BELLA MOSS
FOUNDATION

Clinical Hygiene Guidelines For Veterinary Practices

INFECTION CONTROL EDUCATION FOR VETS NURSES AND OWNERS

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Clinical Areas

Peri-Clinical Areas

Non-Clinical Areas

Procedures

Staff Training Material

For Public Use

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Clinical Areas

- Consulting Room
- Operating Theatre
- Imaging Suite
- Medical Prep Area

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Clinical Areas

Consulting Room

Have clean consulting rooms for elective admits and vaccination; dirty ones for medical cases...

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
CONSULTING TABLE	After each patient	As soon as patient leaves, spray with detergent, wipe down with paper towel. Then respray with disinfectant, allow to dry naturally whilst you write up notes, Rx meds and prepare for next patient, then dry if required.	Dispose of paper wipes after use.	Vet	If you have used your room for a potentially infectious case, call nurse/auxiliary to sanitise room whilst you move to alternate room.
DOOR HANDLES	Wipe down between every consulting period	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary	Good working practices should minimise contamination over time
SINK	Full clean at midday and at end of day	Cream cleanser disposable cloth & rinse. Ensure cleaning of taps, plugs and other associated items. Disinfectant/bleach into plughole. Deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary	
FLOORS	At midday and end of each day or after each consulting session as necessary	Wet mop with detergent then mist with disinfectant. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Nurse/auxiliary	Consulting room floors are a particular risk as walked into by clients with outdoor shoes.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
COMPUTER KEYBOARD & SCREEN	Clean keyboards once daily or after infectious patient. Clean screens daily, disinfect by fogging daily, deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down. Disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	Use waterproof keyboard cover
REFERENCE MATERIALS	Daily wipe down posters & booklets. Weekly dispose of damaged leaflets	Disinfectant with disposable cloth	Dispose of cloth/wipes after use	Nurse/auxiliary	Discard as necessary
SHELVES/WORK TOP	Weekly	Disposable cloth & detergent, then spray disinfectant. Disinfect by fogging daily with room.	Dispose of cloth after use.	Nurse/auxiliary	Avoid shelves and other dust traps e.g. above cupboards if at all possible.
SCALES	Wipe down after every use. Full clean after each consulting session.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
OTOSCOPE AUROSCOPE	After each use	Wipe handle with detergent & disposable cloth. Clean cone with brush or speculum cleaner, then disinfectant	Dispose of wipe after use.	Nurse/auxiliary	
STETHOSCOPE, NAIL CLIPPERS ETC..	After each use	Disinfectant wipes or alcohol gel; Deep clean with biofilm removal twice weekly.	Dispose of wipe after use.	Vet/Nurse/ auxiliary	Encourage each staff member to have their own and mange hygiene personally.
SPRAY BOTTLES	At end of each consulting session	Wipe outside of bottle with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	Ensure any disinfectant used by spray is safe to be used in this way.
THERMOMETER	Clean immediately following use	Preferably use disposable thermometer cover, and wipe using single use cloth/swab soaked in disinfectant.	Dispose of wipe after use.	Vet/nurse	
SEAT/STOOL	At end of each consulting session, Deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of wipe after use.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FRIDGE	Daily clean door handles. Weekly – sanitise inside & out	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of wipe after use.	Nurse/auxiliary	
WALLS	Spot-clean as required. Weekly damp wipe. Weekly deep clean, with biofilm removal. Daily disinfect by fogging with rest of room.	Remove dust from all horizontal surfaces with damp cloth daily. Disinfect by fogging room daily. Wash down walls weekly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage
DOORS	Wipe down once daily with detergent-soaked disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Disposable cloth bucket & detergent, spray with disinfectant then wipe down with disposable cloth, leaving damp for contact time. Deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage
PLUGS, SWITCHES	Daily	Wipe down once daily with detergent- dampened disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Dispose of cloth after use.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
RADIATORS	Disinfect by fogging daily, deep clean monthly.	Weekly wipe down with detergent-soaked cloth, then spray with disinfectant and wipe down with microfiber disposable cloth. Disinfect by fogging at end of each day.	Dispose of cloth after use.	Nurse/auxiliary	
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Ensure blinds are cleanable or avoid installing. Check & discard if damaged or uncleanable
WINDOWS	Clean glass weekly. Dust and wipe windowsills daily. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Disposable cloth bucket, glass cleaning solution. Windowsills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.

- Correct WHO hand wash procedure in consulting room is essential, i.e. wash hands effectively before and after handling any animal before you touch any other surface (e.g. door handle, taps, keyboard, phone).
- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Clinical Areas

Imaging suite

INFECTION CONTROL EDUCATION FOR VETS NURSES AND OWNERS

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOOR HANDLES	Before and after each imaging session	Detergent soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary	Good working practices should minimise contamination over time
X-RAY TABLE	Before and after each imaging session and between each patient, weekly biofilm removal at deep clean. Disinfection daily by fogging with room.	As above	Dispose of cloth after use.	Vet/Nurse	
CONSULTING US TABLE	After each patient & as above	As above	Dispose of cloth after use.	Vet/Nurse	
IMAGING CONTROLS INCLUDING X-RAY TRIGGER SWITCH & COLUMNATION CONTROLS	Any direct or hand touch item must be sanitised before next patient, including cassette. Clean & disinfect daily, fog and deep clean as above	As above	Dispose of microfiber cloth after use	Nurse	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WORKTOP	After each imaging session, daily, fog and deep clean as above	As above	Dispose of microfiber cloth after use	Nurse	
FLOORS	At the end of each day or if significant contamination occurs	Wet mop with detergent daily. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Nurse/auxiliary	
DIGITAL X-RAY KEYBOARD & SCREEN	Clean keyboards once daily or after infectious patient. Clean screens daily, disinfect by fogging daily, deep clean weekly.	Detergent damp cloth or disposable wipes the disinfectant	Dispose of cloth/wipes after use	Nurse	Use waterproof keyboard cover
REFERENCE MATERIALS	Daily wipe down posters & booklets. Weekly dispose of damaged leaflets	Disinfectant with disposable cloth	Dispose of cloth/wipes after use	Nurse	Discard as necessary
PATIENT RESTRAINT DEVICES	After each occasion of use and at the end of the day.	Disposable cloth & detergent, then spray disinfectant.	Dispose of cloth/wipes after use	Nurse	Ensure these are made with cleanable surfaces, replaced when no longer waterproof.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SHELVES	Weekly	Disposable cloth & detergent, then spray disinfectant.	Dispose of cloth/wipes after use	Nurse/auxiliary	
PPE	Weekly unless contaminated	Disposable cloth and detergent then spray with disinfectant.	Dispose of cloth after use.	Nurse/auxiliary	Always store carefully to avoid damage
WALLS	Spot clean as required. Weekly damp wipe. Monthly deep clean, with biofilm removal. Daily disinfect by fogging	Remove dust from horizontal surfaces with damp cloth weekly, Disinfect by fog with room daily. Wash down walls monthly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manager
DOORS	Wipe down once daily with detergent, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Disposable cloth bucket & detergent	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage
RADIATORS	Disinfect by fogging daily, deep clean monthly.	Disposable cloth.	Dispose of cloth after use.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Check & discard if damaged or uncleanable
WINDOWS	Clean glass weekly. Dust wipe window ledges daily, Disinfect by fogging daily, deep clean every 2 weeks, with biofilm removal.	Disposable cloth bucket, glass cleaning solution. Window sills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.

- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Clinical Areas

Operating theatre

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
OPERATING TABLE	After every use	Disposable cloth, detergent, then disinfectant, ensuring concentration and contact time, fog disinfect with room daily. Deep clean with biofilm removal twice weekly.	Dispose of after use. Store bucket/bowl dry.	Nursing / auxillary staff	
DOOR HANDLES	Wipe down twice daily. Spot-clean any contamination at other times	Disposable cloth and detergent, then spray with disinfectant and allow to dry, fog disinfect with room daily.	Dispose of after use. Store bucket/bowl dry.	Nursing / auxillary staff	
FLOOR	Vacuum / sweep and mop between procedures. Full clean at the end of day	Vacuum / sweep and mop. Colour coded microfibre mop and bucket. Full clean at the end of day. Deep clean with biofilm removal twice weekly.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry. Mop head disinfected daily.	Nursing / auxillary staff	Must be deep cleaned at least twice weekly, or prior to any high-risk procedure.
SINKS	Clean at least at the end of the day	Scrub with abrasive cleaner (e.g. Cif), then rinse and spray disinfect. Bleach the drains at least once daily.	Dispose of cloth after use.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SOAP DISPENSERS	Wipe clean at least twice daily	Disposable cloth and spray disinfectant, fog disinfect with room daily.	Dispose of cloth after use.	Nursing / auxillary staff	
PATIENT MONITOR	Clean after use by each patient or whenever soiled	Clean with detergent. Spray with disinfectant, appropriate concentration and contact time. Disinfect by fogging with room daily. Clean and spray disinfect after each patient use.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty.	Nursing / auxillary staff	A common and underrated fomite.
ANAESTHETIC MACHINE	Clean and disinfect hand touch sites between patients, e.g. O2 flow valve and % volatile agent controls.	Cloth and detergent, then spray disinfectant allow to dry naturally.	Dispose of cloth after use.	Theatre nurse	
ANAESTHETIC CIRCUITS	Clean touch and connection points, and disinfect between patients	Detergent clean touch & connection points after each use, clean outside once daily, then spray disinfect and allow to dry, fog disinfect with room daily or change when contaminated.		Theatre nurse	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
THEATRE LIGHT MOBILE	Clean at end of day. Disinfect touch points between patients.	Wipe down with detergent cloth, then spray disinfect then allow to dry naturally. Deep clean with biofilm removal once weekly, fog disinfect with room at end of each day.	Dispose of cloth after use.	Nursing auxillary	
THEATRE LIGHT FIXED	Clean at end of day. Disinfect touch points between patients.	Wipe down with detergent cloth, then spray disinfect then allow to dry naturally. Deep clean with biofilm removal once weekly, fog disinfect with room at end of each day.	Dispose of cloth after use	Nursing / auxillary staff	Often overlooked despite hanging over surgical patients. Nursing staff may require convenient steps to reach top of lamp.
STOOL / SEAT	Clean after use or if soiled, disinfect at least daily.	Washing with warm water and washing up liquid, disinfect spray and allow to dry, fog disinfect at end of each day.	Dispose of cloth daily.	Nursing / auxillary staff	
ET TUBES	Disposable or clean between patients with enzymatic detergent. Deep clean with biofilm removal weekly, Disinfect by fogging daily with room.	Soak in disinfectant, then wash on hot machine wash.	Wash after each use.	Nursing / auxillary staff	Store in clean, closed storage.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
INSTRUMENT AND OTHER TROLLEYS, KICK STANDS.	Clean and spray disinfect between patients. Clean at end of operating, disinfect, deep clean with biofilm removal 2x a week.	Clean with detergent soaked cloth between patients, then spray disinfect and allow to dry naturally. Thorough clean at end of theatre schedule, spray disinfect and allow to dry naturally. Deep clean 2x week with biofilm removal. Disinfect by fogging daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	
WALLS	Wash down walls daily. Spot-clean any dirty areas between procedures. Disinfect by fogging daily, with rest of room.	Disposable cloth, spray disinfectant, disinfectant fog daily with room, deep clean twice weekly or after patient leaves.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
DOORS	Wipe down at least once daily. Spot-clean any dirty areas between procedures. Fog disinfect with room daily.	Disposable cloth, spray disinfectant, disinfectant fog with room daily. Deep clean with biofilm removal when patient leaves or weekly.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
CEILING	Vacuum / Dust daily wipe down weekly. Fog disinfect with room daily.	Disposable cloth and extending handle, fog disinfectant daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
BLINDS	Clean daily, or sooner if visibly contaminated, fog disinfect with room daily.	Disposable cloth and spray disinfectant, or washing machine, fog disinfect daily with room.	Dispose of cloth after use. Store bucket / bowl dry. See laundry policy.	Nursing / auxillary staff	Blinds must be cleanable and disinfectable.
WINDOWS	Clean glass weekly. Dust, wipe, fog disinfect with room daily.	Disposable cloth, spray disinfectant, fog disinfect with room daily. Deep clean windowsill weekly, with biofilm removal.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
RADIATORS	Wipe down daily, fog disinfect with room daily.	Disposable cloth	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
AIR CON UNITS	Deep clean weekly, fog with room daily.	Vacuum cleaner, disposable cloth, deep clean with biofilm remover, spray with disinfectant allow to dry naturally. Fog with disinfectant daily.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry.	Nursing / auxillary staff	
EXTRACTOR FANS	Dismantle and deep clean internally and externally weekly, fog with room daily.	Disposable cloth	Dispose of cloth after use.	Nursing / auxillary staff	

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Clinical Areas

Medical Prep Area

INFECTION CONTROL EDUCATION FOR VETS NURSES AND OWNERS

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
STAFF – SEE ATTIRE SEE PPE	Change uniform as required				Wear appropriate PPE prior to physical contact with any patient.
EXAMINATION TABLE	After each use	After use spray with detergent, wipe down with paper towel. Then respray with disinfectant, allow to dry naturally whilst you prepare for next use. After contact time wipe with dry paper towel if required.	Dispose of paper wipes after use.	Vet	If you have used area for a potentially infectious case, sanitise prior to re-use.
DOOR HANDLES	Wipe down at least daily.	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary	Good working practices should minimise contamination over time
FLOORS	At midday and end of each day.	Wet mop with detergent then mist with disinfectant. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
COMPUTER KEYBOARD & SCREEN	Clean keyboards once daily or after infectious patient. Clean screens daily, disinfect by fogging daily, deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	Use waterproof keyboard cover
SHELVES/WORK TOP	Daily	Disposable cloth & detergent, then spray disinfectant. Disinfect by fogging daily with room. Deep clean with biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	Avoid shelves and other dust traps e.g. above cupboards if at all possible.
SCALES	Wipe down after every use. Full clean at end of day or after any use by a potentially infectious patient.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	
ANAESTHETIC MACHINE	Wipe down after every use. Full clean after each consulting session.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
ANAESTHETIC CIRCUITS	Clean touch and connection points, and disinfect between patients	Detergent clean touch & connection points after each use, clean outside once daily, then spray disinfect and allow to dry, fog disinfect with room daily, or change when contaminated	Dispose of cloth/wipes after use	Nurse/auxiliary	
EXAMINATION LIGHT	Clean at end of day. Disinfect touch points between patients.	Wipe down with detergent cloth, then spray-disinfect, then allow to dry naturally. Deep clean with biofilm removal once weekly, fog disinfect with room at end of each day.	Dispose of cloth/wipes after use	Nurse/auxiliary	
OTOSCOPE AUROSCOPE	After each use	Wipe handle with detergent & disposable cloth. Clean cone with brush or speculum cleaner then disinfectant	Dispose of wipe after use.	Nurse/auxiliary	
PATIENT MONITORS, STETHOSCOPE, NAIL CLIPPERS ETC..	After each use	Disinfectant wipes or alcohol gel; Deep clean with biofilm removal twice weekly, in accordance with manufacturers' recommendations	Dispose of wipe after use.	Vet/Nurse/auxiliary	Encourage each staff member to have their own and manage hygiene personally.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SPRAY BOTTLES	At end of each consulting session	Wipe outside of bottle with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	Ensure any disinfectant used by spray is safe to be used in this way.
THERMOMETER	Clean immediately following use	Preferably use disposable thermometer cover, and wipe using single use cloth/swab soaked in disinfectant.	Dispose of wipe after use.	Vet/Nurse	
SEAT / STOOL	At end of each consulting session, Deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of wipe after use.	Nurse/auxiliary	
WALLS	Spot clean as required. Weekly damp wipe. Weekly deep clean, with biofilm removal. Daily disinfect by fogging with rest of room.	Remove dust from all horizontal surfaces with damp cloth daily, Disinfect by fog with room daily. Wash down walls weekly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOORS	Wipe down once daily with detergent-soaked disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Disposable cloth bucket & detergent, spray with disinfectant then wipe down with disposable cloth, leaving damp for contact time. Deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage
PLUGS, SWITCHES	Daily	Wipe down once daily with detergent dampened disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Dispose of cloth after use.	Nurse/auxiliary	
RADIATORS	Disinfect by fogging daily, deep clean monthly.	Weekly wipe down with detergent soaked cloth, then spray with disinfectant and wipe down with microfiber disposable cloth. Disinfect by fogging at end of each day.	Dispose of cloth after use.	Nurse/auxiliary	
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Ensure any blinds are cleanable or avoid installing. Check & discard if damaged or uncleanable

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WINDOWS	Clean glass weekly. Dust wipe window ledges daily. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Disposable cloth bucket, glass cleaning solution. Windowsills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.

- Correct WHO hand wash procedure in consulting room is essential, i.e. wash hands effectively before and after handling any animal before you touch any other surface (e.g. door handle, taps, key board, phone).
- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Peri-Clinical Areas

- Dispensary
- Kennel Wards
- Isolation Ward
- Laboratory

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Peri Clinical Areas

Dispensary

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOOR HANDLES	Wipe down at least daily.	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary	Good working practices should minimise contamination over time
FLOORS	At end of each day.	Wet mop with detergent then mist with disinfectant. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Nurse/auxiliary	
COMPUTER KEYBOARD & SCREEN	Clean keyboards once daily or after infectious patient. Clean screens daily, disinfect by fogging daily, deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	Use waterproof keyboard cover
REFERENCE MATERIAL	Daily Wipe down posters & booklets. Dispose of damaged leaflets	Disposable detergent damp cloth, disinfect by fogging with room at end of day.	Dispose of cloth/wipes after use	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SHELVES/WORK TOP	Daily	Disposable cloth & detergent, then spray disinfectant. Disinfect by fogging daily with room. Deep clean with biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	Avoid shelves and other dust traps e.g. above cupboards if at all possible.
SINKS	Full clean at end of each day	Cream cleanser disposable cloth & rinse. Ensure cleaning of taps, plugs and other associated items. Disinfectant/bleach into plughole. Deep clean with biofilm removal weekly.	Dispose of cloth/wipes after use	Nurse/auxiliary	
LABEL PRINTER	Wipe clean at midday at end of each day	Wipe with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	
PILL COUNTER	Wipe clean after each use	Wipe with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	
DRUGS OUT BASKET	Empty and wipe clean at end of each day	Wipe with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SPRAY BOTTLES	At end of each consulting session	Wipe outside of bottle with detergent & disposable disinfectant-soaked cloth	Dispose of wipe after use.	Nurse/auxiliary	Ensure any disinfectant used by spray is safe to be used in this way.
SEAT / STOOL	At end of each consulting session. Deep clean weekly.	Detergent damp cloth or disposable wipes then disinfectant wipe down, disinfect by fogging at end of each day. Deep clean and biofilm removal weekly.	Dispose of wipe after use.	Nurse/auxiliary	
WALLS	Spot clean as required. Weekly damp wipe. Weekly deep clean, with biofilm removal. Daily disinfect by fogging with rest of room.	Remove dust from all horizontal surfaces with damp cloth daily, Disinfect by fogging with room daily. Wash down walls weekly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage
DOORS	Wipe down once daily with detergent-soaked disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Disposable cloth bucket & detergent, spray with disinfectant then wipe down with disposable cloth, leaving damp for contact time. Deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Report any areas of damaged paintwork to practice manage

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
PLUGS, SWITCHES	Daily	Wipe down once daily with detergent dampened disposable microfiber cloth, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Dispose of cloth after use.	Nurse/auxiliary	
RADIATORS	Disinfect by fogging daily, deep clean monthly.	Weekly wipe down with detergent-soaked cloth, then spray with disinfectant and wipe down with microfiber disposable cloth. Disinfect by fogging at end of each day.	Dispose of cloth after use.	Nurse/auxiliary	
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	Ensure any blinds are cleanable or avoided. Check & discard if damaged or uncleanable
WINDOWS	Clean glass weekly. Dust wipe window ledges daily. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Disposable cloth bucket, glass cleaning solution. Windowsills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Nurse/auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Nurse/auxiliary	Ensure they are regularly serviced.

