Infection prevention and control

An outbreak information pack for care homes

www.n-somerset.gov.uk
North Somerset Council and North Somerset Clinical Commissioning Group (CCG) takes their duty of care to care home residents extremely seriously and this pack aims to provide clear guidance on infection prevention and control precautions for protecting residents and staff from acquiring infection; and for restricting its spread should it occur.

Objectives

1. To provide information on common infectious diseases in care homes and steps that can be taken to prevent further spread.
2. To clarify communication routes for reporting outbreaks and incidents of infection.
3. Provide information about support and training

Background

Good standards of infection prevention and control reflect the overall quality of care and can help to demonstrate compliance with the Care Quality Commission domains for quality and safety. It can also help to promote confidence in the quality of care for residents and their families. Some infections can spread easily in enclosed settings and so it is essential that staff members remain aware and are able to identify and report promptly. Failure to act promptly and communicate well could lead to further disruption and spread across the healthcare community. Community outbreaks not only have direct burden on institutions such as care homes and schools, but also act as a source for hospital outbreaks so tackling the problem in the community is essential.

All care homes should have a written policy in place on the prevention and control of infection which is based on the Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (updated 2015). The policy should include roles and responsibilities for outbreaks and incident management.
This pack does not replace the toolkit

If you suspect an outbreak of Diarrhoea and vomiting contact the
- North Somerset Environmental Health Team Tel: 01934 634634

For any other outbreak or incident please call the
- Acute Response Centre, Public Health England South West Health Protection Team (in hours or out of hours) on: 0300 303 8162 or
- Environmental Health, North Somerset Council, Health, Safety & Food Team  
  Tel: 01934 634634

Acknowledgments

This resource has been developed and adapted for use in North Somerset and is based on the South Gloucestershire Information pack. Our thanks to Grace Magni and colleagues at South Gloucestershire Council for sharing this resource.


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**Definition of an outbreak and incident**

**Outbreak**
An ‘outbreak’ is an incident where two or more persons have the same disease or similar symptoms and are linked in time, place and/or person association.

An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number at any given time.

**Incidents**
An ‘incident’ has a broader meaning, and refers to events or situations which warrant investigation to determine if corrective action or specific management is needed.

In some instances, only one case of an infectious disease may prompt the need for incident management and public health measures.

**Recognising illness and Risk assessment**

**Recognising illness**
As an example, although influenza-like illnesses may have specific signs and symptoms such as sudden onset of fever, headache, sore throat or cough, older people may present with unusual signs and symptoms. They may not have a fever, and may present with loss of appetite, unusual behaviour or change in mental state.

**Risk assessment**
It is essential to assess the risk of infection to residents and staff so that precautions can be put in place. For example, during a suspected norovirus outbreak, check that you have taken enough precautions to prevent further spread and harm to residents and staff members. This can be checking to see what Personal Protective Equipment (PPE) may be required before a procedure is carried out.
Public Health England South West (PHESW)
Tel: 0300 303 8162 Option 2
Fax 0117 930 0205
Email: agwarc@phe.gov.uk

Public Health England works with other agencies to understand and respond to health threats.
The local Health Protection Team can support care homes by leading on all outbreak related incidents.

Community Infection Control
North Somerset Community Partnership
Email: suzanne.golding-ellis@nsomersetcp-cic.nhs.uk
Telephone: 07867 832808
Landline: 01275 885383

Specialist staff employed or contracted to provide Infection Prevention and Control advice to North Somerset Community Partnership health services such as District Nurses, care workers and others.

Environmental Health
North Somerset Council
Health, Safety & Food Team
Email: foodandsafety@n-somerset.gov.uk
Tel: 01934 634634

Environmental health practitioners have a good understanding of the public health risks associated with care homes and are also able to advise on infection control, they also investigate food poisoning outbreaks.
Reporting outbreaks and incidents: Common scenarios.

Care Homes have a duty to report suspected outbreaks or incidents of infections to the local Health Protection Team.

- **Two or more residents/staff with unexplained diarrhoea and/or vomiting**
  - If D & V to contact Environmental Health Team Tel 01934 634634 or other incidents

- **One case of itchy skin rash**
  - Consider scabies and arrange GP review

- **Two or more residents/staff with chest infections or flu-like symptoms:** cough, runny nose, sore throat, headache, sneezing, limb/joint pains.
  - If GP suspects scabies
  - If there are other residents/staff with itchy skin rash

- **Observe and Review**

Contact Acute Response Centre, Public Health England South West Health Protection Team on 0300 303 8162 option 2; or by email: AGWARC@phe.gov.uk

Do not include any personal data.

General principles of outbreak management

Do you have an outbreak? If unsure call for help early

- **Aim to prevent spread**
- **Isolate/Cohort**
- **Exclude**
- **Restrict/Close**
- **Collect specimens/Record**
- **Inform others**
- **Provide advice**
- **Observe and Review**
Immunisation and vaccinations for staff and residents

Residents

- Annual seasonal influenza vaccination is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely and can cause high rates of death and illness. Some people can be at greater risk of developing complications (typically pneumonias) from influenza and becoming more seriously ill. These include people with chronic lung, heart, kidney, liver, neurological diseases; those with diabetes mellitus and those with a suppressed immune system.

- All those over the age of 65 should receive one dose of pneumococcal vaccine. A single dose is also recommended for all those under 65 years of age who are at an increased risk from pneumococcal infection: people who have a heart condition, chronic lung disease, chronic liver disease, diabetes, weakened immune system and damaged or no spleen.

Staff

- Influenza immunisation is recommended for health and social care workers with direct patient/service user contact such as care home staff, and are expected to be offered flu vaccinations by their employer. Staff immunisation may reduce the transmission of influenza to vulnerable residents, some of whom may have impaired immunity.

- Hepatitis B for staff who may come into contact with residents’ blood or blood-stained body fluids or with residents’ body tissues.

- BCG vaccination which protects against tuberculosis should be is recommended for staff between the ages of 16 and 35 who are at occupational risk of exposure to TB. Contact the PHE local health protection team if you require advice on this.

The Influenza vaccine aims to:

- Reduce the transmission of influenza within health and social care premises

- Contribute to the protection of individuals who may have a suboptimal response to their own immunisations for example, those with chronic health conditions

- Avoid disruption to services that provide their care.

It may be useful to consider having an infection control champion / link person for the care home to give advice on basic infection control issues and help demonstrate that CQC requirements are being met around infection control.

- Liaises between their team and other infection control teams e.g. the hospital and community
- Act as a resource for colleagues e.g. disseminating information on policies and procedures
- Help to identify local infection control problems/issues
- Ensures infection control is included in induction and regular update sessions
- Ensures local infection control policies are developed, implemented and reviewed
- Ensures that residents/clients and relatives are informed of infection control practices as necessary
- Regularly attends Infection Control Link meetings or updates
- Updates and extends own knowledge of infection control.

**Introduction**

The use of Personal Protective Equipment (PPE) is essential for health and safety. Selection of PPE must be based on an assessment of the risk of transmission of micro-organisms to the patient or to the carer, and the risk of contamination of the healthcare worker's clothing and skin/mucous membranes by patients' blood, body fluids, secretions and excretions.

The use of PPE is considered standard in certain situations and is one of the elements of Standard Infection Control Precautions (SICPs), which apply to contact with blood, body fluids, non-intact skin and mucous membranes. Everybody involved in providing care should be educated about SICPs, and trained in the use of PPE. The benefit of wearing PPE is two-fold, offering protection to both patients/clients and those caring for them.

For the purposes of this guideline, the PPE described, which might be used in general health and social care settings, includes:

- Gloves.
- Aprons/gowns.
- Face, mouth/eye protection, e.g. masks/goggles/visors.

This guideline does not contain details of:

Theatre/surgery apparel which is often more comprehensive due to the risks encountered, e.g. the use of head and foot wear.
The use of PPE in situations where particular organisms/infections are present (e.g. specific respiratory infections and the use of specialised masks) which will require guidance from Trust Infection Control staff.

**Gloves**

**How to choose the correct glove**
Every organisation should have in place a risk assessment and policy for glove choice and usage. Purchasing policy should ensure that suppliers meet acceptable criteria for products. It is important to follow the local organisation's policy and procedures.

Gloves are available in a variety of materials. Risk assessment should ensure that the physical characteristics and barrier properties are acceptable, and provide protection against the risks encountered (e.g. microbiological, chemical, cytotoxic).

Gloves must be well fitting to avoid interference with dexterity, friction, excessive sweating and finger and hand muscle fatigue. Therefore, the supply and choice of the correct size and material of glove, e.g. small, medium, large and latex free, in various sizes, is important,

**When to wear gloves**
Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions and excretions; and when handling sharp or contaminated instruments. The attached “Summary guide for the use of personal protective equipment (PPE)” contains further details.

