



Holy Trinity Catholic Primary School
Aspire not to have more but to be more

Infection Control Policy

Holy Trinity is a Catholic Primary School where Core Values, underpin every aspect of school life. Our Mission Statement is:

**Inspired by Christ and His teaching,
Holy Trinity Catholic Primary School educates, nurtures and celebrates
the unique nature and worth of every member of its diverse family.**

The Mission Statement is summed up in our school motto: **'Aspire not to have more, but to be more'**

The aims for all of our school family are:

- *to promote excellence in all aspects of school life, developing each person's ability to recognize and strive for this;*
- *place Christ at the centre of our daily lives, so that our school family may be the leaven of the Gospel values promoted in our mission*
- *to recognize that all members of the community are life-long learners, prepared to accept challenges with confidence and determination*
- *to promote self-discipline and respect, never accepting bullying of any kind and to communicate this belief in a positive and proactive manner.*

These aims are revisited regularly to ensure their relevance and we work to ensure our statement on equality of opportunity and values are understood by all.

1 Introduction

- 1.1 Although the principles of cross infection have been well established for many years, infection control is becoming increasingly important in the school community as a means to safeguard all members of the community. Additional guidance from the National Institute for Health and Clinical Excellence and the Department of Health seeks to address the prevention of Healthcare Associated Infection (HCAI) in the community.
- 1.2 Holy Trinity frequently deals with staff and children who may well be carrying organisms often associated with the spread of infection within the community. Added to this, emerging anti-microbial resistant organisms and blood-borne viral infections require that control of infection remains at the centre of all good health practice within school.
- 1.3 This Infection Control Policy aims to assist all professionals and other staff working in our school. This policy is designed to ensure that:
 - **Cross-infection does not occur between children**
 - **Staff do not acquire infections from the children**
 - **Staff do not pass on their own infections to the children**
- 1.4 This policy is intended to give staff guidance when dealing with children in the school community. It cannot cover all eventualities and further guidance may be needed in some eventualities.

2 Infection Control and the Law

- 2.1 The importance of minimising risks of infection and the control of hazardous practices is clearly laid out in the *Health and Safety at Work Act* (1974), the *Health and Safety at Work Regulations* (1992) and the *Control of Substances Hazardous to Health Regulations* (1999 and 2002) (CoSHH).

- ***The Health and Safety at Work Act (1974)*** requires employers to provide, as far as is reasonably practicable, a safe environment not only for employees, but all persons visiting the site. It requires employees to take reasonable precautions to ensure their safety and the safety of others.
- ***Health and Safety at Work Regulations (1992)*** requires employers to assess the risk to their employees' health and to put in place control measures. In relation to infection control, it is the employer's responsibility to ensure that staff are protected from exposure to infectious hazards through the provision of safe systems of work. These include:
 - Personal protective equipment
 - Hand washing facilities
 - Systems for the management of used instruments
 - Systems for the safe disposal of waste
- ***The Control of Substances Hazardous to Health Regulations (1999 and 2002)*** offers specific guidance regarding protection against hazardous substances, including chemicals and biological agents in the workplace. The employer is responsible for ensuring that guidance and policies are in place and that these are implemented, regularly reviewed and updated.
- It also requires that potentially infectious biological agents being transported, such as clinical waste and pathology specimens, be packaged in accordance with current guidance to prevent accidental exposure to persons outside the surgery.
- ***The Provision and Use of Work Equipment Regulations 1998 (PUWER)*** requires the employer to ensure that work equipment is suitable for the intended purpose and is safe to use. Equipment must be maintained in a safe condition and inspected periodically to ensure that it remains safe. It must be used only by people who have received adequate information, instruction and training. If locum staff are required to use equipment, it must be ensured that they are properly trained in this.

3 Standard (Universal) Infection Control Precautions (see Appendix 1)

3.1 Standard Infection Control Precautions (SICP), often referred to as 'universal precautions', are a single set of activities used by all staff at Holy Trinity in order to reduce the transmission of micro-organisms from both recognised and unrecognised sources of infection.

Blood and body fluids may contain blood-borne viruses (e.g. Hepatitis B, HIV) or other viral and bacterial pathogens as well as prions. Since it is not always possible to know who is infected with, or carrying these pathogens, Standard Infection Control Precautions (formerly known as Universal Precautions) must always be taken when dealing with blood and body fluids; non-intact skin or mucous membranes.

4 Hand Hygiene

4.1 The relationship between hand hygiene and cross infection was proven in the 19th century.

4.2 Hand washing remains the cornerstone of good infection control and is the single most important measure for preventing the spread of infection in the health care setting.

4.3 Aims and Definitions

In the first instance, hand washing aims to remove transient¹ micro-organisms on the skin surface. Prior to any health related activity, such as attending to a fall injury, surgical hand washing must be carried out to reduce transient micro-organisms

4.3 General guidelines for hand hygiene (see Appendix 2)

In order for hand hygiene to be effective, all parts of the hands must be accessible. Intact skin resists colonisation better than skin in poor condition, so be aware of skin care.

4.4 When to wash

There is no set frequency, as hands should be washed when necessary. The following are some examples of when hands should be washed:

- On arrival for duty and before leaving the school.
- Before and after giving direct first aid care.
- After removing gloves in any first aid procedure.

