





	Guidance	for Care H	lomes	
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1. Introduction

We are an NHS Community Infection Prevention and Control (IPC) Team based in North Yorkshire, and our aim is to support care bomes in achieving best practice in IPC. This Workbook complement a range of educational resources and bulletins, further information is available at <u>www.infectionpreventioncontrol.co.uk</u>.

The Workbook is evidence-based using national guidance. intended to be the foundation for best practice in infection prev on and control. By applying the principles within the Workbook, you demonstrate commitment to high quality care a patient safety. The Health and Social Care Act 2008: code actice. the preve and control of infections and related Idan Code prao Department of Health, December J22, state Good in δn prevention and control is essentia hat people who use a ensur health and social care servi s rece e and effective care".

The *IPC Education Framework*, and England, 2023, describes 3 tiers to classify the IPC education a quite pents of staff. The tiers are incremental, building from tier the tier as follows:

Tier 1 - Everyone Werking Repeat and social care settings

Tier 2 - 11 staff working crectly with/providing care to residents and/or the resident environment

Tier 3 - Austaff your sponsible for an area of care

We Workbuck is aimed at all staff and is applicable to staff in each of the 3 tiers. In designed to be undertaken in stages which allows you through the Test your knowledge' sections before moving on to the next action. On completion, your Manager will check that you have acceived 100% competency and sign the 'Certificate of amountain'. You should keep the Workbook as evidence of learning and as an on-going reference guide.

Completion of this Workbook also helps your organisation demonstrate compliance with the *Code of practice* and the Care Quality Commission registration requirements in relation to IPC training.

3. SICPs and TBPs (Standard infection control precautions and transmission based precautions)

NHS England states that there are a number of 'Standard' infection control precautions' (SICPs), see table below these underpin routine safe practice and break the chain of infection which in turn protects residents, visitors and staff. There is then no way of knowing who is infectious, so by applying S. Paro all residents and at all times, best practice becomes second ature and the risk of infection is minimised.

All care staff in all situations involving the car of residents or contact with the resident's environment, just a SICP

- In most cases, without a laboratory test it is implicable to tell who has or is carrying an investion, since every person is a potential infection risks is essential that all staff apply safe systems of working at the copponently.
- Safe working practices thre the quesswork out of protecting yourself and the as you provide care.

Standard infection control precautions
Hand Vg.
Patien, lacement, assessment for infection risk
ersona otective equipment
Respirato, and cough hygiene
safe d posal of waste, including sharps
Safe inagement of blood and body fluid spillages
are management of care equipment
Safe management of linen, including uniforms and workwear
Safe management of sharps and inoculation injuries
Safe management of the care environment

Guidance for Care Homes

Transmission based precautions

In some circumstances, SICPs may not be sufficient to prevent transmission of specific infections. Therefore, additional 'Transmission based precautions' (TBPs) may also need to be taken by staff when caring for residents.

The need for TBPs is based on the:

- Infectious agent that is confirmed or suspected
- Severity of illness
- Transmission route of the infectious agent, bich may be more than one route)
- Procedures undertaken

TBPs are categorised by the following dates of transmission:

Contact precautions

Used to prevent and control infection, transmind via direct contact with the resident, or indirectly from the unidents immediate environment and calles, thement. This is the most common route of transmission of infective

Droplet presentions

Used to present as a patrol invotions transmitted over short distances (about 1 merch) via copy from the respiratory tract of one person directly onto a periodus membrane, e.g. eyes, nose, mouth, of another person. Droph is can penetrate the respiratory system to above the alveolar lovel. It uplets fall rapidly onto surfaces due to their weight

orne planautions

Used to procent and control infections transmitted without necessarily here are resident contact via aerosols from the respiratory tract of one person directly onto a mucous membrane, e.g. eyes, nose, mouth, of another person. Aerosols can penetrate deeper than droplets, to the endpoint (alveoli). Unlike droplets, because the size is much smaller, aerosols can travel on air currents for potentially hours before they fall onto surfaces

