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Public Health, Health Protection

Outbreak Management: An information resource for care homes

Infection Prevention & Control

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CONTENTS

INTRODUCTION

Good standards of infection prevention & control (IPC) reflect the overall quality of care delivered and can promote confidence in the quality-of-care residents and their families receive. In addition, The Health & Social Care Act 2008 and its associated "*Code of Practice on the prevention and control of infections and related guidance*" (Revised 2015)[1] outlines the x10 criterion which apply to all registered providers of healthcare and adult social care in England.

The purpose of this document is to ensure service users are cared for in a safe, clean environment, where the risk of healthcare-associated infections is kept to a minimum, to protect service users from avoidable harm.

OBJECTIVES

Some infections can spread easily in enclosed settings and can result in serious and sometimes life-threatening scenarios. It is therefore essential that staff members remain vigilant and can identify and take prompt action to report and manage any outbreak.

Therefore, the aims of this pack are:

(i) to provide residential and nursing homes with clear guidance on infection prevention & control (IPC) precautions for protecting residents and staff from acquiring infection

(ii) to restrict the spread of any infection through proactive management and reporting, in the event an infection should occur, and

(iii) to clarify communication to promote robust outbreak reporting

DEFINITIONS

An '***outbreak***' is an incident where two or more people have the same disease or similar symptoms and are linked in time, place and/or association of person. An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number at any given time.

An '***incident***' has a broader meaning and refers to events or situations which warrant investigation to determine if corrective action or specific management is needed. In some instances, only one case of an infectious disease may prompt the need for incident management and public health measures.

RECOGNISING ILLNESS

Certain illnesses may have specific signs and symptoms e.g., flu-like illnesses have sudden onset of fever, headache, sore throat, or cough, but older people may present

[1] Dept of Health (2015); Health & Social care Act 2008: *Code of Practice on the prevention and control of infections and related guidance*

with unusual signs and symptoms – they may not have a fever, but they may present with a loss of appetite, unusual behaviours and/or a change in mental state.

Recognising Signs of Deterioration

It is important to recognise signs of deteriorating health early to aid timely treatment. The REACT TO deterioration resource for recognising and managing deterioration in Care Homes is a useful aide memoir designed to support homes to identify signs of deterioration early. To identify changes in a person's health, it is important to understand what is 'normal' for them. Signs that a person may be becoming unwell include:

- New or concerning pain
- Not passing as much urine as usual
- Changes in appetite
- New or worsening confusion.

For more information about the signs of deterioration, please refer to the REACT TO DETERIORATION resource.

Recognising Signs of Sepsis

Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure and death. Medically, sepsis is your body's immune system overresponding to an infection. The clinical signs and symptoms of early sepsis can be vague, subtle, or nonspecific, for instance, a mild tachycardia or fever. This can make early diagnosis challenging, as early signs can be missed by health care providers. Pneumonia, Urinary Tract Infections, and cellulitis are the most common infections that can lead to sepsis, but any infection including influenza or COVID-19 can lead to sepsis. Please **see Appendix 10: Outbreak Management Resources** for an example of a sepsis screening tool.

Risk Assessment

A risk assessment is a careful examination of what in a setting or workplace could cause harm, so that managers can decide whether they have taken enough precautions or should do more to prevent harm, eliminate and/or control the risk. Risks associated with work activities the environment must be assessed and appropriate risk control measures implemented.

When thinking about risk assessment remember:

- A Hazard is anything that may cause harm.

- The Risk is the chance high or low that somebody could be harmed, together with an indication of how serious the harm could be.

Five Steps to Risk Assessment

1. Identify the hazards.
2. Decide who might be harmed and how.
3. Evaluate the risk and decide on the precautions.
4. Record your findings and implement them.
5. Review your risk assessment and update if necessary.

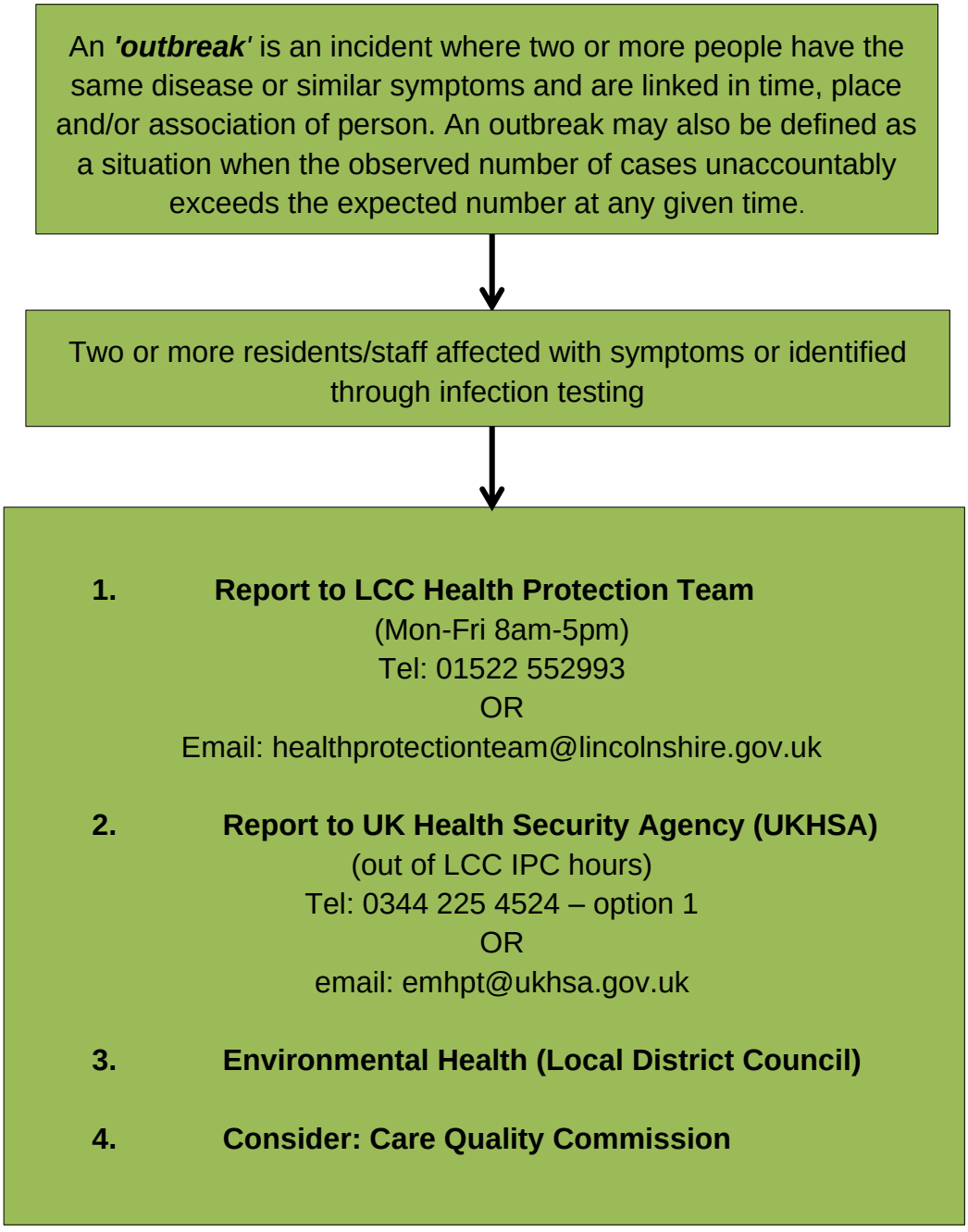
Every care home/ setting should hold a master risk assessment folder for inspection purposes, this should be retained centrally and be available at all times.

During an outbreak it is essential to assess the risk of infection to residents and staff, to ensure that all precautions can be put in place. Control measures should include (where necessary) hand washing for staff, residents and visitors; isolation of affected residents; access to and use of personal protective equipment (PPE); management of waste; management of linen; staff uniform; cleaning of the environment; deep cleaning affected areas at the conclusion of the outbreak – **See Appendix 1: Outbreak Management Checklist.**

Managers or providers may wish to use the template risk assessment provided at the end of this document – **See Appendix 11: Care Home Risk Assessment Template.**

REPORTING & ESCALATION

DIAGRAM 1: REPORTING AN OUTBREAK



Outbreaks in care homes will be routinely monitored by the LCC HPT. If the nature or scale of the outbreak causes concern, this will be escalated in line with the arrangements set out in the East Midlands Communicable Disease Outbreak Management Plan.

Further Information please visit Health Protection – Professional resources

ROLE OF AGENCIES

Agency	Role
Health Protection Team, Public Health, Lincolnshire County Council Tel: **01522 552993 [Mon-Fri 8am-5pm]** Email: healthprotectionteam@lincolnshire.gov.uk Webpage: Health Protection – Professional resources	A Lincolnshire public health team, with specialist staff employed by County Council, to provide Infection Prevention & Control advice
UK Health Security Agency (UKHSA) (East Midlands) Seaton House City Link Nottingham NG2 4LA Tel: **0344 225 4524 – Option 1 [Out of Hours]** Email: emhpt@ukhsa.gov.uk	UK Health Security Agency (UKHSA) provide specialist support to prevent and reduce the impact of: • Infectious disease cases and outbreaks • Chemical and radiation hazards • Major emergencies
Environmental Health District Council	Environmental Health Officers are based within District Councils and work with local partners to address the wider determinants of health, including food safety, housing standards, health and safety, air quality, noise, and environment issues.
Adult Social Care Commercial Team Lincolnshire County Council Email: CommercialTeamPeopleServices@lincolnshire.gov.uk	Commissioning and contract officers carry out reviews and work with residential care homes to gain assurance that service providers are delivering quality care for service users. During contract management meetings, the officers

	observe practice, the environment, review policies and guidance, evaluate service user records and care plans, discuss staff training and support, review training records and quality monitoring
Primary Care Networks (PCNs) The latest contacts for the PCNs in Lincolnshire can be accessed via the ICB if required.	GP practices work together with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas in groups of practices known as primary care networks (PCNs). PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home.

