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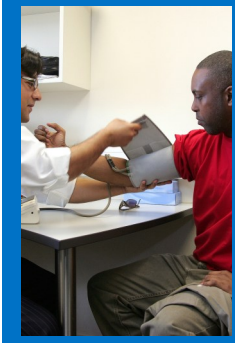
NHS



Preventing Infection Workbook

Guidance for General Practice 6th 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. It is based on the IPC Policies we have produced for General Practice and the *National infection prevention and control manual for England.* This Workbook complements a range of educational resources and bulletins, further information is available at **www.infectionpreventioncontrol.uk.**

The Workbook is evidence-based using national guidance and is intended to be the foundation for best practice for IPC. Applying the principles within the Workbook demonstrates a commitment to high quality care and patient 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, including antimicrobial stewardship (AMS). The tiers are incremental, building from tier 1 to tier 3 as follows:

Tier 1 - Everyone working in health and social care settings

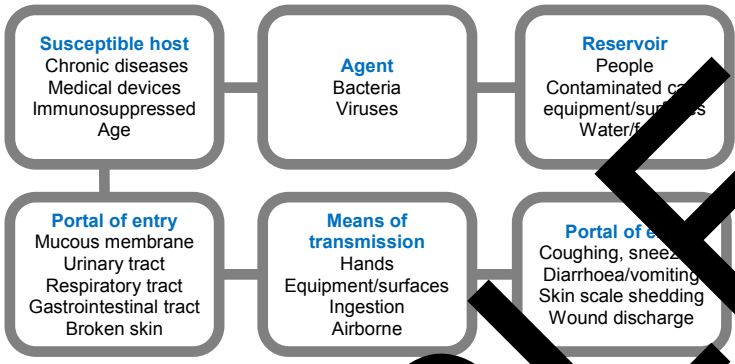
Tier 2 - All staff working directly with/providing care to patients and/or who work in the clinical environment

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

The Workbook provides the IPC knowledge required to underpin the standards of practice expected from staff across each of the 3 tiers. It is designed to be undertaken in stages which allows you to complete the 'Test your knowledge' sections before moving onto the next section. On completion, your Manager will check that you have achieved 100% in IPC knowledge and sign the 'Certificate of completion'. You should keep it as evidence of learning and as an on-going reference guide.

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

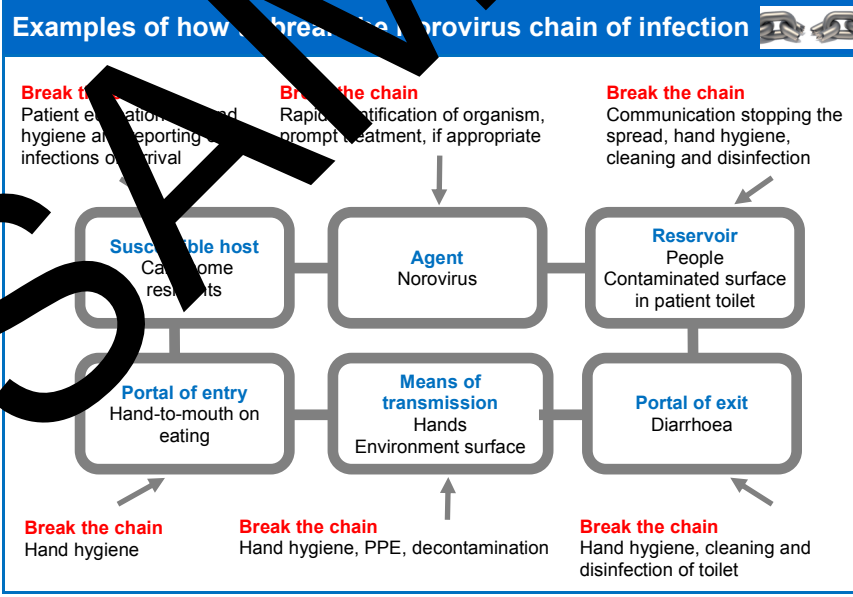
Examples of the chain of infection



Case study: Chain of infection showing how Norovirus can be spread

Janet had symptoms of vomiting and diarrhoea, but still attends the GP surgery for her flu vaccine. Whilst waiting for her appointment she passes type 6 stools in the patient toilet. She informs the receptionist, however the toilet is not put out of use whilst awaiting to be cleaned. Margaret uses the patient toilet and does not wash her hands. The next day, Margaret visits her grandmother in a care home resident, and assists her with eating her homemade biscuits. Both Margaret and her grandmother start with diarrhoea and vomiting. Norovirus outbreak spreads through the care home.

