



Walsall Council



INFECTION PREVENTION AND CONTROL GUIDELINES

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Application

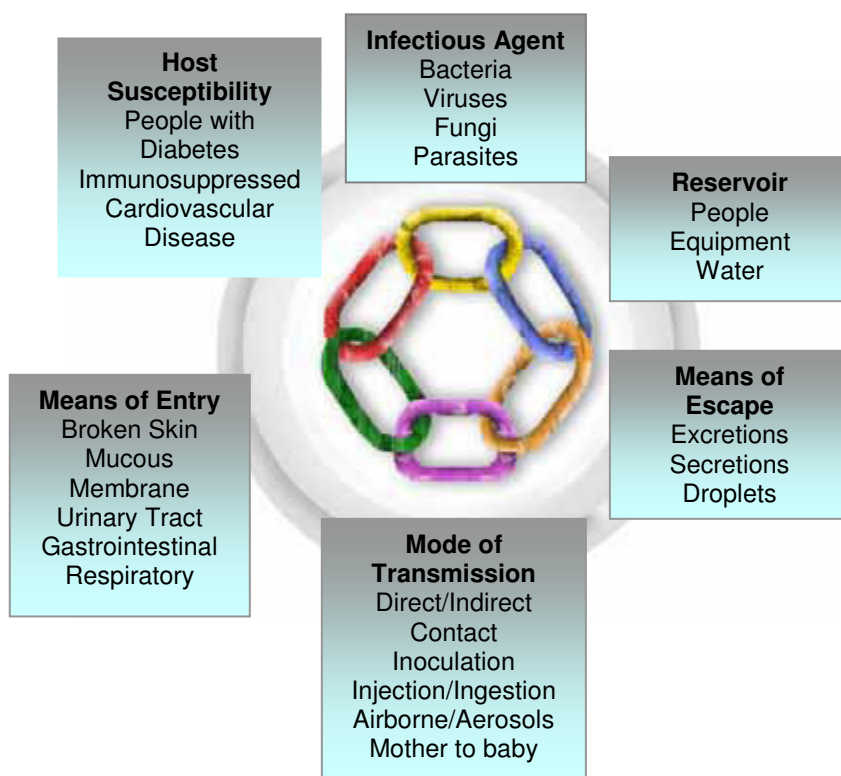
This guidance document applies to all working environments within the council where staff deliver personal care. Directorates will ensure that systems operate to identify, assess and control the risks of infection in the workplace.

Introduction

Infections at work are those created by exposure to harmful micro-organisms such as bacteria, fungi, viruses and parasites. Employees may be harmed by being infected with the micro-organism, by being exposed to toxins produced by the micro-organism, or by an allergic reaction to the micro-organism or substances it produces.

It is not always possible to identify how infection will be spread therefore; precautions to prevent the spread of infection must be followed at all times. These routine procedures are known as Standard Precautions (previously known as Universal). Following these Standard Precautions can break the chain of infection and create a safer environment for staff and clients. (See Figure 1).

Figure 1.



Routes of Infection

Micro-organisms which can cause infection are generally spread by one of four main routes:

(i) Airborne Transmission

In this route, micro-organisms spread by aerosol droplets through the air e.g. respiratory discharges such as coughs and sneezes or contaminated dust.

(ii) Faecal-Oral Transmission

Organisms spread from hand to mouth e.g. a person going to the toilet, not washing hands can then transfer micro-organisms to food which is then eaten.

(iii) Direct Contact Transmission

This can either be directly from person to person, from animal to person or indirectly via things such as inanimate objects.

(iv) Blood and Body Fluid Transmission

This includes a skin penetrating injury e.g. via a contaminated needle or other sharp object or through a bite caused by challenging behaviour or by an infected animal or insect.

Aims and Objectives

To minimise the risk of exposure to harmful micro-organisms and prevent the risk of infection.

1 The Arrangements for Applying the Guidance

1.1 Risk Assessment

The risks from infection at work can be minimised by carrying out a risk assessment and implementing appropriate control measures. In line with the COSHH Safety Management Standard on Hazardous Substances, a risk assessment must be carried out for all work activities where employees may come into contact with infectious micro-organisms at work.

Key factors that need to be considered when assessing the risk are:

- Where the organism may be present e.g. in an animal, person or environment.
- How employees may be exposed e.g. direct skin contact and/or inhalation.
- What effects it may have e.g. infection, cause allergies.
- Exposure i.e. frequency of contact taking into account the systems of work and protective measures in place.
- Who is at risk e.g. employees, visitors, service users.
- Identify employees who may be at greater risk e.g. vulnerable staff.

The aim of the assessment is to enable decisions to be made about the actions needed to prevent or control the risk. This includes the setting up of practical control measures, providing information and training, monitoring exposure and carrying out immunisation and/or health surveillance where the assessment shows that these are required.

