

Aseptic Technique and Clean Technique Procedure

(Infection Prevention & Control policy: Appendix 7)

This Appendix must be read in conjunction with the Infection Prevention and Control Policy

Version: 4

Summary:	Provide a standardised approach to Aseptic Technique and clear indication where a standard aseptic technique is required and when clean technique is indicated	
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Author:	Jacky Hunt, Nurse Infection Prevention & Control (North)	
Accountable Executive Lead:	Paula Hull, Director of Nursing and Allied Health Professionals	

Version Control

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Reviewers/contributors

Name	Position	Version Reviewed & Date
IP&C Team		V2 4.11.13
Sue Benzie		V2 4.11.13
Steve Coopey		V2 4.11.13
Area Matrons		V2 4.11.13
Julie Parsons		V2 4.11.13
Sue Hobbs		V2 4.11.13
Lyn Aldridge		V2 4.11.13
Louise Marshall		V2 4.11.13
Louise Felice		V2 4.11.13
Jude Diggins		V2 21.11.13 on 6.2.14
IPC Committee		V26.2.14
Policy Consultation Group		V2 6.12.13
IPC Team		V322.8.14
Caryn Carr	Lead Tissue Viability Nurse Specialist	2.9.14
IPC Group		7.10.14 (for IPC Gp 4.11.14)
Policy Consultation Group		7.10.14
Caryn Carr	Lead Tissue Viability Nurse Specialist	V3 7.11.16
IPC Team		V3 7.11.16
Caryn Carr	Lead Tissue Viability Nurse Specialist	V4 17.10.18
IPC Team		V4 17.10.18
Sharon Guy	Lead Clinical Educator	V4 17.10.18

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Aseptic Technique and Clean Technique Procedure

1. Introduction

The purpose of this appendix is to:

- 1.1 Provide a standardised approach to aseptic technique (AT) and clear indication where asepsis is required and when clean technique is indicated.
- 1.2 Ensure the principles of asepsis are observed during any invasive procedure that bypasses the body's natural defences i.e. skin or mucous membrane
- 1.3 Ensure compliance with The Health and Social Care Act (Dept. of Health 2015).
- 1.4 Give formal guidance to staff and their managers as to when competence has been achieved in aseptic technique (AT).

Please note that surgical aseptic technique, eg as in an operating theatre, is beyond the scope of this document.

2. Definitions

- 2.1 **Asepsis** - is recognised as the state of being free from pathogenic (harmful) microorganisms
- 2.2 **Aseptic technique (AT)** - is defined as a means of preventing or minimising the risk of introducing harmful micro-organisms onto key parts or key sites of the body when undertaking clinical procedures.

Sterile gloves are not always required for AT. Each procedure must be risk assessed.

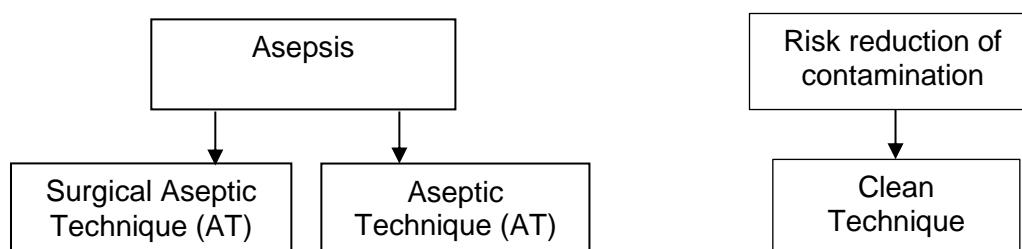
Whether sterile or non-sterile gloves are worn depends if you can avoid touching the sterile parts of equipment which will come into contact with other susceptible sites or parts e.g. their wound/cannula/catheter connection.

If the procedure is complex or the patient is particularly immuno-compromised, sterile gloves must be worn.

If however you can carry out the procedure without touching the key part with your hands, non-sterile clean gloves may be worn (See Section 6 of this Appendix 'Indications Table' as a guide).

These methods have been developed to ensure that only uncontaminated objects/fluids make contact with key parts or key sites

Aseptic technique is traditionally segregated into surgical aseptic technique and aseptic technique:



- 2.3 **Aseptic field** – an aseptic field is an area created to control the environment around the procedure and protect the key parts and key sites. Often this can be achieved by placing a sterile towel/s around the procedure site and on the surface that will hold sterile instruments and other items such as dressings.
- 2.4 **Clean technique** – is a non-touch technique. It is defined as a modified aseptic technique used for certain procedures that acknowledges the use of some non-sterile items/fluids but aims to reduce the risk of contamination by pathogenic (harmful) micro-organisms eg chronic leg ulcer care.
- 2.5 **Clean surface** – wiped surface e.g. wiped with Clinell sanitising wipe, to make free from dust and soil. Cleaning is an important action in removing dirt to help achieve asepsis.
- 2.6 **Healing by secondary intention** – refers to healing of an open wound from the base upwards but is not necessarily a cavity wound or sinus.
- 2.7 **Key site** - an area belonging to the patient where harmful organisms can enter the body and cause infection eg wounds, urinary tract, cannula insertion site.
- 2.8 **Key parts** - refers to the key sterile equipment parts. These key parts are the pieces of equipment that are manufactured sterile and would be in direct contact with the key sites of the patient or other key parts.





They have the potential to transmit harmful microorganisms if they become contaminated. Key parts must be protected from contamination.

Any key part must only come into contact with other key parts (e.g. sterile syringe tip and needle hub). Non-key parts can be gripped firmly.

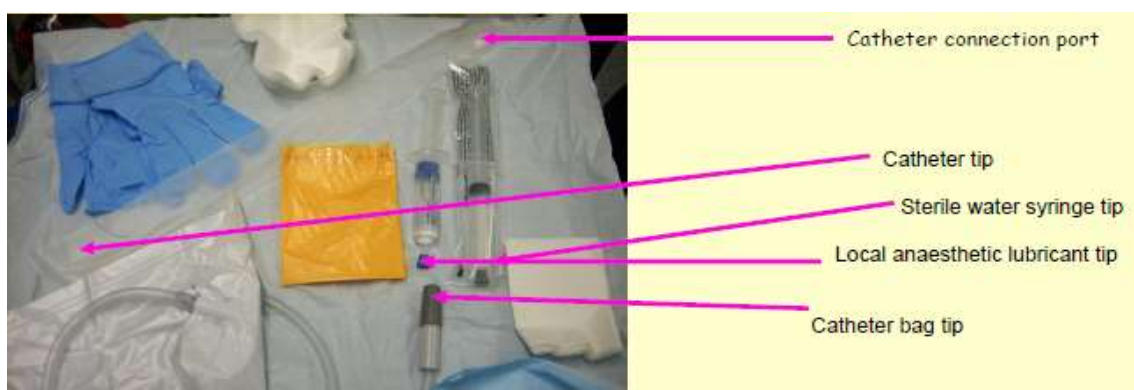
The aim is to prevent contamination of a key part by not touching it. If this is not possible the use of sterile gloves allows the staff member to touch a key part.

For examples of 'key equipment parts' relevant to intravenous therapy, urinary catheterisation and wound care please see pages 6 & 7.



Examples of 'key equipment parts' relevant to Intravenous therapy:

	<p>Syringe needle</p> <p>Syringe needle hub</p> <p>Drug itself</p> <p>Neck of vial/ampoule</p>
	<p>Syringe tip</p> <p>Drug itself</p> <p>Injectable bung</p>
	<p>Giving Set Spike</p> <p>Internal neck/connection point of intravenous fluid bag</p> <p>Infusate fluid</p>
	<p>Sterile part of the dressing in direct contact with the cannula insertion site</p>

Examples of 'key equipment parts' relevant to urinary catheterisation therapy



Examples of 'key equipment parts' relevant to wound care

	<p>Dressing in direct contact with wound</p>	
	<p>Forceps tips or gauze swabs which will be in contact with the wound</p> <p>Sterile Saline</p> <p>Sterile galipot for holding infusate</p>	

THIS IS NOT AN EXHAUSTIVE LIST of KEY PARTS

- 2.9 **Pathogenic microorganism** – a microorganism that is capable of causing harm. See 'asepsis' definition.
- 2.10 **Sterile** - free from micro-organisms. Once a sterile pack has been opened, the contents are no longer considered sterile.
- 2.11 **Surgical Aseptic technique** - Surgical Aseptic technique is a strict process and includes procedures to eliminate micro-organisms from an area. It is practiced by health care workers in operating theatres and some dedicated minor operation areas. This method aims to maintain asepsis and minimise the risk of introducing pathogens into a surgical wound ([Hart 2007](#); [Wilson 2006](#))
- 2.12 **Transient Microorganisms** – microorganisms on the surface of the skin which come and go as we touch things and move around.