- Correct WHO hand wash procedure in consulting room is essential, i.e. wash hands effectively before and after handling any animal before you touch any other surface (e.g. door handle, taps, key board, phone).
- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Peri Clinical Areas

Isolation Ward

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FOOTBATH	At least twice daily or if visibly soiled	Clean/scrub with disposable cloth, with detergent, then refill with fresh disinfectant, correct concentration.	Dispose of cloth after use.	Nursing / auxiliary staff	May be better to change footwear
EXAMINATION TABLE	After every use	Disposable cloth, detergent, then disinfectant, ensuring concentration and **contact time,** fog disinfect with room daily. Deep clean with biofilm removal twice weekly.	Dispose of cloth after use. Store bucket/bowl dry.	Nursing / auxillary staff	Isolation rooms tend to be under used, with incorrect barrier nursing procedures and rarely adequately cleaned after use. Better use and improved procedures are essential.
DOOR HANDLES	Wipe down twice daily. Spot clean any contamination at other times	Disposable cloth and detergent, then spray with disinfectant and allow to dry, fog disinfect with room daily.	Dispose of cloth after use. Store bucket/bowl dry.	Nursing / auxillary staff	
SINKS	Clean at least at the end of the day	Scrub with abrasive cleaner (e.g. Cif), then rinse and spray disinfect. Bleach the drains at least once daily.	Dispose of cloth after use.	Nursing / auxillary staff	Often cleaned inadequately

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SOAP DISPENSERS	Wipe clean at least twice daily	Disposable cloth and spray disinfectant, fog disinfect with room daily.	Dispose of cloth after use.	Nursing / auxillary staff	
FLOOR	Vacuum / sweep and mop between procedures. Full clean at the end of day	Vacuum / sweep and mop. Colour coded microfibre mop and bucket. Full clean at the end of day. Deep clean with biofilm removal twice weekly. Disinfect by fogging with room daily.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry. Mop head disinfected daily.	Nursing / auxillary staff	Must be deep cleaned after patients leave.
KENNEL DOORS	Clean after use by each patient or whenever soiled	Clean with detergent. Spray with disinfectant, at appropriate concentration and contact time. Clean and spray disinfect after each any patient leaves. Disinfect by fogging with room daily. Deep clean with biofilm removal twice weekly.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty.	Nursing / auxillary staff	A common and underrated fomite
FOMITES (BOWLS, FORK, SPOONS)1	Clean after use, disinfect at least daily	Washing with warm water and washing up liquid, disinfect by submersion for contact time, dry naturally.	Dispose of cloth daily.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
LEADS 1	Clean when soiled, preferably dispose after each patient	Soak in disinfectant, then wash on hot machine wash.	Wash at least once daily.	Nursing / auxiliary staff	
BEDDINGS 1	See laundry protocol				
CAGES/BASKETS	Clean after use by each patient, or whenever soiled	Preferably achieve by submersion, detergent first, then disinfectant for appropriate contact time, allow to dry naturally.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty or sooner if indicated.	Nursing / auxillary staff	Client's baskets and cages should never be admitted. Practice cages etc should be easily cleaned and disinfected by submersion.
CLIPBOARDS/ DOOR FURNISHINGS	Clean after use for each patient, or whenever soiled	Clean using detergent then disinfect with damp cloth/spray, then disinfect by fogging daily. Deep clean when patient leaves/ weekly.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty or sooner if indicated.	Nursing / auxillary staff	
SPRAY BOTTLES	At least twice daily	Wipe with disinfectant-soaked disposable cloth. Deep clean with biofilm removal after each use of room. Daily disinfection by fogging with room.	Dispose of cloth after use.	Nursing / auxiliary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
THERMOMETERS	Clean immediately after each use	Preferably use thermometer covers, wipe with disinfectant-soaked single use swab. Deep clean with biofilm removal when patient leaves room.	Dispose of cloth / swab after each use.	Nursing / auxillary staff	
SWITCHES & SOCKETS	Clean once daily	Wipe with disinfectant cloth, fog disinfect daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	
STAFF	See attire protocol				
WASTE BIN	Empty and clean at least daily, more often if contaminated	Disposable cloth and detergent, then spray disinfectant. Deep clean after patient leaves, biofilm removal, fog disinfect.	Dispose of cloth after use. Store upside down until dry, place new liner.	Nursing / auxiliary staff	
TERMINAL CLEAN	After each infectious patient leaves	Disposable cloth with disinfectant spray, biofilm removal, then fog disinfection.	Dispose of cloth after use.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WALLS	Wash down walls daily. Spot clean any dirty areas between procedures. Disinfect by fogging daily, with rest of room.	Disposable microfiber cloth, hand spray with disinfectant, disinfectant fog daily with room, deep clean once weekly with biofilm removal.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
DOORS	Wipe down at least once daily. Spot clean any dirty areas between procedures. Fog disinfect with room daily.	Disposable cloth, spray disinfectant, disinfectant fog with room daily. Deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
CEILING	Vacuum / Dust daily wipe down weekly. Fog disinfect with room daily.	Disposable cloth and extending handle, fog disinfectant daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	
BLINDS	Blinds should not be used in a ward area. If the room must be darkened use cleanable solid plastic shutters.	Wipe down with disinfectant-soaked disposable cloth, fog disinfect daily with room.	Dispose of cloth after use. Store bucket / bowl dry. See laundry policy.	Nursing / auxillary staff	Blinds must be cleanable and disinfectable.
WINDOWS	Clean glass weekly. Dust, wipe, fog disinfect with room daily.	Disposable cloth, spray disinfectant, fog disinfect with room daily. Deep clean windowsill weekly, with biofilm removal.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
RADIATORS	Wipe down daily, fog disinfect with room daily.	Wipe down with detergent soaked disposable cloth daily, deep clean with biofilm removal weekly. Disinfectant fog with rest of room daily.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
AIR CON UNITS	Deep clean weekly, fog with room daily.	Vacuum cleaner, disposable cloth, deep clean with biofilm remover, spray with disinfectant allow to dry naturally. Fog with disinfectant daily.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry.	Nursing / auxillary staff	
EXTRACTOR FANS	Dismantled and deep clean internally and externally weekly, fog with room daily.	Disposable cloth.	Dispose of cloth after use.	Nursing / auxillary staff	

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Kennel Wards

INFECTION CONTROL EDUCATION FOR PETS AND VETS

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
EXAMINATION TABLE	After every use Disinfect by fogging at end of day, weekly deep clean with biofilm removal.	Disposable cloth, detergent, then disinfectant, ensuring concentration and contact time, fog disinfect with room daily. Deep clean with biofilm removal at least weekly increased frequency if infection event has occurred	Dispose of after use. Store bucket/bowl dry.	Nursing / auxillary staff	After any gross faecal/ diarrhoea event, biofilm removal may be necessary.
DOOR HANDLES	Wipe down twice daily. Spot clean any contamination at other times	Disposable cloth and detergent, then spray with disinfectant and allow to dry, wipe with disinfectant soaked microfiber cloth twice during each day. Fog disinfect with room daily.	Dispose of after use. Store bucket/bowl dry.	Nursing / auxillary staff	Ensure proper hand washing by all staff before and after handling any patient and after cleaning cages.
SINKS	Clean at least at the end of the day and after any significant contamination event.	Scrub with abrasive cleaner (e.g. Cif), then rinse and spray disinfect. Bleach the drains at least once daily.	Dispose of cloth after use.	Nursing / auxillary staff	Often cleaned inadequately
SOAP DISPENSERS	Wipe clean at least twice daily	Disposable cloth and spray disinfectant, fog disinfect with room daily.	Dispose of cloth after use.	Nursing / auxillary staff	

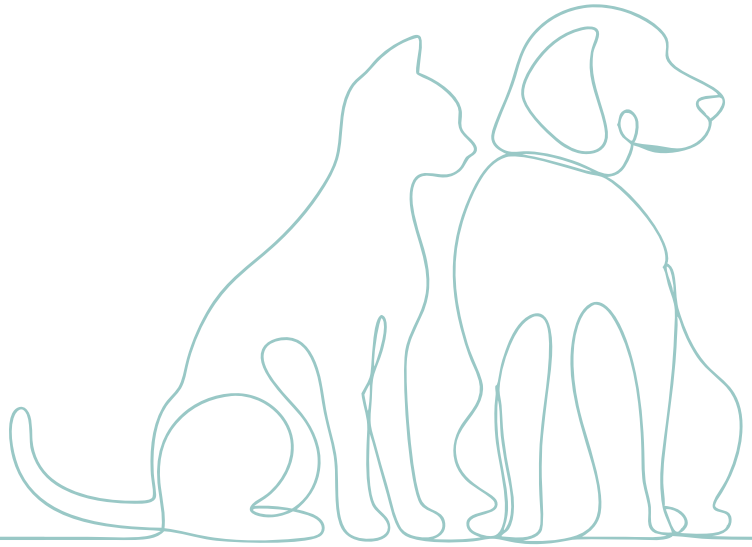
	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FLOOR	Vacuum / sweep and mop midday. Full clean at the end of day	Vacuum / sweep and mop. Colour coded microfibre mop and bucket. Full clean at the end of day. Fog disinfect with room at end of each day. Deep clean with biofilm removal twice weekly.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry. Mop head disinfected daily.	Nursing / auxillary staff	Must be deep cleaned after patients leave.
KENNEL DOORS	Clean after use by each patient or whenever soiled	Clean with detergent. Spray with disinfectant, appropriate concentration and contact time. Disinfect by fogging with room daily. Clean and spray disinfect after each use. Deep clean with biofilm removal at least weekly or after any significant diarrhoea event.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty.	Nursing / auxillary staff	Every cage must be properly recleaned prior to use by a new patient.
FOMITES (BOWLS, FORK, SPOONS) 1	Clean after use, disinfect at least daily	Washing with warm water and washing up liquid, disinfect by submersion for contact time, dry naturally.	Dispose of cloth daily.	Nursing / auxillary staff	
LEADS 1	Clean when soiled, preferably dispose after each patient	Soak in disinfectant, then wash on hot machine wash.	Wash at least once daily.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
BEDDING 1	See laundry protocol				
CAGES/BASKETS	Clean after use by each patient, or whenever soiled	Preferably achieve by submersion, detergent first, then disinfectant for appropriate contact time, allow to dry naturally.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	Clients' baskets and cages should never be admitted. Practice cages etc should be easily cleaned by submersion, prior to disinfection by submersion.
CLIPBOARDS/ DOOR FURNISHINGS	Clean after use for each patient, or whenever soiled	Clean using detergent then disinfect with damp cloth/spray, then disinfect by fogging daily. Deep clean when patient leaves/ weekly.	Dispose of cloth after use. Store bucket / bowl dry. Clean disinfectant spray bottles once empty or sooner if indicated.	Nursing / auxillary staff	
SPRAY BOTTLES	At least twice daily	Wipe with disinfectant-soaked disposable cloth. Deep clean with biofilm removal after each use of room. Daily disinfection by fogging with room.	Dispose of cloth after use.	Nursing / auxillary staff	
THERMOMETERS	Clean immediately after each use	Preferably use thermometer covers, wipe with disinfectant-soaked single use swab. Deep clean with biofilm removal after any infectious event or every 48 hours	Dispose of cloth / swab after each use.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SWITCHES & SOCKETS	Clean once daily	Wipe with disinfectant cloth, fog disinfect daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	
STAFF	See attire protocol				
WASTE BIN	Empty and clean at least daily, more often if contaminated	Disposable cloth and detergent, then spray disinfectant. Deep clean and biofilm removal weekly.	Dispose of cloth after use. Store upside down until dry, place new liner.	Nursing / auxillary staff	
TERMINAL CLEAN	Any effected area, after each infectious patient leaves	Disposable detergent soaked cloth then spray disinfect, disinfectant fog daily with room	Dispose of cloth after use.	Nursing / auxillary staff	
WALLS	Wash down walls daily. Spot clean any dirty areas between procedures. Disinfect by fogging daily, with rest of room.	Disposable cloth, spray disinfectant, disinfectant fog daily with room, deep clean once weekly or after infectious patient leaves.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOORS	Wipe down at least once daily. Spot clean any dirty areas between procedures. Fog disinfect with room daily.	Disposable detergent soaked cloth, spray disinfectant, fog disinfect with room daily. Deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
CEILING	Vacuum / Dust daily wipe down weekly. Fog disinfect with room daily.	Disposable cloth and extending handle, fog disinfectant daily with room.	Dispose of cloth after use.	Nursing / auxillary staff	
BLINDS	Do not use blinds in a ward area, if you need to darken the ward, use solid plastic wipeable shutters.	Disposable detergent soaked cloth, spray disinfectant, or washing machine, fog disinfect daily with room.	Dispose of cloth after use. Store bucket / bowl dry. See laundry policy.	Nursing / auxillary staff	Blinds in a ward environment must be cleanable and disinfect able.
WINDOWS	Clean glass weekly. Dust, wipe, fog disinfect with room daily.	Disposable detergent soaked cloth, spray disinfectant, fog disinfect with room daily. Deep clean windowsill weekly, with biofilm removal.	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	
RADIATORS	Wipe down daily, fog disinfect with room daily.	Disposable detergent soaked cloth	Dispose of cloth after use. Store bucket / bowl dry.	Nursing / auxillary staff	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
AIR CON UNITS	Deep clean weekly, fog with room daily.	Vacuum cleaner, disposable cloth, deep clean with biofilm remover, spray with disinfectant allow to dry naturally. Fog with disinfectant daily.	Empty bag on vacuum cleaner at end of day. Mop bucket cleaned after use & stored inverted to dry.	Nursing / auxillary staff	
EXTRACTOR FANS	Dismantled and deep clean internally and externally weekly, fog with room daily.	Disposable cloth.	Dispose of cloth after use.	Nursing / auxillary staff	Foul air must be extracted i.e. externally from any ward area.



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Peri Clinical Areas

Laboratory

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOOR HANDLES	Wipe down at least twice daily with disinfectant-soaked microfiber cloth. Deep clean weekly,	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Lab technician / nurse / auxiliary	Good working practices should minimise contamination over time
LAB EQUIPMENT	Wipe down daily after use	As above Pay particular attention to touch screens, clean in accordance with manufacturers instructions. All touch areas clean with disinfectant soaked microfiber cloth daily. Disinfect by fogging daily	Dispose of cloth after use.	Lab technician / nurse / auxiliary	
WORK SURFACE	At the end of use each day	As above	Dispose of cloth after use.	Lab technician / nurse / auxiliary	
SINKS	Daily and after any significant contamination	Scrub with abrasive cleaner (e.g. Cif), rinse, then spray with disinfectant and allow to dry. Fog with room daily. Deep clean weekly with biofilm removal.	Dispose of cloth/wipes after use	Lab technician / nurse / auxiliary	Use waterproof keyboard cover

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FLOORS	At the end of each day or if significant contamination occurs	Wet mop with detergent daily. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Lab technician / nurse / auxiliary	
COMPUTER	Use washable keyboard covers	Wipe daily with disinfectant soaked microfiber cloth. Deep clean with biofilm removal weekly. Fog with disinfectant daily with room.	Dispose of cloth/wipes after use	Lab technician / nurse / auxiliary	Discard as necessary
FUME CUPBOARD	After each use, otherwise weekly.	Disposable cloth & detergent, then spray disinfectant. Disinfectant Fogging daily with room. Weekly deep clean with biofilm removal.	Dispose of cloth/wipes after use	Lab technician / nurse / auxiliary	
SHELVES	Weekly	As for fume cupboard above	Dispose of cloth/wipes after use	Lab technician / nurse / auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WALLS	Spot clean as required. Weekly damp wipe. Monthly deep clean, with biofilm removal. Daily disinfect by fogging	Remove dust from horizontal surfaces with damp cloth weekly, Disinfect by fog with room daily. Wash down walls monthly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Lab technician / nurse / auxiliary	Report any areas of damaged paintwork to practice manage
DOORS	Wipe down once daily with detergent, then disinfect by fogging daily. Deep clean monthly with biofilm removal.	Disposable cloth bucket & detergent	Dispose of cloth after use. Store bucket upside down, dry.	Lab technician / nurse / auxiliary	Report any areas of damaged paintwork to practice manage
CEILING	Vacuum and wash monthly.	Wash with detergent soaked microfiber mop on extending handle, monthly Disinfect by fogging with room daily.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Lab technician / nurse / auxiliary	
RADIATORS	Disinfect by fogging daily, deep clean monthly.	As for fume cupboard above	Dispose of cloth after use.	Lab technician / nurse / auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Lab technician / nurse / auxiliary	Check & discard if damaged or uncleanable
WNDOWS	Clean glass weekly. Dust wipe window ledges daily. Disinfect by fogging daily, deep clean every 2 weeks, with biofilm removal.	Disposable cloth bucket, glass cleaning solution. Windowsills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Lab technician / nurse / auxiliary	
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Lab technician / nurse / auxiliary	Ensure they are regularly serviced.
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Lab technician / nurse / auxiliary	Ensure they are regularly serviced.

- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Non-Clinical Areas

- Bathroom
- Reception Rooms
- Staff Room

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Non Clinical Areas

Bathroom

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
TOILET	One full clean daily. Seat, outer & inner bowl, handles, paper dispenser	Disposable cloth & detergent, bleach-based toilet disinfectant in bowl. Disinfect by fogging with room daily. Deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary/cleaner	
SINK	Full clean at end of day	Cream cleanser disposable cloth & rinse. Ensure cleaning of taps, plugs and other associated items. Disinfectant/bleach into plughole. Deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary/cleaner	**WHO Hand wash instructions by sink.**
DOOR HANDLE	Wipe down twice daily	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary/cleaner	
FLOOR	Daily	Wet mop with colour coded mop using detergent, disinfect by fogging at the end of each day.	Hot machine wash mophead at least weekly.	Nurse/auxiliary/cleaner	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WALLS, WINDOWS, DOOR, CEILING	Weekly	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Nurse/auxiliary/cleaner	Report any areas of damaged paintwork to practice manage
SANITARY WASTE BIN	Empty, clean and disinfect daily	Detergent-soaked disposable cloth, then spray with disinfectant. Spray with disinfectant and wipe round with cloth, place new plastic liner.	Dispose of cloth after use.	Nurse/auxiliary/cleaner	
SOAP / DISINFECTANT DISPENSER	Twice daily	As above	Dispose of cloth after use.	Nurse/auxiliary/cleaner	
HAND DRYING FACILITIES	Daily	As above	Dispose of cloth after use.	Nurse/auxiliary/cleaner	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Nurse/auxiliary/cleaner	Ensure they are regularly serviced.

- Mop buckets for this area are colour coded.
- Disinfection is appropriate for visibly clean surfaces; visibly soiled surfaces must be washed before disinfection.
- Damaged surfaces or equipment cannot be cleaned and can harbour debris and bacteria. All surfaces should be checked daily.
- Damaged surfaces or equipment should be repaired or replaced as soon as possible.
- Hard to clean surfaces (e.g. pin boards, Velcro, cloth seats etc.) should be avoided in clinical areas.
- Deep clean, biofilm removal and measure hygiene outcomes monthly.

