Policy:
Decontamination - Environmental Cleanliness & Reusable Equipment

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Keywords | Decontamination, Reusable Equipment/Devices, Cleaning

**Policy Version and advice on document history, availability and storage**

This is version 2 of this policy and supersedes version 1 (October 2010).

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust’s website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version (V1) should be destroyed and if a hard copy is required, it should be replaced with this version.
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1. **Introduction**

Health and Social Care settings contain a diverse population of micro-organisms. Equipment used in patient areas becomes contaminated with blood, other body fluids, secretions and excretions during the delivery of care. Therefore, both the environment and the equipment or therapeutic devices used in the delivery of care must be managed appropriately in order to limit the risk of contamination from micro-organisms, which in turn, could potentially lead to the spread of infection.

Patients / service users within Mental Health & Learning Disability settings can be more susceptible to infection than their counterparts in the community. This is often related to pre-existing disease (e.g. Diabetes), invasive procedures or immunosuppressive treatment. Elderly patients / service users are especially susceptible to infection.

The risk of spreading infection is increased by the fact that patients or service users are admitted with existing physical health conditions, they share facilities within close proximity and have considerable contact with nursing, support and medical staff which provides ample opportunity for the spread of infection.

The high incidence of antibiotic use favours the emergence and spread of resistant bacteria which may be difficult to treat. Infections are costly in terms of prolonged patient stay; extra drug and operative therapy, there are also implications for the patient in terms of pain and suffering. There is an ethical duty to minimise risk to patients, and preventing healthcare associated infection should be an integral part of achieving quality care for patients & service users.

The aim of this policy is to reduce the risk of transmission of micro-organisms, and the subsequent spread of infection, by promoting effective cleaning and decontamination methods of the environment in which the patient / service user is accommodated; and of the equipment or therapeutic devices used in the delivery of care.

2. **Scope**

The target audience for this policy includes each directorate & all staff employed by Sheffield Health & Social Care NHS Foundation Trust (SHSCFT) whether seconded or not, agency staff, volunteers, contractors and apprentices.

Sterilisation requirements will not be discussed as part of this policy because no Directorate will be undertaking any type of steam sterilisation (autoclaving) processes in the Trust.

3. **Definitions**

**Patient** - is used to refer to any individual to whom we, the Trust, provide care. It is interchangeable with service user, resident, client and where appropriate tenant.

**Decontamination** - is the term widely used to collectively describe the combination of processes of cleaning, disinfection and sterilisation (medical Devices Agency, 1993/1996) to make a reusable device safe for further use on patients and safe for the user.

**Medical Device** - is any instrument, apparatus, appliance, material or other article used alone or in combination, intended by the manufacturer to be used for humans for any of the following purposes:
- Control of conception
- Monitoring, diagnosis and investigation
- Treatment, alleviation or compensation for injury or incapacity
• Replacement or modification of anatomy and physiology

**Cleaning** – A process which physically removes visible contamination (blood, body fluids, debris and accumulated deposits) and the majority of micro-organisms normally is using a general purpose detergent. A high standard of cleaning is essential with all surfaces having contact with the cleaning agent.

**Disinfection** – A process used to reduce the number of viable micro-organisms to a level at which they are not harmful. The process may not inactivate some viruses and bacterial spores. Disinfection must be carried out after cleaning has taken place and is achieved by either heat or chemicals.

**Sterilisation** – A process that removes and destroys all micro-organisms including bacterial spores. This is achieved by the use of heat or chemicals to ensure that the item is sterile at the point of use.

**Single Patient Use Equipment** - as stated by manufacturer, may be used a number of times for one patient only, e.g. hoist sling. Such equipment needs to be marked with the appropriate patient’s name, where possible, and disposed of when no longer required.

**Single Use Equipment** - as stated by the manufacturer, must be used once only and must not be reused. Equipment is marked with the single use sign (shown below). Single Use equipment must not be reprocessed under any circumstances.

4. **Purpose**

The over-arching purpose of this policy is to provide clean, safe care for our patients and to ensure that we as a Trust are compliant with Statutory Legislation.

- There is a managed environment, which minimises the risk of infection to patients, staff, visitors and carers.
- There is a system in place that ensures as far as reasonably practicable that all reusable medical devices are appropriately decontaminated prior to use and that the risks associated with decontamination facilities (dirty utility spaces) and processes are adequately managed.
- Health and Safety at Work regulations, which require employers to assess the risks to their employees and patients.
- Control of Substances Hazardous to Health regulations, provide a framework of actions designed to control the risk from a wide range of substances, including biological agents.
- EU council directive 93/42/EEC concerning medical devices; and EU council directive 93/94.EEC (product liability directive) concerning defective products.

5. **Duties**

**The Trust Board, via the Chief Executive will:**

- Ensure there are effective and adequately resourced arrangements for complying with decontamination requirements within the Trust.
- Identify a board level lead for Decontamination.
• Identify a board level lead for Infection Prevention and Control.
• Ensure that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2008).

**Director of Infection Prevention and Control (DIPC):**
The DIPC reports directly to the Chief Executive and the Trust Board. The DIPC duties are
• Corporate responsibility for IPC throughout the Trust
• To promote IPC considerations in other operational and development decisions of the Trust Board
• Overseeing local control of IPC policies and standard operating procedures, guidance & protocols and their implementation in conjunction with the IPC team.
• Challenging inappropriate clinical practice as well as antibiotic prescribing decisions.
• Assessing the impact of all existing and new policies and plans on infection and make recommendations for change.
• Have the authority to set & challenge standards of cleanliness
• Be a full member of the IPC Team and antimicrobial stewardship committee and regularly attend infection control committee meetings
• Being an integral member of the organisation’s clinical governance and patient safety teams and structures.
• Produce & present an annual report on the state of IPC in the Trust & release it publicly.
• Produce & present quarterly reports and an assurance framework to the Trust Board on the organisations performance in relation to IPC
• Provide leadership to the IPC team & IPC programme in order to ensure a high profile for IPC throughout the organisation.

