Podiatrists Board of New Zealand

Code of Practice

INCLUDING

GUIDELINES FOR INFECTION CONTROL

REVIEWED OCTOBER 2006

Index

Introduction 3

1. Delivery of Services 5

2. The Facility 7

2.1 Service 7
2.2 Record Keeping....7

3. Prevention of Cross Infection 9

3.1 Disinfection 9
3.2 Instrument Sterilisation 10
3.3 Infection Control Protocols 13
3.4 Handwashing 16
3.5 Gloves and Protective Clothing....17
3.6 Sharps 18

4. Disposal of Clinical Waste 21

5. Surgical Facility 23

5.1 The Facility....23
5.2 Personnel 23
5.3 Cleaning....24
5.4 Infection Control 24

6. Policy on Infectious Disease 27

7. Review and Evaluation of the Code 31

8. Reference List 32

Introduction

The Podiatrists Board requires the podiatrist to be responsible for providing a suitable environment for the safe practice of podiatry, to adopt sensible quality control procedures and to adopt accepted infection control policies.

Podiatrists have an obligation to take all practicable steps to minimise the potential for harm when providing services to clients.

This Code has been developed to protect the podiatrist and their clients from potential harm. It is expected that podiatrists will appreciate the necessity for such guidelines and will cooperate by adopting, and where applicable adapting their methods to comply with, the Board's recommendations.

Podiatrists must consider all clients as potentially infected with blood borne pathogens. Clients may be asymptomatic or unaware of their carrier or infectious state.

Standard (Universal) Precautions must be adhered to at all times independent or regardless of the patient's medical condition or perceived risk. Standard (Universal) Precautions are infection control measures which apply during the treatment of all clients for the protection of staff, clients and the environment. Such measures involve the use of safe work practices and protective barriers.

Additional precautions are sometimes required in addition to standard precautions. These strategies are designed to prevent the spread of infection to others from patients, known or suspected to be infected or colonised with infectious agents, that would not be contained by standard precautions alone. Additional precautions are used when dealing with patients who have airborne diseases such as active TB, Chicken Pox, Influenza and Measles. Also included are significant

infections with drug resistant bacteria, such as:

- Methicillin Resistant Staphylococcus Aureus (MRSA) where the open wound may be in contact with the treatment site; and
- Vancomycin Resistant Enterococcus (VRE) (eg via faecal contamination), in a hospitalised, or long-term care patient.

Where required, additional precautions include:

- deferring treatment until infectious state is resolved;
- placing the patient at the end of the treatment list to allow time for decontamination/clean up (MRSA or VRE colonised)
- patient and podiatrist wearing additional protective equipment such as masks, gloves and single use gowns
- appropriate cleaning regimes for the patient environment.

Recommendation:

Podiatrists should study the Australasian Podiatry Council Online Learning site "Risk Management". The context is Australian but the issues and responsibilities are relevant to NZ practice.

1. Delivery of Services

1.1 Podiatry may be performed in an office-based clinical facility, in a client's home and in a hospital or rest home facility, or other appropriate premises. However the practice of podiatry, the treatment provided and the associated risks remain the same wherever podiatry is practised. These guidelines are intended to assist the podiatrist to provide quality, safe service by minimising risk to both the podiatrist and the client, wherever podiatry is practised.

1.2 For the purposes of this Code podiatry practice has been divided into three levels of care:

Level One:	Palliation (the integrity of the skin is not breached).
Level Two:	Minor Invasive (breaches of the skin are present or may occur).
Level Three:	Major Invasive (when surgery upon either skin, nail, soft tissue or bone is performed).

It is recognised that palliation may result in a breach of the skin. For example, an unexpected subungual infection, sinus, minor haemorrhage etc. Therefore it is important for the podiatrist to be prepared for one level of treatment to extend into another.

It is recognised that not all podiatric situations require strict aseptic conditions and it is considered unnecessary and impractical to adopt measures appropriate for surgery for levels one and two.

1.3 As the scope of podiatry practice varies from non-invasive to invasive techniques the podiatrist must accept responsibility for minimising the risks to the client which are associated with each level of practice.

