

Management of a Patient Requiring Source Isolation Precautions Policy

This policy describes the processes and procedures to be taken by LPT staff for the management of a patient requiring source isolation precautions within in-patient facilities and the community.

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Which Relevant CQC Fundamental Standards?		

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Version Control and Summary of Changes

Version number	Date	Author	Status	Comments (description change and amendments)
Version 1,	May 2010		Draft 1	Replaces NO 0186 "Infection Control Policy for the Management of a Patient Requiring Source Isolation in Community Hospitals" Reviewed by U. Willis to incorporate requirements of the Health and Social Care Act 2008, Care Quality Commission and NHSLA Standards.
Version, 2	May 2010			Circulated for comments
Version, 3	June 2010			Comments inserted. Forwarded to Clinical Governance for approval.
Version, 4	June 2010			Policy approved by Clinical Governance Committee
Version 5	August 2011			Harmonised in line with LCRCHS, LCCHS, LPT (Historical organisations)
Version 6	August 2014			Reviewed to ensure continuing compliance with the Health & Social Care Act (2008) and in line with current guidelines. Document forwarded to policy group for approval.
Version 7	August 2017			Reviewed and updated in line with latest research and guidelines Removal of need to use alcohol gel following hand decontamination with soap and water when leaving an area with a patient having source isolation precautions. Addition of 'Post infection clean/ terminal clean request sign off form'.

For further information contact: The Infection Prevention and Control Team.

Definitions that apply to this policy

Due Regard	<p>Having due regard for advancing equality involves:</p> <ul style="list-style-type: none"> • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Cohort Nursing	<p>Grouping of patients with the same known infection or symptoms and nursing them within an area of an inpatient facility. It is recommended as a strategy for controlling transmission of healthcare associated infection in the absence of single patient rooms.</p> <p>Cohort nursing is more likely to be used in an increased incident/outbreak situation</p>
Disease	<p>An abnormal condition of a part, organ, or system of an organism resulting from various causes, such as infection, inflammation, environmental factors, or genetic defect, and characterized by an identifiable group of signs, symptoms, or both.</p>
Increased Incidence	<p>The occurrence of two or more patients displaying the same symptoms, which are thought to be of an infective cause and are linked in time or place or, the situation when the observed number of patients displaying the same symptoms exceeds the number expected.</p>
Infection	<p>An organism is present at a site and causes an inflammatory response or an organism is present in a normally sterile site.</p>
Infectious	<p>Caused by a pathogenic microorganism or agent that has the capability of causing infection</p>
Outbreak	<p>The occurrence of two or more cases of the same infection linked in time or place or, the situation when the observed number of cases exceeds the number expected.</p>
Organisms	<p>This is defined as any living thing, in medical terms we refer to bacteria and viruses as organisms</p>
Personal Protective Equipment (PPE)	<p>Specialized clothing or equipment worn by employees for protection against health and safety hazards.</p>
Protective Isolation	<p>Isolation is imposed to protect a patient with a compromised immune system from infection.</p>
Source Isolation	<p>Precautions that are taken in the hospital to prevent the spread of an infectious agent from an infected or colonized patient to susceptible persons.</p>
Symptomatic	<p>Physical or mental sign of disease</p>

1.0 Purpose of the policy

The purpose of this policy is to provide staff employed by LPT with clear and robust infection prevention and control guidelines for the management of a patient requiring source isolation precautions (SIPs). It applies to in patients and patients cared for in their own home.

The aim of this policy is to ensure that staff are aware of their responsibilities for safe practice and take the appropriate precautions to protect themselves, their co-workers and their patients

2.0 Summary of key points

The management of a patient requiring SIPs applies to all staff employed by Leicestershire NHS Partnership Trust (LPT). It includes staff who work on bank, agency or honorary contracts either at the community hospitals or within the community services.

All health professionals should ensure they work within the scope of their professional code of conduct, providing evidence based care which is in accordance with the Health & Social Care Act (2008) (revised 2015) and the latest guidance provided by Public Health England (PHE).

LPT has a wide range of teams and services operating from a large number of sites and also delivers healthcare to people in their homes, including care homes.

This version of the policy has an added appendix (Appendix 5) which is a post infection clean/terminal clean request sign off form. This is to be completed by the nurse in charge within an inpatient facility once the room has undergone a post infection clean by the domestic services.

3.0 Introduction

The provision of healthcare carries with it inherent risks to the health care worker. The policy provides staff with the information they require to enable them to minimise the risk of transmission of infection.

The policy provides staff with the information they require to protect themselves, their colleagues and patients from transmission of organisms from patients with known or suspected infection.

4.0 The management of a patient requiring source isolation precautions

4.1 In-patient facilities

Standard precautions, which are carried out for all patients at all times, will prevent the potential spread of infection from person to person.

The term source isolation precaution (SIPs) is used to indicate that the patient is the known or potential source of infection. Conversely, patients with a compromised immune system are placed in **protective isolation** to protect them from infection which may be transmitted by staff or others (Appendix 1).

