University Hospitals of Derby and Burton
NHS Foundation Trust

Infection Prevention and Control: An Outbreak Information Pack for Care Homes in Derby and Derbyshire

"The Care Home Pack"

Link to National Key Reference Documents: Adult social care: guidance - GOV.UK (www.gov.uk)

Acknowledgements

The original document was produced by Grace Magani, Senior Health Protection Nurse UKHSA and South Gloucestershire Council in September 2015.

- It was reviewed and updated by Grace Magani and Fiona Neely, Consultant in Health Protection, Public Health England in September 2017
- By Grace Magani and Chaamala Klinger, Consultant in Health Protection in September 2018.
- By Fiona Neely and Sarah King in October 2019
- By Grace Magani, Sarah King and Fiona Neely in September 2022
- Derby updates were provided by Donna Foulkes (Acting Community Lead Infection Prevention and Control, University Hospital of Derby & Burton NHS Foundation Trust), Dr Ben Rush (Consultant in Communicable Disease Control, UKHSA) and Hannah Martin (Public Health Support Officer, Derby City Council) in November 2022 and August 2023
- Document reviewed by Dr Ben Rush (Consultant in Communicable Disease Control, UKHSA), Lauren Worrall Advanced Public Health Practitioner and Sabah Azam Community Infection Prevention and Control Administration Assistant March 2025

Permission has been granted for amendments\adaptations for local use by University Hospital Derby and Burton, Community Infection Prevention and Control Team November 2022.

Next Review: August 2026

Updates

Date	What was updated?	By whom
Oct 2019	Deletion of EHO contact details (care homes should go through HPT to contact EHOs for outbreaks or incidents) Immunisation and vaccination for staff and residents – section on flu vaccine for staff updated Deletion of Flu Info sheet for residents and carers (now sent at time of outbreak) Integrated Care Pathways – ICPs- (Checklists) updated and included as Action Cards, rather than in Appendix Insertion of explanation and web link to Winter Readiness Pack	Fiona Neely (HPT) FN FN Sarah King FN
Sep 2022	Insertion of quick link to front page to National key reference documents Additional background information, COVID-19 vaccination and introductory paragraph to IPC Link person included Integrated Care Pathway (Checklist) for Acute Respiratory illnesses rep by Acute Respiratory Infections (Including COVID-19 and Influenza): Checklists for Care Settings removed and replaced with a web link.	Grace Magani Sarah King
February 2023	Contact details updated Appendix 6 inserted Action cards inserted Contents page updated	Hannah Martin Donna Foulkes
March 2023	UKHSA logo added UKHSA contact details updated Flow chart (p.9) updated Update to UKHSA HPT response and provision of UKHSA template letters	Ben Rush
August 2023	Update to UKHSA HPT response details Update to Scabies action card Update to ARI action card	Ben Rush
August 2023	New links added Scabies guidance amended	Hannah Martin

March 2025	New links added RSV vaccination added	Ben Rush Lauren Worrall Sabah Azam

Contents

Executive Summary

Written for care homes, this pack aims to provide clear guidance on infection prevention and control precautions for protecting residents and staff from acquiring infection and for restricting spread should an outbreak 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. Since infections can spread easily in enclosed settings, it is essential that staff members remain aware and are able to identify and to report promptly. Failure to do so can result in serious or life-threatening scenarios.

The COVID-19 pandemic has highlighted the need for good infection prevention measures which can help to prevent infections from happening in the first place. It is crucial that these measures are embedded in everyday practice to help to reduce the need for antibiotics which may lead to resistance and severe health consequences for service users.

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 2022). 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 UKHSA Health Protection Team (in hours or out of hours) on 0344 225 4524

Definitions

Outbreak	An ‘outbreak’ is an incident where two or more persons have the same disease or similar symptoms and are linked in time, place and/or person association. An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number at any given time.
Incident	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. Incidents can cover chemical, environmental and radiological threats to health as well as infectious ones. In some instances, only one case of an infectious disease may prompt the need for incident management and public health measures.

Recognising illness and Risk assessment

Recognising illness	As an example, although influenza-like illnesses may have specific signs and symptoms such as sudden onset of fever, headache, sore throat or cough, older people may present with unusual signs and symptoms. They may not have a fever, and may present with loss of appetite, unusual behavior 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 the role of other agencies

Contacts

Please note that we have endeavored to provide up to date contact numbers but provide no guarantee or can accept no responsibility for whether these contact details are correct.

UKHSA

The local **Health Protection Team** (HPT) can support care homes with health protection incidents (infectious disease outbreaks or chemical, environmental, and radiological hazards). This support includes leading or coordinating the management of incidents, and advising on Infection Prevention and Control and infectious diseases.

Tel: **0344 255 4524**
Email: emhpt@ukhsa.gov.uk (only monitored during normal working hours)

Community Infection Control

There may be specialist staff employed by the local authority or Integrated Care Boards who are able to provide Infection Prevention and Control advice to care homes.

South Derbyshire
Southern Derbyshire is supported by University Hospitals of Derby and Burton NHS Foundation Trust's Community Infection Prevention Control team.
The team is based at Johnson Building, Locomotive Way, Derby, DE24 8PU.
To contact a member of the Community Infection Prevention Control Team, please email uhdb.communityinfectioncontrol@nhs.net or phone **01332 258 190.**

North Derbyshire
North Derbyshire is supported by Chesterfield Royal Hospital NHS Foundation Trust's infection prevention and control team. They are based at Chesterfield Royal Hospital, Calow, Chesterfield, Derbyshire, S44 5BL, and can be contacted by phone on **01246 513 183.**

Tameside
The Tameside IPC team can be contacted on infectionprevention@tgh.nhs.uk or 0161 922 6194

