Infection Control Policy & Procedure

POLICY:
Staff, clients and visitors are protected from preventable exposure to infection.

REFERENCE: PLEASE USE THIS POLICY IN CONJUNCTION WITH HEALTHCARE PROVIDERS & BUG CONTROL INFECTION CONTROL MANUAL. www.healthcareproviders.org.nz

HDSS 5.6 & Infection Control Standard NZS 8142

PROCEDURE:
The Service maintains an Infection Control Program / Team responsible for:

- Consultation & planning including the development of infection control policies and procedures that meet the needs of the institution.
- Identifying risk & relaying controls to staff, residents & visitors.
- Staff, visitor and client education
- Surveillance outcomes & recommendations are made known to staff & residents [handouts / graphs / support as appropriate]. Recommendations ARE reviewed for their success.
- The usefulness of the Surveillance Plan is assessed at each review.
- Complying with standards and regulations including accessing expertise for facility changes.
- Investigation of outbreaks /
Infection Control Policy & Procedure

RISK MANAGEMENT STRUCTURE

Ministry of Health

Benchmarking Stats Program
- Compares with other providers
- Accesses Best Practice Guidelines

District Health Boards

Surveillance & Data Collection

Printouts
- How do we compare?
- Information for staff
- Information for residents

Quality Review Infection Control
- by External Consultant / s
- Manager RN
- Team Leader H&S Reps

Infection Report Forms

Education Program
- Inductions ALL EMPLOYEES
- Manager / RN Training
- Staff Training
- Assessing educators
- Assessing understanding
- Learning sessions in response to surveys
- Learning sessions in response to incidents

Laboratory
- Reporting Notifiable Diseases
- Share Information

Doctors
- Share information
- Agree guidelines

Business Risk Management
- Known Risks Assessed / Rated / Controlled / Minimised
- Emergency / Outbreak & Contingency Planning
New resident infections are reported to the Manager immediately then to the doctor. These are recorded on the Infection Report Form [see next page] using “Standard Definitions of Infection”. Where transfer to appropriate specialist care is needed this is sought at earliest opportunity [measles / Avian Flu / Tuberculosis]

**Surveillance**

The Team Leader is responsible for maintaining monthly statistics on all infections [resident & staff]. Outside consultancy may be contracted to ensure robust review. This must be provided by a Health Professional with sufficient experience in this field. Statistics are presented at three monthly Service Review Meetings. Any clusters of infection inspire immediate meeting of the infection control team.

**Infection rates / incidences**
- Chest infections
- Flu
- Diarrhoeal disease
- Skin and wound infections [includes fungal, scabies & head lice]
- MRSA, ESBL, VRE, Norovirus, TB & Avian Flu
- Eye & Ear [separately]
- Urinary tract infection [*Threshold rate is 1.51 per 1000 occupied bed days*]

**UTI Rationale** [according to Indicators for Safe Aged Care NZS HB 8163: 2005]:
1. Maximise Quality of Life for Residents – Happier residents & staff
2. Less uncomfortable symptoms for them
3. Help reduce resistance to antimicrobial agents
4. Cost effective – workloads / cost of therapies / staffing levels
5th Rationale: Help reduce a risk to staff of cross infection

**UTI Exclusions**: Admitted with UTI or those that contract UTI within 48 hours of admission.

**Data maintained while in our care:**
- The number of infections
- Source (if known)
- Site
- Type
- Frequency
Infection Control Policy & Procedure

NB: Data revealed by Infection Reports is kept in BOTH the client file AND in the exception report folder. Confidentiality IS maintained. Individual residents are NOT identified in the Benchmarking Stats Program.

NB: These are not just documentation of antibiotic usage. They also include incidences where the Standard Definition for Infection was met, and conservative measures proved successful. This also includes infections where no doctor visit occurred.

Quality Reviews

Review of the Infection Control Programme is 6 - 12 monthly, or more frequently as required. It is the Managers responsibility to ensure these reviews are carried out. The Manager may call upon external Health Professional to help ensure the robustness of review. Quality Reviews focus upon Infection Acquisition & Transmission Risks. These risks will be assessed, rated and control measures evaluated. Staffing & resources are assessed for adequacy.

Benchmarking Stats

The Home inputs data directly into Healthcare Help Benchmarking Stats program.

YES [ ] No [ ]

Raw data is inputted monthly. Bed days are inputted monthly. The online program turns this data into an infection rate. Rates of infection can be viewed for each of the months of the year. These rates are measured against Healthcare Help averages. Averages are calculated among other similar providers. We can view our own statistics and the averages of everyone else. Where threshold values have been agreed according to SNZ HB 8163:2005 Indicators for Safe Aged-care & Dementia Care this is shown on the graphs. If our statistics are above the threshold value we need to examine Best Practice Guidelines in an effort to improve care. Best Practice Guidelines are available on the Website for each of the Indicators.

Achievement is benchmarked against desired values, other years and other providers.
Infection Control Policy & Procedure

Infection Report Form

Date: ……………………
Name of sick person: ………………………………………………………………………………… Staff / Client / Visitor

Type of Infection: …………………………………………………………………………………
[NB: please look at standard definitions of infection to decide]

How many hours / days did it last? ………………………………………………………… Please include dates.

What did we do about it?
[Conservative treatment like fluids and Paracetamol etc / saw doctor / other….

Was a specimen sent YES NO Result: …………………………………………………

If an antibiotic was used, what was it called: ……………………………………………

How long was the course: ………………………… Was it successful: YES NO

Future prevention?

Sign off at Service Review Meeting

Sign: ……………………………………………………

Date: ……………………………………………………

Reporting Process

1. Document all infections on the Infection Report Form [reviewed by team leader daily]
2. Report to the Manager any infections of concern at once.
3. Report to other Health Professionals as appropriate – doctor / laboratory
4. It is the manager responsibility to liaise with laboratory for appropriate reporting, in timely fashion. Reporting is to the Ministry of Health.
5. Reporting Requirement Tables are supplied by Diagnostic Medlab. Information from them is readily available immediately upon request.
### Standardised Definition Infection “Cold”

Considered to have a Cold if has at least **two** of the following signs or symptoms:

1. **runny nose,**
2. **sneezing,**
3. **stuffy nose** (congestion), **sore throat** OR **hoarseness** OR **hard to swallow**
4. **dry cough,** or
5. **swollen or tender glands in the neck.**

Fever may or may not be present, symptoms must be new, and allergies must be ruled out.

### Standardised Definition Infection “Flu”

Considered to have Flu if has fever **AND** at least **three** of the following six signs:

1. *chills,*
2. new **headache** OR **eye pain,**
3. **muscle pain,**
4. feeling **unwell** OR **loss of appetite,**
5. **sore throat,** or
6. new **OR** increased **dry cough.**

During flu season, if can be either Lower Respiratory Tract Infection OR flu, then please record as flu.