Source isolation procedure (SIPs)

Patients requiring SIPs should be admitted or transferred to a single room (preferably with en-suite facilities) and the precautions outlined in this policy enforced. In the event of a single room being unavailable for one of the following reasons, it will be necessary to carry out SIPs in the bay/ shared room and/or facilities:

- Single rooms already contain patients with infections that pose a higher risk than the new patient requiring a single room.
- Following a risk assessment, a patient requiring SIPs is deemed to be unsuitable or unsafe to be nursed in a single room due to their medical/physical or mental health.
- Cohort nursing is required; this is when several patients with the same signs and symptoms require SIPs. This is usually due to an outbreak or an increased incident – refer to LPT infection prevention and control policy for the management of a ward with an increased incidence or outbreak of diarrhoea and/or vomiting.

If a single room is not available or not suitable for one of the reasons outlined above, a risk assessment must be carried out by the clinician or nurse caring for the patient.

The outcome of the risk assessment must be documented in the patient's clinical records. The infection prevention and control team must be informed of the outcome of the risk assessment as soon as possible. The risk assessment will ensure, wherever possible, that only patients presenting the least cross infection risk to others will be cared for in the main ward area using SIPs.

Where SIPs are carried out within the bay the procedure must be followed in the same way as for a patient in a single room.

The infection prevention and control team must be informed by telephone when a patient requires SIPs. This should be done as soon as possible. The date, time and reason for SIPs being implemented must be documented in the patient's records. The source isolation notice (Appendix 2), must also be completed and displayed in a

place clearly visible to staff and visitors. No personal information should be on display within this notification.

The nurse responsible for the patient should explain to the patient and relatives the reason for SIPs, what special measures and procedures will be taken and any patient/visitor restrictions.

Environment and equipment

Unnecessary furniture and equipment should be removed from the single room or the bed space before admitting or transferring the patient into that room or bed space.

If a patient is nursed in a single room, the room should contain:-

- Hand wash basin
- Wall mounted liquid soap.
- Paper hand towels in wall mounted dispenser
- A foot operated pedal bin for clinical waste
- Sharps bin, if required and if safe to do so. (If unsafe to leave in the room the outside of the sharps bin should be decontaminated using Chlor clean on removal from the room).

Depending on the patient group it may not be appropriate to have all the items above within the room due to the risk for the patient. In these cases a risk assessment must be undertaken.

All equipment must be cleaned and decontaminated before and after use using Chlor Clean.

The commode should not be used/left by the patient's bedside whether in a bay or in a single room unless absolutely necessary, in which case a risk assessment must be undertaken and recorded in the patients record.

Clean and decontaminate commodes with **Chlor clean** after every use, ensuring all surfaces including the frame and underneath are cleaned. This involves removing the seat and arms from the frame. Once clean the commode must be labelled and dated with 'I am clean' tape. Please refer to the LPT infection prevention and control policy for cleaning and decontamination of equipment, medical devices and the environment, including the management of blood and body fluid spillages).

The patient's charts and notes must not be taken into the room.

If a patient is nursed in a single room, a trolley must be placed outside this room (if appropriate for the area*) containing:

- Clinical waste bag (for double bagging all waste)
- Gloves and aprons (and other PPE if required)
- Alcohol hand sanitiser (unless situated on the wall outside the room)

- Linen bags (red water-soluble inner, white plastic outer). Please refer to the LPT infection prevention and control policy for linen and laundry management.
- Waste tie tags

Additional items should not be stored on the trolley

*If it is deemed unsafe to leave a trolley outside the source isolation room equipment must be retrieved from a suitable storage area prior to each patient interaction. The reason for not leaving the trolley outside of the room must be risk assessed and documented in the patient's record.

If the patient is being isolated in a bay area the following equipment must be available at the bedside on a trolley:

- Clinical waste bags (for double bagging all waste)
- Sharps bin if required and safe to do so (if unsafe to leave on the trolley the sharps bin must be decontaminated with Chlor clean after each use on removal from bed space)
- Gloves and aprons (and other PPE if required)
- Alcohol hand sanitiser unless this is situated at the bedside
- Linen bags (red water-soluble inner, white plastic outer). Please refer to the LPT infection prevention and control policy for linen and laundry management.
- Waste tie tags

The bay must also contain:

- Hand wash basin
- Wall mounted liquid soap
- Paper hand towels in wall mounted dispenser

Depending on the patient group it may not be appropriate to have all the items above within the bay due to the risk for the patient or other patients nursed in the bay. In these cases a risk assessment must be undertaken and documented.

If nursed in a bay, the patient should be allocated a toilet specific for their use whilst they are receiving SIPs.

If a toilet cannot be allocated for the patient then a commode must be allocated but this is not to be used at the patient's bedside. The commode must be taken to a toilet area. Clean and decontaminate commodes with Chlor clean after every use, ensuring all surfaces including the frame and underneath are cleaned. This involves removing the seat and arms from the frame. Once clean the commode must be labelled and dated with 'I am clean' tape. Please refer to the LPT infection prevention and control policy for cleaning and decontamination of equipment, medical devices and the environment, (including the management of blood and body fluid spillages).

