# Break the Chain

**Infection prevention and control and health protection newsletter**
**July 2024**

Welcome to the infection prevention and control and health protection newsletter, produced by the Health Protection Nurses (HPNs) at Bury Council. **It is aimed at anyone working in adult care settings** - please share it with all your staff, including seniors, carers, housekeepers. We would welcome any contributions you may have - there may be something you have introduced in your own area you want to share, a subject you would like us to include, or a question you might have – just let us know. We can be contacted by ringing 0161 253 6900 or emailing infectionprevention@bury.gov.uk

## How prepared are you for heat?

Anyone can become unwell if they get too hot but some people are at higher risk of becoming seriously unwell and even dying. Some, if not all, of the people you care for are likely to be in high-risk groups because of for example their age, existing conditions (physical and/or mental), disabilities, cognitive state, and the effect of medications. Some of the people in your care may not be able to adapt their behaviour so they can cool off (e.g. those with Alzheimer's, reduced mobility or other disabilities).

An ONS study showed that during periods of extreme heat there were more deaths of care home residents than would normally be expected. In July 2022 UK temperatures exceeded 40°C for the first time on record and in England that year it is estimated that 2,803 people aged 65 years and over died that month due to the heat. It is predicted that the number of heat-related deaths per year may triple by 2050.

Interviews of social care workers after the heatwave of 2022, including some from Greater Manchester, showed that awareness of the risks posed by extreme hot weather varied widely, and were often not seen as a priority. Those who took part in the study felt that action was not taken until temperatures had been extreme for a couple of days, rather than planning ahead for when temperatures rose. Staff recognised the effect of extreme heat on them personally and the impact it had on their ability to care, and identified dehydration as a major concern for those they were caring for.

The UKHSA social care study highlighted a general lack of understanding by staff of the risks to health of extreme high temperatures both for the people they are caring for, as well as to occupational health for themselves. While some actions were being taken to help ease the impact of the hot weather during periods of extreme heat, concern was more likely to be linked to comfort rather than risk to life or health, and actions taken were in response to periods of high temperatures rather than preplanned. When they learned about the dangers, including death, many study participants were shocked and said they would pay more attention to extreme high temperatures in future. Impacts of heat on staffing levels - either the direct impact on individual staff or due to external heat-related factors (such as transport issues) - meant increased use of agency staff who were less able to recognise changes in residents' normal behaviour caused by heat.

It is vital that we do what we can to protect residents as much as possible, making sure we prepare in advance of hot weather and know actions to take when it arrives. Don't wait until it's too hot, start planning now so you are as prepared as you can be.

Find out what you can do to help protect staff and residents: review the UKHSA heat health actions for providers, signing up for and monitoring heatwave alerts and check the H&SC actions in advance to aid planning well before hot weather is normally expected.

## Legionella – a risky business

The bacteria that cause Legionnaires' disease are often found in low numbers in natural water sources, such as rivers and lakes. They can also be found in hot and cold water systems, and in the right conditions may grow, increasing the risk of potentially fatal illness.

Care homes, including smaller homes caring for residents with mental health issues or learning disabilities, have a duty of care to residents (who are seen as a risk group for Legionella) and staff to carry out a Legionella risk assessment and implement control measures needed. The risk assessment is valid for as long as there are no changes to the system or of the staff carrying out the control measures**. The measures needed to control the risk should be carried out by a competent person, as should any actions identified in the risk assessment report.** Sending water samples can be part of the risk assessment process but on its own is not enough. Legionnaires' disease can be devastating for older people - a care home in Ashfield was fined £600,000 after a resident, who had gone in for respite, contracted Legionella in the home and died. When the water in the washbasin tap and toilet in his room was tested it was found to contain Legionella. Although the home had a Legionella risk assessment in place it had not been carried out by a competent company, and the temperature checks were not carried out correctly. The home subsequently closed. See below for further examples. HSE can also take action when a risk assessment is not 'suitable or sufficient' even if there has been no case of Legionnaires' disease linked to the premises (see prosecuted for failing to control risk).