Examples of how to break the Norovirus chain of infection



3. SICPs and TBPs

Standard infection control precautions (SICPs)

There are a number of SICPs, see table below. These underpin routine safe practice and break the chain of infection which protects both patients and staff. There is often no way of knowing who is infectious, so by applying SICPs to all patients and at all times, best practice becomes second nature and the risk of infection is minimised.

- 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 well as providing care.

SICPs must be used by all General Practice staff in all situations for contact with patients, care equipment and the general care environment.

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

Bare below the elbows

'Bare below the elbows' (BBE) facilitates good hand hygiene. BBE is about exposing the forearms and being free from wrist and hand jewellery, including dermal piercings (other than one plain band ring). A religious bangle can be worn, but should be moved up the forearm during hand hygiene and secured during patient care activities. Disposable oversleeves, if worn, must be removed and disposed of before hand hygiene is performed. Nails should be short, free from nail varnish, false or gel nails and nail jewellery. Long sleeves, if worn, should be rolled or pushed up to the elbows.

Hand cleaning methods

Handwashing (using the technique shown on page)

Wash hands with liquid soap, water and drying with paper towels when:

- Hands are visibly soiled or dirty
- Seeing a patient who has symptoms of vomiting or diarrhoea
- Seeing a patient with a confirmed or suspected gastrointestinal infection, e.g. norovirus, *C. difficile*

Non-alcohol skin wipes can be used when it is not possible to perform handwashing, e.g. home visits with inadequate hand hygiene facilities. This should be followed by the use of alcohol handrub or equivalent product, and staff must wash their hands at the first opportunity.

Alcohol handrub (using steps 2-8 of the technique on page 15)

In all circumstances, except those listed above, alcohol handrub or equivalent product, offers a practical and acceptable alternative to handwashing for routine hand hygiene.

Surgical hand antisepsis

Liquid soap and warm water followed by alcohol handrub licensed for surgical rubbing, or the use of an antibacterial solution licensed for surgical scrubbing, removes transient as well as resident microorganisms. This level of hand hygiene should be used prior to minor surgery. Alcohol handrub licensed for surgical rubbing can be used between procedures.

- Ensure hand hygiene facilities are available, e.g. wall mounted liquid soap, paper hand towels, alcohol handrub.
- PPE should be worn, applied and removed correctly.
- A foot pedal operated lidded waste bin with a liner should be available and waste disposed of as infectious waste.
- Where possible, ensure good ventilation by opening windows.

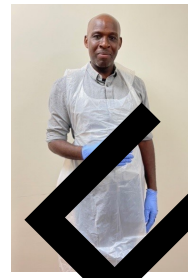
Decontamination of the room or area

- The room or area used for isolation should be decontaminated, e.g. cleaned and disinfected, after use.
- If the room or area cannot be decontaminated immediately, a notice should be displayed stating 'Isolation area - awaiting deep clean, do not enter'.

If transfer to hospital is required, the ambulance service and hospital department should be notified of the infectious status of the patient. Documentation such as a patient passport or 'Inter-health and social care infection control transfer Form', should be completed with details of the patient's infectious status, e.g. confirmed risk, suspected risk 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. Signage is recommended which instructs patients with symptoms of infectious conditions to inform reception staff immediately on their arrival.	☐	☐
2. It is important to follow national guidance for certain infections or new emerging infections.	☐	☐
3. A designated room or area should be clutter free.	☐	☐
4. Decontamination of the room or area used for isolation is not required after use.	☐	☐

Aprons



Disposable aprons should be worn as single use items for one procedure or episode of patient care.

An organisation can procure colour coded aprons if it wants to limit the likelihood the same apron will be worn in different risk areas.

