Health Protection Surveillance Centre

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

hpsc

Preschool and Childcare Facility Subcommittee

Management of Infectious Disease in Childcare Facilities and Other Childcare Settings

Appendices

Appendix A:
Important Legislation Covering Childcare Facilities

The following are the primary pieces of legislation that relate to childcare facilities and infectious diseases.

1. Childcare (Preschool Services) (No 2) Regulations 2006 SI No 604 of 2006 and Childcare (Preschool Services) (No 2) Amendment Regulations 2006 SI No 643 of 2006.
2. Childcare Act 1991, Part 7
3. Safety, Health and Welfare at Work Act 2005
4. Safety, Health and Welfare at Work (General Application) Regulations 2007
5. Safety, Health And Welfare At Work (Biological Agents) Regulations, 1994
6. Regulation (EC) 178/2002 on general food law as transposed by European Communities (General Food Law) Regulations 2007 (S.I. 747 of 2007) as amended.
7. Regulation (EC) No 852/2004 on the hygiene of foodstuffs transposed by European Communities (Hygiene of Foodstuffs) Regulations 2006 as amended SI 369 of 2006 as amended.
6. Regulation (EC) No 882/2004 as transposed by European Communities (Official Control of Foodstuffs) Regulations 2010 S.I> 117 of 2010 as amended.
9. Food Safety Authority Act 1998 as amended.
10. European Communities (General Food Law) Regulations 2007.
11. A Summary of Relevant Food Safety Legislation collated by the FSAI.
12. The European Communities (Drinking Water) Regulations 2007 SI No 106 of 2007.
13. Building Control: Building Regulations 1997 and 2000 (12 technical guidance documents) see page 65 of Guidelines for best practice in the design of Childcare facilities.
14. Infectious Diseases Regulations
    a. Infectious Diseases Regulations S.I. No. 390 of 1981
    b. Infectious Diseases Regulations S.I. No. 707 of 2003
    c. Infectious Diseases (Amendment) Regulations S.I. No. 452 of 2011
15. The Food Safety Authority of Ireland has an excellent portal on Food Hygiene legislation.

Appendix B: National Working Group

The following are the members of the National Working Group:

1. Dr Paul McKeown, Consultant in Public Health, HPSC (Chair)
2. Dr Fiona Ryan, Consultant in Public Health Medicine, Department of Public Health, HSE – South, Cork
3. Ms Helen Murphy, Infection Control/Communicable Disease Nurse Manager, Infection Prevention Society (IPS)
4. Dr Ross Ardill, Faculty of Occupational Medicine
5. Ms Margaret Ruddy, Environmental Health Officer, Environmental Health Officers Association,
6. Ms Fiona Roche, Surveillance Scientist, HPSC

Appendix C: Terms of Reference

Review available guidance on reducing the risk of infection in childcare facilities.

1. Outline current legislation in the area, relating to the protection of human health.

2. Outline methods of transmission of infectious diseases in childcare settings.

3. Make recommendations on measures to implement effective infection control in childcare settings.

4. Make recommendations in relation to the screening and vaccination of children attending childcare facilities.

5. Make recommendations in relation to the screening and vaccination of staff working in childcare settings.

6. Make recommendations in relation to the exclusion of children and staff who are infected with/carrying an infectious disease from childcare settings.

7. Outline current guidance in relation to the built environment and capacity of childcare facilities and make recommendations in relation to reducing the risk of disease transmission.

Appendix D: TB Assessment

All childcare staff should undergo a TB risk assessment as part of their pre-employment health assessment which should include a health declaration and screening tests for TB when appropriate. Staff in childcare settings should be managed largely in the same way as healthcare staff.*

Health Questionnaire and Declaration:

In pre-employment screening for childcare workers the following information should be recorded:

- Suggestive symptoms
- History of BCG (scar check by health professional or documentary evidence of date or age administered)
- Previous history of TB disease (dates or age, duration and type of treatment, name and address of treating physician) including family history
- Previous TST (tuberculin skin test) and result within the previous 5 years if available (documentary evidence of date/age, type of test and result, name and address of treating physician) and
- History and details of contact with known cases of TB (date/age, relationship to the case/s, degree of infectivity of the case).

Screening for TB**
Screening of new employees (undertaken by occupational medicine) should be prioritised as follows:

High priority
Childcare workers arriving in Ireland (or returning to Ireland after an extended period) from countries with a high incidence of TB (≥ 40/100,000 TB cases notified per year): Such individuals require a chest X-ray (provided they are not pregnant) to rule out active TB in addition to a TST (2TU Mantoux test) to detect latent TB infection regardless of BCG vaccination status.

Low priority
In this group, TST is only offered to those who have no (or inconclusive) evidence of prior BCG vaccine. This group will constitute the majority of childcare workers. The Mantoux test is undertaken in this situation to obtain a baseline in case of future exposure in the childcare setting and to offer BCG vaccine if necessary.

* Full details on the investigation and control of cases of TB are available in Guidelines on the Prevention and Control of Tuberculosis in Ireland, 2010 available at http://www.hpsc.ie/hpsc/A-Z/VaccinePreventable/TuberculosisTB/Guidance/File,4349,en.pdf

**please refer to Chapter 9 in Screening in Special Situations (Healthcare Workers) in the above document.

Appendix E:
Contact Details for Public Health Offices

For up to date contact details for the HSE Public Health Offices, please visit: http://www.hse.ie/eng/services/Find_a_Service/Public_Health/

HSE Region	County	Address	Contact Number
Dublin Mid-Leinster	Dublin	Department of Public Health Dr. Steeven's Hospital Dublin 8.	Tel. (01) 6352000 Fax. (01) 6352103
	Laois/Offaly/Longford/ Westmeath	Department of Public Health HSE Area Office Arden Road Tullamore, Co. Offaly.	Tel. (057) 9359891 Fax. (057) 9359906 ID Fax. (057) 9359907 Email: public-health@hse.ie
Dublin North-East	Meath	Department of Public Health Kells Co. Meath	Tel. (046) 9280557 Fax. (046) 9249297
	Meath	Department of Public Health Railway Street Navan Co. Meath	Tel. (046) 9076412 Fax. (046) 9072325
West	Galway	Department of Public Health Merlin Park Galway	Tel. (091) 775200 Fax. (091) 758283 email: publich@hse.ie
	Limerick	Department of Public Health 31-33 Catherine Street Limerick	Tel. (061) 483337 Fax. (061) 464205
	Donegal	Department of Public Health Ballyshannon Co. Donegal	Tel. (071) 9852900 Fax. (071) 9852901
South	Cork	Department of Public Health Sarsfield House Sarsfield Rd. Wilton, Cork	Tel. (021) 4927601 Fax. (021) 4346063 ID Fax Cork (021) 4927370
	Kerry	Department of Public Health Rathass Tralee, Kerry	Tel. (066) 7184548 ID Fax Kerry (066) 7184542
	Kilkenny	Department of Public Health Dublin Road Lacken Kilkenny	Tel. (056) 7784124 Fax. (056) 7784393 ID Fax. (056) 7784599

Appendix F: Chlorine-based Disinfectants

Generally there are two categories of chlorine based disinfectants:

1. *Sodium hypochlorite (Bleach).* Available in liquid form. Examples: Milton, Domestos

2. *Sodium dichloroisocyanurate (NaDCC).* Available as tablets, powders and granules. Examples: Presept, Haz-Tab, Klorosept, Acticlor

GENERAL POINTS TO REMEMBER:

- Always clean the area first, then, apply the disinfectant
- Always follow the manufacturer's instructions regarding dilution and contact time
- Hypochlorites are inactivated by the presence of dirt and are corrosive to some metals
- Non abrasive cream cleansers are suitable for removing stubborn marks on ceramics
- Solutions should be freshly prepared

INDICATIONS FOR USE:

Use	% Hypochlorite	Parts per million available chlorine (ppm available chlorine)
Blood spills	1	10, 000 ppm
Environmental disinfection (walls, floors, toilets, general surfaces)	0.1	1, 000 ppm
Infant feeding utensils, catering surfaces and equipment	0.0125	125 ppm

EXAMPLES:

For Blood Spillages	For Environmental Disinfection
Use neat (gives 10,000 ppm available chlorine)	1: 10 dilution (gives 1,000 ppm available chlorine)
1:10 dilution (gives 10,000 ppm available chlorine)	1:100 dilution (gives 1,000 ppm available chlorine)

Appendix G:
Guidelines for Management of Suspected Outbreaks of Vomiting and/or Diarrhoea in Childcare Facilities

What is diarrhoea?
Diarrhoea is an increase in bowel frequency (three or more bowel movements within 24 hours is indicative). There are many causes of diarrhoea, but sudden diarrhoea in children is usually caused by infections due to bacteria and viruses e.g. *salmonella*, *campylobacter*, norovirus. Diarrhoea in small children can be very dangerous because of the risk of dehydration.

Incubation Period
The incubation period is the time between being exposed to a gastroenteritis germ and developing symptoms of the illness. It depends on the germ involved and can be from one hour to several days but is usually between 12 and 48 hours.

Transmission
Infectious diarrhoea can spread to other children by the faecal oral route (via the mouth but originating in the bowel). Germs are carried in faeces and spread by unwashed hands to surfaces touched by hands (e.g. taps, toilet flush handles, door handles, remote controls, games consoles), food, other children and staff.

Exclusion
All children and staff who develop symptoms of diarrhoea and vomiting should be excluded from the Childcare Facility until at least 48 hours after symptoms have stopped. A longer period of exclusion may be necessary in certain circumstances, e.g. for children under five years and older children who are unable to maintain good personal hygiene, depending on what germ is identified.

When a child develops diarrhoea while in the Childcare Facility, check with the parent/carer whether any food intolerance has been diagnosed, if not, advise the parent to take their child to their GP. Although infection is the most common cause of vomiting in children there are other causes e.g. ingestion of a harmful substance. Sudden uncontrolled vomiting may indicate a viral infection e.g. norovirus.

What to do if a child develops diarrhoea or vomiting in the Childcare Facility?

