

UNIQUE IDENTIFIER NO: C-13-2008
EQUIP-2018-019
Review Date: March 2021
Review Lead: Lead Infection, Prevention and Control Nurse

Section K - Isolation Policy

Version 8

Important: This document can only be considered valid when viewed on the Trust's Intranet. If this document has been printed or saved to another location, you must check that the version number on your copy matches that of the document online.

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Does this document map to other Regulator requirements?	
<i>Regulator details</i>	<i>Regulator standards/numbers etc</i>

Document Version Control	
Version 8	References reviewed and updated, appendices reviewed and updated and EPR elements added where applicable.
Version 7	The full appendices have been added to the policy as they were inaccessible.
Version 6	A quick guide for prioritising who to isolate is available in Appendix 1. Respiratory protection guidance is now available in Appendix 14 and not via a hyperlink. All appendices are available via a PDF quick link.
Version 5	The new isolation signage is available in Appendix 8 – Contact Precautions; Appendix 9 – Respiratory Precautions; Appendix 10 – Protective Isolation. The new Nursing Assessment Tool regarding isolation of patients and the new Transfer of Patients form have been referred to. Carbapenemase Producing Enterobacteriaceae (CPE) has been added to the Infectious Diseases Chart. A hyperlink to the IPC intranet page is available for the breakdown of FFP3 mask usage. The location and availability of pressure rooms is updated – Appendix 5
Version 4	The document has been reviewed and Appendix 1 - Standard Isolation and Appendix 3 - Respiratory Isolation have been removed and replaced with an Infectious Diseases Chart now under Appendix 1. All references to swine flu have been removed and referred to as seasonal flu. An additional appendix has been added as a summary of this document. Community information and a summary of the policy have also been added as Appendix 14 and 15 respectively.

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1. Introduction

Isolation is a key measure in the control of infections, alongside hand hygiene, personal protective equipment and effective cleaning. Through the correct and timely placement of infected patients (suspected or confirmed) into single rooms or cohort bays, it is possible to control the spread and minimise the impact of infectious diseases such as Norovirus, Influenza, and health-care associated infections (HCAIs) such as MRSA and *Clostridium difficile*.

The Health and Social care Act 2008 requires providers delivering in-patient care to ensure that it is able to make available adequate isolation precautions and facilities as appropriate for their patients.

1.1 Key points

- Prompt isolation is essential to control the spread of infection.
- Staff should ensure they are clear on the precautions required for the specific infection they are managing.

2. Purpose

The purpose of this policy is to ensure the correct employment of isolation procedures in order to minimise the risk of cross infection. It sets out Trust guidance regarding the isolation and care of patients with known or suspected colonisation or infection by multi-resistant or pathogenic micro-organisms and provides information regarding the following:

- Why isolation is necessary
- When should isolation precautions be implemented
- Who should be isolated
- How to prioritise the need for isolation
- Where should patients be isolated
- Staff responsibility
- Movement of patients

The policy also aims to:

- Identify isolation needs of colonisation, infection or infectious disease that may be a risk to others ensuring safe placement, management and care of patients
- Ensure timely action to prevent the spread of infection by appropriate isolation of the source patient and appropriate use of personal protective equipment

3. Definitions

Isolation, the placement of a patient within a single room and the implementation of additional precautions for specific conditions, effective in reducing the spread of

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infection within a hospital environment to patients, staff and visitors. The allocation of single rooms must be based on a clinical risk assessment with infection control requirements given priority over bed management/capacity issues.

Isolation may be classified as **Contact, Respiratory** or **Protective**. The elements required to implement isolation effectively are outlined in Appendix 3 along with the required signage.

Contact Isolation (Contact Precautions sign) is necessary for patients who are known or suspected of being colonised or infected with pathogenic micro-organisms spread through **contact** (see Appendix 3)

Respiratory Isolation (Respiratory Precautions sign) is necessary for specific respiratory infections that are spread by the respiratory route through aerosol or droplet transmission (see Appendix 3)

Protective isolation (Protective Isolation sign) is necessary if the patient is immuno-compromised - consequently vulnerable to infection arising from other patients or from the environment. The aim is to protect such infection-susceptible patients from both exogenous (cross-infection) and endogenous (self-infection) (see Appendix 3).

There are a variety of routes by which organisms spread to find a new host; some organisms may spread by more than one route. The most common route of transmission is **contact**. Other routes of transmission include **droplet** and **airborne**.

