
Local Code of Practice

Infection Control in Educational Settings

Section 07

(Version 2.01 – March 2018)

March 2018

STATEMENT:

In order to comply with legislation and fulfil statutory responsibility, the responsible person, the Council or school must make sure that:

- All contractors, service providers, suppliers (vendors) engaged to do work at schools are competent to carry out work safely, in compliance with health and safety legislation and London Borough of Barnet (LBB) H&S policy procedures;
- Sufficient resources and time are made available to fulfil the contract requirements.

SCOPE:

This Local Code of Practice (LCoP) applies to:

- All Managers including Head Teachers in LBB maintained schools responsible for engaging contractors and service providers;
- Partner organisations engaging contractors and service providers on behalf of the council;
- All employees of London Borough of Barnet;
- All contractors and service providers working on behalf of the council.

Issue Control

This Local Code of Practice is issued and managed by the Safety, Health and Wellbeing team.

Issue		Revision		
Number	Date	Number	Date	Amendments
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Version 2.00	2008			Content Amendments' and Formatting
Version 2.01	2018			Content Amendments and formatting
Review Schedule				
Review Conducted		Next Review Date		
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USEFUL CONTACTS

For advice on infectious diseases in educational settings -

- <http://www.publichealth.hscni.net/publications/guidance-infection-control-schools-and-other-childcare-settings-0>
- https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/658507/Guidance_on_infection_control_in_schools.pdf
- <https://www.gov.uk/government/publications/health-protection-in-schools-and-other-childcare-facilities>
-

For general health advice from the World Health Organisation –

- <http://www.who.int/en/>

Hepatitis C Helpline (NHS)

- Tel: 020 7089 6220
- Email: admin@hepctrust.org.uk

Health & Safety Unit

- Tel: 020 8359 7955

1. INTRODUCTION

In order to comply with legislation and fulfil statutory responsibility, the Council must make sure that:

- Adequate infection controls are in place, so far as is reasonably practicable, to minimise any risk of infection to staff and others.
- Substances hazardous to health have been identified, risk assessed and precautions implemented to reduce the level of risk to the lowest practicable level.
- Control measures are used and maintained.
- Employees identified as exposed to hazardous substances receive health surveillance, information, instruction and training on the processes and controls in place.

SCOPE:

This Local Code of Practice (LCoP) applies to:

- All managers including head teachers referred to as managers herein.
- All employees of London Borough of Barnet
-
- All contractors working on behalf of the Council

2. RESPONSIBILITIES

2.1. Head Teachers

Head teachers have a duty to ensure that there are appropriate infection control procedures, to protect the health of employees and any other person. This will involve different procedures for different services, depending on the main work activities. The arrangements made by services must be set out in the Service Area Health, Safety and Welfare Policy.

Educational settings must be able to demonstrate that where there is a risk of infection arising out of the work activity, appropriate systems and procedures are in place to manage the risk by removing it or reducing it to an acceptable level. To achieve this, a risk assessment of any significant infection risks may be needed.

Staff must be made aware of any relevant risk assessments and should receive appropriate information, instruction, training and supervision to enable them to work safely.

Service Areas must establish monitoring systems to ensure Service Area Infection Control Procedures continue to function correctly and should consider the use of:

- Protective clothing and equipment
- Suitable hand washing facilities which are separate from waste disposal and food preparation facilities
- Appropriate waste disposal equipment
- Facilities/equipment to deal with spillage
- Safe systems for the collection, disposal and storage of clinical waste
- Cleaning and disinfection of equipment
- Systems for hazard reporting

2.2. Teaching staff and other employees

Employees have a duty to take reasonable care of themselves and others who may be affected by their acts or omissions.

They are required to comply with this Section and Service Area specific arrangements and procedures on Infection Control. Employees are also required to report to their Line Manager any health and safety hazards or deficiencies in the Infection Control Arrangements they may have identified.

3. GENERAL PRECAUTIONS TO PREVENT AND CONTROL THE RISK OF INFECTION

Instructing Employees on Modes of Transfer

Knowledge of the different routes of transmission of infection enables sensible precautions to be taken to prevent cross infection. The modes of transmission are summarised below:

Direct Contact	Direct physical contact with a source of infection i.e. contact with infected blood/body fluids or infected individuals.
Indirect Contact	Indirect contact may take place via a third party for example when carer's hands are dirty. Other media are inanimate objects such as contaminated clothing, linen, seats and air-rings.
Airborne	Aerosol droplets. Coughing, sneezing, talking and certain respiratory treatment may generate droplets.
Injection	Direct injection of bacteria into cuts or grazes or injection of blood/body fluids on sharp instruments or needles.
Vector-Borne	Infection spread by animals or insects e.g. rabies, malaria and leptospirosis.
Oral	Consumption of contaminated food and drink. Alternatively contaminated hands or objects being placed into the mouth e.g. sucking fingers, pens, etc.

