**Special infection control formerly isolation policy and procedure Policy and Procedure**

**Brief update for COVID-19 2020 added**

|  |  |
| --- | --- |
| **See also:**  | **Located in the following policy folder on the Trust Intranet** |
| Standard infection control procedures  | Infection Control |
| Hand hygiene policy | Infection Control |
| Clostridium difficile policy | Infection Control |
| MRSA policy | Infection Control  |
| Outbreak of diarrhoea and vomiting policy | Infection Control |
| Patient Placement, Transfer & provision of information policy | Infection Control  |
| PPE | Health & Safety |
| Care of the expectant mother | Health & Safety  |

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| --- | --- | --- | --- | --- |
| **Service area** | **Issue date** | **Issue no.** | **Review date** | REGARDS Stamp v2 |
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| **Ratified by** | **Ratification date** | **Responsibility for review:** |
| TICC | 13th December 2017 | Assistant Director of Public and Physical Healthcare |

![MCj04326610000[1]]() **Did you print this document?**

Document published on the Trust Intranet under: Infection Control

Please be advised that the Trust discourages retention of hard copies of policies and can only guarantee that the Policy on the Trust Intranet site is the most up-to date version

**ACCESSIBLE INFORMATION STANDARD**

The Accessible Information Standard directs and defines a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of service users.

Ensure you have considered an agreed process for: sending out correspondence in alternative formats and appointments for patients / service users with communication needs, where this is applicable.

**Checklist for Special infection control formerly isolation policy and procedure**

|  |
| --- |
| **Summary (Plain English)** Summarise the main points of the policy below in a style that is clear and easy to understand. Ensure the whole policy is written in plain English, using simple language where possible and avoiding convoluted sentences and obscure words. The resulting policy should be easy to read, understand and use, |
| This policy provides the information required to determine appropriate isolation precautions based on the route of transmission of an infection. Such precautions are crucial in reducing the risk of cross-infection for both patients and staff. |

|  |  |
| --- | --- |
| **Name / Title of policy/procedure** | Special infection control formerly isolation policy and procedure |
| **Aim of Policy** | The purpose of this policy is to ensure that all healthcare workers employed within the Trust are aware of, and adhere to, infection control isolation precautions.  |
| **Sponsor (Director lead)** | Executive Director of Nursing & Patient Experience |
| **Author(s)** | Interim Assistant Director of Public and Physical HealthcareInfection Control Support Nurse, Strategic & OD |
| **Name of policy being replaced** | Special infection control formerly isolation policy and procedure | **Version No of previous policy: 4** |

|  |  |
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| **Commissioning individual or group:** | TICC (superseded by Physical Health Care and Infection Control Committee in 2019) |

|  |  |  |
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| **Individuals or groups who have been consulted:** | **Date:** | **Response** |
| TICC | 13.12.17 | Approved |
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**Version control (for minor amendments)**

|  |  |  |
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| 13.12.17 | Julie Carvin | Minor changes (ESBL, notifications) |
| 23.03.20 | Hayley Darn | Minor changes – added COVID19 standards  |
| 27th April 2020 | Carolyn Green/Richard Morrow | Minor changes – added COVID19 standards |

**The Derbyshire Healthcare NHS Foundation Trust gratefully acknowledges the work of the Derby Hospitals NHS Foundation Trust and Chesterfield Royal Hospital NHS Trust in the development of this policy. This partnership ensures continuity across 3 providers, streamlining the patient experience.**

**Special Infection Control Precautions (formerly isolation)** **Policy and Procedure**

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**Special Infection Control Precautions (formerly Isolation) Policy and Procedure**

# Introduction and Scope of the Policy

Standard precautions are the principle strategy for the prevention and control of nosocomial infection. Many diseases may be transmitted between patients and potentially between patients and staff. For this reason additional precautions are required. Sometimes it is necessary to isolate patients who are particularly vulnerable to infection for example patients whose immune system may be compromised; this is referred to as protective isolation. Patients who are known or suspected to be infected (or colonised) with highly transmissible or epidemiologically important pathogens may, following a risk assessment, be isolated in order to prevent the spread of infection. Such precautions are known as source isolation precautions.

Protective isolation would also apply to an individual or group who have been identified to have particular characteristics, history or medical conditions which place them in a higher risk category where national guidance directs the trust to facilitate the person treatment and care through protective isolation

The infected / colonised patient, as the source of infection, is segregated from unaffected patients, usually in a single room but, on occasions, within a cohort of similarly affected patients. Physical segregation, combined with other precautions such as the use of protective clothing, is aimed at reducing the likelihood of infections spreading via the airborne, enteric or contact routes.

The extent of the source isolation depends on:

I the infecting organism and the route of transmission

Ii the physical and mental abilities of the patient

This policy provides the information required to determine appropriate isolation precautions based on the route of transmission. Whilst every effort must be made to ensure that patients are isolated as laid down in this policy it is recognised that in certain circumstances such as seasonal outbreaks of diarrhoea and / or vomiting it may not always be possible to do so due to lack of single room accommodation.

The Infection Control Team must be informed of any patient cared for in isolation within and inpatient areas of the Trust.

This policy cannot pertain to those being cared for in their own homes, or in residential settings, however Community staff should find this useful as a method of assessing risk should they be notified of a patient under their care who has a named infection. Community staff will find this useful, however it would be appropriate to seek advice form the Infection Control team to aid risk assessment and care planning in such an event.

The Health Act 2008: Code of Practice for the Prevention and Control of Healthcare Associated Infections states that 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. The Trust also has a responsibility to ensure that adequate isolation facilities are available.

# Purpose and Outcomes

The purpose of this policy is to ensure that all healthcare workers employed within the Trust are aware of, and adhere to, infection control isolation precautions. Such precautions are key in reducing the risk of cross-infection for both patients and staff.