3. SICPs and TBPs

Glove selection guide	Sterile Non-sterile				e		
Procedure and type of contact Ticks indicate which glove to use for the procedures listed and if they should be sterile or non-sterile. Please note that this is not an exhaustive list.	Latex	Nitrile	Latex	'rile	viny	Domestic	
Aseptic technique	✓	✓					
Blood/blood stained body fluids							
Body fluids, e.g. urine, faeces			✓	×	\mathbf{X}		
Clean technique, e.g. dressing pressure or leg ulcers, simple grazes			~	~			
Confirmed or suspected respiratory illp e.g. flu, COVID-19			~	¥			
Decontamination of care equipment			Ň	1	✓		
Domestic tasks						✓	
Sorting soiled laundry			✓	✓	✓		
Urinary catheterisation	✓	✓					
Urine drainage bag emptying			✓	✓	✓		
Venepuncture			✓	✓			

Do not routinely wher gives y ten feeding residents, giving oral medication or performing clencer work.

Apron

A single use disposate apron should be worn phenevel user is a risk of exposure to blood and/or body fluids non-intact skin, mucous membranes or the applent us a confirmed or suspected infection.



Aprons ould also be worn when there is a risk of

contapplation to the front of uniforms or workwear and before an use of direct 'hands on' care with a resident. Aprons should be disposed of between residents and as soon as the care activity is completed.

All care homes are recommended to adopt the national colour code for aprons, such as:

suspected infection transmitted by the droplet or airborne route, such as COVID-19, flu. Prescription spectacles are not considered eye protection. Reusable eye protection should be decontaminated after each use.

Footwear

Footwear must be well maintained, visibly clean, ne slip and support and cover the entire foot to avoid contamination.

Note

- All PPE must be disposed of as soon as the care activity is completed and as per local policities
- Always wash hands or apply acohol handrub a prosposing of PPE.
- PPE should be readily vailable staff and within expiry date.
- PPE should be appropriately fored to ensure it does not become completing ted.
- Headwear, work for the reasons, must be washed and/ or changed daily a immediately if contaminated.

Test y ur k solodge Please tick s const answer	True	False
1. Gloves hould be removed before an apron.		
2. Gloves should be routinely worn for feeding regions.		
3. A yellow apron should be worn when caring for an isolated resident.		
4. Hand hygiene is not required after disposing of PPE.		

Colour	Description
Orange	 Infectious waste: items contaminated with urine, faecer vomit, sputum, pus or wound exudate, from a confirmed, suspected or at risk of infection source. Items may include personal protective equipment (PPE), commence pads, urine bags, single use items, single use backs and dressings. Waste from blood and/or body fluid spillages. Infectious waste may be treated to render it safe prior disposal, or alternatively incinerative in a licensed facility.
Yellow and black	 Offensive/hygiene waste: in a contamented with units, faeces, vomit, sputum, protor would exuda a from condents with no known risk carconfirmed of suspect confection. Items may include Physicontinence pads, urine bags, single use items, single use base, drawings, feminine hygiene, nappies and a content is used PPL Liquids, e.g. une, acces, vol. should be discarded into a foul sewer (since or nilet). They can, however, be such a contract of the second physical and physical actions such a support of the second physical action offer the waste stream, ensuring there is no free uning hypothesent. Offension hygiene waste may be land filled in a permitted or licenses uncility.
Black	 Dom structe: items which do not contain infectious praterials, sharps or medicinal products, e.g. paper towels om handwashing, packaging, newspapers. Clear or opaque waste bags can also be used for domestic waste. Recycling options should be considered where available. Domestic waste may be land filled in a permitted or licensed facility.
Purple	 This waste stream is rarely used in care home settings. Cytotoxic and cytostatic waste: items contaminated with medicines which cause damage to cells. Cytotoxic and cytostatic waste must be incinerated in a mention of the incinerated for item.

Safe disposet - vaste, including sharps (SICP) œ.

