

INFECTION CONTROL MANUAL

PRACTICAL GUIDE TO INFECTION CONTROL - SECTION 1

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POLICY FOR ROUTINE HANDWASHING

Handwashing is the single most important procedure for preventing cross infection.

Aim: Routine handwashing removes most microorganisms from soiled hands. It is essential to wash hands before and after contact with ANY patient and when hands may have become contaminated with microorganisms.

CLEANING AGENT	USE	RATIONALE	PRECAUTIONS
Liquid soap (e.g. Leversoft)	Routine hand washing	Effective in most settings, cost effective and contains emollient	
Antiseptic Cleaning Agents <i>Chlorhexidine - e.g. Hibiscrub, Hydrex</i> <i>Iodine - e.g. Betadine Scrub</i>	For use in theatre/"scrub" areas.	More effective than unmedicated soap for removing resident microorganisms	

POLICY FOR ROUTINE HANDWASHING

CLEANING AGENT	USE	RATIONALE	PRECAUTIONS
Alcohol rubs and gels e.g. Purell alcohol hand rub	<p>As part of routine hand hygiene. Following soap and water wash, rinse and thorough drying of hands.</p> <p>OR INSTEAD of hand washing for example:-</p> <ul style="list-style-type: none"> • Where access to handwashing facilities are difficult or inadequate • Ward rounds <p>NB To be effective alcohol gel must be applied to visibly clean, dry hands</p>	<p>Rapid disinfection of physically clean hands.</p> <p>Effective against most micro-organisms</p>	<p>Physically soiled hands MUST be washed before application of alcohol rub</p> <p>Apply as standard hand washing technique and rub until dry (see handwashing sequence)</p> <p>Must not be applied to gloved hands</p> <p>Flammable, use only as directed MUST be stored in cool place</p>

Note: Any of these cleansing agents may cause skin irritation in Health Care Workers. In case of any skin irritation/damage, the Health Care Worker should cease using the implicated cleansing agent and contact the Occupational Health Department as soon as possible.

HANDWASHING IN A CLINICAL SETTING

ACTION	RATIONALE
Avoid wearing long sleeved garments or roll up sleeves when undertaking hand hygiene.	Ensuring all areas of the hands/wrists are washed effectively.
Wet hands before applying cleansing agent.	Reduces risk of skin sensitisation to cleansing agent.
Dispensers should be wall mounted with disposable cartridges. Sodexo staff should refill soap dispensers. Refilling of the alcohol hand rub dispensers is the responsibility of the nursing staff.	Reduces risk of contamination.
Dispensers should be cleaned daily as part of the Sodexo domestic cleaning schedule.	Reduces risk of contamination.
A sink with elbow or foot operated mixer taps should be used, if possible. If only hand taps are available these can be turned off using paper towels.	Reduces risk of contamination. Allows adjustment of water temperature for optimal washing.
Soft paper towels from a wall mounted dispenser with good drying properties should be used.	Wet surfaces transfer microorganisms more effective than dry ones. Paper towels rub away transient organisms from hands.
Foot operated pedal bins should be used to dispose of paper towels.	Hands will be re-contaminated by lifting the lid of the bin manually.

HANDWASHING IN A CLINICAL SETTING

ACTION	RATIONALE
Keep skin on hands in good condition.	Bacterial counts increase when skin is damaged. Staff are known to reduce the frequency of hand washing when hands are sore and chapped.
Apply good quality hand cream from a dispenser. Refilling of the hand cream dispensers is the responsibility of the nursing staff.	Reduces skin damage. Communal tubs of cream can become contaminated.
Avoid the use of nail-brushes for routine hand hygiene.	To prevent cross infection and skin damage
Apply hand cream before meal breaks and at the end of shift.	The creams are more effective if left in contact with skin for a longer period of time.
Cover any damaged skin on hands with waterproof, impermeable dressings.	Loss of skin integrity increases risk of exposure to blood borne pathogens during skin contact with blood and body fluids.
Always wear disposable gloves when handling blood and body fluids.	Reduces risk of exposure to blood borne pathogens.

HANDWASHING IN A CLINICAL SETTING

ACTION	RATIONALE
Avoid wearing latex gloves unless required (see glove policy).	Reduces risk of latex sensitivity.
WASH hands after gloves are removed.	Gloves do NOT always provide a complete impermeable barrier.
Keep finger nails short and clean.	Microbes can harbour beneath the finger nails.
Do not wear false nails or nail polish.	False nails and nail polish discourage thorough hand washing.
Do not wear wrist watches, bracelets and rings with stones and ridges.	Total bacterial counts are higher on skin under rings, wrist watches and bracelets.

HANDWASHING IN A CLINICAL SETTING

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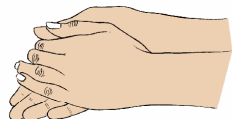
Hand hygiene

Hand hygiene, using a good technique, is the most effective method of preventing cross infection

Hand washing sequence

(Note that the number of “strokes” in each step is 5)

- 1** Wet hands under running water.



- 2** Apply soap, rub palm to palm.



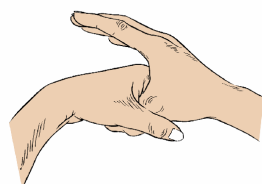
- 3** Rub right hand over back of left hand. Change hands and repeat.



- 4** Interlace the fingers to get soap between the fingers.



- 5** Rub right finger tips into palm of left hand. Change hands and repeat.



- 6** Rub right thumb with left hand. Change hands and repeat.



- 7** Rub left wrist with right hand. Change hands and repeat.

- 8** Rinse hands thoroughly under running water.

- 9** Dry hands thoroughly with paper towels.

Application of alcohol hand gel

(For hands that are not visibly dirty)

Apply the gel on dry hands as for step 2 and work through to step 7

HANDWASHING IN A CLINICAL SETTING

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POLICY FOR PROTECTIVE CLOTHING

Aim: Worn to reduce the transmission of microorganisms between patients and staff and prevention of contamination of blood and body fluids. Protective clothing must be easily accessible in all clinical areas.

	ACTION	RATIONALE
1.2.1.	Gloves All gloves should be clean, disposable, of good quality and well fitting.	For maximum effectiveness.
	None sterile latex gloves should be worn when undertaking venepuncture.	In the event of a needlestick injury, the amount of blood inoculated will be reduced.
	Powdered gloves must not be used.	They are more likely to induce an allergic reaction (see 'Guidelines for the Management of Latex Allergy') and microorganisms may be transmitted on the powder.
	Vinyl gloves must not be used for contact with body fluids or blood. Use non-powdered latex.	They are more permeable to blood borne viruses than latex and have greater chance of splitting.
	Never re-use gloves.	They are single use items.
	Change gloves if you notice any defects.	Protection provided may not be adequate.
	Keep fingernails short.	To avoid punctures.

POLICY FOR PROTECTIVE CLOTHING

	ACTION	RATIONALE
	Washing gloves must not be undertaken.	Gloves may be damaged by soap solution and if punctured unknowingly may cause body fluid to remain in direct contact with skin for prolonged periods.
	Remove gloves at the end of the procedure.	To avoid inappropriate use and contamination of the environment.
	Wash hands immediately.	Gloves may be punctured and hands are easily contaminated as gloves are removed.

Note: Some types of glove may cause skin irritation in Health Care Workers. In case of any skin irritation/damage, the Health Care Worker should cease using the implicated product and contact the Occupational Health Department as soon as possible.

POLICY FOR PROTECTIVE CLOTHING

	ACTION	RATIONALE
1.2.1.	<p>Non Sterile Gloves</p> <p>Must be worn:</p> <ul style="list-style-type: none"> ➤ When contact is likely with body fluids. ➤ When handling chemical disinfectants and cleaning equipment. ➤ When handling blood or blood spillages. ➤ When the Healthcare Worker has cuts/abrasions on the hand that cannot be effectively covered with a waterproof dressing. 	<p>To prevent skin contamination with harmful microorganisms or chemicals.</p>
	<p>Sterile Gloves</p> <p>Wash hands before wearing sterile gloves.</p> <p>Should be worn when carrying out a sterile technique.</p>	<p>To reduce microbial count, to remove dirt and skin oil and leave an antimicrobial residue on the skin to deter microbial growth.</p> <p>To prevent contamination of the site.</p>

Gloves will not prevent inoculation injuries

For further advice on selection/use of disposable gloves see charts 1 and 2 on page 16 and 17.

POLICY FOR PROTECTIVE CLOTHING

	ACTION	RATIONALE
1.2.2.	<p>Plastic Disposable Aprons</p> <p>A plastic apron should be worn when soiling of clothing or uniform is possible and to prevent cross infection to patients e.g.</p> <ul style="list-style-type: none"> ➤ Bed making/handling linen. ➤ Helping a patient with their personal hygiene. ➤ Assisting the patient with toileting. ➤ Carrying out or assisting with an invasive policy. ➤ When serving food to patients. (A blue apron should be worn for this). ➤ Where colour coding of aprons is used written guidance must be available. <p>Aprons should be disposed of at the end of the particular policy and hands washed.</p>	<p>The front of the body is the part most frequently contaminated by microorganisms</p> <p>Plastic disposable aprons provide adequate protection in most circumstances.</p> <p>To reduce the risk of cross infection.</p>

POLICY FOR PROTECTIVE CLOTHING

	ACTION	RATIONALE
1.2.3.	<p>Eye Protection</p> <ul style="list-style-type: none"> • Eye protection is advisable if there is a risk of splashing to the face with blood/body fluids. • Or there is a risk of aerosol production during a policy • Or there is a risk of splashing from potentially harmful substances e.g. disinfectants. <p>Eye protection must be shatter resistant and fracture proof and a comfortable fit, to eliminate need for frequent adjustment. They must fully cover eyes including side shields. They must be single use or decontaminated between use (see decontamination policy).</p>	<p>To prevent exposure of conjunctiva to potentially infectious, or harmful substances.</p> <p>For maximum effectiveness and re-use.</p>

POLICY FOR PROTECTIVE CLOTHING

	ACTION	RATIONALE
1.2.4.	<p>Masks</p> <p>Should be worn:</p> <ul style="list-style-type: none"> ➤ If there is a risk of splashing the face with body substances or aerosol production during a policy. ➤ In certain circumstances when patients are being barrier nursed (see isolation policy) ➤ In operating theatres by Healthcare staff in close contact with patient undergoing surgery. ➤ A new mask must be worn for each operation and should be replaced when it becomes damp. ➤ The mask must be discarded at the end of surgical procedure and NOT left around the user's neck. 	<p>To prevent exposure of mucous membranes to potentially infectious/harmful substances.</p> <p>To help protect the healthcare worker, or patient.</p> <p>To deflect any expired organisms.</p>

Additional protective clothing such as boots, gowns and headgear may be necessary for major surgical procedures.

