



POLICY FOR THE SAFE PLACEMENT OF PATIENTS WITH SUSPECTED OR DIAGNOSED INFECTION

Infection Prevention and Control Policy No 34

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- C Checklist for the Review and Approval of Policy
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EXECUTIVE SUMMARY

This policy describes measures required to minimise the risk of transmission of infection to others when making decisions regarding bed allocation from patients who are infected or colonised with transmissible agents.

A risk assessment must be conducted on every patient with a transmissible disease so that appropriate measures can be taken.

Aims

- To assist staff in assessing infection risks when considering movement of patients.
- To ensure that all patients are individually risk assessed so that appropriate measures may be taken.
- To ensure that patients are cared for in a safe environment with the minimum of discomfort and inconvenience and to provide maximum protection to other patients and staff.

Objectives:

- To ensure that patients are admitted to a clinical area appropriate to their needs
- To ensure that the movement or transfer of patients throughout the Trust occurs only for clinical reasons or follows a legitimate patient pathway e.g. transfer to a rehabilitation area
- To reduce the risk of transmission of infection by minimising the movement of potentially infected patients

1 INTRODUCTION

All NHS Trusts have a duty to ensure that they have appropriate arrangements in place to protect patients from the risk of acquiring a healthcare associated infection (HCAI).

This policy provides guidance for all staff within LTHT on the appropriate use of existing isolation facilities; on the cohorting of patients with the same transmissible disease and on the movement of patients with an alert condition or organism (Appendix D). This policy also provides guidance on the closure of wards for the purpose of infection prevention and control.

2 PURPOSE

The purpose of this policy is to identify measures required to minimise the risk of transmission of infection when making decisions regarding bed allocation from patients who are infected or colonised with transmissible agents to others.

3 DEFINITIONS

A hospital transmissible infection is defined as one that can be communicated to staff and/or patients.

Colonisation occurs when a microbe establishes itself in a particular environment such as a body surface without producing disease.

Alert organisms and conditions are those identified as posing a public health risk to patients, staff or visitors as defined by the Department of Health (Appendix D).

Restriction of wards and departments is made following identification of an outbreak which is a situation where the observed number of cases of an organism in a particular ward or department exceeds the expected number for that area.

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). The isolation, placement and movement of patients with suspected or known communicable diseases are covered in core duties 2f, 6 and 8 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 and Control Committee and the Senior Management

Team.

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- To ensure that the movement or transfer of patients throughout the Trust occurs only for clinical reasons or follows a legitimate patient pathway e.g. transfer to a rehabilitation area
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5.1 Key Principles

- Every patient will be assessed for the risk of transmission of an infection. The risk assessment will take into account the specific organism and site of colonisation or infection (if known), its mode(s) of transmission, and patient factors such as symptoms, immune status and mobility (see alert organism/condition policy). This may need to be in conjunction with the Infection Prevention Team (IPCT).
- Reference to other Infection Prevention and Control policies will be required to fulfil the responsibilities in this policy.
- Every patient with an alert organism or condition that is readily transmissible in hospital and poses a health risk to patients, staff or visitors (Appendix D) should be nursed in accordance with the LTHT Source Isolation Policy. (See alert organism/condition policy.)
- Where there is competition for isolation facilities it may be necessary to prioritise alert conditions/organisms and follow the escalation process. For advice on prioritisation

please contact the IPCT. Out-of-hours cover is provided by the Microbiology Department. The on-call microbiologist can be contacted via switchboard.

