Policy/Procedure/Guideline

Infection Prevention and Control Management Policy

Version no: 1.0

Issue Status: Approved

Date of Ratification: April 2016

Ratified by: Clinical, Governance & Risk Board

Policy Author: Bradley Woods

Policy Owner: CG&RB

Review Frequency: 1 Year

Identifiable Document Code: PTUK022

Last Review: April 2020

Next Review: April 2022

POLICY AWARENESS	
People who need to know this policy in detail	Operational Staff
People who need to have a broad understanding of this policy	Operational Staff
People who need to know this policy exists	All staff

CHANGE CONTROL DETAILS			
Date DD/MM/YY	Version	Description	Reason for changes
11/04/2016	1	New policy	New policy

Policy location:
Main Policy Folder in Control Room and Crew Room
On PTUK Server

Contents

1.0 Introduction

The purpose of Patient Transport UK Infection Control Management Policy, together with the associated local safe practice guidelines, is to state PTUK's infection control systems, describe the evidence-based clinical and decontamination practices to be adopted by staff and to facilitate infection prevention, control and safety systems being incorporated into every facet of ambulance service delivery.

This policy sets out the ways in which PTUK will ensure its infection prevention and control systems, procedures and practices meet the best practice standards defined by Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and implemented by the Code of Practice for the prevention and control of infections in health and social care and related guidance (2010)

"Good infection prevention and control are essential to ensure that people who use health and social care services receive safe and effective care. Effective prevention and control of infection must be part of everyday practice and be applied consistently by everyone. Good management and organisational processes are crucial to make sure that high standards of infection prevention and control are set up and maintained". Code of Practice (2010)

2.0 Purpose

This Policy together with the safe practice guidelines will cover all the aspects of infection prevention and control and decontamination required to protect staff, patients and third parties as well as issues and procedures raised through PTUK's risk management processes or required for statutory purposes. This policy describes the processes to be operated within PTUK to enable and monitor all aspects of this policy.

3.0 Duties

PTUK Ambulance Service is the "responsible body" and must make arrangements for ensuring compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and associated Code of Practice (2010).

3.1 The Clinical Governance & Risk Board (CG&RB) is responsible for receiving and reviewing reports from the Clinical Lead on the effectiveness of the PTUK Infection Prevention and Control Management Policy and to ensure that action is taken to address any adverse incidents and infection trends. The CG&RB will also monitor compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2009 and associated Code of Practice (2010).

The CG&RB has a collective responsibility for preventing and controlling infection risk. The CG&RB must ensure that there is an Infection Prevention and Control Management Policy and associated effective risk management systems in place. The

CG&RB will annually review infection prevention and control arrangements and approve the Annual IPC Programme which provides clear activities, responsibilities and timescales for achieving compliance with the Code of Practice. The CG&RB will receive an annual Infection Prevention and Control report from the Clinical Lead of Infection Prevention and Control, providing details of performance achieved in compliance with the Annual Programme.

3.2 It is the Medical Directors responsibility to ensure implementation of the Infection Prevention and Control Management Policy and that matters relating to infection prevention and control and decontamination are managed effectively.

The Medical Director is the "responsible person" and has overall responsibility for the implementation of PTUK Infection Prevention and Control Policy. The functions of the "responsible person" may be performed by any person authorised by the "responsible person" to act on their behalf.

3.3 Managers and Supervisors in all areas of PTUK are responsible for ensuring this policy is communicated to staff and for ensuring compliance with this policy and the related safe practice guidelines in accordance with their role and responsibilities as defined in individual job descriptions.

Managers and Supervisors are responsible for the assessment of staff under their management as an integral element of annual performance appraisal.

3.4 All staff are expected to understand their role and responsibilities for IPC as defined in their job descriptions. Staff are expected to comply with this policy and related safe practice guidelines and to maintain and increase their knowledge of the subject relative to their role including completion of annual CPD training.

Operational performance and the implementation of the Infection Prevention and Control Policy is the responsibility of each individual member of staff as well as those who support PTUK in the delivery and discharge of its duty of care.

3.5 All Bank staff have a requirement to abide by PTUK policies and procedures including the IPC Policy and to report any breaches to the Clinical Lead. They are also required to attend relevant training including relating to IPC prior to commencement of their role.

