Infection prevention and control

# An outbreak information pack for care homes

Bath & North East Somerset Council

Sirona care & health

NHS
Bath and North East Somerset Clinical Commissioning Group

Public Health England

Bath & North East Somerset (B&NES) Council takes its duty of care to care home residents extremely seriously and this pack aims to provide clear guidance on infection prevention and control precautions for protecting residents and staff from acquiring infection; and for restricting its spread should it occur.

**Objectives**

1. To provide information on common infectious diseases in care homes and steps that can be taken to mitigate them to prevent further spread.

2. To clarify communication routes for reporting outbreaks and incidents of infection.

**Background**

Good standards of infection prevention and control reflect the overall quality of care and can help to demonstrate compliance with the Care Quality Commission (CQC) outcomes. It can also help to promote confidence in the quality of care for residents and their families. Some infections can spread easily in enclosed settings and so it is essential that staff members remain aware and are able to identify and report promptly because this can result in serious and, in some cases, life-threatening scenarios for people.

All care homes should have in place a written policy on the prevention and control of infection which is based on the Code of Practice 2010 (updated 2015). The policy should include roles and responsibilities for outbreaks and incident management.

**This pack does not replace the policy**

## If you suspect an outbreak or incident, please call the Acute Response Centre, Public Health England South West Health Protection Team (in hours or out of hours) on: 0300 303 8162 option 2 option 2

Key Reference document: Prevention and Control of Infection in Care Homes – an information resource and Summary for staff; Available at: www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published

**Acknowledgments**

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Sirona Care and Health, Public Health England South West, BANES Clinical Commissioning Group, B&NES Care Home Managers, B&NES Council Environmental Health, Public Health Team & Commissioners

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# Definitions

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| **Outbreak** | An ‘outbreak’ is an incident where two or more persons have the same disease or similar symptoms and are linked in time, place and/or person association.<br><br>An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number at any given time. |
| **Incidents** | An ‘incident’ has a broader meaning, and refers to events or situations which warrant investigation to determine if corrective action or specific management is needed.<br><br>In some instances, only one case of an infectious disease may prompt the need for incident management and public health measures. |

# Recognising illness and Risk assessment

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| *Recognising illness* | As an example, although influenza-like illnesses may have specific signs and symptoms such as sudden onset of fever, headache, sore throat or cough, older people may present with unusual signs and symptoms. They may not have a fever, and may present with loss of appetite, unusual behaviour or change in mental state. |
| *Risk assessment* | It is essential to assess the risk of infection to residents and staff so that precautions can be put in place. For example, during a suspected norovirus outbreak, check that you have taken enough precautions to prevent harm to residents and staff members. This can be checking to see what Personal Protective Equipment (PPE) may be required before a procedure is carried out. |