¹ Superficial

Easily transferred and acquired via direct contact with people, equipment and the environment

Easily removed by routine hand washing

An important source of cross infection

- After hands have been contaminated (e.g. with blood/body fluids).
- Before and after using the toilet or toileting others.
- Before preparing, handling or eating food.

If staff are unsure if hand hygiene is necessary consider what would be done if your next action was eating a sandwich!

4.5 Requirements

Holy Trinity Catholic Primary School will supply:

- Easily accessible sinks
- Hot and cold water
- Liquid soap from a pump-operated dispenser **NB.** Soap bars must not be used in the school setting as they easily become colonised with bacteria such as *Pseudomonas spp.* and so can act as a source of cross-infection.
- Disposable paper towels in a wall mounted dispenser. Reusable towels are not suitable for the school settings as they become readily contaminated with micro-organisms.

4.6 Routine hand washing

Routine hand washing aims to remove dirt, organic matter and transient micro-organisms, making hands socially clean. Hand washing, using liquid soap and water, is adequate before and after most activities in the school setting.

- Routine hand washing technique (see Appendix 3)
- Remove wrist watches, jewellery and roll up/remove long sleeved clothing
- Wet hands under warm running water and apply liquid soap into cupped hand
- Wash all parts of the hands (including wrists) thoroughly for 10-15 seconds Rinse hands thoroughly under running water
- Dry hands with disposable paper towels

5 Personal Protective Equipment

5.1 Personal Protective Equipment (PPE), usually protective clothing, aims to prevent the transmission of micro-organisms between an injured person and first aid staff. The need to wear protective clothing will depend upon the potential risks associated with the planned task. It is also worn in food preparation areas.

5.2 It is the member of staff's responsibility to assess this risk and decide upon the necessary clothing as appropriate. The Personal Protective Equipment Regulations of 1992 (part of the Health and Safety at Work Regulations) oblige employers to provide protective equipment where hazards cannot be otherwise removed or controlled in the workplace. This same guidance also legally obliges employees to use such equipment where it is provided.

Disposable plastic aprons

Disposable plastic aprons are available for staff to wear when contamination of clothing with blood and body fluids is anticipated, including performing wound dressings.

They are also to be worn for food preparation activities.

Plastic aprons should be discarded after each procedure and between patients.

Protective eyewear

Protective eyewear should be made available for staff to use if the planned procedure is likely to cause splashing of body fluids into the eyes (e.g. dealing with large spillages). Eyewear will be decontaminated according to the manufacturer's instructions.

Gloves

Disposable latex or nitrile gloves will be worn when contact with blood/body fluids is anticipated, during direct contact with non-intact skin or mucous membranes or when dealing with chemicals/ hazardous substances.

Increased awareness of the need to wear gloves as part of standard precautions has resulted in significant increases in usage. It is important to note that gloves are an *additional* precaution; they should not be solely relied upon as a barrier to infection.

5.3 Essentials of glove usage:

Glove usage should be decided following a personal risk assessment of the planned task.

- Gloves are not an alternative to hand washing.
- Hands should be washed before and after glove use.
- Gloves should be changed after each procedure (e.g. between 'dirty' and 'clean' tasks) and between those being administered first aid.

Staff will never re-use disposable gloves. This includes washing or cleaning between tasks.

Non-powdered latex gloves must be used as standard. Evidence suggests that powdered gloves increase the risk of developing a latex allergy. Reports of latex allergy are increasing – remove gloves when not necessary.

Individuals sensitised to latex gloves will be supplied with appropriate alternatives (e.g. nitrile gloves). If a latex allergy is suspected, it must be properly diagnosed by an Occupational Health department or GP. Be aware that those receiving first aid can also suffer latex allergy

Heavy Duty rubber gloves (e.g. 'Marigolds') will be used for washing instruments or general environmental cleaning.

Latex sensitivity

As the use of latex gloves has increased, reports of latex sensitivity amongst people has risen. The risk of allergic reactions is not only related to gloves but can involve other latex based devices. **Staff must seek specialist advice from the school nurse if latex sensitivity is suspected. If the individual child being treated is sensitised, then all notes should be clearly marked In Type I reactions, the individual should wear a Medic Alert bracelet.**

6 Staff Health

6.1 All staff employed by Holy Trinity Catholic Primary School will have an Occupational Health check prior to commencing employment. At this check, the vaccination status of all staff should be checked and primary or booster vaccinations offered as necessary.

6.2 All staff, once employed, are responsible for ensuring that their own boosters are kept up to date.

6.3 All staff are aware of action to be taken following a needlestick injury. This includes immediate first aid, reporting procedures and further management

7 Management of Diagnosed/Suspected Infection in Staff (See Appendix 4)

7.1 From time to time, school staff may develop infections, which could expose others to the risk of infection. Symptoms or signs of infection can appear trivial to staff who are usually fit and well, but can cause severe problems in vulnerable people.

7.2 Early reporting and implementation of suitable control measures can prevent cross-infection and subsequent outbreaks of infection.

7.3 Diagnosed or suspected infections in school staff must be reported by the staff member to the Headteacher ensuring that, where appropriate, confidentiality is maintained. If treatment is deemed necessary, this will be undertaken by the individual's General Practitioner (GP), as appropriate.

