Framework - Interim HSE Guidance on Infection Prevention and Control (IPC)

V.1.1

August 2020

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1.0	18th June 2020	Initial Guidance	AMRIC Team
1.1	10th August 2020	Updated document for publication	AMRIC Team

Contents

SECTION A: OVERVIEW

Introduction

The purpose of Infection Prevention and Control (IPC) is to support and enable the provision of necessary care with the lowest possible infection risk. IPC practice must never become a barrier to patient's access to appropriate and timely care in any setting or location.

Effective IPC is key to providing a high quality, safe healthcare service for the population it serves and a safe environment for those who work or visit health and social care settings. In the context of the current COVID-19 pandemic returning to routine clinical services that were scaled back in the early phase of the pandemic is challenging but is necessary to meet the requirement to provide essential care and deliver necessary service.

The risk of acquiring or transmitting COVID-19 in the healthcare setting (healthcare associated COVID-19), is managed using the same principles that are applied to the many other healthcare associated infections (HAI) and healthcare associated multi-drug resistant organisms (MDROs) that are a risk in this setting. As with other infection risks, in a health and social care setting the risk of COVID-19 cannot be completely eliminated but it can be mitigated. This guidance is intended to provide a framework for each service to enable them to review their IPC processes as they scale up activity during this phase of the pandemic. The focus is on core principles and priorities with reference to interim HSE Guidance on IPC.

Purpose

The purpose of this document is to provide a basis for managers, health and social care workers (HCW)/facilities and services to assess their IPC processes to support continuation of or resumption of service. Many of the required processes will already be in place; however, the current public health emergency provides an opportunity to reassess and adapt local protocols and processes to ensure these processes are fit for purpose in this more challenging context.

In this document, you will find:

- A risk framework based on the hierarchy of control and key IPC principles to consider when planning and delivering services.

- Checklists to support local review.
- A directory of resources that can be accessed to support local IPC planning.

Scope

This document is applicable to all health and social care settings. It is intended that this document will support a multidisciplinary assessment of IPC requirements.

Note re terminology: The term patient has been used throughout however; this document encompasses service users, residents and other individual as applicable to your own setting.

This framework should be considered in association with the Interim IPC Guideline and the Return to work safely protocol.

Assessing IPC requirements

As healthcare settings differ greatly in their function it is not possible to provide a one size fits all approach to managing risk on return to full clinical service. All healthcare facilities and services need to determine the infection risks in their own context considering the nature of the service, the setting and location of the facility, the human and other resources available and the current epidemiology of infection (specifically COVID-19) in the community served. A risk-based approach to managing IPC is outlined in the Interim HSE IPC Guidance.

Nonetheless, the core IPC principles remain the same - the consistent application of **Standard Precautions with all patients in all settings at all times.**

When resuming service, the following risks that require mitigation should be considered:

- Patients may acquire or transmit an infection including COVID-19 in the clinical setting.
- Staff may acquire or transmit an infection including COVID-19 in the clinical setting.
- Visitors or others present may acquire or transmit an infection including COVID-19 in the clinical setting.
- The risk that the IPC measures applied in a healthcare setting or service may be disproportionate to the level of risk and will impact adversely on patient care or service provision.

- The focus on one specific risk (COVID-19) may inadvertently lead to an increase in other risks including the risk of increases in other healthcare associated infections (HAI) or rates of colonisation with MDROS's for example CPE.

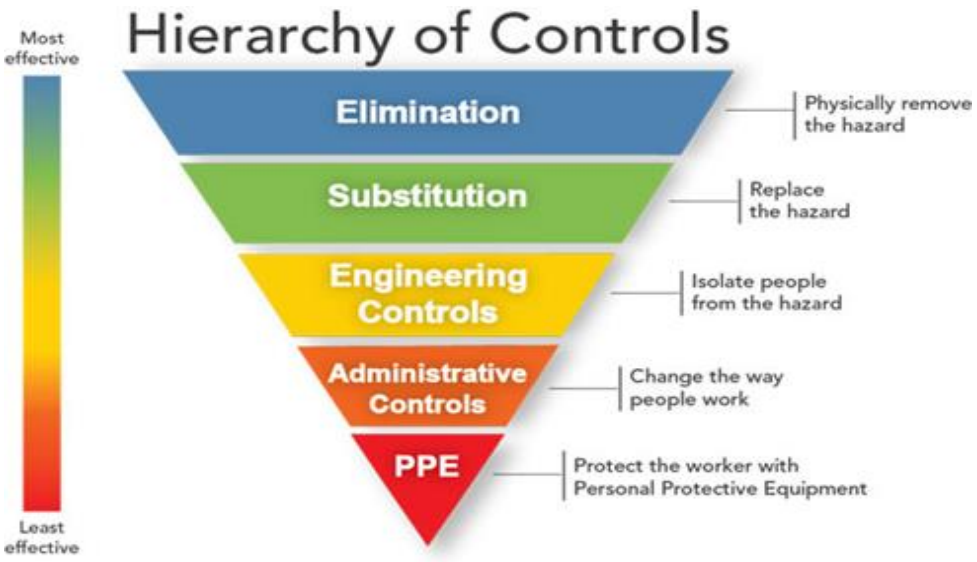
General Considerations

- Each service should identify a local lead or group for IPC who will draft a plan and support its implementation.
- There should be clear governance processes to review, adopt and drive implementation of the draft IPC plan for the service.
- Plans should include staff numbers, skill mix and training, supplies required for IPC, environment, communication, patient/client engagement and surveillance for healthcare associated infections including COVID-19.

Hierarchy of Control – A Framework

Limiting transmission of infection in a healthcare setting requires a range of measures, which can be considered as a hierarchy of controls (Figure 1.)