Sharps containers

Alwa

- Should be the correct size according to usage.
- Must be assembled correctly as per manufacturer's instructions, ensuring the lid is snapped firmly in place all around the rim to avoid spillage or injury.
- Must have the label dated and signed on assembly traceability purposes.
- Must be located in a safe position that avoids spillage and a height that allows the safe disposal of corps. They show not be placed on the floor.
- Must be away from public areas are on of the each of children or confused residents, avoid a cidents
- Must have the lid temporary curve in resition after each use, to prevent the risk of poillage proceidental injury.
- Should not be shaken or the potential ressed down to make room for more sharps or a smith made move or retrieve an item from the barps contained.
- Must be disposed of where the fill line' is reached, to avoid sharps protruding in the optiming.
- Contacts, a waiting discusal should be stored in a secure location. They, but he locked, labelled with the care home details (p int c origin, and date of closure.
 - ast only used for the disposal of sharps.

e correct colour coded sharps container

for the discussed of sharps contaminated with cytotoxic and cytostatic number

Orange lid with matching orange labelled container: for the disposal of sharps not contaminated with medicines

Yellow lid with matching yellow labelled container: for the disposal of sharps contaminated with medicines

Guidance for Care Homes

- Some disinfectants supplied as tablets must be made up with the specified amount of water using a diluter bottle in order to achieve the correct concentration.
- If the dilution of the disinfectant is incorrect and a weak solution is used, any bloodborne virus, e.g. hepatitis B, hepatitis C and HIV, will not be killed. If the dilution is too strong, the equipment or surfaces may be damaged. Always follow manufacturer's in



tructions.

- Diluted chlorine-based disinfectant and bons become less effective after 24 hours. When a colution is made there are and time should be recorded and the solution disposed of after 24 hours.
- To ensure that microorgan uss, e.g. acteria and viruses, are killed, always leave chloring-burged discretcant solutions for 5 -10 minutes coptact time or us subsified by the manufacturer.
- Chlorine-based som dants hay damage soft furnishings and carpets. There ice, do not and warm water, carpet cleaning machine or some cleaner, should be used.
- If soft functions of the views are heavily contaminated with blood or ody unds the cannot be adequately contaminated, they should be disposed of.

Con

Disinfection should be performed to render spillages of blood and/or ody fluids safe to handle before cleaning the area of general purpose neutral detergent and warm water.

 For disinfectants to be effective, they need to achieve the required contact time with the surface, as per manufacturer's instructions. It is, therefore, important to allow surfaces to dry naturally as disinfectants remain active until they are dry.

10. Safe management of care equipment

Cleaning, disinfection and sterilisation is known as decontamination. Safe decontamination of care equipment after use on each resident is an essential part of routine infection control to prevent the transmission of infection.

1. Cleaning

Cleaning with detergent and water uses fluid and friction to physically remove dirt and microorganisms, e.g. bacteria and viruses, from surfaces or care equipment. The process do not necessarily remove all microorganisms, but it lowers their numbers and the risk of spreading intertion.

Detergent and warm water or detergent whee she idea used for the cleaning of any care enforment that has been in contact with intact skin*, e.g. was not that has been in Steam cleaners can also used a nectively for cleaning care equipment. (*Intact skin can be lefined in skin in which there are no breaks, grazes, cuts, etc.)

2. Disinfection

Disinfection with a disinfection product works by killing microorganisms on surfaces on care equipment. This process kills microorganisms **on** of cleaning has taken place first.

Disinfect at product on be in the form of wipes, tablets or solutions, and Clinell Universal Wipes, Chlor-Clean tablets. Some are a forine-based, e.g. Chlor-Clean. Always follow manufacture a instructions for application and contact time.

It is impound to allow a disinfected surface to dry naturally. Disinferents remain active until dry, therefore, it is important there the surface wet to achieve the required contact time. Leave to air dry, do not dry with paper towels.