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Non Clinical Areas

Staff Room

Proven to be one of the greatest sources of contamination

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WORK SURFACES INCLUDING TABLE	If a 24hr facility, wipe down morning, noon and evening. If 8-18hrs only, midday and after work. Clean as though it was a clinical area. Deep clean weekly with biofilm removal.	Detergent-soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal weekly.	Dispose of cloth after use.	Auxiliary	Good working practices should minimise contamination over time. Cover clinical uniform when in staffroom, no animals allowed in. Sanitise hands on entry.
FRIDGE	Make it someone's job to sanitise inside weekly, door and outside daily. Deep clean weekly.	As above	Dispose of cloth after use.	Auxiliary	
KITCHEN CUPBOARDS	Monthly clean inside and out and deep clean	Detergent- soaked disposable cloth, then spray with disinfectant. Disinfect by fogging each day, deep clean with biofilm removal monthly.	Dispose of cloth after use.	Auxiliary	
KETTLE, TOASTER, MICROWAVE THE WORST SOURCES OF CONTAMINATION IN THE PRACTICE SANITISE DAILY	If a 24hr facility, wipe down morning, noon and evening. If 8-18hrs only, midday and after work. Clean as though it was a clinical area. Deep clean weekly with biofilm removal.	As above	Dispose of microfiber cloth after use	Auxiliary	

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
CROCKERY, CUTLERY	Encourage use of dishwasher, everyone loads their own, someone sets it running each day and empties next am.	Dishwasher daily	Dispose of microfiber cloth after use	Auxiliary	
CHAIRS	At the end of each day or if significant contamination occurs.	Wet mop with detergent daily. Disinfect by fogging with room at end of each day. Deep clean weekly with biofilm removal.	Use colour coded microfiber mop and bucket. Hot water washing machine wash mop head weekly. Store bucket dry and upside down.	Auxiliary	
SINKS, TAPS, PLUGS	At the end of each day	Scrub with abrasive cleaner (e.g. Cif), rinse, then spray detergent wipe around with damp cloth. Bleach drains at least weekly.	Dispose of cloth/wipes after use	Auxiliary	
MAGAZINES / REFERENCE MATERIALS	Daily wipe down posters & booklets. Weekly dispose of damaged leaflets	Disinfectant with disposable cloth. Fog disinfect with room daily.	Dispose of cloth/wipes after use	Auxiliary	Discard as necessary

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FLOOR (THIS SHOULD BE A CLINICAL IMPERVIOUS FLOOR AND NOT A CARPET)	Once a week, more often it gets soiled, depending on staff numbers.	Colour coded microfiber mop and floor cleaner detergent. Disinfect with fogging at the end of day with rest of room. Deep clean floor with biofilm removal every 2 weeks.	Dispose of cloth/wipes after use. Mop heads hot wash in washing machine after use.	Auxiliary	Ensure the floor is a durable and cleanable surface.
DISWASHER	Weekly	Outside, Disposable cloth & detergent, then spray disinfectant daily. Fog disinfect with rest of room daily.	Dispose of cloth/wipes after use	Auxiliary	
SOAP DISPENSER	Wipe clean at the end of each day.	Disposable cloth and detergent then spray with disinfectant.	Dispose of cloth after use.	Auxiliary	
WALLS	Spot clean as required. Weekly damp wipe. Monthly deep clean, with biofilm removal. Daily disinfect by fogging	Remove dust from horizontal surfaces with damp cloth weekly, Disinfect by fog with room daily. Wash down walls monthly and deep clean. Spot clean contamination at other times.	Dispose of cloth after use. Store bucket upside down, dry.	Auxiliary	Report any areas of damaged paintwork to practice manage

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOORS	Wipe down once daily. Fog with room daily. Deep clean monthly.	Wipe down with detergent soaked cloth, then spray with disinfectant. Disinfect by fogging daily. Deep clean monthly with biofilm removal	Dispose of cloth after use. Store bucket upside down, dry.	Auxiliary	Report any areas of damaged paintwork to practice manage
CEILING	Monthly	Vacuum, then wipe with disinfectant soaked microfiber cloth on extending handle. Disinfect by fogging with rest of room daily.	Empty vacuum bag at end of each day. Dispose of cloth after use.		
RADIATORS	Wipe down weekly. Disinfect by fogging daily, deep clean, with biofilm removal monthly.	Detergent soaked microfiber cloth, to wipe down daily. Then wipe down with disinfectant soaked cloth. Disinfect by fogging daily with rest of room.	Dispose of cloth after use.	Auxiliary	
BLINDS	Blinds cleaned monthly or sooner if visibly contaminated. Disinfect by fogging daily.	Disposable cloth bucket & detergent, then spray with disinfectant, disinfect by fogging daily with room.	Dispose of cloth after use. Store bucket upside down, dry.	Auxiliary	Check & discard if damaged or uncleanable

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
WINDOWS	Clean glass weekly. Dust wipe window ledges daily. Disinfect by fogging daily, deep clean every 2 weeks, with biofilm removal.	Disposable cloth bucket, glass cleaning solution. Windowsills as for other horizontal surfaces. Disinfect by fogging daily, deep clean with biofilm removal weekly.	Dispose of cloth after use. Store bucket upside down, dry.	Auxiliary	
AIRCON	Wipe down weekly with disinfectant. Fog with room daily. Full clean monthly	Vacuum cleaner. Disposable cloth and appropriate disinfectant (spray bottle or bowl)	Dispose of cloth after use.	Auxiliary	Ensure they are regularly serviced.
EXTRACTOR FANS	Dismantled & cleaned internally & externally every 3 months	Disposable cloth	Dispose of cloth after use.	Auxiliary	Ensure they are regularly serviced.

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Non Clinical Areas

Reception rooms

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
DOOR HANDLES	Wipe down and spray (allow to dry naturally) between every consulting period or after any risk event e.g. infectious patient or contamination.	Disposable cloth & detergent, spray with disinfectant daily or after any risk event. Fog with disinfectant at end of day with room.	Dispose of cloth after use.	Reception team	Apart from separate cat and dog waiting areas, try also to have a clean waiting area, for use only be elective surgery admissions, kittens and puppies for vaccination or annual booster. Immediately after any infectious case seen, if soiled, or otherwise at the end of each Consulting session.
COMPUTER	Use washable covers. Clean once daily then disinfect by spray or fogging at end of the day.	Detergent damp cloth or disposable wipes, then disinfect with spray or fogging deep clean and biofilm removal, weekly.	Dispose of cloth/wipes after use	Reception team	Washable keyboards covers should be used.
SCALES	Wipe down between every consulting period immediately if contaminated or after use by infectious case, disinfect daily by spray or fogging, deep clean with biofilm removal weekly.	Clean with disposable cloth then disinfect by spray or fogging, deep clean weekly with biofilm removal.	Dispose of cloth after use	Reception team	Clean immediately after any infectious case weighed or any urine or other contamination, otherwise at the end or morning admissions and at the end of each day. Deep cleans weekly or after an infectious case or after faecal contamination, using detergent, then a biofilm remover, finally disinfectant.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
FLOOR	Wet mop between consulting periods disinfectant after infectious patients and at least daily. Full vacuum, detergent clean and scrub daily, deep clean, biofilm removal weekly. Fog disinfect daily with room as a whole.	Mop, bucket, detergent, brush attachments to DIY drill and or Rotavac. Disinfectant by fogging. Deep clean with biofilm remover.	Colour coded, microfibre mop heads, mop and bucket cleaned after each use and stored dry. Machine washed at least every three days.	Reception team/ consulting nurse, or cleaner.	Immediately if soiled/ contaminated, otherwise a full detergent clean and disinfection at the end of each day. The whole floor should always look clean. All floors in clinical food prep, laundry and instrument prep areas must be coved extending between 15-20 cm up the wall. If corners or edges of floors appear soiled these are easily cleaned with brush attachments on a rechargeable DIY drill.
MATS	Weekly, more often if contaminated, spray disinfect daily, at least weekly wash.	High temperature machine wash & tumble dry weekly.			
TOYS	Weekly wash with warm water & neutral detergent (e.g. washing up liquid), or between patients, then immerse in safe (non-toxic) disinfectant.	Bucket or sink, disposable cloth & detergent, then disinfect by submersion, for contact time in animal safe disinfectant.	Dispose of cloth after use, Store bucket dry & inverted	Reception team	Discard any damaged toys

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
POSTERS & CLIENT EDUCATIONAL MATERIALS	Use laminated material. Daily wipe down posters & booklets. Dispose of damaged leaflets. Fog with room daily.	Disposable cloth and detergent. Then spray or fog with disinfectant daily.	Dispose of cloth after use.	Reception team	Where possible, posters & client education reading material should be laminated. Remove any damaged or soiled magazines
HAND SANITIZING FOR CLIENTS	Clients to be encouraged to sanitise hands on arrival, after touching other owner's pets, on entry and exit from the consulting room and before leaving. Clients should be trained in biosecurity.	Alcohol gel on reception desk or appropriate point in the waiting room	At end of consulting period. Wipe outside of bottle with detergent & disposable cloth, then spray with disinfectant and allow to dry naturally. Dispose of cloth after use.	Reception team	We do biosecurity as we care about your pet's health.
SEATS	Seat surfaces must be clean and disinfectable. Daily detergent wipe down then disinfect by spray or fogging. Deep clean once a week with biofilm removal.	Wipe down with cloth and detergent, then disinfect by spray or fogging. Deep clean with biofilm removal once weekly. Fog daily with room as a whole.	Dispose of cloth after use. Store bucket / bowl dry.	Cleaner	Report /remove any damaged seating; seat covers must be impervious.
PET STANDS	Dust & tidy once daily.	Disposable cloth	Dispose of cloth after use.	Reception team	Remove any out of date/ damaged items; the frequency of cleaning items is determined by the risk and turnover.

	How often	What with	Care of cleaning materials	Person Responsible	Any Special Comments
SWITCHES/SOCKETS	Dust once daily. Correctly used fogging is safe for use with electrical equipment present.	Disposable cloth, then disinfected with fogging with room as a whole.	Dispose of cloth after use.	Cleaner	
WINDOWS	Clean glass weekly, wipe down window sills with disinfectant daily then disinfect by fogging with the whole room.	Disposable cloth & bucket, glass cleaning solution, disinfect by fogging with product safe and effective by this route.	Dispose of cloth. Store bucket dry.		
DOORS	Detergent wipe down once daily, then disinfect by fogging. Weekly deep clean with biofilm removal.	Disposable cloth bucket & detergent, then fogging with metal and staff safe and effective disinfectant.	Dispose of cloth after use. Store bucket dry.	Cleaner	

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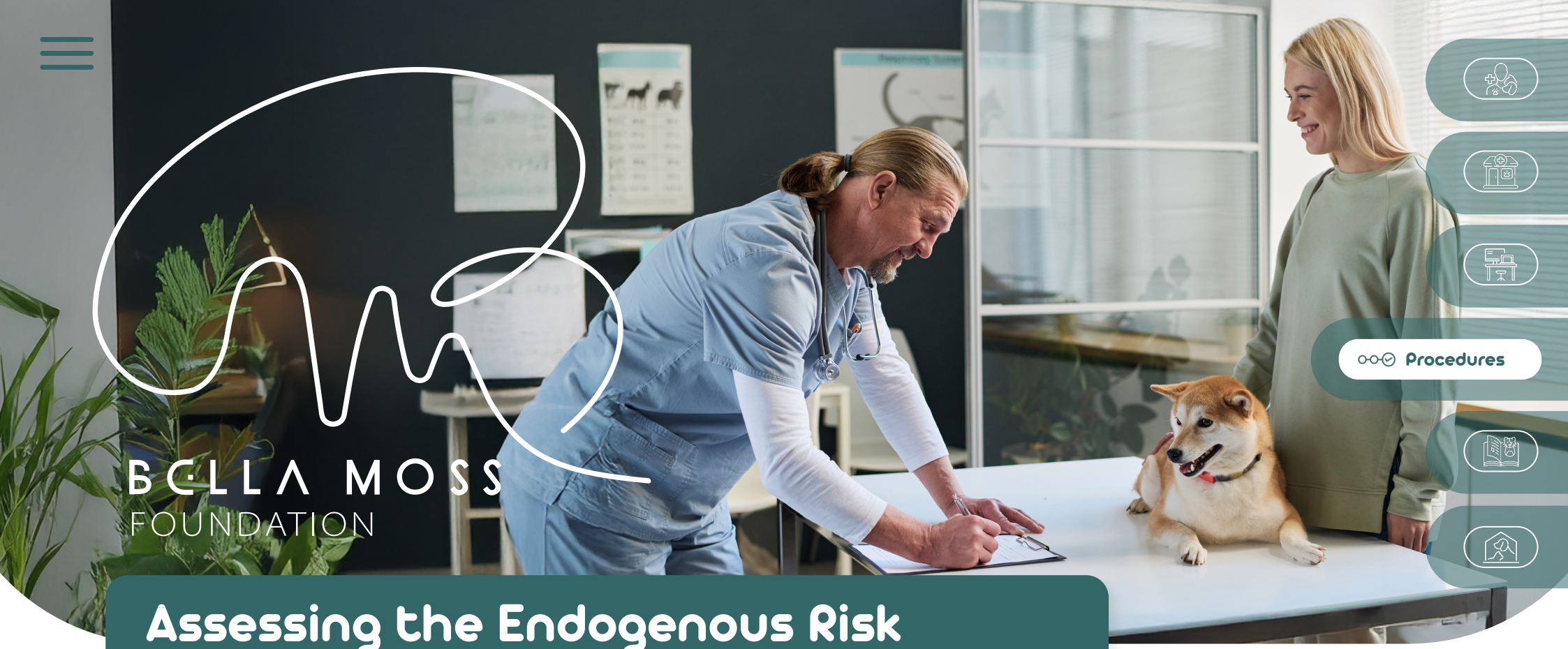
Procedures

- Assessing the Endogenous Risk of Veterinary Patients Before and Upon Arrival at the Clinic
- How to Manage Clean and Dirty Areas in a Veterinary Facility
- Patient Prep for Surgery
- Hand Hygiene
- Laundry
- Waste Guidance



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Procedures

Assessing the Endogenous Risk of Veterinary Patients Before and Upon Arrival at the Clinic

When managing veterinary patients, understanding the endogenous risk—which refers to risks arising from the patient's inherent health conditions, such as pre-existing diseases, genetic predispositions, or physiological factors—is crucial to ensure their safety and tailor the medical approach. The assessment should occur both before the patient arrives at the clinic (pre-arrival) and at the clinic upon arrival (arrival assessment).

Pre-arrival Assessment

Before the patient arrives at the clinic, the risk assessment typically relies on the information provided by the pet owner, the animal's medical history, and any pre-scheduled diagnostics or treatments. This is an opportunity to identify potential risks that may complicate diagnosis, treatment, or recovery.

Key factors to assess before arrival

PATIENT ENDOGENOUS RISK OF INFECTION

In respect of clinical presentation - any patient with a cough, cystitis, gastroenteritis or severe dermatitis presents as risk to the facility and must be managed to Minimise the risk of passing on infection, ideally by being admitted directly into an isolation area where all diagnostics and treatment are performed.
In respect of lifestyle, wildlife, strays, rehomers should all be managed as 'dirty patients' and managed to Minimise risk of cross contamination to other patients.
In respect of owners employment, any family member working in healthcare increases the MRSA risk of the patient and if surgery is planned should be scheduled late in the surgical list.

MEDICAL HISTORY

Understanding the patient's pre-existing conditions (e.g., heart disease, kidney dysfunction, endocrine disorders, etc.) is essential. This helps anticipate complications during treatment.

AGE AND BREED

Certain breeds are predisposed to specific health conditions (e.g., large dog breeds may be at higher risk of hip dysplasia, while brachycephalic breeds may experience respiratory issues). Age also plays a role, with older animals being more susceptible to age-related diseases.

VACCINATION AND PREVENTATIVE CARE STATUS

Knowing whether the patient is up to date on vaccines, parasite prevention, and other preventive care (like spaying or neutering) helps assess risk, particularly for infectious diseases.

PREVIOUS ANAESTHETIC OR SURGICAL HISTORY

Animals with past adverse reactions to anaesthesia or surgery may need special consideration for future procedures.

CURRENT MEDICATIONS

Certain medications (e.g., corticosteroids, anticoagulants) can increase the risk of complications, especially during surgery or anaesthesia. The veterinarian needs to know what medications the animal is on, to adjust the treatment plan accordingly.

OWNER RELATED RISK FACTORS

The animal of any owner who works in any medical care facility carries a greater risk of antimicrobial infection and should be handled and managed on this basis.

OWNER-REPORTED CLINICAL SIGNS OR BEHAVIOURAL CHANGES

Owners may report unusual behaviour or symptoms (e.g., lethargy, difficulty breathing, changes in appetite), which are important signals of potential health risks.

EMERGENCY CONTACT DETAILS

If the patient has a complex medical history, it's crucial to have emergency contact information or a referral from a primary veterinarian to understand potential risks.

Arrival Assessment

Upon arrival at the clinic, further assessments should be conducted to confirm or refine the risk evaluation based on a physical exam and possibly preliminary diagnostics. This is an opportunity to reassess the situation, especially if the animal's condition has changed or new signs have developed.

Key factors to assess upon arrival

PHYSICAL EXAMINATION

A thorough physical examination is essential to detect any immediate or subtle signs of distress, illness, or changes since the pre-arrival evaluation. This may include checking vital signs (e.g., temperature, heart rate, respiratory rate, and blood pressure), assessing hydration status, mucous membrane colour and palpating for abnormalities.

CARDIOPULMONARY FUNCTION

Assess the animal's heart and lung sounds, as abnormalities could indicate undiagnosed conditions that could complicate surgery or other treatments.

LABORATORY TESTS

Depending on the nature of the visit, performing blood work, urinalysis, or imaging tests (e.g., X-rays or ultrasound) can be useful to identify unseen conditions (e.g., kidney failure, anaemia, or cancer).

PAIN ASSESSMENT

Some animals may be in pain due to an acute condition, trauma, or a pre-existing condition like arthritis. Pain management needs to be part of the risk assessment, especially before any procedures.

BEHAVIOURAL SIGNS

Assess how the animal responds to handling (e.g., aggression, anxiety, stress). Some animals may need sedation or special handling protocols to reduce the risk of injury to themselves or staff.

PRE-ANAESTHETIC EVALUATION

If the patient is to undergo anaesthesia, an assessment of their overall suitability for anaesthesia is crucial. This includes checking for factors like heart or kidney function, blood clotting status and electrolyte balance, as these may influence the choice of anaesthetic agents or the need for additional monitoring.

Tools and Scoring Systems

There are various tools and scoring systems used to evaluate patient risk in a clinical setting. For example:

VETERINARY ANAESTHETISTS PHYSICAL STATUS CLASSIFICATION

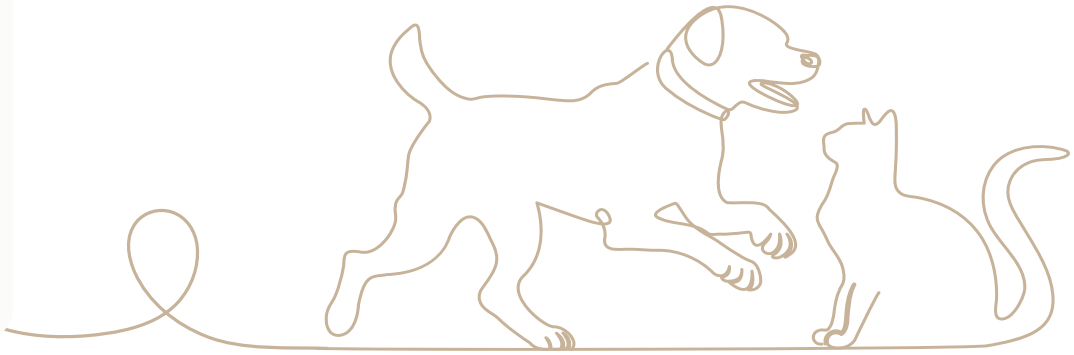
This system grades patients from I (healthy) to V (moribund), helping to determine the risk of anaesthesia.

CANINE/FELINE RISK ASSESSMENT TOOLS

Some clinics use proprietary or published scoring systems that factor in medical history, vital signs and laboratory values to estimate risk before and upon arrival.

Communication Between Owner and Veterinary Team

One of the most important components of risk assessment is ensuring effective communication between the pet owner and the veterinary team. This includes discussing the patient's medical history, any changes since the initial evaluation, and understanding the owner's concerns. It also involves informing the owner of the potential risks associated with treatment options.



Assessing the endogenous risk of veterinary patients both before and upon arrival at the clinic is a dynamic process that involves gathering detailed historical information, conducting a comprehensive physical examination, and, when necessary, performing diagnostics. This two-tiered approach allows veterinarians to anticipate complications, plan for interventions and optimise patient care. By identifying potential risks early, veterinary teams can provide better, safer care and improve overall patient outcomes.

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Hand Hygiene

Hand Hygiene Procedures and Considerations

- Hand hygiene is the core element of infection prevention and control.
- Hands are the main pathway of germ transmission and therefore hand hygiene is the most important measure to avoid cross contamination.
- Efficient, timely hand hygiene substantially reduces potential pathogens on the hands and studies have shown that regular hand washing significantly reduces the risk of nosocomial infection.
- Hand washing removes dirt, organic matter and most micro-organisms acquired through direct contact with a patient, or from the environment. Hands must be washed using soap and warm water when visibly dirty or soiled with blood or other body fluids.
- Alcohol-based hand gels (with a minimum 60% alcohol content) offer a practical and acceptable alternative to hand washing in most situations so long as the hands are not visibly soiled. Alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water, although multiple alcohol applications a day can result in skin drying and cracking in some staff.
- The WHO guide hand hygiene is the recommended framework to use within practice. It is an evidence-based, field-tested, user-centred approach designed to be easy to learn, logical and applicable in a wide range of settings.
- Hand hygiene peer on peer observations and audits are recommended to ensure compliance is maintained.

Pre requisites for a successful outcome from disinfection by fogging:

- Before and after physical contact with any patient, particularly before performing invasive procedures
- Before and after contact with items in the patient's environment
- After any contact with or any activity involving the body fluids or other tissues of a patient
- Before putting on and especially after taking off gloves
- Before eating food, drinking or smoking
- After performing body functions, such as using the toilet or blowing one's nose

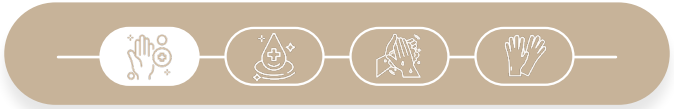
5 Moments of hand hygiene

Based on substantial evidence, the World Health Organisation, '5 Moments for Hand Hygiene' is designed to minimise the risk of transmission of microorganisms between healthcare worker, the patient, and the environment.

The 5 Moments for Hand Hygiene approach defines the key moments when health-care workers should perform hand hygiene.

This approach recommends health-care workers perform hand hygiene:

- Before touching a patient
- Before clean/aseptic procedures
- After body fluid exposure
- After touching a patient
- After touching patient surroundings



Special considerations

CONDITION OF THE SKIN

It is easier to clean intact skin than it is to clean chapped, cracked, cut or abraded skin. It should be remembered that intact skin is the first line of defence against bacteria, and that bacteria adhere more readily to broken and/or inflamed skin.