Gloves should be donned by holding the wrist end of the glove open with one hand to allow the other hand to enter easily (do not wear jewellery other than a wedding band under gloves). See attached “Putting on and Removing PPE”

Gloves must be worn as single use items. They are put on immediately before an episode of patient contact or treatment and removed as soon as the activity is completed. Gloves are changed between caring for different patients, or between different care or treatment activities for the same patient. The same PPE should never be worn for a different patient, client, procedure or area. Never perform hand washing whilst wearing gloves, and never use products such as alcohol-based hand rub to clean gloves.

Gloves are not a substitute for employing good hand hygiene, and this should be performed before donning gloves, immediately after the removal and disposal of gloves, and between every change of gloves. Gloves used for clinical practice may leak even when apparently undamaged, and the use of gloves as a method of barrier protection reduces the risk of contamination but does not eliminate it and hands are not necessarily clean because gloves have been worn. Therefore compliance with hand hygiene measures is essential.

A double gloving strategy should be considered in high risk situations, e.g. exposure prone procedures. The use of gauntlet-style (long arm) gloves to cover the forearms may be necessary in certain situations, e.g. situations where significant exposure to blood and other body fluids is likely, and should be considered within risk assessment procedures.

Torn, punctured or otherwise damaged gloves should not be used and should be removed immediately (safety permitting) if this occurs during a procedure.

**How to remove and dispose of gloves**
Gloves should be removed promptly after use and before touching non-contaminated/clean areas/items, environmental surfaces, or other persons (including the person wearing them). Gloves which have been worn for a procedure/activity should not be worn to handle or write on charts or to touch any other communal, clean surface.

Care should be taken when removing used gloves to avoid contamination of hands and clothing. The wrist end of the glove should be handled and the glove should be pulled down gently over the hand, turning the outer contaminated surface inward while doing so, i.e. the gloves are then disposed of inside out, preferably with the second glove also pulled over the first while removing it so that they are wrapped together. Used gloves should never be placed on environmental surfaces, but disposed of safely and immediately following use, as clinical waste, into appropriate receptacles according to local disposal of waste policies. Hand hygiene should be performed immediately after the removal and disposal of gloves.
Personal Protective Equipment

Aprons and Gowns

When to wear and how to choose an apron/gown

The use of disposable plastic aprons are indicated for a wide array of activities within care settings including “clean” and “dirty” tasks. They must be worn when close contact with the patient, materials or equipment are anticipated, and when there is a risk that clothing may be contaminated with pathogenic micro-organisms or blood, body fluids, secretions or excretions, with the exception of perspiration. “Summary guide to the use of personal protective equipment” contains fuller details.

Aprons/gowns should be appropriate for use, fit for purpose and should avoid any interference during procedures. Colour-coded aprons are often used for specific tasks and/or in specific areas (e.g. when handling or serving food within a clinical area). Never reuse or wash single-use disposable aprons/gowns.

There are many types of gowns available and the most appropriate should be considered following local risk assessment, often involving in the first instance Infection Control staff, Occupational Health services and Procurement departments.

A full-body fluid-repellent gown should be worn, rather than a plastic apron, when there is a risk of significant splashing of blood, body fluids, secretions or excretions (with the exception of perspiration), onto skin or clothing, or for other reasons if indicated by risk assessment.

When to change an apron/gown and how to remove and dispose of it

Aprons/gowns should be changed between patients/clients/procedures. It may be necessary to change aprons/gowns between tasks on the same patient/client to prevent unnecessary cross-contamination. Remove aprons/gowns immediately once a task is finished. Never wear them while moving to a different patient/client/area.

Torn or otherwise damaged aprons/gowns should not be used and should be removed immediately (safety permitting) if this occurs during a procedure. Remove aprons/gowns carefully to avoid contact with the most likely contaminated areas (e.g. the front surface), and prevent contamination of clothes under them. The outer contaminated side of the apron/gown should be turned inward, rolled into a ball and then the item should be discarded immediately, as clinical waste, into appropriate receptacles according to local disposal of waste policies. Never place used aprons/gowns on environmental surfaces. See attached “Putting on and Removing PPE”.

Face, mouth/eye protection, e.g. surgical masks/goggles

How to choose the correct protection and when and how to wear it

Face masks and eye protection must be worn where there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes. “Summary guide to the use of personal protective equipment” contains further details.

Well fitting, fit for purpose, comfortable protection is important to ensure adequate protection. Manufacturers’ instructions should be adhered to while donning face protection to ensure the most appropriate fit/protection. Surgical masks should always fit comfortably, covering the mouth and nose. When not in use for protection, they should be removed and not worn around the neck.

Goggles should provide adequate protection when the risk of splashing is present, e.g. those used must ‘wrap around’ the eye area to ensure side areas are protected. Face shields/visors should be considered, in place of a surgical mask and/or goggles, where there is a higher risk of splattering/aerosolisation of blood/other body fluids.

Face protection should not be touched while being worn and should be removed immediately following a procedure. Face protection should be changed between patients/clients/procedures. It may be necessary to change between tasks on the same patient/client to prevent unnecessary cross-contamination. Remove PPE immediately once you have finished the task, these should never be worn while moving to a different patient/client/area.

Risk assessments will dictate the need for other types of masks, e.g. particulate filter masks, and should be carried out in conjunction with Trust infection control staff. These masks must be correctly fitted and staff must be trained in their use.
If surgical masks become wet or soiled they should be changed in order to ensure continued protection from splashes/splattering to the mouth and nose. The efficacy of surgical masks in providing protection against airborne/droplet infections rather than from splashes of blood/other body fluids is the subject of continuing debate, as is the length of time they can be worn for.

Torn or otherwise damaged face protection should not be used and should be removed immediately (safety permitting) if this occurs during a procedure.

How to remove and dispose of face protection

Remove face protection promptly after use, avoiding contact with most likely contaminated areas, e.g. the front surface. This should be done by handling, for example, the straps/ear loops/goggle legs only (manufacturers’ instructions where given should be followed). The outer contaminated side of masks should be turned inward upon removal for disposal. See attached “Putting on and Removing PPE”

Dispose of disposable masks/face protection safely and immediately following use into appropriate receptacles according to local disposal of waste policies. Used face protection should never be placed on environmental surfaces.

Reusable items (e.g. non-disposable goggles/face shields/visors) should have a decontamination schedule with responsibility assigned and items should be dealt with immediately following use.

Hand hygiene should be performed immediately after removal/disposal of face protection.

Footwear

The correct use of footwear should be considered to promote infection control and prevention practice. When providing care, closed-toed shoes should be worn to avoid contamination with blood or other body fluids or potential injury from sharps. Footwear should be kept clean, and care should be taken when donning/removing shoes at any time during care delivery to avoid hand contamination. Hand hygiene should be performed following the handling of footwear.

Where designated footwear is assigned (e.g. in theatre settings, sterilising departments), policies should be available for the use and care of these, including clear cleaning schedules with responsibilities assigned. The principles applied within policies covering care of equipment should be followed when considering footwear decontamination.

Staff should not wear designated footwear for patient/client procedures outside their area of clinical practice e.g. between wards or in canteen areas.

It is advised that overshoes should not be worn as they can lead to unnecessary hand contamination while donning/removing and can cause aerosolisation of microorganisms due to bellowing when walking.
### Personal Protective Equipment

#### Summary Guide for the use of PPE Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Risk assessment</th>
<th>N/A</th>
<th>V</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Apron/Gowns (depending on risk of significant splashing exposure)</td>
<td>Risk assessment</td>
<td>N/A</td>
<td>V</td>
<td>V</td>
<td>V</td>
<td>N/A</td>
<td>N/A</td>
<td>Risk assessment</td>
<td>V</td>
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<tr>
<td>Face, eye/mouth protection (surgical masks, goggles)</td>
<td>Risk assessment</td>
<td>Risk assessment</td>
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<td>Risk assessment</td>
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<td>Risk assessment</td>
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#### Contact with intact skin. No visible blood, sores.

- Sterile procedures
- Cleaning up incontinence
- Potential exposure to blood/body fluids, e.g. cleaning up spills, taking specimens
- Vaginal examination
- Applying topical lotions, creams, etc.
- Touching patients with unknown skin rash
- Employing/changing urinary catheter bags.

### North Somerset Community Partnership Preventing Infection Control Group (PING)

Champions are encouraged and would be welcome to join the group.

**Aim:** To promote prevention and control of infection through:
- Informed practice
- Effective communication and
- Education

All meetings include an educational/training session and provide a forum to discuss/debate infection control issues.

Skills and competency are obtained through achieving:
- Infection control audits
- Achieve a change in practice in workplace
- Complete an infection control e-learning module
- Attend an infection control update session
- Conduct an interactive session using the ‘Glow-germ Box’ (ultra violet Hand Hygiene training box) in your work base

Meetings are held quarterly (January, April, July and October), they last about 1.5hrs and are held in Castlewood, Clevedon.

