

## Source Isolation Policy

### Infection Prevention and Control Policy No 9

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## Executive Summary

**This policy describes the measures required by clinical teams when a patient is identified with a known transmissible alert organism/condition that requires the patient to be placed into source isolation.**

**A risk assessment must be conducted on every patient with an identified transmissible alert organism or condition so that the appropriate isolation measures can be taken.** See Alert organism/condition policy

## Scope of Policy

To prevent and control the spread of communicable infections within LTHT  
Ensure a safe environment for all patients within LTHT

This policy applies to

All patients at LTHT

All staff employed at LTHT who have direct patient contact.

All students whom have direct patient contact.

## Aim

To ensure that patients whom are suspected or diagnosed with an alert organism or condition are placed in Source Isolation

## Objective

To reduce the risk of transmission of alert organisms (communicable infections) to non-infected patients.

## Key points

**Source isolation is the physical separation of one patient from another, in order to prevent spread of infection. Standard Infection Prevention Precautions must be observed at all times with all patients, including those in isolation.**

- The decision to isolate a patient should be based on whether the patient has a suspected or diagnosed alert organism or condition.
- Isolation should occur within two hours of the clinical area deciding there is a need to isolate. If this is not achieved there must be escalation to the matron for the clinical area (in hours), clinical site manager (out of hours), to ensure appropriate placement. If the matron is unable to find sideroom accommodation, this must be escalated to the Directorate Manager (in hours). If isolation is not possible, the matron will contact the IPCT (in hours) and the clinical site manager will contact the on call microbiologist (out of hours), with the required patient information( appendix B) for a risk assessment.

- Patients identified as MRSA positive following an MRSA screen, who have received decolonisation do NOT require isolation unless other potentially colonised sites have been screened ( e.g. IV access points, catheters)
- Senior staff (e.g. bed placement team/matron for clinical area/clinical site manager) to ensure appropriate placement.
- At a minimum a daily re-assessment and re-evaluation of each patient in isolation must be documented in the nursing notes to ensure appropriate use of isolation facilities.
- The patient must be nursed in a single room with a wash basin and preferably an en-suite toilet. If an en-suite toilet is not available, a commode for sole use of the isolated patient should be kept in the isolation room for the duration of the patient's stay.
- All staff entering the room must put on disposable gloves and apron, which must be removed and disposed of before exiting the room.
- The isolation room door must be closed at all times apart from necessary entrances and exits, unless a documented risk assessment by the ward staff identifies increased risk of harm.
- The number of staff entering the isolation room should be kept to the minimum required for patient care.
- If isolation is for varicella-zoster virus (chickenpox or shingles) measles, mumps or rubella, only staff who are immune to the disease (i.e. by vaccination or previous history of the disease) should attend to the patient. (See alert organism/condition policy)
- Psychological support and reassurance must be given to the patient whilst in isolation.
- The source isolation Poster must be displayed on the door **at all times**.
- All staff entering the room must be aware of the necessary precautions.
- The room/bed space and patient care equipment must be cleaned thoroughly with Chlor-clean (see Source Isolation Cleaning Policy)

## 1. INTRODUCTION

Source Isolation refers to the physical separation of a patient with a known transmissible alert organism/condition from other unaffected individuals in order to reduce the risk of transmission.

## 2. PURPOSE

The purpose of this policy is to outline the preventative measures that need to be in place when a patient has been identified with a known transmissible alert organism/condition within LTHT.

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

### **3. DEFINITIONS**

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

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 (DoH, (1995).

Source isolation (also referred to as Barrier Nursing) is the physical separation of a patient with an identified or suspected transmissible infection (alert organism/condition) into a single side room.

### **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 source isolation of patients with suspected or known communicable infections are covered in core duties 1, 2f, 3, 4a, 4d, 5, 6, 8, 10 and 11.**

#### **4.2. Consultation and Communication with Stakeholders**

The Infection Prevention and Control Committee, 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.

### **5. ASSESSING THE NEED FOR ISOLATION**

A requirement for isolation may be suggested by a clinical presentation (e.g. presence of an “alert condition” such as diarrhoea/vomiting with unknown cause) or a microbiological result (e.g. isolation of an “alert organism” such as MRSA).

