Clostridium difficile

Infection control guidelines for residential aged care facilities
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>Discharge or transfer of residents between healthcare facilities</td>
<td>2</td>
</tr>
<tr>
<td>Why are residents in aged care at risk?</td>
<td>2</td>
</tr>
<tr>
<td>Victorian statutory requirements</td>
<td>3</td>
</tr>
<tr>
<td>Infectious agent</td>
<td>3</td>
</tr>
<tr>
<td>Identification</td>
<td>3</td>
</tr>
<tr>
<td>Method of diagnosis</td>
<td>3</td>
</tr>
<tr>
<td>Incubation period</td>
<td>4</td>
</tr>
<tr>
<td>Specimen collection and transport</td>
<td>4</td>
</tr>
<tr>
<td>Reservoir</td>
<td>4</td>
</tr>
<tr>
<td>Modes of transmission</td>
<td>4</td>
</tr>
<tr>
<td>Prevention and control measures</td>
<td>5</td>
</tr>
<tr>
<td>Standard precautions</td>
<td>5</td>
</tr>
<tr>
<td>Contact precautions for residents with diarrhoea</td>
<td>5</td>
</tr>
<tr>
<td>Isolation</td>
<td>5</td>
</tr>
<tr>
<td>Cohorting</td>
<td>5</td>
</tr>
<tr>
<td>Multi bed rooms</td>
<td>6</td>
</tr>
<tr>
<td>Contact precaution sign</td>
<td>6</td>
</tr>
<tr>
<td>Gloves and gowns</td>
<td>6</td>
</tr>
<tr>
<td>Hand hygiene</td>
<td>6</td>
</tr>
<tr>
<td>Dedicated equipment</td>
<td>6</td>
</tr>
<tr>
<td>Ceasing contact precautions</td>
<td>7</td>
</tr>
<tr>
<td>Resident movement when contact precautions are in place</td>
<td>7</td>
</tr>
<tr>
<td>Cleaning and disinfection of equipment and the environment</td>
<td>7</td>
</tr>
<tr>
<td>Surveillance and diagnosis</td>
<td>7</td>
</tr>
<tr>
<td>Treatment</td>
<td>8</td>
</tr>
<tr>
<td>Additional resources or information</td>
<td>9</td>
</tr>
<tr>
<td>Appendix 1 – Contact precautions</td>
<td>10</td>
</tr>
<tr>
<td>Note - Standard precautions always apply</td>
<td>10</td>
</tr>
<tr>
<td>Appendix 2 – Donning and removing gowns and gloves</td>
<td>11</td>
</tr>
<tr>
<td>Appendix 3 – How to handwash</td>
<td>12</td>
</tr>
<tr>
<td>Appendix 6 – Cover your cough</td>
<td>16</td>
</tr>
</tbody>
</table>
Introduction

*Clostridium difficile* [klo-STRID-ee-um dif-uh-SEEL] is an organism that can be found in the bowel flora of infants and sometimes in adults.

The bowel contains a variety of microorganisms most of which are bacteria. These microorganisms or bowel flora have many functions including stimulating the growth of the intestinal lining, training the immune system of the intestine to prevent or inhibit the growth of disease-causing bacteria and helping the body to digest food.

If the balance of bacteria in the bowel is disrupted and there is a reduction in the number of helpful microorganisms, then harmful bacteria can multiply. This can occur when people are prescribed broad-spectrum antibiotics.

*Clostridium difficile* is one type of gut bacteria that when there is less competition in the gut can multiply and grow in numbers that can cause diarrhoea and illnesses that can be difficult to treat. While *Clostridium difficile* is normally not dangerous to health there are certain varieties or strains which can produce toxins called toxin A and B which are harmful.

In the colon *Clostridium difficile* exists in a vegetative form whereas outside the colon it mostly survives in spore form. Spores are an inactive form of *Clostridium difficile* that enable the bacteria to survive high temperatures, dryness, and lack of nourishment for long periods of time. Once the spores are ingested into the colon they are able to germinate, grow and produce toxins that can cause disease.