IMMUNISATIONS & VACCINATIONS FOR STAFF & RESIDENTS

People working in Adult Social care and people receiving care are encouraged to make sure they receive vaccinations which they are eligible for. In addition, all health and social care staff should be offered Hepatitis B vaccination, annual influenza vaccination, and other immunisations as appropriate for specific roles via their organisation's Occupational Health services.

Lincolnshire County Council (LCC), in partnership with UK Health Security Agency (UKHSA) and NHS England (NHSE), is committed to supporting the annual National Flu campaign, to promote, safe, effective care for service users. For more information about vaccines and vaccination procedures, please refer to The Green Book. This includes details relating to Influenza and Covid-19 vaccinations. In addition, the table below outlines the most common vaccination programmes in Adult Social Care settings.

Service users:	**Annual seasonal influenza vaccination** is recommended for all service users living in and/or receiving residential care, where a rapid spread of infection is likely and can cause high rates of morbidity and mortality. Some people can be at greater risk of developing complications, (typically pneumonias) from influenza and becoming more seriously ill. These include people with complex medical conditions including chronic lung, heart, kidney, liver, neurological diseases, those with diabetes mellitus and those with suppressed immune system. **Respiratory Synctial Virus (RSV) vaccination** from 01 September 2024 a vaccination was commenced to significant health burden posed by RSV. The RSV vaccination program for older adults will target: Adults turning 75 years old on or after 01 Septembers 2024 until their 80th birthday and adults already 75 to 79 years as of 01 September 2024, until their 80th birthday or until 31 August 2025 if they turn 80 within the first year of the program. **Pneumococcal vaccination** is recommended for all service users over the age of 65 years, who should receive one dose of pneumococcal vaccine. A single dose is also recommended for service users under the age of 65 years who are at increased risk from pneumococcal infection, including people with a heart condition, chronic lung disease and chronic liver disease. **Shingles vaccination** from 01 September 2023 service users over the age of 65 years will now be eligible, two doses will be offered and given between 6 and 12 months apart, if a service user turned 65 years prior to 01 September 2023 they will be eligible for the shingles vaccine when

	they turn 70 years old. The shingles vaccine is recommended for all service users aged 70 to 79 years old, they remain eligible until their 80th birthday. When you're eligible, you can have the shingles vaccination at any time of year. The shingles vaccine is not available on the NHS to anyone aged 80 and over because it seems to be less effective in this age group. Service users aged 50 years and over with a severely weakened immune system are also eligible for the shingles vaccine. **Covid vaccination:** Those over the age of 65 years have by far the highest risk from COVID-19 infection, and the risk increases with age. Residents in care homes for older adults have been disproportionately affected by the Covid-19 pandemic. Evidence from the UK indicates that the risk of poorer outcomes from Covid-19 infection increases dramatically with age in both healthy adults and in adults with underlying health conditions. People aged 65 years and older, residents in care homes for older people and those with a weakened immune system continue to be offered boosters as part of the boosters as part of the Covid-19 vaccination programme. The Joint Committee on Vaccination and Immunisation will continue to release detail regarding upcoming booster programmes prior to their implementation dates. **MMR (Mumps Measles Rubella):** Older residents will most likely have immunity from having the virus as a child, or a measles containing vaccinations previously. If the setting has younger residents who attend school or day care centres, they also benefit from it being ensured they are fully vaccinated. **Other vaccinations** where underlying medical conditions indicate (i.e., Hepatitis A vaccination for those with chronic Hepatitis B infection.
Staff:	**Influenza vaccination** is strongly recommended for all health & social care staff with direct patient/service user contact, including residential care home and domiciliary care staff. Staff immunisation may reduce the transmission of influenza to vulnerable service users, reducing the risk of avoidable harm, some of whom will have impaired immunity. **Hepatitis B** for staff that have direct contact with service users' blood, blood-stained body fluids or body tissues, such as sharps. Also, staff that are at risk of being injured or bitten by patients.

	Covid vaccination offers the best protection against the virus both for staff and care home residents. Health and social care staff are strongly encouraged to have had four doses of the Covid 19 vaccine. **MMR (Mumps Measles Rubella):** All healthcare staff are encouraged to ensure that they have received two doses of the vaccination. Measles is very infectious; however, the vaccination gives a high level f protection against the virus. Cases of measles could affect the level of staffing in a setting. Staff can check with their GP that they have received the doses required, we would also advise that staff check their children are up to date with all their routine childhood vaccinations. **Other vaccinations** where underlying medical conditions indicate (i.e., Hepatitis A vaccination for those with chronic Hepatitis B infection).

GENERAL PRINCIPLES OF OUTBREAK MANAGEMENT

It is important to recognise potential outbreaks promptly and for care staff to implement control measures as soon as possible to prevent further cases. Staff must be aware of the signs of infection, particularly in the elderly, e.g., fever, diarrhoea or vomiting, unexpected falls, and confusion. They must also know to report these signs immediately to senior management staff when they occur.[2]

Every residential care home should have an outbreak management plan that clearly outlines communication procedures and defines what information needs to be collated.

To reduce the risk of cross contamination and prevent spread, key principles that need to be applied are as follows **(also see diagram 2 below)**:

- inform and seek advice early
- isolate those that are affected
- restrict visiting
- implement the staff exclusion policy
- take samples
- inform partner organisations e.g., GP, community nurses
- maintain robust records and provide daily updates, restrict visiting
- provide advice to staff, service users and family/friends

The following information should be kept for residents with suspected or confirmed infections or infectious disease, to include name, age, date of birth; GP name & address; date of onset of symptoms and cessation of symptoms; type of symptoms; samples taken (and sent); diagnosis; source of infection (if known); contacts – family, staff, visitors; outcome; whether the case was notified/reported (and date of reporting). Information should also be kept for any staff members that develop similar symptoms.

Examples of forms that can be used to separately record the names of affected staff and affected residents can be found in the following appendices:

- **Appendix 2: General Outbreak Management – Staff Form**
- **Appendix 3: General Outbreak Management – Resident Form**
- **Appendix 4: Influenza Outbreak Management – Resident and Staff Form**
- **Appendix 5: D&V Outbreak Management – Resident Form**

[2] Department of Health (2013) Prevention & control of infection in care homes – an information resource. Available at: https://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published (accessed 01/11/21).

DIAGRAM 2: GENERAL PRINCIPLES OF OUTBREAK MANAGEMENT

ACTION CARDS

Several supportive action cards are outlined as a source of specific guidance, to include:

A. Diarrhoea and Vomiting
B. Clostridium difficile
C. Group Strep A
D. MRSA
E. Influenza like illness
F. Chest Infections
G. COVID-19
H. Scabies

DIARRHOEA AND / OR VOMITING ACTION CARD		Tick
Please consider all the actions below (mark as not applicable [NA] as necessary)		
Definition of D&V outbreak is. ***Two or more cases of diarrhoea and/or vomiting – with evidence of bowel movements which indicate Bristol Stool Chart grading 6 or 7, which are unusual to the resident(s) and/or staff members normal bowel action.***		
1.	**In Hours - Inform the LCC, Health Protection Team – Tel: 01522 552993 Email: healthprotectionteam@lincolnshire.gov.uk** The Health Protection Team will be your first point of contact during an outbreak. Upon notification of the outbreak, the IPC team will cascade this information to the Whole Health Economy IPC group and will notify UK Health Security Agency (UKHSA) on your behalf. The IPC team will provide daily support and advice – the information they will require is as follow: ○ Total number of staff affected ○ Total number of residents affected ○ Number of newly affected residents (per 24 hours) ○ Number of newly affected staff (per 24 hours) ○ Number of residents who continue to be symptomatic ○ To maintain robust record keeping and reduce the risk of confusion it is recommended that resident/staff initials are used to report those affected.	
2.	**Out of Hours - Inform UK Health Security Agency (UKHSA) Tel: 0344 225 4524 (option 1) or Email: emhpt@ukhsa.gov.uk** They will require the following information: ○ Name, address, and telephone number of affected care home ○ Onset of symptoms – date and time ○ Total number of residents in the home ○ Total number of staff employed in the home ○ Number of symptomatic residents and staff, at time of reporting outbreak	
3.	**Consider informing Environmental Health** (if food poisoning is suspected) These are the questions that Environmental Health may ask: ○ Number of meals per day - residents and staff? ○ If staff have been ill, consider if they have eaten from the care home? ○ Are day visitors catered for? And if so, how many? ○ Do you use a distribution kitchen? e.g., are hot meals sent offsite to another satellite kitchen? If so, where? And how many? Has this ceased during the current outbreak? ○ How many residents and staff are ill, time, onset date, symptoms?	