7.4 The necessity for exclusion from work will be discussed with Human Resources and in liaison with the PCT Infection Control Specialist/Health Protection Unit (HPU) as necessary.

8 Sharps Management (see Appendix 5)

8.1 Sharps include needles, scalpels, stitch cutters, glass ampoules and sharp instruments. The safe handling and disposal of sharps is essential in reducing the risk of exposure to blood borne viruses and other pathogens. Non-compliance with sharps good practice guidelines may lead to injury and subsequent legal penalties. The risk of injury can be minimised by adhering to accepted good practice.

8.2 Key points for safe use and disposal:

- Never re-sheath needles manually.
- Dispose of sharps immediately after use.
- Sharps should be placed directly into an approved container by the user. Never leave sharps to be disposed of by someone else.
- Dispose of syringe and needle as one unit directly into a sharps container wherever possible.
- Sharps bins must be correctly assembled. Sign and write the date on the label when assembling. Check that bins have been correctly assembled before using them.
- Containers should be conveniently placed for staff to use. Where appropriate, take the container to the point of use. Trays are available which hold a sharps bin and injection tray.
- Sharps containers should not be placed on the floor, on an unstable surface, on windowsills or above shoulder height. They should be inaccessible to children and unauthorised persons. Be aware that children can find the bright colour of sharps bins attractive.
- Containers should be sealed and disposed of when three-quarters full (do not attempt to press down on container to make more room).
- Never attempt to retrieve any item from a sharps container.

- Containers must not be placed into yellow bags prior to disposal. Do not use tape or stickers to seal sharps containers.
- If a sharps container is damaged, place into a larger sharps container, lock and label prior to disposal.
- Robust footwear with closed toes must be worn for work to avoid sharps injuries to the feet.
- Wear gloves when handling sharps. Although this does not prevent needlestick injuries, the 'wiping' effect of the gloves can reduce the amount of blood transmitted.
- Administrative staff handling sharps bins should ensure that they also comply with these guidelines.

9 Managing Blood or Body Fluids Spillages

9.1 Blood and body fluid spillages must be dealt with immediately. Granules should be used. Disposable gloves and plastic aprons must be worn (use eye protection if splashing is likely).

Using hypochlorite granules (e.g. Haz-tabs, Presept):

- Cover spill completely with granules and wait for the fluid to absorb.
- Leave for 2 minutes.
- Collect granules using disposable paper towels and/or cardboard. Discard as clinical waste
- Clean area with disposable towels
- Dispose of towels and protective clothing as clinical waste.
- Wash hands thoroughly.

9.2 Urine spills should be covered with disposable towels to absorb. Discard towels as clinical waste and clean area with disposable paper towels using chlorine solution of 10,000ppm .

Soft furnishings, such as carpets should be cleaned with general purpose detergent and hot water and steam cleaned as a matter of urgency. Soft furnishings and carpets are not advised in clinical areas.

9.3 A spillage kit will be available for all areas. This kit will contain:

- A laminated guidance sheet on how to deal with spillages
- Hypochlorite granules (for easily confinable spillages only), hypochlorite tablets
- Protective Clothing: Powder Free Latex Gloves, Plastic aprons and Protective Eye Wear
- Paper towels to soak up the spillage
- Yellow clinical waste bags
- Possibly some disposable scoops for small spillages, such as broken specimen bottles.

A designated person will check the kit regularly to ensure that it is stocked up and none of the contents is expired.

10 Clinical Waste Management (Appendix 6)

10.1 Waste disposal is governed by the *Environmental Protection Act (1990)* and the *Hazardous Waste Regulations (2005)*. Good clinical waste management is essential to reduce the risk to staff, children and visitors and to protect the environment.

10.2 It is the responsibility of the person generating waste to ensure that it is segregated according to national guidelines.

11 Safe Handling of Waste

11.1 All staff who handle waste must be informed about its safe handling, segregation and disposal (this includes cleaning and contract staff).

11.2 Yellow bags for clinical waste disposal will be placed in a foot operated pedal bin during use. The first aid room will have ready access to one clinical waste pedal bin.

11.3 The different waste streams will be segregated at all times.

11.4 Bags will be discarded when three-quarters full, be securely tied, labelled and dated with name of area prior to disposal. The contents of bags should not be decanted.

11.5 Waste will be stored in the Medical Room to collection. The area should be clean, secure and inaccessible to unauthorised persons. Clinical waste for collection should be stored in a locked bin.

12 Environmental Hygiene

12.1 Environmental hygiene is an important component of good infection control. Overall, the school environment should be clean, dry, well-lit and well ventilated.

- 12.2 All areas are cleaned and damp dusted regularly. Detergent and hot water is adequate for most routine cleaning requirements (added to this, many disinfectants are not effective in the presence of dirt and organic matter). Equipment such as mops, buckets and cloths are specifically designated for the area of use and stored clean and dry. Colour coding is in use. Mops are washed regularly, stored inverted after use and the heads regularly changed.
- 12.3 School has a service level agreement for the provision of cleaning throughout the campus. A nominated person is identified to oversee cleaning. A written cleaning protocol is available within the school. Reports are made to the Governing Body on the standards reached and maintained.
- 12.4 Clean and dirty work areas are identified to prevent cross contamination. All rooms should be uncluttered to allow easy access for cleaning. Work surfaces, such as desks and the kitchen area, are made of materials that can be easily cleaned.