4. RISK ASSESSMENT FOR MICROBIOLOGICAL HAZARDS

Service Areas are required, by the Corporate Safety Policy Arrangement for the Control of Substances Hazardous to Health (COSHH), to carry out an assessment of the risk to staff from biological agents they may encounter in the course of their work.

The COSHH Assessment should consider the following points:

Hazards	Risk	Control Measures
<ul style="list-style-type: none"> ➤ The bacteria or harmful organism that may be present ➤ The disease they may cause ➤ How and where they are present ➤ How they are transmitted 	<p>Consider the likelihood that the harm from a particular is realised</p> 	<ul style="list-style-type: none"> ➤ The control measures to be applied. ➤ The need for monitoring procedures. ➤ The need for Health Surveillance procedures. ➤ The range of instruction and training to be given to staff, including refresher training

Control Measures will vary according to the specific route of infection and mode of transmission. For control measures relating to specific diseases please see Appendix C.

Appendix A - Hand Washing Procedure

Thorough hand washing is the single most important message in infection control. If hands are properly washed straight after picking up potentially infective bacteria, these bacteria will be easily removed. For peripatetic staff based away from buildings, there may be a need for hand washing facilities on vehicles or at other locations.

The following items are required to ensure effective hand washing:

- Accessible hand wash sinks. These should be separate from sinks used for cleaning equipment or food preparation.
- Elbow or foot operated taps are desirable, as they remove the need to touch taps,
- Liquid soap (bar soaps can harbour bacteria).
- Disposable hand paper towels or warm air hand dryers (re-usable towels become contaminated).

Hand wash posters indicating the correct hand washing technique are helpful to both teach and remind staff of its importance.

How to wash hands effectively

- Remove rings where possible. If rings cannot be removed move up and down to allow the skin under to be washed
- Wet hands up to the forearms, apply soap/cleaner
- Smooth soap/cleanser evenly all over your hands for 10-15 seconds, lather well
- Hold hands down so that water from finger tips drains into sink
- Rub hands together vigorously, use friction on all surfaces i.e. between fingers, under rings etc
- Rinse hands thoroughly holding hands down
- Ensure taps are clean, by washing them in soap and rinse, if necessary, (this is particularly necessary where hands were used for turning on taps)
- Dry hands thoroughly using paper towels or hand dryer, taking special care between fingers
- Dispose of towel in rubbish bin

Appendix B - General Information on Infection Control

Universal Precautions

The following universal precautions can reduce the risk of infection in all circumstances.

- Apply good basic hygiene practices with regular hand washing. Hands should be thoroughly washed:
 - On arrival on duty and end of a span of duty.
 - After using the toilet or administering first aid.
 - Before and after handling food and drink or smoking.
 - Before and after performing personal care tasks.
 - After handling soiled or contaminated equipment, linen or rubbish.
 - Before and after routine use of gloves.
 - After any potential contact with body secretions or infected materials.
- Cover existing wounds or skin lesions with waterproof dressings.
- Avoid invasive procedures if suffering from chronic skin lesions on hands.
- Avoid contamination by appropriate use of protective clothing.
- Protect eyes, mouth and nose from blood where there is risk of splashing
- Prevent puncture wounds, cuts and abrasions in the presence of body fluids
- Avoid usage of sharps (such as needles and blades) wherever possible.
- Institute procedures for sterilisation and disinfection of instruments and equipment and the safe disposal of contaminated waste
- Clear any spillage of blood or other body fluids promptly, and disinfect surfaces.

CONTROL OF BODY FLUID SPILLAGES

General Guidelines

- Ensure protective clothing and equipment is available (see section below on clinical waste)
- Wear disposable gloves and plastic aprons
- Clean up immediately
- Ventilate the area
- Splashes on skin or clothing should be washed off immediately with soap and water
- Because disinfectant and sodium hypochlorite may discolour carpets, spillage should be cleaned with warm soapy water or a germ killing carpet cleaner and dried
- If there is contaminated broken glass, use a scoop and dispose of in a sharps box
- Discard gloves, plastic aprons, and any disposable towels used for mopping up into a yellow bag and/ or a clinical waste bin
- Wash hands after cleaning up the spill

Spills of Body Fluids not visibly contaminated with blood e.g. faeces, vomit, urine,