	○ Have kitchen staff been contacted about possible symptoms? ○ Have any household contacts for kitchen staff & care assistants been unwell with diarrhoea and vomiting symptoms? ○ Are kitchen staff aware of the 72-hour rule for exclusion? ○ Has anyone vomited in the dining room? **Environmental health staff may wish to conduct a site visit, to ask further questions**	
4.	**Care Quality Commission** do not routinely need to be informed, but this documentation can be used to provide evidence for your CQC inspection	
5.	**Staff Actions:** ○ **Report** ALL cases of diarrhoea and vomiting to the person in charge ○ **Document** the details of all symptomatic residents and staff cases on the outbreak management charts – See the following Appendices: ○ **Appendix 2: Outbreak Management – Staff Form.** ○ **Appendix 5: D&V Outbreak Management – Resident Form.** ○ **Close the home to:** ▪ Admissions (Postpone non urgent transfers and assess non urgent hospital outpatient appointments - If hospital appointments are essential and this can be discussed with the health professional the resident is due to see, inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other people). ▪ Hairdressers, chiropodists, and activity coordinators	
6.	**Day Centre's** should be closed unless they can be accessed independently from the home and do not share staff with the home or receive meals from the home's kitchen.	
7.	**Inform visitors of the closure** Put a poster on the entrance of the home **(see Appendix 10: Outbreak Management Resources)** to inform visitors there is an outbreak. Everyone who attends the home needs to report to the person in charge. Visitors are advised to stay away until the home is 72 hours free of symptoms.	
8.	**Inform the affected residents GP** In addition, all visiting health care staff must be made aware of the outbreak, to include community nurses, physiotherapists, occupational therapists, and pharmacists. Non-essential care must be deferred until after the outbreak and **ALL visiting staff MUST wash their hands on entering the premises and on departure. Alcohol hand rub is NOT a suitable alternative.**	
9.	**If a resident requires an emergency admission to hospital**, the home manager (or designated deputy) must inform the ambulance service (EMAS) and Accident & Emergency Department (or the admitting ward), of the homes outbreak (regardless of whether the resident is affected), so the resident can be suitably isolated. In addition, the home manager must complete a **Transfer Form – see appendix 8.**	

10.	**Isolate the affected residents until they have been symptom free for 72 hours, particularly those with vomiting.** Where residents are difficult to isolate (EMI units) try as much as possible to cohort the residents that are symptomatic into one area.	
11.	**Staff Rota** To minimise cross contamination of unaffected areas, cohort staff to provide care to affected versus non affected residents and avoid moving staff between homes and floors, until the conclusion of the outbreak.	
12.	**Stool Specimens** Commence stool monitoring of affected residents see: **Appendix 6: D&V Outbreak Management – Bowel Monitoring Chart** **Appendix 7: Bristol Stool Chart** Consider taking a stool specimen, which must fill half the specimen pot and MUST be watery diarrhea (Bristol Stool 6/7 - NOT formed stools). The specimen can still be taken even if it is mixed with urine, and it is alright to scoop the sample from the toilet or from an incontinence pad. Sampling early may identify the cause of the outbreak and halt the need to take further samples. Samples must be labelled clearly with the affected resident/staff details, the name of the home followed by '***outbreak***' and the tests requested as '***M, C & S and virology***'.	
13.	**Staff Exclusion Policy** Exclude all staff with symptoms until they have been asymptomatic for 48 hours (for kitchen staff, increase exclusion period to 72 hours). Staff should be advised to submit stool samples to their GPs and must be advised not work in any other care home until symptom free for 48 hours.	
14.	**Eating and Drinking** Staff must not eat and drink except in designated areas, e.g., dining room or staff room. Open boxes of chocolates and fruit bowls must be removed and discarded in an outbreak.	
15.	**Staff Uniform** All staff should change out of their uniforms prior to leaving their place of work and wear a clean uniform daily. If uniforms are laundered at home they should be washed immediately, on a separate wash to other laundry and at the highest temperature the material will allow. Staff should wear disposable gloves and aprons whilst cleaning and when attending to personal care. Gloves and aprons should be changed between service users.	
16.	**Cleaning** **Ensure the home is thoroughly cleaned daily** using a hypochlorite (chlorine based) solution 1000 parts per million (e.g., Milton 1:10). To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water.) ○ All eating surfaces, toilet areas, sluice areas and laundry should be cleaned twice daily ○ Commodes and toilet seats must be cleaned after each use ○ Points of contact e.g., door handles, light switches, toilet flushes must be cleaned frequently throughout the day	

	○ Vomit and/or faecal spillages must be covered immediately with disposable paper roll/towel before removing the spillage. Once removed, clean the surrounding area with hot soapy water, followed by disinfection with the **hypochlorite** solution of 1000 parts per million. Always clean a wider area than is visibly contaminated ○ Carpets contaminated should be cleaned with hot soapy water (or a carpet shampoo), once the spillage has been removed with paper towels. The carpet should then be shampooed and/or steam cleaned **Always wear an apron and gloves when disposing of faeces/vomit**	
17.	**Macerator/bedpan washer** Access to an operational macerator or bedpan washer is essential during an outbreak to reduce all risks of cross contamination. All faults must be dealt with immediately as urgent. If you do not have access to either, identify a designated toilet to decant commode contents but do not allow residents to use the toilet until the outbreak is concluded.	
18.	**Reopening** ○ The Health Protection Team, LCC (Tel: 01522 552993) will advise when the home can re-open ○ The affected home should not be reopened until it has been free of symptoms for 72 hours ○ Prior to re-opening, a thorough 'deep clean' should take place of all affected rooms; this means that all floors, surfaces, and equipment should be thoroughly cleaned, flooring washed/shampooed, or steam cleaned, with curtains put through a wash cycle ○ Electrical items such as telephones and computer keyboards also need to be cleaned with a (damp but not wet) cloth. Followed by a disinfectant wipe.	

<table>
<tr><th colspan="2">CLOSTRIDIUM DIFFICILE ACTION CARD
Please consider all the actions below (mark as not applicable [NA] as necessary)</th><th>Tick</th></tr>
<tr><td>1.</td><td>If you have a resident who is Clostridium difficile positive, follow the Department of Health's 'SIGHT' advice, as outlined below (see Appendix 10: Outbreak Management Resources)
<table>
<tr><td>S</td><td>Suspect a case may be infectious where there is no other cause for diarrhoea</td></tr>
<tr><td>I</td><td>Isolate resident while you investigate until clear of symptoms for 72 hrs</td></tr>
<tr><td>G</td><td>Gloves & aprons to be used for all contact with the resident & their environment</td></tr>
<tr><td>H</td><td>Hand wash with soap & water - before and after each contact with the resident & their environment. Alcohol gel does not work against Clostridium difficile</td></tr>
<tr><td>T</td><td>Test the stool - Inform the resident's GP & immediately send a specimen to request Clostridium difficile screening (if three or more instances of Bristol Stool Chart type 5, 6 or 7, within 24 hours] – see appendix 1.</td></tr>
</table>
Please contact the LCC Health Protection Team if any of your residents has recently been discharged from hospital and was diagnosed with Clostridium difficile whilst in hospital.
LCC Health Protection Team – Tel: 01522 552993
Email: healthprotectionteam@lincolnshire.gov.uk
The Health Protection Team will be your first point of contact and will notify UK Health Security Agency (UKHSA) on your behalf.</td><td></td></tr>
<tr><td>2.</td><td>The GP should review any antibiotics that the resident is taking.</td><td></td></tr>
<tr><td>3.</td><td>Other medication such as laxatives and other drugs that may cause diarrhoea should also be reviewed.</td><td></td></tr>
<tr><td>4.</td><td>Review and consider implementation of the Suggested Care Plan for Clostridium Difficile – see Appendix 9</td><td></td></tr>
<tr><td>5.</td><td>Ensure that fluid intake is recorded, and that it is adequate.</td><td></td></tr>
<tr><td>6.</td><td>Record all bowel movements on a stool chart, in line with the Bristol Stool Chart.</td><td></td></tr>
<tr><td>7.</td><td>All residents with diarrhea should be isolated in their own room until they are symptom free for a minimum of 72 hours.</td><td></td></tr>
<tr><td>8.</td><td>Re-enforce Standard Infection Control Precautions to all staff.</td><td></td></tr>
<tr><td>9.</td><td>Residents must be assisted to wash their own hands after using the toilet, commode and/or bedpan.</td><td></td></tr>
</table>

10.	Wear disposable gloves and aprons when carrying out **any** care (i.e., not only when contact with blood and/or body fluids is anticipated).	
11.	If the affected resident does not have their own ensuite toilet, use a dedicated commode (i.e., for their use only), which can remain in their room until they are well. Identify a dedicated area where the commode contents will be decanted.	
12.	Treat all linen as infected, and place directly into a water-soluble bag prior to removal from the room – handle with gloves and apron.	
13.	Routine cleaning with warm water and detergent is important to physically remove any spores from the environment. This should be followed by wiping all hard surfaces with a chlorine based (1000ppm) disinfectant.	
14.	Ensure that visitors wash their hands with soap and water at the beginning and end of visiting.	
15.	It is important to ensure there are adequate stocks of liquid soap, paper towels, single-use gloves, plastic aprons, and pedal operated bins.	
16.	It is not necessary to send further stool samples to the laboratory to check whether the resident is free from infection.	
17.	Symptoms may recur in about one in five people. If this happens, inform the GP, and maintain all enhanced precautions.	