1.2 Immunisation

The need for staff to be immunised is determined by the risk assessment process. Immunisation is a supplement to reinforce other control measures.

Staff groups identified by the risk assessment process as requiring immunisation will have vaccines made available to them free of charge.

The line manager should obtain the vaccine via SHAW Services Occupational Health Department (OHD).

2. Standard Precautions of Infection Control

2.1 Hand Hygiene

Hand washing is widely acknowledged to be one of the most important ways of controlling the spread of infection. Staff may think that they know how to wash their hands but evidence suggests that many people do not use the correct technique. This means that areas of the hands can be missed. The diagram in Appendix 1 demonstrates the hand hygiene procedure that should be followed when washing with soap and water or using alcohol hand gel or rub.

Hands should be cleaned:

- Before and after personal contact with service users
- Following cleaning activities
- Before and after handling food
- Before and after eating, drinking or smoking
- Before and after taking medication
- Before and after inserting contact lenses
- After contact with body fluids
- After removing disposable gloves
- Whenever hands are visibly dirty
- After any activity or contact that contaminates the hands including using the toilet, coughing, sneezing, handling waste etc. even if disposable gloves have been worn.

Alcohol/antibacterial hand gels and rubs are a practical alternative to soap and water where staff do not have immediate access to suitable washing facilities. However, hands that are visibly dirty or potentially grossly contaminated should wherever possible be washed with soap and water and dried thoroughly.

2.2 Hand Preparation

Preparation of the hands increases the effectiveness of cleaning.

Staff identified as at risk from infection and/or deliver personal care should:

- Keep nails short, clean and polish free
- Avoid wearing jewellery, such as wristwatches, bracelets and especially rings with ridges or stones
- Avoid artificial nails
- Cover all cuts and abrasions with a waterproof dressing.

2.3 Hand Washing Facilities

In premises, adequate hand washing facilities must be available and easily accessible. Designated hand washing facilities must be provided in treatment rooms, laundries and kitchens. Designated hand washing facilities must have basins provided with liquid soap dispensers, paper towels and foot-operated waste bins.

Where hand washing facilities are not readily available for example when working at outside locations staff should have access to alternatives i.e. alcohol/antibacterial hand gels and rubs.

Hand Drying

Improper drying can re-contaminate hands that have been washed. Wet surfaces transfer organisms more effectively than dry ones and inadequately dried hands are prone to skin damage. Disposable paper hand towels are the best drying method.

2.4. Personal Protective Equipment (PPE)

Personal protective equipment is used to protect both staff and service users from the risk of cross-infection. It may also be required for contact with animals, hazardous chemicals and some pharmaceuticals. PPE includes items such as gloves, aprons, masks, goggles or visors. In certain situations it may also include hats and footwear.

Disposable Gloves

Gloves should be worn whenever there might be contact with body fluids, mucous membranes, non-intact skin or chemicals. They are not a substitute for hand washing. Disposable gloves are for single use only and they must be removed and discarded appropriately as soon as the task is completed. (This may mean using more than one pair of gloves whilst cleaning the same client). Hands must always be washed following their removal. The disposable gloves provided must be either powder free vinyl or nitrile. Latex gloves must not be issued to staff due to the risk of sensitivity and allergic reaction associated with latex.

The correct procedure for the safe removal of re-usable and single use gloves is shown in Appendix 4.

Disposable Plastics Aprons

These should be worn whenever there is a risk of contaminating clothing with body fluids and when a service user has a known infection. Staff should dispose of them appropriately once the task is completed.

Masks, Visors and Eye protection

These should be worn when a work activity is likely to cause body fluids or substances to splash into the eyes, face or mouth. Masks may also be necessary if infection is spread through the airborne route – for example, multi drug resistant tuberculosis or severe acute respiratory syndrome (SARS). Staff will receive training to ensure that this equipment fits correctly, is handled as little as possible, and changed between service users or tasks. Masks should be disposed of appropriately immediately after use.

2.5 Managing Sharps

A sharp is defined as any item that is capable of penetrating the skin and may be contaminated with blood or other body fluids. Sharps include needles, glass, metal and knives. The main hazards of a sharps injury are Hepatitis B, Hepatitis C and HIV.

Accidents can occur at any stage and to reduce the risk of injury and exposure to blood-borne transmissible diseases, it is vital that staff are provided with training to ensure that sharps are used safely and disposed of carefully.

To avoid injury staff should ensure that:

- Sharps are not passed directly from hand to hand.
- Handling is kept to a minimum.
- Needles are not broken or bent before use or disposal.