- **Direct contact** is the physical transfer from body surface to body surface between an infected or colonised person and a susceptible host. This can be between patients or from staff to patient when performing patient care activities
- **Indirect contact** involves the susceptible host having contact with an intermediate object, such as contaminated instruments, the environment, or care equipment such as commodes, beds, hoists
- **Droplets** are generated from the source patient through coughing, sneezing, talking or singing, as well as certain procedures such as bronchoscopy. Transmission occurs when droplets containing micro-organisms generated from the infected person are propelled a **short distance** through the air and reach someone's conjunctivae, nasal mucosa or mouth
- **Airborne** transmission occurs by dissemination of microorganisms suspended in the air for long periods of time in aerosols or dust.

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4. Duties

The Chief Executive is responsible for ensuring that there are effective infection control arrangements in the Trust.

Managers' responsibilities are to ensure that:

- All staff understand how organisms spread in order to apply correct isolation procedures
- Staff are aware of, have access to and comply with this policy
- Staff are adequately trained in all aspects of this policy

Ward / Department Staff responsibilities are to ensure that they:

- Understand how organisms spread in order that they can apply correct isolation procedure
- Comply with the requirements of this policy
- Attend training as required
- Isolate patients promptly to reduce the risk of spread of infection/protect the immune-compromised patient

All staff working on Trust premises, including contractors' staff, agency, locum staff and Allied Health Professionals are responsible for adhering to this policy and those listed below.

5. Scope

This policy applies to all health care workers working within the Trust and should be used in conjunction with other relevant sections of the Infection Control Policy Manual, including:

Section A:	Infection Prevention and Control Arrangements
Section B:	Notifiable Diseases Policy
Section C:	Standard Precautions
Section D:	Meningococcal Disease
Section E:	Major Outbreaks of Infection Policy
Section F:	Decontamination and Disinfection Policy
Section H/I:	Hand Hygiene Policy
Section J:	Multi Resistant Organisms including CPE, VRE, PRP, ESBL
Section N:	Viral Haemorrhagic Fever Policy (Ebola)
Section P:	Care of the Deceased patient
Section S:	Tuberculosis Policy
Section T:	Multi-Resistant Policy MRSA, PVL
Section U:	MERS-COV Policy
Section W:	Bed Management and Movement of Patients Policy
Section Y/Z:	Control of Management of Clostridium <i>difficile</i> Policy.

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Also the following policies:

- Laundry Policy (general policy)
- Disposal of Waste (general policy)
- Principles for Uniform and Non Uniform Staff (general policy)

6. When should isolation precautions be implemented?

Ward staff may be informed by the Infection Prevention and Control Team (IPCT), Laboratory staff, the patient or via an alert flag on the Electronic Patient Record (EPR) of the presence of an infectious condition or antimicrobial resistant organism. This policy and the appendix herein support the admitting staff in identifying the isolation requirements for their patients.

The IPCT are available to liaise with ward staff to aid risk assessment and prioritisation of isolation, the necessary precautions that should be taken and advice regarding the appropriate placement of patients depending upon demand, capacity and epidemiology.

If appropriate isolation facilities are not immediately available, the Bed Team needs to be notified. If the patient continues to be nursed in a bay area, a Contact Precaution sign must be displayed above the patient's bed in order to alert staff of the need to implement appropriate precautions. The ward staff are to complete a clinical incident form via the Risk Management Portal and notify the IPCT who will document the isolation breach (call during office hours and leave a message on the answer phone out of hours)

The movement of isolated patients for **non-clinical reasons** should be minimised.

7. How to prioritise the need for isolation

Isolation priority depends on a number of factors: the patient and their risk factors; the infection; the sight of the infection; current symptoms; and ward and other patient risk factors. **Please refer to Appendix 1.**

There are situations where isolation may be inappropriate for some patients e.g. falls risk etc. Patients should be isolated when the risk to other patients is greater than the anticipated risk to the individual patient. **Interventions should be in place to ensure the safety and wellbeing of the isolated patient.**

8. Where should patients be isolated?

The most effective form of isolation is in a single room with ensuite facilities and this should always be the first choice for the placement of infected patients. **The door to the room must be kept closed** to provide physical separation from other

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patients. If this is not possible, e.g. falls risk, then this must be documented in the patient's notes.

If single room capacity is exceeded, cohorting may be implemented for patients with the same organism or who display similar signs and symptoms of infection (e.g. diarrhoea and/or vomiting). **This should be discussed with the IPCT.** Where patients are being cohorted the doors should be kept closed to provide physical separation from other patients. **Designated staff** should care for patients who are cohorted within an area of the ward. Toileting/bathing facilities should also be designated.

Whether cohorted or isolated in a single room, appropriate isolation door signage must be displayed (Appendix 3).