- The need to isolate is based on whether the patient has a suspected or diagnosed alert organism or condition (refer to the new LTHT alert organism/condition policy).

The following list identifies some of the common alert organisms/conditions that should be isolated;

- Diarrhoea - if of unknown origin until organism known or reason for diarrhoea identified.
- Symptomatic CDI ie diarrhoea. Type 5 - 7 according to the Bristol Stool chart. Once completely free of symptoms for 48 hours, the patient can be cared for out of single room.
- Suspected norovirus – patient must be vomiting or having diarrhoea and the cause is as yet unknown. Inform the IPCT
- Patients who have *any* previous history of a MRSA colonisation or infection
- Patients who have been hospitalised in the last 6 months, resident in a nursing home or similar long term facility or direct transfer from another hospital.

For a comprehensive list of alert organisms/conditions that should be isolated please refer to LTHT Alert organism/conditions policy.

Patients identified as MRSA positive following an MRSA screen, who have received decolonisation, do **NOT** need to be isolated unless other potentially colonised sites have been screened ( e.g. IV access points, catheters)

### 5.1 Isolation Required

- When a requirement for isolation is identified the time at which this decision is made should be recorded in the nursing notes.
- Isolation should occur within two hours of the clinical area deciding there is a need to isolate.
- If this is not achieved there must be escalation to the matron for the clinical area (in hours), clinical site manager (out of hours), to ensure appropriate placement.
- If the matron is unable to find sideroom accommodation, this must be escalated to the Directorate Manager in hours or on call manager out of hours.
- If isolation is not possible, the matron will contact the IPCT (in hours) and the clinical site manager will contact the on call microbiologist (out of hours), with the required patient information (appendix B), for a risk assessment.
- The date and time of isolation must be recorded in the nursing notes.
- The continuing requirement for isolation must be re-assessed at a minimum daily and documented in the nursing notes, in consultation with the IPCT if necessary.
- The matron for the clinical area must record all failures to isolate daily and report to the directorate manager. Out of hours the clinical site managers will include all failures to isolate in the clinical site managers daily out of hours report which is sent to the matron for that area.

Specific alert organisms/conditions are discussed in various IPC policies: are available for the following:

<b>IPCT Policy</b>	<b>Policy No.</b>
Viral Gastroenteritis	7
<i>Clostridium difficile</i>	8
Infection control management of tuberculosis	12
Transmissible spongiform encephalopathies	13
Meningococcal infection	18
<i>Staphyococcus aureus</i> and MRSA	15
Multi-drug resistant organisms	
VZV	24
Respiratory viruses	25
Scabies	26
Group A <i>Streptococcus</i>	

On confirmation of the alert organism MRSA or C difficile commence the appropriate care plan

## **6. PREPARATION OF THE ISOLATION ROOM**

- All unnecessary equipment and furniture must be removed from the room to facilitate cleaning and limit the potential for contamination.
- All equipment in the room must be dedicated to the isolated patient.
- The room must not be overstocked as equipment that cannot be cleaned will need to be disposed of.
- All personal belongings and equipment must be washable, cleanable or disposable.
- The patient should not keep unnecessary belongings in the room.
- The source isolation poster must be placed on the door (see appendix C).
- Single use gloves and aprons must be set up outside the room. If these are not wall mounted a trolley/table/shelf must be used. This must be well stocked at all times.
- The trolley should contain alcohol hand rub unless proven or suspected *C. difficile* infection, in which case there should be no alcohol rub at this location or outside the room.
- Patient notes (charts and kardex) must be kept outside the room to reduce the risk of contamination.
- The hand wash basin must be stocked with liquid soap, and paper towels always available.

- A sharps bin and tray must be kept in the isolation room. An individual risk assessment must occur to prevent harm to patient and visitors.
- An orange or yellow plastic bag (for clinical waste) and a water soluble alginate bag (for infected linen) must be available in the isolation room.

## **7. PATIENT CARE IN SOURCE ISOLATION**

- Standard Infection Prevention Precautions must be used at all times (please see LTH Standard Infection Prevention Precautions policy).