**Director of Care Standards:**
• Clinical, operational and corporate staff understanding and enacting their responsibilities in meeting regulatory care requirements and standards across all Trust health and social care services.
• Compliance in practice with relevant legislative requirements including: the Mental Health Act; Mental Capacity Act; Care Act; Safeguarding Adults and Children; Infection Prevention and Control; and Health and Safety requirements.
• Compliance with local commissioners’ contractual requirements.
• Effective learning from complaints, incidents and serious incidents.
• Improvements in care / services / quality through the judicious use of the outcomes of inspection, scrutiny, clinical audit, internal audit, use of benchmarking data, incidents, serious incidents, complaints, performance / peer review and from service user / patient and staff experience / feedback.
• Application of effective quality improvement methodology that brings benefit.
• Effective utilisation of staff and service user experience / feedback to improve care / and people’s experience of giving / receiving care.
• Application of research and development in improving practice.
• Use of technology and innovation to enhance the effectiveness, efficiency, safety and accessibility of services.
• Professionally qualified staff being fully registered and / or accredited (revalidation) to practice and duly comply with their respective Codes of Professional Practice.
• Effective clinical governance: that services are safe, responsive, effective, well led and caring.

**Director of Estates and Facilities:**
• Informs the IPC Team of any new builds or refurbishment projects
• Is responsible for waste management provision across the Trust
• Is responsible for environmental domestic cleaning & hotel services across the Trust
• Is responsible for water quality for the Trust e.g. Legionella
Consultant Microbiologist:
- Provides relevant expert advice on a daily basis & supports the IPC Team.
- Advises & supports outbreak control and management as necessary
- Contributes to the review and update of policies and standard operating procedures, guidance or protocols including antimicrobial prescribing policy.
- Involvement in service specification including building and engineering works and purchase of medical or therapeutic devices/equipment.

Decontamination Lead:
- Every healthcare organisation must have a designated Decontamination Lead that has board level responsibility for the effective, technically compliant provision of decontamination services (where necessary).
- Be responsible for the implementation of an operational policy for Decontamination. He/she should ensure that the operational policy clearly defines the roles and responsibilities of all personnel who may be involved in the use, installation and maintenance of decontamination equipment (where appropriate); taking account of best practice & national guidance
- Is responsible for monitoring the implementation of the policy.
- Reports on incidents and on Decontamination related issues and risks to the Infection Control Committee & DIPC.

Medical Devices Safety Officer:
The Clinical Risk & Investigations Lead is the Trusts nominated Medical Device Safety Officer (MDSO) with the MHRA. The key purpose of this role is to promote reporting & learning and safe use of medical devices across the organisation and be the main expert resource in this practice area.

Senior Nurse Infection Prevention & Control Lead:
Support the DIPC and Deputy DIPC and is responsible for:
- Acting as a specialist resource for all health care workers, service users and relatives providing advice on the prevention and control of infection
- Strategic lead of educating staff on matters relating to IPC
- Identifying infection hazards and ensuring measures are taken to reduce those risks
- Monitoring IPC decontamination procedures
- Developing, implementing and monitoring the effectiveness of IPC policies and standard operating procedures, guidance & protocols.
- Managing outbreaks of infection and collecting/analysing mandatory & voluntary surveillance data
- Monitoring, identification and investigation of preventable infection
- Maintaining partnership working with other IPC specialists
- Maintaining an effective Link Worker Forum group
- Production of an annual work programme for IPC and quarterly reports of progress towards objectives set in the programme
- Assessing the risk of infection and advising on allocation of resources or actions required to reduce the risk
- Providing timely information to staff on effective control of infection measures
- Producing an annual report & quarterly reports on behalf of the DIPC
- Reporting relevant healthcare associated infections to the Public Health England (PHE) as directed by the Department of Health
- Provide specialist advice on new build projects and renovation, linen & waste within the Trust
- Facilitates an annual audit programme in regards to IPC

Clinical & Service Directors, Heads of Service, Ward Managers, Managers, Team Leaders
Have responsibility for local performance management with regard to IPC and are responsible for:

- Implementation of the Trust IPC policy and standard operating procedures ensuring that advice & recommendations given by IPC team is followed
- Establishing a cleanliness culture across their areas of responsibility ensuring the Environmental Domestic Cleaning Schedule is followed.
- Ensure every area has a written Departmental Cleaning schedule detailing the reusable equipment & devices which require decontamination between patient use
- Challenging poor practice and bring to the attention of the IPC team & Infection Control committee situations were significant risks have been identified and where local control measures are considered to be potentially inadequate.
- Individual management teams will be responsible for ensuring that staff attend IPC core mandatory & mandatory update training and adhere to Trust IPC policies and procedures.
- Identifying individual staff members to act as a local resource for IPC within each area (Link Workers).
- Facilitating feedback of information related to surveillance data
- Fully engage with the IPC audit process by developing and taking ownership of action plans to address areas of practice where improvement is required
- Ensuring IPC is a standing agenda item on all locally held governance meetings

Infection Control Link Workers will:

- Act as a role model for IPC practices
- Act as the channel for disseminating new information/training/educational opportunities so that staff are kept informed and inform their own clinical or social care areas and teams.

