Livewell Southwest

Isolation and management of the infected patient

Version No. 2.4

Review: April 2019

Notice to staff using a paper copy of this guidance

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

Author: **Director of Infection Prevention & Control**

Asset Number: **531**

Reader Information

Title	Isolation and management of the infected patient. V.2.4
Asset number	531
Rights of access	Public
Type of paper	Policy
Category	Clinical
Document purpose/summary	To ensure all Livewell Southwest (LSW) staff understand and appreciate the importance of isolation and management of the infected patient to reduce the risk of cross transmission
Author	Nurse Consultant Infection Prevention & Control
Ratification date and group	19th January 2016. Policy Ratification Group
Publication date	8th February 2017
Review date and frequency (one, two or three years based on risk assessment)	Three years after publication, or earlier if there is a change in evidence.
Disposal date	The PRG will retain an e-signed copy for the archive in accordance with the Retention and Disposal Schedule. All copies must be destroyed when replaced by a new version or withdrawn from circulation.
Job title	Nurse Consultant Infection Prevention & Control
Target audience	All staff involved in patient care
Circulation	Electronic: LSW intranet and website (if applicable) Written: Upon request to the PRG Secretary on ☎ 01752 435104. Please contact the author if you require this document in an alternative format.
Consultation process	Review by infection prevention and control sub committee and ward managers
Equality analysis checklist completed	Yes
References/sources of information	1. Garner JS, Hospital Infection Control Practices Advisory Committee. Guideline for isolation precautions in hospitals. Infect Control Hosp Epidemiol 1996; 17:53-80, and Am J Infect Control 1996; 24:24-52. Also available at http://www.cdc.gov/ncidod/dhqp/gl_isolation.html. 2. Masterton RG, Mifsud AJ, Gopal Rao G. Review of hospital isolation and infection control precautions. J Hosp Infect 2003; 54: 171-3. 3. Rao GG, Jeanes A. A pragmatic approach to the use of isolation facilities. Bugs and Drugs 1999; 5: 4-6. **Bibliography**

	Ayliffe G A, Babby J R, Taylor L J (1999). Hospital-acquired Infection: Principles and Prevention. Third Edition. Butterworth, Oxford. Philpott-Howard J, Casewell M (1994) Hospital Infection Control. W B Saunders, London. Wilson J (2001) Infection Control in Clinical Practice. Bailliere Tindall, London. Garner JS, Hospital Infection Control Practices Advisory Committee. Guideline for isolation precautions in hospitals. Infect Control Hosp Epidemiol 1996; 17:53-80, and Am J Infect Control 1996; 24:24-52. Also available at http://www.cdc.gov/ncidod/dhqp/gl_isolation.html Masterton RG, Mifsud AJ, Gopal Rao G. Review of hospital isolation and infection control precautions. J Hosp Infect 2003; 54: 171-3. 3. Rao GG, Jeanes A. A pragmatic approach to the use of isolation facilities. Bugs and Drugs 1999; 5: 4-6.
Associated documentation	PHNT Isolation and management of the infected patient policy. **Other relevant LSW policies** 1. Avian Influenza (Management of) 2. Clostridium Difficile Policy 3. Decontamination (Cleaning & Disinfection) Guidelines & Procedures 4. Diarrhoea & Vomiting in a Clinical Area 5. Haemorrhagic Fevers Guidelines (Lassa fever, Marburg disease, Ebola and Congo-Crimean haemorrhagic fever) 6. Hand Hygiene Policy & Procedure 7. Immunisation & Screening for Staff (incorporating screening for Tuberculosis) 8. Influenza: Management & Guidance 9. Linen Policy 10. Meticillin-Resistant Staphylococcus Aureus (MRSA) 11. Outbreak Guidance Pack 12. Tuberculosis (Control of) 13. Verification of an Expected Death, Last Offices and Infection Prevention and Control when handling the deceased (End of Life Policy) 14. Healthcare associated infections – the reporting mechanism. 15. Handling Cadavers

Author contact details	By post: Local Care Centre Mount Gould Hospital, 200 Mount Gould Road, Plymouth, Devon, PL4 7PY. Tel: 0845 155 8085, Fax: 01752 272522 (LCC Reception).

Document review history

Version no.	Type of change	Date	Originator of change	Description of change
0.1	New policy	November 2010	Nurse Consultant Infection Prevention & Control	
1	Ratified	January 2011	Policy Ratification group.	Training section added.
1.1	Extended	March 2013	Director of Infection Prevention & Control	Extended no changes.
1.2	Extended	October 2013	Director of Infection Prevention & Control	Extended no changes.
1.3	Extended	May 2014	Infection Prevention & Control	Extended no changes.
1.4	Formatted & Extended	January 2015	PRG Secretary	Formatted to include LSW Logo. Extended no changes
2	Reviewed	January 2015	Infection Prevention & Control	Reviewed minor changes. New appendices added – H to O.
2.1	Reviewed	January 2016	Infection Prevention & Control	merged two policies together **(Isolation and management of the infected patient and Policy for the admission, transfer & discharge of the infected patient)** as they were very similar and had the same advice in both policies. We removed a lot of repetitive paragraphs.
2.2	Reviewed	April 2016	Infection Prevention & Control	Appendix N added.
2.3	Reviewed	September 2016	Infection Prevention & Control	Appendix N removed.

2.4	Minor amendment	February 2017	Infection Prevention and Control Manager	Appendix M updated (Red box added)

Isolation and management of the infected patient

1 Introduction

These guidelines aim to:

Ensure that patients are appropriately risk assessed for the potential to transmit infectious diseases.

