

**Workforce Health and Wellbeing**

**Control of Infection Policy**

August 2013

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# *Part 1 - Introduction*

***Purpose of the Infection Control Policy***

The Control of Infection Policy is designed to offer practical advice to employees, contractors and managers to enable them to work safely and reduce the risk of infection to themselves and others.

For the purposes of infection control Council workers fall into two broad categories, each of which is discussed briefly below:

*1. Workers at lower risk of exposure*

A large number of NCC staff will be in this group, which includes those working in offices or libraries, for example. These employees are not routinely exposed to an increased risk of infectious disease.

In the majority of cases they do not require any job-specific guidelines for infection control, though they are expected to follow the social norms of good hygiene.

However, they may use this policy should they need to deal with any unusual or unexpected occurrences, such as workplace injuries which cause blood spillage.

*2. Workers at higher risk of exposure*

This group includes many different types of worker, for example those involved with:

* Residential care
* Domiciliary care
* Child care
* Education
* Institutional food preparation and handling
* Animal husbandry and veterinary services
* The Fire & Rescue Service

Each should have their own job-specific guidelines for infection control. However, they will also find this document useful for reference purposes.

***What is infectious disease?***

Infectious diseases are conditions that have the potential to be passed from one person to another, from animal to animal, from an animal to a person or from the environment. The latter includes surfaces within a room which can be contaminated and hence infect people when they touch them – this is a particularly important consideration in the case of norovirus. Infectious diseases are caused by micro-organisms which may in some cases produce harmful and unpleasant symptoms; in other cases they may produce no symptoms at all.

***What is infection control?***

Infection control includes all the behaviours that eliminate or reduce the transmission of infectious disease.

Effective infection control is the result of both individual and group behaviour. It is based on job-specific protocols, guidelines and corporate policy. It is maintained by the continuous implementation of such guidelines, regular staff training and the effective supervision of individual workers.

***Why is infection control so important?***

Communicable or infectious diseases can spread rapidly, particularly in residential homes and educational establishments. It is, therefore, crucial that staff fully comply with this policy and job-specific protocols, where they exist.

Staff should be aware that certain groups of people particularly the very young, the old and those with some types of chronic illness are more susceptible to the consequences of infection.

An effective Infection Control Policy is needed to protect each individual worker, their clients and the wider public from potentially harmful or fatal diseases.

Further Information is provided by Public Health England (PHE), which can be accessed at the following website:

<https://www.gov.uk/government/organisations/public-health-england>

***Communicable diseases in schools***

Please note that the publication 'Is It Catching?' published by the (former) Communicable Disease Control Unit has been superseded by a new webpage on the PHE’s main website. This information, entitled ‘Guidance on Infection Control in Schools and other Child Care Settings’ can be accessed by clicking here:

# [Guidance on Infection Control in Schools and other Child Care Settings’](http://www.hpa.org.uk/web/HPAweb&HPAwebStandard/HPAweb_C/1203496946639)

This should prove a useful reference source, particularly with regard to communicable diseases and their exclusion periods. It is recommended that this link is dragged to the desk top on the school’s main Administration computer. In addition, all hard copies of 'Is It Catching?' should be discarded.

# *Part 2 - Responsibility for Infection Control*

***Individual Workers***

All workers have a duty to follow their job-specific protocols and the Infection Control Policy. They also have a duty to report to their supervisors any deficiencies in their training or in the provision of equipment or facilities. Everyone has a duty to inform their managers of any problems or issues affecting infection control. This includes any incidence of infectious disease in themselves, clients or other persons that they are in contact with. The key types of illness that need to be reported include:

* Diarrhoea and vomiting
* Flu-like illnesses
* Skin infections

It is important that staff should follow the advice that they are given by the GP, other healthcare professionals, PHE or Environmental Health Officers.

***Supervisors***

Supervisors have the most influence on individual workers’ compliance with the Infection Control Policy. Therefore, they are expected to have an enhanced level of knowledge in relation to that Policy and to understand the rationale behind job-specific protocols.

They have a duty to ensure that individual workers comply with such protocols. They must report any problems, deficiencies in equipment or non-compliance to line managers.

***Line Managers***

Line managers have a duty to:

* ensure individual workers undergo adequate initial training in relation to the Infection Control Policy and job-specific protocols (where they exist) and have an adequate understanding of the hazards and risks. Additionally, they should monitor workers’ compliance with such protocols, either directly or through their immediate supervisor and arrange further training, as required.
* ensure that adequate protective equipment and facilities are provided; and that the workers are properly trained in their use
* develop, review and revise job-specific protocols relating to infection control. They should do so by liaising with specialist advisers, such as Public Health England (PHE), Environmental Health Officers, School Nurses, Occupational Health Advisers and Health and Safety Advisers.

***Senior Managers***

Senior Managers have overall responsibility for ensuring that all policies and protocols are adhered to and that managers are all appropriately trained.

***Specialist Advisers***

Specialist advice within the Council is provided by a range of services, including the Occupational Health Unit and the Corporate Health and Safety Team. They are responsible for providing specific advice, as requested, and reviewing protocol and policy documents on a regular basis. Other officers within Public Protection, including Environmental Health Officers and Animal Health Officers may provide specific advice on some infectious diseases as part of their service role to businesses and the public within Northumberland, which can include those provided by the Council e.g. schools and catering. Collectively, they have a remit to keep abreast of national infection control guidelines, statutory regulations and best practice

# *Part 3 - Personal Protective Measures*

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***3.1 Hand Hygiene***

**3.1.1 Importance of Hand Hygiene**

Hand hygiene is a general term that applies to hand washing and the use of alcohol-based hand rubs.

Hand washing remains the single most important method of reducing the spread of infections. This applies equally to the general population as well as those working in higher risk occupations, such as health care.

Hand hygiene is an important means of reducing the risk of transmitting all infectious agents to others and limiting outbreaks of viral illness such as influenza pandemics and gastro-intestinal infections.

