

Assisting with Minor Surgical Procedures



— B E L M A T T —
HEALTHCARE TRAINING

Infection Control & Prevention

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Session Aims and Objectives

AIM

The overall aim of this course is to develop your knowledge and skills to assist with minor surgical or invasive medical procedures

Objectives

- Understand roles & legal responsibilities when assisting registered health care practitioners with minor procedures
- Develop awareness of some of the legal, ethical and professional issues relating to chaperones and one's own role and responsibilities when undertaking chaperoning including:
 - principles of consent,
 - how to raise concerns
 - record keeping
- Develop knowledge of relevant infection control procedures including hand washing and ANTT

Accountability & Delegation

- Consent
- Vicarious Liability
- Duty of Care
- Accountability

HCA Care Certificate

- The Care Certificate was developed jointly by **Skills for Care, Health Education England and Skills for Health.**
- Consists of 15 minimum standards for staff new to the care sector
- Following the Francis report (2013) and the Cavendish review (2013), the Care Certificate was developed for use within all health and social care settings for both new starters at induction, and current HCSW's ***who have not completed an Apprenticeship or NVQ equivalent.***
- Standards contained in the Care Certificate will be used as Competency assessments

The principles of accountability and delegation are relevant to all members of the nursing team. Whether you're a nurse, health care assistant (HCA), assistant practitioner (AP), nursing associate (NA) or student (RCN,2015)

Accountability & Delegation

- Health service providers (Eg Hospitals. GP practices) are accountable to the criminal and civil courts to make sure their activities meet legal requirements.
- In addition, employees are accountable to their employer to follow their contract of duty.
 - Registered practitioners are also accountable to regulatory bodies in terms of standards of practice and patient care, eg NMC, GMC , HCPC
- The law imposes a duty of care on practitioners, whether they are HCAs, APs, nursing associates, students, registered nurses, doctors or others. The duty of care applies whether they are performing straightforward activities such as bathing patients or undertaking complex surgery.
- All practitioners must ensure that they perform competently and that they don't work beyond their level of competence. They must inform a senior member of staff when they are unable to perform competently.

Accountability & Delegation

- To be accountable, practitioners must:
 - Have the ability to perform the activity or intervention
 - accept responsibility for doing the activity
 - have the authority to perform the activity, through delegation and the policies and protocols of the organisation.
- Employers accept vicarious liability for their employees. They are accountable for the actions and omissions of the employee. It is vital that employers make sure employees only work within the limits of their competence.
(CQC ,2021)

Professional responsibility

Never carry out a procedure that you have not been trained to do, signed as competent to do or do not feel confident to do.

Are there any exclusions to performing the skills on specific patients group?
Check the local policy!

Has consent been obtained ?

Registered and non-registered staff have responsibilities to act lawfully

RECORD KEEPING

(RCN., 2019)

If it wasn't written down, it wasn't carried out

- Always work within your local polices but RCN has some useful guidance
- Principles of record keeping are the same regardless of whatever format records are kept

Key principles

- Records should be completed at the time or as soon as possible after the event.
- All records must be signed, timed and dated if handwritten. If digital, they must be traceable to the person who provided the care that is being documented.
- Ensure that you are up to date in the use of electronic systems in your place of work, including security, confidentiality and appropriate usage.
- Records must be completed accurately and without any falsification and provide information about the care given as well as arrangements for future and ongoing care.
- Jargon and speculation should be avoided.
- When possible, the person in your care should be involved in the record keeping and should be able to understand what the records say.
- Records should be readable when photocopied or scanned.
- In the rare case of needing to alter a record, the original entry must remain visible (draw a single line through the record) and the new entry must be signed, timed and dated.
- Records must be stored securely and should only be destroyed following your local policy.

Countersigning

- Record keeping can be delegated to health care assistants (HCAs), assistant practitioners (APs), trainee nursing associates (TNAs), nursing associates (NAs), nursing apprentices and nursing students so that they can document their care.
- As with any delegated activity, the nurse needs to ensure that the HCA, AP, TNA, NA, nursing apprentice or student is competent to undertake the activity and that it is in the patient's best interests for record keeping to be delegated.
- Supervision and a countersignature are required until the HCA, AP, TNA, NA, nursing apprentice or student is deemed competent at keeping records.
- Registered nurses should only countersign if they have witnessed the activity or can validate that it took place.

Always follow your local policy.



Any
Questions





— B E L M A T T —
HEALTHCARE TRAINING

Chaperoning & Consent

Learning outcomes

Understand some of the legal ,
ethical & professional issues
relating to chaperones

Understand what when &
why chaperones are needed

Understand own roles &
responsibility in undertaking
the role of Chaperone

What does
CHAPERONING
mean ?



CGC Definition

An impartial observer present during an intimate examination of a patient



Sheffield theatre nurse admits sexual offences against staff and patients

08 FEBRUARY 2022 | BY GEMMA MITCHELL

A theatre nurse has pleaded guilty to a string of sexual offences, many of which were against staff and patients at the hospital where he worked in Sheffield. Paul Neil Grayson, 51, appeared at Sheffield Magistrates' Court on 4 February where he admitted 17 charges....



Feb 2022

Dr Myles Bradbury-haematologist Cambridge: pleaded guilty in 2014 to 25 offences against 18 boys aged 10 to 16, including sexual assault, voyeurism and possessing more than 16,000 indecent images.



Dr Ayling convicted in 2000 for sexual assault on female patients during intimate examinations

He usually carried out intimate examinations without a chaperone

GP Dr Manesh Shah gets three life sentences for 90 sex offences against patients (2020 sentenced)



News > UK News

ABUSE CLAIMS NHS hospital doctor arrested for 'sexual assault' on a child patient as police 'identify eight more potential victims'

Feb 2022 !

Ayling enquiry: Key findings

Lack of common understanding of the purpose and use of chaperones across the NHS

Recognised that chaperones were used in various settings and circumstances with differing levels of risk to patients and health care professionals

Ayling enquiry recommendations

- Trained chaperones should be available to all patients having intimate examinations
 - Untrained administrative staff or family or friends of the patients should not be expected to act as chaperones
- The presence of a chaperone must be the patient's choice and they must be able to decline a chaperone if they wish
- All NHS Trusts need to set out a clear chaperone policy and should ensure that patients are aware of it and that it is adequately funded. The report recognised that for primary care a policy will have to take into account issues such as one to one consultations in patients' homes and the capacity of practices to meet the requirements of an agreed policy

Where is your practices' chaperone policy ?

CQC Recommendations

- *All staff should have an understanding of the role of the chaperone, Staff should understand the procedures for raising concerns.*
- *Staff who will undertake a formal chaperone rile must have been rained so they develop the competencies required.*
 - *Expectations of chaperones as listed in GMC Guidance*
 - *Guidance of what the training should include*

Expectations of chaperone

- Be sensitive and respect the patient's dignity and confidentiality
- Reassure that patient if they show signs of distress or discomfort
- Be familiar with the procedures involved in a routine intimate examination
- Stay for the whole examination and be able to see what the doctor is doing , if practical
- Be prepared to raise concerns if they are concerned about the doctors behaviour or actions

Training should include:

- What it is meant by the term chaperone
- What is an 'intimate examination'
- Why chaperones need to be present
- The rights of the patients
- Their role & responsibilities. It is important chaperones should place themselves inside the screened-off area rather than outside of the curtains/screens
- Policy and mechanism for raising concerns

Who can be a chaperone ?

Can a family member /friend be a chaperone ?

Does a chaperone have to be a registered health care professionals ?

Does children and adolescents need a chaperone ?

Who can be a chaperone ?

- Ideally member of the clinical team
- Ayling report did state that chaperones do not have to be health professionals but they do need to have some training
 - Eg use of non trained admin staff is not acceptable
- Able to fulfil the expectations of a chaperone
- DBS cleared
- GMC recommends that family members/friends are not suitable chaperones and they are NOT impartial observers
 - Can breach confidentiality and cause embarrassment
- But GMC recommends compliance with patients (reasonable) request if they would like to have family member/friend present in addition to chaperone
- However, in sexual health clinics, family/friends should NOT be used as chaperones due to risk of coercion &/or confidentiality

Children & Young People (CYP)

- CYP's should also be provided with a chaperone
 - Family/friends are not an impartial chaperone
- If a young person refuses chaperone and has capacity to make that decision: needs to be respected (if clinician is comfortable) and documented

Chaperones are there to protect both staff and patients

True or False

Chaperone not needed for female doctor undertaking vaginal examination ?

For intimate examinations

When to use a chaperone ?

When a procedure is embarrassing or distressing for the patient

Chaperone not needed for male doctor examination undertaking PR examination on another man ?

When to use chaperones

For intimate examinations such as examination of:

- Breasts, genitalia, and rectum

GP saw a teenage girl with suspected glandular fever. Without explaining what he was doing, he moved close and began to feel her lymph nodes in armpits. The patient complained the GP had touched her breasts

For some patients it could be any situation where it is necessary to touch them or be very close to the patient

Ophthalmologist needed to do fundoscopy- turned off the light and moved close to the patient- the patient thought he was going to kiss her and complained

When to use chaperone

- There have been cases where doctors have been accused of inappropriate behaviour by patients of own sex

A female GP received a complaint from a female patient who said the GP had put an arm around her and touched her inappropriately while checking her breasts for lumps

The GP had believed a chaperone was not necessary and had not offered one

Declining chaperones

- Many patients find having a 3rd party presents intrusive and embarrassing
- Patients have the right to decline a chaperone and no pressure should be put on patient to accept one
- The offer and the refusal must be documented in the patients notes
- **BUT** clinicians also have the right to protect themselves
 - If clinician does not want to proceed without a chaperone, the reason why you want one present should be explained to the patient
 - Can then change their mind
 - Be referred to another clinician as long as this does not adversely affect the patient's health

Prior to procedure

GMC advise that clinicians should:

- Explain to the patient why an examination is necessary and what it will involve
- Give patient opportunity to ask questions
- Obtain consent and record this in notes
- Introduce by name and job title the chaperone and explain role
- **DO NOT** assist the patient with undressing unless they have asked you to do so or you have checked if they need help
 - The use of a sheet or drape is always advisable during intimate examinations. Some GU Medicine departments use a 'skirt' drape to good effect for this aspect.