1. Contact the parents/guardians to take the child home.
2. Ensure the child's hands are thoroughly washed after every visit to the toilet and before eating.
3. Ensure staff hands are washed before and after changing nappies.
4. Use liquid soap, warm running water and disposable paper towels.
5. Remove spills of faeces or vomit immediately and clean and disinfect the surrounding area.
6. Clean and disinfect toilet seats, flush handles, taps and toilet doors at least twice a day.
7. In the event of two or more cases of unexplained vomiting+/- diarrhoea occurring in the Childcare Facility please ensure that the following measures are followed:
    a. Nominate one of the staff to manage the outbreak. If there are more than two or three cases of unexplained vomiting+/- diarrhoea, suggesting the possibility of an outbreak, notify your local Department of Public Health who will advise on outbreak management and who will liaise with Environmental Health Services.
    b. Keep a list of all symptomatic children/staff. Record the time of onset of symptoms and the exact nature of the symptoms
    c. If a child has diarrhoea /vomiting while on the premises, the parent/guardian should be notified immediately and advised to take the child home. The affected child should be separated from other children until he/she is collected
    d. Segregate (i.e. isolate/separate) ill children from well children
    e. Liaise with Public Health regarding new cases and progress of the outbreak. When a positive stool result has been obtained, please discuss the need for further specimens with Public Health or Environmental Health Service staff

Infection Control during Outbreaks
When there is a suspected outbreak of diarrhoea/vomiting in a childcare facility, effective infection control (Chapter 3) is crucial and, in order to minimise the spread of infection, close attention must be paid to:

- Regular handwashing
- Using Personal Protective Equipment (PPE)
- Ensuring hygienic nappy changing
- Ensuring hygienic management of toys
- Suspending certain communal play activities (e.g. sand or water play, cookery) if considered necessary

- Washing soiled clothing or bed linen should using detergent and hot water (at least 60ºC).
- Proper disposal of waste (e.g. contaminated paper towels, cleaning cloths and nappies, together with used gloves and aprons), should be placed immediately into plastic bags, which are tied securely, and removed to a suitable refuse storage area outside the premises.
- **All ill staff and children should be excluded until 48 hours after symptoms have resolved.**
- Cleaning: should be carried out in accordance with these Guidelines.
- Closure: if there are a number of cases of illness, especially if the germ responsible is a serious one (such as VTEC) the Department of Public Health may advise the childcare facility to close to prevent any other children becoming ill.

Overleaf is an Action Checklist for use in the event of an outbreak of diarrhoea and vomiting in a Childcare Facility.

Specimen Diarrhoea and Vomiting Outbreak Action Checklist

Date completed:	
Checklist completed by (Print):	
Name and Tel No. of Crèche/Nursery:	
Name of Manager:	
Details of Outbreak:	

ACTION CHECKLIST			
PREVENTION	**YES**	**NO**	**COMMENTS**
Inform Public Health of outbreak			
Inform parents/guardians about outbreak and advise re symptoms and exclusion criteria			
Compile a record of ill staff and children and update daily			
Exclude ill children and staff for 48 hrs after symptom resolution			
Manager to monitor that staff are washing hands effectively			
Liquid soap and paper towels available at all times			
Twice daily cleaning of all surfaces with warm water and detergent followed by disinfection with chlorine based disinfectant (e.g. 1000ppm) especially hand contact areas			
Suspend use of soft toys, water and sand play and play dough/cookery activities during the outbreak			
Clean hard toys daily and then disinfect with chlorine based disinfectant (1000ppm) or wash in dishwasher at 60ºC if possible			
Check if staff work elsewhere (agency) and that all staff are well (including agency). Exclude ill staff (see above).			
Suspend new children joining nursery			
Restrict visitors			
Guidelines on handwashing to be displayed in nursery			
Keep staff working in dedicated areas (restrict food handling if possible)			
Machine wash cot sheets, bibs etc at 60ºC			
Thorough clean of nursery at end of outbreak to include cleaning with detergent and water followed by disinfection with a chlorine based disinfectant			
Launder or dry clean curtains in childcare areas at end of outbreak			
Steam clean carpets in childcare areas at end of outbreak			

Diarrhoea and Vomiting Outbreak – Log Sheet for Child Cases

SURNAME (PRINT)	FIRST NAME	DOB	ROOM	GP DETAILS	SEX	DATE OF ONSET	SYMPTOMS	DURATION OF SYMPTOMS	EXCLUDED ?	STOOL SAMPLE DATE	OUTCOME

SHEET NUMBER _____

Diarrhoea and Vomiting Outbreak – Log Sheet for Staff Cases

SURNAME (PRINT)	FIRST NAME	STAFF TITLE	ROOM & WORK LOCATION	GP DETAILS	SEX	DATE OF ONSET	SYMPTOMS	DURATION OF SYMPTOMS	EXCLUDED?	STOOL SAMPLE DATE	OUTCOME

SHEET NUMBER _____

Appendix H:
Design Requirements for a Childcare Facility

The design of, and facilities within, the childcare building impact on the quality of the service offered and has an important role to play in the prevention of the spread of infection within the premises.

SANITARY FACILITIES

- Suitable, adequate, hygienic and soundly constructed sanitary accommodation must be provided for toilet trained children.
- One toilet and one wash hand basin (appropriate height) must be provided for every 10 toilet trained children, preferably en-suite to the play area. Sanitary accommodation and nappy changing areas should not communicate with any occupied room or food room except by means of a hall, corridor, ventilated lobby or ventilated space.
- Suitable, separate, adequate, hygienic and soundly constructed sanitary accommodation must be provided for staff. A minimum of one toilet and one wash hand basin must be provided for every eight staff.
- Wash hand basins must be located at or near to the sanitary accommodation and nappy changing unit.
- All wash hand basins must be serviced with a running supply of hot water and cold water. The hot water to wash hand basins used by the children must be thermostatically controlled to a temperature of 43^0C to prevent children scalding themselves.
- Liquid soap dispensers and wall mounted paper towel dispensers must be provided adjacent to the wash hand basins. Ideally liquid soap dispensers should be wall mounted have individual replacement cartridges that are discarded when empty.
- A pedal bin should be provided for disposal of paper towels.
- Suitable nappy changing facilities must be provided in the premises. These must be separate from occupied rooms including sleep rooms.
- The nappy changing unit must be smooth and easily cleanable.
- Adequate storage should be provided for the children's individual toilet requisites.
- A shower/bath/facility for washing with thermostatically controlled hot water should be provided in full day care services.
- A sealed air tight lidded pedal operated container should be provided for the disposal of soiled nappies.

All environments in which children are cared for should comply with current legislation.

PHYSICAL ENVIRONMENT

- **Floors, walls, ceilings, doors, windows, interior finishes, design**
    - Flooring should be smooth, durable, easily cleanable and non-absorbent. Carpets are only suitable in small designated areas e.g. book corner. Carpets must not be used in the sanitary accommodation.
    - All joints and crevices should be sealed.
    - Skirting boards should be easily cleanable and non-absorbent.
    - Smooth, hard, impervious and easily cleanable surfaces should be used for walls and ceilings.
    - Doors should be flush panelled and provided with a smooth, non-absorbent easily cleanable finish.
    - A sink unit with a constant supply of hot and cold running water may be provided in each playroom for the cleaning of the fixtures and fittings and toys and spillages.
    - A wash hand basin for adult use should be provided in the baby and toddler rooms.
    - Where the children's sanitary accommodation is not located close to the playroom, consideration should be given to provision of a low-level wash hand basin in the playroom for the children in order to encourage the children to wash their hands.
    - Adequate space must be provided for each preschool child attending the childcare facility having regard to the space requirements and guidance set out in the Explanatory Guidance to the Childcare (Pre-School Services) (No2) Regulations 2006.

The recommended areas with regard to "adequate" space are as follows:

Full Day Care and Part-time Day Care

Age of Child	Floor area per child
0-1 years	3.5 sq metres
1-2 years	2.8 sq metres
2-3 years	2.35 sq metres
3-6 years	2.3 sq metres

Sessional Preschool Service / Preschool Service in a Drop-in Centre

Age of Child	Floor area per child
0-6 years	2 sq metres

The space requirements set out above relate to clear floor space per child. Clear floor space means that area available for children's work, play and movement should not include furniture, surplus to the requirements of the child or permanent fixtures.

HOT AND COLD WATER SYSTEMS

Prevention of *Legionella*

For recommended temperatures and detailed information about the prevention and control of Legionellosis please refer to; National Guidelines for the Control of Legionellosis in Ireland, 2009. This document is available to download free from http://www.hpsc.ie/hpsc/A-Z/Respiratory/Legionellosis/Publications/File,3936,en.pdf

Safety considerations

Children under the age of five are at high risk for burns or scalds from hot water or fluids. If hot water is accessible to children e.g. showers or wash hand basins, the temperature should be controlled to a maximum of 43^0C. This may be achieved by installing a thermostatic mixing valve (TMV) into the hot water system.

Children must not have access to the sinks with water temperatures greater than 43^0C.

FIXTURES AND FITTINGS INCLUDING EQUIPMENT AND MATERIALS

- All surfaces, fittings, furniture and play equipment should be durable and easily cleanable.
- All furniture, fixtures, play and work equipment must be in good state of repair and maintained in a clean and hygienic condition. Regularly check for defects/faults, repair or replace as necessary.
- An appropriate supply of clean bedding, towels and spare clothes for the preschool children should be available.
- Ideally children should have their own cots. If this is not possible an adequate supply of bed linen should be provided to ensure that each child has its own linen.
- Cots should be cleaned between each child's use. If soiled with blood or body fluids, clean first, then disinfect with a chlorine based disinfectant (at a concentration of 1,000ppm available chlorine), then rinse and dry.

VENTILATION

- Good ventilation is essential to ensure that all areas are provided with a fresh supply of air and to assist in the removal of germs, stale odours etc.
- Ventilation must be provided in all rooms including playroom, sleep rooms, dining rooms, staff rooms, kitchens, utility rooms/laundry rooms and sanitary accommodation.
- All occupied rooms must have natural ventilation by means of openable windows, of which the openable area must be equivalent to at least one twentieth of the floor area of the room and a permanent vent with a minimum area of $6500mm^2$. Some windows will have the vents incorporated in the frame.
- All rooms should be located on external walls so that openable windows are available.
- Toilets should be independently ventilated from the other rooms. The sanitary accommodation must not communicate with any occupied room except by means of a hall, corridor, ventilated lobby or ventilated space.

The following ventilation guidelines should be achieved: (Table from the Interim Code of Practice in Determining Compliance with the Childcare Preschool Services Regulations (No2) 2006 For the Preschool Inspectorate).

Air changes per hour	Area
10 – 15 air changes per hour	Laundry areas
3 air changes per hour	Toilet compartmentsand sluice rooms
2 air changes per hour	Lobbies, stairways and other access areas
3 air changes per hour	Play and rest areas

- All sanitary accommodation and nappy changing areas must be ventilated directly to the external air.

