Infection prevention and control (IPC) for primary care settings in Ireland: a guide for general practice

RESIST

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Glossary of terms

ABHR	Alcohol based hand rub
AGPs	Aerosol generating procedures
AMRIC	Antimicrobial Resistance and Infection Control
BBV	Blood Borne Virus
DoH	Department of Health
EMI	Emergency management of injuries
GRADE	Grading of recommendations assessment, development and evaluation
HBV	Hepatitis B Virus
HCAI	Healthcare associated infections
HCRW	Healthcare risk waste
HCV	Hepatitis C Virus
HCW	Healthcare worker
HIV	Human Immunodeficiency Virus
IPC	Infection, prevention and control
NaDCC	Sodium dichloroisocyanurate
NCG	National clinical guideline
MDRO	Multidrug resistant organisms
PCRA	Point of care risk assessment
PEP	Post exposure prophylaxis
PPE	Personal protective equipment
SARI	Strategy for the control of antimicrobial resistance in Ireland
WHO	World Health Organisation

Foreword from HSE AMRIC Clinical Lead

Good infection prevention and control practices are essential to ensure that people who use primary care services receive safe and effective care.

Healthcare associated infections (HCAIs) are infections that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The term HCAIs include any infection acquired as a direct result of treatment in any health or social care setting or as a result of healthcare delivery in the community (HIQA, 2017). While the specific risks of HCAI differ depending on the setting in which healthcare is delivered, the basic principles of IPC apply regardless of the setting.

This guide was developed in response to the publication of the Infection Prevention and Control (IPC), National Clinical Guideline, No.30, Department of Health (2023) found here, and replaces *Infection Prevention and Control for Primary care in Ireland: A guide for General Practice (SARI, 2013).*

This guide is intended for use by all staff working in general practice including all clinical, non-clinical administrative and support personnel.

It is important to note this guide refrains from focusing on antimicrobial stewardship (AMS) measures and activities. It is widely accepted that GPs working in general practice regularly consult www.antibioticprescribing.ie for antimicrobial prescribing guidelines and as such AMS will not be covered in this guide.

HSE AMRIC is committed to supporting general practices in strengthening IPC practices and activities. To sustain and support GP practices, HSE AMRIC materials and resources have been incorporated into this guide. These IPC practices and efforts are seen as essential to improve healthcare safety, reduce the spread of infections, and address the growing threat of antimicrobial resistance.

I would like to take this opportunity to acknowledge and thank all those who contributed to the development of this guide, and provided their helpful feedback, in particular:

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- Dr. Edel Doorley, HSE AMRIC GP advisor, (Project Lead) and HSE AMRIC team

Dr. Eimear Brannigan, HSE AMRIC Clinical Lead

Summary of key points for general practice

The following summarises the key points from each section covered in this guide.

Good IPC is the responsibility of all health and social care professionals which includes all clinical, administrative and support staff working in general practice settings
Hand hygiene should be performed as per the WHO 5 moments
Alcohol based hand gel / foams/ rub are the preferred method for hand hygiene for visibly clean hands
Disposable paper towels for drying hands following soap and water hand hygiene is recommended
All employees in general practice should be offered appropriate vaccination: HSE National Immunisation Office and HSE occupational guidance for healthcare settings
Standard precautions are a set of practices that should be implemented in the care of all patients
A point of care risk assessment (PCRA) should be undertaken by healthcare professionals to determine the type of personal protective equipment (PPE) they may require for patient care
Cleaning and disinfection as required of medical equipment / devices is a key part of IPC
Patient equipment must be cleaned (and disinfected as required) between every patient use
All practice staff need to be trained in the correct management of blood and body fluid spills (www.hseland.ie)
Disposable protective couch roll for examination couches is recommended
The management of all waste; domestic / non healthcare risk waste and healthcare risk waste (HCRW), within the GP practice is the responsibility of the service provider and should be clearly defined
All practices should plan for unscheduled events that may require additional contingency measures and IPC transmission based precautions to be implemented such as contact / droplet and airborne precautions.

1.0 Introduction

This IPC guide aims to support staff working in general practice settings to implement standard and transmission based precautions in practice. It has been developed to replace *Infection Prevention & Control Guidance for Primary Care in Ireland: a guide for General Practice (2013)* which is now retired, ensuring general practices have access to guidance aligned directly to the IPC, National Clinical Guideline No.30, Department of Health (2023)

1.1 Purpose of this guide

The overall purpose of this guide is to provide all staff working in general practice with a document that is user friendly, reflects and supports the needs of general practice within the context of current best practice specifically in the area of IPC.

This guide will focus on the application of the IPC, National Clinical Guideline No.30, Department of Health (2023), extracting relevant IPC content including a summary of recommendations, good practice statements and current statutory requirements as they apply to general practice settings. This guide will also identify infection prevention and control (IPC) resources suitable for use in general practice and direct staff on how best to source these materials.

1.2 Guide structure

The document is structured in two parts.

Part A
Part A provides an overall summary of the key recommendations in general practice and an overview of the basics of IPC. A two-tiered approach of standard and transmission-based precautions for IPC in general practice is utilised.

Content is extracted from IPC, National Clinical Guideline No.30, Department of Health (2023) which sets out the standards for IPC in all healthcare settings. This guidance provides a summary of recommendations and good practice statements based on the GRADE (Grading of Recommendations Assessment, Development and Evaluation) approach, providing the underpinning evidence.

For each standard and transmission-based precaution outlined in this guide, there is an IPC, National Clinical Guideline No.30, Department of Health (2023) recommendation referenced. This provides an indication of the strength of the recommendation, reflecting the practical importance of the recommendation and an indication of the strength of the evidence for the recommendation.

This approach is used because in some instances there is a near universal consensus that a practice is very important, but the evidence base may be limited.

This may happen because it is very difficult to design or perform a relevant high-quality study for practical and / or ethical reasons. For each recommendation, there is also consideration of the harms and benefits of the intervention.

Although the principles of IPC contained in the IPC, National Clinical Guideline No.30, Department of Health (2023) applies to all levels of the health sector, including primary care, it is acknowledged that general practice does in some cases warrant tailored approaches to IPC guidance and implementation strategies.

Part B

Part B is a collection of resources and audit templates (Appendices 1 – 9) extracted from existing HSE AMRIC publications, Department of Health resources, as well as templates adapted from the previous Infection, Prevention and Control for Primary Care (SARI, 2013) which have been aligned to IPC, National Clinical Guideline No.30, Department of Health (2023).

1.3 Target audience

The general practice target audience of this guide are:

- General practitioners (GPs)
- General practice nurses
- General practitioners registrars
- General practice phlebotomists
- General practitioners interns and physician associates
- General practice managers
- General practice administration staff

Part A. IPC in general practice

- Summary of the key recommendations in general practice
- Overview of the basics of IPC
- Standard and transmission-based precautions for IPC in general practice.

2.0 Preventing transmission of infections in general practice

Healthcare associated infections (HCAIs) are infections that can develop either as a direct result of healthcare interventions such as medical or surgical treatment, or from being in a healthcare setting.

In order to prevent HCAIs, it is important to understand how infections occur in healthcare settings and then put in place measures to prevent them. If effectively implemented, the two-tiered approach of standard and transmission-based precautions recommended in this guide provides high-level protection to patients, healthcare workers and other people in healthcare settings.

While the specific risks of HCAI differ depending on the setting in which healthcare is delivered, the basic principles of IPC apply regardless of the setting.

Basics of IPC

- Many different infectious microorganisms are present in healthcare settings
- Infectious microorganisms (also called pathogens / bugs) are biological organisms that frequently cause human infection
- Infection refers to the invasion of body tissues by a microorganism
- Microorganisms may only cause infection in a proportion of people to whom they are transmitted and infection may only cause disease in a proportion of people who are infected
- Colonisation, in this context, refers to a situation in which a microorganism is established on a person's body (for example on skin, mucous membrane or wound) but is not causing infection at that time, for example Meticillin resistant *Staphylococcus aureus* (MRSA)
- Infection that does not result in any illness or disease is referred to as asymptomatic infection. Asymptomatic infection is a common phenomenon with some infectious microorganisms, although people who are colonised do not have disease, the organism may spread to others from them, for example asymptomatic COVID 19 infection
- For infection to spread, 6 elements are required; a causative microorganism (pathogen), reservoir, means of transmission, portal of entry, susceptible host,

and portal of exit. These 6 elements form what is commonly referred to as “The Chain of Infection” (Figure 1)

- People who use healthcare services, and healthcare workers, are most likely to be sources of infectious microorganisms due to their workplace exposure and are also the most common susceptible hosts
- Other people visiting and working in healthcare may also be at risk of infection and may be a source of transmission
- In healthcare settings, the main ways that infectious microorganisms spread are by contact (direct and indirect) and through the air. Spread through the air is categorised as either droplet or airborne transmission.

The chain of infection describes how infection is transmitted from one living thing to another. Transmission of infection can occur when the elements forming the “chain of infection” are present.

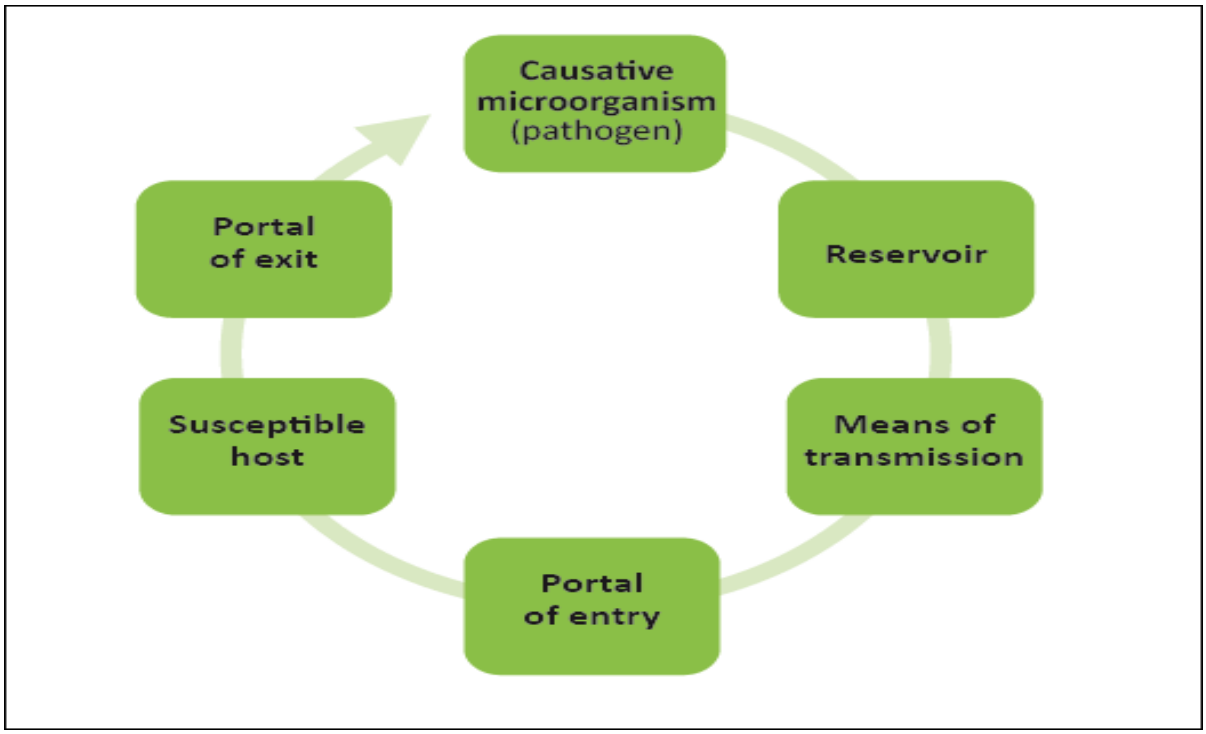

Figure 1. The chain of infection (IPC, National Clinical Guideline No.30, Department of Health, 2023)

The risk to a person contracting and having an adverse outcome as a result of acquiring a healthcare associated infection (HCAI) can be increased as a result of several factors:

1. Age (older people and infants / younger children)
2. Immune status (for example unvaccinated individuals)
3. Wound or devices
4. Medical co-morbidities (for example diabetes, chronic diseases)
5. Virulence of the agent, that is, ability of the microorganism to survive, thrive and cause disease.