- Syringes or needles are not dismantled by hand before disposal.
- Needles are never re-sheathed.
- They plan for the safe handling and disposal of sharps before they are used.
- Used sharps are placed in a special container at the point of use, by the user and not a third party. This should conform to UN Standard 3291 and British Standard 7320.
- Service users who self medicate must be encouraged to dispose of sharps themselves directly into a sharps container at the point of use.
- Sharps containers are not filled by more than two thirds and are stored in an area away from the public.
- Where needles are regularly used consideration should be given to the use of retractable needles.
- Sharps containers must be kept in a secure place away from unauthorised people.

Staff who are identified at risk from injury by discarded needles should be provided with puncture resistant gloves and suitable equipment for safe handling and disposal.

Premises or locations that identify a risk from discarded sharps such as syringes must have suitable equipment available/accessible to remove the sharps. Alternatively, they must liaise with the local Borough/District Council to make arrangements for the area to be made safe.

For information on what to do in the event of a needlestick injury, see Section 3 - Managing Accidents.

2.6 Disposal of Potentially Infectious Waste

There is a legal requirement for waste to be properly handled, segregated, and disposed of depending upon its type (*Department of Health document; Environment and sustainability Health Technical Memorandum 07-01: Safe management of healthcare waste*). Legislation requires the classification of waste on the basis of hazardous characteristics and point of production.

Categories of waste are no longer used (e.g. category 'A' clinical) and reclassification of wastes produced has been undertaken.

The Hazardous Waste Regulations introduced new definitions of hazardousness for infectious wastes. Wastes that contain substances containing viable micro-organisms or their toxins which are known or reliably believed to cause disease in people or other living organisms are hazardous wastes.

Waste that poses an infection risk should be considered as hazardous infectious waste. Hazardous infectious waste includes blood and other materials that may contain blood such as dressings, swabs etc.

Soiled waste such as sanitary products and plasters (from minor first aid treatment) are not considered to be infectious unless specific advice is given to the contrary by a healthcare practitioner.

Offensive waste describes wastes which are non-infectious but may cause offence to those coming into contact with it. Offensive waste includes wastes previously described as human hygiene waste and sanpro waste.

Offensive waste includes:

- Faeces
- Nasal secretions
- Sputum
- Tears
- Urine
- Vomit

Offensive waste may be considered infectious if it contains visible blood or there has been a clinical assessment that an infection exists from the waste e.g. TB in the sputum.

All staff required to handle waste must be appropriately training and instructed to

1. Understand the waste streams (classification).
2. Seal bags effectively and ensure bags are labelled appropriately.
3. Handle filled bags by the neck only.
4. Know the procedure in the event of spillage.

Segregation

1. All wastes produced must be placed in appropriately coloured bags.
2. Each bag must be filled to no more than 2/3rds capacity.
3. Each bag must be securely fastened with adhesive tape or plastic security grips to prevent risks of spillage of contents.

The procedures to be followed for the management of waste are detailed below:

(i) In the Community e.g. Service Users own home, country parks.

Type of Waste	Storage	Method of Disposal
Sharps	Sharps bin	Return to pharmacist if prior arrangements in place or use approved contractor/organisation
Hazardous/Offensive waste	Double Black Bagged	Include with household waste
Infectious waste where service user has a communicable disease	Suitable sealable container or orange bags	Local collection service
Pharmaceutical waste	Not applicable	Return to pharmacist

(ii) In Care Establishments/Services/Schools

Type of Waste	Storage	Method of Disposal
Sharps	Sharps bin	Return to pharmacist if prior arrangements in place or use approved contractor/organisation

Hazardous/Infectious waste	Orange Bagged marked for incineration Only	Collected by approved contractor
Offensive waste	Yellow with black stripe (Tiger Bag) bagged	Collected by approved contractor
	Where macerators are available incontinent aids can be disposed of in this manner	
Pharmaceutical waste	Original or suitable protective container	Return to pharmacist/family/carer

(iii) Other Environments e.g. offices, libraries, area offices

Type of Waste	Storage	Method of Disposal
Sharps	Sharps bin	Collected by approved contractor
Offensive waste including contaminated materials from first aid and body fluids	Double Black Bagged	Include with household waste
Sanitary waste	Sanitary bin	Collected by approved contractor

2.7 Managing Blood and Body Fluids

Protective clothing must always be worn when dealing with body fluid spillages. Such spillages should be dealt with immediately and precautions taken to prevent a reoccurrence.

(i) Spillages

These should be dealt with quickly, taking into account the type of spillage.

