The policies and procedures page of Healthnet holds the most recent and approved version of this guidance. Staff must ensure they are using the most recent guidance.

Authors/Editor       Nurse Consultant
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## Document Review History

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Policy for the admission, transfer & discharge of the infected patient.

1. Introduction

Summary

- Good communication and close working between the Operational Team and the Infection Prevention and Control Team (IPCT) is essential for the safe management of patients.

- Prior to admission (whenever possible), and on transfer and discharge, patients should undergo a risk assessment of the presence of infection and the potential for cross-infection.

- Patients known or suspected to have an infectious disease should be placed in isolation when such facilities exist and if safe to do so.

- In the event of insufficient isolation facilities being available, a risk assessment, based on the severity of the disease and the potential for cross-infection, should be performed by the Ward Manager and IPCT.

- Vital and urgent treatments will not be affected by infection status – the individual’s urgent clinical needs will supersede all other considerations.

- Transfer of infectious patients should be avoided if at all possible.

- Ward staff must ensure that on transfer or discharge, all relevant staff involved in the patient’s onward care are aware of the patient's infection status and that it is clearly documented on the discharge summary (e.g. General Practitioners, District Nurses, Residential/Nursing Home staff) and they should recommend follow-up treatment as appropriate.

- The management of an outbreak will usually involve closure or restriction of a clinical area.

2. Purpose

This policy aims to:

1. Provide guidance on the operational management of patients known or suspected to have an infection.
2. Minimise the risk of cross-infection between hospital inpatients.
3. Duties

This Policy relies heavily on staff taking responsibility for infection prevention and control. The responsibilities necessary for the management and control of infection are outlined below.

3.1 The Chief Executive is ultimately responsible for infection prevention and control and the content of all Policies and their implementation. The Chief Executive delegates the day to day responsibility of implementation of the policies to the Director of Infection Prevention and Control (DIPC) and the Infection Prevention and Control team (IPCT).

3.2 Infection Prevention and Control Team

The Infection Prevention and Control Team (IPCT) is responsible for delivering, managing and developing Plymouth Community Healthcare (PCH) infection prevention and control service. The IPCT comprises of the Director of Infection Prevention and Control, Consultant nurses Infection Prevention and Control, Sister Infection Prevention and Control, Infection Control staff nurse and an administrator. This is a nurse led service with an SLA from the local infection control doctor for advice. The IPCT will:

- Assist ward staff in patient risk assessment for the use of standard isolation or contact precautions
- Advise the Senior Management team, DIPC and clinical staff on the management of outbreaks of infection.

3.3 Directors are responsible for identifying, producing and implementing Plymouth NHS Policies relevant to their area.

3.4 The Assistant Directors will support and enable operational Clinical Leads and Managers to fulfil their responsibilities and ensure the effective implementation of this Policy within their speciality.

3.5 The Modern Matron, Community Matron/ Clinical lead is responsible for ensuring that the development of local procedures / documentation doesn’t duplicate work and that implementation is achievable. Obtain advice from the IPCT for the management of patients with a known or suspected infection. This particularly relates to the admission, transfer and discharge of such patients.

- Obtain advice from the IPCT for the management of outbreaks of infection.
• Inform the IPCT of any operational issues that may have implications for the prevention and control of infection.

• Obtain advice from the IPCT on the redirecting of admissions in the event of ward closure.

• Prior to admission (whenever possible), and on transfer and discharge, patients should undergo a risk assessment of the presence of infection and the potential for cross-infection. This ensures where possible that the appropriate facilities are found and made ready.

3.6 The Doctor in Charge of Patient

• Medical staff responsible for the admission of patients should check all admissions for Clinical Alerts on the patient’s notes and electronic record (IPMS alert triangle) for evidence of previous colonisation with, for example, MRSA, C. difficile or multi-resistant coliforms (e.g. ESBL-producing coliforms). If these are present, a risk assessment for standard isolation precautions should be performed and the IPCT contacted.

• When patients are admitted from domiciliary care including own homes-GPs will not have access to the clinical alert. Inpatient Doctors may not be involved in the admission process at the point of making decisions about admission. Where the responsibility for admissions has been devolved to another Healthcare practitioner, that person carries the same duty to check a patient’s history as detailed above.

• Assist the Ward Manager in assessing the risk the patient poses to others and isolate as appropriate.

• Inform relevant MDT staff of the colonisation status.

Prior to transfer of a colonised/infected patient to another hospital, notify the receiving clinician and IPCT at the receiving hospital.

