NHS
South West Yorkshire Partnership
NHS Foundation Trust

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Director leads:	Director of Nursing, Quality and Director of Infection Prevention and Control
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1. Introduction

Healthcare associated infections such as Meticillin Resistant Staphylococcus Aureus; Clostridium difficile infection, Extended Spectrum Beta-Lactamase, Norovirus and multi resistant organisms may be transmitted between patients and potentially between patients, staff and visitors. Transmission of infection involves a source of infecting microorganism, a susceptible host and a mode of transmission.

When a patient is suspected or known to be suffering from infection, an understanding of the source, route and mode of the transmission (**Appendix 1**) of infection is essential in order to institute the appropriate infection prevention and control principles, including isolation.

Standard precautions must be applied to all patients without exception, inclusive of environmental cleaning, personal protective equipment and hand hygiene.

The isolation of patients must be based on the infection risk, symptoms and transmission in accordance with the relevant infection prevention and control policy

The Medical Practitioner is responsible for ensuring notification of communicable diseases is undertaken.

In the community home setting, isolation of patients is not usually required. However, staff caring for the susceptible or known infected patient must adhere to the principles of infection prevention and control.

Advice should be sought in the first instance from the Infection Prevention and Control Team (IPCT) on the appropriateness of isolating patients. Out of hours, at weekends and bank holidays, through the local on-call Microbiologist available through the hospital switchboard

2. Purpose

This policy has been developed in order to ensure the correct employment of isolation procedures to reduce and minimise the risk of cross infection to patients, visitors and healthcare workers. Minimising the inappropriate movement of patients with infections for non-clinical reasons. Ensuring the organisation complies with the requirements of the Health and Social Care Act (2008) Code of Practice for health and adult social care on the prevention and control of infections and related guidance.

2.1. A summarised planning guide to isolation procedures is provided (**Appendix 2)**. The Consultant in Communicable Disease Control (CCDC) must be notified for infections marked with an asterisk (*).This is the responsibility of the medical staff and notification forms are available for this purpose.

3. Principles

The policy applies to all staff providing care to all patients under the care of the Trust, whether in a direct or indirect patient care role.

4. Definitions

Adherence to this policy is the responsibility of all staff employed by the Trust, including agency, locum and bank staff contracted by the Trust.

NB Excluded from this policy are those working in primary care who are not directly employed nor directly managed by the Trust.

5. Duties

The following duties apply to this policy:

5.1. Trust Board

- The Board will be responsible for ensuring that there are effective arrangements in place for the implementation of the policy

5.2. Executive Management Team (EMT)

- The Executive Management Team will approve the policy

5.3. Director of Infection Prevention and Control

- The Director of Nursing has the responsibility to provide professional infection prevention and control support in relation to the individual's role as the Director of Infection Prevention and Control
- Report directly to the Chief Executive and the Board
- Be responsible for the Infection Prevention and Control Team within the healthcare organisation
- Challenge inappropriate clinical hygiene and decontamination practices
- Ensure that this policy and its associated procedures are fully adhered to within the trust

5.4. IPC Operational Groups and Trust Action Groups (TAGs)

- Will support the implementation of this policy. The policy will be considered and consulted upon by the Infection Prevention and Control Trust Action Groups

5.5. Infection Prevention and Control Team

The Infection Prevention and Control Team will:

- Provide education to clinical staff on decontamination and the risks of cross infection
- Promote excellent infection prevention and control practice in line with the policy
- Ensuring action is taken when staff fail to comply with the policy
- Provide information, advice and training to enable managers and users to undertake risk assessments as required.
- Advise on the appropriate infection prevention and control measures for infected and symptomatic patients
- Support, advise, and provide information to the patient and relatives as appropriate
- Participate in audits to monitor practice in line with current legislation or guidance
- Conduct investigations into areas of special risk advising on safe practice

- Be responsible for the production of the policy and management procedures

5.6. **Practice Governance Coaches/ Matrons/ Modern Matrons/ Quality Governance Leads/Clinical Leads**

- Ensure that the principles of infection prevention and control are adhered to
- Liaise and work closely with the Infection Prevention and Control Team to ensure best practice is followed
- Provide support to staff in difficult situations
- Escalate any situation where safe placement cannot be achieved

5.7. **Team Leaders/ Ward Manager**

- Liaise and work closely with the Infection Prevention and Control Team
- Ensure appropriate personal protective equipment available
- Ensure that their area of responsibility provides a safe clean environment and equipment is decontaminated and fit for purpose
- Ensure that staff are fully informed and adhere to current policies and procedures in relation to Infection Prevention and Control and isolation procedures
- Participate in audits to monitor practice
- Liaise with patients and relatives, providing information as required
- Ensure staff attend training as appropriate
- When unable to isolate a patient to follow the 'Single room escalation procedure'

5.8. **Staff**

- Will adhere to the policies, procedures and guidelines on the prevention and control of infection
- Ensure the correct usage of PPE to prevent transmission of infection
- Attend appropriate training as required
- Inform the Infection Prevention and Control Team of any patients requiring isolation.
- Report failure in protocol on the incident reporting system
- Will maintain accurate records
- Be responsible for liaising with appropriate personnel when patients are discharged

6. Development process

- Isolation of patients is undertaken for two reasons: Source Isolation and to prevent transmission of infection from the infected patient to others

Protective Isolation

- To prevent transmission of infection to a susceptible patient

- In some cases strict source isolation is required to prevent the spread of highly transmissible infections e.g. Diphtheria and Viral Haemorrhagic Fevers using negative pressure facilities.