9. Staff responsibility:

- Provide affected patients and visitors with an explanation of their infection, the need for isolation precautions and treatment, without breaking confidentiality and document in the notes. The Infection Prevention and Control Nurses can be contacted if patients, relatives or visitors require further information
- Ensure that rooms, bays and areas used for isolated patients have dedicated hand hygiene and toileting facilities
- Ensure that there is clear signage to alert staff and visitors to infection control precautions
- Ensure that the doors are kept closed
- Adhere to and ensure colleagues adhere to the associated policies in section 5 including **bare below the elbow**; no stoned rings or jewellery other than a plain wedding band; no long nails, false nails or nail varnish
- Ties should be tucked into shirts or an apron worn; hands must be decontaminated before and after every episode of patient care and/or contact and/or with the patient's immediate environment
- Appropriate PPE must be worn (See Section C, Infection Control Policy)
- The number of staff entering the side room should be kept to a minimum. During ward rounds only essential staff should review the care of the patient within the side room
- Where patients are identified as an infection risk and require isolation, but cannot be accommodated in a side room, this must be escalated to the bed team, the IPCNs and then reported as a clinical incident using the online Risk Management Portal
- If patients with a multi-resistant organism are moved out of a side room when isolation is still appropriate, the area should be cleaned as detailed in the bed space cleaning guidance; an online clinical incident form via the Risk Management Portal must be completed stating the rationale for the move and IPCN's informed
- Fans should not be used and care should be taken when stripping beds to minimise environmental contamination from disturbed organisms
- Any hard copy charts should be kept outside of the side room.

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- Laptops on wheels (LOWs) must not be taken into isolation rooms.
- If used, hand held devices must be cleaned down on leaving the room
- Ensure HPV cleaning is undertaken to all side rooms that have had a patient with: **Confirmed Clostridium difficile toxin positive (C. Diff), Clostridium difficile toxin gene detected , Cabapenemase-Producing Enterobacteriaceae (CPE), Vamcomycin-Resistant Enterococci (VRE), Panton-Valentine Leukocidin (PVL) and MDR MRSA**

Also patients who have a history of C. Diff and/or gene detected and are symptomatic on current admission will require a discussion/risk assessment with an IPCN regarding appropriate cleaning.

Patient placement is an important factor in helping to reduce the risk of cross-infection. If a patient cannot be isolated, consideration should be given to where they are nursed within the ward area:

- Consider a bed space where there is least 'traffic' of other staff/patients. Point of care alcohol gel should be available at all times. This placement is not a substitute for a single side room, and should only be considered as a last resort
 - Contact Precautions sign should be displayed above the patient's bed
 - Other patients within the bay/immediate vicinity should not have wounds or indwelling devices
 - Adherence to hand hygiene and contact precautions must be maintained
 - Wound dressing changes for the patient should not be carried out during periods of high ward activity e.g. cleaning or bed-making
- Please liaise with the IPCT if clarification is required**

The IPCT is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation and assisting with risk assessment where complex decisions are required. The IPCT is also responsible for ensuring this policy remains consistent with the evidence-base for safe practice and for reviewing the policy on a regular basis.

10. Movement of patients

The transfer and movement of patients **should be kept to a minimum** to reduce the risk of infection spreading and should only be undertaken for clinical reasons. (DH 2011)

- If transfer to another ward, e.g. ICU or CCU becomes necessary, the receiving ward must be notified and the Patient Transfer Form (available in the clinical documents repository) must be completed
- If an investigation is necessary and cannot be performed on the ward, **the receiving area must be informed** so that appropriate infection control measures can be taken

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- Arrangements need to be made to minimise contact with other patients, therefore, the investigations for isolated patients should be performed 'last on the list' with the exception of blood borne viruses. When this cannot be achieved, there should be no delays encountered by waiting in the department
- Equipment used to transfer the patient and non-single use equipment used within the department must be **decontaminated** after use, in accordance with Trust policy (Section F: Decontamination and Disinfection Policy)
- Patients transferred to another ward should be provided with a clean bed on their arrival; their previous bed space and bed should be thoroughly cleaned as per the bed space cleaning guidelines and the green **I am clean** sticker placed in a conspicuous space until admission of a new patient
- Staff should ensure that the following assessments have been made regarding the patient prior to transfer to another ward or healthcare setting:
 - Urinary catheter bags should be no more than two thirds full and should be emptied before transfer
 - Wounds should be covered with an impermeable dressing and the wound checked for visible exudate
 - If patients are expectorating sputum, staff should ensure that clean tissues are provided when the patient is being transported
 - Patients with suspected or confirmed but untreated pulmonary TB should wear a theatre mask when being transported through public or patient areas

11. Statutory Notification

Notifiable diseases, including suspected food poisoning must be reported to the proper officer by completing the statutory notification form available in the Notifiable Diseases policy Section B of the Infection Prevention and Control Policies, Appendix 1 for Kirklees patients and Appendix 2 for Calderdale patients.

