BLOOD AND BODY FLUID SPILLAGE POLICY

POLICY

Reference	CPG-TW-ICP4
Approving Body	Infection Prevention and Control Committee
Date Approved	16/04/2019
Issue Date	23rd May 2019
Version	7.0
Summary of Changes from Previous Version	Minor wording changes
Supersedes	v6.0, issued 17th Feb 2017 to Review Date April 2019
Document Category	• Clinical
Consultation Undertaken	Members of Infection Prevention and Control Committee
Date of Completion of Equality Impact Assessment	May 2019
Date of Environmental Impact Assessment (if applicable)	May 2019
Legal and/or Accreditation Implications	To comply with the Health and Social Care Act (2005) and Code of Practice on the Prevention and Control of Infections and Related Guidance (2015)
Target Audience	All Staff
Review Date	April 2022
Sponsor (Position)	Director of Infection Prevention and Control
Author (Position & Name)	Rosie Dixon, Nurse Consultant, Infection Control and Prevention
Lead Division/ Directorate	Diagnostics & Outpatients
Lead Specialty/ Service/ Department	Infection Prevention and Control
Position of Person able to provide Further Guidance/Information	Infection Prevention and Control Specialist

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
None	Not Applicable

CONTENTS

1.0 INTRODUCTION

The Health and Social Care Act 2008: Code of Practice on the prevention and control of infections and related guidance (2015) sets out a criterion by which NHS organisations must ensure that the risk of acquiring Healthcare Associated Infections (HCAI's) are kept to a minimum and that patients are cared for in a clean environment. Compliance with this code is a statutory requirement including the duty to adhere to policies and protocols applicable to infection prevention and control.

Spillages are highly unpredictable and can occur in a wide variety of settings. Dealing with spillages of blood or body fluids may carry a risk of exposure to blood-borne viruses or other pathogens, therefore all spillages of blood and body fluids must be considered as potentially

infectious (Lawrence 2003). The risk will be minimised by following the precautions recommended in this policy, including the correct use of personal protective equipment and effective disinfectant products.

2.0 POLICY STATEMENT

This policy will provide assurance to the Trust Board and Trust Management that processes used within the Trust are robust, reflect best practice, and comply with NHS requirements and legislation. It is a specific requirement of the Health and Social Care Act 2008: (2015) Code of Practice for the prevention and control of healthcare associated infections that the Trust has a clear policy for dealing with body fluid spillages.

This clinical policy applies to:

Staff group(s):

- All clinical staff
- All non-clinical staff within a clinical area
- All Medirest staff

Clinical areas(s):

- All clinical areas at all hospital sites

Patient group(s):

- All patients groups – adult, maternity and paediatrics

Exclusions

- None

3.0 DEFINITIONS / ABBREVIATIONS

Blood or body fluid spillage	spillage of any body fluid including blood, vomit, urine or faecal matter, including diarrhoea
Contamination	presence of harmful microorganisms or the visible presence of blood or any other body fluid on a medical/nursing device or in an environment
Decontamination	combination of processes, including cleaning, disinfection, used to make a re-usable item or an area safe for further patient and staff use
Chlorine releasing agent	an agent recommended for the safe disinfection of all spillage except urine and vomit
Trust	Sherwood Forest Hospitals NHS Foundation Trust
Staff	All employers of the Trust including those managed by a third party on behalf of the Trust
PPE	Personal Protective Equipment
HAI	Healthcare Associated Infection
IPCT	Infection Prevention and Control Team
DIPC	Director of Infection Prevention and Control
ICD	Infection Control Doctor
IPCN	Infection Prevention and Control Nurse
TSE	Transmissible Spongiform Encephalopathy

4.0 ROLES AND RESPONSIBILITIES

Everyone has a responsibility to manage the potential for occupational exposures, including sharps injuries, which can and do occur while delivering care. Those trained in the safe and effective management of blood and/or body fluid spillage must manage the spillage.

