Infection Control Poster

www.HH.NET.nz

STANDARD PRECAUTIONS

CAREFUL HAND WASHING

- short nails
- protective cream
- cover cuts

PROTECT YOURSELF

Personal Protective Equipment
- gloves
- goggles
- gowns
- NO dirty linen touching uniforms

CLEAN & CONTAIN

- Blood spills
- Chemicals
- Animal excretion

SAFE HANDLING
-blood
-chemicals
-animals

- NEVER INTO CUT OR OPEN WOUND!
- Avoid contact with skin
- Avoid contact with nose
- Avoid splashes in eyes

CONTACT PRECAUTIONS
[e.g. scabies, chicken pox, ESBL]

Also need long sleeved gown & gloves

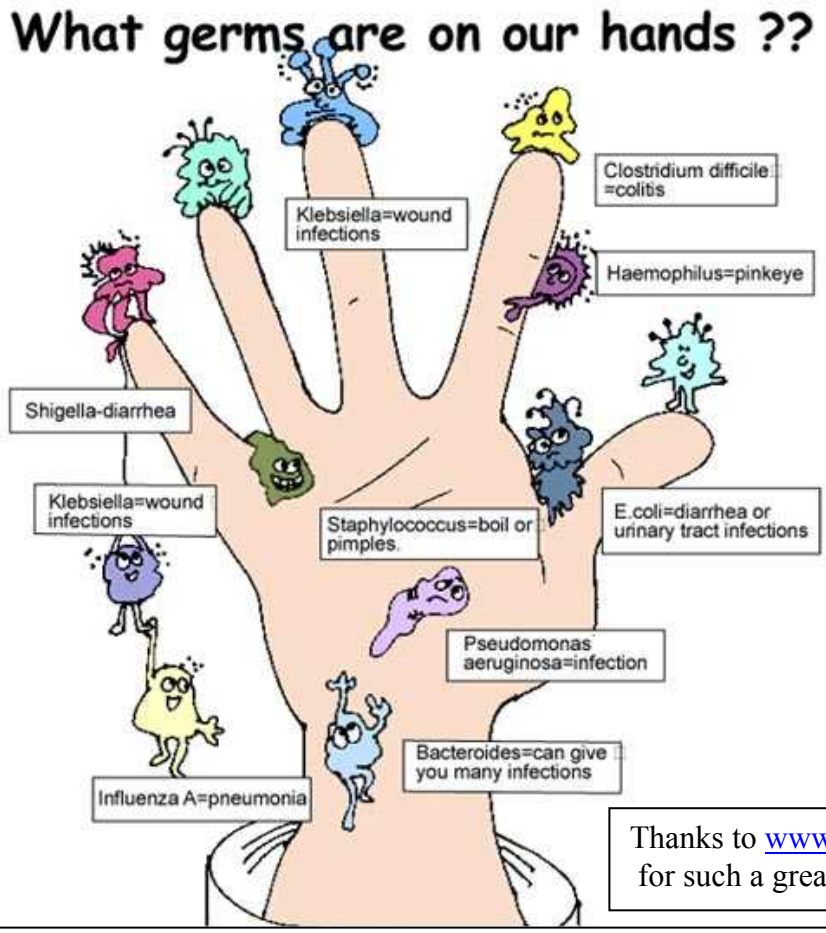
AIRBORNE PRECAUTIONS
[e.g. Norovirus, active tuberculosis]

Also need sufficiently protective mask.

To minimise the risk of Infection

Staff need to be very familiar with this poster [freely available at www.hh.net.nz/posters].

This assessment of knowledge highlights the need to handwash BETWEEN each resident care.



Thanks to www.fghi.com for such a great buggy hand

When do you wash your hands?

- √ At the start of work
- √ Before EATING
- √ Before SMOKING
- √ Before & after putting on gowns
- √ Between resident contact
- √ After touching any resident / or their bed.
- √ Before serving food
- √ After using equipment
- √ After sneezing of touching your nose
- √ After using toilet
- √ After touching animals / working in garden
- √ After touching anything dirty

Practical session with 'magic light' where staff may see under ultra violet light substance left behind after their hand wash is generally well remembered. Link this training to 'contaminating' by touching things with dirty hands or with gloves still on.

Assessment of Knowledge Hand Washing

When do you need to wash your hands? Please tick the boxes and fill in the missing words.

- ☐ At the start of work
- ☐ Before touching r_ _ _ _ _ _ _
- ☐ After t_ _ _ _ _ _ _ residents or clients
- ☐ After using e_ _ _ _ _ _ _
- ☐ Collecting speci_ _ _
- ☐ Before and after doing d_ _ _ _ _ _ s of skin tears or wounds
- ☐ Before serving f_ _ _
- ☐ After using the b _ _ _ r_ _ _
- ☐ Before giving out m_ _ _ _ _ _ _ _ _
- ☐ After sneezing of touching your n_ _ _
- ☐ Any time you don't feel that they are clean
- ☐ Before going home
- ☐ Any other times?

……
……
……
……

Why do we need to wash our hands so much?

……
……
……

What parts of our hands need special attention? Where do the bugs love to live the most?

……
……
……

☐ Passed practical assessment.

Sign…… Designation…… Date ……

Sign…… [Trainer] Date ……

Preventing Cross Infection Essential Concepts:

Hand Washing

When:

- Between ALL resident contact.

[It is effective to role play making your own hands '**unclean**' by coughing, picking teeth or nose then inviting trainee to shake your hand].

- After touching blood, body fluids, secretions, excretions, and contaminated items, even when gloves are worn.
- After gloves are removed avoiding transfer of micro-organisms to other people.
- It may be necessary to wash hands between tasks and procedures on the same patient to prevent cross-contamination of different body sites.

Gloves

- Wear gloves (clean, non-sterile gloves are adequate) when touching blood, body fluids, secretions, excretions, and contaminated items, mucous and broken skin.
- Remove gloves immediately after use, and **before** touching anything else.

Re-used Equipment

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

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

Environmental control of Infection

This is VERY important and should NOT be underestimated. It is essential to prevent cross infection among residents. Wipe tables, chairs, handrails and other frequently touched surfaces with an antibacterial cleaner. Where residents cannot maintain good personal hygiene standards it needs to be part of routines that hands and faces are washed after all meals and after toileting. Also clean and disinfect surfaces on a regular schedule: beds, bed rails, bedside equipment, and other frequently touched surfaces.

