

Livewell Southwest

Aseptic Technique and Wound Cleansing Policy

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Notice to staff using a paper copy of this guidance

The policies and procedures page of Intranet holds the most recent version of this guidance. Staff must ensure they are using the most recent guidance.

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	<p>Hart. S, (2007) Using an aseptic technique to reduce the risk of infection. <i>Nursing Standard</i> 21.47 p43-48</p> <p>Pratt RJ, Pellowe CM, Loveday HP, Robinson N, Smith GW et al (2001). The EPIC project: developing national evidence-based guidelines for preventing healthcare associated infections. Phase 1 guidelines for preventing hospital-acquired infections. <i>Journal of Hospital Infection</i>, 47:S3-S82</p> <p>Preston RM, (2006) Aseptic Technique: Evidenced-based approach for patient safety. <i>British Journal of Nursing</i> 14(10), pp.540-546</p> <p>Wilson, J (2006), <i>Infection Control in Clinical Practice</i>, 3rd Edition, Baillière Tindall: London</p> <p>World Health Organisation (2009) Guidelines on hand care, Geneva, Switzerland: World Health Organisation</p>
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1		Feb. 2007		New policy.
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Aseptic Technique Policy

1. Introduction

- 1.1. Aseptic non-touch technique prevents the introduction of micro-organisms that could cause infection to susceptible sites and hence is important in reducing the risk of Healthcare Associated Infection.
- 1.2. Chronic wounds may be cleansed using a clean technique. This does not require the use of a sterile dressing pack. Gauze toppers and tap water can be used in the community unless the patient is significantly immunocompromised. A clean field should be set up using a clean plastic apron. The clean field should not be set up on the floor. Unless the patient is at high risk of developing infection e.g. patients undergoing chemotherapy with a compromised immune system.
- 1.3. Clinical procedures involving aseptic technique or clean technique should only be performed by staff who have been assessed to be competent in the technique.
- 1.4. The guidelines outlined in this document should be followed when performing clinical procedures that require aseptic technique or clean technique.

2. Purpose

These guidelines aim to:

- 2.1. Ensure clinical procedures are performed in an appropriate manner to maintain asepsis and to prevent infection.
- 2.2. Minimise the risk of acquisition of Healthcare Associated Infection (HCAI) during clinical procedures.

3. Duties

- 3.1 The **Chief Executive** is ultimately responsible for infection prevention and control and the content of all Policies and their implementation. The Chief Executive delegates the day to day responsibility of implementation of the policies to the **Deputy Director of Professional Practice** and the Infection Prevention and Control team (IPCT).
- 3.2 **Directors** are responsible for identifying, producing and implementing policies in relevant to their area.
- 3.3 The **Locality Managers and Deputy Locality Managers** will support and enable operational Clinical Leads and Managers to fulfil their responsibilities and ensure the effective implementation of this Policy within their speciality.

- 3.4 **Ward Managers/Team Leaders** are responsible for ensuring that good Practice is embedded into their clinical areas.
- 3.5 **All staff, both clinical and non clinical** have a responsibility for ensuring they have read, understood and adhere to local Protocols and Policies. Guidance and competencies will be included within clinical training sessions.
- 3.6 Clinical procedures involving aseptic technique should only be performed by staff who have been assessed as competent in the technique. Education, training and assessment in the aseptic technique will be provided to all staff undertaking such procedures. These competencies can be found within specific procedures e.g. urinary catheterisation, pleurx drain.

4. Principles of Aseptic Technique

The principles of aseptic technique are as follows:

- 4.1. Aseptic technique aims to prevent micro-organisms on hands, surfaces or equipment from being introduced to susceptible sites.
- 4.2. The susceptible site should not come into contact with any item that is not sterile.
- 4.3. A non-touch technique should be maintained throughout the procedure.
- 4.4. If there are any breaches during the procedure, the operator must stop the procedure and continue only when asepsis can be resumed.
- 4.5. Where possible, 'clean' procedures should be carried out prior to 'infective' or 'contaminated' procedures.
- 4.6. All open wounds should only be exposed for a minimum amount of time.

5. Aseptic Non-Touch Technique

- 5.1 The Aseptic Non-Touch Technique (ANTT) is a framework to both 'standardise and raise clinical standards whilst undertaking aseptic clinical procedures' (Hart 2007).
- 5.2 It is essential to ensure that hands, even though they have been washed, do not contaminate the sterile / clean equipment or the patient.