In the event of a major incident (e.g. SARS, multi-drug resistant TB), please refer to the microbiology major incident plan for guidance on the use of special protective clothing.

POLICY FOR USE OF GLOVES

Gloves are designed to:-

- Protect the hands from becoming contaminated with organic matter and micro-organisms
- Protect the hands from certain chemicals that will adversely affect the skin condition of the user
- Minimise cross infection by preventing the transfer of organisms from staff to patients or vice versa

Prior to selecting a glove a risk assessment of the task to be undertaken is required to establish whether gloves are needed or not (see chart 1) and which type of glove to use (see chart 2). This assessment should include:-

- The nature of the task
- The risk of contamination
- Barrier efficacy of gloves
- Are sterile or non sterile gloves required
- Patient/User sensitisation

See chart 1.

POLICY FOR USE OF GLOVES

1.3.1 Risk Assessment and Glove Use

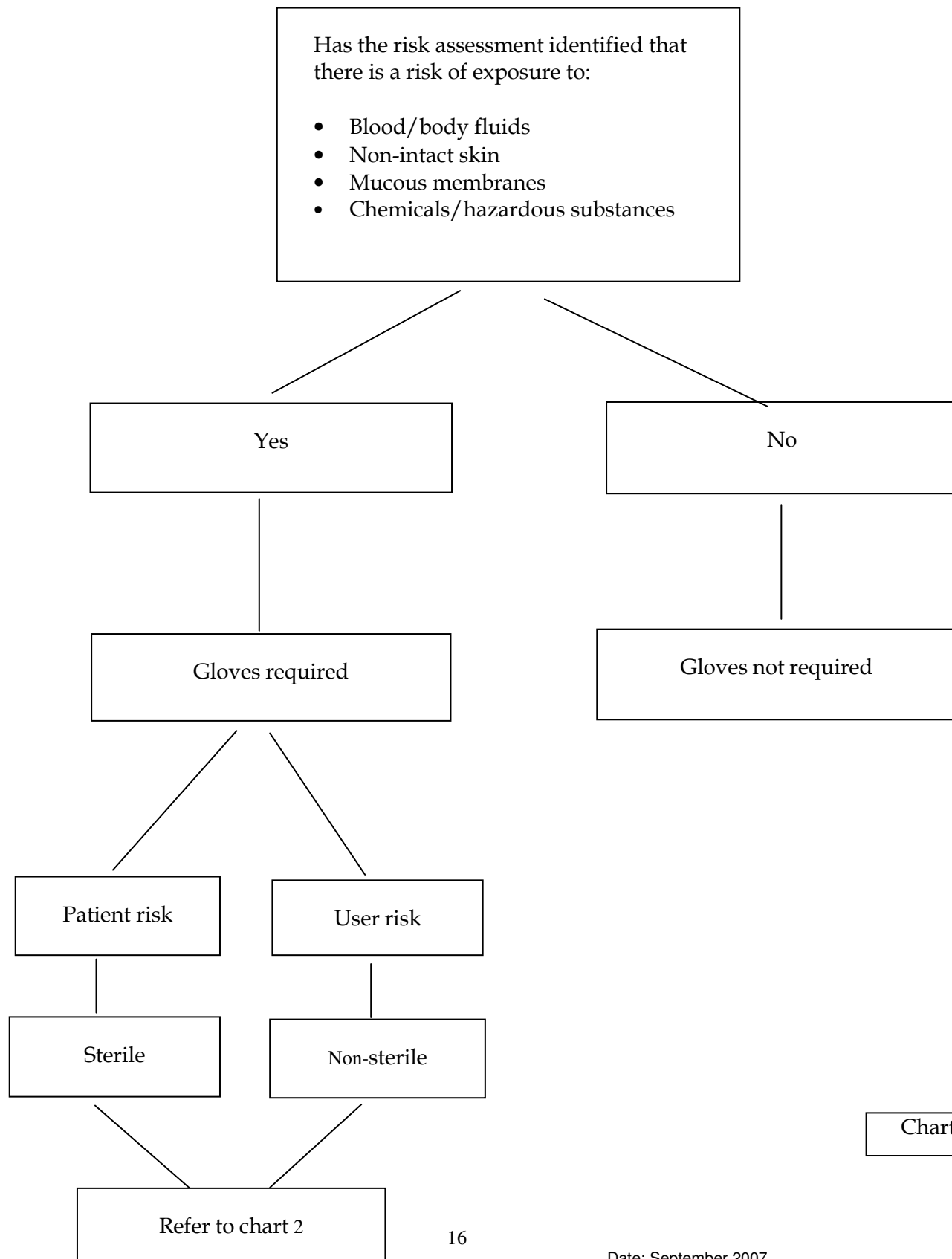


Chart 1

POLICY FOR USE OF GLOVES

1.3.2 Making the Correct Glove Choice

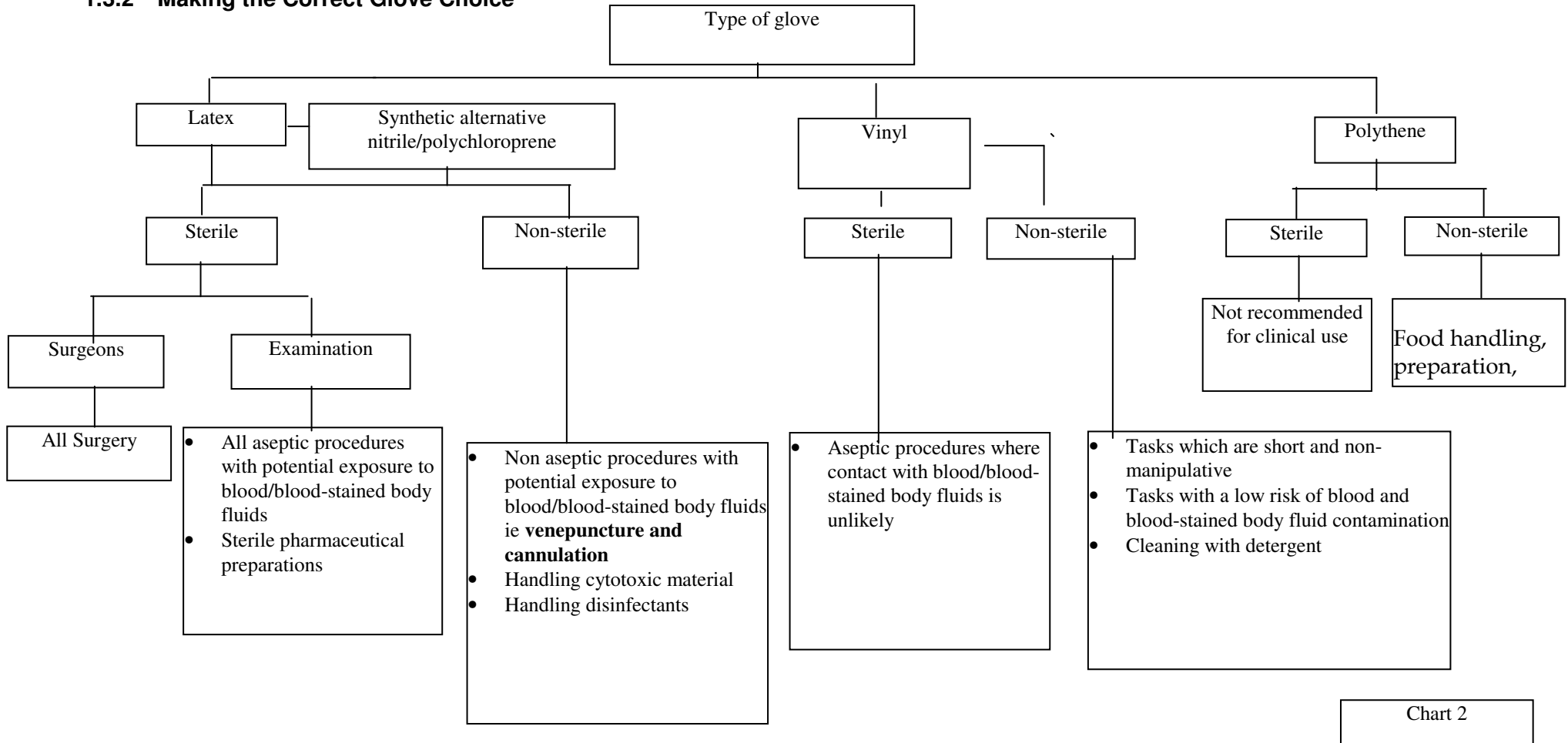


Chart 2

POLICY FOR THE USE OF GLOVES

1.3.3 Properties of Disposable Gloves

Natural Rubber Latex:

- Proven protection against blood borne viruses
- Close fitting, flexible
- Good sensitivity
- Comfortable
- Required when handling disinfectants

Vinyl:

- More permeable to blood borne viruses, therefore, unsuitable for handling blood and blood stained body fluids
- Lower tensile strength
- Rigid, inflexible
- High leakage rate
- Cheap
- Suitable when handling detergents

Polythene:

- Split easily and tear
- Ill fitting
- Not recommended for use in clinical setting (except over a latex glove when carrying out endotracheal suction).

Alternatives to latex are available if sensitisation occurs. Please see Occupational Health for further advice.

Powdered Gloves:

These are not recommended in a health care setting because they:

- Can effect wound healing
- Can lead to airborne allergens and cause asthma and conjunctivitis
- Release airborne particles which could act as vectors for pathogens
- May play a role in adhesion formation
- May contaminate medical devices e.g. epidural catheters

(See also Protective Clothing Policy)

POLICY FOR THE USE OF GLOVES

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POLICY FOR THE ISOLATION OF PATIENTS SUSCEPTIBLE TO INFECTION**PROTECTIVE ISOLATION (Reverse-Barrier Nursing)****Aim:**

To protect those patients whose susceptibility to infection is increased, i.e. they are immuno-suppressed and have an increased risk of acquiring an infection. **It is the responsibility of the nurse in charge to ensure that instructions regarding any necessary precautions are given to staff and visitors.**

ACTION	RATIONALE
Prepare and equip a single room for isolation. The side room is to be cleaned meticulously before the patient is admitted.	To reduce the risk of cross infection.
Ensure a notice is fixed to the outside of the door, advising <i>'Please see nurse in charge before entering.'</i>	Will ensure that all staff / visitors seek proper advice before entering the room, thus avoiding confusion and unnecessary anxiety. To ensure that patient confidentiality is not breached and to notify Sodexo that daily cleaning is required.
Inform Infection Control nurse.	The Infection Control nurse can be used as a valuable resource to facilitate patient care whilst isolated.
All visitors must wash their hands BEFORE entering the side room. Visitors should be limited to close friends and family only. Casual acquaintances or non-essential visitors as well as any visitor with an infection should be excluded.	To reduce the risk of cross infection to the susceptible patient.

