

Isolation and Bed Management Policy

Department / Service:	Infection Prevention Team
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Approved by:	TIPCC
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Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Services
Target staff categories	All Staff Groups

Policy Overview:

This policy is designed to provide guidance on the bed management and isolation of infectious patients. Different types of isolation are described within this policy, and a wide range of infectious conditions are incorporated. The patients covered by this policy include all patients who receive care under Worcestershire Acute Hospitals Trust.

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Healthcare professionals must be prepared to justify any deviation from this guidance.

Latest Amendments to this policy:

The following policies have been amalgamated with revisions where necessary:
 WAHT-INF-015 version 5.7 – Isolation Policy
 WAHT-INF-019 version 5.1 – Infection Control and Bed Management Guideline

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Supporting Documents

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1. Introduction

Micro-organisms (e.g. bacteria, viruses and fungi) can cause a range of infectious diseases/infections. Acquisition of infection while in hospital can lead to extended inpatient admissions. Most infections can be prevented through the implementation of standard infection prevention precautions, as described later in this policy.

However, some diseases that can be transmitted between patients or between patients and staff, require additional precautions in the form of isolation, and specific bed management requirements. Patients who are at greater risk of infection, such as those with reduced immunity, may also require additional precautions to protect them from infection.

The IPT must be notified as soon as possible where a patient has been isolated (due to suspected/known infection) to ensure the correct precautions are implemented. Patients who present with diarrhoea/vomiting must be promptly isolated (within 4 hours unless infectious cause can be confidently excluded) as recommended by the Healthcare Commission (2006). The algorithm (Appendix 1) provides an action plan and timeline to isolation for such cases. Similarly, should there be insufficient isolation facilities available for the number of infectious patients requiring placement, staff in the first instance, should refer to the risk assessment for the prioritisation of side rooms, and then discuss with the Site Management Team (SMT) who will be able to provide assistance with the prioritisation of attribution of isolation rooms according to the level of risk.

A member of the Infection Prevention Team (IPT) is always available for advice. The IPT consists of Infection Prevention Nurses (IPNs) and Consultant Medical Microbiologists (CMMs). They may be contacted for advice on the following extensions, via bleep, or through the hospital switchboard.

Worcestershire Royal Hospital:

IPNs – Ext 38752 Bleep 840

Duty CMM – Ext 30673

Alexandra General Hospital:

IPNs – Ext 44744 Bleep 0227

On Saturdays, there is an IPN available between 0800-1600. On Sundays, and out of hours (OOH), the first point of call for infection prevention issues is the SMT. Should the SMT be unable to resolve an issue, they will contact the Duty CMM (On-Call). The CMM should not be contacted by any persons other than the SMT or senior medical staff for clinical issues.

2. Scope of this document

This policy applies to all healthcare professionals working within the organisation including medical staff, nurses, allied health professionals, students and visiting staff.

It relates to all patient movement into, within, and out from the Acute Trust. Further detailed information is available in the Trusts infection prevention policies, protocols and guidelines available on the Key Documents page of the intranet site.

3. Definitions

Same organism – meaning the organisms causing infection are epidemiologically linked, i.e. their symptoms are related by time, based on the date of onset of the first case, and location.

Don – put on

Doff – remove

4. Duties (Roles and Responsibilities)

The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with this policy

The Chief Executive has overall responsibility for implementation, monitoring and review of this policy. This responsibility is delegated to the Director of Infection Prevention and Control (DIPC), who chairs TIPCC.

The Trust Infection Prevention and Control Committee (TIPCC) will review and ratify the policy and any new evidence base within the time frame set out in the policy.

The Director of Estates and Facilities is responsible for ensuring that isolation facilities are maintained, including correct ventilation parameters.

The Infection Prevention Team (IPT) is responsible for giving infection prevention and control advice as necessary and for assisting with the review of this policy to ensure the policy contains current evidence based guidance.

