Infection.
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NHS

Preventing Infection Workbook

Guidance for Care Homes

13th Edition

Name

Job Title

Contents

Manager to tick sections to be completed

1. Introduction

This Workbook has been produced by an NHS Community Infection Prevention and Control (IPC) Team based in North Yorkshire and is based on the IPC Policies we have produced for Care Homes and the *National infection prevention and control manual for England*. This Workbook complements a range of educational resources and bulletins, further information on these is available at www.infectionpreventioncontrol.co.uk.

The Workbook is evidence-based and is intended to be the foundation for best practice in IPC in care home settings. By applying the principles within the Workbook, you will demonstrate commitment to high quality resident care and safety. The *Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Code of practice)*, Department of Health and Social Care, December 2022, states *"Good IPC, including cleanliness, is essential to ensure that people who use health and social care services receive safe and effective care"*.

The *IPC Education Framework*, NHS England, 2023, describes 3 tiers to classify the IPC education requirements of staff. The tiers are incremental, building from tier 1 to tier 3 as follows:

Tier 1 - Everyone working in health and social care settings

Tier 2 - All staff working directly with/providing care to residents and/or who work in a resident environment

Tier 3 - All staff who are responsible for an area of care

The Workbook content is applicable to staff in each of the 3 tiers.

It is designed to be undertaken in stages which allows you to complete the 'Test your knowledge' questions before moving on to the next section / topic. On completion, your Manager will check that you have achieved 100% in your IPC knowledge and sign the 'Certificate of completion'. You should keep the Workbook as evidence of learning and as an on-going reference guide.

Completion of this Workbook helps your Care Home 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 (SICPs)

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 protects residents, visitors and staff. There is often no way of knowing who is infectious, so by applying SICPs to all residents at all times, best practice becomes second nature and the risk of infection to others is minimised.

All care staff involved in the care of residents or who have contact with the resident's environment, must use SICPs.

- In most cases, without a laboratory test it is impossible to tell who has or is carrying an infection. Since every person is a potential infection risk it is essential that all staff apply safe systems of working at every opportunity.
- Safe working practices take the guesswork out of protecting yourself and others as you provide care.

Standard infection control precautions
Hand hygiene
Patient placement and assessment for infection risk
Personal protective equipment
Respiratory and cough hygiene
Safe disposal of waste, including sharps
Safe management of blood and body fluid spillages
Safe 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

Transmission based precautions (TBPs)

In some circumstances, SICPs may be insufficient to prevent the spread of specific infections, and additional 'Transmission based precautions' (TBPs) may need to be taken by staff when caring for residents with a confirmed or suspected infection.

TBPs are categorised by the following routes of transmission

Contact precautions

Used to prevent and control infections spread by direct contact with a resident, or indirectly from a resident's immediate care equipment and environment. This is the most common route of transmission of infection.

Contact TBPs require staff to wear a disposable apron for direct contact with the resident, their care equipment and environment, e.g. helping a resident get out of bed, help with feeding, cleaning. Gloves are required when exposure to blood or body fluids, mucous membranes, e.g. eyes, nose, mouth, or non-intact skin is anticipated and for specific infectious agents. When there is a risk of splashing of body fluids to the face, eye protection and a fluid resistant surgical mask should also be worn

Droplet precautions

Used to prevent and control infections spread over short distances (about 1 metre) via droplets from the respiratory tract of one person directly onto a mucous membrane, e.g. eyes, nose, mouth, of another person. Droplets can travel through the respiratory tract to just before the alveoli (alveoli). Droplet TBPs require staff to wear a disposable apron, gloves, eye protection and a fluid resistant surgical mask. Droplets fall rapidly onto surfaces due to their weight

Airborne precautions

Used to prevent and control infections transmitted via aerosols from the respiratory tract of one person directly onto mucous membranes, e.g. eyes, nose, mouth, of another person. Aerosols can travel further through the respiratory system than droplets, to within the alveoli (endpoint). Aerosols can travel on air currents potentially for hours before they fall onto surfaces because they are much smaller. For advice on airborne precautions, contact your local Community IPC or UK Health Security Agency (UKHSA) Team

4. Hand hygiene

Hand hygiene is the process of handwashing with liquid soap and warm running water, or using an alcohol handrub, to remove microorganisms, such as bacteria and viruses, and prevent the spread of healthcare associated infection.

