Infectious Bloody Diarrhoea **Invasive Group A Streptococcal Disease** **Legionnaires Disease** **Leprosy**	**Viral Haemorrhagic Fever (VHF)** **Whooping Cough** **Yellow Fever**

Notifiable Diseases (Jersey) Order 1988, law as at 1st January 2017.

It also important to contact the CCDC of any cases of the following:

- Legionella
- Suspected outbreaks of any infection i.e. diarrhoea and vomiting
- One or more cases of scabies in the prison
- Young persons found during screening prior to BCG to have a strongly positive skin test

13 OUTBREAK OF INFECTION

Any suspicion of an outbreak of communicable disease in the prison should be reported to the CCDC/CICN immediately for further investigation, and management advice as appropriate.

The CCDC/CICN should be contacted if:

- There are two or more individuals with vomiting and/or diarrhoea (prisoners or staff)
- There are two or more individuals suffering from the same infectious illness
- There is a high sickness rate amongst staff, which appears to be suffering from the same infectious disease

If the prison is affected (whether the member of staff is directly employed by the establishment or not) the following guidance should be followed:

- Healthcare staff should contact the CCDC/CICN without delay if they suspect there may be an outbreak of infection in the prison
- They must also inform the Public Health Department
- Senior management must be informed and requested to ensure adequate staffing to cope with extra demands of managing an outbreak. Staff working in the prison should not work in other care establishments until the outbreak is declared over by the CCDC
- List all prisoners and staff affected, including age, area/unit where resident/working, onset of symptoms, symptoms suffered, duration of illness, GP and whether a sample has been taken (copies are attached for information)

13.1 Specific Guidance for Outbreaks of Diarrhoea and/or Vomiting

- Isolate symptomatic prisoners in a single cells with their own toilet facilities, or a designated commode if en-suite facilities are not available
- Cohorting of prisoners may be necessary
- Environmental cleaning to be increased. Particular attention should be paid to the toilets, bathrooms, door handles, support hand rails and kitchen units. For the duration of the outbreak, environmental cleaning should be performed using a combined detergent and chlorine agent such as Titan Chlorplus reconstituted to a solution of 1000ppm or 'Red Clinnel' anti-sporicidal wipes
- All staff hand washing areas and the rooms of symptomatic prisoners should have a liquid dispensed soap for the duration of the outbreak
- Prisoners should be encouraged to wash their hands after using the toilet and before eating
- Staff should pay attention to all infection control practices, particularly the washing of hands and wearing protective clothing
- Faecal samples should be obtained from prisoners and staff with symptoms. The microbiology form accompanying the sample should clearly state it is 'part of an outbreak', as this will determine which specific tests are carried out in the laboratory (samples of vomit are not required). Record of out-break form should be completed in the first instance of an outbreak. This form should be completed for both prisoner and staff out-breaks (see appendix 1)
- It may be necessary to close the wing to admissions until 48 hours after the last symptomatic patient has recovered. This will be decided in consultation with the CCDC
- Symptomatic staff must go off duty, and they must remain off work until 48 hours symptom free
- Prisoners should only be transferred 48 hours after their last symptom, and the receiving facility should be informed of the prisoners condition
- Soiled/infected linen must be transferred to the laundry in a sealed soluble bag within a red laundry bag. The washing machine should be an industrial type with sluice and hot wash cycles reaching a

minimum of 71◦C. An industrial dryer should also be used. These should be professionally installed and maintained with precautions to prevent contamination by them creating aerosols

- A thorough deep clean should be undertaken throughout the whole effected environment with a sodium hypochlorite solution of 1,000ppm (Titan Chlorplus) following the cessation of an out-break before IPaC measures are relaxed

14 MANAGEMENT OF INFECTIOUS ORGANISMS WITHIN THE PRISON

Please adhere to HPA Prison policy for specific guidance on the management of infectious organisms within the prison environment. The following is a summary of potential organisms that may be encountered. Full guidance information sheets are available in Appendix 2 or online at www.hpa.org.uk.

14.1 Meningococcal Disease

Medical advice should be sought immediately for prisoners showing symptoms suggestive of meningococcal disease. Usually the admitting hospital will notify the CCDC or Public Health doctor on call at the time of the case. Please advise the CCDC/CICN of prisoners diagnosed with meningococcal disease.

There may be anxiety amongst other prisoners and prison officers and there may be requests for prophylaxis. Prophylaxis will be arranged for contacts identified by the CCDC. Giving antibiotics inappropriately may do more harm than good as it can result in eliminating carriage of non-pathogenic organisms, such as *Neisseria lactamica,* which boost immunity, and actually increase the risk of meningococcal disease.

14.2. Methicillin Resistant Staphylococcus Aureus (MRSA)

Precautions Required
No special precautions are necessary. Standard Principles of Infection Control (especially hand washing) are all that are necessary. However MRSA does act as an opportunity to remind us of the good practices that should **already** be in place.

Prisoners who are positive for MRSA do **not need to be** barrier nursed. However, ideally they should have a single room, or share a room with someone who does not have an open wound or invasive device e.g. urinary catheter, intravenous device. They can mix with other prisoners socially and at mealtimes.

Laundry, crockery and cutlery do **not** need to be handled separately. Again, as long as good practices are already in place, there is no need for additional precautions. Waste should be handled as with any other prisoner that is if the patient is known to have an infection, all waste should be treated as clinical waste.

Treatment of MRSA to be advised by CICN or the CCDC.

14.3. Panton-Valentine Leucocidin (PVL)

The Panton-Valentine Leucocidin (PVL) infection is caused by a strain of *Staphylococcus aureus* that carries a toxin that destroys white blood cells. It can cause infection in individuals with intact skin. PVL normally causes pus producing skin infections e.g. boils or abscesses, and occasionally cellulitis or tissue necrosis.

However, they can cause more severe invasive infections such as septic arthritis, bacteraemia or community-acquired necrotising pneumonia. PVL are more commonly contracted in the community and can affect previously healthy young children and adults.

Risk factors for contraction PVL include those in close contact, especially where there is a risk of trauma, such as contact sports or using contaminated articles such as sharing towels, razors, needles or those who have damaged skin from other activities such as eczema. Closed communities such as prison populations have been identified as risk groups.

If a case is suspected inform the CCDC.

Any boils, abscesses, non-healing wounds or wounds with signs of infection should be swabbed prior to commencing antibiotic therapy.