

Document Control Report
Extension of Review date after overview at IPCC to January 2018

Title			
Aseptic Techniques Policy			
Author Infection Control Team			Author's job title
Directorate Nursing		Sub-directorate	Department Infection Control
		Team / Specialty	
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2.1	Aug 2008	Revision	Final amends to ensure corporate identity requirements.
2.2	Feb 2010	Revision	The February 2010 revision was approved at Patient Safety & Infection Prevention & Control Committee on 26 th Feb 2010.
2.3	Jun 2010	Revision	Minor amendments by Corporate Affairs to document control report, headers and footers and formatting for document map viewing.
2.4	Nov 2010	Revision	Addition of skin disinfection appendix; approved at Infection Control team on 11.11.10. Minor amendments by Corporate Affairs added hyperlinks, contents page numbering updated, document control report updated, and formatting for document map navigation.
3.0	October 2012	Final	Harmonised policy as a result of the merging of Northern Devon Healthcare NHS Trust and NHS Devon community services. Approved by Infection Prevention & Control Committee on 2 nd October following consultation. A summary of key issues and differences is on page 3. The monitoring section has been strengthened as a result of revised NHSLA requirements.
3.1	Nov 2012	Revision	Minor amendments by Corporate Governance to document control report and updating to latest template. Formatted for document map navigation and semi-automatic table of contents. Update to Equality Impact assessment.
3.2	Jan 2016	Revision	Extension of Review date after overview at IPCC meeting in January 2016.
3.3	Oct 2017	Revision	Extension of Review date after overview at IPCC to January 2018.
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Any revision to an NHSLA policy requires the agreement of the Compliance Manager.		

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1 Introduction

This document sets out Northern Devon Healthcare NHS Trust's system for the use of aseptic technique in clinical care situations relating to wounds healing by primary and secondary intention, intravascular lines, enteral feeding tubes, urinary catheters and drainage tubes and other devices that breach the normal skin barrier and other innate bodies defence systems. It provides a robust framework to ensure a consistent approach across all clinical areas of the organisation.

2 Purpose

The purpose of this document is to define what aseptic techniques are, how they vary and when each should be used.

Aseptic technique aims to produce an environment that is free of microbial contamination in order to protect patients from developing infections (Marcovitch 2005).

Depending on the activity and the vulnerability of the patient, aseptic technique can be adjusted outside the operating theatre whilst still maintaining key principles. This allows for greater practicality without compromising safety when the risks of infection by a particular procedure and situation are less.

Where aseptic procedures are performed (DH 2009):

- Clinical procedures should be carried out in a manner that maintains and promotes the principles of asepsis.
- The technique should be standardised across the organisation.

This policy applies to all clinical staff.

Implementation of this policy will ensure a consistent approach to the use of aseptic technique across all clinical areas of the organisation.

NOTE - The dressing of invasive lines is covered by the [Intravascular Devices Policy](#) on the Trust's intranet site.

The full management of open wounds is covered by the [Care of Open Wounds Policy](#) on the Trust's intranet site.

This policy applies to all clinical and medical staff who undertake aseptic procedures

3 Definitions

3.1 Endogenous organisms

Sources of microbes for wound and other site infection can be divided into endogenous and exogenous groups. The endogenous organisms already colonise the skin, orifices and cavities of the patient.

3.2 Exogenous organisms

Micro-organisms with a source from beyond the patient's own body are called exogenous organisms.

3.3 Aseptic (theatre) technique

The level of aseptic practice required in operating theatres.

3.4 Aseptic (procedures) technique

The level of aseptic practice required when undertaking sterile procedures outside of theatres for example urethral and suprapubic urinary catheters, percutaneous gastrostomy tubes, chest drains, arterial lines, epidural lines, central IV lines (including PICC and mid (long peripheral) lines), and interventional radiological procedures.

