


School / Department	
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Scope

This policy deals, primarily, with infection risks associated with the care of students. It is presented in six sections:

1. General Requirements
2. Prevention and Control of Infections
3. HIV and Hepatitis
4. Pandemic and Seasonal Influenza
5. Other Infection Risks
6. Risk Assessments for Infectious Diseases

Policy Summary

This policy describes how infection risks are to be assessed and controlled in the NASAT. Managers are responsible for ensuring that the procedures shown in this document are followed, and must rigorously enforce the universal infection control procedures described in section 1.

1. General Requirements

Managers must assess infection risks to those working on behalf of the NAS and to those using its services. Measures must be introduced in line with this policy to minimise, and where possible, eliminate those risks. This policy does not include the management of all infectious ailments. If a manager is made aware of staff and/or the people we support suffering from an infectious disease that is not dealt with by this policy and there is insufficient in-house expertise is available to conduct suitable and sufficient risk assessments the manager must contact the SQE Team or the Area HR Manager. The SQE Team or the HR team will seek assistance from the organisation's Occupational Health providers.

Great care must be taken to ensure that no one is discriminated against on the grounds that they have a communicable disease. Support must be given and the opportunity provided to discuss fears and anxieties in confidence.

General infection control training must be provided, at induction, for staff supporting people who use NASAT services. Supplementary training will be required where this has been identified through risk assessment.

2. Prevention and Control of infection

Managers must ensure that they have sound infection prevention and control measures in place and should:

- Use risk assessments to help them manage and monitor the prevention and control of infection.
- Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.
- Provide suitable accurate information on infections to the people we support and their visitors.
- Provide suitable accurate information on infections to any person concerned with providing further support or nursing/medical care in a timely fashion.
- Ensure that people who have or develop an infection are identified promptly and receive appropriate treatment and care to reduce the risk of passing on infection to other people.
- Ensure that all staff and those employed to provide care in all settings are fully involved in the process of preventing and controlling infection.
- Have and adhere to policies designed for the individual's care and NASAT policy to help prevent and control infection.
- Ensure, so far as is reasonably practicable, that care workers are free of and are protected from exposure to infections that can be caught at work and that all staff are suitably educated in the prevention and control of infection associated with the provision of the service.

Universal Infection Control Precautions

Universal Infection Control Precautions must be used to avoid contact with blood, bodily fluids and excreta to minimise the risk of infection. The precautions which must be used are:

- Assume everyone is potentially infectious!
- The most effective precaution that can be taken is proper hand washing. Wash hands thoroughly before and after each care activity, preferably with an antibacterial soap; use antibacterial hand cream (see Appendix 1). The use of alcohol rubs is no substitute for proper hand washing; but may be an

appropriate precaution in some circumstances. Where alcohol rubs are used then:

- hands should be free of dirt and inorganic material,
 - the hand-rub solution must come into contact with all surfaces of the hand.
 - the hands must be rubbed together vigorously, paying particular attention to the tips of the fingers, the thumbs and the areas between the fingers until the solution has evaporated and the hands are dry.
- Ensure all skin wounds including abrasions are covered with a waterproof plaster/dressing;
 - Use gloves to prevent hands coming into contact with blood, body fluids or faecal matter. (Care should be taken in the selection of suitable gloves, and latex gloves should not be used where wearers or supported persons have a latex allergy.) Gloves must be disposed of properly after each use and hands are to be washed after disposal;
 - Disposable gloves and a plastic apron may need to be worn when cleaning up spillages of bodily fluids and/or excreta (Refer to COSHH assessment.);
 - Gloves and aprons are to be regarded as clinical waste and disposed of immediately after use ;
 - Yellow plastic bags must be used for the disposal of clinical waste, and the control measures shown in the COSHH assessment must be followed;
 - Dispose of hypodermic needles immediately after use in an approved sharps container. Any sharp must be disposed of by the user at the point of use. Needles must not be re-capped, re-sheathed or bent. Sharps containers must not be filled to more $\frac{3}{4}$ full and must be disposed of as clinical waste;
 - Any exposure incident (e.g. exposure, through the skin or into a cut, to blood or body fluid) should be reported immediately and managed in accordance with the exposure incident procedure, below.
 - Any direct contact with bodily fluids or excreta must be reported as soon as is practicable. If exposure is significant (i.e. contact with broken skin or mucous membrane) then refer to exposure incident procedure shown below.

