Communicable Disease Control Manual

For Schools and Other Childcare Settings In West Yorkshire

May 2012
PLEASE ENSURE ALL STAFF HAVE ACCESS TO A COPY OF THIS GUIDANCE
Acknowledgements

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Foreword

Every day approximately 340,000 children attend school and other childcare settings in West Yorkshire where they acquire knowledge and understanding of the world around them. It is also the place that provides a great learning opportunity for a child's immune system. During our early life we are exposed to a wide range of infectious diseases which is an unavoidable and necessary part of growing up. Vaccinations can only protect against a limited number of diseases, for the rest we must either be exposed to them and build up our own resistance or, if possible, avoid being exposed to them.

Infections can spread quickly in the childcare setting. Many will be minor and self-limiting; though unpleasant for the child, but if large numbers of children are affected then these infectious disease can be disruptive for teachers, parents and the school or nursery as a whole. Staff, as well as pupils, can be affected and vulnerable groups such as immunosuppressed children or pregnant members of staff may be placed at risk. Occasionally an outbreak of a more serious infectious disease may occur which requires specific public health intervention e.g. measles, meningitis.

This document is intended to be a practical guide for teachers and staff to use in any school or childcare setting. It provides information on a broad range of infectious diseases and the steps that can be taken to reduce their spread. I hope that childcare professionals find this booklet a useful source of practical advice and information for dealing with and preventing infections in their schools.

Dr Mike Gent
Interim Unit Director
West Yorkshire Health Protection Unit
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- Athletes Foot
- Chickenpox
- Hand, Foot and Mouth Disease
- Herpes Simplex (cold sores)
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Section 1

Introduction

This handbook has been compiled by the West Yorkshire Health Protection Unit for the use of individuals, schools and other childcare settings. The aim is to provide a comprehensive resource manual on the communicable diseases or infections that can commonly occur in the childcare setting environment and local procedures to be followed if there is a case of infectious disease. Communicable diseases refer to the diseases that can be transmitted from one person to another.

The first section outlines the basics of communicable diseases, local procedures for reporting cases, and brief notes on health of staff and vulnerable children. Specific guidance is given as to when the Consultant in Communicable Disease Control (CCDC) should be notified about cases of communicable disease in childcare settings and when children and staff should be excluded from school when they have a communicable disease.

The second section includes advice on preventative measures for infection control. Childcare settings are an ideal environment for the spread of communicable diseases. Control of infection in these settings depends upon good standards of personal and food hygiene, clean environments, immunisation and adequate care of sick children and staff. It is everybody’s responsibility to ensure that they are aware of procedures in regard to infection control and prevention.

The third section provides information for childcare settings on individual infections regarding prevention and transmission. The information may be useful to distribute to parents if an outbreak of infectious disease occurs in the childcare setting. When there is a problem with a particular disease in the childcare settings, the respective sheets can be photocopied and distributed following discussion with the West Yorkshire Health Protection Unit.

The fourth section includes outbreak management information for schools, nurseries and other childcare settings. This includes guidance and support on how to deal with large numbers of common infections including diarrhoea and vomiting and how to recognise and report an outbreak. References are included in section five.

The last section is the appendices. This includes a quick reference guide on exclusion periods for children affected by infectious disease and their contacts. There are useful telephone numbers, websites, and an audit tool for infection control.

The guidelines aim to prevent cases of communicable disease and their spread whilst interfering as little as possible with the attendance of children at their institute. It is important that the guidelines are carefully studied by all staff and that they are strictly observed.
The Consultant in Communicable Disease Control and Health Protection Nurses/Practitioner

- The West Yorkshire Health Protection Unit (WYHPU) is the local unit of the national Health Protection Agency and is staffed by consultants in communicable disease control and health protection nurse/practitioners.
- The Consultant in Communicable Disease control (CCDC) has statutory responsibility for the control of notifiable diseases and outbreaks within schools.
- The unit is concerned with all types of communicable diseases encountered within schools, and the wider community.
- The unit has a strategic role in the development of policies and protocols for the prevention, management and control of communicable diseases.
- The CCDC has the authority to require additional local notification of diseases.
- The unit is the main source of clinical advice to the Local Education Authority and local schools regarding the prevention of infection and exclusion of children and staff from schools.
- The unit acts as a source of specialist clinical advice to the school nurse/school doctor and head teacher.
- They may be called upon to advise on the exclusion of individual pupils on medical grounds.
- They will, when necessary, liaise with parents about infectious disease matters.
- They will organise any mass treatment or vaccination as necessary.
- They will coordinate the work of others in the control of communicable disease in schools.
- They will liaise with the media in the case of an infectious disease outbreak within a school, in consultation with the Local Authority and school(s) involved.
- The CCDC will inform the Chief Medical Officer through Regional structures of a significant outbreak of infectious disease.

Role of the West Yorkshire Health Protection Unit

The West Yorkshire Health Protection Unit consists of five teams working to control and prevent communicable and infectious diseases. Our work is mainly carried out in partnership with local hospitals, primary care trusts, local authorities and other providers of health services.

The Unit works closely with, and shares communicable disease control functions with, the council’s Environmental Health Teams in Bradford, Calderdale & Kirklees, Leeds and Wakefield.

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Basic Concepts in Communicable Disease Control

Communicable diseases can be spread in a variety of different ways.

1. **Aerosol (small droplet) Spread**
The organisms, which cause the disease, can be spread from the infected person via droplets in the air (caused by coughing or during close conversation) and then inhaled by another person. Examples of diseases spread in this way are colds, influenza (flu), measles and mumps.

2. **Direct Contact Spread**
Skin contact e.g. holding hands can cause the transmission of some contagious skin diseases and infestations such as ringworm and scabies. Head to head contact will also facilitate the transmission of head lice.

3. **Faecal/oral Route of Spread**
For some diseases, e.g. viral gastroenteritis and Hepatitis A, the infecting organism is excreted in the faeces (motions). The hands of an infected person may become contaminated after using the toilet, and can be spread to others through inadequate hand washing. Contaminated food or objects such as toys and flush handles can be routes for such transmission. The infecting organisms can then be transferred to the hands of others and subsequently to their mouths and so effective hand washing is crucial.

4. **Blood/Body Fluid Transmission**
Some communicable diseases cannot be transmitted to other people without direct transfer of body fluids, such as blood or semen, from an infected person into another person’s body. This can only be achieved by means such as injections or unprotected sexual intercourse. These diseases, which cannot therefore be transmitted through normal childcare activities, include Hepatitis B virus and the HIV virus, which is the cause of “AIDS”.

From the above, it should be noted that different diseases would need different infection control approaches to prevent their transmission within childcare settings.

Local Procedure for Reporting Communicable Diseases

Some diseases are termed as **notifiable** (see list of notifiable diseases on following page). This is a process whereby a doctor should notify the West Yorkshire Health Protection Unit (WYHPU) by completing an official notification form. However, some communicable diseases which are not notifiable may also have a public health impact when they are found in the school setting. Some examples of non-notifiable illnesses include:

- Chickenpox
- Shingles
- Scabies

If a childcare setting is informed by a parent that a child has been diagnosed with one of these infections, the overall manager of the establishment should seek advice by contacting the West Yorkshire Health Protection Duty Team on **0113 386 0300**

The following should also be reported promptly by telephone to the Duty Team on 0113 3860300:

a. An increased number of absences for the time of the year, due to illness in children or staff with similar symptoms.
b. Increased reports of vomiting and/or diarrhoea occurring in children or staff.
It is important to seek advice early, especially for infections which have the potential to cause an outbreak (e.g. measles, dysentery, food poisoning) or where an immunisation programme early in the outbreak may prevent some children developing the disease (e.g. Hepatitis A).

**Advice from School Nurses**

The School Nurse is the appropriate person with whom to liaise in matters concerning health and hygiene. Advice may also be requested directly from a member of the West Yorkshire Health Protection Unit Duty Team on 0113 3860300.

**The Law in Relation to Infectious Diseases**

All schools have legal duties, both as employers and as food providers. This is a guide to those duties and to the good practices that will protect the health, safety and welfare of employees, the children in your care, and any others affected by your business. Infectious diseases occur naturally and commonly in school settings. This is a result of the degree of close contact between pupils and between pupils and staff, and the difficulties in maintaining a perfect state of hygiene. Infections acquired in the school may spread to staff, family members and the community. Outbreaks of infection may lead to much disruption of school routine and costly control measures. The guidance given in the following sections is designed to prevent the introduction of infection into the school, where possible, and to limit its spread. Further information can be obtained from the WYHPU.

**Health & Safety at Work etc. Act 1974**

Regulations made under this Act:

- Control of Substances Hazardous to Health Regulations 2002 (COSHH)
- Electricity at Work Regulations 1989
- Health and Safety (First Aid) Regulations 1981
- Health and Safety Information for Employees Regulations 1989
- Management of Health and Safety at Work Regulations 1999
- Reporting of Injuries Diseases and Dangerous Occurrences Regulations
- (RIDDOR) 1995
- Workplace (Health, Safety and Welfare) Regulations 1999

**Food Safety Act**

Regulations made under this Act:

- Food Hygiene (England) Regulations 2006
- Regulation(EC) No 852/2004

**The Public Health Act**

The Public Health (Control of Diseases) Act 1984 and the Health Protection Regulations 2010 are the main pieces of legislation covering the management of Infectious diseases in England and Wales. Requirements under the Act include:

- Notification of diseases
- Surveillance of infectious diseases
• Control of the sale, use and disposal of infected items
• Control of premises affected by infectious diseases. This includes the
  requirement for cleaning and closure of premises
• Control of people through exclusion of affected persons from the workplace, school or home

Local Procedure for Reporting Communicable Diseases

Under the Health Protection (Notification) Regulations 2010 the doctor involved in diagnosing and treating an infectious disease is legally required to notify the CCDC at the Health Protection Unit once the disease is suspected. Schools are not involved in this formal process. However, we ask that head teachers contact the Health Protection Unit if they become aware of any infectious diseases in the school, so that appropriate control measures can be discussed.

Medical Exclusions and School Closures

Medical Exclusions
Parents should be requested not to send their children to school when they are ill; should pupils become ill during school hours parents or identified carer’s should be requested to take them home. When pupils are suffering from infectious diseases they should be excluded from school on medical grounds for the minimum periods recommended, by which time the majority will no longer be infectious. If there are difficulties relating to the need for medical exclusion due to varying advice from health professionals, individual cases should be referred to the CCDC who will arrange for the assessment of the individual situation and give the appropriate advice. The same guidelines apply to school staff. School meals staff are required to comply with the Food Safety legislation enforced by the Local Authority. Formal exclusion of pupils from school on medical grounds is enforceable by the head teacher, acting on behalf of the Local Authority or the managers or governors of a school. School doctors and nurses have no powers in the matter but the head teacher would be expected to act on professional advice. Recommended exclusion periods for individual infectious diseases are outlined in this document. Exposure to infectious disease is not normally a reason for medical exclusion. The CCDC will advise on those occasions when such exclusions are necessary.

In exceptional cases, when parents insist on the return of their child to school when the child still poses a risk to others, the CCDC (acting as the Proper Officer to the Local Authority) may insist that the child should not attend school until they no longer pose a risk to others. This is enforceable under Health Protection (Local Authority Powers) Regulations 2010, Regulation 2. – Requirements to keep a child away from school. In such a case the local authority has to be satisfied that:

• the child is or may be infected or contaminated;
• the infection or contamination is one which presents or could present significant harm to human health;
• there is a risk that the child might infect or contaminate others;
• keeping the child away from school is a proportionate response to the risk to others presented by the child.

In some cases, when dealing with infectious diseases, or contaminations, the CCDC, acting on behalf of the local authority, may require a head teacher of a school to provide a list of names, addresses and contact telephone numbers for all pupils of that school, or such group of pupils attending that school. The head teacher is legally obliged under Health Protection (Local Authority Powers) Regulations 2010 Regulation 3 to provide this information.

Further information about these regulations can be found on the following website: http://www.legislation.gov.uk/
Exclusion from School

Although doctors and nurses have no powers of exclusion from school, it is expected that the head teacher would act on their advice. The suggested minimum periods of exclusion for the common communicable diseases are available on the Health Protection Agency’s website, www.hpa.org.uk, under ‘Guidance on Infection Control in Schools and other Child Care Settings’. Here you can download a poster on exclusion from school due to illness. If a disease is not listed please contact the West Yorkshire Health Protection Unit Duty Team for further information. The rules regarding exclusion apply equally to staff and children with additional special precautions for school catering staff.
List of Notifiable Diseases

Notifiable Diseases are highlighted in red and marked with and *. These diseases must be notified to the Health Protection Agency by a Registered Medical Practitioner.

Acute Encephalitis *
Acute meningitis *
Acute Poliomyelitis *
Acute infectious hepatitis *
Anthrax *
Botulism *
Brucellosis *
Cholera *
Diphtheria *
Enteric fever (typhoid or paratyphoid) *
Food Poisoning *
Haemolytic uraemic syndrome (HUS) *
Infectious bloody diarrhoea *
Invasive group A streptococcal disease and scarlet fever *

Yellow fever *
Malaria *
Measles *
Meningococcal Septicaemia *
Mumps *
Plague *
Rabies *
Rubella *
SARS *
Smallpox *
Tetanus *
Tuberculosis *
Typhus Fever *
Viral Haemorrhagic Fever (VHF) *

Whooping cough *
Legionnaires’ Disease *
Leprosy *
**Staff Health**

All new staff should complete a pre-employment health-screening questionnaire prior to commencing work. This should include immunisation history, e.g. Measles Mumps and Rubella (MMR), tetanus and BCG vaccination. Anyone working in the childcare setting that is found to be suffering from an infectious disease should immediately stop work and seek advice from their GP or from the West Yorkshire Health Protection Unit. The illness should be reported to the HPU.

All staff aged between 16-25 years should be advised to check that they have had **two** doses of MMR. Female workers of child bearing age should ensure that they are immune to Rubella (German Measles). We recommend that they seek the advice of their general practitioner regarding the need for MMR vaccination before starting work.

*For the most up to date advice on childhood immunisation go to [http://immunisation.dh.gov.uk/](http://immunisation.dh.gov.uk/)*

**Sick Children and Staff**

A child who is acutely ill should not be in a childcare setting and advice from the GP will generally reflect this. If a child is obviously unwell on arrival or becomes ill while there, their parent or guardian should be contacted to take the child home and they should be encouraged to seek the advice of the GP or NHS Direct. It is the responsibility of the parent or guardian to let staff within the childcare setting know if the child is ill and the reason for any absence.

It is important to keep a permanent record or register of illnesses occurring in staff and children. This is extremely useful to the WYHPU when investigating an outbreak. It is recommended that the register is maintained and updated daily. It should include:-

- Name, home address, home and work telephone numbers
- The name and address of GP
- Symptoms
- Date of onset
- Room or area the child or staff member is usually located in
- Any action taken
- Children’s vaccination histories should also be included in school/nursery records

There is no statutory requirement for childcare settings to notify West Yorkshire Health Protection Unit of illnesses in children. The statutory responsibility for notifying infectious diseases lies with the attending doctor. However, as delays may occur in the doctor’s notification system, it is helpful if head teachers (or another member of staff) telephone West Yorkshire Health Protection Duty Team to report any case of communicable disease (see list of notifiable diseases on page 12). Notifying diseases serves three purposes:

- It enables early treatment, exclusion and preventative measures to be taken so that the risk of further disease transmissions can be reduced or stopped.
- It helps the identification, investigation and control of outbreaks.
- It can be used for statistical monitoring/surveillance so that trends in certain illnesses can be identified and control programmes monitored.
**Pregnant Staff**

In general, if a pregnant woman develops a rash or is in close contact with someone with a potentially infectious rash, this should be investigated by a doctor. The greatest risk to pregnant women from such infections comes from their own child/children rather than from the workplace.

The following table indicates what action should be taken if a pregnant member of staff think that they may be affected by illnesses which can pose a risk to their health and the health of their baby:

<table>
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<tr>
<th>Illness</th>
<th>Period of contact</th>
<th>Advice</th>
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<tr>
<td>Chickenpox</td>
<td>Any period whilst pregnant</td>
<td>GP and antenatal carer should be informed promptly and a blood may be done to check immunity. Shingles is caused by the same virus as the chickenpox virus. Therefore anyone who has not had chickenpox is vulnerable to the infection if they have close contacts with a case of shingles.</td>
</tr>
<tr>
<td>German Measles (Rubella)</td>
<td>Early pregnancy</td>
<td>GP and antenatal carer should be informed promptly to ensure investigation. The infection can affect the baby if the woman is not immune and she is exposed in early pregnancy.</td>
</tr>
<tr>
<td>Slapped cheek disease</td>
<td>Before 20 Weeks</td>
<td>Can occasionally affect an unborn child, if exposed. Inform antenatal carer as this must be investigated.</td>
</tr>
<tr>
<td>Measles</td>
<td>During Pregnancy</td>
<td>This is serious as it can result in early delivery or even loss of the baby. If a pregnant member of staff has been in contact with someone with measles, antenatal carers should be informed as further action can be taken.</td>
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If you are concerned about any of the above please contact the West Yorkshire Health Protection Unit 0113 386 0300

**Vulnerable Children**

Some children have medical conditions that make them especially vulnerable to infections that would rarely be serious in most children.

- Staff working within childcare settings should be aware of any children who have suppressed immunity. The most common type of immunosuppression in childhood is a child under active treatment for leukaemia or other cancers, and children on high doses of steroids (by mouth). HIV and some very rare diseases may also lower immunity. Parents, or guardians and the school health services should notify childcare settings of such children.

- Vulnerable children are at greater risk of chickenpox and measles. If a vulnerable child is exposed to either of these infections, the parents/guardians should be informed promptly so that they can seek further medical advice as necessary. Shingles is caused by the same virus as chickenpox virus therefore anyone who has not had chickenpox is vulnerable to the infection if they have close contact with a case of shingles.

- It may be advisable for these children to have additional immunisations e.g. influenza and pneumococcal.
Special Groups

Pupils with Complex Needs

Some school pupils are more vulnerable to infection due to underlying health conditions. Any pupil with chronic health problems such as cystic fibrosis, diabetes, or mobility problems might be at an increased risk of infection.

There are a few general infection control good practice points:

- In times of an outbreak of infection inform the parents about any potential risk to their child. Exclusion may be advised.
- Advise parents to seek their doctor’s advice about immunisations.
- Keep all toys and therapy equipment scrupulously clean.

*For peg feeding:*

- Keep all feeds refrigerated and use within 24 hours.
- Use boiled cooled water for feeds and clean equipment after each use. Do not re-use syringes that cannot be adequately cleaned in hot soapy water or are designated as single-use.
- Keep all change mats and toilet areas clean.
- Assist pupils with hand hygiene before eating or drinking if required.
- Scrupulous hygiene is required for intermittent catheterisation.

A care plan should be agreed with parents for all in-situ medical devices such as PEGS or shunts.

Pupils with Cancer

Pupils having specialist cancer care may be advised not to attend school during outbreaks of infection such as chickenpox or measles.

When immunisations are planned in school the pupil’s parents can seek the advice of the specialist paediatrician about the immunisation – it may be postponed until the pupil’s immune system has recovered from chemotherapy.

Boarding Schools

Introduction

Boarding schools have a legal duty to the health, safety and welfare of the pupils in their care and the staff they employ. The steps taken in boarding school to protect pupils and staff from infection are an important element in the quality of care they provide. They have an obligation to ensure the environment is safe for pupils, staff and visitors.

Care of the Infectious Boarder

A boarding school has a duty of care which extends beyond the classroom and the school day. House supervisors will exercise personal judgment about when medical advice should be sought for an individual pupil. If a pupil is diagnosed with an infectious disease a number of options should be considered:

- The pupil returns to the care of the family;
- The pupil goes to the care of the guardian;
- Or the pupil remains at school with the additional support required.
The preferred option will be that which is safest for the pupil whilst minimising spread of infection to others. If remaining on school premises the advice from the West Yorkshire Health Protection Unit (WYHPU) Duty Team may be to ensure that the pupil is not sharing a room or toilet facilities. Such advice may be extended by the WYHPU to contacts of a case in certain infections but is not routine. Infection control guidance is available from the WYHPU but in most circumstances the sensible hygiene precautions recommended for all school activities, coupled with the recommended exclusion, will be adequate.

Pupils with their own kitchen facilities should be advised not to use these if they have had (infectious) vomiting or diarrhoea in the last 48 hours.

Impact of Shared Living Accommodation on Infectious Disease

General
The sustained close living relationship of pupils in boarding accommodation increases the propensity of infections to spread. Boarding schools may face greater challenges in managing outbreaks that occur in all school settings, such as viral gastroenteritis, but also are more likely to be affected by outbreaks of diseases uncommon in non residential settings, for example Group A streptococcal disease, or meningococcal disease. In addition, the boarding school, as a semi-closed community, can suffer high attack rates of infections that establish and as a result may need to review their ability to carry on providing education and residential services. For certain diseases, e.g. a flu pandemic or meningitis, specific guidance will be provided by the WYHPU based on the situation at that time.

