

## Infection Prevention and Control Policy and Guidance

Issue	16
Reference number	QP67
Name of responsible (ratifying) committee	Policy Review Group
Document Manager (job title)	Quality Manager
Date issued	November 2009
Review date	September 2021
Electronic location	Share-point/Policies and Procedures

### Version Tracking

Version	Date Ratified	Brief Summary of Changes	Owner
1	28 Sept 2018	Addition of ESBL information	JP
16v1	01/04/2020	Addition of information regarding Covid-19 and donning and doffing PPE process	JP
2	4 May 2020	Covid-19 update. Page 2, links to gov.uk guidance, refresh links to current RCN guidance page 5; reference to Covid-19 risk assessments page 6; addition of donning and doffing PPE page 10; addition of covid-19 in infection matrix page 15	JP
3	25 Sept 2020	Scheduled review, no material changes; will be kept under review regarding changes in guidance for managing IPC in relation to Covid-19; policy links to up to date Govt/PHE sites	JP

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## **1. Purpose of this document**

This policy supplements Agincare’s Health and Safety Policy which provides policy information regard the company’s commitment to safe working practices including prevention and control of infection.

The purpose of this document is to provide guidance for staff on the importance of limiting the spread of infection and is based on NICE (National Institute for Clinical Excellence) Quality Standard QS61 published in April 2014 which has been endorsed by NHS England, as required by the Health and Social Care Act (2012). NICE Guidance CG139 Healthcare-associated infections: prevention and control in primary and community care also apply as does the 2020 [BGS Covid-19-Managing-the-covid-19-pandemic-in-care-homes](#) and the [Covid-19 guidance for residential care, supported living and home care. All employees are encouraged to keep abreast of updates to gov.uk Covid-19 guidance directly as well as the frequent updates and bulletins sent out regarding such changes internally](#)

All Agincare services must have in their contact directory the details for their local CCG Infection Control Lead and local Health Protection Unit (HPU). This can be found on the local NHS Trust/CCG web site and the contact details should be held in the IPC Lead information file.

It is estimated that 300,000 patients a year in England acquire a healthcare-associated infection as a result of care within the NHS. In 2007, *meticillin-resistant staphylococcus aureus* (MRSA) bloodstream infections and *Clostridium difficile* infections were recorded as the underlying cause of or a contributory factor in, approximately 9000 deaths in hospital and primary care in England. Such statistics are not available for social care services but from this we can see that infection prevention and control remain a priority.

## **2. Introduction**

The 2020 Covid-19 coronavirus pandemic has brought many changes and restrictions into daily practice in relation to infection, prevention and control including enhanced need for use of personal protective equipment (PPE) and periods of isolation and shielding for those deemed extremely vulnerable which includes restriction of activity and of non-essential visitors. Agincare have responded to the situation by ensuring continual updates of government and Public Health England guidance are made available to staff at all times through a variety of means; all Agincare staff are considered to be key workers providing vital support to people who need it and it is imperative that information is shared with all staff. Any staff member can speak to their manager about any concerns and if they have not received regular updates and information can be found in the HR weekly newsletter and on [Agincare News pages](#).

Amendments to this policy include reference to the process for donning and doffing PPE, Risk Management and Training specifically on management of Coronavirus. Separate guidance is sent out regularly based on HM government and PHE guidance and updates to address the hopefully short-term challenges of the Coronavirus pandemic rather than weekly/or frequent, changes to policy

People receiving health and social care are at risk of developing infection as a result of their compromised state of health, underlying medical conditions, or as a result of contact with care interventions from processes such as continence care or wound care. In addition, health and social care settings can provide ideal conditions for microorganisms to be transmitted between those who receive and give care. The close proximity and contact between each party and the continuous contact in a shared working and living environment all contribute to transmission.

A wide variety of healthcare is delivered in health and social care settings. Healthcare-associated infections (HCAI's) arise across a wide range of clinical conditions and can affect people of all ages and care and nursing staff, family members and other carers are also at risk of acquiring infections when caring for people. HCAI's can occur in otherwise healthy individuals, especially if invasive procedures or devices are used; for example, indwelling urinary catheters are the most common cause of urinary tract infections

Infection control is about controlling the spread of communicable diseases between individuals receiving care, staff and visitors. The people we care for are often particularly vulnerable to infection, and as such extra care needs to be taken.

A stomach bug introduced to a care setting can quickly spread resulting in staff going off sick and making individual's care needs increase. So it is vital that you are aware of the importance of limiting the spread of infection.

Infection can be spread through

- Physical contact
- Airborne – sneezing/coughing
- Contact with bodily fluids
- Eating contaminated food

The Health and Social Care Act 2008, details the legal responsibilities of registered care providers in ensuring against the spread of infection.

The 'Code of Practice' for health and adult social care on the prevention and control of infections sets out the 10 criteria determined by the Department of Health with which, if a provider complies will demonstrate that they are meeting the Fundamental Standard regulations (Regulated Activity) Regulations 2014 Not all criteria will apply to every regulated activity; table 1 outlines the criterion appropriate to Agincare regulated activities for which it is the service manager's responsibility to develop their risk assessments.

**Table 1: HSCA 10 Criterion for Infection Prevention and Control**

<b>Regulated Activity</b>	<b>Personal Care (AUK/LICS)</b>	<b>Accommodation for persons who require nursing or personal care  Treatment of disease, disorder or injury (Care and Nursing Homes)</b>
1. Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible people using services are and any risks that their environment and other users may pose to them.	✓	✓
2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.	N/A	✓
3. Ensure appropriate antimicrobial use to optimize patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	N/A	✓
4. Provide suitable accurate information on infections to people using services and their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.	✓	✓
5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive the timely and appropriate treatment and care to reduce the risk of transmitting infection to other people.	✓	✓

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.	✓	✓
7. Provide or secure adequate isolation facilities.	N/A	N/A
8. Secure adequate access to laboratory support as appropriate.	N/A	N/A
9. Have and adhere to policies, designed for the individual's care and provider organizations that will help to prevent and control infections.	✓	✓
10. Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	✓	✓

The full code of practice is available on share-point and managers and IPC Leads should have a copy of this printed and available for reference. The code provides guidance for compliance against each of the criterion.

