Government of JERSEY

Health and Community Services

Infection Control Guidance for Registered Homes, Care agencies, Children's healthcare facilities and day centres.

July 2020

DOCUMENT PROFILE

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Contact details	**Community IPAC Sister (4)44485 or bleep 616 via hospital switchboard**

REGISTRATION NUMBER

CONTENTS LIST:

1. INTRODUCTION

1.1 Rationale

The aim of this guidance is to ensure that all reasonable steps are taken to protect residents/clients and staff from acquiring infections in care homes, own homes and other healthcare facilities. Many infectious diseases have the capacity to spread within care facilities and affect large numbers of people. Infection is a major cause of illness amongst care home residents and may result in avoidable admissions to hospital. This guidance is adapted from best practice guidance *Prevention and Control of Infection in care homes – An information resource,* issued by the Department of Health (2013).

1.2 Scope

This guidance applies to all staff working in care homes, care agencies and other healthcare facilities in the community.

1.3 Roles and responsibilities

The registered person in charge (manager) has a statutory responsibility to ensure good infection control practice within the home/care facility. They should have access to advice on infection prevention and control from a suitably qualified and competent individual. The manager should ensure that appropriate infection control policies and procedures exist, are readily available and understood by all staff members. Staff training on infection prevention and control is recommended to enable them to recognise problems and seek specialist advice from the Community IPAC Sister.

The **Consultant in communicable disease control (CCDC)** has responsibility for the control of infectious disease within the community.

The **Community Infection Prevention and Control Sister** is employed by Health & Community Services and provides advice, training, policy development and facilitates audits in the community.

2. Standard Precautions for Infection Prevention and Control

Health care staff will be able to reduce the risk of contamination to themselves and others from infected body fluids by adhering to standard precautions:

2.1 Hand Hygiene and skin care

Hand hygiene is the single most effective method of preventing cross infection. Hands should be decontaminated in accordance with the World Health Organisation (WHO) 5 moments for hand hygiene:

- Before patient contact
- After patient contact
- Before a clean/sterile procedure
- After handling blood or body fluids

- After leaving the patients environment.

Preparation for effective hand hygiene may be achieved by:

- ❖ Keep nails short and clean
- ❖ Not wearing false or gel nails at work
- ❖ Removal of nail polish
- ❖ Adopting the “bare below elbows” principle.

Handwashing technique:

- Wet hands and apply liquid soap
- Rub hands together for 10-15 seconds using the 6 stage technique (Fig 1)
- Rinse well and dry properly using paper towels
- Nail brushes should not be used but if required must be disposable.

