Sandwell and West Birmingham Hospitals NHS
NHS Trust

LOCAL OPHTHALMIC OPERATIONAL GUIDELINES FOR INTRA VITREAL TREATMENT AND / OR SUB- TENON INJECTIONS

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Approving body	Divisional Governance Group
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ESSENTIAL READING FOR THE FOLLOWING STAFF GROUPS:
1 – BMEC Ophthalmic Clinical Staff
2 – Ophthalmology Clinical Staff

STAFF GROUPS WHICH SHOULD BE AWARE OF THE POLICY FOR REFERENCE PURPOSES:
1 – Trust Ophthalmology Clinical Staff

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1	March 2009	March 2009	June 2010	Changes made in sections 5.4,5.5, 6.1, 7, 8
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CONTENTS

1. Introduction

Many patients present to the Birmingham and Midland Eye Centre and are diagnosed with Age Related Macular Degeneration (ARMD). This is a potentially blinding condition and until recently little could be done to reverse this devastating prognosis. Now, a new treatment has become available in the form of Intra Vitreal Injection (eye injections) which for some patients has had excellent results. In addition some patients will require sub-tenon injections for other ocular conditions. These patients will be referred to BMEC for specialist treatment by General practitioners, opticians, eye units or consultants within the West Midlands and beyond. These eye injections are carried out in the ophthalmic outpatients department under topical local anaesthetic. Both procedures are fairly straight forward and quick and do not require admission.

2. Objectives

2.1 The safe and competent administration of intravitreal and or sub-tenon injections as part of a patient's treatment in the ophthalmic out patient department will be carried out by appropriately trained medical staff.

2.2 The injections will be carried out in a suitably prepared environment.

3. Scope

This policy applies to all staff involved in the delivery of care to ophthalmic patients requiring Intravitreal injections or sub–tenon injections in the ophthalmic out patients department

4. Definitions

GP	–	General Practitioner
BMEC	–	Birmingham and Midland Eye Centre
IVT	–	Intravitreal – into the jelly at the back of the eye
ARMD	–	Age related macular degeneration – degeneration of the macula at the back of the eye
BP	-	Blood pressure
OPD	-	Out Patients Department

5. Specific detail

5.1 Entrance / Reception

Patients will enter through the main entrance of the Birmingham and Midland Eye Centre (BMEC) and report to the receptionist where generic details will be checked and documented and the patient will be booked in. On completion the patient will be directed to the appropriate waiting area to be called by the clinic nurse.

5.2 Waiting area

Patients will wait to be called by the clinic nurse in a designated area within the main ophthalmic out patients department to proceed with the IVT/Sub-tenon Patients' care pathway. Male, female and disabled toilet facilities are available here. A refreshment bar and drinks machine are also available close by. Carousels of patient information leaflets and a manned Focus information desk are also located within the ophthalmic out patient department.

5.3 Clinic details

Patients will be seen in the medical retina outpatient clinics, where a decision will be made for the appropriate treatment to be carried out e.g. IVT or Sub-tenon injection. The patient may be treated on the same day following consultation or booked into the IVT/sub-tenon injection designated clinic. Funding for this treatment will be secured from the patient's Primary Care Trust, this is carried out by the ophthalmic co-ordinator at BMEC.

5.4 Consulting rooms

The initial medical ophthalmic assessment will take place in the clinical examination rooms in ophthalmic OPD where consent will be obtained, and the risks and benefits of the treatment highlighted prior to treatment.

Patient exclusion

- Please refer the patient to the doctor if he/she has any of the following:
- Patient has a history of myocardial infarct <3 months previously.
- Patient has a history of unstable angina.
- Patient has had an acute illness in the last 2 weeks.
- Patient has a history of unstable asthma or any other chest conditions.
- Patient has a history of multiple allergies.
- Patient has a history of jaundice.
- Patient is pregnant, there is a possibility of pregnancy or is breast feeding

Patient preparation prior to treatment

- Patient to be escorted to the IVT/Sub-tenon injection room where procedure will be completed.
- Check patient's name, address and date of birth (DOB) with patient and against notes, complete WHO checklist
- Ensure patient's visual acuity/Logmar is recorded.
- Ensure written consent has been obtained, if so reconfirm with patient if he/she is happy to proceed and understands any risks and the benefits associated with the procedure.
- Ensure the eye to be treated has been marked by the ophthalmologist.
- Check if the patient has any allergies.
- Check notes for patient's general health history and check with the patient if there is any change in general health and medications.
- Instil dilating drops if required as prescribed.
- Instil local anaesthetic drops as prescribed.