Local Authority Environmental Health Officers

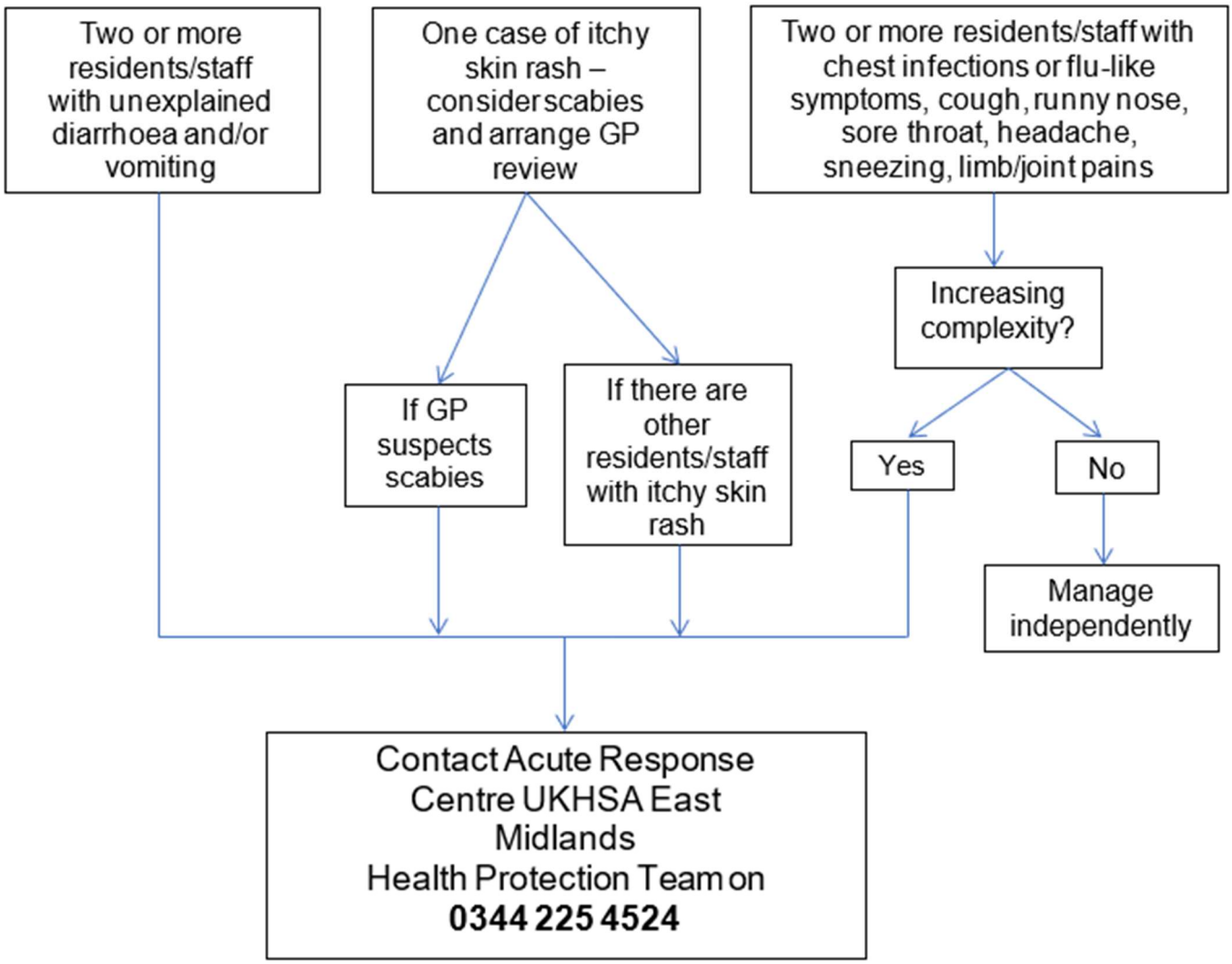
EHOs work with local partners to ensure threats to health are understood and properly addressed. Environmental Health Officers have a very good knowledge of care homes and can advise on infection control particularly if it is thought to relate to food. They will investigate **suspected and confirmed cases of food poisoning and water borne illnesses.**

They also investigate cases of **Legionnaires Disease** and **work-related accidents**, injuries, diseases, and dangerous occurrences.

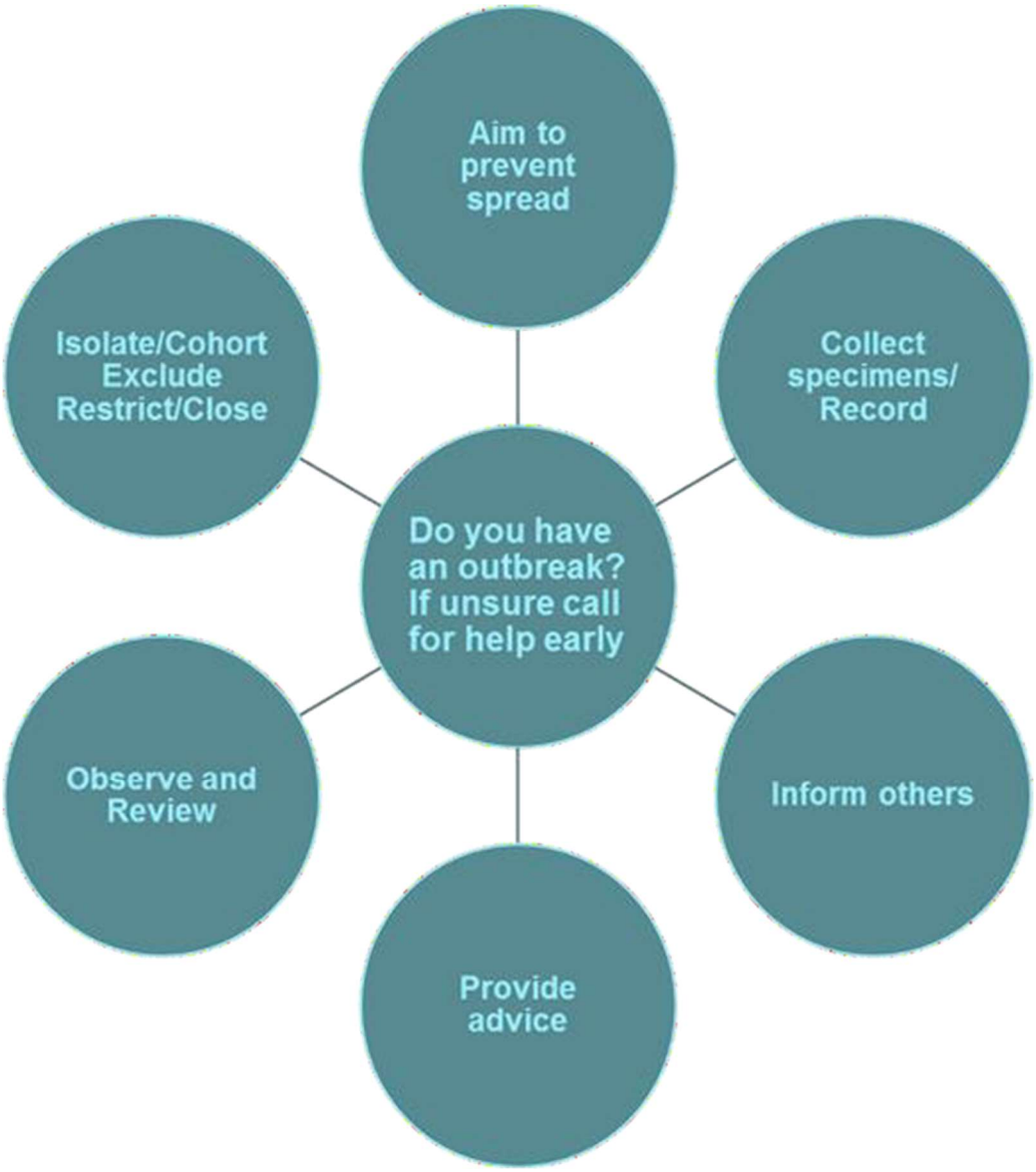
See Appendix 6 for additional EHO Area Contacts

Reporting outbreaks and incidents: Common scenarios.

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



General principles of outbreak management



Immunisation and vaccinations for staff and residents

Residents	**Annual seasonal influenza vaccination** is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely and can cause high 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. All those over the age of 65 should receive one dose of **pneumococcal vaccine**. A single dose is also recommended for all those under 65 years of age who are at an increased risk from pneumococcal infection: people who have a heart condition, chronic lung disease, chronic liver disease, diabetes, weakened immune system and damaged or no spleen. For **COVID-19 vaccination**, please follow current guidance. A single dose of Respiratory Syncytial Virus (RSV) vaccine is recommended for all those turning 75. There is a catch-up campaign for all adults aged 75-79 to receive the virus. The vaccine is also available for pregnant women from 28 weeks of pregnancy.
Staff	**Annual seasonal influenza vaccination** is recommended for health and social care workers with direct patient/service user contact such as care home staff; flu vaccinations may be provided via the employer who has a duty to inform employees of the vaccine recommendations. Flu vaccine for carers is also available free of charge from their own GP or a local community pharmacy. The staff member should take proof that they are a carer when attending for vaccination. **Hepatitis B vaccination** for staff who may come into contact with residents' blood or blood-stained body fluids or with residents' body tissues. **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. For **COVID-19 vaccination**, please follow current guidance The RSV vaccination is also recommended for pregnant women.

The Green Book

Immunisation against infectious disease - GOV.UK (www.gov.uk)

Prevention of influenza and COVID-19 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.

COVID-19 vaccination: offers protection against

severe disease See the Green Book for more details

Infection Prevention & Control Link Person

- An IPC Link person is any member of the care team with special interest in promoting and improving standards of infection prevention and control in their care setting. They may be supported by Local Authority Adult Social Care or NHS Infection Prevention and Control teams

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 IPC Link

Person.....

