unit website [www.hpa.org.uk/Essex](http://www.hpa.org.uk/Essex) under fact sheets.

Biting Bugs	Listeria
Blood-Borne Viruses	Lyme Disease
Chickenpox	Measles
Chlamydia	Meningitis
Conjunctivitis	MMR Information for Parents
Cryptosporidiosis	Molluscum Contagiosum
Diarrhoea and Vomiting	MRSA
Glandular Fever	Mumps
Group A Streptococci	Parvovirus (Slapped Cheek)
Hand, Foot and Mouth	Pertussis (Whooping Cough)
Headlice	Polio
Hepatitis A	Rashes in Childhood
Hepatitis B	Ringworm
Hepatitis C	Rubella (German Measles)
Herpes	Scabies
Immunisation – General Information	Shingles
Impetigo	Threadworms
Influenza	Toxoplasmosis
Legionella	Tuberculosis
	Verrucas

In the event of female prisoners/staff exposure to chickenpox/shingles and Parvovirus in pregnancy please refer to obstetrician/GP.

### 3. Meningococcal and Hib Disease

Medical advice should be sought immediately for prisoners showing symptoms suggestive of meningococcal disease. Usually the admitting hospital will notify the EHPU or Public Health doctor on call at the time of the case.

Please advise the EHPU of prisoners diagnosed with meningococcal disease. There may be anxiety amongst other prisoners and prison officers and there may be requests for prophylaxis. Prophylaxis will be arranged for contacts identified by the EHPU. Giving antibiotics inappropriately may do more harm than good as it can result in eliminating carriage of non-pathogenic organisms, such as *Neisseria lactamica*, which boost immunity. It also undermines efforts to give consistent advice to the public.

The working definition of a 'contact' according to national guidelines is:

***Those who have had close personal and prolonged contact with a confirmed or probable case during the seven days before the onset of illness.***

This includes:

- Household or household equivalent contacts:
  - Those sleeping in the same household/overnight stays
  - Close social contacts
  - Intimate 'kissing contacts' i.e. girlfriends/boyfriends
  - It does not include casual contacts such as:
    - Cheek kissing
    - Attendance at birthday parties and other social events
    - Presence in same office or classroom
    - Sharing cans of drink or cigarettes.
- Healthcare Workers (HCWs) who have been in contact during resuscitation. In general this applies to staff who:
  - Have inserted an endotracheal tube
  - Have given mouth-to-mouth resuscitation.

Numbers of helplines for further information:

- Meningitis Trust – Telephone: 01453 768000  
24 hour helpline: 0800 028 1828  
Website: [www.meningitis-trust.org.uk](http://www.meningitis-trust.org.uk)
- Meningitis Research Foundation – 24 hour helpline: 0808 800 3344  
Website: [www.meningitis.org](http://www.meningitis.org)

#### **4. Management of MRSA**

Please refer to the information sheet on the EHPU website.

##### **What Precautions do you need to take?**

**No** special precautions are necessary.

Standard Principles of Infection Control (especially handwashing) are all that are necessary.

However MRSA does act as an opportunity to remind us of the good practices that should **already** be in place.

Prisoners are **not** barrier nursed. Ideally they are in a single room, or share a room with someone who does not have an open wound or invasive device e.g. urinary catheter, intravenous device.

They can mix with other prisoners socially and at mealtimes.

Laundry or china and cutlery do **not** need to be handled separately. Again, as long as good practices are already in place, there is no need for additional precautions.

Waste should be handled as with any other prisoner - if the patient is known to have an infection, all waste should be treated as clinical waste.

##### **Protocol for Treatment**

Do not swab unless there is clinical evidence of infection.

The condition of the wound should be assessed and documented by a nurse trained in wound assessment. Access specialist advice from the PCT tissue viability/woundcare nurse.

#### **5. PVL**

The Pantan-Valentine Leukocidin (PVL) infection is caused by a strain of *Staphylococcus aureus* that carries a toxin that destroys white blood cells. PVL normally causes pus-producing skin infections e.g. boils or abscesses and occasionally cellulites or tissue necrosis.

However, they can cause more severe invasive infections such as septic arthritis, bacteraemia or community-acquired necrotising pneumonia. PVL are more commonly contracted in the community and affect previously healthy young children and adults.

Risk factors for contraction PVL include those in close contact, especially where there is a risk of trauma, such as contact sports. Prison populations have been identified as risk groups.