Hands may become contaminated from direct contact with a resident, handling care equipment and contact with the general environment.

Hand hygiene is one of the most important ways to prevent the spread of infection. Hands may look visibly clean, but micro-organisms are always present, some harmful, some not. Removal of transient microorganisms is the most important factor in preventing them from being transferred to others.

Evidence and national guidance identifies that effective hand hygiene results in a significant reduction in the carriage of harmful microorganisms on the hands.

There are 2 categories of microorganisms present on the skin of the hands	
Transient	Transient microorganisms are found on the surface of the skin. They are called 'transient' as they do not stay long, 'hitching a ride' on the surface of the hands where they are easily transferred to other people, e.g. to a resident's wound, urinary catheter drainage system or to care equipment and the environment. They are easily removed by routine handwashing with liquid soap and warm running water or the use of alcohol handrub
Resident	Resident microorganisms, often referred to as 'normal flora', are found on the hands in the deep layers and crevices and are on the skin of all people. They play an important role in protecting the skin from harmful bacteria and are not easily removed by routine handwashing with liquid soap and warm running water

5. Patient placement and assessment for infection risk

Any new resident to the home should be assessed for their infection risk on arrival and then throughout their stay.

When a resident has a confirmed or suspected infection, they may require additional 'Transmission based precautions' (TBP's), including isolation. Residents who may present an infection risk include those with diarrhoea, vomiting, fever, respiratory symptoms or an unexplained rash.

Wherever possible, the resident should be isolated in their bedroom from others until they are non-infectious. Being isolated from others can be a frightening or frustrating experience and staff should discuss the situation with the affected resident and their family.

If transfer to hospital is required, the ambulance service and hospital department should be notified of the infectious status of the resident.

A patient passport for Interhealth and social care infection control transfer Form (see page 76) should be used with details of the resident's infection status, e.g. confirmed, suspected or no known risk. The form should be given to any person providing further support or nursing/medical care. A form is available to download at www.infectionpreventioncontrol.co.uk.

Test your knowledge *Please tick the correct answer*	**True**	**False**
1. Any new resident to the home should be assessed for their infection risk on arrival.	☐	☐
2. Wherever possible, a resident with a fever should be isolated in their bedroom from others until they are non-infectious.	☐	☐

Glove selection guide	Sterile		Non-sterile			
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	Nitrile	Vinyl	Domestic
Aseptic technique	✓	✓				
Blood/blood stained body fluids				✓		
Body fluids, e.g. urine, faeces			✓		✓	
Clean technique, e.g. dressing pressure ulcers, leg ulcers, dry wounds, simple grazes			✓	✓		
Confirmed or suspected respiratory illness			✓	✓		
Decontamination of care equipment			✓		✓	
Domestic tasks				✓		✓
Sorting soiled laundry			✓	✓		
Urinary catheterisation	✓	✓				
Urine bag emptying/changing/adding overnight bag			✓	✓	✓	
Venepuncture			✓	✓		

Do not routinely wear gloves when feeding residents, giving oral medication, serving food and beverages or administrative tasks.

Aprons

A single use disposable apron should be worn whenever there is a risk of exposure to blood and/or body fluids, non-intact skin, mucous membranes or the resident has a confirmed or suspected infection.

Aprons should also be worn when there is a risk of contamination to the front of uniforms or workwear and before an episode 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:

7. Respiratory and cough hygiene

Respiratory and cough hygiene is designed to minimise the risk of cross transmission of confirmed or suspected respiratory illness (pathogens) to others.

When a person with a respiratory illness coughs, sneezes, talks, millions of bacterial or viral particles are released from the nose and mouth predominantly in the form of droplets which travel in the air, contaminating people and surfaces within a short distance (1 metre).

Respiratory infections can spread directly from an infected person to another person. If the bacteria or virus lands on another person's mucous membranes, e.g. eyes, nose, mouth, it can then enter the body and cause infection.

If the environment is contaminated during coughing, sneezing or by contaminated hands touching surfaces, it can spread to others who touch the area and then touch their eyes, nose or mouth.