Routes of transmission

In healthcare settings, the main modes of transmission of microorganisms are contact (including blood borne) and spread through the air (droplet and airborne transmission). The modes of transmission vary by type of microorganism and can be seen in table 1.

In some cases, the same microorganism may be transmitted by more than one route (for example norovirus, influenza and respiratory syncytial virus (RSV) can be transmitted by both contact and droplet routes).

Route	Mode of transmission
Contact (e.g: *C.difficile* / *Staph. aureus*)	• **Direct** Direct spread of infection occurs when one person infects the next; by person-to-person contact for example, chicken pox, tuberculosis, sexually transmitted infections etc. • **Indirect** Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens, for example, the hands of a healthcare worker can become contaminated with infectious organisms from contact with a contaminated item of equipment; these may then be spread to a patient
Droplets and aerosols (Eg: SARS / Influenzae)	• Transmission of these viral agents occurs mainly because of the shedding of virus in liquid respiratory particles into the air from the respiratory tract of an infectious person • These particles are shed when coughing, sneezing, talking and breathing. Respiratory particles shed from the respiratory tract can cause infection if the virus in the particles reaches the respiratory mucosa of a susceptible person • The virus can reach the respiratory tract mucosa (eyes, nose and mouth) of a susceptible person in two ways: **1.** Travelling directly through the air to the respiratory tract, or **2**. Indirectly as a result of contamination of hands or other surfaces and subsequent transfer to the respiratory mucosa (see above regarding contact transmission).

Table 1. Routes of transmission (IPC, National Clinical Guideline No30, Department of Health, 2023)

The standard theoretical background to droplet and aerosol transmission

The theoretical background to these distinctions has been that larger, heavier liquid respiratory particles are considered as droplets (i.e. once expelled they quickly ‘drop’ from the air) whereas smaller, lighter liquid respiratory particles suspend in the air for longer periods causing aerosolisation (i.e. remain airborne).

Droplets are expected to land on surfaces or to fall out of the air on to surfaces, including respiratory mucosa, quickly and within a short distance of where they are generated. Spread in this way is known as droplet transmission.

Examples of infections categorised as:

Droplet transmitted:

1. *Neisseria meningitidis*
2. Influenza virus
3. Respiratory syncytial virus

Airborne transmitted

1. *Mycobacterium tuberculosis*
2. Chickenpox
3. Measles

3.0 Managing IPC

Successful IPC involves implementing work practices that reduce the risk of transmission of microorganisms through a two-tiered approach, including:

- Routinely applying basic IPC strategies to minimise risk to both people who use healthcare services and healthcare workers (**standard precautions**)

- Effectively managing microorganisms where standard precautions may not be sufficient on their own – these specific interventions control infection by interrupting the mode of transmission (**transmission-based precautions**).

3.1 Standard precautions

This term refers to those work practices that are applied during care for everyone, regardless of their perceived or confirmed infectious status.

Implementing standard precautions as a first-line approach to IPC in the healthcare environment minimises the risk of transmission of microorganisms from healthcare worker to patient, or from patient to patient, even in high-risk situations.

Standard precautions include:

- Hand hygiene according to the WHO 5 moments for hand hygiene (WHO, 2009)
- Use of appropriate personal protective equipment (PPE)
- Safe injection practices (safe use and disposal of sharps)
- Environmental hygiene
- Management of patient care equipment (single use devices and reprocessing of reusable medical equipment and instruments)
- Respiratory hygiene and cough etiquette
- Aseptic technique
- Waste management
- Handling of laundry and linen.

Why are standard precautions essential?

- People may be placed at risk of infection from others who carry infectious microorganisms
- People may be infectious before signs or symptoms of disease are recognised or detected
- People may be at risk from infectious microorganisms present in the surrounding environment including environmental surfaces or from equipment
- There may be an increased risk of transmission associated with specific procedures and practices.

3.1.1 Hand hygiene

No.	Section	Recommendation	*Grade / level
1	**Hand hygiene**	Routine hand hygiene is performed according to the World Health Organisation technique: • Before touching a patient • Before a clean or aseptic procedure • After body fluid exposure • After touching a patient • After touching a patient's surroundings Hand hygiene must also be performed before putting on gloves and after the removal of gloves.	Strong recommendation, strong evidence
2	**Hand hygiene**	Alcohol-based hand rubs that contain between 60% and 80% v/v ethanol or equivalent should be used for all routine hand hygiene practices.	Strong recommendation, strong evidence
3	**Hand hygiene**	Soap and water should be used for hand hygiene when hands are visibly soiled.	Strong recommendation, strong evidence
4	**Hand hygiene**	In the presence of known or suspected *Clostridioides difficile* and viruses such as norovirus, hand hygiene must be performed as follows: • If gloves are worn and appear intact on removal, then alcohol-based hand rub remains the agent of choice for hand hygiene • If gloves have not been worn, if gloves have been breached or if there is visible contamination of the hands despite glove use, use soap and water to facilitate the mechanical removal of spores • After washing, hands should be dried thoroughly with a single-use towel.	Strong recommendation, weak evidence

Table 2. Hand hygiene recommendations (IPC, National Clinical Guideline No. 30, Department of Health, 2023)

No.	Section	Good Practice Point	*Grade / level
2	**Hand hygiene**	Alcohol-based hand rubs that meet the requirements of European Standard EN 1500 should be used for **routine** hand hygiene practices.	Practice statement

Table 3. Hand hygiene good practice statement (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Effective hand hygiene is the single most important strategy in preventing HCAIs (World Health Organisation, 2009). Ease of access to alcohol-based hand rubs and hand-washing facilities (soap, water and paper towels) can reduce the transmission of HCAIs.

Washing hands with soap and water is required if hands are visibly soiled while either product can be used if hands are visibly clean.

What are the risks with a lack of hand hygiene?

- Infectious microorganisms transmitted by the contact or droplet route can potentially be transmitted by touch
- Some microorganisms are present on the hands most of the time (resident flora) while others are temporarily acquired during the performance of healthcare activities (transient flora)
- Hands can become contaminated through contact with respiratory secretions when coughing or sneezing.

Improved hand hygiene practices have been associated with:

- Sustained decreases in the incidence of infections caused by MRSA and VRE (Pittet *et al.* 2000)
- Reduction in healthcare associated infections of up to 45% in a range of healthcare settings (Department of Health, 2023).

Hand hygiene practices alone are not sufficient to prevent and control infection and should be incorporated into practice as part of a multi-faceted approach to IPC.

Hand hygiene training

Hand hygiene education and training is vital to ensure that healthcare workers have the knowledge and skills to identify opportunities for hand hygiene and to perform hand hygiene using an effective technique. Education and training may be provided in a variety of formats including e-learning and face to face demonstration.

Hand hygiene training can be accessed on HSeLanD (https://www.hseland.ie). At a minimum, all staff working in general practice regardless of grade should complete HSeLanD AMRIC hand hygiene module on induction and every two years thereafter.

When should hand hygiene be performed?

Hands can become contaminated with infectious microorganisms through contact with a person being cared for, their surroundings, the environment, or contact with other healthcare workers. Cross contamination can occur from one site to another in the same person, between healthcare workers and the person cared for, between the person cared for or healthcare workers and the environment or between healthcare workers.

The 5 moments of hand hygiene

The 5 moments for hand hygiene developed by the WHO https://rb.gy/n91s09 :

- Help to protect people who use healthcare services from acquiring infectious microorganisms from the hands of the healthcare worker
- Help to protect people who use healthcare services from infectious microorganisms (including their own) entering their bodies during procedures
- Help to protect healthcare workers and the healthcare environment from contamination with infectious microorganisms.

See figure 2 (patient consultation in a GP setting) and figure 3 (patient consultation in a healthcare setting e.g. residential care facility) for WHO 5 moments of hand hygiene illustrations. Please note that figure 2 does not contain moment 5 as patients do not have their own surroundings unless isolated in a room while awaiting treatment.

Figure 2. The WHO five moments for hand hygiene (WHO, 2012)

Individual actions for reducing risk:

Practical point

To facilitate good hand hygiene in a clinical environment, staff should be “bare above the wrists” when delivering direct patient care:

- Clinical staff should not wear long sleeves. If they do, then sleeves should be rolled up to the elbow
- Watches, wrist bands and other jewellery should be removed (wedding rings are permitted if it is a plain band)
- Fingernails should be kept short and clean
- False nails, gel nails, nail jewellery and nail polish are not to be worn
- Any minor cuts or abrasions are to be covered with a waterproof dressing.

Alcohol based hand rub (ABHR)

Alcohol based hand rubs should be easily accessible at the point of care. Provide ABHR in waiting areas, clinical rooms and consultation rooms. Ensure that ABHRs are replaced as needed according to manufacturer's instructions, and that a designated person in the practice has responsibility for this.

ABHR has:

- Excellent antimicrobial activity against Gram-positive and Gram-negative vegetative bacteria, *Mycobacterium tuberculosis* and a wide range of fungi
- Generally good antimicrobial activity against enveloped viruses including SARS-CoV-2
- Lesser and/ or variable antimicrobial activity against non-enveloped viruses (such as norovirus) depending on the product
- No activity against protozoan oocysts and bacterial spores (such as *C. difficile*).

ABHR poster can be accessed here

Use of alcohol-based hand rub: clinical hand hygiene

- Apply the amount of alcohol-based hand rub recommended by the manufacturer on to dry hands
- Rub hands together so that the solution comes into contact with all surfaces of the hand, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers
- Continue rubbing until the solution has evaporated and the hands are dry
- To ensure ease of access and promote hand hygiene compliance for staff and patients, alcohol hand rub dispensers should be located at all points of care. Undertake a risk assessment when placing ABHR dispensers – do not place near ignition sources / keep out of the reach of children etc.

