York Teaching Hospital NHS
NHS Foundation Trust

Infection Prevention Policy
Isolation Procedures

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Target audience:	All Trust Staff
Relevant Regulations and Standards	Health and Social Care Act 2008
Links to Organisational/Service Objectives, business plans or strategies	HCAI Reduction Strategy

Executive Summary
This policy describes and outlines the isolation procedures required when infection is suspected or proven and there is a risk of spread to other patients.

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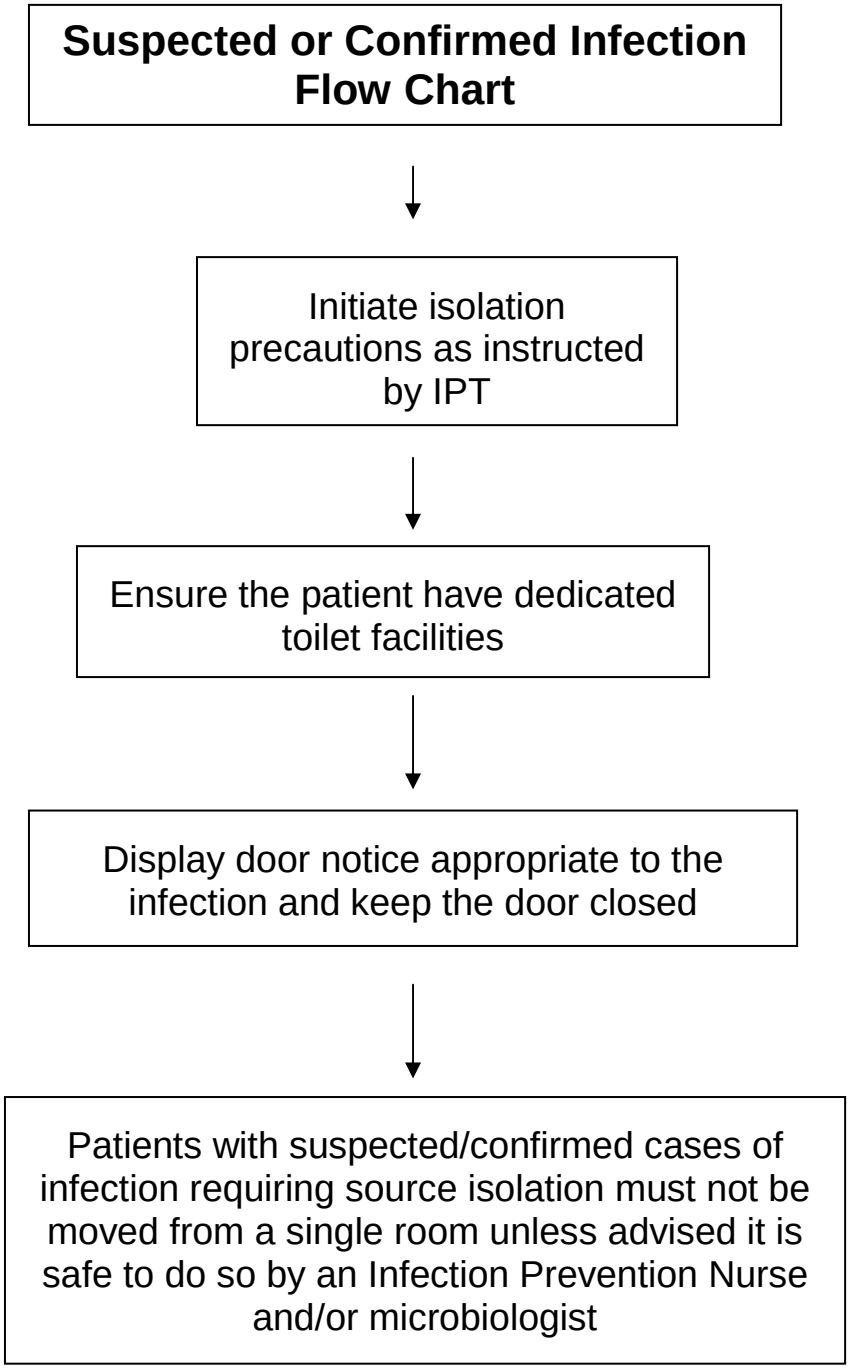
Version History Log

This area should detail the version history for this document. It should detail the key elements of the changes to the versions.

Version	Date Approved	Version Author	Status & location	Details of significant changes
1	February 2008	Infection Control Team	York Hospital	
2	November 2009	Infection Prevention Team	York Hospital	To reflect Hygiene Code Criterion 6 requirements and to cross reference with new and revised Infection Prevention Policies
3		Annette Williams	Infection Prevention Nurse, York Hospital	To use new policy format Revised content
4	November 2013	Linda Horton-Fawkes	Senior Infection Prevention Nurse	Update of content
5	January 2014	Linda Horton-Fawkes	Senior Infection Prevention Nurse	Update of content

Contents

Process flowchart for source isolation



Upon discharge to another health care facility the nurse in charge of the patient's care must complete an Inter-Healthcare Transfer Form which will inform the receiving health care provider of the patient's infection status and precautions required.