Minimise the risk of transmission of infection to other patients, visitors and staff.

2 Purpose

2.1 Infection can spread in hospital among patients, health care staff and visitors. An increasing number of hospital patients are, as a result of their disease or its treatment, particularly susceptible to infection. These guidelines describe the procedures to be followed when caring for them.

2.2 When medical or nursing staff consider that they have an infected patient who may require special precautions not adequately covered in these guidelines, they should consult a member of the IPCT or the on-call Microbiologist for advice. The responsibility for informing staff of all disciplines who may come into contact with a patient managed in isolation lies with the nurse-in-charge of the place of isolation.

2.3 There are two types of isolation:

SOURCE ISOLATION – to prevent the direct or indirect transmission of infection from an infectious patient. Source isolation can be further categorised depending on the route and ease of transmission of an infection.

PROTECTIVE ISOLATION – to protect a susceptible patient from acquiring an infection from other sources, either directly or indirectly.

2.4 Hand decontamination is the single most important factor in the prevention of cross-infection. Hands must be washed on entering and leaving the isolation room, followed by the application of alcohol hand rub. Staff must not wear wristwatches or stoned rings. Patients should be offered appropriate opportunities to wash their hands (e.g. after going to the toilet and before meals). See the Hand Hygiene Policy located on the intranet.

2.5 The need for isolation must be reviewed regularly (Appendix L). This evaluation should be undertaken in consultation with the IPCT. (Implement an Isolation and Daily Review Care Plan, for all in- patients with a suspected or confirmed infection, this care plan can be located on system one or can be obtained from the IPCT).

2.6 It is preferable that an identified nurse(s) is assigned to the patient on each shift to reduce the risk of cross-infection. Where this is not possible, any procedures, e.g. dressings, should be performed last. Medical staff and Allied Health Professionals should ideally visit the patient following the completion of other duties. Medical staff conducting ward rounds should attempt to ensure that patients in isolation are seen last.

2.7 Ward staff should seek advice from the IPCT regarding the patient's movements away from the isolation room (**see Section 11**).

3 Duties

Responsibilities

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) are responsible for delivering, managing and developing the LSW (LSW) infection prevention and control service. The IPCT comprises of the Director of Infection Prevention and Control, Infection Prevention and Control Manager, Infection Prevention and Control Sister, Infection Control staff nurse, Infection Prevention and Control Assistant Practitioner 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 LSW Policies relevant to their area.

3.4 The **Locality Managers** will support and enable operational Managers to fulfil their responsibilities and ensure the effective implementation of this Policy within their speciality.

The **Modern Matron, Community Matron/ Clinical lead** is responsible for:

Ensuring that the development of local procedures / documentation does not 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 (SystmOne) for evidence of previous colonisation with, for example, MRSA, C. *difficile* or multi-resistant colifoms (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 / infection 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 Manager

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

Ensure staff check all admissions for Clinical Alerts on the patient's notes and electronic record (SystmOne) for evidence of previous colonisation with, for

example, MRSA, *C. difficile* or multi-resistant colifoms (e.g. ESBL-producing coliforms) and Carbapenemase Producing Enterobactericeae. 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 / infection status.

Perform a risk assessment for the presence of infections particularly MRSA, Carbapenemase Producing Enterobactericeae 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 LSW Infection Prevention and Control Policies. All staff are also expected to be aware of their duties in ensuring LSW 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 (SystmOne) for evidence of previous colonisation with, for example, MRSA, *C. difficile* or multi-resistant colifoms (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. Management of the infected patient in hospital/community settings

Isolation

4.1 Cross-infection in hospital, community settings may occur by many

routes, including direct contact with a patient, via contaminated hands, through contact with secretions, blood or other bodily fluids, by airborne dispersal, and via inanimate surfaces including medical and surgical instruments. Observation of the general principles of infection control and hospital hygiene will prevent cross-infection in most circumstances, but certain groups of patient require special precautions to prevent transmission of infection.

4.2 **Two categories of special precautions are used in these guidelines.**

Appendix A contains an extensive table outlining which of the two isolation categories should be used. If a particular infection is not included either contact the IPCT or the on-call Microbiologist.

4.2.1 **Standard Source Isolation** for patients who may transmit their infection to others by direct contact, on the hands of attendants or via inanimate objects (fomites). See **Appendix B**.

4.2.2. **TB Source Isolation** for patients who are diagnosed with TB antibiotic sensitivities which are not available for some weeks. See **Appendix C.**

4.2.3**. Protective Isolation** for patients at particular risk of acquiring infections from attendants or other patients, e.g. neutropenia. See **Appendix D**.

4.3 **Source isolation for infection syndromes**

A number of patients requiring source isolation will not yet have had a specific infectious entity identified. It is important to identify those patients who are likely to have disease of an infectious and potentially transmissible aetiology. Important syndromes include:

Diarrhoea and/or vomiting (likely to be norovirus or *C. difficile*).
Standard source isolation.

Known or at high-risk of MRSA infection (includes admission from other healthcare facilities including other hospitals and nursing homes, recent hospitalisation and patients previously known to be colonised).
Standard source isolation.

4.4 **Source isolation for common infections**

The main infectious conditions requiring isolation at LSW are outlined below. Due to the fabric of the buildings in some areas i.e. Plym Neuro Rehab Unit (PNRU) there are fewer than the recommended number of single rooms available. In addition, there may be other reasons for wishing to place a patient in a single room, including the nursing of terminally ill patients and maintenance of single-sex bays. The care and rehabilitation needs of the other patients, not forgetting the specific considerations of caring for those aged 16-19 must also be borne in mind.

