

Isolation policy

EQUALITY IMPACT

The Trust strives to ensure equality of opportunity for all both as a major employer and as a provider of health care. This Isolation Policy has therefore been equality impact assessed by the Infection Control Committee to ensure fairness and consistency for all those covered by it regardless of their individual differences, and the results are shown in Appendix 8.

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VERSION CONTROL SCHEDULE

| Version Number | Issue Date | Revisions from previous issue |
|----------------|------------|---|
| 2 | May 2007 | 2nd Issue <ul style="list-style-type: none"> • Addition of referral to transfer policy, Infection control policy and specific organism policies. • Addition of Appendix 5. Targeted isolation and terminal cleaning. |
| 3 | July 2008 | 3 rd Issue <ul style="list-style-type: none"> • Addition of Appendix 6 The Isolation Priority Scoring System. |
| 4.0 (Final) | March 2010 | Approved by the Infection Control Committee. Amendment to Appendix 5 – isolation cleaning. Amendments to Appendices 2 & 3 to comply with the Health Protection Unit updated list of notifiable organisms and diseases. Appendix 4 updated with the latest (2009) isolation facilities audit data. Addition of Infection Control Transfer form information – section 7.4.4 and Appendix 7. |

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1. INTRODUCTION

The term “Isolation” is the use of infection control precautions aimed at controlling and preventing the spread of infection. There are two types of isolation – Source Isolation (barrier nursing) where the patient is the source of infection and Protective Isolation (reverse barrier nursing) where the patient requires protection i.e. they are immunocompromised. This policy must be read in conjunction with the Infection Control policy and other organism specific policies.

2. PURPOSE

This policy is intended to provide some general principles of isolation precautions, when they may be required and the rationale behind their use. Isolation precautions should be used for patients who are either known or suspected to have an infectious disease, are carrying a multiresistant organism or are particularly vulnerable to infection. It is important however, that staff ensure that standard infection control precautions are used for all patients regardless of their infection status. These include the use of gloves, aprons, masks and visors following a risk assessment to identify the risks of exposure to blood, body fluids and micro-organisms. Further guidance can be obtained from specific Infection Control Policies available on the Intranet and from the Infection Prevention / Control procedure manual.

3. SCOPE OF THE POLICY

This policy is applicable to all staff, patients and visitors of Tameside General Hospital.

4. DEFINITIONS

- **Isolation** - the use of infection control precautions aimed at controlling and preventing the spread of infection.
- **Source Isolation** – (Barrier Nursing). Isolation of a patient who is the source of the infection.
- **Protective Isolation** – (Reverse Barrier Nursing). The physical separation of a patient at high risk from common organisms carried by others. The patient requires protection i.e. they are immunocompromised.

5. DUTIES

The Chief Executive:

Has overall responsibility and is accountable for ensuring that there is a managed environment which minimises the risk of transmission of infection to patients, visitors, staff, contractors and all who use the hospital site for any purpose.

Director of Infection Prevention / Control is responsible for:

- Ensuring that there are effective and appropriate arrangements in place for the isolation of patients when required.

- Funding additional resources necessary to prevent / control an outbreak as appropriate.
- Ensuring that the provision of existing isolation facilities or single rooms are not compromised by future service developments and ward reconfigurations.

The Infection Control Team are responsible for:

- Providing education to clinical staff on the early detection of possible infectious conditions and possible outbreaks.
- Communicating up to date information relating to isolation issues and outbreaks to appropriate personnel within the Trust.
- Advising and co-ordinating the appropriate action to be taken to isolate patients and prevent/limit hospital outbreaks.

The Infection Control team should be informed about:

- Individual patients needing isolation, where a side room is not deemed appropriate for the patient i.e. detrimental to the patients condition e.g. confusion, risk of falls, psychological effect etc.
- Infectious patients and / or staff members where contact tracing will be required e.g. Pulmonary Tuberculosis.
- Potential outbreaks so that advice about appropriate isolation of patients can be given.
- Any area where side rooms are not available for patients requiring isolation.

The Occupational Health Team are responsible for:

- Alerting the Infection Control Team of any infectious conditions amongst Trust employees that could be transmitted during the course of their work.
- Participating in the contact tracing of staff members exposed to infectious conditions as applicable.
- Co-ordinating staff treatment of any infectious disease.
- Reporting of staff symptoms during an outbreak.

Managers/Senior Sisters are responsible for:

- Ensuring dissemination of this policy.
- Ensuring compliance with this policy and ensuring patient safety is maintained.
- Facilitating the delivery of education provided by the Infection Control Team.
- Ensuring staff in their area have the knowledge and skills to work safely.
- Ensuring correct equipment e.g. gloves, aprons, hand sanitisers are available.
- Co-ordinating staff, linen and glove supplies etc. during an outbreak.
- Taking action when staff fail to follow the principles of this Policy.

Clinical teams are responsible for:

- The prompt notification of Infectious diseases (see appendix 1, 2 and 3).
- Communicating to the infection control team details of patients known or suspected of having an infectious disease.
- Ensuring that they comply with this policy.

All staff are responsible for:

- Implementing standard infection control precautions for all patients and abiding by the guidance of this policy.
- Providing the special requirements for the management of patients with specific infections that are either known or suspected by:
 - Ensuring that prompt action is taken and the Isolation policy followed whenever a patient is suspected or known to be infectious.
 - Undertaking a risk assessment on suspected or known infectious patients and moving patients to a side room as appropriate.
 - Ensuring effective communication to other members of the team both verbally and through appropriate clinical protocols / policies and patient care pathways.
 - Ensuring that appropriate PPE is readily available and easily accessible.
 - Liaising, as appropriate, with the Infection Control team and the bed manager when a side room is not available so that a risk assessment can be undertaken.
 - Ensuring that the room / bed space is cleaned in the appropriate way after the discharge / transfer of the patient.
 - Ensuring that they report to Occupational Health / Line manager prior to attending work if they have an infectious illness such as diarrhoea and vomiting.

