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# Common cold

## Description

The common cold is caused by many different viruses that affect the nose and throat. It is the most common infectious illness, especially for young children. Young children may have 8 to 10 colds each year, with the highest number usually being during the first two years in child care, kindergarten or school. A cold in itself is not serious but colds can sometimes lead to other infections such as ear infections and tonsillitis. Symptoms include a runny, stuffed up nose, sneezing, coughing and a mild sore throat, with little or no fever. Nasal discharge is usually clear to start with, and then within a day can become thicker, yellow and sometimes green. Up to a quarter of young children with a cold go on to have an ear infection as well, but this happens less often as the child grows older. Colds are spread directly by contact with airborne droplets (coughing and sneezing), or indirectly by contaminated hands, tissues, eating utensils, toys or other articles freshly soiled by the nose and throat discharges of an infected person.

**Incubation period** - About 1–3 days.

**Infectious period** - 2-4 days after the cold starts.

**Exclusion Period** - There is no need to exclude a child with a common cold, unless the child is unwell.

## Responsibilities of child care providers/staff

Report the infection to the director. Advise the parent the child should stay at home until they are feeling well.

## Responsibilities of the parent

The child should stay at home until they are feeling well.

## Controlling the spread of infection

To control the spread of germs, children should be encouraged to either:

a) Cover their mouth and nose with a tissue when they sneeze or cough, then dispose of the used tissue appropriately. Wash their hands with soap and water, and dry thoroughly; or

b) Cough or sneeze into their upper sleeve, or elbow, not into their hands. Then wash their hands with soap and water, and dry thoroughly. Ensure staff wash and dry hands after contact with soiled tissues or contact with nose and throat discharges.

## Treatment

No specific treatment. Rest, extra drinks and comforting are important. Decongestants and other cold remedies are widely promoted for the relief of symptoms of colds and flu. However there is little evidence that any of these help.<sup>47</sup> In fact, there may be evidence that they can be harmful and may cause unpleasant side effects such as irritability, confusion and sleepiness. Oral decongestants are not recommended for children under the age of 2 years. Cough medicines are not effective in reducing the frequency, intensity or duration of cough. Like fever, the cough is there for a reason – it serves a useful function in clearing mucus from the child's airways and preventing secondary infection. If concerned, take children to the doctor. Do not give aspirin to any child with a fever.

**Comments** Watch for new or more severe symptoms. They may indicate other more serious infections.

# Whooping cough (pertussis)

## **Description**

Whooping cough is a highly contagious bacterial disease which can affect infants, children and adults. It may start with a runny nose, sneezing and then develop into coughing bouts. These coughing bouts can be very severe and frightening. They may end with a 'crowing' noise (the whoop) as air is drawn back into the chest. Vomiting or gagging may follow the coughing bouts. In babies, breathing may be obstructed due to the coughing and as a consequence, they may lack oxygen and turn blue. Adolescents and adults may just have a persistent cough. Young children are especially at risk of severe illness, which may result in hospitalisation. Some have fits (convulsions) and some may develop inflammation of the brain (encephalitis). Whooping cough is particularly serious in children under 2 years of age and hospitalisation is usually necessary. Whooping cough is transmitted by direct contact with droplets from the nose and throat of an infected person.

**Incubation period** - Commonly 7–10 days and not more than 21 days.

**Infectious period** - A person is infectious from the beginning of the illness and may remain infectious for up to three weeks. This time frame can be shortened to 5 days when the person is treated with an appropriate antibiotic.

**Exclusion period** - Exclude for 21 days from the onset of coughing or until the person has taken 5 days of an appropriate antibiotic.

## **Responsibilities of child care providers/staff**

Inform the director. The director should inform parents immediately if their child exhibits symptoms. Parents should then consult their doctor or clinic immediately. In some states and territories, the director is required to report details to the local public health unit. Parents of friends and contacts of the infected child should be notified that the child has been diagnosed as having whooping cough and advised to contact their doctor. Advise the parent to keep the child home for 21 days from the onset of coughing or until they have taken 5 days of an appropriate antibiotic.