3.5 Aseptic (non touch) technique

The level of aseptic practice required for insertion of peripheral intravenous lines, manipulation of intravenous system hubs and lines including changing IV fluids, intramuscular injections, subcutaneous injections, subcutaneous cannula insertion, taking blood specimens, removal of sutures and suctioning from endotracheal or tracheostomy tubes.

3.6 Aseptic (wound management) technique

The level of aseptic practice required when managing wounds older than 48 hours.

4 Responsibilities

4.1 Role of Director of Nursing

The Director of Nursing is responsible for:

- Acting as a second point of contact to support implementation of this policy.
- Ensuring that a replacement primary contact is identified should the original author be re-deployed or leave the organisation.

4.2 Infection Prevention & Control Team

The Infection Prevention & Control Team will support managers in the implementation of this policy by providing guidance and education in the appropriate application of aseptic and clean techniques.

This policy may not cover every eventuality, so it is imperative that professional judgment continues to be applied in all clinical situations. The Infection Prevention and Control Nurses will provide further guidance on request to clarify any aspect of practice not covered by this policy for individual clinical situations.

4.3 Clinical Staff

It is the responsibility of all Trust Clinical Staff to follow the guidance contained in this Policy and report any problems with compliance to their line manager.

5 Contacting the Infection Control Team

The Infection Prevention and Control Team can be contacted in hours on 01271 322680 (ext 2680 internal at North Devon District Hospital), via bleep 011 or out of hours by contacting the on-call Medical Microbiologist via North Devon District Hospital switchboard.

6 Aseptic Techniques

Aseptic technique aims to minimise microbial contamination of wounds and insertion sites during the procedure from exogenous and endogenous sources.

6.1 Aseptic (Theatre) Technique requires:

- Surgical hand hygiene (see [Standard Infection Control Precautions Policy](#)) as below:-
 - For first case of the operating list or between cases if hands or forearms are visibly soiled with blood or body fluids use antiseptic detergents and sterile towels, or liquid soap and water plus alcohol gel, after the wash.
 - Between cases on an operating list providing the hand and forearms are visibly clean alcohol gel alone is agent of choice.
- Sterile gloves (for scrub team).
- Sterile clothing (for scrub team).
- Masks and theatre caps (for the scrub team).
- Exhaust hoods are used for the surgical personnel for some orthopaedic procedures in laminar flow theatres.

- Masks and theatre caps (a) all personnel in laminar flow theatres; b) to be considered for personnel other than the scrub team in the standard ventilation theatres).
- Clean theatre clothing (all personnel in theatre).
- Sterile fields (for instrumentation).
- Antiseptic skin preparation of operative site (for patient).
- Sterile drapes (to create sterile field around the operative site).
- Air control (level of which is determined by the nature of the procedure).
- No touch technique for adding supplies onto sterile fields
- Control of instrumentation (avoiding mixing of sterile (unused) and used instruments/ devices
- Sterile cleaning fluids and irrigants.

Aseptic (theatre) technique is needed when making cuts or insertions into sterile body areas in the Operating Room situation.

For operative procedures, the use of a skin preparation antiseptic prior to incision is required. Chlorhexidine 2% is the agent of choice for pre-surgical incision and prior to intravascular line insertion, and is enhanced when combined in an alcohol base (it must be applied by rubbing for a minimum of 30 seconds and alcoholic solutions allowed to dry by evaporation prior to incision for full effect and to prevent flash burns if using diathermy tools). The first line alternative agent for Chlorhexidine sensitive patients is Povidone –Iodine 10%. (see Appendix B for more information on what preparation to use for which procedure.

6.2 Aseptic (Procedure) Technique requires:

- Antiseptic hand hygiene (see the [Standard Infection Control Precautions Policy](#)) prior to the procedure (soap and water hand-wash or alcohol gel at the completion of the procedure).
- Sterile gloves.
- Sterile plastic apron (found in the procedure pack for wound care) (this is to prevent contamination of the sterile field at the procedure site when working in close proximity to the patient).
- Sterile field for equipment.
- Sterile equipment (including scissors and instruments).
- Sterile field for working area.
- Sterile fluids and irrigants.
- Antiseptic skin preparation for procedural site.