• On transfer back to primary care inform the patient’s General Practitioner of the patient’s infectious status and advise on further management and document in the discharge summary.

3.7 Responsibilities of Ward/Unit Manager

The ward/Unit manager is responsible for ensuring that all members of staff, patients and visitors adhere to good infection control procedures and as such should:

Policy for the admission, transfer & discharge of the infected patient
• Ensure staff check all admissions for Clinical Alerts on the patient’s notes and electronic record (PiMS alert triangle) for evidence of previous colonisation with, for example, MRSA, *C. difficile* or multi-resistant coliforms (e.g. ESBL-producing coliforms). If these are present, a risk assessment for standard isolation precautions should be performed and the IPCT contacted.

• Inform relevant hospital staff of the colonisation status

• Perform a risk assessment for the presence of infections, particularly MRSA, and diarrhoea and/or vomiting

• ensure staff adhere to admission, transfer and discharge protocols

• communicate the infectious status of individual patients on discharge to district nursing, community hospital nursing or nursing home team as appropriate in the discharge summary

• after transfer or discharge of an infected/colonised patient, arrange for the immediate patient environment to be thoroughly cleaned according to the Disinfection and Cleaning Policy.

3.8 **All Staff both clinical and non clinical** must possess an appropriate awareness of their role in the prevention and containment of infection in their area of work. All staff are expected to fully comply with this policy, as well as all NHS Infection Prevention and Control Policies. All staff are also expected to be aware of their duties in ensuring PCH complies with the Code of Practice for the Control and Prevention of Healthcare Associated Infections. A high standard of infection prevention and control must be an integral part of the practice of all staff working in a clinical setting.

Control of infection depends on all staff accepting responsibility for maintaining a high standard of infection control in their practices and reminding others of their responsibilities. These are as follows:

• All staff should be familiar with the practices referred to in this and other infection prevention and control policies, including standard isolation procedures

• Staff responsible for the admission of patients should check the Clinical Alerts on the patient’s notes and electronic record (PiMS alert triangle) for evidence of previous colonisation with, for example, MRSA, *C. difficile* or multi-resistant coliforms (e.g. ESBL-producing coliforms). If these are present, a risk assessment for standard isolation precaution should be performed and the IPCT contacted

• Staff responsible for the admission of patients should perform a risk assessment for the presence of infections.
4. **Admissions, Discharges and Transfer of Colonised/Infected Patients**

**Background**

The source isolation of patients known or suspected to have an infectious disease is important in reducing the risk of transmission of Healthcare Associated Infection. However the patients safety must be taken into account and following a risk assessment and discussion with the IPCT. Minimising the movements of patients is also important to prevent the spread of infection to secondary areas. These considerations have to be balanced against the clinical needs of an individual patient and the operational running of the hospital.

In order to minimise the risk of the spread of infection, the following processes should be undertaken:

a) Prior to admission, and on transfer and discharge, patients should undergo a risk assessment for the presence of infection and the potential for cross-infection, using the risk assessment which is described in the Guidelines for the Management of the Infected Patient in Hospital. Supplementary screening questions for admitted patients are given in Appendix A

b) Patients known or suspected to have an infectious disease should be placed in isolation (preferably a single room with a door which is kept closed) when such facilities exist and only if it is safe to do so

c) In the event of insufficient isolation facilities being available, a risk assessment, based on the severity of the disease and the potential for cross-infection, should be performed by the Ward Manager and IPCT.

d) The management of an outbreak will usually involve closure or restriction of a clinical area.

More detailed guidance on the operational management of patients with specific infections can be found in the following guidelines:

a) Management and Control of Multi-Resistant *Staphylococcus aureus* (MRSA)

b) The Management and Control of PVL-Associated Staphylococcal infections

c) *Clostridium difficile* Guidelines

d) The Management and Control of Glycopeptide-Resistant Enterococci

e) The Management and Control of Resistant Gram-Negative Bacteria

f) Guidelines for the Management of Seasonal Influenza

g) Control of Tuberculosis

h) Management of Diarrhoea and Vomiting in a Clinical Area

i) Guidelines for the Management of the Infected Patient in Hospital
Good communication and close working between the Operational Team and the IPCT is essential for the safe management of patients. The IPCT will inform the Director of Infection Prevention and Control (DIPC) and Senior management team and partner organisations in the event of an outbreak and ward closure. This will be reviewed on a daily basis with an update being emailed every day. The IPCT will convene an outbreak meeting to ensure steps are taken to ensure the ward can be fully operational as soon as possible.