All Staff, Contractors, Agency, Apprentices, Secondees, Volunteers

Have a duty to adhere to infection control policies and associated guidelines. This responsibility to be explicit in all job descriptions and included as part of the annual appraisal system and personal development plans as appropriate. All staff are obliged to:

- Undertake IPC training relevant to their role
- Maintain effective implementation of IPC policies in their area of work
- Report infection control incidents and risks to their line manager, raise incidents via the Risk Department and contacting the IPC Team as necessary.

The Infection Control Committee:

- Receiving a quarterly report from the Senior Nurse to include outbreaks of infection MRSA and Clostridium difficile data
- Monitor Trust compliance with externally set targets i.e. CCG Quality Account
- Monitoring progress against the rolling IPC programme
- Receive, review and endorse the annual IPC report
- Considers national guidelines and their subsequent impact upon the Trust
- Review and endorse Trust policies and standard operating procedures for the prevention and control of infection and monitor implementation ensuring that such policies reflect legislation and published professional guidance including best practice.
- Ensuring that there is an annual programme of Audit in relation to IPC
- Discusses, amend and endorse plans for the management of outbreaks in the Trust
- Advise on the most effective use of resources
- Disseminating information and advice on prevention and control of infection to all Directorates and the Trust Board as appropriate.
- Promote and facilitate education of all grades and disciplines of staff in procedures for the prevention and control of infection.
6. Process

6.1 Risk Assessment
Medical/Healthcare equipment is categorised according to the risk that the particular procedure poses during the procedure. For example, items that come into contact with intact mucous membranes are classified as medium risk and require disinfection between each use as a minimum standard. Items that enter normally sterile body areas, or items that come into contact with broken mucous membranes, are classified as high risk and must be sterile before use.

<table>
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<tr>
<th>Risk</th>
<th>Application of item</th>
<th>Minimum standard</th>
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<tr>
<td>Low (non-sterile)</td>
<td>• In contact with healthy skin e.g. furniture, office equipment, mattresses, surfaces, commodes frames, hoist</td>
<td>Cleaning is usually adequate. Appropriate cleaning methods should be followed i.e. manufactures instructions</td>
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| Medium        | • In contact with intact mucous membranes  
• Contaminated with virulent or readily transmissible organisms (body fluids e.g. patients with MRSA/Norovirus  
• For use on immuno-compromised patients | Cleaning and disinfection (or sterilization)  
Use single use equipment wherever possible |
| High          | • In contact with broken skin or mucous membranes  
• For introduction into sterile body areas | Cleaning and sterilisation or single use |

6.2 Single Use Medical Devices or Equipment
Some high-risk devices cannot be disinfected or sterilised and must be single use. All single use items carry the single use logo displayed previously. Medical devices designated for single use must never be re-used. If a health or social care worker re-uses a single use device they will transfer the legal responsibility for the safe performance & liability of the product from the manufacturer to themselves. After use these items should be disposed of as clinical waste. If there is a choice between single use and reusable items, the single use item would normally be recommended. Legal issues include:
• If a single-use item is reused this may negate the manufacturer’s warranty.  
• The organisation would be liable under criminal law (Provision and Use of Work Equipment 1998) and civil law under the Tort of Negligence if damage or injury is caused by the reuse of single-use items.  
• An employee could be held liable under criminal law (Health and Safety at Work Act 1974) for reusing a single-use item and in civil law under their duty of care.

6.3 Decontamination of Reusable Devices or Equipment
Decontamination is a term used to describe the process of eliminating contaminants, which include micro-organisms and other unwanted material which would otherwise be conveyed to a susceptible site and cause infection or some other harmful response. The effective decontamination of reusable devices is essential to reduce these infection risks.
Decontamination methods will depend on the nature of the micro-organisms present and the infection risk associated with the surface, equipment, device or procedure.

Due regard & consideration prior to purchase of all reusable medical & therapeutic devices must be given to how an object or item is to be decontaminated appropriately between subsequent uses. Those responsible for ordering equipment should follow and complete the risk assessment Appendix G. If further guidance is required then advice can be sourced from the Medical Devices Safety Officer, Infection Control, Medical & Therapeutic Devices Group or the Infection Control Committee.

A written Departmental Cleaning Schedule must be devised by each care area/department detailing equipment and medical devices used in the delivery of health & social care; specifying the persons responsible for cleaning, the frequency of cleaning, the expected outcomes and what cleaning method/product to use. These schedules should be followed and available for audit purposes. Examples of equipment to include are: mattresses (including seclusion mattresses), blood pressure monitors/cuffs, BM kits, ECG machines, couches, stethoscopes, thermometers, saturation probes, phlebotomy chairs, hoist etc…

All medical devices/equipment must be decontaminated between each patient use by the user to prevent cross infection using a risk assessment model. Use only decontamination methods advised by the manufacturer – using any other process might invalidate warranties and transfer liability from the manufacturer to the person using or authorising the process. If the manufacturer does not provide clear guidance for decontamination please seek advice from the infection control team.

The user of the device is responsible for ensuring that it is visibly clean and free from contamination with blood and/or body fluid following each procedure or care episode and prior to sending for service or repair. A completed decontamination certificate must accompany each piece of equipment sent for repair or service whether internally or externally to the Trust. Failure to comply with this request will result in equipment being returned (Appendix H).

Any medical device or piece of equipment which has been withdrawn from service & condemned from all care settings requiring final disposal should be visibly clean (following manufactures instructions); and bagged if necessary prior to final disposal. Large bags for this purpose can be obtained from Transport Services e.g. for mattresses. Areas are responsible for ensuring all devices or equipment is disposed of appropriately and in accordance with the Trusts Waste Policy. A decontamination certificate (Appendix H) will need to be completed and retained by the department/ward/unit disposing of the item; serving as a record that the item has been decontaminated.