12. Psychological effects of isolation

Patients isolated in side-rooms may experience higher levels of anxiety and/or depression (Wilson, 2006). Staff should be sensitive to actions that increase anxiety, such as lack of communication, use of PPE or inconsistencies in care displayed amongst medical and nursing staff.

13. Trust Equalities Statement

Calderdale and Huddersfield NHS Foundation Trust aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over

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others. We therefore aim to ensure that in both employment and services no individual is discriminated against by reason of their gender, gender reassignment, race, disability, age, sexual orientation, religion or religious/philosophical belief, marital status or civil partnerships.

This policy has been through the Trust's EQUIP (Equality Impact Assessment Process) to assess the effects that it is likely to have on people from different protected groups, as defined in the Equality Act 2010.

14. Training and Implementation

All staff should understand how organisms spread in order to apply isolation procedures. Each staff member is accountable for his/her own practice and should always act in a way as to promote and safeguard the wellbeing and interest of patients. Training and information will be provided from a number of sources:

- Trust Induction
- Mandatory Training (E. Learning, Right from the Start and Beyond the Basics)
- Via Trust Intranet
- Ward/Department Managers
- Link practitioners
- Infection, Prevention and Control Team

15. Monitoring Compliance with Procedural Document

Compliance is audited on an annual basis by the IPCT with further audits on an ad-hoc basis. These are reported to the individual Wards, Ward Managers, Matrons and Divisions.

16. References and further reading

1. **Department of Health (2015)**. The Health and Social Care Act 2008: Code of Practice of the prevention and control of infections and related guidance
2. **Department of Health (2011)**. Isolating patients with healthcare associated infection; A summary of best practice.
3. **Hawker J et al (2012)**. Communicable Disease Control and Health Protection Handbook (3rd Edition) Wiley-Blackwell publishing Ltd. Chichester.
4. **Public Health England (2016)**. Infection control precautions to minimise transmission of Respiratory Tract Infections in healthcare settings. Version 2

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5. **Loveday HP et al (2103)** epic3: National Evidence-Based Guidelines for Preventing Healthcare-Associated Infections in NHS Hospitals in England. Journal of Hospital Infection 86S1 (2014) S1-S70
6. **Wilson J (2006)**. *Infection Control in Clinical Practice (3rd Edition)*. . Bailliere-Tindall

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APPENDIX 1

Guidance for prioritising Isolation Facilities for contact and respiratory precautions

If unable to isolate, escalate to the Site Commander and ensure that a clinical incident form is completed by ward / department staff.

Transfer only if there is a CLINICAL NEED and inform the IPCT and receiving area.

For individual patients who have a learning disability, dementia, mental health, delirium, additional physical or sensory needs they should be assessed individually in close conjunction with family and carers to ensure we meet their needs while providing the correct clinical environment to manage infection risks.

Status Red : Patients with these conditions (suspected or proven) MUST be in a single side room		
Diarrhoea – possible infectious cause	Diarrhoea Bristol stool chart type 5-7.	Side-room isolation Contact precautions
Clostridium difficile	Diarrhoea due to <i>C.difficile</i> (either confirmed or pending test results) C-diff gene detected	Side-room isolation within 2 hours Contact precautions
Chicken Pox	With blisters or weeping lesions	Side-room isolation within 15 minutes Respiratory & contact precautions
Shingles	With blisters or weeping lesions that cannot be covered	Side-room isolation Contact precautions
ESBL-producing micro-organisms	E.g. E-coli, <i>Klebsiella</i>	Side-room isolation Contact precautions
MRSA	MRSA infection or colonisation within the previous 3 years or longer if three clear screens not recorded	Side-room isolation Contact precautions
Multi-drug resistant GNB	Suspected or confirmed Carbapenemase-producing Enterobacteriaceae (CPE) Vancomycin Resistant Enterococci (VRE)	Side-room isolation Contact precautions Side-room isolation Contact precautions
Respiratory infections – see mask use guidelines for organism specific directions	Pulmonary TB suspected / confirmed and still infectious Influenza	Negative pressure isolation Respiratory precautions Side-room isolation Respiratory & contact precautions

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	Diphtheria – note lesions are a significant source of infection Respiratory Syncytial Virus (RSV) Whooping Cough (pertussis)	Side-room isolation Respiratory & contact precautions Side-room isolation Respiratory precautions Side-room isolation Respiratory precautions
Skin rashes	Rash of unknown origin Scabies (crusted variant) Suspected or known Measles, rubella,	Side-room isolation Contact precautions Side-room isolation Contact precautions Side-room isolation Respiratory & contact precautions
Travel related infection	Fever related to foreign travel Respiratory infection acquired abroad e.g. suspected/ confirmed MERS-CoV (Middle East Respiratory Syndrome – Coronavirus) Poliomyelitis Viral Haemorrhagic Fever (including Ebola)	Side-room isolation Respiratory & contact precautions Negative pressure isolation and enhanced Respiratory & contact precautions Admit to <u>designated</u> area as per policy / SOP (see CHFT intranet). enhanced Respiratory & contact precautions
Other infections	Meningococcal meningitis / septicaemia (Less than 48 hr antibiotics) Group A Streptococcal Infection (including non-respiratory sites and having had less than 48 hr of appropriate antibiotics) Toxin producing Staphylococcus aureus (e.g. Panton Valentine <u>Leukocidin</u> - PVL)	Side-room isolation Respiratory precautions Side-room isolation Contact precautions Side-room isolation Contact precautions

