

ISOLATION POLICY

To be read in conjunction with all other Trust Infection Prevention and Control Policies.

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DOCUMENT CONTROL

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1. INTRODUCTION

- 1.1 This document describes the practices and procedures to be followed to minimise and control the potential of cross infection with the appropriate and safe use of isolation facilities. It is the responsibility of the Trust to ensure that any patients presenting with an infection or who acquire an infection during treatment are identified promptly and managed according to good clinical practice, for the purposes of treatment and to reduce the risk of transmission (Health and Social Care Act 2008).
- 1.2 Standard infection prevention and control precautions will help reduce the risk of spread of infection. For some inpatients with known or suspected infections isolation in a single room may also be required. In addition some patients may require isolation in a single room to protect themselves from exposure to infections.
- 1.3 This policy sets out the actions to be taken by all Trust staff when caring for all patients in isolation.
- 1.4 Further advice can be obtained from the Infection Prevention and Control Team if required

2. PURPOSE & SCOPE

- 2.1 To provide guidance to staff on isolation practices and reduce the risk of spread of infection.
- 2.2 All staff whatever their grade, role or status, permanent, temporary, full-time, part-time staff including locums, bank staff, volunteers, trainees and students. This Policy will be available to the general public on the Trust Internet.
- 2.3 This policy must also be used in conjunction with the following:
 - Outbreak Control Policy;
 - Hand Hygiene Policy;
 - Sharps Policy;
 - Clinical Waste Disposal Policy
 - Housekeeping Work Instruction/Isolation Cleaning Manual;;
 - Record Keeping Policy;
 - Consent Policy;
 - Health and Safety at Work Legislation and Regulations;
 - Health and Safety Policies and Procedures.
 - Infection Control Policy

3. DUTIES AND RESPONSIBILITIES

3.1 The Trust Board, via the Chief Executive will:

- Ensure there are effective and adequately resourced arrangements for the detection & management of infection within the Trust.
- Identify a board level lead for infection prevention and control.
- Ensure that the role and functions of the Director of Infection Prevention and Control are satisfactorily fulfilled by appropriate and competent persons as defined by DH, (2004b).

3.2 Director of Infection Prevention and Control (DIPC)

- Is responsible for providing assurance to Trust Board in relation to isolation room provision and compliance with isolation practices across the Trust.
- The Infection Prevention and Control Group will ensure that procedures for the implementation of the policy for the detection & management of infection are continually reviewed and improved within the Trust.

3.3 Head of Estates

- Is responsible for ensuring latest national guidance is met in terms of isolation room provision and design.
- Collaborating with Head of Infection Prevention and Control Lead on isolation room maintenance and provision during building development and change.

3.4 Infection Prevention and Control Team

- Support of clinical staff in identifying and risk assessing patients who require isolation and facilitating the location of an appropriate side room.
- Risk assessment and management of patients who are not able to be isolated due to constraints of the ward/ In-patient units
- In event of difficulties locating an appropriate side-room, support clinical staff in employing an alternative such as cohort of patients, or recommending use of side-rooms in alternative areas as able. Working with Clinical teams to facilitate the movement of patients appropriately between wards to allow isolation if required.
- Ensure effective communication between clinical teams when patient movement is required i.e discharges, transfers and admissions between hospitals

3.5 **Ward / Department Managers**

- Are responsible for ensuring all staff working in that area understand and implement the infection prevention and control precautions outlined in this policy.
- Are responsible for ensuring that staff are aware of the policy and requirements for attending training as identified in the Training Needs Analysis. Managers will ensure that staff have attended all relevant training and have current updates.
- Are responsible for ensuring that staff are released to attend relevant Training and for recording attendance at training in local training records. All non-attendance at training will be followed up by managers.
- Are responsible for ensuring individual staff and team's training needs are met through appraisal and in line with the Training Needs Analysis. Training information should be passed to the Learning and Development Department who will update the electronic staff record.

3.6 **All Staff Involved in Clinical Care**

All staff involved in clinical care are responsible for:

- The implementation of infection control precautions appropriate to the patient's condition as outlined in this policy.
- Ensuring all visitors to the ward or department follow any infection prevention and control precautions appropriate to the patient's condition as outlined in this policy.
- Instigating the location of an appropriate side room for any patient that requires isolation and in the absence of facilities in that area to work with the Infection Prevention and Control Team to relocate the patient elsewhere as clinically appropriate.

3.7 **The Learning and Development Team**

- Will be responsible for recording attendance at Training and will advise Operational Managers of non-attendance.
- Is responsible for entering all data relating to Mandatory and Non-Mandatory training attendance onto the Electronic Staff Record (ESR) system and reporting non-attendance to Senior Managers.

