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Managing Infections and Outbreaks

CP008a Common Policies

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1. Introduction
   1. This policy has been developed to support and promote good practice in the investigation, management and control of infectious diseases, outbreaks, or incidents, which may have public health implications. Each control problem will be unique to a situation and may require specific measures to deal with individual circumstances in an MHA service
2. Scope and Purpose
   1. The scope of this policy and associated procedures applies to all MHA services and colleagues, including contractors, volunteers, and visitors, who have direct or indirect contact with people we support and their environment
   2. The information within this document draws upon several sources and the best available evidence including National Institute of Health Care and Excellence (NICE), NHS, Government Departments, and professional regulators. Registered services with the Care Quality Commission (CQC), Care Inspectorate Wales (CIW) must comply with the relevant regulations and Code of Practice (2022) Health and Social Care Act 2008: Code of Practice on the Prevention and Control of Infections and Related Guidance
   3. When caring for individuals and colleagues in relation to COVID-19 or any other new emerging infections, colleagues must refer to the national infection prevention and control guidance and associated external information, links can be located in section 18, Resources
3. Definitions

| Term | Definition |
| --- | --- |
| **Acute Respiratory Infections (ARI)** | Acute respiratory infection (ARI) is defined as the acute onset of one or more of the respiratory symptoms listed at [People with symptoms of a respiratory infection including COVID-19](https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19#symptoms-of-respiratory-infections-including-covid-19) and a clinician’s judgement that the illness is due to a viral acute respiratory infection (for example COVID-19, flu, respiratory syncytial virus (RSV))  Refer to Appendix 4 for more information  <https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19#symptoms-of-respiratory-infections-including-covid-19> |
| **Blood Borne Viruses (BBV’s)** | Blood Borne viruses are spread by direct contact with the blood of an infected person, the main BBV’s of concern are:   * Human immunodeficiency virus (HIV), which causes acquired immunodeficiency syndrome (AIDS) * Hepatitis B virus (HBV) and hepatitis C virus (HCV) which causes hepatitis   These three viruses are considered together because infection control requirements are similar due to similarities in their transmission routes |
| **Care outbreak Risk Assessment (CareOBRA)** | Care Outbreak Risk Assessment (CareOBRA) completed online using the link below. This is an online Care Outbreak Risk Assessment (Care OBRA) Tool for all **Adult Social Care** providers to report:   * NEW **outbreaks of acute respiratory infections (ARI)** e.g. COVID-19, Flu, RSV, chest infections or unknown respiratory infection OR * **Single cases of Influenza (Flu)** * [Care Outbreak Risk Assessment (CareOBRA)](https://forms.ukhsa.gov.uk/ReportAnOutbreak/acute-respiratory-infections-ari---covid-19-flu-or-unknown-infection-in-adult-social-care-settings) |
| **Community Infection, prevention, and Control Teams (IPCT)** | * Deal with day-to-day advice and support where infection control is required and support the local UK Health Security Agency (UKHSA) in responding to outbreaks * Each MHA service should retain a copy of local IPC team protocols and contact details |
| **Infection**  **Outbreak** | * Two or more cases of residents or colleagues with the same infection or symptoms linked in time and place * A greater than expected rate of infection compared with the usual background levels for the place and time where the outbreak has occurred * A suspected, anticipated, or actual event involving microbial or chemical contamination of food or water |
| **Respiratory Tract Infections (RTI’s)** | These are infections affecting parts of the body involved in breathing, such as sinuses, throat, airways, or lungs. RTI’s are mainly caused by viruses and can affect the upper respiratory tract or the lower respiratory tract Upper Respiratory Tract Infections (URTI’s)  * Infections include the common cold, tonsilitis, sinusitis, laryngitis, and flu. * The most common symptoms are headache, aching muscles, a blocked or stuffed up runny nose, sneezing and a sore throat. URTI’s caused by a virus e.g., the common cold, usually get better without any treatment over days or weeks.  Lower Respiratory Tract Infections (LRTI’s)  * Infections include bronchitis (an infection of the airways), pneumonia (lung infection) and tuberculosis, a bacterial lung infection * Flu can affect both upper and lower respiratory tract. * RTI’s caused by bacteria e.g., pneumonia often require antibiotic treatment and in some cases admission to hospital |
| **Standard Infection Control Precautions (SICP’s)** | * A set of infection control practices used to prevent transmission of diseases that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes * Basic infection, prevention, and control measures necessary to reduce the risk of transmitting infectious agents i.e., microorganisms and viruses |
| **Transmission Based Precautions (TBP’s)** | * Second tier of basic infection control to be used in addition to SICP’s for individuals who may have a confirmed or suspected infection for which additional precautions are required * TBP’s will be implemented dependent on the source of infection and route of transmission i.e., contact, droplet or airborne   Decisions for using TBP’s should be based on the following:   * Confirmed or suspected infectious agent * Severity of illness caused * Transmission route of the infectious agent * Procedures   \*Refer to Appendix 1 and 2 for more information |
| **UK Health Security Agency (UKHSA)** | * UKHSA Health protection teams (HPT) provide specialist public health advice and operational support to NHS, local authorities, and other agencies |

1. Blood Borne Viruses

|  |  |  |
| --- | --- | --- |
| Infection | Transmission | Infection Prevention and Control measures |
| **HIV and Hepatitis B & C** | Sexual activity – vaginal, anal, or oral sex  Mother to baby – during pregnancy and childbirth  Exposure from:   * Contaminated needle (sharps injury) * Shared items contaminated with blood * Unsterile tattooing or body piercing * Transfusion of contaminated blood * Direct exposure of mucous membranes or an open wound to infected blood or blood-stained body fluids * Contaminated human bite that breaks the skin | Precautions to prevent exposure to blood and certain body fluids will prevent transmission of these viruses:   * Standard Infection Control Precautions Policy * Use of safety sharps where assessment indicates they will provide safe systems of working * Protection with hepatitis B injection * Appropriate management of sharps and splash injuries * Complete risk assessments to identify any additional control measures required and if immunisation is required for colleagues * Refer to local Infection Prevention Control team (IPCT) |

1. Norovirus (viral gastroenteritis)

General Information

* + 1. Viral Gastroenteritis is usually caused by a virus known as Norovirus, which is highly infectious where outbreaks are common in semi-enclosed environments such as care homes and shared living premises
    2. The illness is usually of a short duration lasting 24-72 hours with a full recovery. If there is any clinical concern their GP must be notified as the symptoms may become more serious with individual who are frail or have underlying health conditions. Once an affected person is 72 hours symptom free, they are considered non-infectious

Transmission

* + 1. Norovirus is highly infectious and is transmitted from person to person primarily through the faecal oral route or by direct person to person spread. Immunity to Norovirus is of short duration, possible only a few months

Signs and Symptoms

* + 1. The incubation period for Norovirus is usually 24-48 hours, but cases can occur within 12 hours of exposure. Symptoms include:
  + Sudden onset of vomiting
  + Watery non-bloody diarrhoea
  + Abdominal cramps
  + Nausea
  + Low grade fever
  + Headache

Control measures

* + 1. Standards Infection Control Procedures (SICPs) and Transmission Based Precautions (TBPs) should be followed
  + Twice daily environmental cleaning during an outbreak to include all communal areas regularly touched by residents
  + Fans must not be used as they can recirculate the virus
  + Remove and replace all drinking vessels, condiments, sauce bottles if exposed
  + It is essential that the correct concentration of all detergents and disinfectants are used
  + Where possible designated colleagues should be allocated to support affected residents, where possible teams should be allocated to units or floors to avoid further risk of transmission
  + Colleagues with symptoms of vomiting and/or diarrhoea should remain away from the service until they are symptom free for 48 hours
  + Affected residents should be supported within their own rooms, wherever possible, until symptom free for 72 hours. En suite facilities should be used or a designated commode
  + Disposable aprons and gloves should be worn when dealing with any body fluids and disposed of in the room and disposed of as infectious waste.
  + Hands must be cleaned with liquid soap, undertaken before leaving the room and again, after exiting the room.
  + Eye protection and a fluid resistant surgical mask (FRSM) should also be worn if a resident is vomiting, dispose as infectious waste in a safe place once outside the room and wash hands after removing
  + Alcohol rub should NOT be used when supporting residents with viral gastroenteritis

Treatment

1. Diarrhoea specimens from affected residents and colleagues are required to determine the cause of the outbreak
2. Specimens can be taken even if contaminated with urine
3. Testing for microscopy and culture (M&C) and virology, should be requested. Diarrhoea specimens are not routinely tested for viruses; therefore, you will be provided with an outbreak reference number (iLog number) by your local IPC Team or the UKHSA team
4. Follow advice from external professional in respect of any treatment
5. C. Difficile (Clostridioides difficule)

General Information

* + 1. Clostridioides difficule (formerly known as Clostridium Difficule) is a bacterium which produces spores that are resistant to air, drying and heat. The spores survive in the environment and are the main route of spreading the Clostridioides difficule (C. Difficule)
    2. C.Difficule is present in the normal intestine of approximately 3-5% of healthy adults as part of the healthy gut flora. However, when antibiotics are taken for an infection they kill off some of the natural good bacteria in the gut, which leaves room for C.Difficule to multiply rapidly, producing toxins causing diarrhoea
    3. In many people, the illness is mild, and a full recovery is usual. However, elderly people, often with underlying illnesses may become seriously ill. C.Difficule spreads through the faecal-oral route (ingestion)

Transmission

* + 1. Transmission can occur through contaminated hands, direct contact with affected individuals, or contaminated surfaces. Affected individuals with diarrhoea secrete large numbers of C.Difficule spores, leading to contamination of the surrounding environment
    2. Antibacterial surface sprays are not effective against C.Difficule, a specific disinfecting agent should be used

