Shropshire Council

Children and Young People's Services

MEDICAL ARRANGEMENTS
GUIDELINES & PROCEDURES FOR SCHOOLS

This document has been agreed by the following professional associations/ trade unions representing Teachers, Headteachers: and Support Staff:

- National Union of Teachers
- National Association of Schoolmasters Union of Women Teachers
- Association of Teachers and Lecturers
- National Association of Headteachers
- Association of School and College Leaders
- Unison
- GMB

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Introduction

The detailed medical arrangements set out have been prepared jointly by Health Professionals and Shropshire County Council. The arrangements are reviewed on a regular basis and form the basis of ensuring that the medical needs of staff and pupils are met at school. The arrangements are to be used as and when necessary and support is available as required from the named contact.

Included as part of this introduction are key action points which act as a reference to arrangements covered in the main document but are important to make particular note of:

Key Action Points:

Medicines: Administration and Use

- Administration of medicines to pupils by teachers is voluntary.
- Any staff should not agree to administer medicines without first receiving appropriate training.
- Heads (and governors) should, where necessary, ensure that the policy and procedures are compatible and consistent with any registered day-care operated either by them or an external provider on school premises.

Health Care Plan for a Child at Risk of Anaphylaxis

- When a child has been diagnosed as having a severe allergic reaction, a clear written policy appropriate to that child should be drawn up.

The Diabetic Child in School

- Children with diabetes should have a individual medical management plan and should take part in the full range of school activities. Schools should try to provide good levels of support which enable parents to attend work rather than having to attend school to test blood glucose levels and administer insulin.

Guidelines for Dealing with and Control of Human Head Lice - Shropshire Health Authority Guidelines

- The detection, control and treatment of head lice infection can only succeed if the individuals involved receive consistent information and advice via the circulation of the Shropshire & Telford PCT leaflet to parents.

Human Immuno Deficiency Virus (HIV) and Hepatitis B Virus

- When risks have been identified, provision of **immunisation**, where appropriate and necessary, protective equipment ;and safe systems of work are to be made and enforced.

Guidelines for the Control of Infection and Communicable Disease

- Guidance Read By sign off sheet should be signed by all appropriate staff
- Effective Hand washing diagram should be used and displayed in all hand washing areas (e.g. toilets). Consider including within curriculum.
- Guidance on contents of first aid boxes should be adhered to.
- In the event a Medical / First Aid Room is not available a suitable alternative should be identified.
- It is acknowledged that Bleach and Chlorine based disinfectants may not be readily available or available at all in a school, however the Health Protection Agency advises its use especially in the event of blood spillages and even more so if that spillage is potentially infected with HIV or Hepatitis. Therefore in appropriate circumstances bleach and chlorine based disinfectants may need to be made available and used even if not kept on site or used regularly on site. If kept on site Chlorine products should be kept in locked areas not accessible to unauthorised people. If bleach and chlorine based disinfectants are used in school they must be used in accordance with set procedures and a COSHH risk assessment must have been carried out. Schools may also wish to consider purchasing a Bio-Hazard spill kit available through WM supplies.
- The cleaning spillages flowchart should be displayed and provided to site and cleaning staff.
- Ensure that guidance on food handling is shared with school food providers.
- Guidance for drinking water should be followed and it is important that drinking water vessels are for individual use only and should be consumed according to guidelines and bottles should not be reused.

Guidelines for Administration of Rectal Diazepam

- Check with the child's parents that the correct information is held about the child. This should include details of all medications prescribed.

Selective Medical Examinations

- It is important that Heads and other relevant staff are familiar with the scheme and how it works and that appropriate information for parents is included in the school prospectus.
- It is also important to ensure parents are kept informed regarding the schedule of medical examinations so they are aware when such examinations take place.

Asthma

- Asthma advice and guidance is now a separate Policy and guidance document.

5.2 Medicines : Administration and Use

5.2.1 Introduction

- The LA has principal responsibility for the safety and welfare of pupils in community schools, community special schools, voluntary controlled schools, maintained nursery schools and pupil referral units. In foundation schools, foundation special schools and voluntary–aided schools the governors carry this responsibility. This document sets out the LA's detailed policy guidelines to schools, clarifying the areas of responsibility for medicines, together with the procedures to be operated should there be a need for medication to be administered in school. These guidelines should, therefore, form the basis of any school policies or practices relating to the administering of medicines in school. If in doubt, those concerned should contact the Shirehall or the Health Professionals for further advice. (See below).

- For the purposes of this document the term "medicine" applies only to medication prescribed by the pupil's doctor, dentist, nurse prescriber or pharmacist prescriber**,** whether in the form of tablets, inhalers, liquids, capsules or creams.

- This document does not, therefore, deal with the contents of "First Aid" boxes which has been the subject of previously issued separate advice, the gist of which being that they should **not** contain any "pills" or "potions".

  "Parent" has the same meaning as defined in Section 576 of the Education Act 1996 and includes any person:-

  ° who is not a parent but who has parental responsibility for the pupil, or

  ° who has care of the pupil – this does not include child-minders, nannies, baby sitters or school staff.

  See Section 5.2.2.1 for further explanation

- This document does not address the responsibilities of school staff when an accident or emergency situation arises, for example where a pupil has a serious accident and parents need to be contacted or an ambulance called. Schools should already have in place procedures to deal with such emergency situations which are clear and known by all staff and parents.

- This document apart from being drawn to the attention of all staff should be filed as a technical paper within the LA's guidance on "Health and Safety Policy and Codes of Practice".

- Some of the LA's special schools cater for children with severe disability some of whom have complex medical problems and who will be on regular medication both at home and at school. Some may also have needs for special nursing care while at school for which arrangements have been made. The guidance set out in this document is not intended to override or modify in any way already established arrangements in such schools.

- The LA hopes that schools will find it possible to co-operate with reasonable and justified requests from parents so that their children need not miss out on their

educational opportunities. The current legal position, the County Council's insurance arrangements, the ability to provide appropriate training where necessary and following these guidelines should ensure that any risk of acting negligently is kept to an absolute minimum. However, if Heads are in any doubt about administering medicines in school or would like further information about Asthma they should consult either the CYPS HR or the Consultant Paediatrician at Shropshire's PCT, or the Consultant Community Paediatrician for the school.

5.2.2 Legal Considerations - Parents, Employers, Headteachers and Teacher/ Employees Responsibilities

5.2.2.1 Parents and Carers

School staff need to have a clear understanding of who has parental responsibility for a particular child. In the event of family breakdown, e.g. divorce or separation, both parents will normally retain parental responsibility unless a court order to the contrary is in place. In relation to unmarried parents, only the mother will have parental responsibility unless the father has acquired it in accordance with the Children Act 1989. Where a court makes a residence order in favour of a person who is not a parent of the child, for example a grandparent, that person will have parental responsibility for the child for the duration of the order.

If the child is 'looked after' by the Local Authority, the child may either be on a Care Order or be voluntarily accommodated. A Care Order places a child in the care of a Local Authority and gives that Authority parental responsibility for the child. In this circumstance, day–to–day responsibility may reside with foster parents, residential care workers or guardians. A Local Authority may also accommodate a child under voluntary arrangements with the child's parents. Under these circumstances the parents will retain parental responsibility acting as partners of the Local Authority.

Parents should provide the school with sufficient information about the child's medical needs if medication or special care is required;

They should agree with the Head the role the school will undertake in supporting the child's needs in accordance with LA policy. Parents should be made aware that this information will be shared with relevant staff to ensure the best care for the child, although the Head should always seek parental consent for this.

Parents should understand that schools have no legal obligation to administer medicines.

5.2.2.2 The Employer

Under the Health and Safety at Work Act etc 1974 employers, including LA's and Governing Bodies, must have a health and safety policy. This policy should incorporate managing the administration of medicines and supporting pupils with complex health needs. This will support schools in developing their own internal operational procedures.

Employers must ensure that their insurance arrangements provide full cover in respect of actions which could be taken by staff in the course of their duties.

It is the employer's duty to ensure that schools have proper procedures in place and that staff are aware of the procedures and are fully trained. Employers must ensure

that staff have appropriate training which gives sufficient understanding, confidence and expertise to support children with medical needs. Arrangements must also be in place to update training on a regular basis.

5.2.2.3 The Governing Body

Schools must develop policies which cover the needs of their own school. These policies should reflect those set down by the employer. The governing body has a general responsibility for all school policies even when it is not the employer. Where the LA is the employer the governing body should follow the health and safety policies and procedures produced by the LA.

5.2.2.4 The Head's Responsibility

- The LA does not discourage Head's from administering medicines in schools. Heads are left to use their discretion as to whether it is practicable in all the circumstances to agree to administer medicines.

- The Head's responsibility is to consider each request for medicine to be administered to a pupil in school on its merits. In so doing the Head should have regard to the best interests of the pupil, but can also consider the implications for the school, especially staff. Where it is thought appropriate for medicines to be administered, the Head should ensure that any instructions and the LA's guidelines are followed carefully and that the school has strict guidelines and agreed procedures in place.

- Staff (and parents) should be made aware of the school policies and practices about administering medicines, and indeed, all first aid treatment, particularly where there are pupils with known medical problems.

- Whether agreeing or refusing to administer medicines in school, the Head's decision will be defensible **if it is clear that s/he has acted reasonably**. Heads have an unquestioned duty to all the children in their care but before accepting responsibility for administering medication to a pupil they should first consider all the circumstances of the case.

- The Head must arrange for staff to receive proper support and appropriate training. If the administration of prescription medicines requires technical or medical knowledge then individual training should be provided for appropriate staff from a qualified health professional – training may be specific to the individual child.

- Heads (and governors) should, where necessary, ensure that the policy and procedures are compatible and consistent with any registered day-care operated either by them or an external provider on school premises. N.B. LA policy should always be taken as the minimum standard.

5.2.2.5 Teachers/Employees Responsibilities

- Teachers have a professional duty to safeguard the health and safety of pupils both when they are authorised to be on the school premises and when they are engaged in authorised school activities elsewhere.

- No teacher can be required to administer medicine or drugs to a pupil or supervise pupils taking medication. However, there is nothing to stop them from undertaking such tasks if they are willing to do so, the parents have given written permission and

where necessary appropriate training has been given by health staff (e.g. school nurse or doctor). As mentioned, the LA's hope is that schools will be able to co-operate with reasonable and justified requests. **Teachers or any other school staff should not agree (or be required) to administer medicines without first receiving appropriate training and consent forms.**

- A person who does not have parental responsibility for a particular child, but has the care of that child (e.g. school staff) may be authorised by statute to do certain things. Section 3 of the Children Act 1989 states that in such circumstances that person "may (subject to the provisions of this Act) do what is reasonable in all the circumstances of the case for the purpose of safeguarding or promoting the child's welfare."

  Whilst it is virtually impossible to define what would be regarded as "reasonable in all the circumstances" as this must be considered on a case to case basis the critical point is that Section 3 Children Act 1989 **potentially protects an individual who becomes actively involved in attempting to safeguard/promote a child's welfare by removing the rigid conclusion that such intervention would automatically and necessarily either constitute criminal assault or alternatively give rise to a civil claim for trespass to the person.**

- Teachers also have a general duty to act "in loco parentis" while pupils are in their care at school (i.e., to act as any reasonable parent would in the same circumstances). Where the Head has agreed to administer and provided the administration of medicine is controlled and undertaken in accordance with the appropriate medical advice (dosage instructions) and these guidelines, the risk of injury should be minimised and staff can be considered to have exercised reasonable care.

- It is recommended that parents make a written request for the school to administer medicines. The school can then provide the parent with the agreement form which should be completed following the initial discussions.

- It is also recommended that a school record of administration of medicines be kept and this record should be accessible to appropriate staff and regularly monitored by a nominated member of staff.

- Although legally it is not possible to disclaim liability for personal injury or death, it is recommended that the Head should obtain a written indemnity from the parent in favour of the Head or the member(s) of staff involved. It is, therefore, important to ensure that the systems set up limit opportunity for negligence.

- Staff who act reasonably and in accordance with appropriate instructions/guidelines are protected by the County Council's insurance policies should any claim for negligence be brought.

  The County Council's Risk and Insurance department has commented as follows:-

  > "Any person under a contract of service with Shropshire County Council or any person volunteering to assist with the discharge of the Authority's functions is indemnified under the terms of our liability policy provided they act in good faith, within the limits of their authority and observe the policy terms and conditions".

In connection with Anaphylaxis (an extreme allergic reaction requiring emergency treatment - the most common cause being food, in particular nuts, fish and dairy products), the County Council's Insurance Brokers have also commented:-

"1. The policy has a "reasonable care" condition and as such anything of this nature should be approached with the attitude that you would apply if you did not have the benefit of public liability insurance.

2. Every effort should be made to prevent known sufferers from coming into contact with products which are known to bring on the reaction.

3. Staff who are to administer the drugs should be trained to do so by people who are qualified and have experience in this field.

4. Any other specialist advice should be sought".

5.2.3. Circumstances in which requests to administer medicines in school may be made

- Children attend school to benefit from organised education. Given the requirements of the National Curriculum it is important that a pupil's time out of school is as little as it possibly can be. School attendance may be interrupted by episodic illness and some pupils have chronic illness which may interfere with their education. With the co-operation of parents, schools and doctors, the disruption to their education can be kept to a minimum. In all cases the objective should be to ensure that the child rather than his/her illness is the focus of attention.

- There are two main sets of circumstances in which requests may be made to a Head for medicines to be administered to pupils at schools:-

  ° cases of chronic illness or long-term complaints, such as asthma, diabetes, epilepsy, cystic fibrosis, anaphylaxis.

  ° cases where pupils recovering from a short term illness are well enough to return to school but are receiving a course of antibiotics, other medicine, etc.

  A third circumstance is cases where pupils who suffer occasional discomfort such as toothache or period pain may require analgesics (pain relievers).

5.2.4 Circumstances in which requests to administer medicines in school may be made that need very careful consideration

- These are cases where professional associations may well advise Heads and other teaching staff not to become involved. However, in some of the following situations Shropshire Heads have previously considered it justified to agree to administer and school staff have been prepared to volunteer and have received appropriate training so that administration has been able to take place in school:-

  ° Where the timing of administration is crucial to the health of the pupil. (i.e. the medication must be administered at a precise time). Should Heads agree to administer in such cases they must ensure arrangements are in place to meet the timing requirements.

- Where some technical or medical knowledge and/or training is required. (However, it may be possible in some circumstances to suitably train a volunteer. Staff will not be being asked to undertake activities that, given proper training, cannot be performed by non medical personnel).

- Where intimate contact with the pupil is necessary. This would include administration of rectal diazepam, assistance with catheters, or use of equipment for pupils with tracheotomies. (However, volunteers have been trained in the past to administer rectal valium in Shropshire Schools).

No decisions in these situations should be made one way or the other without detailed discussion having taken place between school staff, PCT and/or GP and the parents

- Normally, one would expect injections to be administered by a nurse or doctor. A Head would be well advised to undertake injections only if formally authorised by the parent, after guidance from a medical practitioner and appropriate training. However, in an emergency, or on a comparatively rare occasion a Head might feel that s/he would be exercising his or her duty of care to a pupil reasonably by seeing that the injection is administered.

5.2.5 Principles/criteria relevant to the administration of medicines in schools

- Whenever possible, parents should be asked to make arrangements to come into school or for pupils to return home at lunchtime (or other breaktime if convenient) for arrangements.

- Where it is not feasible and/or practicable for parents to administer and the Head is requested to consider administration by the school the following principles apply:-

  - A proper written request is made by the parent.

  - It is clearly necessary for the medicine to be administered during school time. This assumes:

    - that the pupil concerned is properly fit to attend school and if not, he/she should be at home (Heads have the power to return home a pupil they consider not to be well enough to be in school).

    - that the prescribed dosage must be given during the school day. If it is sufficient to dose before and after school then the school should not be being asked to administer additional doses during the school day. Parents should be encouraged to ask the prescribing doctor (or dentist) if it is possible for medication to be prescribed in dose frequencies which enable it to be taken outside school hours.

  - The administration required is simple and straightforward to undertake. Giving a pill or spoonful of medicine is one thing, being asked to undertake complicated methods which might well be seen as unreasonable to expect a teacher "in loco parentis" to undertake are another. (Should this latter situation arise it would be expected that detailed discussions between school staff, PCT and/or GP and parents would have taken place to explain the situation and to ascertain the practicability of the school dealing with the matter e.g., willingness, training etc).

- Many secondary school aged pupils will be capable of carrying and administering their own medication. However, this should be assessed on an individual basis, taking into account age, maturity and capability. There is no set age at which this transition should be made, and there may be cases where it is not appropriate for a child of any age to self-administer. In other cases, wherever possible, the medicine should be self administered under the supervision of an adult. This may be the Head or someone acting with the Head's authority. Parents of pupils carrying and administering their own medication must inform the Headteacher.

- Information on long-term illnesses, such as epilepsy, asthma, diabetes, cystic fibrosis, anaphylaxis, etc, must with consultation and consent of parents be recorded on the pupil's record together with appropriate detailed instructions about how to deal with the administration of any medicines both routinely and in any emergency. It is further recommended that an individual administration record sheet be kept for each pupil with a long term illness.

  All teaching staff (and any other staff the Head considers need to be informed) in contact with the pupil must be sufficiently informed about the pupil's illness to enable them to assist in dealing with health maintenance and emergency situations. All staff concerned must treat this information as confidential.

5.2.6 Procedures to be followed in administering medicines in schools

5.2.6.1 General

- The parent's written request should be received, preferably delivered by the parents, confirming that it is necessary for the pupil to take medicine during school hours. Oral requests from the pupil or parents should only be acted upon in the most extreme cases. The request form should also specify:-

  - the name of the medication;
  - the dosage and time of administration (stating clearly whether timing is critical);
  - the reason for the medication;
  - reason(s)/times when the medication need not be administered (e.g., when there is not an asthma attack);
  - the name and telephone number of the doctor responsible for prescribing the medication;
  - possible interaction with any other medicines or other pain relievers such as paracetamol.
  - emergency contact name and day time telephone number.

  If Heads are unsure about a particular request it is recommended that they ask for a doctor's note to confirm the information required.

- Where it is agreed to administer, the school should provide the parent with the Parental agreement for school to administer medicine form for completion. The medicine, in the smallest practicable amount should then be brought to school by the parent, not the pupil, and delivered personally to the Head or an appropriate member of staff. These medicines must:-

  - be clearly labelled with the pupil's name) (the medicine must be in the
  - be clearly labelled with the contents) original bottle/packaging in
  - be clearly labelled with the dosage) which it was prescribed).

- be clearly labelled with the date
- be kept in a suitably locked cupboard*, away from the pupils. Medicines which need to be kept in a refrigerator may be kept in a closed and labelled airtight container within a domestic refrigerator again not accessible to pupils.
- If there is doubt about how a medicine should be stored the local pharmacist will usually advise.

(*Note: the requirement to keep medication in locked facilities does not apply to asthma inhalers which should either be being carried by the pupil or if the pupil is not capable of undertaking the medication him/herself be readily accessible when needed).

- A written record should be kept of the dates and times of each administration. It is further recommended that parent signed request forms be kept within the administration record file until such time as the period of medication has finished for reference purposes when necessary. Thereafter the request form should be transferred to the pupil's personal file.

  An individual record of administration sheet should be kept for each pupil on long term medication. This again should be filed on the pupil personal file on completion of the medication.

  Such medicine administration records should be transferred as part of the pupil's personal file to any other schools attended.

  It may be sensible for a designated member of staff to be made responsible for administering medication provided suitable other arrangements exist to cover any absence.

- Parents are responsible for informing the school, in writing, if there is any change of dosage.

- Parents are responsible for obtaining fresh supplies of medication.

- Parents are responsible for informing the school if the medication has been stopped by the doctor.

- It should not normally be necessary for non prescription, or over the counter medication to be brought to school for administration by the school. In rare situations where the school have agreed to administer such medication it must be in the original container which will have the name of the medicine, the manufacturer's name, the manufacturer's guide on dosage by age range and the expiry date.

- The school should never give medication which is not properly labelled and/or has no clear guidelines on dosage.

- Pupils with asthma who are normally responsible for their medication at home should be responsible for this at school as well. (Also see separate section about asthma).

5.2.6.2 Administration of analgesics (pain relievers) to pupils

- The school would be acting in loco parentis in providing pain relievers to pupils who suffer discomforts such as headaches, toothache or menstrual pains. To ensure the practice is controlled parents should be contacted prior to any administration of pain relievers. There is also a risk that if pain relievers are not administered in a controlled manner pupils may bring tablets into school and dispense them freely amongst their friends.

- If a pupil suffers regularly from acute pain, such as migraine, the parents should authorise and supply appropriate pain killers for their child's use, with written instructions about when the child should take the medication.

- It should be noted that:-

    - Standard Paracetamol is the only pain reliever that should be used for pupils aged 12 years or over. Only preparations of paracetamol designed specifically for children or younger pupils should be used for pupils under 12 years. Paracetamol in either form should not be given to a pupil receiving other medication from a doctor without first checking with the parent, GP or pharmacist to ensure that there are not likely to be adverse health effects from their interaction.

    - On no account should aspirin or preparations containing aspirin be given to pupils. This is particularly important where pupils under 12 years of age are concerned. Ibuprofen should not be administered.

    - Dosage must always be in accord with the instructions specified on the product container.

    - It is good practice for the member of staff administering the pain reliever to ensure the pupil swallows the tablets to prevent their accumulation. The pupil should also be asked if they have taken paracetamol or any other medication within the last 4 hours.

    - A written record should be kept of the dates and times of each administration in the schools Administration of Medicines Record Log. This record will also provide information about any child requesting frequent analgesia which can be brought to the parent's attention so that further medical assessment can be made.

5.2.6.3 Further procedures affecting all administration of medicines

- Records should be active until a pupil no longer requires the medication, at which point the records would be archived. The parents request form can then be placed in the pupil's personal file. Good record keeping helps to demonstrate that staff have exercised their duty of care and will also help protect staff against litigation if difficulties arise.

- Early Years settings MUST keep written records each time medicines are given.

- School staff should not dispose of medicines. Parents should collect medicines held at school at the end of each term. Parents are responsible for disposal of date expired medicines. In circumstances where parents fail to remove medicines, they can be taken to a pharmacy for safe disposal.

- Information about the School's Policy on the Administration of Medicines and how parents make a request should be included in the school prospectus and in annual updates to all parents.

- All staff should know how to call the emergency services. All staff should also know who is responsible for carrying out emergency procedures in the event of need.

5.2.6.4 Educational Visits and Sporting Activities

Schools and settings should consider what reasonable adjustments they might make to their procedures to enable children with medical needs to participate, as fully as they are able, in visits and sporting activities.
It may be necessary to include an additional member of staff, parent or volunteer to accompany a particular child. Arrangements for taking any necessary medicines will also need to be considered.

Staff supervising trips, visits and sporting activities should be aware of any medical needs and a copy of any health care plans should be taken on trips and visits in the event of the information being required in an emergency.

Any doubts should be resolved in conjunction with parents and medical advice.

5.2.6.5 Health Care Plans for Children with Medical Needs

- The purpose of a health care plan for a child with medical needs is to identify the level of support that is needed. Not all children who have medical needs will require an individual plan. In simpler cases, all that may be required is a short written agreement with parents - consent forms signed by the Headteacher and parents may be adequate. The complexity of the child's needs will be reflected in the care plan.

- An individual health care plan clarifies, for staff, parents and the child, the help that can be provided. Schools should be guided by the child's GP or paediatrician. The plan will need to be reviewed from time to time, and the frequency with which this should be done will be determined by the child's particular needs.

- The plan should be developed with input from the school health service, the child's GP and other health professionals appropriate to the level of support required. Other key inputs will come from: -

    - the Headteacher;
    - the parent or carer;
    - the child (if appropriate);
    - class teacher (primary schools), form tutor/head of year (secondary schools);
    - support staff (as appropriate);
    - staff trained to administer medicines;
    - staff trained in emergency procedures.

- Co-ordinating and Information Sharing – Pupils in secondary schools work in a range of environments with the involvement of many members of staff. Information on children with medical needs will have to be shared with appropriate staff. The Headteacher should delegate the co-ordination role to a suitable member of staff, who will act as a contact point for parents and staff.

- The plan should include identification of staff who should be aware of the health care arrangements and must be updated annually or sooner if appropriate.

- Staff who manage emergency procedures will also need information as necessary to ensure safe evacuation.

- Where pupils engage in off-site education, e.g. F.E. college placements, work placements or educational trips and visits, any medical needs will be considered as part of the risk assessment for the activity. In this context, any restrictions on a child's ability to participate in PE or sport should also be included.

- Information on a child's medical needs should always be dealt with in confidence. The school should always agree, with the child or parent as appropriate, who else should have access to records or other information about a child. If information is withheld from staff they should not generally be held responsible if they act incorrectly in giving medical assistance but otherwise in good faith.

5.2.7 Asthma

Shropshire County and Telford and Wrekin Primary Care Trust have developed the Policy and Guidance for the Management of Asthma in Schools. The Local Authority were involved in the discussions with the above PCT's and have adopted the policy and guidance for use within Shropshire. It has been agreed the document will be published as a stand alone document. The document can be downloaded from the County Councils school website.

5.3 Health Care Plan for a Child at Risk of Anaphylaxis

5.3.1 Introduction

The information provided in this section of the policy document is kindly provided by Shropshire's Acute and Community Children's Services

5.3.2 Important information

Anaphylaxis is an extreme allergic reaction requiring urgent medical treatment. The condition can be fatal if unrecognised and early treatment given.

When a child has been diagnosed as having a severe allergic reaction, a clear WRITTEN POLICY appropriate to THAT CHILD should be DRAWN UP.

It is important that the child is treated normally and that parents are reassured that prompt and efficient action will be taken in accordance with agreed procedures and medical advice.

5.3.3 Anaphylaxis – What Is It?

It is the result of a severe generalised allergic reaction. The whole body is affected, usually within minutes of exposure to the allergen, whether a food, drug or insect sting

The common allergies are:-

- Food e.g. peanuts, eggs fish
- Insect stings
- Immunisation or antibiotics

Some children can react to even minute traces of the allergen

Some children prone to anaphylaxis are also asthmatic. It is usually possible to distinguish between anaphylaxis and a severe asthma episode, although in some children it may not be possible to distinguish between the two. They may merge into one another.

A child experiencing a severe asthma attack will not usually

- Have any facial swelling
- Appear bright red

If there is any doubt, then it is entirely appropriate to administer adrenaline and call 999. Adrenaline will also have a beneficial effect on asthma

5.3.4 Adrenaline - What is it?

Adrenaline is very safe. It is produced naturally by the body.

Adrenaline helps by

- Reversing the symptoms
- Opens airways

- Raises the blood pressure (not a bad thing)

The reaction to adrenaline is usually swift.

If this does not happen it may be necessary to give a second dose after 5-10 minutes

Children/parents should be provided with two adrenaline pens.

The side effects of an unnecessary adrenaline injection are not serious but anaphylaxis is life threatening.

Side effects:-

- Slightly increased pulse rate and blood pressure
- Possible a headache

Following an injection the body will have totally eliminated the drug within 10-15 minutes. Any minor side effects will disappear rapidly.

5.3.5 Signs and Symptoms

Signs and symptoms will normally appear within seconds or minutes after exposure to the allergen. These may include:

- ❖ Complaints of being unwell/very sudden weakness (due to drop in blood pressure)
- ❖ Difficulty in breathing/wheezy
- ❖ Difficulty in swallowing and itching in the mouth/strange metallic taste
- ❖ Marked swelling of mouth, face, lips, tongue, eyes, ears making breathing difficult cyanosis (blue lips)
- ❖ A change in voice or inability to speak
- ❖ Itchy red blotchy rash/flushed complexion, hives anywhere on the body
- ❖ Abdominal cramps and nausea/violent vomiting
- ❖ Fainting/collapse/loss of consciousness

5.3.6 Anaphylactic Shock

1. Reassure - this is extremely frightening

2. One person to ring 999 immediately (this should take priority over all other telephone contacts)
   Inform ambulance service that the child has a history of anaphylaxis and is having breathing difficulties

3. Second person to stay with the child - if the child has collapsed lie him/her on the floor on left side otherwise position the child in the most comfortable

position to assist breathing

4. Look in the mouth for any objects. Remove objects if seen.

5. Check that the device is adrenaline – give adrenaline into the thigh – some older children can self administer adrenaline

6. Record the time when the dose of adrenaline is given

7. Continue to reassure and maintain a clear airway until the ambulance arrives

8. Make a written record of exactly what occurred

5.3.7 Giving Adrenaline via Prepared Injection

1. Open prepared device, as per instructions

2. Place tip on thigh, at right angle to the leg

3. Press firmly into thigh until the mechanism functions and hold in place for 10 seconds

4. Massage the injection area

5. The prepared injection can be given through clothing

5.3.8 School Procedures

1. A separate protocol for each child must be drawn up based on consultation with parents, health professionals and where appropriate the Local Education Authority

2. The Headteacher will arrange for the teachers and other identified staff in the school to be briefed about the child's condition and about other arrangements contained in this document

3. The school will hold, under secure conditions, appropriate medication clearly identified, showing the expiry date

4. Older children can carry Adrenaline

5. Under no circumstances should the medication be given to another child

6. Do not use out of date medication

7. The staff should take all reasonable steps to ensure that the child does not eat any food items unless they have been prepared/approved by his/her parents

8. Whenever the planned curriculum involves cookery or experimentation with food items, prior discussions should be held between the school and parents to agree measures and suitable alternatives

9. Staff need to be aware of management in relation to menus and snacks in schools. If you have any dietetic concerns please do not hesitate to call your local hospital Dietician.