**Please see table below for the relationship between
Surgical AT, AT and Clean Technique**

Asepsis			
	Surgical Aseptic technique	Aseptic Technique	Clean Technique
Aims	Aims to prevent microorganisms on hands, surfaces or equipment from being introduced to a surgical wound whilst in a theatre setting.	Aims to prevent harmful microorganisms on hands, surfaces or equipment from being introduced to a key part or site such as a new wound, catheter or central venous line.	Aims for reducing the risk of contamination by pathogenic microorganisms. The use of sterile equipment and sterile cleansing fluids is not crucial.
Gloves	Sterile only	Non- sterile clean gloves if you can do the task without touching 'key parts or key sites' Sterile gloves if you have to touch 'key parts/sites' to do the task or if the patient is immuno-compromised.	Non sterile
Non-touch technique	Yes	Yes	Yes
Dressings e.g. wound dressings	Sterile	Sterile	Sterile
Cleansing solutions	Sterile	Sterile	Non-sterile
Clean work surface	Yes	Yes	Yes
Sterile paper towel	Yes	Yes	Yes

3. Process - The Basic Principles of Aseptic Technique (AT)

3.1 Planning ahead

Prepare the area and the patient. Assemble everything that is needed in advance of the procedure ensuring you have sufficient time for the procedure and help if needed and eliminate distractions (telephone) where possible.

3.2 Hand Hygiene

Effective hand hygiene is crucial to the prevention of cross infection. Transient bacteria can be removed by effective hand hygiene techniques. This means using the World Health Organisation's 'six-step' decontamination technique that ensures all surfaces of the hands are covered.

For AT and clean procedures either soap and water or alcohol hand sanitiser may be used (see The Trusts Hand Hygiene Procedure, (Infection Prevention and Control Policy: Appendix 6) SH CP 12. Antiseptic hand hygiene products are used for Surgical Aseptic technique. As an addition to this, all clinical staff that undertakes AT must have sleeves that are short or rolled back, no wrist jewellery/watches, no false nails and no stoned rings. Cuts and grazes must be covered with a plaster.

3.3 Environment

Storage of Equipment - Sterile equipment must be stored as recommended by the manufacturer, in clean dry conditions at the correct temperature, off the floor and away from potential damage (e.g. spray from a sink) and protected from dust.

In a home environment, where safe and possible, request a clean, preferably wipeable box from the patient to store sterile equipment (See page 26 for Best Practice Statement – Principles Performing a Wound Care Dressing in Patients own home).

Cleaning – Immediately prior to the procedure, prepare the setting including decontamination of work surfaces using sanitising wipes e.g. Clinell universal sanitising wipes and allow to dry before use.

If a trolley is used, clean trolley with sanitizing wipes e.g. Clinell universal sanitising wipes before use and allow drying before use (start at the top of the trolley and work down). Trolleys used for AT should not be used for other tasks.

Airborne Contamination Control – Aseptic technique procedures in an inpatient environment should not be undertaken for at least 30 minutes after bed making or domestic cleaning. Limit through traffic and number of people in the area where an AT is being performed.

If the AT is interrupted for more than 30 minutes, new sterile packs must be opened as airborne contamination may have occurred. Close doors and windows during procedures wherever possible to minimise dust and eliminate insects. Do not use fans whilst undertaking any procedure. In the community request that pets be removed from the room.

Clinical Rooms – Clinical rooms/procedure rooms should be designed to minimise cross infection risks. New builds should conform to HTM /HBN standards. Refer to Infection Control Team for advice when planning new clinics. Surfaces within the procedure room should be free of clutter such as paper work, books. The room and areas and surfaces that may have been contaminated during a procedure should be cleaned and disinfected between patients e.g. using a Clinell Universal Sanitising wipe. This includes examination couches, dressing trolleys and examination lamps.

Sterility of Equipment - Sterile equipment/dressings used for the procedure must be checked to confirm sterility before use i.e. the pack is not past use by date, packaging is intact and not spoiled by moisture.

Sterile packs, single use tubes, sachets, ampoules, bottles of liquid must always be considered contaminated on the outside (so clean hands after touching and before putting on sterile gloves).inside sterile packs remain sterile if peeled open properly.

3.4 Maintaining an aseptic field.

- Recognize an aseptic area or field (keep clean and dirty areas separate).
- Place only sterile items within the aseptic field.
- Decontaminated items e.g. ampoule cleaned with alcoholic 2% chlorhexidine solution can be placed on the edge of the aseptic field
- If an object comes in contact with a non-sterile object or person or with dust or other airborne particles, the object is no longer sterile. If sterility is breached replace item.
- At no time should the aseptic field be contaminated
- Do not allow people to reach across the aseptic field. Avoid contamination of the aseptic field with non-sterile objects. If a sterile barrier has become wet, cut or torn, consider it contaminated and replace.
- Carry out procedure taking care to avoid contamination of aseptic fields, key parts and key sites. Do not touch key parts unless you are wearing sterile gloves.

- At all times strive for a non-touch technique.
- Dispose of clinical waste as per Trust's 'Handling and Disposal of Healthcare Waste Policy (SH NCP 47)

3.5 Personal Protective Equipment (PPE)

PPE should be worn to prevent the transfer of potentially harmful micro-organisms from patient to staff or staff to patient. For indications on what PPE is required see 'Indications' Section 6 of this Appendix. For information on how to put on sterile gloves without compromising sterility see below.





3.6 Site/skin preparation






Good skin preparation reduces the risk of infection by lowering the risk of contamination from patients own skin flora. For example 2% chlorhexidine gluconate and 70% iso-propanol alcohol wipes should be applied to skin thoroughly for 30 seconds to a minute and allowed to air-dry in order to decontaminate the skin before cannulation.






3.7 Non touch technique

Avoid touching sterile parts of equipment which will be in contact with other key parts and/or the patient's sterile or susceptible sites.

4. Applying the principles of Aseptic Technique

1) Prepare the patient	
Action	Rationale
<ul style="list-style-type: none"> • Have pets removed from the room (if present) • Request that any visitors/relatives also vacate the room for the duration of the procedure. • Ensure bed making and floor vacuuming has ceased for at least 30 minutes. • If in a communal setting ensure privacy e.g. close doors use screens 	<p>To allow dust and airborne organisms to settle before opening the sterile procedure pack.</p> <p>Maintain patients dignity and comfort</p>
2) Prepare the trolley /work surface and collect equipment	
Action	Rationale
 <p>Clean hands. Then clean trolley (or work surface if not using a trolley) with sanitizing wipes or detergent wipes working from top to bottom of trolley.</p> <p>Clean hands after cleaning.</p> <p>Collect equipment together (place on bottom shelf of trolley or other suitable work surface). Check for sterility of the procedure pack and expiry date.</p> <p>Put on a single use apron after cleaning is complete.</p>	<p>To provide a clean working surface. Avoid using waste bin lids and floor spaces in patients homes</p> <p>To remove any contamination of hands acquired during cleaning.</p> <p>To ensure equipment is all to hand so the procedure can be performed as quickly as possible and that sterility has not been breached e.g. out of date, wet torn, plus pack is in date.</p> <p>To protect uniform from contamination and to prevent the uniform becoming a source of contamination for the patient</p>
3) Clean Hands	
Action	Rationale
 <p>Clean hands with liquid soap from a dispenser or alcohol hand sanitiser rub (if hands are visibly clean)</p>	<p>To reduce cross infection risk.</p>

4) Lay out equipment and protect key parts at all times using a non-touch Technique		
Action		Rationale
	Open out the aseptic field using only the corners of the paper.	So that areas of contamination are kept to a minimum
	Check any other packs for sterility and open, tipping their contents gently onto the centre of the aseptic field, without touching any of the sterile contents. Only sterile items can be placed centrally onto the aseptic field, Non sterile- items that have been decontaminated with 2% chlorhexidine gluconate and 70% iso-propanol alcohol wipes and allowed to dry may be placed on the edge of the aseptic field.	Prevents contamination during removal from packaging An orderly aseptic field decreases chance of contaminating key-parts. Protect key-parts and decrease risk of contamination of key sites.
	Place hand in the yellow bag and arrange aseptic field contents as required or use sterile forceps to arrange items.	
	If performing wound care keep hand in sterile yellow bag and remove old dressing. (this bag can later be used as a waste bag) Alternatively non-sterile single use gloves maybe used.	
5) Secure waste bag		
Action		Rationale
	Secure the bag to the trolley side, below the aseptic field. If not using a trolley choose a nearby surface, not in contact with your aseptic field.	Stretching over the aseptic field to discard waste may contaminate the field and any sterile contents.