Signs and Symptoms

* + 1. Symptoms include:
  + Explosive, foul smelling watery diarrhoea, which may contain blood and or mucus
  + Abdominal pain and fever due to the toxins causing fluid loss from the gut and cell damage
  + Dehydration which can be severe due to fluid loss
    1. The symptoms are usually caused by inflammation (swelling and irritation) of the lining of the bowel and can last for a few days to several weeks. Most people develop symptoms whilst taking antibiotics, however symptoms can appear up to 10 weeks after finishing a course of antibiotics
    2. Where this infection is suspected refer to a GP for specific sample testing, providing any information regarding previous or current antibiotic use

Control Measures

* + 1. The main methods of preventing and reducing transmission of C.Difficule are:
  + Prudent antibiotic prescribing, not to be prescribed unless necessary
  + Prompt isolation of residents with suspected or confirmed C.Difficule colonisation or infection, procedures for isolation must be explained to residents and visitors
  + Doors must be kept closed, where possible, to avoid risk of transmission
  + Promptly sending a stool sample for testing
  + Good hand hygiene practice and appropriate use of personal protective equipment (PPE)
  + Reducing the number of spores in the environment by thorough cleaning and then disinfecting with a sporicidal product
    1. The following protocol (SIGHT) should be applied when managing suspected potentially infectious diarrhoea:

|  |  |
| --- | --- |
| S | Suspect that a case may be infective where there is no clear alternative cause for diarrhoea |
| **I** | Isolate the resident in their own room |
| **G** | Gloves and aprons must be worn for all contact with a resident and their environment |
| **H** | Handwashing with liquid soap and warm running water before and after each contact with the resident and their environment |
| **T** | Test the stool for toxins by sending a specimen immediately |

Treatment

* + 1. The individual must be reviewed by their GP promptly:

Antibiotics causing diarrhoea should be stopped, if possible, as should all other drugs that may cause diarrhoea.

1. Anti-motility agents, e.g., Imodium, Lomotil, which are given to stop diarrhoea should not be prescribed
2. Bowel movements must be recorded on a Bristol Stool Chart
3. When a resident has been diarrhoea free for 48 hours and passed a formed stool (type1-4 on the Bristol Stool Chart) or their bowel habit has returned to normal they are no longer infectious and no longer required to isolate.
4. The room should be cleaned and disinfected
5. If a resident develops diarrhoea following a period of being symptom free, they may have been reinfected or relapsed. Isolate immediately, send a repeat sample if more than 28 days since previous toxin positive result, arrange a review with their GP and follow control measures
6. MRSA (Meticillin Resistant Staphylococcus Aureus)

General Information

* + 1. MRSA is a common bacteria that is frequently found on the skin or in the nose of healthy people without causing infection. This is called *Colonisation* where MRSA is present on or in the body without causing infection. Most people who are colonised do not go on to develop an infection.
    2. If the bacteria invade the skin or deeper tissues, and multiplies, an infection can develop. This could be minor, such as pimples, boils, or serious such as wound infections, pneumonia, or bacteraemia (blood stream infection)

* + 1. MRSA infection means that it is present in or on the body causing clinical signs of infection, such as in the case of bacteraemia or pneumonia, or for example in a wound causing redness, swelling, pain and or discharge. Such infection usually occurs in health and social care settings and, in particular, vulnerable people who may be frail, have underlying health conditions, open wounds or have invasive devices, such as catheters.

Transmission

* + 1. Clinical infection with MRSA occurs either from an individual’s own MRSA or by transmission of infection from another person who has MRSA present on their body or has a clinical infection
    2. The main routes of transmission are as follows:
  + Contact from hands or clothing contaminated with skin scales
  + Droplet or aerosol from a person with MRSA infection or colonisation
  + Contact with shared equipment that has not been effectively decontaminated after use
  + Environmental contamination (staphylococci that spread into the environment may survive for a long period in dust)

Signs and Symptoms

* + 1. Individuals with an underlying illness, those with open wounds or who have undergone surgery and those with invasive devices, such as urinary catheters are at higher risk of contracting MRSA. The following symptoms may present and should be referred to a GP for testing if MRSA is suspected
  + Infected areas on the skin – red, swollen, or painful
  + Infected area is warm to the touch
  + Pus or other fluid may be present in the infected area
  + Fever

Control Measures

* + Residents with an active MRSA infection should be isolated with transmission-based precautions (TBPs) in place until they are symptom free
  + The room of a resident who has an active MRSA infection must be deep cleaned at the end of the isolation period
  + Any infected wound or skin lesion should be covered with an appropriate dressing as advised by a healthcare professional. The dressing should be checked frequently for signs of leakage and replaced accordingly until the wound is dry
  + During any isolation period colleagues must wear disposable apron and gloves when providing hands on care and support
  + Disposable apron and gloves are not required to be worn by visitors unless they are providing hand on care and support; strict handwashing must still be performed
  + Residents with MRSA can visit communal areas and mix with other residents
  + If a resident requires hospital admission, the receiving department/hospital should be informed of the resident’s MRSA status

Treatment

* + 1. Any treatment required will be on an individual basis. Antibiotic treatment will only be prescribed if there are **clinical signs of infection.** If a MRSA positive result is diagnosed after a resident has been discharged form hospital, the GP will be informed, and if appropriate prescribe suppression treatment
    2. Suppression treatment consists of 2 separate treatments; body and hair and nasal, which will be prescribed and administered according to manufacturer’s instructions

1. Scabies

General Information

* + 1. Scabies is a skin condition caused by an immune reaction to the mite *sarcoptes scabiei* and their saliva, eggs, and faeces. This infection occurs when the mite burrows in to the skin and lays eggs that hatch into larva. The eggs hatch within 3 to 4 days and into adult mites in 1 to 2 weeks. Within the skin the adult female lays eggs and deposits waste products. Their presence in the skin usually causes itching while the hatching of the eggs produces new larva which can migrate to the surface of the skin and infect new hosts
    2. There are two forms of scabies both caused by the same mite. The most common form of ‘classical scabies’, has fewer than 20 mites all over the body. The rarer type of ‘crusted scabies’ (formerly known as Norwegian), which may be seen in immunosuppressed individuals, can have thousands or millions of mites causing a more severe reaction in the skin. It develops due to an insufficient immune response to the host

Transmission

* + 1. From an infected person:
  + Direct skin to skin contact without appropriate PPE with a person who is infected with scabies (approximately 10 minutes uninterrupted skin to skin contact)
  + The mite cannot jump from person to person but can crawl from one individual to another when there is skin to skin contact for a period of time, e.g., holding hands.
  + Transmission through casual contact, such as hand shaking or hugging is unlikely
    1. Some evidence suggest that mites can live away from a host for up to 4 days. Therefore clothing, bed linen and towels must be safely segregated and washed separately

Signs and Symptoms

* + 1. In a person who has previously had scabies symptoms usually appear between 1-4 days. For those who have never previously had scabies it can take 3-6 weeks to develop after infestation
    2. Diagnosis must be confirmed by a GP or dermatologist.
  + Intense itching, which may become worse at night
  + Tiny red spots on the skin
  + Burrow marks can be found anywhere on the body – 1cm or less, wavy sliver coloured line son the skin with a black dot on one end
  + Warm areas of the body are susceptible i.e., underarms, groin, under breasts, elbow, and knee joints

Control measures

* + 1. Local Community IPC or UKHSA Team must be contacted for advice regarding management and treatment of scabies and if an outbreak is suspected.
  + Residents with crusted scabies should be isolated until the first treatment is completed
  + Resident with classical scabies do not normally need to be isolated, as they do not have skin to skin contact with other residents, this should be assessed for each individual
  + Clean hands and wear disposable gloves when there is close contact i.e., supporting with personal care or prolonged close or skin to skin contact
  + Mites can harbour under nails, therefore the infected person’s nail care is important and should be kept short, where appropriate
  + All colleagues and residents must be assessed for symptoms of scabies infection
  + Other residents, colleagues, relatives, or close contacts may also require treatment; seek advice from the local IPC Team
  + Linen, clothing, and washable footwear should be washed at a minimum of 50°C or as recommended by the manufacturer and tumble dried.
  + Thermal disinfection at 71°C for 3 minutes or 65°C for 10 minutes is advised or washed at the highest temperature for the fabric using an antibacterial laundry sanitiser.
  + Any clothing difficult to wash can be dry cleaned or tumble dried and ironed if the fabric is suitable for ironing at a high temperature.
  + Items that cannot be washed should be placed in a sealed bag to contain the mites for a full 4 days to allow the mites to die
  + Routine cleaning of hard surfaces with general purpose cleaning fluid
  + Soft furnishings and non-wipeable covers shod be removed form use following treatment and kept in a sealed bag for 4 full days, then vacuumed
  + For crusted scabies, increase the frequency of vacuuming and deep clean after completion of treatment

Treatment

* + 1. Treatment consists of the application of two treatments, one week apart. Always seek advice from the local IPC team or prescribing GP

1. Application is best done in the evening
2. The cream must be applied to cool, dry skin to be most effective
3. Clothing nightwear and bed linen of all those treated should be washed as normal
4. Sepsis

General Information

* + 1. Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail
    2. Many doctors view sepsis as a three-stage syndrome, starting with sepsis and progressing through to severe sepsis and finally to septic shock. The goal is to treat sepsis during its mild stage before it becomes more dangerous.
    3. If sepsis progresses to septic shock, blood pressure drops dramatically, and the situation becomes life threatening. Anyone can develop sepsis, but it's most common and most dangerous in older adults or those with weakened immune systems
    4. People most **at risk** of sepsis include those -
  + Who have an infection
  + Who are very young or very old
  + Who are already weakened by a serious illness,
  + Who have just had surgery or who have wounds or injuries
  + With a medical condition or receiving medical treatment that weakens their immune system
    1. Early treatment of sepsis, usually with antibiotics and large amounts of intravenous fluids, improves a person’s chances for survival

Signs and Symptoms

If you suspect sepsis – seek medical help immediately.

