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Information Leaflets  
   - Norovirus  
   - MRSA  
   - Clostridium difficile
PREFACE

Protection of residents from infection is an important part of high quality care, and it also contributes to the safety of the environment for staff and visitors. The Regulation of Care (Scotland) Act 2001 requires care service providers to have appropriate procedures for the control of infection, and in March 2005 Infection Control in Adult Care Homes: Final Standards was published by the Scottish Executive in order to clarify what constitutes best practice in infection control in this setting. This guidance should be read in conjunction with the Standards. Each of the Standards in the Scottish Executive document is accompanied by a helpful audit tool. Managers should make full use of the audit tools to ensure that the home complies with best practice. If you need advice or clarification concerning the implementation of any of the Standards, please contact the Health Protection Team at NHS Highland.
1. INTRODUCTION

1.1 Why infection control is important

Many infections have the potential to spread in a care home, due to the sharing of eating and living accommodation, and the fact that residents may have an increased susceptibility to infection due to various factors:

♦ Age
♦ Immune status
♦ Poor nutrition
♦ Underlying medical conditions such as cancer, diabetes, heart problems
♦ Antibiotic therapy
♦ Incontinence
♦ Indwelling medical devices such as urinary catheters or gastric feeding tubes
♦ Breaks in the skin

Infection control has also become more important due to the increasing numbers of organisms that have become resistant to treatments such as meticillin resistant Staphylococcus aureus (MRSA), Clostridium difficile, the emergence of relatively new organisms such as E.coli O157, and the potential for the spread of blood borne viruses.

Healthcare-associated infections may worsen underlying medical conditions and lead to avoidable admission to hospital, and may occasionally be life-threatening.

Prevention of infection is everyone’s business!

1.2 Who is there to help?

The Health Protection Team of NHS Highland is based within the Public Health Department at Assynt House, Beechwood Park, Inverness. See below for contact details. Advice and guidance is available from the Consultant in Public Health Medicine (Health Protection) who has responsibility for the prevention, surveillance, investigation and control of communicable disease in the Highlands, and the Health Protection Nurse Specialists.

Advice and guidance can be given on all matters relating to infection control, including disinfection, laundry, waste management, and individual client management.

You may also have concern when individuals, either clients or staff, suffer from specific infectious diseases. The following list gives some examples of infections, the occurrence of which may mean you wish to consult the Health Protection Team:

♦ Blood borne viruses (HIV, Hepatitis)
♦ Campylobacter
♦ Clostridium difficile
♦ E.coli O157
♦ Influenza
♦ Legionnaires disease
♦ Lice
♦ MRSA
♦ Salmonella
♦ Scabies (in either residents or staff)
♦ Streptococcal infections
♦ Tuberculosis
♦ Varicella zoster (shingles or chicken pox)

Contact details:

Consultant in Public Health Medicine ((Health Protection)):
Dr Ken Oates

Health Protection Nurse Specialists:
Helen Tissington
Lorraine McKee

Tel: 01463 704886

Environmental Health

Your local Environmental Health office can provide information and advice on food safety. They can be contacted through your local Council Service Point or by emailing env.health@highland.gov.uk if you are in Highland Council Area, or envhealth@argyll-bute.gov.uk if you are in Argyll & Bute.

Other sources of information

NHS Highland provides a range of guidance about communicable disease which can be accessed at: www.nhshighland.show.scot.nhs.uk
Follow the links All Services A-Z/Health Protection Team.
You will find leaflets about various gastro-intestinal diseases, and also Guidelines for the Management of Scabies.
2. **THE CHAIN OF INFECTION**

In order for infection to occur several things have to happen. This is often referred to as the *Chain of Infection*. The six links in the chain are:

- **Infectious Agent** – or the microorganism which has the ability to cause disease

- **The Reservoir** or source of infection where the microorganism can thrive. This may be a person, an animal, any object in the general environment, food or water.

- **The Portal of Exit** from the reservoir. This describes the way the microorganism leaves the reservoir. For example, in the case of a person with flu, this would include coughing and sneezing. In the case of someone with gastro-enteritis microorganisms would be transmitted in the faeces.

- **The Mode of Transmission.** This describes how microorganisms are transmitted from one person or place to another. This could be via someone’s hands, on an object, or through the air.

- **The Portal of Entry.** This is how the infection enters another individual. This could be landing on a mucous membrane, being breathed in, entering via a wound, or a tube such as a catheter.

- **The Susceptible Host.** This describes the person who is vulnerable to infection.

Infections can be prevented by breaking the *Chain of Infection*. The following page illustrates the Chain, and gives examples of actions that can be taken to break it. The overall aim of Standard Infection Control Precautions is to break the Chain.
THE CHAIN OF INFECTION & HOW TO BREAK IT

INFECTION

AGENT
Bacteri, fungi, viruses & protozoa

Rapid, accurate identification of organisms

RESERVOIRS
People, equipment, food & water

Thorough cleaning of the environment & equipment

Disinfection & sterilisation

Ensure staff are healthy & immunised

SUSCEPTIBLE HOST
Underlying illness, surgery

Recognition & protection of high-risk patients

Use of PPE

Hand hygiene

Safe handling of blood & body fluids, cough etiquette etc

PORTAL OF ENTRY
Mucous membranes, broken skin etc

Aseptic Technique

Safe handling and disposal of waste

Catheter Care

Rapid, accurate identification of organisms

MEANS OF TRANSMISSION
Direct contact, objects, contaminated food, air

Isolation when appropriate

Wound Care

Safe handling

Uninfected environment

Hand Hygiene

Disinfection & sterilisation

Ensure staff are healthy & immunised

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3. STANDARD INFECTION CONTROL PRECAUTIONS

3.1 What are Standard Infection Control Precautions (SICPs)?

SICPs are core measures that should be used at all times, in all care settings, by all carers. They are based upon the assumption that every individual could be carrying potentially harmful microorganisms and that there is the potential for transmission.

There are nine elements:

♦ Hand hygiene
♦ Use of personal protective equipment
♦ Prevention of occupational exposure
♦ Management of blood and body fluid spillage
♦ Cleanliness of care equipment
♦ Cleanliness of the environment
♦ Safe handling of linen
♦ Safe handling of waste
♦ Patient placement

In all situations you must assess the risk of the task that you are doing, and not the risk of the patient.

3.2 Transmission Based Precautions

In some situations it may be necessary to use additional infection control precautions know as Transmission Based Precautions. Appropriate advice can be obtained from the Health Protection Team.
4. HAND HYGIENE

4.1 What are your hands carrying?

In any care setting, hand hygiene is the most important activity for preventing the spread of infection from one person to another.

Microorganisms found on hands may be categorised as either “resident” or “transient”. Resident organisms live within the epidermis (for example in hair follicles and sweat glands) and they protect the skin from invasion by more harmful microorganisms. They are not easily removed.

Transient organisms are found on the surface of the skin, and they are transferred by direct contact with other people, equipment or other body sites. As their name implies, who and what a person touches in the course of the day will determine which micro-organisms are on their hands. There are certainly lots of opportunities to pick up micro-organisms. They are an important cause of cross-infection, but the good news is that they are easily removed by good handwashing.

4.2 When should you decontaminate hands?

The following list gives some examples of when hands should always be decontaminated:

- When you arrive at work
- Before preparing, handling or eating food
- After using the toilet
- Whenever hands are visibly dirty
- Immediately before giving personal care to a resident
- Between giving care to different residents
- After bed making
- Before putting on gloves
- After removing protective clothing, e.g., gloves
- After any activity which may result in contamination of the hands
- Before preparing/giving medication
- After any situation that involves direct contact with resident, e.g. bathing, assisting to move, toileting.
- After handling blood or other body fluids
- Before and after emptying urine drainage bags
- After handling laundry and waste
- Before leaving work
4.3 Routine hand hygiene

Choice of cleansing agent

The product chosen must be acceptable to the users, and not have a detrimental effect upon the skin of carers.

In most care settings, handwashing with liquid soap (preferably one that contains an emollient) and water is adequate.

You do not need to use harsh antiseptic soaps as these may make your hands sore with repeated use, and sore hands are more likely to transmit infection.

Liquid soap dispensers should be wall mounted, maintained regularly, and operated by elbow or wrist. The dispenser should have individual cartridges that are discarded when empty in order to reduce the chance of accidental contamination. Do not re-fill bottles.

Ideally, wash basins used by staff should have taps that are wrist, elbow or foot operated.

Soft user-friendly paper towels should be provided for drying, in wall mounted holders that are easy to use and clean.

You may wish to make laminated copies of the 6 Steps of Hand Washing on page 10 and display at all sinks. You can download a colour version in the electronic edition of this document from www.nhshighland.scot.nhs.uk

Correct Technique

♦ Wet hands under running water (this helps to prevent the soap from irritating your skin)
♦ Dispense one dose of soap into cupped hand
♦ Handwash for 10-15 seconds vigorously and thoroughly, without adding more water
♦ To ensure that all skin surfaces are washed follow the 6 Steps of Hand Washing on page 10. Each step consists of five strokes forward and five strokes backward.
♦ Rinse hands well under running water to remove the soap and the micro-organisms that you’ve loosened.
♦ Dry thoroughly with a disposable paper hand towel. Drying well removes lots more micro-organisms
♦ Dispose of paper towel into bins with foot-operated pedals. Do not touch the bin with hands
General principles

♦ Keep nails short and clean
♦ Don’t use nail brushes as scrubbing the skin may damage the surface leading to an increased risk of picking up micro-organisms
♦ Do not wear false nails or nail polish
♦ Avoid wearing jewellery. If you wear a wedding ring wash beneath it to remove any bacteria lurking underneath.
♦ Don’t wear a wristwatch or else you will be tempted not to wash far enough up your wrists. (Remove wrist watch and jewellery before starting work)
♦ Keep your hands in good condition. Sore chapped hands will have millions more germs in the cracks that will be difficult to remove.
♦ Use your own hand cream or a pump-action communal one. Never use tubs of cream that everyone puts their hands into – they grow bacteria really well!
♦ Ensure adequate facilities. Wash hand basins in residents’ rooms should be equipped for hand washing by both residents and carers

Use of alcohol gel

Alcohol handrubs may be useful in some situations when caring for people in the community, but are not recommended for routine use in care homes.

They should be applied using the illustrated 6 Steps technique until the hands are dry. After using on a maximum of five consecutive occasions hands require to be washed with soap and water in order to prevent a build up of residue on the hands.

They must never be used when hands are visibly dirty as organic material can inactivate the alcohol.