Spillage	Cleanser
All body fluids except blood i.e. vomit, urine, faeces	Disinfecting detergent
Blood	Titan Sanitiser /Protect diluted following manufacturers instructions
Body fluid in low risk areas i.e. Establishments or offices where there is a low risk of a spillage of body fluid	Body Spills Pack

(ii) Collecting, handling and labelling samples of body fluid

Staff handling samples should:

- Be instructed how to handle samples safely

- Have the necessary personal protective equipment available i.e. disposable gloves, aprons
- Collect samples in an appropriate rigid, leak proof, (sterile where appropriate) and properly sealed container
- Take care not to contaminate the outside of the container and any associated documentation
- Follow good personal hygiene principles
- Wash hands after removing Personal Protective Equipment
- Samples are to be clearly labelled and identified

2.8 Achieving and Maintaining a Clean Environment

An unclean environment is one of the factors that may contribute towards infection. High standards of cleanliness, good cleaning routines and techniques will help reduce the risk of cross-infection. Good design in buildings, fixtures and fittings is also important.

Cleaning removes contaminants, including dust and soil, large numbers of micro-organisms and the organic matter that shields them, for example, faeces, blood and other bodily fluids. In addition to this, colour-coding cleaning equipment will help to prevent and control the risk of cross contamination, keeping red items (gloves, mops, buckets and cloths) for sanitary areas and other colours for elsewhere.

Cleaning

This is an essential part of a programme for the control of infection. Cleaning uses water and detergent to remove visible contamination but does not necessarily destroy micro-organisms, although it should reduce their numbers. Cleaning is also essential prior to disinfection as this is then much more likely to be effective.

Disinfection

This uses chemical agents e.g. the use of hypochlorites or heat to reduce the number of organisms to a level where they are unlikely to be a danger to health, although it may not necessarily inactivate all viruses and bacterial spores.

The routine use of disinfectants for general cleaning is unnecessary. Thorough regular use of detergent and hot water is sufficient for routine purposes. Titan Sanitiser/Protect is to be used for items which are contaminated with blood. The use of hypochlorites (bleach) is restricted and must only be used after consultation with the Health and Safety Team. Approval to use hypochlorites (bleach) is only normally given to disinfect following an outbreak of a communicable disease such as gastro-enteritis.

All disinfectants are potentially hazardous and must be used with caution; for example hypochlorites (bleach) are irritants, corrodes metals and bleaches fabrics.

The use of disinfectants is governed by the Control of Substances Hazardous to Health (COSHH) Regulations, an assessment of the product should be made prior to use and staff provided with information, instruction and training.

The table below lists cleaning materials and when they should be used:

Agent	Preparation	Use
General purpose detergent	As supplied	Routine and environmental cleaning
Disinfecting Detergent	Follow manufacturer's instructions.	Cleaning all body fluids except blood.
Titan Sanitiser/Protect	Follow manufacturer's instructions.	Blood and body fluid spillages, but not urine, for which hot water and detergent are adequate.
Hypochlorites (Bleach)	If an alternative is unsuitable then conduct a risk assessment before use and follow manufacturer's instructions	Disinfection of hard surfaces and equipment, especially toilets, commodes and baths.
Department for Environment, Food and Rural Affairs (DEFRA) Approved Disinfectant	At approved dilution rates	Staff in regular contact with non domestic animals to use for foot dip and to clean personal protective equipment.

3. Managing Accidents

Accidental exposure to body fluids can occur by:

- Injury penetrating the skin – for example, from needles, instruments, bone fragments or significant bites that break the skin.
- Exposure of broken skin – for example, abrasions, cuts or eczema.
- Exposure of mucous membranes, including the eyes and the mouth.

The action that should be taken immediately following accidental exposure to body fluids, including blood is given below and illustrated in Appendix 2.

(a) Action to be taken by the person exposed:

Immediately stop what you are doing and attend the injury.

- Encourage bleeding of any wound by applying gentle pressure – do not suck.
- Wash well under running water, dry and apply a waterproof dressing as necessary.
- If body fluids splash into eyes, irrigate with cold water.
- If body fluids splash into your mouth, do not swallow. Rinse out several times with cold water.

- Report the incident to your manager and complete an Accident Form
- If line manager is not available contact the Occupational Health Department (OHD).
- If the OHD is not available advice must be sought from the A&E Unit.

(b) Action to be taken by the line manager:

- Initiate an investigation into the cause of the incident.
- If the Service User involved in the incident is known gain information from the Care Plan about medical history.
- Assess the degree of risk to the employee. Incidents that will normally be regarded as high risk are:
 - Needlestick injuries
 - Bites – that break the skin
 - Any incident resulting in the skin being broken
- Contact Occupational Health Department for follow up action/treatment as necessary.
- Inform the OHD of all relevant information about the incident.
- Ensure an accident form is completed.
- Complete/review risk assessment.
- Following an incident, exposed staff should be given time to talk about their concerns, provided with information about the risks arising from the exposure, and informed of the support available from the staff counselling service.