NICE quality standard QS61 lists six quality statements two of which are not applicable to Agincare services (antimicrobial stewardship and insertion and maintenance of vascular devices), the remaining 4 statements are detailed and referenced throughout this guidance document. The full Quality Standard can be seen at <https://www.nice.org.uk/guidance/qs61>

Agincare has a strategy for continuous improvement in infection prevention and control, including accountable leadership (IPC Leads), partnership working with other health and social care professionals and the use of surveillance (health declaration and staff sickness monitoring, outbreak management and audit). Leadership underpins all infection prevention and control, and is vital to ensure that this remains a priority for the organisation as a whole and each person working within it. Agincare's leadership, accountability and governance for infection prevention is provided through the Quality Management Committee's Policy Review Group to ensure policies, procedures and reporting mechanisms are robust and effective, the Quality Management Policy to ensure effective audit and improvement plans, and management of training provision to ensure all staff are conversant with current best practice guidance for infection, prevention and control (NICE QS61 Quality statement 2)

### **3. Policy Statement**

This policy concerns safe working practices for Agincare staff in relation to health and hygiene and control of infection

This policy has been written in accordance with published good practice advice and guidance from NICE guidance CG139 Infection: Prevention and control of healthcare-associated infections in primary and community care 2017, from the RCN Essential practice for infection prevention and control Guidance for nursing staff 2017, the Department of Health Care Home Resource (Prevention and control of infection in care homes – an information resource) published in conjunction with the Health Protection Agency in 2013, and from the Health and

Social Care Act Code of Practice for health and adult social care on the prevention and control of infections

#### **4. Infection prevention and control lead person (IPC Lead)**

Criterion 1 of the Code of Practice says that each organisation should identify a person to lead on infection prevention and control (IPC Lead). This person should have the appropriate knowledge and skills to carry out the role which includes being trained on infection prevention and control issues.

The IPC Lead should report directly to the Registered Manager (if the lead is not the registered manager) and produce an annual statement with regard to compliance with good practice on infection prevention and control and make this statement available to the Care Quality Commission on request.

The IPC Lead should be responsible for the implementation of appropriate policies, procedures, staff training and supervision programmes and should carry out a review of the infection prevention and control programme and activities and produce a report of the outcomes and a programme of improvement, if necessary. (See Agincare's Quality Management Procedure and Infection Prevention and Control audit (AHH) and IPC Lead pack which contains guidance information.

The IPC Lead should challenge inappropriate practice and recommend new policies or new ways of working as necessary. A list of names and contact details of all health practitioners locally who can provide advice and support when needed should be maintained by the IPC Lead; this might include hospital infection control doctors, the local infection control nurse, the local authority, local Health Protection Unit, the Environmental Health Office and any occupational health service used.

#### **5. Risk assessment**

As with other risks to the health and well-being of staff and people who use services, a risk assessment should be carried out to determine the possible risk to the person, their family, friends, Care Workers, other staff or visitors when dealing with infections and infectious material. The Health and Welfare Assessment which is used prior to a person receiving a service would identify any specific needs for instance around catheter care or any current infections and how they are managed and/or treated. Where risks of infection arise during the delivery of care the risks should be assessed using the General Risk Assessment form to identify what the hazard (the risk) is and what control measures are needed. Care home routines ensure measures are in place to prevent and control the spread of infection (Service Location Health and Safety Audit, Infection, Prevention and Control audit, Cleaning and Decontamination Schedules) Where care is delivered in people's own homes (AUK, LICS and Supported Living) additional risk assessments should be carried out by an assessor who has an understanding of infection prevention and control and the Health and Welfare

Assessment and the Health and Safety checklist and safe working methods guide should be used.

Once the risks have been identified, control measures will need to be put into place to prevent or control the risk of infection; those control measures should be transferred to the individual care plan except where there is an environmental or contagion risk in AHH where the action plan from the risk assessment should be available to all relevant persons with their roles and responsibilities clearly outlined.

Legislation only requires the organisation to assess the risks for infection hazards that are 'reasonably foreseeable'. The infection risks and prevention and control measures should be recorded and reviewed on a regular basis and any new measures implemented accordingly. Care workers need to know when a new risk assessment might need to be carried out. This often follows a change in the persons condition.

The General Risk Assessment Form should be used for infection control risk assessments. Appendix 1 provides some examples of an infection control risk assessment using the General Risk Assessment Form. A Covid-19 specific Risk assessment has been instigated in all Agincare premises and is kept under review. In Care Homes where Covid-19 outbreaks have occurred, a Root Cause analysis has been undertaken to identify any potential issues with control of the spread of the infection and where additional 'general' Covid-19 risk assessment are needed to be reviewed. A root cause analysis must be undertaken following and outbreak of any infection to understand the outbreak and learn from matters arising to help prevent further outbreaks (ie Norovirus, influenza)

## **6. Notification and Reporting infectious diseases**

Any outbreak of infectious disease must be reported:

Internally - using Agincare's Accident and Incident report form; this should be logged and included on the monthly audit

Externally – if required; follow the CQC Notification and RIDDOR reporting guidelines contained in the Notification Reporting Procedure Including Deaths, Incidents Accidents and Changes to Regulated Activity and;

- to the Health Protection Unit of the Local Authority or PCT (sometimes these are Regional Units, the IPC Lead will have the contact details)

A list of reportable diseases is contained within the RIDDOR guide and of infection diseases that are reportable is held by the IPC lead in the IPC Lead guide.

## **7. Staff sickness reporting**

See Also Agincare's staff sickness policy (contained within the Absence Management Policy) which outlines what staff should do to report illness, how much time off they are allowed

and how self-certification works and the Statement of Fitness to Work which, provided by GPs, with a statement of fitness to work

If a Care Worker has contracted an infection or disease through work, time off should be allowed to recover fully from the illness. Be aware that some care workers might pass their illness on to family members and then might be off work caring for dependents so you may not be paying for sickness absence for the whole period.

## **8. General Principles of Effective Infection Prevention and Control**

- 8.1 Hand washing and decontamination is the single most important method of preventing the spread of infection.
- 8.2 Everyone involved in providing care should be:
- educated about the standard principles of infection prevention and control **and**
  - trained in hand decontamination, the use of personal protective equipment, waste disposal and the safe use and disposal of sharps.
- 8.3 Wherever care is delivered, staff must have available appropriate supplies of:
- materials for hand decontamination
  - sharps containers personal protective equipment.
- 8.4 People who receive a service and their carers should receive information about:
- the benefits of effective hand decontamination
  - the correct techniques and timing of hand decontamination
  - when it is appropriate to use liquid soap and water or hand rub
  - the availability of hand decontamination facilities (Care Homes)
  - their role in maintaining standards of healthcare workers' hand decontamination.

