Pennine Care
NHS Foundation Trust

DOCUMENT CONTROL	
Title:	**Isolation Policy**
Version:	**4**
Reference Number:	**CL103**

Scope:

This policy applies to all Pennine Care Staff working within a clinical inpatient unit.

Purpose:

The purpose 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.

Requirement for Policy

Keywords:

Cross infection, Isolation, Barrier Nursing

Supersedes:

Version 3

Description of Amendment(s):

General review including references

Owner:

Infection Prevention & Control Team

Accountability:

- Associate Director of Nursing and Healthcare Professionals
- Executive Director Of Nursing, Professional Leadership & Quality Governance

Individual(s) & group(s) involved in the Development:

This document has been developed in collaboration with the following interested parties:

- Infection Prevention & Control Team

Individual(s) & group(s) involved in the Consultation:

The document has been circulated for consultation and comments have been taken into consideration and the document amended accordingly:

- Infection Prevention & Control Team
- Infection Prevention & Control Committee
- Members of all the Borough based Governance Groups

Equality Impact Analysis:	
Date approved:	5th November 2018
Reference:	CL103-EIA103
Freedom of Information Exemption Assessment:	
Date approved:	11th January 2019
Reference:	POL2018-88
Information Governance Assessment:	
Date approved:	11th January 2019
Reference:	POL2018-88
Policy Panel:	
Date Presented to Panel:	14th January 2019
Presented by:	Laura Birch
Date Approved by Panel:	14th January 2019
Policy Management Team tasks:	
Date uploaded to Trust's intranet:	17th January 2019
Date uploaded to Trust's internet site:	17th January 2019
Review:	
Next review date:	January 2022
Responsibility of:	Infection Prevention & Control Team
Other Trust documentation to which this policy relates (and when appropriate should be read in conjunction with):	
CL004	Infection Prevention and Control Policy
CL026	Seclusion, Time Out and other Restriction of Patients Movements Policy
CL075	Outbreak Policy
CL122	Safeguarding Families Policy
CO005	Education Training and Development Policy
CO081	Core & Essential Skills Policy
Policy Associated Documents:	
TAD_CL103_01	Transfer Document
Other external documentation/resources to which this policy relates:	

CQC Regulations **This Policy supports the following CQC regulations:**	
Regulation 12	Safe care and treatment
Regulation 17	Good governance
Regulation 18	Staffing

Contents Page

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. PURPOSE

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 (Heath Act, 2008).

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. RESPONSIBILITIES, ACCOUNTABILITIES AND DUTIES

Overall accountability for procedural documents across the organisation lies with the Chief Executive who has overall accountability for establishing and maintaining an effective document management system, for meeting all statutory requirements and adhering to guidance issued in respect of procedural documents.

Overall responsibility for the confidentiality policy lies with the Caldicott Guardian with delegated responsibility for managing the development and implementation of confidentiality policy procedural documents to the Information Governance Manager.

The Caldicott Guardian is responsible for overseeing and advising on contentious issues of service user confidentiality for PCFT.

Line Managers are responsible for ensuring that all staff, particularly new staff, temporary staff, contractors and volunteers, know what is expected of them with respect to confidentiality and protecting information. They and are also responsible for monitoring compliance with this policy. The Trust has a dedicated Privacy Officer who will monitor for inappropriate access via regular auditing of access, including Break glass processes.

Staff are responsible for maintaining the confidentiality of all personal and corporate information gained during their employment with PCFT and extends after they have left the employ of PCFT.

Individual staff members are personally responsible for any decision to pass on information that they may make.

All staff are responsible for adhering to the Caldicott principles, the Data Protection Act and the Confidentiality Code of Conduct.

Staff will receive instruction and direction regarding the policy from a number of sources:

- Policy/strategy and procedure manuals
- Line manager
- Specific training courses
- Other communication methods (team brief/team meetings/IG bulletins
- Staff Intranet

All staff are mandated to undertake Information Governance training on an annual basis. This training should be provided within the first year of employment and then updated annually as appropriate in accordance with the Core and Essential Skills Policy and the Information Governance training plan.