* + 1. To be diagnosed with sepsis, the person must have at least two of the following symptoms -
  + Probable or confirmed infection
  + Body temperature above 101 F (38.3 C) or below 96.8 F (36 C) – possible rigors
  + Heart rate higher than 90 beats a minute
  + Respiratory rate higher than 20 breaths a minute

**Severe Sepsis**

* + 1. The diagnosis will be upgraded to severe sepsis if the person has at least one of the following signs and symptoms, which indicate an organ may be failing -
  + Significantly decreased urine output
  + Abrupt change in mental status –such as confusion or disorientation
  + Decrease in platelet count
  + Difficulty in breathing - breathlessness
  + Abnormal heart pumping function – feeling dizzy or faint, loss of consciousness
  + Abdominal pain or muscle pains
  + If tested a decreased platelet count
    1. There may also be –
  + Nausea / vomiting / diarrhoea
  + Cold, clammy, pale, or mottled skin
  + Slurred speech

\*\*Refer to NEWS Sepsis Screening tool (nursing)

1. Acute Respiratory Infections (ARI) including COVID-19

Refer to Appendix 4 for more information

* 1. The best way to reduce the spread and mitigate the harm of ARIs is to combine standard infection prevention and control precautions (SICPs) with vaccinations, available medical treatments, and proportionate outbreak management
  2. It is important that all those who are eligible for vaccination, including health and social care workers, take up their offers as soon as they become available to help protect themselves and those around them

Symptoms of Respiratory Infection including COVID-19

* + 1. Symptoms of COVID-19, flu and common respiratory infections include:
  + Continuous cough
  + High Temperature, fever or chills
  + Loss of, or change in, your normal sense of taste or smell
  + Shortness of breath
  + Unexplained tiredness or lack of energy
  + Muscle aches or pains, not due to exercise
  + Loss of appetite, not wanting to eat
  + Headache that is unusual or lasting longer than normal
  + Sore throat, stuffy or runny nose
  + Diarrhoea, feeling sick or being sick
    1. It can be difficult to distinguish between COVID-19, flu and illness caused by other respiratory viruses by symptoms alone and may be more difficult for individuals who are living with dementia or have similar condition whereby they have reduced ability to communicate feeling unwell
    2. Individuals we support and our colleagues may require a clinical review if symptoms persist for longer than expected or worsen. Antibiotics are not recommended for viral respiratory infections. However, antibiotics may be prescribed by an appropriate clinician if a bacterial chest infection is suspected
    3. An ARI outbreak may be suspected when there is an increase in the number of residents displaying [symptoms of a respiratory infection](https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19#symptoms-of-respiratory-infections-including-covid-19)
    4. An ARI outbreak consists of 2 or more positive or clinically suspected linked cases of ARI, within the same setting within a 5-day period. This means the cases may be linked to each other and transmission within the care setting may have occurred
    5. Colleagues should continue to wear facemasks (type IIR) when supporting individuals with suspected or confirmed Respiratory Infections i.e., Flu or COVID-19

1. Whooping Cough

General Information

* + 1. [Whooping cough](https://www.nhs.uk/conditions/whooping-cough/), also known as pertussis, is a highly contagious bacterial infection that mainly affects the lungs and airways and is a notifiable disease in England and Wales. Whooping cough is sometimes known as the 100-day cough because of how long it takes to recover from it.
    2. Whooping cough is a cyclical disease that regularly peaks every 3 to 5 years. Unfortunately, there are increasing rates of whooping cough, following a prolonged period of very low case numbers due to restrictions, and reduced social mixing patterns during the COVID-19 pandemic.
    3. Whooping cough can affect people of all ages and while it can be a very unpleasant illness for older vaccinated adolescents and adults, young babies who are too young to be fully protected through vaccination are at increased risk of serious complications or, rarely, death.

Signs and Symptoms

* + 1. Symptoms often start like a cold, progressing to outbursts of coughing which can sometimes cause vomiting or choking. The cough sometimes has a characteristic ‘whoop’ sound. The most effective way to prevent whooping cough is to be fully vaccinated.
    2. Whooping cough is transmitted through close contact with someone who has the disease when they are coughing or sneezing. Refer to a clinician or contact 111 for out of hours support if a case is suspected.

Treatment

* + 1. Treatment for whooping cough depends on your age and how long you've had the infection.
    2. A doctor may prescribe antibiotics to treat whooping cough if the illness started recently.  Antibiotics are only likely to help symptoms if taken within 2 weeks from the day the cough started. Hospital treatment is usually needed for severe whooping cough.
    3. If a colleague lives with a child younger than 12 months or a pregnant woman they must contact their GP for advice due to the increased risk for younger children.

Control Measures

* + 1. If a person has suspected or confirmed whooping cough use PPE as with Acute Respiratory infections. Refer to Standard Infection Control Precautions Policy for additional guidance on PPE.
    2. Managers and colleagues refer to appendix 3 for more information on exclusion periods from work.

1. Aerosol generating procedures (AGPs)
   1. Aerosol generating Procedures (AGP’s) are medical procedures that can result in the release of aerosols from the respiratory tract. The criteria for an AGP are a high risk of aerosol generation and increased risk of transmission (from patients with a known or suspected respiratory infection). Refer to Aerosol Generating Procedures for further guidance
2. Specimen Collection
   1. A specimen is a sample of body fluid e.g., urine or faeces. All specimens are a potential infection risk; therefore, all specimens must be collected using Standard Infection Control Precautions (SCIPs). Refer to Standard Infection Control Precautions Policy
   2. Specimens should be transported in a rigid container in accordance with the Carriage of Dangerous Goods and use of Transportable Pressure Equipment (2009). All colleagues handling specimens or samples have a responsibility and duty for the safe collection, handling and transporting of specimens and samples outlined within the Health and safety at Work Act (1974) and the Control of Substances Hazardous to Health (COSHH) Regulations (2002)
   3. Colleagues obtaining specimens should ensure:
   * SICPs are always applied when obtaining specimens and appropriate PPE is worn
   * Care is taken to avoid contaminating specimens
   * The container is appropriate for the purpose. If there is leakage or an inappropriate container is used, the specimen will not be processed by the laboratory.
   * Care is taken to avoid spilling the specimen, the lid is securely closed
   * Spillages of blood or body fluids should be dealt with immediately in accordance with Standard Infection Control Precautions
   * Specimens are placed inside the plastic transport bag attached to the request form after they have been labelled
   * Seal the transport bag using the seal provided, not stapled etc.

Storage

* + Wherever possible, obtain a fresh specimen at time when it can be transported to the GP practice in a timely manner
  + Specimens should be received by the laboratory as soon as possible or at least within 24 hours. Any delay can lead to inaccurate results
  + If delivery is delayed, the specimen should be placed in a suitable fridge allocated for specimens only

Specimen and Sample Storage

| **Specimen** | **Container** | **Storage** | **To laboratory** |
| --- | --- | --- | --- |
| **Wound Swab** | Sterile cotton swab containing transport medium. Charcoal medium increases survival of bacteria during transportation | Wound swabs should reach the laboratory on the day that they are taken but can be stored in a specimen fridge overnight. Do **not** leave specimens over the weekend or bank holidays | As soon as possible within 24 hours |
| **Sputum** | Plain universal container | Store at room temperature | As soon as possible within 24 hours |
| **Urine** | Universal container with boric acid | Overnight only in a specimen fridge | As soon as possible within 24 hours |
| **Faeces** | Stool specimen container | Room temperature or in a specimen fridge | As soon as possible within 24 hours |
| **Blood for routine examination** | Specific bottles as supplied | Send directly to laboratory | Direct to laboratory |

Specimen and Sample Procedures

| **Sample** | **Key information** |
| --- | --- |
| **Ear** | No antiseptic or antibiotic in the ear prior to taking the swab |
| **Eye** | Moisten a swab stick in sterile saline. Hold the swab parallel to the cornea and gently rub the conjunctiva in the lower lid.  If for Chlamydia testing, send in specific chlamydia swabs |
| **Faeces** | Ask the service user to defaecate into a receptacle - an ice cream or margarine container can be used if washed and dried or a carrier bag can be used positioned under the toilet seat. Scoop a sample of faeces into the specimen container using the container spoon provided.  Request faecal parasites if history of foreign travel.  **Note**: faecal specimens can be taken even if contaminated with urine.  If the service user has had antibiotic treatment in the past 12 weeks, request Clostridium difficile testing |
| **Nose** | Moisten the swab in sterile water. Move the swab from the anterior nares (front of the nostril) and direct it upwards into the tip of the nose. One swab is sufficient for both nostrils. |
| **Penis** | Retract foreskin. Rotate swab gently in the urethral meatus |
| **Sputum** | Sputum should be expectorated directly into a sterile container. Specimens of saliva are of no value.  Early morning specimens are the most useful |
| **Throat** | When collecting a throat swab, care should be taken to depress the tongue using a spatula, this avoids touching the buccal mucosa or tongue with the swab. Take the specimen from the posterior pharynx, tonsils, area with lesion or visible exudates |
| Mid-stream sample of **urine** (MSU / MSSU) **male** | Retract the foreskin and clean the surrounding urethral meatus with soap and warm water. Ask the service user to urinate, passing the first part into a urinal bottle / toilet, but to collect the middle part of the specimen into a sterile bowl. Pass the remainder into the urinal bottle / toilet. The specimen container must contain boric acid. |
| Mid-stream sample of **urine** (MSU / MSSU) **female** | Clean the genitalia with soap and warm water, wiping from front to back. Ask the service user to urinate, passing the first part into a bedpan / toilet, but to collect the middle part of the flow into a sterile bowl. Pass the remainder into the bedpan / toilet. The specimen container must contain boric acid. |
| **Urine**: Catheter specimen of urine (CSU) | Clean the catheter sampling port with an alcohol swab. Use a sterile syringe to withdraw the specimen. Transfer the specimen in to a urine specimen container. The specimen container must contain boric acid |
| **Wound swabs** | A sample of pus is preferred to a swab. However, if there is not enough pus to provide a sample, take a swab of any pus or exudate present.  If the swab is taken from an ulcer, clean away any debris with saline before taking the swab. Swabbing of dry crusted areas is unlikely to be helpful. |

