Infections occur when germs enter the body, causing it to display symptoms as it tries to destroy the harmful germs. Infections are caused by several different types of germs, which in some way enter our bodies and cause problems. There are different types of germs (sometimes referred to as micro-organisms; micro meaning small and organism meaning living thing):

- **Bacteria** e.g. MRSA, Pseudomonas, EColi
- **Viruses** e.g. Influenza, Norovirus
- **Fungi** e.g. Athletes Foot, Ringworm
- **Protozoa** e.g. Cryptosporidium
- **Prions** e.g. ‘Mad cow’ disease, CJD
- **Parasites** e.g. Scabies, Head lice

When a germ enters the body, and causes an infection, it is called a **Pathogen**.

**Contamination, Colonisation and Infection**

It is vital that everyone understands the difference between these three terms!

- **Contamination**: Surface germs, e.g. on door handles, telephones etc. Doesn’t cause any harm in itself but can be picked up – usually on hands!

- **Colonisation**: This is where bacteria multiply and attach to tissue. At this stage the bacteria are not causing an active infection but have the potential to cause infection. E.g. MRSA can be colonised in a service user’s groin, not causing a problem. However, if that service user goes for hip surgery the MRSA may spread to the wound and cause infection.

- **Infection**: This is where bacteria multiple and invade healthy tissue

**Method of Spread** | **Example of Infections**
---|---
Direct Contact: Direct body surface to body surface. Contact and physical transfer of germs from an infected or colonised individual to a susceptible host | Scabies, Head lice, MRSA contamination on an unwashed care workers’ hands to a service user’s wound or urinary catheter
Indirect Contact: Contamination of an inanimate object by an infected or colonised person, transferred to another person through that object, e.g. service user equipment | Clostridium difficile through a commode that is not properly cleaned prior to use on another service user, HepB through a contaminated endoscope
Droplet: When an infected or colonised person produces droplets through the air which deposit on the eyes, nose or mouth of the host, e.g. coughing, sneezing, talking, suctioning | Rhinovirus (Common Cold) Influenza Meningococcal disease Pertussis
Airborne: When either airborne droplet nuclei or dust particles disseminate infectious agents that remain ineffective over time and distance. Air currents disperse these germs and susceptible people can breathe them in | Tuberculosis Measles Varicella (Chicken Pox)
Common Vehicle: Infectious agents transmitted by contaminated items such as food, water, devices, equipment and medications | Cryptosporidium in water supplies Salmonella Campylobacter
Vector Bone: Vectors transmit infections. Vectors include rats, mice, flies, mosquitoes etc… | Malaria Wiels Disease
The Chain of Infection

How an infection spreads from one person to another is called the “Chain of infection”. If any link in the chain is broken the infection can not spread.

Example of the Chain

**Infectious Agent:** Bacteria, Virus, Fungus etc.

**Reservoir:** E.g. contaminated food, dirty equipment

**Portal of Exit:** blood, faeces, respiratory droplets, skin, scales

**Mode of Transmission** contaminated hands, droplets through air from sneezing

**Portal of Entry:** respiratory tract, gastrointestinal tract, broken skin, urinary tract

**Susceptible Host:** service user, vulnerable person, e.g. child, elderly person etc.

Examples of Breaking the Chain of Infection

Anybody can get an infection! Major risk groups are: Over 65yrs, infants, persons with existing medical conditions, e.g., asthmatics, cystic fibrosis, diabetics

MRSA on healthcare worker’s hands transfers to second service user

Healthcare worker attends to peg site with un-gloved hands, does not wash hands before attending to another service user

What are “Standard Precautions”

Standard Precautions are a group of routine infection prevention and control practices and measures that should be used for all service users at all times, regardless of suspected, confirmed or presumed infectious status, in any setting in which healthcare is delivered. Standard Precautions are based on the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents (germs). Standard Precautions should be used when dealing with:

- Blood (included dried blood)
- Body fluids (secretions and excretions excluding sweat) regardless of whether or not they contain visible blood
- Non-intact skin
- Mucous membranes

Background

Universal Precautions were first introduced in 1985-88 in response to the emergence of HIV and they were primarily designed to protect healthcare workers from exposure to blood borne viruses (e.g. Hep. B, HIV). They were replaced in 1996 by Standard Precautions to incorporate Body Substance Precautions so were intended to protect staff and service users alike. Standard Precautions were expanded in 2007 because of the lessons learnt after the SARS epidemic.

Standard precautions are considered the foundation stone for preventing the transmission of infectious agents in all healthcare settings and they should be applied with all service users at all times regardless of their infectious status.

Standard Precautions

Body fluids frequently contain large numbers of micro-organisms and are a major source of germs which cause healthcare associated infections (HCAI).

The majority of people with blood borne infections, eg. Hepatitis B, Hepatitis C, HIV, will not have any signs or symptoms of infection, others may be in their incubation period, so it is important to treat all people the same.

The key elements of Standard Precautions are:

1. Hand hygiene
2. Use of Personal Protective Equipment (PPE)
3. Service user placement in residential units
4. Healthcare waste disposal
5. Safe handling and disposal of sharps
6. Occupational Health Programme
7. Environmental hygiene
8. Management of blood and body fluid spillage
9. Decontamination of medical equipment
10. Linen handling
11. Management of sharps injury
12. Respiratory hygiene/cough etiquette*
13. Safe injection practices*
14. Use of a facemask when performing special lumbar puncture procedures*

*New additions to Standard Precautions - CDC 2007
Examples of Standard Precautions in Action

<table>
<thead>
<tr>
<th>Germs</th>
<th>Method of Spread</th>
<th>Standard Precaution*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Cold</td>
<td>Sneezing, coughing, hands</td>
<td>Respiratory hygiene</td>
</tr>
<tr>
<td>Rhinovirus</td>
<td></td>
<td>Hand hygiene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of PPE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental hygiene</td>
</tr>
<tr>
<td>MRSA</td>
<td>Hands of healthcare worker</td>
<td>Hand hygiene</td>
</tr>
<tr>
<td>Methicillin Resistant Staphylococcus Aureus</td>
<td></td>
<td>Use of PPE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental hygiene</td>
</tr>
<tr>
<td>C diff</td>
<td>Hands</td>
<td>Hand hygiene</td>
</tr>
<tr>
<td>Clostridium difficile</td>
<td>Contaminated environment and service user equipment</td>
<td>Use of PPE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Environmental hygiene</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Decontamination of medical equipment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Linen handling</td>
</tr>
</tbody>
</table>

In certain circumstances additional precautions/measures may be required in addition to Standard Precautions e.g. service users with confirmed or suspected infectious TB, Pertussis etc.

Additional advice can be obtained from your infection control team / Department of Public Health/ Microbiology Department of local hospital.

**Points to Remember**

- Standard Precautions apply to all service users all the time regardless of whether you know about an infection they may have or not.