If a case is suspected inform EHPU

## **6. Guidelines on the Management Tuberculosis in Custodial Institutions**

## MANAGING PRISONERS WITH SUSPECTED PULMONARY TUBERCULOSIS

STEP ONE	STEP TWO	STEP THREE	STEP FOUR
<b>IDENTIFYING THE PRISONER WITH TUBERCULOSIS</b>	<b>RAPID REFERRAL TO CHEST CLINIC</b>	<b>IMPLEMENTING INFECTION CONTROL PRECAUTIONS</b>	<b>PUBLIC HEALTH</b>
<ul style="list-style-type: none"> <li>• By symptom screening on assessment</li> </ul> <p>OR</p> <ul style="list-style-type: none"> <li>• By self referral by prison primary healthcare services</li> </ul> <p>Signs and symptoms may occur over weeks or months and include:</p> <ul style="list-style-type: none"> <li>• Cough</li> <li>• Weight loss</li> <li>• Dyspnoea</li> <li>• Chest pain</li> </ul>	<p>Basildon – TB Nurse: 01702 224928 Chest Clinic: 01268 593974</p> <p>Chelmsford – Chest Clinic: 01245 440761</p> <p>Colchester – Chest Clinic: 01206 742005</p> <p>Harlow – Chest Clinic: 01279 444445</p> <p>Southend – TB Nurse: 01702 224928 Chest Clinic: 01702 221040</p>	<p>The prisoner with suspected TB should:</p> <ul style="list-style-type: none"> <li>➤ Be managed in a single cell with the door closed</li> <li>➤ Ensure s/he covers her/his mouth when coughing and/or cough into tissues</li> <li>➤ Wear a mask if leaving the cell <b>only</b> if s/he has a productive cough</li> <li>➤ Have all waste such as used tissues disposed of as clinical waste</li> <li>➤ Have their crockery and cutlery washed as normal in the dishwasher</li> </ul>	<p>Inform the Essex Public Health protection Unit of all suspected cases on: 0845 1550069</p> <p>The EHPU will manage any contact tracing required</p> <p>List movements within prison over last three months and list contacts</p>
<p>Assessing for multidrug resistance – ask the following:</p> <ul style="list-style-type: none"> <li>• Has the prisoner a history of prior TB drug treatment: prior TB treatment failure?</li> <li>• Has the prisoner had contact with a known case of drug resistant TB?</li> <li>• Was the prisoner born in a foreign country, particularly one with a high incidence of TB?</li> <li>• Is the prisoner HIV positive?</li> <li>• Has the prisoner been resident in London or been transferred from a London prison?</li> <li>• Is the prisoner between 35 and 44 years of age?</li> <li>• Is the prisoner male?</li> </ul>	<p>Prior to referral, if symptomatic obtain multiple sputum samples (3 with one an early morning sample)</p> <p>If you suspect the prisoner may have multi drug resistant TB inform the clinician on referral</p>	<p>Staff managing a prisoner with suspected TB should:</p> <ul style="list-style-type: none"> <li>➤ Be immune or have been vaccinated against TB</li> <li>➤ Wear a mask when entering the cell <b>only</b> if the prisoner has a productive cough</li> <li>➤ Wear a mask during aerosol producing procedures such as obtaining sputum</li> </ul>	<p>Further guidance can be found on the NICE Guidance Tuberculosis Clinical diagnosis and management of tuberculosis, and measure for its prevention and control available at <a href="http://www.nice.org.uk">www.nice.org.uk</a></p> <p>More information on Tuberculosis is available at <a href="http://www.hpa.org.uk">www.hpa.org.uk</a></p> <p>If you require any further advice, help or information please contact: EHPU on 0845 1550069.</p>

## **Contacts**

The EHPU nurse will co-ordinate the notification and follow-up of contacts whether inside or outside the prison in this district or elsewhere. This includes screening of contacts that could be prison staff.

## **Visitors**

Visitors who have not had close contact with the prisoner prior to diagnosis should be dissuaded from visiting until the end of the infectious period. Those who visit should comply with the isolation precautions.

## **Management of Staff**

For their own protection and that of the prisoners all newly appointed staff and long term voluntary workers should undergo an OH assessment which includes a symptom check and review of BCG status. Staff who missed pre-employment screening should also be screened.

## **Transfer of prisoners undergoing treatment for pulmonary TB**

It is recommended that the prisoner remain in the Prison/YOI until the first 2 weeks of treatment have been completed. However, if it becomes necessary that a prisoner undergoing treatment has to be transferred to another HM Prison, the Prison Medical Officer in consultation with the Physician in Chest Medicine and the CCDC must establish that the prisoner is fit and safe for transfer. The receiving prison should be advised in advance of the prisoner's condition and continuing care.

## **Release of prisoner under treatment for TB**

The prisoner due for release from their custodial sentence should not be released until they have been seen and an assessment made to establish that they are fit and non-infectious by the Prison Medical Officer. This should be done in consultation with the Physician in Chest Medicine and the CCDC. The Prison Medical Officer should keep records of prisoners with tuberculosis and the Principal Medical Officer informed of all cases.

Arrangements should be made for prisoners who are likely to be 'homeless' to be contactable. It may be necessary to arrange hostel accommodation until chemotherapy has been completed.

The following professionals in the proposed area of residence must be notified:

- General Practitioner (GP). To provide continuing care and prescriptions for anti- tuberculosis treatment
- Consultant in Communicable Disease Control (CCDC)
- Physician in Chest Medicine at local hospital.

The prisoner should be supplied with a minimum of two weeks anti-tuberculosis treatment.

Released prisoners for deportation aboard should be treated and be non-infectious prior to departure. The International Division of the Department of Health should be notified.

## **7. Influenza**

If several people are affected with respiratory illnesses endeavour to segregate them whilst symptomatic. (Most prisoners would not warrant prophylaxis but seek medical advice for those at risk if influenza suspected). In the event of pandemic flu, seek advice from the PCT or the EHPU.

## SECTION K - CLINICAL PRACTICE

### 1. Introduction

This section is aimed at healthcare practice that is performed within the healthcare unit. When clinical practice has to occur within the wings, healthcare staff should ensure that the guidelines in this section are followed as much as possible. The Clinical Practices included in the section are:

- Aseptic Technique
- Source Isolation (Barrier Nursing)
- Decontamination of Equipment
- Linen in Clinical Areas
- Management of Non Infectious and Infectious Deceased Prisoners
- Safe Handling of Specimens
- Vaccine Control
- Waste Management.

### 2. Aseptic Technique

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

The aims of aseptic technique are:

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

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

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

- Dressing wounds
- Removal of sutures or clips
- Dressing peripheral or centrally sited intravenous lines
- Removal of drains
- Endotracheal suction
- Dressing tracheostomy sites.

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

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

Many aseptic techniques include a ritualistic practice of cleaning trolleys with alcohol between patients. It is now felt that this serves no useful purpose, and that an area cleaned by detergent and hot water is sufficient, as the sterile field will be created by the sterile towel contained within the dressing pack.

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

### **Management of Chronic Wounds**

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

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

The plastic liner should be disposed of and the bath or bowl should be thoroughly cleaned with detergent and hot water, and then dried to ensure that pathogens are removed.

This process should be undertaken after each separate patient episode.

### **Wound Swabbing**

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

<h3><b>3. Care of Prisoners with Known Infectious Diseases – Source Isolation (Barrier Nursing)</b></h3>
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There are times when it is necessary for an infected prisoner to be cared for in a single occupancy room. Standard Principles of Infection Control must be undertaken. Upon entering and leaving the room all personnel must decontaminate their hands. Wear the appropriate personal protective clothing when assisting the prisoner with personal care e.g. gloves, aprons and, in some circumstances, masks. All personal protective clothing to be disposed of as clinical waste on exiting room.

## DISEASES

More detailed information about diseases can be found in the relevant section of this guidance, and on the EHPU website.