1. Antimicrobial Stewardship
   1. Antimicrobial resistance (AMR) is a significant, and growing threat to public health in the UK and around the world. AMR has been identified as one of the most pressing global challenges this century
   2. Antimicrobial resistance occurs when the microorganisms which cause disease (including bacteria, and viruses) are no longer affected by antimicrobial medicines such as antibiotics, antifungals, that are used to kill them, prevent and treat disease
   3. While resistance is a natural occurrence from a healthcare perspective, it is accelerated by:
   * Inappropriate use of antimicrobial drugs
   * Poor infection prevention and control procedures
   * A lack of new antimicrobial drugs being developed

Our role and responsibilities in supporting Antimicrobial resistance

* + Early prevention of infections, always use Standard Infection Control Precautions (SICPs) when providing care and support for our residents
  + Timely, accurate diagnosis of individuals when they develop symptoms. It is essential that dip sticking of urine is not undertaken to diagnose a urinary tract infection (UTI) in those over 65 years of age or those with a urinary catheter
  + Appropriate prescribing and use of antimicrobials only when there are clinical signs of infection e.g., UTI, for which antibiotics are the most appropriate treatment
  + Effective management of infections ensuring individuals receive their treatment on time, complete the prescribed course and ensure individuals are able to take treatment via the route prescribed

1. Standard Operating Procedures – Managing Outbreaks
   1. Refer to Appendix 1, 2 and 4 for guidance for infection control outbreak management in response to specific infections

Definition of an Outbreak

* + Two or more cases of residents OR colleagues with the same infection or symptoms linked in time or place
  + A greater than expected rate of infection compare with the usual background levels for the place and time where the outbreak has occurred
  + A suspected, anticipated, or actual event involving microbial or chemical contamination of food or water
  1. Local Community Infection Prevention and Control Teams deal with day-to-day advice and support to a wide range of community settings where infection control is important; advice must be followed in the event on an outbreak
  2. Effective control depends on early recognition and timely intervention. All colleagues should be aware of symptoms amongst residents and colleagues, which may indicate a possible outbreak, for example:
  + Cough and/or fever may represent influenza
  + Diarrhoea and/or vomiting may indicate norovirus or food poisoning
  + Skin lesions/rash may indicate scabies

If there is cause to suspect a problem, contact your local community IPC team or UKHSA team.

| Procedures to follow during a Confirmed or Suspected Outbreak | |
| --- | --- |
| **Specimen Collection** | If requested by the GP or local IPCT collect samples for Microbiology, Culture and Sensitivity.  \*Refer to Section 11 for more information |
| **Cleaning Schedules**  **Standard Infection Control Precautions (SICP’s)**  **Transmission based precautions (TBP’s)** | Increase frequency and intensity of cleaning – work with Hospitality Manager and housekeeping teams  Implement **TBP’s** - Second tier of basic infection control to be used in addition to SICP’s for individuals who may have a confirmed or suspected infection for which additional precautions are required   * Make sure any disinfecting agent works against the germs causing the infection – refer to manufacturer’s guidance * All touch points, toilets, taps, and door handles at least three times a day * Use separate cloths, mops, and buckets for each infection area * Wash, clean, and change all affected soft furnishings, including curtains when the outbreak has concluded * Make sure enough alcohol hand gel, protective clothing and yellow waste bags are available for people / staff to use. |
| **Isolation** | Isolation can be distressing for some of the people we support and should be only when essential, following advice and, in an individual’s, best interests.   * Provide explanations for isolation in a way the person can understand * There will be times when it is easier to group people together if they have difficulty staying in one place * Complete a short-term support plan including reasons for isolation, likely duration, precautions and how to support with physical and emotional needs |
| **Admissions, Visitors and Contractors** | In consultation with the area manager and / or on the advice of the local HPT, in some cases, the manager may have to close the service to new admissions, MHA visitors and contractors until the infection outbreak is over.   * Visiting - Communicate with any visitors and provide advice on visiting, how to keep safe and the use of any PPE if required. Refer to latest national guidance regarding support for visitors and our residents * Consider safe visiting, refer to guidance and Infectious Illness Outbreaks Risk Assessment to ensure any restrictions are proportionate and considered in accordance with legislation [Care Quality Commission (CQC) fundamental standard](https://www.cqc.org.uk/guidance-providers/regulations/regulation-9a-visiting-and-accompanying) on visiting and accompanying (Regulation 9A), * Display courtesy notices to alert people visiting the service that colleagues have not managed to speak to. |

Reporting

* + All infections must be reported on RADAR, whether this is a single incident or outbreak.
  + Suspected or confirmed outbreak incidents must be reported to the local Community Infection, prevention, and Control Teams (IPCT) (refer to appendix 4)
    1. The home or scheme manager must produce an annual statement on the local systems in place and how these are monitored. The statement will be completed every February giving details from January to December of the previous year. Statements will be forwarded to MHA’s Safeguarding Lead by March 1 for review and inclusion in the MHA’s overall report due in May / June of each year
    2. The annual statement includes -
  + Information on incidents and outbreaks of infection excluding COVID-19 as this is captured elsewhere
  + Details of how the incident or outbreak was communicated to people using our services, staff, and visitors etc.
  + Outcomes of infection prevention and control audits
  + Risk assessments
  + Training and education of staff

1. Roles and Responsibilities

| Role | Responsibilities |
| --- | --- |
| **MHA Infection, Prevention and Control Lead** | Support, advise and assist in infection prevention and control matters within the organisation.   * Make sure that infection prevention and control is included in all job descriptions and all colleagues and volunteer inductions and training * Develop strategies on infection prevention and control and oversee their implementation * Act on legislation, national policies, and guidance, making sure that required changes to company policies are made * Confirm to the Executive Leadership Team and the Board that policies are fit for purpose   In April of every year, provide a report containing a summary of the home or scheme managers’ annual statements and details of the infection control actions taken by MHA the previous year (including any policy or procedural changes that have been made).  This report will be included in MHA’s overall report due in May / June of each year. |
| **IPC Champions** | The IPC Champions role is to increase awareness of infection control issues in the home/scheme and to motivate staff to improve practice.  Key Role   * Liaises between their team and other infection control teams e.g. Local Authority * Acts as role model and is a visible advocate for IPC and actively promotes IPC issues * Celebrates achievements and best practice * Challenges when standards are not met. * Enables individuals to learn and develop their IPC practice * Act as a resource for colleagues e.g. disseminating information on policies and procedures * Help to identify local infection control problems/issues * Ensures infection control is included in induction for new staff * Ensures that residents/clients and relatives are informed of infection control practices as necessary * Regularly attends Infection Control Champion meetings or updates on a quarterly basis * Updates and extends own knowledge of infection control. * Develops and creates methods for communication such as IPC notice boards, as part of staff meetings * Supports completion of local review/audit/surveillance * Enables others to challenge practice when standards are not met. * Stimulates an interest in others about IPC and the Champion role * Contributes to local risk assessment and patient safety processes. |
| **All MHA Colleagues** | * Must comply with Standard Infection Control Precautions to reduce the risk of infection in all care settings * Work with specialists such as the Local Infection Prevention & Control Team / Nurse (IPCT) * Communicate with Health Protection for advice and to inform and update them about any infection outbreak situation. * Communicate with the Local Environmental Health Officer (EHO) for advice / information, especially if food may be involved. * Inform the person and provide support with the infection about it and make sure relevant documents such as short-term support plans are completed. * Protect others by letting them know about the infection outbreak – this will include people using our services, colleagues, and visitors to the service. * Make sure of thorough cleaning and decontamination. * Complete notification or alert records – RADAR reporting / infection notifications / outbreak records accordance with their role and responsibilities * Report any concerns or issues relating to infection prevention standards, including any personal issues relating to contact with infected persons inside or outside of the service * Report any personal infections to line managers who will complete a risk assessment in relation to the relevant infection. Refer to Colleague exclusion from work guidance (Appendix 2) * Comply with all related policy documents relating to infection prevention and control * Provide updates on an individual’s presentation or changes to their health and wellbeing to senior colleagues |
| **Home/Service Managers** | Managers have overall accountability for compliance with this policy, procedures, and any associated requirements to enable safe and effective implementation of all infection, prevention, and control practices   * Completion of quarterly infection prevention audits, completion of all actions, as required * Notify the local Infection Prevention Control Team (IPCT) if two or more individuals (including colleagues) have the same infection (outbreak) * Follow advice from the IPCT regarding action to take regarding restriction of visitors or closing the home during the outbreak period. Monitor compliance with actions required * Complete all required notifications to internal and external agencies including internal RADAR reporting * Complete annual IPC statement (February) * Ensure sufficient stocks of PPE, additional cleaning products and red bags (for infected clothes and laundry) are available for use * Provide guidance and support to teams, visitors, and significant others regarding the requirements during an infection outbreak * Complete and action any risk assessments in relation to infection, infestation, and transmission risks |
| **Housekeeping** | Comply with this policy and associated infection, prevention, and control procedures   * Follow all cleaning schedules and manufacturer’s instructions for all products, maintaining safe working practices at all times * Follow any recommendations as advised by service managers during an infection outbreak |

1. Training and Monitoring
   1. The relevant service or home manager must make sure all colleagues have training in infection prevention procedures including wearing PPE with additional input tailored to their workplace setting and job roles.
   2. The manager (care homes) will keep overall responsibility for infection control but must consult with colleagues and identify an infection control champion for the home. The champion willagree to attend as much training as possible about infection control and develop a helping / consulting role for all staff. This will mean sharing knowledge, new practices, resources and offering advice. It will not mean that the person must do everything in connection with infection control
   3. Compliance is assessed through MHA’s Infection Control Audits, on a quarterly basis. MHA’s operational auditing process monitors actions completed and outstanding.
   4. Services are subject to external monitoring through local IPC teams and regulatory bodies i.e., Care Quality Commission (CQC)
2. Communication and Dissemination
   1. This policy is disseminated and implemented within all MHA services through MHA’s channels of communication.
   2. Each colleague’s line manager must ensure that all teams are aware of their roles, responsibilities.
   3. This policy will be available to the people we support and their representatives in alternate formats, as required.
   4. Any review of this policy will include consultation with our colleagues, review of support planning, incident reports, quality audits and feedback from other agencies.

