Community Infection Prevention and Control Policy for Care Home settings

Creutzfeldt-Jakob disease

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This guidance document has been adopted as a policy document by:

Organisation: ...........................................................................................................
Signed: ....................................................................................................................
Job Title: ..................................................................................................................
Date Adopted: ...........................................................................................................
Review Date: .......................................................................................................... 

If your organisation would like to exclude or include any additional points to this document, please include below. Please note, the Community IPC Team cannot endorse or be held responsible for any addendums.

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CREUTZFELDT-JAKOB DISEASE

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CREUTZFELDT-JAKOB DISEASE

1. Introduction

Creutzfeldt-Jakob Disease (CJD) is one of a group of diseases called Transmissible Spongiform Encephalopathies (TSEs) which can occur in people or animals. The transmissible agent is an abnormal protein known as a prion. TSEs are characterised by degeneration of the nervous system and are invariably fatal.

CJD has a long incubation period and may not cause symptoms for many years. Clinical features vary depending on the regions of the brain affected, but following onset of symptoms a very rapid deterioration occurs. There are no simple non-invasive tests available to diagnose CJD before symptoms develop, diagnosis can only be confirmed on the death of a resident by a brain biopsy.

In this policy, the term CJD encompasses sporadic CJD, variant CJD (vCJD), familial CJD, and other TSEs. There are several types of CJD:

- **Sporadic:** commonest form caused by a mutant gene. Usual age of onset is late middle age. Most resident present with rapidly progressive dementia with focal neurological signs including ataxia, myoclonus, visual disturbances and rigidity. Death occurs within 4-6 months of clinical onset.

- **Familial:** approximately 15% of cases are inherited and caused by a gene mutation.

- **Iatrogenic:** about 1% are transmitted by medical or surgical procedures including pituitary hormone injections, dura mater grafts, and rarely by neurosurgical instruments. The incubation period can range from 1-2 years for neurological routes of transmission and up to 30 years in some pituitary hormone recipients.

- **Variant CJD (vCJD):** thought to be as a result of eating contaminated bovine food products (same agent responsible for BSE in cattle). Whilst rare, there has been a gradual increase in numbers of people being diagnosed. Tends to affect young adults, with the clinical illness lasting an average of 14 months. Symptoms may include both psychiatric and sensory abnormalities, which are followed by ataxia, myoclonus and other movement disorders and dementia.

2. Transmission

How TSE’s are transmitted is uncertain, but there is no evidence that they are spread from person-to-person by close contact. It is, however, known that transmission of CJD can be associated with medical intervention, e.g.
administration of hormones prepared from human pituitary glands, dura mater preparations, corneal grafts and recently from blood transfusions. CJD/ vCJD has also been reported following brain surgery due to inadequately decontaminated instruments (prion proteins are resistant to decontamination processes).

The Advisory Committee on Dangerous Pathogens has suggested that in people with sporadic CJD, certain tissues have high, medium or low infectivity. There is evidence that the distribution of the abnormal prion protein in tissues is more widespread in the body in residents with vCJD, than in residents with sporadic CJD.

3. Care of a resident with CJD

Normal social or routine clinical contact with a resident with CJD or related disease does not present a risk to staff, relatives or the community. Isolation is not necessary and they can be cared for in a care home setting. No special measures over and above standard infection control precautions are required for caring for CJD or vCJD residents in a community setting, as it is unlikely that a procedure will be undertaken that involves contact with high or medium risk tissues, e.g. brain, spinal cord.

Although cases of CJD/vCJD have been reported in healthcare staff, there have been no confirmed cases linked to occupational exposure.

The following advice is for the care of residents who are known, suspected or at risk of developing CJD or related disorders.

<table>
<thead>
<tr>
<th>Communication</th>
<th>Your local Community Infection Prevention and Control or Public Health England Team should be contacted in order to give appropriate advice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of isolation</td>
<td>Isolation is not required. A resident may be cared for in a care home setting and can socialise and take part in normal activities</td>
</tr>
<tr>
<td>Main infection source</td>
<td>The main potential source of infection is from high risk tissues, especially brain, spinal cord, eye and cerebrospinal fluid (CSF) in sporadic CJD, contact with high risk tissues is unlikely in a community setting. There is no evidence of infectivity in saliva, body excretions or excreta. As the infectivity of other tissues in vCJD is less well understood, standard precautions should be adhered to including covering cuts and abrasions with a waterproof dressing</td>
</tr>
<tr>
<td>Pathology specimens</td>
<td>Body secretions, body fluids (including saliva, blood, and excreta) are all low risk for CJD. It is, therefore, likely that the majority of samples taken will be low risk.</td>
</tr>
</tbody>
</table>
Blood and body fluid samples from residents with, or ‘at increased risk’ of, CJD should be treated as potentially infectious for blood-borne viruses and handled with standard infection prevention and control precautions as for any other resident.

All specimens from a resident with a definite, probable or possible diagnosis of CJD, must be labelled as ‘infection risk’

<table>
<thead>
<tr>
<th>Personal protective equipment</th>
<th>Disposable apron and gloves should be worn when performing any procedure which involves handling body tissue, blood or body fluids and face protection worn if splashing is anticipated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disposal of faeces/urine</td>
<td>No specific precautions are required. Residents may use the toilet provided good personal habits are maintained</td>
</tr>
<tr>
<td>Disposal of Clinical waste</td>
<td><strong>Clinical waste should be disposed of as per local policy</strong></td>
</tr>
<tr>
<td>Cutlery and crockery</td>
<td>No specific precautions. Disposable items are not required</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>No specific precautions are required. Standard infection prevention and control cleaning and disinfection measures should be applied. Refer to the ‘Decontamination of equipment Policy for Care Home settings’</td>
</tr>
<tr>
<td>Linen</td>
<td>No special requirements, linen and clothing should be laundered as usual. Refer to the ‘Laundry including uniforms Policy for Care Home settings’</td>
</tr>
</tbody>
</table>

### 4. Spillages of blood and body fluids

Standard infection control precautions should be followed to clear up spillages of blood and body fluids from residents with, or ‘at increased risk’ of CJD in the community. Spillages should be cleared up as quickly as possible. Refer to the ‘Environmental cleanliness Policy for Care Home settings’.