Note: Antibiotics are not usually helpful for Flu.

### Standardised Definition Infection Lower Respiratory Infection or “Bronchitis”

Three of the following seven signs or symptoms are present:

1. New **OR** increased **cough,**
2. New **OR** increased **sputum** production,
3. New **OR** increased purulence of sputum,
4. **Fever,**
5. Pleuritic **chest pain,**
6. New **OR** increased **bronchial breathing,** **OR**
7. Change in status (new **OR** increased **shortness of breath,** increased **respiratory rate,** worsening mental or functional status).

### Standardised Definition Infection “Pneumonia”

Pneumonia may be diagnosed and counted in this category if **one** of the following criteria is met:

1. Dullness on physical examination of the chest **AND** at least **one** of the following:
   - new onset of **purulent sputum** or change in character of the sputum **OR**
   - **organism cultured** from the blood
2. Patient has a chest radiograph that shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion **AND** at least **one** of the following:
   - new onset of purulent sputum or change in character of sputum **OR**
   - organisms cultured from blood.

Note: Non infectious causes, such as congestive heart failure, need to be ruled out.
Infection Control Policy & Procedure

### Standardised Definition Infection
**“Skin & Wound”**

| Cellulitis / soft tissue / wound infection / ulcer infection |

These infections must meet at least one of the following two criteria:

1. Presence of **pus and discharge** in the wound, skin or soft tissue site.
2. At least two of the following signs or symptoms with no other recognized cause:
   - **worsening mental** / functional status;
   - the presence at the affected site of **pain or tenderness**;
   - localized **swelling**;
   - **redness**;
   - **heat** AND at least one of the following:

Also confirmed by:

1. Organism cultured from wound
2. Organisms cultured from blood.

### Standardised Definition Infection
**“Diarrhoeal Disease / Gastro Enteritis”**

One of the following three criteria must be met:

1. Two or more **loose watery stools** in 24 hours above what is normal for the client;
2. Two or more **vomiting** episodes in 24 hours; **OR**
3. Positive stool culture for a gastrointestinal pathogen **AND** nausea, vomiting, abdominal pain or tenderness, or diarrhoea.

NB: Non infectious causes, such as medication side effects, must be ruled out - e.g. diarrhoea as a side effect of laxatives.

### Standardised Definition Infection
**“eye”**

**Conjunctivitis:**

One of the following must be present:

- **pus** from one or both eyes **OR**
- **redness** with or without itching or pain.

Both trauma and allergies must be ruled out.

### Standardised Definition Infection
**“ear”**

**Ear infection:**

One of the following must be present:

- **physician diagnosis**
- **OR pus** draining from middle ear / **red ear drum** plus **pain**

### Standardised Definition Infection
**“mouth”**

**Oral infection:**

Request doctor diagnosis.

### Standardised Definition Infection
**“nose”**

**Nasal infection:**

Request doctor diagnosis.
### Standardised Definition Infection “Urinary Tract Infection”

Threshold Value 1.51 per 1000 occupied bed days

Considered to have **URINE TRACT INFECTION** if:

Need **three** of the following four signs or symptoms:

1. **Fever OR chills**
2. **Flank pain OR suprapubic pain OR tenderness OR frequency OR urgency**
3. **Worsening of mental status/functional status**
4. Changes in urine: **bloody urine, foul smell, increased sediment AND urinalysis or culture not done.**

B. At least **two** of the four above signs or symptoms **AND** at least **one** of the following:

1. Urinalysis with positive nitrite and/or positive leukocyte esterase
2. Presence of organisms by culture at laboratory

For our Infection Control Surveillance, please count as an infection if the above criteria are met. Where considered to have an infection, but not given antibiotics, please also log this. Surveillance is of infections, NOT a log of antibiotic usage.

NB: Staff filling in Infection Reports need to be trained to understand “Standard Definitions of Infection” and to have been assessed as competent to perform this task. Please seek help from the Manager or your Team leader if you are unsure.

### Training

All staff **MUST BE** inducted, **PRIOR** to commencing work, in the essentials of Hazard Management and Infection Control, including hand washing and Standard Precautions, regardless of their qualifications or other experience. Knowledge is assessed to ensure each new staff member has learned this adequately. The Manager or their delegate is responsible for, and instigates training for staff, and residents. This person attends additional training in ‘Managing an Infection Control Program’. This needs to include sessions for managing & preventing Norovirus, Avion Flu, Tuberculosis, ESBL producing organisms & MRSA, & scabies.
Infection Control Policy & Procedure

Understanding Infection Control:

1. Standard Precautions
2. Contact Precautions – standard precautions & long sleeved gown & gloves
3. Airborne Precautions – plus sufficiently protective mask.

### KEEPING SAFE / STANDARD PRECAUTIONS

<table>
<thead>
<tr>
<th>ACTION</th>
<th>METHOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAREFUL HAND WASHING</td>
<td>Hand care</td>
</tr>
<tr>
<td></td>
<td>- short nails</td>
</tr>
<tr>
<td></td>
<td>- protective cream</td>
</tr>
<tr>
<td></td>
<td>- cover cuts</td>
</tr>
<tr>
<td>PROTECT YOURSELF</td>
<td>Personal Protective Equipment - PPE</td>
</tr>
<tr>
<td></td>
<td>- gloves</td>
</tr>
<tr>
<td></td>
<td>- goggles</td>
</tr>
<tr>
<td></td>
<td>- boots</td>
</tr>
<tr>
<td>CLEAN &amp; CONTAIN</td>
<td>Blood spills</td>
</tr>
<tr>
<td></td>
<td>Chemicals</td>
</tr>
<tr>
<td></td>
<td>Animal excretion</td>
</tr>
<tr>
<td>SAFE HANDLING</td>
<td>NEVER INTO CUT OR OPEN WOUND!!!!!!!!!!!</td>
</tr>
<tr>
<td>- BLOOD</td>
<td>Avoid contact with skin</td>
</tr>
<tr>
<td>- CHEMICALS</td>
<td>Avoid contact with nose</td>
</tr>
<tr>
<td>- ANIMAL PRODUCTS</td>
<td>Avoid splashes in eyes</td>
</tr>
<tr>
<td>COUGH ETIQUETTE</td>
<td>DO NOT COUGH ON OTHERS</td>
</tr>
<tr>
<td>- Beware airborne transmission</td>
<td>Use a disposable tissue</td>
</tr>
<tr>
<td></td>
<td>Contain your cough</td>
</tr>
</tbody>
</table>
PREVENTION & CONTROL OF INFECTION: Staff NEED to be familiar with ALL IC Policy!