If the number of patients requiring isolation exceeds the number of available single rooms, a risk assessment should be performed. The Infection Prevention & Control Team (IPCT) should be contacted to assist with this process. Cohort

nursing may be necessary for large numbers of patients, e.g. with viral gastroenteritis, and advice can be obtained from the IPCT. In some instances it may not be appropriate to isolate some patients because of the risk of harm to themselves and this needs careful consideration and liaison with the IPCT and documentation must reflect the decision making process.

5. Admissions, Discharges and Transfer of Colonised/Infected Patients

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

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.

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.

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 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:

Management and Control of Multi-Resistant Staphylococcus *aureus* (MRSA)
The Management and Control of PVL-Associated Staphylococcal infections
Clostridium *difficile* Guidelines
The Management and Control of Glycopeptide-Resistant Enterococci
The Management and Control of Resistant Gram-Negative Bacteria
Guidelines for the Management of Seasonal Influenza
Control of Tuberculosis
Management of Diarrhoea and Vomiting in a Clinical Area
Guidelines for the Management of the Infected Patient in Hospital
Avian influenza
Resistant Gram Negative Bacteria
Scabies

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.

5.1. Admission of Colonised/Infected Patients

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.

5.2. 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.

5.3. 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.

5.4. 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.

Verbal and written information must be communicated to both the patient and family members when an infection or colonisation has been identified.

Condition	**Isolation**	**Comments**
Viral gastroenteritis	Standard	Clinically diagnosed, or laboratory proven. Maintain isolation until 48 hours symptom-free.
Clostridium difficile	Standard	Maintain isolation until 48 hours symptom-free. Complete 10-14-day course of metronidazole or vancomycin. Clearance specimens are not necessary.
MRSA Glycopeptide-resistant enterococci Penicillin-resistant pneumococci	Standard	Risk assessment required – see relevant Policy or contact the IPCT.
Influenza	Standard	Clinically diagnosed, or laboratory proven. Maintain isolation 5 days after illness onset (7 days for children). If immunocompromised, check duration of isolation with IPCT
Multi-resistant gram-	Standard	Contact IPCT for risk

negatives (e.g. ESBL producers, Acinetobacter, gentamicin- or quinolone-resistant coliforms)		assessment for initiation and discontinuation of isolation.

5.5 General precautions for staff

5.5.1. High standards of medical/nursing/therapy practice will protect staff and other patients from hospital-acquired infection. LSW will use a hierarchy of controls to manage this risk.

5.5.2 Patients should be cared for by the minimum number of staff, consistent with high quality care, to reduce the risk of transmission. Staff must use the processes and procedures set out in these guidelines, and any other approved guidelines, to reduce the risk of exposure; this includes the use of engineering controls where applicable.

5.5.3 Staff should receive appropriate immunisations as outlined in the Staff Immunisation Policy.

5.5.4**.** It is recognised that there will be occasions during the provision of care where a risk of transmission of an infectious agent remains, even after these control measures have been used. In these circumstances, appropriate personal protective equipment (PPE) should also be used, according to the nature of the risk of transmission of infection.

5.5.5 Staff working in the community i.e. visiting care homes, visiting clients in their own home, should risk assess the importance of attending patients/clients during outbreaks of gastro intestinal disease and not visit unless there is an overwhelming reason to do so. If a visit is required then it is prudent to visit the home at the end of the working day if at all possible. Staff should follow standard infection control precautions during the visit and ensure hands are washed/or use hand wipes at the earliest opportunity.

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.

6. 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 (Occupational Health &Wellbeing (OH&WB) must be informed of any samples that staff have submitted). 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.

7. General procedures for source isolation

7.1. **Accommodation**

Patients should be managed in a side-room, as indicated in the appendices. The following rules must be observed when a patient is in isolation, together with any variations included in the appendices:

Keep the patient in a separate room or area and display the appropriate isolation sign (Appendix K, L) outside and implement an isolation and daily review care plan which can be found on system one. A group of patients with the same infection may be isolated in a separate unit or part of a ward (“cohort isolation”).

Orange clinical waste disposal bags should be kept in the room and removed when 2/3 full and disposed of as per the ‘management of waste policy’.

Water-soluble linen bags should be taken into the room as required, filled to no more than 2/3 full, and then removed and placed immediately in a red skip bag which should be kept outside the room and disposed of as per the Linen Policy.

Do not enter the isolation area unless necessary.

Before entering the isolation area leave coats, jackets, etc outside and put on a disposable plastic apron and gloves.

Before leaving the room:

Place all used disposable items, including the apron and gloves, in an orange clinical waste bag for incineration.

Wash hands with liquid soap and water under running water, dry well on a paper towel and then apply alcohol-based hand gel.

If the room has no toilet, provide a bedpan, urinal or commode exclusively for the patient and wear disposable apron and gloves when handling it. If the ward bedpan washer disinfects satisfactorily or disposable bedpans are in use, dispose of excreta by these means:

If a commode has been used, ensure the frame is thoroughly cleaned with detergent, bleach and water before moving out of the area.
Contact the IPCT if further advice is needed. Ensure the contents of bedpan/commode/urinal are covered and secure before transporting to the disposal area.

Gloves should remain on until after the contents have been disposed of - hands should be washed as per policy.

Furniture and equipment should be kept to a minimum. All equipment used must be single-use or able to be decontaminated. Separate personal equipment should be provided, e.g. stethoscope. Foot operated bins should be provided for clinical waste bags and red skip bags for soiled linen. Sharps bins should be brought into the room when required and then appropriately decontaminated and removed. Patient's personal effects should be kept to a minimum.

