Leicestershire Partnership NHS Trust

# The 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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|---|---|---|
| Key Words: | Infection, prevention, control, source, isolation, precautions. | |
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| Type of Policy | Clinical  | Non-Clinical . |

## Contents

## 1.0 Quick Look Summary

The purpose of this policy is to provide staff employed by Leicestershire partnership trust (LPT) with clear and robust infection prevention and control guidelines for the management of a patient requiring source isolation precautions (SIPs). It applies to inpatients 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.

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 UK Health and Safety Agency (UKHSA)

LPT has a wide range of teams and services operating from a large number of sites and 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.

1.1 Version Control and Summary of Changes

| Version number | Date | Comments |
|---|---|---|
| Version 1 | May 2010 | Replaces NO 0186<br>"Infection Control Policy for the Management of a Patient Requiring Source Isolation in Community Hospitals"<br>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.<br>Document forwarded to policy group for approval. |
| Version 7 | August 2017 | Reviewed and updated in line with latest research and guidelines.<br>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.<br>Addition of 'Post infection clean/ terminal clean request sign off form'. |
| Version 8 | February 2022 | Reviewed and updated in line with latest Guidelines. |
| Version 9 | March 2024 | Reviewed and updated in line with latest Guidelines. |

**1.2 Key individuals involved in developing and consulting on the document**

| **Name** | **Designation** |
|---|---|
| Accountable Director | Anne Scott Director of nursing, AHP'S & Quality, Emma Wallis Deputy director of Nursing & quality. |
| Author(s) | Reviewed by Claire King Infection prevention and control nurse |
| Implementation Lead | Amanda Hemsley Head of infection prevention and control |
| Core policy reviewer group | Infection prevention & control assurance group |
| Wider consultation | Infection prevention & control assurance group members |
| Trust Policy group | Trust policy group members |

### 1.3 Governance

| Level 2 or 3 approving delivery group | Level 1 Committee to ratify policy |
|---|---|
| Infection prevention & Control assurance group | Quality & safety committee |

### 1.4 Equality Statement

Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population, and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy, and maternity.

if you would like any public Trust Policy in an accessible format, please email lpt.corporateaffairs@nhs.net and we can send them to you.

### 1.5 Due Regard

LPT will ensure that Due regard for equality is taken and as such will undertake an analysis of equality (assessment of impact) on existing and new policies in line with the Equality Act 2010. This process will help to ensure that:

- Strategies, policies and procedures and services are free from discrimination.
- LPT complies with current equality legislation.
- Due regard is given to equality in decision making and subsequent processes.
- Opportunities for promoting equality are identified.

Please refer to due regard assessment (Appendix 4) of this policy

***Consent***

- *Clinical staff must ensure that consent has been sought and obtained before any care, intervention or treatment described in this policy is delivered. Consent can be given orally and/ or in writing. Someone could also give non-verbal consent as long as they understand the treatment or care about to take place. Consent must be voluntary and informed, and the person consenting must have the capacity to make the decision.*
- *In the event that the patient's capacity to consent is in doubt, clinical staff must ensure that a mental capacity assessment is completed and recorded. Someone with an impairment of or a disturbance in the functioning of the mind or brain is thought to lack the mental capacity to give informed consent if they cannot do one of the following:*

  - *Understand information about the decision.*
  - *Remember that information.*
  - *Use the information to make the decision.*
  - *Communicate the decision.*

### 1.6 Duties within the Organisation

Duties regarding this policy can be located in the LPT Infection Prevention and Control assurance policy.

### 1.7 Definitions that apply to this Policy.

| | |
|---|---|
| **Due regard** | Having due regard for advancing equality involves:<br>• Removing or minimizing disadvantages suffered by people due to their protected characteristics.<br>• Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.<br>Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low. |
| **Cohort Nursing** | 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.<br>Cohort nursing is more likely to be used in an increased incident/outbreak situation |
| **Disease** | 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. |
| **Increased Incidence** | 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. |
| **infection** | An organism is present at a site and causes an inflammatory response or an organism is present in a normally sterile site. |
| **Infectious** | Caused by a pathogenic microorganism or agent that has the capability of causing infection |
| **Outbreak** | 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. |
| **Organisms** | This is defined as any living thing, in medical terms we refer to bacteria and viruses as organisms |
| **Personal Protective Equipment (PPE)** | Specialized clothing or equipment worn by employees for protection against health and safety hazards. |
| **Protective Isolation** | Isolation is imposed to protect a patient with a compromised immune system from infection. |
| **Source Isolation** | Precautions that are taken in the hospital to prevent the spread of an infectious agent from an infected or colonized. patient to susceptible persons. |
| **Symptomatic** | Physical or mental sign of disease |

## 2.0. Purpose and aim of the policy.

The purpose of this policy is to provide staff employed by Leicestershire partnership trust (LPT) with clear and robust infection prevention and control guidelines for the management of a patient requiring source isolation precautions (SIPs). It applies to inpatients 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.