Estates Departments are responsible for:

- Ensuring the ongoing maintenance of ventilation systems and the general environment of the isolation rooms.

Cleaning Contractors are responsible for:

- Ensuring that all rooms and bed spaces used for patients with known or suspected infections are cleaned according to the daily and isolation clean specifications.
- Ensuring that all healthcare cleaners have the knowledge and skills required to undertake daily and isolation cleaning of single rooms used for isolation purposes.
- Ensuring that all staff comply with this policy.

Bed Management are responsible for:

- The bed manager will adhere to the Isolation Priority Scoring System (adapted from the Lewisham Isolation Priority Scoring System with permission from Dr Gopal Rao) and prioritise patients accordingly. (see Appendix 6).
- Liaising with ward staff to ensure that patients are placed appropriately within isolation / single rooms where possible.
- Where the above is not possible due to limited availability, liaising with ward staff to ensure that a Risk Assessment is undertaken in conjunction with Infection Control to identify the most appropriate and safe placement of the 'infected' patient.
- Facilitating the movements of patients requiring isolation to other wards where appropriate.

6. POLICY STATEMENT

Isolation systems are designed to contain the spread of infection with the principal objective to contain the harmful organism and not the infected person. Isolation precautions can be applied to a patient on a multi - bedded ward, a co-hort of patients suspected to have the same pathogen, or to a patient in a single room. Single rooms on a ward are the mainstay of isolation in the Trust. Open ward areas can be effective in controlling the spread of infections transferred by contact as long as appropriate precautions are still implemented. Patients who require strict isolation in a negative pressure isolation room must be transferred to the nearest infectious diseases unit as soon as possible. Negative pressure rooms are not required for most organisms but are of particular value when dealing with highly infectious airborne agents e.g. MDRTB and SARS. Certain diseases (or suspicion of) are notifiable by law to the Health Protection Agency (HPA) - Consultant in Communicable Disease Control (CCDC). The clinician who considers or diagnoses the infection is responsible for the notification. The Trust Infection Control Team should also be informed of these diseases. (Appendices 2 & 3). Hand washing before and after contact with any patient is the single most important measure in preventing the spread of infection.

7. THE POLICY

7.1 CATEGORIES OF PRECAUTIONS AND ISOLATION

The different levels of precautions and isolation required to prevent the spread of infective organisms are detailed below. **It is essential that all members of staff observe these guidelines.**

Three levels of precautions / isolation observed in the Trust are:

- i. Source Isolation: Isolation of a patient who is the source of the infection.
 - a) contact precautions are used in situations where the mode of transfer of the infecting organism is via blood-to-blood contact (e.g. hepatitis);
or by direct contact with a patient;
or indirect contact via the environment;
 - b) the faecal oral route (e.g. viral gastroenteritis and other enteric pathogens);
 - c) respiratory Isolation used to prevent the transmission of infectious diseases over short distances through the air (Pulmonary Tuberculosis, chickenpox)
- ii. Protective Isolation: Isolation of a patient who is immunocompromised and therefore susceptible to getting an infection.
- iii. Strict Isolation used for the isolation of highly communicable diseases. Patients requiring this level of isolation are transferred to an Infectious Diseases Unit as soon as possible.

7.1.1 Source Isolation

7.1.2 Contact / enteric precautions:

Contact precautions are used in situations where the mode of transfer of the infecting organism is via blood-to-blood contact (e.g. hepatitis), the faecal-oral (enteric) route (e.g. viral gastroenteritis and other enteric pathogens) or by contact, usually via the hands, skin, mucous membranes or wounds (e.g. MRSA, VRE).

A single room is preferred, but not always required for this level of precautions. For example,

- patients with infections that are spread by blood to blood contact a single room is preferred, but not essential, unless they are bleeding.
- if a patient has diarrhoea, a single room is preferred.
- if a patient is colonised with MRSA on the skin, a single room is preferred but not essential. If MRSA is found in discharging wounds or the patient has respiratory tract colonisation then the risk assessment would require that a single room is used whenever possible.

Open ward areas can be effective in controlling the spread of infection as long as the same precautions are used as if the patients were in a single room. A single room with its own toilet is preferable. Cohorting may be considered for patients who have the same pathogen.

If a single room is used:

- Visitors and members of staff from other departments must report to the Nurse-in-Charge before entering the room.
- The door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise.
- Patients should not leave the room / ward area to attend other departments without prior arrangement / notification of the receiving department.
- Gloves should be worn if there is any risk from contamination with blood and body fluids.
- Plastic aprons must be worn when soiling of the uniform is likely.
- Masks are not required unless there is the additional risk of airborne spread.
- Full face protection e.g. visor or goggles, must be worn if there is a risk of splashing from blood or body fluids and secretions
- Hands must be washed with soap and water and then disinfected with alcohol gel before entering the room, after patient contact, after contact with potentially infected materials, and after removal of disposable gloves.

7.1.3 Respiratory precautions: e.g. pulmonary tuberculosis, chickenpox, Influenza.

Respiratory isolation is used to prevent the transmission of infectious diseases over short distances through the air. A single room must be used.

- Visitors and members of staff from other departments must report to the Nurse-in-Charge before entering the room.

