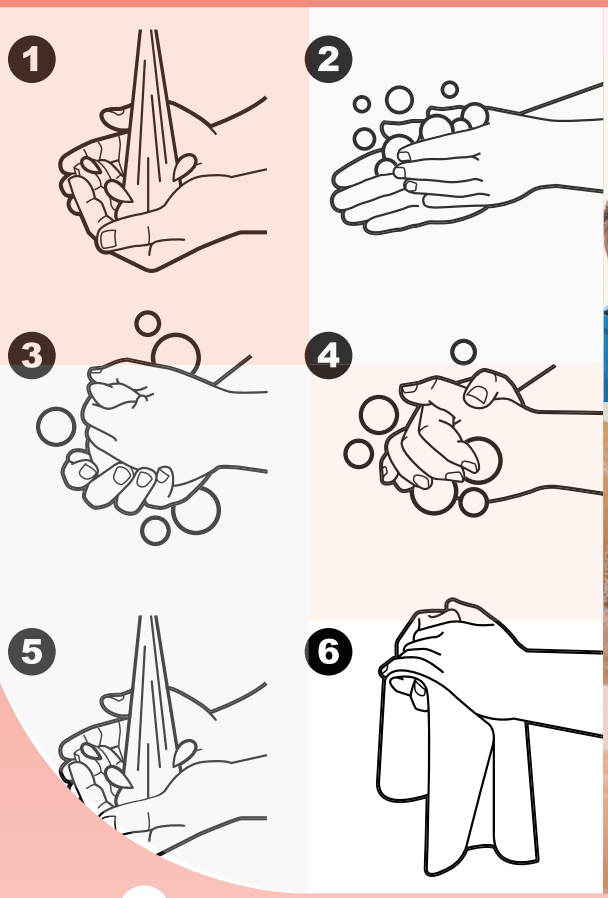
The Spotty Book

Notes on Infectious diseases in Schools and Early Year settings

Public Health England Guidance



This booklet provides general infection prevention and control guidance for schools and child care settings.

Walsall Council

Public Health England

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About Public Health England

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Revisions & Updates

Page number	Revision/Update	Who by	Date
	Whole document review	Helen Trudgeon PHE SW HPT	Aug 17
P11	Routine Childhood Immunisation Schedule	Fiona Neely PHE SW HPT	Aug 18
P15-24	Update of -cleaning, disinfection and suitable facilities guidance, -Dealing with spills of blood and body fluids -Bottle feed prep to amalgamate with and include items developed by Dorset Health Protection Network IPC in Schools Project 2015-16	Fiona Neely PHE SW HPT	Aug 18
P29	Clarification of exclusion period for Chicken pox and consistency with PHE and NICE guidance	Fiona Neely PHE SW HPT	Aug 18
P93	Update on legislation used for Guidelines on Food Hygiene for Childminders	Caroline Fair EHO Poole Fiona Neely PHE SW HPT	Aug 18
P101	New IPC Audit Tool added	Bournemouth, Poole & Dorset Councils, Public Health Dorset & PHE SW HPT	Sept 18

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Acknowledgements

The first edition of the “Spotty Book” was produced in Plymouth in the 1970s. Since then there have been several editions both in Plymouth and in other counties in the South West.
Authors and editors include Paediatricians, Microbiologists, General Practitioners, Nurses and Public Health Physicians. Contributions and comments have been provided by numerous people. Some of the cleaning guidance has been adapted from the Public Health Wales document *www.wales.nhs.uk/sitesplus/888/opendoc/251196.*
This edition provides up to date information, and has been produced for the South West to ensure that advice is consistent across the area. It is designed to be read in conjunction with and to compliment the national Public Health England guidance

Executive summary

This document provides general guidance for school staff and others with children in their care on the prevention and control of infectious diseases.
The advice applies to schools and any other care settings e.g. nurseries, playgroups and child-minders. “School” will be used throughout to indicate all these areas, except where otherwise indicated.
We advise a proactive, preventative approach. A policy on management and exclusion of children and staff members due to illness should be decided by the school. Parents and staff members should be made aware of the policy and advised on the importance of complying with it.

You should consider the following:

1. In general, individuals who are known to be unwell with infectious diseases must not attend school, although mild snuffles and colds need not necessarily prevent an individual attending. If you are unsure whether or not a child or staff member should be in school, please consult the
2. If a child becomes ill during care, parents/carers must be contacted and the child taken home if necessary. It is recommended that schools, child-minders, nurseries and playgroups have a record of each child's GP and alternative phone numbers if you are unlikely to be able to get in contact with the parents/carers.
3. Parents should be requested to notify the school if their child has an infectious disease. Staff members also have a duty to ensure the school is aware if they are unwell or have been diagnosed with an infectious disease.
4. The school should notify parents if a significant risk to other children exists. The Public Health England Health Protection Team has access to many template letters and can help ensure that information to be circulated to parents is accurate and appropriate.
5. The length of time an individual should be excluded from school depends on the type in infection they have had. If in doubt, please contact the Health Protection Team to discuss this.
6. Check that parents and staff members understand your policy and accept that they will have to take time off, or make other arrangements for their child's care, if their child is ill.
7. Be aware of children and staff who are more susceptible to infection due to underlying diseases, treatment or pregnancy. You should note that there may be staff members in the early stages of pregnancy who have not informed the school yet so consider ways of ensuring anyone in that situation could be notified of potential exposure to infectious diseases that may impact on their pregnancy (for example a group email or notice in the staff room).
8. If in doubt seek further advice from your School Nurse, Health Visitor, GP or the Public Health England Health Protection Team

Introduction

Control of infection among children in schools depends upon:

- Prevention
- Early recognition of each case
- Prompt action and follow up

Infections may be:

- Acquired at home or the community and brought into school
- Acquired and spread within school

The information in this document is relevant to staff members as well as children. It is important to remember that members of staff (teachers, classroom assistants, catering, caretaking, clerical etc.) may become infected.

The following guidance provides background information about the most common infections and outlines the appropriate action to be taken to limit their spread. It updates and replaces all previous versions.

The key personnel include:

- Head Teacher/ Principal and Manager
- School Nurse
- Health Visitor (for children in nurseries or play-groups)
- Public Health England (PHE) Health Protection Team
- General Practitioner
- Consultant Microbiologist

Other stakeholders may be requested to attend any meeting if their input is required e.g. Paediatrician, Environmental Health; Occupational Health.

Patient information and the Caldicott principles

In many cases the health protection team will ask for personal details of individuals following notification infectious disease. This information will allow the health protection team to follow up test results and liaise with the relevant health care providers to ensure that the correct public health action is taken following each case. The team will not ask for information that they do not need and follow the Caldicott Principles (in line with the rest of the NHS). These principles are as follows:

- Be able to justify the purpose for using confidential information
- Do not use personal confidential data unless it is absolutely necessary
- Use the minimum necessary personal confidential data
- Access to personal confidential data should be on a strict need-to-know basis
- Everyone with access to personal confidential data should be aware of their responsibilities
- Comply with the law

- The duty to share information can be as important as the duty to protect patient confidentiality.

Please be prepared to assist the health protection team with this and remember that prompt communication between each member of the team will ensure that children and staff are not exposed unnecessarily to infectious diseases and may help to reduce undue anxiety.

What is an outbreak?

An outbreak is defined as two or more linked cases with similar symptoms over and above that which would normally be expected. The school or childcare facility should contact the health protection team as soon as they suspect an outbreak to discuss the situation and agree if any actions are required. More information can be found in chapter 4 of the Health protection in schools and childcare facilities guidance.

More information on infections in childcare settings can be found in chapters one and two of the Health protection in schools and childcare facilities guidance.

Childhood immunisation

The overall aim of the routine childhood immunisation schedule for children in the UK is to provide protection against a range of vaccine-preventable infections and has been designed to provide early protection against infections that are most dangerous for the very young. Booster (repeat) doses and the introduction of other vaccinations as the child gets older are scheduled to provide protection before they reach an age when they become most at risk of these vaccine-preventable diseases.

Influenza (flu) was introduced into the routine immunisation programme for children in 2012. This should contribute significantly to reducing illness and deaths caused by the influenza virus. The 2017 schedule includes flu vaccination for all children between the ages of two and eight years old (including children in reception and school years 1 – 4). This is due every year from September and local agreements may result in these being provided in the school setting.

From autumn 2017 Hepatitis B will also be included as part of the routine childhood immunisation programme.

The UK routine childhood immunisation schedule does change and will be reflected in future editions of this document but can also be found on the Public Health England website here and chapter five of the Health protection in schools and other childcare facilities guidance.

Routine childhood immunisations (from Spring 2018) – see next page

Vaccinations for premature babies

Babies who are born early can be at greater risk from infections than babies born on time. This is because their immune systems are less developed and they do not receive as much natural immunity from their Mothers. It's especially important that premature babies get their vaccines on time, from two months after birth, no matter how premature they are. It may seem very early to give a vaccination to such a tiny baby, but many scientific studies have shown that it's a good time to give them vaccines. Postponing vaccination until they are older leaves them vulnerable to diseases.

The routine immunisation schedule from Spring 2018

Age due	Diseases protected against	Vaccine given and trade name		Usual site
Eight weeks old	Diphtheria, tetanus, pertussis (whooping cough), polio, *Haemophilus influenzae* type b (Hib) and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	Pneumococcal conjugate vaccine (PCV)	Prevenar 13	Thigh
	Meningococcal group B (MenB)	MenB	Bexsero	Left thigh
	Rotavirus gastroenteritis	Rotavirus	Rotarix	By mouth
Twelve weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Rotavirus	Rotavirus	Rotarix	By mouth
Sixteen weeks old	Diphtheria, tetanus, pertussis, polio, Hib and hepatitis B	DTaP/IPV/Hib/HepB	Infanrix hexa	Thigh
	Pneumococcal (13 serotypes)	PCV	Prevenar 13	Thigh
	MenB	MenB	Bexsero	Left thigh
One year old (on or after the child's first birthday)	Hib and MenC	Hib/MenC	Menitorix	Upper arm/thigh
	Pneumococcal	PCV	Prevenar 13	Upper arm/thigh
	Measles, mumps and rubella (German measles)	MMR	MMR VaxPRO[2] or Priorix	Upper arm/thigh
	MenB	MenB booster	Bexsero	Left thigh
Two to eight years old[1] (including children in reception class and school years 1-4)	Influenza (each year from September)	Live attenuated influenza vaccine LAIV[3]	Fluenz Tetra[2]	Both nostrils
Three years four months old or soon after	Diphtheria, tetanus, pertussis and polio	DTaP/IPV	Infanrix IPV or Repevax	Upper arm
	Measles, mumps and rubella	MMR (check first dose given)	MMR VaxPRO[2] or Priorix	Upper arm
Girls aged 12 to 13 years	Cervical cancer caused by human papillomavirus (HPV) types 16 and 18 (and genital warts caused by types 6 and 11)	HPV (two doses 6-24 months apart)	Gardasil	Upper arm
Fourteen years old (school year 9)	Tetanus, diphtheria and polio	Td/IPV (check MMR status)	Revaxis	Upper arm
	Meningococcal groups A, C, W and Y disease	MenACWY	Nimenrix or Menveo	Upper arm
65 years old	Pneumococcal (23 serotypes)	Pneumococcal Polysaccharide Vaccine (PPV)	Pneumococcal Polysaccharide Vaccine	Upper arm
65 years of age and older	Influenza (each year from September)	Inactivated influenza vaccine	Multiple	Upper arm
70 years old	Shingles	Shingles	Zostavax[2]	Upper arm

1. Age on 31 August 2017.
2. Contains porcine gelatine.
3. If LAIV (live attenuated influenza vaccine) is contraindicated and child is in a clinical risk group, use inactivated flu vaccine.

Source: https://www.gov.uk/government/publications/the-complete-routine-immunisation-schedule; accessed 29 Aug 2018

Hand hygiene

Washing hands properly is one of the most important things individuals can do to help prevent and control the spread of many illnesses. Good hand hygiene will reduce the risk of illnesses like flu, stomach upsets and other infections being passed from person to person. Alcohol hand gel can be used if appropriate but should **not** replace washing hands if hands are visibly soiled or when there are gastroenteritis (diarrhoea and vomiting) cases in the school. Alcohol hand gel is not effective against norovirus.

Toilet facilities must have:

- Wall mounted soap dispensers*
- Water that is hot (preferably a mixer tap which can take the water to a safe temperature)
- Paper towels
- Foot action pedal bins

*Bars of soap and fabric hand towels are not acceptable.

- Wet your hands with clean, running water then apply liquid soap.
- Lather hands by rubbing them together. Be sure to lather the back of hands, between fingers and under nails.
- Rub hands for at least 20 seconds
- Rinse hands well under clean, running water
- Dry hands using a clean paper towel or air dry.

Hand washing with warm water and liquid soap is recommended as follows:

- After using (or helping someone to use) the toilet
- After changing a nappy
- Before, during and after preparing food
- Before eating food
- After blowing your nose, coughing or sneezing (or helping someone to blow or wipe their nose)
- Before and after treating a cut or wound
- Immediately after hands have been contaminated with respiratory secretions, blood, faeces, urine or other body fluid
- After handling animals, pet food/treats or cleaning cages
- Whenever hands are visibly soiled

More information can be found in the handwashing section of chapter three of the Health protection in schools and childcare facilities guidance.

Hand Washing Posters –Cut and Paste or Photocopy


Washing your hands
Step 1
Wet hands under warm running water.
1
Step 2
Add soap to aid cleaning and to kill germs.
2
Step 3
Rub well for at least 15 seconds.
3
Remember
Rub the front and back of your hands well and between your fingers!
Step 4
Rinse well under warm running water.
4
Step 5
Dry hands with clean paper towels.
5

Cleaning, disinfection and suitable facilities

The cleanliness of any environment is important to support infection prevention and control. Cleaning staff play an important role in improving the quality of the surroundings. A clean (free from dust, dirt and grease) and dry environment poses little or no threat of infection to healthy adults and children.

Cleaning with detergent and water is normally all that is needed as it removes the majority of germs that can cause disease.
Disinfection reduces the number of germs still further and can be carried out after adequate cleaning has been done. Disinfection should occur when there is a particular risk of infection (e.g. an outbreak of diarrhoea and vomiting). There are many disinfectants that are safe to use around children and pets, (e.g. Milton Solution) and your cleaning staff should have a policy in place for use of these products. Whichever solution is used, check the label to ensure that it is used in line with directions and make sure that it states that it can kill both viruses and bacteria. Hypochlorite solutions should be diluted to 0.1% or 1000 ppm.

There is no legislative requirement to operate a colour-coded cleaning regime. However, it is generally considered good practice to adopt such a scheme when cleaning commercial premises and stops equipment being used in different areas (e.g. toilet and then used in a kitchen). As a result, and given the importance afforded to infection control, the cleaning industry has developed a widely used colour-coding system for all relevant cleaning equipment which should be used in the areas as identified by the various colours. These are;

BLUE	Generally used when cleaning areas that are considered to present a low risk of infection. All equipment can be used to clean classrooms/offices/reception areas etc.
GREEN	All kitchen areas within the school/nursery should use green equipment.
RED	This is for **high risk** areas in relation to the spread of infection, such as toilets/washrooms/showers. Including all fixtures and fittings
YELLOW	Should be used in washroom areas for cleaning all fixtures and fittings and surfaces that are not considered critical in terms of infection. These include worktops/ doors/pipework/towel dispensers/sink and basins

Cleaning and Disinfecting

To effectively clean and disinfect an environment, there must be a three stage process:

- Stage 1: Use a detergent to clean and remove any visible dirt followed by rinsing with clean water.
- Stage 2: Disinfect using a disinfectant at the correct dilution and contact time recommended by the chemical manufacturer. Disinfection will not work on visbly dirty surfaces
- Stage 3: Allow to dry thoroughly

Sanitisers can be used as both a detergent and a disinfectant. When using sanitisers, the three stage cleaning, disinfection and drying process, as described above, must still be carried out. You should apply the sanitiser first to provide a clean surface and then again to disinfect

For disinfectants and sanitisers to work, they must be mixed to the dilution and applied for the contact time that the manufacturer recommends – this can be found on the label of the bottle.

Milton solution is normally the preferred solution to use in childcare settings. It is usually sold at a strength of 2% sodium hypochlorite. All bleach labels will state their percentage concentration – most household bleach sold in supermarkets will be 5%. ALWAYS follow the manufacturers guidelines and safety instructions carefully. Great care is required if bleach is used in childcare settings and an adquate COSHH risk assessment should always be done.

Any bleach or hypochlorite solution should be used at a dilution of 1000ppm.

To make a 1000ppm dilution, using 5% (thin household) bleach:

Add 20ml of bleach, to 980ml of water.

To make a 1000ppm dilution, using 2% Milton:

Add 50ml of bleach, to 950ml of water.

Effective cleaning and disinfection is critical in any childcare setting, particularly when food preparation is taking place. The FSA strongly advises the use of either a dishwasher, a sterilising sink, or a steam cleaner to clean and disinfect equipment and utensils. All areas or surfaces in contact with food, dirt or bodily fluids must be regularly cleaned and disinfected. Training should be provided for the use of any equipment and chemcials. Operation and maintenance of equipment should be according to the manufacturer's instructions, and include regular dishwasher interior cleaning cycles

Disinfectants and sanitisers must at least meet the requirements of one of the following standards:

BS EN 1276 or BS EN 13697

Toilet areas:

More information on environmental cleaning can be found in chapter six of the Health protection in school and other childcare facilities guidance

Toilets in schools and nurseries should be of the correct size for the children. Small children have to slide forward to get off adult size toilets which may result in the seat becoming smeared with urine or faeces.

Cleaning staff should have a policy that they adhere to but this should include a daily clean (at least) and additional clean if visibly dirty.
Standard detergent and warm water is usually ideal for cleaning if there is no evidence of a diarrhoea and vomiting outbreak. During an outbreak, chlorine based detergent should be used.

Decontamination of toilets procedure

Equipment required

- Disposable cloths
- Personal protective equipment (disposable gloves and disposable plastic apron)
- Detergent
- Disinfectant- 1,000 parts per million or combined detergent and disinfectant (sanitizer) acceptable in place of separate detergent and disinfectant
- Designated sink for cleaning equipment with hot and cold running water (not used for handwashing)
- Mop and bucket (colour coded for use in toilet area only)

Method

- Wear personal protective equipment to clean and disinfect toilets and frequent hand contact sites e.g. toilet seats, toilet flush, wash hand basin taps, surfaces, waste bins and door handles, lower part of doors in the toilet area, ideally twice daily or immediately if found to be soiled.
- Clean - use warm water and detergent.
- Disinfect – use disinfectant solution of 1000 parts per million or second spray of 2-in-1 sanitiser if using.
- Store equipment in a designated area for cleaning equipment only.
- Mop heads should be either disposable or have removable heads.
- Store mops upside down and not left soaking in buckets of water.
- If using reusable mop heads, they must be laundered within a washing machine at a high temperature[1] and thoroughly dried on a daily basis. If using disposable mop heads, the heads should be disposed of daily.
- Dispose of personal protective equipment, and wash hands thoroughly.
- Ensure re-usable equipment is dried thoroughly after cleaning[1]

[1] Mimimum 65^{0}C temperature hold for a minimum of 10 mins within the wash cycle; or 71^{0}C for not less than 3 min

Nappy changing:

More information on managing nappies and contaminated clothing can be found in chapter three of the Health protection in schools and other childcare facilities guidance.

