Infection Prevention Procedures

This should be read in conjunction with the Infection Prevention and Control Policy (M 257A) and documentation in (M 257C-W).

Immunisation
All clinical staff are up to date with their routine vaccinations and are immunised against Hepatitis B and Tuberculosis (TB). The practice has additional clearance checks on file for team members who perform exposure prone procedures (EPPs). Staff immunisation records are maintained using M 257J. The principal will pay for the immunisation of employed team members if a charge is incurred.

Accepting patients for treatment
A patient is never refused treatment on the grounds that s/he has an infectious disease; patients who have infections may be unaware or may be unwilling to disclose it. If a patient has a blood borne infection the treating practitioner may obtain specialist advice before treatment commences. See the Briefing on Ebola Guidance (B 115) for the management of patients suspected to have Ebola.

Medical History
A thorough medical history is taken by the practitioner at every consultation with the patient. The medical history is updated by the practitioner if there is a change in status of the patient's medical status or prescription drugs. Confidentiality is maintained for all personal and treatment information.

Personal Protective Equipment
Clinical gloves
Non-sterile low allergy powder free Nitrile gloves are used for clinical treatments. Sterile surgical gloves are used for invasive procedures. The use of gloves does not replace the need for hand hygiene. When removing personal protective equipment, gloves are removed first.

Gloves are single-use only and are discarded as offensive or clinical waste depending on their infectious properties after use on one patient or if damaged during treatment, they are removed prior to retrieving any item from a cupboards or drawers. Used gloves are removed by rolling inside out. Gloves are never worn outside of the treatment room.

The practice does not use latex gloves.

Clinical clothing/workwear
Fresh clinical clothing is worn each day in the treatment room and it is changed if soiled, short sleeves are worn to allow the forearms to be washed. Soiled clothing is stored in a specially labelled container and washed normally at the hottest temperature suitable for the fabric to reduce any potential microbial contamination. Clinical clothing is not worn outside of the practice and outdoor clothes are not worn whilst treating patients. Clothing worn for decontamination is not worn outside of the practice. Footwear is fully enclosed and in good order.

Plastic aprons
Disposable plastic aprons are worn single–use during cleaning activities, decontamination procedures, when changing solutions in an x-ray processor and whilst clearing up a spillage of a hazardous material. An apron is removed by pulling down and tearing the ties, it is gathered together by handling the inside and disposed of as offensive or clinical waste depending on their infectious properties.

Household gloves
Thick household gloves are used for cleaning activities, cleaning instruments or for clearing up a spillage of a hazardous material. After each use they are washed with detergent and hot water and left to dry. Household gloves used for decontamination are replaced weekly, when damaged, or if soil.

Face and eye protection
During treatment, the cleaning up of spillages and decontamination procedures there is a risk of contaminated fluids splashing into the face and eyes. Facemasks and eye protection such as visors are worn to minimise the risk.

Protective eyewear
Protective eyewear is worn whilst treating patients, during decontamination procedures and whilst clearing up a spillage of a hazardous material. As spectacles do not provide sufficient protection, it is advisable to wear a visor or face shield over spectacles. Protective eyewear is also worn whilst changing solutions in an x-ray processor. Eyewear may be reused if cleaned according to manufacturers' instructions. This should take place when it becomes visibly dirty and/or at the end of each session.

Patients always wear protective eyewear during treatment. If patients' eyewear is reused, it is cleaned according to manufacturers' instructions.

Face masks
Facemasks are worn whilst treating patients, cleaning instruments and clearing up an accidental spillage of a hazardous material. Face masks are single use items and are changed after each patient, each decontamination procedure and if they become wet or soiled. Masks are removed without touching the outer surface and disposed of as offensive or clinical waste depending on their infectious properties.

Latex allergy
If a staff member suspects they are suffering from a latex allergy a doctor will be consulted and the employee's condition will be routinely monitored for the rest of their employment. A health surveillance record will be kept with their personal file. In cases of a staff member's latex allergy, nitrile or vinyl gloves and non-latex 'rubber' dam will be substituted. If a patient has latex allergy, non-latex gloves and 'rubber' dam are used e.g. nitrile or vinyl.