10. If the child is to leave the school site, discussions should be held between the school and parents in order to agree appropriate provision and safe handling of medication

- If a child has an anaphylactic episode the school should record on the pupil's personal file information about the anaphylactic episode.

They should include :-

- Date
- Time
- Action taken
- Staff involved
- Details of any 999 calls and response by the Emergency Service
- Contact with the parents

- In the event of an emergency staff may feel apprehensive - this is quite normal

- It is advisable for staff to reflect on the event and to contact parents/ health professionals to address any issues which may have caused concern

5.3.9 Developing a Training Plan

1. Training

Training may be delivered by :-

- Health Visitor
- School Nurse
- Children's Nurse Acute Unit
- Children's Community Nurse

2. There must be adequate numbers of trained persons to provide cover during lunch or other breaks

3. Pupils who self administer must carry their equipment at all times as this is a potentially fatal condition

4. Written authorisation must be obtained from the parent/guardian(s) for children to carry and administer their own medication

6. School staff will receive a certificate indicating that they have successfully undertaken training

7. Staff are recommended for re-training annually or sooner if appropriate

8. Developing a Training Plan

Severe Allergic Reaction - Points to Include

1. What is the child allergic to?
The child may be allergic to other substances.

2. What happens to the child?
Hopefully parents will describe the reaction.

3. Treatment for severe reaction – medication
Expiry details

4. Dietary implications
(Liaise with the dieticians at the RSH and PRH)

5. Where to keep adrenaline
(Bum bag with child, or in a cupboard - is there a spare?)

6. Where to keep instructions about where and how to give adrenaline

7. Is there a medic alert emblem

8. Letter from GP Confirming diagnosis
Consents from parents/guardians/teachers

9. Training

Medical Form

5.3.10 Anaphylaxis - Contract of Care

Name: .....

Age: ..... DOB: .....

Address: .....

.....

.....

Allergy: .....

Allergic Response: .....

.....

Treatment: .....

.....

Contact details:

Name of Parent: .....

Telephone number: .....

Second contact/relationship: .....

Telephone number: .....

Child's GP

Name of GP: .....

Telephone number of GP: .....

Telephone number of nearest hospital: .....

Medical Form

Anaphylaxis - Contract of Care

Has the school received a letter from GP/Paediatrician to confirm administration of adrenaline

Please do not proceed with training if letter not available

……..……

Signature of Trainer Date

Has the school/nursery received a letter from parents giving consent for administration of adrenaline

Please do not proceed with training if letter not available

……

Signature of Trainer Date

Medical Form

Anaphylaxis - Contract of Care

Training

Names of staff volunteers, who have been trained to carry out the appropriate procedure and who will be responsible in an emergency

Name	Date	Name	Date

Anaphylaxis - Contract of Care

Details of Health Professional providing training

Printed name	Signature	Date

Medical Form

Shropshire's Acute and Community Children's Services
Anaphylaxis Teaching Plan

GP Name: ……

Address: ……

……

Tel. No. ……

Child's Name: ……

Date of Birth: ……

Address: ……

……

……

To Whom It May Concern:

The above patient has been prescribed an Adrenaline Pen to be used by a named person in the event of an Anaphylactic reaction as detailed in the patient's Anaphylaxis Teaching Plan.

Doctor's Signature: ……..

Date: ……..

5.3.11 Anaphylaxis

Personal Details

Allergic Reaction to:

1. ……
2. ……
3. ……
4. ……
5. ……
6. ……

Allergic Response:

1. ……
2. ……
3. ……
4. ……
5. ……
6. ……

Medication/Treatment:

Name(s) of Medication	**Expiry Dates**
1. ……	……
2. ……	……
3. ……	……
4. ……	……

Storage Details (Bum bag or cupboard):

……

……

……

Display of Instructions:

……

……

……

Medic Alert Emblem:

……

……

……

5.3.12 Agreement & Conclusion

A copy of these notes will be held by the child's school or nursery where training has taken place and by the training officer

Any changes in routine will be noted and circulated to all involved parties.

Agreed & Signed :

Parent(s)/Guardian(s) :

……

…… **Date:** …….

School/Nursery :

……

5.3.13 Central Register

We would like to share the information about your child's allergy with the Accident and Emergency Department at the Royal Shrewsbury Hospital and Princess Royal Hospital, Telford, and a central register of Children with severe allergies, to be held with the Children's Directorate, Shropshire Community Mental Health NHS Trust.

This information would enable hospital staff to be aware of your child's medical condition should an emergency arise.

A central register would allow us as a Trust to allocate resources to continue training and monitor and audit our service.

Thank you for your co-operation

Child's Name: ……

Date of Birth: ……

Nature of Allergy: ……

Previous Reaction: ……..

Parent's Signature: ……

Dated: …….

5.4	Diabetes Management in School

Shropshire County NHS
Primary Care Trust

DIABETES MANAGEMENT IN SCHOOL

The incidence of diabetes amongst children and young people is increasing. Within Europe, the UK has both the highest number of children diagnosed with diabetes and the lowest number of children achieving good diabetes control (DOH 2007).

Diabetes management can affect daily activities such as school attendance, participation in extra-curricular activities, social inclusion and family life, having an impact on the child's mental health, emotional wellbeing and development (DOH 2007).

It has been shown however, that improved management and control of diabetes in children can improve academic performance and school attendance, reduce hospital admissions, and reduce the chances of developing long term complications of diabetes (DCCT 1993).

The Department of Health (2007) therefore recommend that children and young people be offered a range of diabetes management options and support which have the potential to improve control and encourage/enable self management, and hence lessen the impact diabetes has on their lives.

What does this mean for schools?

Schools should try to provide good levels of support which enable parents to work rather than having to attend school to test blood glucose levels and administer insulin, and they should provide an appropriate environment for these activities. They should also allow children with diabetes to take part in the full range of school activities. (DOH 2007)

This requires:-

- Completion of a Medical Management Plan (see below).
- Storage of blood glucose monitoring equipment, insulin pen and insulin, and hypoglycaemia treatments in accordance with school policy on the safe storage medicines in school.

- Maintenance of consumables needed for diabetes management in school via student's parents/guardian.

- Safe storage of used sharps in an approved container.

- Record of diabetes related activities performed by/on behalf of the student.

Students in secondary schools should be given the option of carrying a blood glucose monitor and fast acting glucose with them to enable the rapid detection and treatment of hypoglycaemia. This will not only encourage and support self-management and reduce time spent out of class in first aid rooms, but also reduce delays in hypoglycaemia treatment which could lead to unconsciousness.

Diabetes Medical Management Plan for Schools

This plan should be completed by the student's diabetes specialist nurse/ school nurse/ health visitor (delete as applicable), parents/guardian and relevant school staff. Annual review should be carried out by parents and school staff, with the involvement of the diabetes specialist nurse if there have been major changes in management.

Name of School:
_____

Date of Plan: _____

Review Dates: _____

_____

_____

Student's
Name:_____

Date of Birth: _____

School Nurse/Health Visitor: _____

Contact Information

Mother/Guardian: _____

Address:_____
_____

Telephone: Home_____Work_____

Mobile_____

Father/Guardian: _____

Address: _____

_____

Telephone: Home _____Work_____Mobile_____

Student's GP Name: _____

Surgery Address: _____

_____

Diabetes Nurse Name: _____ Telephone: _____

Blood Glucose Monitoring

Target range for blood glucose is 4-8 mmols/l.

Usual times to check blood glucose (tick all that apply):-

Before Lunch ☐

Midmorning ☐ Time _____

Midafternoon ☐ Time _____

Before, during (every 30-45 minutes) and after exercise ☐

When student exhibits symptoms of hyperglycaemia (blood glucose level above 10mmols/l ☐

When student exhibits symptoms of hypoglycaemia (blood glucose level below 4 mmols/l ☐

Other (explain):
_____

Can student perform own blood glucose checks? Yes / No

If No, names of school staff to perform on student's behalf:

_____

_____

Insulin Injections

Insulin injection required at lunchtime? Yes / No

If yes, the insulin injection should be given immediately before lunch unless the pre lunch blood glucose result is less than 4 mmols/l, in which case the student should be treated for hypoglycaemia (see below) and should eat lunch before receiving insulin injection.

Name of Insulin:
_____

Usual Lunchtime Dose: _____units

OR flexible dosing using _____units/ _____ grams of carbohydrate.

Dose Amendments: _____units **Date of amendment:** _____

_____ _____

_____ _____

Parental authorization given to advise child/ administer a correction dose (at lunchtime only) for high blood glucose levels using the following adjustments? Yes / No

_____ extra units if blood glucose is _____ to _____ mmols/l

_____ extra units if blood glucose is _____ to _____ mmols/l

_____ extra units if blood glucose is _____ to _____ mmols/l

Parent/guardian signature
_____

Can student give own injections? Yes / No

Can student determine correct amount of insulin? Yes / No

Can student dial up correct dose of insulin? Yes / No

If No, names of school staff to determine dose/ dial up dose/ give injection (delete as applicable) on student's behalf:

_____
_____

Meals/Snacks (time/content/amount)

Mid-morning snack:

_____

Lunch:

_____

Mid-afternoon snack:

_____

Instructions for when food is provided to the class (e.g. party, food sampling, rewards):

_____

Exercise and Sports

A fast-acting carbohydrate such as

_____

and blood glucose monitoring equipment should be available at the site of exercise or sports.

Check blood glucose levels before and during exercise (every 30–45 minutes), and if:-

- **less than 4 mmol/l** below), then — Allow pupil to treat their hypoglycaemia (see eat a carbohydrate snack.
- **4-7 mmol/l** — Allow pupil to eat a carbohydrate snack.
- **7-14 mmol/l** glucose levels — No snack needed, but stop and check blood after 30-45 minutes of exercise. If levels have fallen to less than 7 mmol/l, follow the advice above. If levels have risen to more than 14 mmol/l, follow the advice below. Otherwise carry on.

- **more than 14mmol/l ate a meal or**

If it is more than 2 hours since the pupil last snack, check blood for ketones:-

No ketones present - it should be OK to take part in exercise,
but stop after 30-45 minutes to check blood glucose levels
have fallen. If not stop exercise until blood glucose levels are less than 14 mmol/l.

Ketones present - give a correction dose of novorapid or humalog if able and **do not** exercise until blood glucose levels are less than 14 mmols/l **and** ketones are zero. At this point follow the advice above.

Hypoglycaemia (blood glucose level below 4mmols/l)

Usual symptoms of hypoglycaemia:

_____

_____

_____

Treatment of hypoglycaemia.

Wash hands and check blood glucose level. If below 4 mmols/l, give fast acting sugar to eat or drink such as 3 glucose tablets, Fruit Pastilles, Starburst sweets or 100 mls fizzy drink or squash (non-diet). Wait 15 minutes then re-check blood glucose levels. If still below 4mmols/l, give more sugary food as above. Repeat this process until blood glucose levels are above 4 mmols/l, then give some starchy food such as 2 biscuits, packet of crisps, cereal bar or next meal if due.

If the student is unconscious, having a seizure (convulsion), or unable to swallow, place in the recovery position and call an ambulance (dial 999).

Hyperglycaemia (blood glucose level above 10mmols/l)

Usual symptoms of hyperglycemia:

_____

_____

Treatment of hyperglycaemia.

Allow easy access to drinks and toilet facilities. Be aware that concentration levels, energy levels and mood will probably be affected by high blood glucose levels. If unwell in any way, for example headache, nausea, vomiting, lethargy, contact parents.

Supplies to be Kept at School

Blood glucose meter, blood glucose test strips, results book ☐

Lancet device and lancets ☐

Insulin pen, pen needles, insulin cartridges ☐

Sharps box ☐

Fast-acting source of glucose ☐

Glucogel ☐

Carbohydrate containing snacks ☐

Signatures

I give permission to the school nurse, trained diabetes personnel, and other designated staff members of _____ school to perform and carry out the diabetes care tasks outlined above. I also consent to the release of the information contained in this Diabetes Medical Management Plan to all school staff members and healthcare professionals who may need to know this information to maintain my child's health and safety.

Student's Parent/Guardian

_____ Date: _____

Student's Parent/Guardian Date

_____ Date: _____

This Diabetes Medical Management Plan has been devised by /agreed with:

Student's Diabetes Specialist Nurse/ School Nurse/ Health Visitor (delete as applicable)

_____ Date: _____

School staff representative

_____ Date: _____

Designation _____

Blood Glucose Monitoring

1) Wash your hands and child's hands.

2) If using a new box of test strips, calibrate meter, referring to manufacturer's instructions.

3) Prime finger pricking device and set lancet depth as instructed by child or parent/guardian, or use single use disposable lancet device e.g. Unistik. NB if a child requires assistance with blood glucose monitoring a Unistik or multiclix lancet device should be used.

4) Insert test strip into meter and check calibration number on machine matches the strip.

5) Choose site for finger prick, using the sides of the finger tip (avoid first finger and thumb). Hold finger pricking device firmly against the finger and press the release mechanism to obtain a drop of blood.

6) Place blood onto test strip as per manufacturer's instructions and wait for result.

7) Record result in monitoring diary.

8) Dispose of Unistik device/lancet device in sharps box.

9) Remove test strip from machine and dispose of in a bin. The monitor will switch itself off.

If unable to obtain sufficient blood, check hands are warm and are positioned below the level of the heart and prick finger again. Alternatively, try using a deeper setting on the finger pricking device. Avoid "milking" the finger to obtain more blood as this can affect the blood glucose result.

Insulin injections

Prepare the child for injection, involving them in the process as much as possible.

Preparing the insulin pen for injection:-

1) Wash hands.

2) Attach a new pen needle to the insulin pen.

3) Perform an air shot – dial up 2 units of insulin, hold the pen with the needle pointing upright, tap the pen to allow air to rise, remove needle cover, then press the plunger to expel any air. Insulin should be seen leaking form the needle. If no insulin is seen, repeat the process. Ensure dial has returned to zero.

4) Now dial up the number of units required for injection.

Injection technique:-

1) Use agreed injection site as indicated by child or parents/guardian (outer aspect of thigh, stomach, buttocks).

2) Lift up a small fold of skin between thumb and fore finger.

3) Insert the needle straight down at a 90 degree angle into the skin.

4) Push the plunger on the pen and wait 10 seconds before releasing the skin and removing the needle.

5) Ask child to remove the needle from the insulin pen and dispose of needle in a sharps box, or use a UniGuard needle removing device and dispose of needle and UniGuard in a sharps box.

Hypoglycaemia (refer to child's medical management plan)
Hypoglycaemia is the full name for a hypo or low blood glucose level. Hypos occur when blood glucose levels fall too low for the body to work normally. For most people this happens when their blood glucose levels fall below 4 mmols/l.

Caused by:-
Too much insulin
Not enough food
Delayed/missed meal or snack
Increased/unplanned exercise or activity
Extremes of hot or cold weather
Stress or excitement

Symptoms include:-
Weakness
Shaking
Tingling in fingers and lips
Blurred vision
Headache
Tiredness
Dizziness
Hunger
Confusion

Signs include:-
Looking pale
Shaking
Unusual behaviour
Sweating
Tiredness
Slurred speech

Treatment of hypoglycaemia:-

Check blood glucose level if possible to confirm hypoglycaemia (blood glucose level less than 4 mmols).

Give child fast acting (simple) carbohydrate in the form of:-

100 mls of fruit juice, fizzy drink or squash (not diet).
or
50 mls of Lucozade
or
3 glucose tablets (dextrosol, lucozade etc)
or
3 Fruit Pastels or Star Burst

Or

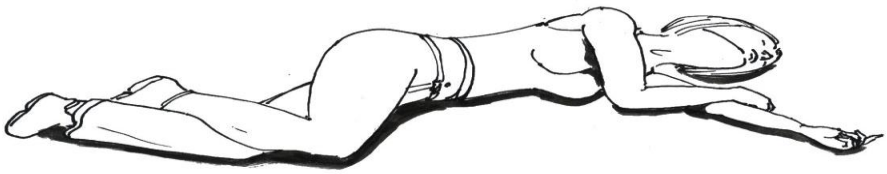
Tube of Glucogel (to be used if child in a confused state and refuses to eat or drink,

but can still swallow safely).

Recheck blood glucose levels after 15 minutes and if still less than 4 mmols repeat the treatment above.

Once blood glucose levels above 4 mmols give child some starchy carbohydrate such as bread, biscuits, cereal bar, crisps etc or next meal if due within 30 minutes.

If the child is unconscious, having a seizure (convulsion), or unable to swallow, place in the recovery position and call an ambulance (dial 999).



The recovery position

References

Diabetes Control and Complications Trial Research Group (1993) The effect of intensive treatment of diabetes on the development and progression of long-term complications in insulin-dependent diabetes mellitus. New England Journal of Medicine, 329(14) 977-86.

Department of Health (2007) Making Every Young Person with Diabetes Matter. London, DOH (2007).

National Collaborating Centre for Women's and Children's Health (commissioned by NICE) 2004. Type 1 Diabetes - Diagnosis and Management of Type 1 Diabetes in Children and Young People. RCOG Press, London.

5.5 Guidelines for Dealing with the Control of Human Head Lice

The detection, control and treatment of head lice infection can only succeed if the individuals involved receive consistent information and advice from the professionals involved. It is extremely confusing for the public to receive a number of different sets of information. By circulating these guidelines widely and making the Shropshire & Telford PCT leaflet readily available it is hoped consistent information will reach the public.

Head lice have prompted Parliamentary discussion and front page exposure in the Wall Street Journal. An estimated £25M is spent on head louse treatment (NHS and non NHS) each year in the United Kingdom. The Public Health Medicine Environmental Group produced the working document on head lice and we have incorporated some of the main points from the document in these guidelines. They are as follows:

- Head louse infection is inadequately understood. There are some disagreements over detection methods, and some treatments have not undergone scientifically valid trials. This lack of knowledge has contributed to confusion about control strategies and needs to be addressed urgently through high quality research. Research into resistance to insecticide treatment is needed.

- Transmission in school has been emphasised, but transmission between friends and within families outside school has been neglected. Head lice are a problem for society and not specifically of health care services or schools.

- Head louse control should be based on teaching the population to detect the parasites by combing.

- Only people with live lice should be treated. The hair of close contacts should be combed and treated if live lice are detected. Nits (empty egg cases) without the presence of live lice are not an indication for treatment. Treatment with insecticide should be repeated after one week to kill emerging lice. If this regime does not work, help should be sought from a training health care professional rather than repeating chemical treatment with the risk of increasing insecticide toxicity.

- All primary health care teams should have a member of staff who is trained in head louse control. Families with recurrent infections may need support.

- Consultants in Communicable Disease Control (CCDCs) should develop guidance and protocols for health care workers (including pharmacists) in their area.

- Insecticide rotation policies are not now recommended as there is no evidence of their value in preventing the development of resistance.

Public Health Medicine Environmental Group (PHMEG). Ref: CDR Weekly, Volume 8, Number 46, November 1998.

From the numerous telephone conversations we have had with schools on this subject we recognise the enormous difficulties you face. We hope that by recommending a strategy which stresses the responsibility of the individual in detecting, combing and treating head lice it will help you move the emphasis away from the school and into the community.

We have found from experience that where schools have ceased to send out standardised letters then the consequent pressure on the school “to do something” has lessened.

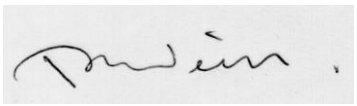
Exclusion of children found to have head lice cannot be supported on health grounds. It is important to accept that many people are unwilling to use insecticides as a treatment and will use

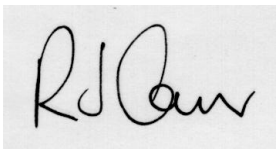
the combing method only. It may take up to six weeks before all lice are removed using this method, therefore exclusion does not appear to be a reasonable option.

The Guidelines recommend liaison with the school nurse where a chid has a persistent head lice problem.

It is hoped the new guidelines provide a supportive framework for you to deal with this ongoing problem and enable you to emphasise to parents their individual responsibility in detecting and treating head lice.

Signed





Dr Patricia O'Neill
CCDC
Shropshire Health Authority

Dr Alwyn Davies
CCDC
Shropshire Health Authority

Dr Rob Carr
CCDC
Shropshire Health Authority

Notes and Guidance for Headteachers

These notes are supplementary to the 2003 Guidelines for dealing with and control of human headlice. Both aim to emphasise the responsibility of the individual in the community for detection, combing and treating the infection.

GENERAL

- Head louse infection is not primarily a problem of schools but of the wider community. It cannot be solved by the school, but the school can help the local community to deal with it.

- Head lice are only transmitted by direct, prolonged head-to-head contact.

- Transmission of lice within the classroom is relatively rare. When it does occur, it is usually from a "best friend".

- Head lice will not be eradicated in the foreseeable future, but a sensible, informed approach, based on fact not mythology, will help to limit the problem.

- At any one time, most schools will have a few children who have active infection with head lice. This is often between 0% and 5%, rarely more.

- The perception by parents and staff, however, is often that there is a serious "outbreak" with many of the children infected. This is hardly ever the case.

SPECIFIC

- Do ensure secretarial or school reception office staff have an appropriate protocol to follow which is in line with new guidelines (see attached).

- Do make sure that your school nurse is informed in confidence of recurrent cases of head louse infection. The school nurse will assess the situation as per section 6(iii) in Communicable Disease and Health Protection Unit guidelines.

- Do ensure information is available for parents who report head lice infection i.e. Communicable Disease and Health Protection Unit leaflet and contact tracing forms.

- Do not send out an "alert letter" to other parents.

- Do not exclude children who have, or are thought to have, head lice.

- Do not agree with angry parents that routine head inspections should be reintroduced. They were never effective.

- Do not take, or support, actions simply "to be seen to be doing something" (such as sending out "alert letters").

- Do not sell or provide fine-toothed combs unless you are sure that the teeth are no more than 0.2mm apart. Use of combs that do not meet this specification has been proven to be ineffective.

- The appropriate clinical advisors are the local pharmacist, the health visitor, the general practitioner and the school nurse.

Ref: Aston R , Duggal H, Simpson J., Headlice Report for Consultants in Communicable Disease Control (CCDS). Public Health Medicine Environmental Group 1998.

Dealing with Reports of Head Lice Infection

Support and Advice for School Secretaries

These notes are supplementary to the 2003 Guidelines for dealing with and control of human headlice. Both aim to emphasise the responsibility of the individual in the community for detection, combing and treating the infection.

- Like the common cold anyone can catch head lice.

- Head lice infection is not a problem that can be solved in school, it is a community problem. A school is only one part of a community.

- When parents report a case of head lice, refer them to the Communicable Disease and Health Protection Unit leaflet.

- Advice on treatment is in the leaflet above.

- If further advice on treatment is requested the appropriate advisers are the local pharmacist, the health visitor, the general practitioner or the school nurse. Please explain this to parents.

- If you are aware there is a particular problem within a family, please refer to your Head Teacher.

- Communicable Disease and Health Protection Unit / Local Education Authority guidelines are in place and routine letters about head lice should not be sent out.

- Copies of the Communicable Disease and Health Protection Unit leaflet and a contact tracing sheet have been distributed with the new policy.

HEAD LICE POLICY

Guidelines for dealing with and control of human head lice in the community

For further information contact

Department of Public Health Medicine
Shropshire County PCT

HEAD LICE POLICY

1. OBJECTIVES

To reduce the risk of insecticidal resistance developing in head lice.

To ensure consistent advice is offered by all personnel involved.

To raise the level of awareness about the nature and management of head lice infection.

2. INTRODUCTION

Like the common cold anyone can catch head lice. It is a community problem, which affects adults and children.

The head louse is a small insect, which lives close to the scalp for warmth and feeds by sucking blood. It moves by crawling through hair and cannot jump or fly.

The female lays five to eight eggs a day, they are glued to the base of the hair shaft and take 5-7 days to hatch.

The louse grows to full size in ten days, and is then ready to lay eggs, and can live for up to 40 days.

Empty egg cases are white and called nits. They grow out with the hair. They are not a source of cross infection.

HOW ARE HEAD LICE SPREAD?

Head to head contact is the only way of spreading head lice.

3. PREVENTION AND CONTROL

Headlice can affect adults and children; therefore the responsibility for the prevention and control of head lice lies with the individual if adult and parent or guardian if a child is affected. Control of head lice infection is possible with proper contact tracing and management of treatments for infections.

All adults should inspect their own and their children's hair at least once a week if head lice are a problem locally. They should use a detection comb (see combing method – 4(i)).

If live lice are found then a treatment option should be chosen and carried out properly.

4. TREATMENT OPTIONS

Each of these treatment options relies on the use of a rigid plastic comb with a 0.2mm space between teeth. Metal combs are not recommended as repeated use can abraid surface of hair[1].

(i) The combing method

The combing method is only likely to be effective in those who are highly motivated, it is not as effective as insecticides.

To facilitate this method:

(i) hair may be washed and conditioned and the conditioner left in. Hair is then parted and combed using a fine comb as described above,

or

(ii) light oil can be applied to the dry hair such as olive oil or grape oil. Hair is then parted and combed using a fine comb. Light oils wash out easily and grape oil will help with the elimination of lice.

The aim is to remove the live lice and eggs. The live eggs are difficult to remove as they are found close to the scalp at the base of the hair shaft. It may therefore be necessary to continue combing for up to six weeks to eradicate lice infection. Combing should be carried out at 2-3 day intervals, to ensure removal of any newly hatched lice[2] (see further reading also).

(ii) Natural remedies

Please note many natural remedies are being promoted

- The perception that herbal products are 'natural' and therefore 'safe' is false.
- All health care staff are advised to seek the guidance of a qualified aromatherapist, herbalist or pharmacist on the value of these remedies, which can be dangerous if used inappropriately. Phenols, phenolic ethers, ketones and oxides (1-8 cineole) appear to be the major toxic components of essential oils such as aniseed, cinnamon leaf, red thyme, tea tree, peppermint, nutmeg, rosemary and pine when used on lice[3].
- Commercially available "off the shelf" natural remedies may be too dilute to be effective.
- All patients/clients should be encouraged to seek appropriate advice (from a qualified aromatherapist, herbalist or pharmacist) before using such remedies.

---

[1] Ref : Insect Research and Development Ltd, Cambridge

[2] Ref : Insect Research and Development Ltd, Cambridge

[3] Ref : Veal, L. The potential effectiveness of essential oils as a treatment for headlice, pediculus humanus capitis. Complementary Therapy Nursing and Midwifery 1996, August 2(4) pp 97-101

(iii) Electric combs

Electric combs are available to buy. They claim to kill lice by means of a small electric discharge. They have no effect on louse eggs. There is no reliable evidence of effectiveness.

(iv) Insecticidal lotions

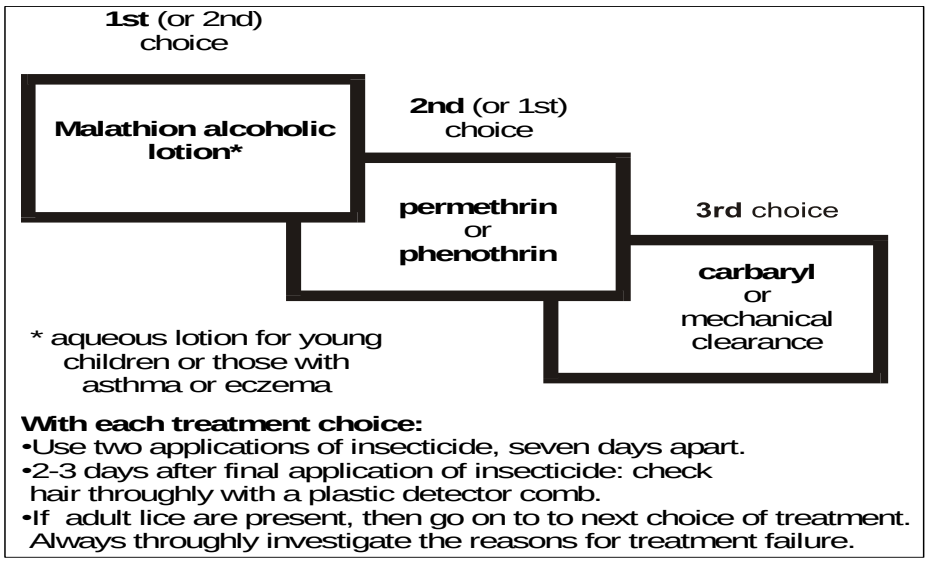
- Check with your Local Health Protection Unit, but most recommend the use of insecticidal lotions NOT shampoos as the contact time with lice when using shampoos is limited and this can render them ineffective[4].
- Cream rinses i.e. Lyclear must be used with care; dilution errors can render these rinses less than 30% effective[5].
- Check with your Local Health Protection Unit, but most no longer recommend a three yearly rotation of lotions.

