

ESSEX HEALTH PROTECTION UNIT

Part of the



INFECTION CONTROL GUIDELINES

DOMICILARY CARE



April 2009

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ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION A – INTRODUCTION AND CONTACTS

1. Introduction

These guidelines have been written for managers and carers working in a person's own home. They replace all previous infection control guidance from the Essex Health Protection Unit (EHPU).

Infection prevention and control is an important part of an effective risk management programme to improve the occupational health of staff.

These guidelines should be read in conjunction with the EHPU Infection Control Guidance for Care Homes.

2. Responsibility

The philosophy of this manual is to encourage individual responsibility by **every** member of staff for infection, prevention and control.

The organisation's directors and registered managers are responsible for ensuring that there are effective arrangements in place for the prevention and control of infections.

3. Contacts

Infection control advice can be obtained from the Essex Health Protection Unit, 8 Collingwood Road, Witham, Essex CM8 2TT.

The main office telephone number is: 0845 1550069.

The Consultants in Communicable Disease Control (CCDCs) and Communicable Disease Control Nurses (CDCNs) are contactable via this number.

Advice is also available on the HPA website: www.hpa.org.uk.

Users are encouraged to ensure they have access to this site as it has advice and information on a wide range of communicable disease issues.

Out of working hours – for **URGENT** communicable disease enquiries:

Contact: 01245 444417, and ask them to page the on-call Public Health Person.

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SECTION B – INFECTION, ITS CAUSES AND SPREAD

1. The Causes of Infection

An understanding of commonly encountered micro-organisms is essential for good infection control practice. Micro-organisms that cause disease are referred to as pathogenic organisms. They may be classified as follows:

Bacteria are minute organisms about one-thousandth to five-thousandth of a millimetre in diameter. They are susceptible to a greater or lesser extent to antibiotics.

Viruses are much smaller than bacteria and although they may survive outside the body for a time they can only grow inside cells of the body. Viruses are not susceptible to antibiotics, but there are a few anti-viral drugs available which are active against a limited number of viruses.

Pathogenic Fungi can be either moulds or yeasts. For example, a mould which causes infections in humans is *Trichophyton rubrum* which is one cause of ringworm and it may also infect nails. A common yeast infection is thrush caused by *Candida albicans*.

Protozoa are microscopic organisms, but larger than bacteria. Free-living and non-pathogenic protozoa include amoebae and paramecium. Examples of medical importance include: *Giardia lamblia* which can cause an enteritis (symptoms of diarrhoea).

Parasites

Worms are not always microscopic in size but pathogenic worms do cause infection and some can spread from person-to-person. Examples include: threadworms and tapeworms.

Ectoparasites i.e. headlice and scabies.

Prions are infectious protein particles. Example: the prion causing (New) Variant Creutzfeldt-Jakob Disease (vCJD).

2. The Spread of Infection

One feature that distinguishes infection from all other disease is that it can be spread, i.e. one person can 'catch' it from another or via a vector (e.g. crawling or flying insects). There are various means by which micro-organisms can be transferred from a reservoir to susceptible individuals.

The modes of spread of infection can be classified as:

Direct Contact

Direct spread of infection occurs when one person infects the next by direct person-to-person contact (e.g. Chickenpox, Tuberculosis, Sexually Transmitted Infections etc.).

Indirect Contact

Indirect spread of infection is said to occur when an intermediate carrier is involved in the spread of pathogens e.g. fomite or vector.

A **fomite** is defined as an object, which becomes contaminated with infected organisms and which subsequently transmits those organisms to another person. Examples of potential fomites are bedpans, urinals, thermometers, oxygen masks or practically any inanimate article.

Crawling and flying insects are obvious examples of **vectors** and need to be controlled. Insect bites may cause infections such as malaria in areas where malaria-carrying mosquitoes live.

Hands

The hands of health and social care workers are probably the most important vehicles of cross-infection. The hands of clients can also carry microbes to other body sites, equipment and staff.

Inhalation

Inhalation spread occurs when pathogens exhaled or discharged into the atmosphere by an infected person are inhaled by and infect another person. The common cold and influenza are often cited as examples, but it is likely that hands and fomites (inanimate objects) are also important in the spread of respiratory viruses.

Ingestion

Infection can occur when organisms capable of infecting the gastro-intestinal tract are ingested. When these organisms are excreted faecally by an infected person, faecal/oral spread is said to occur. Organisms may be carried on fomites, hands or in food and drink e.g. Hepatitis A, *Salmonella*, *Campylobacter*.

Inoculation

Inoculation infection can occur following a "sharps" injury when blood contaminated with, for example, Hepatitis B virus, is directly inoculated into the bloodstream of the victim, thereby causing an infection. Human, animal and insect bites can also spread infection by the inoculation mode.

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SECTION C - NOTIFICATION OF INFECTIOUS DISEASES

1. Introduction

This guideline sets out the procedures for staff to follow in respect of communicable disease control.

2. Responsibilities

Managers

Managers have a responsibility to report to the EHPU relevant notifiable diseases and outbreaks by telephone.

Managers have a responsibility to ensure their staff work in a safe environment and to take all necessary measures to reduce risk.

Clinical and Healthcare Staff

- (a) All staff have an important role in the prevention and control of infection which is an integral quality issue in the care and management of clients and the health and safety of staff
- (b) All staff need to follow all guidelines and participate in the audit
- (c) All staff need to bring infection control issues to the attention of Senior Managers
- (d) All staff need to maintain a high standard of infection prevention and control as a matter of good practice.

3. Reporting and Documentation of Illness - Suspected/Confirmed Outbreak

Any **registered medical practitioner** (i.e. doctor) who becomes aware or suspects that a patient (s)he is attending is suffering from a notifiable disease is required by law (Public Health Control of Disease Act 1984) to send a notification form to the Local Authority Proper Officer forthwith.

While laboratories may report, this does not absolve clinicians from their responsibility to do so.








Although the GP is legally responsible for the formal notification of a number of infectious diseases, any suspicion of an outbreak of communicable disease in the care setting or the community should be reported to the EHPU immediately for further investigation, and management as appropriate.

4. Specific Guidance for Clients with Diarrhoea and Vomiting

4a. Specific Guidance for Clients with Diarrhoea and/or Vomiting

- Advise the client to remain in their own home until they have had 48 hours without symptoms
- Prompt clearing of body fluid spillages (Refer to Section D 5 – Spillage Management)
- Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support hand rails and kitchen units. For the duration of the illness, environmental cleaning should be performed using detergent and hot water followed by a 1,000 parts per million available chlorine such as Milton (see label for environment cleaning strength). Once clients have passed 48 hours without any symptoms it is recommended that the home is thoroughly cleaned, wiping all surfaces and, if possible, cleaning the carpets
- Staff should wash hands with soap and warm water after contact with any body fluids. NB Alcohol Gel alone will not destroy Norovirus or *Cl. Difficile* (Refer to Section D 2 – Hand Hygiene and Skin Care)
- Clients should be encouraged to wash their hands after using the toilet and before eating
- Staff should pay attention to all infection prevention and control practices, particularly the washing of hands and wearing of protective clothing. A new pair of disposable gloves and a plastic apron should be worn for each client
- Faecal samples may be requested by the GP
- Symptomatic staff must go off duty, and they must remain off work until 48 hours symptom free
- Unnecessary visits should be discouraged. Those who choose to visit should wash their hands as they enter and then again when leaving the premises
- Soiled/infected linen – solid matter should be emptied into the toilet. The items should be washed separately, ideally using a programme with a pre-wash and on the highest temperature that the material will tolerate
- Soiled/Infected linen should not be soaked
- Where the client does not have a washing machine soiled items should be stored in a securely tied plastic bag and arrangements made for washing.

THE BRISTOL STOOL FORM SCALE

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on its surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges (passed easily)
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces ENTIRELY LIQUID

Reproduced by kind permission of Dr KW Heaton,
Reader in Medicine at the University of Bristol.
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Diarrhoea is the passing of frequent, urgent loose bowel motions i.e. types 5 to 7 from the Bristol stool form scale. It is at this stage that the condition should be reported to a clinician

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**SECTION D – STANDARD PRINCIPLES OF INFECTION
CONTROL**

1. Standard Principles of Infection Prevention and Control (Universal Precautions)

It is not always possible to identify people who may spread infection to others, therefore precautions to prevent the spread of infection must be followed at all times. These routine procedures are called **Standard Principles of Infection Prevention and Control (Universal Precautions)**.

The recommendations 'Standard Principles' provide guidance on Infection Control Precautions that should be applied by all healthcare personnel and other carers to the care of patients in the community and primary care settings.

Standard Principles of Infection Prevention and Control include:

- Hand Hygiene and Skin Care
- Protective Clothing
- Safe Handling of Sharps (including Sharps Injury Management)
- Spillage Management

All blood and body fluids are potentially infectious and precautions are necessary to prevent exposure to them. Disposable apron and gloves should always be worn when dealing with excreta, blood and body fluids.

Everyone involved in providing care in the community should know and apply the standard principles. Each member of staff is accountable for his/her actions and must follow safe practices.

Facilities must be available to promote the compliance to Standard Principles of Infection Control e.g. Personal protective clothing and handwashing.

2. Hand Hygiene and Skin Care

There are two methods of hand decontamination, which are handwashing, using soap and water, and handrubs, using alcohol or non-alcohol preparations.

Hand decontamination is recognised as the single most effective method of controlling infection.

Hands must be decontaminated:

- Before and after each work shift or work break
- Before and after physical contact
- After handling contaminated items
- Before putting on, and after removing, protective clothing, including gloves
- After using the toilet, blowing your nose or covering a sneeze
- Whenever hands become visibly soiled
- Before preparing or serving food
- Before eating, drinking or handling food, and before and after smoking.