Adherence to this policy will reduce the risk of any avoidable healthcare associated infection. This policy will also ensure compliance with the Health and Social Care Act 2008: Code of Practice for the NHS for the Prevention and Control of Healthcare Associated Infections.

# Definitions Used

|  |  |
| --- | --- |
| **Isolation Room** | A single room designated to a patient with an infectious disease or organism. |
| **Cohort Area** | A designated area used for multiple patients with the same infection e.g. a four bedded bay or a whole ward. |
| **Isolation Code** | The mode of care which must be adhered to in order to safely nurse the infected patient. |
| **Protective Isolation** | Isolation of a severely immunocompromised patient in a single room to protect them against infection. |
| **Source Isolation** | Isolation of a patient known or suspected to have an infection, or to be colonised with resistant organisms. Isolation is considered necessary to reduce the risk of transmission to others |

# Key Responsibilities/Duties

## The Physical Health Care and Infection Control Committee

* Will endorse the Isolation Policy and review as per review dates.
* Will provide the Board with assurances that effective isolation policies and facilities are in place throughout the Trust to minimise the risk of infection transmission.

## Managers/ Matrons/ Clinical Leads/ Heads of Nursing / Ward Managers

* Are responsible for ensuring their own practice complies with this policy and for encouraging others to do so.
* Will ensure the Isolation Policy is implemented and complied with in their areas of responsibility.
* Identify areas whereby non-compliance may occur, e.g. due to building design, other risks
* Ensure any patient in the ward setting being nursed in isolation has this indicated in their electronic patient record, and this will include an assessment of risk and needs and care plan pertaining to the isolation procedures.

## The Infection Control Team

* Are responsible for informing laboratory based diagnosis and advising clinical staff on all aspects of isolation / cohort precautions to be undertaken.
* Will monitor that correct isolation / cohort precautions are in place and adhered to.
* Will liaise with Area Service managers or Matrons regarding isolation requirements and advise accordingly.
* Will provide up to date and timely information on all patients requiring isolation / cohort nursing, socially in a period of increased incidence or activity in partnership with the clinical team.
* Will ensure that CCG / other healthcare facilities Infection Control Teams are informed of any patient requiring isolation / infection control precautions on discharge / transfer.
* Report to the Trust Quality Committee or Trust Board as required by the Assurance framework, and report to the Director for Infection Prevention & Control of any difficulties in the implementation of this policy.

## Individual Employees

* Are responsible for ensuring their own practice complies with this policy and for encouraging others to do so.
* Provide affected patients and visitors with an explanation of their infection, the need for isolation precautions and treatment. The Infection Control Nurses can be contacted if patients and next of kin require further information.
* Must ensure that they follow any specific precautions laid down within this policy, tailored to the needs of the service user in a care plan.
* Must inform the Infection Control Team if a patient who requires isolation cannot be isolated, this will include a review of risk and a plan to manage the safety of this person and other patients.
* Must inform receiving departments / healthcare facilities of a patient’s infectious status and isolation/ infection control precaution requirements prior to transfer / discharge.

# Categories of Special Infection Control Precautions / Isolation

Knowledge of the possible route of transmission is necessary in order to apply isolation precautions appropriately and in particular to select appropriate protective clothing.

There a number of diseases / conditions which a patient may present with that do not require that they are cared for in isolation as long as strict adherence is made to standard infection control precautions. Included in this group are patients who are either Hepatitis B, Hepatitis C, or HIV positive, however these patients should be isolated if they are actively bleeding or have a co infection which requires them to be isolated. The risk of transmission here is from an inoculation incident and so all staff caring for these patients must be familiar with the Inoculation Policy and the immediate actions to be taken should an incident occur. The Infection Control Team can advise on individual cases.

Individual diseases / infections which require the patient to be nursed in isolation are listed in appendix 1. There are three categories of isolation used in this Trust:

Enteric

Contact

Airborne

These categories have been developed across the Derbyshire health Community and are common with other local Trusts. This should ease continuity of care.

Protective isolation is not usually indicated within the mental health services; it is a specialist approach used in those who are severely immunocompromised – such as in haematology, severe burns. If this technique is to be employed, it is under the direct supervision of a specialist consultant and it unlikely to be in use within our service.

## Enteric precautions

Enteric transmission is often referred to as the faecal – oral route. It is when bacteria, viruses and some parasites are passed from the animal or human stool into your mouth. Food, water or hard surfaces can act as a vehicle in assisting this transmission. The microbe is ingested, causes gastrointestinal infection and is excreted in faeces. Transmission to another host occurs when the infected person contaminates his or her hands with faeces and the hands transfer the organism which is then ingested by someone else.

Examples of these are the diarrhoeal illnesses, such as gastroenteritis, rotavirus, Clostridium difficile diarrhoea, Salmonella spp.

The duration of isolation is noted within Appendix 1.

For specific infection control precautions cards see Appendix 2. These are intended as am ‘aide memoire’ for the clinical team, but do not replace the need for a patient specific care plan.

## Contact

Transmission of organisms may occur either by direct or indirect contact.

Direct contact transmission involves skin to skin contact and physical transfer of micro-organisms to a susceptible host from an infected or colonised person, such as occurs when patients are turned, bathed or during other patient care activities that require physical contact. In healthcare workers the dominate vector is contaminated hands of staff.

Indirect contact transmission involves a susceptible host with a contaminated intermediate object, usually inanimate, in the patient’s environment – often referred to as fomites examples are contaminated instruments, bed tables etc.

 Examples of these are MRSA, Streptococcal infections, Pseudomonas aeruginosa, Impetigo.

For specific infection control precautions and duration of isolation see appendix 1.

## Airborne / Droplet Borne

This type of transmission is when droplets are generated from the source person primarily during coughing, sneezing and talking, and during the performance of cough inducing procedures such as suctioning and bronchoscopy. Transmission occurs when the droplets containing micro-organisms are expelled into the air from the infected patient and deposited on the host’s conjunctivae, nasal mucosa or mouth.