6) Clean Hands		
Action		Rationale
	Decontaminate hands using alcohol hand sanitiser.	To prevent contamination from hands to patient or equipment
7) Put on sterile gloves and perform the procedure		
Action		Rationale
	Put on gloves – see Section 6 to determine if sterile or non-sterile gloves are indicated.	Reduce risk of contaminating key parts or key sites with germs from hands.
	Place sterile towel from pack close to part of patient where you will be carrying out the procedure eg below wound.	Protect vulnerable sites like wounds from environmental contamination.
8) Discard Waste as per Trust Policy		
Action		Rationale
	Once procedure completed, fold up remaining non sharp items, including protective clothing and sterile towel in the dressing field and place in disposal bag.	Comply with Trust waste policy
	Seal the disposal bag and dispose of according to Trust policy.	
9) Wipe down trolley/work surface and clean hands and document the procedure		
Action		Rationale
	Clean trolley (or work surface if not using a trolley) with sanitizing wipes or detergent wipes, then clean hands with alcohol hand sanitiser.	To remove any contamination of surface/trolley acquired during the procedure.
	Clean hands with liquid soap from a dispenser or alcohol hand sanitiser (if hands are visibly clean).	To remove hand contamination from the procedure
	Document the procedure.	For communication and to meet legal requirements.

5. Principles of Clean Technique

- The principles / sequence of events for performing a clean technique are in essence the same as that for performing AT , the main difference being that the wound is allowed to be irrigated with or immersed briefly in non-sterile fluids (drinking quality tap water). A clean technique is used for dressing most wounds healing by secondary intention in a non-hospital setting or by patients dressing their own wounds caused through self-harming behaviour. Clean technique should not be used to dress significant wounds that are less than 48hours old, diabetic foot wounds, cavity wounds e.g. with sinus, visible bone or wounds of patients who are significantly immuno-compromised.

Clean technique allows:

- The use of warmed tap water (e.g. administered via a dressing pack tray, clean receptacles in the patient's own home (bath, shower, bucket of water).
- The clean technique uses a non-touch technique where practical (e.g. hands that are wearing non-sterile clean gloves should not touch sterile dressing surfaces which will be in contact with the wound bed). To ensure that the equipment used for the care carried out in a patients home is as clean as possible and convenient for transportation, this Trust recommends that all wound care is carried out using a sterile dressing pack.

Clean technique not intended for use in in-patient areas.

For more details please see Appendices:

- 7.2 Best practice statement for performing a dressing in a home environment
- 7.3 Best practice statement for performing a dressing in a clinic environment

6. Indications Table

Procedure	Aseptic/ Clean Technique	Gloves		Sterile Gown	Apron	Comment
		Sterile	Non-Sterile			
Urinary Catheter						
Bladder washout	Aseptic Technique		√		√	Sterile solutions. Please note routine bladder washouts are not advisable
Insertion urethral or suprapubic catheter	Aseptic Technique	√			√	Sterile normal saline, sterile anaesthetic lubricant (NHS Improvement 2017)
Intermittent self-catheterisation	Clean Technique		Washed hands			NB if intermittent catheterisation is performed by a healthcare worker or anyone else other than the patient or a close family member AT (sterile gloves) must be used.
Urethral catheter care	Aseptic Technique		√		√	Routine meatal hygiene as part of daily personal care –not sterile, NHS Improvement 2017
Obtain a Catheter Specimen of Urine	Aseptic Technique		√		√	Sterile syringe and container, decontaminate port with 2% chlorhexidine gluconate and 70% iso-propanol alcohol wipe
Suprapubic catheter care hospitalised patients	Aseptic Technique	√			√	Sterile normal saline, products and dressings
Suprapubic catheter care for non-hospitalised patients if the insertion took place more than 3 days ago and has sealed	Clean Technique		√		√	Non-sterile solutions e.g. tap water as part of daily personal hygiene.
Wound Care						
Community (non-inpatient setting) Dressing of any wounds by staff that are any of the following: <ul style="list-style-type: none"> • Less than 48 hours old • Contain a cavity • Belong to an immuno-compromised patient • Diabetic foot ulcer 	Aseptic Technique	√			√	Sterile products, solutions and dressings
Community (non-inpatient setting) Dressing of wounds by staff that: <ul style="list-style-type: none"> • Are more than 48 hours old (no cavity present, patient not immuno-compromised, 	Clean Technique		√		√	Sterile dressings Non sterile solutions e.g. tap water,

Procedure	Aseptic/ Clean Technique	Gloves		Sterile Gown	Apron	Comment
		Sterile	Non-Sterile			
no diabetic ulcer)						
Hospital in-patient setting – wounds dressed by staff (including self-harm)	Aseptic Technique	√			√	Sterile products, solutions and dressings
Any cavity wounds all settings	Aseptic Technique	√			√	Sterile products, solutions and dressings
Dressing any wound for an immuno-compromised patient - all settings	Aseptic Technique	√			√	Sterile products, solutions and dressings
Superficial trauma wounds e.g. grit in grazes in MIU	Clean Technique		√		√	
Self-harm wounds (48hours old) dressed by patient themselves any setting	Clean Technique		NA		NA	Non sterile unless deep wounds.
Central Venous Access Device (CVAD)						
CVAD insertion	Surgical Aseptic Technique	√		√		In theatre unless life threatening emergency, use Chloraprep wand, sterile pack, sterile drapes, sterile gown
CVAD care including dressing changes, intravenous additives, parental nutrition	Aseptic Technique	√			√	Sterile solutions, dressings and products only. Decontaminate bungs for injection using sterile 2% alcoholic chlorhexidine wipes.
Peripheral Cannula						
Peripheral cannula insertion	Aseptic Technique		√		Recomm- ended	Sterile products, dressings and solutions -2% alcoholic chlorhexidine skin clean
Peripheral cannula care and medicine administration	Aseptic Technique		√			Sterile products, dressings and solutions -2% alcoholic chlorhexidine to clean bungs
Phlebotomy						
Phlebotomy on patients/patients in an in-patient setting (except Mental Health areas)	Aseptic Technique		√		Consider apron	Disinfect skin with 2% alcoholic chlorhexidine
Phlebotomy in community or outpatient setting	Aseptic Technique		√		Consider apron	Clean skin (warm water and soap) if visibly soiled before procedure.
Blood culture collection	Aseptic Technique		√		√	Sterile products, solutions -2% alcoholic chlorhexidine to clean skin and culture bottle infection ports with 2% alcoholic chlorhexidine (Saving Lives 2011)
Enteral Feeding						
Insertion of nasogastric tube (NG)	Clean Technique		√		√	
Care of NG tube	Clean Technique		√		√	
Insertion of a percutaneous endoscopic	Surgical Aseptic	√		√		Sterile solutions, products and dressings

