



West Lothian
Council



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Procedures on Control of Infection in the Workplace

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PLEASE NOTE:

This document is published on the council website via My Toolkit – Access to HR Services (<http://webwest1/mytoolkit.html>).

Responsibilities

Chief Executive

The Chief Executive is responsible for:

- The implementation of the Council's procedures regarding Control of Infection at Work
- Ensuring all services within the Council follow the procedure
- Ensuring all employees and others who may be affected by their acts or omissions are protected.

Heads of Service

All Heads of Service should ensure that where required:

- Services under their remit have appropriate written procedures in place in relation to control of infection in the workplace
- All employees under their remit who could be affected by infections at work have been made aware of the Control of Infection procedures
- Suitable and sufficient arrangements are in place to provide information, training and supervision in all aspects of control of infection in the workplace
- Procedures are in place for identifying employees who may be at risk from specific sources of infection
- Procedures are in place for assessing and reviewing the use of recommended control measures
- Arrangements are in place to ensure that any personal protective equipment required is suitable for the task, is supplied and is regularly and properly maintained
- Suitable arrangements are in place to ensure appropriate health surveillance is carried out, where required, e.g. following significant exposure to potential source of infection
- Arrangements are in place for ensuring that Occupational Health are notified of employees who may require appropriate immunisation.

Service Managers

Service managers are responsible to their Heads of Service for:

- Implementing this Procedure
- Ensuring there is, at all times, compliance with the procedures
- Assist the Heads of Service in the implementation of their responsibilities.

Unit Managers

Unit managers are responsible to their Service Managers for:

- Implementing this Procedure
- Ensuring there is, at all times, compliance with the procedures.

Health and Safety Manager

The Health and Safety Manager, in conjunction with the Occupational Health Unit, will:

- Keep the Council informed of any changes to best practice guidance
- Review and update the procedures as necessary.

Responsibility of Employees

All Employees must:

- Cooperate with their manager to help implement control measures for matters under their control
- Refer matters beyond their control to appropriate contacts identified in this document and to their manager
- Report infection-related sickness absence to their manager.

Introduction

Infectious agents of many kinds are carried by everyone, and are ever-present in the environment around us. Most are benign, dormant or harmless, but a few represent a very real threat to health and create a major challenge to care providers.

The purpose of this document is to provide practical guidance on procedures to help minimise the risk of infection amongst staff and service users by ensuring good standards of basic hygiene, universal infection control procedures, and by providing staff with appropriate training and equipment.

Managers should draw up local procedures, particular to individual units or services, as necessary. The requirement for such procedures are dependent upon the indications of the risk assessment, for example, where there is known infection or high level risk that represents an assessed hazard. Local procedures must be updated regularly to reflect changing guidance.

Examples included in this procedure are not meant to be exhaustive or specific to your service area, however, the principles of infection control should be consistent and adopted in accordance to individual risk assessment and local procedures.

Sources of Infection

Biological agents such as bacteria, viruses, fungi and parasites cause infection. The natural environment contains enormous numbers of these micro-organisms, most of which are harmless and in some cases are beneficial.

The main sources of infectious (pathogenic) agents include:

- blood and other body fluids such as saliva
- human or animal waste products such as faeces, urine and vomit
- respiratory discharges such as coughs and sneezes
- skin contact with contaminated surfaces
- contaminated food or water.

Transmission of Infection

To cause infection the infectious agent must enter a host by some route. The most common routes are:

- Ingestion – for example, eating/drinking contaminated food/water or from dirty hands
- Inhalation - for example, breathing in air contaminated by coughs, sneezes, dust, spray
- Broken skin - for example, cuts, abrasions, eczema, puncture wounds caused by needles
- Permeable membranes - for example, in the eye, nose, mouth can let fluids through.

Resistance to Infection

Humans have evolved to defend themselves against infection. Unbroken skin provides an effective barrier. The linings of the mouth, throat, gut and airways are also adapted to exclude harmful materials.

If infectious agents pass these barriers the body's second line of defence is its immune system. Specialised cells multiply to destroy intruding micro-organisms. Symptoms of disease such as rashes or fevers are signs of this activity.

Immunity varies between individuals. It can be enhanced by previous exposure to infection or by immunisation, but can be depressed by illness, fatigue, stress etc.