Figure 1: IPC Hierarch of controls



Source: CDC https://www.cdc.gov/niosh/topics/hierarchy/default.html

The concept arises from a health and safety perspective where the most effective control actions focus on eliminating hazards but in a healthcare setting, this can seldom be achieved. In the context of HAI, and specifically the COVID-19 pandemic the key point is that PPE is valuable to manage the residual risk remaining when all other measures to manage risk are in place.

Table 1. Examples of Use of the Hierarchy of Control – consider how such controls could be applied in your setting. All of these points should be considered for each service in the context of the Interim HSE IPC Guidance.

Please note:

- Some of these questions do not apply in every setting.
- Consider which questions are relevant to your specific setting.
- These questionnaires are not intended to be returned to national level - they are to support local /institutional review and planning for IPC.
- In the first instance, questions and gaps should be reviewed and addressed at local/institutional management level and only if they cannot be addressed at that level should they be escalated through the management pathway.

Elimination (remove the hazard)	In the context of HAI, the hazard is related to the presence of staff and patients/service users in a health or social care setting
	Is the service necessary?
	Can the service be delivered remotely (for example telemedicine)?
	Are there elements of the pathway/process of access and delivery of health or social care that add little value and can be eliminated to reduce the time spent in the healthcare setting and the number of people with whom the patient/service user has contact?
Substitution (providing the service in an alternative lower risk setting)	In the context of HAI substitution can mean the substitution of care in higher risk settings for care in lower risk settings
	Can the service be delivered in a setting that is less congregated setting (home/community/out-patients/day care/hospital)?
Engineering controls (providing facilities and equipment that isolate people form infectious microorganisms))	In the context of HAI engineering controls related to the capacity of the buildings/facilities in which health and social care is delivered to support IPC
	Does the building meet current requirements for IPC purposes including enabling minimum distancing between people (patients/service users and staff)?
	Does the building need to be adapted or extended to support IPC including enabling minimum distancing between people and what adaptation is practical (patients/service users and staff)?

	Does the building need to be reconfigured to support IPC including enabling minimum distancing between people and what reconfiguration?
	Does the building need more physical barriers between people and what is practical (for example transparent panels/windows/desk enclosures)
	Does the building need more hand hygiene facilities, storage and waste management facilities and what is practical to do?
	Does the building have appropriate controlled ventilation rooms/facilities to meet the requirements for the service and if not, what adaptation is practical?
	Ensuring that the building structure, fixtures and fittings including toilet and showering facilities are suitable to facilitate effective environmental hygiene
Administrative controls (supporting people in working in ways that mitigate risk of exposure to infectious microorganism)	This relates to how people work in health and social care service and how patient/service users engage with services
	Are there processes in place to ensure appropriate planning, implementation and review for IPC are in place for example in a hospital and IPC Committee and Team?
	Is there access to an appropriate level of IPC expertise to support the service? For example, in a GP practice, have you designated a person with overall responsibility for implementation of IPC?
	Is there a process in place to ensure in so far as practical that people with a communicable infection (including COVID-19) are identified and appropriately directed before they access the service? For example, are people asked about symptoms of COVID-19 before attendance is scheduled?
	Is there a process in place to ensure in so far as practical that staff with a communicable infection (including COVID-19) do not present for work or are identified on arrival at work and are appropriately managed? For example, if staff have diarrhoea on arrival or develop diarrhoea at work is there a process to ensure that they go off duty promptly?
	Is there a process in place to ensure in so far as practical that those who need to access the service and who have a communicable infection (including COVID-19) can be cared for appropriately and in a timely manner? For example, if a person presents to a hospital with tuberculosis is there a pathway to ensure appropriate care?

	Are there processes in place to ensure in so far as possible that those who have a communicable infection (including COVID-19) and who are accessing the service are promptly and effectively physically segregated from other patients/service users? For example, if a person with diarrhoea (due to Norovirus) attends a day-care service is there a pathway to appropriate segregation and care?
	Are there processes in place to ensure in so far as practical that people interact within consistent groups that are as small as possible? For example, in relation to respite care and disability services are the same group of people consistently cohorted together?
	Are there processes in place to ensure that staff have IPC training and/or information appropriate to their role and needs? For example, in a primary care centre has everyone been trained in hand hygiene and Standard Precautions?
	Are there processes in place to ensure in so far as practical patients/service users are supported with information on hand hygiene, cough etiquette, minimum distancing and mask use? For example, is there signage to inform and encourage adherence to IPC practices?
	Are there processes in place to ensure in so far as practical that there is effective surveillance for and response to incidents of HAI including outbreaks? For example, are cases of acute respiratory tract infection recorded and monitored?
	Are there processes in place to ensure in so far as practical periodic monitoring of facilities for wear/damage/breakage of buildings/fixtures and equipment, for documenting defects and ensuring repair or replacement? For example, is there a process to support and encourage staff to document and report defects?
	Are there processes in place to ensure in so far as practical effective environmental cleaning and where appropriate disinfection of the environment? For example, is there a schedule and checklists for routine cleaning
	Are there processes in place to ensure effective cleaning and decontamination of equipment? For example, is podiatry equipment cleaned and decontaminated, are there products available for cleaning stethoscopes between patients?
	Are there processes in place to ensure in so far as practical that antimicrobial agents are appropriately used? For example, in a residential care facility is there monitoring of antimicrobial use in patients with urinary catheters?
	Are there planned preventative maintenance and replacement programmes in place?