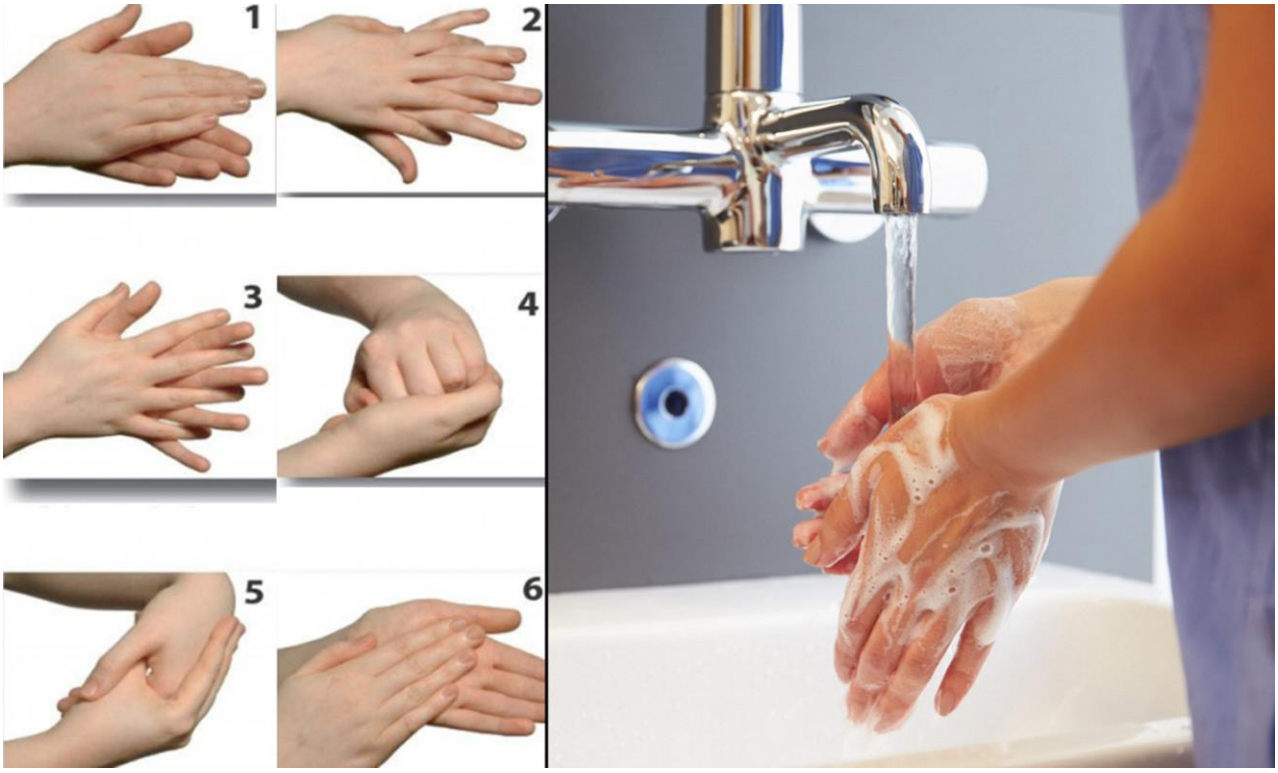

Fig 1. 6 stage technique

Hand hygiene facilities comprising a hand wash basin, hot & cold water (preferably from elbow operated mixer taps), liquid soap (disposable cartridge), and disposable paper towels must be available and easily accessible and not used for any other purpose. A lack of appropriate facilities must be brought to the attention of the manager who has a duty of care to ensure that there are adequate resources and facilities to prevent cross infection.

Alcohol hand rub is an effective alternative to hand washing on visibly clean skin. Alcohol hand rub can be applied directly to the skin using the above 6 stage technique.

Hand Rub is not suitable when caring for clients with unexplained diarrhoea or vomiting and is **not** effective against Clostridium difficile or Norovirus.

2.2 Personal Protective Equipment

The choice of PPE depends on the anticipated risk of exposure to body fluid during a particular activity (Fig 2). Many clinical activities do not involve direct contact with body fluids and therefore do not require the use of PPE.

No exposure to body fluids is anticipated	No PPE
Exposure to body fluids anticipated with no risk of splashing	Disposable gloves and disposable apron
Exposure to body fluids anticipated with risk of splashing	Disposable gloves, apron, eye/mouth/nose protection e.g. visor

Fig 2

Disposable gloves and disposable aprons should be worn as single use and disposed of into the correct waste stream. These should be worn whenever there is a risk of contaminating clothing with a blood or body fluid, or when a resident has a resistant organism or infectious disease. Hand hygiene is essential on removal of any PPE.

2.3 Safe handling of sharps

The risk of needle stick injuries is highest amongst workers in health care environments including care homes. The main risk from a sharps injury is the potential exposure to blood borne viruses (BBV) including Hepatitis B, Hepatitis C & Human Immunodeficiency virus (HIV).
The risk of injury can be reduced by:

- Eliminating the unnecessary use of sharps by changing practice and providing safer sharps incorporating engineered protection mechanisms.
- Providing sharps disposal containers that comply with standards BS 7320/UN329.
- Assembling containers in accordance with manufacturer's instructions.
- Closing the container when not in use without locking.
- Preventing recapping of used needles.
- Using PPE
- Recording incidents/accidents
- Training on the correct use of safer sharps and disposing of used sharps at the point of care.

Locked and labelled sharps containers to be stored in yellow clinical waste bins located in a safe place within the premises. The large bins should be collected by a local contactor as arranged by the care home.

2.4 Accidental exposure to blood/body fluids

In the event of needle stick injuries, bites, splashes to eyes, nose, mouth, or into cuts in the skin:

- Gently encourage the wound to bleed by running it under the tap. Do not suck the wound
- Cover with an appropriate dressing
- Inform your manager
- Attend Emergency Department, give full details of incident and details of the people involved. A risk assessment will be completed with the possibility of bloods being taken
- Appropriate prophylaxis for Hep B/immunoglobulin will be offered if indicated by risk
- The GP to be informed within 12 hours of incident and will take blood in a red top virology bottle for Hep B, C & HIV with the individuals consent. (This is the resident/patient/client).
- Complete an incident form
- Contact the staff immunisation team on 442117 (leave a message) to arrange follow up.
- IPAC can advise on how to carry out sharps audits at regular intervals

2.5 Management of body fluid spillages

Generally, small body fluid spillages can be managed by wiping with an appropriate wipe: Red Clinell (blood) or Green Clinell / Medipal 3 in 1 (urine, faeces, sputum, vomit). Ensure that appropriate PPE is worn.