Single-use devices
Single-use devices such as needles, aspirator tips and mouthwash cups are utilised whenever possible. Single-use devices are never used for more than one patient and are discarded after use in an appropriate manner (e.g. sharps bin, offensive waste, special waste or clinical waste).

This symbol identifies single-use devices: 

Single-patient instruments (England only)
Endodontic reamers and files can be classified as single-patient instruments, meaning that they can be reused, but only on the same patient. Here is the procedure:

Following use, endodontic reamers and files are washed manually, but separately from other instruments.

After sterilisation the endodontic reamers and files are stored separately from other instruments in a view pack. There is a label affixed to the pack with the patient's name, date of birth, staff name, cycle number and the expiry date, which is up to one year after sterilisation. The view pack is kept in the patient's record. If the endodontic reamers and files need to be used after the sterilisation expiry date, they are reprocessed before use.

The following sections on the safe handling of sharps, manual cleaning, washer disinfectors, ultrasonic cleaning and hand hygiene have been laid out so that you can adapt them and print them off as posters

The Safe Handling of Sharps

- Cover any cuts or grazes on the skin with waterproof dressings
- Always wear gloves when handling sharps and follow the hand hygiene guidelines in M 257B
- Only use sharps if absolutely necessary
- Use 'safer sharps' where it is reasonably practicable to do so
- Do not cap/re-sheath needles after use unless it is required to prevent a risk of injury, in which case use a safer sharps device
- The primary user of the sharps will personally dispose of them into the nearest sharps container immediately after use
- Do not walk with a sharp
- Do not rush when handling sharps, even in emergency situations
- If you drop a sharp, pick it up with forceps immediately
- Do not put sharps with dressings, tissues or other items that may hide them from view
- Do not put your hand into the sharps container or try to retrieve items from it
- Do not try to press down in the sharps container to make more room
- Sharps containers should be locked closed when no more than 2/3rds full. Prior to collection they are kept in a secure area
- Keep sharps containers out of the reach of children and vulnerable adults on a level surface above waist level, but below shoulder height. To avoid spillage never put sharps containers on the floor

- Never:
    - Leave sharps lying around
    - Reach into a sharps container
    - Pass sharps directly from hand to hand
    - Overfill a sharps box
    - Put sharps into domestic, offensive, or clinical waste bags
    - Rely on others to dispose of sharps for you

Decontamination of instruments
The staff member undertaking decontamination wears: their clinical clothing, a single-use apron, eye protection, facemask and heavy-duty gloves and full coverage shoes. In case of spillage of decontamination chemicals, there are appropriate chemical neutralisers, first-aid kit and eyewash in x-ray room. Extra saline wash can be found on the ground floor music cupboard.

Instrument decontamination procedures (reprocessing) include:

- Separation and disposal of single-use instruments
- Transport of contaminated instruments to the decontamination area
- Storage of contaminated instruments
- Cleaning
- Manual cleaning
- Inspection
- sterilisation
- Storage

All new instruments including metal matrix bands etc. are decontaminated before use and instruments are always decontaminated before sending for repair or disposal.

Separation and disposal of single-use instruments
Single-use instruments are separated from other contaminated instruments. They are immediately disposed of in the appropriate way as follows:

- Needles, scalpels, sutures, endodontic reamers and files and matrix bands etc, are placed in the sharps bin
- Used and partially used anaesthetic cartridges, radiographic film covers and radiographic film lead etc., are placed in the relevant special waste containers
- Aspirator tips, 3 in 1 tips, saliva ejectors, plastic syringes, bibs, disposable visors paper towels etc, are placed in the offensive or clinical waste bin depending on their infectious properties

Contaminated instruments
The practitioner attempts where possible to remove cements and other hard materials from instruments before setting. It is our goal to dismantle and clean instruments as soon as possible after use, if this cannot be performed immediately, instruments are dismantled and stored in the ‘dirty’ transport container which is a rigid leak-proof container that has a tight fitting lid and covered or in the scrubbing tub with RO water and hospec to maintain humidity until cleaning can be carried out, note that dirty instruments are stored for the least time possible.