## **Responsibilities of parents**

Keep the child home for 21 days from the onset of coughing or until they have taken 5 days of an appropriate antibiotic.

## **Controlling the spread of infection**

Whooping cough can be prevented by immunisation. Fully immunised communities offer the best protection against whooping cough. Erythromycin may be given to family and people in close contact with the disease. Adults and teenagers are susceptible to the illness as well and may carry the bacteria while exhibiting only mild symptoms. To control the spread of germs, children should be encouraged to either:

- a) Cover their mouth and nose with a tissue when they sneeze or cough, then dispose of the used tissue appropriately. Wash their hands with soap and water, and dry thoroughly: or
- b) Cough or sneeze into their upper sleeve, or elbow, not into their hands. Then wash their hands with soap and water, and dry thoroughly.

Ensure staff wash and dry hands after contact with soiled tissues or contact with nose and throat discharges.

**If there is a case of whooping cough within the centre:**

Check the immunisation records for every child who has contact with the child with whooping cough. Look for evidence of vaccination with the DTP vaccine at 2, 4 and 6 months of age, and at 4 years of age. The 'P' in the vaccine is for pertussis which is whooping cough. Children who have received CDT (diphtheria and tetanus for children) at any of these times have not been vaccinated against whooping cough. Any child or adult who lives in the same house as the case **and** also attends the centre **and** has received less than three doses of pertussis vaccine is to be excluded from the centre until they have had 5 days of an appropriate course of antibiotics. If antibiotics have not been taken, these contacts must be excluded for 14 days after their last exposure to a case of whooping cough at home.

**Treatment**

Antibiotics may be given in the early stages to shorten the period of contagiousness of a child with whooping cough. However, these do not lessen the severity or duration of the illness.

# Diarrhoea and vomiting (gastroenteritis)

## Description

Gastroenteritis is an illness triggered by the infection and inflammation of the digestive system. Typical symptoms include abdominal cramps, diarrhoea (an increase in the frequency, runniness or volume of the faeces) and vomiting. In many cases the condition is self-limiting and resolves in a few days. The main complication of gastroenteritis is dehydration, but this can be prevented if the fluid lost in vomit and diarrhoea is replaced. A person suffering from severe gastroenteritis may need fluids intravenously. Some of the causes of gastroenteritis are:

- Viruses – such as *Norovirus*, *Rotavirus* and *Adenoviruses*.
- Bacteria – such as *Campylobacter*, *Salmonella* and *Shigella*.
- Parasites – such as *Giardia* and *Cryptosporidium*.
- Bacterial toxins – the bacteria themselves don't cause illness but their poisonous by-products can contaminate food. For example some strains of staphylococcal bacteria produce toxins that can cause gastroenteritis.
- Chemicals – copper poisoning, for example, can cause gastroenteritis.
- Drugs – certain drugs, such as antibiotics, can cause gastroenteritis in susceptible people. The exact cause of the diarrhoea can only be diagnosed by laboratory tests of faecal specimens. Sometimes multiple specimens must be tested.

**Incubation period** - Viral and bacterial infections, usually 1–3 days. Parasitic infections, 5–15 days.

**Infectious period** - People are infectious for as long as the organisms are present in their faeces, whether or not they have symptoms.

**Exclusion period** - Children are to be excluded from the centre until there has not been a loose bowel motion or vomiting for 24 hours.

## Responsibilities of child care providers/staff

Inform the director, who can then inform parents that the illness is present in the centre. When two or more children in one group are ill with diarrhoea, your public health unit should be contacted for advice and help in controlling the outbreak.

## Responsibilities of parents

Observe the exclusion period.