POLICY FOR THE ISOLATION OF PATIENTS SUSCEPTIBLE TO INFECTION**PROTECTIVE ISOLATION (Reverse-Barrier Nursing)**

ACTION	RATIONALE
Explain the need for isolation to patient and relatives and allow them to express any anxieties they may have.	Reduces anxiety and fulfils legal requirements. Gains patient's trust and co-operation and involves them in care.
The patient should have the opportunity to wash all over / bath / shower daily (bath or shower to be cleaned before use and after). Patient's night clothes and bedding should be changed daily. Wash patient's bowl after use with hot water and general purpose detergent. Dry thoroughly with disposable paper towelling and do not store it on the floor.	This will prevent the acquisition of infection from the environment. Microorganisms proliferate rapidly in wet conditions.
Ensure mattress, pillow covers and patient chairs are intact.	Split waterproof covers are difficult to clean and may act as a reservoir for bacteria.
Patient to avoid contact with other patients.	To prevent patient acquiring infection.
Instruments or equipment to be used on this patient should be thoroughly cleaned before and after use.	To prevent cross infection.

POLICY FOR ISOLATION OF THE INFECTIOUS PATIENT

Introduction

Micro-organisms cause a wide variety of infections. Many take advantage of a host who is susceptible to infection but do not spread from that person to another person. A few micro-organisms cause infections which can spread easily from person to person and are called contagious or infectious diseases. (A list of those most commonly seen is contained in Appendix 1).

This policy must be implemented when patients are admitted with one of the infections listed under the heading 'Routes of transmission for common micro-organism' (Appendix I).

Aim:

To prevent an infectious agent spreading from one patient to another.

Requirements for Isolation Room

Essential

Single room
Clinical handwashing facilities

Desirable

En-suite lavatory and shower with separate handwashing facilities for patient use

Specific Isolation Policies

There are several pathogen specific isolation policies listed below within the infection control manual (see section 5).

Tuberculosis
Vancomycin Resistant Enterococci (VRE)
Clostridium difficile
Methicillin resistant Staphylococcus aureus (MRSA)
Viral Gastro-intestinal infection
Streptococcus (Group A)
Meningitis
RSV
CJD

POLICY FOR ISOLATION OF THE INFECTIOUS PATIENT

ACTION	RATIONALE
Prepare and equip a single room for isolation.	Allows isolation policy to be carried out in an organised manner.
Ensure a notice is fixed to the outside of the door, advising ' <i>Please see nurse in charge before entering</i> '. There should also be a notice inside the room asking people to wash their hands before leaving.	Will ensure that all staff / visitors seek proper advice before entering the room, thus avoiding confusion and unnecessary anxiety and ensures patient confidentiality is not breached and will inform Sodexo that daily room cleaning is required.
Inform Infection Control nurse at earliest opportunity.	Infection Control nurse can be used as a resource to facilitate patients care whilst isolated.
Explain the need for isolation to patient and relatives and allow them to express any anxieties they may have.	Reduces anxiety and fulfils legal requirements. Gains patient's trust and co-operation and involves them in their care.
Disposable aprons and gloves should be worn by all staff when handling blood or body fluids or for contact with patient or their immediate environment.	The use of protective clothing will reduce the risk of contaminating hands and uniforms.
Meticulous attention to hand hygiene before leaving the room by all staff and visitors.	HAND HYGIENE IS THE SINGLE MOST IMPORTANT MEANS OF PREVENTING CROSS INFECTION.
Apply alcohol hand gel prior to entering and after leaving the room.	Highly effective skin disinfectant (on physically clean hands).

POLICY FOR ISOLATION OF THE INFECTIOUS PATIENT

ACTION	RATIONALE
The patient's personal hygiene must not be restricted because of isolation.	Maintaining a high standard of personal hygiene can reduce the level of contamination of the environment.
<p>Wash patient's wash bowl after use with hot water and general-purpose detergent or through a washer disinfectant.</p> <p>Use detergent and water to remove grease and skin debris etc. from bowl. Dry thoroughly with disposable paper towelling and store inverted. (Do not store wash bowls stacked or on the floor).</p>	Micro-organisms proliferate rapidly in wet conditions.
Ensure mattress, pillow covers and patient chairs are intact.	<p>Split waterproof covers are difficult to clean and may act as a reservoir for bacteria.</p> <p>See policy for decontamination and maintenance of foam mattresses.</p>
Dispose of all bed linen into pink water-soluble bags. Pink bag may then be taken out of the room and put into linen skip. Store spare pink bags outside patient's room.	Prompt disposal of used linen into bags will reduce the risk of environmental and uniform contamination. The pink linen bag dissolves in the washing machine and prevents the need for rehandling soiled linen.
Dispose of all waste into yellow clinical waste bags. When $\frac{3}{4}$ full, seal top and take to where waste is stored prior to collection. The waste bag does not need to be double bagged.	Prompt disposal of waste will reduce environmental contamination.

POLICY FOR ISOLATION OF THE INFECTIOUS PATIENT

ACTION	RATIONALE
Patient may use ordinary crockery and cutlery. This should be returned to the kitchen after each meal and washed by the usual method.	The direct transmission of infection from crockery and cutlery is very unlikely providing it is washed thoroughly.
Door to the room to be kept shut, particularly during policies e.g. bed making, wound dressing.	To minimise spread of infection and maintain patient's privacy.
Patient to avoid having social contact with other patients.	To minimise the risk of transmission of infection.
Equipment used on isolated patients should be thoroughly cleaned before use on another patient.	To prevent cross infection. See policy for decontamination of equipment.
If the patient is to be transferred to other wards, departments or hospitals, please inform the receiving area in advance that this patient has been nursed in a single room and that they should contact the Infection Control team for advice.	To avoid confusion and anxiety to both staff and patient and to minimise spread.

For care of the deceased, please refer to Last Offices Policy.

ROUTES OF TRANSMISSION FOR COMMON INFECTIONS

INFECTION	INFECTIVE MATERIAL	ISOLATION	DURATION OF 1. INFECTIVITY 2. ISOLATION
AIDS	Blood, body fluids	None (unless uncontrolled bleeding)	1. Indefinitely
Campylobacter	Faeces	Yes	2. Isolate for duration of diarrhea
Chickenpox	Oral/lesion, secretions	Yes	2. Until lesions are crusted
Cholera	Faeces	Yes	2. Isolate for duration of diarrhoea
Clostridium difficile	Faeces	Yes	2. Isolate for duration of diarrhoea (see separate policy)
Clostridium perfringens	Faeces and lesion secretions	None	
Creutzfeldt-Jacob disease	Blood, brain tissue	None	1. Indefinitely
Croup (usually viral)	Respiratory secretions	Yes	2. Duration of symptoms
Cryptosporidium	Faeces	Yes	2. Duration of diarrhoea
Cytomegalovirus	Urine, respiratory secretions	None	
Diarrhoea, unknown origin	Faeces	Yes	2. Isolate for duration of diarrhoea
Diphtheria pharyngeal	Oral/nasal secretions	Yes	2. Until two nose/throat cultures negative
Diphtheria cutaneous	Lesion secretions	Yes	2. Duration of lesions
Enteropathic E coli infants	Faeces	Yes	2. Duration of symptoms
Gas gangrene	(see Clostridium perfringens)		
Gastroenteritis viral eg SRSV	Faeces, vomit	Yes	2. Isolate for duration of symptoms
Gastroenteritis unknown	Faeces, vomit	Yes	2. Isolate for duration of symptoms
Gonorrhoea	Discharge	None	2. Until 24 h antibiotic treatment

ROUTES OF TRANSMISSION FOR COMMON INFECTIONS

INFECTION	INFECTIVE MATERIAL	ISOLATION	DURATION OF 1. INFECTIVITY 2. ISOLATION
Hepatitis A	Faeces	Yes	2. Until onset of jaundice
Hepatitis B	Blood and body fluids	None (unless uncontrolled bleeding)	2. Until uncontrolled bleeding has stopped
Hepatitis C	Blood and body fluids	None (unless uncontrolled bleeding)	2. Until uncontrolled bleeding has stopped
Herpes Simplex (severe)	Lesion secretions	Yes	2. Duration of lesions
Herpes zoster	Lesion secretions	Yes	2. Until lesions have crusted
Human immunodeficiency virus	Blood and body fluids	None (unless uncontrolled bleeding)	1. Indefinitely 2. Until uncontrolled bleeding has stopped
Impetigo	Skin lesions	Yes	2. Duration of lesions
Influenza	Nasal/oral secretions	Yes	2. Duration of illness
Lassa fever	Blood and body fluids, oral secretions	Seek advice immediately from infection control nurse/doctor	
Legionnaires' disease		None	
Lice head	Hair	None	1. Until treated
Lice body	Clothing	None	1. Until clothing washed
Lice crab	Coarse body hair	None	1. Until treated
Listeria neonate		Yes	2. Duration of illness
Listeria adult		None	
Malaria		None	
Measles	Nasal/oral secretions	Yes	2. 7 days after onset of rash
Meningitis meningococcal	Respiratory secretions	Yes	2. Until 24-48 h of antibiotic treatment
Meningitis haemophilus	Respiratory secretions	Yes	2. Until 48 h antibiotic therapy
Meningitis pneumococcal		None	

ROUTES OF TRANSMISSION FOR COMMON INFECTIONS

INFECTION	INFECTIVE MATERIAL	ISOLATION	DURATION OF 1. INFECTIVITY 2. ISOLATION
Meningitis viral		None	
Meningitis unknown cause		Yes	2. Isolate as advised by Infection Control Doctor
Methicillin resistant Staphylococcus aureus (MRSA)	MRSA Policy Refer to algorithm attached to MRSA policy	Refer to MRSA policy	
Multiresistant bacteria (e.g. ESBL)	Body fluids, lesions, sometimes skin	Yes	1&2. Seek advice from infection control nurse/doctor
Mumps	Oral secretions	Yes	2. Until 9 days after onset of symptoms
Paratyphoid	Faeces/urine	Yes	2. Isolate for duration of illness (may excrete organism for several more weeks)
Pertussis	Oral secretions	Yes	2. Until 7 days after start of treatment
Pneumonia	Respiratory secretions	None (usually)	
Poliomyelitis	Faeces	Yes	2. Until 7 days after onset of symptoms
Rabies	Saliva	Seek advice immediately from infection control nurse/doctor	
Respiratory syncytial virus	Oral/respiratory secretions	Yes	2. Isolate for duration of illness
Rotavirus	Faeces	Yes	2. Isolate for duration of symptoms
Rubella congenital	Urine and oral	Yes	2. Duration of hospitalisation and for any admission until 1 year