GROUP A STREP ACTION CARD		TICK
Please consider all the actions below (mark as not applicable [NA] as necessary)		
1	For all suspected cases, please consult with the Local Health Protection Team. **Invasive GAS is a notifiable disease (NOIDS - *Notifications of infectious diseases*);** Notifiable diseases and causative organisms: how to report - GOV.UK (I*GAS is usually diagnosed by microbiological culture of the affected site. Serology has specific clinical uses and can be discussed with a local infection specialist).*	
2	Before any action/treatment is commenced (of all confirmed cases), please inform: - Health Protection Team, Lincolnshire – Call **01522 552993** or contact via email: HealthProtectionTeam@Lincolnshire.gov.uk Monday – Friday 8am to 5pm. - UK Health Security Agency – Tel: 0344 225 4524 (option 1) [Out of Hours] or email emhpt@ukhsa.gov.uk ***An Outbreak Control Team should be convened if two or more cases have been reported.**	
3	Consider management and treatment response: - Targeted ***or*** mass testing, - Plan subsequent swabbing for confirmed cases, - Targeted prophylaxis, - Mass prophylaxis. **Confirmed cases will require treatment as per plan decided in OCT with MDT colleagues.** **Please ensure that all positive staff DO NOT attend their GP for treatment until advised to do so by UKHSA, ensuring that the correct antibiotic is prescribed.** *Example case:* Giving antibiotic prophylaxis to - ***e.g.,*** Resident positive case, - All close contacts of the case (need to be screened, giving relevant information and support regarding the plan of treatment), - Anyone who is classed as a high-risk contact, - Any close contacts who have a positive throat culture. Two cases or more that are confirmed; send for screening of all relevant staff/residents, liaise with relevant CCG IPC team to support with prescribing and commencement of antibiotic treatment.	
4	Risk assesses all residents/service users and staff to evaluate the chance of infection/transmission to assist with appropriate follow up and treatment of contacts. **All staff and service users identified as High or Medium risk should be treated, even in the absence of symptoms**. (Other relatives or household members of any confirmed positive culture).	

	HIGH	**Symptomatic staff and residents. Any staff who undertake intimate care of residents – day & night staff**		
	MEDIUM	**Asymptomatic residents who have care delivered by high-risk staff** **Staff who have intermittent direct personal contact with residents**		
	LOW	**Staff who have no direct or intimate contact with affected resident** **Asymptomatic residents whose carers are not considered high risk**		
5	Clothes, bedding, and towels should be laundered after the first treatment, to prevent re-infestation and subsequent transmission to others. Machine wash and dry all clothing and bedding of affected residents using the hot water cycle (60 degrees plus for bedding) and as tolerated by the manufacturer guidelines for clothing. Items that cannot be washed should be kept in a sealed plastic bag for at least 72 hours. Review of Infection Control measures: - close contact transmission (respiratory droplets, direct skin contact). - environmental transmission (contact with contaminated objects, such as towels or bedding).			
6	Soft furnishings that have cloth covering should be excluded from use for 24 hours after treatment. These items should then be vacuumed before being put back into circulation and used. Furnishings covered in wipeable material should be vacuumed and cleaned thoroughly with a hard surface cleaner.			
7	Personal protective equipment – face masks, aprons and gloves should be worn when delivering personal care of known infected cases and when changing bedding.			
8	Monitor for anyone classed as a close contact who displays any symptoms of streptococcal infection: *sore throat, high fever, skin infection, muscle aches.*			

MRSA ACTION CARD		TICK
Please consider all the actions below (mark as not applicable [NA] as necessary)		
Like any other resident, those with MRSA should be helped with handwashing if they are unable to do so for themselves. They should be encouraged to live a normal life without restriction but there is need to consider the following.		
1.	Affected residents with open wounds should be allocated single rooms where possible	
2.	Residents with MRSA can share a room but NOT if they or the person they are sharing with has open sores or wounds, urinary catheters, or other invasive devices	
3.	They may join other residents in communal areas such as sitting or dining rooms, providing any sores or wounds are covered with an appropriate dressing, and regularly changed	
4.	Staff members with eczema or psoriasis should not perform intimate nursing care on residents with MRSA	
5.	Staff members should complete procedures for other residents before attending to residents with MRSA	
6.	Staff should perform dressings and clinical procedures in the individual's own room	
7.	Isolation is not generally recommended and may have adverse effects upon resident's mental and physical condition unless there are clinical reasons such as open wounds.	
8.	Inform hospital staff if the person is to attend the Out-patients Department or be admitted to hospital	
9.	Screening of residents and staff is not necessary in Care Homes. If for any reason it is being considered, contact Public Health England for advice. In such cases, also inform the GP who may send wound swabs for investigation	
10.	Contact LCC IPC team for any resident with MRSA who has a post-operative wound, urinary catheter, or invasive device • Health Protection Team, Lincolnshire – Call **01522 552993** or contact via email: HealthProtectionTeam@Lincolnshire.gov.uk Monday – Friday 8am to 5pm. The Health Protection Team will be your first point of contact and will notify UK Health Security Agency (UKHSA) on your behalf.	
11.	If a resident does become infected with MRSA, contact their GP who should contact the Microbiologist for advice on treatment AND inform LCC Health Protection Team for advice. Cover any infected wounds or skin lesions with appropriate dressings.	
12.	**Please also inform LCC Health Protection team of any PVL (Panton-Valentine Leukocidin) producing MRSA, affecting any resident or staff member**	
Residents may be transferred from hospital while *colonised* or *infected* with a variety of antibiotic-resistant bacteria, including Methicillin Resistant Staphylococcus Aureus (MRSA). Often these bacteria will be colonising the skin or gut, without causing harm to the resident, and will not cause harm to healthy people. Because colonisation can be very long-term, it is not necessary to isolate residents known to be colonised with antibiotic-resistant bacteria. Good hand hygiene and the use of standard precautions will help minimise the spread of these organisms in a care home environment.		

Residents colonised with antibiotic resistant bacteria will not routinely require repeated sampling or treatment to clear their colonisation. The resident's GP or the LCC Health Protection Team will advise when this is appropriate.

If a resident, previously known to be colonised with antibiotic-resistant bacteria requires admission to hospital, the referring GP should include this information in the referral letter.

People with MRSA do not present a risk to the community at large and should continue their normal lives without restriction. MRSA is not a contra-indication to admission to a home or a reason to exclude an affected person from the life of a home. However, in residential settings where people with post-operative wounds or intravascular devices are cared for, infection control advice should be followed if a person with MRSA is to be admitted or has been identified amongst residents.

Residents may need to be screened for MRSA colonisation on admission to hospital. The hospital or resident's GP will advise on this, and any subsequent treatment required.

Adapted from page 47/48 of Prevention and Control of Infection in Care Homes.

INFLUENZA-LIKE ILLNESS ACTION CARD		TICK
Please consider all the actions below (mark as not applicable [NA] as necessary)		
1.	Is it an outbreak? Do you have 2 or more residents with the following: Oral or tympanic temperature ≥37.8°C **AND** one of the following: acute onset of at least one of the following respiratory symptoms: ☐ cough (with or without sputum) ☐ hoarseness ☐ nasal discharge or congestion ☐ shortness of breath ☐ sore throat ☐ wheezing ☐ sneezing **OR** an acute deterioration in physical or mental ability without other known cause	
2.	**If you suspect an outbreak inform:** ☐ Health Protection Team Lincolnshire – Call **01522 552993** or contact via email: HealthProtectionTeam@Lincolnshire.gov.uk Monday – Friday 8am to 5pm. ☐ UK Health Security Agency – Tel: 0344 225 4524 (option 1) [Out of Hours] or email emhpt@ukhsa.gov.uk ☐ **GPs of the affected service users**	
3.	If cases fit the definition above, then testing by taking a throat swab is required. Contact your GP to ask for viral swabbing to be done. ☐ Swabs should be dry swabs in viral transport media (usually pinkish fluid in a bottle but may be other colours) ☐ Swabs for chlamydia screens can be used but not charcoal swabs ☐ Swabs can be obtained from local microbiology laboratories ☐ The test requested should be 'testing for respiratory viruses' or 'respiratory virus screen' Test up to 5 of the most recently symptomatic patients/staff members during a care home outbreak.	
4.	Complete a record of affected residents and staff using **Appendix 4: Influenza Outbreak Management – Residents and Staff Form**	
5.	Implement infection prevention & control precautions, e.g., hand washing, use of PPE, increased environmental cleaning	
6.	Encourage affected service users to remain in their room, and rest.	
7.	Ensure the home is thoroughly cleaned daily using a hypochlorite (chlorine based) solution 1000 parts per million (e.g., Milton 1:10). To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water.)	

8.	Maintain daily monitoring of all service users for elevated temperature and other respiratory symptoms to be able to identify affected individuals as early as possible.	
9.	Staff with symptoms should be excluded from work until fully recovered, e.g. at least five days after the onset of symptoms.	
10.	Close the home to; • Admissions (Postpone non urgent transfers and cancel non urgent hospital outpatient appointments - [If hospital appointments are essential and this can be discussed with the health professional the resident is due to see, inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other people). • Hairdressers, chiropodists, and activity coordinators	
11.	Put a poster on the entrance of the home **(see Appendix 10: Outbreak Management Resources)** to inform visitors there is an outbreak. Inform visiting healthcare professionals so they can reorganise their visits to ensure your home is the last home they visit during the day.	
12.	Daily actions: • Nominate a named staff member to coordinate and communicate outbreak information • Maintain & update the Outbreak Chart, recording affected services users / staff • Maintain information about the immunisation status (influenza & pneumococcal) for service users & staff to aid risk assessment	
13.	If a service user requires transfer to hospital during an outbreak – inform the hospital in advance and complete a **Transfer Form – see appendix 8**, to accompany the service user.	
14.	The home should be closed until you are symptom free for 5 days after the onset of the last case.	