In addition to the list above, aseptic (procedure) technique requires a clean surface on which to spread a sterile field. A clean surface is

defined as one that is dry and free of visible dust, soil or other residues (e.g. adhesives). Stainless steel or glass-topped trolleys are helpful to this process and can be made clean by use of detergent, water and drying. In the patient's own home specifying a clean surface can not be mandated, but may be effected by use of a clean tray or table.

Planned aseptic procedures should be undertaken in the cleanest environment that is available. Consideration needs to be given to whether the procedure should be performed in a theatre, for example central line insertion. The risks of moving the patient to such an environment need to be weighed against the potential benefits to be achieved by the highest level of aseptic technique that can be delivered.

All of the sterile items listed must, during the procedure, be utilised in a manner that prevents cross contamination of the equipment from the healthcare professional, the environment and endogenous body sites external to the procedural site itself.

Aseptic (procedure) technique for wound management is needed when a primarily closed surgical wound (stitches, staples or glue) and thermal injuries is less than 48 hours old. After this time the wound will have formed a waterproof seal with a fibrin mesh and aseptic (wound management) technique can be adopted.

Aseptic (procedure) technique is needed for insertion of urethral (including intermittent catheters) and suprapubic urinary catheters, percutaneous gastrostomy and jejunostomy tubes, chest drains, arterial lines, epidural lines, lumbar punctures, central IV lines (including PICC and mid (long peripheral) lines), interuterine devices and interventional radiological procedures. This list is not exhaustive and further advice can be sought from the Infection Prevention and Control Team.

6.3 Aseptic (Non-Touch) Technique (ANTT) requires:

- The application of aseptic principles in an ANTT requires the clinician to avoid contaminating the parts of the sterile or disinfected equipment that is to be inserted into the patient or connected together with the hands or by accidental touching with the environment or patient's skin other than on the disinfected insertion site.
- Soap and water hand-wash or use of alcohol gel before and after the procedure
- Non-sterile examination gloves (this is a minimum requirement – the use of a wound dressing or other specially designed IV insertion pack with sterile gloves and sterile field is preferred if it is available). Sterile gloves must be used for manipulation of central IV lines.
- Plastic apron if splash contamination may occur or there is to be bodily contact with the patient or their immediate environment

- Sterile equipment
- Antiseptic skin preparation (2% chlorhexidine in 70% alcohol is the agent of first choice) at procedural site for insertion of peripheral IV lines. The site must be dry by evaporation prior to making the insertion.
- Antiseptic preparation (2% chlorhexidine in 70% alcohol) of line hub, injection port or sampling point. The site must be dry by evaporation prior to making the insertion/connection. Use of antiseptics prior to changing IV fluid bags is not necessary.

ANTT is required for insertion of peripheral intravenous lines, manipulation of intravenous system hubs and lines including changing IV fluids, intramuscular injections, subcutaneous injections, subcutaneous cannula insertion, taking blood specimens, performing cervical smears, removal of sutures and suctioning from endotracheal or tracheostomy tubes. This list is not exhaustive and further advice can be sought from the Infection Prevention and Control Team.

Skin and device connections require preparation with a 2% chlorhexidine in 70% alcohol wipe. The technique for preparation of skin requires rubbing the site both vertically and horizontally for 20 – 30 seconds and allowing it to dry fully prior to insertion/injection. For device disinfection at least 5 seconds is required followed by drying evaporation. The subcutaneous injection of insulin and blood sampling for blood sugar measurements is regarded as an exception to this rule, meaning that so long as the injection site is visibly clean antimicrobial skin preparation is not mandated. Patients giving their own insulin must be taught to wash their hands prior to preparing and injecting but do not require gloves.