# Reporting and role of other agencies


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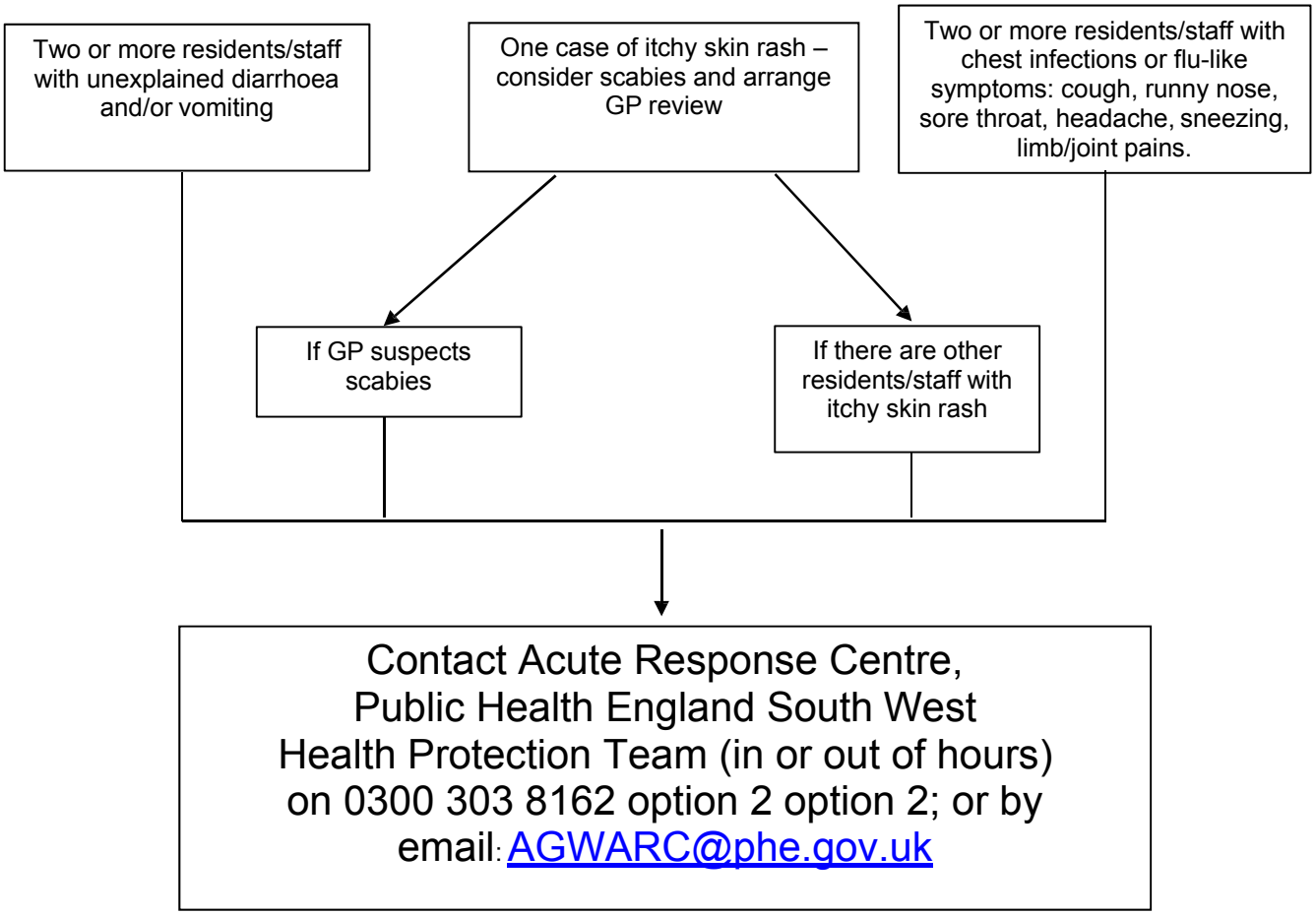
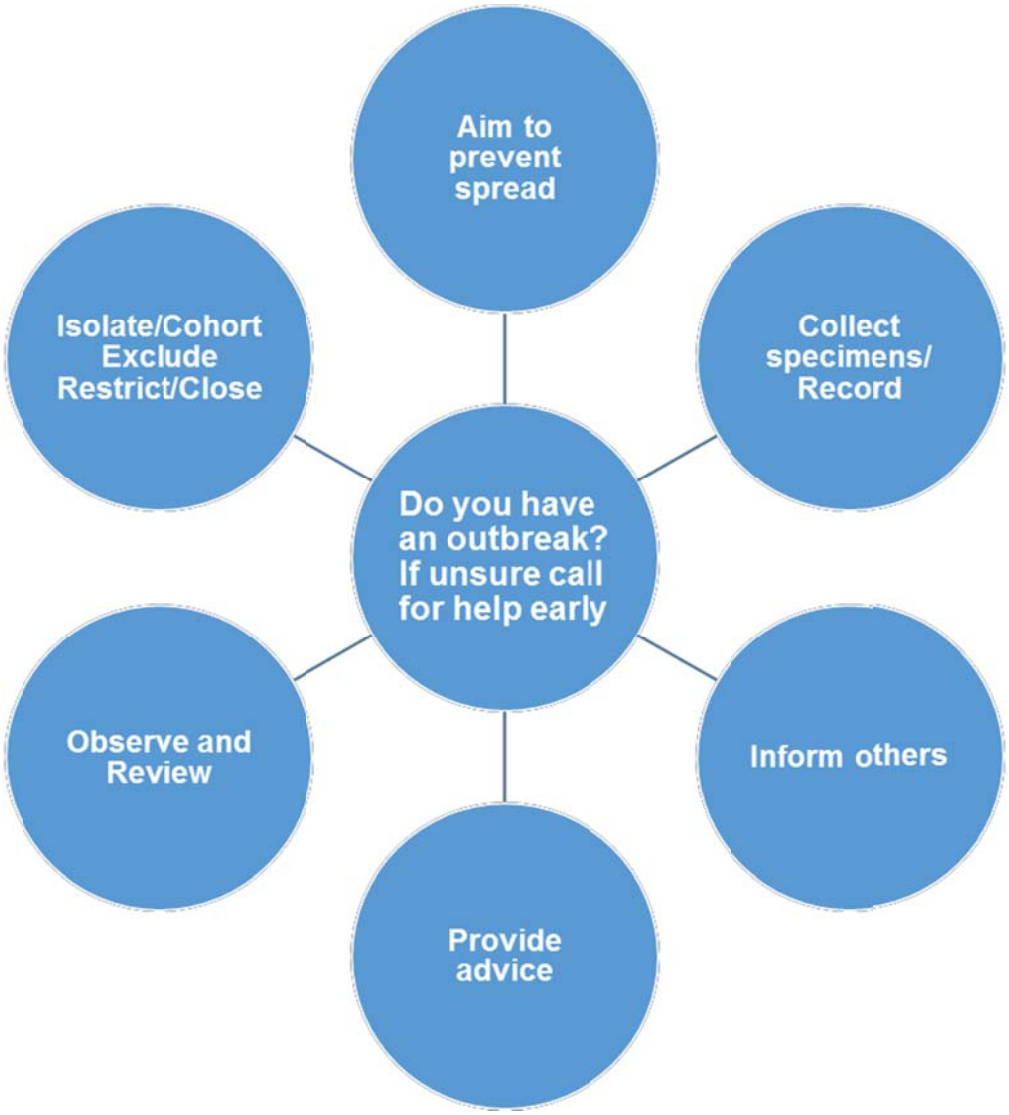
|---|---|
| Public Health England South West (PHESW)<br><br>Tel: 0300 303 8162 Option 2 Option 2<br>Fax 0117 930 0205<br>Email: agwarc@phe.gov.uk | Public Health England works with other agencies to understand and respond to health threats.<br><br>The local Health Protection Team can support care homes by leading on all outbreak related incidents. |
| **Sirona Care & Health Care Homes ONLY**<br>Community Infection Control:<br>Sirona Care and Health<br>Tel: 01225 831758<br>Email: InfectionPreventionTeam@sirona-cic.org.uk | These are specialist staff employed or contracted to provide Infection Prevention and Control advice to Sirona care and health services such as District Nurses, care workers and others. |
| Environmental Health<br>B&NES Council Public Protection & Health Improvement Team<br><br>Tel: 01225 396759<br>Email: public_protection@bathnes.gov.uk | Environmental Health Officers work with local partners to ensure threats to health are understood and properly addressed. Environmental Health Officers have a very good knowledge of care homes and can advise on infection control particularly if it is thought to relate to food. They will investigate suspected and confirmed cases of food poisoning and water borne illnesses.<br><br>They also investigate cases of Legionnaires Disease and work-related accidents, injuries, diseases and dangerous occurrences. |
| Non-Acute Social Care Commissioning Team,<br>Bath and North East Somerset Council<br><br>Tel 01225 477000<br>Email:<br>Commissioning_ContractsConcerns@Bathnes.gov.uk | Commissioning and Contract Officers carryout reviews and work with Care Homes to gain assurance that service providers are providing a quality service.<br><br>During contract reviews the officers observe practice, the environment, look at policies and procedures, residents records, discuss staff training and support and quality monitoring. |
| NHS Bath and North East Somerset Clinical Commissioning Group<br>St. Martin's Hospital<br>Clara Cross Lane<br>Bath BA2 5RP<br>01225 831800<br><br>nicola.murphy13@nhs.net<br>Quality and Patient safety Nurse CCG | The CCG is responsible for monitoring the quality and standards of infection prevention and control in local healthcare services including acute and community services. The CCG is also responsible for supporting continuous quality improvements in relation to infection prevention within primary care services and the independent sector including nursing homes. |

**Reporting outbreaks and incidents: Common scenarios.**
**Care Homes have a duty to report suspected outbreaks or incidents of infections to the local Health Protection Team.**



# General principles of outbreak management



# Immunisation and vaccinations for staff and residents

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| **Residents** | • Annual seasonal influenza vaccination is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely and can cause high morbidity and mortality. Some people can be at greater risk of developing complications (typically pneumonias) from influenza and becoming more seriously ill. These include people with chronic lung, heart, kidney, liver, neurological diseases; those with diabetes mellitus and those with suppressed immune system.<br><br>• All those over the age of 65 should receive one dose of pneumococcal vaccine. A single dose is also recommended for all those under 65 years of age who are at an increased risk from pneumococcal infection: people who have a heart condition, chronic lung disease, chronic liver disease, |
| **Staff** | • Influenza immunisation is recommended for health and social care workers with direct patient/service user contact such as care home staff; and are expected to be offered flu vaccinations by their employer. Staff immunisation may reduce the transmission of influenza to vulnerable residents, some of whom may have impaired immunity.<br><br>• Hepatitis B for staff who may come into contact with residents' blood or blood-stained body fluids or with residents' body tissues<br><br>• BCG vaccination should be offered to previously unvaccinated Mantoux negative staff in care homes who are younger than 35 years of age. Contact the Health Protection Team if you require advice on this. |

# Prevention of Influenza Outbreaks

The Influenza vaccine aims to:

- ☐ Reduce the transmission of influenza within health and social care premises
- ☐ Contribute to the protection of individuals who may have a suboptimal response to their own immunisations
- ☐ Avoid disruption to services that provide their care.