Procedure	Aseptic/ Clean Technique	Gloves		Sterile Gown	Apron	Comment
		Sterile	Non-Sterile			
gastrostomy/jejunostomy (PEG) (PEJ)	Technique					NB No insertion to take place in mental health settings.
Care of PEG / PEJ site if insertion site (less than 3 days old) Saving Lives 2011	Aseptic Technique	√			√	Sterile solutions, products and dressings for insertion site
Care of PEG/PEJ site if insertion site more than 3 days old)	Clean Technique		√		√	Non-sterile solution as part of routine daily personal hygiene, dressing only required if site discharges or if patient prefers.(Saving Lives 2011)
Feeding through enteral tubes (PEG/PEJ) -in hospital setting -if immuno-compromised or -if being fed into the jejunum	Aseptic Technique	√			√	Sterile water for flushing (Saving Lives 2011)
Feeding through enteral tubes in other patients not listed above	Clean Technique		√		√	Tap water (freshly drawn or boiled water) for flushes
Other						
Changing of tracheostomy tube	Aseptic Technique		√		√	Sterile products, solutions and dressings. Initial insertion must be in theatre using Sterile Surgical Aseptic technique unless life threatening emergency.
Tracheostomy care in-patient setting e.g. dressing changes, endotracheal suctioning	Aseptic Technique		√		√	Include face protection when suctioning.
Tracheostomy care in home setting e.g. dressing changes, endotracheal suctioning	Clean Technique (AT if site <72hours old)		√		√	Include face protection when suctioning.
Laryngeal or Oropharyngeal Suctioning	Clean Technique		√		√	Include face protection when suctioning if contact with body fluid aerosols likely
Removal of drains e.g. wound, chest	Aseptic Technique		√		√	No solutions required. Provide sterile dressing if covering needed.
Vaginal examination	Clean Technique		√		√	No solutions required
Insertion of intrauterine device	Aseptic Technique	√		√		Sterile products
Removal of sutures	Aseptic Technique		√		√	Solutions if used must be sterile. If wound dehisced use AT with sterile gloves

7. Training Requirements

- 7.1 Staff will complete required AT 'e learning' and 'e assessment' via the Management, Learning and Education System prior to clinical skills training. Face to face training will be required if the e assessment cannot be passed after 2 attempts.
- 7.2 Staff must be competent (level 3) before performing AT unsupervised. Please see page 21 for competency levels
- 7.3 Staff are made aware of AT procedures as part of clinical skills education eg urinary catheterisation
- 7.4 Following attendance at a clinical skills training session, competency can be achieved following assessment by a practitioner who has achieved competency level 4 or above
- 7.5 Competency must be completed and documented within a 6 month time frame of the training.
- 7.6 The Infection Prevention and Control Team (IPCT) will work with the Area/Modern Matrons, Community Matrons, Clinical Directors, Clinical Leads, Locality Managers and Infection Control Champions and Links to improve adherence to Infection Control policy and appendices.
- 7.7 **LEaD (Leadership, Education & Development Training Needs Analysis)**

See table below

Training Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
AT e learning and e- assessment programme	Once as part of a competency assessment or as required	2-3 hours	e-learning	Delegate	Management, Learning and Education System	Strategic: DIPC Operational: Line Manager
Directorate	Division	Target Audience				
MH/LD	Adult Mental Health	All staff who carry out aseptic technique				
	Learning Disabilities	All staff who carry out aseptic technique				
	Older Persons Mental Health	All staff who carry out aseptic technique				
	Specialised Services	All staff who carry out aseptic technique				
	TQtwentyone	All staff who carry out aseptic technique				
ICS	Adults	All staff who carry out aseptic technique				
	Childrens & Wellbeing	All staff who carry out aseptic technique				
	Dental	All staff who carry out aseptic technique				
Corporate Services	All (HR, Finance, Governance, Estates etc.)	Not applicable				

8. Supporting References

Department of Health (2015) The Health and Social Care Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infections. London: DH.

Hart S (2007) **Using an aseptic technique to reduce the risk of infection.** *Nursing Standard* 21(47): 43-48.

Wilson J (2006) **Infection control in clinical practice.** Edinburgh, Elsevier

Saving Lives (Jan 2011) [click here](#)

NHS Improvement (May 2017) High Impact Interventions Care Processes to Intervention

Appendix 7.1: Aseptic Technique Clinical Competency

	Level of achievement	Level
Novice	Cannot perform this activity satisfactorily to the level required in order to participate in the clinical environment	0
↓	Can perform this activity but not without constant supervision and assistance	1
	Can perform this activity with a basic understanding of theory and practice principles, but requires some supervision and assistance	2
Competent Practitioner	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision	3
↓	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice At this level competence will have been maintained for at least 6 months and/or is used frequently (2-3 times /week) The practitioner will demonstrate confidence and proficiency and show fluency and dexterity in practice This is the minimum level required to be able to assess practitioners as competent	4
	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. At this level the practitioner will be able to adapt knowledge and skill to special/ novel situations where there may be increased levels of complexity and/or risk	5
Expert	Can perform this activity with understanding of theory and practice principles without assistance and/or direct supervision, at an appropriate pace and adhering to evidence based practice. Demonstrate initiative and adaptability to special problem situations, and can lead others in performing this activity At this level the practitioner is able to co-ordinate, lead and assess others who are assessing competence. Ideally they will have a teaching and /or mentor qualification	6

Adapted from: Herman GD, Kenyon RJ (1987) Competency-Based Vocational Education. A Case Study, Shaftsbury, FEU, Blackmore Press, cited in Fearon, M. (1998) Assessment and measurement of competence in practice, *Nursing Standard* 12(22), pp43-47.

Appendix 7.1: Aseptic Technique Clinical Competency

Name:	Role:
Base:	Date of Clinical Skills Training :
Date e assessment passed:	Signature :

Competency Statement:

The participant demonstrates clinical knowledge and skill in the use of aseptic technique without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Practitioner who can demonstrate competence at level 4 or above

Performance Criteria	Assessment Method	Level achieved	Date	Assessor
The Participant will be able to:				
1. Demonstrate practical knowledge in the use of aseptic technique				
a) Define the terms: <ul style="list-style-type: none"> • Surgical Aseptic Technique • Clean technique • Aseptic technique • Key part • Key site • Aseptic field 	Questioning			
b) Describe the general principles of AT	Questioning			
c) Describe the principles of Clean Technique.	Questioning			
d) Describe the factors which affect your choice of gloves for AT (ie sterile , non-sterile)	Questioning			
e) Identify the appropriate technique for commonly performed procedures eg: <ul style="list-style-type: none"> • Enteral feed • Indwelling urinary catheter insertion • Intermittent catheterisation • Peripheral IV device insertion • Administration of IV medication • Phlebotomy • Laryngeal suction via tracheostomy • Wound Care 				
f) Describe how sterile equipment is best stored and how to tell if sterility of equipment has been breached.	Questioning			

Appendix 7.1: Aseptic Technique Clinical Competency

Performance Criteria	Assessment Method	Level achieved	Date	Assessor
2. Demonstrate practical skill to perform an AT procedure	Direct Observation			
a) Inform patient about the procedure and seek verbal consent	Direct observation			
b) Demonstrate appropriate selection of PPE for the task	Direct observation			
c) Demonstrate appropriate selection and preparation of dressings/ devices for the task	Direct observation			
d) Demonstrate preparation of the environment	Direct observation			
e) Demonstrate correct hand hygiene technique (as per Trust Hand Hygiene Appendix)	Direct observation			
f) Demonstrate ability to undertake non touch technique	Direct observation			
g) Demonstrate ability to carry out clean technique	Direct observation			
h) Demonstrate correct method for disposal of waste	Direct observation			
i) Make clear, accurate and contemporaneous records of any actions and omissions.	Direct observation			

Date all elements of Competency Tool completed to level 3 _____

I confirm that I have attended initial training on _____ and that I am confident and competent in aseptic technique

Practitioner _____ Signature _____ Status _____ Date _____

I confirm that I have assessed the above named Practitioner and can verify that he/she demonstrates competency in aseptic technique.

Assessor _____ Signature _____ Status _____ Date _____

Copy of assessment received by Line Manger Signature _____ Date _____

Appendix 7.1: Aseptic Technique Clinical Competency (with suggested answers)

Name:	Role:
Base:	Date of Clinical Skills Training :
Date e assessment passed:	Signature

Competency Statement:

The participant demonstrates clinical knowledge and skill in the use of aseptic technique without assistance and/or direct supervision (level 3 - see level descriptors). Assessment in practice must be by a Practitioner who can demonstrate competence at level 4 or above.