1.4 Some level three procedures, that is: surgery involving bone (for example, exostoses), or extensive soft tissue (for example, neuroma), have the potential to create the highest risk to client's safety. Podiatrists performing at this level will recognise their responsibility by taking all practicable steps to minimise the risk to their clients. This may result in the need to change the way the podiatrist delivers these services to ensure that safe outcomes are achieved.

Recommendation:

Major invasive surgical procedures such as those outlined above should be performed in a dedicated room designed for use as an operating theatre only.

1.5 **Clinical Work Practices**

- Developing good work practices significantly reduces the risk of contamination and therefore infection;
- Preplanning of the infection control strategies to be undertaken is recommended prior to treatment and should become routine
- Patient skin preparation aims to keep micro-organisms below a level which may result in clinical infection
- Any item that comes into and out of the treatment field must be sterilised, cleaned or discarded between each patient
- Instruments or equipment intended for single use and/or labelled as 'single-use' by the manufacturer must be disposed of after use; and
- The use of creams or medicaments must be carefully approached to avoid contamination and cross infection.

2. The Facility

2.1 **Service**

2.1.1 Clients are entitled to competent service which should offer the maximum benefit to the consumer with the minimum potential for harm. Therefore, a podiatry practice should have facilities and equipment which are fully functional and appropriate to the services being provided, and treatment by a podiatrist who is experienced in managing such service.

2.1.2 Clients can expect to receive podiatry services in an environment where their comfort, confidentiality and safety are protected by trained staff who are able to provide timely and appropriate services.

2.1.3 ***Medical Emergency Procedures***

Medical emergencies can occur at any time, in any clinical situation. By carefully screening out unsuitable surgical candidates the risk of emergency arising within the surgical setting will be minimised. However it is possible that a medical emergency may arise despite careful screening. Therefore it is recommended that yearly CPR training is maintained for the podiatrist and all other personnel. It is further recommended that all personnel maintain up to date First Aid certification, renewing certification every two years.

2.2 **Record Keeping**

2.2.1 The collection of health information is essential for the delivery of safe and efficient care. Detailed and accurate records (whether hard copy or on computer disc) on the service provided must be maintained by the podiatrist.

Records must be legible and must comply with Rule 5 of the Health Information Privacy Code 1994 regarding the storage and security of health information.

2.2.2 A log book should be maintained in the operating room detailing the date and time of operation, type of operation, operator's name, length of time tourniquet was in place for, time operation was concluded and any complications encountered.

3. Prevention of Cross Infection

Clients have the right to expect that their exposure to risks of infection and contamination during treatment are reduced to the lowest possible levels. It is the responsibility of the podiatrist to ensure that the environment they provide is as free as practicably possible from such contamination.

3.1 **Disinfection**

3.1.1 All surfaces (floors, storage units, walls), other than those in the waiting room and office should be smooth and easily cleaned. Carpet must not be used in clinical areas. Non slip surfaces are recommended.

3.1.2 The highest standards of routine cleanliness should be established and maintained, prior to, during and after client contact in order to minimise the potential for cross infection.

Recommended cleaning practices include:

a) Vacuuming floors between clients and wet mopping (with detergent and hot water) floors daily.

b) Damp dusting surfaces daily with disinfectant for treatment level one and between clients for treatment levels two and three.

c) Wash basin should be cleaned with an abrasive detergent.

d) Plugs should not be used in wash basins.

e) Curtains, if present, should be washed quarterly

f) Blinds, if present, should be dry cleaned quarterly.

3.2 **Instrument Sterilisation**

3.2.1 Sterilisation is the complete destruction of all micro-organisms. Therefore an item is either sterile or it is not sterile, there are no probabilities. (NZ Sterile Services Manual 1995). By taking all practicable steps to ensure instruments are free from contamination the podiatrist will have taken maximum precautions required to minimise risk to the client.

3.2.2 Consumers have the right to expect the podiatrist to have access to the appropriate instruments for the service that they are providing and those instruments to be in sound working order.

3.2.3 Steam sterilisation is the only safe, reliable and effective means of sterilising instruments. A steam steriliser with a drying cycle allows for the sterilisation and storage of wrapped items before use. A steriliser without a drying cycle is only suitable where unwrapped items are intended for immediate use in sterile conditions.

3.2.4 A practice must have enough instruments to allow sufficient time to decontaminate and process all instruments prior to use.