Any medical device or piece of equipment transferring to another department within the Trust requires a decontamination certificate to accompany the item and the certificate should be retained by the receiving department. (Appendix H).

6.4 Cleaning – General Information

Cleaning is an essential prerequisite to ensure effective disinfection or sterilization of equipment. It is a method of decontamination for non-invasive (low risk) items but should not be used as the only process for high or intermediate risk equipment, where sterilization or disinfection is required. Always refer to manufactures instructions.

The reduction of microbial contamination will depend upon many factors including the efficiency of the cleaning process and the initial contamination. A further reduction will occur on drying, as some micro-organisms cannot multiply on a clean dry surface. Cleaning is the first step in the decontamination process. It must be carried out before disinfection and sterilisation to make these processes effective.
Ideally cleaning tasks should be undertaken in appropriate areas such as dirty utilities. Where appropriate facilities are not available, (within some community settings and supported living accommodation) only items of low risk should be cleaned locally.

Personal protective equipment, including aprons gloves and goggles/visors should be available for staff to wear along with adherence to performing hand hygiene following all cleaning tasks.

Clinell Universal (Green) Wipes are useful for general cleaning activities following use (e.g. hoist, telephone, mouse, keyboard, blood pressure monitors, couch, phlebotomy chairs, work surfaces and mattresses). These wipes contain detergent & biocides which clean & disinfects in a one step process.

Ensure sufficient/recommended contact time between the cleaning product and equipment or item being decontaminated.

6.5 Disinfection – General Information

Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation. Disinfectants can be used in food preparation areas and in contaminated situations where body fluids are present. Disinfection is defined as a process used to kill or remove harmful micro-organisms but it cannot usually kill bacterial spores.

Where a combination of cleaning and disinfection is normally required this includes the use of ‘washer-disinfectors’ such as bed pan washers, dishwashers and laundry. This also includes the use of detergent and water followed by a chemical product when cleaning hard surfaces and reusable equipment.

Disinfection may also be applied to the treatment of skin, mucous membranes, body tissues and cavities through the appropriate application of products.

6.6 Contracted-In Sterilisation Services

When specialist services are commissioned from contractors, a contract should be in place that clarifies the roles and responsibilities of both parties. If the contract is clinically based any sterile equipment should be brought onto the Trust in sealed containers and contaminated products should be disposed of according to the Waste Policy or returned in separate sealed containers to the company contracted to re-sterilise equipment.

6.7 Domestic Environmental Cleaning

The ‘environment’ means the totality of patient’s surroundings when in care premises or transported in a Trust vehicle. This includes the fabric of the building, related fixtures & fittings, and services such as water supplies. To facilitate the cleaning process, it is essential that premises are suitable, fit for purpose and maintained in good physical repair and condition.

In most care areas a daily clean with a detergent based product is adequate. The aim is to remove organic matter and dust and to reduce the bacterial load in the environment. Cleaning in Trust premises should be carried out in line with National Standards for Cleanliness. Domestic staff should have received training and standards should be monitored by Hotel Services on a monthly basis. The national colour-coding should be adopted where possible in other locations such as ‘assisted & supported’ living establishments as best practice.
Additional deep cleaning to all areas will be requested by the infection control team in the event of an outbreak of an infection. Virusolve+ is the product which the trust has decided to adopt as its main product of choice for domestic environmental cleaning activities. In areas where Virusolve+ isn’t available, a Chlorine releasing product (e.g. Chlorclean or Actichlor Plus) mixed to a concentration of 1,000ppm will need to be used for all hard surfaces and hard floors.

Isolation rooms, areas where patients have a transmissible infection are recommended to be cleaned daily using Virusolve+ or a chlorine-releasing product at 1,000ppm. Clinical/qualified staff should ensure housekeeping staff are made aware that enhanced cleaning is required when there is an outbreak or a patient has barrier precautions in place.

A terminal clean will be required at the end of the isolation period and prior to the admission of a new patient. Staff will need to notify the housekeeping staff. Further information on terminal cleaning can be found by referring to the Infection Control Policy and in the Outbreak Management Toolkit. It is not necessary to clean walls, ceilings, windows, radiator covers & light fittings during a terminal clean.

In general the following applies for all areas that provide care to patients:

- Carpets are not recommended in care areas because of the risk of body fluid spills.
- Where carpets are in place, there should be procedures or contracts for regular 6 monthly steam cleaning or shampooing and dealing with spills in the interim periods.
- A written domestic environmental cleaning schedule should be produced specifying the persons responsible for cleaning, the frequency of cleaning, the expected outcomes and which products to use. These schedules should be publicly displayed or available and followed. Hotel Services can be contacted for advice and are responsible for developing these which can then be localised to suit individual departments or areas.
- Work surfaces and floors should be smooth finished, intact, durable of good quality, washable, sealed appropriately and should not allow pooling or ingress of fluids.
- Keep mops and buckets clean, dry and store inverted.
- Mop heads should be removable for laundering daily or disposable single use.
- Preference to disposable cloths which are changed daily.
- Ensure colour coding, in line with the NPSA guidelines, is used for equipment used to clean, toilets, kitchens, general areas and isolation rooms – as displayed above.
- Clean in a systematic way; from clean to dirty, top to bottom using an ‘S’ shaped motion.
- Use of chemicals requires a Control of Substances Hazardous to Health (COSHH) assessment to be carried out.
- Areas undergoing ‘decommissioning’ should be left in a visibly clean state. Estate & Facilities colleagues will usually be co-ordinating and overseeing the closure of departments or areas.
- Reusable bedpans, commode pots and urinals require processing in a washer-disinfector which reached 80°C for a minimum of 1 minute (DH/HPA 2013). Alternatively areas should use Papier Mâché pulp disposable products.
Should urgent environmental cleaning be required e.g. due to adverse incidents; staff should contact Hotel Services Manager in the first instance.