If a chlorine-based disinfectant solution is used, it should be at a dilution of 1,000 parts per million (ppm), or equivalent product as per manufacturer's instructions. However, if care Use of reusable non-invasive care equipment must comply with manufacturer's instructions and decontamination must be undertaken:

- Between each use
- After contamination with blood or body fluids
- Before inspection, servicing or repair

Evidence of decontamination

A schedule, that details what care equipment is to be decontaminated, when to do so and what projects to use, should be in place. Care equipment that has be decontaminated should be labelled out details of the data an signed by the person who performed the depontamination.

Care equipment requiring cervice or repair

When care equipment requires service for repair it should be decontaminated. A 'Declaration of contamination status form should accomparate requipment, stang if the item has or has in the fully decontaminated. A certificate is realiable to downloar a provinfection revention.co.uk.

It is illegal send minated items through the post.

Augit tools

Refer to the Naronal Standards of Healthcare Cleanliness 2021. Includition, nonknly audits for Care Homes to assess the standard or cleanliness of care equipment, mattresses and pressure dieving cushions are available to download at www.unectionpreventioncontrol.co.uk.

Note

 Hoist slings should be single patient use, e.g. are for use by a named resident and should not be used by any other person. <u>10. Safe management of care equipment (SICP)</u>

12. Safe management of sharps and inoculation injuries

An inoculation injury is when blood or body fluid is transferred person-to-person via a cut or puncture wound from a use a sharp or bite, or a splash to broken skin or mucous membrane, e.g. eyes, nose or mouth.

Good practice to prevent a sharps injury

- Disposable gloves must be worn when there is a risk of exposure to blood or body fluids.
- Consider, where appropriate, using afer surp devices o provide a safer system of working.
- It is the responsibility of the user to divise of shurps safely into a sharps container
- Sharps containers show the taken to the point of use, e.g. a resident's pool using the injection tray with an integral sharps compiner and dispose of successful the point of use.



- Never recap use needed be to the high risk of injury.
- Ne provide used shares from one person to another.
- Alway disprace the needle and syringe as 1 unit. Never attemptonemove the needle from the syringe.
 - Always loquest assistance when using sharps with reluctant fuse residents.

Comp ent

to be taken following a sharps or inoculation injury is good practice.

For further details visit www.infectionpreventioncontrol.co.uk.



Note

- The risk of acquiring a blood-borne virus from an infected resident depends on the type of injury and is approximately 1 in 3 for hepatitis B, 1 in 30 for hepatitis C and 1 in 2 of for HIV.
- There is currently no vaccine available for hepath
- Clean hands and wear appropriate PPE when handle sharps.
- Dispose of single use items after one us
- Clean hands after removing are disputing on

Remember

 It is best practice to us offer shall devices to provide safer systems of working.

PE

 Always requiressistance when using sharps with reluctant or confused h. Sten

Te Plea	est war known dee ase til the concerneswer	True	False
1.	Never each used needles due to the high risk of injul		
2	disp tal.		
	ed sharps can be passed from one person to another.		
4.	In the event of a sharps injury where the resident has HIV, PEP should ideally start within 1 hour of the injury.		

Guidance for Care Homes

- Perform the procedure, including cleaning of the skin where applicable.
- Maintain a sterile field throughout the procedure.
- Dispose of all used items in a sealed bag and dispose. appropriately.
- Remove PPE and decontaminate hands.
- Decontaminate the trolley with detergent and warm wat detergent wipes, followed by 70% alcohol-wipes if disinfect is required, and decontaminate hands ag
- Complete appropriate documentati

Clean technique

This is a modified aseptic techniq the p in differences are:

- with one mersed in non-sterile The wound can be clear fluid, e.g. tap water of drive gual
- Non-sterile gloves can be w

dre sing most wounds healing by A clean technique is sea secondary intention su as:

- Press e
- Leg ulc
 - y wound simple grazes

A cl less that

nique should **not** be used for significant wounds that 48 hours old, cavity wounds with a sinus, or when a resident immunosuppressed or diabetic.

