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Approval and Ratification

Referred for approval by: Infection Prevention and Control Team

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Approved by: Infection Prevention and Control Committee

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Executive Director Lead: Director of Nursing

Circulation

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Policy to be uploaded to the Trust's External Website? NO

Review

Review Date: 5th February 2019

Responsibility of: Infection Prevention and Control Team

Designation: Infection Prevention & Control Team

This policy is to be disseminated to all relevant staff.

This policy must be posted on the Intranet.

Date Posted: 17th February 2016

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1 INTRODUCTION

The term 'Isolation' is the use of infection prevention and control (IP+C) 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.

When a patient has been diagnosed as having an infection, it is necessary to consider the mode of transmission of the infection and to institute appropriate measures to prevent cross infection.

2 AIM OF POLICY

The aim of this policy is to ensure that appropriate provision and optimal use of isolation facilities are in place to minimise the risks of cross-infection (Health Act, 2008)

This policy should be read in conjunction with other Trust Infection Prevention and Control Policies.

The patient and, where appropriate, their families and carers will be involved in discussions about the patient's care at every stage while providing personalised care and minimising the use of inappropriate blanket restrictions and restrictive intervention which may impede the patient recovery process (DH, 2015)

3 ROLE AND RESPONSIBILITIES

Refer to Infection Prevention and Control Policy CL4 for individual responsibilities.

4 PRINCIPLES OF ISOLATION

The term "Isolation" is the use of infection prevention and 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
- Protective Isolation (reverse barrier nursing) where the patient requires protection i.e. they are immunocompromised.

Cohort nursing – Where patients cannot be isolated in single rooms, patients with an infection or colonisation with the same organism can be grouped

together in one bay or area of a ward/unit. This should always be discussed and agreed with the IP+C team.

The correct and timely placement of patients with an infection (suspected or confirmed) into isolation can be very effective in reducing the risk of transmission to other patients-

Standard Infection prevention and control Precautions must be observed at all times with all patients including those in source or protective isolation.

Infections can be transmitted in different ways and the aim of isolation is to contain infection while minimising the risks to the patient.

All staff should understand how organisms spread in order to apply correct isolation procedures relevant to the organism and the patient. (See Appendix 1 for Mode of Spread). Infection risks should be assessed as part of the ongoing clinical patient assessment and managed accordingly. Advice should always be sought from a member of the Infection Prevention and Control Team.

5 SOURCE ISOLATION

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. MRSA, Clostridium Difficile

The most effective form of isolation is a single room. If a single room is available this should always be first choice for of a patient with an infection.

Single room isolation is necessary when a patient presents an infection risk to others (Source isolation) or the patient is at risk from others (protective isolation)

Whenever isolation of a patient is considered, the advantages and disadvantages must be weighed up in relation to the associated psychological effects on the patient.

Isolated patients may experience more anxiety and depression, and isolation may hamper rehabilitation. To reduce these risk preparatory information should be given wherever possible incorporating;

- Explanation of the nature of the disease or organism, symptoms and treatment.
- Control methods and their rationale with advice for patients regarding their responsibility and their adoption to correct measures.

If a single room is not available advice from the Infection prevention and control Team should be sought. Single room isolation will not, by itself, prevent the transmission of organisms; it is part of barrier precautions.

Individual patient care should take into account factors, which may increase the risk of spread. In certain situations the infection risks and need for single room isolation may be outweighed by:-

- Severity of illness/condition requiring close observation
- Patient's mental state
- Unavailability of single room accommodation

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.
- Plan care, with advice and assistance from the Infection Prevention and Control Team.
- Obtain relevant microbiology samples to facilitate diagnosis and management.
- Communicate with other members of hospital/unit staff (whilst preserving confidentiality) to ensure compliance with barrier precautions.
- A laminated isolation sign should be prominently displayed, which provides sufficient constructive and educational information, whilst ensuring that there is no breach of confidentiality.
- Limit number of staff entering isolation room.
- En-suite toilet or commode for sole use of isolated patient. Patients may be transferred to rooms near or directly adjacent to a toilet. Staff must then ensure that that toilet is only used for that service user and is kept locked when not in use. Any commode used must be decontaminated thoroughly after use and before use on other patients
- In the event of an outbreak of infection, such as, norovirus, influenza isolation areas need to be identified in advance and should allow for minimal movement of patients within the remainder of the premises.
- Visitors and relatives do not need to wear plastic aprons or gloves for routine social visiting.
- Ideally the door to the room should be kept closed and the patient encouraged to remain inside the room. If this is likely to compromise the patient's care then a documented risk assessment should be carried out. If the patient refuses to consent to isolation, the multidisciplinary team must assess capacity, making reference to the Mental Capacity Act, Deprivation of

Liberty Safeguards etc. (see CL26 Seclusion, Time Out and other restriction of patients movements (within inpatient wards) Policy).