How to Wash Your Hands

Hands that are visibly soiled, or potentially grossly contaminated with dirt or organic material, must be washed with liquid soap and water. Bars of soap not recommended.

	Method	Solution	Task
1	Social (15-30 seconds)	Liquid soap	For all routine tasks
2	Hygienic hand disinfection (15-30 seconds)	Alcohol hand-rub after social clean	In high-risk areas

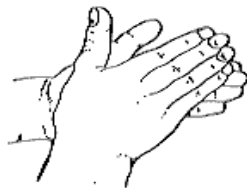
An effective handwashing technique involves three stages:

(a) Preparation

Before washing hands, all wrist, and ideally hand, jewellery should be removed. Cuts and abrasions must be covered with waterproof dressings. Fingernails should be kept short, clean and free from nail polish or nail extensions. Wet hands under warm running water before applying liquid soap or an antimicrobial preparation, ideally from a single-use dispenser.

(b) Washing and Rinsing

The liquid soap solution must come into contact with all the surfaces of the hand. The hands must be rubbed together vigorously for a minimum of 15-30 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly. Don't forget to wash your wrists!



1. Palm to palm.



2. Right palm over left dorsum and left palm over right dorsum.



3. Palm to palm fingers interlaced.



4. Backs of fingers to opposing palms with fingers interlocked.



5. Rotational rubbing of right thumb clasped in left palm and vice versa.



6. Rotational rubbing, backwards and forwards, with clasped fingers of right hand in left palm, and vice versa.

Handwashing technique. (Ayliffe et al. 1978; Lawrence 1985)

(c) Drying

This is an essential part of hand hygiene. Dry hands thoroughly using good quality paper towels.

(d) Handrubs/Alcohol Gels

Alcohol hand gels are not suitable for use on hands that are contaminated with organic matter e.g. faeces or during diarrhoeal illness. The handrub solution must come into contact with all surfaces of the hand. The hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

Emollient Hand Creams

An emollient hand cream should be applied regularly to protect skin from the drying effects of regular hand decontamination. If a particular soap, antimicrobial handwash or alcohol product causes skin irritation, an Occupational Health team or GP should be consulted.

Handwashing Facilities

Liquid soap should be used by healthcare workers.

When paper towels are not available kitchen paper should be used for drying hands.

Your 5 moments for hand hygiene at the point of care



1	BEFORE PATIENT CONTACT	WHEN? Clean your hands before touching a patient when approaching him/her WHY? To protect the patient against harmful germs carried on your hands
2	BEFORE AN ASEPTIC TASK	WHEN? Clean your hands immediately before any aseptic task WHY? To protect the patient against harmful germs, including the patient's own, from entering his/her body
3	AFTER BODY FLUID EXPOSURE RISK	WHEN? Clean your hands immediately after an exposure risk to body fluids (and after glove removal) WHY? To protect yourself and the healthcare environment from harmful patient germs
4	AFTER PATIENT CONTACT	WHEN? Clean your hands after touching a patient and her/his immediate surroundings when leaving the patient's side WHY? To protect yourself and the healthcare environment from harmful patient germs
5	AFTER CONTACT WITH PATIENT SURROUNDINGS	WHEN? Clean your hands after touching any object or furniture in the patient's immediate surroundings when leaving - even if the patient has not been touched WHY? To protect yourself and the healthcare environment from harmful patient germs

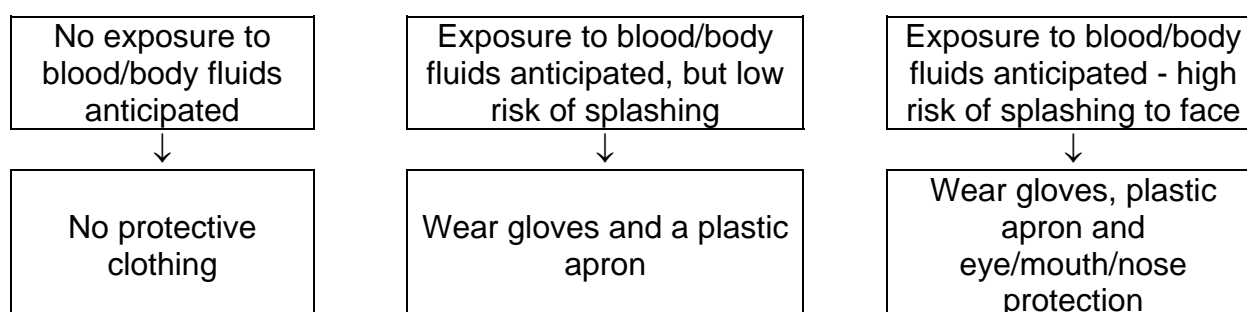
Adapted from WHO World Alliance for Patient Safety 2006

3. Protective Clothing

Selection of personal protective equipment (PPE) must be based on an assessment of the risk of transmission of infection between the client and the risk of contamination of the healthcare workers' clothing and skin by client blood and body fluids.

Assessment of Risk

WHAT TO WEAR WHEN



Types of Protective Clothing

Disposable Gloves

Gloves must be worn for invasive procedures, contact with sterile sites and non-intact skin or mucous membranes, and they should also be worn during all activities that have been assessed as carrying a risk of exposure to blood, body fluids, secretions or excretions, or to sharp or contaminated instruments.

Gloves that are acceptable to healthcare personnel and that conform to European Community (CE) standards must be available.

DO NOT USE powdered gloves or polythene gloves in healthcare activities.

Gloves must be worn as single-use items. They must be put on immediately before an episode of treatment and removed as soon as the activity is completed. Gloves are not a substitute for handwashing.

Gloves should be disposed of via the offensive, non-hazardous route.

Alternatives to natural rubber latex gloves must be available.

To prevent transmission of infection, gloves must be discarded after each procedure. Gloves should **not** be washed between uses as the gloves may be damaged by the soap solution and, if punctured unknowingly, may cause body fluid to remain in direct contact with skin for prolonged periods. Alcohol gels must not be used to clean gloves.

Hands **must** be washed on removal of gloves.

1. Non Sterile Gloves

Should be used when hands may come into contact with blood and body fluids, or equipment contaminated with blood and body fluids.

2. General-purpose Utility Gloves

General-purpose utility gloves e.g. rubber household gloves should be used when coming into contact with possibly contaminated surfaces or items. Colour-coding of such gloves should be used e.g. green for the kitchen, blue for general environmental cleaning, and red for bathrooms, showers and toilets. This will help prevent cross-infection from one area of work to another. The gloves should be washed with GPD and hot water, and dried between uses. They should be discarded weekly, or more frequently if the gloves become damaged.

3. Polyurethane/polythene Gloves (Non-Sterile and Sterile)

Polyurethane/polythene gloves do not act as a barrier to infection. They do not meet the Health and Safety Commission regulations and they do not have a place in clinical application. **DO NOT USE.**

The Infection Prevention Society (IPS) formally the Infection Control Nurses Association – (2002) recommends that gloves should be kept in their original box, and taken from it as and when required. They must not be decanted into an open container, and they must not be put in uniform pockets. They must not be stored on windowsills or on top of waste bins.

Disposable Plastic Aprons

Should be worn when there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions, with the exception of sweat.

Plastic aprons should be worn as single-use items, for one procedure or episode of patient care, and then discarded and disposed of by the appropriate waste route (Refer to Section H -6 Waste Management).

Face Masks and Eye Protection

There are few occasions when facemasks are necessary in the community. However when there is a risk of blood, body fluids, secretions or excretions splashing into the face and eyes e.g. cleaning of commode pots, full face protection i.e. a visor should be worn.

4. Safe Handling of Sharps

All staff should be fully immunised according to national policy. Staff who may have direct contact with blood or blood-stained body fluids should be immunised against Hepatitis B. A blood test to establish immunity should be undertaken one to four months post vaccination and a record of Hepatitis B antibody response should be kept. There is currently no vaccination for Hepatitis C or HIV.

It is the responsibility of the employer to undertake a risk assessment of the need for and to finance Hepatitis B vaccination

Care should be taken to avoid accidental needlestick injury, as exposure to contaminated blood and blood-stained body fluids may be associated with transmission of blood-borne viruses.

Carers undertaking blood glucose monitoring in the community should receive training in the correct technique and safe use of sharps. This could be via the district nurse or practice nurse.

Sharps, i.e. blood glucose lancets should be placed directly into a sharps bin after use. Sharps bins are obtained via the GP on a F10 prescription. (For disposal of the sharps bin refer to Section D – 4 Safe Handling of Sharps)

Sharps include needles, lancets, glass ampoules, sharp instruments, broken crockery and glass. Sharps must be handled and disposed of safely to reduce the risk of exposure to blood-borne viruses. Always take extreme care when using and disposing of sharps. Whenever possible avoid using sharps.

- Clinical sharps should be single-use only
- Sharps must not be passed directly from hand-to-hand and handling should be kept to a minimum
- Needles must not be re-capped, bent, broken or disassembled before use of disposal

- Needle safety devices must be used where there are clear indications that they will provide safer systems of working for healthcare personnel
- Sharps containers must conform to UN3291 or BS7320 standards
- Assemble sharps containers by following the manufacturer's instructions
- Label sharps containers with the source details
- Used sharps must be discarded into a sharps container at the point of use by the user
- Sharps containers must not be filled above the mark indicated on the container
- Close the aperture to the sharps container when carrying or, if left unsupervised, to prevent spillage or tampering
- Place sharps container on a level stable surface
- Carry sharps containers by the handle - do not hold them close to the body
- Never leave sharps lying around
- Do not try to retrieve items from a sharps container
- Do not try to press sharps down in the sharps box to make more room
- Lock the container when it is $\frac{3}{4}$ full using the closure mechanism
- Place damaged sharps containers inside a larger container - lock and label prior to disposal. Do **not** place sharps inside a waste bag
- Containers in public areas must be located in a safe position, and must not be placed on the floor.