- Patients should not leave the room to attend other departments without prior arrangements.
- The door of the room should be kept closed at all times unless the clinical need of the patient dictates otherwise.
- Gloves should be worn if there is any risk from contamination with blood or body fluids.
- Plastic aprons must be worn when soiling of the uniform is likely.
- The infection control team must be contacted for advice re use of surgical or respirator masks.
- Full face protection e.g. visor or goggles should be worn if there is a risk of splashing from blood or body fluids and secretions.
- Hands must be washed with soap and water and then disinfected with alcohol gel before entering the room, after patient contact, after contact with potentially infected materials, and after removal of disposable gloves.

7.2 MATERIALS REQUIRED FOR ISOLATION

7.2.1 Inside the patients room:

In addition to the standard equipment in an isolation room the following dedicated equipment should be provided

- Stethoscope
- Dynamap (blood pressure, pulse, O₂ sats)
- Thermometer

7.2.2 Outside the patients room (or entrance to isolation ward area):

- Danni Centre containing disposable gloves and aprons
- Hand sanitiser
- Masks (if required)

7.2.3 Hand Hygiene:

Handwashing before and after contact with the patient is the single most important measure in preventing the spread of infection. It should be noted that the hands should be wet before the application of soap to prevent dermatitis. Hands should be dried thoroughly. Hands must also be washed after the removal of gloves. Hand sanitiser for hand decontamination should be available both in the room and outside the isolation room.

7.2.4 Laundry:

Linen should be disposed of at the point of use. Used linen should be placed into a white plastic bag. Red alginate (water soluble) and red plastic bags should be used after risk assessing the type of infection / disease. Advice should be sought from the infection control team if unsure re: type or colour of plastic bags to use.

7.2.5 Waste:

Clinical waste should be placed into a yellow clinical waste bag. A bin should be provided inside the room. The bag should be sealed and labelled in the room before

removal to the pick up point.

7.2.6 **Patient charts / notes:**

Patient's charts / notes should be kept outside of the isolation room / area.

7.2.7 **Cutlery and Crockery:**

The use of disposable cutlery or crockery is not required. These items should be sent back to the catering department in the usual manner.

7.3 **CLEANING OF ROOMS**

The micro fibre system should continue to be used. Chlorclean is used in conjunction with the microfibre system for all surfaces.

7.3.1 **Daily:**

Wash all horizontal surfaces using the microfibre system in conjunction with Chlorclean (ISS staff). Nursing staff wipe bed frame, locker, bed table etc with Tuffie 5 sporicidal wipes.

7.3.2 **Isolation Clean:**

Wash all surfaces including the bed, bed frame, locker, bed table and floor with the microfibre system in conjunction with Chlorclean, and Tuffie 5 sporicidal wipes. Then **allow to dry thoroughly before admission of another patient.**

7.4 **TRANSFER OF INFECTED PATIENTS:** (Also refer to Transfer Policy).

As with other Infection Prevention and Control matters, the designated Nurse-in-Charge of the ward has the responsibility to ensure that the necessary information regarding an infected / colonised patient is passed on to a senior member of staff of the receiving ward / department / hospital, prior to transfer.

7.4.1 **Within the hospital:**

Transfers to other wards should be avoided if at all possible. If transfer has to be effected then the receiving ward should be informed of the current status of the patient.

7.4.2 **Visits to other departments including theatre:**

Visits to other departments should be kept to a minimum. When this is required, prior arrangements should be made with the senior staff of the department concerned. Infected patients should spend the minimum amount of time in the department. They should only be sent for when the receiving department is ready and not left in a waiting area with other patients. **These guidelines should never jeopardise clinical need.**

7.4.3 **Ambulance transportation:**

The ambulance service need only be notified prior to transfer if there are any specific precautions above and beyond standard, which they will be required to take.

7.4.4 **Transfer to other hospitals and care facilities including nursing and residential homes:**

Inter-hospital movements should be kept to a minimum. It is the responsibility of the transferring ward to inform the receiving hospital or care facility of the current status of the patient. Document in the nursing notes who has been informed. An infection control transfer form must be completed and a copy sent with the patient. The form can be found in the patients Medway record under clinical letters. (Appendix 7).

7.4.5 **Discharge of patients:**

The General Practitioner, other Health Care and relevant social agencies involved in the patient's care should be informed and advised of any precautions / treatments being undertaken as necessary e.g. MRSA decolonisation. Document in the nursing notes who has been informed.

7.5 **PROTECTIVE ISOLATION**

Protective isolation sometimes referred to as reverse barrier nursing is the physical separation of a patient at high risk from common organisms carried by others. The aim of protective isolation is to prevent the transmission of infection to an immunocompromised patient.

7.5.1 **Key Points**

- The patient should be nursed in a single room preferably with en-suite facilities if available.
- Ensure the isolation room door is closed at **all** times, apart from the necessary entrances and exits.
- All staff entering the room must wash their hands with soap and water and then use the hand sanitiser.
- . Aprons must be worn by all staff when entering the room.
- . Gloves must be worn for contact with body substances.
- . Limit the number of staff entering the isolation room. Reducing the number of staff who come into contact with the patient will further reduce the risk of cross infection.
- Staff who are nursing patients with infections should avoid nursing patients in protective isolation during the same span of duty.
- Staff with infections should not be working in the environment.
- Ensure **all** staff are aware of the necessary precautions.
- . All equipment must be cleaned before being taken into the isolation room and again after use.
- The vacated room must be cleaned thoroughly before it can be reoccupied.
- Visitors do not need to wear plastic aprons or gloves for routine social visiting but they must wash their hands **before** and **after** visiting.

