24.1 MAINTAINING SMS RECORDS

It is critical to be able to easily demonstrate at any time the records which support the ACT Health SMS. This includes but not limited to key documentation such as:

- Completed Planned Inspection Sheets
- Minutes of Staff Meetings
- Workplace Incident Reports
- Preventative maintenance records.

To have this information readily on hand is important for the following reasons:

- Management review of Program
- Audit requirements, both Internal and External (includes ACHS Accreditation)
- Prosecutorial support if ever required.

To present this information in a professional manner it is required that careful thought be given by each relevant Manager to have this information contained in appropriate folders which are always at hand and available to all relevant staff members. SMS records are maintained in accordance with the Records Management Program at ACT Health. This program contains a master list of records to be maintained, recommended method of retention, location, and the period they should be maintained for.

The Record Keeping Guidelines outlined below (24.2 Record Keeping Guidelines) and in section (24.3 Management of OHS Records) on the following page have been developed to support Line Management in this task.

24.2 RECORD KEEPING GUIDELINES

(i) At ACT Health all OHS records, both current and archived, are to be appropriately filed for each relevant year and are indexed to indicate the type of documentation maintained.

Note: Files are to be retained as per TARDiS requirements.

Link to TARDiS
Website Address: http://www.territoryrecords.act.gov.au/recordsdisposal/agencyrecordsdisposalschedules

(ii) All OHS Records, which are not confidential worker information, are to be stored on an official administrative file. An electronic copy can be stored on the shared Q: drive as an easily accessed location that can be readily accessed by any worker.

(iii) It is the responsibility of management to ensure that all relevant OHS records (worker certificates, licences and training records) are collated into official files which are to be securely stored.

(iv) All record keeping procedures are communicated to relevant workers to ensure that they are aware of the circumstances where appropriate records are required to be completed and presented.

(v) Record keeping is an important tool for staff to monitor the performance of their SMS. It is the responsibility of management to ensure that all OHS related records are appropriately created, maintained, stored and readily accessible in a presentable manner at all times.

24.3 MANAGEMENT OF OHS RECORDS

Common Subject	Record Title	Responsibility	Recommended Method of Retention / Storage	Location	Retention Period
Accident / Incident Reports	OCCUPATIONAL HEALTH & SAFETY (OH&S)– Accidents-Incident Reports 2007-08	Line Management	Data Base (SAIR)	Online	Destroy 7 years after last action (11.1.2)
Register of Injuries (First Aid)	OCCUPATIONAL HEALTH & SAFETY (OH&S)– Reporting - Register of Injuries 2007-08	Line Management	Data Base (SAIR)	Online	Destroy 7 years after last action (11.88.1)
Material Safety Data Sheets	OCCUPATIONAL HEALTH & SAFETY (OH&S)– Health Promotion - Material Safety data sheets 2007-08	Line Management	Ring Binder / Chemwatch	Nominated Location	Destroy when hazardous material is disposed of (11.52.3)
Hazardous Substance Register	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Compliance - Hazardous substance register 2007-08	Line Management	Ring Binder	Nominated Location	Destroy 75 years after last entry (11.21.6)
Certificates – Employees	*Option 1:* Staff Development – Training - Certificates - Employees *Option 2:* OCCUPATIONAL HEALTH & SAFETY (OH&S)– Compliance - Certificates - Employees *Option3:* Personnel – Employment Condition - Certificates - Employees	Line Management	File	Manager's / Supervisor Filing Area / SDU / HR	*Option 1:* OHS training – Destroy 7 years after training is completed (15.105.10) Licenses for operating plant – destroy when license expires (11.21.2) *Option 2:* Educational Qualifications – Destroy 75 years after last entry (11.21.6) *Option 3:* 7 years after last action (12.39.2)
Certificates – Plant and Equipment	Equipment and Stores – Maintenance - Inspection – Plant and Equipment	Line Management	Ring Binder	Manager's / Supervisor Filing Area	Destroy 7 years after action completed (3.14.2)
Plant/Equipment Inspections	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Inspection – Plant	Line Management	Ring Binder	Managers Office	Destroy 10 years after last action (11.57.2)

Common Subject	Official Title	Responsibility	Recommended Method of Retention / Storage	Location	Retention Period
Maintenance Records	Equipment and Stores – Maintenance - Inspection – Plant and Equipment	Line Management	Mainét	Online	Ongoing
Plant & Equipment	OCCUPATIONAL HEALTH & SAFETY (OH&S)– Inspections - Plant & Equipment	Property Management & Maintenance	Mainét	Online	Ongoing
Medical Equipment	Health Equipment & Stores – Inspection - Medical equipment	Bio Medical Engineering	Register Electronic Register	Register G Drive	Destroy 10 years after action completed
Testing and Monitoring Records	Option1: OCCUPATIONAL HEALTH & SAFETY (OH&S)– Evaluation - Test and Monitoring Option2: OCCUPATIONAL HEALTH & SAFETY (OH&S)– Risk Management - Test and Monitoring	Line Management	ACT Govt Archive File Ring Binder Online	Manager's Filing Area	Option 1: Destroy 5 years after last action (11.42.1) Option 2: Destroy 75 years after last action (11.57.2)
Internal OHS Audit reports	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Audit - Internal reports	Line Management	Ring Binder	Manager's Filing Area	Destroy 5 years after action completed (11.13.1)
External OHS Audit reports	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Audit – External Reports	Divisional Manager	Individual Reports	Manager's Office IP&M CE Office	Destroy 5 years after action completed (11.13.1)
OHS C'tee Meeting Minutes	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Committees	Chairperson	ACT Govt Archive File Ring Binder Online	Chairperson Filing Area Online	Destroy 5 years after action completed (11.20.2)
Tier 1 OHS C'tee Meeting Minutes	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Committees – Meetings 2007-08	Chairperson	Ring Binder	Chairperson Filing Area Online	Destroy 5 years after action completed (11.20.1)

Common Name	Records Management Centre Official Name	Responsibility	Recommended Method of Retention / Storage	Location	Retention Period
Statistical Data	OCCUPATIONAL HEALTH & SAFETY (OH&S) - Reporting - Injury statistics	Chief Ministers Dept IP&M	Data Base	Chief Ministers Dept	Ongoing
OHS related Staff Meeting minutes	OCCUPATIONAL HEALTH & SAFETY (OH&S) – Committees - Staff Meeting Minutes	Line Management	ACT Govt Archive File Ring Binder	Manager's Filing Area	Destroy 5 years after action completed (11.20.2)
Corrective Action Lists	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Inspection - Corrective action list	IP&M	Ring Binder	IP&M Filing	Destroy 10 years after action completed (11.57.2)
Risk Assessment / Management	OCCUPATIONAL HEALTH & SAFETY (OH&S)- Risk Management	IP&M	Ring Binder	Manager's Filing Area	Destroy 75 years after last action

Note: Bracketed number reflects TARDiS (Territory Administrative Records Disposal Schedule – May 2003) entry number

24.4 STATISTICAL MANAGEMENT STANDARDS

ACT Health has a number of Key OHS Measurement Indicators that support ACT Health's management monitor the OHS performance of individual Divisions, managers or units.

Identifying particular trends will enable practices that are lagging behind ACT Health OHS standards or advanced above Company OHS standards to be appropriately addressed. Examples of indicators are:

- Lost Time Injury Frequency Rate (LTIFR)
- Duration rates of workers off work
- Accident/Incident numbers
- Analysis of preventative actions and controls
- IM case closure rates i.e. average length of time for an IM claim to be finalised.
- Number of inspections completed on time.
- Number of Staff Meetings held on schedule
- Numbers of OHS objectives achieved on time.
- Percentage of incident reduction rates achieved
- Percentage of corrective actions followed up on time.
- Satisfaction of injured/ill workers with Return-to-Work plan.

24.5 OHS SCHEDULE

The OHS Schedule listed in **Appendix 1 - FORMS** provides an overview of all required OHS operations and procedures relevant to ACT Health Divisions over a 12-month period. It has been designed to give at one look the current position of how the SMS is progressing at any point in time within the relevant workplace.

Note: For this Table to be effective it is important that it be kept up-to-date at all times.

Section 25	Approved: Director IP&M	Effective Date: 7.11.2010	Revision 4 Revision Date: 7.11.2010
Subject Description: SMS AUDITS			

SECTION 25

SMS AUDITS

25.1 PURPOSE OF AN AUDIT PROGRAM

The fundamental purpose of an effective audit system is to assess and verify the effectiveness of the ACT Health SMS in terms of strategies to prevent incidents and demonstration of duty of care / due diligence for all staff.

It is a requirement of ACT Health that audits must be conducted on a scheduled basis to determine whether the SMS conforms to the planned arrangements and has been effectively implemented and maintained.

Verification must establish the following ACT Health OHS standards:

- Provide demonstration of compliance to the SMS in terms of:
    - Work Safety Policy
    - OHS Procedures and
    - Safe Work Procedures (SWP's).
- OHS Objectives, Targets and Performance Indicators for injury / illness prevention are developed and being achieved
- Continuous improvement strategies are implemented in consultation with workers
- Implementation of corrective actions and preventive measures
- Conformance to Australian Council of Healthcare Standards (ACHS) EQuIP 4 standards
- Conformance to Work Safety legislative requirements, Codes of Practice and / or Industry Standards
- The SMS has been effectively implemented and maintained

25.2 DEFINITIONS (Based on Australian Standards)

The following definitions are based on relevant Australian Standards.

Audit (AS / NZS 4801: 2001 OHS Management systems): An Audit is a systematic examination against defined criteria to determine whether activities and related results conform to planned arrangements and whether these arrangements are implemented effectively and are suitable to achieve the organisation's policy and objectives.

Audit Evidence (AS / NZS ISO 19011: 2003 Guidelines for quality and / or environmental management systems auditing): records, statements of fact or other information, which are relevant to the audit criteria and verifiable.

Principles of auditing (AS / NZS ISO 19011: 2003): Auditing is characterised by reliance on a number of principles. These make the audit an effective and reliable tool in support of management policies and controls, providing information on which an organisation can act to improve its performance.

Objective Evidence (AS / NZS ISO 8402: 1994 Quality management and quality assurance – Vocabulary) – information which can be proved true, based on facts obtained through observation, measurement, test or other means.

Audit Evidence (AS / NZS ISO 14010: 1996) – verifiable information, records or statements of fact.

25.3 RESPONSIBILITIES

- It is the responsibility of relevant Divisional Heads / Directors / Executive Directors to ensure that each Division undertakes an internal audit conducted as outlined in section 25.4 SMS on a quarterly basis. It is the intention that all elements of the ACT Health SMS will be audited at least once annually by authorised / competent persons.
- It is also the responsibility of relevant Divisional Heads / Directors / Executive Directors to ensure that sufficient time is allocated for auditees to prepare for and participate in the audit shall also be provided.
- It is the responsibility of relevant ACT Health DONS / Directors / Unit Directors / Program Managers to assign resources to ensure that the audit timetable can be met and to report the results to all relevant staff.
- It is the responsibility of relevant Divisional Heads / Directors / Executive Directors to review the actions / outcomes from the various audits conducted and ensure a performance improvement plan has been developed. This is to be conducted in consultation with the relevant Divisional / Tier 2 Work Safety Committee.
- The developing, assigning and progressive monitoring of any Corrective Actions resulting from the audit must be developed, implemented and reported by the DONS / Directors / Unit Directors / Program Managers to the IP&M Director, Injury Prevention and Management using the Quarterly Work Safety Report (refer section 1.5 Corrective Action).
- The following principles relate to auditors and it is expected that all auditors will comply with these principles:
    - Ethical Conduct
    - Fair Presentation
    - Due professional care
    - Independence
    - Evidence-based approach.

25.4 ACT HEALTH AUDIT PROGRAM

25.4.1 AUDITS CONDUCTED

As part of ACT Health overall OHS Management Program the following audits are conducted:

1. ACT Health SMS Internal Audit
2. Independent External Audit of the SMS covering all Divisions once every three years.
3. Australian Council of Healthcare Standards (ACHS) EQuIP 4 requirements which include assessment / audit of ACT Health OHS Management processes.

25.4.2 AUDIT PROGRAM PROCESS

On an annual basis, the ACT Health IP&M in February of each year will provide a proposed Audit Plan outlined in the OHS Activity Schedule. The Audit Plan will consist of:

- Audits, both Internal and Independent External, being conducted in accordance with AS / NZS 4801: 2001 OHS Management systems
- Divisions / Branch / Section to be audited with supporting schedules
- The audit team must include an auditor who is suitably qualified
- All audits are to be conducted in accordance with auditing standards outlined in "AS/NZS ISO 19011:2003 Guidelines for quality and/or environmental management systems auditing".

25.4.3 SMS INTERNAL AUDIT PROCEDURE

25.4.3.1 OHS Management Standards

These are the 25 Standards adopted by ACT Health against which all internal OHS management systems shall be measured. The 25 Standards will be addressed collectively by Quarterly SMS Internal Audits and an Independent External Risk Management Audit. They include the following;

Sect.	Standard	Qty Internal Audit	External Audit
1	Work Safety Policy & Administration	✓	✓
2	Leadership & Responsibility	✓	✓
3	OHS Communication & Consultation	✓	✓
4	OHS Risk Management	✓	✓
5	Planned Inspection Program	✓	✓
6	Training	✓	✓
7	Accident / Incident Reporting & Investigation	✓	✓
8	Return to Work (RTW)	✓	✓
9	Safe Work Procedures (SWP)	✓	✓
10	Management of Hazardous Substances / Dangerous Goods	✓	✓
11	Clinical OHS Hazards		
12	First Aid Administration	✓	✓
13	Security & Emergency Preparedness		✓
14	Fitness for Work	✓	✓
15	Manual Handling Guidelines	✓	✓
16	Preventative Maintenance	✓	✓
17	Design Control		
18	Work Permits / OHS Hazards		
19	Procurement, Contractor, Accommodation & Asset Management	✓	✓
20	Personal Protective Equipment (PPE)		✓
21	ACT Health Safety Rules	✓	✓
22	Staff Welfare & Wellbeing	✓	✓
23	Environmental & Waste Management	✓	✓
24	Management of Information	✓	✓
25	SMS Audits	✓	✓

25.4.3.2 OHS Scheduling:

All 25 sections will be audited at least once every three years. Each operation audited, i.e., Division / Branch / Section will maintain a forward Schedule of Audits and compiled Audit Reports.

25.4.3.3 Resources:

SMS Internal Audit: It is generally anticipated that the SMS Internal Audit will take approximately one to two days per section to conduct the audit.
A group of nominated, trained Internal OHS Auditors will be maintained within ACT Health. A register of these individuals shall be maintained with the Assistant Director, Injury Prevention and Management.

Independent External OHS Management Audit:

- The external consultants utilised to conduct the internal OHS Management Audits must supply at the beginning of each year to the Director, Injury Prevention and Management the following information:
    - Scope of audit activity – Standards to be addressed
    - Audit schedules (frequency).
- Audits are to be conducted in accordance with AS / NZS 4801: 2001 OHS Management systems. A full audit report detailing findings is produced enabling corrective actions to be generated to address any non-conformances and outlining assessment of OHS priority and OHS performance outcomes, i.e., Recommendations.
- External Auditors are to have suitable audit accreditations.

25.5 METHODOLOGY OF INTERNAL & EXTERNAL AUDITS

25.5.1 SMS INTERNAL AUDIT

The SMS Internal Audit will be conducted on a formal basis including an **Opening Meeting** and a **Closing Meeting** with relevant staff. The following techniques will be utilised to gather relevant information and verification:

- **Review** of relevant **documents**
- Scheduled **interviews** with personnel, including management, supervisors, workers and contractors
- **Observation** through site Planned Inspection
- **Informal discussion** with relevant staff members as appropriate.

25.5.2 Audit Acceptance Levels:

The SMS Internal Audit Tool has been designed to provide a "**Yes**" (conforms) or "**No**" (non conformance) response. There will be occasions where a "**not applicable**" or "**cannot be verified**" response arises; however, that is at the discretion of the auditor and is not shown on the audit tool. Where the latter responses are given this will not affect the overall finding of the audit result.

25.5.3 Core Audit Questions (SMS Internal Audit Tool):

Core Audit Questions of the SMS Internal Audit Tool have been developed to ensure that consistent OHS standards are being implemented in all Divisions to meet due diligence requirements. **This is critical to the legal obligations of ACT Health and must be reviewed at each Internal Audit.**

Audit Procedural Guidelines are provided to ensure consistent standards are being by ACT Health SMS Audit Team (refer **Appendix 1 – SMS Forms**).

25.5.4 Extended "Focus Area" Questions:

Extended "Focus Area" questions of the SMS Internal Audit Tool have been developed to ensure that over a 12 month basis Key Focus Areas have been identified to support consistent audit standards. The tool provided enables the **auditor & auditee** the opportunity to "**drill down**" on key areas with the view for identifying & correcting "gaps". This is integral for continuous improvement.

Areas of focus for each quarter are as follows:

1st Quarter	• Implementation of OHS Objectives within each Division • OHS Responsibility, Accountability and Leadership for relevant ACT Health staff.
2nd Quarter	• OHS Communication & Consultation
3rd Quarter	• OHS Risk Management • Training • Review of OHS Objectives within each Division.
4th Quarter	• Accident / Incident Reporting and Investigation • Emergency Preparedness • Manual Handling.

25.5.5 Audit Performance Rating Assessment (PRA Rating):

At the completion of each audit the actual score will be tallied-up and compared against the maximum total from which a percentage score will be determined. The results will be reflected in the chart outlined below:

PERFORMANCE RATING ASSESSMENT	
Green	75% to 100%
Amber	60% to 74%
Red	0% to 59%

25.5.6 Performance Improvement Standards:

It is a requirement that all Audits are to be reviewed with the relevant Divisional Heads / Directors / Executive Directors and those actions / strategies are developed to address identified gaps / non-conformances and areas for improvement.

At each Division / Branch / Section the actions / outcomes from Audits will be reviewed with the relevant Divisional / Tier 2 Work Safety Committee where the Audit Report can be reviewed and strategies developed. Minutes are to reflect this meeting.

The procedure outlined below is to be actioned when the following PRA are received:

- **"Green" PRA Rating level:** ACT Health expects that all Divisions / Branches / Sections operate to a **"Green" PRA Rating level**, i.e., a score of **75% or more**, as this is a direct reflection of "duty of care / due diligence" standards of the relevant Division / Branch / Section. Upon achieving "Green" the focus herein is to consistently improve with higher ratings and not go backwards.
- **"Amber" / "Red" PRA Rating level:** When a "Green" result has not been achieved then the relevant Divisional Heads / Directors / Executive Directors / Injury Prevention and Management Representative are to review the appropriate Action Plan at the time of the Audit to address issues raised. The relevant Divisional Heads / Directors / Executive Directors will review the Action Plan within 30 days with a brief written response to the HSE Manager, Injury Prevention and Management.
- **Consecutive "Red" PRA Ratings:** If a Division / Branch / Section scores below **60% (Red) on two consecutive Audits** then the relevant senior management of that area will determine if appropriate performance counselling is to be instigated.

25.5.7 "CRITICAL REDS"

In all OHS Management Systems there are deemed "**critical elements**" that if not adequately achieved will impact on duty of care / due diligence requirements. These critical elements include the following:

- Failure to comply with ACT Health Consultation standards (e.g. inconsistent Work Safety Committee Meetings
- Failure to comply with ACT Health Planned Inspection standards
- Serious breaches of dangerous substance standards
- Serious breach in work safety practice(s) during an audit.

If a "critical red" is identified within a Division / Section then, regardless of the final score outcome, the audit result will be deemed "red" as outlined **24.5.6 Performance Improvement Standards.**

25.5.8 INDEPENDENT EXTERNAL OHS MANAGEMENT AUDIT

(i) The external consultants utilised to conduct the internal Risk Management Audits must supply at the beginning of each year to the ACT Health Director, Injury Prevention and Management the following:

- scope of audit activity – elements to be addressed
- audit schedules (frequency).

(ii) SMS Audits are to be conducted in accordance with AS / NZS 4801: 2001 OHS Management systems. A full audit report detailing findings is to be produced enabling Corrective Actions to be generated to address any non-conformances and outlining:

- assessment of OHS importance - determined conformance or non compliance of AS / NZS 4801: 2001 OHS Management systems
- OHS performance outcomes - Recommendations.

25.5.9 Continuous Improvement:

"**Recommendations for Improvement**" will be assigned from the findings of the Audit and are an integral element for continuous improvement.

It is the responsibility of the relevant Divisional Heads / Directors / Executive Directors to develop an Action Plan for addressing the "Recommendations for Improvement". Some of these Actions may be included in a "higher level" Action Plan.

A summary of all Actions will be tracked and reported to each relevant Work Safety Committee and the HSE Manager, Injury Prevention and Management until they have been closed out.

25.5.10 Audit Records Worksheets

The audit checklists / worksheets, either completed manually or electronically, as well as any evidence collected during the course of the audit, shall be retained by the Auditor for a period of three years, i.e., for both Internal and External audits.

25.6 REPORTING

24.6.1 SMS Internal Audit Reporting:

On a quarterly basis the individual **Performance Rating Assessment (PRA Rating)** for each Division / Branch / Section will be collated by the HSE Manager, Injury Prevention and Management. Each audited entity, i.e., Division / Branch / Section will be colour rated according to the final outcome of the findings of the audit, i.e., Green, Amber or Red.

This information will be forwarded to the ACT Health Senior Management to review and monitor on a quarterly basis. Each relevant Divisional Heads / Directors / Executive Directors will receive this information thus effectively benchmarking against ACT Health operations.

Note: This reporting process will keep Senior Management informed of all current OHS activities at all operations within ACT Health by using "management by exception" principles, i.e., focus will be directed immediately to all "Red / Amber Operations". This process is a critical strategy to ACT Health SMS Program to promote continuous improvement and system measurement outcomes.

25.6.2 Independent External OHS Management Audit:

For the **Independent External OHS Management Audit** a formal descriptive report will be prepared recording the evidence identified to support the level achieved for each Standard against AS / NZS 4801: 2001 OHS Management systems. These results are to be reported to ACT Health Senior Management Team to include the Chief Executive and Divisional Heads / Directors / General Managers. The Report once confirmed and completed becomes the responsibility of each of the relevant Divisional Heads / Directors / Executive Directors to action.

25.6.3 Distributing the Audit Report:

Both the SMS Internal Audit Report and the Independent External Risk Management Audit Report when compiled and approved are to be forwarded to the Assistant Director, Injury Prevention and Management for distribution. Copies will be sent to the following:

- ACT Health Senior Management:
  - Chief Executive
  - Divisional Heads / Directors / General Managers
  - Director, Injury Prevention and Management
  - Assistant Director, Injury Prevention and Management
- Tier One Work Safety Committee
- Tier Two Work Safety Committee (relevant division)
- Tier Three or Four Work Safety Committee (as required)

25.7 AUSTRALIAN COUNCIL OF HEALTHCARE STANDARDS (ACHS) ACCREDITATION

This audit is conducted by a team of suitably qualified ACHS surveyors every 3 years. The audit accreditation purpose is to determine whether ACT Health is complying with the standards required by the ACHS EQuIP 4 Audit Tool.

The accreditation process covers all aspects of ACT Health operational standards; including OHS requirements.

Excerpt from ACHS Equip 4 Part 2, Section 3.2 Safe Practice and Environment Standard:

"The standard is: The organisation maintains a safe environment for workers, consumers / Patients, Consumers and Clients and visitors.