Non-touch technique

The aim of a non-touch technique is to avoid contamination by not touching key elements, e.g. the inside of a sterile dressing, end of a sterile connection, such as a catheter tube, or other item that will come in contact with a susceptible site.

A non-touch technique can be used for:

- Removal of a urinary catheter
- Changing a catheter drainage bag
- Attaching a catheter night bag

Good practice

- Use standard infection control precautions.
- Dispose of single use items after use.
- Store sterile equipment in clean, dry conditions, off the flow and away from potential damage.

Note

- Safe aseptic technique is reacht upproeffective staff training and the environment of Lequip and being fit for purpose.
- If the procedure can be vin a taken without touching the key site or key part, such as two od, with your hands, then nonsterile glover to be work. If you need to touch the key site or key part with your ords, then sterile gloves must be worn.

Test to knowle ne Please tic the concernment	True	False
1. Only aff the have been trained an assess of as competent should under aseptic technique.	ertake an	
An a eptic technique should be used dressing the wound of a diabetic res	d for lident.	
simple grazes.	ressing	
 Using a non-touch technique avoids contamination by ensuring key elem not touched. 	ents are	

appropriate waste stream.

- Remove disposable gloves and apron and wash hands.
- Always record when the catheter bag is changed.

Overnight drainage bags

If a resident has a leg bag during the day, an additional larger linked drainage bag (night bag) should be used for overnight use. The night bag should be attached to the leg bag to keep the original system intact.

- Always wash hands and wear disposible appendix and glove when attaching a night bag.
- Wipe the leg bag drainage tag with an algohol wipe to reduce the risk of infection.
- Attach the night bag to a struct to ensure that the drainage tap is not touching the floor, to present continuation of the tap.
- When removing the cap from the kiny night bag tube, to prevent contamination, and intection, do not touch the end before attaching it. The onserve tap on the leg bag.
- Night the single to only and should not be reused.
 Empty the urine the hight bag and dispose of the bag in the appropriate waste cream.
 - emove demosable gloves and apron and wash hands.

Jmme

The use of a 'My Catheter Passport' is good practice to help provide continuity of care between health and social care settings.

For further details visit www.infectionpreventioncontrol.co.uk.



2. Good personal hygiene

- For females, it is important after they have passed urine to wipe with toilet paper from front to back and dispose of after each wipe into the toilet or commode.
- Routine personal hygiene should be undertaken a such as a bath or shower.
- If the resident is unable to bathe or shower, staff wash the genital and anal area daily with mild soap warm water.
- When washing the female genital and a bl area, wash, from front to back. The cloth states be rised in war soapy water between each uppe and then discusse of.

Don't ask residents to wait when they need to empty their bladder. Holding a full bladder for they ariods of time can guickly lead to a urinary track exction.

	Colores 1-3 su, ges Normal urine
	1. Clear to purve, surine suggests that the resident is well hydrated.
	2. hight/transparent follow urine suggests an ideal level of Vo. 100
	3. A parker variable honey coloured urine suggests that the real entropy needs to hydrate soon.
	iours 4 suggest the resident needs to rehydrate
	yell a cloudier urine colour suggests the resident is ready a divis.
$\mathbf{\mathbf{Y}}$	5. A larker yellow urine suggests the resident is starting to come dehydrated.
	Amber coloured urine is not healthy. The resident requires more fluid (all fluids count).
	7. Orange/yellow urine suggests the resident is becoming severely dehydrated.
	8. If the urine is this dark, darker than this, red or brown, it may not be due to dehydration. Seek advice from their GP.

18. C. difficile (Clostridioides difficile)

Clostridioides difficile (C. difficile) is a spore-forming bacteria which is an important cause of infectious diarrhoea. *C. difficile* is present in the bowel (gut) of 3-5% of people. Our 'good' buteria (normal flora) keep the growth of *C. difficile* in check. However, when antibiotics are given for an infection, the antibiotics can kill off some of the good bacteria which leaves room for *C. ufficile* to multiply rapidly. The rapid growth of *C. difficile* produces poisons (toxins) that cause inflammation of the bowel and diarrhoea. Diagnosis can be confirmed by law ratory testing of the resident's stools.

