



# **Infection Prevention and Control: An Outbreak Information Pack for Care Homes**

- The “Care Home Pack”

# About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. It does this through world-class science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. PHE is an operationally autonomous executive agency of the Department of Health.

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This document is available in other formats on request. Please call 0300 303 8162 Opt 1, opt 2 or email [agwarc@phe.gov.uk](mailto:agwarc@phe.gov.uk).



## Acknowledgments

The original document was produced by Grace Magani, Senior Health Protection Nurse Public Health England and South Gloucestershire Council in September 2015.

It was reviewed and updated by Grace Magani and Fiona Neely, Consultant in Health Protection, Public Health England in September 2017; and by Grace Magani and Chaamala Klinger, Consultant in Health Protection in September 2018.

Next Review: Sept 2020

## Updates

Date	What was updated?	By whom
Oct 2019	Deletion of EHO contact details (care homes should go through HPT to contact EHOs for outbreaks or incidents)  Immunisation and vaccination for staff and residents – section on flu vaccine for staff updated  Deletion of Flu Info sheet for residents and carers (now sent at time of outbreak)  Integrated Care Pathways – ICPs- (Checklists) updated and included as Action Cards, rather than in Appendix  Insertion of explanation and web link to Winter Readiness Pack	Fiona Neely (HPT)  FN  FN  Sarah King FN

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# Executive summary

Written for care homes, this pack aims to provide clear guidance on infection prevention and control precautions for protecting residents and staff from acquiring infection and for restricting spread should an outbreak occur.

## Objectives

1. To provide information on common infectious diseases in care homes and steps that can be taken to mitigate them to prevent further spread.
2. To clarify communication routes for reporting outbreaks and incidents of infection.

## Background

Good standards of infection prevention and control reflect the overall quality of care and can help to demonstrate compliance with the Care Quality Commission (CQC) outcomes. It can also help to promote confidence in the quality of care for residents and their families. Since infections can spread easily in enclosed settings, it is essential that staff members remain aware and are able to identify and to report promptly. Failure to do so can result in serious and, in some cases, life-threatening scenarios.

All care homes should have in place a written policy on the prevention and control of infection which is based on the Code of Practice 2010 (updated 2015). The policy should include roles and responsibilities for outbreaks and incident management.

**This pack does not replace the policy**

**If you suspect an outbreak or incident, please call the Acute Response Centre, Public Health England South West Health Protection Team (in hours or out of hours) on:**

**0300 303 8162 option 1 (Health Protection) then option 1**

**Areas covered include:** Devon, Cornwall, Isles of Scilly, Somerset, Dorset  
Avon, Gloucestershire, Wiltshire, Swindon

Key Reference document: Prevention and Control of Infection in Care Homes – an information resource and Summary for staff; Available at:

[www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published](http://www.gov.uk/government/publications/infection-prevention-and-control-in-care-homes-information-resource-published)

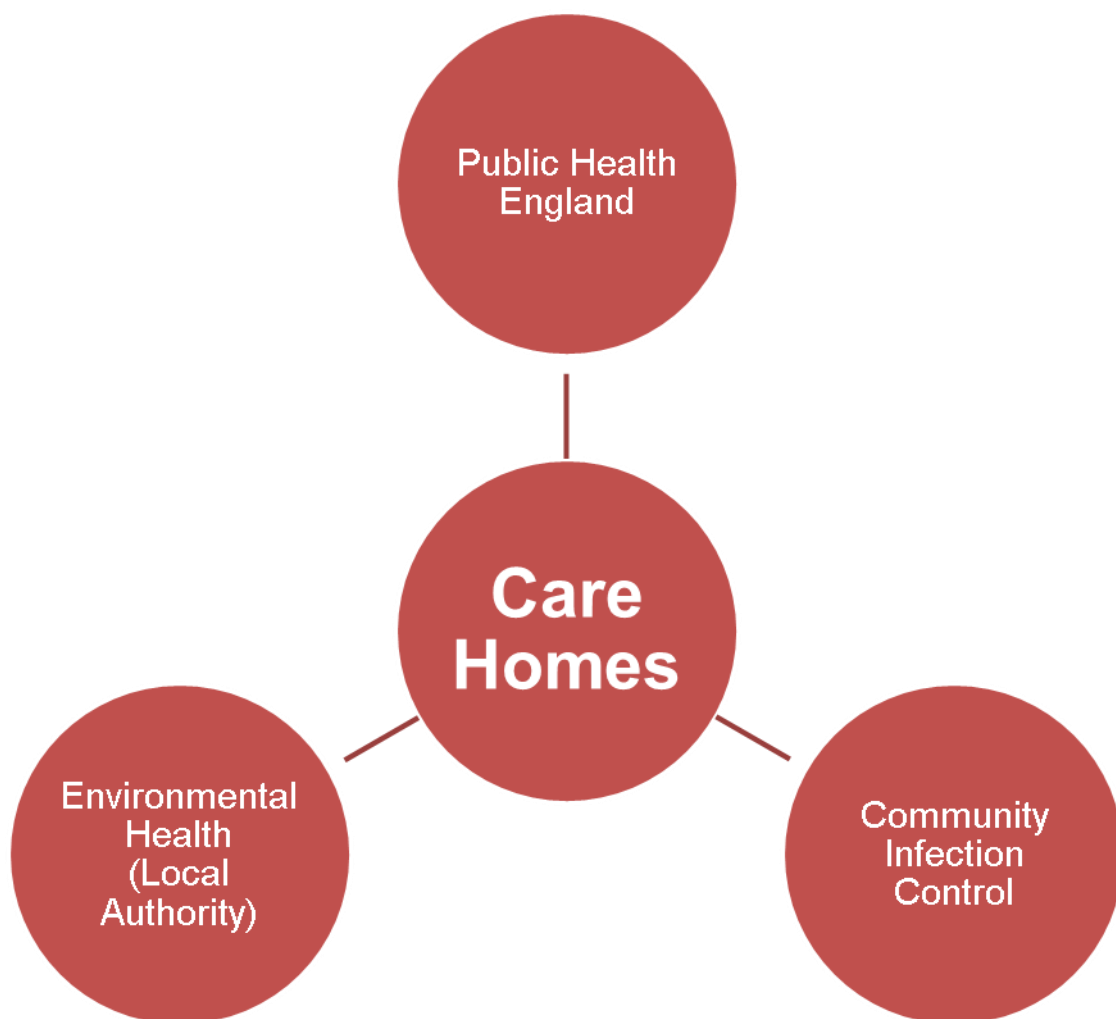
# Definitions

Outbreak	<p>An 'outbreak' is an incident where two or more persons have the same disease or similar symptoms and are linked in time, place and/or person association.</p> <p>An outbreak may also be defined as a situation when the observed number of cases unaccountably exceeds the expected number at any given time.</p>
Incident	<p>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.</p> <p>In some instances, only one case of an infectious disease may prompt the need for incident management and public health measures.</p>

## Recognising illness and Risk assessment

Recognising illness	<p>As an example, although influenza-like illnesses may have specific signs and symptoms such as sudden onset of fever, headache, sore throat or cough, older people may present with unusual signs and symptoms. They may not have a fever, and may present with loss of appetite, unusual behaviour or change in mental state.</p>
Risk assesment	<p>It is essential to assess the risk of infection to residents and staff so that precautions can be put in place. For example, during a suspected norovirus outbreak, check that you have taken enough precautions to prevent harm to residents and staff members. This can be checking to see what Personal Protective Equipment (PPE) may be required before a procedure is carried out.</p>

## Reporting and the role of other agencies



# Contacts

Please note that we have endeavoured to provide up to date contact numbers but provide no guarantee or can accept no responsibility for whether these contact details are correct.

## **Public Health England South West (PHE SW)**

The local **Health Protection Team (HPT)** can support care homes by leading on all outbreak related incidents, advising on Infection Prevention and Control and infectious diseases.

Tel 24 hrs: 0300 303 8162 **0300 303 8162 option 1 (Health Protection) then option 1**

Email: [swhpt@phe.gov.uk](mailto:swhpt@phe.gov.uk)

Fax 01392 367356 (M-F 9-5) for  
Devon Cornwall Somerset Dorset

0117 930 0205 (M-F 9-5) for  
Avon, Glos, Wilts

**Community Infection Control** - There may be specialist staff employed by local authority who are able to provide Infection Prevention and Control advice to care homes.

South Glos: 01225 831758  
Wiltshire: 0300 003 4566  
N Somerset: 01275 546800  
Bristol: 0117 900 2622  
BaNES: 01225 831454  
Gloucestershire: 08454 226166

N, E and Mid Devon and Exeter 01271 311 601  
Plymouth Livewell SW 01752 434167  
Torbay and S Devon NHS Trust: 01803 655757  
Cornwall Partnership Trust 0120825130  
Somerset Partnership 01278 432000  
Dorset Healthcare 01305 361132

**Environmental Health Officers (EHOs)** - EHOs work with local partners to ensure threats to health are understood and properly addressed. Environmental Health Officers have a very good knowledge of care homes and can advise on infection control particularly if it is thought to relate to food. They will investigate **suspected and confirmed cases of food poisoning and water borne illnesses**.