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Protective isolation	For the protection of patients with conditions such as neutropenia	Positive pressure isolation room
End of Life (dying phase)	For privacy and dignity to support patients and their families for a dignified death (unless the patients states they don't want to be isolated by a side room)	Side room
Dementia /Learning disability /Mental Health patients	Family and carers who are required/wish to stay to provide care and support with consideration to EMSA e.g. where the carer is the opposite sex to the patient. Patient who come into hospital with 1:1 or 2:1 as part of their package of care	Side room
Patient who present with challenging behaviour	For example patients with delirium, alcohol withdrawal etc. To maintain patient safety, safety of other patients and others. Support any specialised care pathways for example special needs dental pathway. Maintain privacy and dignity of the patient.	Side room
Patient requiring sensory support ie autism	Where noise and a busy surrounding cause sensory overload and a side room is required to reduce stress to the patient.	Side room
Patient is subject to Mental Health Act or police detention and requires constant supervision	Where the patient's level of need requires 1:1 monitoring as part of their treatment under Mental Health Act such as a suicide risk, or they are supported on the ward by a police officer and to minimise the distress to other patients. Ultimately ensuring patient confidentiality and privacy.	Side room
Status Amber: Patients with these conditions could be managed in main ward after discussion with IPCT		
Gastrointestinal Infections	Previous <i>C. difficile</i> / gene detected (GDH positive) – if the patient is asymptomatic Campylobacter	
Infectious diseases	Parvovirus	
Respiratory infections	Pulmonary TB (not MDRTB), responding to treatment after 2 weeks treatment	
Status Green	Patient with other infections do not require a side room	

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Signs	The appropriate sign should be placed prominently on the door of the patient's single room, or above the patient's bed if they are being nursed on the main ward. See appendices for signage
Door	The door of the side-room should be kept closed at all times. Where this is considered a hazard i.e. falls risk, this should be discussed with the IPCT and rationale clearly documented in the patients records
Hand hygiene	Hands must be decontaminated before entering and prior to leaving the room regardless of glove use. Hands may be decontaminated by washing with soap and water or applying alcohol gel if hands are visibly clean. Hands must be washed with soap and water in cases of <i>Clostridium difficile</i> or viral gastroenteritis. All staff must be bare below the elbow.
Aprons and gloves	Disposable plastic aprons and gloves must be worn by staff for direct contact with patients, their environment, used bed linen, and when handling blood and body fluids. Plastic aprons and gloves are disposed of in the room , unless removing items to the sluice. NB: the use of gloves does not replace the need to decontaminate hands. Hands should be decontaminated before and after wearing disposable gloves.
Masks and / or eye protection	These are not usually necessary, but should be worn during procedures with a high risk body fluids splash/spray which might contaminate eyes or mucous membranes, e.g. during suctioning procedures or the patient receiving chest physiotherapy.
Equipment	It is recommended that equipment should be single-use or designated for an individual patient. Where equipment is not single use or designated to a specific patient, it should be decontaminated with a chlorine releasing agent i.e. Tristel following use. If contaminated with blood or body fluids, please refer to Section C of the Infection Control Manual. Fans should not be used to control the patient's temperature.
Linen	All linen should be treated as infected linen, sealed in a red water-soluble bag within the room and removed to the sluice before being sent to Laundry.
Secretions, excretions	These are treated as infected waste and disposed of in accordance with the waste disposal policy, Section V, Infection Control Manual.
Crockery and cutlery	The use of disposable items is not usually necessary. If in doubt, please discuss with the IPCT.
Notes and charts	Any hard copy documentation is should outside the room / bay / area.
EPR laptop on wheels	The LOW is not to be taken into an isolation room.
Waste	Waste generated from an infected / colonised patient should be disposed of as infected waste
Terminal cleaning	The level of clean required is outlined on the cleaning on discharge poster. Under all circumstances a thorough clean is required of all surfaces of the room / bed area, mattress, bed frame, call bells, duvets and pillows, with a Chlorine releasing agent e.g. Tristel solution, as outlined in the bed space cleaning guidance And where applicable followed by an HPV clean. Care must be taken when cleaning electrical equipment. Curtains should be changed; this includes those curtains in the side room and any bed space curtains if the patient was cohorted in a bay.