6.8 Chlorine Containing Products

Chlorine containing products such as Sodium hypochlorite (e.g. Chlorclean, Actichlor Plus) are used for cleaning & disinfecting (in one step) inanimate surfaces. A concentration of 1,000ppm chlorine is rapidly effective against a wide range of micro-organisms for domestic environmental cleaning tasks. However, a higher concentration such as 10,000ppm available chlorine is recommended for the safe disinfection of blood and grossly contaminated surfaces. Further information on the management of blood & bodily fluid spillages can be found in the Infection Control Policy.

6.9 Decontamination of Linen

The provision of clean linen is a fundamental requirement of care. Incorrect handling, laundering and storage of linen can pose an infection hazard. Further information on linen management can be found in the Infection Control Policy.

All dirty and used linen must be handled with care and appropriate Personal Protective Equipment (PPE) worn by the healthcare/social workers. Linen should be removed from a patient’s bed with care, avoiding the creation of dust and placed into the appropriate colour-coded category. This should stop laundry staff from ‘manually sorting’ the laundry out further upon arrival to the laundry room.

Linen should be divided into basic categories such as:
- Used/soiled linen or clothing – items either worn or used without the contamination of visible blood or bodily fluids
- Foul/infected linen or clothing – items contaminated with visible blood or bodily fluids
- Clothing/heat-labile (Heat labile linen includes any fabric that the normal heat disinfection process and high temperatures could damage e.g. silks & wool - check the manufacturer’s washing instructions).

An alginate bag is a bag used for foul or infected linen. The bag dissolves away when in contact with water. Very wet linen can start the dissolving process from the inside; therefore the colour-coded alginate bag should be placed inside the appropriate colour-coded plastic bag before placing into the colour coded cotton laundry sack. This is to prevent cross-contamination of linen and to protect the healthcare worker and the laundry personnel during transportation and the laundering process. All foul linen or clothing should have a pre-wash or sluice cycle selected on the washing machine. Never manually sluice any items.

Laundry rooms should be physically separate and must have a dedicated accessible hand wash basin available. Clear processes must be in place; a clear working flow from dirty to clean to prevent cross contamination from used laundry arriving in the laundry room. It is acknowledged that in some community supported living accommodations this may not always be possible and the washing machine may be located in communal kitchens. It is recommended that food must not be prepared or cooked at the same time as the washing machine is being loaded or unloaded with laundry.

All purchases of washing machines must be discussed with and approved by the Head of Estates/Water Responsible Person and Infection Control Team before an order is placed.

All washing machines must comply with the guidance in Health Technical Memorandum 01-04: Decontamination of linen for health and social care (2016) and be WRAS approved; provide a sluice cycle for foul laundry and reach satisfactory disinfection temperatures and
holding times. Domestic-type washing machines or tumble dryers are not appropriate. Areas need to consider the ongoing maintenance, servicing and annual calibration arrangements.

The washing process should have a thermal disinfection cycle in which the minimum temperature in the load is maintained at 65ºC (150ºF) for not less than 10 minutes or preferably at 71ºC (160ºF) for not less than 3 minutes.

Trust washing machines or dryers must never be used for clothes of staff or relatives. Staff should follow the guidance in the Dress Code Policy regarding the laundering of staff uniforms or clothes worn for work.

6.10 The Management of Toys

Toys are known to harbour organisms and have been implicated in the spread of infection. It is acknowledged that toys pacify or distract babies / young children helping them to cope with unfamiliar surroundings and procedures. The risk may be modest but toys quickly become soiled rapidly acquiring a generous ‘coating’ of multiple flora; some of which potentially may be harmful. The following principles are to be followed:

• Toys should be included on the departmental cleaning schedule with a clear responsibility identified of who is responsible for them.
• The cleaning schedule should include what to clean them with and the frequency of cleaning. Cleaning daily at the end of the working day/clinic session would be acceptable; however cleaning intermittently if soiled or visibly dirty in the interim period.
• Check toys daily whilst cleaning them for defects and throw away as appropriate.
• Store toys in a plastic lidded wipeable box – recommend weekly cleaning frequency inside and out including the lid with detergent wipes & air dry. Spot check box daily and clean intermittently if soiled/visibly dirty in the interim.
• Toys should be CE marked and be made of hard washable/wipeable plastic wherever possible.
• Wooden toys are not recommended as they cannot be cleaned appropriately as they are porous.
• Remove items such as soft toys i.e. those made from teddy bear pile fabric, wool and dolls due to their hair. These type of ‘furry’ toys are not suitable for communal use.
• Books for babies & toddlers should be discouraged. However books for older children are no more of a risk than magazines which are usually available in most waiting rooms.
• All hard impervious washable equipment e.g. plastic toys are to be cleaned in hot water and detergent. Follow by rinsing in clean water before disinfecting with a suitable product; allow to air dry on absorbent paper in a suitable area. Alternatively they can be thoroughly wiped over with disposal Clinell Universal wipes and allowed to dry.
• If the organic matter cannot be removed from the toys, it is to be disposed of by an appropriate method following the Trusts Waste Management Policy.
• Toys that take batteries and electrical items must be cleaned using Clinell Universal wipes.

6.11 Therapeutic Device Considerations

It is acknowledged that therapeutic devices or equipment falling into this category can have benefits to patients who need additional comfort or sensory stimuli e.g. Empathy Dolls. Care settings wishing to procure such items are strongly advised to consult either the Medical & Therapeutic Devices Group or the Infection Control Committee. Health & social care settings need to be mindful about considering any infection control, health & safety, fire & decontamination considerations or implications prior to purchase. Appendix G can assist with this risk assessment process for infection control considerations.