Responsibility for the cleaning of blood and/or body fluid spillage should be clear within each care setting. As a general rule, for spillages, whether caused by patients, staff or visitors the responsibility is as follows:

- Departments/Clinical area: Departmental/Clinical area staff
- Internal areas including main entrance, corridors, communal areas outside of departments: Soft Facility Management (Medirest Domestic Service)
- Vans: Soft Facility Management (Medirest Transport Service)
- Ward Waste Holds: Departmental/Clinical area staff
- Spillages during transportation on corridors: Soft Facility Management (Medirest Domestic Service)
- Outdoor areas: Soft Facility Management (Medirest Domestic Service)

4.1 Chief Executive

The Chief Executive is ultimately responsible for ensuring that there are effective arrangements for infection prevention and control.

4.2 Director of Infection Prevention and Control

The Director of Infection Prevention and Control (DIPC) has Trust wide responsibility for the development of strategies and policies for the management of infection prevention and control.

4.3 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) will ensure that this policy is maintained and revised according to national guidance. They will also provide advice to ward and department staff on management of blood and body fluid spillage.

4.4 Director of Operation and Divisional Directors

Director of Operation and Divisional Directors will ensure that necessary management arrangements and structures are in place to support all fulfilling their obligation in their role of infection prevention and control practices.

4.5 Matrons/Department Manager/Service Line Managers

Matrons/Department Manager/Service Line Manager are responsible for ensuring that all staff accountable to them are aware of this policy and adhere to its statement. They will actively promote and support all current infection prevention and control measures.

4.6 Ward Leader/Departmental Manager

Ward Leader/Departmental manager will act as excellent role models and are responsible and accountable for infection prevention and control within their sphere of responsibility. They will ensure that all staff are aware of all relevant infection prevention and control measures.

4.7 Infection Prevention and Control Link Representatives

Infection Prevention and Control Link Representatives will disseminate all relevant infection prevention and control information to staff within their own work environment.

4.8 All Trust staff

All staff involved in the support and care of patients or the safe handling of waste must be aware of how to deal safely with any spillage should it occur. Trust staff have a duty to follow this policy, for the safety of all staff, patients and visitors. In addition it is the responsibility of staff to:

- Deal with a spillage if witnessed or discovered
- Receive training in spillage management
- Secure the Hepatitis B vaccine
- Observe standard precautions
- Ensure a supply of personal protective clothing is available

5.0 APPROVAL

Approved at the Infection Prevention and Control Committee after being sent out to members in advance for review and approval.

6.0 POLICY

6.1 Risk assessment

Occupational exposure to blood and/or body fluids, secretions and excretions through spillages poses a potential risk of infection. It is vital that any spillage must be attended to as soon as possible. Under the Control of Substances Hazardous to Health Regulations 2002 (COSHH), a risk assessment of the hazards and associated risks to health must be undertaken to ensure the health and safety of patients, visitors and staff.

Spillages are by nature highly unpredictable, and all spillages must be treated as potentially infectious therefore the risk assessment must consider:

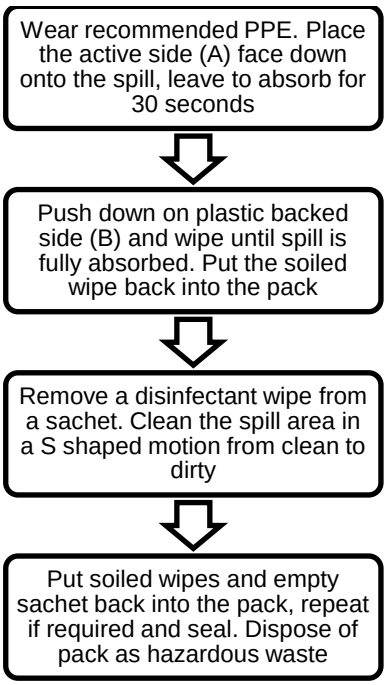
- Content of the spillage e.g. blood, urine or other
- Size of spillage
- Material on which the spillage has occurred e.g. fabric, vinyl, metal

6.2 Spill Kits

There are several types available specifically developed to deal with body fluid spills. These include those containing sodium dischloroisocyanurate (NaDCC) (ie. Haz-tabs, Precept, Actichlor, So-Chlor etc), which are hazardous and time consuming to use. The contracted cleaning services will use these in certain situations.