Equipment

- The area must be situated well away from food preparation, serving and eating areas, and ideally in the toilet area
- Hand Wash basin hot and cold running water, liquid soap, disposable paper towels in the nappy changing area
- Waterproof change mat (without tears) and easy to clean between use
- Disposable sheets for change mat/changing area
- Disposable apron and gloves
- Babies own personal creams/nappies/wipes
- Nappy bags for soiled nappies
- Lidded foot operated waste bin
- Disposable cloths
- Detergent
- Disinfectant (1000 parts per million)
- (Combined detergent and disinfectant – sanitizer- acceptable in place of separate detergent and disinfectant)

Method

- Wash hands and put on disposable apron and gloves
- Place a clean disposable sheet over the change mat/area
- Remove the nappy and clean the baby
- Place soiled nappy and baby wipes into plastic nappy sack
- Apply cream if needed – change gloves or use a clean spatula to dispense the cream. (Creams should be labelled for each child use- do not use one pot for more than 1 child)
- Place nappy sack into waste bin
- Change nappy
- Remove disposable sheet, place into waste bin
- Clean and disinfect change mat and any other areas that may have been touched during the nappy change.
- Clean - use warm water and detergent
- Disinfect – use disinfectant solution of 1000 parts per million or second spray of 2-in-1 sanitizer if using.
- Thoroughly dry change mat and surrounding area with disposable paper towels
- Dispose of PPE, wash hands thoroughly and dry with paper towel

CLEAN AND DISINFECT AFTER EACH NAPPY CHANGE EVEN IF THERE IS NO VISIBLE CONTAMINATION

Soiled clothes

Items of clothing that may become soiled should not be swilled out or left to soak (faecal material can become airborne and can be the cause of contamination on surfaces). Care should be taken to wipe away any faecal matter with wipes/toilet paper and the soiled article should then be placed in a plastic bag and sent home.

All staff when changing children must wear appropriate PPE when dealing with soiled nappy/pants and wash hands after the procedure.

Decontamination of Potties Procedures

Equipment

- Area must be situated well away from food preparation, serving or eating areas, in the toilet or sluice area
- Hot and cold running water
- Disposable cloths
- Paper towels
- Personal protective equipment (disposable gloves and disposable plastic apron – preferably wall mounted out of reach of children)
- Detergent
- Disinfectant - 1000 parts per million OR combined detergent and disinfectant (sanitizer) acceptable in place of separate detergent and disinfectant
- Designated sink for cleaning equipment

Method

- Put on disposable aprons and gloves
- Empty contents of potty carefully into a sluice area (if possible) or toilet
- immerse the potty in a hot water and detergent solution and clean thoroughtly using a disposable cloth. Do not use scrubbing brushes as they can damage the surface and add to the risk of infection. Better to buy economy potties and change them regularly if there is a need
- Wipe potty with a disinfectant solution of 1000 parts per million or second spray of 2-in-1 sanitiser if using.
- Dry thoroughly
- Store the potty in an inverted position and not stacked until required for use
- Thoroughly clean and disinfectant sink
- Dispose of PPE and wash hands thoroughly

NB: It is vital to encourage and facilitate children in washing their hands following using the potty. Alcohol hand gel should not be used as a substitute for washing.

Deep/Terminal Cleaning after an outbreak

Clean all hard surfaces thoroughly, using detergent and hot water, followed by 1000ppm (0.1%) bleach/hypochlorite solution or an appropriate disinfectant, paying particular attention to frequently-touched surfaces; for example – seats, door handles, flushes and taps, contact points, switches, mirrors, vents, bins, furniture. Allow to dry before use and dispose of any potentially contaminated items safely

Steam clean carpets/soft furnishings and change curtains in contaminated rooms or areas (norovirus may remain viable for many days on carpet and curtains). Carpets and soft furnishings should be steam cleaned (or steam vacuumed) using a steam cleaner with a hot drying cycle which reaches a minimum of 70°C, unless the floor covering is heat sensitive and/or fabric is bonded to the backing material with glue. If this is the case then use a suitable, effective carpet shampoo, ideally with virucidal and bacteriocidal properties. Curtains can also be steam cleaned if necessary

Carpets should be allowed to dry before any child/staff member is allowed back into the area. Vacuum cleaning carpets and floor buffing during an outbreak have the potential to re-circulate norovirus and are not recommended. If vacuum cleaners are to be used in non-contaminated areas, they should contain high efficiency particulate air (HEPA) filters which are regularly cleaned and disinfected.

If unable to steam clean soft furnishings, and if they are removable soft furnishings (for example cushions, covers), these should be machine washed in the hottest wash possible for the fabric*

Soft toys should also be machine washed as above and tumble dried.

Ensure (as with cleaning during the outbreak) that cloths are disposed of and non-disposable mop heads are laundered in hot wash (65°C or above) once deep cleaning is complete. They should then be dried thoroughly.

*Minimum 65^0C temperature hold for a minimum of 10 minutes within the wash cycle; or 71^0C for not less than 3 minutes

Dealing with spills of body fluids (environmental)

Staff should have easy access to a spillage kit in the event there is a blood or body fluid spill. Spillage kits should be kept in an area that is accessible to all staff, (preferably not in a locked room) in line with your current policy, especially if it contains spillage granules. Spillage kits don't have to be costly and the kit can be made up at the school.

Suggestions for the kit:

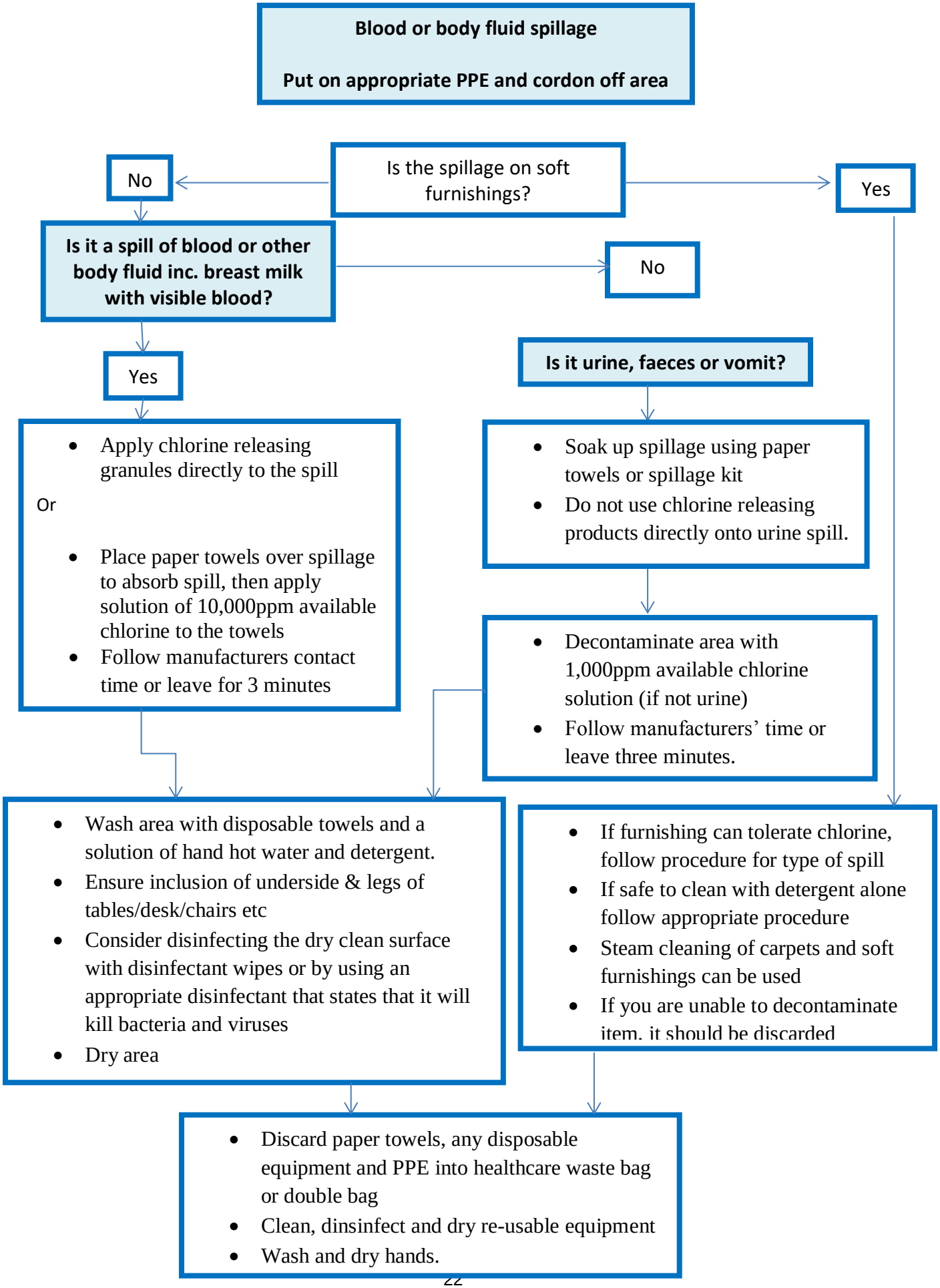
- Coloured plastic bucket – clearly labelled "Spillage Kit"
- Kitchen roll or similar paper to place on spillage
- Plastic bag
- Apron and Gloves
- Spillage granules – not compulsory, but can speed up the cleaning process

Whose responsibility is it to manage body fluid spills?

Ensure that school/nursery guidelines state a plan of action as to who does what after the initial first aid measures. It should clarify whether the staff member continue to clear the spillage or if the caretaker should take over (as they may be the most experienced person and know how to deal with cleaning materials and disinfectants).

Staff should be aware that it is the responsibility of everyone to try to minimise the risk to others by ensuring appropriate first aid measures are initiated.

More information can be found in Chapter three of the Health protection in schools and other childcare facilities guidance.


Blood or body fluid spillage
Put on appropriate PPE and cordon off area
Is the spillage on soft furnishings?
No
Yes
Is it a spill of blood or other body fluid inc. breast milk with visible blood?
No
Yes
Is it urine, faeces or vomit?
Apply chlorine releasing granules directly to the spill
Or
Place paper towels over spillage to absorb spill, then apply solution of 10,000ppm available chlorine to the towels
Follow manufacturers contact time or leave for 3 minutes
Soak up spillage using paper towels or spillage kit
Do not use chlorine releasing products directly onto urine spill.
Decontaminate area with 1,000ppm available chlorine solution (if not urine)
Follow manufacturers' time or leave three minutes.
Wash area with disposable towels and a solution of hand hot water and detergent.
Ensure inclusion of underside & legs of tables/desk/chairs etc
Consider disinfecting the dry clean surface with disinfectant wipes or by using an appropriate disinfectant that states that it will kill bacteria and viruses
Dry area
If furnishing can tolerate chlorine, follow procedure for type of spill
If safe to clean with detergent alone follow appropriate procedure
Steam cleaning of carpets and soft furnishings can be used
If you are unable to decontaminate item, it should be discarded
Discard paper towels, any disposable equipment and PPE into healthcare waste bag or double bag
Clean, dinsinfect and dry re-usable equipment
Wash and dry hands.

Dealing with cuts/abrasions and spills of blood (people)

As we do not always know about every infection that an individual may have, we should take standard precautions whenever we deal with any cuts/abrasions or body fluid spills. Standard precautions are a set of infection control practices used to prevent transmission of diseases (such as Hepatitis C and HIV) that can be acquired by contact with blood, body fluids, non-intact skin (including rashes), and mucous membranes.

Standard precautions should be used for everyone to reduce the risk of unknown (and known) disease transmission and include:

- Wearing gloves when in contact with any accident or injury (washing grazes, dressing wounds, cleaning up blood after an incident) and wearing a disposable plastic apron if possible.
- Carefully cleaning the wound under running water if possible or using a disposable container with water and wipes. Dab carefully dry.
- Covering all exposed cuts and grazes with waterproof plasters.
- If there is a spillage of blood or body fluids, refer to the guidance in the chapter above.
- If someone suffers a bite, scratch or puncture injury that may have introduced someone else's blood or experiences a splash of blood to the eye, area of broken skin or mouth, rinse well with water and seek medical advice.

More information can be found in Chapter three of the Health protection in schools and other childcare facilities guidance.

Bottle Feed Preparation

Ideally, a fresh feed should be made up each time as required. Bacteria can grow very quickly at room temperature and even if stored in a fridge, bacteria can survive and then multiply.

If parents/carers bring made-up bottles of breast milk or formula, refrigerate them straight away. Keep them in the fridge until you are ready to use them and use within 24 hours. Bottles should be clearly labelled with the child's name, date and time.

You should check the temperature of the fridge at least daily to ensure it is keeping food below a maximum of 5˚C. When storing feed in the fridge, ensure the bottles do not become contaminated by other items in the fridge. Wherever possible, settings should have dedicated fridges.

The Safer Food Better Business for Childminders pack gives further information on the preparation and storage of formula and breast milk.

Summary:

Preparation

1. Boil the water and leave to cool in the kettle. Do not leave for more than 30 minutes. The water needs to remain at a temperature of at least 70˚C
2. Stand bottle on clean surface and keep teat and cap on the upturned lid of the steriliser, avoid putting them on the work surface.
3. Pour water from the kettle into the sterilised bottle.
4. Add the formula powder according to the manufacturer's instructions.
5. Reassemble the bottle and shake to mix the product.
6. Cool the feed quickly by holding it under cold running water or stand in a bowl of cold water, avoiding the lid level.
7. Check the feed temperature before administering.
8. Formula left in the bottle after a feed should be thrown away.

Re-warming stored feeds

1. Remove feeds from refrigerator just before they are required
2. Re-warm bottle for no more than 15 minutes (do not use a microwave to warm feeds)
3. To ensure even temperature periodically swirl or shake the bottle
4. Check temperature of milk to avoid scalding the child's mouth
5. Any warmed feed left in the bottle after a feed should be thrown away.

Guidelines on farm and countryside visits


Visiting a farm / centre is an enjoyable and educational experience for many people, particularly children but such visits can never be free from all risks. Farm animals, even those that look clean and healthy carry infections that can be harmful to people. The bacterial infection Escherichia coli O157 (known as E.coli O157) is a particular health risk, especially for children under five as they are more vulnerable to this infection and more likely to develop serious illness once infected. It should be assumed that all cattle, sheep, goats and deer are carrying this infection.
E. coli O157 can survive outside of the body and by touching animals, fences, surfaces around the farm, or being in contact with animal droppings, bacteria can accidentally pass from your hands / gloves to your mouth which can lead to gastrointestinal infection. Eating food that has become contaminated with the bacteria is another way of contracting the infection. It only takes a small number of bacteria to cause infection so washing hands thoroughly with soap and water immediately after contact with animals will reduce the risk of infection.

What to do when visiting a farm

Team Leader:

- Contact the farm prior to the visit and confirm with the management that they have adequate hand washing facilities around the area being visited **or** contact the local Environmental Health Department for advice on farms with the best facilities.
- Check that the farm you are planning to visit has running tap water, pump action soap and paper towels.
- Check that the farm you are planning to visit has a cordoned off area for picnics away from the animals and that it has handwashing facilities.
- Take wet wipes with you to deal with any visible dirt on hands as a quick first aid measure until the child can wash their hands.

The simple rules listed below will help to keep you and your children safe when visiting open farms as many farm animals, particularly cattle, carry bacteria in their stomach and in their faeces which can cause severe stomach pain and diarrhoea. Pregnant

women need to take particular care and specifically should avoid contact with sheep / lambs and their droppings.

- Do not put hands on faces or fingers in mouths while petting animals or walking round the farm
- Do not kiss farm animals or allow children to put their faces close to animals
- Do not eat or drink while touching animals or walking round the farm: This includes not eating sweets, crisps or chewing gum.
- Do not eat anything that has fallen on the floor.
- Do not use gels or wipes instead of washing hands with soap and water. Gels and wipes cannot remove viruses or bacteria when the hands are soiled (however; as a 'first aid' measure use if necessary and then ensure that the person is able to wash their hands as soon as possible (gels and wipes can wipe away the dirt/contamination, but the affected area may still be contaminated with bugs and these can only be killed by using detergent and water). Gels or wipes can then be used after hand washing to give further protection if necessary).

It is important that hands are washed thoroughly with soap and water:

- After you have touched animals, fences or other surfaces in animal areas
- Before eating or drinking
- After removing dirty shoes or boots that have been worn on the farm or garden.
- Supervise children closely to ensure that they wash their hands thoroughly.

If anyone in the group has sickness or diarrhoea within two weeks of visiting a farm they should be advised to contact their GP as soon as possible. If anyone in the group, particularly a young child has bloody diarrhoea, their parent/guardian should be advised that they should seek immediate emergency medical attention.
Children under five should not attend school/nursery/group childcare until they have been free of sickness or diarrhoea for 48 hours. Some infections require further tests to ensure that they are free from infection before they can return to school.
Parents should be encouraged to confirm with their health professional when it would be safe for their child to return to school or nursery.

More information on visits to pettings farms and zoos can be found in chapter eight of the Health protection in schools and childcare facilities guidance.

Deciding to get a resident school pet

Caring for animals requires dedication and commitment. This is an important lesson for children so careful planning is necessary before introducing resident animals into schools. Children, parents and staff must recognise that there is a small risk of transmission of bugs from animals to humans and strict guidelines about washing hands before and after handling the animal should be followed. Washing hands before touching the animal reduces the risk of passing any infections to them and washing hands again after putting the animal back in the cage reduces the risk of any infections from the animals being passed to the children and staff.
Animals should be assessed by a veterinary surgeon for health, temperament and behaviour prior to being introduced to the school.
Careful research must be undertaken into the requirements of any species being considered as a pet. Each school should develop a written policy on animals in school and an individual care plan for each resident animal.

Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly and litter boxes not accessible to children. Children should not play with animals unsupervised

Ensure children wash their hands after putting the pets back into their cages.

Reptiles are not suitable as pets in schools and nurseries as all species can carry salmonella.

More information on managing animals in the school setting can be found in chapter eight of the Health protection in schools and childcare facilities guidance.

Common Childhood Diseases

More information on managing specific infectious diseases can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Chickenpox and Shingles


What is it?

Chickenpox and shingles are caused by the same virus which causes an itchy rash starting with flat red spots that become raised and filled with fluid. Chickenpox is usually a mild childhood illness but there is a risk of complications in people who have a weakened immune system, including young babies and pregnant women.

What are the symptoms?

Chickenpox usually begins with the onset of a slight fever, feeling generally unwell for a couple of days before the spots appear.

The spots can appear everywhere, they usually begin on the scalp/face and back, but they can be seen inside the mouth and genitalia. It is rarely seen on the palms of the hands and soles of the feet. The rash is very itchy. The spots leave scarring if they are scratched and become infected.

The spots look flat and red; these later become raised and filled with fluid. Most children become free from chickenpox in less than two weeks.

Is it infectious?

Chickenpox is spread from person to person; the virus is shed from the nose or throat as droplets or by direct contact. The fluid inside the spot is infectious. Chickenpox is highly infectious during its early stages from one - two days before until five days after spots first appear.

What is the incubation period?

The incubation period of chickenpox is between 13 and 17 days after contact with the infected person. The following groups of people should seek advice from their GP if they are exposed to chickenpox and do not remember if they have been previously infected with the virus:

- Pregnant women
- Babies whose mothers developed chickenpox in the first 28 days of their life

- People who are immunosuppressed (e.g. people having large doses of oral steroids or receiving chemotherapy for cancer / leukaemia / HIV related illness).

Although chickenpox is a mild disease in normal healthy children, it can be serious in individuals whose immune systems are impaired in any way such as those on treatment for leukaemia or who have had a transplant. Many of these individuals may be immune to chickenpox or may have had the vaccine and so are protected but it is important to let their parents know if there is a case of chickenpox in school as they can then take action if necessary (this would usually mean an injection of protective antibody from the doctor).