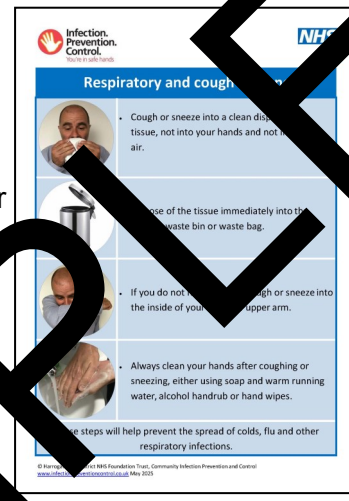
Facial protection

- Facial protection includes eye protection, visors, fluid resistant surgical masks and FFP3 respirator masks.
- Appropriate facial protection should be worn when there is a risk of splashing of blood and/or body fluids **or** substances hazardous to health, e.g. cleaning/disinfecting products, to the face, or the patient has a confirmed or suspected infection transmitted by the droplet or airborne route (see page 10), such as flu, pulmonary TB, rubella, measles.
- For any new or emerging infections, refer to the national IPC guidance on the requirements for facial protection.
- Eye protection must be disposable or reusable. Prescription glasses are not considered as eye protection.
- Facial protection must not be touched when being worn.
- FFP3 (respirator) masks are rarely required in General Practice. Advice on wearing these is issued by the UK Health Security Agency (UKHSA). When either a disposable or reusable FFP3 mask is required, staff must have been fit tested and also perform a fit check each time a mask is worn.

Oversleeves

- Oversleeves must be changed immediately after each patient and/or after completing a procedure or task, even on the same patient, and hand hygiene performed.
- Removed and disposed of if visibly contaminated.

- To cover their nose and mouth with a disposable tissue when sneezing or coughing and using a disposable tissue for wiping and blowing their nose
- To wash their hands with liquid soap and warm running water or use an alcohol handrub after coughing, sneezing, wiping or blowing their nose
- To cough or sneeze into the inside of the elbow or upper arm if a tissue is not available, not into their hands and not into the air
- To dispose of used tissues promptly into a waste bin



A 'Respiratory and cough hygiene Poster' is available to download from www.infectionpreventioncontrol.co.uk

Test your knowledge *Please tick the correct answer*	**True**	**False**
1. Bacterial and viral particles released from the nose and mouth in droplets can travel in the air for a short distance.	☐	☐
2. Respiratory infections can spread directly from an infected person to another person.	☐	☐
3. Ventilation by opening windows can reduce the amount of microorganisms in the air.	☐	☐
4. Cleaning hands with liquid soap and warm water or alcohol handrub is not required after sneezing, wiping or blowing your nose.	☐	☐

Waste stream guide for General Practice (continued)	
Colour *	**Description**
Yellow bag or yellow lidded sharps container	**Waste contaminated with non-hazardous pharmaceuticals or chemicals** Examples are: • Pharmaceutically contaminated sharps and syringe bodies • Contaminated dressings that contain active pharmaceutical properties
Purple bag or purple lidded sharps container	**Cytotoxic or cytostatic medicine waste** Examples are: • Medicine containers with residues of cytotoxic or cytostatic medicines (bottles, infusion bags, syringe bodies) • Items contaminated with cytotoxic or cytostatic medicines, e.g. swabs • Used sharps from treatment using cytotoxic or cytostatic medicines
Blue lidded sharps container	**Medicinal waste classified as non-hazardous** (non-infectious, non-cytotoxic and non-cytostatic). Examples are: • Unused medicines in original packages • Part-full containers containing residues of medicines • Empty medicine bottles
Black bag	**Domestic/municipal waste** (includes items normally found in household waste). Examples are: • Unsoiled couch roll • Food waste • Paper towels

Note: your waste streams may vary depending on waste contractors - check with your waste contractor before implementing the above guidance.

Sharps containers

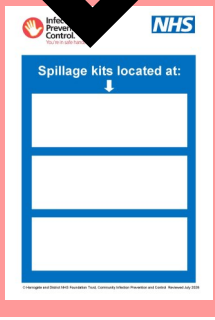
- Must only be used for the disposal of sharps.
- Should be the correct size and colour according to usage.
- Must be assembled correctly in line with the manufacturer's instructions, ensuring the lid is snapped firmly in place all around the rim to avoid spillage or injury.

bucket disinfected with the appropriate disinfectant or equivalent product, cleaned and stored upside down to air dry.

If soft furnishings or other items are heavily contaminated with blood or body fluids and cannot be adequately decontaminated, they should be disposed of in the appropriate waste stream.

Note

- Some spillage kits contain solidifying polymer granules. A National Patient Safety Agency Alert was issued following a number of deaths and incidents related to patients ingesting the product. The Alert advises a risk assessment and establishment of procedures to ensure supplies are securely stored away from the general public.
- All staff need to be trained on the use of spillage kits and be aware of where they are stored.
- Good practice is to display signs indicating where spillage kits are stored. A spillage kit location Poster is available to download at www.infectionpreventioncontrol.co.uk.