This standard should be read in conjunction with criterion 2.1.2 on risk management.
The intent of the Safe Practice and Environment standard is to ensure that the health care environment is safe and health care providers work in a safe manner. Safe Practice and Environment criteria all require the systematic application of risk management principles to determine priorities and eliminate risks or implement controls.

There are five criteria in this standard. They are:
3.2.1 Safety management systems ensure safety and wellbeing for consumers / Patients, Consumers and Clients, staff, visitors and contractors.

3.2.2 Buildings, signage, plant, equipment, supplies, utilities and consumables are managed safely and used efficiently and effectively.

3.2.3 Waste and environmental management supports safe practice and a safe environment.

3.2.4 Emergency and disaster management supports safe practice and a safe environment.

3.2.5 Security management supports safe practice and a safe environment.

Further information on safety can be found on:

- *Needle-stick injury prevention in criterion 1.5.2*
- *protective clothing and equipment provided to staff where necessary and their usage and correct storage monitored in 1.5.2*
- *falls management in 1.5.4*
- *management of incidents and near misses in 2.1.3."*

25.8 AUDIT TOOLS – see Appendix 1 - Forms

Appendix 1	Approved: Director IP&M	Effective Date: 7.11.2010	Revision 4 Revision Date: 7.11.10
Subject Description: SMS FORMS			

APPENDIX 1

SMS FORMS

Form No.	Contents	
OHSF.001	Quarterly Work Safety Report	
OHSF.002	OHS Strategies template	
OHSF.003	Responsibility Statements – Executive Level	
OHSF.004	Responsibility Statements – Director level	
OHSF.005	Responsibility Statement – Manager/Supervisor level	
OHSF.006	Responsibility Statement – Employee Level	
OHSF.007a	OHS Hazard Prompt List	
OHSF.007b	Violence and Aggression Hazard Prompt List	
OHSF.008	Planned Inspection Checklist – Operational Areas	
OHSF.009	Planned Inspection Checklist - Office	
OHSF.010	Training Plan/Register	
OHSF.011	Accident/Incident Investigation Form	
OHSF.012a	Safe Work Procedure Template – version 1	
OHSF.012b	Safe Work Procedure Template – version 2	
OHSF.013	Safe Work Procedure Register	
OHSF.014	Safe Work Procedure Acknowledgement Form	
OHSF.015	Safe Work Procedure Assessment Check	
OHSF.016	First Aid Certificate Form	
OHSF.017	Manual Handling Risk Identification Checklist	
OHSF.018	Manual Handling Action Plan	
OHSF.019	Workstation Self-Assessment Checklist	
OHSF.020	Authorised persons for Confined Space Entry	
OHSF.021	Confined Space Entry Permit	
OHSF.022	Confined Space / Restricted Space Register	
OHSF.023	Hot Work Permit	
OHSF.024	Contractor Audit Tool	
OHSF.025	OHS Activity Schedule	
OHSF.026/27/ 28/29/30	SMS Audit Tools – core and quarterly	
OHSF.031	Danger Out of Service tag	
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ACT Government
Health

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WASTE MANAGEMENT PLAN

FOR

HEALTH DIRECTORATE

AUGUST 2012

HEALTH DIRECTORATE WASTE MANAGEMENT PLAN

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HEALTH DIRECTORATE WASTE MANAGEMENT PLAN

Introduction

1. ISS is responsible for the provision of Domestic and Environmental Services for Health Directorate at the Canberra Hospital (TCH) and the Specified Health Directorate Facilities which includes the requirement to develop and implement a Waste Management Plan for Health Directorate.

2. The purpose of a waste management plan is:

   a. to prevent or reduce waste generation and its harmfulness; and

   b. to recover waste by means of recycling, re-use or reclamation or any other process with a view to extracting secondary raw materials, or to use waste as a source of energy.

3. ISS will ensure that waste is recovered or disposed of without endangering human health and without using processes or methods which could harm the environment.

4. This Plan addresses the management of waste and recyclables at t

5. he Canberra Hospital campus and the other Specified Health Directorate Facilities. This Plan will achieve industry best-practice waste management by focussing on systems that allow for correct segregation and safe handling of all wastes/recyclables.

6. The Plan is based on the following principles:

   a. cradle to grave: where waste is managed from generation to final disposal;

   b. source segregation: where wastes/recyclables are separated at the point of generation to minimise contamination and waste; and

   c. due diligence: ensuring that waste is managed in accordance with statutory and corporate regulations.

7. This Plan will ensure that waste management practices are consistent across all Health Directorate sites.

Aim

8. The aim of this Waste Management Plan is to establish a waste management regime for all Health Directorate sites that minimises the environmental impact of waste generation treatment and disposal.

The Sites Covered by this Plan

9. This Plan addresses the following Health Directorate sites:

   a. The Canberra Hospital campus;

   b. Specified Health Directorate Facilities:

      (1) Belconnen Health Centre;

      (2) Dickson Health Centre;

      (3) Phillip Health Centre;

      (4) Tuggeranong Health Centre;

      (5) Independent Living Centre – Weston;

      (6) Lanyon Family Care Centre;

      (7) Ngunnawal Family Care Centre;

      (8) Brian Hennessy Rehabilitation Centre - Bruce;

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(9) The Cottage - Bruce;

(10) Health Protection Services - Holder;

(11) Moore Street Health Building, 1 Moore Street - Civic;

(12) Supply Warehouse Mitchell;

(13) Sterilising Services Mitchell;

(14) Village Creek Aged Care and Rehab Services; and

(15) Gungahlin Collection Centre

(16) Gungahlin Community Health Centre

c. National Capital Private Hospital.

Scope

10. This Plan addresses the following:

A. Requirements

B. Governance

C. Responsibilities

D. Education

E. Quality

F. Waste Management System

G. Protocols for Effective Waste Management

H. Management principles

I. Implementation.

A. Requirements

11. To meet the aim of the Waste Management Plan, the following requirements will be addressed:

a. Written procedures for management of all waste/recyclables provided to all wards/departments;

b. Provision of suitable receptacles and establishment of systems that support the principles of landfill reduction by reducing, reusing and recycling;

c. Annual review conducted of all relevant waste management policies and procedures;

d. Annual waste audits conducted of all wards/departments;

e. Health Directorate staff provided with reports on waste audit/assessment results and responses obtained from ward/department managers as to issues of non-compliance;

f. Waste audit data used to support annual reporting and benchmarking activities;

g. Regular reporting against KPI's/targets prepared for submission to the Waste Management Committee including waste quantities and benchmarking;

h. Annual report produced on activities/programs to reduce waste and increase landfill diversion and data related to stated KPI's / targets ;

i. Benchmarking activities established;

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j. Annual consultation and reports of liaison with waste contractors to increase landfill diversion rates and types of materials;

k. Any Health Directorate vehicles used for transport of waste will meet all relevant environmental and OHS legislation, policies, standards and guidelines;

l. Written confirmation that wastes transported to appropriately licensed treatment facilities – statements as to management pathways for all waste streams;

m. Provision of containers/equipment that meet all minimum standards:

(1) Maintenance;

(2) Visual appearance; and

(3) Cleaning/hygiene;

n. All ISS staff are trained in appropriate safe handling practices, segregation disposal of waste and legislative requirements. Statement that all staff attended in-service training each year is available;

o. Provision of Health Directorate staff training/education sessions (weekly events) that includes relevant standards/guidelines and legislative requirements;

p. Regular meetings with Stakeholders to discuss service delivery; and

q. Annual consultation with relevant ACT Govt authorities regarding legislative and other requirements.

B. Governance

Corporate Oversight

Waste Management Committee

12. An effective waste management system requires the participation and support of all personnel working in and around Health Directorate. ISS is responsible for managing and operating the waste function for Health Directorate. Accordingly, a Waste Management Committee will be established to oversee the waste management initiatives and opportunities for Health Directorate. This Committee will ensure that there is a balanced approach to waste practices to ensure that patient and staff safety are not compromised.

Composition

13. The composition of the Committee will be:

a. ISS Client Manager (Waste Management Coordinator);

b. Health Directorate Domestic and Environmental Services Contract Manager ;

c. Purchasing Officer, Central Supply;

d. ISS Facilities Manager;

e. Finance Officer;

f. Domestic and Environmental Services Support Officer;

g. TCH campus Divisional Nursing Representatives;

h. Health Centre Representative; and

i. ;

j. Coopted members as required.

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C. Responsibilities

The Committee

14. The Committee will develop a culture of environmentally responsible waste management through information sharing and education.

15. The Committee will monitor the implementation of the Waste Management Plan.

16. The Committee will assume responsibility for the development of an implementation plan including implementation of an ongoing staff education program.

17. The responsibilities of the Waste Management Committee(WMC) are:

a. monitor performance of the Waste Management Plan against KPIs / targets;

b. seek commitment for the implementation of the various waste management actions and obtain the necessary resources (e.g. staff time and budget);

c. prioritise the resources and/or operations to be applied for the assessment and development of specific reduction programs;

d. conduct technical, economic and environmental feasibility analyses of waste reduction options;

e. establish and review waste reduction and recycling targets;

f. specify ISS waste reporting requirements for the WMC;

g. collect data on resources generated/consumed as provided in regular reports and forward reports to Executive management on a regular basis;

h. ensure staff/contractor waste management education sessions are conducted at induction courses and on a regular basis;

i. ensure Waste Management initiatives are in accordance with the relevant criteria as specified in the Australian Council on Healthcare Standards (ACHS);

j. ensure committee representation at stakeholder meetings including those with relevant ACT Govt regulatory authorities;

k. review and endorse policies, protocols and guidelines from Health Directorate and the contractor including those identified for attention through the annual review process conducted by ISS;

l. support and monitor the development and maintenance of benchmarking activities; and

m. ensure records of meetings are maintained.

Health Directorate Responsibilities

18. Health Directorate has a responsibility to conduct its activities in a manner that will minimise the impact on the environment and provide a safe and healthy environment for patients, staff and the community.

19. Health Directorate will:

a. consider the potential impact on the environment when planning any activities, and undertake strategies to minimise the impact as much as possible;

b. develop policy;

c. encourage staff and patients to have respect for, and consider the impact on the environment, with respect to waste disposal;

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d. consider and actively implement strategies to reduce the amount of waste generated from all activities thereby reducing carbon emission. This will be achieved by:

(1) reusing items rather than disposing of them via the waste stream; and

(2) recycling when it is safe and practical to do so.

20. The Health Directorate Waste Management Policy is at Annex B.

ISS Staff Responsibilities

21. ISS staff are key to ensuring the effectiveness of the waste management program. It is essential that ISS staff understand the rationale for waste material segregation, and play an active role in monitoring the effectiveness of segregation practices.

22. ISS staff will implement specific waste reduction programs as identified and prescribed by the Waste Committee.

23. ISS staff will remove only that material left in recycling, clinical or general waste receptacles and boxes/material clearly labelled as rubbish to be removed. ISS staff cannot be responsible for any paperwork or material inadvertently placed in a recycling or general waste bin.

24. ISS staff will not remove or touch any waste designated as chemical, radioactive or hazardous material.

25. The Waste Management System will be monitored by the cleaning supervisor and site management during the term of the contract.

26. In addition, ISS staff will provide feed-back on any non-compliance issues observed during the cleaning activities. This may include contamination of recycling, non-participation in the recycling system, or missing or damaged bins. In this way issues can be promptly addressed by management.

27. ISS staff will be responsible for appropriate disposal of all waste in the appropriate stream.

28. ISS will ensure that all bins/receptacles are emptied in a timely manner before becoming full and dispensing odours.

29. ISS staff will conduct waste audits.

30. ISS will establish and maintain a register of waste management legislations, policies and protocols.

31. ISS staff will conduct education sessions for contractor and Health Directorate staff.

32. ISS will provide regular waste management activity reports as specified by the Waste Management Committee.

33. ISS will obtain and provide volumetric waste data.

34. ISS will provide suitable receptacles.

35. ISS will provide compliance documentation to the Waste Management Committee as required.

36. ISS will maintain the records (minutes) of the Waste Management Committee meetings.

Food Services Staff

36. Food Services staff will be responsible to ensure that all food preparation areas have food waste and any other perishable materials removed to the waste storage area at least twice per day or as required in accordance with food safety regulations.

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On-Site Shops & Cafes Staff

37. Staff working in on-site shops and cafes will be responsible for ensuring all wastes and recyclables are segregated and managed as per the requirements of this Waste Management Plan.

D. Education

Waste Management Education Program

37. Waste management education focuses on the protection of the environment and the safety of people. Staff need to gain appropriate knowledge and skills and evaluate their attitudes to the various work practices that lead to the generation of waste if waste minimisation is to succeed.

38. There are three streams relevant to imparting knowledge of waste in the environment:

a. education in the environment: this describes learning outside the traditional classroom;

b. education about the environment: this is concerned with providing information on the environment and environmental issues. This gives a basic understanding of problems and solutions for decision making on a daily basis; and

c. education for the environment: this develops attitudes and values, therefore enabling choices to be made which will maintain and improve the quality of the environment. By encouraging participation, people believe that their efforts have an impact on the quality of the environment.

Proposed Course

39. A course presented by ISS to Health Directorate staff on waste management could include the following topics:

a. Introduction;

b. Importance of good waste/environment management and why we should recycle;

c. Waste management hierarchy;

d. Waste minimisation principles;

e. Brief overview of legislation pertaining to waste management;

f. Health Directorate policies on environment/waste management;

g. Overview of Health Directorate waste types;

h. Definition of what constitutes clinical waste;

i. Definition of what constitutes sharps;

j. The different types of bins used;

k. Issues relating to waste reduction for Health Directorate;

l. Identification of, and hazards associated with the different types of wastes generated at Health Directorate;

m. Management responsibilities;

n. Importance of effective waste segregation;

o. Appropriate disposal of clinical waste;

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p. Why clinical waste should not be combined with non-clinical waste;

q. Waste, handling, packaging and disposal routes for the different types of wastes generated at Health Directorate; and

r. Cost of disposal from a triple bottom line approach including carbon emission.

Implementation

40. All contractor staff will be required to attend a waste management training session annually. Attendance records will be maintained.

41. Training /education sessions for Health Directorate staff will be conducted weekly. Attendance records will be maintained.

E. Quality

42. To ensure that consistency is applied across all Health Directorate sites in the management of waste, quality measures must be adhered to. ISS will institute the following quality measures in its management of waste:

a. Staff education programs;

b. Waste reduction targets;

c. Waste streaming targets aimed at increasing recycling and reducing clinical waste;

d. Appropriate receptacles to enhance waste streaming;

e. Timely removal of waste so that bins are never full or overflowing;

f. Waste audits;

g. Benchmarking; and

h. Delivery of key performance indicators

Continuous Improvement Program

43. ISS will establish a Continuous Improvement Program to ensure that waste is managed effectively with the aim of reducing waste to landfill across all sites.

44. As part of the Continuous Improvement Program, resource segregation activities will be monitored. Ongoing independent monitoring and reporting back to the Waste Management Committee will ensure that any issues are addressed and corrected and KPI's are achieved.

45. Cleaning contractor staff / supervisor staff will monitor individual ward/department compliance with this Waste Management Plan through scheduled audits.

Staff Education Programs

46. It is essential that all ISS staff, Health Directorate staff, and contractors are educated in waste management principles including recycling and streaming.

Waste Reduction Targets

47. ISS will set targets for improved waste streaming and recycling practices that will be achievable and measurable. Improved streaming practices will reduce landfill waste and clinical waste volumes. Targets must be measurable and achieved within a set timeframe.

48. These targets will incorporate :

a. legislative requirements;

b. Government policy;

c. community expectations;

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d. maximum use of recycling;
e. general site needs;
f. Health Directorate policy;
g. volumes and types of waste;
h. waste with highest cost/greatest hazard;
i. minimal waste of water;
j. current levels of performance;
k. ACHS requirements;
l. Office Smart requirements;
m. Health Directorate reporting requirements; and
n. Baseline data from 2011.

49. Waste streaming targets:

Reduce Recyclables in Landfill Stream

Material/Stream	Baseline 2012	2013	2014	2015
Volume (%) of recyclables in landfill stream.	%	10% reduction	10% reduction	10% reduction

Reduce Recyclables & Landfill in Clinical Waste Stream

Material/Stream	Baseline 2012	2013	2014	2015
Volume (%) of recyclables & landfill in clinical waste stream	%	10% reduction	10% reduction	10% reduction

Waste Audits

50. A complete waste audit will be conducted each year by ISS at all Health Directorate sites. This audit will provide detailed information on Health Directorate's performance against long term goals as well as identify any further resource minimisation initiatives that could be undertaken. ISS will compile all the audit information into a report for Health Directorate:

51. The waste audit report will:

a. provide volumetric measures of specified wastes;
b. identify streams / types of waste generated;
c. identify areas where wastes are generated;
d. identify waste streaming facilities in areas;
e. identify type and locations of signage;
f. identify sources (who) of waste generated;
g. identify staff waste streaming / management knowledge & gaps;

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h. identify non compliances (legislation and policy);

i. identify waste management risks;

j. measure achievements against specified waste streaming targets; and

k. identify waste streaming trends;

52. Waste audit report will provide volumetric measures for :

a. Recyclables in landfill;

b. Recyclables and landfill in clinical waste;

c. Food waste in landfill; and

d. Wastage

53. The waste audit report recommendations from ISS will include (as required);

a. strategies to improve / upgrade waste streaming facilities (includes signage);

b. strategies to address knowledge gaps and non compliance issues;

c. strategies to improve waste streaming practices and outcomes; and

d. strategies to address waste management risks

Benchmarking

54. ISS will benchmark Health Directorate's waste management against like institutions which will provide a firm foundation on which to set goals and parameters for the management of waste across all Health Directorate sites. Benchmarking provides an opportunity to improve waste management by learning from experiences at other like sites. Benchmarking will be undertaken regularly on an agreed schedule with other like facilities, with a minimum of 1 activity undertaken per 6 months.

55. Benchmarking will take into account the following:

a. Outputs i.e. volumes / streams / recycling;

b. Number of staff and beds and outpatients;

c. Occupied bed days;

d. WMC reporting requirements;

e. Different "treatment" activities;

f. Resources and task allocations;

g. Quality assurance programs/procedures;

h. Age and type of equipment; and

i. Implementation of waste management programs

Key Performance Indicators

56. Key Performance Indicators (KPI) have been established for the waste management plan. These KPIs are at Annex C.

F. Waste Management System

Waste Management Hierarchy

57. To manage waste effectively, the following hierarchy will guide all waste initiatives:

a. Reduce;

b. Reuse; and

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c. Recycle.

Reduce

58. Reduction of waste to landfill is the most effective waste management option and forms the first aspect of the Waste Hierarchy. The amount of waste to landfill can be reduced by effective streaming, purchasing and using recyclables, reducing the purchase and use of non recyclables and reusing rather than disposing.

Reuse

59. Reuse forms the second aspect of the Waste Hierarchy and requires an item that is to be disposed of being used again either for the same or new purpose. Reuse of items reduces the environmental impact of waste disposal by reducing landfill.

Recycle

60. Recycling is the third aspect of the Waste Hierarchy. Waste such as glass, paper, metal and plastics can be recycled. Recycled products reduce the environmental impact of waste disposal by reducing landfill and the depletion of natural resources.

Signage

61. The success of the waste/recycling system will depend on having a clearly identified container for each type of material. This is achieved by the use of colour coded containers, symbols and wording. Recommended waste management signage is indicated in 'waste streaming table' (pages 34-35).

Target

62. ISS will strive to ensure a reduction in landfill through the implementation of initiatives to increase waste streaming, recycling and reuse as determined by the waste management committee.

G. Protocols for Effective Waste Management

63. Waste can only be successfully managed by adherence to specific protocols. For the purposes of this Plan, these protocols are:

a. Movement of waste;

b. Mobile Garbage Bins (includes cleaning and maintenance);

c. Paper boxes;

d. Waste flows (streaming);

e. Compliance reporting;

f. Throughput & volumes; and

g. Waste storage.

Movement of Waste

64. Waste must be moved either in the bins in which waste is deposited or on dedicated trolleys so that no waste material or spillage can spill or leak from the container or trolley.

Mobile Garbage Bins

65. Mobile Garbage Bins (MGB) are designated for specific materials based on the colour and or symbols/wording on the MGB. No MGB will be used for any material other than for which it has been designated. Transport of MGBs will be carried out with the lid closed. Any MGB removed from a ward or department will be cleaned at the bin-washing facility before being returned to the ward or department.

66. MGBs are colour coded across Health Directorate sites. The colour codes are:

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a. Black, white or green: general waste;

b. Blue: recyclable paper and secure paper;

c. Red: commingled waste for recycling;

d. Yellow: clinical waste; and

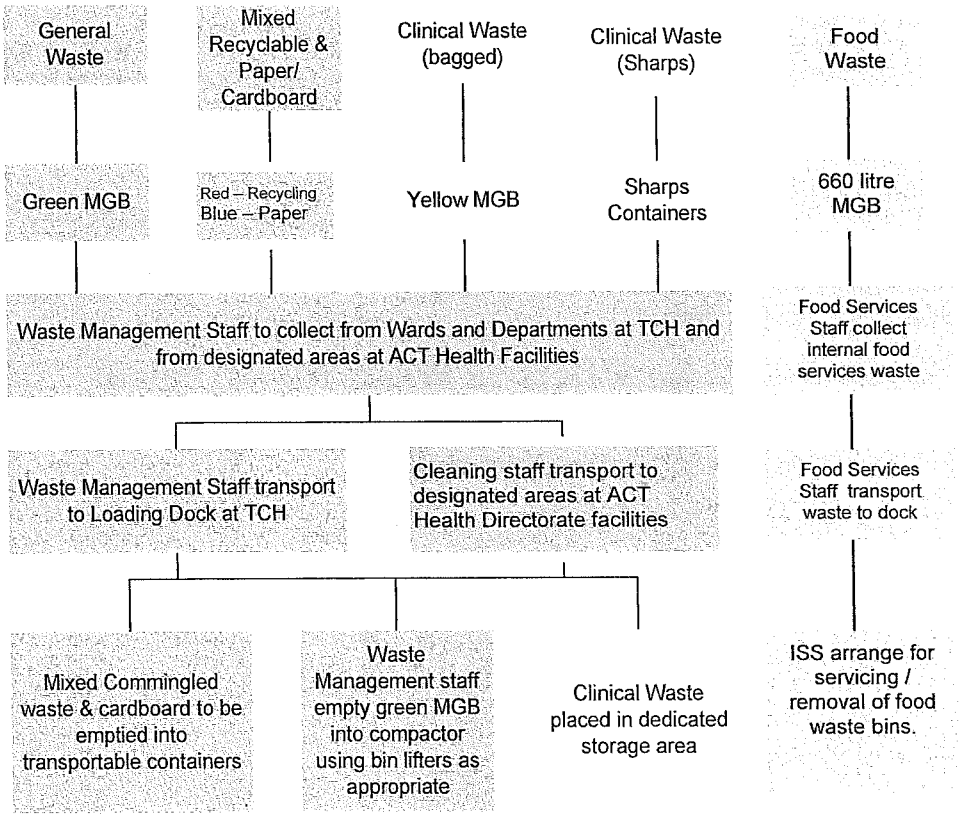
e. Purple: cytotoxic waste.