The aim is for asepsis not sterility. The individual healthcare professionals need to decide between sterile or non sterile field/gloves and simply ask themselves 'can I do this procedure without touching key-parts?'

If the answer is **NO** – they use a sterile dressing pack and sterile gloves.

If **YES** – they wear non-sterile gloves.

5.3 The principle is that you cannot infect a key part if it is not touched. Any key part must only come into contact with other key parts (i.e. syringe tip and needle hub);

- Always wash hands effectively
- Never contaminate key parts
- Touch non key - parts with confidence
- Take appropriate standard infection control precautions

6. Indications for Aseptic Technique

Procedures that require the full use of aseptic technique (as outlined in Section 6) include:

- 6.1. Any medical invasive procedure that breaches the skin or mucous membranes, including tracheostomy care.
- 6.2. Dressing of wounds healing by primary intention (e.g. surgical wounds).
- 6.3. Urinary catheterisation.
- 6.4. Central venous lines insertion and access/manipulation.
- 6.5. Intravenous feeding lines insertion and access.
- 6.6. Suturing.
- 6.7. Vaginal examination during labour.
- 6.8. Removal of surgical drains.
- 6.9. Significantly immune compromised patients undergoing chemotherapy

7 Indications for clean technique

- 7.1 A clean technique can be used for treating:
- 7.2 Tracheal suctioning.
- 7.3 Central venous lines access and manipulation.
- 7.4 Peripheral intravenous cannulae insertion and access.
- 7.5 Taking blood cultures.
- 7.6 Enteral feeding care.
- 7.7 Urinary catheter care (changing and emptying catheter bags, and

obtaining urine samples.

7.8 Chronic wounds

7.9 Leg ulcers

8. Aseptic Technique Guidelines

8.1 Preparation of patient and environment for inpatient settings

8.2 Explain and discuss the procedure with the patient and gain their consent. If English is not the patient's first language, ensure there are suitable arrangements for an interpreter. In the case of children, ensure they and a legal guardian are involved in the consent process.

8.3 Planning is an essential part of the process. Obtain all the equipment needed for the procedure.

8.4 Prepare the patient and environment to allow any organisms to settle before the sterile/ clean field is exposed. Ideally, all activities that can disperse micro-organisms into the air, for example bed-making or cleaning, should cease 30 minutes before a dressing is undertaken. Air movement should be kept to a minimum during the procedure. Ideally, aseptic procedures should be undertaken in a designated clean area, for example a clinical room.

9. Decontamination:

9.1 Decontaminate hands using the ten-stage hand decontamination technique. (Appendix A).

9.2 There must be a dedicated dressing trolley available within the inpatient setting, this should be cleaned with a detergent wipe prior to use. For venepuncture or cannulation, use a sharps tray.

9.3 For community settings, ensure there is a clean and dry surface available for your sterile/ clean field. Refer to the Decontamination guidelines and procedures (cleaning and disinfection) for correct decontamination of equipment.

9.4 Place all equipment required for the procedure on the bottom of the trolley or designated surface. Check all equipment is in date and sterile.

9.5 Put on a single-use, disposable plastic apron. Assess the need for other personal protective equipment.

9.6 In Inpatient ward areas take the trolley or tray to the patient, disturbing the screens as little as possible.

10. Procedure

- 10.1 If carrying out a wound dressing, remove bandages, loosen the outer dressing, taking care not to leave the wound exposed for too long. Ensure that contaminated dressings are disposed of quickly and the bag is not close to the patients face.
- 10.2 Decontaminate hands using soap and water or an alcohol hand rub.
- 10.3 Open the outer cover of the sterile pack and turn out the sterile pack on to the clean work surface (Appendix C).
- 10.4 Open the sterile field using only the corners of the paper, taking care not to lean over the sterile field.
- 10.5 Open any other equipment and drop on to the centre of the sterile field. Ensure that this is performed without touching the equipment itself.
- 10.6 Place hand in the sterile disposable clinical waste bag and arrange the contents on the sterile field.
- 10.7 Decontaminate hands using alcohol rub.
- 10.8 Put on sterile gloves (Appendix D) or clean gloves depending on whether clean or aseptic procedure being used.
- 10.9 Carry out procedure ensuring you maintain asepsis / clean wound. Use a non-touch or clean technique throughout application ensuring that process of keeping one hand clean and one dirty throughout procedure is maintained.