The time the droplets remain suspended in the air or the distance they may travel is dependent on the size of the organism involved and its pathogenicity. Some droplets may remain suspended in the air for long periods of time and may become inhaled by a susceptible host within the same room or over a longer distance from the source patient.

A cough or sneeze may generate droplets which can contribute to the spread of infection. There are some medical procedures which generate much smaller droplets which linger in the air and are classified as aerosols. NHSI and Public health England publish information for health professionals to describe and explain these procedures and these are regularly reviewed and update by NERVTAG (New and Emerging respiratory Virus Threats / Advisory Group). As this guidance is subject to regular update we suggest clinicians use the online public Health England resource page for most up to date guidance.

Skin squames are shed from the skin surface at a rate of 300 million a day and are the main component of dust. Some of the squames carry micro-organisms. Small dust particles may remain airborne for several hours and can be inhaled or settle in wounds.

Examples of these are Chicken pox (varicella), Pulmonary Tuberculosis, Measles.

For specific infection control precautions and duration of isolation see appendix 1

# Managing the Policy and Procedures for Isolation

**It may be necessary for the Infection Control team to recommend nursing a patient in isolation. This will be subject to comprehensive risk assessment by the multidisciplinary team in conjunction with Infection Control, and patient safety will be central to this decision, which will be under regular review. A plan of care will be formulated and regularly reviewed.**

Careful explanation must be given to both the patient and, with consent, relatives on the reason for isolation, the precautions required and the likely duration. This should be documented in the patient care record.

It is important to remember that the patient will not only be physically isolated but may also feel psychologically isolated and therefore must not be neglected. Access to telephones, newspapers and televisions must be provided. This will include additional measures such as iPads, messaging systems and other electronic devices to reduce the risk of psychological distress through the use of technology.

As with any other diagnosis confidentiality must be maintained for the infected patient. Whilst nursing and medical staff on the ward will be aware of the patient’s diagnosis, other health care workers only need to know the risk of infection and precautions to be taken. This does not breach confidentiality**.**

**Mental Capacity Act 2005**

**Using the isolation codes in response to a diagnosis of infection may impact on a person’s ability to move around the ward or area as they may wish and to have contact with other people. For person who does not have capacity to make decisions such restriction of liberty may, in certain circumstances, reach such a degree that they result in he or she being deprived of their liberty, which is unlawful without proper authorization. If there are any concerns as to capacity of the person to make decisions these must be fully explored and documented by the multi -disciplinary team.**

**The Mental Capacity Act Guidance document provides a framework for assessing capacity and recording the decisions made regarding the care plan needs. It should be used accordingly in such situations. If the clinical team think that the level of restrictions imposed on a person without capacity could mean that they are being deprived of their liberty then they must discuss this in the care team, with their Matron or equivalent and contact the Mental Health Act Manager for further advice.**

**The level of restriction placed on an individual nursed in isolation can be minimised by good, person centred care planning. The care team must therefore take all reasonable steps to maintain the persons’ daily routine and personal contacts. Particular attention should be paid in this context to social activity and access to fresh air.**

**A link to this can be found via the Trust Intranet pages.**

## Risk assessment

* Any patient being cared for in isolation must have a needs and risk assessment completed which addresses the risk of isolation and a single room. If this risk is deemed high, or designated by COVID 19 following a positive test or shielding, then the Nurse in Charge must discuss (and document) with the patients Consultant and also the Matron for the area.

## Communication

* Careful explanation must be given to both the patient and, with consent relatives on the reason for isolation, the precautions required and the likely duration.
* It is important to remember that the patient will not only be physically isolated but may also feel psychologically isolated and therefore must not be neglected. Access to telephones, newspapers and televisions must be provided. The least restrictive practice should be considered. Access to advocacy should not be restricted on the grounds of infection control. The advocacy teams are welcome to contact Infection Control for advice if required, but in essence they follow the same procedures as a visitor.
* As with any other diagnosis confidentiality must be maintained for the isolated patient. Whilst nursing and medical staff on the ward will be aware of the patient’s diagnosis, other health care workers only need to know the risk of infection and precautions to be taken. This does not breach confidentiality**.**
* Charts / Treatment Cards etc. must be kept outside the room.
* Ensure the patient has any relevant Infection Control information leaflets. This should be adapted or offered in multiple languages or using an accessible version.
* The need for special infection control precautions is clearly documented in a plan of care for the patient, and this must be communicated to each member of the clinical team as part of each handover process. The electronic patient record should be updated with a time limited alert. Any wider physical health care conditions or risks should be adopted. Signage is not used on a routine basis to indicate an isolation room, however the clinical team must ensure they have robust systems in place to ensure information is handed over correctly, and that risk of cross infection is minimised. Communication with domestic and support staff is included in this statement.

## Documentation

* The date a patient is placed in isolation and the reason must be clearly recorded in the Electronic Patient Record.
* A care plan must be formulated to determine how staff will implement the principles, and to give a basis for evaluation. The needs of the wider multidisciplinary team must be considered here.
* The psychological and physical well-being of the patient should be evaluated daily.
* The date the patient is removed from isolation must be clearly recorded in the nursing records.
* There may be occasions where isolation is not possible. In these instances the reasons must be clearly documented and advice gained from the Infection Control Team.
* The Domestic Supervisor must be informed of any patient being nursed in isolation, as they are required to alter their cleaning routines.