Meningitis
If a pupil is diagnosed with meningococcal disease, classroom contacts are not usually considered to be ‘close contacts’ requiring medical prophylaxis. However, roommates would be considered as close contacts and it is likely that the WYHPU would wish to offer preventative antibiotics and, if appropriate, vaccination to such pupils. Early discussion with the WYHPU is essential. If more than one case was diagnosed this ‘contact group’ would be extended further and the teaching and residential support staff will be involved in identifying social and study groups to assist the WYHPU in making decisions. Staff at the school should be available to support the response to such incidents out of school hours, e.g. at weekends. The WYHPU will advise on the content of communication with parents and will provide information as required. Any media response should ideally be done in partnership.

Group A Streptococcal Disease
This bacterial infection can manifest in several ways but most commonly as a moderate to severe pharyngitis (throat infection) or a skin infection. Sometimes other clinical conditions can result from this infection such as scarlet fever and occasionally renal (kidney) problems. Outbreaks (particularly of pharyngitis) are observed in boarding schools. If an increased number of pupils are noted to have severe throat infections, throat swabs should be sent to the local hospital laboratory. If an outbreak is suspected, or recognised, the WYHPU may recommend extending throat swabs to a defined contact group following discussion with the school.

In this instance antibiotics may be prescribed for symptom-free students who are found to have the bacteria in their throat. The Health Protection Unit will assist with written communication materials.

Influenza
Influenza is an infectious respiratory infection. Typically it occurs seasonally in the winter months. In the general community most respiratory infections are not influenza but an assortment of other viruses causing similar but often milder symptoms. However, once influenza is introduced into a boarding school it is recognised that spread easily occurs resulting in a significant number of affected pupils and staff. Suspected outbreaks should be notified to the WYHPU. They will advise on management which
occasionally may involve offering prophylactic treatment to pupils or staff judged to be at high risk from influenza. The WYHPU will also be able to support the school with cross-infection prevention advice.

There is a vaccine against influenza which is modified each year to reflect the circulating strains predicted for that winter. The vaccine is offered to those with underlying medical conditions which would make them more susceptible to complications of influenza.

**Viral Gastroenteritis**
Outbreaks of viral gastroenteritis occur throughout the community, including schools. When it occurs in a boarding school it can present additional challenges in control. Early advice should be sought from the Health Protection Unit. Standard rules of exclusion from classes apply, i.e. until a 48 hour symptom-free period has elapsed, and this exclusion should also be applied to social activities. Wherever possible, affected children should be accommodated individually or cohorted with other affected children. Meals should be taken separately from unaffected children. Separate toilet facilities should be available for affected children or resident staff. Attention to thorough environmental cleaning is paramount, and hand washing practices should be reinforced. Support is available from the WYHPU.

**Pupils from Overseas**

**Immunisation**

Each country develops its immunisation programme based upon the prevalence of different infections in its population. Just as the disease profile varies, so do the immunisation schedules. Pupils arriving to study in the UK may not have been vaccinated in accordance with UK policy and this can leave them exposed to diseases which are more common in the UK. Schedules from different countries can be checked on the World Health Organisation website at: [www.who.int/immunization_monitoring/en/globalsummary/scheduleselect.cfm](http://www.who.int/immunization_monitoring/en/globalsummary/scheduleselect.cfm).

It is particularly important to check that pupils have been vaccinated against meningitis C and measles, mumps and rubella (MMR). Immunisation advice is available from the school health doctors, or WYHPU.

**Tuberculosis (TB)**

New immigrants into the UK who come from countries with a high risk of TB are offered screening. This helps the health service detect those at risk of TB infection and/or TB disease, so that treatment and/or BCG vaccination can be offered where indicated. Countries with high risk of TB include all those with a TB incidence of more than 40 cases per 100,000 population. Country TB incidence rates are available from [http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/](http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Tuberculosis/)

TB screening may include a skin test (Mantoux test) and/or a blood test or chest x-ray.

**New and Re-emerging Diseases**

Sometimes pupils arrive from countries experiencing outbreaks of serious infections. Staff should remain vigilant to symptoms which might indicate a serious imported infection in a pupil. In circumstances where infections such as Avian influenza are a consideration, schools will be issued with specific guidance to advise them on how to proceed. Suspected cases must be notified to the WYHPU as a matter of urgency. In most instances the possibility of these infections can be quickly excluded. However, early notification for risk assessment to be carried out is essential.
Recommended Advice for Parents of New School and Nursery Starters

The template letter below explains what parents or guardians should do if their child becomes ill with an infectious disease. You may find this letter useful to send to parents or guardians of new starters in the childcare setting.

Dear Parent

Children of school age commonly suffer from infectious diseases. Some of these are given a specific name such as chickenpox or measles, some are termed ‘viral illness’ and others are described by the symptoms they cause such as diarrhoea and vomiting. Most of these are mild, short-lived illnesses in the majority of children but the problem is that they easily spread within the school setting.

In order to reduce the chance of your child being ill at school and to reduce the spread of infectious disease within school, it would be helpful for you to follow these guidelines. These will help you to decide when your child should stay away from school and when they should return and when you should inform the school about any close contact with other cases of infectious diseases.

If children do become ill while at school, we need some information to ensure that they are cared for in the best way. Please ensure that the school has up-to-date daytime contact information for you, details of your child's GP and the name of a trusted person who can be contacted in an emergency. When parents cannot be reached, we need to know who can take responsibility for a decision about your child’s treatment in a healthcare emergency.

Please inform us if your child has been in close contact with a case of:
Infectious diarrhoea (E. coli O157, Typhoid, Shigella dysentery) or Hepatitis A, since germs causing these diseases can be carried and spread by persons who have no symptoms.

It is important that the school is aware of such illnesses so that they are alert to the possible development of outbreaks and the need to take early action to prevent the infection from spreading.

Please inform us of the reason for your child's absence from school
This will allow us to keep track of the illnesses, which are circulating within schools in the area and help us identify the opportunities for preventing further spread.

Please keep your child at home if he/she is unwell
Children who are unwell should not be at school. Illness can affect their ability to cope with class activities and they may spread the illness to other children and staff within the school.

Please ensure your child has completed the course of Childhood Immunisations
To check the childhood schedule of immunisations please refer to http://immunisation.dh.gov.uk/

Children should not attend school/nursery when they have any of the following symptoms:-

**Diarrhoea** - (two or more loose stools within 24 hours)
Diarrhoeal illnesses spread easily amongst young children. If parents keep their children with diarrhoea at home until they are free of symptoms for 48 hours it will help to stop the spread within the school/nursery.
Flu-like symptoms
Vomiting
Persistent and strange sounding cough
Yellowish skin or eyes (jaundice)
Headache and stiff neck - particularly if your child is irritable and generally unwell
Pinkeye - eyes may be sore and sticky
Unusual spots or rashes
Sore throat - or trouble swallowing
Infected skin patches
Severe itching - of body or scalp (except for eczema)

You should contact your GP (family doctor) for any further advice, particularly if the symptoms are severe or persistent. Please pass on information regarding the diagnosis to the school. The length of time your child should stay off school depends upon the cause of the illness (there are recommended exclusion periods for particular conditions), how long the symptoms last and how quickly your child recovers. Your GP should be able to provide you with further information on exclusion periods.

If there is a need for prolonged absence, please discuss this with your Health Visitor, School Nurse or GP and your class teacher, who share responsibility for your child’s welfare. Children who are absent for long periods or have frequent short periods of illness can be affected emotionally by the disruption in their schoolwork and may have difficulty fitting back into their social group in the class. Where a problem is identified early, and a child feels included in positive decisions, they will also feel secure and supported and are less likely to become reluctant to attend class.

Please make provision for alternative care
All children are likely to have minor illness at some stage. This can cause problems if childcare is needed whilst the child is away from school/nursery. The best way to deal with these situations is to plan ahead.

- Find out about your employer’s leave policies
- If it is difficult to take time off work, find an alternative carer. This could be a relative, friend, neighbour or other dependable adult you could ask to help when your child is too ill to be at school.

Thank you for your co-operation.

Your sincerely,

Headteacher.
Section 2: Preventative Measures and Infection Control

Preventative Measures

There are a number of effective and simple measures that employees can undertake to prevent spread of disease in the childcare setting environment. All staff should be aware of the basic principles of hygiene, such as hand washing and not sharing personal items like combs or cosmetics. They should have a general knowledge of infectious diseases and their transmission. Basic first aid techniques are also useful. It is highly recommended that staff have up-to-date immunisation records (including polio) and details of childhood illnesses to which they have natural immunity, particularly, chickenpox.

Hand Washing

Hand washing is the single most important means of reducing the risk of transmitting infection amongst children and staff. Children and adults should be encouraged to develop good hand washing technique. Washing hands is more than simply wetting them. They need to be washed with liquid soap and warm water and dried properly afterwards with a paper towel.

Top Tips for Personal Hygiene

- There should be an adequate supply of hand wash basins placed in strategic places, e.g. Toilets, food preparation areas, nappy changing areas.
- Hand wash basins should be placed at a height that will enable children to wash their hands easily.
- Liquid soap must be readily available at all hand wash basins. Bar soap should not be used as it harbours bacteria and allows for cross infection.
- Paper towels should be provided. Shared cloth or roller towels are not recommended as they may become contaminated and spread infection.
- If hand driers are used children should be supervised.
- Cloth face flannels should be discouraged. Separate paper towels/single use wipes are recommended for each child.
- Nail brushes should not be used as they can allow for bacterial multiplication at the basin.
- Any cuts or abrasions on the hands of staff and children should be covered with a waterproof dressing/plaster.
- It is strongly advised that the school/nursery keep a supply of disposable plastic aprons and (non-sterile) disposable gloves. These will provide protection in the case of extensive soiling and spillages of blood or other bodily fluids.
How to Wash Hands Properly (See Separate Hand Wash Poster – Appendix 4)

1. Always use warm water. It's better to wet hands before applying liquid soap as this prevents irritation.

2. Rub hands together vigorously for about 15 seconds, making sure both sides of the hands are washed thoroughly, especially around the thumbs, between each finger and around and under the nails.

3. Rinse with clean water.

4. Germs spread more easily if hands are wet so dry them thoroughly, preferably with paper towels. Cloth towels should not be used as they allow for cross-infection.

5. Turn tap off. For rigorous hygiene at times when an infection is known to be circulating, turn the tap off using a paper towel to avoid recontamination. Posters could be displayed in the toilets to help remind children to wash their hands.

When to Wash

Some germs can stay alive on our hands for up to three hours and in that time they can be spread to all the things we touch including food and other people. Hands should be washed:

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
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</thead>
<tbody>
<tr>
<td>• Eating food</td>
<td>• Handling raw foods</td>
</tr>
<tr>
<td>• Preparing food</td>
<td>• Using the toilet</td>
</tr>
<tr>
<td>• Serving food</td>
<td>• Changing nappies or toileting a child</td>
</tr>
<tr>
<td>• Smoking</td>
<td>• Clearing or mopping up spillages (e.g. urine, vomit,</td>
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<tr>
<td>• Going home</td>
<td>blood, faeces)</td>
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<tr>
<td></td>
<td>• Blowing or wiping the nose</td>
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<td></td>
<td>• Dealing with waste</td>
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<td></td>
<td>• Smoking</td>
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<td></td>
<td>• Handling pets</td>
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<td></td>
<td>• Gardening</td>
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<td></td>
<td>• Any other situation that is thought likely to have</td>
</tr>
<tr>
<td></td>
<td>contaminated the hands</td>
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</table>

e-bug

e-Bug has a series of educational materials and games on topics associated with microbes and the spread, treatment and prevention of infections. To download the materials, go to: [http://www.e-bug.eu/](http://www.e-bug.eu/)

Dirty Bertie

The Department of Health’s ‘Catch it, Bin it, Kill it’ campaign aims to encourage respiratory and hand hygiene practice to help reduce the spread of germs leading to colds, flu and other illnesses.

For more information, please visit the following link where you will also find a nursery rhyme about coughs and sneezes available to download. [http://www.dh.gov.uk/catchit](http://www.dh.gov.uk/catchit)
Protective Clothing

Under Health and Safety Law, employers are required to provide adequate protective clothing for staff. Single-use, disposable plastic aprons and latex powder free gloves should be worn for all tasks where there is a risk of splashing from blood or other body fluids. Polythene gloves must not be used as they are for catering purposes only and offer inadequate protection for staff against blood bourne viruses. Disposable gloves and aprons must be disposed after each task and should never be used for more than one child. Hands must be washed after the removal of gloves (they are not a substitute for handwashing).

Additional Hygiene and Hand Washing Resources

UK

- **The Bug Investigators** [www.buginvestigators.co.uk](http://www.buginvestigators.co.uk) Teaching resource for years 5, 6 and 7. Card 4 covers ‘How Well Do You Wash’, in teacher’s notes and on poster.


- ‘Learn to Wash Your Hands Well’ [www.teachkidshealth.co.uk](http://www.teachkidshealth.co.uk) A collaboration between Infection Prevention Society, CPHVA (Community Practitioners’ and Health Visitors’ Association), NHS and Reckitt Benkiser (Dettol). Material developed for both Key Stage 1 and 2. Supporting information on website

- **NPSA** [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

  1) Food hygiene campaign and related initiatives, covering PSHE and citizenship curriculum, Key stages 2 & 3.
  2) The cooking bus: information available from website
  3) The Agency also supports local hygiene and numerous schemes UK wide.

- **Health Protection Agency** website has some very useful teaching and classroom resources [http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Handwashing/](http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/Handwashing/)

- **London School of Hygiene and Tropical Medicine** [www.hygienecentral.org.uk/index.html](http://www.hygienecentral.org.uk/index.html) Four promotional booklets ‘Happy, Healthy and Hygienic’. Produced with the support of UNICEF for Burkina Faso and other developing countries.

- [www.my-school-needs.co.uk/hand_washing.htm](http://www.my-school-needs.co.uk/hand_washing.htm)
- [www.wash-hands.com/the_campaign/sammy_soap_the_clean_team_education_pack](http://www.wash-hands.com/the_campaign/sammy_soap_the_clean_team_education_pack)
- [www.food.gov.uk](http://www.food.gov.uk)
Food Hygiene

Bacteria can multiply in food, particularly in warm and moist conditions. This can cause illness in three ways –

- By direct infection of anyone who eats the food
- By producing toxins that poison people without infecting them
- By contaminating other foods.

It is important that there is good temperature control, avoidance of cross-contamination and facilities for hand washing in the kitchen.

Kitchens

Children, particularly young children, are susceptible to food poisoning. It is important that all kitchens undertake food hazard analysis (HACCP) and put controls in place to ensure that food is safe for consumption.

Kitchens are subject to inspection by the Council’s Environmental Health Department and further information about food handling, preparation and storage can be obtained from this department of the Local Authority.

Cooking Activities

- Always start the activity with all children washing their hands (see section on personal hygiene).
- If eggs are being used, ensure they are ‘Lion’ marked or that they are pasteurised and never serve undercooked egg dishes. Also make sure that children do not eat raw egg mixtures. Ensure that the children handle as little raw food as possible and that they wash their hands immediately after touching raw meat.
- Different boards should be used for cooked/ready-to-eat foods than those used with raw foods. Raw meat should be prepared separately to other foods.
- Do not wash raw meat as this can cause contamination of the wash basin and other surfaces.
- Inform children that it is bad practice to cool and reheat leftover food. This may allow bacteria to grow to unsafe levels.
- After cooking, make sure that all crockery, cutlery and cooking utensils are washed properly with hot water and detergent. All equipment and surfaces should be thoroughly cleaned and disinfected. Cleaning cloths should also be changed daily as they allow germs to breed easily.

Detergents remove food/debris and lifts grease.

Disinfectants reduce surface bacteria to a safe level (they do not remove all bacteria totally)

Shaping the Eating Habits of the Next Generation

The Food Standards Agency (FSA) has worked to produce a framework of core skills and knowledge for children and young people. The food competences framework is intended to help childcare settings, amongst others, to provide children and young people with the foundations to make healthy food choices on food along with the knowledge to handle and prepare the food safely, thus helping to reduce the incidence of food poisoning.

For more information on the Food Competencies for Children and Young People go to www.food.gov.uk
**Food Handlers**

If school catering staff contract certain communicable diseases or develop infected lesions on the exposed skin there may be a risk of food contamination. Food handlers are required (under Regulation (EC) No 852/2004, Annex II, Chapter VIII, paragraph 2) to inform their food business operator immediately if they are suffering from or carrying a disease likely to be transmitted through food. This includes:

- Typhoid Fever
- Paratyphoid Fever
- Other Salmonella infections
- Staphylococcal infections likely to cause food poisoning e.g. impetigo, septic skin lesions, exposed infected wounds, boils etc.
- Dysentery
- Diarrhoea - even if the cause of which has not been established
- Hepatitis A (infective jaundice)
- E.coli O157.

The food business operator should not allow a person, confirmed to be or suspected to be, suffering from any of the above diseases, to work in any food handling area in any capacity in which there is any likelihood of directly or indirectly contaminating food with pathogenic microorganisms. **Ideally the food business operator should also notify the Environmental Health Team at their local council.**

Any food handler who develops symptoms of diarrhoea or other symptoms associated with the above diseases should not return to work in any capacity in a food handling area (as above mentioned) until he/she has been **symptom free for at least 48 hours.** This advice also applies to children who may be involved in the handling and preparation of food to be consumed at school or at home. The manager of the food handler who is ill should contact the Head Teacher to discuss exclusion and arrange cover for the duration of absence.

Local Environmental Health Teams carry out the investigation and management of individuals with communicable disease infections. In some cases, the CCDC as the Proper Officer of the Local Authority may require that food handlers remain off work for longer than the 48 hours symptom free period referred to above.

**Farm Visits**

Visits to open farms have become more popular within schools over recent years. They are considered to be both educational and an enjoyable leisurely pastime. Ill health following a farm visit is unusual, however it should be recognised that all animals naturally carry a range of organisms, some of which may be transmitted to humans causing ill health. Such ill health may be potentially very serious, for example, E.Coli O157 bacteria causes diarrhoea and fever but may go on to cause a more severe haemorrhagic colitis (bloody diarrhoea) or haemolytic uraemic syndrome (kidney failure). There are a number of other micro organisms that cause diarrhoea and/or vomiting and this is usually mild or temporary, however some of these organisms can also cause serious complications. However, it is sensible for us all to take the necessary precautions where illnesses are preventable.

Listed below are some precautions for teachers to consider when taking children on a farm visit, in order to reduce the risk of acquiring an infection. These should be considered as part of the risk assessment you carry out prior to the trip.
Before the visit:

- Discuss visit arrangements in advance with the farmer if possible to ensure that:
  (a) Out of bound areas are identified.
  (b) Danger areas are fenced off.
- Agree on the number of adults to supervise children; a general ratio to follow would be 1 adult: 8 pupils, for children under eight years old.
- Talk to the pupils beforehand about farm hazards and discuss any rules, for example not straying from the group or handling any inappropriate equipment.
- Make sure that pupils will be wearing appropriate clothing including sturdy boots or Wellington boots if possible.
- Check that any cuts or grazes on hands are covered with a waterproof dressing.
- Check that the farm has suitable washing facilities, is appropriately signposted, has running water, liquid soap and disposable towels or hot air hand dryer(s).

During and after the visit:

- Pupils should be advised how to behave near animals:
  (a) Told which ones they can touch, feed or stroke safely
  (b) Advised not to kiss them.
  (c) Advised not to taste or eat any animal foods or unpasteurized produce, for example milk or cheese.
  (d) To change or clean any footwear before leaving, remembering that hands need to be washed after any contact with animal faeces on the footwear.

If pupils are advised to listen carefully and follow instructions and information given by the farm staff and you, the teachers, then they should have an enjoyable and educational visit. Should a member of the group show signs of illness (i.e. diarrhoea and vomiting) after a visit, that person or their parent or guardian should be advised that they visit their GP and explain that they have had recent contact with animals.

For further information and advice on farm visits go to [www.hpa.org.uk](http://www.hpa.org.uk) and search for information on ‘farm visits’. The HSE has also developed guidance on preventing or controlling ill health from animal contact at visitor attractions which includes a supplement for teachers and others who organise visits for children. This can be found at: [http://www.hse.gov.uk/pubns/ais23.pdf](http://www.hse.gov.uk/pubns/ais23.pdf)
Pets and Infection Control

Animals may carry infections such as *salmonella* and *campylobacter*. Some of these germs may be transmitted to humans and cause illness, even if the animals appear healthy. Therefore, it is very important that children are encouraged to wash their hands after handling animals. Health and Safety Executive (HSE) guidelines for protecting the Health and Safety of children should be followed.

**Animals In School** (permanently or visiting). Ensure animals living quarters are kept clean and away from food areas. Waste should be disposed of regularly and litter boxes should not be accessible to children. Young people should not play with animals unsupervised. Veterinary advice should be sought for suitability of animals as pets, animal welfare and health. Particular care should be taken with reptiles as these species can carry salmonella.