For further details contact [Suzanne.Golding-Ellis@nsomersetcp-cic.nhs.uk](mailto:Suzanne.Golding-Ellis@nsomersetcp-cic.nhs.uk) or [Helen.Lindsay@nsomersetcp-cic.nhs.uk](mailto:Helen.Lindsay@nsomersetcp-cic.nhs.uk)
Action Cards
ACTION CARD: **Diarrhoea and/or Vomiting**

Please refer to Integrated Care Pathway for Diarrhoea and Vomiting in care homes (Appendix 1)

ACTION CARD: **Respiratory Illness (chest infections)**

Please refer to Integrated Care Pathway for Chest Infections in Care Homes (Appendix 2)
### ACTION CARD: Influenza-like illnesses

Please consider all the actions below (mark as N/A (not applicable) as necessary).

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<tbody>
<tr>
<td><strong>Tick</strong></td>
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<tr>
<td><strong>1.</strong> If you suspect an outbreak, the home should be closed to outside visitors for at least five days since onset in the last case. Inform the Health Protection Team. Information on required samples can be obtained from the Team. Ensure that you inform GPs of the situation in the Home. Be aware that antivirals may be prescribed for residents. Please refer to Integrated Care Pathway for Respiratory Infections in Care Homes.</td>
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<td><strong>2.</strong> Affected residents should remain in their rooms as far as possible.</td>
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<td><strong>3.</strong> Daily monitoring of all residents for elevated temperatures and other respiratory symptoms so as to identify infected residents as early as possible. Start infection control procedures which will help to reduce spread.</td>
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<td><strong>4.</strong> Staff should work in separate teams: one team caring for affected residents and the other caring for unaffected residents.</td>
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<td><strong>5.</strong> Agency and temporary staff in contact with residents with symptoms should not work elsewhere (e.g. in a local acute care hospital) until the outbreak is declared over (i.e. seven days after the onset of the last case). The agency must also be informed of the outbreak.</td>
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<td><strong>6.</strong> Staff and visitors with symptoms should be excluded from the home until fully recovered and for at least five days after the onset of symptoms.</td>
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<td><strong>7.</strong> The elderly, very young and pregnant women, who are at greater risk from the complications of flu, should be discouraged from visiting during an outbreak.</td>
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<td><strong>8.</strong> Inform visiting health professionals of the outbreak and rearrange non-urgent visits to the home.</td>
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<td><strong>9.</strong> Complete outbreak chart for respiratory illness (chest infections).</td>
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<td><strong>10.</strong> Inform the hospital in advance if a resident requires admission to hospital during the outbreak.</td>
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<td><strong>11.</strong> Nominate a key member of staff to coordinate a guided response to the outbreak.</td>
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<td><strong>12.</strong> Provide information about the immunisation status (influenza and pneumococcal) of residents and staff to the Health Protection Team to aid the risk assessment.</td>
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<td><strong>13.</strong> If required, liaise with the GP, pharmacy and Health Protection Team to ensure that antiviral drugs are dispensed in a timely manner.</td>
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**ACTION CARD: Scabies**

Please consider all the actions below (mark as N/A (not applicable) as necessary)

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1. For suspected cases, inform GPs who should confirm the diagnosis with the dermatologist.

   Inform the Health Protection Team of all confirmed cases, BEFORE any treatment is started. This is because treatment is most effective if carried out simultaneously (ideally within a 24 hour period) in a co-ordinated way. Treatment, even for a single case, usually includes close contacts and family members who have had prolonged skin to skin contact – even if they have no symptoms. These should be treated at the same time to prevent re-infection. This is a major event that needs proper co-ordination with several agencies.

2. Assess the chance of possible infection for each resident and staff member as ‘high’, ‘medium’ or ‘low’ risk to aid appropriate follow-up and treatment of contacts. All staff and residents identified as ‘high risk’ or ‘medium risk’ will require treatment even in the absence of symptoms.

   - **High** = Staff members who undertake intimate care of residents and who move between residents, rooms or units. This will include both day and night staff; symptomatic residents and staff members.
   - **Medium** = Staff and other personnel who have intermittent direct personal contact with residents; asymptomatic residents who have their care provided by staff members categorised as ‘high risk’.
   - **Low** = Staff members who have no direct or intimate contact with affected residents, including asymptomatic residents whose carers are not considered to be ‘high risk’.

3. The Care Home manager or nominated PING champion should liaise with the health protection team for support and advice on managing the situation, treatment co-ordination and supply of recording sheets. See Appendix 6 for more information.
**ACTION CARD: Clostridium Difficile**

Please consider all the actions below (mark as N/A (not applicable) as necessary)

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<tbody>
<tr>
<td>1.</td>
<td>If you have any resident with C. diff positive, follow the Department of Health’s “SIGHT” advice: This is also in the suggested care plan in appendix 7. Suspect that a case may be infectious where there is no other cause for diarrhoea. Isolate resident while you investigate and continue until clear of symptoms for 48 hours. Gloves and aprons must be used for all contacts with the resident and their environment. Hand washing with soap and water must be done before and after each contact with the resident and environment. Alcohol gel does not work against C diff. Test the stool by sending a specimen immediately requesting screening for Clostridium difficile (within 24 hours if three or more instances of stool type five, six or seven in a 24 hour period) - see Bristol Stool Chart. Discuss with and inform the resident’s GP. Please contact the Health Protection Team if any of your residents has recently been discharged from hospital and was diagnosed with C. diff whilst there.</td>
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<tr>
<td>2.</td>
<td>The GP should review any antibiotics that the resident is taking.</td>
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<td>3.</td>
<td>Other medication such as laxatives and other drugs that may cause diarrhoea should also be reviewed.</td>
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<td>4.</td>
<td>Ensure that fluid intake is recorded, and that it is adequate.</td>
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<td>5.</td>
<td>Use a stool chart to record all bowel movements.</td>
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<td>6.</td>
<td>All residents with diarrhoea should be isolated in their own room until they have had no symptoms for a minimum of 48 hours.</td>
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<td>7.</td>
<td>Re-enforce standard Infection Control Precautions to all staff.</td>
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<td>8.</td>
<td>Residents must be assisted to wash their own hands after using the toilet/commode/bedpan.</td>
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<tr>
<td>9.</td>
<td>Wear disposable gloves and aprons when carrying out any care (i.e. not only when contact with blood and/or body fluids is anticipated).</td>
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<tr>
<td>10.</td>
<td>If the affected resident does not have their own en-suite toilet, use a dedicated commode (i.e. for their use only) which can remain in their room until they are well.</td>
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<tr>
<td>11.</td>
<td>Treat all linen as infected, and place directly into a water-soluble bag prior to removal from the room.</td>
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<tr>
<td>12.</td>
<td>Routine cleaning with warm water and detergent is important to physically remove any spores from the environment. This should be followed by wiping all hard surfaces with a chlorine based disinfectant (1000ppm).</td>
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<tr>
<td>13.</td>
<td>Ensure that visitors wash their hands at the beginning and end of visiting.</td>
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<tr>
<td>14.</td>
<td>It is important to ensure that you have adequate stocks of liquid soap, paper towels, single-use gloves, plastic aprons and pedal operated bins.</td>
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<tr>
<td>15.</td>
<td>It is not necessary to send further stool samples to the laboratory to check whether the resident is free from infection.</td>
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<tr>
<td>16.</td>
<td>Symptoms may recur in about one in five people. If this happens, inform the GP and maintain all enhanced precautions.</td>
</tr>
</tbody>
</table>
**ACTION CARD: MRSA**

Please consider all the actions below (mark as N/A (not applicable) as necessary)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Like any other resident, those with MRSA should be helped with handwashing if they are unable to do so for themselves. They should be encouraged to live a normal life without restriction but there is need to consider the following.</td>
<td>Tick</td>
</tr>
<tr>
<td>1. Affected residents with open wounds should be allocated single rooms if possible.</td>
<td></td>
</tr>
<tr>
<td>2. Residents with MRSA can share a room but NOT if they or the person they are sharing with has open sores or wounds, catheters, drips or other invasive devices.</td>
<td></td>
</tr>
<tr>
<td>3. They may join other residents in communal areas such as sitting or dining rooms, so long as any sores or wounds are covered with appropriate dressing, and regularly changed.</td>
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<tr>
<td>4. Staff members with eczema or psoriasis should not perform intimate nursing care on residents with MRSA.</td>
<td></td>
</tr>
<tr>
<td>5. Staff members should complete procedures for other residents before attending to residents with MRSA.</td>
<td></td>
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<tr>
<td>6. Staff should perform dressings and clinical procedures in the resident’s own room.</td>
<td></td>
</tr>
<tr>
<td>7. Isolation is not generally recommended, and may have adverse effects upon resident’s mental and physical condition unless there are clinical reasons such as open wounds.</td>
<td></td>
</tr>
<tr>
<td>8. Inform hospital staff if the person is to attend the Out-patients Department.</td>
<td></td>
</tr>
<tr>
<td>9. Generally, screening of residents and staff is not necessary in Care Homes. Contact the Health Protection Team to discuss if for any reason it is being considered, for example, a wound getting worse or new sores appearing. In such cases, also inform the GP who may send wound swabs for investigations.</td>
<td></td>
</tr>
<tr>
<td>10. Contact the Health Protection Team for any resident with MRSA who has a post-operative wound, drip or catheter.</td>
<td></td>
</tr>
<tr>
<td>11. If a resident does become infected with MRSA, contact their GP who should contact the microbiologist for advice on treatment. Also contact the health protection team for advice if required. Cover any infected wounds or skin lesions with appropriate dressings.</td>
<td></td>
</tr>
<tr>
<td>12. Please also inform the Health Protection Team of any PVL (Panton-Valentine Leukocidin) producing MRSA affecting any resident or staff member</td>
<td></td>
</tr>
</tbody>
</table>