In the event of a large spill of body fluids:

- The affected area should not be accessible to visitors or residents until decontaminated
- Appropriate PPE (gloves and apron) should be worn
- Mop up the organic matter with paper towels or disposable cloths and dispose of as non-hazardous waste (unless client is known to have a BBV, resistant organism or infectious disease) then dispose of as hazardous waste.
- Clean hard surfaces thoroughly using a hypochlorite solution e.g. “Acticlor” solution (made up to a concentration of 10,000 ppm) using paper towels or disposable cloth. Discard waste as above.
- For items in repeated contact with hypochlorite solutions, rinse the surface with clean cold water and dry thoroughly, as this will ensure the integrity of stainless steel equipment.
- Empty the bucket/bowl and clean with detergent and water.
- Discard PPE into the appropriate waste stream as above.
- Decontaminate hands.

If spill kits are used they should be kept in a designated place and staff should be made aware of their location and expiry dates.

2.6 Waste management

The responsibility for the day to day management of healthcare waste rests with the person in charge of the healthcare facility, however all staff involved with the generation

or handling of waste also need to be aware of the correct procedures. Collection of waste should be arranged through a licensed healthcare waste disposal contractor.
Waste is classified as Hazardous (yellow bags), Non-hazardous (white bags) or domestic waste (black bags).
Key points for safe handling of waste:

- The safe handling and effective disposal of waste starts with the healthcare practitioner.
- Bags should be securely sealed with appropriate fastening e.g. cable tie when three quarters full and only handled by the neck.
- All waste must be labelled so it is possible to identify the source of the waste.
- All such bags to be taken to a designated storage area.
- Waste collection containers must be covered, locked and stored in a secure area that is of sufficient size to accommodate the volume of waste produced and away from public areas.

Hazardous waste is either medicinal waste, or waste that poses a risk of infection e.g. waste from an individual with a resistant organism, gastrointestinal virus or during an outbreak.
Non-hazardous waste or offensive waste is not infectious although may cause offence to those coming into contact with it e.g. continence pads, dressings, gloves, stoma bags, vomit, sputum.
Domestic waste comes from food, non-contaminated paper and household materials.
Staff have a legal responsibility to safely dispose of waste. Each care provider will need to have a waste disposal risk assessment and safe system of work.

2.7 Laundry and linen

The provision of clean linen is a fundamental requirement of care. Incorrect handling and storage of linen can pose an infection hazard. Care homes can either have on-site laundry facilities or a contract with a commercial laundry.

Requirements for laundering:

- A laundry area designated for that purpose only, with separate ventilation and a flow through system, so that dirty laundry can arrive through one door and be quickly decontaminated, before drying and taken through a separate exit to a clean storage area.
- Surfaces within the laundry area should be of a smooth impervious surface to facilitate effective cleaning.
- An industrial washing machine with sluice and hot cycles is required. This equipment must be professionally installed and maintained.
- An industrial dryer should be used and regularly maintained.
- A regular service and maintenance inspection schedule should be kept.
- Appropriate PPE to be available for staff.
- Hand hygiene facilities including hand wash sink, liquid soap and paper towels to be available along with alcohol hand rub, pedal waste bin and first aid kit.

All dirty/ used linen must be handled with care using gloves and aprons. Always keep the laundry skip outside the room, and keep linen off the floor. Linen should be separated into categories ready for decontamination:

- Used linen and clothing – white cotton sack
- Soiled/infected linen – place into a water soluble/alginate bag then into a red cotton sack

All alginate bags with items should be processed in a cycle that reaches 71ºC for at least three minutes or at 65ºC for at least 10 minutes. Heavily soiled items should have a pre-wash cycle selected.

Uniforms should be laundered on-site as management cannot guarantee they have been washed and dried at the correct temperature. If no on-site facilities are available, staff must transport their uniform home in a separate carrier bag / clean pillow case. Uniforms must be washed separately from other items on a wash 65-71ºC with laundry detergent. Once laundered at home, uniforms should be placed in a plastic bag away from sources of contamination i.e. dust. Uniforms must be changed daily and not worn to and from work unless the staff member is a community health care worker.

2.8 Cleaning & decontamination

The maintenance of high standards of cleanliness on all surfaces and equipment is essential in the prevention and control of infection within the care home environment. It is everyone's responsibility to keep the home and equipment clean.

A clear and concise cleaning schedule should document what is to be cleaned, how often and by whom. Cleaning schedules should be completed on a daily basis after specific tasks. This ensures suitable arrangements are in place for the size of the facility. Both housekeeping staff and healthcare staff must have specific cleaning schedules.

