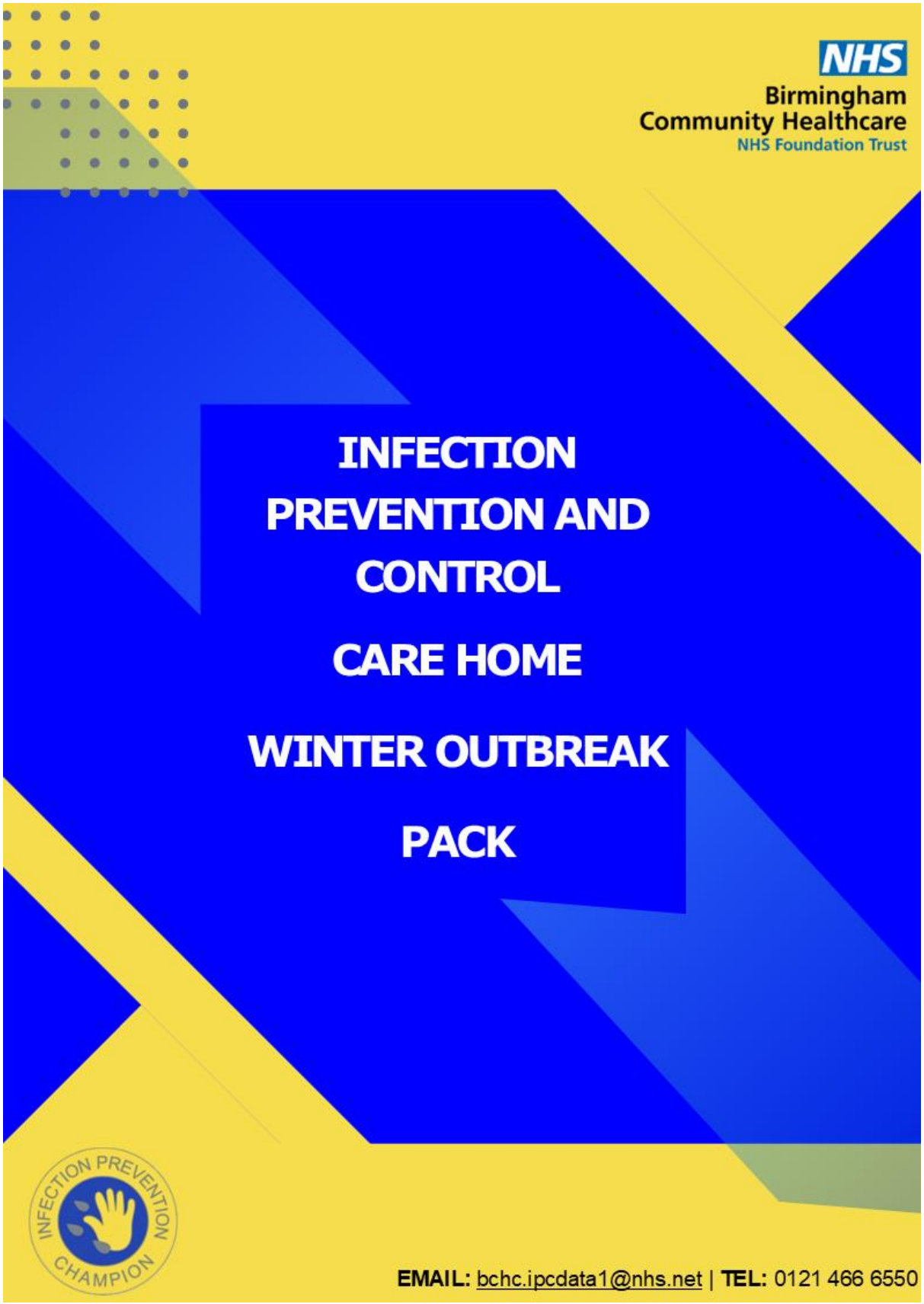

NHS
Birmingham
Community Healthcare
NHS Foundation Trust
INFECTION PREVENTION AND CONTROL
CARE HOME
WINTER OUTBREAK
PACK
INFECTION PREVENTION CHAMPION
EMAIL: bchc.ipcdata1@nhs.net | TEL: 0121 466 6550

IPC Team Contact Poster

BCHC Infection Prevention and Control Care Home Team

Here to help you to improve and maintain a quality service

- IPC Advice
- Outbreak Support
- IPC Audit/reaudit (environment and practice)
- Training and Development –Including IPC Champion training
- Sharing learning and best practice - Newsletter and forums

A team member is on call 9-5 Monday to Friday on

0121 466 6550

Please ask to speak to care home team

Email: bchc.ipcdata1@nhs.net

For IPC web page clink on the link below

Infection Prevention and Control

Contents

Definition of an Outbreak:

- An incident in which two or more people experiencing the same illness are linked in time and place.
- A greater than expected rate of infection compared with the usual background rate for the place and time where the outbreak has occurred.
- A single case for certain rare diseases such as diphtheria, botulism, rabies, viral haemorrhagic fever or polio.
- A suspected, anticipated or actual event involving microbial or chemical contamination of food or water.

Winter Outbreaks

An occurrence of two or more similar illnesses resulting from common exposure that is either suspected or laboratory confirmed.

Cases of Influenza (flu), RSV, COVID-19 and norovirus are seen throughout the year, but in winter they circulate at the same time and can reach high levels.

It is recognised that outbreaks of viral gastroenteritis (e.g., Norovirus) and respiratory illness (e.g., Influenza, COVID-19) are common especially during the winter months, with outbreaks usually affecting care homes, schools and nurseries in the first instance and later seen within hospital settings.

The severity of an outbreak is graded according to several factors:

- The number of patients affected.
- The type and virulence of the organism.
- The endemic status of the organism.
- The resources available and necessary to control an outbreak.
- The media interest.

Standard Infection Control Precautions

Standard Infection Control Precautions (SICPs) are the basic infection prevention and control measures necessary to reduce the risk of transmission of infectious agent from both recognised and unrecognised sources of infection.

