Prevention and control of infection in care homes

Draft for consultation
**Document Purpose**  Consultation/Discussion

**Gateway Reference**

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**Title**  Consultation on The Health and Social Care Act 2008 Code of Practice for health and adult social care on the prevention and control of infections and related guidance and, the supporting document Prevention and control of infection in care homes

**Author**  Department of Health

**Publication Date**  13 Aug 2009

**Target Audience**  PCT CEs, NHS Trust CEs, SHA CEs, Care Trust CEs, Foundation Trust CEs, Medical Directors, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, PCT Chairs, NHS Trust Board Chairs, Independent Healthcare and Adult Social Care organisations

**Circulation List**  other - Professional bodies

**Description**  The Code of Practice and supporting guidance will help providers of health care and adult social care to plan and implement how they prevent and control healthcare associated infections. It sets out criteria that the Care Quality Commission will use to assess compliance with the registration requirement.

**Cross Ref**  Getting ahead of the curve; Winning ways: working together to reduce healthcare associated infections in England; Towards cleaner hospitals and lower rates of infection: a summary of action; Saving Lives: reducing infection, delivering clean and safe care; and Essential steps to safe, clean care: Reducing healthcare associated infections. Health and Social Care Act, Care Quality Commission HCAI registration guidance.

**Superseded Docs**  The Health and Social Care Act 2008 Code of Practice on the prevention and control of healthcare associated infections and related guidance

**Action Required**  N/A

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For Recipient’s Use
Prevention and control of infection in care homes

Draft for consultation

Prepared by: DH Infectious Diseases and Blood Policy Branch,
Health Protection Division
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Introduction

This document aims to provide supporting information to ensure that all reasonable steps are taken to protect residents and staff from acquiring infections in care homes. This document updates *Guidelines on the Control of Infection in Nursing and Residential Homes* (Department of Health, 2006) and reflects the changes to secondary legislation made in the Care Homes (Amendment) Regulations 2008. It should be read alongside the *Code of Practice for health and adult social care on the prevention and control of infections and related guidance*.

This document provides information on the roles and responsibilities of those who provide regulated activities in relation to infection, and those individuals and organisations who have a role in this area. The document also provides information to support care homes in minimising the risk of infection to residents and staff and will help them comply with the criteria in the Code of Practice.

The Code of Practice

The Code of practice and related guidance (‘the Code’) relates to the registration requirement ‘Cleanliness and infection control’ and sets out how the Care Quality Commission (CQC) will assess compliance with this registration requirement. It also provides guidance on how providers of care may meet the registration requirements relating to the prevention and control of healthcare associated infections. It does not replace existing regulatory commitments. All providers of care should also comply with other relevant legislation, such as the Health and Safety at Work etc Act 1974 and the Control of Substances Hazardous to Health Regulations (2002).

Background

Some infectious diseases have the capacity to spread within care homes, where susceptible people share eating and living accommodation. Infection is a major cause of illness among care home residents and may result in avoidable admissions to hospital. The application of this guidance to the prevention and control of infection will minimise the spread of infection in care homes and prove cost-effective.

Infections acquired in hospitals and care homes may be serious and, in some cases, life-threatening. These may worsen underlying medical conditions and adversely affect recovery. Infections may be caused by organisms resistant to antibiotics and the high media profile they generate may alarm residents, their relatives and carers. It is important that clear information on the standards of infection prevention and control in care homes is available for them to allow informed choices and promote confidence in the quality of care provided. Families and carers will want to be assured that the care their relatives and dependants receive is provided in a clean and safe environment.
Effective prevention and control of infection should be embedded in normal practice and applied consistently by everyone. It is particularly important to be aware of the possibility of infection in residents and for care workers to identify these promptly.

Terminology and definitions

The Care Standards Act 2000 section 3 contains the following definition.

"An establishment is a care home if it provides accommodation together with nursing or personal care for any of the following persons:
- persons who are or have been ill
- persons who have or have had a mental disorder
- persons who are disabled or infirm
- persons who are or have been dependent on alcohol or drugs."

For the purposes of this document a care home is an establishment registered as such with the CQC.

Roles and responsibilities

The roles and responsibilities of key personnel in respect of infection prevention and control are as follows:

The Owner (registered provider) is any person, partnership or organisation who provides one or more of the regulated activities and is registered with the CQC, as a registered provider of that service or those services. The owner of a care home is responsible under health and safety legislation for maintaining an environment which is safe for residents, visitors and staff alike. Suitable arrangements and procedures for prevention and control of infection would form part of the health and safety requirements.

The Manager (registered manager) is an individual who is registered with the CQC to manage the regulated activity at particular premises where the registered provider is not in day to day charge. The manager should have access to advice on infection prevention and control from a suitably qualified and competent individual. It is expected that the registered manager will produce an annual statement on the systems in place for the prevention and control of infection and how these are monitored. The report should contain:
- information on incidents and outbreaks of infection;
- risk assessments;
- training and education of staff;
- infection control audits; and
- the actions that have been taken to rectify any problems.
The registered manager should ensure that appropriate infection prevention and control policies and procedures exist, are readily available, understood by all members of staff and are used within the home.

The Care Quality Commission (CQC) is the new independent regulator of health and social care in England. It aims to ensure that better care is provided for everyone, whether in hospital, care homes, people’s own homes, or elsewhere. It regulates health and adult social care services, whether provided by the NHS, local authorities, private companies or voluntary organisation. It also protects the rights of people detained under the Mental Health Act. Their work brings together independent regulation of health, mental health and adult social care. Before 1 April 2009 this work was carried out by the Healthcare Commission, the Mental Health Act Commission and the Commission for Social Care Inspection. These organisations no longer exist.

The Health Protection Agency (HPA), through its local Health Protection Units (HPUs), is responsible for the control of infectious disease within the community. However, although HPUs will wish to ensure that appropriate infection control arrangements are in place in local homes, they are not responsible for providing an infection control service directly to care homes.

The HPA employs Consultants in Communicable Disease Control (CCDC) and/or Consultants in Health Protection (CHP). They may advise, and be appointed as the Proper Officer of the Local Authority, which has statutory duties and powers relating to communicable disease control. The HPU may also employ Health Protection Nurses (HPN). Local HPUs are able to provide specialist advice on infection control to care homes and others in the community when outbreaks and other incidents occur. The local HPU is to be informed of any suspected outbreak of infection in a care home and will provide support in the investigation and management of the outbreak.

The role of the local HPU is to monitor and investigate outbreaks of infection and advise on the control and prevention of outbreaks in the care home. The HPU will decide if an outbreak is ongoing in the home and will initiate and co-ordinate any necessary action to limit further spread. They will advise the provider/manager of any immediate action necessary for infection control. This may require the identification of those at higher risk and separating those who have symptoms from those who do not. If the disease is primarily food-borne, the local authority Environmental Health Practitioner (EHP) may lead the investigation with the support of the HPA.

The Community Infection Prevention and Control Nurse (CIPCN) is usually employed by the primary care trust (PCT) and provides advice, education, training, policy development and audit functions to the community.

The General Practitioner (GP) is responsible for the diagnosis and treatment of all those registered under their care. The GP has an ethical responsibility to consider the implications of a diagnosis of an infectious disease for the health of the public.
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Liaison with the CCDC/local HPU is important in infectious disease control; the GP is responsible for notifying the CCDC/local HPU of certain infectious diseases (see Appendix 3). The GP also has a responsibility to prescribe appropriate antibiotics and be mindful of the link between antibiotic prescription and *Clostridium difficile* infection. The GP is also responsible for following the local antimicrobial prescribing policy and being aware of advice from the local Medicines Management Team, which includes the PCT pharmacy advisors.

The EHPs work for local authorities as Environmental Health Officers (EHOs) who advise on the management of food safety, including hygiene, kitchen design, pest control and waste disposal. EHOs are also responsible for the control of pollution and other environmental nuisances. Their duties include the inspection of food premises, as well as enforcing the provisions of the UK laws and the EU food hygiene legislation. The EHPs also investigate complaints about food and collaborate with the CCDC/local HPU in the investigation of outbreaks, particularly of food- or water-borne illness.

Health and Safety at Work etc Act 1974

The general duties of the Health and Safety at Work etc Act 1974 apply to all care homes, as employers need to protect the health, safety and welfare of employees and the health and safety of the public, so far as is reasonably practicable, and to perform the ‘risk assessment’ as required by the Control of Substances Hazardous to Health (COSHH) regulations.

Risk assessment

Registered manager and providers of care homes will need to undertake risk assessment and one way of doing this is described by the Health and Safety Executive.

Control of Substances Hazardous to Health (COSHH)

Where there may be exposure of staff and residents to hazardous substances, which include dusts, gases, liquids, vapours and biological agents (such as disease causing bacteria), the Control of Substances Hazardous to Health Regulations (COSHH 2002) requires assessment of the risks arising from those exposures. COSHH requires employers, to either prevent that exposure (where reasonably practicable) or to control it adequately. As a guiding principle, the greater the risk posed from a specific hazard, in terms of the severity of an outcome if this risk is realised or the number of individuals potentially affected by the hazard, then the greater the level of intervention required to control the risk. This intervention may require a financial commitment, e.g. provision of appropriate equipment to deal with blood spills or other resources – such as ensuring adequate time is devoted to instruction, training and subsequent supervision of staff.
Exposure that does not arise from the work activity itself, such as catching the ‘common cold’ (an upper respiratory tract infection) from a colleague, need not be included.

In order to comply with the requirements of COSHH there are eight recommended steps, that apply equally to chemical hazards and infection prevention and control within a care setting. When deciding which control measures are required, the ‘hierarchy of control’ should be followed:

- whenever possible a hazard should be eliminated; if this is not possible,
- then a number of control measures limiting exposure need to be employed, supported if necessary by personal protective equipment, such as disposable gloves.

Steps to fulfil COSHH requirements

Step 1  **Assess the risks**
Identify any clinical and biological hazards present or potentially present in the workplace as a result of a work activity, e.g. disinfectants, blood-borne viruses, gastrointestinal viruses. Assess the risks to health which arise, who may be harmed and how.

Step 2  **Decide what precautions are needed**
Decide what precautions are needed, e.g. employment of standard precautions, scrupulous hand hygiene, immunisation against infection etc.

Step 3  **Prevent or adequately control exposure**
Consider these risks and the precautions needed, e.g. protective clothing, gloves, hand hygiene, etc.

Step 4  **Ensure that control measures are used and maintained**
This may require the implementation of a system to check whether staff follow procedures.

Step 5  **Monitor the exposure**
Monitor the exposure of employees to hazardous substances, if necessary. This may mean regular observation and discussion on activities or even chemical or bacteriological sampling.

Step 6  **Carry out appropriate health surveillance**
Where your assessment has identified significant risks, health surveillance, such as, medical checks and the keeping of staff health records, may be necessary or advisable.

Step 7  **Prepare plans and procedures to deal with accidents, incidents and emergencies**
Being prepared for such incidents reduces the health and safety risk when these things happen (see Appendix 4). Examples of emergency plans are spillage control, and procedures for needlestick injuries.

Step 8  **Ensure employees are properly informed, trained and supervised**
It is advisable for each employee to have a training plan and record of progress.
It is important that the assessment is reviewed and revised if there is a significant change to the work activity, resulting in either the addition or removal of hazardous substances from the workplace.

*Health and Safety in Care Homes* (HSG220) (Health and Safety Executive, 2001) provides an overview for care home owners and managers to enable them to meet their legal obligations in this arena. The principle risks found in care homes are covered in detail and guidance given on the processes that safeguard both workers and residents. Examples of risk assessment are provided, as are checklists for training and self-audit.

### Information to support compliance

The following information will aid care homes comply with the criterion 9 set out in the Code.

| The provider of care needs to demonstrate that they have and adhere to policies designed for the individual’s care and provider organisations, that will help prevent and control infections. |

Adherence to policies has been shown to reduce the risk of infection to residents and care workers. There are specific policies and protocols applicable to infection prevention and control that a provider should have in place. Staff training is important and will improve compliance with policies, which should be regularly audited and updated.

#### (a) Standard infection prevention and control precautions

Standard infection prevention and control precautions should be applied by all care workers to the care of residents. All those who provide care should be trained on standard infection prevention and control precautions, which consist of:

- hand hygiene
- the use of personal protective equipment (PPE)
- the safe use and disposal of sharps

### Hand hygiene

Hand hygiene is widely acknowledged to be the single most important activity that reduces the spread of infection. Yet evidence suggests that many care workers do not decontaminate their hands when required nor use the correct technique. Hand hygiene should be performed immediately before each and every episode of direct person contact and after any activity or contact that could potentially result in hands becoming contaminated.

Staff should be trained in the use of liquid soap and water (see Appendix 7) and alcohol handrubs (see Appendix 8) and should understand how and when this should be done. Alcohol handrubs should be used at the point of care. Alcohol handrubs are not suitable
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for use on hands that are contaminated with organic matter (soiled) (e.g. faeces, secretions) or during outbreaks of diarrhoeal illness (for example norovirus or *Clostridium difficile*) when washing hands with soap and water is necessary.

Hand hygiene facilities, that include as a minimum a hand wash basin, supplied with hot and cold water and disposable paper towels, should be available and easily accessible. A lack of or inappropriate facilities should be brought to the attention of the Manager or Owner of the care home who has a duty of care to ensure that there are adequate materials and facilities to prevent cross-infection in the home.

**Personal protective equipment**

Selection of Personal Protective Equipment (PPE) should be based on an assessment of the risk of transmission of micro-organisms to the resident, and the risk of contamination of a care worker's clothing and skin by the resident's blood, body fluids, secretions or excretions.

Disposable gloves and aprons protect both the care worker and the resident from the risks of cross-infection.

**Disposable gloves**

As with all items of PPE, the need for gloves and the selection of appropriate materials should be subject to careful assessment of the task to be carried-out and its related risks to the resident and the care worker.

The assessment should include:
- who is at risk and whether sterile or non-sterile gloves are required;
- what the risk is, i.e. the potential for exposure to blood, body fluids, secretions or excretions;
- where the risk is, i.e. contact with non-intact skin or mucous membranes during general care and any invasive procedures.

Gloves are required when contact with blood or body fluids or non-intact skin is anticipated. They should be single use and well-fitting. Sensitivity to natural-rubber- latex in residents, carers and care personnel should be documented, and alternatives to natural- rubber- latex gloves should be available, e.g. nitrile gloves.

Gloves are not a substitute for hand hygiene. Gloves should be discarded after each care activity for which they were worn and before contact with other items such as telephones, pens and curtains. This will prevent the transmission of micro-organisms to other sites in that individual and to other residents. Washing gloves rather than changing them is not appropriate as this will cause microscopic damage that reduces their ability to protect. Hands should always be decontaminated following removal of gloves as the integrity of gloves is not guaranteed and hands may become contaminated during their removal.
Disposable plastic aprons

These should be worn when there is a risk of clothing being contaminated with blood or other body fluids, or when a resident has a known infection. A disposable plastic apron should be worn during direct care, bed-making or when undertaking the decontamination of equipment.

The apron is as a single-use item used for one procedure or episode of care and then discarded as clinical waste on completion of the task. Hands should be washed and dried thoroughly following this activity.

Aprons should be stored so that they do not accumulate dust that may act as a reservoir for micro-organisms.

Masks, visors and eye protection

These should only be used on the advice of the infection control personnel, when a communicable disease is suspected or when aerosols are generated in the management of airways.

(b) Aseptic technique

Aseptic technique is a term used to describe clinical procedures that have been developed to prevent the contamination of wounds and other susceptible body sites.

The principles of asepsis/aseptic technique require that:

- exposure of a susceptible site is kept to a minimum
- appropriate hand decontamination is performed prior to the procedure
- sterile or non-sterile gloves are used appropriate depending on the nature of the susceptible site and the nature of the procedures being undertaken
- uniform/clothing are protected with a disposable plastic apron
- all fluids and materials used are sterile
- sterile packs are checked for evidence of damage or moisture penetration
- contaminated/non-sterile items are not placed in the sterile field
- single-use items are never reused
- movement in the immediate vicinity of the area in which the procedure is to be performed is minimised.

The principles of asepsis play a vital role in the prevention of infection in all environments. It is the responsibility of each staff member to understand these principles and to incorporate them into their everyday practice.