Spills

Where it is necessary to clean up bodily fluids, an appropriate means of disinfection must be used. If there is a spillage of blood then a chlorine based (1000ppm active chlorine) disinfectant must be used.

Laundry

Care must always be taken and the laundry designed, so that the likelihood of cross contamination from dirty to clean laundry is minimised.

All items should be washed using a cycle that reaches 71°C for at least three minutes, or 65°C for at least 10 minutes.

Cleaning

Cleaning should always start in the cleanest area, working towards the dirtiest area.

A system of colour coded equipment must be used to reduce the risk of cross contamination, where:-

RED	=	Sanitary appliances and washroom floor
BLUE	=	General areas including offices, lounges etc.
GREEN	=	Kitchens and food preparation areas
YELLOW	=	Washbasins and washroom surfaces

Exposure Incident Procedure

In cases of significant exposure it is important to determine the risk of transmission of Hepatitis B, C or HIV. This will require blood tests to be performed on the person at risk and the source. Most A&E departments will be equipped to follow a standard procedure for testing and providing advice.

Action should be taken within 48 hours.

Needle-stick and Bite Injuries

Encourage the site to bleed, squeezing gently from both sides of the entry point. Wash the site for at least 5 minutes in running water, preferably with an anti bacterial soap or household detergent. Cover with waterproof dressing whilst at work.

Mucus Membrane Exposure to Saliva

Wash out the mouth or eyes with copious running water. This should be managed as a significant exposure incident if saliva is blood stained.

Skin Contact

Provided that the skin is unbroken, then the site should be washed with anti bacterial soap. If the skin is broken then treat as a needle-stick injury.

Contaminated Clothing

Handle with care using gloves, remove solids, and wash on a hot cycle as soon as is practicable.

Decontamination of Surfaces Smearred with Faeces

Where it is known that a individual smears then a COSHH assessment must be carried out to identify the measures which must be taken to control the biological risks. The assessment should take into account the frequency, surfaces that may be contaminated, the degree of soiling, solutions and materials to be used and personal protective equipment to be worn. The assessment may also need to deal with decontamination of the individual.

Clinical Waste Procedures

Clinical waste procedures must be developed through the COSHH assessment process as shown in the Hazardous Substances Policy.

The assessment must identify particular hazards, e.g. showering a supported person after "accident" or smearing episode, removal of soiled bed linen to laundry, bagging and disposal of waste to approved contractor, etc.

The assessment should not only deal with the biological hazards but have respect for the individual's dignity.

Disposal - General

Clinical waste must be disposed of properly and in accordance with legislation. Clinical waste is categorised as follows:

Group	Description
A	Soiled surgical dressings, swabs and other soiled waste from treatment areas. All human tissue, including blood (whether infected or not) and all related swabs and dressings. Waste materials, where the assessment indicates a risk to staff handling them, for example from infectious disease cases.
B	Discarded syringe needles, cartridges, broken glass and any other contaminated disposable sharp instruments or items.
C	Not applicable to NASAT
D	Not applicable to NASAT
E	Items used to dispose of urine, faeces and other bodily secretions or excretions assessed as not falling within Group A. This includes used disposable bed pans or bed pan liners, incontinence pads, stoma bags, and urine containers. It will be apparent that Group E contains items which usually present a low level of risk. However, as the actual risk cannot be readily demonstrated, items within this Group should be treated as clinical waste taking into account local circumstances. It should be recognised that while the risk from Group E items may be low they will often be of an offensive nature and adequate steps should be taken in line with the Health and Safety at Work etc Act 1974 for proper handling and disposal arrangements.

Disposal – NASAT Schools

In any NASAT schools, group A, B and E waste must be disposed of by an approved contractor who must confirm that the waste is to be taken for incineration. Group E waste can be disposed of in a licensed landfill site, but it is usually easier to arrange for all categories of waste to be incinerated. A waste transfer note must be obtained from the contractor.