Agincare's Standard Precautions Leaflet (share-point/information leaflets for people using services) should be provided

- 8.5 All staff should adhere to the company Basic Food Hygiene Policy as detailed in the company Health and Safety Policy and the company Basic Food Hygiene Guidance. These ensure that all food prepared for people is prepared, cooked, stored and presented in accordance with the high standards required by the Food Safety Act 1990, the Food Safety (General Food Hygiene) Regulations 1995 and the Food Safety (Temperature Control) Regulations 1995. Any member of staff who becomes ill while handling food should report at once to his or her line manager/supervisor and those staff

reporting illness should see their GP and should only return to work when their GP states that they are safe to do so.

- 8.6 All staff should adhere to this guidance on the use of protective clothing (PPE) and use the disposable gloves and aprons which are provided for staff who are at risk of coming into direct contact with body fluids or performing personal care tasks. Our clothes can pick up infection and pass it from one person to another and so it is important for staff to change gloves and aprons (and wash their hands) between working with different individuals. Agincare provides aprons and gloves routinely however it is the responsibility of care workers to ensure they wear these as required for specific care tasks.

Selection of protective equipment must be based on an assessment of the risk of transmission of microorganisms to the person, and the risk of contamination of the staffs clothing and skin by patients' blood, body fluids, secretions or excretions

8.6.1 Gloves used for direct patient care:

- Must conform to current EU legislation as issued by Agincare (CE marked as medical gloves for single use) <sup>and</sup>
- should be appropriate for the task

8.6.2 Gloves must be worn as single-use items. They must be put on immediately before an episode of care contact or treatment and removed as soon as the activity is completed. Gloves must be changed between caring for different patients, and between different care or treatment activities for the same patient

8.6.3 Ensure that gloves used for direct care that have been exposed to body fluids are disposed of correctly, in accordance with current national legislation or local policies (Health and Safety Policy; disposal of Waste)

8.6.4 Alternatives to natural rubber latex gloves must be available for people, carers and staff who have a documented sensitivity to natural rubber latex

8.7 When delivering direct care:

- wear a disposable plastic apron if there is a risk that clothing may be exposed to blood, body fluids, secretions or excretions **or**

8.7.1 When using disposable plastic aprons or gowns:

- use them as single-use items, for one procedure or one episode of direct care **and** ensure they are disposed of correctly
- Staff should treat every spillage of body fluids or body waste as potentially infectious and clean the area as quickly as possible whilst wearing protective gloves and aprons.

## 8.7.2 Donning and Doffing PPE

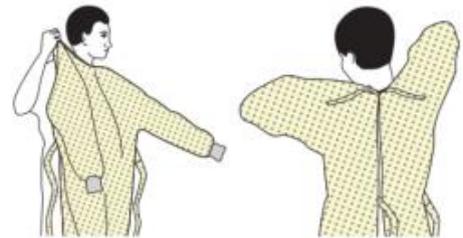
The following pages show the correct procedure for putting on (donning) and taking off (doffing) PPE

### SEQUENCE FOR PUTTING ON PERSONAL PROTECTIVE EQUIPMENT (PPE)

The type of PPE used will vary based on the level of precautions required, such as standard and contact, droplet or airborne infection isolation precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

#### 1. GOWN

- Fully cover torso from neck to knees, arms to end of wrists, and wrap around the back
- Fasten in back of neck and waist



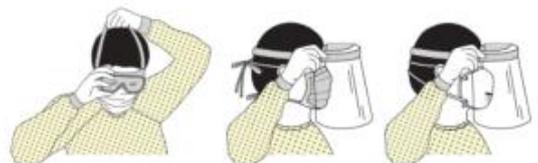
#### 2. MASK OR RESPIRATOR

- Secure ties or elastic bands at middle of head and neck
- Fit flexible band to nose bridge
- Fit snug to face and below chin
- Fit-check respirator



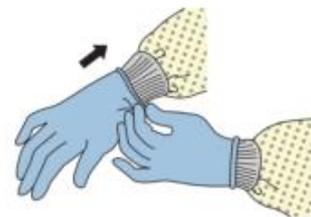
#### 3. GOGGLES OR FACE SHIELD

- Place over face and eyes and adjust to fit



#### 4. GLOVES

- Extend to cover wrist of isolation gown



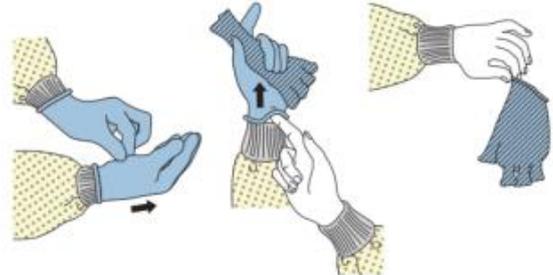
In most circumstances and for standard precautions during personal care, aprons rather than long sleeved gowns are provided; the principles are the same however as the Apron is the first part of the essential PPE kit to be put on

## HOW TO SAFELY REMOVE PERSONAL PROTECTIVE EQUIPMENT (PPE) EXAMPLE 1

There are a variety of ways to safely remove PPE without contaminating your clothing, skin, or mucous membranes with potentially infectious materials. Here is one example. **Remove all PPE before exiting the patient room** except a respirator, if worn. Remove the respirator **after** leaving the patient room and closing the door. Remove PPE in the following sequence:

### 1. GLOVES

- Outside of gloves are contaminated!
- If your hands get contaminated during glove removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Using a gloved hand, grasp the palm area of the other gloved hand and peel off first glove
- Hold removed glove in gloved hand
- Slide fingers of ungloved hand under remaining glove at wrist and peel off second glove over first glove
- Discard gloves in a waste container



### 2. GOGGLES OR FACE SHIELD

- Outside of goggles or face shield are contaminated!
- If your hands get contaminated during goggle or face shield removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Remove goggles or face shield from the back by lifting head band or ear pieces
- If the item is reusable, place in designated receptacle for reprocessing. Otherwise, discard in a waste container



### 3. GOWN

- Gown front and sleeves are contaminated!
- If your hands get contaminated during gown removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Unfasten gown ties, taking care that sleeves don't contact your body when reaching for ties
- Pull gown away from neck and shoulders, touching inside of gown only
- Turn gown inside out
- Fold or roll into a bundle and discard in a waste container