Staff education focuses upon the importance of regular hand washing, and the use of gloves and other barrier protection such as glasses, masks and aprons when dealing with bodily fluids. Staff also need to understand the concept of contamination. It is the manager’s responsibility to ensure this is taught to ALL NEW EMPLOYEES at induction – cooks and cleaners especially.

Hand Washing

- Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items, even when gloves are worn.
- Wash hands immediately after gloves are removed, between patient contacts, and to avoid transfer of micro-organisms to other patients or environments. It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

Gloves

- Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items, mucous and broken skin.
- Remove gloves immediately after use, and before touching anything else, and then wash hands immediately to avoiding transfer of micro-organisms to other people.

Re-used Equipment

Reusable equipment must be carefully cleaned and disinfected after EACH use. Soaking in Milton for 20 minutes is effective. Examples include scissors from the first aid box. Most other equipment is disposable. Nebuliser masks, & spacers [single person use only].

Single Use Items: Discard after use. Do not attempt to sterilise and re-use. Examples include glucometer needles and disposable gloves, dressing packs & catheters / catheter bags & colostomy equipment.

Monitoring other Health Professionals: - essential as they don’t always wash their hands [include Doctors, Lab staff, physio’s, podiatrists AND consultants]. All staff can be diligent here and “OFFER” the use of well stocked hand basins.
Environmental control

Clean and disinfect surfaces as per a regular schedule: beds, bed rails, bedside equipment, and other frequently touched surfaces. Audit the IC cleaning program.

Linen

Make sure that used linen that has blood, and body fluids on it does not touch skin or mouth or nose and does not contaminate your clothing. Avoid transfer of microorganisms to other people and to other places. DO NOT HOLD BUNDLES OF LINEN IN YOUR ARMS!

Droplet precautions (use of mask and gown)

In addition to standard precautions, use droplet precautions, for ANYONE with a cold or flu [infected with microorganisms transmitted by droplets during coughing, sneezing, talking]. Send staff with suspected droplet infections home at once. Discourage any visitors showing signs of droplet infection whoever they are.

Client placement

Try and keep infectious people separate from others. Stay in own rooms, even for meals, so that others are less likely to catch the infection.

Medical Waste

All disposable material containing body fluids must be double plastic bagged and placed in rubbish containers outside.

Soiled Linen

Any soiled linen is treated as potentially infectious.
Soiled linen is placed in a covered bucket, to be carried to the laundry.

Sharps containers are available in the _________________________________ [state where] for the safe disposal of needles and syringes, glass ampoules and any other sharp material. Sharps bins are removed when three quarters full. They are taken to / collected by _________________________________ [state who] for disposal. A new one is then used.
Hand Hygiene Step by Step

1. Wet Hands
2. Use the soap provided in the wall dispenser – one good squirt.
3. Take 30 seconds to rub all surfaces of your hands.
4. Special attention should be given to fingernails, the spaces between fingers, palms and backs of hands.
5. Rinse under the tap.
6. Use a dry paper towel to turn the tap off - beware bugs on the tap handles.
7. Dry with paper towel.

Hand hygiene stops sickness. Bugs on hands have been described as “easy riders” to the next thing you touch. ALL staff need to be assessed & signed off as competent hand washers!

Hand Hygiene Is Required

- After touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn.
- After touching your nose or sneezing!
- After removing gloves
- After touching other people
- Before touching, cooking and serving food
- Before giving out medication
- Before any kind of wound care.
- After touching animals
- After touching anything dirty

When to Wear Gloves:

- When touching blood, body fluids, secretions, excretions and contaminated items. NB: Remove gloves before touching non-contaminated items and before going to another person.
- All staff with cuts, abrasions or skin lesions on their hands must cover these cuts before starting work. Get help, as required if you cannot fix cuts & wounds yourself.

It is important to wash hands or use antimicrobial hand rubs between EVERY resident/ client contact.

Do not use gloves from person to person or area to area.
Infection Control Policy & Procedure

BLOOD Contamination

**Splash**
- WASH Soap Water
- Check skin integrity

  - in eyes? RINSE
  - in nose? BLOW
  - in mouth? SPIT

**Needlestick**
- MAKE BLEED
- WASH Soap Water

**Open Wound**
- WASH Soap Water
- occlusive dressing

- REPORT NOW
- Incident form

**BLOOD Contamination**

Issue Number: 02 Policy provided by HH.NET LTD Issue Date: 01.08.08
Barrier Isolation

Barrier isolation precautions are needed for people with infectious diseases, especially infectious diseases resistant to antibiotics. They are also needed for people with LOW immunity, or poor resistance to organisms. It is unlikely that we would need to use these precautions in the Home, as these resident's are more likely to be in Hospital care.

Cleaning Disinfecting & Sterilising

- Cleaners must use the labelled cleaning solutions provided
- Cleaners must NOT wear gloves from room to room
- Sterilising of used equipment is in Milton Solution [read instructions for dilution]
- Sterilisation takes 20 minutes
- We do NOT perform ANY “sterile” procedures. Dressings are considered “clean”.
- Internal audit checks Infection Controls
  - Household cleaning audit [does the place look & smell nice]
  - Personal cares audits [are residents afforded the same nice care]
  - Audit of infections [Benchmarking Stats]
  - Quality Review of Infections

Pandemic Planning

Elaboration of planning is documented as part of Quality Reviews of Infection Control Program

- Consideration for closing doors
- Consideration for sending residents home to family
- Consideration of staffing levels in a pandemic
- Civil defence & emergency rations & planning

Occupational Health / Needle stick Injury

- Staff are trained to prevent the likelihood of needle stick injury
- Staff must report ANY incidences
- These are counted as part of the Benchmarking Stats and brought up at Service Review [further prevention measures]
MRSA Policy

**POLICY:** To control for infections entering the Home. Most likely source is AFTER ADMISSION TO HOSPITAL. MRSA could be in wounds or in the lungs as a chest infection.

**REFERENCE:**
HDSS 5.6
MOH MRSA Guidelines [This MRSA Policy is an abbreviated version of the MOH Guideline].

**WHAT IS IT?**
MRSA stands for Methicillin Resistant Staphylococcus Aureus, a form of Staphylococcus aureus (SA). [the commonest type of bacteria that can infect humans].

**DEFINITIONS & DIFFERENCES:**

<table>
<thead>
<tr>
<th>Staphylococcus Aureus [SA]</th>
<th>Multi-resistant Staphylococcus Aureus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can live harmlessly on a person's skin or in the nose and does not cause any infection.</td>
<td>Resistant to antibiotics = resistant to penicillins and cephalosporins].</td>
</tr>
<tr>
<td>Usually causes no problems. If it does, the resulting infection is usually trivial and affects the skin, resulting in infected cuts or boils, which are easily treated.</td>
<td>Some antibiotics are still effective, but they may be more difficult to use, and cause side effects.</td>
</tr>
<tr>
<td>SA is more of a threat to hospital patients with deep wounds, catheters or drips, which allow the bacterium to enter the body or to vulnerable patients through extreme age or ill health.</td>
<td>Sometimes MRSA causes skin abscesses, wound healing problems, septicaemia and pneumonia. This usually occurs in susceptible people [those who are very old, young, already sick or debilitated for any reason including illegal drug usage].</td>
</tr>
</tbody>
</table>

No need to swab incoming staff and residents as 1 in 3 will be colonised with Staphylococcus Aureus.