- Do not judge a service user’s potential risk for having an infection by how they present themselves, or if they belong to a high risk group, e.g. IV drug users, prostitutes etc. ‘Clean’ people get infections too! Do not let your personal opinions decide how you treat a service user – Standard Precautions must be applied to every service user.

- Advice on the best precautions to be employed should be sought from the infection control team, Department of Public Health, Microbiology Department.

- Managing the spread of infection is a team effort – all staff must observe Standard Precautions no matter what grade or qualification they possess.

**Group exercise**

Who do we contact if we require additional advice on managing or controlling the spread of infection? Find out who to contact and ensure all staff have access to these details.

Key Messages

1. Up to 50% of all healthcare associated infections could be prevented if people cleaned their hands (WHO, 2009)

2. Prior to Presenting to Work
   - Nails should be cut short
   - No false nails should be worn
   - Remove rings and watches
   - Uniforms/clothing sleeves should “bear below elbow”

3. Hand hygiene must be performed
   - At the beginning and end of each work shift
   - Prior to preparing, handling or eating food
   - Following personal body functions, e.g. going to the toilet, smoking, blowing nose etc.
   - When moving from a domestic to another duty
   - When caring for service user as per ‘five moments’

WHO Five Moments for Hand Hygiene

1. Before touching a patient
2. Before clean / aseptic procedure
3. After body fluid exposure risk
4. After touching a patient
5. After touching patient surroundings
4. What to use

A. Aim to use Alcohol hand rub/gel for the majority of hand hygiene opportunities

B. Wash with Soap & Water
   - When hands are visibly dirty
   - When dealing with certain germs, e.g. *Clostridium difficile*, *Norovirus* etc.

**NOTE:** Consider service users when placing alcohol gels at point of care, certain service users may drink the gels, use them to light fires etc. Perform a risk assessment!

5. Correct Techniques

For more information: E-Learning Hand Hygiene Module (www.hseland.ie) and WHO Hand Hygiene Guidelines.

PATIENT SAFETY TOOL BOX TALKS

SAFE CARE & SUPPORT

PERSONAL PROTECTIVE EQUIPMENT (PPE)

1. Definition: Special clothing we use to protect ourselves from potential splashes of blood/body fluids / chemicals and to protect service users from potential infection caused by healthcare workers.

2. Types
- Gloves
- Masks
- Plastic aprons
- Eye protection: visors/goggles/face shield

3. Needed when: Any chance of contact with body fluids, e.g. emptying catheter bags, handling drips/drains, taking bloods, if there is a risk of catching infection from service user, e.g. T.B. (overleaf).

Healthcare workers should perform a risk assessment prior to wearing PPE and only wear if required. Hand hygiene must be performed before donning PPE and after removing it.

Gloves: Sterile and non-sterile
- Gloves reduce the risk of exposure of staff to service users body fluids, and protect the service user from organisms that may be on healthcare workers hands
- Staff with latex allergy must be provided with alternatives, e.g. nitrile, vinyl gloves
- Powdered latex gloves should never be used
- Always wash hands before and after putting on gloves
- Perform a risk assessment, if you don’t need gloves don’t wear them
- HSE staff must adhere to HSE Latex Policy (2012)

Wearing gloves is never a substitute for good hand hygiene must be performed before putting on gloves, and after removing them!

Masks
- Required for routine care in respiratory tract infections (RTI), e.g. Influenza
- Wear a surgical mask when in direct contact or within 3 feet of the service user. Wear gloves and aprons also when providing direct care to service users with RTI

Main Points
- Surgical masks suitable for most situations
- Change mask if it becomes damp, wet or torn
- Discard mask when leaving the service users’ room
- Wash hands immediately after removal
- Service user should avoid leaving sick room and entering communal areas. If this is necessary, a mask must be worn
- To correctly put on/remove mask see poster overleaf

Aerosol Generating Procedures
FFP2 or FFP3 mask, goggles, long sleeved disposable gown (as these require special “fit” testing, contact Infection Control Team for advice)

Plastic aprons
Prevent blood / body fluid splashes
PPE is the lowest protective measure in the hierarchy of risk controls
Glove Selection Tool*

Is there a risk of exposure to?
Blood/body fluids
Non-intact skin
Mucous membranes
Contaminated linen

NO

No Gloves required

YES

Gloves required

Vinyl

Non-aseptic tasks which are short and with low risk of exposure to blood/body. Cleaning with detergent. Task that won’t pull or twist the gloves

Natural rubber latex or suitable synthetic alternative in line with HSE Latex Policy 2012

Service User Risk

User Risk

Sterile

Non-sterile single

Surgeons

Non-sterile single

Non-aseptic procedures with potential to blood/blood stained, body fluid (see recommended glove choice table). Dealing with blood and body fluids. Handling cytotoxic material.

Service User Risk

Sterile

Non-sterile single

**Adapted from HSE Dublin North East Community Infection Prevention & Control Manual, November 2011. See also WHO Glove pyramid to aid decision making on when to wear gloves or not, page 6, www.who.int/gpsc/5may/**

**Group Exercise**

- Think of examples when you would use gloves, aprons or masks in your work area
- Why must we change PPE between clients?
- Why should we perform hand hygiene before and after wearing gloves?

Certain infections are spread when a person with a respiratory infection coughs or sneezes, or when a healthcare worker suctions a service user with a respiratory infection.

An individual can be infected by inhaling the infection or by touching something that has been sneezed or coughed on (direct contact).

**Preventing Respiratory infections from spreading**

- Ensure all healthcare workers and service users receive the flu vaccine
- Provide disposable tissues and tissue bins in healthcare facilities
- Provide alcohol gel in clinics and at point of care for staff and service users to clean their hands (indirect contact). Risk assess your area to ensure it is safe to do this. If not, HCWs should be provided with pocket hand sanitizers
- Advise service users to turn their heads when coughing/sneezing.
- Maintain a distance of at least 1 metre (3 feet) between service users’ beds
- Ensure the environment is cleaned thoroughly and documented cleaning schedules are in place
- Display respiratory etiquette posters for staff and service users (see overleaf)
- Tie up tissue bins in service user’s room and dispose of promptly
- If service users are being transferred to another healthcare facility, e.g. acute hospital or nursing home, ensure ambulance & receiving staff know of their suspected respiratory infection so precautions can be taken
- Masks may be required in certain situations. Consult infection control/public health for advice

**Common Infections spread by respiratory secretions**

Colds
Influenza
RSV (respiratory syncitial virus)
Tuberculosis
Meningitis
Mumps
Measles
Enterovirus
Pneumonia
Further information and poster downloads available from www.hpsc.ie

**Group Exercise**

It is recommended that all healthcare workers and service user receive the flu vaccine, however the uptake of the vaccine amongst staff has been consistently low across all healthcare settings. What is your attitude to the flu vaccine? If you don’t receive it why not? Explore attitudes and fears amongst yourselves and make receiving the flu vaccine a priority for the staff in your area.