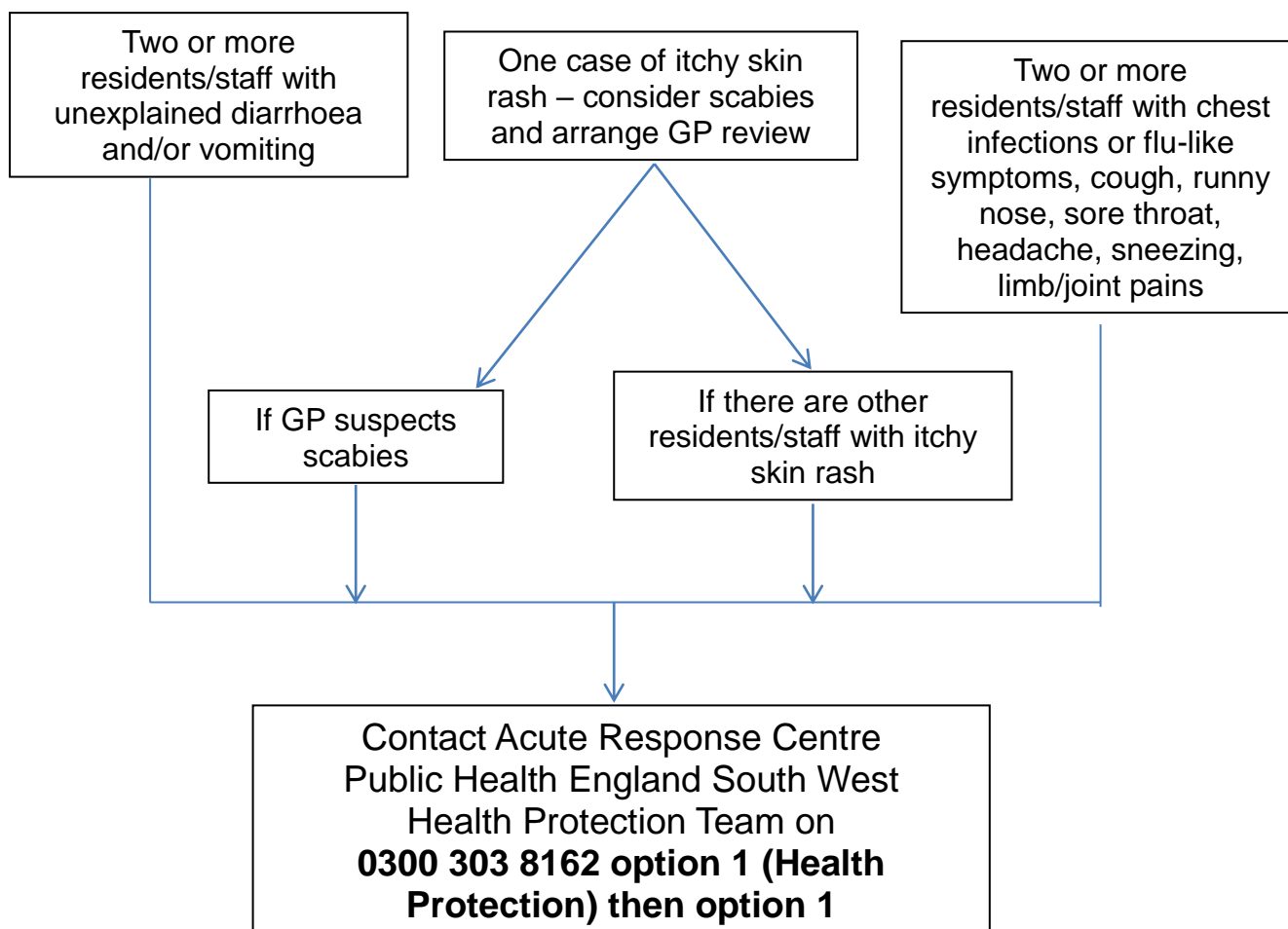
They also investigate cases of **Legionnaires Disease** and **work-related accidents**, injuries, diseases and dangerous occurrences.

The HPT can provide you with details of relevant EHOs and in any case, the HPT should be made aware of non-routine circumstances which give rise to a need for consultation with EHOs



# Reporting outbreaks and incidents: Common scenarios.

Care Homes have a duty to report suspected outbreaks or incidents of infections to the local Health Protection Team.



# General principles of outbreak management



# Immunisation and vaccinations for staff and residents

Residents	<p>Annual seasonal influenza vaccination is recommended for all those living in care homes or other residential facilities where rapid spread of infection is likely and can cause high 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 chronic lung, heart, kidney, liver, neurological diseases; those with diabetes mellitus and those with suppressed immune system.</p> <p>All those over the age of 65 should receive one dose of pneumococcal vaccine. A single dose is also recommended for all those under 65 years of age who are at an increased risk from pneumococcal infection: people who have a heart condition, chronic lung disease, chronic liver disease, diabetes, weakened immune system and damaged or no spleen.</p>
Staff	<p>Influenza immunisation is recommended for health and social care workers with direct patient/service user contact such as care home staff; Flu Vaccinations may be provided via the employer who has a duty to inform employees of the vaccine recommendations. Flu vaccine for carers is also available free of charge from their own GP or a local community pharmacy. The staff member should take proof that they are a carer when attending for vaccination.</p> <p>Hepatitis B for staff who may come into contact with residents' blood or blood-stained body fluids or with residents' body tissues.</p> <p>BCG vaccination should be offered to previously unvaccinated Mantoux negative staff in care homes who are younger than 35 years of age. Contact the Health Protection Team if you require advice on this.</p>

# Prevention of influenza outbreaks

The Influenza vaccine aims to:

- Reduce the transmission of influenza within health and social care premises
- Contribute to the protection of individuals who may have a suboptimal response to their own immunisations
- Avoid disruption to services that provide their care.

See [the Green Book](#) for more details:

# Infection control link person: Key roles and responsibilities

- Liaises between their team and other infection control teams e.g. the hospital and community
- Act as a resource for colleagues e.g. disseminating information on policies and procedures
- Help to identify local infection control problems/issues
- Ensures infection control is included in induction and regular update sessions
- Ensures local policies are developed, implemented and reviewed
- Ensures that residents/clients and relatives are informed of infection control practices as necessary
- Regularly attends Infection Control Link meetings or updates
- Updates and extends own knowledge of infection control .

Name of Infection Control Link Person for this  
Care  
Home.....

Signature and Date

.....

# Action Cards

## ACTION CARD: Scabies

Please consider all the actions below (mark as N/A (not applicable) as necessary)		Tick
1	<p>For suspected cases, inform GPs who should confirm the diagnosis with the dermatologist.</p> <p>Inform the Health Protection Team of all suspected cases, BEFORE any treatment is started. This is because treatment is most effective if carried out simultaneously (ideally within a 24 hour period) in a co-ordinated way. Treatment, even for a single case, usually includes close contacts and family members who have had prolonged skin to skin contact - even if they have no symptoms. They should be treated at the same time to prevent re-infection. <b>This is a major event that needs proper co-ordination with several agencies, therefore, it is crucial that the diagnosis is most likely scabies</b></p>	
2	<p>Assess the chance of possible infection for each resident and staff member as 'high', 'medium' or 'low' risk to aid appropriate follow-up and treatment of contacts. All staff and residents identified as 'high risk' or 'medium risk' will require treatment even in the absence of symptoms.</p> <p>High = Staff members who undertake intimate care of residents and who move between residents, rooms or units. This will include both day and night staff; symptomatic residents and staff members.</p> <p>Medium = Staff and other personnel who have intermittent direct personal contact with residents; asymptomatic residents who have their care provided by staff members categorised as 'high risk'.</p> <p>Low = Staff members who have no direct or intimate contact with affected residents, including asymptomatic residents whose carers are not considered to be 'high risk'.</p>	
3	<p>The Care Home manager or nominated lead should liaise with the health protection team for support and advice on managing the situation, treatment co-ordination and supply of recording sheets. See Appendix 6 for more information.</p>	



Classical scabies

Arrow denotes burrows present.



Crusted/Norwegian  
Scabies



## ACTION CARD: Clostridium Difficile

Please consider all the actions below (mark as N/A (not applicable) as necessary)		Tick
1	<p>If you have a resident who is C.diff positive, follow the Department of Health's <b>'SIGHT'</b> advice: This is also in the <b>suggested care plan</b> in appendix 7.</p> <p><b>Suspect</b> that a case may be infectious where there is no other cause for diarrhoea.</p> <p><b>Isolate</b> resident while you investigate and continue until they are clear of symptoms for 48 hours.</p> <p><b>Gloves and aprons</b> must be used for all contacts with the resident and their environment.</p> <p><b>Hand washing</b> with soap and water must be done before and after each contact with the resident and environment. Alcohol gel does not work against C diff.</p> <p><b>Test</b> the stool by sending a specimen immediately requesting screening for Clostridium difficile (within 24 hours if three or more instances of stool type five, six or seven in a 24 hour period) - see Bristol Stool Chart. Discuss with and inform the resident's GP.</p> <p>Please contact the Health Protection Team if any of your residents has recently been discharged from hospital and was diagnosed with C.diff whilst there.</p>	
2	The GP should review any antibiotics that the resident is taking.	
3	Other medication such as laxatives and other drugs that may cause diarrhoea should also be reviewed.	
4	Ensure that fluid intake is recorded, and that it is adequate.	
5	Use a <b>stool chart</b> to record all bowel movements.	
6	All residents with diarrhoea should be isolated in their own room until they have had no symptoms for a minimum of 48 hours.	
7	Re-enforce Standard Infection Control Precautions to all staff.	
8	Residents must be assisted to wash their own hands after using the toilet/commode/bedpan.	
9	Wear disposable gloves and aprons when carrying out any care (i.e. not only when contact with blood and/or body fluids is anticipated).	
10	If the affected resident does not have en-suite toilet, use a dedicated commode (i.e. for their use only) which can remain in their room until they are well.	
11	Treat all linen as infected, and place directly into a water-soluble bag prior to removal from the room.	
12	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 disinfectant (1000ppm).	
13	Ensure that visitors wash their hands at the beginning and end of visiting.	
14	It is important to ensure that you have adequate stocks of liquid soap, paper towels, single-use gloves, plastic aprons and pedal operated bins.	
15	It is not necessary to send further stool samples to the laboratory to check whether the resident is free from infection.	
16	Symptoms may recur in about one in five people. If this happens, inform the GP and maintain all enhanced precautions.	