- Current facilities for isolation within the Trust include limited single room access. These facilities are not suitable for prolonged accommodation of patients with highly infectious diseases e.g. Diphtheria and Viral Haemorrhagic Fevers.

- Strict guidance must be sort from the Consultant Microbiologist and Infection Prevention and Control Team. This will involve transfer of such patients to an identified infectious diseases hospital in specially equipped ambulances.

- Principally this policy will refer to source isolation.

PRINCIPLES OF ISOLATION

- Ideally, the most effective form of isolation is a single room (Pratt et al 2007)

- Single rooms should always be the first choice for placement of an infected patient.

- Where this is not possible cohort nursing should be employed.

- Cohort nursing involves nursing patients with the same organism (or displaying similar signs and symptoms of infection) as an alternative form of isolation nursing when single room capacity is exceeded.

- Cohort patients should be nursed by designated staff

- Advice on the decision to isolate a patient and guidance on isolation management should always be sought from the Infection Prevention and Control Team

- Individual risk assessment should take into account infection risk; severity of illness requiring close observation, patient's mental state being a contra-indication to single room accommodation and the availability of single room accommodation

- Staff must follow standard infection prevention and control procedures at all times in line with Trust policies

- NB. If the patient's clinical condition is deemed such that isolation would compromise their safety, consultation must be made with the Infection Prevention and Control Team or Microbiology, ensuring a full risk assessment is made with Infection Prevention and Control advice. Actions/decisions must be documented in the patients' health care records.

GUIDELINES FOR SINGLE ROOM AND COHORT NURSING

- Routine explanation of infection, isolation procedures and treatment must be given to affected patients and visitors

- Rooms, bays and areas for isolated patients must have dedicated hand hygiene and toileting facilities for example en-suite or designated commodes

- Use clear signage on doors or walls to alert staff and visitors of isolation precautions. Barrier nursing signage is colour coded dependent on the infection the patient has identified. (**Appendix 3**)

- Reverse barrier nursing is when a patient is isolated to protect them from acquiring an infection. The patient requires reverse barrier nursing if they are immunocompromised and susceptible to acquiring infection from other patients in the shared healthcare environment

- Doors must be kept closed at all times. When this is not possible a risk assessment is undertaken and the reason documented in the patient's care health care records

- Potentially there may be a need to restrict the number of visitors / relatives visiting the affected patient. This will be discussed with the nurse in charge and Infection Prevention and Control Team

- N.B. Restrictions affecting 2 or more service users need Datix reporting as a blanket restriction. This will then need lifting when the service user is no longer symptomatic. This would also be the case if we were restricting service user movement in the case of an outbreak regardless of whether they were the infected individual or not.

MANAGEMENT OF THE ISOLATED PATIENT

Transmission based precautions:

<u>Hand Hygiene</u> (Refer to Hand Hygiene policy)

1. High standards of hand hygiene minimise the risk of cross infection

2. Hand hygiene must be performed before and after each direct patient contact (regardless of glove use)

3. Adequate hand hygiene facilities and alcohol hand gel must be available for use

<u>Personal Protective Equipment</u> (Refer to Standard Infection Prevention and Control Precautions Policy)

4. Disposable aprons must be worn by all staff and visitors assisting in the care of the patient or having contact with their immediate environment

5. Disposable gloves must be worn where there is contact with bodily fluids and when handling contaminated items

6. **Masks (Type I, II or IIR)** must be worn when patient suspected to have or confirmed

to have TB, or suspected or confirmed to have COVID19

7. Visors / eye protection should be worn following a risk assessment, where it is anticipated that the procedure / task may result in blood / body fluids being sprayed or splashed

8. Fans must not be used to control patient's temperature

9. A dedicated single patient use tourniquet must be used

10. Medical notes and charts must be kept outside the room/bay/area

11. Personal protective clothing worn in the isolation room should be disposed of in the room unless dealing with body fluids that require disposal in the sluice

Cleaning and Decontamination

- Refer to the Decontamination policy

- Isolation room/bay/area should be clean and uncluttered with only necessary equipment used

- Where possible dedicated single patient use equipment should be used e.g. commodes and medical equipment

- Multiple patient use equipment must be decontaminated in accordance with the Decontamination Policy

- Protective covers should be used on both disposable and non-disposable bedpans/urinals

- Used bedpan holders, bedpans and urinals must be emptied and placed immediately into washer disinfector at a temperature of 80 degrees Celsius or macerator

- Treat all linen as infected (Refer to Laundry policy)

- Waste must be categorized with regard to the Waste Policy

- Cleaning procedures must be rigorously applied (Refer to Decontamination policy)