1 Introduction & Scope

This policy outlines the management of patients with both confirmed or suspected infection, and the infection control measures needed to minimise the spread of these organisms.

2 Definitions / Terms used in policy

Colonisation is the presence of micro-organisms without tissue invasion.
Infection is the presence of micro-organisms causing a host response such as elevated temperature.
Source Isolation aims to confine the infectious agent and prevent its spread
Protective Isolation aims to protect an immunocompromised patient who is at special risk from environmental organisms or those carried by attending staff and visitors
Transmission Based Precautions - a set of measures that should be implemented when patients are either suspected or known to be infected with a specific infectious agent. (see Appendix C)
Enhanced Precautions – higher level isolation precautions than standard, which include disinfection of the environment and reusable equipment to be deployed for example undiagnosed diarrhoea (see 'Enhanced' door notice) and **may** include use of respirators, full length splash proof gowns visors/goggles etc.

3 Policy Statement

Isolation procedures are required when infection is suspected or proven and there is a risk of spread to other patients, or where there is colonisation with a potentially infectious agent e.g. Meticillin Resistant Staphylococcus Aureus (MRSA)

Isolation procedures are also required to protect the immunocompromised that are at risk from environmental organisms and those carried by staff and visitors.

Appendix C provides an A-Z of infectious conditions that require specific precautions and/or isolation.

4 Equality Analysis

In the development of this policy the Trust has considered evidence to ensure understanding of the actual / potential effects of our decisions on people covered by the equality duty. A copy of the analysis is attached at Appendix 4.

5 Accountability

Operational implementation, delivery and monitoring of the policy resides with:-

All healthcare professionals and volunteers are responsible and accountable to the Chief Executive for the correct implementation of this policy.

Professional staff are accountable according to their professional code of conduct. Medical staff are professionally accountable through the General Medical Council, and nurses are professionally accountable to the Nursing and Midwifery Council.

6 Consultation, Assurance and Approval Process

6.1 Consultation Process

The Trust will involve stakeholders and service users in the development of its policies.

Consultation has taken place with the following stakeholders:

The Stakeholder is the Hospital Infection Prevention and Control Group which has an all encompassing membership.

6.2 Quality Assurance Process

Following consultation with stakeholders and relevant consultative committees, this policy has been through quality assurance checks prior to being reviewed by the authorising committee to ensure it meets the NHSLA standards for the production of policy and equalities legislation and is compliant with the Development and Management of Policies policy.

6.3 Approval Process

The approval process for this policy complies with that detailed in section 6.3 of the Development and Management of Policies Policy. The approving body for this policy is the Hospital Infection Prevention and Control Group.

The Checklist for Review and Approval has been completed and is included as Appendix 5 and the completed Virtual Policy Review Group Checklist is included as Appendix 7.

7 Review and Revision Arrangements

On reviewing this policy, all stakeholders identified in section 6.1 will be consulted. The persons responsible for review are the Hospital Infection Prevention Committee

Subsequent changes to this policy will be detailed on the version control sheet at the front of the policy and a new version number will be applied.

Subsequent reviews of this policy will continue to require the approval of the Hospital Infection Prevention Committee

8 Dissemination and Implementation

8.1 Dissemination

Once approved, this policy will be brought to the attention of all relevant staff working at and for York Hospital NHS Foundation

Trust following the completed Plan for dissemination of the policy (See Appendix 6)

This policy is available in alternative formats, such as Braille or large font, on request to the author of the policy.

8.2 Implementation of Policies

This policy will be implemented throughout the Trust by the Consultants; Clinical Directors; Directorate Manager; Matrons; and Ward Managers via statutory and mandatory training, clinical support visits, practice audits, email and Directorate/Division specific meetings.

In addition to this the following evidence is available to demonstrate compliance with this policy:-

- Agendas, minutes and papers for the Hospital Infection Prevention and Control Group
- Also see evidence annotated in section 10.1

9 Document Control including Archiving Arrangements

9.1 Register/Library of Policies

This policy will be stored on Staffroom, in the policies and procedures section and will be stored both in an alphabetical list as well as being accessible through the portal's search facility and by group. The register of policies will be maintained by the Healthcare Governance Directorate.

If members of staff want to print off a copy of a policy they should always do this using the version obtainable from Staffroom but must be aware that these are only valid on the day of printing and they must refer to the intranet for the latest version. Hard copies must not be stored for local use as this undermines the effectiveness of an intranet based system.

9.2 Archiving Arrangements

On review of this policy, archived copies of previous versions will be automatically held on the version history section of each policy document on Q-Pulse. The Healthcare Governance Directorate will retain archived copies of previous versions made available to them. Policy Authors are requested to ensure that the Policy Manager has copies of all previous versions of the document.

It is the responsibility of the Healthcare Governance Directorate to ensure that version history is maintained on Staffroom and Q-Pulse.