### 5. Inoculation injury and blood or body fluid splashes

Contact with small volumes of blood (including inoculation injury) is considered low risk. Any incident involving used sharps, splashes into the eyes, mucous membranes or contamination of abrasions with blood or body fluids should be dealt with in accordance with ‘Sharps management and inoculation injuries Policy for Care Home settings’ and reported immediately to the Occupational Health Department/GP Practice/A&E department, who will discuss the case with a Consultant Microbiologist.
6. Referral or transfer to another health or social care provider

- Prior to a resident’s transfer to and/or from another health and social care facility, an assessment for infection risk must be undertaken. This ensures appropriate placement of the resident.

- An Inter-Health and Social Care Infection Control (IHSCIC) Transfer Form (see Appendix 1) must be completed for all transfers, internal or external and whether the resident presents an infection risk or not. Please refer to the ‘Inter-health and social care infection control transfer Policy for Care Home settings’.

- The resident’s ‘at risk’ status must be included in any referrals for surgery as head and neck surgery may involve contact with tissues of high or medium infectivity, for which special infection control precautions will be required.

- The ambulance/transport service and receiving area must be notified of the resident’s infectious status in advance.

7. Death of a resident

Please refer to the ‘Care of the deceased Policy for Care Home settings’.

Inform your local Community Infection Prevention and Control or Public Health England Team. Relatives of the deceased may wish to view or have some final contact with the body. Such viewing and possible contact such as kissing need not be discouraged.

Funeral directors must be informed of the infection status. The deceased resident’s body should be placed in a cadaver bag prior to transportation by the Funeral directors.

Under no circumstances must any tissue or organs be used for donation.

8. Infection Prevention and Control resources, education and training

The Community Infection Prevention and Control (IPC) Team have produced a wide range of innovative educational and IPC resources designed to assist your Care Home in achieving compliance with the Health and Social Care Act 2008 and CQC registration requirements.
These resources are either free to download from the website or available at a minimal cost covering administration and printing:

- Over 25 IPC Policy documents for Care Home settings
- ‘Preventing Infection Workbook: Guidance for Care Homes’
- ‘IPC CQC Inspection Preparation Pack for Care Homes’
- IPC audit tools, posters, leaflets and factsheets
- ‘IPC Bulletin for Care Homes’

In addition, we hold educational study events in North Yorkshire and can arrange bespoke training packages and ‘Mock IPC CQC Inspections’. Prices vary depending on your requirements and location.

Further information on these high quality evidence-based resources is available at www.infectionpreventioncontrol.co.uk.

9. References

Department of Health (2012 updated October 2015) Minimise transmission risk of CJD and vCJD in healthcare settings  


NHS England and NHS Improvement (March 2019) Standard infection control precautions: national hand hygiene and personal protective equipment policy

World Health Organisation Creutzfeldt Jakob Disease  
www.who.int/topics/creutzfeldtjakob_syndrome/en/

10. Appendices

Appendix 1: Inter-Health and Social Care Infection Control Transfer Form
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Inter-Health and Social Care Infection Control Transfer Form

The Health and Social Care Act 2008: Code of Practice on the prevention and control of Infection and related guidance (Department of Health 2015), states that "suitable accurate information on infections be provided to any person concerned with providing further support or nursing/medical care in a timely fashion”. This form has been developed to help you share information with other health and social care providers. The form should accompany the patient and, where possible, a copy filed in the patient’s notes.

| Patient Name: .................................................. | GP Name and contact details: .................................................. |
| Address: .............................................................................. |
| NHS number: ................................................................. |
| Date of birth: ................................................................. |
| Patient’s current location: ............................................. |

Receiving facility, e.g., hospital ward, hospice: .............................................

If transferred by ambulance, the service has been notified: Yes ☐ N/A ☐

Is the patient an infection risk:
Please tick most appropriate box and give details of the confirmed or suspected organism

- □ Confirmed risk
- □ Suspected risk
- □ No known risk

Organisms: ..............................................................................

Patient exposed to others with infection, e.g., D&V, Influenza: Yes ☐ No ☐ Unaware ☐

If yes, please state: ..............................................................................

If the patient has a diarrhoeal illness, please indicate bowel history for last week, if known, (based on Bristol Stool Form Scale):

Is diarrhoea thought to be of an infectious nature? Yes ☐ No ☐ Unknown ☐

Relevant specimen results if available

<table>
<thead>
<tr>
<th>Specimen:</th>
<th>Date:</th>
<th>Result:</th>
</tr>
</thead>
</table>

Treatment information:

Is the patient aware of their diagnosis/risk of infection? Yes ☐ No ☐

Does the patient require isolation? Yes ☐ No ☐

If the patient requires isolation, phone the receiving facility in advance: Actioned ☐ N/A ☐

Additional information:

Name of staff member completing form: ..................................................

Print name: .................................................. Contact No: .................................................. Date: ..................................................

Community Infection Prevention and Control, Harrogate and District NHS Foundation Trust

April 2017

www.infectionpreventioncontrol.co.uk