



**Infection Control
And Communicable Diseases
Guidelines for
Early Years and Childcare**

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Contact numbers

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INFECTION CONTROL AND COMMUNICABLE DISEASE GUIDELINES FOR EARLY YEARS AND CHILDCARE SETTINGS

Introduction

Nowadays more children are attending childcare facilities from an early age, as an increasing number of parents go out to work. Although early years and childcare settings aim to provide children with a safe environment for growth, development and learning, it is not uncommon for infectious diseases to occur in these child daycare centres. This is because early years and childcare settings are an ideal environment for the spread of infection and infectious diseases because of the relatively low state of immunity of children and the difficulties in maintaining a high standard of hygiene.

The types of interactions among children, staff, and the environment in nurseries, affect the transmission of infection. Child-to-child interactions are more frequent in provisions, where children are in close proximity and spend time in common areas, such as playrooms, where the sharing of contaminated toys, equipment, and secretions can occur. In addition, childcare employees have close contact with the secretions of children, as routine care often involves holding, cuddling, changing nappies, feeding, and wiping away nasal discharge etc. Hall et al (1978) and Kurtz et al (1972) demonstrated how during outbreaks of respiratory syncytial virus (RSV, which causes bronchiolitis in infants and lower and upper respiratory tract infections at all ages) and whooping cough, workers can be exposed to infection and, as intermediary hosts, transmit it to other children in the nursery.

Once a child is old enough to mix with others, he/she is at risk of picking up infectious diseases from his/her playmates. Lopez et al (1988) describe how during the first five weeks of enrolment in a daycare centre, children have a 25% chance of diarrhoeal illness, while Lee Ford-Jones et al (1987) estimated that parents might lose 4.7 working days per year as a consequence of diarrhoea in a child attending nursery and a total of 15 working days due to all illnesses.

Good infection control measures are essential to protect both children and staff. This can only be achieved with education and awareness. This guidance document aims to provide information on the control and management of infection within an early years and childcare setting. Its loose-leaf format has been deliberately chosen to allow scope for the addition of new policies and to enable limited copying of specified pages.

Note This document has been designed for group care settings – a document specifically designed for childminders is currently under development.

Section 1 Personnel

It is the responsibility of the person operating an early years and childcare setting to ensure that:

- The childcare environment is visibly clean, free from dust and soilage, and acceptable to parents and staff.
- The early years and childcare setting has a designated space, which is inaccessible to children, for the preparation of food and snacks.
- There is an adequate supply of washbasins placed in strategic places, eg nappy-changing areas, toilets, food-preparation areas etc.
- Persons employed for the operation, management and supervision of the facility have adequate qualifications, experience and training.
- Staff have up-to-date immunisation records, including polio.
- Measures are taken to preserve the health and well-being of children and employees, and any child or employee who is sick is excluded from the nursery (refer to Section 19 of this document: Exclusion criteria).

It is advised that the early years and childcare staff keep a supply of plastic aprons and (non-sterile) waterproof gloves to be used:

- a) in cases of infection and outbreaks
- b) to clear up extensive faecal contamination and spillage of blood and body fluids.

Staff should be aware of the following;

- Basic principles of hygiene (hand washing, not sharing personal items such as toiletries, combs etc).
- General knowledge of infectious diseases and parasitic infections, including modes of spread.
- The need to report personal illness and exclude themselves from work if suffering from an infectious disease.
- The importance of keeping a permanent record of illness occurring in children and staff.
- The need to wear disposable waterproof gloves in situation where contact with blood or body fluids is expected, to prevent the transmission of blood-borne pathogens.

Section 2 Modes of transmission / Spread of disease

Infections and communicable diseases can be spread in a variety of different ways. The most frequent are set out below.

Person to person

Direct personal contact with contaminated body secretions or excretions, particularly via hands, or by kissing, biting or sexual contact. Spread of organisms by coughing, sneezing, spitting and talking can also occur through contact with small droplets.

Indirect personal contact via contaminated objects or materials such as toys, pencils, handkerchiefs, soiled clothing and crockery.

Common source

Food, water, body fluids, blood or blood products can act as vehicles for the spread of infectious agents. (Hepatitis B & C virus, and the HIV virus which is the cause of AIDS, cannot be transmitted through normal social contact and nursery activities.)

Airborne

Many infections (including a number of respiratory ones) spread in the air via minute particles produced as a result of coughing or sneezing. Spread can also occur through larger droplets (as described under “direct personal contact” above) or through dust.

Vehicles of spread

In the UK, vehicles including flies, cockroaches, fleas and mosquitoes quickly spread infection by simple physical transfer, eg bacteria carried on the footpads of flies.

Section 3 Immunisations

Immunisation is the safest and most effective way of protecting children against serious infectious diseases and it is strongly recommended that children should be fully immunized. There is little doubt that, in combination with other public health measures, immunisation programmes have been successful in reducing the incidence of disease and related deaths in the UK. When enough people are immunized, the disease is less likely to be transferred from one person to another and so there is less disease in the community as a whole.

One of the consequences of a successful immunisation programme is that it may result in parents believing that their children are no longer at risk of infectious diseases. It is clear, however, that when immunisation levels go down, disease levels rise, and for this reason it is necessary to keep vaccination uptake high to make sure that individual children as well as the whole community continue to be protected from infectious disease.

Recent studies have shown the importance that parents attach to being involved in the decision-making process for immunisation. Care should be taken to ensure that parents feel that their questions have been adequately answered and that their concerns about immunisation have been sensitively considered. For this reason parents of unvaccinated children should be encouraged to seek advice and answers to their questions from their GP or Health Visitor.

Recommended Immunisations Schedule 0–5 Years

- By the age of two all children should have received three doses of Diphtheria/ Pertussis (whooping cough) / Tetanus/ Polio/ Haemophilus Influenzae type b (Hib) and Meningococcal C immunisations and at least one dose of Measles/ Mumps/ Rubella (MMR).
- By the age of five all children should in addition have had a booster of Diphtheria/ Accellular Pertussis (whooping cough)/Tetanus, Polio and a second dose of Measles/Mumps/ Rubella (MMR).