Please follow the laundry recommendations in the IPC policy regarding Empathy Dolls. The protocol can also be downloaded from the IPC webpage & displayed.
7. **Dissemination, storage and archiving (Control)**

This policy will be available on the Trusts intranet site following the ratification process. It will be disseminated via the Infection Control Committee and the Infection Prevention & Control Link Worker Forum; and available to all staff.

Previous versions of this policy will be archived by the Corporate Governance Team. Individual staff are responsible for ensuring that they are accessing and adhering to the latest version of this policy; and delete any previous versions to prevent confusion.

8. **Training and other resource implications**

All staff joining the Trust should attend Core Mandatory Training. The Infection Control session includes a brief overview of decontamination and emphasises its importance in the delivery of care. Staff require Mandatory updates; please refer to the mandatory training policy or discuss with your own line manager. Training data will be collected centrally by the training Department, but each department/team manager is responsible for ensuring that their staff receive training and update any locally held training records.

Staff are reminded that they should seek relevant training and be appropriately trained in clinical procedures e.g. venepuncture or catheterisation where invasive medical devices are used; and maintain their competencies to ensure safe practice.

Should resource implications be identified then appropriate business cases will be produced for consideration.
9. Audit, monitoring and review

This policy will be monitored through the monthly audits performed by Hotel Services and the Housekeeping staff; and via the annual audit programme conducted by the Infection Control Team.

The policy will be reviewed on a 3 yearly basis or as and when legislation changes. This section should describe how the implementation and impact of the policy will be monitored and audited.

<table>
<thead>
<tr>
<th>Monitoring Compliance Template</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum Requirement</td>
</tr>
<tr>
<td>Process for Monitoring</td>
</tr>
<tr>
<td>Responsible Individual/group/committee</td>
</tr>
<tr>
<td>Frequency of Monitoring</td>
</tr>
<tr>
<td>Review of Results process (e.g. who does this?)</td>
</tr>
<tr>
<td>Responsible Individual/group/committee for action plan development</td>
</tr>
<tr>
<td>Responsible Individual/group/committee for action plan monitoring and implementation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 17 HEALTHCARE ASSOCIATED INFECTION RISK MANAGEMENT AND PATIENT SAFETY STANDARDS Categorised guidance on recommended practice and legal and professional standards in Infection Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly audits by Hotel Services/Housekeeping Annual IPC Audit Programme</td>
</tr>
<tr>
<td>Infection Control Committee</td>
</tr>
<tr>
<td>Quarterly &amp; Annual</td>
</tr>
<tr>
<td>Quality Assurance Committee &amp; Board</td>
</tr>
<tr>
<td>Infection Control Committee</td>
</tr>
<tr>
<td>Quality Assurance Committee</td>
</tr>
</tbody>
</table>
10. Implementation plan

<table>
<thead>
<tr>
<th>Action / Task</th>
<th>Responsible Person</th>
<th>Deadline</th>
<th>Progress update</th>
</tr>
</thead>
<tbody>
<tr>
<td>New policy to be uploaded onto the Intranet and Trust website.</td>
<td>Director of Corporate Governance</td>
<td>31.10.2016</td>
<td></td>
</tr>
<tr>
<td>A communication will be issued to all staff via the Communication Digest immediately following publication.</td>
<td>Director of Corporate Governance</td>
<td>Within 5 working days of issue.</td>
<td></td>
</tr>
<tr>
<td>A communication will be sent to Education, Training and Development to review training provision.</td>
<td>Director of Corporate Governance</td>
<td>Within 5 working days of issue.</td>
<td></td>
</tr>
</tbody>
</table>

11. Links to other policies, standards and legislation (associated documents)

- Infection Prevention and Control Policy
- Policy for the Management of Occupational Blood and Body Fluid Exposure Incidents and Administration of Post Exposure Prophylaxis
- Waste Management Policy
- Medical Devices Management policy
- Dress Code Policy
- Mandatory Training Policy
- NICE Quality Standard 139 & 61

12. Contact details

<table>
<thead>
<tr>
<th>Title</th>
<th>Name</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decontamination Lead</td>
<td>Phillip Easthope</td>
<td><a href="mailto:Phillip.Easthope@shsc.nhs.uk">Phillip.Easthope@shsc.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Medical Devices Safety Officer</td>
<td>Vin Lewin</td>
<td><a href="mailto:Vin.Lewin@shsc.nhs.uk">Vin.Lewin@shsc.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Hotel Services Manager</td>
<td>Janet Mason</td>
<td><a href="mailto:Janet.Mason@shsc.nhs.uk">Janet.Mason@shsc.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Health &amp; Safety Advisor</td>
<td>Charlie Stephenson</td>
<td><a href="mailto:Charlie.stephenson@shsc.nhs.uk">Charlie.stephenson@shsc.nhs.uk</a></td>
<td></td>
</tr>
<tr>
<td>Senior Nurse Infection Control</td>
<td>Katie Grayson</td>
<td><a href="mailto:Katie.grayson@shsc.nhs.uk">Katie.grayson@shsc.nhs.uk</a></td>
<td></td>
</tr>
</tbody>
</table>

13. References

http://www.medicaldevices.gov.uk/

http://www.legislation.hmso.gov.uk

Clostridium difficile infection: How to deal with the problem (DH; 2008) Available at: http://www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1232006607827


Sheffield Children’s Hospital Toy Management Protocol


DH (2016) Health Technical Memorandum 01-04: Decontamination of linen for health & social care