11. Cleansing of chronic wounds and leg ulcers

- 11.1 Wounds that are healthy and free from debris do not require cleansing. Routine cleansing of a healthy wound removes beneficial chemicals, can damage delicate tissue, will delay wound healing and can be painful. However all traumatic wounds are considered contaminated and should be cleaned thoroughly, rinsing the wound under running water is very effective.
- 11.2 It is not necessary to dry the wound bed following cleansing as this will cause trauma to the wound bed and damage delicate cells.
- 11.3 Leg Ulcers: Patients who wear bandages for prolonged periods of time may develop a build-up of dead epithelial cells. Regular washing of the limb in warm tap water with an emollient helps remove excess exudate, skin scales and reduce odour.
- 11.4 There is no contra-indication to regular cleansing of the leg. Legs should be washed in a **lined (bin liner)** bucket/bowl and the bucket must be cleaned

with detergent after each use. If the wound is infected the bucket/bowl should be cleaned with an alcohol wipe after washing with detergent.

Suitable cleansing lotions include:

- Warm tap water (body temperature)
- Sterile water
- Sodium Chloride 0.9% (Normal Saline)

This is a sterile solution of sodium chloride 0.9% available in sachets and pods.

The solution should be warmed to body temperature prior to use. Although sodium chloride 0.9% has no aseptic properties it will dilute the concentration of bacteria in the wound.

NOTE: For acute post-operative wounds and for immunocompromised patients, sterile saline should be used. (NICE CG74)

12. Clinical Signs & Symptoms of Infection

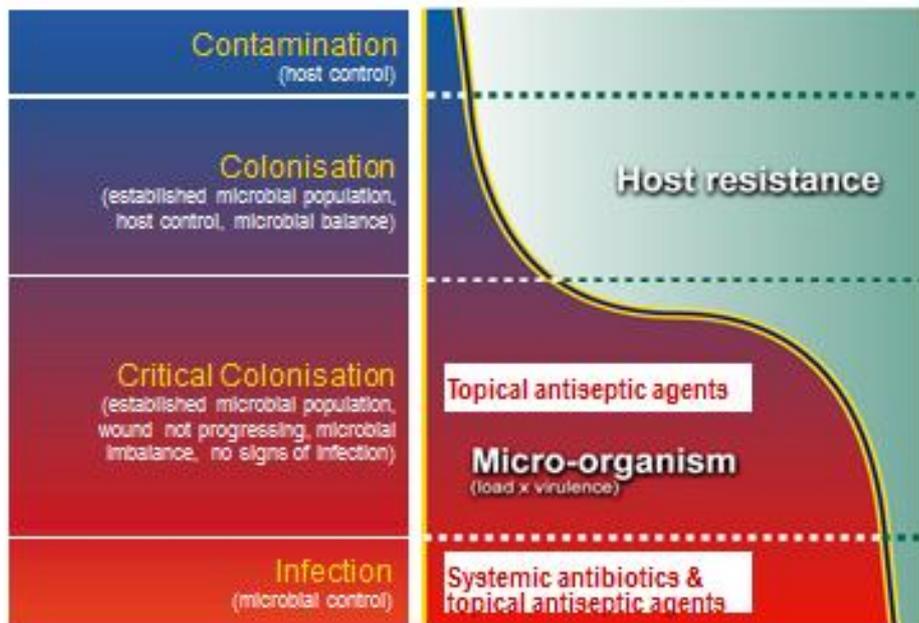
12.1 If there are indications that the patient may have an infection a wound swab should be taken, the GP or physician should be informed and appropriate antibiotic prescription should be discussed.