## ACTION CARD: MRSA

Please consider all the actions below (mark as N/A (not applicable) as necessary)		Tick
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 if 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, catheters, drips or other invasive devices.	
3	They may join other residents in communal areas such as sitting or dining rooms, so long as any sores or wounds are covered with 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 resident'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.	
9	Generally, screening of residents and staff is not necessary in care homes. Contact the Health Protection Team to discuss if for any reason it is being considered, for example, a wound getting worse or new sores appearing. In such cases, also inform the GP who will probably send wound swabs for investigations.	
10	Contact the Health Protection Team for any resident with MRSA who has a post-operative wound, drip or catheter.	
11	If a resident does become infected with MRSA, contact their GP who should contact the microbiologist for advice on treatment.  Also inform the health protection team for advice if required.  Cover any infected wounds or skin lesions with appropriate dressings.	
12	<b>Please also inform the Health Protection Team of any PVL (Panton-Valentine Leukocidin) producing MRSA affecting any resident or staff member.</b>	

See [Appendix 8](#) for more information

## Action Card: D&V

Integrated care pathway (Checklist) for outbreak management of diarrhoea and vomiting in care homes.

NB: Please note that these are reviewed and updated regularly so do not rely on this version for an outbreak but ensure you **contact Public Health England South West Health Protection Team** to **ensure you have the most recent copy**.



# INTEGRATED CARE PATHWAY (Checklist)

## Outbreak Management of Diarrhoea and Vomiting (Care Homes)

### Definition Criteria for an outbreak of Diarrhoea and Vomiting:

*Two or more cases of diarrhoea and/ or vomiting, Bristol Stool Chart grading 6 or 7 unusual to the residents or staff members normal bowel action ([see page 7](#)).*

Full address of outbreak location including postcode	
Onset date and time in first case	
Number of residents currently in the home	
Number of all staff members employed in the home	
Number of symptomatic residents (at time of reporting of outbreak) with onset dates	
Number of staff members symptomatic (at time of reporting the outbreak) with onset dates	
Do people have (please tick)	Diarrhoea: Yes <input type="checkbox"/> No <input type="checkbox"/> Vomiting: Yes <input type="checkbox"/> No <input type="checkbox"/> Abdo pain Yes <input type="checkbox"/> No <input type="checkbox"/> Fever Yes <input type="checkbox"/> No <input type="checkbox"/>
Did cases start to be ill at the same time?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Did cases eat from the same place e.g. home kitchen, food brought in by residents or visitors?	Home Kitchen: Yes <input type="checkbox"/> No <input type="checkbox"/> Food brought in by residents or visitors: Yes <input type="checkbox"/> No <input type="checkbox"/> Other: (please write).....
If yes to the last two questions, this could be food poisoning; please inform Environmental Health Officer and the Health Protection Team (PHE)	

**Instructions:** Work through all the pages of this document, signing and dating each action when it has been implemented and adding case details to the [outbreak chart](#).

NB If you have your own outbreak documentation that is similar to this, there is no need to complete both documents, as long as the appropriate actions are implemented, and this is clearly documented.



Outbreak Care Pathway Communication	Date	Signature
<p>1. <b>Report cases of diarrhoea and vomiting to the person in charge</b> and enter the symptomatic cases details on the <a href="#">outbreak chart</a> attached (residents, staff and visitors) so that you can identify whether symptoms started all at once (food poisoning?) or at different times (which may indicate person to person spread).</p>		
<p>2. <b>If not already done telephone the Public Health England (PHE) Health Protection Team to inform them of the outbreak</b> on 0300 303 8162 Option 1, 1 (Monday to Friday 0900 – 1700hrs).</p> <ul style="list-style-type: none"> <li>If the outbreak commences on a weekend or Bank Holiday and urgent advice is needed, inform the on-call Public Health Specialist using the above number and you will be directed to the Out of Hours number.</li> </ul>		
<p><b>PHE will inform Environmental Health who may contact you.</b> These are the questions that Environmental Health may ask you:</p> <ol style="list-style-type: none"> <li>Number of meals per day - residents and staff?</li> <li>Are day visitors catered for? Number?</li> <li>Is this a distribution kitchen? i.e. are hot meals sent offsite to other satellite kitchens? Where? How many? Has this ceased during the current outbreak?</li> <li>Have the kitchen staff been questioned about possible symptoms?</li> <li>Have any food handlers/care assistants been unwell, even very mild symptoms?</li> <li>Have any household contacts for kitchen staff &amp; care assistants been unwell with diarrhoea and vomiting symptoms?</li> <li>Are they aware of 48-hour rule for exclusion?</li> <li>Has anyone vomited in dining room?</li> <li>Are care assistants routinely excluded from the kitchen?</li> <li>If not, are arrangements in place to exclude them during the outbreak? E.g. alternative facilities available for beverage making or kitchen staff to make beverages and leave out for care assistants to distribute?</li> <li>If staff have been ill, have they eaten from the care home?</li> <li>Is all food equipment maintaining adequate temperature control?</li> <li>Are hot/cold food temperature records up to date and carried out? The EHO may ask you to provide copies of these records.</li> </ol>		



Outbreak Care Pathway Communication	Date	Signature
<p><b>4. There is no longer a need to routinely inform the Care Quality Commission.</b> However, this document can be used to provide evidence for your CQC inspections.</p>		
<p><b>5. Close the home to admissions, transfers and hospital outpatient appointments.</b> Closure does not strictly apply to readmission of existing residents and these should be considered on an individual basis – the health protection team (PHE) can assist with risk assessment.</p> <p>Day centres must also 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).</p> <p>If hospital appointments are essential (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 patients.</p> <p>Any problems or concerns can be discussed with the Health Protection Practitioner if necessary.</p>		
<p><b>6. Inform visitors of the closure and put a poster on the entrance of the home</b> – to inform visitors that there is an outbreak, and everyone needs to report to the person in charge. Visitors are advised to stay away until the home is 48 hours free of symptoms. Visitors must not be stopped from visiting if they wish as long as they are aware they may become ill themselves. Visitors with symptoms must not visit the home until they are 48 hours free of symptoms.</p>		
<p><b>7. Inform visiting health care staff of the outbreak i.e. GPs, community nurses, physiotherapists, occupational therapists, pharmacists.</b></p> <p>Non-essential care must be deferred until after the outbreak</p>		
<p><b>8. Inform the Health Protection Team if a resident requires an emergency admission to hospital.</b> The GP/ paramedics/ care home manager must inform accident and emergency or the admitting ward, so that the resident can be received into a suitable area in A&amp;E/ medical admissions</p>		



Outbreak Pathway Infection Control Precautions	Date	Signature
<p><b>9. Isolate residents in their rooms until 48 hrs symptom free (where condition allows), particularly those with vomiting.</b> Where residents are difficult to isolate (EMI units) try as much as possible to cohort the residents that are symptomatic into one area.</p>		
<p><b>10. Organise staff work rota to minimise contamination of unaffected areas. Try to avoid moving staff between homes and floors</b></p>		
<p><b>11. Obtain a stool specimen as soon as possible from some symptomatic cases.</b> If notified of the outbreak, the health protection team (PHE) will send pre-addressed sample collection kits to the care home. Stool specimens should be 5 to 10 ml and must be diarrhoea (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. If you have contacted Public Health England, they will send sample pots via the post and explain how these are to be used. If you have pots already you can use these, store the sample in a fridge for that purpose only, and await PHE instruction. Please call the health protection team (PHE) with the names of any residents who have had samples sent off. If you have an <a href="#">NHS Net email address</a>, you may email the <a href="#">Specimen Results Chart</a> to our <a href="#">NHS Net email address</a> with the names and DOB column completed. <a href="mailto:phe.swhpt@nhs.net">phe.swhpt@nhs.net</a></p>		
<p><b>12. Exclude all staff members with symptoms until asymptomatic for 48 hours.</b> Staff members should be advised to submit stool samples to their GPs and must be advised not to work in any other care home until asymptomatic for 48 hours</p>		
<p><b>13. Staff must not eat and drink except in designated areas.</b> Open boxes of chocolates and fruit bowls must be removed in an outbreak</p>		












Infection Control Actions	Date	Signature
<p><b>14. Staff should change out of uniforms prior to leaving the home during outbreaks and wear a clean uniform daily.</b></p> <p>If uniforms are laundered at home, they should be washed immediately on a separate wash to other laundry at the highest temperature the material will allow.</p>		
<p><b>15. Reopening</b></p> <ul style="list-style-type: none"> <li>The home should not be reopened until it has been free of symptoms for 48 hours.</li> <li>A 'deep clean' should take place before reopening; this means that all floors, surfaces and equipment should be thoroughly cleaned with hot soapy water, including items such as door handles and light switches.</li> <li>Electrical items such as telephones and computer key boards also need to be cleaned with a (damp but not wet) cloth.</li> <li>Curtains should be laundered, and it is recommended that, if possible, carpets be steam cleaned.</li> </ul>		
<p><b>16. Effective hand hygiene is an essential infection control measure.</b> Ensure sinks are accessible and are well stocked with <b>liquid soap and paper towels for staff and visitors.</b></p>		
<p><b>17. Provide residents with hand wipes and/or encourage hand washing (hand washing is the preferred option for residents who are not bed bound)</b> In communal toilets, paper towels must be used for drying hands. For residents with en suite bathrooms, hand towels are acceptable but should be changed daily.</p>		
<p><b>18. Ensure the macerator/bedpan washer is operational</b> Faults must be dealt with immediately as <b>urgent.</b></p>		
<p><b>19. Laundry soiled by faeces or vomit</b> must be placed directly into a water soluble/infected laundry bag and transferred to the laundry so that laundry staff do not have to handle the item. Launder as infected linen.</p>		





Bristol Stool Chart				
Type 1		Separate hard lumps, like nuts (hard to pass)		
Type 2		Sausage-shaped but lumpy		
Type 3		Like a sausage but with cracks on its surface		
Type 4		Like a sausage or snake, smooth and soft		
Type 5		Soft blobs with clear-cut edges (passed easily)		
Type 6		Fluffy pieces with ragged edges, a mushy stool		
Type 7		Watery, no solid pieces. <b>Entirely Liquid</b>		