(c) Outbreaks of communicable infection
A number of infectious diseases may spread readily to other residents and cause outbreaks. The commonest outbreaks are due to viral respiratory infections and gastroenteritis. The organisms may be spread by hand contact and on occasion by other routes which may include food.

New symptoms in two or more residents, which may indicate a possible outbreak are:
- cough and/or fever (e.g. influenza)
- diarrhoea and/or vomiting (e.g. *Clostridium difficile/norovirus/food poisoning*)
- skin lesion/rash (e.g. scabies).

Communication about the outbreak to all staff, to include agency staff and contractors, is essential. Briefings that provide clear instructions to staff outlining the:
- facts about the transmission and infection control procedures;
- how to clean and decontaminate equipment;
- isolation of an affected resident;
- possible transfer of a resident;
- the importance of hand hygiene for visitors and visiting restrictions;
- discharge of a resident;
- advice for affected staff on exclusion from work and personal hygiene;
- names and contact numbers of infection-control staff.

There should also be a range of printed advice available for staff, family, friends and visitors to be kept fully informed of the situation.

An outbreak of infection is likely to have resource implications for a care home. These may include the need for extra staff and the increased use of disposable items or laundry necessary. Only in exceptional circumstances would there be a need for temporary closure of the premises.

(d) Isolation of residents with an infection

Isolation of infected residents may be necessary to prevent further cases of infection. Ideally single rooms should be available for this purpose and managers of homes will need to consider how best to achieve this. Single rooms should contain hand hygiene facilities with a wall-mounted liquid-soap dispenser and antimicrobial hand rub. Ideally, these rooms should have full en-suite, facilities including a toilet. Where possible, residents with infectious diarrhoea should have sole use of a toilet, which should be thoroughly cleaned between each use. Advice should be sought by the person in charge of the home from the local CIPCN or local HPU. (See Appendix 6 for further information).

(e) Safe handling and disposal of sharps

Staff should be trained in the safe handling and disposal of sharps. Venepuncture and injections should only be carried-out by trained and competent staff.
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- Sharps must not be passed directly from hand to hand, and handling should be kept to a minimum.
- Needles must not be recapped, bent, broken or disassembled before use or disposal.
- Consider the use of needlestick prevention devices where there are clear indications that they will provide safe systems of working for care workers.
- Used sharps must be discarded into a sharps container (conforming to UN3291 and BS 7320 standards) at the point of use by the user. These must not be filled above the mark that indicates that they are full.
- Containers in public areas must be located in a safe position, and must not be placed on the floor. They must be disposed of by the licensed route in accordance with local policy.
- Sharps containers should be taken to the bedside.

Glucose monitoring devices

Care home owners and all staff involved in the management and provision of lancing devices should ensure that correct devices are provided for taking blood samples from diabetic residents. Using the wrong type of lancing device to take blood samples may result in the spread of blood-borne infections. Some lancing devices are intended for self-use, by one person only and staff should not use these to take blood from other residents. Disposable single-use lancing devices must be used for each resident (these are used once and then the entire lancing device is discarded). A non-disposable lancing device can also be used, but this should be one which is intended to be used with disposable single-use lancets. This type of lancing device should be cleaned after use.

(f) Prevention of occupational exposure to blood-borne viruses, including the prevention of sharps injuries

Prevention of occupational exposure to blood-borne viruses includes immunisation against Hepatitis B as set out in Immunisation against infectious diseases (2006) and the application of standard infection prevention and control precautions and the safe handling and disposal of sharps.

(g) Management of occupational exposure to blood-borne viruses and post exposure prophylaxis

It is important that incidents in which staff are exposed to blood and certain body fluids are managed and followed-up appropriately, with the provision of post-exposure prophylaxis if necessary, as there is a risk of blood-borne virus transmission (Human Immunodeficiency Virus [HIV], hepatitis B and hepatitis C). (See Appendix 4).

In the care setting, occupational blood-borne virus transmission can occur after exposure to blood by ‘sharps’ or ‘needlestick’ injury. In some settings, there may be a risk of infection from residents biting staff. Where a significant injury has occurred the procedure outlined in Appendix 4 should be followed.
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Staff who may have come into direct contact with residents’ blood or blood-stained body fluids or with residents’ body tissues should be immunised against hepatitis B (see section on immunisation). There are currently no vaccines to protect against hepatitis C or HIV.

Employers should have a policy on how such incidents should be handled in conjunction with their local CCDC/local HPU or CIPCN/HPN. Unless an employer has access to an occupational health service, it is likely that the assessment and follow-up of such incidents will need to be undertaken by their local emergency department and the person’s GP. In drawing up local policy, employers should clarify and confirm who will be able to provide such a service.

(h) Closure of rooms, wards, departments and premises to new admissions

Only in exceptional circumstances would there be a need for temporary closure of the premises to new admissions because of an outbreak of infection. This will be on the advice of the local CCDC.

(i) Disinfection

Disinfectants should not be used routinely as cleaning agents or deodorants and should not be used for the storage of equipment (e.g. mops). They should only be used at the recommended dilution after the removal of organic debris (e.g. faeces, secretions) and stored and discarded in accordance with the manufacturers’ instructions. Disinfectants should only be used on advice from the local infection prevention and control team but may be introduced to assist in the prevention and control of outbreaks.

(j) Decontamination of reusable medical devices

An automated or mechanical process for the decontamination of reusable medical devices should always be used in preference to a manual process, however, in many instances this is not possible. When using automated methods, for example, washing machines, the process is one of cleaning (removal of “soil”), followed by disinfection, which is achieved by high temperatures (thermal disinfection) within the wash cycle as opposed to the use of chemicals, such as bleach.

Table 1: Recommended decontamination methods

Normal domestic cleaning with warm water, a detergent and thorough drying is suitable for most items in a care home.

If items are contaminated with blood or blood stained body fluids, clean them thoroughly to remove the physical soil and then wipe with a freshly prepared solution of a chorine-releasing agent with a concentration of 10,000 ppm. of available chlorine.

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<th>Description of item</th>
<th>Requirement</th>
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16
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<tr>
<th>Item</th>
<th>Instructions</th>
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<tr>
<td><strong>Baths</strong></td>
<td>After each use, clean with warm water and detergent and dry</td>
</tr>
<tr>
<td><strong>Bedding</strong></td>
<td>Heat disinfection: 65°C for 10 minutes or 71°C for 3 minutes. For heat-sensitive fabrics use a low temperature wash at 40°C and tumble-dry at a minimum of 60°C. See section on laundering pages 38 - 41.</td>
</tr>
<tr>
<td><strong>Bedpans and urinals</strong></td>
<td>Dispose of single-use items in a macerator. If reusable, heat disinfection in bedpan washer–disinfector (e.g. 80°C for 1 minute). Store dry</td>
</tr>
<tr>
<td><strong>Bowls (washing)</strong></td>
<td>Each resident should have their own washing bowl. Clean with warm water and detergent after use. Rinse and dry. Store separately and inverted to avoid contamination.</td>
</tr>
<tr>
<td><strong>Combs</strong></td>
<td>Each resident should have their own comb. Wash frequently.</td>
</tr>
<tr>
<td><strong>Commodes</strong></td>
<td>Clean with warm water and detergent and dry after each use. During outbreaks of infection these items should be for single patient use and decontaminated regularly with 1000ppm chlorine releasing agent.</td>
</tr>
<tr>
<td><strong>Curtains (window)</strong></td>
<td>Should be laundered at least six-monthly.</td>
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<tr>
<td><strong>Drip stands</strong></td>
<td>Clean after each use.</td>
</tr>
<tr>
<td><strong>Flower vases</strong></td>
<td>Change water regularly. Wash vase in hot water and detergent after use and store dry.</td>
</tr>
<tr>
<td><strong>Hoist</strong></td>
<td>Surface clean the hoist frame. Examine material and clips for wear or damage before each use. Slings should be laundered in hottest wash cycle allowable and not shared between residents.</td>
</tr>
<tr>
<td><strong>Glucose-monitoring equipment</strong></td>
<td>see page 15</td>
</tr>
<tr>
<td><strong>Mattresses and covers</strong></td>
<td>Clean covers regularly as part of a routine and before use by a new resident. Rinse thoroughly and dry. Mattresses should be enclosed in a waterproof cover and routinely inspected for damage. Discard if fluids have penetrated into the mattress fabric.</td>
</tr>
<tr>
<td><strong>Nail clippers</strong></td>
<td>All residents should have their own and these should be washed.</td>
</tr>
<tr>
<td><strong>Nebulisers</strong></td>
<td>Clean all parts thoroughly with detergent and warm water between each use. Ensure all parts are thoroughly dried. Refill with sterile water only. Do not share between residents.</td>
</tr>
<tr>
<td><strong>Scissors</strong></td>
<td>Clean following each use.</td>
</tr>
<tr>
<td><strong>Shavers</strong></td>
<td>Each resident should have their own.</td>
</tr>
<tr>
<td><strong>Splints and walking frames</strong></td>
<td>Clean with warm water and detergent and dry.</td>
</tr>
<tr>
<td><strong>Stethoscopes</strong></td>
<td>Wipe earpiece and bell with 70% alcohol following each use.</td>
</tr>
<tr>
<td><strong>Thermometers (electronic, oral, rectal)</strong></td>
<td>Use single use disposable or use a single-use sleeve each time and wipe with 70% alcohol after removal.</td>
</tr>
<tr>
<td><strong>Towels</strong></td>
<td>Each resident should have their own and laundered as for bed linen.</td>
</tr>
<tr>
<td><strong>Trolleys, tables</strong></td>
<td>Clean with warm water and detergent and dry.</td>
</tr>
<tr>
<td><strong>Wheelchairs</strong></td>
<td>Clean with warm water and detergent and dry.</td>
</tr>
</tbody>
</table>
If sterilisation of reusable medical devices is required, it should be sourced from an accredited Sterile Services Department, or single-use disposable instruments should be used.

Some medical devices may be difficult to decontaminate. It is therefore advisable, prior to purchasing equipment, to assess carefully that the recommended decontamination methods are practical, safe and reliable. As assessment will also need to be made whether the equipment can withstand disinfection with a chlorine releasing agent should it be required.

(k) Single-use medical devices

Any device designated as single use only should never be reused under any circumstances and should be disposed of safely once used. The symbol below indicates ‘do not reuse’ and may replace any wording.

(i) Antimicrobial prescribing

Overuse of antimicrobial agents has led to a significant increase in antibiotic resistance in many pathogenic bacteria. Antibiotics are not effective against viral infections and their use may alter bowel flora and allow the colonisation with multi-resistant strains of bacteria (so called “superbugs”) such as meticillin-resistant Staphylococcus aureus (MRSA) and some forms of E. coli. In addition, the use of broad-spectrum antibiotics increases the risk of infection and spread of Clostridium difficile, which may cause serious colitis. In a closed-community, such as a care home, these problems will be magnified. Antibiotics prescribed for one resident should not be used for other residents or staff. Local health organisations have guidelines on antibiotic use that define the appropriate choice of agent for common conditions. These are produced in consultation with the local microbiologist, the CCDC/local HPU pharmacists and prescribing committees. PCTs will have a local antibiotic prescribing policy. When an antibiotic is prescribed the reason and proposed length of treatment should be recorded in the resident’s medical and/or nursing records.

Antimicrobial medicines management

Advice on the management of medicines within a care home may be obtained from the pharmacy adviser of the local PCT. The Medicines Act 1968 stipulates that prescription
medicines should only be administered to the person for whom they have been prescribed, labelled and supplied.

To ensure that the antimicrobial is fully effective many antimicrobials have to be given several times each day, at specific times in relation to food. If a dose of antimicrobial is missed, it should be administered, as soon as possible, unless it is almost time for the next scheduled dose. If it is nearly time for the next dose, the missed dose should not be administered, and the usual dosing schedule should be resumed. Doses should not be ‘doubled’ to catch-up.

**Adverse effects**

Many antimicrobials cause mild side effects such as abdominal discomfort and occasional diarrhoea. These are usually transient, resolve without intervention and are no reason to discontinue the treatment. Some people may, however, develop allergies to specific antibiotics, and may have a reaction to them, that includes skin rashes. The prescriber should be contacted if the symptoms are severe or persist, especially diarrhoea, which may be attributable to *C. difficile*.

**Administration of antimicrobials**

It is important that antimicrobials are administered appropriately to ensure successful treatment and reduce the development of bacterial resistance. The prescriber should be asked to write full and precise instructions on the prescription. Legislation requires that each medicine should have a printed label containing the following information:
- resident’s name;
- date of dispensing;
- name and strength of medicine;
- dose and frequency to be administered.

Milk and antacids may hamper the absorption of some antimicrobials e.g. tetracyclines. The instructions for use should be checked.

Capsules should be swallowed whole. Taking the contents separately or chewing the capsules interferes with absorption of antimicrobials by interfering with the timing of their delayed-release mechanisms. If a person has a problem swallowing the prescribed medication, the prescriber should be contacted and an alternative formulation prescribed.

When administering liquid-formula antimicrobials, the bottle should be shaken vigorously before use, so as to mix the contents and deliver a uniform concentration of the drug every time. A medicinal measuring spoon or syringe should be used to accurately measure the correct dose; household utensils do not generally hold a true teaspoon (5 ml) or tablespoon (10 ml).

**Expiry and storage**
All medicines have an expiry date and should be stored away from heat, moisture and
direct sunlight. Some antimicrobial preparations, particularly liquids, have a very limited
shelf-life and some have special storage requirements therefore each item’s requirements
need checking. The expiry date should be checked before administration and the
medicine returned to the supplier, if the expiry date has passed.

Most but not all antimicrobial suspensions need to be stored in a refrigerator, preferably
one that is specifically designated for the storage of drugs (+2°C to +4°C). The
temperature of the refrigerator should be monitored daily, using an appropriate
thermometer, and periodic audits of drug storage conditions should be undertaken.
Reconstituted antimicrobial powders are unstable and have short expiry dates (one or two
weeks depending on the specific antimicrobial). Partially used or left-over suspensions or
syrups of antibiotics should not be used as they tend to deteriorate on storage.

(m) Mandatory reporting of healthcare associated infections to the HPA

This does not apply to care homes, but they are expected to report outbreaks as in
section (n).

(n) Control of outbreaks and infections associated with specific alert
organisms

Care homes are not expected to monitor alert organisms, but are expected to report
outbreaks of infection.

Care homes should meet the requirements laid down in the Care Standards Act 2000. In
addition, Regulation 37 of the Care Homes Regulations 2001 states that:

“The registered person shall give notice to the Commission without delay of the
occurrence of the outbreak of any infectious disease which in the opinion of any registered
medical practitioner attending persons in the care home is sufficiently serious to be so
notified.”

• All organisations should report significant outbreaks of infection, including outbreaks in
patients who are sectioned under the Mental Health Act 1983, as serious untoward
incidents to the CQC.

• A consultation on new regulations to be made under the amended Public Health
(Control of Disease) Act 1984 to make reporting the responsibility of both registered
medical practitioners and laboratories examining human samples is expected to start
later this year. Thus, the above requirements are subject to change.(see appendix 3)

All staff in a care home should be aware of their role in the prevention and control of
infection and should be suitably trained in these areas. They should also be aware of the
local arrangements for accessing advice on the prevention and control of infection. It is
good practice for the person in charge of each care home to identify a senior nurse or other responsible person who will take a particular interest in infection prevention and who will act as the liaison person for prevention of infections within the home. It is recommended that this person should undertake specific training in infection prevention to enable them to recognise problems as they occur and seek specialist advice from the local HPU.

Any procedures such as isolation and advice on preventing infections should comply with the individual’s need for physical and mental well-being and should comply with relevant health and safety legislation.

If the disease is primarily food-borne, the EHP may lead the investigation with the support of the local HPU.

Prompt diagnosis of a clinical illness helps provide early identification of outbreaks. The GP for the resident will normally make the diagnosis of any infectious illness. If more than one individual develops similar symptoms, a common source of infection may be present; this needs to be investigated and managed to prevent further spread of infection.

The registered manager has the responsibility to report a suspected outbreak of infection to the local HPU, as soon as this is recognised.

Notifiable diseases and infections that could be a potential risk to others (see Appendix 3) should be recorded and reported to the local HPU in accordance with local arrangements.