*Clostridium difficile* can be transmitted from person to person by the faecal-oral route in the form of vegetative cells or spores. *Clostridium difficile* in faecal particles can pass from one person and be introduced into another person via the mouth. There are often intermediate steps in faecal-oral spread including poor or absent cleaning after handling faeces or anything that has been in contact with faeces.

Since 2004 the number of cases of *Clostridium difficile* disease has been increasing around the world. Most of the increase is due to *Clostridium difficile* strains which have been altered and are able to produce more toxins than usual along with being resistant to commonly prescribed antibiotics. These strains are often called hypervirulent strains of *Clostridium difficile*. Such strains have been identified in Australian healthcare facilities including aged care facilities and supported residential services.

People with *Clostridium difficile* associated disease have symptoms ranging from mild diarrhoea to an infection of the large bowel called pseudomembranous colitis. Symptoms of pseudomembranous colitis can include fever, diarrhoea, crampy lower abdominal pain, and sometimes life threatening abdominal bloating, inflammation and damage to the lining of the bowel wall caused by the toxins, perforation of the bowel wall and shock.

Elderly people are especially at risk of *Clostridium difficile* associated disease and people with symptoms are usually older than 60 years. This may be because of changes in bowel organisms, changes affecting the immune system or the presence of underlying diseases as people get older.

The proportion of residents in an aged care/residential care settings with *Clostridium difficile* can range from 4% to 20%. Some residents may be carrying *Clostridium difficile* when they are admitted either from the community or other healthcare settings and an additional 10% to 20% may acquire the organism during their stay.

Residents can be either colonised (when a microorganism is found on or in a person without causing a disease) with *Clostridium difficile* or can have *Clostridium difficile* infection. Residents who are colonised do not have any symptoms of *Clostridium difficile* infection.
Residents who are colonised and do not have any symptoms of \textit{Clostridium difficile} infection (diarrhoea, fever, loss of appetite or abdominal pain) can be managed in residential aged care without additional infection control precautions.

For all residents who develop diarrhoea, staff need to adopt the contact precautions described within this document until 48 hours after their last episode of diarrhoea.

Most aged care facility residents colonised with \textit{Clostridium difficile} will spontaneously clear their faeces by 2 months although prolonged colonisation for 3 or more months has been noted in up to 19\% of residents.

Reoccurrence of \textit{Clostridium difficile} symptoms has been reported in up to 26\% of elderly aged care facility residents despite appropriate treatment. Residents should be carefully monitored for relapse and place in contact precautions if diarrhoea reoccurs.

The proper use of antibiotics is essential in aged care facilities. One study found that up to 70\% of chronic-care patients and 26\% of aged care residents acquired \textit{Clostridium difficile} within 2 weeks of antimicrobial therapy.

Residents who are known to have been colonised with \textit{Clostridium difficile} and develop diarrhoea need to be managed in accordance with the Department of Health guidelines for the management of gastroenteritis in residential care facilities.

**Discharge or transfer of residents between healthcare facilities**

Residents from aged care facilities OR supported residential services identified with \textit{Clostridium difficile} who have been admitted to a hospital can be discharged back to the facility or another facility providing they meet the following criteria:

- The resident has been free of diarrhoea for 48 hours

During a gastroenteritis outbreak at an aged care facility or supported residential service no new residents should be admitted to the facility until the outbreak is over. Avoid transferring patients/residents to other facilities while the outbreak is in progress. If this is unavoidable, ensure that the receiving facility is informed of the outbreak so that they can take appropriate precautions to prevent transmission of illness in their facility.