Paper Boxes

67. Boxes to collect recyclable paper are positioned in wards and departments across all Health Directorate sites. These boxes are to be used for non secure paper only. ISS will collect and empty these boxes into the paper recycling bins in accordance with the Contract.

Waste Flows

68. The following summarises the flow of waste from wards/departments (for the major waste/recyclable types generated at Health Directorate):



Waste Storage

69. Waste storage areas have been allocated within the loading dock area at TCH and at each Health Directorate Facility.

70. ISS staff will deposit materials collected from across the sites into the correct container within the appropriate storage area.

71. These storage areas located within each building will be maintained in a clean and hygienic manner in accordance with the Contract, including cleaning of any spillage that occurs.

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Storage Area Management

72. The waste storage areas will be clearly identified so that wastes/recyclables can be stored correctly. Each stream will be located in a designated area. This will assist in easy identification of correct bins.

73. Legislative and OHS&W requirements will be adhered to for the storage of any hazardous materials and clinical waste.

74. Manufacturer's instructions will be adhered to at all times and will assist in development of SOP's for the operation of all waste equipment such as the compactor and bin lifter.

75. The following conditions relating to security of clinical, food and related waste will be strictly followed:

a. loading and unloading of waste will be carried out in accordance with designated safety procedures and standards of cleanliness will be maintained;

b. relevant records will be completed and maintained;

c. containers in which clinical, food and related waste are stored will be secured when loading/unloading is not taking place;

d. all odours will be monitored and controlled; and

e. spill kits for clinical and cytotoxic waste will be located in the storage areas.

Waste Streams

76. The waste streams to which this Plan refers are:

a. Clinical waste, including sharps;

b. Anatomical waste;

c. Cytotoxic waste;

d. Pharmaceutical waste;

e. Radioactive waste;

f. Laboratory/Chemical waste;

g. Confidential documents;

h. General waste (landfill – non recyclable);

i. Food (organic waste);

j. Paper;

k. Cardboard;

l. Paper handtowel/soiled paper waste;

m. Commingled recyclables;

n. Construction/demolition waste;

o. Other waste, including:

(1) Toner cartridges;

(2) E-waste;

(3) Office supplies;

(4) Fluorescent tubes;

(5) Batteries; and

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(6) Used cooking oil.

77. The waste protocols for these streams are detailed at Annex D.

H. Management Principles

Clinical and Related Wastes

78. Due to the inherent risks to humans generating and handling clinical and related wastes, the environment and the wider community, extreme care will be taken when handling, packaging, transporting and disposing of clinical waste.

79. Clinical and related wastes must:

a. be handled by staff with appropriate training and knowledge and access to appropriate personal protective equipment (PPE);

b. be transported and disposed of in accordance with all legislation and guidelines;

c. clinical and related waste streaming bins & identifications include:

(1) Clinical waste – yellow bags/bins;

(2) Sharps – yellow reusable hard sided containers (labelled sharps);

(3) Anatomical waste for incineration – bin colour may vary (labelled anatomical waste);

(4) Cytotoxic waste for incineration - purple bags/bins;

(5) Cytotoxic sharps for incineration - purple disposable hard sided containers (labelled sharps);

(6) Pharmaceutical waste for incineration - bin colour may vary (labelled pharmaceutical waste);

d. be managed in accordance with *the Clinical Waste Act ACT 1990* and the Code of Practice for the Management of Clinical and Related Wastes, 5th edition, 2007.

Recyclables

80. It is essential to ensure that all recyclables generated across Health Directorate sites are deposited into the appropriate recycling container.

81. The benefits of recycling include:

a. Recovery of valuable resources;

b. Energy and environmental impacts are reduced including carbon emissions;

c. Reduction in the amount of waste requiring disposal to landfill; and

d. Reduction in the cost of waste disposal.

82. The system that will be used for many of the recyclable materials is termed a "commingled" system. This means that all designated recyclables can be deposited into the one container.

General Waste

83. Landfill will remain the repository for materials that are not able to be recycled or are classified as hazardous/liquid wastes. This material (referred to as general waste), will require:

a. A container for wastes to be deposited for storage awaiting collection. This container must be designed so that wastes cannot leak out or escape causing litter/spills, be of a suitable size for the amount of general wastes being

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generated (but not be so large it encourages indiscriminate disposal of other materials), and be able to be collected by the waste transporter;

b. The waste transport contractor to be responsible for emptying the general waste container and ensuring that the contents are disposed of to a site that has been agreed to by the waste generator. The contractor assumes responsibility for safe collection of the wastes both during collection and in transport to the disposal site;

c. The disposal/landfill site. The role of the landfill is to stabilise waste products in a controlled manner. In order to achieve this, it is vital that non - general waste items such as hazardous wastes are excluded from the waste stream. These, if present, can affect the landfill processes and/or cause occupational health and safety risks to all waste handlers and landfill staff;

84. As landfill space is a resource to be conserved, it is essential to ensure that items that either do not need be land filled (e.g. recyclables), and those that have alternate management routes (e.g. composting), are excluded from the general waste stream by at "source segregation".

I. Implementation

85. The Waste Management Plan will be implemented by the Waste Management Committee during 2012 in accordance with the Milestone Schedule at Annex A. It is incumbent on ISS and Health Directorate to facilitate the implementation of this Plan to realise the waste management hierarchy of "Reduce, Reuse, Recycle" so that waste is managed effectively for the safety of the environment, and people at all Health Directorate Facilities.

86. The success of the Plan is dependent on ISS achieving its stated goals in the Contract of:

a. investigating resource efficiencies associated with recycling programs and implementing them;

b. initiating and maintaining consumer participation and feedback mechanisms;

c. research into technologies which will enable Health Directorate to lessen its impact on the environment through reduced waste output;

d. the implementation of and ongoing compliance with the Health Directorate Waste Management Policy and other relevant ACT Government strategies;

e. recommending an efficient and effective process for the removal of all waste (other than clinical waste) from TCH campus and specified Health Directorate sites, including any requirements for a central collection and disposal point that may include a general waste compactor;

f. initiating data collection and analysis for planning and service improvement;

g. designing and implementing training and development programs to minimise waste and increase waste streaming activity per patient episode; and

h. contributing to the Environmental Services Committees and forums as directed/required.

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Annexes:

A. Milestone Schedule
B. Key Performance Indicators
C. Waste Protocols for Specific Materials
D. ISS Implementation Plan
E. Glossary

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ANNEX A TO
WASTE MANAGEMENT PLAN

Milestone Schedule

1. The Waste Management Plan is to be implemented in accordance with the Milestone Schedule as agreed by the Waste Management Committee.

2. A Milestone Schedule is provided below. This schedule is indicative only. It will be finalised by the Waste Management Committee.

Serial	Task	Start	Complete
1.	Convene the Waste Management Committee (WMC)	Nov 2011	Nov 2011
2.	Commence Implementation Plan (for waste plan)	Nov 2011	Nov 2011
3.	Review and implement contractor staff training and education	Nov 2011	Jan 2012
4.	Implement Health Directorate staff training and education	Nov 2011	Jan 2012
5.	Table initial WMC 'waste report'	Feb 2012	Apr 2012
6.	Commence Benchmarking activities	Feb 2012	Jun 2012
7.	Review and revise Waste Protocols (from Waste Plan)	Feb 2012	Jul 2012
8.	Complete waste streaming facility upgrades	Feb 2012	Sep 2012
9.	Implement waste audit program	Jul 2012	Sep 2012
10.	Establish legislation, policy, protocol register (LPP register)	Sep 2012	Oct 2012
11.	Implement food (putrescible) recycling	Sep 2012	Nov 2012
12.	Implement waste audit report recommendations	Oct 2012	Dec 2012
13.	Repeat waste audit program	Jul 2013	Sep, 2013/yearly
14.	Review LPP register	Sep 2013	Oct , 2013/yearly
15.	Implement waste audit report recommendations	Oct 2013	Dec , 2013/yearly

ANNEX B TO
WASTE MANAGEMENT PLAN

Key Performance Indicators – Waste Management Plan

Performance	Standards to be Achieved	Indicators	Compliance
Waste Management Committee (WMC) Reporting	ISS report on waste service information as prescribed by the WMC and in accordance with the Waste Management Plan requirements.	WMC Report	Report provided on a scheduled basis as specified by the WMC.
Waste Audits Reporting	ISS develops a waste audit report that provides information as prescribed in the waste management plan or as specified by the WMC.	Waste Audit Report	Annual waste audits conducted in August. Audit reports provided in November.
Maintain Legislation, Policy and Protocol (LPP) Register	All waste legislation, policy and protocol compiled into a register.	LPP Register	LPP register maintained by ISS, LPP register reviewed and reported on (annually) to WMC by ISS.
Legislation, Policy and Protocol Register Review	ISS conduct a review of the waste legislation, policy and protocol register to identify policies and protocols that require updating. Review includes liaising with relevant government authorities.	WMC Report Policy and Protocol Register	ISS submit a report (annually) that informs the WMC on findings of the legislation, policy, protocol review. Policies and protocols meet current needs.
Waste Management Training & Education	All contractor staff receives waste training. ISS provide Health Directorate staff training and education.	Training Registers Attendance Sheets	100% of contractor staff receives waste training. ISS provide weekly waste training/education activities for Health Directorate Staff.

Performance	Standards to be Achieved	Indicators	Compliance
Waste Services Risk/Hazard Management	All waste incidents, risks, hazards and non compliances identified and reported for follow up.	Risk Audits Environmental Audits Waste Audit Report WMC Report	Systems in place to monitor & report waste management safety issues.
Licensing and Insurance Compliance	Licences and insurances for the transport and management of waste are current.	Copies of current licenses and insurances	Copies of all annual licences and insurances collected by ISS and presented to Health Directorate (Contract's Manager)
Benchmarking Actvities	ISS compares and reports on Health Directorate waste management practices/outcomes with other like healthcare facilities in accordance with waste management plan requirements.	WMC Report	ISS provide benchmarking reports to the WMC at intervals as specified by the WMC.
Waste Streaming Facilities	Adequate waste streaming facilities are accessible to all staff throughout all healthcare facilities.	Streaming Facilities Audit Report	Waste streaming facilities are established/upgraded in accordance with waste audit report recommendations.
Waste Targets	Reduce recyclables entering landfill streams annually. Reduce recyclables and landfill entering clinical waste streams annually..	Audit Report	10% reduction per year of recyclables entering landfill stream. 10% reduction per year of recyclables & landfill entering clinical waste streams.
Waste Collections	All waste bins / containers collected prior to being full or as requested (within 30 mins).	Incident Reports Environmental Audits	Bins are never overfilled and collected upon request within 30 mins.
ACHS EQuIP Accreditation	Meet ACHS requirements against all waste related criterion.	Equip/ACHS Evaluation Report	MA rating or better.

ANNEX C TO
WASTE MANAGEMENT PLAN

Waste Protocols for Specific Materials

Section A

Identification, Safe Handling & Streaming

1. Clinical & related waste
2. General waste
3. Recyclable waste
4. Radioactive waste
5. Dangerous Substances.
6. Personal Protection Equipment
7. Waste Streaming Table

Section B

Transportation, Storage & Maintenance

8. Transportation
9. Storage & Containment
10. Maintenance

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Section A

Identification, Streaming & Safe Handling of Waste

1. Clinical & Related Waste

Definition;

i. waste consisting of a catheter, hypodermic needle, intravenous set, pipette or scalpel;

j. waste consisting of any other instrument or object that has been used in the taking of blood, the testing, processing or handling of blood or blood products, the investigation of human or animal diseases or in analysis or research that involves the use of tissue or fluid specimens, whether human or animal;

k. sanitary waste that originates from or has been in contact with a person who has a transmissible notifiable condition within the meaning of the *Public Health Act 1997*;

l. waste resulting from the investigation or analysis of tissue or fluid specimens, whether human or animal;

m. biological or chemical waste resulting from the investigation of human or animal diseases;

n. waste derived from a prescribed activity, being waste that includes or included human blood, or animal blood in any form other than food waste;

o. human or animal tissue or body fluids, removed during surgery or an autopsy;

p. waste consisting of a cytotoxic substance or waste that is, or is likely to be, contaminated by a cytotoxic substance;

q. waste consisting of anything that has been in contact with waste mentioned in a previous paragraph; and

r. waste derived from the preparation of a human body for burial or cremation.

Types of Clinical & Related wastes include;

A Clinical waste (e.g. items in contact with infectious patients)

B Sharps

C Anatomical waste

D Cytotoxic waste

E Pharmaceutical waste

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A. Clinical Waste

Identification

General clinical waste for the purposes of this document is all the waste generated by the definition of clinical waste (above) that does not fall into the categories of; sharps, anatomical, cytotoxic, pharmaceutical, radioactive or chemical waste. E.g. any gowns/masks used in dealing with infectious patients, any tubing used in administering drugs, any colostomy bags from infectious patients, any waste with blood or other bodily fluids on it.

Streaming

Clinical waste should be disposed of in Yellow MGB or designated yellow bags. Each MGB, in addition to being colour coded , should be clearly marked and bear the clinical waste sign (refer to waste streaming table, page 34).

Safe Handling:

When handling any clinical waste personal must wear the appropriate Personal Protective Equipment (PPE) – please refer to the PPE policy by Health Directorate. When necessary clinical waste deemed particularly infectious or soiled may be double bagged. Waste bags must not be over filled (approx 2/3 of capacity). Bags (temporary containers) must not be excessive in weight (3 kg – 5 kg). All bags should be held away from the body by the closed top of the bag, and placed directly into a mobile garbage bin or trolley

B. Sharps

Identification

Sharps include any waste resulting from medical, nursing, dental, veterinary, pharmaceutical, skin penetration or other related clinical activity, and that contain instruments or devices that:

a. have sharp points or edges capable of cutting, piercing or penetrating the skin (e.g. needles, syringes with needles or surgical instruments);

b. are designed for such a purpose; and

c. have the potential to cause injury or infection.

Streaming;

Place used sharps in designated puncture-resistant yellow sharp containers immediately after use. Each container is clearly marked in conjunction with Health Directorate policies of infection prevention and control. Sharps containers must conform to AS 4031-1992 or AS/NZ 4261-1994 (refer to waste streaming table, page 34).

Safe Handling

Sharps are generated in wards, departments and public toilets.

Note: The potential for transmission of blood-borne diseases is greatest when needles, scalpels and other sharp instruments or devices are used.

Special care must be taken to prevent injuries.

Wherever possible, eliminate the use of sharp devices, especially 'butterflies' and replace with a safety product, e.g. safety syringes/ cannulas, or needleless systems

When disposing of sharps;

- **Don't** recap used needles.
- **Don't** remove used needles from syringes by hand.
- **Don't** bend, break, or manipulate used needles by hand

ALERT

All persons using a sharp object are responsible for its immediate and proper disposal.

Sharps containers should:

- not be filled above the line indicated on the container;
- not be double handled from one container to another;
- be out of reach of children (opening should be approximately 1.2m from floor level);
- be closed before disposal.

C. Anatomical Waste

Identification

Anatomical waste includes limbs, organs, placenta, pathological specimens, biopsy specimens and body tissue taken during laboratory testing, surgery or autopsy and/or resulting from investigation or treatment of a patient. It does not include corpses.

Streaming

Anatomical waste will be deposited into burgundy coloured containers. The biohazard symbol and the words "clinical waste" and/or "anatomical waste" are to be written on the container (refer to waste streaming table, page 34).

Safe Handling

Once deposited into an MGB, no bin liner is to be removed. The lid is to remain closed at all times. ISS will move the MGB to a designated secure storage area until it is removed for destruction.

D. Cytotoxic Waste

Identification

Cytotoxic waste is material that is, or may be, contaminated with a cytotoxic drug during the preparation, transport or administration of chemotherapy. Cytotoxic drugs are toxic compounds known to have carcinogenic, mutagenic and/or teratogenic potential.

Streaming

All sharp and non-sharp cytotoxic waste is to be deposited by the generator into a purple container or MGB and marked with the cell in telophase symbol in white. The words "Cytotoxic Waste" should be clearly displayed on bags and containers.

Sharp cytotoxic waste will only be deposited into a sharps container that is purple, has the telophase symbol and the words "Cytotoxic Waste" clearly displayed (refer to waste streaming table, page 34).

Safe Handling

The lids of mobile bins should be kept closed at all times. Once deposited into an MGB, no bin liner is to be removed. ISS will move the MGB to a designated secure storage area until it is removed for destruction.

E. Pharmaceutical Waste

Identification

Pharmaceutical waste includes pharmaceutical (drug, remedy/medicinal substance) or other chemical substance specified in the Poisons List under the *Poisons and Therapeutic Goods Act 1996*. Pharmaceutical waste, excluding cytotoxics, may arise from expired or discarded pharmaceuticals, those no longer required by patients or departments and waste materials/substances generated during the manufacture and administration of pharmaceuticals.

a) Drugs of Addiction (DA Schedule 8)

Streaming

These items must be kept in the DA safe for pick up by a registered pharmacist. Ward staff are not allowed to destroy any Drug of Addiction other than partly used ampoules whose contents can be tipped into a sharps container or infectious waste bag.

Safe Handling

Destruction of partly used Drugs of Addiction must be annotated in the DA administration book. Contents of partly used infusion bags containing DA should be discarded down the sink and the bag placed in a sharps container. Any discarding of a partially used DA must be witnessed and signed for by two registered nurses.

b) General Pharmaceuticals

Streaming

All unused, partly used or out of date pharmaceuticals should be returned to the pharmacy department. These can be put in the pharmacy return bin located in each ward drug cupboard.

Safe handling

Do not reopen or readminister any left over drugs.

c) **Pharmaceutical Containers**

d) Streaming

Large quantities of plastic containers that have had liquid pharmaceutical should be placed in orange infectious waste bags.

Plastic containers that have contained dry tablets or capsules and are totally empty can be disposed of as general waste.

Glassware that has contained liquids should be disposed of as contaminated glassware (see **Contaminated Glass**).

Glassware that has contained dry tablets or capsules and are totally empty can be disposed of as uncontaminated glassware (see **Uncontaminated Glass**).

Safe handling

Do not pierce any container which holds drugs.

e) **Pharmaceutical Aerosols**

Streaming

There are special containers for pharmaceutical aerosol disposal in the waste disposal area of the pharmacy department.

Safe Handling

Store all aerosols away from heat or sources of combustion. Because pharmaceuticals are incinerated it is necessary to separate pharmaceuticals aerosols to be picked up separately by the waste contractor.

2. General Waste

Identification

General waste is the solid component of the waste stream, which is not recyclable or classified as a hazardous waste. This stream is often referred to as garbage. Examples of general waste include: foam packaging, soiled plastics, nappies, floor sweepings and any other material for which there is not a reuse or recycling option available.

Materials and energy that have no further use are released to the environment as a means of disposal. This is the solid component of the waste stream, which is not recyclable or classified as a hazardous waste.

Streaming

All general waste is to be deposited into designated ward/department general waste bins, MGBs are generally **green** and may be lined with a black plastic liner (refer to waste streaming table, page 34).

Safe Handling

Care should be taken when depositing waste into any MGB container to ensure that the lid can be securely closed so that no waste is deposited onto the ground, or falls out during the emptying process.

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3. Recyclables

There are several streams of recyclable materials including;

Main Streams;

A. Paper – non secure
B. Cardboard
C. Co-mingled
D. Paper - secure

Other Streams;

E. Toner Cartridge
F. E-waste
G. Fluorescent tubes
H. Batteries
I. Construction and Demolition

A. Paper – Non Secure

Identification

Recyclable paper includes printed/typed reports, used files, photocopy paper, computer paper, envelopes (even with windows), bond stock, phone books, manila folders, invoices, newspapers, magazines and brochures

Streaming

Paper is to be disposed of into the Blue MGB containers which are designated for them. The bins often have white lids and should be clearly marked and labelled

Safe Handling

All paper products should have any contaminants removed by the generator prior to disposal. (e.g., staples, binders, sticky tape)

B. Cardboard

Identification

Recyclable cardboard includes cardboard sheets, cardboard boxes and cartons. The majority of this material is sourced from box and carton manufacturers and is supplied as packaging with goods. Waxed cardboard and cartons cannot be recycled.

Streaming

Depending on the size of the cardboard, it should either be deposited directly into the ward/department waste storage area, ***or*** be placed next to a paper recycling MGB.

Safe handling

All cardboard should have any contaminants removed (e.g. staples, binders, sticky tape) by the generator prior to disposal.

C. Comingled

Identification

Commingled recyclables include glass bottles, aluminium and steel cans, clean aluminium foil, HDPE & PET plastic bottles and liquid paperboard.

Streaming

All commingled recyclables should have any contaminants removed (e.g. food, drink, straws).

All commingled recyclables should be deposited by the generator into the dedicated co-mingled recycling MGB (generally red colour) at the ward/department level

Glass should be deposited so that it does not break.

Safe Handling

The MGB should be sufficiently clean so as to not contaminate the recyclables or attract vermin such as ants and mice - this may mean that the container needs to be washed on a regular basis.

D. Paper - Secure

Identification

A confidential document is to be determined at the discretion of the staff member responsible for disposal. This could be patient information, accounts, prescriptions or hospital information. It also includes any document that identifies a staff member.

Streaming

All confidential documents should be either shredded or placed into a *secure, lockable* storage 240 litre MGB located at each ward/department throughout Health Directorate. This storage container is to be labelled Confidential Documents.

If a shredder is available, the person disposing of the document must be responsible for the shredding of confidential documents. Shredded material must be placed into one of the paper recycling floor boxes located around the office. Procedures for handling and disposal of this shredded material are the same as for recycled paper.

Safe Handling

Confidential documents are still Public Records and the Public Record Office (PRO) disposal schedules should be consulted to determine whether disposal or archiving is appropriate. ***Patient, staff and medical records may only be destroyed by the relevant departments or personnel.*** Some documents may be destroyed under Normal Administrative Practice, meaning notification is not

necessary, whilst others require a form to be completed and forwarded to the PRO. If there is any doubt, departments should make inquiries to the Archivist.

In cases of patient related documents that might, under PRO guidelines, be required to be attached to the patient's medical record, contact the Operations Manager Health Information Services.

Ensure that any contaminants removed by the generator prior to disposal. (e.g., staples, binders, sticky tape)

E. Toner Cartridges

The ward or department staff will contact ISS to collect full boxes of toner cartridges.

All full boxes are to be transported to the loading dock. A designated area has been set aside at the loading dock for the collection and storage of the toner cartridges.

The Waste Management coordinator will then contract the designated recycling contractor to collect the used cartridges from the loading dock as required.

F. E-waste

E-waste includes any electronic equipment such as telephones, computers and printers.

Any ward/department needing to dispose of e-waste will contact ISS to arrange collection.

The ISS employee will fill out a disposal sheet, which allows for the inclusion of items with asset numbers. In the event the item is determined to be an asset ISS will bring it to the assets room for inspection by the assets team.

Shared Services ICT procedures for deleting any data from e-waste will be adhered to.

G. Fluorescent Tubes

All staff and/or contractors servicing light fittings that have fluorescent tubes will ensure that they dispose of such tubes via the dedicated containers located in the loading dock.

No fluorescent tubes are to be disposed of via the general waste stream.

Special theatre lights are to be returned to Biomedical Engineering and will be collected by the manufacturer.

H. Batteries

All used batteries are to be stored in dedicated containers located in all wards/departments.

ISS is to be contacted from the ward or department to collect full boxes of batteries

All full boxes are to be transported to the loading dock. A designated area has been set aside at the loading dock for the collection and storage of the batteries.