Standardised Definitions of Infection

Standardised Definition Infection "Cold"	Standardised Definition Infection "Flu"
Considered to have a Cold if has at least **two** of the following signs or symptoms: 1. **runny nose,** 2. **sneezing,** 3. **stuffy nose** (congestion), **sore throat OR hoarseness OR hard to swallow** 4. **dry cough**, or 5. **swollen or tender glands in the neck.** Fever may or may not be present, symptoms must be new, and allergies must be ruled out.	Considered to have Flu if has fever **AND** at least **three** of the following six signs: 1. **chills,** 2. new **headache OR eye pain,** 3. **muscle pain,** 4. **feeling unwell OR loss of appetite**, 5. **sore throat**, or 6. new **OR** increased **dry cough**. During flu season, if can be either Lower Respiratory Tract Infection OR flu, then please record as flu. Note: Antibiotics are not usually helpful for Flu.
Standardised Definition Infection Lower Respiratory Infection or "Bronchitis"	**Standardised Definition Infection "Pneumonia"**
Three of the following seven signs or symptoms are present: 1. New **OR** increased **cough,** 2. New **OR** increased **sputum** production, 3. New **OR** increased purulence of sputum, 4. **Fever**, 5. Pleuritic **chest pain**, 6. New **or** increased **bronchial breathing**), **OR** 7. Change in status (new **OR increased shortness of breath, increased respiratory rate, worsening mental or functional status**).	Pneumonia may be diagnosed and counted in this category if **one** of the following criteria is met: 1. Dullness on physical examination of the chest **AND** at least **one** of the following: - new onset of **purulent sputum** or change in character of the sputum **OR** - **organism cultured** from the blood 2. Patient has a chest radiograph that shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion **AND** at least **one** of the following: - new onset of purulent sputum or change in character of sputum **OR** - organisms cultured from blood. NOTE: Non infectious causes, such as congestive heart failure, need to be ruled out.

Standardised Definitions of Infection

NB: should be printed out and available in a folder for staff to access easily.

Standardised Definition Infection "Skin & Wound"	Standardised Definition Infection "Diarrhoeal Disease / Gastro Enteritis"
Cellulitis / soft tissue / wound infection / ulcer infection These infections must meet at least **one** of the following two criteria: 1. Presence of **pus and discharge** in the wound, skin or soft tissue site. 2. At least **two** of the following signs or symptoms with no other recognized cause: a. **worsening mental** / functional status; b. the presence at the affected site of **pain or tenderness**; c. localized **swelling**; d. **redness**; or e. **heat AND** at least **one** of the following: Also confirmed by: 1. Organism cultured from wound 2. Organisms cultured from blood.	**One** of the following three criteria must be met: 1. Two or more **loose watery stools** in 24 hours above what is normal for the client; 2. Two or more **vomiting** episodes in 24 hours; **OR** 3. Positive stool culture for a gastrointestinal pathogen **AND nausea**, vomiting, **abdominal pain or tenderness, or diarrhoea**. NB: Non infectious causes, such as medication side effects, must be ruled out - e.g. diarrhoea as a side effect of laxatives.
Standardised Definition Infection "eye"	**Standardised Definition Infection "ear"**
Conjunctivitis: **One** of the following must be present: a. **pus** from one or both eyes **OR** b. **redness** with or without itching or pain. Both trauma and allergies must be ruled out.	**Ear infection:** **One** of the following must be present: a. physician diagnosis b. **OR pus** draining from middle ear/ **red eardrum** plus **pain**
Standardised Definition Infection "mouth"	**Standardised Definition Infection "nose"**
Oral infection: Request doctor diagnosis.	**Nasal infection:** Request doctor diagnosis.

Standardised Definitions of Infection

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Standardised Definition Infection "Urinary Tract Infection"
Threshold Value 1.51 per 1000 occupied bed days Considered to have **URINE TRACT INFECTION** if: Need **three** of the following four signs or symptoms: 1. **Fever OR chills** 2. **Flank pain OR suprapubic pain OR tenderness OR frequency OR urgency** 3. **Worsening of mental status**/functional status 4. Changes in urine: **bloody urine, foul smell, increased sediment** **AND** urinalysis or culture not done. B. At least **two** of the four above signs or symptoms **AND** at least **one** of the following: 1. Urinalysis with positive nitrite and/or positive leukocyte esterase 2. Presence of organisms by culture at laboratory

The next page contains an Assessment of Knowledge for RN's / Team Leaders. This assessment tests knowledge of Standardised Definitions, above, the definitions that are generally used in most places in the world.

You cannot track infections in your organisation unless definitions of infection are known / agreed. Is this an infection? Should we count it as an infection? Many facilities only count incidences of antibiotic usage:

- This misses any infections treated conservatively
- Counts as infections where there was none demonstrated but the doctor decided to prescribe antibiotics for other reason.

Sound knowledge of the Standard Definitions of Infection allows better monitoring of infections in your organisation.

Training Resource Infection Reporting - for RN's & Team Leaders

According to recognised Standard Definitions of Infection:

1. David is complaining that he is going to the toilet **"all the time"** and that his urine **"smells bad".**

   Has he got a Urinary Tract Infection? YES ☐ NO ☐

2. May has **itchy weeping** eyes. Has she got conjunctivitis [an eye infection]?

   ☐ YES ☐ NO

3. Does a child have an ear infection when its ear is **very sore** and you can see some **pus seeping out** from the ear?

   ☐ YES ☐ NO

4. Pete has a runny nose, dry cough and swollen glands. He sounds "hoarse" and sneezes a lot. Does he have ☐ a cold

   ☐ the flu

5. If you are **coughing more than you were yesterday** and your **sputum is more yellow** and you are **hot to touch**, could you have bronchitis [upper respiratory infection].

   ☐ YES ☐ NO

6. Mavis had diarrhoea **three times** last night. Has she got a gastro – enteritis?

   ☐ YES ☐ NO

7. Are the following infected or not. Please write YES or NO underneath the symptoms.

Swelling & redness [hand]	Heat [neck]	Pus [Leg wound]	Swelling redness & heat [leg]

Staff 'report' the different infections listed above. They describe infections according to the Standard Definitions of Infection, above & fill in infection Report Forms to match. Also discuss management of these infections: Caregiver RN & GP responsibility.

