ISOLATION UNIT OPERATIONAL POLICY

V4.1

October 2016
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1. Introduction

1.1. The Isolation Unit/Ward is a twelve bedded purpose built facility for the Royal Cornwall Hospital Trust site. The unit comprises twelve en-suite side rooms for the source isolation of patients with a range of communicable infections.

1.2. The service is provided for by Medical Services in partnership with the Hospitals Infection Prevention and Control team and in conjunction with the Site Management Team.

2. Purpose of this Policy/Procedure

This policy sets out the operational function of the Isolation Ward service to the hospital.

3. Scope

This policy applies to all staff working or visiting the Isolation Ward.

4. Definitions / Glossary

Definitions are contained within the text.

5. Ownership and Responsibilities

5.1. Role of the Associate Director for Medical Services

Must ensure that resources are available for health care workers to undertake effective standard and isolation precautions.

5.2. Role of the Clinical Directors for Medical Services

Clinical Directors are responsible for ensuring appropriate levels and expertise of senior and junior medical staff to safely manage patients on isolation ward.

5.3. Role of Identified Consultants for Isolation Ward Clinical Service

To provide and coordinate medical care for isolation ward patients and/or to ensure appropriate clinical management is provided by consultant teams who are allocated isolation ward beds.

5.4. Role of Clinical Microbiologist

Responsible for providing clinical microbiology advice and expertise in the infection related management of patients in isolation ward.

5.5. Role of Senior Matrons/Departmental Managers

Responsible for ensuring that staff are aware of this guidance and that the guidance is implemented and adhered to.
5.6. Role of all Clinical/Divisional Directors
Responsible for ensuring that medical staff are compliant with this policy.

5.7. Role of All Staff
Staff have a clinical and ethical responsibility to carry out effective Infection Prevention and Control procedures and to act in a way which minimises risk to the patient.

Staff working on Wheal Prosper will ensure timely discharges and utilise the discharge lounge where able. Ward staff, namely the nurse in charge will also identify patients suitable for transfer to alternative wards on a daily basis and with the infection control team, consider patients for transfer into isolation beds as identified on the side room log. The agreed priority list is as appendix 3.

5.8. Role of Clinical Site Team
The Site Co-ordination Team and Bed Managers are responsible for ensuring that patients are correctly placed in accordance with this policy, and for escalating any situations where safe placements cannot be achieved.

Site Co-ordination team will endeavour to keep one side room free to accommodate for emergency admissions who require isolation.

5.9. Role of Infection Prevention and Control Team
The Infection Prevention and Control Team are responsible for identifying patients who meet the criteria to be admitted to the isolation ward - as per priority list (appendix 3).

They will visit the isolation ward at least 3 times per week and are responsible for providing any additional infection control training to the isolation ward staff on request.

The infection control team will update the RCHT side room log so that appropriate and updated information is available to the ward team.

6. Standards and Practice

6.1. Primary Purpose of the Isolation Unit
The RCHT Isolation Unit is designed to enable the safe management of patients presenting with communicable disease whilst minimising the risk of transmission to other patients and staff. It is a valuable and important resource that many other acute Trusts do not have. It is vital that it is used appropriately and efficiently and that the admission and discharge policies set out below are followed.

 Patients presenting with the following conditions should be admitted as soon as possible to the Isolation Ward. The agreed priority list is as appendix 3. (See also guidance below for Wheal Prosper admission criteria in suspected or proven tuberculosis).
1) Laboratory confirmed *Clostridium difficile* infection

2) Suspected or confirmed community acquired infective gastroenteritis (including Norovirus*, Rotorvirus, Campylobacter, Salmonella, Shigella, E.Coli 0157, Cryptosporidiosis, Giardiasis and Amaebiasis) (see P 7).

3) Suspected or confirmed Influenza infection.

4) Suspected or confirmed viral exanthum (i.e. patient with a fever and a rash due to viral infection such as rubella, parvovirus, measles etc.)

5) Suspected or confirmed viral haemorrhagic fever

6) Febrile illness (and other infections) on return from travel abroad

7) Suspected or confirmed acute viral hepatitis

8) Suspected or confirmed Chickenpox and shingles

9) Infection or colonization with MRSA (*Methicillin Resistant Staphylococcus aureus*) during current hospital admission where there is a high risk of transmission to others (seek IPAC advice).

10) Infection or Colonization with ESBL (Extended Spectrum beta lactamases) / AmpC betalactamase producing organisms such as *E.coli* and *Klebsiella* species which have been isolated during the current hospital admission and where there is a high risk of transmission to other patients (seek IPAC advice)

11) Confirmed or suspected cases of infection/colonization with carbapenemase producing enterobacteriaceae (CPE)

12) Any other infections with risk of transmission where Infection control team/consultant microbiologist consider isolation.

