

# Guidance on infection control in schools and other childcare settings

Prevent the spread of infections by ensuring: routine immunisation, high standards of personal hygiene and practice, particularly handwashing, and maintaining a clean environment. Please contact the Public Health Agency **Health Protection Duty Room (Duty Room) on 0300 555 0119** or

visit [www.publichealth.hscni.net](http://www.publichealth.hscni.net) or [www.gov.uk/government/organisations/Public-health-england](http://www.gov.uk/government/organisations/Public-health-england) if you would like any further advice or information, including the latest guidance. Children with rashes should be considered infectious and assessed by their doctor.

| Rashes and skin infections                      | Recommended period to be kept away from school, nursery or childminders                 | Comments  |
|---|---|---|
| Athlete's foot                                  | None  | Athlete's foot is not a serious condition. Treatment is recommended   |
| Chickenpox*                                     | Until all vesicles have crusted over  | See: Vulnerable children and female staff – pregnancy   |
| Cold sores, (Herpes simplex)                    | None  | Avoid kissing and contact with the sores. Cold sores are generally mild and self-limiting   |
| German measles (rubella)*                       | Four days from onset of rash (as per "Green Book")                                      | Preventable by immunisation (MMR x 2 doses). See: Female staff – pregnancy  |
| Hand, foot and mouth                            | None  | Contact the Duty Room if a large number of children are affected. Exclusion may be considered in some circumstances   |
| Impetigo  | Until lesions are crusted and healed, or 48 hours after commencing antibiotic treatment | Antibiotic treatment speeds healing and reduces the infectious period   |
| Measles*  | Four days from onset of rash  | Preventable by vaccination (MMR x 2). See: Vulnerable children and female staff – pregnancy   |
| Molluscum contagiosum                           | None  | A self-limiting condition   |
| Ringworm  | Exclusion not usually required  | Treatment is required   |
| Roseola (infantum)                              | None  | None  |
| Scabies   | Child can return after first treatment  | Household and close contacts require treatment  |
| Scarlet fever*                                  | Child can return 24 hours after commencing appropriate antibiotic treatment             | Antibiotic treatment recommended for the affected child. If more than one child has scarlet fever contact PHA Duty Room for further advice  |
| Slapped cheek (fifth disease or parvovirus B19) | None once rash has developed  | See: Vulnerable children and female staff – pregnancy   |
| Shingles  | Exclude only if rash is weeping and cannot be covered                                   | Can cause chickenpox in those who are not immune i.e. have not had chickenpox. It is spread by very close contact and touch. If further information is required, contact the Duty Room. SEE: Vulnerable Children and Female Staff – Pregnancy |
| Warts and verrucae                              | None  | Verrucae should be covered in swimming pools, gymnasiums and changing rooms   |

| Diarrhoea and vomiting illness              | Recommended period to be kept away from school, nursery or childminders                | Comments   |
|---|--|--|
| Diarrhoea and/or vomiting                   | 48 hours from last episode of diarrhoea or vomiting                                    |  |
| <i>E. coli</i> O157 VTEC*                   | Should be excluded for 48 hours from the last episode of diarrhoea                     | Further exclusion is required for young children under five and those who have difficulty in adhering to hygiene practices   |
| Typhoid* [and paratyphoid*] (enteric fever) | Further exclusion may be required for some children until they are no longer excreting | Children in these categories should be excluded until there is evidence of microbiological clearance. This guidance may also apply to some contacts of cases who may require microbiological clearance |
| Shigella* (dysentery)                       |  | Please consult the Duty Room for further advice  |
| Cryptosporidiosis*                          | Exclude for 48 hours from the last episode of diarrhoea                                | Exclusion from swimming is advisable for two weeks after the diarrhoea has settled   |

| Respiratory infections      | Recommended period to be kept away from school, nursery or childminders                                    | Comments  |
|-----------------------------|--|---|
| Flu (influenza)             | Until recovered  | See: Vulnerable children  |
| Tuberculosis*               | Always consult the Duty Room   | Requires prolonged close contact for spread   |
| Whooping cough* (pertussis) | 48 hours from commencing antibiotic treatment, or 21 days from onset of illness if no antibiotic treatment | Preventable by vaccination. After treatment, non-infectious coughing may continue for many weeks. The Duty Room will organise any contact tracing necessary |