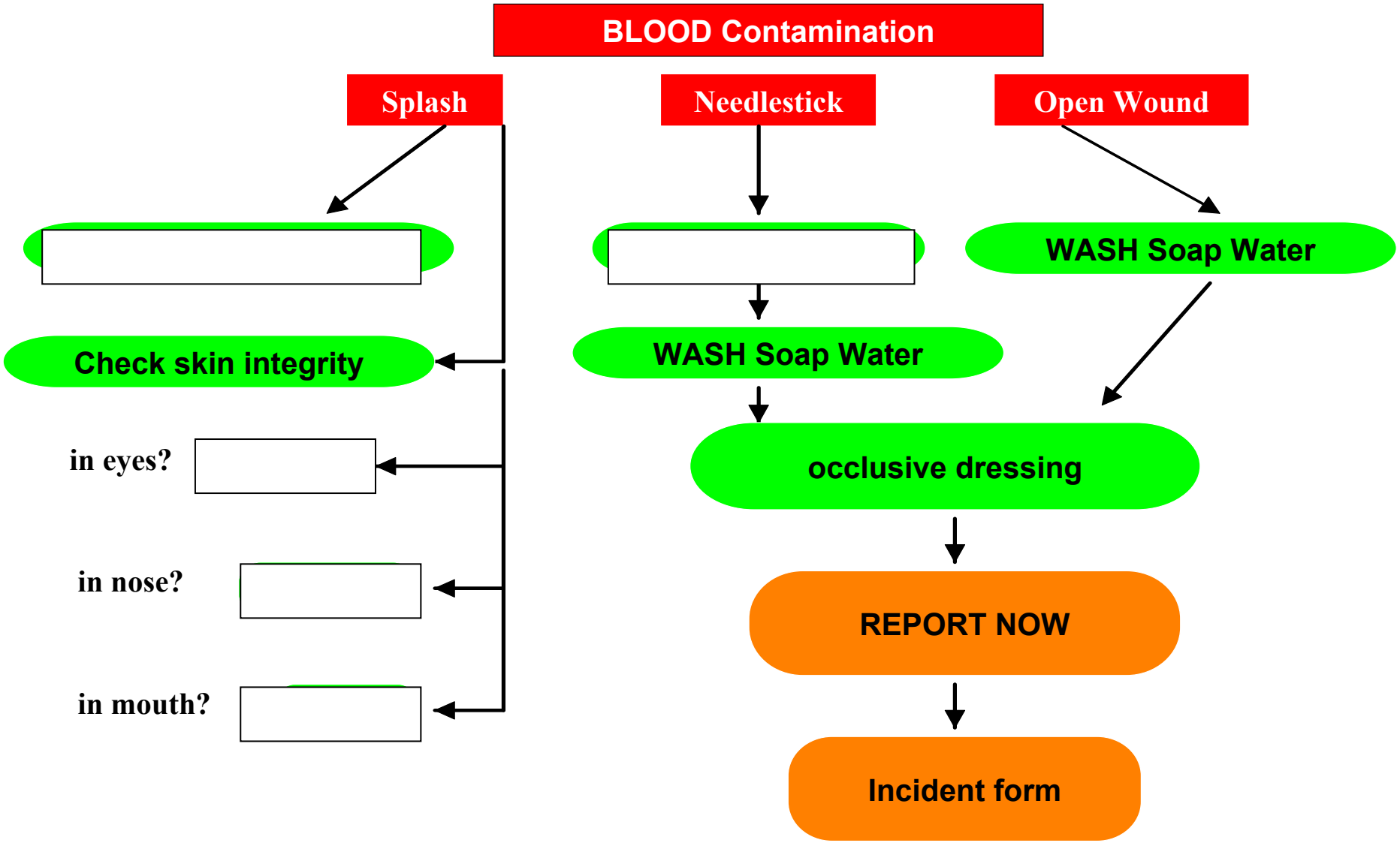
You find a resident with a bleeding nose
Please write what you would do when cleaning up in the blank boxes below?

Assess Knowledge Blood Nose! Blood Spill!	
1. ASSESS THE RISK **How do you assess the risk?** **What do you look at?**	**1. Amount of blood** **2.**
2. PROTECT YOURSELF **How do you protect yourself?** **What personal protective equipment could you need?**	
3. MOP UP **What with?**	
4. WASH **What do you use?**	
5. DRY **What do you use?**	
6. DISPOSE **Where?**	
Spills on carpet **How should we clean this?**	

Sign…… Designation……. Date ……

Sign…… [Trainer] Date ……

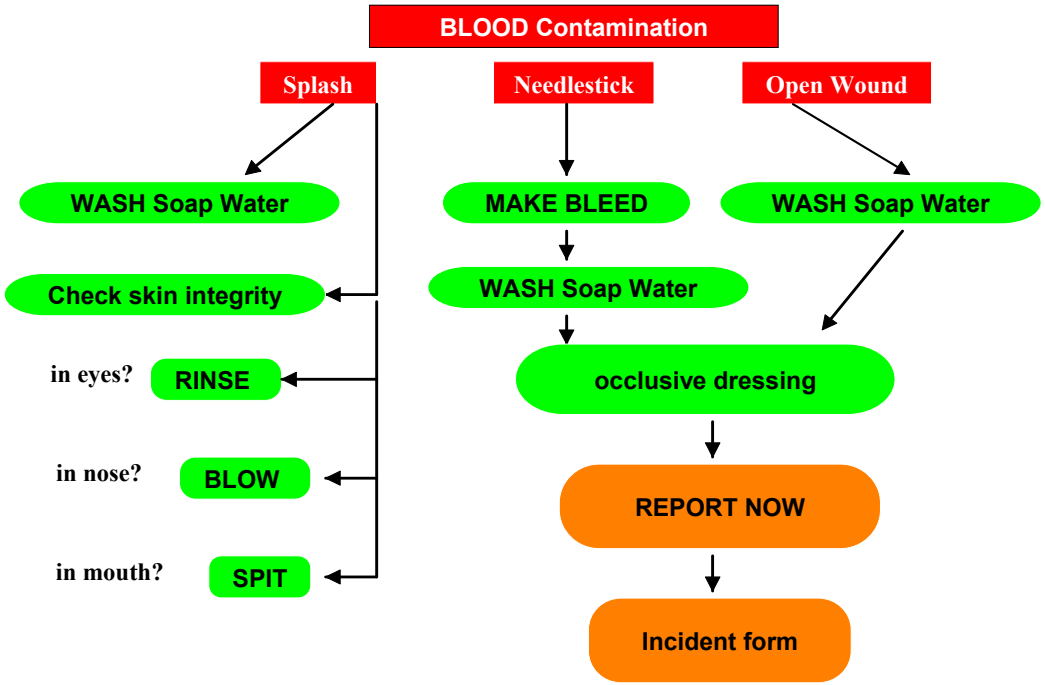
Assessment of Knowledge Blood Spill



Name: _____ Designation: _____ Date: _____

Answers Assessments Knowledge Blood Spill

BLOOD SPILL	
1. ASSESS THE RISK	RISK - amount - source - spread
2. PROTECT YOURSELF	Choose PPE Personal Protective Equipment: - gloves - goggles - gown - apron - gumboots
3. MOP UP	Use paper towel Dispose into plastic bag
4. WASH	Use detergent and warm water
5. DRY	Use paper towel Ensure area is completely dry
6. DISPOSE	Place all paper towels & gloves in plastic bag
Spills on carpet	Mop with paper towels Clean with detergent Shampoo with industrial cleaner ASAP



MRSA


MRSA Infection Identified
Determine site of infection
Decide treatment
Can the area be covered?
Antibiotics
Antibacterial washes
No
Take standard precautions
YES
Wash hands
Occlusive dressing
Wear gloves
Use antimicrobial wash
Clearance
Help client with basic hygiene
YES
NO
Treat rubbish and linen as hazardous
STOP
Decontaminate (clean room)
A single room may not be required
Resident movement should not be restricted providing infection can be covered
Consult infection control policies

MRSA GUIDELINE:

1. Identify carriers & those at risk	**2. Transfers and Entry**
- Swab Clients returning from hospital if they have chest infection or any kind of wound. - Screening during any outbreak will help determine the extent of spread. Taking swabs to determine MRSA: ➢ One nasal swab (Swab both sides of both nostrils). ➢ Swab from the groin. ➢ Swab from site of infections	Clients may return home from hospital with MRSA in wounds. This SHOULD be advised to the Service but this does not always happen [in timely fashion]. Decolonisation therapy [application of antibiotic creams] should **not** be required for people colonised with MRSA **before** their admission to the Home. Screening is not done routinely on Clients awaiting transfer. Consider not accepting clients with catheters [exclusion criteria] or working towards rehabilitation so they are not required.
3. Transmission	**4. Control**
Transmission is by person-to-person spread, most often on the hands of health care staff. ➢ After contact with 'infected' or 'colonised' people ➢ Droplets from people coughing 1. Cover infected wounds 2. Keep people with [MRSA] chest infections in their own rooms. 3. 'Infected' or 'colonised' Clients must stay away from susceptible people. 4. If equipment must be shared, then adequately clean and disinfect before use for another patient. 5. Visitors seeing more than one client should visit MRSA clients last. They should wash their hands carefully before leaving. 6. The environment may act as a reservoir of MRSA.	**Hand hygiene is the single most effective means of preventing the spread of MRSA. [See Hand Washing Policy].** - **Antimicrobial hand wash must be available to Clients and to care staff.** - **Clients identified with MRSA may need education and assistance with regular and thorough hand washing.** - Hand washing between infected parts of the client and other parts of their body is also required. - Using appropriate De-colonisation therapy for clients with MRSA i.e. anti-microbial skin washes and topical antibiotic creams to specific identified sites & special dressings. -

NB: Clients colonised with MRSA should **not** be restricted from participation in social or therapeutic group activities unless there is reason to think that they are shedding large numbers of bacteria and have been implicated in the development of infection in other Clients. Such restrictions cause deprivation of social contact and rehabilitation opportunities.

Training needs to be centred around any resident known to have MRSA and be specific to that person. Staff also need to realise that MRSA is a problem to the weak and unwell rather than the fit & healthy.

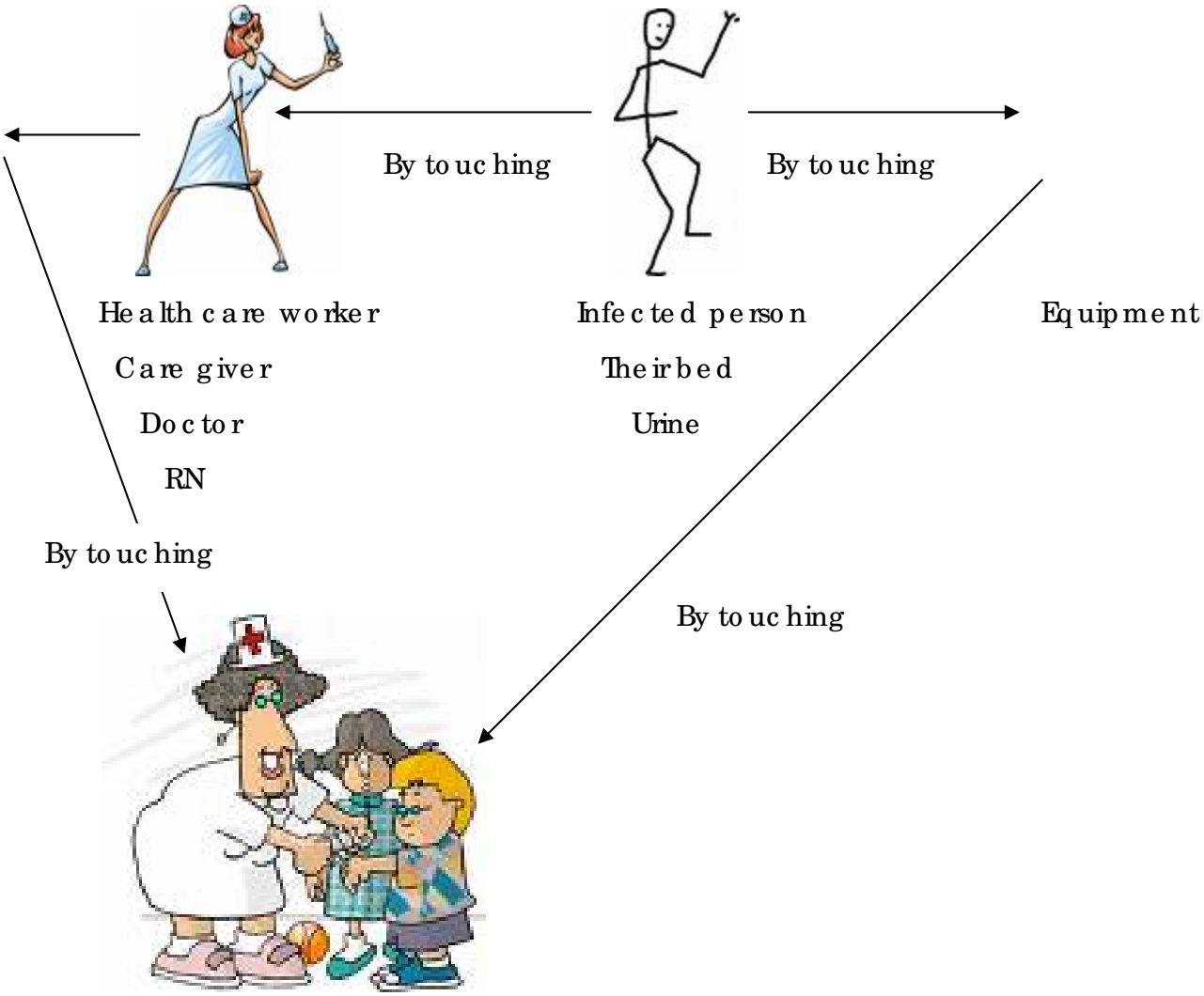
Extended-Spectrum beta-Lactamase Producing Gram Negative Bacilli

Managing People either Infected or Colonised with ESBL Organisms
Tag or **flag the client records** by placing a yellow warning page at the front.
Educate the client and their visitors about Contact Precautions needed to stop infecting others AND their responsibility in diligent adherence to these precautions. Monitor visitors carefully. If visiting more than one person visit ESBL+ people last.
Good Hand Hygiene – with an antibacterial hand wash before and after all client contact. Client must wash hands before leaving the room & after ALL personal cares esp. toileting!
Contact Precautions: 1. Do not move between Clients without decontaminating the hands 2. Use good hand sanitiser like **Microsheild.** Have **plenty available** at strategic points. 3. Have **good hand sanitising equipment** in client room and outside client rooms 4. **Gloves** for contact with patient and their environment 5. **[Long Sleeved] Gowns or plastic aprons:** for contact with patient and their environment 6. Monitor visiting Health Professionals carefully / show them our Contact Precautions
Cleaner: Educate and monitor cleaning & disinfecting of the environment 1. ESBL rooms are cleaned last 2. Wear gown or plastic apron & gloves 3. Use detergent & water for surfaces, furniture & floors 4. Wash walls and the sides of furniture with a bleach solution. 5. Use friction cleaners like Ajax for bathrooms, doorknobs, soap dispensers, toilet seats & chairs & paper towel holders.
Use **separate equipment** for ESBL affected / colonized Clients or clean thoroughly / decontaminate with antibacterial solutions before using on other people.
Dispose of wastes from affected people [e.g. dressings] in double plastic bags
Catheter Management: Strict contact precautions & great care especially in disposal
Signage: Warning signage on client door. Client's door may be left open
Care with client to client contact. Carriers may be with others but should have their "own" chair in lounge. Cover wounds / ensure no incontinence a source of contamination to others or environment.
Carry out regular audits of compliance with Contact Precautions
Notify any receiving facility of the client's ESBL status PRIOR to transfer or discharge.
Discharge: Change curtains. Use detergent & water on surfaces including bed & pillows.