6.4 Aseptic (Wound Management) Technique

This aims to prevent further microbial wound contamination from exogenous sources during the procedure.

Aseptic (wound management) technique can be used with all wounds left open to heal by secondary intention, closed surgical wounds older than 48 hours, dehisced surgical wounds and traumatic wounds that have not been surgically repaired in an operating theatre.

Aseptic (wound management) technique must also be used 48 hours following insertion for dressing tracheostomies, suprapubic urinary catheters, percutaneous gastrostomy (PEG) tubes, wound drains and ambulatory peritoneal lavage tubes.

Aseptic (wound management) technique requires:

- Soap and water hand-wash or use of alcohol gel before and after the procedure
- Plastic apron if splash contamination may occur or there is to be bodily contact with the patient or their immediate environment

- Non-sterile examination gloves (this is a minimum requirement – if wound dressing or other packs are opened the sterile gloves contained within should be used)
- Sterile wound procedure pack
- If undertaking wound care with the wounds listed in this section, warm tap water may be used to irrigate the wound or clean surrounding skin; (preparation of the patient may therefore be undertaken in the shower or bath if required)
- Optional materials for wound dressings
- Sterile primary dressings
- Single patient use containers of products containing multiple doses if required (e.g. yellow soft paraffin and silver sulphadiazine tubes) or pump action dispensers of bulk emollients
- Clean commercially packed bandages for retention, support or compression (reusable bandages washed by the patient in accordance with manufacturer's instructions are acceptable in the patient's own home)
- Single patient use containers, disposable containers or plastic bag lined multi-use buckets filled with warm tap water for washing of legs and feet. Containers other than single use disposables must be lined with intact plastic bag.
- Clean and disinfected reuseable or single use scissors (normally for removal of bandages and dressings).

When undertaking an aseptic (wound management) technique ensure the following are taken into account:-

- Some part used creams may need storage in a fridge (such as silver sulphadiazine cream), so attention should be given to manufacturer's instructions. These containers require clear labeling with patient's name (unless you are in the patient's own home) and date of opening.
- Creams and ointments from multi-use multi-patient containers must be decanted onto an appropriate surface during the preparation period prior to any touching of the patient or their existing dressings. This is good practice for single patient use containers and tubes, which must be kept at the bedside or in the home and not returned to communal stock if any remains at the end of the treatment course (e.g. barrier creams, yellow soft paraffin).
- As a general principle, wounds should only be uncovered for the period of assessment and redressing. Should wounds need preparing in advance for multi-professional staff to view other than the wound dresser then the use of 'cling film' or similar clean plastic can be used to wrap the wound temporarily and cover with a blanket to maintain moisture at wound surface and warmth to maintain comfort, cellular division and prevent

dissemination of wound micro-organisms to the wider environment.

6.5 Education and Training

A training video for aseptic (wound management) technique is available on BOB in the Tissue Viability section. Further clarification on techniques can be sought through the Infection Control and Tissue Viability Teams. Aseptic (theatre) technique will be taught within the department by skilled theatre staff.

7 The Development of the Policy

7.1 Prioritisation of Work

Following vertical integration of the community services from the North Devon Primary Care Trust with the acute services, a requirement was identified to harmonise the two organisations' policies Aseptic and Clean Techniques in order to ensure consistency of advice across the Northern Devon Healthcare NHS Trust.

7.2 Document Development Process

As the author, the Infection Control Team is responsible for developing the policy and for ensuring stakeholders were consulted with.

Draft copies were circulated for comment before approval was sought from the relevant committees.

7.3 Equality Impact Assessment

The Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. An Equality Impact Assessment has been undertaken and there are no adverse or positive impacts ([see Appendix A](#)).

8 Consultation, Approval and Ratification Process

8.1 Consultation Process

The author consulted with stakeholders, including:

- Infection Control Team
- Infection Prevention and Control Committee
- Tissue Viability Team
- CNS IV Fluid Management
- Theatre Manager

- Senior Nurse Forum

Consultation took the form of a request for comments and feedback via email. Hard copies were available on request.