Storage of contaminated instruments overnight
On the few occasions when the team members do not have time to complete the full decontamination of instruments, the following procedure is followed:

- Instruments are pre-cleaned and dried
- They are placed in container clearly marked ‘contaminated instruments’
- The full reprocessing cycle of the dental instruments is carried out as soon as possible, as micro-organisms can accumulate during storage

Manual Cleaning

Take care to avoid splashing or the creation of aerosols,
Maintain a dirty to clean workflow

- Wash your hands
- Wear thick rubber gloves, workwear, single-use plastic apron, full coverage shoes, facemask, eye protectors
- Prepare sinks, equipment and setting down areas
- Dismantle and open instruments
- Fill the clean washing sink with cool water at a temperature recommended by the detergent manufacturer, which should not exceed 45^{o}C
- Fully immerse the instruments and keep them immersed during cleaning, with sharp ends pointing away
- Agitate/scrub the instruments with long handled plastic brushes (not wire brushes)
- Drain the cleaning solution
- Rinse with RO water using a dedicated rinsing bowl that is only used for rinsing in a single sink
- After rinsing drain and, if they are to be wrapped for the vacuum autoclave, dry the instruments with single-use non-linting cloth immediately
- Visually inspect the instruments with an illuminated magnifier:
    - For cleanliness – re-clean items if necessary, paying attention to serrated surfaces e.g. mosquito forceps, jaws of extraction forceps and hinges
    - For function – discard if damaged, blunt, bent or rusted
- Lubricate any relevant items prior to sterilisation, with dedicated 'pre-sterilisation' lubricant (non-oil) following manufacturers' recommendations
- Dispose of cleaning cloths etc. as offensive or clinical waste depending on their infectious properties
- Replace cleaning solution and rinse water after each use
- Wash cleaning brushes with hot water to remove visible soil and store head up (dry)
- Complete any relevant documentation

Sterilisation
The Weekly Autoclave Checklist (M 257E) is followed for the set up and testing of autoclaves at the beginning of the day, and the emptying and cleaning at the end of the day. All sterilisation cycles are recorded on the Autoclave Cycle Log (M 257F) or the Autoclave has a digital recorder and regular backups are taken. To pass the start of day test the autoclave must operate within the following ranges:

Sterilizing temperature range		Approximate pressure (bar)	Minimum Hold Time in Minutes
Minimum	Maximum		
134	137	2.25	3
126	129	1.5	10
121	124	1.15	15

On no account are any safety features interfered with, circumvented or overridden. In case of a test failure, the equipment is taken out of service and the Decontamination Lead is consulted. If necessary, a maintenance engineer will be contacted. The autoclave will not be used unless it passes all tests.

As a pressure vessel each autoclave has a written scheme of examination, it is routinely inspected and tested by a Competent Person (pressure vessels), plus quarterly and yearly testing, inspection and validation as required. Servicing, repair, validation and testing by the engineer is recorded on the Individual Equipment Record (M 271B).

Using a downward displacement autoclave
The autoclave is set up and tested following the steps in the Weekly Autoclave Checklist (M 257E). After cleaning, dry instruments are placed in the autoclave without overloading the trays. Perforated trays, cassettes or racks are used that have been validated for the selected sterilisation cycle. Handpieces are lubricated using a can of oil that is only used before sterilisation (according to the manufacturers' instructions). Instruments are **not** wrapped before sterilisation. A record of the cycle or any faults is made on (M 257F).

Sterile barrier systems
The following are used to wrap instruments:

- A flexible peel pouch (sealed view pack). This is typically supplied sealed on three sides with the remaining side open for the insertion of dental instruments
- Pre-formed rigid trays with die-cut lids (the lid may be permeable or impermeable). These trays are potentially suitable for use with displacement or vacuum sterilisers. Subject to manufacturers' instructions, the trays may be used to contain dental instruments during the sterilisation process and in subsequent storage)
- Header bags. These are manufactured as sealed bags with a heat-sealed permeable closure, which can be peeled off. This is used for storage of larger items

Instrument wrapping
Before wrapping sterilised instruments, the worktop is cleared of clutter and is cleaned with a pre-prepared or single-use disinfectant wipe and allowed to dry.

Instruments are wrapped AFTER sterilisation with a displacement (non-vacuum) autoclave, when dry, in one of the sterile barrier systems above and the expiry date of up to one year in the future.