DH and HPA (2013) Prevention and control of infection in care homes – an information resource

Hertfordshire Partnership NHS Foundation Trust

Somerset Partnership NHS Foundation Trust

South Staffordshire & Shropshire Healthcare NHS Foundation Trust
## Appendix A – Version Control and Amendment Log

<table>
<thead>
<tr>
<th>Version No.</th>
<th>Type of Change</th>
<th>Date</th>
<th>Description of change(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Policy created</td>
<td>July 2010</td>
<td>New policy commissioned &amp; approved</td>
</tr>
<tr>
<td>2.0</td>
<td>Full policy review</td>
<td>Oct 2016</td>
<td>Full review in all sections. New Trust policy template introduced &amp; adopted. Comments included where appropriate during consultation phase prior to ratification.</td>
</tr>
</tbody>
</table>
# Appendix B – Dissemination Record

<table>
<thead>
<tr>
<th>Version</th>
<th>Date on website (intranet and internet)</th>
<th>Date of “all SHSC staff” email</th>
<th>Any other promotion/dissemination (include dates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>July 2010</td>
<td>July 2010</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td>Oct 2016</td>
<td>Oct 2016</td>
<td></td>
</tr>
</tbody>
</table>
### Equality Impact Assessment Process for Policies Developed Under the Policy on Policies

#### Stage 1 – Complete draft policy

#### Stage 2 – Relevance - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If NO – No further action required – please sign and date the following statement. If YES – proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)  

**Infection Control Committee – Sept 2016**

#### Stage 3 – Policy Screening - Public authorities are legally required to have ‘due regard’ to eliminating discrimination, advancing equal opportunity and fostering good relations, in relation to people who share certain ‘protected characteristics’ and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/don’t know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link [https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464](https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464)

<table>
<thead>
<tr>
<th>Protected Characteristic</th>
<th>Does any aspect of this policy actually or potentially discriminate against this group?</th>
<th>Can equality of opportunity for this group be improved through this policy or changes to this policy?</th>
<th>Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>DISABILITY</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GENDER REASSIGNMENT</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PREGNANCY AND MATERNITY</td>
<td></td>
<td></td>
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<tr>
<td>RACE</td>
<td></td>
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<tr>
<td>RELIGION OR BELIEF</td>
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<tr>
<td>SEX</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SEXUAL ORIENTATION</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Stage 4 – Policy Revision - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Impact Assessment Completed by (insert name and date)  

**K Grayson Sept 2016**

---

Decontamination: Environmental Cleanliness & Reusable Equipment (version 2 / October 2016)
Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person’s Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf (relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?
   - [ ] Yes. No further action needed.
   - [ ] No. Work through the flow diagram over the page and then answer questions 2 and 3 below.

2. On completion of flow diagram – is further action needed?
   - [ ] No, no further action needed.
   - [ ] Yes, go to question 3

3. Complete the table below to provide details of the actions required

<table>
<thead>
<tr>
<th>Action required</th>
<th>By what date</th>
<th>Responsible Person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose ‘Format Text Box’ and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.

1.1 What is the policy/decision title? ………………………………………………………………………….

1.2 What is the objective of the policy/decision? …………………………………………………………………

1.3 Who will be affected by the policy/decision? …………………………………………………………………

Will the policy/decision engage anyone’s Convention rights? 2.1 NO

YES

Will the policy/decision result in the restriction of a right? 2.2 NO

YES

Is the right an absolute right? 3.1 YES

NO

Is the right a limited right? 3.2 NO

YES

Will the right be limited only to the extent set out in the relevant Article of the Convention? 3.3

YES

Policy/decision is likely to be human rights compliant

BUT

Get legal advice

Regardless of the answers to these questions, once human rights are being interfered with in a restrictive manner you should obtain legal advice. You should always seek legal advice if your policy is likely to discriminate against anyone in the exercise of a convention right.

Flowchart exit

There is no need to continue with this checklist. However,

- Be alert to any possibility that your policy may discriminate against anyone in the exercise of a Convention right
- Legal advice may still be necessary – if in any doubt, contact your lawyer
- Things may change, and you may need to reassess the situation

4 The right is a qualified right

1) Is there a legal basis for the restriction? AND
2) Does the restriction have a legitimate aim? AND
3) Is the restriction necessary in a democratic society? AND
4) Are you sure you are not using a sledgehammer to crack a nut?

Policy/decision is not likely to be human rights compliant please contact the Head of Patient Experience, Inclusion and Diversity.

Access to legal advice MUST be authorised by the relevant Executive Director or Associate Director for policies (this will usually be the Chief Nurse). For further advice on access to legal advice, please contact the Complaints and Litigation Lead.
Appendix E – Development, Consultation and Verification

Version 2 – updated policy to reflect updated Code of Practice in relation to Decontamination. Trust adoption of new policy template. This policy will be available via the Trust’s intranet site.

This policy has been reviewed by the Senior Nurse – Infection Prevention and Control. It incorporates the changes required by The Health and Social Care Act 2008 (2015): Code of Practice for the Prevention and Control of Infections and related guidance issued by the Department of Health, NICE and Health and Safety Executive. In addition it considers evidence of best practice from organisations such as the Infection Prevention Society and the Hospital Infection Society.

Due to the number of changes the policy has been sent out for consultation with all members of the Infection Control Committee and additional relevant colleagues from 15/08/16 to 07/09/16. Comments were received back from:
- Rob Townsend
- Lorena Cain
- Nikki Littlewood
- Charlie Turner

All comments and corrections were accepted and included within the policy as and where relevant.