4.4 Protection of broken skin

Cuts and abrasions on the hands and forearms should be covered with a waterproof dressing which should be renewed whenever necessary. Avoid invasive procedures if suffering from chronic lesions on hands. Seek medical advice for skin conditions that may be affected by work, including conditions such as eczema and possible allergic reactions.
6 Steps of Hand Washing

Remove any hand and wrist jewellery

1. Wet hands
   - Apply soap
   - Rub hands palm to palm

2. Rub right palm over back of left hand
   - Rub left palm over back of right hand

3. Rub hands palm to palm with fingers interlaced

4. Backs of fingers to opposite palm with fingers locked

5. Rotational rubbing of thumb clasped within palm
   - Repeat for other hand

6. Group fingers together
   - Rub finger tips rotationally in palm of opposite hand
   - Repeat for other hand
   - Rinse hands

Remember

- Dry hands thoroughly with paper towels
- Use foot pedal operation of bin to dispose of used paper towels
- Always cover cuts on hands with a waterproof dressing
- The appropriate use of hand creams can help to prevent hands from becoming dry

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5. PERSONAL PROTECTIVE EQUIPMENT

The use of Personal Protective Equipment (PPE) is essential for health and safety, and offers protection both to residents and carers. PPE is worn in addition to your normal work clothes, whether these are your own or a uniform. Inevitably, the clothes that one wears will become contaminated with microorganisms in the course of the day. However, if PPE is utilised when appropriate then there is little evidence that contamination of clothing plays a major role in the transmission of infection.

PPE includes:

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

In considering what protective clothing might be necessary in any situation it is necessary to carry out a risk assessment. This means asking whether the task you are about to perform gives rise to any possibility of contact with blood or other body fluids. If the answer is yes, then appropriate protective clothing is necessary.

5.1 Gloves

The need for gloves and the selection of appropriate ones must be subject to careful risk assessment. This will involve consideration of the actual task to be carried out, and the potential risks to both the resident and carer.

Gloves must be worn when there is a possibility that your hands will have contact with blood or other body fluids, or organic matter such as faeces. Please refer to the two algorithms:

- Risk assessment and glove use (page 15)
- Glove selection (page 16)

Key Points

- Gloves should neither be re-used nor washed. Liquids may penetrate through microscopic holes in the glove, and the glove may also be damaged if it comes into contact with oils or silicone based lotions, disinfectants or alcohol gel
- Wear gloves only when necessary
- Gloves are not a substitute for handwashing
- Vinyl gloves are suitable for personal care, but they are not suitable for contact with blood or blood-stained fluids
- There is a growing incidence of latex allergy, and latex glove use is the single biggest risk factor. Nitrile gloves should therefore be provided, in preference to latex ones. Never use latex gloves that contain powder, as this increases the risk of allergy
♦ Gloves should be changed after contact with each patient and at the end of each procedure:
  • Bear in mind that it may be necessary to change gloves between tasks on the same resident to prevent cross-contamination
  • Gloves worn for a specific task must be removed before touching uncontaminated areas, or for example, writing in notes

**Removing gloves**

The wrist end of the glove should be held and the glove pulled down gently over the hand, turning it inside out whilst doing so. Dispose of the gloves immediately into a pedal operated disposal bin.

Wash hands immediately.
Risk assessment and glove use:

Are gloves really necessary?

Gloves are NOT required for procedures where there is a minimal risk of cross-infection between patients and staff, e.g.:
- Basic care procedures without contact with blood or body fluids
- Transferring food from food trolleys to patient bedside
- Making uncontaminated beds/changing or removing residents uncontaminated clothing
- Taking recordings (BP, temp, pulse)

Don't wear gloves

Gloves ARE required for procedures where there is a risk of cross-infection between patients and staff and further risk assessment should be carried out.

Is there a high risk of exposure to blood and body fluids?

- yes
  - Is a sterile field required?
    - yes
      - Sterile nitrile
    - no
      - Non-sterile nitrile or synthetic glove with equivalent barrier properties

- no
  - Non-sterile vinyl
Glove Selection

TYPE OF ACTIVITY

- Cleaning by General Services staff
- Food handling, preparation, serving
- General cleaning room
- Blood-borne virus exposure/spillage
- Colour-coded marigolds
- Vinyl
- Non-sterile nitrile
- Polythene
- Non-sterile vinyl
- Non-sterile nitrile
- Sterile nitrile Examination gloves

Tasks where there is a low risk of contamination, non-invasive clinical care, or environmental cleaning e.g.
- Oral care
- Emptying catheter drainage bags
- Emptying urinals/bedpans and suction jars
- Handling low risk specimens
- Clinical cleaning
- Dressing wounds when contact with blood/body fluids is unlikely e.g. gastrostomy dressings
- Applying creams
- Touching patients with unknown skin rash/scabies/shingles
- Making beds/changing clothing of patients in isolation

Procedures involving high risk of exposure to BBVs and where high barrier protection is needed e.g.
- Potential exposure to blood/body fluids e.g. blood spillages, faecal incontinence, blood glucose monitoring, administering enemas/suppositories and rectal examinations
- Handling cytotoxic material
- Handling disinfectants
- Venepuncture/cannulation
- Basic care and specimen collection procedures on patients known or suspected to be high risk of BBV

Procedures which require a sterile field and high barrier protection e.g.: Insertion of urinary catheters
5.2 Aprons

Plastic disposable aprons should be worn whenever there is a possibility of contact with blood/body fluids.

A separate one should be worn for each occasion of care given to each individual resident. Never reuse or wash single-use disposable aprons.

Change aprons between caring for different residents, and between different tasks for the same resident, if necessary to prevent cross-contamination.

Removal of aprons

Remove apron promptly after use by turning the outer contaminated side inward and rolling into a ball. Dispose of immediately into a pedal operated bin.

Wash hands.

Colour coding

It is a good idea to use different coloured aprons for different types of tasks. For example, use white ones when required for personal care, and pink ones for food handling and feeding residents. Another colour can be worn for domestic activities. This is especially important when the same staff are undertaking different types of tasks.

5.3 Face mouth/eye protection

It is unlikely that face, mouth/eye protection will be required routinely in the Care Home setting. One possible exception to this is the use of masks during a flu pandemic.
6. PREVENTION OF OCCUPATIONAL EXPOSURE

All Care Homes should have policies in place to ensure that staff are protected from occupational exposure to micro-organisms, particularly those that may be found in blood and body fluids. Residents must also be protected from any communicable diseases that staff may have.

6.1 Skin care

If any worker has a skin condition that may be affected by work, or has the potential to affect residents or colleagues then they must seek medical advice from their General Practitioner.

If an allergic reaction to any product used in the work environment is suspected this must be investigated by the individual’s general practitioner. It is the responsibility of the employer to provide a suitable alternative in order to ensure safe working practice.

6.2 Blood borne viruses and sharps

In NHS settings, sharps injuries are one of the most common types of injury to be reported to Occupational Health Departments. The greatest risk of a blood borne virus (BBV) being transmitted is as a result of a sharps injury, especially those resulting from injury with a hollow bore needle where blood may remain. Transmission of BBVs may also result from contamination of mucous membranes with splashes of blood/body fluids. There is NO evidence that BBVs can be transmitted through intact skin.

In theory there is a risk of a blood borne infection being transmitted either from a member of staff to a resident, or from a resident to a carer. In practice, employees are unlikely to be undertaking procedures that present a risk to residents.

What are sharps?
Sharps include items such as needles, blood glucose lancets, ampoules, used razor blades and disposable razors that may be contaminated with blood or other body fluids.

Sharps boxes
Sharps boxes must be of a type UN approved, correctly assembled and never be over-filled, i.e. above the manufacturer’s fill line, or ¾ full. The container must be puncture resistant and leak proof. It must be stable and provided with a handle and an aperture which will inhibit the removal of the contents, but will ensure that it is possible to dispose of items using one hand.

Sharps containers must be kept off the floor, away from children, and inaccessible to unauthorised persons.

Complete the label on the container as required when it is brought into use, and again when full, prior to disposal.
When ¾ full it must be sealed, the label properly completed, and sent for disposal as clinical waste.

**It is the responsibility of the person using the sharp to dispose of it correctly.**

**Use of sharps**

- Wear gloves when handling sharps
- Discard all sharps into a sharps container at the point of use.
- Never leave needles or any other sharps lying around
- Always request assistance when using sharps with an uncooperative client
- Never walk about with unguarded sharps
- Never re-sheath needles
- Discard syringe and needle as one unit.
- Do not pass an exposed sharp to another person
- Do not dispose of wrappers, cotton wool, etc in sharps boxes as this may prevent the sharps being dropped in directly, and cause an injury if someone tries to force a sharp in.
- Never remove items from a sharps container
- Dispose of sealed sharps containers as clinical waste

**Sharps/Inoculation Injuries**

A sharps/inoculation injury is when someone else’s blood or body fluid gains access to your blood or tissue. This may be caused by:

- A cut or puncture of your skin by a contaminated sharp
- Contamination of staff wounds by a resident’s blood or body fluid
- Bites which break the skin
- Body fluids splashed into the eye or mouth may also (rarely) transmit infection

*Remember – all sharps injuries are potentially preventable*

**Action to take in the event of a sharps/inoculation injury:**

- Bleeding from a small wound should be promoted for a few seconds by gently squeezing the surrounding skin. Do not suck or scrub
- Wash the wound with warm running water and liquid soap
- Cover wound with a waterproof dressing
- If the eyes are contaminated irrigate for 2 minutes with normal saline or running water. If contact lenses are worn, irrigate both before and after removal
- Contaminated mucus membrane (e.g., nose, mouth) should be washed with plenty of water.
- Report the injury to the person in charge
- Record the incident (see Appendix 1 for sample form)
Assessing the risk

♦ Unused/clean sharp – definitely no risk of infection, (except from the microorganisms on your own skin). Record incident, but no further action.
♦ Used/dirty sharp – source known or unknown, also human bite/scratch/mucus membrane splash. Seek professional advice from Accident and Emergency Department at local hospital or your General Practitioner. This should be within one hour of the incident having taken place.

In a hospital setting, the risk of acquiring a blood borne virus as the result of a sharps/inoculation injury from a source known to be infected has been estimated as follows:

♦ Hepatitis B - around one in three
♦ Hepatitis C - around one on 30
♦ HIV - around one in 300

This means that the risk of acquiring an infection from a sharp/inoculation injury in a low risk population, even when the infection status of the source is unknown, is minuscule. However, this must not be used as a reason for complacency in sharps management.

6.3 Hepatitis B immunisation

Hepatitis B immunisation is recommended for all healthcare workers who may have direct contact with individuals’ blood, blood-stained body fluids or tissues.