Microorganisms, such as bacteria and viruses, can survive in the environment from hours to months, e.g. influenza virus up to 24 hours, COVID-19 up to 72 hours.

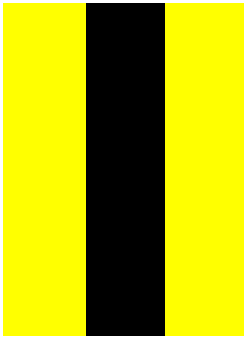
Preventing the spread

Ventilation is very important to reduce the amount of micro-organisms in the air which will contaminate surfaces. Staff should ensure rooms are well ventilated. Windows should be opened regularly, e.g. 10 minutes every hour.

Staff should adopt and promote good respiratory and cough hygiene, encouraging, assisting and advising residents to:

- Cover their nose and mouth with a disposable tissue when sneezing or coughing
- Use a disposable tissue for wiping and blowing their nose

Waste stream guide for Care Home settings

Colour*	Description
**Colour waste streams may vary depending on waste contractors*	
Yellow and black striped bag 	**Offensive waste (non-infectious)** Waste from residents with no confirmed or suspected infection which may be contaminated with body fluids. May be land filled in a permitted or licensed waste facility. Examples are **non-infectious**: • Gloves, aprons, facial protection • Dressings • Stoma or catheter bags • Cardboard vomit/urine bowls[1] • Incontinence pads • Feminine hygiene waste nappies [1] *Liquids, e.g. urine, faeces, vomit, should be discarded into a foul sewer (sluice or toilet). They can, however, be absorbed onto a disposable cloth, e.g. paper towel, and placed in the offensive waste stream, ensuring there is no free flowing liquid present.*
Orange bag or orange lidded sharps container 	**Clinical waste (infectious only)** Waste from residents with confirmed or suspected infection but **not** contaminated with medicines or chemicals. May be treated to render it safe prior to disposal, or alternatively incinerated in a licensed facility. Examples are **infectious**: • Contaminated PPE, e.g. gloves, aprons, facial protection • Items contaminated with urine, faeces, vomit, sputum, pus or wound exudate, e.g. continence pads, urine bags, single use items, single use bowls • Dressings that do not contain an active pharmaceutical product • Waste from blood and/or body fluid spillages • Syringes contaminated with body fluids, but not contaminated with medicines • Used phlebotomy needles and syringe bodies
Yellow lidded sharps container 	**Waste contaminated with non-hazardous pharmaceuticals or chemicals** Sharps waste contaminated with medicines. May be incinerated or undergo alternative treatment in a permitted or licensed facility. Examples are: • Items contaminated with non-hazardous medicines • Used sharps from treatment with non-hazardous medicines

- Always use cold water when diluting chlorine-based disinfectants.
- If the dilution of the disinfectant is incorrect and a weak solution is used, any blood-borne 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 instructions.
- Diluted chlorine-based disinfectant solutions become less effective after 24 hours. When a solution is made, the date and time should be recorded and the solution disposed of after 24 hours.
- To ensure that microorganisms, e.g. bacteria and viruses, are killed, always leave chlorine-based disinfectant solutions for 3-10 minutes contact time or as specified by the manufacturer.
- Chlorine-based disinfectants may damage soft furnishings and carpets. Therefore, detergent and warm water, carpet cleaning machine or steam cleaner, should be used.
- If soft furnishings or other items are heavily contaminated with blood or body fluids that cannot be adequately decontaminated they may need to be disposed of.

Note

- If a mop and bucket are used, they should be in accordance with international colour coding, refer to the 'Safe management of the care environment Policy for Care Home settings'. After use, the mop head should be laundered or disposed of immediately in the appropriate waste stream and the bucket washed with general purpose neutral detergent and warm water and dried with paper towels, and then wiped with a chlorine-based disinfectant at 1,000 ppm available chlorine or equivalent product, as per manufacturer's instructions, and stored upside down to dry.

10. Safe management of care equipment

Decontamination is the process of cleaning and/or disinfection and/or sterilisation to remove or reduce contamination. Decontamination of reusable care equipment after use on each resident is an essential part of routine infection control to prevent the transmission of infection.