The ISS Waste Management coordinator will then contact the designated recycling contractor to collect the used batteries from the loading dock as required.

I. Construction & Demolition Waste

Identification

Construction & Demolition Waste include waste generated from any construction, demolition or building maintenance activity.

Streaming

N/A

Safe Handling

All contractors providing construction and/or demolition services at Health Directorate sites are responsible for disposing of their own waste and will:

Prepare a project specific waste management plan to Health Directorate that incorporates the following:

(1) Waste avoidance, reuse and recycling opportunities;

(2) Management of wastes/recyclables;

(3) Staff training;

(4) OHS&W management;

(5) Processes for material segregation;

(6) Systems details (i.e. waste/recycling containers);

(7) Monitoring procedures.

Contractors are not to deposit any wastes/recyclables into the Canberra Hospital waste management system.

4. Radioactive Waste

Identification

Radioactive Waste includes any object, material, paper, linen or other substance that has had any direct contact with ionising radiation. This includes urine spills on linen, incontinence pads etc, samples prepared for gamma or liquid scintillation counting and low level radioactive materials that have been placed in storage.

Streaming

N/A

Safe Handling

Solid low level radioactive waste that is inert (i.e. no biological material) must be tested to ensure it is ready for disposal (see radiation safety manual).

The waste is to be placed in red waste bag with the radiation symbol and sealed tightly with a plastic or similar tie.

Bags should not be filled more than 75% full or contain more than 2 kg. If the contents are liquid or for some other reason may have a tendency to leak, they are to be double bagged. All bags must be clearly labelled with the contents of the bag and the department and person responsible for generating the contents. Bags should be monitored to ensure the surface dose does not exceed 5 μ Sv/hr. Bags are to be kept inside the department or taken to the Radiation Store.

Solid low level radioactive waste that has biological material must be tested to ensure it is ready for disposal (see radiation safety manual). The waste is to be placed in red waste bag with the radiation symbol and sealed tightly with a yellow plastic or similar tie and placed in a fridge within the department. Bags should not be filled more than 75% full or contain more than 2 kg and if the contents are liquid or for some other reason may have a tendency to leak, they are to be double bagged. After monitoring has established the waste is safe to dispose, the red waste bag is to be placed into an orange waste bag for labelled "clinical waste for incineration only", and disposed of according to the procedure for "clinical waste for incineration only".

Liquid low level radioactive waste (scintillation fluid) is to be placed in containers provided by the contractor. These can be obtained via the Radiation Safety Officer.

The bag or container will be collected and transported by cleaning staff to the waste storage area via (insert means).

This radioactive waste is stored in an enclosed storage area. The area (site) is to be bunded and secure to prevent spillage occurring.

All radioactive waste will be placed into red containers that have the trefoil symbol and the words "radioactive waste" printed on it

5. Dangerous Substances

Identification

Chemicals may be elements, compounds or mixtures and can be in solid, liquid or gaseous form. Chemicals include some cleaning substances. Chemicals may be classified as Dangerous Goods or Hazardous Substances.

The containers for all chemicals are to be disposed of in the same manner as the chemicals unless they are safely and adequately cleaned.

Streaming

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N/A

Safe Handling

All chemicals must be approved for use and storage and handled according to the Dangerous Goods and Hazardous Substances Regulations.

A Material Safety Data Sheet (MSDS) from the supplier of the chemical accompanies each chemical must be kept in a place accessible to users. The MSDS must detail how the chemical is to be disposed and spill kit requirements. If the disposal method is unclear in the MSDS, or if special handling and disposal are required, a departmental policy and procedure should be written.

Disposal of chemicals to the sewer (i.e. down the sink, toilet or pan flusher) should only be undertaken when this is the preferred method of disposal and meets current Trade Waste and Occupational Health and Safety requirements. Laboratory sinks connected to a neutralising pit should be clearly identified (glass waste pipes).

Chemical containers should be emptied and disposed of carefully. According to Dangerous Goods/Hazardous Substances legislation, all empty containers that have contained dangerous goods are to be disposed of in the same manner as the contents unless the chemicals have been cleaned out of the container.

Containers must not be punctured and must be sealed for safe handling. Empty containers must be put out for contractor collection as Dangerous Goods, placed in a yellow clinical bag or contaminated glass pail for high temperature incineration or placed in a black bag for disposal to landfill according to the instructions in the MSDS.

If the containers are cleaned of their contents then all labels relating to the Dangerous Goods or Hazardous Material must be removed or obliterated. These cleaned containers can then be disposed of as general waste or uncontaminated glass.

Chemicals for disposal must be kept in the department and clearly labelled with the name of the substance and the quantity. A Chemical Disposal Manifest form is to be completed by the department wanting to dispose of chemicals and faxed to the current chemical disposal contractor listing the chemicals/chemical containers for disposal.

6. Personal Protective Equipment (P.P.E.)

Precautionary measures such as the use of PPE are required for the management and handling of all types of waste. There are two levels of precautions as defined by Health Directorate Infection Control; Standard Precautions and Additional Precautions.

Standard precautions (defined below) are recommended for the handling of all waste streams.

Standard Precautions are work practices that are required to maintain the basic level of infection prevention and control. Standard precautions include good hygiene practices, particularly hand hygiene and the use of protective barriers against exposure to blood and bodily substances during the handling and management of waste. PPE may include some or all of the following depending on the task being performed and risk of exposure:

- gloves
- gowns
- plastic aprons
- masks
- eye shields or goggles

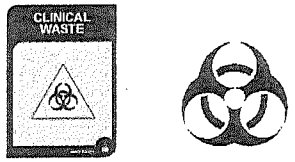
Additional Precautions are used where standard precautions are insufficient to prevent transmission of infection. If required additional precautions are used *in addition* to standard precautions providing a high level of protection for patients, staff and others.

The use of additional precautions is as per Infection Control recommendation and can be tailored to suit individual patients needs. Signage is generally displayed where applicable that indicates what precautions, including PPE, are required.

Further advice or guidance if needed should be sought from Infection Control.

7. Waste Streaming Table

All waste in table below must be streamed by the generator at the point of origin. Bin / container colours may vary from below table

No	Type of waste		Container / Additional Information		PPE used to transport / manage waste (not at point of origin)	Signage
1	Clinical & Related Wastes	Clinical Waste	Yellow Bin	Yellow MGB or designated yellow bags should be clearly marked and bear the clinical waste sign	Gloves/Apron	
		Sharps	Thick Yellow Container	Needle-stick proof containers. Clearly marked as sharps containers.	Needle proof Gloves	 Sharps
		Anatomical Waste	Burgundy Bin	Biohazard symbol and the words "clinical waste" and/or "anatomical waste" are to be displayed on the container	Gloves/Apron/mask	
		Cytotoxic Waste	Purple Bin	Purple container or MGB marked with the cell in telophase symbol in white.	Gloves/Apron/Mask	

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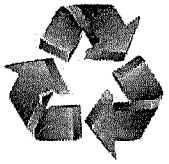
No	Type of waste		Container / Additional Information		PPE used to transport / manage waste (not at point of origin)	Signage
		Pharmaceutical Waste		Should always be secured and locked.	Gloves/mask	
2.	General Waste		Green MGB	Colours may vary (can be black, white or green)	Gloves	
3.	Recyclables – Main Streams	Paper - Non secure	Blue MGB	Bin commonly blue with white lid. Colours may vary	Gloves	 Reduce Reuse Recycle
		Cardboard		Cardboard	Gloves	
		Co-mingled	Red MGB	Bin commonly red. Colours may vary	Gloves	
		Paper – Secure	Blue MGB	Bin commonly blue. Colours may vary	Gloves	
4.	Radioactive Waste		Red Bags / yellow ties	This waste stream is managed by Radiation Oncology Physicists	Gloves/Apron/mask/goggles	
5.	Dangerous Substances		Various	Must be handled, stored and transported in accordance with current legislation	Gloves/Apron/Goggles/Mask	

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Section B

Transportation, Storage & Maintenance

8. Transportation

MGBs and trolleys should be used when transporting waste to decrease spills, minimise collector contact with waste and minimise manual handling. Loads contained in MGBs and trolleys should be less than 55kgs. All bins must be colour coded and marked in accordance Health Directorate policies.

The clinical waste MGB will be transported by ISS staff to the ward/department waste storage area. ISS will transport the MGB to the loading dock and place into the dedicated storage area.

Waste collection times should be routine. All bags should be held away from the body by the closed top of the bag, and placed directly into a mobile garbage bin or trolley. Where waste bags are sealed and stored pending collection, they should be in a secure place with restricted access.

After transportation of waste, all MGBs should be washed and cleaned thoroughly. When cleaning trolleys and MGBs:

- Rinse with cold water then wash with warm water and a neutral detergent.
- Trolleys and MGBs should then be drained to sewer and left to dry.
- Clean trolleys and bins should be stored separately to soiled containers.
- Appropriate personal protective equipment should be worn when cleaning MGBs.
- Waste water may only be diverted to the sewer.

9. Storage & Containment

Storage areas are to be free from odour and must discourage the harbourage of vermin. The holding area should be located away from food and clean storage areas, it must not be accessible to the public, have a lockable door and rigid impervious flooring. Clean up facilities, spills kits, appropriate drainage and bunding should be provided. Where wastes are stored in bins the bin must be locked. A specific area, with adequate drainage, for washing equipment should be designated.

Clinical waste should be transported at the earliest available opportunity for processing. It should be noted that clinical waste is also classified as hazardous waste. Clinical waste will be collected from the loading dock by the contractor (currently SteriHealth), as required.

Waste bags must not be over filled (approx 2/3 of capacity). Bags (temporary containers) must not be excessive in weight (3 kg – 5 kg). Excess air should be excluded without compaction, prior to closure using a bag tie at the point of waste generation. When necessary clinical waste deemed particularly infectious or soiled may be double bagged.

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Clinical waste bins must have lids on them. The lids must remain closed at all times in conjunction with *infection prevention and control* and *dangerous substance* guidelines and protocols.

Trolleys and MGBs must be dedicated singularly for collecting waste and must be made of rigid material, lidded, lockable (if used for storage), leak proof and washable. Dedicated MGBs and trolleys should be labelled according to the type of wastes contained, cleaned regularly and must never be overfilled.

10. Maintenance of the Waste Management System

Maintaining the Waste Management System includes:

A. *Management and removal of waste -*

Waste Service providers are responsible for:

i. The collection of wastes as per the agreed schedule;

ii. Ensuring no build up of waste occurs;

iii. Provision and cleaning of bins as required and maintaining cleanliness of waste areas; and

iv. Arranging for the removal of waste from site

B. *Maintaining and replacing bins -*

Waste service providers are responsible for ensuring all equipment is serviceable and meets required standards for the management, storage and transportation of wastes. This includes repairing or replacing damaged equipment as required.

C. *Reporting Service issues.*

All staff are responsible for reporting waste service issues (including but not limited to: damaged equipment, dirty or smelly bins, waste service not delivered as per agreed schedule).

To report waste service issues contact the ISS help desk.

ANNEX E TO
WASTE MANAGEMENT PLAN

ISS Implementation Plan

Item No.	Strategy	Actions	Start Date	Status; Complete or Open	Progress
1	**Convene the ACTG HD Waste Management Committee**	Invite attendees as per WMP	Nov 11, 2011	Complete	
2	**Develop & commence the implementation plan for the WMP**	Develop plan in conjunction with stakeholders and in accordance with WMP milestone schedule.	Nov 11, 2011	Complete	
3	**Review and maintain waste education training for Contractor and ACT Health Staff**	ACTG HD develop an on-line waste management education package. Contractor to develop and deliver waste management induction training to all new staff. Induction training to include both ISS training requirements and ACTG HD waste management induction training requirements. Signage to be reviewed annually and updated as required. Training to be reviewed annually and updated as required. ACTG HD & contractor staff to attend ACT SMART waste education training where possible.	Nov. 11 2011	Completed	30-40 ISS/ACT Health Staff have attended ACT SMART training. Additional staff may attend where possible.

4	**Develop Waste Management Committee (WMC) Report**	Establish report that includes an updated implementation /action planner – progress report, internal / external benchmarking information (against WMP reduction targets of 10%) and results of annual waste audits (when required).	Feb 1, 2012	Open	Implementation /action planner – progress report completed. Inclusion of internal / external benchmarking and waste audit data pending.
5	**Review and Revise Waste Protocols, Policies**	Review waste protocols for all waste streams, as reflected in the WMP. Review ACTG HD Waste Management Policy.	Feb 1, 2012	Complete	Waste Policy review completed & awaiting Executive endorsement. Waste protocols review completed.
6	**Establish internal and external benchmarking activities**	Obtain waste weights from local provider to establish internal benchmarking / data base. Obtain waste weights from other states to establish external benchmarking /data base.	Feb 1, 2012	Open	Internal benchmarking complete. In principle agreement achieved with external benchmarking partners.
7	**Upgrade waste streaming stations/capacity**	Identify current streaming stations/capacity at local & ward level and temporary storage bays (mobile bins). Upgrades to include TCH and other specified sites under the contract. Identify / secure additional infrastructure (bins, signage) required. Rollout bins and signage where required. Ensure streaming stations are built into all new facilities. Align with the ACT SMART program that supports and provides accreditation for recycling in the ACT.	Feb 1, 2012	Open	Identification of current streaming stations/capacity at local & ward level and temporary storage bays (mobile bins) completed for TCH. Identification of additional infrastructure (bins, signage) required completed for TCH campus. More bins / signage still required. Rollout of bins / signage upgrade has commenced. Upgrade to staff cafeteria recycling station completed. Upgrades to front foyer recycling stations near finalisation. New Mental Health facility opened in April 2012 with streaming stations designed in (completed). D&ES aligned and working with ACT SMART to upgrade recycling outputs.
8	**Implement Waste Audit Program**	Develop annual schedule of clinical and non clinical areas for audit.		Open	

		Develop waste audit guidelines including reporting requirements. Conduct audits in accordance with guidelines. Implement waste audit report/recommendations where required.	1 July, 2012		
9	**Implement Food Recycling**	Identify and confirm food recycling / EPA requirements with relevant authorities. Provide documentation/information to the relevant authorities to facilitate approvals. Upon receipt of approval; indentify recycling processes including infrastructure/ service provider requirements.	1 Sept 2012	Open	Requirements from EPA and Health Protection Services obtained. Draft food recycling protocol completed. Risk assessment pending. Both documents then forwarded to authorities for food recycling approvals.
10	**Establish & maintain on-line Legislation, Policy, Protocol Register**	Conduct a review to identify all relevant waste protocols, policies and legislation. Develop comprehensive register /catalogue of waste governance framework documents. Place register/catalogue on D&ES website. Review annually.	Feb 1, 2012	Open	D&ES website link to waste management is active and contains waste management documents (for review). Updated & comprehensive register pending.

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ANNEX F TO
WASTE MANAGEMENT PLAN

Glossary

Abbreviation/Term	Meaning
Additional Precautions	Precautions used for patients known or suspected to be infected or colonised by highly transmissible pathogens that can be transmitted by airborne, droplet or contact transmission. Additional precautions are designed to interrupt transmission of infection by these routes and should be used in addition to Standard Precautions when transmission of infection might not be contained by using standard precautions alone.
Anatomical Waste	Limbs, organs, placenta, pathological specimens, biopsy specimens and body tissue taken during laboratory testing, surgery or autopsy and/or resulting from investigation or treatment of a patient. It does not include corpses.
Biodegradable	Capable of being decomposed by the action of micro-organisms, macro-organisms, or both.
Chemical Waste	Chemical waste generated by the use of chemicals in medical, veterinary and laboratory procedures.
Clinical waste	Means any waste which has been defined as such in the *Clinical Waste Act 1990.*
Co-mingled collection	Collection of mixed recyclables.
Compactor	Mechanical equipment which compresses materials and reduces its volume.
Container	This refers to any rigid walled receptacle designed for clinical and related waste (or other wastes) to be deposited into it. Retractable syringes are not considered a sharps container in their own right.
Contamination	Any item not designated under the contract as a recyclable.
Cytotoxic Waste	Cytotoxic waste is material that is, or may be, contaminated with a cytotoxic drug during the preparation, transport or administration of chemotherapy. Cytotoxic drugs are toxic compounds known to have carcinogenic, mutagenic and/or teratogenic potential.
General Waste	Assorted waste materials put into the recycling stream, usually characterised by being contained in plastic "garbage" bags. There may or may not be recyclable materials in the bag.
Hazardous waste	Component of the waste stream which poses a danger to humans, the environment, equipment and physical structures.
Landfill	Land used for the burial of waste
LPB	Liquid Paperboard – a Paperboard used for milk and other drink cartons and some detergent packages.
Material Recovery Facility (MRF)	Plant and equipment for sorting and pre-processing materials from the waste stream for resource recovery.
MGB	Mobile Garbage Bin
Non-recyclable	Material that is not recyclable.
Organic waste	Component of the waste stream derived from living organisms.
Package/packaging	Material or item that is used to protect or contain a product during transport, storage, marketing or use.

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Abbreviation/Term	Meaning
Pharmaceutical Waste	Consists of pharmaceutical (drug, remedy/medicinal substance) or other chemical substance specified in the Poisons List under the *Poisons and Therapeutic Goods Act 1996*. Pharmaceutical waste, excluding cytotoxics, may arise from expired or discarded pharmaceuticals, those no longer required by patients or departments and waste materials/substances generated during the manufacture and administration of pharmaceuticals.
PPE	Personal Protective Equipment
Recycled materials	Materials recovered and manufactured into new products of the same general type (which may be manufactured from virgin recycled materials).
Recycle/recycling	Set of processes (including biological) for converting recovered materials that would otherwise be disposed of as wastes, into useful materials and or products.
Resource recovery	Process that extracts material or energy for a useful purpose
Sharps waste	means any waste resulting from medical, nursing, dental, veterinary, pharmaceutical, skin penetration or other related clinical activity, and that contains instruments or devices: • that have sharp points or edges capable of cutting, piercing or penetrating the skin (e.g. needles, syringes with needles or surgical instruments) • that are designed for such a purpose • that have the potential to cause injury or infection,
TCH	the Canberra Hospital
Waste	Materials and energy which have no further use and are released to the environment as a means of disposal.
Waste generator	Any person or organisation that consumes goods and services resulting in addition to the waste stream.
Waste management	Entire process of monitoring process of monitoring, collecting, sorting, storing and transporting for processing and reclamation of materials and energy resources and disposal of waste.
Plastics	
PET	A plastic material – Polyethylene Terephthalate. Clear, tough material that may also be used as a fibre. Can come in different colours (i.e. green). Used in soft drink bottles, as filling for pillows and sleeping bags and other textile fibres.
HDPE	A plastic material - High Density Polyethylene. Very common plastic usually white or coloured, used for milk and cream bottles, shampoo and cleaners, freezer bags and milk crates.
PVC, UPVC, PPVC	Plastic materials in the polyvinyl chloride class. • UPVC is Unplasticised Polyvinyl Chloride which is usually made into clear cordial and juice bottles, blister packs and plumbing pipes and fittings. • PPVC is Plasticised Polyvinyl Chloride and is usually made up into items such as garden hose, shoe soles and blood bags and tubing.
LDPE	A plastic material – Low Density Polyethylene, a soft flexible plastic that is made into the lids of ice cream containers, garbage bags, garbage bins and black plastic sheet material.

Abbreviation/Term	Meaning
PP	A plastic material – Polypropylene, a hard but flexible plastic that has many uses. Examples of uses are icecream containers, potato crisp bags, drinking straws and hinged lunch boxes.
PS & UPS	A plastic material – Polystyrene • PS is a rigid brittle plastic that may appear clear and glassy. It is used for yoghurt containers, plastic cutlery and imitation "crystal" glassware. • UPS – expanded polystyrene is the white material that is made into hot drink cups, food containers, meat packaging trays and fruit boxes.
Other Plastic	There is another category of plastic – category 7 which includes all other plastics including acrylic and nylon.

Standard Precautions

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Definition:

Standard Precautions are work practices that are required to maintain the basic level of infection prevention and control. Standard precautions are recommended for the treatment and care of all patients, all body fluids, secretions and excretions (excluding sweat), regardless of whether they contain visible blood (and include dried bodied substances such as dried blood or saliva), non-intact skin and mucous membranes. Standards precautions includes:

- 'good' hygiene practices, performing hand hygiene before and after patient contact using the 5 moments of hand hygiene.
- the use of protective barriers which may include gloves, gowns, plastic aprons, masks, eye shields or goggles.
- appropriate handling and disposal of sharps and other contaminated or infectious waste, and linen.

use of aseptic techniques.

- use of appropriate antiseptics/disinfectants.

ALERT
Standard Precautions must be used for the treatment and care of all patients, regardless of their known or perceived infectious status.

Hand hygiene, hand care and personal hygiene

Hand hygiene is one of the most important practices for preventing healthcare associated infections. *Refer to Hand Hygiene SOP CED No. 11-50*

Intact skin (ie. without cuts, abrasions or lesions) is a natural defence against infection. Cover any cuts, abrasions or lesions with a water resistant occlusive dressing. Medical advice must be sought for conditions that persist more than a few days, eg. allergic dermatitis, psoriasis, exfoliating dermatitis or cold sores.

Hair/Nails/Jewellery

- Hair must be clean; and long hair secured back off the face and neck – especially in food handling areas and clinical care environments.
- Nails should be clean and short.
- Nail polish and nail enhancements should not be worn by healthcare workers providing patient care.
- No hand or wrist jewellery (other than a plain metal wedding ring) is to be worn in clinical areas.

Hand Hygiene

When should hand hygiene be performed?

The designated 5 Moments for Hand Hygiene must be used by all staff when attending to patient care.

- Moment 1: Before touching a patient.
- Moment 2: Before a procedure.

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- Moment 3: After a procedure or body fluid exposure risk.
- Moment 4: After touching a patient.
- Moment 5: After touching a patient's surroundings.

Hand hygiene should also be performed

- Before commencing work and after completion of work each day.
- Before taking care of particularly susceptible patients, such as those who are immunocompromised and newborns.
- Immediately after removing gloves.

Categories of hand hygiene:

1. General/social hand hygiene
2. Procedural hand hygiene
3. Antimicrobial hand rub
4. Surgical handscrub.

1. General hand hygiene

- Neutral soap is recommended for general/ social hand hygiene.
- Alcohol based hand rubs (ABHR) may be used as an alternate to general handwashing.

Please note:

- If using neutral soap wet both hands with water before applying soap solution.
- Refillable containers and reusable plungers are **NOT recommended in any healthcare settings.** Contamination of hand hygiene products may occur if refillable containers are used.

2. Procedural hand hygiene

- Antiseptic/ antimicrobial agents, eg. Chlorhexidine gluconate 2%, Triclosan 1% or ABHR.

Indications:

- Before performing invasive procedures.
- Before taking care of immuno-compromised patients.
- Between contacts with different patients in high-risk units, eg intensive care, neonatal care, renal dialysis.
- With certain types of Additional Precautions (e.g. Contact Precautions).

Please note:

- Soap residue may inactivate some antimicrobial agents.
- Therefore rinsing is an important component of the hand hygiene technique.

3. Alcohol based handrub

- ABHR may be used as an alternative to handwashing for general and pre procedural hand hygiene or in situations where running water is not available.
- ABHR kill or inhibit the growth of microorganisms, these products do not remove soil/dirt and therefore are unsuitable if hands are visibly soiled.