##  Room Preparation/Equipment

* **The door should remain closed when undertaking personal care, clinical procedures and bed making. Where respiratory precautions are in use, then door closing may be required,** **if there are concerns for patient safety e.g. at risk of falls, self-harm, the Senior Nurse should be contacted to assist in undertaking a risk assessment.**
* Any equipment that is not needed must be removed prior to admission of the patient. Furniture, such as chairs, should ideally be impervious covered, and able to withstand cleaning.
* Access to disposable plastic aprons and non-sterile gloves must be obtained. If this is not possible at the point of care (due to risk), then a locally agreed procedure must be employed (e.g. in a box in the office) which must be relayed at each handover.
* Ensure that a mechanism for infected waste is in place – bag at point of care (and removed) or bio box.
* Equipment such as sphygmomanometers, stethoscopes and thermometers should be dedicated to the patient wherever possible, remain in the room with the patient if appropriate, and be cleaned on discharge. These are available in re-stock cabinets at local level.
* Cleaning of clinical equipment in between sessions should be undertaken in accordance with the cleaning protocols and any additional cleaning requirements depending upon the nature of the outbreak. Liaise directly with the infection control team if it is unclear what schedule / cleaning products should be used.
* Patient hand hygiene must be encouraged; this may include wearing PPE or a mask.
* Any equipment moved out of the isolation room (e.g. hoists) must be decontaminated appropriately prior to storage or use by another patient, with evidence of such cleaning.
* Disposable tourniquets and blood pressure cuffs should be used for patients in isolation and remain in the room if possible until discharged.
* A “Declaration of Contamination Status” form must accompany any equipment, which requires repair or maintenance.
* Ensure mattresses and pillows are intact and encased completely in waterproof covers.
* Isolation rooms and cohort areas must be kept tidy and clutter free to facilitate effective cleaning.
* Locker and table tops should be kept clear, any patient food, such as biscuits, sweets and fruit must be kept covered and inside the locker

## Procedure to be Followed Prior to Entering the Room

* Acquire any equipment (e.g. dressing pack, waste bags, linen bags etc.).
* Wash hands or use alcohol hand rub.
* Put on apron and gloves or other personal protective equipment as required.



## Procedure to be Followed Prior to Exiting the Room

* Dispose of any aprons and gloves into the clinical waste bin inside the room.
* Wash hands with soap and water at the sink, dry hands thoroughly. On exiting the room, always use alcohol hand rub.
* If leaving the room with body fluids / excreta ensure protective clothing is worn until task is complete (e.g. taking commode to dirty utility room), dispose of immediately into clinical waste. Wash hands or use alcohol hand rub.



## Crockery, Cutlery, Water Jugs and Glasses

* Must be washed via a dishwasher. .
* No item of crockery or cutlery used by a patient with an infectious disease is to be washed by hand.
* There is no requirement for any disposable or dedicated items to be used, unless specifically advised by the Infection Control Team.
* Return all these used items to the main kitchen on the trolley. If the trolley is missed, discard uneaten food into the clinical waste bag in the room and cover the tray and crockery with a paper towel for aesthetic reasons.

## Linen and Waste

* All linen should be classed as infected.
* Place in a soluble bag and then into outer plastic bag as policy.
* Take used linen immediately to the collection point; used linen must not be left in the room.
* All waste should be placed into an infected waste bag (orange) or bio box and taken directly to the areas designated waste collection point and placed in the designated container.
* Wash hands after dealing with any waste or contaminated linen.

## Storage of Pharmaceutical Items

* All medicines should be stored in the clinical room / treatment room or drug trolley and not stored in the isolation room

## Patient hygiene

* Bathing and showering are preferable to bed baths to prevent the redistribution of microorganisms
* Baths and showers must be cleaned thoroughly between uses (standard practice). There should be no restriction of access to washing facilities on the grounds of infection control.
* Clean towels and flannels should be used daily, Give consideration to offering the patient disposable wipes, if appropriate.
* Patient hand hygiene is key during times of infection; ensure the care plan covers encouragement of hand hygiene.

## Visitors

* Under certain circumstances some restrictions may be placed on visitors so as to prevent the spread of infection. This will be defined and communicated in any pandemic incidents.
* Children (<12 years), pregnant women and immunocompromised people may be at particular risk from some infections, always take advice from the Infection Control Team.
* Any known specific risks should be reviewed e.g. specific protected characteristics groups should be considered.
* The nurse in charge should discuss with the patient what visitors must do to protect themselves from infection and whether there are any visitors who may be at particular risk of infection. This may include in exceptional events – restricting visiting. The senior nurse and lead consultant psychiatrist of the unit can override this requirement. This can be undertaken in exceptional circumstances and can be defined.
* Visitors rarely need to wear aprons or gloves (unless assisting with personal care or in exceptional pandemic situations); hand washing on leaving an isolation room is usually adequate.
* It is not advisable to visit any other patients in the hospital.
* Visitors carrying any infection (for example influenza, chicken pox, diarrhoea) should be advised not to visit the ward whilst infectious. Contact the infection control team should advice be required.

## Transfer of Patients to Other Departments

* Only in exceptional circumstances would the patient’s infectious status prevent investigations or procedures being undertaken in other departments.
* The nurse in charge is responsible for advising the receiving department e.g. X-Ray, ECG of any necessary precautions to be taken.
* If the patient requires surgery, the receiving operating theatre must be informed of the patient’s infection, preferably 24 hours’ notice should be given.
* An infection control transfer form (see Patient Placement Policy and Approved forms documents on intranet) must accompany a patient who is subject to isolation precautions and being transferred.
* Any staff transporting patients must be advised of any precautions to be taken.
* Wash hands or use alcohol hand rub following a task involving any patient in isolation.
* Following transport of an isolated patient, trolleys / chairs should be wiped down with detergent or alcohol based wipes, paying particular attention to armrests.
* Spillages of blood or body fluids should be cleaned as per policy.

## Ambulance Transport of Patients

* It is the responsibility of the nurse in charge to notify the ambulance service in advance of any precautions they need to take.
* Requiring ambulance transport will not be a barrier to a patients’ discharge. The ambulance service has their own guidelines of how to manage infected patients.

## Transfer to another ward or healthcare provider

* Any patient subject to infection control precautions who is being transferred must be risk assessed prior to transfer as to need for and suitability of transfer.
* The Nurse in Charge is required to ensure that written notification accompanies the patient\*, however in reality conversation will have occurred prior to the transfer. (Use the Infection Control Transfer form)

(\*except in an emergency situation. Clearly document this handover).