The lotions available for treatment are lotions containing:

Malathion	Permethrin	Carbaryl	Phenothrin
Suleo M Prioderm Lotion only Quellada M (water based) Derbac M (water based)	Lyclear Cream Rinse (must be used according to instructions to be effective)	Carylderm Clinicide Derbac C Suleo C	Full Marks

Lotion should be used according to the instructions included with the product. A second application after 7 days is recommended. The Committee on Safety of Medicine and the product information sheets specify that no more than 3 consecutive treatments at weekly intervals should be used. The lotion should not be used again within a six-week period.

Lotions containing Carbaryl are only available on prescription. Current UK advice is for each proven case to be managed individually using a mosaic of treatments.



[4] Ref : Pharmaceutical Journal 1996, Vol 257, pp 188-190

[5] Ref : Insect Research and Development Ltd, Cambridge

5. MANAGMENT OF TREATMENT

- Treatment must be started as soon as infection is noticed. The example Health Protection Unit leaflet describes the treatment in detail. Only those on whom live lice have been detected should be treated.

- The combing methods described are crucial to the successful eradication of lice infection even when insecticidal lotions are used.

- Advice on treatment should be available from practice nurses, health visitors, school nurses, general practitioners, chemists and child health clinics.

- Prior to advice being given the health professionals should ascertain the treatment history and the extent to which insecticidal lotions have been used (see previous paragraph).

The advice should cover:

- the choice of an appropriate method of treatment,

* how to undertake the treatment, especially correct method for wet combing and / or application of lotions, if used,

- who should be treated,

- contact tracing,

- preventative combing methods.

Information relating to insecticides:

Lotions have an alcohol base. They are not suitable for young children or those with asthma or eczema.

Liquids have an aqueous base, while cream rinses contain some alcohol. They are suitable for everyone but may be slightly less effective than lotions.

Supply / prescribe sufficient quantity for two applications:

- At least 50ml is required for each application.
- Some patients with thick hair may require up to 150ml per application.
- Each person affected should receive an individual prescription.

6. RESPONSIBILITIES

(i) Your Local Health Protection Unit

- supply copies of your Local Health Protection Unit leaflet on request,
- offer additional support and advice about treatment if required,
- supply specific information about head lice control and prevention.

(ii) The General Public

Individuals are responsible for ensuring that all contacts of an infected person are aware of the infection. Parents in particular are responsible for the detection and treatment of head lice in their children's hair and their own hair.

(iii) Health Visitors, Practice Nurses, School Nurses should:

- emphasise the responsibility of individuals to detect, treat and prevent infections,
- emphasise the responsibility of individuals to instigate contact tracing,
- in the case of recurrent outbreaks, ensure current policy and advice is being followed, offer advice to individual families particularly affected. Consider further measures in conjunction with general practitioners, your Local Health Protection Unit, community paediatricians, social services, education welfare officers, and head teachers if appropriate.

(iv) School Staff

School staff issue a copy of the Local Health Protection Unit leaflet to all new parents.

School staff should not send out a standardised letter to every parent following a reported case of headlice.

School staff should follow guidelines available.

Exclusion from School

Children should not be excluded from school when found to have a head lice infection.

Schools should use the information accompanying these guidelines.

In cases where persistent infection occurs then the advice of the school nurse should be sought who may seek to involve other agencies (see 6(iii)).

(v) General Practitioners and Practice Staff

General practitioners may prescribe insecticidal lotions when head lice infection has been confirmed.

- Cream rinses should be prescribed with an awareness of their limitations.
- Shampoos should not be prescribed.
- Copies of the Local Health Protection Unit leaflet should be freely available in the practice.
- Concerns about resistance to the insecticide can be addressed to CCDC, your Local Health Protection Unit.

(vi) Pharmacists

- Should stock rigid plastic combs with teeth 0.2mm apart.
- Should obtain a treatment history prior to sale of insecticidal products.
- Should stock the appropriate lotions. Shampoos should not be offered for sale.
- Sale of cream rinses should be accompanied by advice on dilution (preferably lotions should be offered).
- A copy of your Local Health Protection Unit leaflet can be given with all prescriptions and sales of head lice treatment.
- Advice about preventative measures should be offered.

Further reading:

Lice and Scabies
A Health Professionals guide to epidemiology and treatment
Edited David T Roberts
PHLS Publications Office
61 Colindale Avenue
London
NW9 5DF

www.phls.co.uk

Dodd CS
Interventions for treating headlice **(Cochrane Review)**
The Cochrane Library Issue 4, 2002 Oxford. Update Software.

Aston R , Duggal H, Simpson J.
Headlice Report for Consultants in Communicable Disease Control (CCDS).
Public Health Medicine Environmental Group 1998.

NHS Centre for Reviews and Dissemination
Treating head lice and scabies. Effectiveness Matters; 1999: Issue 1.

Roberts RJ et al.
Comparison of wet combing with malathion for treatment of head lice in the UK: a pragmatic randomised controlled trial. Lancet 2000; 356: 540 - 544

Website:

www.patient.org.uk/illnesss/h/headlice.htm (this includes links to useful documents and patient information leaflets)

TRACKING LICE...

To keep head lice away for good, you need to find where they came from.

The source is most likely someone well-known to the family and is probably completely unaware that they have lice!

So, make a list of all people who have been in CLOSE (head to head) contact with the infected person.

CONTACT TRACING SHEET

Every member of the family will need to fill in one of these, even though many names will be duplicated.

All the people on the list will need to check themselves and their families for head lice.

NAME

IN THE HOME:

Parents / Guardian

Brothers / Sisters

Other residents

RELATIVES:

Grandparents

Aunts / Uncles

Cousins

Nephews / Nieces

Other

SOCIAL CONTACTS:

Friends

School friends

Brownies / Guides / Scouts / Cubs

Playgroup etc

Clubs

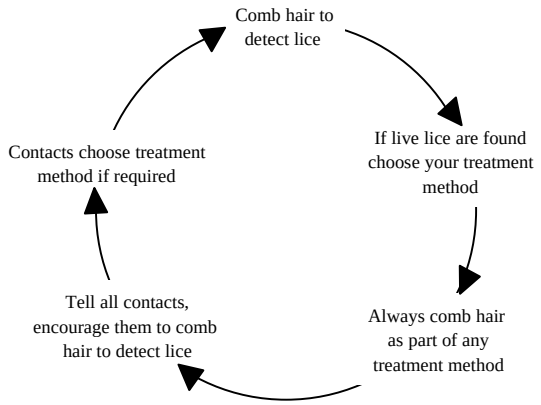
Work colleagues

Note: Pets do not need to be treated.

WHICHEVER TREATMENT IS USED

- Check the heads of all the family and close contacts and treat using one of the three options described.
- Tell all known contacts - e.g. grandparents, aunts, uncles, child minders so they can check their hair and if necessary treat.
- Always continue to comb hair on a regular basis to check for reinfection.

REMEMBER



Prevention is better than cure. Check hair at least once a week if headlice are a problem in your area.

Further Information

This leaflet gives general information. If you require further details and advice about effective combing methods please contact one of the following.

Health Visitor
School Nurse
Practice Nurse / GP
Pharmacist

or

Communicable Disease and Health Protection Unit for Shropshire, Telford & Wrekin
William Farr House
01743 261353

For further copies of this leaflet telephone 01743 261353

The Prevention and Treatment of Head Lice

HEAD LICE

CHECK THEM

TREAT THEM

BEAT THEM

Communicable Disease and Health Protection Unit

Shropshire / Telford & Wrekin
October 2000

Like the common cold anyone can catch head lice. It is a community problem that affects adults and children.

WHAT ARE HEADLICE

Headlice are flat greyish-brown insects, the size of a pinhead, which live in the hair. They like to stay close to the scalp for warmth and feed by biting the scalp and sucking blood.

WHAT ARE NITS

Nits are empty white egg cases. They are not always a sign of actual head lice infection and grow out with the hair.

DETECTION AND PREVENTION

You only have head lice infection if you see live lice in the hair. Lice are most easily detected by fine tooth combing wet conditioned hair. If no lice can be found by careful combing of the hair from the roots then there is no need to consider applying head lice lotions.

WHEN TO COMB

Comb and check hair regularly - once a week. There may be no itching to warn you that headlice are present. It is very important for everyone to check regularly. **Remember - at least once a week.**

HOW TO COMB

COMBING METHOD

Headlice may be detected by this method. If it is done properly headlice may be cleared over a two - six week period.

- Wash hair in normal way with an ordinary shampoo.
- Use a hair conditioner and while hair is wet comb through from roots.

OR

- Use a light oil e.g. olive oil or grape oil on dry hair and comb through from roots.
- Light oils or conditioner makes combing easier, they do not kill lice.
- Use a fine tooth comb (strong plastic if possible). The teeth on the comb should be no greater than 0.2mm apart. Check when you purchase these combs from your local pharmacy.
- Systematically part hair and ensure teeth of comb slot into hair at the roots with every stroke.
- Comb hair over a pale sheet or paper, white towel or pillowcase.
- Clear the comb of lice between each stroke.
- If you find any lice, then repeat this routine every 2-3 days for 2 - 6 weeks so that any lice emerging from the eggs are removed before they can spread or reproduce. This will only work if carried out exactly as described.

TREATMENT

If you find live lice you have three options.

1. COMBING METHOD - on hair washed and conditioned or on dry hair to which a light oil has been applied as described.

2. NATURAL TREATMENTS - these treatments include essential oils or rinses and form part of a combing treatment. Some natural oils can be dangerous if not used properly, use only under the guidance of a qualified aromatherapy practitioner, herbalist or pharmacist. Do not expect these treatments to eradicate the lice - combing is essential.

3. USE INSECTICIDAL LOTIONS and then WET COMB. Please read instructions very carefully about application of the lotions and note that a further application is recommended after 7 days. You can seek advice from your GP, Pharmacist, Health Visitor or School Nurse. You should ensure that the product you are using is a lotion <u>NOT</u> a shampoo.

It is important to wet comb hair after the correct use of the lotion to remove dead lice and any lice which may hatch from eggs as lotions do not always kill the eggs. Continue to wet comb hair every 2-3 days for 7-10 days after the correct use of the lotion.

Do not over use the lotions - a maximum of 3 uses in 3 weeks is recommended. Then do not use again within a 6 week period. Continue to comb and this will reduce the need to use a lotion.

EVALUATION FORM

Medical Form

GUIDELINES FOR DEALING WITH AND CONTROL OF HUMAN HEAD LICE IN COMMUNITY

Completion of this evaluation form will be greatly appreciated.

	YES	NO	DON'T KNOW
Is this document easy to understand?	☐	☐	☐
Is the layout of the document clear and "user friendly"?	☐	☐	☐

Comments

.....

.....

.....

Will you use the information during in-service training / induction training?	☐	☐	☐
Will the document be accessible to all staff?	☐	☐	☐
Will the document help you to target this problem more effectively?	☐	☐	☐

Comments

.....

.....

.....

Please return this form to: Janet Howard, Public Health Nurse, Communicable Disease and Health Protection Unit, Telford & Wrekin PCT, William Farr House, Shrewsbury, Shropshire, SY3 8XL

5.6 Human Immuno - Deficiency Virus (HIV) and Hepatitis B Virus

The premise manager is to ensure the health, safety and welfare of all persons within their areas of control, who may be at risk of both the HIV and Hepatitis B virus.

To achieve this, **risk assessments** must take into account the possibility of contact with these viruses.

When risks have been identified, provision of **immunisation**, where appropriate and necessary, protective equipment ;and safe systems of work are to be made and enforced.

5.6.1 HIV

Human Immuno-Deficiency Virus (HIV) is the virus which can cause AIDS. (Acquired Immune Deficiency Syndrome). Due to the way I which HIV is transmitted, the risk of infection in the workplace is minimal.

Information, advice and where necessary, counselling, is provided through the HIV Co-ordinator or the Occupational Health Department, for all staff who may be concerned about HIV and AIDS issues.

All staff are encouraged to attend **training events**, given to allay fears and anxiety about HIV and AIDS. Any staff requiring this training should inform their Line Manager.

5.6.2 Hepatitis B

Hepatitis is a potentially serious but uncommon disease caused by a virus which can only be transmitted via the exchange of bodily fluids, particularly blood.

The virus cannot pass through intact skin, and cannot be transmitted by food or by sharing soap, towels, cutlery, cups etc. 'Social' kissing, hugging, shaking hands, etc are perfectly safe.

The premise manager is responsible for assessing staff immunisation needs under the Control of Substances Hazardous to Health (COSHH) Regulations 1999. Where immunisation is recommended this should be obtained through staff's own general practitioners. If a charge is made for the immunisation of those staff identified as being at increased risk, then reimbursement can be claimed from the employer.

Health surveillance, as detailed under COSHH Regulations 1999, is to be made of those members of staff who have been identified as being at increased risk to Hepatitis B.

5.6.3 First Aid Arrangements

- Before giving first aid, always cover any exposed cuts or abrasions with a waterproof dressing.

- Wash your hands before and after applying dressings.

- If you are splashed with another person's blood or bodily fluids, wash as soon as possible with ordinary soap and water. Use clean cold tap water if the lips, mouth, tongue, eyes or broken skin are contaminated.

- First-aiders who need to give resuscitation should know that no case of infection has been reported from any part of the world as a result of giving mouth to mouth resuscitation.

- Whenever you need to mop up blood stained body fluids, wear plastic gloves and an apron. Use paper towels for mopping up, then put all items in plastic bags and dispose of them as clinical waste.

- A Bio hazard spill kit can be used to disinfect any contaminated surface. Alternatively, and subject to guidelines in this document regarding bleach, a solution of **household bleach** diluted to one part of bleach to ten parts of water for 30 minutes to disinfect any surface contaminated with body fluids. This will kill both the Hepatitis B and HIV virus.

- Clean contaminated clothes in an ordinary washing machine using the hot cycle.

5.6.4 Needlestick Injuries

- Always perform first-aid in accordance with the above.

- The article which caused the injury is to be retained if possible, and stored safely to provide details of possible infection.

- The incident is to be reported immediately to a senior member of staff.

- The premise manager is to ensure the accident reporting procedures are carried out, including the investigation of the accident and the implementing of remedial actions to be taken where necessary.

- If the injured person has not previously been immunised, then the start of the Hepatitis B vaccine course is advised.

Most needlestick and other exposures to blood result from a failure to follow recommended procedures, the basic rules of hygiene and careless disposal of clinical waste.

5.6.5 Cross References

Health and Safety at Work etc Act 1974
Control of substances Hazardous to Health Regulations 1994
SCC Hepatitis B and Occupational Health - Guidance Notes
SCC Social Services Guidelines on Acquired Immune Deficiency Syndrome (AIDS)

5.7 Infection Control Guidelines

The attached document prepared by the Shropshire County Primary Care Trust and Telford and Wrekin Primary Care Trust pulls together a range of advice about the notification of infectious diseases, how to deal with the media and parents in relation to high profile infection outbreaks, handwashing, cleaning up spillages and other infection control hygiene matters and more detailed information about the infections concerned. The compilation of the information is based upon the experiences of the Health Authority's professional staff and the telephone requests for information received over a four year period.

The document is intended to be used by schools for reference purposes as and when necessary and will support infection control risk assessment processes. The Committee of the Governing Body with responsibility for Health and Safety matters should consider the document to ensure such processes are being undertaken, that relevant safety and hygiene procedures are in place and that any necessary administrative arrangements, e.g. Notification of Infectious Diseases to the Consultant for Communicable Disease Control are operational. An Infection Control Checklist is included at the end of the document as an "aide memoir".

Thereafter, as with all Health and Safety procedures and practices, infection control matters need to be kept under regular review.

Shropshire and Staffordshire Health Protection Unit

Guidelines for the Control of Infection and Communicable Disease

Issue 1
Review 2009

CONTENTS

Sign Off Sheet

Guidance Read By:		
Signature	Name	Date

INFORMATION SHEET

To be completed by School and to be displayed in the office for easy reference

School: _____

_____

_____

School Health Adviser / School Nurse / Health Visitor: _____

The School Health Adviser / School Nurse is regularly in School on: _____

The School Health Adviser / School Nurse can be contacted at: Centre: _____

Tel: _____

The School Health Manager/Team Leader is: _____

Who can be contacted at: _____

_____

_____

Tel No: _____

Health Protection Team Contact: _____

Public Relations Department Contact: _____

Education Department Contact: _____

Occupational Health Provider Contact: _____

PFI Helpdesk Number: _____

ACKNOWLEDGEMENTS

These updated guidelines are based on original guidance documents prepared and issued as separate documents in Shropshire, Telford and Staffordshire by Mandy Beaumont, Kim Gunn and Janet Howard, Health Protection Nurses, Shropshire and Staffordshire Health Protection Team. They incorporate information and original input from numerous sources, which are too many to mention individually, but nevertheless gratefully acknowledged.

Particular thanks go to Gaynor Evans, Health Protection Nurse, Black Country Health Protection Unit, who prepared the original A – Z Infectious Diseases section. Also to Joanne Hooson and Laura Rood for secretarial support.

INTRODUCTION

This guidance provides school staff, school health teams and day nursery owners and staff with advice on the prevention and control of infectious disease in schools and nurseries. It has been developed by the Shropshire and Staffordshire Health Protection Unit and replaces any previous guidance from across the area.

Effective prevention of infection is primarily achieved by education and awareness. This guidance has been designed to assist Head Teachers and Nursery Managers to respond in an appropriate and consistent manner to episodes of communicable disease and infection within their schools.

A brief description of common infectious diseases, outbreak control and contact information is given with special attention to specific diseases such as Meningitis and food poisoning.

The Department of Health published Guidance on Infection Control in Schools and Nurseries (DoH 1999). The guidelines are based on this.

Responsibility for the surveillance, control, investigation and prevention of communicable diseases and infection rests with the Consultant for Communicable Disease Control (CCDC). The communicable disease team including CCDC works in close liaison with Local Authority Environmental Health Officers, Water Authorities, Health and Safety Executive, General Practitioners, Microbiologists and Community Health Staff such as School Health Team and Health Visitors.

The information on diseases is by no means complete but an attempt has been made to provide guidelines, which should enable schools to tackle most of their day to day problems. Specific advice can be obtained by consulting your local Health Protection Team (see contact list) or your school nurse. It is important to emphasis that diagnosis and treatment will be provided by a General Practitioner.

The aim is to provide you with information which can be used:

1. To develop policies which are relevant to your own particular situation.
2. To develop teaching packs for in-service training.
3. To develop information for staff induction packs.
4. To help you target areas for improvement in infection control measures.
5. By individual staff undertaking training courses.

Useful websites are listed on page 13.

Leaflets giving general information and advice about various communicable diseases are available from your local Health Protection Unit (contact numbers on page 10) so that they can be photocopied and used by schools and nurseries as necessary:

Campylobacter	Hepatitis B
Chickenpox	Hepatitis C
Clostridium Difficile	Immunisation and Your Child
Conjunctivitis	Impetigo
Cryptosporidium	Meningitis
Diarrhoea & Vomiting	MRSA
Dysentery due to Shigella	Norwalk-Like Virus
E. coli 0157	Pre School Immunisation
Fifth Disease	Salmonella
Giardiasis	Scabies
Hand, Foot and Mouth Disease	Shingles
Head Lice	Threadworms (Pin Worm)
Hepatitis A	Tuberculosis (TB)

An evaluation form for these guidelines is included and we would be grateful for any comments you may have.

You may print and photocopy any section of this document.

Infection Control and Health & Safety

Infection control is an issue of health and safety and is therefore both an employer and employee responsibility.

The main provisions of Health and Safety legislation relate to infection control in a number of ways:

1. Organisms that can cause infection are subject to risk assessment under the COSHH regulations and Management of Health and Safety at Work Regulation 1992.

2. Various substances such as disinfectants used to prevent cross infection are subject to risk assessment prior to use.

Health and Safety guidance highlights the importance of the risk assessment process i.e.

1. Identify the risk
2. Assess the risk
3. Note current measures which are being used to control or mitigate the risk
4. Inform / train staff
5. Monitor outcomes

This infection control document has been written to provide staff with sufficient background knowledge to undertake a more informed infection control risk assessment.

It is intended to supplement the information in Health & Safety Policy and Codes of Practice documents. This is essential as infection and infection control are specialised subjects.

THE ROLE OF KEY PROFESSIONALS

THE SCHOOL HEALTH ADVISER / SCHOOL NURSE

- Works for the School Health Service which is usually part of the Primary Care Trust responsible for providing Community Health Services to the local population (some independent schools may employ their own School Health Adviser / School Nurse).

- Each State school has a named School Health Adviser / School Nurse.

- Is responsible for health surveillance of pupils in school.

- Is responsible for the co-ordination and delivery of the School Immunisation Programme.

- Provides an advisory and educational role, including staff training and working with pupils in relation to health issues (Personal, Social and Health Education (PSHE)).

- Makes referrals to other agencies / professionals as appropriate.

- Acts as a resource for schools in the event of an outbreak of a communicable disease.

Other health professionals that may be in contact with the school and available for specialist advice include speech therapists, chiropodists, physiotherapists and occupational therapists.

CONSULTANT IN COMMUNICABLE DISEASE CONTROL (CCDC)

- Works on behalf of various organisations including Primary Care Trusts (PCTs) and Local Authorities. CCDCs previously located in Public Health Departments now form part of the Health Protection Agency (HPA).

- Responsibilities include the surveillance, investigation, prevention and control of communicable diseases and drawing up plans for dealing with outbreaks of communicable diseases.

- With others, co-ordinates programmes aimed at the control and prevention of communicable diseases including immunisation against infectious diseases.

- The CCDC is appointed as the 'Proper Officer' to the Local Authority and has certain powers under the Public Health Act (1984) and Public Health Regulations (1988). These powers include admitting people to hospital and excluding them from work, school or nursery if suffering from a specific infectious disease.

- The CCDC works as part of a team including Health Protection Nurses, information and administrative support.

THE ENVIRONMENTAL HEALTH OFFICER

- Works for the Local Authority.

- Has a wide range of functions including food and water safety, infectious disease control, pollution control, health and safety and licensing standards.

- Liaises with the CCDC on all infectious disease matters.

- Will follow up all reported cases of diarrhoea and vomiting to:
  - control further spread
  - try and trace the source
  - prevent a recurrence

- Will follow up other disease cases as requested by the CCDC.

- Will provide support and assistance to the CCDC when an outbreak of illness occurs.

THE GENERAL PRACTITIONER

- All pupils should be registered with a General Practitioner (GP). The name should be recorded in the child's records.

- Is the only practitioner included in this section who can prescribe treatment for a pupil.

- Has a duty to notify the CCDC when a diagnosis is made of a ‘notifiable disease’.
- Can provide information to the school or nursery with the consent of the pupil / parent in respect of an individual pupil who is registered with that General Practice.

useful contact numbers

HEALTH PROTECTION TEAMS

To contact the Consultants in Communicable Disease Control or Health Protection Nurses

South Staffordshire
01785 221126 Office hours
01785 257731 Out of hours and ask for on-call Public Health Consultant

North Staffordshire
01785 221158 Office hours
01782 715444 Out of hours and ask for on-call Public Health Consultant

Shropshire
01743 261353 Office hours
01743 261000 Out of hours and ask for on-call Public Health Consultant

LOCAL ENVIRONMENTAL HEALTH DEPARTMENTS

SOUTH STAFFORDSHIRE

Stafford Borough Council
Civic Centre
Riverside
Stafford
ST16 3AQ Tel: 01785 619379

Cannock Chase District Council
Council Offices
Beecroft Road
Cannock
WS11 1BH Tel: 01543 462621

South Staffordshire District Council
Council Offices
Wolverhampton Road
Codsall
WV8 1PX Tel: 01902 696000

Borough of East Staffordshire
Town Hall
Burton on Trent
DE14 2EB Tel: 01283 508824

Lichfield District Council
Housing and Environmental Services Dept.
Council House
Frog Lane
Lichfield
WS13 6YY Tel: 01543 308725

Tamworth Borough Council
Municipal Offices
Marmion House
Lichfield Street
Tamworth
B79 7BZ Tel: 01827 709445

NORTH STAFFORDSHIRE

Stoke on Trent City Council
Civic Centre
Glebe Street
Stoke on Trent
ST4 1RJ Tel: 01782 234567

Newcastle under Lyme Borough Council
Merrial Street
Newcastle Under Lyme
Staffordshire
ST5 2AG Tel: 01782 717717

Staffordshire Moorlands District Council
Moorlands House
Stockwell Street
Leek
Staffordshire
ST13 6HQ Tel: 01538 483483

SHROPSHIRE

Bridgnorth District Council
Westgate
Bridgnorth
WV16 5AA Tel: 01746 713156

Oswestry Borough Council
Castle Street
Oswestry
SY11 1JR Tel: 01691 677222

South Shropshire District Council
Stone House
Corve Street
Ludlow
SY8 1DG Tel: 01584 813375

North Shropshire District Council
Edinburgh House
New Street
Wem
SY4 5DB Tel: 01939 238466

Shrewsbury and Atcham Borough Council
Guildhall
Frankwell Quay
Shrewsbury
SY3 8HQ Tel: 01743 281353

Telford and Wrekin Council
Derby House
PO Box 214
Lawn Central
Telford
TF3 4LE Tel: 01952 202509

OTHER SOURCES OF INFORMATION

Other sources of information, advice, guidelines and recommendations on infectious diseases and their control can be found at the following websites:

Health Protection Agency (HPA)	Disease Facts and Advice Sheets	http://www.hpa.org.uk
Immunisation	Information on all vaccines	http://www.immunisation.nhs.uk
Immunisation	World Health Organisation immunisation profiles	http://www.who.int/vaccines-surveillance/intro.html
Health Information for Teachers	Government	http://www.wiredforhealth.co.uk
Healthcare A – Z	Information on childhood diseases and links to other websites	www.healthcareA2Z.co.uk

Your local education authority website also contains information.

DEFINITION OF TERMS COMMONLY USED IN INFECTION CONTROL

Body Fluids — Blood, urine, vomit, mucous, faeces, sputum, vaginal secretions, semen, breast milk.

Carrier — Someone who is harbouring and / or excreting a bacteria or virus without suffering from illness.

Case — Someone who has the infection and has the symptoms.

CCDC — Consultant in Communicable Disease Control

Contact — Someone who has been exposed to an infected person or a contaminated environment so that he or she could become infected. Staff are seen as contacts where children are the case, just as children are contacts if the staff are ill. Staff are usually the contacts. Where staff may be vulnerable to serious effects, this will be mentioned under individual illnesses. The person in charge must decide whether staff need more advice in the case of some illnesses, for example as in hepatitis.

The number of children who are contacts varies, according to the organisation of the establishment, age of children and nature of infection.

Therefore no assumption should be made about who is or is not a contact.

Some children will be more vulnerable to the serious effects of specific infections, due for example to underlying illness such as leukaemia. Parents are usually aware of the implications of infection for such children.

EHO — Environmental Health Officer. The EHO works to improve the quality of life for the population with regard to food and environment.

Food-borne Disease — A disease of infectious or toxic nature caused or thought to be caused by the consumption of food or water.

Food Handler — Any person whose work involves touching unwrapped foods to be consumed raw or without further cooking.

NB: Food includes drinks and ice.

Handwashing	Removal of transient micro-organisms by the use of water, friction and soap.
Health Protection Nurses (HPN)	Nurse Specialists in Infection Control and Communicable Diseases
Health Protection Teams (HPT)	Consists of CCDC, HPNs, Epidemiologist and Support Workers
Incubation Period	The time between a person becoming infected and actually showing signs of illness.
Isolation	A way of separating a person with an infection to help prevent this infection from spreading.
Outbreak	Where two or more people, thought to have common exposure, experience a similar illness of proven infection.
Outbreak Control Team	Convened if an outbreak is suspected. Membership would consist of: CCDC HPN School Health Adviser / School Nurse Head Teacher / Nursery Manager EHOs Microbiologist Others such as occupational health and local GPs may also be required depending on the nature of the outbreak.
Period of Infectivity	The time a person remains infectious. This can include the incubation period above.
Primary Care Trusts (PCTs)	Replaced Health Authorities and are responsible for the health of their population.
Proper Officer	Each council has one. All notifiable diseases are reported to this person, it is usually the CCDC.
Route of transmission	The way in which an infection is passed from one person to another. This may be: 1. Direct from person to person, by touch, by breathing in germs, by sexual contact, and contact with blood or infected body fluids and by the faecal - oral route. 2. Indirect i.e. via contaminated food or water.