All staff of residential and other accommodation for those with learning difficulties should also be offered immunisation as higher rates of hepatitis B carriage has been found in certain groups of people with learning difficulties in residential accommodation.

When immunisation is required, the cost must be borne by the employer.

There are no vaccines which protect against hepatitis C or HIV.

6.4 Other immunisations

It is regarded as good public health practice for everyone to be fully immunised. Staff should be asked to consult their GPs to ensure that they are up-to-date with all immunisations and arrange boosters if necessary.

The Scottish Government Health Department recommends that all those involved in direct care should be immunised annually against influenza. This is the responsibility of the employer to arrange and fund. However, staff should be encouraged to be immunised, for the following reasons:

♦ They personally benefit, as they reduce their chances of becoming ill
♦ The organisation benefits because there is reduced absenteeism, and last but not least,
Residents benefit because they are doubly protected

6.5 Protection against tuberculosis

BCG vaccination should be offered to previously unvaccinated Mantoux negative staff in care homes for elderly people who are younger than 35 years of age. Please contact the Health Protection Team if you required advice on this.

Pen Injection devices

Pen injection devices are intended to be used by patients for the self-administration of medication such as insulin. These devices are for patient self-administration only. To avoid the risk of needle stick injury, healthcare workers should not use pen injection devices to administer medication to patients (Scottish Healthcare Supplies 2005). Residents of care homes should be prescribed insulin that is available in vials, and normal disposable syringes and needles used for administration.
7. MANAGEMENT OF BLOOD AND OTHER BODY FLUID SPILLAGES

Spillages of blood, body fluids and excreta may be hazardous to health and should be cleaned up promptly.

A disposable plastic apron and gloves must be worn when dealing with all blood/body fluid spillages.

7.1 Equipment required for dealing with a spillage of blood

- PPE – gloves and apron
- Waste bag
- Disposable towels and disposable scoop if appropriate
- Disinfectant (Solution or granules containing sodium hypochlorite or sodium dichlorisocyanurate with a concentration of 10,000 ppm available). Ensure adequate ventilation when using these disinfectants.
- Warm water and general purpose detergent

Using granules:

- Put on apron and gloves
- Cover spillage with granules
- Leave for 2 minutes (or as recommended by manufacturer) before clearing up with paper towels and/or disposable scoop
- Wash area with general purpose detergent and warm water and paper towels, rinse and dry.
- Discard disposables as clinical waste
- Wash hands

Using sodium hypochlorite solution:

A fresh aqueous solution must be prepared. The concentration used must be equivalent to 10,000 parts per million (ppm) available chlorine. In general this corresponds to 1:5 dilution of household bleach (or 1:2 Milton 2%) but it is emphasised that the strength of individual proprietary brands of bleach may vary and that hypochlorite may deteriorate in storage.

- Put on apron and gloves
- Cover spillage with disposable paper towels
- Gently soak paper towels with solution
- Leave for 2 minutes (or as recommended by manufacturer) and then dispose of as clinical waste
- Wash area with general purpose detergent and warm water, and paper towels; rinse and dry
- Discard all disposables as clinical waste
- Wash hands
Unless the risk is high, if the spillage is on carpet or soft furnishings, omit the use of disinfectant. Ensure that the area is thoroughly cleaned with warm water and detergent, and that it is allowed to dry before further use.

### 7.2 Spillages of Pus, Sputum, Faeces and Vomit

If visible blood is present, treat as above for blood spillage.

If no visible blood present:

- Put on apron and gloves
- Remove spillage with disposable paper towels
- Wash area with general purpose detergent and warm water, rinse and dry.
- Discard disposables as clinical waste
- Wash hands

### 7.3 Spillage of Urine

Chlorine releasing agents added to acidic body fluids such as urine may result in a rapid release of toxic levels of chlorine, therefore follow instructions as per 5.2 “If no visible blood is present”.

If blood is visible, after removal of the spillage, disinfect the surface with sodium hypochlorite aqueous solution prior to washing with hot water.
8. CLEANLINESS OF CARE EQUIPMENT

Cleaning, disinfection and sterilisation are all methods of decontamination that reduce or destroy contaminants, thereby preventing microorganisms from reaching a site where they might cause harm.

**General good practice**
- All equipment must be clean, fit for purpose, and in a good state of repair
- All equipment must be stored in an appropriate area
- Before purchasing any new equipment, ensure that it can easily be decontaminated and recommended cleaning solutions are available
- If there are items of equipment that are not routinely cleaned on a daily basis, there should be a written cleaning schedule and records kept of cleaning undertaken

8.1 Cleaning

Cleaning physically removes the organic material on which microorganisms feed, and will also reduce the load of microorganisms. It is suitable for equipment that comes into contact only with intact skin. It is also essential prior to disinfection and sterilisation.

**How to clean**
- Wear protective clothing, i.e., apron and gloves
- Prepare a fresh cleaning solution appropriately diluted for each task.
- Make up only the quantity required in a clean dry container.
- Some cleaning products are incompatible; only mix if advised by manufacturer.
- Use warm water, a general purpose detergent and disposable cloths or disposable paper towels. It is **not** necessary to use cleaning products that are advertised as being antibacterial
- Change the solution frequently to prevent a build-up of soil or micro-organisms which would recontaminate surfaces.
- Air drying is acceptable for large surfaces, but small areas should be dried with clean disposable paper towels/cloths
- Dispose of cleaning solution promptly in a sluice or dirty utility area
- Remove protective clothing and wash hands before carrying out other duties.

8.2 Single use and reuse items

Certain devices, e.g., nebulisers, may be used a number of times by the same resident, and are described as being appropriate for “single patient use”. However, other devices are designated for “single use”, and as such, must not under any circumstances be reused. (MHRA 2000).
8.3 Disinfection

Disinfection is a process additional to cleaning. It does not kill all micro-organisms, but reduces their number to a level which is not harmful to health.

It is suitable for items that come into contact with mucous membranes, infectious material, blood and other body fluids. It is not required for items that have only been in contact with intact skin.

Disinfectants are readily inactivated by dirt or body fluids and therefore thorough cleaning before disinfection is essential.

When is disinfection necessary?

Disinfection is necessary when items:

♦ are contaminated by blood or body fluids, and/or
♦ come into contact with mucous membranes

How to disinfect

There are two common methods of disinfection; physical and chemical. Physical disinfection is the application of heat – for example the bedpan washer-disinfector. The method of chemical disinfection that is recommended for use in care homes is use of a chlorine releasing agent.

There are two widely used chlorine releasing agents, suitable for use on inanimate surfaces:

♦ NaDCC (sodium dichloroisocyanurate) – e.g. Presept or Haz-tabs
♦ NaClO (sodium hypochlorite) – e.g. Milton

NaDCC is available as tablets, granules or powders, and some also contain a compatible detergent. It is preferred to NaClO because it is:

♦ Easier to prepare
♦ Slightly more efficacious
♦ Less damaging to surfaces

Different concentrations are required in different circumstances, and it is usual to describe the required concentration in “parts per million”, abbreviated to “ppm”. See chart below:

<table>
<thead>
<tr>
<th>Dilution</th>
<th>NaDCC</th>
<th>NaClO</th>
</tr>
</thead>
<tbody>
<tr>
<td>10,000ppm</td>
<td>2×5.0g tabs in 500 mls water</td>
<td>1:2 Milton 2% sterilising fluid</td>
</tr>
<tr>
<td>1,000ppm</td>
<td>2×0.5g tabs in 500 mls water</td>
<td>1:20 Milton 2% (50ml Milton made up to 1 litre of water.</td>
</tr>
<tr>
<td>125 ppm</td>
<td></td>
<td>1:160 Milton 2% (15ml Milton made up to 2.4 litres of water)</td>
</tr>
</tbody>
</table>
Chlorine releasing agents should be diluted with **cold** water. Once prepared, the solution should be used within the time stipulated by the manufacturer or discarded. After disinfection the item/surface must be polished dry using a paper towel.

### 8.4 Sterilisation

Sterilisation is a process that destroys or removes all living micro-organisms including bacterial spores. It is recommended for all items that penetrate intact skin or mucous membranes, and enter vascular systems or sterile body cavities. It will not be undertaken within care homes, though sterile items may be used.
## A-Z DECONTAMINATION POLICY