**Immunisation**

Children should be immunised against serious infections at the earliest possible date and certainly before they attend school or nursery. Some parents are unduly scared by media stories or inaccurate information on the internet about vaccines. The truth is that vaccines provided in the routine childhood immunisation programme are very safe and effective. Moreover, the benefits far outweigh any possible risk. Children are being protected against serious diseases that can be difficult to treat and can have long term effects on the child’s health. There are a minority of children who, for medical reasons, cannot be immunised. Such cases are uncommon and medical opinion should be obtained from the doctor treating the child, so that these children can be appropriately protected against preventable infections.

Parents with concerns about immunisation are advised to discuss with their own family doctor. There are also a number of very helpful websites containing up-to-date information for parents. These include [http://www.dh.gov.uk/health/category/policy-areas/public-health/immunisation/](http://www.dh.gov.uk/health/category/policy-areas/public-health/immunisation/)
Immunisation Schedule

This is the UK Universal Immunisation Schedule. Children who present with certain risk factors may require additional immunisations.

Each vaccination is given as a single injection into the muscle of the thigh or upper arm.

Routine Childhood Immunisation Programme 2012

<table>
<thead>
<tr>
<th>When to Immunise</th>
<th>Disease protected against</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 months old</td>
<td>Diphtheria, tetanus, pertussis (whooping cough), polio and Haemophilus influenzae (Hib) Pneumococcal infection.</td>
</tr>
<tr>
<td>3 months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib), Meningitis C.</td>
</tr>
<tr>
<td>4 months old</td>
<td>Diphtheria, tetanus, pertussis, polio and Haemophilus influenzae type b (Hib), Meningitis C, Pneumococcal infection.</td>
</tr>
<tr>
<td>Around 12 months-13 months</td>
<td>Haemophilus influenzae type b (Hib), Meningitis C. Measles, Mumps and Rubella and Pneumococcal</td>
</tr>
<tr>
<td>3 years and 4 months or soon after</td>
<td>Diphtheria, tetanus, pertussis and polio. Measles, mumps and rubella.</td>
</tr>
<tr>
<td>12 to 18 years old girls only</td>
<td>HPV vaccine against cervical cancer.</td>
</tr>
<tr>
<td>13 to 18 years old</td>
<td>Diphtheria, tetanus and polio.</td>
</tr>
</tbody>
</table>

Non-Routine Immunisations

<table>
<thead>
<tr>
<th>When to Immunise</th>
<th>Diseases protected against</th>
</tr>
</thead>
<tbody>
<tr>
<td>At birth (for babies who are more likely to come into contact with TB than the general population)</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Infants from 6 months of age in a clinical risk group</td>
<td>Seasonal flu</td>
</tr>
<tr>
<td>At birth (for babies whose mothers are hepatitis B positive) or household contacts of a confirmed case.</td>
<td>Hepatitis B</td>
</tr>
</tbody>
</table>

Staff should review their own immunisation status with their GP and ensure that they are protected against diphtheria, polio, tetanus, mumps, measles and rubella. Preparing for a school trip abroad is a good time for everyone to check their status.

Cleaning Of Environments

General Environmental Cleaning

Germs (bacteria and viruses) can be excreted in large numbers in respiratory secretions, vomit and faeces and survive for days on surfaces. ‘Cleaning the environment’ refers to the physical removal of dirt that harbours germs. This is usually with water and detergent. Cleaning does not destroy germs but it can reduce their numbers. To further reduce the level of germs, you need to disinfect the surfaces. This is done with chemicals (such as hypochlorite). For routine cleaning, household detergents and hot water is sufficient but disinfectants should be used for areas where contamination may occur.

All areas should be cleaned regularly as part of a documented cleaning policy and rota. Toilets and frequently touched surfaces should be cleaned as often as practical and especially if visibly dirty. In addition, there should
be arrangements for regular checks on toilet areas so that any accidental spillage or contamination can be dealt with promptly. Floor areas should be easy to clean with carpeted areas kept to a minimum and vacuumed daily. Carpeted areas must be steam cleaned at least every 6 months or as required after soiling. Other surfaces that may have been touched by contaminated hands, e.g. door handles and taps, should also be cleaned daily.

General purpose/household gloves should be used for general cleaning tasks and these should be changed when there is evidence of peeling, cracking or tears. Hands should always be washed after removing gloves and the gloves pulled inside out to dry properly.

Cleaning cloths should be disposable and made from nonshredding fibre. It is recommended that they are used within a colour coded system (e.g. red for toilets and green for kitchens etc). If reusable cloths are employed, they should be washed at least daily on a hot wash cycle (at least 65°C) in a washing machine and immediately dried.

Mops with removable heads should be used and washed at high temperatures in a washing machine at the end of each week or when visibly soiled. If this is not possible, mop heads should be cleaned with hot water and detergent, then a hypochlorite solution (dilution 1:100 = 1000ppm) and dried as quickly as possible. Mops should be stored with the mop head facing upwards, not downwards in the mop bucket. Mop buckets should be kept clean and dry after every use and stored with the mop head pointing upwards. The mops and cloths used in toilets should not be used in any other area.

**Cleaning Programmes**

Maintaining a clean environment is essential to prevent the spread of infection. Germs cannot grow on clean dry surfaces. A **written cleaning schedule** clearly stating what to clean, when to clean and how to clean it, is essential and should include specifics such as toilets, sinks, toys, equipment and general environment (e.g. following contamination due to accidents). The cleaning programme should be agreed and followed by all relevant members of staff. A record should be kept identifying the date and name of the person who completed the cleaning. Shared equipment is a potential source of transmission of infection. Objects which can become contaminated when handled by children or when they put them in their mouth are of particular significance e.g. high chairs or toys. Toys should always be washable and should be regularly washed in hot detergent water and dried, or washed regularly in the washing machine. Soft toys are not recommended for childcare settings as they can become quickly contaminated and are not easily cleaned.

A risk assessment should always be undertaken and use of appropriate personal protective equipment, such as gloves and plastics apron may be advisable.

**What Agents should be Used for Cleaning?**

Detergent and hot water is adequate for cleaning most surfaces and furniture. **This includes toilet areas.** A cream cleanser should be used for dirt that is difficult to remove. Disinfectants should not be used routinely for environmental cleaning. Disinfectants should never be poured down the toilet bowl or drains as they can interfere with the natural decay of sewage.

**In summary:** childcare settings will need the following routine cleaning agents:
- Detergent and hot water – used for cleaning surfaces at end of sessions/day.
- Cream cleanser – used for cleaning surfaces where dirt is difficult to remove.
- Disinfectant spray – used for cleaning surfaces between use.
- A deodoriser may be used if desired in toilet areas. Care should be taken to use them according to the manufacturer’s instructions and to spray them away from the face.
- Bleach/hypochlorite – for environmental cleaning 1000 ppm (parts per million) available chlorine – a 1 in 100 dilution of household bleach. Not for use on metal surfaces.

In specific circumstances e.g. during an outbreak of diarrhoea and vomiting within the childcare setting, additional cleaning materials will be required. For example, if the cause of the outbreak was due to a viral infection then the use of Milton 1:10 may be required, but the Health Protection Nurse or Environmental Health Officer will advise you about this. If vomiting occurs on a carpeted area, this should be steam cleaned, not vacuumed.

What Other Resources are needed?

Separate cleaning equipment should be used for toilets, hand wash areas and non-toilet areas. A standard colour coding system is a useful way of achieving this. An example of colour coding is as follows:

- **Red** mops, cloths and buckets for toilet floors, bowls, urinals, etc.
- **Green** cloths for kitchen areas
- **Blue/yellow** general cleaning

### Specific Cleaning Advice for Items in the Childcare Setting

<table>
<thead>
<tr>
<th>Item</th>
<th>How often</th>
<th>Method</th>
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</thead>
<tbody>
<tr>
<td>Basins and taps</td>
<td>Minimum daily</td>
<td>Clean with hot water and Detergent. Cream cleanser can also be used. Attention to the underside is important</td>
</tr>
<tr>
<td>Bins</td>
<td>Daily</td>
<td>Empty daily. Clean with hot water and detergent and liners to be renewed daily.</td>
</tr>
<tr>
<td>Buckets</td>
<td>After use</td>
<td>Wash with hot water and detergent and store so that they can dry.</td>
</tr>
<tr>
<td>Carpets</td>
<td>Daily</td>
<td>Vacuum daily. There should be a schedule for steam cleaning carpets at least 6 monthly.</td>
</tr>
<tr>
<td>Chairs and tables</td>
<td>Before and after use</td>
<td>Clean with hot water and detergent and dry when visibly dirty.</td>
</tr>
<tr>
<td>Cloths/dusters</td>
<td>Daily Use</td>
<td>Use disposable cloths and throw away at end of the day.</td>
</tr>
<tr>
<td>Drains</td>
<td>Daily</td>
<td>Clean with hot water and detergent.</td>
</tr>
<tr>
<td>Floors</td>
<td>Daily</td>
<td>Clean with hot water and detergent. Suction clean carpeted areas. Steam clean regularly (2-3 months). Disinfectant is required only after contamination with blood/body fluid spillages.</td>
</tr>
<tr>
<td>Furniture</td>
<td>Daily</td>
<td>Surfaces should be damp dusted with disposable cloths</td>
</tr>
<tr>
<td>Mats (nappy changing and sleep mats)</td>
<td>After each use</td>
<td>Surface area manually cleaned and dried between each use and at the end of the day using general purpose</td>
</tr>
<tr>
<td>Category</td>
<td>Frequency</td>
<td>Task Description</td>
</tr>
<tr>
<td>------------------------</td>
<td>---------------</td>
<td>----------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Mops</td>
<td>After use</td>
<td>Use detachable mop heads. Wash in hot soapy water (or in a washing machine if possible), wring out and store mop upside down to dry.</td>
</tr>
<tr>
<td>Surfaces</td>
<td>After use (minimum daily)</td>
<td>Clean with hot water and detergent. Disinfectant is not routinely required.</td>
</tr>
<tr>
<td>Toilet bowls</td>
<td>Daily</td>
<td>Clean with hot water and detergent. Clean only with disinfectant if contaminated.</td>
</tr>
<tr>
<td>Toys</td>
<td>Regularly as scheduled</td>
<td>Toys should be washable. A schedule for regular cleaning should be devised depending on the kind of toy and the likelihood of soiling. All hard toys put in mouth should be removed after use and washed with hot water and detergent, then rinsed with water and dried thoroughly. In an outbreak, toys will need to be washed daily with Hypochlorite/Milton. As per manufacturer’s instructions, rinsed and dried.</td>
</tr>
<tr>
<td>Toilet handles, taps and door knobs</td>
<td>Regularly as scheduled (minimum daily)</td>
<td>Ensure both sides of handles are cleaned as well as sink taps. Attention should be made to the underside of hand dryers.</td>
</tr>
<tr>
<td>Vacuum cleaners</td>
<td>As maker’s instructions</td>
<td>Change the air filter regularly according to the manufacturer’s instructions. Wipe detachable tools with hot water and detergent at least weekly.</td>
</tr>
<tr>
<td>Walls and ceilings</td>
<td>Periodically</td>
<td>Routine cleaning not required. Clean periodically with hot water and detergent. Clean with bleach if contaminated with blood. Mirrors to be polished. Stainless steel should be kept bright.</td>
</tr>
</tbody>
</table>

**Note:** Individual detergent wipes can be used for convenience.

Where advice states to use warm water and detergent, it is expected that the water is not too hot to the hand and that a neutral detergent is used. A risk assessment should always be undertaken and use of appropriate personal protective equipment such as gloves and plastic aprons may be advisable.

Please note that there are specific regulations regarding hygiene in the kitchen. Contact the local Environmental Health Department for further advice.

**Laundry**

Linen and clothing can potentially be sources of cross-infection. Laundering reduces contamination and the risk of infection. A laundry facility needs to have an appropriate industrial washing machine for use including a drying component, and cold pre-wash cycle if not sluice cycle. It is advisable to purchase an industrial type of machine and to consider the cost of ongoing maintenance in general. A laundry area should be designated for
that purpose only, with separate ventilation and hand washing facilities. It should also be situated as far as possible from anywhere that food is prepared and be inaccessible to children. There must be enough space in order that clean and dirty linen are kept well apart. There needs to be a dirty to clean workflow for laundry.

**Handling linen**

Linen used for sleep mats should either be used once and then washed or dedicated for an individual child’s use for a week/few days and then washed. In this case, the linen should be stored and labelled in a bag/box for that child’s sole use.

Used linen should be removed from the sleep mat with care, avoiding the creation of dust, and placed either in a labelled bag/box for that child’s reuse within the week/few days or into a colour coded bag/container (usually white) if it is for washing. The latter should then be secured and brought directly to the laundry if there is no dedicated storage area. Laundry bags should be no more than two thirds full. If used linen is foul/infected or seepage is likely, it must be placed directly into a water soluble linen bag and then into a red linen bag and brought directly to the laundry area. The water soluble bag is then placed directly into the machine. The washing machine would need to be compatible with such a bag so that it dissolves in the hot water. The water soluble bag prevents unnecessary manual handling of foul/infected linen.

Used (foul and soiled) linen should be laundered by a process in which the temperature in the load is maintained at 65˚C (at least 65˚C) for not less than ten minutes or preferably at 71˚C for not less than three minutes. For non-industrial washing machines, at least four minutes mixing time must be added to these times (eight minutes if heavily loaded). If lower temperatures are necessary, there would be a need to consider adding a chemical disinfectant to the wash rinse (e.g. sodium hypochlorite (150 parts per million ppm) available chlorine for at least five minutes), if tolerated by the fabrics involved.

A sluice cycle is necessary for foul/soiled (heavily contaminated or contaminated with blood/body fluid) or knowingly infected linen. Foul/infected linen **should NOT be soaked, rinsed or sluiced by hand** as the operator is subjecting themselves to inhaling fine contaminated aerosol droplets.

The technician should use protective clothing (gloves and apron) when dealing with linen and hands should always be washed after handling linen/detergent. Correct high temperature wash programmes plus detergent products that remove organic residues (e.g. faeces, urine and blood stains) from fabric should always be used as the fabric could otherwise continue to harbour germs.

**Soiled Clothing**

Do NOT manually rinse/soak soiled items (see above). Flush any solid material (E.g. vomit, faeces) into the toilet, carefully avoiding splashing, and then put items in the washing machine, using the pre-wash/sluice cycle followed by a hot wash cycle (as above for foul linen), as tolerated by the material. If this service is not provided at your facility then the soiled clothing should have the solid waste flushed away as before and then be placed into a sealed, waterproof bag for the parent to collect and wash at home. **This latter procedure is the preferred option for best practice as manual handling of foul/soiled clothing is thus minimised for staff.** Explain to parents that washing or rinsing soiled clothing increases staff exposure to germs that can cause disease. Although receiving soiled clothing is not pleasant, parents should be reminded that such a policy protects the health of all staff and children.
Care of Play Equipment

Toys

All **soft toys** should be machine washable and preferably British Standard kite marked. Soft toys are not recommended for multi play use.

All other toys should be easy to clean with soap and water and dried thoroughly. Toys should be cleaned regularly according to a cleaning schedule based on the minimum of one month and maximum weekly. However, any toy used by a child and inserted into the mouth should be cleaned immediately after use. This schedule will assist in disposing of toys that cannot be easily cleaned or that have become damaged.

Play Dough/Plasticine

It is important that children wash their hands before and after use. Skin lesions must be covered. In an outbreak, play with play dough should be suspended until the outbreak is over.

Plastic/Wooden Toys

Toys should be cleaned after use with hot soapy water and then dried thoroughly. (This includes play homes and play tables). Toys should be inspected regularly for breakages and discarded if not intact. Broken toys may harm children and could harbor bacteria.

Electrical/Mechanical Toys

Non-electrical toys should be surface wiped after use with a damp cloth that has been rinsed in hot water and detergent and then dried. Electrical toys surface wiped with an alcohol wipe after being unplugged from the mains.

Storage of Toys

Toys must be stored in a designated container that is rigid and washable. Toy containers should be washed and dried weekly.

Second-hand Toys

It is advised not to accept second-hand toys.

Clinical and Offensive/Hygiene Waste

Clinical

Clinical waste is defined as ‘any waste which consists wholly or partly of human or animal tissues, blood or other body fluids, excretions, drugs or other pharmaceutical products, swabs or dressings, syringes, needles and other sharp instruments’ which unless rendered safe may prove hazardous to any person coming into contact with it. (HMSO 1992)

Used gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot operated bins.

All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than 2/3rds full and stored in a dedicated, secure area whilst awaiting collection.
Always segregate domestic, clinical waste and offensive/hygiene waste.

**Offensive/Hygiene Waste.**

The term offensive/hygiene waste describes waste which is non-infectious and which does not require specialist treatment or disposal, but may cause offence to those coming into contact with it.

Offensive/hygiene waste includes waste previously described as human hygiene waste and ‘sanpro’ waste, and does not need to be classified for transport.

**Examples of offensive/hygiene waste includes:**

- Incontinence and other waste produced from human hygiene.
- Sanitary waste
- Nappies
- Medica/veterinary items and equipment which do not pose a risk of infection, including gowns, plaster casts etc.
- Animal faeces and soiled animal bedding

Indicative treatment/disposal required is landfill in a suitably permitted or licensed site. This waste should not be compacted in unlicensed/permited facilities. The yellow/black bags (tiger bags) should be used for offensive/hygiene waste. These colours are widely recognised for the use of sanitary/offensive/hygiene waste stream.

**Blood and Body Fluid Spillages**

Blood and body fluid spillages may contain blood-borne viruses (for example, Hepatitis B, C, or HIV) or other bacterial and viral pathogens. As it is not always possible to know who is infected with these pathogens, precautions must always be taken when handling any blood or body fluid.

Any spill containing blood/body fluid must be dealt with promptly, preferably using a recognised spillage kit containing granules or a liquid solution of hypochlorite at 10,000ppm, disposable gloves, shovel and waste bag. N.B this differs from 1,000ppm used for general disinfection. Ventilate the area: e.g. open windows. Disposable aprons should always be worn. If there is a risk of blood/body fluid splashing in the face, wear protective eyewear.

Essential items for cleaning up blood spills should be placed at appropriate areas around the school in a safe container. These items include:

- Household bleach (or appropriate disinfectant which is effective against viruses,
- using manufacturer’s instructions
- Paper towels
- Single use/disposable gloves or household rubber gloves
- Disposable apron
- Polythene bags for refuse disposal
Dealing with Spillages

A number of precautions can be taken when handling spillages:

1. Wear protective clothing (gloves, apron etc).

2. Cover the area of the spill with paper towels to absorb the fluid (enveloping) and limit spread.

3. Wait until the fluid has been completely absorbed into the towels.

4. Paper towels should be collected and disposed of as clinical waste (if collection is available) or wrapped in a plastic bag and disposed of into the rubbish bin.

5. The area should then be washed with a suitable disinfectant solution (e.g. Dettol) or preferably with a hypochlorite solution. For carpets, wash with water and as soon as possible, steam clean the carpet.

Procedure for Changing Nappies

Nurseries that produce large quantities of nappies should have a contract with the Local Authority for clinical waste collection or have a contract with a registered waste disposal company.

Disposable, powder-free gloves and plastic aprons should be worn before changing nappies and before any task involving soiled material (e.g. cleaning potties). Clean nappies should be stored at a convenient distance away from the nappy cleaning area to prevent cross contamination. Polythene gloves should not be used under any circumstances.

Nappy changing areas must be in a designated area, located away from food preparation areas. Hand washing facilities should be available in the nappy changing area.

Use changing mats to protect other surfaces. If soiling occurs, wash the mat with warm water and detergent (washing up liquid), and dry before further use. There should be adequate numbers of changing mats and if the plastic covers become cracked or torn, they should be thrown away. If there are no changing mats, use a surface that is smooth and easy to clean. Avoid wood or worn materials.

Cover the changing mat with a paper cover for each nappy change and wash and disinfect the change mat/surface after each nappy change. Detergent/alcohol wipes can be used.

Disinfect the area at least daily and whenever visible contamination occurs. Use disposable gloves and consider a disposable plastic apron if extensive faecal contamination is anticipated.

The nappy bin or offensive/hygiene waste bin should have a foot operated lid and should be separate from household waste.

Soiled clothing or bedding should be washed in a washing machine with a cold pre wash and then a hot wash.
Sharps Injuries

When dealing with cuts and nosebleeds, staff should follow the school/nursery first aid procedure, and record the incident in the accident book.

In the event that children or staff are accidentally injured with a hypodermic needle or are splashed by blood or other blood stained body fluids, the first step is to ensure that the injured person receives appropriate first aid.

If someone injures themselves with a used hypodermic needle or receives a splash injury to their eyes or mouth, the following procedures are advised:

- Encourage the site to gently bleed
- Do not suck the wound, rub or scrub
- Wash the area well with soap and warm running water - do not use antiseptic or skin washes
- Dry and cover with a waterproof plaster
- Splashes into eyes or mouth should be rinsed with copious amounts of water, and before and after contact lenses have been removed
- Document details of incident in the accident/incident book
- Immediate medical advice should be sought at the local accident and emergency department.

Staff should always wash their hands when dealing with other people’s blood, even if they have been wearing gloves or they cannot see blood on their hands. Disposable gloves should be disposed of immediately after use, even if they look clean.