- Always wear disposable gloves and plastic disposable apron
- Use paper towels to soak up the spill, discard directly into a clinical waste bin or bag.
- Clean contaminated area with a suitable disinfectant, and dry thoroughly
- Carpets and fabrics should be cleared with carpet cleaner and dried
- Wash hands after cleaning up the spill

Blood Spills (or other fluids containing blood)

- Wear disposable gloves and disposable plastic aprons
- Ventilate by activating extractors (if available) or opening nearby windows completely. Cover spill with hypochlorite solution and leave for at least 2 minutes. If the spill is urine, and visibly contaminated with blood, use paper towels to soak up the liquid, then neat Milton or other suitable disinfectant
- Clear up spillage with paper towels, or plastic scoop if available, and discard directly into a yellow bag or clinical waste bin
- Wash contaminated area with hot water and detergent
- Aprons, gloves, paper towels, etc., must be put into a yellow plastic bag/clinical waste bin for incineration
- Wash hands after cleaning up the spill

Urine Spillage

- Do not use any chlorine releasing agents, e.g. Domestos, Titan, because chlorine gas may be released.
- If not visibly contaminated with blood, follow guidelines above for a non blood spill
- If visibly contaminated with blood, follow guidelines above for a blood spill

PREVENTION OF CROSS INFECTION IN THE WORKING ENVIRONMENT

All toilet and changing areas must be ventilated, adequately lit and specifically designed to facilitate cleaning. For general hygiene purposes, separate gloves and cloths should be used for toilet, bathroom and kitchen cleaning. Colour coding these items will help to reduce the risk of accidental contamination. Details of these procedures, and of precautions for staff, should be produced by service areas carrying out these functions.

SHARPS INJURY GUIDELINES (these are injuries from sharp equipment, commonly found in refuse, such as needles, broken glass, scalpels etc.)

- Stop what you are doing and attend to the injury
- If there is one available, call a first aider
- Encourage bleeding by squeezing the area around the injury (do **not** suck the wound)
- Wash well with soap and warm running water for at least ten minutes
- Cover with waterproof dressing
- Report incident to Line Manager
- Seek medical advice ASAP if a puncture injury has occurred
- Complete accident/incident form. Include names of all those involved
- Even if the staff member has been immunised against Hepatitis B, these guidelines must be followed

LAUNDRY AND HANDLING OF SOILED CLOTHING/LINEN

To prevent cross infection the following should be ensured:

- Designated laundry area with ventilation directly into the atmosphere
- Designated storage area for soiled laundry, which must be secure, cool, dry and free from pests
- Industrial washing machine with both sluice and hot wash cycles, professionally installed, with precautions to prevent contamination by creating an aerosol
- Maintenance programme established for washing machine and laundry area
- Hand wash facilities - please see
- Supply of waterproof aprons and gloves
- Waterproof laundry bags

Handling Linen

Apron and gloves should be worn when dealing with laundry. Soiled sheets and clothing should be placed in a water soluble red laundry bag and must not be allowed to touch the floors of bedrooms, living rooms or any other surface.

Avoid creating dust when removing linen from resident's bed, and place in the appropriate laundry bag at the bedside. Red laundry bags should be sealed and immediately transported to the defined storage area.

OFFENSIVE WASTE

'Offensive waste' is non-clinical waste that's non-infectious and doesn't contain pharmaceutical or chemical substances, but may be unpleasant to anyone who comes into contact with it.

Waste type	Waste status	Human healthcare	Animal healthcare
Healthcare offensive waste, eg outer dressings and protective clothing like masks, gowns and gloves that aren't contaminated with body fluids, and sterilised laboratory waste	Non-hazardous	18-01-04	18-02-03
Municipal offensive waste, eg hygiene waste and sanitary protection like nappies and incontinence pads	Non-hazardous	20-01-99	20-01-99

You must segregate healthcare offensive waste from both clinical and mixed municipal wastes.

If you've produced more than 7kg of municipal offensive waste, or have more than one bag in a collection period, you must segregate it from any mixed municipal waste.

If you've produced less, you can dispose of your municipal offensive waste in your mixed municipal waste ('black bag'). Use classification code 20-03-01.

CLINICAL WASTE

The Collection and Disposal of Waste Regulations 1988 and the Controlled Waste Regulations 1992 define Clinical Waste as:

- a) any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs and other pharmaceutical products, swabs or dressings, or syringes, needles or other sharp instruments, being waste which unless rendered safe may prove to be hazardous to any person coming into contact with it; and
- b) any other waste arising from medical, nursing, dental, veterinary, pharmaceutical or similar practice, investigation, treatment, care, teaching or research, or the collection of blood for transfusion, being waste which may cause infection to any person coming into contact with it.