See Appendix 8 for more information
Appendices
Public Health Protection Team

INTEGRATED CARE PATHWAY

Outbreak Management of Diarrhoea and/or Vomiting
(Care Homes)

Definition Criteria for an outbreak of diarrhoea and vomiting:

Two or more cases of diarrhoea and/or vomiting, Bristol Stool Chart grading 6 or 7 unusual to the residents’ or staff members’ normal bowel action.

<table>
<thead>
<tr>
<th>Definition Criteria for an outbreak of diarrhoea and vomiting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more cases of diarrhoea and/or vomiting, Bristol Stool Chart grading 6 or 7 unusual to the residents’ or staff members’ normal bowel action.</td>
</tr>
</tbody>
</table>

Outbreak Care Pathway — Communication

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

1. Report cases of diarrhoea and vomiting to the person in charge and enter the symptomatic cases details on the outbreak chart attached (residents, staff and visitors) so that you can identify whether symptoms started all at once (food poisoning?) or at different times (which may indicate person to person spread).

2. Telephone the Health Protection Team to inform them of the outbreak on 0300 303 8162 Option 2 (Monday to Friday 0900–1700hrs).
   If the outbreak commences on a weekend or Bank Holiday and urgent advice is needed, inform the on-call Public Health Specialist via the emergency out of hours number on 0344 257 8195

3. Ensure your local Environmental Health Department is informed of the outbreak Contact 01934 634 634

Instructions: Work through all the pages of this document, signing and dating each action when it has been implemented.

NB If you have your own outbreak documentation that is similar to this, there is no need to complete both documents, as long as the appropriate actions are implemented and this is clearly documented.

You may keep this document for your records but please fax or email only the End of Outbreak Notification form (page 38) to the Health Protection Team at the end of the outbreak.
<table>
<thead>
<tr>
<th>Environmental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>These are the questions that Environmental Health may ask you:</td>
</tr>
<tr>
<td>a. Number of meals per day - residents and staff?</td>
</tr>
<tr>
<td>b. If staff have been ill, have they eaten from the care home?</td>
</tr>
<tr>
<td>c. Are day visitors catered for? Number?</td>
</tr>
<tr>
<td>d. Is this a distribution kitchen? I.e. are hot meals sent offsite to other satellite kitchens? Where? How many? Has this ceased during the current outbreak?</td>
</tr>
<tr>
<td>e. How many residents and staff are ill, time, onset date, symptoms?</td>
</tr>
<tr>
<td>f. Have the kitchen staff been questioned about possible symptoms?</td>
</tr>
<tr>
<td>g. Have any household contacts for kitchen staff &amp; care assistants been unwell with diarrhoea and vomiting symptoms?</td>
</tr>
<tr>
<td>h. Are they aware of 48 hour rule for exclusion?</td>
</tr>
<tr>
<td>i. Has anyone vomited in dining room?</td>
</tr>
<tr>
<td>j. Are arrangements in place to exclude care assistants during the outbreak? E.g. alternative facilities available for drinks making or kitchen staff to make drinks and leave out for care assistants to distribute?</td>
</tr>
</tbody>
</table>

Environmental health staff may visit you to ask further questions.

4. **There is no longer a need to routinely inform the Care Quality Commission of an outbreak.** However, this document can be used to provide evidence for your CQC inspections.

5. **If there is a day centre attached to a home where there is an outbreak, the day centre should be informed without delay so that they can put measures in place to minimise the risk of transmission of infection to their day centre users. Additionally where food is supplied to the day centre from the affected home the Environmental health team should be notified so that they can discuss suitable arrangements for food provision to the day centre.**

   If hospital appointments are essential (this can be discussed with the health professional the resident is due to see), inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other patients.

   Any problems or concerns can be discussed with the Health Protection Team if necessary.

6. **Inform visitors of the closure and put a poster on the entrance of the home – to inform visitors that there is an outbreak and everyone needs to report to the person in charge. Visitors are advised to stay away until the home is 48 hours free of symptoms. Visitors must not be stopped from visiting if they wish to as long as they are aware they may become ill themselves. Visitors with symptoms must not visit the home until they are 48 hours free of symptoms.**

7. **Inform visiting health care staff of the outbreak i.e. GPs, community nurses, physiotherapists, occupational therapists, pharmacists.**

   Non-essential care must be deferred until after the outbreak.
<table>
<thead>
<tr>
<th>Outbreak Care Pathway — Communication</th>
<th>Date</th>
<th>Signature</th>
</tr>
</thead>
</table>
| **8. Inform the Health Protection Team**  
**if a resident requires an emergency admission to hospital.** |      |           |
| The GP/paramedics/care home manager must inform accident and emergency or the admitting ward, so that the resident can be received into a suitable area in A&E/medical admissions |      |           |
| **9. Isolate residents in their rooms until 48 hrs symptom free (where condition allows), particularly those with vomiting.** |      |           |
| Where residents are difficult to isolate  
Dementia Care Units try as much as possible to cohort the residents that are symptomatic into one area. |      |           |
| **10. Organise staff work rota to minimise contamination of unaffected areas. Try to avoid moving staff between homes and floors.** |      |           |
| **11. Obtain a stool specimen as soon as possible from all symptomatic cases.** |      |           |
| Stool specimens must fill half the specimen pot and must be diarrhoea (not formed stools). The specimen can still be taken even if it is mixed with urine and it is alright to scoop the sample from the toilet or from an incontinence pad.  
Sampling early may identify the cause of the outbreak and halt the need to take further samples.  
Samples must be labelled clearly with the resident or staff details, the name of the home followed by ‘outbreak’ and the tests requested as ‘M, C & S and virology’. |      |           |
| **12. Exclude all staff with symptoms until asymptomatic for 48 hours.** |      |           |
| Staff members should be advised to submit stool samples to their GPs and must be advised not work in any other care home until asymptomatic for 48 hours. |      |           |
| **13. Staff must not eat and drink except in designated areas.** |      |           |
| Open boxes of chocolates and fruit bowls must be removed and discarded in an outbreak. |      |           |
| **14. Staff should change out of uniforms prior to leaving the home during outbreaks and wear a clean uniform daily.** |      |           |
| If uniforms are laundered at home they should be washed immediately on a separate wash to other laundry at the highest temperature the material will allow. Staff should wear disposable gloves and aprons when attending to personal care and whilst cleaning. |      |           |
## 15. Reopening

- The home should not be reopened until it has been free of symptoms for 48 hours.
- A ‘deep clean’ should take place before reopening; this means that all floors, surfaces and equipment should be thoroughly cleaned with hot soapy water, including items such as door handles and light switches.
- Electrical items such as telephones and computer key boards also need to be cleaned with a (damp but not wet) cloth.
- Curtains should be laundered and it is recommended that if possible carpets be steam cleaned.
- Once reopened, send the end of outbreak notification form (p38) back to the Health Protection Team, so that your care home can be removed from the list of closed outbreak locations that is sent to the NHS and local authority daily.

## 16. Effective hand hygiene is an essential infection control measure.

Ensure sinks are accessible and are well stocked with liquid soap and paper towels for staff and visitors.

## 17. Provide residents with hand wipes and/or encourage hand washing (hand washing is the preferred option for residents who are not bed bound)

In communal toilets, paper towels must be used for drying hands. For residents with en-suite bathrooms, hand towels are acceptable but should be changed daily.

## 18. Ensure the macerator/bedpan washer is operational

Faults must be dealt with immediately as urgent.

## 19. Laundry soiled by faeces or vomit

Laundry soiled by faeces or vomit must be placed directly into a water soluble/infected laundry bag and transferred to the laundry so that laundry staff do not have to handle the item. Launder as infected linen.

## 20. Ensure the home is thoroughly cleaned daily using hot water and detergent.

All eating surfaces, toilet areas and sluice should be cleaned twice daily using a hypochlorite solution 1000 parts per million (e.g. Milton 1:10. To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water.)