Need to know if incoming residents have MRSA in wounds or chest or in the urine. Careful screening of admissions from Hospital needed.

Not seen as a significant risk to Healthy people.

Those at risk are the old, frail, medically compromised and anyone post surgery, or with wounds.
**MRSA GUIDELINE:**

<table>
<thead>
<tr>
<th>1. Identify carriers &amp; those at risk</th>
<th>2. Transfers and Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Swab residents returning from hospital if they have chest infection or any kind of wound.</td>
<td>Residents who are known MRSA carriers should not be denied entry or re-entry to the Home. [Entry of resistant bacteria is not known to increase facility infection rates].</td>
</tr>
<tr>
<td>- Screening during any outbreak will help determine the extent of spread.</td>
<td>Decolonisation therapy [application of antibiotic creams] should <strong>not</strong> be required for people colonised with MRSA before their admission to the Home. Screening is not done routinely on residents awaiting transfer. Consider not accepting clients with catheters [exclusion criteria] or working towards rehabilitation so they are not required.</td>
</tr>
<tr>
<td>Taking swabs to determine MRSA:</td>
<td></td>
</tr>
<tr>
<td>- One nasal swab (Swab both sides of both nostrils).</td>
<td></td>
</tr>
<tr>
<td>- Swab from the groin.</td>
<td></td>
</tr>
<tr>
<td>- Swab from site of infections</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. Transmission</th>
<th>4. Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transmission is by person-to-person spread, most often on the hands of health care staff.</td>
<td><strong>Hand hygiene is the single most effective means of preventing the spread of MRSA.</strong> [See Hand Washing Policy].</td>
</tr>
<tr>
<td>- After contact with ‘infected’ or ‘colonised’ people</td>
<td>- <strong>Antimicrobial hand wash must be available to residents and to care staff.</strong></td>
</tr>
<tr>
<td>- Droplets from people coughing</td>
<td>- <strong>Clients identified with MRSA may need education and assistance with regular and thorough hand washing.</strong></td>
</tr>
<tr>
<td>1. Cover infected wounds</td>
<td>- Hand washing between infected parts of the client and other parts of their body is also required.</td>
</tr>
<tr>
<td>2. Keep people with [MRSA] chest infections in their own rooms</td>
<td>- Using appropriate De-colonisation therapy for clients with MRSA i.e. anti-microbial skin washes and topical antibiotic creams to specific identified sites &amp; special dressings.</td>
</tr>
<tr>
<td>3. ‘Infected’ or ‘colonised’ residents must stay away from susceptible people</td>
<td></td>
</tr>
<tr>
<td>4. If equipment must be shared, then adequately clean and disinfect before use for another patient.</td>
<td></td>
</tr>
<tr>
<td>5. Visitors seeing more than one resident should visit MRSA clients last. They should wash their hands carefully before leaving.</td>
<td></td>
</tr>
<tr>
<td>6. The environment may act as a reservoir of MRSA.</td>
<td></td>
</tr>
</tbody>
</table>

NB: Residents colonised with MRSA should **not** be restricted from participation in social or therapeutic group activities unless there is reason to think that they are shedding large numbers of bacteria and have been implicated in the development of infection in other residents. Such restrictions cause deprivation of social contact and rehabilitation opportunities.
Strict isolation should be reserved for instances where clients are shedding large numbers of organisms into the environment (for example, large wounds not contained with dressings or lower respiratory tract infections with active coughing). Alternate placement for such clients may be sought.

**Review of Control**

Infections are recorded on Infection Report Forms. These are presented at 3 monthly Service Review Meetings or more often, in the event of outbreak.

**Desired Values:** Where no infections caused by MRSA were found in the preceding year, and few, if any, colonised patients, no additional control measures are needed.

Endemic infection is cause for concern where:

- There is more than 1 infection per 1000 resident days
- More than three infections in a week
- Twice the number of infections in a month than had been observed in the previous three months

In these instances consultation with an experienced infection control expert will be sought.

**Surveillance**

The service relies on the diagnosing laboratory to report any incidences to the appropriate authority. It is the Managers responsibility to ensure reporting of notifiable diseases has occurred.
MRSA Infection Identified

- Determine site of infection
  - Can the area be covered?
    - No
      - Take standard precautions
        - Antibiotics
        - Antibacterial washes
        - Wash hands
        - Wear gloves
        - Use antimicrobial wash
        - Help client with basic hygiene
        - Treat rubbish and linen as hazardous
    - Yes
      - Occlusive dressing
      - Decontaminate (clean room)

- Decide treatment
  - Clearance
    - YES
    - STOP
    - Decontaminate (clean room)
    - A single room may not be required
    - Resident movement should not be restricted providing infection can be covered
    - Consult infection control policies
  - NO
    - Take standard precautions
      - Antibiotics
      - Antibacterial washes
      - Wash hands
      - Wear gloves
      - Use antimicrobial wash
      - Help client with basic hygiene
      - Treat rubbish and linen as hazardous

Use this form as a guideline

Sandra Lee
Health & Safety Consultant
021 726 397
Letter to the Infection Control Team at a Receiving Health Care Facility

Date: ________________________________

The Infection Control Doctor _________________________________________________

Dear Colleague,

The following patient, ________________________________

- been found to be a carrier of methicillin-resistant Staphylococcus aureus (MRSA) at the following sites:
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

- has been nursed in a room with other patients infected with MRSA.

This MRSA strain is resistant to:
  ____________________________________________________________
  ____________________________________________________________
  ____________________________________________________________

This MRSA strain is susceptible to:
  ____________________________________________________________

I understand that s/he is to be transferred to your hospital/hospice/convalescent home. If you would like further details regarding culture results or treatment to date, please do not hesitate to contact us

Yours sincerely

____________________________________
Infection Control Person
What is MRSA?
MRSA stands for Methicillin-resistant Staphylococcus aureus, a **bacteria** or **germ** that normally lives on the skin causing **no harm**.
It likes the warm, moist environment of the nose and groin.
This bug has developed a resistance some of our most often used antibiotics e.g penicillin.
MRSA may be present on the skin for a long time without causing any harm, but if it gets into a wound or break in the skin, it can cause an infection.
When a person has an infection caused by MRSA it can very hard to treat – different antibiotics may help.