Principles of Infection Control

Once in the body, micro-organisms can multiply rapidly if conditions suit them. Infection control is therefore not simply a matter of minimising the quantity of agent entering the body, which is the principal strategy for chemicals.

Infection can only develop if there is a source, transmission route and a suitable host. Infection control techniques seek to eliminate one or more of these three factors:

Source of infection can be eliminated by decontamination techniques using heat (boiling water, autoclave, etc) or chemicals (detergent, disinfectants, etc);

Transmission routes can be blocked by hygiene procedures and/or isolating infected individuals;

Potential **host** individuals can be protected by their own inherent immunity or immunisation procedures.

Decontamination

Decontamination is a general term that means the removal or destruction of pathogenic organisms by a number of methods:

- **Cleaning** is used for items that have been in contact with intact skin or as a prerequisite for disinfection or sterilisation. Cleaning removes soiling, dirt and grease, on which organisms multiply, and some organisms that can survive in dry conditions. This is usually achieved by the use of hot water and neutral detergent.
- **Disinfection** is used on items that do not penetrate the skin but are in contact with mucous membranes or non-intact skin or for low-risk items contaminated with a virulent organism. Disinfection is the partial removal or destruction of organisms except spores. This can be achieved by the use of disinfectant or sanitiser.
- **Sterilisation** is used on items in contact with broken skin/ mucous membranes or introduced into sterile body areas. Sterilisation is the complete removal or destruction of all organisms including spores. This can be achieved by the use of an autoclave (moist heat), gamma irradiation, or chemicals, e.g. ethylene oxide.
- **Single-use items** must not be re-used and there should be no attempt to decontaminate them as there are increased risks of incomplete decontamination, as the item is not manufactured to be decontaminated or possible failure of the item in use, as the decontamination may weaken the structure of the item. If single-use items are decontaminated and re-used, then the product liability is taken on by the persons who decontaminate and re-use.
- **Antiseptic** is a term used for non-toxic disinfectants which are applied to the skin or living tissue.

N.B. If detergents, disinfectants, etc are used, please follow the manufacturers instructions and ensure it is effective against bacteria and viruses, and suitable for use on the affected surface.

Risk Assessment

Groups of employees particularly at risk from infection include those whose activities involve:

- direct skin contact with other people and/or body fluids (e.g. care workers, environmental health officers)
- working with unpredictable people who may bite, scratch, spit, etc
- exposure to human or animal waste or things contaminated by it (e.g. cleaners, pest control officers and dog wardens)
- exposure to contaminated sharps (e.g. care workers, refuse collectors, road workers, NETS and land services workers)
- working with animals, soil or contaminated water (e.g. park rangers, environmental health officers).

Managers must ensure risks assessments have been completed, and where necessary, include appropriate control measures and that local procedures are in place to address infection control needs specific to their service area and/or working activity.

Managers must provide relevant employees with safe working procedures to control these risks in accordance with this procedure.

Please refer to the Council's "Needlestick/Sharps Injuries Procedures" via My Toolkit – Access to HR Services (<http://webwest1/mytoolkit.html>) for further information.

Immunisation

Decontamination and barrier hygiene precautions are preferred to precautionary immunisation because:

- They protect against infections for which there is no vaccine
- Immunisation creates its own health risks
- Post-infection treatments may be safer.

Where a risk assessment determines that decontamination and barrier hygiene precautions may be defeated precautionary immunisation should be considered. **Competent medical advice must be obtained in such cases.** As appropriate, please contact the Occupational Health Unit on 01506 777 155 for further advice.

Hand Care

Hand washing is the single most important procedure for the prevention of cross infection and forms the basis of all universal precautions.

Mandatory Procedures

- Any cuts or abrasions must be covered by an impervious waterproof dressing whilst at work.
- Staff who develop skin conditions resulting in cracked skin or open sores must seek medical treatment as soon as possible and take advice as to whether they are fit to continue undertaking the type of work they are required to do.
- Staff should be aware that a skin irritation could be an allergic reaction to supplied protective gloves or the powder within them, or to a particular brand of gloves, and should seek advice from the Occupational Health Unit.

It should be noted that managers have a responsibility to provide a range of gloves as an alternative e.g. vinyl gloves.