FINGERNAILS

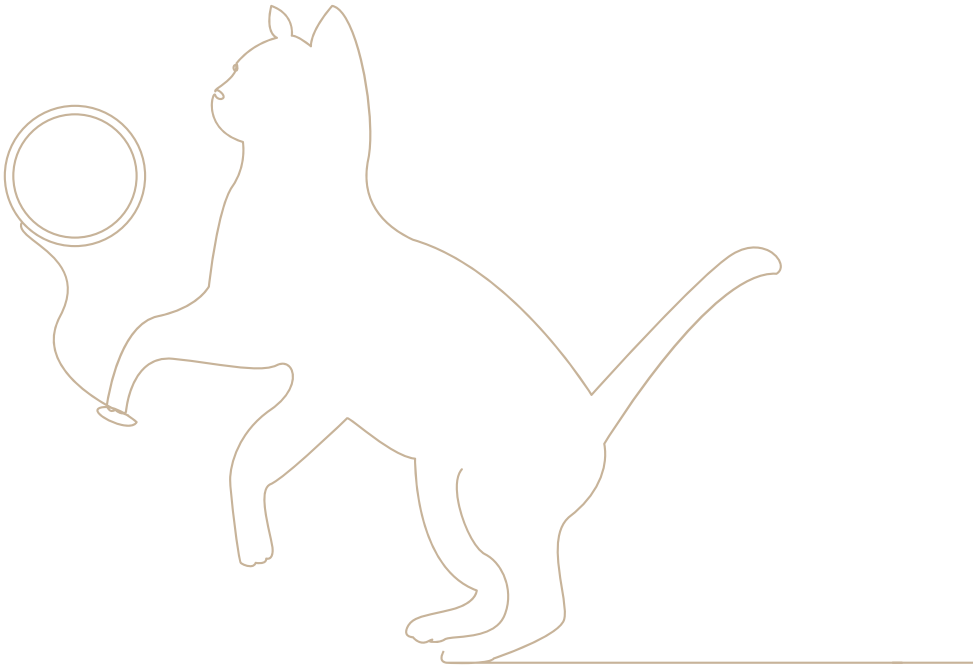
Natural nails more than 3-4 mm long are difficult to clean, can pierce gloves and harbour more microorganisms than short nails. **Artificial nails or nail enhancements** (including nail polish) should not be worn by anyone involved directly in patient care, there is evidence to prove they aid the transfer of micro-organisms from staff to patient.

JEWELLERY

Jewellery physically protects bacteria and viruses from the antiseptic action of alcohol-based hand sanitizers and the mechanical cleaning action of soap and running water. Jewellery should not be worn during patient contact. Rings have been demonstrated to increase the number of microorganisms present on hands and increase the risk of tears in gloves. Plain wedding bands may be worn, but other rings, jewellery, wristbands and wristwatches that may interfere with the efficacy of hand washing and disinfection must be avoided.

A 'BARE BELOW THE ELBOWS' POLICY SHOULD BE ADOPTED

Arms should be kept bare below the elbow to facilitate effective hand hygiene.



Hand washing and/or disinfection technique

Hand washing and/or disinfection should follow World Health Organisation (WHO) guidelines.

Hand disinfection/rubbing (alcohol based hand gels) must take at least 20-30 seconds

1. Apply a palmful of the product in a cupped hand, covering all surfaces
2. Rotational rubbing of fingertips in a pool of gel or wash, backwards and forwards, with clasped fingers of right hand in left palm and vice versa
3. Rub hands palm to palm
4. Right palm over left dorsum with interlaced fingers and vice versa
5. Palm to palm with fingers interlaced
6. Backs of fingers to opposing palms with fingers interlocked
7. Rotational rubbing of left thumb clasped in right palm and vice versa
8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa

Hand washing must take 40-60 seconds (sing happy birthday rhyme twice)

1. Wet hands with water
2. Apply enough soap to cover all hand surfaces
3. Rub hands palm to palm
4. Right palm over left dorsum with interlaced fingers and vice versa
5. Palm to palm with fingers interlaced
6. Backs of fingers to opposing palms with fingers interlocked
7. Rotational rubbing of left thumb clasped in right palm and vice versa
8. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa
9. Rinse hands with water
10. Dry hands thoroughly with a single use disposable towel
11. Use disposable towel to turn off faucet

Examination gloves

- It is a common misconception that using disposable gloves negates the need for hand hygiene.
- Gloves provide a barrier between staff and an exposure risk and with appropriate use, helps prevent the spread of pathogens between animals and within the environment
- Gloves should be worn whenever personnel are likely to come into contact with bodily fluids, secretions, excretions or mucous membranes, with potentially infectious material and/or to provide extra protection for vulnerable patients
- Gloves must be changed when moving from dirty to clean procedures on the same patient, e.g. wound dressing changes
- Gloves must be changed between patients
- Gloves should always be worn when cleaning kennels and environmental surfaces, as well as when doing laundry; this is particularly important when gross contamination is present
- Care should be taken to ensure gloved hands are not used to touch surfaces, or equipment, that will be touched by personnel with non-gloved hands, such as telephones, door handles, keyboards, dressing materials etc
- Following use, gloves should be removed promptly, avoiding contact between skin and the outer glove surface; hands should then be washed, or an alcohol-based gel used immediately after glove removal
- A study by Okomoto et al in 2019 found that 39 percent of workers made errors in removing personal protective equipment (PPE), including gowns and gloves, increasing the incidence of contamination. This study provides evidence that warrants the use of hand hygiene auditing

NATURAL NAILS, ACRYLIC FALSE NAILS AND GEL NAIL POLISH

Acrylic false nails develop increased bacterial load faster than natural nails and are considered inappropriate. Hewlett et al (2018) compared bacterial loads on healthcare workers with natural nails, standard polish and gel polish. Bacterial loads were similar with all three types of nails, however after washing with alcohol based sanitisers, bacterial loads reduced with natural nails and standard polish, but not on workers with gel nail polish. The conclusion was that it is harder to sanitise your hands correctly, with alcohol based hand cleaners, when you have gel nail polish. In light of this, it is recommended that healthcare workers should not use gel nail polish.

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Procedures

How to Manage Clean and Dirty areas in a Veterinary Facility

In a veterinary practice, effectively managing clean and dirty areas is essential for maintaining a hygienic, safe and efficient environment. Proper segregation between clean and dirty areas prevents cross-contamination, ensures that infection control standards are met, and promotes the overall health and safety of both animals and staff. Here are key strategies to manage clean and dirty areas in a veterinary practice:

Create a Clear Layout with Defined Zones

SEPARATE AREAS FOR CLEAN AND DIRTY ACTIVITIES

Design the veterinary facility so that clean and dirty areas are clearly defined and physically separated. The goal is to minimise the risk of contamination by ensuring that tasks involving contaminated items (e.g., waste, blood, or infected materials) are carried out away from clean areas (e.g., surgery rooms, treatment rooms).

- **Clean Areas:** These include spaces like exam rooms, surgical suites, sterile preparation areas and clean storage areas for medical supplies and medications.
- **Dirty Areas:** These include spaces like isolation rooms, treatment areas where procedures that may generate contamination (e.g., wound care, blood draws) are performed, waste disposal areas and laundry facilities.

CLEAR SIGNAGE

Use clear visual indicators, such as signs and color-coded areas, to delineate clean and dirty zones. This helps guide staff and visitors and prevents accidental entry into areas that might lead to contamination.

MONITORING AREAS OF HYGIENE STATUS

Regular unannounced measurement of hygiene / contamination status of surfaces in a facility is invaluable (e.g. ATP testing). It is almost inevitable that without assessment there will be some surfaces which are considered 'clean' which are, inadvertently, 'contaminated: e.g. staff room kettle handle, imaging table, anaesthetic vaporiser and oxygen flow controls, x-ray triggers, patients restraint devices, operating theatre instrument trolleys and operating lights, etc.

Establish a One-Way (air, patient and staff) Flow System

ONE-WAY MOVEMENT OF ANIMALS AND MATERIALS

Design the layout of the veterinary practice to create a one-way flow of animals, equipment, and staff. For example:

- Animals should enter the practice in a designated intake area (dirty zone) where they are assessed, treated, and moved to recovery or boarding areas (clean zone). Admission times / location / staff should be divided between high risk (likely dirty patients), as opposed to high need or elective patients.
- Use a corridor or pathway to move animals through the facility without re-entering previously used spaces.
- Similarly, tools and equipment should not move from dirty areas (e.g. treatment areas, exam rooms) to clean areas for sterilisation before being reused.
- You must be able to move high risk / dirty / contaminated patients from arrival car park, to isolation room, without first entering any clean area of the practice.

SEPARATE EXITS FOR CLEAN AND DIRTY AREAS

Ensure that clean and dirty areas have separate entry and exit points. For instance, patients that are undergoing surgery should be transported via a dedicated route to and from the surgical suite, avoiding other areas where cross-contamination could occur.

Physical Barriers and Segregation

DOORS AND WALLS

Use physical barriers such as walls or closed doors to separate clean and dirty zones. These barriers prevent contaminants from spreading between areas. Consider incorporating doors with air locks or positive pressure in sterile areas (e.g. surgical rooms).

AIR FLOW MANAGEMENT

Control airflow by using positive and negative pressure systems to prevent the movement of contaminants between areas. For example, surgery rooms should have positive air pressure to keep contaminants out, while isolation rooms may require negative pressure (i.e. air extraction) to contain airborne pathogens.

Implement a Dedicated Cleaning and Sterilisation Area

STERILISATION ROOM

Create a dedicated sterilisation room that is separated from both clean and dirty areas. This room should house equipment like autoclaves, sterilisers, and disinfectants used for cleaning surgical instruments and other medical tools.

SOILED UTILITY AREA

A specific «dirty» utility area should be designated for the cleaning and disposal of contaminated items, including soiled bedding, surgical drapes, or any medical waste.

- Ensure this area is equipped with industrial sinks, washing machines, or other necessary tools to clean, disinfect, and handle soiled materials safely.
- **Contaminated Laundry:** Separate laundry areas should be designated for contaminated towels, bedding, and clothing, and must be equipped with appropriate cleaning equipment to prevent cross-contamination.

Use of Proper Cleaning Protocols

ROUTINE CLEANING

Develop and implement a cleaning schedule that addresses how frequently each area should be cleaned. For example:

- **Dirty Areas:** These areas should be cleaned more frequently and with stronger disinfectants (e.g. exam tables, surgical tables, cages). Follow strict protocols for decontaminating high-touch surfaces with biofilm removal whenever a deep clean is undertaken (typically every 1-2 weeks).
- **Clean Areas:** Clean areas should be cleaned and disinfected regularly, but with milder agents that will not compromise sterility (e.g. cleaning exam tables, counters, and storage areas for medical supplies).

DISINFECTION PROTOCOLS

Ensure that proper disinfectants are used for various areas. For example, surgical areas require hospital-grade disinfectants, while surfaces in less critical areas can be cleaned with general-purpose disinfectants.

UNANNOUNCED HYGIENE ASSESSMENTS

(e.g. ATP testing) are essential to assure hygiene protocols and good working practices (i.e. avoiding the creation of fomites).

PROPER USE OF PERSONAL PROTECTIVE EQUIPMENT (PPE)

Ensure that staff wears appropriate PPE (e.g., gloves, masks, gowns) when working in dirty areas. PPE should be disposed of properly before leaving these areas.

Handling and Disposal of Contaminated Materials

WASTE MANAGEMENT

Set up a structured waste management system that includes separate bins for:

- **General waste:** Regular trash, such as packaging and non-contaminated materials.
- **Infectious waste:** Contaminated materials like bandages, needles or used syringes, which should be placed in biohazard containers.
- **Pharmaceutical waste:** Expired or unused medications, including needles and vials.

CONTAMINATED EQUIPMENT HANDLING

All contaminated equipment should be cleaned and sterilised before it moves from dirty to clean areas. Ensure there are dedicated sinks and autoclaves in the dirty area for cleaning instruments before they are moved to the sterilisation area.

Clear Signage and Communication

SIGNAGE FOR ZONES

Use clear, easily understood signage to indicate which areas are clean and which are dirty. This can help staff adhere to the layout and prevent accidental contamination.

IN SOME FACILITIES

The hygiene status of areas is indicated by floor colour, and that of staff by uniform colour. In this manner, any staff member in the wrong place is readily apparent.

WRITTEN PROTOCOLS

Have written hygiene and infection control protocols available for staff to reference. This should include guidance on how to move between zones, clean and disinfect properly, and handle potentially contaminated materials.

Regular Monitoring and Audits

ROUTINE AUDITS

Regular unannounced quantitative rapid tests are invaluable. Audits and sharing results with the staff team is essential to ensure that hygiene protocols are being followed and that there is no contamination between clean and dirty areas.

CONTINUOUS IMPROVEMENT

Adjust the design or procedures as needed, based on feedback, audits and infection control reports to improve hygiene management in the facility.

Staff Training and Protocols

TRAINING OF THE WHOLE PRACTICE TEAM IS ESSENTIAL

It only takes one member of staff failing to wash hands etc., to ruin the hygiene status of the whole facility. An 'Infection Control Champion' should be appointed, trained and given time and authority to monitor and assure working practices and standards are maintained.

TRAINING ON HYGIENE PRACTICES

Ensure that all veterinary staff are trained in proper hygiene protocols, including handwashing, the use of disinfectants, and appropriate handling of animals and equipment.

PERSONAL PROTECTIVE EQUIPMENT (PPE) USAGE

Staff should wear the appropriate PPE when working in dirty areas, and protocols should be in place for proper disposal or cleaning of PPE.

CROSS-CONTAMINATION PREVENTION

Staff should be educated on avoiding cross-contamination between clean and dirty areas. For instance, they should change gloves and wash hands after handling contaminated materials.

By following these strategies, veterinary practices can maintain strict segregation between clean and dirty areas, minimising the risk of infection and providing a safe and hygienic environment for both animals and staff.

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Laundry Protocols

Laundry Protocols

- Uniforms, towels, bedding and drapes can act as fomites, transferring pathogens around the practice, from patient to patient and outside the practice into the community.
- Staff may only wear their uniforms in the practice. Where practice facilities allow, uniforms should be laundered at the practice, separately to other laundry >60°C and changed into on arrival and out of prior to leaving.
- Whilst soiled laundry will be contaminated, the risk of disease transmission is negligible, if handled correctly (Nordstrom et al 2012).
- Staff must wear appropriate PPE, including non-sterile gloves, when handling contaminated laundry to minimize potential zoonotic risk.
- Ensure any broken skin, or wounds, are kept covered.
- Hand washing facilities must be easily available for use after handling laundry.
- Soiled items for laundry must be transferred from source to the laundry in an enclosed receptacle.
- Soiled laundry should be segregated from clean laundry to avoid cross-contamination. The use of impervious laundry bags in each kennel area is recommended; water-soluble bags that fit over wheeled trollies which can be laundered with the bedding are particularly useful.
- Theatre attire (scrubs, reusable gowns/drapes etc) must be washed separately from bedding.
- Domestic washing machines are typically ineffective at killing infectious pathogens so commercial machines are recommended. Machine type, cycle temperature, duration temperature, detergent action and degree of rinsing are all crucial to achieve complete eradication of all pathogens during the laundry process. It is important that your washing machine is serviced at least annually.
- The Water Regulations Advisory Scheme (WRAS) Category 5 regulations applies to all health care organisations, including veterinary practices. WRAS regulation stipulates that any Category 5 fluids (faecal matter, animal waste or pathogens) could be a serious hazard to health and any waste water should not be allowed to backflow and contaminate fresh water supplies. Domestic washing machines generally do not comply with WRAS guidelines; care must be taken to ensure your washing machine is legally compliant.
- Microbe populations on soiled laundry are significantly reduced by dilution and by the mechanical action of washing.
- If laundry is washed in cold water, an approved cold-water detergent must be used according to label directions.
- Hot water washing will not disinfect items by itself. High temperature (> 71.1°C) washing can significantly reduce bacterial numbers, but standard household washing machines often do not reach this temperature, even if the hot water setting is used.

Laundry Protocols

Ideally the following washing machine settings should be used: (HSE.gov)

- Maintain 65 °C for at least ten minutes
- Maintain 71 °C for at least three minutes
- Maintain 82 °C for at least one minute
- The addition of chemicals (i.e. bleach or appropriate disinfectant) is required for heat labile materials or cycles with lower temperatures.
- A biological washing detergent is essential.

The heat and drying effects of tumble drying are vital in the laundering process, and are responsible for decreasing bacterial counts on bedding and clothing. Therefore, laundry should not be considered clean until it has also been dried completely, ideally using the highest heat possible. Tumble drying is recommended, especially for any materials that may have been contaminated with a transmissible infectious pathogen.

Line drying will have the advantage of exposing the surface of the fabrics to ultraviolet (UV) light, provided they hung to dry in the sun. However, all surfaces need to be exposed to sunlight for this method to be effective so care should be taken with hanging items.

Laundry from Infectious Cases

Laundry from potentially infectious cases should be treated separately from all other laundry and should be collected in a water-soluble laundry bag and washed and dried separately.

Staff must wear appropriate PPE when handling contaminated laundry e.g. full PPE, including gloves, face mask, and eye protection, should be worn when handling urine-soaked bedding from a known or suspected case of canine leptospirosis.

For laundry with gross contamination of a potentially infectious nature (e.g. faeces from patients with diarrhoea, urine from an animal with a urinary tract infection), as much organic material as possible should be removed by hand (using gloves and disposable tissue or paper towel). The items should then be pre-soaked in disinfectant (according to manufacturers guidelines and appropriate dilution rates) or bleach solution (9 parts water: 1 part household bleach) for 10- 15 minutes prior to machine washing.

Bleach may also be added to the household detergent in the washing machine as per label instructions.

References

Health & Safety Executive (HSE) Laundry treatments at high and low temperatures https://www.hse.gov.uk/biosafety/blood-borne-viruses/laundry-treatments.htm
Nordstrom J, Reynold K, GerbaC. (2012). Comparison of bacteria on new, disposable, laundered, and unlaundered hospital scrubs, American Journal of infection control, 40,6, pp 539-543

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Procedures

Patient Prep For Surgery

Skin Preparation Principles

The purpose of preoperative skin preparation is to remove transient microorganisms from the skin and to reduce the residual microbial count to sub-pathogenic levels in a short space of time, and with as little tissue irritation as possible (Fossum, 2007). Whilst it is impossible to make the skin completely sterile, the aim is to free the surgical site from a large microorganism burden prior to surgery. Skin preparation has a mechanical and chemical element. Mechanical cleaning is caused by friction, such as rubbing the skin. This is necessary to remove bacteria and enable antiseptic solutions to penetrate the deeper layers of the dermis where there are resident microorganisms. Chemical cleaning involves the destruction of microorganisms and the prevention of 'rebound' microbial growth after scrubbing.
Staff undertaking clipping and initial skin preparation should don a disposable apron and gloves to minimise contamination of uniforms.

Patient skin preparation should comprise three stages:

1 Cliping

Clipping of patient fur should be performed in a separate preparation area outside of the operating theatre area. This room may be used for other purposes, but it is important that it is away from the operating theatre. Clipped hair should be removed by vacuuming (using a designated preparation/theatre vacuum) or by a lint roller. Cleaned and disinfected clipper blades should be used for each patient.

The table and equipment should be cleaned and disinfected between patients.

Ensure the clipper cleaning brushes are disinfected after each use and changed weekly.

2 Initial Skin Preparation

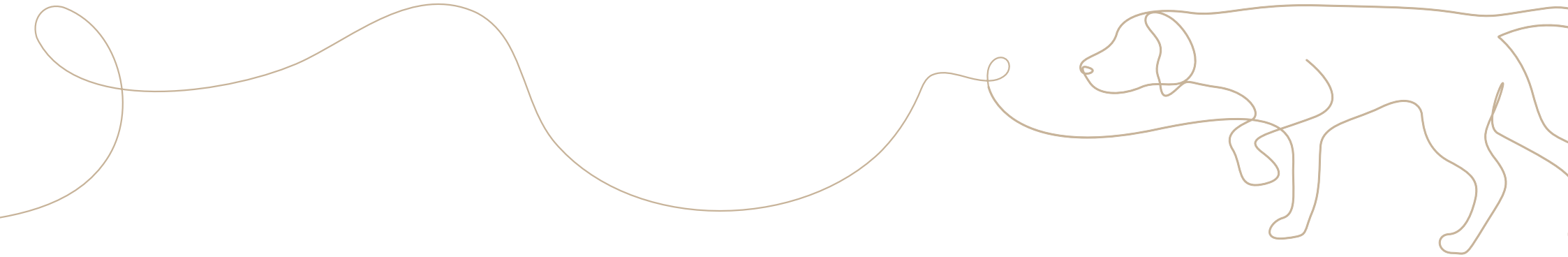
This step should be performed in a separate preparation area outside of the operating theatre area.