What is the treatment?

The most common treatment for chickenpox is aimed at relieving the symptoms:

- A pharmacist can recommend effective itch-relieving products
- Ice lollies may help to reduce a fever
- Paracetamol can be given according to the age of the child. Aspirin must not be given to children under 16yrs old. Ibuprofen should not be given to children with chickenpox.
- Nails should be kept short to prevent damaging the skin from scratching
- Wear loose, cool clothes and keep the room temperature cool as this may help to reduce itching

Are there any complications?

The majority of people affected by chickenpox suffer no long-term effects however there is an increased risk that individuals could develop shingles later in life due to the virus remaining dormant in the body following chickenpox then reactivating later.
Bacterial infections can arise if the blistered areas become contaminated with bacteria.
If chicken pox is circulating in the school at the same time as infections like scarlet fever, contact the health protection team for further advice.
Very occasionally chickenpox infection causes pneumonia, which presents as a persistent high fever and a severe dry cough
Very rarely it can lead to a condition called encephalitis. This is an inflammation of the brain which can occur between seven days and ten days after the onset of the rash
Encephalitis is very rare, and would present with symptoms of drowsiness, headache, neck stiffness, dislike of bright lights and possibly convulsions.

What is the exclusion period for chickenpox?

Individuals should be kept away from school for at least five days from onset of rash AND until all lesion have crusted over.

Is it necessary for individuals with chickenpox to see their Doctor?

There is no requirement to routinely visit a general practitioner if the affected individual has uncomplicated chickenpox. Chickenpox is a self-limiting illness for most children who will usually be completely better within two weeks. Taking the child to a busy doctor's surgery increases the risk of further spread of the virus and there is no specific treatment other than that available from a local pharmacy to relieve symptoms. It is worth recording that a child has had chickenpox on their immunisation record sheet.

What is shingles and how is it different from chickenpox?



Shingles, also known as zoster or herpes zoster, is a painful skin rash caused by the same virus responsible for chicken pox: the varicella zoster virus. An individual will only develop shingles if they have previously been in contact with the virus and had chickenpox. This is because the chickenpox virus remains in the body lying dormant in the roots of nerves and can reactivate many years later. It is not clear why the virus reawakens in some people but it may be that the virus reactivates as the immune system weakens with age or in conditions of stress. The majority of cases of shingles are in men and women ages 60 and older, but children can also become affected.
A person with shingles is infectious to those who have not had chickenpox and should be excluded from school if the rash is weeping and cannot be covered or until the rash is dry and crusted over.

More information on chickenpox and shingles can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Conjunctivitis

What is it?

Conjunctivitis (also known as “pink eye”) is inflammation of the thin layer of tissue that covers the front of the eye (the conjunctiva). It is a very common self-limiting condition that can be caused by a bacterial or a viral infection (infective conjunctivitis). Conjunctivitis can also be caused by allergic reaction to substances such as pollen and dust or when the eye is exposed to irritants including chlorinated water and shampoo.

What are the symptoms?

Symptoms of conjunctivitis are:

- Swelling and watering of the eyes
- Burning sensation
- Feeling of grit in the eye
- Itchy eyes (more common in allergic conjunctivitis).

The white of the eye may appear red or pink and there may be a discharge which causes the eyelids to stick together, making them difficult to open
Light might cause pain in the eye and increase the watery discharge

Is it infectious?

Yes, bacterial or viral conjunctivitis is usually spread from person to person by direct or indirect contact with the discharge from the eye.

Does an affected child or staff member need to be excluded from school?

Exclusion from school if an individual has conjunctivitis is not required unless they are feeling particularly unwell.
Parents should be encouraged to notify the school if their child has conjunctivitis to ensure that staff can take preventative action to reduce the risk of transmission to others. This includes;

- Ensuring that the affected child uses paper towels after handwashing (or has a dedicated hand towel which must be washed / changed daily)
- Ensuring the child does not share flannels while in school
- Discouraging close facial contact between infected and non-infected children.

Hand washing will help to minimise the spread of the infection. Wash hands before treating the eye and again afterwards.

If there are a number of cases of conjunctivitis at one school or nursery, staff should contact the health protection team to discuss further actions as it may be necessary to consider exclusion in these instances.
Generally adults who work in close contact with others or share equipment such as phones and computers should not return to work until the discharge has cleared up.

What is the incubation period?

This is variable depending on the cause, usually:

- One - three days for bacteria
- One -12 days for viruses (but this may be longer for certain eye infections in small babies).

When is it infectious?

Usually from the time symptoms appear until they have resolved. Some patients with viral infections may be infectious for up to 14 days after symptoms start

How can spread be prevented?

- Advise parents to inform schools and nurseries if their child has conjunctivitis.
- Encourage children not to rub their eyes.
- Conjunctivitis often doesn't require treatment as the symptoms usually clear up within a couple of weeks. If treatment is necessary, the type of treatment will depend on the cause. In severe cases antimicrobial eye drops may be prescribed.
- Allergic conjunctivitis can usually be treated with anti-allergy medications such as antihistamines. If possible, avoid the substance that triggered the allergy.
- Washing hands regularly, cleaning any contaminated items (such as toys or crayons) and avoiding sharing pillows or towels will help prevent it spreading.

Newborn babies

- Advise parents to seek advice immediately if there is a possibility their baby has infective conjunctivitis (also called neonatal conjunctivitis).
  If this is not possible, call **NHS 111** or the local out-of-hours service as the GP will need to examine the baby closely for sticky eyes or infective conjunctivitis.

Any newborn baby with infective conjunctivitis will need to be referred to an eye specialist urgently for treatment.

More information on conjunctivitis can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Glandular Fever


What is Glandular Fever?

Glandular fever is an illness caused by a virus.
It is a worldwide disease which can affect both sexes. It mostly affects young adults aged 15 - 26 years in the UK.

What is the incubation period?

Incubation is thought to be usually around four - eight weeks.

How long does the illness last?

The illness lasts two - three weeks but can be up to six weeks and is characterised by:

- Swollen glands
- Fever and sometimes a rash.
- Occasionally patients become jaundiced (turn yellow).

Young children tend to suffer mild symptoms which are often difficult to recognise.

How is it diagnosed?

By a blood test.

Is there any effective treatment?

There is no specific treatment and almost everyone will eventually make a good recovery.

How is Glandular Fever spread?

Spread is by saliva, usually through kissing or being in close contact with a carrier. Small children can be infected by chewing toys contaminated with the viruses. When the acute infection is over the virus can stay in the saliva for a year or more and about a fifth of those affected may have it for much longer than this.

Although it can occur in young children, this condition is much more common in adolescents. It usually takes the form of a sore throat with swollen glands in the neck. Full recovery may take some weeks, during which time the person may feel very washed out. This is not a very infectious disease except with close contact (known as “kissing disease”) and the child should only be kept away if feeling unwell.

How can spread be prevented?

Exclusion is not required if an individual feels well enough to attend school. Prevention is by using hygiene measures including hand washing and thorough cleaning of articles which may be contaminated with saliva.

More information on Glandular Fever can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Hand, Foot and Mouth Disease



What is Hand, Foot and Mouth Disease?

Hand, Foot and Mouth Disease is a common childhood viral illness that can affect adults. This is quite different from Foot and Mouth disease (which is a disease of animals).

What is the incubation period?

The incubation period is three – five days. The person will remain infectious during the acute illness and while the virus remains in the faeces. Infection generally leads to immunity.

It is communicable immediately before and during the acute stage of the illness, and perhaps longer as the virus may be present in the faeces for weeks.

What are the symptoms?

The onset of the disease generally presents as:

- Fever
- Malaise
- Sore mouth
- Development of a rash.
- Mouth lesions appear on the inside surfaces of the cheeks, gums and on the sides of the tongue.
- Raised pink spots that develop into blisters, which may persist for seven to ten days, can also occur as a rash, especially on the palms, fingers, soles and occasionally on the buttocks.

Is it infectious?

The disease is self-limiting and more common in summer and early autumn, mainly in children under ten years of age, but adult cases are not unusual. The disease frequently occurs in outbreaks in groups of children, in a nursery school for example.

The virus is spread by direct contact with nasal and throat secretions or faeces of the infected person. The virus can also be transmitted by aerosol spread such as:

- Coughing and sneezing.
- Hands contaminated from secretions which, if not washed thoroughly may transmit infection.

What is the treatment?

There is no specific treatment for the infection.
The illness is mild and usually clears up by itself in seven to ten days. To help with the symptoms:

- Keep the child cool
- Encourage fluids to prevent dehydration (but avoid acidic drinks like fruit juice)
- Encourage soft foods like ice cream, yoghurt may or soup.
- Give Paracetamol at the dose recommended for the child's age on the box or by the pharmacist. Aspirin must not be given to children under 16 years old.

How can spread be prevented?

There is no requirement to exclude children with Hand, Foot and Mouth Disease if they are well enough to attend. A good standard of hand, personal and food hygiene should be maintained and care when handling articles contaminated with respiratory secretions or faeces, such as tissues, nappies etc. should be encouraged. Hands should be washed after contact with any of the above. These are measures which should be encouraged at all times to prevent this and many other infections.

There is a slight risk to pregnant women and they may wish to avoid close contact with a child during the course of their work activities. Pregnant women who develop any symptoms of rashes during pregnancy should seek advice from their general practitioner or midwife. This is a self-limiting illness and there are no effective treatments for this virus. Treating the symptoms will help and the illness will run its course. Should the person develop the rare additional symptoms of high fever, headache, stiff neck, or back pain or other complications then they need to see a doctor urgently.

More information on Hand, Foot and Mouth Disease can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Head Lice

What are head lice?

Head lice are parasitic insects that only live on human heads. There are three forms of head lice**:**

- **Nits** are head lice eggs. The oval, yellowy white eggs are hard to see and may be confused with dandruff. They attach themselves to the hair shaft and take about a week to hatch. The eggs remain after hatching and many nits are empty egg cases.
- **Nymphs** hatch from the nits. The baby lice look like the adults, but are smaller. They take about 7 days to mature to adults and feed on blood to survive.
- **Adults** are about the size of a sesame seed. They have six legs and are tan to greyish-white. The legs have hook-like claws to hold onto the hair with. Adults can live up to 30 days and feed on blood.

Who catches head lice?

Anyone can catch head lice but preschool children, primary school children and their families are most at risk.

How do you catch head lice?

- Head lice are transmitted through direct, prolonged head-to-head contact so tend to be more commonly seen in children because of play. Sport and transmission through close contacts at home are also common routes for spread.
- Transmission is possible through infected clothes, combs, brushes or towels, but extremely unlikely. The lifespan of a louse is very short once detached from the hair so fumigation is not necessary.
- Head lice cannot jump, hop or swim.
- Head lice are not associated with poor hygiene, are not selective and do not have a preference for clean or dirty hair.

Is it infectious?

The rate of transmission is low.

How serious are head lice?

Head lice are not a serious health problem. Head lice rarely cause anything more than an itchy scalp.

How can spread be prevented?

- Exclusion is not required for head lice.
- Letters and notifications to parents generally do not reduce the risk of transmission and may provoke anxiety so need to be considered with caution.
- Regular head checks by parents and good hair care may help identify head lice early.

What is the treatment?

A diagnosis of head lice can only be made if live lice are seen.

Wet combing method:

- Wash the hair in the normal way, with an ordinary shampoo
- Using lots of conditioner, and while the hair is very wet, comb through the hair from the roots to the ends with a fine-toothed detector comb. Make sure the teeth of the comb slot into the hair at the roots of every stroke
- Clear the comb of lice between each stroke
- Repeat this routine every 3 days for 2 weeks so that any lice emerging from eggs are removed before they mature and spread
- Household contacts of individuals with head lice should also be checked and treated if they are found to have head lice too.

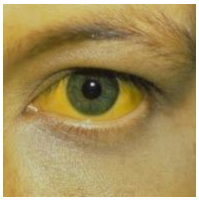
Using lotions:

- Only those with live lice should be treated.
- Dimeticone (a silicone oil), Malathion or Permethrin (insecticides) are recommended treatments which can be bought from the chemist or obtained on prescription.
- It is important that the instructions on the bottle are followed very carefully and that all the family and close contacts are checked and treated if necessary.
- Asthmatics, those with skin problems such as eczema, pregnant women, breast feeding mothers and children under 6 months should be treated under medical supervision.

Treatment should be started as soon as possible on the day of diagnosis but the child does not have to be sent home from school.

More information on Head Lice can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Hepatitis or Jaundice



What is hepatitis?

The word *hepatitis* simply means an inflammation of the liver and can be caused by numerous different things (including viruses, medications and excessive alcohol etc.). Only hepatitis caused by viruses are infectious but if unsure, contact the health protection team for further advice.

Hepatitis A

Hepatitis A (also called infectious hepatitis) is a common form of hepatitis in children. It's caused by the hepatitis A virus (HAV), found in the stool (faeces/poo) of infected people.

What are the symptoms?

- Loss of appetite
- Feeling ‘off colour’
- Some children may become jaundiced, others do not
- Children are often asymptomatic

Hepatitis A can remain in the stool for three - ten months after the initial illness, especially in younger babies and children.

Is it infectious?

Yes. Hepatitis A is spread usually by the faecal-oral route from infected people, most commonly when food and hands are contaminated. As some children may not have symptoms at all, they may readily spread the infection to others unless good hygiene measures are routinely taken.

How can spread be prevented?

- Ensure good hand washing (particularly before handling food and after using the toilet)
- Clean ‘high contact’ and high risk areas such as toilet and kitchen areas, door handles, light switches etc. regularly
- Contact the health protection team for further advice

Individuals with Hepatitis A must be excluded from school while unwell and until seven days after the onset of jaundice (or onset of symptoms if no jaundice). Children under five years old or who are unable to maintain their own hygiene needs must also be

excluded and you should contact the health protection team for further advice regarding when the child would be able to return to school

Household contacts of individuals with Hepatitis A may occasionally require exclusion from school. Contact the health protection team for further advice.

Hepatitis B and C

Known as blood borne viruses, (Hepatitis B is also sexually transmitted), Hepatitis B and C are not common infections in children in the UK. From autumn 2017, Hepatitis B vaccination is part of the UK routine childhood immunisation schedule for children born after 1 August 2017. Children born before August 2017 and staff considered to be at particular risk may also require the Hepatitis B vaccination.

Children considered to be at increased risk include:

- Children born in high prevalence countries
- Children with parents or grandparents born in high prevalence countries
- Children who are part of communities with links to high prevalence countries or risk practices

How can spread be prevented?

Spread is by contact with infected blood and body fluids entering the bloodstream through broken skin or the mucous membranes. Hepatitis B may also be spread through sexual contact.

It is important to understand that an individual's diagnosis may not always be known so all blood and body fluid spills should be considered potentially infectious and spills should be cleared using personal protective equipment (e.g. gloves and aprons) and using spill kits (see section on managing body fluid spills). As long as simple generic infection control measures are in place at all times, the risk of any potential spread will be reduced

- Ensure thorough hand washing of all children and staff after using the toilet, assisting others with personal hygiene and before eating
- Ensure personal hygiene items such as toothbrushes, nail cutters, razor and nail scissors are not shared
- Ensure that any spillage of body fluid is dealt with using disposable gloves and that hands are washed after their removal
- Ensure the school has appropriate sanitary item disposal containers and contracts in place.

Individuals with acute (recent infection with) Hepatitis B may be too unwell to attend school but there is no reason to exclude anyone with Hepatitis B or C if they are well enough. Similarly there should be no restriction to their activities while at school but contact the health protection team if any further advice is required.

Reducing the risk of spread in school

Contaminated injecting paraphernalia are known to be a significant source of hepatitis C infection in the UK. Schools should be aware of their local demographics and the need to adopt drug awareness programs, explaining the dangers of drug use to children frankly and often. Education regarding safe sex for teens is also important to protect them from hepatitis infection (and other sexually transmitted infections) through sexual contact.

Hepatitis B vaccination is recommended for staff of childcare facilities or schools where they may be at risk of exposure e.g. biting, scratching.

More information on Hepatitis A, B and C can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Impetigo



Impetigo is a common and highly contagious skin infection that causes sores and blisters. It's not usually serious and often improves within a week of treatment. It is quite common in young children aged four years or under, but it can affect any age group. Outbreaks can occur in nurseries and schools. The infection is more common in the summer months.

What causes impetigo?

Impetigo is caused by bacteria infecting the outer layers of skin.
The bacteria can infect the skin in two main ways:

- Through a break in otherwise healthy skin, such as a cut, insect bite or other injury
- Through skin damaged as a complication of another underlying skin condition, such as scabies or eczema

Once someone is infected with the bacteria, the infection can be spread easily through close contact such as through direct physical contact, by sharing towels or flannels.

The infection can occur anywhere on the body but lesions are most often seen on the face, flexures and limbs not covered by clothing. At first small blisters develop which then burst to leave a small scabby patch of skin. These crusted lesions are often yellow in colour, can be itchy and spread in small clusters to surrounding skin.

Is it infectious?

Yes. Impetigo is highly infectious whilst the sores are discharging pus. It is spread by direct contact with the lesions and pus. Impetigo can affect people of any age, but it tends to affect children more often than adults.

How can spread be prevented?

Infection is most commonly spread by contaminated hands, but contaminated toys, clothing, equipment and other inanimate objects can also occur. The risk of spread can be reduced by ensuring;

- Good hand hygiene
- Avoiding touching lesions, discharge or wounds
- That items such as towels and facecloths are not shared

- That good cleaning standards are maintained and additional consideration is given to potentially contaminated items such as toys, play equipment and 'high contact' areas like light switches etc.
- Contacting the Health protection team for any further advice.

Affected individuals should be excluded from school until lesions are crusted over or 48 hours after antibiotic treatment has been started.

How impetigo is treated?

This is not an emergency but parents should be encouraged to should seek medical advice for their child. The doctor will probably prescribe a course of antibiotics which may be oral medication or a topical cream to apply to the affected areas depending on the severity of the infection. A swab may also be taken, particularly if the lesions do not respond to treatment. Impetigo usually gets better without treatment in around two to three weeks, but treatment is often recommended because it can reduce the length of the illness to around seven to ten days and can lower the risk of the infection being spread to others.

Potential complications

Impetigo is rarely serious, but in some cases the infection can spread to other areas of the body and cause problems such as cellulitis and scarlet fever.
In very rare cases, impetigo may lead to some scarring, particularly if the affected individual scratches at the blisters, crusts or sores.

More information on Impetigo can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Infectious Diarrhoea and Vomiting (Gastroenteritis)



This may be due to a number of causes including:

Bacteria	Campylobacter Salmonella Shigella (bacillary dysentery) E. coli 0157
Viruses	Rotavirus Small round structured viruses (e.g. Norwalk or Winter Vomiting Disease)
Parasites	Cryptosporidium Giardia

Is it Infectious?

Yes. Diarrhoea and vomiting can have many different causes (including medical conditions, side effects of medications, excessive alcohol etc.) but the cause should be assumed to be an infection until known otherwise. An infection in the gut causing diarrhoea and vomiting (gastroenteritis) can be easily passed to others. Anyone with gastroenteritis should be regarded as very infectious and must be kept away from school until the diarrhoea and vomiting has stopped and they have been passing normal stools for at least 48 hours. If the cause is identified as anything other than Norovirus, the school should contact the health protection team for further advice regarding any further action and exclusion.

What is Norovirus?

Norovirus is the most common cause if infectious diarrhoea and vomiting in the UK and is extremely infectious. Each year, it is estimated that between 600,000 and 1 million people in the UK catch norovirus. The illness is sometimes called the "winter vomiting bug" because it is more common in winter however it is possible to catch the virus at any time of the year.