Contact Precautions

To help us prevent the spread of infection if entering this room **you must:**



Be 'bare below the elbow'



Clean your hands



Wear gloves*



Wear an apron*



Cover any cuts and lesions with a waterproof dressing



Keep the door closed

***These precautions apply when contact with the patient or patient's environment is anticipated**

***Visitors do not routinely need to wear gloves and an apron but must wash hands on entering and leaving room**

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Sign	The appropriate sign should be placed prominently on the door of the patient's single room.
Door	The door of the side-room must be kept closed at all times. Where isolation is considered a hazard to the patient, appropriate safety measures must be instigated and the risk documented in the patients record.
Hand hygiene	Hands must be decontaminated before entering and prior to leaving the room regardless of glove use. Hands may be decontaminated by washing with soap and water or applying alcohol gel if hands are visibly clean. All staff must be bare below the elbow.
Aprons and gloves	Disposable plastic aprons and gloves must be worn by staff for direct contact with patients, their environment, used bed linen, and when handling blood and body fluids. Plastic aprons and gloves are disposed of in the room , unless removing items to the sluice. NB: the use of gloves does not replace the need to decontaminate hands. Hands should be decontaminated before and after wearing disposable gloves.
Masks and/or eye protection (excluding Pulmonary TB)	For respiratory infections respiratory protection is to be worn appropriate to the infection in question. Refer to the Guidance on the use of respiratory and facial protection and mask guidance. For all respiratory infections requiring mask use in the room, the mask is removed only AFTER leaving the room. ,
Masks (this section applies only to pulmonary tuberculosis)	For the patient: patients should be instructed to cover their mouth and nose when coughing and sneezing and provided with disposable tissues. Tissues are to be disposed of into the infected waste bin. All smear-positive patients should wear a surgical mask if being transported through public or patient areas of the hospital. For staff: masks are only required when there is unavoidable exposure to respiratory secretions, e.g. during cough-inducing procedures, bronchoscopy or prolonged care of a high-dependency patient or the patient has known or suspected multi-drug resistant TB. The required mask is an FFP3 mask or powered hood. Refer to the mask guidelines for further details and the TB Policy (Section S, Infection Control Manual).
Secretions, excretions	These are treated as infected waste and disposed of in accordance with the waste disposal policy, Section V, Infection Control Manual.
Crockery and cutlery	The use of disposable items is not usually necessary. If in doubt, please discuss with the IPCT.
Notes and charts	Any hard copy documentation is should outside the room / bay / area.
EPR laptop on wheels (LOW)	The LOW is not to be taken into the isolation room.
Waste	Waste generated from an infected / colonised patient should be disposed of as infected waste
Terminal cleaning	The level of clean required is outlined on the cleaning on discharge poster. Under all circumstances a thorough clean is required of all surfaces of the room / bed area, mattress, bed frame, call bells, duvets and pillows, with a Chlorine releasing agent e.g. Tristel solution, as outlined in the bed space cleaning guidance And where applicable followed by an HPV clean. Care must be taken when cleaning electrical equipment. Curtains should be changed; this includes those curtains in the side room and any bed space curtains if the patient was cohorted in a bay.

Respiratory Precautions

To help us prevent the spread of infection if entering this room **you must:**



Be 'bare below the elbow'



Clean your hands



Wear gloves*



Wear an apron*



Appropriate masks to be worn*
- If unsure please speak to the nurse in charge



Cover any cuts and lesions with a waterproof dressing



Keep the door closed

*These precautions apply when contact with the patient or patient's environment is anticipated

UNIQUE IDENTIFIER NO: C-13-2008**Review Date: March 2018****Review Lead: Lead Infection, Prevention and Control Nurse****Measures used in protective isolation**