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. 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 Point

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

Staff must:-

- Establish and maintain communication with the patient and the 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 the 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 or 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 CL026 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).

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

Cohort

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 hyper-chlorine releasing agent.

A fresh solution of a hyper-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 hyper-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 (TAD_CL103_01). 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 DEPARTMENTS

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 without first discussing this with senior management. Staff may also wish to consult the Information Governance team to ensure any disclosure that is required would be lawful and appropriate.

14. EDUCATION AND TRAINING

Staff requirements for Infection Prevention & Control training is identified in the training needs analysis in the education training and development policy CO005.

15. EQUALITY IMPACT ANALYSIS

As part of its development, this document was analysed to consider / challenge and address any detrimental impact the policy may have on individuals and or groups protected by the Equality Act 2010. This analysis has been undertaken and recorded using the Trust's analysis tool, and appropriate measures will be taken to remove barriers and advance equality of opportunity in the delivery of this policy / procedure

16. FREEDOM OF INFORMATION EXEMPTION ASSESSMENT

Under the Freedom of Information Act (2000) we are obliged to publish our policies on the Trust's website, unless an exemption from disclosure applies. As part of its development, this policy was assessed to establish if it was suitable for publication under this legislation. The assessment aims to establish if disclosure of the policy could cause prejudice or harm to the Trust, or its staff, patients, or partners. This assessment has been undertaken using the Trust's Freedom of Information Exemption Guide, and will be reviewed upon each policy review.

17. INFORMATION GOVERNANCE ASSESSMENT

This Policy has been analysed to ensure it is compliant with relevant information law and standards as in place at the time of approval, and are consistent with the Trust's interpretation and implementation of information governance components such as data protection, confidentiality, consent, information risk, and records management.

Compliance will be reviewed against any changes to legislation / standards or at the next review of this document.

18. SAFEGUARDING

All staff have a responsibility to promote the welfare of any child, young person or vulnerable adult they come into contact with and in cases where there are safeguarding concerns, to act upon them and protect the individual from harm.

All staff should refer any safeguarding issues to their manager and escalate accordingly in line with the Trust Safeguarding Families Policy and Local Safeguarding Children/Adult Board processes.

19. MONITORING

The effective application of this policy, including adherence to any standards identified within will be subject to monitoring using an appropriate methodology and design, such as clinical audit.

Monitoring will take place on a biannual basis and will be reportable to the Quality Group via the Clinical Effectiveness and Quality Improvement Team.

20. REVIEW

This policy will be reviewed three-yearly unless there is a need to do so prior to this; e.g. change in national guidance.

21. REFERENCES

Department of Health. 2007 *Saving Lives: reducing infection, delivering clean and safe care. Isolating patients with healthcare–associated infection: a summary of best practice*. London: Department of Health.

Department of Health, 2015. *Health and Social Care Act.: Code of practice on the prevention and control of infections and related guidance*. London: Department of Health

Dougherty, L and Lister, SE, 2008. *The Royal Marsden Hospital Manual of Clinical Nursing Procedures.(7th ed)* London: Wiley

Masterton, RG, Mifsud, AJ and Gopal Rao, G. Review of hospital isolation and infection control precautions. *Journal of Hospital Infection*. 54 (3) 171-173

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

Taylor, L.Z Babb, J.R Ayliff, G.A.J, 2001 *Hospital acquired infection: principles and prevention.* (3rd ed) London: Hodder Arnold

Wilson, J. 2001 *Infection prevention and control in Clinical Practice*. London: Bailliere

Tindall.

Equality Act 2010

Freedom of Information Act 2000

Health Protection (Notification) Regulations 2010

Public Health (Control of Disease) Act 1984