## 2.1 Introduction

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

All health professionals should ensure that 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 UK Health and Safety Agency (UKHSA)

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.

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 minimize the risk of transmission of infection.

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

## 3.0 The management of a patient requiring source isolation precautions.

### 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.

## Source isolation procedures for patients with suspected or confirmed respiratory infections including SARS-COV2

Patients with suspected or confirmed respiratory infections where cohort nursing is being carried out should be provided with a surgical facemask (type II or type IIR) to be worn in the multi-bedded bays and communal areas of the ward if this can be tolerated. If a patient is unable to tolerate wearing a face mask or has a medical condition preventing them from wearing a face mask as recommended, then a risk assessment will need to be undertaken and the outcome documented within the patients' records.

Surgical masks are not required to be worn by patients in single room source isolation unless another person enters, or the room door is required to remain open.

All patients that are transferring to another care area should be encouraged to wear a surgical facemask (if tolerated) to minimize the dispersal of respiratory secretions and reduce the risk of environmental contamination. Patients should be provided with a new surgical mask at least daily or when the mask becomes soiled or damaged.

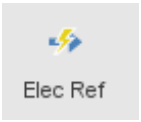
Where possible physical distancing is recommended to remain at a minimum of 1 meter for patients with suspected or confirmed respiratory infection and patients

should be encouraged to remain within their bed space. Depending on the patient group it may not be possible to maintain physical distancing at 1 meter in these cases a risk assessment must be undertaken, and the outcome documented in the patients SystmOne records.

The infection prevention and control team must be informed when a patient requires SIPs. This should be done as soon as possible, and the date, time and reason for SIPs being implemented must be documented in the patient's records. The source isolation care plan must also be completed in the patient's system one records.

**To Make a New Referral to Infection Prevention and Control Service** Choose one of 3 methods below if a patient has an infection / suspected infection or is a known carrier:

- Phone: 0116 295 2320 (Answerphone service)
- Staffnet: Send an automated email alert to IPC via Staffnet. https://staffnet.leicspart.nhs.uk/support-services/infection-prevention-control/contact-us/ipcform/
- E-Referral on SystmOne:




The source isolation notice (Appendix 2) must also be completed laminated 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 that may be required.

This information should also be recorded in the patient handover document where used also the hotel services/domestics handover document to ensure that all staff are notified of any patients within an inpatient setting that are being isolated to enable them to take necessary precautions.

**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 patient's 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 sanitizer 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 and 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 Estates and facilities 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 source isolation using a tray. After the meal, the crockery, cutlery, leftovers, and tray are placed directly into the trolley and 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 an apron when handling body waste. When removing the bed pan/commode from the SIPs area ensure that the contents are covered with an authorised cardboard protector/ bag recommended by the supplier. This should then 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.

(Only items such as Human waste, vomit, faeces, and urine, maceratable wipes and toilet tissue should be placed in a macerator to prevent blockages and break down of the machine)

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

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 the estates team 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 bowels must then be followed. The empty catheter bag can then be disposed of directly into the clinical waste bag.

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**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 always kept clean and tidy. 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 a 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 those patients who are symptomatic.
- If samples have been obtained and a positive result for an infection has been identified.
- if a single patient has a positive result where a bay is isolated the whole bay will need to undergo a post infection clean.

If a patient or in the case of where a bay is isolated all the patients who are symptomatic within the bay have had samples sent and all those samples have returned a negative result. Then providing the medical staff/ANP are satisfied that the symptoms are not due to an infective cause and have carried out a risk assessment then this can be documented in the patients notes and source isolation precautions can be discontinued without the need for a post infection clean.

If a post infection clean is required, then all staff must wear PPE when undertaking cleaning activities and hands must be decontaminated with soap and water 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 and disinfected using Chlor clean and air dry. 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 prevention and Control Team, however when a rapid clean is being undertaken walls will be wiped to reach level (hand height).