5.5 Description of the rooms

The Intra Vitreal Treatment / Sub-tenon room is located in the Ophthalmic Out Patient Department at BMEC. Room No.: (01-143, G-109-01). This is a designated 'clean room'. The room has a lockable unit with cupboards and drawers, a smooth work surface above, an adjustable patient couch, sinks and appropriate lighting. The walls are all washable as is the paintwork and floors.

The room will be used exclusively for giving IVT or Sub-tenon injections, these will be performed by an appropriately trained ophthalmologists. In close proximity to this room is the clean utility room, the recovery room and the dirty utility room.

6.0 The procedure

The procedure trolley will be cleaned as recommended in section 6 of the trust infection control manual-decontamination of equipment, in the clean utility room no.G-119-01 located in clinic area one and adjacent to the IVT/sub-tenon room then wheeled to the IVT/sub-tenon room opposite.

All packs and equipment for these procedures is stored in the IVT room where the trolley will be laid individually for each patient. All equipment for both these procedures is disposable so will be used only once then discarded. Individual sterile packs for IVT containing speculum, syringes, needles and drapes or for sub tenon injections containing Moorfields plain forceps, Barraquer speculum, tenotomy scissors are used. Disposable gowns, gloves, eye pads, masks, plastic aprons are used routinely extra sterile instruments are also available and are used as necessary. Drops used for topical local anaesthetic come in single use minims. No prisms are used.

Before laying the procedure trolley and with due regard to the trust 'Principles of Asepsis' and other appropriate trust guidelines (see references) and on completion of the procedure the nurse should wash her hands adhering to the trust 'Hand Hygiene' guidelines. The use of appropriate personal protective equipment should also be adhered to. The patient's eye site will be cleaned with Povidine Iodine 5-10% alcohol solution (Betadine) by the Doctor prior to the injection being given.

Once the procedure is completed any sharps will be discarded in the sharps bin in the IVT room. All other waste will be removed to the dirty utility room for appropriate disposal. The trolley will then be decontaminated appropriately (see clinical waste and sharps policy).

6.1 Patient care post treatment

- The patient may be discharged home once the patient feels well.
- The patient should be given verbal and written instructions and a GP letter with post procedure advice and contact numbers in case of problems/emergency.
- The patient will be given G.Chlor QID x 5/7 or if contraindicated G.Oflaxacin QID x 5/7.

7. Drugs

The IVT/Sub-tenon drugs to be injected will be available through the hospital pharmacy department. They will be ordered per patient as necessary by medical staff.

13. Clinical waste policy /sharps policy

Once the procedure has been completed the used trolley will be wheeled into the dirty utility room no. G-118-01 located in clinic area one. The disposal of any used needles, syringes, instruments into the sharps bin will take place in the IVT room. The disposal of gowns, masks, drapes, gloves will be completed in the dirty utility room and comply with trust infection control recommendations on the collection and disposal of waste. **(See Appendix 6).**

14. Infection control

The room will be cleaned daily before clinic sessions and between each patient according to the local domestic cleaning, which is adapted from the Trust Infection Control Manual **(see appendix 1).**) Personal protective equipment of aprons, gowns, and gloves are available and used routinely for each patient. Masks are also available but spillage of any body fluids from the eye is likely to be rare and none projectile

Any patient known to have or suspected of having a communicable disease will be treated as the last patient on the list. The IVT room will then undergo appropriate cleaning (**see appendix 2)**
This guideline has been constructed with due regard to the trust infection control guidance manual. (see references)

15. Medical records

The compilation and storage of patients' files will comply with clinic/national policy and will be managed by the medical records team.

General practitioner communication and Medical Secretary Service
Pre or post treatment letters will be sent to all GP's via the Medical Secretaries

16. Training and awareness

All staff both medical and nursing involved in the preparation and administration of this treatment are registered practitioners, having successfully undergone nationally recognised training enabling them to be regarded as competent practitioners. Induction and mandatory training for staff involved in this service delivery is also in place.