- Disinfectants' should not be used routinely as cleaning agents
- Organic debris (faeces, sputum, and urine) may inactivate some disinfectants therefore it is vital to clean up the debris with paper towels prior to using disinfectants.
- Disinfectants must be used at the recommended dilution.
- Disinfectants must be stored and discarded in accordance with the manufacturers.
- Disinfectants must not be used unless agreed by the community infection control sister.
- COSHH regulations must be adhered to.
- Manufacturers should supply clear written decontamination or sterilisation method on all equipment purchased.
- Certain fabrics or materials can be difficult to decontaminate. It is therefore advisable prior to purchasing equipment, to assess if the facilities decontamination methods are safe and practical e.g. steam cleaning.
- Items described as "single use" or "not for reuse" must **not** be reused.

Consideration when purchasing equipment:

- Is it CE marked, this is the Medical and Healthcare products Regulations Agency (MHRA) approved standard?
- Is it appropriate for the task it will be used for?
- Is it easy to clean/ decontaminate and maintain?
- Is it compatible with the decontamination methods used in the facility?
- Is it easily identified as reusable or single use?

3. Procedures

3.1 Deaths

Deceased clients / residents should be treated with due respect and dignity and in a manner appropriate to the religious and cultural background of the deceased. Last offices vary according to religion and cultural practices and may, on occasions be compromised by the need for specific measures to be taken if an infectious disease was associated with the death.

Though most people are not infectious after death, sensible precautions should be taken: disposable gloves and aprons should be worn when washing and preparing the body. Washing the body with soap and water is adequate.

Clean dressings should be applied to any wounds and secured with either tape or a bandage to prevent further leakage from the site.

The precautions for handling a body known to have an infectious disease are essential as the body may still be infectious for a period of time after death. It may be necessary to use a body bag before removal to the undertakers. The undertaker will normally supply a bag if required. If a body bag is required, the body should be placed in a shroud or the person's own clothes and then in the body bag. The identity labels and "Notification of Death" labels should be attached in a way that they may be read through the body bag. A "Danger of Infection" label should also be attached to the outside of the body bag. This alerts the undertaker.

3.2 Animals

Pets can often enhance the quality of life for the elderly and ill. However, there are worries that a resident / client may catch an infection from a pet, especially if the resident's immunity is reduced through age, illness or therapy. Sensible precautions can reduce this risk to an acceptable level:

- Consider having a "pet pass" system in place to ensure all animals bought in are following recommended guidelines
- Only mature, housetrained animals to enter the premises
- All animals have a route for entry to and passage through the premises
- Areas highlighted where animals are not allowed
- All animals should be groomed regularly and checked for signs of infection
- If animals become ill they should not be allowed in the home until fully recovered

- All animals should have received relevant vaccinations
- All animals should be wormed every six months
- Claws should be kept trimmed to reduce the risk of scratches; any scratches on residents must be promptly and thoroughly cleaned and observe for signs of infection
- All animals but especially cats and dogs, should have their coats cleaned regularly along with bedding to control fleas along with insecticides.
- All animals should have relevant pet insurance prior to entering a home or a client's home

If a care facility has their own pets' staff must adhere to good hygiene practices:

- Pets should not be permitted to lick residents or jump on them in a manner which may cause accidents
- After residents and staff have touched pets, they should be encouraged to wash their hands
- Pet feeding areas to be kept clean
- Pets should have their own feeding dishes, which should be washed separately from dishes and utensils used for residents and staff
- Pets should not be fed in the kitchen or other food preparation areas
- Pet food should be separate to food for human consumption
- Appropriate pet insurance must be held by the home

Litter boxes / trays:

- Should be only be cleaned by someone who is healthy
- Should not be cleaned by pregnant women
- Gloves and aprons to be worn
- Use disposable liners to ease of cleaning
- Change litter daily
- Dispose of or place used litter in a plastic bag and dispose of in normal waste stream
- Keep the litter box/tray away from food preparation, storage or eating areas
- The litter boxes /tray should be cleaned once a week with detergent and water followed by disinfectant and allow to stand for 5 minutes in order to kill toxoplasmosis eggs and other microorganisms.

Good general advice and hand hygiene are essential for risk reduction. Residents who are MRSA positive should be discouraged from keeping pets. Evidence suggests that cats, dogs and horses are known to carry MRSA, therefore reducing the risk of transmission in a healthcare facility is important. By ensuring that all the above advice is followed, the physical and psychological benefits of having pets should improve the quality of life of the residents.