Giving Injections

Always wash hands thoroughly prior to giving an injection.

If visibly dirty, skin should be cleaned with an individually packed swab soaked in 70% isopropyl alcohol and left to dry. If skin is clean, this step is not necessary.

Venepuncture and injections should be carried out only by staff who are adequately trained and experienced.

(For occupationally acquired sharps injuries refer to Section E 1 – Management of Sharps Injuries.)

5. Spillage Management

Deal with blood and body fluid spills quickly and effectively.

For spillage of high-risk body fluids such as blood, method 1 is recommended.

For low-risk body fluids, such as non-blood containing excreta, use method 2.

1. Sodium Hypochlorite (Bleach/Milton)

- Prevent access to the area containing the spillage until it has been safely dealt with
- Open the windows to ventilate the room if possible
- Wear protective clothing
- Soak up excess fluid using disposable paper towels
- Remove organic matter using the paper towels and discard
- Cover area with paper towels soaked in 10,000 parts per million of available chlorine and leave for at least two minutes (see on the bottle for concentrations/dilution). Remove and place in waste bag
- Clean area with detergent and hot water and dry thoroughly
- Clean the bucket/bowl in fresh soapy water and dry
- Discard protective clothing
- Wash and dry hands
- Finally go over area with a mechanical cleaner or steam cleaner.

OR

2. Detergent and Water Method

- Prevent access to the area until spillage has been safely dealt with
- Wear protective clothing
- Mop up organic matter with paper towels or disposable cloths
- Clean surface thoroughly using a solution of detergent and hot water and paper towels or disposable cloths
- Rinse the surface and dry thoroughly
- Dispose of materials - wrap and place in domestic waste
- Clean the bucket/bowl in fresh hot, soapy water and dry
- Discard protective clothing as appropriate
- Wash hands
- Finally go over area with a mechanical cleaner or steam cleaner.

N.B. – For spills on carpets and upholstery with or without visible blood

- Wear protective clothing
- Mop up organic matter with paper towels
- Clean area with cold water
- Clean area thoroughly with detergent and hot water
- Discard protective clothing
- Wash and dry hands
- Finally go over area with a mechanical cleaner or steam cleaner.

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SECTION E – MANAGEMENT OF SHARPS INJURIES

1. Occupational Injuries

In the event of a sharp injury/contamination incident these guidelines should be followed:

A sharp injury/contamination incident includes:

- Inoculation of blood by a needle or other sharp
- Contamination of broken skin with blood
- Blood splashes to mucous membrane e.g. eyes or mouth
- Swallowing a person's blood e.g. after mouth-to-mouth resuscitation
- Contamination where the individual has an open wound, and clothes have been soaked by blood
- Bites (where the skin is broken).

When a sharp injury/contamination incident occurs:

1. Encourage bleeding from the wound
2. Wash the wound in soap and warm running water (do not scrub)
3. Dry and cover the wound with a dressing
4. Skin, eyes or mouth contamination, wash in plenty of water
5. Ensure the sharp is disposed of safely
6. Report the incident to immediate supervisor
7. Manager/supervisor should arrange for medical advice as soon as possible – (may need Hepatitis B vaccination/HIV treatment). If necessary, advice can be obtained from the EHPU
8. An incident form should be completed as soon as the recipient of the injury is able (line manager may have relevant patient information that should be conveyed to the doctor).

2. Control Measures

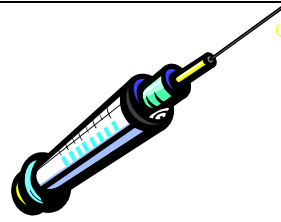
It is the responsibility of the care agency to undertake risk assessment of the need for staff to have Hepatitis B vaccination. Refer to the Immunisation Against infectious Disease Book (2006) [Green book: Department of Health - Public Health](#).

Any staff working in healthcare who handle sharps or hazardous infectious waste should receive a full course of Hepatitis B vaccinations followed by a blood test to establish their immunity.

It is recommended that employers draw up a policy on how an exposure incident should be handled. This should contain contact numbers for both in and out of hours services. The poster below can be used.

What to do after a.....

SHARPS INJURY



Directions for the management of needlestick injuries, and cuts and penetrating wounds, contaminated with blood or blood-stained body fluids



Wash cuts thoroughly with soap and warm water, then gently encourage to bleed. Apply a dressing if necessary.

Splashes to the eyes or mouth should be thoroughly rinsed with running water



Report incident to your manager immediately (if applicable)

Your medical advisor should: -

- a) Take a history and make a risk assessment
- b) Review your Hepatitis B vaccine status
- c) Take 10ml clotted blood from the recipient and, if possible, the 'source' (with informed consent)
- d) Send the samples to the microbiology department marked 'needlestick Injury'
- e) Ensure appropriate follow-up

Complete an accident form

Insert your local arrangements

Please Note

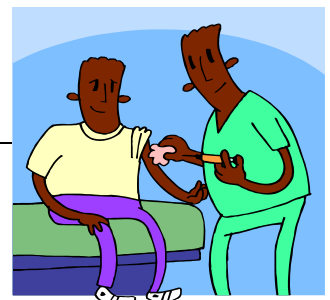
If the source is known or a risk of having HIV the injured person should contact Accident & Emergency, and attend if possible within the hour

Remember

Be prepared – If you are at risk of exposure – get immunised against Hepatitis B Virus



Tel: In hours:- INSERT OWN ARRANGEMENTS HERE
Tel: Out of Hours:- Your local A&E Department



ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION F – MANAGEMENT OF INFECTIOUS DISEASES

1. Introduction

The HPA produces a series of factsheets, which are available from the website, www.hpa.org.uk, under Topics A-Z, and some constructed by the EHPU.

The factsheets include information on incubation periods, method of spread, period of infectivity, exclusion periods and where appropriate the management of contacts.

The factsheets can be photocopied and passed to members of the public.

In addition, there is extended text in this document on MRSA and Clostridium Difficile.
(Refer to Section G - Infestations for further information on Scabies and Headlice.)

2. Factsheets

These factsheets are available on www.hpa.org.uk. Look under Topics A-Z for other diseases and factsheets.

Blood-Borne Viruses	Immunisation – General Information
Bugs, Fleas and Ticks	Impetigo
Conjunctivitis	Meningitis
Diarrhoea and Vomiting	MMR and Immunisations
ESBL	Molluscum Contagiosum
Glandular Fever	Rashes in Childhood
Group A Streptococci	Ringworm
Hand, Foot and Mouth	Scabies
Headlice Management Chart	Verrucas (Warts)
Herpes	

3. Guidelines for the Management of Meticillin Resistant *Staphylococcus Aureus* (MRSA) in the Community

What is MRSA?

MRSA stands for **Meticillin Resistant *Staphylococcus aureus***.

Staphylococcus aureus is a normal skin bacterium which lives harmlessly on the skin of healthy people.

Staphylococcus aureus is found on approximately one third of the population. It lives on the skin and is highest in numbers in warm moist areas such as armpits, groin and nose. Generally it doesn't cause any problems this is called 'colonisation'. However if the bacteria enters the body i.e. through a break in the skin they can cause infection.

MRSA occurs when some strains of the common bacterium of *Staphylococcus aureus* become resistant to treatment with some antibiotics. This means that there is a reduced choice of antibiotics available to treat infection. Many people in the community may have MRSA colonisation and do not suffer any ill effects.

The most common scenario for an individual with MRSA in the community environment is that they have an infection in a wound, which is then slow to heal.

Why is it known as a hospital-acquired disease?

MRSA will spread more readily in the acute hospital setting, owing to the increased vulnerability that patients with an acute illness will have to infection.

When an individual suffers an acute illness, their immunity may be greatly reduced (making them vulnerable to infection). As that individual recovers, so will their immunity.

If an individual makes a complete recovery, their immune system generally makes a full recovery.

If an individual goes on to develop a chronic illness, their immune system may not make a complete recovery. However this deficit in their immune system will be far less than if they were still suffering from an acute illness.

This is why patients who were hospitalised with an acute illness are discharged as soon as they have recovered from their acute episode - meaning they do not stay in a high-risk environment for longer than necessary. Some may be colonised on their discharge from hospital.

What is the difference between colonisation and infection?

Colonisation - means the organism is living on the skin (usually nose, throat, axilla or groin), causing no problem to the individual.

Infection - means that the organism is causing an active infection i.e. the wound is red, hot, inflamed, there may be pain and pus.

What precautions do you need to take in a person's home?

No special precautions are necessary.

Standard principles of infection prevention and control (especially handwashing) are all that are necessary. Because hands play an important part in which micro-organisms can be passed on, hands should be regularly washed especially if you are involved in handling dressings from wounds.

However MRSA does act as an opportunity to remind us of the good practices that should **already** be in place.

A person with MRSA can mix with other people socially, however the person should be advised to avoid contact with vulnerable people i.e. people with open wounds.

There is no restriction for carers entering people's homes that are MRSA positive. However they must ensure that they use gloves and aprons appropriately and decontaminate their hands before attending their next client.

Laundry or crockery and cutlery do **NOT** need to be handled separately. Again, as long as good practice is maintained there is no need for additional precautions.

There are no special precautions necessary for waste generated in the client's home. Waste should be double bagged and placed in the domestic waste stream. If large volumes of waste are generated i.e. large dressing, it is the responsibility of the District Nurse/PCT to arrange an appropriate waste collection.

Maintaining a clean environment and good hygiene will help to reduce the level of the bacteria and the risks of potential spread. The daily removal of dust, keeping surfaces clean and carpets regularly vacuumed should be undertaken.