3. Via contact with animals or insects carrying infection.

4. From mother to baby before or during birth (or during breast feeding).

Spread of Infection Infections may be transmitted in the following ways: Airborne, person to person, ingestion, mother to baby, bloodborne, sexually.

CHILDREN WITH SPECIAL NEEDS

Disability in itself does not pose an increased risk of infection. Children with disabilities are no more likely to transmit infection to others than children without disabilities.

However, children with certain disabilities may find it difficult to observe good personal hygiene. Such children may be unable to tell an adult that they feel unwell. This may be important since many diseases are most infectious before signs of the illness appear. High standards of hygiene will minimise the risk from these children.

If there is a concern about the effect of an infectious disease on a child with disability the Head Teacher can seek advice from the School Health Adviser / School Nurse, the Consultant in Communicable Disease Control (CCDC) or the child's GP. The School Health Adviser / School Nurse can liaise with the GP on behalf of the school.

Vulnerable Children

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

Such children include those being treated for leukaemia or other cancers, children on high doses of steroids by mouth and children with conditions which seriously reduce immunity. Usually schools or nurseries are made aware of such children through their parents, the carers or the School Health Service.

These children are especially vulnerable to chickenpox or measles. If a vulnerable child is exposed to either of these the parent / carers should be informed promptly so that they can seek further medical advice as necessary.

The Child from Abroad

People who come from different parts of the world to live in Shropshire and Staffordshire are generally quite fit and healthy.

Even if infectious disease is more common in the country of origin this does not normally present an increased risk to the public health locally. People arriving for the first time generally register with a GP, if they do have any health problems these can be diagnosed and treated quickly.

Pre-school Age Children

Health visitors who identify or are notified of pre-school or nursery arrivals will review immunisation status in the usual way and make arrangements for TB screening and BCG immunisation if necessary.

School Age Children

Similarly School Health Advisers who identify or are notified of school age new arrivals will review immunisation status and make arrangements for TB screening and BCG immunisation if necessary.

LEGAL AND MANAGEMENT ISSUES IN INFECTION CONTROL

CONFIDENTIALITY

This issue is usually debated in relation to HIV infection, hepatitis B or C carriers but it is relevant to other infections as discriminatory behaviour is quite common. Infection and the fear of contagion are very emotive subjects.

The aim of this section is to encourage debate around issues of confidentiality. Where infection is concerned there is usually a perceived "need to know". Those involved in childcare should ask themselves "Why do we need to know?" or "What are the positive outcomes of such knowledge?".

Frequently the positive outcomes are outweighed by the negative outcomes when confidentiality breaks down and the child is discriminated against in the care environment or the child and family are discriminated against in the community. Infections that are spread via contact with blood or body fluids of an infected person should not pose a problem in the childcare environment provided infection control procedures and standards are adhered to. Many would say there is only a weak argument in favour of the "need to know" in these cases.

Other infections that are spread by person-to-person contact or contact with objects or animals pose different problems and it may be necessary to extend the need to know quite widely. Nevertheless, it is possible to maintain a high degree of confidentiality, even during, for example, TB contact tracing and screening in a school.

Where it is essential to extend the need to know, affected children and their families can be given adequate support to help cope with any discriminating behaviour.

Every situation is different and the pressure on managers, head teachers, nurses etc. to meet this need to know may be excessive, hence the importance of the support and advice available via the infection control team and employing authorities where applicable.

Notifiable diseases

Diseases notifiable under the Public Health (Control of Disease) Act 1984:

Cholera
Plague
Relapsing Fever
Smallpox
Typhus
Food Poisoning

Diseases notifiable under the Public Health (Infectious Diseases) Regulation 1988:

Acute encephalitis
Anthrax
Acute poliomyelitis
Diphtheria
Dysentery (amoebic or bacillary)
Leprosy
Leptospirosis
Malaria
Measles
Meningitis
Meningococcal septicaemia (without meningitis)
Mumps
Ophthalmia neonatorum
Paratyphoid fever
Rabies
Rubella
Scarlet fever
Tetanus
Tuberculosis
Typhoid fever
Viral haemorrhagic fever
Viral hepatitis
Whooping cough
Yellow fever

It is the doctor's responsibility to notify these diseases to the Health Protection Team of their local Primary Care Trust.

How to report INFECTIOUS DISEASES

Please inform the Health Protection Team if you have concerns about the number of children with a particular infection attending your establishment. Advice and support will be given.

Note: Cases of diphtheria, meningitis or other unusual illnesses should be notified by telephone to the Health Protection Team, 01743 261353 – Shropshire

Directions with regard to the Notification of Specific Infectious Disease (see list overleaf) Shropshire and Telford only.

If a teacher becomes aware of any case, or suspected case, of infectious disease affecting any scholar in the school, the fact should be notified at once on Form A to the Health Protection Team.

In all diseases, “contacts” should also be excluded from school where this is stated in the document “Periods of Exclusion for Infectious Diseases” (Revised January 2006) - copy to be found in these guidelines.

Wherever, in addition to notified cases and contacts, there are a considerable number of children absent from unknown causes, the names and addresses of these children should be given.

It is important that the figures required at the foot of the form be accurately stated. “Total number of infected children absent” and “Total number of contacts absent”, means the total to date, inclusive of cases previously notified.

Infectious diseases notified via Head Teachers (Form A) – Shropshire and Telford only:

Chicken pox
Diphtheria
Erysipelas
Hand, foot and mouth disease
Impetigo
Infectious jaundice
Influenza
Measles
Mumps
Paratyphoid
Parvovirus (slapped cheek syndrome)
Ringworm
Rubella
Scabies
Scarlet Fever
Scarletina
Sore throat
Threadworm
Typhoid fever
Whooping cough

Influenza / Sore throat - please use Form A to tell us about overall numbers of children absent from school with these complaints.

Copies of Form A are available via the Health Protection Team Office, 01743 261353.

FORM A

Shropshire Health Protection Unit

Notification of Infectious Disease to: Health Protection Unit, William Farr House, Mytton Oak Road, Shrewsbury SY3 8XL

Names of scholars forwarded (or No. in Admission Register)

School _____ Department _____

Cut along dotted line and keep this section

	Name of Child	Address	Standard / Class	Disease	Date of Onset of Illness	Date of Last Attendance
	CASES ALREADY NOTIFIED SHOULD NOT BE RE-NOTIFIED					
	1					
	2					
	3					
	4					
	5					
	6					
	7					
	8					
	9					
	10					
	11					
	12					
	13					

Date

No. on school register: _____

Total no. of infected children absent: _____

Total no. of contacts absent: _____

Date: _____

Signed: _____

Head Teacher

TO BE KEPT BY HEAD TEACHER IN SCHOOL **FORM A**

SHROPSHIRE HEALTH PROTECTION UNIT

Directions with regard to the Notification of Infectious Disease

If a teacher becomes aware of any case, or suspected case, of infectious disease affecting any scholar in the school, the fact should be notified at once on Form A to the Consultant in Communicable Disease Control, Shropshire Health Protection Unit, William Farr House, Mytton Oak Road, Shrewsbury, Shropshire SY3 8XL.
Tel: 01743 261353

The term "infectious disease" includes measles, whooping cough, mumps, chicken-pox, scarletina or scarlet fever, diphtheria, thyphoid fever, paratyphoid, erysipelas, sore throat, influenza, infectious jaundice, impetigo, scabies, ringworm, parvovirus (slapped cheek syndrome), hand foot and mouth disease, threadworm, rubella.

In all diseases "contacts" should also be excluded from school where this is stated in the Health Protection Unit document Child Care Infection Control Guidelines (Exclusion for Infectious Diseases). This document and the Exclusion charts can be accessed as follows:
Shropshire – Health & Safety CD Rom Section 5 Medical Arrangements
Telford & Wrekin – Health & Safety Manual – paper copy or via internet

When large numbers of children are absent with flu like symptoms or diarrhoea / vomiting it is sufficient to record the total number absent on a particular day.

Wherever, in addition to notified cases and contacts, there are a considerable number of children absent from unknown causes, please contact the CCDC as above.

Note: *Cases of diphtheria, meningitis or other unusual illnesses should be notified by telephone 01743 261353 to the CCDC.*

It is important that the figures required at the foot of the form be accurately stated. "Total number of infected children absent" and "Total number of contacts absent", means the total to date, inclusive of cases previously notified.

EXCLUSION OF CHILDREN

1. Exclusion periods play an important part in limiting the spread of infection. The purpose is to separate a child with a potentially dangerous infectious disease from other children so the infection does not spread.

2. Head Teachers acting on behalf of Local Education Authorities or School Governors can exclude children. The Consultant in Communicable Disease Control has legal powers to exclude but these are very rarely required.

3. Exclusion periods for children have no legal basis. They are minimum periods and recommended on the basis of current research. They are up to date at the time of printing.

4. It is suggested that childcare establishments make their exclusion policy explicit to parents / guardians, preferably in the documentation which is completed and signed when the child is first registered at the establishment.

5. It's generally expected that a child would only return to school / nursery / playgroup if well enough to benefit from it.

6. The exclusion chart should always be used in conjunction with the more detailed information about each infection given in A – Z of Infectious Diseases.

See also: Exclusion charts
Working with Parents and Press

EXCLUSION OF STAFF

General Staff

The same rules of exclusion apply to all members of staff and to peripatetic workers who come to the establishment.

Staff involved in Food Handling

The Food Safety General Food Hygiene (General) Regulations 1995. A person engaged in food handling is directed to inform their supervisor if they are suffering from, or have been in contact with, certain infections (see Outbreak Plan). The supervisor should exclude the employee and inform the EHO and CCDC.

NB Please see definition of Food Handler
Duty of Food Handler in case of illness

FOOD HANDLERS

Food handlers have a duty to report the following illnesses to their employer[6].

Vomiting
Diarrhoea
Skin Rashes
Boils
Infected cuts
Any discharge from ears, eyes, nose or other parts of the body

They should also report:

1. Any attack of diarrhoea and vomiting on holiday, even if they are well on return to work.

2. If they have had close contact with anyone suffering from any of the above symptoms.

NB ***If the employer requires advice about a person's fitness to work, he / she should seek this from the Consultant in Communicable Disease Control or Environmental Health Officer.***

6 Food Safety 'General Good Hygiene' Regulations 1995

Periods of Exclusion for Infectious Disease

DISEASE	EXCLUSION OF PATIENTS	MANAGEMENT OF HOME CONTACTS
BACILLARY DYSENTERY	All cases to be excluded from school until they have been free from diarrhoea for 48 hours unless advised otherwise by the Consultant in Communicable Disease Control (CCDC).	Siblings from primary or nursery schools / classes should be screened but not excluded while awaiting results unless they have symptoms. In cases of doubt Head Teachers should seek advice from the CCDC.
BRONCHIOLITIS (Croup)	During acute stage of illness. Until child feels well enough.	None.
CHICKENPOX	Minimum period of exclusion five days from onset of rash.	Pregnant women should seek advice from their own doctor.
COLD SORES (Herpes Simplex Type 1)	Usually none. Very young children may spread the virus by touching infected sore.	None. Towels and face cloths should not be shared.
CONJUNCTIVITIS	None. Child should be well enough to attend.	None. Towels and face cloths should not be shared.
DIARRHOEA (including Salmonellosis)	All cases to be excluded from school until they have been free from diarrhoea for 48 hours unless advised otherwise by the CCDC.	None.
E. COLI O157	Seek advice from CCDC.	Seek advice of CCDC. Stool specimens will be required. EHOs will co-ordinate this.
GERMAN MEASLES (Rubella)	Minimum period of exclusion five days from onset of rash.	Pregnant women should seek advice from their own doctor.

DISEASE	EXCLUSION OF PATIENTS	MANAGEMENT OF HOME CONTACTS
HAND, FOOT AND MOUTH	None. Children should be well enough to attend.	Close watch to be kept on contacts, it can be transmitted to nearby persons by: i. direct contact with rash, ii. droplets from respiratory tract, iii. faecal hand to mouth route. As virus can remain in the stool for several weeks it is important that careful handwashing is undertaken.
HEPATITIS A (Jaundice)	There is no justification for excluding well older children with good hygiene. Exclusion should still be attempted in nurseries where hygiene may be an issue so causing a risk to adults.	None - but any contacts showing signs of being unwell should be excluded.
HEPATITIS B	None. Child may attend when well enough. Not infectious under normal school conditions.	See section on bloodborne viruses.
HIV infection	None. Child may attend if well enough. Not infectious under normal school conditions.	See section on bloodborne viruses.
IMPETIGO	For 48 hours from start of antibiotic treatment or until the skin has healed. Please note a decision regarding exclusion is based on the extent of the disease. If the affected skin areas are few, occlusive dressings will in most cases render exclusion unnecessary.	None.
LEPTOSPIROSIS	Until child feels well enough.	Transmission from person to person is rare.

DISEASE	EXCLUSION OF PATIENTS	MANAGEMENT OF HOME CONTACTS
MEASLES	Minimum period of exclusion five days from onset of rash. A saliva test is available via GP to confirm diagnosis.	None.
ACUTE MENINGITIS AND SEPTICAEMIA	Until considered by General Medical Practitioner to be free from infection and fit to return to school. CCDC will give advice.	Household contacts may be offered antibiotics. Close contacts of meningitis do not need to be excluded from school / nursery etc. CCDC will give advice
MOLLUSCUM CONTAGIOSIUM	None, but avoid contact with the lesions.	None.
MRSA	None unless child is unwell. Please read MRSA section for details.	Advice available from CCDC.
MUMPS	Minimum period of exclusion until swelling has subsided (five days minimum).	None.
PARVOVIRUSES INFECTION (Fifth Disease or Slapped Cheek Syndrome)	If there are known cases of infection children who are unwell should be excluded. May return on appearance of rash.	Women who may be pregnant should seek advice from their own doctor.
PEDICULOSIS (Infection of Hair with Lice)	None. Children need not be excluded. Where a case of headlice is detected, parents of child should be requested to ensure treatment occurs. Health Protection Unit leaflets detailing treatment should be given.	Follow-up of household and close contacts is essential.
POLIOMYELITIS	Until considered by a CCDC to be free from infection and fit to return to school.	The Head Teacher will be informed regarding freedom from infection and re-admission, by the CCDC.

DISEASE	EXCLUSION OF PATIENTS	MANAGEMENT OF HOME CONTACTS
ROTAVIRUS	See diarrhoea.	
SCABIES	Exclusion unnecessary once adequate treatment of the child has been instituted by the General Medical Practitioner.	Careful follow up and contact tracing are essential especially close family and social contacts. Contacts require treatment.
SHINGLES	Five days from onset of rash or until well enough.	Non-immune people can catch chickenpox from patients with shingles as it is the same virus.
STREPTOCOCCAL INFECTION (Scarlet Fever)	Until clinically recovered and pronounced fit by General Medical Practitioner, or five days after commencing antibiotic therapy if well enough to return.	None - but children for whom recurrent streptococcal infection constitutes a special risk (such as those who have had rheumatic fever) should be advised to stay away in the event of an outbreak of streptococcal infection in the school and referred to their own doctor for treatment.
THREADWORM	None – ask parents to treat.	Treat all family contacts. Strict attention to hand hygiene in school and home.
THRUSH	Until treatment has commenced.	None.
TOXOCARIASIS	None. Cannot be spread from person to person.	None.
TOXOPLASMOSIS	None. Cannot be spread from person to person.	None. Infection can be spread from mother to baby in womb.
TUBERCULOSIS (Primary and Secondary)	At the discretion of the chest physician. Normally excluded from school and not allowed to return until declared to be non-infectious by a chest physician. CCDC will advise.	Contacts showing no signs of tuberculosis need not be excluded, as they will in any case be under medical supervision.

DISEASE	EXCLUSION OF PATIENTS	MANAGEMENT OF HOME CONTACTS
TYPHOID FEVER and PARATYPHOID FEVER	The Head Teacher will be informed regarding freedom from infection and re-admission by CCDC. High risk groups i.e. food handlers, children < 5 years old, older children who may have difficulty in achieving high standards of personal hygiene should have negative stool specimen.	The Head Teacher will be informed regarding freedom from infection and re-admission of siblings and other contacts who work at school including food handlers.
RINGWORM OF THE BODY	Exclusion not normally necessary during treatment unless specifically advised by the CCDC.	Enquire about household or close contacts, contact with farm animals or pets.
RINGWORM OF FEET (Athlete's Foot)	Exclusion from barefoot activities unnecessary but treatment always advisable.	None.
RINGWORM OF THE SCALP	Until started on appropriate treatment.	Enquiries about household or close contacts, contact with household pets or farm animals.
VERRUCAE (Plantar Warts)	Exclusion is not necessary provided the warts remain covered with a waterproof plaster. Pupils with plantar warts need not be excluded from swimming and other barefoot activities provided the warts remain covered with a waterproof plaster.	None.
WHOOPING COUGH (Pertussis)	Minimum period of exclusion 21 days from onset of paroxysmal cough. Reduced to five days if given antibiotics.	None.

THE UNWELL CHILD IN SCHOOL OR NURSERY

Children often become ill in school and nursery or early symptoms of an illness which started at home may become more pronounced during the course of the day.

Management of the Sick Child

While symptoms vary according to the nature of the illness there are certain symptoms that should always give rise to suspicion that a person is suffering from an infectious disease. These include diarrhoea and / or vomiting, high temperature, shivering and rash or skin spots.

- Segregate the child, as far as possible from others in the class, but do not leave the child alone in a room without adult supervision.
- Designate a toilet for sole use by the sick child.
- Contact the parents / carers and ask for the child to be collected where appropriate.
- Seek advice from the School Health Adviser or doctor if available.
- Ask the child to cover nose and mouth when coughing.
- Cover skin lesions which are discharging with a waterproof dressing.
- Teachers, staff and other children should wash their hands after touching the ill child or coming into contact with blood or bodily fluids.
- Medical rooms must be cleaned and disinfected after use and after any contamination of the area with body fluids.

OUTBREAK CONTROL

It is hoped you will give some consideration to the points raised as an outbreak of food poisoning or infectious disease can occur at any time. Forward planning on your part could help reduce the severity, length and outcome of any given outbreak.

DEFINITION OF AN OUTBREAK

An outbreak has been defined as two or more related cases of infectious disease or an incidence of infectious disease in excess of some expectation.

Occasionally one case of an infection with important public health implications may be considered an outbreak e.g. a case of polio or diphtheria.

The Objectives of an Outbreak Plan are as follows:

1. To ensure prompt action
2. To determine the cause of the outbreak
3. To prevent further spread
4. To prevent recurrence
5. To ensure all necessary agencies are promptly informed of a possible outbreak

To achieve these objectives it is essential to have an outbreak plan that is based on the following principles:

1. All staff should be aware of the definition of an outbreak
2. All staff know who to inform in the event of a suspected outbreak
3. All staff are familiar with the infection control policies within the establishment
4. The outbreak plan should be regularly reviewed
5. Good communication networks are established, both within the establishment and with outside agencies

Who to inform

1. General practitioner
2. Consultant in Communicable Disease Control
3. Environmental Health Officer (if outbreak of diarrhoea)
4. Relatives
5. Other personnel specific to area of work
6. Infection Control Nurse
7. Education Authority

See: Useful Contact Numbers
Information regarding food handlers

OUTBREAK PLAN WITHIN ESTABLISHMENTS

Points to remember

1. Ensure relevant agencies have been informed.
2. Relevant microbiological specimens will need to be collected, advice and help will be available.
3. In residential establishments it may be possible to care for all affected children in one area of the building.
4. Review extra requirements to cope with outbreak e.g. staffing levels, linen, disposables.
5. Ensure adequate facilities to launder soiled linen and dispose of any additional waste.
6. In-service training and updates on infection control are essential for good practice. During an outbreak, relate these good practices to the type of infection causing the outbreak.
7. Ensure food service staff are aware of their particular obligations to report illness under the Food Safety (General Food Hygiene) Regulations 1995.

ROLES AND RESPONSIBILITIES IN AN OUTBREAK

Role and Responsibilities of Staff

The head teacher or School Health Adviser / Nurse should inform the Consultant in Communicable Disease Control (CCDC) of any unusual increase in occurrence of illness or absenteeism in schools.

Role of the CCDC

1. A member of the Health Protection Team will assess the extent of the outbreak and ensure that steps are taken to control it and ascertain the source.

2. A member of the Health Protection Team will liaise where appropriate with the:
   - School Nurse / School Health Adviser
   - Environmental Health Officers
   - General Practitioner
   - Local Microbiologist / Hospital Infection Control Doctor
   - The Occupational Health Department of Local Authorities
   - Head teacher or Nursery Manager

3. A member of the Health Protection Team will inform relevant General Practitioners where appropriate of the outbreak so that consistent information is given on exclusion etc.

4. A member of the Health Protection Team will arrange follow up of other community contacts where appropriate and inform other local schools as necessary.

5. If a major outbreak is confirmed – further action will be taken by the Health Protection Team where appropriate, and the Outbreak Plan will be implemented.

6. A member of the Health Protection Team may, in some circumstances, visit the school having been alerted of the possibility of an outbreak.

Role of the Environmental Health Officer

In cases of an outbreak, or suspected outbreak possibly due to food or water, the Environmental Health Officer will be informed by the CCDC.

The Environmental Health Officer will have specific responsibility to:

1. Provide the Health Protection Team with the support to interview the cases, contacts and teachers and where necessary arrange for specimens to be taken.

2. Undertake an inspection of all catering facilities and assess food preparation and food handling practices. Appropriate advice will be given to secure improvements to food hygiene.

3. To take samples of food and / or water where appropriate.

4. Check for contamination in kitchens and other food preparation areas.

5. Make enquiries from kitchen staff about procedures and practices.

Role of the School Health Adviser / School Nurse

The School Nurse / School Health Adviser will have specific responsibilities to:

1. Inform the Health Protection Team promptly of any suspicion of an outbreak.

2. Liaise with the Health Protection Team and provide support as necessary.

3. Liaise with Head Teacher, other School Nurse / Health Advisers and parents.

4. Provide education of staff, parents or children as necessary, in liaison with the Health Protection Team.

Role of the Head Teacher

The Head Teacher will be expected to:

1. Inform promptly the Health Protection Team or School Health Adviser / Nurse if an outbreak is suspected.

2. Provide the Health Protection Team with numbers absent from school – compared to average attendances.

3. Identify lunchtime eating arrangements for pupils i.e. those which have school meals; packed lunches or go home.

4. Provide other relevant information, if necessary.

5. Liaise with Local Education Authority, teachers, governors and parents and peripatetic staff.

6. Inform the Health Protection Team daily of absenteeism rates until outbreak is over.

7. Arrange as necessary further cleaning schedules to cover the outbreak with property services.

8. PFI (Private Finance Initiative) schools should inform the helpdesk number.

Role of the General Practitioner

The General Practitioner will be expected to:

1. Inform the Health Protection Team if he / she notices an increase in specific communicable disease in relation to a geographical area or school.

2. In liaison with the Health Protection Team, provide necessary treatment, advice and counselling to parents.

WORKING WITH PARENTS AND PRESS

For cases likely to cause concern among parents or attract the interest of the press, the Health Protection Team will tell you what advice to give to parents. Previously, members of the Health Protection Team have helped prepare suitable letters to parents (see example).

Advice should also be sought over what comments to give to the press. With many infections only laboratory tests will confirm the diagnosis. Sometimes these can take several days to complete. Normally it should suffice for a school or establishment to simply confirm whether or not a presumptive diagnosis of a particular disease has been made and to divert further technical questioning to the Consultant in Communicable Disease Control (CCDC).

If asked what action the school or nursery etc. is proposing to take, the comment should be that the school will comply with whatever medical advice is given by the CCDC (see sample letter).

model press release using hepatitis a as an example

An outbreak of Hepatitis A has been identified at _____ School. The Health Protection Team has been informed.

The illness is unlikely to spread beyond the affected family and so the risk to other children and staff is small.

Hepatitis is an inflammation of the liver that can be caused by a number of infections and diseases. The type that sometimes causes outbreaks in the community is known as Hepatitis A virus.

After a long incubation period of around 2 – 4 weeks, there may be a sudden onset of flu like symptoms followed by poor appetite, sickness or yellow colouration of the skin (jaundice).

Parents have been notified and given helpful information if they are at all concerned.

MODEL PARENTS' LETTER USING HEPATITIS A AS AN EXAMPLE

For Guidance Only

Dear Parent / Guardian

There have been confirmed reports that (a) pupil(s) from this establishment has / have contracted Hepatitis A and is / are currently being treated appropriately.

The illness is usually confined to the family affected and so the risk to other children and staff is small. There is commonly a long incubation period of 2 - 4 weeks followed by sudden onset of flu like symptoms, poor appetite, sickness and jaundice, which is a yellow coloration to the skin.

The school is working closely with the Health Protection Team to minimise the spread and would like to use this opportunity to stress the importance of effective handwashing techniques that are currently being encouraged in school.

If any member of your family shows any of the symptoms described contact your family doctor immediately and notify the school of your intention to keep your child at home.

Should you require further information or advice, please do not hesitate to contact us. If necessary we will refer your query to the Consultant in Communicable Disease Control or Health Protection Nurse.

Yours sincerely

Head Teacher / Proprietor etc

RECOMMENDATION FOLLOWING AN OUTBREAK OF DIARRHOEAL ILLNESS

Staff and Pupil Illness

Children and staff with diarrhoea and / or vomiting should remain off school until they have been symptom free for 48 hours at least or at CCDC's discretion.

Anyone developing symptoms whilst at school should go home as soon as possible and remain away until they have been symptom free for 48 hours at least or at CCDC's discretion.

Facilities Required

Communal toilets should have liquid soap, paper towels and waste bins. Students and staff must be encouraged to wash and dry their hands thoroughly.

Dry roller towels, cotton hand towels and bar soap should not be used during an outbreak of diarrhoea within the school.

Record Keeping

Accurate records of staff and pupil illness should be recorded during the outbreak. These records should include when the person first became ill and what symptoms they have experienced. Where possible the name of the person's GP should also be noted. Daily contact should be maintained between the school and the Health Protection Team.

Action to be Taken

Increase routine cleaning schedules to at least three times a day (see next page).

Disconnect water fountain. Provide water for children in disposable cups.

Finger painting / sandpits / water troughs / plasticine and dough should not be used during the outbreak.

Toys should be washed every day in washing up liquid and water and dried until the end of the outbreak and then the school or nursery can return to the usual cleaning regime.

Younger children should be encouraged to wash their hands with soap and warm water before arrival at school or nursery as this can reduce the spread of infection from home. Some supervision may be needed for younger children.

It might be useful to communicate what is happening to parents and the Health Protection Team would be happy to liaise with school to provide accurate information for parents.

Cleaning Schedules

Increase routine cleaning schedules to at least three times a day using a bleach based product (1,000ppm available chlorine i.e. thick bleach diluted to 1 in a 100 or thin bleach 1 in 10).

Routine cleaning will not normally include the use of bleach in the school environment. As well as increasing the frequency of cleaning, the products used will also change. It is recommended that details be provided of the circumstances when the bleach based cleaning agents should be used, contact details for permission to use and provision of the equipment.

Cleaning should be done:

1. When all children have gone home.
2. Following break periods, morning and lunchtime.
3. Deep clean at the weekend.

Particular attention should be paid to:

1. Communal toilets
2. Wash basin
3. Taps
4. Flush handles
5. Door handles / push plates

Cloths used for cleaning should be disposable. Separate cloths should be used for toilets and hand washing facilities.

Cleaning staff should be provided with disposable plastic aprons.

All cleaning equipment should be colour coded for ease of identification of area use.

Kitchen cleaning equipment should be stored separately from other cleaning equipment.

Kitchens will normally be cleaned by catering staff in accordance with a planned schedule.

Dining areas may be cleaned by dining room supervisors or general cleaning staff. It is essential that cleaning equipment used to clean away vomit, faecal matter or other body fluids should not be taken from or returned to the kitchen area.

A-Z OF INFECTIOUS DISEASES

BRONCHIOLITIS (Croup)

What is it?

Bronchiolitis is a highly contagious viral infection caused by the respiratory syncytial virus (R.S.V.). It is most prevalent in children under six months but can appear in children up to two years of age. During winter months between November to March it can reach epidemic levels.