See the Green Book for more details:

# Infection Control Link Person: Key roles and responsibilities

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

Name of Infection Control Link Person for this Care Home……..

Signature and Date:…….

# Action Cards

## ACTION CARD: Diarrhoea and/or Vomiting

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

## ACTION CARD: Respiratory Illness (chest infections)

Please refer to Integrated Care Pathway for Chest Infections in Care Homes (Appendix 2)

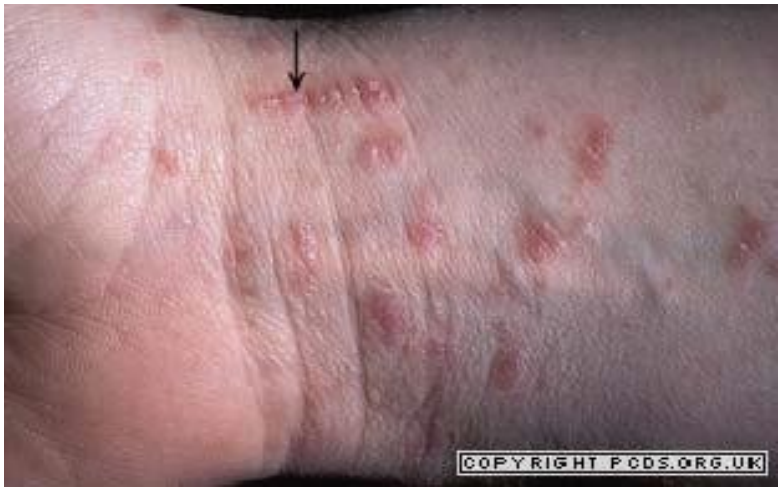
## ACTION CARD: Influenza-like illnesses

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

## ACTION CARD: Scabies

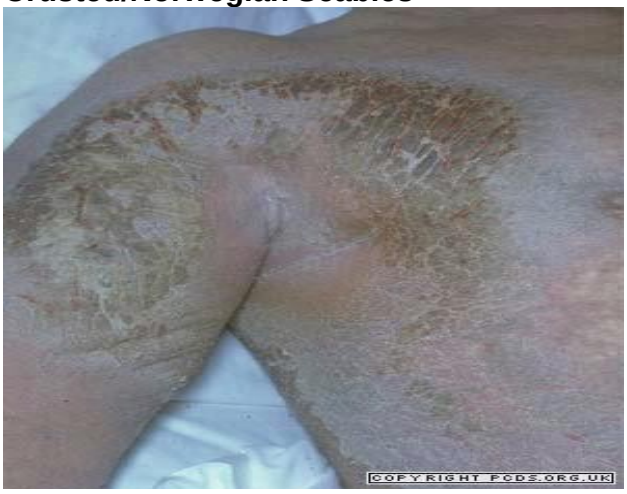
| Please consider all the actions below (mark as N/A (not applicable) as necessary) | | |
|---|---|---|
| | | Tick |
| 1 | For suspected cases, inform GPs who should confirm the diagnosis with the dermatologist if necessary.<br><br>Inform the Health Protection Team of all confirmed cases, BEFORE any treatment is started. This is because treatment is most effective if carried out simultaneously (ideally within a 24 hour period) in a co-ordinated way. Treatment, even for a single case, usually includes close contacts and family members who have had prolonged skin to skin contact - even if they have no symptoms. These should be treated at the same time to prevent re- | |
| 2 | Assess the chance of possible infection for each resident and staff member as 'high', 'medium' or 'low' risk to aid appropriate follow-up and treatment of contacts. All staff and residents identified as 'high risk' or 'medium risk 'will require treatment even in the absence of symptoms.<br><br>High = Staff members who undertake intimate care of residents and who move between residents, rooms or units. This will include both day and night staff; symptomatic residents and staff members.<br>Medium = Staff and other personnel who have intermittent direct personal contact with residents; asymptomatic residents who have their care provided by staff members categorised as 'high risk'.<br>Low = Staff members who have no direct or intimate contact with affected residents, including asymptomatic residents whose carers are not considered to be 'high risk'. | |
| 3 | The Care Home manager or nominated lead should liaise with the health protection team for support and advice on managing the situation, treatment co-ordination and supply of recording sheets. See Appendix 6 for more information. | |

**Classical Scabies**




**Arrows denotes burrows present.**

**Crusted/Norwegian Scabies**



## ACTION CARD: Clostridium Difficile

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

## ACTION CARD: MRSA

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

See Appendix 8 for more information

# Appendices

Public Health England

# Appendix 1

Public Health England South West
Health Protection Team

## INTEGRATED CARE PATHWAY

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

**Definition Criteria for an outbreak of diarrhoea and vomiting:**

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

| | |
|---|---|
| Full address of outbreak location including postcode | |
| Onset date and time in first case | |
| Number of residents / service users currently in the home | |
| Number of all staff members employed in the home | |
| Number of symptomatic residents (at time of reporting of outbreak) | |
| Number of symptomatic staff members (at time of reporting the outbreak) | |
| Do people have (please tick) | Diarrhoea Yes ❑ No ❑<br>Vomiting Yes ❑ No ❑<br>Both ❑ |
| Did cases start to be ill at the same time | Yes ❑ No ❑ |
| Did cases eat from the same place e.g. home kitchen, food brought in by residents or visitors? | Home Kitchen Yes ❑ No ❑<br>Food brought in by residents or visitors Yes ❑ No ❑<br>Other (please write)…….. |
| If yes to the last two questions, this could be food poisoning. | |

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

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

You may keep this document for your records but please fax or post only the End of Outbreak Notification form (page 24) to the Health Protection Team at the end of the outbreak.