PPE should be removed and disposed of in clinical waste bin/bag at the bedside or in the single room immediately following care delivery. Hands must be washed with soap and water, either in the single room or in the bay and dried thoroughly.

If it is deemed unsafe to have paper towels in the bay or single rooms, and therefore immediate hand washing is prohibited, a risk assessment must be undertaken to indicate this and documented in the patients notes. In this instance alcohol sanitiser should be used to decontaminate hands at the bedside following the removal of PPE, then hands must be washed with liquid soap and water at the nearest hand-wash basin and dried thoroughly.

All hand wash basins should have elbow operated taps or be operated by sensor motion. In the event that taps are not elbow operated, taps must be turned off using a clean paper hand towel.

Hand hygiene

Please refer to the LPT infection prevention control policy for hand hygiene.

Personal protective equipment (PPE)

Please refer to the LPT infection prevention and control policy for personal protective equipment for use in healthcare.

Waste disposal

Please refer to the LPT health and safety policy for the management of waste.

Sharps

Please refer to the LPT infection prevention and control policy for the management of sharps and exposure to blood borne viruses.

Linen

Please refer to the LPT infection prevention and control policy for linen and laundry management.

Crockery and cutlery

Disposable crockery and cutlery is not required providing an automatic dishwasher is utilised to clean the crockery and cutlery.

Crockery and cutlery can be adequately decontaminated in a dishwasher with a final rinse temperature of 80°C. The crockery and cutlery does not need to be washed separately to other crockery and cutlery.

Manual washing of the crockery and cutlery must not take place. If an automatic dishwasher is not available then disposable plates, bowls and cutlery etc. must be used.

Food may be delivered to patients in isolation using a tray. After the meal, the crockery, cutlery, leftovers and tray are placed directly into the trolley/removed as per ward protocol. PPE must be worn and hands decontaminated following removal of PPE as per the LPT infection prevention and control PPE policy.

Management of body fluids:-

Disposable bedpans and urinals and vomit bowls

A bedpan carrier should be designated for the sole use of the patient undergoing SIPs and not used for other patients.

The nurse must wear gloves and apron when handling body waste. When removing the bed pan/commode from the SIPs area ensure the contents are covered with an authorised cardboard protector/ bag recommended by the supplier. This should be passed to a second nurse outside the room.

The nurse outside the room/ bed space must don gloves and apron and remove the bed pan to the sluice. Disposable items are placed into the macerator, care being taken not to contaminate the outside of the machine.

The bedpan carrier should be cleaned and disinfected with Chlor-clean. Remove PPE, clean and decontaminate hands.

If the macerator is not available for use, the contents of the disposable bedpan/urinal should be solidified using a solidifying gel, double bagged and disposed of as clinical waste.

If the macerator is broken it must be escalated to estates for repair as an urgent request.

Disposal of urinary catheter bags

Disconnect the catheter bag (as per the LPT urinary catheter policy), empty the contents of the bag directly into the toilet if en-suite facilities are available or the patient has been allocated a toilet for their sole use. Appropriate PPE must be worn, including face protection due to the risk of splash back.

Where an en-suite toilet is not available, the contents of the catheter bag must be emptied into a urinal, the procedure as described above for disposable bedpans urinals and vomit bowls must then be followed. The empty catheter bag can then be disposed of directly into the clinical waste bag.

Cleaning of single rooms and bed spaces where source isolation precautions are in place

All staff are responsible for ensuring that the room or bed space is kept clean and tidy at all times. The domestic staff must be informed that SIPs are required to ensure that they are aware to take the correct precautions. Domestic staff should wear disposable aprons and disposable nitrile gloves when dealing with a bed space or single room where the patient has SIPs in place.

All isolation rooms or bed spaces must have one full clean in the morning and one check-clean in the afternoon to check general cleanliness and waste bins and action accordingly. Chlor-clean must be used to clean and decontaminate the room or bed space and environment.

A designated mop and bucket must be allocated to each patient requiring SIPs, whether in a single room or within the bay. If the patient is nursed in a bay the mop and bucket is for that patient only and should not be used for the bay in its totality. Cleaning cloths must be disposable. Cleaning materials must be in line with the national colour coding requirements (Appendix 3).

Only necessary equipment should be kept inside the room or around the bedside. This will facilitate effective cleaning and decontamination procedures.

If bath/shower rooms cannot be allocated to the patient who is receiving SIPs, then the communal bath/shower rooms must be thoroughly cleaned and disinfected using Chlor-clean immediately after use by the patient with a known or suspected infection.

Discharge/terminal/post infection cleaning of a room or bed space and furniture

Prior to discontinuing source isolation precautions a post infection clean **will need to be undertaken** in the following circumstances:

- If samples have not been obtained for the individual patient within a single room, or, in the case of where a bay is isolated if samples have not been obtained for **ALL** patients who are symptomatic within that bay.
- If samples have been obtained and a positive result for an infection has been identified. In the case of where a bay is isolated if a single patient has a positive result the bay will need to undergo a post infection clean.