Many ABHR products are available to purchase. It is recommended that products used in a clinical setting are compliant with the following standards:

- EN 1500: Hygienic Hand Rub (WHO, 2009)
- In view of the burden of norovirus outbreaks in Irish healthcare settings products should comply with EN 14476

Soap and water

Practical information:

Using liquid soap and water:

- Wet hands under tepid running water and apply soap
- Rub hands together for a minimum of 20 seconds so that the solution comes into contact with all surfaces of the hand paying particular attention to the tips of the fingers, the thumbs and the areas in between the fingers
- Rinse hands thoroughly under running water, then, pat dry with single use paper towels
- Nail brush / bar soap is not recommended in clinical settings
- Antibacterial soap is generally not required. Refer to IPC, National Clinical Guideline No.30, Department of Health, 2023 for further information on suitable products.

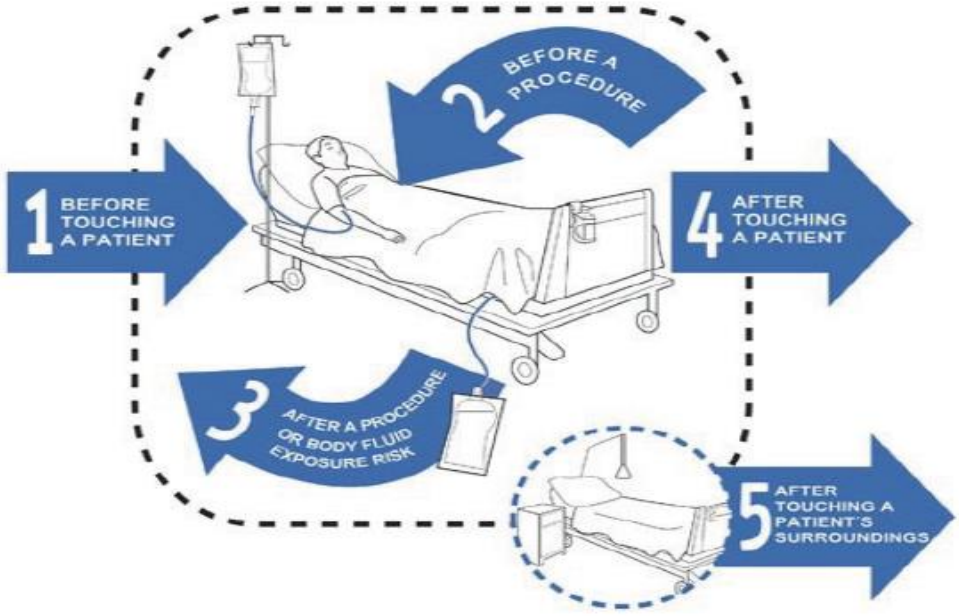

Figure 3. The WHO five moments for hand hygiene (WHO, 2009)

AMRIC posters and materials are available to support general practice staff on effective hand hygiene and appropriate glove use. These free resources are available to order online from www.healthpromotion.ie where they can be downloaded or ordered for delivery. Please see Appendix 1 HSE AMRIC educational resources and Appendix 2 for full suite of posters available to order or download.

3.1.2 Use and management of sharps, safety engineered devices and medication vials

No.	Precaution	Good Practice Point	*Grade / level
3	**Use and management of sharps, safety engineered devices and medication vials**	Dispose of single-use sharps immediately after use into an approved sharps container at the point-of-use. **The person who has used the single-use sharp is responsible for its immediate safe disposal.** Sharps containers must not be filled above the mark that indicates the maximum fill level.	Practice statement

Table 4. Single-use sharps, good practice statement (IPC, National Clinical guideline No.30, Department of Health, 2023)

No.	Section	Statutory requirement	*Grade / level
1	**Use and management of sharps, safety engineered devices and medication vials**	Statutory requirement: 1 SI 135 of 2014 Health and care workers should adhere to good practice related to safe handling of sharps including: • Not passing sharps directly from hand to hand • Keep handling to a minimum • Not recapping, bending or breaking needles after use. Health and care workers must also comply with all legislation that controls the management of Healthcare Risk Waste (HCRW) including sharps and healthcare non risk waste as well as workplace health and safety.	Statutory requirement

Table 5. Statutory requirement for the use and management of sharps, safety engineered devices and medication vials (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Every GP practice should have a standard operating procedure outlining risk assessment, management and advice to staff following a needle stick injury and blood and body fluid exposure.

This section on the use and management of sharps, safety engineered devices and medication vials should be read in association with the HSE policy on the management of sharps and prevention of sharp injuries (2022) and HSE guidelines for the emergency management of injuries (EMI) and post-exposure prophylaxis (PEP) (2024)

What are the risks?

Sharps injuries in healthcare settings may result in the transmission of blood borne viruses such as;

- Hepatitis B Virus (HBV)
- Hepatitis C Virus (HCV)
- Human Immunodeficiency Virus (HIV).

All health and care workers should take precautions to prevent injuries caused by needles, scalpels and other sharp instruments or devices during procedures, when cleaning used instruments, during disposal of used needles and when handling sharp instruments after procedures.

What constitutes an exposure injury?

- Penetration of skin by a needle / sharp that may contain blood i.e. needle stick
- Contamination of broken skin with blood
- Splashes of blood / body fluids into mucous membranes
- Swallowing a person's blood
- Human scratch (where blood is drawn).

Health and care workers may acquire a blood borne virus (BBV) if exposed to infected blood or body fluids. This could be via the mucous membranes (eyes, mouth and nose), through broken skin or through an inoculation injury where the skin is punctured or scratched by a needle or sharp device that has been used in a medical procedure. This final route is known as a needle-stick or sharps injury. Exposure can also occur while cleaning or conducting any activity in a working area where needles or syringes may be present.

Task associated with risk of blood / body fluid exposure	Suggested PPE
Venepuncture	Disposable gloves Consider plastic apron
Wound dressing / irrigation Minor surgical procedure	Disposable gloves Consider mask / visor / plastic apron

Table 6. Exposure risk assessment (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Eliminating workplace hazards

- Eliminating workplace hazard and risk is a fundamental principle of all workplace health and safety legislation
- In Ireland Statutory Instrument Number 135 of 2014 may be cited as European Union (Prevention of Sharps Injuries in the Healthcare Sector) Regulations 2014 is the key element of legislation in this area.

Medication vials

Single use vials:

- Single dose vial medications or solutions that come into contact with normally sterile tissue should be sterile
- The most effective way to avoid cross infection via injection of medication is through the use of single dose vials or ampoules and single use sterile injecting equipment
- Single dose vials or ampoules or prefilled syringes should be used wherever these are available
- These include the use of a sterile single use needle and syringe for each injection given and adherence to practices that prevent contamination of injection equipment and medication
- Medication should be stored and used as per manufacturer instructions, for example, temperature regulations, use by dates, and instructions for reconstitution if needed carefully followed.

How to prevent sharps injuries:

The hierarchy of controls method is a well-recognised approach used to prevent sharps injuries:

1. Eliminate and reduce the use of needles/ sharps if possible
2. Isolate the hazard (safety engineered devices / retractable devices)
3. If both measures cannot or do not provide total protection, the focus is on work practice controls and personal protective equipment (PPE).

Individual actions for reducing the risk of sharp injuries:

- Inform people who use healthcare services that there are risks to health and care workers and others involved in the use and disposal of sharps. Outline the measures taken to reduce these risks
- Become familiar with facility protocols on handling and disposal of sharps and relevant legislation
- Use the appropriate product for the situation and use it as directed - safety devices should be considered where appropriate to minimise risk of injury
- Avoid using needles where safe and effective alternatives are available
- Before using any sharp medical device such as needles or scalpels, always plan for their safe handling and immediate disposal at the point of use
- Make sure every used sharp medical device, such as needles and scalpels, is disposed of properly and that puncture resistant sharps containers are located at the point of use. The requirements for single use sharps containers are specified in ISO 23907:2019.
- Report any needle stick or sharps related injuries promptly in accordance with practice standard operating procedure and ensure the person receives proper follow up care
- Ensure that all staff who are at risk of coming into contact with blood or body fluids are offered vaccination against BBV such as hepatitis B and that their immune response has been checked
- All staff who use or handle sharps should be offered education sessions and professional development sessions on the safe use and disposal of sharps, as well as new safety devices and how to use them.

Disposal of all sharps

- The person who has used a disposable sharp instrument or equipment is responsible for its immediate safe disposal after use
- After they are used, single use syringes and needles, scalpel blades and other sharp items such as capillary tubes and glass should be placed in an appropriate container
- These containers should be clearly labelled, puncture and leak proof, and conform to ISO 23907:2019
- The container should be located at the point of use or, if this is not possible, as close as practical to the use area
- Sharps containers must be appropriately placed so that they are at an accessible height for the health and care worker but out of reach of children and others to prevent hands and fingers entering the disposal unit
- They should also be placed in a secure position or mounted on the wall to prevent tipping (approximately 1.3m minimum off the ground)
- The placement of wall mounted units should be away from general waste bins to minimise the risk of incorrect disposal. It is important to note that wall mounting sharps containers in areas occupied by patients, or freely accessible to patients, may represent a risk of injury
- Sharps containers should not be filled above the mark that indicates the maximum fill level
- The temporary closure should be in place when the container is not in use
- When transporting a sharps bin it should be held by the handle.

How to manage a sharps injury

Please see HSE guidelines for the emergency management of injuries (EMI) and post-exposure prophylaxis (PEP) (2024) for reducing risks if a sharps injury is sustained.

These guidelines are intended for use in emergency medical settings where a patient first presents with an injury (including needle stick or other sharps injury, sexual exposure, human bite, exposure of broken skin or of mucous membranes) where there is a risk of transmission of infection, in particular BBV).

These guidelines are relevant to injuries occurring to members of the public in a community setting and also to injuries sustained occupationally (such as to health and care workers (HCW).

Immediate procedure in the event of exposure injury / contamination

1. **Needle stick / sharps injury**
   - Encourage bleeding of the wound under running water
   - Do not suck the wound
   - Wash the affected area with water, or preferably with saline for sterility. However, clean tap water is sufficient.
   - Dispose of sharp appropriately
   - Use HSE EMI toolkit to determine if exposure was significant.

2. **Muco-cutaneous exposure**
   - Wash the affected area with water, or preferably with saline for sterility. However, clean tap water sufficient.
   - Use HSE EMI toolkit to determine if exposure was significant.

3. **Eye exposure**
   - Irrigate the affected eye with copious amounts of water
   - Use HSE EMI toolkit to determine if exposure was significant.

Note if exposure is deemed significant then you have two patients to consider - the source and the recipient.