Children who are known to be HIV positive or hepatitis B/C positive do not need to be treated any differently from those whose HIV or hepatitis B/C status is not known. Intact skin provides a good barrier to infection, and staff should always wear waterproof dressings on any fresh cuts or abrasions on their hands.

In the case of needle stick injuries, the needle should be disposed of safely. Sharps should be discarded straight into a sharps bin conforming to **BS 7320** and **UN3291** standards. Sharps bins must be kept off the floor (preferably wall mounted) and out of reach of children.

If pupils require injections in school they should bring their own needles etc and sharp boxes. They should be returned to the individuals to be disposed of through their own General Practitioner. They should not be over filled (i.e. less than 2/3rds full)
Human Bites

Human mouths are inhabited by a wide variety of organisms, some of which can be transmitted by bites. Human bites that break the skin are more likely to become infected than dog or cat bites, so it is important that they are treated promptly.

If a human bite does not break the skin:-

1. Wash with soap and water
2. No further action needed

If a human bite breaks the skin:-

1. Wash immediately with soap and water and cover with a dressing
2. Record incident in Accident Book
3. Seek medical advice
   • To treat potential infection
   • For reassurance and information about HIV and Hepatitis B infection

Animal Bites

Most animal bites are less likely to become infected than human bites, but they should still be taken seriously. Rabies is not common in the UK, so vaccination against rabies is not required for bites in this country. People who are bitten abroad in countries where rabies is known to occur should always seek medical attention.

If an animal bite does not break the skin:-

1. Wash with soap and water
2. No further action needed

If an animal bite breaks the skin:-

1. Wash with soap and water
2. Seek medical advice about the possible need for treatment to prevent infection.

If someone becomes generally unwell or the bite looks infected they should seek medical attention.

Guidance on first aid for schools: A Good Practice Guide. Available at www.education.gov.uk
Section 3: Common Infectious Diseases in Children

3.1 Rashes and Skin Disorders

Notifiable diseases are highlighted in red and marked with an asterix. These must be notified to the Health Protection Agency by a Registered Medical Practitioner.

Athletes’ foot (tinea pedis)

What is Athletes’ Foot?

Athletes’ foot is a fungal infection that is caused by the fungi Trichophyton Rubrum and Epidermophyton Floccosum.

Clinical Features

The infection causes scaling/cracking and occasionally blistering of the skin around the toes, toe webs and soles.

Occurrence

Worldwide it is a common disease with adults more commonly affected than children. Infections are more frequent and severe in hot weather. The wearing of training shoes and communal bathing could be responsible for an increase in athletes’ foot.

Mode of Transmission

Direct or indirect contact with the skin of infected persons or contaminated floors, showers and other objects used by an infected person.

Infectious Period

The infectious period is for as long as infection is present- it can be from months to years if untreated.

Management

Treatment with a topical anti-fungal cream must be used. Good personal hygiene must be encouraged, with special care taken to dry between the toes after bathing. The regular use of an anti-fungal dusting powder on the feet and between the toes is helpful along with exposure of the feet to air by wearing sandals. Wash socks of infected individuals on a hot wash to prevent re-infection.

Exclusion

Exclusion from barefoot activities is not necessary with good hygiene practices encouraged. Treatment is always advisable.
**Chickenpox (herpes zoster)**

**What is Chickenpox?**

Chickenpox is a systemic viral infection caused by a herpes virus called varicella-zoster virus (VZV).

**Clinical Features**

Before a vesicular (blister like) rash appears a child may have a fever, headache and myalgia. The rash usually first appears on the trunk and starts as small papules, developing into clear vesicles (blisters) which become pustules and then dry to a crust. There are successive crops of vesicles over several days. The hands and feet are relatively spared from the rash. A more severe illness including pneumonia, hepatitis or disseminated intravascular coagulation may affect the immunocompromised, neonates and occasionally healthy adults, particularly smokers.

**Occurrence**

Chickenpox mainly occurs in children, although the incidence in older children is rising in the UK. There are epidemics every 1-2 years, usually in Winter/Spring. At least 90% of the population has had chickenpox by the age of 15 years old and more than 90% of adults have natural immunity due to having previous chickenpox infection. Second attacks are rare. Infection can remain latent and reoccur years later as shingles in a proportion of older adults and sometimes in children. Mortality is low and increases with age. An average of 26 deaths from chickenpox occurs in England and Wales annually.

**Mode of Transmission**

Chickenpox is highly infectious with the attack rate in susceptible exposed children of 87%. Transmission is by direct person to person contact, by airborne spread of vesicular fluid or respiratory secretions and by contact with articles recently contaminated by discharges from vesicles and mucous membranes.

**Infectious Period**

The incubation period for chickenpox is 2-3 weeks, usually about 15-18 days. Cases are infectious just before the onset of the rash, until 5 days after the first crop of vesicles. Most transmission occurs early in the disease.

**Management**

Chickenpox is notifiable in Scotland but not in the UK.

**Exclusion**

Children should be excluded from school and nursery until 5 days from the onset of the rash, when the spots have crusted over and when they are fully well. Healthcare workers and teachers should stay off work for the same period.
Hand, Foot and Mouth Infection

What is Hand, Foot and Mouth infection?

This is an infection caused by a virus called Coxsackie virus. The virus has two recognised groups, group A (23 serotypes) and group B (6 serotypes). Hand, foot and mouth infection is usually caused by serogroup A16.

Clinical Features

Some of the symptoms are ulcers in the mouth and a vesicular (blister like) rash on the hands, feet and buttocks. These spots can last up to 10 days. Children may have a high temperature and a poor appetite due to the spots in their mouth. This virus is in no way related to animal foot and mouth disease.

Occurrence

Epidemics of hand, foot and mouth occur every 2-3 years with the seasonal incidence peaking in summer and early winter. Children aged 0-4 years are usually affected.

Mode of Transmission

Spread is by direct contact with faeces, pharyngeal discharges or respiratory droplets of an infected person.

Infectious Period

The incubation period is 3-5 days and a person will be infectious during the acute illness and for some time after recovery, as the virus may persist in the faeces for some weeks.

Management

Health education on personal hygiene and reducing overcrowding will reduce the opportunities for exposure to hand, foot and mouth. Single cases of hand, foot and mouth are not required to be reported to Public Health but clusters of cases and outbreaks (two or more cases) in childcare settings should be reported to the Local Health Protection unit on 0113 386 0300

Exclusion

Children should be kept away from school/nursery whilst unwell. However there is no need to keep a child away until the last blister has disappeared providing he/she is otherwise well.
Herpes Simplex (cold sores)

What is Herpes Simplex?

Infection with Herpes Simplex virus (HSV) is characterised by a localised primary infection which can resolve, remain latent and reoccur later. HSV 1 is associated with the infection of the mouth and HSV 2 with genital infection.

Clinical Features

Primary infection produces a painful ulcerating blister like eruption in the mouth with fever. The lesions may develop in other sites such as the nose, eye, finger and perineum as a result of self-inoculation with the virus. The illness resolves after 10-14 days. Complications are rare but herpetic encephalitis (inflammation of the brain) has been reported. HSV persists in the nerve cells, and at a later date may reactivate and cause a painful skin eruption, usually on the lip (cold sore). Reactivation is provoked by sunlight, fever, trauma, menstruation and stress.

Occurrence

The incidence of HSV 1 peaks in preschool aged children. It is rare in infancy because of passive maternal antibody. It is estimated that 50-90% of adults have antibodies to HSV 1.

Mode of Transmission

Humans are the only reservoir of infection. Infection is transmitted by direct contact with saliva, often by kissing or close contact sports. Airborne transmission is unlikely. The virus does not survive for long periods in the environment and it cannot penetrate intact skin. Following exposure 80% of non-immune contacts will be infected.

Infectious Period

The incubation period is 2-12 days and a person may remain infectious for several weeks as a result of intermittent shedding of the virus into the saliva.

Management

Health education and attention to hand washing and personal hygiene may reduce exposure to the virus. Gloves should be worn by health care workers in contact with potential infection. Individuals with HSV should avoid contact with vulnerable groups such as infants, burns patients, people with eczema and impaired immunity. Acyclovir is the drug of choice to reduce shedding of the virus, ease pain and accelerate the healing time.

Exclusion

There is no exclusion time from school or nursery advised in relation to Herpes but treatment is advised. In nursery situations strict hygiene must be maintained to prevent spread by saliva on toys etc.
Impetigo

What is Impetigo?

Impetigo is a skin infection caused by one or both of the bacteria known as Streptococci and Staphylococcus aureus.

Clinical Features

The symptoms are generally itching and crusted lesions with a brown or yellow scab. It may appear as a blistery rash. When the blisters open, they produce a thick golden-yellow discharge that dries, crusts, and adheres to the skin. Impetigo quite often occurs on top of other skin problems such as eczema or insect bites.

Occurrence

Worldwide incidence is more prevalent in areas where there is poor personal hygiene and where people are crowded, especially in warm weather.

Mode of Transmission

It is passed from person to person through direct contact with the discharge from the lesions. It is usually passed from one person to another on hands. Some people can carry the bacteria that can cause impetigo in their noses, throats and on their skin.

Infectious Period

The incubation period is commonly 4-10 days. Impetigo remains infectious as long as the lesions are wet and discharging fluid.

Management

Treatment is usually with oral antibiotics and sometimes also with topical antibiotics. A swab may be taken from the lesion to find out which of the two bacteria is causing the condition.

Advice to prevent transmission is:

- Avoid touching the lesions as much as possible.
- Where possible, cover the affected area with a dressing.
- Use separate towels and flannels.
- Change and launder towels, flannels and clothes daily.
- Personal hygiene is essential. Particular attention should be paid to handwashing, especially after contact with the lesions or their discharge. Infected areas should be carefully washed with mild soap and water.

Exclusion

Affected children should not attend school or nursery until the lesions have crusted over or healed, or 48 hours after antibiotics have been commenced.
**Measles**

*What is Measles?*

Measles is a systemic viral infection caused by a virus called paramyxovirus. Measles is highly infectious but can be prevented by vaccination.

**Clinical Features**

The main features are a high fever, respiratory infection, conjunctivitis, a cough, runny nose and small white spots (Koplik’s spots) in the mucosa of the cheeks. The characteristic rash of measles starts on day three or four. The rash starts initially on the hairline, but spreads rapidly to cover the face, trunk and limbs. It is raised but not itchy. Koplik’s spots fade as the rash appears. The rash fades over a week to 10 days. In vaccinated children the illness is usually mild with a low grade fever, a transient rash and absent respiratory features. Complications of measles are higher in immunocompromised and malnourished children. Complications include pneumonitis, secondary bacterial infection, especially otitis media, pneumonia and encephalitis.

**Occurrence**

In the pre-vaccination era, most people were infected in childhood with the average age of infection being four years old. Large epidemics occurred every 2 years until the introduction of childhood immunisation in 1968. Vaccination programmes have broken the epidemic cycle and measles is now rare. Small outbreaks still occur, however, in unvaccinated groups where there is a history of contact with an imported case of measles.

**Mode of Transmission**

Measles can only be transmitted through direct person-to-person contact. It is transmitted through direct contact with nose and throat secretions or respiratory droplets or by touching a surface that has been contaminated with the droplets and then placing your hands near your nose or mouth.

**Infectious Period**

Measles is highly infectious with the period of communicability starting just before the high fever and other symptoms until 4 days after the rash appeared. Natural infection produces lifelong immunity. Vaccine-induced immunity is lower, but it is also usually life long and can be boosted by exposure to circulating measles virus.

**Management**

Measles is notifiable to Public Health by health professionals. The most effective way of preventing measles is the Measles, Mumps and Rubella vaccine (MMR)

**Exclusion**

A child should be excluded from school or nursery until 4 days after the onset of the rash.
Meningitis and Meningococcal Disease *

What is Meningitis?

The brain is covered by layers of tissues called the meninges. Meningitis occurs if these covering layers become inflamed, usually as the result of an infection. The infection is usually initially in the throat but spreads to the blood stream, causing "septicaemia" and then to the meninges, causing "meningitis".

What causes Meningitis?

Most cases of meningitis are caused by either viruses or bacteria. Viral meningitis is more common and in these cases, symptoms are more often mild. Bacterial meningitis is a serious disease needing urgent diagnosis and treatment. The three most important types which cause meningitis and septicaemia are:

1. **Meningococcal infection**. This is most common in school age children.

2. **Haemophilus influenzae meningitis**. This type of meningitis has almost being eradicated now the Hib vaccine has become available and is part of the routine immunisation that all babies receive.

3. **Pneumococcal** meningitis occurs in young infants but only as isolated cases. It does not spread from person-to-person.

What are the symptoms and signs of Meningococcal infection?

When the infection causes meningitis, the symptoms may be all or any of the following:

- Severe headache
- Stiff neck
- Fever
- Vomiting
- Drowsiness, confusion, unconsciousness
- Discomfort caused by light (photophobia)
- A fine rash like pinpricks, which does not fade when pressed with a glass

When the infection causes predominantly septicaemia, the following symptoms may be the most pronounced:

- A fine rash like pinpricks, which does not fade when pressed with a glass
- Joint or muscle pains
- Cold hands and feet

Not all these symptoms may be present, or they may develop over a period of time.

What should parents do if they think a child might have Meningococcal infection?

Contact their GP as soon as possible. Often by describing the case to the GP, over the telephone it is possible to determine what immediate action should be taken. If he/she is unavailable, go straight to an Accident and Emergency Department, or dial 999. If a GP suspects meningococcal infection, the child will always be admitted to hospital as an emergency. Meningococcal septicaemia and meningitis sometimes develops in a matter of hours and can be very serious or even fatal. On other occasions it might take a slower or milder course. If antibiotics are started early enough, the majority respond very well to treatment.
How is Meningococcal infection spread?

The meningitis germ spreads from person-to-person by coughs and sneezes. It is not very infectious, and very close contact is needed with a case before there is a risk of catching the infection.

How can it be prevented?

People who have been in very close contact with a case of meningitis will be given antibiotics to prevent them from spreading the disease. People who have not had such close contact are at very little risk of catching the disease, and they will not need antibiotics.

Who is a close contact of a case?

The following are definitions of a close contact. They apply to the week preceding the diagnosis of the case. Household members who, within that week:

- Have shared the same house as the case, and/or,
- Have slept in the same room as the case e.g. bedroom or dormitory.

Other people who have been kissing contacts of the index case (intimate mouth kissing only).

How can spread of Meningococcal infection be reduced?

Meningococcal infection is transmitted by droplet spread from person to person. It cannot be passed on by direct contact with clothing, bed linen, furniture, or any other objects or blood.

- Over-crowding, particularly in sleeping quarters, should be avoided.
- Good ventilation, particularly in sleeping quarters, is important.

Prevention of the spread of Meningococcal infection by using antibiotics

Research has shown that close contacts of people with meningococcal infection are at an increased risk of developing the disease (See definition of contacts above.) Therefore, antibiotics are offered to these contacts as a precautionary measure. This reduces, but does not eliminate, the risk to contacts. Research has shown that the close contacts of a case of meningococcal infection have a 13% chance of carrying the same strain of bacteria in their throat. Less close contacts, such as classmates, workmates and casual friends have only a 1.6% chance of carrying the same strain, which is close to the general population carriage rate. Antibiotics are given to close contacts of a case to remove the meningococcus germs, which they may have in the back of their throat if they are a carrier. This reduces the chances of them passing the bacteria on to others. It may also protect the individual by preventing progression of carrier state to meningitis, although this is rare.

However, it is not advisable to give antibiotics to non close contacts of a case of meningococcal infection as they are considered to be at very low risk of infection and taking antibiotics unnecessarily can:

1. Cause meningococci to become resistant to the antibiotics, and so make future protection impossible.
2. Cause side effects which can be serious.
3. Kill bacteria present in the nose and throat which protects against infection. This, paradoxically, can actually put people more at risk of developing meningococcal Infection, if they then pick up the germ from another carrier.
Exclusion

Once a child has recovered from Meningococcal disease and has been treated to clear the infection they can return to school. There is no reason to exclude any siblings or other close contacts of the case from school

Immunisation- See UK schedule on Page 30.

Meningitis C (Men C vaccine) protects against Meningococcal Group C bacteria infection

DTaP/IPV/Hib protects against 5 different diseases- the Hib component provides protection against Haemophilus Type B infection.

Hib/Men C protects against the above.

PCV provides protection against Pneumococcal infections

There is as yet no vaccination for the other common group of meningococci in the UK – Group B

Meningococcal infection in Childcare settings

The cases of meningococcal infection that do occur usually do so as single cases. Clusters of cases of meningococcal infection in childcare settings or in the community are very rare.

Actions for a single case

If one case of meningococcal infection occurs in a childcare setting, antibiotics and immunisation, if appropriate, will be offered only to the high-risk groups listed in the previous section. It is not necessary to offer antibiotics to normal childcare setting contacts.

If a case of meningococcal infection occurs in a childcare setting or nursery, doctors from West Yorkshire Health Protection Unit will get in touch with the Head Teacher. A joint decision will be made as to which parents should be informed of the case by letter, as this depends on how the classes are organised in individual childcare settings. Past experiences have shown that parents are very pleased to be kept informed of cases of infectious disease; they do not panic and they have increased vigilance for the early signs of meningitis if their child becomes ill.

Actions for a cluster of case

If more than one case occurs in a childcare setting, the wider use of antibiotics and vaccines, if appropriate, will be considered, depending on the strains of bacteria, that are responsible for the cases. The decision to give antibiotics and vaccine to a whole childcare setting will only be taken after discussion with the West Yorkshire Health Protection Unit and national meningitis experts, to ensure that the action is both necessary and appropriate.

What will happen if there is a death?

If a pupil or staff member should die from meningitis, the action needed to be taken will be the same as for a case. The parents will be informed by letter in all cases, and antibiotics and vaccine will be used whenever this is considered appropriate. However, there is likely to be considerably more anxiety, and a great deal of media
interest, which may, in itself, be disruptive and upsetting. It is important that the WYHPU is kept in close touch with events in the childcare setting, so that they can offer assistance wherever possible.

**Additional Resources on Meningitis**

The help of national meningitis research organisations can also be invaluable in such circumstances. They have developed considerable experience in offering advice and information on meningitis and have a wide range of excellent educational material available. They also offer support to the victims of meningitis and their relatives and are happy to take over the phone enquiries from members of the public, or from professionals.

Further general information about Meningitis may be obtained from:
- The National Meningitis Trust Helpline 24 hours Tel: 0800 028 18 28
  [www.meningitis-trust.org](http://www.meningitis-trust.org)
- The Meningitis Research Foundation 24-hour Helpline Tel: 080 8800 3344
  [www.meningitis.org](http://www.meningitis.org)

Further information can be obtained from the Health Protection Agency’s website at: (see [http://www.hpa.org.uk](http://www.hpa.org.uk) A-Z topics Meningococcal disease for general information and background information) or by contacting the West Yorkshire Health Protection Unit on 0113 3860300.

NHS Choices- [www.nhs.uk/conditions](http://www.nhs.uk/conditions)
Molluscum Contagiosum

What is Molluscum Contagiosum?

This is a skin infection caused by a member of the Poxviridae family.

Clinical Features

It causes smooth-surfaced white or translucent papules that contain a white core. The lesions vary in number and can occur on the face and body.

Occurrence

Cases of this infection occur in countries worldwide. It is commonly seen in children.

Mode of Transmission

Spread is by direct skin to skin contact. The infection can be spread further on an individual who already has infection by them scratching the lesions and expelling the core of the lesion onto the skin causing further infection.

Infectious Period

The person will remain infectious for as long as the lesions persist.

Management

The infection resolves spontaneously after 6-24 months. The average lifespan of an individual lesion is 2-3 months. Avoid picking and scratching the lesions as this can cause scarring. Avoid sharing towels, flannels and clothing with others.

Exclusion

There is no exclusion period from school or nursery and a child can take part in most activities including swimming.
**Mumps**

**What is Mumps?**

Mumps is a systemic viral infection that is caused by the Paramyxovirus. Complications are common with the virus and it is preventable by vaccination.

**Clinical Features**

Tenderness and swelling of the parotid glands in the neck occurs in 70% of cases. Other common features are nausea, headache, joint pain, fever and mild abdominal pain.

**Occurrence**

Before vaccination was introduced in 1988, mumps caused epidemics every 3 years. In recent years there has been a rise in the incidence of mumps, most affecting teenagers and young adults due to this age group not receiving the MMR vaccination.

**Mode of Transmission**

Mumps is moderately infectious, with transmission occurring through droplet spread and direct contact with saliva of an infected case.

**Infectious Period**

Cases are infectious for a week before the parotid swelling and until ten days after the onset of swelling.

**Management**

Mumps is a notifiable disease. Laboratory confirmation is usually sought through a saliva test. If many childcare setting contacts are unvaccinated, vaccination is advised.

**Prevention**

Measles Mumps and Rubella (MMR)

**Exclusion**

Consider exclusion from school or nursery for 5 days from the onset of parotid swelling.
Ringworm

What is Ringworm?

Ringworm is caused by fungal infections of the skin, hair and nails. Scalp ringworm affects children and is becoming more common.