- Ensure the room is kept clean and uncluttered and that all procedures are carried out effectively and according to relevant trust policies. Source Isolation rooms should be cleaned daily and after all other ward cleaning has been carried out. (See Room Cleaning).
- Medical equipment inside the room must be dedicated to the isolated patient until the patient is discharged or no longer requires isolation. The equipment **must** then be appropriately decontaminated before it can be used on another patient.
- Patient documentation e.g. charts must be kept outside the room
- The vacated room must be cleaned thoroughly before it can be reoccupied. (see Terminal Cleaning – Section 10).

For further advice please contact IP+C, contact details can be found on the IP+C webpage on the Trust intranet.

6 PROTECTIVE ISOLATION

Protective isolation sometimes referred to as reverse isolation or 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. Patients who are particularly susceptible to infection, such as those with severe neutropenia, leukaemia, or receiving immunosuppressive drugs, may require isolation from other patients, staff or the hospital/unit environment.

Management of the Patient Once Isolated

Key Points

- The patient should be nursed in a single room ideally with an ante-room.
- Ensure the isolation room door is closed at **all** times, apart from the necessary entrances and exits.
- The patient must be nursed in a single room with a hand wash basin and preferably en-suite toilet.
- If an en-suite toilet is not available, a commode for the sole use of the patient should be kept in the isolation room.
- The commode should be cleaned thoroughly after each use
- 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.

- Ensure a laminated protective isolation sign is prominently displayed, on the door.
- Ensure **all** staff are aware of the necessary precautions.
- Protective isolation rooms should be cleaned before the rest of the ward/unit, using a fresh solution for each room. Cleaning equipment (separate mop and bucket) must be kept for the sole use of the isolation room.
- 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

7 OUTBREAKS OF INFECTION

Cohorting

When 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) and cared for by staff who will not care for other patients to avoid the risk of cross infection. 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, 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 Outbreak Policy.

8 INFECTIOUS DISEASES REQUIRING STRICT ISOLATION

Current facilities for isolation of patients with an infection within the Trust's in-patient areas include single rooms on wards. These facilities are not suitable for the prolonged accommodation of patients infected with organisms requiring "**strict isolation**", e.g. SARS, diphtheria, viral haemorrhagic fevers, pulmonary anthrax and rabies. **Always** seek urgent advice from the Consultant Microbiologist or a member of the Infection Prevention and Control Team. There should be strict limitation in the number of staff having contact with such patients. Transfer of patients will be to an Infectious Diseases Hospital/Ward in specially equipped ambulances with staff wearing protective clothing.

9 DAILY ROOM AND PATIENTS EQUIPMENT CLEANING

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

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 is in place

All isolation rooms must be cleaned daily with a hypo-chlorine releasing agent.

A fresh solution of a hypo-chlorine releasing agent should be made up and 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

Remember

- **Protective** isolation rooms should be cleaned **before** the rest of the ward.
- **Source** Isolation rooms should be cleaned **after** all other ward cleaning has been carried out.

10 TERMINAL ROOM CLEANING

Following patients discharge/transfer, or when isolation is no longer necessary the room should be cleaned using a hypo-chlorine releasing agent. Domestic Services staff are responsible for cleaning the clinical environment, and the nursing staff for medical equipment.

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

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 must be cleaned using 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

Wall washing is not required unless walls are visibly contaminated.

11 TRANSFER OF ISOLATED PATIENTS WITHIN AND BETWEEN HOSPITALS/UNITS

Transfers should only take place if unavoidable, and in the patient's best interest, i.e. the health of the patient should take priority over the infection problem.

A transfer form must be completed (Appendix 4). The receiving ward must be informed and a single room arranged. In cases of difficulty please discuss with the Infection Prevention and Control Team.

Patients who require isolation must not be transferred onto other wards (except when this is necessary to enable isolation to occur).

12 INVESTIGATIONS - VISITS TO OTHER DEPARTMENT

When patients are sent for an investigation the requesting card should state why the patient is in isolation. The receiving department must 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.
If a wheelchair is used for transferring the patient this must be decontaminated after use

13 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/unit.