Cleaning & Decontamination

Every service user has a right to be treated and cared for in a clean, safe environment. It is the duty of everyone who works in a healthcare facility to ensure the highest standard of cleanliness is maintained. There is a growing body of evidence linking the environment with outbreaks of specific healthcare associated infections, such as VRE, C difficile etc...Cleaning can be done manually (elbow grease, clean cloth, warm water, detergent) or by machines (e.g. dishwasher, bedpan washer etc.).

Terms

Cleaning: is a process which removes dust, soil, large numbers of microorganisms (germs) and the organic matter that protects them e.g. faeces, blood. Cleaning is an essential step prior to disinfection or sterilisation. Cleaning physically removes rather than kills germs.

Disinfection: is defined as the removal or destruction of all germs except bacterial spores and prions (e.g. CJD- ‘Mad cow’ disease). A disinfectant is an agent used in disinfection. A skin disinfectant is a type of disinfectant suitable for use on the skin; skin disinfectants are often called antiseptics. There are two main methods of disinfection: heat disinfection (e.g. method used in bedpan washers) and chemical disinfection (e.g. bleaches and alcohols). It is important to note that skin disinfectants, e.g. Hibiscrub, are not suitable for environmental disinfection, and environmental disinfectants, e.g. bleaches must never be used on the skin.

Sterilisation: A process that renders an object free from viable micro-organisms (germs) including viruses and bacterial spores. Used on reusable invasive medical devices such as theatre implements, some devices used in dentistry etc. It kills all living micro-organisms (germs). Examples of sterilisation methods include steam sterilisers and UV lights.

Cleaning Schedules

1. Cleaning Frequency

Some areas pose a higher infectious risk to patients than others, and should be cleaned more frequently. The following risk categories apply (NHO Acute Hospitals Cleaning Manual 2006):

<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Status</th>
<th>Corresponding Work Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very High Risk</td>
<td>ICU, NICU, Theatre, Endoscopy, Pharma Clean rooms, Renal Dialysis Unit, High Risk Patients, Immuno-compromised patient areas, Special needs areas, Outbreak situations</td>
</tr>
<tr>
<td>2</td>
<td>High Risk</td>
<td>CSSD/TSSU/HSSD,A&amp;E, Isolation Rooms, Catering facilities, Day Hospital/Day Services (includes Chemo Day Ward), OPD (invasive treatments), Treatment &amp; Clinical Rooms, Pharmacy, Surgical, Maternity &amp; CCU Wards</td>
</tr>
<tr>
<td>3</td>
<td>Moderate Risk</td>
<td>All other wards/units, Day activity centres (non-invasive), Rehab. Areas, General Pharmacy, Labs, Mortuary, Radiology (non-invasive), Public areas, on-call accommodation, Physio-therapy department, Occupational therapy, Stairwells</td>
</tr>
<tr>
<td>4</td>
<td>Low Risk</td>
<td>Admin, non-sterile supplies area, archives &amp; record storage areas, workshops, plant rooms, central stores, chapel, fire escapes, library, meeting rooms, retail areas, staff changing facilities</td>
</tr>
</tbody>
</table>
2. Personal protective clothing for cleaning

Gloves
Household gloves are recommended for general cleaning. Gloves should be colour coded in line with cleaning equipment. Hand hygiene should always be performed following glove removal.

Disposable plastic aprons
Aprons should be worn to provide a waterproof barrier while cleaning if contamination of the clothing is likely to occur.

Safety goggles and masks/visors
Should be worn if splashing of fluid during cleaning to the eyes/nose/mouth is anticipated.

3. Recommended Colour Coding for Cleaning Cloths

<table>
<thead>
<tr>
<th>RED DISPOSABLE</th>
<th>WHITE</th>
<th>BLUE</th>
<th>YELLOW</th>
<th>GREEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Toilets and floors of washrooms* (bathroom/toilet/shower/ensuite)</td>
<td>Theatre cleaning</td>
<td>General areas including wards, clinical rooms, offices, departments and public areas</td>
<td>Wash hands basins and washroom surfaces*</td>
<td>Kitchens</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>WHITE DISPOSABLE Isolation room cleaning</td>
</tr>
</tbody>
</table>

4. Cleaning Agents & Antiseptics
Further Information on cleaning products, schedules, frequencies, etc... can be obtained from the National Hospital Office Acute Hospitals Cleaning Manual 2006.

<table>
<thead>
<tr>
<th>Agent</th>
<th>Preparation</th>
<th>Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Purpose detergent/detergent wipes</td>
<td>Detergent with a neutral pH, i.e. a neutral detergent. In general, make up with water as per instructions</td>
<td>Routine and environmental cleaning of hard surfaces and equipment, especially seats, wheelchairs, floors etc..</td>
</tr>
<tr>
<td>Liquid Hypochlorite e.g. Milton 1% solution 100 mls in 1000 mls H2O or, Sodium Dichloroisocyanurate (NaDCC) tab or granules or powders, e.g. Presept, Klorosept, Actichlor</td>
<td>Chlorine tablets, granules or liquid bleach made up to 1,000 ppm in a solution with water. Chlorine tablets or granules, or liquid bleach, made up to 10,000 ppm in water. In all cases must follow manufacturers instructions. Hypochlorite solution or chlorine tablets diluted to 125ppm (0.0125% Hypochlorite)</td>
<td>Disinfection as indicated, e.g. following cleaning if soiled with blood or body fluids, blood spillages etc.. Both suitable for areas with residents infected with <em>C difficile</em> Suitable for catering surfaces and equipment</td>
</tr>
<tr>
<td>70% Isopropyl alcohol</td>
<td>Wipes, e.g. Alco wipes, cliniwipes</td>
<td>For rapid disinfection of smooth clean surfaces, e.g. scissors</td>
</tr>
</tbody>
</table>

Group Exercise
Examine cleaning schedules in your area of work. Is there a policy required on this area? How often are cleaning schedules reviewed, audited and updated. For advice contact your infection control department or local Public Health department.

Important Points to Remember !!

Ask yourself

- What equipment do we use in our area, e.g. sling hoists, glucometers nebulisers, commodes, drip stands etc...
- Is the “item” a medical device or not? and why is that important?
- Is it an invasive medical device? Why is that important?
- Is it single use, single service user use or reusable?
- Where does it fit in on the equipment risk classification table? (see below)
- What does the manufacturer say about the device?
- What if the manufacturer does not say anything? - what should you do?

Prior to Cleaning / Decontamination

- Check if item is single use, single service user use or reusable. Single use items must never be decontaminated and reused under any circumstances
- Ensure all electrical items are plugged out prior to cleaning
- Check manufacturer’s instructions with regard to appropriate cleaning agents to use to preserve integrity of equipment
- Observe items for wear and tear / rust / torn fabric etc. and replace as appropriate.