<table>
<thead>
<tr>
<th>Item</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Auriscopes</strong></td>
<td>Disposable auriscope speculae are available and should be used.</td>
</tr>
<tr>
<td></td>
<td>Non-disposable speculae:</td>
</tr>
<tr>
<td></td>
<td>Wash with detergent and hot water, rinse, then disinfect with NaDCC solution</td>
</tr>
<tr>
<td></td>
<td>(125ppm) for 1 hour, rinse and dry thoroughly.</td>
</tr>
<tr>
<td><strong>Bath hoists and slings</strong></td>
<td>Clean with detergent and hot water. Dry thoroughly.</td>
</tr>
<tr>
<td></td>
<td>Remove footrests when not in use to allow for drying of insertion channels.</td>
</tr>
<tr>
<td></td>
<td>Hoist slings should be for single patient use only, disposable, or laundered</td>
</tr>
<tr>
<td></td>
<td>between use.</td>
</tr>
<tr>
<td><strong>Baths, sinks, washbasins</strong></td>
<td>Clean with detergent or cream cleanser and hot water.</td>
</tr>
<tr>
<td></td>
<td>After bathing infected patients or patients with open wounds, or where there</td>
</tr>
<tr>
<td></td>
<td>has been contamination with blood or body fluids:</td>
</tr>
<tr>
<td></td>
<td>Use non-abrasive chlorine releasing granules, or disinfect with a paper towel</td>
</tr>
<tr>
<td></td>
<td>soaked in NaDCC solution (1000ppm).</td>
</tr>
<tr>
<td><strong>Bed accessories</strong></td>
<td>Wash with detergent and hot water. Dry thoroughly.</td>
</tr>
<tr>
<td></td>
<td>If contaminated with body fluids, wipe with paper towel and hypochlorite</td>
</tr>
<tr>
<td></td>
<td>1000 ppm solution.</td>
</tr>
<tr>
<td><strong>Bed frames</strong></td>
<td>Wash with detergent and hot water. Dry thoroughly.</td>
</tr>
<tr>
<td></td>
<td>Domestic staff should clean bedframes on a weekly basis.</td>
</tr>
<tr>
<td><strong>Beds (specialised)</strong></td>
<td>Refer to manufacturers guidelines.</td>
</tr>
<tr>
<td><strong>Bedpans and bases</strong></td>
<td>If a washer/disinfector is available process at 80° for one minute. Otherwise</td>
</tr>
<tr>
<td></td>
<td>clean with detergent and hot water after each use.</td>
</tr>
<tr>
<td></td>
<td>Clean with hypochlorite 1000ppm if soiled.</td>
</tr>
<tr>
<td></td>
<td>Residents with infective diarrhoea: If heat disinfection not available, use</td>
</tr>
<tr>
<td></td>
<td>hypochlorite (1000ppm), and ensure the same pan is always used for that</td>
</tr>
<tr>
<td></td>
<td>particular resident.</td>
</tr>
<tr>
<td><strong>Bowls (washing)</strong></td>
<td>Each resident should have his or her own bowl. Between uses, clean with hot</td>
</tr>
<tr>
<td></td>
<td>water and detergent, dry with paper towel and store inverted.</td>
</tr>
<tr>
<td><strong>Combs, brushes, clippers</strong></td>
<td>Should be for single patient use only.</td>
</tr>
<tr>
<td></td>
<td>Clean clippers with alcohol impregnated wipe after use.</td>
</tr>
<tr>
<td><strong>Commodes</strong></td>
<td>Wash with hot water and detergent.</td>
</tr>
<tr>
<td></td>
<td>Use chlorine solution (1000ppm) if visibly contaminated.</td>
</tr>
<tr>
<td><strong>Crockery and cutlery</strong></td>
<td>Machine wash, using final rinse water at 80°. Or, hand wash with detergent</td>
</tr>
<tr>
<td></td>
<td>and hot water, followed by hot rinse and air dry.</td>
</tr>
<tr>
<td><strong>Curtains</strong></td>
<td>Launder six monthly or when visibly contaminated. (Keep a record)</td>
</tr>
<tr>
<td><strong>Drainage bags</strong></td>
<td>Empty contents in sluice or toilet. Dispose of bag as clinical waste.</td>
</tr>
<tr>
<td><strong>Dressing trolleys</strong></td>
<td>Clean with hot water and detergent. Dry thoroughly.</td>
</tr>
<tr>
<td><strong>Ice-making machines</strong></td>
<td>Contact Health Protection Nurse Specialist if you have one or are intending</td>
</tr>
<tr>
<td></td>
<td>to purchase one.</td>
</tr>
<tr>
<td><strong>Jugs for emptying catheters</strong></td>
<td>Use disposable ones, or clean in washer-disinfector between use.</td>
</tr>
<tr>
<td>Item</td>
<td>Instructions</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mattresses and pillows</td>
<td>Enclose in an appropriate plastic cover. Wash with hot water and detergent. After infected resident: use hypochlorite solution (1000ppm). If filling becomes contaminated they must be destroyed.</td>
</tr>
<tr>
<td>Nail brushes</td>
<td>Communal ones should not be used. Single use disposable brushes should be available for use in the catering department.</td>
</tr>
<tr>
<td>Nebulisers</td>
<td>Replace mask and tubing monthly. Between uses, wash in hot water and detergent. Dry with disposable towel</td>
</tr>
<tr>
<td>Razors</td>
<td>Disposable razors should be disposed of as sharps. Electrical ones must be for individual patient use only.</td>
</tr>
<tr>
<td>Showers</td>
<td>If not used regularly, flush the system for 2 minutes weekly.</td>
</tr>
<tr>
<td>Stethoscopes</td>
<td>Clean diaphragm between residents with alcohol wipe. Clean ear pieces likewise between staff. Keep in patient’s room for individual use in cases of infection.</td>
</tr>
<tr>
<td>Thermometers</td>
<td>Tympanic thermometer should be used when possible. Electronic and rectal thermometers must be covered with a disposable sheath. Glass mercury thermometers: Wash in warm water and detergent, dry thoroughly and store dry.</td>
</tr>
<tr>
<td>Toilet bowls</td>
<td>Clean at least daily with hypochlorite powder.</td>
</tr>
<tr>
<td>Toilet seats</td>
<td>As for commodes.</td>
</tr>
<tr>
<td>Wash basins</td>
<td>Use cream cleanser.</td>
</tr>
</tbody>
</table>
9. CLEANLINESS OF THE ENVIRONMENT

The Care Home environment should be visibly clean, free from dust and soilage to be acceptable to residents, their visitors and staff.

Regular and efficient cleaning is necessary to maintain the appearance and function of the premises; it is also required to control the microbial population and to prevent the transfer of potentially infectious material.

It is important that the chosen method of cleaning should remove the contamination, and not merely redistribute it.

9.1 Floors

Generally, for hard surfaces wet cleaning methods are preferable to dry ones, as with dry methods there is risk of dispersal into the air of micro-organisms. Moist surfaces encourage bacterial growth, and thorough drying is part of the cleaning process. Impervious flooring should be washed using a neutral detergent and a mop with a detachable, launderable head. Change mop heads daily and send to laundry in an alginate bag. Mop buckets must be washed daily after use, and stored dry and inverted.

If dry dusting of floors is carried out it must be with a dust attractant mop to ensure no dispersal of bacteria.

Vacuum cleaning (with a three stage filtration) is suitable for carpets.

Other hard surfaces

Cleaning with household detergent and hot water remains the most effective method of removing contamination including microorganisms, and therefore damp dusting with disposable paper towelling should be the norm for all hard surfaces. Do not use refillable spray cleaners as they provide a breeding ground for microorganisms.

Points to remember:

♦ Wear protective clothing, i.e., apron and gloves
♦ Prepare a fresh cleaning solution appropriately diluted for each task.
♦ Make up only the quantity required in a clean dry container.
♦ Some cleaning products are incompatible; only mix if advised by manufacturer.
♦ Change the solution frequently to prevent a build-up of soil or micro-organisms which would recontaminate surfaces.
♦ Dispose of cleaning solution promptly in a sluice or dirty utility area
♦ Ensure that equipment is stored clean, dry and in the designated place.
♦ Remove protective clothing and wash hands before carrying out other duties.

9.2 Colour coding

Colour coding of cleaning equipment has been adopted in many NHS settings, and you may wish to consider adopting this practice. It is especially useful if you have staff that also work in the NHS. See chart on the following page.
NATIONAL COLOUR CODING SCHEME FOR CLEANING MATERIALS AND EQUIPMENT

All cleaning items, for example, cloths (re-usable and disposable), mops, buckets, aprons and gloves, should be colour coded. This also includes those items used to clean catering departments.

**Red**
Bathrooms, washrooms, showers, toilets, basins and bathroom floors

**Blue**
General areas including resident’s rooms, departments, offices and basins in public areas

**Green**
Catering department/ kitchens
10. SAFE HANDLING OF LINEN

10.1 What is needed?

♦ A designated laundry area used only for that purpose, with separate ventilation and as far away as possible from anywhere food is prepared
♦ An industrial washing machine with cold sluice cycle and wash cycle temperatures that comply with disinfection standards
♦ Accurate thermometers that register the true wash temperatures should be fitted
♦ All machines should be installed professionally with a cover over the drain to prevent aerosol contamination
♦ An industrial dryer is recommended to ensure thorough drying of linen
♦ There should be a regular maintenance programme and a record kept of these checks as evidence of diligence and care
♦ Hand washing and changing facilities for staff should be available
♦ Different receptacles for clean and dirty laundry should be provided, and there should be separate areas within the laundry area to ensure no contact between clean and dirty linen

10.2 How should linen be handled?

All linen (bedding and clothing) should be handled with care, avoiding the creation of dust, and placed in the appropriate bag at the point of use.

Always wash hands after handling linen.

Linen should be divided by staff into 3 categories:

<table>
<thead>
<tr>
<th>Category</th>
<th>Types of Linen</th>
<th>Inner Bag</th>
<th>Outer Bag</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Used Linen</strong></td>
<td>Ordinary used bed linen, towels etc. including items soiled with urine.</td>
<td>None for dry items. Water soluble bag for items soiled with urine.</td>
<td>White fabric</td>
</tr>
<tr>
<td><strong>Known or Suspected Infected Linen</strong></td>
<td>Linen soiled by faeces, blood, bile, pus or other potentially infected matter.</td>
<td>Water-soluble bag</td>
<td>Heavy gauge transparent polythene bag/colour coded linen bag</td>
</tr>
<tr>
<td><strong>Heat labile fabrics e.g. clothing</strong></td>
<td>Fabrics likely to be damaged by the normal heat disinfection process should be categorised as above but bagged separately.</td>
<td>As required - see above categories</td>
<td>Locally agreed colour-coded bag</td>
</tr>
</tbody>
</table>

♦ Heavily blood-soaked linen should be placed in double yellow clinical waste bags for incineration.
♦ All bags must be securely fastened before being sent to the Laundry, and not over-filled.
♦ Bags should be stored in a designated location that is secure, cool and dry.
♦ The designated storage area should be separated from areas used for the storage of clean linen, food preparation areas, and those parts of the home frequented by residents and their guests.

10.3 How should linen and clothing be washed?

♦ Used linen should be laundered by a process in which the temperature in the load is maintained at 65° for not less than 10 minutes or preferably at 71° for not less than three minutes. For machines of conventional design at least four minutes mixing must be added to these times; up to eight minutes may be needed if the machine is heavily loaded. Use normal washing powder
♦ Foul or infected linen – the inner water-soluble bag should be transferred to the washer without opening, followed by the outer bag which should be washed in a similar fashion. The washing cycle is then the same as for used linen. A sluice cycle is necessary for foul linen. Do not soak or sluice by hand as this may spray bacteria onto surfaces, uniforms and staff.
♦ Heat labile fabrics that are not heavily soiled may be disinfected by adding sodium hypochlorite to the penultimate rinse. This should be of at least five minutes duration and sufficient sodium hypochlorite should be added to achieve a concentration of 150 parts per million of chlorine. Heavily soiled linen should be prewashed at low temperature before a warm or cold wash and rinse disinfection as above.

10.4 Risks to staff

The germs in most soiled and fouled linen are unlikely to cause infection in healthy people provided that care is taken and handling minimised. It is important to ensure that:

♦ Staff are trained to carry out the necessary procedures
♦ Disposable waterproof aprons and gloves are used when dealing with used laundry
♦ Any skin lesions are covered with a waterproof dressing
♦ Linen received in water soluble bags should never be opened or sorted by laundry workers. Instead the water soluble bag should be placed directly into the washing machine
♦ Adequate hand washing facilities are provided and are conveniently located
♦ Protective clothing is removed and hands washed before returning to other duties

10.5 Storage of linen

♦ There should be a separate area for drying, ironing and storage of clean linen, well away from used linen, to prevent contamination.
♦ Clean linen should be stored in a dry area raised at least six inches above the floor level.
♦ Clean linen should not be stored in bathrooms or sluices.
10.6 **Staff uniforms/clothing**

Regardless of whether or not a uniform is provided by the employer, it should never be regarded as a substitute for protective clothing. The requirement for PPE should always be assessed as described in Section 5.