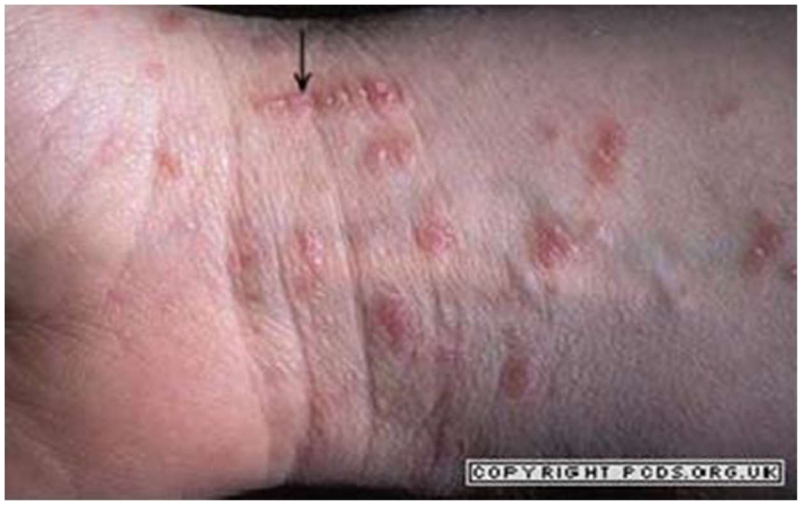
Signature and Date

.....

Action Cards

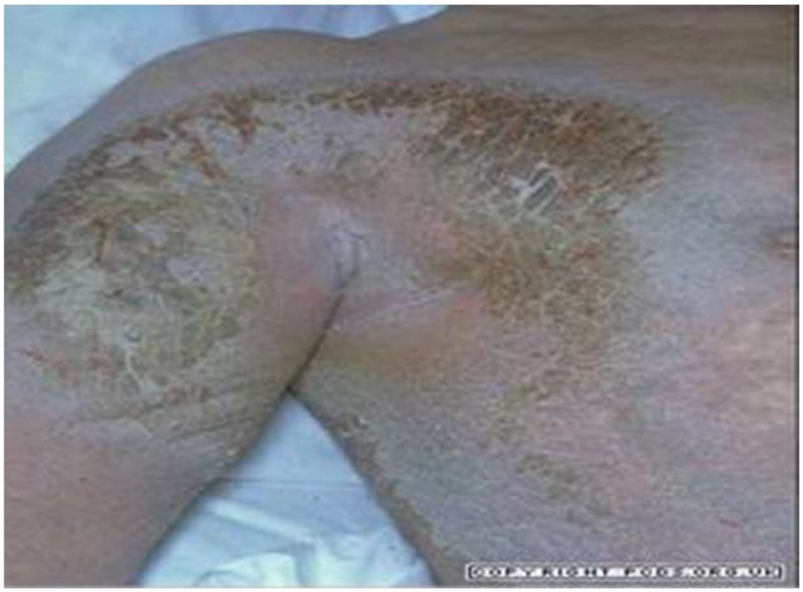
Action card: Scabies

Please consider all the actions below (mark as N/A (not applicable) as necessary)		
		Tick
1	Inform GPs of suspected cases. Scabies is usually a clinical diagnosis, with no reliable test. This means it should be diagnosed on assessment by a clinician, who can discuss with a dermatology specialist if required.	
2	Inform the UKHSA Health Protection Team (HPT) of suspected cases, BEFORE any treatment is started. Scabies can spread easily in a residential setting, and if there is suspicion of an outbreak (multiple cases with evidence of spread), then treatment is most effective if carried out simultaneously on all cases and contacts, ideally within a 24 hour period, and together with laundering of clothes and linen. **This is a major event that needs proper co-ordination with several agencies, therefore, it is crucial that cases are clinically assessed and the diagnosis is most likely scabies.** If there are delays in outbreak treatment, for instance where medication is difficult to supply in sufficient quantities, then the HPT or Outbreak Control Team (OCT) will advise on any interim measures.	
3	Treatment, even for a single case, usually includes close contacts and family members who have had prolonged skin to skin contact or sharing of towels or bed linen - even if they have no symptoms. They should be treated at the same time to prevent re-infection.	
4	Assess the chance of possible infection for each resident and staff member as 'high', 'medium' or 'low' risk to aid appropriate follow-up and treatment of contacts. All staff and residents identified as 'high risk' or 'medium risk 'will require treatment even in the absence of symptoms. High = Staff members who undertake intimate care of residents and who move between residents, rooms or units. This will include both day and night staff; symptomatic residents and staff members. Medium = Staff and other personnel who have intermittent direct personal contact with residents; asymptomatic residents who have their care provided by staff members categorised as 'high risk'. Low = Staff members who have no direct or intimate contact with affected residents, including asymptomatic residents whose carers are not considered to be 'high risk'.	
5	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.	



Classical scabies

Arrow denotes burrows present.



Crusted/Norwegian Scabies

Action card: Clostridioides difficile (C. difficile)

Please consider all the actions below (mark as N/A (not applicable) as necessary)		
		Tick
1	If you have a resident who is C.diff positive, follow the Department of Health's **'SIGHT'** advice: **S**uspect that a case may be infectious where there is no other cause for diarrhoea. **I**solate resident while you investigate and continue until they are clear of symptoms for 48 hours. **G**loves and aprons must be used for all contacts with the resident and their environment. **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. **T**est the stool by sending a specimen immediately requesting screening for Clostridioides difficile (within 24 hours if three or more instances of stool type five, six or seven in a 24 hour period) - see Bristol Stool Chart. Discuss with and inform the resident's GP. Please contact the Health Protection Team if any of your residents has recently been discharged from hospital and was diagnosed with C.diff whilst there.	
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 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. In such cases, also inform the GP who will probably send wound swabs for investigations.	
10	Contact the UKHSA 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. Also inform the health protection team for advice if required. Cover any infected wounds or skin lesions with appropriate dressings.	
12	**Please also inform the UKHSA Health Protection Team of any PVL (Panton- Valentine Leukocidin) producing MRSA affecting any resident or staff member.**	

Action cards: diarrhoea and vomiting

Two or more cases of diarrhoea and/or vomiting, Bristol Stool Chart grading 5, 6 or 7 (loose stools) unusual to the residents or staff members normal bowel action, within a 48-hour period.

Actions required

Is it a new suspected outbreak (first suspected case, or new case following more than 28 days since last outbreak)?
If so, suspect setting needs to:

- **Notify the residents GPs (and manager if out of hours)**

Gather the following information:

- Number of symptomatic cases in residents/staff as well as how many residents/staff are currently living/working in the care home.
- Onset date of first, second, and most recent case
- Symptoms that the cases have had
- Contact details for the care setting including email address that can be accessed and care setting CQC identification code (if known)
- Information on any common food links – party/shared food/or whether more likely to be person to person (viral) spread

- **Notify UKHSA Health Protection Team** (0344 225 4524) who will risk assess the situation and provide you with guidance on what to do next and notify the Environmental Health Team

United Kingdom Health Security Agency

- UKHSA EM Health Protection Team Email: emhpt@ukhsa.gov.uk
- UKHSA EM Health Protection Team Number: 0344 225 4524

Integrated care pathway for outbreak management of diarrhoea and vomiting in 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 (see end of checklist)

Full address of outbreak location including postcode	
Onset date and time in first case	
Number of residents currently in the home	
Number of all staff members employed in the home	
Number of symptomatic residents (at time of reporting of outbreak) with onset dates	
Number of staff members symptomatic (at time of reporting the outbreak) with onset dates	
Do people have (please tick)	Diarrhoea: Yes ❑ No ❑ Vomiting: Yes ❑ No ❑ Abdo pain Yes ❑ No ❑ Fever Yes ❑ No ❑
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 ❑ Food brought in by residents or visitors: Yes ❑ No ❑Other: (please write)……

If yes to the last two questions, this could be food poisoning; please inform Environmental Health Officer and the Health Protection Team (UK Health Security Agency – previously PHE)

Instructions: Work through all the pages of this document, signing and dating each action when it has been implemented and adding case details to the outbreak chart.
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.