**When Should Hands be Washed?**

* After using the toilet for any reason
* After changing babies’ nappies
* When hands are visibly soiled
* After blowing the nose or after sneezing in the hands
* Before and after preparing food, eating, drinking or smoking
* After touching raw meat, poultry or fish
* After handling rubbish
* When visiting or caring for sick people
* After handling pets, animals or animal waste.

**3.1.2 Social Cleaning of Hands**

All Council workers, no matter what their work, are required to follow the social norms of the general population in respect of hand hygiene.

They are expected to wash their hands with soap and water at the times shown in the adjacent box.

Service users and visitors to premises should be encouraged to follow the same social norms of hand hygiene.

**3.1.3 Special Hand Hygiene Protocols**

Workers in groups at higher risk of infectious disease transmission (for example, health care) will need to have an additional job-specific protocol for hand washing, use of gloves and alcohol gels.

**3.1.4 Hand Hygiene for Children**

Service providers and other carers have a responsibility to promote hand hygiene amongst children. Appropriate hand washing facilities and instruction must be provided for them. Active assistance may be required for very young children. Hand washing before touching or eating food and after using the toilet should be actively encouraged, with an appropriate level of adult supervision.

**3.1.5 Hand Hygiene for Vulnerable Adults**

People in the following groups are considered to be more vulnerable to infection than the general population.

* Adults with learning disabilities
* Physically disabled persons
* Elderly people
* Elderly people with dementia

It is essential that that service providers promote effective hand hygiene within these groups:

These people are at increased risk of ill-health from infection due to a combination of factors. They may lack the physical or intellectual capacity to maintain their own hygiene needs. Many of them spend long periods in institutional care, where the danger of cross-infection and outbreaks of disease are greater. Many will be more vulnerable to infection due to poor general health.

Service providers have a responsibility to provide appropriate hand washing facilities. Hand washing before touching or eating food should be actively encouraged, with an appropriate level of supervision. Active assistance must be provided when needed.

**3.1.6 Maintaining Healthy Skin & Nails**

***Breaks in the integrity of the skin***

***Maintaining Healthy Skin and Nails***

• Treat broken skin promptly

• Use moisturising skin-care products regularly

• Use barrier creams when appropriate

• Keep the nails short and clean

• Do not wear artificial nails; make sure nail polish is not chipped

• Keep jewellery to a minimum, such as a watch and wedding ring only

It is important to keep the skin of the hands healthy and intact, as when broken it is highly vulnerable to infections from bodily fluids and other contaminated material.

Any breaks in the skin such as cuts, cracks or abrasions must be covered with a suitable dressing, such as an elastoplast.

It may be necessary to cover the dressing with a water-proof finger stall or to wear disposable gloves.

***Finger nails***

Workers providing personal care to clients are required to keep their finger nails short, smooth and clean. They should clean under their nails with soapy water and a soft scrubbing brush. Wearing long or false nails should be discouraged by managers.

***Barrier creams***

Workers who wash their hands frequently are prone to develop dry, cracked skin. In addition, contact dermatitis from using detergents and other chemicals is common. The skin integrity can be maintained by applying a barrier cream at the beginning of the day and reapplying it, as required. Managers must provide suitable industrial barrier creams for workers that need to hand wash frequently as part of their work.

***Moisturising creams***

The detergent effect of soap washes out the skin’s natural protective oils. These can be replaced by applying simple skin moisturisers, such as E45 or Neutrogena. Managers should encourage workers (including male staff) to moisturise their skin after hand washing.

Managers must ensure that moisturiser creams are available for workers who do not wish to supply their own. Products that combine the effects of barrier cream moisturiser are available.

**3.1.7 Hand Washing Equipment**

The minimum equipment needed for effective hand washing is a dedicated hand wash basin with flowing hot water. The water should be comfortably hot. Soap, preferably in liquid form, should be provided. Special anti-bacterial soaps are not required for general use. Hand drying equipment should be situated immediately next to the hand wash basin.

**3.1.8 Hand Washing Procedure**

In order to decontaminate the hands of germs (bacteria and viruses) the skin must first be physically washed to remove both the visible and invisible soiling. Further decontamination with alcohol-based gels be will only be effective once the hands are physically clean.

The technique described here (and illustrated in the supporting diagram) is recommended for both ordinary workers, and those working in higher risk settings such as health care.



**5 Steps to Hand Washing**

**1. Wet hands with warm running water.**

**2. Add soap, and then rub hands together, making a soapy lather. Do this away from the running water for 15 to 30 seconds, being careful not to wash the lather away. Wash the front and back of the hands, as well as between the fingers and under nails.**

**3. Rinse hands well under warm running water.**

**4. Wipe and dry hands well with paper towel.**

**5. Turn off water using paper towel.**





**3.1.9 Hand Drying Equipment and Materials**

There are several options; each is discussed briefly below:

* Disposable soft paper towels - These should be dispensed from a holder fixed next to the basin. A sufficiently large waste bin of must be provided. Paper towels are the preferred option in food preparation and health care settings.
* Reusable fabric hand towels - These must be regularly changed and should be laundered at the highest possible temperature, in accordance with the manufacturer’s recommendations. These are usually dispensed through a mechanical roller. Single towels should not be shared.
* Warm Air Blowers - These are only suitable for use in general or public toilet facilities.

**3.1.10 Alcohol-based Hand Rubs Technique**

***Purpose***

These anti-septic gel hand rubs are used to decontaminate the hands between hand washes. They are able to destroy some bacteria and viruses present on otherwise physically clean hands. They are widely used in health care settings, where running water is not immediately available.

***When to use alcohol based hand rubs***

These products should be applied following contact with each client, but only if there has been no exposure to bodily fluids, wounds or other contaminated material. If such contamination is known or suspected full hand washing should be performed instead.

***Limitations***

It is important to remember that these products are not a substitute for regular hand washing with soap and water. Alcohol-based hand rubs are only effective once the hands have been physically cleaned using soap and water.