When provided, a fresh uniform should be worn daily; otherwise the carer’s clothes should be changed daily.

Both uniforms and/or carers’ own clothing can be laundered at home in a domestic washing machine at a temperature of 40°C. One of the most important factors in determining the effectiveness of laundering is the ratio between fabric load and water volume. In order to ensure sufficient dilution, it would seem sensible to recommend that the machine is not filled to more than 75% of its capacity in order to achieve adequate dilution. This will facilitate the physical removal of microorganisms.
11. SAFE HANDLING OF WASTE

The safe disposal of waste is an essential component of good infection control practice, and health and safety legislation.

Waste that is produced as a result of healthcare activities is classified as healthcare waste in section 18 of the European Waste Catalogue (ECW), and in Scotland from 1 July 2004, all healthcare waste has had to be consigned with appropriate EWC codes. See Appendix A.

Clinical waste is defined as:

♦ Any waste which consists wholly or partly of:
  • Human or animal tissue
  • Blood or other body fluids
  • Excretions
  • Drugs or other pharmaceutical products
  • Swabs or dressings
  • Syringes, needles or other sharp instruments; which unless rendered safe may prove hazardous or infectious to any persons coming into contact with it.

And:

♦ Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

NHS Scotland provide detailed guidance on waste management in the healthcare setting (both in hospital and community), by way of Scottish Hospital Technical Note 3, but this is currently being revised.

11.1 Risk assessment

There is a need under health and safety legislation for assessments of risk to be undertaken by those managing wastes. All producers of waste have a legal “duty of care” to take all reasonable measures to ensure that waste is managed and disposed of correctly. All producers of waste must therefore:

♦ Assess and record the risk (i.e., the hazard and likelihood of harm)
♦ Develop appropriate policies (to include staff education and training)
♦ Put into place arrangements to manage the risks
♦ Maintain records
♦ Ensure competence, and
♦ Monitor the way these arrangements work.

These responsibilities constitute a legal “duty of care”.
Step 1.
The first step in assessing the risk is to identify the hazards which include:
* The infectious nature of the waste
* The hazards posed by the waste, such as containing dangerous substances, and whether or not sharps are present
* The offensive nature of the waste

Step 2.
Decide who may be harmed as a result of exposure to the hazard. This may be in the local setting - residents, staff, or beyond - external contractors, the general public, and the wider environment.

Step 3.
Determine what actions are necessary to eliminate or reduce people’s exposure to the hazard. For example, use of personal protective clothing, presenting waste in a safe manner, secure storage of waste, first aid facilities, etc.

Step 4.
Record the risk assessment.

Step 5.
Undertake periodic review of the risk assessment to ensure that all agreed procedures are effective, and if necessitated by a change in circumstances, regulations, or products.

Producers of waste have duties under environmental law to:
* Supply a written description of the waste which includes:
  - Its nature, source and quantity
  - Sufficient information to enable people who handle the waste further down the chain to discharge their duty of care
  - Anything likely to affect the handling or disposal of the waste
* Satisfy themselves that the means of treatment and disposal are appropriate to the waste.

11.2 Sanpro waste
Sanpro waste includes any item used for the collection or disposal of human excreta or secreta, e.g., sanitary towels, tampons, nappies and incontinence pads that subject to risk assessment on an individual resident basis, may be excluded from the definition of clinical waste. Such items usually present a low level of risk. When risk assessment identifies that it poses no hazardous properties and that there is no infectious risk, the waste is Sanpro Waste, not Clinical Waste. If adequately wrapped, and free from excess liquid it may be disposed of as Household Waste. There may however be occasions when the status of the resident changes, and further risk assessment demonstrates there to be an infection risk, in which case items should be treated as clinical waste.

However, even when there is deemed to be no infection risk items will often be of an offensive nature when present in bulk or there is inappropriate collection frequency.
It is therefore appropriate in meeting the requirements of the duty of care to package human hygiene waste separately from other waste streams, where the premises generate more than one standard bag over the normal collection interval.

**Points to note:**

Arrangements should be made to ensure the correct segregation of waste into appropriate "streams", i.e., household/black bag, clinical, and pharmaceutical.

♦ Areas where clinical waste is produced should have bag holders with pedal operated lids.
♦ Clinical waste must be collected at least once a week by a registered carrier or by the local authority if this service is available, and all relevant documentation must be retained for at least two years,
♦ All clinical waste containers (bags and bins) should be labelled indicating category of waste and point of origin. Advice on the most appropriate way of doing this can be sought from your carrier, but it is still your responsibility.

11.3 **Bag handling**

Clinical waste bags must be sealed securely at the end of the working day or when ¾ full with a plastic tie, closure or heat sealer purpose-made for clinical waste sacks. Alternatively they may be sealed as follows:

♦ Gather top of bag
♦ Fold the neck of the bag over
♦ Tie the neck by forming a loop and passing the end through the loop creating a knot
♦ Tighten the knot to ensure an effective seal
♦ Do not transfer contents.
♦ If a bag splits, the contents must be cleared wearing protective clothing and as per Spillages (section 5)

11.4 **Storage**

♦ All waste storage areas should be separate from residential, food preparation and general storage areas.
♦ The designated storage area should be easy to clean, have a roof, and be inaccessible to animals and birds.
♦ The area must be secure (lockfast) against unauthorised access.
♦ The area should be cleaned weekly.
♦ Washing and first-aid facilities, protective clothing, and materials for dealing with spillages should all be easily available.

11.5 **Pharmaceutical waste**

All pharmaceutical wastes containing Medicinal Products must be treated and consigned as Special Waste using the appropriate EWC Code. Unused medicines
and other pharmaceutical products should be returned to a pharmacy on behalf of the resident, who will make arrangements for their safe disposal.

The only exception to this is fully discharged sharps, which need not be consigned as Special Waste.
12. PATIENT PLACEMENT

This SICP is about ensuring that individual residents with specific infections are placed appropriately in single rooms. This is not usually an issue in Care Homes because the vast majority of rooms are for single occupancy. However, there are a few double rooms remaining in use, and there may be occasions when staff are unsure about whether someone with an infection can share a room.

In these circumstances, please phone and discuss the situation with a member of the Health Protection Team.
13. COLLECTION OF SPECIMENS

The aim when collecting a specimen is to collect an adequate amount of tissue/fluid, uncontaminated by organisms from any outside source, but preserving any organisms that may be present.

♦ Use the appropriate container; if unsure, check with the laboratory at your local hospital
♦ Label the specimen container with the patient’s details and date prior to collection
♦ Wash hands before and after taking the specimen
♦ Collect an adequate amount in order to increase the possibility of detecting the organism
♦ When taking swabs from dry wounds/body surfaces it is advisable to moisten the bacteriology swab with sterile water or saline to allow for optimum pick-up of organisms
♦ Ensure that the specimen is not contaminated during collection, either by equipment or an individual’s normal flora
♦ Specimens should be obtained prior to the commencement of antibiotic therapy. If therapy has already commenced, specify the antibiotic on the request form
♦ Complete all details on the laboratory form in legible hand writing
♦ Send specimens to the laboratory immediately in order to prevent overgrowth of non-pathogens and the death of pathogenic organism
♦ Refrigerate (at 4°) specimens which cannot be transported immediately. (NOT in a fridge used for food storage)
♦ Place the specimen into the sealable pocket of the plastic bag and close the pocket.
♦ If the specimen is being posted it must be sent first class and clearly labelled: “Pathological Specimen – Fragile with Care”

Do not take specimens for culture unless there are signs and symptoms of clinical infection. Bear in mind, for example, that any wound will be colonised with many organisms, and if swabbed in the absence of clinical infection, the culture result may lead to unnecessary treatment with antibiotics.
14. **FOOD HYGIENE**

When operating a care home all food preparation operations will be covered by food hygiene legislation. This legislation covers a number of areas, including:

1. **Hazard Analysis** - you must have a food safety management system to assess and control the food hazards associated with your operations. You must consider hazards that may arise including temperature control, cross contamination, pest control, staff illness, allergens and stock control. Systems such as 'cooksafe' available from [www.food.gov.uk](http://www.food.gov.uk) can help you meet this requirement;
2. **Cleanliness** – you must ensure your premises and staff maintain high levels of cleanliness;
3. **Structural requirements** - your premises must meet certain structural requirements (e.g. walls, floors, equipment, sinks, lighting);
4. **Staff training** - all staff must be trained in food hygiene appropriate to their duties. (see further comments below);
5. **You must register your business with your local environmental health office**

Your local Environmental Health office can provide information and advice on all these subjects. They can be contacted through your local Council Service Point or by emailing env.health@highland.gov.uk if you are in Highland Council Area, or envhealth@argyll-bute.gov.uk if you are in Argyll & Bute.

*Staff Hygiene awareness*

Before being allowed to start work for the first time, a food handler must receive either verbal or written instruction in the Essentials of Food Hygiene. All other staff should also receive similar instruction as a matter of good practice.

**The essentials of food hygiene:**

- Keep yourself clean and wear clean clothing.
- Always wash your hands thoroughly: before handling food, after using the toilet, handling raw foods or waste, before starting work, after every break, after blowing your nose.
- Tell your supervisor, before commencing work, of any skin, nose, throat, stomach or bowel trouble or infected wound. You are breaking the law if you do not.
- Ensure cuts and sores are covered with a waterproof, high visibility dressing.
- Avoid unnecessary handling of food.
- Do not smoke, eat or drink in a food room, and never cough or sneeze over food.
- If you see something wrong, tell your supervisor.
- Keep perishable food either refrigerated or piping hot.
- Keep the preparation of raw and cooked food strictly separate.
- When reheating food, ensure that it gets piping hot.
- Clean as you go. Keep all equipment and surfaces clean.
- Follow any food safety instructions either on food packaging or from your supervisor.
Full-time kitchen staff also require formal training in food hygiene. Contact your local Environmental Health Officer to discuss what courses are available, and what level of training is appropriate.

Food preparation should not as a rule be undertaken by carers, but if unavoidable, separate clean protective clothing must be worn.
15. OUTBREAKS - GENERAL

What is an outbreak?

An outbreak is defined as two or more cases of the same infection occurring in the home within a short space of time.

Senior staff should be aware of organisms that have the potential to cause an outbreak such as norovirus, salmonella, E.coli O157, Mycobacterium tuberculosis. Also be aware that a potential outbreak does not depend on having received any positive laboratory results; the presence of symptoms is sufficient. Seek advice promptly rather than worrying about ‘false alarms’

As soon as an outbreak is suspected the manager should inform the resident’s General Practitioner and the Health Protection Team.