LATEX GLOVES SHOULD NOT BE PROVIDED due to its high prevalence of skin irritation and is not recommended for use by the Health and Safety Executive.

- Appropriate protective gloves must be worn when handling household chemicals or body products.
- Hands should be washed:
 - On arrival and leaving a job task or work place
 - After using the toilet, coughing, blowing nose
 - After handling potentially contaminated articles
 - Before and after meal breaks
 - Before and after preparing or assisting with food
 - When hands are visibly dirty
 - After removing gloves.

N.B. Wearing protective gloves is not an alternative to hand washing.

- Hands should be dried thoroughly on paper towels. The use of cotton towels are not recommended due to the risk of cross-contamination. Wet hands transfer micro-organisms more effectively than dry ones and organisms can be removed by friction from the paper towel.

Practice Guidance

- Proper hand washing involves the use of hot water with soap or liquid soap on hands that are already wet. Particular attention should be paid to the thumbs, the tips of fingers and the skin and webs between the fingers. See hand-washing diagrams in Annex A for the recommended technique. For routine hand washing, soap and hot water is sufficient.
- Alternatively, apply an alcohol based hand rub or antiseptic gel if soap and water is not available.
- Nail varnish, false nails and jewellery should be avoided and where possible should be removed when washing your hands.
- Staff routinely performing personal care tasks should keep their nails cut short.
- Short sleeves or long sleeves (which can be rolled up) should be worn as long sleeves deter thorough hand decontamination.

Infectious Conditions

Mandatory Procedures

- Staff who believe they are infectious must seek advice specific to the type of work they do from their GP or Occupational Health Unit before undertaking any duties involving direct contact with a person or animal. Staff should consult their line managers about any difficulties.
- Staff working with a known person or animal with a particular infectious condition must seek advice from a relevant health care professional about any additional precautions needed. A risk assessment should be completed by a competent person where the risks are recognised and the precautions to be taken are noted.

Practice Guidance

- Staff with psoriasis, eczema or other exfoliating skin conditions should take extra precaution when undertaking personal care tasks and wear personal protective equipment (PPE) to ensure exposed areas are covered up, as appropriate.
- Baths/showers used by people other than the person with an infectious condition must be thoroughly cleaned after use with a neutral general-purpose detergent.
- A disposable apron must be worn in circumstances when the organism could transfer on to clothing and be carried to another person.
- After each contact with an infectious source, hands must be carefully cleaned according to the hand washing protocol and any PPE should be disposed of and changed between clients, that is, aprons/gloves.
- Some diseases are notifiable. Under the Public Health (Control of Diseases) Act 1984 and Public Health (Infectious Diseases) Regulations 1988, doctors in Scotland have a statutory duty to notify the Consultant in Public Health Medicine at the local Health Board if they are aware that, or have cause to suspect that, a patient is suffering from one of the notifiable diseases.

The list of notifiable diseases can be found on the Health Protection Agency's website at:
http://www.hpa.org.uk/infections/topics_az/noids/menu.htm. Some of these diseases can be found in Annex B.

Handling of Body Products

Whilst blood poses the greatest risk, all body products i.e. blood, vomit, urine, faeces, sputum and saliva, carry some risk of infection. Staff must follow universal precautions i.e. they must treat all body product as if it were infected.

Mandatory Procedures

- When undertaking tasks or handling soiled material where hands or clothing could be contaminated by a body product, staff must wear a disposable plastic apron and gloves.
- Individuals who are soiled with a body product must wash themselves or be washed with plenty of warm soapy water, with disposable cloths. As an alternative or where sanitary facilities are not always available, an alcohol based rub or antiseptic wipes can be used, until you are able to wash properly with warm water.
- In domestic settings, soiled bed linen and clothing must be contained separately in a plastic bag, before being separately machine washed using a cool pre-wash and a hot wash cycle or if other laundry procedures are in place, staff should bag it separately to await collection.
- Any spillage must be covered with sufficient disposable paper towels or cloths to absorb it. Disposable gloves and aprons must be worn. Paper towels or cloths should be disposed of safely (refer to Annex C for further information) and the area should then be thoroughly cleaned with a suitable cleaning product.

Where the use of the cleaning product is inappropriate e.g. on carpet or fabric, plenty of warm soapy water should be used instead. Please refer to the "Disposal of Waste" section for further information.