Performance Criteria	
The Participant will be able to:	
1. Demonstrate practical knowledge in the use of aseptic technique	
a) Define the terms:	<p>Surgical Aseptic technique - Surgical Aseptic technique is a strict process and includes procedures to eliminate micro-organisms from an area eg health care workers working operating theatres</p> <p>Clean Technique - Aims for reducing the risk of contamination by pathogenic micro-organisms. The use of sterile equipment and cleansing fluids is not crucial</p> <p>Aseptic Technique - Aims to prevent harmful microorganisms on hands, surfaces or equipment from being introduced to a key part or site such as a new wound, catheter or central venous line</p> <p>Key Part - are the pieces of equipment that are manufactured sterile and come into direct contact with the patient, which have the potential to transmit infection if they become contaminated.</p> <p>Key Site – an area belonging to the patient where harmful organisms can enter the body and cause infection eg wounds, urinary tract, cannula insertion site.</p> <p>Aseptic Field - an area that is created by placing a sterile towel around the procedure site and on the surface that will hold sterile instruments and other items such as dressings.</p>
<ul style="list-style-type: none"> • Surgical Aseptic technique • Clean technique • Aseptic Technique (AT) • Key Part • Key site • Aseptic field 	
b) Describe the general principles of AT	<ul style="list-style-type: none"> • Planning ahead • Hand hygiene • Protection from infection from the environment (storage of sterile equipment, limiting airborne contamination) • Maintaining an aseptic field • Personal protective equipment • Site/skin prep • Do not touch key parts unless with sterile gloves • Key sites • Key parts • Sterile fluids
c) Describe the principles of Clean Technique.	<p>The principles / sequence of events for performing a clean technique are in essence the same as that for performing an aseptic technique, the difference being the choice of gloves worn and the equipment selected for use. With clean technique sterile equipment is not always used.</p> <p>Clean technique allows:</p> <ul style="list-style-type: none"> • The use of warmed tap water (e.g. administered via a dressing pack tray, clean receptacles in the patient's own home(bath, shower,

Appendix 7.1: Aseptic Technique Clinical Competency (with suggested answers)

Performance Criteria		
	bucket of water). <ul style="list-style-type: none"> • Non -sterile examination gloves (latex free). • Multi-pack secondary absorbent dressings (such as dry un-sterile gauze) for suitable dressings in the community. • Multi-use containers of creams and ointments. These should still be for named individual patients and be handled in a manner that prevents the microbial contamination of the unused part and stored to prevent entry of dust. • If a bucket is used to soak / clean a leg wound for example this must be stored clean and dry. Line buckets with a disposable liner and washed with detergent and water then dry after each use. • Sterile packs and equipment can be used in conjunction with a clean technique if they are convenient and cost effective 	
d) Describe the factors which affect your choice of gloves during AT (ie sterile, non-sterile)	Non- sterile gloves if you can perform the procedure using AT without touching key parts, sterile gloves if you can't.	
e) Identify the appropriate technique for commonly performed procedures eg: <ul style="list-style-type: none"> • Enteral feed • Indwelling urinary catheter insertion • Changing a suprapubic catheter • Peripheral IV device insertion • Administration of IV medication • Venepuncture • Laryngeal suction via tracheostomy • Wound Care 	Enteral feeding (PEG)	Home- clean non sterile gloves and aprons, tap water Hospital- AT , non sterile gloves and apron, sterile water for flushing (Saving Lives 2011)
	Enteral feeding (PEJ)	AT , non sterile gloves and apron, sterile water for flushing (Saving Lives 2011)
	Indwelling urethral catheter insertion	AT- Sterile normal saline, sterile anaesthetic lubricant, sterile gloves, disposable apron.
	Replacing a suprapubic catheter	Home- AT sterile and disposable apron, sterile saline to clean and sterile dressings Hospital – AT sterile and disposable apron, sterile saline to clean and sterile dressings
	Peripheral IV device insertion	AT , non sterile gloves, disposable apron ,skin prep chlorhexidine and alcohol
	Phlebotomy	Home - AT – non sterile gloves, no skin prep if visibly clean Hospital- AT- non sterile gloves, skin prep with chlorhexidine and alcohol
	Laryngeal suction via tracheostomy	In patient- AT non sterile gloves, apron (consider eye protection) Non in patient –Clean technique providing tracheotomy site is more than 48hours old. Non sterile gloves apron (consider eye protection)
	Wound Care	In-patient –AT Non inpatient – Clean technique if wound is older than 48hours old (unless the wound is a cavity or the patient is immuno-compromised.)
f) Describe how sterile equipment is best stored and how to tell if sterility of	Store sterile packs away from moisture, damage, dust and off the floor. In a home environment, where safe and possible, request a clean, preferably wipeable box from the patient to store sterile equipment.	

Appendix 7.1: Aseptic Technique Clinical Competency (with suggested answers)

Performance Criteria	
equipment has been breached.	Sterility check- check the pack is not past use by date, packaging is intact and not spoiled by moisture.
2. Demonstrate practical skill to perform an standard AT procedure	Direct Observation
a) Inform patient about the procedure and seek verbal consent	Direct observation
b) Demonstrate appropriate selection of PPE for the task	Direct observation
c) Demonstrate appropriate selection and preparation of dressings/ devices for the task	Direct observation
d) Demonstrate preparation of the environment	Direct observation
e) Demonstrate correct hand hygiene technique (as per Trust Hand Hygiene Appendix)	Direct observation
f) Demonstrate ability to carry non touch technique	Direct observation
g) Demonstrate ability to carry out clean procedure	Direct observation
h) Demonstrate correct method for disposal of waste	Direct observation
i) Make clear, accurate and contemporaneous records of any actions taken	Direct observation

Date all elements of Competency Tool completed to level 3 _____

I confirm that I have attended initial training on _____ and that I am confident and competent in aseptic technique

Practitioner _____ Signature _____ Status _____ Date _____

I confirm that I have assessed the above named Practitioner and can verify that he/she demonstrates competency in aseptic technique.

Assessor _____ Signature _____ Status _____ Date _____

Copy of assessment received by Line Manger Signature _____ Date _____

Appendix 7.2: Best practice statement for performing a dressing in a home environment

Best Practice Statement - Principles for Performing a Wound Care Dressing in Patients Own Home

Aseptic (sterile) Technique

Aim- to prevent or minimise the risk of introducing harmful micro-organisms onto key parts or key sites of the body when under taking clinical procedures.

Indications for Aseptic Technique

- Any wound that has been created in the last 48 hours or less
- Any wound connecting to a deep body cavity
- If you have identified that the patient is severely immunocompromised e.g. neutropenic
- If a diabetic foot ulcer

Clean Technique

Aim – It is defined as a modified aseptic technique used for certain procedures that acknowledges the use of some non-sterile items/fluids but aims to reduce the risk of contamination by pathogenic (harmful) microorganisms e.g. chronic leg ulcer care

Indications Clean Technique – Any wound care dressing in the home if

- The wound has not been created surgically and is more than 48hours old
- The wound does not connect to a deep body cavity
- The patient is not neutropenic
- The wound is not a diabetic foot ulcer

Appendix 7.2: Best practice statement for performing a dressing in a home environment Infection Prevention Principles of Clean Technique (Wound Care)

1) Storage of Equipment

If more than one visit planned you may need to store equipment within the home. To store equipment free from dust, moisture and soil, ask for the patient to provide a box with a lid (preferably one that can be wiped clean as required with a Clinell Sanitising Wipe). Dressing tape should not be shared between patients, instead leave a roll of tape in the dressing storage bag/box of each patient.

Please make sure you only enter the dressing storage bag/box/cupboard with clean un-gloved hands.

2) Dressing packs

The Trust recommends that you use a procedure pack for each dressing as this provides: a disposable apron, disposable gloves, waste bag and sterile field in a clean manner. Sterile gloves are not essential for clean technique but using a pack system ensures products are easy to store and are transported hygienically. These are available on FP10. Two dressing packs will be required for each significant wound dressing (i.e. wound size greater than 10 cm diameter)




3) Protective Clothing

A plastic disposable apron must be worn to protect your uniform from microbial contamination and skin scales.

Single use gloves are required for body fluid contact as part of standard precautions. Eye protection is only required if splashing of body fluid/blood to the eye is likely.

4) Hands should be washed and single use non-sterile gloves and aprons donned before commencing removal of any existing dressing. Once dressings have been removed and any leg washing /soaking has been completed it is imperative that the single use non-sterile gloves are removed and hands are washed before a fresh pair of disposable sterile gloves are put on ready to perform the dressing itself. If the wound is larger than 10 cm in diameter, the apron should be changed at the same time as the sterile gloves are applied, ready to perform the dressing itself. Alternatively the sterile waste bag from the dressing pack may be used to remove soiled dressings.