How did you know that I have MRSA?
**ANSWER:** From a positive wound swab.

What Happens next?
Further swabs may need to be taken from your nose and groin and from any wounds.
- If MRSA is found on your skin, you may be asked to wash with a special disinfectant soap.
- If MRSA is found in your nose, a special ointment may need to be placed in the nostrils.
You may also be placed on different antibiotics if MRSA is found in your wound.

What does isolation mean?
If you are placed in isolation, it means that people caring for you may have to take special precautions.
The isolation precautions are as follows:
1. You may be placed in a single room to away from other people to protect them.
2. Gloves may be worn by staff coming in contact with you to prevent the MRSA from being transferred onto their hands.
3. Gowns sometimes may be worn by staff to stop MRSA getting on to their clothing.
4. Sometimes masks may need to be worn by those having direct contact with you.
5. You may need to wear a mask if leaving the room.
6. Everybody leaving the room must wash their hands or use the alcohol hand rub/gel provided.

Is MRSA dangerous to my family/whānau?
MRSA is usually only a problem for people who are already weak, so it might be best to think about keeping family/whānau who are already very old or sick safe. We can help with this.

MRSA is not a bacteria that floats in the air. It is spread by touching. It is important that visitors wash their hands before leaving the room and after assisting with any of care.

If your visitors are seeing other people in the home ask them to visit them first before visiting you.

**PLEASE FEEL FREE TO TALK TO STAFF AT ANYTIME - WE ARE HERE TO HELP.**
Extended - Spectrum beta-lactamase Producing Gram Negative Bacilli

**Policy:**
To control for infections entering the Home. Most likely source is AFTER ADMISSION TO HOSPITAL. ESBL

**Reference:**
2007 Draft guidelines for the Control of Multidrug- resistant Organisms in New Zealand.

### What is ESBL?

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bugs that have become resistant to antibiotics that would normally kill them</td>
<td>x</td>
</tr>
<tr>
<td>Bacteria with enzymes that can break down many common antibiotics.</td>
<td>x</td>
</tr>
<tr>
<td>The gut of infected people can harbour these organisms for many months</td>
<td>x</td>
</tr>
<tr>
<td>Found in urine, wounds, sputum, or faeces, rectum &amp; in blood cultures.</td>
<td>x</td>
</tr>
<tr>
<td>Associated with the overuse of antibiotics</td>
<td>x</td>
</tr>
<tr>
<td>Result of poor hand washing / poor infection control</td>
<td>x</td>
</tr>
<tr>
<td>Infected residents can easily infect others just by touching them</td>
<td>x</td>
</tr>
<tr>
<td>Staff can carry the bug on their hands to lots of residents</td>
<td>x</td>
</tr>
<tr>
<td>The gut can hold huge reserves of these organisms</td>
<td>x</td>
</tr>
<tr>
<td>Large numbers of people in the community carry these resistant organisms</td>
<td>x</td>
</tr>
<tr>
<td>They are sick</td>
<td>x</td>
</tr>
</tbody>
</table>

### Risk Factors

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor hand hygiene</td>
<td>x</td>
</tr>
<tr>
<td>Long or frequent hospital stay – especially ICU / operating theatre</td>
<td>x</td>
</tr>
<tr>
<td>Multiple courses of antibiotics</td>
<td>x</td>
</tr>
<tr>
<td>Exposure to broad spectrum antibiotics</td>
<td>x</td>
</tr>
<tr>
<td>Exposure to contaminated equipment or environment.</td>
<td>x</td>
</tr>
<tr>
<td>Strong fit person</td>
<td>x</td>
</tr>
<tr>
<td>Old sick frail</td>
<td>x</td>
</tr>
</tbody>
</table>

✓ Effective hand hygiene for both patient and environmental contact.
✓ Strict adherence to isolation precautions e.g. gloves and gown for direct contact with resident or environment.
Managing People either Infected or Colonised with ESBL Organisms

Tag or **flag the resident’s medical records** by placing a yellow warning page at the front.

**Educate the resident** and their visitors about Contact Precautions needed to stop infecting others AND their responsibility in diligent adherence to these precautions. Monitor visitors carefully. If visiting more than one person visit ESBL + people last.

**Good Hand Hygiene** - with an antibacterial hand wash before and after all resident contact. Resident must wash hands before leaving the room & after ALL personal cares esp. toileting!

**Contact Precautions:**
1. Do not move between residents without decontaminating the hands
2. Use good hand sanitiser like Microsheild. Have **plenty available** at strategic points.
3. Have **good hand sanitising equipment** in resident room and outside resident rooms
4. **Gloves** for contact with patient and their environment
5. **[Long Sleeved] Gowns or plastic aprons:** for contact with patient and their environment
6. Monitor visiting Health Professionals carefully / show them our Contact Precautions

**Cleaner:** Educate and monitor cleaning & disinfecting of the environment
1. ESBL rooms are cleaned last
2. Wear gown or plastic apron & gloves
3. Use detergent & water for surfaces, furniture & floors
4. Wash walls and the sides of furniture with a bleach solution.
5. Use friction cleaners like Ajax for bathrooms, door knobs, soap dispensers, toilet seats & chairs & paper towel holders.

Use **separate equipment** for ESBL affected / colonized residents or clean thoroughly / decontaminate with antibacterial solutions before using on other people.

**Dispose of wastes** from affected people [e.g. dressings] in double plastic bags

**Catheter Management:** Strict contact precautions & great care especially in disposal

**Signage:** Warning signage on resident door. Resident’s door may be left open

**Care with resident to resident contact.**
Carers may be with others but should have their “own” chair in lounge.
Cover wounds / ensure no incontinence a source of contamination to others or environment.

**Carry out regular audits of compliance with Contact Precautions**

**Notify any receiving facility** of the resident’s ESBL status PRIOR to transfer or discharge.

**Discharge:** Change curtains. Use detergent & water on surfaces including bed & pillows.
Infection Control Policy & Procedure

Spread
From the bowel of the infected person **ON THEIR HANDS**
**ONTO ANYTHING THEY TOUCH**

Health care worker
Care giver
Doctor
RN

Infected person
Their bed
Urine

Equipment

By touching

Break the Cycle!
**WASH YOUR HANDS**

Don’t contaminate your uniform – wear gown or apron
Dispose of wound dressings & urine soaked items in double plastic bags
Clean everything thoroughly with hot soapy water & detergent
Use ajax & bleach in water on frequently touched surfaces
Help residents with personal cares
Transmission:
On the hands
This is NOT an airborne organism – masks are not needed
From person to person
From person to environment
From environment to person

ESBL Screening Guideline:
1. Screen anyone coming from any facility where cross infection of ESBL has occurred within the past six months.
2. When ESBL has been found in the room. All contacts in the room must be screened.
3. When resident has had ESBL in the past.