8. POLICY DEVELOPMENT & CONSULTATION

The policy was developed in conjunction and in consultation with the infection control team, using the best available evidence. The authorising body for this policy is the Infection Control Committee.

9. IMPLEMENTATION

The policy will be displayed on the intranet. Audits of Isolation facilities every two years and the yearly environment and practice audits undertaken by the Infection Control team will be used to ensure implementation. The policy will also form a part of the existing Infection Prevention / Control training for both qualified and support staff.

10. MONITORING

Where monitoring has identified deficiencies, recommendations and action plans will be developed and changes implemented accordingly. Progress on these will be reported to the Infection Control Committee.

11. EQUALITY AND DIVERSITY

Tameside Hospital NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

12. REFERENCES

1. Ayliffe, G.A.J, Babb, J.R, Taylor, L.Z (2001) - Hospital Acquired Infection, Principles and Prevention. Third Edition, Arnold page 99.
2. Hospital Infection Society (2001) - Review of Hospital Isolation and Infection Control Related Precautions - Report of the Joint Working Group.
3. Wilson, J. (2001) - Infection Control in Clinical Practice. London: Bailliere Tindall.
4. Newton, J.J. (2001) - Patients perceptions of methicillin-resistant Staphylococcus aureus and source isolation. Journal of Hospital Infection 48: 4, pages 275-280.
5. Dougherty, L and Lister, SE – The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Sixth Edition, Blackwell, pages 74-75.

ISOLATION KEY – Appendix 1

Key:-

SI Source Isolation (contact / enteric / respiratory)
 PI Protective Isolation
 STR Strict isolation

ALL NOTIFIABLE DISEASES MUST BE REPORTED TO THE HEALTH PROTECTION AGENCY, CONSULTANT FOR COMMUNICABLE DISEASE CONTROL AND THE INFECTION CONTROL TEAM IMMEDIATELY (see appendices 2 & 3 for list of notifiable organisms and diseases).

| INFECTION | CATEGORY | INCUBATION PERIOD | LENGTH OF ISOLATION | COMMENTS |
|---|------------------------|--|---|---|
| ADENOVIRUS respiratory (infants) conjunctivitis | SI SI | Variable Variable | Duration of illness Duration of illness | |
| AIDS | PI | | | |
| AMOEBIASIS (dysentery) | SI | 5 days - 3/4 weeks | until 48 hrs symptom free | NOTIFIABLE |
| ANTHRAX pulmonary systemic cutaneous | STR SI SI | 1 - 7 days 1 - 7 days 1 - 7 days (usually 2) | Duration of illness Duration of illness Until lesions free from anthrax | NOTIFIABLE NOTIFIABLE NOTIFIABLE If pulmonary ruled out use SI not STR isolation |
| BRUCELLOSIS | SI | Variable | Duration of illness | Applies for draining lesions |
| CAMPYLOBACTER ENTERITIS | SI | 1 - 10 days | 48 hrs symptom free | NOTIFIABLE |
| CANDIDIASIS (in neonatal wards) | None | Variable | Infectious until treated. | |

| INFECTION | CATEGORY | INCUBATION PERIOD | LENGTH OF ISOLATION | COMMENTS |
|---|------------|---|---|---|
| CHICKENPOX | SI | 14 - 21 days | Up to 5 days after onset of rash in immunocompetent patients. Until all lesions are crusted in immunocompromised patients | Keep away from immunocompromised patients |
| CHOLERA | SI | few hours - 5 days | Duration of illness | NOTIFIABLE |
| CHLAMYDIA TRACHOMATIS | None | Variable | Infectious until treated. | Wear gloves for infected material |
| CLOSTRIDIUM DIFFICILE | SI | Variable | 48 hrs symptom free | See Clostridium difficile policy |
| CONJUNCTIVITIS | None | Variable | | |
| CREUTZFELT JAKOB DISEASE | | | | See TSE policy |
| CYTOMEGALOVIRUS | None | 2 – 4 weeks. However virus can remain latent for long periods. | | Caution with immunocompromised patients |
| DIARRHOEA unknown origin viral eg SRSV, rotavirus | SI SI | Variable Variable | 48 hrs symptom free 48 hrs symptom free | NOTIFIABLE if suspected food poisoning |
| DIPHtheria | STR | 2 - 7 days | Cases are no longer infectious after 3 days of antibiotic treatment. | NOTIFIABLE |
| DYSENTERY Bacterial Amoebic | SI SI | 1 - 6 days 5 days - 3/4 weeks | until 3 negative stools until 48hours symptom free | NOTIFIABLE NOTIFIABLE |
| ESCHERICHIA COLI 0157 | SI | | CONTACT INFECTION CONTROL TEAM | NOTIFIABLE |
| FOOD POISONING | SI | 1 -12 hours | Depends on pathogen | NOTIFIABLE |

| INFECTION | CATEGORY | INCUBATION PERIOD | LENGTH OF ISOLATION | COMMENTS |
|---|----------------|---|---|--|
| GASTROENTERITIS (in babies) | SI | Variable | 48 hrs symptom free | NOTIFIABLE |
| GIARDIASIS | SI | 5 - 25 days + | 48 hrs symptom free | NOTIFIABLE |
| HERPES SIMPLEX Paediatrics Adults | SI SI | 4 - 5 days Variable | Duration of illness Duration of illness | Caution with neonatal and disseminated disease; keep away from immunocompromised patients or those with eczema and burns |
| HERPES ZOSTER (Shingles) | SI | Unknown | Until lesions are 'crusted' | Infectious if lesions are exposed or disseminated |
| HEPATITIS A B C | SI SI SI | 3 - 6 weeks 3 - 6 months 0.5 - 6 months | 48 hrs symptom free Source isolation not always required. Seek advice from the infection control team. | NOTIFIABLE NOTIFIABLE NOTIFIABLE |
| HIV | SI | Variable | | |
| INFLUENZA | SI | 1 - 4 days | Duration of illness | |
| LEPROSY | SI | Variable | Duration of illness | NOTIFIABLE |
| LEPTOSPIROSIS | SI | 4 - 14 days | Duration of hospitalisation | NOTIFIABLE |
| MALARIA | SI | Variable | | NOTIFIABLE |
| MEASLES | SI | 6 - 12 days | 5 days after onset of rash | NOTIFIABLE |