The effectiveness of these products varies greatly for particular organisms, indeed they are known to be ineffective against the *Clostridium difficile* (c.diff.) organism.

***How to use alcohol based hand rubs***

When using alcohol-based hand rubs the gel should be squirted onto each hand (enough to cover an area about the size of a twenty pence coin). This should be enough to cover all areas of the hands, including under the nails. A rubbing motion should be adopted so as to distribute the antiseptic product evenly until the hands feel dry.

The diagram below describes how the rubs should be used:





***3.2 Personal Protective Equipment (PPE)***

A range of PPE is available, which includes the following:

**3.2.1 Disposable Gloves**

Non-sterile, disposable gloves are a useful means of controlling the risk of infection. They provide an additional layer of protection for the worker whenever there might be contact with blood, bodily fluids, mucous membranes or other contaminated biologicalmaterials. However, it is important to remember that the use of these gloves is not a substitute for effective hand washing.

**3.2.2 Choice of Glove**

The choice of glove should be made following a suitable and sufficient risk assessment of the task, the risk to the worker and risk to service users. A choice of sizes must be made available to ensure a correct fit. Gloves should comply with British Standard EN 455-3: 2000.

There are several choices of glove. Each type is discussed briefly below.

**Latex Gloves:** These are the standard glovefor handling blood, blood-stained fluids or other high risk biological materials. However, managers must remain alert to the problem of latex allergies in their workforce and provide a safe alternative, where necessary. A risk assessment should be completed to strictly control the use of latex taking account of the need for occupational health surveillance if this to be the preferred option.

**Nitrile Gloves:** These gloves are made from a type of synthetic rubber. Nitrile has a similar barrier performance to natural rubber latex. Its puncture resistance is far superior to that of latex and all other glove films. Tensile strength and chemical resistance is also typically better. Nitrile gloves are a suitable alternative for individuals with latex allergies.

**Neoprene Gloves:** These gloves are made from another type of synthetic rubber. Neoprene has a similar barrier performance to natural rubber latex. It also exhibits good resistance to many chemical solvents. It provides protection from acids, alcohols, caustic substances, detergents and ketones. Neoprene gloves are a suitable alternative for individuals with latex allergies.

**PVC (Vinyl) Gloves:**  These gloves have a much poorer barrier protection than latex, nitrile or neoprene gloves. They have poor resistance to degradation by chemicals such as alcohol. Vinyl gloves should be limited to short procedures in low-risk situations that do not involve exposure to blood, body fluids or chemicals.

**Polythene:** These gloves are not suitable for use in the health care environment. They are very likely to rip or split at the seams and are, therefore, not suitable for dealing with blood or bodily fluids. However, they are suitable for use in very low risk activities, such as food handling duties.

**3.2.3 Technique**

Disposable gloves are to be used for a single task or procedure only.

They should be put on immediately before the task is to be performed. They must be removed and discarded in an appropriate waste bin as soon as the procedure is completed and before touching any other persons or objects. Hands must always be washed and dried properly following removal of the gloves.

**3.2.4** **Latex or Rubber Allergies**

Allergic reaction to rubber and latex is a serious and growing problem amongst health care workers and others who regularly wear natural latex gloves. Managers must remain alert to the problem of latex allergies in their workforce, promote awareness and provide safe alternatives.

Individual service users may also have latex allergies. Carers must take practical steps to identify people, and prevent them from coming into contact with latex gloves.

Further guidance is available at: <http://www.hse.gov.uk/skin/employ/latex.htm>

**3.2.5 Disposable Plastic Aprons**

Disposable plastic aprons provide a useful means of reducing the risk of cross-infection. They should be worn:

* Whenever there is a risk of contaminating clothing with blood, bodily fluids or other organic material.
* By carers working in close contact with patients or bedding.
* When preparing or serving food.

They should only be used for a single task or patient contact, and then discarded.

They must be stored safely so that they do not accumulate dust which can act as a reservoir for infection.

**3.2.6 Respiratory Protection**

For infection control purposes a face mask or respirator may be used to:

* Protect the wearer from contaminated airborne material.
* Prevent the wearer contaminating others by coughing and sneezing.

***Airborne contamination***

Biological material in the form of airborne dust, droplets, splashes or aerosols is a potential source of infection. This airborne material may be invisible. Workers are highly vulnerable to micro-organisms passing through the mucus membranes of the eyes, nose, mouth and lungs.

***Risk assessment***

A risk assessment must be conducted whenever there is the potential for a worker to be exposed to biological material from human or animal sources. The risk assessment must examine the potential for the generation of airborne biological material and the risk of inhaling this or coming into contact with the mucus membranes of the eyes, nose and mouth.

Workers employed in usually low risk jobs must have a new site-specific risk assessment before starting work at a potentially contaminated site. For example, building workers going into spaces contaminated with bird droppings may need respiratory protection against avian psittacosis infection.

The risk assessment will determine the appropriate control measures and the type of mask and/or eye protection required.

***Choice of equipment***

The choice of equipment will depend upon the hazards identified in the risk assessment.

**3.2.7 Eye and Respiratory Protection**

In situations where respiratory protection is required, it will usually be necessary to protect the mucus membrane of the eyes. Suitable eye protection may be incorporated into the face mask, or worn as a separate item.

The equipment selected must be the correct size and properly adjusted before starting any procedure or activity. The equipment should be handled as little as possible when being worn to avoid contamination with biological material from hands.

Disposable face masks should be used for a single task or procedure only and discarded in the appropriate waste container. Reusable items such as goggles or glasses should be properly decontaminated between uses. Contaminated gloves should be removed and hands washed before removing masks or eye protection.

***3.3 Needle-stick Incidents***

A needle-stick incident occurs whenever the victim’s skin is pierced, cut or broken by a contaminated hypodermic needle (or similar device) or any other contaminated sharp object.

Contamination means the object is known or suspected of having been in contact with human blood, bodily fluids such as urine, faeces, semen, saliva, vaginal secretions or any other human tissue.