Serious symptoms in two or more residents which may indicate a possible outbreak are:
- cough and/or fever (e.g. influenza);
- diarrhoea and/or vomiting (e.g. *C. difficile*/norovirus/food poisoning);
- skin lesion/rash (e.g. scabies).

(o) Handling of instruments and devices in procedures carried out on known or suspected CJD patients, and on patients known to be at risk of CJD (including disposal/quarantine procedures)

Seek advice from the resident’s GP if they are known or suspected to have a form of CJD.

(p) Safe handling and disposal of waste

Due to legislative changes that include the Hazardous Waste (England and Wales) Regulations 2005 and the Lists of Waste Regulations 2005 (which introduce the European Waste Catalogue Codes), there have been substantial changes in the way that waste is defined. Clinical waste is still defined in the Controlled Waste Regulations 1995; however, as a consequence of the Hazardous Waste Regulations 2005, any waste that is deemed
to be infectious or hazardous is considered to be hazardous waste and should be consigned for disposal at suitably licensed facilities.

New guidance on the safe management of healthcare waste (Health Technical Memorandum 07-01) was published in November 2006 and is available on the Department of Health’s website.

The following information about waste disposal is an interim guide. Guidance on local policy should be sought from the local authority, EHP, HPU or PCT.

The following information aims to ensure the safe and efficient segregation, collection, handling and disposal of all waste, and in particular clinical waste/hazardous waste.

Responsibilities

The responsibility for the day-to-day management of clinical/hazardous waste rests with the person in charge. All those working in areas where clinical/hazardous and general waste arise should adopt safe working practices, since failure to do so may result in the establishment being in breach of its statutory obligations as regulated by the Environment Agency under the Environmental Protection Act, 1990.

The person in charge has a duty to ensure that all clinical/hazardous waste is correctly bagged, sealed, tagged and stored before collection for incineration/alternative treatment, as appropriate. Collection of waste should be arranged through a licensed disposal contractor – using licensed carriers to transport the waste to licensed treatment/disposal plants only. If in doubt, the Environment Agency can confirm license details (see www.environment-agency.gov.uk).

Staff training

Management has the responsibility for ensuring that all staff and volunteers are trained by a competent waste manager and that records are maintained and appropriate waste receptacles and equipment are provided.

Those responsible for staff training should ensure that staff use appropriate protective clothing and equipment.

Segregation of waste

All waste should be secured in an approved way and identified with a coded tie or label to indicate source of waste. (See Table 2). Bags should not be closed by an overhand knot. Good practice is to ‘swan neck’ the bags by twisting the top and then turning it over on itself. The bag should then be secured with tape and tie. Bags should not be more than ¾ full.
Areas where clinical/hazardous waste is produced should have foot-operated bins.

Plastic waste bags should be constructed of plastic of a gauge appropriate to intended use, to avoid splitting and spillage of contents.
Table 2: Colour coding of healthcare waste according to infection risk

<table>
<thead>
<tr>
<th>Colour</th>
<th>Description of item</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low-risk healthcare (clinical) waste</td>
<td>• Soiled surgical dressings</td>
<td>Waste which may be “treated”</td>
</tr>
<tr>
<td></td>
<td>• Swabs</td>
<td>Indicative treatment/disposal required is to be “rendered safe” in a suitably permitted or licensed facility, usually alternative treatment plants.</td>
</tr>
<tr>
<td></td>
<td>• Disposables, such as gloves and aprons</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Contaminated wipes and pads, etc</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any other item that has been in contact with the individual (excluding linen)</td>
<td></td>
</tr>
<tr>
<td>Low risk healthcare (sharps)</td>
<td>• Used/unused sharps</td>
<td>Waste which may be “treated”</td>
</tr>
<tr>
<td></td>
<td>• Blades</td>
<td>Indicative treatment/disposal required is to be “rendered safe” in a suitably permitted or licensed facility, usually alternative treatment plants</td>
</tr>
<tr>
<td></td>
<td>• Fully discharged needles with their disposable syringes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All above items should be disposed of into dedicated, UN and BSI approved orange-topped ’sharps’ bins</td>
<td></td>
</tr>
<tr>
<td>High-risk healthcare (clinical) waste</td>
<td>• Medicines</td>
<td>Waste which requires disposal by incineration</td>
</tr>
<tr>
<td></td>
<td>• Pharmaceutical and pharmacy chemicals</td>
<td>Indicative treatment/disposal required by incineration in a suitably permitted or licensed facility.</td>
</tr>
<tr>
<td></td>
<td>• Used/unused drugs/vials</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All above items should be disposed of into dedicated UN-and BSI –approved yellow topped ’sharps’ bins</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tampons and used sanitary towels: where possible dispose of in dedicated sanitary bins</td>
<td>Offensive/hygiene waste</td>
</tr>
<tr>
<td></td>
<td>• Incontinence pads and wipes, gloves or aprons which are not from an</td>
<td>Minimum treatment/disposal required is landfill in a suitably permitted or licensed site. This waste should not be compacted in unlicensed/permited facilities.</td>
</tr>
</tbody>
</table>

5 Offensive/hygiene waste
infectious person

- Normal household waste, food waste, non-contaminated household materials unsuitable for recycling
- General commercial waste
- Non clinical waste

**Domestic (municipal) waste**

Minimum treatment/disposal required is landfill in a suitably permitted or licensed site. Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste.
Any cardboard box
Marked GLASS AND BREAKAGES ONLY and lined with a heavy-duty, clear plastic bag for bottles and breakages. Advice is for broken glass to go into the sharps bin for health and safety reasons. Glass bottles that have been used for medicines, etc seek advice from the pharmaceutical officer.

Marked AEROSOLS ONLY and lined with a clear plastic bag for aerosols, which under The COSHH Act, 2002 should be kept and disposed of separately (Carriage Regulation cover packaging and transport of aerosols in UN approved containers – UN 1950).

Categories of waste

Clinical waste
Low-risk and high-risk clinical waste should be disposed of in orange or yellow streams dependent on disposal route, i.e. alternative technology or incineration, to an appropriately licensed waste disposal plant. This includes:
- soiled surgical dressings, swabs and all other contaminated waste from treatment areas;
- material other than linen from cases of infectious disease;
- all human tissues (whether infected or not) and all related swabs and dressings;
- tampons and used sanitary towels; where possible, these should be disposed of separately in dedicated Sanibins. (Note that this waste can now be segregated for disposal as ‘Offensive Waste’ as described in Table 2 above).

Water authorities now expect that care providers seek authorisation before flushing away disposable bedpan liners, as they are known to block-up pumps and drains. Any discharge of materials to sewers, other than domestic sewage, should have the prior agreement of the statutory responsible body.

Managers are responsible for ensuring that there is an effective procedure for dealing with an accidental spillage (see section on managing spillages). This procedure should include staff training. A named person (head of department/supervisor) and deputy should be designated. There should be proper cleansing of the affected spillage area and any tools or protective clothing used should be correctly dealt with.

Sharps
The following should be disposed of in a sharps container:
- discarded syringes;
- needles;
- cartridges;
- small items of broken glass; and
- any other sharp instruments.
All dedicated sharps containers should conform to UN3291 and BS7320 standards. They should have a coded tie or label and be disposed of when three-quarters full (or within one month when used in a care setting).

**Non-clinical waste or domestic waste**

Other general waste (food waste, non-contaminated household materials) unsuitable for recycling, should be disposed of in black refuse bags.

The Hazardous Waste (England and Wales) Regulations 2005 do not allow mixing of waste; this includes mis-segregation of domestic-type waste into the clinical or hazardous waste stream.

**Bulk storage of waste**

Specific areas (stillages) should be designated for waste storage. Storage should be in a well-drained area, with impervious hard standing and wash-down facilities. The area should be kept secure from unauthorised persons. Storage areas should not be accessible to scavenging animals. Clinical/hazardous waste in orange or yellow bags should be kept separate from general waste in black refuse bags and soiled laundry bags to minimise the risk of accidental cross-contamination. All accidental spillages in the bulk storage areas should be cleaned up immediately.

**Disposal of pharmaceutical products**

Unused drugs and other pharmaceutical products should be returned to the pharmacist; they should not be administered to any resident other than the person for whom they were dispensed.

**(q) Packing, handling and delivery of laboratory specimens**

If pathology specimens are requested, they should be safely contained in an approved leak-proof container. This should be enclosed in another container, commonly a sealable polythene bag. The request form should be placed in the side-pocket of the polythene bag and should not be secured with clips or staples, as these may puncture the bag. Care should be taken to ensure the outside of the container and bag, remain free from contamination with blood and other body fluids. The request form should be completed fully. This includes the individual’s identifier, the test required and relevant clinical details. Guidance on specimen collection and supplies of containers, plus confirmation of transport requirements, including labelling, should be obtained from the local laboratory that provides the diagnostic service.

**(r) Care of deceased persons**

**Notices in respect of deaths**
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Regulation 37 of the Care Homes Regulations 2001 requires all deaths to be reported to the CQC without any delay of a death of a person who uses the service. A verbal notification should always be followed-up in writing.

In the case of deaths due to notifiable diseases, (see Appendix 3), the manager of the home should also inform the local health protection unit by telephone at the earliest opportunity. A death, even if anticipated, may give rise to enquiries which it is easier for the health protection unit to deal with if they have already received information about the death from the home manager.

If a death has to be referred to the coroner, his or her instructions or those of the coroner’s officer should be followed.

Last offices – hygienic management of the dead

The dead should be treated with due respect and dignity and in a manner appropriate to the religious and cultural background of the deceased. Last offices vary according to religion and cultural practices and may, on occasions, be compromised by the need for specific measures to be taken if an infectious disease was associated with the death (see below). Problems not covered in this guidance should be discussed with the undertaker and the local HPU, who may wish to consult the appropriate religious authority.

Though most dead bodies are not infectious, sensible precautions should be taken; disposable gloves and aprons should be worn when washing and preparing the body. If a family wishes to help with the washing and preparation of the body this should normally be allowed.

The body continues to secrete fluids after death. Any leaking orifices should be packed with cotton wool.

Special disinfection measures are not necessary after death. Washing the body with soap and water is adequate.

Dressings, drainage tubes, etc. should be removed, unless the death occurred within 24 hours of an operation or was unexpected, in which case a coroner’s post-mortem is likely. If tubes are to be left in position for this reason, they should be cut to just above skin level, covered with a dressing pad and secured with tape or a loose bandage.

Clean dressings should be applied to any wounds, secured with tape or loose bandage to prevent any further leakage from the wound site. The body should be removed to a cool environment as soon as possible.

Last offices for a person suffering from an infectious disease
The precautions used during life for residents with an infectious disease remain necessary after the person’s death. The body of a person who has had an infectious disease may remain a hazard to those who handle it. In addition, it may be necessary for the body to be placed in a body bag before removal to the undertakers. This information should be communicated to the undertaker without any breach in confidentiality. The undertaker will normally supply a bag, if it is required.

To minimise the risk of infection, disposable gloves and an apron should be worn by those carrying-out the laying-out procedure, whether this is done by staff, the undertaker or, under supervision, by relatives.

If a body bag is required before the body is removed to the undertakers, the body should be placed in a shroud, or the person’s own clothes, and then in the plastic body bag, which should be carefully secured. The identity labels and ‘Notification of Death’ labels should be attached in such a way that they may be read through the body bag. Another ‘Notification of Death’ label and a ‘Danger of Infection’ label should be attached discreetly to the outside of the bag. Neither label should state the diagnosis, which is confidential information, only the type of precautions required, such as the need to avoid embalming in the case of blood-borne viruses. The undertaker should be informed of the danger of infection but without disclosure of the diagnosis. Once the body is sealed in the body bag, protective clothing will no longer be necessary for those who handle the body.

If relatives wish to take the body abroad for a funeral, certificates may be required from the attending doctor and from the local HPU to certify that the body is safe for transport. This will normally be organised by the undertakers, in liaison with the doctor and the local HPU.

The furniture and any equipment in the resident's room should be cleaned thoroughly using hot water and detergent, unless the local HPU advises that disinfection is required. Body fluid spillages and laundry should be dealt with as described on pages 34 and 38-41.

See also “Controlling the risks of infection at work from human remains: A guide for those involved in funeral services (including embalmers) and those involved in exhumation” (Health and Safety Executive, 2005).

(s) Use and care of invasive devices

Invasive devices such as a urinary catheter or intravenous line will increase a resident’s risk of acquiring an infection and the care home should have a policy in place for the care of devices, the policy should be audited on a planned basis. Where residents have an invasive device in place, this should be fully documented in the
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care plan and the resident should be monitored for signs of infection. Staff should be trained in the care of residents with invasive devices.

(t) Purchase, cleaning, maintenance and disposal of equipment

When new equipment is purchased, it is important that ease of decontamination and maintenance of the equipment is taken into account. Disposal of electromechanical equipment should take account of relevant environmental regulations.

(u) Surveillance and data collection

The maintenance of records on cases of infection will need to be sufficiently detailed to meet the needs of the organisation lead for infection prevention and control (OLIPC) to meet his/her obligation to produce an accurate and informed annual statement.

(v) Dissemination of information

Most relatives and friends appreciate the risk of spreading infection to older, vulnerable people. If they have current symptoms of infection, potential visitors should be advised to telephone for advice before a visit. It may be necessary for staff to explain kindly but firmly that under certain circumstances visits should not be made. Visitors should be requested to help staff to keep the risk of infection to a minimum and it may be helpful to display notices that ask visitors with symptoms of infection, particularly those associated with respiratory or gastrointestinal tract, skin or eyes, to speak to the nurse or person in charge before seeing any residents. This applies especially to young children who are more likely to be a source of infection to older relatives.

The local HPU/CIPCN can advise on relevant infection prevention and control precautions that may be required. All visitors should be encouraged to either wash their hands or use an antibacterial handrub at the start and the end of each care home visit.

(w) Isolation facilities

Care homes are not expected to have dedicated isolation facilities for residents, but are expected to implement isolation precautions when a resident is suspected or known to have a transmissible infection. Residents that need to be cared for in specialist facilities will be admitted to a hospital with these facilities.

(x) Uniform and dress code

Not all care staff need to wear uniforms, and uniforms are a not significant source of cross-infection. Nevertheless, the way care staff dress will send messages to the
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residents they care for, and to the public. It is sensible for care homes to consider what messages they are trying to convey and to advise on dress codes accordingly. Both infection prevention and control and public confidence should underpin a care home’s uniform policy, but the two are not necessarily interchangeable. Examples of good and poor care staff practice in uniform/dress code are shown below.

**Table 3: Examples of good and poor practice relating to uniform/dress code**

<table>
<thead>
<tr>
<th>It is GOOD practice for care staff to:</th>
<th>It is POOR practice for care staff to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Wear short-sleeved shirts/blouses when providing care as cuffs become heavily contaminated. Short sleeves also enable good hand hygiene practice.</td>
<td>• Go shopping whilst wearing a uniform or undertake similar activities in public.</td>
</tr>
<tr>
<td>• Change into and out of uniform at work or cover uniform completely when travelling to and from work.</td>
<td>• Wear false nails when giving care directly to an individual as these can harbour micro-organisms and can reduce compliance with good hand hygiene.</td>
</tr>
<tr>
<td>• Wear clear identifiers (uniform and/or name badge) as residents wish to know who is caring for them.</td>
<td>• Wear hand or wrist jewellery/wristwatches (a plain wedding ring is acceptable) as these can harbour micro-organisms and can reduce compliance with good hand hygiene.</td>
</tr>
<tr>
<td>• Change immediately if uniform or clothes become visibly soiled or contaminated.</td>
<td>• Wear numerous badges or other adornments.</td>
</tr>
<tr>
<td>• Tie long hair back off the collar.</td>
<td>• Wear neck-ties (other than bow-ties) in any care activity which involves contact with residents.</td>
</tr>
<tr>
<td>• Keep fingernails short and clean.</td>
<td>• Carry pens/scissors, etc in outside breast pockets.</td>
</tr>
<tr>
<td>• Wear soft-soled, closed-toed shoes which offer protection against spills and dropped sharps.</td>
<td></td>
</tr>
<tr>
<td>• Wear clothes that are machine washable.</td>
<td></td>
</tr>
</tbody>
</table>

The uniforms of staff providing personal care should be changed daily, and the wash temperature should reach the minimum of 60°C for at least ten minutes. This should be followed by thorough drying and hot ironing.