- Communication should take place between the bed managers, the clinical team and the IPCT in relation to the placement of patients where an infection is suspected or diagnosed.
- Local escalation policies should be developed to manage situations where the source isolation policy or this policy cannot be implemented.
- Patients should not be moved, except where a change in their condition necessitates a move or their requirements alter as their physical condition improves.
- In some clinical areas the single room facilities either may not exist or be located far away from the main nurse's base. This can make it difficult to maintain direct supervision and if patients are placed in these single rooms their safety may be compromised. Clinical staff looking after the patient should make this risk assessment, involving the IPCT if needed.
- Elective and emergency surgical admissions should be kept separate during their stay where possible
- If there are areas designated specifically for a group of higher risk patients e.g. haematology, other patients would be admitted to these areas in exceptional circumstances only. This would be decided by the senior medical and nursing staff with responsibility for this area, in consultation with the IPCT.
- If a specific female or male bed is required for general capacity a patient with an alert organism or condition should not be moved out of a single room.
- Patients with MRSA infection should be cared for in a single room where possible.
- Patients with symptomatic CDI must be cared for in a single room, designated cohort bay or designated ward until symptom free for 48 hours.
- Patients with tuberculosis must be cared for in a single room with augmented ventilation facilities until either discharged or a full 2 weeks anti-TB treatment has been completed.
- Diarrhoea of unknown cause – all patients should be cared for in a single room until symptoms have been resolved for a full 48 hours, or cause identified as non-infectious.
- Restriction of wards – should only be undertaken following consultation with a member of the IPCT.
- For any queries not covered in this document please contact a member of the IPCT.

5.2 Risk Assessment and Isolation

Although isolation is recommended for any of the alert conditions and organisms identified in Annex D (see alert organism/condition policy), it may be necessary to prioritise certain conditions/organisms according to availability of isolation facilities. The following list identifies infections that should be isolated (refer to the alert organism/condition policy for a comprehensive list).

- Diarrhoea of unknown origin – until organism known or reason for diarrhoea identified

- Symptomatic CDI i.e. diarrhoea. Type 6 or 7 according to the Bristol stool chart. Once completely free of symptoms for 48 hours, the patients can be cared for out of a single room.
- Suspected norovirus – patient must be vomiting or having diarrhoea and the cause is as yet unknown.
- Clinical MRSA infection

Further advice on prioritising isolation during normal working hours should be sought from the IPCT. Out of hours cover is provided by an on call Consultant Microbiologist.

In some clinical areas the single room facilities either may not exist or be located far away from the main nurse's base. This can make it difficult to maintain direct supervision and if patients are placed in these single rooms their safety may be compromised. For example, patients with a history of falls or confusion, especially if mobile, may be unsuitable for isolation in a single room. Clinical staff looking after the patient should make this risk assessment, involving the IPCT if needed. There may also be local escalation procedures to follow to assist in the management of risk.

5.3 Transferring Infected Patients

Infected patients should only be transferred for essential investigations or treatment. For patients with MRSA, CDI and tuberculosis refer to existing policies. For any other organisms please contact the IPCT for further advice. The ward should notify the department concerned so that appropriate arrangements can be made to prevent the spread of infection. Appropriate documentation should be completed to support communication, please follow the Patient Transfer Policy and see Appendix B.

5.4 Clusters and Outbreaks

If a clinical area is restricted (see below) as a result of a cluster, outbreak or apparent outbreak, patients and/or staff should not be moved into or out of the affected location, unless it would be detrimental to their care not to do so. In such a situation the IPC should be consulted prior to transfer, to confirm any precautions that may be required. Patients who are being accommodated at a location where there is an outbreak may be incubating disease (i.e. infected, but not yet symptomatic). Therefore, patient movements from outbreak situations should follow the same guidance as transferring infected patients.

The Control of an Outbreak of Infection Policy offers further guidance for outbreaks.

5.5 Cohorting of patients

It is often useful to cohort (put together) patients who have the same organism and who are being cared for in the same clinical area. This will help reduce the risk of the organism spreading to other patients. Cohorting is particularly important during outbreaks of norovirus. This organism spreads rapidly and transfers of infected patients are likely to result in an outbreak in the receiving area. The IPCT will discuss any necessary actions with ward managers and bed managers and record any decision taken. The IPCT will

provide a daily review and e-mail update to all relevant parties. Please refer to the Viral Gastroenteritis Policy.

