Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Isolation Policy

This procedural document supersedes: PAT/IC 16 v.8 – Isolation Policy

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Executive Sponsor(s):	Abigail Trainer, Acting Director of Nursing, Midwifery and Allied Health Professionals
Author/reviewer: (this version)	Carol Scholey, Infection Prevention and Control Practitioner
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Target audience:	Trust-wide

Amendment Form

Version	Date Issued	Brief Summary of Changes	Author
Version 9	November 2022	• Added in covid 19 to isolation categories • Updated Appendix 2 Isolation priorities to include Covid 19, VRE and Monkey pox • Updated Appendix 4 Isolation poster • Updated PHE details now UK Health & Security Agency	Carol Scholey IPCP
Version 8	19 August 2019	Substantial changes made throughout - PLEASE READ IN FULL	J Lee IPCP
Version 7	7 December 2016	• Amendments to 4.1- source isolation, management of the patient once isolated • Amendments to 5 - hand hygiene – visitor hand washing specified • Inserted IPC IPOC and hyper link • Amendment to section 10 – SET training/PIR • References updated • Appendix 2 – exclusion and mask advice updated, notifiable diseases highlighted and PHE contact details added • Appendix 4 – Isolation Priorities • Appendix 5 – enhanced IPC poster	J Lee IPCP
Version 6	14 January 2015	• Policy updated in new Trust format • Equality Impact Assessment added	M Madeo Deputy DIPC
Version 5	February 2012	• Page 6 - Section added on “Equality Impact Assessment” • Page 8 - Date and time of Isolation to be recorded in notes escalation plan if not achievable. • Mode of Transmission added in Appendix 1 • Information Required by Consultant Microbiologist – Appendix 3	B. Bacon Lead Nurse IPC

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1 INTRODUCTION

Isolation refers to the use of a single room as a barrier in order to prevent the transmission of organisms responsible for infection. The use of protective clothing is also essential in preventing cross infection and contributes to barrier precautions. When a patient is found, or thought to be suffering from an infection, it is necessary to consider the mode of transmission of the infection and to institute appropriate measures to prevent cross infection. It is important to recognize that it is the micro-organism, which is being isolated and not the patient.

The principles of this policy are underpinned by a review of Hospital Isolation and Infection Control related precautions https://www.nipcm.hps.scot.nhs.uk/media/1650/2021-10-sicp-tbppatient-placement-v2.pdf and the Department of Health Saving Lives: Isolating Patients with Healthcare Infection – A summary of best practice. It is also a requirement of the Health and Social Act 2012 (DH update July 2015) that an evidence based isolation policy exists incorporating local risk assessment findings and measures.

2 PURPOSE

To identify patients presenting with colonisation, infection or infectious diseases that may be a risk to others.

To take timely action to prevent the spread of potentially infectious conditions by appropriate isolation of the source patient and the appropriate use of personal protective equipment (PPE).

To ensure that patients at high risk of infections due to immunosuppression or neutropenia are appropriately isolated and protected to minimise the acquisition of such infections.

To ensure that all staff, departments and any outside agencies likely to be involved in the care of patients have a clear understanding of their roles and responsibilities in preventing the spread of infection.

3 DUTIES AND RESPONSIBILITIES

This policy covers infection prevention and control management issues for Trust staff this includes:-

- Employees
- Volunteers
- Agency/Locum/Bank Staff
- Contractors whilst working on the Trust premises

All staff working on Trust premises, outreach clinics and community settings, including Trust employed staff, contractors, agency and locum staffs are responsible for adhering to this policy, and for reporting breaches of this policy to the person in charge and to their line manager.

Chief Executive: To ensure that infection control is a core part of clinical governance and patient safety programs. Promote compliance with infection control policies and national standards in order to ensure low levels of health care associated infections.

Board of Directors: The Board of Directors and executives, through the Chief Executive, is ultimately responsible for ensuring that systems are in place that effectively manage the risks associated with Infection Control. Their role is to support the implementation of a Board to Ward culture to support a Zero Tolerance approach to Health Care Associated Infections.

The Director of Infection Prevention and Control will provide assurance to the board that effective systems are in place.

Director of Infection Prevention and Control: Is responsible for the development of infection prevention and control strategies throughout the Trust to ensure best practice.

The Infection Prevention and Control Team: (IPCT) is responsible for providing expert advice in accordance with this policy, for supporting staff in its implementation, and assisting with risk assessment where complex decisions are required.

Microbiologists: As part of their role provide expert advice to Clinical site manager (CSM) / senior staff out of hours. They will also be responsible in alerting the IPC team of any new alert organisms and difficulties in isolation out of hours.

Senior Nurses: are responsible for ensuring implementation within their area by undertaking regular audits in ward rounds activities. Any deficits identified will be addressed to comply with policy.

Ward and Department Managers: are responsible for ensuring implementation within their area, and for ensuring all staff who work within the area adhere to the principles at all times.

Consultant Medical Staff: are responsible for ensuring their junior staff read and understand this policy, and adhere to the principles contained in it at all times.

Clinical Site Managers: are responsible for supporting wards to ensure that patients are managed in accordance with this policy, and for escalating any situations where safe placement cannot be achieved.