3.1.3 Routine management of the physical environment

No.	Section	Recommendation	*Grade / level
5	**Routine management of physical environment**	Sites / surfaces should be cleaned and disinfected after spills of blood or other potentially infectious materials	Strong recommendation weak evidence
6	**Routine management of physical environment**	The use of sodium hypochlorite disinfection in addition to cleaning with a detergent solution is recommended for terminal disinfection of healthcare facilities when terminal disinfection is required. For those cases presenting with known or suspected *C. difficile* and norovirus, please refer to HPSC for specific recommendations.	Strong recommendation weak evidence

Table 7. Routine management of physical environment (IPC, National Clinical Guideline No.30, Department of Health, 2023)

No.	Precaution	Good Practice Point	*Grade / level
5	**Routine management of physical environment**	**1.** Clean frequently touched surfaces with detergent solution **at least daily**, when visibly soiled and after every known contamination **2.** Clean general surfaces and fittings when visibly soiled and immediately after spillage **3.** Ensure that water drainage points in sinks drain freely and completely and that surfaces are kept clean and dry.	Practice statement

Table 8. Routine management of physical environment, good practice statement (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Ventilation

For general practice settings, natural ventilation is generally considered appropriate. Emphasis should be on maintaining natural ventilation as much as practical by opening windows and doors, in so far as practical and consistent with comfort and security of patients and staff; the goal is gentle air circulation rather than strong air currents.

Exceptions to this should be justified by completing a risk assessment.

Environmental hygiene

Evidence suggests an association between inadequate environmental hygiene and the transmission of infectious microorganisms in healthcare settings (Dancer, 1999).

Transmission of infectious microorganisms from the environment to patients may occur through direct contact with contaminated equipment or indirectly for example from hands that are in contact with contaminated equipment or the environment and then touch a person.

Environmental surfaces can be safely cleaned using less rigorous methods than those used on medical instruments and devices. The level of cleaning required depends on the objects involved and the risk of contamination.

Routine environmental cleaning

- Routine cleaning with a neutral detergent and water is sufficient the majority of time as part of the routine management of the physical environment
- The additional step of disinfection of the environment may be required, for example after contact with a known infection, or a blood or body fluid spill. Follow manufacturer's recommendations with regard to correct dilution and contact times
- The algorithm figure 4 on the process for routine cleaning and product choice, supports decision making when determining what is required
- Cleaning must always be performed prior to disinfection
- Exceptions to this should be justified by risk assessment.

Use of disinfectants

To kill a microorganism any disinfectant must:

1. Have enough time in contact with the surface to kill the microorganism
2. Be used at the right concentration
3. Be applied to a clean surface
4. Be effective against those particular micro-organisms of concern.

Disinfectant:
Perform disinfection using a chlorine-based product such as sodium dichloroisocyanurate (NaDCC), sodium hypochlorite or another appropriate disinfectant **in addition** to standard cleaning in specific circumstances as required based on institutional guidance or risk assessment. For routine use, a chlorine-based disinfectant should be used with available chlorine at 1000-parts per million. If a non-chlorine-based disinfectant is used it should be a product suitable for use in a healthcare environment with bactericidal (EN16615), sporicidal (17126) and virucidal (EN14476) activity as required and be CE marked (Department of Health, 2023)

Table 9. Disinfection using chlorine based product (IPC, National Clinical Guideline No.30, Department of Health, 2023)

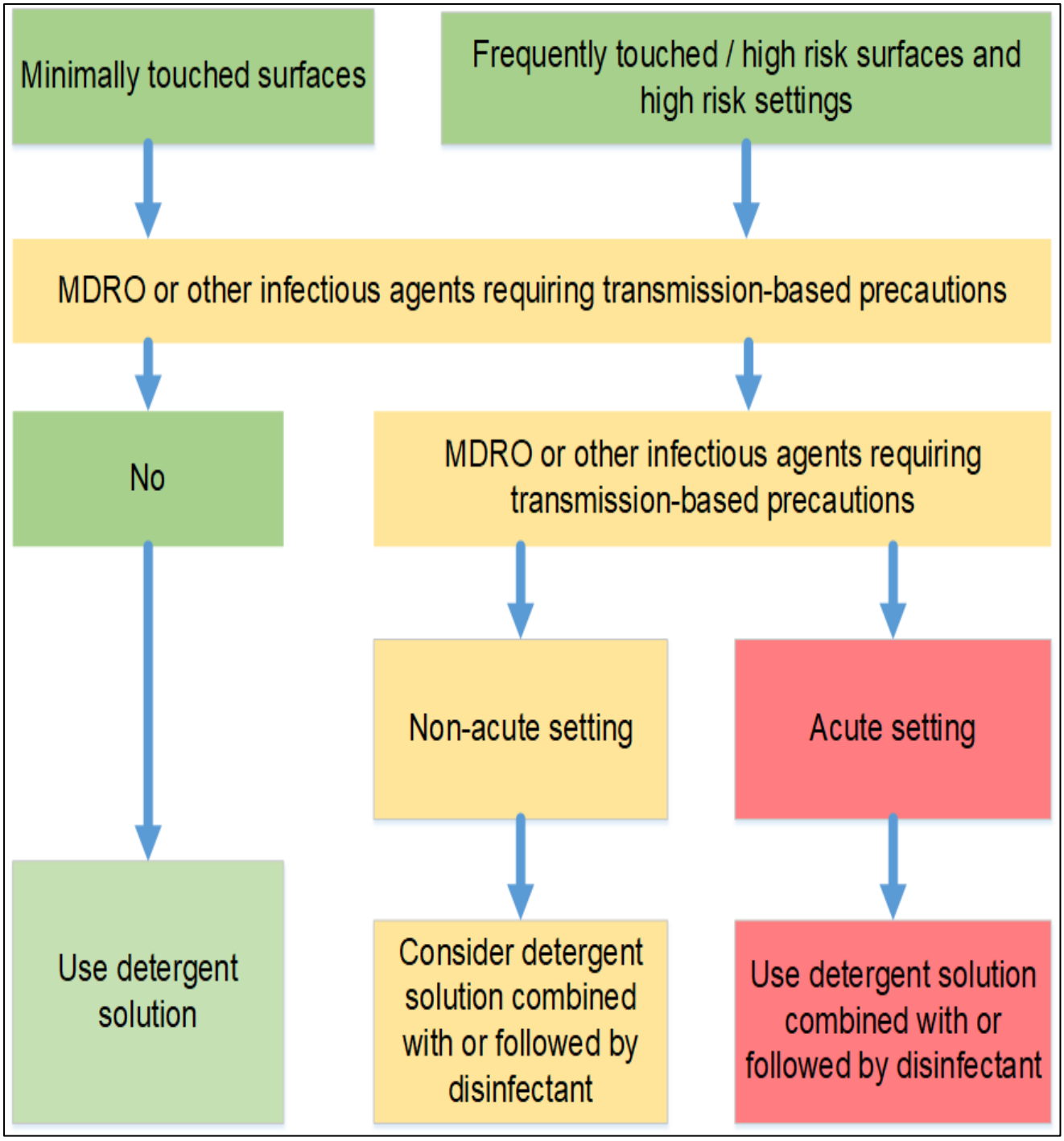

Figure 4. Process for routine cleaning and product choice (IPC, National Clinical Guideline No.30 Department of Health, 2023)

3.1.3.1 Emerging disinfection methods

No.	Section	Recommendation	*Grade / level
6.	**Routine management of physical environment**	The use of sodium hypochlorite disinfection in addition to cleaning with a detergent solution is recommended for terminal disinfection of healthcare facilities when terminal disinfection is required for example in seeking to end *C. difficile* and norovirus outbreaks. Note: terminal disinfection must always occur in the context of a process of terminal cleaning and disinfection.	Strong recommendation, weak evidence
9	**Emerging disinfection methods**	Recommendation AGAINST: The use of surfaces, fittings or furnishing containing materials with antimicrobial properties in healthcare facilities is **not** recommended as the evidence of added value compared with conventional cleaning and disinfection is not well established.	Strong recommendation, weak evidence

Table 10. Routine management of physical environment (IPC, National clinical guideline No.30, Department of Health, 2023)

3.1.3.2 Spills management

No.	Section	Recommendation	*Grade / level
5	**Routine management of physical environment**	Sites / surfaces should be cleaned and disinfected after spills of blood or other potentially infectious materials	Strong recommendation, weak evidence

Table 11. Routine management of spills (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Management of blood and body substance spills

Spills of blood and other high risk body fluids represent an infection risk and should be removed as soon as possible. Body fluids / tissue that should be handled with the same precautions as blood includes:

- Any body fluid containing visible blood
- Vaginal secretions
- Urine
- Faeces
- Vomit

Please refer to Figure 5: HSE AMRIC Management of blood and body spillages for further information.

Safety note:
Chlorine based disinfectants should not be added to a spillage of urine or vomit as it may result in a release of chlorine and chloramine gases.

Appropriate process for managing spills

Volume of spill	Process
Spot cleaning	• Select appropriate personal protective equipment (for example gloves and disposable apron)
	• Wipe up spot immediately with a damp cloth tissue or paper towel or detergent wipe
	• Discard contaminated materials
	• Perform hand hygiene
Small spills (up to 10 cm diameter)	• Select appropriate PPE (for example gloves and disposable apron)
	• Wipe up spill immediately with absorbent material such as paper towels
	• Place contaminated absorbent material into impervious container or plastic bag for disposal
	• Clean the area with warm detergent solution using disposable cloth, wipe or sponge
	• Wipe the area with sodium hypochlorite solution or wipe and allow to dry
	• Perform hand hygiene
Large spills (greater than 10 cm diameter)	• Select appropriate PPE (for example gloves and disposable apron)
	• Cover area of the spill with absorbent material such as paper towels and allow to absorb
	• Remove the absorbent material with absorbed fluid and place in an impervious container or plastic bag for disposal
	• If necessary the process of covering the area with absorbent material such as paper towels may be repeated to absorb remaining fluid
	• Place all contaminated items into an impervious container or plastic bag for disposal
	• Discard contaminated materials
	• Mop the area with detergent solution
	• Wipe the area with sodium hypochlorite and allow to dry
	• Perform hand hygiene.