<p><b>20. Ensure the home is thoroughly cleaned daily using hot water and detergent.</b> If available all eating surfaces, toilet areas and sluice should be cleaned <b>twice</b> daily using a hypochlorite solution 1000 parts per million.</p> <p><b>Disinfection with Hypochlorite Solution</b></p> <ul style="list-style-type: none"> <li>• Disinfect with a freshly prepared 0.1 % hypochlorite solution (1000ppm). It is important to check the label for concentrations.</li> <li>• Recommended hypochlorite solutions at a concentration of 1,000 ppm include: <ul style="list-style-type: none"> <li>○ 50mls of Milton® added to 950mls of water</li> <li>○ Chlor-Clean®, Haz-Tab®, or Presept® tablets, as per manufacturer's instructions using a diluter bottle where applicable. Others may be available.</li> <li>○ 100 ml of household bleach (5% - concentration varies) added to 4900 ml of water</li> </ul> </li> <li>• It is essential that the correct concentration of the solution is made up to ensure that it is effective in killing the virus.</li> <li>• A fresh solution of hypochlorite should be made every 24 hours as the concentration becomes less effective after this time period. The date and time should be recorded when the solution is made up.</li> <li>• Commode and toilet seats require cleaning after each use with soap and water or detergent wipe.</li> <li>• Cover excreta/vomit spillages immediately with disposable paper roll/towel. <b>Always</b> wear an apron and gloves when disposing of faeces/vomit. After removing the spillage, clean the surrounding area with hot soapy water, followed by disinfection with a hypochlorite solution of 1000 part per million. Always clean a wider area than is visibly contaminated.</li> <li>• Carpets contaminated with faeces or vomit should be cleaned with hot soapy water (or a carpet shampoo) after removal of the spillage with paper towels. This should preferably be followed by steam cleaning if possible.</li> </ul>		
<p><b>21. Inform the Health Protection Team when the home has been 48 hours symptom free.</b></p> <p>Either via email to <a href="mailto:swhpt@phe.gov.uk">swhpt@phe.gov.uk</a> or call the Health Protection Team (PHE) on 0300 303 8162 option 1 option 1</p>		

## Outbreak Chart

Location.....Tel no.....Month/year.....

1.

[illegible]

2.		R	=	resident	Rm	=	Room / location
S	=	staff	EHO	=	Environmental Health Officer		
O	=	other	HPU/ICT		Health Protection Unit/Infection Control Team		
D	=	diarrhoea	●-----●		start and end of symptoms		
N	=	nausea	X		date sample sent to laboratory		
V	=	vomit					

## Specimen Results

Care Home Name:

HPZ Number:

Name and DOB	Specimen Type	Date Posted	Lab Results
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:
	Faeces		Bacteriology: C. difficile: Virology:

Please call the health protection team (PHE) with the details of any residents who have had samples sent off. If you have an [NHS Net email address](#), you may email the Specimen Results Chart to our [NHS Net email address](#) with the names and DOB column completed.  
[phe.swhpt@nhs.net](mailto:phe.swhpt@nhs.net)

## Action Card: Respiratory Illness

### Integrated care pathway (Checklist) for Acute Respiratory Infections in care homes (including flu-like illnesses)

NB: Please note that these are reviewed and updated regularly so do not rely on this version for an outbreak but ensure you contact **Public Health England South West Health Protection Team** to ensure you have the most recent copy.



## Public Health England South West Health Protection Team

### INTEGRATED CARE PATHWAY (Checklist)

#### Outbreak Management of Respiratory Illness (Care Homes)

##### Aims and Objectives

###### Aim

To manage outbreaks of respiratory infection efficiently and effectively in order to

- reduce the number of cases and potential deaths and
- reduce disruption to the provision of health and social care services

###### Objectives:

1. All appropriate measures are taken to prevent and control respiratory outbreaks.
2. Suspected outbreaks are detected early and control measures are initiated promptly.
3. All relevant information is documented, to allow review by the care home and the Health Protection Team (HPT), and for the care home to use as evidence of performance for the Care Quality Commission if required.

##### Definition Criteria for an outbreak of respiratory illness

- New onset or acute worsening of one or more of these symptoms: cough, runny nose or congestion, sore throat, sneezing, hoarseness, shortness of breath, wheezing, chest pain AND
- A fever of  $\geq 37.8^{\circ}\text{C}$  OR sudden decline in physical or mental ability

If you notice TWO or more residents or staff meeting these criteria, occurring within TWO DAYS (48 HOURS\*), in the same area of the care home **you might have an outbreak**. Consider influenza as an alternative diagnosis in residents with suspected chest infection

\*The timescale may be flexible dependent on circumstances

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**Instructions:** if you have an outbreak, please work through all the pages of this document, signing and dating each action when it has been implemented.

The only pages you need to return to the HPT are

[Appendix 3 - END OF ACUTE RESPIRATORY OUTBREAK FORM](#) and

[Appendix 4 - log of PATIENT SWABS](#).

Both these forms will also be sent to you as separate documents.

The remainder is for your internal use.

---

## Prevention of Respiratory Outbreaks

### Annual Influenza Vaccine

This should be offered to:

- ☐ Health and social care staff directly involved in the care of their residents or clients.
- ☐ Those living in long-stay residential care homes or other long-stay care facilities where rapid spread is likely to follow introduction of infection and cause high morbidity and mortality.

The aim of this is to:

- ☐ To reduce the transmission of influenza within health and social care premises,
- ☐ To contribute to the protection of individuals who may have a suboptimal response to their own immunisations,
- ☐ To avoid disruption to services that provide their care.

See the [Green Book](#) on the Department of Health Website for more details:

### **Persons most at risk of developing complications**

Some people will be at greater risk of developing complications (typically pneumonias) from Respiratory Tract infections and becoming more seriously ill e.g.:

- ☐ People aged 5 to 65 years with:
  - Chronic lung disease
  - Chronic heart disease
  - Chronic kidney disease
  - Chronic liver disease
  - Chronic neurological disease
  - Immuno-suppression (whether caused by disease or treatment)
  - Diabetes mellitus
- ☐ Pregnant women
- ☐ Young children under 5 years old
- ☐ People aged 65 years and older
- ☐ Obese people with a BMI  $\geq 40$

Infection Prevention Control and Outbreak guidance please see following web link for <https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/>

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## Initial Situation Details

Full address of outbreak location: .....  
 .....Postcode.....

Onset date & time in first case.....

Number of residents:

- Presently in the home:.....
- Presently affected by respiratory illness (at time of reporting the outbreak)....
- Presently in hospital because of respiratory illness.....

Number of staff:

- Employed in the home:.....
- Presently affected by respiratory illness (at time of reporting the outbreak) .....

Communication: WHO TO INFORM	Date	Signature
1. <b>Report cases of respiratory illness (see definition above) to the person in charge</b> of nursing/residential home.		
2. Enter the details of symptomatic cases on the <a href="#">log sheet</a> attached (residents and staff).		
3. <b>Inform all GPs caring for any of the residents</b>		
4. <b>Telephone the Health Protection Team to inform them of the outbreak on 0300 303 8162 Option 1 then Option 1</b>  This will enable you to discuss the outbreak control measures that are needed and the information to be communicated to others		

Outbreak Care Pathway – INITIAL ACTIONS	Date	Signature
<b>5. Consider closing the home to admissions, transfers and hospital outpatient appointments</b>  Closure should be based on a joint risk assessment between the home and the HPT and will depend on the likelihood that this is flu, the number of residents and/or staff affected and their location within the home.  If appointments or transfers are essential, inform the clinic/hospital, so appropriate infection control plans can be made for the resident (inform Hospital Infection Control team)		
<b>6. If the HPT agree that an OUTBREAK is suspected and that closing the home is necessary:</b> <ul style="list-style-type: none"> <li>• <b>Inform family members/visitors of the closure and put a poster on the entrance of the home.</b></li> </ul> Symptomatic visitors should be excluded from the home.		



<p>Visitors with underlying health conditions and at risk of more severe infection should be discouraged from visiting.</p> <p>Visitor access to symptomatic residents should be kept to a minimum.</p> <p>Visitors should be provided with hygiene advice.</p> <p>Non-urgent visits should be rescheduled until after the outbreak is over.</p> <ul style="list-style-type: none"> <li>• <b>Inform visiting health care</b> and other staff of the outbreak i.e. community nurses, physiotherapists, occupational therapists, hairdressers, clergy, pharmacists.</li> <li>• Non-essential visits must be deferred until after the outbreak</li> </ul>		
<p><b>7. If a patient requires urgent admission or outpatient appointment,</b> ensure you inform the following people before the transfer: GP, paramedics, care home manager, accident &amp; emergency and infection control team at the hospital. Please also inform the HPT the next working day.</p> <p>This will ensure that the appropriate infection control precautions are undertaken</p>		
<p><b>8. Isolate symptomatic residents in their rooms until 24 hrs symptom free (where condition allows.)</b></p> <ul style="list-style-type: none"> <li>• Where residents are difficult to isolate, try as much as possible to cohort the residents that are symptomatic into one area i.e. keep symptomatic residents together.</li> <li>• Assume the cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered</li> <li>• If major co-morbidity, immunosuppression, pneumonia, antivirals started &gt;48 hrs after onset or no antivirals received by case, then infectiousness may be prolonged – discuss with HPT</li> </ul>		
<p><b>9. Organise staff work rota to minimise moving staff between homes and floors.</b> If possible, staff should work either with symptomatic or asymptomatic residents (but not both) for the duration of the outbreak.</p>		
<p><b>10. Agency staff exposed during the outbreak should be advised not to work in any other health care settings</b> until at least two days after they have last worked in the home with the outbreak</p>		
<b>Outbreak Care Pathway – SAMPLING</b>	<b>Date</b>	<b>Signature</b>
<p><b>11. If flu suspected, please discuss sampling with the Health Protection Team</b></p> <p>A suitably qualified health care professional should obtain the following samples:</p> <ul style="list-style-type: none"> <li>• Combined nose/throat swab in <b>virus transport medium</b> from cases with the most recent onset of symptoms. Samples from up to five people should be taken (viral swabs are available from local laboratories, the HPT or sometimes from GPs).</li> <li>• Sputum samples for culture</li> <li>• Urine samples for Legionella and pneumococcal antigens</li> </ul> <p>See <a href="#">appendix 1 for recommendations on sampling</a></p> <p><b>12. Write label the specimen and request form</b> with name of care home and “suspected respiratory outbreak” on each form, in addition to patient details. Please include an outbreak number or HP Zone number if this has been given to you.</p>		