Instruments are wrapped BEFORE sterilisation with a vacuum autoclave using one of the sterile barrier systems above. Following sterilisation the instruments are allowed to dry and then a label with the cycle number, the expiry date of up to one year in the future and the signature of the staff member is affixed to the view pack. Written information is not directly written onto the wrapper as this may damage it. If the wrapper is not transparent the label will identify the contents.

Storage of sterilised instruments
Staff hands are clean and new gloves are donned before handling unwrapped sterilised instruments. Instruments are stored in an environment where they are protected against excessive heat and where conditions remain dry.

Storing unwrapped instruments in a clinical area
Following sterilisation, unwrapped instruments are stored for up to one day in a clinical area. Instruments are not stored on open work surfaces, they are protected from contamination in covered drawer inserts/boxes or in covered trays. All unwrapped instruments stored in clinical areas are reprocessed end of the day.

Wrapped instruments
Instruments that were wrapped before sterilisation with a vacuum autoclave or after sterilisation with a non-vacuum (displacement) autoclave are stored for up to one year.

Before using instruments check that:

- If packed, the packaging is intact and the packaging indicates that sterilisation has taken place
- The expiry date has not passed, if it has passed send the instruments for reprocessing
- The instruments with the earliest use by dates are used first (first in first out)
- There is no visible soil
- If in a covered container, the instruments have remained covered

Zoning of surfaces
Areas that could be contaminated during treatment procedures are identified, planning is carried out to keep these areas to a minimum and they are decontaminated in-between patients. If any surfaces are difficult to clean they are protected with a single-use barrier as well as being decontaminated in between patients.

Decontamination of treatment areas
Disinfectant or detergent is used to reduce contamination on surfaces. Spray bottles are used to apply cleaning or disinfecting solutions but as bacteria can contaminate the bottles and become adapted to these solutions and grow in the spray mechanisms, all spray bottles are **single-use and are never refilled**. Cleaning centres on simple techniques using disposable cloths wetted with clean water and detergent, the surfaces are then dried. We use single use Steri wipes + disinfectant wipes and dried with single use towel roll if necessary.

Decontamination of treatment areas in between patients
The areas and equipment cleaned and dried in between patients include:

- Work surfaces
- Dental chair/ unit
- Curing lamp
- Inspection lamp
- Hand controls
- Trolleys (GB/KA surgeries only)
- Spittoons
- Aspirators
- Dental Microscope (KA only)

Decontamination of treatment areas at the end of every clinical session
The areas that are cleaned and dried at the end of each session include:

- Aspirator - by fitting new disposable tips and aspirating Orotol non foaming solution (20ml to 1 litre of water) through each tube
- Spittoon - by allowing the water to run for 30 seconds, then cleaning with a steri wipe + and a single use cloth with pray detergent Viakal. This is then followed by a second rinse with running water 30 seconds
- Dental chair unit- Steri wipe +
- Taps- single use cloth and viakal spray
- drainage points- single se cloth and viakal spray
- splash backs- Steri wipe +
- Cupboard doors- Steri Wipe +
- Sinks- steri wipe + then single use cloth with viakal spray
- Keyboard- Steri Wipe +
- computer screen- Steri Wipe +
- Bottom of chair unit- Steri wipe +
- X-ray unit Steri wipe +
- Microscope unit- Steri Wipe +
- Chair filters flushed and left over night to soak in diluted miltons
- Work surface- Steri Wipe +
- Drain Autoclave system - wipe door seal with towel roll and leave chamber open to air dry
- offensive waste bin- swan neck cable tie and disposed of in yellow locked waste bin
- Clinical waste - orange or yellow bag with swan neck cable tie and disposed of in locked waste bin
- Chair bottle removed and left inverted to fully air dry over night
- Fully wipe down nurses and dentist working chair.
- floors mopped with water and bleach using colour coded yellow mop and bucket.

Computer keyboards
The computer keyboards are protected with keyboard protectors that are easy-clean and waterproof. these are cleaned throughout the day and at the end of every session with Steri Wipe +. The keyboards are never touched with gloved hands.

Decontamination of equipment
RO, sterilisers, x-ray equipment, digital sensors and other equipment are cleaned and decontaminated according to manufacturer's instructions on a routine basis and if sent for repair.