4. Surgical handscrub

- Antimicrobial agents, eg Chlorhexidine gluconate 4%, Povidine-Iodine 7.5%.
- Surgical scrub prior to surgical intervention.

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Hand Hygiene Categories

Type of Handcare	Purpose	Method
General hand hygiene	Remove soil and transient microorganisms	Neutral soap or ABHR for at least 10-15 seconds.
Procedural hand hygiene	Remove or destroy transient microorganisms	Antimicrobial agent for at least 60 seconds or ABHR for 10-15 seconds.
Surgical handscrub	Reduce, remove or destroy transient microorganisms and reduce resident flora	Antimicrobial agent. First wash for the day - 5 minutes duration including the cleaning of fingernails. Subsequent washes between cases - 3 minutes duration, omitting fingernails.
Handrub	Remove or destroy transient microorganisms	Apply handrub to hands rub vigorously over all surfaces of hands until dry 15-30 seconds.

Source: adapted from Larson, APIC Guidelines and ACORN Standards for perioperative nursing 2010-2011.

Hand Hygiene Technique

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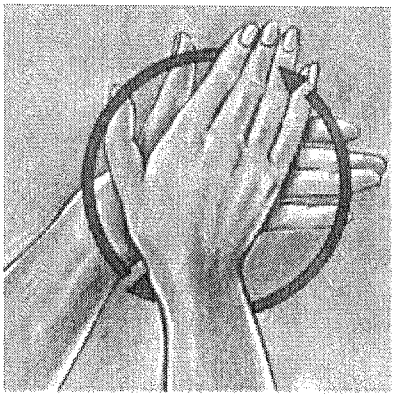
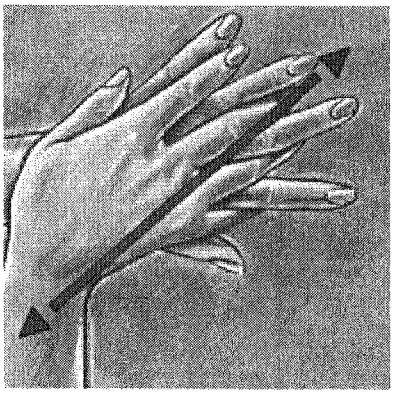
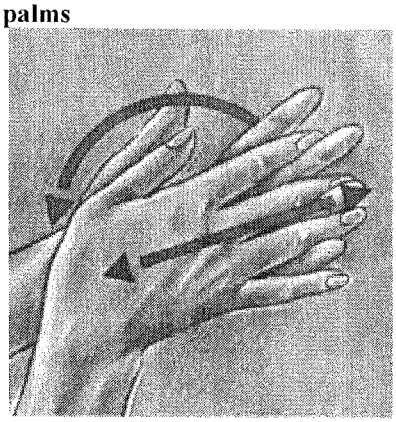


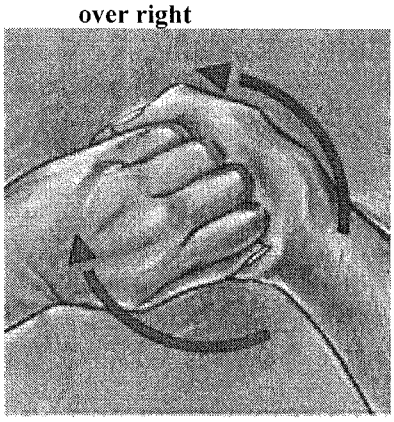
1. Apply hand hygiene product to palms



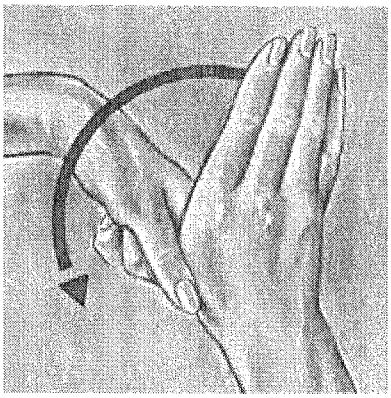
2. Right palm over left, left over right



3. Palm to palm, fingers interlaced



4. Back of fingers to opposing fingers interlocked



5. Rotational rubbing of right thumb clasped in left palm and vice-versa

6. Rotational rubbing backwards and forwards with tops of fingers and thumb of right hand in left and vice-versa

7. If handwashing rinse hands and dry carefully with disposable paper towel.

Personal Protective Equipment (PPE)

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Gloves (*AS/NZ 4011, 4179*) should be worn whenever there is a possibility of contact with:

- blood, including dried blood
- body fluids
- secretions (eg. wound exudate)
- excretions (eg. urine, faeces)
- contaminated items
- mucous membranes
- non intact skin.

NB: Gloves are not required for routine patient care e.g. performing temperatures, blood pressures or for subcutaneous, intramuscular or intradermal injection unless exposure to blood is anticipated.

Mask (*AS 4381*), **Eye Protection (safety glasses, goggles)** (*AS 1337*), **Face Shield** should be worn:

- To reduce the risk of exposure of healthcare workers to splashes or sprays of blood and body substances to the mucous membranes of the eyes, nose and mouth.
- During procedures that generate splashes or sprays of blood, body substances, secretions or excretions.
- Prescription glasses are not considered adequate protection from splash or splatter.
- Eye protection must fit snugly on the face, particularly from the corners of the eye across the brow, to provide reliable protection from splashes, sprays, and respiratory droplets from multiple angles.
- Eye protection is available that fit over prescription glasses with minimal gaps

Gowns/Aprons (AS 3789.2/3789.3) should be worn to:

- protect skin
- prevent soiling of clothing during procedures and patient-care activities likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

Semi-permeable gowns or plastic aprons may be selected if a large degree of soiling is expected.

Footwear should be:

- Fully enclosed, at front and back, and capable of protecting from injury or penetration by sharp objects.

Patient Placement

Patients suspected or identified with transmissible infections must be placed in a single room with ensuite. Examples of these include but are not limited to:

- Multi resistant organisms – MRSA, VRE, ESBL's, MRGN
- Gastroenteritis
- Influenza
- Chicken Pox (Varicella)

- Head lice (Pediculosis)
- Measles
- Meningitis (other than Viral Meningitis)
- Pertussis (Whooping Cough)
- RSV (Respiratory Syncytial Virus)
- Shingles (Herpes Zoster)
- Scabies
- Tuberculosis.

Refer to the Infection Prevention and Control Quick Reference Guide for more extensive listings of isolation requirements.
A single room can be considered for *non infectious patients* who may potentially be at high risk for transmission of microorganisms to others. Such patients would include those with:

- Impetigo or extensive skin lesions including Streptococcus pyogenes skin infections.
- Severe exfoliative skin disorders.
- Uncontained sputum.
- Uncontained secretions or excretions.
- Uncontained wound drainage.
- Faecal incontinence in which incontinence aids are not able to be used.
- Patients with poor hygiene practices and who cannot be expected to assist in maintaining their personal hygiene (incontinent patients with altered mental state).

Aseptic Techniques

Asepsis is the purposeful prevention of the transfer of infection. For details on aseptic techniques, please refer to organisation *SOP TCH11:065: Aseptic Non Touch technique.*

Soiled Patient-Care Equipment

- Soiled or used patient-care equipment should be handled in a manner to prevent skin and mucous membrane exposures, contamination of clothing and transfer of microorganisms to other patients and to the environment. Use Standard Precautions.
- Clinical equipment needs to be cleaned prior to sending for repair. Wiping with warm soapy water is sufficient for most types of equipment. Equipment with patient consumables attached or blood spills cannot be accepted by the Clinical Engineering Department.
- Reusable equipment must be cleaned and reprocessed before use in the care of another patient. *Refer to page 21, Processing of Instruments and Equipment.*

General Cleaning

- Equipment such as cloths, mops and mechanical washing devices should be clean, in working order and should be stored dry between use.
- A neutral detergent is recommended for general cleaning.
- Disinfectants are not recommended for general cleaning.
- All work surfaces should be cleaned regularly.
- Surfaces should be cleaned immediately if soiling or spills occur, or when visibly soiled.
- Routine/ regular cleaning should be undertaken as a good housekeeping measure.

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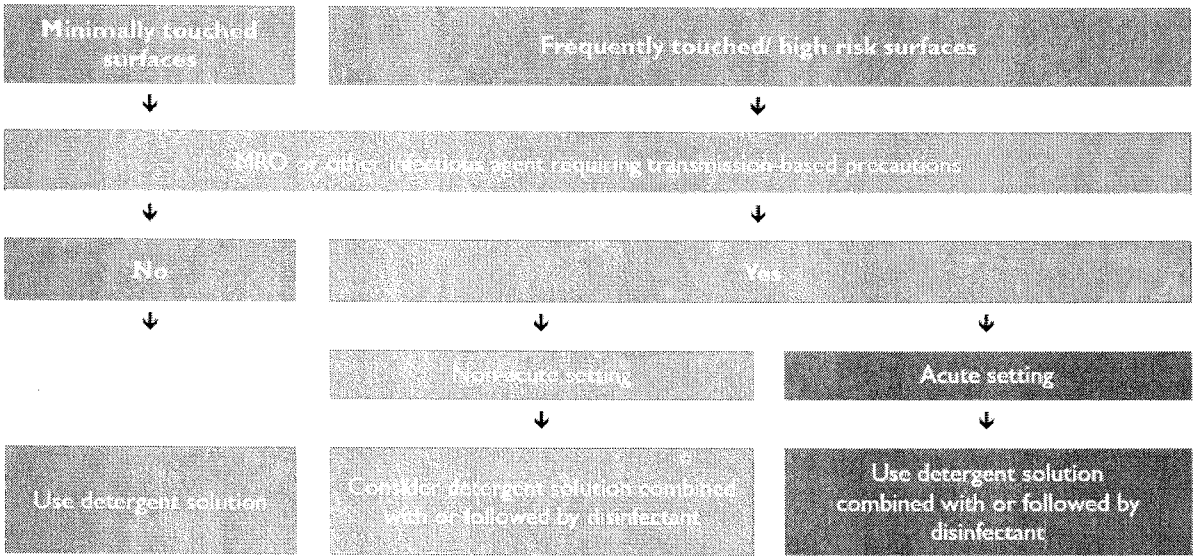
- Specialist areas, such as Operating Rooms should have written guidelines on the frequency of cleaning [see *ACORN Standards for perioperative nursing 2010-2011* and *NHMRC (2010) Australian Guideline for the Prevention and Control of Infection in Healthcare*].
- Terminal cleaning of rooms must be carried out on rooms that have patients with known multi resistant organisms or *Clostridium difficile.*

Processes for routine cleaning



NHMRC(2010) *Australian Guideline for the Prevention and Control of Infection in Healthcare.* Commonwealth of Australia

Management of Blood and Body Substance Spills

In the event of spills of blood and body substance staff involved in the management of the spills should immediately:

- Prevent access to the spill area and obtain a spill kit if a substantial size spill.
- Wear appropriate protective apparel including gloves and eye protection.
- Soak up spill with paper towel/absorbent granules from spill kit.
- Dispose of absorbent material into clinical waste.
- Clean area of spill using neutral detergent/warm water.
- If carpet is involved, mop up spill as much as possible using disposable towels and clean with neutral detergent and have carpet shampooed.

NB: It is the HCW's responsibility to clean the initial spill then contact the cleaner to finalise the cleaning process.

Personal clothing that becomes contaminated with significant amounts of blood or body fluids should be removed ASAP and staff member should shower immediately. In the acute care setting surgical scrubs can be obtained from theatre to be worn as temporary attire.

Linen Management

Definitions

Soiled Linen

These are linens that are soiled by use or fouled by bodily secretions. Linen that is heavily fouled must be treated as infected linen

Clean Linen

Linen that has been laundered as per the standard: AS/NZS 4146:2000 *Laundry Practice* and has not been used or exposed to any contaminants.

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Collection of Soiled Linen

- Soiled linen must be contained (i.e. put in linen bags) at the point of generation and stored in dirty utility rooms/areas, separate from clean linen (at all times).
- Linen bags for soiled linen must be placed on linen skips to ensure the safe handling (at point of generation) and movement of the soiled linen and bags to temporary storage.
- Wet linen must be transported and stored in leak-proof bags (liners).
- All other soiled linen must be placed into standard linen bags.
- Bags of soiled linen (dry or wet) must be a safe weight to handle.
- A safe handling weight varies for each person.
- Bags of dry and soiled linen must not be more than 2/3 full.
- Wet linen weighs significantly more than dry linen. Therefore, bags of wet and soiled linen must contain significantly less linen (i.e. less than 12 wet standard towels).
- Soiled linen must not be decanted, rinsed or sorted in patient care areas.
- Staff must ensure sharps and other objects are not discarded into linen bags.
- Staff handling soiled linen must wear appropriate Personal Protective Equipment (PPE) and adhere to prescribed manual handling practices.
- Staff must perform hand hygiene after handling soiled linen.
- Ward/area Managers are responsible for ensuring availability of linen bags, PPE and hand hygiene product/amenities.

Personal protective equipment (PPE) refers to a variety of barriers, used alone or in combination, to protect mucous membranes, airways, skin and clothing from contact with infectious agents. PPE used as part of standard precautions includes aprons, gowns, gloves, surgical masks, and protective eyewear and face shields. Selection of PPE is based on the type of patient interaction, known or possible infectious agents, and/or the likely mode(s) of transmission.

Management, Transport and Storage of Clean Linen

- Clean linen must be transported/delivered to the Healthcare facility in a clean truck, on clean trolleys covered with protective sheeting.
- Clean linen is transported within the Healthcare facility on clean trolleys and stored in designated clean storage areas.
- Clean linen must be transported and stored separately to soiled linen.
- Staff responsible for managing clean linen are to take all reasonable precautions to ensure clean linen is not exposed to any contaminants and includes:
  - The regular maintenance/cleaning of all clean linen trolleys; and
  - The regular maintenance/cleaning of clean areas where clean linen is stored or transported (e.g. clean linen store rooms, cupboards or lifts).
- Staff must perform hand hygiene before handling clean linen.

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Food Services

- Routinely no special precautions are necessary for the delivery or collection of meals, eating utensils and trays.
- Food services staff to refer to the additional precaution cards (e.g. contact and airborne precautions).
- Regardless of the diagnosis patients can use reusable eating utensils, crockery, cutlery and food trays.
- Hot water and detergent used in hospital dishwashers will effectively decontaminate cutlery, crockery and glass.
- Staff need only to wear gloves when removing food trays from patients in isolation precautions.
- Staff, in accordance with food safety standards, are not to reheat patient meals.

Pathology Specimens

Use Standard Precautions during collection, transport and processing of specimens.
Ensure specimen is appropriately labelled.

- Place specimen in a leak proof container.
- Place specimen container in a sealed biohazard bag.
- Body parts that require disposal must be incinerated. All pathology waste at TCH is disposed of in specific bins (Burgundy colour).

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Patient Resuscitation

- Use mouthpieces, resuscitation bags, or other ventilation devices to avoid contact during mouth-to-mouth resuscitation.

Prevention of Antimicrobial Resistance

Antimicrobial resistance leads to additional costs in human and financial terms. Appropriate use and control of antimicrobials is critical and includes:

- Developing a comprehensive local antimicrobial utilisation plan.
- Overseeing surgical prophylaxis, and
- Ensuring practice guidelines are available for the use of antibiotics.

Strategies for prevention and reduction of antimicrobial resistance:

- A system for monitoring antimicrobial use by hospital location or prescribing service.
- Monitoring of the relationship between antimicrobial use and resistance and

- Applying contact precautions to patients known or suspected to be colonised or infected with epidemiologically important microorganisms that can be transmitted by direct or indirect contact.

For appropriate use of antimicrobial agents refer to Therapeutic Guidelines: Antibiotic, and CHHS12/025 SOP: *Prescribing a restricted antimicrobial.*

Additional Precautions

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What are Additional Precautions?

Additional Precautions are used for patients who are known or suspected to be infected or colonised with important or highly transmissible pathogens.
They must be used in conjunction with Standard Precautions and frequently with each other and include:

- Contact Precautions
  - direct with patient/person contact
  - indirect contact (i.e. contact with contaminated surface or equipment).
- Droplet Precautions
- Airborne Precautions

Contact Precautions are necessary in health care settings where infection transmission may occur due to direct or indirect contact with a transmissible agent.

Direct contact transmission is the most common mode of transmission of health care associated infections, and occurs when microorganisms are transferred from one infected person to another person.
This may occur during:

- assisted personal care
- medical, nursing or allied health care/procedures/activities
- contact with friends, relatives and visitors
- contact with other patients and their friends, relatives and visitors.

Indirect contact transmission involves the transfer of an infectious agent through a contaminated intermediate object or person e.g.

- hands, pens, stethoscopes, shared equipment (blood pressure cuffs and tourniquets)
- inadequately reprocessed equipment/instruments
- patients' magazines
- clothes of people when sitting on patients' beds/furniture
- medical records.

Situations when contact transmission may occur include but are not limited to:

- Colonization or infection with multi resistant organisms (MRO) e.g. MRSA, MRO ESBL or VRE
- Vomiting and diarrhoea due to known or suspected infections e.g. Salmonella, Norovirus, Clostridium difficile
- Varicella zoster (shingles)
- Contagious skin infestations – scabies, head lice.

Management of contact precautions

- Display appropriate signage to ensure all staff are informed of the potential risk. (Attachment 1)
- Single room accommodation

  - Preferably with ensuite or dedicated bathroom and toilet facilities
- During period of severe bed shortages cohort infected person with others with exactly the same organism or with those in whom the infection is a low risk
- Cohorting is less than optimal management and must only be undertaken following consultation with the IPCU staff to ensure compatibility of microorganisms
- Appropriate personal protective equipment (PPE) must be used by all persons entering the restricted isolation space.
- All equipment used must be either single use, single patient use or able to be reprocessed immediately after cessation of use
- Shared equipment to be wiped over between uses with detergent impregnated cleaning wipes
- 5 Moments of Hand Hygiene using antimicrobial handwash or alcohol based hand rub (ABHR) is essential in all contact precaution scenarios
- Cleaning
  - Daily cleaning in the acute setting is with bleach.
  - On discharge use the two step process of cleaning with detergent and water and then disinfecting with bleach.
  - In the community undertake routine cleaning with detergent impregnated wipes, unless blood spill evident, then follow spill management procedure
- On movement of the person to another service delivery area, the receiving unit must be notified of the patient's infectious state and the precautions in place.

Droplet Precautions are required when large particle droplets are generated from a source person during coughing, sneezing, talking or during procedures such as suctioning and bronchoscopy.
Transmission occurs when the droplets are propelled through the air and make contact with the mucous membrane (nose, eyes, mouth) of a susceptible person. Transmission requires relatively close contact as large droplets do not remain suspended in the air and generally only travel short distances.
Examples included, but are not limited to:

- Pertussis
- Meningococcus
- Viral infections including Respiratory Syncytial Virus (RSV), Rubella, Mumps or Influenza (both seasonal and pandemic strains).

Management of droplet precautions

- Display appropriate signage to ensure all staff are informed of the potential risk.
- Respiratory precautions using a surgical mask, used in conjunction with Standard Precautions and transmission based PPE will minimise risks to the staff
- Encourage infected person to comply with cough etiquette and respiratory hygiene
- 5 Moments for Hand Hygiene must be strictly adhered to with antimicrobial hand wash or ABHR
- In the acute setting
  - Single room accommodation with ensuite bathroom is preferred
  - Cohort accommodation must be approved by IPCU staff
  - Special air handling and ventilation is not required
  - On movement of the infected person to another service delivery area, the receiving unit must be notified of the patient's infectious state and the precautions in place

- The infectious patient must wear a surgical mask during transfer.

- In the community setting
  - Requesting the patient to avoid crowded places will also assist in minimising the spread of infection within the general population.

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- Cleaning
  - Daily cleaning in the acute setting is with bleach
  - On discharge use the two step process of cleaning with detergent and water and then disinfecting with bleach
  - In the community undertake routine cleaning with detergent impregnated wipes, unless blood spill evident, then follow spill management procedure

Airborne Precautions minimize the risks associated with the transmission of infectious particles by the dissemination of very small (</= 5 microns) airborne droplet nuclei suspended in the air for extended periods of time, or dust particles containing infectious agents. These small droplets are easily dispersed in air currents. Infection transmission occurs when a susceptible person inhales contaminated air.
Examples included but are not limited to:

- Tuberculosis
- Chicken pox
- Measles
- Pandemic Influenza if in close contact during cough inducing procedures.

Management of airborne precautions

- Display appropriate signage to ensure all staff are informed of the potential risk. (Attachment 3)
- Respiratory precautions (i.e. cough etiquette and respiratory hygiene), used in conjunction with Standard Precautions and PPE will minimise risks to the staff.
  - P2 or N95 masks/respirators should be used in accordance with IPCU staff instruction, direction or signage
    - HCW in high risk areas should have undertaken fit checking in the previous 12 months
- 5 Moments for Hand Hygiene must be strictly adhered to with antimicrobial hand wash or ABHR.
- In the acute setting
  - Negative pressure single room accommodation with ensuite should be used
  - On movement of the infected person to another service delivery area, the receiving unit must be notified of the patient's infectious state and the precautions in place
  - The infectious patient should wear a P2/N95 mask/respirator during transfer.
- In the community setting
  - Requesting the patient to avoid crowded places will assist in minimising the spread of infection within the general population.
- Cleaning
  - Daily cleaning in the acute setting is with bleach
  - On discharge use the two step process of cleaning with detergent and water and then disinfecting with bleach
  - In the community undertake routine cleaning with detergent impregnated wipes, unless blood spill evident, then follow spill management procedure.

Combination of these categories

- Some patients may require a combination of any of the above precautions (e.g. shingles). 1125
- Additional Precautions may be tailored to individual patients' needs therefore it is important to consult Infection Prevention and Control for assistance.

Protective precautions - Immunocompromised Patients

- Immunocompromised patients are usually at increased risk of infection from both their own (endogenous) as well as other sources (exogenous) of microorganisms.
- Hand hygiene (with antimicrobial hand wash or handrub) is the principal strategy for minimising the infection risk for these patients.
- Susceptibility to health care acquired infections (HAI) depends on the severity and duration of their immunosuppression/ illness.
- They may be particularly susceptible to environmental contaminants e.g. Legionnaires' disease or Aspergillus.
- For severely neutropenic patients, refer to unit specific protocols. In some units, positive pressure rooms may be used for severely immunocompromised patients. NB: Positive pressure stops pathogenic organisms getting into the room, i.e. protects patient in the room.

Transfer/transport of patients

- Patient movement/inter ward transfer should be minimised where possible, but should not interrupt the normal course of treatment and rehabilitation.
- Prior to transfer to an allied health service area, other clinical area, or another health care facility, the receiving staff in the new service area must be informed of the Additional Precautions required for patient management. Please ensure that precautions are maintained.
- It is not the responsibility of the receiving health care facility to rescreen the patient on arrival. Patients should not be rescreened before transfer, at the request of the receiving healthcare facility.
- Patients with respiratory conditions must wear a mask to minimise droplet or airborne transmission, when leaving their negative pressure hospital room.
- Apply an occlusive dressing to all exudating wound sites prior to transport/ transfer of patient to another department or service area.
- Notify the mortuary attendant of any additional precautions that were in place prior to death.