Outbreak Care Pathway – INFECTION CONTROL ACTIONS	Date	Signature
<p>13. <b>Effective hand hygiene and safe disposal of respiratory secretions on tissues are essential infection control measures.</b> Ensure handwashing sinks are accessible and are well stocked with <b>liquid soap and paper towels for staff and visitors.</b></p> <p>14. <b>Waste bins that contain tissues used by residents with a respiratory illness should be disposed of as clinical waste.</b></p>		
<p>15. <b>Encourage hand washing amongst all staff, residents and visitors. If residents are unable to wash hands at the sink, provide a bowl of water or hand wipes</b> (a clean individual patient hand towel should be provided daily).</p> <p>16. If handwashing facilities are not readily available offer alternatives such as alcohol gel</p>		
<p>17. <b>Exclude all staff and visitors with symptoms until asymptomatic for 24 hours and fully recovered</b></p>		
<p>18. <b>Staff should change out of uniforms prior to leaving the home during outbreaks</b> 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 on the highest temperature that the material will tolerate.</p>		
<p>19. <b>Staff should make a local risk assessment regarding the suspected organism and the use of personal protective equipment</b> Staff should wear gloves and apron for contact with cases and when handling contaminated items or waste. Surgical face masks may be worn when staff are caring for symptomatic residents. Impact on the home situation should be considered. Please discuss with the Health Protection Team if concerned</p> <p>20. Wearing gloves is no substitute for handwashing after contact with respiratory secretions and between residents.</p>		
<p>21. <b>Ensure the home is thoroughly cleaned twice daily using hot water and detergent.</b> Particular attention should be paid to all surfaces that are frequently handled i.e. door handles, bed tables, eating surfaces, toilet areas and the sluice.</p>		
<b>ACTIONS ONCE OUTBREAK OVER</b>		<b>Signature</b>
<p>1. <b>Inform local hospital</b> and other relevant health and social care services that home has <b>re-opened</b></p>		
<p>2. Complete the <a href="#"><u>END OF ACUTE RESPIRATORY OUTBREAK FORM</u></a> and send to HPT (see Appendix 3)</p>		

## Appendix 1:

### **Sampling of residents during an outbreak of acute respiratory illness in Care Homes**

Samples should be taken as soon as possible from cases with the most recent onset of symptoms. Up to five should be taken if possible

Viral swab - nasal and/or throat – these are special viral swabs. You can obtain these from your local acute Trust or your HPT. If sent by the HPT, they will send you separate instructions on how to take the swab and where to send it for analysis.

Sputum for bacterial culture – for those with chesty cough who can produce sputum

Urine samples - Please use plain urine bottles for Pneumococcal antigen (urinary) + Legionella antigen (non-boric acid or other chemical i.e., NOT the one used for urine culture). Can use same type of container used for sputum); from all symptomatic residents.

#### Labelling

You will need **one form for EACH test** as they are all done in different areas / locations of the labs.

However, if viral nasal *and* viral throat swabs are taken from the same patient, these can be place in the same pack.

For all samples sent, please ensure the following is on request forms:

- Name, Date of Birth, Address of Patient and/or Name & postcode of Care Home/School etc.
- HPZone number (HPT reference number)
- Onset date of symptoms
- Any antibiotics taken
- Clinical details e.g. dry or productive cough, runny nose, pyrexia (temperature), worsening shortness of breath etc
- Date swab taken

Name of care home.....

Date .....

**Appendix 2: Symptomatic Resident and Staff Log sheet - Complete Daily for new symptomatic cases**

RESIDENTS LOG SHEET										
Room	Name & Date of Birth	Date of last flu vaccine	Date of pneumovax vaccine	GP and Surgery Details	THIS OUTBREAK					
					Date of Onset	Symptoms (see codes below)	Seen by Dr (name and date seen)	Diagnosis	Specimen Sent (type of specimens & date sent)	Results

STAFF LOG SHEET										
Job title	Name & Date of Birth	Date of last flu vaccine	Date of pneumovax vaccine (if applicable)	GP and Surgery Details	Date of Onset	Symptoms (see codes below)	Seen by Dr (name and date seen)	Diagnosis	Specimen Sent (type of specimens & date sent)	Results

**Symptoms code:** C=cough (non-productive); CI=cough (producing green or yellow sputum); RN =runny nose; T=temperature; FB=fast breathing/shortness of breath; CS=audible chest sounds; H=headache; LA= loss of appetite; ST=sore throat; V=vomiting; AP=general aches /pains; ILL=duration of illness of  $\geq 3$  day

## Appendix 3:



Protecting and improving the nation's health

### End of Outbreak Form

### Acute Respiratory Outbreaks in Care Homes

**To** Acute Response Centre,  
Public Health England South  
West

**Email:** [swhpt@phe.gov.uk](mailto:swhpt@phe.gov.uk) or [phe.swhpt@nhs.net](mailto:phe.swhpt@nhs.net)

**Fax No.** 0117 930 0205 SW(North) | Fax safe havens  
01392 367356 SW(South) | M-F 9-5

**From:** Name of Care Home

**Fax No.**

Date	No of pages	2 (including this page)
------	-------------	-------------------------

**NB** - Ensure there are **no patient details on this form if emailing**, unless you send it from your [NHS Net account](#) to our [NHS Net account](#).  
**Patient information may be faxed to the safe haven fax number above** (Mon-Fri 9-5).

### Appendix 3:

HPT Ref: HP Zone number		Name of Care Home	
-------------------------	--	-------------------	--

People affected <b>at end of outbreak</b>	Number symptomatic	Number hospitalised	Number ICU admission	Number Died	Name of hospital
Residents					
Staff					

Antivirals given to how many?	Number
Residents - Treatment	
Residents - Prophylaxis	
Staff - Treatment	
Staff - Prophylaxis	

Date home closed to new admissions & transfers (if applicable)	
Date home re-opened to new admissions & transfers	

#### Feedback and Lessons Learnt:

If this outbreak were to happen again, is there anything that:

1. You would do differently?
2. You would like the Health Protection Team to do differently?

If so, please provide details (continue on another page if needed). Thank you.

### Appendix 3:

HPZone number		Name of School/Nursery/Care Home	
---------------	--	----------------------------------	--

Samples taken					
Name of case	DOB	Type of specimen e.g. viral nose/throat swab or sputum culture	Date sent	Which lab?	Results



## Appendix 1

# Transmission, incubation and communicability of respiratory pathogens





<b>Infection</b>	<b>Reservoir</b>	<b>Dominant modes of transmission</b>	<b>Incubation period</b>	<b>Period of communicability*</b>
<b>Rhinovirus or coronavirus</b>	Human	Respiratory droplets, direct and indirect contact with respiratory secretions.	Between 12 hours and 5 days, more usually around 48 hours.	From up to 1 day before* to 5 days after clinical onset.
<b>Influenza virus</b>	Humans are the primary reservoir for human influenza; birds and mammals are likely sources of new human subtypes for influenza A.	Respiratory droplets, direct and indirect contact with respiratory secretions.	Short, usually 1 to 3 days, but possibly up to 5 days.	From up to 12 hours before* to 3 – 5 days after** clinical onset in adults; up to 7 days in young children and occasionally longer.
<b><i>Streptococcus pneumoniae</i></b>	Humans – pneumococci are commonly found in the respiratory tracts of healthy people.	Respiratory droplets, direct and indirect contact with respiratory secretions.	Uncertain, but possibly 1 to 3 days.	Until discharges are clear of virulent pneumococci, but 24 - 48 hours if treated with penicillin. Pneumococci remain viable in dried secretions for many months.
<b>Respiratory syncytial virus (RSV)</b>	Human	Respiratory droplets, direct and indirect contact with respiratory secretions.	Between 1 and 8 days, more usually around 48 hours.	From up to 1 day before* to 5 days after clinical onset, occasionally longer in infants – up to 4 weeks.
<b>Parainfluenza virus</b>	Human	Respiratory droplets, direct and indirect contact with respiratory secretions.	Between 12 hours and 7 days, more usually around 48 hours.	From up to 1 day before* to 5 days after clinical onset.

\* Few data exist which convincingly demonstrate that transmission by asymptomatic persons is important in producing additional symptomatic case

\*\* Carriage may last for longer (7 days or possibly more) in older people with comorbidity and severe enough illness to warrant hospitalisation for this long



## Transmission Dynamics

Respiratory infections are usually spread by close contact through one of four mechanisms:

**Droplet transmission.** Coughing, sneezing, or even talking may generate droplets more than 5 microns in size that may cause infection if droplets from an infected person come into contact with the mucous membrane or conjunctiva of a susceptible individual. The size of these droplets means that they do not remain in the air for a distance greater than a metre, so fairly close contact is required for infection to occur.

**Direct contact transmission** occurs during skin-to-skin or oral contact. Organisms may be passed directly to the hands of a susceptible individual who then transfers the organisms into their nose, mouth or eyes.

**Indirect contact transmission** takes place when a susceptible individual touches a contaminated object, in the vicinity of an infected person and then transfers the organisms to their mouth, nose or eyes.

**Aerosol transmission** takes place when droplets less than 5 microns in size are created and remain suspended in the air. This can sometimes occur during medical procedures, such as intubation or chest physiotherapy. These droplets can be dispersed widely by air currents and cause infection if they are inhaled.