Group A and E wastes should be placed in yellow waste sacks (unless segregating for landfill) in sack holders or other appropriate containers at the point of generation. The sacks should be replaced at periods which are as short as reasonably practicable but, in any case, no longer than one week. Contents should not be transferred from container to container. The sacks should be sealed either with a purpose made plastic tie or closure, or in the case of light gauge sacks, by tying off the neck. Sacks should not be closed by stapling. The sacks should be labelled with the name of the home or school by using a permanent marker.

Group B waste (i.e. sharps) should never be placed in receptacles used for the storage of other wastes. They should be placed in a safe manner into properly constructed sharps containers. Syringes/cartridges and needles should be disposed of intact. Sharps containers should be sealed and sent for disposal when $\frac{3}{4}$ full. The containers should be labelled before removal. They should not be placed in yellow sacks but should be carried separately during storage and transport.

Care must be taken to ensure that people being supported, and others, are not harmed by waste awaiting collection.

3. HIV and Hepatitis

The approximate risks of the development of antibodies in blood serum as a result of infection following a significant exposure incident, if the other person is positive for a blood borne virus, and the victim is not immune, are:

<u>HIV</u>	<u>1 in 300</u>
<u>Hepatitis C</u>	<u>1 in 30</u>
<u>*Hepatitis B</u>	<u>1 in 3</u>

* post exposure prophylaxis with vaccine +/- Hepatitis immunoglobulin given shortly after exposure is highly effective in preventing infection.

Human Immunodeficiency Virus (HIV)

HIV is the human immunodeficiency virus that causes Auto-Immune Deficiency Syndrome (AIDS). This affects the body's normal defence mechanism. The immune system breaks down and is unable to fight off infections and other illnesses that take advantage of a weakened immune system. It should be noted that many individuals who are HIV positive remain healthy for years and continue in normal work. Furthermore between bouts of illness individuals can return to work.

This virus is not readily transmitted from person to person, except direct entry, i.e. in sexual intercourse and across the placental barrier from infected mother to her unborn child. The virus is contained primarily in blood, semen and vaginal secretions. The sharing of hypodermic needles and drug injecting equipment also transmits the virus. It is not spread through the air, or by using workplace facilities like toilets or sinks.

The primary risks within the workplace are from contact of open wounds from body fluids from an infected person, or through needle-stick injury resulting in the injection of blood from a used hypodermic syringe and needle. There is also a small risk during an assault of blood to blood contact through open wounds.

To reduce the risk of cross-infection all employees must use the universal precautions shown above when administering first aid or cleaning up bodily fluids.

Hepatitis

Hepatitis is a RIDDOR reportable if occupationally acquired. Hepatitis means inflammation of the liver. It is a viral infection although it can be caused by excess of alcohol, drugs or medicines and changes in the body's immune systems. There are 3 main viruses that cause hepatitis, they are referred to as A, B and C.

Hepatitis A

Hepatitis A is a virus that causes inflammation of the liver. It is sometimes known as infectious hepatitis and is the illness often associated with trips to hot climates. Whilst its consequences can be unpleasant and debilitating most people recover from it. It is usually transmitted by oral routes as a result of drinking water or eating foods that have been contaminated by faecal matter containing the virus.

Hepatitis B

Hepatitis B is a serious infectious disease of the liver caused by a virus. 30% of people with Hepatitis B have no symptoms at all whilst others experience a flu-like illness which can sometimes be followed days/weeks later by jaundice. Symptoms include jaundice, fatigue, abdominal pain, loss of appetite, nausea and vomiting and joint pain. Some people, particularly those who display no symptoms, can become carriers, therefore unknowingly infecting other people. These carriers may eventually

develop serious liver disease including cirrhosis and liver cancer. Hepatitis B is the major cause of liver cancer.

Hepatitis B transmission occurs when blood or bodily fluids, such as semen and vaginal secretions, from an infected person enters the body of a person who is not immune. This may be via sexual contact or needlestick and sharps exposure.

Hepatitis B is the most virulent and all medical personnel and care staff are considered to be at risk. Immunisation is available for Hepatitis B, and all first aiders and all NASAT employees having direct contact with clients should consider immunisation and to discuss it with their own GP.