PEST PROOFING

- The building must be adequately pest proofed and regular checks undertaken by a competent person.
- Remedial action should be taken as appropriate. Records should be kept of all such checks.
- Pest proofing should be carried out in a manner which does not compromise the safety of children.

Appendix I: General Food Hygiene Requirements in Childcare Settings

An extensive list of Food Hygiene legislation is available from the Food Safety Authority of Ireland. http://www.fsai.ie/legislation/food_legislation.html

For food hygiene requirements refer to the I.S. 340 Hygiene in the Catering Sector or I.S. 344 *Guide to Good Hygiene Practices in Domestic Premises*. Copies copy may be purchased from the National Standards Authority of Ireland at www.nsai.ie.

Childcare facilities must comply with the provisions of the Food Hygiene Regulations 1950-89, the European Communities (Hygiene of Foodstuffs) Regulations 2006 (SI No 369) Regulation, EC 178/2002 and Regulation (EC) No 852/2004. The proprietor must apply to the Health Service Executive for registration of a food business prior to commencement of its operation. An application form for registration is available from your local Environmental Health Office.

FOOD HYGIENE GENERAL REQUIREMENTS

'Milk Kitchen'

Where possible a separate self-contained area should be provided for the preparation of babies' food/bottles (milk kitchen). The milk kitchen may require the following:

- A sink serviced with a constant and instantaneous supply of hot and cold water.
- A wash-hand-basin with suitable handwashing and hand drying facilities.
- Heating and sterilisation facilities.

Alternatively this facility may be provided in the main kitchen or a designated section of the "Baby Room" if these areas are deemed adequate and suitable.

GENERAL REQUIREMENTS FOR THE MAIN KITCHEN

1. The size of the kitchen must be adequate to cater for the nature and extent of the business intended to be carried on therein.
2. If no separate area has been designated for vegetable preparation only prepared vegetables may be used in the premises.
3. A double bowl sink unit or a single bowl sink plus a dishwasher should be provided for wash-up.
4. A separate food preparation sink should be provided and must be designated exclusively for food preparation.
5. A separate wash hand basin with a constant supply of hot and cold water, wall mounted soap and towel dispensers must be provided in the kitchen area exclusively for handwashing
6. The floor should be provided with a smooth, durable, non-absorbent and readily cleanable finish.
7. The walls should be provided with a smooth, durable, impervious and readily cleanable finish.
8. The wall finishes above work surfaces should be scratchproof and impact resistant to a minimum height of 450mm.
9. The walls behind the cooking equipment should be heat resistant.
10. The ceiling should be provided with a smooth, durable and readily cleanable finish.
11. Enclosed light fittings or shatterproof bulbs must be provided.
12. Openable windows in the kitchen should be fitted with fly screens. (Mesh size 16, 1.2mm gap).
13. Adequate refrigeration must be provided on the premises for the storage of chilled and frozen foods.
14. Suitable and sufficient storage facilities must be provided for dry goods.
15. Adequate work surfaces must be provided for the preparation of food, the layout of the kitchen should allow for zoning of different activities so as to prevent cross- contamination between raw foods and cooked or ready-to-eat foods.
16. Accurate indicator thermometers must be provided on all refrigeration units and freezers/refrigeration units must operate at or below 3°C and freezer units at or below –18°C.
17. A suitable system for the venting of steam and heat incorporating a canopy and grease filter should be provided above the cooking and steam or heat emitting equipment.
18. Additional guidance as to adequate and suitable facilities may be found in IS 340 (Hygiene in the Catering Sector) and IS 344 (Hygiene for Domestic-Scale Production).
19. Please consult with the local Environmental Health Officer directly in relation to all aspects of food safety and the kitchen requirements.

Appendix J:
Consultation process

A consultation version of this document was placed on the HPSC website for general consultation in January 2011. The period of consultation was three months.

Individuals

Dr Teresa Kelly SEHO, Pre-School Services, HSE North East, Navan

Dr Julie Heslin Consultant in Public Health Medicine HSE South East

Ms Grainne Parker, Communicable Disease Control Nurse HSE South East

Ms Johanna Costigan, Communicable Disease Control Nurse HSE South East

Ms Clare Murphy A/Child Care Manager HSE South Wexford

Ms Mary Keane, Chief Environmental Health Officer HSE

Dr Ina Kelly Senior Medical Officer HSE Midlands

Ms Rita Melia, National Childcare Policy Advisor, National Children's Nurseries Association, Dublin 12.

Ms Peggy Walker, Director of Information, Irish Preschool Play Association, Dublin 24

Ms Fiona McDonnell, National Specialist, Early Years St Joseph's Hospital, Limerick

Ms Áine Mellett, Principal Community Development Worker, HSE West Ennis

Dr Colette Bonner Deputy Chief Medical Officer, Department of Health and Children.

Ms Clare Murphy A/Child Care Manager HSE – South Wexford

Dr Anthony Breslin Consultant in Public Health Medicine HSE West

Dr Phil Jennings Consultant in Public Health Medicine DPH HSE Midlands

Dr Wayne Anderson, Food Safety Authority of Ireland, Dublin

Ms Sue Codd, Sub Group of the SE Regional Preschool Forum

Ms Phil Mackey, Sub Group of the SE Regional Preschool Forum

Ms Aoibhlinn, Gallagher Sub Group of the SE Regional Preschool Forum

Ms Maura Murphy, Sub Group of the SE Regional Preschool Forum

Dr Robert Cunney, Consultant Microbiologist Health Protection Surveillance Centre

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Mr Brian Mc Keevers Principal Environmental Health Officer HSE Dublin/North East

Mr Lorcan O'Brien, Environmental Health Officers Association

Ms Catriona Syon Senior Environmental Health Officer, HSE W Sligo

Dr Helen Coughlan, Senior Medical Officer, HSE South

Dr Mary Kieran, Senior Medical Officer, HSE South

Ms Deirdre Duffy, Senior Environmental Health Officer Pre-School Inspection Service HSE/Dublin North East Monaghan

Dr Peter Finnegan Consultant in Public Health Medicine HSE North East

Organisations

Preschool Nursing Services Lord Edward Street Dublin

Department of Public Health HSE South

Department of Public Health HSE Midlands,Tullamore

The Environmental Health Officers Association

Resources

There are several resources for childcare facilities that are available for download from the HPSC website. It is **recommended that posters are laminated and placed in suitable locations within the childcare facility to raise awareness** and aid in the prevention and control of infectious diseases.

The resources are listed below:

1. Handwashing Posters for Adults and Children - Poster
2. Changing a Nappy Without Spreading Germs - Poster
3. Summary Guidance on Infection Control in Childcare Settings – Poster
   - **NOTE:** This guidance summary will be made available in two parts. Each part will be formatted for the final publication to fit onto a single A4 page. Both parts can be laminated separately and displayed side by side to provide a quick summary of the guidance in this document.
4. Immunisation Record Cards
5. Sample Cleaning Program and Sample Cleaning Checklist
6. Sample Notification Letters to Parents
7. Infection Control Assessment Tool for Childcare Facilities
   - **NOTE:** This assessment tool is intended as a guide to assist in managing the risk posed by infectious disease threats in a childcare setting – it is not designed to be a series of standards against which performance is to be audited.

The 6 Steps of Hand Washing

Palm to palm

The back of the hands

In between the fingers

The back of the fingers

The thumbs

The tips of the fingers

Wash Your Hands After...

1

Playing with pets

2

Using the bathroom

3

Sneezing, blowing your nose & coughing

4

Touching a cut or open sore

5

Playing outside

6

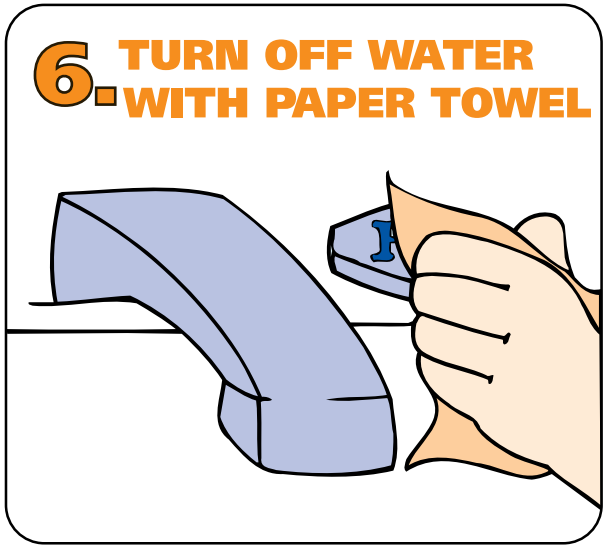
AND Before...

Eating

Developed by University of Nebraska–Lincoln Extension in Lancaster County and Lincoln-Lancaster County Health Department

Be A Germ-Buster

WASH YOUR HANDS



Adapted with permission from Washington State Department of Health

Minnesota Department of Health
Food Safety Center
625 N Robert St, PO Box 64975, St. Paul, MN 55164
651-201-5414, TDD/TTY 651-201-5797, www.health.state.mn.us

Changing a nappy without spreading germs

Australian Government
National Health and Medical Research Council

- Wash your hands.
- Place paper on the change table.
- Always wear gloves when changing a nappy.
- Remove the child's nappy and put it in a 'hands-free' lidded bin.
- Remove any clothes with urine or faeces on them.
- Clean the child's bottom.
- Remove the paper and put it in a 'hands-free' lidded bin.
- Remove your gloves by peeling them back from your wrists, turning them inside out as you go. Put the gloves in the bin.
- Dress the child.
- Wash and dry the child's hands.
- Take the child away from the change table.
- Clean the change table with detergent and warm water.
- Wash your hands.

Part 1:
Guidance on Infection Control in Childcare Settings

GOOD HYGIENE PRACTICE

Hand washing: is one of the most important ways to prevent the spread of infectious diseases, especially those that cause diarrhoea and vomiting, and respiratory illness. The best method is to use liquid soap, warm water and disposable 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 respiratory illness. Encourage all adults and children to cover their mouth and nose with a tissue. Wash hands after using or disposing of tissues.

Personal protective clothing (PPC): Wear disposable non-powdered vinyl or latex-free CE-marked gloves and disposable plastic aprons when there is a risk of getting blood or urine, faeces and vomit onto skin or clothing (for example during nappy changing). Wear goggles if there is a risk of splashing to the face, for example when diluting or handling cleaning chemicals.

Environmental cleaning: Clean the environment, toys and equipment frequently, and thoroughly. Monitor cleaning contracts and ensure cleaners are appropriately trained with access to PPC.