## Controlling the spread of infection

A person with active diarrhoea is more likely to spread the disease than one who is well but has infectious organisms in their faeces. For this reason, children and staff with infectious diarrhoea should not attend the centre until diarrhoea has stopped for at least 24 hours. Do not exclude children or staff with diseasecausing organisms in their faeces but no diarrhoea. Staff with disease-causing organisms in their faeces but no diarrhoea should not be involved in the preparation of food. Make sure that effective hand washing and cleaning procedures are being followed in the centre and at home. Keep cold food cold (below 5°Celsius) and hot food hot (above 60°Celsius) to discourage the growth of bacteria. Reheat food and hold at 70°Celsius for 2 minutes.

## **Treatment**

### **Preventing dehydration in children with gastroenteritis**

Children with diarrhoea need extra fluid to replace what they lose. However, many fluids have too much sugar and the wrong amount of salt. Giving a sick child the wrong kind of fluid can lead to more dehydration and illness.

#### **Breastfed children**

Breastfeeding mothers should continue to breastfeed and offer the breast more often.

#### **Safe drinks**

The best fluids to give contain a mixture of special salts (electrolytes) and sugars. You can buy oral rehydration solution from the chemist. Mix the sachet of powder with water, not other kinds of fluids. Mix solution according to manufacturer's instructions. If children refuse oral rehydration solution they may be given diluted soft drinks or fruit juice.

- Diluted cordial 10ml + 150ml water.
- Diluted soft drink (e.g. lemonade) 50ml + 150ml water.
- Diluted fruit juices 50ml + 150ml water.

#### **Unsafe drinks**

Do not give undiluted fruit juice, fizzy drinks, 'sports drinks' or 'energy drinks' or cordial to children with diarrhoea. They may increase diarrhoea and dehydration.

#### **Bottle/Formula fed babies**

Continue normal strength formula or milk if the child is hungry, and offer oral rehydration solution or safe drinks as recommended above. Remember that withholding formula for more than 24 hours may result in the baby losing weight.

#### **Re-introducing food**

Re-introduce food within 24 hours, even if the diarrhoea has not settled. Suitable foods to start off with include bread, plain biscuits, potatoes, rice, noodles, vegetables, plain meats, fish and eggs. Gradually reintroduce other foods, such as dairy foods and sweet foods such as jelly, honey and jam.

#### **Comments**

Children with diarrhoea, who vomit or who refuse extra fluids should see a doctor. In severe cases hospitalisation may be needed. The parent and doctor will need to know the details of the child's illness while at the centre.

# Chickenpox (varicella)

## Description

Chickenpox is a viral illness that comes on suddenly and is highly contagious. The chickenpox virus is also called *varicella virus*. Chickenpox usually starts with one spot, but more quickly appear, with fever, headache, runny nose, a cough and feeling very tired. The rash starts on the chest and back and spreads to the face, scalp, arms and legs. The rash can develop all over the body, inside the ears, on the eyelids, inside the nose and within the vagina, everywhere. The rash continues to spread for three or four days. It is usually very itchy. Within a few hours after each spot appears, a blister forms. It may appear full of yellow fluid. After a day or so, the fluid turns cloudy. These spots are easily broken and form a scab. The spots heal at different stages, some faster than others, so it is possible the child may have the rash in several stages at once. Some children appear to 'breeze' through chickenpox with just a few spots. Others have a terrible time with hundreds of itchy spots. Chickenpox is more severe in adults and can cause serious and even fatal illness in people who are immunosuppressed. In families with several children, outbreaks can last for weeks, because of the relatively long incubation period. Congenital varicella syndrome has been reported in the first half of pregnancy and may result in congenital malformations, skin scarring and other abnormalities. Severe varicella infection can occur in a newborn baby if the mother has varicella. It is spread by coughing and contact with the fluid from the blisters. One infection gives long-lasting immunity. People rarely get chickenpox twice. Herpes zoster (shingles) is caused by the same virus. It is an eruption in someone who has previously had chickenpox. Direct contact with the moist shingles rash can cause chickenpox in a person who has not already had it.