Remember!

Cleaning, with neutral detergent and water, must always be carried out prior to disinfection and sterilisation.

Always!!

- Remember to clean all surfaces – remember the underside of commodes, legs and hinges of dressing trolleys, underside of treatment couches etc.
- Document who cleaned the equipment and when it was cleaned. For larger items such as drip stands / hoists etc. it may be prudent to develop a ‘label’ to be attached to the item to record cleaning date
- Audit equipment on a regular basis to ensure decontamination is carried out to a high standard, and equipment is functioning properly with no damage / wear and tear
- High level disinfection and sterilisation is a specific skill and should be carried out only by trained staff, e.g. in a CSSD unit. Reusable invasive medical devices must be decontaminated in accordance with the HSE Code of Practice for Decontamination of RIMD, 2007.
Classification of Service User Equipment

Re-Useable Invasive Medical Devices (RIMD)

An invasive medical device can be defined as a device which, in whole or in part, penetrates inside the body, either through a body orifice or through the surface of the body (Medical Device Directive (93/42/EEC)).

<table>
<thead>
<tr>
<th>Symbol on Packaging</th>
<th>Equipment Usage</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Single Use</td>
<td>Cannot not be re-used or re-processed under any circumstance! Examples: needles, syringes, urinary catheters etc.</td>
</tr>
<tr>
<td>Single Service User Use</td>
<td>Single Service User Use</td>
<td>May be used repeatedly on one user – must be cleaned between use as per manufacturers instructions. Example, hoist sling. Replace if damaged or as per manufacturers instructions</td>
</tr>
<tr>
<td>Reusable</td>
<td>Reusable</td>
<td>Can be shared and reused between several service users, must be decontaminated between use, example, BP cuff, wheelchairs</td>
</tr>
</tbody>
</table>

(ref. IMB Safety Notice: SN2010(14))

Spaulding Classification System

In 1968 Earle Spaulding devised a classification system for infection risk associated with the decontamination of RIMD. He believed instruments and equipment should be cleaned and reprocessed according to the level of risk associated with their intended use.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Application</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical</td>
<td>Items in close contact with a break in the skin or mucous membrane or introduced into a sterile body area, e.g. theatre surgical equipment</td>
<td>Requires Sterilisation</td>
</tr>
<tr>
<td>Semi-critical</td>
<td>Items in close contact with intact skin, mucous membranes or body fluids, particularly after use on infected service users or prior to use on immunocompromised service users, e.g. endoscopes</td>
<td>Requires high level disinfection (sterilisation preferred where practical)</td>
</tr>
<tr>
<td>Non-critical</td>
<td>Items in contact with healthy skin or mucous membranes or not in contact with service user, e.g. blood pressure cuff</td>
<td>Can be processed by cleaning (and low level disinfection where necessary)</td>
</tr>
</tbody>
</table>

Group Exercise

Select a piece of equipment from each classification group (single service user use, reusable) used in your area and look at policy around what should it be cleaned with and how frequently etc - glucometers / hoists / slings / commodes etc. Select a ‘single use only’ piece of equipment – is it currently being reused under any circumstances.

Healthcare waste may contain certain materials that renders it hazardous by virtue of its infectious, radioactive, carcinogenic etc properties

- All clinical waste awaiting collection by waste contractors should be stored in locked containers/secure facilities away from client areas
- A risk assessment should be completed to identify the safest method of securing sharps in bins from inadvertent knocking over. All healthcare facilities where sharps are used must follow the requirement of the Sharps law (2014) (http://www.hsa.ie/eng/Legislation/New_Legislation/S_I_135_of_2014.pdf)

### Categories of Healthcare Waste

<table>
<thead>
<tr>
<th>Potentially Infectious</th>
<th>Non-Risk Waste</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Domestic waste</td>
</tr>
<tr>
<td>Laboratory</td>
<td>Confidential material</td>
</tr>
<tr>
<td>Biological</td>
<td>Medical equipment</td>
</tr>
<tr>
<td>Sharps</td>
<td>Potentially offensive material</td>
</tr>
<tr>
<td>Discarded chemicals</td>
<td></td>
</tr>
<tr>
<td>Reagents and toxic flammable medicines</td>
<td></td>
</tr>
<tr>
<td>Radioactive</td>
<td></td>
</tr>
</tbody>
</table>

Waste segregation— it is vitally important that all healthcare workers know how to segregate waste into its appropriate stream.

![Figure 1. Healthcare Waste-Basic Segregation and Packaging Schematic. Note: UN requirements may require the use of inner liners or receptacles for some wastes.](image-url)
Types of Waste containers and indications for use

Yellow Healthcare Risk Waste Bags
- All blood stained or contaminated items (including dressings, bandages etc.)
- Suction Catheters and tubing
- Incontinence waste from known or suspected enteric infections

Yellow Rigid Boxes
- Blood and blood administration sets
- Body fluids but not in bulk and must be solidified
- Disposable suction liners
- Redivac drains
- Drained histopathology waste (no formaldehyde)
- Sputum containers from known or suspected TB cases
- Clinical wastes from Lab permitted (no chemical residues permitted)

Yellow Rigid Bin with Purple Lid
- Small quantities of residual medicines
- Out of date medicines
- Controlled substances
- Pharmaceuticals left over after administration to patients
- Damaged stock from retail pharmacists
- No sharps or free liquids permitted

Yellow Sharps Bin with red/blue Lid
- Used sharps materials such as:
  - Needles, Syringes
  - Scalpels, Sharps tips of IV sets
  - Contaminated slides
  - Stitch cutters, Guide wires
  - Razors
  - Blood stained/contaminated glass

Yellow Sharps Bin with Purple Lid
- Needles, syringes, sharp instruments etc. that have been used for the administration of cytotoxic waste.
- Controlled drugs (discharge first)

Yellow 30/60 litre rigid bin (black lid)
- Non-autoclaved microbiological cultures
- Large / recognisable anatomical body parts
- Waste from known or suspected CJD cases
- Non-autoclaved large metal surgical objects e.g. hips
- Placenta in conjunction with additional leak proof containment
- No sharps or free liquids permitted

Note: Bags and containers should only be filled to agreed level. (2/3 for bags and 3/4 for containers) Tag tracking system should be used as well.

Service user Placement & Transfer

- When deciding where to place a service user consider the potential for spread of infection
- In community settings consider the effect of isolation on a service user compared to the risk of infection, it may not always be prudent to isolate in long term care, mental health, intellectual disabilities settings etc.
- Potential risk of infection spreading - could be suspected or confirmed respiratory or gastrointestinal infection, uncontained excretions or wound drainage, undiagnosed rash etc...