DISEASE	HOW LONG THE DISEASE REMAINS INFECTIOUS
Beta-haemolytic streptococci Group A	The client remains infectious until:  48 hours after the start of appropriate antibiotic therapy
Chickenpox	The client remains infectious until vesicles are dry
<i>Clostridium difficile</i> (Pseudomembranous colitis)	The client remains infectious until diarrhoea has ceased for 48 hours.
Gastro-enteritis	The client remains infectious until symptom free for 48 hours
Hepatitis A	The client remains infectious until 7 days after the onset of jaundice
Hepatitis B + C	As long as client disease is active – maybe for life
HIV	Certain body fluids are infectious
Impetigo	The client remains infectious for 24 hours after start of appropriate antibiotic therapy
Meningococcal Meningitis	The client remains infectious for 24 hours after start of appropriate antibiotic therapy
Mumps	The client remains infectious for 9 days after onset of swelling in salivary glands

Rubella	The client remains infectious for 4 days from onset of rash. Non-immune pregnant staff should not nurse these patients
Scabies	The client remains infectious until one application of a scabicial treatment has been completed
Shigella	The client remains infectious until diarrhoea has ceased for 48 hours
Shingles	The client remains infectious to a person who has not had chickenpox by direct contact with vesicles. The contact will develop chickenpox
Pulmonary Tuberculosis (Open)	The client remains infectious until the first two weeks of appropriate antibiotic therapy have been given. The infectious period may be prolonged for Multi-Drug Resistant TB (MDRTB), seek advice from the Chest Physician or the EHPU.

Precautions should also be taken with clients suffering from the following symptoms, until a diagnosis is confirmed:

- (a) Diarrhoea of unexplained origin
- (b) Pyrexia of unknown origin
- (c) Excessive bleeding
- (d) Rashes of unknown aetiology
- (e) Excessive vomiting.

## PROCEDURES

**Standard Principles of Infection Control should be strictly adhered to at all times (Refer to Section C)**

Once a diagnosis has been made, the client (and family) must have their infectious disease carefully explained, the mode of spread and its significance, if any, for the patients condition.

### Hand Hygiene

Alcohol handrub should be used after normal handwashing, or an antibacterial soap should be used to wash hands.

## **Disposal of Potentially Infected Items**

Contaminated dressings and all disposable items should be disposed of as clinical waste.

## **Urinals and Bedpans**

Washer-disinfectors are recommended. If not available, contents should be emptied down the toilet and flushed away. Care should be taken when cleaning the urinal or bedpan to avoid splashing. A plastic apron and non-sterile latex gloves should be worn. The item should be cleaned with general-purpose detergent and hot water prior to disinfection with a sodium hypochlorite solution (strength 10,000 p.p.m. (1 part household bleach to 10 parts water) and left for 10 minutes). The bedpan/urinal should be dried and stored inverted.

## **Linen**

Infected and/or soiled linen should be placed in a soluble bag within another linen bag. The bag must be closed and transferred to the laundry room. The soluble bag is placed directly into the industrial washing machine on a sluice cycle prior to washing. Should be washed on a hot a wash as the fabric will tolerate, as promptly as possible

## **Crockery and Cutlery**

Disposable items are not required. General-purpose detergent and water as hot as can be tolerated is sufficient, to be washed in the usual kitchen sink or dishwasher.

## **Transporting Clients**

Prisoners who require source isolation should only be sent to other departments/premises (i.e. another prison, hospital out-patient or in-patient departments) when it is essential. Staff involved in the direct care of the prisoner should be informed of the risk, so that the relevant control measures can be implemented.

## **Deceased Prisoners**

**Refer to Section K – 6. Management of Deceased Prisoners.**

## **4. Decontamination of Equipment**

The aim of decontaminating equipment is to prevent potentially pathogenic organisms reaching a susceptible host in sufficient numbers to cause infection.

Certain items are classified as single-use only. These items must never be re-used. If in doubt, refer to the manufacturer's recommendations.

Re-usable equipment should be appropriately decontaminated between each patient using a risk assessment model. Use only the method advised by the manufacturer - using any other process could invalidate warranties and transfer

liability from the manufacturer to the person using or authorising the process. If you have any doubts about the manufacturer's recommendations, seek further advice.

The following definitions are adapted from the Department of Health, HTM 01-01, decontamination of reusable medical devices:

- Cleaning 'is a process which physically removes contamination but does not necessarily destroy micro-organisms. The reduction of microbial contamination cannot be defined and will depend upon many factors including the efficiency of the cleaning process and the initial bio-burden'.
- Cleaning is an essential prerequisite of equipment decontamination to ensure effective disinfection or sterilisation can subsequently be carried out.
- Disinfection 'is a process used to reduce the number of viable micro-organisms, which may not necessarily inactivate some viruses and bacterial spores. Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation'.
- Sterilisation 'is a process used to render the object free from viable micro-organisms, including spores and viruses'.

### **Risk Assessment**

Medical equipment is categorised according to the risk that particular procedures pose to patients - by assessing the microbial status of the body area being manipulated during the procedure. For example, items that come into contact with intact mucous membranes are classified as intermediate risk and require disinfection between each use as a minimum standard. Items that enter normally sterile body areas, or come into contact with broken mucous membranes, are classified as high-risk and must be sterile before use.

## Risk Assessment for Decontamination of Equipment

Risk	Application of Item	Minimum Standard
Low	<ul style="list-style-type: none"> <li>In contact with healthy skin or</li> <li>Not in contact with patient</li> </ul> e.g. furniture, mattresses, surfaces, commodes	Clean
Intermediate	<ul style="list-style-type: none"> <li>In contact with intact mucous membranes or</li> <li>Contaminated with virulent or readily transmissible organisms (body fluids) or</li> <li>Prior to use on immuno-compromised patients</li> </ul> <b>e.g. thermometers, auroscope earpieces. Items used in the vagina or cervix must be sterilised</b>	Clean and disinfect, or single-use
High	<ul style="list-style-type: none"> <li>In contact with a break in the skin or mucous membrane or</li> <li>For introduction into sterile body areas, for example uterine sounds, instruments used for surgical/operative procedures</li> </ul>	Clean and sterilise, or single-use

Adapted from Medical Devices Agency, Part 2 (1996) now MHRA

***The decontamination of surgical instruments within the prison is not recommended. All surgical instruments that are required for general procedures such as clip insertion, forceps, scissors and vaginal speculum should be single-use.***

## A-Z of Equipment and the Decontamination Method

### Use

### Available Chlorine

Blood Spillages  
Environmental disinfection

10,000ppm  
1,000ppm

Ensure that manufacturers' instructions are followed to obtain correct concentration of solution.