Vancomycin Resistant Enterococci [VRE] Contain the Spread

From the bowel of the infected person **ON THEIR HANDS**

ONTO ANYTHING THEY TOUCH



Break the Cycle!

WASH YOUR HANDS

Don't contaminate your uniform – wear gown or apron

Dispose of wound dressings & urine soaked items in double plastic bags

Clean everything thoroughly with hot soapy water & detergent

Use ajax & bleach in water on frequently touched surfaces

Help Clients with personal cares

Guidelines for the Management of VRE

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

REFERENCE: Infection Control Service Handout Auckland City Hospital.

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

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

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

COLONISATION TREATMENT = NONE

INFECTION TREATMENT = there are still some antibiotics that work.

CONTROLS TO KEEP SAFE: Allocate a single room.

1. Thorough hand washing for the infected person and everyone else as well.
   - After using the toilet
   - Before and after preparing food
   - After cleaning
2. Normal household cleaning is sufficient.
3. Launder towels, clothes and bedding as usual. No special temperature or detergent required.
4. Cutlery and plates washed as usual.
5. Wounds need a waterproof dressing if they have VRE in the wound.
6. Inform all Healthcare workers of the VRE positive status. Flag this at the top of the client Integrated Notes under allergies in red.
7. Use gloves and gowns for contact with blood or body fluids.

MANAGEMENT OF NOROVIRUS OUTBREAK:

Universal Precautions:

1. Careful Hand washing

Using running water & liquid soap for at least 15 seconds. Dried with a paper towel.

- When they look dirty
- After taking gloves off
- After 6 -8 uses of alcohol rub
- Before beginning & before leaving work

2. Good hand Hygiene

Alcohol based hand rubs readily available throughout the Home for use:

- Between ALL person to person contact
- After touching any surface in an infected person's isolation room.
- BEFORE food preparation
- Before and after any break in work
- Between 'DIRTY' & 'CLEAN' procedures on the same person.

3. Gloves

Disposable latex used when:

- Having to touch faeces / vomit
- By cleaning staff – a new pair for EACH room!

4. Face Protection

Surgical masks [like in the operating theatre] worn when anywhere near vomit or faeces.

5. Waterproof Aprons

- For ALL client contact
- When sluicing soiled linen
- At all times by the cleaner
- When emptying commodes / bedpans.

6. Laundry

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

People Management

Client

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

Staff

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

Visitors

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

Ancillary visits

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

Transfers

- Do NOT transfer in or out unless essential.
- Warn receiving facilities FIRST!

Print this out as posters for use in the event of outbreak as a quick guide for staff.

Managing a Resident with Tuberculosis [TB]

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

UNDERSTANDING TB:

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

This training is useful so that staff understand this disease.

People recuperating in Rest Homes are highly UNLIKELY to have active TB. This training is designed to reassure staff who are concerned that a resident had TB in the past.

This training should also include understanding of TB medications.

Assessment of Knowledge Tuberculosis

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Note: This training is not necessary unless there are residents that have a history of tuberculosis.

Name: _____ Designation: _____ Date: _____

Name: _____Trainer: _____ Date: _____

Management of Waste and Hazardous Substances

POLICY:

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

REFERENCE:

Infection Control Standard NZS 8142

HSE Amendment Act 2002

PROCEDURE:

Soiled Disposable Waste: This includes bloodstained waste and soiled wound dressings, disposable pads, or human waste. This should be: ❑ Placed in two plastic bags – one inside the other. ❑ Secured at the top – tie in a knot. ❑ Container used is strong wheelie bin on wheels with lid. ❑ This is collected no less than weekly	**Soiled or blood stained linen:** Place in a covered bucket / plastic lined linen bag for transfer to the laundry. Soak in strong 'napisan' or other bleach. Bleach is effective against infectious micro-organisms. Use correct amount as directed. This linen is laundered separately from other linen. Drying the linen in a clothes drier for 10 minutes on high also achieves disinfection.
Wet linen: This is collected in covered buckets, or plastic lined linen bags for transfer to the laundry for processing.	**Sharps:** [disposable syringes, needles, glass ampoules and other sharp objects]. These are placed in special sharps containers immediately after use. When containers are three quarters full arrange for collection by Medical Waste Disposal Contractor or take to chemist for disposal and replace containers at the same time.

Special Cultural Considerations for Biological Waste

There is no particular different way of disposing of infectious waste or dressings from Maori or other cultures.

Trainers Notes: Trainers should check that there is more than adequate equipment for staff to double bag infectious waste, that bins are not filled to overflowing, that no one pushes full waste into the bin by hand, that collections are timely, and that there are adequate supplies of hand wash, towels and soups for both staff & residents. Check also the fullness & process for disposing of sharps containers. All the training in the world will do no good where staff are unable to easily dispose of waste then wash well afterwards.

Assessment of Knowledge
Management of Waste and Hazardous Substances

How would you dispose of Soiled Waste? : This includes bloodstained waste and soiled wound dressings, disposable pads, or human waste.

- Place in a p _ _ _ _ _ _ v b _ _. Tie up the top and put inside another one.
- Tie in a knot at the top
- This rubbish goes into a strong wheelie bin on wheels with lid.
- This is never o _ _ _ _ _ _ _ _ _.
- It is collected no less than weekly

Wet linen:

This is collected in:

- C _ _ _ _ _ _ b _ _ _ _ _ _
- P_ _ _ _ _ _ lined l_ _ _ _ bags for transfer to the laundry for processing.

NEVER carried against **o _ _ _ _ _ _ _ _!**

Soiled or blood stained linen:

Place in a covered bucket / plastic lined linen bag for transfer to the laundry.

Soak in strong 'napisan' or other b _ _ _ _ _. Bleach is effective against infectious micro-organisms. Use correct amount as directed.

This linen is laundered s _ _ _ _ _ _ _ _ _ from other linen.

Drying the linen in a clothes drier for 10 minutes on high also achieves disinfection.

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

These are placed in specials _ _ _ _ _ containers I_ _ _ _ _ _ _ _ _ _ after use. When containers are three quarters full arrange for collection by Medical Waste Disposal. Take to chemist for disposal and replace containers at the same time.