The use of SICPs, however, does not eliminate the need to isolate potentially infectious diseases e.g. COVID-19, Influenza, RSV (Respiratory syncytial virus) or Norovirus.

SICPs must be used **by all staff, in all care settings, at all times** and **for all patients/individuals,** whether infection is known or not, to ensure the safety of patients/individuals, staff and visitors. See Appendix 1

The elements of SICPs are:

- patient placement and assessment for infection risk (screening/triaging/testing)
- hand hygiene
- respiratory and cough hygiene
- personal protective equipment
- safe management of the care environment
- safe management of care equipment
- safe management of healthcare linen
- safe management of blood and body fluids
- safe disposal of waste (including sharps)
- occupational safety: prevention and exposure management

Transmission Based Precautions (TBPs)

Transmission based precautions (TBPs) are additional measures (to SICPs) required when caring for residents / individuals with a known or suspected infection. The type of precautions will depend on the transmission route and the outbreak pathogen.

TBPs are based upon the route of transmission and include:

A. **Contact precautions** - Used to prevent and control infections that spread via direct contact with the resident or indirectly from the resident's immediate care environment (including care equipment). This is the most common route of infection transmission. Pathogens spread via this route include scabies and bacteria such as C. *difficile* and Staphylococcus aureus. **Norovirus and respiratory infections can also be spread via this route.** See Appendix 2

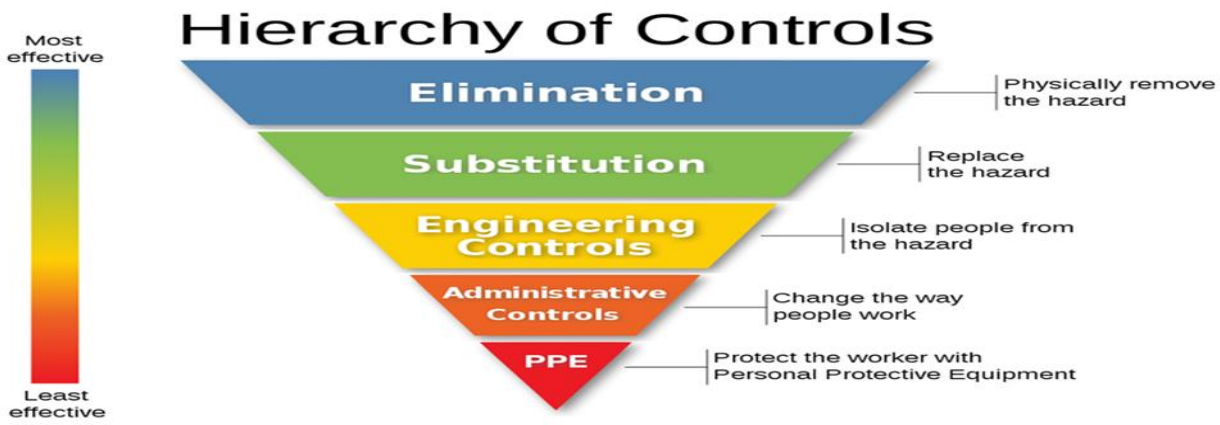
B. **Droplet precautions** -. Measures used to prevent, and control infections spread over short distances (at least 1 metre) * via droplets from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Seasonal influenza, COVID-19 are predominantly spread via this route. Other pathogens spread via this route include mumps. See Appendix 3

C. **Airborne precautions** - Measures used to prevent, and control infection spread without necessarily having close contact, via aerosols from the respiratory tract of one individual directly onto a mucosal surface or conjunctivae of another individual. Aerosols penetrate the respiratory system to the alveolar level. Respiratory infections can spread via this route. Aerosol generating procedures (AGPs) increase the risk of spread by the airborne route. Other pathogens that can spread through airborne transmission include Tuberculosis, Chicken Pox and Measles. See Appendix 4

Principles of Outbreak Management

The Hierarchy of Controls

The risk of infection transmission can be mitigated by safe systems of work outlined in the hierarchy of controls. This advocates reducing the risk through systems and processes, such as resident screening, video consultations, ventilation, enhanced cleaning and appropriate use of PPE.



Resident placement and assessment for infection risk

If a resident develops Respiratory symptoms, they must be isolated immediately, if the resident meets the eligibility criteria a COVID-19 swab should be obtained, a full respiratory screen may be requested or recommend by UKHSA as part of suspected outbreak to confirm diagnosis.

COVID-19 and Influenza The duration of isolation precautions should be continued for at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for 48 hours.

- **Symptom onset or day swab obtained – whichever was first**.

RSV (Respiratory syncytial virus) precautions/isolation should continue up to 7-8 days after the onset of symptoms. For prolonged illness i.e. pneumonia, control measures need to remain in place.

Immuno-suppressed individuals may remain infectious for a longer period of time; discontinuation of isolation precautions should be discussed with GP or Infection control team.