Section 4 Hand Hygiene

Why is hand washing so important?

Hands are used for all sorts of activities during the course of a day and can become easily contaminated, eg after we have been to the toilet or during nappy changing. Sprunt et al (1973) demonstrated how germs are transferred onto hands by simply touching the buttocks of a baby, even if the nappy is not soiled. Germs on a child's hand can easily be passed to other children's hands by direct contact or by contamination of objects, eg toys. Once on the hands it is easy for germs to get into the mouth. Many infections are spread this way. If hands are thoroughly washed, for example after using the toilet, the number of germs they carry will be greatly reduced. Washing hands before eating helps to further reduce the risk of eating germs that may have contaminated hands.

Hand washing facilities

- There should be an adequate supply of washbasins in strategic places, eg nappy-changing areas, toilets, food-preparation areas etc.
- Washbasins should be placed at a height that will enable children to wash their hands easily.
- **Warm water should be available** since children are more likely to wash their hands if the water is comfortably warm. Also soap will produce a better lather in warm water and so clean hands more effectively.
- **It is recommended that liquid soap always be used** as bar soap can quickly become contaminated with germs. *If bar soap is used it should not be sitting in a pool of water in a soap dish, but should be allowed to drain so that it stays reasonably dry.* Liquid soap dispensers should be simple to use and easy to clean, and have disposable pack inserts of a microbiologically clean product. Topping-up is unsafe and should never be permitted. The agents selected should be assessed locally as acceptable and non-harmful to the skin.
- **It is recommended that paper towels and tissues be provided** and placed within easy reach of the sink, but beyond splash contamination. Thorough drying following hand washing is important: this mechanical process probably removes more bacteria than any other part of the hand washing procedure. Recent evidence demonstrates that the presence of bacteria is reduced by 91% simply by thoroughly drying hands with a paper towel. Paper hand towels dry hands rapidly, and several people at once can use dispensers, but they represent ongoing costs both in consumables and disposal of resulting waste. They are, however, considered to result in the lowest risk of cross infection and are the preferred option, as shared cloth or roller towels may become contaminated and lead to the transmission of infection.
- If cloth towels are used a separate towel must be provided for each child. These should be hung to dry on a hook or rail. These towels should be changed daily, or before if damp or visibly soiled. Remember children will share towels (even if they are not supposed to do so) and this can be an excellent way of spreading infection.

- There is conflicting evidence regarding the effectiveness of warm air hand-dryers. Newer models are less noisy than their predecessors, though they still take what many regard as an unacceptable time to dry the hands. This might deter children from washing hands in the first place.
- Nailbrushes should not normally be used, as they can be a reservoir for bacterial multiplication at the basin.

Key points for hand hygiene

Staff and children should follow the recommended hand washing procedure as follows to reduce the risk of disease transmission in the early years and childcare setting. **(See also handwashing poster next page.)**

- 1) Wet hands under running water.
- 2) Apply liquid soap.
- 3) Rub hands vigorously without adding more water for at least 10 seconds.
- 4) Wash all surfaces, including back of hands, wrists, paying particular attention to fingertips, thumbs and between fingers.
- 5) Rinse hands well under running water.
- 6) Dry hands, preferably with a single use disposable paper towel.

Staff must wash their hands:

- a) When they enter the early years and childcare setting in the morning, and before going home.
- b) Before they prepare, serve or eat food.
- c) Before and after smoking (if allowed on the premises).
- d) After they change nappies, handle soiled clothing, or wipe the nose of a child.
- e) After any cleaning procedure.
- f) After contact with blood or body fluids.
- g) After they have been to the toilet, either themselves or with a child.
- h) After handling pets, pet cages or other pet objects.
- i) After outdoor activities (eg playing with children in a sandpit).
- j) Before giving or applying medication to a child or self.

Children should wash their hands:

- a) Before they eat or drink.
- b) After they use the toilet, and after having their nappies changed.
- c) After they come into contact with a child who may be sick.
- d) After playing on the playground.
- e) After handling pets, pet cages or other pet objects.

How else can hands be protected? Any fresh abrasions, cuts etc on hands should be covered with an impermeable waterproof dressing.

Who else can help? The Health Visitor or Communicable Disease Unit can assist nurseries in education on personal hygiene and hand washing.

Section 5 Toileting

Children on the toilet

Children will only develop good hygiene practices if they are provided with adequate facilities, for example:

- Clean child size toilets, preferably with lids to the seats.
- Adequate supplies of soft toilet tissue in each toilet cubicle.
- Hand washing facilities. Children should not have to leave the toilet area to reach washbasins. If hand-washing facilities are some distance from the toilets, children will either not wash their hands (because it is inconvenient or they forget) or they may contaminate other children and objects before washing their hands.

Children should be supervised to ensure they wash their hands after using the toilet.

Children in nappies

Any early years and childcare setting that accepts children who are still in nappies must have appropriate facilities for changing nappies. Tables used for play or preparing/ serving food must not be used for this purpose.

- Clean nappies should be stored at a convenient distance from the nappy-changing area to prevent cross-contamination.
- It is recommended that a supply of disposable gloves and aprons is available, for use during possible outbreaks of gastroenteritis etc or if extensive faecal contamination is anticipated.
- Hand washing facilities for staff (hand-wash basin, liquid soap, paper towels) must be available in the nappy changing room.
- The nappy changing area should be placed away from the food preparation/ storage areas and any areas where food is consumed.
- Staff undertaking nappy changing should not be involved in the preparation of food.
- The nappy-changing surface should be smooth, non-absorbent and easily cleaned as changing mats can become contaminated and act as a reservoir for germs. All

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mats should be checked weekly for breaks or tears in the covering.