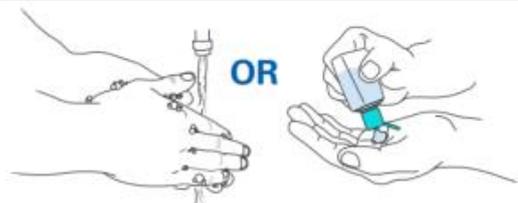


### 4. MASK OR RESPIRATOR

- Front of mask/respirator is contaminated — **DO NOT TOUCH!**
- If your hands get contaminated during mask/respirator removal, immediately wash your hands or use an alcohol-based hand sanitizer
- Grasp bottom ties or elastics of the mask/respirator, then the ones at the top, and remove without touching the front
- Discard in a waste container



### 5. WASH HANDS OR USE AN ALCOHOL-BASED HAND SANITIZER IMMEDIATELY AFTER REMOVING ALL PPE



Always dispose of used PPE safely and before moving on to the next period of care or duties

## **9. Waste disposal**

Effective waste disposal: Non-clinical waste should be disposed of in the normal manner for the service (ask your manager about waste disposal services, care homes will have a contract, domiciliary care will use the household refuse collectors); ensure waste bags are filled to no more than three-quarters full.

Clinical waste must be disposed of safely and legally; care homes will have a separate clinical waste contract. In the care home, ask your manager about the processes and bag colour codes and which are to be used for example, yellow bags for clinical waste, red bags for infected/contaminated waste; these are usually standard across all services although some contractors may use different colour bags. Clinical waste and infected waste is usually double bagged; find out the process for your individual service. If clinical waste yellow sacks are in use at a person's home they should be sealed and stored safely to await collection by an authorised collector as arranged by the person using services or their representative. If a person using services does not have arrangements for the disposal of clinical waste, domestic waste services can be used although clinical waste products should be double bagged, not overfilled and disposed of safely.

Waste must be segregated immediately by the person generating the waste into appropriate colour-coded storage or waste disposal bags or containers defined as being compliant with current national legislation and local policies (Agincare's Health and safety Policy; waste Disposal)

In people's own homes educate people and their families/carers about the correct handling, storage and disposal of health care waste

## **10. Effective Hand Washing and decontamination**

People receive healthcare from healthcare workers who decontaminate their hands immediately before and after every episode of direct contact or care. NICE QS61 Statement 3. (Agincare considers the term healthcare worker as interchangeable with adult social care worker)

Effective hand decontamination even after wearing gloves results in significant reductions in the carriage of potential pathogens on the hands and decreases the incidence of preventable healthcare-associated infections, leading in turn to a reduction in morbidity and mortality. Hand decontamination is considered to have a high impact on outcomes that are important to patients.

Hands must be decontaminated in all of the following circumstances:

- immediately before every episode of direct contact or care, including aseptic procedures
- immediately after every episode of direct contact or care
- immediately after any exposure to body fluids

- immediately after any other activity or contact with a person's surroundings that could potentially result in hands becoming contaminated
- immediately after removal of gloves

Staff should ensure that their hands can be decontaminated throughout the duration of care work by:

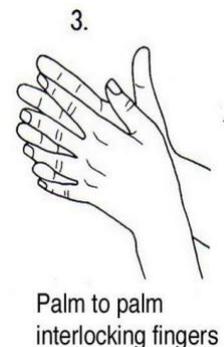
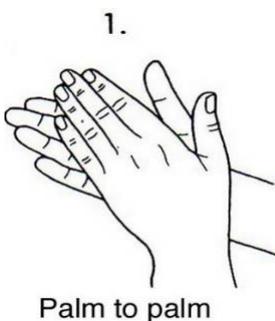
- being bare below the elbow when delivering direct care (or wearing protective plastic sleeves if the staff member's culture does not permit bare arms)
- removing wrist and hand jewelry
- making sure that fingernails are short, clean and free of nail polish
- covering cuts and abrasions with waterproof dressings.

An effective hand washing technique involves three stages: preparation, washing and rinsing, and drying. Preparation requires wetting hands under tepid running water **before** applying liquid soap or an antimicrobial preparation. The hand wash solution must come into contact with **all** of the surfaces of the hand. The hands must be **rubbed** together vigorously for a minimum of 20 seconds, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers. Hands should be rinsed thoroughly before drying with good quality paper towels or air dryer.

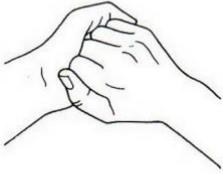
When decontaminating hands using an antimicrobial alcohol handrub, hands should be free from dirt and organic material. The handrub solution must come into contact with all surfaces of the hand. The hands must be **rubbed** together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers, until the solution has evaporated and the hands are dry.

An emollient hand cream can be applied regularly to protect skin from the drying effects of regular hand decontamination. If a particular soap, antimicrobial hand wash or alcohol product causes skin irritation speak to you manager about obtaining a suitable alternative (you may seek advice from your pharmacist)

Follow these seven steps to ensure you clean your hands properly.

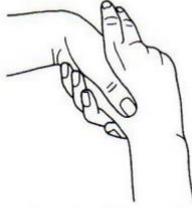


4.



Rubbing of backs of fingers into palms

5.



Rotational rubbing of thumb clasped over opposite palm - swap hands

6.



Rotational rubbing of fingers into palms - swap hands

**Step 7 – Ensure hands are rinsed under running water and dried on a paper towel.**

**N.B. This technique should also be applied when putting on alcohol gel.**

**Alcohol gel is NOT a substitute for hand washing.**

### **11. Invasive devices**

As a social care provider, Agincare staff are often expected to support people with invasive devices such as catheters, stoma or peg feeds. Support is limited to maintenance and monitoring of such devices, not to insertion although in Agincare Nursing Homes, Registered Nurses may insert urinary catheters when deemed competent to do so.