- Enhanced cleaning must be performed twice daily and documented accordingly (**Appendix 5**)

- All staff must be aware of individual responsibilities for undertaking regular cleaning (Refer to Decontamination policy) All staff including domestic staff must be aware of which rooms require terminal cleaning and when these have been completed

Movement

- Transfer and movement of patients must be kept to a minimum to reduce the risk of cross infection

- Transfer and movement of patients must only be undertaken for clinical reasons

- The vacated room must be decontaminated following transfer/discharge, with Chlor-clean or HPV but is determined by the organism

If transfer is necessary

- Inform the Infection Prevention and Control Team

- Receiving area must be informed of infection status to ensure implementation of infection control measures. Ensure the Inter Health Care Transfer form is fully completed and accompanies the patient **(Appendix 6**)

- Hand hygiene and personal protective equipment procedures must be strictly maintained

- Equipment used for transfer of patient must be decontaminated after use

Discontinuing Isolation

- The need to continue with isolation precautions should be assessed on a daily basis in conjunction with the Infection Prevention and Control team

Isolation can be stopped when:

- The patient is no longer at risk of spreading infection to others

- The duration of isolation dictated by the specific disease and treatment criteria has been met.

- If in doubt, contact the Infection Prevention and Control Team

Prioritisation of single rooms/ on-suite rooms

- Prioritisation for the use of single rooms must remain for patients with infection control needs. The following is a guide to prioritisation needs for the following infections/micro-organism.

For the following conditions, isolation is mandatory; suspected or confirmed

- Open Pulmonary Tuberculosis

- Group A Streptococcal Infection. This includes any patients presenting with a spreading cellulitis with open or bullous lesions/ necrotizing fasciitis

- Chicken pox, Measles and wet Shingles

- Meningococcal septicemia/meningitis/or meningitis of uncertain cause (until 24 hours of appropriate antibiotic therapy completed)

- Infectious gastroenteritis (diarrhoea and/or vomiting – including Clostridium Difficile

and other enteric infections)

- Neutropaenia (neutrophils <1.0 g/L)
- Resistant organism for example VRE, CPE and Candida auris
- MRSA (see MRSA policy)
- COVID 19 until sample negative or for 14 days if sample positive

NB A patient's need for isolation should be reviewed on a per shift basis to ensure efficient use of single rooms. Where all isolation facilities are exhausted, it is essential that a thorough review of side room occupation is undertaken as a matter of urgency.

Please refer to **Appendix 4** for single room escalation procedure when no isolation facilities are available

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.

7. Approval and ratification process

This policy has been reviewed at the SWYPFT Policy Ratification Group and submitted by the Lead Director for approval at EMT.

8. Process for Review

This policy will be reviewed every three years from the date of approval. An earlier review other than that specified above may be required to meet changes in legal, statutory or good practice standards**.**

8.1. Stakeholder involvement

The organisation recognises that policies need to be developed in consultation and communication with a range of stakeholders. The following list identifies some of the individuals or groups who have been consulted in the development of this policy. This is not an exhaustive list.

Stakeholder	**Level of involvement**
Executive Management Team	Approval
Director of Infection Prevention and Control	Initiation, lead, development, receipt, circulation
Infection Prevention and Control Trust Action Group (IPC TAG)	Commissioning, development, consultation, dissemination, implementation, monitoring.
Infection Prevention and Control Team	Development, consultation, dissemination, implementation, training, audit
Health and safety TAG (H&S TAG)	Consultation, development, implementation, monitoring
Drugs and Therapeutics Sub Committee	Consultation, development, dissemination, implementation,

Business Delivery Units (BDUs), Modern Matrons, Managers	Consultation, disseminate, implement, monitor
Staff side	Consultation

9. References

Department of Health (2008) The Health Act Code of Practice for the Prevention and Control of Health Care Associated Infections

Damani D (2003) Manual of Infection Control Procedures. 2nd Edition. Greenwich Medical Media: London.

Department of Health (2006) The Health Act 2006 Code of Practice for The prevention and Control of Health Care Associated Infections.

National Audit Office (2000) The Management and Control of hospital acquired infection in acute NHS Trusts' in England.

Plowman R, Graves N, Griffin N et al. (2000) Socioeconomic burden of hospital acquired infection. PHLS: London.

Pratt et al 2007 Journal of Hospital Infection, February 2007, Volume 65

The Royal Marsden Hospital (2015) Manual of Clinical Nursing Procedures ninth edition.

Contact Details for Infection Prevention and Control Team, Local Authority and Public Health England

10. Version control

This policy has been updated from its previous format and is version 3

11. Dissemination

This policy is available in read only format via the document store on the Trust intranet. Staff are informed of any changes to the policy via the weekly staff communication on the Trust intranet and a communication from the IPCT via the home page of the Intranet and other media forms.

12. Implementation

Support to assist implementation of this policy is available from the IPCT. Additional downloadable information is also available on the infection prevention and control pages on the intranet.

12.1 Training

IPC training is mandatory for all staff. This will be as advised by the annual training needs analysis (TNA) identified by the Learning and Development Lead.