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. **If not already done telephone the UK Health Security Agency (UKHSA) Health Protection Team to inform them of the outbreak** on 0344 225 4524 (Monday to Friday 0900 – 1700hrs). • If the outbreak commences on a weekend or Bank Holiday and urgent advice is needed, inform the on-call Public Health Specialist using the above number and you will be directed to the Out of Hours number.		
UKHSA will inform Environmental Health who may contact you. These are the questions that Environmental Health may ask you: 1. Number of meals per day - residents and staff? 2. Are day visitors catered for? Number? 3. 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? 4. Have the kitchen staff been questioned about possible symptoms? 5. Have any food handlers/care assistants been unwell, even very mild symptoms? 6. Have any household contacts for kitchen staff & care assistants been unwell with diarrhoea and vomiting symptoms? 7. Are they aware of 48-hour rule for exclusion? 8. Has anyone vomited in dining room? 9. Are care assistants routinely excluded from the kitchen? 10. If not, are arrangements in place to exclude them during the outbreak? E.g. alternative facilities available for beverage making or kitchen staff to make beverages and leave out for care assistants to distribute? 11. If staff have been ill, have they eaten from the care home? 12. Is all food equipment maintaining adequate temperature control? 13. Are hot/cold food temperature records up to date and carried out? The EHO may ask you to provide copies of these records.		
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.		
5**. Close the home to admissions, transfers and hospital outpatient appointments**.		

Closure does not strictly apply to readmission of existing residents and these should be considered on an individual basis – the health protection team (UKHSA) can assist with risk assessment. 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). If hospital appointments are essential (this can be discussed with the health professional the resident is due to see), inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other patients. Any problems or concerns can be discussed with the Health Protection Practitioner 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 as long as they are aware they may become ill themselves. Visitors with symptoms must not visit the home until they are 48 hours free of symptoms.		
7**. Inform visiting health care staff of the outbreak i.e. GPs, community nurses, physiotherapists, occupational therapists, pharmacists.** Non-essential care must be deferred until after the outbreak		
8**. Inform the UKHSA Health Protection Team if a resident requires an emergency admission to hospital**. The GP/ paramedics/ care home manager must inform accident and emergency or the admitting ward, so that the resident can be received into a suitable area in A&E/ medical admissions		
9. **Isolate residents in their rooms until 48 hrs symptom free (where condition allows), particularly those with vomiting.** Where residents are difficult to isolate (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 some symptomatic cases.** If notified of the outbreak, the UKHSA Health Protection Team (HPT) will decide whether stool samples are necessary, based on the clinical and epidemiological details provided. Not all instances of multiple diarrhoea/vomiting cases in a care home will constitute an outbreak, and not all such outbreaks will require stool samples to be sent. At any time, a GP may also request a stool sample for a resident when they feel it is clinically indicated for that patient. Samples like this are not always relevant to an outbreak, since it depends on what tests are requested and whether the sample is linked to others in the lab. It is therefore important to follow HPT advice for stool sample requirements when they are being requested as part of an outbreak. Sampling early may identify the cause of the outbreak and halt the need to take further samples.		

If the HPT require stool samples to investigate or confirm an outbreak, they will either arrange these through the local GP, or through the local authority's Environmental Health Officers (EHOs). The GP or EHOs will provide appropriately labelled pots with the relevant test requests and instructions on how and where to submit them. Stool specimens should be 5 to 10 ml 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. Please confirm with the HPT which residents (names and DOBs) have had samples successfully submitted. This can be done by calling the HPT, or using an NHS.net address to email the HPT at phe.emhpt@nhs.net, or empht@ukhsa.gov.uk.		
12. **Exclude all staff members with symptoms until asymptomatic for 48 hours.** Staff members should be advised to submit stool samples to their GPs and must be advised not to work in any other care home until asymptomatic for 48 hours		
13. **Staff must not eat and drink except in designated areas**. Open boxes of chocolates and fruit bowls must be removed in an outbreak		
14. **Staff should change out of uniforms prior to leaving the home during outbreaks and wear a clean uniform daily**. If uniforms are laundered at home, they should be washed immediately on a separate wash to other laundry at the highest temperature the material will allow.		
15. **Reopening** • The home should not be reopened until it has been free of symptoms for 48 hours. • A 'deep clean' should take place before reopening; this means that all floors, surfaces and equipment should be thoroughly cleaned with hot soapy water, including items such as door handles and light switches. • Electrical items such as telephones and computer keyboards also need to be cleaned with a (damp but not wet) cloth. • Curtains should be laundered, and it is recommended that, if possible, carpets be steam cleaned.		
16. **Effective hand hygiene is an essential infection control measure.** Ensure sinks are accessible and are well stocked with **liquid soap and paper towels for staff and visitors.**		
17. **Provide residents with hand wipes and/or encourage hand washing (hand washing is the preferred option for residents who are not bed bound)** In communal toilets, paper towels must be used for drying hands. For residents with en-suite bathrooms, hand towels are acceptable but should be changed daily.		
18. **Ensure the macerator/bedpan washer is operational** Faults must be dealt with immediately as **urgent**.		

19. **Laundry soiled by faeces or vomit** 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. **Disinfection with Hypochlorite Solution** • Disinfect with a freshly prepared 0.1 % hypochlorite solution (1000ppm). It is important to check the label for concentrations. • Recommended hypochlorite solutions at a concentration of 1,000 ppm include: ○ 50mls of Milton® added to 950mls of water ○ Chlor-Clean®, Haz-Tab®, or Presept® tablets, as per manufacturer's instructions using a diluter bottle where applicable. Others may be available. ○ 100 ml of household bleach (5% - concentration varies) added to 4900 ml of water • It is essential that the correct concentration of the solution is made up to ensure that it is effective in killing the virus. • A fresh solution of hypochlorite should be made every 24 hours as the concentration becomes less effective after this time period. The date and time should be recorded when the solution is made up. • Commode and toilet seats require cleaning after each use with soap and water or detergent wipe. • Cover excreta/vomit spillages immediately with disposable paper roll/towel. **Always** wear an apron and gloves when disposing of faeces/vomit. After removing the spillage, clean the surrounding area with hot soapy water, followed by disinfection with a hypochlorite solution of 1000 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 UKHSA Health Protection Team when the home has been 48 hours symptom free. Either via email to phe.emhpt@nhs.net (from NHS.net email addresses) or emhpt@ukhsa.gov.uk (from non-NHS.net email addresses) or call the Health Protection Team (UKHSA) on 0344 225 4524		

Outbreak Chart

Location……Tel no…….. Month/year……

Names of cases *Example*	R S O	D N V	R m	Gender (M,F)	Date of birth	Dates of start and end of symptoms ●——X
Informed HPT						
Number of new cases today						
No. symptomatic residents/staff today						
Number of beds closed today						

R = resident
S = staff
O = other
D = diarrhoea
N = nausea
V = vomit

Rm = Room / location
EHO = Environmental Health Officer
HPU/ICT = Health Protection Unit/Infection Control Team
●----------● = start and end of symptoms
X = date sample sent to laboratory