	For example, is there programme for maintenance and replacement of bed-pan washers?
	Are there processes in place to ensure that waste is appropriately segregated and managed? For example, in the homecare environment is there a plan in place for managing healthcare risk waste (for example sharps, vac dressings) in the homecare setting where required?
	Are there processes in place to periodically audit /review adherence to key IPC guidance (in particular hand hygiene and environmental hygiene)? For example, in a community mental health service is there a periodic check that guidance on being bare/above the wrist is being adhered to?
	Is there access to appropriate medical advice related to occupational health requirements for all staff for example in a residential care facility? For example, does everyone know who to contact if they have a needle-stick injury?
	Is there programme to ensure that staff and patients/service users are encouraged and supported to have all appropriate vaccinations? For example, in physical and sensory disability services is uptake of MMR by staff and clients reviewed?
	Is there a process to ensure that all IPC related supplies (cleaning, disinfection, PPE) meet appropriate standards/specifications and are fit for purpose? For example, does hand gel meet the requirement for 60 to 80% alcohol?
	Is there appropriate access to sample collection and laboratory analysis for infectious disease (including COVID-19)?
Personal Protective Equipment (PPE)	In the context of HAI PPE can be taken to include gloves, aprons, gowns, coverall suits, goggles, face shields, mask and hand hygiene supplies
	Are staff competent in risk assessing the tasks they commonly perform and in selecting appropriate PPE? Appendix 1 refers
	Are there adequate supplies of items of PPE commonly used and a process for stock monitoring and reordering? For example, does a hospital have a process to ensure that it has adequate supplies of both surgical and respirator face masks for the service it provides?
	Is training and support for use of PPE adequate? For example, have people been trained in donning and doffing?
	Is guidance on use of PPE clear and readily accessible? For example, do people have access to HSE training videos and posters?

Conclusion

Controlling the risk of healthcare associated infection during the COVID-19 pandemic remains grounded in doing what has always been good IPC practice – if this has not been fully implemented in the past, it is essential that it happens now.

The checklists below are intended to support you in addressing many of the key issues outlined above in more detail.

SECTION B: CHECKLISTS

Note:

- Some of these questions do not apply in every setting.
- Consider which questions are relevant to your specific setting.
- These questionnaires are not intended to be returned to national level they are to support local /institutional review and planning for IPC.
- Questions and gaps should first be reviewed and addressed at local/institutional management level and only if not, they cannot be addressed at that level should they be escalated through the management pathway.

Checklist 1 Measures to promote social distancing (Appendix 2 refers)

Measure(s)	Yes/No	Notes
Has a staff awareness campaign to promote social distancing rules been implemented? Example: Broadcast messaging to staff		
Communications posters and signage in place		
Lifts/Elevators/Stairs		
Have rules been introduced for the number of people who can safely maintain minimum distancing in the elevator? Example: Signage to support minimum distancing		
Is use of stairs encouraged where the person is able to use the stairs? Is there a single file notice for stairs and keeping distance? Example: Signage		
Changing facilities		
Has consideration been given as to how to ensure adequate space to support minimum distance when changing into/out of uniform/scrubs? Example: Re-purposing rooms for this if required		
Has consideration been given to the feasibility of providing secure lockers for staff to provide a safe place to leave personal items including rings, watches, phone and bags? Example: Re-purposing rooms for this if required		

Measure(s)	Yes/No	Notes
Clinical Areas		
Is the clinical space configured to support minimum distancing between patients/service users and staff?		
Has the requirement for physical partitions between patient care spaces (beds or chairs) been considered (partitions may be fixed or mobile depending on overall clinical requirements including emergency access)?		
Canteen/Restaurant/Dining facilities (if available onsite – please see HPSC Guidance for Food Service Businesses)		
Have seating arrangements in these areas been adapted to allow for minimum distancing between staff members who are eating?		
Has the queuing system for the service of hot and cold foods been adapted to ensure staff members can maintain minimum distance between themselves and the next person in the queue?		
Has contact between serving staff and those ordering food been minimised by distance or shielding where required? Example: Perspex shields		
Are cash-free/contactless payment methods available where possible?		
Are queues for payment managed in line with minimum distancing rules?		
Where practical is there a one-way flow system in the canteen with entrance and exit only doors or other arrangements to avoid congregation at entrance and exit points?		
Are alternative facilities available on the site to reduce the congregation of staff in the main canteen/restaurant? Example: A coffee dock		
Are out-door seating areas for staff dining/breaks available?		
Have staggered breaks/extended opening hours been introduced?		
Dining areas/Staff rooms/rest areas		
Have seating arrangements in these facilities been adapted to allow for minimum distancing between staff		

Measure(s)	Yes/No	Notes
members who are eating/having a break?		
Are breaks staggered to ensure minimum distancing where required?		
Have alternative options for refreshments and rest been provided on site to facilitate minimum distancing? Example: A coffee dock		
Are out-door seating areas available for staff dining/breaks where possible?		
Are there arrangements for staff to have breaks in separate areas during outbreaks where this is required?		
If overnight accommodation is provided has the facility been reviewed to ensure that common areas support minimum distancing, the facilities in other respects support minimising staff interaction and that cleaning and laundry services are appropriate?		
Work stations in Nurses stations, office, Clinical Areas and Clinical Teams		
Have the number of people who are likely to congregate at the ward workstation been limited to ensure compliance with minimum distancing?		
Where required have alternative/ additional workstations been established in clinical areas to prevent congregation of staff?		
Are daily clinical handovers and huddles conducted in a manner that respects minimum distancing rules and confidentiality? Example: A space that is big enough or reduce number who attend		
Group activities for patients/service users		
Have measures been implemented to adapt the usual routine for group activities to support minimum distancing?		
Have communal dining areas been modified to support minimum distancing?		
Have activities with small groups of residents, which require no physical contact be reintroduced where needed for welfare of service users?		