All staff involved in the support of people with invasive devices must ensure that the risk of infection is minimised by the completion of the specified procedures as they have been taught and deemed competent which are necessary for the safe care of the person and maintenance of the device

The healthcare professional responsible for the safe insertion of the device will also have been responsible for the education of the person and their family members or carers about the safe management of the device or equipment, including techniques to prevent infection. Agincare staff should reinforce this and teach people and their carers about good practice in relation to general infection, prevention and control precautions. (NICE QS61 statements 4 & 6)

## 12. Infestation

### 12.1.1 Infection matrix

Disease or organism	Mode of transmission	Period of infectivity	Additional infection control precautions	Notify HPU
<b><i>Bacillus cereus</i> food poisoning</b>	<ul style="list-style-type: none"> <li>Food</li> </ul>	Not infectious	None. Retain food samples	Yes
<b>Body lice</b>	<ul style="list-style-type: none"> <li>Person to person</li> </ul>	Until treated	Single room until treated; launder bedding and clothing	No
<b><i>Campylobacter</i> spp.</b>	<ul style="list-style-type: none"> <li>Food</li> <li>Hand to mouth</li> <li>Pet faeces</li> </ul>	While diarrhoea persists	Single room if incontinent; separate toilet	Yes, as the infection could be the result of food poisoning
<b>Chickenpox (varicella)</b>	<ul style="list-style-type: none"> <li>Airborne</li> <li>Contact with rash</li> </ul>	Infectious for 1-2 days before onset of symptoms and 6 days after rash appears	Single room Pregnant staff or visitors who are not immune should avoid contact	Yes
<b>Clostridial food poisoning (<i>C. perfringens</i>)</b>	<ul style="list-style-type: none"> <li>Food</li> </ul>	Not infectious	None. Retain food samples	Yes
<b><i>Clostridium difficile</i></b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Environmental contamination</li> </ul>	While diarrhoea persists	Single room, separate toilet	Yes if there is a risk of cross infection
<b>Cold sore (herpes simplex)</b>	<ul style="list-style-type: none"> <li>Direct contact with lesions</li> </ul>	Until lesions are crusted	Use gloves for handling lesions, feeding or mouth care	No
<b>Conjunctivitis</b>	<ul style="list-style-type: none"> <li>Direct contact with the discharge</li> </ul>	Until 48 hours after treatment	Gloves/no touch technique when dealing with discharge/ personal and hand hygiene	If 2 or more related cases are suspected
<b>Coronavirus (<i>MERS, SARS, Covid-19</i>)</b>	<ul style="list-style-type: none"> <li>Airborne</li> <li>Hand to mouth</li> <li>Person to person</li> </ul>	Variable; 2-14 days incubation period. Current (2020) guidance requires 14 days isolation and 28 days clear	Full PPE including mask, visor if risk of droplets from aerosol generating procedure. Isolation 14 days	Yes
<b><i>Cryptosporidium</i> spp.</b>	<ul style="list-style-type: none"> <li>Water</li> <li>Hand to mouth</li> </ul>	While diarrhoea persists	Single room/separate toilet	Yes
<b>E Coli</b>	<ul style="list-style-type: none"> <li>Food</li> <li>Hand to mouth</li> </ul>	Variable but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/incontinent	Single room until 48 hours after diarrhoea stops. Separate toilet. Retain food sample	Yes

<b>Fleas</b>	<ul style="list-style-type: none"> <li>From pets</li> <li>Person to person</li> </ul>	Until treated	Single room until treated. Treat pets. Launder resident's clothing and bedding Vacuum room daily	no
<b>German measles (rubella)</b>	<ul style="list-style-type: none"> <li>Droplet, direct contact with infectious secretions</li> </ul>	Incubation period of 14–17 days. (range 14 – 21). Individuals are infectious from about one week before, and at least four days after, the onset of the rash.	Single room. Pregnant staff should know their immune status and seek advice if not immune. Non-pregnant staff should be immunised if susceptible.	Yes
<b>Giardia lamblia</b>	<ul style="list-style-type: none"> <li>Water</li> <li>Hand to mouth</li> </ul>	Until treated	Single room if incontinent	Yes
<b>Head lice</b>	<ul style="list-style-type: none"> <li>Person to person</li> </ul>	Until treated	Combing egg cases (nits) and live lice from hair	no
<b>Hepatitis A</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Food</li> </ul>	The incubation period is 15 –50 days, average 28–30 days. Maximum infectivity occurs during the latter half of the incubation period and continues until 7 days after jaundice appears.	Single room Separate toilet	yes
<b>Hepatitis B</b>	<ul style="list-style-type: none"> <li>Contact with infected blood or other body fluids</li> <li>Sexual transmission</li> </ul>	Variable but can be for life	Strict application of standard precautions including care with sharps and body fluids	Yes for acute infection No for chronic carrier state
<b>HIV/AIDS</b>	<ul style="list-style-type: none"> <li>Contact with infected blood or other body fluids</li> <li>Sexual transmission</li> </ul>	For life	Standard precautions including care with sharps and body fluids	No
<b>Impetigo</b>	<ul style="list-style-type: none"> <li>Direct contact with lesions</li> </ul>	Until crusted over	Single room until 48 hours after treatment started. Cover lesions if mixing with other people	If more than 2 cases suspected
<b>Infectious mononucleosis (glandular fever)</b>	<ul style="list-style-type: none"> <li>Contact with saliva</li> </ul>	Variable, may be several weeks	Care with articles of soiled nasal or throat discharges. Encourage hand hygiene	No
<b>Influenza or influenza like illness</b>	<ul style="list-style-type: none"> <li>Droplet</li> <li>Direct and indirect contact</li> </ul>	While symptomatic	Single room, reinforce importance of respiratory and hand hygiene	If influenza is confirmed

				by laboratory. Otherwise if more than 2 cases suspected
<b>Measles</b>	<ul style="list-style-type: none"> <li>Airborne</li> <li>Direct contact with infected secretions</li> </ul>	Incubation period is approximately 10 days (range 7 – 18 days) from exposure to onset of fever and, usually, 14 days before the rash appears. The person is infectious from four days before the rash onset and 4 days after rash appearance	Single room. Pregnant staff should know their immune status and seek advice if not immune.	Yes
<b>Mumps</b>	<ul style="list-style-type: none"> <li>Droplet</li> </ul>	Incubation period around 17 days (range 14 - 25). Greatest infectivity is from 2 days before the onset of symptoms to 4 days after symptoms appear.	Single room	Yes
<b>Norovirus</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Droplet</li> </ul>	Up to 48 hours after symptoms have resolved	Single room Separate toilet Very likely to cause outbreaks	Yes
<b>Pinworms, threadworms</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Airborne during bed making</li> </ul>	Until treated	Personal hygiene including hand hygiene Vacuum room daily	If more than 2 cases suspected
<b>Pulmonary tuberculosis</b>	<ul style="list-style-type: none"> <li>Airborne if 'open' case (Sputum smear positive), otherwise not infectious</li> </ul>	Normally 2 weeks after starting treatment	Single room if sputum positive	Yes
<b>Rotavirus</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Droplet</li> </ul>	Up to 48 hours after symptoms have resolved	Single room, separate toilet Very likely to cause outbreaks	Yes
<b>Salmonella</b>	<ul style="list-style-type: none"> <li>Food</li> <li>Hand to mouth</li> </ul>	Variable but unlikely to infect others by 48 hours after diarrhoea stops	Single room until 48 hours after diarrhoea stops. Separate toilet Retain food samples	Yes