Clinical Features

In scalp ringworm, infection starts with a red spot that spreads leaving a scaly bald patch. The hair may become brittle and break easily. In ringworm of the body (particularly the trunk and legs) the skin has red spots with flat scaly ring shaped areas around them. Infection of the nail appears as a change in colour and thickening of the nail bed. Infection of the foot is more commonly known as athletes’ foot with scaling/cracking and occasionally blistering of the skin between the toes.

Occurrence

Scalp ringworm affects mainly children and is becoming more common in the UK. Until recently, the infection was spread from infected animals, but now spread from humans is more common. Ringworm of the body is increasing but this could be related to the close association of humans with their pets. Persons who are immunocompromised are at increased risk of fungal infections.

Mode of Transmission

Ringworm is caught by direct skin to skin contact of an infected person or animal (cat or dog). Infection can be spread by indirect contact with objects or surfaces soiled with hair or skin scales. This infection can go on for months or years if untreated.

Infectious Period

The infectious period lasts for as long as the infection is present – it may be from months to years if untreated.

Management

Skin ringworm can be treated by applying a cream prescribed by a doctor or purchased at the chemist for a period of 2-4 weeks. Tablets or syrup are needed to treat nail and scalp infections. A doctor can only prescribe these drugs. If the possible cause of infection is a family pet, the animal should be examined and treated if necessary by a vet.

Advice to a child to prevent the transmission of ringworm to others:

- Activities in a childcare setting involving close skin to skin physical contact, which could spread the infection to others, should be restricted.
- Children should be encouraged to have high standards of hygiene and wash their hands frequently.
- Towels and personal clothing of affected individuals should be laundered regularly.
- Possible animal sources in the childcare setting should be considered.

Exclusion

Once effective treatment has been started no exclusion is necessary. In general it is not necessary to ban swimming once a child is receiving treatment. If the infection becomes widespread across the school advice should be sought from your local Health Protection Unit.
**Rubella**

**What is Rubella? (German measles)**

Rubella is a systemic infection caused by a virus which is a member of the Togaviridae.

**Clinical Features**

Symptoms of rubella include a sore throat, conjunctivitis and a mild fever for 2-3 days before the macular rash appears. The lymph nodes of the neck are swollen. Recovery is usually rapid and complete.

**Occurrence**

Rubella is now rare in the UK due to vaccination programmes being in place for many years. Rubella being one of the components of MMR. Occasional outbreaks occur in susceptible young adult males who are too old to have been vaccinated. Prior to vaccination 5% of susceptible pregnant women caught the disease causing outbreaks of congenital rubella syndrome and associated terminations of pregnancy. Congenital rubella syndrome causes defects that range from mild deafness to multiple defects of organs. There are now fewer than 10 cases a year of the congenital rubella syndrome in the UK.

**Mode of Transmission**

Transmission is by direct person-to-person contact and by respiratory droplets. There are no carriers.

**Infectious Period**

Rubella is moderately infectious with infectivity one week before the rash appears and for four days after the onset of a rash. The risk of congenital rubella syndrome in susceptible pregnant women is greater than 90% in the first trimester, 50% in the second trimester and is zero near term.

**Management**

Laboratory confirmation of rubella should be sought (saliva test in the UK). Rubella should be notified to Public Health by Health Professionals. It is important to vaccinate the affected child and contacts if they are unvaccinated, with MMR. Pregnant women who have been in contact with rubella must have a blood test to detect susceptibility or early evidence of infection (antibody). Susceptible women should be vaccinated postpartum and infected women may have to consider a termination.

**Prevention**

Measles Mumps and Rubella (MMR)

**Exclusion**

A child must be excluded from school or nursery until six days after the onset of the rash. A community wide vaccination programme may be required if vaccine uptake is low in an area.
Scabies

What is Scabies?
Scabies is a skin condition caused by a mite that burrows under the skin causing an allergic reaction, which results in severe itching. Although mostly found on the hands, the mites can be at a number of sites but they are too small to be seen with the naked eye.

Clinical Features
Clinical features of scabies include itching that may not start until 2-6 weeks after infestation for people who have not had scabies before, or between 1-4 days after infestation for those that have. A symmetrical rash may appear anywhere on the body but it is particularly common on the wrists, waist, inner thighs and ankles. In children the head, neck, palms and soles may be affected. Elderly people and some people with severe illnesses may have more of a generalised rash and only a small amount of itching or even no itching at all (atypical scabies). The rash may look scaly, like eczema (crusted scabies). Both of these conditions are more infectious than classical scabies because there are large numbers of mites on the skin or in the crusts.

Occurrence
In the past scabies was associated with overcrowding and poor personal hygiene. The prevalence of scabies shows a cyclical pattern of 10-30 years. Major increases in the prevalence of scabies have occurred since 1991.

Mode of Transmission
It is passed from person to person through direct, frequent skin to skin contact such as holding hands. Clothing, bedding or towels do not generally spread it unless they have been contaminated immediately beforehand, or if people are shedding large skin scales as with Crusted Scabies.

Infectious Period
Scabies remains infectious until treated. Infectiousness depends on the number of mites on the affected person. Usually there are only 10-20 mites, but in atypical scabies there are many more and this particular form of scabies is very infectious.

Management
Scabies can be treated with a lotion that is applied to the skin for a number of hours and then washed off. The family doctor should diagnose and provide a prescription for a child and their family. Most treatments can also be bought from a chemist with advice from the Pharmacist. Single infestations within a family are uncommon; therefore close contacts of the affected person must also be treated as they may have scabies even if they do not have the symptoms yet. It is important for the affected person and their contacts to be treated at the same time so they do not re-infect each other. Usually, lotions are only applied from the neck down but it is often advised to include the head, ears and face for elderly people and children or for those in whom treatment has failed. It is important that they follow the instructions in the leaflet carefully to ensure that the treatment is effective.

Itching may continue for up to 4 weeks after treatment but it does not mean that the treatment has failed. It is due to the substances causing the allergy remaining in the body for a while. If the symptoms continue after this period, the individual should consult a doctor who may suggest the treatment is repeated, or consider other causes.

Exclusion
Affected children should not attend school or nursery until they and the rest of the family have completed their first treatment.
Scarlet Fever *

**What is Scarlet Fever?**

Group A streptococci bacteria causes scarlet fever. Streptococci are part of the normal flora of the respiratory, gastrointestinal and genitourinary tracts.

**Clinical Features**

Scarlet fever causes pharyngeal and skin infection. It is characterised by a sore throat and a skin rash (a very fine erythema) that spares the face. Facial flushing and peripheral pallor of limbs is common.

**Occurrence**

Scarlet fever is found worldwide with 20% of individuals carrying group A streptococci asymptptomatically in their pharynx.

**Mode of Transmission**

Streptococcal infection is commonly transmitted by contact with carriers of the infection, particularly nasal carriers. It is spread by sneezing and coughing, it is highly infectious.

**Infectious Period**

The incubation period is 1-4 days. The infectious period is commonly 2-3 weeks for untreated sore throats. Antibiotic treatment usually terminates transmissibility within 24 hours. Having treatment for the illness speeds recovery and reduces the risk of complications.

**Management**

Penicillin should be prescribed and given for the treatment of the infection.

**Exclusion**

The child should not attend school or nursery until 24 hours after commencing antibiotic treatment.
Shingles (Herpes Zoster)

What is Shingles?

Shingles is caused by the reactivation in an individual of latent varicella-zoster virus. This means the individual who has already had chickenpox virus in the past has a reactivation of the virus. The virus genomes lie dormant in the brain stem and spinal cord.

Clinical Features

Herpes zoster usually begins with pain in the trunk where a vesicular, painful rash appears. This rash can persist for several days and even weeks.

Occurrence

Shingles occurs mainly in middle or older age.

Mode of Transmission

Shingles is not as infectious as chickenpox. Transmission is via person to person contact with vesicular fluid or respiratory secretions.

Infectious Period

Patients with shingles are usually only infectious if the lesions are exposed or disseminated. Infectivity is increased in immunosuppressed individuals.

Management

The infected individual will be given supportive treatment to treat the symptoms.

Exclusion

There is no exclusion period for shingles if the area is not exposed. If, however, the lesions are weeping and cannot be covered then they may need excluding, due to the risk of cross infection.
Slapped Cheek (Fifth Disease)

What is slapped cheek?

Slapped Cheek syndrome is an infectious condition caused by a virus called Parvovirus B19.

Clinical Features

In children, a mild flu-like illness may occur prior to the classic symptom of a red rash to the face. This rash may also appear on the body, arms and legs. The rash tends to quickly fade but may reoccur or is prolonged on exposure to sunlight or heat (e.g. a hot bath) for up to 3 weeks or more. In adults there may be a rash, but this may not be as typical as that in children. Joint pains/arthritis may also occur in adult infection.

Occurrence

Infection occurs at all ages, although children aged 5-15 years are at the greatest risk. School outbreaks usually occur in early Spring.

Mode of Transmission

It is passed from person to person through contact with infected secretions from the nose and throat, i.e. by coughs, sneezes, shared toys etc. It is most infectious before the rash occurs and it can also be passed from mother to baby during pregnancy.

Infectious Period

The incubation period is usually 13-18 days. The infectious period is from 7 days before the rash appears until the onset of the rash.

Management

The infection is caused by a virus and is therefore not treated with antibiotics. If affected, you will become well without specific treatment. Slapped cheek can be harmful to pregnant women who need to ensure they wash their hands before eating and drinking and following contact with secretions from affected children. They should also avoid sharing eating utensils with affected children. Advice should be sought from their doctor, as blood tests may be required to check for immunity to the infection. People with aplastic anaemia or who are immunocompromised should also seek medical advice.

Exclusion

Exclusion from the childcare setting is not advised, as long as the child feels well. People are infectious before the rash develops and few remain infectious afterwards.
Warts and Verrucae

What are warts and verrucae?

Warts and verrucae are viral infections of the skin caused by the Human Papilloma viruses. A verrucae is a type of wart.

Clinical Features

Common warts are flesh coloured or brown with a rough surface. They can appear anywhere on the body. Flat or planar warts are smaller, flat and in clusters on the hands, neck and face. Plantar warts (verrucae) grow inwards and are painful. These are common on the feet of adolescents and children.

Occurrence

Warts are common in childhood with 4-20% of schoolchildren having warts at any one time.

Mode of Transmission

They are caught by direct contact with a wart or by indirect contact with a surface touched by a wart. A person scratching the wart and spreading the virus to another part of their skin can cause further self-infection.

Infectious Period

Warts are infectious for as long as they are present.

Management

Nearly all warts get better by themselves in time. Verrucae treatments can be used and in some cases a doctor may remove persistent warts by freezing or excision. Children should be advised to avoid direct contact with warts. Children who have warts must cover them with a plaster and be discouraged from picking or scratching the wart to prevent further spread of warts on themselves and to others.

Exclusion

Children should not be excluded from the childcare setting. Affected children can go swimming as long as the verrucae are covered. Verrucae warts should be covered in swimming pools with swimming socks and with plasters in gyms and changing rooms.
Respiratory Illness

Common Cold

The common cold is caused by a number of viruses, particularly the rhinoviruses.

Symptoms

The usual symptoms are malaise (i.e. feeling poorly), irritation of the nose and throat and catarrh. It is sometimes accompanied or followed by ear or chest infections. Colds are most common in the autumn and winter and most people have between 1 and 6 colds each year.

Spread

Colds are easily spread from person to person by coughs and sneezes. They spread rapidly within families and childcare settings where there are many people in close proximity. The infective period is from 24 hours before until 5 days after symptoms begin.

Prevention

There are no specific treatments but there are many proprietary preparations available from pharmacists to ease the symptoms. There is no immunisation against the common cold. Antibiotics are not effective against colds. Taking them unnecessarily will not speed up your recovery and will only increase resistance of bacteria to antibiotics.

Exclusion Period

Children with a cold should only be excluded from the childcare setting if feverish (temperature of 38°C/100.4 °F or above) and/or feeling miserable. Contacts of such children should go to the childcare setting as normal.
Influenza (Seasonal Flu)

What is it?

Influenza (or seasonal flu) is caused by various strains of the influenza virus.

Symptoms

The usual symptoms are fever, headache, aching muscles, prostration, sore throat and cough. Nausea, vomiting and diarrhoea can occur, especially in children. It is sometimes accompanied or followed by chest infections that can be severe. It often occurs in epidemics, predominantly during the winter months, which can be associated with many deaths, particularly in elderly people. Flu is generally a milder illness in children, although the attack rate may be very high.

Spread

Influenza is spread from person to person by coughs and sneezes. It can spread rapidly within families and childcare settings where there are many people in close proximity. The infective period is from 3 to 5 days after symptoms begin.

Prevention

There are no specific treatments. Symptoms can be eased by one or more of the many proprietary preparations available from pharmacists. **Children should not be given preparations containing aspirin.** Children affected by influenza should be encouraged to rest and drink plenty of water or other fluids. Children should be encouraged to cover their mouths when coughing and use paper tissues when sneezing. Hand washing, therefore needs to be encouraged, and supervised for younger children. Each year vaccines against the likely common types of the virus are prepared and should be given to people at risk, particularly the elderly and those with chronic heart, chest or kidney diseases. Healthy children and adults do not need immunisation, although children with asthma should be protected.

Exclusion Period

There are no recommended times of exclusion for an infected child. Children should not return to the childcare setting until they are fully recovered without a fever or any of the symptoms mentioned above, as they are still infectious. Any contacts of children with flu should go to the childcare setting as normal. If a child has any symptoms whilst at the childcare setting, the parent should be asked to collect them as soon as possible to limit the spread of illness to other children.

It is also advisable for them to stay away from people who are likely to suffer more serious illness, such as the very young, the elderly and those with chronic health problems.

Further information can be obtained by visiting [http://www.hpa.org.uk](http://www.hpa.org.uk) select topics A-Z then select influenza.
Tuberculosis *

What is Tuberculosis?

Tuberculosis (TB) is an infection of the lungs and/or other organs, usually caused by Mycobacterium tuberculosis, but it is occasionally caused by Mycobacterium bovis or Mycobacterium africanum.

Clinical Features

Only 5% of those who contract TB show clinical signs of disease either in the lungs or other organs. This can lead to serious forms of the disease such as meningitis or milary TB occurring within a few months of the initial infection. Early symptoms are fatigue, fever, night sweats and weight loss. Chest symptoms occur in later disease, including cough (usually productive), haemoptysis and chest pain. The remaining 95% heal their primary TB lesion without any intervention although the bacilli survive in a latent form which may then reactivate in later life in half of those affected. Non-pulmonary TB is more common in children, ethnic minorities and those with impaired immunity. The most commonly affected sites are lymph nodes, pleura, genitourinary system, bones and joints.

Occurrence

Within the U.K TB rates are highest in Black Africans, South Asians and Afro-Caribbeans. 62% of cases are now in non-white groups. Rates increase with age and are higher in deprived communities.

Mode of Transmission

TB is contracted by inhalation of Mycobacterium tuberculosis bacilli in droplet form. Bacilli may be inhaled from an infected individual who is coughing or sneezing. The bacilli remain in the air for long periods of time. The risk of transmission depends on the amount of bacilli in the sputum, the closeness of contacts and duration of the contact with the infected person and the susceptibility of the contact.

Infectious Period

The infectious period is as long as there are viable organisms in the sputum (smear positive sputum). Appropriate treatment of an infectious case renders most individuals non-infectious after two weeks of compliant therapy.

Management

All cases of TB should be notified to Public Health. Cases should be referred for specialist assessment and treatment under the guidance of a paediatrician specialising in TB management.

Exclusion

Exclusion of an infectious child in a school or nursery would be at the discretion of the TB Team and Consultant in Communicable Disease.
**Whooping Cough (Pertussis)**

**What is whooping cough?**

Whooping cough is an acute bacterial infection caused by Bordetella pertussis.

**Clinical Features**

The illness starts with a cough, cold and a fever. Over the next week the cough progresses into bouts of coughing with vomiting, characterized by a whooping sound. The cough lasts for two to three months. Young infants do not whoop but spasms of coughing can be followed by periods of apnoea.

**Mode of Transmission**

Transmission is by droplet spread from an infectious case, often an older sibling or parent. Carriers do not exist. Mild cases of pertussis in vaccinated individuals can be a source of infection.

**Infectious Period**

An infected individual is highly infectious in the early stage of the disease, infectiousness then decreases and the case is normally not infectious 3 weeks after the onset of the whooping cough, although in 20% of cases infectivity can last for up to 6 weeks.

**Management**

Referral should be made by the individual’s General Practitioner to the West Yorkshire Health Protection Unit to ensure advice and follow up is arranged.

**Prevention and Treatment**

Accellular Pertussis vaccine is given in a child’s primary course of vaccinations. A booster dose is also given prior to starting school.

Children and adults can catch pertussis even if they were vaccinated in the past because vaccine immunity wanes over time.

**Exclusion**

Children should be excluded from school or nursery until 5 days after antibiotic treatment has started and until they are fully recovered.
3.3 Fact Sheets for Other Infections

Notifiable diseases are highlighted in red and must be notified to the Health Protection Agency by a Registered Medical Practitioner.

Conjunctivitis

What is Conjunctivitis?

Conjunctivitis means inflammation of the eye and can affect one or both of the eyes. Haemophilus influenzae (viral cause) and streptococcus pneumoniae (bacterial cause) are the most common infecting agents.

Clinical Features

Symptoms include red, itchy, inflamed conjunctivae with a mucopurulent discharge.

Mode of Transmission

Contact with discharges from the eyes or upper respiratory tracts of infected persons. From contact with contaminated fingers, clothing and other articles such as eye make up.

Infectious Period

Usually from the time symptoms appear until they have resolved.

Management

Promote good personal hygiene measures, especially hand and face washing. Recommend eye ointment or cream is obtained from the G.P to treat both eyes if the conjunctivitis is due to a bacterial organism. Viral conjunctivitis is highly contagious but will clear without treatment.

Exclusion

No formal exclusion is necessary. However, young children may be unwell and “miserable” so should be kept off school until they feel better.

It there are a number of cases in the school/nursery parents may be requested to keep their children away until the infection has cleared.
Glandular Fever (Epstein Barr Virus)

What is glandular fever?

Glandular fever is caused by the Epstein-Barr virus (EBV), which is a member of the herpes virus group. It is a viral syndrome characterised by the presence of atypical mononuclear cells in the blood.

Clinical Features

The symptoms are fever, tonsillitis, swollen glands and rarely hepatitis. Young children generally have a mild illness. After recovery the EBV persists in lymphoid tissue of the throat and salivary glands and is associated with intermittent viral excretion into the saliva.

Occurrence

In developed countries infection occurs in adolescence and early adult life. Attack rates may be as high as 50%.

Mode of Transmission

Most cases are spread from asymptomatic carriers. The virus is spread through contact with saliva, either directly due to kissing or indirectly on hands and objects.

Infectious Period

The incubation period is 4-6 weeks. A person may remain infectious for a year or more. Life long immunity follows infection, although latent infection can reactivate.

Management

Health education and hygiene measures are important in reducing exposure to saliva.

Exclusion

No formal exclusion is necessary. Individuals with symptoms can be very poorly and fatigued following infection and require time off school to recuperate fully.
Head Lice (Pediculus Humanus Capitis)

What are Head Lice?

Head lice are wingless insects that infest the head of humans only and feed by sucking blood.

Clinical Features

Many early infestations are asymptomatic (have no symptoms). Itching and scratching of the scalp may occur 2-3 weeks after the onset of infestation. There can be enlargement of the lymph nodes in the neck due to secondary bacterial infection, or a rash on the nape of the neck due to an allergic reaction to lice faeces. Diagnosis depends on detecting live lice on the head. Empty eggshells (nits) are not proof of active infestation.

Occurrence

The most commonly affected groups are primary school children, their families and contacts. People of any social class and ethnic group can be affected. After puberty, girls appear to have higher infestation rates than boys.

Mode of Transmission

Head lice clamber from shaft to shaft in dry hair and move readily from person to person when heads touch. Head lice may also be spread via brushes and hats but this is not proven. Head lice quickly die of dehydration within 48 hours when removed from the scalp. Head lice cannot jump or fly from person to person.

Infectious Period

A person will remain infectious for as long as there are live lice on the head. Anyone with hair can be affected and re-infestation may occur.

Management

Lice can only be reliably detected by combing wet lubricated hair with a fine toothcomb. This is because combing in dry hair is unreliable as lice can move rapidly away from any disturbance. If lice are present in wet hair, they either fall out or are stuck to the comb. Health visitors and school nurses are involved in the education of parents about head lice. Emphasis should be placed on the parents’ responsibility to prevent, detect and treat infestations as well as alerting contacts. Parents should be responsible for brushing or combing their children’s hair daily and using a detector comb each week to detect infestation. Parents must ensure that all contacts of infested family members are informed as well as informing the children’s school, nursery or playgroup that their child has head lice. The parent will be referred to a pharmacist who can explain the use of a detection comb and wet combing to confirm active infestation and discuss the two treatment options. The pharmacist will need to have evidence of lice in a container or on a piece of sticky tape before a lotion treatment can be purchased. This is because a number of treatments are available and resistance to lice can occur if products are used wrongly. Chemical treatments should only be used if live lice are confirmed and after treatment the hair should be wet combed to check for lice again.