(c) Action to be taken by the Occupational Health Department

- Check the immune status of the exposed employee if known, and discuss their immune status with the employee.
- Dependent on best practice, offer the employee the chance to have their blood tested and stored if required. (Note: the OHD may charge for storage).
- Offer the employee counselling.
- If the employee is exposed to a transmissible disease, further advice from the microbiologist will be sought as to whether treatment is required.
- Where possible blood should be taken from the client (if known) following counselling and the client tested for Hep B, C and HIV (This will be arranged by the GP).

(d) Contacting the Accident and Emergency Unit (A&E)

- If the OHD is not available and the incident is deemed 'high risk' advice must be sought from the A&E Unit.

4. Reporting of Infectious Incidents

4.1 The Reporting of Incidents, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR).

There is a requirement in RIDDOR for employers to report acute illness requiring medical treatment, where there is reason to believe that this resulted from an exposure to a pathogen or infected material. Managers are responsible for reporting any occupational disease to the Health and Safety Executive.

4.2 The Health Protection (Notification) Regulations 2010

These Regulations require the reporting of infectious diseases to local authorities. These are known as notifiable diseases.

Under the above Regulations the doctor who makes the diagnosis (confirmed or suspected) of a notifiable disease is required to notify the Proper Officer of their Local Authority. The Proper Officer is usually the Consultant in Communicable Disease Control (CCDC) based in the West Midland Health Protection Unit

Other agencies may also have to be informed of incidents of notifiable diseases e.g. Care Quality Commission (CQC) Department for Environment, Food and Rural Affairs (DEFRA). The relevant requirements for the notification of diseases must be followed at all times.

5. Special Considerations for First Aiders

The risk of being infected whilst carrying out first aid duties is small. The following precautions can be taken to reduce the risk of infection:

- Cover any cuts or grazes on your skin with a waterproof dressing.
- Wear disposable gloves when dealing with blood or any other body fluid.
- Use suitable eye protection and a disposable plastic apron where splashing is possible.
- Use devices such as a resuscitator when giving mouth-to-mouth resuscitation, but only if you have been trained to use them.
- Wash hands after the procedure.

Body Spills Kits should be made available where Titan Sanitiser/Protect is not readily available.

6. Vulnerable Employees

If there is a known infectious risk, managers must consider if any of the staff exposed would be at increased risk due to their own health. These groups would include:

New or Expectant Mothers

Some infections in pregnancy may cause damage to the developing baby and pregnant staff should not work with these infectious hazards. (Advice must be sought from the Health and Safety Team or Occupational Health Unit, on individual cases when appropriate.) Main risks are from chicken pox, rubella, measles like rashes and certain zoonoses such as toxoplasmosis and psittacosis. All pregnant staff must have a risk assessment completed as soon as their pregnancy is known.

Those with lowered immune system (immunocompromised)

This would include those being treated with radiotherapy and chemotherapy for cancer, and high doses of steroids or illness that affects immunity such as Leukaemia, HIV. These individuals are more likely to develop some infections and these may be more severe. Advice must be sought from the Occupational Health Department on an individual case basis and an individual risk assessment carried out.

Glossary of Terms

For the purpose of this guidance the following terms apply:

Blood-Borne Viruses (BBV's). These are viruses that some people carry in their blood that may cause diseases in certain people and few or no symptoms in others. The virus can spread to another person whether the carrier of the virus is ill or not. e.g. HIV, Hep B and Hep C.

Body Fluids. These include blood and other body fluids e.g. urine, faeces, saliva, sputum, vomit, breast milk, semen and vaginal secretions and sources of blood/body fluids such as human bodies, animal carcasses and raw meat.

Body Spills Kit. Products and kits specially designed for the safe removal of body fluids (blood, urine, vomit, etc.) in order to ensure a safe working environment and high level of hygiene. Kits usually consist of items such as solidifying granules, disinfectant spray, gloves, bio hazard disposal bag, bag closure etc.

Consultant in Communicable Disease Control (CCDC)/ Proper Officer. Local Authorities have a statutory responsibility to control infectious diseases within their areas and to facilitate this a CCDC is formally appointed as the Proper Officer of Local Authority to take the lead in the control of communicable diseases. The CCDC is based at the West Midlands Health Protection Unit (See useful contact numbers)

Infection. This is the process that occurs when micro-organisms gain access to a host and there is evidence of tissue invasion or damage. This evidence may be redness or swelling, temperature, pus, pain or abnormal bleeding.

Notifiable Diseases. These are diseases and/or infections that are reportable to the Health and Safety Executive (HSE), Environmental Health or the Consultant in Communicable Disease Control (CCDC). (See Useful Contact Numbers below)

Zoonoses. These are infections that are transmitted from animals to humans.