Bury Council staff can access a free introductory course - Legionella awareness - Bury Council e-Learning

Helpful info here: About Legionnaires Disease | Symptoms, Causes, Diagnosis, Treatment (legionellacontrol.com)

Paid for e-learning here: legionella management Courses & Training | reed.co.uk

Legionella Awareness | St John Ambulance | St John Ambulance (sja.org.uk)

**Please note that if you are identified as the responsible person for your setting the courses above may not be enough to ensure competence** (see HSE legionnaires - what you must do for details of what competence involves and to check your understanding of what you or your nominated person - who carries out the actions needed to manage the risk - need to be able to do here: HSE legionella checks ).

**Media and other reports related to legionella issues in care homes:**

Mansfield 2023 - home for people with learning disabilities which failed to effectively manage the legionella risk rated inadequate by CQC (subsequently closed)

Essex 2015 – care home fined £3 million after death of resident from legionella; lack of training, management oversight and failure to have a system for flushing through the plumbing system

Reading 2012 – death from legionella of man admitted for intermediate care; inquest identified flaws, in particular in regard to training, staff record-keeping and audit-taking. £100,000 fine for provider

Nottinghamshire 2018 – death of care home resident investigated by police; issues with legionella control contributed to inadequate CQC rating

Hampshire 2017 – death of 57 year old care home resident from legionella; fined £150,000 plus undisclosed amount paid to family in settlement; identified lack of training of staff responsible for managing risk

## Free Infection Prevention and Control Training

- Adult Social Care Training and Development Fund: a guide for employers - GOV.UK (www.gov.uk) includes funding available for training for staff in e.g. oral care in health and social care (level 2 certificate)
- QNI—IPC Champions Network, next on-line meeting 13th August, 2024: Hand hygiene and PPE https://qni.org.uk/news-and-events/events/infection-prevention-and-control-ipc-champions-meeting/
- E-learning for health: Hot weather guidance for carers (need to register to access): https://www.e-lfh.org.uk/programmes/hot-weather-guidance-for-carers/

# Does your disinfectant product cut it?

The Health Protection Team are aware that some providers are not using appropriate products for disinfection, or are using products with a long contact time. This article outlines latest guidance.

**What is the difference between cleaning and disinfection?**

**Cleaning** physically removes contamination, including some microorganisms and, if soiling (i.e. something is visibly dirty) is present, it is an essential step before effective disinfection or sterilisation can be performed. Cleaning does not necessarily destroy all microorganisms, even if a surface looks cleaner. The cleaning of equipment and work surfaces is best done using detergent and warm water. It is also important to ensure that the cleaning product used will not damage equipment and work surfaces.

**Disinfection** aims to reduce the number of microorganisms present to a level that is unlikely to cause infection. For practical purposes, disinfection may destroy or inactivate many or all pathogenic microorganisms, but not spores. Successful disinfection is very much dependent on the number of microorganisms initially present. Therefore, physical cleaning is essential prior to effective disinfection taking place.

See HSE - Methods of decontamination for more information.

**What disinfectant products should be used, and when?**

The National infection prevention and control manual (NIPCM) for England, an evidence-based practice manual for use by all those involved in care provision in England states:

**In section 1.6:**

- routine disinfection of the environment is not recommended however, 1,000ppm available chlorine should be used routinely on sanitary fittings
- cleaning protocols should include responsibility for, frequency of, and method of environmental decontamination

**In section 1.8:**

- Spillages of blood and other body fluids see Appendix 9, details use of a chlorine based product (strength dependent on whether the spill contains blood)
- Includes information about use of alternative products if they conform with the relevant standards and are appropriate for the intended use.

**In section 2.3:**

- Patient isolation/cohort rooms/area must be decontaminated **at least daily**, this may be increased on the advice of IPCTs/. These areas must be decontaminated using either:
  - a combined detergent/disinfectant solution at a dilution of 1,000 parts per million available chlorine (ppm available chlorine (av.cl.)); or
  - a general-purpose neutral detergent in warm water followed by a solution of 1,000ppm av cl.