Appendix 7.2: Best practice statement for performing a dressing in a home environment

 Clean hands	
1a) Taking down old dressing	Put on non-sterile gloves (from small bagged supply stored in patients dressing bag/box at home) and apron from dressing pack.
1b) leg washing	As for 1a)
 Remove used gloves (and apron if wound greater than 10cm diameter) and clean hands	
2) Re- dressing the wound	Wear sterile gloves and apron
 Remove used gloves and apron and clean hands	

In order to ensure gloves and aprons are stored hygienically, it is recommended that these items are obtained from dressing packs rather than being carried separately by the staff member in home settings. However a small supply of non-sterile gloves can be decanted and stored in a clean plastic bag in the patients dressing box/bag in the home. Do not carry supplies of non-sterile gloves in your pockets.

Appendix 7.2: Best practice statement for performing a dressing in a home environment

4) Working from a clean surface

Identify an area to perform the dressing within the home, which is free from obvious soiling, place a sterile towel from your dressing pack place under the area you are performing the dressing. A Clinell sanitising wipe may be used to clean surfaces prior to dressing procedures if concerned. If you are likely to perform a dressing on a patient with a heavily exudating wound or patient is neutropenic, consider extra protection e.g. MedMat®.

5) Scissors

Re-usable scissors (e.g. FFQ5255 bandage scissors in NHS catalogue) can be left in the patient's home and used for all procedures on the same patient except for: a) Cutting a sterile primary dressing b) Dressing a wound which requires aseptic technique.

If performing a) or b) use single-use sterile scissors. Pre manufactured key hole dressings for drains, supra -pubic catheters are available in the NHS catalogue. Single-use scissors must only be used once. Dispose of single-use scissors directly into a sharps bin.

Single patient use re-usable scissors should be wiped with a Clinell sanitising wipe after each dressing and if they become visibly soiled. Store the scissors in the patient's equipment box if safe to do so.

If using re-useable scissors to cut tubular bandage from a communal roll of bandage, please allocate a pair of scissors for cutting bandages, which does not come into contact with the patient.

6) Hand Hygiene

Ask the patient or their carers to provide liquid soap and disposable paper towels for your visit. Carry your own supply of alcohol hand rub with you into the home (or leave a bottle in the patient's equipment box if safe to do so) to supplement facilities in the home. Clinell Sanitising wipes can be used for hand hygiene

Minimum hand cleaning standard = decontaminate:

- Before removing any existing dressing AND
- Before redressing the wound itself AND
- After finishing the dressing/removing gloves and aprons

Appendix 7.2: Best practice statement for performing a dressing in a home environment

Use tap water for irrigation of wounds if clean technique is indicated. If wound soaking is indicated, wounds may be submersed for short periods (a few minutes) in drinking quality tap water, held in a lined reusable plastic bucket/bowl (dedicated for this purpose and kept in the home) or in a clean single use papier-maché bowl.

If using a reusable bucket/ bowl please ensure the liners are single use and changed for each leg wash (even if the wounds are going to be dressed together at the same time). Mix hot and cold tap water to achieve correct water temperature.

After each leg wash, discard any liner and discharge bucket/bowl water down the toilet (whilst wearing eye protection). Wipe bucket/bowl with a Clinell wipe if it is to be re-used.


Only sterile items (except the tap water itself) should come in contact with the wound. Please use:

- sterile gauze (e.g. from the dressing pack) for any wiping of the wound when in the bucket of water
- sterile gauze or sterile towel for drying the wound and wound margins (clean linen towel, blue roll towelling is acceptable for drying the rest of the leg but should not be used on the wound directly)

If concerned about the quality of the tap water or if (eg discoloured) use sterile saline for irrigation.

NB Do not soak wounds in buckets of water in a in-patient setting as this can easily contaminate the environment in this communal setting of vulnerable patients. Use sterile saline only (and aseptic technique) when dressing; a wound that has been created in the last 48 hours or less, any wound connecting to a deep body cavity, any diabetic foot ulcer and if you have identified that the patient is severely immunocompromised e.g. neutropenic.

8) Dressings/ and creams

Only use sterile primary dressings for clean technique and apply them using a non-touch technique. Do not save any dressings bearing the single use logo  in opened packages for future use. Avoid sharing creams of emollients between patients. If using multi-dose single patient topical agents e.g. medical honey NEVER bring the tube near the wound. Instead decant the agent into a syringe or onto a sterile dressing/gauze/corner or your sterile field. If using an emollient pump dispenser, ensure that you operate it with your elbow, or decant a small amount of emollient into a container before commencing the dressing, to avoid contaminating the pump with your soiled hands. Please note a single sterile probe may be used to both probe and pack the same wound providing it only has contact with the wound or the sterile field.

Appendix 7.3: Best practice statement for performing a dressing in a wound clinic environment

Best Practice Statement - Principles for Performing a Wound Care Dressing in a Wound Clinic

To be read in conjunction with 'Standard for a Generic Treatment Room'

Aseptic (sterile) Technique

Aim- to prevent or minimise the risk of introducing harmful micro-organisms onto key parts or key sites of the body when under taking clinical procedures.

Indications for Aseptic Technique

- Any wound that has been created in the last 48 hours or less
- Any wound connecting to a deep body cavity
- If you have identified that the patient is severely immunocompromised eg neutropenic
- If a diabetic foot ulcer

Clean Technique

Aim – It is defined as a modified aseptic technique used for certain procedures that acknowledges the use of some non-sterile items/fluids but aims to reduce the risk of contamination by pathogenic (harmful) microorganisms eg chronic leg ulcer care

Indications Clean Technique – Any wound care dressing in the home if

- The wound has not been created surgically and is more than 48hours old
- The wound does not connect to a deep body cavity
- The patient is not neutropenic
- The wound is not a diabetic foot ulcer

Appendix 7.3: Best practice statement for performing a dressing in a wound clinic environment Infection Prevention Principles of Clean Technique (Wound Care Clinic)

1) Storage of Equipment

Sterile equipment must be stored as recommended by the manufacturer, in clean dry conditions at the correct temperature, off the floor and away from potential damage (e.g. spray from a sink, open windows) and protected from dust, moisture and soil. Please make sure you always remove protective clothing and clean hands before entering dressing supply storage areas.

2) Dressing packs

The Trust recommends that you use a procedure pack for each dressing as this provides: a disposable apron, disposable gloves, waste bag and sterile field in a clean manner. Sterile gloves are not essential for clean technique but using a pack system ensures products are easy to store and transport in a hygienic manner. These are available on FP10. . Two dressing packs will be required for each significant wound dressing (ie wound size greater than 10 cm diameter)




3) Protective Clothing

A plastic disposable apron must be worn to protect your uniform from microbial contamination and skin scales.

Single use gloves are required for body fluid contact as part of standard precautions. Eye protection is only required if splashing of body fluid to the eye is likely.

Hands should be washed and single use non-sterile gloves and aprons donned before commencing removal of any existing dressing. Once dressings have been removed and any leg washing /soaking has been completed it is imperative that the single use non-sterile gloves are removed and hands are washed before a fresh pair of disposable sterile gloves are put on ready to perform the dressing itself. If the wound is larger than 10 cm in diameter, the apron should be changed at the same time as sterile gloves are applied, ready to perform the dressing itself.

Appendix 7.3: Best practice statement for performing a dressing in a wound clinic environment

 Clean hands and put on non-sterile gloves and apron	
1) Taking down old dressing and leg washing	Non sterile gloves and apron
 Remove used gloves (and apron if wound greater than 10cm diameter) and clean hands	
2) Re- dressing the wound	Sterile gloves and apron
 Remove used gloves and apron and clean hands	

4) Working from a clean surface

A Clinell sanitising wipes must be used to clean surfaces eg dressing trolley prior to dressing procedures. If you are likely to perform a dressing on a patient with a heavily exudating wound or patient is neutropenic, consider extra protection eg MedMat®.

Perform the dressing in an area which is free from obvious soiling/dust/open windows and place a sterile towel from your dressing pack place under affected limb for dressing. If the affected limb is not in contact with any horizontal surface but is hanging down it is acceptable to use clean disposable blue roll on the floor to rest the patient's feet on, providing the disposable blue towel is not in contact with any wound.