A trolley or protective clothing dispenser should be prepared outside the room to provide equipment relevant to the care being given, e.g. gloves and plastic aprons. The patient's documents and charts should be kept outside the room to allow easy access. Other protective equipment such as visors and masks may be required.

Transfer of patients in isolation should be avoided if possible. However, if necessary, transfer should be discussed with the IPCT and the person arranging the transfer must inform both the receiving department including care homes and those involved in the transport of the patient.

Deep cleaning of the cubicle. See section 7.2 and the Decontamination (Cleaning & Disinfection) Guidelines & Procedures.

Put all used linen in a water-soluble bag within a red linen bag and securely fasten.

Spillages should be dealt with as described in the Decontamination (Cleaning & Disinfection) Guidelines & Procedures.

7.2. **Cleaning of room, linen, clothing, mattresses and pillows**

7.2.1 Hotel Services should be contacted to arrange the implementation of enhanced cleaning twice daily for the duration of the isolation period (Decontamination (Cleaning & Disinfection Guidelines & Procedures Policy). Once deep cleaning has been completed twice daily enhanced cleaning should be discontinued. Housekeeping/domestic staff should be reminded about protective clothing and

the procedures required. When the room is occupied, all contact surfaces should be damp dusted with detergent and hot water using a disposable cloth twice daily. The floor should be mopped daily with detergent and hot water. Floors must not be mechanically cleaned. When implementing enteric precautions, pay particular attention to sanitary ware and use a sodium hypochlorite 1% solution.

7.2.2 Put all linen in a water-soluble bag within a red linen bag and securely fasten.

7.2.3 All mattresses and pillows must be protected with an intact plastic cover. On discharge, these should be checked as should the mattress. They should be cleaned using detergent wipes/cleaned with standard strength bleach solution depending on the infective organism. The room (environment and furniture) should be cleaned thoroughly using detergent and hot water followed by sodium hypochlorite 1% solution to surfaces that will tolerate it. If mattresses or pillow covers are damaged or not made of plastic, these should be disposed of as clinical waste. Curtains from isolation areas must be changed.

7.2.4 Clean all patient equipment, e.g. drip stand, commode, with detergent and hot water followed by sodium hypochlorite 1% solution (10,000 available parts per million ppm) of chlorine to surfaces that will tolerate it.

7.3. Return of instruments and other items to the Sterilisation and Disinfection Unit.

7.3.1 Notify the Sterilisation and Disinfection Unit (SDU) by telephone that equipment is about to be returned and from which category of patient. All items should be placed in a yellow plastic bag (do not staple), which should then be placed in the normal blue return bag, the neck of which should be secured. Blue bags are available from SDU on request. The bags will be collected by SDU staff where possible but, if other arrangements are made, handlers should be made aware of the contents by clear labelling of the outer bag**.**

7.4. Return of medical equipment for cleaning and disinfection

7.4.1 All used medical equipment for maintenance, repair or for relocation should be sent to the Sterilisation and Disinfection Unit. Advice about transfer arrangements should be obtained from the SDU Manager (Derriford) who will advise regarding the use of decontamination certificates to indicate use on a high infectious risk patient or not respectively. On return MEMs will attach a decontamination certificate as appropriate.

7.5. Enquiries

7.5.1 Enquiries about this policy and its implementation should be made to any member of the IPCT on extension 34167.

8. Psychological considerations

8.1 Consideration should be given to psychological needs and sufficient time

allocated to the patient in isolation. This is particularly important for children and frail older people in isolation rooms. Visiting should be actively encouraged in accordance with the patient's wishes.

8.2 Dependant on the type of infection, it may be necessary to keep the isolation room door closed. If this is the case, the door should be closed at all times apart from necessary entrances and exits. If this is not possible due to psychological or patient safety reasons, then a risk assessment that identifies the increased risk of harm must be undertaken by the ward staff and clearly documented in the patient's nursing notes and on the isolation and review care plan (Appendix J).

8.3 **Mental Health Considerations**

8.3.1 Infection prevention and control clearly needs to be balanced in regards to the safety of patients/clients. Consideration of people with mental health needs is not confined just too mental health units but is applicable across all in patient services. A risk assessment needs to be performed to assess whether it is safe to isolate a patient and should be done in conjunction with the IPCT and documented in the patients medical notes. Infection prevention and control should not compromise patient or staff safety.

8.3.2 Rehabilitation/therapies should not be compromised when a patient is being treated either with a known infection or has been identified as being colonised with an organism. Therapy staff are required to organise and prioritise their case load effectively to minimise the risk of cross infection i.e. ensure that those patients who are isolated receive their therapy later in the day. Those patients who are colonised should be able to continue their therapy following consultation with the ward staff and or IPCT.

8.3.3 Patients with diarrhoea and, with a known infective cause should in most instances wait until 48 hours after their last symptom, or until their usual bowel habit has resumed and, the room has been deep cleaned. For some patients having loose stool is their normal bowel habit in particular those on liquid feed regimes. This needs to be addressed on a case by case basis and with the IPCT. If a patient attends the gym then enhanced cleaning by domestic staff will be required following the session and should be discussed with the ward manager and domestic staff.

9. The deceased infected patient

9.1 For patients with high-risk infections, e.g. HIV, hepatitis B, C or *Mycobacterium tuberculosis*, use a cadaver bag. Complete all required documentation.

9.2 Other infections do not require a cadaver bag unless there is leakage of body fluids, which will protect handlers, as the body remains potentially infectious after death.