Standard Documents

Appendix 1 Effective Hand Hygiene

Appendix 2 Managing Accidental Exposure to Body Fluids

Appendix 3 Guidance on Infections

Appendix 4 Correct Removal of Re-usable and Single use Gloves

Useful Contact Number

West Midlands Health Protection Unit

Elgar House
Green Street
Kidderminster
DY10 1JF
Telephone: 01562 756 300

Email: WestMidlandswest@hpa.org.uk

(This organisation can provide expert advice on Infection Control related issues)

Infection Prevention and Control

Public Health Department
NHS Walsall
Jubilee House
Bloxwich Lane
Walsall
WS2 7JL
Telephone: 01922 619972

SHAW Services Occupational Health

Challenge Building
Hatherton Street
Walsall
WS1 1YG
Telephone 01922 653521

Appendix 1 Effective Hand Hygiene

Breaking the Chain

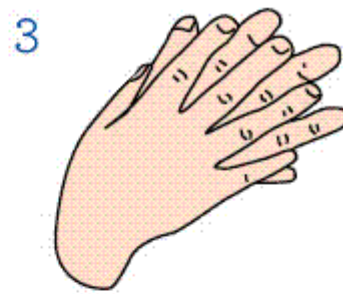
Hand Washing Technique



Wet hands under running water.



Apply soap and rub palms together to ensure complete coverage.



Spread the lather over the backs of the hands.



Make sure the soap gets in between the fingers.



Grip the fingers on each hand.



Pay particular attention to the thumbs.



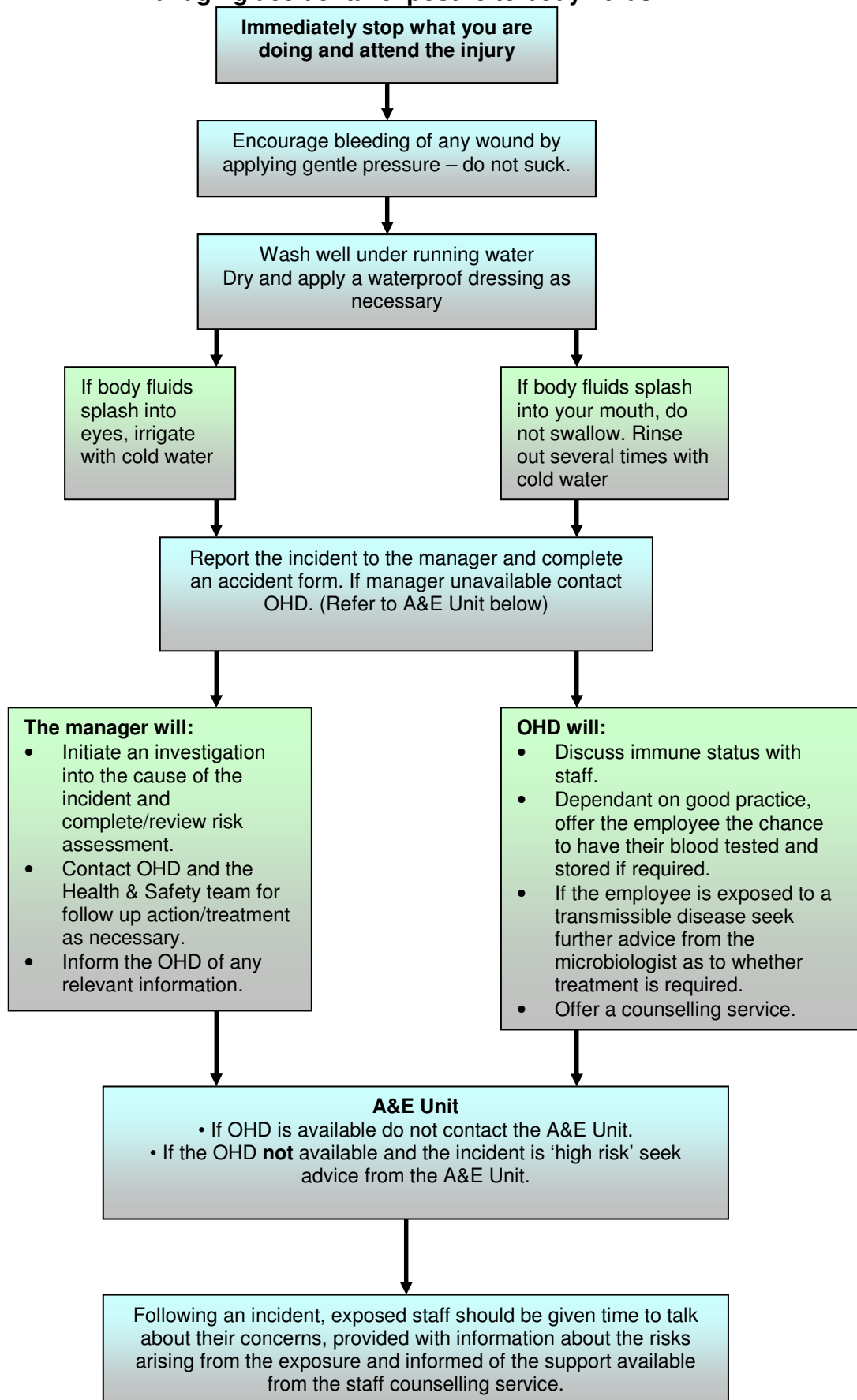
Press fingertips into the palm of each hand.