Couch and seating for examining patients must be easy to clean (fluid impermeable material, no splits or tears). Fresh blue disposable roll should be placed on the couch for each patient. At the start and end of each clinic, wipe the couch with Clinell Sanitising Wipes (JT118 for pack of 200). Also wipe if visibly soiled or used by a known infected patient. Do not use linen on the couch unless it is disposed of/ changed between each patient.

Appendix 7.3: Best practice statement for performing a dressing in a wound clinic environment

Dignity blanket - provide a single use disposable dignity blanket or machine launder reusable linen after each patient.

Pillows – All pillows should be covered to make them impermeable to fluids. Wipe pillow with Clinell sanitising wipe at the start and end of each clinic and if visibly soiled. Disposable pillow cases or re-usable linen cases may be used if disposed of/ changed between each patient.

Computer And Keyboard Used in the Treatment Area - a wipeable key cover or be a wipeable keyboard should be used. The keyboard should tolerate wiping with a Clinell sanitising wipe at the beginning and end of each clinic and if obviously soiled.

BP cuffs – Wipe with a Clinell sanitising wipe after each use and protect from body fluid contact.

Privacy screens - must be wipeable with a Clinell sanitising wipe or detergent and hot water. Non-wipeable screens must be able to be laundered in a washing machine. Wipe/laundry screens if visibly soiled, if used for patients with a known infection and at least 6 monthly*

5) Scissors

Only single use scissors should be made available in a clinic environment and discarded after each use into a sharps bin.

A re-useable scissor (eg FFQ5255 bandage scissors in NHS catalogue) can be repeatedly used for the cutting of bandages from communal supply rolls e.g. tubigrip providing this scissor is not used for patient care.

6) Hand Hygiene

Hands must be cleaned throughout the procedure with either alcohol hand sanitiser (if hands are visibly clean) or soap and water. Dry hands using disposable paper towels. NB Clean hands after changing protective clothing

Minimum hand cleaning standard = decontaminate:

- before removing any existing dressing
- before redressing the wound itself
- and on finishing the dressing.

Use tap water for irrigation of wounds if clean technique is indicated. If wound soaking is indicated, wounds may be submersed for short periods (a few minutes) in drinking quality tap water, held in a lined reusable plastic bucket/bowl (dedicated for this purpose) or in a clean single use papier-maché bowl.

Appendix 7.3: Best practice statement for performing a dressing in a wound clinic environment

If using a reusable bucket/ bowl please ensure the liners are single use and changed for each leg wash (even if the wounds are going to be dressed together at the same time). Mix hot and cold tap water to achieve correct water temperature.

Do not fill the bucket directly from a hand washing sink or kitchen sink - If no other clean water source is available fill the bucket in these areas using a clean jug filled from the kitchen tap/hand washing sink). After use, discard the bucket fluid into a **sluice type outlet** (ie not hand wash sink). A sluice type outlet includes a slop hopper, toilet in a non-inpatient area or cleaners sink. If a toilet is in use it must be cleaned with a Clinell sanitising wipe after each bucket emptying. Staff should wear disposable gloves, aprons and face protection when decanting body fluids, followed by hand washing. The lid should be closed when flushing the toilet to reduce aerosol spread. If more than one toilet available in the clinic then limit the discarding of fluid to one toilet and keep it out of action for the duration of the clinic.

Only sterile items (except the tap water itself) should come in contact with the wound. Please use:


- sterile gauze (eg from the dressing pack) for any wiping of the wound when in the bucket of water
- sterile gauze or sterile towel for drying the wound and wound margins (clean linen towel, blue roll towelling is acceptable for drying the rest of the leg but should not be used on the wound directly)

After each leg wash, discard any liner and discharge bucket/bowl water down the dirty outlet (whilst wearing eye protection). Wipe bucket/bowl with a Clinell wipe if it is to be re-used.

If concerned about the quality of the tap water or if (eg discoloured) use sterile saline for irrigation.

Use sterile saline only (and aseptic technique) when dressing; a surgical wound that has been created in the last 48 hours or less, any wound connecting to a deep body cavity, any diabetic foot ulcer and if you have identified that the patient is severely immunocompromised eg neutropenic

8) Dressings/ and creams

Only use sterile primary dressings for clean technique and apply them using a non-touch technique. Do not save any dressings bearing the single use logo  in opened packages for future use. If using multi-dose single patient topical agents eg medical honey NEVER bring the tube near the wound. Instead decant the agent into a syringe or onto a sterile dressing/gauze/corner or your sterile field. If using a emollient pump dispenser, ensure that you operate it with your elbow, or decant a small amount of emollient into a galipot before commencing the dressing, to avoid contaminating the pump with your soiled hands. Please note a single sterile probe may be used to both probe and pack the same wound providing it only has contact with the wound or the sterile field.

Appendix 7.4: Generic treatment room standard

Infection Prevention and Control requirements for a generic clinic involving invasive procedures eg wound care, podiatry clinics and clinics involving urinalysis

NB Non-invasive /minimal invasive clinics (eg speech therapy, counselling, consultation, MSK, occasional phlebotomy or BP monitoring) are not required to conform to these minimum standards other than the requirement for a hand washing sink as outlined below.

Element	Minimum Standards for an Generic Clinic Involving Invasive Procedures - Existing Site
Hand wash sink	<p>Clinical Hand Wash Sink (HBN 00-10) (HBN 00-9 IPC In Built Environment) Clinical wash-hand basins should be installed in all clinical areas and be :</p> <ul style="list-style-type: none"> • Dedicated for hand washing only (not instrument decontamination or body fluid discharge) • Plug should not be used to allow for hand washing under running water • Integral back outlet the sink surround e.g. grout/splashback must be intact and easy to clean • Situated near patient/patient i.e. in the room if invasive procedures performed or in adjacent room. • Hand washing sinks must be supplied with liquid soap from a clean dispenser, disposable paper towels and a black bag waste bin. Alcohol rub must be available for staff in the clinic room (but not at sink). • Sinks ideally should be operated by lever action (e.g. elbow) or sensor taps (with single self-draining spout). If elbow taps are not available disposable towels can be used to switch of the taps. • A clinical hand wash sink must be accessible and should not be sited behind curtain rails • TMV3-approved thermostatic mixing valve (either fitted directly to tap or integral within it, in accordance with Health Technical Memorandum 04-01); <p>Visitor/patient hand wash sink</p> <ul style="list-style-type: none"> • Must be present in the toilet areas • As above except hand drying may be by air drier or disposable paper towels (not fabric towel)
Flooring	<ul style="list-style-type: none"> • No carpet in any area where clinical procedures are performed or where there is a risk of body fluid spillage -HFN30, HBN 00-9 (IPC In Built Environment) • The floor must be easily cleaned (a wooden floor is acceptable if sealed) • Place an incontinence pad on the floor if the wound is exudating heavily
Furniture and horizontal work surfaces	<ul style="list-style-type: none"> • All surfaces and furniture including chairs should be smooth (no deep chips and scratches), easy to clean. Surfaces that can be contaminated with body fluid must be able to tolerate chlorine releasing solution (10,000ppm of av.chlorine). • Work surfaces must be free from extraneous items and clutter