- Commode and toilet seats require cleaning after each use with soap and water or detergent wipe.
- Cover excreta/vomit spillages immediately with disposable paper roll/towel. Always wear an apron and gloves when disposing of faeces/vomit. After removing the spillage, clean the surrounding area with hot soapy water, followed by disinfection with a hypochlorite solution of 1000 parts per million. Always clean a wider area than is visibly contaminated.
- Carpets contaminated with faeces or vomit should be cleaned with hot soapy water (or a carpet shampoo) after removal of the spillage with paper towels. This should preferably be followed by steam cleaning if possible.

## 21. Inform the Health Protection Team when the home has been 48 hours symptom free.

Use the End of Outbreak Notification which can be found at page 38.
Appendix 1

**Bristol Stool Chart**

<table>
<thead>
<tr>
<th>Location</th>
<th>Tel no</th>
<th>Month/year</th>
<th>Names of cases</th>
<th>R/S</th>
<th>O/W</th>
<th>Rm</th>
<th>MF</th>
<th>Date of birth</th>
<th>Dates of start and end of symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example</td>
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</tbody>
</table>

Informed Environmental Health
Informed HPT
Number of new cases today
No. symptomatic residents today
Number of beds closed today

R = resident/patient  N = nausea  X = date sample sent to laboratory
V = vomiting  D = diarrhoea
S = staff  EHO = Environmental Health Officer
O = other  HPT = Health Protection Team
Rm = Room/Location

---

46
To: Acute response Centre, Public Health England South West  
Email: agwarc@phe.gov.uk  
Fax no: 0117 930 0205 (safe haven)

From Care Home: .................................................................
Fax no: .....................................................................................
Date: .....................................................................................
No. of pages including this one ...........

Care Home End of Outbreak Notification Form

NB – Ensure there are no resident details on this form if emailing.
Resident information may be faxed to the safe haven fax number above.

The purpose of this form is to:
1. Provide feedback to the Health Protection Team on the outcome of the outbreak
2. Take the care home off the list of closed care homes that is sent daily to NHS and social care commissioners and providers.

How many people:
Living / working at the care home?
Symptomatic?
Hospitalised?
Died?

| Residents |
| Staff |
| Others, e.g. visitors |

Lab Test Results

<table>
<thead>
<tr>
<th>Type of specimen (e.g. faeces)</th>
<th>Dates sent</th>
<th>What the specimen was tested for, e.g. bacteriology, virology, C. diff, etc.</th>
<th>Results* (if known)</th>
</tr>
</thead>
</table>

*If you would like the Health Protection Team to chase up some lab results, please fax us the names and dates of birth of each person and which test results are awaited.

Feedback and Lessons Learnt:
If this outbreak were to happen again, is there anything that:
1. You would do differently?
2. You would like the Health Protection Team to do differently?
3. Have you identified any training needs?

If so, please provide details (continue on a 2nd page if needed). Thank you.

PHE Reference Number (if known): HPZ_

INTEGRATED CARE PATHWAY
Outbreak Management of Respiratory (Chest) Infections (Care Homes)

Aims and Objectives

Aim: To manage outbreaks of respiratory infection efficiently and effectively in order to reduce the number of cases and potential deaths.

Objectives:
1. All appropriate measures are taken to prevent and control respiratory outbreaks.
2. Suspected outbreaks are detected early and control measures are initiated promptly.
3. All relevant information is documented, to allow review by the care home and the Health Protection Team (HPT), and for the care home to use as evidence of performance for the Care Quality Commission if required.

Definition Criteria for an outbreak of respiratory illness

*Two or more cases of chest infection or flu-like illness among residents diagnosed by GP / duty doctor within one week in one residential / nursing home*

Note that colds are not included in this outbreak definition.

1 Chest Infection/pneumonia: At least two of the following symptoms: cough, producing sputum (yellow/or green) breathlessness, wheeze, chest pain, fever, sore throat, fever/temperature (>38ºC) Crackly or bubbly chest sounds.
2 Flu like illness usually starts rapidly with a fever/temperature >38ºC OR complaint of feverishness PLUS two or more of the following: headache, cough, sore throat or malaise AND duration of illness of at least three days.
3 Cold = runny nose or blocked nose, sore throat, headache, non-productive cough
Appendix 2

Initial Situation Details

Full address of outbreak location:
...............................................................................................................................
...............................................................................................................................
...............................................................................................................................
............................................................................................................................... Postcode ..........................................................

Onset date and time in first case ..........................................................

Number of residents:
- Presently in the home: ..........................................................
- Presently in hospital: ..........................................................
- Presently affected by respiratory illness (at time of reporting the outbreak) ..........................................................

Number of staff:
- Employed in the home: ..........................................................
- Presently affected by respiratory illness (at time of reporting the outbreak) ..........................................................

If there is a current suspected or confirmed outbreak, please go straight here.

Instructions: Please work through all the pages of this document, signing and dating each action when it has been implemented. If a stated action is not appropriate, you need to document why this is and sign it.

Please fax or post only the End of Outbreak Notification form (page 38) to the Health Protection Team at the end of the outbreak.

Communication: WHO TO INFORM

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

1. Report cases of respiratory illness (see definition above) to the person in charge of nursing/residential home.

2. Enter the details of symptomatic cases on the log sheet attached (residents and staff).

3. Inform all GPs caring for any of the residents with symptoms.

4. Telephone the Health Protection Team to inform them of the outbreak on 0300 303 8162, option 2 (Monday to Friday 0900 – 1700hrs) OR if the outbreak commences on a weekend or Bank Holiday contact the On-Call Public Health Specialist on 0344 257 8195.

This will enable you to discuss the outbreak control measures that are needed and the information to be communicated to others.

Outbreak Care Pathway – CARE HOME ACTIONS

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

5. Close the home to admissions, transfers and hospital outpatient appointments.

If appointments are essential, discuss with the Health Protection Team prior to the appointment, so appropriate plans can be made for the resident to be seen at the end of clinic in order to avoid contact with patients. (HPT to inform Hospital Infection Control team)

6. If the HPT agrees that an OUTBREAK is suspected and that closing the home is necessary:

- Inform family members/visitors of the closure and put a poster on the entrance of the home to inform visitors that some residents have chest infections and that it is recommended that visitors do not visit until the home has had no new cases for three days (five if flu strongly suspected or confirmed). This will reduce the risk of spread amongst residents, staff and visitors alike.
Appendix 2

- Visitors must not be stopped from visiting if they wish as long as they are aware they may become ill themselves. Visitors, including children should not visit if they are unwell themselves.
- Inform visiting health care and other staff of the outbreak i.e. community nurses, physiotherapists, occupational therapists, hairdressers, clergy, pharmacists, agency staff
- Non-essential visits must be deferred until after the outbreak

7. Inform the Health Protection Team if a resident requires an emergency admission to hospital. The GP/paramedics/ care home manager must agree who will inform accident and emergency (A&E) so that the resident can be received into a suitable area; and then do so. (For elective admissions, GP and hospital medical staff to decide if essential or possible to postpone).

8. If possible, symptomatic residents should be cared for in single rooms (where condition allows). If this is not possible:
   - Symptomatic residents should be cared for in areas well away from those without symptoms e.g. in separate floors or wings of the home.
   - Where residents are difficult to isolate, try as much as possible to cohort the residents that are symptomatic into one area.
   - If the organism is unknown, assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered

9. Organise staff work rota to minimise moving staff between homes and floors. If possible, staff should work either with symptomatic or asymptomatic residents (but not both) for the duration of the outbreak.

10. Agency staff exposed during the outbreak should be advised not to work in any other health care settings until the cause is identified.

11. Monitor all residents for elevated temperatures and other respiratory symptoms to identify infected residents early so that infection control measures can be promptly started to reduce further spread.

Outbreak Care Pathway – SAMPLING

12. If flu is suspected, a suitably qualified health care professional may be required to obtain:
   - Combined nose/throat swab in virus transport medium from cases with the most recent onset of symptoms. Up to five should be taken (swabs are available from local laboratories).
   - Sputum samples for culture
   - Urine samples for Legionella and pneumococcal antigens
   Please inform the Health Protection Team who will advise you further.

13. Write name of care home, with suspected respiratory outbreak on each form, in addition to resident details.

14. Exclude all staff and visitors with symptoms until no longer symptomatic and fully recovered.

15. Staff should change out of uniforms prior to leaving the home during outbreaks and wear a clean uniform daily. Uniforms laundered at home should be washed immediately on a separate wash to other laundry.
Outbreak Care Pathway – INFECTION
CONTROL ACTIONS

16. Effective hand hygiene and safe disposal of respiratory secretions on tissues are an essential infection control measure. Ensure handwashing sinks are accessible and are well stocked with liquid soap and paper towels for staff and visitors.