Chief operating officer / On-call Managers: are responsible for providing senior and executive leadership to ensure implementation of this policy, and for ensuring infection risks are fully considered and documented when complex decisions need to be made regarding capacity and patient flow.

4 CATEGORIES OF ISOLATION

Isolation **must not** compromise the clinical care of the patient. There are two categories of isolation:

Source isolation: The infected/colonised patient, as the source of infection, is segregated from unaffected patients, usually in a single room with ensuite toilet facilities. If ensuite facilities are not available, a designated toilet/commode must be identified for the infected patient's use. When a number of patients are affected by an infection they may have to be cohorted together in a closed bay. Physical segregation, combined with other precautions such as the use of PPE is aimed at reducing the likelihood of infections spreading via airborne, droplet or contact routes.

The extent of isolation depends on:

- The infecting organism and the route of transmission
- The physical and mental abilities of the patient
- Risk assessment of susceptibility of other patients
- Facilities available for isolation

Protective isolation: when a patient is at risk from others. Protective isolation is the segregation of the susceptible patient, who are immuno-compromised or immunosuppressed in order to prevent the acquisition of infection from other patients, staff or visitors.

4.1 Source Isolation – The Decision to Isolate

Source Isolation is indicated for conditions such as:

- Meticillin-resistant Staphylococcus aureus(MRSA)
- *Clostridioides difficile* (C Diff) and Glutamate dehydrogenase (GDH)
- Patients with extended spectrum β lactamase producers (ESBLs) i.e. E.Coli, Klebsiella Chickenpox
- Measles
- Glycopeptide Resistant Enterococci and Vancomycin Resistant Enterococci, (GRE and VRE)
- Pulmonary Tuberculosis
- Middle East respiratory syndrome (MERS) & SARS-CoV-2 (Covid-19)
- Diarrhoea and or vomiting
- Influenza
- Meningitis
- Fevers from the tropics in which an infectious cause cannot be ruled out

The decision to isolate a patient should be based on the infection risk, symptoms and risk of transmission in accordance with the relevant infection prevention and control policy e.g. Pulmonary Tuberculosis.

When a requirement for isolation is identified the time and date at which this decision is made should be recorded in the nursing and/or medical notes. Isolation should occur within two hours of the clinical area deciding there is a need to isolate e.g. unexplained diarrhoea. Refer to **Appendix 1** – Isolation Planning guide

If isolation within two hours is not achieved there must be escalation to the Matron for the clinical area (in hours), CSM (out of hours), to ensure appropriate placement. If the Matron or CSM is unable to find a single-room accommodation, this must be escalated to the infection prevention and control team (in hours) or on-call microbiologist (out of hours) with the required patient information for a joint risk assessment. See **Appendix 2** for Isolation priorities.

In situations where source isolation is not available, cohort source isolation in bay areas with doors which can be accessed independently, maybe considered for patients who have been identified as having the same clinical diagnosis, suspected symptoms or clinical risk category. Cohorting patients' carries a significant risk of re-infection/re-colonisation, therefore cohorting should be considered only in situations where single room source isolation is not possible and for the shortest time possible.

Where isolation is not possible (i.e. ESBL, MRSA) please refer to **Appendix 3.** This information is required to be relayed to the microbiologist or IPC team if available so that where possible the safest advice will be given where the patient should be nursed and the precautions that should be taken to prevent cross contamination.

Display an Isolation Precautions poster **Appendix 4**, where any potential alert organism is being cared for, this could be displayed on entrance to the bay or outside an isolation room.

If isolation is for childhood diseases (i.e. Infections such as measles, mumps, rubella, for which routine vaccination occurs or chicken pox), only staff who are immune to the disease should attend to the patient.

In the emergency department at Doncaster Royal Infirmary and Bassetlaw Hospital, cases of possible infection, from Ebola, or other new infections (such as Covid 19 during the initial stages of the pandemic), are to be directed immediately to the designated area and isolated. This then allows the doors between the Emergency department and waiting area to be on 'Lock down'.

PATIENTS LACKING CAPACITY

Sometimes it will be necessary to provide care and treatment to patients who lack the capacity to make decisions related to the content of this policy. In these instances staff must treat the patient in accordance with the Mental Capacity Act 2005 (MCA).

- A person lacking capacity should not be treated in a manner which can be seen as discriminatory.

- Any act done for, or any decision made on behalf of a patient who lacks capacity must be done, or made, in the persons Best Interest.

- Further information can be found in the MCA policy, and the Code of Practice, both available on the intranet.

4.2 Preparation of the Source Isolation Room

It is particularly important to keep the door closed when the side room is used for isolating a patient with an airborne infection (i.e. Covid 19, Influenza and C Diff)

If a single room is indicated it is preferable that it has ensuite toilet and washing facilities.

Remove all non-essential furniture and equipment. Ensure that appropriate equipment is available:

Inside the room

- Hand washing facilities.
- Clinical waste bag holder/bin.
- Thermometer, BP cuff & tourniquet (preferably disposable).
- Stethoscope (if required).
- Toileting (commode) and wash facilities (if no ensuite).
- A wall clock should be displayed. This is to prevent sensory deprivation of time.