Cleaning of blood and body fluid spillages: Clean up spillages of blood, faeces, and vomit immediately. Wear gloves and a plastic apron. Always follow the manufacturer's instructions when using chemical disinfectants and ensure the disinfectant you use is effective against bacteria and viruses and is suitable for use on affected surfaces. Never use mops for cleaning up blood and body fluid spillages – use disposable paper towels and discard into a closed waste bin. Ensure a spillage kit is available for blood spills.

Laundry should be dealt with in a separate dedicated facility. Wash soiled linen separately at the hottest wash the fabric will tolerate. Wear disposable gloves and a plastic apron when handling soiled linen. Place childrens soiled clothing in a plastic bag before sending it home; do not rinse soiled clothing by hand.

Waste: Recycle waste in accordance with local authority policy. Store used nappies/pads in leak proof, easy to clean airtight containers. Discard gloves, aprons and soiled dressings in black bags in foot-operated pedal bins. Waste bins should be no more than two-thirds full and stored in a dedicated, secure area while awaiting collection.

SHARPS INJURIES AND BITES

If skin is broken, 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 your local DPH for advice, if unsure.

ANIMALS

Animals may carry infections, so wash hands after handling animals.

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. 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 pets in schools and nurseries, as all species carry salmonella.

Visits to farms. Please contact your local environmental health department who will provide you with help and advice when you are planning to visit a farm or similar establishment. For more information see Chapter 8 of the main document.

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 child minders will normally have been made aware of such children. These children are particularly vulnerable to chickenpox or measles, 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 immunizations, for example pneumococcal and influenza.

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. 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 exposure. The GP and antenatal carer will arrange a blood test to check for immunity. Shingles is caused by the same virus as chickenpox, so anyone who has not had chickenpox is potentially vulnerable to the infection if they have close contact with a case of shingles.
- Rubella (german measles). If a pregnant woman comes into contact with rubella 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 (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 under the age of 25 working with young children should have evidence of two doses of MMR vaccine.

*The above advice also applies to pregnant students

IMMUNISATIONS

Immunisation status should always be checked at 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 organized through the child's GP. The most up-to-date immunisation advice is available on www.immunisation.ie.

Schedule of immunization for children born on or after 1st July 2008

At birth	BCG	One injection
2 months old	Diphtheria, tetanus, pertussis, polio ,Hib and Hepatitis B (DTaP/IPV/Hib/Hep B) Pneumococcal (PCV)	One injection One injection
4 months old	Diphtheria, tetanus, pertussis, polio ,Hib and Hepatitis B (DTaP/IPV/Hib/Hep B) Meningococcal C (Men C)	One injection One injection
6 months old	Diphtheria, tetanus, pertussis, polio ,Hib and Hepatitis B (DTaP/IPV/Hib/Hep B) Pneumococcal (PCV) Meningococcal C (Men C)	One injection One injection One injection
12 months	Measles Mumps and Rubella (MMR) Pneumococcal (PCV)	One injection One injection
13 months	Hib Meningococcal C	One injection One injection
4 – 5 years	Diphtheria, tetanus, pertussis, polio (DTaP/IPV) Measles Mumps and Rubella (MMR)	One injection One injection

STAFF IMMUNISATIONS

All staff should undergo a full occupational health check prior to employment; this includes ensuring they are up to date with immunizations. All staff aged 16-25 should be advised to check they have had two doses of MMR.

Part 2:
Infectious Disease Exclusion Recommendations for the Childcare Setting

Prevent the spread of infections by ensuring: routine immunization, high standards of personal hygiene and practice, particularly handwashing, and maintaining a clean environment.

Please contact your local Department of Public Health (DPH) on.....

Or visit www.hpsc.ie if you would like any further advice or information, including the latest guidance.

Common Rashes and Skin Infections	Recommended period to be kept away from crèche	Comments
Chickenpox	Until scabs are dry, usually 5-7 days from onset of rash	*SEE: Vulnerable Children and Female Staff - Pregnancy*
German measles (rubella)	Seven days from onset of rash	Preventable by immunization (MMR x 2) *SEE: Female Staff - Pregnancy*
Hand, foot and mouth	None, once child is well	Contact your local DPH if a large number of children are affected. Exclusion may be considered in some circumstances
Impetigo	Until lesions are crusted and healed, or 24 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*
Ringworm	Exclusion not usually required	Treatment is required
Scabies	Children can return after first treatment	Household and close contacts require treatment
Scarlet fever	Child can return 24 hours after commencing antibiotic treatment	Antibiotic treatment recommended for the affected child
Slapped cheek/fifth disease. Parvovirus B19	None	*SEE: 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. *SEE: Vulnerable Children and Female Staff - Pregnancy*

Diarrhoea and Vomiting Illness	Recommended period to be kept away from crèche	Comments
Diarrhoea and/or vomiting	48 hours from the last episode of diarrhoea or vomiting	
E. coli O157 VTEC	Further exclusion required - cases excluded until 2 negative stool specimens taken at least 48h apart	This guidance may also apply to some contacts who may require microbiological clearance Public Health will provide advice
Typhoid [and paratyphoid] (enteric fever)	Further exclusion may be required for some children until they are no longer excreting	This guidance may also apply to some contacts who may require microbiological clearance Public Health will provide advice
Shigella (dysentery)	Further exclusion may be required for certain types of Shigella infections	Please consult your local DPH for further advice
Cryptosporidiosis	Exclude for 48 hours from last episode of diarrhoea	Exclusion from swimming pools is advisable for two weeks after the diarrhoea has settled

Respiratory infections	Recommended period to be kept away from crèche	Comments
Flu (influenza)	Until recovered	*SEE: Vulnerable children*
Tuberculosis	Always consult your local DPH	Requires prolonged close contact for spread
Whooping cough (pertussis)	Five days 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.

Other infections	Recommended period to be kept away from crèche	Comments
Conjunctivitis	None	If an outbreak/cluster occurs, consult your local DPH
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)	In an outbreak of Hepatitis A, your local DPH will advise on control measures
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: Chapter 3 in main document*
Meningococcal meningitis/ septicaemia	Until recovered	Meningococcal C is preventable by vaccination. There is no reason to exclude siblings or other close contacts of a case. Your local DPH 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. Your local DPH will advise 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 minimize any danger of spread. If further information is required, contact your local DPH
Mumps	Exclude child for five days after onset of swelling	Preventable by vaccination (MMR x 2)
Threadworms	None	Treatment is recommended for the child and household contacts
Tonsillitis/Pharyngitis	None in most cases If caused by streptococcal (bacterial) infection child can return 24 hours after commencing antibiotic treatment	There are many causes, but most cases are due to viruses and do not need an antibiotic

Outbreaks: if a childcare facility suspects an outbreak of infectious disease, they should inform their local DPH.

Immunisation Record Cards

CHILD BORN BEFORE JULY 2008			
VACCINE	**1st DOSE DATE**	**2nd DOSE DATE**	**3rd DOSE DATE**
BCG			
5in1 Diphtheria Tetanus Pertussis Polio Hib			
Men C			
Hib Booster			
MMR			
Other vaccines			

Primary Childhood Immunisations

Name _____ DOB _____

Immunisation/ Vaccine name	Age given	Manufacturer	Batch number	Expiry date	Route/ Site	Dose given	Administered by	Date
BCG								
Visit 1 1								
6 in 1								
PCV								
Visit 2 2								
6 in 1								
Men C								
Visit 3 3								
6 in 1								
PCV								
Men C								

BCG = Bacille Calmette-Guérin (TB vaccine)
6 in 1 = Diphtheria, Haemophilus influenzae B (Hib), Hepatitis B, Pertussis (Whooping cough), Polio, Tetanus

PCV = Pneumococcal conjugate vaccine
Men C = Meningococcal C

Primary Childhood Immunisations

Name _____ DOB _____

Immunisation/ Vaccine name	Age given	Manufacturer	Batch number	Expiry date	Route/ Site	Dose given	Administered by	Date
Visit 4 4								
MMR								
PCV								
Visit 5 5								
Men C								
Hib								
Other								

PCV = Pneumococcal conjugate vaccine
Men C = Meningococcal C

MMR = Measles, Mumps, Rubella
Hib = Haemophilus influenzae B

School Immunisations

Name _____ DOB _____

Immunisation/ Vaccine name	Age given	Manufacturer	Batch number	Expiry date	Route/ Site	Dose given	Administered by	Date
4 in 1								
MMR								
Td								
HPV Dose 1								
Next Appointment date								
HPV Dose 2								
Next Appointment date								
HPV Dose 3								
Other								

4 in 1 = Diphtheria, Pertussis, Polio, Tetanus
MMR = Measles, Mumps, Rubella
Td = Tetanus, low dose diphtheria
HPV = Human papillomavirus

Cleaning Schedules

The following areas within a childcare facility require routine cleaning:

Walls, floors, windows, window-sills, ceilings, light fittings and covers, doors, including handles, toilets, wash hand basins, cupboards, shelving, radiator and radiator covers, refrigerator, food storage facilities, sinks, tables, (including underside and legs), work and play surfaces, chairs, crockery, cutlery, toys etc.

The tables below outline the cleaning methods and frequencies required for the main areas within a childcare facility that need cleaning. In addition, a sample cleaning schedule is provided that can be modified to suit an individual childcare facility.

These schedules will be made available in Microsoft Word format so that they can be modified for your own use.