EQUIPMENT	CLEANING METHOD
Baths	To be cleaned between users. With gloved hand, clean bath surface, grab rails and taps with hot water, GPD and paper towels, or general-purpose wipes. Rinse.
Bath water additives	There are no antiseptic solutions that should be added to the bath. When antiseptic bathing is prescribed, the agent should be applied directly to the skin instead of soap.
Bedpans	Disposable recommended or Automated Washer/Disinfector recommended if not available. Clean thoroughly using paper towels, warm water and GPD. Rinse, dry and store inverted. Disinfection using sodium hypochlorite solution 1000 ppm will be required if the client has enteric symptoms.
Beds, backrests, bed cradles and mattresses	To be cleaned between users with hot water and GPD, or general-purpose wipes. If soiling is evident then immediately clean as above and then wipe over with chlorine-releasing compound.
Bidets	To be cleaned after each use. Clean surface of pan and taps with hot water and GPD, or general-purpose wipes, using disposable paper towels and gloved hand and then flush.
Bowls - patient washing	Clean between each use with hot water and GPD, or general-purpose wipes, using disposal paper towels. Rinse and store dry.
Commode armrests and seats	If no soiling is evident, clean with hot water and GPD, and dry using paper disposable towels. If soiling is evident, or there is an outbreak of diarrhoea, or the previous user had a loose stool, clean with hot water and GPD, or general-purpose wipes. Wipe over with a chlorine-releasing compound (e.g. Presept, Chlortabs). <b>Use separate wipes for armrests and seats.</b>

Ear pieces from auroscopes	Single-use recommended. Clean thoroughly with GPD and hot water, using thin brushes to clean inside. Rinse and dry thoroughly before storage.
Ear syringe 'Propulse'	Before first use of the day and after each patient use – clean ear pieces in GPD and warm water solution. Fill tank with sodium hypochlorite solution (Milton) 125ppm. Run this solution through the tubing ensuring the absence of any air bubbles. Allow at least 10 minutes in order for disinfection to take place. Empty tank and tubing, rinse with sterile water for irrigation, dry with disposable, non-shredding paper towel and try to ensure that tubing is as dry as possible.
ECG Equipment - Electrodes - Leads - Machine	<ul style="list-style-type: none"> <li>- Use disposable</li> <li>- Wipe well with hot water and GPD, or general-purpose wipes</li> <li>- Wipe over with damp cloth, keep covered when not in use</li> </ul> <p>Follow manufacturers' guidance</p>
Examination couches	Surface must be in good repair, clean with hot water and GPD, or general-purpose wipes, at start and finish of each session or if becomes soiled. Cover with disposable paper roll and change between each client use.
Hoists and slings	After each client use, clean thoroughly using hot water and GPD, or general-purpose wipes and store dry. Single-use patient slings are also available.
Nail brushes	Single-use only.
Nebulisers	<p>Single patient use nebuliser and tubing recommended. Clients should have their own nebuliser units, which should be washed with hot water and GPD, or general-purpose wipes between use. Store dry. On completion of treatment, dispose of nebuliser. Follow manufacturer's instructions.</p> <p>Nebulisers which are used in the surgery or loaned to clients must be thoroughly decontaminated between patient uses. All tubing, mask, and filters should be disposed of after use, and replaced with new, disposable components before the item is used by another client.</p> <p>Staff must maintain a register of use (giving patient details and date of use) for each nebuliser including a record of the decontamination process detailing the date, time, cleaning method used, items replaced, and the signature and name of the member of staff responsible.</p>

Suction equipment	<p>Suction units with disposable components are recommended. After each use (or 24 hours if in frequent use) the disposable components should be disposed of as clinical waste.</p> <p>Non-disposable bottles – recommend change to disposable.</p> <p>Tubing should be disposable.</p> <p>Filters - these should be replaced when wet and at appropriate intervals in keeping with the manufacturer's instructions.</p>
Thermometers	Single-use recommended.
Trolleys (dressing trolleys)	Clean top and all surfaces with hot water and GPD, or general-purpose wipes daily. Dry thoroughly. If trolley becomes contaminated between patient use, wash with GPD and hot water again.
Urinals	<p>Single-use recommended, as manual cleaning is both difficult and unsatisfactory.</p> <p>See bedpans.</p> <p>Non-disposable urinals - wearing disposable plastic apron and gloves, empty urine into the toilet, clean thoroughly using paper towels, hot water and GPD. Rinse, dry and store inverted.</p> <p>Ideally each patient should have a designated urinal.</p>
Urine jugs	<p>Single-use recommended.</p> <p>Reusable - Wearing gloves and apron, a separate clean jug should be used for each urine collection. Empty the contents into the toilet and rinse. Clean thoroughly with hot water and GPD using disposable paper towels. Rinse and dry. Store inverted.</p>
Weighing scales	Line with disposable paper towel. Wash bowl of scales with GPD and hot water, or general-purpose wipes if they become soiled before next baby is weighed and at the end of each clinic session.
Work surfaces	<p><b>General Cleaning</b></p> <p>Use GPD and hot water, or general-purpose wipes.</p> <p><b>Contaminated Surfaces</b></p> <p>Clean with GPD and hot water, or general-purpose wipes, and then wipe with 1% sodium hypochlorite solution.</p>

## Environmental Cleaning

This section is applicable to all areas, residential and healthcare within the prison. The environment plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk. They should be kept to a minimum by regular cleaning and by good design features in buildings, fittings and fixtures.

A written cleaning schedule should be devised specifying the persons responsible for cleaning, the frequency of cleaning and methods to be used and the expected outcomes:

- Work surfaces and floors should be smooth-finished, intact, durable of good quality, washable and should not allow pooling of liquids and be impervious to fluids
- Carpets are not recommended in treatment rooms or areas where clinical procedures will take place because of the risk of body fluid spills
- Where carpets are in place, there should be procedures or contracts for regular steam cleaning and dealing with spills
- Keep mops and buckets clean, dry and store inverted
- Mop head should be removable for frequent laundering, or single-use if this is not possible
- Provide single-use, non-shedding cloths or paper roll for cleaning
- Keep equipment and materials used for general cleaning separate from those used for cleaning up body fluids
- Colour-coded cleaning equipment, such as mop heads, gloves and cloths for toilets, kitchens and clinical areas. Use different colours for each area
- Use general-purpose detergent for all environmental cleaning - follow the manufacturer's instructions.