4. Management of residents with resistant organisms/infections/outbreaks

4.1 Diarrhoea and/or vomiting

Diarrhoea and/or vomiting in elderly or vulnerable people is common and does not always have an infective origin. Some possible causes are over use of laxatives, change in diet, existing conditions and underlying bowel disease. Diarrhoea and/or vomiting if caused by a viral illness is usually short lived but can cause outbreaks which spread rapidly e.g. Norovirus, or food poisoning.
If the resident has two or more episodes of loose stools:

- Isolate in own room with own toilet facilities
- Inform the GP
- Collect a specimen of diarrhoea and send to the lab (if requested by GP) especially if they have recently had a course of antibiotics
- Keep the resident isolated until 72 hours symptom free
- Increase the environmental cleaning in the room to twice daily
- Strict hand hygiene with soap and water, do not use alcohol hand rub
- Use PPE disposable gloves and aprons
- If 2 or more cases with similar symptoms occur within a few days then contact the infection control sister on 444485 or bleep 616 through the hospital switchboard for advice and support. The IPAC sister will request a list of those residents and staff affected by email. The Jersey Care Commission must also be informed.
- Consider closing the home to visitors if an outbreak is suspected following discussion with infection control
- If food borne infection is suspected, Environmental Health should be contacted to investigate
- If a resident is discharged from hospital before being symptom free for the whole 72 hours, they must be isolated with own toilet facilities until they have been clear of symptoms for 72 hours.

4.2 Clostridium difficile

Clostridium difficile infection (CDI) is a gram positive, spore forming bacteria that is present in the gut of up to 1-3% of healthy adults. This increases to some 30% in healthcare settings such as care homes. The main risk factor for CDI in the elderly is the use of antibiotics and some people may develop diarrhoea up to several months after having antibiotics. CDI produces toxins which damage the lining of the bowel and lead to symptoms. In the majority of residents/clients the illness is mild and a full recovery is usual, however some may become seriously dehydrated and occasionally some may develop pseudo membranous colitis (a severe form of the disease) which can be life threatening.

The symptoms of CDI:

- Watery, explosive, offensive smelling diarrhoea (type 5, 6 or 7 Bristol stool chart)

- Fever (sometimes)
- Loss of appetite
- Nausea
- Abdominal pain/tenderness

Control and prevention of CDI:

- Early diagnosis and intervention – notify GP and get a specimen to send for CDI
- Isolation of the affected person until they have had at least 48 hours normal stools (up to type 4 Bristol stool chart)
- Daily monitoring of fluid intake and output whilst resident is having diarrhoea
- Use PPE – disposable gloves and aprons when attending to affected person
- Environmental cleanliness using recommended chlorine based disinfectants and wiping hard surfaces with Clinell Red sporicidal wipes at least once daily
- Equipment to be cleaned with Clinell red wipes after each use
- Disposal of waste as hazardous (yellow bag)
- Ensure residents have own toilet facilities or designated commode
- Strict and thorough hand washing with soap and water after removal of PPE and after every contact with the resident and their environment
- Use short courses of antibiotics rather than longer courses – discuss with GP
- All linen and clothing to be treated as infected – alginate bag and red cloth bag
- Cutlery/crockery can be placed in a dishwasher that reaches temperatures of 65ºC
- On cessation of symptoms a terminal clean must be carried out using chlorine based disinfectant, soft furnishings and carpets can be steam cleaned.
- Repeat specimens are not required for clearance.

NB. Alcohol hand rub is not effective at removing Clostridium difficile spores or Norovirus

4.3 Methicillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a strain of Staphylococcus Aureus that is resistant to commonly used antibiotics e.g. Flucloxicillin, therefore the options for treatment of infection are limited.
Colonisation occurs when it is present on or in the body for a significant period of time but causes no ill effects. However if a resident/client requires a surgical intervention or invasive procedure then it is good practice to decolonise the skin using specific treatments prior to the procedure as this will reduce the risk of MRSA being introduced inside the body where it could cause disease.
Infection with MRSA occurs when the presence pf MRSA causes clinical symptoms e.g. inflammation, swelling, pus formation. MRSA infection can occur in the skin and soft tissues, lungs, bones, joints or in the blood stream.