## Staff work wear

* Staff who wear uniforms as part of their role are advised to change into their uniform when they arrive at work and travel to and from work in their own clothes.
* Specific outbreaks may have particular guidance related to uniforms and / or work wear. Colleagues will need to be vigilant in regards to communications or specific advice from the infection control team.



## Diagnosis of a Notifiable Disease

* Please see appendix 2 for a list of those conditions currently notifiable under the Health Protection (Notification) Regulations 2010.
* Any diagnosis of a notifiable condition must be coupled with an urgent discussion with the Consultant Microbiologist.
* The appropriate form (NOID 2010) form should be completed and sent to the Public Health England as below

|  |
| --- |
| PHE East Midlands Health Protection Team, Public Health England, Seaton House City Link, Nottingham, NG2 4LATel: 0344 2254 524 (select option 1) in and out of hours |

* A copy of the NOID form must be held in the patient electronic reocrds
* The NOID form is available on contacting the ICT or PHE
* An incident reporting form must be completed and initially graded as high risk, and sent to the CEO.

# Monitoring Compliance and Effectiveness

The Infection Control Team will undertake isolation audits, and will escalate any non-compliance with this policy to the relevant Senior Nurse or Head of Nursing.

##### The wards teams have the ongoing support of the Infection Control Team to ensure effective implementation of the policy.

Where a patient is being nursed in isolation, the clinical team will ensure that they have informed their Matron, who will oversee a patient centred focus.

##### Isolation audits will be reported to the Infection Control Committee, who will also decide on the frequency of audit.

# Training and implementation

The training needs for the relevant staff groups will be met as defined in the Trust Compulsory Training matrix, as a part of Infection Prevention & Control Training.

Ward managers will be responsible for ensuring that staff are briefed as to the content of the policy.

Additional support can be obtained from the Infection Control team.

# References

Department of Health (2006). The Health Act 2006: A Code of Practice for the Prevention and Control of Healthcare Associated Infections.

Department of Health (2007). Saving Lives: Reducing Infection, Delivering Clean and Safe Care.

Nauseef WM, Maki DG. A study of the value of simple protective isolation in patients with granulocytopenia. *NEJM* 1981;304:448-453.