**Nursing staff** are responsible for documenting that cleaning has been completed using the 'Post infection clean/terminal clean request sign off form' (Appendix 4/5). 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 or other area, the ward where the patient is located must contact the receiving department to ensure appropriate precautions can be taken. Arrangements should be made to minimize any delay and possible contact with other patients en route as well as in the visiting department.

When patients are required to visit other departments, they should be encouraged to wear a face covering or surgical masks (type II or IIR) to prevent the transmission of SARS-COV2 and other respiratory infectious agents in health and care settings. However, depending upon the patient group, it may not always be appropriate for them to wear a face mask or face covering, in these cases a risk assessment must be undertaken, and the outcome clearly documented in the patients SystmOne notes.

Any unnecessary equipment must be moved out of the room wherever possible prior to the patient's visit. 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, the 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 6).

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 continue to 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 by 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 a clinical waste bin, and then wash their hands with soap and water and dry them thoroughly, before further decontaminating them with alcohol sanitiser.

**Therapy**

Patients who are undergoing SIPS can continue to receive therapy in preparation for their discharge from hospital. However, the following precautions must be taken during any therapy sessions. Therapy assessments are required:

- The patient must be last patient seen for the day by therapy team staff.
- During contact with the patient, staff must ensure that they wear appropriate PPE and that they wash their hands with soap and water before donning and after doffing of PPE.
- If the patient requires to go to a gym for therapy, then the patient will need to be last patient on the list and the only patient in the gym. Once therapy has completed then any equipment or touch points used by the patient will need to be cleaned with Chlo clean solution. The patient will also need to be encouraged to wear a FRSM if safe/able to wear one and encouraged to their wash their hands with soap and water before and after each session.

**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 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 the patient.

**Disposal of infected cadavers**

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

**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 (i.e., 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.

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**<br>Aetiology unknown & draining | None (unless microbiological isolate indicates) | | | See advice for relevant organism |
| **Auto Immune Deficiency Syndrome (AIDS)**<br>See Human Immunodeficiency Virus (HIV) | | | | |
| **Amoebiasis**<br>Dysentery<br>Liver abscess | <br>Source<br>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**<br>Cutaneous | <br>Source | <br>Contact | | <br>Until completion of successful treatment |
| **Ascariasis** | None | | | |
| **Aspergillosis** | None | | | |
| **Botulism** | None | | | |
| **Bronchiolitis** | Source | Airborne | Cough/ Productive sputum | Clinical recovery or discharge home |
| **Bronchitis**<br>Adults<br>Infants & young children | <br>None<br><br>Source | Airborne | <br>Cough/ Productive sputum | Clinical recovery or discharge home |
| **Brucellosis** | None | | | |

| | | | | |
|---|---|---|---|---|
| **Campylobacter**<br>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.<br><br>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)**<br><br>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)<br><br>Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected infectious nature policy |
| **Cellulitis**<br>Intact skin<br>Exudation | None (unless microbiological isolate indicates) | See advice for relevant organism | | |
| **Cholera**<br>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**<br>Adults<br>Infants & young children | None<br>Source | Respiratory | Cough/ Productive sputum | Clinical recovery or discharge home |
| **Conjunctivitis**<br>Neonatal<br>(Not a sticky eye) | Source | Contact | | 24 hours of appropriate antibiotic therapy |
| **SARS- Covid-19** | Source | Respiratory | Cough | Refer to current action card for covid-19 source isolation guidance. |
| **Carbapenem resistant organisms (CRO, CRE, CPE, CPO or XDR)** | Source | | Wounds, urinary catheters and or UTI, Ventilated patients or patients with productive cough, patients with intravenous devices, patients who wandering and unable to comply with good hand hygiene, Urinary and faecal incontinence. | Until discharge home |
| **Croup** | Source | Respiratory | | Clinical recovery or discharge home |
| **Cryptococcosis** | None | | | |
| **Cryptosporidiosis**<br>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.<br><br>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<br><br>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 Mononucleosis) | Source | Respiratory | | 2 weeks after onset of symptoms |
| **Gonorrhea** | 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)**<br>**Risk factors present.**<br>**No risk factors present** | Source<br>None | Contact | Open wounds, lesions risk of bleeding | Dependent on clinical assessment |
| **SARS** | | | | |
| **Hepatitis A (HAV)**<br>**Risk factors present.**<br><br>**No risk factors present** | Source<br><br>None | Contact | Ingestion of food, water or other objects contaminated with faecal matter from an infected person (even in microscopic amounts) | Dependent on clinical assessment |