BDUs and Service managers are responsible for ensuring that all their staff attend mandatory IPC training sessions.

The IPCT will offer training in a number of formats e.g. face to face, e-learning, DVD, to accommodate the diversity of the service.

13. Document control and archiving

13.1 Current policies and procedures

This current policy will be available on the intranet in read only format.

13.2 Historic policies and procedures

A central electronic read only version of Versions 3 of this policy will be kept in a designated shared folder to which all staff can request access.

Documents will be retained in accordance with requirements for retention of non-clinical records.

14. Monitoring compliance with the policy

The Annual Infection Prevention and Control Programme is monitored and a quarterly written report is produced to demonstrate compliance. This quarterly report is scrutinised at the IPC TAG where achievements and exceptions are discussed. Progressive action then planning takes place if required. This report is then in turn processed through the internal and external governance arrangements within the organisation.

Any incidents will be reported by the DATIX system. Any outbreaks and untoward incidents will also be reported through the IPC TAG and other appropriate Governance Committees.

The IPC TAG has developed the following key indicators (KPI) to enable adequate performance management of Clostridium difficile practice within the organisation and to ensure continuous quality improvement of the KPI scores:

- reductions in the number of untoward incidents associated with infection
- reductions in the number of clearly defined outbreaks of infection
- number of infection control audits undertaken
- environmental audit scores
- meeting trajectories for HCAI as set locally and nationally

These KPIs are monitored and reported to the IPC TAG on a quarterly basis and a report is included in the infection prevention and control annual report and programme for the coming year.

The IPC TAG will commission annual audits by the Quality Improvement and Assurance Team / data analyst (QIAT / data analyst) of the infection prevention and control practice of all staff on behalf of the DIPC. These reports and action plans will form the basis of the infection prevention and control assurance framework objectives for the coming year.

They are also responsible for facilitating the monitoring and auditing the hand hygiene technique of staff on an annual basis. The audit results will be provided to the IPCT for action plans to be generated if required and to QIAT / data analyst for an audit report which will be included in the IPC annual report.

This audit will also be supported by action plans generated from regular monitoring and kitchen inspections carried out by the Facilities Department and by the Service user Led Assessment Care Environment Team inspections (PLACE) as part of the requirements for Care Quality commission (CQC) registration.

15. Associated documents and supporting references

This document has been developed in line with guidance issued by NICE, NHS England and Public Health England. It should be read in conjunction with the:

- Infection Prevention and Control policies
- Local Antibiotic Prescribing Policy
- Clostridium difficile policy
- Confidentiality policy
- Health and Safety policy
- Legionella (Control of and Water Safety) policy
- COSHH guidance
- Incident Reporting and Management (including Serious Untoward Incidents) policy
- Occupational Health and Wellbeing policy
- Human Resources policy
- Mandatory training policy
- Whistle blowing policy

APPENDIX 1

Mode of Transmission

Airborne	• Microorganisms transmitted directly, to susceptible patients, in dust and skin cells carried by the air during procedures. • The microorganism is dispersed widely and over long distances **Human** Skin scales, wound dressings, bedding and respiratory Droplets **Aerosolised fluid** Nebulisers, humidifiers, showers and cooling towers **Dust** Building work, sweeping and bed making
Droplet	• Microorganisms transmitted in respiratory droplet nuclei sneezing, coughing and talking. • The microorganism is dispersed over short distances only
Contact	**Direct** Microorganisms transmitted from person to person and by the hands of healthcare workers. Skin, mucous membrane, blood and body fluid **Indirect** Microorganisms transmitted to susceptible people via contaminated objects (faecal oral route) Equipment, environment and food
Blood borne	**Blood borne** Exposure to blood/body fluid infected with microorganisms Including exposure to needle stick and sharps injuries and contaminated intravenous infusion fluids

APPENDIX 2

ISOLATION PRECAUTIONS - PLANNING GUIDE This guide outlines measures to prevent cross-infection within the hospital environment. * - Notifiable to CCDC

Disease	What is infected	Route of Spread	Single room	Personal Protective Equipment	Linen	Period of precaution	Comments
Acquired Immune Disease	Blood and body fluids	• Blood or infected tissue • Sexual exposure • Vertical transmission • Breast milk • Occupational exposure e.g. sharps injury	No unless bleeding profusely	Yes For contact with blood or body fluids	Infected If contaminated with blood or body fluids	On going throughout admission	Full face visor if risk of splashes or sprays
Campylobacter*	Faeces	Faecal oral Ingestion of organism	Yes	Yes contact with diarrhea	If soiled treat as infected	Until symptom free for 48 hrs	
Candida auris	Dependent on site of colonization/ infection	• Direct contact	Yes	Yes for direct contact	Treat as infected	For remainder of inpatient episode	Refer to the Detection and management of Candida auris policy and screening criteria
Chicken Pox	Respiratory secretions Discharge from vesicle fluid	• Direct contact with vesicle • Droplet/airborne • Indirect contact with freshly soiled clothing/linen	Yes **With door closed**	Yes For direct patient contact	Infected	Until lesions are crusted and dry	Non immune and pregnant staff to avoid contact with affected patient
CJD and CJDv	Brain, eye, nerves and lymphoid tissue	• Direct and Indirect contact	Not usually	Yes For contact with blood or body fluids **Gloves** For direct patient contact	If soiled treat as infected	On going throughout admission	Special care with surgical instruments