4. **EXPLANATIONS OF TERMS USED**

- 4.1 **Source Isolation** - Used for patients suffering from a communicable / infectious disease or carriers of a communicable / infectious disease. Use of source isolation prevents the spread of infection to others (see Appendix B)
- 4.2 **Protective Isolation** – Used to protect immunological compromised patients from the risk of infection from other patients, visitors and staff (see Appendix C)

- 4.3 **Cohort Nursing** – Refers to the nursing of a group of patients with the same infection within a confined area such as a bay or a ward.
- 4.4 **Negative Pressure Room** – A single room with a negative pressure ventilation system, used for patients who are isolated because they are a risk of infection to other patients. As the door of the room is opened because of the negative pressure inside, air is sucked into the room. Air from the room is released to the outside via a filter away from inlets of other ward or department areas (only available in Acute NHS Foundation Trust).
- 4.5 **Positive Pressure Room** – Single room with positive pressure ventilation system, used for patients who are at risk of infection from other patients and the clinical environment. Air that enters the room is filtered to remove particles and microorganisms. The air in the room is kept at a higher pressure so as the door is opened air from outside will not enter the room. (only available in Acute NHS Foundation Trust)
- 4.6 **Category A Infections** – Infectious substances or pathogens that present a severe risk of infection to humans – see list Appendix F.
- 4.7 **Category A Linen** – Linen used on patients with suspected or confirmed category A infection.
- 4.8 **Category A waste** – All waste products generated during the care of patients with suspected or confirmed Category A infection.
- 4.9 **The Trust** – Somerset Partnership NHS Foundation Trust

5. **MODES OF TRANSMISSION**

- 5.1 Infection can spread by a number of methods: Contact, airborne, droplet, faecal-oral, vector, inoculation and vertical. Details of each mode of transmission can be found in Appendix A.

6. **WHO SHOULD BE ISOLATED?**

- 6.1 All inpatients with known or suspected infection or colonisation with a multi-resistant organism should be isolated, as detailed in the A-Z Guide (Appendix D).
- 6.2 All patients with suspected infective cause for loose stools- type 7 on the Bristol Stool Chart and/or vomiting Please see Appendix F.
- 6.3 All inpatients with suspected or confirmed neutropenia would be isolated within an appropriate Acute NHS Foundation Trust facility.
- 6.4 Staff should ensure the reasons for the patient being isolated are clearly explained to the patient and their carers/family. Staff should ensure they are

fully able to understand this information and, if necessary, a professional interpreter should be used.

7. ISOLATION PRIORITY SYSTEM / COHORT OF PATIENTS

- 7.1 Where indicated, patients should be isolated as soon as practically possible, immediately for category A infections and within 4 hours for other potentially infectious patients. When a side room is unavailable or it is not possible to comply with this time frame, follow the actions outlined in Appendix B.
- 7.2 Until the patient is isolated source isolation precautions (Appendix B) should be applied wherever the patient is currently situated. Neighbouring patients should be reviewed and their risk of being situated next to a patient with a known or suspected infection assessed and moved to other bed spaces within the ward if necessary. Advice can be obtained from the Infection Prevention and Control Team or the on call microbiologist.
- 7.3 In the event of insufficient side room availability, patients should be isolated according to risk. A side room priority tool is available to support staff making this decision, as detailed in Appendix E. Further advice is available from the Infection Prevention and Control Team or Consultant Microbiologist.
- 7.4 In the event of an inability to isolate patients such as during an outbreak or the presence of several patients on a ward with the same infection, the cohort of these patients may be considered. The decision to cohort patients will be made in collaboration with the Infection Prevention and Control Team or the on-call Consultant Microbiologist and the Director of Nursing and Patient safety/ Infection Prevention and Control in conjunction with the clinical teams on the ward. Referral should be made to the Outbreak Management Policy.
- 7.5 Whilst staff should endeavour at all times to meet the diverse needs of the patient and their carers/family, occasionally the need to ensure isolation may necessarily have to outweigh these needs for a limited period of time. The reasons for this should be clearly given to the patient in a format or language they can understand and this should be recorded on the patient's clinical records. Staff should endeavour to meet these needs at the earliest opportunity.

8. TRAINING REQUIREMENTS

- 8.1 The Trust will work towards all staff being appropriately trained in line with the organisation's Staff Mandatory Training Matrix (training needs analysis). All training documents referred to in this policy are accessible to staff within the Learning and Development Section of the Trust Internet.
- Trust Induction training – basic Infection Prevention and Control Awareness

- Annual mandatory Infection Prevention and Control update
- Hand washing training

9. EQUALITY IMPACT ASSESSMENT

- 9.1 All relevant persons are required to comply with this document and must demonstrate sensitivity and competence in relation to the nine protected characteristics as defined by the Equality Act 2010. In addition, the Trust has identified Learning Disabilities as an additional tenth protected characteristic. If you, or any other groups, believe you are disadvantaged by anything contained in this document please contact the Equality and Diversity Lead who will then actively respond to the enquiry.

10. MONITORING COMPLIANCE AND EFFECTIVENESS

10.1 Monitoring arrangements for compliance and effectiveness

Overall monitoring will be by the Clinical Governance Group

10.2 Responsibilities for conducting the monitoring

The Infection Prevention and Control Assurance Group will monitor procedural document compliance and effectiveness where they relate to clinical areas.