The Department of Health "Green Book" 2006 Immunisation Against Infectious Diseases (Section 18) states:

"A higher prevalence of hepatitis B carriage has been found among certain groups of those with learning disabilities in residential accommodation than in the general population. Close daily living contact, and the possibility of behavioural problems, including biting and scratching may lead to staff and other clients being at increased risk of infection.

Similar considerations may apply to staff in day care settings and special schools for those with severe learning disability. Decisions on immunisation should be made on the basis of local risk assessments. In settings where the client's behaviour is likely to lead to significant exposures on a regular basis (e.g. biting), it would be prudent to offer immunisation to staff even in the absence of documented hepatitis B transmission."

Indications are that the prevalence of Hepatitis is increasing. It is also a fact that many individuals who come into NASAT care have more complex and challenging behaviour than has previously been the case.

NASAT' policy is that all staff appointed to posts that involve regular contact with supported persons should be offered immunisation against hepatitis B at the Charity's expense ([see Appendix 3 for specimen letter to medical service](#)).

A single booster dose five years after the primary course should be sufficient to retain immunity.

Risk assessments must be conducted locally and must show the following risk related control measures, dependant upon risk rating.

Low Risk

Universal infection control precautions must be adopted. Additional control measures are at the discretion of the manager responsible.

Medium Risk

Universal infection control precautions must be adopted. Immunisation is available at the Charity's expense. All staff must be comprehensively apprised of the risks, and the action to be taken in the event of a significant exposure.

High Risk

Where a high risk has been identified it is strongly recommended that all staff be immunised against Hepatitis "B". Those unable or unwilling to be vaccinated, or who are non responders to vaccine, must ensure that their line managers are aware of this, and of the action to take in the event of exposure.

Hepatitis C

The virus causing Hepatitis C has only recently been identified and not a lot is known about the disease. 80% of people with Hepatitis C have no sign or symptoms. The symptoms and transmission are similar to Hepatitis B. However there is no vaccine to prevent infection.

4. Pandemic and Seasonal Influenza

NASAT encourages employees to be vaccinated against seasonal influenza.

Outbreaks of pandemic influenza are few and far between but can have serious repercussions when they occur. Local managers have a responsibility to develop and maintain contingency plans that will enable continuity of services in the event of an outbreak. Copies of all plans and updates must be sent to the Head of SQE who will, in the event of an outbreak, act as a central point for coordination. The corporate plan is shown at appendix 4.

5. Other Infection Risks

Tetanus

Tetanus is an acute disease characterised by muscle rigidity and painful spasms, often starting in the muscles of the jaw and neck. It is a disease which is reportable under RIDDOR if occupationally acquired.

Employees at greatest risk are those working in the grounds and gardens. The bacteria exist in spores in the soil and suitable breeding grounds are dirty wounds, puncture wounds, burns and bites. Road and agricultural accidents also produce a risk of tetanus.

In the UK effective protection is provided by active immunisation of school children. For the general population of the UK it is state policy for tetanus vaccinations to be kept up to date. For adults booster doses are not necessary for intervals of less than 10 years. If booster doses of this vaccine are given at intervals of less than ten years they may cause excess adverse reaction.

Employees should be aware of their own tetanus status and if they are not they should contact their own GP, and if doubt still remains they should request a booster which will be provided by the NHS.

Gastrointestinal Infections, Clostridium Difficile and Norovirus

Many gastrointestinal infections are caused by poor hygiene and sanitation and poor food hygiene, resulting in diarrhoea. Diarrhoea infections are contagious. They can be spread from person to person via dirty hands, through direct contact with faecal matter, contaminated food or drink, handling contaminated toys or equipment, and some pets. Staff suffering from these infections must be symptom free for 48 hours before returning to work.

Norovirus – This is an extremely contagious disease, often called winter vomiting bug. There is no vaccine for Norovirus. It comes on very quickly, but also passes very quickly, with no long lasting effects.

Clostridium Difficile (C. Difficile) is a specific intestinal infection that can be more serious leading to a very severe illness with ulceration and bleeding from the colon (colitis) and, at worst, perforation of the intestine and peritonitis. It can be fatal. It mostly affects elderly people with other underlying diseases, and those who have been treated with broad spectrum antibiotics. It is most prevalent in hospitals and

nursing homes, but all managers in NASAT should be aware of the risk, and the need to obtain a proper diagnosis for those suffering with diarrhoea.