### **7.1. Hand hygiene - staff**

- **Inside the isolation room *all* hand decontamination must be with liquid soap and water.**
- Hand decontamination is required in the following circumstances:
  1. Immediately before putting on gloves and apron to enter the isolation room;( alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for source isolation is *C. difficile*)
  2. Immediately after removing gloves and apron;
  3. Immediately before donning gloves and apron if these are replaced whilst in the room (e.g. following a procedure);
  4. Immediately before leaving the room;
  5. Immediately after leaving the room(alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for source isolation is *C. difficile*)

### **7.2. Hand hygiene – patient**

- The patient is a potential source of spread of organisms to staff, visitors and the environment. He/she should be instructed to decontaminate hands before eating and after going to the toilet. Liquid soap and water should be used in these circumstances.

### **7.3. Hand hygiene – visitors**

- See VISITORS, below.

### **7.4. Personal protective equipment (PPE)**

- Single use gloves and apron must be worn on entering the source isolation room and at all times whilst in the room.
- When the reason for source isolation is tuberculosis, the use of masks is indicated in certain circumstances, as indicated in the Tuberculosis Policy.

- If a procedure is carried out that requires close physical contact with the patient or is/her immediate environment (e.g. bed bathing, moving patient, changing a dressing, cleaning up a biological spill etc.) the gloves and apron should be removed, hands decontaminated, and then gloves and apron replaced
- Gloves and apron should be discarded in the clinical waste bag inside the isolation room (apron first, then gloves).
- If blood/body fluid sprays or splashes are likely there may be an indication to use additional PPE (e.g. safety spectacles, goggles, masks and visors). Refer to Standard Infection Prevention Precautions policy or consult the IPCT for further advice.

### **7.5. Disposal of body fluids, waste and linen**

- Dispose of all excreta promptly, preferably into the patient's own toilet. If the sideroom does not have an en-suite place waste into the orange clinical waste bag in the isolation room. To prevent spills and splashes use absorbent loose powder or soluble sachets to gel bodily fluids as required.
- Ensure thorough and frequent cleaning of the commode/toilet using Chlorclean solution of 1000ppm.
- Deal with any blood/body fluid spillage immediately, wearing appropriate protective clothing and disinfecting the spillage with 10,000 ppm chlorine releasing solution. (using the Biohazard Spill Kit)
- Place waste contaminated with blood/body fluids directly into the orange clinical waste bag in the isolation room. As soon as these bags are 2/3 full the bags must be tied in a swan neck and a tag attached indicating place of origin. The bags must be removed from the room to the waste storage area and a new orange clinical waste bag placed in the isolation room.
- All linen within the isolation room must be placed into water soluble alginate bags. This includes unused linen when the room is no longer required for isolation purposes. The alginate bags must then be placed into the red plastic laundry bags.
- Double bagging of clinical waste and linen is unnecessary; as studies have shown that the outer surface of the bags does not become significantly contaminated.
- Place all disposable sharps in the sharps bin in the sideroom immediately after use.

### **7.6. Crockery/cutlery**

- All crockery/cutlery must be decontaminated in a dishwasher with a final rinse temperature of 80°C.
- Washing by hand is inadequate.
- There is no requirement for disposable crockery and cutlery to be used.

### **7.7. Bathing**

- To reduce the risk of cross-infection, patients with infections must be bathed last.
- The bath should be cleaned with Chlorclean (1,000 ppm) after use by the isolated patient (this method of disinfection is adequate for use after bathing infected patients).
- If showers are used the procedure is as for baths.

### **7.8. Dressings**

- Wounds should be dressed in the isolation room using aseptic technique.

### **7.9. Cleaning**

- Follow the Source Isolation Cleaning Guidelines using Chlor-clean. This should be used as a minimum once a day throughout the room, including the bed, bed space, fixtures and fittings and on all patient care equipment.
- The nurse in charge must inform the locality supervisor of the need for isolation cleaning.
- The vacated bed, bed frame and mattress must be thoroughly cleaned with Chlor-clean before it can be reoccupied (See Terminal Cleaning Protocol).
- Isolation rooms should be cleaned last; after other rooms, bays and general areas on the ward
- Single use gloves and yellow aprons must be worn when cleaning isolation rooms, and hands washed before leaving the room.
- Special attention must be given to all horizontal surfaces and frequently touched surfaces, such as door handles/door push plates, nurse call system, toilet areas and sink taps.
- Following discharge or transfer of the patient from the isolation room, the room must be thoroughly cleaned (see Terminal Cleaning Protocol). Curtains and walls need only be washed if visibly soiled.