CONSENT

Obtaining patients permission to proceed

Implied or expressed consent

- Expressed consent is where you have been given specific permission to do something
- Can be verbal or written
 - Verbal consent should be documented in the patients notes
 - Harder to verify later
- Implied consent is where consent from the service user is not expressly spoken or written but can be taken as understood,
 - EG giving their arm for blood pressure reading

Valid consent

- Voluntary – the decision to either consent or not to consent to treatment must be made by the person, and must not be influenced by pressure from medical staff, friends or family
- informed – the person must be given all of the information about what the treatment involves, including the benefits and risks, whether there are reasonable alternative treatments, and what will happen if treatment does not go ahead
- capacity – the person must be capable of giving consent, which means they understand the information given to them and can use it to make an informed decision

Children/Adolescent consent

Do all parents have parental responsibility ?

NO

Throughout the United Kingdom, a ***mother*** automatically acquires parental responsibility at birth.

Parental responsibility by ***a father*** varies according to where and when the child's birth was registered

For births registered in England, Wales or Northern Ireland:
A father acquires parental responsibility if he is married to the mother at the time of the child's birth or subsequently.

An unmarried father will acquire parental responsibility if he is recorded on the child's birth certificate (at registration or upon re-registration) from 1 December 2003 in England or Wales and from 15 April 2002 in Northern Ireland

Can other people have parental responsibility?

Unmarried father can acquire parental responsibility by way of a court registered parental responsibility agreement with the mother or

by obtaining a parental responsibility order or a residence order from the courts.

Married stepparents and registered civil partners can acquire parental responsibility in the same ways.

Parental responsibility awarded by a court can only be removed by a court

Children and Young people can expect:

- to be kept as fully informed as they wish, and as is possible, about their care and treatment
- health professionals to act as their advocates
- to have their views and wishes sought and taken into account as part of promoting their welfare in the widest sense
- to be the individual who consents to treatment when they are competent to do so
- to be encouraged to take decisions in collaboration with other family members, especially parents, if this is feasible
- to be able to expect that information provided will remain confidential unless there are exceptional reasons that require confidentiality to be breached.

Competent under the age of 16 ?

For a young person under the age of 16 to be competent, s/he should have:

- The ability to understand that there is a choice and that choices have consequences
- The ability to weight the information and arrive at a decision
- A willingness to make a choice (Including the choice that someone else should make the decision)
- An understanding of the nature and purpose of the proposed intervention
- An understanding of the proposed intervention's risks and side effects
- Freedom from undue pressure

If a competent young person can consent to treatment, does it also follow that s/he can refuse treatment?

NO....not always

In England, Wales and Northern Ireland, a competent refusal can be overruled by a court or by a person with parental responsibility.

Health professionals faced with an informed refusal of a treatment they believe to be beneficial should take legal advice – for example a refusal of lifesaving treatment or treatment that would prevent permanent injury

https://www.bma.org.uk/-/media/Files/PDFs/Practical%20advice%20at%20work/Ethics/Children%20and%20young%20people%20toolkit/childrenyoungpeopletoolkit_full.pdf

Gillick/Fraser competence

- ❑ When consenting children to medical treatment, the terms ‘Gillick competence’ and ‘Fraser guidelines’ are frequently used interchangeably despite there being a clear distinction between them.
- ❑ Gillick competence is concerned with determining a child’s capacity to consent.
- ❑ Fraser guidelines, on the other hand, are used specifically to decide if a child can consent to contraceptive or sexual health advice and treatment.
- ❑ By confusing them, we lose crucial details necessary for obtaining consent.

During Procedure

- Ensure the patient is informed of what is being done
- Ensure their privacy is maintained as much as possible, eg blankets, screens etc
- Make sure you are positioned where you can observe the patient and what the clinician is doing if practical
- Be prepared to raise concerns if you are concerned about the clinicians behaviour or action
- Ensure the examination/procedure stops if the patients asks
- BE very careful about making any personal comments as patient more likely to misunderstand when/if feeling embarrassed /vulnerable

After the procedure

- Ensure any queries or concerns are addressed
- All examination details must be documented including:
 - Consent
 - Name and job title of chaperone present
- Any other information given

A GP was accused of making inappropriate comments while examining a young female patient. The complaint was made several months later and the doctor could not remember who had acted as a chaperone , although he was sure he would not have conducted an intimate examination without one as the practice had a strict policy in chaperone use

As there was no record of chaperones name or position, the complaint was upheld

Any questions





— B E L M A T T —
HEALTHCARE TRAINING

Infection Prevention & Control

What is a
Healthcare Associated Infection
(HCAs)?

What is a Healthcare Associated Infection (HCAs)?

WHO definition

"HCAs, also referred to as "nosocomial" or "hospital" infection, is an infection occurring in a patient during the process of care in a hospital or other health care facility which was not present or incubating at the time of admission"

NICE definition

"Infection that develops either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting"

Why is Infection Prevention so Important?

- NICE has estimated that 300,000 patients a year in England acquire a HCAI as a result of care within the NHS
- Over 6% of hospital patients in England acquire some form of infection
- Cost to NHS around £1 billion per year
- Estimated £56 million after discharge from hospital
- HCAs prolong a patient's period of ill health and cause pain and suffering which is not measurable
- It is everyone's responsibility to monitor and prevent HCAs

Who is
most at
risk?



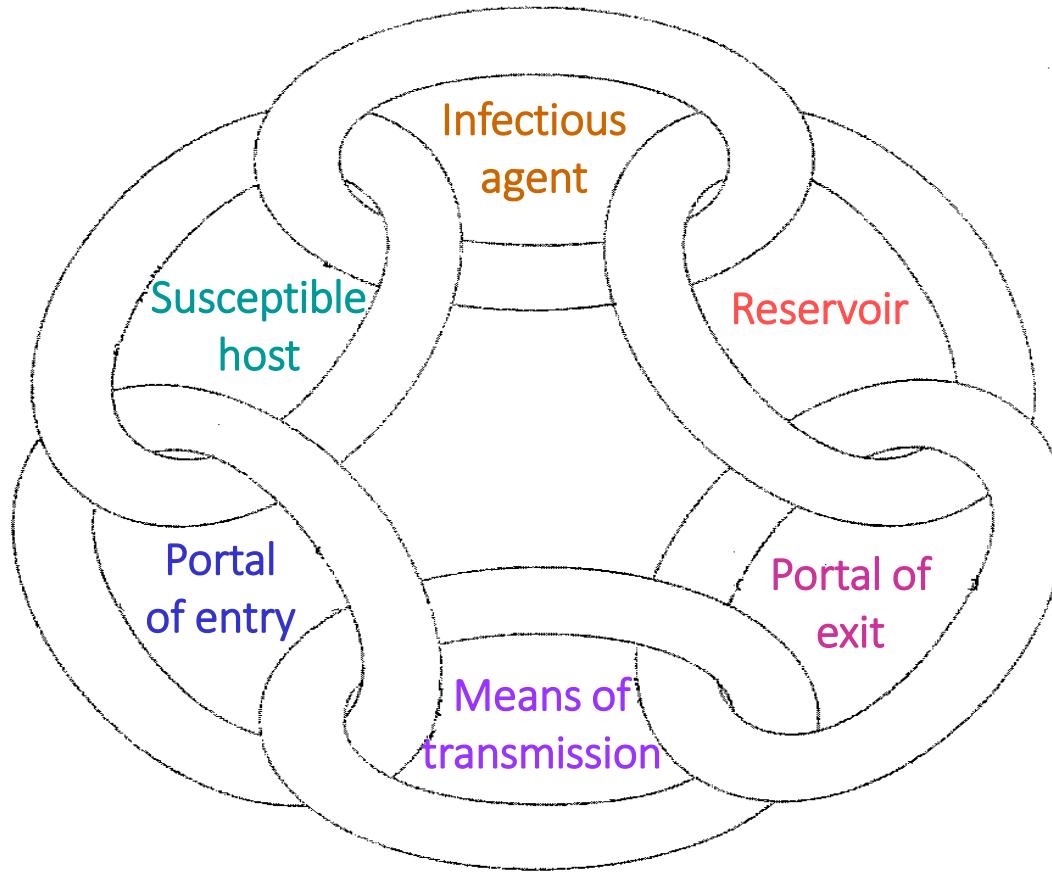
Who's most at risk?

There are numerous factors that increase the risk of individuals acquiring an infection or increase the risk of a reoccurrence.

What factors increase the risk of individuals acquiring an infection?

- Age – very young esp premature babies, sick children and elderly
- Compromised immune system – e.g. from some medications like chemo or steroids
- Medical conditions – e.g. diabetes
- Inappropriate antibiotic use
- Poor infection prevention practice or standards

What is the chain of infection?



Transmission of infection depends on 6 elements which link together like a chain

Reservoirs/ Exit /Entry

- Where micro-organisms reside and multiply
- Without reservoirs infectious agents could not survive and be transmitted
- Site of exit provides a way for a micro-organism to leave a reservoir
- Portal/site of entry is the site through which the micro-organism enters its new host and causes infection

What are some sources of reservoirs ?

List some entry points for infection.

List some exit points for infection



Reservoirs

- Where micro-organisms reside and multiply
- Without reservoirs infectious agents could not survive and be transmitted
- Site of exit provides a way for a micro-organism to leave a reservoir
- E.g. any orifice (nose, mouth etc.) via any bodily substance



Portals of Exit

- **Secretions**
 - substance necessary for the body is secreted by organs and glands inside the body, eg hormones , saliva
- **Excretions**
 - excretion mainly deals with the elimination of wastes like sweat and urea, that are of no use to the body.