Prevention

Wet comb well lubricated hair with a detector comb every three days to two weeks. All contacts of a case should be examined for head lice by wet combing and treated as necessary.

Check your local School Policy for Head lice

It is not necessary to exclude children with head lice from school or nursery
**Hepatitis A**

**What is Hepatitis A?**

Hepatitis A is a viral infection which causes acute infection of the liver, which is spread primarily by the faeco-oral route.

**Clinical Features**

In some cases, no symptoms may be present. When symptoms are present, they can include jaundice, fever and dark urine. Symptoms are influenced by age with 10% under the age of 6 years developing jaundice, 40% have fever and dark urine and 60% with symptoms of nausea/vomiting, malaise and diarrhoea. Half of older children and three quarters of adults develop jaundice after 2-3 days.

**Occurrence**

The incidence has decreased in developed countries over the last 50 years. There appears to be a cyclical pattern of disease in many countries every 6-10 years. The majority of confirmed cases are those aged 5-44 years, although younger cases are more likely to be asymptomatic and are not always diagnosed. Around 14% of cases are known to have travelled abroad. Other groups at risk include those in contact with a case of hepatitis A (family or nursery), homosexually active men, intravenous drug abusers, haemophiliacs and residents and workers in institutions for the mentally handicapped.

**Mode of Transmission**

The virus is spread primarily by the faeco-oral route with secondary transmission to household and nursery contacts aided by transmission via fomites. Travelers’ to endemic countries risk exposure via food and water. Infected food handlers with poor personal hygiene may also contaminate food.

**Infectious Period**

The incubation period is 15-45 days. The infectious period is from 2 weeks before onset of jaundice until one week after. Immunity to previous infection is life-long.

**Management**

Hepatitis A is notifiable to Public Health. Good hygiene practices should be explained and the case and symptomatic contacts excluded until one week after the onset of jaundice (if no jaundice, precautions until 10 days after onset of symptoms. See risk groups on page?). Vaccination should be offered to relevant family, sexual and household contacts. People travelling abroad to countries where sanitation is poor are at risk of becoming infected. They should be immunised before travelling.

**Exclusion**

The hepatitis A case and contacts must be excluded until 7 days after the onset of jaundice (if no jaundice, precautions until 7 days after onset of symptoms).
**Hepatitis B**

**What is Hepatitis B?**

Hepatitis B is a viral infection which affects the liver (Hepatitis means inflammation of the liver). Although it occurs worldwide, it is more common in certain areas, such as the Middle & Far East, Italy, Asia, Central and South America. After exposure to the virus, it can take 6 weeks to 6 months for you to develop Hepatitis B.

**Clinical Features**

Many people never have symptoms of Hepatitis B, they just carry the virus in their blood. Some of the symptoms of infection include: jaundice, lethargy, abdominal pain, loss of appetite and pale faeces and dark urine.

**Occurrence**

Acute Hepatitis in the U.K. and Western Europe is uncommon. The annual incidence is less than 1 per 100,000, but the true incidence is higher as 70% of infections are subclinical. Some ethnic groups have higher rates of infection, notably those from South-East Asia and the Far East.

**Mode of Transmission**

The Hepatitis B virus is found in a number of body fluids, e.g. blood, breast milk, vaginal secretions and semen. It can transmit by various routes:

- By sharing contaminated needles or other drug-injecting equipment
- By unprotected penetrative sex (without a condom)
- On rare occasions, from an infected mother to her baby, mainly during delivery. The risk is greater if the mother is also infected with HIV
- Mothers can breast feed as the transmission rate of Hepatitis B is low
- Through exposure to infected blood e.g. Needle/other equipment sharing by drug users, contaminated piercing/tattooing equipment.
- Blood transfusion in countries where donors and their blood products are not screened for Hepatitis B. (All UK blood is screened.)
- Contamination of an open wound with blood.

Hepatitis B cannot be caught by sitting next to an infected person, sharing crockery, using public toilets or by swimming in public pools.

**Infectious Period**

The incubation period is 3-6 months. Carriers of Hepatitis B surface antigen who are also e antigen positive and/or e antibody negative are much more infectious than those who are e antigen positive. Patients who do not become carriers and develop natural immunity are immune for life.

**Management**

The majority of people who catch Hepatitis B fully recover without treatment. However 10% of cases become chronic carriers of the virus. This carrier state occasionally leads to liver disease in later life (approximately 25% of cases).

**Exclusion**

There is no exclusion for Hepatitis B and the child’s school or nursery do not need to be informed of a child’s status (this remains confidential). Universal precautions will prevent the transmission of Hepatitis B.
Hepatitis C *

What is Hepatitis C?

Hepatitis C is a viral infection that affects the liver (Hepatitis means inflammation of the liver). Tests for Hepatitis C virus have only been available since 1989.

Clinical Features

Acute Hepatitis C is a mild infection with ¾ of those affected having no symptoms. Jaundice, a common sign of Hepatitis, is unusual in Hepatitis C individuals. Symptoms, though not common, may include: a short flu-like illness, nausea and vomiting, diarrhoea, loss of appetite, weight loss and itchy skin.

Occurrence

In the U.K, Belgium and other Western European countries 0.1%-1% of the general population have Hepatitis C infection. Infection is more common in groups exposed to the virus in the past, such as injecting drug users and those who have had blood transfusions prior to the screening of donated blood, including haemophiliacs.

Mode of Transmission

- Hepatitis C can be transmitted in the following ways:
- Through a blood transfusion in a country where blood is not tested for the Hepatitis C virus. All U.K. blood for transfusion is tested
- By sharing contaminated needles or other drug-injecting equipment
- By using non-sterile equipment for tattooing, acupuncture or body piercing
- By unprotected penetrative sex (without a condom)
- On rare occasions, from an infected mother to her baby, mainly during delivery. The risk is greater if the mother is also infected with HIV
- Mothers can breast feed as the transmission rate of Hepatitis C is low at 4% in both breast and bottle fed babies.

Infectious Period

The incubation period can be up to 6 months. It is estimated that around 15-20% of infected people clear their infections naturally within the first 6 months of infection. For the remainder, hepatitis C is a chronic infection that can span several decades and can be life-long

Management

Serious liver disease early in the course of infection is rare. Of those infected with Hepatitis C at least 80% continue to be infected with the virus and are said to be carriers. At present there is no vaccine for Hepatitis C and current treatments are ineffective. Following a diagnosis, an individual with Hepatitis C will be referred to a Gastroenterologist to discuss possible treatments and measures to prevent the further transmission of Hepatitis C to others.

Measures to prevent further transmission of Hepatitis C

- Advise not to share toothbrushes/razors
- Advise not to share needles or syringes if individuals inject themselves. Do not access other peoples medication when using injecting equipment (e.g. insulin vials)
• Advise patients to inform their health care professional that Hepatitis C has been diagnosed if they are admitted to hospital or they attend for dental treatment.

Exclusion

There is no exclusion for Hepatitis C and the child’s school or nursery do not need to be informed of a child’s status (this remains confidential). Universal precautions will prevent the transmission of Hepatitis C.

HIV/AIDS

The diagnosis of HIV/ Aids is based on laboratory test results. HIV is very rare in children in the UK. Advice on individual cases can be sought from the West Yorkshire Health Protection Unit. Tel 0113 386 0300
Malaria*

What is Malaria?

Malaria is a potentially fatal parasitic blood infection that is transmitted by the bite of the female anopheline mosquito.

Clinical Features

The most common sign is a fever that is periodic in nature. The disease must be considered in anyone who has been exposed to the parasite, by travel, blood transfusion, or in rare cases, airport malaria.

Occurrence

Malaria is endemic in more than 100 countries throughout Africa, Central and South America, Asia and Oceania. Between 1370 and 2500 cases of malaria are reported each year in England and Wales, with 4-16 deaths per year.

Mode of Transmission

Increasing numbers of cases are occurring in Europe as people are travelling worldwide to places where they can be exposed to malaria. Absence of the insect vector in the U.K. and Europe means there is no risk of secondary cases. There is in rare cases a risk of 'airport malaria' when an infected mosquito introduced to Europe bites someone before dying. There are also rare transmissions through blood donation and needlestick injuries.

Infectious Period

Untreated or insufficiently treated individuals can remain infective for 1-3 years depending on the species of mosquito that bite them.

Management

Diagnosis is by demonstrating parasites in the blood. Blood samples should be taken at the height of the fever, and the appropriate treatment given. Complications are associated with high levels of parasites in the blood and are more common in children and travellers. Individuals should be reviewed in 28 days following treatment to confirm parasitological and clinical cure.

Exclusion

There is no exclusion but children should be fully recovered before returning to the childcare setting. Absence of the insect vector in the U.K. and Europe means there is no risk of secondary cases.
MRSA

What is MRSA?

Methicillin-Resistant Staphylococcus aureus.

Staphylococcus aureus (SA) is a type of bacteria (germ) found mainly in the nose and on the skin of many healthy people. It is normally harmless and you don’t know you have it, but it can sometimes lead to infection causing boils, abscesses and wound infections. Such infections can usually be easily treated with antibiotics. However, some Staphylococcus aureus germs are resistant to methicillin which is a type of antibiotic; this is Methicillin-Resistant Staphylococcus aureus or MRSA. Many commonly prescribed antibiotics are not effective against these germs.

Colonisation.

As with Staphylococcus aureus described above, some people have the germ present but it does not cause them any harm or infection. This is known as being COLONISED (or being a carrier) and you probably won’t know you have it.

Infection

MRSA can be carried naturally on the skin. It is only when it gets into the body through a wound or broken skin such as a rash, cut or sore, or through a medical drip or drain that it can cause an infection. MRSA may also be responsible for pneumonia and blood poisoning. People with the infection will develop signs – for example, fever and pain. If MRSA infection is suspected, laboratory tests are carried out so that the correct treatments can be given.

Can I only catch MRSA in hospital?

MRSA exists in the community, and people who are colonised may go into hospital with the germ on their skin without them knowing they have it. In general healthy people are at a low risk of infection with MRSA. Family and friends can visit patients in the hospital.

How is MRSA spread?

MRSA is most commonly spread via hands, equipment and sometimes the environment. That’s why thorough hand-washing and hand-drying are important in helping to prevent the spread of the bacteria, as well as cleaning equipment after use and keeping the general environment clean.

How is MRSA prevented?

No special cleaning methods are required in the community setting, though good general cleanliness is important in helping prevent the spread of infection generally. People with MRSA colonisation can live their normal lives at work and home. Good hand washing and drying is important in preventing the spread of any infection, not just MRSA.

Exclusion

No exclusion from school is required. Any wounds should be covered with a dressing.
Norovirus

What is Norovirus?

Norovirus is one of the most common causes of gastroenteritis (stomach bugs) in England and Wales. It is also known as ‘winter vomiting bug’ or ‘Norwalk-like virus’.

What are the symptoms?

Symptoms of Norovirus infection begin around 12 to 48 hours after becoming infected and usually last 12 to 60 hours. They will start with the sudden onset of nausea followed by projectile vomiting and watery diarrhoea. Some people have a raised temperature, headaches and aching limbs. Most people recover within 1-2 days, however some people (usually the very young or elderly) may become very dehydrated and require hospital treatment.

How is it spread?

The virus spreads easily from person to person and can survive for several days on surfaces like kitchen worktops and door handles. It can be spread through contact with an infected person, through contact with surfaces or objects that are contaminated with the virus, or by eating contaminated food or water. It frequently causes outbreaks in schools, nurseries, nursing homes and hospital wards.

Who is most at risk of getting Norovirus?

There is no specific group who are at risk of contracting Norovirus – it affects people of all ages. The very young and elderly should take extra care if infected, as dehydration is more common in these age groups.

How is Norovirus treated?

There is no specific treatment for Norovirus apart from letting the illness run its course. It is important to drink plenty of fluids to prevent dehydration. It may not be necessary to contact your doctor as most people recover within 1-2 days. However, if symptoms worsen or persist for more that 48 hours, contact your family doctor or take advice from NHS Direct on 0845 4647.

Are there any long-term effects?

No, there are no long term effects of Norovirus.

Now that I have had it, can I get it again?

Unfortunately immunity to the virus is often only short-lived and it is possible to become infected again. However, having recurrent bouts of the infection may provide some protection for the future.

How can I avoid passing it on to my family and other people?

It is recommended that patients in hospitals or nursing homes with Norovirus are isolated until at least 48 hours after their symptoms have ceased.

Food handlers, children attending schools or nurseries, childminders and those in close contact with other people (such as nursing staff) should remain at home for 48 hours after their symptoms have ceased.
People with Norovirus should also delay any visits to hospitals, care or nursing homes or schools until fully recovered and don’t visit people who are especially vulnerable to infection, such as elderly relatives.

Although it is not always possible to prevent getting Norovirus, good hygiene can help to limit the spread of the infection.

- Wash your hands frequently and thoroughly, particularly after using the toilet, changing nappies, and before preparing food.

- Disinfect any surface or objects that could be contaminated with Norovirus. It is best to use a bleach-based household cleaner. Always follow the instructions on the cleaning product.

- Avoid eating raw, unwashed produce.

- Toilets should be flushed after each use. The toilet seat should be put down prior to flushing to prevent any aerosol. You should also keep the surrounding toilet area clean and hygienic.

- Clothes that have become contaminated should be placed in a sealed bag and sent home with the parent to wash; they should not be sluiced in the school premises

- If visiting someone in hospital, even if you are well, obey the signs for hand washing before entering and after leaving the wards.
Rotavirus

What is Rotavirus?

Rotavirus is a viral infection which causes fever, watery diarrhoea and vomiting. It is one of several causes of gastro-enteritis. It usually causes more severe illness in the elderly and children between 6 months old and 5 years old and sometimes requires admission to hospital.

Clinical Features

There is usually a sudden onset of diarrhoea and vomiting often accompanied with a mild fever. Occasionally there is blood in the stools. The symptoms usually last between 3 to 8 days but those affected may still be infectious until 8 days after their symptoms have started. Symptoms usually occur between 24 and 72 hours after exposure to the virus.

Occurrence

Rotavirus is a common cause of diarrhoea in children. It has been estimated that a third of hospital admissions for childhood diarrhoea are due to Rotavirus. Most cases occur in winter.

Mode of Transmission

Rotavirus generally spreads in the faeces of an affected person. Contact with an affected person is the usual source of infection. Viruses can be picked up on the hands during play activities and going to the toilet. Shared drinks and food (e.g. ice creams) may also be a way of spreading infection and should be discouraged.

Infectious Period

Children affected may still be infectious until 8 days after their symptoms have started. Hand washing is essential in the prevention of the spread of infection. Everyone should wash their hands after using the toilet, before eating, and after handling any potentially contaminated items e.g. laundry.

Management

Rotavirus is a self-limiting infection, in other words it is allowed to run its course and the child will gradually become well again. It is important, however to treat the child’s symptoms of fever, diarrhoea and vomiting. This will help to prevent further complications like dehydration. Measures to prevent transmission of infection are:

- Hand washing is essential in the prevention of the spread of infection.
- Both the child and their carer should wash their hands after using the toilet, before eating, and after handling any potentially contaminated items e.g. laundry.

Exclusion

Children should be excluded from nursery or school until 48 hours after the diarrhoea and vomiting have settled.
**Salmonella**

*What is Salmonella?*

Salmonella is a bacterial infection that commonly causes acute gastro-enteritis.

**Clinical Features**

The severity of the illness is variable, but most cases have loose stools, of moderate volume that do not contain blood or mucus. Diarrhoea usually lasts 3-7 days and may be accompanied by fever, abdominal pain, myalgia and headache. Other symptoms such as nausea may precede diarrhoea, and malaise and weakness may continue after the gastro-enteritis has resolved.

**Occurrence**

This is worldwide and is classified as a foodborne disease because contaminated food is the predominant mode of transmission. Salmonellosis occurs at all ages, although incidences of infection are highest in young children. Salmonella appears to peak in late Summer and this is thought to be due to more rapid multiplication of bacteria at higher temperatures.

**Mode of Transmission**

Salmonella infection is acquired by the ingestion of the organisms. In most cases this is through the consumption of contaminated food. Salmonella infection is carried by many animals, leading to contamination of foodstuffs before their arrival in the kitchen. Such food sources are undercooked poultry or meat, raw or undercooked eggs and raw or inadequately pasteurised milk. Such foodstuffs can be the source of cross-contamination to other foods that may not be cooked before eating e.g. salad. Salmonellae can multiply at temperatures from 7 to 46°C and inadequate heating will allow small numbers of organisms to multiply and develop into an infective dose. Heating to 70°C for 2 minutes is required to kill the organism. Person to person spread via the faeco-oral route may occur without food as a vehicle. The risk is highest during the acute diarrhoeal phase of the illness. Children pose a particular risk of person to person spread of infection due to inadequate hand washing.

**Infectious Period**

The incubation period can range from 6 hours to 3 days or longer depending on the number of organisms ingested. Most cases occur within 12-36 hours of ingestion. The infectious period varies with most cases excreting the organism for a few days up to a few months. The median duration is five weeks but approximately 5% of children under five years of age will excrete the organism for a year. Immunity to salmonella infection is partial, with reinfection possible.

**Management**

Salmonella is notifiable to Public Health. Hygiene advice, particularly on hand washing should be given to all cases and their family. Children should be excluded from the childcare setting until they are 48 hours free of diarrhoea. Symptomatic household contacts should be identified and advised by Environmental Health. Antibiotics should not be given routinely in uncomplicated gastro-enteritis or to eliminate carriage. Those at risk of severe disease (newborn infants, sickle cell, inflammatory bowel disease or cardiovascular diseases) are exceptions, as are patients with signs of systemic disease.

**Exclusion**

Children should be excluded from school and nursery until they are 48 hours free from diarrhoea.
Shigella

What is Shigella?

Shigella are a genus of bacteria that cause intestinal infection. S. Sonnei is the most common type of bacterial infection in the U.K. and causes relatively mild illness.

Clinical Features

S. Sonnei infection causes only mild and transient diarrhoea and rarely cause dysentery. Other species are more likely to cause abdominal pain and diarrhoea (often watery) which can be accompanied by malaise, fever, nausea and vomiting. Approximately 40-50% then develop mucus and/or frank blood in the stool (dysentery). Asymptomatic infection and excretion can occur.

Occurrence

Shigellosis is primarily a disease of children, with the highest reported incidence in those under 5 years of age, followed by those 5-14 years. Boys have a higher rate than girls, but the reverse is seen in ages 15-44. Large outbreaks of non- Sonnei infection are uncommon in the U.K. but family outbreaks appear to be more frequent in those of South Asian ethnicity.

Mode of Transmission

Man is the only significant reservoir of infection. Transmission is via the faeco-oral route either directly or by contaminated food, water or the environment. Direct person to person spread is common in households and institutions, particularly those containing young children. Shigellae may survive up to 20 days in favourable environmental conditions (i.e. cool, damp and dark). This can lead to transmission via lavatory seats ,towels, other vehicles contaminated with faeces and unclean hands. Flies may transfer the organism from faeces to food.

Infectious Period

The incubation period is between 12 and 96 hours, but may be up to one week. The infectious period is primarily during the diarrhoeal illness. However cases maintain a low level of infectivity for as long as the organism is excreted in the stool, which is 2-4 weeks on average.

Management

Shigella is notifiable to Public Health and healthcare professionals will provide appropriate hygiene advice to cases and their contacts. Infected individuals should be excluded from work and school until 48 hours after their diarrhoea stops. Obtain details of any nursery or infant school attended and check to see if there are any other cases, reinforce hygiene measures, particularly hand washing. Mild cases will recover without antibiotics (multiple drug resistance is increasing). Antimotility drugs should be avoided.

Exclusion

Children should be excluded from school or nursery until 48 hours symptom free of diarrhoea if shigella sonnei. Children under the age of five years will require negative stool samples before they return to school or nursery if they are suffering from shigella Flexneri, doydii or dysenteriae.
Or as advised by Environmental Health.
Threadworm

What is Threadworm?

A threadworm is a small worm, which can live in the lower bowel. They hatch from very small eggs that cannot be seen by the naked eye.

Clinical Features

Threadworm can be present with no symptoms at all. Adults and children can suffer from an itchy bottom, particularly at night, which can disturb their sleep. When the itching is severe in children it may cause bed-wetting. Worms can often be seen in the faeces after the child has been to the toilet.

Occurrence

Threadworm is common in temperate regions, particularly amongst children.

Mode of Transmission

Eggs from the threadworm can get under the fingernails via an infected person’s hands and the child can then swallow these. The eggs can be found in clothing and bedding but they are not caught from animals. Once the eggs are swallowed they can hatch into worms and after 14 days they can lay eggs of their own.

Infectious Period

The child will be infected until treatment is completed. Re-infection is common and infectious eggs can spread directly on fingers or indirectly on bedding, clothing and in environmental dust.