Table 12. Appropriate processes for managing spills (IPC, National Clinical Guideline No.30, Department of Health, 2023)

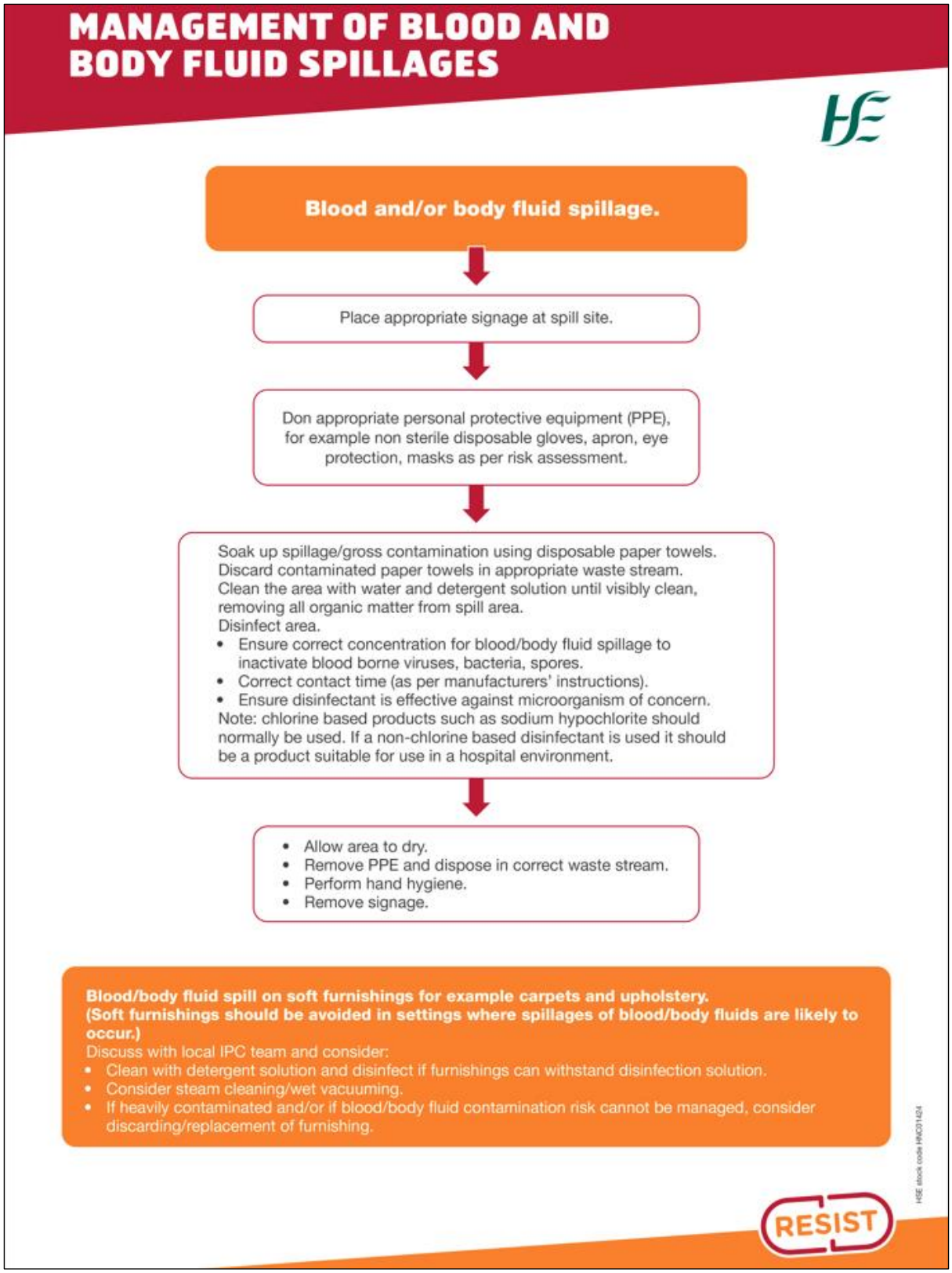

Figure 5. Management of blood and body spills, HSE AMRIC, 2021

AMRIC posters and materials are available to order online from www.healthpromotion.ie where they can be downloaded or ordered for delivery. Please see Appendix 2 for full suite of posters available to order or download.

3.1.3.3 Shared clinical equipment

No.	Precaution	Good Practice Point	*Grade / level
6	**Routine management of equipment**	Clean shared clinical equipment that comes into contact with skin, but not with mucosa, blood or body fluids, (that is non-critical equipment in the Spaulding classification) with a detergent solution between use on different people. Disinfection is also appropriate where indicated (for example colonisation with a MDRO). Exceptions to this should be justified by risk assessment.	Practice statement
7	**Routine management of physical environment**	Use surface barriers to protect surfaces such as examination couches that are in contact with a person's skin particularly if those surfaces are likely to be touched frequently with gloved hands during delivery of care or are likely to be contaminated with blood or body fluids or are difficult to clean. If release of body fluids is expected, the barrier should be impermeable. If the surface beneath the barrier is dirty or wet on removal of the barrier, the underlying surface should be cleaned and, if appropriate, disinfected. Exceptions to this should be justified by risk assessment.	Practice statement

Table 13. Routine management of physical environment, good practice statement (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Management of shared clinical equipment

Most equipment in GP practices will be **non-critical** and will be single use (vaginal speculums) or shared equipment that needs cleaning between patients.

This table below explains the level of risk and frequency of cleaning required for shared patient equipment.

Level of risk	Process	Example	Storage
Non critical (contact with intact skin)	Clean as necessary (after every use) with detergent solution. Disinfect if required.	• Blood pressure cuff • Stethoscopes • Sphygmomanometers • Crutches • Non-invasive probes	Store in a clean, dry place to prevent environmental contamination
Semi-critical (contact with intact mucous membranes or non-intact skin)	Clean as soon as possible after use. Steam sterilisation preferred	Vaginal speculum (reusable speculum only)	Store to prevent environmental contamination. May be more appropriate to use disposable in GP setting

Table 14. Classification of risk associated with shared equipment (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Cleaning and disinfection of shared clinical equipment

- While shared clinical equipment that comes into contact with intact skin only is unlikely to introduce infection, it can act as a vehicle by which infectious microorganisms are transferred between people
- Shared equipment should be cleaned with a detergent solution after each use with cleaning agents compatible with the piece of equipment being cleaned as per manufacturer instructions
- Detergent cleaning wipes are a practical way of applying the detergent solution. Where indicated disinfection may also be required following routine cleaning
- It is best practice to refer to the manufacturer's instructions and product safety data sheet prior to using disinfectants. Choosing a disinfectant that is compatible with the surface material is integral in order to avoid damage to the equipment.

Recommended method of cleaning for shared clinical equipment

The following table outlines the method of cleaning for most commonly used shared clinical equipment in general practice. This list is not exhaustive.

Equipment	Recommended method of cleaning
Airway	Single use – discard after use and do not reuse
Baby weighing scales	• Line the scales with disposable paper towels and change towel lining between babies • Clean with detergent wipes after every patient use or if visibly soiled clean and disinfect (body fluids)
Blood pressure cuffs	• Clean with detergent wipes after every patient use • If contaminated with blood / body fluids - can be cleaned and disinfected or if single patient use discard into clinical waste stream
Ear piece (or other components in contact with mucous membranes) for ear irrigation equipment	Single use only – discard after use
Ear irrigation equipment	Clean with detergent wipes after every patient use or if visibly soiled disinfect (follow manufacturer's instructions)
Ear piece for otoscope	Single use only – discard after use
ECG equipment	• Single use electrodes - discard after use • Straps and machine clean with detergent wipes after every patient use or if visibly soiled disinfect (follow manufacturer's instructions)
Examination couch	• Cover with disposable paper towel and change after each patient • Clean with detergent wipes after every patient use and clean and disinfect if visibly soiled • Disinfect appropriately if transmissible infection (i.e. *C. difficile*) or if soiled with blood or body fluids
Dressing trolley	• Clean with detergent wipes before and after every patient use • Clean and disinfect if contaminated with blood / body fluids
Glucometer	• Clean and disinfect after every patient use. • Follow manufacturer's instructions on disinfection
Nebulizer	• Single use masks and tubing – discard after use

Oxygen mask/ tubing	Single use – discard after use
Peak flow meters with filters	• Single use inserts - discard after use • Clean meter with detergent wipes after every patient use or clean and disinfect if soiled (as per manufacturer's instructions)
Speculum	Single use – discard after use
Sphygmomanometer	• Clean with detergent wipes after every patient use • Additional disinfection may be required if soiled with blood or body fluids / in presence of MDRO (Follow manufacturer's instructions)
Stethoscope	Clean with detergent wipes after every patient use
Thermometers	Use disposable tip covers
Tourniquets	• Single use preferred • If single use not available clean with detergent wipes and dry thoroughly between every patient use • Discard in clinical waste if contaminated with blood or body fluids

Table 15. Recommended method of decontamination for equipment used in patient care (IPC, National Clinical Guideline No.30, Department of Health, 2023)

3.1.4 Reprocessing of reusable / invasive medical devices (RIMD)

Single use items are preferable. In the event reusable invasive medical devices are used, they should be handled in a manner that minimises the risk of patient, HCW and environmental contact with potentially infectious material. Due to the variation in access to local decontamination units, where reusable invasive medical devices can be safely reprocessed, IPC promote the use of disposable devices in general practice.

Principles of reprocessing reusable invasive medical devices include:

- Before purchase, health care facilities should ensure that manufacturer's reprocessing instructions are provided and can be followed by the general practice staff
- Any medical device (instruments and equipment) that is to be reused requires reprocessing – cleaning, disinfection and / or sterilisation
- The minimum level of reprocessing required for reusable instruments and equipment depends on the individual situation and manufacturer's instructions (that is the body site and the way in which the instrument will be used)
- Single use medical devices should not be reprocessed for reuse. Exceptions to this should only be considered in an emergency situation, be based on a risk assessment and be for the shortest possible period of time.

Reusable medical devices

Practice actions for reducing risk with reprocessing reusable medical devices:

1. Familiarisation with ISO and EN standards and facility protocols on cleaning, disinfecting and sterilisation
2. Use the appropriate product for the situation and use as directed
3. Participate in educational sessions and professional development sessions on reprocessing instruments and equipment particularly when sterilising or disinfecting equipment is introduced.

Single use devices (SUD)

Single use devices are medical devices intended for use on an individual patient during a single procedure and then discarded. They must be clearly labelled "do not reuse". A medical single use device must clearly display a label the single use symbol, which means that the medical device must only be used once and then disposed of in the correct manner.

3.1.5 Respiratory hygiene and cough etiquette

Respiratory hygiene / cough etiquette should be promoted for all patients who present with signs / symptoms of respiratory disease (for example cough / febrile / rhinorrhoea / congestion).

Steps in respiratory hygiene and cough etiquette

Anyone with signs or symptoms of a respiratory infection, regardless of the cause, should follow or be instructed to follow respiratory hygiene and cough etiquette as follows:

1. Keep contaminated hands away from the membranes of the mouth, eyes and nose
2. Cover the nose with disposable single use tissues when coughing, sneezing, wiping and blowing nose
3. Ensure patients have access to tissues / hand hygiene facilities and face masks if needed etc.
4. If no tissues are available, cough or sneeze into the inner elbow rather than the hand
5. Hands must be cleaned after coughing, sneezing, using tissues, after contact with respiratory secretions or objects contaminated by these secretions
6. In health care facilities patients with symptoms of respiratory infections should ideally sit at least 1m away from others and wear a surgical mask if they can tolerate this. If available and compatible with patient care, health care facilities should place these patients in a separate area while waiting for care
7. Optimise natural ventilation by opening windows and doors in so far as practical and consistent with comfort and security of patients and staff; the goal is gentle air circulation rather than strong air currents.
8. Check www.hpsc.ie for guidance on infection prevention during specific infection outbreaks.

Staff:

- HCWs with viral respiratory tract infections should not attend for work and should remain at home at least until such time as their symptoms have resolved
- All workers should be offered vaccinations as relevant to their role, for example seasonal influenza, COVID-19 (see the following links HSE National Immunisation Office and HSE Occupational Health Guidance for further information).

Patients:

- Vaccination should be promoted in all healthcare settings for example seasonal influenza, COVID-19, pneumococcal
- Respiratory hygiene and cough etiquette are particularly important for people on droplet precautions
- Wearing a surgical mask (if tolerated) assists in reducing dissemination of respiratory virus in symptomatic patients and should be offered to all patients with symptoms of viral respiratory tract infection presenting in a healthcare setting
- Use of a mask is in addition to and not instead of the requirement to maintain distance from others.