Means of Transmission

Direct Contact

- Hands
- Mother to baby



Indirect Contact

- Food and water – ingestion
- Air-bourne e.g. coughing, sneezing
- Sharps – blood-borne viruses e.g. hep B, C, HIV
- Dirty equipment – i.e. touched by an infected person
- Vector-borne – i.e. bite from mosquito or ticks e.g. Lyme's disease a bacterial infection spread to humans by infected ticks



Portals of Entry

Portal/site of entry is the site through which the micro-organism enters its new host and causes infection



Medical devices



Breaks in the skin



Ingestion



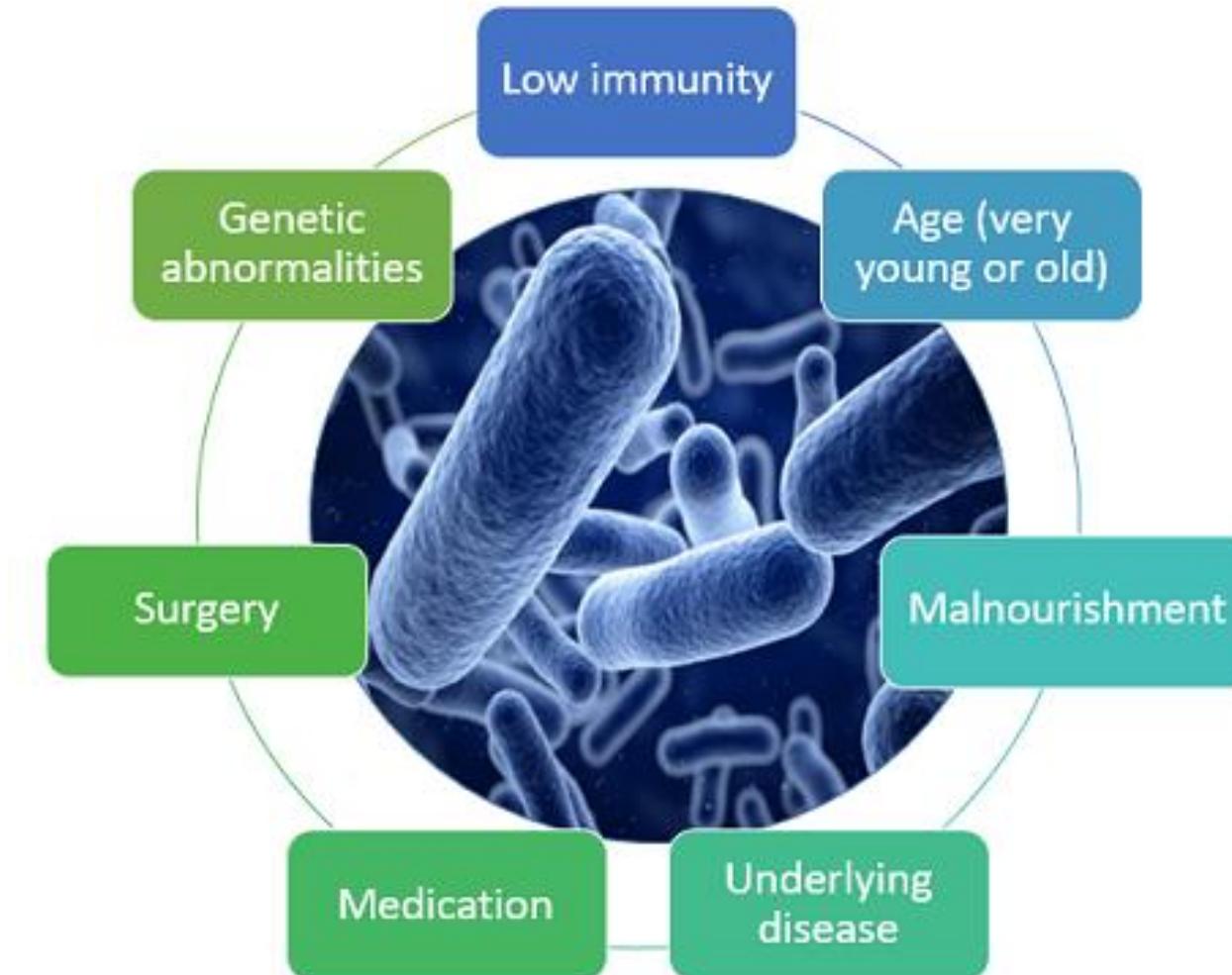
Inhalation



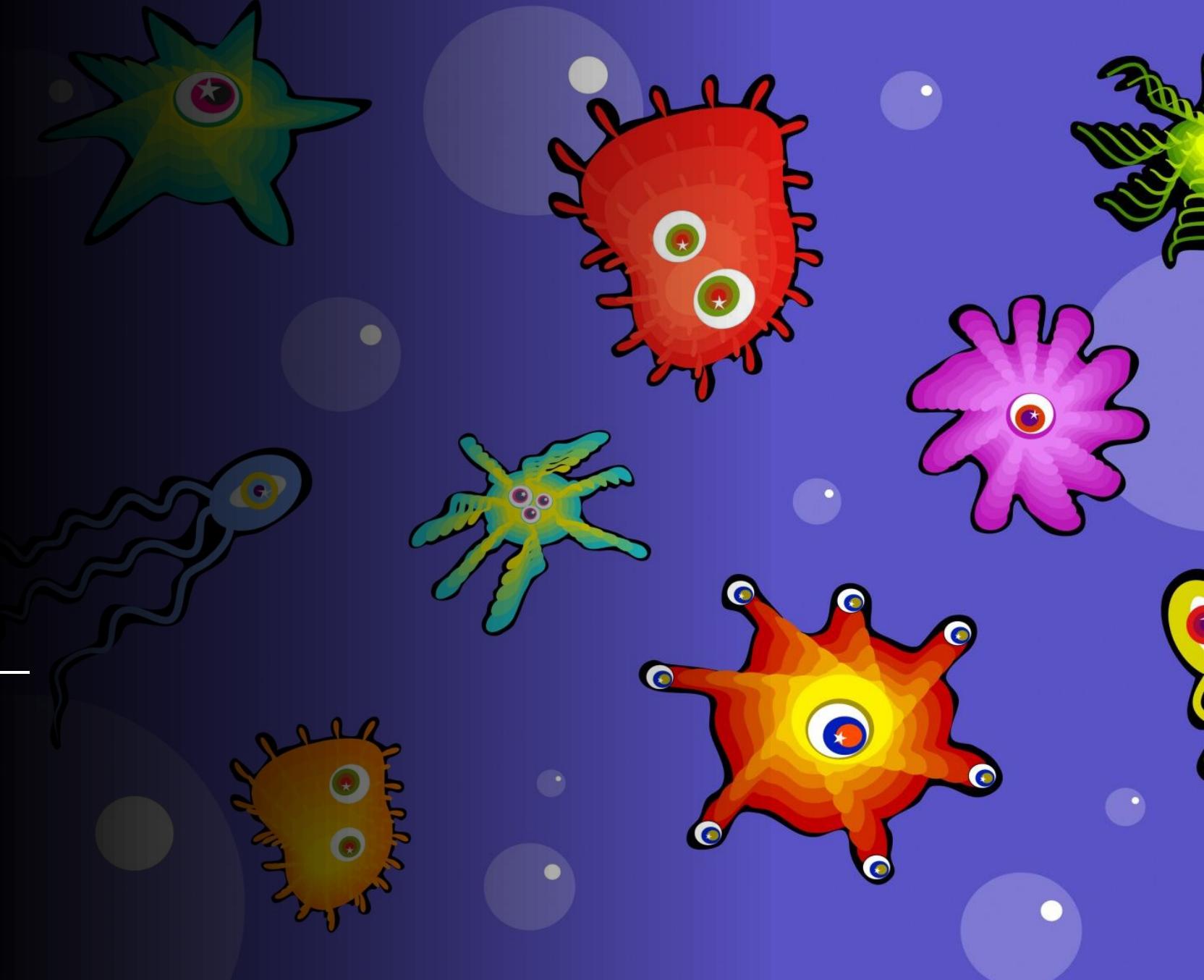
Sexual contact

Susceptible Host

Some individuals have poor physical resistance and are more susceptible to infection due to -



List some
microorganisms
that causes
diseases



What causes disease?

Bacteria

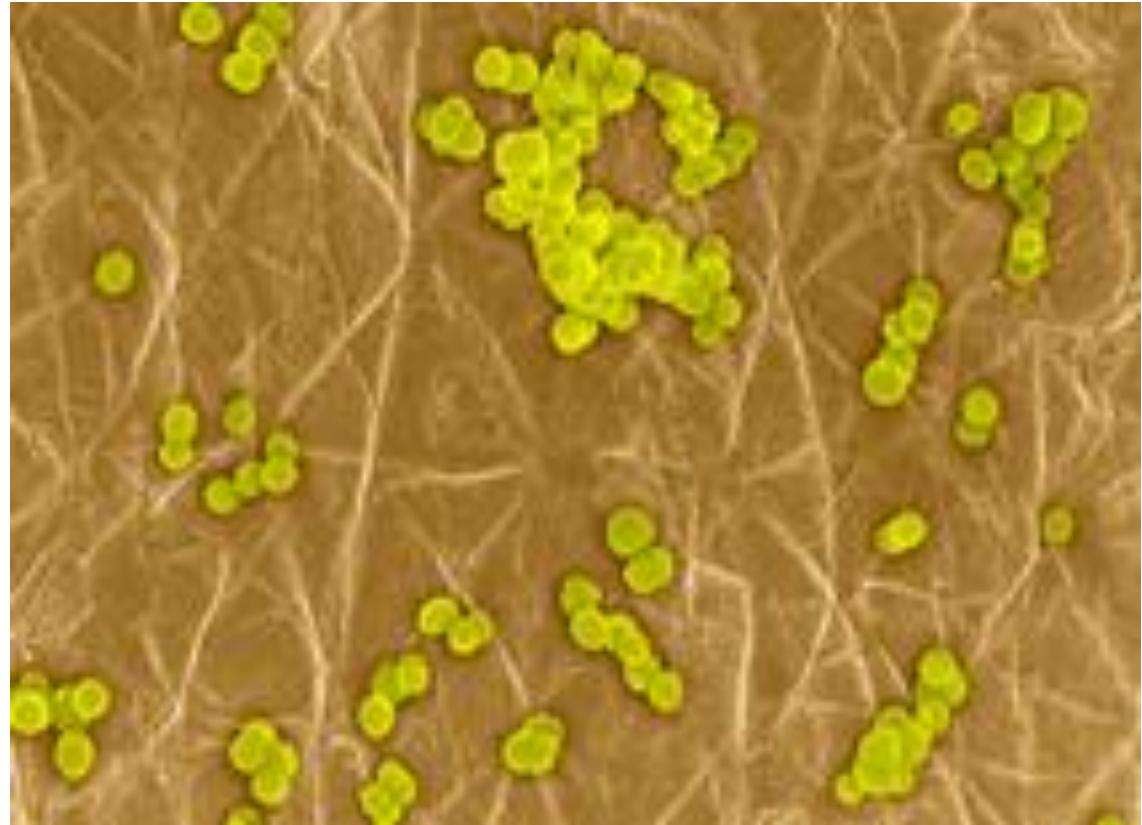
Bacteria which are microscopic single-celled organisms

Can live within soil, in the ocean and inside the human gut

Relationship with humans is complex

Good bacteria e.g. live within our gut and help with digestion or used to curdle milk to make yogurt

Bad bacteria which is destructive causing diseases like pneumonia, urine infections, wound infections



What causes disease?