If a patient, or in the case of where a bay is isolation, **ALL** patients who are symptomatic within the bay have had samples sent and **ALL** the samples have resulted as negative, then providing the medical staff/ANP are satisfied that the symptoms are not due to an infective cause and document this in the patients notes, then the source isolation precautions can be discontinued without the need for a post infection clean.

If a post infection clean is required:

All staff must wear PPE when undertaking cleaning activities. Hands must be decontaminated following the removal of PPE.

Before discontinuing SIPs the area and equipment must be cleaned and decontaminated. If the patient is to remain in the room following the discontinuation of SIPs the room or bed space must still undergo a discharge/terminal/post infection clean prior to discontinuing SIPs.

If a post infection clean cannot be facilitated at the time that the SIPs are able to be discontinued, then the SIPs must remain in place until this has been undertaken. Even if the patient no longer requires SIPs and is no longer themselves thought to be infectious, their environment will remain contaminated until the discharge/terminal/post infection clean has been completed effectively.

Curtains must be removed and double bagged as infected linen prior to cleaning and disinfecting the room or bed space. Once cleaning and disinfection of the room or bed space is completed clean curtains should be hung.

Clean and disinfect all surfaces with Chlor-clean. The mop handle and bucket must be cleaned, disinfected using Chlor clean and dried. Cloths used for cleaning must be disposable and be disposed of as clinical waste.

Cleaning or disinfection of walls or ceiling is only required if visibly contaminated or at the discretion of the Infection Control Team.

Nursing staff are responsible for documenting that cleaning has been completed using the 'Post infection clean/terminal clean request sign off form' (Appendix 4). Completed forms must be filed on the ward and not in the patient's notes.

Any dressings, bandages, ward welcome packs and paper (not an extensive list), left in a patient's room following discharge or discontinuation of SIPs that cannot be cleaned and decontaminated must be double bagged and disposed of as clinical waste

Unused pharmaceutical products

Unused medications from rooms or bed spaces where SIPs have been undertaken must be placed into a clear disposable plastic bag, labelled "Source isolation" and then returned to Pharmacy in the usual way.

Visits to other departments

When patients who are receiving SIPs need to visit other departments within a community hospital, the ward where the patient is located must contact the receiving department to ensure appropriate precautions can be taken. Arrangements should be made to minimise any delay and possible contact with other patients en route as well as in the visiting department.

Any unnecessary equipment must be moved out of the room wherever possible prior to the patient visiting. If not removable it must be covered with a disposable or washable cover.

Areas where patients with known infections are likely to need to visit should not be used as routine storage areas for equipment.

All equipment within the department, whether used or not by the patient, should be cleaned and decontaminated after the patient has visited the area unless it is covered beforehand.

Porters, nursing and other staff must wear PPE only when in direct contact with the patient. This is not necessary when escorting the patient through the hospital. After use the trolley, bed or wheelchair must be cleaned and disinfected with Chlor-clean.

The ambulance liaison officer must be told when patients requiring SIPs are transferred to another hospital for investigations or as potential inpatients and must be informed of the transit precautions required. The receiving hospital department must also be told of the need for SIPs.

The transferring ward will need to complete the Essential Steps Inter-healthcare infection control transfer form (Appendix 5).

Cleaning and decontamination of the environment is essential to prevent transmission of potentially pathogenic organisms. The environment and any equipment within the area, unless covered must be cleaned and decontaminated appropriately.

Visiting arrangements

Patients who are undergoing SIPs may be visited by family and friends. Visitors do not routinely need to wear PPE. However, advice must be provided by the nursing staff.

For example:

- They should be encouraged to decontaminate their hands before visiting the patient and washing their hands with soap and water and then decontaminating with hand sanitiser after their visit.
- They should be discouraged from visiting other patients whilst the person they are visiting is undergoing SIPs.
- If visitors or relatives are involved with direct patient care, they should then wear disposable nitrile gloves and aprons for this task, removing them after use and placing them into clinical waste, and then to wash their hands with soap and water and dry them thoroughly, before further decontaminating them with alcohol sanitiser.

4.2 Patients in their own homes

Patients who are being cared for in their own home do not pose as great a risk to others as within the healthcare environment. This is due to the fact that they are not usually nursed in an environment with other susceptible individuals.

When visiting patients with a known or suspected infection, a high standard of infection prevention and control must be maintained in order to prevent carriage of organisms between patients.

All practices identified for caring for a patient in an inpatient area including; hand hygiene, use of personal protective equipment and cleaning of equipment (belonging to LPT) must also be applied for patients in their own homes. Carers and/or relatives caring for someone with an infection should be advised to wash their hands before and after carrying out care.

For cleaning and decontamination of equipment belonging to LPT please refer to the LPT infection prevention and control policy for cleaning and decontamination of equipment, medical devices and the environment (including the management of blood and body fluid spillages).

If possible, plan as the last visit of the day for this patient.

4.3 Disposal of infected cadavers

Please refer to LPT policy and guidelines for the care of the deceased.