- Managers must ensure that the necessary equipment is available to deal with spillages in offices, depots or similar establishments.

Practice Guidance

- Staff must remember that fingernails and rings can tear gloves and should take care that such damage does not occur.

Disposal of Waste

Waste contaminated by body products should be disposed of safely and in accordance with current legislation and guidance.

Mandatory Procedures

- All waste contaminated by body products must be disposed of promptly.
- Liquid waste, faecal matter and vomit must be flushed down the toilet or sluice if available.
- Solid waste e.g. paper towels used for spillages, used protective gloves, aprons etc must be placed in a plastic bag, such as a bin liner or carrier bag and then placed in a second plastic bag. This, in turn, must be tied and disposed of through the normal refuse collection. Care must be taken that the bags are not subsequently punctured, are safely contained prior to collection and that the risk of spillage on transfer is minimised.
- In domestic settings, waste resulting from clinical procedures performed by care assistants e.g. dressings, catheter bags etc., must be double bagged and disposed of as described above, unless the relevant health care professional makes other arrangements.
- In other establishments, a local protocol for disposal must be established following a risk assessment. For instance:
 - Medical waste i.e. incontinence pads, wipes and protective gloves (soiled) will go into yellow bags.
 - Clinical waste i.e. gloves, aprons, protective gloves (unsoiled) will go into the specified, separate bins.
- The disposal of needles and other sharps is the responsibility of the care professional or self-medicating user concerned must be disposed of using a BS standard sharps container.

Accidents and Similar Incidents

Not all situations can be anticipated and staff should be alert and exercise their common sense, in addition to following established procedures. Please refer to the Council's "Needlestick/Sharps Injuries Procedures" via My Toolkit – Access to HR Services (<http://webwest1/mytoolkit.html>) for further information.

Mandatory Procedures

Where body or waste products come into contact with intact skin, they must be washed off with warm water and soap as soon as possible. No further action is necessary. However, action must be taken if:

- The skin is broken by a bite or scratch
- The skin is breached by a sharp object contaminated by body fluids
- The body fluids are splashed onto broken skin, mucous membranes or the eyes.

In these circumstances, the affected part must be washed immediately and thoroughly with soap and copious quantities of running warm or cold (not hot) water. Any bleeding should be encouraged. In the case of eyes, they should be flushed with lukewarm water, saline or a proper eye-wash solution.

The accident must be reported to a manager as soon as possible and an incident form completed. This should include details of the nature of the incident and whether the skin was broken or mucous membranes contaminated.

A medical professional at your General Practice or St John's Hospital must inspect the wound, as soon as possible and certainly on the same day. If the source is known to have an infectious condition this should be communicated to the health professionals inspecting the wound.

Practice Guidance

Accidents may well involve broken glass or other sharp objects. Be careful to protect the skin from cuts and punctures. Gloves do not protect against such injuries.

Emergency intervention or urgent first aid may require action before proper protective clothing can be put on. Contact with body or waste products should be kept to a minimum and washed off the skin at the earliest opportunity.

Infestations

Mandatory procedures

- In the case of infestation, such as fleas, staff must take reasonable precautions to prevent the spread of infestation. It is recognised that infestation can occur within any establishment. It may be more prevalent in buildings that have been occupied by pets or have been vacant for a period of time or buildings that are considered dirty. In such cases, staff should wear appropriate protective equipment.
- If significant infestation is noted within a private dwelling which staff are required to enter, the owner should be asked to arrange treatment from Pest Control prior to any work taking place. Pest Control can carry out treatment within offices, houses and vehicles and do not charge for treatment carried out in domestic premises.
- A risk assessment must be completed to indicate the level of risk to both staff and users of the establishment.

Food Hygiene

Staff must conform to the requirements of the Food Hygiene Regulations 1995 and the Food safety Act 1990. All new staff involved in the handling of food should complete a food hygiene module within their induction programme.

Further information relating to the aforementioned regulations can be obtained via line management.

Practice Guidance

Training and advice on food hygiene is an integral part of induction training for all food handlers.

Refresher training should also be carried out in accordance to food handling guidelines.

Personal Protective Equipment (PPE)

Uniforms where provided should be worn at all times and PPE should be used in addition to normal work clothing. PPE is not a substitute for safe systems of work but is complimentary to it.