There are at least 25 different strains of noroviruses known to affect humans. There is no specific treatment for norovirus so symptoms should be treated as needed. Norovirus symptoms usually do not last more than a couple of days but individuals can feel extremely unwell during this period.

If symptoms start at school:

- Isolate away from other students
- Ensure that a dedicated toilet is nearby and should only be used by symptomatic students / staff
- All lever/light switches, handles and other 'high contact' items must be cleaned regularly with detergent and water and then disinfected with a hypochlorite solution. Bathrooms should also be thoroughly cleaned as above.
- Send any symptomatic individuals home as soon as possible.
- Siblings who are asymptomatic can remain in school
- Contact the health protection team for further advice and guidance

What are the symptoms?

- Vomiting
- Diarrhoea and/or abdominal pain
- Fever
- Headache

The symptoms may occur singly or in combination. Dependant on the cause, the illness usually lasts only a short time and may require no specific treatment, however parents should be encouraged to seek medical advice should blood be present in the faeces/diarrhoea, if symptoms persist or if a child appears particularly unwell.

How can spread be prevented?

Spread occurs when the organism enters the gut by the mouth or when contaminated hands or objects are put in the mouth (including contaminated food or drink). Spread can also occur after an affected individual vomits.

- Strict attention to personal hygiene is important to reduce the spread of the disease. Good hand hygiene after going to the toilet, changing an affected nappy and before eating food is essential.
- Hands should be washed with running water and liquid soap then dried with paper towels. Hand sanitiser (e.g. alcohol gel) can be used in addition to hand washing but should not replace it in this situation.
- Designated bathroom facilities should be identified for exclusive use of any symptomatic individuals.
- Toilets should be cleaned after use with a 0.1 % (1000ppm) hypochlorite solution.
- Additional environmental cleaning should be implemented which includes 'high contact' areas such as door handles, flush handle, light switches and under the rim of the toilet seat. Consideration must be given to the age of the children affected (small children will hold onto a different parts of the toilet and doors than an adult)
- Pets or farm animals may be a source (see guidelines on Farm and Country Visits).
- Ensure hands are washed after handling animals, animal feed or bedding, taking off outdoor footwear, playing in the garden or in the playground.

What is an outbreak?

An outbreak is defined as two or more linked cases with similar symptoms over and above that which would normally be expected**.** The school should contact the health protection team as soon as they suspect an outbreak to discuss the situation, obtain an integrated care pathway and discuss any actions required.
A checklist for managing diarrhoea and vomiting outbreaks can be found in appendix three of the Health protection in schools and other childcare facilities guidance.

The health protection team will give advice on:

- Infection prevention and control
- Cleaning /disinfection
- Exclusion
- Obtaining samples of faeces / vomit from affected students and staff

An outbreak committee may be convened if necessary with representation from school staff to advise on the investigation and control of illness.

Boarding Schools

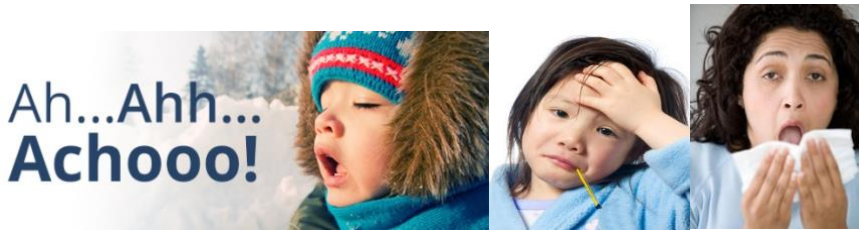
Boarding schools must ensure that symptomatic students are sent home or go to stay with their guardians. Staying in the boarding houses may infect other students and staff. The health protection team can provide further advice and guidance..

Further infection control precautions will be addressed at the time of an incident. It is important that the school:

- Isolate symptomatic students until they can be sent home (potentially in the medical centre or cohort in a separate dormitory from other students))
- Identify a dedicated bathroom to be used only by those who are symptomatic
- Wash any soiled laundry or clothes separately on a wash that is stated by the wash label
- Ensure appropriate personal protective equipment such as gloves and aprons are worn when any personal care is given or cleaning is undertaken.
- Ensure good hand hygiene is undertaken
- Considers access to handwashing facilities near the dining room as hands should be cleaned before a meal. If handwashing facilities are not available, an alternative may be wall mounted hand gels at every entrance. This may have to be attended by staff members when introduced, but as a ‘duty of care’ it is important for this to become a part of partaking of a meal. The health protection team can provide advice if required.

More information on Gastroenteritis can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Influenza



What is influenza?

Influenza (commonly known as flu) is a viral respiratory illness caused by infection with a virus (usually influenza A or B). Influenza is usually more severe than a simple cold (although the illness can be mild in some cases).More severe illness is associated with the elderly, very young and those with other chronic medical conditions like chest or heart disease and diabetes but can occur in people who are fit and well of any age group.

What are the symptoms of influenza?

The most common symptoms of influenza are an abrupt onset of:

- Fever
- Shivering
- Headache
- Sore throat
- Muscle ache
- Dry cough
- Lethargy

People can confuse uncomplicated mild influenza with a heavy cold. Unfortunately some people call even a simple cold ‘a touch of flu’ which is incorrect as they are caused by different viruses.

How serious is influenza?

- Most people recover completely from influenza in a matter of days or a week. For others (e.g. the elderly, those with other illnesses (such as chest or heart disease, or diabetes) and newborn babies), influenza can be a very serious illness or even fatal.
- Serious illness from influenza is usually not due to the flu itself, but to secondary bacterial infections causing lung infections (bronchitis and pneumonia) or to a worsening of underlying chronic medical condition such as heart disease.

What are the symptoms of the common cold and how do they differ from simple (uncomplicated) influenza?

Cold symptoms are limited to the nose and throat with runny nose, sneezing, watery eyes, throat irritation and headache. The symptoms usually occur gradually and only rarely cause a high fever or body aches. In those with chronic respiratory conditions e.g. people with asthma, a cold can make those conditions worse for a few days.

Symptom	Common Cold	Influenza with symptoms
Fever	Uncommon and then low (under 38°)	Common and often a high fever (over 38°)
Aching muscles – body	Rare	Common
General malaise and lack of energy	Rare	Common
Headache	Common	Common
Running nose	Almost always	Common but a minor feature
Sneezing	Almost always	Common but a minor feature
Watery eyes	Common	A minor feature
Throat irritation	Almost always	A minor feature
Coughing	Common	Common

What type of viruses cause influenza?

There are three main types of influenza virus known as A, B and C. Only influenza types A and B are important in human disease. Influenza B usually produces less severe illness than Influenza A.

Is it infectious?

Influenza is very infectious and spreads easily in crowded or enclosed spaces. The virus changes regularly so the strain will vary each year, resulting in the need for annual vaccination. On average, an infectious person will infect another one to two non-immune people.

What is the incubation period?

Usually about two to three days (but can be from one to seven days).

What is the treatment?

- Most people with influenza need no special treatment. Influenza is caused by a virus so antibiotics do not help unless there is a complication. Occasionally, a special 'antiviral' medicine may be given
- Affected individuals should be excluded from school while feeling ill (until at least 24 hours after the resolution of any fever) as this also reduces the chance of spreading the infection to others.
- Affected individuals should rest and drink lots of fluids to prevent dehydration.
- Paracetamol can be given to reduce the fever but aspirin must not be given to children.
- Parents should be advised to seek medical advice if an individual appears particularly unwell or has other medical conditions.

When is a person with influenza infectious to others?

- The infectious period varies slightly from person to person and depending on the current strain but in an adult, they can pass on the infection from the day before their symptoms appear and remain potentially infectious for three - four days.
- Children are similar but they can remain infectious for up to seven days after onset.

The risk to others is not constant throughout and may vary according to individual factors.

How can spread be prevented?

Influenza is spread in two main ways:

- By people breathing in the larger droplets coming from infectious people coughing or sneezing. If the infected person doesn't cover his or her mouth and nose, people within a range of three meters can be infected. Smaller droplets and 'aerosols' seem to be less liable to carry the virus. Because only the larger droplets are infectious it is generally only people close to an infectious person who are at risk.
- Influenza infection can also be spread by direct contact of the mucous membranes of the nose, mouth and throat with virus, for example from the hands of infectious people who have rubbed their noses.

Spread can be prevented by;

- Encouraging individuals who are eligible to have the influenza vaccine. In 2017, all children from two to eight years old (including those in reception to year group four) are eligible to receive the vaccine. This programme will include more year groups in the future so schools should liaise with their relevant school health team (or health protection team) if further information is required. Individuals falling into the risk categories listed below are also eligible for

influenza vaccinations and should be encouraged to receive it. Staff and children aged six months to 65 years with:

- Chronic lung disease
- Chronic heart disease
- Chronic kidney disease
- Chronic liver disease
- Chronic neurological disease (including learning disabilities)
- Immuno-suppression (whether caused by disease or treatment)
- Diabetes mellitus
- Pregnant women
- Staff aged 65 years and older
- Obese people with a BMI > 40

- Individuals with symptoms should be excluded from school until they have recovered and for at least 24 hours after the resolution of any fever.
- Good respiratory hygiene should be encouraged (covering noses and mouths with disposable tissues when coughing or sneezing and discarding it after use).
- Good hand hygiene should also be encouraged (after using the toilet and before eating as per usual but also after coughing, sneezing or assisting others with respiratory hygiene).
- Additional environmental cleaning should be implemented which includes 'high contact' areas such as door handles, flush handle, light switches

This should all be routine practice whether or not there is an outbreak.

What is an outbreak?

An outbreak is defined as two or more linked cases with similar symptoms over and above that which would normally be expected**.** The school should contact the health protection team as soon as they suspect an outbreak to discuss the situation, obtain an integrated care pathway and discuss any actions required.

The health protection team will give advice on:

- Infection prevention and control
- Cleaning and disinfection
- Exclusion
- Taking swabs (nose/throat) from affected individuals

An outbreak committee may be convened if necessary with representation from school staff to advice on the investigation and control of illness.

Boarding Schools

Boarding schools must ensure that symptomatic students are sent home or go to stay with their guardians. Staying in the boarding houses may infect other students and staff. The health protection team can provide further advice and guidance.

Further infection control precautions will be addressed at the time of an incident. It is important that the school:

- Isolate symptomatic students until they can be sent home (potentially in the medical centre or cohort in a separate dormitory from other students))
- Ensure good hand and respiratory measures are maintained during the outbreak

During an outbreak the health protection team will contact the school regularly to monitor the situation and collect information about new cases to ensure appropriate interventions are implemented. Schools should ensure that the ‘Record of cases’ table in the integrated care pathway is updated daily and is easily available to discuss with the health protection team when required.

More information on Influenza can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Measles



What is Measles?

Measles is a highly infectious viral illness that can be very unpleasant and can sometimes lead to serious complications. The success of the MMR vaccine means that cases of measles are uncommon in the UK. However, the number of cases has risen in recent years and there have been some high-profile outbreaks (e.g. between November 2012 and July 2013 a measles outbreak in the Swansea area led to over 1,200 reported cases).

Is the MMR Vaccine safe?

It is thought that the rise in the number of cases of measles is due to a reduced uptake of the MMR vaccine following speculation linking the vaccine to autism in 1998. Numerous studies were subsequently undertaken which found no link between the MMR vaccine and autism.

What are the symptoms?

The initial symptoms of measles usually appear around ten days after infection and disappear about seven -ten days later.

The initial symptoms can include:

- Cold-like symptoms (such as a runny nose, watery eyes, swollen eyelids and sneezing)
- Conjunctivitis or red eyes and sensitivity to light
- High temperature (fever), which may peak at around 40°C (104°F)
- Tiredness, irritability and a general lack of energy,
- Lack of appetite
- Aches and pains
- Dry harsh cough
- Small white spots (Koplick spots) may be seen inside the mouth. These can persist for several days.
- Diarrhoea and/or vomiting are common.
- A red blotchy rash normally develops about three -four days after the first symptoms. It usually starts on the head and neck, spreading down the body. The rash often turns a brownish colour and gradually fades over a few days.
- Children are initially usually quite unwell and miserable for three - five days until the fever settles and the rash fades.

Most children are better within seven - ten days. An irritating cough may persist for several days after other symptoms have gone.

Is it infectious?

Yes. Measles is extremely infectious.

What is the incubation?

The incubation period is about ten days (ranging between seven and 18 days).

How is measles diagnosed?

Diagnosis can be challenging as measles is rare in the UK so many GPs have not seen a case. The doctor may diagnose measles from the combination of symptoms, particularly the characteristic rash and Koplick spots. They should also discuss their findings with a member of the health protection team who be will able to advise on the prevalence of measles in that area at the time of symptoms. An oral fluid test is also usually requested to confirm the diagnosis.

What is the treatment for measles?

There is no specific medicine that kills the measles virus. Treatment aims to ease symptoms until the body's immune system clears the infection. For most cases, rest and simple measures to reduce a fever are all that are needed for a full recovery.

The following measures are often useful:

- Children should drink as much as possible to prevent dehydration.
- The child should be kept cool (but not cold). Ice-lollies are a useful way of giving extra fluid and keeping cool.
- Paracetamol or ibuprofen can be taken to ease fever and aches and pains (aspirin should not be given to children).
- Gently clean away any crustiness from the eyelids and lashes using cotton wool soaked in water.
- Close curtains or dim lights to help reduce any light sensitivity.
- Antibiotics do not kill the measles virus and so are not normally given. They may be prescribed if a complication develops, such as a secondary bacterial ear infection or secondary bacterial pneumonia.
- Cough remedies have little benefit on any cough but may sooth an irritated throat.

Are there any complications?

The main serious complications to look out for are:

- Drowsiness.
- Dehydration. This may be developing if the child drinks little, passes little urine, has a dry mouth and tongue or becomes drowsy.
- Breathing difficulties.
- Convulsion (fit).

The individual will need to go to their nearest accident and emergency (A&E) department if they develop any of these symptoms. The A&E department should be notified before or on arrival that the child has a rash and measles is suspected.

How can spread be prevented?

An individual with measles will be infectious from four days before onset of their rash until four days after so should be excluded as soon as measles is suspected until five days after the onset of rash.

Encourage parents to seek medical advice (ringing the healthcare provider before arrival to advise them that their child has a rash).

Contact the health protection team as soon as any measles cases are notified to the school. If there are any individuals in the school who may have been in contact with the individual and are pregnant, unimmunised or have weakened immune systems, advise them to contact their GP immediately and notify the health protection team as soon as possible.

Encourage all children over the age of one to have MMR vaccination and ensure all staff date are up to date. If staff are unsure of their vaccination status they can ask their Practice Nurse.

More information on measles can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Meningitis and Septicaemia



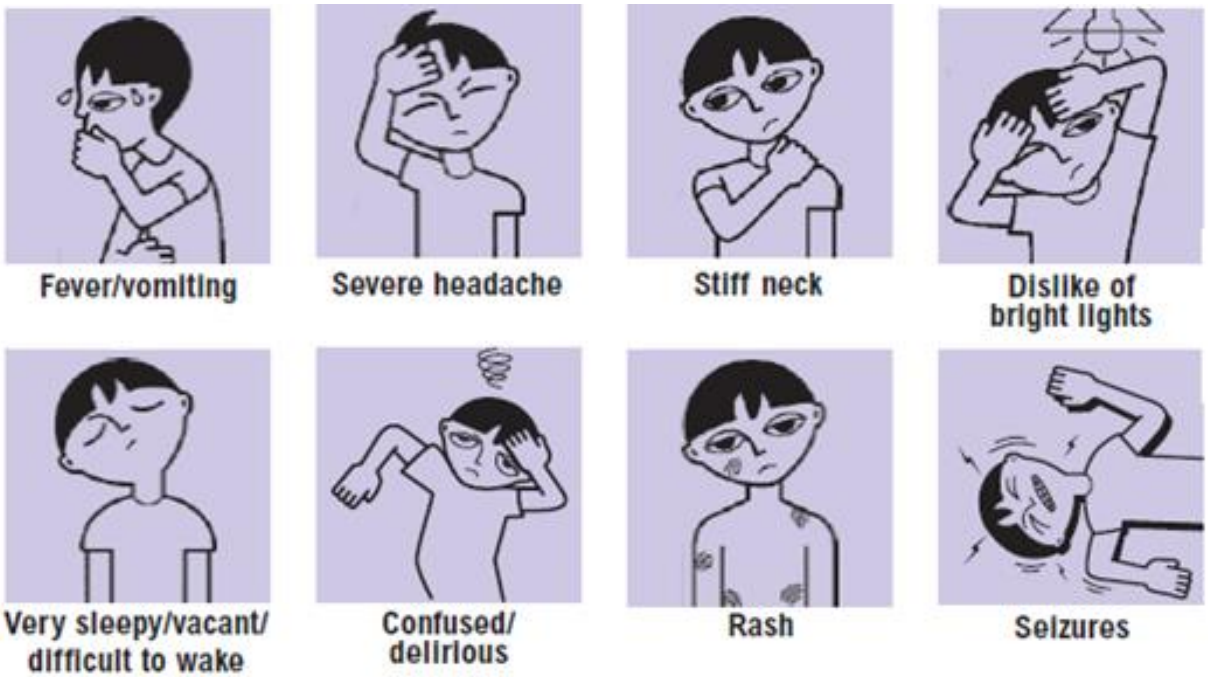
What are meningitis and septicaemia?

There are many different causes of meningitis but the two most common organisms are viruses and bacteria.

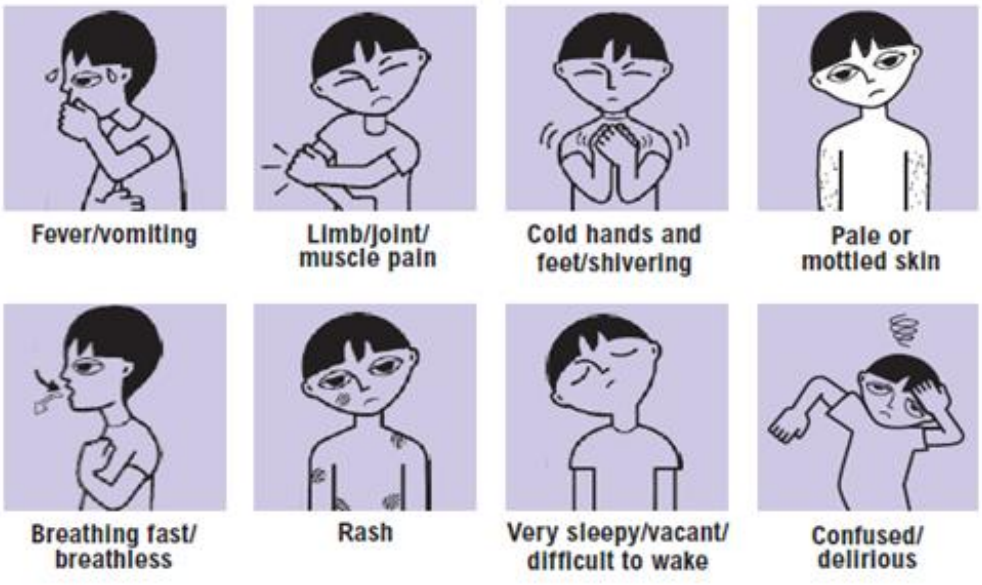
- Viral meningitis is usually a mild disease but it can make people very unwell. Many thousands of cases occur each year, mostly affecting babies and children. Although most people will make a full recovery some are left with serious and debilitating after-effects.
- Bacterial meningitis can be life-threatening and needs urgent medical attention. Most people who suffer from bacterial meningitis recover but many can be left with a variety of after-effects. Meningococcal disease is a serious bacterial infection which causes meningitis and septicaemia.