**Incubation period** - The average incubation period is 14 to 15 days, but may range from 10 to 21 days.<sup>78</sup>

**Infectious period** - From two days before the rash appears (that is, during the coughing, runny nose stage) and until all blisters have formed scales or crusts.

**Exclusion period** - Exclude until all blisters have dried. This is usually at least 5 days after the rash first appeared in unimmunised children and less in immunised children.

## Responsibilities of child care providers/staff

Report the infection to the director. Remind parents that aspirin should not be given. Pregnant women should be advised to avoid contact with chickenpox. Immunisation for chickenpox during pregnancy is not recommended and pregnancy should be avoided for one month following chickenpox immunisation.<sup>80</sup> If pregnant women are concerned, they should contact their doctor.

## Responsibilities of the parents

Keep the child home until all blisters have dried. This is usually at least 5 days after the rash first appeared in unimmunised children and less in immunised children.

## Controlling the spread of infection

Chickenpox can be prevented by immunisation. Fully immunised communities offer the best protection against chickenpox. Chickenpox vaccination is free for all children at 18 months of age from 1st November 2005. Vaccination

after exposure is usually successful in preventing chickenpox when given within 3 days of exposure and may be successful when given up to 5 days after exposure. Non-immune child care staff should be immunised against chickenpox. Varicella zoster immunoglobulin (VZIG) may be given to some contacts that are at very high risk of complications because of other medical problems. This is not recommended for normal healthy children. Cover the nose and mouth when coughing or sneezing. Dispose of soiled tissues after wiping a runny nose or which are soiled with nose or throat discharges. Wash and dry hands carefully. Do not share eating utensils, food or drinking cups. Thoroughly wash toys that infants and toddlers put in their mouths.

### **Treatment**

There is no specific treatment, but calamine lotion or phenelgan may soothe the itch. The use of a medicine containing paracetamol may be considered to lower the child's temperature or relieve discomfort. Never give aspirin to children who develop fever after exposure to chickenpox. Aspirin appears to increase the risk of Reye's Syndrome, a rare but serious disorder characterised by sleepiness and vomiting. Reye's Syndrome can lead to coma and death.

# Hand, foot and mouth disease

## **Description**

This is a mild viral illness and has nothing to do with animal diseases with similar names (e.g. foot and mouth disease in livestock). Symptoms include a slight fever, loss of appetite, blisters in the mouth and on the hands and feet, and a sore mouth for a few days before the ulcers or blisters appear. Affected young children may refuse to eat or drink. Less commonly, blisters may be seen in the nappy area. Hand, foot and mouth disease is spread through contact with the fluid in the blisters. This is most likely to occur when the virus becomes airborne during coughing, singing, talking, etc. Contact with faeces can also spread the infection.

**Incubation period** - Usually 3–5 days.

**Infectious period** - As long as there is fluid in the blisters. The faeces can remain infectious for several weeks.

**Exclusion period** - Exclude until all blisters have dried.

## **Responsibilities of child care providers/staff**

Report the illness to the director.

## **Responsibilities of parents**

Observe exclusion period.

## **Controlling the spread of infection**

Allow blisters to dry naturally. The blisters should not be deliberately pierced because the fluid within the blisters is infectious. Follow good hand washing and cleaning procedure.

## **Treatment**

Usually none is required.

# Head lice (Nits) (Pediculosis capitis)

## Description

Head lice are tiny insects. They do not have wings, so they cannot fly. Head lice have strong claws and swing from hair to hair – they cannot jump. They live on the hair and suck blood from the scalp. Head lice can only be spread from one person to another by direct head-to-head contact.

Anyone can get head lice – they have no preferences for cleanliness, hair colour, hair type, ethnicity or age. Head lice are a nuisance but they do not cause disease or illness. Itching is often the first thing that raises concern about head lice, however it is not a reliable sign of head lice. Head lice need to spend their entire life on human heads to survive. Head lice will die from dehydration within 6 – 24 hours when removed from the human head, depending upon humidity and when they last fed.