12.2 General observations should be taken including pulse and temperature and blood pressure, use sepsis flowchart (Appendix E)

Signs and symptoms of infection include:

- Redness – tracking cellulitis
- Pain – throbbing
- Oedema – swelling
- Change in temperature – heat
- Pus or high viscosity exudate
- Sudden necrosis

Microbial Progression in Wounds



2 Bowler PG, Jones SA, Walker M, Parsons D. Microbicidal properties of a silver-containing Hydrofiber® dressing against a variety of burns wound pathogens. *J Burn Care Rehabil.* 2004;25(2):192-196

Please see Screening Tool & Sepsis Flow Chart Appendix D

13. Post-Procedure

- 13.1 Ensure correct disposal of sharps (see Safe Management and Disposal of Sharps policy).
- 13.2 Place all used disposable items, including the apron and gloves, in an clinical waste bag for incineration. Ensure correct disposal of waste. In the community this is the refuse collection. For infected waste refer to policy - 'Safe Handling & Disposal of Healthcare Waste' - Flow chart
- 13.3 The trolley/sharps tray should be cleaned with a detergent wipe. Spillages of blood or high-risk body fluids should be dealt with according to the Decontamination Guidelines and Procedures. (Cleaning and Disinfection) of medical devices and patient care equipment policy.
- 13.4 Decontaminate hands using the ten`-stage hand decontamination technique (Appendix B; please see Hand Hygiene Policy and Procedure.

14. Documentation

Document fully the procedure in nursing and/or medical notes. Including details of who carried out the procedure, any devices or dressings used, particularly if any left in situ, and deviation from prescribed procedure. Observations of the wound.

15. Competence

Clinical procedures involving aseptic technique should only be performed by staff who have been assessed as competent in the technique using the competency framework.

Competencies

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Director of Operations

Date: 20th July 2016

Appendix A

Ten-stage Hand Decontamination Technique

Effective hand washing technique involves three stages: preparation, washing, rinsing and drying.

Preparation requires wetting hands under tepid running water **before** applying liquid soap or an antimicrobial preparation. The hand wash solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 10-15 seconds paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly prior to drying with good quality paper towels.

When decontaminating using alcohol hand rub, hands should be free of dirt and organic material. The hand rub must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers until the solution has evaporated and dried.



1. Wet hands with water



6. Rub the backs of fingers to opposing palms with fingers interlocked



2. Apply enough soap to cover all hand surfaces



7. Rotational rubbing of left thumb clasped in right palm and vice versa move to rotational rubbing of both wrists



3. Rub hands palm to palm



8. Rotational rubbing, backwards and forwards with tops of fingers of right hand in left palm and vice versa



4. Rub the palm of one hand over the back of the other with interlaced fingers and vice versa



9. Rinse hands with water



5. Rub palm to palm with fingers interlaced



10. Dry thoroughly with a towel

Hand Drying

Wet surfaces transfer micro-organisms more effectively than dry ones. Consequently, the method of hand drying is also important.

Skin Care/Staff Issues

Staff are encouraged to apply an emollient hand cream regularly to protect skin from the drying effects of regular hand decontamination. Staff should only use the products available in the clinical areas as these have been specifically designed not to interact with soaps and alcohol hand rub.

If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation, seek advice from the Staff Health and Wellbeing Department.

Appendix B

Aseptic Technique Guidelines

1. Explain and discuss the procedure with the patient. Assess and identify all equipment needed. Prepare environment

2. Clean the trolley with a detergent wipe and place all equipment required onto the bottom shelf of the trolley.

3. Wash hands with soap and water using the ten-stage hand washing technique. Put on a single-use, disposable plastic apron. Take the trolley to the patient.



4. Open dressing pack and empty contents onto the top shelf of the trolley.



5. Decontaminate hands using the alcohol hand rub. If carrying out a wound dressing, loosen the dressing tape taking care not to expose wound, and decontaminate hands.



6. Open the sterile field.



7. Empty the contents of any additional packs/equipment required onto the sterile field.



8. Decontaminate hands using alcohol hand rub.



9. Place hand in yellow bag and arrange sterile field as required.



10. Keeping the bag on your hand remove the dressing and invert the bag to enclose the soiled dressing.



11. Secure the bag to the side of the trolley below the sterile field.



12. Decontaminate hands using alcohol hand rub.



13. Put on sterile gloves – see Appendix D.



14. Once procedure completed, fold up remaining items of the dressing field and place in disposal bag. Remove gloves and apron and place in disposal bag.



15. Seal the disposal bag and dispose of according to Trust policy.



16. Wash hands with soap and water using the six-stage hand washing technique.

17. Document procedure in nursing and/or medical notes.

Appendix C

Application of Sterile Gloves



Fig. 1



Fig. 2



Fig. 3



Fig. 4



Fig. 5

Appendix D

Sepsis flowcharts



Sepsis charts.doc