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| Outbreak Care Pathway - Communication | Date | Signature |
|---|---|---|
| **1. Report cases of diarrhoea and vomiting to the person in charge** and enter the symptomatic cases details on the outbreak chart attached (residents, staff and visitors) so that you can identify whether symptoms started all at once (food poisoning?) or at different times (which may indicate person to person spread). | | |
| **2. Telephone the Health Protection Team to inform them of the outbreak** on 0300 303 8162 Option 2 Option 2 (Monday to Friday 0900 – 1700hrs).<br><br>• If the outbreak commences on a weekend or Bank Holiday and urgent advice is needed, inform the on-call Public Health Specialist via the emergency out of hours number on 0344 257 8195. | | |
| **3. Ensure your local Environmental Health Department is informed of the outbreak** Contact Tel: 01225 396759 | | |
| **Environmental Health**<br>These are the questions that Environmental Health may ask you:<br>1. Number of meals per day- residents and staff?<br>2. If staff have been ill, have they eaten from the care home?<br>3. Are day visitors catered for? Number?<br>4. Is this a distribution kitchen? I.e. are hot meals sent offsite to other satellite kitchens? Where? How many? Has this ceased during the current outbreak?<br>5. How many residents and staff are ill, time, onset date, symptoms?<br>6. Have the kitchen staff been questioned about possible symptoms?<br>7. Have any household contacts for kitchen staff & care assistants been unwell with diarrhoea and vomiting symptoms?<br>8. Are they aware of 48 hour rule for exclusion?<br>9. Has anyone vomited in dining room?<br>10. Are arrangements in place to exclude care assistants during the outbreak? E.g. alternative facilities available for drinks making or kitchen staff to make drinks and leave out for care assistants to distribute?<br><br>Environmental health staff may visit you to ask further questions. | | |
| **4. There is no longer a need to routinely inform the Care Quality Commission.** However, this document can be used to provide evidence for your CQC inspections. | | |

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| Outbreak Care Pathway - Communication | Date | Signature |
|---|---|---|
| **5. Close the home to admissions, transfers and hospital outpatient appointments**.<br>Day centres must also be closed (unless they can be accessed independently from the home and do not share staff with the home or receive meals from the home's kitchen). Also close the home to hairdressers, chiropodists and activity co-ordinators.<br><br>If hospital appointments are essential (this can be discussed with the health professional the resident is due to see), inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other patients.<br><br>Any problems or concerns can be discussed with the Health Protection Team if necessary. | | |
| **6. Inform visitors of the closure and put a poster on the entrance of the home –** to inform visitors that there is an outbreak and everyone needs to report to the person in charge. Visitors are advised to stay away until the home is 48 hours free of symptoms. Visitors must not be stopped from visiting if they wish to as long as they are aware they may become ill themselves. Visitors with symptoms must not visit the home until they are 48 hours free of symptoms. | | |
| **7. Inform visiting health care staff of the outbreak i.e. GPs, community nurses, physiotherapists, occupational therapists, pharmacists.**<br><br>Non-essential care must be deferred until after the outbreak | | |
| **8. Inform the Health Protection Team if a resident requires an emergency admission to hospital**.<br>The GP/ paramedics/ care home manager must inform accident and emergency or the admitting ward, so that the resident can be received into a suitable area in A&E/ medical admissions | | |

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| Outbreak Care Pathway - Infection Control Precautions | Date | Signature |
|---|---|---|
| **9. Isolate residents in their rooms until 48 hrs symptom free (where condition allows), particularly those with vomiting.**<br>Where residents are difficult to isolate (EMI units) try as much as possible to cohort the residents that are symptomatic into one area. | | |
| **10. Organise staff work rota to minimise contamination of unaffected areas. Try to avoid moving staff between homes and floors** | | |
| **11. Obtain a stool specimen as soon as possible from all symptomatic cases.**<br>Stool specimens must fill half the specimen pot and must be diarrhoea (not formed stools). The specimen can still be taken even if it is mixed with urine and it is alright to scoop the sample from the toilet or from an incontinence pad.<br><br>Sampling early may identify the cause of the outbreak and halt the need to take further samples.<br><br>Samples must be labelled clearly with the resident or staff details, the name of the home followed by 'outbreak' and the tests requested as 'M, C & S and virology'. | | |
| **12. Exclude all staff with symptoms until asymptomatic for 48 hours.**<br>Staff members should be advised to submit stool samples to their GPs and must be advised not work in any other care home until asymptomatic for 48 hours. | | |
| **13. Staff must not eat and drink except in designated areas**.<br>Open boxes of chocolates and fruit bowls must be removed and discarded in an outbreak | | |
| **14. Staff should change out of uniforms prior to leaving the home during outbreaks and wear a clean uniform daily.**<br>If uniforms are laundered at home they should be washed immediately on a separate wash to other laundry at the highest temperature the material will allow. Staff should wear disposable gloves and aprons when attending to personal care and whilst cleaning. | | |
| **15. Reopening**<br>• The home should not be reopened until it has been free of symptoms for 48 hours.<br>• A 'deep clean' should take place before reopening; this means that all floors, surfaces and equipment should be thoroughly cleaned with hot soapy water, including items such as door handles and light switches.<br>• Electrical items such as telephones and computer key boards also need to be cleaned with a (damp but not wet) cloth. | | |

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| Outbreak Care Pathway - Infection Control Precautions | Date | Signature |
|---|---|---|
| carpets be steam cleaned.<br>• Once reopened, send the end of outbreak notification form back to the Health Protection Team, so that your care home can be removed from the list of closed outbreak locations that is sent to the NHS and local authority daily. | | |
| **16. Effective hand hygiene is an essential infection control measure.** Ensure sinks are accessible and are well stocked with **liquid soap and paper towels for staff and visitors.** | | |
| **17. Provide residents with hand wipes and/or encourage hand washing (hand washing is the preferred option for residents who are not bed bound)**<br>In communal toilets, paper towels must be used for drying hands. For residents with en-suite bathrooms, hand towels are acceptable but should be changed daily. | | |
| **18. Ensure the macerator/bedpan washer is operational**<br>Faults must be dealt with immediately as **urgent**. | | |
| **19. Laundry soiled by faeces or vomit** must be placed directly into a water soluble/infected laundry bag and transferred to the laundry so that laundry staff do not have to handle the item. Launder as infected linen. | | |
| **20. Ensure the home is thoroughly cleaned daily using hot water and detergent.** If available all eating surfaces, toilet areas and sluice should be cleaned twice daily using a hypochlorite solution 1000 parts per million (E.g. Milton 1:10. To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water.)<br>• Commode and toilet seats require cleaning after each use with soap and water or detergent wipe.<br>• Cover excreta/vomit spillages immediately with disposable paper roll/towel. **Always** wear an apron and gloves when disposing of faeces/vomit. After removing the spillage, clean the surrounding area with hot soapy water, followed by disinfection with a **hypochlorite** solution of 1000 part per million. Always clean a wider area than is visibly contaminated. | | |
| • Carpets contaminated with faeces or vomit should be cleaned with hot soapy water (or a carpet shampoo) after removal of the spillage with paper towels. This should preferably be followed by steam cleaning if possible. | | |
| **21.** Inform the Health Protection Team when the home has been 48 hours symptom free. Use the End of Outbreak Notification Form at the back of this document. | | |
| | | |

Public Health England

# Bristol Stool Chart

| | | |
|---|---|---|
| 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** |

## Outbreak Chart

Location…… Tel no…….. Month/year……..