9.3 For more details on the care of the deceased infected patient see the End of Life policy (**Verification of an Expected Death, Last Offices and Infection Prevention and Control when handling the deceased)**

10. Monitoring Compliance and Effectiveness/Quality Control.

10.1 Compliance with this policy will be monitored by the IPCT in their audit cycle. Audits.

The infection prevention and control team produce an annual audit plan for the provider services at LSW.

It is the responsibility of the IPCT to ensure audits are carried out professionally and any deficits highlighted to the locality and ward manager or the designated manager at the time of the audit. All locality and ward managers, matrons will be sent a report within 48 hours and have a two week period to respond.

The IPCT will use the Quality Improvement Tool for safe handling of linen.
The frequency of audit for the linen service 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 within 3 months.

All policies are required to be electronically signed by the Lead Director. Proof of the electronic signature is stored in the policies database.

The Lead Director approves this document and any attached appendices. For operational policies this will be the Locality Manager.

The Executive signature is subject to the understanding that the policy owner has followed the organisation process for policy Ratification.

Signed: Lead Nurse, Director of Infection, Prevention and Control

Date: 20th January 2016

Appendix A

Isolation requirements for common conditions
(based on CDC guidelines: http://www.cdc.gov/ncidod/dhqp/gl_isolation.html)

Diagnosis	Duration of isolation	Route of spread	Required Isolation
Major undressed or draining abscess; uncontrolled skin and soft tissue infection; impetigo	Duration of illness or until abscess or wound can be covered/dressed	Contact	Standard
Adenovirus pneumonia or conjunctivitis	Duration of illness	Contact	Standard
Anthrax (cutaneous & pulmonary)	Duration of illness	Contact	Standard (Contact on-call Microbiologist immediately)
Chickenpox [1-3]	Until all vesicles have crusted over	Contact/airborne	Standard (Strict if pneumonia or ward with vulnerable individuals)
Diarrhoea of unknown origin[4]	Duration of diarrhoea	Faecal-oral	Standard
Gastroenteritis[4] including *Clostridium difficile*, Salmonella, Shigella, Cholera, Campylobacter, norovirus, Rotavirus	48 hrs after symptoms cease	Faecal-oral	Standard
Enterotoxigenic *Escherichia coli* (e.g. 0157)	Contact IPCT	Faecal-oral	Standard
Enterovirus infection	Duration of illness (children & incontinent adults only)	Faecal-oral	Standard
Hepatitis A	Until jaundice develops and is continent	Faecal-oral	Standard
Herpes simplex	Duration of illness	Contact	Standard

Neonatal and extensive primary disease (Isolation is not required for recurrent disease)			
Influenza	Duration of illness (Do not confuse primary influenza and secondary bacterial pneumonia. Usually non-infectious by day 7 after onset of 'flu symptoms)	Respiratory	Standard
Diagnosis	**Duration of isolation**	**Route of spread**	**Required Isolation**
Measles[1]	Duration of illness	Respiratory	Standard/Strict (Depends on the age and health of local contacts)
Meningococcal infection	First 24 hours after starting treatment	Respiratory	Standard
Multi-resistant bacteria (including MRSA)	As per specific policy	Contact	Standard
Mumps[1]	2 days before to 9 days after parotitis appears	Respiratory	Standard/Strict (Depends on the age and health of local contacts)
Parainfluenza	Duration of illness	Respiratory	Standard
Parvovirus induced aplastic anaemia	First 7 days of transient aplastic crisis. Duration of hospitalisation in	Respiratory	Standard

	the chronically infected		
Poliomyelitis[2]	Contact Medical Microbiologist		
RSV	Duration of illness	Respiratory	Standard
Rubella[1, 2]	7 days before to 10 days after rash	Respiratory	Standard/Strict (Depends on the age and health of local contacts)
Shingles (zoster)	Until all lesions crusted	Contact	Standard
Streptococcus pyogenes (Group A streptococcus) infection including scarlet fever	Until 24 hours successful treatment	Contact	Standard
Typhoid & paratypyhoid	Contact IPCT	Faecal-oral	Standard
Viral Haemorrhagic Fever or fever in a traveller to an endemic area in the previous 21 days	Contact Medical Microbiologist	Contact (possible respiratory)	Contact on-call Microbiologist immediately
Whooping cough	Until 7 days after starting effective therapy (*If established whooping phase and antibiotics not indicated then isolate until 4 weeks after onset of illness*). A proportion of cases may be infectious for longer – do not discontinue isolation with discussion with IPCT.	Respiratory	Standard

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.

Potential risk to pregnant staff and visitors.

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).

Clean surfaces with detergent, bleach (hypochlorite 1%) and water to surfaces that will tolerate it. Under certain circumstances, the IPCT may recommend use of a steam cleaner.

Common conditions that are often inappropriately isolated:

Condition	Comment
Scabies (except encrusted scabies)	Encrusted (‘Norwegian’) scabies is heavily encrusted disease associated with a particularly high mite load.
Meningitis (other than meningococcal)	For meningococcal disease, the patient can be considered non-infectious once than 24 hours of treatment has been given.
Legionnaires disease	There is no person-to-person transmission.
Recurrent cutaneous herpes simplex	

Appendix B

Standard Source Isolation

Accommodation
A single-bedded room is generally suitable, unless directed otherwise by the IPCT.

When several patients are affected, as in an outbreak, cohort nursing in one or more bays or an entire ward may be appropriate. For management of individual infections, please see relevant specific infection control policies.

Visitors

Visitors should seek permission of the nurse-in-charge before entering and should be encouraged to wash hands on entry and exit of the isolation room. In general visitors of patients isolated in Standard Isolation do not need to take any specific precautions providing they are not visiting other clinical areas unless enteric precautions are in place.