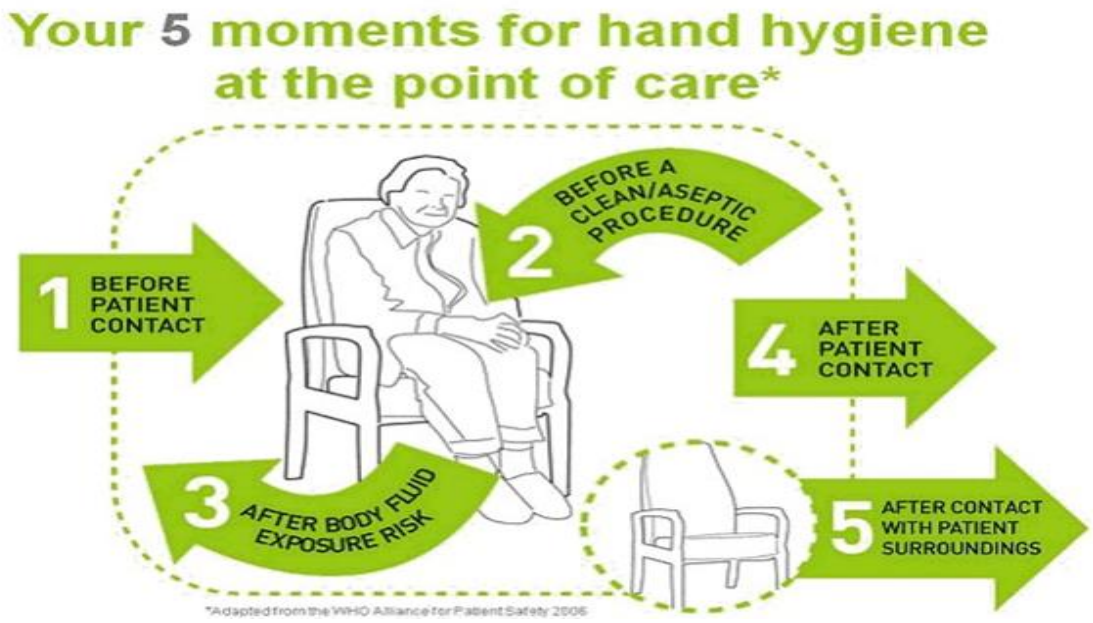
Diarrhoea or Vomiting

If a resident develops symptoms of diarrhoea and/or vomiting, they must be isolated immediately, and where possible a stool specimen obtained to confirm diagnosis. Isolate until 48 hours clear of symptoms.

Hand Hygiene

Hand hygiene is considered an important practice in reducing the transmission of infectious agents, including Healthcare Associated Infections when providing care. Hands should be decontaminated in line with **"My 5 Moments of Hand Hygiene"** (World Health organisation (WHO)), with soap and water or alcohol-based hand rub

*** For Norovirus Soap and Water Must Be Used.**



Personal Protective Equipment (PPE)

Before undertaking any procedure, staff should assess for anticipated or likely exposure to blood and/or bodily fluids and ensure PPE is worn that provides adequate protection against the risks associated with the procedure or task being undertaken.

All PPE should be:

- located close to the point of use (where this does not compromise resident safety, for example, learning disabilities).
- stored safely and in a clean, dry area to prevent contamination.
- within expiry date
- single use unless specified by the manufacturer.
- donned (put on) immediately prior to task or procedure
- changed immediately after each resident and/or after completing a procedure or task.
- safely doffed (removed) to avoid self-contamination, immediately after completing task/procedure and disposed of into the correct waste stream.

Gloves must:

- be worn when exposure to blood and/or other body fluids, non-intact skin or mucous membranes is anticipated or likely.
- be changed immediately after each resident and/or after completing a procedure/task even on the same resident.
- be donned immediately before performing an invasive procedure and removed on completion.
- Hand hygiene must be performed before donning and after doffing of gloves.

Aprons must be:

- worn to protect uniform or clothes when contamination is anticipated or likely i.e., providing direct care.
- changed between residents and/or after completing a procedure or task.

Thumb Loop Gowns must be:

- worn when there is a risk of extensive splashing of blood and/or body fluids.
- worn when undertaking aerosol generating procedures.
- worn when a disposable apron provides inadequate cover for the procedure or task being performed such as surgical procedures or contact with skin rash such as scabies.
- changed between residents and/or after completing a procedure or task.

Eye or face protection (including full-face visors) must: be worn if blood and/or body fluid contamination to the eyes or face is anticipated or likely and **always during aerosol generating procedures**.

- not be impeded by accessories such as piercings or false eyelashes.
- not be touched when being worn.

NB. Regular corrective spectacles are not considered as eye protection.

*Note: Reusable eye protection should be decontaminated after removal and stored in a clean dry place.

A fluid resistant surgical face mask (FRSM Type IIR) mask must:

- be worn with eye protection if splashing or spraying of blood, body fluids, secretions or excretions onto the respiratory mucosa (nose and mouth) is anticipated or likely.
- be worn when providing direct care within 1 metre of a suspected/confirmed respiratory infection.
- be well-fitting and fit for purpose, fully cover the mouth and nose (manufacturers' instructions must be followed to ensure effective fit and protection)
- not be touched once put on or allowed to sit on/under chin or dangle around the neck.
- be replaced if damaged, visibly soiled, damp, uncomfortable or difficult to breathe through and when leaving an outbreak area.

Filtering facepiece (FFP3) respirator

- FFP3 respirator (EN149:2001) should be worn when undertaking aerosol generating procedures for individuals with respiratory infection.
- Any Health Care worker required to wear an FFP3 respirator must undertake fit testing by a competent person prior to using it.

Donning/doffing videos for AGP and Non-AGP

Aerosol Generating Procedure
Non- Aerosol Generating Procedure

*Note: Where FFP3 mask is required staff must be "mask fit tested" for the correct mask.

Cleaning and Decontamination

Effective cleaning and decontamination are pivotal in preventing the spread of infection.

Cleaning and decontamination should be undertaken by staff appropriately trained for the procedure and in the use of appropriate personal protective equipment (PPE). PPE should consist of apron, gloves, (eye protection and fluid repellent facemask if there is anticipated/likely risk of splashing or exposure to respiratory droplets). Pay particular attention to frequently touched surfaces.

Single Use Equipment

Where possible use **single use** items identified by the above symbol
OR

Single patient (resident) use items which can be used multiple times for the identified resident and must be decontaminated and changed in line with manufacturer's instructions.
OR
Where single use is not possible, use dedicated care equipment in the individual's room. If it is not possible to dedicate pieces of equipment to the individual, such as or moving aides, these must be decontaminated immediately after use and before use with any other patient.

Outbreak Cleaning

For cleaning requirements during a suspected or confirmed outbreak please follow the enhanced cleaning/Terminal cleaning flow chart as appropriate.
Cleaning equipment must be colour coded in line with National colour coding.

RED	Bathrooms, washrooms, showers, toilets, basins and bathroom floors.
GREEN	Ward kitchen areas and patient food service.
BLUE	General areas: wards, departments, offices and basins in public areas.
YELLOW	**Isolation areas.**

Enhanced Daily Cleaning

Cleaning should be increased to a minimum of twice daily.