**Exclusions**

1) Children under the age of 16 years

2) Patients with Cystic Fibrosis

**Tuberculosis:**

Patients with suspected or confirmed Pulmonary Tuberculosis (caused by M.TB complex), or extra-pulmonary TB when MDR TB is suspected or pulmonary involvement has not been excluded, need to be assessed for transmission risk by a respiratory physician and IPAC team to determine appropriate placement.

High risk patients, and patients admitted non-electively with suspected pulmonary TB who have not yet been assessed by a respiratory
physician, should be managed in Wheal Prosper Ward. The Respiratory Team must be informed within 24 hours of admission. Low risk cases can be managed in the side rooms of Wellington ward.

6.2. Visiting

- To facilitate patient care and effective cleaning, visitors are limited to 2 per bed
- Visitors under 12 years to be allowed only in exceptional circumstances (children must be supervised at all times)
- Patients and their visitors admitted to the ward to be given detailed information regarding the ward visiting hours as per hospital visiting policy
- Relatives who provide personal care for patients should wear aprons and gloves
- All visitors must be advised to hand wash thoroughly before and after visiting
- Visitors must not sit on the beds and should refrain from eating on the ward or using patient toilet facilities
- Any visitor on antibiotic treatment (currently or in the previous month) or who is immuno-suppressed (e.g. receiving cancer treatment) should be made aware of the risk and discouraged from visiting the unit
- If visiting other patients in the hospital, visitors must make the visit to the Isolation Unit their last visit

6.3. Discharge Criteria

All patients need to have a daily review for discharge or transfer from isolation ward.

6.4. General Operation of the Isolation Unit

6.4.1. Bed Management on the Isolation Unit

- Patients attending ED and/or admitted to MAU/SRU with suspected or confirmed communicable disease should be prioritised for admission/transfer to the Isolation Ward to prevent transmission of disease around the hospital and to improve patient flow through these areas. In certain situations, it may be appropriate to admit patients directly to the unit from the community (e.g. known Clostridium difficile patients with confirmed relapse) providing medical staff are present to assess the patient on arrival to the unit.
- Admission to the unit will be co-ordinated by the Site team in conjunction with the IPAC team, admitting medical team and Nurse in Charge.
- All patients that meet the admission criteria (section 6) with a NEWS score of less than 5 (or less than 3 for any individual observation) and who are clinically stable, should be transferred to the Isolation unit. Appropriateness of admission to Wheal Prosper for patients with a NEWS score of 4 or above should be discussed with the Consultant responsible for the ward.
- All patients will receive a medical review daily to identify those who may be transferred out of the unit. A list of those suitable for
transfer out will be available on the ward to allow planning of unit capacity and optimisation of isolation beds.

6.4.2. Nurse Management of Patients and Nurse Staffing
- Bank staff may only be used if confirmed up-to-date with mandatory training in infection control.
- Once a staff member has commenced on a shift in the unit, they cannot be moved from the Isolation Unit to be sent to other wards. Staff will be notified prior to shift commencement in the unit if they have to report elsewhere – this will be in response to patients numbers on the unit and the need to demonstrate effective use of resources, unless there are exceptional circumstances – this will be reflected via DATIX
- Nursing staff to undertake cannulation and venepuncture routinely for patients
- Nursing staff to be trained in infection control practices

6.4.3. Medical Management of Patients and Medical Staffing
- Patients transferred into the Isolation Unit will be medically managed by a Consultant from the Renal and Endocrine Teams allocated 6 beds each with input from microbiology Consultants.
- Patients with orthopaedic or surgical infections may only be transferred to the Isolation Unit where there is a documented agreement from the speciality consultant that the patient will remain under the care and responsibility of the speciality team and will be regularly reviewed by the named consultant for the duration of their stay.
- Patients with confirmed *Clostridium difficile* will be reviewed on a weekly basis by a team comprising Infection Prevention and Control Nurse, Microbiologist and Gastroenterologist.
- Patients with confirmed *Clostridium difficile* infection from surgical or orthopaedic specialities will be managed under joint care of the specialities and the medical team
- Out of hours cover to be provided from the Division of Acute Medicine’s on-call Doctor
- Patients admitted to the isolation ward often have significant comorbidities. Refer to roles and responsibilities.

6.4.4. The Role of the Isolation Unit during an outbreak of Norovirus
- Ideally, patients in the community with suspected Norovirus should not be admitted to secondary care. Every attempt should be made to manage them in the community or residential care with support from GP’s and district nurses (AND Acute Care at Home if IV rehydration is needed). The Isolation Unit will be used as the primary access unit for those patients who have been identified prior to accessing services at RCHT, as having suspected Norovirus where admission is unavoidable
- Patients in ED or MAU who have symptoms of Norovirus infection, where no other clinical cause can be identified for the symptoms, are to be admitted to the Isolation Unit. A medical plan of care must be initiated prior to admission to the unit and a full diarrhoea risk assessment completed.
• The Isolation Unit nursing staff are responsible for ensuring that all patients admitted directly to the unit (from home, community, ED) have a post take Consultant review.