12. References

Decontamination of the Environment SWBH/CO1/028

Decontamination of Equipment SWBH/CO1/029

Principles of Asepsis SWBH/CO1/025

Multi resistant Gram negative Micro-organisms SWBH/CO1/020

Multi resistant Gram Positive Organisms SWBH/CO1/019

Sharps and clinical waste (Segregation, Collection and Disposal) Infection Control Guidelines SWBH/CO1/010

IFC Protective Clothing SWBH/CO1/009

Management of Blood and Body Fluid Spillages SWBH/CO1/008

IFC Hand Hygiene SWBH/CO1/006

Care and Management of Patients with known or suspected communicable infections SWBH/CO1/012

Management of medical services SWBH/019/065

Infection control. Linen segregation and management SWBH /CO1/007

Appendix 1

Domestic Cleaning of the BMEC Intra-Vitreal /Sub-tenon /Treatment Room

Frequency of Cleaning

Daily for fixtures - e.g. sinks, floors, work surfaces, bins, and cupboards.

- Technical equipment e.g. the reclining chair should be cleaned by nursing staff after use on each patient.
- Blood spillages should be cleaned by nursing staff in accordance with the 'Decontamination of Spillages Guidelines' (see Appendix 7).
- Detergent and water should be used for routine cleaning between patients (see Appendix 4).
- Disposable cloths - e.g. green roll or disposable paper towels should be used to clean surfaces and be discarded after use. Reusable cloths should NOT be used.
- Mops should be cleaned following use with detergent and water, and stored head upright.
- Walls and ceiling should be cleaned every six months or when visibly soiled.

In the event of an infected case, the 'Barrier Cleaning Policy' (intranet) should be followed and the appropriate disinfectant used.

- Buckets should be cleaned and dried thoroughly following use, and inverted to prevent reservoirs of water.
- Work should commence in clean areas, e.g. IVT room and progress to Dirty areas - e.g. sluice.
- All solutions used must be made to the correct dilutions.
- All solutions must be disposed of appropriately following use.
- All equipment should be stored clean and dry, (see Appendix 3).

Appendix 2

Infection Control Principles on the care and management of patients with Known or Suspected Communicable Infections

It should be remembered that a common sense approach should be adopted when applying practical infection control measures and that the holistic needs of the patient should always be considered.

Procedure for preparation and cleaning of the BMEC IVT/Sub-tenon room for patients who are suspected or have been diagnosed as an infection control risk:

Rationale: To prevent the risk of cross infection

Infection Risk

1. Hepatitis B
2. H.I.V/AIDS
3. Methicillin/Multi Resistant Staphylococcus Aureus (MRSA)
4. Tuberculosis including pulmonary tuberculosis

Preparation of the IVT/Subtenon Room

1. Disposable equipment will be used
2. All unnecessary furniture and equipment to be removed from the room.
3. Circulating staff to wear plastic aprons/disposable gowns and gloves.
4. Scrub team to wear disposable plastic aprons under disposable gowns.

During the procedure

1. Infected cases should be done last on the list
2. Any spillage should immediately be cleared from floors with appropriate agent please **(see Appendix 7).**
3. The number of people entering and leaving should be limited, by having a second circulating nurse outside the door, who can then assist the circulating nurse inside the room by passing any further equipment or instructions which may be required.

Appendix 3

Disinfection and Sterilisation

It must be noted that all instrumentation used in these procedures will be for single use only (disposable) being discarded immediately after use.

Introduction

The aim of this section is to inform the user of the most appropriate method of decontamination to be used for equipment and the environment. If appropriate, always use the B Braun for decontamination of equipment. Non disposable equipment used on a patient with a known or suspected infection should be returned to B Braun. Always decontaminate equipment prior to service or repair.

Cleaning

Cleaning with soap or detergent will remove most micro-organisms from a surface. A further reduction in numbers occurs as the surface dries. Thorough cleaning and drying will be adequate treatment for most surfaces and furniture in the hospital environment. Cleaning of equipment before disinfection or Sterilisation is also required.