| INFECTION | CATEGORY | INCUBATION PERIOD | LENGTH OF ISOLATION | COMMENTS |
|-----------------------------------|------------|-------------------|---------------------------------|--|
| MENINGITIS | | | | |
| meningococcal | SI | 2 - 10 days | 48 hrs after start of treatment | NOTIFIABLE |
| other bacterial | SI | | | NOTIFIABLE |
| viral | SI | 3 - 10 days | Duration of illness | NOTIFIABLE |
| M.R.S.A. | | | Contact Infection Control Team | See MRSA policy |
| MUMPS | SI | 12 - 28 days | 9 days after onset of symptoms | NOTIFIABLE |
| | | | | |
| OPHTHALMIA NEONATORUM | SI | 3 - 9 days | Duration of illness | NOTIFIABLE |
| | | | | |
| PARVOVIRUS B19 | SI | Variable | Duration of illness | Keep away from immunocompromised patients and pregnant staff |
| PLAGUE | STR | 1 - 6 days | Until negative | NOTIFIABLE |
| POLIOMYELITIS | SI | 3 - 35 days | Until stool negative for virus | NOTIFIABLE |
| Q FEVER | SI | 2 - 3 weeks | 7 days after onset | |
| | | | | |
| RABIES | STR | 1 - 8 + weeks | Length of illness | NOTIFIABLE |
| RESISTANT ORGANISMS | | | Contact Infection Control Team | See Specific policies |
| RESPIRATORY SYNCYTIAL VIRUS (RSV) | SI | Variable | Duration of illness | |

| INFECTION | CATEGORY | INCUBATION PERIOD | LENGTH OF ISOLATION | COMMENTS |
|--|--------------------------|----------------------------------|---|--|
| ROTAVIRUS | SI | Variable | 48 hrs symptom free | |
| RUBELLA | SI | 14 - 21 days | 5 days after onset of rash | NOTIFIABLE |
| SALMONELLA INFECTIONS | SI | 12 hrs - 3 days | 48 hrs symptom free (food handlers may need negative stool sample) | NOTIFIABLE |
| SCABIES Norwegian | None SI | 2 - 6 weeks | Infectious until treated Isolate until patient has received 2 lots of treatment 1 week apart | |
| SHIGELLOSIS | SI | 12 hrs - 3 days | Until 3 negative stools | NOTIFIABLE |
| SRSV | SI | Variable | 48 hrs symptom free | |
| STAPHYLOCOCCUS (MRSA) | | | Contact Infection Control Team | |
| STREPTOCOCCAL INFECTIONS | SI | Variable | Until 24 IV antibiotic treatment | |
| TUBERCULOSIS Pulmonary Multi – drug resistant (pulmonary) Non-pulmonary | SI STR None | Variable Variable Variable | 2 weeks after start of treatment Negative sputum culture | NOTIFIABLE NOTIFIABLE |
| TYPHOID AND PARATYPHOID (including carriers and urine carriers) | SI | 6 - 21 days | Until 2 negative stools (food handlers) otherwise 48hrs symptom free. | NOTIFIABLE |
| VIRAL HAEMORRHAGIC FEVERS - IMMEDIATELY CONTACT EITHER THE INFECTIOUS DISEASES UNIT, HPA, CCDC, ON-CALL MICROBIOLOGIST OR VIROLOGIST OR THE INFECTION CONTROL TEAM FOR ADVICE. DO NOT ADMIT SUSPECTED CASE UNTIL ADVICE HAS BEEN SOUGHT AND MINIMISE CONTACT WITH PATIENT | | | | |
| VRE | SI | Variable | Contact Infection Control Team | |
| WHOOPING COUGH | SI | up to 21 days | 3 weeks after onset or 7 days after start of antibiotic treatment | NOTIFIABLE |
| WOUNDS (with resistant organisms) | SI | Variable | Contact Infection Control Team and Tissue Viability Nurse. | |
| | | | | |

APPENDIX 2

List of notifiable organisms and diseases

These organisms and diseases should be reported to GMHPU from clinicians using one of the forms contained in the notifications books which should be sent to: Greater Manchester Health Protection Unit, Floor 7B, Peel House, Albert Street, Eccles M30 0NJ

There is a statutory duty to notify patients suspected of suffering from one of the infectious diseases listed in the Public Health (Control of Disease) Act 1984 and the Public Health (Infectious Diseases) Regulations 1988 (See list below). All notifications are payable to the notifying clinician at £3.26 per notification. All notification certificates need to be signed and the name of the notifying clinician clearly printed.

Cases of salmonella, campylobacter and cryptosporidiosis are not of themselves notifiable, but if you think the infection is due to food poisoning you should submit a certificate giving "suspected food poisoning" or "FP" as the disease. If you suspect food poisoning it is helpful if you arrange for the patient to submit a faeces specimen for laboratory examination while they still have symptoms.

If you suspect that a patient has measles, mumps or rubella, please send in a notification certificate and we will send a salivary kit to assist in confirming the diagnosis.