8.2 Policy Approval Process

This current revision was approved at 02 October 2012 pending 2 weeks for final comments. If comments were minor the committee did not require it to be returned for approval.

8.3 Ratification Process

This policy does not require ratification by the Board.

9 Review and Revision Arrangements including Document Control

9.1 Process for Reviewing the Policy

The policy will be reviewed every three years. The author will be sent a reminder by the Corporate Governance Manager four months before the due review date. The author will be responsible for ensuring the policy is reviewed in a timely manner and that the reviewed policy is approved by the Infection Prevention and Control Committee.

If this policy has been identified as required by the NHS Litigation Service (NHSLA), the author will ensure the Compliance Manager is sent an electronic copy.

All reviews will be recorded by the author in the Document Control Report.

9.2 Process for Revising the Policy

In order to ensure the policy is up-to-date, the author may be required to make a number of revisions, e.g. committee changes or amendments to individuals' responsibilities. Where the revisions are minor and do not change the overall policy, the author will present the revised version to the Clinical Manager for Infection Control or the Director of Infection Prevention and Control for approval.

Significant revisions will be presented to the Infection Prevention and Control Committee for approval.

For NHS Litigation Authority (NHSLA) policies, the author will notify the Compliance Manager when a revision is being made or when the document is reviewed. The Compliance Manager will ensure that the revised document meets the NHSLA/CNST standards.

All revisions will be recorded by the author in the Document Control Report.

9.3 Document Control

The author will comply with the Trust's agreed version control process, as described in the organisation-wide Guidance for Document Control.

10 Dissemination and Implementation

10.1 Dissemination of the Policy

After approval, the author will provide a copy of the policy to the Corporate Governance Manager to have it placed on the Trust's intranet. The policy will be referenced on the home page as a latest news release.

Information will also be included in the regular Chief Executive's Bulletin which is circulated electronically to all staff.

An email will be sent to senior management to make them aware of the policy and they will be responsible for cascading the information to their staff.

In addition, staff will be informed that this policy replaces any previous versions.

10.2 Implementation of the Policy

Line managers are responsible for ensuring this policy is implemented across their area of work.

The Infection Control Team will be available for advice on any aspect of this policy.

11 Document Control including Archiving Arrangements

11.1 Library of Procedural Documents

The author is responsible for recording, storing and controlling this policy.

Once approved, the author will provide a copy of the current policy to the Corporate Governance Manager so that it can be placed on the Trust's intranet site. Any future revised copies will be provided to ensure the most up-to-date version is available on the Trust's intranet site.

11.3 Archiving Arrangements

All versions of this policy will be archived in electronic format within the Infection Control policy archive. Archiving will take place by the Lead CNS Infection Control once the final version of the policy has been issued.

Revisions to the final document will be recorded on the Document Control Report. Revised versions will be added to the policy archive held by the Infection Control Team.

11.3 Process for Retrieving Archived Policy

To obtain a copy of the archived policy, contact should be made with the Infection Control Team.

12 Monitoring Compliance With and the Effectiveness of Procedural Documents

12.1 Process for Monitoring Compliance and Effectiveness

Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by including education for relevant staff on mandatory e-learning and on EPSU (essential patient safety updates) for nurses.

Audit will be undertaken as set out in the Infection Control Operational Policy annual audit schedule following implementation of this updated policy.

Results will be reported to PSIPCC annually. Where non-compliance is identified, support and advice will be provided to improve practice. This may include additional training for specific groups of staff; increased frequency of audit and observation of clinical practice.

12.2 Standards/ Key Performance Indicators

Key performance indicators comprise:

- Reduction of vascular line site infections from national prevalence survey 2006 and for urinary catheter site infections data collected during 2012.
- Clinical staff perform techniques correctly when observed either on individual occasions or during formal audit of practice. Formal audit of practice will initiate in January 2013.