## Infection Control

### Residents

Enhanced surveillance for further cases should be initiated by way of daily monitoring of all residents for elevated temperatures and other respiratory symptoms. It is important to identify infected residents as early as possible in order to implement infection control procedures such as isolation and reduce the spread of infection. If possible, symptomatic residents should be cared for in single rooms. If this is not possible, symptomatic residents should be cared for in areas well away from residents without symptoms. If the design and capacity of the care home and the numbers of symptomatic residents involved are manageable, it is preferable to isolate residents into separate floors or wings of the home. Movement of symptomatic residents should be minimised. If the organism is unknown, assume cases will be infectious for up to 5-7 days following the onset of symptoms or until full recovered.

Resident's clothes, linen and soft furnishings should be washed on a regular basis and all rooms kept clean. More frequent cleaning of surfaces such as lockers, tables, chairs, televisions and floors is indicated, especially those located within one metre of a symptomatic resident. Hoists, lifting aids, baths and showers should also be thoroughly cleaned between residents.

Residents should have an adequate supply of tissues, as well as convenient and hygienic methods for disposal. Residents should cover their nose and mouth with disposable single-use tissues when sneezing, coughing, wiping and blowing noses and clean their hands or use handrubs (microbicidal handrubs, particularly alcohol-based) afterwards.

Depending on the nature of the infection and the impact on those affected, consideration might in very specific circumstances be given to the use of surgical

facemasks by affected residents (if this can be tolerated) when they are within one metre of other individuals (unless microbiologically confirmed to share the same infection). The Health Protection Team will advise if this is necessary.

## Staff

If possible, care home staff should work either with symptomatic or asymptomatic residents (but not both) and this arrangement should be continued for the duration of the outbreak.

Agency and temporary staff who are exposed during the outbreak should be advised not to work in any other health care settings until the cause is identified and appropriate advice given.

Symptomatic staff and visitors should be excluded from the home until no longer symptomatic. Children and adults vulnerable to infection should be discouraged from visiting during an outbreak. Consistent with resident welfare, visitor access to symptomatic residents should be kept to a minimum.

Frequent hand washing has been proven to be effective in reducing the spread of respiratory viruses. Staff should clean their hands thoroughly with soap and water or a handrub (microbicidal handrubs, particularly alcohol-based) before and after any contact with residents. Consideration should also be given to placing handrub dispensers at the residents' bedsides for use by visitors and staff. It is advisable to recommend carrying out a risk assessment before introducing handrubs into the workplace.

Staff should wear single use plastic aprons appropriately when dealing with residents.

Barrier measures such as gloves, gowns and facemasks (the higher the filtration the better) are also effective in reducing the spread of respiratory viruses if used correctly. Any decision about the use of personal protective equipment (PPE) needs to be taken in the light of the organism and the impact on the home. The Health Protection /team can advise on the level of infection control needed.

More stringent infection control is needed when aerosol generating procedures (such as airway suction and CPR) are carried out on cases or suspected cases. Such procedures should be performed only when necessary and in well ventilated single rooms with the door closed. Numbers of staff exposed should be minimised and FFP3 respirators and eye protection should be used in addition to gowns, gloves and universal precautions.

Staff, residents and visitors should be encouraged to avoid touching their eyes and nose to minimise the likelihood of infecting themselves from viruses picked up from surfaces or other people.

Uniforms and other work clothing should be laundered at work if there are facilities for this. If laundered at home the general advice on washing work clothes would apply. Uniforms should never be worn between home and the place of work.

Clinical waste should be disposed of according to standard infection control principles.

Depending on the causative organism, there may be a case for staff at risk of complications if infected (e.g. pregnant or immuno-compromised individuals) to avoid caring for symptomatic residents. A risk assessment will need to be carried out on an incident by incident basis.

## Appendix 2

### Guidance on influenza outbreaks in care homes – Posters

Also available for downloading on <https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/care-guidance/>



Public Health  
England

## Do 2 or more residents or staff have the following symptoms?



Fever of  
**37.8°C**  
or above



New onset or acute worsening of  
one or more of these symptoms:

- cough
- hoarseness
- runny nose or congestion
- shortness of breath
- sore throat
- wheezing
- sneezing
- chest pain



Sudden  
decline in  
physical or  
mental ability

If you notice 2 or more residents or staff meeting these criteria, occurring within 2 DAYS (48 HOURS), in the same area of the care home **you might have an outbreak.** Consider influenza as an alternative diagnosis in residents with suspected chest infection

Call the Health Protection team on 0300 303 8162

Option 1 Option 1

or

Email: [swhpt@phe.gov.uk](mailto:swhpt@phe.gov.uk)





# Guidance on outbreaks of influenza (flu) in care homes



**Do 2 or more residents or staff have the following symptoms?**



**Fever of  
37.8°C  
or above**



**New onset or acute worsening of one or more of these symptoms:**

- cough
- hoarseness
- runny nose or congestion
- shortness of breath
- sore throat
- wheezing
- sneezing
- chest pain



**Sudden decline in physical or mental ability**

If you notice 2 or more residents or staff meeting these criteria, occurring within **2 DAYS (48 HOURS)**, in the same area of the care home **you might have an outbreak**. Consider influenza as an alternative diagnosis in residents with suspected chest infection.



Contact your community infection control team (CICT) or PHE health protection team (HPT) immediately and take the infection control measures listed here



**What the CICT or HPT will do:**

- work with care home staff and GPs to identify the cause of the outbreak
- advise on infection control measures
- work with GPs to advise on treatment and prevention

## INFECTION PREVENTION AND CONTROL MEASURES

All residents and staff should be offered seasonal flu vaccination each year

### Hand hygiene and protective clothing

- ensure that liquid soap and disposable paper towels are available at all sinks
- wash hands thoroughly using liquid soap and water before and after any contact with residents
- provide 70% alcohol hand rub for visitor use and supplementary use by staff
- staff should wear single-use plastic aprons and gloves as appropriate when dealing with affected residents. The HPT will advise on the use of surgical masks. Dispose of all these as infectious waste

### Cleaning and waste disposal

- provide tissues and no-touch bins for used tissue disposal in public areas
- provide tissues and covered sputum pots for affected residents. Dispose of these as infectious waste
- wash residents' clothes, linen and soft furnishings on a regular basis, and keep all rooms clean

Clean surfaces of lockers, tables & chairs, televisions and floors etc frequently. Always clean hoists, lifting aids, baths and showers thoroughly between patients.

### Reducing exposure

- consider closing the home (and any day care facility) to new admissions if the HPT confirms an outbreak
- residents should not transfer to other homes/attend external activities
- residents should only attend out-patient or investigation appointments where these are clinically urgent
- care for residents with symptoms in single rooms until fully recovered and for at least 5 days after the symptoms started
- affected residents should remain in their rooms as far as possible. Discourage residents with symptoms from using common areas
- as far as possible staff should work in different teams: one team caring for affected residents and the other caring for unaffected residents
- agency and temporary staff in contact with residents with symptoms should not work elsewhere (e.g. in a local acute care hospital, or other care home) until 2 days after last exposure
- staff and visitors with symptoms should be excluded from the home until fully recovered
- the elderly, very young and pregnant women, who are at greater risk from the complications of flu, should be discouraged from visiting during an outbreak
- inform visiting health professionals of the outbreak and rearrange non urgent visits to the home, if possible
- inform the hospital in advance if a resident requires urgent attendance at hospital



## Appendix 3

### Scabies: Infection control precautions in nursing and residential homes



<h2>Laundry</h2>	<p>Clothes, towels, and bed linen should be machine-washed after the first application of treatment, to prevent re-infestation and transmission to others. Items that cannot be washed can be kept in plastic bags for at least 72 hours to contain the mites until they die. This includes heat labile items.</p> <p>Machine wash and dry bedding and clothing of scabies residents using the hot water and hot dryer cycles (60 degrees plus for linen and as tolerated by the clothing materials involved).</p>
<h2>Environment</h2>	<p>Soft furnishings, which have cloth coverings, should be kept out of use for 24hours after treatment in order to allow the mites which may be on the fabric to die. These items should then be vacuumed.</p> <p>Those covered in vinyl should be wiped down with a hard surface cleaner following treatment.</p> <p>In cases of <b>crusted (Norwegian)</b> scabies vacuuming and damp dusting of the environment is essential.</p>
<h2>Isolation</h2>	<p><b>Residents with scabies do not normally require isolation.</b></p> <p>However, residents with crusted (Norwegian) scabies who are highly contagious require isolation precautions until treatment has been completed.</p> <p>Aprons and gloves should be worn for personal care of known infected cases.</p>

Further information on scabies:

[www.patient.co.uk/health/scabies-leaflet](http://www.patient.co.uk/health/scabies-leaflet)



## Appendix 4

### Suggested care plan for confirmed *Clostridium difficile* case

### **Suggested Care Plan Once *Clostridium difficile* is confirmed**

#### **Isolation**

- Isolate and barrier nurse in a single room (with en suite 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 48 hours and has passed a stool that is normal for them.
- The resident may come out of isolation once they have been free of symptoms and loose stools for 48 hours **and** have passed a stool that is normal for them.

#### **Monitoring of resident**

- Document a plan of care in the resident's notes. Keep a written record of all monitoring carried out and care given, including 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 ill or have more profuse diarrhoea should be referred to hospital.**
- Residents who are ill need to be monitored hourly day and night.
- Keep a fluid balance chart, recording all drinks taken and the number of times the resident passes urine (and how much, if possible) and the number of times the resident has their bowels open.
- Record all bowel actions on a bowel chart, as per the Bristol Stool Chart.
- Record the resident's temperature daily. Report to GP if outside normal limits.
- Monitor the resident for abdominal pain. Report to GP if pain develops.
- Monitor the resident's blood pressure four hourly (this should always be done in nursing homes and if possible in residential care homes). Report to GP if 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 admitted to hospital, please call the hospital **before the resident arrives** so they can arrange immediate isolation and prevent a hospital outbreak. Call the infection control team or A&E ward Manager, as appropriate to time of day. **Tell the ambulance crew in advance.**

#### **Treatment**

- Request a GP visit to assess the resident.
- Treatment with antibiotics is usually required. The recommended therapy for mild disease is metronidazole 400mg three times per day for ten-14 days.
- Metronidazole is not always indicated for patients with very mild symptoms i.e. less than four liquid stools in 24 hours and not systemically unwell.
- The GP may stop treatment early if a rapid clinical response with full recovery is seen.
- If diarrhoea fails to respond after five days of treatment with metronidazole contact the GP. The GP may switch to oral vancomycin 125mg four times per day for a further ten days. The GP may wish to discuss treatment with the Consultant Microbiologist.
- The GP will decide whether any other antibiotics that the resident is taking should be stopped where it is safe to do so.