10.3 Methodology to be used for monitoring

Incident reporting and monitoring

10.4 Frequency of monitoring

The Infection Prevention and Control Assurance Group reports to the Clinical Governance Group quarterly.

10.5 Process for reviewing results and ensuring improvements in performance occur.

Audit results will be presented to the Senior Managers Operational Group for consideration, identifying good practice, any shortfalls, action points and lessons learnt. This Group will be responsible for ensuring improvements, where necessary, are implemented.

11. COUNTER FRAUD

- 11.1 The Trust is committed to the NHS Protect Counter Fraud Policy – to reduce fraud in the NHS to a minimum, keep it at that level and put funds stolen by fraud back into patient care. Therefore, consideration has been given to the inclusion of guidance with regard to the potential for fraud and corruption to

occur and what action should be taken in such circumstances during the development of this procedural document.

12. RELEVANT CARE QUALITY COMMISSION (CQC) REGISTRATION STANDARDS

12.1 Under the **Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3)**, the **fundamental standards** which inform this procedural document, are set out in the following regulations:

Regulation 9:	Person-centred care
Regulation 10:	Dignity and respect
Regulation 11:	Need for consent
Regulation 12:	Safe care and treatment
Regulation 13:	Safeguarding service users from abuse and improper treatment
Regulation 14:	Meeting nutritional and hydration needs
Regulation 15:	Premises and equipment
Regulation 16:	Receiving and acting on complaints
Regulation 17:	Good governance
Regulation 18:	Staffing
Regulation 19:	Fit and proper persons employed
Regulation 20:	Duty of candour
Regulation 20A:	Requirement as to display of performance assessments.

12.2 Under the **CQC (Registration) Regulations 2009 (Part 4)** the requirements which inform this procedural document are set out in the following regulations:

Regulation 16:	Notification of death of service user
Regulation 17:	Notification of death or unauthorised absence of a service user who is detained or liable to be detained under the Mental Health Act 1983
Regulation 18:	Notification of other incidents

12.3 Detailed guidance on meeting the requirements can be found at <http://www.cqc.org.uk/sites/default/files/20150311%20Guidance%20for%20providers%20on%20meeting%20the%20regulations%20FINAL%20FOR%20PUBLISHING.pdf>

Relevant National Requirements

Health and Social Care Act, 2012

NICE guidance: Clinical diagnosis and Management of Tuberculosis and Measures for its Prevention and Control

13. REFERENCES

13.1 References

Control of Communicable Diseases Manual, Seventeenth Edition, 2000. J. Chin (Editor) American Public Health Association
Environment and Sustainability Health Technical Memorandum – Safe Management of Healthcare waste, 07-01. Department of Health, November 2013.

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Infection Control In the Built Environment HBN 00-009, Department of Health, July 2013

King's College London, Nursing Research Unit, Issue 4 2007 accessed 20.09.08 <http://www.kcl.ac.uk/content/1/c6/03/09/92/PolicyIssue4.pdf>

London Haematology Dieticians Group. *Dietary Advice for Patients with Neutropenia, information leaflet*. Great Ormond Street, London.

NICE guidance: Clinical diagnosis and Management of Tuberculosis and Measures for its Prevention and Control, Royal College of Physicians, March 2011.

Preventing Secondary Meningococcal Disease in Healthcare Workers: recommendations of a working group of the PHLS Meningococcus Forum, 2001. JM Stuart, AB Gilmore, A Ross, W Patterson, JS Kroll, EB Kaczmarski, S MacQueen, P Keady, P Monk, *Communicable Disease and Public Health Vol 4 No 2*.

The Health Act: Code of practice for the prevention and control of healthcare associated infections (2012) www.dh.gov.uk.

The NHS Healthcare cleaning manual, March 2009 www.nhsestates.gov.uk

Lewis SJ, Heaton KW (1997). "Stool form scale as a useful guide to intestinal transit time". *Scand. J. Gastroenterol.* 32 (9): 920–4.

13.2 **Cross reference to other procedural documents**

All other Trust Infection Prevention and Control policies currently available on the Trust Intranet.

Consent to Examination and Treatment Policy

Consent and Capacity to Consent to Treatment Policy

Development & Management of Organisation-wide Procedural Documents Policy and Guidance

Hand Hygiene Policy

Health and Safety Policy

Infection Prevention and Control Policy

Learning Development and Mandatory Training Policy

Record Keeping and Records Management Policy

Risk Management Policy

Staff Mandatory Training Matrix (Training Needs Analysis)

Training Prospectus

Untoward Event Policy

Serious Incidents Requiring Investigation

All current policies and procedures are accessible in the policy section of the public website (on the home page, click on 'Policies and Procedures'). Trust Guidance is accessible to staff on the Trust Intranet.