Disinfection

Disinfection using either heat or chemicals will destroy non-sporing bacteria and most viruses, reducing them to a safe level. Disinfection is required for items in contact with intact skin or mucous membranes e.g. respiratory equipment and not intentionally invasive or associated with a patient with particularly transmissible/virulent infections. Chemical disinfection should only be used if heat treatment is impractical or undesirable, e.g. for skin, flexible endoscopes, etc.

Sterilisation

Sterilisation means the complete destruction or removal of all micro - organisms, including bacterial spores. Items involved with a break in the skin or mucous membranes should be sterilised, e.g. surgical instruments, wound care products, and products intended for parenteral use or for instillation into body cavities.
Autoclaving with steam above atmospheric pressure (121°C - 134°C), or dry heat (160°C180^{o}C) are acceptable methods for hospital use. Chemicals with sporicidal activity may sterilise but are less reliable, require rinsing to remove toxic residues and should be avoided if possible. Control of substances hazardous to health (COSHH) regulations must be followed when using any toxic or irritant substance. Alternative methods are available for heat sensitive equipment - e.g. ethylene oxide.

Appendix 4

Approved Chemical Disinfectants

To comply with COSHH Regulations always follow the manufacturers recommended guidelines when using chemical disinfectants.
If appropriate, personal protective clothing must be worn.
Disinfectants must be mixed with tepid/cold water **NOT HOT**

Only **recommended disinfectants** approved by Infection Control must be used

CHEMICAL NAME and **RECOMMENDED CONCENTRATION**

Alcohol (Isopropanol or Ethyl) 60-70% provided as a single use wipe or diluted ready for use with emollient e.g. for skin disinfection

Chlorine releasing agents, Usage concentrations are:
Usually supplied in tablet form.
Use concentrations are:-10,000 ppm (ppm - parts per million) for blood spillage*.
* A non-abrasive chlorine releasing powder may also be used for spillage. 1,000 ppm for environmental surfaces. 125 ppm 1:80 1.25% infant feed bottles

Disinfection Of Skin And Mucous Membranes
Operation site Povidone-iodine 5-10% alcohol solution
('Betadine' alcoholic solution) is available.

Appendix 5

Equipment-Cleaning and Decontamination

Due to the design and use of equipment purchased throughout the Trust being so diverse the aim of this section is to give the user general guidelines and recommendations for the cleaning and decontamination.

Any equipment purchased should have the ability to be decontaminated. It is the responsibility of the user to ensure that any equipment purchased is adequately decontaminated, and a regular programme of cleaning and maintenance is in situ to ensure the equipment is adequately decontaminated and maintained in optimum condition if appropriate.

When purchasing an item of equipment the manufacturers' guidelines should be reviewed to ascertain the recommended method of decontamination.
The following are some points which must be considered:

- How is the item of equipment decontaminated
- Can it withstand cleaning with detergent and water at high temperatures.
- Can it withstand disinfectants e.g. chlorine releasing agents.

If the manufacturer's guidelines state specific disinfectants, the following needs to be considered:

(i) Does the use and storage comply with COSHH?
(ii) Will they adequately decontaminate?
(iii) How cost effective is the disinfectant?
(iv) Can it be adequately and safely stored?
(v) What is the availability of the disinfectant and is there an alternative?

Prior to sending any equipment for maintenance the user has a responsibility to ensure it has been decontaminated adequately and a 'decontamination certificate' has been completed (SWBH/019/065). Any equipment which has been used on a patient with a known or suspected infection must be returned to B Braun as instructed in the B Braun instruction manual.

Suction Equipment

- Protective clothing should be worn (aprons, gloves, goggles) when disposing of body fluids to prevent contamination from spillage and avoid a splash injury.
- Suction catheters should not be left attached. Must be discarded as clinical waste following use.
- Where practical granules should be used to reduce the volume of liquid.
- Disposable suction containers must be discarded as clinical waste. In a container/clinical waste bag approved to UN3291.
- Reusable suction bottles MUST be cleaned following use (wear personal protective equipment - PPE) and dried.
    - If suction has been used on a patient with a known or infected communicable disease it must be returned to HSSU following use. HSSU must be notified prior to transport.

Appendix 6

Collection and Disposal of Waste

Introduction

The collection, transportation and disposal of waste must comply with 'The Environmental Protection Act (1990), Carriage of Dangerous Goods/Classification, Packaging and Labelling (CDGCPL2 - 1996) and be in accordance with HTM2065 Guidelines.