3.1.6 Aseptic technique

No.	Section	Recommendation	*Grade / level
10	Aseptic technique	Sterile gloves are used for surgical aseptic procedures and contact with sterile sites	Strong recommendation, weak evidence

Table 16. Aseptic technique (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Aseptic technique protects patients during invasive clinical procedures by employing a variety of IPC measures that minimise, as far as practicably possible, the presence of pathogenic microorganisms.

The principles of asepsis / aseptic technique

Asepsis is defined as the absence of pathogenic (harmful) microorganisms, such as bacteria and viruses. The principles of asepsis / aseptic technique are:

- Reducing activity in the immediate vicinity of the area in which the procedure is to be performed
- Keeping the exposure of a susceptible site to a minimum
- Checking all sterile packs to be used are in date and there is no evidence of damaged packaging or moisture penetration
- Ensuring all fluids to be used are in date
- Not reusing single-use items
- Ensuring contaminated / non-sterile items are not placed in the sterile field
- Ensuring appropriate hand decontamination prior to, during and after the procedure.

When aseptic technique is performed, asepsis is ensured by:

- Using sterilised equipment
- Hand hygiene
- Identifying and protecting key parts and key sites
- Cleaning and disinfecting key sites
- Use of a non-touch technique
- Use of sterile equipment
- Disinfecting key parts prior to use (for example scrub the hub) for example asepsis during long acting reversible contraception (LARC) insertion.

Core IPC components of aseptic technique

- While the principles of aseptic technique remain constant for clinical procedures, the level of practice will change depending upon a standard aseptic technique risk assessment
- Aseptic technique cannot always be applied due to emergency or uncontrolled environmental conditions. Where this occurs, healthcare workers should aim to use the principles of aseptic technique
- Hand hygiene, gloves and aseptic fields are key points to consider.

When should an aseptic technique be used?

The following are some examples of when an aseptic technique should be used. This is not an exhaustive list:

- When inserting an invasive device
- When dressing wounds less than 48 hours old
- When dressing wounds healing by primary intention, for example surgical wounds
- When dressing deep wounds that lead to a cavity or sinus
- When dressing burn wounds
- Minor surgery procedures
- Suturing wounds
- Insertion of intrauterine devices (IUDs).

What is the difference between surgical and standard aseptic technique?

Standard aseptic technique

Clinical procedures managed with standard aseptic technique will characteristically be technically simple, short in duration (approximately less than 20 minutes) and involve relatively few and small key sites and key parts. Standard aseptic technique requires a main general aseptic field and typically nonsterile gloves. The use of critical micro-aseptic fields and aseptic technique is essential to protect key parts and key sites.

Surgical aseptic technique

Surgical aseptic technique is demanded when procedures are technically complex, involve extended periods of time, large open key sites or large or numerous key parts. To counter these risks, a main critical aseptic field and sterile gloves are required and often full barrier precautions. Surgical aseptic technique should still utilise critical micro-aseptic fields and aseptic technique where practical to do so.

3.1.7 Waste management

"At least 1/3 of risk waste is non-contaminated clean material"

www.greenhealthcare.ie

There is a requirement for separation of waste at source into HCRW and non-risk waste. HCRW is any waste that poses a risk due to its potential infectious nature and includes items contaminated with blood or body fluids, contaminated waste from patients with transmissible infectious diseases and other healthcare infectious waste.

In all cases prompt segregation and effective containment of HCRW will minimise potential exposure to the waste until safely disposed of, this is central to managing the risk.

In Ireland, the Waste Management Act (1996, revised 2024) places the primary responsibility for waste and its disposal on the producer or holder of the waste

When handling waste

- There is a requirement for separation of waste at source into HCRW and non-risk waste
- Apply standard precautions to protect against exposure to blood and body substances during handling of waste; perform hand hygiene following the procedure
- Segregation should occur at the point of generation
- Waste should be contained in the appropriate receptacle, identified by colour and label, and disposed of according to the facility waste management plan
- Healthcare workers should be trained in the correct procedures for waste handling
- Waste bags should not be overfilled
- Sinks and shower drains should not be used for disposal HCRW such as body fluids.

Healthcare waste (risk and non-risk waste)

Solid or liquid waste arising from the healthcare setting must be segregated at the point of origin into; (i) HCRW and (ii) Healthcare non-risk waste

HCRW	Non HCRW
• Hazardous / dangerous waste due to being infectious or contents could cause injury • Infectious material defined as substances containing viable microorganisms including bacteria, viruses, fungi and toxins	• Non infectious • Non chemical
Includes: • Blood or items soiled with blood • Items contaminated with faeces, urine or breast milk of known suspected transmissible micro-organisms • Incontinence wear of known or suspected enteric pathogens (e.g. *C. difficile*) • Sharps • Pharmaceuticals (unused drugs)	**Includes:** • Domestic waste • Confidential waste • Patient care equipment (items not contaminated with blood / body fluids) • Potentially offensive material deemed noninfectious (empty urine specimen pots / stoma bags / pregnancy tests / urine drainage bags)

Table 17. Healthcare waste, risk and non-risk waste (adapted from SARI, 2013 and aligned to IPC, National Clinical Guideline No.30, Department of Health, 2023)

Disposal of urine

- Urine samples may be emptied into the toilet / sluice and the container placed in black / clear bag
- Where there is no immediate access to a toilet, urine samples should be placed (still in primary container) in a yellow rigid bin with yellow lid
- Staff should always perform hand hygiene after handling specimens.

Safety note: Hand washing facilities should only be used for the purpose of hand washing i.e. should not be used for disposal of any body fluids (including urine) as this may give rise to the potential for infection from taps and sinks.

Waste segregation

Waste segregation must take place at the time of origin.

Figure 6.Segregation and packaging of HCRW and non-risk waste (Department of Health, 2014)

Resources

PDF copy of HSE segregation and packaging of HCRW and non-risk waste poster 2014 available for print https://bit.ly/4IXicZl

Best practice on bin placement for HCRW

Figure 7. Best practices on bin placement (HSE, Green Healthcare. greenhealthcare.ie)

For GP settings adapt the principles of good practice of bin placement to your clinical setting.

Resources

- HSE healthcare waste: best practice guide on bin placement
- For additional information see the following HSE Climate change and health and HSE healthcare waste management
- HSE guidelines for the preparation for transport of patient specimens and other biological materials
- See Appendix 2 for additional resources

3.1.8 Handling of linen

- The use of linen, such as blankets, pillowcases and fabric handtowels, in general practice are **NOT** recommended as it is not practical to launder items between each patient
- Best practice is to use disposable paper products, for example paper towels and couch roll
- All fabric blinds, curtains and screens should be visibly clean with no blood, bodily substances, dust, dirt, debris, stains or spillages
- If linen is used in the healthcare setting, please refer to refer to IPC, National Clinical Guideline No.30, Department of Health, 2023 (Volume 1, section 3, No. 3.1.8 Handling of linen, page 87).

3.2 Personal protective equipment (PPE)

No	Section	Recommendation	*Grade / level
17	**Personal protective equipment**	PPE including use of gloves, respiratory protection, face protection, aprons or gowns should be used as required by the task being performed and in line with standard or transmission-based precautions.	Strong recommendation, weak evidence
18	**Personal protective equipment**	Wear personal protective equipment; to protect the face and eyes during procedures that generate splashes or sprays of blood and body substances into the face and eyes, when entering the patient-care area when an airborne-transmissible infectious microorganism is known or suspected to be present and when entering the patient care area where AGPs associated with an increased risk of infection are performed on people with known or suspected infectious microorganisms normally transmitted by the droplet route.	Strong recommendation, weak evidence
19	**Personal protective equipment**	Single-use gloves are worn for: • Each invasive procedure • Direct contact with sterile sites and non-intact skin or mucous membranes • Any activity that has been assessed as carrying a risk of exposure to blood and body substances. Routine use of gloves for all clinical contact with people cared for is not appropriate. Use of gloves is not an alternative to hand hygiene.	Strong recommendation, weak evidence

Table 18. Personal protective equipment (IPC, National Clinical Guideline No.30, Department of Health, 2023)

PPE refers to a variety of barriers, used alone or in combination, to protect mucous membranes, airways, skin and clothing from contact with infectious microorganisms.

PPE used as part of standard precautions includes aprons, gowns, gloves, surgical masks, protective eyewear and face shields. Selection of PPE is based on the type of interaction with the person cared for, known or possible infectious microorganisms and the likely mode of transmission of those microorganisms.

Point of care risk assessment (PCRA)

Every interaction in general practice should include a risk assessment of the potential for infection transmission.

PCRA is an integral part of standard practice which should be performed by every HCW before every patient / resident / client interaction to allow them to accurately assess the risk of exposing themselves and / or others to infectious agents / transmissible microorganisms. This PCRA supports the selection of appropriate actions and PPE in addition to any IPC recommendations already in place such as patient placement and occupational aspects, (including healthcare worker vaccination) to further minimise any risk of exposure.

The HSE AMRIC point of care risk assessment (PCRA) and guide on how to use a point of care risk assessment for infection, prevention and control can be found on these links and Appendix 3.

Decision making about PPE

Selection of PPE must be based on assessment of the risk of transmission of infectious microorganisms to the person cared for or health and care worker and the risk of contamination of the clothing or skin of health and care workers or other staff by patients' blood, body substances, secretions or excretions.
Local policies and current health and safety legislation should also be considered.

Factors to be considered are:

- Probability of exposure to blood and body substances
- Type of body substance involved
- Probable type and probable route of transmission of infectious microorganisms.

Appropriate sequences and procedures for putting on and removing PPE are described below.

All PPE must meet appropriate standards. PPE should also be used in accordance with manufacturer's recommendations. PPE is always used as well as and not as a substitute for hand hygiene.

When to wear PPE

The HSE-AMRIC point of care risk assessment can assist in determining what PPE to wear for certain circumstances https://rb.gy/8hnjjo

Sequence for putting on and removing PPE

To reduce the risk of transmission of infectious microorganisms, PPE must be used appropriately. The sequence for putting on and removing PPE is illustrated in posters and videos published to the HSPC website and can be found on this link https://rb.gy/s63jqp

- Posters on how to put on PPE https://rb.gy/0tt69d
- Posters on how to take off PPE https://rb.gy/7rmhiz

In certain settings, patients may also be required to wear PPE. However, there may be issues around adherence when dealing with specific groups of people such as paediatric patients or people with dementia or claustrophobia. In these cases, other IPC measures should be applied.

Use of PPE by a patient should not be made a condition of access to care.