<b>DOMESTIC</b>	<b>CLEANING</b>
Bucket (plastic)	Empty contents down toilet or slop hopper. Rinse with 0.1% chlorine-releasing compound (1000 ppm sodium dichloroisocyanurate e.g. Precept, Haztabs or 1000 ppm sodium hypochlorite e.g. bleach) and dry
Mop (wet)	Rinse, dry and store head up after use; heat disinfect in washing machine and dry thoroughly weekly
Mop (dry)	Vacuum after each use
Lavatory brushes	Rinse in flushing water and store dry
Suggested colour-coding of cleaning equipment	Refer to Colour-code for hygiene
Floors	Dust control - dry mop. Wet cleaning - wet mop, wash with hot water and GPD. If known contamination - follow with 0.1% chlorine-releasing compound (1000 ppm sodium dichloroisocyanurate e.g. Precept, Haztabs or 1000 ppm sodium hypochlorite e.g. bleach)
Furniture and fittings	Damp dust with hot water and detergent. If known contamination - follow with 0.1% chlorine-releasing compound (1000 ppm sodium dichloroisocyanurate e.g. Precept, Haztabs or 1000 ppm sodium hypochlorite e.g. bleach)
Lavatory seat and handle	If soiling is evident, or there is an outbreak of diarrhoea, or the previous user had a loose stool, clean with hot water and GPD followed by 0.1% chlorine-releasing compound (1000 ppm sodium dichloroisocyanurate e.g. Precept, Haztabs or 1000 ppm sodium hypochlorite e.g. bleach)
Showers	Should be clean and maintained. Launder curtains 3 monthly. Shower heads should be de-scaled when necessary
Walls and ceilings	Not an infection problem. When visibly soiled use hot water and detergent. Splashes of blood, urine or known contaminated material should be cleaned promptly with 0.1% chlorine-releasing compound (1000 ppm sodium dichloroisocyanurate e.g. Precept, Haztabs or 1000 ppm sodium hypochlorite e.g. bleach)

## Colour-Code for Hygiene

Based on the Safer Practice Notice – Colour-coding hospital cleaning materials and equipment, published by the National Patient Safety Agency.

### National Colour Coding Scheme



**THE GOLDEN RULE: WORK FROM THE CLEANEST AREA TOWARD THE DIRTIEST AREA. THIS GREATLY REDUCES THE RISK OF CROSS-CONTAMINATION.**

1. The aim of a colour-coding system is to prevent cross-contamination
2. It is vital that such a system forms part of any employee induction or continuous training programme
3. A minority of people are colour-blind in one or more colours. Some individuals may not know this and colour identification testing should form part of any induction training
4. Always use two colours within the washroom/sanitary area
5. The colour-coding system must relate to all cleaning equipment, cloths and gloves.

Monitoring of the system and control of colour-coded disposable items against new stock release is extremely important.

## **Decontamination Equipment Prior To Inspection, Service, Repair Or Loan**

Do not send contaminated equipment elsewhere without decontaminating first. Before dispatch, complete and attach a certificate, which states the method of decontamination used, or the reason why it was not possible (NHS Management Executive 1993). Equipment that is impossible to decontaminate is likely to be complex, high technology and heat-sensitive. Often it cannot be decontaminated without being dismantled by an engineer - in this case attach a biohazard label to the item. Complete the clearance certificate and advise staff on protective measures.

## Documentation

A completed clearance certificate must be attached to the equipment prior to work being carried out. A suggested letter is:

From: \_\_\_\_\_

To: \_\_\_\_\_

Make and description of equipment item: \_\_\_\_\_

\_\_\_\_\_

Model/Serial/Batch Number: \_\_\_\_\_

\_\_\_\_\_

Other distinguishing marks: \_\_\_\_\_

\_\_\_\_\_

- This equipment/item has not been in contact with blood or other body fluids. It has been cleaned in preparation for inspection, servicing or repair.
- This equipment has been decontaminated. The method used was:  
\_\_\_\_\_
- This equipment could not be decontaminated. The nature of risk, and safety precautions to be adopted are:  
\_\_\_\_\_

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Position: \_\_\_\_\_ Address: \_\_\_\_\_

## 5. Linen in Clinical Area

### IN THE HEALTHCARE UNIT

It is strongly recommended that linen is kept to a minimum.

#### Couches

- The surface of all couches must be of a washable impermeable fabric
- The condition of the surface of all couches should be regularly checked (minimum once monthly) to ensure the fabric remains intact
- The couch should be covered with disposable paper towel, which must be changed between patients
- If the paper towel becomes soiled and the soiling seeps through to the surface of the couch, the couch must be decontaminated before use by another patient. If contaminated with blood use a sodium dichloroisocyanurate compound (e.g. Presept, Sanichlor)
- If the contaminate is another body fluid, general-purpose detergent and warm water is sufficient to decontaminate the surface of the couch
- Pillows are not considered essential as all couches should have head-tilts. However, if pillows are used, they should be sealed within a plastic impermeable cover. Disposable pillow cases should then be used. These should be discarded once weekly or more frequently if they become soiled. If standard pillow cases are used, they must be washed weekly or more frequently if they become soiled
- Blankets/sheets are not considered essential. For modesty, a length of disposable paper towel should be used to cover exposed parts of the body.

#### Curtains

- At windows, it is recommended that washable blinds are used
- Around couches, curtains should only be used if required to protect patient's modesty
- There should be an environmental cleaning schedule, which should include blinds and bed curtains to be washed twice yearly.

## **Terry Towels**

- There is no place for terry towels in healthcare. Hands should be dried on paper towels
- If used to protect the patient whilst performing ear syringing (instead of the correctly designed receptacle), each patient should be provided with a clean towel (or disposable paper towel) that is placed in the laundry immediately after use.

## **When Linen is Used**

- All linen must be changed at least weekly, or more frequently if soiled
- Place linen soiled with body fluids in a leak-proof, water soluble bag and arrange prompt laundering
- Used linen must be laundered at 71<sup>0</sup>C for 3 minutes or 65<sup>0</sup>C for 10 minutes.