Test your knowledge *Please tick the correct answer*	True	False
1. When dealing with spillages, appropriate personal protective equipment is not required.	☐	☐
2. The manufacturer's instructions should be followed when using a spillage kit.	☐	☐
3. If a mop and bucket is used, the mop head should be disposed of and the bucket disinfected.	☐	☐
4. Heavily contaminated items that cannot be adequately decontaminated should be disposed of in the appropriate waste stream.	☐	☐

10. Safe management of care equipment

Cleaning and/or disinfection and/or sterilisation are known as decontamination. Safe decontamination of reusable medical equipment and care equipment before its first use and after each use is an essential part of routine infection control to prevent the transmission of infection.

There are 3 levels of decontamination that can be used	
1. Cleaning	Is a process which physically removes dirt, dust, body fluids and thereby lowers the number of microorganisms, e.g. bacteria and viruses present.
2. Disinfection	Is a process which removes or kills pathogenic (disease causing) microorganisms using a disinfectant agent or method.
3. Sterilisation	Is a process for the complete destruction or removal of microorganisms, including spores.

1. **Cleaning - for items in contact with intact skin and non-infectious patients**
   Detergent wipes or general purpose neutral detergent, warm water and single use cloths should be used for the cleaning of any reusable medical or care equipment, e.g. examination couch, disposable pillow case, stethoscope, doppler, that has been in contact with intact skin (for example skin which has no breaks, grazes, cuts). Cleaning is essential before disinfection or sterilisation is carried out.

2. **Disinfection - follows cleaning, for items in contact with non-intact skin, mucous membranes, body fluids, confirmed or suspected infectious patients**
   Disinfectants are not effective if dirt or visible soiling is present.

   Disinfectants can be in the form of a wipe, tablets or liquids.

11. Safe management of linen, including uniforms and workwear

Linen or fabric items are not recommended for use as it is not practical to launder them between each patient.

Routine use of disposable couch roll is not required as the couch should be cleaned after each patient. When required disposable couch roll can be used to cover the couch, pillow, or maintain the patient's modesty for procedures where this is required and disposed of after each use.

Pillows, if used, should be encased in an undamaged, sealed wipeable plastic cover and decontaminated after each use.

All blinds, curtains and screens (disposable or fabric) should be visibly clean with no blood, bodily substances, dust, dirt, debris, stains or spillages. The frequency of changing/cleaning is determined by assessing each functional area containing window blinds, curtains and screens, and assigning the area to one of the six functional risk (FR1-6) categories. Fabric curtains or screens should be laundered by a professional laundry service.

Washing uniforms or clothing worn at work

It is good practice to change in and out of uniform at work, or completely cover uniform when travelling to and from work.

It is not good practice to wear neckties (other than bow ties) or lanyards during direct patient contact.

Always:

- Wear a clean uniform at the start of each shift and have enough uniforms to facilitate this

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 with a used instrument or needle
- Spillage of blood or body fluid onto damaged skin, e.g. graze, cut, rash, burn
- Splash of blood or blood stained body fluid into the eyes, nose or mouth
- Human bite causing skin to be br

Many accidental exposures to blood and body fluids are not classed as inoculation incidents e.g. splashes onto intact skin. In these circumstances, washing the contaminated area thoroughly with liquid soap and water/running water is all that is required. Exposure to sterile sharps are also not considered to be inoculation injuries.

Good practice to prevent a needlestick/sharps injury

- Where possible use safety sharps devices which have a protection mechanism incorporated, ensuring the mechanism is deployed before disposal.
- **Never** recap needles due to the high risk of injury.
- Dispose of the needle and syringe as one unit. If it is necessary to detach the needle, great care must be taken, preferably using the device on the sharps container.
- Sharps should be disposed of at the point of use by the person using the sharp.
- Never pass used sharps from person-to-person as it increases the risk of injury.
- Request assistance when using sharps with reluctant or confused patients.

Red Sanitary areas including sinks in sanitary areas	**Blue** General areas, e.g. waiting/ consulting rooms and sinks in general areas
Green Kitchens	**Yellow** Isolation, treatment and minor operation rooms

- Cleaning cloths should be single use.
- All products used for decontamination must be within their expiry date.
- Cleaning equipment should be cleaned, dried or left to air dry after use and not left to soak overnight.
- Reusable mop heads should be replaced regularly depending on the frequency of use and laundered whenever visibly stained.