The Health Protection Team will advise on any action that needs to be taken to manage the outbreak. You should also inform the Care Commission: Under the Regulation of Care Act, Regulation 114/21(2)(a) “a provider of a care home shall give notice to the Care Commission without delay of the occurrence of the outbreak in the care home 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".
16. **VIRAL OUTBREAKS**

Outbreaks of vomiting and diarrhoea caused by viruses, usually norovirus, have unfortunately increased substantially in recent years.

Norovirus is highly infectious. It can be spread by the faecal oral route, aerosols produced when people vomit, and by touching contaminated surfaces and objects in the environment.

The incubation period is 12 to 48 hours.

16.1 **Symptoms**

- Vomiting, which may be projectile
- Nausea
- Diarrhoea
- Headache
- Fever
- Muscle aches

The illness usually lasts for between 24 and 48 hours, and treatment is directed mainly at ensuring that residents do not become dehydrated.

16.2 **Actions**

- Contact Health Protection Team
- Keep a record of all cases (photocopy page 43 for this purpose). Fax daily updates to Health Protection Team on 01463 717666
- Ensure that all Standard Infection Control Precautions are being strictly adhered to.
- Use Aide-Memoire (photocopy page 44 for this purpose)

16.3 **Cleaning during an outbreak**

- Wear disposable gloves and aprons
- Clean more frequently
- Ensure any disinfecting agent being used is appropriate and being correctly used.
- Keep separate disposable cloths, mops etc for the infected area.
- Keep all equipment scrupulously clean
- Discard gloves and aprons after use
- Clean toilet and tap handles more frequently (i.e., several times a day)
- Seek advice from the Health Protection Nurse Specialist regarding what terminal cleaning may be necessary

The Health Protection Team will arrange for one of your local Environmental Health Officers to visit and advise.
OUTBREAK MONITORING FORM

CARE HOME: ___________________________  DATE: ____________  TIME: ______________

<table>
<thead>
<tr>
<th>No</th>
<th>Room No</th>
<th>Surname</th>
<th>Forename</th>
<th>DOB</th>
<th>Staff or Resident</th>
<th>Diagnosis (if relevant to D&amp;V)</th>
<th>Symptoms D/V/Nausea etc</th>
<th>Date of Onset</th>
<th>Date of Last Symptoms</th>
<th>Specimen Taken Yes/No &amp; Date</th>
<th>Results &amp; Date</th>
</tr>
</thead>
</table>

Working with you to make Highland the healthy place to be
### Aide-Memoire for Managing Norovirus Outbreaks in Care Home Setting

<table>
<thead>
<tr>
<th>Please tick when control measure is in place:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure of regular washing of hands with soap and water after caring for cases or contract with environment</td>
<td></td>
</tr>
<tr>
<td>Isolation of symptomatic individuals</td>
<td></td>
</tr>
<tr>
<td>Cohort nursing of symptomatic individuals</td>
<td></td>
</tr>
<tr>
<td>Provision of gloves and aprons for wearing during contact with cases or the environment</td>
<td></td>
</tr>
<tr>
<td>Closure of home to new admissions and closure of day care</td>
<td></td>
</tr>
<tr>
<td>Avoid transfer to other homes/hospitals etc <em>(unless medically indicated and after consultation with Health Protection Team)</em></td>
<td></td>
</tr>
<tr>
<td>Exclusion of affected staff from the home immediately and until asymptomatic for 48hrs</td>
<td></td>
</tr>
<tr>
<td>Provision of notices for visitors specifying any restrictions imposed with emphasis on hand hygiene</td>
<td></td>
</tr>
<tr>
<td>Removal of exposed food items such as fruit</td>
<td></td>
</tr>
<tr>
<td>Cleaning and disinfection of vomit and faeces spillages promptly as per local policy</td>
<td></td>
</tr>
<tr>
<td>Documentation of the frequency of routine ward, bathroom and toilet cleaning <em>(increased frequency of usual practice and also cleaning of frequently touched areas)</em></td>
<td></td>
</tr>
<tr>
<td>Use of freshly prepared 0.1% (1000ppm) chlorine releasing agent to disinfect hard surfaces <em>(after cleaning with neutral detergent)</em></td>
<td></td>
</tr>
<tr>
<td>Closure of home for at least 72 hrs after the last new case and 72 hrs after uncontained vomiting or diarrhoea</td>
<td></td>
</tr>
<tr>
<td>Thorough cleaning including change of curtains</td>
<td></td>
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<tr>
<td>Cleaning of carpets and soft furnishings with hot water and detergent or steam clean <em>(avoid vacuum cleaning)</em></td>
<td></td>
</tr>
<tr>
<td>Avoidance of staff working in affected areas from working in unaffected areas <em>(including agency and bank staff)</em></td>
<td></td>
</tr>
<tr>
<td>Guidelines and decontamination facilities (washing, changing, cleaning uniform) available to staff who become grossly contaminated from body fluids (blood, urine, faeces, etc)</td>
<td></td>
</tr>
</tbody>
</table>
17. MRSA

*What is MRSA?*

*Staphylococcus aureus* is a type of bacteria found on human skin, and carried by up to 50% of the population. It is normally harmless, but if it gains access to tissues beneath the skin it may cause infections ranging from boils and abscesses to bronchopneumonia and septicaemia.

Resistance to antibiotics has been recognised as a problem since their introduction and some strains of *Staphylococcus aureus* have now acquired resistance to a wide range of antibiotics. Meticillin is a type of penicillin no longer used for treatment but used in the laboratory to test for resistance, and MRSA thus stands for *Meticillin Resistant Staphylococcus aureus*.

Neither *Staphylococcus aureus* nor MRSA cause illness in people who are generally healthy, and therefore do not pose a risk to the health of staff, the general public or family members (including babies and pregnant women).

MRSA causes the same range of infections as non-resistant strains of *Staphylococcus aureus*, but may be more difficult to treat.

A person is described as colonised with MRSA if it is living on their skin, (often just inside the nose) without harming their health. Some people will carry MRSA and be completely unaware of doing so.

*How is it spread?*

Care worker’s hands are the main route of spread. Contaminated hands will in turn contaminate the environment.

Some people who are described as “staphylococcal dispersers” may heavily contaminate the environment. An example of this is a person with eczema who may shed large amounts of MRSA contaminated skin scales into the environment.

*Points to note*

♦ Carriage of MRSA should not normally prevent discharge from hospital to a patient’s own home, or to a Care Home
♦ If simple hygiene measures are followed, carriers are not a hazard to relatives, staff or other members of the community
♦ The practice of Standard Infection Control Precautions in the care of all residents will prevent most cases of transmission of MRSA, and good handwashing is the most important method of preventing the spread of infection by contact.
How should residents with MRSA be cared for?

♦ They may share a room as long as neither they nor the person with whom they are sharing has open sores or wounds, catheters or other invasive devices.
♦ They may receive visitors and go out of the home, for example to see their friends or family.
♦ They may join other residents in communal areas such as sitting or dining rooms, so long as any sores or wounds are covered with an appropriate dressing which is regularly changed. (An appropriate dressing is one that is impermeable such as a hydrocolloid, or a vapour permeable film or membrane.)
♦ No additional precautions are necessary for laundry.

Special precautions

♦ Complete procedures for other residents before attending to residents with MRSA.
♦ Perform dressings and clinical procedures on a resident with MRSA in the resident’s own room.
♦ Seek advice from the Health Protection Nurse Specialist if the patient has a post-operative wound, drip or catheter.
♦ Isolation is not generally recommended, and may have adverse effects upon the mental and physical condition of the resident.

Hospital appointments etc.

♦ If admitted to hospital, the receiving ward must be informed of a person’s MRSA history, even if not currently positive.
♦ Inform hospital staff if the person is to attend the Out-patients Department.
♦ If an ambulance is required the service should be informed.

Screening

Residents should only be screened prior to a planned hospital admission if requested by the admitting hospital.

The only other instance when specimens should be obtained is in the presence of clinical infection that necessitates treatment. In this case, a specimen should only be taken from the infected site; do not screen other areas.

There is no justification for screening staff, except in the event of a extensive outbreak and when there is the possibility of staff being implicated in the transmission of infection (rather than colonisation). Staff screening should never be undertaken except on the advice of the Health Protection Team.

Treatment and decolonisation

If a resident has an infection for which treatment is indicated, then this should be on the advice of the GP who will prescribe antibiotics. If you have any queries or concerns, please speak to a member of the Health Protection Team.
Generally, decolonisation of residents is not necessary in Care Homes, and you should always contact the Health Protection Team to discuss if for any reason it is being considered.
18. CLOSTRIDIUM DIFFICILE

What is Clostridium difficile (C.diff)?

C. diff is a bacteria that is present in the intestine of about 3% of healthy adults. It is also common in babies—up to two thirds of infants have it in their intestines, but it rarely causes problems. It is estimated that about 20% (one in five) of hospitalised patients over the age of 65 carry C. diff.

C.diff does not like being exposed to oxygen, so when it finds itself in an environment when it is exposed to oxygen it forms spores in order to survive. The bacterial cell becomes covered in a protective layer which enables it to survive in adverse conditions, and it is generally very difficult to kill using either heat or disinfection. If a person picks up spores from the environment and ingests them, once they reach the intestine they will germinate and flourish.

Risk factors

The elderly are most at risk, and in fact about 80% of the cases reported are in the over 65 age group. Immunocompromised people are also at risk, as are those who have had any bowel surgery.

Taking antibiotics makes people more susceptible to develop illness, because any antibiotic will disrupt the balance of all the different bacteria that are normally in the intestine, thus making it easier for C. diff to flourish.

How is it transmitted?

Although some people already have C. diff in their intestines, in most cases illness develops after cross-infection from someone else. This may be directly from the infected person, on the hands of carers, or from the environment. Someone who has diarrhoea caused by C.diff will excrete large numbers of spores, so cleaning and hygiene are very important to ensure they don’t spread to other people. Healthy carriers can also be a source of infection.

Infection can also be acquired from community sources, such as spores in the soil, carriage by pets (dogs, cats, horses), contaminated foods, or exposure to household contacts with diarrhoea.

Why is it a problem?

There are approximately 160 different types of C.diff. Some types produce toxins, and it is the toxins that cause damage to the lining of the intestine. The damage to the intestine then results in some or all of the following signs and symptoms:

♦ Watery diarrhoea (stool has a distinctive foul smell and is often green in appearance)
♦ Low grade fever
♦ Loss of appetite
♦ Nausea
♦ Abdominal pain/tenderness

In severe cases the infection and inflammation of the intestine can lead to death.