Sample Cleaning Program

General Environment Cleaning Program

Area/Item	Method	Frequency/Comments
Tables/ window sills / door and cabinet handles	Clean with neutral detergent, warm water and clean cloth	Daily and immediately if soiled i.e. if soiled with blood or body fluids, following cleaning, disinfect, rinse and dry
High chairs/dining tables	Clean with neutral detergent, warm water and clean cloth and dry with disposable paper towels	Before and after use; if soiled with blood or body fluids, following cleaning, disinfect, rinse and dry
Washable floor covering	Wash with detergent, warm water and clean utensils Vacuum clean to remove dirt when children are not present.	Daily and immediately if soiled e.g. spillage Vacuum daily
Carpets	Clean with an approved carpet cleaning method Vacuum	Clean carpets only when children will not be present to ensure the carpet is dry before next use Clean carpets at least monthly in infant areas, at least every 3 months in other areas or immediately when soiled Daily
Small rugs	Launder	Weekly

Walls/Ceilings	Clean with warm water and general purpose detergent. If soiled with blood or body fluids, following cleaning, disinfect	Routine cleaning not required except in areas of frequent hand contact, such as lower wall/door frames in areas occupied by toddlers
Waste bins	Empty Clean with neutral detergent and warm water	Daily Weekly and immediately if soiled
Mops and cleaning cloths	Mop heads should be washed in warm water and detergent, rinsed and air dried Reusable cloths must be laundered daily on a hot wash cycle (at least 60°C) in a washing machine and then tumble dried	After daily use After daily use

Toilet Area Cleaning Program

Area/Item	Method	Frequency / Comments
Wash hand basins, taps, surrounding counters, soap dispensers.	Clean with detergent and warm water.	At least daily and immediately if soiled. If soiled with blood or body fluids, following cleaning, disinfect, rinse and dry.
Both sides of toilet seat, toilet handles, door knobs or cubicle handles.	Clean with detergent and warm water.	At least daily and immediately if soiled. If soiled with blood or body fluids, following cleaning, disinfect, rinse and dry.
Toilet bowls	Use toilet cleaner as per manufacturers instructions.	At least daily and immediately if soiled.
Potties	Clean with detergent and warm water and if soiled, disinfect with a chlorine based disinfectant with 1000 ppm available chlorine.	Immediately after each use.

Toy Cleaning Program

Item	Method	Frequency / Comments
Soft toys – if shared.	Machine washed in a hot cycle according to manufacturers instructions.	Daily. If soiled, take out of use immediately.
Hard toys/items that go into the mouth or have been in contact with salvia or other body fluids.	Clean with warm water and detergent, rinsed and dried thoroughly. Alternatively, they may be washed in a dishwasher.	After each child's use.
Other hard toys e.g. dolls house, climbing frame.	Clean with warm water and detergent, rinsed and dried thoroughly.	Weekly or immediately if soiled.
Sheets and pillowcases, individual cloth towels (if used), combs and hairbrushes, face cloths. (None of these items should be shared among children.)	Machine washed in a hot cycle according to manufacturers instructions.	Weekly or after each use if used by different children. Take out of use immediately when visibly soiled.
Blankets and sleeping bags.	Machine wash to manufacturers instructions	Monthly. Take out of use immediately if soiled and machine wash.
Dress-up clothes	Machine wash to manufacturers instructions	Weekly/Monthly according to usage or more frequently if required.
Cots and cot mattresses	Clean with detergent and warm water, rinse and dry.	Weekly, before use by a different child, and immediately if soiled or wet.

Sample Cleaning Checklist

Cleaning Checklist

Week starting _____

Area /Item to be cleaned	Frequency of Cleaning	Days of the Week							Managers Signature
		Mon	Tues	Wed	Thurs	Fri	Sat	Sun	
Tables	Daily, after use and prior to food being served	✓ initials	✓ initials	✓ initials	✓ initials	✓ initials			
Window sills	Twice Weekly	✓ initials		✓ initials					

Sample Notification Letters to Parents

Below are a selection of letters to parents informing them of certain, milder infectious diseases that, after discussion with your local Department of Public Health, you may find useful to be able to send to parents. If a case appears in your childcare facility, the letters may help to provide information for parents and to allay anxiety

These letters will be made available in Microsoft Word format so that they can be modified to suit your own needs.

Sample notification letters to parents for the following conditions are available:

1. Chickenpox
2. Hand, Foot and Mouth Disease
3. Head Lice/Nits
4. Impetigo
5. MRSA
6. Parvovirus
7. Ringworm
8. Rubella (German Measles)
9. Scabies
10. Scarlet Fever
11. Threadworms
12. Winter Vomiting Disease (Norovirus)/General Gastro

1. Chickenpox

Date:

Dear Parent or Guardian:

There has been a case of Chickenpox within your child's crèche/preschool and your child may have been exposed. If your child has not had Chickenpox before it is quite likely that he/she will catch it.

What is Chickenpox?
Chickenpox is a common childhood illness. Fever and cold symptoms are often the first signs of illness and are followed by the appearance of the typical rash. The rash starts as small pink bumps, often around the neck, ears, back and stomach. These develop a little water blister, which in turn becomes yellow and oozy and ultimately crusty as it dries. The rash spreads outwards to involve the whole body finally involving the lower arms and legs. People may have only a few spots or may be virtually covered with them. In children it is usually a relatively mild illness however occasionally complications develop.

Why should I be concerned about Chickenpox?
Chickenpox can be a devastating infection in people with a seriously weakened immune system (e.g. patients with leukaemia or after organ transplantation).
In adults, Chickenpox is a much more significant illness than in children and there is a greater risk of complications developing. Chickenpox in pregnancy may cause severe illness and, in the early stages of pregnancy, may result in abnormalities in the baby.

What should I do now?
If your child is normally healthy, Chickenpox is likely to be a relatively mild illness and no specific precautions are necessary. Symptoms usually develop 10 to 21 days after exposure. The infected person can spread infection for up to three days before the rash appears and until the last pox is crusted and dry.
If your child has a weakened immune system, please contact your Doctor and let then know that they may have been exposed.

What should I do if I think my child has Chickenpox?
If you suspect Chickenpox, do not bring the child into a crowded surgery waiting room, as this may only spread the infection further. Contact your doctor to confirm the diagnosis. Do not use Aspirin or any products that contain aspirin to control fever if your child has Chickenpox, as this has been associated with the development of a rare but serious disease called Reye's syndrome.

Can my child stay in crèche/preschool?
Many children with Chickenpox are too sick to attend pre-school and are more comfortable at home. Children can spread the infection to others as long as there are any spots, which are not crusted and dried. Children with chickenpox or shingles should be excluded from school/nursery until scabs are dry this is usually five-seven days after the appearance of the rash. Children with spots that are crusted and dried can safely attend school.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have about Chickenpox.

Yours sincerely,

2. HAND FOOT AND MOUTH DISEASE

Date:

Dear Parent or Guardian:

There has been a case of Hand Foot and Mouth Disease within your child's crèche/pre-school and your child may have been exposed.

What is Hand, Foot and Mouth Disease? This is a disease caused by a group of viruses which usually affects young children. It causes blisters on hands and feet, and mouth ulcers inside the cheeks and on the tongue. Also they may have a sore throat and high temperature. These symptoms last for 7–10 days.

Is it dangerous? No. Complete recovery is the rule.

Is it the same as foot and mouth disease in cows? No. A completely different virus causes Foot and Mouth disease in cows.

How is it spread? The virus is spread by coughs and sneezes, and is also found in the faeces of infected children. Some children infected with the virus do not have symptoms but can still pass it to others.

Is there any treatment?
There is no specific treatment for Hand, Foot and Mouth Disease – it is usually a mild and self-limiting illness. If a child feels unwell paracetamol (such as Calpol or Disprol) may help.
Antibiotics and creams or ointments for the blisters are not effective. Children recover just as quickly without them.

What is the incubation period?
Symptoms start 3-5 days after exposure to the virus.

How long are children infectious?
Children who are ill are infectious. They can carry the virus in their faeces for many weeks after they have recovered and so may continue to pass it on.

How long should children stay away from crèche/preschool?
Children who are unwell should be kept off school until they are feeling better.
Keeping children off school for longer than this is unlikely to stop the virus spreading. There may be other children in the school who appear well but are spreading the virus.

How can spread be prevented?
Since the virus is found in faeces, scrupulous attention must always be paid to hand washing after using the toilet.

Can you catch it more than once?
Yes, but children who are ill during an outbreak at school or nursery are unlikely to get it again during the same outbreak.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have about hand, foot and mouth disease.

Yours sincerely,

3. HEADLICE/NITS

Date:

Dear Parent or Guardian:

There has been a case of Headlice within your child's crèche/pre-school and your child may have been exposed.

What are Headlice? Headlice are little insects with moving legs. They are often not much bigger than a pin head, but may be as big as 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 shaft for very long. They can only live on humans; you cannot catch them from animals.

What are Nits? Nits are not the same thing as lice. Nits are egg cases laid by lice, stuck on to hair shafts; they are smaller than a pin head and pearly white. If you have nits it doesn't always mean that you have head lice. When you get rid of all the lice, the nits will stay stuck to the hair until it grows out.

How are they spread? Anyone can pick up headlice. They are most common among children as they often put heads together during play allowing the lice walk from one head to the next. Lice can also be passed indirectly by using someone else's hairbrush, combs or hats. Headlice do not reflect standards of hygiene. They are just as willing to live in clean or dirty hair.

Can you stop them? The best way is for families to learn how to check their own heads. This way they find any lice before they have a chance to breed. They can then treat them and stop them being passed round the family. The way to check head is called "detection combing". This should be done regularly and in the case of a confirmed infection in one family member, the other members of the household should carry out "detection combing" twice weekly for one week.

How do I do detection combing? You need a plastic detection comb, good lighting and an ordinary comb.

- Wash the hair well, then dry it with a towel. The hair should be damp, not dripping.
- Make sure there is good light, daylight is best.
- Comb the hair with an ordinary comb.
- Start with the teeth of the detection comb touching the skin of the scalp at the top of the head.
- Draw the comb carefully towards the edge of the hair.
- Look carefully at the teeth of the comb in good light.
- Do this over and over again from the top of the head to the edge of the hair all directions, working round the head.
- Do this for several minutes. It takes 10 to 15 minutes to do it properly forreach head.
- If there are headlice, you will find one or more lice on the teeth of the comb. A magnifying glass may be useful identifying lice.

Who needs treatment? Only treat those who have living, moving lice. If more than one family member have lice treat all those at the same them.

How do I treat them? A headlice lotion (not shampoo) should be used. Ask your local chemist, public health nurse or family doctor which lotion to use, and how long to leave it on.

- Put the lotion on to dry hair.
- Use the lotion in a well ventilated room or in the open air.
- Part the hair near the top of the head, put a few drops on to the scalp and rub it in. Part the hair a bit further down the scalp and do the same again. Do this over and over again until the whole scalp is wet.
- You don't need to put lotion down long hair any further than where you would put a pony-tail band.
- Keep the lotion out of the eyes and off the face.
- Let the lotion dry on the hair. Some lotions catch fire, so keep well away from flames, cigarettes, stoves and other sources of heat. Don't use a hair dryer.
- Treat all of them again seven days later in the same way with the same lotion.
- Check all the heads a day or two after the second treatment. If you still find living, moving lice, ask your public health nurse or family doctor for advice.

Yours sincerely,

4. IMPETIGO

Date:

Dear Parent or Guardian:

There has been a suspected case of Impetigo in your child's crèche/preschool/nursery, and your child may have been exposed. Although impetigo is not usually a serious condition, it is very infectious, and if not treated promptly, complications can occur (e.g. kidney disease).