**Why are residents in aged care at risk?**

In an aged care/residential care facility antibiotic treatment, the presence of a nasogastric tube or a gastrostomy feeding tube (PEG), fecal incontinence and the use of certain medicines that decrease the production of acid in the stomach have been shown to increase the chances of someone acquiring \textit{Clostridium difficile}. The supplying pharmacist can assist with the identification of these medicines.
Victorian statutory requirements

*Clostridium difficile* is not a notifiable condition in Victoria and as such single cases do not need to be notified to the department. However, in settings such as residential aged care notifying suspected gastrointestinal illness outbreaks is strongly encouraged. An outbreak is defined as 2 or more residents/staff having onset of vomiting and/or diarrhoea within 72 hours of each other (that cannot be explained by medication or other medical conditions) and are linked.

Infectious agent

*Clostridium difficile* is a spore forming, Gram positive anaerobic bacillus that produces toxins.

Identification

Clinical features of *Clostridium difficile* infection include

- increased frequency of *watery, loose* or *unformed stools* which has no other cause or source.
- fever.
- loss of appetite.
- abdominal pain/tenderness or crampy lower abdominal pain.

Residents who are at risk of *Clostridium difficile* infection include

- those who are receiving antibiotics or have received antibiotics in the last 4-6 weeks.
- those with a nasogastric tube or gastrostomy feeding tube (PEG).
- those who have recently had gastrointestinal surgery or manipulation.
- those receiving drugs that decrease the production of acid in the stomach.
- those with serious underlying diseases or immunocompromised conditions.
- those who have been in a healthcare facility for a long period of time.

Method of diagnosis

- Staff should notify the facility management/supervisor, infection control staff and the resident’s doctor of a resident who may have symptoms associated with *Clostridium difficile*.
- Diagnosis requires laboratory testing of the resident’s stool for the organism or its toxin.
  - Stool culture for *Clostridium difficile* and/or a toxin test.
- A single specimen from a resident at the onset of symptoms is usually sufficient.
- Residents who do not have diarrhoea associated with *Clostridium difficile* should not be tested (unless it is part of a boarder epidemiological investigation).
Incubation period

- Following exposure to *Clostridium difficile* it may only be 2-3 days before a resident acquires the organism.

Specimen collection and transport

- Diarrhoea specimens (an unformed stool that takes the shape of the container) should be collected in a clean watertight specimen container.
- Specimen containers should be placed in a specimen collection bag or biohazard bag.
- Specimens should be transported to the laboratory as soon as possible.
- Specimens should be refrigerated (non-food storage refrigerator) until collected.

Reservoir

- *Clostridium difficile* is shed in the faeces.
- Residents with diarrhoea caused by *Clostridium difficile* usually have large numbers of the organism in their stool.
- There can be extensive spreading of *Clostridium difficile* from residents with diarrhoea.
- *Clostridium difficile* may persist in the environment for months and are resistant to many commonly used disinfectants, antiseptics and cleaning agents.
- *Clostridium difficile* can survive for long periods of time on contaminated environmental surfaces and equipment.
- Surfaces, equipment and devices that become contaminated with faeces can become a source of transmission for *Clostridium difficile*. The following have been implicated in *Clostridium difficile* transmission and outbreaks:
  - Commodes and toilets
  - Bath
  - Telephones
  - Electronic thermometers
  - Surfaces in resident’s rooms.

Modes of transmission

- By direct transfer of the organism from a resident with *Clostridium difficile* to an item (i.e. thermometer, commode) or environment followed by another resident touching a contaminated item or environment and ingesting the organism via the mouth.
- By direct transfer from contaminated hands of a resident with *Clostridium difficile* to a non colonised or non infected resident.
- By indirect transfer from contaminated hands of staff who have touched contaminated items or environments and transferred the organism to a non colonised or non infected resident.
Prevention and control measures

Standard precautions
The use of standard precautions is an essential infection control strategy for minimising transmission of infections between residents. Standard precautions apply for all residents in aged care and are designed to reduce the risk of transmission of microorganisms for both recognised and unrecognised sources of infection.