Note, the mental health of the patient may dictate that it is unsafe to leave some of this equipment within the room.

Outside the room

- Appropriate PPE in dedicated dispensers, where possible.
- Alcohol hand rub.
- All Nursing and Medical notes to be remain outside the room.
- The permanent source isolation signage should be displayed.

Many studies have shown the detrimental effect of isolation on patients' psychological well-being. Some patients may find it beneficial to leave their isolation room for short periods of time or for mobilisation purposes. If patients wish to leave their isolation rooms for short periods, consultation with the IPC team should occur and a risk assessment undertaken. This may be easier to achieve during quieter periods on the ward, such as rest periods. This must be carefully explained to patients who may find it confusing.

Management of the Patient Once Isolated

Key Points:

The objective of single room isolation is to minimise the risk of cross-infection.

Staff must:-

- Establish and maintain communication with the patient and relatives regarding the need for single room isolation.
- Provide an information leaflet (for the specific isolate) to the patient/family
- Hand decontamination: always wash hands with soap and water or alcohol gel prior to entering and on leaving the isolation room.
- Plan care, with advice and assistance from the Infection Prevention and Control Team.
- Obtain relevant microbiology samples to facilitate diagnosis and management.
- Commence IPC isolation IPOC care sheet, WPR36372.
- Good communication is essential with other members of hospital staff (whilst preserving confidentiality) to ensure compliance with barrier precautions.
- A laminated isolation sign must be prominently displayed, which provides sufficient constructive and educational information, whilst ensuring that there is no breach of confidentiality.
- Ensuite toilet facilities must be available for patients with loose stools. Type 5- 7 on the Bristol
  stool chart. If a commode is used this must be decontaminated thoroughly after each use and returned to the isolation room. On discharge the commode is to remain in the room for hydrogen peroxide vapour (HPV) if occurring, or decontaminated thoroughly before another patient use.
- The door to the room **must** be kept closed (if an airborne infection) and the patient encouraged to remain inside. If either of these are likely to compromise the patient's care then a documented risk assessment should be carried out daily in the Isolation IPOC.
- On occasion it may be necessary for the patient to have physiotherapy in the ward corridor. Again, a documented risk assessment should be carried out prior to commencing the activity.
- Ensure the room is kept clean and uncluttered and that all procedures are carried out effectively and according to relevant hospital policies. Source Isolation rooms should be cleaned twice daily and documented.
- Visitors do not need to wear plastic aprons or gloves for routine social visiting unless assisting with hands on care.
- Medical equipment inside the room must be dedicated to the isolated patient until the patient is discharged or deemed no longer to require isolation. The equipment **must** then be appropriately decontaminated before it can be used on another patient. Ensuring use of 'I'm clean' tape to indicate the equipment has been cleaned and ready for reuse. No equipment used for a patient in isolation should be used on any other patient without adequate decontamination.

- All Patient documentation e.g. charts must be kept outside the room.
- The vacated room must be cleaned thoroughly before it can be reoccupied. (see 6.2 Terminal Cleaning) If a confirmed case of GDH or C.Diff is nursed in the room it should be treated with HPV before reuse. (Fogging) (see 6.3).
- Hand hygiene must also be performed between different patient care activities to prevent cross contamination of different body sites. If the patient has diarrhoea, soap and water must be used for hand hygiene rather than alcohol rub. Hand hygiene should also be undertaken on leaving an isolation room.

4.3 Protective Isolation

The purpose of protective isolation is to provide a safe environment for patients who have an increased susceptibility to infection because they have a compromised immune system or extensive skin loss due to burns or other trauma.

Generally these patients are most at risk from their own resident flora (endogenous infection) but must also be protected from the risk of cross infection (exogenous infection).

As most infections are endogenous, there should be an emphasis on patient education regarding hand washing and basic hygiene.

The decision to institute protective isolation (reverse barrier) is made by the clinician caring for the patient or on the advice of the infection prevention and control team, Haematologist or Oncologist.

Management of the Patient Once Isolated

Key Points

- Hand decontamination: always wash hands with soap and water or alcohol gel prior to entering and on leaving the isolation room.
- Discourage visitors with symptoms of infections or known exposure to infections e.g. chicken pox, colds, diarrhoea.
- Discourage visitors with small children where possible.
- No flowers or plants as they may be a source of Aspergillus or other pathogens.
- Patients must receive education on good hygiene practices. This must include washing hands before eating and after toileting and encouraging a good cough etiquette.
- Staff with infections should not be working in the environment.
- Ensure all staff are aware of the necessary precautions.

- Visitors do not need to wear plastic aprons or gloves for routine social visiting unless assisting with hands on care.
- The immunocompromised patient is at increased risk of food-borne illness. In general, foods fruit and vegetables should be packaged or peeled and dairy products should be individually packaged and pasteurised. Pate, liver, soft cheeses, ice and tap water should be avoided and live yoghurts are not advised.
- All categories of staff working must be screened for chickenpox and encouraged to have seasonal influenza vaccine.