13 School Equipment, including Toys

- 13.1 Equipment available in schools has been associated with the transmission of enteric viruses and bacteria. The following is expected for equipment and toys used in our school:
- Equipment available for general use must be, wherever possible, wipe-clean.
 - Soft toys should only be used for specific therapy purposes and must be resistant to laundering at 70°C.
 - Equipment must be subject to a regular cleaning schedule. Weekly is advised. Equipment and toys must be cleaned immediately if contaminated with blood or body fluids.

14 Medical Equipment

- 14.1 Re-processing medical equipment potentially provides a highly effective route for cross infection.
- 14.2 Compliance with existing guidance on decontamination is essential to provide infection risk reduction and ensure the highest attainable levels of public safety.
- 14.3 In school, this most commonly applies to the school inhaler and spacer.
- 14.4 We will review our systems for decontamination to ensure that they are in line with current guidance, this will occur annually or more frequently when needed.
- 14.5 Decontamination will be a part of equipment procurement. When buying new equipment an assessment will be made of the ease of effective cleaning and decontamination of that object.

15 Single Use Items

- 15.1 Guidance from the Medical Devices Agency – now the Medicines and Healthcare Products Regulatory Agency (MHRA) clearly states that devices intended for single use should *never* be re-processed. Potential hazards include the following:
- Infection - single-use devices may not allow thorough decontamination and/or sterilization processes.
 - Some materials used in device manufacture can absorb certain chemicals during chemical cleaning, which can then gradually leach from the material over time.
 - Reprocessing single-use devices may affect the capabilities and/or the materials from which the device is made.
 - Some devices may experience stress during each cycle of reuse, leading to device failure in use, or the device not performing as intended.
 - The status of the reprocessed device can become unclear as a result of inadequate labelling.
- 15.2 Manufacturers' instructions will always state if an item is for single use only. This is the symbol:



- 15.3 Anyone who reprocesses or reuses a single use device bears full responsibility for its safety and effectiveness.

16 Decontamination

16.1 Definition

Decontamination: A general term for the destruction or removal of microbial contamination to render an item safer. This will include methods of cleaning, disinfection and sterilization.

16.2 Decontaminating equipment on site

If decontamination is to be carried out on site, consideration should be given to:

a) Manufacturer's instructions

Manufacturers must, by law, provide instructions for use and guidance on decontamination for each piece of equipment supplied since 1998. Failure to adhere to these guidelines may damage the equipment (e.g. steam sterilizing plastics with low melting points). It may also invalidate any warranties and transfer liability from the manufacturer to the re-processor/ person who authorised the re-processing.

Staff will always seek further advice if confirmation/clarification of instructions is needed.

b) Level of risk

Equipment can be categorised according to the risk it poses to people. This is based on an assessment of the *procedure* to be performed:

Risk	Application	Recommendation
Medium	Items in contact with intact skin, mucous membranes or body fluids, particularly after use by infected persons	Sterilization or disinfection required. Cleaning may be acceptable in some agreed situations.
Low	Items in contact with healthy skin or mucous membranes or not in contact with patient	Cleaning

17 Equipment to be sent for inspection, service or repair

17.1 Any equipment potentially contaminated with blood/body fluids, or has been exposed to persons with a known infectious disease should be decontaminated before being sent to third parties for inspection, service or repair. An example of this would be an iPad or laptop.

17.2 All equipment to be inspected, serviced or repaired must be labelled indicating that the item either:

- Has not been in contact with blood or body fluids or
- Has been cleaned and decontaminated or
- Could not be decontaminated

17.3 If equipment cannot be decontaminated (for example if device needs to be dismantled by an engineer), a biohazard label should be attached, together with a completed label explaining this.

18 Cleaning

18.1 Definition

Cleaning: A process that removes contaminants including dust, soil, large numbers of micro-organisms and the organic matter (e.g. faeces, blood) that protects them.

Effective cleaning is a pre-requisite of an effective disinfection process. Items which are dusty, soiled or contaminated with organic matter will not be effectively disinfected. It must also be remembered that disinfection and sterilization are ineffective against prions (the causative agents of CJD and vCJD). Cleaning is the only effective way of removing these from equipment.

18.2 Cleaning

Equipment should be washed in a dedicated deep sink (to immerse equipment and avoid cross contamination).

Equipment should be fully immersed under still water to clean. Running under a tap is not acceptable unless the item is unable to withstand immersion.

Equipment should be thoroughly washed in detergent and warm water. Disinfectant solutions are not required and may compromise cleaning.

Cleaning equipment (e.g. brushes) should be kept clean and dry between use. Brushes should not be stored in disinfectant solutions.

Staff should wear protective clothing to minimise the risk of contamination.

Instruments should be stored dry prior to cleaning.

18.3 **Disinfection**

A process used to reduce the number of viable micro-organisms but may not inactivate some microbial agents, such as certain viruses and bacterial spores. Disinfection processes should only be limited to equipment which cannot be reprocessed using other methods.