For further information on clinical waste please visit <https://www.gov.uk/how-to-classify-different-types-of-waste/healthcare-and-related-wastes>

Clinical waste is categorised by the Health and Safety Executive as follows:

Group A	<p>All human tissue, including blood, (whether infected or not), animal carcasses and tissue from veterinary centres, hospitals or laboratories, and all related swabs and dressings</p> <p>Waste materials, where the assessment indicates a risk to staff handling them, for example from infectious disease cases</p> <p>Soiled surgical dressings, swabs and all other soiled waste from treatment areas</p>
Group B	Discarded syringe needles, cartridges, broken glass and any other contaminated disposable sharp instruments or items.
Group C	Microbiological cultures and potentially infected waste from pathology departments (laboratory and post-mortem rooms) and other clinical or research laboratories.
Group D	Certain pharmaceutical and chemical wastes.
Group E	<p>Items used to dispose of urine, faeces and other bodily secretions or excretions assessed as not falling within Group A</p> <p>This includes used disposable bedpans or bedpan liners, incontinence pads, stoma bags and urine containers.</p> <p>It should be recognised that while the risk from Group E items may be low, they will often be of an offensive nature and adequate steps should be taken, in line with the general duties under Health and Safety at Work etc. Act, for proper handling and disposal arrangements.</p> <p>Other Group E items, not mentioned specifically are sanitary towels, tampons and nappies.</p>

Storage Requirements

Clinical waste should be stored in a designated area, prior to collection (e.g. Container). Signs should be considered.

Clinical waste must be kept separate from domestic waste at all times.

Colour coding should be adopted for waste:

- Black or grey bags/bins for normal household waste
- Yellow bags/bins for clinical waste
- Red plastic bags for infected linen
- Clear plastic for non-infected linen

Clinical waste storage containers/areas should be locked and inaccessible to unauthorised persons, and vermin.

A clinical waste storage container/area should be able to be disinfected, and sited on a well drained and impervious hard standing.

Clinical waste storage areas must not be near food preparation areas, and should be adequately lit.

Clinical Waste Disposal

The disposal of clinical waste is governed by the following legislation:

- Health and Safety at Work Etc. Act 1974
- Control of Pollution Act 1974
- Control of Pollution (Special Waste) Regulations 1980
- Collection and Disposal of Waste Regulations 1988
- Control of Pollution (Amendment) Act 1989
- Environmental Protection Act 1990
- Controlled Waste (Registration of Carriers and Seizure of Vehicles) Regulations 1991
- Environmental Protection Duty of Care Regulations 1991
- Controlled Waste Regulations 1992
- Control of Substances Hazardous to Health Regulations 1999

<p>Disposal of Group A Waste</p>	<p>These wastes should be placed in a suitable yellow clinical waste storage bag, or clinical waste bin if only small quantities are generated.</p> <p>Yellow storage bags should be suspended in pedal operated lidded holders and removed at least daily, or when three quarters full. Bags should be securely tied before removal, and deposited into a clinical waste storage container for collection by a Licensed Waste Operator.</p> <p>Group A Wastes must be incinerated at an authorised site.</p> <p>Yellow bag holders must be: suitable for size of bag fitted with a close fitting, foot pedal operated lid designed to facilitate easy cleaning, with smooth surfaces impermeable, and disinfected regularly inside and out</p> <p>Waste Storage Containers should be impervious, facilitate disinfection, pest resistant, and prevent unauthorised access.</p> <p>THE CONTENTS OF A YELLOW BAG MUST NEVER BE EMPTIED LOOSE INTO THE CONTAINERS.</p> <p>Clinical waste bins, like sanitary waste bins, are made of a ridged plastic but, unlike sanitary waste bins, they must be yellow and fitted with a foot pedal operated lid.</p> <p>Waste Storage Containers should be emptied weekly and clinical waste bins collected every 30 days.</p>	<p><i>Handling A Clinical Waste Bag Or Bin</i></p> <p>Each bag/bin should carry a clear label stating place of origin and contents. The Head of Service should ensure that a Manual Handling Assessment is made where there is a risk of an injury when handling a clinical waste bag or bin.</p>
<p>Disposal of Group B Waste</p>	<p>Includes discarded needles, body fluid contaminated broken glass etc</p> <p>Discarded sharps should be placed in a purpose designed container conforming to British Standard 7320 (1990). Sharps containers should be of a capacity adequate to hold items of all shapes and sizes arising, and should be sealed when three quarters full, or at intervals of one week, whichever comes sooner. Full sharp boxes must be incinerated at a licensed site.</p> <p>DO NOT PRESS DOWN SHARPS IN A BOX TO CREATE MORE ROOM</p> <p>In recent years has been the casual discarding of syringes in Council void properties and public places and Service Areas who identify staff who may encounter syringe needles must produce a risk assessment that is communicated to the staff.</p> <p>Control measures to be considered include: training staff in procedures identified by risk assessment, and to be vigilant. wearing of suitable heavy-duty gloves. use of disposable tongs use of sharps box. instructing staff on first aid treatment for needle stick injuries</p>	<p>Where possible, yellow bags and clinical waste bins should be conveyed by a trolley designated for the purpose. The trolley should be designed to facilitate easy cleaning, with smooth surfaces,</p>
<p>Disposal of Group C Waste</p>	<p>The Authority's Mortuary should comply with the Health Service Advisory Committee's publication "Safe Working and the Prevention of Infection in the Mortuary and Post-Mortem Room".</p> <p>Schools should follow the advice issued by CLEAPSS School Science</p>	