14. APPENDICIES

14.1 For the avoidance of any doubt the appendices in this policy are to constitute part of the body of this policy and shall be treated as such. This should include any relevant Clinical Audit Standards

Appendix A	Modes of Transmission
Appendix B	Categories of Isolation – Source Isolation
Appendix C	Categories of Isolation – Protective Isolation
Appendix D	A-Z Guide of Infectious and Communicable Diseases
Appendix E	Category A Infectious Diseases
Appendix F	Bristol Stool Chart

MODES OF TRANSMISSION

Contact – Hands are the most common mode of spread but it can also occur indirectly via contact with contaminated equipment or the environment.

Airborne – This occurs by the spread of small, airborne particles containing infectious agents that remain suspended in the air and are dispersed over distances by air currents where they are then inhaled by a susceptible individual.

Droplet – This occurs when respiratory droplets carrying infectious agents travel over short distances (up to 3 feet) directly from the respiratory tract of an infectious individual to the mucosal surface of a susceptible individual. Respiratory droplets are generated by coughing, sneezing or talking. Droplets may also settle on horizontal surfaces and can cause indirect contact transmission via individual's hands.

Faecal-oral – This is the transmission of enteric bacterial infection from the gut of one person that is ingested by another resulting in infection.

Vector – This is the spread of infection via a living creature.

Inoculation – This is the inoculation of an infected body substance into the tissue of another (e.g., sharps injuries)

Vertical – This is the transmission of infection from mother to baby such as via placenta or breast milk.

CATEGORIES OF ISOLATION – SOURCE ISOLATION

Once the need for source isolation is identified the patient should be isolated in a single side room. The door should remain closed unless risk assessment indicates patient safety is compromised. For some conditions negative pressure ventilation rooms are required which are only available within the Acute NHS Trust sector. Refer to Appendix D, A-Z Guide for details.

Category A Infections – Patients with these infections will usually be transferred as soon as possible to specialist centres for infectious diseases. Source isolation is essential. Please contact the Infection Prevention and Control Team or the on- call microbiologist immediately.

Inability to Isolate - If insufficient side rooms are available staff should undertake the following action in chronological order until the patient is isolated:

- a) Investigate availability of side rooms on other wards. Input may be required from the patient's medical team, and Infection Prevention and Control Team
- b) Refer to the side room priority tool (Appendix E) to assess the risk of all patients to ensure side room usage is prioritised; advice is also available from the Infection Prevention and Control Team.
- c) Complete an incident form if any patient who requires source isolation cannot be isolated due to side room unavailability.
- d) Where possible, cohort patients with the same infections, advice should be sought from the Infection Prevention and Control Team

Communication – The patient is to be informed of the reason for isolation and given appropriate disease specific patient information leaflets e.g. MRSA leaflet. Appropriate signage should be placed on the door of the room or above the bed to ensure staff are aware of the precautions that should be undertaken without breaking confidentiality. Notes and charts should be kept outside the room.

Hand Hygiene - Hands must be decontaminated prior to and following direct contact with the patient or their environment. Hands may be decontaminated with either alcohol gel or soap and water unless the patient has a history of diarrhoea when soap and water **must** always be used. Hands must be decontaminated prior to leaving the room.

Personal Protective Equipment (PPE) -

- a) Aprons – Should be worn for all activities and put -AFTER entering the room. They should be removed and disposed of as clinical waste in an orange bag as detailed in the Waste Management Policy, prior to leaving the room. Hands should be decontaminated before leaving the room.
- b) Gloves – Should be worn for all activities that involve direct patient contact. They should be removed and disposed of as clinical waste in an orange bag

(as per Waste Management Policy) prior to leaving the room. The use of gloves is **not** a replacement for hand decontamination in the event of patient contact, which should still occur before placement and after removal of gloves.

- c) Masks – For most conditions masks are not required. Infections where masks are required are detailed in the A-Z Guide (Appendix D). If used they should be disposed of as clinical waste prior to leaving the room.
- d) Eye protection – For most conditions eye protection is not required. Infections where eye protection is required are detailed in the A-Z Guide (Appendix D). If used they should be disposed of as clinical waste prior to leaving the room.
- e) Respirators – For most conditions respirators are not required. Infections where respirators are required are detailed in the A-Z Guide (Appendix D). If used they should be disposed of as clinical waste prior to leaving the room.
- f) Fluid Repellent Gowns – For most conditions fluid repellent gowns are not required. Infections where these gowns are required are detailed in the A-Z Guide (Appendix D). If worn they should be disposed of as clinical waste prior to leaving the room.

Equipment - Equipment in side rooms should be kept to a minimum. Any equipment required should, where possible, be dedicated for use by the patient in source isolation and remain in the room until isolation precautions are stopped. Equipment that is used by other patients must be decontaminated before leaving the room, according to manufacturer's guidelines and in line with the Decontamination Policy, prior to use on another patient. Single patient use equipment should be considered. Bed pans and urinals should be covered and transferred to the sluice for immediate disposal. Fans should not be used.