ROUTES OF TRANSMISSION FOR COMMON INFECTIONS

INFECTION	INFECTIVE MATERIAL	ISOLATION	DURATION OF 1. INFECTIVITY 2. ISOLATION
Rubella acquired	Oral secretions	Yes	2. Until 5 days after onset of rash
Salmonella	Faeces	Yes	2. Isolate for duration of symptoms (may excrete organism for several more weeks)
Scabies	Skin	None (usually)	1. Until treated
Shigella	Faeces	Yes	2. Isolate for duration of diarrhoea
Staphylococcus aureus extensive lesions	Pus	Yes	2. Until culture negative (seek advice from Infection Control Nurse)
Streptococcus (Groups A, C, G)	Lesions	Yes	2. Until 48 hours of antibiotic treatment or culture negative. Seek advice from Infection Control Doctor
Streptococcus erysipelas	Skin	Yes	As above
Streptococcus cellulitis	Skin	Yes	As above
Streptococcus puerperal fever	Vaginal secretions	Yes	2. Until 48 hours of antibiotic treatment or culture negative. Seek advice from Infection Control Doctor
Streptococcus pharyngitis	Oral secretions	Yes	As above
Streptococcus scarlet fever	Oral secretions	Yes	See streptococcus A, C and G
Tetanus		None	
Toxoplasmosis		None	
Tuberculosis pulmonary (open)	Oral/respiratory	Yes	2. Until clinical improvement (1-2 weeks after antibiotic therapy)

ROUTES OF TRANSMISSION FOR COMMON INFECTIONS

INFECTION	INFECTIVE MATERIAL	ISOLATION	DURATION OF 1. INFECTIVITY 2. ISOLATION
Tuberculosis pulmonary (smear positive)	Secretions	Yes	2. Until clinical improvement (1-2 weeks after antibiotic therapy)
Tuberculosis non-pulmonary i.e. other site/organ		None	
Typhoid	Faeces/urine	Yes	2. Isolate for duration of symptoms (may excrete organism for several more weeks)
Typhus		None	
Viral haemorrhagic fevers	Blood and body fluids, oral secretions	Seek advice immediately from Infection Control Nurse/Doctor	
Whooping Cough	See pertussis		

CLEANING ISOLATION ROOMS

Aim:

To reduce the level of contamination within the environment or on equipment.

Daily cleaning of room by Domestic Staff:

1. Mop and bucket to be kept for the isolation room(s) only. Mop head to be changed daily. Bucket must be washed daily and stored dry (colour coded).
2. Damp dust all horizontal surfaces daily, using detergent and hot water and disposable cloths / paper towels.
3. Clean hand wash basins daily/soap dispensers/towel dispensers daily.

Staff to wear aprons and gloves whilst cleaning the room. These should be removed before leaving the room and hands washed immediately.

Cleaning of Equipment before use by another patient:

Wipe over the surface of the equipment using a solution of Chlor-clean using disposable cloth/paper towels.

Note: *Battery operated equipment or electronic equipment - must be wiped over with a damp cloth, which has been rinsed in detergent and hot water then wiped over using an alcowipe. See Decontamination of electro-medical Devices policy or contact the Infection Control Nurse for further details.*

TERMINAL CLEANING OF ISOLATION ROOMS

Terminal Cleaning of an Isolation Room after Discharge of Patient:

Please inform a member of the Infection Control team of patients discharge or when isolation is no longer required.

Thorough cleaning with Chlor clean solution using a disposable cloth is needed for the following items:

- Locker
- Bed table
- Sink area (toilet / commode)
- Bed frame/cot sides
- Mattress cover (check for permeability/see decontamination of mattress policy)
- Wash bowl
- Clean floor with detergent and water only
- Change the curtains within the room (only on advice of Infection Control Nurse)
- Wipeable pillows are to be used with these patients (available from laundry on request)
- Wall washing is not necessary unless advised by a member of the Infection Control team

<p>8am – 7.30pm, inform Sodexho on ext. 5430 that room needs to be cleaned and disinfected, and that the curtains require changing (if appropriate).</p>
<p>7.30pm – 8am, nursing staff clean and disinfect room. Inform Sodexho on ext. 5430 that curtains require changing next day. (If MRSA patient).</p>
<p>Mon – Fri: 9am – 9pm & Sat-Sun: 9am – 4pm, inform Patientline of discharge on ext. 5506(answer phone).</p>
<p>At other times, nursing staff remove headsets and discard. Clean Patientline set using general purpose detergent on a disposable cloth and then wipe with Alcowipe.</p>

POLICY FOR THE ISOLATION OF THE INFECTIOUS PATIENT

References

Ayliffe GAJ, Fraise AP, Geddes AM, Mitchell K, (2000), Control of Hospital Infection. 4th Edition, Arnold Publishers

Fenelon L (1995), Protective Isolation: who needs it? Journal of Hospital Infection. Vol 30 (Supplement) p218-222

Hospital Infection Society, Working Party Report (1998), Revised guidelines for the control of methicillin-resistant *Staphylococcus aureus* infections in hospitals. Journal of Hospital Infection. No 39 p253-290

Pellow CN, Pratt RJ, Loveday HP, Harper P, Robinson N, Jones SRLJ, (2004) Updating the evidence- based guidelines for preventing healthcare-associated infections in NHS hospitals in England: a report with recommendations. British Journal of Infection Control. Vol 5 No 6

LAST OFFICES POLICY

Aims:

To minimise the infection risk to health care workers handling the deceased prior to and during transfer to the mortuary and the undertakers.

For policy guidance please refer to The Royal Marsden Hospital Manual of Clinical Nursing Polycys 6th Edition (Trust intranet link- <http://192.168.32.52/cd/rmm/content/mars21.htm>).

Body bags must be used for:-

- a) Infections/pathogens listed in appendix A.
- b) If seepage of blood/body fluids cannot be contained despite following all the measures in the protocol.

NB – Many undertakers routinely embalm bodies. Once a body is placed in a body bag undertakers are unwilling to embalm bodies for viewing. It is necessary to warn relatives that this is likely to happen and try to ensure that they pay their **last respects** in the clinical area before the body is placed in a body bag. If advice is needed, contact a member of the Infection Control team. Out of hours contact the **medical** microbiologist on call, via the switchboard.

LAST OFFICES POLICY

Appendix A

1.6.3 List of infections/pathogens that require use of a body bag (ie Hazard Group 3 Pathogens)

Hepatitis B, C and D

HIV

Salmonella paratyphi (paratyphoid)

Salmonella typhi (typhoid)

Shigella dysenteriae (dysentery)

E. Coli 0157

Mycobacterium tuberculosis (M.t.b.)

[A body bag is **only** required when exudate is present or likely to be a problem].

Group A Streptococci

[A body bag is only required when exudate is likely to be a problem **AND/OR** the group A streptococcal infection has not been **treated** (check with infection control doctor/nurse).]

Note: Clostridium difficile, methicillin resistant Staphylococcus aureus and Vancomycin resistant enterococci are **NOT** an infection HAZARD in this context and do not require a danger of infection label or body bag.

LAST OFFICES POLICY

Appendix B

1.6.4 New Body Identification Label

UNIVERSITY HOSPITALS OF SOUTH MANCHESTER NHS FOUNDATION TRUST

LABEL FOR BODY IDENTIFICATION

I certify that this is the body of

Name..... Age

(BLOCK CAPITALS)

Address.....

.....

.....

Who died on
Ward..... On..... at..... am /
pm

Jewellery (if any on body)

.....

.....

.....

Hazard Group 3 Pathogen Yes/No/Don't Know **[If yes, use Danger of Infection Label here]**

Signed

Nurse in Charge

**UHSM214
September 1997**

These forms can be obtained from:- The SF Taylor printed stationary catalogue
N.B Please do not use photocopies of this label

LAST OFFICES POLICY

References

Advisory Committee on Dangerous Pathogens (1995). Categorisation of biological agents according to hazard and categories of containment. HMSO ISBN 0 7176 1038 1

Department for Work & Pensions (2002) What to do after a Death in England & Wales. Stationery Office. London.

Health Services Advisory Committee (1991). Safe working and the prevention of infection in the mortuary and post-mortem room. HMSO ISBN 0 1188 5448 8

Royal Marsden Manual (2004) Manual of Clinical Nursing Policys. Blackwell Publishing. London.

POLICY FOR SKIN DISINFECTION PRIOR TO PERCUTANEOUS INJECTION

The policy should be followed for all percutaneous injections (e.g. intra-muscular and subcutaneous), venepuncture and cannulation. For further guidance on Central Venous Catheters, please refer to policy 2.8.

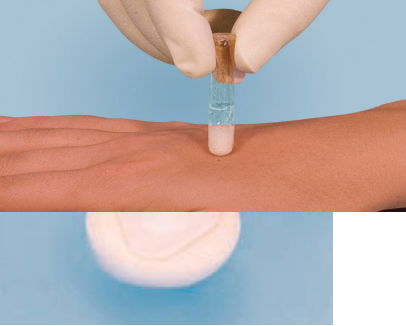



General information

ACTION	RATIONALE
The patients skin, if visibly soiled should be cleaned with soap and water.	To reduce the risk of infection.
Wash hands or use alcohol handrub.	To reduce transient micro-organisms on hands and prevent cross infection.
Put on disposable latex gloves (for further info, see glove policy 1.3)	Universal precautions- gloves should be worn if there is risk of contact with blood or body fluids.
Disinfect the patients skin with the Trust approved product for 30 seconds and allow to air-dry (see appendix 1)	Skin cleansing/antiseptis of the injection site is one of the most important measures for preventing infection, e.g. abscess formation.
Once the skin is disinfected the injection site must not be touched or palpated. If it is necessary to repalpate, then the cleaning regime must be repeated	To maintain asepsis.

POLICY FOR SKIN DISINFECTION PRIOR TO PERCUTANEOUS INJECTION

University Hospital of South Manchester 

NHS Foundation Trust

Product	Picture of Product	Uses
<p>Chloraprep (3ml) (2% Chlorhexidine Gluconate in 70% isopropyl alcohol)</p> <p>Not for use with babies under 2 months</p> <p>Order code MRB306</p>		<ul style="list-style-type: none"> • Insertion of central lines, arterial lines, PICC lines, ports etc • Maintenance and removal of CVC
<p>Chloraprep FREPP (1.5ml) (2% Chlorhexidine Gluconate in 70% isopropyl alcohol)</p> <p>Not for use with babies under 2 months</p> <p>Order code MRB303</p>		<ul style="list-style-type: none"> • Collection of blood cultures
<p>Chloraprep SEPP(.67ml) (2%chlorhexidine gluconate and 70% isopropyl Alcohol)</p> <p>Order code MRB302</p>		<ul style="list-style-type: none"> • For Peripheral Cannulation
<p>Sani-cloth CHG 2% (2% Chlorhexidine Gluconate in 70% isopropyl alcohol) FOR MEDICAL DEVICES ONLY</p> <p>Order code MRB302</p>		<ul style="list-style-type: none"> • Cleaning of ports, hubs prior to use • Cleaning of tops of blood culture bottles
<p>Steret H (0.5% Chlorhexidine Acetate in 70% isopropyl alcohol)</p> <p>Order code MRB298</p>		<ul style="list-style-type: none"> • Cleaning skin prior to venepuncture, S/C and IM injection

POLICY FOR SKIN DISINFECTION PRIOR TO PERCUTANEOUS INJECTION

References

Department of Health (2001) Guidelines for preventing infections associated with the insertion and maintenance of central venous catheters. Journal of Hospital Infection. 47(Suppl), S47-67

Department of Health (2006, revised 2007) Saving Lives: reducing infection, delivering clean safe care. London

Department of health.(2006) The Health Act 2006- Code of practice for the prevention and Control of healthcare associated infections. London

Maki, D.G. et al. (1991) Prospective randomized trial of povidone iodine, alcohol and chlorhexidine for prevention of infection associated with CVC and arterial catheters. Lancet. 338, p339-43.