Screen:
1. Rectal swab or faeces
2. Chronic ulcers
3. Surgical wounds and stoma sites.
4. Catheter specimens. NOT MSU.

NB: The laboratory form needs to state that these samples are specifically for screening for ESBL. Otherwise, they may not be processed correctly!

NB: Residents colonised with ESBL organisms should not be restricted from participation in social or therapeutic group activities unless there is reason to think that they are shedding large numbers of bacteria and have been implicated in the development of infection in other residents. Such restrictions cause deprivation of social contact and rehabilitation opportunities.
Infection Control Policy & Procedure

Guidelines for the Management of Norovirus Outbreak

**POLICY:** To control for the spread of the Norovirus infection & optimise the rehabilitation of those affected.

**REFERENCE:** A+ Guidelines for the Management of Norovirus in Hospital and Elderly Care Organisations.

**DEFINITION:** Norovirus is a highly infectious gastroenteritis [inflammation / infection of the tummy and digestive tract]. Two or more residents with the same symptoms of diarrhoea & vomiting at the same time = an “outbreak”.

This can cause: nausea, vomiting, abdominal cramps and diarrhoea. Also, fever, chills, muscle aches and general tiredness. **People become sick from eating food where the Norovirus has grown.** Feelings of sickness can take from 10 to 50 hours to develop. It may last from 24 to 48 hours. Norovirus may stay in the stools even after a person feels well again. A person may remain contagious for up to two weeks after recovery. It is capable of living on in the environment so decontamination of all surfaces in the rooms of sick people is essential to stop ongoing spread. Recovery brings with it short term immunity.

**TRANSMISSION:**

Once sick, people with Norovirus become highly contagious:

Direct Transmission – from touching affected people

- through their vomit,
- from touching faeces

Air borne - others can get sick by breathing the virus in assisting anyone who is vomiting.

**TREATMENT:**

1. Drink plenty of fluids especially if sick with diarrhea & vomiting – gastrolyte [electrolyte drink] may be useful.
2. Beware of dehydration in the elderly
3. Rest
**MANAGEMENT OF NOROVIRUS OUTBREAK:**

### Universal Precautions:

1. **Careful Hand washing**
   - Using running water & liquid soap for at least 15 seconds. Dried with a paper towel.
   - When they look dirty
   - After taking gloves off
   - After 6 - 8 uses of alcohol rub
   - Before beginning & before leaving work

2. **Good hand Hygiene**
   - Alcohol based hand rubs readily available throughout the Home for use:
     - Between ALL person to person contact
     - After touching any surface in an infected person’s isolation room.
     - BEFORE food preparation
     - Before and after any break in work
     - Between ‘DIRTY’ & ‘CLEAN’ procedures on the same person.

3. **Gloves**
   - Disposable latex used when:
     - Having to touch faeces/vomit
     - By cleaning staff - a new pair for EACH room!

4. **Face Protection**
   - Surgical masks [like in the operating theatre] worn when anywhere near vomit or faeces.

5. **Waterproof Aprons**
   - For ALL resident contact
   - When sluicing soiled linen
   - At all times by the cleaner
   - When emptying commodes/bedpans.

6. **Laundry**
   - Collect in covered buckets or linen bags
   - Avoid sluicing if possible
   - Send communal linen out to be laundered commercially.

### People Management

#### Resident
- Have the right to be kept fully informed about the outbreak and any infections that they might be exposed to.
- Well residents and unwell should both remain in their rooms or in their own groups.
- Cease communal activities.
- Stop outside visits such as hairdresser.
- Each resident needs their own dedicated toilet or commode.

#### Staff
- Staff with sick family [diarrhea & vomiting] should NOT come to work
- Assign selected staff to work ONLY in the affected area
- Use staff who may have been sick and recovered [wait 24hrs after recovery]

#### Visitors
- Close the Home to ALL visitors where possible.
- If visiting is essential escort these visitors and do not allow contact with other residents.
- Family should be informed prior to arrival, or at least by signage on the door(s).
- Visitors with sick family [diarrhea & vomiting] should NOT come to visit.

#### Ancillary Visits
- Stop hairdresser/podiatrist visits
- Limit health professional visits to essential visits.

#### Transfers
- Do NOT transfer in or out unless essential.
- Warn receiving facilities FIRST!
DECONTAMINATION DURING NOROVIRUS OUTBREAK:

Cleaning Guideline

1. Educate cleaner Universal Precautions!
2. Cleaner to wear water proof plastic apron and rubber latex gloves
3. Change gloves - new for each room!
4. Damp dust residents’ rooms daily.
   - Do all horizontal surfaces
   - Do door handles, taps and hand basins
   - Then do toilet paper dispensers, flush buttons, toilet seats then bowls
   - Use a disposable cloth - new for each room!
   - Use a bleach solution [1ml to 2 litres of water] made up fresh each day.
   - Clean toilets of sick people 3-4 times EACH SHIFT!
5. Separate mops for clean and affected areas - launder or soak in bleach after use.
6. Separate buckets for clean and affected areas - wash in hot soapy water, dry & store upside down.
7. No vacuuming during the outbreak. No machine polishing of floors.
8. After the outbreak clean all surfaces in affected peoples rooms well with the bleach solution. Include mobility aids and personal items like TV’s & radios.
9. Give the kitchen a thorough spring clean with the bleach solution.
10. Maintain good cleaning and disinfecting of the environment [use bleach].

Laundry Guideline

1. Send communal laundry offsite for commercial cleaning during the outbreak.
2. Collect laundry in covered buckets or covered linen bags on trundlers.
3. Avoid sluicing if possible
4. Protect face: goggles / surgical face mask /
5. Protect hands: latex gloves.
6. Wash soiled laundry separately with bleach added in the rinse cycle [1 cup per full load].
Data, Analysis & Reporting [Norovirus is a Notifiable Disease]

Send three specimens [total] [from as many infected persons as possible].
Treat as Norovirus until outbreak confirmed [will take 10 days]

<table>
<thead>
<tr>
<th>Number of Staff affected</th>
<th>Number of residents affected</th>
<th>Incident Recording</th>
<th>Analysis</th>
<th>File Ministry of Health Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of days affected</td>
<td>Room numbers</td>
<td>Time of diarrhea episodes</td>
<td>Use spreadsheet</td>
<td>Laboratory confirms outbreak</td>
</tr>
<tr>
<td>Severity</td>
<td>Bed days occupied</td>
<td>Time of vomiting</td>
<td>Graph number of cases by time &amp; date</td>
<td>Laboratory will assist with notifying MOH</td>
</tr>
<tr>
<td>Where family affected also</td>
<td>Discharge dates</td>
<td>Were staff exposed?</td>
<td>Follow progress Epidemic Curve On graph.</td>
<td>Manager carries reporting responsibility</td>
</tr>
<tr>
<td>Where family affected prior to outbreak or subsequent to.</td>
<td>Were they infected by staff?</td>
<td>Did they become sick later?</td>
<td>Establish if outbreak is ongoing</td>
<td>MOH supplies reporting template</td>
</tr>
</tbody>
</table>

Signage:

**STOP!**

Residents of this Home have symptoms of Viral Gastroenteritis!
(Vomiting & Diarrhoea)

You could easily catch this. We want to protect you. Please contact a staff member BEFORE entering.