| Names of cases<br><br>*Example* | R/ S/ O/ | D/ N/ V/ | Rm | M / F | Date of birth | Dates of start and end of symptoms<br>●——X | | | | | | | | | | | | | | | | | | | | |
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| Informed Environmental Health | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Informed HPT | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of new cases today | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No. symptomatic residents today | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Number of beds closed today | | | | | | | | | | | | | | | | | | | | | | | | | | |

R = resident/patient
V = vomiting
S = staff
O = other
N = nausea
D = diarrhoea
EHO = Environmental Health Officer
HPT = Health Protection Team
X date sample sent to laboratory
●----------● start and end of symptoms
Rm = Room / location

Public Health England

| | | | |
|---|---|---|---|
| | Acute Response Centre,<br>Public Health England South West | **Email:** | agwarc@phe.gov.uk |
| **To** | | **Fax No.** | 0117 930 0205 (safe haven) |
| **From:**<br>**Care Home** | | **Fax No.** | |
| **Date** | | **No of pages** | (including this page) |

# Care Home End of Outbreak Notification Form

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

The purpose of this form is to:

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

| How many people: | Living / working at the care home? | Symptomatic? | Hospitalised? | Died? |
|---|---|---|---|---|
| Residents | | | | |
| Staff | | | | |
| Others, e.g. visitors | | | | |

**Lab Test Results**

| Type of specimen E.g. faeces | Dates sent | What the specimen was tested for, e.g. bacteriology, virology, C. diff, etc. | Results* (if known) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

Feedback and Lessons Learnt:

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

1. You would do differently?
2. You would like the Health Protection Team to do differently?

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

PHE Reference Number (if known): HPZ_____

# Appendix 2

Public Health England

**Public Health England South West Health Protection Team**

## INTEGRATED CARE PATHWAY

### Outbreak Management of Respiratory (Chest) Infections (Care Homes)

**Aims and Objectives**

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

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

**Definition Criteria for an outbreak of respiratory Illness**

*'Two or more cases of chest infection[1] or flu-like illness[2] among residents diagnosed by GP / duty doctor within one week in one residential / nursing home'*

Note that colds[3] are not included in this outbreak definition.

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

**Initial Situation Details**

Full address of outbreak location: ……..
……Postcode……..
Onset date & time in first case……
Number of residents:

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

Number of staff:

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

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

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

Please fax or post only the End of Outbreak Notification form (page 29) to the Health Protection Team at the end of the outbreak.

| **Communication: WHO TO INFORM** | **Date** | **Signature** |
|---|---|---|
| 1. **Report cases of respiratory illness (see definition above) to the person in charge** of nursing/residential home. | | |
| 2. Enter the details of symptomatic cases on the **log sheet** attached (residents and staff). | | |
| 3. **Inform all GPs caring for any of the residents** with symptoms | | |
| 4. **Telephone the Health Protection Team to inform them of the outbreak on 0300 303 8162, option 2** (Monday to Friday 0900 – 1700hrs) OR **If the outbreak commences *on a weekend or Bank Holiday* contact the On-Call Public Health Specialist** on 0344 257 8195.<br><br>This will enable you to discuss the outbreak control measures that are needed and the information to be communicated to others. | | |
| **Outbreak Care Pathway – CARE HOME ACTIONS** | **Date** | **Signature** |
| 5. **Close the home to admissions, transfers and hospital outpatient appointments**.<br>If appointments are essential, discuss with the Health Protection Team prior to the appointment, so appropriate plans can be made for the resident to be seen at the end of clinic in order to avoid contact with patients. (HPT to inform Hospital Infection Control team) | | |
| 6. **If the HPT agrees that an OUTBREAK is suspected and that closing the home is necessary:**<br>• **Inform family members/visitors of the closure and put a poster on the entrance of the home** to inform visitors that some residents have chest infections and that is recommended that visitors do not visit until the home has had no new cases for three days (five if flu strongly suspected or confirmed). This will reduce the risk of spread amongst residents, staff and visitors alike.<br>• Visitors must not be stopped from visiting if they wish as long as they are aware they may become ill themselves. Visitors, including children should not visit if they are unwell themselves.<br>• Inform visiting health care and other staff of the outbreak i.e. community nurses, physiotherapists, occupational therapists, hairdressers, clergy, pharmacists, agency staff.<br>• Non-essential visits must be deferred until after the outbreak | | |
| 7. **Inform the Health Protection Team if a resident requires an emergency admission to hospital**. The GP/paramedics/care home manager must agree who will inform accident and emergency (A&E) so that the resident can be received into a suitable area; and then do so. (*For elective admissions, GP and hospital medical staff to decide if essential or possible to postpone).* | | |

| | | |
|---|---|---|
| 8. **If possible, symptomatic residents should be cared for in single rooms (where condition allows).** If this is not possible:<br>• Symptomatic residents should be cared for in areas well away from those without symptoms e.g. in separate floors or wings of the home.<br>• Where residents are difficult to isolate, try as much as possible to cohort the residents that are symptomatic into one area.<br>• If the organism is unknown, assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered. | | |
| 9. **Organise staff work rota to minimise moving staff between homes and floors.** If possible, staff should work either with symptomatic or asymptomatic residents (but not both) for the duration of the outbreak.<br>10. Agency staff exposed during the outbreak should be advised not to work in any other health care settings until the cause is identified. | | |
| 11. **Monitor all residents for elevated temperatures and other respiratory symptoms** to identify infected residents early so that infection control measures can be promptly started to reduce further spread. | | |
| **Outbreak Care Pathway - SAMPLING** | **Date** | **Signature** |
| 12. **If flu is suspected, a suitably qualified health care professional may be required to obtain**:<br>• Combined nose/throat swab in virus transport medium from cases with the most recent onset of symptoms. Up to five should be taken (swabs are available from local laboratories[1]).<br>• Sputum samples for culture<br>• Urine samples for Legionella and pneumococcal antigens<br>**Please inform the Health Protection Team who will advise you further**.<br>13. Write name of care home, with suspected respiratory outbreak on each form, in addition to resident details | | |
| 14. **Exclude all staff and visitors with symptoms until no longer symptomatic and fully recovered** | | |
| 15. **Staff should change out of uniforms prior to leaving the home during outbreaks** and wear a clean uniform daily. Uniforms laundered at home should be washed immediately on a separate wash to other laundry. | | |

| **Outbreak Care Pathway – INFECTION CONTROL ACTIONS** | **Date** | **Signature** |
|---|---|---|
| 16. **Effective hand hygiene and safe disposal of respiratory secretions on tissues are an essential infection control measure.** Ensure handwashing sinks are accessible and are well stocked with **liquid soap and paper towels for staff and visitors.** | | |
| 17. Waste bins that contain tissues used by residents with a respiratory illness should be disposed of as clinical waste. | | |
| 18. **Encourage hand washing amongst all staff, residents and visitors. If residents are unable to wash hands at the sink, provide a bowl of water or hand wipes**. A clean individual resident hand towel should be provided daily for all residents. If handwashing facilities are not readily available offer alternatives such as alcohol gel | | |
| 19. **Staff should make a local risk assessment regarding the suspected organism and the use of personal protective equipment** such as gloves and aprons. Staff should wear gloves and apron for contact with cases and when handling contaminated items or waste.<br>20. Wearing gloves is no substitute for handwashing after contact with respiratory secretions and between residents. | | |