Standard precautions consists of the following elements:

1. routine hand hygiene, with antiseptic-containing soap and water using (see handwashing diagram Appendix 3) or the use of alcohol rub(Appendix 4), including:
   - before touching a resident (including undertaking personal care, administering oral medicines, assisting with toileting or meals)
   - before a procedure (including wound care, injections, PEG feeds, blood glucose levels)
   - after a procedure or body substance exposure risk (including handling a urinary bottle, bedpan, tissues, cleaning dentures, cleaning spills or urine faeces or vomit from patients surroundings)
   - after touching a resident (after any activities described in a and b)
   - after touching a residents surroundings (including beds, curtains, linen mobility aids)
   - after removing gloves.

2. the use of protective personal equipment (PPE) such as masks and protective eyewear if there is a risk of a body fluid splash.

3. consistent and correct glove use.

4. the use of gowns to prevent contamination of uniform or clothing: gowns should be changed between residents.

5. safe injection practices.

6. respiratory hygiene/cough etiquette (Appendix 6).

7. putting all soiled linen in a linen bag in each resident’s room.

8. maintaining regular cleaning of environment and patient/resident care equipment.

Contact precautions for residents with diarrhoea
Contact Precautions are additional precautions which should be used for all residents who develop diarrhoea including suspected or confirmed *Clostridium difficile*. Contact precautions are intended to prevent transmission of organisms such as *Clostridium difficile* which can be spread by direct or indirect contact with the resident or the resident’s environment.

Contact Precautions include the following.

Isolation
All residents with *Clostridium difficile* who have diarrhoea should be isolated and cared for in a single room where practical.

Cohorting
1. If single rooms are limited residents with the same *Clostridium difficile* species and diarrhoea can be cohotered (grouped or roomed together).
2. When cohorting and moving from one resident to another staff must change their gown and gloves and perform hand hygiene.

3. Do not room together residents who in addition have other known problem organisms (i.e. do not put a resident with MRSA in the same room as a resident with Vancomycin Resistant Enterococci [VRE]).

**Multi bed rooms**

1. If a resident is identified with *Clostridium difficile* and is located in a multi-bed room contact precautions should commence in the multi-bed room.

2. Where possible the resident with *Clostridium difficile* should be moved to a single room or cohorted with resident/s with the same *Clostridium difficile* species until they meet the criteria for ceasing contact precautions. If this is not possible implement strict contact precautions for this resident in the multi-bed room.

3. Residents who do not have any symptoms of *Clostridium difficile* and have shared a room with someone who has been identified with *Clostridium difficile* should not be moved from these multi-bed rooms for at least 48 hours to ensure they are symptom free.

**Contact precaution sign**

Place a contact precaution sign outside the resident’s room to remind staff and others about strict protocols required.

**Gloves and gowns**

1. All staff must wear gloves and a gown for all contact with residents who have diarrhoea. (Appendix 2)

2. Wash hands or apply alcohol-based hand rub if hands are soiled or potentially contaminated before donning gloves.

3. If visitors do not have contact with other residents in the facility they are not required to wear gowns and gloves as they are unlikely to transmit *Clostridium difficile* between residents.

4. Visitors should be instructed in hand hygiene whenever entering and leaving the isolation room.

5. Visitors of residents with diarrhoea should be discouraged from visiting other residents in the home.

6. Change gloves immediately if visibly soiled and after touching or handling surfaces or material contaminated with faeces. Gloves should always be changed between residents.

7. Remove gown and gloves before exiting the room (Appendix 2).

8. Wash hands with an antiseptic-containing soap and water or an alcohol-based hand rub on exiting a room of a patient who is in contact precautions.

**Hand hygiene**

Wash hands (Appendix 3) with an antiseptic-containing soap and water or use an alcohol-based hand rub (Appendix 4).

During norovirus outbreaks use an antiseptic containing antiseptic-containing soap for hand washing as it is more effective against noroviruses.

**Dedicated equipment**

Provide dedicated patient care items and equipment such as stethoscopes, thermometers, blood pressure cuffs to each resident or ensure strict disinfection between each use.
Ceasing contact precautions
1. Residents may have contact precautions ceased when:
   – The resident has been free of diarrhoea for 48 hours
2. A bowel chart should be used to determine when a resident meets the above criteria for ceasing contact precautions.