Diseases notifiable (to Local Authority Proper Officers) under the Public Health (Infectious Diseases) Regulations 1988:

- Acute encephalitis
- Acute poliomyelitis
- Anthrax
- Cholera
- Diphtheria
- Dysentery
- Food poisoning
- Leptospirosis
- Malaria
- Measles
- Meningitis (*meningococcal, pneumococcal, haemophilus influenzae, viral, other specified or unspecified*)
- Meningococcal septicaemia (without meningitis)
- Mumps
- Ophthalmia neonatorum
- Paratyphoid fever
- Plague
- Rabies
- Relapsing fever
- Rubella
- Scarlet fever
- Smallpox
- Tetanus
- Tuberculosis
- Typhoid fever
- Typhus fever
- Viral haemorrhagic fever
- Viral hepatitis (*Hepatitis A, Hepatitis B, Hepatitis C, other*)
- Whooping cough
- Yellow fever

Appendix 3 – Urgent Notifications

The following may constitute an acute public health emergency requiring prompt investigation and instigation of control measures. Please telephone the GMHPU on 0161 786 6710 to report these as a matter of urgency:

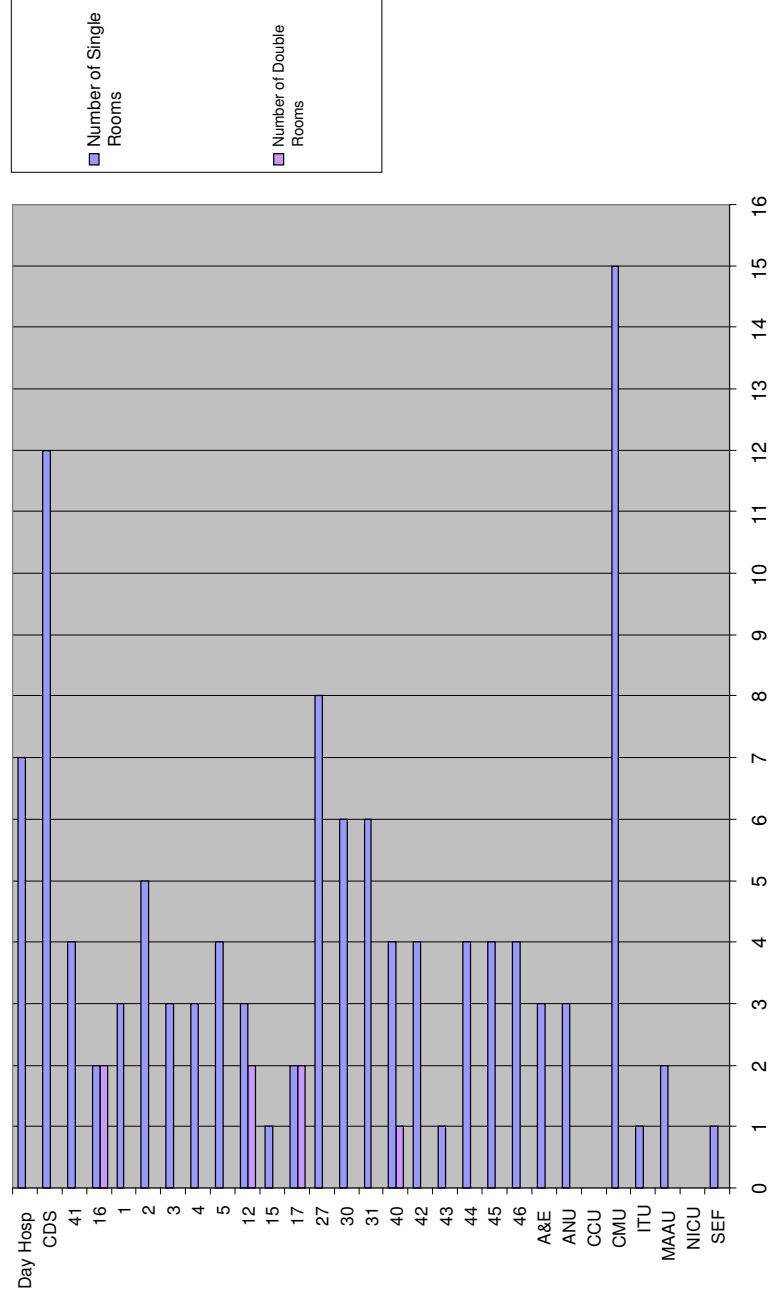
- Avian influenza
- Bacillus anthracis
- Bordetella Pertussis
- Clostridium botulinum
- Corynebacterium diphtheriae & ulcerans
- E coli O157 or any other confirmed or suspected VTEC
- Hepatitis A
- Acute hepatitis B
- Clinically suspected and microbiologically confirmed cases of HIB and Meningococcal meningitis/septicaemia
- Measles
- Legionella
- Polio
- Multi-drug resistant tuberculosis
- Rabies
- Salmonella typhi and paratyphi
- SARS
- Shigella (flexneri, boydii & dysenteriae)
- Smallpox
- Vibrio cholera
- Viral haemorrhagic fever
- Francisella tularensis
- Burkholderia pseudomallei
- Yersinia pestis

Urgent notifications outside normal working hours should be phoned through to the on-call team for Greater Manchester Health Protection Unit via Tameside switchboard on 0161 331 6000.

The hospital infection control team (0161 922 6599) and the Consultant Medical Microbiologist (0161 922 4086) must also be informed.