Further information and guidance can be found on MHA’s intranet in the [Connect with Infection Prevention and Control](https://intranet.mha.org.uk/Interact/Pages/Section/Default.aspx?Section=8325)

* 1. Infection, Prevention, and Control Group meeting minutes are also available on the intranet
  2. For any specific queries relating to Infection, Prevention and Control contact MHA’s IPC lead [infection.control@mha.org.uk](mailto:infection.control@mha.org.uk)
  3. Queries and issues relating to this policy should be referred to the Standards and Policy Team [policies@mha.org.uk](mailto:policies@mha.org.uk)

1. Impact Assessments (Inc. EDI)
   1. Equality, Diversity, and Impact Assessment to be confirmed.
2. Resources

[Infection, Prevention and Control](https://intranet.mha.org.uk/Interact/Pages/Section/Default.aspx?Section=8325)

* 1. For clinical policies and procedures refer to the associated policy for more information
  2. Additional polices related to Infection, Prevention and Control can be located on MHA’s intranet:
  + Standard Infection Control Precautions
  + Infectious Illness Outbreaks Risk Assessment
  + Infection Control - Annual Statement
  + Infection Control - Outbreak Record
  + Infection Control - Equipment Cleaning Checklist
  + Infection Control – Equipment Decontamination Record
  + Infection Control – Mattress and Cushion Inspection
  + Infection Control Audits (Care Homes)
  + Infection Control Audits (Retirement Living)
  + Aerosol Generating Procedures
  + Waste Disposal Policy
  + Sharps Safety and Management
  + COSHH
  + Uniform and Dress Code Policy
  + Code of Conduct
  + Housekeeping (HKH) Policies
  + Incident response and Escalation Policy
  1. External References, Resources, and Guidance used to develop this policy document

* + [Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) - GOV.UK (www.gov.uk)](https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-acute-respiratory-infection/infection-prevention-and-control-ipc-in-adult-social-care-acute-respiratory-infection-ari" \l "if-a-staff-member-has-symptoms-of-acute-respiratory-infection)
  + [Care Outbreak Risk Assessment (Care OBRA)](https://forms.ukhsa.gov.uk/ReportAnOutbreak/acute-respiratory-infections-ari---covid-19-flu-or-unknown-infection-in-adult-social-care-settings)
  + [Supporting safer visiting in care homes during infectious illness outbreaks](https://www.gov.uk/guidance/supporting-safer-visiting-in-care-homes-during-infectious-illness-outbreaks?utm_medium=email&utm_campaign=govuk-notifications-topic&utm_source=5208034b-673e-4317-bdf5-874ebcbd6adc&utm_content=immediately) (gov.uk)
  + [Infection Prevention and Control: resource for adult social care](https://www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings/infection-prevention-and-control-resource-for-adult-social-care#general-information)
  + [Standard Infection Prevention Control Precautions (SICPs)](https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/nipcm/chapter-1-standard-infection-control-precautions-sicps/) Wales

* + [Wales: Infection, prevention and Control Measures for Acute Respiratory Infections, including COVID-19](https://phw.nhs.wales/services-and-teams/harp/infection-prevention-and-control/guidance/infection-prevention-and-control-measures-for-acute-respiratory-infections-ari-including-covid-19-for-health-and-care-settings-wales2/)
  + [Health and Social care Act 2008: code of practice on the prevention and control of infections and related guidance](https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance/health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance" \l "guidance-tables)
  + [NICE: Infection Prevention and Control](https://www.nice.org.uk/guidance/qs61)
  + [Care Homes - Infection Prevention Control](https://www.infectionpreventioncontrol.co.uk/care-homes/)
  + [Health and Safety Executive – Control of Substances Hazardous to health](https://www.hse.gov.uk/coshh/)
  + [HSE; The Carriage of Dangerous Goods Act 2009](https://www.hse.gov.uk/cdg/regs.htm)

1. Appendices
   * Appendix 1: Infection control – information and reporting
   * Appendix 2: Infection Control Outbreak Management
   * Appendix 2: Colleague exclusion from work for infection
   * Appendix 4: Infection, Prevention and Control, Acute Respiratory Infections including COVID-19

**Appendix 1 - infection control - information and reporting**

**Note:** More information is available on MHA’s Infection Prevention and Control intranet page [Infection Prevention and Control](https://intranet.mha.org.uk/Interact/Pages/Section/Default.aspx?Section=8325)

| **Infection** | **Report to** | **Possible Causes** | **Isolation Required** | **Precautions** | **Special Instructions** | **Cleaning** |
| --- | --- | --- | --- | --- | --- | --- |
| **Blood borne Infections** | GP  Community Infection, Prevention and Control Teams (IPCT) | Jaundice associated with Hepatitis B and C or HIV  Direct contact with an infected person’s  blood or body fluid presents a hazard | No | * Standard Precautions * PPE * Laundry to be placed and washed in red sealed bag (60° for at least 10 minutes or 71° for 3 minutes or at the highest temperature for the fabric with a sanitising detergent * Hep B Immunisation | care with -   * sharps and bodily fluids human bites/scratches * contamination of abrasions * splashes of body fluids onto mucous | Hot water and detergent  Oxivir |
| **Food Poisoning** | GP  Community Infection, Prevention and Control Teams (IPCT) | * Staphylococcal * Clostridium * E.Coli * Salmonella * Campylobacter * Listeria * B Cereus * Shigella | No as not infectious | * None - review hand hygiene * Continue Food Safety * Colleagues must remain away from work for 48 hours after the end of an infection such as D&V | Retain food samples  May need to have stool samples taken (EHO will advise). | Hot water and detergent  CCA0101-RTU Sanitiser  Oxivir |
| **Gastroenteritis**  **Diarrhoea and Vomiting** | GP  Community Infection, Prevention and Control Teams (IPCT) | * NoroVirus * Rotavirus * E.Coli * Salmonella * Shigella * Clostridium Difficile * Viral Gastroenteritis | Single room and separate toilet  (may be difficult if person is living with dementia) | * Standard Precautions * PPE * Meticulous handwashing * Laundry to be placed and washed in red sealed bag (60° for at least 10 minutes or 71° for 3 minutes) at the highest temperature for the fabric with a sanitising detergent | Report if two or more cases occur  May need to have stool samples taken (HPT will advise) | Extra cleaning – especially door handles.  Hot water and detergent  Oxivir |
| **MRSA** | GP  Community Infection, Prevention and Control Teams (IPCT) | Staphylococcus Aureus | Only if an open wound is present and not covered | * Standard Precautions * PPE * If open wound - Laundry to be placed and washed in red sealed bag (60° for at least 10 minutes or 71° for 3 minutes or at the highest temperature for the fabric with a sanitising detergent | Advise hospitals or other medical agencies if being admitted or outpatient appointment | Hot water and detergent  Oxivir |
| **Acute Respiratory Infections (ARI)**  **including COVID-19** | GP  Community Infection, Prevention and Control Teams (IPCT)  UKHSA HPT | * Bacteria * Viral (incl. influenza) * Pneumonia   COVID-19 virus | Yes, for colds / flu and COVID-19  No if pneumonia | * Standard Precautions * PPE * Use tissues once only. * Cover mouth to cough & wash hands * Laundry to be placed and washed in red sealed bag 60° for at least 10 minutes or 71° for 3 minutes or at the highest temperature for the fabric with a sanitising detergent | Report if two or more residents suspected | Hot water and detergent  Oxivir |
| **Skin Infections / Infestations** | GP  Community Infection, Prevention and Control Teams (IPCT)  UKHSA HPT | * Scabies * Shingles (Herpes Zoster) * Impetigo * Pinworms, Threadworms * Cold sores (Herpes Simplex) * Fleas * Head / Body Lice | Yes, until lesions are crusted, or treatment is complete  Separate toilet or commode | * Standard Precautions * PPE * Special laundry instructions | Treat all contacts at the same time if two or more people with scabies  cold sores, fleas, head / body lice are not reportable, but RADAR reporting will be required if more than two people with the same issue. | Hot water and detergent  Oxivir |
| **Tuberculosis** | GP  Community Infection, Prevention and Control Teams (IPCT)  UKHSA HPT | * Pulmonary TB | Yes, until two weeks after treatment has started - | * Laundry to be placed and washed in red sealed bag 60° for at least 10 minutes or 71° for 3 minutes or at the highest temperature for the fabric with a sanitising detergent | Infection Control will advise on contacts | Hot water and detergent  Oxivir |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Notifiable under the Public Health (Control of Disease) Act 1984** | | | | | |
| Cholera | Food Poisoning | Plague | Relapsing Fever | Smallpox | Typhus |
| **Notifiable under the Public Health (Infectious Diseases) Regulations 1988** | | | | | |
| Acute Encephalitis | Acute Poliomyelitis | Anthrax | Diphtheria | Dysentery (Amoebic and Bacillary) | Leprosy |
| Leptospirosis | Malaria | Measles | Meningitis | Meningococcal Septicaemia (without meningitis | Mumps |
| Ophthalmia Neonatorum | Paratyphoid Fever | Rabies | Rubella | Scarlet Fever | Tetanus |
| Tuberculosis | Typhoid Fever | Viral Haemorrhagic fevers | Viral Hepatitis | Whooping cough | Yellow fever |

Advice about the reporting of cases may be obtained from the Health Protection England or Public Health Wales.