***High risk incidents***

A person is considered to be at higher risk of infection when:

* he/she sustains deep penetrating wounds
* he/she makes contact with an object contaminated with fresh human blood
* the source is known to have or is suspected of having specific infections, for example HIV, Hepatitis B or Hepatitis C
* the medical history or infection status of the human source cannot be checked
* the origin and prior use of the sharp object is unknown.

Supervisors and line managers have a duty of care to ensure that all workers are aware of the hazards from contaminated sharps and know the appropriate first aid measures. They should also promote a safety culture where workers are encouraged to report such incidents rather than concealing them out of embarrassment.

**Action Following a Needle-stick Incident**

**Immediate First Aid**

1. Carefully remove any small embedded sharp objects. Dispose of these safely.

2. Encourage small wounds to bleed by squeezing firmly.

3. Wash the wound site with soap under warm running water (do not scrub).

4. Apply a suitable first aid dressing to the wound site.

**Within ½ hour**

5. Report incident to supervisor.

6. Record incident on the Accident Report Form (ACC1) or on-line so that a record of the injury can be logged

7. Identify the human source of contamination and note any known increased risk factors.

**Within 1 hour**

8.All injured persons mustattend the nearest NHS Accident & Emergency department so that:

a. the risk of infection can be assessed

b. a blood sample can be taken, following exposure

c. further treatment of the wound can be rendered

d. post-exposure drug treatment can be given (if required). Ideally, high risk cases should start treatment within one hour.

**Within 12 hours**

9.Manager must request a blood sample from the source patient or client for screening of high risk infections. Formal consent must be obtained. Blood sampling and counselling should be arranged via the source’s GP or other medical specialist.

**Note**: Do not remove large, deeply embedded objects. Do not wash large, actively bleeding wounds. In both cases apply first aid as appropriate. Go immediately to A&E or call for an emergency ambulance.

***Occupational Health Service***

The County Council’s Occupational Health Unit based at Loansdean, Morpeth should be informed as a matter of course in such instances and will be in a position to provide further advice as necessary.

[occupational@northumberland.gov.uk](mailto:occupational@northumberland.gov.uk)

Telephone: 01670 626148 or 01670 623149

***Post-exposure counselling***

Initial assessment and treatment should be at an Accident & Emergency Unit. Subsequent counselling, treatment and testing should be arranged as per locally agreed care pathways.

***3.4 Bodily Fluids***

***General***

Blood is identified as the highest risk body fluid. For safety purposes it should be assumed that all blood is potentially infected with a virus such as HIV, Hepatitis B or Hepatitis C. A dedicated blood spill kit containing granular bleach is recommended in any establishments that deal with blood spillages on a regular basis.

In addition, it is important that suitable precautions are always taken when dealing with all other body fluids such as faeces, urine, vomit and sputum. As they may contain a range of pathogenic micro-organisms there is a risk of infection if contact with contaminated matter should take place.

Vaccination should only be recommended for staff working in spheres where a serious risk of infection has been identified, such as caring for high-risk clients in a residential setting. If vaccination is offered for those in medium risk occupations managers should make clear that such staff have the right to refuse inoculation. Further information is given in Part 4.

***Emergency procedures***

If the skin is contaminated with blood or body fluid, the substance should be washed off thoroughly with soap and water as soon as possible. The area should not be scrubbed, as intact skin provides a barrier to infection. If there has been a risk of cross-infection by the transfer of body fluids into an open wound, for example if a service user bites an employee and breaks the skin, then the needlestick injury procedure must be followed.

***Clean-up procedure***

Body fluid spills should always be cleaned up immediately. When undertaking this activity, staff should wear appropriate PPE, usually disposable gloves and a disposable plastic apron, if there is a risk of splashing contaminated matter or chemicals,. It is important that colleagues avoid getting splashes in their eyes, nose, mouth, open sores or cuts.

Any surfaces where spills occurred should be cleaned and disinfected using a disinfectant/detergent that will kill both bacteria and viruses, such as Shield. Manufacturer’s instructions should be followed at all times. Liquid bleach should be avoided due to the risk of it reacting with other cleaning products and this substance should not be used on urine. Effective hand washing following all clean-up operations is essential (see section 3.1).

Used pads, gloves, aprons, soiled dressings and sharps should be treated as clinical waste. Such items should be stored in pedal bins in a secure area for collection and removal by a registered contractor using correct containers or bags. All containers or bags should be less than two-thirds full. Any mops used should be cleaned in a cleaning equipment sink, rinsed with disinfectant solution and dried. If spillage is on fabric or carpet then these items should be either disposed of or steam cleaned, as appropriate.

***Cleaning up blood or body fluids visibly stained with blood***

If the spillage is excessive, the bulk of it should be removed by physical means first and the rest disinfected. This should be treated with a suitable disinfectant following the manufacturer’s guidance. Then, wearing gloves and apron, the cleaning agent should be removed with disposable absorbent material, such as paper towels, and discarded into a clinical waste bag. The area should be cleaned using detergent and water and allowed to dry.

***Cleaning up excreta and other body fluids***

**Excreta:** should be discarded directly into the toilet using disposable absorbent material, such as toilet paper. Particular care should be taken if large quantities of material are to be removed, in which case a disposable scoop should be used.

**Vomit:** vomiting creates plumes of particles which may land on any surface or object thus spreading infectious agents over a wide area. Deposited material could then be inhaled or ingested if hand to mouth contact is made with the surface or object. It is therefore difficult for cleaning to be fully effective, as although the vomit itself is removed residual material can remain and this continues to pose a risk. Elevated levels of hand washing to minimise the hand to mouth risk are therefore still appropriate after cleaning.

The key hygiene issue is that vomit is cleaned up and all hard surfaces are thoroughly cleansed as well. If contamination occurs in an area with carpet and soft furnishings, strongly consider steam cleaning the area as virus can survive in these materials and be released as an aerosol and lead to further infection in residents and staff working in that area.