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**

Standard Infection Prevention and Control Measures for acute respiratory infections, including COVID-19 and Influenza (Flu)	
Key Guidance	
• DHSC Infection prevention and control in adult social care settings • DHSC Infection prevention and control in adult social care: COVID-19 supplement • NHS England National infection prevention and control manual for England • UKHSA Influenza-like illness (ILI): managing outbreaks in care homes • UKHSA Living safely with respiratory infections, including COVID-19 • UKHSA COVID-19 vaccination programme • UKHSA Ventilation to reduce the spread of respiratory infections, including COVID-19UKHSA	Tick / Comments
Vaccination: refer to UKHSA The complete routine immunisation schedule for eligibility and 'The Green Book' for disease specific information UKHSA Immunisation against infectious disease	
All eligible residents are up to date with their vaccinations: - COVID-19 - Influenza - Shingles - Pneumococcal	
All eligible staff are up to date with their vaccinations - COVID-19 - Influenza - MMR - Hepatitis B	
There is a record of staff and resident vaccinations including those who declined	
Infection Prevention and Control (IPC) – general	
An Infection Prevention and Control (IPC) policy is available to all staff which includes guidance on standard infection control precautions DHSC Infection prevention and control: resource for adult social care and additional precautions required for COVID-19 infections DHSC Infection prevention and control in adult social care: COVID-19 supplement	
There is/are IPC champion/s who encourage/s good practice and carries out regular audits of practice	
All staff have received training on IPC at induction (inc. bank/agency staff) All staff have received annual refresher on IPC (including bank/agency staff)	

IPC – hand and respiratory hygiene	
There are adequate stocks of liquid soap and disposable paper towels and they are available at each hand wash basin which is dedicated only to handwashing.	
Alcohol hand rub/gel is available for staff at the point of care, especially where handwash basins are not readily accessible (consider individual gel containers if necessary)	
Hand hygiene practices of staff (how and when to clean hands and being 'bare below the elbow' are monitored for example by observing practice	
Posters for hand and respiratory hygiene are displayed widely for staff and visitors e.g. Catch-it, Bin it, Kill it poster (infectionpreventioncontrol.co.uk) NHS England » National infection prevention and control manual for England – appendices Campaign Resource Centre	
Residents are encouraged/helped to clean hands regularly	
Residents have easy access to tissues and waste bins for their safe disposal in their rooms and in communal spaces	
IPC – Linen, waste, and environmental cleaning	
General waste, Clinical waste disposal systems are in place, including foot operated bins	
Linen is managed appropriately, and water-soluble bags are available (and used for linen generated by persons with infection)	
Staff wear a clean uniform daily & change out of their uniforms prior to leaving the setting. If uniforms are laundered at home, they should be washed at the highest temperature that the material will tolerate.	
Cleaning equipment (e.g. cloths) is single-use wherever possible	
A cleaning schedule is available with clear responsibilities for individuals	
Cleaning staff have received induction/refresher training including correct use and storage of cleaning products and colour coding of equipment	
Surfaces and high touch areas are cleaned frequently (and increased if a resident/s has an infection) with detergent (or a combined detergent/disinfectant product)	
A hypochlorite disinfectant is available for use in affected rooms/areas	
Equipment/facilities that must be shared by residents, (e.g. hoists, baths and showers etc.) is thoroughly cleaned and then disinfected with a chlorine-based solution (1000 ppm) and allowed to dry between each use	
IPC – other environmental considerations	
Ventilation is maximised e.g. windows opened to allow flow of air across communal rooms from outside	
Communal areas are uncluttered, and chair position helps to encourage spacing between residents	
Mixing of staff and residents between different areas of the setting is minimised as far as is reasonable and practicable (and as long as this does not adversely affect health and wellbeing of residents)	
Visiting by friends / family	
Visitors are advised and encouraged to clean their hands regularly when in the setting	

Visitors undertaking personal care are trained in how to use PPE	
Visitors know that they should not enter the setting if they are feeling unwell. See DHSC COVID-19 supplement to the infection prevention and control resource for adult social care	
Care planning	
Residents (and staff) who are at higher risk of COVID-19 have been identified See guidance: • UKHSA & DHSC COVID-19: guidance for people whose immune system means they are at higher risk • UKHSA Reducing the spread of respiratory infections, including COVID-19, in the workplace • NHS HR guidance on protecting vulnerable staff	
Every resident has a care plan as agreed with them, their relatives (as appropriate) and their GP. This includes advance care planning, mental capacity assessments, plans to deal with walking with purpose, end of life considerations & hospitalisation, access to COVID-19 drug treatments for those who are eligible etc. See British Geriatric Society: Managing the COVID-19 pandemic in care homes	
Safer visiting guidance	
See guidance: • Supporting safer visiting in care homes during infectious illness outbreaks - GOV.UK	

Checklist for all Cases of COVID-19, Influenza-Like-Illness (ILI) or unidentified Acute Respiratory Infection (ARI)

These items are additional to those in the previous checklist i.e. - **Standard Infection Prevention and Control Measures for all acute respiratory infections, including COVID-19 and Flu**	
Symptomatic **staff** are not in the workplace.	
Symptomatic **residents** are isolated in their room/accommodation, with access to their own bathroom wherever possible and their own equipment	
Symptomatic **staff or residents** who have received a letter advising that they are eligible for COVID-19 treatments should test by COVID-19 LFD immediately on recognizing symptoms. Positive tests should be managed as per guidance (COVID-19 supplement to the infection prevention and control resource for adult social care).	
Individual symptomatic residents do not require respiratory illness testing unless there is a clinical indication or other concern.	
When there are **two or more symptomatic residents** within a 14 day period, respiratory illness testing should be conducted as clinically indicated. It is possible to have more than one type of respiratory infection in an outbreak. • If COVID-19 is suspected, up to the first 5 symptomatic residents should be tested by COVID-19 LFD, with two or more cases constituting an outbreak. • If influenza is suspected, swabs for testing will be arranged via the GP or local UKHSA Health Protection Team (0344 225 4524). If this occurs within flu season, the HPT may arrange for antivirals before testing is conducted or results are known.	
Additional measures to encourage isolation when required are in place (e.g. increased staffing and activities see Maintaining-Activities-for-Older-Adults-during-COVID19.pdf (healthinnovationnetwork.com))	
If isolating fully is not possible (e.g. a resident who walks with purpose), steps to reduce risk are considered e.g. mask wearing if tolerated, increased cleaning and disinfection of touched surfaces outside of the room and providing access to outdoor spaces within the grounds through a well ventilated route where they will not come into contact with others	
Visitors to symptomatic residents are aware of the possible infection and are risk assessed prior to visit (1 visitor can visit in any circumstance if safe for them to do so)	
Staff are aware of the symptoms to look out for and are trained in the use of pulse oximeters and NEWS2/RESTORE2 tools to monitor residents with symptoms (links to further resources in DHSC COVID-19 supplement to the infection prevention and control resource for adult social care	
Any resident case who has received a letter advising that they are eligible for COVID-19 antivirals or monoclonal antibody therapeutic treatments- are supported to follow the instructions within the letter and/or contact their GP (note: the HPT cannot advise on therapeutic treatments for COVID-19)	

Checklist for all outbreaks of Acute Respiratory Infection (ARI) including Flu and COVID-19

These items are additional to those in the previous checklists i.e.