Practice Guidance

- Gloves must be worn at all times as they provide a reliable method for reducing the acquisition of micro-organisms. They are single use items and when removed, should be disposed of as clinical waste. Gloves should be changed between tasks or different working activities. The wearing of gloves does not remove the need for hand washing as the integrity of gloves cannot be taken for granted and hands may also become contaminated during their removal.
- Disposable plastic aprons should be worn where there is a risk that clothing or uniform may become exposed to blood, body fluids, secretions and excrement, with the exception of sweat. They should be also used when working with materials or equipment that may lead to contamination of their clothing and uniform. Plastic aprons should be worn as single use items for one procedure or activity then discarded and disposed of as clinical waste.
- Eye protection should be worn when reconstituting and using disinfectants, if there is a risk of splashing. They should also be worn if there is a risk of bodily fluids or other contamination splashing into the eyes.
- Facemasks should be worn when there is a risk of transferring infection to an open wound or a client with reduced immunity. If required, this will be advised by the line manager. A facemask could also be used to help mask noxious, unpleasant smells.
- Other PPE may be issued as identified by the risk assessment, such as arm protectors. The same regulations relating to their disposal as clinical waste still applies (refer to "Clinical Waste" section).
- In all cases of PPE, including gloves, they should be used in accordance with the manufacturer's instructions and having regard for any limitations of that product.

To maintain their original non-porous performance gloves should be:

- Used within their specified limits
 - Used within their shelf life
 - Stored in cool, dark, conditions
 - Changed when damaged
 - Extreme temperatures must be avoided.
- Advice on glove selection can be found in Annex D and on the Health and Safety Executive website:

<http://www.hse.gov.uk/latex/pdf/gloveselection.pdf>

Specialist Advice

Practice Guidance

Where these procedures do not appear to cover a situation or where staff continues to have concerns they should be discussed with their line manager and advice should be sought from:

- Health and Safety (01506 777 153)
- The Occupational Health Unit (01506 777 155).

External Support Services

- Health Protection Agency

Health Protection Scotland
Clifton House
Clifton Place
Glasgow
G3 7LN
Tel: 0141 300 1100
Fax: 0141 300 1170
Email: hpsenquiries@hps.scot.nhs.uk

- Environmental Health Agency

Scottish Environmental Protection Agency
SEPA Corporate Office
Erskine Court
Castle Business Park
Stirling
FK9 4TR
Tel: 01786 457700
Fax: 01786 446885

- Health Board

Lothian NHS
Deaconess House
148 Pleasance
Edinburgh
EH8 9RS
Tel: 0131 536 9000
Fax: 0131 536 9164

Pregnant Workers

Some infections, if caught by a pregnant woman, can pose a danger to her unborn baby. These infections include:

- **Chickenpox (Varicella)**

This can affect the pregnancy of a woman who has not previously had the disease. If a pregnant woman is exposed early in pregnancy (the first 20 weeks) or very late in pregnancy (the last three weeks before birth) she should promptly inform her GP and whoever is giving her antenatal care so a blood test can be taken to check her immunity. Please note, shingles is caused by the same virus as chickenpox; anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.

- **German measles (Rubella)**

If a pregnant woman who is not immune to rubella is exposed to this infection in early pregnancy her developing baby can be affected. Female staff should be able to show evidence of immunity to rubella or, if that is not available, have a blood test and, if appropriate, immunisation. If a woman who may be pregnant comes into contact with rubella she should inform her GP promptly.

- **Slapped cheek disease (Parvovirus B19)**

Occasionally, parvovirus can affect an unborn child. If a woman is exposed early in pregnancy (before 20 weeks) she should promptly inform whoever is giving her antenatal care as this must be investigated promptly.

- **Measles**

During pregnancy, this can result in early delivery or even loss of the baby. If a woman is exposed to measles, immediately inform whoever is giving antenatal care to ensure appropriate investigations.

If there is a pregnant worker within your service area or you are completing a pregnancy risk assessment, you may wish to advise the person of the above information.

Additionally, if an employee has a known infectious disease, consent must be obtained to advise the pregnant woman that there is a co-worker with a potential infectious disease. If the pregnant worker remains concerned, she may wish to seek further medical advice and reassurance from her General Practitioner or midwife.