Recommendations for sterilisation of instruments:

a) It is required that all reusable instruments (including burrs) are steam sterilised between clients.

b) It is required that all instruments that may penetrate body tissues must be sterile at the time of use.

c) Where possible a separate sterilising room should be used for cleaning, ultrasound, sterilising and storing sterile supplies.

d) The efficacy of the sterilisation process should be monitored regularly to ensure the effectiveness of the unit. The processes must be validated before use, routinely calibrated and monitored, and the equipment maintained to give assurance that the parameters within the sterilising chamber are such that the items can be considered sterile. The steriliser should be calibrated at least annually by a qualified tradesperson with written proof of the testing and compliance. The sterilisation process must be revalidated after servicing, modifications or technical changes to the steriliser, or changes to packaging, contents of trays or packs, or changes to load sizes. A daily monitoring procedure must be carried out, recording the results for legal reference. Monitoring the sterilisation process can be done in three different ways – chemical, biological and physical.

   (i) Chemical indicators do not prove sterility, only that the items have been subjected to the sterilising process. An unchanged indicator does indicate sterilisation failure. It is recommended that a chemical indicator be used with every article for packaged loads and every load of unwrapped items.

   (ii) Biological indicators are recommended to be used at least annually using either an on-site self contained biological test kit or sending samples to the local medical laboratory for testing. Either way, records must be maintained. Biological indicator monitoring must take place at commissioning, after a major service and after changes to challenge pack or load.

   (iii) Physical testing is available on some steam sterilisers which have build in chart recorders, gauges and printed readouts which provide verifiable evidence that sterilisation has taken place.

e) Instruments sterilised after use, but where sterility does not need to be maintained, must be stored dry in a covered container.

f) All articles must be thoroughly cleaned prior to being processed by sterilisation:–

- gross soil should be removed by rinsing used items under cold running water. Items should be soaked in warm to cool water with the addition of the correct amount of cleaning agent.
- a brush is required to remove all organic matter from instruments, especially serrated instruments. Hold the items under the water to prevent aerosols when scrubbing. Rinse items in warm to hot water. The brush should be steam sterilised daily.

g) Some instruments may require dismantling prior to cleaning and sterilisation.

h) Gloves must be worn for the handling of articles prior to sterilisation and disinfection. Kitchen gloves seem to be the most suitable for cleaning procedures. At the end of the day or at the end of cleaning procedures, wash the gloves in clean detergent solution and hang out to dry overnight.

i) Mechanical Cleaning: Ultrasonic cleaners are machines designed to clean instruments with the use of sound waves which implode on contact with the instrument surface creating a “sucking” action which assists in the removal of soil. When ultrasonic cleansers are used the lid of the tank must be securely closed at all times during operation.

An appropriate time for cleaning is up to 12 minutes.

It is recommended that Cleaning agents should be used to remove residual soil and organic matter for instruments and equipment. This detergent should be biodegradable, non-corrosive, non-toxic, low foaming, free rinsing, mildly alkaline and contain no perfumes, chlorines, lanoline, fatty soaps or glycerine.

3.2.5 ***Documentation***

Every load sterilised must be allocated a batch control number which is recorded in the steriliser log book and includes the following information:

- the date of processing
- the number of the load for the day; and
- the number of the steriliser used (if the practice has more than one steriliser)

The batch control number must:

- be labelled on every pack in the load; and
- be recorded on the case record of the patient on whom the instruments were used.

3.2.5 ***Labelling***

Non-permanent marker pens should be used for labelling. Ball-point pens may make minute perforations in packs or bags.

3.3 **Infection Control Protocols**

3.3.1 Podiatrists have a responsibility to know their Hepatitis B Virus (HBV), Hepatitis C Virus (HCV), and Human immunodeficiency Virus (HIV) status. Podiatrists who may have been exposed to HBV, HCV and HIV through personal risk behaviour, exposure to blood products or occupational accidents are encouraged to seek testing in order to determine their serological status.

It is recommended that podiatrists who know or believe themselves to be infected seek appropriate counsel regarding their continued practice of podiatry and act upon that advice in order to protect patients from exposure to infection.