4.4 Transport of Infected/Infectious Patients

Movement of infectious or potentially infectious patients must be kept to a minimum. When it is necessary to transport patients to other wards or departments, precautions to minimize the risks of transmission must continue.

If it is possible to delay an investigation without adversely affecting the patients management this should be considered. However the presence of an infectious disease should not delay urgent clinical investigations.

The **receiving area must** be informed prior to transfer to ensure that they have the appropriate precautions in place and that appropriate facilities are available.

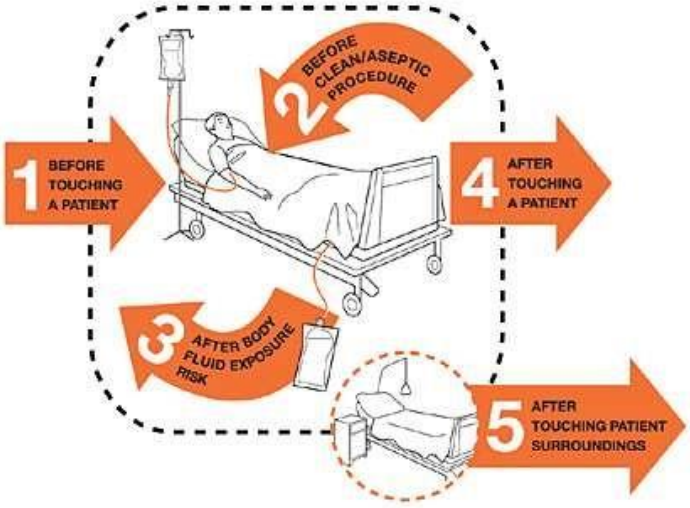
Patients with known or suspected infections must as far as possible be seen at the end of the list and not be left in the waiting areas. This will allow adequate cleaning of the environment and equipment following the appointment and reduce the risks of transmission to other patients.

Check specific infection control policies for advice and guidance. Consult the infection control team for any further advice or guidance.

5 HAND HYGIENE

Hand washing is considered the single most important factor to reduce the risk of Healthcare Associated Infections. Hand decontamination has a dual role in that it can protect both the patient/visitor and the healthcare worker, from acquiring micro-organisms which may cause them harm.

Hand hygiene – staff
Inside the isolation room *all* hand decontamination must be with liquid soap and water. Hand decontamination from staff is required in the following circumstances:



Hand hygiene – patient

The patient is a potential source of spread of organisms to staff, visitors and the environment. Patients should be encouraged to decontaminate hands prior to eating and after use of the toilet.

Liquid soap and water should be encouraged for all patients if their hands are visibly soiled. Approved hand wipes may be used at lunch times for those less able however the mobile patient should always be encouraged to wash hands with soap and water or use the hand gel provided at the bedside.

Hand Hygiene – visitor

The visitor is a potential source of infection to staff and patients. Visitors should be encouraged to use hand gel or wash hands before entering and leaving the ward, and following any hands on care with the patient.

6 ENVIRONMENTAL AND EQUIPMENT CLEANING

Thorough physical cleaning **must** be the first step in any decontamination process. Failure to achieve this reduces the efficacy of subsequent decontamination measures. Ensuring use of tape to indicate the equipment has been cleaned and ready for reuse.

6.1 Twice Daily Room and Patients Equipment Cleaning

Domestic Services staff are responsible for cleaning the clinical environment, and the nursing staff for medical equipment, i.e. drip stands, commode

Single use plastic apron and disposable gloves should be put on before cleaning takes place. A fresh disposable mop head, cleaning cloth and cleaning solution is needed for every side room or patients bed space if cohort nursing in place.

All isolation rooms **must** be cleaned twice daily with the Trust approved disinfectant, with an interval of at least 8hrs between cleans. When cleaning an isolation Room /Bay, use yellow disposable cloths, pay particular attention to horizontal surfaces and frequently touched areas, such as door handles, nurse call buzzer, toilet areas, bed frame, mattresses, patients table and locker.

Remember it is recommended that:

 Protective isolation rooms should be cleaned **before** the rest of the ward.

6.2 Terminal Room Cleaning

Following patients discharge/transfer, or when isolation is no longer necessary the room should be cleaned using the Trust approved disinfectant.

Domestic Services staff are responsible for cleaning the clinical environment, and the nursing staff for medical equipment.

Fabric curtains must be removed and sent to the laundry as infected linen, before commencing a terminal clean.

IT IS NOT NECESSARY TO CHANGE DISPOSABLE CURTAINS (THESE ARE REPLACED ON A REPLACEMENT PROGRAMME) WITH THE EXCEPTION OF A PATIENT WITH KNOWN C.DIFF INFECTION

All unused disposable equipment should be discarded into clinical waste bin. It is not necessary to remove the contents of paper towel and soap dispensers.

All areas of the room cleaned using yellow disposable cloths, pay particular attention to horizontal surfaces and frequently touched areas, such as door handles, nurse call buzzer, toilet areas, bed frame, mattresses, patients table and locker.