Wash hands with soap and water –
wear disposable gloves and plastic apron

Clean room, floors, sinks, toilets and all surfaces and equipment (pay particular attention to all patient contact areas such as table, locker, Patient line, chairs, door handles, taps, walking aids etc.,)
Wash walls if visibly soiled

Toilets and bathrooms must be thoroughly cleaned after each use.

Use separate cleaning equipment
(single-use disposable cloths, disposable mop heads)

Clean all areas with detergent and water then disinfect with a 1,000ppm available chlorine where no blood or blood-stained body fluid is present. Alternatively, 'Chlor-clean' may be used. In the case of blood or blood-stained body fluid spillage all washable surfaces should be cleaned with detergent and water then disinfected with 10,000ppm available chlorine.

Dispose of cloths, gloves and apron in an orange clinical waste sack

Wash hands with soap and water
For further advice contact unit manager or nurse in charge

Terminal Clean

Once the patient is free from diarrhoea for forty-eight hours the room should be terminally cleaned with chlorine containing agents (this should be performed even if the patient is not moving room)

Wash hands with soap and water – wear disposable gloves and plastic apron

Clean room, floors, sinks, toilets and all surfaces and equipment (pay particular attention to all patient contact areas such as table, locker, Patient line, chairs, door handles, taps, walking aids etc.,) Wash walls if visibly soiled.

Inspect pillows and mattress internally and externally, if internally damaged/contaminated discard and replace. Wipe covers of bed mattresses and pillows with warm water and detergent and dry thoroughly.

Use separate cleaning equipment (single-use disposable cloths, disposable mop heads)

Clean all areas with a chlorine-based disinfectant to 1,000 parts per million (ppm) where no blood or blood stained body fluid is present. In the case of blood or blood-stained body fluid spillage all washable surfaces should be cleaned with detergent and water then disinfected with 10,000ppm available chlorine.

Remove cubicle curtains for cleaning and place in a red alginate bag and then into a red laundry bag.

Dispose of cloths, gloves and apron in an orange clinical waste sack

Wash hands with soap and water

For further advice contact unit manager or nurse in charge

Management of Linen

Linen from affected residents should be treated as infectious.

- Place directly into a red water-soluble bag at point of care.
- Once used the bag should be sealed and placed into a secondary linen bag or basket.
- The bag should then be removed from the resident's room and taken directly to the laundry facility.

Management of waste

All waste to be disposed of as cat B (orange bagged waste) in line with Health Technical Memorandum (HTM) 07-01: Safe and sustainable management of healthcare waste.

Orange (infectious) waste stream must be used for the disposal of items contaminated with infectious blood or bodily fluids such as dressings, swabs, catheters, and PPE.

Minimise Risk dependant on Waste consignments/contract. Where an infectious waste stream is not available waste should be double bagged prior to disposal.

The Outbreak checklist can support in the assurance process by demonstrating IPC precautions have been implemented. See Appendix 5

Visitors

Visitors should be informed of an outbreak situation and advised not to visit if experiencing any of the following symptoms:

- A new cough
- A high temperature
- Respiratory symptoms
- Diarrhoea and or vomiting within the last 48hours.
- New unexplained rash

See Appendix 5

Respiratory Tract infection (RTI)
RTI is an infectious process affecting any part of the upper and/or lower airways.
Symptoms of a RTI can include fever (temperature 37.8 or above) rhinorrhoea (runny nose), cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing, chest pain or in older people an acute deterioration in physical or mental ability without other known cause.

Definition of respiratory outbreak

An outbreak may be suspected when there is an increase in the number of residents displaying symptoms of a respiratory infection. If 2 or more linked care home residents develop symptoms of a respiratory infection within 5 days of each other, the care home should undertake a risk assessment as soon as possible and report via the CareOBRA system, commence outbreak measures, implementing “Droplet precautions” (Airborne precautions for Aerosol generating procedures (AGP)).
Report an outbreak

Testing

Any symptomatic residents eligible for COVID-19 treatments should be tested as soon as possible when they develop symptoms of an ARI (using COVID-19 LFD tests obtained for this purpose), up to 5 linked symptomatic residents with most recent symptom onset. If further residents develop respiratory symptoms, they should only be tested if they are eligible for COVID-19 treatments or if advised by the HPT.

Common Causes

Common causes of RTIs include viruses such as rhinoviruses, coronavirus, influenza and Respiratory Syncytial Virus (RSV); and bacteria such as pneumococci **(S. pneumoniae***)* and haemophilus (**H. influenzae).**

The majority of RTIs are self-limiting, viral infections of the upper respiratory tract. Although RTIs can happen at any time, they are most common from September through till March. The peak activity for RTIs due to influenza occurs during the autumn and winter seasons in temperate regions.

Routes of Transmission

- Droplet transmission
- Airborne route during and after Aerosol Generating Procedures (AGPs)
- Direct contact transmission
- Indirect contact transmission

Respiratory and cough hygiene

'Catch it, bin it, kill it'

Residents, staff and visitors should be encouraged to minimise potential respiratory virus transmission through good respiratory hygiene measures.

Management of suspected / confirmed respiratory outbreak

- Isolate/cohort symptomatic residents, request medica/GP review, complete CareOBRA and inform Infection Prevention and Control Team.

- Any symptomatic residents eligible for COVID-19 treatments should be tested as soon as possible when they develop symptoms of an ARI

- **Droplet** transmission-based precautions must be implemented i.e., **gloves, aprons, face protection** (**Universal mask wearing** during respiratory outbreak) and hand hygiene in line with WHO "My 5 Moments of Hand Hygiene". - using soap and water or Alcohol based hand rub for visibly clean hands.

- Droplet precautions poster displayed.

For AGP Airborne transmission-based precautions must be implemented.
Each resident should have appropriate respiratory illness/IPC care plan in place

- Ensure all staff are informed of the outbreak situation and the precautions required.