Please use document in Appendix C to monitor affected patients

5.6 Restriction of wards or departments

A ward may need to be restricted to admissions to prevent the spread of an organism. This decision should be made in consultation with the ward manager, matron/bed manager and the on-call Consultant Microbiologist. If the CMM is not available in the required timescale, other personnel who may approve decisions on ward restriction are the IPCD and the Nurse Consultant in IPC. **Decisions to re-open restricted beds are made by the IPCT, in consultation with the clinical area and the on-call Consultant Microbiologist.**

If bed shortages are critical then the Divisional General Manager or Director of Infection Prevention and Control (DIPC) may override IPCT recommendations on ward restriction.

A member of the IPCT will review restricted areas on a daily basis. They will provide verbal and e-mail updates daily to a group of identified individuals who have responsibilities for the area concerned. Once the area has been re-opened the IPCT will provide a summary of what happened to the DIPC, affected clinical area and the IPCT. The IPCT will provide a daily review and e-mail update to all relevant parties (Appendix C).

5.7 Ventilated Isolation

Ventilated isolation is required only in specific circumstances. Any patient who has or is believed likely to have multi-drug resistant tuberculosis or other severe infection transmitted by the respiratory route (e.g. severe adult respiratory syndrome, SARS) should be isolated in a negative pressure isolation room. If such a facility is needed a member of the IPCT or Consultant Microbiologist (if out of hours) should be contacted immediately.

5.8 Elective and Emergency Admissions

Elective and emergency surgical admissions should be kept separate during their stay where possible. This is because elective admissions will have been pre-screened prior to admission and received decolonisation therapy if appropriate. Additionally, patients admitted acutely are more likely to have a transmissible infection than patients admitted electively. It is accepted that the need to manage current levels of variation in both elective and acute patients means that this aim may not be possible. However, every effort should be made to place patients in the most appropriate area.

6 RESPONSIBILITY FOR DOCUMENT DEVELOPMENT

Lead Director: Ruth Holt, Director of Infection Prevention and Control

Membership of the Steering Group:

Juliette Cosgrove, Lead Nurse Patient Safety

Gillian Hodgson, Infection Prevention Nurse Consultant

Richard Hobson, Lead Infection Control Doctor

Lorna Johnson, Matron Infection Prevention

7 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.

8 IDENTIFICATION OF STAKEHOLDERS

The key stakeholders in this policy are staff involved in caring for patients with known or suspected infections and managers responsible for the provision of facilities for this patient group.

9 CONSULTATION PROCESS

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

10 APPROVAL AND RATIFICATION

This policy will be approved by the Senior Management Team.

11 PROCESS FOR REVIEW/REVISION OF THIS POLICY

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.

12 COMMUNICATION/DISSEMINATION OF THIS POLICY

Directors – communication directly by e-mail and discussion at Senior Management Team meetings.

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-Bulletin.

13 IMPLEMENTATION OF THIS POLICY

This policy will be implemented immediately following dissemination.

14 PROCESS FOR MONITORING COMPLIANCE/EFFECTIVENESS

Any time a patient cannot be isolated appropriately this must be recorded by clinical staff and escalated through local systems.

Records of non-availability of single rooms should be monitored by the Divisions and reported to the Infection Prevention and Control Committee via the Divisional IPC Group.

15 REFERENCES/ASSOCIATED DOCUMENTATION

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Health and Safety Executive. **COSHH: a brief guide to the regulations: What you need to know about the Control of Substances Hazardous to Health (COSHH) Regulations.** 2002. London. HSE.

Health Protection Agency Centre for Infections, National Public Health Service for Wales, CDSC Northern Ireland and Health Protection Scotland. **Eye of the Needle Surveillance of Significant Occupational Exposures to Blood Borne Viruses in Healthcare Workers.** November 2005. London

APPENDIX A - EQUALITIES IMPACT ASSESSMENT

Section 1 Screening				
Does this policy or procedure impact on staff patients or public? S = Staff PA = Patients PU = Public (enter below)	How relevant is the policy to achieving the duties under race legislation? 0 = none 1 = a little 2 = some 3 = very (enter below)	How relevant is the policy to achieving the duties under disability legislation? 0 = none 1 = a little 2 = some 3 = very (enter below)	How relevant is the policy to achieving the duties under gender legislation? 0 = none 1 = a little 2 = some 3 = very (enter below)	Could this policy disadvantage any group due to Race, Disability or Gender R = Race D = Disability G = Gender N = None (enter below)
S, PA	0	0	0	N
Section 2 Assessing impact				
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* Please put NA if this is not applicable	Race The policy is inclusive and applies to all patients	Disability The policy is inclusive and applies to all patients	Gender 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 - INFECTION PREVENTION TRANSFER FORM