Carbapenamase producing Enterobacteriacea	Dependent on site of colonisation /infection.	• Direct contact	Yes	Yes for contact with blood and body fluids	Treat as infected	For duration of inpatient stay	Refer to Detection and management of CPE policy and screening criteria
COVID 19	Respiratory secretions	• Direct contact with respiratory secretions • Droplet	Yes	Gloves, apron for close contact with patient or patients environment FFP3 mask for aerosol generating procedures Fluid repellent surgical mask for suspected or confirmed cases	Treat as infected	For duration of 14 days from onset of symptoms	Full face visor if risk of splashing
Glycopeptide Resistant Enterococcus (GRE)	Dependant on site of colonisation or infection	• Direct contact	Yes	Yes for contact with blood and body fluids	Treat as infected	For duartion of inpatient stay	Refer to the policy Principles for the Prevention & Control of Glycopeptide Resistant Enterococcus (GRE)

Disease	What is infected	Route of Spread	Single room	Personal Protective Equipment	Linen	Period of precaution	Comments
Influenza	Respiratory Secretions	• **Respiratory** • **airborne**	**Yes With door closed**	**Yes for direct contact**	Treat as non infected	Duration of illness	Masks must be worn Refer to HPA pandemic flu guidance
Legionnaire	Lung tissue	• Airborne • Water	**No**		Treat as non infected		Not thought to be transmissible person to person
Measles	Respiratory Secretions	• Droplet spread • Indirect contact	**Yes With door closed**	Yes For contact with respiratory secretions	Treat as non infected	For 4 days after the rash has appeared	Non immune staff to avoid contact with affected patient
Meningococcal Meningitis (bacterial)	Respiratory Secretions	• Droplet spread • Direct contact – mucous membrane	**Yes**	Yes For contact with respiratory secretions	Treat as non infected	Until patient has received 24 hrs of appropriate antibiotic therapy	Prophylaxis indicated for close family contacts - discuss with Microbiologist
Pneumococcal Meningitis	Respiratory Secretions	• Droplet spread • Direct contact – mucous membrane	**Yes**	Yes For contact with respiratory secretions	Treat as non infected	Until patient has received 24 hrs of appropriate antibiotic therapy	
MRSA	Dependent on site of colonisation / infection	• Direct contact	**Yes**	**Yes for direct contact**	Treat as infected	Until advised by Infection prevention and control	Refer MRSA screening Policy MRSA policy
Mumps	Respiratory Secretions	• Droplet spread • Direct contact – mucous Membrane	**Yes**	Yes For contact with respiratory secretions	Treat as non infected	For 9 days after onset of swollen glands	Non immune staff to avoid contact with affected patient

Rotavirus	Faeces, vomit and Respiratory secretions	• Droplet spread • Faecal oral	Yes	Yes For contact with diarrhoea and respiratory secretions	Infected	Until symptom free for 48 hrs	Refer to outbreak policy if many babies affected
Respiratory Syncytial virus	Respiratory Secretions	• Droplet spread • Direct contact with respiratory secretions	Yes	Yes For contact with respiratory secretions	Infected	Until symptom free	
Rubella *	Respiratory secretions	• Droplet spread • Direct contact with • respiratory secretions	Yes	Yes For contact with respiratory secretions	Treat as non infected	For 7 days after onset of rash	
Salmonella *	Faeces	• Faecal oral	Yes	Yes For contact with diarrhea	Infected if soiled	Until 48 hrs symptom free	
Scabies	Skin	• Scabies mite • Direct skin to skin contact	No	Yes For direct patient contact	Treat as non infected	Until successfull y treated	Dermatology referral is recommended for in patient areas.
SARS *	Respiratory Secretions	• Droplet spread • Direct contact with • respiratory secretions • Airborne	Yes **With door closed**	Yes	Infected	Duration of illness	Masks must be worn. Seek urgent advise from infection control
Shingles	Vesicle fluid	• Direct contact with vesicle fluid • Indirect contact with soiled linen	Yes	Yes For direct contact with vesicle fluid	If soiled treat as infected	Until lesions are crusted and dry	Non immune staff to avoid contact with affected patient
Pulmonary TB	Sputum	• Airborne • Direct contact with • respiratory secretions	Yes **With door closed**	Yes For contact with respiratory secretions	Infected	Until 2 weeks after effective compliant treatment	Staff should wear special filter masks when exposed to respiratory droplets Only immune staff to attend patient

Vancomycin resistant enterococcous (VRE	Dependant on site of colonisation or infection	• Direct contact	Yes	Yes for direct contact	Treat as infected	For duration of inpatient stay	
Whopping cough (pertussis)	Respiratory Secretions	• Airborne • Direct contact with nasal and throat secretions	Yes **With door closed**	Yes For contact with respiratory secretions	Treat as non infected	Until 5 days appropriate antibiotic therapy	Restrict contact with infants and young children until pt has received at least 5 days treatment