Monitoring and Review

This procedure will be reviewed from time to time and as necessary by the Council, in consultation with the recognised trade unions and other relevant parties, as determined by the Council.

Annex A – Hand Hygiene Factsheet

An effective hand hygiene policy can reduce the risk of spread of infection. The procedure reflects the principles of good practice related to hand hygiene, developed by 'The EPIC Project: Developing National Evidence based Guidelines for Preventing Healthcare Associated Infections' commissioned by the Department of Health (England).

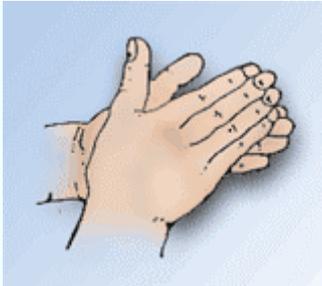
Induction programmes for all staff should include a hand hygiene procedure:

- a) Hand decontamination must take place immediately before and after every episode of direct contact/ care or any activity that potentially results in hand contamination.
- b) Use of liquid soap and water for hands visibly soiled or potentially contaminated with dirt or organic material.
- c) Use of alcohol-based hand rub or hand washing with liquid soap and water to decontaminate hands between different caring activities or job tasks.
- d) Removal of all wrist and, ideally, hand jewellery before regular hand decontamination begins.
- e) Covering all cuts and abrasions with a waterproof dressing. Food handlers should use blue waterproof dressings.
- f) Effective hand washing including:
 - Wetting hands under tepid running water before applying liquid soap
 - Hand wash solution must come into contact with all surfaces of hands
 - Vigorous rubbing of hands for minimum of 10-15 seconds with particular attention to tips of fingers, thumbs and between fingers
 - Thorough rinsing
 - Drying with good quality paper towels.
- g) Effective alcohol hand rub technique:
 - Use only on hands free of dirt and organic material
 - Hand rub solution must come into contact with all surfaces of hands
 - Vigorous rubbing of hands, with particular attention to tips of fingers, thumbs and between fingers, until the solution evaporates and hands are dry.
- h) Application of an emollient hand cream regularly to protect skin from drying effects of regular hand decontamination.
 - i) Access to staff health advice in the event of skin irritation caused by a particular soap, hand hygiene or alcohol product.

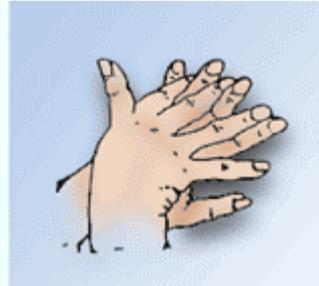
Recommended Hand Washing Technique

Figure 1: The six step hand wash technique

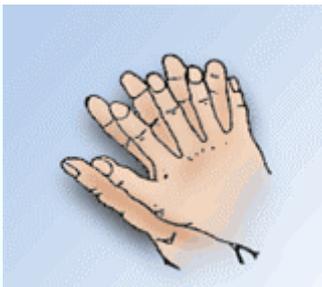
For each step, use five forward strokes and five backward strokes.



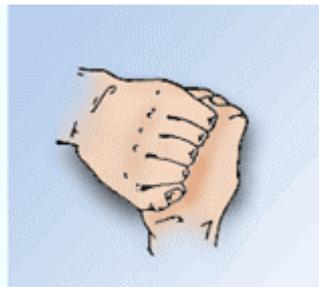
1. Rub your hands together palm to palm.



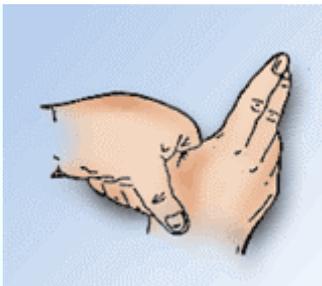
2. Rub your right palm over the back of your left hand, and then your left palm over the back of your right hand.



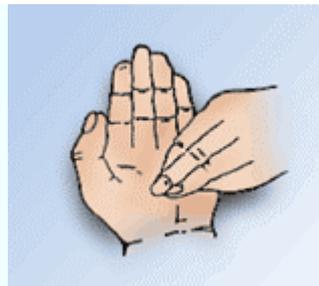
3. Rub your hands together palm to palm with your fingers interlaced.