9.3 Process for Retrieving Archived Policies

To retrieve a former version of this policy from Q-Pulse, the Healthcare Governance Directorate should be contacted.

10 Monitoring Compliance and Effectiveness

This policy will be monitored for compliance with the minimum requirements outlined below.

10.1 Process for Monitoring Compliance and Effectiveness

In order to fully monitor compliance with this policy and to ensure that the minimum requirements of the NHSLA Risk Management Standards for Acute Trusts are met, the policy will be monitored as follows:-

Minimum requirement to be monitored	Process for monitoring	Responsible Individual / committee/ group	Frequency of monitoring	Responsible individual / committee/ group for review of results	Responsible individual / committee/ group for developing an action plan	Responsible individual / committee/ group for monitoring of action plan
a. Hand Hygiene	Hand hygiene audits	ward/ department staff	Monthly	Wards access via q-drive. Matrons/Ward Managers to review	Matrons/Ward Managers to review IPC Team	Matrons/Ward Managers to review IPC Team
b. Decontamination Equipment	Environment Audits	Matrons/ clinical leads	Monthly	As above	As above	As above
c. Decontamination Environment	Matrons and domestic audits	Matrons/ Domestics	According to risk category for each ward / department	Matrons/Domestic Supervisors	Matrons/Domestic Supervisors	Matrons/Domestic Supervisors
d. Isolation	IPT documentation records. CPD whiteboard records.	IPC Nurses/Bed Managers & ward staff	For individual patient cases	IPC Nurses/Bed Managers & ward staff	IPC Nurses/Bed Managers & ward staff	IPC Nurses/Bed Managers & ward staff
e. Data	CPD data, laboratory database surveillance by IPT	Audit and Surveillance nurse	Monthly	IPT	IPT	IPT

Minimum requirement to be monitored	Process for monitoring	Responsible Individual / committee/ group	Frequency of monitoring	Responsible individual / committee/ group for review of results	Responsible individual / committee/ group for developing an action plan	Responsible individual / committee/ group for monitoring of action plan
f. Attendance at statutory and mandatory training	CLAD attendance records/registers by CLAD and Directorate/Divisional lead managers	CLAD reports to IPT	Quarterly	Managers/Heads of Dept	Managers/Heads of Dept/IPT	Managers/Heads of Dept/IPT

10.2 Standards/Key Performance Indicators

Infection Prevention performance data

Decontamination of equipment guidelines

CLAD statutory and mandatory training/attendance records

Hand Hygiene compliance data

11 Training

Any training requirements identified within this policy that are of a 'Corporate Statutory or Mandatory nature will be outlined in the Statutory/Mandatory Training Brochure. This can be accessed via the link on Staff Room, the Q:\York Hospital Trust\Mandatory Training or the organisation's online learning platform.

If this training is deemed to be Statutory or Mandatory and is not identified within the Statutory/Mandatory Training Brochure then application must be made by the Policy Author to the Corporate Learning and Development Team to have it added.

These training requirements are used to develop the customised profiles that can be viewed by learners when they access their personal online learning account. It is then the learner's responsibility to undertake this learning with the support of their line manager and the line manager's responsibility to review this at annual KSF appraisal.

The Corporate Statutory and Mandatory Training Identification Policy and Procedure document describes the processes relating to the identification, review, delivery and monitoring of statutory and mandatory training including non-attendance.

12 Trust Associated Documentation

YHFT [CORP.RL10] Policy for the Development and Management of Policies

YHFT [CLIN.IC19] Infection Prevention Guidelines for the Decontamination of Reusable Communal Devices and the Environment

YHFT [CLIN.IC12] Infection Prevention Guidelines for Effective Hand Hygiene

YHFT [CLIN.IC6] Infection Control Standard Precautions Guidelines
YHFT [CLIN.IC9] Laundry Management Guidelines
Control & Management of *Clostridium Difficile Infection* (CDI)
Control and Prevention of Extended Spectrum Beta Lactamase (ESBL)
Pulmonary Tuberculosis Guidelines
Viral Haemorrhagic Fever (VHF) Guidelines

13 External References

Health Protection Agency guidelines:
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/ESBLs/GeneralInformation/#How_can_the_spread_be_controlled

14 Appendices

Appendix 1: Source Isolation
Appendix 2: Escalation Procedure for Inability to Isolate
Appendix 3: Transmission Based Precautions
Appendix 4: Equality Analysis
Appendix 5: Checklist for Review and Approval
Appendix 6: Implementation Plan
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Appendix 1 – Source Isolation

Isolation and preparation of the room

Isolation whenever possible should be carried out in single rooms. Exceptions may arise when patients are too ill, or unsafe to be isolated. These cases must be discussed with the relevant clinician and the Infection Prevention Team (IPT).

Hydrogen peroxide vapour (HPV) disinfection is required for side rooms where patients with CDI have been cared for before occupied by another patient. This may also be required for bays/wards – IPT will advise.

The appropriate door notice must be displayed outlining the precautions specific to the infection being isolated.