Impact of Additional Precautions on patients & their family

- Patient information pamphlets on certain infections are available (e.g. VRE, MRSA and Clostridium difficile).
- Patients with infectious conditions should be informed about the risk of transmission of their infection to others.
- A sensitive, informative explanation of the reasons for the precautions should be given to the patient and their family/ carers before (or as soon as practicable after) the implementation of the Additional Precautions. Infection Prevention and Control staff member will attempt to visit all patients to distribute an information pack.
- A patient's perception of an infection risk or their reaction to the use of Additional

Precautions may be influenced by their:

- cultural beliefs
- past experience
- incomplete or incorrect information
- social isolation
- the 'stigma' associated with some infectious diseases, eg. Tuberculosis.

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Care of Deceased Person

- Standard Precautions apply.
- If Additional Precautions were required before death, the same precautions should be continued after death.
- Notify the Mortuary Attendant and document Additional Precautions required.
- Prior to transport, the deceased person should be contained in a disposable plastic mortuary bag with the sealed opening positioned uppermost.
- Label the outside of the body bag with the additional precautions required.
- In hospital, viewing/touching/handling of the deceased by relatives is permitted unless deceased person has a condition on List B, see below.
- If the deceased is suspected of having had a **Viral Haemorrhagic Fever** contact the ACT Chief Health Officer prior to taking care of the body.
- Where the deceased had **active disseminated Varicella Zoster Virus** (VZV) or **active shingles** only staff with VZV immunity should manage the deceased person.

NB: Care of the infectious body after death

The suspected or confirmed diseases (listed below) require the body to be placed in a **hermetically sealed bag**, which will not be reopened, under the provisions of the NSW Public Health (Disposal of Bodies) Regulation 2002, clause 13 (4), as agreed to by the Public Hospitals and the ACT Funeral Industry.

Staff are to label the body **Infectious Disease, List B:**

- Anthrax
- Diphtheria
- CJD
- Plague
- Smallpox
- Yellow fever
- Viral Haemorrhagic Fevers (Lassa, Ebola, Marburg, Congo Crimean fevers).

The equipment to hermetically seal the bag is available from the mortuary.

Sample Signs

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Contact Precautions

Droplet Precautions

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Droplet Precautions

eg: Influenza, Norovirus, RSV, Pertussis, Meningococcus

SINGLE ROOM	**Single room with ensuite** **Door to remain closed**
HAND HYGIENE	Perform hand hygiene with **anti microbial hand wash or alcohol based handrub** Hand hygiene must be performed on entering and leaving room
GOWNS	**Yellow disposable long sleeve gown** to be worn Gown to be discarded prior to leaving the room **Visitors are required to wear gown and gloves**
GLOVES	**Gloves required for contact** with patient, equipment and the immediate patient surroundings
MASK	**Surgical mask** required when in the room **P2 / N95 Mask** to be worn during **aerosolising procedures** *i.e NPA collection, suctioning* ***Mask to be removed AFTER leaving the room*** *For intra-hospital transfer - patient is to wear mask*
FACE / EYE PROTECTION	Wear when likelihood of splash or spray of body fluids
EQUIPMENT / NOTES / MEDICATION CHARTS	**Dedicated equipment** for single patient use or clean equipment on removal from the room **Patient's notes and charts are NOT to be taken into the room**
FOOD SERVICES	**Gloves and surgical mask** to be worn for food delivery Gloves and mask are to be **changed between each patient** and hand hygiene performed **Gown are not required**
CLEANING	Daily cleaning with detergent and water Terminal cleaning with diluted bleach solution Replace all curtains and bed screens at terminal clean
WASTE DISPOSAL	All waste to be placed in a **clinical waste bin inside the patient's room** **Masks** to be disposed of in a **clinical waste bin OUTSIDE the patient's room**

RESTRICT VISITORS

Perform hand hygiene before and after visiting patient.

Visitors to use same precautions as the health care worker *i.e. mask, gown and gloves.*

Droplet precautions are designed to reduce the risk of transmission of micro-organisms via the respiratory route.

Droplets are generated by coughing, sneezing, vomiting or from diarrhoea.

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Airborne Precautions

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Airborne Precautions

eg: Pulmonary TB, Chickenpox, Measles

SINGLE ROOM	**Negative pressure single room** with ensuite **Door to remain closed**
HAND HYGIENE	Perform hand hygiene with **anti microbial hand wash or alcohol based handrub** Hand hygiene must be performed on entering and leaving the room
GOWNS	**Gown required ONLY if likely contact with body fluids or skin lesions**
GLOVES	Gloves required **ONLY** if likely contact with body fluids or skin lesions
MASK	**P2 / N95 mask required** ***Mask to be removed AFTER leaving the room*** *For intra-hospital transfer - patient is to wear mask*
FACE / EYE PROTECTION	Wear when likelihood of splash or spray of body fluids
EQUIPMENT / NOTES	**Dedicated equipment** preferable or clean equipment on removal from the room **Patient notes and charts are NOT to be taken into the room**
FOOD SERVICES	**Gloves and P2 / N95** mask to be worn for food delivery Gloves and mask are to be **changed between each patient** and hand hygiene performed **Gown are not required**
CLEANING	Daily cleaning with detergent and water Terminal cleaning with diluted bleach solution Replace all curtains and bed screens at terminal clean
WASTE DISPOSAL	All waste to be placed in a **clinical waste bin inside the patients room** **Masks** to be disposed of in a **clinical waste bin OUTSIDE the patients room**

RESTRICT VISITORS

Perform hand hygiene before and after visiting patient

Visitors to use same precautions as the health care worker
i.e. mask, gown and gloves.

Airborne precautions are designed to reduce the transmission of micro-organisms by the airborne route

TCH Infection Prevention and Control 05/10

Waste Management – Identification, Streaming and Safe Handling

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NB: - Please refer to Health Directorate Policy CED10-046

Basic Principals - Personal Protective Equipment (P.P.E.) and Infection Control (IC)

Precautionary measures such as the use of PPE are required for the management and handling of all types of waste. There are two levels of precautions as defined by ACT Health Infection Control; Standard Precautions and Additional Precautions.

Standard precautions (defined below) are recommended for the handling of all waste streams.

Standard Precautions are work practices that are required to maintain the basic level of infection prevention and control. Standard precautions include good hygiene practices, particularly hand hygiene and the use of protective barriers against exposure to blood and bodily substances during the handling and management of waste. PPE may include some or all of the following depending on the task being performed and risk of exposure:

- gloves
- gowns
- plastic aprons
- masks
- eye shields or goggles

Additional Precautions are used where standard precautions are insufficient to prevent transmission of infection or risk of injury. If required additional precautions are used *in addition* to standard precautions providing a high level of protection for patients, staff and others.

The use of additional precautions is as per Infection Control recommendation and can be tailored to suit individual patients needs. Signage is generally displayed where applicable that indicates what precautions, including PPE, are required.

Further advice or guidance if needed should be sought from ACT Health Infection Control.

Waste should be segregated at point of use into appropriate containers and labelled correctly as described in Waste Streaming (page 26).

There are 5 main categories of waste including;

1. **General waste**
2. **Recyclable waste**
3. **Clinical waste**
4. **Radioactive waste**
5. **Dangerous Substance Waste**

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General waste;

Identification

General waste is the solid component of the waste stream, which is not recyclable or classified as a hazardous waste. This stream is often referred to as garbage. Examples of general waste include: foam packaging, soiled plastics, nappies, floor sweepings and any other material for which there is not a reuse or recycling option available. Materials and energy which have no further use and are released to the environment as a means of disposal.

Streaming

All general waste is to be deposited into designated ward/department general waste bins, Mobile Garbage Bins (MGBs)are generally green and may be lined with a black, white or clear plastic liner. In clinical areas there are white (50lts) bins with a clear liner for general waste

Safe Handling

Care should be taken when depositing waste into any MGB container to ensure that the lid can be securely closed so that no waste is deposited onto the ground, or falls out during the emptying process.

Recyclable Waste;

a) Paper (Non - secure)

b) Co- Mingled

c) Paper (Secure)

Paper (Non-secure)

Identification

Recyclable paper includes printed/typed reports, used files, photocopy paper, computer paper, envelopes (even with windows), bond stock, phone books, manila folders, invoices, newspapers, magazines and brochures.

Streaming

Paper is to be disposed of into the Blue MGB containers. The bins may have white or blue lids and should be clearly marked and labelled as non secure waste.

Safe Handling

All paper products should have any contaminants removed by the generator prior to disposal. (e.g., staples, binders, sticky tape)

Co-Mingled

Identification

Commingled recyclables include glass bottles, aluminium and steel cans, clean aluminium foil, HDPE & PET plastic bottles and liquid paperboard

Streaming

All commingled recyclables should have any contaminants removed (e.g. food, drink, straws).

All commingled recyclables should be deposited by the generator into the dedicated co-mingled recycling MGB (generally red colour) at the ward/department level

Safe Handling

The MGB should be sufficiently clean so as to not contaminate the recyclables or attract vermin such as ants and mice - this may mean that the container needs to be washed on a regular basis

Glass should be deposited so that it does not break. If broken should be disposed of in a sharps bin.

Paper (Secure)

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Identification

A confidential document is determined at the discretion of the staff member responsible for disposal. This could be patient information, accounts, prescriptions or hospital information. It also includes any document that identifies a staff member.

Streaming

All confidential documents should be either shredded or placed into a *secure, lockable* storage 240 litre MGB located at each ward/department throughout ACT Health. This storage container is to be labelled Confidential Documents.

If a shredder is available, the person disposing of the document must be responsible for the shredding of confidential documents. Shredded material must be placed into one of the paper recycling floor boxes located around the office. Procedures for handling and disposal of this shredded material are the same as for recycled paper.

Safe Handling

Confidential documents are still Public Records and the Public Record Office (PRO) disposal schedules should be consulted to determine whether disposal or archiving is appropriate. ***Patient, staff and medical records may only be destroyed by the relevant departments or personnel.*** Some documents may be destroyed under Normal Administrative Practice, meaning notification is not necessary, whilst others require a form to be completed and forwarded to the PRO. If there is any doubt, departments should make inquiries to the Archivist.

In cases of patient related documents that might, under PRO guidelines, be required to be attached to the patient's medical record, contact the Operations Manager Health Information Services.

Ensure that any contaminants removed by the generator prior to disposal. (e.g., staples, binders, sticky tape)

Clinical and Related Wastes;

a) Clinical waste

b) Sharps

c) Anatomical Waste

d) Cytotoxic Waste

e) Pharmaceutical Waste

Clinical Waste

Identification

General clinical waste for the purposes of this document is all the waste generated by the definition of clinical waste (above) that does not fall into the categories of; sharps, anatomical, cytotoxic, pharmaceutical, radioactive or chemical waste. E.g. any gowns/masks used in dealing with infectious patients, any tubing used in administering drugs, any colostomy bags from infectious patients, any waste with blood or other bodily fluids on it.

Streaming

Clinical waste should be disposed of in Yellow MGB or designated yellow bags. Each MGB, in addition to being colour coded, should be clearly marked and bear the clinical waste sign.

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Safe Handling

When handling any clinical waste personal must wear the appropriate Personal Protective Equipment (PPE) – please refer to the PPE policy by ACT Health. When necessary clinical waste deemed particularly infectious or soiled may be double bagged. Waste bags must not be over filled (approx 2/3 of capacity). Bags (temporary containers) must not be excessive in weight (3 kg – 5 kg). All bags should be held away from the body by the closed top of the bag, and placed directly into a mobile garbage bin or trolley

Sharps

Identification

Sharps include any waste resulting from medical, nursing, dental, veterinary, pharmaceutical, skin penetration or other related clinical activity, broken glass or crockery instruments or devices that:

i. have sharp points or edges capable of cutting, piercing or penetrating the skin (e.g. needles, syringes with needles or surgical instruments);
ii. are designed for such a purpose; and
iii. have the potential to cause injury or infection.

Streaming

Place used sharps in designated puncture-resistant yellow sharp containers immediately after use. Each container is clearly marked in conjunction with ACT Health policies of infection prevention and control. Sharps containers must conform to *AS 4031-1992* or *AS/NZS 4261-1994*

Safe Handling

Sharps are generated in wards, departments and public toilets.

Note: The potential for transmission of blood-borne diseases is greatest when needles, scalpels and other sharp instruments or devices are used.

Special care must be taken to prevent injuries.

Wherever possible, eliminate the use of sharp devices, especially 'butterflies' and replace with a safety product, e.g. safety syringes/ cannulas, or needleless systems

When disposing of sharps;

- **Don't** recap used needles.
- **Don't** remove used needles from syringes by hand.
- **Don't** bend, break, or manipulate used needles by hand

ALERT

All persons using a sharp object are responsible for its immediate and proper disposal.

Sharps containers should:

- not be filled above the line indicated on the container;
- not be double handled from one container to another;
- be out of reach of children (opening should be approximately 1.2m from floor level);
- be closed before disposal.

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Anatomical Waste

Identification

Anatomical waste includes limbs, organs, placenta, pathological specimens, biopsy specimens and body tissue taken during laboratory testing, surgery or autopsy and/or resulting from investigation or treatment of a patient. It does not include corpses.

Streaming

Anatomical waste will be deposited into burgundy coloured containers. The biohazard symbol and the words "clinical waste" and/or "anatomical waste" are to be written on the container

Safe Handling

Once deposited into an MGB, no bin liner is to be removed. The lid is to remain closed at all times. The MGB is moved by the waste management staff to a designated secure storage area until it is removed for destruction

Cytotoxic Waste

Identification

Cytotoxic waste is material that is, or may be, contaminated with a cytotoxic drug during the preparation, transport or administration of chemotherapy. Cytotoxic drugs are toxic compounds known to have carcinogenic, mutagenic and/or teratogenic potential.

Streaming

All sharp and non-sharp cytotoxic waste is to be deposited by the generator into a purple container or MGB and marked with the cell in telophase symbol in white. The words "Cytotoxic Waste" should be clearly displayed on bags and containers.
Sharp cytotoxic waste will only be deposited into a sharps container that is purple, has the telophase symbol and the words "Cytotoxic Waste" clearly displayed

Safe Handling

The lids of mobile bins should be kept closed at all times. Once deposited into an MGB, no bin liner is to be removed. The MGB is moved by the waste management staff to a designated secure storage area until it is removed for destruction.

Pharmaceutical Waste

Identification

Pharmaceutical waste includes pharmaceutical (drug, remedy/medicinal substance) or other chemical substance specified in the Poisons List under the *Poisons and Therapeutic Goods Act 1996*. Pharmaceutical waste, excluding cytotoxics, may arise from expired or discarded pharmaceuticals, those no longer required by patients or departments and waste materials/substances generated during the manufacture and administration of pharmaceuticals. For streaming and safe handling purposes see the below 4 categories are:

i. Drugs of Addiction (DA Schedule 8)
ii. General Pharmaceuticals
iii. Pharmaceutical Containers
iv. Pharmaceutical Aerosols

Drugs of Addiction (DA Schedule 8)

Streaming

These items must be kept in the DA safe for pick up by a registered pharmacist. Ward staff are not allowed to destroy any DA other than partly used ampoules whose contents can be tipped into a sharps container or infectious waste bag.

Safe Handling

Destruction of partly used Drugs of Addiction must be annotated in the DA administration book. Contents of partly used infusion bags containing DA should be discarded down the sink and the bag placed in a sharps container. Any discarding of a partially used DA must be witnessed and signed for by two registered nurses.

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General Pharmaceuticals

Streaming

All unused, partly used or out of date pharmaceuticals should be returned to the pharmacy **department. These can be put in the pharmacy return bin located in each ward drug** cupboard.

Safe Handling

Do not reopen or readminister any left over drugs

Pharmaceutical Containers

Streaming

Large quantities of plastic containers that have had liquid pharmaceutical should be placed in orange infectious waste bags.

Plastic containers that have contained dry tablets or capsules and are totally empty can be disposed of as general waste.

Glassware that has contained liquids should be disposed of as contaminated glassware (see Contaminated Glass).

Glassware that has contained dry tablets or capsules and are totally empty can be disposed of as uncontaminated glassware (see Uncontaminated Glass).

Safe Handling

Do not pierce any container which holds drugs.

Pharmaceutical Aerosols

Streaming

There are special containers for pharmaceutical aerosol disposal in the waste disposal area of the pharmacy department.

Safe Handling

Store all aerosols away from heat or sources of combustion. Because pharmaceuticals are incinerated it is necessary to separate pharmaceuticals aerosols to be picked up separately by the waste contractor.

Radioactive Waste;

Identification

Radioactive Waste includes any object, material, paper, linen or other substance that has had any direct contact with ionising radiation. This includes urine spills on linen, incontinence pads etc, samples prepared for gamma or liquid scintillation counting and low level radioactive materials that have been placed in storage.

Streaming

The waste is to be placed in red waste bag with the radiation symbol and sealed tightly with a plastic or similar tie by Radiation staff.

All radioactive waste will be placed into red containers that have the trefoil symbol and the words "radioactive waste" printed on it.

Safe Handling

Note: Radioactive Waste is handled by appropriately qualified Radiation Technicians ONLY in accordance with relevant legislation and radiation safety protocols

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Dangerous Substances

Identification

Dangerous Substances may be elements, compounds or mixtures and can be in solid, liquid or gaseous form and include some cleaning substances. Chemicals may be classified as Dangerous Goods or Hazardous Substances.

Streaming

Chemicals for disposal must be kept in the department and clearly labelled with the name of the substance and the quantity. A Chemical Disposal Manifest form is to be completed by the department wanting to dispose of chemicals and faxed to the current chemical disposal contractor listing the chemicals/chemical containers for disposal. (if unsure contact the Dangerous Substance Coordinator ext 43778).

Chemical containers that have been cleaned, had all labels relating to the Dangerous Goods or Hazardous Material removed or obliterated can then be disposed of as general waste or uncontaminated glass.

Disposal of chemicals to the sewer (i.e. down the sink, toilet or pan flusher) should only be undertaken when this is the advised method of disposal and meets current Trade Waste and Occupational Health and Safety requirements. Laboratory sinks connected to a neutralising pit should be clearly identified (glass waste pipes).

Safe Handling

All chemicals must be approved for use and storage and handled according to the Dangerous Goods and Hazardous Substances Regulations.

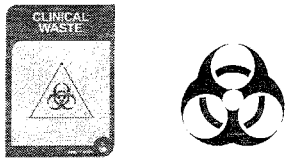
An appropriate and current Material Safety Data Sheet (MSDS) for each chemical, must be available for to all staff and visitors. If the disposal method is unclear in the MSDS, or if special handling and disposal are required, a departmental spill procedure should be implemented and accompany spill procedure materials and personal protective equipment.

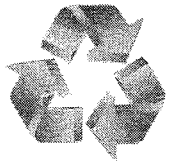
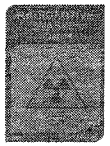
Chemical containers should be emptied and disposed of carefully. According to Dangerous Goods/Hazardous Substances legislation, all empty containers that have contained dangerous goods are to be disposed of in the same manner as the contents unless the chemicals have been cleaned out of the container.

Containers must not be punctured and must be sealed for safe handling. Where empty containers have stored dangerous substances deemed inappropriate for cleaning / decontaminating they must be provided to the Dangerous Substance Coordinator for disposal at the cost to the originating unit. For all other containers, they are to be either placed in a yellow clinical bag or contaminated glass pail for high temperature incineration or in a black bag for disposal to landfill according to the instructions in the MSDS.

Waste Streaming

All waste in table below must be streamed by the generator at the point of origin. Bin / container colours may vary from below table

No	Type of waste		Container / Additional Information		PPE used to transport / manage waste (not at point of origin)	Signage
1	Clinical & Related Wastes	Clinical Waste	Yellow Bin	Yellow MGB or designated yellow bags should be clearly marked and bear the clinical waste sign	Gloves/Apron	
		Sharps	Thick Yellow Container	Needle stick proof containers. Clearly marked as sharps containers.	Needle proof Gloves	 Sharps
		Anatomical Waste	Burgundy Bin	Biohazard symbol and the words "clinical waste" and/or "anatomical waste" are to be displayed on the container	Gloves/Apron/mask	
		Cytotoxic Waste	Purple Bin	Purple container or MGB marked with the cell in telophase symbol in white.	Gloves/Apron/Mask	
		Pharmaceutical Waste		Should always be secured and locked.	Gloves/mask	

No	Type of waste		Container / Additional Information		PPE used to transport / manage waste (not at point of origin)	Signage
2.	General Waste		Green MGB	Colours may vary (can be black, white or green)	Gloves	
3.	Recyclables – Main Streams	Paper - Non secure	Blue MGB	Bin commonly blue with white lid. Colours may vary	Gloves	 Reduce Reuse Recycle
		Cardboard		Cardboard	Gloves	
		Co-mingled	Red MGB	Bin commonly red. Colours may vary	Gloves	
		Paper – Secure	Blue MGB	Bin commonly blue. Colours may vary	Gloves	
4.	Radioactive Waste		Red Bags / yellow ties	This waste stream is managed by Radiation Oncology Physicists	Gloves/Apron/mask/goggles	
5.	Dangerous Substances		Various	Must be handled, stored and transported in accordance with current legislation	Gloves/Apron/Goggles/Mask	

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Reprocessing of Instruments and Equipment

Key points:

- Items intended for single use must **NOT** be reused in accordance with Therapeutic Goods Association (TGA) regulations.
- **All instrument reprocessing commences with cleaning.**
- Reprocessing of medical equipment must be in accordance with Australian Standard AS4187- 2003 (*Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities and office based practice*) or Australian/New Zealand standard AS/NZS 4815:2001 office based healthcare facilities not involved in complex patient procedures and processes (i.e. cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment).
- Level of reprocessing depends on the intended use of the item, e.g. critical, semi-critical and non-critical use (Refer to table on the level of reprocessing required for specific items and procedures at end of this section).

Definitions:

- **Cleaning:** the removal of all foreign material from objects, such as soil/organic material, and the reduction in the number of microorganisms from a surface. Cleaning is normally done with water, mechanical action and detergents. ***Cleaning must be done before disinfection and sterilization.***
- **Disinfection:** the inactivation of non-sporing microorganisms using either thermal (heat alone, or heat and water) or chemical means.
- **High level disinfectant:** a disinfectant that kills all microbial pathogens, except large numbers of bacterial endospores, when used as recommended by its manufacturer. Exposure time is generally specified in manufacturer's instructions and is shorter than time required for sterilization.
- High level disinfectants used in Australia must comply with TGA, *Therapeutic Goods Order Number 54 –standard for composition, packaging, labeling and performance of disinfectants and sterilants.*
- **Sterilisation:** complete destruction of all microorganisms including spores by means of heat, gas, steam and / or irradiation.

When is something 'clean'?

Effective cleaning ensures that instruments and equipment are clean to the naked eye (macroscopic) and free from any protein residues and other stains.

Reprocessing of Critical items:

- Items should be rinsed to remove gross soiling as soon as practicable, then cleaned with detergent and water. Standard Precautions should be used.
- Further reprocessing of items should be performed by ACT Sterilizing Services or approved equipment reprocessing unit according to AS/NZS 4815:2001.

Reprocessing of Semi-Critical Items:

- Items should be rinsed to remove gross soiling as soon as practicable, then cleaned with detergent and water. Standard Precautions should be used when handling the item.
- Further reprocessing of items should be according to an approved reprocessing unit in accordance with AS4187-2003 or AS/NZS 4815:2001.
- Some equipment, such as heat-sensitive equipment like endoscopes, may have to be processed in specialised clinical areas. These areas must have written guidelines for reprocessing according to AS4187 or AS/NZS 4815:2001.