The policy has been circulated to all members of the Infection Control Committee and the Medical & Therapeutic Devices Group and Hotel Services Manager for verification, comment/approval prior to being presented for ratification.
Appendix F – Policies Checklist

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. **Cover sheet**
   All policies must have a cover sheet which includes:
   - The Trust name and logo ✔
   - The title of the policy (in large font size as detailed in the template) ✔
   - Executive or Associate Director lead for the policy ✔
   - The policy author and lead ✔
   - The implementation lead (to receive feedback on the implementation) ✔
   - Date of initial draft policy ✔
   - Date of consultation ✔
   - Date of verification ✔
   - Date of ratification ☐
   - Date of issue ☐
   - Ratifying body ✔
   - Date for review ✔
   - Target audience ✔
   - Document type ✔
   - Document status ✔
   - Keywords ✔
   - Policy version and advice on availability and storage ✔

2. **Contents page**

3. **Flowchart**
   N/A

4. **Introduction**

5. **Scope**

6. **Definitions**

7. **Purpose**

8. **Duties**

9. **Process**

10. **Dissemination, storage and archiving (control)**

11. **Training and other resource implications**

12. **Audit, monitoring and review**
   This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).
## Monitoring Compliance Template

<table>
<thead>
<tr>
<th>Minimum Requirement</th>
<th>Process for Monitoring</th>
<th>Responsible Individual/group/committee</th>
<th>Frequency of Monitoring</th>
<th>Review of Results process (e.g. who does this?)</th>
<th>Responsible Individual/group/committee for action plan development</th>
<th>Responsible Individual/group/committee for action plan monitoring and implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Describe which aspect this is monitoring?</td>
<td>e.g. Review, audit</td>
<td>e.g. Education &amp; Training Steering Group</td>
<td>e.g. Annual</td>
<td>e.g. Quality Assurance Committee</td>
<td>e.g. Education &amp; Training Steering Group</td>
<td>e.g. Quality Assurance Committee</td>
</tr>
</tbody>
</table>

### 13. Implementation plan

### 14. Links to other policies (associated documents)

### 15. Contact details

### 16. References

### 17. Version control and amendment log (Appendix A)

### 18. Dissemination Record (Appendix B)

### 19. Equality Impact Assessment Form (Appendix C)

### 20. Human Rights Act Assessment Checklist (Appendix D)

### 21. Policy development and consultation process (Appendix E)

### 22. Policy Checklist (Appendix F)
Appendix G – Decontamination Evaluation & Risk Assessment Form

DECONTAMINATION EVALUATION & RISK ASSESSMENT FORM
To be completed at the time of requisition by the requesting area/service

<table>
<thead>
<tr>
<th>Item:</th>
<th>Requisition form number:</th>
</tr>
</thead>
</table>

Briefly describe the item/equipment and its intended use:

Dose any part of the equipment (including accessories) come into contact with the patient/client or their blood or body fluids? YES/NO – If yes please provide details

For parts of the equipment not coming into contact with the patient/client or their blood or body fluids:

a) How is the item to be routinely cleaned e.g. from dust

b) Who will carry out this process, how often & where?

c) How will the item be decontaminated if inadvertent contact with blood or body fluids occurs?

d) Who will carry out this process & where?
For parts of the equipment coming into contact with the patients/clients intact skin:

a) How is the item to be cleaned between uses?

b) Who will carry out this process, how often & where?

c) How will the item be decontaminated if inadvertent contact with blood or body fluids occurs?

d) Who will carry out this process & where?

For parts of the equipment coming into contact with non-intact skin, mucous membranes, blood or body fluids or are to be introduced into sterile body cavities: (use single use disposable equipment wherever possible)

a) How is the item to be cleaned between uses prior to disinfection/sterilisation?

b) Who will carry out this process, how often & where?

c) How will the item be disinfected/sterilised?

d) Who will carry out this process & where?

If the equipment is to be transferred to another area/location for processing from where it has been used:

a) Has the department/location that will be cleaning/disinfecting/sterilising the item agreed to this & the methods to be used? YES/NO – please provide details

b) How will the equipment/item be transported to & from the processing department/location e.g. containers/bags used and by whom?
Please provide details of the person completing this risk assessment:

Name:

Date:

Position:

Contact details: (email & phone)

Please provide details of the person to contact if the reviewer needs to ask further questions or to discuss the situation if the proposed process needs to be referred to the Medical & Therapeutic Devices Group/Medical Devices Liaison Officer/Infection Control Team; if different from the individual named above

Name:

Position:

Contact details: (email & phone)

Please retain a copy for your records. If further advice is required please submit a copy of this to the Infection Control Team. Thank you for your time & assistance.
Appendix H – Decontamination Certificate

Decontamination Certificate

Before any equipment is sent for repair/service, transferred between departments or for final disposal both within and outside Sheffield Health and Social Care premises it must be decontaminated and a certificate completed. Please tick:

- Items for service or repair – the certificate must accompany the equipment.
- Items for final disposal – please complete the certificate and retain in the department/ward/unit area
- Items transferring between departments – please complete the certificate and give to the receiving department

Ward/Department:

Description of equipment:

Make:  Model:  Serial Number:

Please select ONE box and tick accordingly:

- To the best of my knowledge this equipment has NOT been in contact with potentially infected material e.g. blood, bodily fluids and therefore has not been contaminated.
- This equipment MAY be contaminated by potentially infected material and has been decontaminated externally on its outer surface as per decontamination policy.
- This equipment MAY be contaminated but could not be decontaminated because, please give details

The above piece of equipment has been appropriately decontaminated following patient usage and is now ready for repair/service, transfer or final disposal.

Signature_____________________________ Date_____________________________

Name_____________________________Designation_____________________________