Patients

Patients are advised not to leave this area without permission.

Visitors and staff should observe these rules:

Door	Keep closed (an external window may be opened)
Plastic Aprons*	Wear when in the room
Masks*	Not necessary
Gloves*	Wear for all body fluids contacts
Hand washing	After removing and disposing apron and gloves. Then wash hands and apply alcoholic hand-rub.
Crockery & cutlery	Return to kitchen and wash in dishwasher
Excreta	See section 7.1 (f)
Linen	See section 7.1 (k)
SDU equipment	Return to SDU in a sealed yellow bag with a blue return Bag clearly labelled with a ‘Danger of Infection’ label.
Medical equipment for Maintenance	Inform Maintenance Department (MEMs) before return and attach ***orange*** decontamination certificate.

Pathology requests	Put “Danger of Infection” label on request form and specimen. Use leak proof containers and send specimen and form in a sealed polythene specimen bag.

(*Disposable items. After use place in an orange waste bag)

Appendix C

TB Source Isolation (See 'Control of Tuberculosis' Guidelines)

Accommodation

Usually when a patient is diagnosed with TB antibiotic sensitivities are not available for some weeks. The following factors should alert you to the possibility of resistant TB:

Past history of treated TB
Contact with known resistant TB
Birth, travel or residence in an area with a high prevalence of resistant TB e.g. Asia, Africa, Latin America, Eastern Europe.
HIV infection
Failure to clinically respond to treatment e.g. fever after 2 weeks of treatment or persistently positive sputum smears e.g. after over 2 months of treatment.

Table 1. Minimum requirements for the isolation of patients with suspected or **proven TB.**

Type of patient/contacts	Infectious	Potentially infectious*	Non-infectious
Drug sensitive disease			
Other patients immunocompetent	Single room	Open ward	Open ward
Other patients immunocompromised	Negative pressure room†	Single room	Open ward
Drug-resistant disease			
Other patients immunocompetent	Single room	Open ward	Open ward
Other patients immunocompromised	Negative pressure room†	Single room	Open ward
MDR-TB (suspected or known)			
Other patients immunocompetent	Negative pressure room‡ *in specialist Unit*	Single room	Open ward#
Other patients immunocompromised	Negative pressure room† *in specialist Unit*	Negative pressure room‡	Single room

* **'Potentially' infectious = three negative consecutive smears but one** or more cultures positive or culture unknown/awaited

† Room with continuously and automatically monitored negative pressure

‡ Single room with intermittently and manually monitored negative pressure

Criteria for determining non-infectiousness more stringent than for drug- sensitive and non-MDR disease.

Patients with HIV should not be managed on a ward in which there is a patient with infectious tuberculosis.

Due to the intermittent nature of release of the bacteria in respiratory secretions, an individual cannot be assumed smear negative until THREE consecutive smears have been examined.

Non-pulmonary tuberculosis can be assumed to be non-infectious providing there is no external discharge of smear-positive pus.
For further information on isolation and duration of isolation (usually the first 14 days of effective treatment), please contact the IPCT.

Visitors

Do not enter without express permission of clinician in charge. Contact with members of family who have had prolonged contact prior to admission will not usually be prohibited.

Patient

Do not leave room without permission.

Visitors and Staff observe these rules:

Door Keep doors closed.

Plastic aprons Not required unless contact with patient's secretions.

Gloves Worn as for Standard Infection Control Precautions.

Masks Under normal circumstances there is no need for a patient or visitors to wear such masks unless the patient is unable to expectorate into a tissue. FFP3 Respiratory Masks should be worn by:

all persons entering the room of a patient with suspected or confirmed MDR-TB while the patient is considered infectious

all persons present in the room during bronchoscopy and cough-inducing or aerosol-generating procedures

those health care workers and carers in regular or prolonged close contact of any case of TB e.g. Chest physiotherapy.

A small number of FFP3 Respiratory Masks are kept in the Emergency Department, the respiratory wards and Chest Clinic.

Crockery & Cutlery	Return to kitchen and wash in dishwasher.
Linen	See section 7.1 (k)
SDU equipment	Treat as equipment used on patients on the open ward.
Pathology requests	Put “Danger of Infection” labels on all requests that may contain infectious secretions, including sputum and pus from tuberculosis lesions.

Contact the Infection Prevention and Control Team or the on call Consultant Microbiologist if a suspected case of tuberculosis is admitted.

Appendix D

Protective Isolation

Accommodation

Protective isolation in the form of single room accommodation may be necessary for those patients who may require it

Visitors

Do not enter without permission of the nurse-in-charge.

Patient

Do not leave this area without permission

Visitors and staff observe these rules:

The number of staff having access to the patient should be limited wherever possible. No admittance should be given to anyone, including staff, who have a cough/cold or other transmissible infection. No eating or drinking by visitors should be permitted in the room

Door	Keep closed
Plastic aprons*	Wear at all times
Gloves*	Wear at all times
Hands	Wash with soap and water and rub alcohol hand gel on entering area and after removal of apron and gloves
Excreta	See section 7(f)
Linen	See section 7(i)
Crockery & Cutlery	Return to kitchen and wash in dishwasher
SDU equipment	Return to SDU in normal way
Equipment for maintenance	Inform Maintenance Department (MEMs) of location of use. No special decontamination necessary
Pathology requests	Send in normal way

*Disposable items. After use, place in an orange bag for incineration.
Linen and waste should be removed directly and disposed of per the waste management policy

Appendix E. Plymouth Infection Priority System (PIPS)

Date:

Clinical area:

Patient Name:

Hospital number:

Does the patient have an infection?: YES/NO (if YES, please complete the risk assessment below)

Criteria	Classification	Score
ACDP Category		
Route		
Evidence of transmission		
Significant resistance		
Susceptibility of other patients*		
Prevalence		
Dispersal		
Total score		

Appendix F

Characteristics of common infectious conditions

Condition or infection	Category	Mode of transmission	Evidence of transmission	Specific guidance
Chickenpox (varicella)	2	Air-borne/contact	Strong	
Clostridium difficile	2	Faeco-oral	Strong	Isolate until 48 hours symptom-free
Diarrhoea &/or vomiting of unknown origin	2	Faeco-oral/droplet	Strong	Review with Microbiology results
Ectoparasites (scabies, lice)	2	Contact	Strong	Isolate for first 24 hours of treatment
Encephalitis (viral)	2	Faeco-oral/contact	Poor	
Glycopeptide-resistant enterococci	2	contact	Strong	
Gastroenteritis (campylobacter, salmonella, shigella, *E.coli* O157, viral incl. norovirus)	2 or 3*	Faeco-oral/droplet	Strong	Moderate risk for *E.coli* O157
Hepatitis A & E	2 or 3**	Faeco-oral	Poor	Isolate for first 7 days of jaundice
Influenza	2	Droplet	Strong	
Measles, Mumps & Rubella	2	Droplet	Strong	
Meningitis (viral & bacterial)	2 or 3***	Droplet/faeco-oral	Moderate	
Meningococcal septicaemia	2	Droplet	Moderate	Isolate for first 24 hours of treatment
Meticillin-resistant *Staphylococcus aureus* and PVL-producing *S. aureus*	2	Contact	Strong	High risk for skin disperses and expectorating infected sputum
Multi-resistant gram-negatives (incl. ESBLs)	2	Contact	Strong	
Penicillin-resistant pneumococci	2	Droplet	Strong	
Respiratory syncytial virus	2	Droplet	Strong	
Rotavirus	2	Faeco-oral/droplet	Strong	
Shingles (zoster)	2	Contact	Moderate	
Streptococcus pyogenes (incl. scarlet fever)	2	Droplet/contact	Strong	Isolate for first 24 hours of treatment
TB (pulmonary)	3	Air-borne	Strong	Isolate for first 14 days of treatment
Typhoid/paratyphoid fever	3	Faeco-oral	Weak	
Viral Haemorrhagic Fever	4	Blood-borne	Moderate	Contact On-Call Microbiologist Urgently
Whooping Cough	2	Droplet	Moderate	Isolate for first 5 days of treatment

* *Shigella dysenteriae* Type 1 and verocytotoxigenic *E. coli* (e.g. O157:H7, O103) are ACDP Category 3

** Hepatitis A is ACDP Category 2 and Hepatitis E is Category 3

*** Rare imported causes that are ACDP Category 3 include Japanese B, Murray Valley, St. Louis, Russian Spring Summer, Eastern Equine, Western Equine and Venezuelan Equine Encephalitis, as well as West Nile Fever.

Appendix G

Scoring for the Plymouth Isolation Priority System

Criteria	Classification	Score	Comments
ACDP Category	2 3 4	5 10 40	
Route	Air-borne Droplet/Faeco-oral Contact Blood-borne	15 10 5 0	
Evidence of transmission	Strong Moderate Poor Nil	10 5 0 -10	
Significant drug resistance	Yes No	5 0	MRSA, GRE, resistant coliforms
High susceptibility of other patients	Yes No	10 0	Specific for different infections and patient populations
Prevalence	Sporadic Endemic Epidemic	0 -5 -5	
Dispersal	High risk* Moderate risk** Low risk	10 5 0	For contact and droplet transmission
Total score			

* Includes exfoliative skin conditions (e.g. eczema, psoriasis), faecal incontinence, expectorating infected sputum and tracheostomy secretions

** Includes organism in catheter urine sample or wounds

Appendix H

Examples of the Plymouth Isolation Priority System

1. A 20-year old female with chicken pox on a maternity ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Air-borne	15
Evidence of transmission	Strong	10
Significant resistance	No	0
Susceptibility of other patients*	Yes	10
Prevalence	Sporadic	0
Dispersal	Not applicable	0
Total score		**40**

* Risk to other susceptible pregnant ladies

2. A 50-year old male with chicken pox on a general medical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Air-borne	15
Evidence of transmission	Strong	10
Significant resistance	No	0
Susceptibility of other patients*	No	0
Prevalence	Sporadic	0
Dispersal	Not applicable	0
Total score		**30**

* Risk assessment required for other susceptible patients (e.g. pregnant, immunosuppressed)

3. A 78-year old male with an MRSA wound infection on a general surgical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10
Significant resistance	Yes	5
Susceptibility of other patients	Yes	10
Prevalence	Endemic	-5
Dispersal	Medium risk	5
Total score		**35**

4. A 68-year old male with MRSA colonisation on a general medical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10
Significant resistance	Yes	5
Susceptibility of other patients	No	0
Prevalence	Endemic	-5
Dispersal	Low risk	0
Total score		**20**

5. A 78-year old male with an MRSA pneumonia on a general surgical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10
Significant resistance	Yes	5
Susceptibility of other patients	Yes	10
Prevalence	Endemic	-5
Dispersal	High risk	10
Total score		**40**

6. A 78-year old male with an MRSA wound infection on a general surgical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10
Significant resistance	Yes	5
Susceptibility of other patients	Yes	10
Prevalence	Endemic	-5
Dispersal	Medium risk	5
Total score		**35**