The risk of infection from hospital waste is low, providing the correct procedures are followed to ensure the safe handling, transportation and disposal of waste. There are certain items which because of their nature are not acceptable for disposal by landfill. Therefore special arrangements need to be made for the disposal of these items which should be clearly identifiable as requiring special treatment and incineration.

Clinical waste (Orange plastic bags)

- This should include items of waste contaminated with blood and body fluids - e.g. wound dressings, swabs, contaminated wipes, colostomy bags, sputum containers, disposable redivac drains etc.
- All waste from patients with a known or suspected infection - e.g. tuberculosis,
- Hepatitis B or as recommended by the Infection Control Department should be disposed of as clinical waste.
- Clinical Waste Bags must be labelled PRIOR to use with the Trust, Location and Date.
- Clinical waste should be placed in orange plastic bags which when three quarters full, are secured with a plastic bag tie.
- Clinical Waste bags must be stored in a designated locked area prior to collection.

Sharps

- The containers used for sharps must be approved to current British standards (BS7320).
- The contents should be limited to devices which may cause physical injury or those items which cannot be separated from them - e.g. syringes.
- The lid must be securely closed prior to use.
- Sharps boxes must be labelled PRIOR to use with the Trust, Location, Date and name of person assembling the box.
- Sharps boxes must have the aperture temporarily closed between use.
- Sharps boxes must be sealed when they are two thirds full.
- They must be stored in a designated locked area, prior to collection.

NB: SHARPS BOXES MUST NOT BE OVERFILLED. SHARPS MUST NOT BE PROTRUDING FROM SHARPS BOXES. CLINICAL WASTE MUST NOT BE LEFT ON THE CORRIDORS FOR COLLECTION.

Swift bins

Swift bins are used in designated areas for the storage of clinical waste prior to collection for incineration. Where Swift Bins are used, they must be kept locked.

Human tissue

- This waste must be double bagged into clinical waste bags or placed inside UN approved rigid container. Labelled PRIOR to use as above.

- The bag/container must then be stored in a designated locked area prior to collection.

Laboratory waste
- All laboratory cultures and any patient specimens for discarding should be rendered safe, if possible, before leaving laboratory premises (the method will usually be autoclaving).
- This waste should then be disposed of as clinical waste.

Cytotoxic waste
- In areas where cytotoxic waste is used, specific guidelines must be followed.
- Cytotoxic waste must be disposed on in UN approved boxes clearly labelled 'Cytotoxic Waste'. The boxes must also be labelled with the Trust, Location and Date.
- Cytotoxic waste must be stored in designated locked areas (Pharmacy) prior to collection and not stored with Clinical Waste.
- Prior to transporting cytotoxic waste for incineration a 'Pre-Notification' form must be completed.

Glass/aerosols
- Aerosol containers must not be included with waste for incineration due to the danger of explosion.
- Glass and aerosols must be disposed of into designated containers.

Radioactive waste
- All items containing radio active waste must be placed in a designated 'approved' container. Clearly labelled Radioactive waste.
- The container must then be placed inside a red swift bin for collection.

Domestic waste - black plastic bags
- All other types of waste, not included in the above categories, should be regarded as domestic waste and placed in **black plastic bags**.
- To prevent spillage, it is important that these bags are not overfilled and are **securely fastened.**
- Contents must not be transferred loose from one bag to another.
- SHARPS AND 'SPECIAL WASTE' MUST **NOT** BE DISPOSED OF AS DOMESTIC WASTE.

Any queries regarding the management of waste please contact the Transport Department on Ext. 4597.

Appendix 7

Spillages

Introduction

Microbes are normally present in the environment of the home and hospital, but most are harmless and only a small proportion cause infections in susceptible people. They can be removed by thorough cleaning with a detergent solution. Microbes die rapidly on clean, dry surfaces, and thus there is little advantage in the routine use of chemical disinfectants. The use of disinfectants is restricted to the cleaning up of spillages likely to be contaminated with microbes causing specific infections - e.g. typhoid, food poisoning, Mycobacterium tuberculosis, hepatitis, HIV.