Measure(s)	Yes/No	Notes
Are group activities arranged to ensure that the same people are consistently grouped together where possible (pods) and a log is kept of those attending wherever practical?		
Have all room availability been maximised to support group activities with the least practical mixing of groups of people?		
Minimising mixing of different staff groups		
Have work practices been organised to ensure in so far as practical that staff members work in groups that are as small and as consistent in terms of membership as possible (pods)?		
Staff from other service areas /departments		
Is access to wards/units/service areas limited to only those staff who are required to sustain the service?		
Have patterns of movement been reviewed to minimise staff use of clinical/service areas to transit between areas of a building?		
Reception areas		
Are perspex screens in place to shield reception staff where people are presenting for information/appointment where appropriate?		
Do reception staff have access to tissues and surgical masks to provide to patients/service users if required?		
Waiting areas for visitors		
Have waiting areas and seating capacity been adapted to allow for minimum distancing? Example: Appointment based so limit the requirement for waiting areas		
Have measures been implemented to minimise wait times in the waiting area and to avoid congestion? Example: People advised to wait in car if practical		
Visiting		
Has technology been utilised (where feasible) to promote social interaction among residents and family/friends? Example: Use of tablets and video-links		

Measure(s)	Yes/No	Notes
Is there a plan in place to manage visiting that balances patient's needs for visitors with IPC requirements? Note. Visits are allowed by appointment generally; only one visitor can come to visit someone at a time. Only a small number of visitors can be in the clinical area at a time. Visitors should be asked about symptoms of COVID-19 when making the appointment to visit and the request to visit should be declined if the visitor has symptoms or is a COVID contact.		
Offices		
Has the layout in offices been examined and desks re-arranged where possible to allow staff to maintain minimum distancing?		
Has the requirement for screens between desks been considered if maintaining distance is difficult?		
Has consideration been given to work arrangements that limit the number of people in the office at any one time? Example: Facilitating work from home where appropriate, staggering shifts etc.		
Other Comments		

Checklist 2 Education and Training Infection Prevention and Control

Measure(s)	Yes/No	Notes
Does your service have access to appropriate infection prevention and control support? Example: Community IPCN, Health protection nurse in Public Health		
Does your service have a clear process for contacting public health when required? Example: Directory of numbers for Public Health		
Are staffing levels/ratio's/WTE's adequate to allow staff the time necessary to ensure IPC practice is adhered to?		

Is there practical and accessible IPC guidance available consistent with national or other relevant guidelines?		
Is training in IPC provided for all new staff at induction and for existing staff 2 yearly? Example: Hand hygiene training		
Is training in IPC documented?		
Are staff aware of the resources available to support knowledge and training e.g. hseland, videos on www.hpsc.ie?		
Are staff given dedicated time to undertake essential training in IPC?		
Are staff aware of how to access the most up to date information on COVID-19 relevant to their workplace?		
Are mechanisms in place to monitor compliance with recommended practices in particular hand hygiene? Examples: Acute: observational hand hygiene audits Community: checklists of hand hygiene facilities, bare above the wrist policies		
Is there access to relevant support for staff re occupational health and wellbeing?		
Are appropriate facilities provided for staff attending mandatory face-to-face training as required?		
Have staff completed training in the following areas		
▪ Self-monitoring for COVID-19 and actions to take when reporting illness/accessing testing		
▪ Standard and Transmission-based precautions		
▪ Has training addressed the following key elements of Standard Precautions		
➢ Hand hygiene		
➢ Respiratory Hygiene and Cough etiquette		
➢ Appropriate use of PPE		
➢ Donning and Doffing PPE		
➢ Preventing Sharps Injuries		
➢ Management of Healthcare risk and non- risk waste		
Patients		

Are supports available for patients to adhere to IPC practices (for example tissues, hand wipes)?		
Other Comments		

Checklist 3 Patients and visitors

Measure(s)	Yes/No	Notes
Are patients informed of the rationale for the measures being applied and what their own responsibilities are in terms of IPC?		
Are visual prompts about the importance of regular hand hygiene, minimum distancing, respiratory hygiene and cough etiquette, appropriate mask use in place at the entrance, in reception and waiting areas? Example: Posters, Flat screen displays, audio messages, floor signage		
Is there a system in place for assessment for evidence of COVID-19 that is relevant to the facility/institution? Example: Pre-attendance questionnaire, symptom/temperature and history of contact checked on arrival		
Is there a plan in place to manage visiting that balances patient's needs for visitors with IPC requirements? Note. Visits are allowed by appointment generally; only one visitor can come to visit someone at a time. Only a small number of visitors can be in the clinical area at a time. Visitors should be asked about symptoms of COVID-19 when making the appointment to visit and the request to visit should be declined if the visitor has symptoms or is a COVID contact		
Are information leaflets available for patients and visitors?		
Other Comments		

Checklist 4 Waste management

Measure(s)	Yes/No	Notes
General		
Are systems in place for the safe management of healthcare waste (risk and non-risk waste) for all settings (acute hospital and community including homecare)?		
Is your waste management service in line with HSE policy?		
Training		
Are up to date policies and procedures available?		
Have staff received up to date training in the appropriate segregation, handling transport and storage of waste appropriate to their setting?		
Implementation		
Are there appropriate waste bags and bins available to allow for correct segregation of waste?		
Can waste be segregated at the point of generation?		
Are the waste bins suitable for use in the areas they are in? Example: Correct specification		
Are visual prompts displayed which support correct segregation of waste? Example: Posters, labels for bins		
Is there a frequency schedule for checking/emptying bins appropriate to the level of activity in individual areas?		
Is there a schedule for cleaning and maintenance of waste bins?		
Does the service have an action plan to address the sustainability/environmental impact of its waste management policies?		
Compliance		
Is there a system for monitoring compliance with the segregation, management, packaging and storage of waste?		
Patients		
Are services available for patients to dispose of healthcare risk waste appropriately? Example: Self-medicating patients in the community – sharps		

Measure(s)	Yes/No	Notes
Other Comments		

Checklist 5 Environmental hygiene

Measure(s)	Yes/No	Notes
Resources		
Are existing cleaning resources adequate to allow regular cleaning of frequently touched surfaces in high through put areas?		
Is there a schedule for general maintenance and replacement of cleaning equipment?		
Are the roles and responsibilities of all persons involved in cleaning clearly outlined e.g. activities performed by external contractors, staff members?		
Are cleaning staff aware of the materials and methods for cleaning near patient equipment?		
Training		
Have staff who perform cleaning received training relevant to their role on hand hygiene and standard and transmission-based precautions?		
Do staff who perform cleaning know what personal protective equipment they require for performing routine cleaning and terminal cleaning in different settings?		
Have staff who perform cleaning received training in donning and doffing PPE?		
Environment		
Has your facility ensured all non-essential items have been removed (declutter)? Note. Removing personal items is generally not appropriate in a residential setting where the room represents the persons home		
Are all surfaces and floors made of suitable materials and in a good state of repair to facilitate cleaning? Example: Are surfaces smooth and intact and made of impervious material		