The single room should have its own toilet and adequate hand hygiene facilities (liquid soap and disinfectant gel). Where personal toilets are not available the patient should be designated their own commode/bedpan if appropriate.

Consumables must be kept to a minimum as items that cannot be cleaned must be disposed of after patient discharge.

The door should be kept closed unless there is a greater risk to the patient e.g. falls, please discuss with IPT and record outcome in patients notes.

The following must be available and located **outside** the room:

- Disinfectant hand gel (this must also be available at the point of care inside the room).
- Personal Protective Equipment (PPE)

- Drug charts, observation charts, care plans, etc.

Cohort isolation

Cohort bays or wards may need to be established when single room isolation is not possible and significant numbers of the same infection occur simultaneously. This will be decided by the IPT in consultation with relevant clinicians, operational staff and patient flow team, if an outbreak has occurred or is suspected this will be declared by the IPT. Cohorted patients should be cared for by designated staff assigned to care for these patients only.

Transfer of isolated patients within and between hospitals

Any transfers of isolated/infected patients **must** be discussed with the IPT and Infection Prevention Consultant prior to moving the patient. Each transfer will be considered case by case and advice given accordingly. The receiving department must be advised by the transferring ward staff of the details of the infection and of any special precautions that may be required. Portering staff must be advised of any special requirements prior to transfer.

When transferring isolated patients to other hospitals or health care facilities their infection status must be documented on the Inter-Healthcare Transfer Form and ambulance control must be notified if enhanced precautions are required.

When isolation precautions are no longer required

Before another patient is allocated the room/space:

- The room or cohort facility must be thoroughly cleaned/disinfected as advised by IPT
- Disposable equipment **must** be disposed of.
- Items that cannot be effectively cleaned/ decontaminated must be disposed of and replaced.

Decision to remove a patient from isolation

The decision to remove patients from isolation contrary to existing advice or parameters, or to transfer them elsewhere **must not be made** without prior consultation with the IPT and/or the relevant clinician. Out of hours discussion must be held with the on-call infection prevention nurse (IPN) or Clinical Microbiologist via the hospital switchboard.

- Infection Prevention measures must remain in place until the IPT advise otherwise.
- The reason for the decision to move a patient from isolation must be documented in the patient's notes.

Appendix 2 – Escalation Procedure for Inability to Isolate

On occasions it may not be possible to place all patients who require isolation in a side room. Inability to isolate will require escalation to senior staff.

The Infection Prevention Team in collaboration with the Consultant Microbiologist is responsible for the clinical decision on which patient(s) should be isolated or cohorted in order to control the spread of infection.

In order to make this decision the Infection Prevention Team & Microbiologist will require the following information:

- The infection status of each patient currently in single rooms
- A description of the physical layout of the wards including;
    - number of beds
    - number and type of bays
    - number and location of side rooms
    - whether any parts of the ward is part of a corridor for through traffic
    - symptoms of clinical infection e.g. 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 and when specimen was taken)
    - 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.)
    - current/recent incidences of ‘’inability to isolate’’ resulting in patients with infections being nursed in open bays
    - clinical requirements (e.g. speciality specific treatment/care or clinical reasons why isolation might compromise patient safety)

It will not be possible for the Infection Prevention Team/Microbiologist to make a decision on isolation if this information is not available.

If still unable to isolate an infected patient

Ward staff must alert the Bed Managers, Matron and IPT during office hours and complete an AIR's form if unable to isolate a patient.

If a patient has diarrhoea and there is no clear non infective cause i.e. condition, medication e.g. laxatives, procedure related, isolation must take place within 2 hours. If this is not possible the shift coordinator must complete an AIR's form in conjunction with following the escalation procedure.

In office hours contact Infection Prevention Team for advice on how to ensure patient safety by risk assessing cases that cannot be isolated.

Out of hours the Bed Managers will liaise with the Infection Prevention Team on how to ensure patient safety by risk assessing cases that cannot be isolated.

(The above guidance is applicable for all cases of infection that require isolation)

During extreme circumstances (defined below), a decision may need to be taken to use beds on closed wards. This must be done through detailed risk assessment involving Infection Prevention (IP), Consultant Microbiologist, Director on call and Bed Managers (and by the day Clinical Director CD). The assessment must be documented by all involved parties to ensure evidence, assurance and mitigation.

The decisions must be made pre-emptively in order to plan effectively and reduce the risk to patients i.e. within office hours when all pertinent parties are available to consider all options.

Patients being admitted to closed areas must be fully advised of the situation and associated risks and this must be documented in the patient's notes.

Patients admitted to the closed ward must be cohorted separately from affected patients.

Staffing must be sufficient and allocated separately to affected and non affected bays and side rooms

Extreme Circumstances:

- **Minus significant number of beds such that safety is compromised by delays in warding from pressures in ED or other areas**
- **Cancellation of high risk elective admissions posing a risk to patients (to be agreed by CD)**
- **Majax**

*** Negative Pressure Ventilation**

York Hospital does not have this facility, patients will need to be transferred to the nearest available hospital i.e. Leeds, Newcastle. IPT and the Infection Prevention Consultant **must** always be made aware of such cases who will advise on interim management until a transfer can be made.