Frequent hand washing is one of the best ways to prevent the spread of infection. Transmission can also be prevented by the use of protective clothing, safe handling, use and disposal of sharps, good management of clinical waste, blood and body substance spills, good food hygiene practices, the washing of laundry and linen.

These diseases are not considered to be a major problem for NASAT provided that the controls within the HACCP system and the Universal Infection Control Precautions are strictly adhered to. It is worth noting that should the Society use contract catering then their HACCP system should be vetted prior to any contract being agreed.

MRSA

Methicillin Resistant Staphylococcus Aureus is the full name for MRSA (sometimes referred to as the 'superbug'). It belongs to the Staphylococcus aureus family of germs. Staphylococcus aureus is a very common cause of bacterial infections such as boils, carbuncles, infected wounds, deep abscesses and bloodstream infection (or bacteraemia).

Universal Infection Control Precautions must be used when working with those with MRSA.

Tuberculosis (TB)

TB is an infectious disease that mainly affects the lungs, but it can affect other parts of the body such as the skin or other organs. It is most prevalent in Africa and Asia, but presents an increasing risk in the UK, particularly in major cities.

TB is transmitted by breathing droplets in the air that contain the bacterium, but it is not highly contagious. These are spread when someone with TB coughs or sneezes. It is usually only passed on when people are living in prolonged close contact with an infected person, e.g. in the same household. TB is only infectious when it affects the lungs. Many people who become infected with TB don't realise they have been exposed to the infection because their immune system successfully fights it off.

The symptoms may include:

- a persistent cough - there may also be lots of phlegm, sometimes containing blood
- fever
- swollen glands, especially in the neck
- tiredness
- loss of appetite
- weight loss
- night sweats
- chest pain when you breathe in, caused by inflammation of the membranes lining your lungs (pleurisy)

People are more likely to get TB if they:

- already have a weakened immune system (e.g. from HIV/AIDS or from taking medicines that suppress the immune system)

- have diabetes
- regularly come into contact with people who have TB lung infection
- are young or elderly
- are malnourished
- smoke or drink alcohol excessively
- live in overcrowded housing
- travel to, or come from, places where TB is common

A doctor who has diagnosed TB, using a simple test, will prescribe antibiotics that may need to be taken for six months, or more. It's very important to take the full six-month course of antibiotics and to take them regularly, otherwise the bacteria may develop resistance to the antibiotics. Treatment with antibiotics is usually effective, provided that the full course of medication is taken as prescribed.

6. Risk Assessments for Infectious Diseases

Where there are significant risks to employees from infectious diseases the Manager(s) must ensure that a fully documented risk assessment is carried out, examining the roles of employees at risk, the areas of risk, and the frequency and duration of risk. This assessment is to be signed by the Manager/Principal and Risk Assessor and by employees at risk. A copy of the assessment must be retained in the personal files of any employees at risk. The Risk Assessor should review all such risk assessments half yearly to ensure that no salient fact has changed.

Where there are no significant work related risks of contracting a serious infectious disease there will be no need to conduct a risk assessment or introduce additional control measures, e.g. an office worker who has no contact with supported persons will not normally need to be immunised against Hepatitis B.

Managers have a responsibility to make sure that universal infection control precautions (UICPs) are always used. This is the most effective control measure and all assessments must show these as the first precautionary measure.

The following table shows some of the factors which must be taken into account when conducting assessments.

Disease	Seriousness	Likelihood Factors for Consideration	Mandatory Controls
HIV/AIDS	High (3)	• PWS /Colleague infected	UICP
Hepatitis A	Medium (2)	• Sharps • Bites / Scratch	UICP
Hepatitis B	High (3)	• PWS history e.g. institution	UICP See Hepatitis B on page 7
Hepatitis C	High (3)	• Means of transmission	UICP
Tetanus	High (3)	• Work type • Contact	UICP and immunisation for those working in grounds

Gastrointestinal	Medium (2)	<ul style="list-style-type: none"> • Age of PWS • Challenging Behaviour 	UICP and reporting protocol for those involved in food preparation
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Key Management Actions

- Ensure staff are aware of the Universal Infection Control Procedures and make sure that they put them into practice as a matter of routine.
- Reduce cross infection risks using the measures shown in the policy.
- Carry out risk assessments for contagious diseases, as necessary.
- Invoke the emergency incident procedure if necessary.
- Managers of residential accommodation must implement the measures shown in section 4.