4.4 Patients for whom admission to an acute hospital is required:

There may be occasions where the isolation facilities within community inpatient areas are inadequate for a patient's condition (ie if the patient requires negative pressure rooms) and the patient requires admission to an acute hospital.

In these situations, the practitioner involved with, and responsible for, the patient must discuss transfer details with the appropriate consultant within the acute hospital. In most cases, although not always, this is likely to be a consultant within the Infectious Diseases Unit at UHL.

Please contact the infection prevention and control team if you require any advice regarding this.

4.5 Conditions requiring source isolation precautions or no isolation precautions, and period of isolation

DISEASE OR INFECTING AGENT	PRECAUTIONS REQUIRED	ROUTE OF INFECTION	RISK FACTORS	PERIOD OF ISOLATION
Abscess Aetiology unknown & draining	None (unless microbiological isolate indicates)			See advice for relevant organism
Auto Immune Deficiency Syndrome (AIDS) See Human Immunodeficiency Virus (HIV)				
Amoebiasis Dysentery Liver abscess	Source None	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool or stool normal for them, or discharge home
Anthrax Cutaneous	Source	Contact		Until completion of successful treatment
Ascariasis	None			
Aspergillosis	None			
Botulism	None			
Bronchiolitis	Source	Airborne	Cough/ Productive sputum	Clinical recovery or discharge home
Bronchitis Adults Infants & young children	None Source	Airborne	Cough/ Productive sputum	Clinical recovery or discharge home
Brucellosis	None			

Campylobacter Gastroenteritis	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool (or stool that is normal for them) or discharged Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected infectious nature policy
Candidiasis	None			
Clostridium Difficile (CDT) Gastroenteritis	Source	Faecal - oral	Diarrhoea	Clinical recovery - Until free from diarrhoea for 48 hours and has passed a formed stool (or stool that is normal for them) Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected infectious nature policy
Cellulitis Intact skin Exudation	None (unless microbiological isolate indicates)	See advice for relevant organism		
Cholera Gastroenteritis	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool (or stool that is normal for them) or discharge home
Creutzfeld Jacob Disease (CJD) and variant CJD	None	Care for specific invasive procedures.		Refer to LPT management of TSE, including CJD and vCJD policy,

Common cold Adults Infants & young children	None Source	Respiratory	Cough/ Productive sputum	Clinical recovery or discharge home
Conjunctivitis Neonatal (not a sticky eye)	Source	Contact		24 hours of appropriate antibiotic therapy
Croup	Source	Respiratory		Clinical recovery or discharge home
Cryptococcosis	None			
Cryptosporidiosis Gastroenteritis	Source	Faecal - oral	Diarrhoea	Clinical recovery –48 hours free from diarrhoea and has passed a formed stool, or discharged
Cytomegalovirus	None			
Dengue	Source	Mosquito Bite	Contact with body fluids	Dependent on clinical assessment
Diarrhoea and/or vomiting	Source	Faecal - oral	Diarrhoea/ Vomiting	Clinical recovery –48 hours free from diarrhoea and/or vomiting and the patients has passed a stool that is normal for them or a formed stool or until a non-infectious cause has been established or patient discharged. Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infection policy
Dysentery Shigella	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool or stool that is normal for them.

E-coli causing diarrhoea/vomiting	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool or stool that is normal for them Refer to LPT management of a patient with diarrhoea and/vomiting that is of a suspected or confirmed infection policy
Encephalitis	None			
Enterobiasis	Source	Faecal - oral		Until completion of treatment
Epiglottitis	Source	Respiratory		24 hours of appropriate antibiotic treatment
Epstein Barr virus	Source	Respiratory		2 weeks after onset of symptoms
Erysipelas	Source	Contact		24 hours of antibiotic treatment
Gas Gangrene	None			
German measles (Rubella)	Source	Respiratory		5 days from onset of rash
Glandular Fever (Infectious Mononeucleosis)	Source	Respiratory		2 weeks after onset of symptoms
Gonorrhoea	None			
Haemophyllis Influenza	Source	Respiratory	Cough/ Productive sputum	Clinical recovery or discharge home
Hand, foot and mouth disease	Source	Contact	Lesions	Clinical recovery or discharge home
Human Immunodeficiency Virus (HIV)			Open wounds,	Dependant on clinical assessment

Risk factors present No risk factors present	Source None	Contact	lesions risk of bleeding	
Hepatitis A (HAV) Risk factors present No risk factors present	Source None	Contact	Ingestion of food, water or other objects contaminated with faecal matter from an infected person (even in microscopic amounts) Sex with an infected person	Dependant on clinical assessment
Hepatitis B (HBV) Risk factors present No risk factors	Source None	Contact	Open wounds, lesions, risk of bleeding	Dependant on clinical assessment
Hepatitis C (HCV) Risk factors present No risk factors present	Source None	Contact	Open wounds, lesions, risk of bleeding	Dependant on clinical assessment
Influenza (Pandemic)	Source	Respiratory/ contact	Sputum generating procedures	7 days from clinical onset or clinical recovery
Legionnaires	None			
Leprosy Smear positive Smear negative	Source None	Respiratory/ Contact		Negative smears
Leishmaniasis	None			