Bath, shower, basins and toilets should be cleaned regularly with your usual products. Cleaning protocols should also include regular cleaning of high surfaces, curtains, carpets, extractor fans and radiators.

Treatment and Screening

It is not necessary to treat MRSA colonisation.

Screening means that swabs are taken from various parts of the body and tested for MRSA. This may be required if the client is due to go in to hospital. If the results are positive then treatment may be required prior to admission to hospital.

In these cases you will be advised of the protocol by the Hospital or PCT Infection Control Team or the District Nurse.

4. Specific Guidance for Clients with *Clostridium difficile*

What is *Clostridium difficile*?

Clostridium difficile is a bacterium of the intestine, which can be found in 3% of both healthy and ill people. There are millions of different types of bacteria in the body which are important for health. These protective bacteria help to break down and digest food and also help to ward off many harmful or foreign bacteria. In a healthy person all the bacteria live in a state of balance with one another.

People over the age of 65 years are more susceptible to contracting a *Clostridium difficile* infection.

What is *Clostridium difficile* colitis?

When there is an imbalance of bacteria flora in the gut, *Clostridium difficile* takes over and produces two toxins that affect the body to give the symptoms of the disease. The symptoms may include diarrhoea and cramping pain at first, and, in the later stages, flu-like symptoms, nausea, vomiting and blood in the stool/faeces.

How is *Clostridium difficile* colitis diagnosed?

The disease is suspected if a person has been taking, or is currently taking, antibiotics and is suffering with abdominal cramps and diarrhoea. A diagnosis is made by a laboratory test using a stool sample to confirm whether or not the toxin is present in the intestine. The results are usually available within 24 hours. Some patients may have *Clostridium difficile* in their stool but without the symptoms of diarrhoea. It is unlikely that they have *Clostridium difficile* colitis. A person is only deemed infectious if they have diarrhoea.

Contamination of the Environment

Clostridium difficile spores can survive in the environment for a very long time. It is very important to keep the clients home clean and dust free. This will reduce the risk of infection and transmission.

Caring for a client in their own home with diarrhoea (the following is for any diarrhoea including *clostridium difficile* and *norovirus*)

If a client has profuse diarrhoea the GP should be informed. The client may need to be admitted to hospital for treatment. A stool sample may be requested.

The client should not be returned to their own home until they have had no episodes of diarrhoea for at least 48 hours.

Hand Decontamination

The most important preventative measure in preventing the spread of *Clostridium difficile* is handwashing with soap and warm water to remove the contamination from your hands. Most alcohol gels **do not** kill *Clostridium difficile* spores and should not be used.

Personal Protective Equipment

Carers should wear single-use gloves and aprons when dealing with any body fluids

Laundry

Faecal matter should be emptied into the toilet .Soiled linen should be washed separately on a pre-wash followed by the hottest wash that the material will tolerate.

Environment

Spillages of faecal matter should be cleared up with absorbent paper towels then cleaned with detergent and hot water, followed by disinfecting with a chlorine-releasing agent such as bleach. Follow the instructions on the side of the bottle for a 1 in 10,000 solution. Equipment such as toilets and contact points i.e. toilet flush handles should also be decontaminated in the same way.

Caution should be used when using chlorine agents as it may cause damage.

Risks to Healthcare Workers

Risk of transmission to healthcare workers is low. However if healthcare workers are on antibiotics they should maintain standard principles of infection prevention and control, particularly if they are dealing with patients suffering from diarrhoea.

ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION G – INFESTATIONS

1. Prevention and Control of Headlice in the Community

Introduction

Headlice are found on adults and children. They are transferred from person-to-person wherever head-to-head contact occurs. This is generally at social gatherings or within a household environment.

Treat when headlice are found. The Pharmacist or GP should offer advice and assistance to carers when required. Information on headlice can be found on the HPA website.

www.hpa.org.uk/infections/topics_az/wfhfactsheets/WFHheadlice.htm

2. Some Facts about Headlice and Nits (*Pediculus humanus capitis*)

Headlice can be more efficiently found by combing through (preferably wet) hair with a detection comb. Divide the hair into sections and hold the comb at angle of 45°. If lice are found, that person should be treated.

When a client is found to have headlice, all other household contacts who are likely to have head-to-head contact must be carefully checked using the detection comb. Especially small children. It may be necessary to discuss this with visiting friends and family. .

Headlice lotions (or shampoos) should not be used as a preventative measure.

3. Treatment - for when Lice are Found

Only treat those with a **proven** headlice infection.

There are three options for the treatment of headlice:

1. Wet Combing

This method does require perseverance. However, if this treatment appears to continually fail, treatment with insecticides may still be required.

- Wash the hair in the normal way with an ordinary shampoo
- Make sure the teeth of the comb slot into the hair at the roots with every stroke. This should be done over a pale surface, such as a paper towel or the bath

- Clear the comb of lice between each stroke
- Wet lice find it difficult to escape, so removal with the comb is easier
- This routine should be repeated every day for 2 weeks, so that any lice emerging from the eggs are removed before they can mature, mate and lay more eggs.

2. Insecticides (pesticides)

There are three chemical insecticides available. However, there is evidence that some headlice have become resistant to particular insecticides. This may lead to problems of eradicating headlice from an individual's head.

Insecticides should *ONLY* be used if live lice are found.

The insecticides are **Malathion, Pyrethroids (Phenothrin and Permethrin)** and **Carbaryl**. Carbaryl can only be prescribed by a healthcare professional (e.g. GP and some nurses), the other two chemicals can be purchased from a pharmacy.

All products must be used according to manufacturer's guidance. Insecticides are not effective on eggs therefore a second application is required a week later to kill the newly hatched lice. Fine comb the hair every 3-4 days between applications and for at least a further 2 weeks after the final application is recommended

Insecticides are available in alcohol and aqueous-based preparations. Individuals that suffer from asthma, eczema etc should avoid alcohol-based products. Please check the suitability of the product with the pharmacist.

Insecticides must not be used more than once a week, and not for more than 3 consecutive weeks.

3. Non-pesticide Lotion

Non-pesticide lotion – Dimeticone compound (proprietary name Hedrin)- coats headlice and smothers them. There is no resistance to this lotion. However careful application is required for effective killing of the lice. It is important to follow the instructions on the pack, ensuring that the lotion is applied evenly and is combed throughout the length of the hair.

Two applications, one week apart, is required to kill hatching lice. To check effectiveness use a detector comb 24 hours after the second treatment. Further applications can be used if headlice remain present after the second course of treatment.

Contact Tracing

Contact tracing is an important part of the control of headlice infestation. Contacts will be other individuals who have had head-to-head contact lasting approximately one minute or more in the past month.

Social contacts outside of the home may include family members, friends and other social groups.

A contact list should be formulated by each person with headlice. This list will be fairly short. Every person on the list should then be told that they have been in contact with a person who has had headlice and that they should have their own hair checked.

4. Prevention and Control of Scabies in the Community

Introduction

Scabies is an allergic response to an infestation of the skin by the mite *Sarcoptes scabiei*. The mites penetrate through the skin and excavate burrows at the epidermal/dermal junction. The female mite lays eggs which hatch after 3-4 days. Newly hatched larvae exit the burrows and appear on the surface of the skin before forming their own tunnels. The burden of mites can range from 10-20 to several thousand in people who are severely immunocompromised (Norwegian Scabies). Scabies is distributed worldwide and is endemic in many developing countries.

Recognition of Symptoms

The most frequent symptom is itching which may affect all parts of the body and is particularly severe at night. There may be no sign of infection for 2-6 weeks after exposure.

Occasionally small vesicles may be visible along the areas where the mites have burrowed. A papular rash may be visible in areas such as around the waist, inside the thighs, lower buttocks, lower legs, ankles and wrists. Firm nodules may develop on the front folds of the axillae and around the navel and in males around the groin. Pale burrows described as a "greyish line resembling a pencil mark" may be present in the skin between the fingers, but are less commonly seen than textbooks suggest.

Failure to find burrows does **not** exclude scabies as a diagnosis.

It should be emphasised that scabies may be difficult to recognise particularly if scratching, inflammation or infection have obscured the presentation. Also scabies can look atypical in anyone with immature or impaired immunity such as very young children, those with Down's syndrome, alcoholics or the very elderly. In immunosuppressed people, such as those with HIV or those on immunosuppressive therapy, a more severe hyperkeratotic form may develop (Norwegian Scabies).

Mode of Transmission

Scabies mites are generally not capable of surviving off the host long enough to establish a new infection as they quickly become too dehydrated and weak.

Mites are passed directly from the skin of one person to another with prolonged contact. The likelihood of transmission increases with the duration and frequency of skin to skin contact.

Fomites and animals are not implicated in transmission.

Incubation

The incubation period is 2–6 weeks before onset of symptoms in those infected for the first time. Symptoms may occur 1–4 days after re-exposure.

Outbreaks

Outbreaks occur particularly in residential/nursing homes, mental healthcare establishments, long-stay hospital wards and pre-school nurseries.

Treatment

When a case of Scabies is suspected in the client the GP should be informed. Treatment should be prescribed (see below). If more than one person lives in the same household and has physical contact with the symptomatic client they should also be treated. If friends and family of the symptomatic client have physical contact i.e. holding hands for prolonged periods, they too should be treated. If the contacts do not have symptoms one treatment of the insecticidal cream is required, however if the contacts are showing signs of scabies two treatments will be necessary 7 days apart.

Healthcare workers that provide personal care for the client will also require treatment. (If the healthcare worker has developed signs of scabies their family contacts will also need treatment.) Inform the line manager – it may be necessary to check other clients with whom the healthcare worker has had direct contact. For further advice the EHPU should be contacted.

Symptomatic people should be treated using 2 applications of insecticidal cream at 7-day intervals. Non-symptomatic contacts require only one treatment. Further advice is available from the EHPU.