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14 Associated Documentation

- [Care of Open Wounds Policy](#)
- [Incident Reporting Policy](#)
- [Intravascular Devices Policy](#)
- [Standard Infection Control Precautions Policy](#)

Appendix A: Equality Impact Assessment Screening Form

Equality Impact Assessment Screening Form			
Title	Infection Control Aseptic Techniques Policy		
Author	Andrew Kingsley, Clinical Manager of Infection Control and Tissue Liability		
Directorate	Nursing		
Team/ Dept.	Infection Control		
Document Class	Document Status	Issue Date	Review Date
Policy	Revision	November 2012	November 2015
1	<p>What are the aims of the document?</p> <p>This document sets out Northern Devon Healthcare NHS Trust's system for the use of aseptic technique in clinical care situations relating to wounds healing by primary and secondary intention, intravascular lines, enteral feeding tubes, urinary catheters and drainage tubes and other devices that breach the normal skin barrier and other innate bodies defence systems. It provides a robust framework to ensure a consistent approach across all clinical areas of the organisation.</p>		
2	<p>What are the objectives of the document?</p> <p>The purpose of this document is to define what aseptic and clean techniques are and when they should be used.</p> <p>Aseptic technique aims to produce an environment that is free of microbial contamination in order to protect patients from developing infections (Marcovitch 2005). Depending on the activity and the vulnerability of the patient, aseptic technique can be adjusted outside the operating theatre whilst still maintaining key principles. This allows for greater practicality without compromising safety when the risks of infection by a particular procedure and situation are less.</p>		
3	<p>How will the document be implemented?</p> <p>Implementation of this policy will ensure a consistent approach to the use of aseptic technique across all clinical areas of the organisation.</p>		
4	<p>How will the effectiveness of the document be monitored?</p> <p>Monitoring compliance with this policy will be the responsibility of the Lead CNS Infection Control. This will be undertaken by auditing all new and reviewed policies before they are presented to the Board for ratification to ensure they are compliant with this policy on a rolling basis. Where non-compliance is identified, support and advice will be provided to improve practice. This may include additional training for specific groups of staff; increased frequency of audit and observation of clinical practice.</p>		
5	<p>Who is the target audience of the document?</p> <p>This policy applies to all clinical staff.</p>		
6	<p>Is consultation required with stakeholders, e.g. Trust committees and equality</p>		

	groups? Yes			
7	Which stakeholders have been consulted with? <ul style="list-style-type: none"> • Infection Control Team • Infection Prevention and Control Committee • Tissue Viability Team • CNS IV Fluid Management • Theatre manager 			
8	Equality Impact Assessment Please complete the following table using a cross, i.e. X . Please refer to the document “A Practical Guide to Equality Impact Assessment”, Appendix 3, on Tarkanet for areas of possible impact. <ul style="list-style-type: none"> • Where you think that the policy could have a positive impact on any of the equality group(s) like promoting equality and equal opportunities or improving relations within equality groups, cross the ‘Positive impact’ box. • Where you think that the policy could have a negative impact on any of the equality group(s) i.e. it could disadvantage them, cross the ‘Negative impact’ box. • Where you think that the policy has no impact on any of the equality group(s) listed below i.e. it has no effect currently on equality groups, cross the ‘No impact’ box. 			
Equality Group	Positive Impact	Negative Impact	No Impact	Comments
Age			X	
Disability			X	
Gender			X	
Gender reassignment			X	
Human Rights (rights to privacy, dignity, liberty and non degrading treatment)			X	
Marriage and civil partnership			X	
Pregnancy, maternity and breastfeeding			X	
Race / Ethnic Origins			X	
Religion			X	

or Belief				
Sexual Orientation			X	
	<p>If you have identified a negative discriminatory impact of this procedural document, ensure you detail the action taken to avoid/reduce this impact in the Comments column. If you have identified a high negative impact, you will need to do a Full Equality Impact Assessment, please refer to the document "A Practical Guide to Equality Impact Assessments", Appendix 3, on Tarkanet.</p> <p>For advice in respect of answering the above questions, please contact the Equality and Diversity Lead.</p>			
9	<p>If there is no evidence that the document promotes equality, equal opportunities or improved relations, could it be adapted so that it does? If so, how?</p> <p>No</p>			