Name: _____ Designation: _____ Date: _____

Name: _____Trainer: _____ Date: _____

Scabies Treatment & Management:

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

Containing Outbreaks:

IMMEDIATE

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

NEXT DAY

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

Follow Up

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

Guide to Managing Client with Scabies / Scabies Outbreak

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

Educate the client.

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

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

Contact Precautions:

Standard precautions plus long sleeved gown and gloves for personal cares.

Cleaner: Use a warm soapy solution. Only use disinfectant if the scabies are hard to overcome.

1. Scabies rooms are cleaned **last** [DAILY]
2. Wear plastic apron & gloves.
3. Pay special attention to bathrooms, handrails, commode chairs commode chairs and community areas.
4. Use disposable cloths and throw them out as Hazardous Waste.

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

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

Catheter Management: as usual

Signage: Warning signage on client door.

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

Carry out regular audits of compliance with Standard Precautions

Notify any receiving facility of the client's status PRIOR to transfer or discharge.

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

Healthcare Help Assessment of Knowledge Infection Control

There is ONE [1] wrong answer in each definition below.
Can you find **the odd man out** and put a cross beside it?

Definitions:

1. **Bodily fluids**

All bar ONE, below, are bodily fluids.

- ❑ Blood
- ❑ Sweat
- ❑ Tears
- ❑ Urine
- ❑ Pus
- ❑ Spit
- ❑ Mucous
- ❑ Bad breath

2. Contaminate - *"To make unclean by contact"*

Which one, below, does NOT contaminate:

- ❑ My uniform by sitting on a resident's bed
- ❑ By carrying dirty linen in my arms
- ❑ By touching a dirty dressing then touching the clean one
- ❑ By sneezing in a resident's room
- ❑ Leaving things lying around
- ❑ Using a dirty mop
- ❑ Putting dirty linen on the floor

3. Infect

"To get into a wound or into the blood stream, urine or into a person's body and cause illness". Which ONE below will **NOT** infect?:

- ❑ MRSA, VRE, ESBL [resistant to antibiotics bugs]
- ❑ Hepatitis
- ❑ Asthma
- ❑ Viruses
- ❑ Flu Virus
- ❑ Common Cold
- ❑ Bacteria
- ❑ Fungi like tinea
- ❑ E coli in urine

4. **Disinfect** [Which **ONE,** below, does **NOT** disinfect?]

"Using a chemical or bleach to wipe out micro-organisms" [bugs].

- ❑ Milton [sterilises scissors]
- ❑ Napisan
- ❑ Janola
- ❑ Spray & wipe with bleach in it.
- ❑ Water
- ❑ Savlon or Detol
- ❑ Hand sanitiser
- ❑ Bleach

5. Susceptible

"More likely to get sick". Some people are more likely to get sick from micro-organisms & resistant bugs. Who is **NOT** likely to get sick?

- ❑ Very old
- ❑ Most frail
- ❑ People after operations
- ❑ Very young
- ❑ People already unwell.
- ❑ People with catheters
- ❑ Care staff & support workers
- ❑ Malnourished people

Transmission is the way that micro-organisms get from one person to another.

Mary is the cook. She must be careful NOT to **transmit** bacteria from raw food to salads. This kind of **transmission** could happen if she used the same c_____ b____ for the salad after cutting up raw meat.

Janice & Tui always do the wet round at the end of the afternoon shift together. They wear gloves to protect THEMSELVES. This is good. No one wants to touch bodily fluids. They take the gloves off between each resident and wash their hands before starting on the next person. Janice got an itchy nose while changing Mrs Green. She rubbed her nose against her upper arm so she would not to t_____ any bugs from her g_____ to her own n___.

Infected. Infection is when a micro-organism sets up a life for itself. A person can be infected with a micro-organism and either:

a) Get sick
b) Be a **carrier** [not get sick]

Alice is the cleaner. She uses gloves while resident rooms in the Rest Home. They protect **HER.**

a) She makes Mrs Brown's bed then cleans her room using gloves & a disinfectant. Vancomycin Resistant Enterococci [VRE] are on Mrs Browns bed.
b) Mrs White has a visitor. The VRE are **transmitted onto her visitors hands** by touching Mrs Brown & by touching her bed.
c) She swallows them as they eat afternoon tea together. The visitor also becomes **I**_____ with VRE.
d) She does not get sick but she could be called a **c** _____ of VRE.

Alice does not get **infected.** She takes the gloves off after cleaning the room and washes her hands.

The visitor did not need to get infected with VRE. How could she have prevented this?

Answer: _____

Direct Infection: *"Person to person"* like sneezing on someone who later gets a cold or the flu. Tick the **three** examples below that are **direct infection**?

- ❑ Cold sores are passed on by k_____
- ❑ Scabies can be passed among members of the family touching each other.
- ❑ Aids is hard to catch without sleeping with an **infected** person, or being in direct contact with their blood [intravenous drug users]
- ❑ Infections can be passed to other people from equipment we have used on a very sick person.

Indirect Infection: *"This is from objects"* that are contaminated by micro-organisms. A good example of this is from equipment we have used or resident's touching furniture with dirty hands if no one has helped them to wash.

Cross Infection: When one person has an infection and it is transmitted to another person, who then gets sick. If one person has a Norovirus [with very bad vomiting and diarrhoea] and the care giver looking after them gets sick with Norovirus as well. This would be considered **c____ in_____.**

But it can also be from one part of a person to another. An old lady picks at an **infected** ulcer on her leg then picks at an itchy mosquito bite on her arm. The mosquito bite also becomes infected. This is also **cross infection.**

What ways can we prevent cross infection?

1. By covering w_____
2. Careful____ _____
3. Keeping sick people _____. This is also called isolation.
4. Care when handling linen not to hold it against ours___
5. Clean short fingernails
6. Good personal hygiene and helping residents with theirs
7. Not sharing d____b_____
8. Staying at home from work when you have f__
9. Making sure that residents have a clean f_____ to wash their face, and it is their own one, not shared. Same with towels.
10. Wearing gloves when touching infected e___ that need cleaning

Answers Assessment of Knowledge Infection Control

www.HH.NET.nz

There is ONE [1] wrong answer in each definition below.
Can you find the odd man out and put a cross beside it?
Definitions:

1. **Bodily fluids**

All bar ONE, below, are bodily fluids.

- ✓ Blood
- ✓ Sweat
- ✓ Tears
- ✓ Urine
- ✓ Pus
- ✓ Spit
- ✓ Mucous
- ❑ Bad breath

2. Contaminate

"To make unclean by contact" How might you make yourself unclean?

- ✓ By sitting on a resident's bed
- ✓ By carrying dirty linen in my arms
- ✓ By touching a dirty dressing then touching yourself
- ✓ By sneezing in a resident's room
- ❑ Leaving things lying around
- ✓ When using a dirty mop
- ✓ After dropping linen on the floor

3. Infect

"To get into a wound or into the blood stream, urine or into a person's body and cause illness". Which ONE below will **NOT** infect?:

- ✓ MRSA, VRE, ESBL [resistant to antibiotics bugs]
- ✓ Hepatitis
- ❑ Asthma
- ✓ Viruses
- ✓ Flu Virus
- ✓ Common Cold
- ✓ Bacteria
- ✓ Fungi [like tinea]
- ✓ E coli in urine

4. **Disinfect**

To kill bugs. [Which **ONE**, below, does **NOT** disinfect?]