- **Standard Infection Prevention and Control Measures for all acute respiratory infections, including COVID-19 and Flu**
- **Cases of COVID-19, ILI or ARI**

Isolation of residents and exclusion of staff	
Staff are regularly monitoring residents (and themselves) for new symptoms and/or any deterioration that requires medical review	
Symptomatic staff are excluded from work and have been tested for COVID-19 if appropriate (see previous table)	
Symptomatic residents are tested as clinically indicated (new symptomatic residents do not necessarily require any testing, see previous table on p.29)	
Symptomatic and/or positive tested residents are isolated in their rooms with dedicated bathroom facilities and equipment where possible	
If isolation in single rooms is not possible: symptomatic residents are cohorted in one room/area of the home	
Staff cohorting is in place: where possible, staff have been divided into teams, with one team caring for residents who are symptomatic and one team caring for the other residents. Where possible agency staff are not allocated to caring for symptomatic residents.	
Agency staff have been 'block booked' and/or encouraged to work in the same setting during the outbreak to avoid 'seeding' of outbreaks between settings. They have been informed of the outbreak and need to watch out for symptoms and stop working immediately if symptomatic and get tested for COVID-19.	
Permanent staff are working in only this setting as far as possible to prevent 'seeding' to other settings	
Use of communal areas has been limited and strategies are in place to support people who walk with purpose and/or are isolated - See The British Geriatric Society: Managing the COVID-19 pandemic in care homes See Maintaining-Activities-for-Older-Adults-during-COVID19.pdf (healthinnovationnetwork.com) for ideas to support resident activities when in isolation/during outbreak restrictions)	
Pulse oximetry is available to monitor residents' oxygen saturation (in a care home) • They are appropriately decontaminated between residents • Staff understand how to use these and how to recognize and communicate any deterioration to GP/NHS 111	
Care homes can revert to the guidance for management of single cases 5 days after the last positive or symptomatic case.	
Restriction of admission/closure	
Potential new admissions during this outbreak have been individually risk	

assessed – see note below	
An outbreak does not mean automatic closure for new admissions. However, each **new admission should be risk assessed.** Risk assessment can be based on, extenuating circumstances taking into account the number of residents and/or staff affected, their location within the setting, whether symptomatic residents can be effectively isolated, cohorting possibilities for staff, staffing levels, availability of PPE, compliance with recommended testing, vaccination coverage etc. Settings should contact relevant stakeholders for support in risk assessment if the outbreak is increasing in complexity.	
Transfers	
Planned transfers and appointments have been reviewed (including with GP where appropriate) and for those which are clinically necessary and cannot be postponed- the receiving setting/department and transport service have been informed of the outbreak and resident's current infection status prior to transfer	
Medical Emergencies: Staff are aware of the need to communicate the setting's outbreak status and the infection status of the resident to the ambulance service and receiving hospital/setting	
Recent hospital admission- The hospitals to which residents have recently been admitted (for whatever reason) in the days prior to the outbreak being identified, have been informed of the setting's outbreak status	
Provide a surgical mask for a resident to wear for their transfer, if tolerated	
Cleaning, waste disposal, laundry	
Cleaning frequency has been increased especially of rooms of people with symptoms/infection, touch points in corridors outside these rooms (especially if door cannot remain closed) and in communal areas.	
The cleaning schedule is being maintained and documented, with clear responsibilities. Those undertaking these duties are trained.	
If not used already, disposable/ single use cleaning cloths are available and are used.	
A 1000 ppm Hypochlorite disinfectant is available and used during the outbreak after surfaces are cleaned with detergent (or a combined detergent/disinfectant is in use). It is made up and stored correctly as per manufacturer's instructions	
A plan is made for a deep clean of the setting once the outbreak is over	
Water soluble linen bags are available and used for the laundry generated by a person with a known/suspected infection	
Hazardous/clinical waste bags are available and used for potentially contaminated waste	
The setting is well ventilated with outside air, especially in communal areas/corridors	
Guidance on laundry, environmental cleaning, waste management and ventilation can be found in DHSC Infection prevention and control: resource for adult social care, DHSC COVID-19 supplement to the infection prevention and control resource for adult social care and UKHSA Linen processing within adult social care: information sheet	
Visiting	
Each resident should (as a minimum) be able to have one visitor at a time inside	

the care home. End of life visits are always facilitated.	
Visitors are encouraged to wear a mask while in setting and know not to visit if feeling unwell	
Visitors providing personal care are tested as per guidance and are trained in the appropriate use of PPE (see DHSC COVID-19 supplement to the infection prevention and control resource for adult social care for more details)	
Notices and Communications	
Notices about the outbreak are displayed at all entrances including exclusion information for staff or visitors with symptoms	
Notices are outside the rooms of symptomatic residents	
If required, letters for Relatives, Staff, Residents have been sent (templates held by HPT, setting should contact HPT to discuss if they are concerned that further communications may be required)	
All relevant **GPs** have been informed of the presence of a respiratory outbreak. The HPT can provide a **template letter**	
The individual GPs have been informed that their registered patient/s has a confirmed infection	
Visiting health professionals e.g. district nurses, physiotherapists etc have also been informed of the outbreak. Visits should be deferred unless essential and if visits occur, appropriate PPE should be worn (as for staff)	
Note: the HPT does not need to be informed of uncomplicated COVID outbreaks, but will support if there is clinical complexity and/or concern. If the HPT is notified of an outbreak, they will inform other local partners of the outbreak, including LA and ICB.	
Documentation	
A log of cases is being maintained to monitor the outbreak (you may wish to use log sheet below)	

Additional COVID-19 specific interventions

Isolation/Exclusion periods	
Staff and resident cases with a positive COVID-19 test result should: • Isolate (stay away from work/other residents) for a minimum of 5 days after the day their positive test was taken (day 0) • Return (to work/to normal routine within the home) once they feel well and do not have a high temperature, or after 10 days. • Avoid contact with people at higher risk from COVID-19 for 10 days after their positive test, even if returned to work/normal routine before then. Staff and resident cases with respiratory symptoms (including a temperature) but no test result should try to isolate (avoid contact with others) if possible, while symptoms are present.	
Close contacts of COVID-19 cases	
Close contacts have been identified and risk assessments made- see below	
Those most at risk of infection are those who live in the same household as someone with COVID-19 or have stayed overnight with that person during their infectious period. There is no requirement for close contacts to isolate. However, close contacts should: • Minimise contact with the person who has covid-19 • Avoid contact with anyone who is at higher risk of severe covid-19 infection • Follow the advice regarding testing and isolation if they develop symptoms of COVID-19. For staff who work with people at highest risk of becoming seriously unwell with COVID, a risk assessment should be undertaken, and consideration given to redeployment during the 10 days following last contact with the case	
Testing for COVID-19 and lifting of outbreak restrictions	
Follow current guidance (COVID-19 supplement to the infection prevention and control resource for adult social care).However, if further advice sought/received from HPT or IPC, ensure this is reviewed by a senior member of staff.	
• For standard outbreaks in residential care homes for the elderly, outbreak restrictions should remain in place until 5 days after the last positive or symptomatic case, or as otherwise advised by the UKHSA HPT or OCT if convened. • If, at initial risk assessment, it is considered unlikely that transmission between the cases occurred within your setting, and that the cases are likely unrelated to the setting (i.e. a cluster), then the HPT may advise that outbreak restrictions can be lifted sooner. If a high priority variant is detected through whole genome sequencing, then extended outbreak restrictions may be implemented, as advised by the HPT.	