- Each shift should maintain up-to-date records of all symptomatic residents and staff. See Appendix 6

- Linen from affected residents should be treated as infectious, segregated in a red water-soluble bag and placed in a secondary bag/basket, which should be removed from the room and taken directly to the laundry or stored in the designated collection area.

- Restrict staff movements between floors/ care homes.

- Dispose of exposed food such as fruit.

- Single-use/single-patient (resident)-use equipment to be used wherever possible.

- All reusable equipment should be decontaminated after each use with universal combined detergent/disinfectant wipes such as Clinell Green wipes.

- Use disposable cleaning products including mops and cloths in-line with national colour coding. Where re-usable mops suitable, for use with chlorine releasing disinfectants are used, these must be laundered immediately after use.

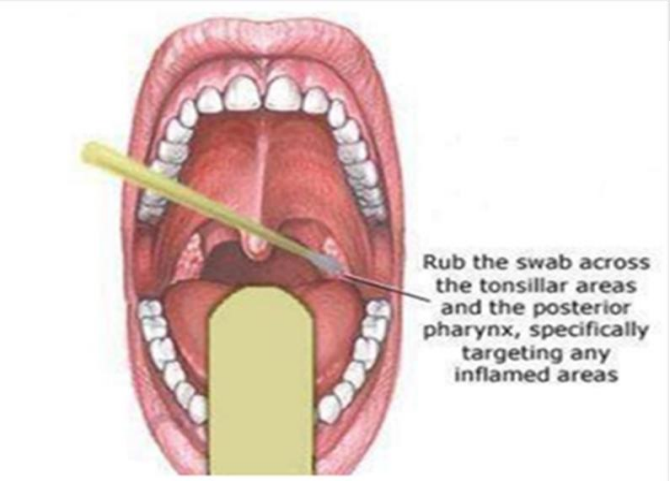
- For emergency transfers residents should where tolerated wear a surgical face mask (providing this does not compromise clinical care) and inform receiving unit.

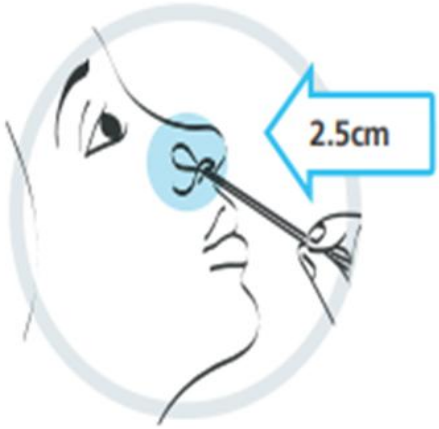
- Orange (infectious) waste stream must be used for the disposal of items contaminated with infectious blood or bodily fluids such as dressings, swabs, catheters, and PPE. Minimise Risk dependant on Waste consignments/contract. Where an infectious waste stream is not available waste should be double bagged prior to disposal.

- Consider restricting non-essential visitors (especially children) to minimise the spread of this virus, visitors who have respiratory symptoms should be advised not to visit.

- Terminal clean must be undertaken following an outbreak, including the removal and laundering of all bed linen and curtains.

Swabbing





Upper respiratory tract viral sample (COVID-19 lateral flow is a test)

Throat swab taken asking resident to stick their tongue out (or by depressing the tongue) and gently swabbing the area between the uvula and in front of the tonsils.

- Care should be taken to avoid touching other parts of the mouth which may contaminate the swab.
- For the nasal swab, tilt resident's head back 70 degrees. Gently insert and rotate the swab, (less than 3cm into one nostril (until resistance is met)). Rotate the swab several times against the nasal wall.
- Put the end of the swab into the tube so it's in the liquid and swirl the swab around as explained in the test kit instructions, then close the lid
- Squeeze some drops of liquid from the tube onto the test strip (the test kit instructions tell you how many drops)
- Wait for the time shown in your test kit instructions and read your result
- **Do not leave the test longer than the waiting time given in the test kit instructions, as this can affect the result.**

Viral Gastroenteritis (Norovirus)

Norovirus (and Rotavirus) are the most common cause of outbreaks of gastroenteritis worldwide and both hospitals and nursing homes are significantly associated with high attack rates. Outbreaks occur throughout the year, although cases rise to more than 80% from November to April. Norovirus is highly transmissible requiring ingestion of as few as 10-100 viral particles to cause illness. The incubation period is usually 24-48 hours although as little as 12 hours has been reported.

Suspected case of Norovirus

A. Vomiting: Two or more episodes of vomiting of suspected infectious cause* occurring in a 24-hour period

B. Diarrhoea: Two or more episodes of Bristol Stool Chart type 6-7 in a 24-hour period (note: Consideration to be given if other infection suspected e.g. Clostridium/Clostridioides difficile Bristol Stool Chart type 5-7). See Appendix 7

C. Diarrhoea and vomiting: One or more episodes of both symptoms occurring within a 24-hour period

*Not associated with prescribed drugs or treatments and not associated with reaction to anaesthetic or an underlying medical condition or existing illness.

Confirmed case of Norovirus = a, b or c above with microbiological confirmation

Norovirus Outbreaks

Suspected outbreak: Two or more suspected cases, as defined above, occurring in the same care unit within a 48 Hour period.

Confirmed outbreak: As above with laboratory confirmation.

Outbreaks can start abruptly and spread quickly – to minimise their impact on residents and the home they must be recognised, reported and controlled swiftly.

Common symptoms of Norovirus

- Projectile vomiting and/or diarrhoea with sudden onset
- Nausea, headache, abdominal pain and a general feeling of being unwell.
- (NB one or more symptoms may be present at any given time)

The symptoms of Norovirus infection begin around 12-48 hours after becoming infected. The symptoms usually last for 12–60 hours. Most people make a full recovery within 1-2 days; however, some people (the very young or elderly) are at increased risk of dehydration.

Transmission

- Person to person, or by indirect contact from contaminated surfaces by the faecal oral route; risk of infection from aerosols of projectile vomiting.
- Environmental contamination, particularly commodes/toilets.
- Contaminated food and water source.