- ✓ Milton [sterilises scissors]
- ✓ Napisan
- ✓ Janola
- ✓ Spray & wipe with bleach in it.
- ❑ Water
- ✓ Savlon or Detol
- ✓ Hand sanitiser
- ✓ Bleach

5. Susceptible

"More likely to get sick". Some people are more likely to get sick from micro-organisms & resistant bugs. They are more susceptible. Who is **least** likely to get sick? NOT susceptible. Please tick ONE box below.

- ❑ Very old
- ❑ Most frail
- ❑ After operations
- ❑ Very young
- ❑ People already sick
- ❑ People with catheters
- ✓ Care workers
- ❑ Malnourished people

Transmission is the way that micro-organisms get from one person to another.

Mary is the cook. She must be careful NOT to **transmit** bacteria from raw food to salads. This kind of **transmission** could happen if she used the same **cutting board** for the salad after cutting up raw meat.

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Alice is the cleaner. She uses gloves while resident rooms in the Rest Home. They protect **HER.**

c) She swallows them as they eat afternoon tea together. The visitor also becomes **infected** with VRE.
d) She does not get sick but she could be called a **carrier** of VRE.

Alice does not get **infected.** She takes the gloves off after cleaning the room and washes her hands.

The visitor did not need to get infected with VRE. How could she have prevented this?

Answer: **By washing her hands before eating. By NOT sitting on Mrs White's bed where the microorganisms had been shed. By NOT kissing Mrs White on the lips.**

Direct Infection: *"Person to person"* like sneezing on someone who later gets a cold or the flu. Tick the **three** examples below that are **direct infection**?

- ✓ Cold sores are passed on by **kissing**
- ✓ Scabies can be passed among members of the family touching each other.
- ✓ Aids is hard to catch without sleeping with an **infected** person, or being in direct contact with their blood [intravenous drug users]
- ❑ Infections can be passed to other people from equipment we have used on a very sick person.

Indirect Infection: *"This is from objects"* that are contaminated by micro-organisms. A good example of this is Alice, the cleaner, on the previous page.

Cross Infection: When one person has an infection and it is transmitted to another person, who then gets sick. If one person has a Norovirus [with very bad vomiting and diarrhoea] and the care giver looking after them gets sick with Norovirus as well. This would be considered **cross infection**

But it can also be from one part of a person to another. An old lady picks at an **infected** ulcer on her leg then picks at an itchy mosquito bite on her arm. The mosquito bite also becomes infected. This is **cross infection.**

What ways can we prevent cross infection?

1. By covering **wounds**
2. Careful & thorough **hand washing**
3. Keeping sick people **apart**. This is also called isolation.
4. Care when handling linen not to hold it against our **self.**
5. Clean short fingernails
6. Good personal hygiene and helping residents with theirs
7. Not sharing **drink bottles.**
8. Staying at home from work when you have **flu**
9. Making sure that residents have a clean **flannels** to wash their face, and it is their own one, not shared. Same with towels.
10. By using different coloured **cutting boards** for meat & vegetables.

Nutritional and Safe Food Management

It is VERY important that those preparing, handling & heating and storing food are aware known Food Hazards:

Microbiological	**Chemical:**	**Physical:**
Bacteria, fungi, virus.	Chemicals, pesticides, herbicides & insecticides	Objects not supposed to be in food – hair, band aid
Campytobacter, Listeria and Salmonella.	Disinfectants, detergents and cleaning products	Cause injury – glass or other object

Training can be broken into sections as per critical Contamination Points:

Critical Point Number 1 – Personal Hygiene

- Staff must wear the regulation uniform.
- Aprons are changed at the end of the shift, or more frequently if soiled.
- Hair must not be able to fall into food.
- No smoking in food areas.
- Cuts must be covered. Gloves may be used as well.
- Staff with eye, ear or other wound discharge, colds and flu or diarrhea must not work in the kitchen.
- Staff must not touch the face or nose while working, or sneeze into food.

Critical Point Number 2 – Contamination during preparation

- Clean, well maintained kitchen including a suitable hand washing area.
- Well cleaned / sanitized food preparation areas including extractor fans / range hoods. Beware build up of fatty residues.
- Protective equipment is supplied and worn.
- Trained staff aware of dangers.
- Staff wash their hands thoroughly.
- Wear disposable gloves for salads, sandwiches and cold meat.
- Wash food handling equipment between raw and cooked foods.
- Always use separate chopping boards for cooked and raw foods- identify and store these boards separately.
- AWARE cross infection– i.e. keeping cooked food away from raw food, soiled hands, soiled work surfaces, soiled equipment, clothing and utensils.
- Testing food with a clean spoon only.

- Pests, insects and vermin are controlled [eradicated from] the food preparation and storage areas.
- Cleaning materials are provided and stored away from foodstuffs.
- No animals in the kitchen and storage areas.

Critical Point Number 3 – Cooking

- Complete thaw of frozen meat before cooking – no drips onto food stored below! Thaw food on the bottom shelf in the refrigerator.
- Poultry and pork are cooked at 70 degrees at their center or above.
- Chicken & pork are thoroughly cooked [no blood within]

Critical Point Number 4 - Storage

Refrigerator:

- Check temperature daily - it should be between 0 & 4 degrees. Log this.
- Cooked foods are stored separately from raw food - cooked foods are placed on shelves above raw foods in the refrigerator.
- Left over food is covered and dated [include time] when stored in the refrigerator. Minimize by accurately calculating portions needed.
- Food that has been stored in the refrigerator for more than 24hrs is thrown out – cook responsibility.
- High-risk foods that have been out of the fridge for more than two hours, are discarded [cook responsibility].
- Liquids in jugs in the refrigerator must have lids.
- Food is cooled as quickly as possible, i.e. small portions, in a cooler place, until refrigerated. It must be cooled within 90 minutes.
- Hot food should not be placed in the refrigerator, as it warms other foods.

Freezer:

- Check temperatures daily - minus 18 degrees. Keep a log of this.
- Thawed food once defrosted is not refrozen unless it is cooked first.
- Stock is rotated as for fridge.
- Meat should be on shelves lower than other frozen foods.
- Foods are labeled and dated if required.
- Routine maintenance for the freezer is included part of general maintenance.

Reheating Food:

- When re-heating cold food, it must reach a temperature of at least 70 degrees for two minutes.
- Reheated food that is not eaten MUST be discarded.