Rinse and dry thoroughly with a clean towel.

Appendix 2

Managing accidental exposure to body fluids



Appendix 3

GUIDANCE ON INFECTIONS

GENERAL INFECTIONS

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
CHICKENPOX	15–18 days.	From 1 day before up to 5 days after the appearance of rash.	Exclude for 5 days from onset of rash.	If a vulnerable person or pregnant woman is exposed to chickenpox or shingles they should be informed of the contact and be advised to seek appropriate medical advice.
SHINGLES	Re-activation of Chicken Pox virus.	Infectious only if lesions are exposed.	Only those people who have previously had chicken pox can get shingles.	
CONJUNCTIVITIS (viral or bacterial)	Depends on cause.	Whilst eye is inflamed, spread by contact, sharing towels etc.	Until treatment has begun and inflammation has started to resolve.	Good personal hygiene can reduce the risk of transmission.
FIFTH DISEASE (Slapped Cheek Syndrome/ Parvovirus)	5-7 days.	Probably from 7-14 days after initial contact.	Until clinically well. Rash does not indicate infectivity.	If a pregnant woman is exposed to Parvovirus she should promptly inform her GP.
GERMAN MEASLES (RUBELLA)	14–21 days.	From a few days before to 5 days after onset of rash.	5 days from appearance of rash.	If a pregnant woman is exposed to Rubella she should promptly seek advice from her GP.
GLANDULAR FEVER	33–49 days.	Once symptoms have subsided, risk is small apart from very close contact, e.g. kissing.	Until clinical recovery.	None.

Appendix 3

GUIDANCE ON INFECTIONS

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
HAND, FOOT AND MOUTH DISEASE	3–7 days.	Probably from 1 day before to a few days after onset of symptoms.	Until clinically well. Rash does not indicate infectivity.	None.
HEPATITIS A (Infective Hepatitis)	2-6 weeks.	From 7 - 14 days before to 7 days after onset of symptoms.	7 days from onset of jaundice and when clinically fit with no symptoms.	None.
INFLUENZA	1-5 days.	Probably up to 7 days in young children; 3-5 days in adults.	Until clinically well.	Immunisation is available for certain vulnerable groups.
MEASLES	10–15 days.	A few days before up to 5 days after onset of rash.	5 days from onset of rash.	None.
MENINGOCOCCAL DISEASE MENINGITIS/ SEPTICAEMIA	2-10 days (Commonly 2 – 5 days).	Whilst organism is present in naso-pharynx (back of the nose and throat).	Until clinical recovery. CCDC will advise.	No exclusion for contacts receiving antibiotic prophylaxis.
MENINGITIS not due to meningococcal infection	Varies.	Varies.	Once person is well they can return to school.	
MUMPS	12–21 days.	From a few days before onset of symptoms to subsidence of swelling.	Until swelling has subsided or when clinically recovered 5 days from onset of swollen glands.	None.

Appendix 3

GUIDANCE ON INFECTIONS

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
SCARLET FEVER AND OTHER STREPTOCOCCAL INFECTIONS	2–5 days	Whilst organism is present in the naso-pharynx (back of nose and throat) or skin lesion	5 days after commencing antibiotics	None
TONSILITIS	Varies depending on organism	Varies depending on organism	Until clinically well	None
TUBERCULOSIS	Variable	Whilst organism is present in sputum	CCDC will advise – usually requires at least 2 weeks of treatment	Exclusion is not necessary after 2 weeks of treatment. Screening of contacts is routine policy in cases of pulmonary TB
WHOOPING COUGH	10–14 days	7 days after exposure to 21 days after onset of paroxysmal coughing ('the whoop').	5 days after commencing antibiotics	None
WORMS	Variable	Until worms are treated	Until treated, may return with strict advice on good hand hygiene	Close contacts, ie family members will require treatment