OUTBREAK MANAGEMENT OF RESPIRATORY (CHEST) INFECTIONS ACTION CARD		TICK
Please consider all the actions below (mark as not applicable [NA] as necessary)		
1.	Inform the Local County Council Health Protection Team if there is a suspected or confirmed case meeting the case definition in place at the time – 'Two or more cases of chest infection or flu-like illness amongst residents diagnosed by GP / duty doctor within one week in one residential / nursing home' Note that colds are not included in this outbreak definition. 1. Chest Infection/pneumonia: At least two of the following symptoms: cough, producing sputum (yellowy/green) breathlessness, wheeze, chest pain, fever, sore throat, fever/temperature (>38ºC) Crackly or bubbly chest sounds. 2. Flu like illness usually starts rapidly with a fever/temperature >38ºC OR complaint of feverishness PLUS two or more of the following: headache, cough, sore throat or malaise AND duration of illness of at least three days. 3. Cold = runny nose or blocked nose, sore throat, headache, non-productive cough	
2.	**Key Contacts for Early Advice and Support include:** ☐ Health Protection Team, Lincolnshire – Call **01522 552993** or contact via email: HealthProtectionTeam@Lincolnshire.gov.uk Monday – Friday 8am to 5pm. ☐ UK Health Security Agency – Tel: 0344 225 4524 (option 1) [Out of Hours] or email emhpt@ukhsa.gov.uk ☐ **GPs of the affected service users**	
3.	• If cases fit the definition above, then testing by taking a throat swab is required. Contact your GP to ask for viral swabbing to be done. Swabs should be dry swabs in viral transport media (usually pinkish fluid in a bottle but may be other colours) • Swabs for chlamydia screens can be used but not charcoal swabs • Swabs can be obtained from local microbiology laboratories • The test requested should be 'testing for respiratory viruses' or 'respiratory virus screen' • Test up to 5 of the most recently symptomatic patients/staff members during a care home outbreak.	
4.	Implement infection prevention & control precautions, e.g. hand washing, use of PPE, increased environmental cleaning.	
5.	Encourage affected service users to remain in their room, and rest.	
6.	Ensure the home is thoroughly cleaned daily using a hypochlorite (chlorine based) solution 1000 parts per million (e.g. Milton 1:10). To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water)	
7.	Maintain daily monitoring of all service users for elevated temperature and other respiratory symptoms to be able to identify affected individuals as early as possible.	
8.	Staff should be allocated to work in separate teams, to facilitate caring for affected service users versus non affected	
10.	Close the home to: ☐ Admissions (Postpone non urgent transfers and cancel non urgent hospital outpatient appointments - [If hospital appointments are essential and this can be discussed with	

	the health professional the resident is due to see, inform the nurse in charge about the outbreak so that they can arrange for the resident to be seen possibly at the end of the day and as quickly as possible avoiding exposure to other people). Hairdressers, chiropodists, and activity co-ordinators	
11.	Inform visiting healthcare professionals so they can reorganise their visits to ensure	
12.	Put a poster on the entrance of the home **(see Appendix 10: Outbreak Management Resources)** to inform visitors there is an outbreak. Encourage all essential visitors to follow good hand-hygiene practices.	
13.	**Daily actions:** Nominate a named staff member to co-ordinate & communicate site information to people using the facilities. Maintain site and staff information about the current status of the site re influenza Infections and ensure that all staff know how to report and react to any suspected cases. Ensure that risk assessments are regularly reviewed to take account changes in the current legislation and government guidance.	
14.	If a service user requires transfer to hospital during an outbreak – inform the hospital in advance and complete a **Transfer Form – see appendix 8**, to accompany the service user.	
15.	The home should be closed until you are symptom free for 5 days after the onset of the last case.	

CORONAVIRUS IN CARE SETTINGS: MANAGEMENT OF KNOWN OR SUSPECTED CASES		Tick
Please consider all the actions below (mark as not applicable [NA] as necessary)		
1.	Service users who are at higher risk of severe outcomes from COVID-19 may be eligible for COVID-19 treatments if they become unwell. If a service user who is eligible for COVID-19 treatments develops COVID-19 symptoms, they should be tested as soon as possible with an LFD. Care homes should ensure that LFDs are available for those who are eligible. There are available free of charge via their local pharmacy. Providers should ensure that at least 3 tests are available per eligible service user. If a service user who is eligible for treatment tests positive for COVID-19, the provider (care home) should organise assessment for treatment. In Lincolnshire, this is via NHS 111. People who are not eligible for COVID-19 treatments are no longer required to test if they develop symptoms of respiratory infection unless specifically advised by the HPT or other local partner.	
2.	Acute Respiratory Infection (ARI) outbreak consists of 2 or more positive or clinically suspected linked cases within a five-day period. The care home should undertake a risk assessment to determine if there is an outbreak and if outbreak control measures are needed. The provider should inform the HPT (or local partner) of a suspected outbreak.	
3.	**Key Contacts for Early Advice and Support include:** • Health Protection Team, Lincolnshire – Tel: 01522 552993 8am to 5pm • UKHSA – Tel: 0344 225 4524 (option 1) [Out of Hours]	
6.	**Outbreak Management Measures** If an outbreak is suspected, **t**he HPT will **advise** on the use of multiplex PCR to test up to 5 linked symptomatic service users with the most recent onset. Service users with symptoms of ARI and who have a high temperature or do not feel well enough to do their usual activities should be supported to stay away from others to protect those who are at high risk of severe outcomes. Service users who **are not** eligible for COVID-19 treatments should be supported to stay away from others until they no longer have high temperatures and no longer feel unwell. Service users who test positive should be supported to: • Stay away from others for a minimum of 5 days after the onset of respiratory symptoms, after 5 days, the service user can return to their normal activities if they feel well enough to do so. • Receive at least one visitor at a time with appropriate IPC precautions • Go into outdoor spaces within the care home grounds through a route where they are not in contact with other residents • Avoid contact with other people who are eligible for Covid-19 treatment for 10 days after a positive test. After 5 days, the service user can return to their normal activities if they feel well enough to do so. Further residents should only be tested if they are eligible for COVID-19 treatments. All outbreak measures should be proportionate. LCC HPT will be able to advise you if further measures are required, this may involve wider testing if there are specific concerns.	

7.	**Implement infection prevention & control precautions:** • Good hand hygiene should be implemented before entering and after leaving the room or house. • Belongings and waste must remain in the room or house and the door should remain closed. • Staff should wear appropriate PPE, in line with infection control precautions, such as gloves, apron, and fluid resistant surgical masks, all PPE should be disposed of in clinical waste, as per policy. • If possible, allocate a toilet and washing facilities for the individual and if this is not possible, aim for them to use facilities after everyone else and clean them in line with guidance. • The room should be cleaned regularly, and the wider home should implement an outbreak standard of cleaning practice. • Cleaning of the wider environment should be undertaken daily using a hypochlorite (chlorine based) solution 1000 parts per million (e.g., Milton 1:10). To achieve this, dilute 1 Milton 4g tablet in 500mls water, or add 1 part Milton 2% solution to 10 parts water.) • Staff should be allocated to work in separate teams, to facilitate caring for affected service users versus none affected.	
10.	**Staff Testing** Health Care Staff who **are** eligible for Covid-19 treatments should take an LFD test if they have symptoms of a respiratory illness and follow the guidance for people who are eligible for Covid-19 treatments. Health Care Staff who **are not** eligible for Covid-19 treatments no longer need to test if they develop symptoms of a respiratory infection. Staff who have symptoms of a respiratory infection and who have a high temperature or do not feel well enough to work, are advised to stay at home and avoid contact with other people. Health Care Staff should follow the guidance for people with symptoms of a respiratory infection including Covid-19.	
11.	**Visiting arrangements** Contact with relatives and friends is fundamental to care home residents' health and wellbeing and visiting should be supported. Visitors should be asked to follow the IPC processed put in place by the care home such as practising hand hygiene and wearing appropriate PPE e.g., face masks. Visitors should not enter the care home if they are feeling unwell, even if they have tested negative for Covid-19, are fully vaccinated and have received their booster.	
12.	**Visiting Professionals** Health, social care and other professionals may need to visit residents within care homes to provide services. Visiting professionals should follow the PPE recommendations as per other visitors. Visiting professionals and all other visitors should not enter the home if they are feeling unwell, even if they have tested negative for Covid-19, are fully vaccinated and have had their booster.	
13.	**Daily actions:** ☐ Nominate a named staff member to co-ordinate & communicate outbreak information ☐ Maintain & update Outbreak Management Records, recording affected services users /staff ☐ Maintain information about the immunisation status (influenza & pneumococcal) for service users & staff to aid risk assessment	

14.	If a service user requires transfer to hospital during an outbreak – inform the hospital in advance and complete a **Transfer Form – see appendix 8**, to accompany the service user.	
15.	The home should remain in outbreak management until advised to reopen by the local Health Protection Team.	

SCABIES ACTION CARD	TICK
Please consider all the actions below (mark as not applicable [NA] as necessary)	

1. For all suspected cases, please consult with the service user's **GP to confirm a diagnosis. If a virtual consultation, ensure images of affected skin are shared with the GP.**

2. Before any treatment is commenced (of all confirmed cases), please inform:

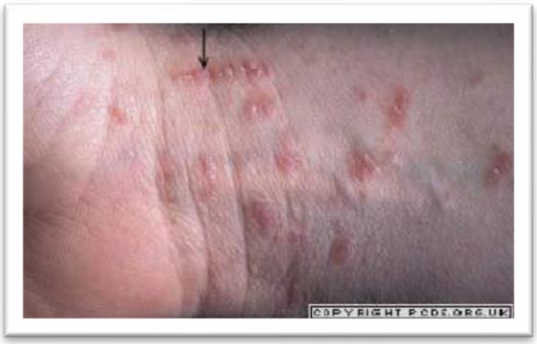
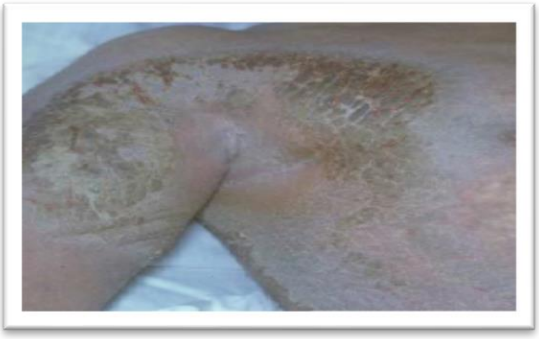
- LCC Health Protection Team, Lincolnshire – Call **01522 552993** or contact via email: HealthProtectionTeam@Lincolnshire.gov.uk Monday – Friday 8am to 5pm.
- UK Health Security Agency – Tel: 0344 225 4524 (option 1) [Out of Hours] or email emhpt@ukhsa.gov.uk
- **GPs of the affected service users**

3. Treatment is most effective when carried out simultaneously and in a co-ordinated manner (ideally within 24 hours) – and usually includes close contacts and family members who have had prolonged skin to skin contact (even if they have no symptoms). These should all be treated at the same time to prevent reinfection. **Confirmed cases will require two treatments 7 days apart**

4. Risk assess all service users and staff to evaluate the chance of infection to assist with appropriate follow up and treatment of contacts. **All staff and service users identified as High or Medium risk should be treated, even in the absence of symptoms**.