6.3 Hydrogen Peroxide Vaporisation (HPV – Fogging)

This method of chemical disinfection is used within the hospital when the environment has been potentially contaminated with a virulent pathogen e.g. *C Diff*, *GDH*. In order to adopt this level of decontamination the area to be 'fogged' will require a thorough terminal clean. All the equipment and items within the vicinity to be 'fogged' will need to be placed in such a manner to allow for maximum exposure of its surface area to the HPV process. HPV needs to be undertaken by trained and competent staff who will be familiar with potential health and safety hazards associated with this procedure for further information.

It will take approximately 3 hours for a single room/bay to undergo HPV and be ready for clinical use.

7 INVESTIGATIONS – VISITS TO OTHER DEPARTMENTS

When patients are sent for an investigation the requesting card should state why the patient is in isolation. The receiving department should be contacted by telephone prior to arrival of the patient to ensure that adequate precautions can be taken.

In order to minimise contact and reduce the risk of cross infection, isolated patients should be taken directly to and from other departments and not left in waiting areas.

Service Assistants/Porters do not need to wear protective clothing unless they are likely to come into contact with the infectious material. Standards of hand hygiene should be made prior to and after completion of transporting the patient.

8 OUTBREAKS OF INFECTION

Where there are significant numbers of patients infected or colonised with the same organism, it may be impossible to nurse all the affected patients in single rooms. Symptomatic patients may be grouped together in a dedicated area (e.g. in one bay) this is known as cohort nursing.

For effective cohort nursing in bays, ideally bays should have doors that can be closed to provide physical separation from other patients.

When there are competing demands for single rooms, bed managers and the infection prevention and control team should jointly agree on the appropriate placement of patients for non-clinical reasons. The procedure for isolation in an outbreak situation is clearly stated and explained in the Management and Control of Incident/Outbreak of Infection (PAT/IC 20).

9 CONFIDENTIALITY

All patients have a right to dignity, privacy and respect. It is essential to maintain confidentiality regarding the patient's illness. Certain infections or outbreaks of infection arouse interest and speculation by the media and staff must not divulge such information within or outside the hospital.

10 TRAINING/SUPPORT

All staff should understand how organisms spread in order to apply isolation procedures. Each staff member is accountable for his or her practice and should always act in such a way as to promote and safeguard the well-being and interest of patients. Staff will receive instructions and direction regarding infection prevention and control practice and information from a number of sources:

- Trust Induction.
- Trust Policies and Procedures available on the intranet.
- Ward/departmental/line managers.
- SET mandatory training.
- Infection Prevention and Control Educational displays/posters.
- Trust Infection Prevention and Control Team.
- Infection Prevention and Control Link Practitioners will be provided with education sessions about the policy at their meetings which will facilitate local training and supervision to take place.
- Advice is also available from the Doncaster & Bassetlaw Hospitals internet sites.

11 MONITORING COMPLIANCE WITH THE PROCEDURAL DOCUMENT

Monitoring	**Who**	**Frequency**	**How Reviewed**
The policy will be reviewed in the following circumstances:-	IPCT	Every three years routinely, unless: • When new national or international guidance are received. • When newly published evidence demonstrates need for change to current practice. • Action required from Post Infection review (PIR) Serious Incident Investigation Report	Approved Procedural Document (APD) database Policy will be approved and ratified by the Infection Prevention and Control Committee
Compliance with policy to negate cross-infection	IPCT	Weekly	"Alert organism review" to monitor adherence with the policy.
Training needs for infection prevention and control	Ward and Department Managers Training and Education Department	Annually	Staffs Professional Development Appraisal Training will be captured via the OLM system as part of annual SET training

Incident Reporting via Datix System	IPCT and ward staff	On Occurrence	Incidence of Datix, reviewed and any recommendations will be made at IPC Committee meeting

12 DEFINITIONS

Best Interest - There is no single definition of Best Interest. Best Interest is determined on an individual basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision should be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.

Hydrogen Peroxide Vaporisation (HPV Fogging) - HPV significantly reduces environmental contamination. This method of disinfection is used within the Hospital Deep Cleaning Programme and following a patient with *GDH, Clostridium difficile and CPE.* The room must be terminally cleaned and HPV undertaken on discharge.

Best Interest Assessment – A Best Interest assessment is determined on an individual patient basis. All factors relevant to the decision must be taken into account, family and friends should be consulted, and the decision must be in the Best interest of the individual. Please see S5 of the MCA code of practice for further information.

13 EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. (See Appendix 5)

14 ASSOCIATED TRUST PROCEDURAL DOCUMENTS

This policy should be read in conjunction with other Trust Infection Control Policies, particularly:

- Chickenpox/Shingles Management Policy(PAT/IC 15)
- Cleaning and disinfection of Ward-based Equipment (PAT/IC 24)
- Clostridium Difficile Infection (CDI) Policy (PAT/IC 26)
- Gastroenteritis Minor Outbreak Policy (Diarrhoea and Vomiting) (PAT/IC 27)
- Hand Hygiene (PAT/IC 5)
- Management of sharps injuries and blood and body fluid exposure incidents (PAT/ IC 14)
- Management and Control of Incident/Outbreak of Infection (PAT/IC 20)
- Meningococcal Infections – Management of Cases and Contacts (PAT/ IC 12)
- Mental Capacity Act 2005 – Policy and Guidance, including Deprivation of Liberty Safeguards (DoLS) (PAT/PA19)
- MRSA Screening and Management of Patients with MRSA (PAT/IC 6)
- Multi-Resistant Gram-Negative Bacteria - Prevention and Control Policy (PAT/IC 28)
- Privacy and Dignity Policy (PAT/PA28)
- Scabies – Guidance on Management (PAT/IC 7)
- Standard Infection Prevention and Control Precautions Policy (PAT/IC 19)
- Tuberculosis Care of the Patient with smear negative/positive Pulmonary Tuberculosis in Hospital (PAT/IC 23)
- Waste Management Policy (CORP/HSFS 17)
- Variant Creutzfeldt-Jakob Disease (vCJD) and Transmissible Spongiform Encephalopathy Agents (TSE): Minimising the Risks of Transmission (PAT/IC 4) Fair Treatment for All (CORP/EMP 4)
- Equality Analysis Policy (CORP/EMP 27).

15 DATA PROTECTION

Any personal data processing associated with this policy will be carried out under 'Current data protection legislation' as in the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016.

For further information on data processing carried out by the trust, please refer to our Privacy Notices and other information which you can find on the trust website: https://www.dbth.nhs.uk/about-us/our-publications/uk-data-protection-legislation-eu-generaldata-protection-regulation-gdpr/

16 REFERENCES

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4. Epic3: National evidence based guidelines for preventing healthcare-associated infections in NHS hospitals in England. Loveday HP, Wilson JA, Pratt RJ et al. (2014). Journal of Hospital Infection 86 (Supplement 1) S1- S70

5. Infection Control in Clinical Practice Updated Edition, 3e. London: Bailliere Tindall. Wilson, J. (2019)

6. The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Tenth Edition 2020. Dougherty, L and Lister, SE

APPENDIX 1 – ISOLATION PLANNING GUIDE

*Notifiable infection

Disease	What is Infected	Route of Spread	Single Room	Door Closed	PPE (Gloves and Apron)	Masks	Treat Linen as Infected	Period of Precautions	Comments
Acquired Immune Deficiency Syndrome (AIDS) or HIV Infection	Blood and Body Fluids	• Blood or infected tissues. • Sexual exposure. Vertical transmission Breast milk. • Occupational exposure e.g. sharps injuries.	X Unless bleeding profusely.	X	√ If contact with blood or body fluids	√ full face visor if risk of splashes or sprays.	√ if contaminated with blood or body fluids	On-going throughout admission.	For occupational exposure e.g. sharps injuries see policy PAT/IC14
Campylobacter*	Faeces	By ingestion of organisms faecal oral route.	√	√	√	X	√	Until symptom free for 48 hours.	
Chickenpox	Respiratory secretions, discharge from vesicle fluid	• Direct contact with vesicle. • Droplet or airborne secretions. • Indirect contact with freshly soiled articles of clothing or linen.	√	√	√	X	√	5 days from the onset of the rash and until the lesions are crusted and dry.	Non-immune and pregnant staff to avoid contact with affected patient. See policy PAT/IC15.
CJD and vCJD *	Brain, eye, nerves, lymphoid tissue	Direct and indirect contact.	√	√	√	X	√	On-going throughout admission.	Special care with surgical instruments see policy PAT/IC4.
Clostridioides difficile and GDH	Faeces	By ingestion of organisms via faecal oral route.	√	√	√	X	√	Until advised by IP&CT	Review antibiotic use, HPV on discharge/transfer
Covid 19 (SARS_CoV2)	Respiratory secretions	Respiratory. Airborne.	√	√	√	√ Surgical mask with Visor Or FFP3 if AGP	√	Isolate for 10 days	Patient contacts may require screening if symptoms develop

Diarrhoea +/- vomiting, known or suspected food poisoning*	Faeces and vomit.	By ingestion of organisms from faeces or vomit; faecal oral route.	√	√	√	X	√	Until symptom free for 48 hours, or infective cause ruled out	Remember Outbreak Policy if more patients become symptomatic PAT/IC20).

Disease	What is Infected	Route of Spread	Single Room	Door Closed	PPE (Gloves and Apron)	Masks	Treat Linen as Infected	Period of Precautions	Comments
E. Coli 0157*	Faeces	By ingestion of organism (faecal/oral)	√	√	√	X	√	Until symptom free for 48 hours.	Can cause haemolytic uremic syndrome
Group A Streptococcus*	Saliva and wound exudate	Respiratory secretions Contact with fluid from lesions.	√	X	√	X	√	Until 48 hours of appropriate antibiotics	Staff developing a sore throat should refer to Occupational Health.
Hepatitis A*	Faeces	By ingestion of organisms faecal oral route.	√	√	√	X	X Unless soiled	7 days from onset of symptoms or onset of jaundice	
Hepatitis B*	Blood and body fluids	• Blood or infected tissue. • Sexual exposure. • Vertical transmission. • Occupation exposure e.g. sharps injuries.	X Unless bleeding profusely	X	√	X	X Unless soiled	On-going throughout admission.	