Measure(s)	Yes/No	Notes
Are furnishings; appropriate to the setting, easy to clean?		
Has a legionella risk assessment been completed and corrective actions taken as required?		
Policies and procedures		
Are cleaning schedules in place, which are appropriate to the type of activities, and footfall in the areas?		
Are policies and procedures in place for cleaning in non -public areas? Example: Staff spaces		
Are protocols available for cleaning methods?		
Are protocols available for the management of spillages of blood/body fluids?		
Are spill kits available (where appropriate)?		
Are staff familiar with and have access to the manufacturer's instructions for the appropriate dilution and use of detergents and disinfectants?		
Are standard operating procedures (SOPS) available for the care and maintenance of cleaning equipment? Example: Floor scrubbers, hoovers, mops etc.		
Has the frequency of cleaning in areas of high throughput been reviewed and increased as required? Example: Toilet facilities in ED departments and OPD		
Compliance		
Is there a system for monitoring /assuring high standards of environmental cleaning are in place?		
Other Comments		

Checklist 6 Hand Hygiene

Measure(s)	Yes/No	Notes
Training		
Have all staff completed two yearly hand hygiene training?		

Measure(s)	Yes/No	Notes
Has the service engaged with the relevant HSE hand hygiene train the trainer programme?		
Implementation		
Is there adequate access to hand hygiene facilities? Example: Availability of clinical wash hand basins appropriate to your service		
Is there an adequate supply of alcohol-based hand rub and is it available for use at the point of care?		
Are adequate supplies of alcohol-based hand rub available at entrances and waiting areas?		
Are there visual prompts to support good hand hygiene technique? Example: Posters displayed at wash hand basins in toilets		
Compliance		
Does your facility have a schedule for periodic review /audit hand hygiene facilities?		
Does your service consider/audit barriers to effective hand hygiene technique? Example: Wearing jewellery, false nails, long sleeves		
Where appropriate does your facility have a frequency schedule for undertaking observational hand hygiene audits to monitor hand hygiene compliance?		
Where appropriate do you have trained observational hand hygiene auditors? Note. Acute services only		
Patients		
Has the service considered ways to support good hand hygiene practice amongst patients?		
Visitors		
Is there access to alcohol-based hand rub or hand hygiene facilities for visitors?		
Are visual prompts displayed to support good hand hygiene practices for visitors? Example: Posters		
Other Comments		

Checklist 7 Personal Protective Equipment (Appendix 1 refers)

Measure(s)	Yes/No	Notes
Training		
Have all staff received training in donning and doffing PPE?		
Does your service have a schedule for updating staff training in the use of PPE?		
Have all relevant staff been fit tested (using quantitative or qualitative Measures) for respirator facemasks and taught how to fit check?		
Implementation		
Does the service have a system in place to monitor supplies of PPE?		
Does the service know whom to contact before PPE supplies run low?		
Are visual prompts available in relevant area that display the correct sequence for donning and doffing PPE?		
Are adequate supplies of PPE available at or near the point of care?		
Is there clearly defined process for escalation of concerns regarding items of PPE and are staff informed and empowered to use the process?		
Are there visual prompts to remind staff about the safe use of surgical facemasks and respirator facemasks and the safe use of gloves?		
Is there a process for confirming suitability of all items of PPE on receipt? Note. This is particularly important with donated items of PPE		
Compliance		
Does your service have a system in place to monitor the appropriate use of PPE?		
Patients/residents/service Users		
Is written information available for patients on the safe use of cloth face covers /masks including how to put them on and remove them?		
Other Comments		

Checklist 8 Patient Care Equipment

Measure(s)	Yes/No	Notes
General		
Have all staff received training in the care and maintenance of care equipment relevant to their role and setting?		
Are all staff aware of their roles and responsibilities in relation to the care and maintenance of care equipment?		
Are manufacturer's instructions for individual care items available to staff tasked with cleaning and decontaminating reusable items?		
Does the service have separate designated areas for storing clean and dirty equipment?		
Have staff been trained in difference between single use, single patient use and reusable equipment?		
Implementation		
Does the service have written SOPs for the cleaning and decontamination of individual care items?		
Does the service have frequency schedules for the cleaning and decontamination of reusable care items after use and before use with different patients between use on care equipment?		
Does the service have a system in place to monitor whether care equipment is cleaned and decontaminated between patients (trace systems)?		
Are maintenance schedules in place?		
Is there a schedule for replacing worn or damaged equipment?		
Are there adequate supplies of reusable equipment to allow staff sufficient time to decontaminate equipment appropriately?		
Do staff know how to escalate concerns about problems with the condition or supply of equipment?		
Is there a system in place to differentiate between equipment that has and has not been cleaned and decontaminated? Example: Coloured stickers		

Measure(s)	Yes/No	Notes
If reusable invasive medical devices are used, is there a person with designated responsibility to ensure appropriate decontamination?		
Compliance		
Is there a system in place to monitor equipment has been cleaned?		
Other Comments		

SECTION C: DIRECTORY OF RESOURCES

Education and Training in Infection Prevention and Control

Infection prevention and control core competencies

Core Infection Prevention and Control Knowledge and Skills: A framework document. May 2015