It is very important that the cream remains on the skin for the prescribed contact time. If clients perform their own care they should be advised to reapply the cream to any areas washed during the contact time.

Following Treatment

It is not uncommon for a person to have itching for up to 4 weeks after successful treatment. Antihistamines may be helpful. In clients with dry skin conditions emollient cream will moisturise the skin.

Infectiousness

The person with scabies is a risk to other people if they have prolonged physical contact. The person is deemed non-infectious once the first application of treatments has been applied. Due to the long incubation time a person may have contracted the infection but have no symptoms. They will be potentially infectious to others during this time. This is why non-symptomatic contacts are treated. For the carer it is important to be vigilant with their other clients for signs and symptoms of scabies.

LYCLEAR DERMAL CREAM IS THE TREATMENT OF CHOICE

Lyclear Dermal Cream is suitable for use by adults, including the elderly and children over 2 months old. Children between 2 months and 2 years should be treated under medical supervision.

- Ensure that the entire surface of the body is covered from the hairline on the head to and including the soles of the feet. **This should include the area behind the ears and the face, avoiding the area around the eyes, otherwise the treatment may not be effective.** If the person to be treated has little or no hair the scalp should also be included
- Areas of skin normally covered by extensive dressings should be exposed, and Lyclear cream applied onto the intact skin up to and around the wound. The dressing may then be replaced (co-ordinate with district nurse)
- Apply the cream to clean, dry and cool skin. Do not apply following a bath or shower
- Pay particular attention to the areas behind the ears, between the fingers and toes, wrists, under the arms, external genitalia, buttocks and under finger and toe nails
- The whole body should be washed thoroughly 8 - 12 hours after treatment, with warm water
- Be sure to **reapply any cream washed** off during the treatment period e.g. after handwashing. It is important to ensure the client understands that they should not wash for 8 hours and if they do they must reapply the cream to washed areas. If the client is unable to understand they may need supervision for the 8 hour contact time
- Directly after treatment, change bed linen and wear freshly laundered clothes
- Lyclear Dermal Cream disappears when rubbed gently into the skin. It is not necessary to apply the cream until it remains undetectable on the surface
- Where possible, the cream is best applied by someone other than the person receiving treatment. This makes it easier access difficult to reach parts of the body
- Carers should wear disposable gloves when applying creams
- Carers will need to assist the client especially with areas that they can't reach i.e. the back or feet.

It may be necessary to prescribe two tubes of cream per treatment to ensure all areas of the body are covered thoroughly, bearing in mind very dry areas of skin will absorb more of the cream.

The following table shows the approximate amount of cream to be used as a **single** application:

Adults and children over 12 years	1 tube, but large people may require up to 2 tubes but no more than 2 tubes
Children aged 5 to 12 years	Up to half a tube
Children aged 1 to 5 years	Up to one quarter of a tube
Children aged 2 months to 1 year	Up to one eighth of a tube

NB THE BRITISH NATIONAL FORMULARY STATES THAT: Manufacturer recommends application to the body but to exclude head and neck. However, application should be extended to the scalp, neck, face and ears. Eyes should be avoided.

There is increasing evidence that scabies may also affect the face and failure to treat this area could result in an incomplete and therefore unsuccessful treatment.

ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION H – CLINICAL PRACTICE

- Aseptic Technique
 - Wound management/Wound swabbing
 - PEG dressing
 - Enteral Feeding
 - Urinary Catheter Care
- Care of Patients with known Infectious Disease
- Management of Deceased Clients
- Decontamination
- Laundry Management
- Safe Handling of Specimens
- Waste Management.

1. Aseptic Technique

Generally wounds of clients in the community should be attended to by the district nurse team. However, on occasions it may be necessary to undertake **small dressings or procedures i.e. enteral feeding**.

Carers should report wounds to a health professional i.e. the district nurse or GP if:

- The wound is large
- The wound is bleeding or producing pus
- The wound doesn't show signs of healing within 24 - 48 hours
- The wound smells
- The skin around the wound is red, hot or swollen
- The client has a temperature.

Aseptic technique is the term used to describe the methods used to prevent contamination of wounds and other susceptible sites by organisms that could cause infection (Marsden Manual of Clinical Nursing Procedures).

The aims of aseptic technique are:

- To prevent the introduction of pathogens to the site
- To prevent the transfer of pathogens from the client to staff or other client.

An aseptic technique should be used when undertaking the following procedures (this list is not exhaustive):

- Dressing wounds
- Care of enteral feeding lines
- Removal of sutures or clips
- Endotracheal suction
- Dressing tracheostomy site.

The procedure is undertaken either with forceps or sterile gloved hands. The important principles are that the susceptible site should not come into contact with any item that is not sterile.

Any items that have been in contact with the wound will be contaminated and should be disposed of safely or decontaminated.

Bacteria acquired on the clothing during the procedure may be transferred into the wound of another client, therefore a clean disposable apron should be used for each dressing procedure.

Aseptic procedure

1.	Clean the area to be used as a sterile field i.e. tray	This could be a tray, top of table or a bedside table. Clean with Chlorhexidine in 70% spirit and paper towels. If not available a disinfectant should be used
2.	Equipment	Have all equipment required accessible: sterile dressing, fluids for cleaning, tape, appropriate dressing
3.	Explain procedure to client. Put client into a appropriate position to do the dressing	
4.	Loosen the old dressing	
5.	Clean hands	Wash and dry hands or use alcohol gel preparation
6.	Open outer packing of sterile pack on to prepared surface. Open sterile field using the corners of paper	
7.	Open any other sterile packs onto sterile field	
8.	Place hand into the disposable bag and remove old dressing, invert bag and stick to side of sterile field	Stick disposable bag to appropriate surface allowing easy access to place used swabs etc into it, without travelling over sterile field
9.	Clean hands	Using alcohol gel
10.	Put on sterile gloves	Do not touch sterile outside surface of the gloves
11.	Undertake procedure	Wound dressing, percutaneous endoscopic gastrostomy (PEG) dressing, catheterisation

Adapted from The Royal Marsden Hospital Manual of Clinical Procedures – Seventh Edition 2008.

a. Wound Management

The above procedure should be followed when undertaking a sterile dressing and the principles should be used for non-sterile dressings.

For all wound dressings the area should be cleaned from clean to dirty i.e. the cleanest bit of wound to areas that have a discharge or discolouration.

Wound Swabbing

Swabbing should only be undertaken by the district nurse if wound or site of the invasive device exhibits signs of infection. Swabs should not be taken routinely, or if wound/site is healing.

b. Percutaneous Endoscopic Gastrostomy (PEG) Care

Percutaneous endoscopic gastrostomy (PEG) dressing

Until the site is healed care should be undertaken by a qualified clinician or nurse only.

The first change of dressing of a new stoma site should be performed 24 hours (unless bleeding) after placement using an aseptic technique. Until granulation of the stoma canal has taken place the dressing should be changed daily using aseptic technique and sterile of 0.9% sodium chloride.

Long-term care of site

Stoma site should be washed daily with warm water and thoroughly dried.

c. Enteral Feeding

The following procedures should only be performed by carers if they have been trained by an appropriate clinician to undertake them. The carer should know who to contact and how to contact them in the event of a problem with the system.

Preparation and Storage of Feeds

Effective hand hygiene must be carried out before starting feed preparation.

Wherever possible pre-packed, ready-to-use feeds should be used in preference to feeds requiring decanting, reconstitution or dilution.

The system selected should require minimal handling to assemble and be compatible to the enteral feeding tube.

When decanting, reconstituting or diluting feeds, a clean working area should be prepared and equipment dedicated for enteral feed use only should be used.

Where ready-to-use feeds are not available, feeds may be prepared in advance, stored in a refrigerator, and used within 24 hours.

The system selected should require minimal handling to assemble, and be compatible with the patient's enteral feeding tube.

Feeds should be mixed using cooled boiled water or freshly opened sterile water and a no-touch technique.

Feeds should be stored according to the manufacturer's instructions and, where applicable, food hygiene legislation.

Administration of Feeds

Minimal handling and an aseptic no-touch technique should be used to connect the administration system to the enteral feeding tube.

Ready-to-use feeds may be given for a whole administration session, up to a maximum of 24 hours. Reconstituted feeds should be administered over a maximum 4 hour period.

Administration sets and feed containers are for single-use and must be discarded after each feeding session.

In some areas, single patient use syringes are used to administer drugs. Check the packaging to ensure it is **single patient** (may be used several times on the same person) use, and, if it is, follow the manufacturer's instructions on decontamination between uses. Good practice would be to use a single patient syringe for a maximum of 24 hours.

Care of Enteral Feeding Tube

The stoma should be washed daily with warm water and thoroughly dried.

To prevent blockage, the enteral feeding tube should be flushed with fresh tap water before and after feeding or administering medications.

Enteral feeding tubes for clients who are immunosuppressed should be flushed with either cooled freshly boiled water or sterile water from a freshly opened container.

d. Prevention and Control of Infection in Urinary Catheter Care

Generally if a person in the community has a urinary catheter in situ the district nursing team will be involved with the care. The person will be placed on a care pathway by the district nurse which requires regular review and updating. Within the pathway there is a section on who can undertake the daily care and it requires this person to have received appropriate training. Carers should be aware of these documents and ensure that they understand them.

Carers should be able to recognise and report urinary tract infections.

Routes of Entry for Infection

Urinary catheters are inserted to provide urinary drainage. They may be introduced via the urethra or into the bladder through a supra-pubic procedure.

Comprehensive information, advice and support is available from the continence advisors.

Bacteria may enter the bladder of the catheterised patient in one of four ways:

- Introduced with the catheter at the time of insertion
- Travel along the outside of the catheter
- Travel along the inside lumen of the catheter
- Through a break in the closed system i.e. when taking a sample.