- Nappy changing mats and surfaces within the designated area should be wiped with hot soapy water and dried or wiped with a baby wipe after every change, when visibly soiled, and at the end of each day.
- The area should be cleaned daily and whenever visible contamination occurs.
- Children's skin should be cleaned with a disposable wipe or cotton wool. Flannels should not be used to clean bottoms. Nappy creams, lotions etc should be labelled with the child's name and must not be shared between children.
- Used disposable nappies should be discarded in pedal-operated bins that are lined with plastic bags. These bins should be kept away from the reach of children.
- Early years and childcare settings that produce a substantial number of used nappies should make arrangements for appropriate disposal (eg a contract with a waste disposal company).
- Staff must wash and dry their hands after every nappy change, before handling another child or leaving the nappy changing area.

Children on potties

- Potties should be used only in a designated area (eg in toilet or nappy changing areas), away from play facilities and away from where food and drink are prepared or consumed.
- Hand washbasins suitable for use by children and adults should be available in areas where potties are used.
- After use, the contents of the potty chair should be emptied into the toilet. The potty chair should then be washed in hot soapy water in a sink used only for this purpose, and dried. It must not be washed in a sink used for washing hands.
- Staff should wear household rubber gloves while emptying and cleaning potties. They should then thoroughly wash the gloves whilst still wearing them, remove and leave to dry, and **wash hands**. Alternatively disposable gloves may be worn.

Children should be supervised to ensure they wash their hands after using the potty.

Section 6 Group toothbrushing programmes

How to keep programmes clean and safe

Toothbrushes and other personal items should not be shared. A member of staff must always monitor toothbrush programmes.

Supervisors should:

- ✓ Wash hands before.
- ✓ Cover cuts and sores on the hands.
- ✓ Keep toothbrushes/cups etc separate for pupils – no sharing.
- ✓ Name-mark toothbrushes and colour code for classes.
- ✓ Toothpaste-to-brush contact should be indirect.
- ✓ Rinse brushes in water after use.
- ✓ Store toothbrushes dry.

What are the risks of viral cross infection?

- ✓ If the above are observed, the risk is extremely low. Viruses (HIV, Hep B & C) are mainly transmitted from person to person from blood to blood.

Dummies

The sharing of items such as dummies may result in the transmission of infection. The labelling, or use of some other method of identification that would ensure dummies are not shared, is appropriate.

Section 7 Linen

If laundry is undertaken on site, this should be in a designated area, away from food preparation and with hand washing facilities available. Early years and childcare settings processing laundry on site must undertake the following:

- Make sure dirty laundry is transported and stored safely so that children cannot get access to it.
- Provide a washing machine with sluice (pre-wash) and hot wash cycle.
- Provide suitable drying facilities and a separate area for storing clean linen.
- Provide separate hand wash facilities within the laundry area.
- Provide appropriate protective clothing for staff (gloves and plastic apron when handling fouled/infected linen or clothing).
- Staff must never manually sluice or soak linen and clothing soiled with body substances (urine, faeces, blood): they should use the sluice or rinse cycle on the washing machine.
- Linen, eg sheets, pillow slips and blankets, should be washed using domestic washing powder on a hot wash cycle, preferably at a temperature of 71°C or above. (The normal wash temperature of 40–60°C may not achieve satisfactory heat disinfection.) Other washing, eg clothes, should be washed on the hottest possible wash that will not damage them.
- Launder cloths and towels used in the kitchen separately from clothes and bed linen.

All staff must wash hands after handling used linen.

Section 8 Environmental cleaning (general areas)

A clean environment is essential to prevent the spread of infection, as germs cannot grow on a clean dry surface. It is important to make sure any damaged surfaces are replaced, since germs can accumulate and survive in rough areas and scratches.

Generally, using a neutral detergent, hot water and drying will be adequate for most surfaces and furniture. Disinfectants should not be used for environmental cleaning unless absolutely necessary, as they can be both harmful and toxic.

Floor, low shelves, doorknobs and other surfaces often touched by children wearing nappies should be cleaned with clean water and detergent solution: do not use disinfectants for general cleaning.

Basins & taps (excluding kitchens): Clean at least daily with detergent solution.

Bins: Clean daily with detergent solution.

Buckets: Wash after use with detergent solution. Dry and store inverted.

Carpets: Vacuum daily. There should be a schedule for cleaning carpets at least six-monthly.

Vacuum cleaners: Change the air filter regularly according to the manufacturer's instructions. Wipe detachable tools with a detergent solution.

Cloths/Dusters: Use disposable ones and throw away at the end of each day.

Drains: Clean daily with a detergent solution. Never clean drains with disinfectant.

Furniture: Surfaces should be damp-dusted daily with colour coded disposable cloths.

Mops: Use detachable mop heads. Wash after use in hot, soapy water, wring out and store mop inverted to dry.

Toilet bowls, toilet seats and flush handles: Clean at least daily using hot water and detergent. Disinfectant is not routinely required. In addition there should be arrangements for regular checks on toilet areas so that any accidental spillage or contamination can be dealt with promptly.

Tabletops and feeding trays: Must be cleaned immediately prior to serving food.

Section 9 Toys, paddling pools, sand pits

Sharing of toys amongst toddlers in childcare centres is a matter of routine. The problem of infection in children is aggravated by the normal behaviour of children themselves:

- Both well and unwell children handle toys.
- Toddlers between the ages of two and four have been observed to put a hand or an object in the mouth once every three minutes.
- Close contact of young children is almost constant unless children are specifically segregated.
- Younger children are incontinent of faeces before toilet training.
- Younger children lack proper personal hygiene because of their age.

A number of environmental items including toys have been thought to be implicated in the transmission of germs. If toys are shared they should be capable of being thoroughly cleansed. A schedule for regular cleaning should be devised, depending on the kind of toy and the likelihood of soiling.

Soft toys: Infections have been transmitted by toys. Soft toys in particular may be a problem and should be discouraged. If soft toys are to be used in play, staff should ensure that they are machine washable to ensure that adequate cleaning can be carried out should they become contaminated with body fluids.