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/guidelines/

www.hpsc.ie

On-line E- Learning courses

- COVID-19- Resource packs
- ANTT-Aseptic Non-Touch Technique
- Breaking the chain of infection
- Introduction to infection prevention and control
- Hand hygiene for HSE Clinical Staff
- Hand Hygiene for HSE Non-Clinical Staff
- National Decontamination
- Putting on and taking off PPE in acute healthcare settings
- Putting on and taking off PPE in Community Healthcare settings

Available by registering at hseland

http://www.hseland.ie/dash/Account/Login

COVID-19 Guidance and Educational Tools

Guidance

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/

Posters

A range of posters on are available to download including

- Personal Protective Equipment (PPE)
- Healthcare setting
- Respiratory Hygiene Posters

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/posters/

Video resources for COVID

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/videoresources/

- Acute health setting COVID -19 video resources
- GP Primary Care Setting COVID-19 video resources
- Non-clinical staff COVID-19 video resources

Webinar resources

https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/webinarresourcesforipc/

Infection Prevention and Control Guidelines

IPC National Guidelines

National infection Prevention and Control Guidelines for healthcare facilities in Ireland (June 2020)

Primary Care Guidelines

Infection prevention and control for primary care in Ireland: A guide for general practice. April 2014

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/guidelines/File,14612,en.pdf

www.hpsc.ie

Home Helps and Personal Assistants

Infection prevention and control: An information booklet for home helps and personal assistants September 2014.

https://www.hpsc.ie/a-z/microbiologyantimicrobialresistance/infectioncontrolandhai/guidelines/

Health Care Associated Infections

Health care associated infection and antimicrobial resistance - general resources

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/resources/general/

Infection prevention and control programmes

Minimum requirements for Infection Prevention and Control Programmes (WHO) 2019

https://www.who.int/infection-prevention/publications/min-req-IPC-manual/en/

Standards for Infection Prevention and Control

Health Information and Quality Authority (HIQA) Standards

https://www.hiqa.ie/areas-we-work/standards-and-quality

National Standards for Infection Prevention and Control in the Community

https://www.hiqa.ie/reports-and-publications/standard/national-standards-infection-prevention-and-control-community

National Standards for prevention and control of healthcare associated infections in acute healthcare services

https://www.hiqa.ie/reports-and-publications/standard/2017-national-standards-prevention-and-control-healthcare

Occupational Health

Guidance on the Emergency Management of injuries and post exposure prophylaxis (PEP)

https://www.hpsc.ie/a-z/EMIToolkit/

National Immunisation guidelines

https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/

COVID-19

https://www.hse.ie/eng/staff/workplace-health-and-wellbeing-unit/covid-19-guidance

Estates

Infection Control Guiding Principles for Buildings Acute Hospitals and Community Settings

General Resources

Regional Departments of Public Health

How to access your local Department of Public Health

How to access Infection Prevention and Control advice in Community Settings

Useful websites

Health Protection Surveillance Centre **www.hpsc.ie**

Public Health England

Health Protection Scotland

World Health Organisation (WHO)

Environmental Protection Agency USA List of Disinfectants with efficacy against SARS CoV2 (Note there is no equivalent European version of this list available –

https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2#filter_col1

Patient Leaflets

https://www.hse.ie/eng/about/who/healthwellbeing/our-priority-programmes/hcai/hcai-amr-information-for-patients-and-public/patient-leaflets/patient-leaflets.html

Appendix 1: Appropriate Use of Personal Protective Equipment (PPE)
PPE - considerations for STAFF

Selection of PPE must be based on an assessment of the risk of transmission of infectious agents to the patient or carer and the risk of contamination of the clothing or skin of staff by patients' blood, body substances excretions or secretions.

Local policies and current health and safety legislation should also be taken into account.

- On April 21 2020, the National Public Health Emergency Team(NPHET) made a decision to extend the use of surgical masks in healthcare settings to the following:
  - Surgical masks should be worn by healthcare workers when they are providing care to people and are within 2m of a person, regardless of the COVID-19 status of the person.
  - Surgical masks should be worn by all healthcare workers for all encounters, of 15 minutes or more, with other healthcare workers in the workplace where a distance of 2m cannot be maintained.
- For the purpose of this guidance, healthcare workers should don a mask if they anticipate being within 2m or more of other healthcare workers for a continuous period of 15 minutes or longer. It is not intended that healthcare workers should attempt to estimate in the morning the total duration of a sequence of very brief encounters that may occur during the day.
- Wearing masks when providing care for certain categories of patient, for example patients who may need to lip-read, can present practical difficulties for patient care. In such circumstances, it is appropriate to perform an institutional risk assessment.
- If there are situations where it is not appropriate for healthcare workers to deliver care wearing a surgical facemask, the wearing of a visor may be considered, as although not equivalent to a mask, it does provide a substantial measure of protection.

Situational assessment for PPE

No physical contact

The tasks/activities performed do not involve touching the skin or clothing of a patient and there is no or minimal contact with the patient's immediate surroundings.
Examples: removing medicines from packaging, prompting people to take their medicines, preparing food for people who can feed themselves without assistance or cleaning, entering room to leave a food tray, giving out medication or switching off a call bell or alarm on a monitor.
NO PPE required. Hand hygiene as per WHO 5 Moments.

Low contact AND there are NO risk of exposure to blood, body fluids, non- intact skin or mucous membranes
The tasks/activities being performed provide minimal opportunity for the transfer of viruses or bacteria to the skin or clothing.
Examples include helping to feed a patient, assist a patient to sit up in bed, take a patient's observations, perform a clinical examination or check a urinary drainage bag.
PPE is unlikely to be required. Hand hygiene as per WHO 5 Moments.

Low contact AND there is a LOW risk of exposure to blood, body fluids, and non-intact skin or mucus membranes
The tasks/activities performed provide some opportunity for the transfer of viruses or bacteria to the skin or clothing of a healthcare worker, which can be minimised by wearing gloves and performing hand hygiene as per WHO 5 Moments.
Examples: insert a peripheral IV cannula, obtain a respiratory sample, and assist with oral hygiene, examining a wound, emptying a urinary drainage bag.
PPE: Gloves +/- disposable plastic apron depending on the task undertaken.