Linen - All soiled and dirty linen from source isolated patients must be sealed in an alginate/dissolvable bag in the room and then placed in a white laundry bag prior to sending to the laundry. Patients' own clothing needs no special treatment unless soiled, in which case it should be placed in a patient clothing dissolvable bag before being returned to patients' relatives or friends. Please refer to Laundry Protocol for further information.

Waste – The normal rules of segregation of domestic and clinical waste apply in source isolation rooms. Items such as newspapers, flowers etc may still be disposed of as domestic waste in black bags. Used PPE such as gloves and aprons should be disposed of as clinical waste in an orange bag. Please refer to the Waste Management Policy. The only exceptions to this are if **Category A infection** is suspected or confirmed. A patient with an active Category **A** Infection will require Acute NHS Trust intervention.

Visitors - Visitors' hands should be decontaminated prior to entry and on exit from the side-room with either gel or soap & water unless the patient has a history of diarrhoea when soap & water must always be used. Visitors do not need to wear any PPE unless they are carrying out personal care for the patient, when it should be worn in line with that recommended for staff.

Patient Attendance in Other Departments for Treatment / investigation -

Treatments or investigations should not be delayed. The receiving department and ambulance service (where appropriate) should be informed in advance so appropriate precautions can be taken and the patient spends as little time in the department as possible. Individual advice is available from the ~~Matron~~ ~~for~~ Infection Prevention and Control Team.

Cleaning - Cleaning of isolation rooms should be done in line with the Trust cleaning schedules. Enhanced cleaning with 100% Sodium Chloride required for patients isolated with clostridium *difficile* and gastroenteritis (norovirus). On discharge of the patient or termination of isolation precautions, the room must undergo a terminal clean according to Trust cleaning practices.

Deceased Patients - Any infection control practices employed during inpatient stay should be continued during last offices. Mortuary staff and Undertakers should be informed of any infection and a body bag used e.g. leakage of body fluids. Further advice is available from Infection Prevention and Control Team if required.

PROTECTIVE ISOLATION

Once the need for protective isolation is identified the patient should be isolated in a single side room with the door closed at all times.

Single Room - Isolate patient in a single room / positive pressure room according to clinical need, preferably en-suite. The door must remain closed at all times.

Communication - The patient and their visitors should be informed of the reason for isolation. Appropriate signage should be placed on the outside of the door to the room. to ensure all staff are aware of the precautions that should be undertaken without breaking confidentiality.

Hand Hygiene - Hands should be decontaminated by staff and visitors prior to entering the room, prior to and following direct patient contact and contact with the environment using either gel or soap and water, unless the patient has a history of diarrhoea when soap and water must always be used.

Personal Protective Equipment -

- a) Aprons – Should be worn for all activities by staff and visitors and put on prior to entering the room. They should be removed and disposed of as domestic waste after leaving the room, unless the patient has an infection in which case they should be regarded as clinical waste.
- b) Gloves – Should be worn for all activities that involve direct contact with blood, body fluids or contact with mucous membranes as per Standard Precautions Policy. They should be removed and disposed of after leaving the room. The use of gloves is not a replacement for hand decontamination which should still occur prior to patient contact and on removal of gloves.
- c) Masks, eye protection, respirators and fluid repellent gowns – Should not be required unless the patient has an infection. In which case refer to the A-Z Guidance (Appendix D). If used it should be removed and disposed of as clinical waste.

Equipment - Equipment in side rooms should be kept to a minimum and any required should, where possible, be dedicated for use by the patient in isolation, remaining in the room. All equipment should be cleaned before being taken into the room. Advice on equipment cleaning can be gained from the manufacturer's instructions or via the Decontamination Policy. No special precautions are needed for the removal of equipment from the room unless the patient has an infection.

Food / Water / Crockery & Cutlery - Attention should be taken with the preparation of food (liaise with Infection Prevention and Control Team. Filtered water can be used for drinking. Crockery and cutlery should be stored in a sealed, dry container after dish washing.

Linen - No special precautions are required for linen.

Waste - No special precautions are required for waste disposal, please follow the Waste Management policy.

Staff - Staff must not look after patients in protective isolation if they have any infection.

Visitors - Visitors should avoid visiting if they have any infection.

Flowers - Flower water can contain bacteria which may harm immunocompromised patients, therefore neither fresh flowers or plants are allowed in protective isolation rooms.

Patient Attendance for Treatment / Investigation - The patient is at increased risk of infection once outside the isolation room however attendance for investigations / treatments may still need to occur. The patient should be in the receiving department for as little time as possible and returned to the ward as soon as possible after the procedure. The receiving department and where necessary, the ambulance service should be made aware. Masks are **not** required. The patient must not wait in communal areas.

Cleaning - No special cleaning procedures are required unless the patient has a current infection however cleaning staff should be made aware of the precautions they need to take such as hand hygiene and the wearing of an apron before entering the room.