Appendix 7.4: Generic treatment room standard

Element	Minimum Standards for an Generic Clinic Involving Invasive Procedures - Existing Site
Waste	<p>Sharps Boxes - Boxes for the disposal of scalpels, needles or any other sharps should comply with BS 7320 and UN3291. The sharps box lid colour code is: Purple – for sharps contaminated with cytotoxic or cytostatic drugs Orange- sharps waste not contaminated with any drugs/chemicals Yellow- sharps waste contaminated with any drugs/chemicals</p> <p>Waste bags-</p> <p>Black – for non hazardous waste Orange- infectious waste with no chemical contamination include all blood soiled waste Yellow- infectious waste with chemical contamination Tiger stripe waste – offensive waste but not known to be infection risk</p> <p>The waste generated in the clinic is the responsibility of SHFT staff. In the absence of waste storage and collection from the clinic site arrangements must be made to transport the waste back to a SHFT waste storage and collection point eg base health centre or make arrangements with an approved contractor. If staff agree to transport waste in their own vehicles they must do so in an UN approved containers (i.e. rigid, leak proof, sealed, secured). NB The sharps box itself is a UN approved container for transportation. Suitable containers include 'Biobin' single use orange boxes.. If no tiger stripe waste bag available, use orange bag waste stream Label sharps bins/ waste bags so that the source of the waste can be identified eg tag, tape, or post code marked on box</p>
Decontamination	<p>As per Trust Decontamination policy.</p> <p>Couch and seating for examining patients must be easy to clean (fluid impermeable material, no splits or tears). Fresh blue disposable roll should be placed on the couch for each patient. At the start and end of each clinic, wipe the couch with Clinell Sanitizing Wipes (JT118 for pack of 200). Also wipe if visibly soiled or used by a known infected patient. It must also tolerate disinfectants to decontaminate blood stained fluids.</p> <p>Dignity blanket -provide a single use disposable dignity blanket or machine launder reusable linen after each patient.</p> <p>Pillows – All pillows must be covered to make them impermeable to fluids. Wipe pillow with Clinell sanitising wipe at the start and end of each clinic and if visibly soiled. Disposable pillow cases rather than linen cases should be used if a pillow case is required.</p> <p>Computer And Keyboard Used In The Treatment Area- a wipeable key cover or be a wipeable keyboard should be used. The keyboard should tolerate wiping with a Clinell sanitizing wipe at the beginning and end of each clinic and if obviously soiled.</p> <p>BP cuffs – Wipe with a Clinell sanitizing wipe after each use and protect from body fluid contact.</p> <p>Buckets - must be lined with a single use disposable liner (e.g. single use waste bag) before filling with water, to prevent contamination of the bucket itself. Do not fill the bucket directly from a hand washing sink or kitchen sink. If no other clean water source is available fill the bucket in these areas using a clean jug filled from the kitchen tap/hand washing sink).After use, discard the bucket fluid into a sluice type out let (ie not hand wash sink). A sluice type outlet includes a slop hopper, toilet in a non inpatient area or cleaners sink. If a toilet has to be used it must</p>

Appendix 7.4: Generic treatment room standard

Element	Minimum Standards for an Generic Clinic Involving Invasive Procedures - Existing Site
	<p>be cleaned with a Clinell sanitising wipe after each bucket emptying. Staff should wear disposable gloves, aprons and face protection when decanting body fluids, followed by hand washing. The lid should be closed when flushing the toilet to reduce aerosol spread. If more than one toilet available in the clinic then limit the discarding of fluid to one toilet and keep it out of action for the duration of the clinic. To clean out the bucket with a Clinell sanitising wipe, store bucket dry.</p> <p>Privacy screens - must be wipeable with a Clinell sanitizing wipe or detergent and hot water. Non-wipeable screens must be able to be laundered in a washing machine. Wipe/laundry screens if visibly soiled, if used for patients with a known infection and at least 6 monthly*</p>
Storage	<ul style="list-style-type: none"> • Store clean supplies in a clean, dust protected area (e.g. box, covered trolley or cupboard). • Clean supplies and used supplies must be stored and transported in separate containers. • Clean and dirty areas should be kept separate and the workflow patterns of each area should be clearly defined. • The design and finish of ancillary areas should facilitate good cleaning. • They should have facilities for hand-hygiene and sufficient storage for supplies and equipment. IPC Built Environment 2013 HBN 09 00
Cleaning of Environment <small>National Standards of Cleanliness in the NHS 2007*</small>	<p>Clinics must have a cleaning schedule in place to keep them clean and dust controlled:</p> <p>Daily: Floors, chairs, tables, hand wash containers, waste receptacles, toys, toilets, sinks, examination couch, low surfaces, treatment area – may need additional cleaning if clinics run ‘back to back’</p> <p>Weekly: door handles, switches, internal glazing, high surfaces</p> <p>Monthly: walls and ceilings (dust), radiators, ventilation grilles</p> <p>6 monthly: external glazing, curtains/blinds</p> <p>Yearly: Walls and ceiling (wash)</p> <p>All spills and body fluid contamination must be cleaned immediately with a 1% chlorine releasing solution eg Sanichlor, Milton.</p>

Standards for New Build of Generic Clinic Involving Invasive Procedures

All new builds must comply with national guidelines (currently HNB 11-01).

- Non-invasive/minimal invasive procedures (injections and taking blood) – must comply with standard for examination room
- Invasive (breaks skin surface, biopsy, removal of warts, endoscopy, leg ulcer clinic) must comply with standard for a treatment room including mechanical ventilation

Appendix 7.4: Generic treatment room standard

Element	Standard required
Clinical hand wash sink	<ul style="list-style-type: none"> • Dedicated for hand washing only (not instrument decontamination or body fluid discharge) • Clinical sinks should not have a plug or a recess capable of taking a plug (NHS Estates’ HBN 4 and HBN 00-10). • No overflow outlet NHS Estates’ HBN 4 and HTM 00 10 • Taps should not be aligned so as to run directly into the drain aperture. HBN 00-10 HTM 00 02 • Fitted with non-touch taps (if lever tap used –the fixed height of lever tap on the basin is 1095mm- must have space to move freely).HBN00-03 • The dimensions of a clinical sink must be large enough to contain splashes and therefore enable the correct hand-wash technique to be performed .The project of the sink from back panel or wall should be a 350-500mm projection HBN 00-10 • Use a TMV3 approved thermostatic mixing valve as per HTM 04-01 • The sides of the sink should be curved to prevent splashing. • Integrated back outlet HBN00-03 • Connect to concealed services HBN00-03 • Situated near patient/patient in the room where the clinical procedures are performed. It must be accessible and should not be sited behind curtain rails. • Supplied with liquid soap from a clean dispenser, disposable paper towels and a black bag waste bin. • Should be sealed to a waterproof splashback HBN 00-10 HTM 00 02 • The sink surrounds must be intact and easy to clean.
Flooring	<ul style="list-style-type: none"> • Flooring should be seamless and smooth, non slip, easily cleaned and appropriately wear resistant.* • There should be covering between the floor and wall to prevent accumulation of dust and dirt in the corners /crevices* • Any joints should be welded or sealed where they are unavoidable.* • Wood, unsealed joints and tiles should be avoided as they can become reservoirs for infection.* • Skirting should be seamless with the flooring* • Flooring should be made of a material not physically affected by detergents and disinfectants likely to be used <p>* IC in the built environment HBN00-09</p>
Furniture and horizontal work surfaces	<p>Work Surfaces*</p> <ul style="list-style-type: none"> • All surfaces should be impervious and designed for easy cleaning (free from clutter). • All surfaces near plumbing fixtures should be smooth, non-porous and water resistant • All surfaces should be free of fissures, open joints and crevices that will retain or permit the passage of dark particles • All joints with adjoining walls or fixed equipment such as sinks should be sealed






Appendix 7.4: Generic treatment room standard

	<ul style="list-style-type: none"> All surfaces should withstand the effects of regular cleaning with both detergent and disinfectant products eg 1% chlorine solution. <p>Soft Furnishings*</p> <ul style="list-style-type: none"> Are seem free or heat sealed where ever possible Can be easily cleaned Will not be physically affected by detergents, disinfectants or steam cleaning Will dry quickly
Waste	As per “Existing Site” Standards.
Decontamination	As per “Existing Site” Standards
Storage	As per “Existing Site” Standards If clinic regularly held in a setting consider a storage cupboard with adequate space to store all clean supplies, off the ground, dust protected and dry.
Cleaning of Environment	As per “Existing Site” Standards

Appendix 7.5: Skin preparation

Skin prep = disinfect skin with single- use Clinell skin wipe (blue box) which contains 2% Chlorhexidine & 70% Isopropyl Alcohol Order code VJT 169



Procedure	Skin prep required	
	Non -inpatient setting (e.g. own home)	In-patient setting
Peripheral cannulation	 Yes	 Yes
Sub-cutaneous syringe drivers	 Yes	 Yes
Phlebotomy	No Clean the skin if visibly dirty with soap and water. No other skin prep advised.	 Yes
Intra-muscular injections	No Clean the skin if visibly dirty with soap and water. No other skin prep advised.	No Clean the skin if visibly dirty with soap and water. No other skin prep advised
Sub-cutaneous injections	No Clean the skin if visibly dirty with soap and water. No other skin prep advised	No Clean the skin if visibly dirty with soap and water. No other skin prep advised
Blood sugar monitoring	No Clean the skin if visibly dirty with soap and water. No other skin prep advised	No Clean the skin if visibly dirty with soap and water. No other skin prep advised