3.3.2 Podiatrists should be tested to determine whether they:

i) have HBV infection, or

ii) are susceptible to HBV infection, or

iii) are already immune to HBV infection

It is recommended that all podiatrists be vaccinated against HBV where appropriate (that is, if not immune and not infected), and retested to confirm immunity following vaccination.

It is further recommended that podiatrists who are found to be HBV infected should be tested to determine whether they are highly infectious (ie. HBeAg or HBV DNA positive). Podiatrists who have HBV infection and are HBeAg or HBV DNA positive should not perform exposure-prone procedures.

3.3.3 The contaminated hands of personnel are potentially the most significant transmitter of cross infection in the health care setting.

i) Handwashing decreases contamination of the hands and helps to prevent nosocomial infections.

ii) The importance of handwashing cannot be overemphasised. It is one of the simplest and most consistent methods of preventing the spread of infectious agents from one person to another. It is a safety skill that protects both the client and the podiatrist.

iii) Intact skin is itself a barrier to the transmission of infection. Podiatrists should accept responsibility for their skin integrity prior to commencing work. All cuts, abrasions and open skin areas must be occluded with a waterproof dressing prior to commencement of work.

3.3.4 ***Skin Conditions***

Podiatrists who have dermatitis, eczema, paronychia or any other skin lesions may put clients and other health care workers at risk because:–

i) The dermatitic skin is more likely to be colonised with potentially pathogenic organisms.

ii) Handwashing of the dermatitic skin does not appreciably reduce skin bacterial counts.

iii) Personnel with dermatitis tend to avoid handwashing.

Recommendations to alleviate the above problems:

a) Refraining from treating clients until severe conditions have resolved.

b) Rinsing and drying hands thoroughly.

c) Using individual (personalised) hand creams, (contaminated hand lotions have been associated with outbreaks of nosocomial infections).

d) Alternating handwash solutions.

e) Wearing gloves. (However wearing gloves may exacerbate dermatitis due to a change in the residual flora and the number of bacteria present).

3.3.5 Nails should be short and kept free from cracked and chipped nail polish. Artificial nails must not be worn.

3.3.6 Long hair should be tied back.

3.3.7 Rings, bracelets and wristwatches should not be worn during level one procedures and must not be worn during level two and three procedures as they are a potential source of cross infection.

3.3.8 Prior to handwashing and the commencement of treatment, wherever possible, preset the chair, lights, instruments etc.

3.4 **Handwashing:**

3.4.1 Ideally handwashing facilities should consist of a basin with mixer taps and foot, knee or elbow controls, an elbow operated antibacterial soap dispenser and a wall mounted paper towel dispenser.

3.4.2 Basic hand washing requires vigorous mechanical action. Fifteen seconds is recommended. The use of ordinary soap under running water and vigorous mechanical action removes most transient and some resident bacteria from the hands temporarily, and is suitable practice for level one procedures. Use alcohol rub, gel or rinse for routine hand decontamination when hands are not visibly soiled – i.e. accessing items outside treatment zone or when hand washing facilities are not available.

It is **recommended** that antibacterial soap is used for level two and three procedures. When liquid antibacterial soap is used containers should be disposable rather than refillable. Containers should never be "topped up".

3.4.3 Non sterile nail brushes are not recommended as they harbour bacteria and may cause damage around the nail bed thus increasing the risk of paronychia.

3.4.4 To prevent recontamination of clean hands use paper towels to turn off taps (if hand control) and discard.

Recommended handwashing practices are:

a) Before, between, and after all direct client contacts.

b) Before and after handling clinical and surgical equipment.

c) After performing any personal bodily function (eg: blowing and wiping nose, using the toilet, combing hair, scratching the body or before eating).

d) Before and after handling specimens.

e) When hands are obviously soiled.

f) Before wearing gloves, after removing gloves and prior to going home.

g) After handling client's footwear.

3.4.5 Domiciliary podiatrists should carry a liquid soap dispenser and disposable paper hand towels to each destination.

3.5 Gloves and Protective Clothing

For the protection of both client and podiatrist it is recommended that gloves be worn when there is an anticipated or evidenced contact with blood or body fluids.