**(y) Immunisation of service users**

Care home owners need to ensure that residents (service users) are up to date with general immunisations, including seasonal influenza vaccination. Some important diseases that may be relevant in a care home setting are listed below. For a full and comprehensive guide on all matters relating to vaccine-preventable diseases refer to
Influenza

Annual influenza immunisation is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely to follow introduction of infection and cause high morbidity and mortality. Immunisation is also recommended for the elderly i.e. all those over 65 years and those aged 6 months and over with chronic chest, heart, liver, kidney disease, diabetes or those who are immunosuppressed as a result of disease or treatment.

Pneumococcal infections

A single dose of pneumococcal vaccine is recommended for all those aged 65 years and over and those under 65 years of age who are at an increased risk from pneumococcal infection. These medical risk groups include: people who have a heart condition, chronic lung disease, chronic liver disease, diabetes, a weakened immune system and a damaged spleen or no spleen.

The following information will help care homes to comply with the other criteria list in the Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

Cleaning

Premises and facilities should be provided with policies and materials in accordance with best practice guidance. The development of local policies should take account of infection prevention and control advice given by the relevant expert and should address the following:

General cleaning
Care homes should be cleaned and kept clean to the highest possible standards as residents and the public expect, and have a right to, the highest standards of hygiene. Care providers should be aware that standards of cleanliness are seen as an outward and visible sign of the overall quality of care provided. Individuals are likely to have significant concerns about the quality of care available in premises that do not appear clean.

A key component of providing consistent high-quality cleaning is the presence of a detailed plan setting out all aspects of the service and defining clearly the roles and responsibilities of all staff, from managers through carers to domestics. Where cleaning services are provided by private contractors, this plan should also set out management arrangements to ensure the provider delivers against the contract. Contracting-out the cleaning service does not mean contracting-out responsibility, and
managers will need to ensure that there are suitable arrangements in place to monitor standards and to deal with poor or unsatisfactory performance.

A range of advice and guidance has been provided to the NHS in the area of cleanliness, both in terms of providing services and in monitoring the standards. While this has, in general, been designed with NHS hospitals in mind, most of it is applicable to care homes with little or no adjustment. The following source documents will be of particular interest.

**National specifications for cleanliness**

These specifications set out in clear and simple terms the standard expected across a range of 'elements', which taken together cover all the important aspects of cleanliness encountered in keeping premises, equipment to fixtures and fittings clean. In addition, it provides a simple auditing/monitoring process, which allows care providers to check on performance against agreed standards.

**Revised Healthcare Cleaning Manual**

The revised manual is a detailed, easy-to-follow, step-by-step document demonstrating the correct way to clean and gives details of cleaning materials and equipment (and maintenance of equipment) needed to help achieve the highest possible standards of cleanliness. It includes sections that cover the prevention and control of infection, health and safety, risk assessment and training. It provides detailed methods for general cleaning (furniture, fixtures and fittings and walls), floors, kitchens, washrooms and sanitary areas. There is also advice covering specialist areas (including cleaning of isolation rooms) and equipment.

When read in conjunction with the National Specifications for cleanliness, this guidance can help health and social care providers identify standards of cleanliness and what systems and processes they need to put in place to deliver and monitor those standards.

**Minimum cleaning frequencies**

Having clearly defined cleaning tasks, it is crucial to ensure that they are carried out at the required frequency. This will also help to determine precisely what cleaning resource is needed. Cleaning frequency charts should be available on request. An example of a minimum cleaning frequency schedule is contained within the *National Specifications for Cleanliness*.

**Colour coding**

Ensuring the risks from cross-contamination through inappropriate cleaning practices are kept to a minimum will be assisted by the presence of a clear system for the
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coding of cleaning equipment. The National Patient Safety Agency issued a standard
colour code for cleaning materials in January 2007 and this is recommended to all
care homes (see Appendix 9).

Managing spillages of blood or other body fluids

Blood and body fluids may contain a high concentration of micro-organisms, which
should be made safe immediately after the spillage has occurred. Clearing blood or
body fluid spillages may expose the care worker to the risk of infection and every care
should be taken to ensure the member of staff is protected by the appropriate use of
personal protective clothing (see Appendix 4).

The care home should have a spillage kit available for use in clearing spills on hard
surfaces and floors and staff should be aware of the contents of the kit and trained in
its use and in the proper management of biohazard and body fluid spillages.
The spillage kit should contain a disposable scoop for clearing any spillages of
needles or any other sharp items that may have spilled out of their container. Gloved
hands must not be used to pick up used needles. Sharps should be discarded into an
approved rigid container (see section on waste).

If the incident involves a spillage of blood on soft furnishings and carpets these should
be taken out of use and steam cleaned. Written instructions for use of spillage kits
should be available and followed.

Education and training

Some of the caring activities involved in health and social care carry the risk of
infection for both residents and their carers; therefore, it is important that care home
staff are trained in the prevention and control of infection, to promote evidence-based
best practice. Training on the prevention and control of infection, as well as the links
between antibiotic prescribing and C.difficile should be in induction programmes for
new staff and in ongoing training programmes. It is good practice to keep training
records and include training on the prevention and control of infection as part of job
descriptions, personal development plans and appraisals for all staff groups.

It is important that all members of staff, from domestic through to senior management,
have a clear understanding of their responsibilities to prevent the spread of infection,
and are familiar with any infection prevention and control policies and procedures that
are in place.

In most settings, it has been found that regular audits of practice and educational and
constructive feedback to employees has a beneficial role to play in developing the
working practice of employees.
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Skills for Care are creating a national workforce development strategy for social care and more information is available at www.skillsforcare.org.uk, including Common Induction Standards, Skills for Care (2005) and a Knowledge Set for Infection Prevention and Control, Skills for Care, 2005) http://www.skillsforcare.org.uk

Food services including food safety and food brought into the care setting

Legislation

Owners and catering managers should be aware of legislation relevant to food and other services within a nursing home and should be registered as food businesses by the Local Authority Environmental Health department, which will advise on food safety requirements. In enforcing the legislation, EHPs are entitled to inspect catering facilities in care homes: the emphasis will be on risk prevention and the provision of advice. The regulator registering homes under the Care Homes Regulations Act will take note of reports from EHPs.

The food safety management procedures in place need to be proportionate to the business activity and should include more effective controls where consumers are more vulnerable, as is likely to be the case in care homes.

The Food Standards Agency (FSA has developed a range of tools to assist food businesses in complying with this new requirement and these can be found on the FSA website (www.food.gov.uk). Whatever procedures are chosen, it is a requirement of the legislation that they are documented and should demonstrate how the business ensures that the food it produces is safe to eat. Further information on the new legislation and its impact on food businesses, including the Hazards Analysis and Critical Control Point (HACCP) -based tools, can be found at: www.food.gov.uk/foodindustry/hygiene

A food safety management pack, Safer Food, Better Business (SFBB), can be found on the FSA’s website at www.food.gov.uk/catering/sfbb. It was developed to help small catering businesses, such as restaurants and cafés, comply with the new regulations and implement food safety control systems. As residents in care homes are a vulnerable group, additional supplementary advice covering protecting food, gift food and mini-kitchens, has been developed and is available at: www.food.gov.uk/multimedia/pdfs/sfbbcarehomes.pdf

Detailed guidance on food safety and the provisions of the relevant legislation is beyond the scope of this document. Managers of homes are strongly recommended to visit the FSA website or contact their local EHP for information.

Staff training
All staff engaged in food preparation or handling should be supervised and instructed and/or trained to a level sufficient to enable them to prepare food safely.

**High-risk foods**

Certain foods will present more of a risk of food-borne illness to care home residents than others. These foods include meat, poultry, fish, eggs and milk and products made from the latter. If these foods are incorrectly handled, prepared and stored, certain bacteria, which may be present or have contaminated them, may multiply and/or produce toxins to levels that are likely to cause illness. The danger of food-borne illness will be reduced with the proper implementation of a system of identifying and controlling food safety risks and the appropriate training of food-handling staff.

**Gifts of food**

Visitors frequently bring food in to the care home for residents. It is preferable for this food to be of a low risk nature, such as fruit, biscuits, chocolates and pre-packaged fruit drinks.

Visitors should be discouraged from bringing foods that are required to be kept hot. If chilled food is brought in, it should be transported to the care home in a chilled container and labelled with the resident’s name and the date. Such food should be placed in a refrigerator which is maintained at a temperature of +4°C to +8°C (and used only for this purpose); if food is not consumed within 24 hours, it should be disposed of safely. Managers should ensure that residents and visitors are aware of this policy.

**Immunisation**

Care home owners need to ensure that residents and staff are up to date with general immunisations, including seasonal influenza vaccination. Some important diseases that may be relevant in a care home setting are listed below. For a full and comprehensive guide on all matters relating to vaccine-preventable diseases refer to *Immunisation Against Infectious Disease 2006 – The ‘Green Book’*, (Department of Health, 2006).

**Influenza**

Annual influenza immunisation is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely to follow introduction of infection and cause high morbidity and mortality. Immunisation is also recommended for the elderly i.e. all those over 65 years and those aged 6 months and over with chronic chest, heart, liver, kidney disease, diabetes or those who are immunosuppressed as a result of disease or treatment.
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Influenza immunisation is highly effective in preventing the disease in working-age adults; Immunisation is also recommended for staff directly involved in social care, especially for staff in nursing and care homes who look after older people. Staff immunisation may reduce the transmission of influenza to vulnerable residents, some of whom may have impaired immunity and thus reduced protection from any influenza vaccine they have received themselves.

Pneumococcal infections

A single dose of pneumococcal vaccine is recommended for all those aged 65 years and over and those under 65 years of age who are at an increased risk from pneumococcal infection. These medical risk groups include: people who have a heart condition, chronic lung disease, chronic liver disease, diabetes, a weakened immune system and a damaged spleen or no spleen.

Hepatitis B

Hepatitis B vaccination is recommended for the following groups considered at increased risk:
- care workers who may have direct contact with human blood or blood-stained body fluids or with human tissues; this includes any staff who are at risk of injury from blood-contaminated sharp instruments or being deliberately injured or bitten by people;
- staff caring for those with learning difficulties;
- individuals receiving regular blood or blood products and their carers;
- people with chronic renal failure;
- people with chronic liver disease.

Tetanus (lockjaw) – residents and staff

Most staff should have had a primary course of immunisation in childhood and adequate booster doses for tetanus, including one on leaving school. Older staff, those from overseas and residents, however, may not have had either a primary course or adequate booster doses. Cases of tetanus have a high fatality rate, and it is recommended that the immunisation status of all staff and residents is checked and appropriate action taken.

Linen and laundry

The provision of clean linen is a fundamental requirement of care. Incorrect handling, laundering and storage of linen can pose an infection hazard. Some small care homes for people who have a learning disability or mental health needs, will be providing laundry services that are similar to ordinary, domestic arrangements found in most family homes. This type of arrangement can continue. However, the following applies to larger care homes.
When setting-up a care home, owners should consider whether they are going to have an on-site laundry or make other arrangements. Proper facilities for an on-site laundry are expensive; commercial washing machines, dryers, ongoing costs of maintenance and labour are high. A long-term contract with a commercial laundry or hospital could be a more satisfactory solution.

Infection can be transferred between contaminated and uncontaminated items of clothing, laundry and the environments in which they are stored. Even during a normal washing cycle a number of micro-organisms can be passed between clothing and linen, and will only be partially removed during the rinse cycles. Thorough drying of the laundry, however, does reduce the levels of contamination to a point that no longer poses a risk.

Within the care home, specific hygiene measures should be taken to reduce these risks, including:
- correct handling of laundry to prevent the spread of infection;
- appropriate disinfection of the laundry.

Requirements for laundering

- A designated laundry area for that purpose only, with separate ventilation and a flow-through system, so that clean and soiled linen are separated throughout the process.
- An industrial washing machine with sluice and hot wash cycles is required (71°C for at least three minutes or 65°C for at least ten minutes). This should be professionally installed and maintained with precautions to prevent contamination.
- An industrial dryer should be used to dry all clothing and linen, this should be regularly serviced.
- Ironing will provide the final process of linen decontamination.
- Documentary evidence (log book) of service and maintenance inspections should be kept and available for inspection.
- Appropriate personal protective clothing and eye protection should be available for all staff.
- Hand decontamination facilities should be available, including a hand hygiene basin with lever taps and no plug or overflow, liquid soap and disposable paper towels should be available along with a pedal-operated clinical and domestic waste bin and first aid kit.

Under no circumstances should a manual sluice facility or sluicing basin be used or situated in the laundry room.

Handling dirty linen
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All dirty linen should be handled with care and attention paid to the potential spread of infection. Plastic aprons and suitable gloves should be worn for handling dirty or contaminated clothing and linen. Linen should be removed from a resident’s bed with care, avoiding the creation of dust, and placed in the appropriate segregation category outside the room. Personal clothing should also be removed with care and placed in the linen bag, not placed upon the floor. Linen and other dirty laundry should not be held close to the chest to prevent contamination of the uniform (an apron should be worn). Linen should be separated into categories ready for washing, negating the need for additional handling within the laundry. Laundry staff should never empty bags of linen onto the floor to sort the linen into categories – this presents an unnecessary risk of infection. After handling linen, hands should be decontaminated.

Linen should be divided into three basic categories ready for decontamination; many care homes currently use water-soluble/alginate bags within cotton sacks in a wheeled trolley to facilitate this separation, keeping linen off the floor before taking the bags to the laundry.

Policy on the management of linen may differ from area to area. The following advice is given as a suggested practical approach to the management of laundry within the care home. Further advice can be sought from your local CIPCN/HPU. If linen is sent to an off-site laundry, the company should be made aware of its nature and written guidelines should be followed. The care home manager and laundry staff should be satisfied that the laundering of items sent will meet decontamination guidelines.

Categorisation and segregation of linen

It is the responsibility of the person handling linen to ensure that it is segregated appropriately. For the large scale processing of linen in a commercial setting three categories should be used, these can be colour coded as follows:

- used linen and clothing – white cotton sack. Soiled linen should be placed into a clear, water-soluble/alginate bag, clothing into a separate water-soluble/alginate bag, within a white cotton sack.
- heavily soiled/infected linen – red cotton sack. Heavily soiled items should have any solids removed prior to being placed into a red, water-soluble/alginate bag within a red cotton sack. Infected linen includes linen with blood or other body fluids present that could contain pathogenic organisms, e.g. viral gastroenteritis or blood where blood-borne viruses could be present.
- clothing and heat-labile linen (heat sensitive) – off-white cotton sack. This should be placed into a clear, water-soluble/alginate bag within an off-white cotton sack. Heavily soiled clothing should be placed into a red, water-soluble/alginate bag (see above).

Manual soaking/sluicing should never be carried-out. The pre-wash/sluice cycle in the washing machine should be used after removing any solids.
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The laundering process

Many micro-organisms will be physically removed from the linen, by the detergent and water, during the washing cycle. Washing at high temperatures, above the normal domestic 40°C wash, will allow the temperature of the water to disinfect the items.

All linen/clothing should enter the laundry through the dirty entrance, and should not be stored but processed quickly.

The laundry staff should never open the inner water-soluble bags. Instead, the bags should be transferred to the washing machine for decontamination. Washing machines should not be overloaded.

All items should be processed in a washing cycle that reaches 71°C for at least three minutes or 65°C for at least ten minutes. Heavily soiled/infected linen should also have a pre-wash cycle selected. Heat-labile items should be washed at the highest temperature possible for the item. If the item has been heavily soiled or is infected, it should be placed in a red, water-soluble bag and a prewash cycle selected, along with an appropriate disinfectant, e.g. oxygen-releasing or bleaching agent should be added to the washing process. Regularly washing items below 65°C without using a bleaching agent may allow biofilms to build-up in the machines.

All items should then enter a drying process within an industrial dryer and ironed. Once removed they should be stored in a clean area, above floor level and not be kept in the laundry area.

Occupational health

Each care home should have appropriate policies for the protection of staff through health screening for communicable diseases, management of exposure to infections (which should include the local provision for emergency treatment out of hours), relevant immunisations, training and compliance with health and safety legislation. Such policies should apply to all agency and locum staff and to those on short-term contracts.