Resident movement when contact precautions are in place
1. Limit resident movement outside the isolation room to medically necessary/essential procedure or activities.
2. Communicate the *Clostridium difficile* status to other departments/healthcare facilities before transfer so that appropriate contact precautions can be implemented at the accepting department/healthcare facility.

Cleaning and disinfection of equipment and the environment
1. If resident care equipment must be shared the items must be cleaned and disinfected between each resident use.
2. **Clean and disinfect each resident’s environment daily with a sporicidal agent** such as a Sodium Hypochlorite (bleach containing) and include the following:
   – High touch (frequently touched) surfaces such as door handles, IV fluid pumps, bed rails
   – Room furnishings including over-bed tables, chairs, bedside tables, furniture, telephone, sinks, floors, commodes and toilets
   – Dedicated equipment including commodes, thermometers, stethoscopes, blood pressure cuffs and wheelchairs.
4. Educate cleaning staff on proper cleaning techniques frequently.

Surveillance and diagnosis
1. Staff should be alert for *Clostridium difficile* in residents who develop diarrhoea with no other recognised cause (that cannot be explained by medication or other medical conditions).
2. Staff should notify the facility management/supervisor, infection control staff and the resident’s doctor of the possibility of a resident with *Clostridium difficile* infection particularly any resident with:
   – increased frequency of **watery, loose or unformed** stools
   – fever
   – loss of appetite
   – abdominal pain/tenderness or crampy lower abdominal pain.
3. Staff should commence a bowel chart (i.e. The Bristol Stool Form Chart – see Appendix 5) for all residents who develop diarrhoea with no other recognised cause.
4. Staff should collect a faecal specimen as guided by the residents doctor or doctors (an unformed stool that takes the shape of the container) for laboratory testing.
5. Testing of stool specimens from residents who do not have symptoms for *Clostridium difficile* or its toxins (including a ‘test for cure’ after treatment) is not recommended.
**Treatment**

1. *Clostridium difficile* infection usually occurs in residents who are on antibiotics or who have been on antibiotics. In some cases if the antibiotics can be discontinued the symptoms will usually resolve within 2-3 days.

2. In residents who have ongoing symptoms the infection can usually be treated with an appropriate course of antibiotics which the doctor will prescribe.

3. Residents **need to be carefully monitored** to ensure that they are responding to therapy and that there is no deterioration in their condition.
Additional resources or information


CDC *Clostridium difficile infections* http://www.cdc.gov/ncidod/dhqp/id_Cdiff.html

CDC *Personal protective equipment (PPE) in healthcare settings* http://www.cdc.gov/ncidod/dhqp/ppe.html


Appendix 1 – Contact precautions

**Note - Standard precautions always apply**

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<th>Contact precautions</th>
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<tr>
<td>Single room</td>
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<tr>
<td>Contact precaution isolation sign</td>
</tr>
<tr>
<td>Door closed</td>
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<tr>
<td></td>
</tr>
<tr>
<td>Mask/eye protection</td>
</tr>
<tr>
<td>Gown</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Gloves</td>
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<td></td>
</tr>
<tr>
<td>Reusable patient care items cleaned</td>
</tr>
<tr>
<td>and disinfected</td>
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<td></td>
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<tr>
<td></td>
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<td></td>
</tr>
<tr>
<td>Dedicated equipment</td>
</tr>
<tr>
<td>(i.e. stethoscope, blood pressure</td>
</tr>
<tr>
<td>cuff, thermometer)</td>
</tr>
<tr>
<td>Linen – leak resistant bag at point</td>
</tr>
<tr>
<td>of use</td>
</tr>
<tr>
<td>Disposable meal tray</td>
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<tr>
<td>Change cubicle curtains at discharge</td>
</tr>
</tbody>
</table>