Ward/ Department based staff are provided with a kit that contains the disinfectant peracetic acid and hydrogen peroxide within the super absorbent pad. This is proven to kill all known micro-organisms associated with blood, vomit, urine and faecal spills which include hepatitis B and C, HIV, clostridium difficile and norovirus. It has a high fluid capacity of over 1,000ml.
A spillage kit should be kept in each clinical area (depicted below) so that all the equipment for dealing with a spillage is available in one place. Staff who deal with a spillage are responsible for ensuring that the spillage kit is replaced after it has been used. Please refer to instructions on the packaging when using the kit.

Process to manage spillage



COSHH assessments must be carried out for all chemical disinfections, and staff must be aware of the implications of these assessments for storage and use of the product and first aid in the event of exposure e.g. a splash to the eye.

6.3 Staff that handle blood or body fluids

Only staff who have received appropriate training should deal with blood and/or body fluid spillages. All staff that handle blood or body fluids must:

- Cover all cuts or lesions with a waterproof dressing while on duty
- Wear disposable, non-sterile nitrile gloves and a disposable plastic apron when:
  - dealing with blood and body fluids
  - exposure to blood or body fluid is anticipated
  - for all venepuncture procedures
- Laboratory staff, protective gloves must be worn for all blood and high risk samples in line with the Pathology Standard operational Policy

6.4 Spillage of blood, high risk body fluids and blood-stained body fluid on impervious flooring

Spillage of blood and body fluids:

- Cerebral-spinal fluid (CSF)
- Peritoneal fluid
- Pleural fluid
- Pericardial fluid
- Synovial fluid
- Amniotic fluid
- Semen and vaginal secretions
- Any other body fluid containing visible blood
- Saliva in association with dentistry
- Unfixed tissues and organs

Recommended procedure:

- Cordon off the affected area
- Don appropriate personal protective equipment (PPE)
- Make sure spillage kit available (see 6.2)
- The kit consists of a super absorbent pad measuring 40x40cm, containing a special two layered non-woven pad covered with a plastic backing
- The pad will absorb up to a litre of fluid and once absorbed the fluid will trigger an oxidative reaction within the pad itself which will neutralise all the pathogens within the spill
- It also comes with two individually wrapped disinfectant wipes to complete the clean and allow any staining from the original spill to be removed
- Dispose of disposable towels, gloves and disposable apron carefully as clinical waste
- Decontaminate hands thoroughly
- Replenish spillage kit (as necessary)

If a spill contains glass or other sharps, these must be picked up first with forceps and disposed of carefully into a sharps container.

6.5 Spillage of low-risk body fluids on impervious flooring

- Nasal secretions
- Saliva not associated with dentistry
- Sputum
- Sweat
- Tears

Recommended procedure:

- Cordon off the affected area
- Don appropriate PPE
- Using disposable paper towels remove all traces of visible spillage, dispose of as clinical waste
- Once the residual waste has been removed the area must be cleaned thoroughly using a general purpose detergent solution in warm water, using disposable cloths, rinse and dry
- Clean the bucket in fresh water and general purpose detergent, rinse and dry
- Dispose all disposable towels, gloves and disposable apron carefully as clinical waste
- Decontaminate hands thoroughly

6.6 Urine, faeces, vomit and other fluids e.g. pus: Use Spill Kit as detailed carpets and soft furnishings

The disinfectants used to decontaminate spillage of blood and other body fluids may cause damage to carpets and soft furnishings. It is therefore advised in areas where spillages of blood and body fluids are likely, that floor coverings and furniture be carefully selected as these must be able to withstand the decontamination procedures as indicated.

Where spillage has occurred in a carpeted area, treat according to the type of spillage outlined above. Contact the Helpdesk on extension 3005 as soon as possible in order that the carpet can be domestically cleaned using carpet suction cleaner after the spillage has been treated.

6.6 Spillage in vehicles

All vehicles transporting specimens must carry a spillage kit containing disinfectant, detergent wipes, personal protective equipment, absorbent material and a clinical waste bag. Drivers must be trained in the management of blood and body fluid spillages as outlined within this policy.