The Site Management Team (SMT) is responsible for sourcing a suitable placement for a patient with an infectious disease.

The Occupational Health Department is responsible for assisting with staff surveillance as necessary and staff vaccination.

Consultants, Matrons, Line Managers and Heads of Department are responsible for ensuring that policies, procedures and guidelines, access to education and training are made available to all staff to ensure staff competence, minimise the risk of infection transmission, and ensure clinical practice is in line with Trust policy.

All Staff are responsible for ensuring that they understand and implement this policy.

5. Policy Detail

Adherence to standard infection prevention and control precautions will help in reducing the risk of acquiring infection from patients whose infectious status is unknown, particularly in those with blood borne diseases.

However, it is sometimes necessary within the hospital environment to take additional precautions when a patient is known to have, or suspected of having an infectious disease (see Policy for Notifying Suspected Infectious Diseases and Causative Organisms for notifying procedure).

Any patient with a disease which is infectious to others should be nursed in a single-room with appropriate infection control precautions in order to prevent the spread of infection to others. This should not compromise the individual patients' clinical care or prevent them from undergoing any procedure indicated for investigation or treatment.

Inevitably, the demand for single-room accommodation often exceeds the facilities that are available, and the placement of patients in any clinical area, including single-room accommodation should be risk assessed according to:

- The known/suspected organism causing infection
- The risk of transmission to others, and mode of transmission
- The severity of infection which could be caused
- The susceptibility of other patients to infection
- The reasons why patients are currently occupying the single-room accommodation
 - E.g. if related to non-transmissible infection, the need to protect the individual from infection, or for non-infection related indications.

5.1 Isolation Category

Isolation Risk Assessment and Patient Placement

The potential for transmission of infection or infectious agents should be assessed by staff at the patient's entry to the care area and should be continuously monitored throughout the patient's stay. Staff should therefore ensure that all patients admitted under their care are promptly assessed for infection status using the appropriate admission assessment on arrival to the care area, and if possible, prior to accepting a patient from another care area. Staff should refer to the aide memoire relating to general principles of isolation (Appendix 2).

Isolation need is then risk assessed through referring to and/or completing the following documentation, or discussing with the IPT:

- Rapid Diarrhoea and Vomiting (D&V) Risk Assessment (Appendix 3)
- A – Z of Infectious Pathogens/Diseases (Appendix 4)

Once a need for isolation has been identified, staff should ensure that the risk assessment for the prioritisation of side rooms is completed to assist the SMT and Bed Managers with placement of the patient where single-room accommodation is not immediately available, or the requirement of single-room accommodation exceeds the facilities available (see Appendix 5 for process). This risk assessment should be reviewed every 48 hours.

******The infection status of the patient must then be clearly recorded in the patients medical notes, on the patient electronic white board system and CAPP tool, including patient placement decision******

Once a patient is isolated, it is vital that laminated isolation door signs are attached to the outer aspect of the door. Laminated isolation door signs are available to order from Xerox or on the intranet. Special notices are available for paediatrics. The sign should be attached to the door of the single-room or visible area, e.g. bay door when cohort nursing. When attaching the appropriate

laminated isolation door sign, it is imperative that the relevant boxes on the sign are ticked to indicate whether or not respiratory protective equipment (RPE) is required.

Single-room Nursing

A single en-suite room under negative pressure ventilation with the door closed is the required means as to prevent the transmission of organisms spread by the **airborne route**.

A single en-suite room with the door closed is preferred for infection spread by the **droplet route**.

A single (preferably en-suite) room is the favoured means to prevent the transmission and gross contamination of the environment outside the room with certain organisms that may be spread via the **contact route**.

Isolation is not necessary for infections spread by the blood borne route.

****Exceptions to this may be when there is heavy blood loss****

For patients who are at an increased risk of acquiring infection from other patients, for example, they are immunocompromised, placement in a single en-suite room with the door kept closed and under positive pressure.