3 Final Skin Aseptic Preparation

This stage should be performed following initial skin preparation, once the patient has been moved to the operating theatre and positioned for surgery. This should be carried out in a sterile theatre area under aseptic conditions.

Initial Skin Preparation Methodology

- If the patient is to undergo limb surgery, the distal portion of the limb can be bandaged, e.g. using a cohesive bandage.
- Feet can be cleaned and soaked in an examination glove with a scrub solution of 4% chlorhexidine gluconate and warm water in equal parts.
- Prepare a scrub solution of 4% chlorhexidine gluconate and warm tap water in equal parts in a sterile kidney dish. Ensure correct dilution rates are used (NB – an appropriately diluted alternative disinfectant such as povidone iodine should be used in patients sensitive to chlorhexidine).
- **Do not make up solutions in bulk and use across the days (or weeks) surgical load. Antiseptic contamination can be a source of infectious outbreaks.**
- Non-sterile examination gloves should be worn, to prevent cross-contamination. Using lint free gauze swabs, scrub the surgical site area using a methodical back and forth motion (McDonald Vox San, 2006) (McMillan, 2014) for 90 seconds, starting at the incision site and moving out to the periphery. Using a new swab each time, repeat this procedure until swabs are clean.
- If right handed use the left hand to pick up a swab and pass it to the right hand to prevent contamination. (vice versa if left handed)
- Excessive pressure is not necessary and will abrade the skin, causing inflammation and the wound may be more prone to healing complications if the dermal layer is compromised. It will also cause the native skin microbes to rise to the surface.
- Once the surgical site area has been adequately prepped as above, the patient can be moved into the operating theatre.



Final Skin Preparation

- Before removing the examination gloves, correctly position the patient appropriately for the required procedure. If limb surgery is to be performed it is useful to suspend the limb to prevent contamination of the surgical site.
- Remove and dispose the examination gloves, wash hands and replace with a pair of sterile surgical gloves.
- Another scrub solution of 4% chlorhexidine gluconate solution should be prepared (1 part chlorhexidine: 1 part warm water). Again, using lint free gauze swabs, the surgical site should be scrubbed using a back and forth motion until the correct contact time has been achieved (3-5 mins)
- The final sterile skin preparation is carried out using a solution of 2% chlorhexidine gluconate and 70% isopropyl alcohol. This can be achieved using a commercial, sterile applicator, or using an alcohol based chlorhexidine solution. Evidence strongly suggests that 2% chlorhexidine and 70% isopropyl alcohol is superior in skin preparation and has demonstrated significantly better antimicrobial activity than other combinations
- Remove the applicator from the sterile wrapper and hold the sponge facing downwards.
- Allow the area to dry and it is now ready to be draped. The patient's final skin antisepsis preparation is complete.
- Any adverse reactions to skin antiseptic agents should be reported in the practice's adverse event reporting system.

References

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Procedures

Waste Guidance for Infection Control- Bin It Safely

Types of Waste

GENERAL WASTE

- Paper, Cardboard, Wrappings, Food bags, Plastic
- If uncontaminated by body fluids/solids, medicines or other potentially infectious contaminants. These items are general waste and recyclable or Black bag disposable

OFFENSIVE WASTE

- Non infectious body fluids, animal contaminated beddings, contaminated disposable wipes.
- The majority of the healthcare waste for practice. Routine kennel waste, wipes etc.
- Must not be contaminated with medicines or infectious material

Black
General non healthcare waste

Yellow & Black striped
Offensive Waste (Non-Hazardous)

Orange Bag/Bin
Hazardous Waste for processing

Yellow Bag/Bin
Hazardous Waste for incineration

Purple Bag/Bin
Cytotoxic/Cytostatic Medicines*

Blue Bin
Medicinal Waste (Non-Hazardous)

* for a list, see reading list below

HAZARDOUS WASTE

- Waste contaminated with infectious material. For practical purposes this will be healthcare wastes from isolation kennels
- Waste contaminated with Cytotoxic or Cytostatic medicines*
- Laboratory Waste

MEDICINAL WASTE

- Wastes contaminated with medicines
- Non-hazardous. Majority of medicines, used syringes, empty vials, contaminated packaging
- Hazardous Medicinal Waste. Waste contaminated with Cytotoxic or Cytotoxic/Cytostatic Medicines*.
- Sharps
- Hazardous waste all except Cytotoxic/Cytostatic* contaminated sharps
- Hazardous. Cytotoxic/Cytostatic* contaminated sharps

Further information:

- www.bsava.com Guide to the use of Veterinary Medicines
- www.bva.co.uk Waste Guideline (members area only)

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Staff Training Material

- Cleaning Methods and Disinfection Control Protocols
- How do you Assess the Hygiene Status of your Veterinary Facility
- Taking a Practice on an Infection Control Journey
- Why are barrier nursing protocols important in the veterinary care of pet animals
- Designing a Veterinary Facility with Infection Control in Mind
- In respect of veterinary practice hygiene, if you are not measuring it you cannot manage it.
- As professionals working in the Veterinary Sector, what should the Science and Experiences of Covid have taught us?
- Why is Positive Surveillance for Nosocomial Infection Vital in Veterinary Practice

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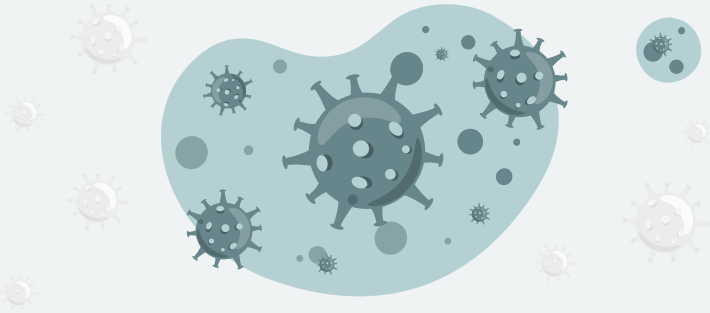
Staff Training Material

Cleaning Methods and Disinfection Control Protocols

How to use this guide

The emergence of multi-drug resistant bacteria, both within human healthcare facilities and veterinary practices has pushed the consideration as to the 'cleanliness' of all medical premises to the front of the public's minds and this could be considered as something which was maybe long overdue.

With no enforceable standards regarding the cleanliness of veterinary practices, there is a wide variation in what practices deem as being: 'adequate', 'aseptic' and appropriate levels of cleanliness for their practice environment and, indeed, what is appropriate for a small rural practice may well be very different from what should be expected for a busy 24/7 Referral and ECC facility. The reality is that most practices are managed rather as islands in an archipelago, in the manner deemed appropriate by the local tribal leader, otherwise referred to as a Clinical Director or Partner.



In these current days of antimicrobial resistance (AMR), post Covid and pre X pandemics, we must remember that

75% of new human infectious diseases are zoonotic, i.e. come from animals who could be our patients.

It is indeed past the time when a professional standard of cleanliness should be detailed and required of all practices. For this to be the case, whilst cleaning and disinfection methods can be suggested, it then becomes mandatory that the outcomes of infection control are quantified (measured) scientifically, so that not only we think we are doing it right, but we can prove we have based on the level of cleanliness measured.

OBJECTIVES AND AIMS OF THIS PROJECT

1. Empower them to investigate their own short fallings
2. Create their own solutions

It is only by getting all the staff team to buy into the problems and their own solutions, that they then own the outcomes and take pride in achieving them. It is by you personalizing these guidelines to fit your own practices, together with discussing challenges and solutions within the practice team & emphasising the importance of hygiene to the whole practice, that things will change.

When starting to create such protocols, many areas of cleaning and disinfection can be overlooked and so, working methodically, we (hopefully) have covered all the vital aspects. Indeed, it is only by using a significant number of swabs post sanitisation on a regular basis, that reservoirs of contamination, poor working practices or cleaning methods are discovered, which can then be corrected. See separate guidelines on post sanitisation measurements; it really is not taxing and need not be expensive. Moreover, having applied such techniques in many practices, we are convinced it is the only way to be certain that we are doing a sufficiently good job.

It is only by going through this process that we discovered that the dirtiest item in every practice is the kettle in the staff room, that oxygen flow nobs and volatile anaesthetic % control wheel, x-ray exposure trigger, x-ray collimation controls and cassettes, as well as patient restraint devices all tend to be overlooked in the vast majority of practices. So we have been on a journey over the last few years, we know what can be achieved and, by reducing contamination levels, we will also reduce veterinary practice acquired infection rates.

These guidelines should help practices working towards the RCVS Practice Standards Scheme. Looking to the future we hope our guidelines will provide a useful resource for the planned Infection Control module of the new modular Practice Standards.

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Staff Training Material

Designing a Veterinary Facility with Infection Control in Mind

When designing a veterinary facility, practice hygiene is of utmost importance for both the health of the animals being treated and the safety of staff and clients. Proper hygiene ensures that infections are prevented, surfaces remain clean, and the facility is a safe environment for animals, their owners, and staff. Here are several key considerations for integrating hygiene into the design of a veterinary practice:

Layout and Flow of the Facility

SEPARATION OF CLEAN AND CONTAMINATED AREAS

To prevent cross-contamination, design separate zones for clean and contaminated activities. For example, treatment rooms, surgery areas, and laboratories should be distinct from areas where pets are boarded or groomed.

ONE-WAY FLOW

Design the layout to encourage a one-way flow of animals and staff. For example, animals should enter the facility in a designated intake area, be treated or examined in a separate area, and leave through a different exit.

ISOLATION AREAS

Ensure there are isolated rooms or areas for animals with contagious diseases to prevent the spread of infections, moreover that high risk patients can gain access to these areas, without first contaminating clean areas of the facility.

AVOID SHARP INTERNAL ROOM CORNERS

As these are challenging to sanitise.

DESIGN OUT DUST TRAPS

Cupboards should go up to the ceiling so there is no dust trap on top of them. Ensure that all surfaces that must be sanitised are accessible. Ensure that all equipment is put away in cupboards, rather than being left out on shelves.

DO NOT ADMIT PATIENT CARRIERS OR EQUIPMENT WITH PATIENTS

Cat carriers, dog beds and toys are often the most contaminated surfaces in any vet facility; prevent their entry into your facility.

Materials Selection

NON-POROUS SURFACES

Choose materials that are easy to clean and disinfect, such as non-porous surfaces (e.g., stainless steel, epoxy-coated floors, sealed concrete), even in the clients' waiting area, as clients typically have low knowledge or awareness of the importance of infection control and hygiene. Avoid porous materials like untreated wood or carpeting that can harbour bacteria and other pathogens.

SEAMLESS SURFACES

Design with seamless surfaces in mind, as joints and seams in flooring, walls, and counters can trap dirt and bacteria.

ANTIMICROBIAL COATINGS

Consider using antimicrobial coatings for high-touch areas to reduce the buildup of bacteria, mould, biofilm or organic material.

Flooring

SLIP-RESISTANT FLOORING

Flooring should be non-slip and easy to clean. Rubber or vinyl flooring are good options for wet environments where spills may occur.

WATERPROOF FLOORING

Use waterproof flooring in areas prone to moisture, like exam rooms, surgery and bathing areas, to prevent water damage and bacterial growth.

COVING

The flooring in all clinical areas must include a jointed waterproofing of the bottom 15-25cm of the walls (coving).

Airflow and Ventilation

PROPER VENTILATION

Ensure good ventilation throughout the building to reduce airborne pathogens, (70% of the top 20 pathogens in veterinary practice have the ability to be airborne). The use of exhaust fans in surgery or treatment rooms helps maintain sterile environments and removes contaminated air.

HEPA FILTERS

Install high-efficiency particulate air (HEPA) filters in areas where sensitive animals are treated, to improve air quality and reduce allergens and airborne pathogens.

CLEAN FILTERED AIR

Should be introduced into clean areas, and soiled or contaminated air should be removed from more contaminated areas, thereby reducing the risk of contaminated air moving into clean areas.

Waste Management

MEDICAL WASTE DISPOSAL

Provide a well-designed and easily accessible area for disposing of medical waste (needles, bandages, etc.) in accordance with local regulations. This should be clearly separated from regular trash.

ANIMAL WASTE DISPOSAL

Design a designated area for handling animal waste. For example, use covered bins and waste disposal systems in areas like exam rooms and kennels.

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Cleaning/Changing Stations

HAND HYGIENE STATIONS

Install handwashing sinks or sanitising stations throughout the facility, especially in treatment areas, waiting rooms, and near animal handling areas. Ensure easy access to soap, water, and paper towels or hand dryers.

CLEANING SUPPLIES STORAGE

Provide ample space for the storage of cleaning materials, disinfectants and tools in a safe and organised manner. Ensure these supplies are easily accessible but out of reach of animals or clients.

ENSURE THAT STAFF ARRIVING TO WORK IN HOME SHOES/CLOTHES

Can change into clean work uniforms on arrival at work, without first contaminating clinical areas with home clothes.

Animal Handling and Safety

EXAM AND TREATMENT TABLES

Tables should be made of durable, easy-to-clean materials. They should also be adjustable to accommodate various animal sizes and allow staff to maintain proper hygiene while handling animals.

KENNELS AND CAGES

Design kennels with smooth, non-porous surfaces and ensure they are easy to clean and disinfect. Cages should also be large enough to allow animals to move comfortably while minimising stress.

ENSURE THAT SURFACE HYGIENE IS ASSURED BY REGULAR TESTING

ATP testing yields quantified surface hygiene assessment within seconds, to assure cleaning methods and clean working practices (i.e. avoidance of fomite creation).

Sterilisation and Surgical Areas

SURGICAL SUITE DESIGN

The surgical area should be designed with a clean, controlled environment in mind, with proper sterilisation stations for surgical instruments. Positive air pressure can be used to prevent contaminants from entering. No member of staff may enter a theatre at any time without applying suitable PPE, in particular a face mask.

AUTOCLAVE AREA

Designate a space for autoclaves and sterilisation equipment that is separate from areas where animals are treated to ensure a controlled environment for sterilising instruments.

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Lighting

BRIGHT, UNIFORM LIGHTING

Proper lighting is essential for cleanliness and safety. Well-lit spaces help staff spot potential issues with cleanliness and helps to ensure proper cleaning and sterilisation can take place.

UV-C LIGHTING

Some veterinary facilities use ultraviolet (UV-C) lighting in certain areas to help disinfect and kill germs in the air.

Maintenance and Inspection

EASY-TO-MAINTAIN DESIGN

Ensure that the building's design allows for easy maintenance of hygiene standards. For example, a design that allows staff to easily inspect and clean hard-to-reach areas can help maintain cleanliness.

REGULAR INSPECTIONS

Implement regular unannounced quantified measurements of cleanliness / contamination and inspections, in order to be able to assure clients, staff and owners of the hygiene outputs and standards. All areas should be measured, as apparent low risk areas or surfaces (e.g. kettle handles in staff rest areas) can often be the reservoir of contamination that is spread around the facility.

Client Education and Communication

CLEAR SIGNAGE

Use signs to educate clients on hygiene practices, such as using hand sanitisers, keeping pets on leashes, or not bringing sick animals into public areas.

WAITING AREA CONSIDERATIONS

Design a waiting area that encourages cleanliness. Use antimicrobial furniture and ensure that waiting rooms have ample space to keep animals and people distanced to reduce the risk of spreading germs.

By prioritising these aspects of hygiene in the design of a veterinary facility, you'll create a safe, functional, and clean environment that supports animal health, staff well-being, and client satisfaction.

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Staff Training Material

How do you Assess the Hygiene Status of your Veterinary Facility

Assessing practice hygiene risks in a veterinary facility is a critical component of infection control and overall patient and staff safety and should be conducted unannounced, on a regular (typically monthly) basis. Identifying and addressing potential hygiene risks helps to prevent nosocomial infections, maintain a clean and safe environment, and ensure the proper care of animals. A thorough hygiene risk assessment involves reviewing multiple aspects of the facility, procedures and personnel practices. Here's a comprehensive guide on how to assess the hygiene risks in a veterinary facility:

Evaluate the Facility Layout and Zoning

SEPARATION OF CLEAN AND DIRTY AREAS

Ensure that there is a clear distinction between clean areas (e.g. examination rooms, surgery suites) and dirty areas (e.g. isolation rooms, treatment areas, waste disposal zones). Cross-contamination between these zones should be minimised.

FLOW OF ANIMALS AND PERSONNEL

The layout should support a one-way flow for animals and personnel. Animals should not be moved through clean areas after being in dirty areas. Personnel should also be aware of the movement between zones and should follow protocols for changing PPE when transitioning.

ISOLATED HIGH-RISK ZONES

High-risk areas such as surgery suites, intensive care units (ICU) or isolation rooms should be isolated from other areas. Ensure that these zones are equipped with appropriate air filtration systems and that the layout minimises the risk of cross-contamination from other parts of the facility.

Assess Cleaning Protocols and Frequency

SURFACE AND EQUIPMENT CLEANING

Review cleaning protocols for surfaces, including floors, countertops, cages and exam tables. Are the surfaces being cleaned regularly with appropriate disinfectants? Ensure that high-touch areas (e.g. door handles, light switches, computer keyboards) are cleaned frequently, use ATP testing or alternate affordable, quantitative, patient side testing with rapid result availability.

EQUIPMENT STERILISATION

Review how medical equipment (e.g. surgical instruments, stethoscopes, thermometers) is sterilised and disinfected. Are autoclaves, sterilizers, and other cleaning equipment functioning properly? Do staff follow proper sterilisation protocols?

WASTE DISPOSAL

Assess how contaminated materials (e.g. surgical waste, soiled bedding, used bandages) are disposed of. Are there clearly designated areas for handling medical and animal waste? Are waste containers appropriately labelled and securely closed to prevent exposure?

Review Infection Control Procedures

HAND HYGIENE

Evaluate the availability and usage of hand hygiene stations. There should be no potential to touch an animal or any item of contaminated waste in any room in which you are unable to sanitise your hands before opening the door. Are staff regularly washing their hands or using hand sanitisers, particularly after handling animals, cleaning, or touching contaminated surfaces? Are handwashing stations well-stocked with soap, paper towels, and alcohol-based hand sanitisers? Good practice indicates that peer-on-peer hand-washing audits are conducted in all areas on a monthly basis.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

Assess the use of PPE, such as gloves, masks, gowns, and face shields. Are staff trained in the proper use and disposal of PPE? Do they understand when these are required, such as during surgery, while handling infectious animals, or when cleaning contaminated areas?

BARRIERS TO INFECTION SPREAD

Look for barriers such as disposable drapes, covers for exam tables, and protective gear for staff that reduce the risk of direct contact with contaminated surfaces or animals. Are these barriers regularly replaced or cleaned?

Inspect Ventilation and Air Quality

AIRFLOW AND FILTRATION

Evaluate the facility's ventilation system. Are there mechanisms in place (e.g. exhaust fans, HEPA filters) to control the flow of air and reduce the spread of airborne pathogens? Clean filtered air should be introduced into surgical areas, isolation rooms, and recovery areas from where air flows to less critical areas, to maintain cleanliness. Filtered air should be introduced into clean areas (e.g. theatres) and exhausted from contaminated areas (e.g. wards and laboratories) to ensure that air is always passing from clean to dirty and not vice-versa.

AIRBORNE CONTAMINATION

In high-risk areas like surgical rooms or ICUs, ensure that there is positive pressure (air flows in but not out) to keep contaminants from entering. In isolation rooms, negative pressure (foul air is extracted) to assist prevent the spread of airbone infection. Remember 70% of the top 20 pathogens in veterinary practice have the ability to be passed airborne. You cannot sanitise an airborne infection without airspace sanitisation, i.e. airborne disinfection by fogging, using a disinfectant with safety and efficacy certification for use in this way.

Assess Risk of Cross-Contamination

ANIMAL HANDLING

Review how animals are handled throughout their visit. Are there protocols in place to limit direct contact between healthy animals and those with infectious conditions? Are animals with contagious diseases isolated immediately upon arrival?

USE OF COMMON AREAS

In areas such as waiting rooms, kennels, and grooming spaces, assess whether there is a risk of cross-contamination between animals. Are these areas cleaned and disinfected regularly? Are animals with contagious conditions segregated from others in these spaces?

SHARED EQUIPMENT

If animals share equipment (e.g. exam tables, leashes, toys), assess how these items are cleaned and disinfected between uses. Shared items can be a significant source of cross-contamination.

EVALUATE, TRAIN AND ASSESS THE RISKS OF EXOGENOUS CONTAMINATION

i.e. infection risks from outside of the patient, i.e. spread of infection on staff uniforms, equipment, patient food / water, fomites around the building etc. Such risks commonly arise due to lack of monitoring, poor training and poor working practices.