What is Impetigo?
Impetigo is a bacterial infection of the skin caused by the same bacteria that commonly cause sore throats i.e. group A streptococci, although it can also be caused by Staphylococcus aureus or a mixture of the two. It can cause small blisters on the skin which break and become covered with a yellow crust. Impetigo commonly affects the hands and face although it can spread to other parts of the body especially if the skin is broken.

Who catches Impetigo?
Anyone can catch impetigo, but most cases occur in children and babies and in crowded environments e.g. schools and nurseries.

How is Impetigo spread?
Impetigo is usually spread by direct contact with someone who is infected or indirectly by sharing towels; face cloths, clothes or toys that have been used by someone who is infected. The bacteria are present in the skin lesions. Secretions from the sores/lesions are infectious. Hands that touch the rash/sores can become contaminated and can pass the infection to other body sites or other people.

How is Impetigo diagnosed?
Impetigo can usually be diagnosed by simply looking at it. If you suspect your child has Impetigo, you should attend your GP for confirmation and treatment.

How is Impetigo treated?
Your GP will usually prescribe an antibiotic ointment. Sometimes, if the rash is more extensive or is spreading rapidly, an oral antibiotic will be needed.

Should children with Impetigo be excluded from a crèche/preschool/nursery?
Children diagnosed with Impetigo should remain out of the crèche/pre-school/nursery until the sores have stopped blistering or crusting, or until lesions are crusted and healed, or 24 hours after commencing antibiotics.

How can you stop the spread of Impetigo?

- All cases of Impetigo should be treated appropriately and promptly.
- Good personal hygiene is important in preventing infection. Children and household members should be encouraged to wash their hands frequently especially after touching the rash/sores or applying skin ointment. Fingernails should be kept short.
- Children with Impetigo should be discouraged from touching the sores/rash to prevent further spread.
- Cuts and scratches should be kept clean and any conditions that involve broken skin i.e. nappy rash, eczema should be treated promptly.
- Sheets, towels and face cloths should not be shared

Your Family Doctor will be able to answer any further questions you may have on Impetigo.

Yours sincerely,

5. Meticillin-Resistant *Staphylococcus aureus* (MRSA) - FACTSHEET

What is MRSA?
Staphylococcus aureus is a type of bacteria (germ) that is often found on the skin and in the nose of healthy people. Most people who carry staphylococcus on their skin or in their nose (about one in three people) will not suffer any ill effects. People who carry these bacteria on their skin or in their nose without showing any signs or symptoms of infection are described as being "colonised".

Meticillin **R**esistant **S***taphylococcus* **a***ureus* (MRSA) is a specific type of staphylococcus that no longer responds to many commonly used antibiotics such as penicillin.

Occasionally these bacteria cause infections (e.g. impetigo, boils, abscesses or infected wounds) if they enter the body through a break in the skin due to a cut, sore or surgical incision. This is most likely to occur in people who are already ill. A few people however, may develop more serious infections such as septicaemia also known as "bloodstream infections," especially people who are already ill in hospital or have long term health problems.

Staphylococci (including MRSA) are usually spread from person to person on unwashed hands, particularly after having direct contact with a draining wound (e.g. cut or sore) but it can also be spread by touching items used by an infected person e.g. soiled dressings.

The main ways to prevent infection are to wash your hands and care for wounds properly.

Exclusion:
Children/infants known to carry *Staphylococcus aureus* (including MRSA) on the skin or in the nose do not need to be excluded from the childcare setting.

Children who have draining wounds or skin sores producing pus will only need to be excluded from a childcare setting if the wounds cannot be covered or contained by a dressing and/or the dressing cannot be kept dry and intact.

How to limit spread:

- Hand washing with soap and running water is the most effective way to prevent the spread of infection.
- Keep cuts and scrapes clean and covered until healed; watch for signs of infection, such as pus, redness, warmth and swelling.
- Do not share personal items e.g. towels, facecloths, flannels, bedding and clothes.
- Cover infected wounds with clean dressings
- If a dressing needs to be changed in the child care setting, gloves should be worn by the care giver and hands should be washed before and after changing the dressing
- Discard soiled items (e.g. dressings) in a sealed plastic bag before placing it in a domestic waste bin

Resources:
Useful information on MRSA can be found at http://www.hpsc.ie/hpsc/A-Z/MicrobiologyAntimicrobialResistance/EuropeanAntimicrobialResistanceSurveillanceSystemEARSS/ReferenceandEducationalResourceMaterial/SaureusMRSA/

6. SLAPPED CHEEK SYNDROME (PARVOVIRUS)

Date:

Dear Parent or Guardian:

There has been a case of Slapped Cheek Syndrome (caused by parvovirus B19 and sometimes called Fifth Disease) within your child's crèche/ pre-school and your child may have been exposed.

What is "Slapped Cheek Syndrome"?
It is a mild rash illness that occurs most commonly in children. The ill child typically has a "slapped-cheek" rash on the face and a lacy red rash on the trunk and limbs. Occasionally, the rash may itch. An ill child may have a low-grade fever, malaise, or a "cold" a few days before the rash breaks out. The child is usually not very ill, and the rash resolves in 7 to 10 days. It is caused by infection with human parvovirus B19.

Can adults get Parvovirus B19 infection?
Yes, they can. An adult who is not immune can be infected with parvovirus B19 and either have no symptoms or develop the typical rash of slapped cheek syndrome, joint pain or swelling, or both. The joint pain and swelling usually resolve in a week or two, but they may last several months. About 50% of adults, however, have been previously infected with parvovirus B19, have developed immunity to the virus, and cannot get fifth disease.

Is parvovirus B19 infectious?
Yes. A person infected with parvovirus B19 is infectious during the early part of the illness, before the rash appears. By the time a child has the characteristic "slapped cheek" rash he/she is probably no longer contagious and may return to school crèche/preschool.

How does someone get infected with parvovirus B19?
Parvovirus B19 has been found in the respiratory secretions (e.g., saliva, sputum, or nasal mucus) of infected persons before the onset of rash, when they appear to "just have a cold." The virus is probably spread from person to person by direct contact with those secretions, such as sharing drinking cups or utensils.

Is parvovirus B19 infection serious?
Fifth disease is usually a mild illness that resolves on its own among children and adults who are otherwise healthy. Parvovirus B19 infection may cause a serious illness in persons with anaemia or weakened immune system. Occasionally, serious complications may develop from parvovirus B19 infection during pregnancy.

Can parvovirus B19 infection be prevented?
There is no vaccine or medicine that prevents parvovirus B19 infection. Frequent handwashing is recommended to decrease the chance of becoming infected. Excluding persons with Slapped Cheek Syndrome from crèche is not likely to prevent the spread of the virus. People are infectious before they develop the rash.

I am pregnant and have been exposed to a child with parvovirus B19. What should I do?
You should contact your doctor, who may wish to do a blood test. Usually, there is no serious complication for a pregnant woman or her baby if exposed to a person with slapped cheek syndrome. About 50% of women are already immune to parvovirus B19, and these women and their babies are protected from infection and illness. Even if a woman is susceptible and gets infected with parvovirus B19, she usually experiences only a mild illness. Likewise, her unborn baby usually does not have any problems attributable to parvovirus B19 infection.

Sometimes, however, parvovirus B19 infection will cause the unborn baby to have severe anaemia and the woman may have a miscarriage. This occurs in less than 5% of all pregnant women who are infected with parvovirus B19 and occurs more commonly during the first half of pregnancy. There is no evidence that parvovirus B19 infection causes birth defects or mental retardation.
Yours sincerely,

7. RINGWORM

Date:

Dear Parent or Guardian:

There has been a case of Ringworm within your child's crèche/ pre-school and your child may have been exposed.

What is ringworm?
Ringworm is a fungal infection of the skin that can affect different parts of the body. How it looks depends on where it is. On the skin it presents as a roughly circular scaly itchy rash. Sometimes there may be small blisters and even pus filled spots. It can involve the nails causing them to thicken and discolour. On the scalp it often starts as a small bump, gradually spreading outwards and is associated with hair loss. On the feet there may be cracking between the toes.

What should I do now?
As Ringworm spreads through skin contact or through contact with infectious skin flakes shed into clothes or the environment, it can easily spread within a crèche/preschool. It is important that you check your child's skin and hair for the presence of any suspicious lesion.

What should I do if I think my child has Ringworm?
If you see any suspicious areas on your child's skin or scalp, bring the child to your family doctor. He will be able to decide, either by looking at it directly, by examining it with special light or by examining some skin cells under the microscope whether or not it is Ringworm. Once the diagnosis is made treatment can be given. It is important that the rest of the family are checked for ringworm. Also check and treat symptomatic pets.

Can my child stay in crèche/preschool?
Yes. However, to prevent the spread of infection to others it is important that the affected child receive appropriate treatment.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have about Ringworm.

Yours sincerely,

8. RUBELLA (GERMAN MEASLES)

Date

Dear Parent or Guardian:

There has been a case of Rubella within your child's crèche/ pre-school and your child may have been exposed. MMR (measles, mumps, rubella) vaccine is given at 12 months of age and as a preschool booster at 4-5 years. If your child received the MMR vaccine when he/she was 12 months of age or older, the chance of him/her developing Rubella is extremely low. If, however, your child has not been vaccinated then it is quite possible that he/she might get Rubella.

What is Rubella?
Rubella is a mild viral illness that causes little problem for children. In childhood it causes a mild flu like illness with mild swelling of the glands, particularly those at the back of the neck and a fine pinkish red rash. In addition adults can develop painful joints (arthritis).

Why should I be concerned about Rubella?
If a pregnant woman develops Rubella in the early stages of pregnancy her unborn baby may also be infected and the consequences can be devastating. Rubella infection in the unborn can cause severe mental retardation, eye defects, heart problems and a wide variety of other congenital abnormalities.

Who gets Rubella?
Anyone who is not immune to it and who has contact with someone with Rubella can get Rubella. People who have either received Rubella vaccine (part of the MMR) or who have had Rubella should be immune. A simple blood test can tell whether or not you are immune to it. As many viral illnesses are similar to Rubella, and are often mistaken for it, you cannot consider yourself immune unless you have had the blood test or been vaccinated.