Hard-surfaced toys: Should be cleaned daily using hot soapy water followed by drying as frequently as necessary throughout the day (according to perceived contamination and at least at the end of the day).

Mechanical toys: Should be surfaced wiped daily after use with a damp cloth that has been rinsed in hot water and detergent and then dried.

Play dough/plasticine: Skin lesions should be covered and hands washed before and after play. Replace soft modelling materials and dough regularly.

Books: Inspect weekly and wipe surfaces. Books that are visibly soiled/contaminated with body fluids should be discarded. Books with signs of dampness or mildew should also be disposed of.

Paddling pools easily become contaminated. Children who have diarrhoea and vomiting should not be allowed into the pool. Time in the pool should be restricted and stopped immediately if faecal soiling occurs. Children in nappies should be cleaned

before being allowed into the pool. The plastic or inflatable pool should be emptied, cleaned with detergent and hot water and stored dry after use. **Water Activities must be closely supervised.**

Sand pits: Sand may on occasions act as a vehicle for spreading infection. The pit must be capable of draining properly and will require regular raking, ideally on a daily basis but never less than weekly. Sand should be changed every term or when it becomes discoloured or foul smelling. The aim should be to keep the sand as dry as possible and inaccessible to pets and pests. Sand play structures with covered lids are fine as long as:

- a) They do not allow water to pool.
- b) They have air holes to allow air circulation.

When an outbreak of gastroenteritis occurs, play with sand, water and plasticine/play dough should be suspended until the outbreak is over.

Section 10 Animals in nursery (permanent or visiting)

Animals may carry infections, especially gastroenteritis. Guidelines for protecting the health and safety of the children should be followed.

- Animal living quarters should be kept clean. Do not wash cages etc in food hygiene areas. All waste should be disposed of regularly. Litter boxes should not be accessible to children or pregnant staff.
- Young children should be supervised when playing with animals and **must wash their hands after handling animals.**
- We strongly discourage early years and childcare settings from keeping terrapins and reptiles as pets, as all species can carry salmonella.

Farm Visits

Over the past few years a number of children have contracted disease from animals following a farm visit. Some of these are of little consequence, but a number may cause considerable distress especially to children, and can on occasion cause serious disease. Visits to farms are educationally beneficial and, provided a few commonsense precautions are observed, they can be safely enjoyed by children.

Please see appendix for the Health and Safety Executive (HSE) information sheet on farm visits.

Section 11 Head Lice

Head louse infection is a problem of the whole community. Parents start to worry more about lice when children start to socialize within group settings as they think the lice are being caught there. In fact many infections are caught from family and friends in the home and community. It is not just children who get lice: adults get them too.

You can get head lice if you hold your head still, pressed firmly for at least one minute, against the head of someone who has lice. Many people only realize they have head lice when itching starts. By then they may have had head lice for 2–3 months without knowing it. However, some people never get the itch. They may have a few lice on their heads for years without knowing it, and can pass them on to other people.

Parents should be advised to examine children regularly for signs and symptoms of infection and arrange prompt treatment. Advice may be sought from their local Health Visitor or GP.

For further information see Appendix 3 Head Lice: The Truth and the Myths – Notes for Families

Section 12 Female staff in an early years and childcare setting: pregnancy

Some infections can pose a risk to the unborn child if acquired by the mother during pregnancy. These include:

- **Chickenpox**

This can affect the pregnancy of a woman who has not previously had the disease. If she is exposed in the first 20 weeks or last three weeks of pregnancy she should seek prompt medical advice from her GP/antenatal clinic.

- **German Measles (Rubella)**

The unborn child can be affected if an expectant mother who is not immune to German measles is exposed in early pregnancy. It is strongly recommended that all children be vaccinated against German measles as this greatly reduces the risk of exposure. Any non-immune expectant mother who is exposed to German measles should seek advice from her GP/antenatal clinic.

- **Slapped cheek disease (parvovirus)**

Occasionally this condition can affect an unborn child. Any woman exposed early in pregnancy (before 20 weeks) should promptly inform whoever is giving her antenatal care.

- **Cytomegalovirus (CMV)**

This is a common virus, from the same group as the chickenpox virus. Most of us pick it up in childhood, often without knowing it. Practising good hygiene, ie hand washing, will help prevent it, but expectant mothers who are exposed to a known case should inform whoever is giving them their antenatal care.

Section 13 **Cleaning up body fluid spills**

- Spills of body fluids: urine, faeces and vomit must be cleaned up immediately.
- Wear disposable gloves and remove as much of the spillage as possible by mopping up with absorbent toilet tissue or paper towels: these can be disposed of by placing into a plastic waste sack (or flushing down the toilet if there are only small amounts).
- For spillages indoors, clean the area with detergent and hot water, rinse and dry.
- For spillages outdoors (eg playground), sluice the area with water.

Cleaning up body fluid spills – blood

- Blood spillages must be cleaned up immediately.
- Wearing disposable gloves and apron, remove as much of the spillage as possible by mopping up with absorbent toilet tissue or paper towels.
- It is not necessary to use household bleach to clean the area. Thorough cleaning with detergent and water will suffice. How well the cleaning is done is more relevant than the chemical used.
- If however decontamination with chemicals is the chosen policy of the early years and childcare setting, then the following guidance should be followed.
- Cover area with paper towels and then soak towels with 10,000 ppm 1% hypochlorite solution eg Milton 2 diluted 50/50 with cold water, or 1 part Domestos and 10 parts water. Alternatively sprinkle chlorine-releasing granules on spill. Leave at least two minutes before clearing away.
- Clean area with detergent and water.
- Hands should be washed after removing gloves and apron.
- Blood or other body fluid spillage on carpets and upholstery should be cleaned with warm soapy water or a proprietary liquid carpet shampoo, since the use of hypochlorites may discolour fabrics.
- Blood on clothing should be treated by simply washing, preferably in a washing machine.

NB COSHH hazard At this concentration chlorine releasing concentrations are both toxic and corrosive and should be used only in well-ventilated areas and on hard surface floors. Please be aware and follow manufacturers' instructions on all chemical products.