Management of suspected / confirmed Norovirus outbreak

- Isolate/cohort symptomatic residents, medical GP review, contact UKHSA and inform Infection Prevention and Control Team.

- Contact precautions required (i.e. gloves and aprons) and handwashing with **soap and water** for direct care/ contact with resident's environment as per WHO "5 Moments of Hand Hygiene"

- Stool samples should be obtained where possible for symptomatic residents until **confirmation of organism**. Specimens should be labelled as suspected outbreak.

***Each resident should have an appropriate D&V - IPC care plan.**

- Ensure all staff are informed of the outbreak situation and the precautions required.

- Restrict staff movements between floors/ care homes.

- Each shift must maintain up-to-date records of all symptomatic residents and staff. Appendix 7

- Bowel chart should be maintained using Bristol Stool Chart.

- Single-use/single-patient-use equipment to be used wherever possible. All reusable equipment should be decontaminated after each use with universal combined detergent/disinfectant wipes such as “Clinell” Green wipes.

- Use disposable cleaning products including mops and cloths in-line with national colour coding. Where re-usable mops suitable for use with chlorine releasing disinfectants are used, these must be laundered immediately after use.

- Clean vomit and faeces spillages promptly using spills wipe/kit or mop up excess with paper towels then clean the area using a combined detergent /disinfectant solution such as “Chlorclean or Peracetic acid pods” or detergent and water followed by hypochlorite solution 1,000ppm. Protective clothing must be worn.

- Linen from affected residents should be treated as infectious, segregated in a red water-soluble/alginate bag and placed in a secondary bag or basket, which should be removed from the room and taken directly to the laundry or stored in the designated collection area.

- Consider restricting non-essential visitors (especially children) to minimise the spread of this virus, visitors who have symptoms of D&V should be advised not to visit.

- Dispose of exposed food such as fruit.

- Orange (infectious) waste stream must be used for the disposal of items contaminated with infectious blood or bodily fluids such as dressings, swabs, catheters, and PPE. Minimise Risk dependant on Waste consignments/contract. Where an infectious waste stream is not available waste should be double bagged prior to disposal.

- Terminal clean must be undertaken following an outbreak, including the removal and laundering of all bed linen and curtains.

  The outbreak checklist can be used to provide assurance that all IPC measures have been implemented Appendix 8

Appendix 1 Standard Precautions

NHS Birmingham Community Healthcare NHS Foundation Trust

Standard Precautions

Infection prevention and control precautions to be used by all staff for all residents at all times.

Hand hygiene before and after every contact with a resident or their surroundings.

Safe handling of used Sharps, linen and waste.

Clean all equipment before and after use.

Wear an apron for direct resident contact or gown when there is a chance of body substance splash or spray .

Wear gloves when handling blood and body fluids.

Wear face protection if body substance splash is likely.

Ensure body fluid spills are managed promptly.

Encourage and support residents with hand and respiratory hygiene.

BCHC IPC CARE HOME TEAM SICP AUG 2024

Appendix 2 Contact Precautions

NHS Birmingham Community Healthcare NHS Foundation Trust

Contact Precautions

In addition to Standard Infection prevention and control precautions.

BEFORE ENTERING THE RESIDENTS ROOM

Hand hygiene before contact with a resident or their surroundings.

Don apron for direct resident contact or gown when there is a chance of body substance splash or spray.

Put on gloves if blood and body fluid exposure is likely.

PRIOR TO LEAVING THE RESIDENTS ROOM

Remove gloves

Perform hand hygiene.

Remove apron/ gown

Perform Hand Hygiene.

Dispose of PPE as Clinical waste

Clean and Disinfect Equipment

BCHC IPC CARE HOME TEAM CONTACT PRECAUTIONS AUG 2024

CONTACT PRECAUTIONS

Disease/Condition	When and how long	Notes
Multi-resistant organisms (MRSA, VRE, CPE, ESBL)	Single Room – All personal care to be provided in residents own room.	Gloves only needed if body substance exposure is anticipated
Chickenpox or Shingles *Varicella-Zoster* virus	At least 7 days, until all lesions dry and crusted	Combined with Airborne Precautions for primary chickenpox, or for shingles in an immunocompromised resident.
Scarlet Fever, invasive group A Streptococcal infection (iGAS)	Until 48hrs effective antibiotics	
Scabies	Until 24hrs after treatment	
Lice – Head, Body or Pubic	Until 24hrs after treatment	
Clostridioides difficile	Until 48 hours after the last loose stool	MAINTAIN AN ACCURATE STOOL CHART
Gastroenteritis, suspected infective	Until 48 hours after the last loose stool or vomit	
Norovirus	Until 48 hours after the last loose stool or vomit	
Rotavirus gastroenteritis	At least 8 days and until symptoms have resolved	

BCHC IPC CARE HOME TEAM CONTACT PRECAUTIONS AUG 2024

Appendix 3 Droplet Precautions

NHS Birmingham Community Healthcare NHS Foundation Trust

Droplet Precautions

In addition to Standard Infection prevention and control precautions.

BEFORE ENTERING THE RESIDENTS ROOM

Perform Hand Hygiene

Don apron for direct resident contact or gown when there is a chance of body substance splash or spray.

Don surgical mask,. Don eye protection if risk of splashing

Put on gloves

PRIOR TO LEAVING THE RESIDENTS ROOM

Remove gloves .

Perform Hand Hygiene.

Remove apron/gown

Remove Eye protection

Perform Hand Hygiene.

Remove surgical mask

Perform Hand Hygiene

Dispose of PPE As Clinical waste.