The reusable intra-oral film/sensor is decontaminated by- single use barrier envelopes and Steri Wipe +The OPG bite stick is decontaminated by - Manually scrubbed and autoclave cycle
The Ceph ear pieces are decontaminated by -Steri Wipe +

Any equipment defects found during decontamination are reported to the Decontamination Lead and dealt with accordingly. Domestic cleaning of equipment is covered in M 257I.

Disinfection of impressions and appliances before sending to laboratory
Following removal from the mouth, impressions and appliances are immediately rinsed under running water until visibly clean. They are then immersed in the impression disinfectant bath with Perform ID or Steradif for the manufacturer's recommended period of 15 minutes or Bossklein impactive P for the recommended 60 seconds. The impression/appliance is then rinsed thoroughly and packaged for dispatch to the laboratory. If using spray disinfectant, to avoid inhalation the object is placed inside a plastic bag and sprayed and left sealed in the bag for the time recommended by the spray manufacturer. A label is applied to the impression bag to inform the laboratory that the impressions/appliances have been disinfected.

Appliances received from the laboratory are disinfected as follows: They are immersed in the impression disinfectant bath for the manufacturer's recommended period, and they are then rinsed thoroughly before they are placed in the patient's mouth.

Laboratory infection prevention
The Laboratory Infection Prevention Questionnaire (M 257K) is sent to our dental laboratories, it has been reviewed to ensure that each laboratory is using appropriate disinfection methods. It is also used to inform the laboratories that all impressions and appliances are disinfected before being sent to them.

Equipment or instruments to be sent for repair
Equipment is cleaned and disinfected and if appropriate sterilised before sending for repair. If it cannot be sterilised it is cleaned and disinfected. The equipment is labelled as disinfected or sterilised as appropriate.

X-ray equipment
X-ray film sleeves are handled with gloves; care is taken not to touch the actual film with the gloved hand. Film sleeves are disposed of in the offensive waste bin. Heat sterilizable or single use film-holders are used. Single-use covers are used on digital x-ray film. The equipment is disinfected according to manufacturer's instructions.

Dental unit waterlines
Water gap
To ensure that infective agents are not introduced into the water supply this practice has an air gap between mains water and any water delivery equipment that comes into contact with blood or saliva.

Practice water
The practice always makes sure that the hardness of water used during the decontamination cycle is compatible with the detergent chosen. The water used for decontamination is from a reverse osmosis filter tap. The practice is in a hard water area and we now use a water conductivity meter to monitor and ensure out filter is changed when needed.

All taps are flushed on Monday morning or following a holiday at the beginning of the first session for two minutes. Routine monitoring of water temperature and quality is carried out by a spare nurse on a monthly basis who follows the checks in the water management log. A Legionella risk assessment is performed annual basis by Bison assist

The water used in dental units is

- Delivered by a bottled water delivery system. The bottle is emptied at the end of the day, washed out with RO water and left upside to dry. If there is visual contamination it is flushed with disinfectant and washed

Waterlines are flushed for three minutes at the beginning and end of the day or after a prolonged period of non-use such as lunch. In between patients they are flushed for 30 seconds.

Waterlines are disinfected daily by the dental nurse using either Oxyginal or Proxy solution, and a weekly shock treatment is carried out by the dental nurses

Waterlines are emptied at the end of the day.

The infected team member
It is the responsibility of all dental healthcare personnel to maintain an awareness of their health. Should a person consider that s/he has contracted an infectious disease or may have been exposed to one the Decontamination Lead should be contacted before any further work is carried out. It may be necessary to modify working patterns or avoid certain procedures or even to stay at home. In the case of major disease an expert opinion will be obtained. See Briefing on Engaging Individuals with HIV (B 170).

Dealing with spilt, potentially infective materials
If there is a spill of blood or other potentially infective body fluid the following actions are taken:

- The process is initiated as soon as possible
- The staff member dons a mask, disposable apron, protective eye-wear and thick gloves
- Absorbent tissues or kitchen roll are placed onto the spill until it is completely absorbed
- Hypochlorite is made up either freshly using hypochlorite-generating tablets or at least weekly in clean containers at 10,000ppm available chlorine. Care is taken to avoid corrosive damage to metal fittings etc.
- The hypochlorite is poured onto the tissues to soak them, It is left to soak for at least 10 minutes
- More tissues are placed to absorb the hypochlorite solution
- The tissues are collected with two pieces of card such as two record cards and placed in a sealed bag in the offensive or clinical waste bin depending on their infectious properties
- The area is wiped with the hypochlorite solution afterwards

Clinical clothing is changed if it becomes soiled with potentially infective materials. Alcohol is NOT used for cleaning in this situation. If the surface is metal, the surface is cleaned with water and detergent and dried after the use of bleach, to remove any traces of bleach, which can damage metal surfaces.