		unless poor hygiene/incontinent		
<b>Scabies</b>	<ul style="list-style-type: none"> <li>Person to person (close contact)</li> </ul>	Until treated	Single room until 48 hours after treatment. Launder bedding and clothing	If more than 2 cases suspected
<b>Shigella</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Water or food contaminated by infected water</li> </ul>	Variable but unlikely to infect others by 48 hours after diarrhoea stops unless poor hygiene/incontinent	Single room until 48 hours after diarrhoea stops. Separate toilet Very likely to cause outbreaks	Yes
<b>Staphylococcal food poisoning</b>	<ul style="list-style-type: none"> <li>Food</li> </ul>	Not infectious	None Retain food samples	Yes
<b>Shingles</b>	<ul style="list-style-type: none"> <li>Usually reactivation (of chicken pox)</li> <li>Direct contact with rash</li> <li>Airborne</li> </ul>	Until lesions crusted	A person with shingles may mix with others if rash can be covered	If management of cases poses difficulties
<b>Viral gastroenteritis</b>	<ul style="list-style-type: none"> <li>Hand to mouth</li> <li>Droplet</li> </ul>	Variable, maybe several days after symptoms resolve	Single room, separate toilet Very likely to cause outbreaks	If more than 2 cases occur
<b>Whooping cough</b>	<ul style="list-style-type: none"> <li>Droplet</li> </ul>	5 days after start of appropriate antibiotic treatment	Single room	Yes

### 12.1.2 Meticillin Resistant Staphylococcus Aureus (MRSA)

MRSA is a strain of Staphylococcus Aureus that is resistant to many antibiotics and can colonise the skin (colonisation is the presence of the bacteria in the absence of infection). Staphylococcus Aureus is found on about a third of the population, usually in moist areas such as armpits, groin and nose although can also be found on hands. People colonised with MRSA are not ill and can carry it for a few days, weeks or even their whole life, they will be unaware they are a carrier, it does not harm them and they have no symptoms. MRSA causes harm when it enters the body for example, through a cut or wound. It can cause pimples and boils or more serious problems such as wound and chest infections; in more serious cases it can cause bloodstream infections.

All staff must apply and use standard precautions for infection control during the care of all people using services and those delivering care to people known to be colonised with MRSA have a duty to effectively manage the infection.

High standards of environmental and equipment cleanliness must be maintained and the persons MRSA status must be communicated to any receiving clinical department on transfer of care (see Agincare's Transfer Policy and Passport)

Once an MRSA positive blood culture has been confirmed advice should be sought from the local PCT infection control lead. MRSA is not reportable under the RIDDOR notification process.

### **12.1.3 Wounds**

MRSA is a common cause of wound infection, after either accidental injury or surgery. This manifests as a red, inflamed wound, which may also be swollen and painful. The wound may break open or fail to heal, and a wound abscess could develop.

### **12.1.4 Superficial Ulcers**

Pressure ulcers, varicose ulcers and diabetic ulcers (all due to poor blood supply and superficial skin damage) are often sites of MRSA colonisation or infection.

### **12.1.5 Invasive Devices**

MRSA may infect the entry site of invasive devices such as PEG feeds, intravenous lines and urinary catheters causing local inflammation with pus. From this, the MRSA can enter the bloodstream, causing bacteraemia. People with urinary tract infections may have abdominal pain and a temperature, and infection often causes the urine to go cloudy and smell.

### **12.1.6 Deep Abscesses**

If MRSA spreads from a local site to the bloodstream, it can lodge at various sites in the body (e.g. lungs, kidneys, bones, liver or spleen) and cause one or more deep abscesses distant from the original site. These can be painful, with high fever and signs of inflammation near the infection. The person will be very unwell and may have rigors (shivers) and low blood pressure (shock).

### **12.1.7 Lung Infections**

MRSA can cause lung infections, although this is rare. Lung infections are most common in people who are on a ventilator with a tube in the trachea, bypassing the defences of the nose and throat. MRSA can gain entry to the lungs via the tube and cause pneumonia, which may be fatal.

## **12.2 Management of MRSA**

Once an MRSA positive blood culture has been confirmed advice should be sought from the local PCT infection control lead. MRSA is not reportable under the RIDDOR notification process and is not a risk to other people using services, staff or visitors if good basic hygiene is maintained. The major source of transmission of MRSA is via the hands of care workers.

People with MRSA should not be restricted in their activities and need not be isolated although the following should be observed:

- People with MRSA can go out as normal and can receive visitors

- People with MRSA can share a room unless either party has open wounds or sores
- Staff with eczema, psoriasis or with open wounds that cannot be covered should not perform personal care for persons with MRSA. All staff should wear gloves when providing personal care but if the staff member has any open lesions they should be covered and it is advisable to double glove
- People with MRSA can join in communal activities and use communal space providing any wounds are covered with appropriate dressings

The necessary precautions staff should take are the basic infection control precautions already discussed especially rigorous hand washing and personal hygiene.

## **12.3 Diarrhoea and Vomiting**

### **12.3.1 Norovirus**

Small round structured viruses (SRSVs e.g. norovirus), are the most common cause of outbreaks of gastro-enteritis in care settings. Outbreaks can affect both people using services and staff, sometimes with attack rates in excess of 50%.

Norovirus infections are usually associated with relatively mild and short lived symptoms and affected individuals in the community rarely seek medical attention. However outbreaks involving people using services and staff in care settings can have a significant impact on services and in domiciliary care can be transferred from one vulnerable person to another through poor hygiene practices of the care workers involved. It is therefore essential that cases are detected early and isolated appropriately to prevent spread and major outbreaks. These viruses are relatively resistant to alcohol gel so as with all hand hygiene procedures, soap and water *must* be used when washing hands.