4.1. Admission of Colonised/Infected Patients

- Patients should undergo a risk assessment of the presence of infection and potential for cross-infection this should be performed by the Ward Manager with assistance from the IPCT.

- Where there is an increased risk of transmission, source isolation in a side room is required when such facilities exist and if it is safe to do so.

- In the event of insufficient isolation facilities being available, a risk assessment, based on the severity of the disease and the potential for cross-infection, should be performed by the Ward Manager and IPCT. The outcome of the risk assessment and recommendations should be recorded in the patient's record.

4.2. Transfer and Movement of Colonised/Infected Patients within the Hospital

- Transfer or movement of infectious patients should be avoided if at all possible.

- There should be clear communication between departments about the patient’s infection status and transfer should only proceed when the receiving area are fully prepared.

- Infected/colonised patients are usually able to attend clinical service departments for necessary investigations or treatments. Contact the IPCT if further advice is required.

- Within the hospital, a nurse should accompany the patient if there is a cross-infection risk. The receiving department should be advised of necessary precautions in advance.

- Measures to reduce the risk of transmission should be taken. The colonised patient should be last on any list, avoid excessive waiting in the Department and surfaces exposed to the patient or their potentially contaminated secretions should be decontaminated according to the Disinfection and Cleaning Policy.
• Clinical areas such as Physiotherapy, Occupational Therapy, Radiology and Theatres should have their own local protocols for managing infected patients.

4.3. Transfer of Colonised/Infected Patients to another Hospital or Long-Term Care Facility

• It is the responsibility of the ward manager or senior discharging clinician to inform the receiving ward’s or care facility’s nursing and ambulance staff of the patient’s infection status and the medical staff to inform the receiving doctors or General Practitioner and should be clearly documented on the discharge summary.

• The ambulance service should be notified by the ward staff of any necessary precautions when booking transport.

• If discharged to a nursing/residential home, the home’s senior nursing staff should be made aware of the infection status by the ward manager and it should be documented on the discharge summary. Rarely should this hamper patient discharge.

• For certain infections, the IPCT will communicate with their colleagues at the receiving hospital, to ensure continuity of infection control precautions.

4.4. Discharge of Colonised/Infected Patients

• Ward staff must ensure that on discharge, all relevant staff are aware of the patient's infection status (e.g. General Practitioners, District Nurses, Residential/Nursing Home staff) and should recommend follow-up treatment as appropriate. This should be based on advice received from the IPCT.

• Reference to the patient’s infection status must be made in the discharge notes/letter by the doctor in charge of the patient.

• After transfer or discharge of an infected/colonised patient, the immediate patient environment should be thoroughly cleaned according to the Disinfection and Cleaning Guidelines. Information on the requirements for specific individual infections can be found in the relevant policy. There should be a special emphasis on cleaning ‘patient-touch’ surfaces.

4.5 Isolation Facilities

Patients known or suspected to have an infectious disease should be placed in isolation when such facilities exist. A list of infectious conditions that should be managed is isolation is given in Appendix C. In the event of insufficient isolation
facilities being available, a risk assessment, based on the severity of the disease and the potential for cross-infection, should be performed by the Ward Manager and IPCT. This will determine optimal utilisation of such facilities and will also reduce the risk associated with managing infectious patients for whom isolation is not possible. In certain circumstances, patients with an infectious disease of the same aetiology may be grouped together and nursed as a cohort.

Discontinuation of isolation should occur on the advice of the IPCT

Further details on patient isolation can be found in the Management of the Infected Patient in Hospital Policy.

4.6 Closure of Clinical Areas

During an outbreak, a ward or bay may be closed to admissions and discharges. The criteria for closure will vary with nature of the infectious agent and this decision will be based on a risk assessment by the IPCT. Further guidance is given in policies for the management of individual infections. Ward closure does not mean the ward will be vacated. In cases where it is unclear whether there is an outbreak, patients may still be admitted (i.e. the ward or bay is ‘restricted’). In the event of a ward being closed or restricted, all discharges to external agencies should be suspended. Patients can still be discharged to their own home. On closure of the ward, the IPCT will call an outbreak meeting which should be attended by relevant ward, medical, operational and domestic staff. Appropriate control measures will be recommended at this meeting and a report produced and disseminated. Staff will be alerted of any closures/restrictions via an email. The DIPC and IPCT will be aware of any outbreaks and will inform and advise the Senior managers as necessary. Once a ward has been re-opened, it remains good practice to ensure that any receiving unit is informed that the discharging ward has been closed and that they may consider isolating the asymptomatic patient on transfer.