NB this list is not exhaustive - in keeping with the national guidance based on current evidence

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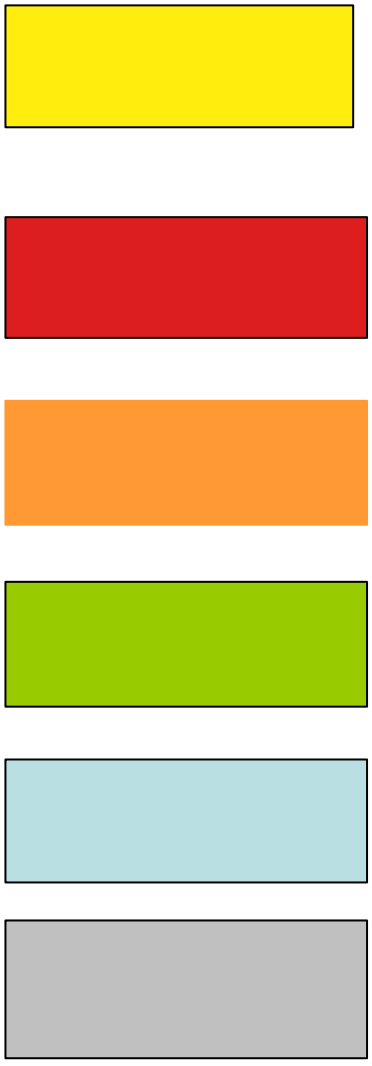
Colour Codes for Barrier Nursing Signs



- Clostridium difficile
- Methicillin Resistant Staphylococcus aureus (MRSA)
- Enteric (affecting bowel)
- Respiratory
- Reverse Barrier Nursing
- General Barrier Nursing

BARRIER NURSING

All Visitors:

- **Please wash and dry your hands before entering and on exiting the room**
- **Please ask the nurse before entering so that she/he can explain any precautions you need to take**
- **Please close the door behind you**
- **Please ask the nurse/matron or member of the Infection Prevention and Control team to explain anything you are unsure of**

All Staff

- **Please adhere to standard Infection Prevention and Control precautions at all times**
- **Please check care plan/ward guidance if you are unsure about any Infection Prevention and Control procedure**

PLEASE NOTE

The range of barrier nursing signage can be printed from the Infection Prevention & Control Intranet page

APPENDIX 4

Isolation Escalation Procedure

When an individual requires isolation for infective reasons and refuses to be / or is unable to be isolated, the following procedure must be followed:

Organisms	Personnel to Involve	Enhanced IPC Precautions
1. HCA organisms – MRSA, infective diarrhoea, CDI	Person in charge of the unit (Ward Manager/ Team Leader/PGC/ Modern Matron) ↓ Ward doctor / consultant ↓ Infection Prevention and Control Team (in hours) ↓ Microbiology Consultant ↓ District Director	• Confine the individual to the least areas possible • Enhanced cleaning – regular decontamination of frequently touched surfaces (numerous times per day) • Risk assessment • Record keeping • Incident report (Datix)
2. Multiresistant organisms – CPE, VRE, GRE	As per section 1 plus: ? DIPC / Director of Nursing ? CCDC PHE ? Trust Legal department	As per section 1 plus:
3. Respiratory organisms – Influenza, TB, MDR TB and COVID 19	As per section 1 plus: ? DIPC / Director of Nursing (for TB) ? CCDC PHE (for TB) ? Trust Legal department (for TB)	As per section 1 plus: • Respiratory PPE

APPENDIX 5

ISOLATION – CLEANING CHECK LIST

Domestic Services provided by_____

Ward:_____ Room/Bay:_____

Date Isolation Cleaning Commenced:_____

Domestic/Service/Ward Assistants should wear a yellow plastic apron and yellow gloves to carry out the cleaning

Chlor-Clean (Chlor- clean or alternative antimicrobial detergent) must be used as per manufacture instructions

Patient Environment - 2 x Daily Clean

On discharge full terminal clean performed

Responsibility –Domestic services

Date		Time	Signature	Print Name
	Day 1 Frequency 1			
	Frequency 2			
	Day 2 Frequency 1			
	Frequency 2			
	Day 3 Frequency 1			
	Frequency 2			
	Day 4 Frequency 1			
	Frequency 2			
	Day 5 Frequency 1			
	Frequency 2			
	Day 6 Frequency 1			
	Frequency 2			
	Day 7 Frequency 1			
	Frequency 2			

APPENDIX 6

Inter-healthcare infection control transfer form

Action

When transferring service users to another care setting it is vital to inform the receiving ward or unit if they have an infection. This can be done using the form overleaf and following these instructions.

PLEASE NOTE: If a service user being transferred is suspected or confirmed as being infectious, please contact the Infection Prevention and Control Team (ICT) at the receiving facility within normal working hours BEFORE the transfer is carried out and BEFORE transport is arranged.

This form should be completed by the transferring facility and supplied to the receiving healthcare establishment. Complete the form in full whether a service user presents an infection risk or not.