HIGH	Symptomatic staff and residents. Any staff who undertake intimate care of residents – day & night staff
MEDIUM	Asymptomatic residents who have care delivered by high-risk staff Staff who have intermittent direct personal contact with residents
LOW	Staff who have no direct or intimate contact with affected resident Asymptomatic residents whose carers are not considered high risk

5. There are two main types of scabies – (i) Classic and (ii) Crusted (Norwegian) scabies, as shown below. Residents who present with classic scabies do not usually require isolation, however, residents with Crusted (Norwegian) scabies are highly contagious and DO require isolation precautions until treatment has been completed.

Classic Scabies [Arrow identifies presence of burrows]	**Crusted (Norwegian) Scabies**
	

6. Clothes, bedding and towels should be laundered after the first treatment, to prevent re-infestation and subsequent transmission to others. Machine wash and dry all clothing and

	bedding of affected residents separate from other laundry using water soluble/ red alginate bags, using the hot water cycle (60 degrees plus for bedding) and as tolerated by the manufacturer guidelines for clothing. Items that cannot be washed should be kept in a sealed plastic bag for at least 72 hours.	
7.	Soft furnishings that have cloth covering should be excluded from use for 24 hours after treatment, to ensure any mites which may be on the fabric are eradicated. These items should then be vacuumed before being put back into circulation and used. Furnishings covered in wipe able material should be vacuumed and cleaned thoroughly with a hard surface cleaner. In cases of Crusted (Norwegian) Scabies vacuuming and damp dusting of the environment is essential management.	
8.	Aprons and gloves should be worn when delivering personal care of known infected cases and when changing bedding.	

APPENDIX 1: OUTBREAK MANAGEMENT – CHECKLIST

1. INFORM

- ☐ Report Outbreak to Health Protection Team (LCC) **[Tel: 01522 552993 – In Hours 08:00am – 17:00pm]**
- ☐ Report Outbreak to UK Health Security Agency (UKHSA) **[Tel: 0344 225 4524 Option 1 – Out of Hours]**
- ☐ (Consider) informing Local Environmental Health (if appropriate)
- ☐ Inform GP's, Staff, Residents & Visitors of the Outbreak, and other visiting staff
- ☐ Put up Outbreak Posters & Provide relevant information leaflets.
- ☐ Advise visitors not to attend (esp. children, immune-compromised & anyone with Symptoms)
- ☐ Ask visitors to report to the staff member in charge
- ☐ Ask visitors to report any symptoms to staff

2. HANDWASHING

- ☐ **Remove all alcohol-based rub/gel – it is NOT effective with D&V outbreaks**
- ☐ Ensure **ALL** staff wash their hands **before** and **after** every resident contact
- ☐ Ensure all clients have their hands washed after going to the toilet, before meals and after any episode of diarrhoea and/or vomiting
- ☐ Ensure **ALL** visitors wash their hands before and after every resident contact
- ☐ Ensure sufficient soap (via a single cartridge dispenser) and hand drying facilities (paper towels) are available
- ☐ Ensure catering staff are aware of the precautions required in food preparation and the importance of hand washing
- ☐ Ensure that hand wash basins are free from any clutter – i.e., flannels, towels, toothbrushes etc.

3. PERSONAL PROTECTIVE EQUIPMENT

- ☐ To be kept outside the affected resident's room and put on before entering
- ☐ Wear single use disposable gloves and aprons whilst caring for the affected resident, cleaning up diarrhoea and during environmental cleaning of affected areas
- ☐ If there is no automated sluice machine and waste must be emptied down the toilet, staff should wear gloves, aprons, face mask and eye protection whilst emptying and cleaning the commode or bed pan
- ☐ Clinical waste bags should be placed inside the resident's room for disposal of PPE
- ☐ PPE must be worn when handling contaminated linen

4. CLEANING

- ☐ De-clutter the resident's room as much as possible to assist in minimising contamination by spores and store food stuffs such as sweets, fruit and biscuits in air-tight containers in a cupboard
- ☐ Clean the environment and any patient equipment twice a day and disinfect with a chlorine-based solution. Pay special attention to lavatories and

commodes.

- Each day, frequently clean contact points touched by hand, e.g., door handles, light switches, and call bells etc.
- All equipment e.g., blood pressure monitors etc. should remain in the resident's room for the duration of the illness.
- Treat all waste as infectious waste during the outbreak
- When the resident has recovered and isolation has ceased, the resident's room must be thoroughly deep cleaned
- Deep cleaning must include cleaning all surfaces, equipment, curtains, soft furnishings, washing walls and flooring to include steam cleaning or shampooing the carpet

5. COHORTING

- Isolate symptomatic residents as per action card
- Allocate dedicated staff to care for symptomatic residents versus non-symptomatic residents
- Allocate dedicated staff to clean affected areas
- If there are no sluice facilities, identify a dedicated toilet for disposing of commode contents
- Do NOT allocate catering staff to care for affected residents or to clean affected area

6. RESTRICT MOVEMENT

- Suspend communal activities and any excursions
- In the event of an outbreak in a care home, the home should immediately stop visiting (except in exceptional circumstances such as end of life) to protect vulnerable residents, staff, and visitors. Risk assessment to be done with help of HPT.
- Reschedule any non-urgent hospital appointments
- Consider suspending the use of the communal areas e.g., dining room, lounge

7. EXCLUDE SICK STAFF

- Exclude affected staff as per action card

8. LINEN

- Instruct staff in the correct management of handling soiled linen
- Ensure staff wear PPE when handling soiled linen
- Ensure adequate supplies of linen containers and leak proof bags
- Ensure **RED** (water soluble) bags are used for soiled linen
- Ensure ALL soiled linen is washed at the correct temperature
- Ensure ALL laundry staff wash their hands on entering and leaving the laundry
- Ensure that the washing machines are put through an empty hot wash cycle at the end of each day.

9. TRANSFERS

- Avoid transferring clients to other institutions while the outbreak is in progress

- Reschedule ALL NON-URGENT appointments
- If a transfer to hospital is necessary, ensure receiving hospital is aware of the outbreak and complete a TRANSFER FORM, to accompany the resident
- Restrict admissions of any new residents until the outbreak is over
- Ensure all returning residents are placed into protective isolation until the outbreak concludes.

10. REPORTING & PATHOLOGY TESTING

- Inform HPT team in Lincolnshire County Council – **Tel: 01522 552993 – [In Hours]**
- Inform UK Health Security Agency (UKHSA) – **Tel: 0344 225 4524 (option 1) – [Out of Hours]**
- Ensure samples are taken and the request form is correctly complete
- Update Health Protection Team/UKHSA of any notifiable events, including.
  - **Death of a client or staff member**
  - **A food handler developing diarrhoea and vomiting**
  - **Sudden increase in number of cases over a 24-hour period**
  - **Receipt of a pathology result identifying a potential foodborne source**

11. DOCUMENTATION

- Ensure accurate records are maintained daily, to record all affected residents and staff
- During an outbreak of diarrhoea and vomiting ensure staff use the **Bristol Stool Chart (see Appendix 7)** on each affected resident to document each bowel motion to monitor fluid loss and frequency of motions.

APPENDIX 2: GENERAL OUTBREAK MANAGEMENT – STAFF FORM

Name of residential Care Home					Tel. No:								
Date Outbreak Commenced:					Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Date Return to Work	Specimen date & results
No.	**Name of Staff**	**Job Role**	**Symptoms**	**Date sick leave commenced**									
E.g.	*Jo Bloggs*	*Carer*	*D&V*	*13.03.15*	*N*	*V*	*D, V*					*18.03.15*	*Yes – awaiting results*

APPENDIX 3: GENERAL OUTBREAK MANAGEMENT – RESIDENT FORM

Name of residential Care Home	Name of Manager
Date Outbreak Commenced:	Tel. No:

No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
Isolated En-suite PPE Available		Yes / No Yes / No Yes / No											

No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
Isolated En-suite PPE Available		Yes / No Yes / No Yes / No											

No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
Isolated En-suite PPE Available		Yes / No Yes / No Yes / No											

APPENDIX 4: INFLUENZA OUTBREAK MANAGEMENT – RESIDENT AND STAFF FORM

HP Zone Number: *(completed by LCC HPT)*				
Name of Setting:				
Setting Address:				
Principal contact name:				
Principal contact role:				
Principal contact phone:				

Minimum info required for response

Further information - can be completed by the care home

Medication information - to be completed by practitioner issuing medication

Initial Information Required				Additional Information to be completed by Care Home									Section completed by ICB HPT				
Title	Forenames	Surname	DOB	GP	Resident/ Staff Member	Clinically at risk?	Health Issues e.g., allergies/ renal impairment/ relevant medication/ underweight	Exposure type (Treatment/ Prophylaxis)	Date of exposure	Swab Taken? Insert V (viral) or B (bacterial)	Swab Result	Additional screening infomration	No. boxes issued - if 0, state reason for decline or decision not to issue	Date issued	Batch no.	Exp.	Issued by