# APPENDIX 1: DISEASE-SPECIFIC SPECIAL INFECTION CONTROL (ISOLATION) PRECAUTIONS

| **Disease/Infecting Agent** | **Infective Material** | **Precautions Indicated** | **Period of Isolation Precautions** | **Precautions Necessary** |
| --- | --- | --- | --- | --- |
|  |  | **Single room** | **Gown/****Apron** | **Gloves** | **Mask** | **Linen** |  |  |
| ABSCESS1. Draining (aetiology unknown)
 | Pus | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Duration of discharge | Wound and skinModify precautions when organisms identified |
| 1. Closed
 |  None |
| Acquired Immune Deficiency Syndrome (AIDS) | Blood & body fluid | Not usually | ......................................................................................................... | Refer to Blood Borne virus guidelines in the Infection Control Manual |
| AMOEBIC DYSENTERY\* | Faeces | Yes if patient hygiene poor | Yes if soiling likely | Yes for touching infective material | No | Treat as infected | Until clinical recovery | Enteric precautions |
| ANTHRAX (CUTANEOUS)\* | Lesion exudate | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until culture-negative | Wound and skin.Respiratory |
| ANTHRAX (PULMONARY/SYSTEMIC) \* | Respiratory secretions | Yes | Yes+ | Yes+ | Yes | Treat as infected | Until clinical recovery | Respiratory precautions**URGENT - TRANSFER TO ISOLATION UNIT** |
| ASPERGILLUS |  None  |
| AVIAN FLU | Respiratory secretions | Yes | Yes+ | Yes+ | Yes | Treat as infected | Until clinical recovery |  |
| BACILLARY DYSENTERY(See Shigella) \* | Faeces | Yes (door may be left open) | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until asymptomatic for 48 hours and patient has normal stools | Enteric precautions |
| BACTERIAL SEPTACAEMIA |  |  |  |  |  |  |  | Not unless in certain areas |
| BODY LICE | Lice | Yes | Yes + | Yes for touching infective material+ | No |  | Until treated |  |
| BOTULISM |  None  |
| BRONCHITIS Adult |  None  |
| BRONCHITIS Infant and young children | Respiratory secretions | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until clinical recovery | Respiratory precautions |
| BRONCHIOLITIS | Respiratory secretions | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until clinical recovery | Respiratory precautions |
| BRUCELLOSIS \* |  None - but contact Infection Control  |
| CAMPYLOBACTERENTERITIS \* | Faeces | Yes if patient hygiene poor | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until clinical recovery and patient has normal stools | Enteric precautions |
| CANDIDA INFECTIONS |  None |
| CHICKEN POX\*(varicella zoster) | Respiratory secretions/Vesicle fluid | Yes | Yes for direct patient contact+ | Yes for direct patient contact+ | No  | Treat as infected | Until 7 days after last crop of vesicles appear | Respiratory/contact precautions. Wherever possible only staff known to be immune should attend the patient. |
| CHLAMYDIACONJUNCTIVITIS\*notifiable if neonate | Eye secretions | No | No | Yes for touching infective material | No | Normal | Until clinical recovery | contact precautions |
| CHOLERA\* | Faeces | Yes  | Yes+ | Yes+ | No | Treat as infected | Until 3 negative faeces specimens | Enteric precautions |
| CLOSTRIDIAL INFECTIONS (except CLOSTRIDIUM DIFFICILE) |  None |
| CLOSTRIDIUM DIFFICILE | Faeces  | Yes  | Yes+ | Yes+ | No  | Treat as infected | Until normal stools for 48hrs | Enteric precautions – see Clostridium difficile policy in Infection Control Manual |
| CONJUNCTIVITIS | Exudate | No | Yes+ | Yes for touching infective material+ | No | Normal | Until clinical recovery | Contact precautions |
| COVID19 | Respiratory secretions  | Yes | Apron YesGown for AGP | Yes | YesFRSM or equivalentFFP3 - for AGP | Treat as infected  | Follow the most up to date guidance provided by Public health England. If unclear speak to the Infection Control Team | Respiratory  |
| CREUTZFELDT-JACOB DISEASE\* | Brain and lymphoid tissue  | No | Yes+ | Yes for touching infective material+ | No | Normal | Duration of hospitalisation | See CJD policy in Infection Control Manual |
| CRYPTOSPORIDIUM ENTERITIS\* | Faeces | Yes if patient hygiene poor | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected if in single room | Until clinical recovery | Enteric precautions |
| CYTOMEGALOVIRUS INFECTIONS | Respiratory secretions/urine | No | Yes+ | Yes for touching infective material+ | No | No | Until discharge | NoneBlood/body fluid |
| DIARRHOEA AND/OR VOMITING OF UNKNOWN CAUSE\*notifiable if food poisoning | Faeces/vomit | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Depends upon causative organism (if isolated) Or 48 hours symptom free  | Enteric precautions |
| DIPHTHERIA\* | Respiratory secretions | Yes | Yes - gown over apron+ | Yes+ | Yes | Treat as infected | Until clinical recovery | Respiratory precautions contact Consultant Microbiologist |
| DYSENTERY\* | Faeces  | Yes  | Yes + | Yes+ | No  | Treat as infected | Until 48hrs symptom free |  |
| ESCHERICHIA COLI 0157\*  | Faeces | Yes  | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until 48 hours asymptomatic | Enteric precautions |
| EXTENDED SPECTRUM BETA LACTAMASE PRODUCING BACTERIA (ESBL’s), AMP C CPE, E.coli Urinary tract infections | Faeces, UrineDependant on site positive to ESBL | Yes  | Yes | Yes | No | Treat as infected | Until discharge – review by infection controlDiscuss with microbiology | Direct contact precautions as discussed with ICT |
| FOOD POISONING (SALMONELLA)\* | Faeces | Yes if patient hygiene poor | Yes+ | Yes for touching infective material+ | No | Treat as infected | Until symptom free and until patient has normal stools | Enteric precautions |
| GENITAL HERPES |  None contact infection control |
| GLANDULAR FEVER |  None |
| HEAD LICE |  None contact infection control |
| HEPATITIS A\* | Faeces | Yes if patient hygiene poor | Yes+ | Yes for touching infective material+ | No | Treat as infected  | Until 7 days after onset of jaundice | Enteric precautions |
| HEPATITIS B\*  | Blood/body fluids | Not usually |  | Refer to Blood Borne virus guidelines in the Infection Control Manual |
| HEPATITIS C\* | Blood/body fluids |  | Refer to Blood Borne virus guidelines in the Infection Control Manual |
| HEPATITIS - NON-A, NON-B (ENTERIC) \* | Faeces | ....................................................................................................................... As Hepatitis A Enteric precautions |
| HEPATITIS E \* | Faeces | ...................................................................................................................... As Hepatitis A Enteric precautions |
| HERPES SIMPLEX (SKIN, ORAL AND GENITAL) | Lesion secretions | Only if disseminated | Yes+ | Yes for touching infective material+ | No | Normal | Until clinical recovery | Contact precautions |
| HERPES ZOSTER (SHINGLES) | Lesion fluid | Yes | Yes+ | Yes for touching infective material+ | No | Treat as infected | Until all lesions are scabbed | Contact precautionsStaff in contact should be immune to VZ |
| HIV – see AIDS | Blood and body fluids | Not usually |  | Refer to Blood Borne virus guidelines in the Infection Control Manual |
| IMPETIGO | Lesion secretions | Yes | Yes+ | Yes for touching infective material+ | No | Treat as infected | While lesions are present | Contact precautions |
| LASSA FEVER \* |  See Viral Haemorrhagic Fever section |
| LEGIONNAIRES’ DISEASE |  None |
| LEPROSY\* New Case  | Nasal secretions, skin lesions | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until treated (approx. 3 months) | Contact precautions |