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

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

# Care Home End of Outbreak Notification Form

| | | | |
|---|---|---|---|
| **To** | Acute Response Centre,<br>Public Health England South West | **Email:**<br>**Fax No.** | agwarc@phe.gov.uk<br>0117 930 0205 (safe haven) |
| **From:**<br>**Care Home** | | **Fax No.** | |
| **Date** | | **No of pages** | 1 (including this page) |

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

The purpose of this form is to:

3. Provide feedback to the Health Protection Team on the outcome of the outbreak
4. Take the care home off the list of closed care homes that is sent daily to NHS and social care commissioners and providers.

| How many people: | Living/working at the care home? | Symptomatic? | Hospitalised? | Died? |
|---|---|---|---|---|
| Residents | | | | |
| Staff | | | | |
| Others, e.g. visitors | | | | |

**Lab Test Results**

| Type of specimen E.g. viral swabs of nose and throat, sputum | Dates sent | What the specimen was tested for, e.g. bacteriology, virology, C. diff, etc. | Results* (if known) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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

Feedback and Lessons Learnt:

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

3. You would do differently?
4. You would like the Health Protection Team to do differently?

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

PHE Reference Number (if known): HPZ_____

**Symptomatic Resident and Staff Log sheet - Complete Daily for new symptomatic cases**

| RESIDENTS LOG SHEET | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Room** | **Name & Date Of Birth** | **Date of last flu vaccine** | **Date of pneumovax vaccine** | **GP and Surgery Details** | **THIS OUTBREAK** | | | | | |
| | | | | | **Date Of Onset** | **Symptoms (see codes below)** | **Seen by Dr (name and date seen)** | **Diagnosis** | **Specimen Sent (type of specimens & date sent)** | **Results** |
| | | | | | | | | | | |
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| STAFF LOG SHEET | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **Job title** | **Name & Date Of Birth** | **Date of last flu vaccine** | **Date of pneumovax vaccine (if applicable)** | **GP and Surgery Details** | **Date Of Onset** | **Symptoms (see codes below** | **Seen by Dr (name and date seen)** | **Diagnosis** | **Specimen Sent (type of specimens & date sent)** | **Results** |
| | | | | | | | | | | |
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**Symptoms code**: C=cough (non-productive); CI=cough (producing green or yellow sputum); RN =runny nose; T=temperature; FB=fast breathing/shortness of breath; CS=audible chest sounds; H=headache; LA= loss of appetite; ST=sore throat; V=vomiting; AP=general aches /pains; ILL=duration of illness of ≥3 day

# Appendix 3

## Transmission, incubation and communicability of respiratory pathogens

| Infection | Reservoir | Dominant modes of transmission | Incubation period | Period of communicability* |
|---|---|---|---|---|
| **Rhinovirus or coronavirus** | Human | Respiratory droplets, direct and indirect contact with respiratory secretions. | Between 12 hours and 5 days, more usually around 48 hours. | From up to 1 day before* to 5 days after clinical onset. |
| **Influenza virus** | Humans are the primary reservoir for human influenza; birds and mammals are likely sources of new human subtypes for influenza A. | Respiratory droplets, direct and indirect contact with respiratory secretions. | Short, usually 1 to 3 days, but possibly up to 5 days. | From up to 12 hours before* to 3 – 5 days after** clinical onset in adults; up to 7 days in young children and occasionally longer. |
| ***Streptococcus pneumoniae*** | Humans – pneumococci are commonly found in the respiratory tracts of healthy people. | Respiratory droplets, direct and indirect contact with respiratory secretions. | Uncertain, but possibly 1 to 3 days. | Until discharges are clear of virulent pneumococci, but 24 - 48 hours if treated with penicillin. Pneumococci remain viable in dried secretions for many months. |
| **Respiratory syncytial virus (RSV)** | Human | Respiratory droplets, direct and indirect contact with respiratory secretions. | Between 1 and 8 days, more usually around 48 hours. | From up to 1 day before* to 5 days after clinical onset, occasionally longer in infants – up to 4 weeks. |
| **Parainfluenza virus** | Human | Respiratory droplets, direct and indirect contact with respiratory secretions. | Between 12 hours and 7 days, more usually around 48 hours. | From up to 1 day before* to 5 days after clinical onset. |

** Few data exist which convincingly demonstrate that transmission by asymptomatic persons is important in producing additional symptomatic cases*
*** Carriage may last for longer (7 days or possibly more) in older people with comorbidity and severe enough illness to warrant hospitalisation for this long*

## TRANSMISSION DYNAMICS

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

- **droplet transmission** – coughing, sneezing, or even talking may generate droplets more than 5 microns in size that may cause infection if droplets from an infected person come into contact with the mucous membrane or conjunctiva of a susceptible individual. The size of these droplets means that they do not remain in the air for a distance greater than a metre, so fairly close contact is required for infection to occur.
- **direct contact transmission** – this occurs during skin-to-skin or oral contact. Organisms may be passed directly to the hands of a susceptible individual who then transfers the organisms into their nose, mouth or eyes.
- **indirect contact transmission** – takes place when a susceptible individual touches a contaminated object, in the vicinity of an infected person and then transfers the organisms to their mouth, nose or eyes.
- **aerosol transmission** – takes place when droplets less than 5 microns in size are created and remain suspended in the air. This can sometimes occur during medical procedures, such as intubation or chest physiotherapy. These droplets can be dispersed widely by air currents and cause infection if they are inhaled.

## INFECTION CONTROL

### Residents

- Enhanced surveillance for further cases should be initiated by way of daily monitoring of all residents for elevated temperatures and other respiratory symptoms. It is important to identify infected residents as early as possible in order to implement infection control procedures such as isolation and reduce the spread of infection. If possible, symptomatic residents should be cared for in single rooms. If this is not possible, symptomatic residents should be cared for in areas well away from residents without symptoms. If the design and capacity of the care home and the numbers of symptomatic residents involved are manageable, it is preferable to isolate residents into separate floors or wings of the home. Movement of symptomatic residents should be minimised. If the organism is unknown, assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered.
- Resident's clothes, linen and soft furnishings should be washed on a regular basis and all rooms kept clean. More frequent cleaning of surfaces such as lockers, tables, chairs, televisions and floors is indicated, especially those located within one metre of a symptomatic resident. Hoists, lifting aids, baths and showers should also be thoroughly cleaned between residents.
- Residents should have an adequate supply of tissues, as well as convenient and hygienic methods for disposal. Residents should cover their nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses and clean their hands or use handrubs (microbicidal handrubs, particularly alcohol-based) afterwards.
- Depending on the nature of the infection and the impact on those affected, consideration might in very specific circumstances be given to the use of surgical facemasks by affected residents (if this can be tolerated) when they are within one metre of other individuals (unless microbiologically confirmed to share the same infection). The Health
- Protection Team will advise if this is necessary.