Scientific research<sup>93</sup> has shown:

- Sharing hats presents no risk. It does not increase the chance of getting head lice. Researchers examined hats worn by 1000 school children and found no head lice even when many head lice were found on the children's heads.
- Placing hair grooming implements in a container of very hot water (60°C) for at least 30 seconds will kill any head lice caught in the comb after grooming. A domestic hot water service usually does not reach 60°C. If you do not have a thermometer, it may be easiest to use water shortly after it has gone off the boil.
- Researchers examined 118 carpeted classroom floors and found no head lice or eggs. When the students from those rooms were examined, they had a total of 14, 563 live head lice on their heads.

**Incubation Period** - The head louse starts as a small egg about the size of a grain of salt which the female louse glues to the base of the hair shaft. Most often these eggs (nits) are found in the hair behind the ears, at the back of the neck, or around the crown and under the fringe. The eggs hatch in 7–10 days. They mature into an adult louse, which is a wingless insect 2–3 mm long with a flat body and six legs. The adult louse is capable of laying eggs after 6-10 days.

**Infectious Period** - As long as the eggs or lice are alive. Live eggs are glued to the hair shaft, usually within 1.5cm from the scalp.<sup>94</sup> Head lice can only survive on human heads and they must feed every 6 hours or they will die from dehydration.<sup>95</sup> Eggs need to be on the head to hatch.

**Exclusion Period** - Exclusion is NOT necessary if effective treatment (see 'Treatment') is commenced prior to the next day at child care (i.e. the child doesn't need to be sent home immediately if head lice are detected). An effective treatment is when a treatment is used and all the lice are dead.

## Responsibilities of child care providers/staff

Reducing head-to-head contact between all children during activities when the centre is aware that someone in the centre has head lice. Support parents and children who have head lice by providing factual information, reducing parental anxiety and by not identifying individual children as having head lice.

## Responsibilities of parents

Check child's head once a week for head lice. If head lice are found, begin treatment immediately and check for effectiveness (see 'Treatment') and keep checking every 2 days until no lice are found for 10 consecutive days. You

may send your child back to child care as soon as effective treatment has commenced. Your child is not a risk to others as long as treatment has commenced.

### **Controlling the spread of infection**

Educate staff, children and parents about head lice. **Identification of an individual child with head lice is usually a marker of head lice in a much larger group and a group approach rather than an individual approach is needed.** Keep families informed if there is someone within the centre with head lice. Recommend that staff and children tie back long hair to reduce the chance of transmission.

### **Detection**

Itching is often the first thing that raises concern about head lice; however it is not a reliable sign of head lice. Most children who itch do not have head lice. You can have head lice and not know. Lice move fast in dry hair and are easy to miss. If you find head lice early, they are easier to treat. Everyone (adults and children) in the family needs to be checked. Check everyone's head once a week. If a close contact has head lice, keep checking every 2 days until no lice are found for 10 consecutive days. If you find head lice, you need to decide on a treatment option. Using hair conditioner and combing is the most effective way of finding, and treating, head lice. Conditioner and combing can be used for detection and/or treatment. The conditioner stuns the lice for some minutes so they can be easily removed. Conditioner and combing are reasonably inexpensive. It also avoids the use of head lice chemicals (pesticides).

### **Conditioner and combing technique**

1. Untangle dry hair with an ordinary comb.
2. Apply hair conditioner to dry hair (use white conditioner as it makes it easier to see the nits). Use enough conditioner to thoroughly cover the whole scalp and all hair from roots to tips.
3. Use the ordinary comb to evenly distribute conditioner and divide the hair into four or more sections using hair clips. A mirror helps if combing yourself.
4. Change to a head lice comb.
5. Start with a section at the back of the head. Place the teeth of the head lice comb against the scalp. Comb the hair from the roots through to the tips.
6. Wipe the comb clean on a tissue after each stroke. In good light, check for head lice. Adult lice are easier to see – young lice are difficult to see. A magnifying glass will help. You may see some eggs.
7. Comb each section twice until you have combed the whole head. If the comb becomes clogged, use an old toothbrush, dental floss or safety pin to remove the head lice or eggs.