Meningitis means swelling of the lining around the brain and spinal cord. In some cases, bacterial meningitis can lead to septicaemia (blood poisoning). Meningitis and septicaemia are caused by many different organisms but the meningococcal bacteria is the most common serious kind. Meningococcal disease is very dangerous and can come on very quickly.

What are the signs and symptoms of meningitis?



What are the signs and symptoms of septicaemia?



What is the treatment?

- Antibiotics are used to treat bacterial meningococcal disease
- The earlier the treatment, the better the prospect of recovery. Often GPs will give treatment even before the person is admitted to hospital.
- If meningitis or septicaemia is suspected, contact the doctor immediately. If the doctor is unavailable the affected individual should be taken to the nearest Accident and Emergency or Walk-In Department. Prompt action is vital.

How soon can an individual return to school after meningitis or septicaemia?

- Cases are followed up by the hospital consultant; and the decision will be made when they are fully recovered.
- There is no reason to exclude any siblings or other close contacts of the case from school.

Meningococcal Disease

What is the risk of spread?

Meningococcal disease is spread through respiratory droplets and direct contact with nose and throat secretions. Close prolonged contact is needed to pass the bacteria from one person to another.

- The risk of getting the disease is very low. Although meningococcal disease is infectious and can occasionally cause outbreaks, 97 out of every 100 cases have no known link to any other cases.
- The meningococcal bacteria is very common and at any time about one in ten individuals carry them harmlessly in their noses and throats.

- The bacteria are passed by close contact, so family members of a case and others who have close contacts (such as a boyfriend or girlfriend) in the previous seven days may be at slightly higher risk of being exposure to meningococcal and will be offered antibiotics.
- Close contact in residential accommodation such as student halls of residence or boarding schools can slightly increase the risk for the spread of infection.
- Preventive antibiotics in the school setting are usually are only recommended in the rare event of two cases occurring in the same school or playgroup within a short space of time.
- The bacteria cannot live longer than a few moments outside the human body, so they are not carried on items like clothes and bedding, toys or dishes, water supplies, swimming pools, or buildings.
- An individual being treated for meningococcal disease will usually no longer be infectious after 24 hours of appropriate antibiotic treatment.
- An individual with meningococcal disease will need immediate medical attention but once they have been treated, can return to school as soon as they are well enough.
- Exclusion is not necessary for any close contacts (unless they also have symptoms of meningococcal disease).

Is there an incubation period?

- Yes. Symptoms normally appear within two to seven days of picking up the bacteria.
- **Be aware - symptoms can develop within hours and immediate treatment is vital.**

Are there vaccines available to protect against meningococcal disease?

Effective vaccines are available to prevent some types of meningococcal disease as part of the UK Routine childhood immunisation schedule.

What does the rash look like?

Septicaemia occurs if the bacteria enter the bloodstream. A characteristic rash develops and may start as a cluster of pinprick blood spots under the skin, spreading to form bruises under the skin. The rash can appear anywhere on the body.

Do the glass test

Press the side of a clear glass to the skin. The spots/rash may fade at first but keep checking.

A rash that does not fade under pressure is a sign of meningococcal septicaemia. This is a MEDICAL EMERGENCY DIAL 999

- Do not wait for a rash. If someone is ill and getting worse, get medical help immediately
- On dark skin the spots/rash can be more difficult to see.

Bacterial meningitis (other than meningococcal disease)

There are several causes of bacterial meningitis other than meningococcal disease.

Haemophilus influenzae type b (Hib)

Hib bacteria can cause meningitis and septicaemia (blood poisoning). Before the vaccine was introduced in 1992, Hib was the leading cause of meningitis in children under 5 years of age, with around 800 cases and 25 deaths reported each year. Cases of Hib meningitis are now rare, with around 30 – 40 cases reported annually in the UK. Hib is part of the combined vaccine that also protects against diphtheria, tetanus, and pertussis (whooping cough) and polio. This combined vaccine is offered to children as part of the UK Routine childhood immunisation schedule.

Viral meningitis

Most people with viral meningitis will have mild flu-like symptoms, such as:

- Headaches
- Fever
- Generally not feeling very well

In more severe cases of viral meningitis, your symptoms may include:

- Neck stiffness
- Muscle or joint pain
- Nausea and vomiting
- Diarrhoea
- Sensitivity to light (photophobia)

Unlike bacterial meningitis, viral meningitis doesn't usually lead to septicaemia (blood poisoning).

Is there an incubation period?

- Yes. Symptoms normally appear within two to seven days of picking up the virus.
- **Be aware - symptoms can develop within hours.**

Action check list for all schools:

Single case of suspected Meningitis or septicaemia in a student or staff member	The school should contact the health protection team with details of the individual. The health protection team will contact microbiology and the medical team to obtain further information. The health protection team will then follow up with the school to discuss any further action required. If the diagnosis is likely to be meningococcal disease, the health protection team will: • Discuss composition of a letter of reassurance to parents / guardians to raise awareness of signs and symptoms • Discuss the rational for antibiotic prophylaxis for close household contacts and why school contacts are unlikely to receive prophylaxis

Two or more students or staff members with suspected meningitis is or septicaemia	Further public health action may be required when two or more individuals who are linked at the school have confirmed or probable meningococcal disease within a short period of time (usually four weeks). The health protection team will: • Establish an outbreak team including school staff members, school nurse and public health professionals • Discuss the need for antibiotics within the school and to a defined close contact group within the establishment (e.g. dormitory contacts, classroom contacts, children who share common social activities and/or close friends). • Discuss composition of a letter of reassurance to parents / guardians to raise awareness of signs and symptoms. • Lead on any media messages or involvement. In the event of an two or more cases the health protection team will liaise with: • Microbiology • GPs • Local Director of Public Health and their team within the local authority

If staff or students have a general question about meningitis, septicaemia or require support, there are two charities available (9am – 5pm Monday – Friday).

- Meningitis Now: 0808 80 10 388, helpline@meningitisnow.org or https://www.meningitisnow.org/

- Meningitis Research Foundation: 080 8800 3344 or https://www.meningitis.org/

More information on Meningitis and Septicaemia can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Molluscum Contagiosum

What is Molluscum Contagiosum?

Molluscum contagiosum is an infectious skin disease transmitted from person-to-person. It is caused by the molluscum contagiosum virus, a member of the poxvirus family. Infection leads to the formation of small flat circular skin lesions, which may be flesh coloured, white, translucent or yellow. The lesions may appear anywhere on the body except the palms and soles and will not normally cause discomfort. In general, school age children and teenagers tend to experience lesions on the face, trunk, hands and feet whilst adults tend to have lesions on the lower trunk, genitalia and inner thighs.

How can spread be prevented?

- Avoid direct contact with a lesion (in adults this is often sexual contact)
- Ensure the individual has their own towels and clothing.
- Ensure contaminated items such as clothing and toys are cleaned appropriately.

How is it diagnosed?

A doctor will make the diagnosis after seeing a typical lesion. If there is doubt the lesion may be excised or sampled and examined at a laboratory. Laboratory confirmation of Molluscum contagiosum virus infection by Public Health England is made by electron microscopy.

Prevention and treatment

Infection with molluscum contagiosum virus can be prevented by avoiding direct contact with lesions or objects that may have come into contact with the lesions.

- Infected patients should be careful not to share towels with others in a household
- Keep the lesion(s) covered when taking part in P.E. or other communal sporting activities
- Scratching should be avoided as this will;
    - Enlarge the site of infection and consequently the number of lesions suffered by the patient
    - Increase the likelihood of spread of the virus to others
    - Increase the likelihood of secondary, bacterial infection of the lesion
    - Increase the likelihood of scarring.

How long will the lesions last?

In patients with a normal immune system, the lesions will resolve over time without any treatment (usually six months but possibly up to two years). The lesions will usually leave no

scarring unless they have been excessively scratched and/or bacterially infected. Some doctors may recommend piercing the spots and application of iodine. It is also possible to cauterise lesions.

Should children stay away from School?

There is no need to stay away from school, it is a self-limiting condition.

Mumps


Mumps is an infection caused by a type of virus called a paramyxovirus. It is very contagious and spread in saliva, the same way as a cold or flu. This means it can be caught from an infected person coughing, sneezing, etc. It can also be caught from touching infected objects - for example, door handles.

Mumps infection is less common since the introduction of the measles, mumps and rubella (MMR) vaccine in the UK. Mumps infection is now most common in children who have not received the vaccine.

It is very unusual for children under one year to have mumps.

What are the usual symptoms of mumps?

- Swelling and pain of one or both parotid glands are the usual main symptoms. The parotid glands are the main salivary glands. They are just below the ears and cannot normally be seen or felt when well. The salivary glands make saliva which drains into the mouth.
- The mouth may feel dry.
- Chewing and swallowing may be sore.
- Fever (high temperature); headache, feeling tired and being off food may develop for a few days. These symptoms may occur before parotid gland swelling occurs.
- Mild abdominal (tummy) pain may occur.
- Some individuals may have no symptoms at all,

The swelling of the parotid glands usually lasts for 4-8 days. Mumps is normally a mild illness, but complications sometimes occur so vaccination is included as part of the UK Routine childhood immunisation schedule.

The immune system makes antibodies during the infection. These clear the virus and then provide lifelong immunity. It is therefore very rare to have more than one episode of mumps.

How is mumps diagnosed?

A doctor will usually diagnose mumps based on symptoms and the type of glands that are swollen. A saliva swab may also be taken and sent to the laboratory to confirm the diagnosis.

What is the treatment for mumps?

There is no medicine that kills the mumps virus. Most people start to feel better after about one week with no long-term problems.

Treatment aims to ease symptoms until the body's immune system clears the virus.

- Paracetamol or ibuprofen can ease fever and pain. Aspirin should not be given to children
- Give children lots to drink, particularly if they have a fever. Fruit juice may stimulate the parotid gland to make more saliva, causing more pain so water is best if this occurs.

Are there any complications of mumps?

Complications in young children are rare. Teenagers and adults are more likely to develop complications, which may include one (or more), of the following:

- Approximately 25% of males with mumps over the age of 12 years will develop a painful swollen testis and occasionally both are affected. In very rare cases this may cause infertility.
- Hearing loss can sometimes occur in people with mumps. This is usually only transient and improves with time. Very rarely, mumps can cause permanent deafness.

How can spread be prevented?

Mumps is highly infectious and can be spread by droplets from the nose, throat and by saliva.

- Encourage staff and children to practice good hygiene at all times
- Individuals should be encouraged to have good respiratory hygiene (covering nose and mouth with a disposable tissue when coughing or sneezing, discarding it immediately afterwards and washing hands straight away).
- Regular hand washing should be encouraged (especially after coughing, sneezing, helping affected individuals with their respiratory hygiene, contact with potentially contaminated objects etc.).
- Exclude individuals with suspected mumps from school until five days after their glands have swollen.
- Advise parents to seek medical review.

Mumps immunisation

An effective vaccine to prevent mumps (the MMR vaccination) is available as part of the UK Routine childhood immunisation schedule. Vaccination is encouraged even if an individual has a history of suspected mumps as many other viruses cause similar symptoms so mis-diagnosis is a possibility. Mumps can be prevented in 95% of cases by having the routine MMR vaccination in childhood or later in life.

More information on mumps can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Parvovirus or Fifth Disease (slapped cheek)


What is slapped cheek syndrome?

This is a viral disease due to Parvovirus B19 (fifth disease syndrome) and is spread by respiratory droplets.

What are the symptoms?

Symptoms initially appear as:

- 'Flu-like' illness and then the
- Bright red 'slapped cheeks' rash appears followed by a reddish rash on the body. This rash may last for up to 3 weeks.
- A few children, but most adults, have mild joint pains.
- Headache
- Mild fever
- Sore throat
- Parvovirus is usually a mild illness.

Some individuals may have no symptoms at all

The illness is commonest in the four -ten year old age group and outbreaks are common in primary schools in the later winter through to early summer.

Who is usually affected with Parvovirus?

Slapped cheek syndrome usually affects children. Studies have shown that 60% of adults in the UK have antibodies to parvovirus B19 and following infection, immunity is thought to last for life.

What is the incubation period?

The incubation period is six -11 days.

How can spread be prevented?

Spread is by the respiratory route and a person is infectious three to five days before the rash occurs.

Exclusion is not required as an individual is no longer infectious once the rash appears.
It is difficult to avoid contact with people who have parvovirus B19 as they often have no symptoms during the infectious phase.
Request that parents notify the school of the diagnosis so that pregnant contacts can be informed.

Pregnancy and parvovirus

Advise any members of staff who may be pregnant that they will need to see their GP or midwife as soon as possible following exposure (even if they are well). There is no routine screening test for Slapped Cheek in pregnancy so their GP may do a blood test to check for antibodies to the virus from a current or previous infection.

More information on parvovirus can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Panton-Valentine Leukocidin (PVL)

What is PVL?

Staphylococcus aureus (*S. aureus*) is a bacterium that is a normal part of the skin flora (bacterium and fungi that live on healthy skin), particularly the moist surfaces of the body such as inside the nostrils, the armpits and in the groin area. There are different strains of staphylococcus aureus, some of which are more likely to cause infections than others. Strains that secrete a toxin called Panton-Valentine Leukocidin (PVL) are more likely to cause infections, particularly of the skin.

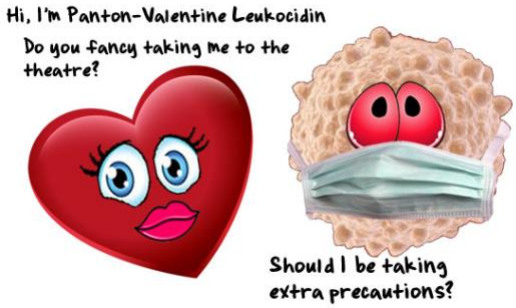
The number of cases of PVL producing *S. aureus* has been rising over the past few years but still remains relatively low. Almost all of the cases identified so far have been in normally fit healthy people, including children attending nurseries, schools and further education.

What are the symptoms?

Infections caused by PVL strains of *S. aureus* normally cause cellulitis (inflammation of layers under the skin) and pus-producing skin infections (e.g. abscesses, boils and carbuncles). They can on very rare occasions, lead to more severe invasive infections such as septic arthritis, blood poisoning or a severe form of pneumonia.

Why do people get PVL *S. aureus* infections?

Not all people with PVL *S. aureus* will suffer an infection. When these occur they are usually associated with the presence of other risk factors such as overcrowding, skin abrasions resulting from close contact sports such as wrestling or rugby or using contaminated articles such as sharing towels, razors, poor hand hygiene and damaged skin from other conditions such as eczema.



How can spread be prevented?

An individual with PVL *S. aureus* may require antibiotic treatment and household contacts will also usually need decolonisation (wash treatments to prevent any further spread in the household). The risk to other students, staff and the general public of becoming infected with PVL *S. aureus* is small.

- Exclusion is not required for Individuals provided they feel well, are able to maintain good hand hygiene and the infected skin is covered with a clean dry dressing which will stay dry and in place until the end of the school day.
- Individuals should not be at school if they have a boil that requires drainage or a newly discharging boil or abscess where the leakage cannot easily be contained.
- Individuals should not take part in contact sports or use communal gym equipment until their skin lesion has totally healed.
- Those with eczema or a more generalised skin condition should remain off school until treatment has been completed and/or discussed with local Health Protection Team.

Spread can be prevented through;

- Covering any open or weeping wounds
- Standard personal hygiene (regular showering/bathing)
- Regular changing of linen and underwear
- Avoiding sharing personal items (e.g. toothbrushes, face cloths, towels)
- In shared facilities (for instance, in gyms or halls of residence) it is good practice to use:
    - hand wash with liquid soap and use disposable towels
    - always place a towel on the bench/equipment before using
    - ensure the facilities are cleaned frequently and that there is good ventilation to the locker room and showers.

Contact the health protection team if any further advice is required or if there appears to be more than one case in the school.

Respiratory Syncytial Virus

Respiratory syncytial virus (RSV) is also referred to as Bronchiolitis. RSV is a very common virus and almost all children will have been infected by the time they are two years old. In older children and adults RSV may cause a cough or cold, but in young children it can cause bronchiolitis.

What are the symptoms?

Most children with bronchiolitis have mild symptoms and recover within two weeks but occasionally complications such as breathing difficulties can occur. The early symptoms of bronchiolitis tend to appear within a few days of becoming infected and are usually similar to those of a common cold, such as:

- Blocked or runny nose
- Cough
- Slightly high temperature (fever)

The symptoms usually get worse during the next few days before gradually improving. During this time the child may develop some of the following symptoms:

- A rasping and persistent dry cough
- Rapid or noisy breathing (wheezing)
- Brief pauses in their breathing
- Feeding less and having fewer wet nappies
- Vomiting after feeding
- Being irritable

Although most cases of RSV are not serious, these symptoms can be very worrying and parents should be advised to seek medical attention if they have any concerns.

Who is most at risk?

Bronchiolitis is very common in infants and is usually mild. However, there are several things that can increase chances of developing the condition. These include:

- Being born prematurely (before week 37 of pregnancy)
- Being under two months of age
- Having congenital heart disease (a birth defect that affects the heart)
- Having chronic lung disease of prematurity (when injury to the lungs causes long-term respiratory problems in premature babies)
- Being breastfed for less than two months or not at all
- Being exposed to smoke, for example if parents smoke

- Having brothers or sisters who attend school or nursery, as they are more likely to come into contact with a virus and pass it on

Is it infectious?

Yes, the virus is spread through the respiratory route by tiny droplets of liquid from the coughs or sneezes of someone who is infected. If the infected person doesn't cover his or her mouth and nose, people nearby can be infected. RSV can also be spread by direct contact of the mucous membranes of the nose, mouth and throat with virus, for example from the hands of infectious people who have rubbed their noses. RSV can survive on a surface for up to 24 hours so toys and other 'high contact' areas such as desks and chairs can also led to infection

An infected child can remain infectious for up to three weeks, even after the symptoms have gone.

How can spread be prevented?

RSV is very common and easily spread but the following measures can reduce the risk:

- Encourage good respiratory hygiene (covering noses and mouths with disposable tissues when coughing or sneezing and discarding it after use)
- Good hand hygiene should also be encouraged (after using the toilet and before eating as per usual but also after coughing, sneezing or assisting others with respiratory hygiene)
- Additional environmental cleaning should be implemented which includes 'high contact' areas such as door handles, flush handle, light switches
- Wash and dry eating utensils after use
- Wash or wipe toys and surfaces regularly
- Keep newborn babies away from people with colds or flu, particularly during the first two months of life or if they were born prematurely (before week 37 of pregnancy)
- Exclude any symptomatic individuals until they have recovered
- Encourage parents to seek medical review if their child is under 12 weeks old or has an underlying health problem, such as a congenital (present from birth) heart or lung condition. While it is unusual for children to need hospital treatment for RSV, the symptoms can get worse very quickly.

Call 999 for an ambulance if:

- The individual has severe breathing difficulties or exhaustion from trying to breathe
- The individual has a rapid breathing rate
- The individual is unarousable (unable to wake) or if roused, they do not stay awake
- The individual's breathing stops for a long period (more than 10 seconds at a time), or there are regular shorter pauses in breathing of 5-10 seconds

- The individual's skin begins to turn very pale or blue, or the inside of their lips and tongue are a blue colour (known as cyanosis).

Contact the health protection team if any further advice is required.

Ringworm


What is it?