It is desirable that all staff have access to occupational health advice. Each new member of staff should complete a pre-employment health questionnaire and give information about residence overseas, previous and current illness and immunisation against relevant infections.

Policies need to be in place that set-out action to be taken if a staff member is injured by any needle or other sharp objects which may be contaminated by body fluids (see Appendix 4).
Appropriate policies should be available to ensure that residents are protected from staff with communicable diseases. Such policies should clearly set-out the responsibilities of staff members to report episodes of illness to their manager – this is particularly important after travel abroad. When necessary, staff may need to be excluded from work until they have recovered or the results of specimens are available; as care homes vary in terms of the vulnerability of their residents to infection, policies may differ between homes. Advice should be sought from the local CCDC/local HPU (see Appendix 10 – Exclusion from work).

Pest control

Kitchens and food stores provide ideal conditions for pests. Pests contaminate and spoil food; rodents damage the fabric of buildings from the woodwork to electric cables. Control measures should include the following:

- a named member of staff should take on the role of pest monitoring officer and liaise with an environmental health officer from the local authority or a reputable commercial pest control company;
- stop pests entering with well-fitting doors, covered drains, fly screens or bird-netting;
- look out for evidence of the presence of pests – droppings, nests, chew-marks on wood or cables (in the case of rodents); or, for insects, droppings, egg cases, vomit marks, damaged food containers, webbing caused by moths or the presence of the live insects themselves;
- discard any foodstuffs or other articles affected by pests, including milk from bottle tops that have been pecked by birds;
- clean up any spillages and decaying food immediately; carry out regular inspection and rotate any stock; use rodent-proof containers with well-fitting lids; store food off the ground;
- produce and display a pest control policy;
- consider the use of a properly installed electric, flying-insect killer and a waste compactor;
- use plastic wheelie bins for all waste as these can be easily cleaned.

Pets

Pets can often enhance the quality-of-life for care home residents. There is potential for a resident to acquire an infection from a pet, especially if the resident’s immunity is reduced through age, illness or therapy. Sensible precautions will reduce this risk to an acceptable level.

The Senior Manager should ensure that a knowledgeable person is responsible for the animal and that there is no risk of contravening the relevant safety legislation. There should be a written agreement within the establishment to ensure full understanding of:
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- the types of animals allowed for the purposes of ‘pet therapy’ – only mature, house-trained pets are acceptable;
- the control and permitted behaviour of pets while on the premises;
- the routes for entry to and passage through the premises;
- the areas where pets are not allowed;
- any insurance liability of owners and handlers.

Care homes should consider having a local ‘Pet Pass’ system in place to check that all animals brought into the home are within the following recommended guidelines:

- all animals should be regularly groomed and checked for signs of infection or other illness;
- if pets become ill, diagnosis and treatment by a vet should always be sought and the animal should not be returned to the home until restored to health;
- all animals should have received relevant inoculations;
- all animals should be wormed regularly (every six months);
- claws should be kept trimmed to reduce the risk of scratches; any scratches on residents should be promptly and thoroughly cleaned and observed for signs of infection;
- pets should have been exercised before being allowed to meet with residents;
- all pets, but especially cats and dogs, should have their coats cleaned regularly; bedding should also be cleaned regularly and insecticides used, as necessary, on the environment and the pet to control fleas; specialist advice should be sought if problems occur.

Care home staff need to be familiar with good hygiene practice in relation to pets. These include:

- pets should not be permitted to lick residents;
- after residents and guests have touched animals, they should wash their hands well;
- pet feeding areas should be kept clean;
- pets should have their own feeding dishes, which should be washed separately from dishes and utensils used for residents and staff;
- pets should not be fed in the kitchen or other food preparation areas;
- recognised commercial brands of pet food should be used and pet food containers, once opened, should be kept separate from food for human consumption.

Litter boxes should be dealt with as follows:

- they should be cleaned by someone who is healthy and not pregnant;
- a protective apron and gloves should always be worn when litter boxes are being cleaned;
- a disposable liner should be fitted to the box for easy cleaning;
- litter should be changed daily;
- litter should be sealed in a plastic bag and disposed of in accordance with local guidance;
- the box should not be situated near food preparation, storage or eating areas;
the box should be disinfected weekly by filling with boiling water which is allowed to stand for at least five minutes, in order to reduce the risk of Toxoplasma infection.

Water for drinking and non-drinking purposes

Water for drinking

The provision of clear, palatable and safe drinking water is fundamental to the protection of public health. Water from the "mains" is treated to high standards and should be assumed, unless homes are expressly notified otherwise, to be safe to drink at the point of delivery. The importance of a continuous safe water supply to homes is, nevertheless, such that they should enquire about becoming registered by their local water undertakers in the event of a service failure. Advice on the safe use of private water supplies (for example, drawn from a well or borehole) is available from local authorities.

Water coolers and ice-making machines in care premises should be mains fed or supplied from sealed containers and not topped-up. Contamination can be minimised by regular cleaning and maintenance in accordance with the manufacturer's recommendations. Because of bacterial contamination, ice from these sources should not be used in contact with surgical or open wounds.

Water for non-drinking purposes

Water is used for a variety of non-drinking purposes in homes but can be a source of a variety of bacteria including the cause of Legionnaires’ disease which is usually associated with hot water services and recirculating cooling water systems. *Legionella* bacteria are naturally widespread in water, particularly stagnant water systems where biofilm may build-up and resist decontamination by heat, chlorination and biocides. The route of infection is usually inhalation of contaminated water droplets from ventilation systems, showers and whirlpool spas.

To reduce the risk, water distribution systems should be free of ‘dead legs’ and ‘spurs’ and hot water should be stored at 60°C or above, cold water at 25°C or below. Warning notices to the effect that ‘hot water may cause harm’ may not be enough to safeguard older people or the poor-sighted and prevention and control strategies should be in place to minimise the risk of healthcare-associated legionellosis and scalding. Further guidance on controlling Legionella is available from the Health & Safety Executive. Advice may also be sought from the Local Authority Environmental Health department.

Pools

Spa pools (also known as hot tubs, whirlpool spa, whirlpools or Jacuzzi™) allow people to sit in warm water agitated with air and water jets. The water is not replaced after each use, but is disinfected and recirculated.
It is critical that the spa pool is correctly designed, constructed and installed, and then managed safely to both meet legal standards and reduce the risk of infections.

The use of hydrotherapy pools in the care-setting can on occasion cause chest, ear, skin and gastrointestinal infections. Because of the difficulty in maintaining a safe water quality, pool maintenance is essential and management programmes, which include the treatment of the water, cleaning and disinfection of the system and monitoring the water quality, should be established.
Bibliography

Blood-borne viruses


[www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf](http://www.dh.gov.uk/assetRoot/04/01/44/74/04014474.pdf)

Built environment


Care home standards and regulations

Department of Health (2002). *Care homes for older people: national minimum standards.*
[www.dh.gov.uk/assetRoot/04/06/77/78/04067778.pdf](http://www.dh.gov.uk/assetRoot/04/06/77/78/04067778.pdf)


Clostridium difficile


Decontamination


Medicines and Healthcare products Regulatory Agency (2006). *Sterilization, disinfection and cleaning of medical equipment: guidance on decontamination from the Microbiology Advisory
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Committee to Department of Health. 
http://www.mhra.gov.uk/Publications/Safetyguidance/Otherdevicesafetyguidance/CON007438

Environmental cleaning


http://www.npsa.nhs.uk/nrls/improvingpatientsafety/cleaning-and-nutrition/


Essential Steps


Food safety

www.food.gov.uk/multimedia/pdfs/eggleaflet.pdf

Food Standards Agency website www.food.gov.uk:
- Regulation (EC) 852/2004 on the hygiene of foodstuffs
- Regulation (EC) 853/2004 laying down specific hygiene rules for food of animal origin
- Regulation (EC) 854/2004 laying down specific rules for the organisation of official controls on products of animal origin intended for human consumption

www.food.gov.uk/multimedia/pdfs/gpgguidelines.pdf

Glucose monitoring devices

Medicines and Healthcare products Regulatory Agency. Medical Device Alert. Lancing devices used in nursing homes and care homes. 6 December 2006
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http://www.mhra.gov.uk/PrintPreview/PublicationSP/CON2025400

Health and safety


Health and Safety Executive (2005). Controlling the risks of infection at work from human remains A guide for those involved in funeral services (including embalmers) and those involved in exhumation. www.hse.gov.uk/pubns/web01.pdf


Immunisation


Laundry/linen

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Medical device management


Medicines management


Meticillin resistant Staphylococcus aureus (MRSA)


Pest control


Prescribing


Information on the common conditions managed in non-acute settings can be found at: http://www.cks.nhs.uk/home (CKS, Clinical Knowledge Summaries (formerly PRODIGY)).

Standard infection prevention and control precautions

Waste


Water


Other useful resources

British Pest Control Association^6^ – www.b pca.org.uk

Department of Health – www.dh.gov.uk

Health Protection Agency – www.hpa.org.uk

National Resource for Infection Control – www.nric.org.uk

National Pest Technicians Association^7^ – www.npta.org.uk
References

1. Also refer to the “Prevention of health-care associated infection in primary and community care” (NICE, 2003)
2. Post-exposure prophylaxis is available for hepatitis B (vaccine and/or hepatitis B immunoglobulin) and HIV (antiretroviral drugs). At present there is no effective post-exposure prophylaxis against hepatitis C infection. However, there is evidence that early treatment of acute hepatitis C infection may prevent chronic hepatitis C infection. This underlines the need for careful management and follow-up of occupational exposures and early referral for specialist occupational medicine and gastroenterology/hepatology/infectious diseases assessment, if an infection may have been transmitted.
3. A healthcare product other than medicines used for the diagnosis, prevention, monitoring and treatment of disease, injury or disability. This means everything from artificial hips to wound dressings, incubators to insulin delivery devices, scanners to scalpels, and wheelchairs to commodes.
4. The Royal Pharmaceutical Society of Great Britain (RPSGB) has recently published new guidance – The Handling of Medicines in Social Care. The guidance outlines the current legislation that applies to all medicines in care homes irrespective of how they were obtained. Details are given of the statutory requirements for the provision of written policies and procedures, and the recording of all medicines.
5. The use of yellow/black for offensive/hygiene was chosen as the colours have historically been universally used for the offensive/hygiene waste stream.
6. The British Pest Control Association (BPCA) promotes the highest standards of professionalism within the industry and plays a major role in enhancing these standards by way of training courses and examinations, publications, exhibition and conferences.
7. The National Pest Technicians Association (NPTA) is a nationally recognised Pest Control Association with more than 700 members. It was established in 1993 to represent all those who are employed or have an interest in the Pest Control Industry and to strive to promote a professional approach to Pest Control.
8. This applies until October 2010, at which point these organisations will be registered under the Health and Social Care Act 2008 against a full set of registration requirements.
9. CCDC – Consultant in Communicable Disease Control.
10. HPU – Health Protection Unit.
Appendix 1: How infections are spread

The chain of infection

Micro-organisms

There are many types of micro-organisms, some of which cause illness and some of which do not. Many micro-organisms live in or on some parts of the body (e.g. skin, mouth, intestinal tract) and are known as the body’s normal flora. Some of these may cause illness if they find their way into other areas of the body. An example of this is where micro-organisms normally found in the bowel enter the bladder and may then have the potential to cause infection.

Normal skin flora is known as ‘resident’ and is there continuously they are essential for good health. Resident bacteria rarely causes infection except in special circumstances such as during surgery or insertion of catheters and other invasive devices. Resident skin flora lives naturally on the skin and is difficult to remove by normal hand hygiene techniques, although the numbers of micro-organisms will be reduced by this process.

Many other micro-organisms are acquired or deposited on the skin from other staff or residents or from the environment and are known as ‘transient’. These do not live permanently on the skin and are readily removed or destroyed by thorough and frequent hand hygiene.

The reservoirs of infection

The reservoirs of micro-organisms may be people, the environment or equipment. The human body is the most common reservoir for micro-organisms. A person with salmonella, tuberculosis or hepatitis B may act as a source of infection to others because the micro-organisms are present in some of the body fluids and can be passed on to others.

Contaminated food may also act as a reservoir of infection. A common example of this is the presence of Salmonella spp. If food contaminated with Salmonella is not thoroughly cooked, individuals who consume it can become infected.

The environment can also be contaminated by micro-organisms shed by people with an infection. This can then spread to others. Regular cleaning minimises this risk.

Poorly maintained or incorrectly decontaminated equipment can also act as a reservoir of micro-organisms. For example, inadequately maintained and shared commodes can be contaminated with micro-organisms that cause diarrhoea.

Point of entry

Every micro-organism needs to have an entry point into the human body; different micro-organisms have different ways of achieving this. For example salmonella bacteria need to enter
the body through the mouth. Tuberculosis enters our bodies through the nose and mouth and then passes into the lungs. Hepatitis B virus enters the body via the bloodstream. Organisms causing urinary tract infections may enter during poor catheter care.

Point of exit

As well as needing an entry point, micro-organisms also need an exit point. Salmonella bacteria are excreted through faeces. A tuberculosis bacterium uses the same entry and exit point, that is, the lungs, mouth and nose.

Method of spread or mode of transmission

All micro-organisms need a way of spreading. This varies with different types of organisms. Hands play a big part in spreading infection. Micro-organisms may be present in body excretions and secretions. If hands come into contact with these the micro-organisms may be carried from one person to another unless the hands are properly decontaminated. Some micro-organisms may be spread in the air. The viruses that are responsible for colds and influenza are found in nasal secretion, saliva and sputum. Coughing or sneezing near another person may pass on these viruses in the droplets or aerosol produced. Touching your face will contaminate your hands with these viruses.

Modes of transmission include:
- aerosol
- droplet
- faecal–oral
- direct contact (person-to-person), often by contaminated hands
- indirect contact (food, water, fomites [inanimate objects], the environment)
- blood and body fluid
- insects and parasites.

Susceptible host

For infection to occur once micro-organisms have reached their ‘target’ the person should be at risk of infection, although susceptibility to infection may vary from person-to-person.
Risk factors for infection

Factors that affect a person’s susceptibility to infection include:
- age (the very young and very old are more vulnerable to infections);
- immune status;
- physical well-being;
- psychological well-being;
- hygiene;
- underlying or chronic diseases or medical conditions (e.g. diabetes, chronic chest and heart problems or cancer);
- other existing infections;
- medical interventions (e.g. an indwelling medical device);
- medical therapies (e.g. cancer chemotherapy or steroids).

Decontamination

Decontamination can be achieved by a number of methods, which fall into the following three categories:

- cleaning physically removes contamination but does not necessarily destroy micro-organisms. It removes micro-organisms and the organic matter on which they thrive. Cleaning is a necessary prerequisite to effective disinfection or sterilization. This will be the most common choice of decontamination method within the care home setting.
- disinfection reduces the number of viable micro-organisms but may not necessarily inactivate some microbial agents, such as certain viruses and bacterial spores.
- sterilization renders an object free from viable micro-organisms including viruses and bacterial spores.

The choice of decontamination method depends on the risk of infection to the person coming into contact with equipment or medical devices. Such items can be categorised into three risk groups:

- high risk items are those used to penetrate skin or mucous membrane or enter the vascular system or sterile spaces. They need to be sterilized if reusable, but single-use items are preferred.
- intermediate risk items are those which come into contact with intact mucous membranes or may be contaminated with particularly virulent or readily transmittable organisms. Such items require cleaning followed by disinfection or sterilization.
- low risk items are those which come into contact with intact skin or do not come into contact with the resident. They require cleaning. See Table 1 for recommended decontamination methods.
Appendix 2: General guidance on the management of infections

This is general advice on how to prevent the spread of infection if individual cases occur in care home residents. Most of the diseases listed will have been diagnosed by a doctor (usually the resident’s GP), who should be the source of advice on treatment of the individual's illness.

Care homes are expected to meet the requirements laid down in the Care Standards Act 2000. In addition, Regulation 37 of the Care Homes Regulations 2001 states that:

“The registered person shall give notice to the Commission without delay of the occurrence of the outbreak of any infectious disease which in the opinion of any registered medical practitioner attending persons in the care home is sufficiently serious to be so notified.”