Appendix 1 - Effective Hand Hygiene

EFFECTIVE HAND HYGIENE



1. Palm to palm.



2. Right palm over left dorsum and left palm over right dorsum.



3. Palm to palm, fingers interlaced



4. Backs of fingers to opposing palms with fingers laced



5. Rotational rubbing of right thumb clasped in left palm, and vice versa.



6. Rotational rubbing, backwards and forwards, with clasped fingers of right hand in left palm, and vice versa.

Appendix 2 - Hepatitis B Virus Letter

I have received information on Hepatitis B and have been verbally apprised of the risks of contracting Hepatitis B, and the action to be taken in the event of a significant exposure.

Following a review of all the facts, I have made a conscious decision not to be inoculated at the expense of the NASAT.

Signed:

Name:

Job Title:

Date:

For Office Use:

Risk Assessment Conducted Date:
(attached)

Principal Signature:

Appendix 3 - Hepatitis B Virus Vaccination Specimen Letter

Address of GP/Local Medical Service

Insert Date

Dear Sir/Madam

REF: Insert Employee's Name

Insert Employee's Name has accepted a post as **Insert Job Title** which will involve work with people with autism and Asperger Syndrome who may display challenging behaviour.

As a matter of policy, they have been advised to be immunised against Hepatitis B and to undergo a follow up blood test for Anti-HBs to confirm immunity, at our expense.

As we are a registered charity we would be grateful if you would charge the cost of the vaccine and blood test only rather than your standard charge.

Thank you in anticipation.

Yours sincerely

Name
Principal

Appendix 4 – Pandemic Influenza Corporate Contingency Plan

Introduction

This corporate contingency plan seeks to identify the risk of pandemic influenza to NASAT operations and sets out actions which need to be taken prior to an outbreak and action which may need to be taken subsequently. It is particularly important that managers develop plans and maintain them in a state of readiness.

The information shown here has been obtained, largely, from the UK Influenza Pandemic Contingency Plan, October 2005, Annex J - Information for Other Organisations. The latest information from the World Health Organisation is also included.

Planning assumptions are based on information derived from previous pandemics, i.e. Spanish Flu (1918), Asian Flu (1957) Hong Kong Flu (1968) and Swine Flu (2009) but it is clear that there will be many features of a future Pandemic Influenza that are unknown.

If a particular crisis develops then this corporate contingency plan may be superseded. It is essential that managers satisfy themselves that they are working to the latest plan. Every effort will be made to ensure that managers are kept fully informed. Updated copies and information will be provided by the SQE Team.

The General Risk

The outbreaks or epidemics of influenza which occur most winters affect some 5 to 10% of the population. The vast majority will have an unpleasant but self limiting illness or even no symptoms, with less than 0.05% consulting their GP. Those most at risk of serious illness or death (the elderly, and those with chronic underlying diseases) are offered annual vaccination. Death from flu is usually due to complications such as secondary bacterial infections, e.g. pneumonia, or exacerbation of an underlying disease, rather than the direct effects of the influenza virus itself.

An influenza pandemic arises when an entirely new strain of influenza virus emerges to which most people are susceptible. Thus it is spread widely. Some important features of influenza pandemics are:

- They are unpredictable;
- They may occur at any time of year;
- They are most likely to start outside the UK and gradually spread; this spread has been divided into phases allowing an escalated response according to the scale and geographic spread of the pandemic;
- Spread to the UK may take several months, but may be shorter;
- Once established in the UK, the disease is likely to spread rapidly over 2-3 weeks and then gradually decline over the next 4-6 weeks, a second wave of illness may occur 6-9 months later;
- Some 20 to 30% of the population or even more may be affected over a 1-2 year period, including children and normally fit young adults;

- A far greater proportion of people could require hospitalisation or may die than for seasonal flu.