17. Waste bins that contain tissues used by residents with a respiratory illness should be disposed of as clinical waste.

18. Encourage hand washing amongst all staff, residents and visitors. If residents are unable to wash hands at the sink, provide a bowl of water or hand wipes. A clean individual resident hand towel should be provided daily for all residents. If handwashing facilities are not readily available offer alternatives such as alcohol gel.

19. Staff should make a local risk assessment regarding the suspected organism and the use of personal protective equipment such as gloves and aprons. Staff should wear gloves and apron for contact with cases and when handling contaminated items or waste.

20. Wearing gloves is no substitute for handwashing after contact with respiratory secretions and between residents.

21. Ensure the home is thoroughly cleaned twice daily using hot water and detergent. Particular attention should be paid to all surfaces that are frequently handled i.e. door handles, bed tables, eating surfaces, toilet areas and the sluice.

---

1 GPs to stock a few of these at each surgery at the beginning of each winter.

---

Appendix 2

To: Acute response Centre, Public Health England South West
Email: agwarc@phe.gov.uk
Fax no: 0117 930 0205 (safe haven)
From: Care Home: .................................................................
Fax no: .............................................................................
Date: ........................................... No. of pages including this one .........

Care Home End of Outbreak Notification Form

NB – Ensure there are no resident details on this form if emailing. Resident information may be faxed to the safe haven fax number above.

The purpose of this form is to:

3. Provide feedback to the Health Protection Team on the outcome of the outbreak

4. Take the care home off the list of closed care homes that is sent daily to NHS and social care commissioners and providers.

<table>
<thead>
<tr>
<th>How many people:</th>
<th>Living/working at the care home?</th>
<th>Symptomatic?</th>
<th>Hospitalised?</th>
<th>Died?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Others, e.g. visitors</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Lab Test Results

<table>
<thead>
<tr>
<th>Type of specimen</th>
<th>Dates sent</th>
<th>What the specimen was tested for, e.g. bacteriology, virology, C. diff, etc.</th>
<th>Results* (if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td>E.g. viral swabs of nose and throat, sputum</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If you would like the Health Protection Team to chase up some lab results, please fax us the names and dates of birth of each person and which test results are awaited.

Feedback and Lessons Learnt:

If this outbreak were to happen again, is there anything that:

1. You would do differently?
2. You would like the Health Protection Team to do differently?
3. Have you identified any training needs?

If so, please provide details (continue on a 2nd page if needed). Thank you.

PHE Reference Number (if known): HPZ_
Symptomatic Resident and Staff Log sheet – Complete Daily for new symptomatic cases

### RESIDENTS LOG SHEET

<table>
<thead>
<tr>
<th>Room</th>
<th>Name &amp; Date of Birth</th>
<th>Date of last flu vaccine</th>
<th>Date of pneumovax vaccine</th>
<th>QP and Surgery Details</th>
<th>THIS OUTBREAK</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Date of Onset</td>
</tr>
</tbody>
</table>

### STAFF LOG SHEET

<table>
<thead>
<tr>
<th>Job title</th>
<th>Name &amp; Date of Birth</th>
<th>Date of last flu vaccine</th>
<th>Date of pneumovax vaccine (if applicable)</th>
<th>QP and Surgery Details</th>
<th>Date of Onset</th>
<th>Symptoms (see codes below)</th>
<th>Seen by Dr (name and date seen)</th>
<th>Diagnosis</th>
<th>Specimen Sent (type of specimens &amp; date sent)</th>
<th>Results</th>
</tr>
</thead>
</table>

**Symptoms code:**
- C = cough (non-productive);
- CI = cough (producing green or yellow sputum);
- RN = runny nose;
- T = temperature;
- FB = fast breathing/shortness of breath;
- CS = audible chest sounds;
- H = headache;
- LA = loss of appetite;
- ST = sore throat;
- V = vomiting;
- AP = general aches/pains;
- ILL = duration of illness of 3 days

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### Transmission, incubation and communicability of respiratory pathogens

<table>
<thead>
<tr>
<th>Infection</th>
<th>Reservoir</th>
<th>Dominant modes of transmission</th>
<th>Incubation period</th>
<th>Period of communicability*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhinovirus or coronavirus</td>
<td>Human</td>
<td>Respiratory droplets, direct and indirect contact with respiratory secretions.</td>
<td>Between 12 hours and 5 days, more usually around 48 hours.</td>
<td>From up to 1 day before* to 5 days after clinical onset.</td>
</tr>
<tr>
<td>Influenza virus</td>
<td>Humans are the primary reservoir for human influenza; birds and mammals are likely sources of new human subtypes for influenza A.</td>
<td>Respiratory droplets, direct and indirect contact with respiratory secretions.</td>
<td>Short, usually 1 to 3 days, but possibly up to 5 days.</td>
<td>From up to 12 hours before* to 3 – 5 days after** clinical onset in adults; up to 7 days in young children and occasionally longer.</td>
</tr>
</tbody>
</table>
| *Few data exist which convincingly demonstrate that transmission by asymptomatic persons is important in producing additional symptomatic cases.

| Streptococcus pneumonia   | Humans – pneumococci are commonly found in the respiratory tracts of healthy people. | Respiratory droplets, direct and indirect contact with respiratory secretions. | Uncertain, but possibly 1 to 3 days. | Until discharges are clear of virulent pneumococci, but 24 –48 hours if treated with penicillin. Pneumococci remain viable in dried secretions for many months. |
| Respiratory syncytial virus (RSV) | Human | Respiratory droplets, direct and indirect contact with respiratory secretions. | Between 1 and 8 days, more usually around 48 hours. | From up to 1 day before* to 5 days after clinical onset, occasionally longer in infants – up to 4 weeks. |
| Parainfluenza virus        | Human   | Respiratory droplets, direct and indirect contact with respiratory secretions. | Between 12 hours and 7 days, more usually around 48 hours. | From up to 1 day before* to 5 days after clinical onset. |

**Carriage may last for longer (7 days or possibly more) in older people with comorbidity and severe enough illness to warrant hospitalisation for this long...**
TRANSMISSION DYNAMICS

Respiratory infections are usually spread by close contact through one of four mechanisms:

- **droplet transmission** – coughing, sneezing, or even talking may generate droplets more than 5 microns in size that may cause infection if droplets from an infected person come into contact with the mucous membrane or conjunctiva of a susceptible individual. The size of these droplets means that they do not remain in the air for a distance greater than a metre, so fairly close contact is required for infection to occur.

- **direct contact transmission** – this occurs during skin-to-skin or oral contact. Organisms may be passed directly to the hands of a susceptible individual who then transfers the organisms into their nose, mouth or eyes.

- **indirect contact transmission** – takes place when a susceptible individual touches a contaminated object, in the vicinity of an infected person and then transfers the organisms to their mouth, nose or eyes.

- **aerosol transmission** – takes place when droplets less than 5 microns in size are created and remain suspended in the air. This can sometimes occur during medical procedures, such as intubation or chest physiotherapy. These droplets can be dispersed widely by air currents and cause infection if they are inhaled.

INFECTION CONTROL

Residents

- Enhanced surveillance for further cases should be initiated by way of daily monitoring of all residents for elevated temperatures and other respiratory symptoms. It is important to identify infected residents as early as possible in order to implement infection control procedures such as isolation and reduce the spread of infection. If possible, symptomatic residents should be cared for in single rooms. If this is not possible, symptomatic residents should be cared for in areas well away from residents without symptoms. If the design and capacity of the care home and the numbers of symptomatic residents involved are manageable, it is preferable to isolate residents into separate floors or wings of the home. Movement of symptomatic residents should be minimised. If the organism is unknown, assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered.

- Resident’s clothes, linen and soft furnishings should be washed on a regular basis and all rooms kept clean. More frequent cleaning of surfaces such as lockers, tables, chairs, televisions and floors is indicated, especially those located within one metre of a symptomatic resident. Hoists, lifting aids, baths and showers should also be thoroughly cleaned between residents.

- Residents should have an adequate supply of tissues, as well as convenient and hygienic methods for disposal. Residents should cover their nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses and clean their hands or use handrubs (microbicidal handrubs, particularly alcohol-based) afterwards.

- Depending on the nature of the infection and the impact on those affected, consideration might in very specific circumstances be given to the use of surgical facemasks by affected residents (if this can be tolerated) when they are within one metre of other individuals (unless microbiologically confirmed to share the same infection). The Health Protection Team will advise if this is necessary.

Staff

- If possible, care home staff should work either with symptomatic or asymptomatic residents (but not both) and this arrangement should be continued for the duration of the outbreak.

- Agency and temporary staff who are exposed during the outbreak should be advised not to work in any other health care settings until the cause is identified and appropriate advice given.