Appendix 3

SKIN INFECTIONS

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
HEADLICE (PEDICULOSIS)	Lice eggs hatch in a week and reach maturity in 8-10 days	As long as lice remain alive	Exclusion is not necessary however, treatment should be administered as soon as possible after detection of live lice – all contacts should be checked	Examination of family is required and treatment undertaken if live lice are detected. Head lice can only move from one head to another during head to head contact of at least 1 minute.
IMPETIGO (Streptococcus pyogenes and Staphylococcus aureus)	Usually 4-10 days, but can occur several months after colonisation	Whilst lesion remains moist	Until the lesions have crusted or healed. Treatment is rapidly effective.	None
MOLLUSCUM CONTAGIOSUM	19-50 days: 7 days to 6 months	Unknown, probably as long as lesions persist	No exclusion necessary	None
RINGWORM OF FEET (ATHLETES FOOT)	Unknown	As long as lesions are present	Exclusion from school or barefoot exercise not necessary once treatment commenced	None

Appendix 3

GUIDANCE ON INFECTIONS

INFECTION	USUAL INCUBATION PERIOD (DAYS)	INFECTIOUS PERIOD (DAYS)	ADVICE ON RESTRICTIONS AND EXCLUSIONS	FURTHER INFORMATION
RINGWORM OF SCALP	10-14 days	As long as active lesions are present	Exclude until treatment has commenced. Treatment usually lasts several weeks	None
RINGWORM OF BODY	4-10 days	As long as lesions are present	Exclude until treatment has commenced	None
ROSEOLA (Sixth Disease)	10 days range 5-15 days	Unknown	No exclusion necessary	None
SCABIES	2-6 weeks	Until treated	Exclusion until the day after the first treatment	Mites are transferred during prolonged skin to skin contact. Those who have had prolonged skin to skin contact should have simultaneous treatment
VERRUCAE PLANTARIS (PLANTAR WARTS)	2-3 months	Unknown, probably as long as lesion visible	Not generally necessary. PE and swimming may continue providing lesion is covered with a waterproof plaster	None

Appendix 4

Correct removal of gloves

Reusable gloves (chemically resistant)

Follow the steps shown

Wipe or rinse gloves and remove carefully to protect your skin from contamination

Dispose of gloves in a suitable container

- Always select the correct size gloves
- Use gloves for no longer than one day

Store gloves on a clean surface for re-use

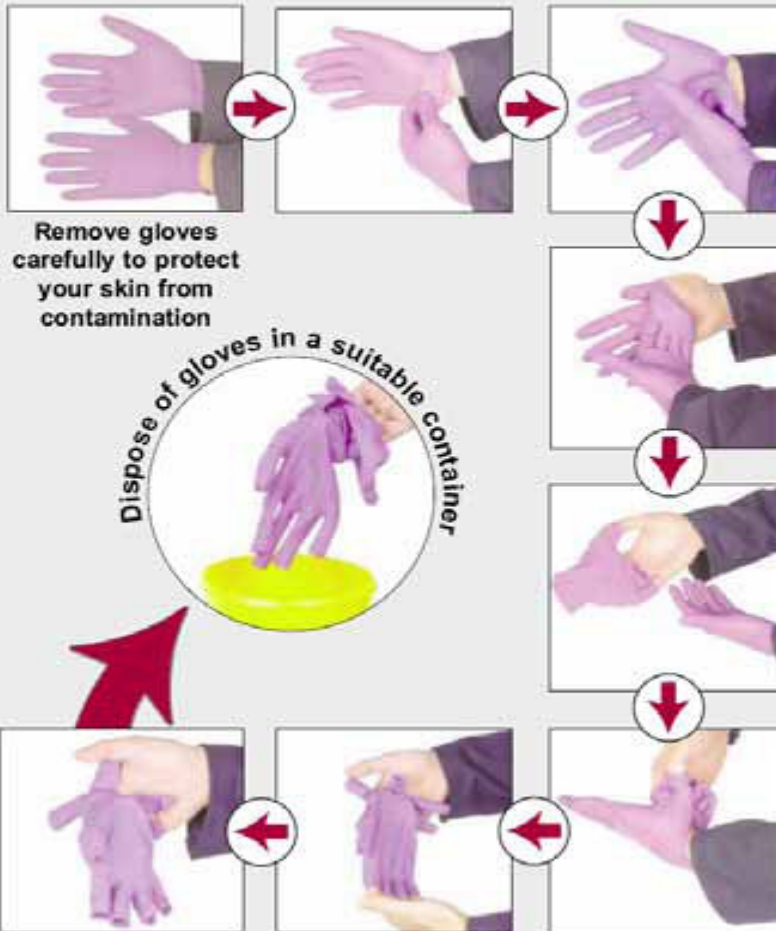
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Appendix 4

Correct removal of gloves

Single use gloves (splash resistant)

Follow the steps shown



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