Reprocessing of Non-Critical items:

- Items should be rinsed to remove gross soiling as soon as practicable, using Standard Precautions when handling item.
- Items are cleaned with detergent and water and mechanical action and stored dry.
- To ensure optimal effectiveness of cleaning, some types of equipment, such as bowls, kidney dishes etc., may be cleaned in a utensil washer.
- Utensil washers and pan sanitisers must meet Australian Standards.
- For specialised equipment, refer to manufacturer's cleaning instructions.

CJD

For the reprocessing of instruments used in procedures where a risk of CJD transmission exists, please refer to the CJD CH&HS SOP on CJD and CJD fact sheet section 3.

Table - Level of reprocessing required for specific items and procedures

Level of Risk	Application	Process	Storage	Example
Critical	Entry or penetration into sterile tissue, cavity or blood stream	Sterilisation by steam under pressure	Sterility must be maintained: - packaged items should be allowed to dry before removal from steriliser; - the integrity of the wrap must be maintained	Instruments used in invasive surgical and dental procedures, eg. arthroscopes, laparoscopes, oral surgical instruments, ERCP instruments and podiatry instruments capable of penetrating or abrading the skin.
Semi-Critical#	Contact with intact mucosa or non-intact skin	Steam Sterilisation is preferred where possible	Store to protect from environmental contamination	Breathing circuits, vaginal speculae, instruments for routine dental procedures, buffs used in dental laboratories
Semi-Critical#	Contact with intact mucosa or non-intact skin	If the equipment will not tolerate steam sterilisation, use high level chemical disinfection or automated chemical processing systems	Store to protect from environmental contamination	Fibre-optic scopes: sigmoidoscopes, gastroscopes, colonoscopes, bronchoscopes Transoesphageal echocardiograph
Non - Critical	Contact with intact skin	• Cleaning with detergent and water • If required, disinfect these items, after cleaning, with 70% alcohol (eg alcohol wipe)	Store in a clean dry place	IV infusion pumps, PCAs, stethoscopes, blood pressure cuffs, sphygmomanometers, Mercury thermometers, Abdominal ultrasound transducer

Australian Government Department of Health and Aging, Communicable Diseases Network (CDNA) (2004). *Infection Control Guidelines: for the prevention of transmission of infectious diseases in the health care setting*, Biotext, Canberra.

Notes:

- # For semi-critical items – sterilisation is preferred where possible
- Do not store instruments in disinfectant before or after any form of processing

Antiseptics, Disinfectants and Sterilants

It is important to provide guidance to staff on the definitions and the correct use of antiseptics, disinfectants and sterilants. To maintain the most antimicrobial effectiveness, information will be supplied on the degree of success in killing or inhibiting the growth of microbes in each group, what circumstances the group can be used and when to use them. This document does not cover the cleaning of surfaces, the cleaning procedures, or the physical sterilisation of medical devices. For further information on cleaning processes please follow ACORN Standards and AS/NZ Standards 4187.

Important Points to Remember

- Cleaning, disinfection and sterilising are separate processes for the decontamination of items.
- Cleaning of medical equipment is an essential pre-requisite for all disinfection or sterilization processes, as organic residue renders many chemical disinfectants and sterilisation processes inactive.
- After initial cleaning is carried out instruments should be thoroughly rinsed. If the items are not dried the disinfectant solution may be further diluted making the solution less effective.
- Disinfectants are **NOT** cleaning agents.
- Disinfectants do **NOT** sterilise.
- Disinfection is carried out by using either thermal (heat and water) or chemical means.
- Always use antiseptics, disinfectants and sterilants in accordance with the manufacturer's recommendations – to ensure the product's effectiveness.
- Only Therapeutic Goods Administration (TGA) registered disinfectant with manufacturer's instructions specifying its effectiveness against specific infectious organisms are to be used.

Performance of chemical disinfectants is affected by factors that include:

- Initial number of micro organisms present.
- Temperature (usually 25°C is the optimal temperature).
- pH and the concentration of the chemical used.
- Biocidal (failure of the microorganism to multiply) action of the agent.
- Effective contact between the biocidal agent and the microorganisms.

Using chemical disinfectants and sterilants

Use chemical disinfectants with caution and always follow the manufacturer's instructions.

- Refer to the Manufacturer's instructions and the Material Safety Data Sheets (MSDS) before use.
- Wear personal protective equipment as recommended.
- Ensure adequate ventilation.

Antiseptic group

Antiseptics	Activity Range	Types available	Uses/Comments
Chlorhexidine	Good: bacteria most viruses most fungi Mycobacterium Variable: some viruses some fungi Poor: bacterial spores Ineffective: CJD	Chlorhexidine 0.5% in Ethanol **(Alcohol based hand rub)**	Used as a **hand rub** to disinfect hands for routine care and prior to carrying out aseptic procedures.
		Chlorhexidine 2%	Used for **hand washing** prior to performing an aseptic procedure such as central line change, wound dressing. Can be used as a **pre operative wash.**
		Chlorhexidine 4%	Used as **hand scrub** in high risk areas in hospitals such as Operating Rooms and Day Surgery Units.
		Chlorhexidine 0.05% with cetrimide 0.5%	Antiseptic for cleansing of **dirty wounds**. Used mainly in Emergency Departments and Operating Rooms. *Caution:* Not to be used for perineal toilets, meatal or urethral catheter care because of its irritating effect. May damage tissue with prolonged use.
		Chlorhexidine 0.015% with cetrimide 0.15%	General ward use for perineal toilets, meatal hygiene, urethral catheter care and clean wounds.
		Chlorhexidine 1% swab stick (Persist)	Used in children for **skin disinfection** prior to invasive procedures e.g.intravascular catheter insertion/other drains sites. Allow to dry to be effective.
		Chlorhexidine 2% and Ethanol 75% swabs (Solu V, Solumed)	Used for **skin disinfection** prior to invasive procedures e.g.intravascular catheter insertion/other drains sites. Allow to dry to be effective.

Antiseptics	Activity Range	Types available	Uses/Comments
Iodine preparations (antiseptic)	May be inactivated by organic matter. Antiseptic-strength iodine preparations are not usually sporicidal.	Povidone Iodine 10% solution (antiseptic)	Useful as a **skin disinfectant** - including as a surgical scrub. Skin preparation prior to surgery. Used for lacerations, abrasions and minor wounds. ***Caution:*** *Prolonged use on wounds may delay healing.* NB: Some people are sensitivity to iodine and may be unable to use. Povidone-iodine is much less irritant than iodine itself. Not recommended for use on premature newborn infants and neonates. Limited use in pregnancy and lactation (possible risk of iodine absorption and its effect on thyroid function).
		Povidone Iodine Surgical Scrub 7.5% (skin antiseptic)	Recommended for **hand scrubbing** prior to aseptic procedures and surgery in high risk areas e.g. Operating theatre. Used as an alternative to Chlorhexidine 4% (hand scrub).
Triclosan	Broad spectrum bactericidal activity	Triclosan 1% hand and body wash	***Used as an*** *antimicrobial handwash* ***pre procedure or when caring for patients in additional precautions.***
		Triclosan 1% w/v preop wash .	***Can be used as a*** *pre operative wash.*

Disinfectant Group

Chemical Disinfectant	Activity Range	Uses/Comments
Alcohols	Good: bacteria most viruses most fungi Mycobacterium Variable: some viruses some fungi Poor: bacterial spores Ineffective: CJD	**Ethanol:** • 70% w/w ethanol acts rapidly and dries quickly. • 90% w/w ethanol is a useful viricide. • 100% Ethanol is **not** an effective disinfectant. **Isopropyl** • Most effective at 60 - 70% v/v General properties: • **Surface disinfectant** • May be combined with other bactericidal compounds for skin disinfection. • **Non-critical items disinfectant** (if recommended by manufacturer). • Does not penetrate organic matter well, surfaces and items need to be cleaned prior to disinfection as alcohol acts as a fixative. • Items and surfaces disinfected with alcohol should be allowed to dry before being used again. **Caution:** Alcohol is highly flammable
Quaternary Ammonium Compounds (Ammonia) (surface disinfectant)		Generally not recommended for use other than as a **surface disinfectant**. Fresh batches of the disinfectant should be made up daily as it easily becomes contaminated with *Pseudomonas.*
Chlorine and Chlorine Compounds. (*Actichlor Plus* - chlorine and detergent mix)	Effective against Viruses, Bacteria, Spores, Yeasts and Moulds.	Can be used for **general surface cleaning**. One step chlorinated detergent and disinfectant which cleans and disinfects in a single application. Can also be used for terminal cleaning of a room after it has been occupied by a patient with an infectious disease.

Hypochlorites (bleach)	Good: bacteria viruses fungi Variable: bacterial spores and Mycobacterium	General purpose disinfectant for **surfaces and semi-critical and non-critical items and** decontamination of blood spills. Surfaces and items need to be cleaned prior to disinfection and disinfectant **must remain on surface for 10 minutes.** Can be used for terminal cleaning of a room after it has been occupied by a patient with a transmissible / infectious disease. **Unsuitable for some metal** items as it is corrosive. Working concentration: 1000 ppm = 0.1% available chlorine.
Phenolics	Good: bacteria fungi Mycobacterium Variable: some viruses Poor: some viruses (non-enveloped viruses, eg. Hepatitis A Virus & CJD	***General purpose disinfectant for*** *surfaces and non-critical items.* ***Used for bacterial decontamination of the hospital environment including floors, benches and walls.*** Can also be used for terminal cleaning of a room after it has been occupied by a patient with a transmissible / infectious disease. Disinfectant **must remain on surface for 10 minutes.** Absorbed by rubber and plastics. Do not use on food preparation surfaces/equipment. Diluted form unstable. Fresh batches of the disinfectant should be made up. Avoid contact with skin/mucous membranes.
Wipes – detergent impregnated general surface - 70% Isopropyl Alcohol wipes.	Good: bacteria most Viruses most fungi Variable: bacterial spores mycobacterium	Used to disinfect hard surfaces. General surface disinfectant. *Caution:* General purpose detergent wipes can be used on intact skin however it is not recommended

Sterilant Group.

Sterilant group	Activity Range	Uses/comments
Peracetic acid and other peroxide compounds *i.e. Hydrogen peroxide*	Good: bacteria viruses fungi bacterial spores Variable: Mycobacterium. Poor: bacterial spores CJD	**High level instrument disinfectant for critical and semi-critical items** that cannot withstand steam under pressure or dry heat sterilisation. Used in automated machines to chemically sterilize medical, surgical and dental instruments. Can also be used to clean non-porous surfaces in hospital. Items need to be cleaned prior to disinfection - reduced activity in presence of organic matter. Corrosive to some metals, i.e. Copper, brass, bronze, plain steel and galvanized iron. Peracetic acid is highly irritant to skin and should only be used as directed. Hydrogen peroxide and potassium monoperoxygen sulfates have low toxicity and irritancy.
Orthophthalaldehyde (OPA)	Good: bacteria viruses fungi bacterial spores (slow acting) Variable: Mycobacterium Ineffective: CJD	**High level instrument disinfectant for critical and semi-critical items** that cannot with stand steam under pressure or dry heat sterilisation. Items need to be cleaned prior to disinfection. **Caution:** Should not be sprayed onto surfaces. Gluteraldehyde highly irritant - possible carcinogen. Should be used only in accordance with manufacturer's instructions. Use in well ventilated areas and with staff wearing personal protective attire.

Staff Health Issues

Pre-employment Screening

To ensure protection of staff and patients against potentially infectious diseases, appropriate screening, testing and vaccination of health care workers is recommended (see references).

Pre-employment screening may include appraisal of medical history and immunisation records for Hepatitis B, measles, mumps, rubella, varicella, tetanus, and tuberculosis. Serological testing may be carried out for certain vaccine-preventable diseases.

Vaccination

The infectious risks to particular types of workers often vary between and within health care establishments. Vaccination policies will be based on two main categories of staff

- At risk - all persons who have physical contact with, or potential exposure to blood or body substances.
- Low risk - persons who have no greater exposure to infectious diseases than does the general public, e.g. some clerical staff (e.g. Human Resources), gardening staff.

The vaccination program is targeted to staff in the first category, based on the degree of risk of exposure to certain diseases. Unless otherwise indicated, current vaccination policies are based on the recommendations of the NHMRC (2008). *The Australian Immunisation Handbook*, 9th edition. AGPS. Canberra.

In accordance with NHMRC guidelines, all Health Care Workers, particularly those who may be exposed to blood or body substances, *should be vaccinated against Hepatitis B.*

Staff with infectious conditions

In general, adherence to standard and additional precautions, vaccinations and a high standard of general hygiene in the workplace should protect health care workers (HCW's).

Alert

Certain conditions require that staff be *redeployed* from their normal duties to an area of lower risk or *excluded* from work. Refer *to Draft SOP Exclusion periods for staff working in the Healthcare setting who have been exposed to or have developed an infectious disease.*
In such a case or where there is any doubt, the person should alert their supervisor and discuss an individual assessment and/or clearance with Infection Prevention and Control, an Infectious Diseases Physician or GP.

1. Skin conditions

- Staff with either shedding and/or weeping skin conditions or damaged skin are at increased risk of acquiring infection from others and/or transmitting infection to others. For example, allergic eczema, psoriasis, exfoliate dermatitis and cold sores.

2. Acute Respiratory condition

Staff with respiratory conditions may need to be excluded from work. This depends on

- the type of infection (refer to *Quick Reference Table and Factsheets*).
- the condition of the staff member (*'do you feel sick?'* is a good indicator).
- the nature of the work.
- staff who have a persistent cough should be checked by their GP and ensure that pertussis (whooping cough) is excluded. If a staff member has a diagnosis of pertussis infection, Infection Prevention and Control should be advised.

3. Diarrhoeal condition

- Staff with diarrhoea should be excluded from work until 48 hours after the last symptom.
- Longer periods of exclusion apply to food handlers.
- Refer *Quick Reference Table* or *Fact Sheets*.

4. Herpes Simplex Virus

- HCW should cover lesion with an occlusive dressing whenever possible.
- When lesions are uncovered the HCW must be excluded from caring for neonates and immunocompromised patients (severely neutropenic patients), or working in operating rooms and delivery suite until 48 hours after anti viral medication has commenced or until lesion is dry.
- HCW 's can be deployed to a non-clinical area.

5. Varicella Zoster Virus (VZV) (Chicken pox and shingles)

- HCW should know their status of immunity of VZV. This can be ascertained through a blood test.
- Immunisation is available for non-immune HCW's. Immunoglobulin is available for HCW's who are non-immune and have impaired immune response, including pregnant women.
- Non-immune HCW's must not care for patients who have VZV.
- HCW's who are non-immune are excluded from direct patient contact from day 10 until day 21 after exposure to Chickenpox (staff could be redeployed to a non-clinical area during this time).
- HCW can receive post-exposure prophylaxis (PEP) with the vaccine; if they do receive PEP, the HCW can come to work but must exclude themselves if they develop a rash.
- **Chickenpox** infected HCW's must remain off work until all lesions are dry and no new lesions have occurred for 48 hours.
- **Shingles** affected HCW's should remain off work until 48 hours after commencement of appropriate antiviral medication, providing no new lesions have occurred in that time. On return to work, all lesions should be covered with an occlusive dressing. If untreated, HCW should not return to work until all shingles lesions are dry.

HIV/ HBV/ HCV infected Health Care Workers

Refer to *Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus Infected Health Care Workers Policy. Communicable Diseases Control, ACT Health Directorate via Intranet.*

This policy recommends that **health care workers undertaking exposure prone procedures** should be aware of their status in regard to the blood-borne diseases, HIV (Human Immunodeficiency Virus), HBV (Hepatitis B Virus) and HCV (Hepatitis C Virus).

Exposure-prone procedures are characterised by the potential for direct contact between the skin (usually finger or thumb) of the HCW and sharp surgical instruments, needles, or sharp tissues (spicules of bone or teeth) in body cavities or in poorly visualised or confined body sites (including the mouth). Exposure prone procedures are a subset of *invasive procedures*, which include any surgical entry into tissue, body cavities or organs, or repair of traumatic injury.

HCW who are HIV, HBV or HCV positive (as defined in the policy) must not perform exposure prone procedures unless otherwise directed by The Advisory Panel.

Staff at increased risk of infection

People who are highly immuno-suppressed would normally be unable to work.
Examples of pre-disposing conditions are:

- Neutropenia (< 1000 x 10^9 WC/L), which is often associated with cancer chemotherapy.
- Disseminated malignancy.
- Infections, which produce immuno deficiency, e.g. HIV.

If the person is well enough to work, their work environment and tasks should be assessed to enable them to work safely. Please consult with treating doctor and /or Infection Prevention and Control Professional or Infectious Diseases Physician.

Pregnant Health Care Workers

It may be that pregnant women as a group are more susceptible to some infections, although not to the same extent as immunocompromised individuals.

Pregnant staff members should be given an opportunity to avoid contact with specific infectious risks. Discuss this with your obstetrician or GP and supervisor or Infection Prevention and Control Professional or Infectious Diseases Physician.

Immunodeficient and pregnant HCW's should be advised to avoid direct and prolonged contact with patients known to have CMV.

Occupational Exposure Management

Definition: *An occupational exposure* is defined as an exposure that puts the worker at risk of becoming infected with a pathogenic organism (e.g. Hepatitis B, Hepatitis C and HIV) while performing duties at work.

Needlesticks/ sharps injury or exposure of non-intact skin/ mucosal membrane to blood and body substances can result in the transmission of the pathogenic organism.

Flow Chart for Management of Occupational Exposures

Occupational Medicine Unit (OMU) available Monday – Friday during office hours
After hours, Weekends or Public Holidays - Contact Afterhours CNC.

Step 1

Administer First Aid

Skin exposure / Penetrating injury
- Wash exposed area with soap and water.
- Do not encourage bleeding.
- Cover the wound

Eye Splash
- Gently rinse with water or normal saline
- Do not rub eyes

Mouth splash
- Rinse mouth with water

Step 2
Report ORE to immediate supervisor at the time of the injury / exposure.

Responsibility of Supervisor
- Ensure first aid measures have been performed
- Ensure exposed staff member reports to OMU or after hours CNC immediately after the exposure.
- Assists with the completion of Staff Accident incident report(SAIR) / RISKMAN

Step 3
Seek treatment / management

CH&HS – OMU or A/H CNC
Calvary - Infection Prevention & Control (IP&C) or after hours ED
CJJH - Infection Prevention & Control

Responsibilities of OMU / IP&C / ED
- Assessment the injury / exposure
- Organise appropriate testing and treatment
- Update vaccinations if necessary
- Initiate counselling
- Organise investigation of source person (if known)

Step 4
Follow up – Exposed Staff member to contact:
HC&HS – OMU
Calvary and CJJH - IP&C

Responsibilities of OMU / IP&C staff

- Discuss results and arrange follow-up testing
- Continue counselling
- Arrange further vaccination / screening if required

Occupational Exposure management for others

ACT Health Directorate Staff – report ORE to OMU

General Public - report to ED

Police / Ambulance / Emergency Services Staff - report to ED, Canberra Sexual health Centre or manage as per organisation guidelines.

ISS Cleaner – Notify ISS supervisor. Managed by an external service provider.

Contracted staff – report to ED

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Facilities Management

Key points:

Essential components of the Infection Prevention and Control program are:

- Maintenance of equipment and associated environments, and documentation of maintenance/testing processes.
- Consideration of Infection Prevention and Control aspects when selecting and purchasing equipment and products (e.g. how will the equipment be cleaned; can the equipment be cleaned?).
- Infection Prevention and Control must sign off on any proposed renovations before building commences and on completion before hand over to the new occupier.

Contractors:

If personnel are contracted to carry out specific functions within the health care facility, these contractors must perform their work in accordance with the relevant organisational policies and Australian Standards. Written contracts must specify the appropriate Australian Standard that is to be adhered to.

Air Conditioning Units:

Wherever air conditioning units are installed, air purity is to be maintained by regular maintenance of the air conditioning filter.

In areas, which are considered to be air cleanliness sensitive, e.g. Operating Rooms, High Efficiency Particulate Air (HEPA) filters are fitted. Registered testing officers from the National Testing Authority (NATA) inspect these specialised areas regularly. Infection Prevention and Control should see reports on a regular basis.

Cooling Towers:

There is a preventative maintenance program in operation to prevent Legionnella contamination. This consists of regular cooling tower cleaning, water treatment and testing, according to Australian Standard No. AS/NZS 3666:2002, Air-handling and water systems of buildings – Microbial control. Warm water systems must comply with ACT regulations.

Refrigeration Units:

Refrigeration units in all areas are to be checked and maintained according to the schedules documented in the Maintenance/ Engineering Department. Reports should be available for review by Infection Prevention and Control.

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Sterilisers, Washer/ Disinfectors, Ultrasonic cleaners, Aeration cabinets and associated equipment:

The above equipment is to be maintained as per AS 4187 – 2003, Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities. NSW. AGPS.

Documentation/Reports:

A periodic report is to be submitted to the Healthcare Standard 3 Committee, documenting details of all preventative maintenance and repairs performed on the above mentioned equipment.

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Notification of Notifiable Diseases

ACT Health Directorate facilities follow the *Public Health Act 1997* by the mandatory reporting of notifiable diseases to the Public Health Officers within the Communicable Diseases Control Section of ACT Health Directorate. It is important to remember that all Medical Practitioners, Pathology and Authorised Nurse Professionals staff are obligated to report certain infectious diseases to the Communicable Diseases Unit.

Surveillance is important for a number of reasons:

- **Outbreaks/ Intervention**. Early detection of outbreaks of infectious diseases allows for health planning and to evaluate interventions and/or preventative programs.
- **Identify critical trends**. Information provided by notifications indicates the incidence and prevalence of communicable/ infectious diseases in the community. Allows for monitoring so that action can be taken if critical trends emerge, i.e. outbreak or epidemic.
- **Public Health programs.** Identifies important areas for research and allows estimates of the size of a health problem.

Procedures

1. What diseases to notify

- A list of notifiable diseases is in Attachment 1. This list comes from the Reporting of Notifiable Conditions *Public Health Act 1997, Code of Practice 2006.*

2. When to notify

- An initial diagnosis (*suspected or confirmed*) of any of these diseases.

3. Who to notify

- Notify the facility's Infection Prevention and Control Professional.
- The Infection Control Department will notify the Communicable Disease Control (CDC) Unit in the ACT Health Directorate, by telephone or facsimile.
- ACT Pathology is obliged to contact CDC of a notifiable disease either via an automated system or technician initiated.
- The ACT Health Protection Service Public Health Officers may require additional information for follow-up and contract tracing in some cases.
- A non ACT resident requires notification to relevant State Public Health Jurisdictions.