- Symptomatic staff and visitors should be excluded from the home until no longer symptomatic. Children and adults vulnerable to infection should be discouraged from visiting during an outbreak. Consistent with resident welfare, visitor access to symptomatic residents should be kept to a minimum.

- Frequent hand washing has been proven to be effective in reducing the spread of respiratory viruses. Staff should clean their hands thoroughly with soap and water or a handrub (microbicidal handrubs, particularly alcohol-based) before and after any contact with residents. Consideration should also be given to placing handrub dispensers at the residents’ bedsides for use by visitors and staff. It is advisable to recommend carrying out a risk assessment before introducing handrubs into the workplace.

- Staff should wear single use plastic aprons appropriately when dealing with residents.

- Barrier measures such as gloves, gowns and facemasks (the higher the filtration the better) are also effective in reducing the spread of respiratory viruses if used correctly. Any decision about the use of personal protective equipment (PPE) needs to be taken in the light of the organism and the impact on the home. The Health Protection Team can advise on the level of infection control needed.

- More stringent infection control is needed when aerosol generating procedures (such as airway suction and CPR) are carried out on cases or suspected cases. Such procedures should be performed only when necessary and in well ventilated single rooms with the door closed. Numbers of staff exposed should be minimised and FFP3 respirators and eye protection should be used in addition to gowns, gloves and universal precautions.
Appendix 3

- Staff, residents and visitors should be encouraged to avoid touching their eyes and nose to minimise the likelihood of infecting themselves from viruses picked up from surfaces or other people.
- Uniforms and other work clothing should be laundered at work if there are facilities for this. If laundered at home the general advice on washing work clothes would apply. Uniforms should never be worn between home and the place of work.
- Clinical waste should be disposed of according to standard infection control principles.
- Depending on the causative organism, there may be a case for staff at risk of complications if infected (e.g. pregnant or immuno-compromised individuals) to avoid caring for symptomatic residents. A risk assessment will need to be carried out on an incident by incident basis.

Influenza Outbreaks: Information leaflet for Residents and Carers

1. What is a flu (influenza) outbreak?
   Flu-like illness affects many people during the winter months. Two or more cases of flu-like illness occurring within 48 hours in residents or staff from the same care home indicate that an outbreak of influenza is possible.

2. Recommended precautionary measures for homes with a possible flu outbreak
   If the staff in the care home suspect an outbreak, they will ensure that measures are in place to reduce the risk of spread to other residents. They may also advise restrictions on staff and resident movements.
   The local Health Protection Team will be supporting them in ensuring:
   - adequate control measures are taken to prevent the spread of infection
   - affected residents or staff receive appropriate treatment and
   - residents, staff and carers receive appropriate and timely information on the measures being taken

3. What are the specific measures that staff can take?
   - Wash hands frequently with soap and water and dry thoroughly
   - Dispose of used/dirty tissues as clinical waste
   - Ensure frequent cleaning of surfaces
   - Ensure that supplies for hand washing are available where sinks are located
   - Provide tissues to residents and visitors who are coughing or sneezing so that they can cover their mouth and nose.
   - Staff should use appropriate infection control precautions while dealing with affected residents e.g. gloves, single use apron

4. How can residents and carers help?
   - Residents with flu symptoms should
   - Avoid using common areas
   - Cover their mouth and nose with a tissue when coughing or sneezing
   - Sit at least 3 feet away from others, if possible
   - All residents can:
   - Discourage visitors, especially children and vulnerable adults
   - Support the home by adhering to other restrictions which may be needed

   Carers, family and friends should not visit the home if they have flu symptoms.
Appendix 5

Guidance on Influenza Outbreaks in Care homes (including poster)

1. What is an outbreak of influenza?
   Two or more cases of flu–like illness occurring within 48 hours in residents or staff who are in close proximity to each other in the care home indicates that an outbreak of flu is possible. Your local Health Protection Team will confirm whether or not there is an outbreak.

2. How can you reduce the risk of influenza transmission in care homes?
   - Wash hands frequently with soap and water and dry thoroughly
   - Ensure frequent cleaning of surfaces
   - Cover your mouth and nose with a tissue when coughing or sneezing
   - Dispose of used/dirty tissues as clinical waste

3. What precautions should you take if you suspect a possible outbreak of flu in the care home?

3.1 Care of residents
   1. The first priority is the care of residents. If possible affected residents should be cared for in single rooms, or in the same area of the care home, to reduce the risk to other residents who are not affected.
   2. Ensure that standard infection control precautions are in place.
   3. Inform the local Health Protection Team as soon as possible.

3.2 Informing local Health Protection Team
   The Health Protection Team staff will:
   - Advise whether there is an outbreak, and collect further information.
   - Offer advice on whether further tests or treatment is required
   - Liaise with other health care professionals who may be involved with the care of residents.
   - Ensure that detailed information on infection control precautions is made available, and
   - Monitor the progress of the outbreak, and offer support for any other control measures that may be required

3.3 Reinforce Infection Control Measures
   In the event of an outbreak, the standard infection control measures that should be in place in all health and care settings should be maintained, and environmental cleaning measures should be enhanced.

3.4 Additional key measures recommended during outbreaks are outlined below. These cover three main areas:
   - Restrictions to visitors and staff
   - Respiratory hygiene
   - Droplet precautions

Further advice on these matters can be obtained from your local Infection Control Nurse or Health Protection Team.

Restrictions to residents, visitors and staff
   - Restrict visitor access to symptomatic residents to the minimum that is required for resident welfare. Children and vulnerable adults should be discouraged from visiting during an outbreak.
   - Exclude symptomatic staff and visitors until fully recovered and at least five days after the onset of symptoms.
   - Agency and temporary staff who are exposed during the outbreak should be advised not to work in other health or care settings until the outbreak is over.

Respiratory hygiene
   Respiratory hygiene/cough etiquette is essential when an outbreak of flu is being considered. Recommended measures include:
   - Putting up signs at entrance or common areas instructing residents and visitors to inform staff if they have respiratory symptoms, and discouraging visitors with symptoms.
   - Providing tissues to residents and visitors who are coughing or sneezing so that they can cover their mouth and nose.
   - Residents with symptoms of respiratory infection should be discouraged from using common areas where feasible. Residents should have an adequate supply of tissues and covered sputum pots, as well as convenient and hygienic methods of disposing of these.
   - Ensuring that supplies for hand washing are available where sinks are located and providing dispensers of alcohol-based hand rubs in other locations.
   - Encouraging coughing persons to sit at least 1 metre away from others, if possible.

Droplet precautions
   - If possible symptomatic residents should be cared for in single rooms until fully recovered and at least five days after the onset of symptoms. If this is not possible then group together suspected flu residents with other residents suspected of having flu.
   - If possible, staff should work with either symptomatic or asymptomatic residents (but not both), and this arrangement should be continued for the duration of the outbreak.
   - Staff should use appropriate infection control precautions while dealing with affected residents e.g. gloves, single use apron etc.
   - The Health Protection Team will advise on the appropriate use of surgical masks.
Appendix 6

Scabies: Infection Control Precautions in Nursing and Residential Homes

**LAUNDRY**

Clothes, towels, and bed linen should be machine-washed after the first application of treatment, to prevent re-infestation and transmission to others. Items that cannot be washed can be kept in plastic bags for at least 72 hours to contain the mites until they die. This includes heat labile items.

Machine wash and dry bedding and clothing of scabies residents using the hot water and hot dryer cycles (60 degrees plus for linen and as tolerated by the clothing materials involved).

**ENVIRONMENT**

Soft furnishings, which have cloth coverings, should be kept out of use for 24 hours after treatment in order to allow the mites which may be on the fabric to die. These items should then be vacuumed.

Those covered in vinyl should be wiped down with a hard surface cleaner following treatment.

In cases of crusted (Norwegian) scabies vacuuming and damp dusting of the environment is essential.

**ISOLATION**

Residents with scabies do not normally require isolation. However, residents with crusted (Norwegian) scabies who are highly contagious require isolation precautions until treatment has been completed.

Aprons and gloves should be worn for personal care of known infected cases.

Further information on scabies:

www.patient.co.uk/health/scabies-leaflet
**Suggested Care Plan**

**Once Clostridium difficile is confirmed**

**Isolation**
- Isolate and barrier nurse in a single room (with ensuite wc if possible). Commodes and bedpans should be dedicated for the sole use of the affected resident whilst symptomatic.
- If it is difficult to isolate the resident due to their mental health needs, extreme care will need to be taken to make sure any spillages are cleaned immediately. It may be necessary to employ additional staff to help care for residents in isolation or who need one-to-one care.
- Continue to isolate until the resident has been free of symptoms and loose stools for 48 hours and passed a stool that is normal for them.
- The resident may come out of isolation once they have been free of symptoms and loose stools for 48 hours **and** have passed a stool that is normal for them.