6.7 Spillage from a sharps container

If used sharps are spilled from a sharps container, the following procedure must be followed (correct assembly of containers should prevent such an occurrence):

- Don appropriate PPE
- Gather up spilled sharps using a dust pan and brush or forceps and put them into a new appropriate sized sharps container
- Follow procedure as for blood spillage (refer to section 6.3)
- Dispose all disposable towels, gloves and disposable apron carefully as clinical waste
- Decontaminate hands thoroughly

6.8 For patient in risk groups for any transmissible spongiform encephalopathy (TSE)

All surfaces contaminated with blood, CSF or brain tissue must be cleaned using a Spillage Kit.

7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

The IPCT will audit the provision and completeness of spillage kits bi-annually on site visits. Any recommendations from the audit, in the form of an action plan, are fed back to respective managers who must ensure that issues are addressed. The summary results of the bi-annual audit will be reported to the Infection Prevention and Control Committee, where compliance with this policy will be monitored.

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Compliance with access to spill kits	Facilities management	Joint monitoring audits	annually	IPCC
As above	Infection control team	As above	As above	IPCC

8.0 TRAINING AND IMPLEMENTATION

All new staff who join the Trust including temporary and locum staff must undertake hand hygiene training as part of their induction to the Trust. All Trust staff must undertake an annual update to fulfil their mandatory training at scheduled training dates.

9.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix A
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix B

10.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

Evidence Base:

- Health and Safety Executive. 1999. *The management of health and safety at work regulations 1999.*
- Health and Safety Executive. 2002. *The control of substances hazardous to health regulations (COSHH) 2002.*
- Health and Safety Executive. 1974. *Health and Safety at Work Act.*
- Health and Social Care Act 2008 :(Updated 2015) *Code of Practice on the prevention and control of infections and related guidance*.
- Lawrence. J. 2003. *Infection control in the community.* Churchill Livingstone. London
- UK Health Departments. 1998. *Guidance for Clinical Health Care Workers: Protection against infection with blood borne viruses. Recommendations of the Expert Advisory Group on Hepatitis.*

Related SFHFT Documents:

This document should be used in conjunction with other relevant Trust Infection Prevention and Control and Trust policies such as:

- Standard operating procedure on infection prevention and control (ICP 1)
- Disinfection policy for Sherwood Forest Hospital (ICP 5)
- Policy for the use of personal protective equipment (ICP 9)
- Hand hygiene policy (ICP 17)
- Trust waste policy
- Sharps, Needle stick and Post-Exposure Prophylaxis (PEP) Policy (including any bodily exposures or inoculation injury"
- Pathology Standard operational Policy

11.0 KEYWORDS

- Spill; fluids; kit; kits; safe handling; blood; stain; stainage; stains; vomit; urine; faecal matter; diarrhoea;

12.0 APPENDICES

- Appendix A – Equality Impact Assessment form
- Appendix B – Environmental Impact Assessment form

APPENDIX A – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Blood and Body Fluid Spillage Policy			
New or existing service/policy/procedure: Existing			
Date of Assessment: 16/05/2019			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	N/A	None
Gender	None	N/A	None
Age	None	N/A	None
Religion	None	N/A	None
Disability	None	N/A	None
Sexuality	None	N/A	None
Pregnancy and Maternity	None	N/A	None
Gender Reassignment	None	N/A	None
Marriage and Civil Partnership	None	N/A	None
Socio-Economic	None	N/A	None

Factors (i.e. living in a poorer neighbourhood / social deprivation)			

What consultation with protected characteristic groups including patient groups have you carried out?

- **Sent to all members of IPCC**

What data or information did you use in support of this EqIA?

- **National Guidance**

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?

- **No**

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

For high or medium levels of impact, please forward a copy of this form to the HR Secretaries for inclusion at the next Diversity and Inclusivity meeting.

Name of Responsible Person undertaking this assessment:
Sally Palmer

Signature: S Palmer

Date: 16/05/19

APPENDIX B – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	
Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	