Additional Influenza (Flu) specific interventions

Isolation/Exclusion periods	
Symptomatic residents or residents who have tested positive for flu are being isolated in their rooms until at least 5 days after the date of onset of their symptoms and until free of fever for at least 24 hours and are feeling well	
Symptomatic staff or staff who have tested positive for flu are being excluded from work but may return when they feel well enough to do so AND they have been fever free for at least 24 hours	
Note: If there is any doubt as to infection or co-infection with COVID-19 then isolation should be maintained as per COVID-19 guidance. For those with major underlying illnesses, immunosuppression or pneumonia, infectiousness with influenza may be prolonged.	
Antivirals	
There is a list (for example using log sheet below) which is being kept up to date of all residents confirmed with, or who have symptoms of influenza	
There is a list (for example using log sheet below) of all residents who may have been exposed to influenza	
There is an awareness of which staff are in high risk groups for complicated influenza (see Flu vaccine (NHS)) and have who have not been vaccinated for 'flu in the current season	
If Flu is confirmed or considered to be highly likely, the HPT will recommend antivirals for **all symptomatic residents** and for **all exposed residents**, if they can be given within 36-48* hours of onset of symptoms or exposure respectively. Antivirals will be prescribed by a GP and will be recommended regardless of the flu vaccination status of the resident. For **staff**, the HPT will only recommend antivirals as a preventative measure for staff if the staff member is • - in a high-risk group for flu AND • - has not had their seasonal flu vaccination for the current season at least 14 days previously AND • - they were not wearing the appropriate PPE when exposed Treatment of symptomatic staff with antivirals is a clinical decision and should be made by the individual's GP. *within 48 hours for oseltamivir; within 36 hours if zanamivir is required	
Letters to staff, residents, visitors and GPs	
Any letters provided by the HPT (in the outbreak email) have been sent	
End of Outbreak	
For influenza or any respiratory virus other than COVID-19, the outbreak can be declared over if there are no new cases after 5 days since the onset of symptoms in the most recent case.	

Appendix 1: Transmission, incubation, and communicability of some 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 case

** 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 meter, so fairly close contact is required for infection to occur.

Direct contact transmission 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 meter 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 meter of other individuals (unless microbiologically confirmed to share the same infection). The UKHSA 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 UKHSA 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 (it is the consensus view of the UK IPC cell that only open suctioning beyond the oro-pharynx is currently considered an AGP, that is oral/pharyngeal suctioning is not an AGP) is 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 2: 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 4 days to contain the mites until they die. This includes heat labile items. Machine wash and dry bedding and clothing of scabies residents using the hot water and hot dryer cycles (60 degrees plus for linen and as tolerated by the clothing materials involved).
Environment	Soft furnishings, which have cloth coverings, should be kept out of use for 24hours after treatment in order to allow the mites which may be on the fabric to die. These items should then be vacuumed. Those covered in vinyl should be wiped down with a hard surface cleaner following treatment. In cases of **crusted (Norwegian)** scabies vacuuming and damp dusting of the environment is essential.
Isolation	**Residents with scabies do not normally require isolation**. However, residents with crusted (Norwegian) scabies who are highly contagious require isolation precautions until treatment has been completed. Aprons and gloves should be worn for personal care of known infected cases.

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

Appendix 3: Suggested care plan for confirmed Clostridioides difficile case

Suggested Care Plan Once Clostridioides difficile is confirmed

Isolation

- Isolate in a single room (with en-suite toilet 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.

Monitoring of Resident

- Document a plan of care in the resident's notes. Keep a 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). Residents who are **systemically ill or have more profuse diarrhoea** should be referred to hospital.
- Residents who are ill need to be monitored hourly day and night.
- Keep a fluid balance chart. Recording all drinks taken and the number of times the resident passes urine (and how much if possible) and the number of times the resident has their bowels open.
- Record all bowel actions on a bowel chart, such as 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 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 the A&E ward manager, as appropriate to time of day. **Tell the ambulance crew** in advance.

Treatment

- Request a GP/Primary Care visit to assess the resident.
- Treatment with antibiotics is usually required. The recommended therapy

for mild, moderate or severe *C. difficile* infection is Vancomycin 125mg orally four times a day for 10 days.

- Second line antibiotics for a first episode of mild, moderate or severe *C. difficile* infection if Vancomycin is ineffective.
- The prescriber will review whether any other antibiotics that the resident is taking should be stopped, where it is safe to do so.

Handwashing

- Remember that **alcohol gel does not work against *C. difficle***.
- Wash hands with soap and water.
- GPs and other visiting healthcare professionals must wash their hands.
- Visitors will need to wash their hands with soap and water 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:

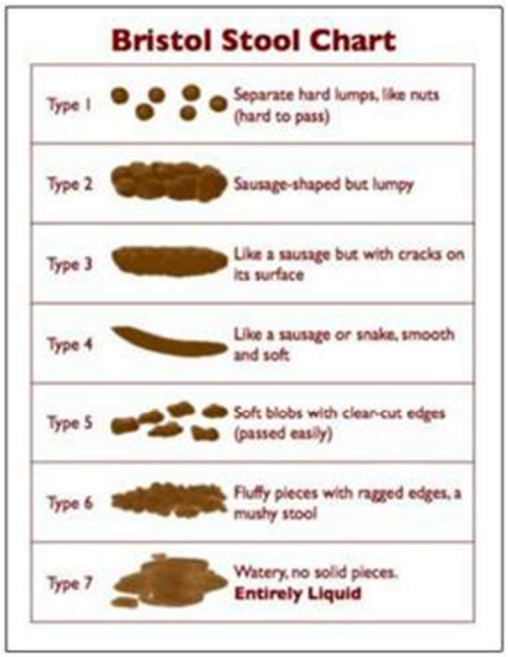
Stool Chart

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



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**

Appendix 4: 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- an information resource

Appendix 5: Urinary Tract Infection Prevention Resources

- Urinary Tract Infection Leaflet
- Tackling Dehydration Leaflet
- What signs and symptoms should you look out for?
- When should you get help?
- ‘To dip or not to dip’ Leaflet
- Urinary Tract Infection Assessment Tool

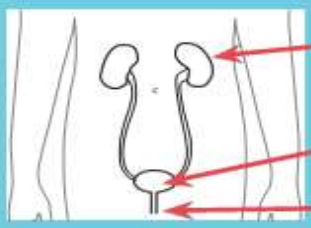
TARGET

Urinary tract infections (UTIs)

A leaflet for older adults and carers

What is a urine infection?

A urine infection occurs when bacteria in any part of the urine system cause symptoms.



Kidneys make urine

Bladder stores urine

Urethra takes urine out of the body

If a urine test finds bacteria but you are otherwise well, do not worry, this is common, and antibiotics are not usually needed. However, severe urine infections can be life threatening.

What you can do to help prevent a urine infection

Are you drinking enough? Look at the colour of your urine.

- Drink enough fluid (6-8 glasses) so that you pass pale coloured urine regularly during the day, and to avoid feeling thirsty, especially during hot weather
- Avoid drinking too many fizzy drinks or alcohol
  There is no proven benefit of cranberry products
- Prevent constipation. Ask for advice if needed
- Maintain good control of diabetes

Stop bacteria spreading from your bowel into your bladder:

- Wipe genitals from front to back after using the toilet
- Change pads and clean genitals if soiled
- Keep the genital area clean and dry; avoid scented soaps
- Wash with water before and after sex

Speak to your pharmacist about referral to a GP or other treatments.

Version 1.0, Published: June 2018, Revision: June 2021

Tackling dehydration

Dehydration in warmer weather can cause a significant increase in the incidence of urinary tract infection (UTI) and other severe infections associated with it.

Here are some key facts to help prevent your patients becoming dehydrated:

1 Keep drinking

- Adults need a minimum of 1.5 litres of fluid every day
- This is equivalent to at least 8 large cups or mugs of fluid

2 Any fluid is good fluid

- The most important thing is to consume sufficient fluids. It does not matter what form this fluid takes. Coffee and tea are a preferred source of fluids for many people and have been shown to have no significant dehydrating effect
- Fluid rich foods such as jelly, ice cream and yoghurt can also supplement fluids in drinks

3 Look out for signs of dehydration

- Dry skin or mouth, dark coloured urine, headaches, confusion and drowsiness can all be signs of dehydration

4 Older people and young children are particularly vulnerable

- Make sure everyone has a cup they can use easily. Cups that are heavy or have small handles can be very difficult to hold
- Some people may also need assistance to hold the cup and drink. Avoid straws for those with difficulty swallowing, due to increased risk of choking
- Encourage those worried about incontinence not to stop drinking if they are concerned about leaking urine. Concentrated urine resulting from not drinking can irritate the bladder and increase the risk of infection

www.ips.uk.net

For more information please visit
https://www.england.nhs.uk/commissioning/nut-hyd/10-key-characteristics/
http://www.hps.scot.nhs.uk/pubs/detail.aspx?id=3464
https://www.uel.ac.uk/academic-schools/nursing-midwifery/research/richard-wells-research-centre/research-projects/i-hydrate

Infection Prevention Society

What signs and symptoms should you look out for?