Risk factors for C. difficile

The risk factors associated with a wiring difficile are:

- Age incidence is much ther in the aged over 65 years
- Recent antibiotic treatment (Marin 3 meths)
- Recent hospital dmission
- Previous history
 Sigle
- Bowel surgery or lax ves
- Proton 2000, http://www.ication.such as omeprazole

What does d'acile cause?

may have block in it, abdominal pain or tenderness, fever. The illustration can average rious consequences, including death.

How is **C** ifficile spread?

Outbreaks in care homes. It is spread mainly by:

- Contaminated hands of residents and staff
- Contaminated surfaces and care equipment, C. difficile spores can survive on surfaces for months or even years

 When a resident is symptom free for 48 hours and has passed a formed stool (Type 1 to 4 - see below) or their bowel habit has returned to normal, they are no longer infectious and isolation precautions are no longer required. A negative stool specimen is not required.

4. Decontamination

(2 or

ased

Definition of diarrhoea: An

- Toilets should be decontaminated after each episode of prrhoes with a sporicidal chlorine-based disinfectant solution, or equip product as per manufacturer's instructions (see page 31).
- If a commode is used, this should be decontainated after each episode of diarrhoea with a solution as above, suring all surfaces, e.g. arms, underside of seat
- Wash laundry from an infected rest ant as intected lin.
- All equipment must be cleaned a pre removed from the Nom as above.
- Clean resident rooms at least oily with a sporicidal disinfectant as above. Discard chlorine-bas de lutions per 24 hours.
- Deep clean the room, including curves and soft furnishings, when the resident is specified for 18 house and their bowel habit has returned to normal. This workels prevent reinfection.

and 7 ho		L istol stool	form scale
s 5, 6 ; e remen nd warm ith diarr	T de 1		Separate hard lumps, like nuts (hard to pass)
i.e. ty Plea pap ar ents w	Type 2	ester	Sausage shaped, but lumpy
s ho ho or re	Type 3		Like a sausage, but with cracks on its surface
of 24 of 24 i with	Type 4		Like a sausage or snake, smooth and soft
ery or li durat e was · when	Type 5		Soft blobs with clear cut edges (passed easily)
of wate /ithin a must b g water	Type 6	A State	Fluffy pieces with ragged edges, a mushy stool
more) only, w hands runninę	Type 7	-	Watery, no solid pieces, ENTIRELY LIQUID

8. C. difficile (Specific infection)

Norgine Ltd.

Reader in Medicine at the University of Bristol. © 2000

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19. MRGNB, incl.

Preventing Infection Workbook

disinfectant solution (see page 31), or equivalent product as per the manufacturer's instructions.

- Normal laundry procedures are adequate for linen from a resident colonised with MRGNB. Resident's clothing should be wasted at the highest temperature recommended by the manufacture.
- Laundry from a resident infected with MRGNB should be handle and washed as infected linen.
- Crockery and cutlery should be washed as normal.
- The room of a resident who has had an at the infection or diarn should be deep cleaned at the end of the ison for period.

Note

- If required, complete a IHSC transfer form (see page 76).
- Giving antibiotics to as in comath, solonised) residents to clear the organism is no real mment of because it is not actually causes an infection. A tibiotic treatment is only required for a close with cluical signs of MRGNB infection.

Test con knowle ge Please til whe con swer	True	False
1 MRG B are commonly found in the gastro- intesting tract as part of the normal flora.		
When MacGNB causes an infection, it is difficult to treat.		
KGNB can spread by the contaminated hands of residents and staff.		
4. Residents with MRGNB colonisation who have diarrhoea need to be isolated.		