Leptospirosis	None			
Head Lice	Source	Contact	Prolonged contact	Until resolved following effective treatment Refer to LPT management of head lice policy
Listeriosis	None			
Lyme disease	None			
Malaria	None			
Measles	Source	Respiratory		5 days from onset of rash
Meningitis Confirmed or suspected Viral/ bacterial	Source	Respiratory		24 hours of appropriate antibiotic treatment (bacterial) Length of acute illness
Molluscum contagiosum	Source	Contact		Until after appropriate treatment
Mumps	Source	Respiratory		10 days from onset
Meticillin-Resistant Staphylococcus Aureus (MRSA) High risk areas Low risk areas Risk factors present No risk factors present	Source Source Source None	Contact Contact Contact	Productive cough, Heavily exudating wounds, heavily exfoliating	Whilst displaying one or more risk factors and until 3 negative screens achieved Refer to LPT management of patients with MRSA policy

			skin	
Mycobacteria (atypical)	None			
Necrotising Fasciitis Strep. pyogenes	Source	Contact		24 hours of antibiotic treatment
Nocardia	None (source for oncology & transplants)	Clinical Recovery		
Paratyphoid fever & carriers	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool
Pertussis (Whooping cough)	Source	Respiratory	Cough	Clinical recovery
Pharyngitis Adults Infants & young Children	None Source	Respiratory		Clinical recovery
Pneumonia Children Adults	Source None	Respiratory	Cough	Until Discharge home Unless advised by microbiology/Infection Control Team
Polioyelitis	Source	Faecal - oral	Diarrhoea	7 days from onset of diarrhoea
Psittacosis	Source	Respiratory		7 days from onset

Puerperal sepsis	Source	Contact		24 hours of appropriate antibiotic treatment
Rabies	Strict Immediate transfer to Infectious Diseases Unit	Contact with secretions/ body fluids		Until decision by Infection Control Doctor/Infectious Diseases Consultant/CCDC
Respiratory syncytial virus	Source	Respiratory		Until 2 weeks post asymptomatic
Ringworm	None			
Rubella Acquired Congenital	Source Source	Respiratory		5 days from onset of rash For at least one month after delivery
Sudden Acute Respiratory Syndrome (SARS)	Strict Immediate transfer to Infectious Diseases Unit	Respiratory Contact		Until clinical recovery
Salmonella	Source	Faecal - oral	Diarrhoea	Clinical recovery – 48 hours free from diarrhoea and passed a formed stool Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature policy
Scabies Classical (Atypical) Norwegian (Crusted)	Source Source	Contact Contact		Until completion of 2 courses of treatment 2 weeks apart Repeat treatment may be necessary Discuss with Dermatologist Refer to LPT management of patients with scabies policy

Scarlet fever	Source	Respiratory Contact		24 hours of antibiotic treatment
Shingles (Herpes Zoster)	Source	Contact	Leaking vesicles Not cared for by staff if they have no immunity (Refer to LPT staff health relating to communicable disease policy)	All lesions scabbed over and dry Refer to LPT management of chickenpox/shingles, including screening processes policy
Shigella	Source	Faecal - oral	Diarrhoea	Clinical recovery - 48 hours free from diarrhoea and passed a formed stool
Strep. pyogenes (Group A Streptococcal Infection includes Necrotising fasciitis)	Source	Contact		24 hours of appropriate of antibiotics
Syphilis	Source (if risk factors are present)	Contact	Weeping lesions	Until lesions are dry
Tapeworm	None			
Tetanus	None			
Threadworm	None			
Tonsillitis Children	Source	Respiratory		Until Clinical Recovery
Toxoplasmosis	None			
Transmissible	None		Care for specific	refer to LPT policy on TSE, including CJD

Spongiform Encephalopathy			invasive procedures	and vCJD policy
Tuberculosis Pulmonary/Miliary Smear Negative, Smear Positive, Multidrug Resistant TB	Admit to Single room Source	Respiratory	Productive cough	Until Agreement between clinician and Control of Infection Officer Refer to LPT management of patients with confirmed or suspected TB policy
Typhoid fever and Carriers	Source	Faecal - oral	Diarrhoea	Clinical recovery
Vancomycin Resistant Enterococci (VRE) With risk factors No risk factors	Source None	Contact	Diarrhoea Urinary Catheter Wounds Central lines	Isolate whilst risk factors are in situ.
Varicella zoster (Chicken pox)	Source	Contact/ Respiratory	Leaking vesicles	All lesions scabbed and dry Refer to LPT management of chickenpox/shingles, including screening processes policy
Vomiting	Source	Contact Faecal - oral		If thought to be infective - 48 hours from last episode Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature policy

Viral gastroenteritis	source	Faecal/oral	Diarrhoea/ vomit	Until free from diarrhoea for 48 hours and has passed a formed stool Refer to the LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature policy
Viral Haemorrhagic Fever (Lassa fever, Marburg fever, Ebola fever, Crimean)	Strict High security and transfer to Infectious Diseases Unit	Respiratory contact		Until decision by Infection Control Doctor/Infectious Diseases Consultant/
Yellow Fever	none			

5.0 Training

There is a need for training identified within this policy. In accordance with the classification of training outlined in the Trust Human Resources & Organisational Development Strategy this training has been identified as mandatory and role development training.