| | | | | |
|---|---|---|---|---|
| | | | Sex with an infected person | |
| **Hepatitis B (HBV)**<br>**Risk factors present**<br>**No risk factors** | Source<br>None | Contact | Open wounds, lesions, risk of bleeding | Dependent on clinical assessment |
| **Hepatitis C (HCV)**<br>**Risk factors present.**<br>**No risk factors present** | Source<br>None | Contact | Open wounds, lesions, risk of bleeding | Dependent on clinical assessment |
| **Influenza** (Pandemic) | Source | Respiratory/ contact | Sputum generating procedures | 7 days from clinical onset or clinical recovery |
| **Legionnaires** | None | | | |
| **Leprosy**<br>**Smear positive.**<br>**Smear negative** | Source<br>None | Respiratory/ Contact | | Negative smears |
| **Leishmaniasis** | None | | | |
| **Leptospirosis** | None | | | |
| **Head Lice** | Source | Contact | Prolonged contact | Until resolved following effective treatment<br><br>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**<br>Confirmed or suspected<br>Viral/ bacterial | Source | Respiratory | | 24 hours of appropriate antibiotic treatment (bacterial)<br>Length of acute illness |
| **Molluscum contagiosum** | Source | Contact | | Until after appropriate treatment |
| **Mumps** | Source | Respiratory | | 10 days from onset |
| **Meticillin-Resistant Staphylococcus Aureus (MRSA)**<br>High risk areas<br>Low risk areas<br>Risk factors present<br>No risk factors present | <br><br><br>Source<br>Source<br>Source<br>None | <br><br><br>Contact<br>Contact<br>Contact | <br><br><br>Productive cough, heavily exudating wounds, heavily exfoliating skin | Whilst displaying one or more risk factors and until 3 negative screens achieved<br><br>Refer to LPT management of patients with MRSA policy |
| **Mycobacteria** (atypical) | None | | | |
| **Necrotising Fasciitis**<br>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**<br>(Whooping cough) | Source | Respiratory | Cough | Clinical recovery |
| **Pharyngitis**<br>Adults<br>Infants & young Children | None<br>Source | Respiratory | | Clinical recovery |
| **Pneumonia**<br>Children<br>Adults | Source<br>None | Respiratory | Cough | Until Discharge home<br>Unless advised by microbiology/Infection Control Team |
| **Poliomyelitis** | 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**<br>Acquired<br>Congenital | Source<br>Source | Respiratory | | 5 days from onset of rash<br>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<br><br>Refer to LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infectious nature policy |
| **Scabies** Classical<br>(Atypical)<br>Norwegian (Crusted) | Source<br>Source | Contact<br>Contact | | Until completion of 2 courses of treatment 2 weeks apart<br>Repeat treatment may be necessary<br>Discuss with Dermatologist<br>Refer to LPT management of patients with scabies policy |
| **Scarlet fever** | Source | Respiratory<br>Contact | | 24 hours of antibiotic treatment |
| **Shingles**<br>(Herpes Zoster) | Source | Contact | Leaking vesicles<br>Not cared for by staff if they have<br>no immunity.<br>(Refer to LPT staff health relating to communicable disease policy | All lesions scabbed over and dry<br>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 Spongiform Encephalopathy** | None | | Care for specific invasive procedures | refer to LPT policy on TSE, including CJD and vCJD policy |
| **Tuberculosis** Pulmonary/Milliary 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)**<br>With risk factors<br>No risk factors | <br>Source<br>None | <br>Contact | Diarrhoea<br>Urinary Catheter<br>Wounds<br>Central lines | Isolate whilst risk factors are in situ. |
| **Varicella zoster**<br>(Chicken pox) | Source | Contact/<br>Respiratory | Leaking vesicles | All lesions scabbed and dry.<br><br>Refer to LPT management of chickenpox/shingles, including screening processes policy |
| **Vomiting** | Source | Contact<br>Faecal - oral | | If thought to be infective - 48 hours from last episode<br><br>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<br><br>Refer to the LPT management of a patient with diarrhoea and/or vomiting that is of a suspected or confirmed infectious. nature policy |
| **Viral Hemorrhagic Fever (Lassa fever, Marburg fever, Ebola fever, Crimean)** | Strict<br>High security and transfer to Infectious Diseases Unit | Respiratory contact | | Until decision by Infection Control Doctor/Infectious Diseases Consultant/ |

| | | | | |
|---|---|---|---|---|
| **Yellow Fever** | none | | | |

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

**Telephone: 0116 295 2320 (Answerphone service)**

## 4.0 Monitoring Compliance and Effectiveness

Compliance with this policy is outlined in the LPT infection prevention and control policy.