14 EDUCATION and TRAINING

Staff requirements for IP+C training is identified in the training needs analysis in the education training and development policy CO5

15 AUDIT AND MONITORING

Refer to Infection Prevention and Control Policy CL4 for audit responsibilities

16 EQUALITY IMPACT ASSESSMENT

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

17 REFERENCES

Hospital Infection Society (2001) - Review of Hospital Isolation and Infection Control Related Precautions - Report of the Joint Working Group.

Wilson, J. (2001) - Infection prevention and control in Clinical Practice.
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Tindall.

Ayliffe, G.A.J, Babb, J.R, Taylor, L.Z (2001) - Hospital Acquired Infection, Principles and Prevention. Third Edition, Arnold page 99.

Department of Health (2007) Saving Lives: reducing infection, delivering clean and safe care. Isolating patients with healthcare-associated infection. A summary of best practice.

Newton, J.J. (2001) - Patients perceptions of methicillin-resistant Staphylococcus aureus and source isolation. Journal of Hospital Infection 48: 4, pages 275-280.

Dougherty, L and Lister, SE – The Royal Marsden Hospital Manual of Clinical Nursing Procedures. Seventh Edition 2008

Health and Social Care Act (2008, revised 2015): Code of Practice on the prevention and control of infections and related guidance, DH

[Public Health \(Control of Disease\) Act 1984](#) and the [Health Protection \(Notification\) Regulations 2010](#).

Appendix 1

MODES OF TRANSMISSION		
Contact	Direct	Hands are the most common mode of spread
	Indirect	Indirectly via contact with contaminated equipment or the environment.
Airborne		This occurs by the spread of small, airborne particles containing infectious agents that remain suspended in the air and are dispersed over distances by air currents where they are then inhaled by a susceptible individual.
Droplet		This occurs when respiratory droplets carrying infectious agents travel over short distances directly from the respiratory tract of an infectious individual to the mucosal surface of a susceptible individual. Respiratory droplets are generated by coughing, sneezing or talking. Droplets may also settle on horizontal surfaces and can cause indirect contact transmission via individual's hands.
Faecal-oral		This is the transmission of enteric bacterial infection from the gut of one person that is ingested by another resulting in infection
Vector		This is the spread of infection via a living creature
Inoculation		This is the inoculation of an infected body substance into the tissue of another (e.g., sharps injuries)
Vertical		This is the transmission of infection from mother to baby such as via placenta or breast milk

Appendix 2
LIST OF NOTIFIABLE ORGANISMS AND DISEASES

These organisms and diseases should be reported to GMHPU by clinicians

Greater Manchester HPT, 2nd Floor 3 Piccadilly Place, London Road,
Manchester, M1 3BN

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 0344 2550562 option 3, option 1 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 Pennine Care NHS Foundation Trust switchboard on 0161 331 6000.
The Trust infection Prevention and control team:

Appendix 4

TRANSFER DOCUMENT

Patient/client details: (insert label if available) Name: Address: NHS Number: Date of birth:	Consultant: GP: Current patient/client location: Transferring facility – hospital, ward, care home, other: Contact no: Is the ICT aware of transfer? Yes/No															
Receiving facility – hospital, ward, care home, district nurse Contact no: Is the ICT/ambulance service aware of transfer? Yes/No	Is this patient/client an infection risk? <i>Please tick most appropriate box and give confirmed or suspected organism</i> <div style="text-align: center;"> Confirmed risk <input type="checkbox"/> Organism: <input type="checkbox"/> Confirmed risk Organism: <input type="checkbox"/> Suspected risk Organism: <input type="checkbox"/> No known risk </div> Patient/client exposed to others with infection e.g. D&V Yes/No															
If patient/client has diarrhoeal illness, please indicate bowel history for last week: (based on Bristol stool form scale, see previous page)																
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:																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;">Specimen:</td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> <td style="width: 20%;"></td> </tr> <tr> <td>Date:</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Result:</td> <td></td> <td></td> <td></td> <td></td> </tr> </table>	Specimen:					Date:					Result:					Treatment information:
Specimen:																
Date:																
Result:																
Other information: Has the patient/client been given an information leaflet about their infection? Yes/No																
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 phone the receiving unit in advance																
Signature of staff member completing form: Print name: Date of Transfer: Contact number:																