Management

A doctor can diagnose threadworm from the child’s symptoms. Sometimes eggs can be detected by using sticky tape on the anus to be examined under a microscope in the laboratory. Treatment is in the form of medication that is either bought from the chemist or available on prescription. It is important that all family members are treated. An initial course of treatment should be followed by a second course two weeks later to kill worms that have matured in that time. Advise children how to wash their hands and under their fingernails properly, especially after using the toilet and before eating. Advice should be given regarding the washing of clothes and bedding at least weekly. Changing of underclothes and washing the bottom area daily to remove eggs are advised. Sleeping in underwear may help to stop the spread of excreted eggs by preventing direct contact of the fingernails with the anus. It is important to change the underwear in the morning. Nail biting should be discouraged and nails should be kept as short as possible. Different flannels and towels should be used for different family members.

Exclusion

There is no exclusion, children can go to school or nursery as long as they practice good personal hygiene and treatment is obtained.
Section 4: Managing Outbreaks of Diseases Causing Diarrhoea and Vomiting

Outbreak of Norovirus or Rotavirus Information for Schools

**Norovirus** is a frequent cause of diarrhoea and vomiting in schools and occurs mostly in winter, giving it the nickname of the ‘winter vomiting disease’. It is also referred to as the Norwalk-like virus or as small structured virus (SRSV). The infection is mild and self-limiting (12 to 60 hours). Vomiting is the predominant symptom and outbreaks are often explosive in their onset with projectile vomiting affecting more than 50% of susceptible people. Incubation period is 15 to 48 hours and usually staff and students are affected. The virus is easily transmitted from person to person and can survive in the environment.

**Rotavirus** is the most common cause of infantile gastroenteritis. Almost every child will have an infection before her/his fifth birthday. Infection in adults is uncommon because immunity is long-lasting. The incubation period is 48 hours and the prominent features are diarrhoea and vomiting. It has been estimated that approximately 18,000 children are hospitalised annually in England and Wales due to rotavirus-related disease.

**Three steps to prevent the spread of Norovirus and Rotavirus**

- Good hygiene is essential with everyone washing their hands before meals, after the toilet and hand washing before food preparation.
- Areas are ventilated during both winter and summer. This makes it difficult for viruses to survive on hard surfaces.
- All surfaces within the toilet area are cleaned scrupulously.

**Management of an outbreak of diarrhoea and vomiting**

Essential steps in the management of a suspected outbreak are outlined on the flow-chart in the following pages.

- Enforcing the 48 hour exclusion period for staff and students with symptoms
- Reinforcing good hand washing practices
- Increased attention to environmental cleaning, and
- Early notification of outbreak and monitoring of absences

These are the main actions that can reduce the spread of seasonal outbreaks of diarrhoea and vomiting commonly seen in winter in institutions.

For outbreaks that may be food-borne, Environmental Health Officers may conduct further investigations and provide further advice on specific control measures.
Outbreak plan template for schools

Schools are strongly advised to produce a documented Outbreak plan, outlining roles and responsibilities of the Head/staff members, when an outbreak caused by a notifiable infection occurs. The plan should be reviewed on an annual basis.

It is advised that the following be included in an Outbreak Plan.

- **School Details**

  | School: |  |
  | Address and telephone number: |  |
  | Name of Head Teacher: |  |
  | Name of Deputy Head: |  |

- **School Nurse Details**

  | Name of School Nurse: |  |
  | Location: |  |
  | Telephone Number: |  |

- **Sickness monitoring and Outbreak Management**

  | Details of the person who has been identified to have the responsibility for Coordinating Outbreak management within the school | Details of the person who has been given the responsibility for monitoring sickness both in children and staff in order to aid early detection of outbreaks in school |

- **List the systems in place to monitor the levels of statutory notifiable illness in the school.**

- **Details of who should be responsible for notifying the Communicable Disease Control team of a suspected Outbreak at the school.**

  (It is recommended that two people are identified to allow for sick leave)

  | Contacts | Contact Details |
  | 1st contact |  |
  | 2nd contact |  |
Responsibilities:

- To be responsible for compiling a list of ill children/staff which should include name, date of birth, address, GP details if known, home contact telephone number and onset date of illness if known.

- To update your local health protection unit of any new cases of illness on a daily basis until the Outbreak is declared closed by the communicable disease team.

- To monitor that the 48 hours symptom free rule is complied with. (Ensure there are systems in place to facilitate this).

- To inform the School Nurse of the outbreak.

- Ensure that systems for the control of the infection within the school are put into immediate effect after consultation with the Head teacher and Health Protection Nurse in the CD team. i.e. consider suspending outside school activities.

Heads of Schools should be responsible in consultation with the health protection team for producing information either verbally or written for parents when required.

Heads of Schools should ensure that adequate hygiene facilities and appropriate practices are adhered to at all times, but especially when dealing with bodily fluids i.e. faeces, vomit, blood, urine, semen, and saliva. This is essential to reduce the spread of infection and to prevent the outbreak escalating. The ‘Infection Control Audit Tool for Schools’ details the standards that you should be aiming to achieve.

Date:  
Signature of Head Teacher:  

Date for Review:  
(Name Printed)
School Closure
School closure is rarely necessary as an outbreak control measure. It should only be considered when there are good reasons to expect that closure will appreciably reduce the likelihood of exposure. The strongest cases for closure may arise in residential schools and in day schools that serve a scattered rural population. Since 1945 there has ceased to be the means under the Public Health Act 1936 whereby a school could be required to close. When circumstances arise in which a closure may be indicated, it is simpler if this is affected by the head teacher in consultation with the Local Authority and the CCDC. Should school closure be required to control an outbreak the WYHPU will support the school on media liaison.
10 Steps for Cleaning Toilet Areas

Refer to COSHH Risk assessment for cleaners

1. Wash areas initially with a detergent and water especially when obviously contaminated

2. Please ensure that hypochlorite/Milton is being used. It should be diluted as recommended in the product instructions using a measuring device.

3. When using a hypochlorite solution, water should be tepid and not hot because hot water causes the bleach to evaporate.

4. Always check the product label for health and safety information. Rubber gloves should be worn.

5. It is recommended that cloths are disposable and are only used once. If this is not possible, wiping cloths should be soaked in disinfectant solution between uses and dried after disinfection.

6. Toilets bowls should be cleaned at least once a day with Milton. Cleaning of the toilet bowl should also occur whenever fouling of the toilet pan is noticed. (Please ensure that there are adequate supplies of toilet paper, liquid soap and paper towels.)

7. As frequently as possible, all surfaces likely to be handled should be wiped over with a Milton solution. In an outbreak situation, this should be at least three times a day (for example, after morning break, after the lunch break and after school ends).

8. Always start wiping down at the ‘clean end’ first (i.e. the entrance door, towel dispenser, soap dispenser, basins, taps, etc). Regular rinsing and recharging of the cloth and disinfectant solution is essential.

9. Then concentrate on the WC cubicles, door handles, hand plates, toilet paper dispenser, cistern handle/chain pull. Wipe over the toilet seat and rim of bowl. Finally, dispose of the wiping cloth and rubber gloves when single use.

10. Do not forget to wash your own hands afterwards, even though you have worn rubber gloves.

Risk Groups and Exclusion of Food Workers

Risk Groups

Group A
Any person of doubtful personal hygiene or with unsatisfactory toilet, hand washing or hand drying facilities at home, work or childcare setting.

Group B
Children who attend pre-school groups or nursery.

Group C
People whose work involves preparing or serving unwrapped foods not subject to further heating.

Group D
Clinical and social care staff who have direct contact with highly susceptible patients or persons in whom a gastrointestinal infection would have particularly serious consequences.
Exclusion of Food Workers
A food worker is responsible for informing his/her employer that they are ill (Regulation EC. No 852-2004. European Parliament. Annex II Chapter VIII. Paragraph 2). The Local Authority are not responsible for excluding an individual from work or paying them for this exclusion.

General requirements that should be met by an employee before returning to work in the food area.

- No vomiting for 48 hours once any treatment has ceased.
- Their bowel habit has returned to normal for 48 hours either spontaneously or following cessation of treatment with anti-diarrhoeal drugs.
- Good hygiene practice, particularly hand washing, is observed in all circumstances.
- There are some exceptions to this rule, notably enteric fever (Salmonella typhi and paratyphi), E.coli O157 and Hepatitis A.

The Communicable Disease Control Team will provide specific advice in these instances.

People who do NOT pose an increased risk
People not in the risk groups present a minimal risk of spreading gastrointestinal illness and may return to any form of work 48 hours after they have recovered clinically and their stools have returned to ‘what is normal for them’. Exceptions to this are typhoid and paratyphoid, or E.coli O157 where microbiological clearance is required.

Further information can be obtained from http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/GastrointestinalDisease/ Or by contacting the West Yorkshire Health Protection unit (see http://www.hpa.org.uk follow topics A-Z link select specific infection for up-to-date contact details).

Section 5: References


Health Protection Agency website www.hpa.org.uk


With thanks to North Yorkshire and the Humber HPU for information in the boarding schools section, pg 19.
Section 6: Appendices

Appendix 1: Recommended Exclusion Period for Common Infections

Guidance on Infection Control in Schools and other Child Care Settings

Prevent the spread of infections by ensuring: routine immunisation, high standards of personal hygiene and practice, particularly hand washing, and maintaining a clean environment.

Please contact your local Health Protection Unit (HPU) on 0113 3860300 if you would like any further advice or information.

<table>
<thead>
<tr>
<th>Illness</th>
<th>Recommended period to be kept away from school, nursery, or childminders</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diarrhoea and/or vomiting</td>
<td>48 hours from last episode of diarrhoea or vomiting (48 hour rule applies)</td>
<td>Exclusion from swimming maybe considered</td>
</tr>
<tr>
<td>E.Coli O157 VTEC</td>
<td>48 hours from the last episode of diarrhoea</td>
<td>Exclusion applies to young children and those who may find hygiene practices difficult to adhere to. Local HPU will advise. Exclusion from swimming should be for 2 weeks following last episode of diarrhoea.</td>
</tr>
<tr>
<td>Typhoid* [and paratyphoid*] (enteric fever)</td>
<td>Further exclusion may be required after 48 hours.</td>
<td>Exclusion applies to young children and those who may find hygiene practices difficult to adhere to. Local HPU will advise. Exclusion from swimming should be for 2 weeks following last episode of diarrhoea.</td>
</tr>
<tr>
<td>Shigella (Dysentery)</td>
<td>Exclusion may be necessary.</td>
<td>Exclusion (if required) applies to young children and those who may find hygiene practices difficult to adhere to. Local HPU will advise. Exclusion from swimming should be for 2 weeks following last episode of diarrhoea.</td>
</tr>
<tr>
<td>Respiratory Infections</td>
<td>Recommended period to be kept away from school, nursery, or childminders</td>
<td>Comments</td>
</tr>
<tr>
<td>‘Flu’ (influenza)</td>
<td>Until recovered.</td>
<td>Vulnerable children</td>
</tr>
<tr>
<td>Condition</td>
<td>Incubation Period</td>
<td>Preventive Measures</td>
</tr>
<tr>
<td>----------------------------</td>
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</tr>
<tr>
<td>Tuberculosis*</td>
<td>Always consult the HPU.</td>
<td>Not usually spread from children. Require quite prolonged close contact for spread.</td>
</tr>
<tr>
<td>Whooping cough* (Pertussis)</td>
<td>Five days from commencing antibiotic treatment or 21 days from onset of illness if no antibiotic treatment.</td>
<td>Preventable by vaccination. After treatment non-infectious cough may continue for many weeks. HPU will organise any contact tracing necessary.</td>
</tr>
<tr>
<td>Rashes/ Skin</td>
<td>Recommended period to be kept away from school, nursery, or childminders</td>
<td>Comments</td>
</tr>
<tr>
<td>Athlete’s foot</td>
<td>None.</td>
<td>Athlete’s foot is not a serious condition. Treatment is recommended</td>
</tr>
<tr>
<td>Chicken pox</td>
<td>5 days from onset of rash.</td>
<td>See: vulnerable children and female staff-pregnancy.</td>
</tr>
<tr>
<td>Cold sores (herpes simplex)</td>
<td>None.</td>
<td>Avoid kissing and contact with the sores. Cold sores are generally a mild self-limiting disease.</td>
</tr>
<tr>
<td>German Measles (rubella)*</td>
<td>6 days from onset of rash.</td>
<td>Preventable by immunisation (MMR x 2 doses). See: female staff-pregnancy.</td>
</tr>
<tr>
<td>Hand, foot &amp; mouth</td>
<td>None.</td>
<td>Contact HPU if a large number of children are affected. Exclusion may be considered in some circumstances.</td>
</tr>
<tr>
<td>Impetigo</td>
<td>Until lesions are crusted or healed or 48 hours after commencing antibiotic treatment.</td>
<td>Antibiotic by mouth may speed healing and reduce infectious period.</td>
</tr>
<tr>
<td>Measles*</td>
<td>4 days from onset of rash</td>
<td>Preventable by immunisation (MMR x 2 doses). See: vulnerable children and female staff-pregnancy.</td>
</tr>
<tr>
<td>Other infections</td>
<td>Recommended period to be kept away from school, nursery or childminders</td>
<td>Comments</td>
</tr>
<tr>
<td>Ringworm</td>
<td>Exclusion not usually required</td>
<td>Treatment is important and available fro pharmacist. N.B. For ringworm of scalp treatment by GP is required. Also check and treat symptomatic pets.</td>
</tr>
<tr>
<td>Roseola (infantum)</td>
<td>None.</td>
<td>None.</td>
</tr>
<tr>
<td>Condition</td>
<td>Children can return after first treatment.</td>
<td>Two treatments 1 week apart for cases. Contacts should have 1 treatment; include the entire household and any other very close contacts. If further information is required contact your local HPU.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Scabies</strong></td>
<td>24 hours after commencing antibiotics.</td>
<td>Antibiotic treatment recommended for the affected child.</td>
</tr>
<tr>
<td><strong>Scarlet fever</strong></td>
<td>None.</td>
<td>See: vulnerable children and female staff-pregnancy.</td>
</tr>
<tr>
<td><strong>Slapped cheek/fifth disease. Parvovirus B19</strong></td>
<td>None.</td>
<td>See: vulnerable children and female staff-pregnancy.</td>
</tr>
<tr>
<td><strong>Shingles</strong></td>
<td>Exclude only if rash is weeping and cannot be covered.</td>
<td>Can cause chicken pox in those who are not immune i.e. not had chicken pox. It is spread by very close contact and touch. If further information is required contact your local HPU. See: vulnerable children and female staff-pregnancy.</td>
</tr>
<tr>
<td><strong>Warts and Verrucae</strong></td>
<td>None.</td>
<td>Verrucae should be covered in swimming pools, gymnasiums and changing rooms.</td>
</tr>
<tr>
<td><strong>Other infections</strong></td>
<td>Recommended period to be kept away from school, nursery or childminders</td>
<td>Comments</td>
</tr>
<tr>
<td><strong>Conjunctivitis</strong></td>
<td>None</td>
<td>If an outbreak/cluster consult HPU.</td>
</tr>
<tr>
<td><strong>Diphtheria</strong></td>
<td>Exclusion is important. Always consult with HPU.</td>
<td>Preventable by vaccination. HPU will organise any contact tracing necessary.</td>
</tr>
<tr>
<td><strong>Glandular fever</strong></td>
<td>None</td>
<td></td>
</tr>
<tr>
<td><strong>Head lice</strong></td>
<td>None</td>
<td>Treatment is recommended only in cases where live lice have definitely been seen. Close contacts should be checked and treated if live lice are found. Regular detection (combing) should be carried out by parents.</td>
</tr>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>Exclusion until 7 days after onset of jaundice (or 7 days after symptom onset if no jaundice) Always consult with HPU.</td>
<td>Good personal and environmental hygiene will minimise any possible danger of spread of hepatitis A. See: cleaning up body fluid spills and PPE information.</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong> and <strong>C</strong></td>
<td>None</td>
<td>Hepatitis B and C are not infectious through casual contact. Good hygiene will minimise any possible danger of spread of both hepatitis B and C.</td>
</tr>
<tr>
<td>Condition</td>
<td>Duration</td>
<td>Treatment/Prevention Details</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td><strong>HIV/AIDS</strong></td>
<td>None.</td>
<td>HIV is not infectious through casual contact. There have been no recorded cases of spread within a school or nursery. Good hygiene will minimise any possible danger of spread of HIV. <strong>SEE:</strong> cleaning up body fluid spills and PPE information.</td>
</tr>
<tr>
<td>Meningococcal meningitis* / septicaemia*</td>
<td>Until recovered</td>
<td>Meningitis C is preventable by vaccination. There is no reason to exclude siblings and other close contacts of a case. The HPU will give advice on any action needed and identify any contacts requiring antibiotics.</td>
</tr>
<tr>
<td>Meningitis* due to other bacteria</td>
<td>Until recovered</td>
<td>Hib meningitis and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings and other close contacts of a case. Always contact the HPU who will give advice on any action needed and identify contacts requiring antibiotics.</td>
</tr>
<tr>
<td>Meningitis viral*</td>
<td>None</td>
<td>Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required.</td>
</tr>
<tr>
<td>MRSA</td>
<td>None</td>
<td>Good hygiene. In particular hand washing and environmental cleaning, are important to minimise any danger of spread. If further information is required contact your local HPU.</td>
</tr>
<tr>
<td>Mumps*</td>
<td>Five days from onset of swollen glands.</td>
<td>Preventable by vaccination. (MMR x 2 doses).</td>
</tr>
<tr>
<td>Threadworms</td>
<td>None</td>
<td>Treatment is recommended for the child and household contacts.</td>
</tr>
<tr>
<td>Tonsillitis</td>
<td>None</td>
<td>There are many causes, but most cases are due to viruses and do not need an antibiotic.</td>
</tr>
</tbody>
</table>

*Denotes a notifiable disease. It is a statutory requirement that Doctors report a notifiable disease to the proper officer of the Local Authority. In addition, organisations may be required via locally agreed arrangements to inform there local HPU. Regulating bodies (e.g. Office for Standards in Education (OFSTED)/Commission for Social Care Inspection (CSCI)) may wish to be informed – please refer to local policy.
## Appendix 2: Useful Telephone Numbers

<table>
<thead>
<tr>
<th>West Yorkshire HPU</th>
<th>Bradford Environmental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>6th Floor South East&lt;br&gt;Quarry House&lt;br&gt;Quarry Hill&lt;br&gt;Leeds&lt;br&gt;West Yorkshire&lt;br&gt;LS2 7UE</td>
<td>Health Protection Services&lt;br&gt;6th Floor&lt;br&gt;Jacobs Well&lt;br&gt;Bradford&lt;br&gt;BD1 5RW</td>
</tr>
<tr>
<td>Telephone: 0113 386 0300</td>
<td>Telephone: 01274 434067</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calderdale Environmental Health</th>
<th>Kirklees Environmental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calderdale MBC&lt;br&gt;Calderdale Environmental Services&lt;br&gt;Northgate House&lt;br&gt;Northgate&lt;br&gt;Halifax&lt;br&gt;HX1 1UN</td>
<td>Kirklees MC, Environmental Services&lt;br&gt;Environmental Services&lt;br&gt;Riverbank Court&lt;br&gt;Wakefield Road&lt;br&gt;Huddersfield&lt;br&gt;HD5 9AA</td>
</tr>
<tr>
<td>Telephone: 01422 392321/329310</td>
<td>Telephone: 01484 226456</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Leeds Environmental Health</th>
<th>Wakefield Environmental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Environmental Health Department&lt;br&gt;Millshaw House&lt;br&gt;Millshaw Lane&lt;br&gt;Churwell&lt;br&gt;Leeds&lt;br&gt;LS11 0LS</td>
<td>Environmental Health Department&lt;br&gt;Housing and Public Protection&lt;br&gt;Regeneration Services&lt;br&gt;Newton Barr&lt;br&gt;Wakefield&lt;br&gt;WF1 2TX</td>
</tr>
<tr>
<td>Telephone: 0113 2476286</td>
<td>Telephone: 01924 305969</td>
</tr>
</tbody>
</table>

## Useful Websites

- NHS Direct 0845 4647 - NHS Direct Online - [http://www.nhsdirect.nhs.uk](http://www.nhsdirect.nhs.uk)
- For up-to-date information on individual diseases and outbreaks - Health Protection Agency - [http://www.hpa.org.uk](http://www.hpa.org.uk)
- Department of Health - [http://www.dh.gov.uk](http://www.dh.gov.uk)
- World Health Organisation - [http://www.who.int](http://www.who.int)
# INFECTION CONTROL AUDIT

Date of Audit: ............................................................................................................................................................

School: ........................................................................................................................................................................

Completed by: ................................................................. Role: ........................................................................................................................................................................

Assisted by: ................................................................. Role: ........................................................................................................................................................................