## 5.0 References & Bibliography

DH (2010) Health Protection Legislation (England). Guidance 2010. Health Protection Regulations, London https://www.legislation.gov.uk

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 Estates and facilities Waste Management Policy (2024)

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 (2022)

LPT The management of the infection prevention and control risks of patients with TB within LPT policy (2024)

LPT Infection Prevention and Control Management of patients with Scabies (2024)

LPT Infection Prevention and Control Management of patients with diarrhea and/or vomiting that is of a suspected or confirmed infectious nature including the clinical management of patients nursed as inpatients within LPT with an increased incidence or outbreak of diarrhea and/or vomiting policy. (2023)

LPT Infection Prevention and Control Management of Transmissible Spongiform Encephalopathy (TSE) including Creutzfeldt-Jacob Disease (CJD) Variant CJD (vCJD) (2023)

LPT Infection Prevention and Control Personal Protective Equipment for use in Healthcare Policy (2023)

LPT Infection Prevention and Control Staff Health relating to a Communicable Disease Policy (2022)

NHS England (2023) National infection prevention and control manual for England V2.4

# 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 undergoing 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**

Appendix 2

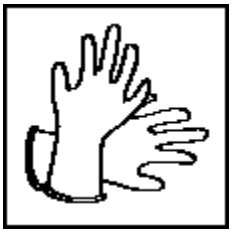
# Infection Prevention and Control Team

## SOURCE ISOLATION PRECAUTIONS

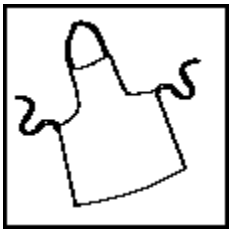
**FOR IN-PATIENT FACILITIES**

**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.**

---

Appendix 3

NHS
National Patient Safety Agency

# 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** | **Blue** |
| Bathrooms, washrooms, showers, toilets, basins and bathroom floors | General areas including wards, departments, offices and basins in public areas |
| **Green** | **Yellow** |
| Catering departments, ward kitchen areas and patient food service at ward level | Isolation areas |

Your local contact for hospital cleaning is:

Appendix 4

## 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 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.

Appendix 5

## 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<br>Windowsill<br>etc. | |
| Fixtures and Fittings: Light fittings<br>Switches<br>Curtain Rails<br>Shelving<br>Door handles<br>radiators<br>etc. | |
| Furniture: Table<br>Wardrobe/cupboard<br>Chair<br>Bed frame<br>etc. | |
| En-suite: toilet<br>Fixtures and fittings<br>Floor | |
| Bin: Outside<br>New bin liner | |
| Hand Wash sink<br>Deb dispensers<br>Paper towel dispenser | |
| Any other items specific to the area | |
| | Yes/No/Comments |
| Wardrobes and cupboards emptied and cleaned inside | |

**Items to be cleaned and decontaminated by nursing staff.**

***Nursing Duties***

| | |
|---|---|
| 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 …….**

Appendix 6

| **Transfer Letter/Inter-Healthcare Transfer Form** | |
|---|---|
| From:<br>To:<br>Date:<br>Transferring facility e.g., ward, care home etc.:<br><br>Receiving facility e.g., hospital, ward, care home, district nurse etc.: | |
| **PATIENT DETAILS** | **G.P.** |
| Name:<br>Address:<br><br><br>Date of birth<br>……<br>NHS number<br>…… | |
| **NEXT OF KIN: -** | **REASON FOR ADMISSION** |
| Aware of admission: Yes ☐ No ☐ | |
| **PAST MEDICAL HISTORY/ ALLERGIES** | **CURRENT MEDICATIONS** |
| | |
| **GP/DOCTOR/CONSULTANT- CLINICAL SUMMARY OF TREATMENT** | |
| | |
| Print Name on completion: Date:<br>Contact No: | |
| **NURSING SUMMARY: -** | |
| (Activities of daily living) | |

| | |
|---|---|
| Print name on completion: | |
| Contact No: | Date: |

**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 diarrheal 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:

**Transmission Based Precautions**

Transmission based precautions are the second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent further infection transmission.