Monitor and Evaluate Staff Training and Compliance

TRAINING IN HYGIENE PRACTICES

Evaluate whether all staff, including veterinarians, technicians and support staff, receive regular training on hygiene protocols, infection control procedures and PPE usage. Are staff up to date with the required hygiene and infection control training and is there a documented record available?

STAFF COMPLIANCE

Assess how well staff adhere to hygiene protocols. Are staff members following hand hygiene and PPE guidelines? Is there regular oversight or auditing to ensure compliance with cleaning and sterilisation procedures?

STAFF AWARENESS

Regularly test staff knowledge of infection control procedures. This could be done through quizzes or practical observations to ensure staff are competent in handling hygiene and infection control procedures.

PEER-ON-PEER, MONTHLY HAND WASH AUDITS

Are advised in all veterinary facilities.

Examine Animal and Facility-Specific Risk Factors

ANIMAL POPULATION RISK

Consider the type of animals being treated in the facility. Are there specific animal populations at higher risk for infection (e.g. immune-compromised animals, young puppies or kittens, elderly animals, or those with pre-existing conditions)? Does the facility have protocols in place to address the increased hygiene needs of these animals?

SURGICAL AND CRITICAL CARE AREAS

Evaluate the cleanliness and infection control measures in areas where surgery or critical care is provided. Are sterilisation protocols followed meticulously? Are high-risk procedures and post-operative care areas carefully monitored for signs of infection?

Assess Environmental Control Measures

CLEANING MATERIALS AND DISINFECTANTS

Review the types of cleaning agents and disinfectants used in the facility. Are they effective against the pathogens common in veterinary settings? Do staff use them according to the manufacturer's instructions, including dilution rates and contact time?

PPE, UNIFORM, LINEN AND LAUNDRY HANDLING

Evaluate how soiled linens, bedding and towels are handled. Are they washed and disinfected appropriately? Is the laundry area kept clean and free of contamination?

Check Record-Keeping and Incident Documentation

INFECTION TRACKING

It is vital that 'positive nosocomial infection surveillance' is applied in any veterinary facility. Review the records of infections or hygiene-related incidents in the facility. Are there logs for tracking infections, particularly nosocomial infections, and are these being regularly reviewed? Are there protocols for reporting infections and how are these infections addressed?

AUDITS AND INSPECTIONS

Review the documentation of routine hygiene audits, which must include regular, unannounced multi-site (typically 100 swabs for a referral hospital, 50 for small animal hospital, 25 for a standalone facility with a low case load of minor surgical patients, 15 for a non-surgical branch surgery – as a starting point, once average swab results for the whole facility are no more than 50% above the recommended threshold, then swab numbers can be reduced by half, but the frequency of testing should be maintained as 'monthly') quantitative surface testing, e.g. application of ATP testing and inspections. Regular unannounced ATP testing will detect any reservoirs of contamination or infection, as well as poor working practices.

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Assess Client and Public Interaction

CLIENT EDUCATION

Evaluate how the practice educates clients on hygiene practices. Are clients instructed on how to keep their animals clean and healthy? Are there signs and guidelines to promote hygiene, such as instructions for handling pets in the waiting room or proper disposal of waste? Is the important of 'positive surveillance for nosocomial infection' shared with clients and their assistance sought?

CLIENT ACCESS TO HYGIENE STATIONS

Are hand sanitisers and hygiene stations available for clients in the waiting areas? Is there enough signage to remind clients to practice proper hygiene when entering or exiting the facility?

A hygiene risk assessment involves a detailed review of the veterinary facility's layout, cleaning protocols, infection control measures, staff practices and environmental factors. Identifying potential hygiene risks and addressing them proactively can help prevent the spread of infections, safeguard animal and staff health, and improve overall facility safety and quality of care. Regular assessments, ongoing staff education, and consistent monitoring are essential to maintaining high hygiene standards in any veterinary practice.

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Staff Training Material

In respect of veterinary practice hygiene, if you are not measuring it you cannot manage it.

There are several methods to measure cleanliness in a medical environment, each with its own advantages and applications. Quantifying surface contamination in a medical setting is critical for ensuring a clean and safe environment, especially in places like hospitals, clinics, and laboratories. Surface contamination can harbour pathogens, including bacteria, viruses, and fungi, and can lead to infections or cross-contamination. There are several methods to quantify contamination, depending on the type of contaminant and the level of sensitivity required. Here are the common approaches.

Visual Inspection

HOW IT WORKS

Trained personnel visually inspect surfaces for obvious dirt, stains, or biological material. It may involve the use of UV light to detect hidden organic residues.

LIMITATIONS

This method is subjective and cannot quantify microbial contamination accurately. It is best used for preliminary checks or for gross contamination but is now proven to be characteristically grossly over-optimistic and inaccurate, yielding a false sense of security. This method alone is no longer deemed appropriate.

Adenosine Triphosphate (ATP) Testing

HOW IT WORKS

ATP testing uses a bioluminescence reaction to detect the presence of ATP, a molecule found in all living cells. Swabs or wipes are used to sample surfaces, and the amount of ATP detected correlates with the level of contamination.

QUANTIFICATION

The amount of light emitted from the ATP reaction is measured in relative light units (RLU), and this value is compared to a predefined threshold to assess the contamination level.

ADVANTAGES

Provides rapid results, usually within seconds. It is sensitive to organic contamination (including bacteria, fungi, and animal cells e.g. blood or plant cells).

LIMITATIONS

ATP can be present from non-microbial sources, like cleaning products or food residues, which may lead to false positives.

Microbial Sampling (Swab Testing)

HOW IT WORKS

Swabs are taken from surfaces and cultured in a laboratory to identify the types and quantity of microorganisms present. The swab may be analysed for bacterial or viral load through culture techniques or molecular methods (e.g., PCR).

QUANTIFICATION

The number of colony-forming units (CFUs) is counted to quantify bacterial contamination. The result may be expressed as CFU per square centimetre or other units depending on the surface area.

ADVANTAGES

Directly quantifies viable microorganisms on surfaces. Culture-based methods provide identification of specific pathogens.

LIMITATIONS

Takes longer (typically 24-72 hours) and requires laboratory infrastructure.

Contact Plate (Settling Plate) Method

HOW IT WORKS

A contact plate containing a nutrient agar medium is pressed against a surface for a short period. Microorganisms on the surface will transfer to the plate, which is then incubated to allow growth.

QUANTIFICATION

CFUs are counted on the plate after incubation to assess microbial load.

ADVANTAGES

Simple and effective for detecting surface contamination.

LIMITATIONS

May not always provide a representative sample if not enough microbial matter is transferred to the plate, and it typically only detects microorganisms that settle on the plate during the short time it's in contact with the surface.

Wipe Sampling

HOW IT WORKS

A sterile wipe is used to sample a known area of a surface. The wipe is then placed in a buffer solution, and the solution is tested for microbial contamination or other residues.

QUANTIFICATION

The amount of contamination is usually reported in CFUs or through biochemical or chemical tests (e.g., proteins, pathogens).

ADVANTAGES

Can cover larger areas than a swab and allows for more thorough sampling.

LIMITATIONS

The method can be labour-intensive, and the buffer solution may dilute the contamination, potentially underestimating the true amount.

Fluorescent Dyes or Markers

HOW IT WORKS

Fluorescent markers (such as fluorescein or rhodamine) are applied to surfaces, and the surfaces are then wiped or scrubbed. The remaining fluorescence is measured using a fluorometer, indicating how much of the marker is still present.

QUANTIFICATION

Fluorescent readings are correlated to the level of contamination on the surface, often with a threshold indicating acceptable contamination levels.

ADVANTAGES

Fast and non-invasive; provides quantitative data on surface cleanliness.

LIMITATIONS

Only applicable to certain types of contamination (those that the fluorescent markers can bind to) and may not detect all microbial contaminants.

Surface Sampling via Contact Biopsy (Scraping)

HOW IT WORKS

A surface is scraped to collect debris and microorganisms. The collected sample is analysed for microbial load or contaminants.

QUANTIFICATION

Samples are analysed in a lab for CFU counts or other markers of contamination.

ADVANTAGES

Can collect a relatively large sample from rough surfaces.

LIMITATIONS

May be more invasive than other methods and may not be practical for all types of surfaces.

Chemical Indicators

HOW IT WORKS

Chemical indicators, such as pH indicators or special tests for proteins or organic material (e.g., protein tests for blood or bodily fluids), are used to quantify contamination.

QUANTIFICATION

Based on colour change or reaction intensity.

ADVANTAGES

Some methods (e.g., blood residue testing) provide specific information about certain types of contamination.

LIMITATIONS

Limited in scope; does not directly measure microbial contamination.

Real-time PCR (Polymerase Chain Reaction)

HOW IT WORKS

Surface samples are analysed using PCR to detect and quantify DNA or RNA of specific pathogens or microorganisms.

QUANTIFICATION

Quantitative PCR (qPCR) is used to measure the concentration of target DNA, and the results are reported in copies per sample or per unit area.

ADVANTAGES

Highly sensitive, capable of detecting low levels of contamination, and specific for pathogens.

LIMITATIONS

Requires specialised equipment and expertise and may not differentiate between live and dead organisms.

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Environmental Monitoring Systems

HOW IT WORKS

Automated systems or integrated sensor technologies can continuously monitor surfaces for contamination, typically detecting specific pathogens or microbial presence.

QUANTIFICATION

Real-time data collection, often displayed on a dashboard that shows contamination levels over time.

ADVANTAGES

Can provide ongoing data and help manage infection control in real-time.

LIMITATIONS

Can be expensive and may require sophisticated infrastructure.

Factors to Consider

SURFACE TYPE

Porous surfaces may require different sampling methods compared to smooth, non-porous ones.

LEVEL OF CONTAMINATION

The sensitivity required will vary depending on the level of contamination expected.

TYPE OF CONTAMINANT

Specific tests may be needed for certain types of contaminants (e.g., blood, bacteria, viruses).

REGULATORY STANDARDS

Medical settings often follow specific guidelines for surface contamination, such as the CDC, WHO, or other healthcare organisations' protocols.

The method you choose will depend on the level of contamination, the type of microorganism or residue you are detecting, and the speed and sensitivity required. For routine surface contamination monitoring, ATP testing, microbial swabbing, and wipe sampling are commonly used. However, for more specific pathogen detection, methods like PCR or microbial culturing may be necessary.

After considerable research, in practice trials and testing, BMF is of the opinion that ATP testing provides a very useful, rapid and economic quantifiable test, which is invaluable for assessing surface contamination, also for detecting both reservoirs of contamination / infection, but also poor working practices. Where persistent failures are detected, ATP may be usefully backed up by the use of microbiology testing.

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Staff Training Material

Taking a Practice on an Infection Control Journey

INFECTION CONTROL EDUCATION FOR VETS NURSES AND OWNERS

Infection Control Journey

Professor Dame Sally Davies, the government's Chief Medical Officer stated that AMR was as great as Global Warming. – meaning the concerns/ Risks/threat – should prob qualify this.

Hopefully all readers are now well aware and completely supportive of the concept that the routine use of prophylactic antibiotics in elective surgical and medical cases should be avoided due to concerns about antimicrobial resistance (AMR). Exceptions include: surgeries lasting longer than 1.5 hours, known breach of asepsis, pre-existing tissue infections, surgical implantations, or where postoperative infections could be life-threatening (e.g., CNS surgery). Professor Dame Sally Davies, Chief Medical Officer, has likened AMR to global warming in terms of its significance.

Research has demonstrated AMR as a global problem, with the MCR-1 plasmid detected in food-producing and companion animals not only in China but across the globe (Liu et al., 2016). This plasmid, found in a range of bacteria, allows bacterial pathogens to bypass the slow process of natural selection and allows them very rapidly to spread resistance through direct genetic transfer.

Nosocomial (hospital-acquired) infections are prevalent in veterinary hospitals, with incidence rates ranging

from **4-9%** (Mielke, 2010) ···→ but could be as high as **32%**

compared to a human level of 5-10% (Burke, 2003) but it is suggested that 10-70% of these cases are preventable (Harbarth et al 2003).

These infections arise within 48 hours of admission until up to 30 days following discharge, and include UTIs, surgical wound infections, and infectious diarrhoea. Historically efforts focused on the control of infectious diseases such as canine parvovirus, more recently, zoonotic infections like MRSA, C. difficile and MRSP have been of particular concern. Veterinary staff and their pets, due to their frequent exposure, are at higher risk of MRSA, and consequently contribute to patient contamination.

To improve infection control

It is recommended that a key staff member undertakes an infection control CPD course. This individual would serve a role similar to that of an infection control Matron in human hospitals. However, the entire team must adopt new working practices, prioritising infection control. Nosocomial infection risk increases just by meeting veterinary staff and is proportional to the patient's condition and length of hospitalisation; practices should separate high-risk and low-risk patients accordingly.

We have been warned and so how can we best achieve changes on a day-to-day basis within our own facilities. BMF advocates that a key member of 'long term staff', should enrol on a structured, externally validated 'infection control and hospital biosecurity' CPD course, e.g.

http://www.bvna.org.uk/cpd/infection-control

A post similar to the infection control Matron within every human hospital, but the whole Team must be involved to implement and continue the changes.

This article is based on a journey involving one of the BMF Trustees in their own practice. A series of staff meetings were arranged, with mandatory attendance by all clinical and non-clinical staff members.

The stage was set and the problems were discussed. It was explained that all practices will suffer nosocomial infections, the incidence in veterinary practice is stated to be:

4-32%

but that in well managed facilities the levels can be lower.

Infection Control Journey

Professor Dame Sally Davies, the government's Chief Medical Officer stated that AMR was as great as Global Warming. – meaning the concerns/ Risks/threat – should prob qualify this.

The key point learnt is that each type of patient (species, breed, sex, age and ongoing health status), creates a differing 'risk of infection'. The risk presented by each patient must be assessed, managed and controlled. High risk patients should be separated from low-risk patients, elective surgical patients should be kept separate from high risk patients. Rooms used by patients of differing risk status should be classified differently, (high, medium, low risk). Ideally, elective and orthopaedic surgical patients should be kept in 'clean' wards, treated by 'clean vets and nurses', in a theatre which is only used for 'clean' patients.

Proper cleaning protocols must be applied based on risk levels (frequency, diligence, appropriate disinfectant in respect of likely pathogens, delivery method, concentration and contact time). Surfaces which are already recognized as likely to be contaminated (floors, cages) are likely to be regularly disinfected and are generally very clean, but a leading cause of contamination is fomite transmission, primarily through staff hands. Common areas of concern include hand-contact surfaces such as door handles, stethoscopes, and keyboards. Staff uniforms, shoes, and separation between clinical and non-clinical areas must also be managed to prevent contamination and we need to identify these areas within our own practices. Apart from endogenous infection from patients and fomite spread by staff hands, staff clothing (changing into clean uniforms on arrival at work, and not contaminating clothing, e.g. cuddling patients or pets then working in a sterile situation), only wearing clinical shoes (only worn in clean areas of the hospital) in clinical areas and limiting entry into clinical areas and limiting entry into clinical areas to clinical staff are also important.

Hand wash facility check list

In your facility, are their hand wash or sanitisation facilities in all of the following situations	YES	NO
Before clients or staff enter a consulting room		
Before any staff member enters any clinical area		
Before entering and on leaving a staff room or changing room		
After handling any patient, before you touch a door handle, i.e. before leaving the room, e.g. any ward, consulting, diagnostic or triage room		
Before leaving a laboratory		
Any other situation where hands may become contaminated		
Are all staff, students, visitors trained in hand washing		
Is a monthly hand wash audit carried out		

Writing an infection control policy with standard operating procedures (SOPs) ensures everyone follows the same protocols

Infection Control in Practice: A Long-Term Commitment

Staff practices such as wearing clean uniforms and using only clean clinical shoes in designated areas, along with adhering to safe and efficient practices aligned with the practice's infection control policy, are crucial. These measures are not just important during inspections but represent a long-term change in working habits. An effective infection control policy should not be just a document on the shelf but a guide to how we must work and live within the practice.

We recognize that certain surfaces in clinical areas, such as floors and cages, will inevitably become contaminated. These areas must be cleaned, including deep cleaning and biofilm removal, at a frequency proportional to their contamination level and location. After cleaning, an appropriate disinfectant, effective against likely pathogens, (eg parvo/lepto) should be applied using a method suitable for the route of contamination. For example, solid surfaces like floors and cages may need different disinfectant methods compared to air-borne pathogens like kennel cough or psittacosis. Disinfectants must also be safe for staff and patients during application.

Engaging Staff in Infection Control

Maximizing the benefit of staff meetings involved explaining the risks and encouraging staff to identify and take ownership of those risks. Staff should pride themselves on suggesting solutions. At this point, an infection control staff member should formalize a written infection control policy, including Standard Operating Procedures (SOPs), which should be created, agreed upon, and shared with the entire team.

Managing Hygiene Improvements

It is vital to understand that «looking clean» or «smelling clean» does not guarantee that an area is free of bacterial contamination. The next step in your infection control journey is identifying those areas where contamination may be lurking, even if unnoticed. Enhanced cleaning protocols and monitoring methods are key to this process.

Monitoring Cleaning Effectiveness

OVERT AND COVERT MONITORING

Overt monitoring of cleaning has been shown to be effective but time-consuming. Covert monitoring, though challenging, may provide more authentic results when staff are unaware they are being observed.

FLUORESCENT GEL/SPRAY/POWDER

This cost-effective tool can visually demonstrate to staff whether cleaning has been effective and can verify hand-washing efficiency.

ATP TESTING

Adenosine triphosphate (ATP) testing is a sensitive and quantitative method to measure biological contamination. It is a nucleoside triphosphate, a small molecule used in cells as a coenzyme and is often referred to as the «molecular unit of currency» of intracellular energy transfer. ATP transports chemical energy within cells for metabolism, used for the synthesis of proteins and membranes, movement of the cell, cellular division, etc.. ATP is one of the end products of photophosphorylation, aerobic respiration, and fermentation, and is used by enzymes and structural proteins in many cellular processes, including biosynthetic reactions, motility, and cell division. ATP levels have been proven to be closely related to the level of contamination/cleanliness, and testing can detect areas where cleaning has failed. ATP testing has been used for decades to validate hygiene standards, particularly in food production and healthcare settings.

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Application of ATP Testing

The real value of ATP testing is determining when cleaning has not met necessary standards. It offers real-time verification of cleaning and hand-washing efficacy. It allows infection control managers to pinpoint problem areas, assess risks, and implement solutions before contamination leads to infections. The references provided below, give long-term data on outcome measuring in a number of human healthcare situations: published independent data has shown: 40-70% reduction in cleaning failures over a five-year period (Hartlepool / North Tees Hospitals), a 35% reduction in C difficile. cases, a 39%, in another case a 51% reduction in nosocomial infection rates, a 77-92% reduction in contamination levels.

In our test veterinary settings, ATP testing has been invaluable. For example, surfaces expected to be contaminated (reception desks, consulting room floors) were found clean, while items like door handles, stethoscopes, and keyboards were problematic. Other difficult-to-clean items, such as ultrasound controls, anaesthesia flow meters, and even x-ray cassettes, were identified as areas needing attention.

Infection Control: An Ongoing Effort

Infection control is not a task for the week before an inspection. It must be a regular, ongoing effort embraced by the entire clinical team. Human healthcare recommendations suggest unannounced hygiene audits at least three times a year. Within the veterinary sector, the recommended frequency of audits may vary:

- Referral and teaching hospitals: monthly
- Veterinary hospitals: monthly
- Veterinary practices: every two months
- Veterinary clinics: every four months

Unexpected Findings

Non-clinical areas, such as staff rooms, often harboured the most bacterial contamination. Items like the hot water tap, frequently handled by unsanitised hands, proved to be the most consistently contaminated. Solutions such as retraining staff and installing hands-free, infrared-controlled hand sanitizers have proven effective in resolving these issues.

Key Learnings for Optimizing Practice Hygiene

ANTIMICROBIAL RESISTANCE (AMR)

Hygiene standards must be optimized to prevent nosocomial infections, as reliance on prophylactic antibiotics is no longer viable.

STAFF RESPONSIBILITY

A dedicated staff member must be trained, given authority, and time to manage infection control, supported by a structured, externally-verified training program.

PRACTICE-WIDE COMMITMENT

Infection control systems will only succeed with full support from management and staff. We have a responsibility.

EFFECTIVE CLEANING

Cleaning before disinfection (including biofilm removal) is essential. ATP testing is highly advantageous for verifying cleaning efficiency.

ASSESSMENT IS ESSENTIAL

«Looks clean, smells clean» does not guarantee cleanliness. Some form of verification is essential to assess cleanliness.