Appendix 5: D&V Outbreak Management – Resident Form

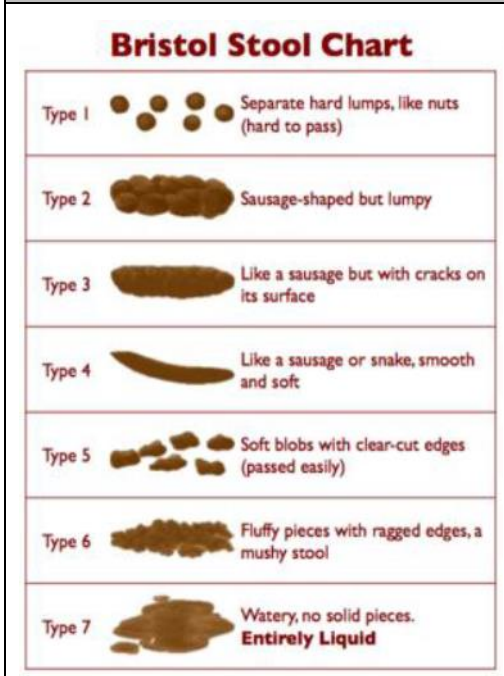
Name of residential Care Home:		**Name of Manager**	
Date Outbreak Commenced:		**Tel. No:**	

No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Possible Cause of D&V	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
					Antibiotics **Yes** / No Laxatives **Yes** / No Other Meds **Yes**/ No State: Altered bowel habit? **Yes** / No									
Isolated Yes / No En-suite Yes / No PPE Available Yes / No														

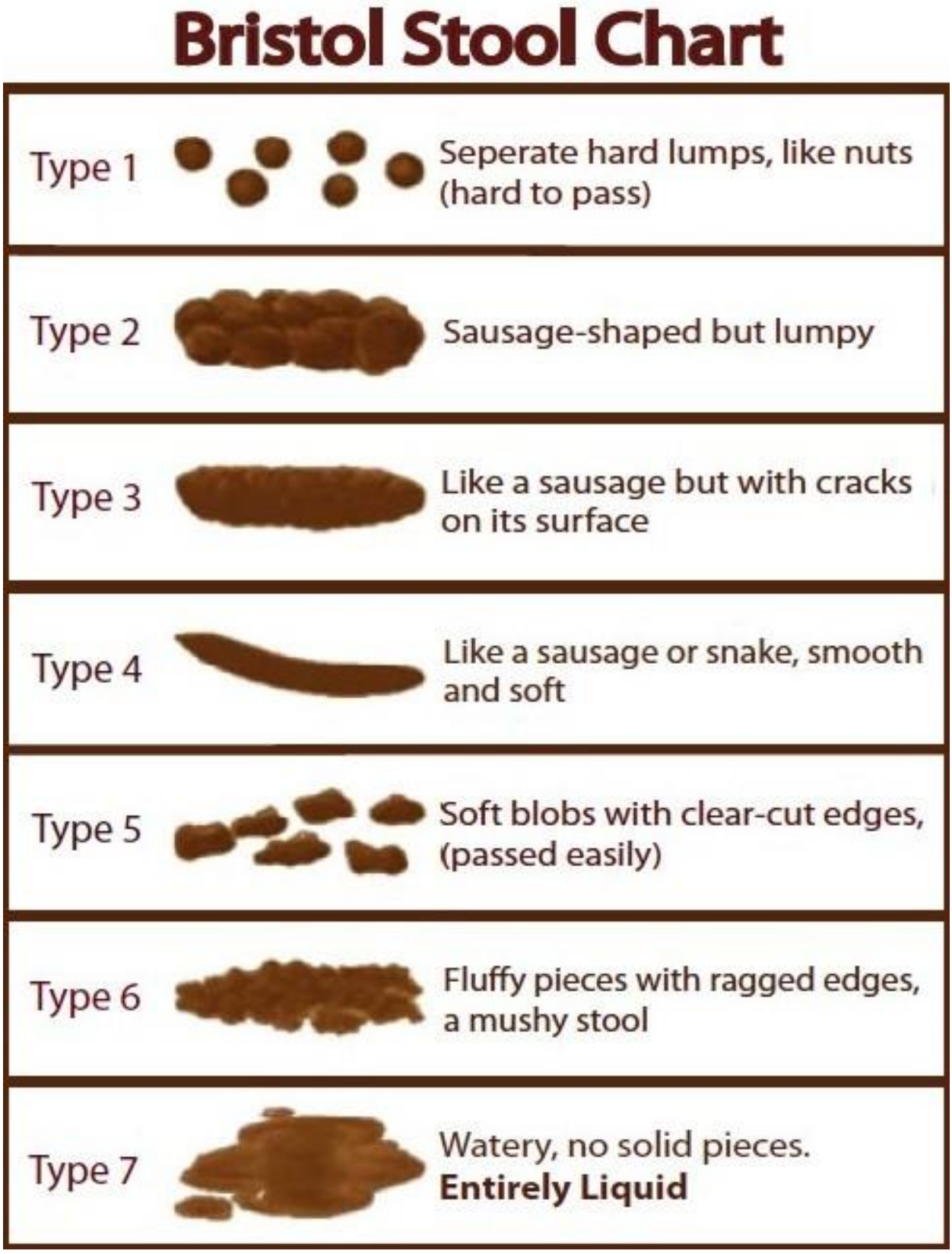
No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Possible Cause of D&V	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
					Antibiotics **Yes** / No Laxatives **Yes** / No Other Meds **Yes**/ No State: Altered bowel habit? **Yes** / No									
Isolated Yes / No En-suite Yes / No PPE Available Yes / No														

No.	Room No.	Resident's Name	DoB	Date & Time Symptoms Commenced	Possible Cause of D&V	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Specimen Date & Result	Comments
					Antibiotics **Yes** / No Laxatives **Yes** / No Other Meds **Yes**/ No State: Altered bowel habit? **Yes** / No									
Isolated Yes / No En-suite Yes / No PPE Available Yes / No														

APPENDIX 6: D&V OUTBREAK MANAGEMENT – BOWEL MONITORING CHART

Name of Resident:		Date of Birth: or NHS No.						Date:				
Name of Care Home:	**Date**	**Time**	**Colour**	**Amount (S,M,L)**	**Bristol Scale (1-7)**	**Blood**		**Mucous**		**Date Specimen sent to lab**	**Specimen Result**	**Signature**
Example:	*01.09.15*	*13:15*	*Light brown*	*Large*	*6*	*Y*		*Y*		*01.09.15*	*Pending*	*J Bloggs*
												
Amount Guide: *Small* *¼ of bedpan OR pad* *Medium* *½ bedpan OR pad* *Large* *Most of bedpan OR pad*												

APPENDIX 7: BRISTOL STOOL CHART



APPENDIX 8: TRANSFER FORM

1. RESIDENT DETAILS Name: Address: Date Of Birth: NHS No.	**2. GP DETAILS** Name: Address: Tel. No:
1. TRANSFERRING FACILITY Name of Home: Address of Home: Tel. No:	**Is there a known infection risk?** ☐ No known Risk ☐ Confirmed risk ☐ Suspected risk *If you have ticked a box, please specify what infection risk: e.g. Covid-19, Norovirus, Influenza etc.*
Have you informed the receiving service of the infection risk? ☐ YES – identify name of Ward/Dept &staff member ☐ NO	
Relevant specimen results: ***[including admission screens, MRSA, C.Diff, Norovirus]***	
Is the client aware of their diagnosis/risk of infection?	☐ Yes ☐ No
Does the client require isolation?	☐ Yes ☐ No
Does the client have any of the following in place?	☐ DNACPR ☐ DoLs ☐ Living will
Are the next of kin aware of the transfer	☐ Yes ☐ No
Contact details for next of kin: Name: Relationship: Address: Tel. No:	

Date:	**Staff member completing the form:**	**Tel. No of home:**

APPENDIX 9: SUGGESTED CARE PLAN FOR CLOSTRIDIUM DIFFICILE

Isolation	□ Isolate and barrier nurse the affected person in a single room (with ensuite WC if possible). Commodes and bed pans should be dedicated for the sole use of the affected resident whilst symptomatic. □ If it is difficult to isolate the resident due to their mental health needs, extreme care will need to be taken to make sure any spillages are cleaned immediately. It may be necessary to employ additional staff to help care for residents in isolation or who need one-to-one care. Continue to isolate until the resident has been free of symptoms and loose stools for 72 hours. The resident may come out of isolation once they have passed a stool that is normal for them.
Monitoring of resident	□ Document a plan of care in the resident's note, to evidence a written record of all monitoring and care given, to include a daily record of the resident's condition and bowel movements. □ Monitor the resident's condition carefully as this infection can cause rapid dehydration and rapid deterioration (within hours). Patients who are systemically unwell or have more profuse diarrhoea must be referred to their local GP □ Residents who are ill need to be monitored hourly day and night, to include. ○ An accurate fluid diary, recording all drinks taken ○ An accurate output chart to record the number of times the resident passes urine and how much and the number of times the resident has their bowels open ○ ALL bowel actions on a bowel chart, documenting the type of stool as per the Bristol Stool Chart ○ The resident's temperature daily - Report to the GP if the temperature is outside normal limits ○ Monitor the resident for abdominal pain, if pain develops, inform the GP ○ Monitor the resident's blood pressure every four hours (this should always be done in nursing homes and if possible, in residential care homes) – Inform the GP if it falls outside normal limits □ If the resident becomes confused, stops eating or if you are at all concerned inform the GP □ Keep the resident and their relatives informed about their condition and why you are taking special precautions. If the resident is transferred to hospital, please call the hospital before the resident arrives so they can arrange immediate isolation and prevent a hospital outbreak. Inform the Infection Control Team, the Operations Manager or the A&E Manager, as appropriate to time of day. Tell the ambulance crew in advance.