If, for any reason, the door cannot be kept closed, or the patient cannot be isolated as the patient is deemed to be at risk (e.g. for falls or mental health reasons), the appropriate risk assessment must be completed and the decision documented in the patient's medical notes.

A number of rooms at the Worcestershire Royal Hospital site have positive and negative air flow systems that operate when the door is closed to increase the protection to patients and staff. These rooms are identified by a grey Magnehelic gauge above the door that must be monitored to ensure that air flows are operating appropriately (Appendix 6). Staff must ensure that appropriate risk assessment is carried out to identify whether Magnehelic controlled single-rooms are required for the infectious disease/pathogen dependent upon the transmission route of the pathogen; if staff are unsure, they should contact the IPT for support.

Cohort Nursing

If multiple patient cases of infection with the same organism are confirmed (such as in outbreaks), or if single-room accommodation is unavailable, cohorting of patients may be considered appropriate. In these circumstances, it is considered best practice to ensure that patients are separated by at least 3 feet (1m) and bed curtains can be drawn as an additional physical barrier (HPS, 2014;PHW, 2015).

If possible, a dedicated team of staff to care for patients in isolation/cohort rooms/areas should be allocated.

Duration of Isolation

Patients should remain in isolation/cohort with the door closed whilst they remain symptomatic and/or are considered infectious.

Before discontinuing isolation, individual patient case risk factors should be considered and the clinical judgement of those involved in the patients management. If staff remain unsure, then advice from the IPT may be sought in individual cases.

Example: immunocompromised patients who may have prolonged shedding of certain micro-organisms.

5.2 Transmission Routes

Transmission of nosocomial pathogens is due to at least 5 basic mechanisms described below:

Airborne:

Infectious organisms are transmitted through droplets < 5 microns in diameter. Droplets may remain suspended in the air for a prolonged period of time and travel long distances. Droplets may be produced by talking, coughing and sneezing, or by procedures such as bronchoscopy or endo-tracheal suctioning. Susceptible hosts may be infected several metres away from the source.

Examples: SARS, Chickenpox, Tuberculosis, Measles.

Droplet:

Infectious organisms are transmitted through droplets > 5 microns in diameter. These droplets do not remain suspended in the air for a prolonged period of time, and usually travel short distances. These droplets may be produced by talking, coughing and sneezing, or during invasive procedures such as bronchoscopy. Close contact usually less than one metre is necessary for transmission to occur.

Examples: Meningococcal meningitis, MRSA, chest infections.

Contact (Direct or Indirect):

Skin-to-skin contact and the direct physical transfer of micro-organisms can occur from one patient or healthcare professional to another. Direct contact examples include handshaking and providing direct personal care. Indirect contact refers to contact with an inanimate surface contaminated with micro-organisms, such as contaminated stethoscopes and commodes.

Examples: CPE, MRSA wound infection, ESBL, scabies.

Infections in the faecal-oral group are also spread by contact, however, hand/equipment-to-mouth is required.

Examples: Salmonella, *Clostridiodes difficile*

Other infectious agents may also be transmitted via contamination of the food/water supply, equipment, solutions, needles, multi-dose vials, or other articles that are used by more than one patient.

Blood borne:

Some micro-organisms can be transmitted by contaminated blood or tissue coming into contact with the patient's own blood or mucous membranes.

Examples: HIV, Hepatitis B.

5.3 Isolation and Transmission Based Precautions

Hand Washing:

Apply sanitising hand gel before entering an isolation room. Wash hands with soap and water before leaving an isolation room. Once outside, apply sanitising hand gel.

This must be communicated to all visitors of the patient that are entering the isolation room/areas.
NB: hand washing is particularly important where patients have symptoms of viral gastroenteritis or *Clostridioides difficile* diarrhoea, as sanitising hand gel alone is ineffective at removing infectious particles e.g. *Clostridioides difficile* spores.

