

CONSIDERATIONS FOR THE PREVENTION AND CONTROL OF INFECTION FOLLOWING PATIENT DEATH

Infection Prevention and Control Policy No 11

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Name of originator(s)/author(s):	Gillian Hodgson Nurse Consultant Infection Control Reviewed/ revised by Sue Whiteley Senior Infection Prevention Nurse
Name of responsible committee/individual:	Infection Prevention and Control Committee/Director of Infection Prevention and Control
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EXECUTIVE SUMMARY

Scope of policy

This policy applies to:

- All staff employed at LTHT who have direct patient contact.

Key Points

- Standard Infection Prevention and Control Precautions should be used for all patients.
- Body bags are used for high risk cases only.
- Inform mortuary staff if there is a known high risk of infection.

Aims: All LTHT staff are aware of their role and methods by which infection can be prevented and controlled in the event of patient death.

Objectives: To prevent and control the risks of infection associated with patient death.

1 INTRODUCTION

The time surrounding the death of any patient is distressing for both relatives and staff. It is important that guidelines are followed so that distress is not exacerbated.

This policy will apply in the majority of situations; however some areas within the Trust will have specific arrangements which have been agreed with the Infection Prevention Team. A copy of these arrangements should be kept in the infection prevention manual on the wards/department concerned.

2 PURPOSE

The purpose of this policy is to identify the necessary precautions to take to prevent and control infection following a patient's death, and when extra caution needs to be utilised.

Failure to follow this policy could result in the instigation of disciplinary procedures.

3 DEFINITIONS

Nosocomial infection – an infection acquired as a result of a period of hospitalisation or treatment that was neither present nor incubating at the time of admission.

4 DUTIES

4.1 Duties within the Organisation

As a healthcare establishment LTHT has a duty of care that is covered by the Health and Safety Act (1974) (HSE 2003), COSHH (HSE 2005) and The Health Act (DH 2006). Considerations for the prevention and control of infection following patient death is covered in core duties 2, 3 and 11 of this Act.

4.2 Consultation and Communication with Stakeholders

The Infection Prevention and Control Committee, The Chief Nurse Team and the Infection Prevention Team have commented on and contributed to this policy. The policy will be approved by the Infection Prevention Committee and the Senior Management Team.

5 DO INFECTIONS CONTINUE TO POSE A HAZARD AFTER DEATH?

- Micro-organisms (bacteria, viruses, etc.) can continue to thrive following patient death therefore precautions taken when the patient was alive should be continued following death, i.e. Standard Infection Prevention and Control Precautions for all patients and any additional precautions in place for known or suspected infections (ref. LTHT Standard Infection Control Precautions policy). General guidance on the carrying out of last offices can be found in The Royal Marsden Manual, Chapter 23, (see reference list).

6 WHAT IS DONE TO MINIMISE THE RISK?

The risk of body fluid leakage is minimised:

- All orifices must be packed where leakage is anticipated or evident.
- All wounds, intravenous sites or breaks in the skin must be sealed with an occlusive dressing.
- If a body is expected to leak blood and/or body fluids beyond the capacity of the packing, the body must be placed in a body (cadaver) bag.
- Appropriate personal protective equipment (gloves and apron as a minimum) are used where there is risk of contact with blood and/or body fluids.

Body bags are used in high risk cases:

- Known or suspected blood borne viruses, i.e. **HIV & AIDS Hepatitis B or C**;
- Known or suspected **open pulmonary Tuberculosis**;
- Known or suspected **Transmissible Spongiform Encephalopathies**;
- **Those expected to leak blood or body fluids beyond the capacity of the packing (see above).**
- Patients with known nosocomial infections such as MRSA or *Clostridium difficile* infection **do not** require body bag precautions. If you are in any doubt whether a case requires placing in a body bag, contact the Infection Prevention Team.

'Danger of Infection' Labels are used to identify high risk cases:

- In high risk cases (defined above) the body itself must have a yellow 'Danger of Infection' label attached to it.
- Mortuary cards attached to the body and body bag must have yellow 'Danger of Infection' labels attached to them (do not write details of the infection on these cards in order to maintain confidentiality).
- Between 0830 and 1700 hours alert the mortuary staff that the body has left the ward. Outside these hours the portering staff should place a yellow "danger of infection" sticker on the door of the refrigerated store unit in which the body has been placed.

It is important that **mortuary** staff are informed where there is a risk of infection whilst keeping the diagnosis confidential, however it must be made clear what type of precautions are required. All enquiries by mortuary staff about any potential risk should be directed to the patient's medical staff.

Clostridium difficile:

When patients have had a confirmed *Clostridium difficile* toxin positive result and this has been named as a contributing factor on the death certificate a **root cause analysis** investigation must be undertaken.

7 CONTROLLING THE RISK OF EXPOSURE IN NON-EMPLOYEES

Religious and cultural considerations

- There are considerable variations according to religion and culture regarding practices for death and dying. If there is a need for involvement of non -Trust staff those persons will need to be informed of any risks of infection and advised of control measures that should be used.

Viewing by relatives

- For patients with known infection, viewing of the body by friends and relatives should take place on the ward prior to putting the body into a cadaver bag, even if this necessitates keeping the body on the ward longer than usual. Once the body has left the ward, viewing may be more distressing for relatives due to the effects of the body bag on the body, and more difficult to arrange if the funeral director adheres strictly to infectious diseases regulations.
- When relatives wish to view the body they will need to be advised of any risk of infection risk if they touch or kiss the deceased.
- Relatives must be informed of any precautions they need to take following contact, e.g. hand hygiene.