Assessment for Catheter Equipment

Indwelling urinary catheters should be used only after alternative methods of management have been considered.

The client's clinical need for catheterisation should be documented and reviewed regularly, and the urinary catheter should be removed as soon as possible.

Catheter insertion and changes should only be undertaken by a qualified clinician or nurse and should be documented in the client's medical notes.

Catheter Insertion

Catheterisation is an aseptic technique. Insertion should only be performed by a qualified clinician or nurse.

Catheter Maintenance

Indwelling catheters should be connected to a sterile closed urinary drainage system or catheter valve.

The closed system should not be opened for any reason as to do so will increase the risks of an infection.

Carers must decontaminate their hands and wear a new pair of clean, non-sterile gloves before manipulating a client's catheter, i.e. emptying a urine bag, and must decontaminate their hands after removing their gloves.

Urine samples must be obtained from a sampling port using aseptic technique. This should be undertaken by the district nurse only.

A link system should be used to facilitate overnight drainage, to keep the original system intact. Drainage bag should be placed at the tap end and the tape left open. The overnight bag should be **single-use** and disposed of each morning by disconnecting and closing tap then emptying the urine into the toilet. The bag can then be placed in the domestic waste.

The area around the insertion site (Meatus) should be washed daily with soap and water when undertaking personal hygiene.

Catheters should be changed only when clinically necessary or according to the manufacturer's current recommendations by a clinician only.

Carer should ensure that the connection between the catheter and the urinary drainage system is not broken except for good clinical reasons.

Urinary drainage bags should be positioned below the level of the bladder, and should not be in contact with the floor.

The urinary bag should be changed when advised by the district nurse.

Emptying of Catheter Bag

The catheter bag should be emptied frequently enough to maintain urine flow and prevent reflux. A designated clean container should be used avoiding contact between the urinary drainage tap and container. The urine can be flushed down the toilet and the container washed and dried. Report changes in the urine to the District Nurse.

2. Care of Patients with known Infectious Diseases

When a client has a known infectious condition whilst living in their own home the responsibility for preventing the spread of this infection to others lies with the individual carer.

Undertaking basic Standard Principles of Infection Prevention and Control will facilitate this. (Refer to Section D - 1.)

It is important for carers to have some knowledge of these risks. The table below indicates the infectious period for some conditions. For further advice contact EHPU or refer to the HPA website www.hpa.org.uk.

In Residential Settings

Within the client's home setting, traditional barrier nursing is not necessary. It is important for carers to appreciate that when they are caring for someone with a known, or suspected, infectious disease, there is the potential for cross-infection if basic infection control principles are not followed.

Pregnant carers should be aware that some infections may present a risk to them. If there is concern they should discuss with their line manager. Advice can be obtained from the EHPU.

Diseases

More detailed information about diseases can be found in the relevant section of these guidelines, and on the HPA website www.hpa.org.uk.

DISEASE	HOW LONG THE DISEASE REMAINS INFECTIOUS
Chickenpox	Infectious until vesicles are dry (usually about 5 days)
<i>Clostridium difficile</i> (Pseudomembranous colitis)	Infectious until 48 hours after last episode of diarrhoea
Gastro-enteritis	Infectious until symptom free for 48 hours
Impetigo	Infectious until lesions are crusted or healed. However infectivity will be reduced following 24 hours of appropriate antibiotics

Mumps	Infectious for 9 days after onset of swelling in salivary glands
MRSA	Risk of infection if open wounds present
Rubella	Infectious for 4 days from onset of rash. Non-immune pregnant staff should not nurse these patients
Scabies	Infectious until one application of a scabicial treatment has been completed
Shingles	Infectious to a person who has not had chickenpox by direct contact with the fluid of the vesicles. The contact will develop chickenpox
Pulmonary Tuberculosis (Open)	Infectious until the first two weeks of appropriate antibiotic therapy have been given. The infectious period may be prolonged for Multi-Drug Resistant TB (MDRTB)

Precautions should be taken with clients suffering from the following symptoms until a diagnosis is confirmed. If these are new symptoms the carer must ensure that the GP is informed.

- (a) Diarrhoea of unexplained origin
- (b) Temperature of unknown origin
- (c) Excessive bleeding
- (d) Rashes of unknown cause
- (e) Excessive vomiting.

Procedures when Dealing with a Infectious Client

Standard Principles of Infection Control should be strictly adhered to at all times (Refer to Section D - 1).

Hand Hygiene

Alcohol handrub should be used after normal handwashing, or an antibacterial soap should be used to wash hands.

Alcohol handrub should not be used as the first line for hand decontamination when dealing with infections such as diarrhoea.

Disposal of Potentially Infected Items

Depending on the quantity produced, small amounts may be wrapped and placed in the domestic waste stream. If large amounts of infectious waste are generated discussion with the district nurse is necessary. If appropriate they can arrange for a hazardous waste collection to be made from the client's home. **(Refer to Section H – 6 Waste Management .)**

Commodes and Commode Pots

Manual cleaning is not good practice, however in a person's home there is little choice. Carers should wear personal protective equipment i.e. single-use apron, gloves and face protection i.e. visors. The contents of the pot should be carefully emptied into the toilet then rinsed with warm water and detergent followed by a disinfectant such as bleach/Milton. It may be necessary to use a toilet brush but care must be taken to prevent splash into the eyes or mouth.

The commode should be cleaned with detergent and warm water followed by wiping with a solution of bleach/Milton (see the side of the container for concentrations – the solution should be made for “environmental cleaning”). Then dry the commode.

Linen

Should be washed on as hot a wash as the fabric will tolerate, as promptly as possible. Faecal or vomit contamination should be emptied into the toilet before placing in washing machine. Contaminated items should be washed separately from other laundry. A cycle that has a pre-wash should be used as this will act as a sluicing wash removing soil before hot water is added. Soiled linen must not be left to soak as this creates a risk of spread of infection.

If laundry is not undertaken by the carer – faecal/vomit should be emptied into toilet prior to the item being sealed in a plastic bag, with a note attached warning that items are soiled and may be a risk of infection.

Crockery and Cutlery

Crockery and cutlery do not pose a high risk of infection to others as these items will not be used by others outside the household. However good practice would be if the client has a dishwasher items should be placed in and washed on the hottest wash. If dishwasher is not available items should be washed in detergent and hot water and dried. Disposable items are not required.

Deceased Clients

Standard Principles of Infection Prevention and Control should be maintained when a client dies. It will be the mortuary/funeral director staff's responsibility to deal with the deceased. However if an infection is known they should be informed of the potential infectious risk.

Personal Protective Equipment (PPE)

A risk assessment must be made for each client contact episode in order that the correct protective clothing is worn. If the carer is not planning to have any direct contact with the client or the immediate surroundings, protective clothing is not necessary.

Carers should have supplies of disposable gloves and aprons.

Daily Cleaning

If a client has an infectious condition such as diarrhoea the environment may become contaminated. Areas such as the toilet/bathroom may have high concentrations of organisms. If infection is present or suspected additional cleaning will be necessary. The use of a bleach/Milton solution should be used where appropriate i.e. bathrooms.

Horizontal surfaces should be kept clean and free of dust (dust can harbour organisms such as MRSA and Clostridium difficile)

3. Management of Deceased Clients

The deceased should be treated with the due respect and dignity appropriate to their religious and cultural background.

Most bodies are not infectious, however through the natural process of decomposition the body may become a source of potential infection.

Employer guidelines should be followed in the event of a death, including contacting next of kin. If it is necessary to handle the deceased standard principles of infection prevention and control should be observed.

4. Decontamination

The aim of decontaminating equipment and the environment is to prevent organisms that can cause infection from entering the body.

There are 3 processes for decontamination. In a person's own home cleaning is the main process necessary. On occasions it may be necessary to follow cleaning with a disinfection process.

When undertaking any aseptic technique sterile equipment will be required. Refer to table below.

The Medical and Healthcare Products Regulatory Agency (MHRA) defines the following terms:

- **Cleaning** 'is a process which physically removes contamination but does not necessarily destroy microorganisms'. The reduction of microbial contamination

cannot be defined and will depend upon many factors including the efficiency of the cleaning process and the initial bio-burden

Cleaning is an essential prerequisite of equipment decontamination to ensure effective disinfection or sterilisation can subsequently be carried out

- **Disinfection** 'is a process used to reduce the number of viable microorganisms, which may not necessarily inactivate some viruses and bacterial spores'. Disinfection will not achieve the same reduction in microbial contamination levels as sterilisation.
- **Sterilisation** 'is a process used to render the object free from viable microorganisms, including spores and viruses'.

Classification of Infection Risk Associated with the Decontamination of Medical Devices

Risk	Application of Item	Minimum Standard
High	<ul style="list-style-type: none"> • In close contact with broken skin or broken skin or broken mucous membrane • Introduced into sterile body areas 	Cleaning followed by sterilisation
Medium	<ul style="list-style-type: none"> • In contact with mucous membranes • Contaminated with particularly virulent or readily transmissible organisms • Before use on immunocompromised patients 	Cleaning followed by sterilisation or disinfection NB: Where sterilisation will damage equipment, cleaning followed by high level disinfection may be used as an alternative
Low	<ul style="list-style-type: none"> • In contact with healthy skin • Not in contact with patient 	Cleaning

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Within the client's home environment the majority of equipment to be decontaminated will require cleaning, or cleaning and disinfection. Items that require sterilisation will be purchased sterile, and require disposal after single-use.

Cleaning

Thorough cleaning with detergent and warm water followed by rinsing and thorough drying. This is necessary for items such as commodes that come into contact with intact skin.

Disinfection

Wiping with a solution of disinfectant such as bleach/Milton after cleaning. This is necessary for items that have been contaminated i.e. diarrhoea that could contain organisms such as Clostridium Difficile or Norovirus.