Hepatitis C*	Blood and body fluids	• Blood or infected tissue. • Sexual exposure. • Occupation exposure e.g. sharps injuries.	√	√	√	X	X Unless soiled	On-going throughout admission.	
Influenza	Respiratory secretions	□ Respiratory. □ Airborne.	√	√	√	√ Surgical mask with Visor	X	At least 5 days from onset of illness, until asymptomatic, if patient immunosuppressed exclude for 10days	Patient contacts may require screening and antivirals. DW virology
Legionnaires*	Lung tissue	Water (air conditioners, airborne by very fine aerosols).	X	X	Standard practice	X	X		Not thought to be transmissible person to person.

Disease	What is Infected	Route of Spread	Single Room	Door Closed	PPE (Gloves and Apron)	Masks	Treat Linen as Infected	Period of Precautions	Comments
Measles *	Respiratory Secretions	•Droplet spread. •Direct contact via soiled linen	√	√	√	√ FFP3, as per national guidance	X	For 4 days from the onset of the rash	Non- immune staff to avoid contact with affected patient.
Meningococcal Meningitis (bacterial)*	Respiratory Secretions	• Droplet spread. •Direct contact with mucous membranes	√	√	√	√ Surgical mask for first 24hrs	X	Until the patient has received 24hrs of appropriate antimicrobial therapy	Prophylaxis indicated for close family contacts see Policy PAT/IC12
Pneumococcal Meningitis	Respiratory Secretions	• Droplet spread. • Direct contact with mucous membranes	√	√	√	√ Surgical mask for first 48hrs	X	Until the patient has received 48hrs of appropriate antimicrobial therapy	

Monkey Pox	Respiratory secretions or lesions	Droplet spread or contact with lesions	√	√	√	√ Surgical mask or FFP3 if patient coughing	√	Afebrile for 72 hours and until there have been no new lesions for 48 hours and lesions have crusted over	Avoid contact is pregnant, immunosuppressed or under the age of 12
MRSA	Site dependent and whether colonized or Infected	Direct contact with patient and their environment	√	X	√	X	√	Until advised by the Infection Prevention and Control team	See MRSA policy PAT/IC6
Multi Resistant Gram negative bacteria e.g. Carbapenemase-producing Enterobacteriaceae (CPE)	Dependent on site	Direct contact with patient and their environment	√	√	√	X	√	Until advised by the Infection Prevention and Control team	See Policy PAT/IC 28
Mumps*	Respiratory secretions	• Droplet spread. • Direct contact with nasal or throat secretions. • Indirect contact via soiled linen.	√	√	√	√ Surgical mask	√	For 5 days from the onset of parotid swelling	Non-immune staff to avoid contact with affected patient.

Disease	What is Infected	Route of Spread	Single Room	Door Closed	PPE (Gloves and Apron)	Masks	Treat Linen as Infected	Period of Precautions	Comments
Rotavirus	Faeces, vomit, respiratory secretions	□ Droplet Spread □ Faecal oral	√	√	√	√ surgical masks	X	Until symptom free for 48hrs	Remember Outbreak policy PAT/IC20 if many babies affected. Wear a surgical facemask when vomiting.
Respiratory Syncytial Virus (RSV).	Respiratory secretions	• Droplet spread. • Direct contact with respiratory secretions.	√	√	√	√ surgical masks	X	Until symptom free In Neo natal Unit until neg Nasopharyngeal aspirate	Immunosuppressed patients will need extended isolation

Rubella*	Respiratory secretions	• Droplet spread. • Direct contact with respiratory secretions.	√	√	√	√ surgical masks	X	For 5 days after onset of rash.	
Salmonella*	Faeces	Faecal oral spread.	√	√	√	X	√	Until diarrhoea free for 48 hours.	
Scabies	Skin	• Scabies mite. • Prolonged direct skin to skin contact (20 mins approx.).	√	√	√	X	√	Patient with Scabies should be isolated in a single room with the door closed until 24 hours after treatment has commenced (NHS England 2023), unless, they are Norwegian/crusted scabies when patient should be isolated until full treatment has been completed. Linen to be treated as infected.	Referral to Consultant Dermatologist recommended see policy PAT/IC7.
SARS / pandemic influenza*	Respiratory secretions see policy PAT/IC10.	• Droplet spread. • Direct contact with respiratory secretions. • Airborne.	√	√	√	√ FFP3 masks	√	Duration of illness.	Seek urgent advice from the Infection Prevention and Control Team
Shingles (Herpes Zoster)	Vesicle fluid	• Direct contact with vesicle fluid. • Indirect contact with soiled linen.	√	√	√	X	√	Until lesions are crusted and dry.	Staff who are non-immune should not care for the patient.
Tuberculosis (TB) - Pulmonary*	Sputum See NICE guidelines for multi drug resistant TB (MDTB)	• Airborne, • Direct contact with respiratory secretions.	√	√	√	√ FFP3 masks	√	Until 2 weeks after effective compliant treatment.	See policy PAT/IC23.If MDTB will require Negative pressure room