Pratt et al (2006)Epic 2 National Evidence-Based Guidelines for preventing Healthcare Associated Infections in NHS hospitals in England. Journal of Hospital Infection(2007)65s;1-64

RCN (2003) Standards for Infusion Therapy. Royal College of Nursing, London.

POLICY FOR HOSPITAL OUTBREAK CONTROL*Contents*

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POLICY FOR HOSPITAL OUTBREAK CONTROL

Introduction

This policy document takes account of the recommendations in the Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections, EL(91)123 Communicable Disease Control, HSC(95)10 Hospital Infection Control and HSC 2000/02, and The Management and Control of Hospital Infection "Winning Ways"(2003).

These circulars require that the Trust has:

- Clearly established management arrangements for hospital infection prevention and control, with clearly defined responsibilities and lines of authority and communication.
- Plans for the control of outbreaks appropriate to local situations.
- Clearly established criteria in relation to closures of wards, departments and premises to new admissions.
- Clearly established arrangements for hospital management to respond to outbreaks of infection in the community.
- Means to inform relevant staff and external agencies of these arrangements and plans.

This section therefore, describes the arrangements for the investigation and management of outbreaks of infection within University Hospitals of South Manchester NHS Foundation Trust.

Each incident is different and requires specific measures to deal with the individual circumstances. It should be noted however, that certain basic arrangements are necessary and will be applicable to all outbreaks of infection that may be encountered. It would be expected that funding for outbreaks would be met through the Trust's divisional structure.

Recognition of the increase in number of infections

Clusters of infections linked by time and place may be identified by a number of methods. Such clusters may represent an outbreak where cross-infection has taken place, though this is not always the case.

Infections may be identified if a pathogenic micro-organism is cultured in the Microbiology Laboratory. Laboratory reports are reviewed daily by members of the Infection Control Team to enable early detection of a potential outbreak.

POLICY FOR HOSPITAL OUTBREAK CONTROL

Alternatively, infections may also be diagnosed on clinical grounds, either alone or in combination with microbiological investigations. If nursing or medical staff suspect that there might be an outbreak in progress they should inform the infection control nurse or duty microbiologist as soon as possible to enable investigation to commence (including weekends and bank holidays).

However, outbreaks may arise insidiously and may reach considerable proportions before becoming manifest, particularly if they occur in outpatient departments (e.g. Legionnaire's disease), following discharge from hospital or have long incubation periods (e.g. Hepatitis B, Tuberculosis). Prompt reporting to the Health Protection Unit/ Health Protection Agency will aid recognition of these.

Investigation of the increase in number of infections (see flow chart, page 32)

Not all clusters represent outbreaks, but all require further investigation.

The Infection Control Team will take immediate steps to collect information from wards and departments to determine whether a cluster of cases represents an outbreak by:

- Visiting the site/maintain regular telephone communication.
- Confirming information
- Collecting baseline information from the cases

Initial investigations should be undertaken promptly and at the end of this time it should be possible to:

- State whether an outbreak is occurring
- Provide some assessment of its severity
- State whether an outbreak is confined to hospital or whether there are implications for the community generally
- Form a preliminary hypothesis
- Initiate any immediate control measures
- Decide upon further microbiological, environmental and epidemiological investigations

Once an outbreak is suspected, a case definition must be established and all cases identified. Data should be collected from all those affected for epidemiological purposes and the Infection Control Doctor/DIPC define if an outbreak is in progress.

If no outbreak exists, the person reporting the potential outbreak will be informed, reassured and encouraged to make further reports if required.

If the outbreak is of a limited extent and is confined to the hospital, the Infection Control Team, in liaison with relevant clinicians and nurses, can deal with the outbreak. The Consultant in Communicable Disease Control should be informed of such limited outbreaks, cases of notifiable diseases and all organisms and diseases of public health importance.

POLICY FOR HOSPITAL OUTBREAK CONTROL

For other outbreaks the DIPC/Infection Control Doctor in conjunction with the CCDC should declare a Major outbreak and establish an Outbreak Control Team (OCT). The PCT should be informed of any outbreaks.

Definition of an outbreak

An outbreak may be defined as:

- A rate of infection or illness above the expected rate for that place and time, where spread is occurring through cross infection, or person-to-person.
- A single case of a rare disease, may lead to initiation of the hospital outbreak control policy as this may have hospital or community implications.

Outbreaks of infection may vary in extent and severity ranging from a few cases to a large number of food poisoning cases, affecting hundreds of people. Recognition of an outbreak may be difficult, therefore medical and nursing staff must be vigilant at all times.

A MAJOR outbreak is defined as one where

- A large number of people, or multiple cohorts of people, are affected and may include residents from beyond the local HPU area
- The organism involved is unusually pathogenic (*e.g.* diphtheria, viral haemorrhagic fever *etc*)
- There is a potential for transmission to large numbers of people (*e.g.* widespread distribution of food product, public water supply *etc*).

The definition of an outbreak of *Clostridium difficile* is dependent on the background rate of individual ward areas. Statistical probabilities will be used to define outbreaks of *Clostridium difficile* on an individual ward basis.

Control of the outbreak

The following basic concepts are applicable to all situations:

- Persons at risk must be protected
- The source and mode of spread of the infection must be ascertained and appropriate control measures are put in place
- Intervention must take place to halt spread
- Surveillance of control measures should be continued

Because of the variability of outbreaks, it is not possible to specify arrangements for all situations.

POLICY FOR HOSPITAL OUTBREAK CONTROL

Outbreak Control Meeting

Once an outbreak has been declared, the Director of Infection Prevention & Control (DIPC) or the Infection Control Doctor (ICD) or delegated representative will call and chair an outbreak control meeting to plan the response to the outbreak and institute control measures. The outbreak control team will be comprised of those attending the outbreak control meeting. Initial actions to control the outbreak will not be delayed pending the first outbreak control meeting being convened. (See appendices for roles and responsibilities).

The Chair is responsible for the conduct of the meetings. In attendance will be:

In all cases:

- Director of Infection Prevention and Control (Chairperson)/ or delegated representative
- The Infection Control Doctor/Nurse Consultant/Infection Control Team Leader
- Divisional General Manager (or representative)
- Infection Control Nurse
- Medical Consultant from affected ward (or representative)
- Divisional Head Nurse/Matron
- Nurse Manager for affected area
- Trust Domestic Monitoring Manager
- Sodexo Hotel Services Manager
- Atkins Estates Representative
- Trust Linen Monitoring Manager

Others may include:

- Chief Nurse (or representative)
- Emergency Planning Manager/Business Continuity Manager
- Risk Manager
- Communications Officer
- Health Protection Unit/Agency
- Community Infection Control Team
- Occupational health physician (where staff illness is involved)
- Catering officer or chief environmental officer (if the infection is likely to be food or water-borne)
- Allied Healthcare Professional representative for affected area
- Management (other than those already included)
- Central sterile supplies department
- Supplies department
- Pharmacy Department.
- Trust Estates Representative
- South Manchester Healthcare Limited (SMHL) Manager
- Regional epidemiologist
- Manchester PCT

POLICY FOR HOSPITAL OUTBREAK CONTROL

It is the responsibility of all those invited to ensure that a deputy attends if they are unable to do so.

Ward/department closure and re-opening arrangements

In some instances, closure of a ward to admissions and transfers to other wards, departments or healthcare facilities is required to control and prevent further spread. This decision will be made by the Consultant Microbiologist/Infection Control Doctor/Director of Infection Prevention and Control and criteria for re-opening be established. The Hospital Incident Reporting System (HIRS) will be used to document and communicate closures and the Chief Nurse will be responsible for informing the Executive team.

The Infection Control Team will have input in the management arrangements for redirecting admissions and ensure the ward/department re-opens promptly following appropriate environmental decontamination.

The Infection Control Team will inform the Community Infection Control Team of ward closures to ensure intermediate care settings are considered.

Procedure at the meeting

The Outbreak Control Meeting will be chaired by the Director of Infection Prevention and Control/Infection Control Doctor or nominated representative. Minutes will be taken at all meetings of the Outbreak Control Team to enable a final report to be written on cessation of the outbreak.

The Chair of the meeting will direct and co-ordinate management of the outbreak.

It is the responsibility of the Chief Nurse to provide adequate secretarial/clerical assistance to permit accurate recording of all issues discussed and all decisions made.

The Chair will briefly outline the nature of the outbreak. S/He will then remind the senior representatives of each discipline present that they are now personally responsible for the work of that discipline. Hence, the dissemination of information from the meeting will be the responsibility of the named individuals present. It will also be their responsibility to provide information to the next meeting in person or by ensuring their deputy attends (in which case responsibility then passes to that person.)

Management arrangements should ensure that the Outbreak Control Team is equipped with resources that will enable co-ordination of efforts being made to control the outbreak.

POLICY FOR HOSPITAL OUTBREAK CONTROL

These may include

- Telecommunications support
- An area that the outbreak control may be co-ordinated from
- Extra support from other services, e.g., pathology, domestic services, etc.
- Clerical Support

If necessary the Chairperson will contact an appropriate specialist physician such as a Consultant in Infectious Diseases (North Manchester General Hospital on 0161-795 4567).

If necessary the Consultant in Communicable Disease Control will request assistance from the Director of the Health Protection Laboratory and notify the Centre for Infections at Colindale, London.

At the close of the meeting, the Chairperson will state the date, time and place of the next meeting. S/he will reiterate the personal responsibilities of each member to attend the next meeting or else ensure that another individual from their discipline attends.

Meetings of the Outbreak Control Team will be held at intervals appropriate to the stage of the outbreak, decided upon by the Outbreak Control Team. The responsibility for calling other meetings rests with the Chairperson of the meeting.

Subsequent Meetings

At each subsequent meeting, the Chairman will ask the members in turn to provide an update of the situation in their discipline. S/He will encourage free exchange of information and ensure that any options are fully discussed and acted upon. At each meeting, the format of the meeting shall be considered and whether its adjustment to a R6 or Serious Untoward Incident (SUI) is required depending on patient or organisational disruption.

