Infection Control Procedure

SOP · US · Updated 2026-07-13 · Square brackets are placeholders to replace with your own details.

An infection control procedure is the written routine that stops infections moving between the people you care for and the people who do the caring — hand hygiene, personal protective equipment, cleaning and disinfection, and what happens the moment someone is exposed. It turns CDC guidance into the specific habits of your team, in your building, on every shift.

The foundation is standard precautions: the CDC's principle that every patient's blood and body fluids are treated as potentially infectious, every time, regardless of diagnosis. Precautions that depend on knowing who is infectious fail precisely when it matters, because the most dangerous patient is the one nobody has flagged yet.

This template gives you the full procedure: the standard precautions baseline, the hand hygiene routine, PPE selection and the donning and doffing sequence, cleaning and disinfection of environment and equipment, and the exposure response that should be pinned up long before anyone needs it.

Purpose and scope

This procedure sets out how [Your company] prevents and controls infection at [site/service]. It applies to all staff — clinical, care, housekeeping, and administrative — plus students, volunteers, and contractors working in areas where the precautions apply.

[Name/role] is the infection control lead: they own this procedure, the training that goes with it, and the review after any exposure or outbreak. Where [Your company] has occupational exposure to blood or other potentially infectious materials, this procedure operates alongside the written exposure control plan OSHA requires, kept at [location].

Standard precautions

Standard precautions apply to every patient and client contact, every time, regardless of diagnosis or appearance. They are the floor, not the ceiling:

- Treat all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes as potentially infectious.
- Perform hand hygiene at the moments listed below — the single most effective control in this document.
- Select PPE based on the anticipated exposure for the task, not the patient's chart.
- Handle sharps per the sharps procedure: no recapping, disposal at the point of use into the sharps container, containers replaced before full.
- Practice respiratory hygiene: cover coughs, mask symptomatic people where appropriate, and follow [site rules] on staff working while symptomatic.
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Apply transmission-based precautions (contact, droplet, airborne) on top of standard precautions when a known or suspected infection requires them — per the current CDC guidance and [site isolation procedure].

Hand hygiene

1. Clean hands before touching a patient or client, before any clean or aseptic task, after body fluid exposure risk, after touching the patient, and after touching the patient's surroundings — the CDC's moments, learned as a rhythm, not a poster.
2. Use alcohol-based hand rub as the default: cover all surfaces of both hands and rub until completely dry.
3. Wash with soap and water instead when hands are visibly soiled, after caring for anyone with suspected or confirmed C. difficile or norovirus [per site policy], and after using the restroom.
4. Remove rings and wrist items per [site policy], keep nails short, and cover cuts with a waterproof dressing before the shift.
5. Perform hand hygiene immediately after removing gloves — gloves are not a substitute for clean hands.
6. Keep dispensers stocked and working; report empty dispensers to [name/role] the same day, because an empty dispenser sets the real compliance rate.

Personal protective equipment

1. Select PPE for the task using the matrix at [location]: gloves for contact with blood, body fluids, or contaminated items; gown when clothing or skin may be soiled; mask and eye protection when splashes or sprays are possible; respirator [type] where airborne precautions apply.
2. Don in order: hand hygiene, gown, mask or respirator (seal-check the respirator), eye protection, gloves last — gloves go over the gown cuffs.
3. Doff in order: gloves, eye protection, gown, then hand hygiene, then mask or respirator last, touching only the ties or straps — the front of used PPE is contaminated.
4. Change PPE between patients and whenever it is torn, soiled, or saturated; never wear the same gloves from one patient to the next.
5. Discard used PPE at the point of removal into [waste stream], not carried down the corridor.
6. Report PPE shortages to [name/role] immediately — improvising PPE is how exposures happen, and OSHA requires the employer to provide it at no cost to workers with occupational exposure.

Cleaning and disinfection

1. Clean before you disinfect: disinfectant applied over visible soil does not work.
2. Use the products on the approved list at [location], at label dilution, and honor the wet contact time on the label — a surface wiped dry early was not disinfected.
3. Clean high-touch surfaces (bed rails, door handles, call bells, faucets, shared keyboards) at [frequency] and between patients or clients.

4. Clean shared equipment (blood pressure cuffs, hoists, thermometers, wheelchairs) between every use per the equipment matrix at [location].
5. Handle laundry as potentially contaminated: minimal agitation, no sorting in care areas, bagged at the point of use per [site procedure].
6. Clean blood and body fluid spills immediately per the spill procedure: PPE on, absorb, clean, disinfect with [approved product], and dispose into [waste stream].
7. Sign the cleaning schedule as tasks complete — the signed schedule is the evidence the routine happened.

Exposure incidents

1. For a sharps injury or bite that breaks skin: wash the wound with soap and running water immediately — do not squeeze it.
2. For a splash to eyes, nose, or mouth: irrigate with water or saline for [duration per site procedure].
3. Report to the [person in charge] immediately — post-exposure treatment for some pathogens is time-critical, so this is minutes, not end-of-shift.
4. Seek evaluation per the exposure control plan: [occupational health provider / emergency department], with the source information the assessor will need.
5. Record the incident on the exposure log and incident report; where OSHA recordkeeping applies, [name/role] handles the recordable determination.
6. Debrief within [days]: what allowed the exposure, and what changes — device, technique, staffing, or this procedure itself.

Records and review

Training records, cleaning sign-offs, exposure logs, and incident reports are kept at [system/location] for [period] — exposure and medical records for the retention period the exposure control plan specifies. They are what an OSHA inspector, licensing surveyor, or attorney will ask for first.

This procedure is reviewed [frequency, e.g. annually], after every exposure incident or outbreak, and whenever CDC guidance or the services [Your company] provides change. Owner: [name/role]. Next review due: [date].

How to use this template

1. Map your services against the precautions first: which tasks involve exposure risk, which areas need which PPE, and where transmission-based precautions could apply.
2. Build the PPE matrix and the equipment cleaning matrix for your actual rooms and devices — a generic list protects nobody.
3. If any role has occupational exposure to blood, confirm your written exposure control plan exists and matches this procedure — OSHA requires the plan, the vaccination offer, and the post-exposure follow-up.
4. Fill in the exposure response contacts and post them where exposures happen, not just in the binder.

5. Train everyone against this procedure with a sign-off, including housekeeping and temporary staff, and refresh at [frequency].
6. Audit monthly with fresh eyes: watch five hand hygiene moments, one doffing sequence, and one equipment clean — fix the routine, not just the person.

Official guidance

- CDC — Infection control
- OSHA — Bloodborne pathogens and needlestick prevention
- OSHA — Healthcare