***Dealing with unexpected contamination***

Some work activities do not routinely involve the need to clear up spillages of body fluids. Where this is the case a proprietary ‘Emergency Spill Pack’ may be purchased which includes all the necessary equipment for dealing with the occasional spillage.

***3.5 Hygiene Arrangements for Service Users***

* Items required for the purposes of maintaining each service user’s good personal hygiene, such as bath towels, face cloths, razors, toothbrushes and combs must not be shared as they can transmit infection between individuals as well as becoming contaminated with blood or other body fluids.
* All such personal items should be readily identifiable as belonging to a particular individual either by labelling them or keeping them in a particular location
* All personal equipment should be washed regularly, disinfected, if appropriate, in order to reduce the risk of infection, and replaced often.

# *Part 4 – Specific Guidance for High-risk Groups*

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| --- | --- |
| 4.1 | Commercial Food Preparation & Residential Care Services |
| 4.2 | Exposure to Environmental Hazards |
| 4.3 | Immunisation Against Hepatitis B |

**4.1 Commercial Food Preparation & Residential Care Services**

***Introduction***

Within the County Council certain activities which are part of its normal service delivery require specific additional measures to deal with any potential infection control issues. For catering activities, food safety law requires the reporting of infections or potentially infectious illness to management. The concerns about people who handle food also apply to those people who are in close physical contact with service users. Whatever the service the Unit Manager has a legal duty to exclude specific workers with certain illnesses and to ensure that those who have been ill are fit to return to work. To make the process of dealing with serious infections in staff easier, a ‘Fitness to Work’procedure has been developed and adopted. This procedure will allow managers to be sure that they are making the right decision when interviewing staff before they come back into the workplace. It does not apply to service users.

***The `Fitness to Work' Procedure***

This procedure is based on a simple reporting system which is linked to certain high risk activities that members of staff undertake. It involves making formal records regarding a few key issues. The activities are:

* handling open food
* administering personal care to service users

The questions to ask are included in a pad of forms. The employee should complete the form when:

* he/she returns to work after illness

If the worker has been travelling abroad and returns home with symptoms (particularly gastro-intestinal illness or influenza like illness) they should not come to work and should inform their line manager that they are unwell.

Though not specified on the form an employee should be aware of the possibility of transmission of illness when a household contact is ill, but do not need to stay off work and inform their manager unless they develop symptoms.

Depending upon the answers given the manager will:

* Permit the employee to return to duties
* Alter the employees duties until they are cleared to return e.g. move a food handler from kitchen duties to an office activity
* Send the employee home until the symptoms have ceased - 48 hours symptom-free in the case of diarrhoea and vomiting)

A series of questions and answers have been reproduced below to help colleagues comply with the Fitness to Work Procedure. Further information regarding different types of illnesses has also been included there. Individual workers are legally obliged to report to their manager any condition which could result in an outbreak of infection. This, in turn, allows the manager to fulfil his/her duty to take action when this happens.

***`Fitness to Work' - FH2 Forms***

A pad containing duplicate copies of FH2 forms should be kept by each establishment. In most cases both copies will stay in the book. If it is necessary to send the top copy to PHE in order to obtain further advice, the second copy should be kept to demonstrate what actions have been taken.

***Fitness and control of illness***

Section Four of this document gives details on the management of illness affecting service users.

***Access to kitchen areas by service users in Residential Centres and Day Care Services***

If service users have access to kitchen areas used for catering purposes a higher risk of cross-infection exists. For this reason the following guidelines have been adopted as good practice in the interests of maintaining a hygienic kitchen environment.

All service users entering the kitchen must be capable of adhering to the procedure for hand washing. Hand washing must take place every time the kitchen is used. Each service user should be assessed to ensure that he/she is capable of undertaking this task.

Service users should not have access to food in refrigerators unless under supervision. They must not be allowed to store their own food in the same fridge used for general catering purposes. Service users may have access to refrigeration facilities for tea and coffee making.

As a general rule and in order to minimise risks, service users should not be involved with the preparation of meals containing high risk foods such as cooked meats.

All service users involved with the preparation of food should wear suitable protective clothing.

For more detailed advice regarding food hygiene and cross-infection risks colleagues should refer to departmental food safety procedures.

***Points to Help Staff Comply with the Fitness to Work Procedure***

1. ***Completion of forms***

***Do I have to fill forms FH2 in every time someone has been off sick?***

In order to avoid excessive paperwork it may be sufficient to refer to questions one and two on form FH2. If the illness is obviously not infectious, for example sinusitis or ear ache, and the answers to question one, two and four are negative, then the normal return to work procedure should be followed.

***Which illnesses are covered?***

The written procedure relates to the most common causes of illness and the ones about which there are most concerns. To simplify the paperwork, reference has not been made to every conceivable infectious disease. For this reason some additional reference material has been included in this guidance so that managers are generally aware whether or not they should be seeking advice in other areas. If in doubt the manager should contact the PHE or Occupational Health.

**2. *More about the illnesses***

*Why is the written procedure necessary?*

If an individual is infected with certain pathogenic organisms they can transmit infections through the workplace hence suitable prevention and control measures need to be in place.

Managers need to be able to justify their decisions when allowing a return to work and this procedure helps them to do that.

***Diarrhoea and vomiting***

Anyone who has diarrhoea and/or vomiting must immediately report this to their manager and stop duties. They should not return to the work area until 48 hours after all symptoms have ceased. Note: certain gastro-intestinal infections in staff who handle food as part of their work require submission of negative faecal speimens before returning to work to meet PHE requirements.

In general, the presence of household contacts that have diarrhoea and/or vomiting would not affect an individual’s ability to carry out their duties safely.

However, it is important that members of staff are aware that if people within their household have symptoms of gastro-intestinal illness they should take extra precautions in the home and should promptly report any symptoms to their manager. Furthermore, they should stay off work until they are at least 48 hours clear of symptoms

***Shouldn't good hygiene practice avoid problems?***

Not necessarily. Anyone with active diarrhoea presents an infection risk and should stay off work.