A-Z GUIDE OF INFECTIOUS AND COMMUNICABLE DISEASES

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
Abscess where dressings do not contain drainage.	Contact with exudate	Source isolation, separate washing / showering facilities	Until drainage contained by dressing	Aprons for direct contact, gloves for contact with dressings and contaminated linen.	
Acquired Immune Deficiency Syndrome (AIDS / HIV)	Inoculation of infected blood or mucosal exposure to infected blood or body fluids.	None	NA	Standard Precautions	Ensure safe sharps handling practice. In event of death use a body bag.
Anthrax <ul style="list-style-type: none"> • Cutaneous • Gastrointestinal • Pulmonary 	Contact from handling with infected animals, particularly skins Ingestion of anthrax contaminated meat Inhalation of large amounts of spores from infected animal fur or hide	None as not spread via direct human to human None None	NA NA NA	Gloves and aprons for contact with any skin lesions Standard precautions for body fluids	Anthrax will form spores once shed from the body that survive for decades and are a high source of further infection. In event of death the body should be placed in an air tight body bag. Notifiable disease
Avian Flu (H5N1)	Direct contact with	Source Isolation in	Until advised by	Long sleeved, fluid	Notifiable disease

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
<p>To decide whether patient fits the case definition for a human case of avian influenza refer to the latest Algorithm for the management of returning travellers and visitors from countries affected by avian influenza (H5N1) available at www.hpa.org.uk/Topics A-Z, avian influenza, algorithm.</p>	<p>infected birds or contact with surfaces contaminated with secretions or excretions from infected birds</p>	<p>negative pressure room with door closed.</p>	<p>infection control team</p>	<p>resistant gown, gloves, face visor and FFP3 mask. Worn for entering room and all patient contact. Before leaving the room remove gown & gloves and dispose of as clinical waste and wash hands. Then remove visor and repeat hand hygiene. Once outside the room, remove mask using recommended technique to avoid contamination of face and dispose of as clinical waste. Perform hand hygiene again.</p>	<p>Immediately inform Infection Prevention and Control Team</p>

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
Body and Head Lice	Direct contact with infested clothing or bedding	None	NA	Standard precautions	Hospital linen should be placed in an alginate bag and then a white linen bag. Patients own clothing should be placed in an alginate bag and washed in a domestic washing machine at minimum of 55° C or as high as clothing will allow.
Botulism	Ingestion of food in which toxin / spores are present. Usually from inadequate heating of food before canning or preservation.	None	NA	Standard precautions	Notifiable disease
Bronchiolitis (see RSV)					
Campylobacter	Faecal oral. Usually from eating under cooked meat (often poultry) or unpasteurised milk, untreated water Handling of raw meat without effective hand decontamination	Source isolation, dedicated toilet facilities	Until free of diarrhoea for 48 hours	Standard precautions	Notifiable disease
Cellulitis where drainage cannot be contained by dressings.	Contact with exudate	Source isolation	Until drainage contained by dressings	Standard precautions plus gloves when	

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
				handling soiled dressings or linen soiled with exudates.	
Chicken Pox (Varicella-zoster virus)	Airborne – inhalation of respiratory droplets. Contact with respiratory secretions or vesicle fluid	Source isolation.	Until all lesions crusted over	Gloves & Aprons for direct care as may be in contact with vesicles and respiratory secretions	Inform Infection Prevention and Control Team Should not be nursed by non immune staff, particularly if pregnant. Non immune pregnant visitors should not visit patient. See Varicella Policy
Cholera	Faecal - oral from ingestion of untreated water or contaminated food	Source isolation with dedicated toilet facilities	Until free of diarrhoea for 48 hours	Standard precautions	Inform infection prevention and control Team Notifiable disease
Clostridium difficile (See Clostridium difficile policy)	Faecal - oral	Source isolation, dedicated toilet facilities.	Until free of diarrhoea for 72 hours	Gloves & Aprons for direct care	Hands must be washed with soap & water Twice daily cleaning of isolation room with Hypochlorite solution
Creutzfeldt-Jakob Disease (See CJD policy)	Inoculation with contaminated tissue, particularly brain, spinal cord and eye tissue or from contaminated surgical instruments.	None as no person to person spread	NA	Standard precautions for daily care. During surgical procedures use liquid resistant gown, double glove, mask & goggles or face visor.	Notifiable disease Surgical procedures should where possible be scheduled for the end of the list and use disposable equipment. If disposable equipment is not available contact SSD for decontamination advice.