**Consider!!!**

- Is the service user likely to contaminate the environment or are they unable to maintain appropriate hygiene? Does the service user have any uncontrolled secretions or excretions?
- How is the micro organism spread (droplet, airborne, contact)?
- Availability of single rooms / en-suite rooms?
- Options for room sharing, e.g. co-horting

Occasionally it is necessary to transfer a service user to another unit or healthcare facility. Every facility should have a written guideline with regard to how service users are transferred, and the responsibilities of staff when transferring service users.

**Ask yourself - Does the service user know they have an infection???

If you are transferring a service user with a known or suspected infection **always:**

- Notify the accepting unit or facility of the service user’s infection status. Depending on the unit the person to notify could be the infection control nurse/Assistant Director of Nursing / CNM2 on unit etc… (telephone and written transfer letter)
- Notify the ambulance service if extra precautions are needed.
- If service user is being discharged home inform the Public Health Nurse and GP
- Maintain service users dignity and privacy at all times

**When a service user is being transferred from another area to your unit:**

- Perform a risk assessment
- Consider the need for screening, if it is not necessary do not screen
- Consider the place you are putting the new service user, will they be beside a vulnerable service user, e.g. in the case of a service user with MRSA are you putting them in a room with service users who have wounds/urinary catheters etc.
- If you are unsure how to manage the infection contact your infection control team / Department of Public Health for advice.

**A service user should not be discriminated against because she/he has an infection!!!!**

An outbreak may be defined as the occurrence of a number of infections at a greater rate than expected within a specific geographical area and over a defined period of time.

*Put simply, two or more people who have contracted the same germs who can be linked to the same place at the same time.*

Common causes of Outbreaks in the healthcare setting:

- Influenza
- Norovirus (“Winter Vomiting Bug”)
- *Clostridium difficile*
- Scabies
- *Methicillin Resistant Staphylococcus aureus* (MRSA)
- *Vancomycin Resistant Enterococci* (VRE)

**Notifiable Diseases**

Some infections must be notified to Public Health. Records of these infections are kept to provide information on outbreaks, unusual clusters of a disease, provide an alert if an infection is getting out of control etc…To see a full list: http://www.hpsc.ie/NotifiableDiseases/ListofNotifiableDiseases/File,678,en.pdf

**What signs should you look for?**

Signs and symptoms of an infection in two or more people (service users and staff) that happen in close time proximity where close contact has occurred.

For example:

- high temperature
- increased or worsening cough
- vomiting and /or diarrhoea
- increased wound exudates, foul smelling, purulent discharge
- delayed wound healing
- acute confusion/change in mental status
- unexplained rash
What should you do if you suspect an outbreak?

Any member of staff may suspect an outbreak. If you suspect one, it is essential, no matter what grade or qualification you have, that you report it to the person in charge immediately, this could be the CNM2, Medical doctor, etc.... The role of outbreak management is to look after service users/staff who are sick, and also prevent the infection from spreading to others.

Remember that failing to manage an outbreak can result in death or severe illness in vulnerable service users.

Controlling Infections is a team effort

Example of Outbreak Log

An outbreak log must be kept in any area where there is a suspicion that an outbreak may be occurring. This should be readily available for review by Public Health, Environmental Health, Infection Control etc… The log should contain the following information:

- Patient/staff member name and DOB
- Onset of symptoms (date and time)
- Symptoms
- Specimen/swab sent (where from, date sent)
- Treatment given (antimicrobial, isolation, precautions in place)
- Diagnosis (include specimen/swab result and date result obtained)

Group Exercise

How would you deal with the following scenario…

- 2 service users and 1 staff member have symptoms of vomiting and diarrhoea at 4am in the morning. What will you do?
PATIENT SAFETY TOOL BOX TALKS

SAFE CARE & SUPPORT

STAFF ROLES IN AN OUTBREAK SITUATION

Ward staff/carers/nurses/domestics

- Be constantly vigilant for signs of infection in service users
- Report any suspicions to CNM2/person in charge immediately
- Follow advice from Public Health/Infection Control with regard to additional infection control precautions which may need to be instigated based on how the confirmed or suspected infection is spread. This may include enhanced cleaning, isolation of clients with symptoms etc...
- Protect yourself when in close contact with infectious service user through standard precautions. Discuss with infection control/public health any additional practices which may be needed to contain and control infections (transmission based precautions). Report to CNM2/person in charge if you have symptoms
- Perform strict hand-hygiene (WHO 5 moments)
- Ensure you have read and understood any guidelines/policies that are relevant (infection control). Seek advice from your line manager if unsure

CNM2

- Report to Assistant Director of any suspected outbreaks without delay.
- Ensure medical attention is received for infectious service user
- Keep staff movement to a minimum to prevent spread to other wards/units
- Send any staff with symptoms home, advise them to seek GP advice
- Liaise with stores department urgent orders of PPE, additional cleaning and decontamination supplies, etc… that may be required
- Management of the outbreak takes precedence over any budgetary restraints, however, ensure only supplies that are required are brought into the isolation room, as once the client is better all supplies from that room will be discarded
- Ensure specimens are taken from infected service user and sent to appropriate lab
- Ensure standard precautions, and any additional precautions are adhered to. If isolation is not possible, cohort service user with similar symptoms in an area of the ward away from other service user
- Restricted visiting must be put in place, inform relatives of reason for this
- Ensure outbreak log is maintained (example below)
- If client is being transferred to another facility ensure the facility and ambulance service are informed of the outbreak situation and what preventative measures they should take

Assistant Director of Nursing/Medical Officer

- Provide support to ward/CNM2
- Inform the following people of suspected or confirm outbreak: General Practitioner or Medical Officer, HSE Regional Public Health Department, HSE Local Environmental Health Service (if suspected food or waterborne illness), Community/Hospital Infection Control Nurse, and Director of Nursing/Hospital
- Ensure relevant policies and procedures are available to staff onward/unit

Staff who experience symptoms of vomiting and/or diarrhoea are requested to remain off duty for at least 48 hours after their last symptom.

Management of Sharps & Safe Injection Practices

What are ‘sharps’?
Sharps are defined as any needles, scalpels, or other articles that could cause wounds or punctures to personnel handling them (Mosby’s Medical Dictionary, 8th edition. © 2009, Elsevier)

In line with Sharps Legislation (2014) all healthcare services should carry out a risk assessment in relation to how they manage sharps, required staff training and the provision of vaccines for healthcare workers. Needle free and retractable devices should be used where possible.