#### **Handwashing**








- **Remember that alcohol gel does not work against Cdiff.**
- Wash hands with soap and water.
- GPs and other visiting health care professionals must wash their hands.
- 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.
- As is usual best practice, ensure all residents are encouraged to wash hands with soap and water at appropriate times.

This is an example of the type of record chart you will need:

<h2 style="margin: 0;">Stool Chart</h2>			
<b>Resident's Surname</b>	.....	<b>Date of birth</b>	.....
<b>Forenames</b>	.....	<b>Room number</b>	.....

**MUST BE COMPLETED EVERY SHIFT, INCLUDING WHEN NO STOOLS PASSED**

DATE	TIME	BRISTOL TYPE	APPROX AMOUNT	COLOUR	FRESH BLOOD PRESENT? (call GP)	MUCUS PRESENT? (call GP)	SAMPLE SENT	SIGNATURE

<b>Bristol Stool Chart</b>	
Type 1	 Separate hard lumps, like nuts (hard to pass)
Type 2	 Sausage-shaped but lumpy
Type 3	 Like a sausage but with cracks on its surface
Type 4	 Like a sausage or snake, smooth and soft
Type 5	 Soft blobs with clean-cut edges (passed easily)
Type 6	 Fluffy pieces with ragged edges, a mushy stool
Type 7	 Watery, no solid pieces. <b>Entirely Liquid</b>

### Type 5, 6 or 7

- Patient to be isolated
- Stool sample to be sent  
- request *Clostridium difficile* toxin test on the laboratory form
- Document actions taken in nursing notes
- Inform GP for medical assessment

**Personal Protective Equipment (PPE)**

- To be kept outside the 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 has to 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 to be used when handling contaminated linen.

**Cleaning****The environment must be kept thoroughly clean to prevent spores spreading**

- Declutter the resident's room as much as possible, to assist in minimising contamination by spores.
- Food stuffs such as sweets, fruit and biscuits should be kept in air-tight containers in a cupboard.
- Clean the environment and any patient equipment twice a day with detergent, followed by a weak bleach solution (one part bleach to ten parts water solution) on areas that will tolerate bleach. Pay special attention to lavatories and commodes. Clean anything that is touched by hand – eg door handles, light switches, call bells etc.
- All equipment (blood pressure monitors etc) should remain in the resident's room for the duration of the illness.
- Treat all waste as clinical infected waste.
- When the resident has recovered and isolation has ceased, the resident's room must be deep-cleaned. This means cleaning all curtains and soft furnishings, washing walls, cleaning all surfaces and steam cleaning the carpet.
- All surfaces and equipment must be cleaned with detergent followed by bleach solution (where bleach will not damage the surface) before being used elsewhere in the home.
- Consideration should be given to discarding items that cannot be cleaned by the above method.

**Recurrent disease**

C diff-associated diarrhoea recurs in around a third of cases and often requires further treatment. One recurrence is often followed by further recurrences and sometimes long-term treatments are used. New exposure to antibiotics is important in recurrence, especially cephalosporins and quinolones. Recurrence may be due to new strains of C diff rather than inadequate treatment of previous infection.

**Root Cause Analysis**

In line with Department of Health requirements, all cases of C diff are followed up with a 'root cause analysis'. This means that the resident's care will be reviewed, to try and identify why the resident developed *Clostridium difficile*. It is a 'non-blame' process and is a way of learning lessons (nationally) and improving patient care. Following a confirmed case, the Primary Care Trust will contact you to arrange the root cause analysis.

Produced by Liz Maddock and Sue Kingsbridge, Surrey & Sussex Health Protection Unit

[www.hpa.org.uk](http://www.hpa.org.uk)

September 2010 - Revision date September 2012

With thanks to East Sussex Hospitals NHS Trust, Brighton and Sussex University Hospitals NHS Trust, Brighton and Sussex Medical School, NHS Brighton and Hove, NHS East Sussex Downs and Weald, NHS West Sussex and local care homes for their contributions and advice.

**References**

- 1 Department of Health (2008) "Clostridium difficile infection – How to deal with the problem" Department of Health, London, December 2008
- 2 Lewis SJ, Heaton KW (1997) "Stool form scale as a useful guide to intestinal transit time" Scandinavian Journal of Gastroenterology 32(9)920-4. doi: 10.3109/00365529709011203.PMID 9299672

## Appendix 5

### Antibiotic-resistant bacteria



### **Antibiotic-resistant bacteria**

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, the CIPIC or the local 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 residents 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 will 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, Available at:

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/214929/Care-home-resource-18-February-2013.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/214929/Care-home-resource-18-February-2013.pdf)



## Appendix 6

# Urinary Tract Infection Prevention Resources

Urinary Tract Infection Leaflet

Tackling Dehydration Leaflet

‘To dip or not to dip’ Leaflet

Urinary Tract Infection Assessment Tool

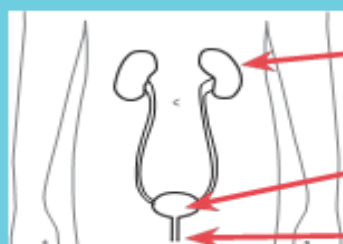


## Urinary tract infections (UTIs)

A leaflet for older adults and carers

### What is a urine infection?

A urine infection occurs when bacteria in any part of the urine system cause symptoms.



Kidneys make urine

Bladder stores urine

Urethra takes urine out of the body

If a urine test finds bacteria but you are otherwise well, do not worry, this is common, and antibiotics are not usually needed. However, severe urine infections can be life threatening.

### What you can do to help prevent a urine infection

**Are you drinking enough? Look at the colour of your urine.**



← Drink more →



- Drink enough fluid (6-8 glasses) so that you pass pale coloured urine regularly during the day, and to avoid feeling thirsty, especially during hot weather
- Avoid drinking too many fizzy drinks or alcohol
- There is no proven benefit of cranberry products
- Prevent constipation. Ask for advice if needed
- Maintain good control of diabetes



### Stop bacteria spreading from your bowel into your bladder:

- Wipe genitals from front to back after using the toilet
- Change pads and clean genitals if soiled
- Keep the genital area clean and dry; avoid scented soaps
- Wash with water before and after sex

**Speak to your pharmacist about referral to a GP or other treatments.**

version 1.0, published: June 2016, revision: June 2021



## What signs and symptoms should you look out for?

### Consider these symptoms if you have a urinary catheter:



- Shivering or shaking
- High or low temperature
- Kidney pain in your back just under the ribs

### New or worsening signs of urine infection in all people:

- Pain or burning when passing urine
- High or low temperature
- Shivering or shaking
- Urgency (feeling the need to urinate immediately)
- Pain in your lower tummy above pubic area
- Incontinence (wetting yourself more often than usual)
- Passing urine more often than usual
- Cloudy urine, or visible blood in your urine
- Confusion, change in behaviour, or unsteadiness on feet

### Although confusion is caused by urine infection, consider other things that may also cause confusion

- |                       |  |
|-----------------------|--|
| • Pain                | • Side effects of medicine                   |
| • Constipation        | • Other infection                            |
| • Poor sleep          | • Change in your routine or home environment |
| • Low mood            | • Poor diet                                  |
| • Not drinking enough |  |

## What can you do to help feel better?



- Drink enough fluid so that you pass urine regularly during the day, especially during hot weather.  
Drink enough fluids to avoid feeling thirsty and to keep your urine pale.  
If you're worried about wetting yourself, see your doctor or nurse for advice

- Ask for advice from your pharmacist / carer
- Take paracetamol regularly, up to 4 times daily to relieve fever and pain



## What might your pharmacist/nurse/doctor do?

- If your symptoms are likely to get better on their own you may receive self-care advice and pain relief
- Ask you to drink more fluids
- Ask you for a urine sample
- You may be given an antibiotic with self-care advice



## Always trust your pharmacist's / nurse's / doctor's advice about antibiotics

1. Antibiotics can be life saving for serious urine infections
2. But antibiotics are not always needed for urinary symptoms
3. Common side effects of taking antibiotics include thrush, rashes, vomiting and diarrhoea
4. Antibiotics affect the bacteria in your bowel, which may make them resistant to antibiotics for at least a year
5. Keep antibiotics working, only take them when your doctor / nurse advises them

## When should you get help?

The following symptoms are possible signs of serious infection and should be assessed urgently

Contact your GP Practice or contact NHS 111 (England), NHS 24 (Scotland dial 111), NHS direct (Wales dial 0845 4647), or GP practice (NI)

Shivering, chills and muscle pain



Feeling very confused, drowsy or slurred speech



Not passing urine all day



Temperature is above 38°C or less than 36°C



Trouble breathing



Kidney pain in your back just under the ribs



Visible blood in your urine



Very cold skin



Symptoms are getting a lot worse, or not starting to improve within 2 days of starting antibiotics



Trust your instincts, ask for advice if you are not sure how urgent the symptoms are

# Tackling dehydration

Dehydration in warmer weather can cause a significant increase in the incidence of urinary tract infection (UTI) and other severe infections associated with it.