High risk of acquiring MRSA:

- Previous MRSA infection or colonisation
- Living in a care facility
- Indwelling devices (catheter, stoma, PEG)
- Wounds (chronic and surgical)
- Contact with other residents/clients known to have MRSA

- Surgical interventions
- Long periods of antibiotic treatment
- Immunosuppression

Treatment:

- Clinical infection – GP is responsible for prescribing antibiotic therapy
- New colonisation - GP to offer full decolonisation treatment (table 1)
- Long term carriers (non-healing wounds, in-dwelling devices, failed decolonisation) – Prontoderm foam daily for the long term

Table 1 – MRSA treatment

Prontoderm Foam (5 days)	Apply once a day after routine washing, not to be washed off skin. Can be used on hair
Prontoderm nose gel (5 days)	Apply up each nostril using either a finger or cotton bud three times a day
Chlorhexidine mouthwash (5 days)	Gargle three times a day. If a client cannot gargle then a spray can be used

Control and Prevention of MRSA:

- Screen new admissions (nose, throat, groin & any wounds/indwelling devices)
- Always moisten the charcoal swab with normal saline prior to swabbing
- Label the swab and complete the form with GP name, test etc.
- Staff to wear PPE (disposable gloves and aprons) when undertaking personal care with a resident/client with MRSA
- Good hand hygiene
- Linen and waste to be treated as infected
- Room to be cleaned daily according to a robust cleaning schedule with neutral detergent and water to minimise dust. Particular attention should be made to horizontal surfaces. Should be cleaned last on the cleaning schedule
- Once a week the room should be cleaned with a chlorine solution (not required for peoples own homes) made up to a concentration of 1,000ppm to reduce the likelihood of the environment becoming a reservoir for microorganisms to thrive
- Equipment can be decontaminated after use with single use detergent/disinfectant wipes e.g. Clinell Green or Medipal 3in1.
- Cutlery and crockery can be cleaned as normal in a dishwasher
- Once a resident is deemed clear (3 negative screens: at least 5 days between each screen, no wounds or indwelling devices) then the room will be cleaned with detergent and water, followed by wiping with chlorine solution 1,000ppm, and soft furnishings and carpets steam cleaned.

4.4 Multi-Drug Resistant Gram Negative Bacteria (MR-GNB) including Extended Spectrum Beta Lactams (ESBL

MDR-GNB's are germs which cause infections (pneumonia, meningitis, bloodstream infections and surgical site infections) that are not killed by some of our best antibiotics. The number of infections caused by MDR-GNB's has increased recently and are problematic in both the hospital and community settings. The most frequently isolated ones include *Klebsiella species, E.coli, Acinetobacter species and Enterobacter species.*

ESBL's and Amp C beta lactamases are enzymes produced from bacteria that are resistant to cephalosporins e.g. Ceftazidime and Cefotaxime. They are also resistant to many other broad spectrum penicillin's. They have spread rapidly since 2003, causing infections, such as UTI's and other infections in both hospital and community settings.

Carbapenamases are enzymes produced by some bacteria which become resistant to carbapenem antibiotics e.g. Meropenam and Ertopenam. Carbapenam antibiotics are currently the only class of B-lactam antibiotics reliably active against Enterobacteriaceae with ESBL or Amp C activity.

Risk factors:

- Antibiotic usage, particularly broad spectrum agents
- Prolonged hospital stays
- Admission to hospital ICU, Renal or haematology/oncology units

Treatment and prevention:

- Residents with MDR-GNB should be isolated in single rooms with en-suite facilities. They may join other residents' in communal areas as long as the risk is reduced e.g. covering any wounds
- Good hand hygiene
- Staff must wear PPE (disposable gloves and aprons) when carrying out personal care and handling linen of the resident
- Resident's room to be cleaned daily with neutral detergent ad water at the end of the cleaning schedule, using dedicated or disposable cleaning equipment
- Once a week the room should be cleaned with a chlorine solution (not required for peoples own homes) made up to a concentration of 1,000ppm to reduce the likelihood of the environment becoming a reservoir for microorganisms to thrive
- Weekly application of bleach or hypochlorite solution 1000 ppm to sink and shower taps, toilet u bends and toilet roll holders as part of a cleaning schedule
- Equipment can be decontaminated after use with single use detergent/disinfectant wipes e.g. Clinell Green or Medipal 3in1 or using a chlorine based solution of 1,000ppm. Equipment should be dedicated for the sole use of the affected resident.
- Cutlery and crockery can be cleaned as normal in a dishwasher
- Linen and waste must be treated as infected
- In the event of death or discharge then the room will be cleaned with detergent and water, followed by wiping with chlorine solution 1,000ppm, and soft furnishings and carpets steam cleaned.
- All curtains and linen should be laundered and treated as infected.