What are the common symptoms?

The condition starts like a cold, developing nasal discharge 1 - 2 days later. An irritating cough may develop and could last for several weeks. Rapid and / or wheezy breathing can occur and there could be some difficulty with feeding.

How is it transmitted?

From infected nasal secretions on hands or toys rubbed across the eyes or nose. It is not usually transmitted by coughing. The original source is usually an older sibling or parent with a cold or chest infection.

What is the incubation period?

Between 5 - 8 days.

What is the treatment?

Treat the symptoms. Hospital admission is sometimes required for this if there is difficulty in breathing.

How can the spread of bronchiolitis be reduced?

If you suspect that someone has the infection, seek medical advice from the GP immediately. Encourage the child to take extra fluids orally. It may help to sit the child in a steam filled environment and encourage plenty of rest.

Wash all toys in hot soapy water and dry them thoroughly, do **not** let other children play with them.

Use good hand hygiene techniques and wash hands prior to contact with a child.

In nursery establishments wear disposable gloves and aprons when handling the child if an infection is suspected and isolate them from other children until they can be collected by parents.

Keep the child away from other children until fully recovered.

CHICKENPOX (Varicella Zoster)

What is it?

Chickenpox is a highly contagious viral infection common in children but can affect all age groups if natural immunity has not been acquired.

What are the symptoms?

Usually the infection starts with a raised temperature, a general feeling of malaise and a sudden appearance of an itchy rash. The rash starts as a flat reddish spot and becomes raised and blistered. The blisters burst within a day or two and dry up leaving a hard crust. This eventually separates and drops off without leaving a scar. The spots appear mainly on the body but can also appear on mucous membranes particularly in the mouth and the blister ruptures leaving shallow ulcers.

How is it transmitted?

The virus is spread by droplet infection from secretions from the nose and throat of an infected person. Chickenpox is infectious from four days prior to the onset of the rash until about five days after the rash appears.

What is the incubation period?

10 - 21 days following contact with the virus.

What is the treatment?

There is no specific treatment but treat the symptoms. A paracetamol preparation may be helpful to reduce temperature and relieve aches and calamine lotion to reduce itching.

What is the exclusion period from school?

A minimum of five days from the onset of the rash or until the child feels well.

Advice to parents

This highly infectious disease is usually mild and those who acquire the infection in childhood develop a natural immunity. If exposed to Chickenpox during pregnancy there may be some risk to the foetus or newborn baby if the mother has no antibodies to chickenpox or shingles. Pregnant mothers in contact with or suffering from chickenpox should seek advice from their own GP.

NB Pneumonia, although a rare complication, may be part of a severe form of the illness. This occurs particularly in immuno-suppressed children.

See also: Shingles

COLD SORES (Herpes Simplex Type I)

What are they?

Cold sores are a type of viral infection caused by the herpes simplex virus. It is extremely common.

What are the symptoms?

Lesions forming on and around the mouth, which blister and rapidly crust over to form scabs. The lesion formation is often preceded by a tingling sensation around the mouth or nasal area. Recurrent infection is common as the virus lies dormant in the body until triggered by factors such as respiratory infections, sunshine, menstruation or stress.

How are they transmitted?

By direct contact with a sore.

What is the incubation period?

2 - 12 days following contact with an infected person.

What is the treatment?

Usually there is no treatment, as they will heal spontaneously. If a tingling sensation is felt prior to the lesion developing, an antiviral preparation e.g. Acyclovir may reduce or prevent an outbreak. Anaesthetic preparations may help once a sore has broken out.

What is the exclusion period from school?

It is not usually necessary to exclude the child.

Advice to parents

At the time of outbreak reduce facial contact. The affected person should use their own towels and face cloths and wash them frequently. Children may feel a general malaise and occasionally have a raised temperature. A paracetamol preparation may be helpful in reducing temperature at this time.

CONJUNCTIVITIS (Sticky eye)

What is it?

An inflammation of the conjunctiva, a thin covering over the eye. Caused by a variety of organisms, commonly viruses and bacteria such as staphylococcus, streptococcus or pseudomonas. There are other causes, which are found in newborn babies but are rare in school / nursery aged children. The inflammation could be due to an allergy such as make up or pollen.

What are the symptoms?

The eye may look red and inflamed. A discharge may or may not be present. The eyelids may stick together if the discharge is profuse. It can affect one or both eyes.

How is it transmitted?

By direct contact with an infected person or from towels and face cloths used by an infected person. In babies it could be that an infection has been acquired during the delivery from organisms present in the vagina.

What is the incubation period?

Dependent on the organism.

What is the treatment?

Refer immediately to the General Practitioner for treatment, usually eye drops or ointment (chloramphenicol). If symptoms persist following treatment eye swabs should be taken to identify the causative organism.

Exclusion from school?

None, child should be taken to see GP for treatment. In cases involving very young children further advice may be required. Children should be well enough to attend school / nursery.

Advice to parents

When treatment has been prescribed it is advisable to bathe the eyes before applying treatment to remove any discharge. Tip the head back and pull down the lower lid before applying the medication being careful not to touch the eye with the applicator as this could re-infect the eye.

If the inflammation is the result of an allergic reaction or viral infection bathing with sterile water may bring relief.

Keep all towels and face cloths separate and wash them frequently.

Discourage swimming until the infection is cleared and discourage rubbing of the eyes. Encourage good hand hygiene to prevent re-infection.

DIARRHOEA AND VOMITING

What is it?

Diarrhoea is a change in bowel habit and involves the passing of stools more frequently than usual and they are loose. These stools may be liquid or may contain blood.

Vomiting / diarrhoea type illnesses are caused by eating food contaminated by bacteria or the toxins (poisons) they produce. Some causes are unrelated to food. The cause may be due to viruses (see also rotavirus).

What are the symptoms?

Different bacteria / viruses cause illnesses of varying severity, but stomach pains, fever, aching limbs, sickness and diarrhoea tend to be common to all illnesses.

How is it transmitted?

The illness is passed on by:

1. Person to person contact, usually following inadequate hand washing following a visit to the toilet.
2. Via food contaminated by an infected person.
3. Respiratory spread in some types of diarrhoea caused by viruses.

It is possible for a person to have only mild symptoms but to still be highly infectious. Also, a person who has had the illness and returns to the school environment within the exclusion period may still be infectious.

What is the incubation period?

This depends on the cause.

What is the treatment?

This depends on the cause and referral to GP is advised.

Exclusion from school?

The exclusion period is 48 hours from the time symptoms have subsided.

Please note the additional information for food handlers in Exclusion and Outbreak details.

Advice to carers / parents / teachers

Obviously, if two children are ill in the same class then an increased vigilance over hand washing procedures and advice regarding exclusion to the parents involved may help stop the outbreak from developing further.

If other children become involved then it may be necessary to look for a common source and the standard letter to parents should be circulated (see model in Section A).

Food handlers should be reminded of their responsibilities and should report any of the symptoms listed previously to both yourselves and their General Practitioner.

Where the outbreak is found to be due to a specific cause such as salmonella, dysentery, campylobacter, or Hepatitis A, the Environmental Health Officer will be informed and will instigate a full investigation to try to establish the source of the outbreak.

When it is known that several children are suffering with sickness and diarrhoea symptoms, it is essential that the toilets and adjacent areas are cleaned and disinfected regularly throughout the day and always after playtimes and dinner breaks. These areas must be well ventilated to allow drying of all surfaces.

In addition, all children must be supervised in the toilet areas so that they all wash their hands thoroughly after using the toilets.

Close attention to hand washing practices is the single most important factor in preventing spread of these illnesses.

See Food Hygiene
Outbreak Policy
Exclusion Details and sample letter for parents
Spillages - Body Fluids
Domestic cleaning
Rotavirus

INFORMATION FOR ALL PARENTS

For Guidance Only

An Outbreak of Vomiting / Diarrhoea

A number of children have been ill with symptoms of stomach pains, diarrhoea and vomiting at the school. In order to limit the spread of this illness the following advice should be followed.

1. The single most important factor in preventing the spread of this type of illness is strict attention to hand washing, particularly after attending the toilet and before handling food, this includes thorough drying of hands.
2. To achieve this children need careful supervision.
3. If your child develops any of the above symptoms, he / she should not attend school and should remain away from school for 48 hours after the symptoms have subsided.
4. The germs involved in the spread of this illness thrive in wet, moist conditions; therefore it is essential that all surfaces in the bathroom / toilet areas are thoroughly dried after cleaning. Normal household cleansers are suitable for cleaning.
5. Children may show obvious signs of illness but the symptoms can be less severe in adults. If your work involves food handling and you develop symptoms you should not report for work, but consult your GP and promptly notify your employer.

If these measures are followed, it should be possible to stop the spread of this illness.

If a member of your family becomes ill and symptoms are severe, please inform your family doctor. This is particularly important in young infants and elderly family members.

E. COLI O157

What is it?

E. coli O157 is a bacteria which causes diarrhoea. There are five other categories of E. coli bacteria and they all cause slightly different diarrhoeal type illness.

What are the common symptoms?

The child does not usually have a temperature. The diarrhoea may vary from mild with no blood to the passing of dark blood. Children may be generally unwell when diarrhoea is mild, but can also be very seriously ill requiring hospitalisation if diarrhoea is bloody and severe. Other complications may occur such as failure of kidneys.

How is it transmitted?

By consuming contaminated food, quite often inadequately cooked beef, especially minced beef, but also by drinking unpasteurised milk or eating unwashed fruit and vegetables contaminated with animal excrement.

The infection is easily passed from one infected person to others especially in families, nurseries or similar settings.

What is the incubation period?

Between 2 – 8 days following contact.

What is the treatment?

Hospital admission is sometimes required if the symptoms are severe.

What is the exclusion period?

Exclude family from school / nursery / food related work until stool tests are found to be negative. Seek advice from CCDC.

Advice to parents and carers

How can the spread of E. coli be reduced?

- Drink only pasteurised milk.
- Don’t eat undercooked meat.

- Wash fruit and vegetables.
- Attention to hygiene and hand washing if the child has contact with farm areas.
- Person to person spread can be reduced by hand washing after using the toilet or changing nappies.
- Keep toilet and nappy changing areas scrupulously clean.
- In nursing establishments carers must wear gloves and aprons when doing nappies.
- If child has diarrhoea whilst at school or in nursery, isolate from other children until the parents collect the child.
- Child should not return until tested negative.

HAND, FOOT AND MOUTH DISEASE

What is it?

It is a viral infection usually affecting children under the age of 10 years. Occasionally it is seen in older children and adults.

What are the common symptoms?

The child may present with a sore throat, high temperature (pyrexia) and blisters appear inside the mouth and throat and on the hands and soles of the feet.

How is it transmitted?

Through close contact with nasal secretions of an infected person and through the faeces. The faeces may be infectious for several weeks after the person has recovered.

What is the incubation period?

3 - 5 days.

What is the treatment?

There is no specific treatment and symptoms usually last between 7 and 10 days.

What is the exclusion period from school?

None. Ensure the child is well enough to attend school / nursery. Ensure young babies are able to feed properly – blisters can cause discomfort whilst bottle-feeding.

Advice to parents

Seek advice from your GP if you are at all worried. Treat the temperature by giving a paracetamol preparation and encourage your child to drink plenty of fluids. Wash your hands using a good hand hygiene technique especially before handling food, after contact with your child and after visiting the toilet and continue the hand hygiene for several weeks following the infection as the faeces may still be infected.

HEADLICE

What are they?

Headlice are flat greyish-brown insects, the size of a pinhead, which live in the hair. They like to stay close to the scalp for warmth and feed by biting the scalp and sucking blood.

Nits are empty white egg cases. They are not always a sign of actual head lice infection and grow out with the hair.

What are the common symptoms?

1. Itching - frequently children are seen scratching their heads.

2. Some children develop a rash on their neck. If this is seen parents should look for lice in the hair.

3. Live lice are seen in the hair.

How is it transmitted?

By close head to head contact with someone who has lice.

What is the incubation period?

The female lays five to eight eggs a day and these take five to seven days to hatch. The lice grow to full size in 10 days and can then lay eggs. They can live for up to 40 days.

The important thing is to remove lice and eggs from the hair before they hatch. This is why we emphasise regular fine combing.

What is the treatment?

If you find live lice you have three options:

1. **Combing method** – On hair washed and conditioned or on dry hair to which a light oil has been applied.

2. **Natural treatments** – These treatments include essential oils or rinses and form part of a combing treatment. Some natural oils can be dangerous if not used properly, use only under the guidance of a qualified aromatherapy practitioner, herbalist or pharmacist. Do not expect these treatments to eradicate the lice – combing is essential.

3. **Use insecticidal lotions and then wet comb** – Please read instructions very carefully about application of the lotions and note that a further application is recommended after seven days. You can seek advice from your GP, Pharmacist, Health Visitor or School Nurse. You should ensure that the product you are using is a lotion, **not** a shampoo.

It is important to wet comb hair after the correct use of the lotion to remove dead lice and any lice which may hatch from eggs as lotions do not always kill the eggs. Continue to wet comb hair every two to three days for seven to ten days after the correct use of the lotion.

What is the exclusion period from school?

None.

Advice to parents

Like the common cold, anyone can catch head lice.

You only have headlice infection if you see live lice in the hair. Lice are most easily detected by fine tooth combing wet conditioned hair. If no lice can be found by careful combing of the hair from the roots then there is no need to consider applying head lice lotions.

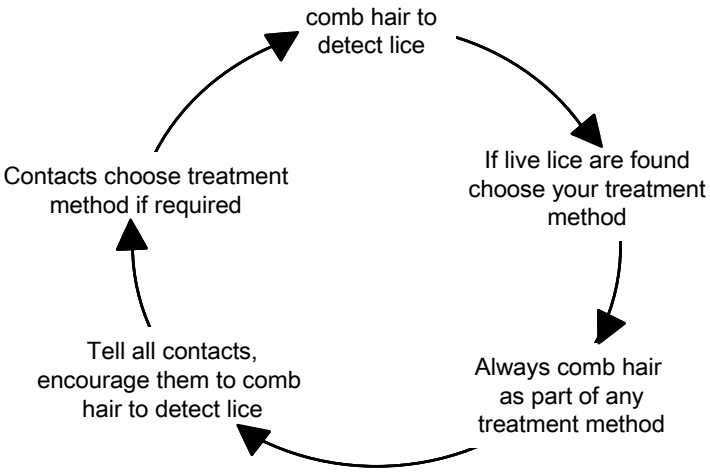
Comb and check hair regularly – once a week. There may be no itching to warn you that headlice are present. It is very important for everyone to check regularly. **Remember – at least once a week.**

Tell all known contacts e.g. grandparents, aunts, uncles, childminders, so they can check their hair and if necessary treat.

Check the heads of all the family and close contacts and treat using one of the three options described.

Always continue to comb hair on a regular basis to check for re-infection.

Remember:



Prevention is better than cure. Check hair at least once a week if headlice are a problem in your area.

HEPATITIS A

What is it?

Hepatitis A is a viral disease, which affects the liver. It occurs most often in school children and young adults. It may be known as infectious hepatitis (it is a different disease from Hepatitis B, detail of which can be found in the section discussing Bloodborne Viruses).

What are the symptoms?

The illness usually begins with a sudden onset of fever (temperature), feeling unwell, loss of appetite, nausea, and stomach pain which is followed within a few days with jaundice: a yellow discoloration of the whites of the eyes and often the skin. Children may have mild infections without jaundice.

How is it transmitted?

The infection is most commonly spread from person to person by infected stools. The stool is infectious for two weeks before the person becomes ill and for about a week after the jaundice appears. People travelling abroad to developing countries where sanitation is poor are at risk of becoming infected. They should be immunised before travelling.

What is the incubation period?

Illness may appear between two to six weeks after contact with an infected person.

What is the treatment?

There is no specific treatment for Hepatitis A. Most patients can be looked after at home.

What should I do if someone has the illness?

Seek advice from your GP. Hepatitis A is a notifiable disease. Close contacts can be protected from infection by immunisation.

Make sure there is very strict personal hygiene - hands must be washed after using the toilet and before handling food. Toilets (handles and seats) must be kept clean.

(Please read also the information on Diarrhoea and Sickness).

Exclusion from school?

Younger children or nursery children should stay away until they feel well and at least seven days after the onset of the jaundice. This is because it is more difficult to ensure personal hygiene in this age group.

If the child is older and has good hygiene then they can attend school if they are well enough.

IMPETIGO

What is it?

Impetigo is a skin infection caused by bacteria, usually streptococci or staphylococci. It is highly infectious.

What are the symptoms?

The lesions may start as a small spot, which blisters very rapidly and has a watery discharge. It quickly crusts over leaving brown crusts and these will drop off without leaving a scar.

How is it transmitted?

By direct contact with an infected person and by sharing towels or face cloths of an infected person.

What is the incubation period?

4 - 10 days.

What is the treatment?

Seek advice from the General Practitioner. Small lesions can be treated with antibacterial ointments, e.g. Fucidin. Larger lesions may be more effectively treated with antibiotics given by mouth e.g. Erythromycin or Flucloxicillin. Impetigo can often be misdiagnosed as eczema and application of steroids can produce extremely rapid spread of infection.

What is the exclusion period from school?

Until all crusts have dropped off or treatment has been given for 48 hours. If affected skin areas are few using occlusive waterproof dressings will make exclusion unnecessary.

Advice to parents

Impetigo is highly infectious and each infected person should have his or her own towel and face cloth, which should not be used by other members of the household. Discourage children from scratching the lesions and encourage frequent and effective hand washing.

LEPTOSPIROSIS (Weil's Disease)

What is it?

A rare bacterial infection.

What are the symptoms?

Common features are fever, headache, chills and severe muscle pain. It is caused by an organism called leptospira and there are many types of this organism.

How is it transmitted?

Occurs worldwide and is spread via the urine of infected animals, contaminating fresh water, moist soil and vegetation.

The organism gains entry to the body via cuts and abrasions on the skin, usually after immersion (e.g. swimming) in infected water.

Incubation period

From 4 - 19 days.

What is the treatment?

Refer to GP.

Specific

Ensure children cover all cuts and abrasions with waterproof dressing prior to activities involving fresh water e.g. pond dipping.

Ensure children wear waterproof boots.

Discourage "horseplay" during water activities.

Emphasise the hand washing message.

It is a recreational hazard to bathers, campers and sportsmen in infected areas.

Exclusion period from school

Transmission from person to person is rare - child can return when well enough.

Advice to parents and staff

Recognise the potential for contaminated waters to spread infection.

Control of rodents particularly close to recreational areas.

Control of domesticated animals to prevent contamination of living areas by animal urine.

MEASLES

What is it?

Measles is a viral infection.

What are the symptoms?

A red blotchy rash appears, firstly behind the ears on the face spreading downwards and covering the whole of the body. Tiny white spots on a bright red background (koplicks spots) may appear inside the mouth. The rash begins to fade after three – four days. There may also be a history of fever, conjunctivitis and cough before the onset of the rash.

A saliva test is available to confirm the diagnosis.

The commonest complication is a severe chest infection. Encephalitis or inflammation of the brain occurs in 1 in a 1000 cases, started a week or two after the rash appears.

How is it transmitted?

By direct contact with a person infected, usually by sneezing or coughing. It is infectious from one day prior to the onset of the rash until four days following its onset.

What is the incubation period?

10 - 14 days following contact with infected person.

What is the treatment?

There is no specific treatment but a paracetamol preparation may help in reducing temperature and calamine lotion to reduce the itching.

What is the period of exclusion from school?

A minimum of five days from the onset of the rash.

Advice to parents

The incidence of measles has dramatically fallen since the introduction of measles vaccine (measles, mumps and rubella) at the age of 15 months, and a booster dose at school entry.

Measles can have serious side effects including brain damage and uptake of immunisation is strongly recommended. If parents are concerned that their child should not have the vaccine they should discuss it with their own GP.

All children should receive two doses of the MMR vaccine to ensure optimum protection against measles.

MENINGITIS

What is it?

Meningitis is an inflammation of a membrane that surrounds the brain. It can be caused by bacteria meningococci and pneumococci and less commonly Haemophilus Influenzae Type B (Hib). A much milder form of meningitis can be caused by viruses or as a secondary infection from measles, mumps or rubella.

Signs and symptoms

BACTERIAL MENINGITIS IS A MEDICAL EMERGENCY AND PROMPT ACTION IS NECESSARY.

There is a very rapid onset of symptoms, often non-specific initially but can include headache, fever, nausea and vomiting, rash, photophobia, neck rigidity. The child may become drowsy. Babies may present with a high-pitched scream and bulging fontanelle. Not all of the symptoms will necessarily be present.

Older Children and Adults
Severe headache
High temperature
Vomiting
Dislike of bright lights
Neck stiffness, joint pains
Drowsiness or confusion - coma
Rash - see below

Babies
Difficult to wake
High temperature
Fretfulness
Refusing feeds / vomiting
High pitched / moaning cry
Pale or blotchy skin
Rash

Skin Rash

Red purple spots or bruises sometimes appear with some forms of meningitis (meningococcal).

These can be anywhere on the body and they do not turn white when pressed - most easily shown by pressing a glass against the rash.

They are due to bleeding under the skin caused by septicaemia (blood poisoning). This is a medical emergency and needs urgent treatment.

Please see address of Meningitis Trust under useful contacts. Excellent fact sheets are available.

How is it transmitted?

By very close contact (kissing contact). All members of the family sleeping under the same roof as the case should be treated with prophylactic antibiotics. Antibiotics would not normally be given to work or school friends of an infected person unless there was a cluster of cases.

What is the incubation period?

Depending on the causative organism between 2 - 10 days.

What is the treatment?

Bacterial meningitis must be treated as soon as possible with antibiotics and hospital admission is usually necessary. Viral meningitis is much milder and usually resolves without treatment.

What is the period of exclusion from school?

Until clinically well and considered by GP to be fit to return to school.

Advice to parents

When a case of meningitis occurs the advice offered to parents will be co-ordinated by a member of the Health Protection Team. It is extremely important this co-ordination takes place as conflicting advice further exacerbates the extreme anxiety and fear felt by parents, family and other contacts.

Excellent educational leaflets about Meningitis are available in various languages from:

National Meningitis Trust
Fern House
Bath Road
Stroud
Gloucestershire
GL5 3TJ

Tel: 01453 768000

Fax: 01453 768001

Web site: www.meningitis-trust.org.uk

A 24 hour help line is available: 0845 6000 800

MOLLUSCUM CONTAGIOSUM

What are the signs?

Small pale raised lumps appear on the body (except the palms and soles). The number may vary from person to person.

What is it?

A viral skin disease resulting in small lumps on the body, which may enlarge and join together.

How is it transmitted?

Usually by direct contact with the lesions.

What is the incubation period?

Between 1 and 6 months.

What is the treatment?

Left alone the lesions usually disappear spontaneously after a few months but can last for two years. Occasionally they may be frozen by a doctor, which can reduce the length of time the person is infected.

What is the exclusion period from school?

There is no need to exclude the child from school, but to avoid contact with the lesions. Visible ones may be covered for activities such as P.E.

Advice to parents

The lumps will disappear spontaneously after a few months. Dissuade your child from scratching them and cover with a dry dressing if necessary.

If the lesions become red or inflamed seek medical advice as they may have become infected and antibiotic ointment or cream may be required.

MRSA

What is MRSA?

MRSA stands for Methicillin Resistant Staphylococcus Aureus and, like the Sensitive Staphylococcus Aureus (SSA), is a bacteria that lives on our bodies and usually its presence is harmless. The only difference between MRSA and SSA is that MRSA is resistant to some commonly used antibiotics.

30% of the population carry the SSA in their nose without becoming aware of it. SSA only becomes a problem if it causes an infection and to do this it must enter the body through a break in the skin or a surgical incision.

MRSA, if present, will also live quite harmlessly on the body of individuals and, like SSA, only becomes a problem if it causes an infection. MRSA can also be treated but the treatment is more complicated and expensive than the treatment for SSA.

There are many people in the community carrying SSA and MRSA with no ill effects.

Because MRSA infections are complicated to treat, it makes sense to try and limit the spread of the bacteria both in a community such as a school and in hospitals.

Obviously, preventing the spread of any bacteria in hospital is vital as many patients are seriously ill and cannot cope with additional infection. The preventative methods used will reflect this.

In a school, the situation is very different and preventative methods will depend very much on assessment of the risk to children and staff in the school. Many of the preventative methods in place in hospital are neither practical nor necessary within a school community.

Infection control measures to prevent spread of MRSA must be based on risk assessment.

Infection Control Measures

Infection control aims to break the chain of transmission of any bacteria present. Most of the control measures are based on common sense and reflect a level of hygiene which most of us would have in our own homes. They are not just useful in control of MRSA but help prevent spread of most other common germs such as salmonella, E. coli, shigella and many common viruses.

There are two elements:

1 Individual responsibility

1. Attention to hand washing.
2. Safe disposal of potentially infected items e.g. tissues.
3. Ensuring managers are made aware of any situation that may pose an infection risk.
4. Discussing return to work after an infectious illness with a manager.
5. Maintaining a clean environment and clean equipment.

2 Overall responsibility

1. Setting up working practices that enable infection control measures to take place.
2. Provision of equipment required to ensure adequate infection control.
3. An overall “culture” and awareness of infection control.

These important elements should already be in place.

Please refer to Health & Safety Policy on Codes of Practice in Primary, Secondary and Special Schools, Section 5, Technical Papers - Child Care Infection Control Guidelines issued by Personnel Services and Central Safety Unit.

Important Messages

Children who are carrying MRSA can attend school. If they are only carrying MRSA they will not have all the signs of infection; they are usually well.

A child who has an actual infection due to MRSA will be unwell and not fit to attend school.

Having an infection makes people unwell.
Carrying bacteria on the body does not make people unwell.

The following precautions are particularly important:

- MRSA is known to spread from person to person on the hands.
- Individuals are advised to cover all cuts and abrasions with waterproof plasters.
- Ensure the children wash their hands appropriately.

Wash your hands frequently and thoroughly. Ensure all skin surfaces are washed. Ensure all skin surfaces are dried using paper disposable towels.

General Measures

Remove toys which have been contaminated by sucking, dribbling etc. and ensure they are washed at the end of school session. Rinsing under a tap will be sufficient in most cases.

Ensure all equipment is wiped down with warm soapy water at the end of each session.

Have a regular routine for cleaning of larger play items, especially equipment.

Use of disinfectants for cleaning toys, play items and the environment is not necessary unless they have been contaminated with faeces or blood. Soap and water is perfectly adequate in most cases.

Ensure all equipment, including mops etc. used for cleaning is washed after use and stored to dry. Do not use cleaning solutions that have been standing - always make up fresh.

These are basic infection control measures and if a child is known to be carrying MRSA, it is very unlikely that any additional measures will be required.

MUMPS

What is it?

It is a viral infection affecting the salivary glands in the neck and throat.

What are the symptoms?

Sub clinical infection is common i.e. the child may appear perfectly well. General feeling of being unwell, pyrexia (raised temperature) and enlargement of one or both parotid glands. A child may complain of earache and difficulty swallowing. Occasionally the submandibular glands are affected.

How is it transmitted?

By droplet infection i.e. by sneezing or coughing or by direct contact with infected saliva.

What is the incubation period?

Between 12 - 23 days, commonly 18 days. It is especially contagious from one week before the onset of swelling, until swelling subsides.

What is the treatment?

Treat the condition conservatively. A preparation of paracetamol may help treat symptoms of malaise and high temperature. Rest as much as possible and encourage extra fluids as the person may not be able to swallow easily.

Exclusion from school?

Five days from onset of swollen glands, until the person is clinically well and swelling subsides.

Advice to parents

Non specific - encourage the child to consume extra fluids and soft diet as he / she can tolerate. Encourage child to rest and give a paracetamol preparation as prescribed to reduce fever. All children should receive two doses of the MMR vaccine to ensure optimum protection against mumps infection.

PARVOVIRUS / SLAPPED CHEEK SYNDROME

(Fifth Disease)

What is it?

It is a viral infection, usually mild in children though adult women may be more unwell. It often occurs in small outbreaks.

What are the symptoms?

A facial rash mimicking a slapped face often preceded by a sore throat, lethargy and raised temperature. Adult women may develop inflamed joints after the acute illness. This usually settles spontaneously.

How is it transmitted?

Normally through droplet infection, coughing and sneezing. It is infectious prior to the onset of the rash.

What is the incubation period?

Between 4 - 20 days following contact with the virus.

What is the treatment?

Usually no treatment is required but a paracetamol preparation may be helpful in reducing a high temperature.

What is the exclusion period from school?

Until the person feels well. Once the rash has appeared the child is no longer infectious.

Advice to parents

Pregnant women in contact with this infection should speak to their own GP.