General guidelines

The routine management of spillage of faeces (not diarrhoea) vomit, urine, and wound exudates can be managed in the same way. This will ensure that the carer is protected.

Protective clothing

- Disposable non - sterile gloves must be worn.
- Plastic apron must be worn.
- Goggles must be available to use for preventing splashes to the eyes.

Procedure

- Always use freshly prepared solutions in a clean container.
- Using a polypropylene bowl, dilute approximately 10 ml of general purpose detergent - e.g. Hospec in 1 litre of water.
- Use disposable paper towels to remove/clean up the spillage. Discard the paper towel without returning it to the bowl. Dispose of as clinical waste.
- Continue until surface is clean and dry.
- If a mop and bucket is used to clean up spillage - they must be washed with detergent and water and stored dry after each use.

In specific instances where spillage of body fluids has occurred from a patient with suspected or confirmed infection. The additional use of a chlorine releasing agent after disinfection e.g. Sanichlor tablets or chlorine releasing powder e.g. Diversey is recommended (see List of Approved Disinfectants).

DO NOT USE CHLORINE RELEASING AGENTS ON URINE SPILLS !!

(Ref Department of Health. Safety Action Bulletin. 'Spills of Urine: Potential Risk of Misuse of Chlorine Releasing Disinfecting Agents. SAB (90) 41 May 1990)

Blood spillages

Blood or blood stained spillages:

Disinfectant required - Chlorine releasing agents e.g. Sanichlor tablets, or chlorine releasing powder e.g. Diversey.

Concentration required -

1) In the presence of blood 10,000 ppm available chlorine.
2) If blood has previously been removed 1,000 ppm available chlorine.

Protective Clothing

- Aprons
- Gloves

- Eye protection (if splashing likely)

Procedure

Visually assess the size of the spillage and proceed accordingly.

For small blood spillage s - less than 30 mls

Sprinkle with a non-abrasive chlorine releasing powder, e.g. Diversey, until all fluid is absorbed, then remove using paper towels. Wipe over surfaces with a wet paper towel and dry. All waste must be discarded as clinical waste.

For large blood spillage s - greater than 30 mls

- Dilute chlorine releasing tablets in appropriate volumes of cold/tepid water.
- **DO NOT USE HOT WATER**
- Cover the spillage with paper towels so that all liquid is absorbed, then discard as clinical waste.
- Wipe over the contaminated area using a disinfectant soaked paper towel. Do not return used paper towels to the solution.
- Continue until cleaning is complete.
- Dry surface.
- Prepare a fresh solution if necessary.

If a mop and bucket is used to clean up large spillages:

- They must be disinfected after use.
- Wash out mop and bucket with detergent and water.
- Prepare fresh solution of chlorine releasing agent and immerse mop for **10 minutes** in solution.
- Rinse in fresh water, wring and store dry
- Dispose of chlorine solution, rinse and invert bucket to dry.

NB - Spillages of sputum can be removed as described for Blood spillages.

Identification of Patients with known or suspected infections

On Admission:

NOTE: Patients undergoing IVT/sub tenon's injection treatment do not normally require admission

Any patient having the Intra Vitreal Treatment/Sub-tenon injection with a known or suspected infection will be done last on the list they will be notified to infection control as having a known or suspected infection, they are then highlighted on the Patient Information system with the relevant precautions identified i.e. blood, enteric, airborne, contact, MRSA.

Where patients have diarrhoea & vomiting and come from a nursing/residential home, Infection Control should be informed about the details of the home as there is an alerting mechanism that needs to be followed (i.e notifying the HPA/PCT).

Post Admission:

If more than 2 cases of diarrhoea & vomiting occur on a ward and are unrelated to the patient's original clinical condition, the Infection Control Team must be alerted.

General Principles

(i) Entrance and Exit

- The door of the room must be kept closed at all times unless otherwise indicated.
- The room must be equipped only with items required to nurse the patient.
- Place laminated either Source / Protective isolation sign on the door as required.

(ii) Protective Clothing (see Protective Clothing SWBH/COI/009, intranet)

Aprons

- A disposable apron must be worn when caring for a patient with a known or suspected infection.
- Aprons must only be used once and then disposed of (as clinical waste) before leaving the room/bed space.