and be impermeable. There should be no harbourage for insects. The trolley should be disinfected at the end of each working day.

If staff are required to move clinical waste bags or bins by hand, they should be trained to:

- wear appropriate protective clothing
- check that storage bags are effectively sealed and/or lids secured at both the beginning and end of the movement
- handle bags by the neck only
- never throw or drop the bin or bag
- keep the bag or bins away from the member of staff's truck. (The Manual Handling Regulations 1992 should be considered)
- know the procedures in case of accidental spillage and reporting hazards/accidents
- ensure origin of waste is clearly marked on bag or bin
- understand the problems relating to sharps and aerosol disposal. (Aerosol must not be incinerated)

Transfer Of Waste By Contractor To Site Licensed To Receive Clinical Waste

Heads of Service who are responsible for establishments "producing" clinical waste, which is transferred to an incineration site, must establish procedures to ensure:

- that the waste is packed safely and securely so that there is no possibility of it escaping
- where clinical waste is transported by a contractor, that the carrier of waste is registered, or is exempt from the requirement to register
- the relevant establishment manager issues a transfer note and a description of the waste to the contractor
- copies of the transfer note and description of waste are kept for a period of two years
- that the incineration facility is licensed or authorised for receipt of the type of clinical waste

Personal Protective Clothing And Clinical Waste

All members of staff should wear appropriate "CE marked" protective clothing when handling body fluids or potentially contaminated materials. A risk assessment should be performed to determine the most appropriate supplies, however as general guidance, the following may be required:

- Non sterile latex/vinyl gloves
- Sterile latex gloves
- General household gloves for cleaning equipment
- Single use disposable plastic aprons

Plastic protective goggles, spectacles or visors

Risk Assessment Guidance on Biological Hazards in Service Areas

The purpose of this Appendix is to assist Heads of Service to identify work related biological hazards, and reduce risk to employees by advising them on vaccination.

The list of occupations is not exhaustive and is based on generic information. If you require specific advice contact the Health and Safety Unit.

Persons at Risk	Hepatitis A	Hepatitis B	Tetanus	Polio	Tuberculosis	Diphtheria	Rubella (German Measles)	Typhoid	Leptospirosis	Comments
Education Service, Leisure and Youth Workers										
Teachers, classroom assistants, nursery assistants and midday supervisors working with pupils who have physical or mental disabilities in: <ul style="list-style-type: none"> • Schools for special needs • Special units within schools • Special units 	✓	✓	✓	✓						
Physical Education Teachers			✓						✓ *	* If involved in water sports
Grounds Maintenance Staff			✓							
Staff who are regularly involved in outdoor pursuits			✓						✓ *	* If involved in water sports
Other Teaching Staff					✓ *					* For staff who have been exposed to known cases of TB
Housing, Community Care, Children and Families										
Residential care staff working with children and adults who are physically or mentally handicapped	✓	✓	✓	✓						
Residential care staff working with children and adults who exhibit challenging behaviour	✓	✓	✓	✓						
Day centre care staff	✓	✓	✓	✓						
Homeless persons officers, social workers and care workers	✓	✓	✓	✓	✓	✓	✓			
Planning, Highways and Design										
Surveyors			✓ *							* Where regularly exposed to soil