Examples of Sharps

- Needles
- Syringes
- Scalpels
- Sharps tips of IV sets
- Contaminated slides
- Stitch cutters
- Guide wires
- Razors
- Blood stained/contaminated glass

How sharps are disposed of
Sharps must be disposed of appropriately to prevent needle stick injury. There are two types of sharps disposal bins:

- Yellow Sharps Bin with red/blue Lid
  Dispose needles, syringes, scalpels, tips of syringes, sharp instruments etc., IV sets, contaminated slides, stitch cutters, guide wires, razors, blood stained/contaminated glass

- Yellow Sharps Bin with Purple Lid
  Dispose needles, syringes, sharp instruments etc… that have been used for the administration of cytotoxic waste

Management of sharp bins
- Store away from service users/visitors
- Wall mount – do not leave open boxes on desks/floors etc.
- Close when 2/3 full
- All sharps bins must be tagged
- Never re-cap needles
- Never pass a used needle from one person to another
- Never overfill sharps bins
Safe Injection Practices

- All injections should be prepared in a clean area. This area must not be used for the disposal of used needles and syringes, handling blood samples or any material contaminated with blood or body fluids.
- Eliminate the unnecessary use of sharps. Where this is not possible, use sharps with safety engineered protection mechanisms.
- Needle and syringes are sterile, single-use items and must not be reused for another client or to access a medication or solution that might be used for a subsequent client.
- Wear a surgical mask when placing a catheter or injecting material into the spinal canal or subdural space.
- Single-dose vials should be used wherever possible. Single-dose vials must not be used for multiple clients.
- Residual products must not be combined for later use.
- Restrict multi-dose vials wherever possible to a single patient.
- Do not use bags or bottles of intravenous fluids as a common source of supply for multiple patients. Intravenous fluids and intravenous sets are single use sterile items for use by a single patient.
- Consider a syringe or needle/cannula contaminated once it has been used to enter or connect to a patients’ intravenous infusion bag or administration set.

Remember!!!!

- **Never** re-cap needles
- **Never** pass a used needle from one person to another
- **Never** overfill sharps bins

All health care facilities should have a policy on the management of needle stick and other sharps related injuries and blood and body fluid exposure.

This guideline should include:
- First aid procedure
- Immediately reporting the injury/exposure to relevant line manager
- Medical risk assessment and screening of source service user (if known)
- Medical risk assessment for post-exposure prophylaxis (PEP)
- Counselling and follow-up testing.

Examples of sharps injury / Blood and body fluid exposure

- Accidental inoculation of blood by a needle or other sharp*
- Contamination of broken skin with blood
- Splashes of blood/body fluids onto mucous membranes (e.g. mouth, eyes)
- Human scratches/bites (where blood is drawn)

*Sharps may include:
- Needles
- Scalpels
- Sharps tips of IV sets
- Contaminated slides
- Stitch cutters
- Guide wires
- Razors
- Blood stained/contaminated glass
Management of Sharps Injury and Blood and Body Fluid Exposure

Immediate action to be taken following sharps injury and/or blood and body fluid exposure !!!!

The following procedure should occur in the event of exposure:

• Encourage bleeding from the wound
• Wash the wound in running water, do not scrub
• Cover the wound with a dressing
• Skin, eyes, mouth – wash in plenty of water
• Ensure the sharp is disposed of safely
• Report incident immediately to line manager.
• Complete an incident report form as per local policy
• The injured person should attend either the occupational health service or their ED department for prompt risk assessment. Urgent treatment may be required for high risk injures (PEP).

Remember!!!!!

. Bleed it
. Wash it
. Cover it
. Report it

Further information on the emergency management of injuries (EMI Toolkit) is available at: www.hpsc.ie/A-Z/EMIToolkit/

High Risk Medications- Insulin Safety

Insulin is a potent, lifesaving medication, but if prescribed or administered inappropriately has the potential to cause harm. It is therefore considered a ‘High Risk’ medication.

Safe use of Insulin

1. The abbreviation ‘u’ or ‘iu’ should not be written for units. The word ‘units’ must be written in full. U can look like 0 (zero) and IU can look like 1U or 10 which can result in overdoses.

![Fig.1. Unapproved abbreviation](image1)

![Fig.2 Approved Abbreviation](image2)

2. All insulins should be measured in insulin pens or in appropriately-sized insulin syringes marked in units. Tuberculin and other 1ml or 2ml syringes should **NOT** be used.

![Fig.3 Insulin Syringe](image3)

3. The strength of insulin products is standard at 100 units/ml.

![Fig.4. 100 Units/ml](image4)

4. A second practitioner, either medical or nursing, should perform an independent second check of insulin doses. This second check must:
   - include all aspects of administration irrespective of route or administration method,
   - be conducted from preparation through to actual administration and documentation of administration,
   - include the use of any devices and calculations.

![Fig.5. Second check](image5)
Other safety tips:

- Insulin pens are designed for ‘single patient’ use only. Sharing of pens, even when needles are changed, could result in transmission of pathogens to patients who use the same pen.
- Insulin pens should be labeled with the patients’ details – Remember one pen, one patient.
- A sterile, disposable needle must be attached to an insulin pen for each use.
- Never store an insulin pen with a needle attached. Dispose of the needle carefully in the Sharps bin.
- Never draw insulin from a pen cartridge using a syringe and needle. There is potential for air embolism and incorrect dosages may be delivered if a dose is withdrawn manually and the cartridge then returned to the pen and used.
- Record the date opened on the insulin. Protect open, in-use pens from excessive heat (>25°C) and discard by their expiry date or 4-6 weeks after first opening as specified by the manufacturer, whichever is soonest.

Acknowledgments: Irish Medication Safety Network, August 2012
SERVICE USER FALLS PREVENTION IN HEALTHCARE

THINK ACE !!!!

ASSESS

Investigate service users falls history as this is the strongest predictor of future falling is a previous fall (HSE 2008, Lyons, 2005). Include falls at home & in hospital during the past one-year.

On admission, using the appropriate falls risk assessment tool:

- Complete falls risk assessment on all service users > 60yrs.
- Complete falls risk assessment on service users <60yrs who had a history of fall in the past 12 months or,
- If your nursing assessment identified that a falls risk assessment is required.

CARE PLAN

Initiate appropriate care plan and ensure the following:

- Service user has been orientated to ward layout
- Call bell is in working order & in reach of service user and its use explained.
- All other service user necessities are within easy reach at all times
- All walkways are kept clear of objects that could pose a threat to service user safety
- There is adequate night lighting.
- Service user is wearing appropriate footwear and that the service user's clothing is not trailing
- Service user wears correct glasses /lenses, if required
- Service user is on appropriate seating following occupational therapist assessment.
- Leave bed in low position with brakes on when service user is unattended.
- Referral to relevant member of multidisciplinary team
- If hip protectors are considered Apply in line with local guideline/policy service user.