1. Cleaning

Cleaning uses fluid and friction to physically remove dirt and microorganisms, e.g. bacteria and viruses, from surfaces or care equipment. The process does not necessarily remove all microorganisms, but it lowers their number and the risk of spreading infection.

Detergent and warm water or detergent wipes should be used for the cleaning of any care equipment that has been in contact with intact skin*, e.g. walking frame, wheelchair. Steam cleaners can also be used effectively for cleaning care equipment. (*Intact skin can be defined as skin in which there are no breaks, grazes, cuts etc.)

2. Disinfection

Disinfection with a disinfectant product works by killing some, but not all, microorganisms on surfaces or care equipment. This process kills microorganisms **only** if cleaning has taken place first.

Disinfectant products can be in the form of wipes, tablets or solutions. Some products are chlorine-based. Always follow manufacturer's instructions for application and contact time.

It is important to allow a disinfected surface to dry naturally. Disinfectants remain active until dry, therefore, it is important to leave 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

- Uniforms and workwear should be washed separately from other clothing to prevent contamination.
- Uniforms should be washed at 60°C. Workwear should be washed at the highest temperature recommended by the manufacturer.
- After washing garments, they should be dried thoroughly, tumble drying or ironing will further reduce any micro-organisms present after washing.

Note

- Don't shake used linen as microorganisms will be dispersed into the air and contaminate the environment.
- Avoid holding used linen and clothing against your body.
- To reduce the risk of infection to staff, water-soluble bags should not be opened before placing in the washing machine.
- Gloves are **only** required to be worn for making beds with clean linen when there is a risk of exposure to blood and/or body fluids or the resident has a confirmed or suspected infection.

Test your knowledge *Please tick the correct answer*	**True**	**False**
1. When handling linen, care should be taken to reduce the risk of spreading infection.	☐	☐
2. A disposable apron and gloves should be worn when handling infected linen.	☐	☐
3. Uniforms and workwear can be washed at home with other clothing.	☐	☐
4. Always avoid holding used linen and clothing against your body.	☐	☐

12. Safe management of sharps and inoculation injuries

An inoculation incident is where the blood/body fluid of one person could gain entry into another person's body, such as:

- A sharps/needlestick injury which breaks the skin with a used instrument or needle
- Spillage of blood or body fluid onto broken skin, e.g. graze, cut, burn, eczema
- Splash of blood or blood stained body fluid into the eye, mouth or nose
- Human bite causing skin to be broken

Many accidental exposures to blood and body fluids are, therefore, not classed as exposure incidents, e.g. splashes onto intact skin.

Good practice to prevent sharps injury

- Clean hands and wear appropriate personal protective equipment (PPE) when handling sharps. Disposable gloves must be worn where there is a risk of exposure to blood or body fluids.
- Use safer sharps devices where available.
- Sharps containers should be taken to the point of use, e.g. a resident's room, using an appropriate tray with an integral sharps container.

- It is the responsibility of the user to dispose of sharps safely into a sharps container at the point of use.
- Never recap, bend or break needles or pass sharps from hand-to-hand.
- Always dispose of the needle and syringe as one unit.
- Always request assistance when using sharps with reluctant or confused residents.

13. Safe management of the care environment

Cleanliness of the environment is important to support infection prevention and control, help reduce the incidence of healthcare associated infection and ensure confidence. All staff, and in particular cleaning/housekeeping staff, play an important role in improving the quality of the environment and maintaining standards. Dust and dirt can allow microorganisms, e.g. bacteria and viruses, to multiply and spread, effective cleaning is, therefore, essential.

- To facilitate effective cleaning, surfaces should be free from clutter, smooth and wipeable.
- The environment should be well maintained, in good state of repair and with adequate ventilation.
- Most microorganisms are found in dust and dirt, so cleaning or vacuuming alone can significantly reduce the number of organisms in the environment.
- Outbreaks of infection have been associated with environmental contamination.

National colour coding scheme

All care homes are recommended to adopt the national colour code for cleaning materials and equipment (see below). All cleaning items, e.g. cloths and mops (reusable and disposable), buckets, aprons and domestic gloves, should be colour coded.