| LEPROSY Treated |  None |
| LEPTOSPIROSIS(See Weil’s disease) | .............................................................................................................................. See Weil’s disease |
| LISTERIA INFECTION  |  None |
| MALARIA\* |  None -see Blood and body fluid management policy |
| MARBURG DISEASE \* | ..................................................................................................................................See Viral Haemorrhagic Fever section |
| MEASLES \* | Respiratory secretions | Yes | Yes+ | Yes for touching infective material+ | No(Yes if not immune) | Treat as infected | Until 7 days from onset of rash | Respiratory precautions.Only staff known to be immune should attend the patient. |
| MENINGITIS\*(HAEMOPHILUS/ meningococcal/ viral or other)  | Respiratory secretions | Yes | No | No | No | Normal | Until 48 hours after the start of effective antibiotic treatment | Respiratory precautions for first 48 hours.  |
| MRSA | Variable; may include pus or sputum | Yes  | Yes+ | Yes+ | No | Treat as infected | Until discharge or 3 negative cultures each a week apart | Contact precautionsRespiratory precautions if pneumonia or chest infection-see MRSA policy in Infection Control Manual |
| MULTI-RESISTANT ORGANISMS - DESIGNATED BY THE CONSULTANT MICROBIOLOGIST | Variable; may include pus, urine, sputum | Not usually | Yes+ | Yes for touching infective material+ | Not usually | Usually normal | Until culture negative | Precautions depend on site of infection.Contact either Consultant Microbiologist or Infection Control Nurse for specific advice. |
| MUMPS\* | Respiratory secretions | Yes | Yes+ | Yes for touching infective material+ | No | Treat as infected | 10 days after onset | Respiratory precautions |
| PARATYPHOID FEVER \* | Faeces and urine | Yes  | Yes+ | Yes+ | No | Treat as infected | Until 3 negative faeces specimens. Food handlers require 6 negative specimens at 2-weekly intervals. | Enteric precautions |
| PERTUSSIS\*(whooping cough) | Respiratory secretions | Yes | Yes+ | Yes for touching infective material+ | No | Treat as infected | Until 7 days after effective antibiotic treatment | Respiratory precautions |
| PNEUMONIA (Pneumococcal) |  None |
| PNEUMONIA (Staphylococcal) | Respiratory secretions | Yes | Yes if soiling likely+ | Yes+ | No | Normal | Until culture negative | Respiratory precautions |
| POLIOVIRUS INFECTION POLIOMYELITIS\* | Faeces/respiratory secretions | Yes | Yes+ | Yes for direct patient contact+ | No | Treat as infected |  | Enteric precautions. Only staff with immunity should attend the patient. |
| PSEUDOMEMBRANOUS COLITIS(CLOSTRIDIUM DIFFICILE) | Faeces | Yes | Yes+ | Yes for infective material+ | No | Treat as infected | Until clinical recovery.48 hours asymptomatic & until patient has normal stools | Enteric precautions |
| PSEUDOMONAS AEROGINOSA INFECTIONS | Variable; may include urine or pus | Not usually | Yes+ | Yes for touching infective material+ | No | Normal | Until culture negative | Contact precautions |
| PSITTACOSIS |  None |
| RINGWORM | Affected skin area | No | No | Yes for touching infective material | No | Normal | Until clinical recovery | Contact precautions |
| ROTAVIRUS ENTERITIS | Faeces | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until 48 hours after symptoms have ceased (72 hours in children) | Enteric precautions.  |
| RSV/RESPIRATORY SYNCYTIAL VIRUS(See Bronchiolitis) | Respiratory secretions | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until clinical recovery | Respiratory precautions |
| RUBELLA\* | Respiratory secretions | Yes | No | Yes for touching infective material | No-yes if not immune | Treat as infected | Until 7 days after onset of rash | Respiratory precautions.Only staff who are immune should attend patient. |
| SCABIES | Scabies mite |  |  |  |  |  |  |  |
| SCARLET FEVER\* | Respiratory secretions | Yes | No | Use for touching infective material | No | Normal | Until 48 hours after the start of effective antibiotic treatment | Respiratory precautions |
| SHIGELLA INFECTIONS\*(See Bacillary Dysentery) | Faeces | Yes  | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until asymptomatic for 48 hours & until patient has normal stools | Enteric precautions |
| SHINGLES | ..................................................................................................................................................................... See Herpes Zoster |
| BETA-HAEMOLYTIC STREPTOCOCCUS GROUP A | Variable but include pus or respiratory secretions | Yes | Yes if soiling likely+ | Yes for touching infective material+ | No | Normal | Until 48 hours after start of effective antibiotic treatment | Respiratory or contact |
| BETA-HAEMOLYTIC STREPTOCOCCUS (OTHER GROUPS) | Variable ; may include pus or respiratory secretions | Not usually | Yes if soiling likely+ | Yes for touching infective material+ | No | Normal |  | Contact precautions |
| SYPHILIS (PRIMARY OR SECONDARY) | Mucocutaneous lesions | No | No | Yes  | No | Normal | Until 48 hours after start of abx treatment | Contact precautions |
| TAPEWORM | Faeces | No | Yes if soiling likely+ | Yes for touching infective material+ | No | Normal |  | Enteric precautions |
| TETANUS\* |  None |
| TONSILLITIS (STREPTOCOCCAL) | Respiratory secretions | Yes | No | Yes for touching infective material | No | Normal | Until 48 hours after start of effective antibiotic treatment | Respiratory precautions |
| TOXOCARIASIS |  None |
| TOXOPLASMOSIS |  None |
| TUBERCULOSIS\*GENITO-URINARY  |  None High Risk stickers needed for urine specimens |
| TUBERCULOSISORTHOPAEDIC\* | Exudate/pus | No | Yes if soiling likely+ | Yes for touching infective material+ | No | Normal |  | Wound and skin precautions |
| TUBERCULOSIS PULMONARY (CLOSED)\* |  None |
| TUBERCULOSIS PULMONARY(OPEN) \* | Respiratory droplets | Yes  | Yes+ | Yes if handling sputum+ | See policy | Treat as infected | Until sputum specimen is AFB negative | Respiratory precautions see TB Policy in Infection Control Manual |
| TYPHOID FEVER \* | Faeces and urine | Yes (door may be left open) | Yes if soiling likely+ | Yes for touching infective material+ | No | Treat as infected | Until 3 negative faeces specimens at weekly intervals | Enteric precautions |
| VARICELLA | ............................................................................................................................... ................................... See Chickenpox |
| VANCOMYCIN RESISTANT ENTEROCOCCI (VRE) |  |  |  |  |  |  | See VRE Policy in Infection Control manual |  |
| **VIRAL HAEMHORRAGIC FEVERS\* (Marburg, Lassa, Ebola)** | Blood, body fluids and respiratory secretions | **Yes – door closed** | Yes - gown over apron+ | Yes+ | Yes | Treat as infected | **Discuss with Microbiologist**  | **CONTACT CONSULTANT MICROBIOLOGIST URGENTLY**  |
| WEIL’S DISEASE\*(See Leptospirosis) | Urine and blood | No | No | Yes  | No | Normal | During hospital stay | Blood and body fluid precautions |
| WHOOPING COUGH \* | .................................................................................................................................................................... See Pertussis |
| WOUNDS INFECTED (SEE MULTI-RESISTANT ORGANISMS) | Exudate/pus | Not usually | Yes if soiling likely+ | Yes for touching infective material+ | No | No | Until culture negative | Wound and body fluid precautions |