An R6 is when a disruptive incident event occurs which has a direct impact on Trust activity. A fully copy of the R6 Policy is available on the Emergency Planning extranet site.

For a definition of a SUI and the process of managing a SUI, please refer to the 'Policy for the Management and investigation of incidents including the management of serious untoward incidents' on the Trust intranet.

POLICY FOR HOSPITAL OUTBREAK CONTROL

Control of a Major Outbreak

Once a major outbreak of infection has been identified the functions of the OCT are to:

- Take all necessary steps to enable continuing clinical care of patients during the outbreak
- Co-ordinate all arrangements for the investigation of the source and cause of the outbreak
- Co-ordinate the control measures to be employed
- The Chairperson ensures that adequate communication channels are established and that the allocation of responsibilities is clear
- Assess the need for additional supplies and staff, particularly nurses and junior medical staff
- Provide clear instructions and/or information for ward staff and others such as domestics, physiotherapists and radiographers
- Consider the need for outside help and expertise
- Ensure communication with the local Primary Care Trusts, NHS North West and Health Protection Agency.
- Agree arrangements for notification and information to patients, relatives and visitors
- Meet as frequently as necessary in the circumstances of the particular outbreak and that an agreed written record of all meetings is maintained.
- Ensure that prompt and accurate information is available to the media
- Prepare a preliminary report, ideally within 48 hours, interim reports if necessary and a final report
- Define the end of the outbreak and evaluate the lessons learned and ensure mechanisms are put in place to prevent a re-occurrence. A final meeting will be held following the end of the outbreak to disseminate this information to all stakeholders.

Release of Information

- The designated manager will be responsible for the release of information in the normal way to the relatives of those patients affected.
- The Chairperson will be responsible for the provision of information concerning the outbreak to the Trust's Chief Executive in liaison with the communications officer.
- The Chairperson of the Outbreak Control Meeting will be responsible for the provision of interim information to the Trust Board, Health Protection Unit and for a formal report at the conclusion of the outbreak. Copies of the report and recommendations will be provided to the relevant DGM where the outbreak is confined to specific services.

POLICY FOR HOSPITAL OUTBREAK CONTROL

- Information concerning the outbreak will be released to the Press or Public following discussion with the Infection Control Team. The Trust Press Officer will liaise with the PCT press officer.. The Outbreak Control Team and Executive representative will approve press releases.
- The Executive on Call will be responsible for the notification of an outbreak to the NHS North West.

Dealing with major outbreaks in the community

Major outbreaks in the community are dealt with by the local Health Protection Unit. However, there are two main types of community outbreak which need to be considered as they have implications for the trust:

Outbreaks in the community which may result in a sudden increase in notifications have implications for the Trust.

Communication between

Acute outbreaks

Acute outbreaks develop quickly, usually over a matter of a few hours- days. If an increased level of admissions is anticipated a “red alert” should be declared and only emergency cases admitted. As the situation becomes clearer the Trusts “Major Incident Plan” should succeed this.

Non-acute outbreaks

These outbreaks develop over a number of days or even weeks and often involve large numbers of people. Close collaboration and co-operation is necessary during an outbreak of this type between the Consultant in Communicable Disease Control, Community Infection Control Nurses, General Practitioners and Hospital staff. This is to enable the outbreak to be followed and effective planning for hospital admissions to take place. A hospital response outbreak control group (HROCG) should be formed and will need to include:

- The Trust Infection Control Team
- The Director of Infection Prevention and Control
- Trust Chief Nurse
- Relevant clinicians
- Consultant in Communicable Disease Control

POLICY FOR HOSPITAL OUTBREAK CONTROL

- Medical Director
- Occupational health physician
- Bed Manager
- Duty Manager
- Environmental health officer
- General practitioner representative
- Local Health Protection Unit
- Social services representative
- Community director of nursing services

The Consultant in Communicable Disease Control will investigate and control the outbreak in the community and keep all staff informed of events. There are specific aspects of a community outbreak, which must be dealt with promptly and efficiently. The HROCG must:

- Review admission policies, including assessing the need to stop non-urgent admissions and the need for arrangements for patient isolation
- Make an assessment of the need for ward closure and emptying of ward areas to make space for increased numbers of admissions
- Determine the need to move staff from other clinical areas and the possible use of bank/agency staff
- Instigate appropriate infection control measures quickly
- A named individual to act as press liaison is determined
- Purchasers are informed of the likely disruption to normal contracts
- Define the end of the emergency in the hospital

POLICY FOR HOSPITAL OUTBREAK CONTROL

References

- Health Act 2006 Code of Practice for the Prevention and Control of Health Care Associated Infections
- Communicable Disease Control Policies (1991) No. 1 - The Investigation, Management and Control of Episodes of Infectious Disease in Health Service Hospitals and the Community at Large.
- Public Health (Control of Diseases) Act 1984.
- Public Health (Infectious Diseases) Regulations 1988.
- HSG (93) 56 Public Health: Responsibilities of the NHS and the Roles of Others.
- Department of Health (1995) Hospital Infection Control - Guidance on the Control of Infection in Hospitals.
- Civil Contingencies Act (2004) HMSO

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF A MAJOR OUTBREAK – Appendix 1**ACTION TO BE TAKEN BY:****DUTY MANAGER (OUT OF HOURS)**

Visit/liaise with the ward affected as soon as possible to assist and supervise as necessary.

Check to see if there are any cases or suspected cases on other wards in the hospital.

Report findings promptly to the microbiologist on call.

Instigate and co-ordinate immediate control measures (as directed by the Microbiologist), across the Trust (out with the affected ward/s) to prevent possibility of spread across the hospital.

Inform the General Manager on-call and the bed manager (if wards/departments are closed).

If a major outbreak is effecting Trust activity, discuss with General Manager on call to arrange an R6 meeting.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 2**ACTION TO BE TAKEN BY:****NURSE IN CHARGE OF AFFECTED WARD(s)**

Liaise with the microbiologist on call/Infection Control Nurse daily as necessary.

Inform Clinician in charge of affected patients.

Keep accurate records of date and time of onset of symptoms of patients and staff as cases occur and report new cases to the Infection Control Nurse.

Provide a list of staff who are/were ill or who are/were contacts as appropriate for the Occupational Health Department (and the Outbreak Control Team (OCT) if a major outbreak)

Ensure that appropriate isolation/cohort precautions as advised by the Infection Control Team are in place.

Ensure that appropriate clinical specimens are collected as advised by the Infection Control Team.

Ensure non-essential staff have restricted entry to the ward if advised by the Infection Control Team.

Keep patients and visitors informed of the situation (patient/visitor advice leaflets are available from the Infection Control Team). Specialist advice may be sought from the Infection Control Team

Cohort staff/patients as advised by the Infection Control Team.

Ensure that patient shared equipment/environment is cleaned according to the required standard (as defined by the appropriate Policy or the Outbreak Control Team). Report to Sodexo Hotel Services Manager and Matron any problems with environmental cleaning standards/staffing level difficulties.

Attend Outbreak Control Meetings in absence of Matron and ensure relevant information is communicated to ward staff

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK – Appendix 3**ACTION TO BE TAKEN BY:****CLINICIAN IN CHARGE**

Treat patients who are ill as a result of the outbreak in consultation with microbiologist and/or consultant in infectious diseases.

Ensure junior medical staff who are ill to report to occupational health.

Liaise with Infection Control Team (ICT) about the need for ward closure or restriction of admissions/transfers/patient investigations in other areas of the hospital.

Update other consultant medical colleagues and junior medical staff on a daily basis about the outbreak and any action required.

Adhere to Infection Control precautions/policy as advised by the Outbreak Control Team.

Attend the Outbreak Control Team (OCT) meetings as required.

Assist the OCT in the preparation of information for patients/relatives and the press if required.

In the event of a Norovirus outbreak or major outbreak, restrict the movement to affected wards of medical students/junior medical staff.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 4**ACTION TO BE TAKEN BY:****MATRON/HEAD OF NURSING/ASSISTANT GENERAL MANAGER**

In the event of an outbreak the affected Division(s) must delegate a named senior nurse/manager (outside of the ward environment), to manage the situation locally.

Attend the Outbreak Control Meetings and report on local operational issues

Liaise between the ward(s) and other service/departments to ensure that the outbreak control measures are implemented particularly domestic services.

Ensure that staffing levels on the ward(s) are regularly reviewed and seek the advice of the ICT on use of Bank and Agency Staff.

Ensure that there are enough local supplies of consumables to implement adequate control measures

Report to the Divisional General Manager and Clinician in Charge on progress of the outbreak on a daily basis

In the event of a deep clean of the environment prior to re-opening, act as co-ordinator unless there is a senior experienced nurse on duty, who has the appropriate knowledge and authority to act as co-ordinator and ensure there is additional staff for cleaning patient shared equipment.

Ensure that there is consistency of flow of communication at ward level.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 5**ACTION TO BE TAKEN BY:****THE DIRECTOR OF INFECTION PREVENTION AND CONTROL/CHIEF NURSE (OR NOMINATED DEPUTY)**

Call the initial and subsequent outbreak control meeting(s) and act as Chairperson.

Liaise with the Infection Control Doctor when defining an outbreak

Advise and liaise with the Chief Executive about the situation generally and restriction of admissions and staff movements specifically.

Advise and liaise with the catering Manager, in conjunction with the CCDC and EHO's about cleaning of kitchen and amendment of food handling procedure if this is appropriate.

Liaise with the General Manager of SMHL and Director of Trust Estates and Facilities to ensure adequate provision of cleaning/laundry/catering/portering/maintenance facilities.

Liaise with The Medical Director and risk Manager for the Trust on actions taken to control the outbreak

Assist in developing a briefing note with the Trust Press Officer

Ensure that a senior management representative is delegated as source of information to whom all requests for information should be directed.

Monitor the effectiveness of communication on a daily basis through out the outbreak

Be responsible for approving and circulation of outbreak meeting minutes to the Outbreak Control Team

Provide written interim reports (as appropriate), and final outbreak report for the Trust Board/ICC

Ensure a summary of the outbreak is included in the annual report

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 6**ACTION TO BE TAKEN BY:****THE INFECTION CONTROL DOCTOR (CONSULTANT MICROBIOLOGIST IN ABSENCE)**

Confirm an outbreak is in progress and diagnosis and establish a case definition

Review the available data to decide means of transmission, i.e. contact, food-borne, faecal-oral, or airborne.

Inform the Duty microbiologist at the HPA in the event of a MAJOR OUTBREAK

Visit the ward(s) as necessary in the event of a MAJOR OUTBREAK to identify other cases, investigate outbreak and give advice as soon as practicable. This will be done together with the Infection Control Nurse and CCDC where appropriate.

Advise and liaise with consultants about possible transfer of patients and restriction of admissions, and the need to designate a ward for the care of affected patients.