Red	Blue
Bathrooms, showers, toilets, basins and bathroom floors	General areas, including lounges, offices, corridors and bedrooms
Green	**Yellow**
Kitchen areas, including satellite kitchen areas, and food storage areas	Bedrooms when someone has an infection and is cared for in their own room (isolated)

14. Antimicrobial stewardship

An increasing number of common infections are becoming resistant to the antimicrobials used to treat them. This is referred to as 'antimicrobial resistance' (AMR) which is a significant and growing threat to public health in the UK and around the world.

'Antimicrobial stewardship' (AMS) is part of the fight against AMR. The purpose of AMS is to:

- Ensure the right antibiotic for the right person, at the right time, with the right dose and the right route
- Improve antibiotic prescribing and public awareness of AMR

What can care home staff do to tackle AMR?

- Preventing infections spreading through consistent use of 'Standard infection control precautions' (SICPs) and, when required, 'Transmission-based precautions' (TBPs).
- Informing the person in charge of any signs of deterioration in a resident's condition.
- Supporting residents to take any antimicrobial treatment on time and to complete the prescribed course.
- Become an 'Antibiotic Guardian'. Simply make a pledge at http://antibioticguardian.com/.

Test your knowledge *Please tick the correct answer*	True	False
1. Antimicrobial resistance is when infections are resistant to treatments.	☐	☐
2. Antimicrobial stewardship is part of the fight against antimicrobial resistance.	☐	☐
3. Consistent use of 'Standard infection control precautions' can help to tackle AMR.	☐	☐
4. Staff should support a resident to complete their prescribed course of antibiotics.	☐	☐

exhaustive list):

- Dressing wounds less than 48 hours old and those healing by primary intention, e.g. surgical wounds
- Dressing deep wounds that lead to a cavity or sinus
- Inserting an invasive device, e.g. urinary catheter
- If a resident is immunosuppressed, diabetic or at high risk of infection
- Dressing burn wounds

Procedure for dressing a wound

- Staff undertaking an aseptic technique should be free from infection, e.g. colds, sore throats, septic lesions.
- Staff should be 'Bare below the elbows' and wash hands or use alcohol handrub.
- Decontaminate the dressing trolley with detergent and warm water or detergent wipes, clean top to bottom, clean to dirty. Large and flat surfaces should be cleaned using an 'S' shape pattern, starting at the point furthest away, overlapping slightly, but taking care not to go over the same area twice.

- Collect dressing pack and equipment, check all items are in date and packaging is intact. Place on the bottom shelf of the dressing trolley.
- Put on a disposable apron.
- Loosen the adhesive or tape on the existing dressing.
- Decontaminate hands again.
- Open sterile dressing pack. Add any extra items without compromising the sterile field.
- Use the waste bag like a glove to arrange the items on the

16. Specimen collection

A specimen is a sample of body fluid collected, e.g. urine, faeces, sputum. All specimens are a potential infection risk so must be collected using 'Standard infection control precautions' (SICPs) and transported in a sealed rigid container.

Taking routine specimens, with the exception of blood samples, **should be avoided** to help reduce inappropriate prescribing of antibiotic treatment. Specimens should only be taken if there are signs of a clinical infection (see indications in table below) or instruction from of a GP or nurse.

Specimen collection and storage

- Wash hands before and after specimen collection and wear appropriate personal protective equipment (PPE).
- Specimens must be labelled correctly including relevant clinical details and any recent antibiotic history.
- Wherever possible, obtain a fresh specimen. Specimens should be sent in the correct container as soon as possible.

Specimen	Indication	Container and storage
Wound swab	Swelling, redness, heat, a yellow or green discharge, increased discharge of fluid, wound breakdown, fever.	Sterile cotton swab in transport medium. Charcoal medium increases survival of bacteria during transportation.
Sputum	Productive cough (green/yellow) or presence of blood in sputum.	Plain universal container (white top*). 
Urine	Refer to signs and symptoms of UTI on page 8.	Universal container with boric acid preservative (red top*) should be filled to the 'fill line'. 
Faeces (stools)	Diarrhoea, increase in frequency, presence of blood, abdominal pain.	Stool specimen container (blue top*) , at least 1/3-1/2 full or as per local policy. 