Gloves

- Must be worn prior to contact with blood / body fluids or when handling contaminated articles (Sterile gloves should be worn when indicated e.g. Aseptic procedures)
- *Hand hygiene must be adhered to when removing gloves*

Masks

- When recommended particle filter masks help to protect from droplet infection e.g. multi drug resistant tuberculosis; meningococcal meningitis; SARS.
- Masks must be securely fitted and cover the nose and mouth.
- Only masks that are approved to EU standards must be worn.
- Masks should be put on before entering the room
- NB: all staff wearing masks should undertake 'fit testing' to ensure they are competent in their use and management.

(iii) Hand Hygiene (see Hand Hygiene policy SWBH/COI/006, intranet)

- Compliance with a good hand hygiene technique before / after contact with the patient is the most important measure in preventing the spread of infection.

(iv) Infected Linen

- Place linen in a water soluble bag prior to placing inside a red plastic bag
- *Linen used on patients who are MRSA positive does not need to be treated as infected unless blood stained or soiled*. Place inside a white plastic linen bag (SWBH/co1/007)
- Ensure that no sharps or other extraneous materials are left in linen as this may cause injury to the laundry staff, or damage machinery.

(v) Equipment

- Do NOT place equipment in paper dressing/used instrument bags with BIOHAZARD labels attached
- Do NOT place equipment used on the above patients, directly into the HSSU bins within the ward/department
- ALWAYS USE a sterilin/autoclavable bags
- BE SURE that the bag used is large enough to contain the items being sent
- ALWAYS TIE the bag securely
- ALWAYS PLACE the bag in the appropriate HSSU bin for collection
- Please ensure that all Sharps are disposed of into an approved container and not sent back to HSSU

(vi) Crockery and Cutlery

- Use normal utensils and return to central kitchen in the usual way.
- For patients with blood borne viruses who may be bleeding from the mouth – seek advice from ICT.

(vii) Bed Pans and urinals.

- Cover and remove immediately to the macerator. Bed pan bases / commodes should be kept for the use of the infected patient only and must be decontaminated after each use.

(viii) Clinical Waste

- All waste designated as clinical waste must be placed into an orange clinical waste bag (approved to UN3291). All bags must be secured with a 'clinical waste tie prior to disposal.
- Where yellow 'swift bins' are used to store clinical waste ready for collection swift bins must remain locked when not in use!

(ix) Disposal of Sharps

- All sharps must be disposed of at the point of use inside a sharps box approved to BS7320
- Sharps must not be left unattended
- Sharps boxes must be assembled correctly and the person assembling the sharps box must sign appropriate place on label
- The aperture to the sharps box is closed (temporary closure in place) when not in use
- The aperture is double clicked (to permanently close) prior to disposal

(x) Specimens (see Specimen Collection and Transportation SWBH/COI/011, available on intranet)

- Specimen forms must be labelled correctly, indicating site, relevant history and ward/department.
- Specimens from patients with known or suspected infection must NOT be placed in the Air tube transport system (shute).
- Specimens from patients with known or suspected infections MUST be labelled BIOHAZARD

(xi) Patient telephone, television, bedside equipment

- All equipment must be cleaned between each patient use and when soiled as per agreed cleaning protocols.
- Following discharge/transfer of a patient the foam ear pieces (from the headset) should be removed and discarded. This will enable Patient line staff to identify which terminals require cleaning. All terminals should be cleaned between patient use.

(xii) Visitors incubating infections

- Visitors should be encouraged to let staff know if they have a communicable infection, which may be transmitted to hospital patients (see Information Leaflet- 'Visiting Someone in Hospital'), intranet.

Restriction of Visitors

- Dependent upon the nature and extent of the communicable infection visitors may need to be restricted to minimise the risk of transmission. This should be done in consultation with Infection Control and the Hospital Director.

Restriction of Children

- In high risk areas where transmissible infections are involved children should be restricted, except in exceptional circumstances and following discussion with Infection Control. If children are allowed to visit a risk assessment should be undertaken and documented in patients notes outlining relatives are aware of their responsibility for risk.

IVT Check List

Date:	**Signature:**
Confirm Identity.	
Consent.	
Site Marked.	
Allergies.	
TTO's.	
Discharge information.	
Leaflet.	