***Infections of the skin, nose, throat, eyes or ears - What should be included?***

Scaly, weeping, pustular lesions, which cannot be adequately covered with a coloured waterproof dressing, warrant the need for action to be taken and exclusion from work where this sort of infection could contaminate food during preparation or may cause cross-infection or the infection of wounds when care activities are being undertaken.

Any minor cuts must be covered with coloured waterproof dressing as soon as they occur as such injuries are a source of pathogenic bacteria.

In most cases this should not include colds, chest infections (though these could be included in the case of Residential Care Homes). Normally it is sufficient to wash hands frequently as needed when an individual has a cold. Good hygiene techniques should be practised, including the use of disposable handkerchiefs

***Special cases***

*Contact with people who have gastro-intestinal illness*

Food handling staff should be aware that for some infections, if a member of their household (or other close contact) is diagnosed with an infection, they may be excluded from work as part of the public health control measures; this will usually be until they have submitted specimens for screening and been found to be clear of infection. Rather than detail all circumstances in this policy, staff should be aware of the importance of these actions and follow advice/request for screening specimens given by Environmental Health or PHE staff. Line managers should be aware that staff may be excluded from work as a result of contact with a case of some illnesses and that this public health advice should be followed.

***Other Infectious illnesses***

If a worker attends work with infectious illnesses not covered above the manager should refer the matter to the Occupational Health Unit which can liaise with the PHE, as necessary.

The PHE has produced a factsheets giving further Information on a range of other infectious diseases. This can be accessed by clicking the link below.

<http://www.hpa.org.uk/Publications/InfectiousDiseases/Factsheets/>

**4.2 Exposure to Environmental Hazards**

People whose work involves or could involve contact with water courses may be exposed to biological hazards. High risk environments include the following:

* stagnant water
* sewage
* sewerage systems
* drains
* ponds
* lakes
* rivers
* reservoirs
* culverts
* canals
* construction sites
* flooded buildings.

The main risks to their health come from leptospirosis (Weil's disease), Hepatitis A and general gastro-intestinal illness.

Leptospirosis is a serious and sometimes fatal infection that is transmitted to humans by contact with urine from infected rats. The bacteria can get into the body through cuts, scratches and abrasions and through the lining of the mouth, throat and eyes after contact with infected urine or contaminated water.

The kind of activities which may expose people to risk include inspection of culverts and bridges, contact with sewerage systems, ground maintenance or management, waste transport and disposal, recreational activities (water sports and associated maintenance), warden type activities and sampling. Although the nature of these activities may be very diverse, the actual control methods are similar.

***People at risk***

Anyone involved in the above activities are at risk.

***Assessment of risk***

The identification of exposure to infection and degree of risk should be an integral part of the risk assessment process.

***Evaluation of risk***

a) **Nature of task**

Some activities present a greater risk of exposure. As an example, work which entails extensive direct contact with the source of infection, such as recreational activities, should be classified as medium to high risk. Conversely, some activities which involve minimal direct contact and will be low risk.

b) **Frequency of task**

Those employees who are involved on a regular basis and whose job entails frequent exposure to potential sources of infection are high risk. Where work is spasmodic or only occasionally carried out then the risk is likely to be low.

c) **Environmental factors**

Certain environmental conditions or seasonal variations can influence the possibility of contracting infectious diseases and will need to be reflected in the risk assessment process, where appropriate. This would include the time of year, seasonal variations, vermin controls, flood conditions and site specific circumstances.

d) **Location of work**

The location of an activity needs to be considered if it increases the likelihood of contact with sources of infectious diseases, such as sewage treatment works

***Control measures***

There are various measures which should be considered where high risks are identified. These are likely to vary depending on the specific work and may include:

* Hepatitis A vaccination

<http://media.dh.gov.uk/network/211/files/2012/07/chap-17.pdf>

* Evaluation of working methods.
* Provision of adequate information, instruction and training relating to the hazards involved with the work including how to recognise symptoms associated with infection.
* Identification of individuals who need to be issued with a leptospirosis warning card.
* Implementation of suitable cleaning, maintenance and storage arrangements for all equipment including PPE.
* Provision of readily available facilities to ensure good personal hygiene.
* Ensuring that any wounds are covered with waterproof dressings before work starts.
* Ensuring that waste materials are correctly handled, stored and disposed of
* Provision of PPE, including overalls, gloves and goggles

**4.3 Immunisation Against Hepatitis B**

Workers may be at increased risk of being infected with the Hepatitis B virus if they are classified as being part of an ‘at risk’ group.

At risk groups of employees are those workers who fall within the following definitions:

1. Workers whose clients are themselves at risk of or who could be at risk of developing serious complications because their lifestyle involves one or more of the following:

* drug users who self-inject
* people who change their sexual partners frequently
* men who have sex with men
* babies born to infected mothers
* close family and friends of infected people
* patients who receive regular blood transfusions or blood products
* people with any form of liver disease
* people with chronic kidney disease
* people travelling to high-risk countries
* prostitutes
* people who work somewhere that places them at risk, such as nurses, prison wardens, doctors, dentists and laboratory staff
* prisoners
* families adopting children from high-risk countries

1. Workers who may be exposed to uncontrolled quantities of blood or body fluids on a regular basis whilst performing procedures. This could include care workers providing nursing care but would not include first aiders in office-based situations.
2. Workers who are likely to be exposed to blood products from high risk clients on a person-to-person basis, for example through contact with body fluids during a violent incident.

***Putting the risk into context***

The incidence of reported occupationally-related infection is very low. Though this should provide reassurance, it should not be used as an excuse for complacency. The main control measures for protection will always be safe working practice. The following information on immunisation gives additional protection in specific high-risk situations.

***Implementation***

Those identified above should be the subject of an individual risk assessment and, where appropriate, offered immunisation against Hepatitis B.

When making a decision about whether to offer immunisation managers should determine if an individual is more at risk carrying out his/her duties than a member of the public conducting normal day-to-day activities.

To help managers make this decision advice can be obtained from the Occupational Health Unit.