Persons in charge of care homes are reminded of the need to keep a record of residents suffering from any infectious disease. They are encouraged to remind the doctor of the duty to notify the diseases listed in Appendix 3, and should themselves immediately contact the CCDC/local HPU by telephone to alert them to the occurrence of a case of any notifiable disease.

Whenever an outbreak of any infectious disease is suspected within a care home, the person in charge should also contact the CCDC/local HPU.

Care homes should ensure that they provide suitable and sufficient information on each resident’s infection status whenever they are moved from the care of one organisation to another (see Appendix 11).

Management of persons cared for in isolation

It is important to remember that the resident in isolation will be both physically and psychologically isolated. When a decision about isolating an infected resident is taken, it is important to consider the likely effect on the resident. Older people may become disorientated and confused by isolation, which should therefore be avoided unless really necessary. The local HPU/ CIPCN will advise on the management of individual cases that pose difficulties. Verbal and written information should be given to both the resident and visitors; the local HPU/CIPCN may have leaflets explaining individual infections which the home can use. The information should include the details and reason for the isolation, the likely duration, precautions required and the ways in which the client’s psychological and physical needs will be met, e.g. availability of telephone, newspapers and visiting times.

Planning of a client’s care should take into account the extra time required for isolation procedures, i.e. putting on and taking off personal protective clothing, psychological support and extra time to take in food and drinks. Isolation precautions can be implemented for a resident in their own room.
Diarrhoea and vomiting

Diarrhoea in older people is common and does not always have an infective origin. Other possible causes are over-prescription of laxatives, change in diet and underlying bowel disease. Nevertheless, all cases should be taken seriously and presumed to be infectious until advised otherwise.

The resident’s GP should be notified. If infection is suspected, the GP may arrange for specimens to be sent to the laboratory. This is particularly important if the diarrhoea follows a course of antibiotic treatment.

If more than two cases, suspected or known to be infectious, occur within a few days, the local HPU/CCDC should be notified.

Residents who are vomiting should be kept in a single room, as long as symptoms persist. Most acute diarrhoeal infection is caused by viruses, for example, norovirus (Winter vomiting disease), and is short-lived, but the symptoms and their effect on older people can be severe. There is often little warning of the vomiting and, the environment may become heavily contaminated and the infection will spread rapidly to other residents and staff. It is, therefore, important that infected residents are isolated until 48 hours after the symptoms have settled and staff excluded from work. Management of cases should be planned following a risk assessment, which should consider continence, personal hygiene, overall health, likelihood of physical contact with other residents or their food, the facilities available and the vulnerability of other residents. The local HPU/CIPCN can advise on this process.

Infected residents should, if possible, have sole use of a designated toilet as long as their symptoms persist. In the case of a likely norovirus infection, they should keep a designated toilet facility for 48 hours after their symptoms have settled.

It is important that an enhanced cleaning regime, using a bleach-based product used at the correct concentration, is carried out on the environment and equipment (Note: bleach should not be used on soft furnishings). Clean disposable cloths and washable mops should be used to clean frequently touched hard surfaces and should occur at least twice-daily during an outbreak. Particular focus should be on toilet seats, door/toilet handles and sink taps.

Hand washing with soap and water is vital to minimise the spread of infection and should be actively promoted. Care staff should be able to access liquid soap and paper towels easily. Alcohol handrub is not effective at deactivating the viruses and bacteria that cause diarrhoeal outbreaks.

The local health protection team will advise on any special measures necessitated by an outbreak.
Prevention and control of infection in care homes – draft for consultation

If food-borne infection is suspected, the HPU/EHP should be contacted and samples of food and of faeces/vomit should be retained for investigation. Sudden onset of symptoms in several residents and/or staff over 24–48 hours may suggest a food-borne problem.

Consideration should be given to the safety of visitors of residents with infections, particularly if the visitors are older people or the very young.

Information should be prepared for visitors which should ask them not to visit if they have had symptoms of diarrhoea or vomiting within the previous 48 hours.

Most residents with diarrhoea or vomiting can be cared for in the home environment, as the symptoms are likely to subside within 48 hours. In the event of hospital assessment / admission being necessary, the receiving hospital should be notified about the possibility of infection before the resident arrives, so that appropriate precautions can be put in place to prevent infection spread.

If a resident is discharged from hospital within 48 hours of the last symptoms of diarrhoea and vomiting, every effort should be made to care for them in a single room with a dedicated toilet and appropriate precautions until they have been clear of symptoms for 48 hours.

**Clostridium difficile Infection**

*Clostridium difficile* (C. difficile) or “C. diff”, as it is often referred to, is a major cause of antibiotic-associated diarrhoea and colitis (an infection of the intestines).

*C. difficile* is a bacterium that can be found in the large intestine (gut) of adults. It is usually kept in check by the normal bacteria flora found in the intestine. For many it poses no threat, but certain antibiotics given to individuals may disturb this balance and allow the *C. difficile* to multiply in the intestine and produce toxins. The toxins may damage the lining of the intestine which can result in symptoms ranging from mild diarrhoea to profuse watery diarrhoea becoming progressively more severe accompanied by fever, vomiting or abdominal cramps to severe life-threatening colitis.

Individuals who have been treated with broad-spectrum antibiotics are at greatest risk of *C difficile* disease. Infections occur mainly in individuals in hospitals and care homes particularly elderly people with other underlying conditions.

In many cases the disease develops after cross infection from another infected individual, either through direct person-to-person contact, via care staff, or via a contaminated environment. An individual who has diarrhoea caused by *C. difficile*, will excrete large numbers of spores in their faeces. The general environment including surrounding furnishings, equipment, toilet facilities, commodes, etc is very likely to become contaminated with the spores. The spores may survive for a long period of time in the environment, therefore, increasing the risk of cross-infection.
Prevention and control of infection in care homes – draft for consultation

The registered manager or nominated deputy of a care home is responsible for reporting to the HPU if more than two cases of diarrhoea, suspected or known to be infectious, occur within a few days.

Prevention and control measures include standard infection control precautions and specifically:

- effective hand washing with liquid soap and hot water. Do not rely solely on alcohol gels as this does not kill *C. difficile* spores;
- good infection prevention and control practice at all times;
- isolation of individuals with confirmed or suspected *C. difficile* diarrhoea;
- the wearing of gloves and aprons when caring for the individual, especially when handling bed pans, faeces and assisting with toileting and hygiene needs;
- keeping the environment clean at all times with an enhanced cleaning schedule for toilet facilities. A chlorine-based cleaning agent should be used as part of the cleaning protocol to reduce the risk of spores surviving in the environment;
- prudent antibiotic prescribing to reduce the use of broad-spectrum antibiotics so that the natural protection of an individual is not weakened.

Respiratory infections

Respiratory infections are very common and may be serious in older or debilitated people. They may be viral or bacterial in origin. The risk of respiratory infections can be reduced by annual influenza vaccination of older residents, and younger residents with serious underlying health problems. Influenza immunisation for care staff can also reduce the likelihood of a ‘flu outbreak’ occurring. Older residents should also receive a pneumococcal vaccine.

Many respiratory infections are spread by the airborne route (as well as contact), so the residents should be nursed in a single room during the acute illness, particularly if they are coughing and sneezing. Residents, staff and visitors should be encouraged to minimise transmission of respiratory infections through the following good hygiene measures:

- cover nose and mouth with disposable single-use tissues when sneezing, coughing or wiping and blowing noses.
- dispose of used tissues promptly in the nearest waste bin.
- wash hands after coughing, sneezing, using tissues or contact with respiratory secretions and contaminated objects.
- keep hands away from the eyes, mouth and nose.
- some residents may need assistance with containment of respiratory secretions; those who are immobile will need a receptacle (such as a plastic bag) readily at hand for immediate disposal of tissues and a supply of hand wipes and tissues.

The GP may arrange for sputum specimens/respiratory secretions to be sent to the laboratory.

If an outbreak of respiratory disease in a residential home is suspected, the local CCDC/ local HPU should also be contacted. They may arrange for the collection of further specimens, and suggest the use of antiviral medication if indicated.
Consideration should be given to the safety of those visiting residents with infections, particularly older people and very young visitors.

If residents require admission to hospital during a possible outbreak of respiratory infection, the admitting hospital should be informed of the infection risk before the resident arrives.

Pneumonia, unless associated with a viral influenza-like illness, is unlikely to be infectious to others. Nevertheless, the resident may be very ill and nursing in a single room is desirable.
Skin infections/infestations

It may be necessary to care for a resident in a single room until treatment of skin infections/infestations (such as scabies or lice) is complete, or during the acute/weeping phase of a skin infection.

Residents with infections should be treated with tact and their confidentiality should be protected. Although this applies to all types of infection, some infestations can lead to particular social stigmatisation.

The local HPU/CIPCN can advise on local policies on the treatment of infestation e.g. scabies. They can also advise on how to co-ordinate the treatment of a large group of residents and/or staff and visitors if this is required.

Consideration should be given to the safety of visitors of residents who have an infection, and they should be provided with information about symptoms and treatment.

Visiting care workers (e.g. district nurses or physiotherapists) who have close physical contact with residents should be informed if a resident has a skin infection or infestation.

If a resident with a skin infection, or an active or partially treated infestation, requires admission to hospital, the admitting hospital should be informed of the condition.

Blood-borne virus infections

Residents with jaundice due to hepatitis B or C, or those who are carriers of the viruses or have HIV infection, do not need to be isolated. Standard precautions, including care with sharps disposal, should be strictly observed. Special precautions need to be observed if they are receiving kidney dialysis.

Antibiotic-resistant bacteria

Residents may be transferred from hospital while colonised with a variety of antibiotic-resistant bacteria. Examples include MRSA and ESBL-producing E. coli. Often these bacteria will be colonising the skin or gut, without causing harm to the resident, and will not cause harm to healthy people.

Because colonisation can be very long-term, it is not appropriate to isolate residents known to be colonised with antibiotic-resistant bacteria. Good hand hygiene and the use of standard precautions will help minimise the spread of these organisms in a care home environment.

It is not recommended that residents are treated routinely in an attempt to rid them of colonisation with antibiotic-resistant bacteria while in residential care or that they are sampled repeatedly to monitor the colonisation. The resident’s GP or the local HPU will advise when this is appropriate.
If a resident, previously known to be colonised with antibiotic-resistant bacteria, requires admission to hospital, this information should be added to the referral note.

People with MRSA do not present a risk to the community at large and should continue their normal lives without restriction. MRSA is not a contra-indication to admission to a home or a reason to exclude an affected person from the life of a home. However, in residential settings where people with open post-operative wounds or intravascular devices are cared for, infection control advice should be followed if a person with MRSA is to be admitted or has been identified amongst residents.

Most planned admissions of residents to hospital will need to screened for MRSA colonisation. The hospital or resident’s GP will advise on this and any subsequent treatment required.
Appendix 3: Notifiable diseases

The current list of notifiable diseases is below, however, the Department of Health is currently consulting on proposed new notification regulations that include changes to the list. The paper is available at: http://www.dh.gov.uk/en/Consultations/Liveconsultations/DH_102134 The final version of the notification regulations is due to be published and implemented during 2010.

A doctor who becomes aware or suspects that a person whom he/she is attending is suffering from one of the following infectious diseases, he/she is required to report it to the Proper Officer, of the local authority, usually the CCDC\textsuperscript{9}/ local HPU\textsuperscript{10}

**Under the Public Health (Control of Disease) Act 1984**
- Cholera
- Food poisoning
- Plague
- Relapsing fever
- Smallpox
- Typhus

**Under the Public Health (Infectious Diseases) Regulations 1988**
- Acute encephalitis
- Acute poliomyelitis
- Anthrax
- Diphtheria
- Dysentery (amoebic or bacillary)
- Leprosy
- Leptospirosis
- Malaria
- Measles
- Meningitis
- Meningococcal septicaemia (without meningitis)
- Mumps
- Ophthalmia neonatorum
- Paratyphoid fever
- Rabies
- Rubella
- Scarlet fever
- Tetanus
- Tuberculosis
- Typhoid fever
- Viral haemorrhagic fever
- Viral hepatitis
- Whooping cough
- Yellow fever
Appendix 4: Occupational exposure

**Occupational exposure to blood or body fluids**
Needlestick injuries, cuts, bites, splashes into eyes, nose, mouth or over cuts/abrasions on skin

**FIRST AID**
Encourage wound to bleed. Wash contaminated area with copious amounts of water
DO NOT SUCK THE WOUND! DO NOT SCRUB THE AREA OR USE A NAILBRUSH
Cover wound with an appropriate dressing

Report the accident to the person in charge as soon as possible
Complete a Sharps Injury/Blood Splash Risk Assessment Form/RIDDOR form

Splash to broken skin/eyes with blood or with other blood-stained body fluids, e.g. urine

**Medium/high risk**

Monday to Friday
Telephone your GP and ask to be seen as soon as possible
At all other times
Telephone your local Emergency Department and ask to be seen

Take a written account of the incident, agreed and signed by the person in charge, and information on the resident/staff with whose blood/body fluids you have been accidentally contaminated

Your GP or Emergency Department staff will assess the risk
Blood samples may be taken

Appropriate prophylaxis for hepatitis B and HIV will be offered if indicated by risk

Complete an Incident Form (This is in addition to the Sharps Injury Risk Assessment Form)

Follow-up may be indicated and member of staff may be asked to attend a genitourinary medicine clinic for counselling and/or further treatment

Splash to intact skin with blood or with other low-risk body fluids, e.g. urine, NOT visibly blood-stained

**Low risk**

If injured member of staff agrees that exposure is low risk – no further action need be taken

Encourage wound to bleed. Wash contaminated area with copious amounts of water
DO NOT SUCK THE WOUND! DO NOT SCRUB THE AREA OR USE A NAILBRUSH
Cover wound with an appropriate dressing

Report the accident to the person in charge as soon as possible
Complete a Sharps Injury/Blood Splash Risk Assessment Form/RIDDOR form

Splash to broken skin/eyes with blood or with other blood-stained body fluids, e.g. urine

**Medium/high risk**

Monday to Friday
Telephone your GP and ask to be seen as soon as possible
At all other times
Telephone your local Emergency Department and ask to be seen

Take a written account of the incident, agreed and signed by the person in charge, and information on the resident/staff with whose blood/body fluids you have been accidentally contaminated

Your GP or Emergency Department staff will assess the risk
Blood samples may be taken

Appropriate prophylaxis for hepatitis B and HIV will be offered if indicated by risk

Complete an Incident Form (This is in addition to the Sharps Injury Risk Assessment Form)

Follow-up may be indicated and member of staff may be asked to attend a genitourinary medicine clinic for counselling and/or further treatment

Splash to intact skin with blood or with other low-risk body fluids, e.g. urine, NOT visibly blood-stained

**Low risk**

If injured member of staff agrees that exposure is low risk – no further action need be taken

First aid
Encourage wound to bleed. Wash contaminated area with copious amounts of water
DO NOT SUCK THE WOUND! DO NOT SCRUB THE AREA OR USE A NAILBRUSH
Cover wound with an appropriate dressing

Report the accident to the person in charge as soon as possible
Complete a Sharps Injury/Blood Splash Risk Assessment Form/RIDDOR form

Splash to broken skin/eyes with blood or with other blood-stained body fluids, e.g. urine

**Medium/high risk**

Monday to Friday
Telephone your GP and ask to be seen as soon as possible
At all other times
Telephone your local Emergency Department and ask to be seen

Take a written account of the incident, agreed and signed by the person in charge, and information on the resident/staff with whose blood/body fluids you have been accidentally contaminated

Your GP or Emergency Department staff will assess the risk
Blood samples may be taken

Appropriate prophylaxis for hepatitis B and HIV will be offered if indicated by risk

Complete an Incident Form (This is in addition to the Sharps Injury Risk Assessment Form)

Follow-up may be indicated and member of staff may be asked to attend a genitourinary medicine clinic for counselling and/or further treatment

Splash to intact skin with blood or with other low-risk body fluids, e.g. urine, NOT visibly blood-stained

**Low risk**

If injured member of staff agrees that exposure is low risk – no further action need be taken

First aid
Encourage wound to bleed. Wash contaminated area with copious amounts of water
DO NOT SUCK THE WOUND! DO NOT SCRUB THE AREA OR USE A NAILBRUSH
Cover wound with an appropriate dressing

Report the accident to the person in charge as soon as possible
Complete a Sharps Injury/Blood Splash Risk Assessment Form/RIDDOR form

Splash to broken skin/eyes with blood or with other blood-stained body fluids, e.g. urine

**Medium/high risk**

Monday to Friday
Telephone your GP and ask to be seen as soon as possible
At all other times
Telephone your local Emergency Department and ask to be seen

Take a written account of the incident, agreed and signed by the person in charge, and information on the resident/staff with whose blood/body fluids you have been accidentally contaminated

Your GP or Emergency Department staff will assess the risk
Blood samples may be taken

Appropriate prophylaxis for hepatitis B and HIV will be offered if indicated by risk

Complete an Incident Form (This is in addition to the Sharps Injury Risk Assessment Form)

Follow-up may be indicated and member of staff may be asked to attend a genitourinary medicine clinic for counselling and/or further treatment

Splash to intact skin with blood or with other low-risk body fluids, e.g. urine, NOT visibly blood-stained

**Low risk**
Appendix 5: Requirements to prevent infection

NOTE: as part of the consultation process we would appreciate feedback if this appendix is helpful.