## **SENDING LAUNDRY TO A COMMERCIAL LAUNDRY**

Commercial laundries should be consulted re their own infection control precautions, the prison service will need to comply i.e. colour-coding.

If a prisoner's laundry is sent to a commercial laundry, by collection or delivery, it should be checked whether they have any special instructions, e.g. a colour-coding system.

Usually laundry bags are colour-coded in the following way:

- Used linen - a white bag
- Foul linen - a sealed clear soluble bag within a white or blue bag
- Infected linen - a sealed clear soluble bag within a red bag.

### **Note:**

If the foul or infected linen is excessively wet it may be necessary to place the soluble bag within a clear polythene/plastic bag within a blue or red bag.

## **STAFF UNIFORMS OR WORK CLOTHES**

There must be sufficient uniforms provided so freshly laundered clothing can be worn for each shift or work session.

Access to spare clothing if staff clothing items become contaminated (for example, splashed with blood and/or body fluids).

Staff must presume some degree of contamination, even on clothing which is not visibly soiled.

Staff must change out of their uniform promptly at the end of the shift.

Uniforms or work clothes should be washed as soon as possible on as hot a wash as the fabric will tolerate. Cardigans/jumpers should be washed at least weekly. Ideally at 65°C for 10 minutes.

Uniforms should not be washed with new-born baby, elderly persons or immuno-compromised persons clothing.

The majority of bacteria and viruses will not survive away from the host and would not present a high-risk of infection on clothing. However, within a mass of body fluid, organisms would survive longer.

Shoes should be cleaned immediately if contaminated with body fluids, using general-purpose detergent and hot water - disposable gloves should be worn.

Staff should not wear jewellery; fingernails should be short and free of nail varnish (false nails are unacceptable) and hair should be worn neatly in a style that does not require frequent re-adjustment.

## **6. Management of Non-Infectious And Infectious Deceased Prisoners**

This guideline sets out the procedures for staff to follow for the management of non-infectious and infectious deceased patients.

### **MANAGEMENT OF DECEASED PATIENTS**

The deceased should be treated with the due respect and dignity appropriate to their religious and cultural background. Last Offices, which vary according to religious and cultural practices, may be compromised by the need for specific measures if an infectious disease was associated with the death, or co-existed at the time of death. Any problems should be discussed with the Consultant in Communicable Disease Control who may wish to consult the appropriate priest or religious authority.

Most bodies are not infectious, however through the natural process of decomposition the body may become a source of potential infection whether previously infected or not, therefore sensible precautions should be taken routinely.

- Disposable gloves and aprons should be worn when washing and preparing the body
- Washing the body with soap and water is adequate
- Dressings, drainage tubes, etc. should be removed unless the death occurred within 24 hours of an operation or was unexpected in which cases a post-mortem is likely

- Clean dressings should be applied to any wounds
- Profusely leaking orifices may be packed with gauze or cotton wool.

### **ADDITIONAL LAST OFFICES FOR A KNOWN INFECTED BODY**

The body of a person who has been suffering from an infectious disease may remain infectious to those who handle it.

Body bags are available from either the undertaker or the stores centre where all other care equipment is requested from.

The mortuary/funeral director staff should be informed of the potential infectious risk.

If the deceased has died from one of the following infectious diseases listed below, the body will need to be placed in a cadaver bag.

Anthrax	Plague
Brucellosis	Acute Poliomyelitis
Chickenpox/Shingles	Psittacosis
Cholera	Pyrexia of unknown origin
Diphtheria	Q fever
Food Poisoning (if faeces is present)	Rabies
Hepatitis B	Tuberculosis (infective)
Hepatitis C	Viral Haemorrhagic Fever
HIV/AIDS	Yellow fever
Leprosy	
Meningococcal Septicaemia (with or without meningitis)	

or if there are large quantities of body fluids present.

A 'Notification of Death' label and a 'Danger of Infection' label should be attached discreetly to the outside of the bag. Neither label should state the diagnosis which is confidential information. It is the responsibility of the certifying clinician to ensure the funeral directors have sufficient information about the level of risk of infection and stating the type of precautions required.

Once the body is sealed in the body bag, protective clothing will no longer be necessary.

Relatives and friends who wish to view the body should do so as soon after death as possible. The bag can be opened by a member of staff wearing gloves and plastic apron, but relatives should be told that there is a risk of infection and should be advised to refrain from kissing or hugging the body. In some rare instances the bag should not be opened e.g. if the patient suffered from Anthrax, Plague, Rabies and Viral Haemorrhagic Fever.

Further advice on specific infectious diseases can be found in the Infection Control Guidelines for Funeral Directors, or advice can be sought from the EHPU.

## **7. Safe Handling of Specimens**

Clinical specimens include any substance, solid or liquid, removed from the patient for the purpose of analysis.

Staff should be trained to handle specimens safely.

### **General Principles**

- All specimens should be collected using **Standard Principles Of Infection Control** (i.e. wearing of appropriate gloves, disposable plastic apron and washing and drying of hands before and after the procedure)
- When a patient is asked to provide a specimen, they should be provided with the appropriate container and given instructions as to how to collect the specimen
- Laboratory approved containers must be labelled with patient identification details, date of specimen and specimen details. The lids should be screwed on tightly. The container with the specimen must be placed in an individual transparent plastic transport bag as soon as it has been labelled
- The transport bag must be sealed. The request form must always accompany the specimen but should not be put inside the bag with the specimen. If a wound swab, state type of wound, where on the body, whether deep or superficial and if antibiotics have been used either topical or systemic
- Specimens must be sent to the laboratory as soon as possible after collection. This will mean planning work load carefully. Whilst awaiting transport, specimens should be stored securely, for as short a time as possible i.e. not overnight and away from food and medicines
- If specimens have to be stored awaiting transport for more than 4 hours, specimens should be stored in an air tight container in a designated fridge - **not a food fridge or a drug fridge**
- Sputum specimens must be received by the laboratory within 24 hours
- Transportation of samples to Laboratories – samples should be placed in a sealed leak-proof container. The container should be decontaminated regularly and when blood or body fluid spills occur.

**NB. In the event of a suspected outbreak of infection it is important for specimens to be collected promptly and for the request form to be marked as 'Possible Outbreak'. Stool specimens should be sent as soon as an outbreak is suspected e.g. the second loose stool.**

## **8. Vaccine Control**

Vaccines are biological products that need to be stored under controlled conditions to maintain their potency and efficacy.