RINGWORM

(Tinea Capitis - the scalp) (Tinea Corporis - the body) (Tinea Pedis - the foot [Athletes foot])

What is it?

Ringworm is a fungal infection of the skin most common in children. It is usually caused by Microsporum canis contracted from cats and dogs.

What are the symptoms?

It is easily recognised on the body as flat, spreading, red ring like lesions. On the scalp there is often concern about hair loss as there is scaling of the skin and breaking of the hairs.

How is it transmitted?

By direct contact with an infected animal or person.

What is the incubation period?

Usually 4 - 10 days.

What is the treatment?

It is advisable to see the General Practitioner as soon as possible who may prescribe an antifungal cream or tablets.

What is the exclusion from school?

This is not normally required. No restrictions are needed on barefoot activities for those with athletes foot.

Advice to parents

Once treatment has commenced the child may attend school as normal. Lesions should be covered where possible, especially during swimming. There are no restrictions for those children with athletes foot but it is advisable to seek treatment.

Each infected person should have a separate towel and face cloth and encourage good effective hand hygiene particularly after handling animals. Any hair loss that has occurred will grow back again.

Please note

Check all pets and animals and treat those infected.

Check with schools how swimming pools are cleaned as this fungus grows well in shower rooms and damp areas.

ROTAVIRUS (causing Diarrhoea & Vomiting)

What is it?

This is a diarrhoea type illness caused by a virus, not a bacteria. There are many viruses that cause this type of illness. Rotavirus is more common in the winter months and affects younger children.

What are the symptoms?

Stomach pains, fever, sickness and diarrhoea. The diarrhoea may be severe and symptoms can last for four – six days.

How is it transmitted?

The virus is not usually found in the stool after the eighth day of illness. Please see information on Diarrhoea and Sickness and note that Rotavirus may be spread via the respiratory route.

What is the incubation period?

Approximately 24 - 72 hours.

What is the treatment?

Advice from GP to prevent child becoming dehydrated.

Exclusion from school

As for all diarrhoea vomiting type illnesses. Please see information regarding diarrhoea and vomiting for more information about preventing the spread.

GERMAN MEASLES / RUBELLA

What is it?

It is usually a mild illness caused by the Rubella virus.

What are the symptoms?

There may be a slight fever and a general feeling of malaise accompanied by a pink macular rash lasting three - four days. Generalised lymphadenopathy may be present. The infection may also present with headache and conjunctivitis. Definite diagnosis is made by a blood test for antibodies for the virus but this is rarely carried out in children. A new test on saliva is now available.

How is it transmitted?

Usually by direct contact through coughing and sneezing and is contagious as long as virus is present in nose or throat.

What is the incubation period?

Usually 16 - 18 days.

What is the treatment?

Rest and a paracetamol preparation may help relieve symptoms.

What is the period of exclusion from school?

At least five days following the onset of the rash or until the person feels well.

Advice to parents

The illness itself is usually mild in children. It is potentially dangerous to the developing foetus particularly in the first 12 weeks of pregnancy. There can be devastating congenital abnormalities including brain damage, deafness and heart defects. The result of infection can even be fatal to the foetus resulting in miscarriage. All children should receive two doses of the MMR vaccine to ensure optimum protection against Rubella (German Measles).

SCABIES

What is it?

Scabies infection is caused by a mite, which burrows under the skin. The mite is extremely small and can just be seen with the naked eye and the aid of a torch. The mites may be found between fingers, inner wrists, elbows, on the head, under the arms, on the breast, on the back and in the groin and genital areas.

What are the symptoms?

A rash is distributed evenly on the body excluding centre of back, chest and head. This rash will cause intense irritation and due to scratching is often accompanied by secondary infection. The rash does not normally affect the head or face but may do so in those under the age of two years, the mite can sometimes be found there especially if the hair is thin.

How is it transmitted?

By close contact particularly hand holding. It is not that easily transmitted from ordinary skin to skin contact - it is common in children holding hands and during play.

What is the incubation period?

Anywhere between 2 days and 6 - 8 weeks after contact with an infected person. The rash appears and people complain of itching.

What is the treatment?

A lotion can be prescribed by a General Practitioner or purchased from a chemist, and applied as per instructions preferably to cool skin ***not*** after hot bath. It is important to remember that if the child is under two years of age or the affected person has sparse hair, the scalp should be treated.

Please ensure nails are cut short and areas around nail beds, beneath nails, between toes and fingers and behind ears are treated thoroughly. ***All*** members of the household should be treated at the same time. Bed linen and clothing does not need to be washed but many prefer to do so.

A second application of the lotion is required 5 – 7 days later.

What is the period of exclusion from school?

Once the person has been treated they can go back to school the following day.

Advice to parents

With small children it may be advisable to inform close friends as with head lice.

It is important to note that the itching may continue for several days following treatment, but observe for reduction in redness and rash.

Please remember other close contacts, who are not necessarily members of the household, may need treatment.

A separate scabies policy is available from the Health Protection Unit if required.

SCARLET FEVER

What is it?

This is a particular form of streptococcal infection (see streptococcal disease also) that is accompanied by a rash.

What are the symptoms?

These include a very sore throat, pyrexia (raised temperature) and a fine red rash that is raised to the touch. The rash appears mainly on the neck, chest, under the arms and inner thigh, the face appears flushed.

How is it transmitted?

By close contact with an infected person. It is infectious from the start of the sore throat until 24 hours after starting of antibiotics.

What is the incubation period?

Between 1 - 3 days.

What is the treatment?

Antibiotics by mouth, penicillin is the antibiotic of choice. Paracetamol may help to reduce the fever.

What is the period of exclusion from school?

Five days after commencing antibiotics.

Advice to parents

Seek advice from your General Practitioner. Encourage rest and plenty of fluids to drink, this will help to reduce the high temperature. Remember your child may be unable to tolerate a normal diet due to the sore throat and soft diet may be more appropriate. Avoid contact with babies as much as possible.

SHINGLES

What is it?

Shingles is a reactivation of the virus that causes chickenpox. Shingles occurs in people who have previously had chickenpox. The person affected may have other illnesses that lower resistance to infection and allow the chickenpox virus to reactivate in this way.

What are the common symptoms?

The rash or blisters appear in irregular groups on a particular part of the body. They follow the path of the nerves. There is also severe pain around the part of the body affected.

How is it transmitted?

By direct contact with the rash and fluid in the blisters. An individual in contact with shingles will not catch shingles **but** individuals who have not had chickenpox may go onto develop chickenpox.

What is the treatment?

Treatment is available from the GP in tablet form and sometimes as a liquid to paint on the blisters.

What is the exclusion period from school?

Minimum of five days from onset of rash or until person feels well enough.

Please note exposure to shingles poses the same problems for pregnant women as exposure to chickenpox (see chickenpox).

STREPTOCOCCAL DISEASE

What is it?

These include a range of conditions including severe sore throats, which if left untreated can last for three weeks, skin infections and pneumonia. Scarlet fever is one form of streptococcal infection (see separate information).

How is it transmitted?

Through close contact with infected person or those carrying the bacteria but have no signs of illness and it is usually through contact with nasal secretions or droplets.

What is the incubation period?

1 - 3 days.

What is the treatment?

Antibiotic therapy prescribed by the GP.

How long should the child be excluded from school?

Five days after the antibiotics therapy has started or until they feel well.

Advice to parents

Seek advice from your General Practitioner. If your child has a high temperature encourage them to drink extra fluids and a paracetamol preparation may be useful to help reduce temperature and relieve aches and pains. Keep your child at home for at least 24 hours following the start of antibiotics to reduce the risk to other children or until your child feels well.

THREADWORM (Pinworm)

What are they?

They are a form of white worm (enterobius vermicularis) that live in the bowel. They are very common in children but can affect anyone. They are not harmful. Many people will not know they have them.

What are the symptoms?

Most commonly itching around the anal area especially at night when the worms can be seen around the anal sphincter laying their eggs while the child is sleeping. White worms appear in the stool approximately ½ inch long looking like cotton threads.

A secondary infection may occur due to scratching the area and girls can develop a vaginal discharge.

How is it transmitted?

The eggs are trapped under the nails when the infected person is scratching and due to inadequate hand washing, especially after using the toilet, the eggs can be passed on through food preparation or direct contact. The eggs are swallowed and the cycle starts again. Eggs can also be passed on through infected face cloths, towels, bed linen and even in dust.

What is the incubation period?

Between 2 and 6 weeks.

What is the treatment?

A preparation can be purchased from the pharmacy without prescription or from your General Practitioner. All the family should be treated.

What is the period of exclusion from school?

It is not necessary to exclude but urge parents to seek treatment.

Advice to parents

Threadworm is a very common problem:

- Ensure nails are kept short
- Affected person should wear pyjamas or underpants in bed to prevent scratching
- Wash thoroughly around bottom in the morning
- Have separate towels for each person
- Change underclothes and bed linen frequently
- It is important to reinforce frequent and effective handwashing especially after visiting the toilet and before eating
- It is important that ***all*** members of the household are treated at the same time as this infection is easily transmitted from one to the other

THRUSH (Candidiasis)

What is it?

Thrush is an infection caused by a fungus called Candida albicans.

The most usual sites of infection are the mouth, vagina, nappy area and nail beds.

What are the common symptoms?

Nappy rash - rash starts around anus and spreads to skin in contact with nappy. Well-marked areas of redness are present.

Vaginal thrush - redness of vagina and labia accompanied by severe itching plus a thick white discharge.

Oral thrush - the inside of the mouth is raw and inflamed, covered with patches of creamy white exudate that cannot be dislodged.

How is it transmitted?

In babies by cross infection from mother at birth or from other infants especially if bottle-fed. Via articles contaminated by secretions e.g. toys an affected baby has held to mouth. Direct contact with infected nail beds.

What is incubation period?

Variable 2 - 5 days for thrush in infants.

What is the treatment?

Diagnosis by GP. Treatment may be applied directly to the thrush lesion or tablets given.

What is exclusion period from school?

Exclude until treatment has commenced, especially in nurseries where young babies are cared for. Until babies are well enough and able to feed properly.

How can the spread be reduced?

1. Prompt diagnosis and treatment
2. Strict attention to handwashing
3. Strict attention to cleaning and sterilisation of feeding bottles
4. Careful disposal of contaminated articles such as nappies or facial tissues

TOXOCARIASIS

What is it?

Toxocara is a common parasite of dogs and cats. The microscopic eggs of toxocara (commonly called round worm) are spread in the faeces of infected dogs and cats.

Nearly all puppies are infected via their mothers and start to pass eggs in their stools by the time they are four weeks old.

Toxocara reach soil via the infected faeces of dogs where they incubate for 1 -3 weeks before becoming infective.

They then remain infectious in soil for many months to years. Random soil tests will frequently reveal presence of infection.

How is it transmitted?

People catch toxocariasis by accidentally swallowing mature TOXOCARA eggs. Infection is more common in younger children and may be transmitted via direct contact with contaminated soil, e.g. children playing, putting dirt in their mouths, or indirectly by eating unwashed raw vegetables.

What are the symptoms?

When the toxocara egg is swallowed it hatches and the larval worm enters the blood stream and body tissues to circulate in the body. The majority of children who acquire this infection do not show any signs of illness. Diagnosis is difficult but the most publicised symptoms are problems with vision and even loss of vision.

What is the period of exclusion from school?

Toxocariasis cannot be transmitted from person to person therefore there is no exclusion period.

Prevention

Pet owners

Importance of adequate worming regimes for pets
Clear litter trays daily before eggs become infective
Clear up faeces after pet has defecated in a public place

Parents / Carers to protect children

Cover sandpits to keep out cats
Do not allow children to suck grass
Prevent toddlers from putting soil in their mouths
Do not allow eating during play outdoors
Wash raw vegetables / fruit carefully

WASH HANDS

- AFTER HANDLING PETS
- AFTER OUTDOOR PLAY
- BEFORE EATING

Toxocariasis is a problem for the community at large to address and prevention depends very much on responsible pet ownership.

TOXOPLASMOSIS

What is it?

Toxoplasma cysts can be found in all types of fresh raw meat, cat faeces and soil.

Cats harbour the parasite in the gut and excrete the cysts in their faeces.

Other animals harbour the parasite in muscle and tissue but do not pass infected faeces. It can be passed in the milk of infected animals. Cats frequently become infected by catching and eating infected rodents or birds. Sheep and goats can carry the parasite.

What are the signs?

In humans there may be no signs of infection or alternatively there may be an illness resembling glandular fever.

What is the treatment?

This is not normally given to healthy people who acquire the infection. Following infection natural immunity develops and this is long lasting.

Infection in people with poor immunity can be serious e.g. those with leukaemia.

Infection in early pregnancy can be very serious as the infection can cross the placenta to the baby. Therefore in such cases doctors may decide to treat.

What is the incubation period?

Incubation period varies from 5 - 23 days from ingestion of undercooked meat or infection associated with cat faeces.

What is the period of exclusion from school?

It is not spread directly from person to person (apart from mother to baby in womb) so no exclusion is necessary.

How is it transmitted?

1. By consuming undercooked infected meat
2. Contact with grass, soil, sand, litter contaminated with cat faeces

Toxoplasma cysts when passed by the cat become infective 1 - 5 days later and can remain infectious in soil or water for up to one year. Cysts in the flesh of infected meat remain infectious until the meat is adequately cooked.

Prevention - see Toxocariasis

In addition emphasise:

1. Handwashing
2. Thorough cooking of meat
3. Avoid consumption of unpasteurised milk
4. Daily emptying of litter trays before any cysts passed by cat become infective

Pregnant women should:

1. Avoid cleaning litter trays (unless known to be immune to Toxoplasmosis)
2. Wear gloves during gardening and when likely to have contact with soil
3. Avoid contact with lambing ewes

Toxoplasmosis is a community infection and, like toxocariasis, prevention depends very much on responsible pet ownership.

TUBERCULOSIS

Tuberculosis is still quite a common disease.

It usually affects the lungs (Pulmonary TB) but can affect other parts of the body e.g. glands, bones, joints or kidneys.

It is important to understand that some cases of tuberculosis are more infectious than others therefore management of each case will differ slightly.

Pulmonary TB is spread by "droplet infection" i.e. in droplets of the breath when an infectious person talks or coughs.

IT IS NOT AN EASY INFECTION TO CATCH

Contact tracing is carried out as a routine measure and precaution to ensure the affected person has not passed the disease onto someone they live with or had close contact with.

The numbers of contacts seen will depend on the type of tuberculosis diagnosed and the site of the infection.

Treatment is supervised by regular attendance at the Chest Clinic.

Once treatment has commenced tests will be carried out to ensure the affected person has become non-infectious. As soon as they are non-infectious they can then return to work or school on treatment.

Points to remember:

TUBERCULOSIS CAN BE CURED **if the treatment prescribed is taken** ***REGULARLY AS PRESCRIBED*** **and for the** ***LENGTH OF TIME NECESSARY.***
This may be six or nine months.

If you are concerned that an adult or child within your area may not be taking the treatment as prescribed, please contact the school nurse or member of the Health Protection Team to discuss your anxieties in confidence.

VERRUCAE

What are they?

They are a type of wart caused by a virus.

What are the signs?

A hardened lump varying in size usually raised around the edge and a black spot can sometimes be seen in the centre. They usually appear on the feet but occasionally are seen on the hands.

How is it transmitted?

Probably through damp or wet surfaces, swimming pools or shower areas. School children are often affected.

What is the incubation period?

2 - 3 months.

What is the treatment?

These will often disappear spontaneously if left alone and are not causing discomfort. They will usually disappear 12 - 24 months after infection and a natural immunity to the virus will result. If treatment is required refer to a General Practitioner or Chiropodist. Salicylic Acid has proved effective or a podophyllin preparation applied locally, although this would not normally be used on young children due to its toxicity.

What is the period of exclusion from school?

This is not necessary, nor is it necessary to exclude children from swimming or P.E. where they are required to be barefoot. When children are required to be barefoot a waterproof plaster should be worn.

Advice to parents

Unless verrucas are painful do not treat.

A verruca sock has little effect on preventing the spread of the virus, although some public pools insist these are worn at times of infection.

WHOOPING COUGH

What is it?

Whooping cough (pertussis) is a chest infection caused by bacteria. It is most common in children but can occur at any age.

What are the symptoms?

Initial symptoms are catarrh and a cold, which then develop into a cough. Children often whoop or vomit after a spasm of coughing. Babies can become quite exhausted by the coughing and may have difficulty in feeding because of it. The illness may last for a number of weeks and some cases can be severe. Cough can persist for one - two months.

How is it transmitted?

Via the breath and saliva of people who are infected. People with whooping cough are very infectious from two to four days before they start coughing until up to 21 days afterwards. Antibiotics can shorten the infectious period to five days if started early in the illness.

What is the incubation period?

Usually between 7 and 10 days.

What is the treatment?

The main treatment is care of babies by observation, lifting them if they cough, preventing inhalation of vomit and feeding as necessary. Some children may need to be nursed in hospital. Antibiotics can help in some cases.

Exclusion from School?

Minimum period of exclusion 21 days from onset of cough. Reduce to 5 days or until well enough if antibiotics are given.

Advice to parents

Whooping cough (pertussis) vaccine is part of the normal childhood vaccination schedule given at 2, 3 and 4 months. Whooping cough can have serious side effects therefore uptake of the vaccination is strongly recommended.

Parents who are concerned about their children having the vaccine should discuss it with their GP.

BLOODBORNE VIRUSES

Introduction

The specific viruses detailed are Hepatitis B, Hepatitis C and HIV.

It is important to read this section in conjunction with the following guidelines:

1. Accidental exposure to blood or sharp object contaminated with blood / needlestick injury
2. Body fluids - spillages
3. Blood - spillages
4. Waste disposal
5. Personal protection

Please remember the importance of personal protection at all times.

DO NOT MAKE ASSUMPTIONS ABOUT WHO MAY OR MAY NOT BE INFECTED.

High standards of personal and environmental hygiene are expected at all times.

There are many issues linked to the spread of bloodborne viruses, which are beyond the scope of these guidelines.

BLOODBORNE VIRUSES

Some General Problems in Childcare

Incontinence

A nappy changing policy should be available.

1. All cuts and abrasions should be covered on hands.
2. Staff should **always** wear gloves and aprons for a known infection or foul nappy.
3. Soiled nappies disposed of as clinical waste (see guidelines).
4. Changing area thoroughly cleaned and dried using disposable cloths or paper towels.
5. Hands washed thoroughly.

Soiled clothing can be placed in plastic bag to go home or alternatively washed in machine on pre-wash and then on a hot wash cycle.

Sucking, mouthing and chewing

Care should be taken in selecting toys etc. for all children; surfaces and fabrics should be washable and able to withstand disinfection.

Biting

This causes a problem in any circumstances. Children who are a known infection risk will be assessed individually.

Make children aware of dangers of the following:

Blood brothers / sisters - cutting the skin and mingling of blood.

Ear piercing / tattooing - if instruments are not properly sterilised.

Particular school subjects and activities where risk may occur:

1. Design and Technology, Craft, Art, Home Economics.

2. Music - if wind or brass instruments are shared and children have cuts or sores on lips or bleeding gums.

   Precautions:
   - Thoroughly wash and dry mouthpieces in hot water and detergent solution after use.
   - Never share reeds.
   - If it is not possible to wash the area the mouth is in contact with, then thoroughly clean with a swab soaked in 70% spirit solution.

3. Science - Pupils should not give blood or cell samples for science demonstrations.

4. Sport - outdoor pursuits.

   Do not present a cross infection problem provided child is well enough to participate.

   NB In event of accident prompt First Aid with all relevant precautions.

See – Personal Protection

Ref. HIV & AIDS: A Guide for the Education Service Department Education and Science

HEPATITIS B

Hepatitis B occurs worldwide

A person can become infected with the Hepatitis B virus and remain free of illness or alternatively can show symptoms such as abdominal discomfort, vomiting, lack of appetite which progresses to jaundice.

The virus can remain in the system for six months or longer and in some cases the person becomes a chronic carrier of the virus. There are different strains of the virus therefore different degrees of infectivity.

Whilst the virus is present in the body it can be transmitted or passed on to others in certain ways:

1. Via blood, i.e. if the blood of an infected person comes into contact with broken skin of a second person **or** if infected blood comes into contact with mucus membrane where tiny abrasions may be present, as in the vagina or the inside of the mouth.
2. Via semen and vaginal fluids during sexual activity (particularly during high risk activities such as anal intercourse). Sexual activity carries a risk because the virus is in contact with mucus membrane that is extremely delicate and microscopic abrasions can easily occur.
3. Biting and scratching have been shown to transmit the virus.
4. Via blood on infected needles either as a result of needlestick injury or IV drug users sharing needles.
5. From mother to unborn baby or during the delivery.

General Infection Control Advice

Normal standards of cleanliness are sufficient to protect the infected person and others he / she may live with.

1. Cutlery and crockery can be washed in hot soapy water or dishwasher.
2. Different cloths should be used for cleaning in kitchen and bathroom.

3. A Hypochlorite solution, i.e. household bleach, diluted 1 part bleach to 10 parts water is the disinfectant of choice for the bathroom and toilet. Work surfaces in the kitchen can be cleansed with a solution of 1 part bleach to 800 parts water

   If blood is spilt or semen ejaculated inappropriately Hypochlorite granules e.g. Precept granules can be used to cover the spill and then cleaned up. Alternatively paper towels soaked in bleach can be placed over the spill and then cleaned up. If shoes are contaminated they should be cleaned also as above. Plastic disposable aprons and disposable gloves should be worn for these procedures.

   Hands should be washed thoroughly afterwards. Paper towels, gloves, etc. should be disposed of carefully into yellow plastic bags i.e. designated bags for clinical waste, stored in a designated area and collection arranged via Local Authority Environmental Health Services.

4. Laundry - use hot wash cycle of washing machine with pre wash (see Section B - Laundry).

   Heat sensitive articles that are blood stained can be rinsed and then washed.

   Carpets or upholstery, where use of bleach is inappropriate, can be scrubbed using a detergent and left to dry thoroughly and then a carpet cleaner used (see “Dealing with Spillages”).

5. Normal household rubbish can be disposed of as usual.

Personal Hygiene of Infected Person

1. Wear gloves for gardening to prevent injury.
2. Wash hands thoroughly after visiting toilet.
3. Cover all cuts and abrasions promptly.
4. Used tampons or flushable sanitary towels should be flushed in toilet. If not, place in sanitary bin.

The Infected Person should not:

- Donate blood or sperm.
- Carry an organ donor card.
- Attempt to share toothbrushes or razors.
- Share needles or syringes if an intravenous drug user.

The person is advised to tell health care workers and carers they are Hepatitis B positive.

It is not an infection spread by ordinary social contact therefore it is not necessary to tell employers unless the person works in a health care setting.

Health care workers and other professionals should consult their occupational health department about Hepatitis B vaccine if they consider themselves to be at risk.

"Live-in" contacts of the Hepatitis B infected person should ideally be vaccinated against the disease.

Hepatitis B is a cause for concern - not panic.

HEPATITIS C

Hepatitis C is a virus that affects the liver.

Hepatitis C has a long incubation period of 6 - 8 weeks. It is caught in a very similar way to Hepatitis B except that sexual transmission is much less common.

The illness caused is mild and in many cases there are no symptoms. Only 10% of patients become jaundiced.

Some people go on to become chronic carriers of the infection and can develop liver disease some years later.

Cross infection occurs as for Hepatitis B but with greater emphasis on spread via infected blood.

General Infection Control advice - please see Hepatitis B.

There is no vaccine available as yet.

HIV AND AIDS

AIDS (Acquired Immune Deficiency Syndrome) is a severe life-threatening condition first recognised as such in 1981.

A person is only diagnosed as suffering from AIDS i.e. an AIDS case if:

1. Certain infections are present
2. Certain types of cancer are diagnosed
3. Certain other illnesses are present

This diagnosis of AIDS is based on criteria used worldwide and represents the late stages of infection with the Human Immunodeficiency Virus (HIV).

- A person who is infected with the Human Immunodeficiency Virus is said to be HIV positive.
- The length of time between HIV infection and the development of any of the conditions that lead to a diagnosis of AIDS is variable.

These conditions develop as a result of the damage HIV causes to the immune system of the infected person.

Research is ongoing and medical treatment at the moment aims to prevent the onset of life threatening infections and illnesses.

- HIV positive people can remain well for many years.
- Worldwide and United Kingdom statistics show an increase in heterosexual HIV infection with the inevitable increase of infection in children.

Depending on circumstance other members of the family may also be HIV positive so the support offered to the family will need to reflect this.

Infection is passed on in the same way as Hepatitis B and C.

General Infection Control Advice

As for Hepatitis B

Personal Hygiene of Infected Person

As for Hepatitis B

In addition to these guidelines, to protect themselves HIV positive persons should not:

1. Empty and clean cat litter trays (NB see Danger of Toxoplasmosis)
2. Eat uncooked fruits and vegetables unless thoroughly washed
3. Eat undercooked meat dishes

Remember HIV infection damages the immune system of the affected person therefore susceptibility to food borne disease can be increased. Strict adherence to food hygiene regulations should eliminate this problem.

At the present time it is thought that well HIV positive children are no more susceptible to normal childhood illnesses than others.

Queries about immunisation programmes for HIV positive children should be referred to their General Practitioner or Consultant responsible for their care.

DISCARDED HYPODERMIC NEEDLES IN AND AROUND SCHOOLS AND NURSERIES

Injuries from discarded hypodermic needles around school and nursery playgrounds are of concern. The risk of contracting a blood borne infection however is very low.

Action

- If needles are found follow the Education Department Guidelines.
- If you are concerned about imminent danger and want to remove the danger by collecting the needles then you must take the following precautions:
  - Do not handle needles with bare hands, use a dust pan and brush.
  - Place in a designated sharps box if available, alternatively;
  - Place them in a screw top container (not glass) with lid, or a strong plastic box with lid. Keep them in a safe place out of children's reach to await collection.
- Children should be warned about the dangers of playing on rubbish heaps.
- Weekly inspection (or more frequently if necessary) of school grounds and surrounding areas should be carried out.
- Children should be warned not to touch any needle or a sharp medical object but to report to a teacher or nursery assistant at once.

FIRST AID

Action to be Taken Following Splashes of Blood or Body Fluid onto the Skin or Eyes

Skin	Eyes
Wash blood off the skin immediately with soap and water.	Rinse eyes with copious amounts of water.
Report to LEA and record on Accident Report Form. In the nursery setting internal reporting systems must be adhered to.	

Action to be Taken Following a Needlestick Injury or Human / Animal Bite or Scratch

- **Stop what you are doing.**
- **Make the wound bleed (do not suck).**
- **Hold wound under warm running water for a few minutes.**
- **Cover wound with waterproof dressing.**
- **Report incident to Head Teacher who should record event on Accident Report Form and send to LEA.**
- **Obtain immediate medical advice from Occupational Health Provider, HPU, Accident and Emergency Department or GP.**

For local contact numbers see page 2.

For Health Protection Teams / Environmental Health see pages 10 - 12.

GENERAL INFECTION CONTROL GUIDELINES

PERSONAL PROTECTION AGAINST INFECTION

There are many reasons why one person should be more susceptible to infections than another. It is important to consider the wider social and environmental issues, for example poverty, damp housing and overcrowding.

An individual may be susceptible because of:

1. Cuts / abrasions on skin allow entry of infecting organisms
2. Lack of immunisations
3. Underlying disease weakening the body's ability to fight infection
4. Drug treatments with the same effect as above
5. Poor dietary intake
6. Stress

Personal Protection - children and carers

1. Cover all cuts and abrasions on hands and arms
2. Maintain high standards of personal hygiene at all times
3. Ensure that immunisations are kept up to date (see Immunisation)
4. Use protective clothing supplied appropriately (see Protective Clothing)
5. Administer prompt First Aid in the event of injury

See also Blood borne viruses' general problems in Child Care

PERSONAL PROTECTION IS A TWO WAY PROCESS.

- *EMPLOYERS HAVE RESPONSIBILITIES AS SET OUT IN HEALTH AND SAFETY LEGISLATION.*
- *EMPLOYEES HAVE A RESPONSIBILITY TO PRACTICE SAFELY USING THE GUIDANCE AND MEANS PROVIDED BY EMPLOYERS.*

Infection within an establishment may mean the introduction of additional protective measures.

CARERS, BY PRACTICAL EXAMPLE, CAN INFLUENCE THE CHILD'S ABILITY TO PROTECT THEMSELVES AND OTHERS FROM INFECTION.

HAND WASHING

The most important measure in control and prevention of infection is to ensure good personal hygiene at all times. This means hand washing with hot soapy water and thorough drying before meals and after using the toilet.

Personal hygiene and hand washing education sessions can be carried out by school advisers.

Lesions on hands including sores and cuts should always be covered with a waterproof dressing (blue detectable plasters if handling food).