Treatment	□ Request a GP visit to assess the resident - There may be an indication to commence treatment with an antibiotic. □ Please refer to links below for up-to-date treatment recommendations from UKHSA and medication management from the BCAP Formulary. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/321891/Clostridium_difficile_ management_and_treatment.pdf http://www.bcapformulary.nhs.uk/
Hand Hygiene	□ Remember that alcohol gel does not work against Clostridium difficile. □ Residents and staff must wash hands with soap and water, including GPs and other visiting health care professionals □ Visitors will need to wash their hands with soap and water on arrival and on leaving the resident's room. □ Visitors should only go into their sick relative/friend's room and should not go into other areas of the home whilst the resident has symptoms.

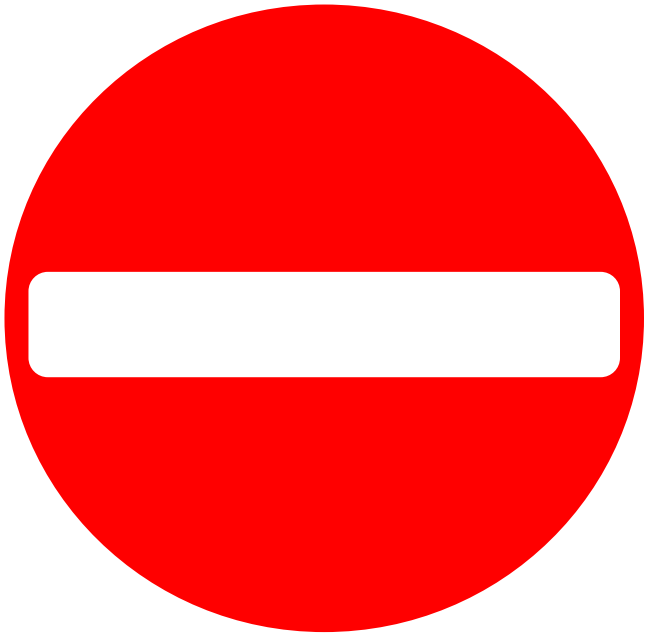
APPENDIX 10 – OUTBREAK MANAGEMENT RESOURCES

SIGHT OUTBREAK MANAGEMENT QUICK GUIDE

	**S**	**Suspect** a case may be infective where there is no clear alternative cause for diarrhoea
	**I**	**Isolate** the patient and consult with the infection control team (ICT) while determining the cause of the diarrhoea
	**G**	**Gloves and Aprons** must be used for all contacts with the patient and their environment
	**H**	**Hand washing** with soap and water should be carried out before and after each contact with the patient and the patient's environment
	**T**	**Test** the stool for toxin, by sending a specimen immediately

INFECTION PREVENTION & CONTROL

NOTICE TO ALL VISITORS



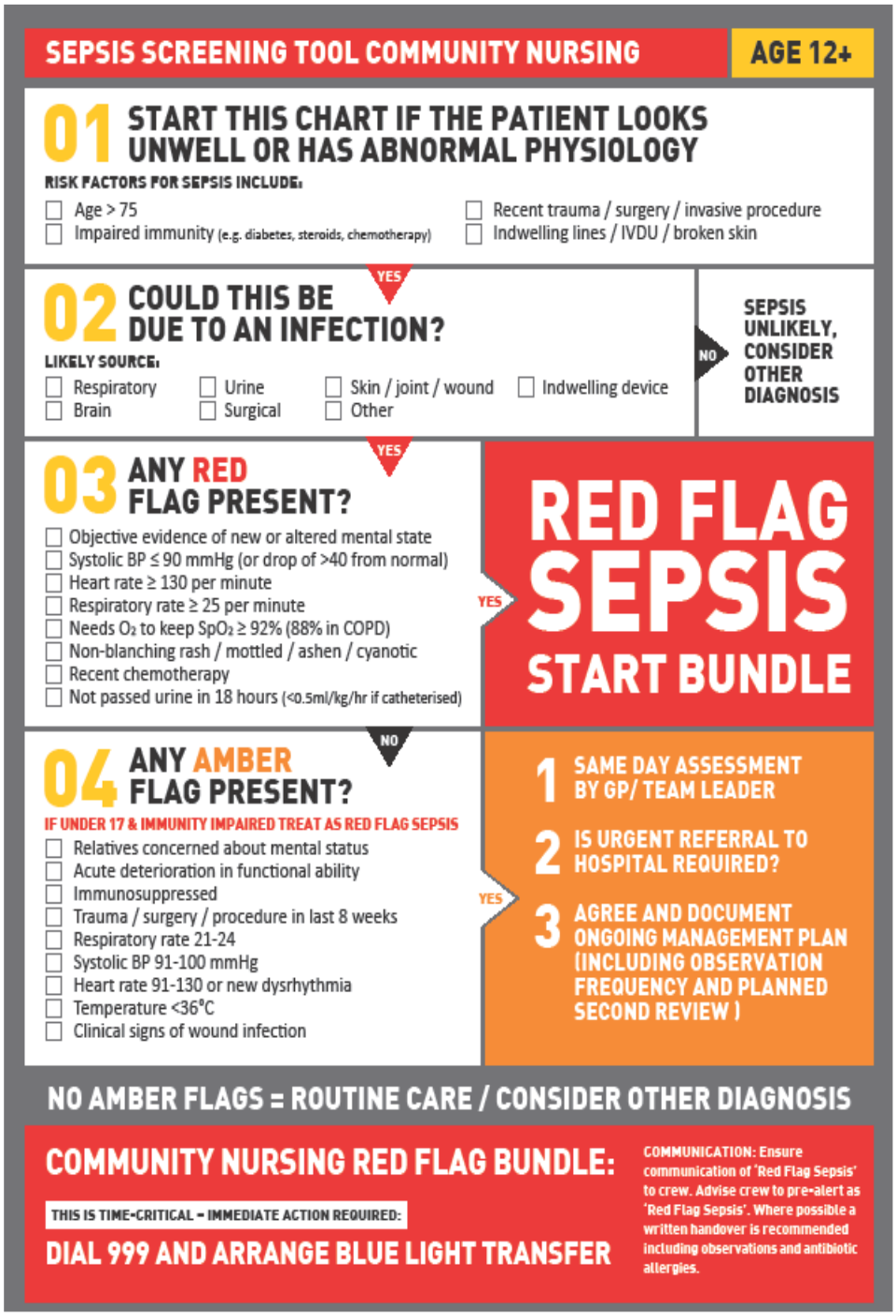
We are currently experiencing an outbreak and are closed to non- essential visits

In order to reduce the potential spread of infection, we politely request that you:

- Report to the staff member in charge
- Please ensure you thoroughly wash your hands with soap and water when entering and exiting the care home
- Follow any instructions provided by the care home staff
- Keep visiting to a minimum
- Deter children from visiting

Thank you for your co-operation

SEPSIS SCREENING TOOL



[Click here](#) for more resources relating to sepsis

APPENDIX 11 – CARE HOME RISK ASSESSMENT TEMPLATE

RISK ASSESSMENT DETAILS

Establishment	
Location	

Details of activity:

Date of assessment	
Name of person carrying out assessment	

Managers Signature	Date

RISK MATRIX & RATING

POTENTIAL OUTCOME

Catastrophic	Loss of life/ failure to provide minimum safe level of care
Major	Staffing loss significantly impacting provision of care/ long-term (30+ days) illness in staff or service user
Moderate	Illness of 7-30 days with no long-term effects. Staffing loss disrupting some elements of care.
Minor	Short-term health impacts (<7 days)
Insignificant	Minimal impact

LIKELIHOOD

Highly likely	More likely to occur
Likely	
Possible	
Unlikely	
Remote	Less likely to occur

POTENTIAL OUTCOME

Catastrophic					
Major					
Moderate					
Minor					
Insignificant					
	Remote	Unlikely	Possible	Likely	Highly Likely

LIKELIHOOD

RISK RATING		ACTION
	HIGH	URGENTLY REVIEW/ADD CONTROLS & MONITOR (IF LIKELY OR HIGHLY LIKELY – STOP WORK, SEEK COMPETENT ADVICE, NOTIFY H&S TEAM)
	MEDIUM	REVIEW/ADD CONTROLS (AS FAR AS REASONABLY PRACTICABLE) & MONITOR
	LOW	MONITOR CONTROL MEASURES

Hazard and related condition / activity	**Persons at risk**	**Existing control measures**	**Additional Control Measures**	**Risk rating after existing & additional control measures** Potential Outcome x Likelihood = Risk Rating (e.g. Minor x Unlikely = Low)
E.g. Increased risk of transmission of infection from X illness	*All building users including staff, residents, catering, cleaning staff, visitors, essential health & social care personnel & contractors*	*Follow the Public Health Standard Operating Procedures and Action Card for X illness* *Any further cases in residents or staff, the HPT may conclude following a risk assessment that outbreak control restrictions may be lifted.*		
ACTION PLAN (insert additional rows if required)	To be actioned by:		Action completed:	
Additional control measures to reduce risks so far as is reasonably practicable	Name	Position	Date	Signature

1		•		
2		•		
3		•		
4		•		
5		•		

COMMENTS AND INFORMATION *Use this section to record how the risk assessment & control measures have been communicated to relevant people, and any other comments and information*

Scheduled date of next review *Minimum annually, or if there are any significant changes, or following an incident or near miss*	**Are there any changes to the activity since the last review?** *Clarify that all the controls are still in place and how monitored on a regular basis*	**Signature of manager**	**Date of review**