| Other infections                        | Recommended period to be kept away from school, nursery or childminders                             | Comments  |
|---|---|---|
| Conjunctivitis                          | None  | If an outbreak/cluster occurs, consult the Duty Room  |
| Diphtheria *                            | Exclusion is essential. Always consult with the Duty Room   | Family contacts must be excluded until cleared to return by the Duty Room. Preventable by vaccination. The Duty Room will organise any contact tracing necessary  |
| Glandular fever                         | None  |   |
| Head lice                               | None  | Treatment is recommended only in cases where live lice have been seen   |
| Hepatitis A*                            | Exclude until seven days after onset of jaundice (or seven days after symptom onset if no jaundice) | The duty room will advise on any vaccination or other control measure that are needed for close contacts of a single case of hepatitis A and for suspected outbreaks.   |
| Hepatitis B*, C, HIV/AIDS               | None  | Hepatitis B and C and HIV are bloodborne viruses that are not infectious through casual contact. For cleaning of body fluid spills. SEE: Good Hygiene Practice  |
| Meningococcal meningitis*/ septicaemia* | Until recovered   | Some forms of meningococcal disease are preventable by vaccination (see immunisation schedule). There is no reason to exclude siblings or other close contacts of a case. In case of an outbreak, it may be necessary to provide antibiotics with or without meningococcal vaccination to close contacts. The Duty Room will advise on any action needed. |
| Meningitis* due to other bacteria       | Until recovered   | Hib and pneumococcal meningitis are preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. The Duty Room will give advice on any action needed   |
| Meningitis viral*                       | None  | Milder illness. There is no reason to exclude siblings and other close contacts of a case. Contact tracing is not required  |
| MRSA                                    | None  | Good hygiene, in particular handwashing and environmental cleaning, are important to minimise any danger of spread. If further information is required, contact the Duty Room   |
| Mumps*                                  | Exclude child for five days after onset of swelling   | Preventable by vaccination (MMR x 2 doses)  |
| Threadworms                             | None  | Treatment is recommended for the child and household contacts   |
| Tonsillitis                             | None  | There are many causes, but most cases are due to viruses and do not need an antibiotic  |

\* denotes a notifiable disease. It is a statutory requirement that doctors report a notifiable disease to the Director of Public Health via the Duty Room.

Outbreaks: if a school, nursery or childminder suspects an outbreak of infectious disease, they should inform the Duty Room.

## Good hygiene practice

**Handwashing** is one of the most important ways of controlling the spread of infections, especially those that cause diarrhoea and vomiting, and respiratory disease. The recommended method is the use of liquid soap, warm water and paper towels. Always wash hands after using the toilet, before eating or handling food, and after handling animals. Cover all cuts and abrasions with waterproof dressings.

**Coughing and sneezing** easily spread infections. Children and adults should be encouraged to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues. Spitting should be discouraged.

**Personal protective equipment (PPE).** Disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons must be worn where there is a risk of splashing or contamination with blood/body fluids (for example, nappy or pad changing). Goggles should also be available for use if there is a risk of splashing to the face. Correct PPE should be used when handling cleaning chemicals.

**Cleaning** of the environment, including toys and equipment, should be frequent, thorough and follow national guidance. For example, use colour-coded equipment, follow Control of Substances Hazardous to Health (COSHH) regulations and correct decontamination of cleaning equipment. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPE.

**Cleaning of blood and body fluid spillages.** All spillages of blood, faeces, saliva, vomit, nasal and eye discharges should be cleaned up immediately (always wear PPE). When spillages occur, clean using a product that combines both a detergent and a disinfectant. Use as per manufacturer's instructions and ensure it is effective against bacteria and viruses and suitable for use on the affected surface. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard clinical waste as described below. A spillage kit should be available for blood spills.

**Laundry** should be dealt with in a separate dedicated facility. Soiled linen should be washed separately at the hottest wash the fabric will tolerate. Wear PPE when handling soiled linen. Children's soiled clothing should be bagged to go home, never rinsed by hand.

**Clinical waste.** Always segregate domestic and clinical waste, in accordance with local policy. Used nappies/pads, gloves, aprons and soiled dressings should be stored in correct clinical waste bags in foot-operated bins. All clinical waste must be removed by a registered waste contractor. All clinical waste bags should be less than two-thirds full and stored in a dedicated, secure area while awaiting collection.

**Sharps, eg needles,** should be discarded straight into a sharps bin conforming to BS 7320 and UN 3291 standards. Sharps bins must be kept off the floor (preferably wall-mounted) and out of reach of children.

## Sharps injuries and bites

If skin is broken as a result of a used needle injury or bite, encourage the wound to bleed/wash thoroughly using soap and water. Contact GP or occupational health or go to A&E immediately. Ensure local policy is in place for staff to follow. Contact the Duty Room for advice, if unsure.

## Animals

Animals may carry infections, so wash hands after handling animals. Health and Safety Executive for Northern Ireland (HSENI) guidelines for protecting the health and safety of children should be followed.