Section 14 Cuts, bites and needlestick injuries

Cuts

When dealing with cuts and nosebleeds, staff should follow the early years and childcare setting's first aid procedure: the incident should also be recorded in the accident book. It is good practice for staff to use disposable gloves when dealing with all wounds. If such an approach is used there is a negligible risk of blood-borne virus spread.

Human Bites

Human mouths are inhabited by a wide variety of organisms, which can be transmitted by bites. Human bites which break the skin are more likely to become infected than dog or cat bites. There is a theoretical risk of transmission of Hepatitis B from human bites. Though HIV can be detected in the saliva of people who are HIV positive, there is no documented evidence that the virus has been transmitted by bites.

If a bite does not break the skin

1. Clean with soap and water.
2. No further action required.

If a bite breaks the skin

1. Clean immediately with soap and water.
2. Record incident in Accident Book.
3. Seek medical advice:
 - a. To treat potential infection.
 - b. For reassurance and information on HIV and Hepatitis B infection.

Animal bites

In the UK there have been no reported cases of rabies, therefore vaccination is not required. If an animal bite breaks the skin, wash with soap and water and seek medical advice about possible need for treatment to prevent infection, eg antibiotics/tetanus.

Needlestick injury

On rare occasions children or staff may injure themselves on discarded used hypodermic needles which they have found. As well as ensuring that the injured person gets any necessary care, it is important that the needle is disposed of safely to avoid the same thing happening to others. If a discarded needle or syringe is found, it should be

carefully placed in an empty drinks can or similar container and disposed of in a waste bin. If discarded needles are found frequently, arrangements should be made for the early years and childcare setting to have a sharps box for proper disposal, and the safety issues should be discussed with and reported to the local Police and Environmental Health.

If someone pricks or stabs themselves with a used hypodermic needle:

- a) Encourage the wound to bleed.
- b) Wash the wound thoroughly with soap and running water.
- c) Cover it with a waterproof dressing.
- d) Record it in the accident book.
- e) Seek immediate medical advice from GP or A&E Department about possible need for immunisations (eg Tetanus, Hepatitis B).

Locally there has been no documented evidence of people acquiring HIV or Hepatitis B from discarded needles. Nevertheless Hepatitis B immunisation is recommended in these incidents, so it is important to seek immediate medical advice.

Section 15 Diarrhoea and/or vomiting outbreak

Where several related cases of an infection occur, it will be necessary to investigate the outbreak more thoroughly. The steps required to investigate an outbreak of disease are outlined below. Several steps in the sequence may run in parallel.

1. Inform your manager/Officer-in-charge/Co-ordinator if you believe you have a problem ie more than expected numbers of children off ill or displaying symptoms.
2. Inform the Communicable Disease Nurse (CDN) who will give you immediate infection control advice (see contact numbers at front of this manual).
3. Inform Environmental Health Department (see contact numbers at front of this manual).
4. Make a list of children with symptoms and staff: the Environmental Health Officers will require this to follow up cases. ***A template form for photocopying is available: see Section 16.***
5. The Communicable Disease Nurse in conjunction with the Greater Manchester Health Protection Unit and Environmental Health Officers will assess the situation and decide what, if any, further action is necessary either to investigate the source of the outbreak or to stop further spread.
6. Where necessary the Communicable Disease Nurse or a member of the Greater Manchester Health Protection Unit will visit the nursery and offer further advice and information for parents.

Note: Whilst it is acknowledged that collecting this data before contacting the Environmental Health Officer and Communicable Disease Nurse will use valuable nursery resources, such an appraisal does save time and allows for a quicker and more effective response. Collecting this data should happen at the same time as the Environmental Health Officer and Communicable Disease Nurse are contacted.

7. The list should include:

- A list of the names, ages, addresses, telephone numbers and GPs of the children/staff who are ill (it is good practice to hold routinely a list of the phone numbers and GPs).
- The start date of the illness.
- The main symptoms.

The list should be up-dated daily.

Also note the following:

- Are any particular groups or classes affected?
 - Does the illness only involve children who eat food prepared at the nursery (provide a menu), or does the illness also affect children who eat food prepared and brought in by parents (make a note)?
 - What is the usual percentage of children absent? Has this changed?
8. Ensure domestic staff are aware of the situation so that environmental cleaning can be increased (especially toilets/door/flush handles) and regular checks on toilet areas made.
 9. Ensure hot water, soap (preferably liquid soap) and paper towels are available in the toilets of both children and staff.
 10. Staff should reinforce good hand hygiene with children, especially after going to the toilet and before eating and drinking – supervision of handwashing should be undertaken.
 11. Objects which can become contaminated when handled by children or when they put them in their mouths are of particular significance, eg toys should be cleaned and dried after use.
 12. Exclude children with symptoms from the nursery until they have been symptom-free for the period advised by the Health Protection Unit or Environmental Health.
 - 1.3 Advise staff members with symptoms to refrain from work until they have been symptom-free for 48 hours.

When an outbreak of gastroenteritis occurs, play with sand, water and plasticine/play dough should be suspended until the outbreak is over.

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Section 17 Suspected meningococcal infection

Meningitis is a rare disease. Around 2,000 cases are reported each year in England and Wales (population 52 million), which means that a GP might see only one or two cases in his/her entire career. Meningitis is largely a seasonal disease: rather than being spread throughout the year, cases in the UK mainly occur in winter.

When a case occurs in a child who attends an early years and childcare setting, the most important thing is that all parents are given adequate information. Usually this will be in the form of a letter from the nursery manager and a meningitis information leaflet.