# APPENDIX 2: NOTIFIABLE DISEASES, WITH EXPLANATORY NOTES AND GUIDANCE ON THE NEED FOR URGENT NOTIFICATION

NB: This Table is only for guidance and each case should be considered individually.

|  |  |  |
| --- | --- | --- |
| **Notifiable diseases** | **Definition / comment** | **Likely to be urgent?** |
| Acute encephalitis |  | No |
| Acute meningitis | Viral and bacterial. | Yes, if suspected bacterial infection. |
| Acute poliomyelitis |  | Yes |
| Acute infectious hepatitis | Close contacts of acute hepatitis A and hepatitis B cases need rapid prophylaxis. Urgent notification will facilitate prompt laboratory testing. Hepatitis C cases known to be acute need to be followed up rapidly as this may signify recent transmission from a source that could be controlled. | Yes |
| Anthrax |  | Yes |
| Botulism |  | Yes |
| Brucellosis |  | No – unless thought to be UK-acquired |
| Cholera |  | Yes |
| COVID-19  | Emerging profile – follow Public Health England guidance. | Yes |
| Diphtheria |  | Yes |
| Enteric fever (typhoid or paratyphoid fever) | Clinical diagnosis of a case before microbiological confirmation (e.g. case with fever, constipation, rose spots and travel history) would be an appropriate trigger for initial public health measures, such as exclusion of cases and contacts in high risk groups (e.g. food handlers). | Yes |
| **Notifiable diseases** | **Definition / comment** | **Likely to be urgent?** |
| Food poisoning | Any disease of infectious or toxic nature caused by, or thought to be caused by consumption of food or water (definition of the Advisory Committee on the Microbiological Safety of Food). | Clusters and outbreaks, yes.For specific organisms see Table 2. |
| Haemolytic uraemic syndrome (HUS) |  | Yes |
| Infectious bloody diarrhoea | See also HUS in Schedule 1 and VTEC in Schedule 2. | Yes |
| Invasive group A streptococcal disease and scarlet fever |  | Yes, if IGAS. No, if scarlet fever |
| Legionnaires’ Disease |  | Yes, |
| Leprosy |  | No |
| Malaria |  | No, unless thought to be UK-acquired |
| Measles |  | Yes |
| Meningococcal septicaemia |  | Yes |
| Mumps | Post-exposure immunization (MMR or HNIG) does not provide protection for contacts. | No |
| Plague |  | Yes |
| Rabies | A person bitten by a suspected rabid animal should be reported and managed urgently, but if a patient is diagnosed with symptoms of rabies, they will not pose a risk to human health. | Yes |
| Rubella | Post-exposure immunisation (MMR or HNIG) does not provide protection for contacts. | No |
| **Notifiable diseases** | **Definition / comment** | **Likely to be urgent?** |
| SARS |  | Yes |
| Smallpox |  | Yes |
| Tetanus |  | No, unless associated with injecting drug use |
| Tuberculosis |  | No, unless healthcare worker or suspected cluster or multi drug resistance |
| Typhus |  | No |
| Viral haemorrhagic fever (VHF) |  | Yes |
| Whooping cough |  | Yes, if diagnosed during acute phase |
| Yellow fever |  | No, unless thought to be UK-acquired |

**NB:** Registered Medical Practitioners are also required to notify suspected cases of other infections (“other relevant infection”) or contamination (“relevant contamination”) that present, or could present, significant harm to human health.

Any notifiable disease diagnosed within the Derbyshire Healthcare NHS Foundation Trust must­ be discussed with the Consultant Microbiologist.

An untoward incident form must be completed in addition to the NOIDs form. The incident form must be graded as ‘major’, and submitted in line with the Trust Untoward Incident Reporting procedure.

Health Protection Agency Contact details:

|  |
| --- |
|  **The Proper Officer, Health Protection Team**  |
| PHE East Midlands Health Protection Team, Public Health England, Seaton House City Link, Nottingham, NG2 4LATel: 0344 2254 524 (select option 1) in and out of hours service |

# REGARDS EIRA: Assessing Equality Relevance (Stage 1)

1. Name of the service / policy / project or proposal (give a brief description):

|  |
| --- |
| Policy for managing service users with identified infections |

2. Answer the questions in the table below to determine equality relevance:

|  |  |  |  |
| --- | --- | --- | --- |
|  | Yes | No | Insufficient data / info to determine |
| Does the project / proposal affect service users, employees or the wider community, and potentially have a significant effect in terms of equality? | Yes |  | In COVID 19 BAME over representation/ at riskAt risk or shielded groups.  |
| Is it a major project / proposal, significantly affecting how functions are delivered in terms of equality? | Yes |  | Cohort nursing and management in COVID 19 outbreak |
| Will the project / proposal have a significant effect on how other organisations operate in terms of equality?  | Yes |  | In COVID 19 BAME over representation/ at riskAt risk or shielded groups. |
| Does the decision/ proposal relate to functions that previous engagement has identified as being important to particular protected groups? |  | 🗸 |  |
| Does or could the decision / proposal affect different protected groups differently? | Yes |  | Yes MH patients may be at risk of overly restricted practice, isolation in the community 7 days and in hospital 14 days. DON has written to national group to outline the risks. |
| Does it relate to an area with known inequalities? |  | 🗸 |  |
| Does it relate to an area where equality objectives have been set by our organisation? | Yes |  |  |

1. On a scale of high, medium or low assess the policy in terms of equality relevance.

|  |  |  |
| --- | --- | --- |
|  | Tick below: | Notes: |
| High |  | If ticked all ‘Yes’ or ‘Insufficient data’ |
| Medium | 🗸 | If ticked some ‘Yes’ and / or ‘Insufficient data’ and some ‘No’ |
| Low |  | If ticked all ‘No’ |

**EIRA completed by: Julie Carvin, Infection Control Support Nurse**

**Date: 13.12.17. Reviewed by Carolyn Green 27th April 2020**