Disease	What is Infected	Route of Spread	Single Room	Door Closed	PPE (Gloves and Apron)	Masks	Treat Linen as Infected	Period of Precautions	Comments
Viral Haemorrhagic Fevers*	Bodily fluids	Contact – direct/indirect	√	√	√	√	√	STRICT ISOLATION – Transfer to Infectious Disease unit	Seek Urgent advice from the Consultant Microbiologist Additional PPE depending on risk e.g. possible / probable case.
Vancomycin Resistant Enterococci (VRE)	Body fluids/wounds, carried in faeces	Contact direct and indirect	√	√	√	X	√	Isolation required if symptomatic to diarrhoea, or present in wound/urine	See PAT IC/17 Management of Patients with Glycopeptide Resistant Enterococci
Whooping Cough (pertussis)*	Respiratory secretions	• Airborne. • Direct contact with nasal and throat secretions.	√	√	√	√ Surgical mask	X	Until 5 days after appropriate antibiotic therapy commenced	Restrict contact with infants and young children until patient has received at least 5 days of treatment.

***Notifiable infection; - there is an electronic Notification of Infectious Diseases form (e noid) to complete access here** www.yhphnetwork.co.uk for Yorkshire and Humber.

DONCASTER UK Health Security Agency (formerly PHE) - Out of Hours number - 0113 3860300 patients

Telephone0344 2254 524 (option 1), Out of hours advice 0344 2254 524

BASSETLAW

or email phe.emhpt@nhs.net patients

APPENDIX 2 – ISOLATION PRIORITIES

High **Do not remove from isolation without prior discussion with IPC/duty microbiologist**	Medium	Low
• Diarrhoea and/or vomiting of unknown origin • Suspected/Confirmed C.Diff/GDH/Norovirus/ Campylobacter • Suspected/Confirmed Pulmonary TB • Suspected/Confirmed Chicken Pox/Shingles/Measles/Monkey pox • MRSA in blood/ sputum/ exudating wound/ mupiricin resistance • E.coli 0157/salmonella • Norwegian Scabies • Suspected/Confirmed Influenza or Covid 19 • Viral Haemorrhagic fever • VRE with symptoms	• ESBL/AMP C • GRE • Mumps • Meningitis • Strep A on high risk areas • Open weeping TB lesions to skin • MRSA positive post full screen and on treatment as per policy • MRO • RSV	• Previous MRSA • Previous GDH/C Diff without symptoms • Previous VRE without symptoms

APPENDIX 3 – INFORMATION REQUIRED BY ON CALL CONSULTANT MICROBIOLOGIST WHEN SEEKING ADVICE RE ISOLATION

The on call microbiologist should only be contacted when all available isolation facilities have been explored. Ideally isolation options should be discussed with the IPC team before 5 pm weekdays. In order to make an informed decision the Microbiologist will require the following information:

a. The up to date infection status of each patient on the ward e.g. screen results.

b. A description of the physical layout of the wards and patient location including number of beds.

c. The number and location of side rooms and the occupancy status.

d. Symptoms of clinical infection e.g. purulent discharge, diarrhoea and/or vomiting and coughing/expectorating patient.

e. The site or specimen from which the infection has been isolated (e.g. wound swab, sputum etc.).

f. The organism that is causing the infection (if known).

g. Psychological and other medical factors that may prevent isolation (e.g. presence of depression/anxiety, need for observation etc.).

h. Current/recent incidences of ''inability to isolate'' resulting in patients with infections being nursed in open bays.

i. Clinical requirements (e.g. speciality specific treatment/care or clinical reasons why Source Isolation might compromise patient safety).

It will not be possible for the Microbiologist to make a decision on source isolation if this information is not available.

APPENDIX 4 – INFECTION CONTROL PRECAUTION POSTER

APPENDIX 5 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/Project/ Strategy	Division/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
Isolation Policy PAT IC 16 v.9	Corporate Nursing, Infection Prevention & Control	Carol Scholey - Infection Prevention and Control Practitioner	Existing Policy	July 2022

1) Who is responsible for this policy? Infection Prevention & Control Team

Describe the purpose of the service / function / policy / project/ strategy?
It demonstrates the Trust commitment to provide staff with guidance to maintain safe practice.

2) Are there any associated objectives? Legislation, targets national expectation, standards- Department of Health

3) What factors contribute or detract from achieving intended outcomes? – Nil

4) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - No

- **If yes, please describe current or planned activities to address the impact** – Nil

5) Is there any scope for new measures which would promote equality? N/A

6) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	No	Neutral

b) Disability	No	Neutral
c) Gender	No	Neutral
d) Gender Reassignment	No	Neutral
e) Marriage/Civil Partnership	No	Neutral
f) Maternity/Pregnancy	No	Neutral
g) Race	No	Neutral
h) Religion/Belief	No	Neutral
i) Sexual Orientation	No	Neutral

7) Provide the Equality Rating of the service / function /policy / project / strategy – tick (✓) outcome box

Outcome 1 ✓	**Outcome 2**	**Outcome 3**	**Outcome 4**

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: August 2025

Checked by Date: M. Boyack. Lead Nurse Infection Prevention and Control **Date:** August 2022