The course directory e source link below will identify: who the training applies to, delivery method, the update frequency, learning outcomes and a list of available dates to access the training. <http://www.leicspart.nhs.uk/Library/AcademyCourseDirectory.pdf>

A record of the event will be recorded on ULearn as appropriate. The governance group responsible for monitoring the training is the Infection Prevention and Control Committee and Quality Assurance Committee.

6.0. References and bibliography

DH (2010) Health Protection Legislation (England). Guidance 2010. Health Protection Regulations, London

DH Essential Steps to Safe Clean Care (2007)

Health and Safety at Work etc Act 1974

Health and Social Care Act 2008; Code of practice on the Prevention and Control of Infections and related guidance (updated July 2015). DH

LPT Health and Safety Waste Management Policy (2015)

LPT Infection Prevention and Control Cleaning and Decontamination of Equipment, Medical Devices and the Environment, (including the Management of blood and body fluid spillages) Policy (2015)

LPT Infection Prevention and Control Hand Hygiene Policy (2015)

LPT Infection Prevention and Control Linen and Laundry Management Policy (2015)

LPT Infection Prevention and Control Management of an Increased Incidence or Outbreak of infection Policy (2015)

LPT Infection Prevention and Control Management of Chickenpox/Shingles, including screening processes policy (2015)

LPT Infection Prevention and Control Management of head lice policy (2015)

LPT Infection Prevention and Control Management of Meticilliin Resistant Staphylococcus Aureus policy (2017)

LPT Infection Prevention and Control Management of patients who are suspected to have or diagnosed with tuberculosis (2016)

LPT Infection Prevention and Control Management of patients with Scabies (2015)

LPT Infection Prevention and Control Management of patients with diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature policy. (2015)

LPT Infection Prevention and Control Management of Transmissible Spongiform Encephalopathy (TSE) including Creutzfeldt-Jacob Disease (CJD) Variant CJD (vCJD) (2017)

LPT Infection Prevention and Control Personal Protective Equipment for use in Healthcare Policy (2015)

LPT Infection Prevention and Control Staff Health relating to a Communicable Disease Policy (2015)

National Resource for Infection Control – www.nric.org.uk

Infection Prevention and Control Team

Protective Isolation

The purpose of protective isolation is to provide a safe environment for patients who have an increased susceptibility to infection because of immunosuppression (a reduction in the efficiency of the immune system which increases their risk of acquiring an infection).

Such patients may be:

- those with prolonged neutropenia (as a result of chemotherapy for example)
- patients who have undergone bone-marrow transplantation
- patients with excessive burns
- infection with HIV
- some genetic disorders, such as cystic fibrosis
-

(Note this list is not extensive)

If these patients contract an infection it can be life-threatening. Many patients whilst in their acute stage will be managed in specialist units.

For those patients who are immune-compromised and nursed within a community hospital it is imperative that good standard infection prevention and control measures are employed. Ideally they should be nursed in a single room. If this is not possible a risk assessment should be undertaken to take into account the other patients in the bay they will be nursed with.

Immunocompromised individuals should never be placed in the same room or adjacent to people with a known infection.

If patients with suspected or known infections are nursed in a bay due to lack or inappropriateness of single rooms a risk assessment must include whether any immuno-compromised patients are also nursed in the same bay and therefore put at risk.

Consideration must be given with regards to moving the immuno-compromised patient if the patient with the suspected or known infection cannot be moved.

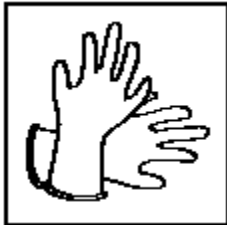
Infection Prevention and Control Team

SOURCE ISOLATION PRECAUTIONS

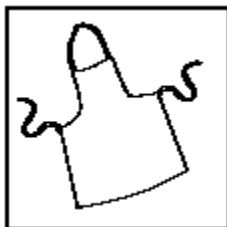
FOR IN-PATIENT FACILITIES

Visitors: Before entering the room please speak to the nurse looking after the patient

All staff: Before entering the room and having contact with the patient or any items in the room you **MUST**



Wear disposable gloves



Wear a disposable plastic apron

All visitors and staff *please* wash your hands before leaving the room.

National colour coding scheme for hospital cleaning materials and equipment

All NHS organisations should adopt the colour code below for cleaning materials. All cleaning items, for example, cloths (re-usable and disposable), mops, buckets, aprons and gloves, should be colour coded. This also includes those items used to clean catering departments.

Red

Bathrooms, washrooms, showers, toilets, basins and bathroom floors

Blue

General areas including wards, departments, offices and basins in public areas

Green

Catering departments, ward kitchen areas and patient food service at ward level

Yellow

Isolation areas

Your local contact for hospital cleaning is:

Guidance on how to use the Post infection Clean/Terminal Clean request sign off form

This sign off form has been developed to give assurance that the post infection clean/terminal clean is completed to a standard that is acceptable and all elements are carried out to a satisfactory level. It has been developed following concerns from a number of ward staff around the standards of cleaning and decontamination of the environmental area following the discontinuation of source isolation precautions.