Practical Information:

Type	Recommended Use	Characteristics
Plastic apron	Suitable for general use when there is the possibility of sprays or spills or exposure to blood or body substances during low-risk procedures. Worn during contact precautions when limited patient contact is likely.	Fluid impervious. Single-use, for one procedure or episode of patient care. Disposable.
Full body gown	Worn when there is a risk of contact of the HCWs skin with broken skin, when extensive skin to skin contact (for example caring for a patient infected with scabies) is likely, or a risk of contact with blood and body substances which are not contained (for example caring for a patient who is vomiting). Worn when there is the possibility of extensive splashing of blood and body substances or there is a risk of exposure to large amounts of body substances (for example in some operative procedures). Worn when exposed to AGPs associated with an increased risk of infection.	Fluid impervious. Single-use and disposable. Long sleeved so clothing and exposed upper body areas are protected. Always worn in combination with gloves and other PPE where indicated as per PCRA.
Sterile gown	Fluid impervious. Single-use and disposable or reusable after reprocessing. Long sleeved so clothing and exposed upper body areas are protected. Always worn in combination with gloves and other PPE where indicated.	Pre-packaged

Table 19. Personal protective equipment recommended use (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Face and eye protection

Type of care	Indications for use	Face and eye protection required
Routine care	Routine exam	Not required unless caring for a person on droplet precautions (surgical mask) or airborne precautions (FFP2 mask)
Procedures that generate splashes / sprays	Clean wound or emptying catheter bag.	Protective eyewear/ full length face shield Fluid resistant surgical mask

Table 20. Personal protective equipment for face and eye protection (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Guidance when using a surgical mask include:

- Masks should be changed when they become soiled or wet
- Masks should never be reapplied after they have been removed
- Masks should not be left dangling around the neck
- Touching the front of the mask while wearing it should be avoided
- Hand hygiene should be performed upon touching or discarding a used mask.

Practical information for glove use

Gloves	Indications for use	Examples
Non-sterile gloves	Potential for exposure to blood, body substances, secretions or excretions including contact with contaminated equipment or environment. Contact with non-intact skin or mucous membranes.	Venepuncture. Vaginal examination. Management of minor cuts and abrasions.
Sterile gloves	Potential for exposure to blood, body substances, secretions or excretions. Contact with susceptible sites or clinical devices where sterile conditions should be maintained.	Surgical aseptic technique procedures for example Urinary catheter insertion. Complex wound dressings. Clinical care of surgical wounds or drainage sites.
Gloves suitable for clinical use		
Synthetic gloves (for example nitrile) procedures involving high risk of exposure to blood-borne virus and where high barrier protection is needed		
NRL (latex) glove is generally avoided because of concerns regarding latex hypersensitivity. If used select powder-free latex gloves to minimise the risk of latex sensitivity or allergies		

Table 21. Glove use (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Resources

HSE Safe use of gloves https://rb.gy/oezjhy

HSE Gloves off https://rb.gy/ycheh4

See Appendix 2 for ordering these free resources

3.3 Transmission based precautions

No.	Section	Recommendation	*Grade / level
12	**Contact precautions**	Hand hygiene be undertaken and personal protective equipment (PPE) be used as appropriate when healthcare workers have contact with people or with body fluids of people who require contact precautions.	Strong recommendation, weak evidence
13	**Contact precautions**	Where possible patient-dedicated equipment or single-use patient-care equipment be used for people on contact precautions. If common use of equipment for multiple people on contact precautions is unavoidable, clean the equipment, disinfect / sterilise if appropriate and allow it to dry before use on another person.	Strong recommendation, weak evidence
14	**Droplet precautions**	Healthcare workers implement droplet precautions when caring for people known or suspected to be infected with microorganisms transmitted by respiratory droplets. This includes wearing a surgical mask in the patient care environment when a minimum distance from a person on droplet precautions cannot be maintained.	Strong recommendation, weak evidence

15	**Airborne precautions**	Airborne precautions, in addition to standard precautions, are implemented in the presence of known or suspected infectious microorganisms that are transmitted from person-to-person by the airborne route and when Aerosol Generating Procedures (AGPs) associated with an increased risk of infection are performed on people with known or suspected infectious microorganisms normally transmitted by the droplet route.	Strong recommendation, weak evidence

Table 22. Transmission-based precautions (IPC, National Clinical Guideline No.30, Department of Health, 2023)

Transmission-based precautions are additional work practices in situations where standard precautions alone may be insufficient to prevent transmission of a known or suspected infection.

Within GP practice settings transmission based precautions may be required to contain a suspected or known infection until the patient leaves the setting, or are transferred to another healthcare setting.

Transmission-based precautions should be tailored to the particular infectious microorganisms involved and its mode of transmission. The HSE AMRIC Point of care risk assessment (PCRA) should be conducted.

Examples of infections categorized as

Droplet transmitted:

1. *Neisseria meningitidis*
2. Influenza virus
3. Respiratory syncytial virus

Airborne transmitted

1. *Mycobacterium tuberculosis*
2. Chickenpox
3. Measles

4.0 Risk assessments in general practices

All healthcare services, including GP practices, should determine the risks in their own context and select the appropriate course of action. Therefore, it is necessary for services and facilities to regularly conduct IPC risk assessments and ensure that all staff understand their responsibility in managing these risks.

How to assess my general practice for risks?

The following are resources which you may find useful when completing a risk assessment;

- The HSE Enterprise Risk Management Policy and Procedures 2023 provides additional information on risk management in the healthcare system in Ireland
- HSE AMRIC Point of care risk assessment (PCRA) poster and HSE AMRIC How to use PCRA guide

4.1 The risk management process

The HSE Enterprise Risk Management Policy and Procedures 2023 outlines the risk management process as summarised below:
Establishing the context i.e. the identification and assessment of risks requiring management
Risk assessment is comprised of three steps: a) **Risk identification** – a risk is something that may happen that could impact on the delivery of clean safe care. Ideally a risk should be identified before an incident has happened. (b) **Risk analysis** – is a process that is used to gain a better understanding of the risk identified and the level of risk associated with it. Assessing the level of associated risk takes account of controls in place to mitigate the risk. (c) **Risk evaluation** – this is a process to determine if the level of risk is acceptable. If the risk is not acceptable it is essential to consider how to treat the risk.

3. **Risk treatment** - this is the process of selecting and implementing measures to modify the risk. Monitoring and review is an essential component of the risk management process.

Table 23. Risk management process (HSE Enterprise Risk Management Policy and Procedures, 2023)

4.2 Case study: Measles virus outbreak

The Department of Public Health informs a general practice of an outbreak of measles.

The Department of Public Health will assist the practice with advice about management of potential exposures.

Information about the outbreak is communicated to all practice staff.

Establish the context: The context is a large general practice in the outer suburbs of Dublin, which caters for a diverse group of patients including disadvantaged groups and many young families.

Risk assessment

a) **Risk identification**: The risk is transmission of measles virus in the practice.
b) **Risk analysis**: measles is a highly transmissible infection; routes of transmission include airborne transmission.

   The degree of risk depends on the number of non-immune patients or staff in the general practice and community, and also the appropriateness of IPC practices in place.

   There is a risk of transmission of measles, primarily from infectious patients in the waiting room.

   The infection can be transmitted to any susceptible person breathing the same air as the infectious patient while the patient is present and for up to two hours after the patient has left the area.

   The infection also has the potential for indirect contact transmission if droplets settle on to surfaces.

   If appropriate IPC measures are already in place, then the risk may already be adequately addressed (treated).

c) Risk evaluation: If it is assessed as likely that a patient with measles will attend the practice and be in contact with a susceptible person and the consequence of transmission of measles is assessed as moderate to major, this is not an acceptable level of risk and additional risk treatment is required promptly.

Risk treatment: Suspected cases and cases of measles should be identified as quickly as possible and be managed from an IPC perspective as infectious cases whilst awaiting laboratory results.

Intermediate responses may include:

- Establish if all staff members are immune to measles
- Place signs at the entrance to the practice advising people to phone if they suspect they have measles or if they have a skin rash and temperature
- When there is a high risk of measles, implement the Screening for Potential Infectious Disease (for example measles) for administrative / reception staff document will help reduce risk available here
- Examine suspected cases in their own home where possible or arrange for them to be seen when the surgery is otherwise empty, for example at the end of a clinical session
- Communicate with the public by local media and or social media and display information for people coming to the practice at reception warning about suspected measles cases
- Identifying and managing any person that presents at the practice with suspected measles or similar symptoms for example suspected cases should avoid the waiting room
- Suspected cases should be given a surgical mask to wear and if at all possible taken to a separate room where they can be assessed by staff who are known to be immune to measles. If there is no separate room and they travelled to the surgery by car, it may be possible for them to wait in the car until they are seen
- Perform the consultation in a room which can remain vacant for two hours after consultation with suspected cases
- Identify any known high-risk patients (for example infants and unvaccinated children, immunocompromised patients) who may have an appointment at the general practice and consider potential for exposure
- Respiratory etiquette and hand hygiene can be encouraged through communication / information resources and staff
- Thorough surface and environmental cleaning and disinfection
- Clinically suspected and confirmed cases should be notified to the Medical Officer of Health promptly (Public Health Department).

Long-term measures may include:

- Providing additional education to staff on measles identification and management including the process for reporting this notifiable disease to the Medical Officer of Health and use of airborne precautions
- Review staff vaccination policy and records
- At risk staff who are not known to be immune and have not been vaccinated can be identified and encouraged to be immunised
- Consider which risks need to be actively managed, how this will be achieved and prioritise which actions to take based on the impacts.

Table 24. Case study: measles virus outbreak (IPC, National Clinical Guideline No.30, Department of Health, 2023)

5.0 Staff health and safety

The protection of healthcare workers from infection must be an integral part of the IPC and occupational health and safety programmes of every healthcare facility.

While the organisation has a duty of care to healthcare workers, staff members also have a responsibility to deliver patient care, to protect themselves and to avoid putting others at risk.

Five key measures of protection against infection prevention are:

- Health status screening and vaccination. All healthcare workers should be appropriately vaccinated in accordance with current national recommendations
- Education on safe work practices minimises the transmission of infection
- Safe systems of work within workplaces designed to minimise the transmission of infection
- Physical protection including the use of appropriate PPE when required
- Reporting systems for compliance to include reporting as required to statutory bodies and identifying breaches of IPC protocols.

Resources
The National Immunisation Advisory Committee (NIAC) Immunisation Guidelines for Ireland

6.0 References

Dancer SJ. (1999) Mopping up hospital infection. Journal of Hospital Infection 43:85-100

Department of Health (2023) IPC, National Clinical Guideline No.30.

Department of Health and Children (2020), Healthcare risk waste management, segregation, packaging and storage guidelines for healthcare risk waste. 4th edition

Department of Health and Children (2010), Healthcare Risk Waste Management Segregation Packaging and Storage Guidelines for HealthCare Risk

Health Information and Quality Authority (HIQA), (2017) National Standards for the Prevention and Control of Healthcare Associated Infection in Acute Healthcare Services.

HSE Public Health: National Health Protection Office (2024). Guidelines for the Emergency Management of Injuries (EMI) and Post-Exposure Prophylaxis (PEP) Version 1.1

HSE Enterprise Risk Management Policy and Procedures 2023

HSE Climate change and health (including links to waste management)

HSE National Immunisation Office

HSE Occupational Health Guidance

HSE policy on the management of sharps and prevention of sharp injuries (2022) Version 3

Pittet D, Hugonnet S, Harbarth S, et. al. (2000) Effectiveness of a hospital-wide programme to improve compliance with hand hygiene. The Lancet.356:1307-1312

A strategy for the control of antimicrobial resistance in Ireland – SARI (2013) Infection, Prevention and Control for Primary Care (SARI, 2013): a guide for general practice.