Biological Risk Chart by Occupation/Type of Work

Occupation	Tetanus	Polio	Tuberculosis	Hepatitis A	Hepatitis B	Hepatitis C
Asylum seekers	low	low	high	low	low	low
Building Control Officers	high	low	low	low	low	low
Care workers	mod	low	low	mod	mod	low
Cemetery & Crematorium	high	low	low	low	low	low
Children & Family Centres	mod	low	high	mod	mod	low
Civil Engineering & Sewer Operatives	high	high	low	high	high	high
Day Centre Staff	mod	low	mod	mod	mod	low
Environmental Health Officers	high	low	low	low	low	low
Escorts	high	low	mod	low	low	low
First Aiders	low	low	low	low	mod	low
Grounds Maintenance	high	low	low	mod	mod	low
Home Care	low	low	mod	mod	mod	low
Homeless Person Officers	low	low	high	low	low	low
Mortuary Officers	high	high	high	high	high	high
Neighbourhood Wardens	high	low	low	low	low	low
Nursery school	low	mod	high	mod	mod	low

Occupation	Tetanus	Polio	Tuberculosis	Hepatitis A	Hepatitis B	Hepatitis C
Park & Countryside Rangers	high	low	low	low	low	low
PE Teachers & outdoor pursuit staff	mod	low	low	low	mod	low
Pest Controllers	high	low	low	low	low	low
Pest Controllers – Needle stick collection	high	Low	Low	Low	High	High
Play co-ordinators	low	low	low	low	low	low
Refuse & Cleaning	high	low	low	low	low	low
Residential Care	mod	low	mod	mod	mod	low
Sewer Construction	high	high	low	high	high	high
Social workers	low	low	high	low	low	low
Social workers and family support	low	low	high	mod	mod	low
Special educational needs	mod	mod	low	mod	mod	low
Swimming pools	high	low	low	low	low	low
Team /project workers	low	low	high	low	low	low
Trading Standards	high	low	low	low	low	low
Vehicle Maintenance	high	low	low	low	high	low
Void Property Staff	high	high	low	high	high	low

Appendix C - Immunisation Information

IMMUNISATION

Immunisation is recommended where Service Areas have identified in their risk assessments that an individual may be at risk, and that immunisation will control this risk. Service Areas should keep records of all their staff vaccinations and immune status, and issue reminders for repeat immunisation if necessary. However, immunisation is not an alternative to good infection control practices and cannot be enforced.

Employees should contact their General Practitioner to carry out any necessary vaccinations. In certain cases the General Practitioner may levy a charge, and this cost should be borne by the responsible Service Area.

For all immunisations medical advice should be sought when

- Pregnant
- Suffering from acute febrile illness (except in the presence of a tetanus-prone wound)
- The individual has experienced a severe reaction to a previous dose

Disease Information	Vaccination		Comments
	Primary Dose	Reinforcing Dose	
Tetanus	<p>3 doses at 4 weekly intervals of 0.5ml absorbed tetanus vaccine.</p> <p>Primary immunisation is usually given during infancy</p>	10-yearly intervals	<p>Common reactions may include some localised pain, redness and swelling.</p> <p>Although the duration of immunity is thought to be 10 years, an adult who has received five doses of tetanus absorbed vaccine, either in childhood or as an adult, does not require further boosters other than at the time of injury.</p>
Polio	<p>3 doses each of 3 drops at 4 weekly intervals</p> <p>Primary immunisation is usually given during infancy.</p>	Necessary every 10 years only if in "high risk" group	As the vaccine strain poliomyelitis virus may be present in the faeces of recently immunised persons, strict personal hygiene following contact with faeces is necessary
Typhoid	<p>Typhoid fever is caused by salmonella typhi, which is acquired mainly through food and drink that has been contaminated with the excreta of an infected person.</p>	A single dose, 0.5ml, repeated every 3 years for those at risk.	<p>There are now 3 types of typhoid vaccine available. Two are given by injection and a third is given by mouth.</p> <p>The new injection type is "Typhim VI" which is an inactivated vaccine.</p>
Hepatitis A	<p>Hepatitis A Virus (HAV), is transmitted person to person, by contaminated food and water</p>	One dose followed by a booster at 6 -12 months	
Hepatitis B	<p>Transmission of Hepatitis B Virus (HBV) is commonly as a result of blood/body fluid to blood/body fluid contact, including injury with a contaminated sharp instrument.</p>	<p>Three doses given at 0, 4 and 24 weeks, and a post-vaccine screen one month after the third dose of vaccine, and thereafter a single dose booster every 3-5 years.</p>	<p>Accelerated Course Available</p> <p>Used when rapid immunisation is required, e.g., following exposure to Hepatitis B virus (HBV). It involves 3 doses at 0, 4 and 8 weeks with a booster after 1 year and thereafter a booster every 3 - 5 years. The dose is as described left.</p>

Appendix D - Hepatitis/HIV

Hepatitis

Hepatitis means inflammation of the liver. It may be caused by viral infections and drugs, of which the most common is alcohol. Although hepatitis viruses range from A – G, the most common are hepatitis A, B (the more serious) and C.