3.6 PTUK's Occupational Health provider is responsible for ensuring (incompliance with criterion 10 of the Code of Practice) that, so far as is reasonably practicable, all members of PTUK staff (and contractors) are free of and are protected from occupational exposure to infections. This is achieved by:

- All staff having access to Occupational Health services
- Ensuring that Occupational Health policies on the prevention and management of occupationally acquired transmissible infections are in place and are cross-

referenced in the IPC safe practice manual (as per Criterion 10 of the Code of Practice)

- Ensuring a comprehensive programme of immunisation is available to PTUK staff based on local risk assessment as described in Immunisation against infectious diseases (DOH)-the Green Book and other relevant Department of Health Guidance as published
- Ensuring vaccines are available free of charge to employees if risk assessment indicates that it is necessary

4.0 Consultation and Communication with Stakeholders

4.1 The biggest stakeholder with regard to this policy is the public. As such this policy must be available to members of the public on request. On receipt of an email enquiry or an enquiry via the website, the Chief Operating Officer will arrange to forward a copy. Telephone enquiries will most probably initially come to control staff, who will forward a copy electronically via email or post a hard copy to the enquirer's address.

4.2 Staff are made aware of this policy on induction, and where it can be found.

4.3 Staff are informed of new revisions or subsequent versions of this policy via internal email and the posting on notice boards.

5.0 Definitions

5.1 Patient Transport UK, is referred to throughout this document as "PTUK" or "The company".

5.2 OHS is the Occupational Health service which is provided by The Integrated Care Partnership.

6.0 Process for Monitoring Compliance

6.1 Governance Officer will conduct audits as per the Audit Schedule agreed by the CG&RB, reporting back to the CG&RB on a 6 monthly basis to ensure that compliance is achieved.

7.0 Standards/Key Performance Indicators

7.1 Compliance Criterion-PTUK is required to demonstrate

7.1.1 Systems to manage and monitor the prevention and control of infection are in place. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them. *(Refer also to Outcome 6, Regulation 24 Cooperating with other providers contained in CQC Guidance about compliance)*

7.1.2 Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infection. *(Refer also to Outcome 10, Regulation 15 Safety and suitability of premises contained in CQC Guidance about compliance)*

7.1.3 Provide suitable accurate information on infections to service users and their visitors. *(Refer also to Outcome 1, Regulation 17 Respecting and involving service users contained in CQC Guidance about compliance)*

7.1.4 Provide suitable accurate information on infections to any person concerned with providing further support on nursing / medical care in a timely fashion. *(Refer also to Outcome 6, Regulation 24 Cooperating with other providers contained in CQC Guidance about compliance)*

7.1.5 Ensure that people who have or develop an infection are identified promptly and receive the appropriate treatment and care to reduce the risk of passing on the infection to other people.

7.1.6 Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.

7.1.7 Criterion 7 does not apply to Independent Ambulance providers.

7.1.8 Criterion 8 does not apply to Independent Ambulance providers.

7.1.9 Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections.

4.1 Standard infection prevention and control precautions
4.2 Aseptic technique
4.3 Safe handling and disposal of sharps
4.4 Prevention of occupational exposure to blood-borne viruses (BBVs), including prevention of sharps injuries
4.5 Management of occupational exposure to BBVs and post-exposure prophylaxis
4.6 Disinfection
4.7 Decontamination of reusable medical devices
4.8 Single-use medical devices
4.9 Safe handling and disposal of waste
4.10 Care of deceased persons
4.11 Use and care of invasive devices
4.12 Purchase, cleaning, decontamination, maintenance and disposal of equipment
4.13 Dissemination of information
4.14 Uniform and dress code

7.1.10 Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to occupational infections and that all staff are

suitably educated in the prevention and control of infection associated with the provision of health and social care

8.0 References

Health and Social Care Act 2008 (Regulated Activities) Regulations 2009

Health and Social Care Act 2008 - Code of Practice (2010).

Care Quality Commission 2008 (www.cqc.org.uk)

9.0 Appendices

Appendix 1
Appendix 2

Appendix 1 - Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
5.	**If so can the impact be avoided?**	N/A	
6.	**What alternatives are there to achieving the policy/guidance without the impact?**	N/A	
7.	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to Human Resources, together with any suggestions as to the action required to avoid/reduce this impact.

Appendix 2 - Checklist for the Review and Approval of Procedural Document

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	
2.	**Rationale**		
	Are reasons for development of the document stated?	Yes	
3.	**Development Process**		
	Is the method described in brief?	Yes	
	Are people involved in the development identified?	Yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	Yes	
	Are the references cited in full?	Yes	
	Are supporting documents referenced?	Yes	
6.	**Approval**		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Does the document identify which committee/group will approve it?	Yes	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	Yes	
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Yes	
	Does the plan include the necessary training/support to ensure compliance?	Yes	
8.	**Document Control**		
	Does the document identify where it will be held?	Yes	
	Have archiving arrangements for superseded documents been addressed?	Yes	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Yes	
	Is there a plan to review or audit compliance with the document?	Yes	
10.	**Review Date**		
	Is the review date identified?	Yes	
	Is the frequency of review identified? If so is it acceptable?	Yes	
11.	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Yes	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name		Date	11/04/2020
Signature			
Committee Approval			
If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name		Date	11/04/2020
Signature			