Sign	The appropriate sign should be placed prominently on the door of the patient's single room.
Door of positive pressure isolation room	The door to the side-room should be kept closed at all times. Positive pressure systems will only work where this is maintained.
Hand hygiene	Hands must be decontaminated before entering and prior to leaving the room regardless of glove use. Hands may be decontaminated by washing with soap and water or applying alcohol gel if hands are visibly clean. All staff must be bare below the elbow.
Plastic aprons and gloves	Disposable plastic aprons and gloves must be worn by staff for direct contact with patients, their environment, used bed linen, and when handling blood and body fluids. Plastic aprons and gloves are disposed of in the room , unless removing items to the sluice. NB: the use of gloves does not replace the need to decontaminate hands. Hands should be decontaminated before and after wearing disposable gloves.
Single Room / Positive pressure room	A single room is required for neutropaenic patients (neutropaenia refers to a neutrophil count of <0.5). A room with positive pressure ventilation is advised, providing that the patient does not have any evidence of transmissible infection such as MRSA or pulmonary TB. See the rooms chart for location of positive pressure room facilities and for procedure for change of pressure.
Plants and flowers	These are not be allowed in the room as they may be a source of <i>Aspergillus spp</i> or other fungal spores. Cut flowers can also provide a reservoir for gram-negative organisms.
Electric fans	These are not allowed in the room, as the grills trap dust, providing a potential reservoir for micro-organisms.
Visitors	Relatives, visitors and staff who are suffering from an infection or have been in recent contact with infection should avoid entering the room. During the neutropaenic phase, visitors should be limited to two people. There should not be more than four people in the single room at one time.
Environmental cleaning	The room requires a thorough daily clean using hot water and detergent, using dedicated cleaning equipment that is not used elsewhere, including high-level damp dusting.
Linen	No special requirements Bed linen should be changed daily and curtains monthly.
Diet	Neutropaenic patients should receive sterile or filtered drinking water (PAL filters available on ward 12, HRI). Ice should be obtained from sterile water sachets, as tap water and ice machines can be contaminated with micro-organisms. The patient should receive a clean diet that is cooked / provided in the hospital, to protect from food-borne organisms. Food not cooked in the hospital should be avoided.
Personal hygiene - patient	A high level of personal hygiene should be maintained. Patients should use wipes provided by the hospital to wash with and discard after each use. If face cloths are used, they should be sent home to be laundered daily. Toilet facilities should be kept clean.
Waste disposal	There are no special requirements for waste disposal (see Waste Policy, Section U/V).

Protective Isolation

To help protect this patient from infection
if entering this room **you must:**



Be 'bare below the elbow'



Clean your hands



Wear gloves*



Wear an apron*



**Cover any cuts and lesions
with a waterproof dressing**



Keep the door closed

***These precautions apply when contact with the
patient or patient's environment is anticipated**

***Visitors do not routinely need to wear gloves and an apron
but must wash hands on entering and leaving room**

UNIQUE IDENTIFIER NO: C-13-2008

Review Date: March 2018

Review Lead: Lead Infection, Prevention and Control Nurse

APPENDIX 3

Pressure Room Availability at CRH

Ward 1 - 1D – Room G-074 SR 4 available

Ward 2 - 2C – Room 1-073 unavailable as used as an assessment room

2D – Room 1-072 available

Ward 3 3C – Room 005 No pressure gauge outside the side room

Ward 4 - 4C – Room 3-071, 3-075 unavailable as both used as examination rooms

4D – Room 3-094 currently open as medical otherwise unavailable

Ward 5 - 5C – Rooms G-068, G-054, G-072, G-058 all available

5D – Rooms G-073, G-069 both unavailable as the ward is closed

Ward 6 - 6C – Room 1-074 SR 4 available

6D – Room 1-075 SR 1 unavailable as the ward is closed

Ward 7 - 7C – Room 2-072 SR 1 available

7D – Room 2-073 SR 4 available

Ward 8 - 8C – Room 3-074 SR 4 available

8D – Room 3-073 SR 1 available

SCBU - Rooms 015, 016 available if required

ICU/HDU - Rooms 006, 013, 015, 025 only 2 pressure rooms available

CCU - Room CC-013 SR 1 available

PROCEDURE FOR CHANGE FROM NEGATIVE TO POSITIVE PRESSURE (NB. All pressure rooms are set centrally to negative pressure)

MONDAY - FRIDAY 8am - 5pm

- Clinical Lead to contact Infection Control Nurse with request
- Infection Control Nurse to contact Engie Help Desk on Ext: 4634 to request change in pressure AND complete form for switch to take place
- Engie personnel to complete form
- Switch to be completed and checks made to ensure pressure change

Out of hours (MONDAY - FRIDAY 5pm - 8am and WEEKENDS/BHs)

- Clinical Lead to contact ISS Duty Manager
- ISS Duty Manager to contact Infection Control Nurse on Call
- ISS Duty Manager to commence completion of form for switch to take place
- Infection Control Nurse to authorise Matron on Call or Site Co-Ordinator to sign form
- ISS Duty Manager to contact Engie on Call
- Engie on Call to complete form
- Switch to be completed and checks made to ensure pressure change

NB: please ensure that a form is completed for the return of a room to negative pressure when positive pressure is no longer required e.g. on discharge of patient or transfer to another area

All forms to be retained in file at main reception

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Review Lead: Lead Infection, Prevention and Control Nurse

SWITCH +/- PRESSURE

Room Number: Ward:

Date:

Requested By (Clinical Lead) Name:

Title:

Authorised By Infection Control Nurse (Mon – Fri 8am - 5pm)
Or Duty Matron or Site Coordinator (5pm - 8am Mon – Fri and Weekends)