Despite its name ringworm does not have anything to do with worms. It is a fungal infection of the skin, hair or nails and is also known as tinea. Ringworm often looks like a round, red or silvery patch of skin that may be scaly and itchy. It is caused by various types of fungi and infections are named after the parts of the body that are affected (namely, face, groin, foot, hand, scalp, beard and nail).

What are the symptoms?

The ring spreads outwards as it progresses. There may be one patch or several patches of ringworm and in more serious cases the skin may become raised and blistered.

Who is affected?

Ringworm is common. It's estimated that 10-20% of people will have a fungal skin infection at some point during their lifetime. People of all ages can be affected by ringworm, but children are particularly susceptible to it. Scalp ringworm (tinea capitis) is most common in children who have not reached puberty, particularly African-Caribbean children and those who live in urban areas. Body ringworm can affect anyone of any age, although groin infections are more common in young men.

Scalp ringworm

Scalp ringworm in children is becoming more common in the UK, particularly in urban areas. Until recently this was usually spread from infected animals but now spread between humans within families and in schools is more common. The symptoms of scalp ringworm include:

- Small patches of scaly skin on the scalp, which may be sore
- Brittle hair leading to patchy hair loss
- An itchy scalp

In more severe cases, symptoms can also include:

- Small, pus-filled sores on the scalp
- Crusting on the scalp which may spread to the face, neck and trunk

Body ringworm

The symptoms of body ringworm include:

- A ring-like rash with a prominent red margin and a central scaly area

In more severe cases:

- The rings may multiply, grow in size and merge together
- The rings may feel slightly raised to the touch and the skin under the rash may be itchy
- Blisters and pus-filled sores may form around the rings

Foot ringworm (athlete's foot)

The symptoms of foot ringworm (athlete's foot) include:

- An itchy, dry, red and flaky rash, usually in the spaces between the toes

In more severe cases:

- Cracked skin in the affected area
- Blisters, which may ooze or crust

Is it Infectious?

Yes, ringworm is highly contagious and can easily spread among people.

How can spread be prevented?

Spread is by direct skin to skin contact with an infected person or animal (and with athlete's foot, by indirect contact with contaminated surfaces).

The risk of spread can be reduced by

- Washing and drying feet well in cases of athlete's foot
- Ensuring anyone with ringworm of the feet wears sock and trainers and that feet are covered for physical education
- Avoiding direct skin contact with the rash
- Ensuring objects such as towels, hairbrushes and bedding are not shared.
- Avoid contact with any animals such as dogs and cats with ringworm.
- Exclusion is not required for individuals with athlete's foot. Individuals with skin and scalp ringworm can return to school once they have started treatment with anti-fungal agents.
- Advise parents to seek medical review, especially if their child has scalp ringworm as this type of ringworm is treated with antifungal tablets only available on prescription.

Individuals affected by ringworm can be advised of the following;

- In the case of a groin or foot infection, change underwear or socks daily as fungi can persist in flakes of skin
- Wash areas of skin affected by ringworm daily and dry thoroughly, paying particular attention to skin folds and the areas between the toes
- In the case of scalp infection, do not share combs, hairbrushes or hats
- Wash clothes, towels and bed linen frequently
- Wear loose-fitting clothes, preferably made of cotton or other natural materials

What is the treatment?

Ringworm is easily treated using:

- Antifungal creams
- Tablets
- Shampoo

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Contact the health protection team for guidance if more than two children have the same symptoms

More information on ringworm can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Rotavirus

What is Rotavirus?

Rotavirus infection is the most common cause of gastroenteritis (inflammation of the intestines) in children under five years of age worldwide. The inclusion of the rotavirus vaccine into the Routine childhood immunisation schedule for babies in 2013 has led to a decline in cases amongst infants in the UK.

What are the symptoms?

Symptoms include watery diarrhoea, usually with vomiting, fever and stomach cramps. Symptoms usually last from three to eight days. Adults may become infected but repeat infections are generally less severe than infections during childhood.

Who is at risk?

Infants and young children are most at risk of rotavirus disease as they can become severely dehydrated and may require hospitalisation.

Is it infectious?

Yes, rotavirus is highly infectious.

How can spread be prevented?

Rotavirus is highly contagious and is mainly transmitted by the faecal-oral route, although respiratory transmission may also occur.

- Staff and children should be encouraged to practice good hygiene at all times.
- Symptomatic individuals should be excluded from school until 48 hours after the symptoms have subsided.
- Send the child home as soon as symptoms develop and advise parents to seek medical advice.
- Staff should always use appropriate personal protective equipment when handling blood or body substances (see section on managing spills of body fluids).
- Parents should be encouraged to ensure their child's immunisations are up to date as rotavirus vaccination is available as part of the UK Routine childhood immunisation schedule.

More information on rotavirus can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Rubella (German measles)



What is rubella?

Rubella, also called German measles or 3-day measles, is a disease caused by the rubella virus. Rubella is generally a mild illness that does not result in long-term problems although it can cause congenital rubella syndrome if acquired during pregnancy (leading to damage to the baby including deafness, cataracts and brain damage).

Rubella vaccine is part of the UK Routine childhood immunisation schedule. The MMR vaccine protects 90% of immunised people from getting this disease. Rubella is now a very rare disease in school aged children and most commonly affects men in their 20s.

What causes rubella?

The rubella virus is most often spread through droplets of fluid from the mucous membranes of an infected person. These droplets can be spread by:

- Coughing, sneezing, talking
- Sharing food and drinks.
- Touching a surface contaminated with the droplets and then touching eyes, nose, or mouth before washing hands.
- Less commonly, the virus can be acquired through contact with infected blood if it gets on broken skin or on hands which are not then washed immediately.

What are the symptoms?

Symptoms of rubella include:

- Mild fever
- Swollen glands (especially behind the ear and at the back of the head),
- Skin rash that starts on the face and spreads to the neck, chest and the rest of the body.
- Older children and teenagers may have fever, eye pain, sore throat, and body aches. They may or may not develop a rash.
- Up to 50% of individuals with rubella may not develop any symptoms.

Is it infectious?

Yes, rubella is most contagious a few days before the rash develops until five to seven days after it appears. It can take between 14 and 21 days for an individual to develop symptoms after they have been infected with the virus.

How is it treated?

There is no specific treatment for rubella but symptoms can be managed as necessary. Paracetamol type analgesia can be given to children and adults for fever. Do not give aspirin to anyone younger than 16yrs because of the possible link to kidney problems

Can spread be prevented?

Spread is by the respiratory route so good respiratory hygiene should be practiced as standard in the school.

- Good respiratory hygiene should be encouraged (covering noses and mouths with disposable tissues when coughing or sneezing and discarding it after use).
- Good hand hygiene should also be encouraged (after using the toilet and before eating as per usual but also after coughing, sneezing or assisting others with respiratory hygiene).
- Individuals with rubella should be excluded from school as soon as symptoms develop until six days after the onset of the rash.
- Encourage all parents to ensure their children are up to date with their immunisations and that they have had two MMR vaccinations in line with the UK Routine childhood immunisation schedule. Staff who are unsure about their vaccination history can speak to their Practice Nurse.

Pregnancy and rubella

Advise any members of staff who may be pregnant that they will need to see their GP or midwife as soon as possible following exposure (even if they are well). Generally, rubella causes only mild illness with no long-term problems. However, if an individual is pregnant and become infected with the rubella virus, this can have serious effects on their baby's development.

More information on rubella can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Scabies

Scabies is a skin infection caused by a mite. It can be uncomfortable but is not a serious disease.

What are the symptoms?

The appearance of the rash varies but tiny pimples and nodules are characteristic. Secondary infection can occur if the rash has been scratched. The scabies mites are attracted to folded skin such as the webs of the fingers. Burrows may also be seen on the wrists, palms, elbows, genitalia and buttocks. Itching is the main symptoms, particularly when warm or at night.

How is it transmitted?

It is transmitted by skin to skin contact in a warm environment e.g. by children holding hands. The scabies mite does not survive for long outside the human body and cannot be picked up just from clothes.

How can spread be prevented?

Scabies is infectious so infected individuals should be excluded until after their first treatment has been completed. Affected individuals do need to seek medical review to as treatment is required. Lotions can be purchased from a chemist or obtained on prescription from the doctor.

- The whole family should be treated at the same time even if only one person has obvious scabies.
- If more than one child in a class has scabies and it appears that transmission may be taking place at school, then the health protection team should be notified as classmates may also require treatment.

More information on scabies can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Scarlet fever



What is Scarlet Fever?

Scarlet fever is a bacterial illness that causes a distinctive pink-red rash. Scarlet fever is also known as scarlatina, although this often refers to a milder form of the disease. It can follow a sore throat or a skin infection (impetigo) caused by particular strains of streptococcus bacteria.

What are the symptoms?

Symptoms of scarlet fever generally take two to five days to appear after infection.
The illness often starts with

- Sore throat
- Headache
- High temperature (fever)
- Swollen neck glands
- Loss of appetite
- Nausea or vomiting
- Red lines in the folds of the body, such as the armpit, which may last a couple of days after the rash has gone
- A white coating on the tongue, which peels a few days later leaving the tongue red and swollen (this is known as strawberry tongue)
- A general feeling of being unwell
- Rash developing 12 to 48 hours later
    - Red blotches are the first sign of the rash. These turn into a fine pink-red rash that feels like sandpaper to touch and looks like sunburn.
    - This usually starts in one place, but soon spreads to other parts of the body. It commonly affects the ears, neck, chest, elbows, and inner thighs and groin, and may be itchy. The rash does not normally spread to the face however, the cheeks become flushed and the area just around the mouth stays quite pale. The rash will turn white a glass is pressed against it.
    - The rash usually fades after about a week, but the outer layers of skin, usually on the hands and feet, may peel for several weeks afterwards.

In milder cases (scarlatina), the rash may be the only symptom.

Are there any complications?

Most cases of scarlet fever cause no complications especially if the condition is properly treated. In the early stages there is a small risk of:

- Ear infection
- Throat abscess (painful collection of pus)
- Sinusitis (inflammation of the sinuses)
- Pneumonia (inflammation of the lungs)
- Meningitis (inflammation of the membranes surrounding the brain and spinal cord

Is it Infectious?

Yes, scarlet fever is extremely contagious.

What is the incubation period?

Symptoms of scarlet fever usually develop two to five days after infection, although individuals will be contagious before showing signs of the illness.

What is the treatment?

Scarlet fever used to be a very serious disease but treatment with antibiotics means that most cases today are mild. With proper treatment, serious complications from scarlet fever are very unlikely however, there is a small risk of the infection spreading to other parts of the body such as the ear, sinuses and lungs. Most individuals with scarlet fever feel better after about a week even without treatment but as antibiotics reduce the length of time that an individual is contagious, speeds up recovery and reduces the risk of complications from scarlet fever, then treatment is still recommended.

The symptoms of scarlet fever may be relieved by:

- Drinking plenty of cool fluids or eating soft foods (if the individual has a sore throat)
- Taking paracetamol to bring down a high temperature
- Using calamine lotion or antihistamine tablets to relieve itching

How can spread be prevented?

Spread is by the respiratory route so good respiratory hygiene should be practiced as standard in the school.

- Good respiratory hygiene should be encouraged (covering noses and mouths with disposable tissues when coughing or sneezing and discarding it after use).
- Good hand hygiene should also be encouraged (after using the toilet and before eating as per usual but also after coughing, sneezing or assisting others with respiratory hygiene).
- Encourage parents to seek medical review and antibiotic treatment
- Individuals with scarlet fever should be excluded from school until they have been on a course of antibiotics for at least 24 hours. Individuals who do not take antibiotic treatment will be infectious for two to three weeks.

- Avoid sharing contaminated eating utensils, cups and glasses, clothes, baths, bed linen or towels.
- Avoid touching any open or weeping wounds (streptococcal skin infections such as impetigo are cause by the same bacteria as scarlet fever).
- Ensure the health protection team are notified if there is an outbreak or if chicken pox is circulating in the school at the same time.

Can individuals catch scarlet fever more than once?

It is possible to catch scarlet fever more than once, although this is rare.

More information on scarlet fever can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

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Threadworms



What are Threadworms?

Threadworms, also known as pinworms, are tiny parasitic worms that hatch eggs in and infect the large intestine of humans. Threadworms are the most common type of worm infection in the UK and they are particularly common in young children under the age of 10.

What are the symptoms?

- Intense itching around the bottom (or the vagina in girls) particularly at night when the female worms are laying eggs
- Disturbed sleep as a result of the itching which can lead to irritability and loss of concentration

In some cases threadworms may be visible on bed clothes or sheets at night. They may also be noticeable in stools. The worms look like threads of white cotton about one centimetre long.

Severe or persistent threadworm infections can cause:

- Loss of appetite
- Weight loss
- Skin infection around the rectum if bacteria enter any scratches caused by itching (wearing cotton gloves while sleeping may help prevent this)
- Difficulty getting to sleep or staying asleep
- Bedwetting

What is the treatment for threadworms?

- Everyone in the household (even if they do not have any symptoms) will require treatment as the risk of the infection spreading is high.
- Treatment will involve a single dose of a medication called mebendazole to kill the worms.
- Another dose can be taken after two weeks if necessary.
- During treatment and for a few weeks afterwards, it is also important to follow strict hygiene measures to avoid spreading the threadworm eggs. This involves:
    - Regularly vacuuming your house
    - Thoroughly cleaning the bathroom and kitchen.
    - If an individual is pregnant, breastfeeding or very young then hygiene measures are usually recommended without medication.

Is it infectious?

Yes, threadworms lay their eggs around an infected person's bottom, usually at night. Along with the eggs, the worm also secretes mucus that causes itching.
If the eggs get stuck on the person's fingertips when they scratch, they can be transferred to their mouth or onto surfaces and clothes. Other people who touch an infected surface can then transfer the eggs to their mouth.

What is the incubation period?

Threadworm eggs can survive for up to three weeks before hatching. If the eggs hatch around the anus, the newly born worms can re-enter the bowel. Eggs that have been swallowed will hatch inside the intestine. After two weeks the worms reach adult size and begin to reproduce, starting the cycle again.

How can spread be prevented?

Re-infection is common and infectious eggs are also spread to others directly on fingers or indirectly on bedding, clothing and environmental dust. It is not always possible to prevent a threadworm infection, but the risk can be significantly reduced by always maintaining good hygiene.

- Treatment can be obtained from pharmacies but if affected individuals are pregnant, breastfeeding or children are under two years old then they will need to see their GP.
- Exclusion is not required for threadworm but parents should be encouraged to inform the school of a diagnosis.
- Good hand hygiene is essential, particularly after going to the toilet and before mealtimes.
- Staff should wear personal protective equipment such as gloves when changing nappies or taking the child to the toilet. Hands should be washed after gloves are removed.
- Toys and other 'high contact' areas such as desks and door handles should be cleaned regularly.
- Fingernails should be kept short
- Affected individuals should be encouraged to wear pajamas or pants to bed
- Encouraging affected individuals not to scratch the affected area around their bottom or vagina as this will help prevent re-infection and reduce the risk of the infection spreading to other people
- Kitchen and bathroom surfaces should be kept clean.

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More information on threadworm can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

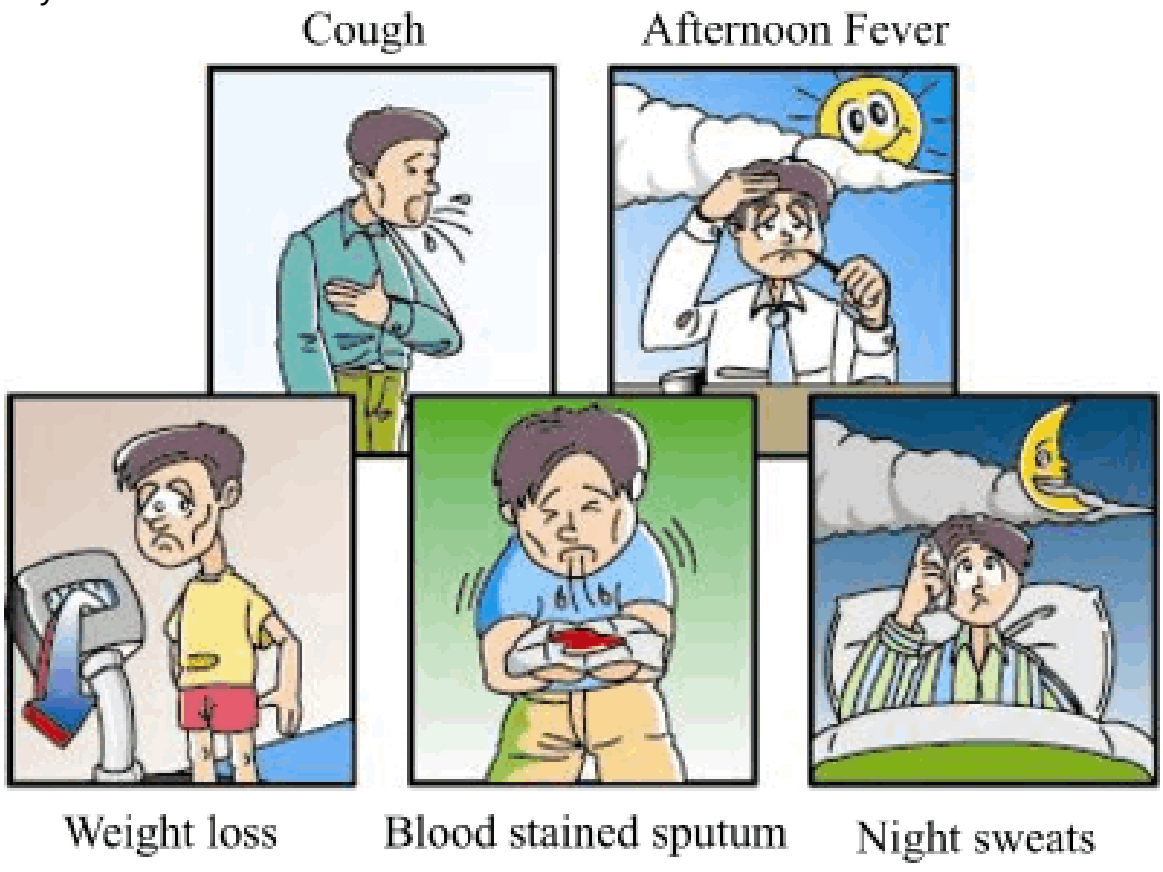
Tuberculosis

What is Tuberculosis (TB)?

Tuberculosis (TB) is caused by a Mycobacterium. It is a bacterial infection spread through inhaling tiny droplets from the coughs or sneezes of an infected person. TB can affect any part of the body, including the lymph nodes, bones, brain and nervous system. It is only infectious if it is found in the lungs (pulmonary TB), mouth or larynx.

What are the symptoms of TB?

The symptoms of TB depend on where the infection occurs**.** TB usually develops slowly and symptoms might not begin until months or even years after an individual was initially exposed to the bacteria. In some cases the bacteria lie dormant in the body but don't cause any symptoms; this is known as latent TB and is not infectious to others. If an individual has symptoms of TB, this is known as active TB but is only infectious if it is in the lungs, mouth or larynx.



People with TB might have all or some of the following symptoms;

- Cough for more than three weeks
- Loss of appetite
- Unintentional weight loss
- Fever (particularly at night)
- Breathlessness
- Chest pain

TB in a part of the body other than the lungs may produce a lump or swelling which can be painful.

Is it Infectious?

Some (but not all) people who develop TB of the lungs, mouth or larynx are infectious to others. Spread is by the respiratory route so only happens when an individual is in close proximity to someone with infectious TB for a long time and inhales sufficient quantities of the bacteria (usually if the infectious individual has been coughing). The incubation period is long (four to twelve weeks).