Recommendations for the use of gloves and protective clothing:

a) Sterile gloves must be used to protect the client and the wearer during invasive procedures (a procedure in which there is deliberate intent to sharply or bluntly penetrate intact skin), or when open wounds are touched. It is required that sterile gloves are worn for some level two procedures and all level three procedures.

b) Non sterile gloves should be used to protect the wearer when hands are likely to become contaminated with potentially infective material, ie blood, body fluids, etc. It is recommended that non sterile gloves are worn during level one and some level two procedures.

c) Gloves must always be changed between clients.

d) Hands must be washed immediately after removing gloves because whilst wearing gloves the hands become hot and moist allowing resident micro- organisms to proliferate at an accelerated rate.

e) To avoid inhaling infective material, masks should be worn during nail grinding. Nail dust constitutes an occupational hazard to podiatrists who use nail drills. The hazards of nail dust include damage to eyes, ears or face by flying debris. Glasses or goggles help to prevent such damage. To avoid inhaling infective material (such as keratin, keratin hydrolysates, microbial debris and viable fungal elements including saprophytes and dermatophytes) masks should be worn during nail grinding. Nail dust extracting drills should minimise the occupational hazard of exposure to nail dust.

f) Masks, protective glasses and impermeable clothing must be worn when blood or body fluids are likely to splash.

3.6 **Sharps**

Special care must be taken to prevent injuries caused by scalpels, needles and other sharp objects during procedures and during handling, cleaning or disposal of sharps after procedures.

Recommendations for the safe use of sharps:

a) Needles must not be recapped by hand, or bent or broken prior to disposal.

b) All sharps must be disposed of immediately after use into an appropriate puncture resistant, waterproof and leak proof container designed specifically for the purpose, with a clearly visible Biohazard symbol.

c) The sharps container must be located as close as practicable to the use area.

d) It is recommended that a policy of recording and following up cases of exposure to the blood/serum/body fluids of clients from sharps injury be adopted.

e) A white board should be mounted on the operating room wall to monitor ingoing and outgoing sharps.

Recommendations to follow exposure to blood or body fluids:

a) Encourage bleeding.

b) Cleanse vigorously with copious soap and water.

c) For eyes, nose and mouth, rinse thoroughly with clear running water or saline.

d) Cover the wound with an adhesive waterproof dressing.

e) Ascertain status of source where possible.

f) Follow established institutional protocol if the situation is applicable.

g) Following incidents involving blood or body fluids which are considered high risk consult your doctor or microbiology laboratory for blood tests.

Potential risk incidents are:

a) Contact with used needles or other sharp objects.

b) Splashing of blood or body fluids onto a mucous membrane (eg, eyes or mouth) or onto a fresh unhealed wound (less than 24 hours old).

c) Sustaining a bite which breaks the skin.

4. Disposal of Clinical Waste

4.1 The Resource Management Act 1991 requires that a policy is developed that states how waste is disposed of.

4.2 The owner of the practice which generates the waste is ultimately responsible for correct disposal even if sub-contracted.

4.3 NZ Standard 4304-1990 defines "special waste" as soiled dressings, swabs and other contaminated waste from treatment areas – this includes nail clippings and tissue, disposables (ie syringes, hypodermic needles, scalpels, razors, gloves) and masks.

THIS STANDARD IS REGULATED BY LOCAL WASTE MANAGEMENT BYLAWS

4.4 Podiatrists are advised to contact their local body authorities for specific area regulations.

Recommendations for the disposal of clinical waste:

a) Sharps containers must be disposed of when 3/4 full by high temperature incineration.

b) All contaminated medical waste such as gauze, dressings etc are to be disposed of in an appropriate container and destroyed by high temperature incineration.

c) Materials not defined as "special waste" may be disposed of as normal "rubbish".

5. Surgical Facility

5.1 **The Facility**

5.1.1 Standards outlined in this section apply to a dedicated room designated for use as a surgical facility only.

5.1.2 The surgical facility, or a clinical/office based facility, may be used for some surgical procedures (for example, certain nail and wart procedures).

5.1.3 However, a dedicated surgical facility should be employed for invasive surgery, that is surgery that involves bone (for example, exostoses), or extensive soft tissue (for example, neuroma).

5.1.4 It is the responsibility of the podiatrist to properly maintain the surgical facility according to acceptable minimum standards.