7. A 78-year old male with a PVL-producing MRSA pneumonia on a general medical ward

Criteria	Classification	Score
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10

Significant resistance	Yes	5
Susceptibility of other patients	Yes	10
Prevalence	Sporadic	0
Dispersal	High risk	10
Total score		**45**

8. A 73-year old female on a general medical ward with a catheter-associated urinary tract infection due to an ESBL-producing coliform

Criteria	**Classification**	**Score**
ACDP Category	2	5
Route	Contact	5
Evidence of transmission	Strong	10
Significant resistance	Yes	5
Susceptibility of other patients	No	0
Prevalence	Endemic	-5
Dispersal	Medium risk	5
Total score		25

Appendix I

Risk Assessment for Admitted Patients

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*

All admitting wards should screen patients within six hours of admission as per MRSA Policy.
Has the patient been transferred from another hospital or care setting?
Has been known to have previously been colonised with MRSA?
Is the patient a newly identified case of MRSA?
Has the patient been colonised and received a round of eradication therapy?

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.

Tuberculosis

Tuberculosis should be suspected in any patient with a cough without other cause lasting more than three weeks with or without weight loss, anorexia, fever, night sweats or haemoptysis.

The following groups are particularly at risk: immigrants from high incidence areas (areas with a prevalence of > 40 cases per 100 000 population), especially within 1-2 years of leaving an endemic country; the homeless; HIV-positive; injecting drug users; solid organ transplantation; haematological malignancy; jejuno-ileal bypass; chronic renal failure or receiving haemodialysis; gastrectomy; receiving anti-TNF therapy (e.g. infliximab, etanercept and adalimumab); silicosis; chronic alcoholics and the elderly.

Fever of unknown origin from overseas

Recent travel outside of Europe, North America or Australia.

Travel to and area endemic for Viral Haemorrhagic Fever (VHF) in the 21 days prior to onset of fever.

Contact IPCT or on-call Microbiologist

Appendix J. Risk assessment for the traveller returning from Africa with a fever – exclusion of VHF

Suspected VHF: Contact on-call Microbiologist

This is designed to be simple questionnaire that can be used to rapidly screen out the vast majority of travellers who are not at risk of being infected with VHF. The occasional patient who is a possible case, i.e. fever and left endemic area in the last 21 days if identified, should be discussed immediately with the on-call Microbiologist.

1. Has the patient been to an endemic country for VHF in the last month?

Yes (go to question 3) **No** (minimal risk of VHF)

These include: Guinea, Sierra Leone, Liberia, Cote d'Ivoire (Ivory Coast), Ghana, Togo, Benn, Nigeria, Maili, Burkina Faso, Niger, Central African Republic, Cameroon, Gabon, Democratic Republic of Congo, Sudan, Chad, Congo, Equatorial Guinea. This list cannot be exhaustive and travel to adjacent countries may pose a small risk.

2. Has the patient had a febrile illness of less than 21 days duration that started whilst in or within 21 days of leaving the endemic country?

Yes (go to question 3) **No** (minimal risk of VHF)

3. Has the patient:

Travelled outside of major cities?

Had contact with sick individuals or been to health care facilities in the endemic country?

Been in contact with rats or their excreta?

Been in direct contact with wild animals?

If the answer to any of the questions in part 3 are yes, then **DO NOT** take any blood samples other than a clotted and EDTA sample of blood for examination of malaria. If the film is negative for malaria, contact the on-call Microbiologist immediately.

If blood tests are required for urgent and lifesaving investigations, blood can be submitted to the laboratory and safely processed on automated analysers, but when any sample is submitted, it must be taken **BY HAND** and the receiving biomedical scientist must be informed.

Please refer to the Haemorrhagic Fevers policy for further information.

Appendix K

Infection Prevention and Control Blue Poster for D&V

Please speak to a nurse before entering.

Please ensure that you wash and dry your hands before entering and leaving the room/ unit.

Thank you

Appendix L

Infection Prevention and Control Poster Green Poster for all other infections

Please speak to a nurse before entering.

Please ensure that you wash and dry your hands before entering and leaving the room/ unit.

Thank you

Appendix M

Routine Samples for In-Patients with a Suspected Infection

Patients who have a negative C diff result but continue to have type 6/7 stools must have repeated samples every 4th day until the diarrhoea stops as the diagnosis may change. Failure to do so may result in an infection being untreated. C diff testing must be requested for patients under the age of 65.

Patient Symptomatic

↓

Document patient's symptoms in Patient's notes, Update Whiteboard, with relevant

↓

Inform Patient
Take Sample, update patient's notes and whiteboard
Risk Assess isolation measures
Isolate Patient- If unable to isolate record rationale for decision
Implement appropriate care plan
Document Rationale for Decision

↓

Inform Hotel Services
Implement Enhanced Clean (Include the Whole Bay if Patient is not in isolation) and ensure monitoring form is signed
Inform Infection Control Team

↓

Results to be followed up on a daily basis by Ward Staff via ILAB

↓

Negative
Inform Patient
No Further Action
Stop Enhanced Cleaning and Isolation
Document in Patient's Notes and Update Whiteboard

Positive
Inform Patient
Agree Treatment Plan with Patient
Ensure appropriate treatment is prescribed
Follow relevant policy guidelines, reswab as appropriate
Continue with Enhanced Cleaning of room or bay
Daily review of Patient's Observations to include fluid balance, nutrition intake and stool charts if appropriate
Inform Locality Manager who will report to relevant committees

↓

When patient has completed treatment/ moved bed space/asymptomatic instigate deep clean (to include whole bay if patient has not been isolated) (refer to decontamination flow chart for guidance).