4. Rub your left fist in your right palm, and then your right fist in your left palm.



5. Rotate your right thumb in your left palm, and then your left thumb in your right palm.



6. Rub your right fingers in your left palm, and then your left fingers in your right palm.

N.B. Don't forget to wash your wrists

Annex B – Incubation Period, Communicability and Suggested Exclusion Criteria for Communicable Diseases

Key: CPHM - Consultant in Public Health Medicine

GENERAL INFECTIONS

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease ¹
Chickenpox / Shingles	15 – 18	From 1 - 2 days before and up to 5 days after the appearance of the rash	5 days from onset of rash (until spots are dry)	No
Conjunctivitis (viral or bacterial)	3 – 29 days, but depends on cause	Whilst eye is red and discharging	Until treatment has begun and inflammation has started to resolve	No
Diphtheria	2 – 5 days	Whilst the organism is present in nose, throat or skin lesions	Until advised by the CPHM or GP	Yes
German Measles (Rubella)	14 - 21 days	From 7 days before to 5 days after onset of rash. Most infectious 1 – 3 days before onset	5 days from appearance of rash	Yes
Glandular Fever	28 – 42 days	Once the symptoms have subsided risk is small apart from very close contact i.e. kissing	Until clinical recovery	No
Hand, Foot and Mouth Disease	3 – 5 days	Usually while symptoms persist	Until clinically well – presence of rash does not usually indicate infectivity	No

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease¹
Hepatitis B	45 – 180 days	Some weeks before and variable period after onset of symptoms	Until advised by the CPHM or GP	Yes
Hepatitis C	14 – 42 days	About 7 days and variable period after the onset of symptoms	Usually none if clinically fit	Yes
Human Parvovirus (Fifth Disease/Slapped Cheek)	6 – 14 days	For 7 days before the rash appears and a few days after	Until clinically well. Pregnant contacts should seek medical advice	No
Leptospirosis	2 – 30 days	Symptoms usually develop 7-12 days after initial infection with leptospire	Usually none if clinically fit	
Measles	10 – 15 days	From a few days before to 4 days after onset of rash	4 days from onset of rash	Yes
Meningitis including Meningococcal Disease	2 – 10, dependent upon causative organism	Whilst organism is present in the nose and mouth	Until clinical recovery	Yes
Mumps	12 – 21 days	From a few days before the onset of symptoms to subsidence of swelling	Until swelling has subsided or when clinically recovered	Yes
Streptococcal Illness (e.g. Scarlet Fever and Tonsillitis)	1 – 3 days	Whilst organism is present in nasopharynx or skin lesion	Until clinical recovery or 48 hours after antibiotic treatment starts	Yes
Tuberculosis	25 – 90 days	Whilst organism is present in sputum. Usually non-infectious 2 weeks after starting treatment with standard antitubercular drugs	On the advice of the CPHM and Exclude until treatment has been commenced and found to be effective	Yes
Whooping Cough (Pertussis)	10 – 14 days	Less than a week after exposure and if treated with antibiotics to 21 days if not treated with antibiotics	21 days from onset of paroxysmal cough or 5 days after commencement of antibiotics	Yes

GASTRO-INTESTINAL ILLNESS

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease¹
Campylobacter	1 - 10 days	Whilst organism is present in stools, but mainly until diarrhoea has ceased for 24 - 48 hours	Until clinically fit and diarrhoea-free for 48 hours	No
Cryptosporidiosis	3 – 11 days	Variable, usually while diarrhoea present. 2 – 4 weeks from onset of symptoms	Until clinically fit and diarrhoea-free for 48 hours	No
E Coli 0157	1 – 6 days	Whilst organism is in stool, but much more infection while symptomatic	Until clinically fit and diarrhoea-free for 48 hours	Yes
Giardiasis	5 – 25 days	Whilst cysts are present in the stools, but mainly while diarrhoea is present	Until free from symptoms for 48 hours	No
Hepatitis A	15 – 50 days	From 7 - 14 days before to 7 days after onset of symptoms	7 days from onset of symptoms e.g. jaundice and when clinically fit with no symptoms	Yes