If you NEED to visit then PLEASE WASH YOUR HANDS THOROUGHLY BEFORE LEAVING.

For the Home’s entrances &

**STOP!**

This Resident has symptoms of Viral Gastroenteritis!
(Vomitting & Diarrhoea)

You could easily catch this. We want to protect you. Please contact a staff member BEFORE entering.

PLEASE WASH YOUR HANDS THOROUGHLY! USE HAND RUBS!

for affected Residents doors
Guidelines for the Management of VRE

POLICY: To control for the spread of Vancomycin Resistant Enterococci & optimise the rehabilitation of those affected.

REFERENCE: Infection Control Service Handout Auckland City Hospital.

DEFINITION / INFORMATION: Enterococci are bacteria normally found in the bowel & vagina – where they cause no harm. However, in very sick people, they can cause harm in wounds, the bladder, kidneys or blood. Usually antibiotics are used successfully. But, when these enterococci become resistant to ordinary antibiotics AND resistant to Vancomycin [the “last line” antibiotic] they are much harder to treat. Concern is for large numbers of people in hospitals becoming colonised as this can lead to disease. Colonisation may last months or years. Fortunately, most people colonised with VRE never develop an infection.

COLONISATION: The resistant enterococci are present in the bowel or vagina without causing illness.

INFECTION: The resistant enterococci are present in bladder, kidneys or blood causing illness.

COLONISATION TREATMENT = NONE

INFECTION TREATMENT = there are still some antibiotics that work.

CONTROLS TO KEEP SAFE: Allocate a single room.

1. Thorough hand washing for the infected person and everyone else as well.
   - After using the toilet
   - Before and after preparing food
   - After cleaning

2. Normal household cleaning is sufficient.

3. Launder towels, clothes and bedding as usual. No special temperature or detergent required.

4. Cutlery and plates washed as usual.

5. Wounds need a waterproof dressing if they have VRE in the wound.

6. Inform all Healthcare workers of the VRE positive status. Flag this at the top of the resident Integrated Notes under allergies in red.

7. Use gloves and gowns for contact with blood or body fluids.
Management of Waste and Hazardous Substances

POLICY:

All waste is disposed in accordance with infection control practices in order to minimise the risk of contamination though unnecessary exposure.

REFERENCE:

Infection Control Standard NZS 8142
HSE Amendment Act 2002

PROCEDURE:

<table>
<thead>
<tr>
<th>Soiled Disposable Waste:</th>
<th>Soiled or blood stained linen:</th>
</tr>
</thead>
<tbody>
<tr>
<td>This includes bloodstained waste and soiled wound dressings, disposable pads, or human waste. This should be:</td>
<td>Place in a covered bucket / plastic lined linen bag for transfer to the laundry.</td>
</tr>
<tr>
<td>- Placed in two plastic bags - one inside the other.</td>
<td>Soak in strong ‘napisan’ or other bleach. Bleach is effective against infectious micro-organisms. Use correct amount as directed.</td>
</tr>
<tr>
<td>- Secured at the top - tie in a knot.</td>
<td>This linen is laundered separately from other linen.</td>
</tr>
<tr>
<td>- Container used is strong wheelie bin on wheels with lid.</td>
<td>Drying the linen in a clothes drier for 10 minutes on high also achieves disinfection.</td>
</tr>
<tr>
<td>- This is collected no less than weekly</td>
<td></td>
</tr>
</tbody>
</table>

Wet linen:

This is collected in covered buckets, or plastic lined linen bags for transfer to the laundry for processing.

Sharps: [disposable syringes, needles, glass ampoules and other sharp objects].

These are placed in special sharps containers immediately after use. When containers are three quarters full arrange for collection by Medical Waste Disposal Contractor or take to chemist for disposal and replace containers at the same time.

Special Cultural Considerations for Biological Waste

There is no particular different way of disposing of infectious waste or dressings from Maori or other cultures. Be patient with auditors who imagine that there might be such differences. No waste is incinerated on site.
ANTIBIOTIC PRESCRIBING [ANTIMICROBIAL POLICY]

POLICY: We promote appropriate & prudent prescribing of antibiotics in line with accepted guidelines, in collaboration with our prescribing doctors and with the back up of our pharmacy & diagnosing laboratory.

RESPONSIBILITY:
It is the resident's own GP who is responsible for guidance on the management of safe antibiotic use.

PROCEDURE:

- Narrow spectrum antibiotics should be used in preference to broad spectrum antibiotics.
- Treatment should be evaluated as soon as laboratory results are available.
- Then, treatment should change to the narrowest spectrum antibiotic available.
- Prescriptions should have stop dates on them.
- Where a doctor prescribes an antibiotic to "prevent" infection they need to show that this is Best Practice and have a guideline available to direct them. Otherwise, prophylactic antibiotic use is discouraged. This includes long term antibiotic cover for urine infections.
- Prescribers need to be using accepted guidelines in New Zealand and to have access to back up from Diagnostic Medlab and other specialists.
- Audit will look at this carefully
  - Statistics kept are NOT just a log of antibiotic use but a real look at ALL infections according to Standard Definition of Infection
  - The use of adequate tests while prescribing antibiotics
  - Compliance with accepted prescribing rules
  - Review could also look at susceptibility patterns in organisms [what antibiotics are most effective on the bugs we are culturing]. This information is available from the diagnosing laboratory, should we have sufficient infections. Small Homes may not.
- Individuals, who stop taking the antibiotics once the symptoms have lessened, but before they have finished their complete course of medication, often have not
Infection Control Policy & Procedure

- Overcome the bacteria. When making the commitment to start a course of antibiotics, the commitment should be made to finish it.

- This is because; surviving bacteria may cause a reinfection, often with increased resistance to the antibiotic in question.

- It is important to realise that Viruses cause many common diseases. **Antibiotics don’t work against viruses.**

- Over exposing them to antibiotics gives them more chance to become even more resistant.

- Antibiotic usage is monitored by the Home. All infections are recorded on an Infection Report Form filed in the Exception Reporting Folder and in the residents’ own notes.