Although the movement of patients from a closed ward should be restricted, this should not delay essential clinical investigations or procedures. In such cases, a risk assessment should be performed and the IPCT are available to assist with this process.

The admission of patients to a closed ward can never be recommended and should only be considered when, on the balance of risks, not admitting is likely to cause more distress and harm to the patient than admitting. All other reasonable alternative solutions must have been exhausted. Information for on-call managers and nurse managers admitting patients into a ward closed due to gastroenteritis is given in Appendix E.

On re-opening of the clinical area, cleaning and decontamination of the environment and equipment should be performed as described in the Disinfection and Cleaning Policy.
4.7. Staff

Certain infectious conditions, even with proper precautions, pose a significant risk to staff. In addition, staff may also be responsible for the transmission of disease. In the event of an outbreak, restrictions on staff movement may be recommended. Staff working on affected wards should be restricted to that ward for the duration of the outbreak. Other staff, including Doctors, Physiotherapists, Occupational Therapists, Radiographers and Social Workers, can continue to work on both affected and unaffected wards. However, affected wards should be visited last whenever possible. Under these circumstances, meticulous hand hygiene, including the use of alcohol gel on entering and leaving clinical areas, and the correct use of protective personal equipment are particularly important.

4.8 Community Staff

Community staff should if possible visit known clients with infections last on their list. When the IPCT are advised of an outbreak in a care home colleagues who are community based are informed via an email. If a care home is closed with, for example, viral gastroenteritis then community staff should only visit if absolutely necessary and make it their last visit of the day.

Staff with symptoms of gastroenteritis should inform their line manager immediately and then leave work. They should be issued with a specimen pot and yellow request form in order that they can submit a stool specimen. The form should clearly indicate where they work in the hospital and may be submitted to Microbiology either directly or via their General Practitioner. Staff should not return to work until 48 hours free of symptoms.

If agency staff are used, they will need to be offered 2-3 days of work, as they will be unable to work elsewhere in the hospital for 48 hours following their contact with the ward during the outbreak.

5 Education

- Corporate induction programme for all staff must include local guidance on infection control, particularly hand hygiene and standard infection control precautions.

- Infection control must be considered part of the professional development for all staff. It should also be included in appraisal and Mandatory update training for all staff.
• Further training on the Admission, transfer and discharge of patients will be provide at the Infection Prevention and Control Liaison Practitioners meetings and as when required in clinical areas.

6 Monitoring Compliance and Effectiveness

Compliance with this policy will be monitored by the IPCT in their audit cycle which has been agreed by the Infection Control Sub Committee for PCH.

• The infection prevention and control team produce an annual audit plan for the provider services at PCH.
• It is the responsibility of the nurse consultants to ensure audits are carried out professionally and any deficits highlighted to the ward manager or the designated manager at the time of the audit. All ward managers, matrons will be sent a report within 48 hours and have a two week period to respond.
• The IPCT will use the Infection Control Nurse Community audit tool on the management of the infected patient and isolation policy
• The frequency of audit for the policy will be annually unless an area fails to meet the standard and requires additional support.
• If the standard fails to be met then the manager will be required to produce an action plan, a subsequent audit will be carried out both by the Infection Prevention and Control team and the manager of the unit within 3 months.

7 Associated Documentation

NHS LA 1.2.8 & 2.2.8
CQC Essential Standards of Quality & Safety
The Hygiene Code

8. References

Appendix A - Risk Assessment for Admitted Patients

To allow correct and appropriate isolation, a risk assessment should be performed on all patients. Supplementary questions for patients admitted to PCH include:

**Viral gastroenteritis (usually norovirus)**

Has the patient had any nausea in the last 48 hours?
Has the patient vomited in the last 48 hours?
Has the patient had any diarrhoea in the last 48 hours?
Have any family members had any nausea in the last 48 hours?
Have any family members vomited in the last 48 hours?
Have any family members had any diarrhoea in the last 48 hours?

If the answer is ‘Yes’ to any of these questions, consider admission directly into an isolation room or cohort area. Contact the IPCT if further advice is needed.

**Meticillin-resistant *Staphylococcus aureus***

Is the patient previously known to be colonised with MRSA?
Is the patient being admitted from another hospital or other healthcare facility?
Is the patient being admitted from a residential home?
Has the patient been an inpatient in a hospital or other healthcare facility during the last 3 months?