- On notification of a suspected case of meningococcal infection in an early years or childcare setting, the Communicable Disease Nurse or member of the Greater Manchester Health Protection Unit will contact the relevant establishment.
- Reassurance will be offered to the setting/provision, and if the provider wishes this will be supported by a visit from a member of the Greater Manchester Health Protection Unit.
- Information leaflets will be provided for the nursery for distribution to parents and staff. See Appendix 4 for Meningitis Trust Leaflet.
- It is important that parents are informed of a possible case of meningococcal infection in writing from the person in charge of the nursery. **A specimen letter is included in Section 18 of this manual, but it is sensible to discuss this carefully first with a member of the Health Protection Unit.**
- A member of the Health Protection Unit will be available to speak to parents or guardians and staff as requested.
- Contact tracing is not necessary in isolated cases. The Greater Manchester Health Protection Unit will decide who, if anyone, needs to be given antibiotics (usually close family members living in the same household). **There is no increased risk to other children from an isolated case in a nursery, and antibiotics are not required.**
- In the unlikely event of there being two or more cases which are thought to be connected in an early years or childcare setting, the Health Protection Unit would consider further control methods.

All press enquiries should be referred to and dealt with by the Greater Manchester Health Protection Unit.

Section 18 Specimen letter in the case of suspected meningitis

Dear parents,

I wish to inform you that a child at (name of provision) has developed suspected meningitis. The Department of Public Health/Greater Manchester Health Protection Unit has advised me that there is no increased risk to other children who attend the early years and childcare setting. However you may care to look at the enclosed information leaflet, which provides relevant information. The child attends on _____.

If you have any concerns whatsoever about your child's health, please do not hesitate to seek appropriate medical advice from your General Practitioner.

Yours sincerely,

SECTION 19 EXCLUSION CRITERIA No child who is unwell should be in a childcare facility. The following exclusion criteria refer to “well” children. All medical conditions should be treated in strict confidence. If you are concerned about the public health aspects of any disease consult the Communicable Disease Unit before divulging any information about staff or children to staff members or others.
Further information, leaflets and advice available from Communicable Disease Nurse

TO MINIMISE THE RISK OF INFECTION TO OTHER CHILDREN AND STAFF		
RASHES AND SKIN	Recommended period to be kept away from nursery school (once child is well)	COMMENTS
Athletes foot	None	
Chickenpox	For five days from onset of rash	It is not necessary to wait until spots have healed or crusted. (IMPORTANT: see Female Staff In Childcare Facilities -Pregnancy).
Cold sores (Herpes simplex virus)	None	Usually a mild disease not justifying time away from childcare
German measles (rubella)	Five days from onset of rash	Most children and staff should be immune due to vaccination. (IMPORTANT: see Female Staff In Childcare Facilities - Pregnancy).
Hand, foot and mouth disease	None	Usually a mild disease not justifying time away from childcare
Impetigo	Until lesions are crusted or healed	Antibiotic treatment by mouth may speed healing. If lesions can reliably be kept covered exclusion may be shortened.
Measles	Five days from onset of rash	Measles is now rare in the UK since the commencement of the MMR schools campaign in 1994.
Ringworm (Tinea)	None	Proper treatment by the GP is important Scalp ringworm needs treatment with an antifungal by mouth

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Scabies	Until treatment commenced	Outbreaks have occasionally occurred in childcare facilities. Exclusion is not indicated provided treatment is started. All persons in the household should be treated at the same time.
Scarlet fever	Five days from commencing antibiotics	Treatment recommended for the affected child
Slapped cheek or Fifth disease (Parvovirus)	None	(IMPORTANT : see Female Staff In Childcare Facilities - Pregnancy). Exclusion is ineffective as nearly all transmission takes place before the child becomes unwell
Warts and verrucae	None	Affected children may go swimming

SECTION 19 EXCLUSION CRITERIA

DIARRHOEA & VOMITING ILLNESS	Recommended period to be kept away from nursery school (once child is well)	COMMENTS
Diarrhoea and/or vomiting (with or without a specified diagnosis)	Until diarrhoea and vomiting have settled i.e. no symptoms for at least 48 hours.	Usually there will be no specific diagnosis and for most conditions there is no specific treatment. For advice please contact the Environmental Health Department.
E.coli	Depends on the type of E.coli	SEEK FURTHER ADVICE from the Greater Manchester Health Protection Unit via the Communicable Disease Nurse
Cryptosporidium	Until diarrhoea and vomiting have settled i.e. no symptoms for at least 48 hours.	For advice please contact the Environmental Health Department
Dysentery (Shigella)	Until diarrhoea has settled i.e. no symptoms for at least 48 hours.	For advice please contact the Environmental Health Department
Giardia	Until diarrhoea has settled i.e. no symptoms for at least 48 hours.	For advice please contact the Environmental Health Department.
Salmonella and *Campylobacter	Until diarrhoea and vomiting have settled i.e. no symptoms for at least 48 hours.	For advice please contact the Environmental Health Department
RESPIRATORY	Recommended period to be kept away from childcare (once child is well)	COMMENTS
'Flu' (influenza)	None	Flu is most infectious just before and at the onset of symptoms.
Tuberculosis	Health Protection Unit or TB Nurse will advise	Generally requires quite prolonged, close contact for spread. Not usually spread from child to child in childcare environments.
Whooping cough (Pertussis)	Five days from commencing antibiotic treatment	Treatment (usually with erythromycin) is recommended though non-infectious coughing may still continue for many weeks. High levels of immunisation provide the best protection.