  Alternative cleaning agents/disinfectant products may be used with agreement of the local IPC team *.
- Increased frequency of decontamination/cleaning schedules should be incorporated into the environmental decontamination schedules for areas where there may be higher environmental contamination rates, eg:
  - toilets/commodes particularly if patients have diarrhoea; and
  - "frequently touched" surfaces eg, door/toilet handles, locker tops, over bed tables and bed rails.
- Following patient transfer, discharge, or once the patient is no longer considered infectious the ir room should be decontaminated (terminal decontamination) using either:
  - a combined detergent disinfectant solution at a dilution (1,000ppm av.cl.); or
  - a general-purpose neutral detergent in warm water followed by a solution of 1,000ppm av.cl. (or alternative locally agreed cleaning product).

* A disinfectant product which meets EN 1276 (bactericidal) should be used in areas unlikely to be contaminated by body fluids, and EN 14476 (virucidal) for areas with known or likely body fluid contamination. In outbreaks a product which meets both standards should be used.

**Continued overleaf**

## Does your disinfectant product cut it? (continued)

**What else do I need to do?**

- Employers must ensure that cleaning products and protocols are managed and risk assessed in accordance with the COSHH regulations – Control of substances hazardous to health (COSHH) – health and safety topics in cleaning.
- Manufacturers' guidance and recommended product 'contact time' must be followed for all cleaning/disinfection solutions; ensure you are aware of your products' contact times, the shorter the contact time the more effective the disinfectant is.
- Ensure solutions of disinfectant are made up to the correct strength and managed according to manufacturer's instructions – sodium hypochlorite (bleach) solutions should be disposed of after 24 hours.

**Be aware:**
Most non-bleach shop bought products may contain some disinfectant product, but not to the level required in a care setting. These products are primarily intended for the domestic environment rather than professional use and do not provide the required level of anti-bacterial and anti-viral protection. In addition some have a contact time of 5 minutes – the time the product needs to be left in place to be effective before drying the area – which is unlikely to be practical in care settings.

## Could your residents ditch the caffeine?

The importance of good hydration is well known, especially for older people*. It can help reduce urinary tract and other infections, helps regulate body temperature, keep joints lubricated, maintain circulation and nutrients getting to cells, and organs functioning properly. It may also improve cognitive function in people with dementia and prevent delirium.

Some people, especially as they get older, drink less because they are worried about needing the toilet. Caffeine, which occurs naturally in tea and coffee and is present in some soft drinks, has a diuretic effect, affecting the bladder and bowels and increasing the urgency for using the toilet. You've probably experienced the effect of caffeine on your bladder – feeling an increased urge to wee more or to move your bowels after a strong coffee and maybe having to rush to the loo. Imagine you are older (and therefore more sensitive to caffeine) and with a less stable bladder or less controllable bowels and not as able to get to the loo in a hurry. You'd probably be less likely to accept a drink of tea or coffee or to finish it because of worrying about not making it in time.

Inspired by a trial carried out by the University of Leicester Hospitals NHS Trust (ULH) serving only decaffeinated tea and coffee to patients, which showed a 30% reduction in toileting related falls (and a 61% reduction when introduced more widely in the trust), a care home company with 8 nursing and residential homes in the south east of England took part in a study on the effects of introducing decaffeinated tea and coffee for its residents. This showed a nearly 35% reduction in the number of toilet related falls. ULH also showed a 63% reduction in reports of overactive bladder symptoms in patients attending continence clinics who switched to decaffeinated drinks.

Falls account for the highest number of injury related deaths in the over 75s and are a big factor in fractures among older people. People in care homes are often older, frailer and more immobile than people living at home, and are 3 times more likely to fall. As well as reducing the possibility of toilet related falls, if residents feel able to drink tea and coffee without the same effects on their bladder and bowels it is quite possible they may be more likely to drink more, being less afraid of having to rush to the loo or of having an 'accident'.

Many older people prefer to drink tea and coffee than cold drinks. Could your home consider talking to residents and staff about switching to decaffeinated tea and coffee? Imagine fewer urgent requests to go to the loo and toilet related falls to deal with, possibly less incontinence, maybe residents more likely to drink and therefore less time spent coaxing someone to finish a brew, and even knock-on effects such as fewer infections. Your residents may also sleep better at night. Maybe something to think about?

**To read the report of the trial in care homes and how they went about it go to:**
Decaffeination-and-Falls-Prevention_Final_Online.pdf

*unless fluid restriction is advised due to e.g. conditions causing fluid retentio