- Antibiotics are not routinely given prophylactically. Antibiotics are more usually used once bacterial infection is confirmed, and according to symptoms, and best practice guidelines. In this way, antibiotics may follow conservative measures [that are known to be just as effective] the antibiotics that are most likely to work are prescribed first, rather than blind prescribing, except where the resident is likely to worsen or suffer by awaiting sensitivity results. Similarly, anti-bacterial agents, or anti-fungal agents.

- Prescribing antibiotics is a collaborative decision, involving the resident, their family (where appropriate), and staff. Antibiotic prescribing is not at the sole discretion of the doctor.

- Prescribed antibiotics need to be taken exactly as prescribed. E.g:
  - If prescribed tds or three times per day – take each dose about 8 hours apart rather than at meal times.
  - Six Hourly [4 times daily] – e.g. at 6am / noon / 6pm and midnight
  - With Food
  - With Milk
  - Before a meal
⇒ Not taken with some other medication
⇒ If in liquid form shake the bottle well first
⇒ Keep refrigerated if this is stated
⇒ Stop the course at the end of the prescribed time – if there is a little left in the bottle please discard [this need not be taken].
⇒ Old tubes of antibiotic ointment should also be discarded at the end of the prescribed time and not saved to use another time.

Each six months a Quality Review of Infection Control is undertaken by the Infection Control Coordinator. The Health & Safety Committee, an external consultant and staff usually comprise this team meeting. Results are shared with staff, prescribing doctors and any other stakeholders deemed appropriate.

Residents taking vitamin supplements and alternate medicines should share this information with the doctor. Where these are taken regularly they are listed in Care Planning.
Managing a Resident with Tuberculosis [TB]

**POLICY:** That residents recovering from Tuberculosis may recuperate in the Home, as appropriate. Those with active TB would be managed in another facility. Residents that have been assessed as no longer able to pass the TB on should be treated as any other resident.

**UNDERSTANDING TB:**

<table>
<thead>
<tr>
<th>WHAT IS TUBERCULOSIS?</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is caused by a bacteria that affects the lungs.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>It can spread to other parts of the body.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Active TB, left untreated is likely to be fatal.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>TB is a disease of poverty more often seen in the third world</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>TB is also seen in AIDS sufferers because they have less immunity</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>TB is an airborne disease so you can catch it from a cough</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Most people in New Zealand are at risk from TB</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Many New Zealanders had BCG Vaccination at school</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>This will offer some immunity but it may not be full protection</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Staff in Rest Homes need pre employment screening about their TB status</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Staff in Rest Homes should routinely be offered vaccine for TB</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Staff who have had contact with TB need to declare this when employed</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>
Managing a Resident with Scabies

**POLICY:** To quickly detect any resident with scabies infection, to contain and control so that the likelihood of outbreak is reduced and in the event of outbreak to notify and contain immediately. NB: Outbreak needs reporting to the District Health Board.

**DEFINITION:** Scabies is caused by a mite [sarcoptes scabei]. Infections result in itching and scratching. The microscopic female burrows into the skin and lays eggs. This does not cause itching; rather the body has an immune reaction to the burrows. Red lumps, pustules, papules are found on:

- Hands and between fingers
- Wrists and arms
- Private parts

So, in the beginning a person might have scabies for some two – 6 weeks before their body starts reacting to the mites - during this time they are contagious. Subsequent reinfections will have a much quicker response and the itching and scratching will be much more immediate [perhaps within 48hours].

**ISOLATION:** Standard Precautions and Contact Precautions are required.

<table>
<thead>
<tr>
<th>WHAT IS Scabies</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caused by a mite that burrows into the skin</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Easily spread from person to person</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Main aim is to prevent outbreak</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>RN assessment needs to assess all new residents skin thoroughly</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Spread is by touching an infected person's skin</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>You can catch it from bedding of an infected person - LESS LIKELY</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>They can make you very sick</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Scabies can be very distressing</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Vaccine against scabies</td>
<td></td>
<td>x</td>
</tr>
</tbody>
</table>
Scabies Treatment & Management:

Diagnosis is by sighting a burrow [black speck of mites can be seen] or from skin scrapings. Treatment needs to kill the mite before soothing the skin to allow healing to occur. Use scabicide solution ALL OVER from the neck down. Creams to sooth skin may be needed as a dermatitis type reaction is caused by the body’s own reaction to the burrowing mites. Keep fingernails short and prevent harm to the skin by rigorous scratching.

Containing Outbreaks:

IMMEDIATE

- Treat all infected people on the same day. This includes staff and anyone else known to be infected.
- Make sure everyone knows how to apply the scabicide lotion / cream to their entire body [especially between fingers, under fingernails & soles of feet]. Residents will need to be assisted.
- Leave the lotion on for 12 – 24 hours. Reapply if you need to wash a particular area.
- Explain that this kills the mite [not the itch]. The cream should not be applied ongoing.

NEXT DAY

- Everyone may wash now.
- Also wash all linen and clothing using hot water and a hot drier. Anything not washed should NOT touch bare skin for at least 72 hours.
- Itching may be helped by keeping cool and refraining from scratching
- Wash all clothing and bed linen daily.

Follow Up

- Itching does not stop immediately. If it is still bad in a week, then repeat the treatment.
- Make sure that all contacts of the infected resident / s are followed up after one month.
- Scabies is easily passed from one person to another by touching skin. Remember itching is good reason to be suspicious.
# Guide to Managing Resident with Scabies / Scabies Outbreak

**Tag or flag the resident’s medical record** by placing a yellow warning page at the front.

**Educate the resident**
- Scabies is a mite
- It burrows into the skin
- The body sets up an allergic itching reaction to this
- Best to keep visitors away during 1st 24 hour treatment time.

**Good Hand Hygiene** – with an antibacterial hand wash before and after all resident contact.

**Contact Precautions**:
- Standard precautions plus long sleeved gown and gloves for personal cares.

**Cleaner: Use a warm soapy solution. Only use disinfectant if the scabies are hard to overcome.**
1. Scabies rooms are cleaned **last** [DAILY]
2. Wear plastic apron & gloves.
3. Pay special attention to bathrooms, handrails, commode chairs, commode chairs and community areas.
4. Use disposable cloths and throw them out as Hazardous Waste.

**Dispose of wastes** from affected people [e.g. dressings] in double plastic bags.

**Catheter Management**: as usual

**Signage**: Warning signage on resident door.

**Care with resident to resident contact**
Residents need to understand that others may catch the scabies from their skin to skin contact. This won’t be ongoing once the mite is killed, even though the itching may persist for a week or two.

**Carry out regular audits of compliance with Standard Precautions**

**Notify any receiving facility** of the resident’s status PRIOR to transfer or discharge.

**Discharge**: Use detergent & water on surfaces including bed & pillows. Air the room well. Make up beds with a new set of linen, including coverings.