*If unable to place residents in a single room they can be roomed with another resident who has the same organism*
Appendix 2 – Donning and removing gowns and gloves

How to don gowns
- Select appropriate type of gown
- Opening is in the back
- Secure at neck and waist

How to remove gowns
- Unfasten ties
- Peel gown away from neck and shoulder
- Turn contaminated outside toward the inside
- Fold or roll into a bundle
- Discard

How to don gloves
- Select correct type and size
- Insert hands into gloves
- If wearing a gown extend gloves over gown cuffs

How to remove gloves – Step 1
- Grasp outside edge of the glove near the wrist
- Peel away from hand, turning glove inside-out
- Hold in opposite gloved hand

How to remove gloves – Step 2
- Slide ungloved finger under the wrist of the remaining glove
- Peel off from inside, creating a bag for both gloves
- Discard
Appendix 3 – How to handwash

How to Handwash?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

- Duration of the handwash (steps 2-7): 15-20 seconds
- Duration of the entire procedure: 40-60 seconds

1. Apply enough soap to cover all hand surfaces;
2. Rub hands palm to palm;
3. Right palm over left dorsum with interlaced fingers and vice versa;
4. Palm to palm with fingers interlaced;
5. Backs of fingers to opposing palms with fingers interlocked;
6. Rotational rubbing of left thumb clasped in right palm and vice versa;
7. Rotational rubbing, backwards and forwards with clasped fingers of right hand in left palm and vice versa;
8. Rinse hands with water;
9. Dry hands thoroughly with a single use towel;
10. Use towel to turn off faucet;
11. Your hands are now safe.

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A World Alliance for Safer Health Care
Clean Your Hands
Appendix 4 – How to use hand rub

How to Handrub?

RUB HANDS FOR HAND HYGIENE! WASH HANDS WHEN VISIBLY SOILED

Duration of the entire procedure: 20-30 seconds

1a. Apply a palmful of the product in a cupped hand, covering all surfaces;

1b. Rub hands palm to palm;

2. Right palm over left dorsum with interlaced fingers and vice versa;

3. Palm to palm with fingers interlaced;

4. Backs of fingers to opposing palms with fingers interlocked;

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

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

7. Once dry, your hands are safe.

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May 2006
### Appendix 5 – Stool chart

#### The Bristol Stool Form Scale

<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Separate hard lumps, like nuts (hard to pass)</td>
</tr>
<tr>
<td>2</td>
<td>Sausage-shaped but lumpy</td>
</tr>
<tr>
<td>3</td>
<td>Like a sausage but with cracks on its surface</td>
</tr>
<tr>
<td>4</td>
<td>Like a sausage or snake, smooth and soft</td>
</tr>
<tr>
<td>5</td>
<td>Soft blobs with clear-cut edges (passed easily)</td>
</tr>
<tr>
<td>6</td>
<td>Fluffy pieces with ragged edges, a mushy stool</td>
</tr>
<tr>
<td>7</td>
<td>Watery, no solid pieces ENTIRELY LIQUID</td>
</tr>
</tbody>
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Reproduced by kind permission of Dr. K. Heaton, Reader in Medicine at the University of Bristol. Produced by Merieux Limited, manufacturer of Minocin®.
Date commenced: _____/_____/_______

Given name : _____________________________________________________
Surname : _____________________________________________________
Date of birth : ____/____/______

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Amount</th>
<th>Stool type number</th>
<th>Aperient in last 24hrs</th>
<th>Continence</th>
<th>Specimen collected</th>
</tr>
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**Key:**
- **Amount**: Small = S, Medium = M, Large = L, Ooze = O
- **Stool type**: Refer to Bristol Stool Form Scale
Appendix 6 – Cover your cough

Protect yourself and your family
Cover your cough and sneeze

1. Cover your mouth and nose with a tissue when you cough or sneeze.

2. Put your used tissue in the rubbish bin.

3. Wash your hands with soap and running water. Dry your hands thoroughly with a disposable paper towel.

Stay germ free and healthy