**How is it diagnosed?**

If a resident has diarrhoea for which there is no obvious cause, a stool sample can be sent to the laboratory for testing. It is difficult to grow *C. diff* in the laboratory, so the routine test is to detect the toxin.

**Care of a resident with C. diff infection (CDI)**

The GP will review any antibiotics that the resident is taking. In mild cases of infection just stopping the antibiotics may be sufficient for the person to recover. Sometimes it is necessary to prescribe special antibiotics. Other medication such as laxatives and other drugs that may cause diarrhoea should also be reviewed.

Ensure that fluid intake is recorded, and that it is adequate.

Use a stool chart to record all bowel movements (See Appendix 2).

**If you have any resident who has a C. diff positive stool sample, please contact the Health Protection Team. Please also inform the Team if one of your residents has recently been discharged from hospital and was diagnosed with C. diff whilst there.**

**Prevention of cross-infection**

♦ All residents with diarrhoea should be isolated in their own room until they have had no symptoms for a minimum of 48 hours
♦ Re-enforce Standard Infection Control Precautions to all staff
♦ Remember to assist residents to wash their own hands after using the toilet/commode/bedpan

In addition to SICPs:

♦ Wear disposable gloves and aprons when carrying out any care (i.e. not only when contact with blood and/or body fluids is anticipated)
♦ 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
♦ Treat all linen as infected, and place directly into a water-soluble bag prior to removal from the room
♦ Pay special attention to daily cleaning of the environment. Routine cleaning with warm water and detergent is important to physically remove any spores from the environment
♦ After cleaning with warm water and detergent, wipe all hard surfaces with a chlorine based disinfectant (1000ppm)
♦ Ensure that visitors wash their hands at the beginning and end of visiting

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It is important to ensure that you have adequate stocks of liquid soap, paper towels, single-use gloves, plastic aprons and pedal operated bins.

Please note that plain soap and water is adequate for hand washing. Alcohol gel does not kill the spores.

**When can these extra precautions be stopped?**

It is not necessary to send further stool samples to the laboratory to check whether the patient is free from infection. Additional precautions can be stopped when the resident has been completely free from symptoms for 48 hours and a normal formed stool has been achieved. Isolation can also be stopped at this time.

Symptoms may recur in about one in five people, so if this happens, inform the GP and recommence all precautions.

**Further resources**


**Leaflet**

NHS Highland has produced a leaflet, *Information about Clostridium difficile* for use in the community. This can be copied and given to staff, residents and visitors.
19. IMMUNISATION OF RESIDENTS

The Scottish Government Health Department recommends that all people who reside in long-stay health or social care facilities should receive annual influenza vaccination. In addition, all those over the age of 65 should receive one dose of pneumococcal vaccine.

Vaccines may be administered by a district nurse or practice nurse who is authorised to do so under a NHS Highland Patient Group Direction (PGD) which means that individual signed prescriptions are not required. However, PGDs cannot be used by nurses employed in Care Homes.

In order for a nurse employed by a Care Home to administer vaccines on behalf of the GP, there must be a valid prescription, or signed order for the individual resident. This may be on a NHS GP10 form, or the medicine administration kardex, or equivalent with the resident’s own name. Any nurse administering vaccines must be competent to do so.

For further information see:

♦ NHS Highland Immunisation Procedure
♦ NHS Highland Policy for the Handling and Storage of Vaccines

Both of the above are available at: http://www.nhshighland.show.scot.nhs.uk

Follow the links All Services A-Z/Health Protection Team/Public Health Guidance.

Further detail about prescribing and administering flu vaccine can be found at: http://www.carecommission.com
20. CARE OF URINARY CATHETERS

Indwelling urethral catheters should only be used after considering all alternative methods of managing urinary incontinence.

A Catheter Care Resource Pack may be obtained from:

Lesley Randall
Continence Nurse Advisor
01540 664577
lesley.randall@nhs.net

In 2004 NHS Quality Improvement Scotland published a Best Practice Statement Urinary catheterisation & catheter care, and this is available at:

Guidance about the management of bacterial urinary tract infection in people with catheters is included in SIGN Guideline 88, Management of suspected bacterial urinary tract infection in adults, available at:
http://www.sign.ac.uk/pdf/sign88.pdf
21. ENTERAL FEEDING

Enteral feeding is the preferred method of providing nutrition to individuals who are unable to take food orally. This may be via a naso-gastric tube, or a gastrostomy tube. In the community, gastrostomy feeding is usually via a Percutaneous Endoscopic Gastrostomy, (PEG).

Infection control is an important aspect of their care, because of the possibility of contamination of either the feed, or the gastrostomy site, which can cause serious infections, particularly in vulnerable individuals.

If you have residents who receive nutritional support in this manner you should ensure that you have a policy in place.

If you require any help or guidance, please contact the enteral feeding specialist dietitian at Raigmore Hospital (tel 01463 704000)
22. LAST OFFICES

See NHS Highland infection control guidance, *Managing infection risks during last offices.* Available at: [http://www.nhshighland.scot.nhs.uk](http://www.nhshighland.scot.nhs.uk) Click on All Services A-Z/Health Protection Team/NHS Highland Infection Control Policies

Section 1 of the above policy gives general advice concerning risk assessment and the application of standard infection control precautions.
23. EDUCATION RESOURCES

23.1 Education for the Infection Control Key Worker

Standard 3 of the Infection Control in Adult Care Homes: Final Standards which was published by the Scottish Executive in 2005 indicates that designated Infection Control Key Workers should have formal training. The Cleanliness Champions programme devised by NHS Education for Scotland is a suitable course and can be accessed via ScotCollege.

Contact details:
HAI Registrations
ScotCollege
Crosslet House
Argyll Avenue
Dumbarton
G82 3NS
Tel 01389 768444
Email: annesinclair@scotnursing.com

For further information see also: http://www.nes.scot.nhs.uk/hai/champions/

The Infection Control Key Worker must be given ring-fenced time for training (their own, and that of others) and audit.

23.2 Hand Hygiene

NHS Education for Scotland has developed a web-based learning package, Promoting Hand Hygiene in Healthcare. It is available free of charge at: www.nes-hai.info Although it is designed to be accessed and studied online by individuals, you may wish to print off the material and use to run a group learning session.

The Health Information & Resources Service of NHS Highland (tel 01463 704646) has a Hand Inspection Cabinet which is available to borrow. It is designed to demonstrate that effective hand hygiene requires the correct technique. Stickers reminding people of the need to wash hands are also available.

Care Homes in Argyll & Bute Council area can arrange to borrow one from the Infection Control Nurses at Lorn & Islands Hospital, tel 01631 789018

23.3 Induction training

It is essential to include education about infection control as part of the induction of any new member of staff. This includes:

♦ Staff who give direct personal care
♦ Staff with minimal contact with residents
♦ Staff who have contact with resident-related equipment
♦ Volunteers who fall into any of the above three categories

As part of induction all of the above staff should:

♦ Be informed of the person who is the Infection Control Key Worker
♦ Be given time to read this guidance provided by the NHS and any organisational policies relating to infection control
♦ Have the opportunity to discuss the above with the Infection Control Key Worker.
♦ Be given practical instruction by the Infection Control Key Worker in hand hygiene
♦ Senior staff should also be aware of the role of the Health Protection Team, and know how and in what circumstances to contact them

At the end of the induction period, and preferably within two weeks of being appointed, the new staff member should be able to demonstrate knowledge of the chain of infection, all Standard Infection Control Policies, and correct practice of hand hygiene.

All training given should be recorded.
24. PANDEMIC INFLUENZA

24.1 Pandemic flu – what is it?

Pandemic flu is when there is a worldwide outbreak of flu. This happens when a new flu virus emerges, that is able to spread easily from person to person. Because the virus is new, the human immune system will have no pre-existing immunity, and everyone will therefore be susceptible. This makes it likely that people who contract pandemic flu will experience more serious disease than that caused by normal flu.

There were three worldwide flu pandemics in the last century: in 1918/1919 “Spanish flu”; in 1957/1958 “Asian flu”, and in 1968/1969 “Hong Kong flu”. These pandemics were caused by new subtypes of flu that probably formed by a combination of genes from both avian and human flu viruses. There is concern that the currently circulating strain of avian influenza/bird flu (H5N1) may combine with another strain, or adapt to the human body and result in a pandemic.

Perhaps at the moment the idea of a pandemic seems quite a remote possibility, and it's very tempting to put off thinking about it! However:

"Most experts believe that it is not a question of whether there will be another severe pandemic, but when."

24.2 How is flu transmitted?

Flu is one of the most difficult infectious diseases to control because the virus spreads rapidly and easily from person to person. This is through two routes:

♦ Direct via droplets expelled from infected people (coughing, sneezing and talking) which land on the mucous membranes of other people and enter the body
♦ Indirect via hands touching contaminated surfaces, and then touching the nose, mouth or eyes

The good news is that careful hand hygiene and environmental cleaning can easily deactivate the virus.

24.3 What can be done to prepare?

As a provider of community care, it is important that you start now to prepare a robust plan to ensure the continuity of your business in the event of an outbreak of pandemic influenza.

The nature of a Care Home is such that an infection like flu can spread very quickly to many of the residents, so your plan should take into account the fact that more people will need more care than is usual. This will have to be managed with fewer staff, as it is expected that in a pandemic, healthy younger people will also be
infected. Over the course of the pandemic up to 50% of the population may become ill, and staff will be off work, either because they are ill themselves, or because they are caring for relatives.

Try to work out now how you will cope with this situation. Identify which aspects of your service are essential and must carry on, and which might be stopped if necessary. How many staff do you need to do the basics? How many relatives and other volunteers might be able to come in and help? It will help if you start to put your plans down on paper, and look at what training and preparation will be necessary.

Other very practical issues:

Health & Safety—you still have a duty to protect your employees

Training & education—for staff who may be asked to take on alternative roles

Staff welfare—e.g. sick leave policy, protecting those most at risk such as pregnant women; what to do if schools close

Identify now the person in your home who should start writing your plan. If you are part of a larger organisation work on this may already have started, but you will still need to work out how to plan at a local level.

A wealth of guidance has been published nationally, updated in autumn 2007 and is available at:

http://www.scotland.gov.uk/Topics/Health/health/AvianInfluenza/PandemicFlu/planning/frameworks

http://www.scotland.gov.uk/Topics/Health/health/AvianInfluenza/PandemicFlu/planning/infection-control

Below are the titles of some of the documents that you should access:

♦ **Planning for pandemic influenza in community care: an operational and strategic framework**

♦ **Planning for pandemic influenza in community care: guidelines for community care staff.** This is just a short document, and it would be useful to print out a few copies and encourage all staff to read it.