<p>Patient/client details: (insert label if available)</p> <p>Name:</p> <p>Address:</p>	<p>Consultant</p> <p>GP:</p> <p>Current patient/ client location:</p> <hr/> <p>Transferring facility - hospital, ward, care home, other:</p> <p>Contact no:</p>
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<p>Receiving facility - hospital, ward, care home, district nurse</p> <p>Contact no:</p> <p>Is the PCT/ambulance service aware of transfer?</p>	<p>Is this patient/client an infection risk?</p> <p><i>Please tick most appropriate box and give confirmed or suspected organism</i></p> <p><input type="checkbox"/> Confirmed risk Organism:</p> <p><input type="checkbox"/> Confirmed risk Organism:</p> <p><input type="checkbox"/> Confirmed risk Organism:</p>
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If patient/ client have diarrhoeal illness, please indicate bowel history for the last week:
(based on Bristol stool form scale)

.....

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

Specimen:					
Date:					
Result:					

Other information:

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

Does the patient/ client require isolation? Yes/No

Name of staff member completing form:

Print name: Contact number:

For further advice please contact the infection prevention and control team

APPENDIX C - WARD OUTBREAK DETAILS

Bedstate:

Date: (KEY: AB's; antibiotics, Lax; Laxatives, Res; result)

Patients name	Diagnosis	Bed No	DOI And time	AB's	Lax	Spec Date sent + Res												

Bedstate:

Date: (KEY: AB's; antibiotics, Lax; Laxatives, Res; result)

Patients name	Diagnosis	Bed No	DOI And time	AB's	Lax	Spec Date sent + Res												

APPENDIX D - 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	

	Title of document being reviewed:	Yes/No/Unsure	Comments
5.	Evidence Base		
	Is the type of evidence to support the document identified explicitly?	Y	
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are supporting documents referenced?	Y	
6.	Approval		
	Does the document identify which committee/group will approve it?	Y	
	If appropriate have the joint Human Resources/staff side committee (or equivalent) approved the document?	N/A	
7.	Dissemination and Implementation		
	Is there a communications plan to identify how this will be done?	N	
	Does the implantation 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	

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

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			

HOSPITAL INFECTION CONTROL

Guidance on the control of infection in hospitals

ANNEX E

“ALERT CONDITIONS” AND “ALERT ORGANISMS” RELATING TO THIS POLICY

ALERT CONDITIONS

Suspected or infective diarrhoea (Bristol Stool Chart severity 6 or 7)

Infective diarrhoea (Bristol Stool Chart severity 6 or 7) and/or vomiting (includes food poisoning, dysentery, cholera, viral gastroenteritis and *Clostridium difficile* infection)

Tuberculosis

Chicken pox/shingles (*Herpes zoster*)

Measles

Mumps

Rubella

Whooping cough

Scarlet fever

Other childhood exanthemata

Scabies

Meningitis

Meningococcal septicaemia

Ophthalmia neonatorum

Diphtheria

Poliomyelitis

Viral haemorrhagic fevers

Plague

“ALERT ORGANISMS”

Organisms causing the alert conditions listed above

Meticillin-resistant *Staphylococcus aureus* (MRSA)

Streptococcus pyogenes

Penicillin-resistant *Streptococcus pneumoniae*

Glycopeptide-resistant enterococci (GRE)

Clostridium difficile

Verotoxin producing strains of *Escherichia coli* (eg *E. coli* O157)

Salmonella or *Shigella* species

Gentamicin-resistant, extended spectrum beta-lactamase-producing and quinolone-resistant Gram-negative rods

Other multi-antibiotic-resistant bacteria (as determined by IPC team)

Respiratory viruses - respiratory syncytial virus, parainfluenza and influenza viruses