Cleaning products

When using cleaning products, always use the appropriate personal protective equipment (PPE), e.g. disposable apron and gloves, and wear facial protection if there is a risk of splashing to the face.

Detergents

Use general purpose neutral detergent, warm water and single use cloths or detergent wipes.

Disinfectants

Disinfectants are not required for routine cleaning.

Disinfection should be performed following a consultation/ treatment with a patient who has a confirmed or suspected infection. It should also be used following contamination with blood or body fluids (refer to the 'Safe management of blood and body fluid spillages', see pages 30-31).

Cleaning is essential before disinfection is carried out, unless a

14. Antimicrobial stewardship

Antimicrobial resistance (AMR) is a significant and growing threat to public health in the UK and around the world.

Staff in General Practice are the first point of contact for and manage the vast majority of patients with infection and infectious disease. Antimicrobial stewardship (AMS) is part of the fight against AMR. The purpose of AMS is to:

- Ensure the right antibiotic for the right patient, at the right time, with the right dose and the right route, causing the least harm to the patient and future patients
- Prevent overuse, misuse and abuse of antimicrobials

What is needed in General Practice to tackle AMR?

- Optimal infection prevention and control practice through consistent use of SICPs and, where required, TBPs.
- Each General Practice should have an AMS Lead.
- Timely, accurate diagnosis of infection in patients when they develop symptoms (see section 16).
- Appropriate prescribing and use of antimicrobials in accordance with local antimicrobial prescribing policies and national guidance.
- General Practice staff should encourage patients to use antibiotics responsibly.

Test your knowledge *Please tick the correct answer*	True	False
1. Antimicrobial stewardship (AMS) is part of the fight against antimicrobial resistance.	☐	☐
2. AMS aims to prevent the overuse, misuse and abuse of antimicrobials.	☐	☐
3. General Practices should have an AMS Lead.	☐	☐

significant wounds that are less than 48 hours old, cavity wounds or wounds of patients who are significantly immunosuppressed, have diabetes or are at high risk of infection.

Aseptic technique competency

- Only staff trained and competent in an aseptic technique should undertake the procedure.
- An 'Aseptic technique competency: Annual Assessment Tool' should be completed on an annual basis. Available to download at www.infectionpreventioncontrol.co.uk.
- Training records and audit tools should be available for inspection.

Summary for wound dressings		
Description	**Aseptic technique**	**Clean technique**
Gloves	Sterile	Non-sterile
Dressings	Sterile	Sterile
Cleansing solution	Sterile water/saline/ antiseptic	Tap water (drinking quality)

Symbols and their meaning	
2028-01-31 Use by date, i.e. use by 31 January 2028	2026-01 Date of manufacture, i.e. manufactured during January 2026
Do not reuse, single use, use only once	**LOT ABC123** Batch code

16. Specimen collection

A specimen is a sample of human tissue or body fluid, such as blood, urine, faeces, pus or sputum, taken from a patient to identify microorganisms, e.g. bacteria and viruses, that cause disease and to provide medical direction for appropriate treatment. Sometimes, specimens are obtained for monitoring purposes, e.g. checking for blood and kidney disease.

All specimens are a potential infection risk to staff and should be handled and transported safely. Therefore, all specimens must be collected using 'Standard infection control precautions'.

Microscopy, culture and sensitivities (MC&S) is the process in which microorganisms and their antimicrobial sensitivities are identified.

Specimens for MC&S should only be taken if there are indications of a clinical infection (see tables, pages 51 and 52). This helps reduce the risk of inappropriate antibiotic prescribing.

Wherever possible, aim to obtain a fresh specimen. As much relevant clinical information, e.g. symptoms, current or recent antibiotic treatment, recent travel abroad, should be included on the specimen form to ensure the most appropriate tests are undertaken in the laboratory.

Taking specimens in General Practice or the community

- Wash hands before and after specimen collection.
- Wear appropriate personal protective equipment (PPE).
- Care should be taken not to contaminate the specimen, the outer container or label.
- Ensure the lid is securely closed and place the container in the plastic transport bag.

- Specimens should be labelled correctly, all details completed on the form and placed in the appropriate specimen bag.

17. Venepuncture

Venepuncture is the procedure of entering a vein with a needle in order to obtain a sample of blood.