Waste
The dental team members are responsible for ensuring that waste is:

- Correctly segregated
- Stored safely and securely on the premises
- Packaged appropriately for transport
- Described accurately and fully on the accompanying documentation when removed
- Transferred to an authorised person for transport to an authorised waste site;
- Appropriately registered for hazardous waste (if the practice produces more than 500kg) of hazardous waste per year with necessary records and returns at premises (Wales only)

Practice waste is segregated and disposed of in accordance with the procedures set out in the Waste Management Policy (M 233-WMP)-England / (M 233-WMP(W))-Wales.

Hand Hygiene Policy and Procedure

Clean hands are essential to minimise the risk of cross infection and to safeguard the health of the hands:

- Fingernails are kept short, smooth and clean. Staff undertaking dental procedures do not have nail enhancements such as false nails, nail art or nail varnish. When viewed from the palm side, no nail is visible
- The practice does not use bar soap or nail brushes. Nails are cleaned with a blunt 'orange' stick
- Team members are aware that gloves do not replace the need for hand hygiene and that alcohol wipes are not used as a substitute for hand rubs
- Hand and wrist jewellery is removed prior to the clinical session (rings can be worn on a neck chain for convenience)
- Bins are foot or sensor operated
- Team members are aware that when referring to the term 'hand hygiene', either handwashing or using antimicrobial-based hand rub is acceptable
- Antimicrobial hand rubs conforming to BS EN 1500 can be used on visibly clean hands as an alternative to hand washing. Hands are rubbed using the technique on the Hand Hygiene Poster (M 257G) for about 20-30 seconds, until they are dry
- Hands are washed following the technique on the hand hygiene poster (M 257G), with cool water using mild liquid soap, rubbing hands for at least 15 seconds, then rinsing thoroughly. Hands are then dried with a soft, high quality disposable paper towel, taking care not to damage the skin. The entire process should take 40-60 seconds
- Hand hygiene is carried out:
    - Before and after each treatment
    - Before after and after the removal of PPE
    - Following the washing of dental instruments
    - Before contact with sterilised instruments (wrapped or unwrapped)
    - After cleaning or maintaining decontamination devices used on dental instruments
    - At the completion of decontamination work
- Hands are washed:
    - At the beginning of each clinical session
    - If they are visibly soiled
    - Before donning PPE
    - If there is a build up of antibacterial hand rub (follow manufacturers' advice on the maximum number of uses of hand rubs before washing)
    - After coming in contact with body fluids or cleaning an area contaminated with diarrhoea or vomiting
    - At the end of each clinical session after removing eye protection, face mask and apron
- A hypoallergenic, water-based hand cream is applied at the end of each clinical session (Note that it is not to be applied before donning gloves as it may damage their integrity)
- The Hand Hygiene Poster (M 257G) is displayed above every hand washing basin

Surgical Hand Washing Policy and Procedure

Surgical hand washing is carried out before aseptic surgical procedures. Our policy is that:

- Medicated hand soap such as chlorhexidine gluconate 4% or povidone iodine 7.5%/10% is used, unless there is a sensitivity to antiseptic cleaners in which case hands are washed with a plain liquid soap instead followed by two applications of antibacterial-based hand rub. All antimicrobial hand rubs conform to BS EN 1500
- Fingernails are kept short, smooth and clean. Staff undertaking aseptic courier procedures do not have nail enhancements such as false nails, nail art or nail varnish. When viewed from the palm side, no nail is visible
- The practice does not use bar soap or nail brushes. Nails are cleaned with a blunt 'orange' stick
- Team members are aware that gloves do not replace the need for hand hygiene and that alcohol wipes are not used as a substitute for hand rubs
- Hand and wrist jewellery is removed prior to the clinical session
- Bins are foot or sensor operated
- A hypoallergenic, water-based hand cream is applied at the end of each clinical session (Note that it is not to be applied before donning gloves as it may damage their integrity)