Use this form for all inter-healthcare facility admissions, transfers and discharges, including:

- all service users admitted to hospital from a shared-living environment (eg a care home);
- all ward-to-ward inter-hospital transfers or discharges; and
- all discharges where healthcare may be involved.

HOW TO USE THIS FORM

- Complete the form for every service user transfer to another healthcare facility.
- Complete the form prior to booking ambulance or other transport.
- A ‘confirmed risk’ service user is one who has been confirmed as being colonised or infected with organisms such as MRSA, glycopeptide-resistant enterococci, pulmonary tuberculosis and enteric infections including *Clostridium difficile*.
- Service users with ‘suspected risks’ include those who are awaiting laboratory tests to identify infections/organisms or who have been in recent contact with an infected service user, eg in close proximity to an infected service user.
- Service users with ‘no known risks’ do not meet either of the two criteria above.
- For service users with diarrhoeal illness, please use the Bristol stool chart to indicate the frequency and type of stools over the past week. Please indicate in the ‘confirmed’ or ‘suspected’ risk box if the diarrhoea is known or suspected to be infectious.
- Please use the ‘Other information’ box to list protective equipment being used to assist in service user care. This equipment may include gloves, aprons or masks.
- After completing the form, please **print** your name and contact details in the box provided.

APPENDIX 7

Inter-healthcare Infection Control Risk Assessment Transfer Form

To be completed by South West Yorkshire Partnership NHS Foundation Trust and given to receiving healthcare worker on transfer of service user into another healthcare setting

<table>
<tr><td>Service user details: (insert label if available)

Name:

Address:

NHS Number:

Date of birth:</td><td>Consultant:

GP:

Current service user location:

Transferring facility – hospital, ward, care home, other:

Contact no:

Is IPCT aware of transfer? Yes/No
(If no contact IPCT for risk assessment prior to transfer. Use on-call microbiologist if out of hours)</td></tr>
<tr><td>Receiving facility – hospital, ward, care home, district nurse

Contact no:

Is IPCT/ambulance service aware of transfer?
Yes/No</td><td>Is the service user an infection risk?
Please tick most appropriate box and give confirmed or suspected organism

▫ Confirmed risk Organism:
▫ Confirmed risk Organism:
▫ Suspected risk Organism:
▫ No known risk
Service user exposed to others with infection e.g. D&V - Yes/No
(If yes give further details)</td></tr>
<tr><td colspan="2">If service user has diarrhoeal illness, please indicate bowel history for last week:
(Based on Bristol stool form scale attached)

Is the diarrhoea thought to be of an infectious nature? Yes/No
(If yes, has the person had any symptoms within the last 48 hours, please give details)</td></tr>
<tr><td colspan="2">Relevant specimen results (including admission screens – MRSA, glycopeptides-resistant enterococcus, C.difficile, multi-resistant Acinetobacter and treatment information, including antibmicrobial therapy:</td></tr>
<tr><td>Specimen:
Date:
Result:</td><td>Specimen:
Date:
Result:</td></tr>
<tr><td colspan="2">Treatment information:</td></tr>
<tr><td colspan="2">Existing Care Plans:</td></tr>
<tr><td colspan="2">Other information:</td></tr>
<tr><td colspan="2">Is the service user aware of their diagnosis/risk of infection? Yes/No</td></tr>
<tr><td colspan="2">Does the service user require isolation? Yes/No

Should the service user require isolation, please phone the receiving unit in advance.</td></tr>
<tr><td colspan="2">Signature of staff member completing form ……

Print Name: Contact number:</td></tr>
</table>

Appendix 8

Contact numbers

Infection Prevention and Control Team	01226 644340	Email: IPC@swyt.nhs.uk
Consultant Microbiologist Barnsley BHNFT	01226 730000	
Consultant Microbiologist Calderdale, Kirklees and Mid Yorks	0844 811 8110	
Public Health England	0113 386 0300	

Equality Impact Assessment Tool

Date of Assessment: 07.09.2020

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
1	**Name of the document that you are Equality Impact Assessing**		Infection Prevention & Control Isolation Policy
2	**Describe the overall aim of your document and context?** **Who will benefit from this policy/procedure/strategy?**		The overall aim of the policy is to describe the Trust's approach to the prevention of infection by the isolation of infected patients until they are deemed non-infectious to others. All staff
3	**Who is the overall lead for this assessment?**		Director of Nursing, Quality and designated Director of Infection Prevention and Control
4	**Who else was involved in conducting this assessment?**		Infection Prevention & Control Team
5	**Have you involved and consulted service users, carers, and staff in developing this policy/procedure/strategy?** **What did you find out and how have you used this information?**		National data used and the BAME dashboard
6	**What equality data have you used to inform this equality impact assessment?**		National data on the BAME dashboard
7	**What does this data say?**		
8	Taking into account the information gathered above, could this policy /procedure/strategy affect any of the following equality group unfavorably:	Yes	
8.1	**Race** Some infectious diseases disproportionately effect individuals of certain race for example COVID 19. Some infectious diseases are more prevalent in certain countries such as Candida Auris	Yes	1. Risk assessment to be completed for vulnerable staff 2. Appropriate use of PPE 3. Isolation should cease as soon as possible for example review specimens in a timey manner.