Clean and Disinfect Equipment

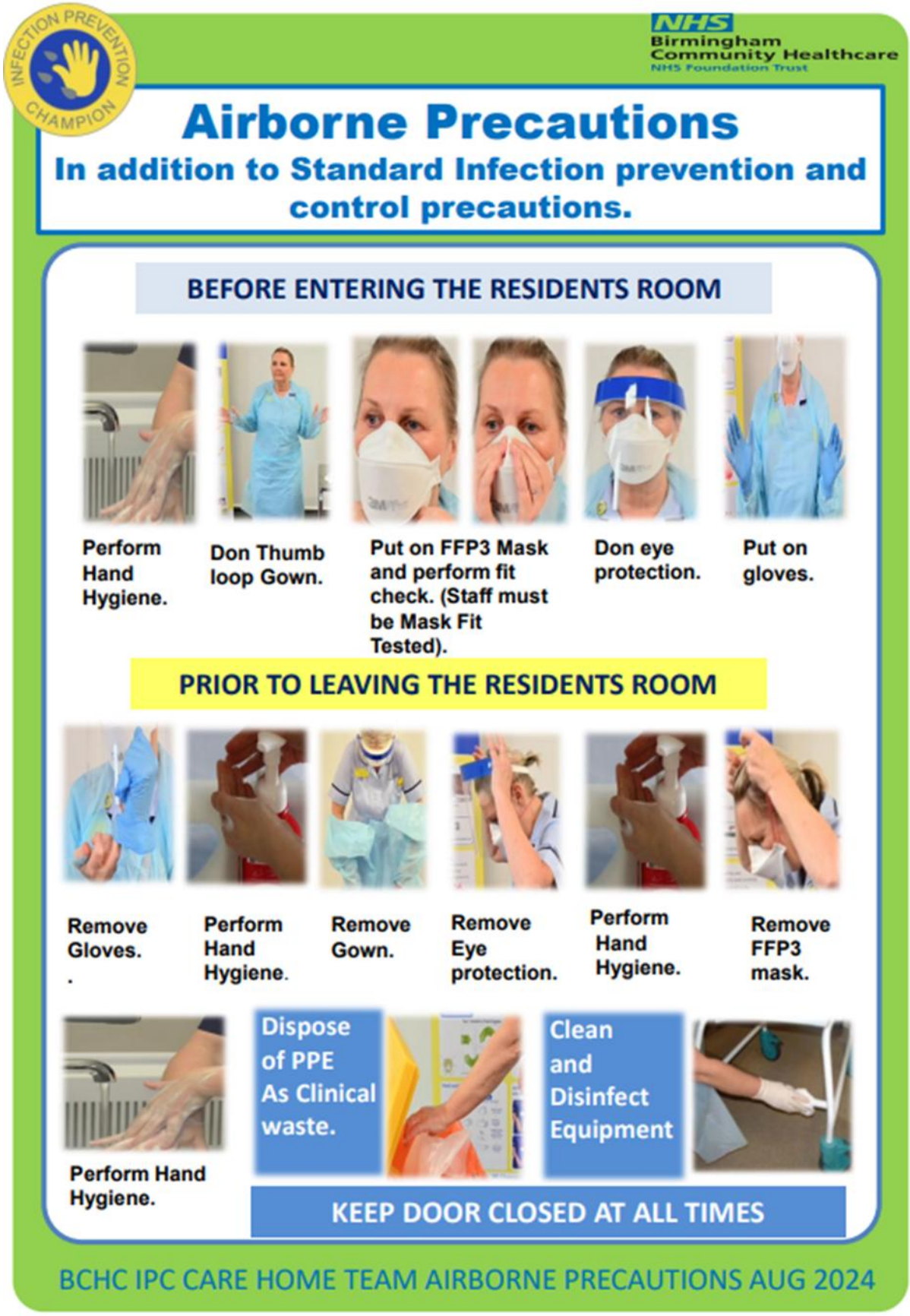
BCHC IPC CARE HOME TEAM DROPLET PRECAUTIONS AUG 2024

DROPLET PRECAUTIONS

Disease/Condition	When and how long
Influenza	For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours
COVID-19	For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours
Respiratory Syncytial Virus (RSV)	For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours

BCHC IPC CARE HOME TEAM DROPLET PRECAUTIONS AUG 2024

Appendix 4 Airborne Precautions



AIRBORNE PRECAUTIONS

Disease/Condition	When and how long
Tuberculosis – Pulmonary or laryngeal disease, confirmed or suspected	Until advised by Chest Clinic medical officer or specialist nurse
Measles, confirmed or suspected	Until four days after onset of rash
Influenza	Care of suspected and confirmed influenza patients during aerosol generating procedures. For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours
Respiratory Syncytial Virus (RSV)	Care of suspected and confirmed RSV patients during aerosol generating procedures. For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours
COVID – 19	Care of suspected and confirmed COVID-19 patients during aerosol generating procedures. For at least 5 days from symptom onset as long as symptoms are resolving and there has been no fever for at least 48 hours
Primary Chickenpox, or shingles in an immunocompromised patient (Varicella-Zoster virus)	Use Airborne Precautions combined with Contact Precautions. Isolate for at least seven days, until all lesions are dry and crusted

BCHC IPC CARE HOME TEAM AIRBORNE PRECAUTIONS AUG 2024

Appendix 5 Visitors signage

Infection Prevention and Control
Important information for everybody entering the building!

Dear Visitor,

During Outbreak season.

- Our residents can be very susceptible to picking up seasonal infections
- The spread of these infections could cause the home to close.

It is very important that you do not visit if you feel unwell
Please do not visit if you are experiencing any of the following symptoms:

- A new cough
- A high temperature
- Respiratory symptoms
- Diarrhoea and or vomiting within the last 48hours.
- New unexplained rash

Visitors may be requested to wear masks when visiting their loved ones to reduce the risk of transmission of infection.