The average incubation period for norovirus associated gastro-enteritis is 12-48 hours. The illness is characterized by a sudden acute onset of vomiting (may be projectile), watery diarrhoea and abdominal cramps and nausea. In addition headache, fever and malaise are common. Some or all of the above symptoms may be present. Symptoms last between one and three days and recovery is usually rapid. Dehydration is the most common complication and people using services may require replacement fluids.

Noroviruses are highly contagious and are transmitted primarily through the faecal –oral route either by person to person spread or via contaminated food or water. In addition noroviruses can be spread via airborne infected particles following vomiting. Transmission can also occur through hand transfer of the virus to the mouth following contact with environmental surfaces and equipment which have been contaminated with either faeces or vomit.

Diagnosis of norovirus infection can often be made on clinical grounds from their characteristic features. However the infection can also be confirmed following testing of a stool sample. When an outbreak is suspected, it is imperative to institute infection control measures immediately without waiting for confirmation from stool testing.

There is no effective treatment for noroviruses. It is a self-limiting illness which will cease within a few days. It is important to ensure prompt fluid replacement to prevent dehydration and its complications.

### **12.3.2 Clostridium Difficile (diarrhoea)**

*Clostridium difficile* is a bacterium (sometimes referred to as C diff). Symptoms may be mild to severe diarrhoea which may be frequent accompanied by abdominal pain and fever.

Those at risk include the elderly, people who have reduced ability to fight infection and people who have received antibiotics for infection but which also may have killed off normal bowel bacteria thereby increasing the risk of *Clostridium difficile* infection.

A small proportion of the healthy adult population can carry these bacteria in the gut, without any problem due to the good bacteria within the gut. When given antibiotics, the good bacteria are killed off, allowing the C diff to grow in the gut. The bacteria can produce toxins which cause damage (inflammation) to the gut lining resulting in diarrhoea and because of this some sufferers can develop a severe form of the infection, which could result in death.

## **12.4 Management of Diarrhoea and Vomiting**

Any person using services with more than two episodes of unexplained diarrhoea and/or vomiting within 24 hours must be isolated and all staff informed. In care homes residents should remain isolated for up to 48 hours after symptoms have stopped. In domiciliary care isolation is often more difficult although care workers must inform family members of the risk of infection, how to manage the symptoms and remind them of basic hygiene procedures; care workers can leave supplies of gloves for families and carers to use. Non-essential visitors should be discouraged from visiting during an outbreak and visitors that do attend will be reminded to wash their hands and use alcohol/sanitising gel after their visit. All persons will be advised not to eat or drink whilst in an affected area.

Care Home Staff must refer to the Gastroenteritis Outbreak Management Policy, guidance and Toolkit (Share-point) for management and control of the spread of the norovirus, *Clostridium difficile* or any diarrhoea and vomiting infection. This toolkit is based on the norovirus toolkit produced by the Health Protection Agency and provides guidance as well as charts and record keeping documents; alternatively care homes can source their own local authority environmental health department toolkit details of which should be held in contact directory in the IPC Lead information file

Records must be kept of the episodes of vomiting on a fluid chart and stool chart for episodes of diarrhoea. When dealing with symptomatic people who use services the necessary precautions staff should take are the basic infection control precautions already discussed especially rigorous hand washing and personal hygiene

Ensure that the environment is kept scrupulously clean. Spillages of vomit and or diarrhoea should be cleaned immediately using approved sanitizer/disinfectant followed by detergent and hot water. Surfaces and equipment should be wiped over in affected areas using necessary COSHH products and precautions

Any staff member with unexplained diarrhoea and/or vomiting must not work until they have been symptom free for 48hours.

## **12.5 Scabies**

Scabies is a contagious infection caused by a mite (*Sarcoptes scabiae* var. *hominis*). The condition is triggered by an allergic reaction to the saliva & faecal material excreted by the mite. It is a worldwide disease, more common in overcrowded conditions. It can affect any individual irrespective of social class or race. It is characterised by itching and signs of reddish, slightly elevated tracts may occur. Miniature pustules and abrasions soon appear; scratching of these areas may lead to secondary bacterial infection.

Scabies only lives on humans and therefore cannot be caught from pets or other animals. Transmission is by direct personal contact i.e. by prolonged skin-to-skin contact of a sexual or social nature, and thus a quick handshake or hug will not spread the infection. Mites usually pass from person-to-person in close communities, particularly within households. It is recognised that the spread is not limited to family members, but includes everyone who has intimate personal contact with infected individuals. Infection occurs following transference of mites, which burrow into the skin. People who have acquired the infection for the first time may not show any symptoms for 2 - 4 weeks, so this makes spread of the disease difficult to identify and contain particularly in care homes.

The newly mated female burrows through the skin, often at the finger webs, wrists and elbows. Eggs are laid in the burrows at a rate of 2 - 3 per day for up to 2 months where they mature, and larvae emerge from the eggs 3-4 days after they have been laid. After emerging from the egg, the larva passes through two moults before becoming adult mite; adult mites mate. The entire life cycle can be completed in 10-14 days, and mites live for around 30 days.

The incubation period for a first infection is usually 2 - 4 weeks in people without previous exposure, as the mites faecal contamination takes time to cause an allergic reaction. Subsequent infection will cause an allergic reaction within one week. Scabies can be easily managed when treatment is performed correctly. However, as a result of the extended incubation period there may also be carriers without symptoms who can re-infect others after treatment has been performed. It is therefore important to undertake a thorough risk assessment when planning treatment.

The most common areas affected are between the fingers (finger webs), wrists, elbows, armpits, waist, thighs, genitalia, nipples, breasts and lower buttocks. In infants, young children the elderly and those who are chronically ill, the mites can be found on the face,

ears and scalp. It should be recognised that scabies causes an allergic reaction, and the itch and the rash may not always coincide with the actual site of the mite.

### **12.5.1 Management of Scabies**

All members of the affected household or care home should be treated simultaneously even in the absence of symptoms. It is also important to stress that this is not limited to family members but should include everyone who has had intimate contact with infected affected individuals, e.g. care workers, assessors, coordinators. Some over the counter topical applications are available but all persons who have been in contact with an infected person are advised consult their GP for advice and prescription and then follow the instructions on the preparation. All persons should be treated at the same time (preferably within twenty four hours).

There is no evidence to suggest that scabies is transmitted on clothing, towels and bedding, therefore no special cleaning or laundering measures other than the usual hygienic ones are required following treatment

If scabies infection is identified or suspected within a care setting then the chance of possible infection for each person using the service and staff member/s should be assessed as 'high', 'medium' or 'low' risk, this will aid the appropriate follow-up and treatment of contacts.