Appendix 4

Number of Single/Double Rooms per Ward/Dept 2009



Appendix 5
Cleaning of Isolation Rooms / Bed Spaces / Full Ward
Areas

Isolation is the physical separation of one patient from another, in order to prevent the spread of infection. The patient may be nursed in a side room or may have to be treated on the open ward in a cohort situation.

AIM: To ensure the isolation area is cleaned correctly, therefore minimising the spread of infection.

Isolation Cleaning. (Whilst patient is symptomatic).

- The infection control team will advise ward staff as to whether a patient requires isolation.
- The domestic supervisor will ensure that all healthcare cleaners working in the area are aware of the cleaning procedure. Microfibre to be used in conjunction with Chlorclean.
- Isolation cleans are to be carried out daily or as directed by the infection control team.
- Isolation areas are to be cleaned last, after the other rooms, bays and general areas of the ward.
- Nursing staff are responsible for cleaning patient care equipment using the Tuffie 5 sporicidal wipes.

Terminal Cleaning. (When patient becomes asymptomatic or has been discharged from hospital).

- Follow the same procedure as the isolation clean.
- Change the curtains in the immediate vicinity / wipe blinds.
- Wall washing is only necessary if soilage is present.

Appendix 6

In order to make optimal use of isolation facilities /side rooms the bed manager needs to perform an isolation risk assessment.

The risk assessment system (designed by Dr Gopal Rao, Lewisham) is based on the infective organism, its resistance profile, risk and mode of spread and patient characteristics as detailed on page 23.

The bed manager will adhere to the Isolation Priority Scoring System and prioritise patients accordingly. Patients will be assessed daily and evaluation for the continued need for isolation should be taken in conjunction with the Infection Prevention/Control Team. If there are no single rooms available and the Isolation Priority Scoring system indicates the need for isolation the bed manager should contact the Infection Prevention/ Control Team for advice.

Isolation Priority Scoring System

(Adapted from the Lewisham Isolation Priority Scoring System LIPS).

This system of prioritisation is based on current knowledge of the causative organisms, its resistance profile, risk and mode of spread and patient characteristics. It should help in making pragmatic decisions about isolation by ascribing a score to each of the following factors;

- Advisory Committee on Dangerous Pathogens (ACDP) classification.
- Route of transmission and dispersal characteristics of the patient
- Evidence for transmission
- Prevalence of infection in the hospital
- Antibiotic resistance
- Susceptibility of other patients
- Dispersal characteristics of the patient.

Isolation Priority Scoring System

Each case is prioritised into very high, high or medium priority depending on their total score and assigned to an appropriate isolation facility or cohort nursed.

| Score | Priority | Appropriate isolation facility |
|--------------|-----------------|---|
| >60 | Very High | Out to regional IDU (Infectious Diseases Unit) |
| 25-60 | High | Side-room on main ward +/- Bathroom facilities |
| <20 | Medium | As available/Cohort nursing |

The Isolation Scoring System lists common conditions encountered in hospital practice. Scores vary depending on factors related to each case and this list is not exhaustive. In those cases the isolation priority score must be calculated individually and the patient assigned an appropriate isolation facility.

Additional strategies for minimising the risk of transmission should also be considered:

- Does the patient need admission at all?
- Are vaccinations or prophylactic antibiotics appropriate for contacts?
- Are staff adequately protected e.g. pregnant women and varicella?
- Notifiable diseases should be reported to the Health Protection Agency on statutory notification forms.

Isolation Priority Scoring System

| Condition or infection | ACDP category | Route of transmission | Evidence of spread | Antibiotic resistance | Variable factors e.g patient susceptibility , dispersal risk | Score | Length of isolation | Risk category |
|--------------------------------------|---------------|-----------------------|--------------------|-----------------------|--|-------|---|----------------------|
| Chicken pox | 2 | airborne | Strong | Little | Ante natal /post natal/neonatal | 50 | Until spots crusted | HIGH |
| | | | | | Oncology or immunocompromised patients. | 50 | | HIGH |
| | | | | | all other wards | 40 | | HIGH |
| Clostridium difficile | 2 | Faeco-oral | moderate | Little | Faecal incontinence &/or symptomatic | 35 | Until diarrhoea resolved for 48 hours | HIGH |
| Diarrhoea (infective) e.g norovirus | 2 | Faeco –oral | Strong | Little | Faecal incontinence | 40 | Until diarrhoea resolved for 48 hours | HIGH |
| | | | | | Continent & cooperative | 35 | | |
| E coli 0157 | 2 | Faeco-oral | nil | N/A | | 0-10 | | MEDIUM |
| Hepatitis B | 3 | Blood borne | poor | N/A | Avoid inoculation injury with blood or body fluids | 15 | No isolation unless uncontrolled bleed risk | MEDIUM |
| HIV /AIDS | 3 | Blood borne | nil | N/A | Refer to specific infection/organism | 0-65 | Refer to microbiologist | MEDIUM/ VERY HIGH |
| Lice - head | 2 | contact | poor | N/A | No need to isolate avoid head to head contact | 10 | Treat ASAP | MEDIUM |
| | | | | | Paediatric or non compliant patients | 15 | 24 hrs after treatment | MEDIUM |
| Lice body | 2 | Contact | strong | N/A | No need to isolate | 20 | 24 hours after treatment | MEDIUM |
| Measles | 2 | Airborne | strong | N/A | Antenatal /post natal wards | 50 | 14 days | HIGH |
| | | | | | Oncology/ immunocompromised patients | 50 | | |
| Meningitis | 2 | droplet | poor | little | Cough wear a facemask if risk of splash/contact with nasopharyngeal secretions | 25 | 48 hours with effective antibiotic therapy | HIGH |
| | | | | | NO COUGH | 15 | | MEDIUM |