REGULAR AUDITS

Ongoing, unannounced hygiene audits using ATP or microbiology testing are crucial to maintain standards and reduce contamination levels. In human research, hospital acquired infections were reduced by 30-51%.

DISINFECTANT EFFICACY

Ensure that disinfectants meet the necessary standards for bacterial, viral, and fungal reduction.

AIRBORNE PATHOGENS

For airborne infections (e.g., cat flu, kennel cough), fogging with non-corrosive disinfectants is highly effective. 70% of the top 20 pathogens can be airborne.

HAND SANITIZATION

Proper hand sanitization, in line with WHO guidelines, is essential before and after patient handling. Non-touch dispensers should be available in convenient locations.

HIGH-RISK AREAS

Areas like consulting tables and floors, though frequently cleaned, may not be as problematic as commonly touched items like door handles and stethoscopes.

NON-CLINICAL AREAS

Staff rooms and other shared spaces often have the highest bacterial contamination and should be regularly disinfected.

SEPARATION OF CLINICAL AND NON-CLINICAL

Clinical staff, areas, and clothing should be kept separate from non-clinical counterparts.

DIFFICULT-TO-CLEAN OBJECTS

Items such as oxygen flow meters and patient restraint devices are common fomites that require extra attention.

No one knows how clean their practice is without regular testing. Once infection control issues are identified and resolved, staff can take pride in maintaining high hygiene standards, improving the overall safety and well-being of patients and staff alike.

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Staff Training Material

As professionals working in the Veterinary Sector, what should the Science and Experiences of Covid have taught us?

Abstract

Covid has focused many minds in respect of infection control, biosecurity, zoonosis and nosocomial infections. If anything positive can come from the pandemic, perhaps it may be a 'light bulb moment' just as cleanliness was for Florence Nightingale so many years ago, teaching us all some important and uncomfortable home truths. Covid was not the first, nor will it be the last global pandemic. All of us in health care sectors have a duty of care to patients, staff and populations alike, to take basic infection control procedures.

1.27 million

human deaths occured woldwide in 2019 due to antimicrobial resistance

10 million

human deaths due to antimicrobial resistance are predicted by 2050

The critical need for improved levels of hygiene, especially within the healthcare sectors (together with responsible antimicrobial use), has never been greater.

80%

reduction in pathogen load is achieved through detergent cleaning alone, whilst combined 'disinfectant cleaning' does not maintain a surface clean for any longer than detergent alone.

OPTIMAL OUTCOMES ARE ACHIEVED BY APPLYING A 'TWO PHASE PROCESS'

1. Removal of the bio-load by detergent cleaning
2. Application of an effective disinfectant.

Moreover, we cannot rely on human cleaning and disinfection alone in busy clinical settings. We must use procedures and techniques which can run simultaneously with 'on-going clinical activities' that are proven to be safe (to patients, staff and the environment) and effective (to national or international standards), within the specific clinical setting. We must test and measure outcomes, we must investigate nosocomial and zoonotic incidents. We must continue to learn and improve.

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Introduction

Now that it seems most likely that the infection was derived from bats or other wildlife species in a 'wet market' in Wuhan, China, (Haider et al 2020), we are reminded that differing inpatients and outpatients each carry a variable endemic contagion risk to our facilities, staff and other patients (Wright et al 2008), and patients should be assessed and managed at all stages of their journey through our facility, on a contagion and infection risk control basis.

Covid is not the first, nor will it be the last, zoonotic pandemic infection.

>60%

of known infectious diseases in people can be spread from animals

75%

of new or emerging infectious diseases in people come from animals.

They can be spread in a number of ways, including direct or indirect contact, vector-borne, foodborne or waterborne (MSD 2021).

Whilst some here in the UK take pride in being an island race, Covid has been a timely reminder that in these days of globalisation, high population densities and frequent international travel, infection and contagion control must be considered on a global sense, in which the weakest link in the chain creates the greatest risk.

As veterinarians – clinicians and business owners, we have a duty to our clients and our businesses to maintain effective control of contagious infections (both those we know about now, as well as those that are as yet unknown). Such infections are not only important to our clients, patients, staff and business, but sick animals are accepted to be the source of 75% of new emerging infectious diseases of humans (MSD 2021).

Whilst we have all been focusing on Covid-19, Laximinarayan (2022) reminds us of the 'forgotten pandemic of anti-microbial resistance'. Laximinarayan quotes Murray (2022) in estimating 1.27 million human deaths globally due to AMR in 2019, a figure which is almost identical to the combined global deaths, over the same period, caused by HIV and Malaria, whilst WHO figures (November 2019 to January 2022) for Covid 19 are four times higher, albeit over a longer time period.

Anti-microbial Resistance (AMR)

Despite all the hype of the last 5 years, the recent Lancet publication (Laximinarayan 2022) demonstrates clearly that

AMR is the silent pandemic, killing more people than Malaria or AIDS and close to Covid-19

So despite the infection control measures thrust upon us by the experience of Covid, we are still failing to meet the challenges of infection control and hence, as a spin off, of the AMR pandemic. Responsible use of antibiotics is essential but, more importantly, we must continue the drive to reduce the requirement for antibiotics by improved animal husbandry (in particular, in food producing species) and this can only be achieved by improved biosecurity and infection control, by improved standard operating procedures, better cleaning, disinfection and the monitoring of the outcomes of infection control.

NOSOCOMIAL INFECTIONS AND CONTAMINATED SURFACES

Whilst we have all been excited and focused on Covid, we are reminded that in recent years the incidence of nosocomial infections in humans subsequent to hospital visits, was outed as a scandal (Boyce 2016).

In a London teaching hospital (French et al 2004)

70%
% of ward swabs failed for MRSA prior to cleaning.

66%
of swabs still failed for MRSA after traditional cloth and mop cleaning and disinfection.

1.6%
was the failure rate after disinfection by fogging with a peroxide-based disinfectant.

Gebel et al (2013) confirmed the role of contaminated surfaces in the transmission of pathogenic microorganisms causing healthcare-acquired infections.

EFFECTIVENESS OF CLEANING AND DISINFECTION PROCEDURES

White et al (2007) demonstrated that the bacterial load is reduced by 80% from surfaces by detergent cleaning alone and disinfectant cleaning does not generally maintain a surface pathogen free for any longer than detergent alone (Dharan et al 1999), whilst a 'two stage cleaning', with detergent removal of bioload, followed by disinfectant treatment achieved the best results overall. Moreover, there is laboratory evidence suggesting that biocides used at a sub-lethal concentration may trigger the expression of biocide resistance and/or select bacteria resistant to antibiotics (Maillard & Denyer 2009, Karatzas et al 2008). In light of this, biocides are not recommended for use in situations where environmental conditions will compromise their efficacy, i.e. where excessive organic material remains present, as cleaning has not been undertaken prior to disinfection.

HYGIENE CONTROL AND MONITORING

86,4%

of unannounced cleanliness audits in human hospitals, using bacterial swab culture (Anderson et al. 2011), revealed hygiene failure, while adenosine triphosphate (ATP) testing, a faster method providing immediate results at the patient's bedside, showed a failure rate of 84% (Schabrun & Chipchase 2006).The use of post cleaning hygiene monitoring using florescent markers, ATP or microbiological testing has proven valuable in improving cleaning efficacy (Carling et al 2016).

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AUTOMATION OF DISINFECTION PROCEDURES

Dancer (2012), demonstrated that in any busy clinical situation, simple infection control procedures are abandoned, ignored or forgotten when staff are overworked. Indeed, all hygienic practices are consistently challenged on a busy ward. For this reason, the use of automated disinfection procedures, using aerosolisation of effective antimicrobial solutions is of great assistance, although no one should ignore the need for the regular use of detergents to remove organic material prior to disinfection.

Byrns and Fuller (2011) trialled various methods of aerosolisation of biocides for the sterilisation of spaces in buildings. Where effective biocidal agents were applied, they reported high levels of efficacy, noting the benefit of reaching and penetrating into areas which would not otherwise be sanitised, or that at the end of a busy day just get missed or forgotten about. However, the technique is not universally recommended unless the agent used is safe for staff and patients, or in situations where the facility can be emptied prior to application.

Many automated systems can only be used when clinical areas are empty of patients and staff, which inevitably limits their application, especially when applied in facilities with multiple patients which are rarely, if ever, empty. In contrast, where automated systems use effective agents that can safely be used with either patients and/or staff in situ, such that regular timed, automated delivery can be maintained, the optimal efficacy is achieved, although few antimicrobial solutions meet these exacting requirements (efficacy and safety).

Some disinfectant compounds comprising of a surfactant plus an antimicrobial substance such as a quaternary ammonium are designed to minimize bacterial contamination of surfaces by maintaining their antimicrobial activity on surfaces for weeks or months. To date, the ability of these compounds to prevent contamination of surfaces for prolonged time periods is unclear. Two studies have reported persistent antimicrobial activity of varying levels for differing time periods (Baxa et al 2011, Tamimi et al 2014). Further evaluation of organosilane-type compounds using a variety of application methods appears warranted.

Disinfectant application techniques, either by the use of aerosolisation or application of some disinfectants with a microfiber cloth, are demonstrated to have marked advantages over the use of a cotton-based cloth, as QAC compounds can bind to cotton, rendering the availability for disinfection partially limited (Engelbrecht et al 2013).

It should be remembered that, just as antibiotics (e.g. penicillins and cephalosporins) are available in 'generations', so too are many of the disinfectants. Categorisation and consideration of the efficacy and safety of a disinfectant product should not be based simply on the class of constituent chemical, but rather on external certification by a government approved laboratory in respect of: its patient and user safety, its efficacy (against standard pathogen types and models), as well as its environmental residue safety. Users should be aware of what constitutes efficacy, based on the requirements within their own geographical area.

In the UK, standards require:

- **Log^5 kill of bacteria** (standard tests e.g. Staph., Pseudomonas, Mycobacterium, E. Coli,)
- **Log^4 kill of viruses** (standard tests e.g. FMDV, AI, Parvo, - enveloped and non-enveloped)
- **Log^3 kill of fungae and yeasts** (standard tests e.g. *Aspergillus* spp, Trichophyton, Candida)
- **Log^4 kill of bacterial spores**

Clinicians must be aware of the necessary contact time for their disinfectant under standard operating conditions (i.e. temperature and concentration), and must consider if this is achievable, e.g. the spraying of a dirty consulting room table and immediate wiping with a dry paper towel before the next patient is ushered in, may not be realistic or effective.

For busy clinicians managing excessive caseloads, the expectation of relying solely on human staff to complete effective cleaning and disinfection in the clinical workplace has proven flawed. In truth, effective disease control cannot be delegated to overstretched cleaning and nursing staff, as the importance of proper cleaning and disinfection is simply too important and the results of failure may be severe.
Facility cleaning protocols must emphasize the importance of periodic deep cleaning, including the chemical removal of the lipid surface layer. The frequency of both routine and deep cleaning should be based on the potential contamination risk and the impact of contamination in each clinical setting.

Disinfectant Efficacy against Covid and Why?

NEW DISINFECTANTS AND APPLICATION TECHNIQUES

In these challenging times, any disinfectant used in veterinary practice must have proven efficacy against Covid-19, as well as all standard veterinary pathogens, relevant to the practice in question.

Coronaviruses are a large family of viruses. Some coronaviruses that infect animals can be spread to people and then spread between people, but this is rare. This is what happened with SARS-CoV-2 (i.e. Covid-19), which likely originated in bats. Such infections may cause cold-like illnesses in people. Others cause illness in certain types of animals, such as cattle, camels, and bats. The Centre for Disease Control (2021), has shown that a number of animals worldwide have been infected with COVID-19, including pets such as cats and dogs, farmed mink, and large cats, gorillas, and otters in zoos, sanctuaries, and aquariums. Reptiles and birds have not been affected by this virus. The UK Government has reported that Covid can infect a range of animals. Their published advice is as follows:
Animals can catch SARS-CoV-2. It is rare, and they may show only mild clinical signs and recover within a few days. We don't yet know all of the animals that can get infected. There is evidence that the following species can catch the virus that causes COVID-19:

- Big cats
- **Coatimundi**
- Domestic cats
- Dogs
- **Minks**
- Ferrets and polecats
- **Fruit bats**
- **Hyenas**
- Primates
- **Pangolins**
- **Pigs** (these are less prone to catching SARS-CoV2)
- **Raccoon dogs**
- Rodents, including hamsters
- **White-tailed deer**

There is growing evidence that mink, cats, white-tailed deer and hamsters can spread the virus through close contact with their own species in captivity.
Animal fur can act as a carrier (known as fomite transmission) for the virus that causes COVID-19 for short periods of time, in the same way as other surfaces.

Limited evidence suggests that COVID-19 can pass:

- From infected humans to the listed animals after close contact or sharing their equipment or airspace; this is referred to as reverse zoonosis, a good case example is described by Koeppel (2022)
- Between mink kept in captivity and then transferred to humans in close contact
- From infected hamsters to humans in close contact
- Between ferrets, raccoon dogs, white-tailed deer and mice infected by experimental testing
- Between ferrets infected by experimental testing and transfer to humans

As veterinarians, we must be cognisant of the risk of covid infection in both domestic and other animals in order that we can reassure and protect pet owners, staff and business owners alike. We must do all that is possible and responsible to manage the risk so that the chances that any out-patient or hospitalised pet visiting our facility might contract covid and take the infection home to then transfer it to their owner is minimised. Likewise we must minimise the risk of staff being infected from any patient whether it be domestic, farm animal or wildlife.

In the article above, we have described the need for detergent cleaning of surfaces prior to disinfection, and we have highlighted with references the typically poor outcomes achieved when cleaning and disinfection is left in the hands of clinical staff, but that automated non-touch disinfection methods, (subsequent to cleaning), is the infection control method of choice.

Fogging

This is the application of a biocide / disinfectant solution (of external, quality-controlled government licensed laboratory proven efficacy) which sanitises large areas of a building quickly and effectively. It can kill off the virus and other biological agents in the air and on surfaces. The task involves spraying a fine mist from a spray gun which is then left to evaporate. Some fogging solutions require the air space to be cleared of patients and staff and for the operator to wear a chemical suit, gloves and an air-fed ventilator and sealed mask etc. The product used must be safe on equipment such as printers, computers, patient vital monitors, etc. The mist is exceptionally fine but is still effective in penetrating all areas to control the virus, this is particularly important when controlling air borne infections, e.g. Coronaviruses (including Covid-19), Kennel Cough, Cat Flu, Equine Influenza, Strangles, Psittacine Beak and Feather Disease, Newcastle Disease, Avian Influenza, Mycobacterium, Foot and Mouth Disease, Psitticosis, Distemper, Mycoplasma and many more.

Fogging in the Veterinary Environment

First check the efficacy of your disinfectant, request a copy of the efficacy test certificate.
Foggers can be plug-in electrical, battery-operated electrical, plugged-in compressed air, or static compressed air (typically ceiling suspended). Equipment can be staff-operated, or automatated, i.e. to go off at certain times of day/night, and to run for a certain duration. Generally, a droplet size of 5-10u is optimal in achieving a dry mist and dampness to surfaces, without creating surface fluid and thereby a risk to electrical equipment.

Pre requisites for a successful outcome from disinfection by fogging:

1. The disinfectant applied must be effective against all 'pathogens of interest'.
2. A disinfectant that is non-corrosive to metal, so that it can be delivered in appropriate fogging equipment.
3. Preferably a disinfectant that is safe to use by fogging, whilst patients and staff remain in or walk through the area being fogged, means that automated programmes are effective as they are not interrupted by clinical demands.
4. The disinfectant applied must be effective at the concentration at which it is administered by the fogger, (bear in mind that if a disinfectant is effective against pathogen A when used at 1:250, but is only recommended for use by fogging at 1:2000, then whilst it may be safely used by fogging at that concentration, it is not anticipated to be effective).

Few veterinary disinfectants meet the above criteria, critical review of the literature will be required to ensure that a safe and effective agent is being used.

SO WHAT HAVE WE LEARNT ABOUT INFECTION CONTROL

It is more important than ever.

Any disinfectant must have proven efficacy against Covid, as well all relevant veterinary pathogens.

Automated disinfectant delivery by fogging is the most efficacious delivery form for control of both Covid and all other pathogens which remain pathogenic on any solid surface, although prior detergent cleaning is important.

Fogging is pointless if the disinfectant used is not efficacious at the concentration recommended.

Very few veterinary disinfectants have proven efficacy against all relevant pathogens and can be safely delivered by fogging, however there are exceptions.

Cleaning and regular removal of the biofilm layer to maintain efficacy of disinfectant remains important.

Measuring and monitoring the outcomes of:- cleaning, disinfection, infection control, prevalence of nosocomial infection is essential.

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Staff Training Material

Why are Barrier Nursing Protocols important in the Veterinary Care of Pet Animal

Barrier nursing protocols in veterinary care are a set of infection control practices designed to prevent the spread of infectious diseases between animals, people and the environment within a veterinary clinic or hospital. These protocols are particularly important in preventing the transmission of zoonotic diseases (those that can pass from animals to humans) and nosocomial infections (infections acquired infections in the hospital setting).

Key Components of Barrier Nursing Protocols

WHEN SHOULD BARRIER NURSING CARE BE PROVIDED FOR VETERINARY PATIENTS

- If your pet is demonstrating any signs consistent with infectious disease, (contagious to other patients or humans), then barrier nursing is advised in order to minimise the risk of infection being passed on.
- If your pet is immune-compromised or, for any other reason, particularly susceptible to the deleterious effects of any infectious disease, they may also be 'barrier nursed' for their own protection.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- **Gloves:** Veterinary staff should wear gloves when handling animals or items that may be contaminated, such as bedding, cages, or equipment.
- **Masks:** Surgical masks or respiratory protection should be worn to prevent the spread of airborne pathogens, especially when handling animals with respiratory infections or during procedures. Mask MUST always be worn by any human entering an operating theatre at anytime.
- **Gowns/Aprons:** Protective clothing should be worn to prevent contamination of the veterinary staff's clothes and to reduce the risk of cross-contamination between animals and the clinic.
- **Eye protection:** In certain situations, such as when dealing with contagious diseases transmitted through body fluids, goggles or face shields may be used.

ISOLATION AND SEGREGATION

- **Isolation of infected patients:** Animals that have contagious diseases, or are suspected of carrying infectious pathogens, should be isolated from healthy animals to prevent transmission.
- **Designated isolation rooms:** Clinics should have separate rooms for animals with contagious diseases, with restricted access to minimise the risk of infection.
- **Clear signage:** Signs should be posted to indicate isolation areas and to remind staff of the protocols required for entry and exit.

STRICT HYGIENE PRACTICES

- **Hand hygiene:** Handwashing with soap and water or using alcohol-based hand sanitisers should be done after each patient interaction, especially if gloves have been worn.
- **Cleaning and disinfection:** All surfaces, equipment, cages and tools should be disinfected between uses to prevent the spread of pathogens. High-touch areas like doorknobs, counters and waiting areas should be cleaned regularly.
- **Working surfaces and frequent touch surfaces:** Should be regularly monitored for evidence of contamination to prove efficacy of sanitisation.
- **Footwear protection:** Disposable shoe-covers or dedicated footwear may be worn when entering isolation areas to prevent contamination from spreading between areas of the clinic.

Key Components of Barrier Nursing Protocols

ANIMAL HANDLING AND CARE

- **Limit contact:** Limit handling of infected or contagious animals to essential personnel only. This reduces the risk of transferring infectious material to other animals or areas of the clinic. For reasons of minimising the risk of transfer or spread of disease, but also to minimise the risk of human (zoonotic) infection, there may be occasions when you are advised not to visit your pet, or to visit them in a consulting or alternate area, where the potential spread of infection can be mitigated.
- **Use of dedicated equipment:** Instruments, bedding, and other items used for infected animals should be kept separate and sterilised or disposed of after use.
- **Minimise cross-contact:** If possible, avoid transferring animals between rooms and ensure that any necessary movements are done with the utmost care and hygiene, to avoid contaminating common areas or other patients.

STAFF TRAINING AND PROTOCOL ADHERENCE

- **Ongoing education:** All clinic staff should be trained in infection control practices, including the proper use of PPE, the importance of hand hygiene, and the need for segregation of infected animals.
- **Clear policies:** The clinic should have written guidelines and policies for barrier nursing practices, and staff should adhere to them consistently.

Why Barrier Nursing Protocols Are Important for Veterinary Patients

PREVENTION OF NOSOCOMIAL INFECTIONS

Barrier nursing protocols are vital in preventing nosocomial (hospital-acquired) infections in veterinary clinics. When animals undergo procedures or are hospitalised, they are at risk of acquiring infections from other animals or from contaminated surfaces. Adhering to barrier nursing practices helps prevent these secondary infections.