Here are some key facts to help prevent your patients becoming dehydrated:



## 1 Keep drinking

- Adults need a minimum of 1.5 litres of fluid every day
- This is equivalent to at least 8 large cups or mugs of fluid

## 2 Any fluid is good fluid

- The most important thing is to consume sufficient fluids. It does not matter what form this fluid takes. Coffee and tea are a preferred source of fluids for many people and have been shown to have no significant dehydrating effect
- Fluid rich foods such as jelly, ice cream and yoghurt can also supplement fluids in drinks

## 3 Look out for signs of dehydration

- Dry skin or mouth, dark coloured urine, headaches, confusion and drowsiness can all be signs of dehydration

## 4 Older people and young children are particularly vulnerable

- Make sure everyone has a cup they can use easily. Cups that are heavy or have small handles can be very difficult to hold
- Some people may also need assistance to hold the cup and drink. Avoid straws for those with difficulty swallowing, due to increased risk of choking
- Encourage those worried about incontinence not to stop drinking if they are concerned about leaking urine. Concentrated urine resulting from not drinking can irritate the bladder and increase the risk of infection

[www.ips.uk.net](http://www.ips.uk.net)

For more information please visit:  
<https://www.england.nhs.uk/commissioning/hut/hyd/10-key-characteristics/>  
<http://www.ips.soc.nhs.uk/pubs/detail.aspx?id=3464>  
<https://www.uwl.ac.uk/academic-schools/nursing-midwifery/research/richard-wells-research-centre/research-projects/hydrate>

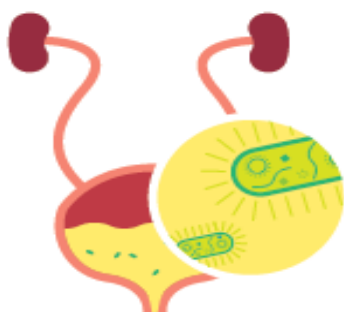
**ips** Infection Prevention  
Society

## To Dip or Not to Dip?



'To Dip or Not to Dip' is an evidence-based pathway which aims to improve the diagnosis and management of Urinary Tract Infections (UTI) in older people living in care homes. This pathway has been shown to reduce antibiotic use and hospital admissions for UTI. This leaflet explains more about UTIs and the 'To Dip or Not to Dip' care pathway.

### Bacteria in the Urine in Older People



The presence of bacteria in the urine in older people does not necessarily mean there is an infection that requires antibiotics. Bacteria can live harmlessly in the urine of older people. In fact, around 50% of older people have bacteria in the urine without causing any symptoms. In those with a long-term urinary catheter, this rises to 100%.

### What's the Problem with Urine Dipsticks?



Urine dipsticks are often used in the diagnosis of UTI in older people living in care homes. A positive result for 'nitrite' (bacterial marker) or 'leucocyte' (white blood cell marker) may be a normal finding because of the high proportion of older people that have bacteria in the urine. Often, if a resident has a positive dipstick result and has non specific symptoms, such as had a fall or is drowsy, they are inappropriately diagnosed with a UTI. The real diagnosis may be missed and the resident may receive antibiotics unnecessarily.

### Antibiotics: More Harm than Good?



Antibiotics are powerful and precious drugs. Bacteria can develop antibiotic resistance. This means that antibiotics won't work when a person really does need them and these resistant bacteria can spread very easily in a care home setting. Side-effects, such as rashes and stomach upset are common in older people receiving antibiotics. A life-threatening infection called *C.difficile* diarrhoea (or '*C.diff*') can be caused by antibiotics. Everyone has a responsibility to protect antibiotics and they should only be used when there is strong evidence of a bacterial infection.

### To Dip or Not to Dip Pathway



In the pathway, urine dipsticks are not used, instead care home staff use a UTI Assessment Tool which focuses on the signs and symptoms of the resident and what actions to take. The tool was developed with specialist healthcare professionals and care home staff and is based on best practice guidelines. Obtaining a urine sample in residents with suspected UTI is very important to enable the best, and safest, antibiotic to be chosen.

**Questions? Please Contact the Care Home Manager.**

In partnership with Public Health  
Nottinghamshire County Council



*'To Dip or Not to Dip' is an original quality improvement project by Elizabeth Beech and Mandy Slatter (NHS Bath and North East Somerset CCG) and is based on the Scottish Antimicrobial Prescribing Group Decision Aid for Suspected UTI in Older People 2016.*





## Assessment tool: Guidance for care home staff regarding older people (>65 years) with suspected UTI

Complete resident's details, flow chart and actions (file in resident's notes). **DO NOT PERFORM URINE DIPSTICK (unless requested by GP\*)**

Resident:..... DOB:..... Completed by:..... Date:..... Care Home:.....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">Any symptoms suggesting alternative diagnosis?</th> <th style="text-align: center;">Tick if present</th> </tr> <tr> <td>Respiratory: shortness of breath, cough/sputum, new chest pain</td> <td></td> </tr> <tr> <td>Gastrointestinal: nausea/vomiting, new abdominal pain/cramps, new onset diarrhoea.</td> <td></td> </tr> <tr> <td>Skin/soft tissue: new redness, warmth, swelling, purulent drainage (pus).</td> <td></td> </tr> </table>	Any symptoms suggesting alternative diagnosis?	Tick if present	Respiratory: shortness of breath, cough/sputum, new chest pain		Gastrointestinal: nausea/vomiting, new abdominal pain/cramps, new onset diarrhoea.		Skin/soft tissue: new redness, warmth, swelling, purulent drainage (pus).		<div style="border: 2px solid orange; padding: 10px; text-align: center;"> <b>UTI unlikely.</b>          Phone GP practice for advice on management.       </div>
Any symptoms suggesting alternative diagnosis?	Tick if present									
Respiratory: shortness of breath, cough/sputum, new chest pain										
Gastrointestinal: nausea/vomiting, new abdominal pain/cramps, new onset diarrhoea.										
Skin/soft tissue: new redness, warmth, swelling, purulent drainage (pus).										

New Problem	Tick if present
Inappropriate shivering/chills OR temperature < 36°C or >38°C. If measured document.....°C	
Lower back pain (flank/kidney pain)	
New or worsening confusion or agitation	

**Does the person have a catheter?**

YES      NO

UTI possible – Actions needed	Tick when done
Obtain <b>urine sample</b> and arrange <b>catheter change</b> if catheterised: see reverse of form.	
Phone GP practice for advice on management.	
Encourage fluids.	

New Problem	Tick if present
Pain on passing urine	
Need to pass urine urgently OR new or worsening incontinence	
Need to pass urine much more often than usual	
Lower abdominal or back pain (suprapubic or flank/kidney pain)	
Blood in urine	
Inappropriate shivering/chills OR temperature <36°C or >38°C. If measured document.....°C	
New or worsening confusion or agitation	

**1 OR MORE TICKS**

→

**2 OR MORE TICKS**

→

**UTI unlikely**

If concerned about resident, please seek guidance from GP practice OR 111 out of hours

**NO TICKS**

→

**LESS THAN 2 TICKS**

→

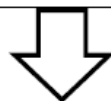
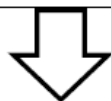
**Could it be SEPSIS**

Slurred speech, Extreme shivering/muscle pain, Passing no urine in 18 hours, Severe breathlessness, "I feel like I might die", Skin mottled/discooured?

**Get medical help immediately!<sup>3</sup>**

## Obtaining a Urine Sample in Patients Assessed to have Symptoms of a UTI

### Residents with urinary catheters: sampling and changing catheter



#### For Nursing Residents

- Only an **appropriately trained person** must take catheter urine sample, using aseptic non-touch technique.
- If antibiotics are prescribed for UTI, catheter change should be performed by an **appropriately trained person** where possible before antibiotics are commenced.

#### For Residential Residents

- Contact **Community Nursing Service** 0300 323 3316 to arrange for a sample to be taken.
- If antibiotics are prescribed for UTI, catheter change should be arranged with **community nurse** where possible before antibiotics are commenced.

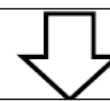
**Prior to prescribing antibiotics to treat a UTI clinicians should carry out a full clinical assessment to review medical history, physical examination, pulse, BP, temperature & symptoms<sup>4</sup>. As a minimum this information could be acquired following a telephone consultation with the patient and/or main carer. A face-to-face review must be completed in cases of uncertain diagnosis. Results of dipstick testing must not be used to diagnose a UTI in patients 65 years and older.**

Follow the Greater Manchester Antimicrobial Guidelines when prescribing antibiotics for UTI<sup>5</sup>."

#### References

1. NHS Nottingham, UTI assessment form. Guidance for Care Home Staff
2. SIGN 88: Management of suspected bacterial urinary tract infection in adults July 2006 (updated July 2012)
3. The UK Sepsis Trust – Sepsis symptom card.
4. NICE (2015) QS90 Urinary tract infections in adults
5. Greater Manchester Antimicrobial Guidelines November 2017 access via [www.gmmmg.nhs.uk](http://www.gmmmg.nhs.uk)

### Residents without a urinary catheter: obtaining a urine sample



#### Urine cultures are very important in the elderly to guide antibiotic choice

- Try to obtain a urine sample, in a clean single use container, when the resident is in the middle of passing urine (rather than at the start).
- Collect the urine in a sterile sample container e.g. Green urine monovette tube.
- Fill in the resident's details and type of sample carefully to help the lab to process it.
- Samples should be taken to the GP practice as soon as possible. If there is a delay, they can be refrigerated until taken to the GP practice at the next available opportunity.
- Ensure that the GP practice know that the patient's symptoms must be reported on the form submitted to the lab.

**\*In certain circumstances the GP may request a dipstick test in order to exclude a UTI with a **negative result**. Diagnosis of UTI should be based on clinical assessment and symptoms NOT on a positive result.**





## Appendix 7

# Winter Readiness Pack – Infectious Diseases

Further detailed information on Infectious Diseases particularly related to:

- winter readiness - flu and norovirus
- infection prevention and control
- recognition and management of outbreaks is available on

<https://www.england.nhs.uk/south/info-professional/public-health/infection-winter/>

Please ensure all your staff are familiar with this Care Home Pack and the online Winter Readiness Pack