Methods of disinfection:

Chemical disinfectants (e.g. peracetic acid, alcohol, chlorine releasing agents).

Washer disinfectors. – uses a combination of physical cleaning and heat to disinfect equipment. This can either be a process prior to re-use or make items safe to handle before further processing. **NB:** Do not decant disinfectants and chemicals into containers not designed for this purpose.

Holy Trinity will employ Milton tablets or fluid. To make concentrated solution (10,000 PPM) there will be the addition of 50 ml water and will be used for the decontamination of blood and bloody body fluid spills. To make dilute solution (1,000 PPM) there will be the addition of 500 ml water and it will be used for the decontamination of surfaces that may be lightly (i.e. not visibly) contaminated with pathogenic viruses. **COLD water will always be used for dilution.**

18.4 **Sterilization**

Definition

Sterilization: A process used to render an object free from all living organisms. Sterilisation is an absolute term.

Methods of sterilization

Moist heat (saturated steam) e.g. steam cleaner

18.5 **Storage of Instruments after Sterilisation**

Sterile equipment should be stored dry and off the floor.

19 **Influenza**

NB: *In the event of a declared Influenza Pandemic, these guidelines will be superseded by the Local Pandemic Influenza Plan.*

19.1 Influenza is an acute viral infection, which generally presents with an abrupt onset of fever, chills, headaches, myalgia and dry cough. In uncomplicated cases, symptoms resolve in 3-5 days, although a brief period of fatigue may follow recovery.

Influenza is highly infectious and with a short incubation period of 1-3 days, can be spread rapidly especially in residential care settings.

Influenza is generally milder in children than adults and more severe in those with underlying disease, particularly those with the following:

- chronic respiratory and cardiac disease
- renal and liver failure
- diabetes mellitus
- immunocompromised due to illness or treatment
- and those over the age of 65 years

Complications may occur and these include:

- otitis media (in children)
- bronchitis
- pneumonia, usually due to a superimposed bacterial infection with either *Staphylococcus aureus*, *Streptococcus pneumoniae* or *Haemophilus influenzae*.

19.2 **Immunization Against Influenza**

School will liaise fully with the PCT in order to ensure the priority group of children participate in the immunization programme

19.3 **Contraindications to Vaccination:**

The vaccine should not be given to individuals who have had a confirmed anaphylactic reaction to a previous dose of vaccine or to any component of the vaccine. The vaccine is prepared in hens eggs and should not be given to those individuals where there is a confirmed anaphylactic hypersensitivity to egg products. School will ensure that all medical records are kept up to date in order to support the PCT in the discharge of the immunisation programme, as well as parents will allow..

20 Influenza/ Coronavirus Pandemic

- 20.1 There is always the potential for a worldwide increase in influenza or Coronavirus with either a new strain or subtype of the virus, which causes widespread outbreaks (Pandemic). It is essential that Holy Trinity develops plans to effectively respond to notification of a pandemic.
- 20.2 The biggest risk to the school will be the impact of staff illness, as affected individuals require at least 3 days and usually a week away from work. It is possible that at least a third of the work force could be absent at the peak of the outbreak.
- 20.3 In the event of an Influenza Pandemic, staff will be informed when the Pandemic Plan comes into effect.

21 Ectoparasites

- 21.1 Ectoparasites include Head Lice, Body Lice, Pubic Lice and the Scabies Mite. Lice live on the skin or inner layers of clothing. Once parted from their host, they soon die, although the nits or eggs may remain viable for long periods. Transmission is by contact either with the hair (head or pubic lice) or clothing (body lice) of the host. Infection with the scabies mite is currently increasing and there have been a number of cases of resistance to the usual treatments. It requires extended direct contact for transmission of the mite i.e. skin to skin contact for about 3 to 5 minutes. In a school, where children and staff are in close contact, the spread of ectoparasites can be a common occurrence.

21.2 Head Lice (Nits)- *Pediculus humanus capitis*

The adult is a flesh coloured insect which moves very fast. It feeds on human blood. Bites cannot be felt but repeated bites lead to sensitisation and irritation (itching) of the scalp. The eggs, which are difficult to see, are glued to individual hairs just above the roots. The incubation period is approximately 7-8 days. "Nits" are empty egg shells and are easier to see because they appear white and shiny. The empty shells are harmless. The live lice are transmitted by prolonged head to head contact.

Identification of Head Lice Carriage

Holy Trinity advocates the wet combing method to parents:

1. Wash the hair in the normal way.
2. Using a comb and lots of conditioner, firstly comb the tangles out of the hair over a pale surface or paper towel. Clean the comb between each stroke using with a piece of tissue. Then repeat the process with a proprietary 'nit' comb. Combing a small section of hair from the roots to the end and cleaning the comb after each stroke.
3. Examine the tissue after each combing for traces of lice.
4. After completing the combing, rinse and dry the hair in the usual way.

If live lice are identified, then an appropriate eradication method should be used on all members of the household.

Treatment of Head Lice

If head lice are detected, then the treatment options available are the 'Wet Combing' method described above, or insecticide lotions. Parents can be advised by their pharmacist, GP or the school nurse.