Name: Signature:

Title:

Tick Relevant Box

Switch from + to -

Switch from - to +

Concept Task Number:

Carried out by

Name: Signature:

Date: Time:

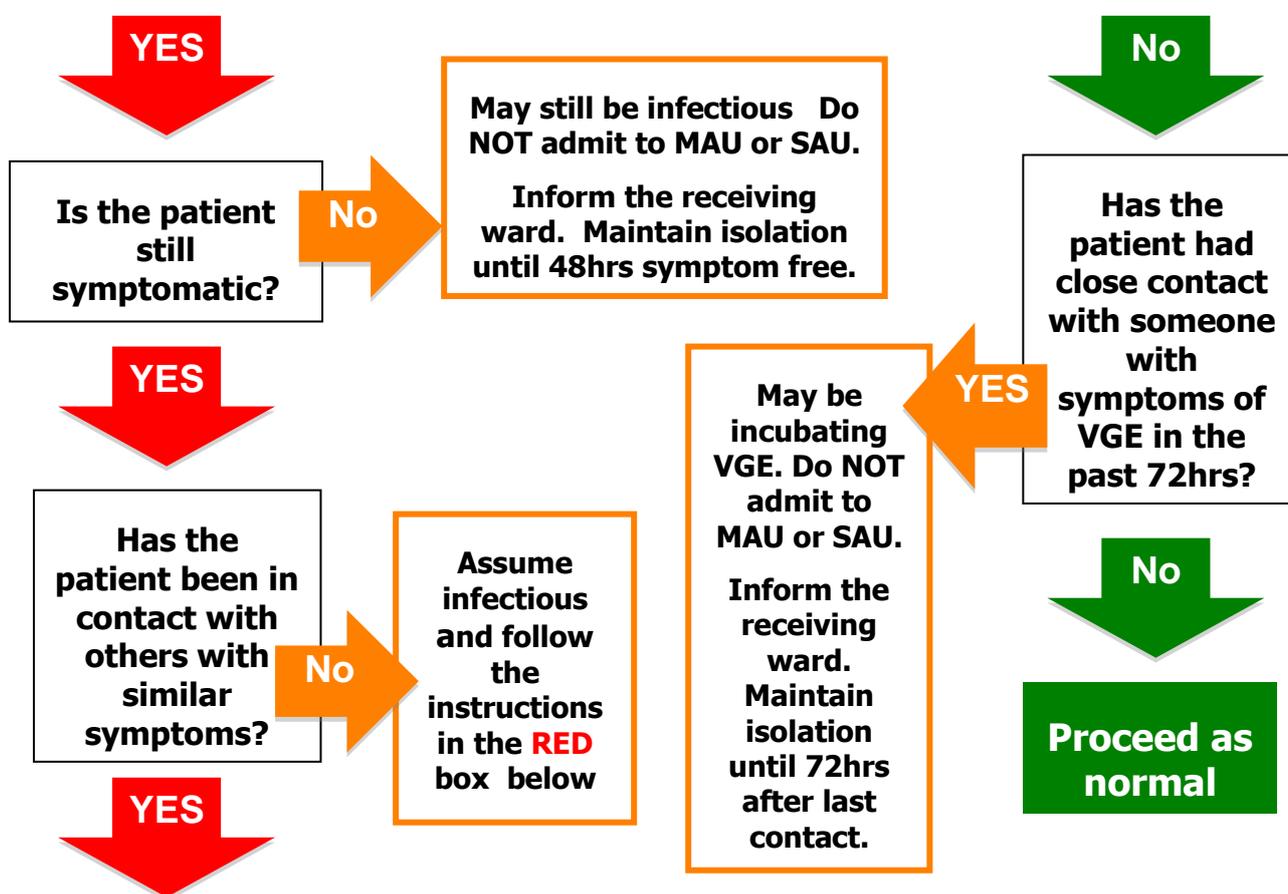
Confirmation of Pressure status:

Viral Gastroenteritis (VGE) screening tool Risk Assessment for admission to Hospital

Use this tool to assess anyone being admitted to hospital to minimise the risk of cross-infection and service disruption. Document response in the IPC assessment tool in EPR and actions to take in general documentation.

ASK THE PATIENT/CARER ON ASSESSMENT IN A&E OR GP PRIOR TO ADMISSION TO MAU OR SAU.

**Is there a history of one or more of the following VGE symptoms:
Diarrhoea, vomiting & abdominal cramps now or in the last 48hrs?**



Probable VGE.

Do NOT admit to MAU or SAU

Inform the receiving ward and implement:

- ✓ Isolation – ideally ensue, following contact precautions
- ✓ Stool Specimen
- ✓ Stool/fluid balance Chart
- ✓ Notify the IPCT