Viruses

Viruses are very tiny agents

Made of genetic material inside a protein coating

Viruses cause common infectious diseases e.g. common cold flu, warts

Also cause severe illnesses e.g. HIV/AIDS, hep B, Ebola, COVID-19

Like hijackers

Invade living normal cells and use them to multiply and produce other viruses like themselves

Can kill, damage or change cells and make you sick

May not always get sick as immune system may fight it off

Antibiotics do not work, treatment is mainly symptomatic

Antivirals for some diseases may help

Vaccines can help prevent against viral disease



What causes disease?

Parasites

A parasite is an organism that lives on or in a host

It gets its food from, or at the expense of, its host

Parasites can cause or transmit disease in humans termed as a 'parasitic disease'

Many parasites do not cause disease

Infestation refers to parasitic diseases caused by lice, fleas, ticks, and some mites, that live on a host

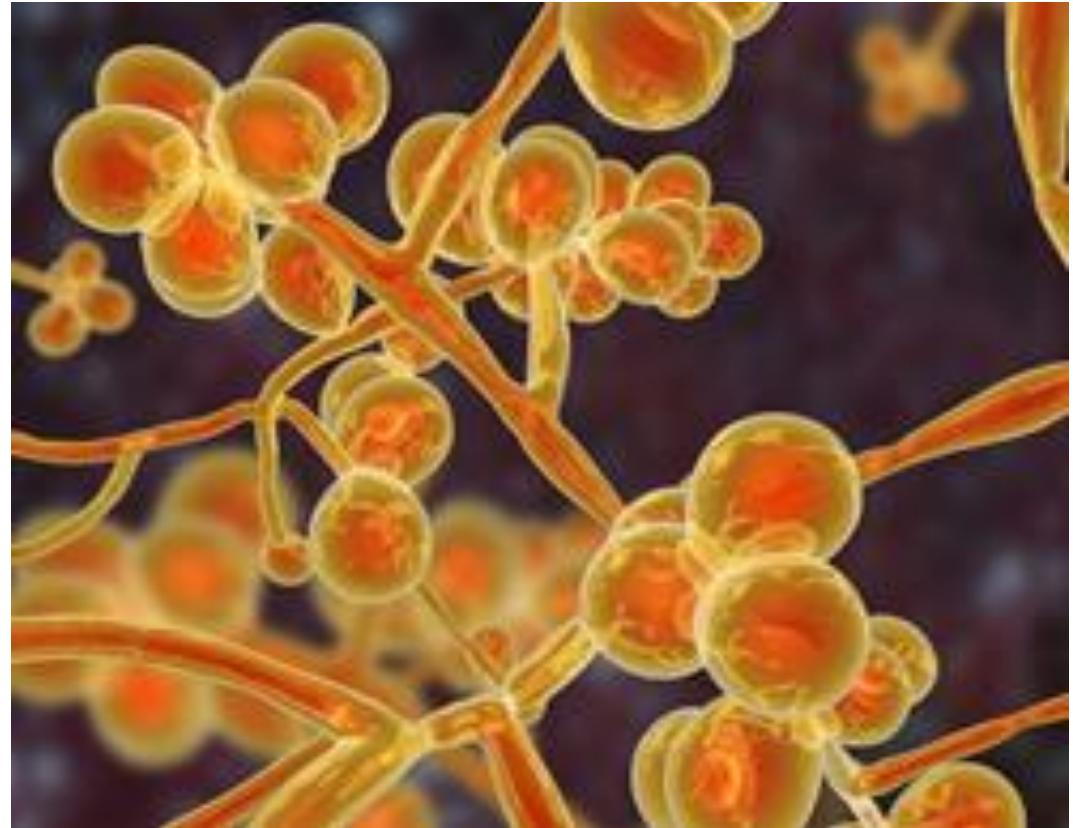
It can also refer to worms and protozoa (worm) that live in the internal organs or tissues of its host



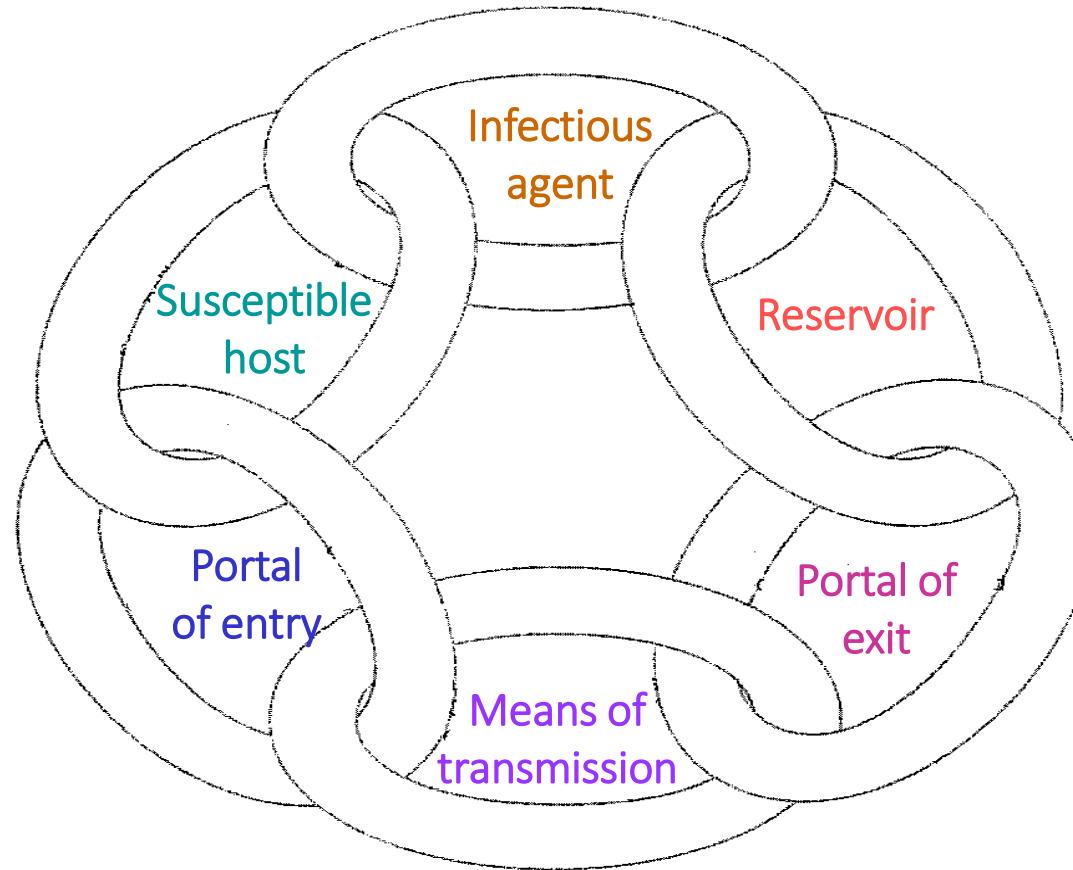
What causes disease?

Fungal

- Fungi are primitive organisms
- Examples are mushrooms, mould and mildew
- They live in air, in soil, on plants and in water and some live in the human body
- Only about half of all types of fungi are harmful
- Some fungi reproduce through tiny spores in the air
- Spores can be inhaled or they can land on the skin
- Individuals are more likely to get a fungal infection if they have a weakened immune system or take antibiotics
- Fungi can be difficult to kill
- For skin and nail infections, (e.g 'athletes foot') topical medication can be used
- Some oral antifungal medicines are also available for serious infections like HIV antiviral drugs



What is the chain of infection?



Breaking any link in the chain will assist in preventing the spread of micro-organisms.

How can the chain be broken?

The chain of infection can be broken by taking Standard or Universal Precautions



What are Standard Precautions?

- Hand hygiene (washing) – most effective measure in preventing transmission of infection and reducing HCAIs
- Management and safe disposal of clinical waste
- Cleaning and decontamination (environment and equipment)
- Management of body fluid spillages
- Personal Protective Equipment (PPE)
- Safe Use and Disposal of Sharps

Hand hygiene (washing) and Procedures

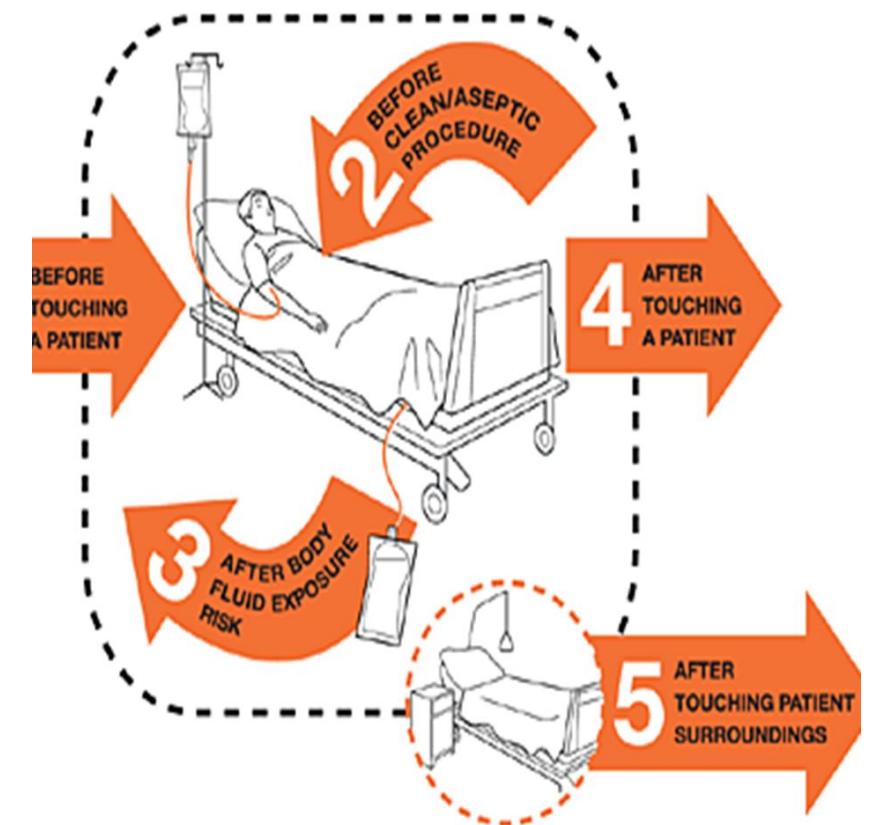
Single, simplest most effective way to prevent the spread of infection!