- In many healthy people the immune system (the body's natural defense against infection and illness) kills the bacteria and no symptoms develop.
- Sometimes the immune system cannot kill the bacteria but manages to prevent it from spreading in the body. The individual will have no symptoms but the bacteria will lie dormant in the body and sometimes may activate months or even years later. While the bacteria is dormant, the individual is not infectious to others. This is known as latent TB.
- If the immune system fails to kill or contain the infection, it can spread to the lungs or other parts of the body and symptoms will develop slowly over a few weeks or months. This is known as active TB and may become infectious to others if the active TB is in the lungs, mouth or larynx and is not treated.

Without treatment, latent TB could develop into an active TB infection at a later date, particularly if the immune system weakens.

- Children are rarely infectious (usually diagnosed when an adult, relative or close friend is found to have TB)
- Even if an individual has infectious TB, exclusion from school is not usually necessary once treatment has been taken for 2 weeks. Staff and students with non-pulmonary TB do not require exclusion and can return to school as soon as they are well enough.
- Adults with TB may be infectious so children in close contact may need medical assessment and this should be discussed with the health protection team.

What is the treatment?

Treatment for tuberculosis (TB) depends on which type an individual has and will involve a course of different antibiotics over several months. The individual will be monitored by a TB treatment team who will ensure they are on the appropriate antibiotic regime. It is extremely important that individuals with TB take their antibiotics everyday as prescribed.

Can a contact of someone with TB attend school?

When someone is diagnosed with TB their treatment team will assess whether other people are at risk of infection and require screening. Close contacts (usually people living in the same household as the individual with TB) may be screened. Occasionally wider social and workplace contacts may also require screening. The TB team will work with the health protection team to assess screening requirements and arrange appointments as required. If contacts of someone with TB are well and do not have any symptoms of TB then there is no reason why they cannot still attend school while waiting for their screening appointment.

How can spread be prevented?

If an individual is diagnosed with TB of the lungs, mouth or larynx they may be contagious up to about two to three weeks after starting their course of treatment. Individuals do not usually need to be isolated during this time, but it is important to take some basic precautions reduce the risk of spread to others. These precautions are:

- Exclusion from work, school or college until the TB treatment team advises it is safe to return (usually after two weeks of treatment)
- Ensure good respiratory hygiene is performed (use a disposable tissue to cover the mouth when coughing, sneezing or laughing, dispose of the tissue afterwards and wash hands immediately)
- Open windows when possible to ensure a good supply of fresh air
- Ensure the affected individual has their own bedroom until they are no longer infectious
- Advise parents to take their child for medical assessment if they have any signs or symptoms of TB (such as a cough lasting for more than three weeks, unintended weight loss and/or profuse night sweats)
- Contact the health protection team for more advice and to ascertain whether or not screening of school contacts may be required.

More information on tuberculosis can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Warts and Verrucas


Warts are small lumps caused by a viral infection and often develop on the skin of the hands and feet. Warts vary in appearance and may develop singly or in clusters. Some are more likely to affect particular areas of the body. Verrucas are warts that usually develop on the soles of the feet. Warts are non-cancerous, but can resemble certain cancers. Most people will have warts at some point in their life. They tend to affect children and teenagers more than adults.

What causes warts?

Warts are caused by an infection with the human papilloma virus (HPV).
The virus causes an excess amount of keratin, a hard protein, to develop in the top skin layer (epidermis). The extra keratin produces the rough, hard texture of a wart.

What are the symptoms?

Warts are not usually painful, but some types, such as verrucas, may hurt. They can occasionally itch or bleed. There are several different types of warts, all varying in size and shape.

Are they infectious?

Warts aren't considered very contagious, but they can be caught by close skin-to-skin contact. The infection can also be transmitted indirectly from contaminated objects or surfaces, such as the area surrounding a swimming pool. Individuals are more likely to get infected if their skin is wet or damaged. After becoming infected, it can take weeks or even months for a wart or verruca to appear.

What is the treatment?

- Warts usually clear up without treatment (although this can takes years)
- The length of time it takes for a wart to disappear will vary from person to person and they tend to last longer in older children and adults.
- In adults and people with a weakened immune system, warts are less likely to clear up on their own or respond well to treatment.

There are a number of treatments available for warts. However, no single treatment is 100% effective, and the wart may return. The aim of treatment is to remove the wart without it returning and without leaving any scarring.

How can spread be prevented?

It is difficult to prevent warts and verrucas spreading completely but the following measures can help to stop spread:

- Avoid touching other warts and verrucas (but ensure hands are washed if individuals touch their own).
- Ensure individuals have their own towels, flannels shoes and socks.
- Encourage individuals to wear clean socks every day.
- Discourage walking barefoot in school (or any public place)
- Ensure warts and verrucas are covered with a waterproof plaster or sock when swimming.
- Exclusion is not required if an individual has warts.
- Encourage medical review if an individual has a ward that bleeds, changes in appearance, spread or causes then significant pain, distress or embarrassment.

Whooping Cough (Pertussis)


Whooping cough (pertussis) is a highly contagious bacterial infection of the lungs and airways. The condition usually begins with a persistent dry and irritating cough that progresses to intense bouts of coughing. The gasping for breath after one of these coughing bouts causes a distinctive "whooping" noise which is how the condition gets its name.
Other symptoms include:

- A runny nose
- Raised temperature
- Vomiting after coughing

The coughing can last for around three months (another name for whooping cough is the "hundred day cough").

What causes whooping cough?

Whooping cough is caused by a bacterium called Bordetella pertussis which infects the lining of the airways, mainly the windpipe (trachea) and the two airways that branch off from it to the lungs (the bronchi).
This leads to:

- A build-up of thick mucus which causes the intense bouts of coughing as the body tries to expel it
- Swollen airways which makes breathing more difficult and causing the "whoop" sound as an affected individual gasps for breath after coughing

People with whooping cough are infectious from six days after exposure to the bacteria to 21 days after the "whooping" cough begins (without treatment). The bacteria are passed from person to person by infected droplets which are spread by coughing and sneezing. Pertussis activity tends to peak every three to four years in the UK.

Who is at risk?

The disease is usually more serious (even fatal) in children of pre-school age. Vaccination is recommended as part of the UK Routine childhood immunisation schedule. Pregnant women are also advised to receive the vaccine when they are between 16 and 32 weeks pregnant to maximise the likelihood that their baby will be protected from birth. Most cases occur in adults but symptoms tend to be less serious, although the persistent cough can be frustrating and unpleasant.

Treating whooping cough

If whooping cough is diagnosed during the first 21 days of infection, a course of antibiotics may be prescribed. This is to prevent the infection being passed on to others. It is important to take steps to avoid spreading the infection to others, particularly babies under six months of age. Antibiotics will not usually be prescribed if whooping cough is diagnosed in the later stages of infection (21 days after the onset of symptoms) as the individual will no longer be infectious to others and antibiotics will not improve symptoms at this stage.

The GP will advise on how to manage the infection at home using some simple self-care measures such as rest and drinking plenty of fluids. Babies under a year old are likely to be admitted to hospital as they are most at risk of severe complications such as serious breathing difficulties.

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How can spread be prevented?

- Advise parents to seek medical review for their child as soon as possible if whooping cough is suspected.
- Good respiratory hygiene should be encouraged (covering noses and mouths with disposable tissues when coughing or sneezing and discarding it after use).
- Good hand hygiene should also be encouraged (after using the toilet and before eating as per usual but also after coughing, sneezing or assisting others with respiratory hygiene).
- Exclude any individuals with whooping cough until they have had 48 hours of appropriate antibiotic treatment and feel well enough to return or after 21 days from onset of illness if no antibiotic treatment has been taken.
- Encourage parents to have their child immunised against whooping cough.

More information on whooping cough can be found in chapter nine of the Health protection in schools and childcare facilities guidance.

Pregnant staff /students

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, they should be advised to see their GP or midwife as soon as possible. The greatest risk to pregnant women from such infections comes from their own child/children rather than the workplace. Some specific risks are:

Chickenpox

Chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.

Influenza (Flu)

There is good evidence that pregnant women have a higher chance of developing complications if they get flu, particularly in the later stages of pregnancy. One of the most common complications of flu is bronchitis, a chest infection that can become serious and develop into pneumonia. The vaccine is available from September to January/February each year. It can be given at any time during pregnancy and will also help to protect the baby in the early months.

Rubella (German measles)

If a pregnant woman comes into contact with German measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.

Parvovirus B19 (Slapped cheek disease)

Parvovirus B19 can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks) the treating GP or Midwife should be consulted as soon as possible.

Measles

Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is providing her antenatal care to ensure appropriate follow up.

Whooping Cough (Pertussis)

Whooping cough can be very serious for newborn babies who are too young to be immunised themselves so the national immunisation schedule recommends that women between 16 and 32 weeks pregnant be immunised to maximise the likelihood that the baby will be protected from birth.

More information on staff health can be found in chapter seven of the Health protection in schools and other childcare facilities guidance.

Guidelines on food hygiene for childminders

Legal Requirements

If meals are being prepared for children then registration as a Food Business is required. Application forms for registration can be obtained from the District Council Environmental Health Department.

Compliance with the Food Safety and Hygiene (England) Regulations 2013 is required to ensure that prepared food is safe, supplied hygienically and all hazards are controlled.

Food handlers should also attend an approved food hygiene course or hold a Basic Food Hygiene Certificate or equivalent.

Kitchen Standards

A good domestic standard of kitchen equipment and facilities is acceptable. A double/twin sink for correct wash and rinse/sterilisation procedures is expected but a single sink used in conjunction with a dishwasher is satisfactory. In addition, a separate wash hand basin (with soap and hand drying facilities) and both hot and cold water supplies is a requirement. This should ideally be installed in the kitchen but if you have one in a utility room or ground floor toilet then this is also acceptable. It is recommended that the use of a sanitizer (chemical bactericidal cleaning agent) be used on work surfaces, cutting boards and all equipment in contact with food.

A household fridge set to work at less than 8^{o}C is necessary and a simple plastic thermometer stored in the appliance will indicate the correct working temperature or that the thermostat should be adjusted.

A washing machine in the kitchen is acceptable but the laundering of clothes should be carried outside the food preparation times.

Avoid carpeted kitchens, artex ceilings and ensure that pets and pet foods, potted plants and cleaning chemicals/materials are kept out of the food room generally but particularly during food preparation.

Food Handling

It is important that you are up to date with food handling practices. You may wish to contact your local environmental health department for advice.

In addition, you should make sure hands are washed and utensils and surfaces thoroughly cleaned before preparing food and that food is:

- stored at an appropriate temperature
- in date
- thoroughly cooked or reheated
- partly eaten or used food is not re-offered
- commercial baby foods are stored and cooked following the manufacturer's recommendations
- Microwaved food is allowed to reach the appropriate temperature before it is given to the child.

Food handlers with diarrhoea or vomiting must be excluded from school and **should not handle or prepare food until 48 hours after full recovery.**

More information on staff health can be found in chapter seven of the Health protection in schools and other childcare facilities guidance.

Frequently asked questions about outbreaks in schools/nurseries

How do we know if it is viral or bacterial in nature?

Informing the health protection team at the start of an outbreak will enable the team to assess the likely nature of the outbreak. The following information is important:

- Symptoms
- Numbers affected
- Timescales, dates of onset of illness, duration of illness in affected individuals (the health protection team understands that this information may be difficult to collect and may be incomplete).
- Stool samples are important, particularly to rule out more serious causes of infection

If the outbreak is thought to be related to food handlers/food then the local environmental health officer at your council will also be involved.

Throat swabs in some situations may be required to confirm diagnosis in outbreaks in children that are respiratory in nature (e.g. in a flu outbreak). This may be undertaken in school following liaison between the head teacher, nursery manager, school nurse, the health protection team and the local microbiology service.

What happens when a child vomits in the food hall?

The child should be sent home as soon as possible. Any vomit should be cleaned up immediately and placed into a plastic bag, secured and disposed of safely. Under no circumstances should vomit go into the food preparation area as this could lead to further contamination of the environment. Any children in the immediate vicinity of the vomiting should be offered alternative food stuffs as the likelihood is that their food will have been contaminated by aerosol droplets. Any individuals in the vicinity of the vomiting should wash their hands.

Under what circumstances would the school/nursery need to be closed?

This would depend on a number of issues (such as the numbers of children and staff with the illness and whether the school can manage its normal business safely and effectively). The health protection team does not have the power to close the school/nursery as this decision should be made by the head teacher and the Local Authority (if appropriate).

Will every area of the school/nursery need to be cleaned even if it has not been contaminated?

A risk assessment will be made by the Health Protection Team and the head teacher or nursery manager. It is important that a record is kept of potentially contaminated areas (i.e. where vomiting has occurred). If there are only a moderate number of cases and the areas have been cleaned appropriately then a thorough general clean will suffice in most cases once the outbreak is deemed to be over.

Appendix1

Suggested letter for parents: D&V

Please note that this is an example template only and the health protection team should be contacted to discuss the outbreak before this letter is circulated.

Dear Parent/Guardian

I am writing to let you know that a number of children and staff at school/nursery have had gastro-enteritis over the last few days.

I have been advised by Public Health England and the local Environmental Health Department that this is a mild illness probably caused by a virus, but that it is very infectious. The most usual symptom is vomiting. Some people may have diarrhoea and/or abdominal pain. Symptoms rarely last for more than 24 – 48 hours. The incubation period (time it takes for the illness to develop) is between 24 and 48 hours.

If your child is affected, please keep him or her off school/nursery. He or she should not return until 48 hours after the diarrhoea and vomiting have stopped.
The virus is easily spread from person to person. Good hygiene by everyone in the family reduces the risk. This means washing hands with soap and warm water after going to the toilet and before preparing or eating food.

It is important to clean up carefully when someone has been sick as vomit is very infectious. It is important to clear up spills of vomit or faeces immediately, by thorough washing of the contaminated environment with detergent and hot water. For hard surfaces, (floor, work tops etc., an additional disinfection with a dilute solution of Milton or household bleach (according to manufacturer's instructions) will reduce the contamination. DO NOT MIX these substances with soap and water. Be sure that each family member uses separate towels and flannels which are changed and washed frequently.

Hand washing after visiting the toilet, cleaning up spillages and before handling food is the most important element of reducing the risk of infection.

We are ensuring the school/nursery is thoroughly cleaned to reduce any further risk.

If you need any further advice you can phone Public Health England Tel: 0300 303 8162 or NHS 111

Yours faithfully

Head Teacher/Nursery Manager

Appendix 2

Suggested letter for parents: Flu-like illness

Please note that this is an example template only and the health protection team should be contacted to discuss the outbreak before this letter is circulated.

Date

Dear Parent/Guardian

I am writing to let you know that a number of children and staff at school has had [many/several] students off sick with a flu-like illness (cough, headache, fever and body aches). Some students have been sick (vomiting) or have had diarrhoea.

If your child is unwell with symptoms of flu please make sure they stay off school until they are fully recovered. If your child has vomited or had diarrhoea, they must stay away from school until **48 hours** after the symptoms have stopped.

You can lower the risk of passing on viruses like this by washing your hands, before preparing food or eating - and remember to wash them thoroughly after going to the toilet. If you have symptoms of the flu, use a tissue when you cough or sneeze, and dispose of it by throwing it in the bin or flushing it down the toilet.

If you need any further advice you can phone NHS 111 or Public Health England on 0300 303 8162

Yours faithfully

Head Teacher/Nursery Manager

Appendix 3

Notifiable infectious diseases

The following list contains all the infectious diseases that health care providers have to report to the health protection team under the Health Protection (Notification) Regulations 2010:

- Acute encephalitis
- Acute infectious hepatitis
- Acute meningitis
- Acute poliomyelitis
- Anthrax
- Botulism
- Brucellosis
- Cholera
- Diphtheria
- Enteric fever (typhoid or paratyphoid fever)
- Food poisoning
- Haemolytic uraemic syndrome (HUS)
- Infectious bloody diarrhoea
- Invasive group A streptococcal disease
- Legionnaires' disease
- Leprosy
- Malaria
- Measles
- Meningococcal septicaemia
- Mumps
- Plague
- Rabies
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhus
- Viral haemorrhagic fever (VHF)
- Whooping cough
- Yellow fever

Other diseases that may present significant risk to human health must also be reported.

Appendix 4

Exclusion Table

The table below is correct at time of printing. The current exclusion table can be found in the Health protection for school, nurseries and other childcare facilities guidance.

Infection	Exclusion period	Comments
Athlete's foot	None	Athlete's foot is not a serious condition. Treatment is recommended.
Chickenpox	Five days from onset of rash	Blister on the rash must be dry and crusted over
Cold sores (herpes simplex)	None	Avoid kissing and contact with the sores. Cold sore are generally mild and heal without treatment
Conjunctivitis	None	If an outbreak or cluster occurs, consult your local health protection team
Diarrhoea and vomiting	Whilst symptomatic until 48 hours after resolution of symptoms	See diarrhoea and vomiting section of guidance. Seek further advice from your local health protection team if unsure
Diphtheria*	Exclusion is essential. Always consult with your local health protection team	Preventable by vaccination. Family contacts must be excluded until cleared to return by your local health protection team
Flu (Influenza)	Until recovered	Report outbreaks to your local health protection team
Glandular Fever	None	
Hand foot and mouth	None	Contact your local health protection team if a large number of children are affected. Exclusion may be considered in some circumstances
Head lice	None	Treatment only recommended when live lice are seen
Hepatitis A*	Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice)	In an outbreak of hepatitis A, your local health protection team will advise on control measures
Hepatitis B*, C*, HIV	None	Hepatitis B, C and HIV are blood borne viruses that are not infectious through casual contact. Contact your local health protection team for more advice.
Impetigo	Until lesions are crusted/healed of 48 hours after starting antibiotic treatment	Antibiotic treatment speeds healing and reduces the infectious period
Measles*	Four days from onset of rash and recovered	Preventable by vaccination (2 doses of MMR). Promote MMR for all pupils and staff. Pregnant staff contacts should seek prompt advice from their GP or midwife
Meningococcal meningitis/septicaemia*	Until recovered	Meningitis ACWY and B are preventable by vaccination. Your

		local health protection team will be able to advise
Meningitis* due to other bacteria	Until recovered	Hib and pneumococcal meningitis are preventable by vaccination. Your local health protection team will be able to advise
Meningitis viral*	None	Milder illness than bacterial meningitis. Siblings and other close contacts of a case need not be excluded
MRSA	None	Good hygiene, in particular handwashing and environmental cleaning are important to minimise spread. Contact your local health protection team for more information
Mumps*	Five days after the onset of swelling	Preventable by vaccination with 2 doses of MMR. Promote MMR for all pupils and staff
Ringworm	Not usually required	Treatment is needed
Rubella (German measles)	Four days from onset of rash	Preventable by vaccination with 2 doses of MMR. Promote MMR for all pupils and staff. Pregnant staff contacts should seek prompt advice from their GP or midwife
Scarlet fever	Exclude until 24 hours of appropriate antibiotic treatment completed	A person is infectious for 2-3 weeks if antibiotics are not administered. In the event of two or more suspected cases, please contact your local health protection team for more advice
Scabies	Can return after first treatment	Household and close contacts require treatment at the same time
Slapped cheek/Fifth disease/Parvovirus B19	None (once rash has developed)	Pregnant contacts of case should consult with their GP or midwife
Threadworms	None	Treatment recommended for child and household
Tonsillitis	None	There are many causes but most cases are due to viruses and do not need an antibiotic treatment
Tuberculosis (TB)	Always consult your local health protection team BEFORE disseminating information to staff, parents or carers	Only pulmonary (lung) TB is infectious to others. Needs close, prolonged contact to spread
Warts and verrucae	None	Verrucae should be covered in swimming pools, gyms and changing rooms
Whooping cough (pertussis)*	Two days from starting antibiotic treatment or 21 days from onset of symptoms if no antibiotics	Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. Your local health protection team will organise any contact tracing.