**If colleagues are exposed to an occupational hazard, an incident may be RIDDOR Reportable.**

**Appendix 2 - Infection Control Outbreak Management –** Action to take in response to specific infections

\*Transmission Based Precautions (TBP’s) must be implemented for all Infection Outbreaks in addition to Standard Infection Prevention Precautions (SICP’s)

| **Disease or causative**  **organism** | **Mode of transmission** | **Period of infectivity** | **Additional Infection control precautions (TBP’s)** | **Notes** | **Notifications**  **(All reportable infections to be placed on Radar)** |
| --- | --- | --- | --- | --- | --- |
| ***Bacillus cereus***  **Food Poisoning** | Food  (preformed  toxin) | Not infectious. | None. | Retain food samples. | * GP * Infection Control (Team / Nurse) * Health Protection Team * EHO |
| ***Campylobacter***  ***Spp.*** | Food  Hand-to- mouth  Pet faeces | While diarrhoea | Single room if incontinent. (may be difficult if person is living with dementia) Separate toilet. | A local risk assessment should be undertaken to determine if pets in contact with resident need to be examined by a vet. | * GP * Infection Control (Team / Nurse) * Health Protection Team * EHO |
| **Chickenpox**  **(varicella)** | Airborne | Infectious for 1–2 days before the onset of symptoms and 6 days after rash appears or until lesions are  crusted (if longer). | Single room. | Pregnant colleagues and visitors who are not immune should avoid contact. Local HPU will advise on the management of contacts and may advise immunoglobulin and early antiviral therapy. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Clostridial food**  **poisoning**  **(*C. perfringens*)** | Food | Not infectious. | None. | Toxin formed in gut after  ingestion. Retain Food  samples | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Clostridium**  **difficile** | Hand-to-mouth | While diarrhoea | Single room. | May need treatment with antibiotics. Likely to cause outbreaks. | Yes- if there is a risk of cross  Infection   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Cold sore**  **(herpes**  **simplex)** | Direct contact with sore | Until lesions crusted. | Use gloves for handling lesions, feeding or mouth  care. |  | No |
| **Conjunctivitis** | Direct contact with  the discharge | Until 48 hours after treatment. | Gloves/no touch  technique when  dealing with  discharge. Personal  hygiene/hand  hygiene. |  | If two or more related cases are suspected   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| ***Cryptosporidiu***  ***m* spp.** | Water  Hand-to-mouth | While diarrhoea  persists. | Single room.  Separate toilet. |  | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| ***Escherichia coli***  **including**  **verotoxin-**  **producing *E.***  ***coli* (VTEC)** | Food  Hand-to-mouth | Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/Incontinent. | Single room until 48 hours after diarrhoea stops.  Separate toilet. | Retain food samples. Complications include haemolytic uremic syndrome.  Contact the HPU for advice on contact tracing and sampling. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **German**  **measles**  **(rubella)** | Droplet, direct  contact with  infectious  secretions. | Incubation period of  14–17 days. (range 14  – 21).  Individuals are infectious from about one week before, and at least four days after, the onset of the rash. | Single room | Pregnant colleagues should know their immune status and seek advice if not immune.  Non-pregnant colleagues should be immunised if susceptible. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Giardia lamblia** | Water  Hand-to-mouth | Until treated | Single room, if incontinent. Separate toilet. |  | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Hepatitis A** | Hand-to-mouth  Food | The incubation period is 15 –50 days, average 28–30 days. Maximum infectivity  occurs during the latter half of the incubation period and continues until 7 days after  Jaundice appears. | Single room.  Separate toilet. | May be asymptomatic but can be severe and prolonged in older people. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Hepatitis B** | Contact with  infected blood or other body fluids  Sexual  transmission | Variable, but can be for life. | Strict application of standard precautions, including care with sharps and body  fluids | Immunisation of some colleagues may be recommended. | Yes – for acute infection(jaundice)  No – for chronic  carrier state   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Hepatitis C** | Contact with  infected blood or other body fluids | For one or more weeks prior to onset of the  first symptoms; may persist indefinitely. May be lifelong infection | Standard precautions  including care with sharps and body fluids. |  | Yes – for acute infection (jaundice)  No – for chronic carrier state   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **HIV/AIDS** | Contact with infected blood or other body fluids  Sexual transmission | For life. | Standard  precautions,  including care with sharps (see pages 30  - 31) and body fluids. | Resident’s GP, consultant and the Local  HPU will collaborate with management. | * No |
| **Impetigo**  **(*staphylococcal***  ***Or***  ***streptococcal*)** | Direct contact with  lesions | Until crusted over. | Single room until 48 hours after treatment started.  Cover lesions if mixing with other  residents. | The bacterium may be carried in the nose of infected resident, other residents or staff. | If more than two cases  Suspected   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Infectious**  **mononucleosis**  **(glandular**  **fever)** | Contact with saliva | Variable – may be several weeks. | Care with articles soiled with nasal or throat discharges. Encourage hand  hygiene. |  | No |
| **Influenza or**  **influenza-like**  **illness** | Droplet  Direct and indirect  contact. | While symptomatic. | Single room.  Reinforce the  importance of  respiratory and hand hygiene. | Immunisation of residents. | If influenza is confirmed by laboratory. Otherwise, if more than two cases suspected   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Measles** | Airborne, direct  contact with  infectious  secretions. | Incubation period is approximately 10 days (range 7 – 18 days) from exposure to onset of fever and, usually,  14 days before the  rash appears. The | Single room | Local HPU will advise on the management of contacts. Pregnant colleagues should know their immune status and seek advice if not immune.  All colleagues should have received 2 doses  of MMR or have natural immunity. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Mumps** | Droplet | Incubation period  around 17 days (range  14 - 25). Greatest infectivity is from 2 days before the onset of symptoms to 4 days after symptoms  appear. | Single room. | Local HPU will advise on the management of contacts. Colleagues should have received 2 doses of MMR. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Norovirus** | Hand-to-mouth  Droplet | Up to 48 hours after symptoms have  resolved. | Single room.  Separate toilet. | Very likely to cause outbreaks. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Pinworms,**  **threadworms** | Hand-to-mouth  Airborne during bed  making | Until treated. | Personal hygiene,  including hand  hygiene. | Vacuum room of infected person daily for several days. | If more than two cases  Suspected   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Pulmonary**  **tuberculosis** | Airborne if ‘open’  case (sputum smear positive). Otherwise not  infectious | Normally 2 weeks after starting treatment. | Single room if sputum smear positive. | Local HPU will advise on the management of contacts  (residents and staff). | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Rotavirus** | Hand-to-mouth  Droplet | Up to 48 hours after symptoms have  resolved. | Single room.  Separate toilet. | Very likely to cause outbreaks. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| ***Salmonella* spp.** | Food  Hand-to-mouth | Variable, but unlikely to infect others by 48 hours after diarrhoea stops, unless poor hygiene/  incontinent. | Single room until 48 hours after diarrhoea stops.  Separate toilet. | Retain food samples.  Organism can be in stools for weeks/  months after infection. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Scabies** | Person-to-person  (close contact) | Until treated. | Single room until 24 hours after treatment Launder resident’s clothing and bedding | Untreated or the immune suppressed may develop more severe form of scabies. In this case it may be necessary to treat other residents, colleagues, and family members. | If more than two related cases suspected   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| ***Shigella* spp.** | Hand-to-mouth  Water or food contaminated by infected water | Variable, but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/  incontinent. | Single room until 48 hours after diarrhoea stops.  Separate toilet. | Very likely to cause outbreaks. Complications include haemolytic uremic syndrome. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Staphylococcal**  **food poisoning** | Food (preformed  toxin) | Not infectious. | None | Retain food samples.  Food contamination from infected fingers, eyes, etc. of food handlers likely. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Shingles**  **(herpes zoster)** | Usually, reactivation  (of chickenpox)  Direct contact with rash  Airborne | Until lesions crusted | A resident with shingles may mix with other residents if rash can be covered. | Colleagues and residents should not be in contact unless immune to chickenpox. | If management  of case poses  difficulties   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Viral**  **gastroenteritis**  **(undiagnosed)** | Hand-to-mouth  Droplet | Variable. May be several days after  symptoms resolve | Single room.  Separate toilet. | Very likely to cause outbreaks. | If more than two cases occur   * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **Whooping**  **cough**  **(pertussis)** | Droplet | Five days after start of appropriate antibiotic  treatment. | Single room | Local HPU will advise on the management of contacts. | * GP * Infection Control (Team / Nurse) * Health Protection Team |
| **INFESTATIONS** | | | | | |
| **Body lice** | Person-to-person  Contact with infected clothing or bedding | Until treated. | If new resident, single room until treated. (may be difficult if person is living with dementia)  Disposable gloves and a plastic apron should be worn to remove all clothing | Launder resident’s  Clothing and bedding.  A hot wash cycle (60ºc or more) must be used for any clothing washed within the home. Fifteen minutes in a hot tumble dryer kills lice and eggs. | * No |
| **Fleas** | From pets  Person-to-person | Until treated. | If new resident, single room until treated.  Treat pets. Launder resident’s clothing and bedding. | Vacuum room of infected person daily for several days, with particular attention to pest resting sites. | No |
| **Bed Bugs** | From room to room and person - person | Until Treated | Keep the bedroom clean and clear of clutter where bed bugs can hide, especially clothing.  Use a protective cover over the mattress.  Vacuum regularly.  Seal any cracks or crevices in the walls | Extermination is recommended but not always effective  **\*\*Mattresses not purchased by MHA must not be brought into a care home due to the increased risk of infestation** | * No |
| **Head lice** | Person-to-person | Until treated | Combing egg cases (nits) and live lice from hair. |  | * No |