We wash our hands for surgical procedures following WHO guidance by:

- Scrubbing each side of each finger, between the fingers, and the back and front of the hand for 2 minutes
- Then scrubbing the arms whilst keeping the hand higher than the arm at all times. We wash each side of the arm from wrist to elbow for 1 minute
- Repeating this process on the other hand and arm whilst keep the hand higher than the arm at all times
- Rinsing hands and arms by passing them through water in one direction only, from finger tips to elbow. Do not move the arm back and forth through the water
- Proceeding to the treatment area holding hands above elbows
- Drying hands and arms using a sterile towel and aseptic technique
- Applying hand rub using the technique found in M 257GB after donning cap and mask
- Donning gloves and other surgical attire such as gowns, etc.

Additional notes:

- If at any time the hand touches anything, the scrub must be lengthened by 1 minute for the area that had been contaminated
- Care should be taken not to splash water onto surgical attire]

Ventilation
A high volume aspirator is used to keep aerosol to a minimum. The aspirator vents outside of the building are not positioned where someone could inadvertently breathe the expelled air. A rubber dam is used whenever possible to further reduce splatter. The treatment room is adequately ventilated. (NOTE an open window may suffice or if there is no window, a mechanical ventilation system should refresh the air in the surgery.)

Kitchen
The staff kitchen is kept clean and tidy. Instruments and equipment are not cleaned in the staff kitchen sink. Clinical materials are not stored in the same fridge as food.

Tidiness
General tidiness and cleanliness of the practice is maintained for health and safety reasons and for the comfort of our patients. Every team member is responsible for tidiness, orderliness and cleanliness. Boxes are never left in public areas and staff regularly check the patients' toilets throughout the day. The Practice Manager has overall responsibility.

End of day routines
At the end of the day the treatment rooms are left tidy, with all sharp instruments stored away. It is the responsibility of the dental nurse to ensure that clinical waste bins are emptied and sharps bins are left where they cannot be disturbed and that all surfaces have been decontaminated.

The nurse must also ensure that no sharp or contaminated instruments or potentially infective materials are left in the treatment room; this includes splashes around the spittoon or on the floor and appliances that have been removed from the patient's mouth.

Disinfectants
The disinfectants used in this practice are: Steri Wipe +, clinell spray disinfection, hospec, perform ID, Stera Dif, Bossklein impactive IP, Viakal spray, Miltons and Bleach.

Disinfectants are stored in: Individual surgeries and locked in a store designated COSHH cupboard.

Disinfectants are disposed by: Dental Nurses's

Sharps spillage
In case of a sharps spillage, the most senior member of staff should stay by the spillage to keep other personnel clear. The nearest person is sought to bring the sharps spillage kit, which consists of:

- Heavy duty gloves
- Dust pan
- Rigid piece of straight edged cardboard or plastic
- A spare sharps container (not assembled)
- A sharps container larger than containers in use in the practice (unassembled). The container must be large enough to place the type of sharps containers used in the practice inside it

The senior staff member should wear heavy-duty gloves and gently ease the loose sharps onto the dustpan using the rigid piece of cardboard or plastic. These are then carefully placed in the spare sharps container and the lid applied. This procedure must be carried out with extreme caution as sharps can penetrate heavy-duty gloves.

In the case of a single discarded sharp, if the sharp is fully visible, the senior person present may feel able to safely pick it up and place it promptly in a sharps container. Otherwise follow the same procedure as for a spillage.

If a sharps container has been over-filled and cannot be closed, do not retrieve items from it. Instead wear heavy-duty gloves and place it in the larger unassembled container in the sharps spillage kit. Then carefully assemble and lock the outer container.

Providing and maintaining a clean environment, domestic cleaning
Our procedures and governance for cleaning follow the National specifications for cleanliness in the NHS (2007).