EVALUATE: Reassess the service user’s falls risk:

- Weekly
- If service user’s criteria change
- If service user falls

FALLS PREVENTION IS EVERYBODY’S RESPONSIBILITY
Multidisciplinary Post-Fall Process Flow – What to do if a Service User falls

(Adapted from Mid-Yorkshire Hospital Trust and the NSW Clinical Excellence Commission 2008)

Service User Falls

Assess he/she (temp., pulse, B/P, Respiratory arte, SaO₂, blood sugar). Repeat falls risk assessment
Ascertain cause of fall
Initiate appropriate nursing care plan/interventions
Inform medical staff

NO

Medical Staff to follow Medical Flow Chart

Was fall un-witnessed or is a head injury suspected

YES

Perform neurological observation and act promptly on changes in neurological status (e.g. decreased consciousness level, headache, vomiting or pupil changes) as per service policy

Refer to the relevant Allied Health Professional (AHP) if indicated. AHP will then follow relevant flow chart

Complete Incident Report Form

Inform service user’s next of kin (with his/her consent)

Nurse to document fall in Progress Notes & Ward Falls Log Book. Notify CNM/Nurse in charge and Nursing Administration of fall

Reassess patient using appropriate risk assessment tools

Continue to monitor service user’s progress

Special Considerations:

- Patient on anticoagulant and/or antiplatelet therapy and patients with a known coagulopathy are at greater risk of intracranial haemorrhage.
- Anticoagulant/platelet therapy includes Warfarin, eparin, Aspirin, Clexane, Clopidogrel Plavix).
- Alcohol dependent patients should be considered to have a coagulopathy

Acknowledgements: Nursing Practice Development Department and MDT Falls Prevention Committee, Conolly Hospital, Blanchardstown. July 2012
Responding to Elder Abuse in an Acute setting - the 3 R’s

As an employee of the HSE - you have a Duty of Care to Recognise, Record and Report cases of Elder Abuse. This Guide will assist you with the basics. For further information, refer to the HSE polices and Professional Guidelines and Standards which are outlined.

**Recognise**

**What is Elder Abuse?** “A single or repeated act or lack of action occurring within any relationship where there is an expectation of Trust, which causes harm or distress to an older person or violates their human and civil rights” Protecting our Future (DOHC 2002)

**Forms of Abuse include:**

- **Physical:** including hitting, slapping, pushing, kicking, misuse of medication, restraint or inappropriate sanctions,
- **Sexual:** including rape, sexual assault, or sexual acts that the older person has not, or could not consent to, or into which he or she was compelled to consent.
- **Neglect:** including ignoring medical or physical care needs, failure to provide access to appropriate health or social care services, the withholding of the necessities of life such as medication, adequate nutrition, medication.
- **Financial:** including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions or the misuse of property, possessions or benefits.
- **Psychological:** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks.

**Record**

Any indicators of the above should be recorded in the patients chart. Good clinical notes and assessments (both medical and social) not only aid good decision making they also help protect the older person at risk of abuse.

Note what the older person is saying to you – but also take into account non verbal communication ques. Also note any repeat or frequent admissions into hospital with unclear or unexplained reasons why.

Also don’t forget your own individual professional Guidelines (e.g. An Bord Altranais- Working with Older People Guidelines 2009 and the Medical Council - Guide to Conduct and Professional Ethics 2009) which will assist and enable you in dealing with suspected cases of elder abuse.
Report

There are HSE policies which oblige you to report your concerns of elder abuse e.g. Responding to and Recognising Elder Abuse HSE 2007, Trust in Care HSE 2005, Employee Code of Standards and Behaviour HSE 2009.

Your hospital may have an elder abuse specific policy, this will also assist and guide you in knowing who, when and where to report your concerns to.

Discuss and report any concerns that you might have with your line manager (Clinical nurse manager/Consultant/ Clinical lead).

Where appropriate complete an Incident Report form.

Your line manager (in consultation with others when required - such as clinical lead, Consultant, DON, Risk Manager), will decide who will inform other relevant statutory services – e.g older persons social work dept, Gardai, HIQA or Coroner.

Also be aware of the HSE’s guidelines on Protected Disclosures in the Workplace which may also assist you.

Acknowledgements: Geraldine O’Brien, Principal Social Worker, Services for Older Persons, PCCC Cavan/ Monaghan, 2012
KEY CONSIDERATIONS FOR HOSPITAL STAFF

Principles for Best Practice in Responding to Child Protection and Welfare Concerns include:

- Welfare of children is paramount
- Children have a right to be heard
- Parents/carers have a right to respect
- Balance struck between protecting children and respecting needs/rights of Parents and Families. Where there is conflict, the Child's welfare must come first.
- Early intervention and family support is paramount
- Separating children from parents should always be a last resort
- When working with adults, consider impact of adult's behaviour on child and act in the child's best interest

Definitions: (Children First, 2.1)

Neglect: An omission, where the child suffers significant harm or impairment of development by being deprived of food, clothing, warmth, hygiene, intellectual stimulation, supervision and safety, attachment to and affection from adults, medical care.

Emotional Abuse: Emotional abuse is normally to be found in the relationship between a parent/carer and a child rather than in a specific event or pattern of events. It occurs when a child's developmental need for affection, approval, consistency and security are not met. Unless other forms of abuse are present, it is rarely manifested in terms of physical signs or symptoms.

Physical Abuse: Is that which results in actual or potential physical harm from an interaction or lack of interaction, which is reasonably within the control of a parent or person in a position of responsibility, power or trust.

Sexual Abuse: When a child is used by another person for his or her gratification or sexual arousal or for that of others.

Welfare Concerns: A problem experienced directly by a child, or by the family of a child, that is seen to impact negatively on the child’s welfare or development, which warrants assessment and support.

Points to Remember

1. The severity of a sign does not necessarily equate with the severity of the abuse.
2. Neglect is as potentially fatal as physical abuse.
3. Experiencing recurring low-level abuse may cause serious and long-term harm.
4. Child abuse is not restricted to any socioeconomic group, gender or culture.
5. Challenging behaviour by a child or young person should not render them liable to abuse.
6. Exposure to domestic violence is detrimental to children’s physical, emotional and psychological well-being.
7. It is sometimes difficult to distinguish between indicators of child abuse and other adversities suffered by children and families.
8. Neglectful families may be difficult to engage.
9. Families where neglect and abuse are prevalent may go to considerable lengths to deceive professionals.
Other key considerations

Retrospective Disclosures by Adults: Establish whether there is any current risk to any child who may be in contact with alleged abuser. If any risk is deemed to exist to a child who may be in contact with an alleged abuser, the counsellor/health professional should report the allegation to the HSE Children and Family Services without delay.

Confidentiality and the sharing of information: The effective protection of a child often depends on the willingness of the staff in statutory and voluntary organisations involved with children to share and exchange relevant information. It is therefore critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information. Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. They are not intended to limit or prevent the exchange of information between different professional staff with a responsibility for ensuring the protection and welfare of children. The provision of information to the statutory agencies for the protection of a child is not a breach of confidentiality or data protection. (Please also refer to the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012).

What does “Children First” say about the Role and Responsibilities of Hospitals?

1. Hospital staff are in a pivotal position to identify cases where reasonable grounds for concern exist regarding the protection and welfare of children and to participate in the assessment of those concerns.

2. Concerns by hospital staff should be reported to line management. Hospital management should act in a protective and preventive manner by referring any concerns to the appropriate agencies in respect of children and families who are in need of support services.