Waste Management Act (1996, revised 2024) Law Reform Commission Ireland

World Health Organisation. Guide to Implementation (2009). A guide to the implementation of the WHO Multimodal Hand Hygiene Improvement Strategy.

World Health Organisation (2012) 5 moments for hand hygiene paediatric consultation

7.0 Membership of the project team

Print Name	Title
Dr. Edel Doorley	HSE AMRIC GP Advisor and Project Lead
Eimear O'Donovan	HSE AMRIC Assistant Director of Nursing
Dr. Gwen Regan	Director of Nursing, IPC, HSE Access and Integration
Breedge Finn	HSE AMRIC Project Manager

8.0 Governance and approvals

Print Name	Title
Dr. Eimear Brannigan	HSE AMRIC Clinical Lead

Part B: IPC resources

Appendix 1: HSE AMRIC educational resources

A suite of bespoke AMRIC eLearning resources is available to provide additional educational content on topics contained within this guidance. A detailed list of all the AMRIC modules is available in the AMRIC Hub at https://www.hseland.ie
This online and development portal is available across all healthcare settings, HSE and non-HSE.

1. AMRIC eLearning modules
2. AMRIC Basics of IPC
3. AMRIC Introduction to IPC and Antimicrobial Resistance
4. AMRIC Hand Hygiene
5. AMRIC Standard and Transmission-Based Precautions
6. AMRIC Personal Protective Equipment
7. AMRIC Respiratory Hygiene and Cough Etiquette
8. AMRIC Management of Blood and Body Fluid Spills
9. AMRIC Routine Management of the Physical Environment
10. AMRIC Aseptic Technique
11. AMRIC Antimicrobial Resistance and Multi Drug Resistant Organisms
12. AMRIC Healthcare Associated Infections (HCAI): An Overview for Managers
13. AMRIC Outbreak – Prevention and Management
14. AMRIC Surgical Antibiotic Prophylaxis
15. AMRIC *Clostridioides difficile* Infection
16. AMRIC Antimicrobial Stewardship in Practice
17. AMRIC Prevention and Management of Urinary Tract Infection
18. AMRIC Prevention of Peripheral and Central Venous Catheter Related Infections
19. AMRIC The Basics of Microbiology and Surveillance
20. AMRIC IPC Risk Assessment
21. AMRIC The Role of the Registered Nurse / Midwife in Antimicrobial Stewardship (AMS)

Appendix 2: Poster resources

- **Printed resources for health care professionals** include the following:
    - HSE Standard precautions January 2023 V1.0 https://rb.gy/3frd92
    - HSE AMRIC How to hand wash poster https://rb.gy/bqskqf
    - HSE AMRIC How to hand rub https://rb.gy/c3y7g5
    - HSE Safe use of gloves https://rb.gy/oezjhy
    - HSE Gloves off https://rb.gy/ycheh4
    - HSE AMRIC Point of care risk assessment (PCRA) poster https://rb.gy/rwyhyy
    - HSE AMRIC How to use PCRA guide https://rb.gy/059la1
    - HSE (2024) IPC recommendations for the use of Personal Protective Equipment (PPE), V3. 21.08.2024 https://rb.gy/46qdic
    - HSE: How to put on personal protective equipment (PPE) https://rb.gy/0tt69d
    - How to take off Personal Protective Equipment (PPE) https://rb.gy/7rmhiz
    - A suite of resources including posters, videos and webinars relating to the safe donning and doffing of PPE is accessible at https://rb.gy/xyqx45
    - Follow appropriate sequence and procedure for putting on and removing PPE as outlined in HSE training materials, see poster section in: https://rb.gy/6rqwvi
- **Educational video resources** available on HPSC website https://rb.gy/ki4jzo

There are a number of AMRIC print resources available to order including awareness posters, guidance posters and patient information leaflets. These free resources are available to order online from www.healthpromotion.ie

Ordering is very straightforward, just set up a professional account when registering. To access the AMRIC resource select 'RESIST' from the search box. This will bring up the many items that are currently available to health professionals to order. Please allow seven days for the order to be completed.

Appendix 3: Point of care risk assessment (PCRA)

Point Of Care Risk Assessment (PCRA)

Infection prevention & control (IPC)

To be carried out before each patient* interaction

IMPORTANT Check patient's symptoms/ MDRO status/ travel history	Does the patient have unexplained rash, cough, sneezing / unexplained diarrhoea / fever or known MDRO. Suspected or confirmed droplet (eg influenza, meningitis) or airborne illness (e.g. chicken pox, measles, MDRX TB)	If yes:	PPE (as per below) determined by level of anticipated contact and type of activities. For suspected/confirmed droplet/airborne illness - medical (droplet) or respirator (airborne) mask as minimum
HANDS Perform hand hygiene as per WHO 5 moments	Can my hands be exposed to blood, body fluids, non intact skin, mucous membranes or contaminated items	If yes:	Don gloves
MUCOUS MEMBRANES	Will I be exposed to a splash, spray, cough, sneeze while I am within 2 metres of a patient/client	If yes:	ADD Facial protection (includes mask & goggles or visor)
SKIN/CLOTHING	Will my skin/clothing come in direct contact with blood, body fluids, non intact skin or items contaminated with body fluids	If yes:	Low contact activity = apron High contact activity = gown
IF CONDUCTING AN AEROSOL GENERATING PROCEDURE	Aerosol generating procedure (AGP) Does the patient have a suspected droplet/airborne illness or an emerging respiratory pathogen	If yes:	ADD FFP2/3 respirator

REMEMBER: Hand Hygiene (WHO 5 moments) to protect patients and yourself

*The term patient refers to patients, service users, clients, residents, person, supported individual

RESIST

Adapted from Nova Scotia Health authority/IWK Health Centre, Canada

Appendix 4: GP audit of safe management (handling and disposal) of sharps

		Yes	No	N/A	Issues Identified
1	Does your practice have a Management of Sharp Policy?				
2	Sharp containers in use comply with ISO 23907:2019 standards?				
3	Safety devices are available for use where required?				
4	Sharp containers have not been filled above the manufacturer's guideline and are free of protruding sharps?				
5	Sharp containers have been assembled correctly, dated and signed?				
6	Sharp containers are used in accordance with ergonomic manual handling principles (i.e. off the floor and using brackets)?				
7	Inappropriate re-sheathing of needles does not occur (observe or question a member of staff)?				
8	The temporary closure mechanism is used when Sharp containers are not in use?				
9	Sharp trays with integral sharps containers are available for use at the point of care. These trays are visibly clean and compatible with the sharps containers in use?				
10	Sharp should be disposed of directly into a sharp container at the point of use/care (if observed)?				
11	Once full the sharp containers are sealed and locked bins are stored in a locked room, cupboard or container, away from public access?				
12	An empty sharp container is available on the cardiac arrest trolley?				
13	Staff are aware of posters / policy detailing the procedure in the event of needle stick / sharp injury?				

Date:	
Auditor:	
Proposed date of re-audit?	

Appendix 5: Sharps audit outcome template

Audit Aim: Review of safe handling and disposal of sharps within general practice

Outcome: Sharps will be handled in accordance with guidelines in order to negate the risk of sharps injury

Audit Strengths:
1.
2.
3.
4.

Audit Weakness:	**Quality Improvement Plan / Person Responsible:**
Improvements required:	Actions necessary for improvement:
1.	
2.	
3.	
4.	

Signature of auditor: _____ Date: _____
Signature of practice manager: _____ Date: _____

Appendix 6: Audit template for alcohol based hand rub (ABHR) Hand Hygiene facilities

Section 1: Hand Hygiene using alcohol based hand rub (ABHR) audit template*				
	Criteria for staff	**Yes**	**No**	**Issues Identified**
1	Alcohol based hand rub (ABHR) is available in disposable single use cartridges or containers.			
2	The ABHR conforms to the national specification for alcohol based hand rubs.			
3	ABHR is available at entrances/exits.			
4	ABHR is available in clinical areas.			
5	ABHR is available at the point of care.			
6	Hand hygiene is promoted and encouraged for visitors.			
7	Hand hygiene is encouraged and promoted for patients / service users.			
8	An emollient hand cream is available for staff.			
9	Hand hygiene education is provided to staff on induction and every two years thereafter.			
10	Hand hygiene training records are available for inspection.			

Date:	
Auditor:	
Proposed date of re-audit	

*Adapted from HSE Community IPC Nursing Healthcare Audit Tools 2024

Appendix 7: Outcome audit template for using alcohol based hand rub (ABHR) Hand Hygiene

Audit Standard: That hand hygiene facilities using alcohol based hand rub (ABHR) complies with Department of Health, National Clinical Guideline No. 30
Outcome: Alcohol based hand rub (ABHR) hand hygiene is optimised within GP practice settings

Audit Strengths:
1.
2.
3.
4.

Audit Weakness:	**Quality Improvement Plan/Person responsible:**
Improvements required:	Actions necessary for improvement
1.	
2.	
3.	
4.	

Signature of auditor: _____ Date: _____
Signature of practice manager: _____ Date: _____

Appendix 8: GP audit of healthcare risk waste management

Audit Standard: Standard: That waste segregation and management complies with The Segregation, Packaging and Storage guidelines for Healthcare Risk Waste (Department of Health and Children, (DOHC 2010)					
		Yes	**No**	**N/A**	**Issues Identified**
1	A waste management policy is in place within the setting and staff are aware of their duty in relation to this?				
2	All waste is segregated appropriately at point of generation?				
3	Healthcare risk waste (HCRW) bins are available where required?				
4	HCRW bins are lidded, foot operated and in good working order?				
5	HCRW bins are emptied and replenished when ¾ full, or at a minimum daily / after clinic?				
6	HCRW bags are sealed using a “swan neck” method?				
7	HCRW generated in the practice is tagged for traceability as per waste management policy?				
8	There is a dedicated area for the safe storage of HCRW (inaccessible to the public)?				
9	The HCRW storage area is clean and there is evidence of a cleaning schedule?				
10	The HCRW storage area is cleaned immediately following a spill?				
11	Contingency plans are in place should additional waste collection be required outside of normal routine collections?				
12	Appropriate PPE is available for staff handling HCRW?				
13	There is evidence that the waste contractor is registered with a valid license?				

Date:	
Auditor:	
Proposed date of re-audit?	

Appendix 9: GP audit of healthcare risk waste management

Audit Standard: That waste segregation and management complies with 'The segregation, packaging and storage guidelines for healthcare risk waste (Department of Health and Children, 2010)
Outcome: Appropriate Health Care Risk Waste Management

Audit Strengths:
1.
2.
3.
4.

Audit Weakness:	**Quality Improvement Plan / Person responsible:**
Improvements required:	Actions necessary for improvement:
1.	
2.	
3.	
4.	

Signature of auditor: _____ Date: _____

Signature of practice manager: _____ Date: _____