What should I do now?
If you and your child have received Rubella vaccine or you have been tested and know that you are immune, there is no need for concern. If your child is 12 months or older and has not received the vaccine, bring them to your family doctor for vaccination. The vaccine will not protect them if they have been exposed this time, but it will protect them from future exposures. If you are pregnant or likely to become pregnant, please contact your doctor and find out whether or not you are immune to Rubella. If you are not immune (and are not pregnant), then contact your doctor and arrange to get the vaccine.

What should I do if I think my child has Rubella?
If your child develops a flu-like illness, with a fine red rash and swelling of the glands behind the ears, arrange for your doctor to see the child. He will be able to tell you if it looks like Rubella and will advise you what to do. If you suspect Rubella, do not bring the child into a crowded surgery waiting room, as this may only spread the infection further. There is no treatment for Rubella and symptoms resolve over a few days.

Can my child stay in crèche/preschool?
Children with rubella must stay at home until at least seven days after the appearance of the rash.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have about rubella and the MMR vaccine.

Yours sincerely

9. SCABIES

Date:

Dear Parent or Guardian:

There has been a case of scabies within your child's crèche/pre-school and your child may have been exposed. We are bringing this to your attention because scabies can spread rapidly unless all affected children are promptly treated.

What is scabies?
Scabies is an infestation of the skin with a tiny mite smaller than a pinhead. The mites burrow anywhere in the skin, mostly on hands, and cannot be seen. The rash is caused by the body's reaction the mite and the scratching that occurs.

How could my child get scabies?
Anyone can get Scabies. The mite passes from person to person through skin contact. Scabies is unlikely to be caught by short contact such as shaking hands. Longer contact is needed but could be as little as 5 to 10 minutes. Children playing together are especially likely to pass it from one to the other. The itching may occur anytime from two to eight weeks after catching the mites, so mites can pass to someone else before the rash appears.

How will I know if my child has scabies?
If your child develops an itchy rash bring the child to their doctor.

What should I do if my child has scabies?
A variety of special lotions and creams that kill mites are available at the chemist. It is best to see your doctor first to be sure that it is scabies. It is important to follow the instructions that come with the lotion carefully, as there are a number of different preparations available. As spread within households is common, it is a good idea to treat all family members at the same time ever if there are no symptoms. A person with scabies should get two treatments one week apart.

Thank you for giving this your attention. Your family doctor or chemist will be able to answer any further question that you might have concerning scabies and the preparations available to treat it.

Yours sincerely

10. SCARLET FEVER

Dear Parent

There has been a case of Scarlet Fever within your child's crèche/pre-school and your child may have been exposed.

What is Scarlet Fever?
Scarlet fever is a scattered red rash and high temperature caused by bacteria (Group A streptococci). Occasionally these bacteria can cause kidney or heart complications. Prompt treatment with an antibiotic usually prevents these complications. Treatment will also prevent spread to others.

What are the symptoms of Scarlet Fever?
A scattered red rash that is often most marked in the creases of the joints and over the stomach. It usually blanches (goes white) when pressed on. The skin may feel rough to the touch, sometimes described as feeling like sandpaper. Someone with Scarlet Fever will have evidence of a Streptococcal infection somewhere, usually in the throat or sometimes in the skin.

What should I do if I think my child has it?
If your child develops any of these symptoms bring him/her to your doctor for examination. Tell the doctor that another child in the crèche/preschool has Scarlet Fever.

If my child has Scarlet Fever what should I do then?
The doctor will prescribe an antibiotic for your child. It is important that the child takes the full course of medicine.

Can my child stay in crèche/preschool? Your child can return to crèche/preschool when he/she is well and has finished 1 full day of antibiotic.

What can I do to prevent spread of infection at home?
The bacteria are spread through contact with nose and mouth secretions so:

- Wash hands thoroughly after wiping nose.
- Wash hands thoroughly before preparing food.
- Wash dishes well in hot soapy water.
- Do not share cups, straws, spoons, eating utensils etc.
- Do not share toothbrushes.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have concerning scarlet fever.

Yours sincerely,

11.THREADWORMS

Date

Dear Parent or Guardian:

A child in your child's crèche/pre-school has been diagnosed with worms. We are bringing this to your attention because worms can spread rapidly among children unless all affected children are promptly treated.

What are threadworms?
The threadworm is a common parasite, which at some time will cause infection in almost every child.

How could my child get worms?
Anyone can become infected with threadworms. Furthermore people can become infected on several different occasions. The worms live in the intestine. The adult female worm leaves the intestine at night to lay her eggs on the skin surrounding the anus. Children irritated by the presence of the worms scratch their bottoms, picking up the eggs onto their hands in the process. These eggs are then carried to the mouth, swallowed, and once in the intestine they can hatch and mature into the adult worm. In a similar fashion the child may, by putting their fingers into another mouth or by touching food, pass the eggs to their classmates and to other family members. Eggs can also be transferred indirectly as they can get onto bedding and clothes and survive for up to two weeks.

What should if do if my child has worms?
A variety of agents are available to treat worms including some, which are available without prescription at the chemist. Threadworms are easily passed on to other members of a family so it is a good idea to treat all family members at the same time even if there are no symptoms. The treatment should be repeated after two weeks to make sure it has worked. After treatment all bedding and underwear should be washed in the hot cycle in the washing machine to destroy any eggs present.

Thank you for giving this your attention. Your family doctor or chemist will be able to answer any further questions that you might have concerning worms and the preparations available to treat them.

Yours sincerely

12. NOROVIRUS (WINTER VOMITING DISEASE)

Date:

Dear Parent or Guardian:

There has been a case of Norovirus (winter vomiting disease) within your child's pre-school and your child may have been exposed.

What is Winter Vomiting Disease?
A virus known as norovirus causes winter vomiting disease. The virus usually causes short-lasting outbreaks but can be very contagious. The infection has caused many outbreaks in the community and in health care settings in recent years.

What are the symptoms of Winter Vomiting Disease?
Symptoms include:

- Nausea (often sudden onset).
- Vomiting (often projectile).
- Watery diarrhoea.

Some people may have a raised temperature, chills, muscle aches and symptoms begin around 12 to 48 hours after becoming infected. The illness is usually brief, with symptoms lasting only about one or two days. Most people make a full recovery within one to two days, however some people (usually the very young or elderly may become very dehydrated and require hospital treatment).

How is Winter Vomiting Disease spread?
People can become infected with the virus in several ways, including:

- Contact with an infected person, especially contact with vomitus or stools.
- Contact with contaminated surfaces or objects and then touching mucous membranes.
- Consuming contaminated food or water.

What can be done to prevent infection?
It is often impossible to prevent infection; however, taking good hygiene measures around someone who is infected can decrease your chance of getting infected.

- Frequent hand-washing including before eating or preparing food and after toilet use/nappy changing.
- Thoroughly clean and disinfect contaminated surfaces immediately after episode of illness by using a bleach-based household cleaner.
- Flush or discard any vomit and/or faeces in the toilet and make sure that the surrounding area is kept clean.

Are Noroviruses contagious?
Noroviruses are very contagious and can spread easily from person to person. Both faeces and vomit of an infected person contain the virus and are infectious. People infected with norovirus are contagious from the moment they begin feeling ill to two to three days after recovery. Some people may be contagious for as long as two weeks after recovery.

It is important for people to use good hand-washing and other hygienic practices after they have recently recovered from norovirus illness. In addition, noroviruses are very resilient and can survive in the environment (on surfaces etc.) for a number of weeks.

Can my child stay in school?
It is extremely important that people who have been ill with vomiting or diarrhoea should remain out of school/work for two full days after their symptoms have stopped. This advice particularly applies to children, food handlers and staff.

Thank you for giving this your attention. Your family doctor will be able to answer any further questions that you might have about winter vomiting disease.

Yours sincerely,

INFECTION CONTROL AUDIT TOOL

Pre-School Facilities

This generic audit checklist is for use in reviewing infection control in childcare settings.

Name of Pre-school:

Telephone Phone number:

Manager's name:

Date of audit:

Completed by:

Acknowledgment:
West London Health Protection Unit. Guidelines for the Control of Infection and communicable disease in Nurseries and other Institutional Early Years Settings in South West London Sector 2003.

Adapted from West Midlands Infection Control Nurses Association Audit Tool, 1998.

INSTRUCTIONS FOR USE OF AUDIT TOOL:
This is an Excel Audit Tool which can be filled in directly using Microsoft Excel software to enable automatic calcuation of results.
There are six standards to be audited against in the Infection Control Audit Tool.
Each standard has multiple questions.
Please highlight the correct answer by marking a **1** in the relevant box for each question.
These figures will be automatically summed up to calcuate the percentage compliance for each standard.

STANDARD 1

Hands will be washed correctly, using a cleaning agent, at the facilities available, to reduce the risk of cross infection.

		Please highlight correct answer by marking a **1** in the relevant box below		
	Hand Hygiene	**Yes**	**No**	**N/A**
1	Liquid hand soap dispenser at all staff/ children's hand wash sinks /toilet areas			
2	All areas are free of bar soap			
3	Paper towels dispenser at all staff/ children's hand wash sinks /toilet areas			
4	All sinks are free from nail brushes			
5	Hot & cold running water is available at sinks (preferably via mixer taps).The hot water from sinks used by children are thermostatically controlled to a maximum of 43ºC			
6	Wash hand sinks in non rest areas are free from tea cups and drinking facilities			
7	Sinks are kept clear e.g. no equipment soaking in the sinks and are easily accessible			
8	There is a foot operated bin for waste towels in close proximity to hand washing sinks			
9	The above bins are fully operational			
10	There is a hand washing message/technique poster on display by hand washing area/s			
11	There are separate toilet facilities for staff with separate hand washing facilities			
12	There are separate, dedicated hand washing sinks for staff and children to use in toilet/ nappy changing areas. Sinks are readily accessible in or near playrooms			
13	Children are taught /supervised in hand washing and hand drying techniques			
14	Children wash their hands after using the toilet, after handling animals, before eating			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 1 = **0%**

Findings/ Comments:

STANDARD 2

The Preschool will demonstrate adherence to the Child Care (Pre-school) Regulations 2006 and will reflect best practice to reduce the risk of cross infection to children/staff visitors, while providing appropriate protection to staff

		Please highlight correct answer by marking a **1** in the relevant box below		
	Protective Clothing	**Yes**	**No**	**N/A**
1	Non powdered,non sterile latex/vinyl/synthetic gloves CE approved			
2	Disposable plastic aprons			