* Specimen container type and colour top may vary depending on the manufacturer.
** Do not use urine dipsticks for catheterised adults and the over 65's.

contamination and infection, do not touch the end of the catheter.

- When removing the cap from the new catheter bag tube, to prevent contamination and infection, do not touch the end of the tube.
- Empty the urine from the bag and dispose of the bag in the appropriate waste stream.
- Remove disposable gloves and apron and wash hands.
- Always record the date 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 disposable apron and gloves when attaching a night bag.
- Wipe the leg bag drainage tap with an alcohol wipe to reduce the risk of infection.
- Attach the night bag to a stand to ensure that the drainage tap does not touch the floor, to prevent contamination of the tap.
- When removing the cap from the new night bag tube, do not touch the end before attaching it to the drainage tap on the leg bag to prevent contamination and infection.
- Night bags are single use only and should not be reused. Empty the urine from the night bag and dispose of the bag in the appropriate waste stream.
- Remove disposable gloves and apron and wash hands.

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 daily.
- If the resident is unable to bathe or shower, staff should wash the genital and anal area daily with mild soap and warm water.
- When washing the female genital and anal area, wash from front to back.

Don't ask residents to wait when they need to empty their bladder. Holding a full bladder for long periods of time can quickly lead to a UTI.

Colours 1-3 suggest normal urine	
	1. Clear to pale yellow urine suggests the resident is well hydrated.
	2. Light/transparent yellow urine suggests an ideal level of hydration.
	3. Darker yellow/pale honey coloured urine suggests that the resident may need to rehydrate soon.
Colours 4-8 suggest the resident needs to rehydrate	
	4. A yellow, cloudier urine colour suggests the resident is ready for a drink.
	5. Dark yellow urine suggests the resident is starting to become dehydrated.
	6. Amber coloured urine is not healthy. The resident requires more liquid. All fluids count (except alcohol).
	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.
Note: Some medications, supplements and foods, can affect the colour of urine.	

- 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

- Toilets should be decontaminated after each episode of diarrhoea with a sporicidal chlorine-based disinfectant solution (see pages 31 and 32) or equivalent product, as per manufacturer's instructions.
- If a commode is used, this should be decontaminated after each episode of diarrhoea with a solution as above, ensuring all surfaces, e.g. arms, underside of seat, are cleaned.
- Wash laundry from an isolated resident as infected linen.
- All equipment must be cleaned before removal from the room as above.
- Clean the resident's room at least daily with a sporicidal disinfectant as above. Discard chlorine-based solutions after 24 hours.
- Deep clean the room, including curtains and soft furnishings, when the resident is symptom free for 48 hours and their bowel habit has returned to normal. This will help prevent reinfection.

Definition of diarrhoea: An increased number (2 or more) of watery or loose stools, i.e. two Type 5, 6 and 7 only, within a duration of 24 hours. Please remember: hands must be washed with liquid soap and warm running water when dealing with residents with diarrhoea.

Bristol stool form scale

Type 1	Separate hard lumps, like nuts (hard to pass)
Type 2	Sausage shaped, but lumpy
Type 3	Like a sausage, but with cracks on its surface
Type 4	Like a sausage or snake, smooth and soft
Type 5	Soft blobs with clear cut edges (passed easily)
Type 6	Fluffy pieces with ragged edges, a mushy stool
Type 7	Watery, no solid pieces, ENTIRELY LIQUID

disinfectant solution (see pages 31 and 32) 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 washed at the highest temperature recommended by the manufacturer.
- Laundry from a resident who is isolated with MRGNB should be handled and washed as infected linen.
- Crockery and cutlery should be washed as normal.
- The room of a resident who has had an active infection or diarrhoea should be deep cleaned at the end of the isolation period.

Note

- If required, complete the relevant transfer form (see page 76).
- Antibiotic treatment is only required for people with clinical signs of MRGNB infection. Giving antibiotics to asymptomatic (colonised) residents to clear the organism is not recommended because it is not actually causing an infection.