| Condition or infection | ACDP category | Route of transmission | Evidence of spread | Antibiotic resistance | Variable factors e.g patient susceptibility , dispersal risk | Score | Length of isolation | Risk category |
|--|---------------|-----------------------|--------------------|-----------------------|---|-------|--|---------------|
| Mrsa Medium and high risk areas Low risk areas ICN will advise | 2 | Contact | strong | serious | Skin shedder e.g eczema or sputum colonised. >1 site colonised (excluding sputum) uncovered wound nasal carriage only post full screen & on mupirocin | 50 | Indefinite | HIGH |
| | | | | | | 35 | | |
| | | | | | | 0 | | |
| Mrsa with mupirocin resistance | 2 | contact | strong | serious | | 45 | Indefinite | HIGH |
| Penicillin resistant Streptococci pneumonia | 2 | Droplet | strong | Moderate | Cough | 50 | Until cough resolves | HIGH |
| | | | | | | 40 | | No cough |
| Respiratory Syncytial Virus (RSV) | 2 | Contact & Droplet | strong | N/A | Non epidemic situation | 40 | Until symptoms resolved | HIGH |
| | | | | | Epidemic situation | 35 | | HIGH |
| Salmonella or Shigella | 2 | Contact | Strong | Little | Faecal incontinence | 40 | Until diarrhoea resolved for 48 hours | HIGH |
| | | | | | Continent & cooperative | 35 | | HIGH |
| Scabies (confirmed) | 2 | Contact | Strong | N/A | Avoid prolonged skin to skin contact | 20 | 24 hours after treatment | MEDIUM |
| Streptococcus group A & G | 2 | Droplet | Strong | Little | Surgical wards | 30 | 24 hours with effective antibiotics | HIGH |
| | | | | | Other wards | 20 | | MEDIUM |
| Tuberculosis (positive smear) | 3 | Airborne | Strong | Little | Refer to Tuberculosis Policy | 55 | 2 weeks after treatment | HIGH |
| Tuberculosis –MDRTB (or high probability) | 3 | Airborne | Strong | Serious | | 65 | Until smear negative Transfer to North Manchester | VERY HIGH |
| VRE (Vancomycin Resistant Enterococci) | 2 | Contact | Strong | Serious | Immunocompromised | 40 | Indefinite | HIGH |
| | | | | | Other wards | 30 | | HIGH |
| | | | | | Faecal colonisation, no diarrhoea | 20 | | MEDIUM |

Appendix 7

INFECTION CONTROL TRANSFER FORM

(Must be completed and sent to receiving organisation prior to transfer. To be completed by qualified nursing staff for all patients being transferred/discharged to another health care provider including Nursing or Residential care).

| | | | |
|---|--|--|--------|
| Patient Details: | | Consultant: | |
| NAME: DoB: UNIT No: NHS No: | | Transferring Ward: Contact no: Is the Infection Control Team aware of transfer? Yes/No Note: do not transfer any patient with diarrhoea unless discussed with the infection control team | |
| Receiving facility – (hospital, ward, care home, district nurse) Contact no: Is the Infection Control Team aware of transfer? Yes/No Is the ambulance service aware of transfer? Yes/No | | Is there a known or suspected risk of infection associated with this patient/client? Please tick most appropriate box and give confirmed or suspected organism <input type="checkbox"/> Confirmed risk Organism: <input type="checkbox"/> Confirmed risk Organism: <input type="checkbox"/> Suspected risk Organism: <input type="checkbox"/> No known risk Patient/client exposed to others with infection eg D&V Yes/No | |
| If patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol stool form scale) | | | |
| Is the diarrhoea thought to be of an infectious nature? Yes/No | | | |
| Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP, C. difficile, multi-resistant Acinetobacter SPP) and treatment information, including antimicrobial therapy: | | | |
| Specimen | | | |
| Date | | | |
| Result | | | |
| Treatment information: | | | |
| Other information: | | | |
| Is the patient/client aware of their diagnosis/risk of infection? | | | Yes/No |
| Does the patient/client require isolation? | | | Yes/No |
| Should the patient/client require isolation, please discuss with the Infection Control Team (ext 6679 / 6599 and phone the receiving unit in advance. | | | |
| Name of staff member completing form: | | Print name: | |
| Contact number: | | | |

For further advice, please contact infection control team ext 6679 / 6599

Appendix 8

Equality Impact Assessment Tool

| | | Yes/No | Comments |
|----|---|--------|---|
| 1. | Does the policy/guidance affect one group less or more favourably than another on the basis of: | No | |
| 1. | Does the policy/guidance affect one group less or more favourably than another on the basis of: | No | |
| | • Race | No | |
| | • Ethnic origins (including gypsies and travellers) | No | |
| | • Nationality | No | |
| | • Gender | No | |
| | • Culture | No | |
| | • Religion or belief | No | |
| | • Sexual orientation including lesbian, gay and bisexual people | No | |
| | • Age | No | |
| | • Disability - learning disabilities, physical disability, sensory impairment and mental health problems | No | |
| 2. | Is there any evidence that some groups are affected differently? | No | |
| 3. | If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable? | No | There is no discrimination in this guidance |
| 4. | Is the impact of the policy/guidance likely to be negative? | No | |
| 5. | If so can the impact be avoided? | N/a | |
| 6. | What alternatives are there to achieving the policy/guidance without the impact? | N/a | |
| 7. | Can we reduce the impact by taking different action? | N/a | |

14. REVIEW

This policy will be formally reviewed in March 2012, or earlier depending on the results of monitoring.