Guidance for Care Homes

20. MRSA (Meticillin resistant Staphylococcus aureus)

MRSA is a variety of a common bacteria *Staphylococcus aureus* which live harmlessly on the skin and in the nose and throat of about 1/3 of people. MRSA is resistant to some of the commonly used antibiotics, e.g. Flucloxacillin.

Where is MRSA found?

MRSA prefers to live in the nose, armpit, groin and wound people. It can also be found in the environment, in dust and been found in hospitals and in care homes.

How is MRSA spread?

From person-to-person by direct such contact, or from contaminated stoppes of care equipment. MRSA carebe spin of the me next person on hands that have not been washed thoroughly.

MRSA colonisation

People carrying Kontobacteria e.g. to their skin, in their nose or in long-standing women over as leg ulcers, who do not have clinical signs of infection are same be colonised, but not infected. The MRSA back is are simply 'hitching a ride' on the surface of the body without causing an infection or illness and are not usually her infunctionality people. These people are infolly never that they are carrying the bacteria. Colonisation may be long-term.

A infectio

People carbecome infected with MRSA when the bacteria enters the body and causes illness, e.g. abscess, boil, local skin infection. It may cause serious illness such as a bloodstream infection (bacteraemia). Signs of infection include fever, pain, redness and increased wound discharge. Urgent medical advice should be sought. If infection is present, antibiotic treatment will be prescribed and suppression treatment may be given.

viral particles than droplets are produced which can remain in the air for longer and travel further than 1 metre

Procedures within care homes which are categorised as AGPs include respiratory tract suction beyond the oro-pharynx oral/pharyngeal suction) and/or cough assisted proced es.

Procedures such as taking a diagnostic throat/nost wab, administration of humidified oxygen, the use of nebun administer medication, are not considered an AGP.

What tests should to be taken?

It is important to obtain viral swabs from synchomatic residents atory and/or staff for the management of esses his will help in the diagnosis of the spirator Illness d sure the correct treatment is given. THEGP will a /ise on the swabs/ tests and treatment required.

Respiratory and cough), iene

Encourage and assist resident with qu respiratory and cough hygiene (see pares 21 and 2).

Management of trest of the the respiratory illness It is important to relate to your all policy for guidance. To help spread of Nepiratory illnesses, standard infection reduce recaules (SICN) should always be followed together control with the llowi principles:

Commication	3. Isolation
2 hy, ene	4. Decontamination.

Com unication

omes should inform their local Infection Prevention and Car Introl (IPC) or UK Health Security Agency (UKHSA) Team if they have a confirmed or suspected case of a respiratory illness that requires isolation.

If the care home is classed as having an outbreak, the care home should be closed to admissions and follow outbreak management procedures.



How is viral gastroenteritis spread?

The virus is present in an infected person's vomit and diarrhoea. A person is infected after swallowing the virus which usually happens by a hand-to-mouth action, e.g. when eating.

Viral gastroenteritis is spread by:

- Contaminated hands of residents, staff and visit.
- Contaminated surfaces and care equipment
- Contaminated food (food can be contaminated when be prepared by anyone infected with viral stroenteritis)

Management of a resident with any strok veritis

Early detection of an outbreak war help reduce the board of infection and the duration of the outbreak. It is important to refer to your local policy for guidance.

To help reduce the spread of iral gas conteritis, standard infection control precaution (St. Ps) should always be followed together with the blowing 4 bey prociples:

1		C	^	m	m		ni	ic	a	F
	•		U			u			a	u

iene

3. Isolation

4. Decontamination.

. Comi in

2. Ha

If you support an outbreak, contact your manager immediately who will liaise with the appropriate agencies.

the en ance informing visitors of the outbreak.

During an outbreak, visitors and non-essential services, e.g. dresser, should be discouraged.

- Obtain stool specimens from all residents and staff with diarrhoea to determine if Norovirus is the cause of the outbreak.
- Staff with symptoms should inform their manager and remain off duty until symptom free for 48 hours.