Appendix 3 - Transmission Based Precautions

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Isolation	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Abscess (aetiology unknown)	Direct contact	Standard	While abscess is draining	No	No	No	
Adenovirus infection (respiratory disease in infants and young children)	Respiratory droplets, direct contact	Respiratory, masks not required	While symptomatic	Yes	Yes	No	In epidemics cohort nursing may be necessary.
Amoebic dysentery	Faecal-oral route person to person	Enhanced	While excreting cysts	Yes	Yes	Yes	
Anthrax cutaneous pulmonary	Direct contact with spores in soil, contaminated animal, airborne inhalation of spores	Standard	As agreed by microbiology consultant & physician in charge of care	No	Yes	Yes	There is no evidence of person to person spread except in rare cases of pulmonary anthrax.
Botulism	Ingestion of toxins, contamination of wound by spores in soil	Standard	N/A	No	No	Yes	
Bronchiolitis (infants and young children)	Respiratory, secretions	Respiratory, masks not required	While symptomatic	Yes, may cohort with other confirmed cases	Yes	No	Usually caused by respiratory syncytial virus (RSV). Discourage visits by babies < 1 year old.

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Isolation	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Campylobacter	Faecal-oral route contaminated foods	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	Person to person spread rare. Notifiable as suspected food poisoning.
Chickenpox (Varicella)	Respiratory, direct contact with vesicles	Respiratory, masks not required	Until all lesions have dried	Yes	Yes	No	Exclude non-immune staff. Immunosuppressed patients and staff should avoid contact, if exposed check antibodies. Pregnant contacts should be advised. Monitor all patients on the ward if status unknown, consider quarantine if still inpatient after 14-17 days
Cholera	Faecal-oral route	Enhanced	Until cleared by CCDC	Yes	Yes	Yes	
Clostridium difficile	Faecal-oral route	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes, disinfection of whole ward twice daily, toilets four times a day	No (informal for clusters & outbreaks)	Associated with antibiotic use, stop all unnecessary abx. Hand wash with soap & water at POC. No patient movement until discussed with micro/IPT

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Congenital Rubella	Urine, Respiratory secretions	Respiratory, masks not required	During any admission for first 12 months after birth	Yes	Yes	Yes	Pregnant staff members should be excluded from caring for infected patients during the first trimester.
CJD (Creutzfeldt-Jakob disease)	Unknown	Standard	Duration of admission	No	No	Yes	CNS tissues are infectious; track/destroy instruments after neurosurgery. Contact microbiologist for advice.
Croup	Respiratory secretions	Respiratory, masks not required	While symptomatic	Yes	Yes	No	
Cryptosporidium	Faecal-oral route water borne	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	Informal notification to CCDC.
CMV (Cytomegalovirus)	Urine Respiratory secretions	Standard	Duration of admission	No	No	No	
Diarrhoea	Faecal-oral route person to person	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	No	If suspected food poisoning inform CCDC.
Diphtheria	Pharyngeal secretions, respiratory	Standard and Airborne	Until negative culture results	Yes	Yes	Yes	Contact tracing necessary.

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
E.Coli 0157 or Vero toxin producing (VTEC) E.Coli	Faecal-oral via contaminated food or water	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	Discuss with micro and CCDC
Food Poisoning	Faecal-oral route, person to person	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	Telephone notification to CCDC/HPU.
Gastro-enteritis	Faecal-oral route, person to person airborne (vomit)	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes - informal for out-breaks	Official notification if suspected food poisoning.
Glandular fever	Respiratory secretions	Standard	While symptomatic	No	No	No	
Gonorrhoea	Sexual, direct contact with exudate from lesions	Standard	Until 24 hours effective antimicrobial therapy given	No	No	No	

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Haemophilus Influenzae type B	Respiratory secretions	Respiratory, use surgical masks for general care within 3ft of patient FFP3 for Aerosol Generating procedures (AGP)	Until asymptomatic	Yes	Yes	Yes	Contact tracing.
Hepatitis A (HAV)	Faecal-oral Contaminated food/person to person	Enhanced	Until one week after onset of jaundice	Yes	Yes	Yes	Acute infective hepatitis is notifiable (whatever the virus).
Hepatitis B (HBV)	Parenteral/ Sexual	Standard	See comments	See Comments	See comments	Yes (Acute cases only)	Single room only necessary if there is significant risk of contamination by blood and body fluids e.g. trauma, haematemesis. Sharps injuries must be reported to Occupational Health Dept.
Hepatitis C (HCV)	Parenteral/ Sexual	Standard	Duration of admission	See Comments for Hep B	See comments for Hep B	Yes	