Pandemic influenza thus occurs when a strain of the influenza A virus develops to which there is limited or no immunity across the world. This virus can arise from a virus which causes influenza in animals. The reason that there is such attention to these animal influenzas is that there is the potential that the strain mutates to form a completely new virus which has the serious effect of the animals virus (causing serious illness in humans as it does in animals) and which in addition passes easily from human to human. This can happen either with a mutation to a new strain or by the virus mixing DNA with normal human flu if a human was to be infected with both viruses to create a new pandemic strain.

In the event of an epidemic or pandemic of influenza with a novel virus, like normal seasonal influenza the virus is spread by aerosols from the infected person talking, coughing and sneezing. It can also be passed on through hand and face contact after touching another person or contaminated surface.

Risk to NASAT

Previous pandemics have shown that most people are susceptible to a new virus but older people may have some immunity due to exposure to similar viruses earlier in life. Children are particularly at risk and attack rates of 90% have been experienced in schools.

The disease is likely to spread within 2 to 3 weeks and then decline over the next 4 to 6 weeks with a second wave 6 to 9 months later. It is likely that 20 – 30% of the population would be affected over a 1 to 2 year period (5 to 10% affected by normal flu epidemics).

Local contingency planning should assume that 25% of staff will lose 5 to 8 working days over 3 months with peak absenteeism at weeks 8 to 9.

General Control Measures

There will be no vaccine against pandemic influenza at the outbreak. A vaccine could take some time to produce after the particular strain of the virus causing the pandemic is identified. It would then be given to healthcare and essential workers first. Managers should make their own representation to their local authority, asking that their essential workers be included in the local authority contingency planning arrangements. More information on the availability of vaccines and the status of essential workers can be found on the Health Protection Agency website www.hpa.org.uk and the Health Protection Scotland website www.hps.scot.nhs.uk

In the event of infection with influenza, the government has stockpiled supplies of medication, an antiviral drug, which has been shown to cut short the period of sickness if given early in the course of the disease. However the mainstay of the response to the pandemic lie in general control measures as below.

In the event of a pandemic affecting the UK, an education campaign would be commenced to reduce the likelihood of spread of the infection. Advice to stay at home if ill, avoid unnecessary travel and meetings, wash hands frequently, cover mouth and nose with tissue when sneezing / coughing, etc. would be provided through the media. Should the need arise then this advice will be reinforced by NASAT in order to reduce the spread of influenza throughout the organisation.

Where appropriate these additional control measures should be implemented in NASAT:

- Alcohol hand rub,
- Sanitisers for work tops and contact surfaces,
- Self monitoring,
- Cutlery and dishwashing either by machine or hot soapy water,
- Care with laundry and washing using the disinfection cycle.

Action to be taken by Managers

1. Managers of residential accommodation must draw up a contingency plan showing how they would maintain the service with 25% absenteeism and increased illness of people we support. They must consider:
 - a. Replacements for sick staff
 - b. Treatment of the sick people we support
 - c. Procedure for admission to local hospitals
 - d. Informing parents / next of kin
 - e. Decision on service closure (e.g. day services, programmes)
 - f. Continuity of provision of supplies including medication and food.
2. Links with agencies currently providing staff top-up should be strengthened, and where there are no such arrangements then these should be made.
3. Links with the Health Protection Units to be made. Details of local Health Protection Units can be found by entering the postcode on www.hpa.org.uk
4. School Principals and managers responsible for Day Services must consider the consequences of shutting down and draw up a suitable plan.
5. Managers of essential services throughout NASAT should consider the possible implications of a pandemic and draw up contingency plans.
6. The control measures listed above should be implemented at the commencement of any pandemic.

Action that will be taken in the Event of a Serious Outbreak

1. The Head of SQE will set up and maintain a national reporting centre. Contact details such as email address, phone number and fax number will be provided, when necessary.
2. Area Managers will report to the centre on a daily basis.
3. Local managers will report to Area Managers giving the numbers of people we support who are affected and the numbers of employees unable to carry out their duties, at each location.
4. Local managers will report the number of agency staff employed and any concerns they have about the ability to maintain service. Closure decisions will only be made by the NASAT Board of Directors.