3. All front-line staff, particularly in emergency departments, must be alert to indicators of actual or potential child abuse or neglect. Standardised record systems should be adopted by hospitals in order to highlight repeated visits by children presenting with injuries. (Staff member(s) needs to be aware of past presentations whilst assessing the current case). Concerns noted by any staff member should be reported to line management. A multidisciplinary approach is essential. Medical and social histories should be obtained and accurately recorded, covering the following areas: (i) circumstances of the child’s presentation to hospital, (ii) details of injuries or other signs of neglect, (iii) explanations offered by parents/carers and/or child, (iv) general demeanour of parents/carers and/or child, (v) family history, (vi) whereabouts and safety of other siblings or children in the same situation, (vii) whether or not the child should be admitted in order to guarantee safety.

4. It is essential that an open and honest approach is taken with parents/carers, who must be given full information about the concerns that exist, the need for any further medical or social assessments, and the intention of the hospital staff to report the concern to the HSE Children and Family Services.

5. The child must be kept appropriately informed of developments and should be allowed an opportunity to offer his or her view, taking into account level of maturity and stage of development.

Medical examinations: The cooperation of parents/carers should be sought for any examinations and assessment considered necessary. If cooperation is not forthcoming, the possibility of legal action should be considered and conveyed to parents/carers (see Chapter 5, Paragraph 5.18.3).

Fatal child abuse: Where a child has died as a result of suspected or confirmed child abuse, the following actions must be taken by hospital authorities: (i) An Garda Síochána and the HSE Children and Family Services must be notified immediately; (ii) the Coroner must be notified; (iii) the protection of other children in the family must be urgently considered; (iv) the bereavement needs of the family must be addressed with sensitivity.

Where can I get more information?

Children First, National Guidance for the Protection & Welfare of Children 2011; Our Duty to Care, DoHC 2002; HSE Child Protection and Welfare Practice Handbook, 2011; Standard Reporting form; FAQ sheets and Information on Advice, Guidance and Support are all available to access at www.hse.ie/go/childrenfirst

Acknowledgements: Mr. Seamus Deeney, Chair for Child Protection Conferencing, Cavan/Monaghan, Child and Family Services, Ms. Déirdre Horan Martin, Children First Information & Advice Officer, Cavan and Monaghan, Child and Family Services and Children First Information & Advice Officers Nationwide.
What is Children First?

‘Children First’ 2011 - is the HSE National Guidance which promotes the safety and well-being of all children. ‘Children First’ is intended to assist people in identifying and reporting child abuse and neglect and outlines how to deal effectively with concerns. It highlights the role and responsibilities of the H.S.E. and An Garda Síochána, the two agencies with the statutory responsibility for child protection. It offers guidance and outlines the roles and responsibilities of all agencies and organizations to protect children.

The HSE Child Protection & Welfare Practice Handbook 2011, is a companion to Children First and an aide to delivering accountable, consistent and deliverable practice.

What are your responsibilities?

HSE Staff Responsibility for the Protection and Welfare of Children 2010: This HSE Policy is effective from 24th May 2010 and applies to all HSE staff. There are different levels of responsibilities for Designated Officers (full list on Appendix 10, Children First 2011) and the wider staff group of Non-designated Officers.

Responsibilities of HSE Designated Officers

- To clarify with the person making the report that he/she is making a formal report
- To inform that person they are protected in law from civil liability if they report to you as a designated Officer reasonably and in good faith (See below, Protection for Persons Reporting Child abuse Act 1998)
- To establish if reasonable grounds for concern exist (see below)

Protections for Persons Reporting Child Abuse Act 1998: This Act came into operation on 23 January 1999. The main provisions of the Act are:

' (i) the provision of immunity from civil liability to any person who reports child abuse 'reasonably and in good faith' to designated officers of the HSE or to any member of An Garda Síochána; (ii) the provision of significant protections for employees who report child abuse, and, (iii) the creation of a new offence of false reporting of child abuse’

Section 176 of the Criminal Justice Act 2006 : This act introduced the criminal charge of reckless endangerment of children. It states:

‘A person, having authority or control over a child or abuser, who intentionally or recklessly endangers a child by – (a) causing or permitting any child to be placed or left in a situation which creates a substantial risk to the child of being a victim of serious harm or sexual abuse, or (b) failing to take reasonable steps to protect a child from such a risk while knowing that the child is in such a situation, is guilty of an offence.’

The penalty for a person found guilty of this offence is a fine (no upper limit) and/or imprisonment for a term not exceeding 10 years.
What to do if you have a concern/(s) about a child?

In the Children First: National Guidance, ‘a child’ means a person under the age of 18 years, excluding a person who is or has been married.

1. Do I Have reasonable Grounds for concern? (see below) **Record my concerns.**

2. Report to my line manager without delay and consult with the Child and Family Duty Social Work Service if needed at this point. (Remember to check all past presentations of the child, be aware of indicators of abuse; patterns over time may be significant to this current case). **Record outcomes and all decisions.**

3. Inform and consult with Parents (and Child where appropriate) as soon as possible unless doing so would endanger the child. **Record their responses.**

4. If Reasonable grounds for concern exist, Report to HSE Child and Family Services Duty Social Worker without delay. **In an emergency contact the Gardai. Record outcomes and keep copy of all Standard Reporting Forms** (refer to your Hospital policies)

5. Participate in assessment of concerns where appropriate.

6. At any stage of this process you can consult/report to the Duty Social Worker, HSE Child and Family Services even if your line manager has no further concerns about the children.

Guidelines for Recognition

There are three stages in the identification of child neglect or abuse:

1. Considering the possibility
2. Looking out for signs of neglect or abuse
3. Recording of information

What Constitutes Reasonable Grounds for a Child Protection or Welfare Concern?

- An injury or behaviour that is consistent both with abuse and an innocent explanation, but where there are corroborative indicators supporting the concern that it may be a case of abuse.
- Consistent indication over a period of time that a child is suffering from emotional or physical neglect.
- Admission or indication by someone of an alleged abuse.
- A specific indication from a child that he or she was abused.
- An account from a person who saw the child being abused.
- Evidence (e.g. injury or behaviour) that is consistent with abuse and unlikely to have been caused in any other way.

**If in doubt, check it out and remember Always Children First!!!!**

INSERT YOUR LOCAL CHILD AND FAMILY DUTY SOCIAL WORK DEPARTMENT HERE: ______________________

INSERT YOUR LOCAL GARDA STATION NUMBER HERE: ________________________________________________

**Acknowledgements:** Mr. Seamus Deeney, Chair for Child Protection Conferencing, Cavan/Monaghan, Child and Family Services, Ms. Déirdre Horan Martin, Children First Information & Advice Officer, Cavan and Monaghan, Child and Family Services and Children First Information & Advice Officers Nationwide.