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
(Delta Hepatitis) Hepatitis D	Parenteral/ Sexual	Standard	Until patient is HBsAg negative	See comments for Hep B	See comments for Hep B	Yes	Co-infection or superinfection with Hepatitis B.
Herpes Simplex	Direct contact with saliva secretions	Standard	While lesions are present	No	No	No	Staff with active lesions should avoid contact with newborns, patients with eczema or burns or who are immunosuppressed.
Herpes Zoster (Shingles)	Direct contact with blister fluid	Standard - single room if possible	Until lesions are dry and crusted	Yes	No	No	Much less infectious than Chickenpox but refer to comments on Chickenpox (varicella)
HIV	Vertical, sexual, parenteral	Standard.	See comments	See comments	See comments	No	Single room is only necessary if patient has a concurrent infectious disease or there is a risk of blood contamination e.g. haemorrhages. ***NB Sharps injuries must be reported immediately - post exposure prophylaxis (PEP) may be required***

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Impetigo	Direct contact via skin scales	Standard	Until 24 hours antimicrobial therapy completed	Yes	Yes	No	
Influenza (seasonal)	Respiratory secretions	Respiratory, see comments	Until a-symptomatic	Yes	No	No	In outbreaks cohort patients. See Respiratory Guidelines for mask use
Legionnaires Disease	Inhalation, not person to person	Standard	Duration of admission	No	No	Yes	CCDC/PHE needs to be informed as this requires environmental investigation.
Malaria	Bite of infected mosquito	Standard	Duration of admission	No	No	Yes	If suspected, take blood sample during pyrexial episode to confirm diagnosis.
Meningitis (viral)	See comments	Standard	See comments	See comments	See comments	Yes	Depending upon patient's condition isolation in a single room may be required. Contact the IPT/micro for advice.
Measles	Droplet or direct contact with nasal or throat secretions	Respiratory, masks not required	Until 5 days after onset of rash	Yes	Yes	Yes	Exclude non-immunised staff.

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Meningococcal Disease (Septicaemia or Meningitis)	Droplet or direct contact with respiratory secretions	Respiratory, masks not required	Until 24 hours completed treatment	Yes	Yes	Yes	Prophylaxis to be given to close household contacts.
Meningitis Pneumococcal	Respiratory secretions	Standard	While symptomatic	No	No	Yes	
Meningitis Tuberculosis	Inhalation	Respiratory, FFP3 required only for AGP	Until pulmonary TB excluded	Yes	Yes	Yes	
Methicillin Resistant Staphylococcus aureus (MRSA)	Direct contact	Standard	Until has had a set of negative results as per guidelines	Yes	No	No	
Mumps	Direct contact with respiratory secretions and urine	Respiratory, masks not required	Until 9 days after onset of symptoms	Yes	No	Yes	Exclude non-immunised staff.
Necrotizing fasciitis (Strep A)	Droplet or direct contact	Standard	Until 24 hours after starting appropriate antibiotic therapy	Yes	Yes	No	

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Norovirus	Direct contact with faeces and vomit	Enhanced	Until 72 hours after last symptoms have ceased	Yes	Yes	Yes	Cohort in outbreaks. Stop staff movements and patient transfers.
Rabies	Direct contact with respiratory secretions and other body fluids	Standard	Duration of admission	Yes	Yes	Yes	Attendant staff should be immunised, discuss with micro & CCDC
Respiratory syncytial virus (RSV)	Direct contact with respiratory secretions. Inhalation	Respiratory, masks not required	While symptoms persist	Yes	Yes	No	Cohort confirmed cases during outbreaks.
Respiratory Viruses	Direct contact with respiratory secretions. Inhalation	See comments	For course of treatment	Yes	Yes	Yes	If symptoms are associated with foreign travel within the last month suspect new emerging strain, wear FFP3 masks for all care
Rotavirus	Contact with faeces	Enhanced	Until 48 hours after last symptoms have ceased	Yes	Yes	No	
Rubella (German Measles)	Direct contact with respiratory secretions. Inhalation	Respiratory, masks not required	For 5 days after onset of rash	Yes	Yes	Yes	Exclude non-immune pregnant staff and visitors

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
SARS (Severe Acute Respiratory Syndrome)	Airborne	Respiratory. Use FFP3 masks, visors, waterproof disposable gowns and gloves	10 days following last symptoms	Negative pressure ventilation in single room (Not available at York or Scarborough)	Yes	Yes	Do not transport patient anywhere without discussing with the Microbiologist, CCDC & IPC
Staphylococcal skin infection (scalded skin syndrome)	Direct contact	Standard	Until culture negative	Yes	Yes	No	
Salmonellosis	Faecal-oral	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	Suspected food poisoning. Notify CCDC/PHE
Scabies	Prolonged direct contact with skin.	Standard	For 24 hours after starting treatment	No	No	No	
Scarlet Fever	Direct contact or Droplet	Respiratory, masks not required	For 24 hours after starting antibiotic therapy	Yes	Yes	Yes	
Shigellosis (Bacillary dysentery)	Faecal-oral route	Enhanced	Until > 48hrs clear of symptoms	Yes	Yes	Yes	
Shingles (refer to Herpes Zoster)							