We pay particular attention to the maintenance of appropriate standards of cleanliness and hygiene in relation to:

- Dental practice premises
- Equipment and reusable medical devices
- Materials to be used in the treatment of service users, where such materials are at risk of being contaminated

To achieve this we have appropriate documentation as outlined in our *Domestic Cleaning Policy (M 233-DCL).*

All team members share the responsibility for maintain a clean and safe environment. Cleaning requirements are:

- Identified
- Risk Assessed
- Allocated to the appropriate person
- Performed to the required standard

Cleaners
The cleaners are provided with training in health and safety infection prevention, and the specific instructions for cleaning the rooms of the practice. Details are kept in the cleaner's staff training record (M 222E). Staff are trained how to spot clean if required to do so.

General cleaning
The practice is cleaned according to the schedule in M 257I. The colour coding for household gloves, buckets and cleaning cloths is based on the NPSA 'Colour coding hospital cleaning materials and equipment':

- RED - bathrooms, washrooms, showers, toilets, sinks and floors in sanitary areas
- BLUE - general areas including waiting rooms and consultation rooms (not treatment rooms), decontamination floors and walls, reception and offices including sinks in general areas
- GREEN – kitchen/food areas
- YELLOW – treatment rooms, decontamination rooms and isolation areas (e.g. doffing areas)

Cleaning Guidelines and Procedure

- Cleaners wear a clean uniform for each shift, and if the uniform becomes visibly contaminated or soiled they change into another one as soon as they can
- Uniform sleeves should either end above the elbow or be kept rolled up above the elbow when undertaking cleaning duties
- Wristwatches and jewellery are removed before any cleaning activity
- Protective domestic gloves and a disposable plastic apron are worn for all cleaning activities
- Cleaning equipment is colour coded e.g. mop heads, gloves and cloths used for toilets, kitchens and clinical areas. Different colours are used for each area according to the list above
- Non-shedding cloths or paper rolls are used for cleaning
- General-purpose detergent is used for all environmental cleaning following the manufacturers' instructions, unless there is a known contamination
- Equipment and materials used for general cleaning are kept separate from those used for decontamination
- Mops and buckets are kept clean and dry, with mop heads stored up and buckets stored upside down
- Where carpets are in place, they have regular steam cleaning and spot cleaning
- Team members are aware of contact times for the products they use and follow manufacturer's instructions

Cleaning procedures

- Plastic bucket contents are emptied down the toilet; buckets are rinsed and cleaned with general purpose detergent then dried. If body fluids have been in contact with the bucket, it is rinsed after cleaning with a 0.1% (1000 ppm available Cl) hypochlorite solution

- Mops are disposable and the mop is discarded weekly or sooner if heavily soiled or contaminated with body fluids. After use mops are washed with hot water and GPD then dried and stored head up. If mop has ben contaminated it is washed with warm water and general purpose detergent then rinsed with a 0.1%
  (1,000 ppm available Cl) hypochlorite solution
- Dry mops are vacuumed after each use
- Lavatory brushes are rinsed in flushing water and stored dry
- Cleaning is always performed from top to bottom and clean to dirty
- Large and flat surfaces are cleaned using an 'S' shape motion, starting at the point furthest away, then overlapping slightly whilst avoiding recontamination
- Damp cloths (hot water and detergent) are used when dusting, with high horizontal surfaces being cleaned first
- Floors are always cleaned last, with adequate safety signage placed while floors are cleaned and dry. Once floors are completely dry, the signs are removed so as not to be a trip hazard
- Dust is kept to a minimum on floors with the use of a vacuum or dry mop
- If there is a known contamination on furniture or fittings, cleaning is followed with a 0.1% (1,000 ppm available Cl) hypochlorite solution
- Walls, ceilings, equipment cases, fixtures and fittings are cleaned with hot water and detergent. If there are splashes of blood, or known contaminated material these are cleaned promptly with 0.1% (1,000 ppm available Cl) hypochlorite solution

General
There is no eating, smoking or drinking in the treatment room. Disposable cups are used for the patient mouthwash and disposable bibs are used to protect the patient's clothes. The sharps container and clinical/ offensive waste bins are kept out of reach of the patients and their companions.

Audit, training and review
The infection prevention and control procedures are audited as follows:

iComply members England: Twice a year using either the iComply templates or digital audit tool.

Training is provided at induction and on the job throughout the year. The procedures are regularly reviewed. All team members undertake verifiable continuing professional development on infection prevention and control topics every year.