Managers must bear in mind that immunisation is not compulsory and individuals should be informed that they can refuse it. Any such refusal should be recorded within the specific personalised risk assessment.

# *Part 5 – Dealing with Outbreaks of Infectious Disease*

|  |  |
| --- | --- |
| 5.1 | Introduction |
| 5.2 | Role of Proper Officer |
| 5.3 | Authorised Officers |
| 5.4 | Legal Notification |
| 5.5 | Managing Illness |
| 5.6 | Monitoring in Residential Establishments |
| 5.7 | Outbreaks inResidential Establishments |
| 5.8 | Seasonal Influenza |
| Appendix 1 | Outbreak of Infection Questionnaire |
| Appendix 2 | Details about Proper Officer, Authorised Officers and Notifiable Diseases |

**5.1 Introduction**

Outbreak is a term used to describe an occurrence of disease greater than would otherwise be expected in a particular time and place.

Each establishment should identify a senior member of staff who will take responsibility for infection control and will act as the liaison person.

This procedure details the steps to be taken when a major outbreak occurs. It is not possible to list all these measures in respect of every conceivable outbreak, only the general steps and guidance, which should be followed.

**5.2 Role of the ‘Proper Officer’**

Control of infectious disease in Northumberland’s population is overseen by a ‘Proper Officer’ appointed by the Council. The Proper Officer must ensure that control measures are established to contain the infection and that certain cases of illness are investigated where appropriate. Please refer to Appendix 2 for details.

**5.3 Authorised officers of the Council**

Some officers within the Public Protection service of the Council are authorised to carry out investigations into certain illnesses associated with food or water bourne infection. Please refer to Appendix 2 for further details.

**5.4 Legal Notification of Infectious Diseases**

Legal notification of infectious disease is the responsibility of a Registered Medical Practitioners (RMPs), more commonly known as a ‘GP’. They must notify the PHE and Proper Officer of the LA within set timescales, where they suspect a patient has, or a dead person had, a ‘Notifiable Illness’. See Appendix 2 for details of these illnesses).

**5.5 Managing Illness**

Managers should be aware of illness in their staff or clients and report increased levels of illness to the Occupational Health team and record absences through the sickness reporting procedure. As part of this, managers will need have an understanding of the ‘usual’ levels of any symptoms in their clients. However, they should err on the side of caution when reporting illness, as it is better to over-report than miss an outbreak.

If managers have concerns about the health and/or clinical condition of any of their clients they should access medical care via the GP or hospital, as appropriate. Workers may be asked to collect specimens from clients as part of the outbreak investigation. They will be advised about the methods to be undertaken when doing this and will receive support from the Public Protection Services or local Healthcare Services, as necessary.

Managers should be aware of the possible impact of an outbreak of illness in their service area. This may include staffing levels and changes to service arrangements, such as closing venues to admissions or preventing clients from being discharged, as well as imposing restrictions on the movements of clients and members of staff.

**5.6 Monitoring in Residential Establishments**

A log book should be kept to record the following information relating to service users and members of staff who have suspected and confirmed infections:

• Name, age and sex of service user or member of staff

• General Practitioner's name and notification date

• Date and onset of symptoms

• Samples sent and results (if known)

• Diagnosis

• Source of infection, if known

• Outcome.

**5.7 Outbreaks in Residential Establishments**

All residential establishments should develop specific arrangements the aim of which is to prevent and manage outbreaks of infectious disease. These are based on the standards described in this document. Additionally, there is sector specific-guidance available on the PHE website. A useful aid-memoir is provided in the appendix and focuses on some key areas of risk when dealing with outbreaks in residential establishments.

Owing to the number of infectious diseases which can spread to service users, isolation of the service user may be required. Two service users with the same infection can be cared for in the same room, however, single rooms should be available if required. Rooms should be fitted with basins for the purposes of hand washing. In the event of an outbreak affected persons should use separate toilet facilities from those who are unaffected. Members of staff should not share facilities with service users in these circumstances. In day care establishments where clients become ill, it may not be possible to isolate facilities in this way. In these cases disinfection procedures should be applied rigorously.

**5.8 Seasonal Influenza**

Influenza or 'flu' is a respiratory illness caused by infection with the influenza virus. The influenza virus is unstable and new strains and variants are constantly emerging. Symptoms usually include headache, fever, cough, sore throat, aching muscles and painful joints.

***High-risk Groups***

The following sections of the population are deemed to be at high risk:

* Young Children – as they have a greater risk of being infected because they have not developed immunity to the virus.
* Elderly People – as they are at increased risk of developing severe complications.
* People who have problems with their respiratory, cardiac or immune systems – as they are more likely to develop severe symptoms if they become infected.

***Vaccination***

Flu vaccinations are 70-80% effective in healthy adults in years when there is a good match between the vaccine and the strains of flu in circulation.

Employees providing residential care, domiciliary care and essential services should be encouraged to request routine vaccination from their GP before winter.

The best time to be vaccinated is between late September and early November. A previous flu infection or vaccination will not necessarily provide protection against further infections because, as previously indicated, the virus is continually changing and different types circulate each winter.