High contact and a low risk of exposure to blood, body fluids, non- intact skin or mucus membranes
The tasks/activities performed provide a low- moderate risk for transfer of virus or bacteria to the skin and clothing of a HCW.
Examples include changing incontinence wear, assisting a highly dependent patient with toileting, wound care (leg ulcer).
PPE: **In most instances, gloves and a disposable plastic apron will be sufficient for the task being undertaken**.

High contact AND there is a HIGH risk of exposure to blood, body fluids, Non- intact skin or mucus membranes

There is an increased likelihood of spraying or splashing of body fluids, excretions and secretions including respiratory droplets during the tasks/activities performed.

Examples: when performing operative procedures, assisting in trauma cases in ED.

PPE: Recommended when providing clinical care and within a 2m distance of patients. If there are no other indications for transmission-based precautions and you are not within a 2m distance of the patient then no PPE is required.

Degree of anticipated contact	Likelihood of exposure to blood, body fluids, mucus membranes or non-intact skin	Disposable Gloves	Disposable Plastic Apron	Gown	Surgical Face mask for source control i.e. to protect from onward transmission	Surgical facemask for personal protection	FFP2 Mask for personal protection	Eye/Facial Protection
No direct physical contact with the patient		No	No	No	As per NPHET decision May be sessional use	No	No	No
Low	No risk of exposure to blood, body fluids, non- intact skin or mucus membranes	No	No	No	As per NPHET decision May be sessional use	No	No	No
	Risk of exposure to blood, body fluid, non- intact skin or mucus membrane	Yes	Risk Assess- may not be required in some scenarios	No	As per NPHET decision May be sessional use	No	No	Risk assess -unlikely to be required in most scenarios.
High	Low Risk of contamination with splashes, droplets of blood or body fluid	Yes	Yes	No	As per NPHET decision May be sessional use	No	No	Risk assess unlikely to be required in most scenarios

Degree of anticipated contact	Likelihood of exposure to blood, body fluids, mucus membranes or non-intact skin	Disposable Gloves	Disposable Plastic Apron	Gown	Surgical Face mask for source control i.e. to protect from onward transmission	Surgical facemask for personal protection	FFP2 Mask for personal protection	Eye/Facial Protection
	High risk of contamination with splashes, droplets of blood or body fluid but procedure is not an aerosol generating procedure	Yes	Either a gown or plastic apron * depending on activity and amount of cover required		No	Yes And should be removed after the procedure is complete	No	Risk assess -may be required in some scenarios
All	Aerosol Generating Procedure	Yes	Either a gown or plastic apron *depending on the activity and amount of coverage required		No	No	Yes**	Yes

Disposable plastic aprons are sufficient in most instances and should be worn by healthcare workers to protect their uniform or clothes from contamination when providing direct patient care and during environmental and equipment decontamination.

Disposable fluid repellent long sleeved gowns or long-sleeved gowns or coveralls should be worn when a disposable plastic apron provides inadequate cover of staff uniform or clothes for the procedure or task being performed and when there is a risk of splashing of body fluids such as during AGPS in higher risk areas or in operative procedures.

**FFP2/FFP3 respirator face mask. The decision whether to wear a respirator or a surgical facemask when performing AGPs on NON COVID 19 patients depends on a risk assessment. Factors to consider, whether any other transmissible infection is suspected, the current epidemiology of COVID-19, if the person was tested for COVID 19 in advance of procedure, whether the patient has signs or

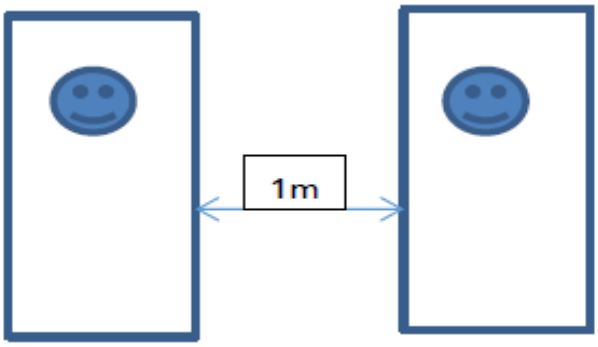
symptoms of respiratory illness, whether the patient is a close contact of a confirmed /suspected case of COVID 19, if the patient has cocooned for 14 days prior to procedure.

Appendix 2: Distancing

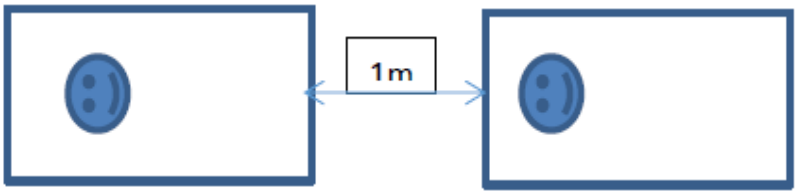
The following reflects distancing that meets IPC requirements as informed by COVID-19 pandemic.

Spacing between beds and trolleys

When lined up side to side a minimum distance of 1m is required from edge of bed/trolley to edge of bed/trolley.



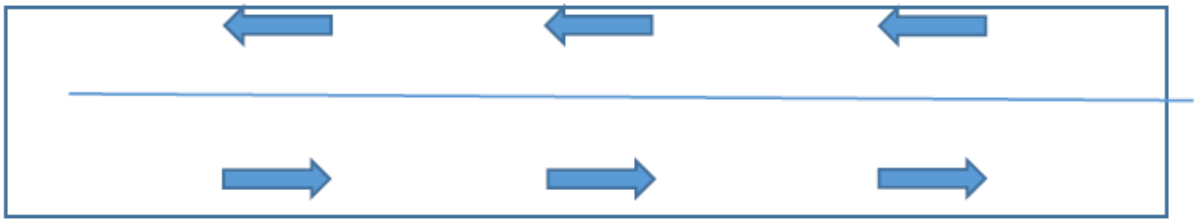
When lined up end to end a minimum distance of 1m is required from foot of bed/trolley to head of bed/trolley.