• In-patients from other wards at RCH with suspected or confirmed Norovirus must not be transferred to the unit unless a decision has been made by the IPAC Team to do so as part of a Trust escalation policy, in accordance with current HPA guidelines.

7. Dissemination and Implementation

7.1. The Trust will demonstrate that this document has been issued, read and implemented as follows:

• Inclusion in the Weekly Bulletin
• Inclusion in the Document Library on the Trust’s Intranet, which all staff are encouraged to use to gain access to Controlled Documents
• Distribution to relevant Ward and Departmental Managers
• Inclusion in the Quarterly Link Practitioner meeting
• Inclusion in the Infection Prevention and Control newsletter
• Distribution to the Clinical Site Team

8. Monitoring compliance and effectiveness

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Compliance with admission criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lead</td>
<td>Infection Prevention and Control Team</td>
</tr>
<tr>
<td>Tool</td>
<td>Side room log</td>
</tr>
<tr>
<td>Frequency</td>
<td>Daily Monday – Friday</td>
</tr>
</tbody>
</table>

Reporting arrangements
Concerns with compliance with admission criteria will be escalated by the Ward and Deputy Sisters to the Specialty Medicine Matron and Infection Prevention and Control Team.

Acting on recommendations and Lead(s)
The Specialty Medicine Matron and Infection Prevention and Control Team will act on recommendations on a case by case basis with the relevant people involved.

Change in practice and lessons to be shared
Where themes are identified these will be shared through the governance processes within Medical Services and within the Infection Prevention and Control Team.

9. Updating and Review

This policy will be reviewed at least every 3 years by the Infection Prevention and Control Department in co-ordination with the Specialty Medicine Matron and Clinical Director for Specialty Medicine, or more frequently if considered necessary.
10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Diversity & Human Rights Policy' or the Equality and Diversity website.

10.2. Equality Impact Assessment
The Initial Equality Impact Assessment Screening Form is at Appendix 2.
### Appendix 1. Governance Information

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Isolation Unit Operational Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>21 October 2016</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>21 October 2016</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>21 October 2019</td>
</tr>
</tbody>
</table>
| Directorate / Department responsible (author/owner): | Dr A Collinson  
Dr P Chakrabarti  
L. Dickinson |
| Contact details:                | 01872 254969                      |
| Brief summary of contents       | Provides details of the admission criteria to the isolation ward. |
| Suggested Keywords:             | Infection prevention and control  
Isolation  
Communicable diseases |
| Target Audience                 | RCHT PCH CFT KCCG                 |
|                                 | ![Checkmark]                      |
| Executive Director responsible for Policy: | Medical Director |
| Date revised:                   | October 2016                      |
| This document replaces (exact title of previous version): | Isolation Unit Operational Policy |
| Approval route (names of committees)/consultation: | Medical Services Governance and Quality Board |
| Divisional Manager confirming approval processes | Sheena Wallace  
(Medical Services Associate Director) |
| Name and Post Title of additional signatories | Stephen Creely  
(Clinical Director Speciality Medicine) |
| Signature of Executive Director giving approval | {Original Copy Signed} |
| Publication Location (refer to Policy on Policies – Approvals and Ratification): | Internet & Intranet  
![Checkmark]  
Intranet Only |
| Document Library Folder/Sub Folder | Clinical / Infection Prevention & Control |
| Links to key external standards | Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 12 |
| Related Documents:              |                                   |
### Training Need Identified?

No

### Version Control Table

<table>
<thead>
<tr>
<th>Date</th>
<th>Version No</th>
<th>Summary of Changes</th>
<th>Changes Made by (Name and Job Title)</th>
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<tbody>
<tr>
<td>Jan 2011</td>
<td>V1.0</td>
<td>Initial Issue</td>
<td></td>
</tr>
<tr>
<td>Jun 2011</td>
<td>V2.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 2013</td>
<td>V3.0</td>
<td></td>
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<tr>
<td>Dec 2014</td>
<td>V4.0</td>
<td>Review of admission criteria. Amendments to roles and responsibilities. Re-formatted to current Trust Template.</td>
<td>Andrew Collinson DIPC Prithwi Chakrabarti Infection Control Doctor Louise Dickinson, DIPC</td>
</tr>
<tr>
<td>May 2016</td>
<td>V4.1</td>
<td>Addition and incorporating priority list (Appendix 3).</td>
<td>Trish Prady – Matron Speciality Medicine</td>
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**All or part of this document can be released under the Freedom of Information Act 2000**