Microbes on hands can be classified as either transient or resident

- Resident flora – usually low virulence, rarely cause infection except when introduced into the body through urinary catheters or open wounds
- Transient flora – consist of many different pathogenic micro-organisms. Can be removed quickly and effectively with soap and water

When to decontaminate hands

- Hands must be decontaminated in accordance with the World Health
- Organisation (WHO) '5 Moments for hand hygiene'
 - Before patient contact
 - Before an aseptic procedure
 - After body fluid exposure risk including blood, excretions, mucous membranes, open wounds or wound dressings and after any procedure that may have caused faecal contamination like assisting a patient to the toilet
 - After patient contact
 - After contact with a patients surroundings including contact with medical equipment



Hand hygiene (washing)

Single, simplest most effective way to prevent the spread of infection!

- Use liquid soap and running water
- Alcohol rub hand sanitisers

Ensure that you are aware of and follow your practice guidelines for hand hygiene

Hand Washing

Soap and water removes transient micro-organisms and visible dirt

Liquid soap required and running water

Bar soap is not permitted for staff hand washing in healthcare settings

Cover cuts

Bare below the elbows

Remove jewellery (rings with stones and ridges trap bacteria)

Dedicated hand washing sinks should be available in all clinical areas

Sinks should have elbow operated mixer taps

Can use hand creams to maintain skin integrity

Hand Washing Method

- Wet hands thoroughly first
- Apply liquid soap
- Rub all parts of the hands for 15-30 secs ensuring ALL surfaces of hands and wrists are covered with soap
- Rinse hands thoroughly
- Dry hands thoroughly using disposable paper towels

Hand Washing Methods

Hand-washing technique with soap and water



Wet hands with water



Apply enough soap to cover all hand surfaces



Rub hands palm to palm



Rub back of each hand with palm of other hand with fingers interlaced



Rub palm to palm with fingers interlaced



Rub with back of fingers to opposing palms with fingers interlocked



Rub each thumb clasped in opposite hand using a rotational movement



Rub tips of fingers in opposite palm in a circular motion



Rub each wrist with opposite hand



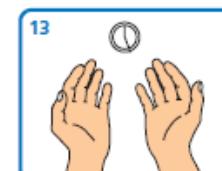
Rinse hands with water



Use elbow to turn off tap



Dry thoroughly with a single-use towel



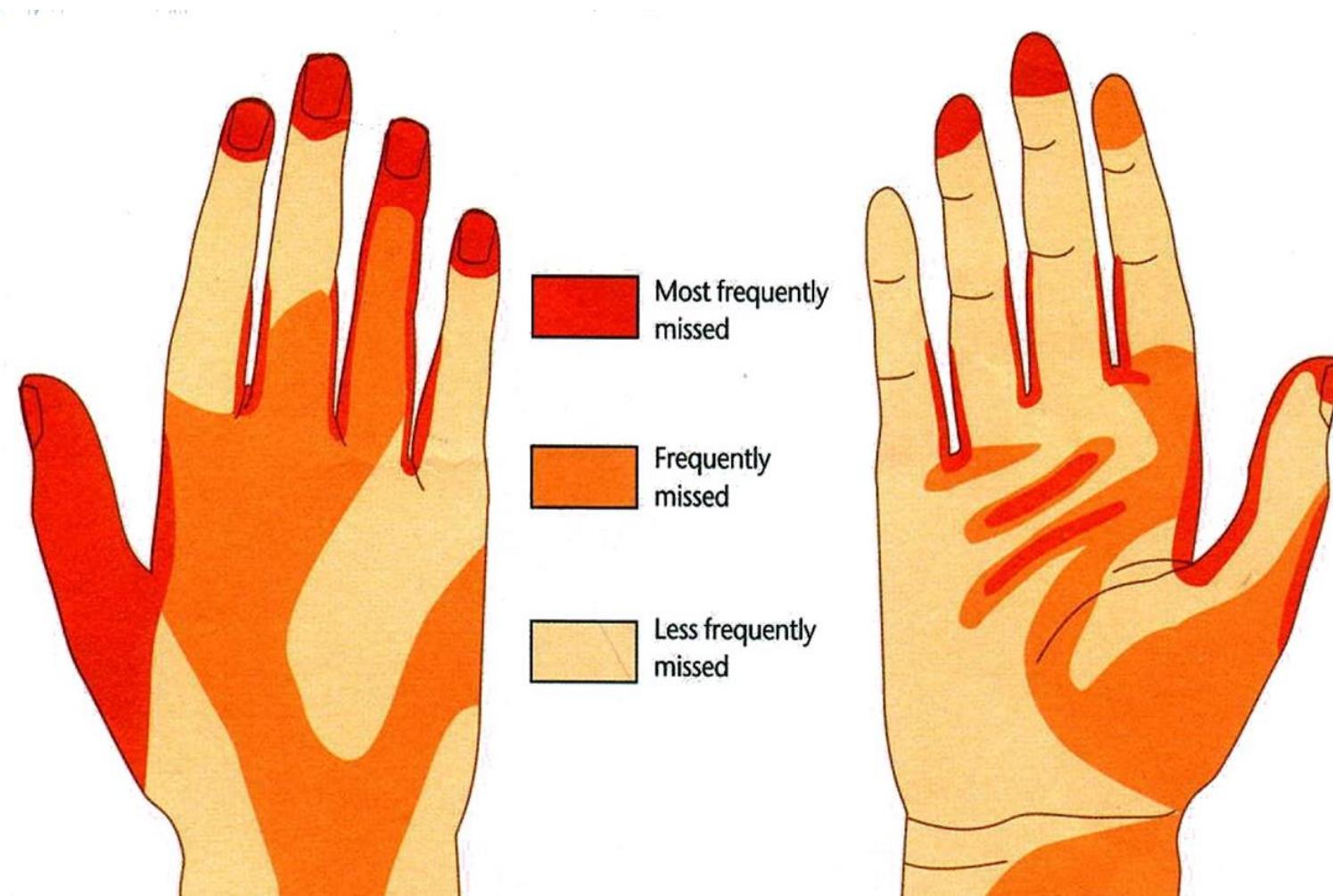
Hand washing should take 15–30 seconds



Lovely nails?

Evidence shows that artificial nails harbour micro-organisms and have been proven to have spread infection

Areas frequently missed...



Using Alcohol Gels/Hand Rubs

Alcohol hand gels/rubs are effective alternative to routine hand washing IF the hands are visibly clean

Useful when soap and water not readily available

Facilitates timely hand hygiene

Must be available either in a dispenser at the point of care or can be carried by staff

Apply enough alcohol gel to thoroughly cover your hands

Rub hands together briskly until dry

Alcohol Gel Method

NHS

Alcohol handrub hand hygiene technique – for visibly clean hands

- 

1 Apply a small amount (about 3 ml) of the product in a cupped hand
- 

2 Rub hands together palm to palm, spreading the handrub over the hands
- 

3 Rub back of each hand with palm of other hand with fingers interlaced
- 

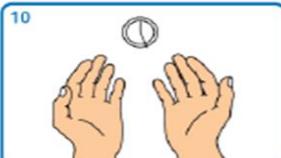
4 Rub palm to palm with fingers interlaced
- 

5 Rub back of fingers to opposing palms with fingers interlocked
- 

6 Rub each thumb clasped in opposite hand using a rotational movement
- 

7 Rub tips of fingers in opposite palm in a circular motion
- 

8 Rub each wrist with opposite hand
- 

9 Wait until product has evaporated and hands are dry (do not use paper towels)
- 

10 The process should take 15–30 seconds

cleanyourhands campaign

© Crown copyright 2007 283373 1 p 1k Sep07
Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care

NHS
National Patient Safety Agency

Using Alcohol Gels/Hand Rubs

When is alcohol gel NOT effective?

Alcohol gel is ineffective against –

- D&V caused by suspected Norovirus or Clostridium difficile (C-diff)



Management and Safe Disposal of Clinical Waste

- Key principles of clinical waste regulations relate to correct –
 - Segregation
 - Storage
 - Disposal
 - Documentation of waste

Waste disposal



INFECTIOUS WASTE STREAM

DO's			
✓	✓	✓	✓
INFECTIOUS GLOVES	SWABS AND DRESSINGS	NAPPIES AND INCO PADS	APRONS

DON'T's			
X	X	X	X
NO NEEDLES AND SHARPS	NO FOOD AND DRINK	NO RECYCLABLES	NO MEDICINES

GENERAL WASTE

DO's		
✓	✓	✓
POLYSTYRENE PACKAGING AND CUPS	FOOD AND FOOD PACKAGING	PAPER TOWELS

DON'T's		
X	X	X
NO CLINICAL WASTE	NO WASTE ELECTRICAL ELECTRONIC (WEEE)	NO SHARPS AND NEEDLES



TIGER WASTE STREAM - OFFENSIVE WASTE WHICH IS NON-INFECTIOUS

DO's		
✓	✓	✓
NON-INFECTIOUS GLOVES	SWABS AND DRESSINGS	NAPPIES AND INCO PADS

DON'T's		
X	X	X
NO INFECTIOUS WASTE	NO NEEDLES AND SHARPS	NO MEDICINES

RECYCLABLE WASTE

DO's		
✓	✓	✓
PAPER AND CARDBOARD	RECYCLABLE PACKAGING	PLASTIC BOTTLES

DON'T's		
X	X	X
NO GENERAL WASTE	NO WASTE ELECTRICAL ELECTRONIC (WEEE)	NO CLINICAL WASTE

Health Technical Memorandum 07-01 – Safe management of healthcare waste in General Practice- (not a complete list)

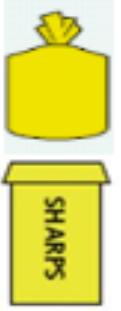
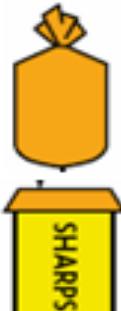
- cytotoxic and cytostatic waste if used (purple lidded)
- other medicines
 - Medicine waste container
 - Vials in sharps bins
 - Medicated (for example antibiotic) intravenous should be disposed off as waste medicines
- sharps in sharps boxes
- clinical waste (orange bag);
 - The waste is suitable for disinfection processes such as autoclaves, rather than requiring incineration.
 - But not medicinally- or chemically-contaminated wastes; or offensive waste
 - any contaminated dressing that does not contain an active pharmaceutical agent can be discarded in the orange bag;
- Clinical waste (yellow bag)
 - items that (a) are infectious clinical waste and (b) have an additional second characteristic (for example, chemical or pharmaceutical) that makes incineration the sole disposal option
 - anatomical wastes and tissue samples
 - Medicine waste
- offensive waste (yellow/black bag);
 - Eg nappies
- domestic waste (black/clear or other appropriate bag);
 - Eg magazines
- waste chemicals;
- gypsum; special container.