The doctor or specialist in communicable diseases will visit you and should be able to give you information and advice on the likely cause of the illness and the actions you should take to prevent anyone else becoming ill.

You may want to ask the following questions and make notes of what you are told so that you can explain to your staff and other people who want information.

What did the doctor say was likely to be the cause of the illness?

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How is it likely to be transmitted?

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Is it possible that more people will become infected?
Could this include our staff?

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Does the illness have to be ‘notified’ to the Health Protection Agency?
If so who will do this?

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Will anyone need to be immunised to prevent them getting ill?
If so who will arrange this?

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Prevention and control of infection in care homes – draft for consultation

What might have caused or carried the infection? e.g., food, water

How long may the infection last for?

What should we look for to know if the infection is coming to an end?

Do we need to put the person who is ill in a separate room?

Can they be allowed to mix with other residents and have visitors?

Do they need to have any other separate facilities? e.g., separate toilet or washing facilities

Does the staff need to take any special precautions? e.g., wearing gloves, aprons or masks, taking extra care with ‘sharps’

How should we deal with the bed linen and clothing?
Prevention and control of infection in care homes – draft for consultation

Should any of the staff be kept out of contact? e.g., staff who are pregnant or have broken skin on their hands

What should we do with our pet animals?

Who can I speak to if I need more advice urgently?

Are there any samples or records I should keep? e.g., samples of the meals we are serving, names of staff who do not come to work.
## Appendix 6: List of diseases

<table>
<thead>
<tr>
<th>Disease or causative organism</th>
<th>Mode of transmission</th>
<th>Period of infectivity</th>
<th>Infection control precautions</th>
<th>Treatment of linen</th>
<th>Notes</th>
<th>Notify CCDC [local HPU]</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GASTROENTERITIS (DIARRHOEA AND VOMITING)</strong></td>
<td></td>
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</tr>
<tr>
<td><em>Campylobacter</em> spp.</td>
<td>Food Hand-to- mouth Pet faeces</td>
<td>While diarrhoea persists</td>
<td>Single room if incontinent Separate toilet</td>
<td>Treat as infected</td>
<td>All pets in contact with resident should be examined by vet</td>
<td>Yes (as potential food poisoning)</td>
</tr>
<tr>
<td><em>Clostridium difficile</em></td>
<td>Hand-to-mouth Environmental contamination</td>
<td>While diarrhoea persists</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td>May treatment with antibiotics. Likely to cause outbreaks</td>
<td>Yes</td>
</tr>
<tr>
<td><em>Cryptosporidium</em> spp.</td>
<td>Water Hand-to-mouth</td>
<td>While diarrhoea persists</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><em>Giardia lamblia</em></td>
<td>Water Hand-to-mouth</td>
<td>Until treated</td>
<td>Single room if incontinent Separate toilet</td>
<td>Treat as infected</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Viral gastroenteritis (undiagnosed)</strong></td>
<td>Hand-to-mouth Droplet</td>
<td>Variable. May be several days after symptoms resolve</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td>Very likely to cause outbreaks</td>
<td>If more than two cases occur</td>
</tr>
<tr>
<td><em>Norovirus</em></td>
<td>Hand-to-mouth Droplet</td>
<td>Up to 48 hours after symptoms have resolved</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td>Very likely to cause outbreaks</td>
<td>Yes</td>
</tr>
<tr>
<td><em>Rotavirus</em></td>
<td>Hand-to-mouth Droplet</td>
<td>Up to 48 hours after</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td>Very likely to cause outbreaks</td>
<td>Yes</td>
</tr>
<tr>
<td>Organism</td>
<td>Mode of transmission</td>
<td>Contact period</td>
<td>Treatment</td>
<td>Retain food samples</td>
<td>Complications</td>
<td>Yes/No</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------------------------------------------------------</td>
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</tr>
<tr>
<td><em>Escherichia coli</em> including verotoxin-producing <em>E. coli</em> (VTEC)</td>
<td>Food (hand-to-mouth)</td>
<td>Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/incontinent</td>
<td>Single room until 48 hours after diarrhoea stops Separate toilet</td>
<td>Treat as infected</td>
<td>Complications include haemolytic uraemic syndrome</td>
<td>Yes</td>
</tr>
<tr>
<td><em>Salmonella spp.</em></td>
<td>Food (hand-to-mouth)</td>
<td>Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/incontinent</td>
<td>Single room until 48 hours after diarrhoea stops Separate toilet</td>
<td>Treat as infected</td>
<td>Organism can be in stools for weeks/months after infection</td>
<td>Yes</td>
</tr>
<tr>
<td><em>Shigella spp.</em></td>
<td>Hand-to-mouth, water or food contaminated by infected water</td>
<td>Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/incontinent</td>
<td>Single room until 48 hours after diarrhoea stops Separate toilet</td>
<td>Treat as infected</td>
<td>Very likely to cause outbreaks Complications include haemolytic uraemic syndrome</td>
<td>Yes</td>
</tr>
<tr>
<td><em>Bacillus cereus</em> food poisoning</td>
<td>Food (preformed toxin)</td>
<td>Not infectious</td>
<td>None</td>
<td>No special treatment</td>
<td>Retain food samples</td>
<td>Yes</td>
</tr>
<tr>
<td>Clostridial food poisoning</td>
<td>Food</td>
<td>Not infectious</td>
<td>None</td>
<td>No special treatment</td>
<td>Toxin formed in gut after ingestion</td>
<td>Yes</td>
</tr>
<tr>
<td>(C. perfringens)</td>
<td>Food (preformed toxin)</td>
<td>Not infectious</td>
<td>None</td>
<td>No special treatment</td>
<td>Retain food samples</td>
<td>Food contamination from infected fingers, eyes, etc. of food handlers likely</td>
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</tbody>
</table>

**RESPIRATORY (CHEST) INFECTIONS**

| Influenza or influenza-like illness | Droplet Direct and indirect contact. | While symptomatic | Single room. Reinforce the importance of respiratory and hand hygiene. | No special treatment | See page 37 Immunisation | If influenza is confirmed by laboratory. Otherwise if more than two cases suspected |
|-----------------------------------|------------------------------------|------------------|----------------------------------------------------------------|----------------------|--------------------------|-----------------------------------------------------------------------------------------------------------------------------------|-----|
| Pulmonary tuberculosis            | Airborne if ′open′ case (sputum smear positive). Otherwise not infectious | Normally 2 weeks after starting treatment | Single room if sputum smear positive | Treat as infected | CCDC [local HPU] will advise on the management of contacts (residents and staff) | Yes |

**SKIN INFECTIONS**

<p>| Cold sore (herpes simplex) | Direct contact with lesions | Until lesions crusted | Use gloves for handling lesions, feeding or mouth care | No special precautions | | |
|----------------------------|-----------------------------|----------------------|--------------------------------------------------------|----------------------|--------------------------||
| Shingles (herpes zoster)   | Usually reactivation (of chickenpox) Direct contact with rash | Airborne | Until lesions crusted | Should sleep in single room but may mix with other residents during the day if rash can be covered | Treat as infected | Staff and residents should not be in contact unless immune to chickenpox | If management of case poses difficulties |
| Impetigo                   | Direct contact              | Until crusted        | Single room until | Treat as infected | The bacterium may be | If more than two cases |</p>
<table>
<thead>
<tr>
<th>Infection</th>
<th>Mode</th>
<th>Duration</th>
<th>Precautions</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>(staphylococcal Or streptococcal)</td>
<td>With lesions over 48 hours after treatment started</td>
<td>Cover lesions if mixing with other residents</td>
<td>carried in the nose of infected resident, other residents or staff</td>
<td>suspected</td>
</tr>
<tr>
<td>Fleas</td>
<td>From pets Person-to-person</td>
<td>Until treated</td>
<td>If new resident, single room until treated Treat pets Launder resident’s clothing and bedding</td>
<td>No special precautions</td>
</tr>
<tr>
<td>Head lice</td>
<td>Person-to-person</td>
<td>Until treated</td>
<td>Combing egg cases (nits) and live lice from hair</td>
<td>No special precautions</td>
</tr>
<tr>
<td>Body lice</td>
<td>Person-to-person</td>
<td>Until treated</td>
<td>If new resident, single room until treated Launder resident’s clothing and bedding</td>
<td>No special precautions but may be desirable to wash separately from other laundry</td>
</tr>
<tr>
<td>Pinworms, threadworms</td>
<td>Hand-to-mouth Airborne during bed making</td>
<td>Until treated</td>
<td>Personal hygiene including hand hygiene</td>
<td>No special precautions but may be desirable to wash separately from other laundry Avoid aerosol spread during</td>
</tr>
<tr>
<td>Disease</td>
<td>Mode of transmission</td>
<td>Duration of infection</td>
<td>Precautions during infection</td>
<td>Treatment after recovery</td>
</tr>
<tr>
<td>---------</td>
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<td>-----------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Scabies</td>
<td>Person-to-person (close contact)</td>
<td>Until treated</td>
<td>Single room until 24 hours after treatment</td>
<td>No special precautions but may be desirable to wash separately from other laundry</td>
</tr>
</tbody>
</table>

**BLOOD-BORNE INFECTIONS**

<table>
<thead>
<tr>
<th>Disease</th>
<th>Mode of transmission</th>
<th>Duration of infection</th>
<th>Precautions during infection</th>
<th>Treatment after recovery</th>
<th>Actions for suspected multiple cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>Contact with infected blood or other body fluids Sexual transmission</td>
<td>For life</td>
<td>Standard precautions, including care with sharps (see page 15) and body fluids</td>
<td>Treat as infected if contaminated with blood or bloodstained body fluids</td>
<td>Resident’s GP, consultant and the CCDC [local HPU] will collaborate with management</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Contact with infected blood or other body fluids Sexual transmission</td>
<td>Variable, but can be for life</td>
<td>Strict application of standard precautions, including care with sharps (see page 15) and body fluids</td>
<td>Treat as infected if contaminated with blood or bloodstained body fluids</td>
<td>Immunisation of some staff may be recommended (see page 37)</td>
</tr>
<tr>
<td>Hepatitis C</td>
<td>Contact with infected blood or other body fluids</td>
<td>For one or more weeks prior to onset of the first symptoms; may persist in</td>
<td>Standard precautions including care with sharps (see page 15 and body fluids)</td>
<td>Treat as infected if contaminated with blood or bloodstained body fluids</td>
<td>Yes – for acute infection (jaundice) No – for chronic carrier state</td>
</tr>
<tr>
<td>Disease</td>
<td>Mode of transmission</td>
<td>Incubation details</td>
<td>Isolation requirements</td>
<td>Treatment notes</td>
<td>Isolation required</td>
</tr>
<tr>
<td>--------------------------</td>
<td>----------------------------</td>
<td>---------------------------------------------------------</td>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Chickenpox (varicella)</td>
<td>Airborne</td>
<td>Infectious for 1–2 days before the onset of symptoms and 6 days after rash appears or until lesions are crusted (if longer)</td>
<td>Single room</td>
<td>Treat as infected</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>Contact with rash</td>
<td></td>
<td></td>
<td>CCDC/local HPU will advise on the management of contacts and may advise immunoglobulin and early antiviral therapy. See Green Book</td>
<td></td>
</tr>
<tr>
<td>Whooping cough (pertussis)</td>
<td>Droplet</td>
<td>Five days after start of appropriate antibiotic treatment</td>
<td>Single room</td>
<td>Treat as infected</td>
<td>Yes</td>
</tr>
<tr>
<td>Measles (rubeola)</td>
<td>Airborne, direct contact with infectious secretions.</td>
<td>Incubation period is approximately 10 days (range 7 – 18 days) from exposure to onset of fever and,</td>
<td>Single room</td>
<td>Treat as infected</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>CCDC/local HPU will advise on the management of contacts. Pregnant staff should know their immune status and seek advice if not immune.</td>
<td></td>
</tr>
</tbody>
</table>
usually, 14 days before the rash appears. The person is infectious from four days before the rash onset and 4 days after rash appearance

| German measles (rubella) | Droplet, direct contact with infectious secretions. | Incubation period of 14–17 days. (range 14 – 21) Individuals are infectious from about one week before and at least four days after the onset of the rash | Single room | Treat as infected visitors who are not immune should avoid contact. CCDC [local HPU] will advise on the management of contacts | Pregnant staff should know their immune status and seek advice if not immune. Non-pregnant staff should be immunised if susceptible. | Yes |

Mumps | Droplet | Incubation period around 17 days (range 14 - 25) . Greatest infectivity is from 2 days before the | Single room | Treat as infected | CCDC/local HPU will advise on the management of contacts. Staff should have received 2 doses of MMR. | Yes |
<table>
<thead>
<tr>
<th>Condition</th>
<th>Mode of transmission</th>
<th>Incubation period</th>
<th>Onset of symptoms to 4 days after symptoms appear</th>
<th>Consider need to treat as infected</th>
<th>Precautions</th>
<th>If two or more related cases are suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conjunctivitis</td>
<td>Direct contact with the discharge</td>
<td>Until 48 hours after treatment</td>
<td>Gloves/no touch technique when dealing with discharge. Personal hygiene/hand hygiene</td>
<td>Consider need to treat as infected</td>
<td>-</td>
<td>If two or more related cases are suspected</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Hand-to-mouth Food</td>
<td>The incubation period is 15 – 50 days, average 28–30 days. Maximum infectivity occurs during the latter half of the incubation period and continues until 7 days after jaundice appears</td>
<td>Single room Separate toilet</td>
<td>Treat as infected</td>
<td>May be asymptomatic but can be severe and prolonged in older people. No carrier state</td>
<td>Yes</td>
</tr>
<tr>
<td>Infectious mononucleosis</td>
<td>Contact with saliva</td>
<td>Variable – may be several</td>
<td>Care with articles soiled with nasal</td>
<td>No special treatment</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>(glandular fever)</td>
<td>weeks</td>
<td>or throat discharges</td>
<td>Encourage hand hygiene</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-------</td>
<td>---------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Prevention and control of infection in care homes – draft for consultation*
Appendix 7: Hand-washing technique

Hand-washing technique with soap and water

1. Wet hands with water
2. Apply enough soap to cover all hand surfaces
3. Rub hands palm to palm
4. Rub back of each hand with palm of other hand with fingers interlaced
5. Rub palm to palm with fingers interlaced
6. Rub with back of fingers to opposing palms with fingers interlocked
7. Rub each thumb clasped in opposite hand using a rotational movement
8. Rub tips of fingers in opposite palm in a circular motion
9. Rub each wrist with opposite hand
10. Rinse hands with water
11. Use elbow to turn off tap
12. Dry thoroughly with a single-use towel

Hand washing should take 15–30 seconds

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Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
Appendix 8: Alcohol handrub technique

Alcohol handrub hand hygiene technique – for visibly clean hands

1. Apply a small amount (about 3 ml) of the product in a cupped hand.
2. Rub hands together palm to palm, spreading the handrub over the hands.
3. Rub back of each hand with palm of other hand with fingers interlaced.
4. Rub palm to palm with fingers interlaced.
5. Rub back of fingers to opposing palms with fingers interlocked.
6. Rub each thumb clasped in opposite hand using a rotational movement.
7. Rub tips of fingers in opposite palm in a circular motion.
8. Rub each wrist with opposite hand.
9. Wait until product has evaporated and hands are dry (do not use paper towels).
10. The process should take 15-30 seconds.