Liaise with the Infectious diseases Consultant and consider (where appropriate), transfer of affected patients to North Manchester General Hospital

Liaise with the Trusts Surveillance Officer to assist with the documentation of the data

Advise the Senior MLSO in the Microbiology laboratory if specific tests are required or if there is to be a substantial increase in specimens particularly over the week-end.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 7**ACTION TO BE TAKEN BY:****THE INFECTION CONTROL NURSE**

The ICN should visit/liaise with the wards affected as soon as possible to investigate and give appropriate advice. If circumstances suggest an outbreak of infectious disease:

Notify

- The Infection Control Doctor (or consultant Microbiologist in absence)
- Director of Infection Prevention & Control (DIPC) and Chief Nurse
- The local Health Protection Unit/CCDC/Community ICT as appropriate

Discuss with the DIPC/ICD the need to close the ward/department to admissions and transfers.

Advise the Nurse in Charge of the Ward(s) on nursing procedures as necessary according to the appropriate policy including the isolation/cohort of patients.

Arrange for details of cases to be provided (i.e. staff and patients with symptoms) on standard forms.

Arrange an iLog number and for appropriate specimens e.g. food, faeces, blood etc to be collected and sent to the laboratory for investigation.

Attend outbreak meetings on a daily basis.

Liase with CCDC about the nature of epidemiological information to be collected and its presentation.

Liase with Sodexho Hotel Services Manager, Atkins Estate Representative, Catering Manager and Domestic Contract Manager and advise them of appropriate control measure to be undertaken.

Advise staff and managers of key personnel who visit wards, e.g. Allied Health Professionals, of the control measures.

Advise the nurse in charge about management of staff and any restrictions imposed.

Provide information on an ongoing basis to patients, relatives and staff written and verbal about the outbreak and the control measures.

Discuss the management of staff cases with the Occupational Health Department.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 8**ACTION TO BE TAKEN BY:****GENERAL MANAGER**

Confirm that the DIPC/ICD/CCDC and Occupational Health Physician have been notified.

On the advice of the ICT the Trust Chief Executive in liaison with the appropriate consultants will stop new admissions to the ward if necessary, until the outbreak has been contained and the cause established.

Authorise arrangements to ensure the availability of extra staff, disposable items and other resources as necessary for example. A patient help-line during a MAJOR OUTBREAK

Liaise with the Trust Press Officer and agree all press statements before release.

Ensure that the OCT is informed of name and contact point for administrator on call throughout outbreak.

Attend MAJOR OUTBREAK meetings.

Liaise with the Outbreak Control team about the need for cohorting patients on affected ward(s)

Ensure that Infection Control leads within the Division are aware of the outbreak and the need to observe control measure. (E.g. Limiting movement of medical staff from ward to ward).

Re-locate pre-admission/assessment clinics from ward areas on the advice of the OCT.

Lead an R6 meeting if escalated.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF A MAJOR OUTBREAK- Appendix 9**ACTION TO BE TAKEN BY:****CONSULTANT IN COMMUNICABLE DISEASE CONTROL/PUBLIC HEALTH NURSE**

As “proper officer” for the local authority with statutory responsibility for the control of notifiable diseases and food poisoning the CCDC must satisfy himself/herself that all necessary steps are being taken.

- To assess the extent of the outbreak
- To determine the route of transmission
- To control it
- To ascertain the source

In order to do this it will usually be necessary to visit the hospital, in conjunction with the ICD and ICN and Catering Manager if appropriate.

Inform the Environmental Health Department and obtain the assistance of the Environmental Health Officers (EHOs) in carrying out the duties list in 1 above.

When an outbreak is believed to be food borne he/she together with the ICT and EHOs will inspect the hospital kitchen, review food handling procedures, give any necessary advice and arrange for specimens of suspected food to be dispatched to the Public Health for examination.

Conduct epidemiological investigations in conjunction with the ICT and EHOs.

Notify the Director of Public Health, where appropriate

Notify Regional Epidemiologist.

Arrange for regular (at least daily) updating of information and action by visits to the hospital and attendance at all outbreak meetings.

Follow up community contacts if any.

Inform and liaise with general practitioners, health visitors and community teams as appropriate.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF AN OUTBREAK- Appendix 10**ACTION TO BE TAKEN BY:****OCCUPATIONAL HEALTH NURSE/DOCTOR**

Arrange for appropriate specimens as advised by the ICT to be submitted by staff contacts (wards, kitchens, domestics) who may be involved if this is considered necessary by the DIPC/ICD and CCDC.

Arrange with appropriate managers for exclusion of kitchen and/or ward staff who have symptoms or who should be excluded for other reasons and notify manager when fit to return.

Exclusion and return to work by staff should be decided in accordance with the relevant policy. The period of exclusion may be different in each outbreak. The ICT will advise on this.

Arrange for routine specimens/screening to be taken where necessary using appropriate iLog number. Keep systematic records and report anonymised results at Outbreak Meeting

Advise on staff counselling and welfare where appropriate.

Attend outbreak meetings as required.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF AN OUTBREAK- Appendix 11**ACTION TO BE TAKEN BY:****CHIEF NURSE**

1. Arrange for an incident room to be provided on site with access to direct line telephone, fax, whiteboard and filing facilities in the event of a MAJOR OUTBREAK.
2. Arrange for daily update bulletin to be disseminated to staff and displayed in areas of the hospital where staff congregate e.g. staff restaurant etc if this is considered necessary by the Outbreak Control Team (OCT)
3. Update The Chief Executive and Executive on call during the progress of the outbreak.
4. Arrange for additional secretarial support as required.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF AN OUTBREAK- Appendix 12

NOROVIRUS INFORMATION FOR BED MANAGER

What is Norovirus?

Norovirus is a frequent cause of D&V in the community and the commonest cause of outbreaks of gastroenteritis in hospitals. Transmission occurs by vomiting, by faecal-oral spread or by consumption of contaminated food. Most infections are seen during the winter ('Winter Vomiting Disease') and outbreaks usually occur at this time of year. The infection is self-limiting and usually mild. However, since large numbers of patients and staff may be involved, outbreaks of SRSV can be a major disruption to health care service provision.

Who should be isolated in a single room?

- Any patient being admitted with diarrhoea and or vomiting (which is suspected as due to an infective cause)
- Any patient being admitted from a Nursing Home or other hospital ward where there is a known or suspected Norovirus outbreak
- Any patient being urgently transferred from an affected ward within the Trust to a none affected ward and must be done in discussion with the Infection Control Team

Emergency admissions with D&V

Any patient being admitted with diarrhoea or vomiting- thought to due to an infective cause should be admitted to a single room until 48 hours symptom free. It is reasonable to admit patients with suspected Norovirus onto a ward already closed due to Norovirus but only following medical assessment to confirm no other cause for the symptoms. In the event of multiple ward closures, it should be agreed by the Infection Control Team the best ward to admit to. We need to avoid admitting to new cases onto a ward, which is at the end of the outbreak as this may prolong the outbreak and delay reopening of the ward. The ICN and the Bed Manager should liase daily to discuss this.

The bed managers should inform the Infection Control Team of any patients admitted with D&V suspected to be a viral cause. This can be done in the morning for any overnight admissions.

Elective Admissions with D&V

In the event where it is known that an of an elective admission has symptoms of diarrhoea or vomiting thought to due to an infective cause, or where the patient has been recently exposed to probable Norovirus- admission should be delayed to prevent introducing the virus onto a ward.

POLICY FOR HOSPITAL OUTBREAK CONTROL

Please also see the policy for the Management of patients with acute viral gastro-enteritis, section 5, Infection Control Manual.

IN THE EVENT OF ANY OUTBREAK- Appendix 13**ACTION TO BE TAKEN BY:****SODEXHO HOTEL SERVICES MANAGER**

Attend OCT meetings as required.

Ensure that advice about the use of disinfectants by domestic staff as given by the ICT is communicated to the Manager of Sodexho and is implemented.

Ensure that cleaning procedures as advised by ICT are monitored and ensure high standards of cleanliness are attained.

To restrict the movement of staff to minimise the risk of cross infection. Staff must not move from an affected ward to a non-affected ward during an outbreak.

Inform the contractor about the need for domestic staff to report relevant illness to the Occupational Health Department and affected staff must not return to work until they are free from symptoms for 48hrs.

Ensure that symptomatic domestic/facilities staff are removed from work until 48hrs symptom free or as advised by the Occupational Health Department.

Monitor that movement of domestic staff is restricted as advised by the ICT.

Ensure that timely deep cleaning of the environment is carried out according to policy and monitor the area before it is re-opened. Every effort should be made to carry out deep cleaning promptly to prevent delay in reopening wards to admissions.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF A FOOD BORNE OUTBREAK- Appendix 14**ACTION TO BE TAKEN BY:****TRUST CATERING MONITORING MANAGER AND CATERING MANAGER**

Ensure all food handlers who have had symptoms of gastro-intestinal illness, septic or other relevant skin conditions, are referred to Occupational Health and refrain from work until 48 hours symptom free and pronounced fit by Occupational Health before return to work.

Provide:

Food Samples (if available) as required by the ICT, CCDC and EHO
Menus

Provide records relating to:

Temperature controls
Deliveries
Storage
Cleaning schedules/ methods/instruction
Supervisor checklists
Rotas
Training records (induction, in house/accredited, refresher, hazard analysis)
Controls and monitoring of CCP's
Personal hygiene (standards, jewellery, uniform etc)
Flow Charts
HACCP procedures
Audits of Suppliers
Water Supply (potable)
Pest Control
Complaints (procedures/recent complaints)

Ref: Environmental Health Food and Epidemiology Quality Manual (FSA Framework Agreement) 2007

If the outbreak is throughout the Trust, it may be necessary to restrict food delivered from the main food supplier until they have been investigated and found to be safe. In this instance an alternative NHS approved supplier should be sourced.

In the event that the outbreak is isolated, the Regeneration kitchen should be inspected with the EHO prior to deep cleaning of surfaces and equipment.

Attend Outbreak Control Team meetings as required

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF AN OUTBREAK- Appendix 15**ACTION TO BE TAKEN BY:****LINEN MONITORING MANAGER**

Linen manager should ensure adequate supplies of laundry, linen bags and curtains are available.

Ensure adequate staffing is in place (linen/domestic) to remove and re-hang curtains.

Liaise with the ICT and the ward(s) or department involved.

Inform laundry contractors about the outbreak.

Attend Outbreak Control Team meetings as required.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF A MAJOR OUTBREAK- Appendix 16**ACTION TO BE TAKEN BY:****HPA LABORATORY DIRECTOR**

Attend Outbreak Control Team (OCT) meetings as appropriate

Advise on nature of specimens to be collected.

Provide laboratory results from patients involved in the outbreak as soon as possible to the DIPC/ICD.