# Appendix 3 - Colleague exclusion from work for infection

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Minimum Exclusion Period | |
| A – Z of Disease | Period of infectivity | Colleagues suffering from infection / disease | Contact with a case of infection at own home / external |
| Chickenpox | Infectious for 1-2 days before the onset of symptoms and six days after rash appears or until lesions are crusted | Six days from onset of rash | None - Non-immune pregnant women should seek medical advice |
| Acute Respiratory Infection (ARI)including COVID-19 | Onset of ARI symptoms  COVID-19 – positive test | Stay at home until no longer presenting with symptoms – risk assessment required before return | Risk assessment with line manager  SIPC’s procedures/PPE etc. |
| Diarrhoea and Vomiting | As long as organism is present in stools, but mainly while diarrhoea lasts | Until clinically well and 48 hours without symptoms. HPT, EHO or Infection Control Team may advise a longer period (C Diff is 72 hours) | Notifiable if part of an outbreak – (2 or more cases) |
| Food Poisoning -   1. Staphylococcal 2. Clostridium 3. E.Coli 4. Salmonella | Dependent on type of infection the incubation period could be from three to four days. | Until clinically well and 48 hours without diarrhoea or vomiting. HPT, EHO or Infection Control Team may advise a longer period. | HPT, EHO or Infection Control Team will advise on local policy. |
| Gastroenteritis  including salmonellosis and shigellosis | As long as organism is present in stools, but mainly while diarrhoea lasts | Until clinically well and 48 hours without diarrhoea or vomiting. HPT, EHO or Infection Control Team may advise a longer period | HPT, EHO or Infection Control Team will advise on local policy. |
| Glandular Fever | When symptomatic | Until clinically well | None |
| Head Lice | As long as lice or live eggs are present | Exclude until treated | Exclude until treated |
| Hepatitis A | The incubation period is 15-50 days - average 28-30 days. Maximum infectivity occurs during the latter half of the incubation period and continues until seven days after jaundice appears | One week after onset of jaundice | None - immunisation may be advised by GP |
| HIV /AIDS | For life | None | None |

**Colleague exclusion from work for infection (page 2)**

|  |  |  |  |
| --- | --- | --- | --- |
|  | | Minimum Exclusion Period | |
| A – Z of Disease | Period of infectivity | Colleagues suffering from infection / disease | Contact with a case of infection at own home / external |
| Impetigo | As long as purulent lesions are present | Until skin is healed or 48 hours after treatment started | None, avoid sharing towels |
| Measles | Four days before & four days after rash appears | Four days from onset of rash | None |
| Meningitis | Varies with organism | Until clinical recovery | None |
| Mumps | Greatest infectivity from two days before onset of symptoms to four days after symptoms appear | Four days from onset of rash | None |
| Ringworm  1. Tinea Capitis (head)  2. Tinea Corporis (body) | As long as active lesions are present  As long as active lesions are present | Exclusion may not always be necessary unless epidemic suspected | None |
| Rubella (German Measles) | One week before until five days after onset of rash | Four days from onset of rash | None |
| Scabies | Until mites and eggs have been destroyed | Until day after treatment is given | None - GP to treat family or other contacts |
| Shingles | Until after the last of the lesions are dry | Until all lesions are dry – minimum six days from onset of rash | None |
| Streptococcal Sore Throat and Scarlet Fever | As long as organism is present in throat, usually up to 48 hours after antibiotic is started | Until clinically improved - usually 48 hours after antibiotic is started | None |
| Threadworms | As long as eggs present on perianal skin | None but requires treatment | Treatment necessary |
| Tuberculosis | Depends on part infected. Residents / colleagues with open TB usually become non-infectious after two weeks of treatment | If open TB, until cleared by TB clinic. No exclusion necessary in other TBs | Will require medical follow up |
| Verrucae (Plantar Warts) | As long as wart is present | None - cover with waterproof dressing for swimming / if bare foot | None |
| Whooping cough | One week before until three weeks after onset of cough or five days after start of antibiotic treatment | Until clinically well but check with HPT / Infection Control Team | GP advice if living with a pregnant woman or child. |