Hepatitis A Virus (HAV) is an enterically transmitted acute infection of the liver.

Transmission

- faeco-orally from other humans
- Through contaminated water and food. e.g. shellfish from sewage contaminated waters.

Prevention strategy

- Follow standard practice (Universal Precautions)
- Good personal hygiene, especially toilet hygiene in nurseries and schools
- Exclude infected food handlers from work
- Health education
- Immunisation procedure for staff at risk

Hepatitis B Virus (HBV), at work, HBV is transmitted through infected body fluids, accidental needle stick injury or getting cut or grazed with a contaminated item.

Transmission

- Person to person by a number of blood borne routes, e.g., horizontal transmission via skin inoculation, contamination of mucous membranes or damaged skin, or by sexual transmission.
- Vertical transmission (mother to baby) may occur intrauterine or perinatally.

Prevention strategy

- Comprehensive health education
- Immunisation procedure for staff at risk
- Availability of advice and counselling
- Adherence to infection control policy
- Follow standard practice (Universal Precautions)

Hepatitis C virus (HCV) is a major public health concern.

Transmission

- Same as HBV, except for sexual transmission, which is uncommon.

Occupational exposure, e.g. needle stick accidents and tattooing practices, account for small proportions of incidents. Although Hepatitis C is frequently asymptomatic, over half of those with acute infection may develop chronic hepatitis.

Prevention Strategy

As for HBV (except there is no HCV vaccine).

HIV and AIDS

Human Immunodeficiency virus (HIV) is the cause of HIV related illnesses including AIDS. People can have HIV without being ill with AIDS, but their body fluids remain infectious.

Acquired Immune Deficiency Syndrome (AIDS) is a severe life threatening clinical condition that causes the body's normal defences to fail and, therefore, be unable to protect itself from illness and infection.

Transmission

- Accidental injection by infected needles, instruments or glass.
- Contamination of cuts, abrasions or eyes etc, by infected body fluids

Appendix E - Tuberculosis

TB is an infection that can affect the lungs, causing a serious illness. It is now readily curable, as long as it is properly diagnosed and the right drugs are used in the correct way.

TB is spread from person to person in a similar way to colds and 'flu, although it needs somewhat more long-term exposure to an infected person for the disease to spread. The commonest symptom of TB is a cough, sometimes accompanied by phlegm, which can be bloodstained. There may also be chest pain, loss of appetite and weight, and a fever with sweating, particularly at night, and swollen lymph glands in the neck.

People who have received the BCG vaccination have some protection, which will help the body to fight off the infection

TB is a Public Health issue. The control and treatment of TB is the general responsibility of the PCT, co-ordinated by the Consultant in Communicable Disease Control (CCDC). Doctors are obliged by Public Health legislation to report any confirmed case that they become aware of to the local Environmental Health Department, who advises the CCDC accordingly.

Who is at risk?

- Anyone who has not developed natural immunity to TB, and those with a compromised immune system, or those having specific therapy e.g. steroid or chemotherapy
- Anyone who has not been vaccinated against TB
- People living in over crowded and poorly lit conditions, and the undernourished
- Post mortem attendants
- Staff in close contact with and delivering personal care to residential clients
- Staff in close contact with asylum seekers from countries known to have a particularly high incidence of TB
- Staff in close contact with persons known to have been rough sleepers
- Most healthy and well nourished people are at low risk.

Safe Working Practices

Exposure to droplet infection is impossible to avoid, so the best protection is vaccination.

Within the care sector:

- Wear mask (only for the first two weeks of the individual's treatment, thereafter it is not necessary).
- Avoid unnecessary dust when removing linen from a resident's bed. Place in the appropriate laundry bag at the bedside.

Vaccination BCG - in the UK, most children are immunised with the BCG vaccination. This usually occurs in early teens, which should provide lifelong immunity. The BCG vaccination normally leaves a permanent lumpy scar in the skin, which may confirm that vaccination has been performed.

If you think you have been exposed to TB,

- Visit your GP to determine if you are protected or not:
- If you have had contact with a person with active TB inform your manager.
- if in your job you are in constant contact with people from countries with a high incidence of TB, talk to your GP about further immunisation.