***** Remember: soap and water for patients with vomiting or diarrhoeal illnesses*****

Personal Protective Equipment for Staff and Visitors:

Personal protective equipment (PPE) is available for all staff when entering an isolation room/cohort bay.

Please see the separate protocol for guidance on hospitalised patients that may have suspected/confirmed cases of Severe Acute Respiratory Syndrome (SARS), Avian Influenza and other severe viral respiratory infections.

Plastic Apron: Don a disposable plastic apron before entering an isolation room. Full length long-sleeved disposable gowns are available when extra protection is required.

Visitors: are not required to wear an apron unless they are involved with assisting in the provision of direct care involving the risk of blood/body fluid contact. There may, however, be occasions where the IPT will advise visitors to wear an apron when visiting a patient in an isolation room.

Example: MERS Co-V, CPE.

Hand hygiene must be performed with soap and water after removing the plastic apron.

Gloves: Don gloves before entering the isolation room. Gloves are worn to reduce gross contamination of the hands from infected sites/surfaces.

Visitors: are not required to wear gloves unless they are involved with assisting in the provision of direct care involving the risk of blood/body fluid contact.

Masks: Don face masks or RPE before entering the room for **airborne** infections. For **droplet** infections, face masks/RPE can be fitted in the room before close contact or sputum inducing procedures. Where additional protection is required (e.g. during aerosol generating procedures (AGPs), or for specific respiratory pathogens) an FFP3 mask will be required. These masks require formal fit testing procedures by trained personnel.

Please refer to Appendix 7 for general guidance regarding when to wear surgical face masks or FFP3 masks.

Visitors: may be required to wear a face mask/RPE on entering an **airborne/droplet** isolation room if indicated to do so by the isolation door sign.

Hands must be washed with soap and water after removing the face mask/RPE.

Eye Protection: Wear as for standard precautions to protect against splashes of blood/body fluid to the eye, and with the fluid shield mask without a visor.

Visitors: will not be required to wear eye protection.

Linen:

All linen within an isolation room/cohort area should be treated as “infected”. Linen should be placed into a red soluble bag inside the isolation room/cohort area. Place the soluble bag into the white plastic outer laundry bag outside of the isolation room/cohort area and apply the infected linen tape. The white plastic outer laundry bag must be kept outside of the isolation room/cohort area, ensuring white plastic outer laundry bags are specific to each area, and do not move between areas. Secure the bag before removing it **immediately** to the appropriate disposal room wearing apron and gloves. This “infected” linen should not be stored in the ward dirty utility. Linen bags and infected linen tape are available from the linen room.

Specimens:

Care must be taken to ensure that leaking specimens are not sent to the microbiology laboratories. Similarly, care must be taken to ensure sufficient information on the specimen forms is provided to ensure appropriate care can be taken in the laboratory. All specimens should be enclosed in an appropriate plastic specimen bag. Where hard copy specimen request forms are required, this should be securely attached to the outside of the specimen bag.

Crockery and cutlery:

Heat disinfection is essential. Items should be returned to the central wash up or zonal kitchen as normal for processing through an industrial standard automated dishwasher. If these dishwashers are unavailable for any reason, this must be escalated in a timely manner to ensure identification of alternative routes for processing. Items that are wet on removal from the dishwasher should be allowed to air-dry, or paper towels used if immediate drying is required.

Bedpans/Urinals:

The bedpan washer or macerator should be used in the normal way. Care should be taken to use disposable bedpan supports or clean any re-usable bedpan support/commode with a disinfectant sporicidal wipe (e.g. red Clinell wipe) after each use where a bedpan washer is not available. For further information, please refer to the Trust General Decontamination Protocol.

Medical Equipment:

Use single-use items where possible. Reusable non-invasive equipment should be dedicated to the isolation/cohort area and decontaminated prior to use on another patient. For this reason, avoid the use of any equipment that cannot be easily cleaned/disinfected. An increased frequency of decontamination should be considered for reusable non-invasive communal equipment when used in isolation/cohort areas. Avoid soft toys in paediatric isolation.