Consider these symptoms if you have a urinary catheter:

- Shivering or shaking
- High or low temperature
- Kidney pain in your back just under the ribs

New or worsening signs of urine infection in all people:

- Pain or burning when passing urine
- High or low temperature
- Shivering or shaking
- Urgency (feeling the need to urinate immediately)
- Pain in your lower tummy above pubic area
- Incontinence (wetting yourself more often than usual)
- Passing urine more often than usual
- Cloudy urine, or visible blood in your urine
- Confusion, change in behaviour, or unsteadiness on feet

Although confusion is caused by urine infection, consider other things that may also cause confusion

- Pain
- Constipation
- Poor sleep
- Low mood
- Not drinking enough
- Side effects of medicine
- Other infection
- Change in your routine or home environment
- Poor diet

When should you get help?

The following symptoms are possible signs of serious infection and should be assessed urgently

Contact your GP Practice or contact NHS 111 (England), NHS 24 (Scotland dial 111), NHS direct (Wales dial 0845 4647), or GP practice (NI)

Shivering, chills and muscle pain		Feeling very confused, drowsy or slurred speech	
Not passing urine all day		Temperature is above 38°C or less than 36°C	
Trouble breathing		Kidney pain in your back just under the ribs	
Visible blood in your urine		Very cold skin	

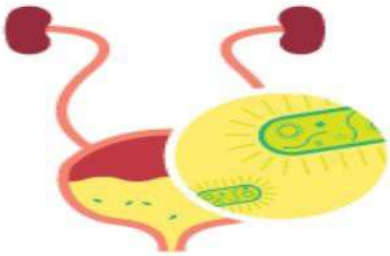
Symptoms are getting a lot worse, or not starting to improve within 2 days of starting antibiotics

Trust your instincts, ask for advice if you are not sure how urgent the symptoms are

To Dip or Not to Dip?

'To Dip or Not to Dip' is an evidence-based pathway which aims to improve the diagnosis and management of Urinary Tract Infections (UTI) in older people living in care homes. This pathway has been shown to reduce antibiotic use and hospital admissions for UTI. This leaflet explains more about UTIs and the 'To Dip or Not to Dip' care pathway.

Bacteria in the Urine in Older People



The presence of bacteria in the urine in older people does not necessarily mean there is an infection that requires antibiotics. Bacteria can live harmlessly in the urine of older people. In fact, around 50% of older people have bacteria in the urine without causing any symptoms. In those with a long-term urinary catheter, this rises to 100%.

What's the Problem with Urine Dipsticks?

Urine dipsticks are often used in the diagnosis of UTI in older people living in care homes. A positive result for 'nitrite' (bacterial marker) or 'leucocyte' (white blood cell marker) may be a normal finding because of the high proportion of older people that have bacteria in the urine. Often, if a resident has a positive dipstick result and has non specific symptoms, such as had a fall or is drowsy, they are inapproapriately diagnosed with a UTI. The real diagnosis may be missed and the resident may receive antibiotics unnecessarily.

Antibiotics: More Harm than Good?

Antibiotics are powerful and precious drugs. Bacteria can develop antibiotic resistance. This means that antibiotics won't work when a person really does need them and these resistant bacteria can spread very easily in a care home setting. Side-effects, such as rashes and stomach upset are common in older people receiving antibiotics. A life-threatening infection called *C.difficile* diarrhoea (or *'C.diff'*) can be caused by antibiotics. Everyone has a responsibility to protect antibiotics and they should only be used when there is strong evidence of a bacterial infection.

To Dip or Not to Dip Pathway

In the pathway, urine dipsticks are not used, instead care home staff use a UTI Assessment Tool which focuses on the signs and symptoms of the resident and what actions to take. The tool was developed with specialist healthcare professionals and care home staff and is based on best practice guidelines. Obtaining a urine sample in residents with suspected UTI is very important to enable the best, and safest, antibiotic to be chosen.

Questions? Please Contact the Care Home Manager.

In partnership with Public Health Nottinghamshire County Council

Nottinghamshire County Council

'To Dip or Not to Dip' is an original quality improvement project by Elizabeth Beech and Mandy Slatter (NHS Bath and North East Somerset CCG) and is based on the Scottish Antimicrobial Prescribing Group Decision Aid for Suspected UTI in Older People 2016.

UK Health Security Agency

Assessment tool: Guidance for care home staff regarding older people (>65 years) with suspected UTI

Complete resident's details, flow chart and actions (file in resident's notes). **DO NOT PERFORM URINE DIPSTICK (unless requested by GP*)**

Resident:..... **DOB:**.....

Completed by:..... **Date:**.....

Care Home:.....

Any symptoms suggesting alternative diagnosis?	Tick if present
Respiratory: shortness of breath, cough/sputum, new chest pain	
Gastrointestinal: nausea/vomiting, new abdominal pain/cramps, new onset diarrhoea.	
Skin/soft tissue: new redness, warmth, swelling, purulent drainage (pus).	

ANY TICKS → **UTI unlikely.** Phone GP practice for advice on management.

NO

YES ← **Does the person have a catheter?** → NO

New Problem	Tick if present
Inappropriate shivering/chills OR temperature < 36°C or >38°C. If measured document.....°C	
Lower back pain (flank/kidney pain)	
New or worsening confusion or agitation	

New Problem	Tick if present
Pain on passing urine	
Need to pass urine urgently OR new or worsening incontinence	
Need to pass urine much more often than usual	
Lower abdominal or back pain (suprapubic or flank/kidney pain)	
Blood in urine	
Inappropriate shivering/chills OR temperature <36°C or >38°C. If measured document.....°C	
New or worsening confusion or agitation	

1 OR MORE TICKS →

UTI possible – Actions needed	Tick when done
Obtain **urine sample** and arrange **catheter change** if catheterised: see reverse of form.	
Phone GP practice for advice on management.	
Encourage fluids.	

← 2 OR MORE TICKS

NO TICKS →

UTI unlikely
If concerned about resident, please seek guidance from GP practice OR 111 out of hours

← LESS THAN 2 TICKS

Could it be SEPSIS
Slurred speech, Extreme shivering/muscle pain, Passing no urine in 18 hours, Severe breathlessness, "I feel like I might die", Skin mottled/discoloured?
Get medical help immediately![3]

Adapted from NHS Nottingham's assessment tool by Medicines Optimisation Bury CCG Version 1.3 January 2018

Appendix 6: Environmental Health Officer- Additional Area Contact

Amber Valley	01773 570 222 Switchboard and out of Hours / 01773 841335 (Environmental Health Direct) Envhealth@ambervalley.gov.uk
Bolsover	01246 217 273 or 02146 231 111
Chesterfield	01246 345 345 food@chesterfield.gov.uk
Derby City	01332 640779 FoodandSafety.Duty@derby.gov.uk
Derbyshire Dales	01629 761 100 or 01629 761 212
Erewash	0115 907 2244
High Peak	0345 129 7777 or 01298 28400 Food.safety@highpeak.gov.uk
NE Derbyshire	01246 217 273 or 02146 231 111
NW Leicestershire	01530 454 545
S Derbyshire	01283 595949 or 01283 595 795 or 07976 081957