### **7.10. Investigations/visits to other departments**

- Ideally, investigations should be performed in the isolation room.
- If visits to other departments/wards are unavoidable, the receiving department must be contacted to ensure that adequate precautions are taken. If there are any problems the IPCT should be contacted.
- In principle the patient from the isolation room should be seen last in the visiting department; and if waiting occurs in that department, the patient in isolation needs to be physically separated in another room to minimise contact with other patients.

### **7.11. Transfer to other wards/healthcare institutions**

- These should only take place if unavoidable, and should be discussed with the IPCT first.
- The Infection Control Transfer Form should be completed for all patients( see Patient Transfer policy Appendix A)
- The receiving ward must be informed so that a room for isolation can be arranged.
- The IPCT will inform the relevant Infection Prevention Nurse about the transfer to other institutions
- The patient's health should take priority over the infection problem and will require medical clarification; e.g. if the patient is required to be transferred to ITU or CCU.

### **7.12. In the case of death**

- In order to protect the mortuary staff; the LTHT policy for handling deceased patients with known infection must be followed.

## **8. VISITORS**

- Explain the reason for isolation, maintaining confidentiality where appropriate. If available, give information leaflet on specific infection.
- Visitors should be advised to wash their hands with liquid soap and water in the following circumstances:
  - Hands are visibly soiled;
  - Following close physical contact with the patient or his/her immediate environment.
  - In addition, visitors should be advised to clean their hands with liquid soap and water after removing gloves and apron (if worn, see below) and immediately before entering and leaving the isolation room(alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for source isolation is *C. difficile*)
- Visitors should be advised not to have contact with other patients on the ward.
- Disposable gloves and apron should be worn by visitors only if they are going to have close contact with the patient (e.g. helping with patient's physical care). The IPCT may advise on other situations when this is necessary. The visitor should be advised on appropriate disposal of PPE (see above).
- For some infections it may be necessary to exclude visitors from isolated patients, due to disease susceptibility. Advice should be sought from the IPCT and/or the specific disease policy.

## **9. REMOVING A PATIENT FROM SOURCE ISOLATION**

- A patient should be removed from isolation when he/she is no longer at risk of spreading infection to others (refer to the new LTHT alert organism/condition policy). This may be decided following consultation with a member of the IPCT or on the basis of an IPCT policy (e.g. after 48 hours symptom free following gastroenteritis or *C. difficile* infection).
- At a minimum daily assessment and evaluation of the patient's symptoms are therefore important.
- Some specific disease policies give criteria on when isolation precautions can be stopped.
- If in doubt, discuss with the IPCT.
- The vacated room must be cleaned thoroughly (see Terminal Cleaning Protocol) using the same solutions and equipment that have been used for isolation cleaning. All equipment and belongings must be cleaned before being brought out of the room or used again. Any unused disposable items, which may be contaminated and cannot be cleaned, must be disposed of.

## **10. RESPONSIBILITY FOR DOCUMENT DEVELOPMENT**

### **Lead Director**

Ruth Holt

### **Steering Group**

Martin Parkinson

Gillian Hodgson

Richard Hobson

IPC team

## **11. 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.

## **12. 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.

## **13. CONSULTATION PROCESS**

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

#### **14. APPROVAL AND RATIFICATION**

This policy will be approved by the Senior Management Team.

#### **15. PROCESS FOR REVIEW/REVISION**

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.

#### **16. COMMUNICATION/DISSEMINATION**

**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-Bulletin.

#### **17. IMPLEMENTATION**

This policy will be implemented immediately following dissemination.

#### **18. MONITORING COMPLIANCE/EFFECTIVENESS**

Any time a patient cannot be isolated appropriately the clinical team must document and record such incidences. These should then be escalated and communicated to the appropriate line manager, bed placement team and the IPCT.