Legislation

- The Environmental Protection Act 1990 (including the Duty of Care Regulations) is main legislation
- Responsibility under H&S at Work Act (1974) to store and dispose of clinical waste and sharps safely
- Clinical waste must be segregated immediately by the person generating the waste into appropriate colour bags or storage containers
- Must be labelled, stored, transported & disposed of in accordance with National Legislation.
- Have you read your practices Waste Management Policy?

Waste Segregation and Disposal

- You have a duty of care to ensure that clinical waste is disposed of in a safe and appropriate way
- Ensure you follow your local policy on waste management as the colour code system for bags could differ in your organisation

Container	Type of waste	Disposal reqt
	Cytotoxic/ cytostatic	High temperature incineration
	Infectious contaminated with chemicals or medicines	High temperature incineration
	Infectious—soiled dressings or swabs with visible signs of blood that may be infected	Alternative treatment (eg rotoclave) or incineration
	Offensive— dressings, swabs, incontinence pads, disposable clothing	Landfill

Sustainability in the NHS

- Health & Social care is responsible for an estimated 4-5% of UK's carbon footprint
 - NHS England committed to reaching net zero carbon emission by 2040
- **BUT** Pandemic has procured significantly additional waste
- WHO estimates that one and a half billion units of PPE weighing 87 000 tonnes, were procured between March 2020 and November 2021 and shipped to countries around the world t
- Most of this is however, as it does not include PPE bought outside the initiative or waste generated by the public, such as disposable face masks.
- Over 140 million covid-19 test kits have been shipped globally, generating 2600 tonnes of non-infectious waste and 731 000 litres of chemical waste,
- In addition, over eight billion doses of vaccine have been administered, producing 144 000 tonnes of additional waste in the form of syringes, needles, and safety boxes.
- One in three healthcare facilities globally do not safely manage healthcare waste, let alone the additional covid-19 load, the report said.
- This rises to 60% in the least developed countries.
 - As a result, healthcare workers are potentially exposed to needle stick injuries, burns, and pathogens.
 - Communities may also be impacted if they live near poorly managed landfills and are exposed to contaminated air from burning waste, poor water quality, or disease carrying pests.

Cleaning and Decontamination

- Decontamination of the environment and equipment is important in reducing cross infection and reducing risks of HCAIs
- Decontamination is combination of
 - cleaning
 - disinfection
 - sterilisation
- Ref to National Specifications for Cleanliness in the NHS: Guidance on setting and measuring cleanliness outcomes in primary care medical and dental premises by national Patient Safety Agency (NPSA)



Cleaning and Decontamination of Environment and Equipment

- Important to use correct cleaning/disinfection products when cleaning equipment or an environment
- Should be dust free and clean from spillages
- Correct solutions for body fluid spillages – spills kits
- Cleaning plans
- Cleaning schedules
- Patient equipment should be decontaminated between uses
- Use of detergent and hot water or detergent wipes is sufficient (followed by drying)

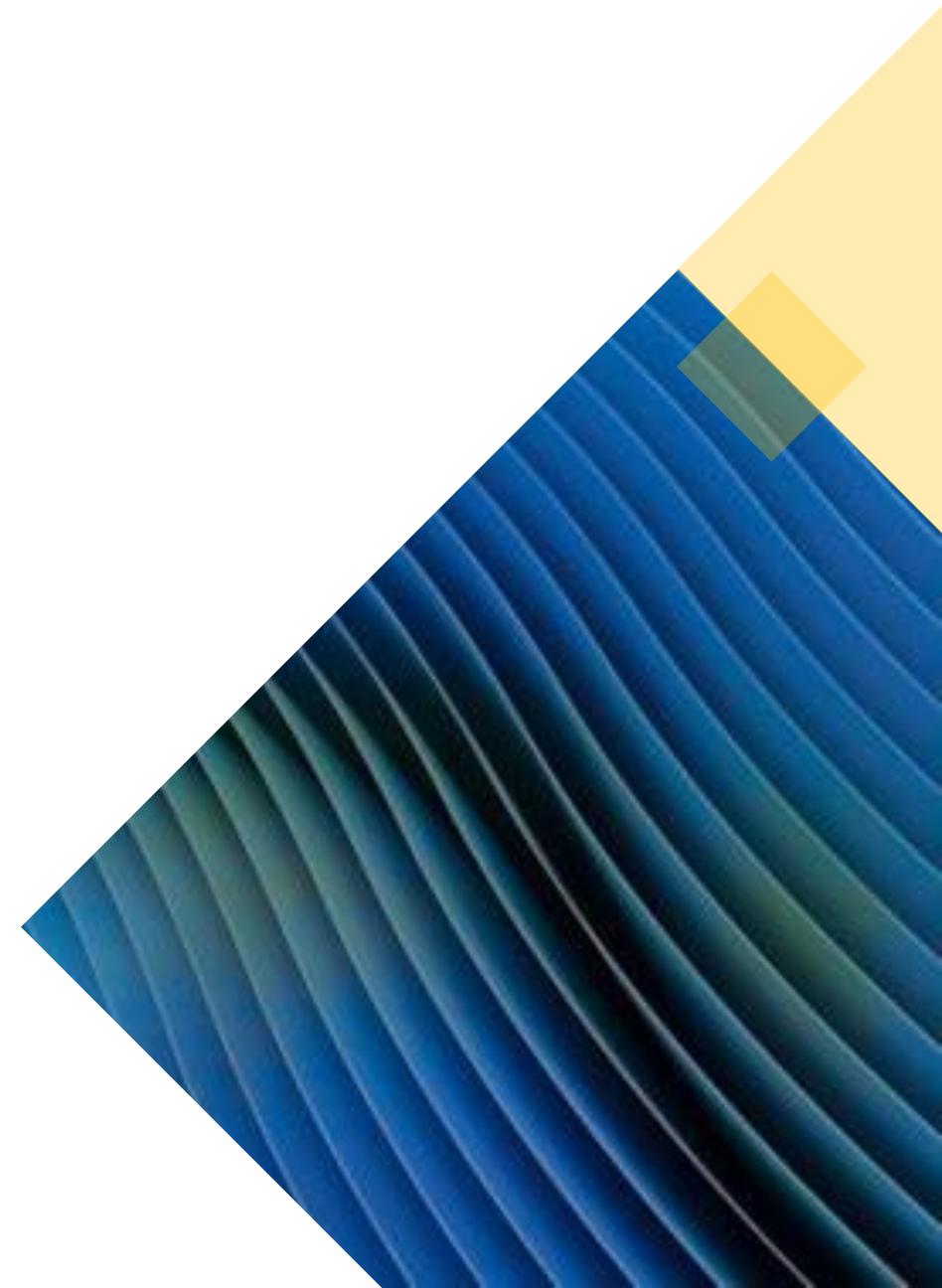
Management of body fluid spillages

Includes blood, faeces, vomit, urine and pus, all of which may contain disease-causing micro-organisms

These are hazardous to health

Need to follow the Control of Substances Hazardous to Health (COSHH) Regulations [4]

Do you know what your Practice policy is?



Management of body fluid spillages

Best practice includes –

- Using a spills kit (if available)
- Cordon off area and deal with spillage asap
- Use PPE
- Follow correct procedure in line with Practice Policy
- Ensure all waste safely disposed off



Body Fluid Exposure or Sharps Injury

Direct inoculation of blood/high risk body fluids from contaminated needles or instruments

Contaminated of broken skin with bloody/body fluid through cuts, abrasions and eczema

Blood/body fluid splashes into the eye, nose or mouth

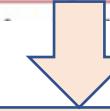


Safety issues: 2004-2013

4830 significant exposures to blood born virus (BBV)



Virus	Published risk of transmission	Healthcare workers exposed, 2004-2013	Seroconversions, 2004-2013	Observed risk of transmission
HBV	One in 3 	590	0	-
HCV	One in 30 	2566	9	1 in 285
HIV	One in 300 	1478	0	-



9 HCV sero-conversions occurred after occupational exposure. 8 of the 9 received anti viral therapy of whom 7 are known to have achieved viral clearance

Safety

- The National Audit Office (NAO 2003)
 - The report stated needlestick and sharps injuries accounted for 17% of accidents to NHS staff and were the second most common cause of injury, behind moving and handling at 18%.
 - At least four UK HCW's are known to have died following occupationally acquired HIV infection
 - Since 1996, the HPA has received reports of nine HCW's who have been infected with HCV because of occupational exposure
 - With 40,000 reported incidents a year and at least as many unreported, needlesticks and sharps injuries are a significant issue.
 - The management of health, safety and welfare issues for NHS staff New edition 2005

Immunisation & PEP

Hep B vaccine

- HBV exposure and for whom immunisation status was reported, 96% were known responders to HBV vaccine and NO HBV seroconversions have been reported

Post Exposure Prophylaxis

- 97% of all healthcare workers exposed to HIV who started PEP , did so within 72 hours
 - 89% did so within 24 hrs
- NO HIV seroconversions have been reported

Safety issues: some facts & figures

71% of exposures involved a percutaneous needle stick

Reported annual percutaneous injuries increased by 22% over 10 year period

Mucotaneous injuries increased by 61% (from 90 to 145)

65% of exposures occurred in wards, theatres and A&E although overall, numbers are declining on wards

- 45% were nurse, midwives & HCA
- 41% by doctors
- 5% by dentist

- 65% of injuries occurred during a clinical procedure
- 27% after but before disposal
- 10% after used and after disposal

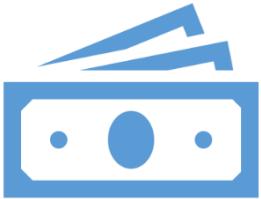
**If I am stuck with an infected needle what is the risk
of Blood -borne virus**