Waste:

All waste must be disposed of as Clinical Waste (orange waste stream) in accordance with the Trust Waste Management Policy.

Cleaning:

Domestic Housekeepers/Supervisors must be informed immediately if an isolation room or cohort area is in use. Domestic staff must then follow guidance contained within the Trust Cleaning Policy for the cleaning of an isolation room/cohort area.

Specifically, levels of cleaning with a Trust approved disinfectant and equipment should be increased in cases of infection and/or colonisation of a known/suspected pathogen.

In addition, for acute respiratory tract infections, it is essential that all frequently-touched surfaces and all horizontal surfaces are decontaminated after each and every AGP.

Last Offices:

Staff undertaking last offices for patients with known/suspected infectious disease should follow the Trust Last Offices policy.

For further information, please refer to [Health and Safety Executive](#) guidance.

Porters involved in portering the deceased to the Mortuary should don appropriate PPE (gloves and apron) when transferring the deceased across from one bed to the other. Porters should then ensure they take off PPE and undertake hand hygiene with soap and water prior to transferring the deceased to the Mortuary. PPE should then be worn in the Mortuary for further handling of the deceased. There is no requirement to wear PPE whilst transferring the deceased from the ward to the Mortuary.

5.4 Paediatric Isolation

Worcestershire Acute Hospitals Trust is following guideline from Birmingham Children's Hospital that it is more important to provide isolation rooms for children with specific infections rather than routinely isolating babies under one year for protective reasons. The Trust policy is to isolate babies under 6 months for ease of nursing and vaccination protocols.

Most common childhood infections are included within Appendix 4. Further guidance on isolation can be found in the Trust Paediatric Priority Scoring for Isolation Policy (found on the Key Documents intranet page).

5.5 Specialist Ward Policies and Protocols

MAU

Single-room availability is very limited in the Medical Assessment Unit (MAU) areas, and as a general rule infectious patients should be admitted directly into a single (preferably en-suite) room elsewhere, rather than risk exposing other patients to infection, who may themselves then be transferred to other open ward areas and become infectious to others. This is particularly important for highly transmissible infections.

Laurel 3 Haematology and Silver Oncology Unit– WRH

Single-rooms are available for immunocompromised patients. The main ward areas can also accommodate immunocompromised individuals.

In some cases general medical patients (medical outliers) may have to be admitted to these wards because of bed shortages. The following patient groups are **excluded** from this, and must under no circumstance be admitted to these areas (unless there is a specific haematology/oncology reason for admission to either of these wards):

- Patients known to be CPE positive
- Patients known to have had CPE contact (either environmental or direct patient contact)
- Patients who require readmission to an acute ward from Avon 4 or Evergreen.

Avon 3 Infectious Diseases Unit – WRH

Patients with known or suspected infection have priority when allocating single-rooms on Avon 3.

If non-infectious patients are occupying these rooms because of bed shortages, they must be moved out as a priority if these rooms are later needed for infectious patients, particularly those identified in alarmed negative pressure rooms with appropriate infection control precautions.

ICU, High Dependency Units and CCU - Countywide

Infectious patients should not be routinely admitted to the countywide Intensive Care Units (ICU) , however, there are some instances where their admission is based on clinical need; under these circumstances, countywide ICUs have dedicated single-room facilities. At AGH, patients with suspected/confirmed **airborne/droplet** infections should only be placed in a single-room once a risk assessment has been carried out and determined to be safe whilst works are being carried out.

In some additional instances (where clinical need takes precedence e.g. high visibility), it may be necessary to cohort patients into specific areas of the units. Staff should ensure that these areas are physically separate and under the care of a designated team of staff in order to reduce the risk of cross-infection.