All staff should wash their hands thoroughly after cleaning contaminated surfaces, even if gloves have been worn.

HAND HYGIENE GUIDELINES

General Principles

Hand hygiene is the best way to reduce cross infection. Hand washing must be practised by everyone.

After:

- going to the toilet
- dealing with sick people
- handling their bedding
- handling their clothes
- contact with sick room equipment
- preparing food
- after handling, feeding or cleaning pets or pet equipment

Before:

- preparing or serving food
- eating meals or snacks
- treating injuries
- assisting others to eat

Warm water, soap and paper towels must be available at all sites, at all times. *(Ansari et al 1991 Taylor 1978).*

Soap should preferably be of the liquid variety in a cartridge type dispenser.

Children must be encouraged to wash their hands after every visit to the toilet. Handwashing by children after using toilets and before meals should be supervised routinely in nurseries and infant schools.

Towels brought in from home by children (other than for sporting activities) are not recommended as contamination from towel to towel can easily occur.

EFFECTIVE HAND WASHING

- use appropriate amount of soap to produce a lather
- hands must be wet under running warm water before applying soap
- hands should be washed vigorously for 15 - 30 seconds
- particular attention should be paid to thumbs, finger webs and between fingers
- hands should be thoroughly rinsed under running water
- hands should be dried thoroughly after washing using disposable paper towels

1.

2.

3.

4.

5.

6.

BODY FLUID SPILLAGE

All body fluids have the potential to be infectious. It is not possible to identify people who have an infection and it is important for everyone to apply the principles of universal precautions. This will help to protect children, staff and members of the public from infection.

(UK Health Departments 1998).

Universal precautions include the following activities:

- Hand washing
- Covering cuts and grazes with waterproof dressings
- Protective clothing e.g. gloves
- Safe handling of waste, sharps and laundry
- Safe disposal of body fluids and cleaning up of body fluids
- First aid and prompt reporting of injuries involving blood and body fluids

Body fluids are:

- Vomit
- Blood
- Sputum
- Urine
- Faeces
- Vaginal secretions
- Semen
- Breast milk

Schools and nurseries should have a supply of the following protective clothing which must be used when cleaning up body fluids. These can be ordered from your usual suppliers.

Type of Glove	**Activity**
Non-sterile disposable vinyl or nitrile gloves	Contact with blood and other body fluids
General household gloves	General cleaning and handling waste
Single use disposable plastic aprons	Contact with blood and other body fluids

Infection Control Nurses Association (1999)

All body spillage must be cleaned up immediately. Under no circumstances should body fluid spillage be left to be cleaned up by cleaners at the end of the school day. If there is broken glass never pick it up with your fingers, even when wearing gloves – use a paper or plastic scoop and dispose in the sharps box or sturdy plastic container with lid.

(See “cleaning spillages flow” chart – page 133)

PROTECTIVE CLOTHING

All staff are advised to wear clothing that can be easily laundered should contamination with body fluids occur. A change of clothing should be available at the work place if such contamination occurs.

The following protective clothing should be provided:

1. Vinyl or nitrile gloves where exposure to body fluids may occur
2. Disposable plastic aprons for use:
    - when nappy changing
    - whenever there is a risk of contamination of clothing with body fluids
    - when clearing spillages of body fluids

There may be circumstances where additional protective measures need to be taken.

EXTRACT FROM HEALTH & SAFETY AT WORK REGULATION

The following is based on the regulation that came into force on 1st January 1993 from the Health & Safety Executive:

PERSONAL PROTECTIVE EQUIPMENT AT WORK REGULATIONS 1992

The act relates to the provision of protective clothing for employees who may be exposed to a risk to their health or safety while at work.

> *Every employer shall ensure that suitable protective equipment is provided to his employees who may be exposed to a risk to their health or safety while at work except where and to the extent that such risk has been adequately controlled by other means which are equally or more effective.*

Employers shall ensure that an assessment is made to determine whether the personal protective equipment they intend to provide is suitable.

The above are two examples where the act requires the employer to provide protection where it has been identified. You should refer to the original document for the full details; under copyright we cannot reproduce the whole document.

MEDICAL ROOM / FIRST AID ROOM

APPROVED EQUIPMENT FOR FIRST AID USE

Contents of First Aid Boxes

Each First Aid Box should contain these minimum quantities of the following items AND NOTHING ELSE:

- One card giving general first aid guidance (available from suppliers of equipment)
- Twenty individually wrapped sterile unmedicated adhesive dressings (plasters) of assorted sizes
- Two sterile eye pads with attachments
- Four individually wrapped triangular bandages
- Six safety pins
- Six medium sized (approximately 12cm x 12cm) sterile unmedicated wound dressings (individually wrapped)
- Two large sized (approximately 18cm x 18cm) sterile unmedicated wound dressings (individually wrapped)
- One pair of disposable gloves

Notes

In areas where food is handled, it is recommended that the plasters are of the blue detectable type, so that they would be readily seen if falling into food. First aid boxes in kitchens should therefore contain dressings of this type. At least some of the adhesive dressings in all first aid boxes should be of the waterproof type for application where appropriate.

Where mains tap water is not available, sterile water or saline solution (0.9% concentration) should be kept in sealed bottles for emergency eye irrigation. In educational establishments, running water is always available and so this requirement will not normally arise. It may, however, be useful to keep emergency eyewash bottles in chemical laboratories and practical areas including sports areas where these are at some distance from washrooms.

First aid boxes should be kept stocked with a sufficient number of each item for the foreseeable needs, based on experience and past usage, but each box must contain the minimum quantities listed above. It is probably useful to carry a back-up stock of these items in a locked cupboard to allow for prompt replenishment of the contents of boxes.

In all cases, soap and water and disposable paper towels or tissues should be available for the cleaning of wounds or blood spillages in accordance with these guidelines. In cases where these are not readily available, individually wrapped moist cleansing wipes may also be kept with first aid materials.

Medical / First Aid Rooms

Whilst first aid rooms are not a requirement they may already exist in many educational establishments. It may contain a couch or bed, blankets and suitable carrying equipment. Where a specially equipped first aid room is not available, there should at least be an area where an injured or sick person can rest in reasonable comfort until medical assistance arrives or they are taken home. A period of rest after a minor injury is often enough to enable a person to recover sufficiently to continue their day's activities. Where a first aid room is provided, there should be a designated person in charge. The room must:

- Be clean, warm and well lit.
- Have adequate handwashing facilities (hot and cold water, soap and paper towels).
- Have first aid equipment as listed overleaf.
- Have appropriate protective clothing (disposable latex/vinyl gloves, plastic aprons, eyes/face protection).
- Have a bed which is covered in an intact, water repellent covering which is easily cleaned.

CLEANING

ENVIRONMENTAL HYGIENE IS AN ESSENTIAL PART OF INFECTION CONTROL

DO NOT DISINFECT UNTIL YOU HAVE CLEANED FIRST

The purpose of cleaning:

1. To maintain appearance
2. To maintain function of an object
3. To control bacteria

The choice of cleanser has to consider all three purposes.

Thorough cleaning will remove contaminants such as:

1. Dust or soil
2. Large numbers of bacteria
3. Organic matter such as blood or faeces, which harbour bacteria or viruses

Thorough drying of equipment and good ventilation of areas will further reduce numbers of bacteria.

IMPORTANT POINTS

1. Cleaning contracts should specify who is responsible for ensuring cleanliness of individual areas e.g. classrooms, kitchens, toilets etc.

2. Each establishment should have a planned cleaning regime to cover all areas and equipment. This includes toys, sandpits, dough / plasticine, water troughs and classroom sinks.

3. Cleaning equipment should be colour coded for use in individual areas such as food service area, toilets and bathrooms, general accommodation and outdoors.

4. Cleaning equipment should ALWAYS be thoroughly washed after use and stored to dry:
   - Mop head upwards
   - Buckets inverted

5. Cloths (if not disposable) preferably dried outdoors.

6. Vacuum filters should be changed regularly.
    - Tanks in scrubbing machines emptied and drained
    - Brushes removed and cleaned

Bacteria have been found in water which has been allowed to accumulate in equipment

For those responsible for purchasing equipment:

1. Check with manufacturers regarding cleaning instructions for equipment, including children's toys.

2. A good quality detergent is adequate for most situations.

3. Detergents that are:
    - Anionic / non-ionic have good detergent qualities for environmental cleaning, for example any good quality liquid detergent such as Fairy Liquid
    - Cationic detergents are less efficient cleaners but manufacturers will stress their ability to destroy bacteria. NB this ability is somewhat limited, examples Roccal, Dettol ED, Cetavlon, Tego, Zephirin, Jeyes Pine

4. Consider Health and Safety COSHH implications of products purchased.

There are many areas within the environment which provide ideal environments for organisms to breed, which may cause illness and disease. General cleaning is often sufficient to reduce the organisms to a satisfactory level but sometimes disinfectants may need to be used. This in turn will help to reduce the risk of cross-contamination and illness.

Bacterial organisms often like damp / wet environments and therefore care should be taken to clean those areas used frequently in the environment as well as those used occasionally but with a potentially high level of organisms.

There are four main areas within the home that have the potential to harbour organisms / bacteria:

1. Containers i.e. vessels which hold liquid constantly or occasionally
2. Cleaning equipment
3. Household surfaces i.e. hand and food contact
4. Other surfaces

Type of Risk	Potential level of organisms	Amount of daily contact	Prevention– how and when to clean
Containers Toilet bowls Sink u-bends Plastic washing up bowls Draining boards Nappy buckets	High (organisms breed quickly even after cleaning)	Occasional contact	▪ Regular cleaning with disinfectant ▪ Use a continuous action or slow release action disinfectant i.e. rim block / toilet block ▪ Well-maintained equipment – replace old and damaged
Cleaning Equipment Dishcloths / sponges Floor cloths Washing up brushes Scouring pads Face cloths / sponges Nail brushes Toothbrushes Showerheads Humidryers	High	Constant contact	▪ Clean all types of cloths / sponges after every use ▪ Kitchen cloths cleaned using a disinfectant or in a hot wash (60°) ▪ Dry cloths / sponges immediately to prevent a damp environment for organisms ▪ Special attention to showerheads if water does not drain away ▪ Well maintained equipment – replace regularly

Type of Risk	Potential level of organisms	Amount of daily contact	Prevention– how and when to clean
Contact Surfaces (hand and food) Chopping / cutting boards Kitchen work surfaces Fridge / freezer surfaces Cooking hob / oven Eating / cooking utensils Baby feeding materials Toys	Medium	Constant contact	▪ Clean food surfaces before and after use ▪ Wash surfaces with hot water and detergent - rinse well ▪ Large surfaces can be cleaned using a clean cloth and disinfectant or cleaner ▪ Wipe over toilet handles, taps, door handles (fridge / freezer) regularly with a disinfectant ▪ Dry surfaces straight away
Other Surfaces All floors (carpet, tile, wood, lino) Walls Bedroom furniture Living room / dining room furniture	Low	Occasional contact	▪ Clean surfaces / furniture regularly ▪ Keep dry and well maintained ▪ Disinfect only when necessary i.e. spillage, urine, vomit etc.

DISINFECTION

In most areas thorough cleaning with a good quality detergent solution e.g. washing up liquid, will be adequate to maintain good hygiene standards and control bacteria.

The use of disinfectants is recommended as follows:

1. In food service areas
2. When clearing up spillages of body fluids
3. During outbreaks of specific infections
4. Many establishments will use disinfectants in bathroom, toilet and nappy changing areas. When a disinfectant is used at the correct strength it will reduce the numbers of bacterial or viruses present to a level not harmful to health

THOROUGH CLEANING IS ESSENTIAL AS DISINFECTANTS WILL NOT WORK IN THE PRESENCE OF DIRT OR ORGANIC MATTER SUCH AS FAECES

CHLORINE - BASED DISINFECTANTS

These disinfectants are widely recommended as they are active against HIV and Hepatitis viruses and a wide range of bacteria.

There are two Groups:

1. **Hypochlorite**
   e.g. Chlorous, Domestos, Milton

2. **Sodium dichloroisocyanurates (NaDCC)**
   e.g. Presept, Sanichlor, Haz-tab, Titan, Diversey

PLEASE NOTE

NaDCC tablets, powders, granules are very stable when stored dry but in common with all Hypochlorites unstable in solution.

Therefore solutions must be used immediately.

They must be diluted and used according to manufacturer's instructions to be effective.

Dilutions of hypochlorite solutions e.g. Domestos

Blood spills		1 part solution / 10 parts water
Environmental disinfection		1 part solution / 100 parts water
Infant feeding	)	
Utensils, catering	)	1 part solution / 500 part water
Surfaces and equipment	)	

NB Consider Health and Safety COSHH implications when using chlorine - based disinfectants.

5 DO'S FOR USING DISINFECTANTS

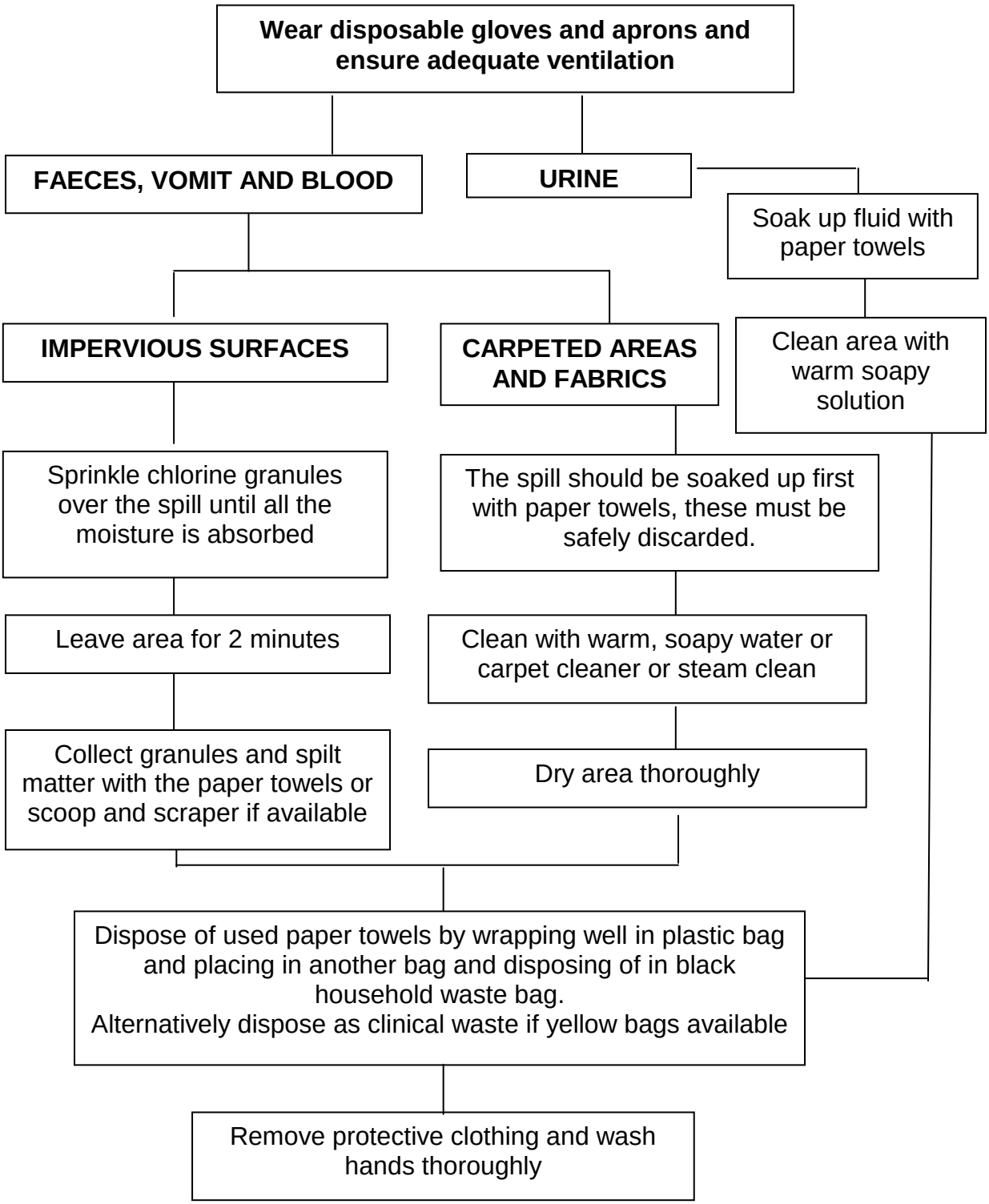
- DO MEASURE DISINFECTANT AND WATER CORRECTLY
- DO USE A CLEAN, DRY BUCKET
- DO WASH AND CLEAN DIRT AWAY FIRST THEN DISINFECT THE AREA
- DO THROW AWAY YOUR DISINFECTANT SOLUTION WHEN TODAY'S WORK IS DONE
- DO REMEMBER THAT INCORRECTLY STORED DISINFECTANTS CAN BECOME CONTAMINATED BY BACTERIA AND ACTUALLY *SPREAD INFECTION*

8 DON'TS FOR USING DISINFECTANTS

- DON'T EXPECT A DISINFECTANT TO STERILIZE
- DON'T STORE CLEANING TOOLS IN DISINFECTANT
- DON'T "TOP UP" DISINFECTANT SOLUTIONS
- DON'T USE YESTERDAY'S SOLUTION - MAKE UP FRESH
- DON'T USE ANY DISINFECTANT THAT IS NOT SUPPLIED BY THE ESTABLISHMENT YOU WORK FOR
- DON'T MIX TWO DISINFECTANTS TOGETHER
- DON'T ADD DETERGENT TO A DISINFECTANT SOLUTION
- DON'T EXPECT DISINFECTANT TO MAKE DIRT SAFE

REMEMBER: CLEAN FIRST, THEN DISINFECT IF NECESSARY

CLEANING SPILLAGES



If spillage kit not available for impervious surfaces soak up fluid with paper towels and wipe area over with bleach (1 in 10 solution).

DO NOT use chlorine-based product on urine spills. Instead soak up fluid with paper towels and clean area with warm soapy water.

Note:

- There may be a release of free chlorine from the treated area when hypochlorite or other chlorine containing compounds are applied. Ventilation of the area will be necessary.

- As the application of sodium hypochlorite may discolour carpets, spillage should be cleaned with warm soapy water or carpet cleaner and dried.

- Chlorine products should be kept in locked area not accessible to unauthorised people.

- Data sheets should be kept with product and staff should be made aware that bleach has been used (COSHH Regulations).

WASTE DISPOSAL

Safe disposal of waste is an integral part of good infection control measures.

Currently waste should be managed in line with the Environmental Protection Act 1990 [1], the supporting Code of Practice "Duty of Care" [2] and Health and Safety at Work Act 1974 [3] – new guidance is coming out soon.

If unsure seek advice from your Local Education Department or Environment Agency Office.

Specific advice should be sought from the above re disposal of:

1. Radioactive waste
2. Cytotoxic waste
3. Pharmaceutical waste

The categories of waste most frequently seen in childcare establishments are:

1. **General Waste** - a mixture of paper packaging etc. possibly with a proportion of putrescible (e.g. food) waste.
   Disposal Method - Black bag collection. Disposal – landfill.

   NB Aerosols, glassware and cans - separate disposal or carefully wrapped in newspaper. Secure tamper proof storage prior to collection. Disposal - landfill. Consider Recycling.

2. **Waste Food** - The bin for waste food should not be used for paper refuse. Ideally it should be removed from premises at the end of each working day. External storage facilities should be cleaned thoroughly on a planned basis. Dustbin lids should fit tightly to prevent insect and animal access.

3. **Clinical Waste**

Definition:

Any waste which consists wholly or partly of human or animal tissue, blood or other body fluids, excretions, drugs or other pharmaceutical products (see above), swabs or dressings, syringes, needles or other sharp instruments.

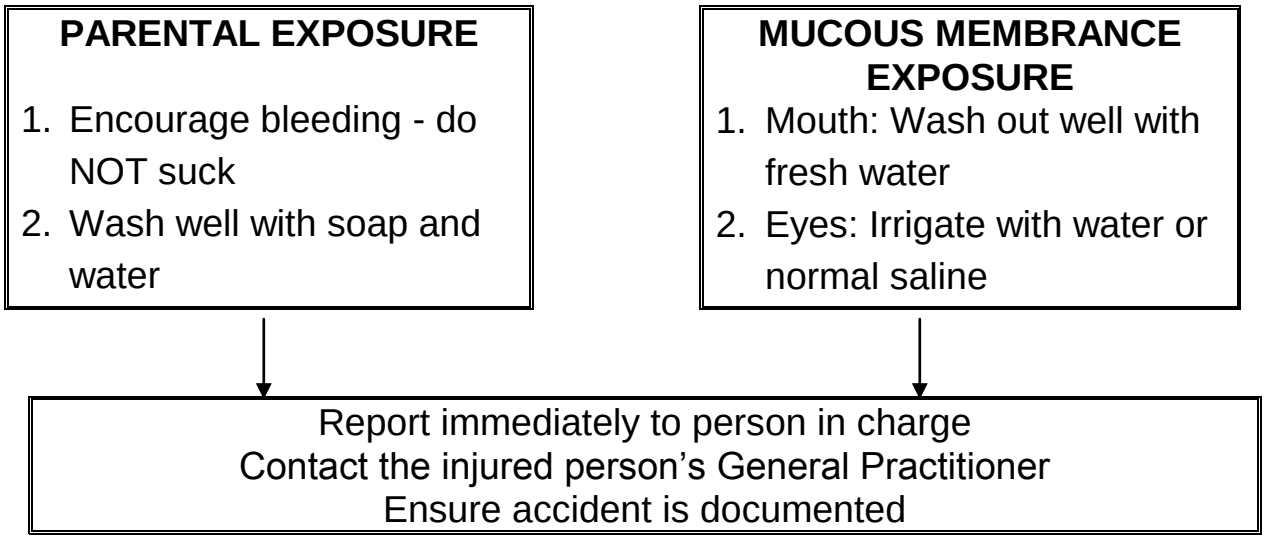
It should be disposed into yellow clinical waste bags.

Needles and other sharps into British Standard lockable SHARPS BOX.
BOXES should be ¾ full then sealed, locked prior to disposal.
Sharps boxes should not be placed inside a yellow bag.

DANGERS OF INJURY AND CROSS INFECTION ARE DUE TO THE INAPPROPRIATE DISPOSAL OF NEEDLES OR SHARP INSTRUMENTS INTO WASTE DISPOSAL BAGS INSTEAD OF A SHARPS BOX

ACCIDENTAL EXPOSURE TO BLOOD AND / OR NEEDLESTICK / SHARPS INJURY

See also section on blood borne viruses



Shropshire and Telford – advice is available from Microbiologists at Shrewsbury and Telford Hospitals – 01743 261000

Staffordshire – advice is available from the Health Protection Team – 01785 221126 / 58

LAUNDRY

This guidance applies to all laundry facilities in childcare premises.

Employers have an obligation under the Health and Safety at Work Act 1974 to:

1. Prevent risk of infection to staff handling linen
2. Ensure staff are aware of potential dangers associated with wrongful disposal of sharp objects in linen bins

Laundry can be divided into:

1. Used i.e. normally soiled
2. Foul i.e. contaminated with urine, faeces, vomit or blood
3. Infected i.e. laundry arising from use where an infection is known
4. Heat labile i.e. children's clothing

Where laundry services are provided by contract off site advice should be sought to ensure correct segregation of linen and clothing prior to dispatch.

Protection of staff and clients

1. Linen should not be sorted or counted in client areas
2. Hands must be washed after handling all laundry
3. Protective clothing should be available and used i.e. rubber gloves, plastic aprons

Where laundry is done on site used linen should not be manually soaked or sluiced - use pre-wash cycle on machines. Any solid matter contaminating linen should be discarded via the toilet or sluice hopper.

Safe systems of work should ensure dirty linen is handled as little as possible i.e. handle once at time of removal, once as it goes into the machine.

In residential premises it is recommended that all foul or infected linen is placed in dissolvable laundry bags, which can be placed directly into the washing machine without further need to handle linen.

Disinfection of linen will normally be achieved with the machine programmed on a hot wash and the linen going through the drying cycle.

If heat labile clothing is categorised as infected this can be disinfected by the addition of domestic bleach to the penultimate rinse. Bleach should not be used on fabrics treated for fire retardance.

Storage

All clean linen must be stored in a dry area above floor level - not in bathroom or sluices areas.

It is essential washing machines and dryers are serviced regularly to ensure the temperatures are achieved as stated.

Ideally drainage from machines should be closed rather than into an open sump from the machine.

DOMESTIC STAFF

All domestic staff should understand principles involved whilst cleaning the establishment and, therefore, require training.

Objectives of training

To enable domestic staff to:

1. To understand the principles of colour coded systems for cleaning
2. Recognise the need for maintaining cleaning equipment in good order
3. To be able to use disinfectants/detergents properly, appropriately and safely
4. Recognise the importance of domestic service staff to the maintenance of hygiene and preventing the spread of infection
5. Understand the basis of food hygiene
6. Be aware of correct procedures for disposal of waste

NB Be aware of the importance of:

Personal protection
Handwashing
Reporting incidents / accidents
COSHH
Handling laundry

IMMUNISATION

PROTECTIVE IMMUNISATION FOR ADULTS

Protection against polio and tetanus should be kept up to date.

Women of childbearing age who are unsure if they have had rubella (German Measles) can be tested and if the test is negative are advised to have the rubella vaccine.

Other vaccines may be recommended in the event of an outbreak.

Immunisation of Staff

Staff should check with their GP that they are up to date with their immunisations. Staff who work in certain environments may be at increased risk of exposure to Hepatitis B. Where after undertaking a risk assessment, Head Teachers are of the opinion that staff are exposed to a higher than normal risk (e.g. working with children who bite), staff should be offered immunisation against Hepatitis B. Further advice on determining the likely level of risk can be obtained from the Occupational Health Provider.

Infections and Pregnancy

Infections in the community (not just in schools) may pose some risk to the pregnant woman and her unborn baby. Examples are Rubella, Chickenpox and Parvovirus infection.

In the event of exposure pregnant staff should inform the clinician managing their pregnancy.

Reassurance is all that is required in most cases. Often laboratory tests will show that the staff member is already immune to the infection.

Any pregnant woman who develops a rash should see her GP or midwife promptly.

PROTECTIVE IMMUNISATION FOR CHILDREN

Immunisations routinely available:

Diphtheria, Tetanus, Pertussis (Whooping Cough), Polio, Haemophilus Influenza Type B infection (Hib), Group C Meningococcal infection, Measles, Mumps, Rubella, Pneumococcal.

New routine Childhood Schedule to be introduced LATe 2006
NB for current schedule see www.immunisation.nhs.uk

AGE	**IMMUNISATION**
Two months	First Polio, Diphtheria / Tetanus / Pertussis / Hib and Pneumocccal vaccine
Three months	Second Polio, Diphtheria / Tetanus / Pertussis / Hib and Menigitis C
Four months	Third Polio, Diphtheria / Tetanus / Pertussis / Hib, Meningitis C and Pneumoccal
Twelve months	Hib and Meningitis C
Thirteen months	MMR (I) and Pneumoccal
School entry	Polio, Diphtheria / Tetanus / Pertussis and second MMR (MMR II)
At risk babies and children of all ages	Discuss with School Nurse or Health Visitor
School leaving	Polio, Diphtheria / Tetanus

The following vaccines will be offered only to children who are considered to be at risk:

- BCG
- Hepatitis B
- Hepatitis A
- Influenza

FOOD HANDLING

GUIDELINES FOR PACKED LUNCHES

The preparation and storage of packed lunches prior to consumption can pose a number of food safety problems.

Peak periods for food poisoning occur during the summer months, so extra care is needed during this period.

At room temperature, harmful bacteria, if present, will multiply rapidly. Foods high in protein e.g. egg and cooked meats are often used in making sandwiches and are perfect breeding grounds for bacteria particularly when combined with moisture and warmth.

If foods have been handled frequently prior to consumption, they are more likely to have been contaminated with bacteria.

HANDY HINTS FOR SANDWICH MAKING

- Check that sandwich fillings are fresh and, if using pre-packed meats, ensure that the "use by" dates are not exceeded. Always follow the manufacturer's storage instructions.

- Wash your hands thoroughly in warm soapy water before starting to prepare food and after handling raw meats.

- Chopping boards should always be thoroughly cleaned and disinfected before and after use, and after being used to prepare raw meats. Use a proprietary food safe disinfectant such as Milton, Dettox etc.

- Where possible, separate utensils should be used for preparing raw and cooked foods. Alternatively, make sure that you wash equipment in hot soapy water before reusing it.

- Fruit, vegetables and salads should be washed thoroughly in clean, cold running water.

- Lunch boxes should be made of durable materials such as plastic, and should be

thoroughly washed between each use.