SECTION 19 EXCLUSION CRITERIA

OTHERS	Recommended period to be kept away from childcare (once child is well)	COMMENTS
Conjunctivitis	None once treatment started	If an outbreak occurs consult the Greater Manchester Health Protection Unit via the Communicable Disease Nurse.
Cytomegalovirus	None	Often asymptomatic. See Female Staff In Childcare Facilities - Pregnancy.
Glandular fever (Infectious mononucleosis)	None	
Head lice	None	Treatment is recommended only in cases where live lice have definitely been seen." Alert " letters should not be sent out. (see Leaflet in appendices)
Hepatitis A	5 days from onset of jaundice or pale stools	For advice please contact the Environmental Health Department or the Health Protection Unit via the Communicable Disease Nurse. <u>WHO MUST BE CONTACTED IF MORE THAN ONE CASE</u>
Meningitis & meningococcal septicaemia	The Communicable Disease Nurse/Health Protection Unit will give specific advice on any action needed	There is no reason to exclude from childcare facilities siblings and other close contacts of a case.
Mumps	Five days from onset of swollen glands	The child is most infectious before the diagnosis is made.
Threadworms	None	Transmission is uncommon in childcare facilities but treatment is recommended for the child and family.
Tonsillitis	None	There are many causes, but most cases are due to viruses and do not need an antibiotic. For one cause, streptococcal infection, antibiotic treatment is recommended.
HIV/AIDS	HIV is not infectious through casual contact. There have been no recorded cases of spread within a nursery. There is NO indication to inform staff or pupils if someone in the childcare facility is HIV positive. (See BODY FLUID SPILLAGES)	

HEPATITIS B AND C

Although more infectious than HIV, hepatitis B and C have only rarely spread within a school setting. Universal precautions will minimise any possible danger of spread of both hepatitis B and C. **(See BODY FLUID SPILLAGES)**

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Section 20 Infection Control Audit (Childcare Facilities)

Date: _____ Nursery: _____
 Start time: _____ Finish time: _____

Key to responses:
 Full compliance Y Non-compliance N

Standard: The environment will be maintained appropriately to prevent the risk of cross infection.

Section 1 – GENERAL ENVIRONMENT

	Y	N	Comment
1. All areas are clean and dust free.	<input type="checkbox"/>	<input type="checkbox"/>	
2. Furniture is clean and in a good state of repair.	<input type="checkbox"/>	<input type="checkbox"/>	
3. All walls are visibly clean and free from dust.	<input type="checkbox"/>	<input type="checkbox"/>	
4. Cots/beds are clean, linen is changed & laundered regularly ie between use & following contamination.	<input type="checkbox"/>	<input type="checkbox"/>	
5. Mattresses are covered with a waterproof cover.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Mattress covers are in a good state of repair. Test: randomly select a mattress, examine mattress – no staining should be visible, mattress should be impermeable to fluids. Place a paper towel beneath the mattress cover, & press down for 10 seconds, pour 30mls of water onto area, press down for another 30 seconds. Remove & examine paper towel for signs of leakage through cover.	<input type="checkbox"/>	<input type="checkbox"/>	
7. High chairs are clean & regularly washed when soiled with detergent and hot water.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Does the childcare provision have a cleaning regime which advocates colour coded systems and use of damp dusting with detergent and hot water?	<input type="checkbox"/>	<input type="checkbox"/>	

Section 2 – NAPPY CHANGING AREA

	Y	N	Comment
Nappy changing area			
9. Area is away from food preparation area.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
10. The nappy changing area is visibly clean.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
11. Clean nappies are stored a convenient distance away from nappy changing area to prevent cross-contamination.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
12. Hand washing facilities are available in nappy changing area.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
13. Liquid soap & disposable paper towels are available.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
14. The nappy changing surface is smooth, non- absorbent and easily cleaned.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
15. Nappy changing mats & surfaces are cleaned with detergent & hot water and dried or wiped with a baby wipe between every change.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
16. Mats are checked weekly for breaks and tears in the covering.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
17. Disposable gloves/ plastic aprons are available in case of extensive faecal contamination.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
18. Staff undertaking nappy changing are not involved in food preparation.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

Section 3 – TOILET AREAS

	Y	N	Comment
Children's Toilets			
19. There are sufficient toilets (one per 10 children) and hand wash-basins available, which are the correct height for the children.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
20. Toilets & surrounding area are clean & free from extraneous items.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
21. Liquid soap, disposable paper towels & warm running water are available.	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>
22. If non-disposable towels are used, are these clearly identified for each individual child?	<input type="checkbox"/>	<input type="checkbox"/>	<hr/>

- | | | | |
|---|--------------------------|--------------------------|--|
| 23. Non-disposable towels are hung between uses with sufficient space between them to reduce chances of cross-contamination. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 24. There are adequate supplies of toilet paper. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 25. Staff hand washing facilities are available. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 26. Children are taught hand-washing technique and are supervised during toilet & hand washing activities. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 27. Potties are processed correctly between use ie emptied into toilet, washed in hot soapy water in a designated sink and dried. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 28. Potty chairs are clean & free from soiling. | <input type="checkbox"/> | <input type="checkbox"/> | |

Section 4 – PLAY EQUIPMENT

- | Toys | Y | N | |
|---|--------------------------|--------------------------|--|
| 29. Toys are clean, in a good state of repair and easily washable. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 30. A regular cleaning programme is undertaken for all toys. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 31. Play dough is fresh and clean. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 32. Outside sand pits are covered to protect sand from soiling by animals, and are raked at least weekly. | <input type="checkbox"/> | <input type="checkbox"/> | |

REFERENCES

Department for Education and Employment Guidance on infection control in schools and nurseries: "Our Healthier Nation".

"Head Lice: The Truth and the Myths – Notes for families" – Community Healthcare Bolton NHS Trust.

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APPENDIX 1

Farm Visits - ill health at open farms (HSE)

Please click on the link below to view the Health and Safety Executive (HSE) Information Sheet:

<http://www.hse.gov.uk/pubns/ais23.pdf>

APPENDIX 3

Head Lice: The Truths and Myths – Notes for Families

The Lice

- Head lice are small insects with six legs. They are often said to be “as large as a match head” – in fact, they are often not much bigger than a pin head, and rarely bigger than a sesame seed (the seeds on burger buns).
- They live on or very close to the scalp, and don’t wander far down the hair shafts for very long.
- The louse’s mouth is like a very small needle. It sticks this into the scalp and drinks the blood.
- They can only live on human beings – you can’t catch them from animals.
- Nits are not the same thing as lice. Lice are the insects, which move around the head. Nits are egg cases laid by lice, stuck on to hair shafts. They are smaller than a pin head and are pearly white.
- You only have head lice if you can find a living, moving louse (not a nit) on the scalp.