	Procedures	**Yes**	**No**	**N/A**
3	Staff are aware of the procedure for dealing with blood spillage (ask one randomly)			
4	Staff members seen are wearing/using (or not using) protective clothing appropriately?			
5	Records are kept regarding children's vaccination history & sickness episodes			
6	Nappy changing protocol is available			
7	Disposable paper towel is used to protect nappy changing mat	Yes	No	N/A

	The Availability of Policies/Records on the Following:	**Yes**	**No**	**N/A**
7	Handwashing			
8	Cleaning policy (inc. frequency rota/protocol, use of disinfectants, equipment use and storage)			
9	Outbreak recognition and management			
10	Management of general waste			
11	Management of blood/ body fluid spillages			
12	Use of protective clothing			
13	Care of toys and play equipment (including cleaning)			
14	Laundry and management of linen/soiled clothing			
15	Product material safety data sheet- detergents/disinfectants			
16	Zoo/farm visits +/- pets management. Pet visits to pre-school			
17	First Aid			
18	Training of staff in infection control			
19	Staff health and illness exclusion policy			
21	Child illness exclusion policy			
22	Child and staff illness log book (to be kept on the premises)			
21	The policies are regularly reviewed/up to date (i.e. yearly)			
22	Access to current copy of poster of "Guidance on Infection Control in Childcare settings 2012"			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 2 = **0%**

Findings/ Comments:

STANDARD 3

The pre-school environment will be appropriately maintained to reduce the risk of cross infection

		Please highlight correct answer by marking a **1** in the relevant box below		
	Environment, cleaning and toys	**Yes**	**No**	**N/A**
1	All general areas are clean and uncluttered			
2	There is a documented, regular cleaning programme in operation			
3	There is limited use of carpet (restricted to reading area)			
4	Carpet areas are vacuumed daily and steam cleaned routinely every 2 to 3 months or as needed			
5	Surfaces (e.g. chairs/tables/floors and walls) are impervious with wipeable surfaces			
6	Equipment/furniture is in a good state of repair			
7	There is a robust repair/replacement system in place			
8	Mops are clean and stored inverted/hung to dry between use			
9	Buckets are clean, dry & inverted after use			
10	Separate cleaning equipment is used to clean the toilets, the kitchen and the playroom			
11	Cleaning cloths are single use and non-shedding			
12	Kitchen cleaning equipment and toilet/bathroom mops/buckets are stored separately			
13	High chairs/chairs/ tables/cots are cleaned after use			
14	Water play pools are emptied daily, washed with detergent/hot water and left dry overnight			
15	Sandpits have fitted lids when not in use and sand is kept clean and dry. Sand is renewed regularly			
16	Toys are all of a washable material			
17	All hard toys are washed weekly routinely, unless contaminated			
18	All soft toys are washed after use (on hot wash)			
19	Playdough replaced regularly			
20	Sleep mattresses are in a good state of repair and waterproof			
21	Sleep mattresses are cleaned between use and stored dry			
22	Bed linen is clean and either changed after each child's use or stored separately for an individual child's use over a set period			

	Environment, toilets/nappy changing	Yes	No	N/A
23	Toilet fixtures and fittings are intact			
24	Toilet seats/ changing mats are clean			
25	Changing mats are intact			
26	Changing mats are covered with paper towels before each use			
27	Changing mats are on a flat surface for baby changing			
28	Cleaning materials are available for use by staff to clean toilets/potties			
29	There are separate toilet and hand washing facilities for staff			
30	Does the sanitary accomodation/nappy changing area/lobby area communicate with any occupied room			
	Are the sanitary facilities/nappy changing area/lobby area adequately ventilated			
31	Toilets/urinals/hand wash basins are at a low level for the children using them or hop ups are available			
32	All toilet rolls are on holders/in dispensers			
33	Creams /lotions/wipes are for one childs use only			
34	Are potties provided and are the potties washed and stored appropriately			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 3 = **0%**

Findings/ Comments:

STANDARD 4

Waste will be disposed of safely without risk of contamination or injury and within current guidelines

		Please highlight correct answer by marking a **1** in the relevant box below		
	Waste Management	**Yes**	**No**	**N/A**
1	Foot operational pedal waste bins are available in bathroom/toilet/hand washing areas			
2	Foot operational pedal waste bins are in working order			
3	Appropriate black or clear bags are used for disposal of gloves and aprons)			
4	Recyclable waste and domestic waste is correctly segregated			
5	Waste bags are less than ¾ full and securely tied			
6	Domestic waste is stored in designated area prior to disposal			
7	The storage area is locked and inaccessible to unauthorised persons and pests			
8	Nappies are disposed of in a leakproof, cleanable and sealable /airtight container			
9	Food and hazardous waste is stored in covered containers			
12	Bins are routinely cleaned inside and out			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 4 = **0%**

Findings/ Comments:

STANDARD 5

Detergents/disinfectants are used correctly to reduce the risk of infection

		Please highlight correct answer by marking a **1** in the relevant box below		
	Disinfectants and detergents	**Yes**	**No**	**N/A**
1	Disinfectants/detergents are used appropriately i.e. in accordance with manufacturer's instructions			
2	Disinfectants/detergents are stored in a locked cupboard when not in use			
3	Product material safety data sheets are available			
4	A chlorine based disinfectant is available for use with blood spillages.			
5	A spillage kit is readily available			
5	Cleaning products are not decanted from original container			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 5 = **0%**

Findings/ Comments:

STANDARD 6

Laundry will be handled and disposed of safely with minimised risk of contamination/ cross infection to children and staff

		Please highlight correct answer by marking a **1** in the relevant box below		
	Laundry Management	**Yes**	**No**	**N/A**
1	There is a separate laundry area			
2	Foot operational pedal waste bins are in available in laundry area			
3	Foot operational pedal waste bins are in working order			
4	Dirty linen is segregated in appropriate bags i.e. between any foul and non foul linen			
5	Dirty laundry bags are stored away from away from clean linen			
6	Clean linen is stored in a defined clean area			
7	There is a separate sink for hand washing with liquid soap and paper towels			
8	The washing machine has a sluice/pre wash cycle and regular maintenance contract			
9	Childrens soiled clothing is stored in sealed, plastic bags for collection by parent and is not manually washed by staff			
	Total	**0**	**0**	**0**

Percentage compliance for Standard 6 = **0%**

Findings/ Comments:

ACTION PLAN FOR STANDARD NUMBER

This sheet should be used for creating an action plan for each standard, as necessary. Please complete legibly and retain a copy of this plan and the other comment sheets etc for your own records. Please photocopy as required for each standard.

Preschool

Date

Problem identified

Action planned to resolve problem

Resources required to achieve outcome/potential or actual limitations and how these might be overcome:

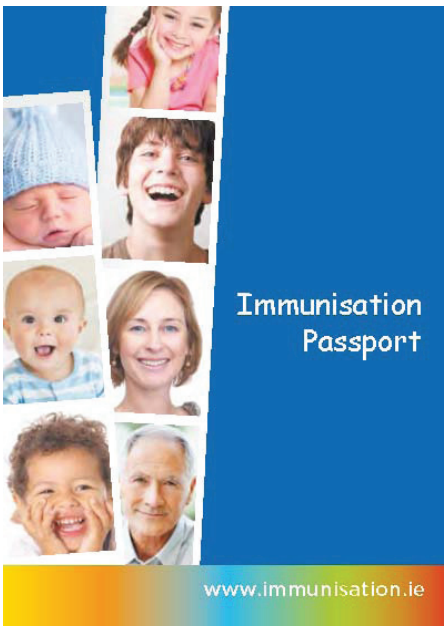
Person responsible for outcome:

Planned date to achieve outcome:

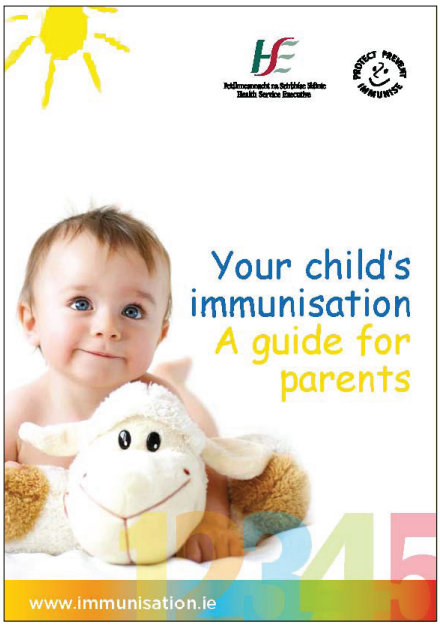
Planned date to review outcome/reaudit:

13. IMMUNISATION MATERIALS

Immunisation passport in use since April 2011

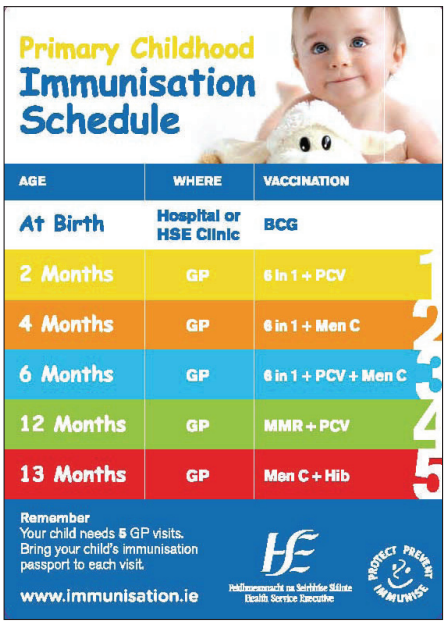


Booklet in use since April 2011

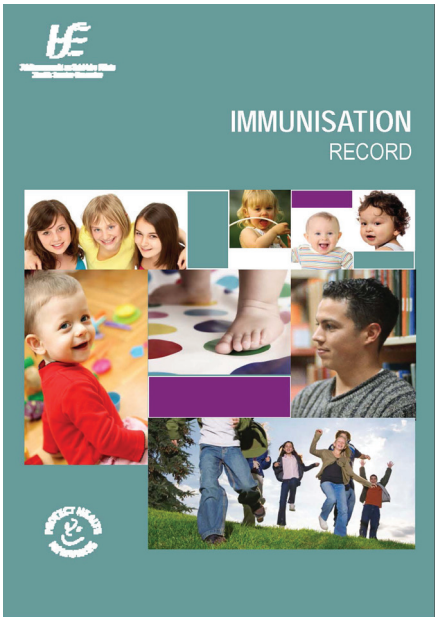


Poster in use since April 2011

Poster in use since April 2011



Record book in use from July 2008 – March 2011



Feidhmeannacht na Seirbhíse Sláinte
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