Corridors

People passing corridors is unlikely to be a major factor in spread of infection in healthcare if people do not form informal groups in the corridor. However, the possibility cannot be excluded. Therefore, newly constructed corridors should be of sufficient width to facilitate social distancing between people passing in the corridor. Where practical the layout should support unidirectional flow when this is required. In many existing buildings, unidirectional flow may have limited application because the building lay out does not support it or patients/service users and staff cannot be expected to use a long circuitous route to get from A to B following a one-way system when there is a short route direct route the other way. A user-unfriendly one-way system could be counterproductive to some degree since it could increase footfall as

well as impair efficiency. Marking a corridor as illustrated regardless of width may help to manage the risk of physical contact in corridors and thus to manage risk.



Lifts/Elevators

Newly installed lifts should be of sufficient size to facilitate social distancing. Many existing lifts are quite small. The number of people that can be accommodated in the lift with appropriate distance will depend on the size of lift and the purpose it is used for. In a lift for transporting a patient's /resident's in a bed, no one other than essential persons should be in the lift at that time. In lifts used for people standing or using chairs consideration should be given to maximise distance between people in the lift. The most practical arrangement is probably to demarcate the lift into halves or quarters with signage indicating that people are intended to stay in the half/quadrant and face forward (limiting face-to-face contact). Time in the lift is likely to be brief (minutes) and if people with symptomatic infection are not present, briefly occupying a lift with someone is very unlikely to contribute significantly to spread of droplet transmitted infection such as SARS-CoV-2 if people do not have physical contact and avoid informal group discussions. Excessively restricting the number of people who can use the lift could become counterproductive if the consequence is the number waiting for the lift build up at busy times.

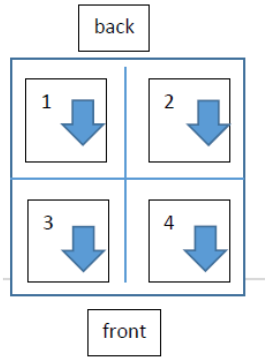
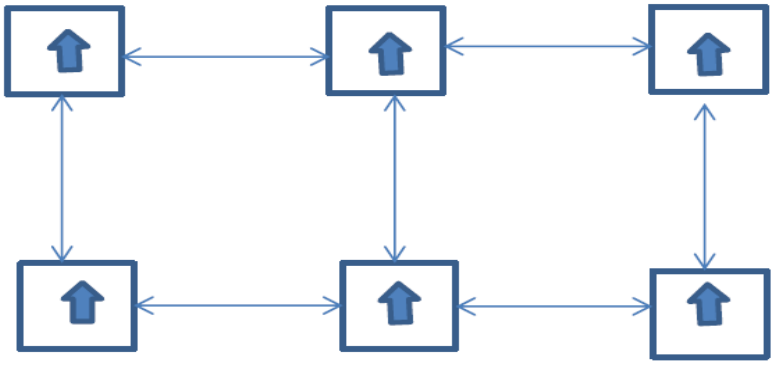


Diagram of seating arrangements in a public or patient waiting area



Ideally, seats available for use should be arranged to maintain distance. If the seating area is managed as clinical space with controlled access, a minimum distance of 1m must be maintained. The distance applies side to side and between seats in different rows. All seats should face the same direction (as per arrows) to avoid people being seated face to face. Where distance cannot be maintained in waiting areas patients and those who accompany them should wear a cloth face covering or provided with a surgical mask. Note where a patient is accompanied by a person and that person is from their household there is no requirement to maintain social distance.

Partitions/Screens

The priority in the first instance is to ensure that people with symptoms of COVID-19 (such as fever, cough, shortness of breath, sudden loss of sense of taste or smell) do not attend for work. If no virus is present, the virus cannot spread.

Patients of course need to be able to attend – the key there is to identify patients with suspected CVOID-19 as quickly as possible and to manage them with specific additional measures (single room etc.).

All of the measures applied otherwise are intended to manage the residual risk related to the possibility that a person (patient or worker) who may be infectious but is present in a general care areas or a work space but are not recognised.

The primary controls intended to manage spread of infection due an infectious person being present but unrecognised are hand hygiene, respiratory etiquette maintaining distance and surgical mask use in accordance with NPHET recommendations. The risk associated with droplet transmitted infection declines progressively with increasing distance therefore if it is not possible to maintain required social distance at all times in all settings the goal should be to keep as much distance as possible. Consideration should also be given to optimizing the natural ventilation of rooms and offices through window opening where possible.

If adequate distance cannot be maintained the use of screens is a practical measure to reduce exposure to droplet and can minimise the need to wear masks for extended periods when healthcare workers are seated at desks or similar situations in a shared space for an extended period.

In this context, the screen is intended to prevent droplets from one person impacting on the face or workspace of the other person. It is sufficient that the screen blocks the pathway from the nose and mouth to the face and workspace of the other person for most of the time. Screens do not need to be floor to ceiling. If two people are seated at workstations for most of the time the screen should be sufficient width and height to ensure that if the sneeze of cough while seated that the droplets impact on the screen not on the other persons face or work station.

Where screens are used in a clinical areas, (oncology day wards/dialysis units/ED) the height and width should be adequate to prevent spray from the nose and mouth of one person impacting on the face or space of another person – so the screen is required mainly in relation to the position of the head for most of the time when the person is present. Screens do not need to be floor to ceiling. Screens may be fixed or mobile depending on overall clinical requirements including emergency access.

Screens should be cleaned with detergent and water once or twice per day in an office space. In clinical areas, the screen should be cleaned with detergent and water or detergent wipes after the patient vacates the space and before the next patient arrives.

ENDS