Recommendations for the surgical facility:

The surgical facility, including its usage, structural design, size, location relative to other rooms, sterilising and scrub facilities, should be comparable to the minimum required in a hospital setting for the type of surgery being performed.

5.2 **Personnel**

5.2.1 Only personnel properly attired and required for the procedure should be allowed in the operating area.

5.2.2 Personnel numbers and their activity should be restricted to minimise the risk of contamination. Unnecessary activity, including idle talk and movement of unscrubbed observers, should be kept to a minimum.

5.2.3 Unscrubbed observers should be attired in a scrub suit, hat, shoe coverings and be masked.

5.2.4 All hair (long hair, beards, moustaches, sideburns) should be fully covered.

5.3 Cleaning

5.3.1 The operating room should be cleaned each morning, between cases and terminally at the end of the day.

5.3.2 Initially the room should be damp dusted with a suitable disinfectant to reduce the concentration of airborne micro-organisms.

5.3.3 *Floors:*– Prior to the beginning of a surgical case, the floor should be wet with a detergent/ disinfectant, mopped using a suitable disinfectant, then rinsed with clean water.

5.3.4 *Walls:*– Should be wiped down with alcohol or other appropriate disinfectant at the end of the day and spot cleaned in between cases with a chlorine disinfectant.

5.3.5 *Horizontal Surfaces:*– Should be damp dusted using a clean disposable cloth (working from the higher surfaces to those closest to the ground) prior to a case, between cases and at the end of the day.

5.3.6 *Weekly Cleaning:*– Should include the cleaning of cabinet shelving, autoclave and air conditioning filters.

5.4 Infection Control

5.4.1 The adoption of Standard (Universal) Precautions as outlined in Section 3 (Prevention of Infection) will reduce the risk of cross infection in the surgical environment.

5.4.2 However, when a high risk client is encountered, it is advisable to combine Universal Precautions with modifications to usual work practices, to reduce the risk of accidental contamination and exposure to infection:-

Recommendations for high risk situations:

a) Double gloves to be worn by the podiatrist and the assistant.

b) Manual manipulation to be kept to a minimum.

c) The use of retractable scalpel blades and magnetic pads for sharp instruments.

d) Ensuring sharp instruments are placed away from the Mayo table.

e) Announcing when a sharp instrument is to be passed.

f) Instruments to be used to load and unload needles and scalpels.

g) Where possible the use of staples, electrocautery, instrument ties and other non touch suturing techniques.

h) Instruments to be used to handle, stabilise and retract tissue.

i) If an injury is sustained the instrument involved must not be reused.

6. Policy on Infectious Disease

6.1 The most effective means of preventing Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) transmission in health care settings is by strict adherence to standard (universal) precautions and established infection control practices. These decrease the opportunity of direct exposure to blood and body fluids for both health care workers and patients. To increase public and practitioner safety, the undergraduate courses in podiatry must include adequate education in the appropriate infection control and occupational health and safety techniques and procedures.

6.2 All patients who may have been exposed to HBV, HCV and HIV through personal risk behaviour, exposure to blood products or occupational accidents should be advised to seek testing in order to know their own serological status. All podiatrists who may have been exposed to HBV, HCV and HIV through personal risk behaviour, exposure to blood products or occupational accidents should seek testing in order to know their own serological status. All podiatrists who perform exposure-prone procedures should be tested to determine whether they:

(a) have HBV infection, or

(b) are susceptible to HBV infection, or

(c) are already immune to HBV infection. All podiatrists should be encouraged to be vaccinated against HBV where appropriate (ie if not immune and not infected), and retested to confirm immunity following vaccination.

6.3 Podiatrists found to be HBV infected should be tested to determine whether they are highly infectious (ie HBeAg or HBV DNA positive). Podiatrists who have HBV infection and are HBeAg or HBV DNA positive should not perform exposure-

prone procedures. The decision to prevent such a podiatrist from performing exposure-prone procedures should be taken by an expert panel after reviewing all relevant information.

6.4 HBV, HCV or HIV infection alone does not justify either refusing registration of a podiatrist or limiting professional duties. Evidence of unwillingness to comply with infection control standards or functional impairment which interferes with professional performance bought to the attention of the Podiatrists Board, will be dealt with under sections 47 and 48 of the Health Practitioner Competence Assurance Act 2003.