### **Treatment Options**

The two most important things to think about when choosing and using treatments are safety and effectiveness.

### **Conditioner and Combing Treatment**

If you choose the conditioner and combing as a treatment, follow all the steps described in 'Conditioner and combing technique'. Keep combing the whole head until all the hair conditioner is gone. Repeat the conditioner and combing daily until you find no more head lice for 10 consecutive days. It is important to continue for 10 days to remove all the adult lice and any young lice that hatch from the eggs before they can reproduce.

## **Chemical Treatment**

When choosing a chemical treatment product, ensure you only choose chemical treatments that are designed specifically to treat head lice. Choose only chemical treatments which have an 'Aust. L' or 'Aust. R' number on the label. These products are licensed or registered with the Therapeutic Goods Administration (TGA) in Australia. This means they are approved for safety. Be wary of chemical treatments which are not officially approved. Chemical treatments are divided into 4 groups according to the active ingredient. These groups are: Pyrethrins, Synthetic Pyrethroids, Organophosphates and Herbal and Essential Oils. If you use a chemical treatment and it does not kill the head lice, choose a product with a different active ingredient from a different group. Products from the same group will probably not work as the active ingredient is likely to be the same. Your pharmacist can help you choose a product. There is no chemical treatment which will kill eggs. The eggs will continue to hatch after the treatment. Therefore it is essential to apply the second treatment one week later to kill any young lice that have hatched. The conditioner and combing treatment can be used in between to help remove the lice that are hatching. There is no chemical treatment that will work for everyone. Resistance to chemical treatments is a problem in Australia. Research into this problem is continuing. The only way of dealing with resistance is to check for effectiveness every time you use a chemical treatment.

### **Effectiveness of chemical treatments**

It is essential to check for effectiveness after each application of a chemical product (refer to instructions above). Some head lice are resistant to some chemical treatments. This means that this treatment will not be effective in killing head lice. To check for effectiveness after treating for head lice, use a fine tooth head lice comb (preferably a metal comb) to comb all of the hairs from roots to tips. After each sweep, wipe the combings onto a tissue. Repeat until all the hair has been combed at least twice. Wait for 5 minutes. Observe the lice for movement.

**Effective:** If all the lice are dead the treatment has been effective.

- Apply the same product every 7 days (maximum 3 times) to kill the lice hatching from the eggs. Use conditioner and combing every 2 days in between to improve the effectiveness of the treatment.
- After first application eggs will be present. In 7 days use conditioner and combing to detect lice. If lice are found, apply product again in 7 days.
- After third application, if lice are still present, continue using conditioner and combing only.

**Ineffective:** If some lice run around or wave their legs and antennae, the treatment has not been effective.

- If a treatment has not been effective, select a product with a different active ingredient. Show the pharmacist your current treatment and request advice on choosing an alternative treatment or consider using the conditioner and combing technique.

# **Roseola (exanthum subitum, sixth disease)**

## **Description**

This common contagious viral infection is marked by the sudden onset of a high fever which lasts 3 – 5 days and then falls, at which time a rash appears. The rash may look similar to the measles rash, but appears first on the body. The high temperature can last from a few hours up to 3 – 5 days. The rash lasts from a few hours to 1 – 2 days. It usually affects children between the ages of 6 months and 3 years.<sup>101</sup> Although it can lead to febrile convulsions, roseola is usually a mild illness. Roseola is spread by airborne droplets from the nose and throat, and indirectly by contact with hands, tissues and other articles soiled by nose and throat discharges. The disease is also spread by direct contact with the saliva of an infected person.

**Incubation period** - Around 10 days.

**Infectious period** - Saliva, nasal discharge and other respiratory secretions are most infectious from a few days before until several days after the rash appears.