Appendix F - Meningitis

Meningitis is inflammation of the membrane lining (meninges) of the brain and the spinal cord. There are many different types of bacteria and viruses that can cause meningitis.

Generally, untreated bacterial meningitis can be fatal, whereas if viral, the condition is less severe and subsides without treatment. About 10% of people have the bacteria in their throats without harm to anyone. People at risk are young children (one to five years), teenagers and young adults.

Bacterial Meningitis is an acute infection, caused by a species of the Neisseria meningococcus (of which type A, B and C are important). Groups B and C are most common in the UK. Early detection and treatment is vital for full recovery. The condition is notifiable to the Consultant in Communicable Disease Control, and the Environmental Health Authority for contact tracing.

Transmission

- Person to person through respiratory droplets (coughs and sneezes).
- Direct contact with nose and throat secretions,

Incubation

3 to 4 days - up to 7 days.

Symptoms

Commence with a sore throat or headache and may progress rapidly within several hours to drowsiness and signs of meningitis such as fever, vomiting, headache, stiff neck, photophobia, joint pain and fitting.

A rash, (red spots or blotches that do not blanch under glass tumbler pressure), may be present, often accompanied by septicaemia.

Close Contacts

These are people who have had close prolonged contact with the case in the week before the onset of symptoms. Managers should respond quickly to any reported cases and contact occupational health immediately.

Safe Working Practices

Anyone who has been in close contact with individuals who may have the disease should contact their doctor the same day.

Appendix G - Infection Control Monitoring Sheet

Date	
Time	
Name of Establishment	
Manager	

This monitoring sheet is for the use of managers of centres and services where infection control measures are necessary. Copies of the sheets should be kept as a record of these inspections.

Standard	Issue	Yes	No	Comments	Follow Up Action	Date Complete
Hand washing	Liquid soap is available at all sinks?					
	Paper towels or hand dryers are available near all sinks?					
	No re-usable towels in use?					
	There are no nail brushes present on sinks (Except in food preparation areas)?					
	Staff involved in dealing with body fluids/clinical waste are not wearing jewellery?					
	Skin under jewellery is washed if jewellery cannot be removed?					
	No cups or drinking facilities at hand washing sinks?					
	Easy access to hand washing sink?					

Standard	Issue	Yes	No	Comments	Follow Up Action	Date Complete
Personal Protective Equipment	Are suitable gloves available?					
	Are disposable plastic aprons available?					
	Is eye and face protection available and used where necessary?					
Body Fluid Spillage	The appropriate disinfectant is available for cleaning up body fluid spillage?					
	Are staff are aware of the procedure for dealing with body fluid spillage?					
The Environment	All general areas are clean?					
	Changing room, toilets, bathrooms are clean and free from extraneous items?					
	Sluice macerator areas are free from extraneous items?					
	Kitchens are clean and not used for storage of laundry or clinical waste?					
	Toys are cleanable or machine washable and are clean and in good state of repair?					
	Cleaning specification is met?					
	Cover blankets are laundered and changed if contaminated?					
	Foot operational bins are always used for disposal of clinical waste?					

Standard	Issue	Yes	No	Comments	Follow Up Action	Date Complete
Waste Disposal	The clinical waste policy is available and staff are aware of specific procedures?					
	Foot operational bins are in working order?					
	Suitable yellow bags are used for disposal of waste (where yellow bag system operates)?					
	Waste bags are less than 3/4 full and securely tied before they are transported?					
	Household waste is placed in black bags and securely tied?					
	Clinical waste is stored only in designated area prior to disposal?					
	The storage area is locked and inaccessible to unauthorised persons and vermin?					
	Clinical waste and domestic waste is correctly segregated?					
	Bags are labelled to show place of origin?					
	Facilities are available to deal with spillage i.e. dustpan and brush and appropriate 'disinfectant'?					

Standard	Issue	Yes	No	Comments	Follow Up Action	Date Complete
Waste Disposal	Protective Clothing e.g. gloves and aprons are available to staff handling?					
	Collection of clinical waste bins and bags is undertaken regularly by a registered co and disposed of by incineration at a licensed site?					
Handling of Sharps	Sharps boxes are available for use					
	The box is not more than 3/4 full with no protrusion?					
	The sharps box is assembled correctly – check lid is secure?					
	The sharp box is labelled with point of origin?					
	Sharps are disposed of directly into sharps box?					
	Staff are aware of sharps injury policy and procedure to take in case of accident?					
	Sharps boxes are stored above floor level and safely out of reach of children?					
Chemical	Disinfectants are used at the correct dilution and appropriately?					
	COSHH Assessments are available					