Attachment 1: Infectious and Notifiable Diseases

• Acquired Immunodeficiency Syndrome • Anthrax	○ Lyssa Virus
• Arbovirus infection –	○ Lyssavirus unspecified
○ Dengue Fever	○ Australian Bat Lyssavirus
○ Ross River Virus ○ Murray Valley encephalitis	○ Duvenhague virus
○ Japanese encephalitis	○ Rabies (quarantinable)
○ Arboviral encephalitis	○ European Bat 1&2
○ Barmah Forest Virus	Malaria
○ Arboviral infection (not elsewhere	Measles

specified) o Kunjin Virus o Flavivirus	
• Avian Influenza (quarantinable)	Meningococcal infection
• Botulism	• Mumps
• Brucellosis	• Paratyphoid
• Campylobacteriosis	• Pertussis
• Chlamydial trachomatis	• Plague (quarantinable)
• Cholera (quarantinable)	• Pneumococcal disease (invasive)
• Creutzfedt-Jakob Disease (all forms including classical and variant)	• Poliomyelitis – wild type and vaccine associated
• Cryptosporidiosis	• Psittacosis (Ornithosis)
• Haemloytic uraemic syndrome (HUSS) • Haemophilus influenzae type b infection	o Q Fever
• Diptheria	o Rubella and Congenital Rubella Syndrome
• Donovanosis	• SARS (quarantinable)
• Equine morbillivirus	• Salmonellosis
• Food poisoning (not elsewhere specified)	• Shigellosis
• Gastrointestinal illness cluster	• Shiga Toxin-producing and Vero Toxin-producing
• Giardiasis	• Smallpox (quarantinable
• Gonococcal infection	• Syphilis
• Haemolytic Uraemic Syndrome	• Tetanus
• Haemophilus influenza serotype b (Hib)	• Tuberculosis
• Hepatitis A	• Tularemia
• Hepatitis B	• Typhoid
• Hepatitis C	• Varicella
• Hepatitis C	• Viral haemorrhagic fevers
• Hepatitis D	• Lassa
• Hepatitis (not elsewhere specified) if acquired through infection	• Marburg
• Human Immunodeficiency Virus (HIV) and AIDS	• Ebola
• Influenza (laboratory confirmed)	o Unspecified or unclassified
• Legionnellosis	o Yellow fever
• Leprosy	o Yersiniosis
• Leptospirosis	
• Listeriosis	

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Related Legislation and Policies

ACT Public Health Act 1997 Code of Practice 2006
ACT Public Health Regulation 2000
NSW Public Health (Disposal of Bodies) Regulation 2002

Australian Standards

Australian Standard 4187 – 2003, *Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities.* NSW: Standards Australia.

Australian and New Zealand Standard 3666 – 2002, *Air –handling and water systems of buildings – microbial control.* NSW: Standards Australia.

Standards Australia, AS 4187-2003. *Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of associated environments in health care facilities.* NSW: Standards Australia.

Standards Australia, AS/NZS 4815:2001. *Office based health care facilities not involved in complex patient procedures and processes – Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment.* NSW: Standards Australia

Therapeutic Goods Association, *Therapeutic Goods Order No.54.* Standards for disinfectant and sterilants (1996) and amendments TGO s4a and TGO S4B.

References

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ACT Pathology Microbiology Unit Manual: MB01–*Notification of Infectious Diseases to Public Health*, 2010.

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CONTRACTOR SAFE WORK PRACTICE and COMPLIANCE POLICY

DOCUMENT CONTROL

Document No:	**CED08-033**
Action required:	**Compliance is mandatory**
Document classification:	**Policy**
Authorised by:	**ACT Health Chief Executive**
Authored by:	**Injury Prevention & Management**
Applies to:	**All ACT Health Staff**
Distributed to:	**All ACT Health Staff**
Review date:	**June 2011**

1. POLICY STATEMENT

ACT Health is committed to providing a safe and healthy workplace for its employees, contractors and their employees. ACT Health expects that all employees, contractors, sub contractors and their employees will understand and comply with relevant national, state and local legislation, standards, procedures and best practice in relation to safe work practice. In particular all contractors shall comply with all ACT Health relevant policies and guidelines. ACT Health is to be notified by the contractor prior to commencement of work at any ACT Health site.

2. PURPOSE

The purpose of this policy is to set out ACT Health expectations of contractors working for ACT Health, particularly in relation to the contractor/s implementing safe systems of work and complying with ACT Health safety practices.

A contractor is any company, partnership, other entity, or individual that does not have a direct employment relationship with ACT Health and has an agreement to provide ACT Health with services, product or, in relation to ACT Health infrastructure, carry out construction, alteration, improvement, refurbishment, demolition or other works.

Some individual contractors will meet the definition of an employee of ACT Health as defined by the Occupational Health and Safety Act 1989 and are to be managed in relation to health and safety in the workplace under all other ACT Health policies and guidelines.

5. RESPONSIBILITIES

ACT Health Contract Manager

General

Under the ACT Occupational Health and Safety Act 1989, ACT Health has a duty of care to ACT Health employees whether or not a contractor is in control of the workplace. The ACT Health officer managing the contract of a contractor and the senior managers approving the contract cannot delegate overall safety responsibility.

In administering a contract ACT Health will:

- Obtain and evaluate information regarding the contractor employer's safety performance, safe work practices and programs and ensure that only contractors who have been assessed under the procurement guidelines as meeting the occupational health and safety competence requirements for the work required will be approved to undertake work;
- Require a contractor to submit a comprehensive Occupational Health and Safety plan and/or Safe Work Method Statements for the specific contract undertaken as well as any necessary licences or standards applicable to the approved work. **This will include copies of the contractor's OHS Policy, Workers Compensation Policy and Drug and Alcohol Policy;**
- Provide information and directions to the contractor on ACT Health's safety policies and procedures and guidelines.
- Explain the site Emergency Plan to the contractor and require the contractor to ensure that this information is made available to all employees of the contractor and sub-contractor who will work at the site prior to commencement of work.
- Review all contract requirements related to health and safety with the contractor including but not limited to:
  - Rules, procedures, compliance and reporting
  - Personal protective equipment
  - Special work permits or specialized work procedures, for example hot work permits
  - Emergency signals and procedures that may be put into operation in areas where the contractor's employees may be working
  - Required response to alarms.
- Conduct an inspection of the worksite before work start up so any information about known or potential on-site hazards particularly non-obvious hazards are documented and thoroughly communicated to the contractor. These will include but not be limited to fire, explosion, toxic release, chemicals, creation of dust and noise, concealed services, radiation, biohazards, waste and restricted entry into potentially hazardous areas.
- Ensure that all affected employees of ACT Health receive written notification and training on all hazards to which a contractor will introduce them to during the contract work and limit as necessary the entry of employees into contract work areas.
- During the period of the contract, review and evaluate the contractor's fulfilment of his/her responsibilities and compliance with legislation and ACT Health directions.

contractors need to be signed in as an ACT Health visitor with the appropriate visitors identification;

- Instruct on appropriate behaviour on the worksite, for example that inappropriate language and harassing behaviour is unacceptable and not condoned or tolerated. All employees and sub contractors to be aware and understand ACT Health Code of Conduct.
- Provide a First Aid system and equipment, as per ACT WorkCover Code of Practice - "First Aid in the Workplace";
- Maintain a register of injuries, including notification to ACT Health, of any accident or incident or near miss that occurs at an ACT Health worksite;
- Maintain good housekeeping in the workplace on a daily basis. Remove rubbish from the worksite and maintain the site to be clean and tidy; and
- Prior to the handover of a work site, the site shall be completed to a standard agreed with ACT Health. This should include a pre-handover review by relevant stakeholders, including but not limited to:
  - Infection Control
  - IP&M
  - ACT Health Project Manager
  - Divisional Head, etc

6. CROSS REFERENCE AND FURTHER READING

- ACT Health TCH Contractor Site Safety Handbook

G:\Injury Prevention and Management\HSI

- *Height Safety* – refer to OHS (General) Regulations 2007 and Scaffold and Lifts Regulation 1950
- *Confined Space Entry* – refer to AS 2685 – 1995 located on ACT WorkCover site under *Codes of Practice and OHS (General) Regulations 2007*

ACT Government
Health

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Policy
Health Directorate Waste Management

Policy Statement

To comply with the requirements of:

- the *Clinical Waste Act 1990*), and the
- Australian Standard 3816 (AS/NZS 3816):1998 *Management of Clinical and Related Wastes*, relating to the handling and disposal of waste streams and provision of a safe and healthy work environment for all employees, contractors, patients and visitors

Health Directorate Divisions, Branches and Units will follow processes outlined in the Health Directorate Waste Management Plan.

Compliance requirements include:

- Provision of waste stream guidelines in all areas;
- Provision of the appropriate containers, equipment and systems to support the principles of reduce, reuse and recycle;
- education and training of waste management staff and contractors, about regulatory responsibilities and waste and environment management principles.

Purpose

- The Waste Management Policy and Plan supports divisions, branches and units to comply with the legislation.

Scope

This policy applies to all divisions, branches and units who, in accordance with the principles of waste segregation and minimisation, will handle and dispose of waste according to relevant legislative requirements and standards.

Roles & Responsibilities

- The Business & Infrastructure Domestic & Environmental Services Manager is responsible for the Domestic and Environmental Services contract management, and achievement of agreed deliverables.
- The Domestic & Environmental Services Contractor is responsible for the provision of Domestic and Environmental Services for the Health Directorate, and meeting objectives of waste stream volume and environmental impact.
- All staff will comply with this Policy for the handling of, and disposal of, waste in designated waste streams.

Evaluation

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Outcome Measures
Health Directorate is compliant with the requirements of the Waste Act, the ACT Government Waste Management Strategy and AS/NZS 3816 to prevent or reduce waste generation and harm to people and the environment.

Method
Compliance assurance is managed and monitored regularly via the monthly contract management meetings and as required by the Domestic & Environmental Services Manager with the contractor in relation to deliverables expected to be achieved under the contract such as systems reporting, to resolve any issues.

Related Legislation, Policies and Standards

Legislation
Clinical Waste Act 1990
Radiation Act 1983
Environment Protection Act 1997

Standards
National Occupational Health and Safety Council '*Storage and Handling of Workplace Dangerous Goods*' National Standard [NOHSC: 1015 (2001)]
AS/NZS 3816:1998 *Management of Clinical and Related Wastes*
National Safety & Quality Health Service Standard 3*: Preventing & Controlling Healthcare Associated Infections*

Other
Health Directorate Waste Management Plan

Definition of Terms

Waste streams – different types of waste designated by colour coding or signage and managed according to specific protocols.

Waste stream measurement~~volume~~ – measurement by weight of each waste type.

References

The Australian Council on Healthcare Standards, the ACHS EQuIP5 Guide 2010
Code of Practice for the Management of Clinical and Related Wastes, 6th Edition, 2010
ACT Government's *No Waste by 2010* Strategy

Attachments

Health Directorate Waste Management Plan

INFECTION PREVENTION AND CONTROL POLICY

Document Number:	CED06-008
Publication date:	August 2006
Document Classification:	Policy
Authored by:	Health Care Associated Infections Reference Group, ACT Health
Applies to:	All Clinical Staff of ACT Health
Distributed to:	All Clinical Staff of ACT Health
Replaces Doc. No.:	N/A
Status:	Final
Review date:	June 2009
Authorised by:	CE, ACT Health
Authorising Signature:	

1. Purpose and Scope

The ACT Health Infection Prevention and Control Policy is designed to minimise the risk of patients within our health care system developing infections. The policy is also designed to minimise the risk of health care workers acquiring infections through occupational injury or exposure.

2. Policy

The aim of infection prevention and control is to minimise the infection risks associated with the provision of healthcare. Divisions and streams will have an infection prevention and control program with the following elements;

- Identifies major infection risks in accordance with legislative requirements;
- Ensures any responsibilities relating to notification of diseases are met;
- Ensures staff are instructed in and understand their infection control responsibilities;
- Ensures external service providers, carers and visitors comply with the organisation's infection control requirements;
- Includes a system to assess infection risks, determine priorities and eliminate risks or implement controls; and
- Ensures effective communication of information relating to infection risks to staff, patients and the public.
- Orientation training for all staff and other training where appropriate

The Health Care Associated Infections Reference Group will oversee infection control policy development across all ACT Health Divisions and Streams. A list of the policies and procedures that are to be maintained by this Reference

Annex A:
Legislation or overarching policy:

Food Handling Policy – provides ACT Health Staff with information to ensure high quality food handling standards are initiated, implemented and maintained.

Infection Control for Office Practices and Other Community Based Services Code of Practice 2005 – provides information for office practices and other community based services.

Notification of Infectious Diseases Policy – provides ACT Health staff with information relating to reporting actual or suspected incidents of notifiable infectious diseases and instigating appropriate management strategies (ACT Health Act).

Reporting of Notifiable Conditions Code of Practice 2006 – lists all notifiable conditions.

Single Use Policy – clearly states the position of ACT Health regarding re-use of single use equipment (TGA).

Waste Management Policy – informs staff about the management of waste generated within ACT Health (Clinical Waste Management Act).

Across ACT policy and procedure:

Animals in the Workplace Policy – provides procedural information for ACT Health Staff regarding management of animals in the workplace.

Aseptic Technique Policy – provides ACT Health Staff with information to enable them to consistently and conscientiously practice principles of asepsis.

Disease Specific Infection Control Policies – the manual details guidelines relating to infectious diseases.

Equipment Processing Policy – provides staff with information regarding the safe and effective reprocessing (cleaning, rinsing, drying, packaging, sterilizing and storage) of reusable client care equipment, that is to be used in a sterile site AS 4187.

Fingernail Enhancement Policy – to reduce the possibility of a potential reservoir of pathogenic bacteria, which may result in nosocomial infection when wearing fingernail enhancements whilst administering care.

Environmental Cleaning Policy – informs staff about the requirements for environmental cleaning within ACT Health clinics and premises.

Flowers and Pot Plant Policy – to reduce the possibility of a potential reservoir of pathogenic bacteria which may result in nosocomial infection.

Induced Sputum Collection Policy – ensures that induced sputums are collected in a safe manner for all patients and staff.

Infection Control in the Clinic Setting – provides ACT Health Staff with information to maximise infection prevention and control in the clinic setting.

Infection Surveillance Policy – provides ACT Health Staff with information to enable them to undertake timely, appropriate, and effective monitoring and reporting of received infections in clients, acquired infections in clients, infections in staff members and actual or potential outbreaks of infections.

Pathology Specimen Handling Policy – ensures the safe collection and transport of pathology specimens.

Pest Control and Eradication Policy – provides ACT Health Staff with the information to manage an infestation of pests.

Sterile Stock Policy – to maintain the integrity of sterile stock and supplies and to minimise the risks of damage or contamination from any source, in any clinical, storage or operational setting or environment.

Toys in the Work Place – minimise the risk of the association of toys in the development and transmission of infection in the workplace.

Dengate, Melissa

From: Dengate, Melissa
Sent: Wednesday, 23 December 2009 5:50 PM
To: 'Greg Sims'; 'Karen.farmer@au.issworld.com'
Cc: Bradbury, Ralph
Subject: Helpdesk disposal checklists & process
Attachments: B - Distribution Process - Ref for ACTH Revised 23Dec09.doc; A - Asset Mgt Disposal Checklist - Revised 23Dec09.doc; C - Disposal Checklist -Ref for ACTH - Revised 23Dec09.doc

Hi Greg,

I have attached the revised Assessment Management Checklist for Disposal of Equipment (attachment A) to be trialled at the helpdesk. The trial should highlight if any further amendments may be required.

Also attached are 2 reference documents intended to provide clarification including a flowchart detailing the process for requesting item distribution for repair and disposal (attachment B) and an example of the Checklist to give ACT Health staff an understanding of the questions that will be asked by the Help Desk operators (attachment C).

The dissemination of these documents should assist in a greater understanding of the distribution process overall for ISS and ACT Health staff.

Please advise if you have any issues with the attached. If there are no issues I will forward the reference documents to Irene Lake for circulation to nursing staff and look into approval to post on the ACT Health intranet also.

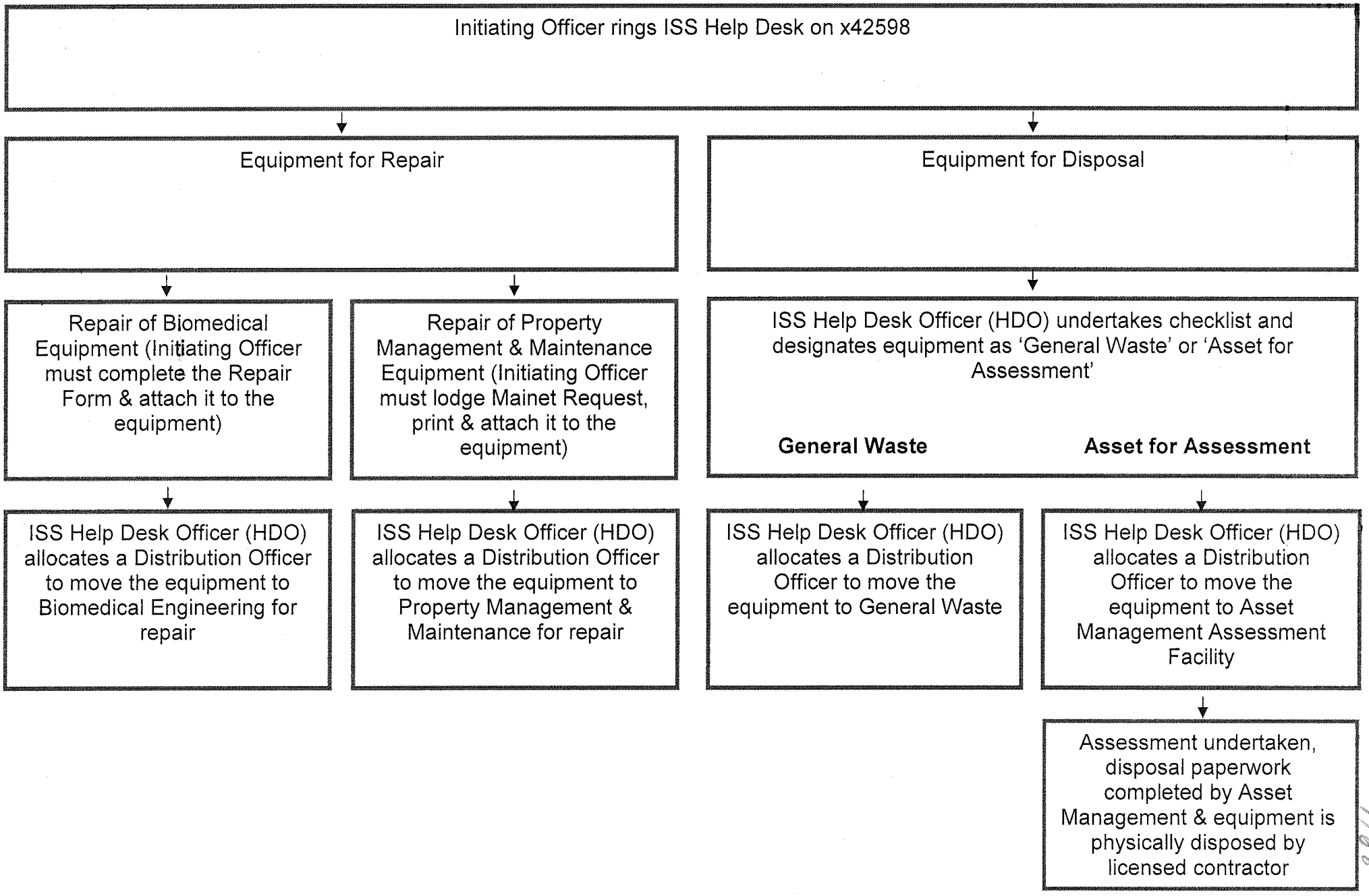
Kind Regards,

Melissa Dengate

Project Officer
Infrastructure Support
Environmental Services
Ph: 6205 8584

Attachment B

Guideline for ACT Health staff to request repair and disposal of equipment via Distribution Service provided by ISS Health Services



Attachment A

ASSET MANAGEMENT CHECKLIST FOR DISPOSAL OF EQUIPMENT

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3 ITEMS MAXIMUM PER JOB – IF MORE, REFER INQUIRY TO MEL DENGATE ON EXT 58584 *JOB REQUEST #:*

Name / Title of Initiating Officer:	
Contact Phone number:	
Initiating Area (name & location):	
Date:	
Comments:	

Description & Detailed Location of Item (eg Chair, Bld 3 Level 2 Room 4)	
Height (approx):	
Width (approx):	
Weight (approx):	

Are there any dangerous substances present? Complete below to determine if Safe to be moved:

If any of the below are ticked, end call & ensure form is collected by Asset Management for action (ext 51825)

Explosive ☐ Toxic Substances ☐ Acids ☐ Medical Gases ☐ Flammable ☐

Asbestos ☐ Radiation ☐ Pathology / Laboratory Items ☐

Does it have a Barcode / Asset Label? **YES**☐ **NO**☐ (End call. Move to General Waste)

If YES complete the below & arrange ISS distribution officer to move it to the Assessment Facility

Barcode / Asset Number:				
The reason for disposal:	Obsolete	☐	Surplus	☐
Is the item in good working order?	Yes	☐	No	☐

Description & Detailed Location of Item (eg Chair, Bld 3 Level 2 Room 4)	
Height (approx):	
Width (approx):	
Weight (approx):	

Are there any dangerous substances present? Complete below to determine if Safe to be moved:

If any of the below are ticked, end call & ensure form is collected by Asset Management for action(ext 51825)

Explosive ☐ Toxic Substances ☐ Acids ☐ Medical Gases ☐ Flammable ☐

Asbestos ☐ Radiation ☐ Pathology / Laboratory Items ☐

Does it have a Barcode / Asset Label? **YES**☐ **NO**☐ (End call. Move to General Waste)

If YES complete the below & arrange ISS distribution officer to move it to the Assessment Facility

Barcode / Asset Number:				
The reason for disposal:	Obsolete	☐	Surplus	☐
Is the item in good working order?	Yes	☐	No	☐

Description & Detailed Location of Item (eg Chair, Bld 3 Level 2 Room 4)	
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Asbestos ☐ Radiation ☐ Pathology / Laboratory Items ☐

Does it have a Barcode / Asset Label? **YES**☐ **NO**☐ (End call. Move to General Waste)

If YES complete the below & arrange ISS distribution officer to move it to the Assessment Facility

Barcode / Asset Number:				
The reason for disposal:	Obsolete	☐	Surplus	☐
Is the item in good working order?	Yes	☐	No	☐

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BELOW IS A SAMPLE CHECKLIST DETAILING THE INFORMATION ACT HEALTH STAFF NEED TO PROVIDE TO ISS HELPDESK OFFICERS FOR ITEM DISPOSAL REQUESTS.

(THE CHECKLISTS ARE COMPLETED AND ACTIONED BY ISS HELPDESK OFFICERS)

ASSET MANAGEMENT CHECKLIST FOR DISPOSAL OF EQUIPMENT

3 ITEMS MAXIMUM PER JOB – IF MORE, REFER INQUIRY TO MEL DENGATE ON EXT 58584

Name / Title of Initiating Officer:	
Contact Phone number:	
Initiating Area (name & location):	
Date:	
Comments:	

Description & Detailed Location of Item (eg Chair, Bld 3 Level 2 Room 4)	
Height (approx):	
Width (approx):	
Weight (approx):	

Are there any dangerous substances present? Complete below to determine if Safe to be moved:

If any of the below are ticked, end call & ensure form is collected by Asset Management for action (ext 51825)

Explosive ☐ Toxic Substances ☐ Acids ☐ Medical Gases ☐ Flammable ☐

Asbestos ☐ Radiation ☐ Pathology / Laboratory Items ☐

Does it have a Barcode / Asset Label? **YES**☐ **NO**☐ (End call. Move to General Waste)

If YES complete the below & arrange ISS distribution officer to move it to the Assessment Facility

Barcode / Asset Number:				
The reason for disposal:	Obsolete	☐	Surplus	☐
Is the item in good working order?	Yes	☐	No	☐