**Exclusion period** - Nil. If the child feels unwell they should not attend the centre until they are feeling better.

## **Responsibilities of child care providers/staff**

Report the infection to the director.

## **Responsibilities of parents**

Although there is no exclusion period for roseola, if the child feels unwell they should not attend the centre until they are feeling better.

## **Control of spread**

Follow good hand washing procedures. Dispose of soiled tissues appropriately.

## **Treatment**

None

# Impetigo (school sores)

## Description

Impetigo is a bacterial skin infection caused by either the *Staphylococcus* or *Streptococcus* organism, or both. It is very common in children and is very easily spread, but with care spread can be reduced. Impetigo appears as a flat, yellow, crusty or moist patch on the skin, usually on exposed parts of the body such as the face, arms and legs. The sores are often greater than 1cm in diameter. It usually starts with a blister or a group of blisters. Dry, cracked skin is an ideal area for growth of bacteria. This infection spreads easily to other parts of the infected person's body. It is transferred to other people by direct contact with sores or contaminated clothes.

## Staphylococcus

*Staphylococcus* (or staph) are bacteria that are found on the skin and in the nose of people. Staph are usually harmless, but they can sometimes cause infection and serious illness.

## Streptococcus

*Streptococcus* (or strep) are bacteria usually known as either group A or group B. Group A strep is often found in the throat and on the skin and cause no symptoms of illness. Most Group A strep infections are relatively mild illnesses such as 'strep throat' or impetigo. On rare occasions, these bacteria can cause other severe and even life-threatening disease. Group B strep is the most common cause of sepsis (blood infection) and meningitis (infection of the fluid and lining surrounding the brain) in newborns. Group B strep is a frequent cause of newborn pneumonia.

**Incubation period** - 1–3 days.

**Infectious period** - As long as there is fluid weeping from the sores. Usually it has stopped being infectious about 24 hours after treatment with an antibiotic has started and healing has begun.

**Exclusion period** - Exclude until the child has received antibiotic treatment for at least 24 hours.

## Responsibilities of child care providers and parents

Report the infection to the director.

## Responsibilities of parents

Observe the exclusion period. Any sores on exposed skin should be covered with a waterproof dressing.

## Controlling the spread of infection

Emphasise the importance of good hand washing procedures for all personnel and children in the centre. Sores on exposed surfaces should be covered with a waterproof dressing.

## Treatment

The doctor may recommend the use of antibiotic ointment or antibiotics taken by mouth. Refer the child back to the doctor if the condition does not improve.

# Conjunctivitis

## Description

Conjunctivitis is an inflammation of the conjunctiva, the clear membrane that covers the white part of the eye and lines the inner surface of the eyelids. The inflammation can have many causes, the commonest of which are infection, allergy and irritation.<sup>109</sup>

**Infectious conjunctivitis** is usually caused by either bacteria or viruses. If it is caused by a bacteria both eyes are almost always infected, although it may start in one eye. There is likely to be a gritty feeling and pus. Conjunctivitis from a virus may involve one or both eyes, causing red, itchy eyes and watering of the eyes.

**Allergic conjunctivitis** occurs more frequently among children with allergic conditions such as hay fever. If it comes from an allergy, there are often other signs of allergy such as itchy nose and sneezing, the eyes feel itchy and are watery. Allergic conjunctivitis typically affects both eyes at the same time.

**Irritant conjunctivitis** can be caused by chemicals such as those in chlorine and soaps or air pollutants such as smoke and fumes. Allergic and irritant conjunctivitis is not infectious. The different types of conjunctivitis can have different symptoms. In addition, symptoms can vary from child to child. One of the most common symptoms is discomfort or pain in the eye, which may feel like having sand in the eye. Many children have redness of the eye. They may also have swollen eyelids and be sensitive to bright lights. Discharge from the eye may accompany the other symptoms. In infectious conjunctivitis caused by bacteria, the discharge will be somewhat thick and coloured white, yellow or green. Sometimes the discharge will cause the eyelids to stick together when the child awakens in the morning. In allergic conjunctivitis or infectious conjunctivitis caused by a virus, the discharge may be thinner and may be clear. Viral and bacterial conjunctivitis can be spread by direct contact with eye secretions or indirectly by contact with towels, washcloths, and tissues etc that have been contaminated with eye secretions. In some cases it can be spread by insects such as flies.