HBV 1 in 3

HCV 1 in 30

HIV 1 in 300

Safety



Cost to practitioner

Immeasurable stress

Lifestyle changes

Possible premature death



Cost to employer

Covering sickness

Treatment costs

Litigation

Recruitment and retention of staff

Safety

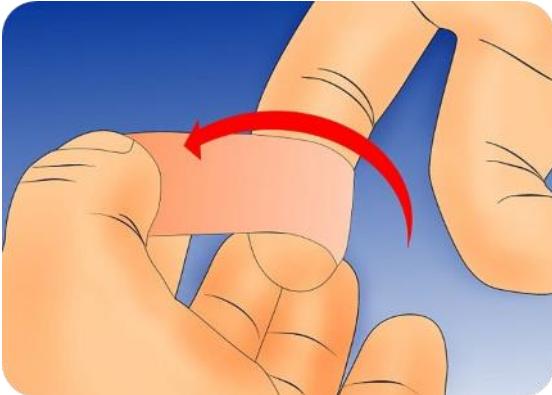
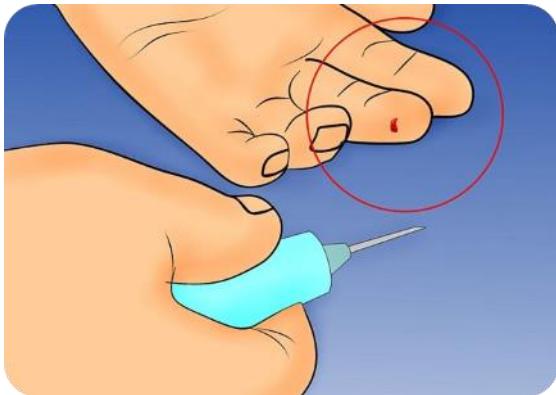
- Standard Precautions
- Skin
 - Cuts or abrasions in any area of exposed skin should be covered.
- Gloves
 - Well fitting clean gloves must be worn during procedures where there may be contamination of hands by blood/body fluids.
- Hand Washing
 - The use of gloves does not preclude the need for thorough hand washing between procedures.
- Aprons
 - Where there is a possibility of blood spillage.
- Eye Protection
 - Where there is a danger of flying blood splashes .
- Sharps Container
 - Needles are not to be resheathed prior to disposal into approved sharps container.

Safe Management and Handling of Sharps

- Users responsibility to discard safely
- Dispose immediately at point of use
- Never re-sheath needles
- Don't pass needles/syringes from hand to hand
- Dispose as a single unit
- Use approved bins
- Assemble sharps bins correctly
- EU Sharps Regulations 2013 (needle safe devices)
- Do a risk assessment
- Audit compliance



Immediate Action in the Event of a Sharps Injury



ALLOW IT TO BLEED
do not suck, squeeze
or scrub the wound

WASH IT
with soap, under running
water

COVER IT
with a waterproof
dressing

REPORT IT
immediately

- Assess risk and take appropriate action –
 - Attend Occupational Health or ED Dept if appropriate
 - Identify source of contamination eg patient details

Do YOU know your Practices Process?

Personal Protective Equipment (PPE)

- Gloves, aprons, goggles, masks
- Be worn when needed depending on task
- Risk assess likely exposure and PPE required
- Protects uniform
- Protects you from chemicals and body fluids
- Protects the patient
- Wear only for the task, remove and dispose of immediately
- Wash hands



Putting on PPE

- Don't → Decontaminate
- Ask → Apron
- My → Mask
- Great → Goggles
- Grandma → Gloves



Removing on PPE

- Go → Gloves
- And → Apron
- Get → Goggles
- My → Mask
- Dog → Decontaminate



Any Questions



**Wash your hands!
YOU
know where they've been!**



03-WA 314-F4 Wash Hands



— B E L M A T T —
HEALTHCARE TRAINING

Aspect Non Touch Technique – ANTT



ANTT Objectives

By the end of this session you will be able to:

- Explain what ANTT is and why it is important
- Describe Key Principles to avoiding HCAs using ANTT
- Describe the principles of effective hand hygiene
- Discuss Types of Asepsis
- Discuss Key Parts and Key Sites
- Know the process

What is the Aseptic Non-Touch Technique (ANTT)?

Definition from ANTT Core Clinical Guidelines (2020) -

“ANTT is a method used to prevent contamination of wounds and other susceptible sites by ensuring that only sterile objects and fluids come into the contact with these sites and that the risk of contamination is minimised”.

<https://www.antt.org/>

What are the aims of Aseptic Non-Touch Technique (ANTT)?

- To reduce the risk of Healthcare Associated Infections (HCAs) into susceptible sites such as wounds, blood or bladder during clinical procedures
- To prevent the transfer of bacteria/viruses or other micro-organisms from one patient to another
- To prevent the transfer of bacteria/viruses or other micro-organisms from patients to staff and staff to patients

Basic Principles for preventing HCAs using ANTT

- Correct ANTT prevents contamination and transfer of bacteria/viruses or other micro-organisms from hands, surfaces and equipment to patients during procedures
- Correct ANTT requires **KEY PARTS** and **KEY SITES** to be identified and protected at all times
- Key parts must only come into contact with other key parts and / or key sites

What are Key Sites?

- Any non-intact skin or broken skin such as an open wound
- Any insertion or access sites for medical devices connected to the patient such as an IV urinary catheter



What are Key Parts?

- The sterile components of equipment used during a procedure
- Examples include bungs, needle hubs, syringe tips, dressing packs etc.



How can we prevent HCAIs using ANTT?

What are the key principles to consider when performing any invasive procedure?

- To create and maintain a sterile field and safe environment
- Hand hygiene
- To use appropriate Standard Infection Control Precautions for the procedure
- To prepare the patient
- Never to contaminate key-parts
- To touch non-key-parts with confidence

What environmental control is needed?

Ensure no avoidable environmental risks present

These may include but not limited to –

- Consulting room furniture
- Chairs, desks
- Curtains too close to examination coach
- Waste bins

Hand Hygiene

- Effective hand hygiene is an **essential** component of ANTT
- Either routine or surgical hand hygiene is required depending on the procedure about to be performed
- **Routine Hand Hygiene** refers to the use of soap/solution and water
- **Surgical Hand Hygiene** requires the use of an approved antimicrobial skin cleanser or waterless hand rub formulation

Protective Personal Equipment (PPE)

Use of Gloves –

- Gloves are single-use items
- If it is necessary to touch key parts or key sites directly, **sterile gloves** must be used to minimise the risk of contamination
- If key parts or key sites are not touched directly non-sterile gloves may be used to protect from blood or body fluids or exposure to toxic drugs during administration
- Gloves do not replace the need for hand hygiene
- Hand hygiene must be performed before and after glove use

What other PPE might be required?

Other PPE –

- Gowns
- Aprons
- Eye protection e.g. visors / goggles / glasses
- Masks
- Consider what level of PPE is required if assisting with minor surgery

Aseptic Field

Before commencing a procedure requiring ANTT –

- Determine the aseptic field required and how the field will be managed
- Aseptic field must be managed to ensure that key parts and key sites are protected
- The aseptic field should be prepared as close as possible to the time of actual use

Aseptic Field Management

- Select a tray or trolley of an appropriate size to ensure key parts are adequately contained within the aseptic field
- Clean appropriately and allow to dry before placing any items in or on the tray or trolley
- If a surface remains wet then asepsis will be compromised
- The aseptic field may also need to be extended by draping the patient
- The sterile drape will provide additional work space where sterile equipment may be placed as well as protecting the key site from contamination

Non-touch Technique

- Non-touch technique is an important component even when sterile gloves are used
- Unfortunately it's well documented that hand hygiene is not always correctly performed and even if correctly performed hand hygiene cannot always remove all pathogenic organisms
- Therefore a non-touch technique is a vital component of achieving asepsis
- Non-touch technique is a technique where your hands do not touch and contaminate key parts and key sites
- The safest way to protect a key part is not to touch it!

Two main types of ANTT

- Depending on complexity of procedure, duration, number of key parts/sites and the clinician competency, there are 2 types of ANTT –
 1. Surgical ANTT
 2. Standard ANTT
- The underlying principles of ANTT are:
 - Always decontaminate hands effectively
 - Never contaminate key-parts or patient's susceptible site
 - Touch non-key parts with confidence
 - Take appropriate infection prevention and control precautions

Surgical-ANTT

- Surgical-ANTT is required when procedures are –
 - Technically complex
 - Long duration (approx. >20mins)
 - involve large open key sites or numerous key parts
- OR
 - if the clinician is inexperienced or does not feel confident to perform the procedure **without** touching key sites or parts
- To counter the risks –
 - A main critical aseptic field is required
 - Sterile gloves as well as full PPE are required
 - A non-touch technique where practical to do so

Standard-ANTT

- Standard-ANTT is required when procedures are –
 - Technically simple
 - Short duration (approx. <20mins)
 - involve relatively small or few key sites or key parts
- OR
 - The clinician should feel competent and experienced to perform the procedure **without** touching key sites or parts
- To counter the risks –
 - A main critical aseptic field is required
 - Non-sterile gloves can be used if no contact with key parts/sites
 - A non-touch technique critical to protect key parts/sites

ANTT Procedure

- Risk assess and decide type of procedure required i.e. standard or surgical
- Make environment safe
- Select appropriate PPE required
- Clean trolley/tray to be used
- Ensure ALL key parts always protected
- Sterile items must only be used once and then disposed into waste bag
- Key sites only touched with sterile items
- Sterile items must not come into contact with non-sterile items

ANTT Procedure continued...

- On completion, remove gloves and wash hands
- Dispose of all waste (including sharps) in appropriate bins/bags
- Clean all equipment thoroughly
- Allow equipment to dry before putting away
- Ensure all surfaces touched cleaned well
- Wash hands
- If minor surgery – ensure any samples collected labelled and stored for pathology with form as per Practice process

Do's and Don'ts – should you use a steret to clean key parts?



Small sterets are too small to clean Key-Parts safely



Use a **LARGE alcowipe** containing 2% chlorhexidine and 70% alcohol

Do's and Don'ts – what do we think about dropping items onto a tray?

- Do not **DROP** your equipment into your tray

(There is a risk some Key-Parts will touch the tray)

- Key-Parts should **NEVER** be touched
- Only Key-Parts should touch other Key-Parts



Do's and Don'ts – which tray below is correct?