Other service areas may consider implementing a voluntary staff vaccination programme in situations where the Council’s business continuity plan suggests that such employees undertake essential services*.*

***Specific Advice for Schools***

PHE has issued the specific advice for schools which can be accessed via the hyperlink below:

<http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/SeasonalInfluenza/InformationForThePublic/influinfluenzafactsheet/>

***Further Advice***

More detailed information and advice is available at:

<http://www.hpa.org.uk/infections/topics_az/influenza/seasonal/flufaq.htm>

**Appendix 1**

**Outbreak of Infection Questionnaire**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **No** | **Question** | | **Answer** | **Actions/Details** | **By Whom** | **Timescale** |
| **1** | Is the Fitness to Work Procedure in place for staff?  Is it being observed? | | Yes-No-N/A  Yes-No-N/A |  |  |  |
| **2** | Will additional facilities be required? | | Yes-No-N/A |  |  |  |
| **3** | | Will admission to hospital be necessary? | Yes-No-N/A |  |  |  |
| **4** | | Is medical treatment necessary? | Yes-No-N/A |  |  |  |
| **5** | | Is medical advice required to determine this? | Yes-No-N/A |  |  |  |
| **6** | | Does the establishment need to be closed to admissionsuntil there has been cessation of symptoms in last resident for 48 hours. | Yes-No-N/A |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **7** | Will isolation facilities be needed?  (Medical advice must be sought to determine this.) | Yes-No-N/A |  |  |  |
| **8** | Are any additional members of staff required? | Yes-No-N/A |  |  |  |
| **9** | Has a member of staff been nominated to liaise with official bodies such as PHE and Public Protection Service? | Yes-No-N/A |  |  |  |
| **10** | Has a standard explanation been decided upon for communication to service users and relatives? | Yes-No-N/A |  |  |  |
| **11** | Are adequate supplies of consumable items such as disinfectants available? | Yes-No-N/A |  |  |  |
| **12** | Are any special measures for staff protection required?  (In the case of immunisation medical advice must be sought.) | Yes-No-N/A |  |  |  |
| **13** | Do any members of staff work at any other establishment? | Yes-No-N/A |  |  |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **14** | Do the members of staff who have been identified in question 12 pose a risk to persons in the other establishment? | Yes-No-N/A |  |  |  |
| **15** | Are arrangements in place to deal with the event of death of a patient? | Yes-No-N/A |  |  |  |
| **16** | Has a chronological list of all persons affected, together with their symptoms, been drawn up? (PHE requires this information)  This must be recorded in chronological order and include the information detailed in the log book. | Yes-No-N/A |  |  |  |
| **17** | Analysis of food samples must be undertaken if food poisoning is suspected. | Yes-No-N/A |  |  |  |

**Appendix 2 – Role of the ‘Proper Officer’**

Every Local Authority (LA) must appoint a ‘Proper Officer’ to receive and forward information about notifications of infectious disease (statutory notifications from GPs and self referrals from cases who report themselves direct to the Council or Public Health England) within the area. In the County of Northumberland, the Proper Officer role has been assigned to the Director and named deputies of the Public Health England North East Centre.

The investigation and control of certain infectious diseases (mostly gastro-intestinal illnesses spread via food or water) within the resident population of Northumberland is carried out by the Public Protection Commercial Team within the Council’s Public Protection Group. In carrying out this role the Commercial Team (Environmental Health Officers and other specialist staff) liaise with the Public Health England North East Health Protection Team.

Other disease infections are investigated and controlled by staff from the Public Health England North East Health Protection unit.

The Proper Officer is responsible, amongst other things, for receiving and forwarding information on infectious diseases in their area and for disclosing such information to:

* The Proper Officer for another local authority in which the patient usually resides or a deceased person usually resided if they are not a resident of the County
* The Proper Officer of the Port Health Authority/Local Authority where the port is located from which the patient disembarked, if relevant and outside Northumberland

Proper Officers may exercise ‘powers of entry and inspection’.

**5.3 Authorised Officers**

As well as appointing a Proper Officer the LA must also authorise officers to exercise the powers specified in the Public Health (Control of Disease) Act 1984 and associated Regulations. An officer of the LA must have written authorisation to act in matters on behalf of the LA, for example signing documents. In addition, powers of entry and inspection require a warrant, order, or 24 hours’ notice. The Head of Public Protection and officers in the Public Protection Commercial Team are so authorised to act in any case requiring infectious disease control within the resident population of Northumberland and at any premmises in the county including NCC premises.

The powers include:

* Power to keep a child away from school
* A requirement to provide information on contact details of children attending school
* Require the disinfection or decontamination of things or premises
* Request for co-operation for health protection purposes
* Restrict contact with, access to, or relocation of dead bodies

**5.4 Legal Notification of Infectious Diseases**

A Registered Medical Practitioners (RMPs) must notify the proper Officer about:

* A notifiable disease listed in Schedule 1 of the Health Protection (Notification) Regulations 2010 (see below)
* Another infection not in Schedule 1 of the above statute which presents (or could present) a significant harm to human health
* been contaminated in a manner which presents (or could present) a significant harm to human health

Public Health England (who employs the nominated Proper Officer for Northumberland) will contact the NCC Public Protection service where there is an outbreak of an gastrointestinal disease and liaise on measures necessary to control the infection and investigate the cause. For other diseases HPA will intervene.

If a person is suspected of having food poisoning, this may only be formerly diagnosed and reported by an RMP.

The main purpose of notification is to enable PHE and Proper Officer to undertake prompt investigation, assess the risk to the public and formulate an effective response to cases of infectious disease or contamination (including exposure to chemicals or radiation) that present, or could present, a significant risk to health.

The second benefit of notification is the accumulation of data for use in the epidemiological surveillance of infections and contamination. This makes it possible for PHE and Proper Officer to monitor the effectiveness of existing interventions, identify the need for new ones and inform the planning of healthcare services.

As the above mechanism exists any approaches from the Media in respect of an outbreak should be referred to PHE.

**Notifiable Diseases**

|  |  |  |  |
| --- | --- | --- | --- |
| Acute encephalitis | Diphtheria | Legionnaires’ Disease | Rubella |
| Acute meningitis | Enteric fever (typhoid or paratyphoid fever) | Leprosy | SARS |
| Acute poliomyelitis | Food poisoning | Malaria | Smallpox |
| Acute infectious hepatitis | Haemolytic uraemic syndrome (HUS) | Measles | Tetanus |
| Anthrax | Infectious bloody diarrhoea | Meningococcal septicaemia | Tuberculosis |
| Botulism | Invasive group A streptococcal disease and scarlet fever | Mumps | Typhus |
| Brucellosis |  | Plague | Viral haemorrhagic fever (VHF) |
| Cholera |  | Rabies | Whooping cough |
|  |  |  | Yellow fever |