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
Cryptosporidium	Faecal-oral	Source isolation with dedicated toilet facilities	Until diarrhoea free for 48 hours	Standard precautions	
Cytomegalovirus (CMV)	Excreted from urine, saliva, breast milk, vaginal secretions. Contact with above and mucosa.	Source isolation in neonates	For duration of hospital stay	Standard precautions	
Diarrhoea (undiagnosed)	Faecal – oral	Source isolation with dedicated toilet facilities	Until free of diarrhoea for 72 hours or infection excluded	Standard precautions	
Diphtheria (pharyngeal)	Airborne via inhalation of respiratory droplets or contact with items contaminated with secretions	Source isolation	Until completion of antibiotic treatment and 2 microbiological cultures of nose and throat taken 24 hours apart are negative. These should be taken 24 hrs after stopping antibiotic therapy.	Standard precautions plus fluid repellent face mask if working within 3 feet of patient.	Notifiable disease
Diphtheria (cutaneous)	Contact with secretions from skin lesions	Source isolation	Until completion of antibiotic treatment and 2 microbiological cultures of skin lesions taken 24 hours apart are negative. These	Standard precautions	Notifiable disease

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
			should be taken 24 hrs after stopping antibiotic therapy.		
E Coli 0157	Faecal-oral following ingestion of contaminated foods, particularly minced beef.	Source isolation with dedicated toilet facilities	Until free of diarrhoea for 48 hours	Standard precautions	Notifiable disease
Extended Spectrum Beta Lactamase (ESBL) producing organisms	Direct contact	Source isolation (Please see priority side room tool)		Standard precautions	
Gastroenteritis	Faecal oral	Source isolation with dedicated toilet facilities	Until free of diarrhoea for 48 hours	Standard precautions	Notifiable disease if due to food poisoning
Giardia	Faecal-oral often from drinking untreated water or swimming in fresh water	Source isolation with dedicated facilities	Until free of diarrhoea for 48 hours	Standard precautions	
Glandular fever (Epstein-Barr Virus)	Exchange of oral secretions	None	NA	Standard precautions	
Glycopeptide Resistant Enterococci (VRE)	Contact with urine or faeces from carrier	Source isolation if patient incontinent of urine or faeces or if has diarrhoea	Until incontinence has resolved and/or until no diarrhoea for 48hrs	Standard precautions	
Hepatitis A	Faecal-oral	Source isolation	Until 1 week after	Standard	Notifiable disease

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
		with dedicated toilet facilities	onset of jaundice	precautions	
Hepatitis B & C	Inoculation of infected blood or mucosal exposure to infected blood or body fluids.	None	NA	Standard precautions	Notifiable disease Ensure safe sharps handling.
Herpes Simplex	Contact with saliva or secretions from lesions	Source isolation for neonates and other patients if lesions are wet or disseminated.		Standard precautions but ensure gloves used when potential contact with fluid from lesions	Health care workers with herpetic lesions should have no contact with neonates or immunocompromised patients.
HIV (see Acquired Immune Deficiency Syndrome)					
Impetigo	Contact with skin lesions	None	NA	Standard precautions ensure gloves worn for contact with lesions	
Influenza	Respiratory secretions	Source isolation	5 days after onset of symptoms	Standard precautions	Refer to Trust Pandemic Flu Guidance
Legionnaires	Contaminated water source e.g. showers	None	NA	Standard precautions	
Leptospirosis	Blood and urine	None	NA	Standard precautions	Notifiable disease Ensure safe sharps handling
Measles	Airborne and by direct contact with	Source isolation.	Until 4 days after onset of rash	Gloves and aprons for patient contact.	Notifiable disease Patient to wear surgical mask if

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
	nasal or throat secretions or secretions on soiled articles				needs to be transferred around the hospital. Non immune staff should not care for the patient.
Meningitis – meningococcal	Respiratory secretions	Source isolation	Until 48 hours of antibiotic therapy	Standard precautions. Masks only required if undertaking procedures that result in physical contact with droplets/secretions e.g. airway management, patient coughing within 3 feet of staff	Notifiable disease
Meningitis - Viral	Respiratory secretions / faeces	Source isolation until diagnosis confirmed	Once diagnosed as viral meningitis no longer needs isolation	Standard precautions	Notifiable disease Commonly caused by enterovirus
MRSA	Direct contact	Source isolation	Until 3 clear screens	Standard precautions	See policies: MRSA screening MRSA management
Mumps	Respiratory secretions	Source isolation	Until 9 days after onset of swelling	Standard precautions	Notifiable disease
Pertussis – see Whooping cough					
Pyrexia of unknown origin following foreign					

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
travel (see Viral Haemorrhagic fever)					
Respiratory syncytial virus (RSV) / bronchiolitis	Droplet spread In direct contact from contaminated surfaces or equipment	Source isolation	Duration of illness	Standard precautions	Usually effects children. Young children should avoid visiting patient.
Rubella	Respiratory secretions	Source isolation	7 days after appearance of rash	Standard precautions	Notifiable disease Pregnant women to have no contact. If contact occurred before diagnosis contact Occupational health or GP
Scabies (see policy on Scabies)	Prolonged skin to skin contact	Source isolation only if Norwegian (crusted scabies) is suspected or confirmed	Until 24 hours after appropriate treatment	Aprons and gloves for patient contact, bed making and handling of used linen / patient clothes. If Norwegian scabies suspected or confirmed exchange use of apron for use of long sleeved gown. Once 24 hours of treatment given revert to PPE according to standard precautions.	
Salmonella	Faecal-oral or	Source isolation	Until free of	Standard	Notifiable disease