21.3 Scabies- *Sarcoptes scabiei*

Infection with the scabies mite is very difficult to detect until the infested individual becomes allergic to proteins in the excreta of the mite. This causes increasingly intensive itching particularly at night. Also, the burrow is a diagnostic lesion of scabies; it is a discoloured, raised line, which may be straight, tortuous or dotted.

Common sites of infection are the webs of fingers, wrists, flexors of the arms, the axillae, lower abdomen, genitalia, buttocks and feet.

A long-standing infection may often be confused with eczema and diagnosis should be made by a Medical Practitioner with knowledge of this type of infection. The infection with the appearance of eczema is highly infectious, known as 'Crusted scabies' or 'Norwegian scabies'. This form is usually seen in neglected patients with mental health problems, elderly care patients or in immunocompromised patients.

Treatment of Scabies

Often, people who are diagnosed as having scabies will require two treatments, one week apart. Fumigation or environmental cleaning is unnecessary. Even after the treatment has been given, there may still be symptoms, especially itching, as the excreta will still be present.

Other Recommendations

Staff and children cannot enter the campus until 24 hours after completion of the treatment..

21.4 MRSA Within The Community

People within the community are at a lower risk from MRSA as they are less likely to be seriously ill and less likely to come into contact with other vulnerable persons. Staff still need to be aware of MRSA but in most cases good, basic infection control precautions will be sufficient.

Prevention Of Spread

Standard Infection Control Procedures should be employed. Good hand hygiene is the most essential measure to stop the spread of MRSA both from those known and those not known to be carriers.

21.5 Tuberculosis

There are a number of bacteria within the Mycobacteria family and these are widely distributed throughout the world but only a few species are pathogenic to man. Mycobacteria are different to most other bacteria in that they contain a waxy layer inside their cell wall. This makes it difficult for the immune system to deal with infections and also complicates treatment.

The most common mycobacterial infections are caused by *Mycobacterium tuberculosis*. The most common primary site of infection is the lungs (pulmonary tuberculosis), but bones, joints, the brain and meninges and other internal organs may be affected.

Care Protocol For First Two Weeks

Once a person has commenced treatment for suspected tuberculosis, they generally remain infectious only for the first two weeks of treatment unless there is a suspicion of a resistant or multi-resistant strain of tuberculosis. The person will remain at home as directed by the Chest Physician TB Nurse Specialist until confirmatory diagnosis and up to fourteen days of specific chemotherapy has been completed (advice will be given by the TB Nurse Specialist). There is no need for separate crockery or cutlery.

21.6 Chicken Pox and Shingles

Chickenpox and shingles are both caused by the virus Varicella zoster. The primary infection with this virus is Chicken Pox and subsequent reactivations, Shingles. Staff with direct contact who have no known history of chicken pox should seek advice from their GP.

Primary Infection: Chickenpox

The virus is infectious via upper respiratory secretions for up to four days prior to the spots appearing. The individual then remains infectious until all the vesicles have dried and crusted (usually about five days from the appearance of the last vesicle). If someone has had chickenpox in the past, usually they are not susceptible to a second infection and they will not acquire and pass on the virus to others. The only exception to this is if the person is immunocompromised

Reactivation Disease: Herpes Zoster (Shingles)

Shingles only occurs in persons who have already had chickenpox. Individuals who have not had chickenpox may acquire it from patients with shingles

Varicella zoster virus poses a significant risk of infant morbidity and mortality in pregnancy. Pregnant members of staff who have not had chickenpox must consult their GP as soon as possible following exposure to the Varicella zoster virus.

Appendix 1

Standard Infection Control Precautions are:

Hand hygiene: Hands should be washed or decontaminated with alcohol based hand hygiene products before and after all procedures. If skin is contaminated with blood or body fluid, wash off immediately with soap and running water.

Broken skin: Cuts and abrasions on the hands/forearms should be covered with a waterproof dressing.

Sharps: Needles, blades and other sharp instruments should be placed directly into a rigid sharps container by the user. *Never re-sheath or break needles.* Discard needle and syringe as one unit into the sharps bin wherever possible. Seal sharps bin when three-quarters full and label and date before disposal.

Protective clothing: Gloves should be worn for direct contact with blood/body fluid, and for direct contact with non-intact skin or mucous membranes. Plastic aprons should be worn whenever contamination of clothing with blood/ body fluid is anticipated. Protective eyewear should be worn where there is a risk of blood/body fluid splashing into the face.

Blood and body fluid spillages: Spills of blood or body fluids should be dealt with promptly using hypochlorite solution or other appropriate method. Protective clothing should also be worn.








Waste Disposal: Waste contaminated with blood or body fluids should be discarded directly into a yellow clinical waste bag for incineration.

Medical equipment: Instruments for re-use should be decontaminated between patients according to current guidance.