**Incubation period** - 24–72 hours.

**Infectious period** - Viral and bacterial conjunctivitis are infectious while there is discharge from the eye. Conjunctivitis caused by chemicals or allergies is not infectious.

**Exclusion period** - Exclude until the discharge from the eyes has stopped unless doctor has diagnosed a non-infectious conjunctivitis.

## Responsibilities of child care providers/staff

Inform the director and the parents of the child. The child should see a doctor for proper diagnosis and treatment.

## Responsibilities of parents

Observe the exclusion period. The child should see a doctor for proper diagnosis and treatment.

### **Controlling the spread of infection**

Effective hand washing is essential, especially before and after touching the eyes or face. Dispose of soiled tissues appropriately. Do not share towel, washcloths, etc.

### **Treatment**

Antibiotic eye drops or ointment may be prescribed by a doctor. Regular cleaning of the eyes may make the child feel better. It is important to use a separate cotton wool ball or tissue for each eye to avoid crossinfection and use warm but not hot water. Wipe the closed eye gently but firmly to remove the excess pus – do not clean inside the eyelids as this may cause damage to the conjunctiva or the cornea (the clear front of the eye).

## **Meningococcal infection**

### **Description**

A severe infection caused by *Neisseria meningitidis* bacteria, also commonly known as the 'the meningococcus'. There are 13 different groups of meningococcus, but most infections in Australia are caused by groups B and C. The meningococcus is carried harmlessly in the nose and throat of up to 20% of people. In a small number of people, for uncertain reasons, the meningococcus will spread from the nose and throat into the blood stream, and cause serious illness. Meningococcal diseases can affect all age groups, but is most common in children under 5 years of age, and in the 15-24 years group. In Australia, 5 to 10% of people who have meningococcal disease die within a few hours of becoming unwell despite rapid treatment. Symptoms in babies and young children include fever, refusing feeds, fretfulness, vomiting, rash of reddish purple spots or bruises, high-pitched or moaning cry, pale or blotchy skin. The child may be difficult to wake. The bacteria is spread in respiratory secretions by close and prolonged person-to-person contact such as occurs in a household. Meningococcal disease can happen at any time of the year, but is most common in winter and spring.

**Incubation period** - Usually 3–4 days.

**Infectious period** - The child is infectious as long as organisms are present in the nose and throat. This will be less than 24 hours after they are treated with effective antibiotics.

**Exclusion period** - Exclude until a course of an appropriate antibiotic has been completed.

### **Responsibilities of child care providers/staff**

A child with this infection should see a doctor immediately. The director should immediately inform and seek help from the local public health unit.

**Responsibilities of parents**

Observe the exclusion period. Any very close contacts of someone with meningococcal disease, such as family members, need a short course of antibiotics to kill any of the bacteria they may have in their nose or throat. All very close contacts are usually treated because there is no easy and quick way of finding out who may have the bacteria in their nose or throat.

**Controlling the spread of infection**

If appropriate, public health authorities will arrange for other children and staff of the centre to be given a course of an appropriate antibiotic. Careful hygiene practices are important to prevent the spread of any infection. These include effective hand washing and appropriate disposal of used tissues. The meningococcus does not survive for long outside the human body.

Meningococcal C infection can be prevented by immunisation. Meningococcal C immunisation is recommended for all children at 12 months of age. Fully immunised communities offer the best protection against meningococcal C infection. Meningococcal C vaccination does not protect against meningococcal B infection.

**Treatment**

A child with meningococcal infection will be treated in hospital with antibiotics.