DISINFECTION METHODS

Disinfection methods apply to handwashing, skin preparation and equipment. Disinfection of equipment should be limited and, where possible, disposable or autoclavable equipment used instead. If disinfection is required, use the method recommended by the manufacturer.

Chemical	Advantages	Disadvantages	Uses
Chlorine-based: Hypochlorites (e.g. Domestos, Milton) NB Undiluted commercial hypochlorite contains approx. 100,000ppm available chlorine	<ul style="list-style-type: none"> • wide range of bacterial, virucidal, sporicidal and fungicidal activity • rapid action • non-toxic in low concentrations • can be used in food preparation • cheap 	<ul style="list-style-type: none"> • inactivated by organic matter • corrosive to metals • diluted solutions can be unstable • needs to be freshly prepared • does not penetrate organic matter • bleaches fabrics • need ventilation 	<ul style="list-style-type: none"> • can be used on surfaces and for body fluid spills
Sodium Dichloroisocyanurates (NaDCC) e.g. Presept, Haz-Tab, Sanichlor	<ul style="list-style-type: none"> • slightly more resistant to inactivation by organic matter • slightly less corrosive • more convenient • long shelf life 	<ul style="list-style-type: none"> • as above 	<ul style="list-style-type: none"> • as above
Alcohol 70% e.g. isopropanol	<ul style="list-style-type: none"> • good bactericidal, fungicidal and virucidal activity • rapid action • leaves surfaces dry • non-corrosive 	<ul style="list-style-type: none"> • non-sporicidal • flammable • does not penetrate organic matter • requires evaporation time 	<ul style="list-style-type: none"> • can be used on surfaces, or for skin and hand decontamination
Chlorhexidine e.g. hibiscrub, chlorhexidine wound cleaning sachets	<ul style="list-style-type: none"> • most useful as disinfectants for skin • good fungicidal activity • low toxicity and irritancy 	<ul style="list-style-type: none"> • limited activity against viruses • no activity against bacterial spores • inactivated by organic matter 	<ul style="list-style-type: none"> • for skin and hand decontamination

Hypochlorite Use

Blood Spillages

10,000 Available Chlorine (ppm)

Environmental disinfection

1,000 Available Chlorine (ppm)

Ensure that manufacturers' instructions are followed to obtain correct concentration of solution.

SINGLE-USE EQUIPMENT

Single-use means that the manufacturer:

- Intends the item to be used once, then thrown away
- Considers the item unsuitable for use on more than one occasion
- Has insufficient evidence to confirm that re-use would be safe.

The Symbol for single-use equipment:



If an item is designated as single-use it must only be used once. If used more than once the user will be held responsible for any detrimental affects.

Single patient use means that the item can be reused if re-processed using an appropriate method and is used on the **same patient only**. The duration of use is dependent upon undertaking a risk assessment of individual risk factors.

The MDA (1995) guidance suggests that reprocessing and re-using such items may pose hazards for patients and staff, if the reprocessing method has not been validated. Therefore re-use of single-use products is not advisable unless the outcomes have been taken into account. The Consumer Protection Act 1987 will hold a person liable if a single-use item is reused against the manufacturer's recommendations.

DECONTAMINATION OF EQUIPMENT

In a client's own home it is difficult to undertake best practice in decontamination which would be that items should not be manually cleaned but go through an automated process. The Following table suggests cleaning measures that will decontaminate the item but may present a risk to the healthcare worker.

A-Z OF EQUIPMENT AND THE DECONTAMINATION METHOD

EQUIPMENT	CLEANING METHOD
Baths	To be cleaned between uses. Clean bath surface, grab rails and taps with hot water, GPD and paper towels, or GPD wipes. Rinse
Bedpans/ Commode Pots	Reusable pans/pots to be decontaminated by washing with detergent and hot water and dried. Disinfect using a chlorine-releasing compound after cleaning if client has an infection or damaged skin
Beds and Mattresses	Keep dust free. If mattress has a waterproof cover, clean with hot water and GPD, or GPD wipes and dry. If soiling is evident then immediately clean as above and then wipe over with chlorine-releasing compound (bleach/Milton)
Bidets	To be cleaned after each use. Clean surface of pan and taps with hot water and GPD, or GPD wipes, and then dry using disposable paper towels
Wash Bowls	Clean between each use with hot water and GPD, using disposal paper towels or GPD wipes. Rinse and store dry
Commode Armrests and Seats	If no soiling is evident, clean with hot water and GPD, and dry using paper disposable towels. If soiling is evident, or there is diarrhoea, clean with hot water and GPD, or GPD wipes. Wipe over with a chlorine-releasing compound (e.g. bleach/Milton). Use separate wipes for armrests and seats

Hoists and Slings	<p>Slings should be cleaned regularly and when soiled. Depending on type they should either be laundered following manufactures instruction or cleaned with hot water and GPD, or GPD wipes and wiped dry. If soiled with body fluids wipe over with a chlorine-releasing compound (e.g. Milton)</p> <p>Hoist should be cleaned regularly with hot water and GPD, or GPD wipes and wiped dry. If soiled with body fluids wipe over with a chlorine-releasing compound (e.g. Milton)</p>
Nebulisers	<p>Single patient use nebuliser and tubing recommended. Units should be washed with hot water and GPD, or GPD wipes between use. Store dry. Follow manufacturer's instructions. Residuals of treatments must not be left in the nebuliser</p>
Thermometers	<p>Clients own - Clean with a disinfectant wipe Single-use disposable – as per manufacturer's instructions</p>
Urinals	<p>Reusable urinals to be decontaminated by washing with detergent and hot water and dried and store inverted Disinfect using a chlorine-releasing compound (bleach/Milton) after cleaning if client has an infection</p>
Walking Frames, Wheelchairs etc.	<p>Clean weekly with GPD and hot water, or GPD wipes and dry. If contaminated with body fluids disinfect using a chlorine-releasing compound (bleach/Milton) after cleaning if client has an infection</p>
Work Surfaces	<p>General Cleaning Use GPD and hot water, or GPD wipes. Contaminated Surfaces Clean with GPD and hot water, or GPD wipes, and then wipe with a 10000 ppm available chlorine solution</p>

DECONTAMINATION OF THE ENVIRONMENT

Environmental Cleaning

The environment plays a relatively minor role in transmitting infection, but dust, dirt and liquid residues will increase the risk. They should be kept to a minimum by regular cleaning.

- Work surfaces and floors should be kept clean and dust free. The most important component of an effective cleaning programme is the regular removal of dust from all horizontal surfaces
- GPD and water should be used for all environmental cleaning – follow the manufacturer's instructions. Disinfectant, such as a chlorine-releasing solution, should only be used to decontaminate spills of body fluids, or after a known case of infection i.e. diarrhoea
- Whilst colour coding (see below) of cleaning equipment in a client's home is not practicable, carers should ensure that cleaning equipment used in the bathroom/toilet should not be used in the kitchen
- Single-use mop heads should be used however if reusable mop heads are used these should be laundered in the washing machine on a hot wash and dried
- Single-use, non-shedding cloths or paper roll should be used for cleaning and drying
- All equipment used for cleaning, including vacuums, should be clean and maintained properly.

Colour-Code for Hygiene

Based on the Safer Practice Notice – Colour-coding hospital cleaning materials and equipment, published by the National Patient Safety Agency.

This may not all be possible in domiciliary settings.

National Colour Coding Scheme



THE GOLDEN RULE: WORK FROM THE CLEANEST AREA TOWARD THE DIRTIEST AREA. THIS GREATLY REDUCES THE RISK OF CROSS-CONTAMINATION.

1. The aim of a colour-coding system is to prevent cross-contamination
2. It is vital that such a system forms part of any employee induction or continuous training programme
3. A minority of people are colour-blind in one or more colours. Some individuals may not know this and colour identification testing should form part of any induction training
4. Always use two colours within the washroom/sanitary area
5. The colour-coding system must relate to all cleaning equipment, cloths and gloves.

Monitoring of the system and control of colour-coded disposable items against new stock release is extremely important.

DOMESTIC	CLEANING
Bucket (plastic)	Empty contents down toilet. Wash with GPD and dry
Mop (wet)	Disposable recommended. Reusable, heat disinfect in washing machine and dry thoroughly daily, or more frequently if necessary. Store dry
Lavatory Brushes	Rinse in flushing water and store dry
Floors	Dust control - dry mop. Wet cleaning - wet mop, wash with hot water and GPD
Lavatory Seat and Handle	If soiling is evident, or there is diarrhoea, clean with hot water and GPD followed by chlorine-releasing compound (i.e. Milton) 1,000 ppm
Showers	Should be clean and maintained. Launder curtains 3 monthly. Shower heads should be descaled when necessary

5. Laundry Management

IN THE CLIENTS OWN HOME

Laundry Practices

Carers should always wear gloves and a disposable apron whilst handling laundry.

Hands must be washed after removal of protective clothing.

Soiled laundry should be washed separately – soiling should be emptied into the toilet prior to washing.

Ideally the soiled items should be washed using a pre-wash cycle. Heat labile clothing must be washed at the highest temperature possible according to the item's fabric care instructions. Cotton items such as towels should be washed at 65°C.

If it is not in the client's "contract" to do laundry – soiling should be removed as above then the item should be placed in a water soluble* or plastic bag for whomever undertakes the laundering. (*Soluble bags should be suitable for domestic washing machines. This enables contaminated laundry to be placed into the machine (on a pre-wash cycle) whilst in the soluble bag thereby reducing the risks of body fluid contamination and potential infection risk). (For further advice contact the EHPU.)

On no account must items be left to soak as this is a health and infection risk.

Tumble-drying and ironing are also heat disinfection processes.