At the WRH site, patients with known or suspected infections must not be routinely admitted to Surgical HDU (SHDU) or Vascular HDU (VHDU) due to cross-infection risks. If no single rooms are available, admission must be based on clinical need following a stratified risk assessment and clearly documented in the patients medical notes. Staff must pay particular careful attention to minimise the risk of cross-infection with other patients e.g. a FlexiSeal system to contain diarrhoea may be appropriate.

The single room on the Coronary Care Unit (CCU) is only to be used for coronary care patients with infections.

Patients should be moved to appropriate single-room accommodation elsewhere as soon as they are clinically fit.

Elective Orthopaedics – Countywide

These beds are only for elective patients who have been screened for MRSA and found to be **negative**. Medical and Trauma outliers must not be admitted to these areas.

5.6 Discharge/Re-Use of the Room

Patients who are being transferred to other hospitals, nursing or residential homes may need ongoing isolation/infection control precautions. These must be discussed at the time of arranging transfer, and the receiving unit must be informed of any infectious conditions and whether patients are currently symptomatic.

The risk assessment (Appendix 8) should be completed prior to arranging discharge of any patient involved in an outbreak due to viral gastroenteritis and a Care Home Discharge information letter (Appendix 9) sent with the patient if transfer is approved

Patients may be discharged to home when medically fit for discharge (MFFD) and must be given the appropriate infection prevention and control advice to prevent spread to other family members.

Single-rooms used to nurse infectious patients require differing amounts of time to be cleared of nursing equipment and cleaned (depending on the causative infectious organism) before the use by

another patient. Rooms are not ready for use until clean and air dry. Please refer to the Trust Cleaning Poster for guidance on which form of decontamination is required for the causative infectious organism, and by the advice of the IPT.

5.7 Outbreaks

During an outbreak of an infectious disease, it is important that affected patients are not transferred to other wards, hospitals, nursing or residential homes whilst symptomatic, unless isolation facilities are available (and the receiving unit is fully informed of the outbreak and agrees to the transfer).

In addition, staff should not work in other areas to which the infection could spread. The IPT will determine the best way to manage the outbreak in consultation with managers.

Occasionally, bays or whole wards will be closed to admissions to reduce the risk of infection to new patients and aid control of an outbreak. Patients should not be admitted to closed wards or bays without prior discussion with the IPT.

6. Implementation

6.1 Plan for implementation

- Launch to Matrons at Senior Nurses Meeting, Ward Sisters and Infection Prevention Link Nurses at their relevant meetings for wider dissemination to ward and departmental nursing staff.
- Launch to all clinical staff through Trust Brief
- Launch to all medical colleagues via Clinical Directors and presentation at relevant speciality meetings if requested.

6.2 Dissemination

- Instruction to all clinical staff of revised policy via weekly Trust Brief.
- Ward and departmental based clinical staff via Infection Prevention Link Nurses.
- Updated policy to be made available via the Trust Key Documents intranet page.

6.3 Training and awareness

It is a mandatory requirement that all new Trust employees must attend a Trust corporate induction programme, which includes IPC training. It is the responsibility of the line manager to ensure that IPC issues are covered in all local inductions and that this is documented.

It is a mandatory requirement that all clinical and non-clinical staff update their infection control training annually, either by attendance at a formal session, or using and completing online or e-learning resources. It is the line manager's responsibility to ensure that this occurs.

Different modalities are available to facilitate compliance with mandatory training requirements. These include attendance at formal lectures, ad hoc teaching, and access to online training. Records of staff training are kept centrally on the ESR database and locally by Directorates as required.

7. Monitoring and compliance

Audit mechanisms and processes will be put in place to ensure that isolation and bed management processes are appropriate.

The Trust will have systems for monitoring compliance with isolation and bed management. The key indicators will be internal and external audit findings, corrective actions and incident reports.

8. Policy Review and Dissemination

This policy will be reviewed every three years or earlier if regulations change by the named individual on the front of the policy and circulated for comment prior to approval by the Trust Infection Prevention and Control Committee (TIPCC).