If the answer is ‘Yes’ to any of these questions, perform a MRSA screen according to the Policy for the ‘Management and Control of MRSA’. All patients at risk of MRSA should be considered for isolation, especially the following:

- Patients with MRSA infected wounds, especially if extensive and suppurating
- Patients with MRSA pneumonia
- MRSA-colonised patients with exfoliative skin disorders (e.g. eczema and psoriasis).

Contact the IPCT if further advice is needed.
Appendix B - Isolation Requirements for Common Conditions

This is based on CDC guidelines: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html.

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<th>Duration of isolation</th>
<th>Route of spread</th>
<th>Required Isolation</th>
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<tr>
<td>Major undressed or draining abscess; uncontrolled skin and soft tissue infection; impetigo</td>
<td>Duration of illness or until abscess or wound can be covered/dressed</td>
<td>Contact</td>
<td>Standard</td>
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<td>Adenovirus pneumonia or conjunctivitis</td>
<td>Duration of illness</td>
<td>Contact</td>
<td>Standard</td>
</tr>
<tr>
<td>Anthrax (cutaneous &amp; pulmonary)</td>
<td>Duration of illness</td>
<td>Contact</td>
<td>Standard</td>
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<td>Chickenpox 1-3</td>
<td>Until all vesicles have crusted over</td>
<td>Contact/airborne</td>
<td>Standard (Strict if pneumonia or ward with vulnerable individuals)</td>
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<td>Diarrhoea of unknown origin 4</td>
<td>Duration of diarrhoea</td>
<td>Faecal-oral</td>
<td>Standard</td>
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<td>Gastroenteritis 4 including <em>Clostridium difficile</em>, Salmonella, Shigella, Cholera, Campylobacter, norovirus, Rotavirus</td>
<td>48 hrs after symptoms cease</td>
<td>Faecal-oral</td>
<td>Standard</td>
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<tr>
<td>Enterotoxigenic <em>Escherichia coli</em> (e.g. 0157)</td>
<td>Contact IPCT</td>
<td>Faecal-oral</td>
<td>Standard</td>
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<tr>
<td>Enterovirus infection</td>
<td>Duration of illness (children &amp; incontinent adults only)</td>
<td>Faecal-oral</td>
<td>Standard</td>
</tr>
<tr>
<td>Hepatitis A</td>
<td>Until jaundice develops and is continent</td>
<td>Faecal-oral</td>
<td>Standard</td>
</tr>
<tr>
<td>Herpes simplex</td>
<td>Duration of illness</td>
<td>Contact</td>
<td>Standard</td>
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<td>Neonatal and</td>
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<td>Diagnosis</td>
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<td>Route of spread</td>
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<td>Influenza</td>
<td>Duration of illness (Do not confuse primary influenza and secondary bacterial pneumonia. Usually non-infectious by day 7 after onset of ‘flu symptoms)</td>
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<td>Respiratory</td>
<td>Standard/Strict (Depends on the age and health of local contacts)</td>
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<td>Meningococcal infection</td>
<td>First 24 hours after starting treatment</td>
<td>Respiratory</td>
<td>Standard</td>
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<td>Multi-resistant bacteria (including MRSA) and PVL-producing staphylococci</td>
<td>As per specific policy</td>
<td>Contact</td>
<td>Standard</td>
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<td>Mumps¹</td>
<td>2 days before to 5 days after parotitis appears</td>
<td>Respiratory</td>
<td>Standard/Strict (Depends on the age and health of local contacts)</td>
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<td>Parainfluenza</td>
<td>Duration of illness</td>
<td>Respiratory</td>
<td>Standard</td>
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<td>Parvovirus induced aplastic anaemia</td>
<td>First 7 days of transient aplastic crisis. Duration of hospitalisation in the chronically infected</td>
<td>Respiratory</td>
<td>Standard</td>
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<td>Duration of illness</td>
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<tr>
<td>Rubella¹,²</td>
<td>7 days before to 10 days after</td>
<td>Respiratory</td>
<td>Standard/Strict (Depends on the age)</td>
</tr>
</tbody>
</table>
Policy for the admission, transfer & discharge of the infected patient

<table>
<thead>
<tr>
<th>Condition</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scabies (except encrusted scabies)</td>
<td>Encrusted (‘Norwegian’) scabies is heavily encrusted disease associated</td>
</tr>
</tbody>
</table>