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Appendix B: Skin and Intravascular Device Disinfection guide

<h2 style="text-align: center;">Skin and Intravascular Device Disinfection</h2> <h3 style="text-align: center;">WHAT PRODUCT TO USE FOR WHAT PROCEDURE?</h3>		
<p>2% CHLORHEXIDINE in 70% ALCOHOL – 500ml BOTTLE</p>  <p>NHS Supplies Code - MRB613</p>	 <p>NHS Supplies Code – VJT103</p>	<p>0.5% CHLORHEXIDINE in 70% ALCOHOL SPRAY PUMP</p>  <p>Order from Pharmacy</p>
<p>USE FOR:- (Apply to skin with sterile gauze, rub the site horizontally and then vertically for a total of 30 seconds and allow to air dry to maximise the antiseptic effect <u>before</u> you make your incision/insertion)</p> <ul style="list-style-type: none"> • Surgical skin preparation (NOTE : if red stain required order on MRB334) • Central venous catheter insertions. (If using pack, use product provided) • Chest drain insertions <p>NOTES: <i>Do not use on neonates if <32weeks (use a 0.05% CHG reparation)</i> <i>Due to low risk for arachnoiditis secondary to chlorhexidine contamination the above preparation is not advised for CNS access (epidural insertions, lumbar punctures, spinal anaesthetics) – use a 0.5% CHG in 70% alcohol solution</i></p>	<p>USE FOR:-</p> <ul style="list-style-type: none"> • Peripheral IV cannulations • Arterial line cannulations • Subcutaneous device insertions • Port and hub access • Venepuncture • IM injections • Joint aspiration • Breast biopsies • Blood cultures (skin and bottle tops) • Arterial blood samples (stabs and line samples) • Ampoule and vial tops (prior to opening) • Urinary catheters – ports pre-sampling & taps after emptying bag <p>NOTES: <i>Do not use on neonates if <32weeks (use a 0.05% CHG preparation)</i> <i>Due to low risk for arachnoiditis secondary to chlorhexidine contamination the above preparation is not advised for procedures accessing CNS (epidural insertions, lumbar punctures, spinal anaesthetics) – use a 0.5% CHG in 70% alcohol solution</i></p>	<p>USE FOR:- (After spraying, rub the site horizontally and then vertically for a total of 30 seconds with sterile gauze and allow to air dry to maximise the antiseptic effect <u>before</u> you make your insertion)</p> <ul style="list-style-type: none"> • Epidural insertions • Lumbar punctures • Spinal anaesthetics • Pre-preparation of central IV line insertion sites. Final skin preparation prior to insertion must be 2% Chlorhexidine

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Appendix C: Which technique to use

Type of technique	Example procedures	Key features of technique
Aseptic (Theatre) Technique	All procedures in operating theatres	<p>Surgical hand hygiene (see Standard Infection Control Precautions Policy)</p> <p>Sterile gloves (for scrub team)</p> <p>Sterile clothing (for scrub team)</p> <p>Masks and theatre caps (for the scrub team)</p> <p>Exhaust hoods are used for the surgical personnel for some orthopaedic procedures in laminar flow theatres</p> <p>Masks and theatre caps</p> <p>(a) all personnel in laminar flow theatres;</p> <p>b) to be considered for personnel other than the scrub team in the standard ventilation theatres)</p> <p>Clean theatre clothing (all personnel in theatre)</p> <p>Sterile fields (for instrumentation)</p> <p>Antiseptic skin preparation of operative site (for patient)</p> <p>Sterile drapes (to create sterile field around the operative site)</p> <p>Air control (level of which is</p>