Don't leave Key-Parts unprotected and exposed



Key-Parts should always be protected (By Critical Micro Aseptic Fields)

Summary

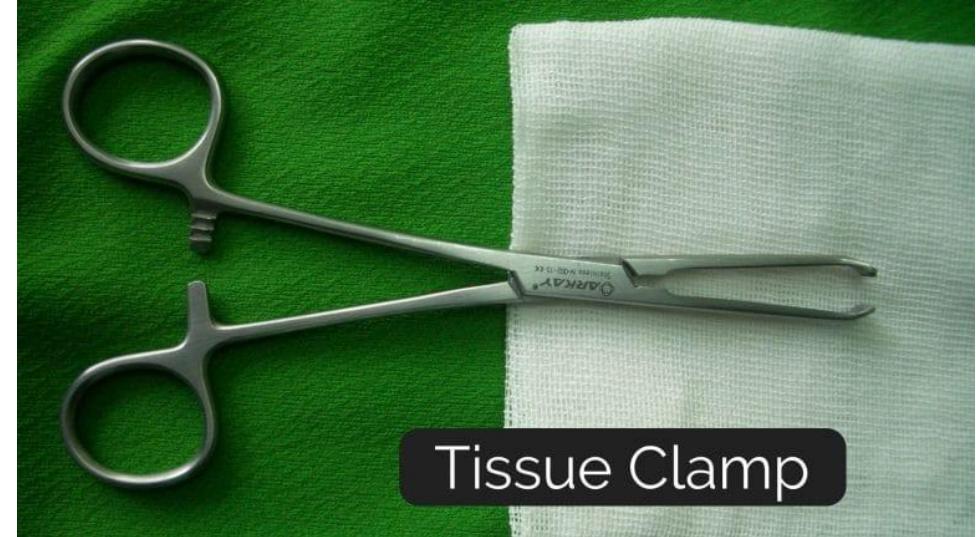
- ANTT required for ALL invasive procedures
- ANTT reduces risk of patients acquiring an infection by ensuring asepsis of hands, surfaces and equipment
- This minimizes risk of introduction of pathogenic material into susceptible sites on patient
- Risk assessment required to decide appropriate ANTT
- Standard ANTT – for clinical procedures that are simple, short and involve few/small key parts/sites BUT must be carried out without touching key parts/sites e.g. simple wound dressings
- Surgical ANTT – for clinical procedures that are complex, long duration, involve large open key sites or many key parts e.g. minor surgery
- Key sites/parts MUST be always protected
- Non-touch technique is vital component of achieving asepsis

Common Surgical Equipment



Dissecting Forceps

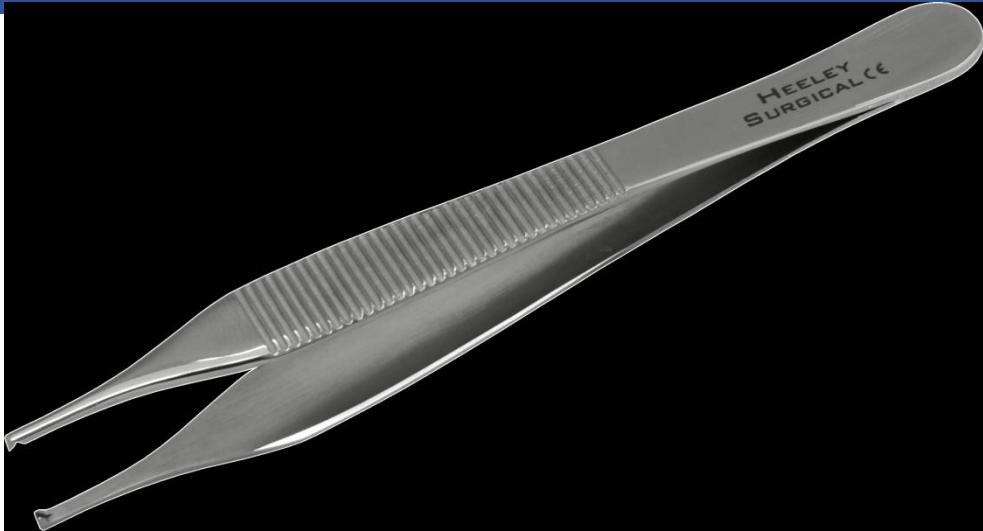
- Also known as dissectors, pick-ups, grabbers and thumb forceps.
- Look like a large pair of tweezers and vary in size and shape
- Can be toothed or non toothed



Tissue Clamp

- Tissue clamps have a similar design to hinged-forceps
- Used to block or occlude blood vessels or other luminal tissues (such as bowel).
- Depending on their use, clamps can be:
 - atraumatic (e.g. for use on bowel),
 - designed to crush tissue,
 - or have features specific to them so they don't slip (e.g. for vessel occlusion).

Common Surgical Equipment

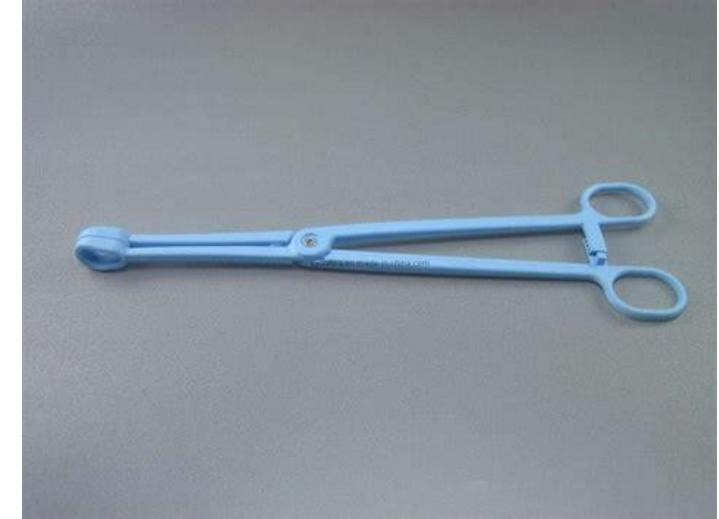


- Looks like a pair of scissors but instead of two blade-like parts, two arms which meet to press together instead of cut
- Many different types- you are likely to see Artery Forceps (clamping arteries) and Needle holder (for suturing)
- Size and shapes depends of the type
- Generally only non-toothed forceps are used inside the body tissues as they are less traumatic
- Toothed forceps are usually used for picking up skin edges during skin closure or to hold on to the needle

Common Surgical Equipment



**Sponge Holder
Forceps**



Sponge forceps do not have sharp hooks or teeth but small grooves.

- A swab on a stick is provided by wrapping a gauze swab around the Rampley sponge forceps
 - Useful for cleaning and prepping the skin, or dabbing blood without causing tissue damage

Common Surgical Equipment



Handheld Retractor

- Unlikely to be used for minor procedures
- Are used to improve the view of the surgical field by pulling tissue or organs out of the



Surgical Scissors

- A myriad of different scissors in use.



Scalpel

- The handle is called a B.P handle
- The blades themselves are disposables



Most places would use disposable

Suture Material



2 main types:

- Absorbable
- Non Absorbable

Sutures

Material size

- Scalp 3/0
- Face 5/0-6/0
- Hands/feet 4/0-5/0
- Forearm/arm 3/0
- Thigh/leg 3/0

Removal times

- Scalp 7 days
- Face 4-5 days
- Neck 7 days
- Torso 10-14 days
- Upper limb 7-10
- Lower limb 10-14

Managing specimens

The Collection, Handling and Transport of Specimens

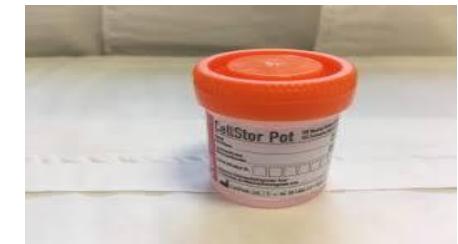
- A clinical specimen can be defined as any bodily substance, solid or liquid, that is obtained for the purpose of analysis, examples include blood, sputum, pus, urine, faeces, and skin tissue.
- Staff handling specimens are responsible and have a duty to safely collect, handle and transport specimens outline under the Health and Safety at Work Act (1974) and COSHH Regulations 2002 (amended 2004)
- Prompt, accurate laboratory reports are possible only if the specimen is properly collected, with the accompanied request form detailing patient information, stored and transported safely.
- If specimens are not stored and transported safely, they pose a risk of infection to staff, patients and the wider public.

Common specimens

Specimen	Container	Technique	Storage
Axilla	Cotton tipped swab transport medium – can be moisten with sterile water or used dry	Roll over skin armpits	specimen fridge no longer than 24 hrs
Eye	Cotton tipped swab with appropriate transport medium should be used for suspected bacterial eye infections. For conjunctivitis a viral swab with viral transport medium	Gently roll the swab over the conjunctival sac inside the lower lid. Hold the swab parallel to the cornea to avoid injury.	specimen fridge no longer than 24 hrs
Faeces	15mls or walnut size - Stool container (blue top) with 'scoop'.	You can collect a sample even if contaminated, with urine. Indicate this on form information	specimen fridge no longer than 24 hrs
High Vaginal Swab	High Vaginal Swab	Circle around the high vaginal wall once	No refrigeration :send directly to lab
MSU	10mls Universal (white top) or Boric acid (red top) bottle	First few seconds of the stream should be discarded. If the patient cannot participate then, collect in a sterile container and transfer to bottle	specimen fridge no longer than 24 hrs
Pus	Depending on sample either Cotton tipped swab transport medium or sterile container.	Loose debris should be removed prior to swab. The deepest part of the wound should be sampled, avoiding the superficial microflora). Swabs should be well soaked in pus. If in a container the volume should ideally be 1ml	No refrigeration - send directly to lab
Wound	Cotton tipped swab transport medium	Obtain the specimen prior to any dressing or cleaning procedure of the wound. Rotate on the area to collect exudate from the wound	specimen fridge no longer than 24 hrs
History pathology	All specimens to be placed in and covered by 10% neutral buffered formalin and stored at room temperature#	-	No refrigeration - send directly to lab
Cytology	non-gynae, cyst fluids, etc - a white top Universal container	-	specimen fridge no longer than 24 hrs

Essential data required on samples and request forms

	Essential	Desirable
Sample	<ul style="list-style-type: none">• NHS, CHI or Health and Care Number• Patients full name or unique coded identifier• Date of birth and/or hospital number	<p>Date and time</p> <ul style="list-style-type: none">• Nature of sample, including qualifying details, e.g. left, distal etc. especially if more than one sample per request is submitted
Request form	<p>NHS, CHI or Health and Care Number*</p> <ul style="list-style-type: none">• Patient's full name or unique coded identifier• Date of birth and/or hospital number• Gender• Patient's location and destination for report• Patient's consultant, GP or name of requesting practitioner• Investigation(s) required	<ul style="list-style-type: none">• Clinical information including relevant medication (which is sometimes essential)• Date and time sample collected (which is sometimes essential)• Patient's address including postcode• Practitioner's contact number (bleep or extension)• Identified if a female is known to be pregnant (which is sometimes essential)



Any
Questions





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