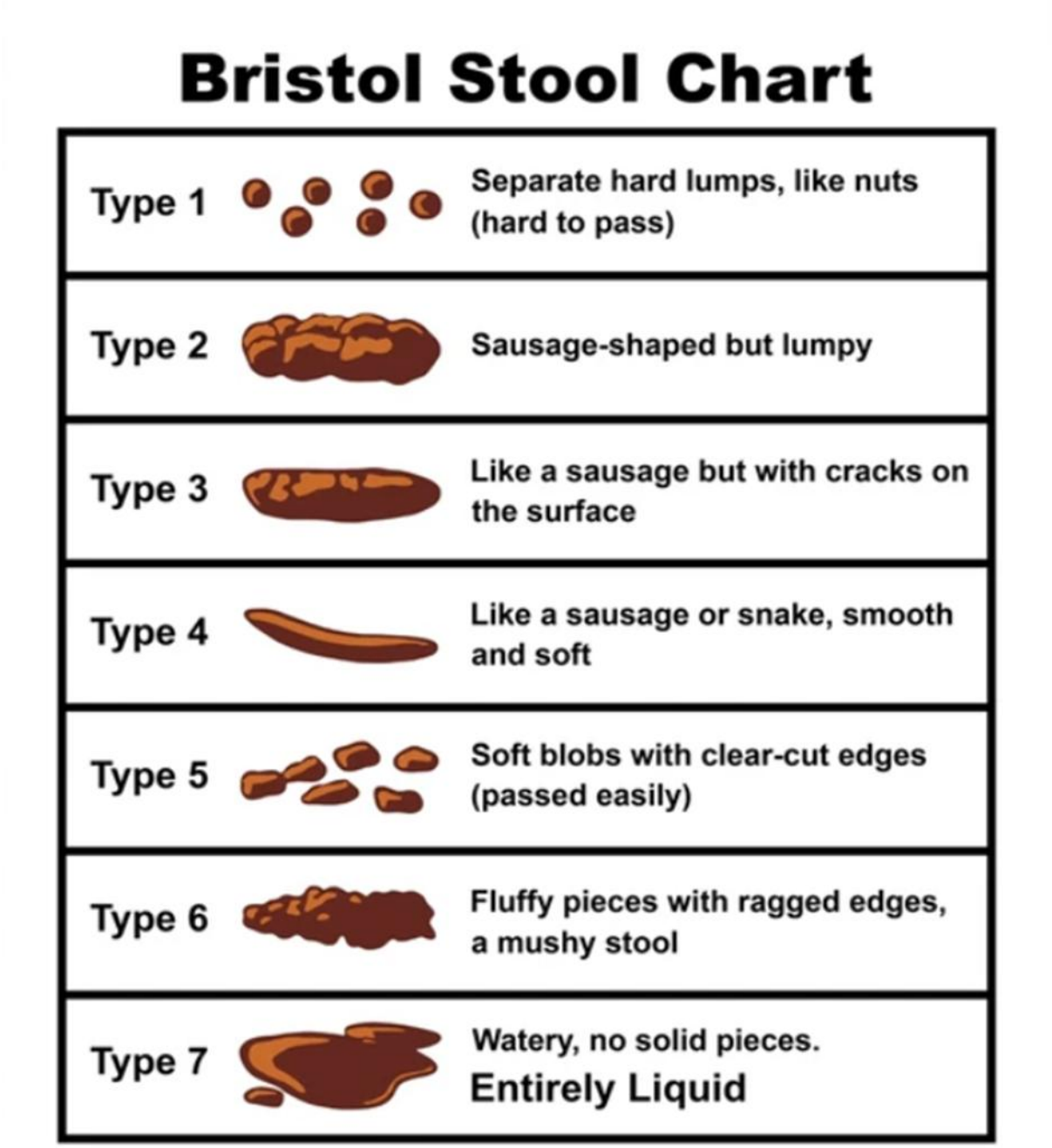
If you are unsure, please check with staff before entering the home.

Remember!

- To keep well this winter, it is essential to continue to practice good infection prevention and control both at work and home such as good hand hygiene,
- Keep yourself, your loved ones and our residents protected by keeping yourself up to date with your winter vaccinations.

Thank You
Infection Prevention and Control

Appendix 6 Bristol Stool Chart



Appendix 7 Daily Summary Sheet

Name of Resident	Room No.	Date of Onset	Symptoms	Resident on antibiotics/laxatives	Date Specimen sent	Results	Date symptoms	Resident outcome e.g. Hospitalise

Appendix 8 Outbreak Checklist

Care Home		**Audit Score**		
Onset date of Outbreak		Date audit completed		
Type of Outbreak				
End Date				
Number of days closed				

Care Home	**Number**	**Audit Score**	**Number**	
Number of residents involved at the commencement of the outbreak		Number of staff involved at the commencement of the outbreak		
Total number of residents involved at the finish of the outbreak		Total number of staff involved at the finish of the outbreak		

Management	**Yes**	**No**	**N/A**	**Comments**
Identification and reporting of the outbreak completed within 24 hrs.				
G.P has been informed and are aware of the situation				
Have effective infection prevention and control measures been implemented and maintained.				
Is a copy of up-to-date outbreak paperwork available including Bristol stool charts.				
Is effective clear and concise communication evident during this outbreak.				
Have specimens/swabs been collected or requested for symptomatic residents				
Provision of cleaning equipment, PPE and linen is adequate				
Provision of equipment, laundry and staff is in place for terminal clean of rooms and the end of the outbreak.				

Communication	**Yes**	**No**	**N/A**	**Comments**
Symptomatic cases have been reported to the person in charge and recorded on a log sheet (residents and staff)				
Visitors are being informed of the home outbreak situation, and a notice has been placed at the entrance.				
Visiting health care staff are being informed of the outbreak i.e. GP's, and Allied Health professionals				
All nonessential services have been deferred until after the outbreak i.e. Chiropodist, hairdresser, decorators				
Symptomatic residents are being isolated in their rooms in line with guidance i.e. 5 days for respiratory, 48hrs symptom free for D&V				

Reference

UK Health Security Agency (2023) Norovirus Toolkit; A resource for Care Homes.

Department of Health (2008) (updated 2022) The Health and Social Care Act 2008 – Code of Practice on the prevention and control of Infections and related Guidance

NHS England (2022 updated 2023) National infection prevention and control manual. Guidance

Department of Health/UK Health Security (2024) Agency Infection prevention and control (IPC) in adult social care: acute respiratory infection (ARI) Updated 28 March 2024

UK Health Security Agency (2024) Guidance COVID-19: testing from 1 April 2024