### **STORAGE**

- Vaccines must be stored under the conditions recommended in the product literature
- On arrival, vaccines should be checked to ensure the cold chain has not been broken and for signs of damage or leakage
- A nominated person, who has received specific training in this practice, should make sure vaccines are correctly stored and handled by staff
- Store vaccines in a fridge designed for this purpose
- Ensure strict stock rotation with new vaccines being placed behind older stock
- Prevent overstocking and allow air to circulate around all stock
- Do not store in fridge door or in separate drawers in the bottom of the fridge as air cannot circulate
- Ensure systems are in place to prevent accidental disconnection of the electricity
- Do not store items other than vaccines in the same fridge
- Defrost and clean regularly, storing vaccines in an alternative fridge during the procedure
- Vaccines should be protected from light
- Expired vaccines, or part-used vaccines, should be disposed of by incineration by a registered waste contractor.

### **TEMPERATURE CONTROL**

- Vaccines must be kept between 2<sup>0</sup>C and 8<sup>0</sup>C during transportation and delivery, and must not directly touch ice packs
- Store vaccine between 2<sup>0</sup>C and 8<sup>0</sup>C and not below freezing. Monitor fridge temperature using a minimum/maximum thermometer, and record results daily.

### **ADMINISTRATION**

- Use reconstituted vaccine according to the manufacturer's recommendations

- Multi-dose vials without preservative (most live virus vaccines) should be discarded within one hour of first use
- Vials containing a preservative should be discarded within 3 hours, or at the end of a session
- Remove vaccines from the fridge for the minimum length of time before administration - discard any opened in error
- Do not prepare vaccine in advance of immunisation as this increases the risk of administering the wrong vaccine and may affect the temperature. Prepare each vaccine for the individual who is to receive it
- You do not have to routinely cleanse skin unless it is visibly dirty. If alcohol or other antiseptics are used, they must be completely dry otherwise the live vaccines may be inactivated
- Multi-dose vials may be used for one session only - discard any remaining at the end of the session

## **9. Waste Management**

Waste legislation in England has been updated in line with that in Europe. The old clinical waste classification system using groups A to E should no longer be used, as the groups do not reflect the appropriate segregation for treatment or disposal.

This guidance should be read in conjunction with Waste Management 2, the European Waste Catalogue and the Department of Health's Environment and Sustainability – Health Technical Memorandum 07-01: Safe management of Healthcare waste. 2006

(<http://www.dh.gov.uk/assetRoot/04/14/08/93/04140893.pdf>)

Each Prison should have a "Waste Policy". The responsibility for ensuring such policy is in place lies with the Governor. The Prison is responsible for ensuring that contracts are in place for collection and safe disposal of hazardous waste from their premises. Consultation with the waste management provider is essential to ensure appropriate documentation is generated when necessary i.e. consignment notes. The prison is also responsible for monitoring the performance of their staff and waste contractors.

This guidance contains an outline of Waste Definitions and should not to be used as a substitute for a prison waste policy.

### **Definition of Healthcare Waste**

Waste regulation requires the classification of waste on the basis of hazard characteristics and point of production

## Wastes produced by Healthcare

Examples of waste produced in the healthcare sector	
Hazardous waste	Non-hazardous waste
Infectious waste (see below)	Domestic waste (black-bag or municipal waste)
Fluorescent tubes	Food waste
Laboratory chemicals	Offensive/hygiene waste
Cleaning chemicals	Packaging waste
Oils	Furniture

## Hazardous Waste

### Clinical waste

The Controlled Waste Regulations define clinical waste as:

- (a) .... Any waste which consists wholly or partly of human or animal tissue, blood or other bodily fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles or other sharp instruments, being waste which unless rendered safe may prove hazardous to any person coming into contact with it:

and

- (b) Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.”

Broadly, clinical waste can be divided into two categories of materials:

- Waste which poses a risk of infection
- Medicinal waste.

## Infectious Waste

The Hazardous Waste Regulations define as:

H9: Infectious Substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in man or other living organisms. (Traditionally known as “**clinical waste**”)

## Medicinal Waste

Classified into two categories:

- (f) cytotoxic and cytostatic medicines (Classified as Hazardous Waste)
- (g) medicines other.

Failure to segregate cytotoxic and/or cytostatic medicines from other medicines will mean that the entire medicinal waste stream will need to be classified as hazardous.

Cytotoxic and cytostatic classifications can be found in the NIOSH Alert or the BNF.

## Offensive/Hygiene

Non-infectious (human waste and sanpro (sanitary protection) waste such as nappies, incontinence pads etc), which does not require specialist treatment or disposal, but which may cause offence to those coming into contact with it.

## Waste Segregation

Segregation of waste at the point of production into suitable colour-coded packaging is vital to good waste management.

See <http://www.dh.gov.uk/assetRoot/04/14/08/93/04140893.pdf> section 7 for colour-code tables.

The main change in colour-coding that affects healthcare is the change from yellow bags/sharps bins to orange bag/sharps bins for most of the waste that is generated in a healthcare setting (see table below).

Yellow bags will only be used in “high-risk” settings such as an infectious diseases hospital/ward.

Purple and yellow striped bags and purple-topped sharps bins - cytotoxic/cytostatic waste. The bags are for IV tubing etc contaminated with the drugs.

## Colour-coding key to segregation system






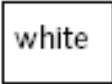
Colour	Description
 Yellow	<i>Waste which requires disposal by incineration</i> Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility.
 Orange	<i>Waste which may be “treated”</i> Indicative treatments/disposal required to be “rendered safe” in a suitable permitted or licensed facility. <i>Usually alternative treatment plants (APT’s) However this waste may also be disposed of by incineration.</i>
 Purple	<i>Cytotoxic and Cytostatic Waste</i> Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility
 Yellow & Black	<i>Offensive/hygiene waste</i> Indicative treatments/disposal required is landfill in a suitable permitted or licensed site. This waste should not be compacted in unlicensed/permitted facilities.
 Black	<i>Domestic (Municipal) Waste</i> Minimum treatments/disposal required is landfill in a suitable permitted or licensed site. Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste.
	<i>Amalgam waste</i> For recovery

Table from HTM07-01: Safe management of healthcare waste.