Who should complete the form?

The member of nursing staff that is requesting the post infection/terminal clean should complete the form relating to the request

The member of nursing staff that is checking the elements to ensure that the post infection/terminal clean is undertaken to an acceptable standard should complete those elements of the form.

If any elements are not deemed to be to an acceptable standard this should be rectified at the time and before any source isolation precautions are discontinued if the patient is remaining in the bed space, or a new patient is transferred into that bed space.

If the area consists of several bed spaces (i.e. a bay or dormitory) then all elements of that area need to be cleaned to an acceptable standard before the form is signed off

The elements that are to be cleaned and decontaminated by nursing staff also need to be completed correctly prior to the form being signed off.

The elements of the form can be completed by a healthcare assistant, however the form must be signed off by a qualified nurse who has overall responsibility for ensuring the elements have been completed satisfactorily.

When should the form be completed?

The form should be completed each time a post infection clean/terminal clean is requested. Source isolation precautions need to be continued until the post infection clean/terminal clean has been carried out in its entirety.

Where should the form be stored?

These forms should be stored locally; a suggestion is that they are stored within the assurance folder, but this is not mandatory. The important factor to be considered is that they need to be available for audit purposes and to be checked during matron walk rounds/IPC walk rounds.

Who should be form be escalated to?

If there are any issues with the cleaning and decontamination of the environment they need to be escalated at the time. The issues also need escalating to the ward manager/matron so that trends can be monitored through the service directorate IPC meeting and the cleaning forum

Infection Prevention and Control Team

Post infection clean/terminal clean request sign off form

Hospital **Ward**

	Yes/No/comment
Person requesting clean	
Date clean requested	
Time clean requested	
Bed space or area required for clean	
Person accepting task	
Date clean commenced	
Time clean commenced	
Chlor clean used	
Domestics wearing appropriate PPE	
Yellow coded cleaning equipment	
All areas checked as clean:	
Building: Floor Windowsill etc.	
Fixtures and Fittings: Light fittings Switches Curtain Rails Shelving Door handles radiators etc.	
Furniture: Table Wardrobe/cupboard Chair Bed frame etc.	
En-suite: toilet Fixtures and fittings Floor	
Bin: Outside New bin liner	
Hand Wash sink Deb dispensers Paper towel dispenser	
Any other items specific to the area	

Items to be cleaned and decontaminated by nursing staff

Nursing Duties

	Yes/No/Comments
Wardrobes and cupboards emptied and cleaned inside	
Air mattress sent to Medstrom for decontamination, or non-air mattress cleaned at ward level using chlor clean	
All sundry items removed and disposed of	
All nursing equipment cleaned and decontaminated using chlor clean	
All beds within bay/area/room that were in areas receiving source isolation precautions made with clean linen	
Any other items (please specify)	

Signed as completed by qualified nurse

Name

Designation

Date **Time**

MULTIDISCIPLINARY TEAM ONGOING ACTIONS AND PLANS

(Aids/ equipment used)

DETAILS OF CURRENT CARE PACKAGE

Who	When	Frequency	Contact

Medication Aid: Yes No Type:.....
 Approximate Weight:-

DNAR order in place within LPT Yes No
 Form sent with patient: Yes No

100% Continuing Health Care Funding Yes No
 Waterlow Score:-

INTER-HEALTH INFECTION CONTROL INFORMATION:-

Is this patient an infection control risk?
 (please tick the most appropriate box and give confirmed or suspected organism)

Confirmed risk
 Organism:.....

Suspected risk
 Organism:.....

No known risk
 Organism:.....

Patient exposed to others with infection (e.g.: D&V) Yes No

If patient has diarrhoeal illness, please indicate bowel history for last week:-
 (Assessed with Bristol Stool Chart)

Is the diarrhoea thought to be of an infective nature? Yes No

Relevant specimen results (including admission screens – MRSA, glycopeptide-resistant enterococcus SPP, *C. Difficile*, multi-resistant *Acinetobacter* SPP) and treatment information, including antimicrobial therapy:

Specimen:				
Date:				
Result:				

Treatment information:

Other information:

Is the patient aware of their diagnosis / risk of infection? Yes No

Does the patient require isolation? Yes No
(please inform the receiving area in advance)

Is the Infection Control Nurse aware of the transfer? Yes No
 If no why not?

Is EMAS aware of the transfer? Yes No

Print Name on completion: _____ :
 Contact No: _____ Date: _____

Key individuals involved in developing the document

Name	Designation
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Julie Williams	Infection Prevention and Control Nurse
Amanda Hemsley, Annette Powell, Antonia Garfoot, Mel Hutchings Andy Knock	Infection Prevention and Control team

Circulated to the following individuals for comment

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Kathy Feltham	Lead Nurse MHSOP
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