1. Exclude non-immune staff. A list of staff and their immune status to these viruses should be kept on paediatric, maternity, oncology and infectious diseases wards.
2. Potential risk to pregnant staff and visitors
3. Give hyper-immune globulin (ZIG) to non-immune, immunosuppressed and pregnant patients. Potentially non-immune staff should not attend patients. If they do, they should not attend susceptible patients between 8 and 21 days after their initial contact (as they may themselves be infectious).
4. Clean surfaces with standard hypochlorite (1,000 ppm available chlorine) or use steam cleaner if due to viral gastroenteritis.
<table>
<thead>
<tr>
<th>Meningitis (other than meningococcal)</th>
<th>with a particularly high mite load. For meningococcal disease, the patient can be considered non-infectious once that 24 hours of treatment has been given.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legionnaires disease</td>
<td>There is no person-to-person transmission.</td>
</tr>
<tr>
<td>Recurrent cutaneous herpes simplex</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C - Considerations When Risk Assessing who to Isolate

To allow correct and appropriate isolation, a risk assessment Isolation Priority System should be performed on all patients. If further advice is required, contact the IPCT.

1. Route of admission
Airborne and droplet transmission are greater priorities than contact.

2. Is this infection a common endemic problem at PCH?
MRSA on the wards for instance is a common occurrence and whilst every effort should be made to prevent transmission, there are likely to be other unrecognised colonised patients on the wards making source isolation less important than good hand hygiene.

3. Is this a clinical infection or colonisation?
Colonised patients are less likely to transmit infections than infected patients due to lower overall numbers of infectious particles.

4. Risk of dispersal
Is this an infection, such as norovirus or MRSA pneumonia, that is likely to disseminate widely or a condition such as colonisation with a resistant gram-negative infection that is unlikely to transmit except on the hands of staff.

5. Vulnerability of other patients on the ward
Where there are many debilitated and suppressed patients on the ward, isolation of the source patient, or indeed of the debilitated patient, may be needed. There are special groups of vulnerable patients that need to be considered. If the ward is a prenatal ward, then certain bugs not considered a problem in other populations take on a special significance, e.g. chickenpox is a problem in a young pregnant population, but not in an elderly population.

6. Virulent nature of the organism
Certain organisms are highly virulent. Such organisms, e.g. ACDP category 3 and 4, generally warrant isolation even if transmission is unlikely. Category 3 and 4 organisms, listed below, are not an exhaustive list and the full list is available at [www.hse.gov.uk/pubns/misc208.pdf](http://www.hse.gov.uk/pubns/misc208.pdf)

**Category 3**
- Tuberculosis
- Typhoid and other Enteric fevers
- Escherichia coli 0157
- Diphtheria

**Category 4**
- Viral Haemorrhagic Fevers, e.g. Ebola, Marburg and Lassa fevers.
Appendix D - Information for On-Call Managers Admitting Patients to a Ward Closed due to Gastroenteritis

The admission of patients to a closed ward can never be recommended and should only be considered when, on the balance of risks, not admitting is likely to cause more distress and harm to the patient than admitting. All other reasonable alternative solutions must have been exhausted.

To ensure patients and staff are fully protected and aware of why potentially contradictory decisions are being made:

- Patients being admitted to a closed area must be informed, as should accompanying relatives.

- The on-call Manager/Nurse Manager must inform the patient that they are being admitted to an affected ward and why. This information should be documented in the patient’s notes.

- If possible, position the patient in a side room or a bay with the least symptoms or into a bay that has been thoroughly cleaned.

- Re-assure the patient that every measure will be taken to reduce the risk of their being infected with gastroenteritis.

- Explain the symptoms of gastroenteritis and hand them an appropriate information leaflet. Viruses such as the norovirus are the most common cause of community acquired gastroenteritis, with up to 5% of the population having disease in any one year. The hospital’s problems mirror what is occurring in the community.

- Explain when they are admitted into the ward that discharge will be to the patient’s own home only. Transfer to other establishments will be avoided to reduce the risk of further spread in the short term.

- Vital and urgent treatments will not be affected – the individual’s urgent clinical needs will supersede all other considerations.

- Routine non-urgent investigations may be delayed because of being on a closed ward.

Acknowledgement: Cambridgeshire and Peterborough Mental Health Partnership NHS Trust and IPCT PHNT
All policies are required to be electronically signed by the Lead Director or Assistant Director.
(The policy will not be accepted onto Healthnet until the e signature is received.)

The proof of signature for all policies is stored in the policies database.

The Lead Director, Assistant Director or Head of Service approves this document and any attached appendices.

Signed:

Date: 3 May 2011