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Streptococcal Disease Group A	Direct contact or Droplet.	Standard	Until 24 hours after starting antibiotic therapy	Yes	Yes	No	
Streptococcal Disease Group B (Septicaemia or Meningitis)	Direct contact	Standard	Ongoing	Yes	Yes	Yes – if it is Meningitis	Isolate for meningitis
Syphilis (congenital primary and secondary)	Direct contact with infected lesions	Standard	Until 24 hours after starting antibiotic therapy	Yes	No	No	Syphilis without lesions requires no special precautions
Tetanus	No person to person spread	Standard	None	No	No	Yes	
Tuberculosis (pulmonary) Multi Drug Resistant-TB	Inhalation Inhalation	Respiratory, FFP3 required only for AGP MDR requires negative pressure isolation	Until 2 weeks after treatment has commenced Until advised by IPT	Yes Yes	No Yes.	Yes Yes	If multi-drug resistant TB suspected transfer to negative pressure facility (not available at York or Scarborough)

Disease/ Infection	Mode of Transmission	Precautions required	Duration of Precautions	Single Room	Enhanced Cleaning and Disinfection	Notify CCDC/ PHE	Comments
Tuberculosis (non-respiratory)	Direct contact affected body fluids	Standard	Following completion of antibiotic therapy in responsive patients	No	No	Yes	Investigations required to eliminate pulmonary infection
Typhoid Fever	Faecal-oral route, person to person spread	Standard	On advice from microbiology consultant	Yes	Yes	Yes	
Viral Haemorrhagic Fever (VHF) (suspected)	Person to person spread by contact with body fluids	Standard	On advice from CCDC	Yes	Yes	Yes	See Public Health England for advice
Whooping Cough (Pertussis)	Airborne	Respiratory, masks not required	48 hours after commencing Erythromycin or 2 weeks after starting paroxysms if Erythromycin not given	Yes	Yes	Yes	

Appendix 4 - Equality Impact Assessment Tool

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

Name of Policy:	Isolation Procedures

1.	**What are the intended outcomes of this work?** Unification of Infection Preventions practices.	
2	**Who will be affected?** All staff, patients and visitors who attend YTHFT	
3	**What evidence have you considered?** Current DH guidelines i.e. Health & Social Care Act 2008 and Equalities Act 2010	
a	**Disability –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
b	**Sex –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
c	**Race –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
d	**Age –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
e	**Gender Reassignment –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
f	**Sexual Orientation –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
g	**Religion or Belief –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
h	**Pregnancy and Maternity.** – none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
i	**Carers/relatives –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	
j	**Other Identified Groups –** none identified – issues identified through ongoing monitoring will be assessed on a case by case basis	

4.	**Engagement and Involvement**	
a.	Was this work subject to consultation?	Yes via the HIPCG
b.	How have you engaged stakeholders in constructing the policy	Discussion at HIPCG meeting and circulation to all stakeholders with opportunity to comment
c.	If so, how have you engaged stakeholders in constructing the policy	Circulated via e-mail and presented at committee with the opportunity to comment
d.	For each engagement activity, please state who was involved, how they were engaged and key outputs – this policy was sent to operational directors, microbiologists, infection prevention practitioners, estates and the corporate nursing team via e-mail links to the website on Staffroom all of whom had the opportunity to comment within a time frame of several weeks prior to submission	
5.	**Consultation Outcome**	
a	Eliminate discrimination, harassment and victimisation	See the analysis in sections 3a–j
b	Advance Equality of Opportunity	Neutral/no impact i.e. doesn't impact adversely
c	Promote Good Relations Between Groups	Neutral/no impact i.e. doesn't impact adversely
d	What is the overall impact?	Positive impact i.e. Consistency in practice and a user friendly document
	Name of the Person who carried out this assessment: L Horton-Fawkes	
	Date Assessment Completed 20/01/14	
	Name of responsible Director V. Parkin	

Appendix 5 Checklist for the Review and Approval

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

	Title of document being reviewed:	Yes/No/ Unsure	Comments
1	**Development and Management of Policies**		
	Is the title clear and unambiguous?	yes	
	Is it clear whether the document is a guideline, policy, protocol or procedures?	yes	
2	**Rationale**		
	Are reasons for development of the document stated?	yes	
3	**Development Process**		
	Is the method described in brief?	yes	
	Are individuals involved in the development identified?	yes	
	Do you feel a reasonable attempt has been made to ensure relevant expertise has been used?	yes	
	Is there evidence of consultation with stakeholders and users?	yes	
	Has an operational, manpower and financial resource assessment been undertaken?	yes	
4	**Content**		
	Is the document linked to a strategy?	yes	
	Is the objective of the document clear?	yes	
	Is the target population clear and unambiguous?	yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	Are the intended outcomes described?	yes	
	Are the statements clear and unambiguous?	yes	
5	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	yes	
	Are key references cited?	yes	
	Are the references cited in full?	yes	
	Are local/organisational supporting documents referenced?	yes	
5a	**Quality Assurance**		
	Has the standard the policy been written to address the issues identified?	yes	
	Has QA been completed and approved?	yes	
6	**Approval**		
	Does the document identify which committee/group will approve it?	yes	
	If appropriate, have the staff side committee (or equivalent) approved the document?	yes	
7	**Dissemination and Implementation**		
	Is there an outline/plan to identify how this will be done?	yes	
	Does the plan include the necessary training/support to ensure compliance?	yes	
8	**Document Control**		
	Does the document identify where it will be held?	yes	
	Have archiving arrangements for	yes	