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Adapted from World Health Organization Guidelines on Hand Hygiene in Health Care
Appendix 9: National colour coding for National Colour Coding Scheme

- **Red**: Bathrooms, washrooms, showers, toilets, basins and bathroom floors
- **Blue**: General areas including wards, departments, offices and basins in public areas
- **Green**: Catering departments, ward kitchen areas and patient food service at ward level
- **Yellow**: Isolation areas
### Appendix 10: Exclusion from work

The following table gives advice on the minimum period of exclusions from work for staff members suffering from infectious disease (cases) or in contact with a case of infection in their own homes (home contacts). Advice on work exclusions can be sought from the care home occupational health advisor or local CCDC/local HPU/HPN/CIPCN.

<table>
<thead>
<tr>
<th>Disease</th>
<th>Period of infectivity</th>
<th>Minimum exclusion period</th>
<th>Home contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chickenpox</td>
<td>Infectious for 1–2 days before the onset of symptoms and 6 days after rash appears or until lesions are crusted (if longer)</td>
<td>Case: Six days from onset of rash</td>
<td>Home contact: None. Non-immune pregnant women should seek medical advice</td>
</tr>
<tr>
<td>Conjonctivitis</td>
<td>Until 48 hours after treatment</td>
<td>Case: Until discharge stops</td>
<td>Home contact: None</td>
</tr>
<tr>
<td>Erythema infectiosum (slapped-cheek syndrome) Erythrovirus B19</td>
<td>Four days before until 4 days after onset of rash</td>
<td>Case: Until clinically well</td>
<td>Home contact: None. Pregnant women should seek medical advice</td>
</tr>
<tr>
<td>Gastroenteritis (including salmonellosis and shigellosis)</td>
<td>As long as organism is present in stools, but mainly while diarrhoea lasts</td>
<td>Case: Until clinically well</td>
<td>Home contact: CCDC/local HPU or EHP may advise a longer period of exclusion</td>
</tr>
<tr>
<td>Glandular fever</td>
<td>When symptomatic</td>
<td>Case: Until clinically well</td>
<td>Home contact: None</td>
</tr>
<tr>
<td>Giardia lamblia</td>
<td>While diarrhoea is present</td>
<td>Case: Until 48 hours after first normal stool</td>
<td>Home contact: None</td>
</tr>
<tr>
<td>Hand, foot and mouth disease</td>
<td>As long as active ulcers are present</td>
<td>Case: One week or until open lesions are healed</td>
<td>Home contact: None</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>The incubation period is 15–50 days, average 28-30 days. Maximum infectivity occurs during the latter half of the incubation period and</td>
<td>Case: One week after onset of jaundice</td>
<td>Home contact: None – immunisation may be advised (through GP)</td>
</tr>
</tbody>
</table>

CCDC/local HPU or EHPPO will advise on local policy.
<table>
<thead>
<tr>
<th>Condition</th>
<th>Duration</th>
<th>Isolation Period</th>
<th>Home Isolation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>For life</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Measles</td>
<td>Up to 4 days before until 4 days after rash appears</td>
<td>Four days from onset of rash</td>
<td>None</td>
</tr>
<tr>
<td>Meningitis</td>
<td>Varies with organism</td>
<td>Until clinical recovery</td>
<td>None</td>
</tr>
<tr>
<td>Mumps</td>
<td>Greatest infectivity from 2 days before onset of symptoms to 4 days after symptoms appear</td>
<td>Four days from onset of rash</td>
<td>None</td>
</tr>
<tr>
<td>Rubella (German measles)</td>
<td>One week before until 5 days after onset of rash</td>
<td>Four days from onset of rash</td>
<td>None</td>
</tr>
<tr>
<td>Streptococcal sore throat and scarlet fever</td>
<td>As long as organism is present in throat, usually up to 48 hours after antibiotic is started</td>
<td>Until clinically improved (usually 48 hours after antibiotic is started)</td>
<td>None</td>
</tr>
<tr>
<td>Shingles</td>
<td>Until after the last of the lesions are dry</td>
<td>Until all lesions are dry – minimum six days from onset of rash</td>
<td>None</td>
</tr>
<tr>
<td>Tuberculosis (TB)</td>
<td>Depends on part infected. Residents with open TB usually become non-infectious after two weeks of treatment</td>
<td>In the case of open TB, until cleared by TB clinic. No exclusion necessary in other situations</td>
<td>Will require medical follow-up</td>
</tr>
<tr>
<td>Threadworm</td>
<td>As long as eggs present on perianal skin</td>
<td>None but requires treatment</td>
<td>Treatment necessary</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>As long as case harbours the organism</td>
<td>Seek advice from CCDC/local HPU</td>
<td>Seek advice from CCDC/local HPU</td>
</tr>
<tr>
<td>Whooping cough</td>
<td>One week before until 3 weeks after onset of cough (or 5 days after start of antibiotic treatment)</td>
<td>Until clinically well, but check with CCDC/local HPU</td>
<td>None</td>
</tr>
</tbody>
</table>
## Appendix 10 Exclusion from work (continued)

<table>
<thead>
<tr>
<th>SKIN CONDITIONS</th>
<th></th>
<th></th>
<th>Minimum exclusion period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disease</td>
<td>Period of infectivity</td>
<td>Case</td>
<td>Home contact</td>
</tr>
<tr>
<td>Impetigo</td>
<td>As long as purulent lesions are present</td>
<td>Until skin has healed or 48 hours after treatment started</td>
<td>None. Avoid sharing towels</td>
</tr>
<tr>
<td>Head lice</td>
<td>As long as lice or live eggs are present</td>
<td>Exclude until treated</td>
<td>None. Avoid sharing hair brushes.</td>
</tr>
<tr>
<td>Ringworm</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Tinea capitis (head)</td>
<td>As long as active lesions are present</td>
<td>Exclusion not always necessary until an epidemic is suspected</td>
<td>None</td>
</tr>
<tr>
<td>2. Tinea corporis (body)</td>
<td>As long as active lesions are present</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>3. Tinea pedis (athlete’s foot)</td>
<td>As long as active lesions are present</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Scabies</td>
<td>Until mites and eggs have been destroyed</td>
<td>Until day after treatment is given</td>
<td>None (GP should treat family)</td>
</tr>
<tr>
<td>Verrucae (plantar warts)</td>
<td>As long as wart is present</td>
<td>None (warts should be covered with waterproof dressing for swimming and barefoot activities)</td>
<td>None</td>
</tr>
</tbody>
</table>
## Appendix 11: Transfer form

<table>
<thead>
<tr>
<th>Resident's details:</th>
<th>Consultant:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td>GP:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>NHS number:</td>
<td>Resident's current location:</td>
</tr>
<tr>
<td>Date of birth:</td>
<td>Transferring facility – hospital, ward, care home, other:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Receiving facility – hospital, ward, care home, district nurse</th>
<th>Is this resident an infection risk? Please tick most appropriate box and give confirmed or suspected organism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact telephone number:</td>
<td>Confirmed risk __________Organism:</td>
</tr>
<tr>
<td>Is the ambulance service aware of the transfer? Yes/No</td>
<td>Confirmed risk __________Organism:</td>
</tr>
<tr>
<td></td>
<td>Suspected risk __________Organism:</td>
</tr>
<tr>
<td></td>
<td>No known risk __________</td>
</tr>
<tr>
<td></td>
<td>Has this resident exposed to others with infection e.g. diarrhoea and vomiting Yes/No</td>
</tr>
</tbody>
</table>

| If resident has diarrhoeal illness, please indicate bowel history for last week: |
| Other relevant information e.g. specimen results/treatment: |

| Is the resident aware of their diagnosis/risk of infection? Yes/No |
| Does the resident require isolation? Yes/No                      |

Should the resident require isolation, please phone the receiving unit in advance.

Signature of staff member completing form: .................................................................
Print name:
Contact telephone number:
Appendix 12: Pre-employment medical questionnaire

Guidance notes
The purpose of the Pre-employment Health Questionnaire is to provide information about your medical history which will assist in the following ways:

- to ensure that you are medically suitable for the proposed job;
- to advise, where necessary, on any reasonable adjustments to your work or workplace to suit you, so that any underlying health problem is not made worse by work;
- to ensure that you do not have a medical condition which could pose a risk to your safety or to that of your colleagues, residents or members of the public;
- to help us identify if there is a risk of developing a work related illness from any hazards in the proposed workplace.

Pre-employment Screening takes into account both current and previous health factors.

The medical data on this form will remain confidential to xx. The medical contents of this form will not be disclosed to anyone without your explicit or written consent.

Please ensure you answer all the questions. Failure to fully complete this questionnaire will result in a delay to your health clearance and subsequent start date.

---

Please complete this form in black ink.

Section 1. Personal Details

Mr/Mrs/Miss/Ms/Dr./ other …… Male/Female Home address:

Surname:

Forename(s): Maiden Name (if applicable) Home Tel:

Mobile:

Work Tel:

Date of Birth:
Section 2  Details of Job Applied for:

Job Title:  
Full time/Part time/Temporary

Start date:  
End date  (If short-term contract)

Section 3  Medical History

If the answer to any of the following questions is “Yes” please give details

All staff groups complete this section

<table>
<thead>
<tr>
<th>Health Question</th>
<th>Yes</th>
<th>No</th>
<th>If Yes give details with dates here</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are you at present, receiving any treatment or regular medication supervised by your doctor?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you ever been retired on ill health grounds?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Do you need any specific aids/adaptations to assist you at work/study, whether or not you have a disability?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you ever had a medical problem which was caused or made worse by work / school / University?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you lost time from Work/University due to illness in the last 2 years?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Have you ever been treated for:

- Mental Health problems (including anxiety, depression, eating disorders, Alcohol or drug Abuse)?
- Back Pain?
- Musculoskeletal problems (such as arthritis, pains in arms or legs, restricted movement)?
- Skin problems (including Eczema or Dermatitis)?
• Epilepsy?

• Diabetes?

• Asthma?

• Cough which lasted for more than 3 weeks or have been investigated for TB?

7. Do you have any allergies? *(including sensitivity to medicines, foods or other substances such as Latex)*

---

**Section 4 All Staff groups to complete**

**Access to your medical records**

In order to process your health clearance we may on occasion need to access your medical records either from your GP or your treating Specialist. We will not contact them without your explicit consent. Please read and complete the section below. In the event that we need to write to your GP/Specialist we will still contact you to let you know. Completion of this section will ensure the process is undertaken with minimal delay to your start date.

**Access to Medical Reports Act 1988**

Under this Act you have the right to see medical reports about you supplied by doctors who have treated you. You also have the following rights:

1. Your employer must notify you when they intend to apply for a report and must ask your consent for the report to be supplied.

2. If a report is requested your General Practitioner/Consultant must be told whether or not you wish to see the report.

3. You may ask to see the report before it is sent to your employer.

4. If you wish to do this it is your responsibility to make arrangements to see the report and you are responsible for paying any reasonable fee charged by the doctor for supplying the report. You have 21 days from the date of your employer’s request to make arrangements to see the report.

5. If you disagree with the contents of the report you may ask the doctor to amend it. If he/she does not agree with these amendments you may not yourself alter the report, but you can add your own amendment.

6. Your doctor has no obligation to show you the whole or any part of the report, should he/she feel that the contents are likely to cause substantial harm.

7. You may ask to see the report at any time up to six months after it is requested. However, after the expiry of the 21-day period, you may not change the content.

---

**PLEASE COMPLETE THE CONSENT FORM BELOW.**

I understand my rights under the Access to Medical Reports Act 1988 and have read the summary of these rights provided.
**Prevention and control of infection in care homes – draft for consultation**

I agree/do not agree* to a medical report on my health being supplied
I wish/do not wish* to see the report before it is supplied.

* Please delete as appropriate

Signature ……………………………………………………………………….. Date ......................

Name (Block capitals)
…………………………………………………………………………………………………….

Name of General Practitioner (even if not based in the UK)
…………………………………………………………………………………………………….

Address
…………………………………………………………………………………………………….
…………………………………………………………………………………………………….

Tel number: …………………………………
Fax number: …………………………………

Name of treating Specialist (If Applicable)
…………………………………………………………………………………………………….

Hospital Address
…………………………………………………………………………………………………….
…………………………………………………………………………………………………….

Tel number: …………………………………
Fax number: …………………………………

**Section 5 Declaration All Staff Groups to complete this section**

Before signing this declaration please ensure you have answered all the questions as instructed providing further details as required. Please ensure the consent form is also signed and fully completed.

1. I hereby agree to inform Occupational Health Service of any changes in my health which may affect my ability to work.
2. I understand my responsibility to notify Occupational Health Service if I think I am carrying a serious communicable condition such as Hepatitis B / Hepatitis C / HIV or TB.
3. I acknowledge that my personal details will be stored both electronically and manually by the Occupational Health Service in accordance with the Data Protection Act 1998. This information will be retained for:
a. Six months if you are not selected for the position applied for,
b. During your period of employment and for an additional 40 years to comply with the Control of Substances Hazardous to Health amended Regulations 2004.
4. If I have any concerns about how this information is handled I will contact the Occupational Health Service.
5. I declare that the information provided by me in this entire form is true and complete to the best of my knowledge. I understand that any deliberate omission, falsification or misrepresentation in this record my result in disciplinary action by my employer.

Signed: …………………………………………………………………………………………… Date: …………..

Section 6  For Management Use Only

1. Reason for delay to health clearance:
   - Needs to complete questionnaire
   - For confirmation of immunity status or pathology results
   - Further information on health required
   - For a GP / Specialist report
   - Appointment for Nurse Health Interview offered
   - Appointment for Doctor Medical offered
   - Other

2. Pending:

<table>
<thead>
<tr>
<th>Date</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Outcome
   - Fit
   - Fit with restrictions
   - Unfit

4. Signature:
   Date:
Appendix 13: Working group membership

Membership

Dr Richard Slack (Chair), Regional Microbiologist and Consultant in Communicable Disease Control, Health Protection Agency, East Midlands, and Public Health Medicine Environmental Group

Ms Esther Dias, Lead Officer Infection Prevention and Control, Bromley PCT and Infection Prevention Society

Prof. Brian Duerden, Inspector of Microbiology and Infection Control, Department of Health

Ms Rachel Flowers, Consultant in Public Health, Newham PCT

Mr Ian Gray, Principal Policy Officer, Chartered Institute of Environmental Health

Dr Ruth Lockley, Consultant Medical Microbiologist, University Hospitals of Coventry and Warwickshire, and Public Health Medicine Environmental Group

Dr Pat Nair, Director, Norfolk/Suffolk/Cambridgeshire Health Protection Unit, East of England, and Public Health Medicine Environmental Group

Ms Beverley Reilly, Lead Nurse, Infection Prevention and Control, North Tees PCT and Infection Prevention Society

Ms Alyson Smith, Consultant in Health Protection, Thames Valley HPU

Dr Robert Spencer, Consultant Medical Microbiologist, Health Protection Agency, Bristol, and Chairman, Hospital Infection Society

Ms Virginia Storey, formerly Head of Quality and Health Policy, Commission for Social Care Inspection

Secretariat

Ms Carole Fry, Nursing Officer Communicable Diseases, Department of Health

Ms Mary Robinson, Project Manager, Department of Health
This guidance was produced in association with:

Infection Prevention Society (Incorporating ICNA)
www.ips.uk.net

The Infection Prevention Society (Incorporating the Infection Control Nurses Association) exists to promote the advancement of education in infection prevention and control for the benefit of the community as a whole, in particular by the provision of training courses, accreditation schemes, education materials, meetings and conferences.

Public Health Medicine Environmental Group (PHMEG)
www.phmeg.org.uk

The PHMEG aims to promote interest in communicable disease control, environmental health and other aspects of work to protect the public health.

Chartered Institute of Environmental Health (CIEH)
www.cieh.org

The CIEH is a professional body which aims to maintain, enhance and promote improvements in environmental and public health through knowledge, understanding and campaigning.