Storage Areas:

- Containerization within storage areas.
- Stock is used in order of age - rotate stock forward using older stock first

Assessments of Knowledge can follow a practical session, in and around food preparation & storage areas. For new cooks it is sufficient to ask them the questions verbally in the knowledge assessment. If answers show good understanding, then document responses [e.g. good understanding described]. Remember, not everyone is good at writing things down. If you take this approach:

- Do not give away answers
- Give examples to make the question clear
- Ask open questions
- Ask yes / no questions where appropriate
- Use simple words [avoiding jargon or complex language]
- Do not rely upon job history elsewhere as proof that your new employee has sufficient understanding of food contamination to keep your residents safe.
- Where knowledge is inadequate, back track over the training and repeat the assessment once the new employee has had a chance to upskill.
- Remember, this needs to be PRIOR to work commencement. It's harder to ask for changes in habit once bad habits have been established AND residents may risk food illness [Norovirus] in the meantime.
- Follow up with spot checks and practical HELP during the first month in particular.
- The kitchen is a critical area of Business Risk. It is costly in terms of human anguish, staff stress and money if groups of residents become sick with diarrhea and vomiting.
- Infection control in the kitchen is ALL ABOUT PREVENTION!

Assessment of Knowledge for staff who prepare, distribute or store food

Critical Point Number 1 – Personal Hygiene

1. When would you change your apron and send it to the laundry?

   a) At the end of _____

   b) And if it got d _ _ _ _

2. What are our rules about your hair in the kitchen?

3. You notice that one of the other staff has a cut on their finger. What are the rules about cuts?

4. Where is the staff 1st Aid Box? Is it available to you at all times?

5. Please select the boxes where staff must **NOT** be in the kitchen because of the risk of infection:

   - ☐ Eye infection
   - ☐ Ear infection
   - ☐ Weeping wound
   - ☐ Cold or flu
   - ☐ If I have had diarrhea in the past 24 hours.
   - ☐ Headache

6. How might a healthy person contaminate food without meaning to or without realizing it? Hint this is a simple answer, like by rubbing their itchy nose. How else?

Critical Point Number 2 – Contamination during preparation

1. What is the single BEST way to PREVENT food contamination?

2. You know it is not safe to use the same knife for meat and then for vegetables? What other cross infection can you think of?

3. You see a mouse run behind the fridge. What would you do?

Critical Point Number 3 – Cooking

1. How could frozen meat contaminate other food when it is thawing?

2. Chicken & pork must be thoroughly cooked [no blood within]. What temperature helps ensure safety?

Critical Point Number 4 - Storage

1. The fridge temp is checked daily. Today it is reading 8 degrees. What do you do?

2. Where are cooked foods stored in the fridge?

3. Where are raw foods stored in the fridge?

4. What are some other rules about storing food?

   Hint [cover the food] and write the t _ _ _ and d _ _ _.

5. Food is thrown out that is more that _ _ hours old.

6. It is OK to put hot food in the fridge YES NO

7. The freezer temperature is recorded daily. Today it is – minus 5 degrees. What do you do?

8. You defrosted a roast for resident dinner, then the manager arrived with fish and chips. What do you do with the roast? Can it go back in the freezer?

9. You are reheating a mince meal cooked yesterday and kept cool and safe in the fridge. How would you reheat it?

10. The resident does not eat this meal. What do you do with it?

END

Norovirus Outbreak Self Survey for Rest Homes

How Prepared are YOU?

Protection

TRAINING

Ref: SNZ 8134: 2008
Ref: HH.NET Training Module 11 – Infection Control & Outbreak Prevention
Ref: Bug Control Infection Control Manual: www.healthcareproviders.org.nz

☐ Have Bug Control Resource Manual for training guide how to put on a gown & outbreak resource!

☐ Staff knowledge assessed as competent- Critical Risk Points in Food Preparation.

☐ Staff knowledge assessed as competent standard precautions & outbreak response.

☐ Staff knowledge assessed as competent- Protecting self using gowns, masks and gloves - practical

SUSCEPTIBLE POPULATION

☐ BEWARE catching this on community visits. Stay well away from sick people.

☐ We enquire about the health of people where residents go to visit.

Hydration supplies

☐ **Fluid for sick people** Enalyte [or similar hydrating fluid on standby if cannot hold food down]

→ enough for several sick people over a long weekend on supply at all times

☐ **Food for sick people** Rice cook & strain the juice. Cook fresh green vegetables & strain the juice. Combine vegetable juice water and starch from cooked rice water to nourish sick people.

☐ Fluid Balance Chart kept [spares in Infection Outbreak box] Frequent fluids to all sick people.

Resident Care Equipment

It's a good idea to purchase bulk of one colour linen [e.g. bright yellow] to be used only by sick people:

- **flagged infectious by colour.**
- **boosts regular supplies**
- **ensures enough linen left for well residents**

☐ Outbreak towels → when towels start to go tatty retire to the outbreak box
→ flannels [more the better / can use disposable]
→ handtowels [very useful double as flannel or towel]

☐ Zinc and Castor Oil

- Essential to control risk of excoriated skin [sore bottoms]
- Chemist should make up 12 small pots very cheaply [one each affected person]

☐ Soothing Baby Wipes (one for each toilet and one in each sick person's room)

☐ Protect sofas and cushions before they are soiled

☐ Lots of big plastic bags for linen – especially if you decide to send it off site.

☐ Linen Skips: plastic lids / pedal operated and leak proof.

☼ Isolation supplies

☐ Laminated Work Instructions for staff.

☐ Laminated Signage for each door – entrances and sick residents bed rooms

☐ Long-sleeved gowns (mark inside and outside with marker pen) Much cheaper in bulk ordered in advance. Can be **very** expensive if needing same day delivery.

☐ Plastic stick-on hooks for back of doors [coat hangers work in an emergency]

☐ Hand gel – 2 litre bulk supply: smaller pumps for every sick person's room / at each entry point / in the lounge and in the dining room.

☐ Gloves (at least one months supply at hand at all times)

☐ Full face visor masks

☐ Masks for people doing the laundry – Capes medical (3N)

☐ Best Protection Masks = 3m (N95 Health Care particulate respirator), moulded splash resistant

NB: this is a light airborne virus. Visor offers far more protection and is easier to wear.
→ Goggles and masks still expose skin near nose and eyes

☐ Shoe covers – don't tramp the virus to every room.

☼ Cleaning supplies: Outbreak Clean up Box

☐ Heavy duty gloves right size for cleaner

☐ Bulk supply of detergent

☐ Ammonias + Bleach

☐ Dust pan + broom

☐ Paper towels or news Paper (mop up and discard)

☐ Good supply disposable clothes / old linen [retire tatty linen to the outbreak kit]

☐ Cleaning products with ammonia (As purchased from supermarket)

☐ Disposable hand towels and cleaning cloths (clean toilet/wall area after each use)

☐ Bleach sol 1:10 [keep at least 2 litres]

☐ Kitchen tidy bags

☐ Big bags (knot top)

☐ Environmental Cleaning contains outbreaks: Steam Cleaner → Walls / Curtains / Mattresses / Furniture
[reduces workload / very effective against the virus]

NB: It's a VERY good idea to have a dedicated cleaner on at all times during an outbreak. This can be well worth while as it cuts down risk of spread to well people and directly supports efforts of care staff.