**This document is to be retained for 10 years from the date of expiry.**

**This document is only valid on the day of printing**

**Controlled Document**

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.
Appendix 2. Initial Equality Impact Assessment Form

| Name of the strategy / policy / proposal / service function to be assessed (hereafter referred to as policy) (Provide brief description): | Isolation Ward Operational Policy |
| Directorate and service area: | Medical Services |
| Name of individual completing assessment: | Louise Dickinson |
| Telephone: | 01872254969 |

1. Policy Aim*
   Who is the strategy / policy / proposal / service function aimed at?
   To provide staff with guidance to admit patients appropriately to the isolation ward

2. Policy Objectives*
   Correct isolation of patients

3. Policy – intended Outcomes*
   That patients will be placed appropriately on the isolation ward and that the ward is utilised correctly.

4. *How will you measure the outcome?
   Daily side room log

5. Who is intended to benefit from the policy?
   Patients

6a) Is consultation required with the workforce, equality groups, local interest groups etc. around this policy?
   b) If yes, have these *groups been consulted?
   C). Please list any groups who have been consulted about this procedure.

7. The Impact
   Please complete the following table.

<table>
<thead>
<tr>
<th>Equality Strands:</th>
<th>Yes</th>
<th>No</th>
<th>Rationale for Assessment / Existing Evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there concerns that the policy could have differential impact on:

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<table>
<thead>
<tr>
<th><strong>Sex (male, female, transgender / gender reassignment)</strong></th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Race / Ethnic communities / groups</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Disability - Learning disability, physical disability, sensory impairment and mental health problems</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Religion / other beliefs</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Marriage and civil partnership</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Pregnancy and maternity</strong></td>
<td>✓</td>
</tr>
<tr>
<td><strong>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</strong></td>
<td>✓</td>
</tr>
</tbody>
</table>

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation - this excludes any policies which have been identified as not requiring consultation. or
- Major service redesign or development

8. Please indicate if a full equality analysis is recommended. **No**

9. If you are not recommending a Full Impact assessment please explain why.

None of the equality strands have been identified in the initial impact assessment.

**Signature of policy developer / lead manager / director**

Louise Dickinson

**Date of completion and submission**

03.12.14

**Names and signatures of members carrying out the Screening Assessment**

1. Louise Dickinson

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**Keep one copy and send a copy to the Human Rights, Equality and Inclusion Lead,**
C/o Royal Cornwall Hospitals NHS Trust, Human Resources Department, Knowledge Spa, Truro, Cornwall, TR1 3HD

A summary of the results will be published on the Trust’s web site.
Signed: Louise Dickinson
Date: 2nd December 2014
Appendix 3 – Priority list of Patients for Wheal Prosper

1. Suspected E Bola
2. Confirmed CPE
3. Norovirus/Gastroenteritis from ED
4. Clostridium Difficile*
5. Influenza A & B (Strongly suspected or confirmed on current admission)
6. Patients with other highly resistant micro-organisms (as advised by Consultant Microbiologist / IPAC team).
7. TB**
8. CMV, Chicken pox and Shingles
9. Confirmed MRSA (within 2 years)
10. Confirmed ESBL*** if within 2 years or patient has risk factors.
11. Febrile illness on return from foreign travel

*on current admission or previous C diff confirmed and patient is symptomatic/Clinicians suspects on-going infection / relapse.
**pulmonary with clear documented plan from respiratory team prior to transfer to Wheal Prosper
***/Amp C/ K1 on current admission or if within 2 years and patient has risk factors as per ESBL/Amp C policy.

NB patients who are at significant risk of deterioration should be assessed to determine whether higher care is required prior to transfer

Guidance on Process
If patient has diarrhoea, a diarrhoea assessment tool needs to be completed by both a Staff Nurse and/or Doctor prior to acceptance onto Wheal Prosper.

Dates and times of samples sent and or results to be clearly documented and communicated to Wheal Prosper Staff Nurse on handover.

Nurse in charge on Wheal Prosper to liaise with Bed Manager / Site Coordinators daily to recognise patients who are not infected and who could be moved to other areas. (When 3 trained on WP NIC to attend 12.00 bed meeting to agree potential bed moves in coordination with site team and other operational pressures.)

Mindful of multiple bed moves and communication with clinical teams about clinical ownership of patients – See Wheal Prosper Draft Standing Operating Procedure

Goal
PDSA - Aim to achieve 90% active infective patients from above criteria as side room log (current performance 60%)

Lisa Waine (Ward Sister – Wheal Prosper)
Jo Anderton (Deputy Sister – Wheal Prosper)