Dissemination of the document will be as per the Trust Policy for Policies (WAHT-CG-827). Reference to the relevant Infection Prevention policies will also be made during induction, annual and other update sessions for staff. The policies will be available to view on the Trust Key Documents page on the intranet.

9. References

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10. Background

10.1 Equality requirements

The equality risk assessment for this policy has been undertaken and may cause restrictions for some groups. (See Supporting Document 1).

10.2 Financial risk assessment

The financial risk assessment for this policy has been undertaken and may require additional resources. (See Supporting Document 2)

10.3 Consultation

This key document has been circulated to key stakeholders and representative of the target audience for comment prior to finalisation before being submitted for approval by TIPCC.

Contribution List

This key document has been circulated to the following individuals for consultation;

Key individuals involved in developing the document

Name	Designation
Emma Yates*	Consultant Microbiologist/Co-Infection Control Doctor
Lara Bailey	Senior Infection Prevention Nurse
Kerrie Howles*	Senior Infection Prevention Nurse

Circulated to the following individuals for comments

Name	Designation
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Dr M Ashcroft	Consultant Microbiologist
Dr C Catchpole	Consultant Microbiologist
Dr H Morton	Consultant Microbiologist
Dr T Gee	Consultant Microbiologist
Dr J Berlet	Divisional Medical Director - SCSD
Dr J Trevelyan	Divisional Medical Director - Medicine
Dr J Walton	Divisional Medical Director – Urgent Care
Dr P Rajjayabun	Divisional Medical Director - Surgery
Dr A Thomson	Divisional Medical Director – Women & Children's
Dr M Ling	Consultant for Infectious Diseases
Dr M Roberts	Consultant ID Physician
Simon Noon*	Principal Engineer
Tracey Cooper*	Deputy Director for Infection Prevention and Control
Heather Gentry	Lead Infection Prevention Nurse
Iain Johnston*	Senior Infection Prevention Nurse
Jiji Jacob	Infection Prevention Nurse
Maxine McDonald	Infection Prevention Nurse
Susan Pitts	Infection Prevention Nurse
Angela Roxburgh-Powell	Infection Prevention Nurse
Nigel Jones	Infection Prevention Nurse
*	Indicates comments received from these individuals

Circulated to the following CDs / Heads of department for comments from their directorates / departments

Name	Directorate / Department
Robin Snead	Head of Operations
Sherri Cheal	Head of Capacity
Keith Taylor	Bed Manager WRH site
Thomas Taylor	Bed Manager Alexandra site

Circulated to the chair(s) of the following committee's / groups for comments;

Name	Committee
Ms Vicky Morris	Trust Infection Prevention and Control Committee (TIPCC)

10.4 Approval Process

The draft document will be submitted to TIPCC for awareness prior to the receipt of comment, and again for approval once comments received before document code and version number are confirmed and the policy is released for placement on the Trust intranet.

The final draft will be checked to ensure it complies with the correct format and that all supporting documentation has been completed.

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy / guidance affect one group less or more favourably than another on the basis of:		
	Age	No	
	Disability	No	
	Gender reassignment	No	
	Marriage and civil partnership	No	
	Pregnancy and maternity	No	
	Race	No	
	Religion or belief	No	
	Sex	No	
	Sexual orientation	No	
2.	Is there any evidence that some groups are affected differently?	Yes	Restrictions regarding cadaver management where restricted preparation of the deceased body is recommended may be against cultural procedures
3.	If you have identified potential discrimination, are any exceptions valid, legal and / or justifiable?	No	
4.	Is the impact of the policy / guidance likely to be negative?	Yes	Visiting restrictions
5.	If so can the impact be avoided?	No	
6.	What alternatives are there to achieving the policy / guidance without the impact?	None	
7.	Can we reduce the impact by taking different action?	Yes	Impact reduced by allowing visiting if affecting patient well-being or assistance with direct care

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	Yes, manpower to cohort nurse
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None