**High risk:** are staff members who undertake intimate care of people using services and who move between people who use services. This will include both day & night staff.

**Medium risk:** are staff and other personnel who have intermittent direct personal contact with people using services. It will also include non-symptomatic people who have their care provided by staff members categorised as 'high risk'.

**Low risk:** those at lowest risk are staff members who have no direct or intimate contact with affected people who use services e.g. gardeners, maintenance, catering & laundry staff. It also includes non-symptomatic people whose carers are not considered to be 'high risk' i.e. their direct personal care is provided by staff members who have not undertaken intimate care of symptomatic people who use the service or who have not worked in affected area(s).

Care workers do **not** need to stay off duty provided that they have observed the minimum contact time for their initial treatment.

Where care workers have responsibility for applying the liquids/cream to people using services, they should wear disposable gloves to do so.

### **12.6 Extended spectrum beta lactamase (ESBL) bacteria**

Beta-lactamases are enzymes produced by some bacteria that may make them resistant to some antibiotics. ESBL production is associated with a bacteria usually found in the bowel.

ESBL bacteria can be present in the bowel of individuals without their knowledge and may survive there harmlessly until the person becomes ill or requires antibiotic therapy. Anyone can get an ESBL producing bacteria. Patients in hospital/care homes with open wounds, urinary catheters, drainage tubes and those who are ill are at a higher risk of getting an ESBL bacteria.

Anyone receiving a lot of antibiotics, in particular if the course of antibiotics has not been completed for the prescribed period of time, may be at increased risk of getting the bacteria.

Anyone who has had contact with a patient/client that already has an ESBL producing bacteria is also at higher risk.

ESBL bacteria can be spread from person to person on contaminated hands of both patients and healthcare workers. The risk of transmission is increased if the person has diarrhoea or has a urinary catheter in place as these bacteria are often carried harmlessly in the bowel.

Though ESBL producing bacteria are resistant to a number of commonly used antibiotics, there are antibiotics available to treat infections caused by these bacteria.

In some circumstances, treatment can be given at home but more severe infections may require treatment in hospital. If antibiotic treatment is necessary your doctor will discuss this with you.

Some people will carry ESBL resistant bacteria in their bowel without having an active infection and may not require treatment

### **12.6.1 Management of ESBL**

It is important that special precautions are taken to stop ESBLs spreading.

Effective control measures include:

- Thorough hand hygiene. Wash hands with soap and water regularly and particularly before eating and after using the toilet. Hand sanitisers can be used at other times for hand hygiene.
- Thorough hand hygiene for family and friends before visiting and on leaving and especially if they have provided personal care. There is no need to restrict visitors.
- Isolation– this may occur in hospital but is not usually necessary in the care homes or the community.
- Thorough cleaning of equipment and surfaces such as commodes and toilet seats between use.
- Care staff should follow standard precaution guidelines and wear a disposable plastic apron and disposable gloves and it is important they wash their hands when these are removed.
- Washing laundry with detergent and warm water.
- Antibiotics should only be taken if they are absolutely necessary and when they have been prescribed for you by a healthcare professional.
- Antibiotics should be taken as prescribed and the full course of treatments should be completed.
- Antibiotics do not work against viruses such as colds and flu.

## **Contractual impact**

Agincare's policies and procedures are to be followed in conjunction with the requirements of the contracts under which you provide services. There may be occasions where the contract contains requirements which appear to contradict or be in addition to, standard Company policy. In these instances you are to:

- If the requirement is in addition to standard Company policy - adhere to the terms and conditions of your contracts
- If the requirement is lesser than standard Company Policy - follow Company policies and procedures

If you require any further clarification please contact the Commercial Department for guidance

## **Training**

The management team of Agincare believe that, in order to provide a quality service, Agincare requires high quality staff who are suitably trained, supervised and supported.

Agincare policies and procedures are referenced in the induction programme and are available for staff in their work place (Care Home or Branch office). Staff will be informed of how to access all policies, procedures and related documentation and of how to seek further advice regarding Agincare's agreed ways of working. Staff should be provided with regular updates to encourage continuous improvement and include latest good practice.

Agincare is committed to provide an ongoing programme of support for all staff. This includes supervisions, appraisals and training which will be in line with company policy, contractual obligations and current best practice

## **REVIEW OF THIS POLICY**

Review of this document is recorded on the controlled index and reviewed annually as part of the management review systems.

**Name:** Policy Review Group

**Date:** September 2020

**Appendix 1: Example of Infection Prevention and Control Risk Assessment**

Hazards identified (including estimate of severity)	Persons exposed including numbers and patterns of exposure	Detail any existing controls in place	Relevant legislation / standards if known	Hazard severity H M L	Likelihood H M L	RISK H M L	Additional control measures required (who actioned and by when)	Date actioned	Review date(s) & signature
Person using service has influenza	Care workers Family Friends	Use of PPE, restricted access to visitors	HSCA, HSAWA	H	H	H	<ul style="list-style-type: none"> <li>Care workers are made aware of presence of infection</li> <li>Staff are offered the 'flu vaccination</li> <li>Use PPE especially face masks when within 1m of person using services</li> <li>Ensure hand hygiene takes place at regular intervals</li> <li>Dispose of tissues in normal household waste</li> <li>Clean clothes and bed linen in normal wash</li> <li>Provide information to family and friends to keep them safe</li> </ul>		
Care worker is a	Person using services,	Care worker not to	HSCA, HSAWA	H	H	H			

Hepatitis carrier	family Other staff	work with persons with open wounds  Use of PPE					<ul style="list-style-type: none"> <li>• Care worker should keep all wounds covered</li> <li>• Use of PPE required by care worker to protect people from infection</li> <li>• Care worker should not be sent to support people with open wounds if the care worker has an open wound themselves</li> </ul>		
Person has a long term catheter in place and has a urinary tract infection	Care workers, Family	Care Workers aware of infection  PPE/hand hygiene	HSCA, HSAWACOS HH	H	H	H	<ul style="list-style-type: none"> <li>• Care workers made aware of presence of infection</li> <li>• Use PPE especially gloves and aprons when dealing with the catheter</li> <li>• Ensure hand hygiene takes place at regular intervals</li> <li>• Dispose of urine appropriately</li> <li>• Ensure any leakages are cleaned up using detergent immediately</li> <li>• Provide information to family and friends to keep them safe</li> </ul>		