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
	ingestion of infected meat or animal products, particularly undercooked meats or eggs	with dedicated toilet facilities	diarrhoea for 48 hours	precautions	Food handlers may need further screening before returning to work.
Scarlet Fever (see Streptococcal disease Group A)					Notifiable disease
Shigella	Faecal-oral	Source isolation with dedicated toilet facilities	Until free of diarrhoea for 48 hours	Standard precautions	Notifiable disease Food handlers may need further screening before returning to work.
Shingles (Varicella-zoster virus – reactivation of previous chicken pox infection)	Contact with vesicle fluid. In non-immune individuals may cause chicken pox.	Source isolation	Until vesicles crusted.	Gloves & aprons for direct contact as may be in contact with vesicle fluid	Inform infection control team. Staff not immune to chicken pox should avoid contact with vesicle lesions. Refer to Chicken Pox policy
Streptococcus (Group A strep)	Contact with infected lesions or respiratory secretions	Source isolation	Until 48 hours of antibiotics	Standard precautions	
Tuberculosis (TB) (Active Respiratory) If actively infectious will be inpatient in Acute NHS Trust	Airborne during coughing, sneezing or aerosol generating procedures	Source isolation Negative pressure room only required if immune-compromised patients on ward	Until patient has had 14 days of appropriate antibiotic therapy	Standard precautions FFP2 mask needed if having prolonged contact, patient has persistent cough or during aerosol inducing procedures	Notifiable disease Refer to TB policy If patient needs to leave room must wear FFP2 mask until has had 14 days of appropriate antibiotic therapy in Acute NHS Trust

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
Known or suspected Multi-drug resistant Tuberculosis (MDRTB) (Active Respiratory) If actively infectious will be inpatient in Acute NHS Trust	Airborne during coughing, sneezing or aerosol generating procedures	Source isolation in negative pressure room	Until antibiotic sensitivity is confirmed and patient has received 14 days of the appropriate antibiotics	Standard precautions plus FFP3 masks for all care	Notifiable disease Refer to TB policy If patient needs to leave room must wear FFP3 mask until has had 14 days of sensitive antibiotic therapy in Acute NHS Trust
Typhoid fever	Faecal-oral by ingesting food or water contaminated by faeces or urine of infected individuals.	Source isolation with dedicated toilet facilities	Until 3 consecutive negative faecal cultures obtained at least 24 hours apart and at least 48 hours after antibiotics have stopped.	Standard precautions	Notifiable disease
Typhus	Infected body feed on human blood via bites and defecate simultaneously. Faecal matter then enters the superficial lesions on the skin causing infection.	Source isolation	Until delousing of infestation of lice is completed then no isolation is required.	Aprons and gloves for all patient contact until delousing is completed	Notifiable disease

Disease / Organism	Mode of Transmission	Isolation Precautions	Duration of Isolation	PPE	Additional Comments
Viral Haemorrhagic Fever (VHF) <ul style="list-style-type: none"> • Ebola Virus • Marburg Virus • Lassa Fever • Crimean-congo fever Will need URGENT transfer to specialist centres for infectious diseases	Direct contact with: <ul style="list-style-type: none"> • Blood • Sputum • Saliva • Semen • Urine • Faeces And accidental inoculation with contaminated needle	Source isolation, closed door essential (see VHF policy for details)	Until secretions/blood free of virus. May be up to 10 weeks.	Long sleeved gowns, gloves, fluid repellent mask, visor or goggles	Notifiable disease See also VHF policy
Whooping cough (see pertussis)	Airborne and direct contact with respiratory secretions	Source isolation	Until 5 days after the appropriate antibiotic therapy.	Standard precautions plus fluid repellent mask when working within 3 feet of patient.	Notifiable disease
Wounds (infected) where drainage or exudate not contained by dressings	Contact with exudate	Source isolation	Until exudate contained by dressing	Standard precautions plus gloves when handling soiled dressings or linen soiled with exudates.	

Somerset Partnership NHS Foundation Trust

CATEGORY A INFECTIOUS DISEASES

Infectious Substances Affecting Humans (UN 2814) – Excluding Cultures

Ebola virus

Flexal virus

Guanarito virus

Hantaan virus

Hantavirus causing haemorrhagic fever with renal syndrome

Hendra virus

Junin virus

Kyasanur Forest disease virus

Lassa virus

Machupo virus

Marburg virus

Monkeypox virus


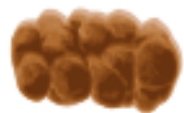





Nipah virus

Omsk haemorrhagic fever virus

Sabia virus

Variola virus

Bristol Stool Chart

Type 1		Separate hard lumps, like nuts (hard to pass)
Type 2		Sausage-shaped but lumpy
Type 3		Like a sausage but with cracks on the surface
Type 4		Like a sausage or snake, smooth and soft
Type 5		Soft blobs with clear-cut edges
Type 6		Fluffy pieces with ragged edges, a mushy stool
Type 7		Watery, no solid pieces. Entirely Liquid