		<p>determined by the nature of the procedure)</p> <p>No touch technique for adding supplies onto sterile fields</p> <p>Control of instrumentation (avoiding mixing of sterile (unused) and used instruments/ devices</p> <p>Sterile cleaning fluids and irrigants.</p>
Aseptic (Procedure) Technique	<p>All insertions of:-</p> <ul style="list-style-type: none"> • Urinary catheters (urethral (inc. intermittent) and suprapubic • Gastrostomy tubes • Jejunostomy tubes • Chest drains • Arterial lines • Central IV lines (including PICC and mid lines) • Epidural lines • Lumbar punctures • Interuterine devices <p>All interventional radiological procedures</p>	<p>Antiseptic hand hygiene (see the Standard Infection Control Precautions Policy) prior to the procedure (soap and water hand-wash or alcohol gel at the completion of the procedure)</p> <p>Sterile gloves</p> <p>Sterile plastic apron (found in the procedure pack for wound care) (this is to prevent contamination of the sterile field at the procedure site when working in close proximity to the patient)</p> <p>Sterile field for equipment</p> <p>Sterile equipment (including scissors and instruments)</p> <p>Sterile field for working area</p> <p>Sterile fluids and irrigants</p> <p>Antiseptic skin preparation for procedural site.</p>
Aseptic (Non-Touch) Technique - ANTT	<p>All insertions and manipulations of:-</p> <ul style="list-style-type: none"> • peripheral intravenous lines • intravenous system hubs and lines including changing IV fluids • subcutaneous cannulae <p>Injections and sampling</p> <ul style="list-style-type: none"> • intramuscular 	<p>Hand hygiene – before and after with soap and water or alcohol gel</p> <p>Antiseptic skin preparation</p> <p>Non-sterile examination</p>

	<ul style="list-style-type: none"> • subcutaneous • blood specimens • cervical smears <p>Procedures</p> <ul style="list-style-type: none"> • removal of sutures • suctioning from endotracheal or tracheostomy tubes. 	<p>gloves</p> <p>Plastic apron if splash contamination may occur or there is to be bodily contact with the patient or their immediate environment</p> <p>Sterile equipment</p> <p>Antiseptic preparation (2% chlorhexidine in 70% alcohol) of line hub, injection port or sampling point. The site must be dry by evaporation prior to making the insertion/connection. Use of antiseptics prior to changing IV fluid bags is not necessary.</p>
<p>Aseptic (Wound Management) Technique</p>	<p>All wounds:-</p> <ul style="list-style-type: none"> • left open to heal by secondary intention • closed surgical wounds older than 48 hours • dehisced surgical wounds • traumatic wounds that have not been surgically repaired in an operating theatre. <p>48 hours following insertion for dressing:-</p> <ul style="list-style-type: none"> • tracheostomies • suprapubic urinary catheters • percutaneous gastrostomy (PEG) tubes • wound drains and ambulatory peritoneal lavage tubes. 	<p>Hand hygiene – before and after with soap and water or alcohol gel</p> <p>Plastic apron</p> <p>Sterile wound procedure pack (extra gloves maybe single use non-sterile examination type)</p> <p>Warm tap water (prep patient in the shower or bath if required)</p> <p>Sterile primary dressings</p> <p>Single patient use containers of products containing multiple doses if required - Some part used creams may need storage in a fridge (such as silver sulphadiazine cream), so attention should be given to manufacturer's instructions. These containers require clear labeling with patient's name (unless you are in the patient's own home) and date of opening.</p> <p>Clean commercially packed</p>

		<p>bandages for retention, support or compression (reusable bandages washed by the patient in accordance with manufacturer's instructions are acceptable in the patient's own home)</p> <p>Plastic bag lined multi-use buckets filled with warm tap water for washing of legs and feet.</p> <p>Clean and disinfected reuseable or single use scissors (normally for removal of bandages and dressings).</p>
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