***denotes a notifiable disease. It is the statutory requirement that doctors report a notifiable disease to the proper officer of the local authority (usually a consultant in communicable disease control).**

Health Protection Agency (2010) Guidance on Infection Control in Schools and other childcare settings. HPA: London

Appendix 5

IPC Audit Tool

See over

INFECTION PREVENTION CONTROL AUDIT TOOL CHILDCARE SETTINGS

NAME OF CHILDCARE SETTING	
NAME OF PERSON COMPLETING AUDIT	
DATE AUDIT UNDERTAKEN	
DATE OF NEXT REVIEW	

Developed by Public Health Wales (Health Protection Team, N Wales) and Poole Borough Council December 2012

Reviewed and updated by Bournemouth, Poole and Dorset Councils in collaboration with Public health Dorset, April 2017

Reviewd and updated by PHE SW Health Protection Team, September 2018

STANDARD 1: INFECTION PREVENTION AND CONTROL ARE SEEN AS AN INTEGRAL PART OF THE DELIVERY OF SERVICE IN THE CHILDCARE SETTING AND IS AFFORDED HIGH PRIORITY

1.1 GENERAL MANAGEMENT

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Is there a named lead person responsible for infection prevention and control?	Ask who the lead person is and do they know they are: 1. responsible for completion of this audit tool 2. Aware of relevant infection control guidance.				
2	Are there up to date local contact numbers available to obtain advice pertaining to infection prevention and control?	Ask for the list of contact numbers. Check they are the most up to date				
3	Can the person in charge (on any shift) state who they would alert if they suspected an outbreak of illness?	Ask the person in charge to describe the actions taken				
4	Is there a record kept of all absences including sickness (staff and children) and reason?	Check records Check for evidence of application of the 48 hr rule in cases of gastrointestinal illness i.e. the individual is excluded until 48 hrs symptom free				
5	Is information given to parents about exclusion due to gastrointestinal illness?	Check if there is documentation provided to parents explaining exclusion and gastrointestinal illness				

1.2 STAFF HEALTH

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are staff encouraged to ensure that their immunisations are up to date and in line with current national guidelines and an in house record kept?	All staff should undergo a full Occupational Health check prior to employment; this includes ensuring that they are up to date with immunisations. All staff aged 16 -25 should be advised to check they have had two doses of MMR. Randomly select two members of staff and ask whether their immunisation status has been assessed Hepatitis B immunisation may apply to staff in day care settings for those with severe learning disability if significant exposures on a regular basis (e.g. biting) occur. Decisions on immunisation should be made on the basis of local health protection recommendations.				
2	Does the childcare setting have an exclusion policy for staff / children?	1. Ask two staff if they know about exclusion from work for gastrointestinal infection (48 hr rule). 2. Public Health England document "Health Protection in Schools and other Childcare Facilities 2017" provides exclusion advice.				
3	Do all staff have access to personal protective equipment (PPE)?	Check that disposable gloves and disposable plastic aprons are accessible in key areas (nappy change / toilet areas / laundry). Nitrile / neoprene or equivalent gloves are only required if contact with blood is anticipated Plastic/polythene gloves are not appropriate. ALL GLOVES MUST BE NON-ALLERGENIC.				

1.3 STAFF TRAINING

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Is infection prevention and control included in all staff induction programmes?	Check training includes: hand hygiene, use of personal protective equipment, nappy change procedures, cleaning procedures for managing faecal / vomit incidents, decontamination of equipment, waste disposal, laundry management				

1.4 GUIDELINES/ POLICIES

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are up to date infection prevention and control policies and guidelines available and accessible by staff?	Check staff have access to documents, check they are up to date and include: Hand Hygiene, PPE, nappy change , use of potties, waste disposal, management of blood / body fluid spillage, laundry, zoo, farm and other animal contact visit guidance				
2	Does the childcare setting have a written cleaning schedule including chemicals, methods and frequencies?	The schedule includes the environment, toys and equipment, chemicals used, and storage of cleaning equipment				
3	Are there clearly outlined staff responsibilities for cleaning dedicated areas/equipment?	Identify who is responsible for cleaning specific areas (e.g. toilets/kitchen)and specific equipment (toys)				
4	Does the childcare setting have a disposal contract with a registered waste disposal company?	Ask the person in charge who the contractor is Ask to see the last three Consignment Notes from the carrier.				

STANDARD 2: HAND HYGIENE WILL BE PERFORMED USING THE CORRECT FACILITIES AT THE APPROPRIATE TIME TO PREVENT CROSS INFECTION TO BOTH CHILDREN AND STAFF

2.1 HAND WASHING

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are hand wash basins used by staff and children visibly clean?	Check for cleanliness				
2	Are all hand wash basins free from extraneous items?	Hand wash basins should **only** be used for hand washing. The use of nailbrushes is not recommended. There should be no cups / other equipment in these basins				
3	Is hot and cold water available at all hand wash basins?	Mixer taps are preferred Temperature monitoring valves preferred				
4	Is liquid soap available for use at all hand wash basins?	Liquid soap available is suitable for frequent use. Soap dispensers should not be topped up to minimise cross infection. Bar soap should be removed				
5	Are paper towels available at all hand wash basins in an enclosed dispenser?	Paper towels should be soft tissue with sufficient supply in the dispenser at all times				
6	Are there foot pedal operated domestic waste bins available for the disposal of paper towels?	Visually check, check in working order				
7	Is hand washing promoted in the childcare setting using visual methods and demonstration?	Check for the presence of hand washing technique posters by hand wash basins and if staff supervise children in their hand washing/ drying Check that children wash their hands before eating / outdoor play.				

8	Can staff list the occasions BEFORE and AFTER which they should wash their hands?	Ask 2 members of staff. May include: After using the toilet After taking a child to the toilet After cleaning equipment/environment After removal of gloves Before feeding children Before preparing or handling food				
9	Can staff demonstrate a satisfactory hand washing technique?	Ask 2 members of staff to wash and dry their hands and observe				
10	Are children encouraged to wash their hands at appropriate times?	Before eating After using the toilet After activities that may lead to soiling / contamination of hands				

STANDARD 3: THE ENVIRONMENT – TOILETS/NAPPY CHANGE FACILITIES/USE OF POTTIES SHOULD BE MANAGED TO REDUCE THE RISK OF CROSS INFECTION TO CHILDREN, STAFF AND VISITORS

3.1 TOILET AREAS

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are there dedicated hand washing facilities for staff in all toilet areas?					
2	Do staff have separate toilet facilities to children?					
3	Are the toilet(s) visibly clean?	Check visually. Toilet seats, flushes and toilet bowls are cleaned at least daily and any contamination is cleaned immediately				
4	Are toilet(s) in a good state of repair?	Check for damage				
5	Is there a mechanism to ensure that toilet cleaning can be carried out as needed?	Check for a supply of detergent wipes or other cleaner				
6	Are toilets free from inappropriate items?	Check for items that are not used in a toilet				

3.2 NAPPY CHANGE FACILITIES

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are there dedicated hand washing facilities for staff in the nappy change areas?	The facilities should be located in the nappy change area (should not have to leave the room to hand wash)				
2	Is the nappy change area sited in a dedicated area within the nursery and have items related to the procedure close to hand?	The nappy change area should not be located near play areas / food preparation areas or used as a storage space. A dedicated sink is located nearby used for cleaning (equipment) only.				

3	Are change mats in a good condition and fit for purpose?	Check change mats are waterproof, clean and intact				
4	Are change mats covered with paper towels before each use?	Check this procedure is in place and if paper is disposed of and renewed for each child				
5	Are change mats decontaminated between children?	Change mats should be decontaminated between each child by: - Cleaning with warm water and detergent; Then - Wiping with a hypochlorite solution (1,000ppm) or suitable equivalent OR Use a suitable combined detergent-disinfectant equivalent to using the two stage procedure above - Drying Use disposable cleaning cloths				
6	Are soiled disposable nappies placed into an individual plastic bag (nappy sack)?					
7	Are there suitable lidded, foot operated containers for storing soiled nappies?	Check visually				
8	Do children have their own basket, creams etc. e.g. sudocrem?	Check that there are **no** communal pots/tubes of cream used on children. All children should have their own individual creams / ointments etc.				
9	Can staff demonstrate a nappy change procedure that minimises the risks of cross infection?	Ask / observe 2 members of staff to demonstrate the nappy change procedure. Check points: Correct hand washing procedure Correct use of PPE Minimising cross contamination by being hand conscious during the nappy change process Whenever possible staff undertaking nappy changes are not food handlers				

3.3 USE OF POTTIES

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are potties used in a dedicated area?	Toilet area or nappy change area would be appropriate. Away from play areas and areas where food is served				
2	Are the contents of the potty disposed of appropriately?	Directly into a toilet or sluice hopper				
3	Are potties cleaned and disinfected after each use?	Emptied potties should be decontaminated between each child by: - Cleaning with warm water and detergent Then - Wiping with a hypochlorite solution (1,000ppm) or suitable equivalent OR Use a suitable combined detergent-disinfectant equivalent to using the two stage procedure above - Drying THEN Decontaminate the sink/surrounding area using the procedure above This process should be undertaken in a designated sink for cleaning equipment NOT used for hand washing Use disposable cleaning cloths				
4	Are clean potties stored correctly?	Not stacked one inside the other				

STANDARD 4: LAUNDRY WILL BE HANDLED TO MINIMISE THE RISK OF CONTAMINATION/CROSS INFECTION TO CHILDREN AND STAFF

4.1 LAUNDRY

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Is there a separate laundry area?	Laundry facilities should not be in food preparation areas / toilet areas / any area that could potentially present a risk for cross infection The area should be well ventilated				
2	Are there dedicated hand washing facilities for staff in the laundry area?	The facilities should be located near the laundry area				
3	Dirty / used linen and clean linen are stored separately from each other?	Used or dirty laundry should be stored in separate colour coded bags / containers so as to be clearly identifiable from clean laundry				
4	Is foul or soiled linen laundered adequately?	Foul and soiled linen should be laundered separately from used linen. A pre wash cycle should be used followed by a hot wash, 65^{o}C for not less than 10 minutes or 71^{o}C for not less than 3 minutes or equivalent				
5	Are children's clothes sent home for washing?	Clothing should NOT be sluiced or manually washed by staff but placed in a plastic bag and handed over to the parent at the end of the session. Solid waste can be tipped into a toilet. Bagged clothing should be kept separate from clean (not placed on the child's peg for collection by parent)				

STANDARD 5 THE NURSERY ENVIRONMENT WILL BE MAINTAINED APPROPRIATELY TO MINIMISE THE RISK OF CROSS INFECTION

5.1 CLEANING - GENERAL

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	All general areas clean and uncluttered?					
2	Are cleaning / disinfectant products available for decontamination of equipment and the environment?	Check there are cleaning and disinfectant products available that are appropriate for the environment and that there are instructions on use that follow the manufacturer's guidance e.g. poster Check COSHH data sheets are available.				
3	Can staff describe which products to use for routine cleaning?	Ask 2 members of staff and check against local guidance. Disinfectants and sanitisers should comply with BS EN 1276 or BS EN 13697				
4	Do staff know how to deal with blood / bodily fluid (faeces / urine / vomit) spills?	Ask a member of staff to describe the procedure. Is there a chart for staff to refer to?				
5	Is there limited use of carpet and is it cleaned appropriately?	Baby room only Carpets should be vacuumed daily and steam cleaned 6 monthly or more regularly if needed				
6	Can surfaces (floors, tables, chairs) be cleaned easily?	These surfaces should be made of an impervious material easy to wipe				
7	Are all furnishings and fitting in a good state of repair?	Where there is damage, check for evidence of action taken to ensure repair or replacement				
8	Are mops / buckets stored clean and dry and in an appropriate area?	Check storage and cleanliness of mops and buckets – equipment for kitchen area should be separate from those for other areas in the nursery				
9	Are cleaning cloths single use?	Preferable to reusable to reduce the risk of cross infection				

5.2 CLEANING – PLAY EQUIPMENT / TOYS / OTHER

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are all toys made of a washable material and in a good state of repair?	Check a sample of toys visually				
2	Are toys cleaned regularly and decontaminated if required?	Cleaning should include washing with hot water and detergent or a hot wash if laundered dependent on the type of toy. If decontamination is required then the item[#] should be cleaned initially with warm water and detergent Then - Wipe with a hypochlorite solution (1,000ppm) or suitable equivalent - Rinse OR Use a suitable combined detergent-disinfectant[#] equivalent to using the two stage procedure above - Dry [#]If compatible with item and manufacturers' instructions <u>All toys should be washed daily if children put them in their mouths</u> • Soft toys should be washed at least weekly • Older children's' toys and larger equipment should be cleaned on a weekly basis • Books should be clean and intact				

	Question	Guidance	√	X	N/A	Comment on how this is achieved
3	Are water play pools emptied daily, washed with detergent and hot water and left to dry overnight?	Ask a member of staff				
4	Do sand pits have fitted lids when not in use and sand is changed regularly?	Sand should be changed about monthly for indoor sand pits and the tank washed with detergent and hot water before replacing the sand. Any sand lost from the sand pit is disposed of				
5	Is play dough replaced regularly?	Ask a member of staff				
6	Are animals (pets) cared for in a manner which reduces the risks of cross infection to children and staff	Check: 1. Is there a designated member of staff responsible for any pets? (ensure that pregnant women are aware of the risk of toxoplasmosis infection from contact with cat faeces) 2. Pets are not permitted into food preparation areas 3. Animal food once opened is kept separate from food for human consumption 4. Children and staff wash their hands after having contact with pets 5. Any equipment (cages / food or water bowls) are washed in an appropriate sink / area.				
7	Are dummies/toothbrushes managed to prevent cross infection?	Babies / children only use their own dummy / toothbrush Toothbrushes are stored separately Dummies are disinfected using an appropriate solution between uses				
8	Suspension of communal play if outbreak of gastrointestinal illness	If there are children with gastrointestinal illness suspend until resolved: Water Play Play Dough Sand Play Cookery				

STANDARD 6: INFECTION CONTROL ISSUES IN RELATION TO FOOD PREPARATION

6.1 FOOD PREPARATION AND STAFF

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Do you have dedicated catering staff that produce all food provided? Does this include all meals and preparing feed bottles?	Having staff whose duties are food preparation **only** may reduce the risk of cross-contamination.				
2	If care staff also prepare food, do you have a rota that ensures that staff on nappy changing / toileting duties are not preparing food and feeds that day?	Establishing a rota where staff on nappy changing /toileting duties are not preparing food and feeds the same day may reduce the risk of cross-contamination.				
3	Is access to the kitchen limited to staff that are preparing food / feeds? I.e. is the kitchen also used by staff for making their own lunch and drinks?	Restricting access to food preparation areas may reduce the risk of cross-contamination.				
4	Is food / feeds prepared or reheated anywhere else in the nursery e.g. baby room?	It is preferable that all food / feed is processed in the kitchen.				
5	Have all care staff that undertake food / feeds preparation duties undertaken food hygiene training and been trained in Safer Food Better Business (or equivalent food safety management system in place)?	Staff must be trained and / or supervised to a level appropriate for their duties. **Refer to your SFBB management plan for advice.** SFBB packs for caterers and childminders are available at https://www.food.gov.uk/business-guidance/safer-food-better-business				

6	Are care staff undertaking food / feeds preparation duties provided with clean aprons for food preparation use only?	Clean aprons for food preparation use only should be provided, preferably single-use disposable plastic aprons. You may wish to have different coloured disposable aprons for kitchen use to distinguish from aprons used in nappy changing.				
7	Are all staff that prepare food / feeds aware of the 48 hour exclusion rule?	Ask catering staff if they know about exclusion from work for gastrointestinal infection (48 hr rule).				
8	Is there a poster showing hand washing technique by the kitchen hand wash basin?	Check for the presence of hand washing technique posters by hand wash basins				

6.2 Bottle preparation/feeding

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Have staff preparing and/or administering feeds received training?	Ask a member of staff how they would prepare and administer a feed and check against manufacturers instructions.				
2	If feeds are prepared in advance by parents/childcare setting are they labeled and stored correctly in the fridge?	Ask a member of staff. Feeds should be labeled with the date, time of preparation, formula used, child's name and preparers name. Feeds can be stored for up to 24 hours at the back of a refrigerator at no more than 5°C. Ideally, feed should be made as you need them.				
3	Are feeds warmed and administered correctly?	Ask a member of staff. Re warm for no more than 15 minutes Do not use microwave to re warm feeds Check temperature of milk to avoid scalding child's mouth Discard any leftover feed straightaway.				

4	Has feeding and preparation equipment been cleaned and sterilised correctly prior to being used?	All equipment used for the preparation and administration of feeds must be thoroughly cleaned in hand hot water and detergent, rinsed and sterilised using an approved method.				

6.3 EQUIPMENT AND CLEANING

	Question	Guidance	√	X	N/A	Comment on how this is achieved
1	Are there dedicated hand washing facilities for staff in the kitchen?	A hand wash basin supplied with hot and cold or appropriately mixed warm water, liquid soap and paper towels must be available. This basin must not be used for other purposes.				
2	Are there dedicated cleaning equipment and chemicals for use only in the kitchen available? E.g. mop, mop bucket, brush, cloths, cleaning chemicals, sanitiser.	Equipment and chemicals for use in the kitchen should be kept separate from those used elsewhere in the premises. You may wish to establish a colour-coded scheme for mop handles, mop buckets etc so that all staff are aware of what is to be used where.				
3	Are mop buckets emptied, washed and disinfected appropriately after use?	Mop buckets must not be emptied down the kitchen sink. Mops, mop buckets and other dirty equipment or materials must not be washed in the kitchen sink.				
4	Are cleaning staff aware of the systems you have in place?	Make sure that if you employ contract cleaners they are aware of what equipment to use where and of the need to adhere to the cleaning regime you have put in place.				

ACTIONS IDENTIFIED FROM THE AUDIT

	AUDIT SECTION	ACTIONS IDENTIFIED	DATE TO BE COMPLETED BY	PERSON RESPONSIBLE	DATE ACTION COMPLETED
STANDARD 1	1.1 General Management				
	1.2 Staff Health				
	1.3 Staff Training				
	1.4 Guidelines / Policies				
STANDARD 2	2.1 Hand Hygiene				

	AUDIT SECTION	ACTIONS IDENTIFIED	DATE TO BE COMPLETED BY	PERSON RESPONSIBLE	DATE ACTION COMPLETED
STANDARD 3	3.1 Toilet areas				
	3.2 Nappy Changing Facilities				
	3.3 Use of Potties				
STANDARD 4	4.1 Laundry				
STANDARD 5	5.1 Cleaning - General				
	5.2 Cleaning – Play Equipment / Toys / Other				

	AUDIT SECTION	ACTIONS IDENTIFIED	DATE TO BE COMPLETED BY	PERSON RESPONSIBLE	DATE ACTION COMPLETED
STANDARD 6	6.1 Food Preparation and Staff				
	6.2 Equipment and Cleaning				
	6.3 Bottle preparation/feeding				

Appendix 6

School Nursing Service Contact Details

The service operates a ‘single point of access’ which is operational between 9am and 5pm weekdays.

Harden Health Centre
Harden Road
Walsall
WS3 1ET

Tel: 01922 423349
Email: SchoolNursing@walsallhealthcare.nhs.uk