## Waste Packaging and Colour-coding

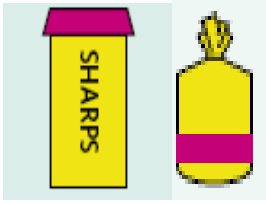
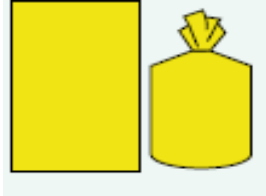
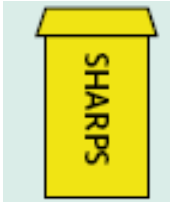
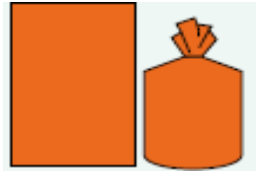
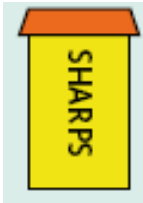


Waste receptacle	Waste type	Example contents	Treatment / disposal
	Sharps contaminated with cytotoxic and cytostatic medicinal products	Sharps used to administer cytotoxic products	Incineration
	Infectious and other waste requiring incineration including anatomical waste, diagnostic specimens, reagents or test vials, and kits containing chemicals.	Anatomical waste from theatres  Category A infectious substance i.e. ebola fever, viral haemorrhagic fever, smallpox	Incineration
 <p>Receptacle must be UN approved for liquids</p>	Partially discharged sharps not contaminated with cyto products	Syringe body with residue medicinal products i.e. undischarged sharps	Incineration
	Infectious waste, potentially infectious waste and autoclaved laboratory waste	Soiled dressings i.e. bandages, plastic single-use instruments	Licensed/ permitted treatment facility  Needs to be treated to render safe
	Sharps not contaminated with medicinal waste Or Fully discharged sharps contaminated with medicinal products other than cytotoxic and cytostatic medicines	Sharps from phlebotomy	Suitably authorised incineration or alternative treatment facility
	Offensive hygiene waste	Human hygiene waste i.e. incontinence pads, nappies and non-infectious disposable equipment, bedding and plaster casts	Deep landfill
	Domestic waste	General refuse, including packaging, confectionery products, flowers	Landfill

Table adapted from HTM07-01: Safe management of healthcare waste.

## HANDLING OF WASTE

- Waste should be segregated at the point of origin
- Personal protective clothing should be worn when handling waste
- Waste should be:
  - Correctly bagged in appropriate colour-coded bags which must be UN-approved and comply with BS EN ISO 7765:2004 and BS EN ISO 6383:2004
  - Double bagged where:
    - The exterior of the bag is contaminated
    - The original bag is split, damaged or leaking
  - Kept in a rigid-sided, fire retardant holder or container with a foot-operated lid, and, so far as is reasonably practicable, out of the reach of children
  - Only filled to  $\frac{3}{4}$  full
  - Securely sealed and labelled with coded tags at the point of use to identify their source.
- Waste should not be:
  - Decanted into other bags, regardless of volume
  - Contaminated on the outside
  - Re-used
  - Sharps must be disposed of into approved sharps containers which meet BS 7320/UN 3291
  - Sharps containers should **NEVER** be placed into any waste bag.

## DISPOSAL OF WASTE

Waste should be placed in an appropriate bag.

The bag should be removed and securely fastened at least once a day or when  $\frac{3}{4}$  full, labelled with its place of origin (e.g. prison details) and placed in the designated clinical waste collection point.

### Disposal of sharps

Fully discharged syringes, needles, razors, ampoules and other sharps should always be placed in an appropriate sharps container. These items should never be placed in a waste bag of any kind.

Care should be taken to ensure that sharps containers are correctly assembled according to the manufacturer's instructions.

Use the appropriately sized sharps container to prevent used sharps being stored for long periods of time.

Sharps containers must be sealed, labelled with the point of origin and placed in the designated clinical waste collection point when  $\frac{3}{4}$  full.

Sharps containers should conform to BS 7230/UN 3291.

### **Disposal of Aerosol Cans/Glass/Bottles/Broken Crockery/Dry Cell Batteries**

Consult your waste management provider re the disposal of these items.

### **STORAGE OF WASTE**

Hazardous waste should be removed from point of generation as frequently as circumstances demand, and at least weekly.

Between collections, waste should be:

- Stored in correctly coded bags, with bags of each colour-code kept separate
- Situated in a centrally designated area of adequate size related to the frequency of collection
- Sited on a well-drained, impervious hard standing floor, which is provided with wash-down facilities
- Kept secure from unauthorised persons, entry by animals and free from infestations
- Accessible to collection vehicles.

### **CURRENT LEGISLATION**

- Health & Safety at Work etc Act 1974
- The Management of Health and Safety at Work Regulations 1999
- Environmental Protection Act 1990
- Environmental Protection (Duty of Care) Regulations 1991
- The Waste Management Licensing Regulation 1994
- Controlled Waste Regulations 2002
- Healthcare Waste Management and Minimisation 2000
- The Waste Incineration (England and Wales) Regulation 2002
- The Pollution Prevention and Control (England and Wales) Regulation 2000)

- The Chemicals (Hazard Information and Packaging for Supply) Regulations 2002
- Control of Substances Hazardous to Health Regulations (COSHH) 2002
- The Landfill (England and Wales) Regulation 2002
- The Carriage of Dangerous Goods and Use of Transportable Pressure Equipment Regulations 2004
- The Hazardous Waste (England and Wales) Regulations 2005
- The List of Waste (England) Regulations 2005

### **Current Guidance Documents**

- Environmental Agency - Hazardous Waste – Technical Guidance WM2 2003
- DOH – Environment and Sustainability - Health Technical Memorandum 07-01: Safe Management of Healthcare Waste 2006
- The National Institute for Occupational Safety and Health (NIOSH) Alert – Preventing Occupational Exposures to Antineoplastic and Other Hazardous Drugs in Health Care. September 2004

# DENTAL UNIT

## SECTION L - DECONTAMINATION OF INSTRUMENTS AND EQUIPMENT USED IN THE DENTAL SURGERY

Refer to the EHPU Dental Guidelines on [www.hpa.org.uk/Essex/](http://www.hpa.org.uk/Essex/) under Policies and Procedures.

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