# Appendix 4 – Infection, Prevention and Control (IPC) for Acute Respiratory Infections (ARI’s), including COVID-19

| Topic | Action |
| --- | --- |
| **IPC Best Practice** | * Hand hygiene between tasks with soap and water or alcohol-based hand rub * Respiratory and cough hygiene (catch it, bin it, kill it!) * Regularly letting fresh air into rooms and shared areas (for more information on ventilation, see guidance on [Ventilation to reduce the spread of respiratory infections, including COVID-19](https://www.gov.uk/guidance/ventilation-to-reduce-the-spread-of-respiratory-infections-including-covid-19)) * Cleaning of shared equipment, especially after use * Regular cleaning of the environment with particular attention to frequently touched surfaces and shared areas * Appropriate use of personal protective equipment (PPE) * Correct handling and segregation of waste and infectious linen * Adult social care clients should also be supported to contribute to SICPs by handwashing, cough hygiene and other simple measures as appropriate. |
| **Vaccination** | It is important that all those who are eligible for vaccination, take up their offers as soon as they become available to help protect themselves and those around them.   * Information will be provided for all vaccination campaigns with Q&A leaflets, posters, and stickers available on campaigns via the [DHSC campaign resource centre](https://campaignresources.dhsc.gov.uk/campaigns/) * Commencing the consent process for residents in good time to maximise uptake for eligible people in residential care settings |
| **COVID-19 Vaccination** | COVID-19 vaccines are offered during seasonal campaigns to those at high risk of serious disease from COVID-19 and who are therefore most likely to benefit from vaccination. Additional vaccination doses may be available outside seasonal campaigns to severely immunosuppressed individuals, in line with [Green Book Chapter 14a COVID-19](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1186479/Greenbook-chapter-14a-4September2023.pdf) recommendations.   * Latest information on [COVID-19 vaccine campaigns](https://www.nhs.uk/conditions/covid-19/covid-19-vaccination/) and [COVID-19 vaccination programme](https://www.gov.uk/government/collections/covid-19-vaccination-programme). |
| **Flu Vaccination** | Flu vaccination is an important defence against severe outcomes caused by the flu virus and reduces the risk of co-infection with COVID-19 and flu. People who are at higher risk of flu-associated serious illness and death, including older people and those in clinical risk groups, continue to be prioritised in seasonal campaigns for vaccination.   * Frontline social care workers, including both clinical and non-clinical staff who have contact with people with care and support needs, should also be made aware of the flu vaccination offer, when available, by their employer. * Carers are also eligible for Flu vaccines, which reduce the risk of becoming seriously unwell. [More information about flu vaccinations for carers](https://www.gov.uk/government/publications/flu-immunisation-for-social-care-staff/flu-vaccination-guidance-for-social-care-workers#identification-needed-to-prove-you-are-a-social-care-worker-or-carer) * Separate advice on flu vaccination is available for [social care providers](https://www.gov.uk/government/publications/flu-immunisation-for-social-care-staff/flu-immunisation-for-social-care-and-hospice-staff-guidance-for-providers) and [staff](https://www.gov.uk/government/publications/flu-immunisation-for-social-care-staff/flu-vaccination-guidance-for-social-care-workers) |
| **COVID-19 Treatments** | * People who are at higher risk of severe outcomes from COVID-19 may be [eligible for COVID-19 treatments](https://www.nhs.uk/conditions/covid-19/treatments-for-covid-19/) if they become unwell * If someone who is eligible for COVID-19 treatments develops [COVID-19 symptoms](https://www.nhs.uk/conditions/covid-19/covid-19-symptoms-and-what-to-do/), they should be tested as soon as possible with a LFD test. * These LFD tests will be provided by National Health Service England (NHSE) and are available from your [local pharmacy [nhs.uk]](https://urldefense.com/v3/__https:/www.nhs.uk/service-search/pharmacy/find-a-pharmacy__;!!C98Db8Ma!KlvNNBKETtQCA15OGcwdo4_zusp6L_z-qXYKB6FH1f9Ca0MfvU0fheB2vP9hOLc9g2_erLz9HkxfacGgTnkm3cP0EZ8L8PDfpAg$). * If eligible, Individuals should have received a letter from the NHS explaining how to access COVID-19 treatments and be made aware by their doctor or specialist at the point they are diagnosed with a qualifying condition or start a qualifying treatment * If someone who may be eligible for COVID-19 treatments tests positive for COVID-19,   organise an assessment for COVID-19 treatments for them.   * If in doubt, contact the Local Integrated Care Board (ICB) who can advise on how to arrange an assessment of eligibility for COVID-19 treatments. See [NHS guidance on COVID-19 treatments](https://www.nhs.uk/conditions/covid-19/treatments-for-covid-19/) for more information * Treatments are most effective if started early and ideally provided within 5 days of symptom onset. It is therefore essential to test eligible people with symptoms as soon as possible so that they can access treatments in time if they test positive for COVID-19 |
| **COVID-19 testing** | * From **1 April 2024**, outbreak management for COVID-19 will move in line with other [acute respiratory infections [gov.uk]](https://urldefense.com/v3/__https:/www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-acute-respiratory-infection__;!!C98Db8Ma!KlvNNBKETtQCA15OGcwdo4_zusp6L_z-qXYKB6FH1f9Ca0MfvU0fheB2vP9hOLc9g2_erLz9HkxfacGgTnkm3cP0EZ8LJjjp4xw$). * Please continue to use this guidance to manage COVID-19 outbreaks in your setting. Where appropriate, please contact [Health Protection Teams [gov.uk]](https://urldefense.com/v3/__https:/www.gov.uk/health-protection-team__;!!C98Db8Ma!KlvNNBKETtQCA15OGcwdo4_zusp6L_z-qXYKB6FH1f9Ca0MfvU0fheB2vP9hOLc9g2_erLz9HkxfacGgTnkm3cP0EZ8LCnXKINs$) (HPTs) or other local partners who may, as part of outbreak management, undertake a risk-based assessment to advise whether testing using Polymerase Chain Reaction (PCR) is required. * **COVID-19 testing** - All regulated adult social care settings should now be using the spreadsheet titled ‘Record-keeping multiple registration spreadsheet’ This allows settings to register rapid lateral flow tests   <https://www.gov.uk/government/publications/covid-19-testing-services/covid-19-testing-for-organisations--5>  <https://www.gov.uk/government/publications/organisation-testing-registration-record-of-users> |
| **COVID-19 testing for people eligible for treatment** | * LFD tests for this purpose are supplied by the NHS and should be accessed from a local pharmacy * Pharmacies may ask questions about an individual’s medical history to confirm eligibility for free tests and update patient records for future test orders * Accessing tests on behalf of their service users should provide the pharmacy with the details of eligible individuals where required, including any relevant letters or e-mails about COVID-19 treatments, if these are available. The required details include:   + Medical condition(s) that indicate the service user is eligible   + The service user’s nhs number (if available)   + The service user’s full name   + The service user’s date of birth   + The address of the care setting   More details from the NHS  [NHS England » NHS Lateral Flow Device (LFD) Tests Supply Service: Advanced Service](https://www.england.nhs.uk/primary-care/pharmacy/nhs-ltd-tests-supply-service/) and  [Who can get a free NHS COVID-19 rapid lateral flow test](https://www.nhs.uk/nhs-services/covid-19-services/testing-for-covid-19/who-can-get-a-free-nhs-covid-19-rapid-lateral-flow-test/). |
| **Recording Test Results and Reporting (Regulated Services)** | * A record should be kept of COVID-19 test results if a care home undertakes COVID-19 testing to identify if COVID-19 is causing an outbreak (or when HPTs or other local partners advise additional testing). All results should be recorded, even if test results are negative or void. * The care home should notify the UKHSA HPT (or other local partner) if a COVID-19 outbreak is identified * In an outbreak scenario, care homes should use tests that have been [ordered via the order portal for outbreak testing.](https://eur01.safelinks.protection.outlook.com/?url=https%3A%2F%2Frequest-testing.test-for-coronavirus.service.gov.uk%2F&data=05%7C02%7CClaudia.Salvagno%40ukhsa.gov.uk%7C22f7f7f7614c4387593008dc20e6cb4e%7Cee4e14994a354b2ead475f3cf9de8666%7C0%7C0%7C638421428882829948%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C0%7C%7C%7C&sdata=eW9zS7Gp6ttTegTWWYnvDAWpZws6OfGA08xjmv0IHyE%3D&reserved=0) Tests acquired through NHS local pharmacies may only be used for people eligible for COVID-19 treatments |
| **Colleagues with symptoms of ARI** | * Colleagues who have [symptoms of respiratory infection](https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19#symptoms-of-respiratory-infections-including-covid-19) and who have a high temperature or do not feel well enough to go to work are advised to stay away from work and try to avoid contact with other people. They should not return to work until they no longer have a high temperature (if they had one) or until they no longer feel unwell. * Managers should undertake a risk assessment before staff return to work in line with normal return to work processes. * The staff member should also follow the [guidance for people with symptoms of a respiratory infection including COVID-19](https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19) * Colleagues do not need to take a COVID-19 test if they develop symptoms of a respiratory infection unless they are eligible for COVID-19 treatments. * Colleagues do not need to take tests for any other ARIs, unless indicated by a clinician |
| **Colleagues testing positive for COVID-19** | * If a colleague tests positive for COVID-19, they should stay away from work for a minimum of 5 days from onset of symptoms, or the day they took their test if they do not have symptoms, and follow the [guidance for people who have a positive COVID-19 test result](https://www.gov.uk/guidance/people-with-symptoms-of-a-respiratory-infection-including-covid-19#PositiveResult). * After 5 days, they can return to work once they feel well, and do not have a high temperature. * If they are still displaying respiratory symptoms when they are due to return to work, they should speak to their line manager who should undertake a risk assessment, which may in exceptional circumstances require medical advice |
| **Outbreak Management**  **(Regulated Services)**  **Care Outbreak Risk Assessment** | Care Outbreak Risk Assessment (CareOBRA) are to be completed online using the link below.  This is an online Care Outbreak Risk Assessment (Care OBRA) Tool for all **Adult Social Care** providers to report:   * NEW **outbreaks of acute respiratory infections (ARI)** e.g. COVID-19, Flu, RSV, chest infections or unknown respiratory infection OR * **Single cases of Influenza (Flu)**   [Care Outbreak Risk Assessment (CareOBRA)](https://forms.ukhsa.gov.uk/ReportAnOutbreak/acute-respiratory-infections-ari---covid-19-flu-or-unknown-infection-in-adult-social-care-settings)   * The HPT will advise on the use of multiplex PCR to test up to 5 linked symptomatic residents with most recent symptom onset. Any symptomatic residents eligible for COVID-19 treatments should also be tested as soon as possible when they develop symptoms of an ARI using COVID-19 LFD tests obtained for this purpose, even if they are also tested by PCR. * If further residents develop respiratory symptoms, they should only be tested if they are eligible for COVID-19 treatments or if advised by the HPT.   Have the following information available **before you start to complete this form:**   * The postcode of your setting * The Unique Organisation Number (UON)\* and/or CQC Location ID of your setting * Total number of Residents/Clients (service users) and Staff in your setting * Number of service users and/or Staff with symptoms (cases) * Dates of symptom onset for cases * Test results (and date of test) for anyone tested (please include test results for any ARI e.g. COVID, Flu, RSV) * Number of residents/clients and staff vaccinated, or not, for both COVID-19 and Influenza (Flu)   Please DO NOT include any person identifiable information about people receiving care in this form (e.g. names and date of births) What happens nextAs soon as you have answered the questions and “submitted” your data into the Care OBRA Tool, you will receive:An automatic “Acknowledgement Email” stating whether you have reported a single case or a low-risk, medium-risk or high priority outbreak; The email will also contain a copy of the data that you have input into the Tool and a Care OBRA reference number [in the format OS\_XXXX] and  * A second automatic “Advice Email” which gives you information and advice on how to manage the situation that you have reported   For **Low Risk** COVID-19 outbreaks, all the advice you will need to manage your outbreak safely should be in the automated advice email  For **High Priority outbreaks**, the HPT or the CICT (as per local arrangements) will look at the information that you have submitted and will always call you back (the same or next day, including weekends or bank holidays) to assess your outbreak further and/or give you further advice  **High Priority – also call the Health Protection Team (HPT) out of hours service, during the daytime, if possible.** If you don’t call the HPT, your outbreak will only be picked up by the team the next working day  For **Medium-Risk** COVID-19 outbreaks, the HPT or the CICT (as per local arrangements) will look at the information that you have submitted on the next working day.  They will use this information to decide whether, in addition to the advice given in the automated email, they feel that they or their partner organisations (e.g. local authority or NHS) can assist you further with your outbreak.  If you feel you have not received an appropriate response, then call your HPT or your CICT (as per local arrangements) |
| **Individuals testing positive** | * Individuals who test positive for COVID-19 who are [eligible for COVID-19 treatments](https://www.nhs.uk/conditions/covid-19/treatments-for-covid-19/) should be supported to access appropriate treatments as quickly as possible * Inform their GP of a positive result   **Individuals with COVID-19 or flu**   * Should be supported to stay away from others for a minimum of 5 days after the onset of respiratory symptoms. After 5 days, the resident can return to their normal activities if they feel well and no longer have a high temperature. * If the individual is still unwell after 5 days, they should be supported to continue to stay away from others until they feel well and they no longer have a high temperature, and for usually no longer than 10 days in total. * Seek clinical advice for anyone who is still unwell or has a temperature after 10 days, if not done already |
| **Admission from Hospital** | * Based upon the high vaccination coverage in the general population, [infection prevention and control measures [gov.uk]](https://urldefense.com/v3/__https:/www.gov.uk/government/publications/infection-prevention-and-control-in-adult-social-care-settings__;!!C98Db8Ma!KlvNNBKETtQCA15OGcwdo4_zusp6L_z-qXYKB6FH1f9Ca0MfvU0fheB2vP9hOLc9g2_erLz9HkxfacGgTnkm3cP0EZ8L5roDvVE$) and access to [COVID-19 treatments [nhs.uk]](https://urldefense.com/v3/__https:/www.nhs.uk/conditions/covid-19/treatments-for-covid-19/__;!!C98Db8Ma!KlvNNBKETtQCA15OGcwdo4_zusp6L_z-qXYKB6FH1f9Ca0MfvU0fheB2vP9hOLc9g2_erLz9HkxfacGgTnkm3cP0EZ8LsUdFU6I$), routine COVID-19 testing of asymptomatic patients transferring from NHS settings into a care home will end in line with admissions from other care settings and the community. * From **1 April 2024** a risk-based approach to the management of hospital discharges into care homes will be taken. This approach should be implemented collaboratively between the NHS setting and the care home. * Individuals who are tested before discharge into a care home who test positive for an ARI can be admitted to the care home if the home is satisfied that they can be cared for safely. * For residents discharged from hospital who tested positive for COVID-19 but had no symptoms, they should be supported to stay away from others for 5 days from the day the test was taken. |

1. Version Control

| Version | Version Date | Revision Description / Summary of Changes | Author | Next Review Date |
| --- | --- | --- | --- | --- |
| 1 | August 2023 | Review and restructure of policy and documents  Integrated multiple documents for ease of reference, updated from NHS IPC guidance (April 2023) | IPC Lead  (Safeguarding Lead)  Head of Standards & Policy | June 2025 |
| 2 | February 2024 | Section 10 – Acute Respiratory Infections (ARI) including COVID-19 updated to reflect guidance released in January 2024  Appendix 3 - Colleague exclusion from work amended to include ARI/COVID-19  Appendix 2 – Bed Bugs infestation, mattresses must not be brought into care homes  Appendix 4 – Table of Guidance for ARI/COVID-19 | Head of Standards & Policy  IPC Lead | June 2025 |
| 3 | April 2024 | Appendix 4 – Infection Prevention and Control for Acute Respiratory Infections and COVID-19 updated to reflect changes in guidance:   * Testing * Admission form Hospital * Outbreak management, HPT – access to testing   Applicable from 1st April 2024 | Head of Standards & Policy | March 2026 |
| 4 | 29th April 2024 | Section 14 – included reference to Infectious Illness and Outbreak risk assessment  Included external reference to new visiting and accompanying legislation guidance |  |  |
| 5 | June 2024 | Linen and laundry procedures amended to reflect new uniforms - Thermal disinfection at 71°C for 3 minutes or 65°C for 10 minutes is advised *or washed at the highest temperature for the fabric using an antibacterial laundry sanitiser.* | Head of Standards & Policy  Hospitality Manager  IPC Lead | March 2026 |
| 6 | September 2024 | Interim Compliance review  Checked all links  Formatting reviewed  Section 11 - Whooping Cough section added due to the recent increase in cases for adults | Head of Standards & Policy  IPC Lead | March 2026 |