8 RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

Lead Director: Director of Infection Prevention and Control

Sue Whiteley

Gillian Hodgson

Richard Hobson

Consultation through Infection Prevention and Control Committee

9 EQUALITY IMPACT ASSESSMENT

The Policy has been assessed for its impact upon equality, Appendix A. The Leeds Teaching Hospitals Trust is committed to ensuring that the way that we provide services and the way we recruit and treat staff reflect individual needs, promote equality and does not discriminate unfairly against any particular individual or group.

10 IDENTIFICATION OF STAKEHOLDERS

The key stakeholders in this policy are LTHT staff involved in caring for patients in the event of their death and managers responsible for the provision of facilities for this patient group.

11 CONSULTATION PROCESS

This policy will be consulted on by the Infection Prevention and Control (IPC) Committee and its sub groups and the Chief Nurse Team.

12 APPROVAL AND RATIFICATION

This policy will be reviewed two years from the date of approval or following significant changes in the management of patients with known or suspected infection.

13 PROCESS FOR REVIEW/REVISION OF THIS POLICY

This policy will be reviewed in September 2010.

14 COMMUNICATION/DISSEMINATION OF THIS POLICY

Directors – communication directly by e-mail and discussion at TMB

Senior operational and corporate managers – communication directly by e-mail and to be notified by Directors through line management briefing

All staff – Trust communications channels including e-mail

15 IMPLEMENTATION OF THIS POLICY

This policy will be implemented immediately following dissemination.

16 PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

METHOD	RESPONSIBILITY
Documented evidence of Infection Prevention and Control as a regular agenda item at all levels within the organisation (examples of minutes, dedicated meetings, etc.)	Trust Board – Chief Executive TMB – Chief Executive; DIPC CMT clinical governance meetings – Divisional manager; Head of CMT Matrons meetings – Chief Nurse; Deputy Chief Nurses Sisters meetings - Matrons
Incorporation of IPC into job descriptions of all staff	Director of Human Resources
Incorporation of IPC into personal development plans/KSF framework of all staff- view appraisal documentation and monitor at performance review	Clinical leads; matrons; ward/departmental managers
Audit of compliance with the Health Act (DOH 2006)	Chief Executive; DIPC

17 STANDARDS/KEY PERFORMANCE INDICATORS

The performance of LTHT against the policy will be monitored through key indicators including:

- Assessment against the Department of Health Code of Practice for the Prevention and Control of Healthcare Associated Infections using the Saving Lives self assessment tool

- Infection prevention and control element of Health and Safety audits (annual)

18 REFERENCES/ASSOCIATED DOCUMENTATION

Department of Health (1998): Guidance for Clinical Health Care Workers: Protection Against Infection with Blood-borne Viruses. Recommendations of the Expert Advisory Group on AIDS and the Advisory Group on Hepatitis. HMSO, London.

HMSO (2003) Safe Working and the Prevention of Infection in the Mortuary and Post Mortem Room. Health Services Advisory Committee.

The Royal Marsden NHS Trust (2004): Manual of Clinical Nursing Procedures. Blackwell Science, Oxon. 4th Edition.

Appendix A - EQUALITIES IMPACT ASSESSMENT

Section 1 Screening				
<p>Does this policy or procedure impact on staff patients or public? S = Staff PA = Patients PU = Public</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under race legislation?</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under disability legislation?</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>How relevant is the policy to achieving the duties under gender legislation?</p> <p>0 = none 1 = a little 2 = some 3 = very</p> <p>(enter below)</p>	<p>Could this policy disadvantage any group due to Race, Disability or Gender?</p> <p>R = Race D = Disability G = Gender N = None</p> <p>(enter below)</p>
S, PA, PU	0	0	0	N
Section 2 Assessing impact				
<p>Please specify in the relevant box any thing that you have included in the policy which helps to meet the Race Disability or Gender Equality Duties*</p> <p>Please put NA if this is not applicable</p>	Race	Disability	Gender	
	The policy is inclusive and applies to all patients	The policy is inclusive and applies to all patients	The policy is inclusive and applies to all patients	

* The equality duty is to eliminate unlawful discrimination and promote equality of opportunity and good relations between different groups.

Appendix B - Checklist for the Review and Approval of Policy

To be completed and attached to the policy when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/Unsure	Comments
1.	Title		
	Is the title clear and unambiguous? Is it positively named in respect of the behaviour, actions, established position it seeks to achieve?	Y	
	Is it clear whether the document is a policy, guideline, protocol or standard?	Y	
2.	Rationale		
	Are reasons for development of the document stated?	Y	
3.	Development Process		
	Is the method described in brief?	N	
	Are people involved in the development identified?	Y	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	Y	
	Is there evidence of consultation with stakeholders and users?	Y	
4.	Content		
	Is the objective of the document clear?	Y	
	Is the target population clear and unambiguous?	Y	
	Are the intended outcomes described?	Y	
	Are the statements clear and unambiguous?	Y	
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	

	Title of document being reviewed:	Yes/No/Unsure	Comments
	Are supporting documents referenced?	Y	
6.	Approval		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	Dissemination and Implementation		
	Is there a communications plan to identify how this will be done?	N	
	Does the implementation plan include the necessary training/support to ensure compliance?	N	
8.	Document Control		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	N/A	
9.	Process to Monitor Compliance and Effectiveness		
	Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	Y	
	Is there a plan to review or audit compliance with the document?	Y	
10	Review Date		
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
11	Overall Responsibility for the Document		
	Is it clear who will be responsible for	Y	

	Title of document being reviewed:	Yes/No/Unsure	Comments
	co-ordinating the dissemination, implementation and review of the document?		

Individual Approval

If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.

Name		Date	
Signature			

Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.

Name		Date	
Signature			