<table>
<thead>
<tr>
<th></th>
<th>School Policies and Procedures</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The school’s policies include up to date infection control procedures</td>
<td></td>
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<tr>
<td>2</td>
<td>Procedures reflect Local Authority (LA) guidance and evidence-based best practice</td>
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<tr>
<td>3</td>
<td>The school has a policy for dealing with potentially infectious spills</td>
<td></td>
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<tr>
<td>4</td>
<td>The school has an emergency management plan which includes outbreak plans</td>
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<tr>
<td>5</td>
<td>Parents are informed of the school’s policy for excluding infectious pupils</td>
<td></td>
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<tr>
<td>6</td>
<td>Exclusion periods for staff and pupils are enforced</td>
<td></td>
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<tr>
<td>7</td>
<td>The school has up to date contact details for parents</td>
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<tr>
<td>8</td>
<td>Parents inform the school if their child is particularly vulnerable to infections</td>
<td></td>
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<tr>
<td>9</td>
<td>The school has a copy of the HPA guidance on infection control in schools **</td>
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<tr>
<td>10</td>
<td>Infection control procedures are included in staff induction and training</td>
<td></td>
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<tr>
<td>11</td>
<td>Staff have access to the list of notifiable diseases</td>
<td></td>
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<tr>
<td>12</td>
<td>Staff have access to telephone numbers for key health contacts</td>
<td></td>
<td></td>
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<tr>
<td>13</td>
<td>Immunisation status is checked at school entry</td>
<td></td>
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<tr>
<td>14</td>
<td>Staff receive appropriate immunisations</td>
<td></td>
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<tr>
<td>15</td>
<td>Annual influenza vaccination is recommended for those at risk</td>
<td></td>
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<tr>
<td>16</td>
<td>Female staff of child-bearing age are advised to check immunity to rubella</td>
<td></td>
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<tr>
<td>17</td>
<td>Pregnant staff are aware of additional infection risks</td>
<td></td>
<td></td>
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<tr>
<td>18</td>
<td>The risk of Legionnaire's disease from water storage systems is assessed</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>19</td>
<td>Control measures to prevent Legionnaire's disease are implemented</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Staff are aware of the action required following exposure to blood-borne viruses</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Ease of decontamination is assessed prior to purchasing equipment</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>22</td>
<td>Hand hygiene is included in staff induction</td>
<td></td>
<td></td>
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<tr>
<td>23</td>
<td>Pupils are taught about the importance of personal hygiene as part of the curriculum</td>
<td></td>
<td></td>
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<tr>
<td>24</td>
<td>Pupils are encouraged to wash their hands before eating and after using the toilet</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>25</td>
<td>Hand hygiene is promoted (e.g. by displaying suitable posters)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>26</td>
<td>Hand basins are supplied with hot (less than 43°C) and cold water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>27</td>
<td>Liquid soap is available at all hand basins</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>28</td>
<td>Paper towels are available at all hand basins</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>29</td>
<td>Sufficient waste bins (ideally foot-operated) are available</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Waste bins are not overfull or odorous</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>There are no communal bars of soap, nailbrushes or refusal</td>
<td></td>
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<tr>
<td><strong>32</strong></td>
<td>Staff and pupils use paper tissues when coughing and sneezing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>33</strong></td>
<td>Pupils are discouraged from sharing personal care items (hairbrushes)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Personal Protective Equipment (PPE)</strong></td>
<td></td>
<td></td>
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<tr>
<td><strong>34</strong></td>
<td>Disposable gloves (of appropriate sizes) and aprons are accessible to staff</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>35</strong></td>
<td>Suitable eye protection is available for tasks where there is a risk of splashing</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>36</strong></td>
<td>PPE carries the Communauté Européene (CE) mark</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>37</strong></td>
<td>Gloves are low-protein and powder free</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>38</strong></td>
<td>Non-latex gloves (e.g. nitrile) are available for staff with latex allergies</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>39</strong></td>
<td>Staff know when and how to use PPE</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>School Meals Service</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>40</strong></td>
<td>The catering facilities are registered with the LA</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>41</strong></td>
<td>There is a satisfactory food safety management system in place</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>42</strong></td>
<td>The LA routinely inspects the catering facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>43</strong></td>
<td>Inspection reports are monitored by the school</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>44</strong></td>
<td>LA inspection reports are satisfactory</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>45</strong></td>
<td>Any problems highlighted by LA inspections are swiftly addressed</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>46</strong></td>
<td>Food handlers who are infectious are excluded from work</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>47</strong></td>
<td>Catering staff report any illness or symptoms to their manager immediately</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>48</strong></td>
<td>The catering manager informs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No.</td>
<td>Description</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>49</td>
<td>Staff understand and follow the food safety management system</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50</td>
<td>Adequate cleaning procedures are in place and followed by staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>51</td>
<td>Staff are suitably trained, supervised and instructed in food hygiene matters</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>There are sufficient hand basins with hot and cold running water</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Liquid soap and paper towels are available</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>54</td>
<td>Kitchen cleaning materials are stored away from other cleaning items and food</td>
<td></td>
<td></td>
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<tr>
<td>55</td>
<td>There is a thermometer in the fridge and freeze</td>
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<tr>
<td>56</td>
<td>Daily temperatures are recorded</td>
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<tr>
<td>57</td>
<td>Temperatures are rectified if inadequate (fridges must be &lt;8°C, freezers &lt;18°C)</td>
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<tr>
<td>58</td>
<td>There are no inappropriate items (e.g. animal food, medicine) in the fridge</td>
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<tr>
<td>59</td>
<td>Food products are within their expiry dates</td>
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<tr>
<td>60</td>
<td>Open food is stored in covered containers</td>
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<tr>
<td>61</td>
<td>Waste bins are clean and in good condition with a securely fitting lid</td>
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<tr>
<td>62</td>
<td>Dining tables are cleaned and disinfected immediately before food is served</td>
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<tr>
<td>63</td>
<td>Dining room chairs are cleaned regularly</td>
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<tr>
<td>64</td>
<td>Food spills are removed immediately</td>
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<tr>
<td>65</td>
<td>Surfaces are cleaned and</td>
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<tr>
<td><strong>disinfected (as appropriate) prior to serving food</strong></td>
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<tr>
<td>66</td>
<td><strong>Fruit and vegetables are washed thoroughly before consumption</strong></td>
<td></td>
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<tr>
<td>67</td>
<td><strong>Hands are washed before handling food</strong></td>
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<tr>
<td><strong>Packed Lunches</strong></td>
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<tr>
<td>68</td>
<td><strong>Parents are aware of the importance of good food hygiene</strong></td>
<td></td>
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<tr>
<td>69</td>
<td><strong>There are cold storage facilities for pupil’s packed lunches</strong></td>
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<tr>
<td><strong>Food Safety in the Classroom</strong></td>
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<td>70</td>
<td><strong>Pupils are taught food hygiene rules</strong></td>
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<td>71</td>
<td><strong>High standards of hygiene are encouraged</strong></td>
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<tr>
<td><strong>Drinking Water</strong></td>
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<tr>
<td>72</td>
<td><strong>Contact details for the water company are available</strong></td>
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<tr>
<td>73</td>
<td><strong>Pupils have free access to drinking water throughout the day</strong></td>
<td></td>
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<tr>
<td>74</td>
<td><strong>Drinking water is available at several points (not from outlets in or near toilets)</strong></td>
<td></td>
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<tr>
<td>75</td>
<td><strong>Drinking water outlets are decontaminated regularly and well maintained</strong></td>
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<tr>
<td>76</td>
<td><strong>Pupils can carry their own drinking water bottle that they can clean every day</strong></td>
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<tr>
<td><strong>Laundry</strong></td>
<td></td>
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<tr>
<td>77</td>
<td><strong>Laundry facilities are situated away from food areas and inaccessible to pupils</strong></td>
<td></td>
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<tr>
<td>78</td>
<td><strong>There is a hand basin with liquid soap and hand towels</strong></td>
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<tr>
<td>79</td>
<td><strong>The washing machine has a pre-wash cycle</strong></td>
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<tr>
<td>80</td>
<td><strong>Staff do not rinse or wash soiled fabrics by hand</strong></td>
<td></td>
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<tr>
<td>81</td>
<td><strong>Staff wear appropriate PPE when handling soiled laundry</strong></td>
<td></td>
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<tr>
<td>82</td>
<td><strong>Staff wash their hands after handling laundry and after removing gloves</strong></td>
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<tr>
<td>83</td>
<td>Leak-proof laundry bags are available</td>
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<tr>
<td>84</td>
<td>Staff are aware of the procedure for dealing with pupils with soiled clothing</td>
<td></td>
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<tr>
<td>85</td>
<td>Fabrics are laundered using effective methods</td>
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<tr>
<td><strong>Waste Disposal</strong></td>
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<tr>
<td>86</td>
<td>Appropriate PPE is worn when handling waste</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>87</td>
<td>Hands are washed after handling waste</td>
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<tr>
<td>88</td>
<td>The school has notified the Environment Agency that it produces clinical waste and appropriate paperwork is completed</td>
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<tr>
<td>89</td>
<td>There is a foot-operated clinical waste bin in the medical room</td>
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<tr>
<td>90</td>
<td>Clinical waste bins are cleaned and disinfected regularly</td>
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<tr>
<td>91</td>
<td>Clinical waste bags are not filled more than two-thirds full</td>
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<tr>
<td>92</td>
<td>Filled bags are labelled and stored in a secure designated area for collection</td>
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<tr>
<td>93</td>
<td>Sharps bins conform to BS7320</td>
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<tr>
<td>94</td>
<td>Sharps bins are kept out of reach of pupils</td>
<td></td>
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<tr>
<td>95</td>
<td>Sharps bins are not filled more than two-thirds full</td>
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<tr>
<td>96</td>
<td>Filled sharps bins are sealed and stored in a secure designated area for collection</td>
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<tr>
<td>97</td>
<td>Staff are aware of the procedure for dealing with discarded sharps found on the premises</td>
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<tr>
<td>98</td>
<td>Clinical waste is collected by an authorised waste carrier</td>
<td></td>
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<tr>
<td>99</td>
<td>Household waste is placed in black plastic bags (or appropriate recycling bins)</td>
<td></td>
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<tr>
<td>100</td>
<td>Sanitary disposal units are not overfull or odorous</td>
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<tr>
<td><strong>Pest Control</strong></td>
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<tr>
<td>101</td>
<td>Staff segregate waste correctly</td>
<td></td>
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<tr>
<td>102</td>
<td>Staff report building defects and signs of infestation promptly</td>
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<tr>
<td>103</td>
<td>The school responds swiftly to staff reports</td>
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<tr>
<td>104</td>
<td>A pest control company carries out regular inspection and treatment as necessary</td>
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<tr>
<td><strong>Animals</strong></td>
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<tr>
<td>105</td>
<td>There is a written policy concerning animals on the school premises</td>
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<tr>
<td>106</td>
<td>A knowledgeable staff member is responsible for animal care</td>
<td></td>
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<tr>
<td>107</td>
<td>Animal equipment is cleaned and disinfected regularly</td>
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<tr>
<td>108</td>
<td>Animals have up to date immunisations and treatments</td>
<td></td>
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<tr>
<td>109</td>
<td>Hands are washed after contact with animals or their equipment</td>
<td></td>
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<tr>
<td>110</td>
<td>Staff are aware of procedures to be followed when wild animals are found</td>
<td></td>
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<tr>
<td>111</td>
<td>Pupils practice good hygiene during lessons involving any contact with animals</td>
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<tr>
<td><strong>Classroom and Sports Equipment</strong></td>
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<tr>
<td>112</td>
<td>Health and Safety Executive guidance regarding farm visits is adhered to</td>
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<tr>
<td>113</td>
<td>Rotas’ are in place to make sure equipment is cleaned regularly</td>
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<tr>
<td>114</td>
<td>Equipment is stored in clean dry containers/cupboards</td>
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<tr>
<td>115</td>
<td>Equipment is visibly clean</td>
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<tr>
<td>116</td>
<td>Modelling materials are replaced regularly</td>
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<td>117</td>
<td>Sandpits are covered when not in use</td>
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<tr>
<td>118</td>
<td>Sandpits are raked regularly</td>
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<tr>
<td>119</td>
<td>Discoloured or foul smelling sand</td>
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<tr>
<td><strong>Swimming Pools</strong></td>
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<tr>
<td>120</td>
<td>The pool manager maintains the pool with adequate levels of disinfection</td>
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<tr>
<td>121</td>
<td>The pool manager follows appropriate protocols for pool maintenance and cleaning</td>
<td></td>
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<tr>
<td>122</td>
<td>The pool manager has a procedure for dealing with contamination incidents</td>
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<tr>
<td>123</td>
<td>Pupils with diarrhoea are excluded from swimming</td>
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<tr>
<td>124</td>
<td>Pupils follow the pool hygiene procedures</td>
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</tbody>
</table>

**Audit score:**

**Date next audit due:**

**
See HEALTH PROTECTION AGENCY 2010 Guidance on infection control in schools and other child care settings. Available at: [www.hpa.org.uk](http://www.hpa.org.uk)
## Cleaning Audit

**School**

**Date of audit**

**Completed by**

<table>
<thead>
<tr>
<th><strong>Cleaning and maintenance</strong></th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A regular cleaning programme is documented</td>
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<tr>
<td>2. Surfaces are clean and intact</td>
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<tr>
<td>3. Cleaning equipment is well maintained and functions properly</td>
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<td>4. There is a repair request system in place</td>
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<tr>
<td>5. Damage to surfaces and equipment is swiftly rectified</td>
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<tr>
<td>6. Cleaning equipment and chemicals are stored in a clean dry cupboard</td>
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<td>7. Cleaning equipment and chemicals are in accessible to pupils</td>
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<tr>
<td>8. Cleaning equipment is clean, dry and in good condition</td>
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<td>9. Mops are stored inverted or hanging</td>
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<td>10. Buckets are stored upside down</td>
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<tr>
<td>11. Disposable cloths/paper towels are available for clearing spills</td>
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<td>12. Disposable gloves and aprons are available for clearing spills</td>
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<td>13. Clinical waste bags are available for clearing spills</td>
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<tr>
<td>14. Suitable disinfectants are available for clearing spills</td>
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<tr>
<td>15. COSHH assessments are available for all hazardous cleaning chemicals*</td>
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<td>16. Chemical containers are clearly marked with the product name and usage instructions</td>
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<td>17. Reusable cloths and cleaning equipment are colour coded</td>
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<tr>
<td>18. Cloths and cleaning equipment are decontaminated after each</td>
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<tr>
<td>19.</td>
<td>There is a sink available for cleaning equipment</td>
<td>Yes</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>20.</td>
<td>Hand washing facilities are available for cleaning staff</td>
<td></td>
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<tr>
<td>21.</td>
<td>Liquid soap and paper towels are available for staff at hand basins</td>
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</table>

**Staff knowledge and Practice**

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<tbody>
<tr>
<td>22.</td>
<td>Staff know where to find COSHH assessments/safety data</td>
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<tr>
<td>23.</td>
<td>Staff know what action to take in the event of a spillage or accident</td>
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<tr>
<td>24.</td>
<td>Staff understand the colour coding system</td>
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<tr>
<td>25.</td>
<td>Staff never mix chemicals</td>
<td></td>
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<tr>
<td>26.</td>
<td>Staff use appropriate personal protective equipment (PPE)</td>
<td></td>
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<tr>
<td>27.</td>
<td>Staff wash their hands after cleaning (after removing gloves)</td>
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<tr>
<td>28.</td>
<td>Staff are available during the school day to undertake emergency tasks</td>
<td></td>
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<tr>
<td>29.</td>
<td>Staff are aware of the procedure for dealing with spills of blood/body fluids</td>
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</tbody>
</table>

**School Premises**

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>30.</td>
<td>All areas are clean and uncluttered</td>
<td></td>
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<tr>
<td>31.</td>
<td>The environment and equipment smells, fresh clean and pleasant</td>
<td></td>
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<tr>
<td>32.</td>
<td>Waste bins are emptied daily</td>
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<tr>
<td>33.</td>
<td>Waste bins are free from odours and visible dirt</td>
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<tr>
<td>34.</td>
<td>Waste bins are cleaned and disinfected regularly</td>
<td></td>
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<tr>
<td>35.</td>
<td>Hard floors are dry and free from debris and removable stains</td>
<td></td>
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<tr>
<td>36.</td>
<td>Carpets are dry, free from debris and removable stains and not odorous</td>
<td></td>
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<tr>
<td>37.</td>
<td>Walls and ceilings are dry and free from debris and removable marks</td>
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<td>38.</td>
<td>Furniture and fittings are dry and</td>
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<td></td>
<td>free from debris and removable stains</td>
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<tr>
<td>39.</td>
<td>Classroom equipment is stored in a clean dry condition</td>
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<td></td>
<td>Towels, showers and changing rooms</td>
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<tr>
<td>40.</td>
<td>Surfaces are clean and dry and free from debris, scale, mould and mildew</td>
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<td>41.</td>
<td>All areas are free from odours</td>
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<tr>
<td>42.</td>
<td>Toilets, hand basins and showers are in good repair.</td>
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<td>43.</td>
<td>Toilets are fitted with seats and lids</td>
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<tr>
<td>44.</td>
<td>Toilet bowls are free from removable stains, smears and lime scale</td>
<td>Yes</td>
<td>No</td>
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<td>45.</td>
<td>Toilet paper is available in every cubicle</td>
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<tr>
<td>46.</td>
<td>Sanitary disposal units are available in all female toilets</td>
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<td>47.</td>
<td>Sanitary disposal units are not overfull or odorous</td>
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<tr>
<td>48.</td>
<td>Liquid soap and paper towels are available at all hand basins</td>
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</tbody>
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Audit score:

Areas requiring action:

Action required to meet acceptable standards of cleanliness and hygiene (state who is to complete each action and by when):
Date next audit due:
# School Outbreak Log Sheet

**School Name:**

**School Address:**

**Head Teacher:**

**Date form completed and sent to WYHPU:**

**Form completed by:**

**Number of pupils and age range:**

**Contact details:**

<table>
<thead>
<tr>
<th>Surname</th>
<th>First Name</th>
<th>DOB</th>
<th>Sex</th>
<th>Class or form</th>
<th>Symptoms</th>
<th>Date of onset</th>
<th>Excluded from School?</th>
<th>Date recovered</th>
<th>GP’s Name</th>
<th>Recent activities*</th>
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<tbody>
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</tbody>
</table>

**Surname**

**First Name**

**DOB**

**Sex**

**Class or form**

**Symptoms**

**Date of onset**

**Excluded from School?**

**Date recovered**

**GP’s Name**

**Recent activities***
* Include dates and brief details of any recent school trips or activities person has been involved in, particularly foreign travel, farm visits, animal handling, swimming, or water sports. Use a second sheet to record details if necessary.

Details of any action the school has taken……………………………………………………………………………………………………………………………………………………………………
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Have you washed your hands?

1. Wet your hands and use 1 squirt of soap.
2. Wash the palms and backs of your hands.
3. Wash between your fingers.
4. Wash the tips of your fingers and your thumbs.
5. Rinse and dry your hands.
Guidance on Outbreaks of Diarrhoea and Vomiting in Schools and Colleges

What is viral gastroenteritis
- A sudden onset of diarrhoea and/or vomiting.
- A highly infectious viral illness spreading easily from person to person.
- Spreads via the faecal/oral route – hands to mouth.
- Often due to Norovirus (sometimes referred to as winter vomiting or the 24 hour bug).
- Other symptoms often include nausea, abdominal cramps, headache and fever.
- Illness is usually of a short duration and most people are better within 48 hours.
- Drinking lots of fluids is vital to avoid the effects of dehydration.

Do you have an outbreak?
- An outbreak is an increased number of pupils and/or staff with diarrhoea and/or vomiting than would normally be expected.

Cleaning
- Cleaning staff should be informed that their role is vital in reducing the spread of infection.
- To assist effective cleaning, keep clear work areas/surfaces, etc.
- Disinfection - make up a hypochlorite solution, e.g. Milton 2% at a dilution of 1 in 20, i.e. 50 ml of Milton added to 1 litre of water. If household bleach is used, dilute to 1 in 100 (see manufacturer’s instructions).
- A fresh solution should be made every 24 hours.
- Diarrhoea and/or vomit should be cleaned up immediately using hand-hot soapy water and paper towels. Dispose in a plastic bag and seal.
- Disinfect uncarpeted areas by using the hypochlorite solution (made up as above).
- Clean carpeted areas by using hand-hot soapy water and steam clean do not vacuum.
- When toilets have been used by pupils/staff with diarrhoea and/or vomiting, they should be cleaned with detergent followed by the hypochlorite solution.
- Disposable gloves and aprons must be worn during this procedure.
- Door handles, stair hand rails and other similar surfaces should be cleaned a minimum of twice per day using the hypochlorite solution.
- Ventilate the building well (open windows to ensure a fresh distribution of air).
- Keep internal doors shut.

Key Message
- The West Yorkshire HPU will liaise with the Head Teacher and can provide information to parents, GPs and help deal with media enquiries.
- Pupil/staff who are ill should NOT return to school until they are 48 hours symptom free, e.g. 48 hours since their last episode of diarrhoea and/or vomiting.
- Outbreaks are common in schools and colleges.

4 steps to keep gastroenteritis outbreaks in check
- Early recognition and reporting.
- Good/effective hand hygiene.
- Good/effective cleaning.
- Good/effective communication.

Hand hygiene
- Effective hand hygiene is the single most important preventative measure that can be taken to reduce the impact and spread of viral gastroenteritis.
- Every opportunity should be taken to ensure all pupils/staff practice effective handwashing, particularly after toileting and before eating.

All schools should aim to achieve the following standards:
- all handwashing stations are in working order
- running hot water is available
- liquid soap is available
- paper towels are available.

Poster courtesy of NYAH HPU