Records of non-availability of single side room incidences and a record of hand hygiene compliance for that clinical area should be monitored by the Divisions and reported to the IPCC via the Divisional IPCC Group.

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## **20. GLOSSARY OF TERMS**

### **Host**

A living organism (in this case man) which another organism can live and be sustained on or within.

**IPCT** Infection Prevention and Control Team.

### **Carriage / or carrier**

Can be defined as a person that harbours a specific disease in the absence of signs and symptoms of infection and is therefore potentially infectious to others. The carrier state may exist in the individual as unknown (healthy, asymptomatic carrier) or during a period of convalescence. In either case the carrier state may be of a short duration (transient carrier) or long term duration (chronic carrier)

### **Cleanable**

The ability to be cleaned easily or without damage.

**Colonisation**

The presence of a micro-organism at a body site on or in a patient, not causing infection.

**Disposable**

Designed to be discarded after single use.

**Infection**

Symptoms and signs caused by pathogenic (harmful) micro-organisms. These would include local evidence of inflammation (e.g. pain, redness, tenderness, swelling, heat), systemic effects (e.g. fever, hypotension and shock) and presence of raised inflammatory markers (e.g. white blood cell count and C-reactive protein, CRP).

**Washable**

Capable of being washed without shrinking, fading or the like

Alert Organisms and Conditions

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 (DoH 1995)

## 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><b>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*</b></p> <p><b>Please put NA if this is not applicable</b></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**

### **Information required before contacting IPC for source isolation risk assessment**

The information that needs to be available when assessing the risk of transmission of infection (cross-infection) includes:

- Symptoms of clinical infection eg purulent discharge, diarrhoea and/or vomiting and coughing/expectorating patient.
- The site or specimen from which the infection has been isolated (e.g. wound swab, sputum etc).
- The environment in which the patient is being managed (i.e. the susceptibility of other patients to the infection)
- The organism that is causing the infection (if known)
- The behaviour of the patient (e.g. tendency to wander, disruptiveness, mobility etc.)
- Psychological and other medical factors (e.g. presence of depression/anxiety, need for observation etc.)
- Existence of failure to isolate resulting in patients with infections being nursed in open bays.
- Clinical requirements e.g. speciality specific treatment/care

## **SOURCE ISOLATION**

- **Do not enter this room unless it is necessary**
- **Contact the Nurse in Charge before entering this room**
- **The door of this room should be kept closed**
- **Disposable gloves and apron must be put on before entry, worn at all times in this room and removed and discarded immediately before exit.**

### **Hand hygiene precautions**

- **Hands must be decontaminated with alcohol gel or washed with liquid soap and water before entering and after leaving this room.**
- **Hands must be washed with liquid soap and water if gloves and apron are replaced whilst in the room (e.g. following a procedure).**
- **Hands must be washed with liquid soap and water following removal of apron and gloves and before leaving the room**

## LTHT

### MRSA RISK ASSESSMENT TOOL

To be used in conjunction with LTHT MRSA Pathway, Acute Admissions (April 2009)

1

LOW  
RISK

- Admitted from home
- No hospital admission within the previous 6 months
- No history of MRSA colonisation or infection

2

HIGH  
RISK

- Any previous history of MRSA colonisation or infection
- Resident in nursing home or similar long term care facility
- Direct transfer from another hospital
- History of hospitalisation within the 6 months

Risk assessment must be completed on admission and documented in nursing notes

**Risk Score 1** - No action required

**Risk Score 2** - Commence MRSA decolonisation with topical body/hair wash and nasal cream as prescribed.  
Manage according to Source Isolation policy in single room or cohort accommodation as available.  
Instigate local escalation procedure if not possible.

Time of decision to isolate should be recorded in nursing notes

Isolation should occur within 2 hours if not escalation to matron (in hours) or clinical site manager (out of hours).