Venepuncture breaches the circulatory system, therefore, to minimise the risk of injury and/or infection to staff and patients 'Standard infection control precautions' (SICPs) and where required, 'Transmission based precautions' (TBPs) should be applied.

The procedure should only be undertaken by appropriately trained and competent staff.

Venepuncture complications

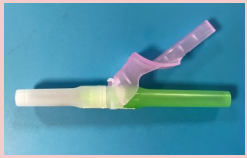
Each step in the process carries risks for both the patient and the member of staff.

Staff are at risk of transmission of a blood-borne virus if a sharps injury occurs from a contaminated venepuncture needle.

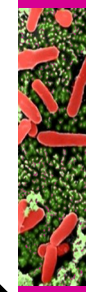
Patients are at risk of haematoma, accidental arterial puncture, nerve damage or infection. Infection is rare at the venepuncture site, but is a risk as microorganisms from the patient's own skin flora and those from the member of staff or environment can be introduced into the bloodstream.

Best practice

- Check items are within the expiry date and the packaging is intact.
- Where possible, use a safer sharp device to reduce the risk of accidental injury.



- Perform hand hygiene before and after the procedure.
- Single use tourniquets should be disposed of after each use.



Prevention of *C. difficile*

The main methods of preventing *C. difficile* are:

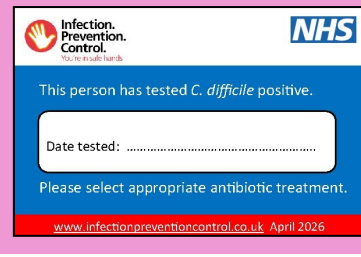
- Good antimicrobial stewardship following your local 'Antimicrobial stewardship Policy', ensuring antibiotics are only prescribed when necessary
- Hand hygiene with liquid soap and warm running water after contact with each patient (and their environment if a home visit is undertaken, including immediately prior to leaving)

Precautions for *C. difficile* colonisation or infection

- Always use 'Standard infection control precautions' (SICPs) and, where required, 'Transmission based precautions' (TBPs) should be used on a risk assessed basis.
- Alcohol handrub is not effective against *C. difficile.*
- If a patient has been symptomatic in the past 48 hours (or has an episode of diarrhoea whilst in the General Practice), the immediate environment, such as couch, work surfaces, toilet, should be cleaned and then disinfected with a sporicidal disinfectant product (see sections 10 and 13).
- Communicate *C. difficile* status to any receiving health and social care providers (see page 18).

Note

- There are a number of local initiatives across the country where patients with *C. difficile* are provided with a '*C. difficile* card' which helps to alert care professionals of their *C. difficile* diagnosis and to help make the correct decisions about their treatment, particularly, PPI's, antibiotics and antimotility agents.



19. MRGNB, including CPE

Some types of Gram-negative bacteria, which live naturally in the gut, have developed the ability to be resistant to many commonly used antibiotics. These bacteria are known as Multi-resistant Gram-negative bacteria (MRGNB). Not only are these bacteria resistant to antibiotics, but they can also pass on this resistance to other types of bacteria. The types of bacteria that most commonly develop this ability include:

- *Escherichia coli (E. coli)*
- Klebsiella
- Pseudomonas
- Enterobacter
- Acinetobacter

If MRGNB cause an infection, for example urinary tract infection, pneumonia or wound infection, they are very difficult to treat as they are resistant to many antibiotics.

Over recent years, another type of MRGNB known as carbapenemase-producing Enterobacterales (CPE) has been identified. These resistant strains of bacteria produce an enzyme that destroys the powerful group of antibiotics, such as imipenem which is used in hospitals. Until now, these have been the 'last resort' antibiotics relied on when other antibiotics have failed to treat infections.

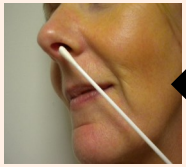
In the UK, over the last number of years, there has been a rapid increase in infection and colonisation by CPE bacteria causing a number of outbreaks.

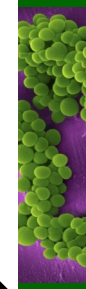
It is important to remember that MRGNB are not usually a problem to people who are healthy, but are a risk to vulnerable people.