	Title of document being reviewed:	Yes/No/ Unsure	Comments
	superseded documents been addressed?		
9	**Process for Monitoring Compliance**		
	Are there measurable standards or KPI to support monitoring compliance of the document?	yes	
	Is there a plan to review or audit compliance with the document?	yes	
10	**Review Date**		
	Is the review date identified?	yes	
	Is the frequency of review identified? If so, is it acceptable?	yes	
11	**Overall Responsibility for the Document**		
	Is it clear who will be responsible for coordinating the dissemination, implementation and review of the documentation?	yes	

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	L. Horton-Fawkes	Date	20/01/14
Signature	*Linda Horton-Fawkes*		
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	Vicki Parkin	Date	20/01/14

Appendix 6 Implementation Plan

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	**Isolation Procedures**
Date finalised:	
Previous document in use?	**Yes**
Dissemination lead	**Infection Prevention Team (IPT)**
Which Strategy does it relate to?	**HCAI reduction strategy**
If yes, in what format and where?	**Intranet and Internet**
Proposed action to retrieve out of date copies of the document:	**Healthcare Governance Directorate will hold archive**

To be disseminated to:	**1) All Staff**	**2) Members of the Public**
Method of dissemination	**Via Intranet, Staff Matters, Formal Training**	**Via the Internet**
who will do it?	**IPT**	**IPT**
and when?	**January 2014**	**January 2014**
Format (i.e. paper or electronic)	**Electronic**	

Dissemination Record

Date put on register / library	**January 2014**
Review date	**January 2017**
Disseminated to	**All Staff**
Format (i.e. paper or electronic)	**Electronic**
Date Disseminated	**As above**
No. of Copies Sent	**N/A**
Contact Details / Comments	**IPT Ext 5860**

Appendix 7 Virtual Policy Review Group Checklist

All policy/procedure authors are required to complete the table below, entering ticks or text in the relevant box and to be open and honest about any implications. Failure to identify implications may lead to the document approval process being delayed.

Policy Title: Isolation Procedures

Policy Author L. Horton-Fawkes **Policy Owner V. Parkin**

Date of submission to VPRG February 2014

	Yes	No	Not Sure	N/A	Comments
CLaD Does the policy/procedural document require staff to be formally trained?	✓				**This policy is a true representation of the content of Statutory Mandatory Training for Infection**
Would the training be classified as Statutory/Mandatory and is this already included in the Statutory/Mandatory Training Brochure?	✓				
Does training require the learner to access statutory or mandatory learning material/content on line?	✓				

	Yes	No	Not Sure	N/A	Comments
Procurement Will the introduction of the document incur additional costs associated with equipment, disposables, maintenance agreements etc?		✓			
What is the likely additional cost associated with the above?				✓	
Information Technology Will the introduction of the document require an increase in computer hardware?		✓			
Are there any software, IT training or software license requirements associated with the document's introduction? If so, what are the estimated costs associated with this?		✓			
Information Governance Are there any information governance issues associated with the introduction of the document?		✓			

	Yes	No	Not Sure	N/A	Comments
HR Will there be any impact on staffing levels or any other HR related issues? (If so give details)			✓		**Staff need to be released to attend the statutory/mandatory training**
Estates and Facilities Will there be any significant impact on Estates and Facilities associated with the introduction of the document? (If so, give details)			✓		**There may be potential demand to increase isolation capacity**
Communications Will the introduction of the document require significant communications team input?		✓			
Risk and Legal Are there risks associated with the introduction of this document?		✓			**Staff compliance with this policy will reduce risks to the organisation**
Are there any legal implications associated with the introduction of this document?		✓			
Will the introduction of the document require the production of significant additional or new patient information?		✓			

	Yes	No	Not Sure	N/A	Comments
Occupational Health Will the introduction of the document have any potential implications on the OH department?		✓			
Health and Safety/Security Will the introduction of the document have any significant health and safety or security implications for the Trust?		✓			
Corporate Will the introduction of the document have any corporate governance implications for the Trust not covered above?		✓			
Finance Are there any changes from the proposed document which have a financial impact? If you answered yes to the above question, please provide detail.			✓		

If you answered yes to the first question, has a business case been submitted? Enter details alongside relevant entry **Submitted and Approved** (Include Business case No.) **Being written** (Please provide planned timeframes for submission) **Saving being Declared** **None of the above** (Please give a brief explanation of the reasons why a business case has not been submitted or savings declared)	**Not applicable**