### Staff

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

- Agency and temporary staff who are exposed during the outbreak should be advised not to work in any other health care settings until the cause is identified and appropriate advice given.
- Symptomatic staff and visitors should be excluded from the home until no longer symptomatic. Children and adults vulnerable to infection should be discouraged from visiting during an outbreak. Consistent with resident welfare, visitor access to symptomatic residents should be kept to a minimum.
- Frequent hand washing has been proven to be effective in reducing the spread of respiratory viruses. Staff should clean their hands thoroughly with soap and water or a handrub (microbicidal handrubs, particularly alcohol-based) before and after any contact with residents. Consideration should also be given to placing handrub dispensers at the residents' bedsides for use by visitors and staff. It is advisable to recommend carrying out a risk assessment before introducing handrubs into the workplace.
- Staff should wear single use plastic aprons appropriately when dealing with residents.
- Barrier measures such as gloves, gowns and facemasks (the higher the filtration the better) are also effective in reducing the spread of respiratory viruses if used correctly. Any decision about the use of personal protective equipment (PPE) needs to be taken in the light of the organism and the impact on the home. The Health Protection /team can advise on the level of infection control needed.
- More stringent infection control is needed when aerosol generating procedures (such as airway suction and CPR) are carried out on cases or suspected cases. Such procedures should be performed only when necessary and in well ventilated single rooms with the door closed. Numbers of staff exposed should be minimised and FFP3 respirators and eye protection should be used in addition to gowns, gloves and universal precautions.
- Staff, residents and visitors should be encouraged to avoid touching their eyes and nose to minimise the likelihood of infecting themselves from viruses picked up from surfaces or other people.
- Uniforms and other work clothing should be laundered at work if there are facilities for this. If laundered at home the general advice on washing work clothes would apply. Uniforms should never be worn between home and the place of work.
- Clinical waste should be disposed of according to standard infection control principles.
- Depending on the causative organism, there may be a case for staff at risk of complications if infected (e.g. pregnant or immuno-compromised individuals) to avoid caring for symptomatic residents. A risk assessment will need to be carried out on an incident by incident basis.

# Appendix 4

## Influenza Outbreaks: Information leaflet for staff, residents, carers, friends and family

**1. What is a flu (influenza) outbreak?**

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

**2. Recommended precautionary measures for homes with a possible flu outbreak**

If the staff in the care home suspect an outbreak, they will ensure that measures are in place to reduce the risk of spread to other residents. They may also advise restrictions on staff and resident movements.

The local Health Protection Team will be supporting them in ensuring:

- adequate control measures are taken to prevent the spread of infection
- affected residents or staff receive appropriate treatment and
- residents, staff and carers receive appropriate and timely information on the measures being taken

**3. What are the specific measures that staff can take?**

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

**4. How can residents, carers, friends and family help?**

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

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

# Appendix 5

## Guidance on Influenza Outbreaks in Care homes (including poster)

**1. What is an outbreak of influenza?**

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

**2. How can you reduce the risk of influenza transmission in care homes?**

- Wash hands frequently with soap and water and dry thoroughly
- Ensure frequent cleaning of surfaces
- Cover your mouth and nose with a tissue when coughing or sneezing
- Dispose of used/dirty tissues as clinical waste

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

***3.1 Care of residents***

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

***3.2 Informing local Health Protection Team***

The Health Protection Team staff will:

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

***3.3 Reinforce Infection Control Measures***

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

***3.4 Additional key measures*** recommended during outbreaks are outlined below. These cover three main areas:

- Restrictions to visitors and staff
- Respiratory hygiene
- Droplet precautions

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

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

- ***Respiratory hygiene***

  Respiratory hygiene/cough etiquette is essential when an outbreak of flu is being considered. Recommended measures include:
  - Putting up signs at entrance or common areas instructing residents and visitors to inform staff if they have respiratory symptoms, and discouraging visitors with symptoms.
  - Providing tissues to residents and visitors who are coughing or sneezing so that they can cover their mouth and nose.
  - Residents with symptoms of respiratory infection should be discouraged from using common areas where feasible. Residents should have an adequate supply of tissues and covered sputum pots, as well as convenient and hygienic methods of disposing of these.
  - Ensuring that supplies for hand washing are available where sinks are located and providing dispensers of alcohol-based hand rubs in other locations.
  - Encouraging coughing persons to sit at least 3 feet away from others, if possible.

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

# Guidance on outbreaks of influenza in care homes

**Do 2 or more residents or staff have the following symptoms?**

Fever of 37.8˚C or above

**OR**

Sudden decline in physical or mental ability

**PLUS**

New onset or acute worsening of one or more of these symptoms:

- cough (with or without sputum)
- runny nose or congestion
- sore throat
- sneezing
- hoarseness
- shortness of breath
- wheezing
- chest pain

If you notice **2 or more** residents or staff with these symptoms occurring within **2 DAYS (48 HOURS)**, in the same area of the care home **and their GP(s) confirm the illness may be influenza**

**You might have an outbreak**

***Contact the health protection unit immediately***

and take the infection control measures listed below.

**What the Health Protection Unit will do:**

- Work with care home staff and GPs to identify the cause of the outbreak.
- Work with infection prevention and control nurses to advise on infection control measures.
- Work with GPs to provide treatment and prevention.

## INFECTION PREVENTION AND CONTROL MEASURES

All residents and staff should be offered seasonal flu vaccination each year

### Hand hygiene and protective clothing

- Ensure that **liquid soap and disposable paper towels** are available at all sinks.
- **Wash hands** thoroughly using liquid soap and water **before and after** any contact with residents.
- Provide **70% alcohol hand rub** for visitor use and supplementary use by staff.
- Staff should wear single-use **plastic aprons and gloves** as appropriate when dealing with affected residents. The HPU will advise on the use of surgical masks. Dispose of all these as infectious waste.

### Cleaning and waste disposal

- Provide **tissues** and no-touch bins for used tissue disposal in public areas.
- Provide tissues and covered sputum pots for affected residents. Dispose of these as infectious waste.
- **Wash** residents' clothes, linen and soft furnishings on a regular basis, and keep all rooms clean.
- **Clean surfaces** of lockers, tables & chairs, televisions and floors etc frequently. Always clean hoists, lifting aids, baths and showers thoroughly between patients.