Routes of transmission

MRSA can be spread by:

- **Direct contact:** person-to-person, e.g. touching or dressing a wound
- **Indirect contact:** medical devices, care equipm t or care environment that have not been appropriately decontaminated

How to take a nasal swab for MRSA s ening	
	• Wash hands, apply apron nd non-steril gloves. • Place a few ops of e er steri 9% sodium chl de or st le water onto the swab taking are no ntaminate the swab.
	• Place t of the wab inside the nostril at the angl shown. is not ne essa to insert the swab too far into t nos il.
	• Gentl tate the swab ensuring it is touching inside of the nostril. • Repeat the process using the same swab for the other nostril.
	• Place the swab into the container. • Remove and dispose of gloves and apron and clean hands. • Complete patient details on the container and specimen form. Request 'MRSA screening' under clinical details on the form.



- Repeat screening and suppression treatment is not required unless the patient has recurrent infection, is particularly vulnerable, poses a special risk to others, e.g. healthcare worker, or spread of infection is continuing in close contacts.
- Communicate PVL-SA status to any receiving health and social care providers (see page 18).

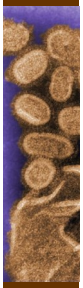
Note

- An advice sheet 'PVL-SA Information for service users' is available to download at www.infectionpreventioncontrol.co.uk

It's a fact

- Panton and Valentine were two doctors who discovered this toxin which kills white blood cells (leukocytes), and is known as 'leukocidin'.
- PVL-SA boils are reported as particularly painful in comparison to their size and can leave a scar when healed.

Test your knowledge *Please tick the correct answer*	True	False
1. PVL-SA produces a toxin which destroys white blood cells.	☐	☐
2. PVL-SA should be suspected if a patient has recurrent boils, abscesses, or if there is a history of PVL-SA in any close contact.	☐	☐
3. Risk factors for PVL-SA include close contact sports, living is closed communities or having a compromised skin integrity.	☐	☐
4. Repeat screening after suppression treatment is always required.	☐	☐



22. Respiratory illnesses

Respiratory illnesses are a major cause of hospitalisation, morbidity and death in the elderly and are amongst the most common winter ailments, predominantly due to a viral infection. People suffering from underlying chronic health conditions become more susceptible and vulnerable to severe disease. Vaccination provides the best protection against acquiring or spreading specific respiratory infections.

Acute respiratory infections of public health significance include influenza (flu), COVID-19 and *Streptococcus pneumoniae*.

Other viral infections, such as human metapneumovirus, respiratory syncytial virus (RSV), parainfluenza and rhinovirus, are not usually considered to be of public health concern.

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

Routes of transmission

Respiratory viruses are spread by:

- Predominantly droplet transmission. Droplets are generated during coughing, sneezing, talking. If droplets from an infected person come into contact with the mucous membranes, e.g. 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 equipment and can infect others if touched and the person then has contact with their eyes, nose, mouth
- Aerosol transmission is usually associated with an aerosol generating procedure (AGP). An AGP can result in the release of airborne particles (aerosols) from the respiratory tract, when treating someone with a confirmed or suspected viral infection. During an AGP, smaller viral particles than

23. Viral gastroenteritis/Norovirus

Viral gastroenteritis is usually caused by a virus known as Norovirus, other less common causes include Rotavirus and Sapovirus. The incubation period for viral gastroenteritis ranges from 24-48 hours, but cases can occur within 12 hours of exposure.

Viral gastroenteritis is highly infectious and can spread easily from person-to-person, therefore, it is important to use 'Standard infection control precautions' (SICPs) and, where required, 'Transmission based precautions' (TBPs).

Viral gastroenteritis symptoms

Symptoms of viral gastroenteritis can include:

- Sudden onset of vomiting which can be projectile
- Watery non-bloody diarrhoea
- Abdominal cramps
- Nausea
- Headache, low grade fever

The illness lasts 24-72 hours with no long-term effects.

Routes of transmission

Norovirus is transmitted primarily through the faecal/oral route by:

- **Direct contact:** person-to-person, e.g. hands that have not been washed thoroughly
- **Indirect contact:** faecally contaminated food or water. Medical devices, care equipment or care environment, that have not been appropriately decontaminated, e.g. toilet flush button/hand, toilet assistance rails
- **Also, via the droplet route:** infectious droplets in vomit can remain in the air and be swallowed by another person

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Written and produced by
Community Infection Prevention and Control
Harrogate and District NHS Foundation Trust
Tel: 01423 557340
www.infectionpreventioncontrol.co.uk
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