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease¹
Poliomyelitis	3 – 21 days	Whilst virus is present in stools	Until advised by the CPHM or GP	Yes
Salmonella (Food Poisoning)	1 – 5 days, but varies depending upon cause	Variable, usually while diarrhoea present	Until clinically fit and diarrhoea-free for 48 hours	Yes
Shigella (Bacillary Dysentery)	1 – 7 days	Whilst organism present in stool but much more infections while symptomatic	Until clinically fit and diarrhoea-free for 48 hours	Yes
Threadworm	14 – 30 days	Whilst eggs are being produced	None	No
Typhoid and Paratyphoid Fever	7 – 21 days	Whilst organism is present in stools or urine	On the advice of the CPHM and until clinically fit	Yes

SKIN INFECTIONS

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease¹
Viral Gastroenteritis (e.g. Norovirus)	4 hours – 4 days depending upon causative organism	Varies according to virus	Until clinically fit and until symptom free for 48 hours	No
Impetigo (Streptococcus pyogenes and Staphylococcus aureus)	4 - 10 days, but can occur several months after colonisation	Whilst lesions remain moist or until 48 hours after starting antibiotic	Until 48 hours after starting antibiotics	No
Pediculosis* (Head Lice)	Lice eggs hatch in a week and reach maturity in 8 - 10 days	As long as eggs or lice remain alive	Until after treatment has been undertaken	No
Ringworm of the body* (Tinea / Trichophytosis)	4 - 10 days	As long as active lesions are present	None	No
Ringworm of feet (Athlete's Foot)	10 - 14 days	As long as lesions are present	None	No
Ringworm of the scalp* (Tinea / Trichophytosis)	10 - 14 days	As long as active lesions are present	None	No
Scabies*	14 – 42 days, but with re-exposure only 1 - 4 days	Whilst live mites are present	Exclusion only necessary for 24 hours after treatment. Close contacts (family and those who have had prolonged skin to skin contact will need treating at the same time as they may be incubating scabies	No

Disease	Usual incubation period (days)	Period of communicability	Minimum period of exclusion of staff at work	Notifiable disease ¹
Verrucae Plantaris (Plantar Warts)	2 - 3 months	Unknown, probably as long as lesion is visible	None	No

¹ To be reported to the CPHM by the GP or hospital doctor

* It is important that the rest of the family are checked for head lice, scabies and ringworm

Annex C – Spillages of Blood or Body Fluids Factsheet

Spillages of blood/body fluids should be dealt with immediately.

Persons unsure of how to deal with spills of blood and body fluids safely should seek advice before attempting to clean up.

How to deal with spillages of blood or body products other than urine or vomit:

- Put on disposable gloves and apron. Use eye protection if there is likely to be splashing
- **If using granules**, pour carefully over spillage until all visible liquid is soaked up
- **If using solution**, prepare a 1% available chlorine bleach solution
- Soak up spillage with disposable paper towels and carefully pour the bleach solution on the top until all of the paper is damp with solution
- Leave for two minutes and then clear up into secure, suitable waste bag(s)
- Wash area with general purpose detergent and hot water
- Place disposable paper towels, gloves and apron in suitable waste bag(s) and securely tie
- Wash hands thoroughly

How to deal with spillages of urine or vomit:

- Put on disposable gloves and apron. Use eye protection if there is likely to be splashing
- Using paper towels, remove all traces of visible spillage, placing towels into secure, suitable waste bag(s)
- Wash area with general purpose detergent and hot water
- Place disposable paper towels, gloves and apron in suitable waste bag(s) and securely tie
- Wash hands thoroughly

Annex D – A Guide to the Use of Aprons and Gloves

Where necessary, it is advisable for each service area to develop a guide specific for their use.

N.B. The suggested items should be disposable and used only once.

ACTIVITY	PLASTIC APRON	NITRILE /VINYL GLOVES	POLYTHENE GLOVES	HOUSEHOLD RUBBER GLOVES
Contact with intact skin and no visible blood/body fluids	-	-	-	-
Cleaning up spillage of blood/body fluids	X	X	-	-
Contact with human or animal waste	X	X	-	-
Skin contact with contaminated surfaces	X	-	-	X
Using disinfectants, cleaning agents	X	-	-	X
Contact with contaminated food or water	X	-	X	-



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