REDUCTION OF DISEASE TRANSMISSION

Contagious diseases can spread quickly within a veterinary clinic if proper isolation and hygiene protocols are not followed. By implementing barrier nursing, clinics can prevent cross-contamination between patients and minimise the spread of diseases such as kennel cough, feline infectious peritonitis (FIP), or parvovirus.

PROTECTION OF VULNERABLE PATIENTS

Some animals, particularly those with compromised immune systems (e.g., young, elderly, or immunosuppressed animals), are more susceptible to infections. Barrier nursing protocols help protect these vulnerable patients from potentially serious, hospital-acquired infections.

IMPROVED PATIENT OUTCOMES

By minimising the risk of infections, barrier nursing contributes to quicker recoveries for patients and reduces the overall length of hospital stays. This is especially important for patients with serious conditions who may have a weakened immune system.

PROTECTION OF VULNERABLE PATIENTS

Some animals, particularly those with compromised immune systems (e.g., young, elderly, or immunosuppressed animals), are more susceptible to infections. Barrier nursing protocols help protect these vulnerable patients from potentially serious, hospital-acquired infections.

PROTECTING VETERINARY STAFF

Barrier nursing protocols protect veterinary staff from potential infections, including zoonotic diseases that could be transmitted during treatment. This is especially important for veterinarians and technicians who work closely with animals and are at higher risk of exposure.

Barrier nursing protocols are essential in maintaining a safe and clean environment in veterinary clinics. They help prevent the spread of infections, protect both animals and humans from potential diseases, and ensure the best possible care for all patients. By minimising cross-contamination, ensuring proper hygiene, and implementing isolation procedures, barrier nursing protocols play a crucial role in safeguarding the health of animals and the people who care for them.

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Why is Positive Surveillance for Nosocomial Infection Vital in Veterinary Practice

Positive surveillance for **nosocomial infections** (also known as **hospital-acquired infections** or **HAIs**) is critical in any healthcare setting, including veterinary practices, due to the significant health risks it poses to both animals and staff. Nosocomial infections are infections that are acquired while an animal is being treated in a healthcare facility, and these infections can have severe consequences if not properly detected, managed, and prevented. Here's why positive surveillance for nosocomial infections is essential:

Nosocomial Infection Monitoring

Almost all veterinary facilities believe that they don't have a problem, and yet published data for prevalence ranges from 2.8 – 34%, so the reality is that we all have a problem. Traditionally practices recognise a HAI when they see an inflamed or dirty surgical wound. However, nosocomial infections are defined as infections that arise within 48 hours of hospital admission, three days of discharge from hospital or within 30 days of a surgical procedure. They may be evidenced by an inflamed, swollen or discharging wound, but also often by any respiratory disease, vomiting, diarrhoea, cystitis, dermatitis, etc. In many situations the clinician is totally unaware of the latter scenarios. It has been shown that reported incidence of nosocomial infections increases by 30% as soon as a facility uses 'positive surveillance'. So your consent form includes additional wording:-

Dear **&client**

We are delighted to hear that **&name** is coming in to us as an inpatient for medical or surgical care. We can assure you we are dedicated to providing **&name** with the best possible level of care.

In light of the incidence of human 'hospital acquired infection' (HAI), we are all aware of the risk of any inpatient acquiring such an infection, subsequent to a period of hospitalisation.

A HAI, otherwise known as a 'nosocomial infection', is defined as an infectious condition which affects an inpatient in the period between '48 hours after admission and 28 days after discharge'. Such infections can present as:

- Coughs or other respiratory signs
- Gastro-intestinal infections (e.g. vomiting or diarrhoea etc.)
- Urinary signs (e.g. cystitis, increased frequency and reduced volume of urination)
- Post operative wound infections
- Fever

Research Evidence:- Stull & Wease (2015) showed that the incidence of HAI in veterinary practice ranges from 2.8-16%; Hayley (1985) demonstrated that HAI levels can be reduced by 32% by the application of positive surveillance.

At **XXXXXX** Veterinary Hospital we are unaware of any significant level of HAI in our patients; however, 'best practice' advises that we should be applying positive surveillance.

To that end we would like to encourage you to contact us if you are concerned that **&name** might be suffering from an HAI following **&hisher** period of hospitalisation. In this event, please either contact reception, speak to our staff at the time of any consultation or email **XXXXXXXXX.**

Please be reassured that there is no reason for concern or worry; this communication is just a small part of our commitment to providing the very best possible care for &animal.

Every practice should be applying positive surveillance for HAI.

Early Detection and Prevention

IDENTIFYING INFECTIONS EARLY

Active surveillance helps detect infections at an early stage, often before clinical signs become apparent. This allows for timely intervention, such as administering appropriate antibiotics or isolating infected animals, which can prevent the infection from spreading to other animals or staff members.

IDENTIFYING INFECTION HOTSPOTS

By consistently monitoring infection rates, facilities can identify common sources or hotspots of infections, such as specific rooms, procedures, or patient populations that are at higher risk. This enables targeted interventions to prevent outbreaks.

Preventing Cross-Contamination

PREVENTING SPREAD TO OTHER PATIENTS

In a veterinary setting, animals with compromised immune systems or those undergoing surgery are particularly vulnerable to infections. If an infection goes undetected, it can spread to other animals, especially in environments like boarding areas, exam rooms, or surgical suites. Positive surveillance helps prevent cross-contamination by ensuring that infected animals are isolated quickly and infection control measures are applied.

STAFF PROTECTION

Nosocomial infections can also affect veterinary staff. Some infections may be zoonotic (able to be transmitted from animals to humans). Surveillance helps reduce the risk of staff becoming infected and potentially spreading the infection outside the practice.

Reducing Antibiotic Resistance

CONTROLLING ANTIBIOTIC USE

Monitoring infections allows veterinary staff to identify the specific pathogens causing infections and tailor treatment appropriately. Overuse or misuse of antibiotics, a common cause of **antimicrobial resistance (AMR)**, can be mitigated by ensuring that antibiotics are only used when necessary and in appropriate doses. Positive surveillance can help prevent the inappropriate use of antibiotics and reduce the development of resistant strains.

EFFECTIVE ANTIMICROBIAL STEWARDSHIP

By tracking patterns of infection, practices can implement better antimicrobial stewardship protocols, ensuring that they are using the right treatments for the right infections, and avoiding broad-spectrum antibiotics unless absolutely necessary.

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Improving Patient Outcomes

REDUCING MORBIDITY AND MORTALITY

Nosocomial infections can lead to serious complications, extended hospital stays, and even death. Positive surveillance allows for timely treatment and appropriate isolation measures to improve patient outcomes by preventing these infections from worsening or becoming systemic.

OPTIMISING RECOVERY

Infections that develop post-surgery or after intensive treatment can delay recovery, increase the length of hospitalisation, and lead to additional complications. Early detection of infections enables veterinarians to treat them promptly, reducing the impact on recovery times and improving overall patient care.

Monitoring Infection Trends

TRACKING PATTERNS OVER TIME

Positive surveillance helps track infection rates over time, providing valuable data on infection trends within the facility. This information can help determine whether infection control strategies are effective or need to be modified. For instance, if the incidence of surgical site infections increases, the facility may need to review its sterilisation procedures, surgical protocols, or postoperative care routines.

BENCHMARKING AND QUALITY IMPROVEMENT

Data collected through surveillance can be used to benchmark against industry standards, ensuring that the veterinary practice is adhering to best practices. Infection surveillance is a cornerstone of quality improvement programs that aim to enhance patient care.

Supporting Infection Control Protocols

GUIDING INFECTION CONTROL MEASURES

Surveillance data can guide infection control measures, such as adjusting cleaning and disinfection protocols, modifying personal protective equipment (PPE) requirements, or improving sterilisation techniques in surgical areas. Positive surveillance provides the evidence needed to reinforce or change practices to control the spread of infections.

STAFF TRAINING AND AWARENESS

Regular surveillance results can highlight gaps in knowledge or compliance among staff. If certain types of infections are frequently observed, it could point to the need for additional staff education or changes in hygiene practices. This ensures that all staff members are aware of and adhere to infection control measures.

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Regulatory Compliance and Accreditation

MEETING LEGAL AND REGULATORY REQUIREMENTS

Many regulatory bodies, including veterinary medical associations and government health agencies, require active surveillance and reporting of nosocomial infections to ensure patient safety. Positive surveillance helps veterinary practices meet these requirements and maintain accreditation status.

ACCREDITATION STANDARDS

Accreditation bodies, such as the **American Animal Hospital Association (AAHA)**, often have infection control standards that require regular surveillance. Facilities that meet these standards demonstrate their commitment to high-quality, evidence-based care and patient safety.

Promoting Public Confidence

TRUST IN THE FACILITY

Clients trust veterinary practices to provide safe, effective care for their animals. Knowing that a practice is actively engaged in surveillance and taking steps to prevent and control nosocomial infections can enhance client confidence. Transparency about infection control practices can also reassure clients that their pets are receiving the best possible care in a hygienic environment.

PUBLIC HEALTH

Some nosocomial infections, especially those caused by resistant pathogens, can pose a threat to public health. Positive surveillance ensures that practices are not only protecting the animals in their care but also minimising the potential impact on the broader community.

In summary, **positive surveillance for nosocomial infections** is crucial for maintaining a safe and effective veterinary practice. It enables early detection, helps prevent cross-contamination, optimises patient outcomes, supports infection control efforts, and ensures compliance with regulatory standards. It is a proactive approach that contributes to the overall health and safety of both animals and veterinary staff, while also safeguarding the reputation and quality of the practice.

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- Is your Veterinary Practice following proper Infection Control measures
- What can Pet Owners do to minimise risk of HAI in their Pets

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Is your Veterinary Practice following proper Infection Control measures

As a pet owner, ensuring that your veterinary practice is following proper infection control measures is crucial to safeguarding your pet's health and minimizing the risk of hospital-acquired (nosocomial) infections. Veterinary facilities should have clear protocols in place to prevent the spread of infections and create a clean, safe environment for both animals and staff. Here are some key signs that your pet's veterinary practice is taking infection control appropriately.

Cleanliness of the Facility

ANY FACILITY TAKING INFECTION CONTROL SERIOUSLY

Will be proud of the fact they are doing this and will not mind a genuine concerned client asking to see their 'Practice Biosecurity and Infection Control Policy', sharing with you who their 'Infection Control Champion' is, or their latest infection control audit. In fact many concerned practices now place their audit results on their websites and their infection control external assessment on their front door etc. A responsible practice is likely to ask for your assistance in conducting 'positive surveillance for nosocomial infection', by asking you to monitor for and inform them if your pet shows any signs of a hospital-acquired infection. Indeed, they use their infection control commitment and status as a marketing tool.

GENERAL CLEANLINESS

The veterinary clinic should appear clean, well-maintained, and free from visible dirt or clutter. Floors, counters, waiting rooms, and examination rooms should be regularly cleaned and disinfected. A clean practice is an important first indicator that hygiene and infection control are prioritised.

STERILE AREAS

If you can see areas where sterile procedures occur, like the surgery room or treatment areas, they should look well-maintained and free of contamination. Surfaces and surgical equipment should be disinfected regularly, and the area should not show signs of poor cleanliness or disorganisation.

Proper Handling of Animals

SEPARATION OF SICK AND HEALTHY ANIMALS

A responsible veterinary practice will keep sick or contagious animals separated from healthy ones. They should be asking what your pets presenting signs are prior to your arrival at the practice. There should be distinct, designated areas for animals with infectious diseases (e.g., isolation rooms). Ask how the clinic separates animals with infectious conditions or those being treated for contagious diseases.

ISOLATION PROTOCOLS

If your pet needs to be hospitalised or stay for an extended period, check whether there are specific isolation protocols in place for animals with contagious conditions. This ensures that infection doesn't spread to other animals.

Staff Hygiene and Personal Protective Equipment (PPE)

VISIBLE USE OF PPE

Staff should be wearing appropriate personal protective equipment (PPE) such as gloves, gowns, masks, and face shields when necessary. For instance, when performing surgeries, treating infectious animals, or handling biological materials (e.g., blood, bodily fluids), veterinarians and technicians should use PPE to prevent cross-contamination.

HAND HYGIENE

Staff should be regularly washing their hands or using hand sanitisers, especially between animal consultations or after handling potentially contaminated materials. It's also a positive sign if they change gloves between handling animals or after touching dirty surfaces.

Infection Control Protocols

CLEAR INFECTION CONTROL POLICIES

Ask about the clinic's infection control protocols. A responsible practice will have documented guidelines for cleaning and disinfecting exam tables, cages and other equipment. They should also be able to explain how they sterilise surgical instruments and handle medical waste.

DISINFECTION OF EQUIPMENT AND SURFACES

Ensure that the clinic regularly disinfects high-touch surfaces such as door handles, countertops, examination tables and waiting room chairs. Veterinary practices should use hospital-grade disinfectants on surfaces where animals are treated, and equipment should be sterilised after each use.

Visible Cleaning and Sterilisation Procedures

STERILISATION OF INSTRUMENTS

Ask how instruments used in surgery or diagnostics are cleaned. Veterinary practices should have an autoclave or similar sterilisation equipment to properly sterilise surgical instruments, and this process should be done after every use.

SEPARATE CLEANING AREAS

Ideally, veterinary facilities should have designated areas for cleaning soiled items (e.g., a "dirty utility" room for disposing of waste, washing bedding, and cleaning soiled equipment). These areas should be separate from where clean items or animals are handled.

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Waste Disposal Procedures

PROPER WASTE DISPOSAL

Ensure that the clinic has an appropriate waste management system in place. Biohazardous materials such as used needles, surgical gloves, soiled bandages, or contaminated items should be disposed of in clearly labelled, secure containers. Check for biohazard waste disposal signs and make sure the facility follows regulations for waste handling.

SOILED LAUNDRY

Ask about how the clinic handles soiled towels, bedding, or surgical drapes. These items should be handled in a controlled manner to prevent contamination and washed using appropriate disinfecting laundry practices.

Handling of Contaminated Animals and Materials

CONTAMINATION PROTOCOLS

Ask how the clinic handles animals with known or suspected contagious diseases. There should be clear protocols to prevent the spread of infection between animals, including the use of separate isolation areas and protective barriers for both animals and humans.

SEPARATE EXAMINATION AREAS

Check if the clinic has separate examination rooms or areas for animals with respiratory, gastrointestinal, or other infectious conditions. If an animal is sick, it should be handled in a dedicated area away from healthy animals to reduce the risk of transmission.

Monitoring of Infections

POSITIVE SURVEILLANCE

A veterinary practice should monitor infection rates within its facility. If you ask, they should be able to describe how they track and handle nosocomial (hospital-acquired) infections. Regular audits of infection control practices help identify and mitigate risks early.

STAFF TRAINING ON INFECTION CONTROL

The clinic should provide regular training for staff on infection prevention and control measures. This includes training in the proper use of PPE, sterilisation procedures, and handling of hazardous materials.

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Communication with Pet Owners

TRANSPARENCY IN INFECTION CONTROL

Ask the practice about its infection control procedures, and a professional clinic should be open about how they keep animals safe from infections. If they seem defensive or unclear about their practices, this might be a red flag.

GUIDANCE FOR POST-VISIT CARE

For surgical or post-procedure cases, the clinic should provide clear instructions on how to care for your pet at home, particularly to prevent infections (e.g., keeping wounds clean, preventing licking, monitoring for signs of infection).

Certifications and Accreditation

ACCREDITATION

Some veterinary clinics are accredited by recognised bodies like the **American Animal Hospital Association (AAHA), or the Bella Moss Foundation (BMF).** These practices are required to meet specific hygiene and infection control standards. You can ask whether the clinic is AAHA or BMF-accredited or holds other relevant certifications.

REGULATORY COMPLIANCE

A veterinary clinic should comply with local or regional regulations for infection control and hygiene. Practices that comply with or exceed these standards demonstrate a commitment to maintaining high levels of hygiene.

Monitoring and Reporting

INFECTION TRACKING AND AUDITING

A well-managed veterinary facility should regularly monitor infection control effectiveness through audits and incident reports. If you ask about recent infection rates or what steps the clinic is taking in response to an outbreak, they should be able to provide specific answers.

To ensure that your pet's veterinary practice is following appropriate infection control measures, pay attention to the overall cleanliness of the facility, the use of proper PPE, the segregation of clean and dirty areas, and the transparency of the staff about their hygiene protocols. Don't hesitate to ask questions about how the clinic handles infection control, sterilisation, waste disposal, and cleaning procedures. A well-run veterinary practice will be open and thorough in explaining how they prevent infections and safeguard the health of both animals and humans.

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What can Pet Owners do to minimise risk of HAI in their Pets

Nosocomial infections (also known as hospital-acquired infections or HAIs) can occur in veterinary clinics or hospitals and they pose a risk to both pets and humans. Pet owners can take several steps to minimise the risk of such infections, especially when their pets require medical care. Here's what pet owners can do.

Maintain Good Hygiene

TOILET BEFORE VISITING THE VETERINARY

Ensure your pet has had suitable opportunity To toilet prior to visiting the veterinary facility.

WASH HANDS REGULARLY

Always wash hands thoroughly with soap and water before and after handling your pet or any surfaces in the clinic.

USE HAND SANITISER

In cases where soap and water are not available, hand sanitisers with at least 60% alcohol can be effective.

DISINFECT PET'S BELONGINGS

It is best to avoid taking any of your pet's belongings into the veterinary facility. Anything that you do take in and later take home with you, such as your pet's collar, leash, etc., must be well cleaned and disinfected prior to taking it back inside your own home.

WORKING IN HEALTHCARE SETTING

If you or any member of your household works in any healthcare setting, bring this to the notice of the veterinarian, as such a link increases your pet's risk of antimicrobial resistant bacterial infection.

Keep Up to Date with Vaccines

VACCINATE PETS

Ensure your pets are up to date with all essential vaccines to protect them from common infectious diseases.

FOLLOW VETERINARY ADVICE

Discuss with the vet the most appropriate vaccines and preventative measures for your pet based on their risk factors and lifestyle.

AVOID FEEDING YOUR PET ANY 'RAW DIETS'

Avoid feeding raw diets in the 10 days prior to or during hospitalisation

Avoid Exposure to Contaminated Areas

LIMIT TIME IN HIGH-RISK ENVIRONMENTS

Avoid bringing pets to the clinic unless absolutely necessary. If possible, wait in the car or outside the waiting area with your pet to limit exposure to any potentially infected surfaces or animals.

CHOOSE A REPUTABLE CLINIC

Ensure that the veterinary clinic follows stringent infection control protocols. Look for clinics with a clean and well-maintained environment. Some clinics advertise their infection control / hygiene status. No responsible veterinary practice should mind a client asking to see their 'practice biosecurity and infection control policy', or a copy of their latest infection control audit.

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Ensure Proper Disinfection

SANITISATION OF PET CARRIERS

Clean and disinfect your pet's carrier or any travel equipment before and after visits to the clinic.

ENSURE CLINIC CLEANLINESS

Confirm that the clinic has proper sanitation protocols in place, including regular cleaning and disinfection of common areas, treatment rooms, and medical equipment.

Monitor for Symptoms

OBSERVE FOR ILLNESS

After a visit to the clinic, during the forty-eight hours following a visit, during 72hours following discharge or within 30 days of a surgical procedure, monitor your pet for any unusual signs of illness such as fever, lethargy, respiratory, skin, urinary or digestive issues. Early detection can help address any infections quickly.

PROMPTLY ADDRESS ANY CONCERNS

If you suspect your pet has contracted a nosocomial infection, contact the veterinarian immediately for further assessment.

Follow Veterinary Instructions Carefully

ANTIBIOTIC USE

If prescribed antibiotics or other medications, ensure your pet completes the full course as directed. Incorrect use can lead to antibiotic resistance and other complications.

MONITOR ANY SURGICAL WOUNDS

If any swelling or discharge is observed, contact the veterinary practice as soon as possible.

IT IS NOT NORMAL OR DESIRED

For any patient to lick or clean a wound following surgery, any tendency to do this should be discussed with the veterinarian and if necessary, the wound should be covered, or a collar or alternate measure taken to prevent access to the wound.

ISOLATION PROTOCOLS

If your pet has a contagious disease, follow isolation protocols to prevent spread to any other animals in the clinic.

YOUR VETERINARIAN

Your veterinarian is likely to have given you advice in respect of dietary and water intake and any advised restriction on exercise, climbing stairs or jumping onto furniture, etc. Any such advice must be followed carefully.

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Vaccinate and Protect Yourself

HUMAN PROTECTION

If you or any members of your household have compromised immune systems, take extra precautions when handling pets, especially when visiting the vet.

Limit Contact with Other Animals

AVOID CONTACT WITH SICK ANIMALS

When at the clinic, try to keep your pet away from other animals who may be showing signs of illness to reduce the risk of cross-contamination.

By taking these steps, pet owners can help reduce the risk of nosocomial infections, keeping both their pets and themselves healthier and safer during veterinary visits.