Who and Where?

- Anybody can get head lice but they are much rarer in adults.
- Head louse infection is a problem of the whole community, not just in schools and childcare facilities.
- Infection is common during school holidays as well as during term time. Parents start to worry more about lice when children go back to schools and childcare because they think the lice are being caught there.
- A lot of infections are caught from close family and friends in the home and community, not from the school or childcare environment.
- It’s not just children who have them; adults get them too.
- It’s often said that head lice prefer clean, short hair. In fact, they probably don’t much care whether hair is dirty or clean, short or long. Short hair may make it easier for them to get from one head to another.

How you get them

- Head lice can walk from one head to another when the heads are touching for some time.
- You are very unlikely to pick up head lice from brief contact with other people. The longer you have head-to-head contact with someone who has lice, the more likely it is you will get them too.
- They can't swim, fly, hop or jump. The idea that they can jump may have come from the fact that, when dry hair is combed, a head louse caught on the teeth of the comb is sometimes flicked off by static electricity (this is one reason why detection combing should be done with the hair damp).
- You don't get them from objects such as the chair back. Although it's possible that a louse might get from one head to another if a hat is shared, this is very unlikely. It's not the way infection is usually caught.

What happens next

- If you catch one or two lice, they may breed and increase slowly in number. At this stage, most people don't have any symptoms and won't know they have lice unless they look very carefully for them.
- For the first two or three months, there is usually no itch, but then the scalp may start to itch badly. This is due to an allergy, not to the louse bites themselves.
- Most people only realise they have head lice when this itch starts. By then they've had lice on their head for two or three months without knowing it.
- In most infections, there aren't more than a dozen or so lice on the scalp at any one time.
- Some people never get the itch, including adults. They may have a few lice on their heads for years without knowing it, and can pass them to other people.
- Louse droppings may fall on to the pillow during the night. Pillows may then get dirty more quickly than usual.

Prevention – can you stop them?

- Combing is an important part of good personal care, but head lice are not easily damaged by it. Good hair care may help to spot lice early and so help to control them. There is no evidence that the old slogans "Break its legs, so it can't lay eggs" or "A legless louse is an eggless louse" have any truth in them.

- The best way to stop infection is for families to learn how to check their own heads. This way they can find any lice before they have a chance to breed. They can then treat them and stop them going round the family.
- The way to check heads is called “detection combing”. It can be done as often as families want to.
- If a living moving louse is found on one of the family’s heads, the others should be checked carefully. Then any of them who have living lice should be treated at the same time.

How to treat head lice

- You should only ever treat someone for head lice if you have found a living moving louse.
- The best treatment is to use lotion (not shampoo) from the chemist or your local doctor’s surgery.
- If you are sure you have found living lice after proper treatment, don’t keep putting more lotion on: ask advice from the local chemist, health visitor, family doctor, or the school nurse.

The problems won’t go away

- The problem may not be head lice at all. Often we think there are lice when there aren’t really any there. We all start to itch as soon as head lice are mentioned.
- There are other causes for itching of the scalp. Using head louse lotion can make these worse.
- Using lotion over and over again can cause dermatitis, which itself makes the head itch.
- When living, moving lice are found they can almost always be cleared by using the right lotion. This will only work if enough of it is used, if it is put on in the right way, and if any other family members who have lice are treated properly as the same time.
- A day or two after using the lotion, you sometimes find little lice still there. These have hatched out of the eggs since you put the lotion on, and will be killed if you put the lotion on again after seven days.
- When you have got rid of the lice, you might still itch for two or three weeks. This doesn’t mean you still have lice. Check the head carefully. Remember, you don’t

have head lice if you can't find a moving living louse.

- When you have got rid of all the lice, the nits (empty egg cases stuck on the hairs) will still be there. This doesn't mean you still have lice, and you shouldn't treat again no matter how many nits there are if you can't find a living louse.
- People who think their children keep on getting head lice may have made the mistakes listed above, and may keep on "treating" lice which have long since been cleared, or were never even there in the first place.
- If children do really keep on having living lice, this is most likely to be due to not doing the treatment properly and not treating all those close contacts who have also been found to have lice. Remember, if infection really does keep on happening, it is almost always from a member of the family, or a close friend. It is rarely from other children in the classroom/playroom except from a "best friend".
- If you still have problems, ask your family doctor, local chemist, or health visitor if a wet-combing method to remove the head lice might help.

What schools & childcare facilities can do

- Schools/childcare facilities must remember that most lice are caught in the family and the local community, not in the classroom/playroom.
- "Nitty Norah" head checks will not help, but the School Nurse/Health Visitor can advise and support parents to check their own families.
- "Alert" letters should not be sent out. These can cause an "outbreak" of imaginary lice.
- Children who may have lice should not be excluded from school/childcare: if they do have lice, they will probably have been there for weeks already. The School Nurse or Health Visitor can help the parents to make sure whether there really are lice there, and how to get rid of them if they are.
- Talks for parents by the School Nurse or Health Visitor can be helpful.

What families can do

- Make sure that all family members know about good hair care, including regular, thorough combing.
- The only way which works to control head lice, is for the family to check their own heads.

- Check all the family's heads every now and then with a special plastic detection comb from the chemist's shop.
- All the family means everyone (adults as well as children) in the same household.
- Only if you are sure you have found living, moving head lice in your family, tell your relatives and close friends so that they can check their own heads. Treat any of your family you are sure have lice at the same time. Ask at the chemist's, the surgery, or the School Nurse/Health Visitor which lotion you should use.
- Remember, never use the lotions unless you are sure you have found living, moving head lice (not nits).
- Try not to worry too much about head lice. They are unpleasant, but they rarely do any harm other than causing an itchy scalp.

APPENDIX 4

Meningococcal Meningitis / Septicaemia Leaflet

Please click on the link below to view an information leaflet produced by the Meningitis Trust

http://www.meningitis-trust.org/area/what_is_meningitis.pdf