6.5 In view of the lower risks of transmission podiatrists who have HBV infection, but are HBeAg and HBV DNA negative, may be allowed to continue to perform exposure-prone procedures. The decision to allow such podiatrists to continue to perform exposure-prone procedures should only be made after consideration by an expert review panel and counselling of the podiatrist by member(s) of that panel.

6.6 Podiatrists who are not HBV infected (ie HBsAg negative) and who fail to produce protective levels of antibody following vaccination (ie anti HBs>10) should be referred for specialist advice (eg consideration of alternative methods of vaccine administration) and offered HBV specific immunoglobulin following recognised episodes of exposure to HBV infection.

6.7 Podiatrists who know or believe themselves to be infected with HBV, HCV, or HIV could put patients at risk and so must seek appropriate counsel and act upon that advice. This advice could include a requirement not to practise, or to limit practice in certain ways. No podiatrist with such infection should continue in clinical practice merely on the basis of his/her own assessment. It is unethical, and could be deemed professional misconduct, for a podiatrist so infected to act in a way that puts a patient at risk.

6.8 A podiatrist who has counselled an HBV, HCV, or HIV infected podiatrist to modify practice in order to safeguard patients, and who is aware that this advice is not being followed, has the duty to inform the Podiatrists Board that the fitness to practise of that podiatrist may be seriously impaired. If non-compliance continues it may be necessary for the Board to use its full jurisdiction to impose conditions upon the registration of that podiatrist.

6.9 Mandatory screening of podiatrists for HBV, HCV, or HIV is not recommended; in the present state of medical knowledge this is not justified by the very low risk of transmission from health care workers to patients. Those podiatrists who perform exposure-prone procedures have a responsibility to know their HBV, HCV and HIV status.

6.10 Requiring podiatrists to inform patients that they themselves are infected with HBV, HCV, or HIV would only serve as a deterrent to their seeking voluntary testing and medical evaluation. A podiatrist, like any other person, has a right to privacy and confidentiality where there is no risk to the public.

6.11 The Podiatrists Board will maintain a list of podiatrists who are prepared to act as consultants to advise podiatrists or students as to how they may need to limit their practice when suffering from HBV, HCV, or HIV.

Notes: Exposure-prone procedures

Exposure-prone procedures are characterised by the potential for direct contact between the skin (usually the finger or thumb of the podiatrist) and sharp surgical instruments or needles in body cavities or in poorly visualised or confined body sites including the mouth.

7. Review and Evaluation of the Code

The effectiveness of the Code will continued to be reviewed after the first year of its operation and then at intervals of not more than three years.

If necessary, amendments to the Code will be made following consultation with the profession.

This Code reflects the current state of infection control knowledge and every effort has been made to ensure its accuracy. However podiatrists should be aware that the Code could be altered in the future to reflect changes in knowledge concerning infection control policy.

8. Reference List

1. Southern Regional Health Authority Standards of Practice and Infection Control Policy, 1995.
2. New Zealand Podiatric Medical Association (Inc), “New Zealand Guidelines for the Control of Cross Infection in Podiatric Practice”, 1994.
3. New Zealand Society Of Podiatrists (Inc), “Infection Control: Standards for Clinical and Domiciliary Practice", 1994.
4. Central Institute of Technology, Faculty of Health Sciences, Department of Podiatry, “Infection Control Procedures”, 1993.
5. Australian Capital Territory Skin Procedures Act 1994.
6. New Zealand Sterile Services Manual, 1995.
7. Fenton, Charles F. and Harvey, Peter Marshall, “Office-based Surgery, a Risk Management Manual for Doctors of Podiatric Medicine.
8. Lin Lochead “Disinfection, Sterilisation, and Infection Control: Guidelines for Podiatry” © 1996 References for Review 2006
9. Lin Lochead “Disinfection, Sterilisation, and Infection Control: Guidelines for Podiatry 2000”.
10. AS/NZS 4815:2001. Office-based health care facilities not involved in complex patient procedures and processes-Cleaning, disinfecting and sterilizing reusable medical and surgical instruments and equipment, and maintenance of the associated environment
11. Australasian Podiatry Council (2005) National Infection Control Guidelines for Podiatrists
12. APodC Online Education. **http://www.apodc.com.au/**