♦ **Pandemic influenza: Guidance for infection control in hospitals and primary care settings**

Further information on this important topic will be issued separately, as it is an area which is continually being updated. However, if you would like any specific advice to help produce your own plan, please do not hesitate to contact the Health Protection Team.
## Appendix 1

### SHARPS INOCULATION INJURY REPORTING FORM

#### Employee Information:

<table>
<thead>
<tr>
<th>Name</th>
<th></th>
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<tbody>
<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Tel</td>
<td></td>
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<tr>
<td>Place of work</td>
<td></td>
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<tr>
<td>Position held</td>
<td></td>
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<tr>
<td>GP</td>
<td></td>
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</tbody>
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#### Incident:

<table>
<thead>
<tr>
<th>Date/Time of Incident</th>
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<tbody>
<tr>
<td>Date/Time of reporting</td>
<td></td>
</tr>
<tr>
<td>Place of injury</td>
<td></td>
</tr>
<tr>
<td>Details</td>
<td></td>
</tr>
</tbody>
</table>

#### Nature of Injury:

| Unused/clean sharp?     |   |
| Used/dirty sharp?       |   |
| Bite?                   |   |
| Mucus membrane splash?  |   |

#### Check:

| Gloves worn?            |   |
| Appropriate first aid administered? |   |
| Medical advice – date & time         |   |
| Details of advice given            |   |
## STOOL RECORD CHART

Name: ____________________________  Date of Birth: ____________________________

Date sample sent: ____________________________

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>TYPE No.</th>
<th>DESCRIPTION/COMMENTS (please refer to chart overleaf)</th>
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</thead>
<tbody>
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<tr>
<td>Type</td>
<td>Description</td>
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<tr>
<td>------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
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<td></td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on its surface</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces ENTIRELY LIQUID</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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BIBLIOGRAPHY


What is norovirus?

Norovirus is a virus (a type of germ much smaller than bacteria) that causes gastro-intestinal illness. In the past it has been known by many names: Norwalk-like virus, SRSV (small round structured virus), gastric flu, and winter vomiting disease.

What illness results from infection?

The incubation period, which is the time from first swallowing the virus to becoming ill, is 12-48 hours. The main symptom is vomiting, but people also suffer from:

- Diarrhoea
- Nausea
- Abdominal cramps
- Headache
- Muscle aches
- Chills and fever

How does it spread?

The virus only infects humans. Illness is able to spread when virus particles from an infected person get into the gut of another person. This can happen in several ways:

- Poor hygiene after going to the toilet
- Virus particles spread in the air from vomit when someone has been sick
- Virus particles can fall onto any object in the environment and be picked up by another person
- Via contaminated food or water
- Shellfish (e.g., oysters) from sewage contaminated water

How are infections treated?

There is no specific treatment. Symptoms usually last 24-48 hours. Although it is unpleasant, most people make a full and speedy recovery. It is important to drink plenty to make sure that you don’t become dehydrated. Clear fluids like water and diluted fruit juice are recommended.

Should I see my GP?

You should consult your GP if one or more of the following applies to you:

- there is blood in your diarrhoea
- you have severe abdominal pain
- the diarrhoea has lasted for 48 hours

How can infection be prevented?

Good standards of personal and food hygiene will help to prevent spread. Unfortunately it spreads very quickly, especially where groups of people are together such as in schools or care homes. Always:

- Wash hands after using the toilet or changing nappies
- Cook raw shellfish before eating
- Wash fruit and salads before eating

How should hands be washed?

Always use warm, running water and a mild, preferably liquid, soap. (It is not necessary to use soaps labelled as antiseptic or antibacterial.)

- Wet hands and apply a small amount of soap
- Rub hands together vigorously for 10-15 seconds
- Pay special attention to areas between fingers, finger tips, and palms.
- Rinse hands under warm running water
- Dry thoroughly on a clean dry towel.

If someone in your household has norovirus:

- The infected person should not prepare food.
- Soiled bedding and clothes should be washed on the hot cycle of your washing machine.
- Clean surfaces (toilet seats, flush handles, door handles and taps) at
least daily with bleach diluted as per manufacturer's instructions.

- If cleaning up diarrhoea or vomit, wear rubber gloves; wash the surface with hot soapy water, rinse, and allow to dry. Use paper towels or disposable cloths, and dispose of carefully and immediately in a plastic bag (e.g., used carrier).
- The infected person should not share towels/flannels with anyone.

All persons with diarrhoea should remain off work or school until they have had no symptoms for 48 hours.

Information produced by:
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What is MRSA?

MRSA stands for methicillin resistant Staphylococcus aureus.

Staphylococcus aureus (S.aureus) is a type of bacteria that is found in the noses of about 1 in 3 people. It likes to live in warm moist areas such as the nostrils, armpits and groin. Such people are said to be colonised by S. aureus, and called “carriers”. This means that the bacteria are living on the person, but not causing an infection. If the bacteria are able to enter the body, such as through a cut, this may result in infection. Most infections caused by S. aureus can be treated with antibiotics. MRSA is a particular type of S. aureus that has become resistant to many commonly used antibiotics. It is not a threat to a healthy person, and usually only causes infection in someone with weakened defences.

So is MRSA harmful?

Both ordinary S. aureus, and MRSA, can cause serious infections in patients who have lowered defences against infection. The following groups of people are at risk:

- Patients having surgery. Open wounds create an ideal way in for MRSA.
- Patients in a burns ward because skin is the body’s normal first line of defence against infection.
- Patients in Intensive Therapy Units (ITU). This is because they already have a serious illness.
- Patients who have long or repeated stays in hospital
- Patients who have been treated with lots of antibiotics.

Generally, anyone who is in hospital is already ill and more prone to infection. It is very important to try and stop the spread of MRSA in hospital. Some of the antibiotics used to treat serious MRSA infections are very powerful, and can have unpleasant side-effects.

If you visit someone in hospital who has MRSA they will probably be in a single room, and any special precautions necessary will be explained to you.

How does MRSA spread?

The main way that MRSA is spread is on people’s hands. The most important action that everyone can take to help stop spread is regular hand hygiene.

Hand hygiene is especially important before and after:

- Visiting someone in hospital
- Helping to dress wounds
- Touching urine drainage catheters/bags

How should hands be washed?

Always use warm, running water and a mild, preferably liquid, soap. (It is not necessary to use soaps labelled as antiseptic or antibacterial.)

- Wet hands and apply a small amount of soap
- Rub hands together vigorously for 10-15 seconds
- Pay special attention to areas between fingers, finger tips, and palms.
- Rinse hands under warm running water
- Dry thoroughly on a clean dry towel.

What should I do if I or a member of my family is a carrier of MRSA?

Nothing special!

It is very important to realise that MRSA does not cause problems in healthy people. People with MRSA can socialise as normal, and do all their usual activities. Bedding and clothing
can be laundered in the usual way, and crockery and utensils can be washed as normal.

However, there are exceptions:

If someone who is or has been colonised or infected with MRSA has to be admitted to hospital, or has an Out Patient Appointment, please inform the hospital staff in advance.

Extra caution may be necessary if someone in your household:
- Has problems with their skin,
- Has a urine drainage catheter,
- Is a healthcare worker,
- Has a problem with their immune system not working properly.

If you have any concerns about MRSA please discuss them with your GP or district nurse, or telephone the number on the back of this leaflet.

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Date issued: Nov 2007
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What is *Clostridium difficile*?

*Clostridium difficile* (C.diff) is a type of bacteria (germ) that lives in the guts of 3 out of 100 adults without causing any symptoms of illness at all. There are lots of different types, and some types of the bacteria produce toxins which cause illness.

Where does C. diff come from?

*C. diff* bacteria cannot grow in air, but they change into spores and in this form they are able to survive for long periods of time in the environment. It is very difficult to kill the spores, even when using disinfectants, so they may be present on surfaces and equipment even after very thorough cleaning.

For a person to become infected they must swallow *C. diff* spores or bacteria. People can come into contact with the bacteria in hospital if the environment, equipment or healthcare workers’ hands or clothes are contaminated. It is also possible to come into contact with the bacteria in the community as it is present in soil and the guts of some animals.

There is a higher risk of infection after taking antibiotics.

What illness results?

*C. diff* can cause a wide range of symptoms: diarrhoea, stomach pain and fever. In many cases the illness is mild and will last only a few days. In some cases the illness can be more severe lasting for several weeks, with symptoms of severe diarrhoea (sometimes bloody) and stomach pain.

How do I know if I have the infection?

A sample of your faeces will be sent to the laboratory to test if you are infected with *C. diff*. The result can take 1-2 days.

How are infections treated?

If the illness is mild, taking plenty of fluids is usually enough to ensure rapid improvement in health. If you are taking an antibiotic your GP may decide to stop it to assist in your recovery.

Sometimes it is necessary to give specific treatment against *C. diff* and two antibiotics – metronidazole and vancomycin – are very effective.

Metronidazole is taken by mouth and often prescribed as the first choice.

Some people may need more than one course of this antibiotic.

If this does not work, vancomycin, which is also taken by mouth, may be prescribed.

How can spread of this infection be prevented?

The most effective way to prevent the bacteria from spreading is good hand washing, by the person suffering from the illness and anyone who assists them, particularly after having been to the toilet.

How should hands be washed?

Always use warm, running water and a mild, preferably liquid, soap. It is not necessary to use soaps labelled as antiseptic or antibacterial. Do not use alcohol hand rubs as alcohol does not kill the spores.

- Wet hands and apply a small amount of soap
- Rub hands together vigorously for 10-15 seconds
- Pay special attention to areas between fingers, finger tips, palms and thumbs.
- Rinse hands under warm running water
- Dry thoroughly on a clean dry towel.
If someone in your household has diarrhoea caused by *C. diff*:

- The infected person should not prepare food.
- Soiled bedding and clothes should be washed separately from other items, at the hottest temperature suitable to the fabric. Do not fill the machine to more than ¾ full.
- Equipment e.g. commode used by the infected person should be cleaned after each use.
- Clean surfaces (toilet seats, flush handles, door handles and taps) at least daily with bleach diluted as per manufacturer’s instructions.
- Ensure toilet lid is down before flushing.
- If cleaning up diarrhoea or vomit, wear rubber gloves; wash the surface with hot soapy water, rinse, and allow to dry. Use paper towels or disposable cloths, and dispose of carefully and immediately in a plastic bag (e.g., used carrier).
- The infected person should not share towels/flannels with anyone.

All persons with diarrhoea should remain off work or school until they have had no symptoms for 48 hours.

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**Information about Clostridium difficile**

Working with you to make Highland the healthy place to be

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