Ensuring Good Hand Hygiene

- **Cover all cuts/abrasions with occlusive dressing.**
- **Keep nails short. Do not wear nail varnish or artificial nails. These have been proven to increase the number of coliforms on the hands.**
- **Jewellery should be kept to a minimum (i.e. plain band ring only – no stones. Ensure that the area under this is washed and dried).**
- **Do not wear wristwatches or bracelets during procedures. Roll up sleeves, as the wrists must be washed.**
- **Ensure that liquid soap and disposable paper towels are of good quality and are acceptable to the user(s).**
- **Hand cream is advised to protect skin from drying at the end of each session. Individual tubes or pump dispensers only should be used. Communal tubs should be avoided.**
- **Staff with skin conditions such as dermatitis should seek expert advice for treatment and management.**

Hand Washing Technique

 <p>1. Moisten hands and apply soap or antiseptic wash. Rub palms together</p>	 <p>2. Rub the back of each hand, ensuring no area is missed.</p>
 <p>3. Interlace the fingers, to clean the interdigital spaces.</p>	 <p>4. Rub the fingertips on the opposing palm.</p>
 <p>5. Clasp the hands together, ensuring the thumbs are well cleaned.</p>	 <p>6. Clasp the fingers together to clean the backs</p>
 <p>7. Make sure the wrists are cleaned. Rinse the hands thoroughly, and dry well using paper towels.</p>	

Risks from Infections carried by others

INFECTION	PATIENT RISKS	ADVICE TO STAFF
BLOOD BORNE VIRUSES (BBV) including Hepatitis B Hepatitis C HIV	<p>The risk of transmission of a blood borne virus from a member of staff to another is extremely low.</p> <p>Not all staff will be aware of their possible infectious status therefore standard infection control precautions should be applied at all times.</p>	<p>Staff should seek advice from their GP as soon as possible following diagnosis or if concerned that they may have been exposed to a BBV.</p> <p>An assessment will be made regarding further clinical management and in consultation with the HPU if a staff member is diagnosed, whether some modification of working practices is necessary.</p>
INFECTED SKIN LESIONS or skin conditions, i.e. infected psoriasis, eczema, impetigo etc.	<p>A bacterial infection is the usual cause, which can then be spread to others.</p> <p>Particularly vulnerable are those with open lesions, surgical or traumatic wounds, the immuno-compromised or neonates.</p>	<p>Staff suffering with these infections may be required to remain off duty until the infection has resolved unless it can be covered by an occlusive dressing.</p>
CHICKEN POX / SHINGLES (VARICELLA)	<p>Non-immune and immune-suppressed people may require active protection.</p>	<p>Non-immune staff, i.e. those, who have not had the disease, should avoid contact with affected people until 5 days from onset of rash.</p> <p>Non-immune pregnant staff (if < 20 weeks pregnant or in last 3 weeks of pregnancy) or immune-suppressed staff who have had contact with affected clients should discuss their exposure with their GP</p>
COLD SORES and GENITAL HERPES INFECTIONS	<p>Caused by the herpes simplex virus, which may expose some people who are immuno-compromised, neonates and pregnant women to particular risks.</p> <p>Viral encephalitis may ensue in these susceptible patients.</p>	<p>Depending on working environment staff may need to remain off duty until resolution of symptoms and lesions are dry. Seek GP guidance.</p> <p>Do not touch lesions, wash hands thoroughly.</p>
DIARRHOEA and / or VOMITING	<p>These may be symptoms of food poisoning or viral infection, which can result in cross infection causing outbreaks.</p> <p>Viral outbreaks spread rapidly and vulnerable people are at particular risk.</p>	<p>Staff must remain off duty until 24 hours after resolution of the symptoms. Food handlers must discuss their condition with the Head teacher before returning to work.</p> <p>School will notify the Infection Control Specialist if more than 12 members of the school community affected.</p>
INFLUENZA	<p>A viral infection which usually spreads to others and if prompt action is not taken. It can cause high morbidity and mortality rates.</p>	<p>Staff should remain off duty until resolution of symptoms.</p> <p>Up take of influenza vaccine is recommended for both school staff and vulnerable children.</p>
MRSA	<p>A Bacterial infection that can cause problems in debilitated patients.</p>	<p>Staff will not be screened for MRSA unless this has been advised by the Infection Control Specialist.</p>
RUBELLA	<p>Cases are infectious until 5 days after onset of rash.</p>	<p>Non-immune pregnant staff, i.e. those who have no history of disease and/or no positive antibody test must seek guidance from the GP especially in the first trimester.</p>

INFECTION	PATIENT RISKS	ADVICE TO STAFF
SCABIES	<p>People may be infected by affected other.</p> <p>Infected people remain contagious until 24hrs post-treatment.</p>	Staff contacts of infested people may require treatment.
SORE THROATS	<p>These may have many causes but are usually viral or streptococcal infection and they can cause severe infections in vulnerable people.</p>	Staff should remain off duty until resolution of symptoms, especially if unwell and with a severe sore throat.
TUBERCULOSIS	<p>Physical isolation is required for people who are pulmonary smear positive.</p> <p>Isolation should continue until at least 14 days after commencing appropriate anti-tuberculosis therapy and / or until advised by TB specialist / team.</p>	The necessity for exclusion of diagnosed staff or children from school should be discussed with the Occupational Health specialist or the person's chest physician.
PARVOVIRUS (FIFTH DISEASE)	<p>Mild, non-febrile viral disease characterized by erythema of cheeks.</p> <p>Most infectious prior to development of rash but not infectious thereafter.</p>	<p>Can cause foetal abnormality.</p> <p>Pregnant staff less than 20 weeks pregnant seek advice from obstetrician.</p>