**Animals in school** (permanent or visiting). Ensure animals' living quarters are kept clean and away from food areas. Waste should be disposed of regularly, and litter boxes not accessible to children. Children should not play with animals unsupervised. Hand-hygiene should be supervised after contact with animals and the area where visiting animals have been kept should be thoroughly cleaned after use. Veterinary advice should be sought on animal welfare and animal health issues and the suitability of the animal as a pet. Reptiles are not suitable as pets in schools and nurseries, as all species carry salmonella.

**Visits to farms.** For more information see <https://www.hseni.gov.uk/publications/preventing-or-controlling-ill-health-animal-contact-visitor-attractions>

## Vulnerable children

Some medical conditions make children vulnerable to infections that would rarely be serious in most children, these include those being treated for leukaemia or other cancers, on high doses of steroids and with conditions that seriously reduce immunity. Schools and nurseries and childminders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox, measles and parvovirus B19 and, if exposed to either of these, the parent/carer should be informed promptly and further medical advice sought. It may be advisable for these children to have additional immunisations, for example pneumococcal and influenza. This guidance is designed to give general advice to schools and childcare settings. Some vulnerable children may need further precautions to be taken, which should be discussed with the parent or carer in conjunction with their medical team and school health.

## Female staff\* – pregnancy

If a pregnant woman develops a rash or is in direct contact with someone with a potentially infectious rash, this should be investigated by a doctor who can contact the duty room for further advice. The greatest risk to pregnant women from such infections comes from their own child/children, rather than the workplace.

- Chickenpox can affect the pregnancy if a woman has not already had the infection. Report exposure to midwife and GP at any stage of pregnancy. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.
- German measles (rubella). If a pregnant woman comes into contact with german measles she should inform her GP and antenatal carer immediately to ensure investigation. The infection may affect the developing baby if the woman is not immune and is exposed in early pregnancy.
- Slapped cheek disease (fifth disease or parvovirus B19) can occasionally affect an unborn child. If exposed early in pregnancy (before 20 weeks), inform whoever is giving antenatal care as this must be investigated promptly.
- Measles during pregnancy can result in early delivery or even loss of the baby. If a pregnant woman is exposed she should immediately inform whoever is giving antenatal care to ensure investigation.
- All female staff born after 1970 working with young children are advised to ensure they have had two doses of MMR vaccine.

\*The above advice also applies to pregnant students.

## Immunisations

Immunisation status should always be checked at school entry and at the time of any vaccination. Parents should be encouraged to have their child immunised and any immunisation missed or further catch-up doses organised through the child's GP.

For the most up-to-date immunisation advice and current schedule visit [www.publichealth.hscni.net](http://www.publichealth.hscni.net) or the school health service can advise on the latest national immunisation schedule.

| When to immunise                     | Diseases vaccine protects against   | How it is given                |
|--------------------------------------|---|--------------------------------|
| 2 months old                         | Diphtheria, tetanus, pertussis (whooping cough), polio and Hib  | One injection                  |
|                                      | Pneumococcal infection  | One injection                  |
|                                      | Rotavirus   | Orally                         |
|                                      | Meningococcal B infection   | One injection                  |
| 3 months old                         | Diphtheria, tetanus, pertussis, polio and Hib   | One injection                  |
|                                      | Rotavirus   | Orally                         |
| 4 months old                         | Diphtheria, tetanus, pertussis, polio and Hib   | One injection                  |
|                                      | Pneumococcal infection  | One injection                  |
|                                      | Meningococcal B infection   | One injection                  |
| Just after the first birthday        | Measles, mumps and rubella  | One injection                  |
|                                      | Pneumococcal infection  | One injection                  |
|                                      | Hib and meningococcal C infection   | One injection                  |
| Every year from 2 years old up to P7 | Influenza   | Nasal spray or injection       |
|                                      | Influenza   | Nasal spray or injection       |
| 3 years and 4 months old             | Diphtheria, tetanus, pertussis and polio  | One injection                  |
|                                      | Measles, mumps and rubella  | One injection                  |
| Girls 12 to 13 years old             | Cervical cancer caused by human papillomavirus types 16 and 18 and genital warts caused by types 6 and 11 | Two injections over six months |
| 14 to 18 years old                   | Tetanus, diphtheria and polio   | One injection                  |
|                                      | Meningococcal infection ACWY  | One injection                  |

This is the Immunisation Schedule as of July 2016. Children who present with certain risk factors may require additional immunisations. Always consult the most updated version of the "Green Book" for the latest immunisation schedule on [www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book](http://www.gov.uk/government/collections/immunisation-against-infectious-disease-the-green-book#the-green-book)

From October 2017 children will receive hepatitis B vaccine at 2, 3, and 4 months of age in combination with the diphtheria, tetanus, pertussis, polio and Hib vaccine.

**Staff immunisations.** All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunisations, including two doses of MMR.

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