| Type of precaution | Definition/when to be used | Isolation | PPE | Transport/movement of patient |
|---|---|---|---|---|
| **Contact** | Patients with known or suspected infections that represent an increased risk for contact transmission such as CDT, CRO or MRSA. | • Appropriate patient placement<br>• Single room with en-suite if available | • Gloves<br>• Apron<br>• Gown (only if risk of splash from blood/bodily fluids)<br><br>*Don PPE before room entry and doff appropriately before exiting the patient's room. Ensure hands are washed using soap and water.* | Risk assessments must be completed for any activities outside the patient's room.<br><br>Areas visited outside the patient room must be cleaned after use. |
| **Droplet** | Patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient | • Appropriate patient placement<br>• Single room with en-suite if available | • Gloves<br>• Apron<br>• Gown (only if risk of splash from blood/bodily fluids)<br>• FRSM to be worn by staff and patient (if able to) | Risk assessments must be completed for any activities outside the patient's room. |

| | | | | |
|---|---|---|---|---|
| | who is coughing, sneezing or talking. | | *Don PPE before room entry and doff appropriately before exiting the patient's room. Ensure hands are washed using soap and water.* | Areas visited outside the patient room must be cleaned after use. |
| **Airborne** | Patients known or suspected to be infected with pathogens transmitted by the airborne route such as Tuberculosis, Measles, Chickenpox, disseminated herpes zoster. | • Appropriate patient placement<br>• Single room with en-suite if available<br>• Restrict susceptible healthcare personnel from entering room of patients known or suspected to have Measles, Chickenpox, disseminated zoster or Smallpox if other immune healthcare professionals are available. | • Gloves<br>• Apron<br>• Gown (only if risk of splash from blood/bodily fluids)<br>• FRSM/FFP3 to be worn by staff dependent on infection type*<br><br>*Discuss with the IPC team<br><br>*Don PPE before room entry and doff appropriately before exiting the patient's room. Ensure hands are washed using soap and water.* | Risk assessments must be completed for any activities outside the patient's room.<br><br>Areas visited outside the patient room must be cleaned after use. |

Prioritize cleaning and disinfection of the rooms of patients on contact precautions ensuring rooms are frequently cleaned and disinfected (e.g., focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient at least daily or prior to use by another patient If outpatient settings Focusing on frequently touched surfaces and equipment in the immediate vicinity of the patient. Full post infection clean to take place once source isolation has been stepped down and curtains will require changing

## Appendix 1 Flowchart(s)

## Appendix 2 Training Requirements

Training Needs Analysis

| | | |
|---|---|---|
| **Training topic:** | The management of a patient requiring source isolation precautions policy | |
| Type of training:<br>(see study leave policy) | ☐ Not required<br>Mandatory (must be on mandatory training register)<br>x Role Essential (must be on the Role Essential Training register)<br>☐ Desirable | |
| Directorate to which the training is applicable: | ☐ Adult Mental Health<br>☐ Community Health Services<br>X Enabling Services<br>☐ Families Young People Children / Learning Disability/ Autism Services<br>☐ Hosted Services | |
| Staff groups who require the training: | Clinical staff involved in direct patient care | |
| Regularity of Update requirement: | 2 yearly | |
| Who is responsible for delivery of this training? | E-learning level IPC training Level 1 & 2 | |
| Have resources been identified? | Yes E-learning packages | |
| Has a training plan been agreed? | Yes | |
| Where will completion of this training be recorded? | X ULearn<br>☐ Other (please specify) | |
| How is this training going to be monitored? | | |
| **Signed by Learning and Development Approval name** | | **Date: April 2024** |

## Appendix 2 The NHS Constitution

- The NHS will provide a universal service for all based on clinical need, not ability to pay.
- The NHS will provide a comprehensive range of services.

| | |
|---|---|
| Shape its services around the needs and preferences of individual patients, their families and their carers | x |
| Respond to different needs of different sectors of the population | x |
| Work continuously to improve quality services and to minimise errors | x |
| Support and value its staff | *x* |
| Work together with others to ensure a seamless service for patients | x |
| Help keep people healthy and work to reduce health inequalities | x |
| Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance | x |