First Aid Following Sharps Injury

Encourage puncture site to bleed by applying pressure (do not suck)

Wash site liberally with soap and warm running water without scrubbing

Cover with waterproof plaster

Wash exposed eyes/mucous membranes thoroughly with running water or saline, before and after removing any contact lenses

Remove offending item and dispose of it carefully into an approved sharps bin

Report incident to designated member of staff *immediately*

Seek *immediate* medical advice from the designated risk assessor/Occupational Health (or A&E if not available)

Categories of Waste

<i>Category</i>	<i>Description</i>	<i>Disposal</i>
Clinical waste	Soiled dressings human tissue, blood, swabs and contaminated waste from treatment.	Yellow clinical waste bag for incineration.
Domestic waste	Uncontaminated waste e.g. paper, wrappings.	Black plastic waste bag for land-fill, re-use or recycle.
Clinical sharps	Used sharps items.	Sharps container which complies with British Standard 7320:1990. For incineration.

Appendix 7

Notification of Infectious Disease

A member of staff who suspects that any member of the school community is suffering from one of the following infectious diseases must notify the Head teacher immediately who will then notify the PCT:

Anthrax*	Paratyphoid fever*
Cholera*	Plague*
Diphtheria*	Poliomyelitis (acute)*
Dysentery (amoebic or bacillary)	Rabies*
Encephalitis (acute)	Relapsing fever
Food poisoning**	Rubella
Leprosy*	Scarlet fever
Leptospirosis	Smallpox*
Malaria	Tetanus
Measles	Tuberculosis - all forms
Meningitis*	Typhoid fever*
Meningococcal Septicaemia* (without meningitis)	Typhus*
Mumps	Viral haemorrhagic fever*
Ophthalmia neonatorum	Viral hepatitis
	Whooping cough
	Yellow fever

* For diseases marked with an asterisk, please telephone your Consultant in Communicable Disease Control.

** Cases of food poisoning or dysentery in a food handler should be notified.

Glossary

Aerosol:	Small airborne droplets of fluid.
Allergy:	A condition where there is an exaggerated response to an <i>antigen</i> . This may be local or general.
Antibiotic/ Antimicrobial:	A substance that selectively inhibits or kills micro-organisms with minimal toxic effect on the patient.
Antigen:	A substance regarded as foreign by the body, which the immune system reacts against.
Antiseptic:	A <i>disinfectant</i> solution that can be used on living tissue such as skin.
Aseptic:	Sterile.
Communicable:	see <i>Infectious</i> .
Contamination:	The presence on an item of any substance that should not be there, e.g., dirt or <i>pathogenic micro-organisms</i> .
Cross-infection:	The transmission of <i>infection</i> between individuals, be they staff, patients or both.
Disinfectant:	A chemical that can be used in <i>disinfection</i> .
Disinfection:	The reduction of micro-organisms to an acceptable level. This process does not destroy <i>spores</i> , or some <i>viruses</i> .
Epidemic:	A rise in the usual level of a disease over a short period of time.
Exposure Prone Flora:	A procedure which may lead to contact with blood and/or body fluids <i>Micro-organisms</i> (usually bacteria) found living in a particular environment in or on the body, e.g. on the skin. Also see <i>Commensal</i>
Hypochlorite:	Bleach containing chlorine.
HPU/ HPA:	Health Protection Unit/Health Protection Agency.
Immunisation:	The process of artificially inducing <i>immunity</i> to <i>infection</i> by a particular <i>micro-organism</i> . See also <i>Immunity</i> , <i>Vaccination</i> .
Immunity:	Protection against <i>infection</i> by a particular <i>micro-organism</i> . Results from <i>infection</i> or <i>immunisation</i> .
Infection:	The growth of <i>pathogenic</i> organisms within the body in a manner likely to cause disease.
Infectious:	Able to be transmitted from one person to another.
Infectivity:	Description of how easily an organism is able to spread.
Inoculation:	The introduction of <i>micro-organisms</i> into a medium where they can grow, e.g. blood or laboratory media.
Microbe/ Microbial:	See micro-organism.
Micro-organisms:	Organisms usually only visible by visual aids e.g. microscopes. These include bacteria, viruses and fungi.
Needlestick:	Puncture of the skin by a needle or other sharp object.
Outbreak:	The occurrence of two or more related cases of an <i>infection</i> , or where there are more cases of an <i>infection</i> than would normally be expected.
Pandemic:	An <i>epidemic</i> spanning several countries.
Pathogenic:	Disease causing.
Prophylaxis:	Measures or medication taken to prevent complications following an incident.
Spores:	Resistant casings used by some bacteria and fungi to survive adverse environmental conditions. These are often resistant to <i>disinfection</i> .
Sterilisation:	A process removing or destroying all micro-organisms, including <i>spores</i> .
Transmission:	The transfer of a disease from one person to another.
Vaccination:	Inducing <i>immunity</i> by the administration of a <i>vaccine</i> .
Vaccine:	A preparation of killed or inactivated micro-organisms or extracts used to artificially induce immunity.
Virulence:	A measure of the ability of a micro-organism to cause disease.
Virus:	A <i>micro-organism</i> only capable of reproduction within living cells. These are often resistant to disinfection.