STAFF UNIFORMS OR WORK CLOTHES

Staff who are at risk of contaminating their clothes by body fluids should always change out of their uniforms on arriving home. If their uniform becomes heavily contaminated whilst on duty the carer should change uniforms before visiting another client.

Uniforms or work clothes should be washed as soon as possible on as hot a wash as the fabric will tolerate. Cardigans/jumpers should be washed at least weekly.

The majority of bacteria and viruses will not survive away from the host and would not present a high risk of infection on clothing. However, within a mass of body fluid organisms would survive longer.

Shoes should be cleaned immediately if contaminated with body fluids, using GPD and hot water - disposable gloves should be worn.

6. Waste Management

The management of Healthcare Waste has changed in line with the new Hazardous Waste Regulations.

The new Department of Health document is entitled: **Environment and Sustainability – Health Technical Memorandum 07-01: Safe Management of Healthcare Waste**. This guidance has been produced to provide a framework for best practice in waste disposal. The guidance is designed to help healthcare organisations and other producers of waste to meet their legislative requirements.

HTM 07-01 is available from the Stationary Office or it may be electronically downloaded from DH website www.dh.gov.uk/publications or http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_063274.

It is strongly recommended that Care Agencies consult the HTM 07-01.

Care Agencies should ensure that waste collection if necessary is written into the client's contract. i.e. who is responsible for the cost of collection if clinical waste is generated.

If the Care Agency is providing social care only for the client the waste generated would be classed as domestic. However if they are providing Nursing Care and are the only provider of that care, the agency should assume responsibility for the waste.

If nursing care is provided by a district nurse it is the responsibility of the Primary Care Trust (PCT) to arrange appropriate collection and disposal.

Waste generated in a clients home will predominately be domestic waste and should be treated in the same way.

Small amounts of clinical waste i.e. a small wound dressing can be placed in the domestic waste. If large amounts of clinical waste are generated an assessment of the waste will be necessary.

1. DEFINITIONS

Clinical Waste

- a) Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products, soiled swabs or dressings, or syringes, needles or other sharp instruments, being waste which, unless rendered safe, may prove to be hazardous to any person coming into contact with it; and
- b) Any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any other person coming into contact with it.
(Controlled Waste Regulations 1992)

The regulations subdivide healthcare clinical waste into:

- 1. Waste that poses a risk of infection (infectious waste)
- 2. Medicinal waste.

Infectious Waste

The Hazardous Waste Regulations define this as:

H9 Infectious: Substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in man or other living organisms.
(Traditionally known as “**clinical waste**”).

Colour-coding key to segregation system







Colour	Description
 Yellow	Waste which requires disposal by incineration Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility
 Orange	Waste which may be “treated” Indicative treatments/disposal required to be “rendered safe” in a suitable permitted or licensed facility. <i>Usually alternative treatment plants (APT’s) However this waste may also be disposed of by incineration</i>
 Purple	Cytotoxic and Cytostatic Waste Indicative treatments/disposal required is incineration in a suitable permitted or licensed facility
 Yellow & Black	Offensive/Hygiene Waste Indicative treatments/disposal required is landfill in a suitable permitted or licensed site. This waste should not be compacted in unlicensed facilities
 Black	Domestic (Municipal) Waste Minimum treatments/disposal required is landfill in a suitable permitted or licensed site. Recyclable components should be removed through segregation. Clear/opaque receptacles may also be used for domestic waste
 White	Amalgam Waste For recovery

Table from HTM07-01: Safe management of healthcare waste. Figure 4

The use of yellow/black for offensive/hygiene waste was chosen as these colours have historically been universally used for the sanitary/offensive/ hygiene waste stream.

8. CURRENT LEGISLATION

- Health & Safety at Work etc Act 1974
- Control of Pollution Act 1974
- Collection and Disposal of Waste Regulations 1988
- Control of Pollution (Amendment) Act 1989
- Environmental Protection Act 1990
- Environmental Protection (Duty of Care) Regulations 1991
- Controlled Waste Regulations 1992
- The Special Waste Regulations 1996
- HTM Environment and Sustainability 07-01 Safe Management of Healthcare Waste Department of Health 2006
- Healthcare Waste Management and Minimisation 2000.

ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION I – FOOD HYGIENE

1. Introduction

This section is relevant for carers that prepare or handle food.

This guideline sets out the procedures for staff to follow for food hygiene.

2. Legislation

All individuals who handle food should follow basic food hygiene practices to ensure contamination and subsequent disease does not occur.

All carers involved in the handling of food should be aware of the legislation relevant to food management. The main legislation is the Food Safety Act 1990 and its related regulations (General Food Hygiene Regulations (1995) and The Food Safety (Temperature Control) Regulations (1995)).

3. Basic Requirements for Food Safety

The following basic principles should be observed:

- It should be ensured that the food purchased is of good and wholesome quality and is subsequently stored, prepared, cooked and served in hygienic conditions
- Check “use by” dates. Use food within recommended times
- Do not provide/eat food containing uncooked eggs. Keep eggs in the fridge
- **Food Preparation Areas.** All food preparation surfaces should be cleaned before use with hot water and GPD
- **Pets.** Keep pets away from food and preparation areas
- **Cross Contamination.** Care must be taken not to contaminate cooked foods with raw foods. Ideally there should be a separate chopping board and utensils for each type of food (e.g. raw meat, cooked meat and raw and cooked perishables)

- **Hands and Hand-washing.** Hands **must** be washed thoroughly following any cleaning session, after toilet visits, before handling food and between handling different food types e.g. raw and cooked meats
- **Refrigerators.** All fridges should be defrosted and cleaned regularly. Should a spillage occur or food become stale the whole interior of the fridge should be cleaned with hot water and GPD and dried thoroughly
- **Food.** Food should be stored at the correct temperature. The fridge should be kept at 5° C or lower. The freezer should be kept at minus 18°C or below. In the care home, it is essential that a record of daily temperature recordings is kept
- **Storage.** Store raw meat and fish at the bottom of the fridge ensuring juices do not drip on to salads and vegetables. Raw meat and defrosting foods should be stored in covered dishes, or boxes which can catch drips. All sealed dry foods should be stored on shelves or in cupboards. Food should not be stored on the floor. Open packs of food should be stored in containers or packaging sealed to inhibit the entry of animals. Open bottles, such as squash, sauces and jams may require storage in the refrigerator. Follow manufacturer's guidelines
- **Defrosting.** All foods should be defrosted in the fridge or microwave, not at room temperature (unless specified on the packaging). Do not re-freeze uncooked food. Cook before you freeze again
- **Cooking.** Always follow cooking times on the labels and in cookbooks. Cook food thoroughly so that the temperature reaches 70° C for at least 2 minutes. Ideally food should be eaten as soon as it is cooked or prepared. Never re-heat food
- **Leftovers.** These should not be left out unnecessarily. Cold food should be covered and put directly into the fridge. Hot food should be cooled for one hour at room temperature and then placed in the fridge. All leftovers should be eaten within 2 days
- **Crockery and Cutlery.** A mechanical dishwasher incorporating a hot drying cycle should be used if possible. If a dishwashing machine is not available, hot water and GPD should be used for washing. Wherever possible, dry with disposable heavy-duty paper towel. If used, tea towels are to be changed daily and laundered at least 65° C
- **Dishcloths.** Should be changed daily and laundered at least 65°C.

ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

SECTION J – STAFF HEALTH

1. Occupational Health Service

If you have access to an occupational health service you should refer to any written guidance issued by them.

2. Principles of Staff Health

Carers are not in general at increased risk of acquiring communicable diseases. However, it is wise to take some basic precautions:

- Care Agencies should keep a record of staff immunisation histories, to facilitate action should an incident occur
- Consider the need to vaccinate staff who have not completed a primary course of the following routine childhood vaccine:
 - Diphtheria
 - Tetanus
 - Polio
 - MMR for those 35 and under (2 doses 3 months apart)
 - Meningitis C vaccine for those 25 and under (1 dose).

As a general public health measure, regular boosters are NOT required, nor should individuals have more than 5 doses of tetanus unless they sustain a high-risk injury.

- The Control of Substances Hazardous to Health (COSHH) Regulations 1994 require employers to undertake a risk assessment of their environment and to bring into effect measures necessary to protect their workers who may be exposed to Hepatitis B (Green Book)
- Employers are expected to organise and pay for vaccination of any workers who are considered to be at risk. They are also expected to keep records of who has been vaccinated
- Carers who handle sharps e.g. needles, lancets etc., who are at risk of being contaminated with the blood of others, should have a full course of Hepatitis B vaccine, including measurement of antibody levels. (Blood test 2 months after final dose of vaccine.) This will apply to carers that undertake blood glucose monitoring by using lancets. Details of the schedules are available in the DOH document “Immunisation Against Infectious Disease 2006” (The Green Book) found at www.dh.gov.uk. Staff should be aware of “sharps injury” procedure **(Refer Section E – Management of Sharps Injuries)**

- Carers from countries with high incidence of TB should be assessed on employment and on an annual basis for symptoms suggestive of tuberculosis e.g. persistent cough, weight loss, night fevers etc. The review should be on an individual basis with a face-to-face interview. A list of countries classified as high risk can be found at the end of this section and is also available from www.immunisation.nhs.uk. (the list can be found on the Tuberculosis fact sheet)

Everyone who was born, or has lived in a country other than Western Europe, North America, Australia or New Zealand should be considered a potential at risk for TB. A detailed list of countries with an incidence of more than 40/100,000 is available from the WHO website www.who.int.

- Consider BCG vaccination for staff under 35 years old whose parents or grandparents were born in a TB high prevalence country
- Influenza Immunisation – the DOH recommend that social care employers (especially nursing and care homes where older people are cared for) should offer yearly immunisation to their staff.

ESSEX HEALTH PROTECTION UNIT INFECTION CONTROL GUIDELINES DOMICILIARY CARE

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