## Appendix 3 Due Regard Screening Template

| Section 1 | |
|---|---|
| Name of activity/proposal | The Management of a patient requiring source isolation precautions policy |
| Date Screening commenced | 07-03-2024 |
| Directorate / Service carrying out the assessment | Enabling Infection prevention and control team |
| Name and role of person undertaking. this Due Regard (Equality Analysis) | Claire King Infection prevention and control nurse |
| Give an overview of the aims, objectives, and purpose of the proposal: | |
| AIMS:<br><br>The aim of this policy is to provide staff employed by LPT with a clear and robust infection prevention and control guidelines for the management of a patient requiring source isolation precautions (SIPS). This policy applies to both inpatients and patients who are cared for in their own homes. | |
| OBJECTIVES:<br><br>The objective 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. | |

| Section 2 | |
|---|---|
| Protected Characteristic | If the proposal/s have a positive or negative impact, please give brief details |
| Age | None identified |
| Disability | None identified |
| Gender reassignment | None identified |
| Marriage & Civil Partnership | None identified |
| Pregnancy & Maternity | None identified |
| Race | None identified |
| Religion and Belief | None identified |
| Sex | None identified |
| Sexual Orientation | None identified |
| Other equality groups? | None identified |

| Section 3 | |
|---|---|
| Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below. | |
| Yes | No |
| High risk: Complete a full EIA starting click here to proceed to Part B | Low risk: Go to Section 4.<br><br>x |

| Section 4 |
|---|
| If this proposal is low risk, please give evidence or justification for how you reached this decision: |
| |

| | | | |
|---|---|---|---|
| | | | |
| Signed by reviewer/assessor | Claire King | Date | 07-03-2024 |
| *Sign off that this proposal is low risk and does not require a full Equality Analysis* | | | |
| Head of Service Signed | Emma Wallis | Date | April 2024 |

## Appendix 4 Data Privacy Impact Assessment Screening

Data Privacy impact assessment (DPIAs) are a tool which can help organisations identify the most effective way to comply with their data protection obligations and meet Individual's expectations of privacy.
The following screening questions will help the Trust determine if there are any privacy issues associated with the implementation of the Policy. Answering 'yes' to any of these questions is an indication that a DPIA may be a useful exercise. An explanation for the answers will assist with the determination as to whether a full DPIA is required which will require senior management support, at this stage the Head of Data Privacy must be involved.

| | | |
|---|---|---|
| **Name of Document:** | The management of a patient requiring source isolation precautions policy | |
| **Completed by:** | Claire King | |
| **Job title** | Infection prevention and control nurse | **Date 07-03-2024** |

| **Screening Questions** | **Yes / No** | **Explanatory Note** |
|---|---|---|
| **1.** Will the process described in the document involve the collection of new information about individuals? This is information in excess of what is required to carry out the process described within the document. | N | |
| **2.** Will the process described in the document compel individuals to provide information about them? This is information in excess of what is required to carry out the process described within the document. | N | |
| **3.** Will information about individuals be disclosed to organisations or people who have not previously had routine access to the information as part of the process described in this document? | N | |
| **4.** Are you using information about individuals for a purpose it is not currently used for, or in a way it is not currently used? | **N** | |
| **5.** Does the process outlined in this document involve the use of new technology which might be perceived as being privacy intrusive? For example, the use of biometrics. | N | |
| **6.** Will the process outlined in this document result in decisions being made or action taken against individuals in ways which can have a significant impact on them? | N | |
| **7.** As part of the process outlined in this document, is the information about individuals of a kind particularly likely to raise privacy concerns or expectations? For examples, health records, criminal records or other information that people would consider to be particularly private. | N | |
| **8.** Will the process require you to contact individuals in ways which they may find intrusive? | **N** | |

| | |
|---|---|
| **If the answer to any of these questions is 'Yes' please contact the Data Privacy Team via Lpt-dataprivacy@leicspart.secure.nhs.uk<br>In this case, ratification of a procedural document will not take place until review by the Head of Data Privacy.** | |
| **Data Privacy approval name:** | **n/a** |
| **Date of approval** | |

Acknowledgement: This is based on the work of Princess Alexandra Hospital NHS Trust