- Ensure that materials used for wrapping foods are suitable. For example, use food quality cling film, sandwich bags or aluminium foil.

- If your child's sandwiches are prepared the night before use, they should be stored in the refrigerator overnight.

- Cooked meats, fish and eggs are high risk foods and should be refrigerated. **If a refrigerator is not available at school, or ice packs are not used, then low risk foods such as jam, fruit and hard cheese should be chosen.** The lunch box should be stored in a cool place and always out of direct sunlight.

- Small ice packs are available from some stores that will fit inside the lunch box to help to keep the food cool. Small cool bags are also available.

Remember a rise in temperature will affect your packed lunch.

FOOD HANDLING IN THE CLASSROOM

Although the amount of food preparation in the classroom may be minimal, attention must be given to food hygiene in order to reduce the likelihood of food-related illness.

The classroom is a flexible working space used for many activities. If food is to be handled the following points should be considered.

General

- Work surfaces should be capable of being kept clean.
- Laminated plastic tables are suitable for food work. Damaged or wooden tables should not be used unless they are covered with clean plastic table cloths which are kept just for food work.
- The food preparation area should be well lit.
- Outdoor clothing, such as coats and footwear, should be kept away from the food preparation area.
- School pets should be removed from the food preparation area.
- A separate sink should be available for washing food and equipment. If a separate sink is not available, then activities should be separated by "time" ensuring that the sink and surrounding area are thoroughly cleaned before the food activity begins.
- There must be access to a separate wash hand basin so that hands can be washed thoroughly before food activities begin.

Storage of Food

- Refrigeration may be required for certain foods. Highly perishable foods, such as cooked meat, should be kept at 5°C or below. It is good practice to refrigerate prepared food if it is not to be consumed immediately.

- Food should be kept covered at all times, even whilst stored in the refrigerator in order to reduce the likelihood of contamination.

- Cooked food or food intended for consumption without further processing should be stored on shelves above raw foods.

- Dry foods, such as flour, oats and beans, should be kept in covered containers and stored in a cool dry place. Containers with tight-fitting lids will also prevent pest infestation. If ingredients are transferred into containers, then a record of the "best before" date should be kept.

- Raw meat and dirty vegetables should be kept separate from cooked food.

General Hygiene

- Separate utensils should be used for preparing raw meat and other food. If separate utensils are not available then equipment should be thoroughly washed in hot soapy water between uses.

- Work surfaces, sinks and equipment should be thoroughly cleaned and disinfected before and after use, and after preparing raw meat. Use a food safe proprietary disinfectant such as Milton, Dettox etc. Disposable dishcloths should be used.

- Disposable dishcloths are preferable – they should always be thrown away at the end of each food session. Alternatively, disinfect regularly with Milton etc.

- Make sure that everyone washes their hands using warm soapy water before handling food, after using the toilet, stroking pets or handling raw meat and waste.

- Cover all cuts and wounds with clean waterproof plasters (blue coloured plasters can be used as they can be easily identified should they fall into food).

- Teachers and pupils should avoid preparing food if suffering from sickness, diarrhoea, colds, coughs or other infections.
- Long hair should be tied back before starting food work.
- Roll or tie up sleeves before preparing food.
- Jewellery, such as rings, should be removed as they harbour bacteria.
- Clean, protective aprons or overalls should be worn.

DRINKING WATER IN SCHOOLS AND NURSERIES

Staff and pupils should have reasonable access to safe drinking water in schools and nurseries. Drinking water facilities should not be situated in toilets. Drinking water vessels should be for individual use only. Communal drinking water vessels should not be available for use. If water dispensers are used these should be regularly cleaned and maintained in accordance with manufacturer's instructions.

In existing premises where drinking water is provided within the toilet area disposable cups should be provided. Taps, sinks and drinking water fountains must be cleaned and disinfected regularly.

Daily Cleaning of Taps

- Wash hands first.
- Use a disposable cloth or dedicated colour coded cloth which is renewed daily.
- Wipe clean the outside of the tap with hot water and detergent, paying particular attention to the handle and outlet or nozzle.

Weekly Cleaning of Taps

- Remove any slime from inside the outlet or nozzle with a thin brush or cotton bud.
- Clean the tap and inside of the nozzle or outlet with hot water and detergent.
- Rinse the tap and inside of the nozzle or outlet with clean water followed by a food safe chlorine based disinfectant.
- Allow the disinfectant to remain in contact with the surfaces for 2 - 3 minutes (or as recommended by the manufacturer).
- Run water to waste for two minutes to flush away any remaining disinfectant

Water Dispensers

Dispensing heads should be cleaned following the advice above relating to taps.

Water dispensers should not normally be refilled from tap water unless designed for this purpose. Vessels will need to be cleaned and disinfected following manufacturer's instructions between uses if this is the case.

The rim of cups and bottles should not come into contact with the tap or dispensing head to avoid contamination with saliva.

Please note

Those responsible for letting cleaning contracts must ensure that this advice is observed in future contracts.

ANIMALS AND INFECTION CONTROL

PETS IN SCHOOLS AND NURSERIES

If a school chooses to keep a pet the value and contribution to the pupils education and development should be clearly stated. The welfare of the pet must also be considered.

All pets, dogs, cats, birds, rodents and exotic animals are capable of spreading diseases. Any animal/pets brought into school should be subject to a full risk assessment, following CLEAPPS (Schools science advisory body) guidance.

Whilst not wishing to discourage pets, a few basic points will minimise risks of cross infection.

- Hands must be washed after contact with all pets.
- Cuts and open skin lesions should be covered and direct contact with animals prevented.
- Keep pets and their food and equipment out of the kitchen and away from all surfaces including in the classroom where food is prepared or eaten.
- Keep all pet food bowls separate and wash them after use in separate facilities. Sinks must be cleaned and disinfected after use. Hands must be washed.
- Keep cat litter trays clean. Remove soiled areas of the litter within 24 hours. Change tray daily. Children and pregnant staff members should not handle litter trays.
- Dogs should not be allowed on to the school site with the exception of guide dogs and dogs used for security purposes.
- Pets should be prevented from soiling the school and school playgrounds / playing fields. If children play in these areas ensure they wear shoes and wash hands afterwards especially prior to eating.
- Pets' living and sleeping areas must be clean with good ventilation to prevent airborne infection.

- Bird cages must be cleaned out weekly and floor grit changed twice weekly.

- Hutches should be cleaned out daily especially in warm weather and a thorough clean once weekly, dismantling the hutch completely.

- Aquaria. It is important that fish tanks, gold fish bowls and terrapin aquaria are kept clean and germ free to prevent green algae build up on glass.

- Sinks used for cleaning pet cages and equipment etc. must be cleaned and disinfected after use.

Bites and Scratches from Pets

Domestic animal and pet bites and scratches are not uncommon injuries. The mouths and claws of animals contain bacteria which may cause bites and scratches to become infected. If bites or scratches occur please follow the advice for First Aid on Page **114.**

FARM VISITS AND ASSOCIATED INFECTION RISKS

Introduction

Farm visits are becoming popular and many working farms encourage such visits from schools and other educational groups.

A number of diseases may be passed from animals to man. A few general precautions and some advice will help to minimise the risk of transmission.

The Problems

Several school groups have contracted diseases from animals in the past. Some of these are of little consequence but a number may cause considerable distress particularly to children. Several organisms including campylobacter, salmonella, E.coli and cryptosporidium commonly present in livestock animals may cause gastroenteritis in humans. These organisms may be found in faecal droppings or elsewhere in the farm environment. The risk of infection is increased if any item containing these organisms is eaten, or if the child's hands become contaminated and they then suck their fingers.

Preventive Measures

Most diseases acquired from animals can be prevented by cleanliness. A pre-visit talk about hygiene measures and reinforcement during the visit is useful.

Preparation for the Visit

As part of the risk assessment the following points should be followed:

1. Check that the farm is well managed, that the ground and public areas are as clean as possible and that suitable First Aid arrangements are in place. Animals should be prohibited from any outdoor picnic areas.
2. Check that the farm has suitable hand washing facilities, appropriately signposted, with running water, soap and disposable towels or hot air hand dryer(s). Any potable water taps should be appropriately designated in a suitable area.

3. Ensure that there is an adequate number of adults to supervise the children, taking into account the age and stage of development of the pupils (see also *HSE Guidance note AIS23 Avoiding ill health at open farms*).
4. Explain to pupils that they cannot be allowed to eat or drink anything, including crisps, sweets, chewing gum etc. while touring the farm, because of the risk of infection.
5. Ensure suitable precautions are in place where appropriate e.g. in restricted areas such as near slurry pits or where sick animals are isolated.

During the Visit

1. If children are in contact with or feeding farm animals, warn them not to place their faces against the animals or put their hands in their own mouths afterwards.
2. After contact with animals and particularly before eating and drinking, ensure all pupils wash and dry their hands thoroughly. If young children are in the group, hand washing will need to be supervised.
3. Meal-breaks or snacks should be taken well away from areas where animals are kept, and pupils warned not to eat anything which may have fallen on the ground. Any crops produced on the farm should be thoroughly washed in potable water before consumption.
4. Ensure pupils do not consume unpasteurised produce, for example milk or cheese, or taste animal feedstuffs, such as silage and concentrates.
5. Manure or slurry presents a particular risk of infection and pupils should be warned against touching it. If they do, ensure that they thoroughly wash and dry their hands immediately.

At the end of the visit

1. Ensure all children wash their hands thoroughly before departure.
2. Ensure footwear is as free as possible from faecal material.

The most important points for teachers / parents and farmers are as follows:

1. Children should not drink raw milk (unpasteurised) or eat any animal food. Discourage children from putting fingers in their mouths.
2. Ensure children wash their hands well after handling the animals particularly before eating or drinking. Animals may carry dried faeces on their skin.
3. Children should not be allowed in the lower walkway of herring-bone parlours when milking is in progress.
4. Children should remove soiled clothing and wash their hands following a visit.
5. Pregnant teachers are advised not to handle ewes who are feeding lambs or lambs who are not yet weaned. *(DEFRA 2002).*

Picnics and packed lunches

During such farm visits and other day trips children may be provided with a packed lunch either by the catering department or parents. As indicated above it is essential that children wash their hands thoroughly before eating, but handling and storage of the food prior to consumption is also important.

Picnics and packed lunches often comprise of high risk foods, that is food that will support bacterial growth that may cause illness. The temperature that the food is kept at prior to consumption is important in preventing such illness.

Where food is supplied by the catering department it will normally be stored in insulated containers and the caterer will advise that the food be consumed within four hours of being removed from refrigerated storage. The timing of lunchtime must therefore be considered when planning the activity.

Where parents provide the packed lunch they may not be aware of the storage facilities prior to consumption or how long the food will be out of chilled storage. The “guidelines for packed lunches” (page 143) should be issued to parents.

INFECTION CONTROL CHECKLIST FOR CHILDCARE ESTABLISHMENTS / SCHOOLS

This is included for guidance purposes. Some of the items on the checklist may not be relevant to your establishment and it may be necessary to add others for areas offering specialised care.

It is intended as an aide-memoir and we hope you will find it useful.

INFECTION CONTROL CHECKLIST

YES / NO

SECTION 1 – ENVIRONMENT

Medical room

1. Handwash basin, liquid / bar soap and paper towels are available.
2. All sterile products are stored above floor level.
3. Items of sterile equipment are in date (randomly select two items and check date).
4. Dressing trolleys are clean and in good state of repair.
5. Bed linen is changed and laundered regularly and immediately between use or following contamination.
6. Mattress cover is in a good state of repair.

Toilet areas

7. Toilet areas are clean and free from extraneous items.
8. Toilets are in good repair and clean (floors free of spillage).
9. Appropriate cleaning materials are available.
10. Toilet, urinals and wash basins are at a suitable height.
11. Hot and cold water is supplied.
12. Soap, toilet paper and drying towels are provided.
13. Cloth towels (if used) are changed at least daily.
14. Paper towel dispensers are replenished at regular intervals.
15. There is no evidence of misuse of soap, toilet paper or towels.
16. Disposal units for sanitary towels are provided.
17. Children wash their hands before lunch.
18. Separate toilet and handwashing facilities are available for staff.

YES / NO

Changing Areas

19. Changing areas are clean and free from extraneous items.
20. There is no evidence of multi-use toilet items e.g. creams.
21. There are impervious surfaces for changing children.
22. Changing mats are in good repair with cleaning programme between use.
23. Adequate waste bins are provided.
24. Handwash basin, liquid / bar soap and paper towels are available.
25. Protective clothing is provided for staff.

Miscellaneous

26. Cleaning equipment is colour coded according to area of use e.g. kitchens, toilets, general areas.
27. All cleaning equipment is thoroughly cleaned after each use and stored dry.

Comments

SECTION 2 - WASTE DISPOSAL

28. A waste disposal policy and / or chart is available to staff.
29. Clinical waste, food waste, household waste and glass is segregated correctly.
30. Waste bags are less than 2/3 full, securely sealed and labelled.
31. There are foot operated bins in working order for clinical waste (yellow bag).
32. Waste bags are stored safely, secure from access by public and children.

Comments

YES / NO

SECTION 3 - SHARPS HANDLING AND DISPOSAL (Needles, Blades etc.)

33. Sharps boxes are available and conform to ICC recommendations.
34. Box is less than 2/3 full.
35. Box is free from protruding sharps.
36. Sharps box is assembled correctly.
37. Sharps box is labelled with point of source.
38. Sharps are disposed of directly into a sharps box following use.
39. Sharps boxes are stored above floor level and safely out of reach of children.
40. Appropriate storage and collection arrangements for sharps boxes are in place.
41. A written procedure is available for all staff on action to be taken following sharps injury.

Comments

SECTION 4 – EQUIPMENT

42. Suction equipment is clean and dry. Catheter is not attached.
43. Thermometers are stored dry.
44. There is no evidence of single use items being re-used.
45. Vaccine transport, storage and usage is within current guidelines.
46. Toys are wipeable or machine washable and are clean and in a good state of repair.
47. A First Aid Box is available at a central point.
48. The First Aid Box contains waterproof plasters.
49. Disposable gloves are located within (or next to) the First Aid Box.

YES / NO

Comments

SECTION 5 - DISINFECTANTS

50. Written instruction about the correct dilution and use of disinfectants are available to staff.
51. Spillages and splashes of blood are removed with appropriate disinfectants.
52. Gloves and aprons are available.
53. A deep sink is available for washing equipment and used only for this purpose.
54. A disinfection policy is available for decontamination of all reusable equipment.

Comments

SECTION 6 – INFECTION CONTROL PRACTICE

55. Leaflets emphasising correct handwashing technique are available.
56. Jewellery e.g. watches / stoned rings are not worn by staff when handwashing.
57. A poster demonstrating good handwashing technique is available by a least one sink.
58. Gloves are available (sterile and non sterile) and worn where applicable.
59. Disposable plastic aprons are available and worn where applicable.
60. Staff can demonstrate good handwashing technique.
61. Staff can locate the Infection Control Policy.
62. Staff can describe cleaning and disinfectant procedure in event of blood / body fluid spillage accurately.

YES / NO

Comments

REFERENCES

These references are in addition to those already included in texts:

Hawker J, Begg N,Blair I,Reinjes R, Weinberg J
Communicable Disease Control Handbook
2nd Edition, 2005, Blackwell

Lawrence J, May D (Ed)
Infection control in the community
Edition 2003, Churchill Livingstone

Heymann DL (Ed)
Control of Communicable Diseases Manual
18th Edition, American Public Health Association

Ayliffe GAJ, Coates D & Hoffman PN (1993)
Chemical Disinfection in Hospitals
Public Health Lab Service

BMA (1990)
A code of practice for The Safe Use and Disposal of Sharps
ISBN 0727902946

Consumer Protection Act (1987) London HMSO
The General Product Safety Regs 1994
SI 1994: 2328

Control of Substances Hazard on to Health Reg 1988 ACOP
ISBN 0717604276

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Immunisation Against Infectious Disease
Updated - now online via www.immunisation.nhs.uk

First Aid at Work: General Guidance for Inclusion in First Aid Boxes
ISBN 0717604403

First Aid at Work
H & S (First Aid) Regs 1981 and guidance ACOP
ISBN 0717604268

Our Health and Safety Policy Statement
A Guide to preparing a safety policy statement for a small business
ISBN 0717604241

Personal Protective Equipment at Work Regs 1992
Guidance on regulation
ISBN 0717604152

Safe Disposal of Clinical Waste London HMSO
ISBN 011886355X

Workplace (Health & Safety and Welfare)
Regs 1992 ACOP
ISBN 0717604136

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Ansari SA, Springthorpe VS, Sattar SA, Tostawaryk W, & Wells GA (1991) comparison of cloth, paper and warm air drying in eliminating viruses from washed hands. *American Journal of Infection Control* 19(5) 243-9

Taylor LJ (1978) An evaluation of hand washing techniques (Parts 1 and 2*) Nursing Times* Jan 12 and 19 54:108

UK Health Departments (1998) *Guidance for Clinical Health Care Workers: protection against infection with blood borne viruses.* London. Department of Health.

Health and Safety Executive (1994) *Control of substances hazardous to health regulations* (revised) London HMSO

Infection Control Nurses Association (1999*) Glove Usage Guidelines* London ICNA

Food Safety Act 1990

Food Safety (General Food Hygiene) Regulations (1995) London HMSO

Department of Health (1995) *Food Handlers Fitness to Work: Guidelines for Food Business Managers* London DoH

Department for Environment, Food and Rural Affairs 2002. *Advice to pregnant women during lambing season.* London DoH

Guidelines for the Control of Infection with Verocytotoxin producing Escherichia coli (VTEC). Subcommittee of PHLS Advisory Committee on Gastrointestinal Infection. Communicable Disease & Public Health Vol 3 No 1 March 2000

Investigating Notifications of Food Poisoning & Similar Gastrointestinal Illness – Guidelines Produced by the Staffordshire Food Liaison Group May 1995 revised Jan 2002

National Standards for Under Eights Day Care & Childminding – Full Day Care. Department for Education & Skills 2001

HSE Guidance note AIS23 *Avoiding ill health at open farms*

5.8 Guidelines for Administration of Rectal Diazepam

5.8.1 Introduction

This guidance has been produced in consultation with the Shropshire County PCT.

5.8.2 Guidelines for the Administration of Rectal Diazepam

- Check with the child's parents that you have the correct information about their child. This should include details of all medications prescribed
- Always give rectal diazepam/stesolid according to the dosage prescribed by the Doctor for the child receiving it
- The rectal diazepam is provided in plastic tubes by the parents with instructions as to how and when to administer it
- Rectal tubes are available in 2.5mg, 5mg and 10mg doses – a small amount of the solution is intended to be left in the tube after the dose has been given
- Rectal diazepam may be stored at room temperature

Equipment

- The prescribed medication in child's own rectal valium box
- Identification of the above medicine
- Identification of the strength of medicine
- Identification of the expiry date
- Disposable gloves

Guide for Treatment of Seizures

- Never leave the child alone
- At all times the child's safety must be maintained during a seizure. Most seizures are self limiting and the child will recover spontaneously
- Loosen tight clothing and remove spectacles
- Protect and support the head by placing something soft underneath
- Move possible hazards away
- Prevent people from crowding the child

- When the seizure has stopped, put the child in the recovery position and speak quietly and reassuringly

- Allow the child to recover in his or her own time. Recovery time is individual and will vary from time to time

- The child may be confused for a while or may need to sleep

- Stay with the child until they are fully conscious

Method

Ensure privacy, dignity and respect for the child. Where possible two staff should be present

Communicate with the child. Inform them of your intentions

1. Turn the child on their side with their knees drawn up towards the chest and underpants pulled down

2. Twist off top of the tube

3. insert the tube gently into the rectum angling the nozzle towards the belly button (umbilicus)

4. Empty the tube by pressing with thumb and index finger only when fully inserted into the rectum

5. Once given, continue to squeeze the tube whilst withdrawing it

6. Hold the buttocks together for a few moments

7. Keep the child in the same position where possible for two minutes to avoid seepage of the medication

8. Clean around the site of insertion if possible

9. Make the child comfortable

10. Record the date and time of the drug administration and sigh the drug administration record

11. Stay with the child until they have fully recovered. Should the child continue to convulse following the prescribed regime telephone 999

12. Inform parents/carers of the incident

5.9 Selective Medical Examinations

5.9.1 Introduction

The Community Child Health Services in Shropshire and Telford & Wrekin Local Authority areas are provided by Services for Children & Young People who are part of the Telford & Wrekin Primary Care Trust. They include Community Paediatricians, CAMHS, Therapists and Community Paediatric Nurses. The main base is:-

Longbow House
Harlescott Lane
Shrewsbury Tel. 01743-450800
Shropshire, SY1 3AS. Fax. 01743-450801

Some Medical, Therapy and CAMHS staff covering the East of the county work from bases in Telford. School Nurses are employed by both Telford & Wrekin and Shropshire County PCTs and are based within local Cluster/MAT teams.

Prior to September 1996, all children were offered a Routine School Entry Medical examination during their first year at school. This was replaced by a Selective Medical system so that a child of any age can be offered an appointment to see a Community Paediatrician (School Doctor) at the request of the parent, school or School Nurse if there are concerns regarding their health in relation to their education. The designated School Nurse for the school routinely measures the height and weight and checks the hearing of all infants as soon as possible after school entry and children are also offered routine vision testing. Following height and weight screening, School Nurses may refer a child on for a Selective Medical if children are significantly overweight or small for their age. A child may also be flagged up for a Selective Medical by a Consultant/Community Paediatrician following previous health or development concerns.

5.9.2 Selective Medical Process

5.9.2.1 If parents or school staff identify that a child might have health problems, the first step is to fill in the Selective Medical Form in consultation with parents and/or guardians and forward this to the School Nurse. In some cases, the School Nurse may be able to refer directly to an appropriate agency without involving the Community Paediatrician, e.g. to an Audiology/Hearing Clinic, to an Enuresis/Bed Wetting Clinic, to an Optician, or to the family GP if this seems to be the most appropriate course of action. If the School Nurse feels that a Selective Medical would be helpful, she then forwards the Form to the appropriate Community Paediatrician. If the Community Paediatrician decides that a Selective Medical would not be appropriate, the form will be returned to the School Nurse for an alternative course of action such as a CAF, TAC or CAMHS referral. If the Community Paediatrician decides to offer a Selective Medical, the form will be forwarded to the School Health Department at Longbow for processing.

5.9.2.2 On receipt of the Selective Medical Referral Form, School Health staff at the Health Centre will send one of three School Medical Review letters to parents, depending on the source of the referral, asking parents to fill in the attached form which indicates whether or not they would like to be sent a Selective Medical appointment at their local clinic. If parents fail to reply, no further action is taken unless a further request is made by the School Nurse. If parents confirm that they would like a Selective Medical, an appointment is made for the child to be seen by the designated Community Paediatrician for the school at a local clinic as soon as this can be arranged.

5.9.2.3 If the Selective Medical goes ahead, the Community Paediatrician will take a full Medical History and will examine the child and will then offer any advice which is appropriate to parents and will refer on to any other agencies that may be able to help such as Hospital Consultants or Therapists. On the whole, CAMHS referrals will need to be made in conjunction with local Cluster/MAT Teams. In most cases, the Selective Medical will be a one-off process but Community Paediatricians can arrange to review children in their clinics at a later date if necessary.

5.9.2.4 In most cases, the Community Paediatrician will obtain appropriate parental/carer consent to pass information back to the child's school and will write a letter to inform the Headteacher of their findings which should be copied to the School Nurse, the General Practitioner and anyone else involved with the child. Basic information about the child will also be registered on the Child Health computer system.

5.9.2.5 If a Headteacher wishes to discuss a child directly with the designated School Community Paediatrician, appropriate parental/carer consent should first be obtained and the Community Paediatrician can be contacted via Longbow House. Community Paediatricians also carry out Medical Examinations for children undergoing Statutory Assessment of their Special Educational Needs, initial Looked after Medicals and 14+ Transitional Review Medicals (in Special Schools and where children with complex needs attend mainstream schools). It may also be useful for Community Paediatricians to occasionally attend TAC meeting if a child has complex medical issues but it is generally not possible for Community Paediatricians to attend Core Group Meetings or Annual Statement Reviews.

5.9.2.6 In order for routine screening to take place and for information about children to be kept up-to-date on the Child Health computer, it is essential that schools make sure that information about <u>all</u> new entrants is registered with the School Health Department at Longbow.

5.9.2.7 Information about the School Health Service should be provided to all parents of new entrants via the School Prospectus. Schools must also provide parents with a Consent Form to give permission for the School Nurse/Hearing/Vision Screening and these should be retained by the school to show to the School Nurse/Vision Tester. Services for Children & Young People at Longbow House should be provided with a list of children for whom consent has <u>not</u> been obtained.

5.9.2.8 Any queries regarding the Selective Medical process should initially be discussed with the School Nurse or if she is unavailable, with the School Health Service at Longbow House.

5.9.3 Facilities necessary

Community Paediatricians will require a room that provides an appropriate and safe environment for the child to undergo the examination.

The table below details the checklist to be completed by the Community Paediatrician.

A reasonable standard of decoration and floor covering	
Adequate space for tasks and accommodation of people	
Light	
Privacy	
Access to hand washing facilities	
Seating for child and parents	
Desk and chair for Community Paediatrician and Nurse	
Access to telephone facilities	
Appropriate access and waiting area for parents near examination room	
Appropriate heating	
Quietness	

If the school is unable to provide the above facilities or if additional equipment (e.g. examination couch is required for a specific child), it may be more appropriate for an alternative venue to be sought. It is the responsibility of the Community Paediatricians to identify a suitable venue for each child's examination and to inform the Services for Children and Young Persons' Team

5.9.4 Administrative Details

Appointment Processing

Each school to provide the Child Health Department with a list of new school entrants prior to the term in which they start.

Issue of Information to Parents

Each school is asked to ensure that the following entry in their school prospectus is included and distributed.

SCHOOL HEALTH SERVICE

The following information sets out the arrangements for routine services provided by the School Health Service in conjunction with the school.

The School has a named School Nurse …… who is based at …….. and whose telephone number is ……..

The School also has a named School Doctor who is a Community Paediatrician.

During your child's first term in the Reception Class, he or she will be offered a health check, including a measurement of height and weight and a hearing test which will be carried out by the School Nurse. Your child will also have a vision test carried out by an Orthoptist. During Year 6, your child will be offered height and weight screening by the School Nurse as part of the national initiative to monitor obesity levels. You will be asked to give your consent before these procedures take place.

If you have any concerns about your child's health, including bedwetting, soiling or behaviour at home, you can contact the School Nurse who will be pleased to discuss those concerns with you and arrange to see you and your child if this would be helpful.

The School Health Service operates a system of Selective Medicals which are offered if parents, school staff or the School Nurse have concerns about the health of any child in school. In all cases, full discussion will take place with parents and parental consent will be obtained before an appointment with the Community Paediatrician is made.

REFERRAL FORM FOR SELECTIVE MEDICAL

Name of Child: _____ Date of Birth _____

Address: _____ Tel. No. _____

_____ Post Code _____

NHS No. _____

School: _____ Referral Date _____

Source of referral:
(1) Child on additional needs list
(2) Parent
(3) Headteacher
(4) School Nurse
(5) Community Paediatrician
(6) Consultant Paediatrician
(7) Selective Medical Review
(8) Other

Reasons for referral *(Please state concerns in a reasonable amount of detail)*:-

_____

_____

_____

_____

_____

_____

_____

Please confirm that this referral has been discussed with parents ☐

When form completed by School please return to School Nurse

Action by School Nurse _____

_____

School Nurse name *(print)* _____ Signature _____

Action by Community Paediatrician: Selective Medical ☐ Time required ☐

Other: _____

_____

Paediatrician's Name *(print)*: _____ Signature _____

FOR OFFICE USE ONLY (CHLD HEALTH, LONGBOW HOUSE, HARLESCOTT LANE, SHREWSBURY)

LETTER SENT ☐ REPLY TO CONSENT ☐

CODE: SEL-MED (6.2.08)

5.9.5 Consent Form

The Services for Children & Young People will provide Consent Forms for schools who will then issue them to parents for signature.

- Signed consent forms to be retained by the school
- Services for Children and Young People to be provided with a list of children for whom consent has not been obtained.

A sample of the current form is shown below:

CSD/ Date

Dear Parent

CONSENT TO SELECTIVE SCHOOL MEDICAL PROCEDURE

I consent to ……..……. (Date of Birth) ……..

Being included in the Selective School Medical programme and to receive:

i) a general health check by the School Nurse consisting of a height and weight measurement and a hearing test.

ii) a vision test being carried out by an Orthoptist.

Full name of Parent or person having parental responsibility for child.

(Block Capitals): …….

Signature: …….

Date: …….