The continuing requirement for isolation must be re-assessed at a minimum daily and documented in nursing notes.  
Discuss with IPCT if necessary

Appendix E

**COHORT SOURCE ISOLATION**

- **Do not enter this area/room unless it is necessary**
- **Contact the Nurse in Charge before entering this area/room**
- **The door of this area/room should be kept *closed***
- **Disposable gloves and apron must be put on by all staff before entry, changed between patients, worn *at all times* in this room and removed and discarded immediately before exit.**

**Hand hygiene precautions - staff**

**In cohort source isolation *all* hand decontamination within the room/area must be with liquid soap and water.**

6. Hands must be decontaminated Immediately before putting on gloves and apron to enter the isolation room;( alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for cohort source isolation is *C. difficile or viral gastroenteritis*)
7. Hands must be washed with soap and water immediately after removing gloves and apron (e.g. following a procedure or any contact with a patient or their immediate environment);
8. Hands must be washed immediately before donning gloves and apron if these are replaced whilst in the room (e.g. following a procedure, between patients);
9. Hands must be washed immediately before leaving the room;
10. Hands must be decontaminated immediately after leaving the room(alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for cohort source isolation is *C. difficile or viral gastroenteritis*)

## Appendix F

### COHORT SOURCE ISOLATION CLINICAL PRACTICE

#### Key Points

- The source isolation Poster must be displayed on the cohort area door **at all times**.
- The source isolation cohort area door must be closed at all times apart from necessary entrances.
- Single use gloves and aprons must be set up outside the cohort area. If these are not wall mounted a trolley/table/shelf must be used. This must be well stocked at all times.
- A sharps bin and tray must be kept in the cohort area. An individual risk assessment must occur to prevent harm to patient and visitors.
- Single use gloves and apron must be worn by all **staff** on entering the source isolation cohort area and at all times whilst in the room. These items must be removed and disposed of before exiting the room.
- Dispose of all excreta promptly, preferably into the patient's own toilet. If the cohort area does not have access to designated toilet facilities, place waste into the orange clinical waste bag in the isolation room. To prevent spills and splashes use absorbent loose powder or soluble sachets to gel bodily fluids as required.

#### Hand hygiene - staff

- **In source isolation all hand decontamination within the room/area must be with liquid soap and water.**
- Hand decontamination is required in the following circumstances:
  10. Immediately before putting on gloves and apron to enter the isolation room;( alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for cohort source isolation is *C. difficile* or *viral gastroenteritis*)
  11. Immediately after removing gloves and apron (e.g. following a procedure or any contact with a patient or their immediate environment);
  12. Immediately before donning gloves and apron if these are replaced whilst in the room (e.g. following a procedure, between patients);
  13. Immediately before leaving the room;
  14. Immediately after leaving the room(alcohol rub may be used as an alternative for hand decontamination in this instance unless the reason for cohort source isolation is *C. difficile* or *viral gastroenteritis*)

## APPENDIX G - 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
<b>1.</b>	<b>Title</b>		
	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	
<b>2.</b>	<b>Rationale</b>		
	Are reasons for development of the document stated?	Y	
<b>3.</b>	<b>Development Process</b>		
	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	
<b>4.</b>	<b>Content</b>		
	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	
<b>5.</b>	<b>Evidence Base</b>		
	Is the type of evidence to support the	Y	

	<b>Title of document being reviewed:</b>	<b>Yes/No/Unsure</b>	<b>Comments</b>
	document identified explicitly?		
	Are key references cited?	Y	
	Are the references cited in full?	Y	
	Are supporting documents referenced?	Y	
<b>6.</b>	<b>Approval</b>		
	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	
<b>7.</b>	<b>Dissemination and Implementation</b>		
	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	
<b>8.</b>	<b>Document Control</b>		
	Does the document identify where it will be held?	Y	
	Have archiving arrangements for superseded documents been addressed?	N/A	
<b>9.</b>	<b>Process to Monitor Compliance and Effectiveness</b>		
	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	
<b>10</b>	<b>Review Date</b>		

	Title of document being reviewed:	Yes/No/ Unsure	Comments
.			
	Is the review date identified?	Y	
	Is the frequency of review identified? If so is it acceptable?	Y	
<b>11</b>	<b>Overall Responsibility for the Document</b>		
.	Is it clear who will be responsible for co-ordinating the dissemination, implementation and review of the document?	Y	

<b>Individual Approval</b>			
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			
<b>Committee Approval</b>			
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			