### Reducing exposure

- **Close the home** (and any day care facility) to new admissions if the HPU confirms an outbreak.
- Residents should **not transfer** to other homes or attend external activities.
- Residents should only attend out-patient or investigation appointments where these are clinically urgent.
- Care for residents with symptoms in **single rooms** until fully recovered **and for at least 5 days** after the symptoms started.
- Affected residents should **remain in their rooms** as far as possible. Discourage residents with symptoms from using common areas.
- Staff should work in **separate teams**: one team caring for affected residents and the other caring for unaffected residents.
- Agency and temporary staff in contact with residents with symptoms should **not work elsewhere** (e.g. in a local acute care hospital) until the outbreak is declared over (i.e. **7 days after the onset of the last case**).
- Staff and visitors with symptoms should be excluded from the home until fully recovered **and for at least 5 days** after the onset of symptoms.
- The elderly, very young and pregnant women, who are at **greater risk** from the complications of flu, should be discouraged from visiting during an outbreak.
- Inform visiting health professionals of the outbreak and **rearrange non-urgent visits** to the home.
- Inform the hospital in advance if a resident requires admission to hospital during the outbreak.

# Appendix 6

## Scabies: Infection Control Precautions in Nursing and Residential Homes

| | |
|---|---|
| **LAUNDRY** | Clothes, towels, and bed linen should be machine-washed after the first application of treatment, to prevent re-infestation and transmission to others. Items that cannot be washed can be kept in plastic bags for at least 72 hours to contain the mites until they die. This includes heat labile items.<br><br>Machine wash and dry bedding and clothing of scabies residents using the hot water and hot dryer cycles (60 degrees plus for linen and as tolerated by the clothing materials involved). |
| **ENVIRONMENT** | Soft furnishings, which have cloth coverings, should be kept out of use for 24hours after treatment in order to allow the mites which may be on the fabric to die. These items should then be vacuumed.<br><br>Those covered in vinyl should be wiped down with a hard surface cleaner following treatment.<br><br>In cases of **crusted (Norwegian)** scabies vacuuming and damp dusting of the environment is essential. |
| **ISOLATION** | **Residents with scabies do not normally require isolation**. However, residents with crusted (Norwegian) scabies who are highly contagious require isolation precautions until treatment has been completed.<br><br>Aprons and gloves should be worn for personal care of known infected cases. |

Further information on scabies:
www.patient.co.uk/health/scabies-leaflet

# Appendix 7

**Suggested Care Plan**
**Once Clostridium difficile is confirmed**

**Isolation**

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

**Monitoring of resident**

- Document a plan of care in the resident's notes. Keep a written record of all monitoring carried out and care given, including a daily record of the resident's condition and bowel movements.
- Monitor the resident's condition carefully as this infection can cause rapid dehydration and rapid deterioration (within hours). **Patients who are systemically unwell or have more profuse diarrhoea should be referred to their local GP / Professional Line.**
- Residents who are ill need to be monitored hourly day and night.
  Keep a fluid balance chart, recording all drinks taken and the number of times the resident passes urine (and how much, if possible) and the number of times the resident has their bowels open.
- Record all bowel actions on a bowel chart, as per the Bristol Stool Chart. Record the resident's temperature daily. Report to GP if outside normal limits. Monitor the resident for abdominal pain. Report to GP if pain develops.
  Monitor the resident's blood pressure four hourly (this should always be done in nursing homes and if possible in residential care homes). Report to GP if outside normal limits.
- If the resident becomes confused, stops eating or if you are at all concerned inform the GP.
  Keep the resident and their relatives informed about their condition and why you are taking special precautions.
- If the resident is admitted to hospital, please call the hospital **before the resident arrives** so they can arrange immediate isolation and prevent a hospital outbreak. Call the infection control team or A&E ward Manager, as appropriate to time of day. **Tell the ambulance crew in advance.**

**Treatment**

- Request a GP visit to assess the resident.
- There may be an indication to commence treatment with an antibiotic.
- Please refer to links below for up to date treatment recommendations from PHE and medication management from the BCAP Formulary.

  https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321891/Clostridium_difficile_management_and_treatment.pdf

  http://www.bcapformulary.nhs.uk/

**Handwashing**

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

This is an example of the type of record chart you will need:

# Stool Chart

**Resident's Surname** …….. **Date of birth** ……..

**Forenames** …….. **Room number** ……..

**MUST BE COMPLETED EVERY SHIFT, INCLUDING WHEN NO STOOLS PASSED**

| DATE | TIME | BRISTOL TYPE | APPROX AMOUNT | COLOUR | FRESH BLOOD PRESENT? (call GP) | MUCUS PRESENT? (call GP) | SAMPLE SENT | SIGNATURE |
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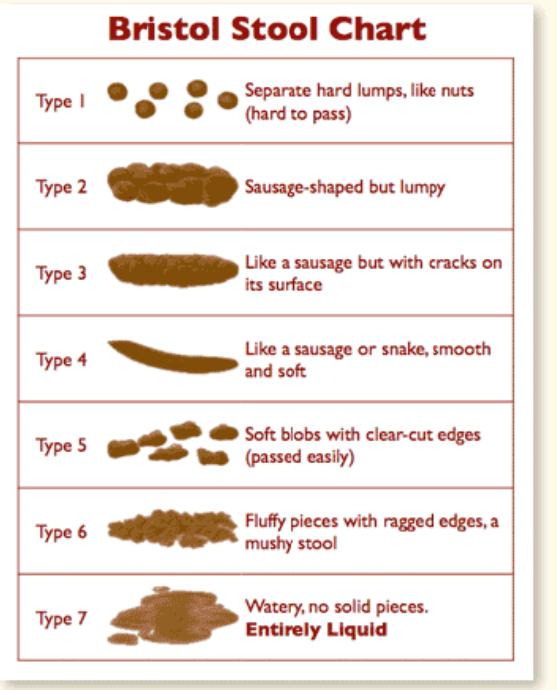


## Type 5, 6 or 7

- **Patient to be isolated**
- **Stool sample to be sent - request Clostridium difficile toxin test on the laboratory form**
- **Document actions taken in nursing notes**
- **Inform GP for medical assessment**

**Personal Protective Equipment (PPE)**

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

**Cleaning**
**The environment must be kept thoroughly clean to prevent spores spreading**

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

**Recurrent disease**

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

**Root Cause Analysis**

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

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www.hpa.org.uk
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**References**

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2 Lewis SJ, Heaton KW (1997) "Stool form scale as a useful guide to intestinal transit time" Scandinavian Journal of Gastroenterology 32(9)920-4. doi: 10.3109/00365529709011203.PMID 9299672

# Appendix 8

**Antibiotic-resistant bacteria**

Residents may be transferred from hospital while colonised or infected with a variety of antibiotic-resistant bacteria, including Methicillin Resistant Staphylococcus Aureus (MRSA). Often these bacteria will be colonising the skin or gut, without causing harm to the resident, and will not cause harm to healthy people.

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

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

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

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

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

Adapted from page 47/48 of Prevention and Control of Infection in Care Homes, Available at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214929/Care-home-resource-18-February-2013.pdf

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