4.5 Scabies

Scabies is a contagious infection caused by a mite *Sarcoptes scabiae* which burrows unto the upper layer of the skin. The female lays eggs in the tracks of the burrows. The eggs and the mite proteins produce an allergic reaction and it is this reaction which is responsible for the characteristic itching and rash. Signs of reddish, slightly elevated tracts may also occur. Miniature pustules and excoriations soon appear which may lead to secondary bacterial infections due to itching. The most common areas affected are between the fingers, wrists, elbows, armpits, waist, thighs, genitalia, nipples, breasts and lower buttocks. In some people the mites can be found on the face, ears and scalp.

Scabies is host specific i.e. it lives on humans, therefore scabies cannot be caught from pets or other animals. Transmission is by direct contact i.e. by prolonged skin contact of a sexual or social nature, therefore a quick hug or handshake is unlikely to spread the infection. People who have acquired the infection may not show any symptoms for 4-6 weeks, so this makes spread of the disease difficult to contain in facilities such as care homes. An outbreak is two or more cases diagnosed by a clinician. Scabies can be easily managed when treatment is performed correctly. It is therefore important to undertake skin assessments for at least two weeks post treatment.

Treatment and prevention:

- Identify symptomatic residents/clients and / or staff
- Waste to be treated as hazardous (yellow bag)
- Linen can be laundered in the usual way – not infectious
- Isolation of residents is not required
- Staff to wear PPE – disposable gloves and aprons for direct care
- Inform the GP's of residents to request a visit
- Inform the JCC and CICN for advice and support
- Prepare a list of all close contacts including staff, other residents and regular visitors
- Organise treatment for residents with the GP's
- Organise treatment for the staff
- Infected staff do not need to stay off duty provided they have observed the minimum contact time for their initial treatment
- First line treatment is Permethrin 5% dermal cream. To be applied over the whole body, including the face, neck, scalp and ears and washed off after 8-12 hours.
- Pregnant and breastfeeding women can use Permethrin 5% cream unless they have an allergy to chrysanthemums, in which case guidance to be sought from GP
- Treatment of staff and residents should be performed at the same time (within a 24 hour period) This will interrupt the chain of infection
- Two applications to be applied 7 days apart.
- If symptoms persist 4 weeks after treatment GP to reassess
- Scabies do not live in furniture therefore normal environmental cleaning is sufficient
- Inform family members to advise of awareness of symptoms
- Place a notice in the reception area to inform visitors to the home

Hyperkeratotic Scabies (known as Norwegian, crusted and atypical scabies) is a highly contagious form of scabies. A more intensive treatment (Ivermectin) along with

Permethrin 5% will be required on the advice of a medical professional. People may require 2 or 3 applications on consecutive days to penetrate the skin crusts and kill the mites. Please contact the CICN on 444485 for advice and support.

4.6 Covid

Covid is the infectious disease caused by the most recently discovered coronavirus. This new virus and disease were unknown before the outbreak began in Wuhan, China in December 2019. At the time of writing Covid is a global pandemic affecting many countries.
The most common symptoms of Covid-19 are fever, dry cough and tiredness. Other symptoms may include headaches, loss of taste or smell, aches and pains, sore throat, GI changes (some people have reported a change in stool colour) or a rash on the skin. Some people become infected but only have mild symptoms. Most people recover from the disease without needing hospital treatment, however a small percentage of people become very ill and develop breathing difficulties requiring hospital treatment.

Diagnosis and prevention:

- Prompt identification and Isolation of any resident/client suspected to have Covid
- Inform the GP who will arrange review and swabbing
- If positive result the contact tracing team will be in touch with the facility
- Staff must wear surgical mask, disposable apron and gloves when carrying out direct care. Visor to be worn if resident is coughing
- Strict hand hygiene on removal of PPE and between residents/clients
- Surgical mask to be worn at all times – can be changed if damaged, becomes moist or after staff breaks
- All staff to adhere to the donning and doffing guidance
- All linen and waste to be classed as infected (yellow hazardous waste bags and red linen bags).
- Cutlery/crockery can be cleaned as normal in a dishwasher
- Equipment can be decontaminated after use with single use detergent/disinfectant wipes e.g. Clinell Green or Medipal 3in1 or using a chlorine based solution of 1,000ppm. Equipment should be dedicated for the sole use of the affected resident.
- Room to be cleaned daily according to a robust cleaning schedule with neutral detergent and water to minimise dust followed by a chlorine solution (not required for peoples own homes) made up to a concentration of 1,000ppm to reduce the likelihood of the environment becoming a reservoir for microorganisms to thrive Particular attention should be made to horizontal surfaces. Should be cleaned last on the cleaning schedule
- Symptomatic staff must remain absent from work and call the helpline on 445566 to arrange swabbing
- To safeguard staff and residents, it would be optimal if staff could work in smaller groups
- Suspend visiting and group activities if an outbreak occurs
- Staff and residents to physically distance as per government guidelines.