**Monitoring of resident**
- Document a plan of care in the resident’s notes. Keep a written record of all monitoring carried out and care given, including a daily record of the resident’s condition and bowel movements.
- Monitor the resident’s condition carefully as this infection can cause rapid dehydration and rapid deterioration (within hours). **Patients who are systemically ill or have more profuse diarrhoea should be referred to hospital.**
- Residents who are ill need to be monitored hourly day and night.
- Keep a fluid balance chart, recording all drinks taken and the number of times the resident passes urine (and how much, if possible) and the number of times the resident has their bowels open.
- Record all bowel actions on a bowel chart, as per the Bristol Stool Chart.
- Record the resident’s temperature daily. Report to GP if outside normal limits.
- Monitor the resident for abdominal pain. Report to GP if pain develops.
- Monitor the resident’s blood pressure four hourly (this should always be done in nursing homes and if possible in residential care homes). Report to GP if outside normal limits.
- If the resident becomes confused, stops eating or if you are at all concerned inform the GP.
- Keep the resident and their relatives informed about their condition and why you are taking special precautions.

- If the resident is admitted to hospital, please call the hospital **before the resident arrives** so they can arrange immediate isolation and prevent a hospital outbreak. Call the infection control team or A&E ward Manager, as appropriate to time of day. **Tell the ambulance crew in advance.**

**Treatment**
- Request a GP visit to assess the resident.
- Treatment with antibiotics is usually required. The recommended therapy for mild disease is metronidazole 400mg three times per day for ten-14 days.
- Metronidazole is not always indicated for patients with very mild symptoms i.e. less than four liquid stools in 24 hours and not systemically unwell.
- The GP may stop treatment early if a rapid clinical response with full recovery is seen.
- If diarrhoea fails to respond after five days of treatment with metronidazole contact the GP. The GP may switch to oral vancomycin 125mg four times per day for a further ten days. The GP may wish to discuss treatment with the Consultant Microbiologist.
- The GP will decide whether any other antibiotics that the resident is taking should be stopped where it is safe to do so.

**Handwashing**
- Remember that alcohol gel does not work against C diff.
- Wash hands with soap and water.
- GPs and other visiting health care professionals must wash their hands.
- Visitors will need to wash their hands with soap and water on arrival and on leaving the resident’s room.
- Visitors should only go into their sick relative/friend’s room and should not go into other areas of the home whilst the resident has symptoms.
- As is usual best practice, ensure all residents are encouraged to wash hands with soap and water at appropriate times.
Appendix 7

Personal Protective Equipment (PPE)

- To be kept outside the resident’s room and put on before entering.
- Wear single use disposable gloves and aprons whilst caring for the affected resident, cleaning up diarrhoea and during environmental cleaning of affected areas.
- If there is no automated sluice machine and waste has to be emptied down the toilet, staff should wear gloves, aprons, face mask and eye protection whilst emptying and cleaning the commode or bed pan.
- Clinical waste bags should be placed inside the resident’s room for disposal or PPE.
- PPE to be used when handling contaminated linen.

Cleaning

The environment must be kept thoroughly clean to prevent spores spreading

- Declutter the resident’s room as much as possible, to assist in minimising contamination by spore.
- Food stuffs such as sweets, fruit and biscuits should be kept in air-tight containers in a cupboard.
- Clean the environment and any patient equipment twice a day with detergent, followed by a weak bleach solution (one part bleach to ten parts water solution) on areas that will tolerate bleach. Pay special attention to lavatories and commodes. Clean anything that is touched by hand – e.g. door handles, light switches, call bells, etc.
- All equipment (blood pressure monitors etc) should remain in the resident’s room for the duration of the illness.
- Treat all waste as clinical infected waste.
- When the resident has recovered and isolation has ceased, the resident’s room must be deep-cleaned. This means cleaning all curtains and soft furnishings, washing walls, cleaning all surfaces and steam cleaning the carpet.
- All surfaces and equipment must be cleaned with detergent followed by bleach solution (where bleach will not damage the surface) before being used elsewhere in the home.
- Consideration should be given to discarding items that cannot be cleaned by the above method.
**Recurrent disease**

C diff-associated diarrhoea recurs in around a third of cases and often requires further treatment. One recurrence is often followed by further recurrences and sometimes long-term treatments are used. New exposure to antibiotics is important in recurrence, especially cephalosporins and quinolones. Recurrence may be due to new strains of C diff rather than inadequate treatment of previous infection.

**Root Cause Analysis**

In line with Department of Health requirements all cases of C diff are followed up with a ‘root cause analysis’. This means that the resident’s care will be reviewed, to try and identify why the resident developed Clostridium difficile, It is a ‘non-blame’ process and is a way of learning lessons (nationally) and improving patient care. Following a confirmed case, the clinical commissioning group (CCG) will contact you to arrange the root cause analysis.

Produced by Liz Maddock and Sue Kingsbridge, surrey & Sussex Health Protection Unit www.hpa.org.uk
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**References**


**Antibiotic-resistant bacteria**

Residents may be transferred from hospital while colonised or infected with a variety of antibiotic-resistant bacteria, including Meticillin Resistant Staphylococcus Aureus (MRSA). 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 necessary 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.

Residents colonised with antibiotic resistant bacteria will not routinely require repeated sampling or treatment to clear their colonisation. The resident’s GP or the PHE local Health Protection Team will advise when this is appropriate.

If a resident, previously known to be colonised with antibiotic-resistant bacteria requires admission to hospital, the residents GP should include this information in the referral letter.

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 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.

Residents will need to be screened for MRSA colonisation on admission to hospital. The hospital or resident’s GP will advise on this and any subsequent treatment required.

Adapted from page 47/48 of Prevention and Control of Infection in Care Homes, Available at: https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published
Viral Gastro-Enteritis Information Sheet
Community & Consumer Services

Additional information on cleaning

**Disinfectants**

The virus is exceedingly hardy, and able to withstand the action of many chemical disinfectants.

There are two methods of killing the virus that is recommended:

- **Hypochlorite 1000ppm (parts per million)** solution. Bleach/hypochlorite is the only chemical for which there is strong evidence that it kills the virus, and it is therefore recommended that this is used to disinfect all hard surfaces, including all areas of the toilet, and any hand rails.

- **Heat.** There is evidence that the virus is killed at temperatures in excess of 60°C and above, and therefore steam cleaning at this temperature can be used to clean soft furnishings, i.e.: carpets and seat coverings.

**Hypochlorite 1000ppm (0.1%)**

The most economical method of obtaining a 1000ppm hypochlorite solution is to use normal household bleach. Household bleach is approximately 5% sodium hypochlorite, and therefore a 0.1% (1000ppm) solution can be obtained by diluting in a ratio of 1 part bleach to 50 parts cold water, e.g. 10ml bleach to 500ml cold water. Once diluted, it must be used within 24 hours or disposed of. **You must ensure that the surface is cleaned first with a detergent and water, as the disinfection process can be prevented by the presence of dirt and organic matter.** There are also other formulations, for example as tablets, which may be more convenient (because they clean and disinfect at the same time, so it is a one step process), but check with manufacturers regarding instructions to obtain a 1000ppm solution. E.g. Chlorclean, Sanichlor, Milton).

Areas that need to be cleaned and disinfected:

- **Priority:** All areas where people have had symptoms of diarrhoea and vomiting (the virus can aerosol up to 30 feet (9 metres) during a vomiting episode so all surfaces need to be cleaned)

- **Priority:** All toilets

- **Priority:** All communal areas, concentrating on the areas where people touch, i.e.: door handles, light switches.

- Any areas which could have been contaminated by infected waste or linen e.g. waste storage area, if a plastic bag has split, e.g. laundry room used to wash contaminated clothes or material.

Areas which are lower risk so could be left if no time/manpower available:

- **Low risk:** Rooms where no symptomatic people have been.

- **Very low risk:** Non-communal areas where no symptomatic people have been

If you require further information please contact the Food Safety Team on 01934 634634.
Your 5 moments for HAND HYGIENE

1. BEFORE PATIENT CONTACT
   WHEN: Clean your hands before touching a patient or their body fluids
   WHY: To protect yourself and the healthcare environment from harmful patient germs

2. BEFORE A SEPSIS TASK
   WHEN: Clean your hands immediately before any aseptic task
   WHY: To protect the patient against harmful germs on your hands

3. AFTER BODY FLUID EXPOSURE RISK
   WHEN: Clean your hands immediately after an exposure-risk body fluids
   WHY: To protect yourself and the healthcare environment from harmful patient germs

4. AFTER PATIENT CONTACT
   WHEN: Clean your hands after touching a patient or his/her immediate surroundings
   WHY: To protect yourself and the healthcare environment from harmful patient germs

5. AFTER CONTACT WITH PATIENT SURROUNDINGS
   WHEN: Clean your hands after touching any object or surface in the patient’s immediate surroundings
   WHY: To protect yourself and the healthcare environment from harmful patient germs