Test your knowledge *Please tick the correct answer*	**True**	**False**
1. MRGNB are able to resist many commonly used antibiotics.	☐	☐
2. MRGNB are a problem for healthy people.	☐	☐
3. The majority of people with MRGNB are colonised and do not require antibiotics.	☐	☐
4. Contact 'Transmission based precautions' and isolation are required when a resident with MRGNB has diarrhoea.	☐	☐

MRSA screening

In accordance with national guidance, screening of some patients is undertaken by hospitals. Screening is not usually required in a care home.

If a MRSA positive result is diagnosed after a resident has been discharged from hospital, the GP will be informed and, if appropriate, will prescribe suppression treatment.

Suppression treatment

The aim of suppression treatment is to reduce the number of MRSA bacteria to a less harmful level. Treatment usually consists of a 5 day course of an antibacterial body wash and hair treatment, as well as a nasal ointment. At the end of the 5 day course, swabs to check for MRSA clearance are not usually required.

Management of a resident with MRSA

It is important to refer to your local policy or guidance. To help reduce the spread of MRSA, 'Standard infection control precautions' (SICPs) should always be followed together with the following 4 key principles:

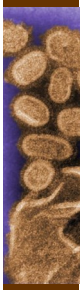
1. Communication	3. Resident placement
2. Hand hygiene	4. Decontamination

Communication

- There is no justification for refusing to admit residents with MRSA.
- Staff should be aware that if a resident has MRSA in a wound, it should be covered with a dressing.

Hand hygiene

- Clean hands using liquid soap and warm running water or alcohol handrub. Alcohol handrub is effective against MRSA if hands are visibly clean.
- Encourage residents to wash their hands or use skin wipes to clean clean hands after using the toilet and before meals.



22. Respiratory illnesses

Respiratory illnesses are predominantly due to a viral infection. They are amongst the most common winter ailment and are a major cause of hospitalisation, ill health and death among the elderly. Those suffering from underlying chronic health conditions become more susceptible and vulnerable to severe disease. Vaccination provides the best protection against respiratory illness and spreading infection.

Acute respiratory illnesses include influenza (flu), COVID-19, human metapneumovirus, respiratory syncytial virus (RSV), parainfluenza and rhinovirus.

Respiratory illness symptoms vary but commonly include a continuous cough, high temperature, shortness of breath, body aches and tiredness.

How are respiratory viruses spread?

Respiratory viruses are spread by:

- Predominately droplet transmission. Droplets are generated during coughing, sneezing, talking. If droplets from an infected person come into contact with the mucous membranes, eyes, nose, mouth, of another person, they can cause infection. Droplets remain in the air for a short period and can travel about 1 metre. They can land on surfaces and care equipment and, if touched, infect others if that person then touches their eyes, nose or mouth
- Aerosol transmission is usually associated with an aerosol generating procedure (AGP). An AGP is a medical procedure that can result in the release of airborne particles (aerosols) from the respiratory tract, when treating someone with a confirmed or suspected virus. During an AGP, smaller viral particles than droplets are produced which can remain in the air for longer and travel further than 1 metre

How is viral gastroenteritis spread?

The virus is usually spread from the vomit and diarrhoea of an ill person. When vomiting or diarrhoea occurs, a fine mist (particles) containing the virus is introduced into the air and can be easily spread to others in a wide area from:

- Direct contact with an infected person
- Contact with contaminated surfaces or care equipment
- Swallowing viral particles that are in the air
- Eating/drinking food or water contaminated with viral particles
- Consuming contaminated food

Management of a resident with viral gastroenteritis

Early detection will help reduce the spread 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 viral gastroenteritis, 'Standard infection control precautions' (SICPs) should always be followed together with the following key principles:

1. Communication	3. Resident placement
2. Hand hygiene	4. Decontamination.

1. Communication

- If you suspect an outbreak, inform your manager immediately.
- The home should be closed to admissions and display a notice at the entrance informing visitors of the outbreak and the precautions they should follow.
- During an outbreak, non-essential services should be discouraged.
- Obtain stool specimens from all residents and staff with diarrhoea to determine the cause of the outbreak.
- Staff with symptoms should inform their manager and remain off duty until symptom free for 48 hours.

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July 2025

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