Refer to appendix 1 should there be a surge in Covid-19 activity

4.7 Influenza

Influenza is a contagious viral infection that attacks your respiratory system – nose, throat and lungs. It can cause mild to severe illness and at times can lead to death. Influenza virus is spread when people with the virus cough, sneeze or talk, sending droplets of the virus into the air and potentially into the mouths or noses of people nearby. The droplets will also contaminate hard surfaces or equipment touched by the affected person. Incubation period is 1-4 days for seasonal influenza following exposure. The person is then contagious 24 hours pre-symptoms and through 5 days of illness. Immunocompromised people will be contagious for longer.

Diagnosis and prevention:

- Prompt identification and isolation of any resident/client suspected of having influenza
- Inform their GP to arrange review and swab if applicable
- Staff to wear surgical mask, disposable gloves and apron when carrying out direct care of the resident/client
- Strict hand hygiene on removal of PPE and between residents/clients
- Strict respiratory hygiene
- Treat linen and waste as infected (yellow bag for waste and red bag for linen)
- Cutlery/crockery can be cleaned as normal in a dishwasher
- Room to be cleaned daily according to a robust cleaning schedule with neutral detergent and water, followed by a chlorine solution made up to a concentration of 1,000 ppm to reduce contamination of hard surfaces
- Equipment can be decontaminated after use with single use detergent/disinfectant wipes e.g. Clinell Green or Medipal 3in1 or using a chlorine based solution of 1,000ppm. Equipment should be dedicated for the sole use of the affected resident.
- If 2 or more cases with similar symptoms occur within a few days then contact the infection control sister on 444485 or bleep 616 through the hospital switchboard for advice and support. The Jersey Care Commission must also be informed.
- Encourage all staff and residents/clients to have the annual influenza vaccine
- The resident/client can resume normal activities once they are symptom free
- Once a resident is fully recovered then the room will be cleaned with detergent and water, followed by wiping with chlorine solution 1,000ppm, and soft furnishings and carpets steam cleaned.

4.8 Outbreak Management

An outbreak could be defined as two or more residents/clients with similar symptoms in a health care facility. Diarrhoea and vomiting are the most common causes of outbreaks due to the vulnerability of the client group.
Management:

- Isolate the affected person in their room
- Staff to wear appropriate PPE
- Treat all linen and waste as hazardous (infected)

- Obtain specimens through the GP if appropriate
- Increase the cleaning in communal areas ie. Corridors, dining room, lounge and toilets
- Consider using disposable crockery and cutlery and dispose of as hazardous waste
- Contact the Community Infection Control Sister on 444485 or bleep 616 through hospital switchboard for advice and support on a daily basis
- Consider closing the home to visitors
- Keep residents/clients isolated until either 72 hours symptoms free (if D&V) or until symptoms settle
- Affected staff to stay off work until 48 hrs symptom free (if D&V) or until symptoms settle
- Carry out a deep clean of the facility prior to reopening

4. DEVELOPMENT AND CONSULTATION PROCESS

A record of who is involved in the development of this document. This may include HCS committees, service users and other agencies.

4.1 Consultation Schedule

Name and Title of Individual	Date Consulted
Cheryl Kennealy - JCF	August 2020
Audrey Murphy - JCC	July 2020
Environmental Health	July 2020
IPAC	July 2020

Name of Committee/Group	Date of Committee / Group meeting
Infection Prevention & Control Team	20/8/20

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8. IMPLEMENTATION PLAN

A summary of how this document will be implemented.

Action	Responsible Officer	Timeframe
IPAC Team	Eleanor Burrell	3 months from ratification date
Jersey Care Commission	Audrey Murphy	

Appendices

Appendix 1

Procedures and phone numbers in the event of a surge in cases (2 or more with covid symptoms):

Isolate suspected cases
Wear appropriate PPE according to current guidelines
Call GP to assess and arrange swabbing
Limit staff attending to suspected/positive cases
Consider closing facility to visitors
Waste and linen to be treated as infectious

Please refer to guidance from the websites and numbers below

Helpline	445566
IPAC	444485 or 07797733451 hssinfectioncontrol@health.gov.je
Workforce planning	nursebankoffice@health.gov.je
Emergency Accommodation	emergencyaccommodation@gov.je
Government website	www.gov.je/coronavirus
Jersey Care Commission	https://carecommission.je/contact-us/