8.2	**Disability** Many LD/autistic people find change traumatic. E.G. LD/autistic people have selective methods of communication and the use of Face Masks and Face Coverings could potentially cause stress for both the autistic person but also their parent/carer. Service users who have a disability may find isolation more difficult. Disability Percentage No 75.00% Yes 25.00%	Yes	1. Ensure that Face Masks and Face coverings do not prevent communication with people who rely on non-verbal communication as much as possible –**re communicating with Deaf patients, staff and visitors** 2. Employ strategies to reduce isolation effects 3. Ensure people are made aware that services are still available – not just for COVID19 – link to Campaigns 4. Individually risk assess all staff and service users
8.3	**Gender**	No	
8.4	**Age** Older individuals are more at risk of certain infections so may spend disproportionate lengths of time isolated	No	1. Employ strategies to reduce isolation effects 2. Ensure that isolation is not longer than is necessary.

	Equality Impact Assessment Questions:		Evidence based Answers & Actions:
8.5	**Sexual Orientation**	No	N/A
8.6	**Religion or Belief** Page 7 advises alcohol hand gel be available**.** Alcohol gel for hand hygiene- It is recognised that Some faith communities would prefer not to use alcohol-based products. Religion Belief Percentage Atheism 50.00% Christianity 16.67% I do not wish to disclose my religion/belief 8.33% Other 25.00% Total 100.00%	No	1. Alcohol hand gel for external use has been sanctioned by the Muslim Scholars Board 2002 2. Hand washing with alcohol gel is secondary to soap and water 3. In exceptional circumstances an alcohol free gel can be provided
8.7	**Transgender**	No	N/A
8.8	**Maternity & Pregnancy** Staff, service users and carers who are pregnant are more vulnerable to COVID 19 and to certain other infectious diseases	Yes	Service users who are pregnant should avoid contact with any other individuals who have known or suspected transmissible infection see appendix 2
8.9	**Marriage & Civil partnerships**	No	N/A
8.10	**Carers*Our Trust requirement***	No	No identified detrimental effects to carers from this policy

9	**What monitoring arrangements are you implementing or already have in place to ensure that this policy/procedure/strategy:-**	This policy aims to standardise the approach to infection control and the isolation of infected patients The application of isolation will be monitored by the IPC team for each infection and outbreak situation requiring isolation and by the clinical teams.
9a	**Promotes equality of opportunity for people who share the above protected characteristics;**	Yes Infection prevention and control is non-discriminative and applies to everyone.
9b	**Eliminates discrimination, harassment and bullying for people who share the above protected characteristics;**	The policy does try to eliminate any bullying, harassment or discrimination as the policy will be equally applied for all who fit the infectious isolation needs category and for those who need to be isolated to protect from others eg reverse barrier nursing.
9c	**Promotes good relations between different equality groups;**	Yes
9d	**Public Sector Equality Duty – "Due Regard"**	Yes
10	**Have you developed an Action Plan arising from this assessment?**	No
11	**Assessment/Action Plan approved by**	**Signed: Sue Burns Date: 07-09-2020** **Title: Infection Prevention & Control Nurse**
12	***Once approved, you must forward a copy of this Assessment/Action Plan to the Equality and Inclusion Team:*** **inclusion@swyt.nhs.uk** **Please note that the EIA is a public document and will be published on**	

	Equality Impact Assessment Questions:	Evidence based Answers & Actions:
	the web. **Failing to complete an EIA could expose the Trust to future legal challenge.**	

Checklist for the Review and Approval of Procedural Document

To be completed and attached to any policy document when submitted to EMT for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Y	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
	Is it clear in the introduction whether this document replaces or supersedes a previous document?	Y	
2.	**Rationale**		
	Are reasons for development of the document stated?	Y	
3.	**Development Process**		
	Is the method described in brief?	Y	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	Trust wide Policies and Procedures group
	Is there evidence of consultation with stakeholders and users?	EMT	
4.	**Content**		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are supporting documents referenced?	Y	
6.	**Approval**		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent)	N/A	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	approved the document?		
7.	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	Y	
	Does the plan include the necessary training/support to ensure compliance?	Y	
8.	**Document Control**		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	Y	
9.	**Process to Monitor Compliance and Effectiveness**		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
10.	**Review Date**	Y	17.11.17
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
11.	**Overall Responsibility for the Document**		Infection Prevention and Control Team
	Is it clear who will be responsible implementation and review of the document?	Y	

Version Control Sheet

This sheet should provide a history of previous versions of the policy and changes made

Version	Date	Author	Status	Comment / changes
1	13/4/11	Adele Watson IPCN	Final	Barnsley Care Services Direct
2	5/5/14	Julie Hartley IPCN	Final	New document including specific infectious disease advice table and colour coding for isolation Trust wide
3	17/11/17	Sue Burns IPCN	Final	Minimal changes to reflect needs of all business delivery units
4	21/09/20	Sue Burns IPCN	Final	Changes to meet the COVID 19 guidance