Together with the DIPC/ICD give advice on appropriate control measures.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF A MAJOR OUTBREAK- Appendix 17**ACTION TO BE TAKEN BY:****DIRECTOR OF PUBLIC HEALTH**

Attend Outbreak Control Team (OCT) meetings as appropriate.

Act as press spokesperson where appropriate.

Brief the NHS North West and Chief Executive and the Primary Care Trust (PCT) regularly.

Ensure that CCDC has been given adequate resources to investigate and control the outbreak.

POLICY FOR HOSPITAL OUTBREAK CONTROL

IN THE EVENT OF ANY OUTBREAK- Appendix 18**ACTION TO BE TAKEN BY:****TRUST PRESS OFFICER/COMMUNICATIONS OFFICER**

Attend Outbreak Control meetings as required.

Provide press statement as briefed by the Outbreak Committee and the Chief Executive if considered necessary.

Deal with press enquiries about the outbreak in consultation with the Infection Control Team.

POLICY FOR HOSPITAL OUTBREAK CONTROL

Appendix 19 Staff contact details (which will be updated annually)

Infection Control Team

Mr Mark Welch, Director of Infection Prevention and Control	0161 291 6605 Or mobile phone via switchboard
Dr B Isalska, Consultant Microbiologist/ Infection Control Doctor	0161 291 2885 or mobile phone, via switchboard
Dr Mairi Cullen, Consultant Microbiologist	0161 291 2885 or mobile phone, via switchboard
Dr Ibrahim Hassan, Consultant Microbiologist	0161 291 2885 or mobile phone, via switchboard
Dr Nigel Stanbridge, Consultant Microbiologist	0161 291 2885
Amanda Pagett, Team Leader Infection Control	0161 291 2630 or via switchboard at Wythenshawe Hospital
Infection Control Nurses Office	0161 291 2630

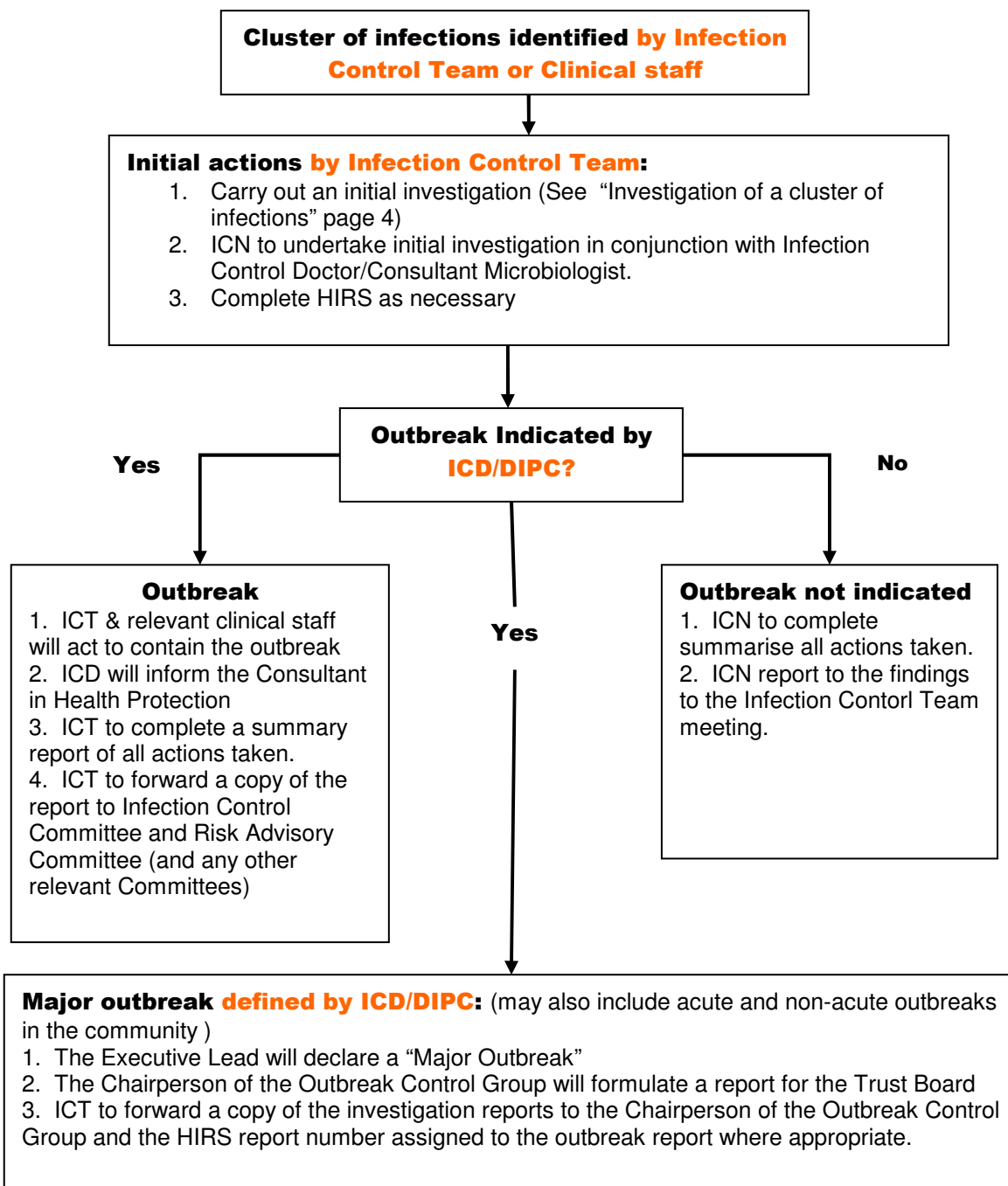
POLICY FOR HOSPITAL OUTBREAK CONTROL

Other personnel

Dr Ken Mutton, Consultant Virologist	0161 276 5687 or on-call Consultant Virologist via switchboard at Central Manchester 0161 276 1234
Dr John McNamara, Consultant Occupational Health	0161 291 2726
Professor Eric Bolton,	Head Unified Service Central Manchester Healthcare Trust Tel. 0161 276 5745
Health Protection Agency (HPA) Laboratory Service	0161 276 5687 or Central Manchester Switchboard 0161 276 1234 and ask for on-call virologist.
Mr Dave Weston Lead Biomedical Scientist, Microbiology	0161 291 4759
Erika Duffel Consultant for Communicable Disease Control	0161 786 6710 Erika.duffell@gmphu.nhs.uk
Sally Webster Community Infection Control Nurse	0161 946 8242 http://www.manchesterpct.nhs.uk/health/infection/
Leasa Benson Community Infection Control Nurse	0161 946 8242 http://www.manchesterpct.nhs.uk/health/infection/
Fiona Gilchrist Pharmacist	Aircall via switch
Virus Reference Laboratory – Colindale	Tel. 0208 200 4400 Tel. 0208 358 3225 (out of hours)
CAMR (Centre for Applied Microbiology Research) Special Pathogens Reference Unit, Dr Graham Lloyd	Tel. + 44 (0) 1980 612224 (direct) Tel. + 44 (0) 1980 612100 (24 hours) e-mail: specialpathogens@hpa.org.uk
Centre For Infections – London	0208 200 4400 0208 200 6868 (24 hours) http://www.hpa.org.uk/infections/default.htm
NHS Direct, Bolton	01204 599 521 or 01204 599 502

POLICY FOR HOSPITAL OUTBREAK CONTROL

APPENDIX 20 : FLOW CHART OF OUTBREAK ACTIONS



ICT = Infection Control Team
 ICD = Infection Control Doctor
 ICN = Infection Control Nurse

POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED MANAGEMENT AND MOVEMENT OF PATIENTS

INTRODUCTION

Background

The risks of health care associated infection (HCAI) are greatly increased by extensive movement of patients within the hospital, by very high bed occupancy and by an absence of suitable isolation facilities (DoH, Winning Ways 2003). The Department of Health's programme to reduce HCAI including MRSA requires a review of the patient journey for emergency and planned patients to identify and reduce the risks of infection transmission that are associated with movement of potentially infected patients (DoH, Saving Lives 2005). The need for restricting movement of infected patients between wards and for rapid isolation of infected patients has been emphasised in a Healthcare Commission Report into outbreaks of *Clostridium difficile* (Healthcare Commission, 2006).

Rationale

This policy sets out the infection prevention and control principles that must be applied to bed management and movement of patients to minimise the risk of infection.

Scope

This policy applies to all staff involved in patient care and management including patient placement and should be used in conjunction with other relevant sections of the Infection Control

Manual including;

Hospital Outbreak Policy

Section 1: Isolation of the infectious patient

Section 4: Decontamination Policy

Section 5: Organism specific Policy (MRSA, CDT, TB etc)

Principles

This policy is based on published evidence, national guidelines and local experience. Although patient safety is paramount, no patient should be denied necessary investigation or treatment solely on the grounds of having an infection.

Allocation of single rooms

- Allocation of single rooms must be based on a clinical risk assessment with infection control requirements and given priority over bed management/capacity issues (Healthcare Commission, 2006).
- Patients with a known alert organism (.i.e. MRSA/CDT/TB) being transferred from other hospitals must be admitted to a single room.
- Priority for side rooms should be given to patients with high risks of multiresistant organisms, including MRSA, (Section 5: Organism specific Policy (MRSA, CDT, TB etc)

POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED MANAGEMENT AND MOVEMENT OF PATIENTS

- All patients with acute diarrhoea should be isolated and assumed to be infective until symptoms are settled for at least 48 hours or a non infective cause has been established by the medical team.

- * If unable to isolate a potential infectious patient or colonised MRSA patient a HIRS form must be completed by the receiving ward.

- * If these patients are to be nursed in a bay with other patients strict infection control practices are to be adhered to. Appropriate use of personal protective equipment (PPE), Meticulous hand hygiene and regular assessment of isolation rooms is required to aid a prompt extradition of these patients away from vulnerable patients on the ward. Matrons of that area should be informed of this situation upon immediate application and this should be documented in the variance on care pathways.

- * Advice regarding isolating patients can be obtained from infection control department on EXT 2630 or contact a consultant microbiologist via switch.

- * Other infections requiring isolation are listed in Section 1 Isolation Policy, and include patients during the infectious period (either suspected or confirmed) with pulmonary TB, chicken pox, measles as well as others.

Infection Prevention and Control Risk Assessment

- On admission patients should be assessed for risk factors for multiresistant organisms, including MRSA. Those risk factors being:

- Previous MRSA (isolate if patient has not had 3 negative MRSA screens)
- Previous hospital admission within the last 3 months
- Admissions and transfers in from a nursing/residential home
- Health care employees
- Transfer from overseas healthcare settings.

(If possible these patients should be isolated whilst awaiting results)

- If a patient is a known MRSA carrier and is being nursed in a main bay, avoid placing patients with invasive devices or wounds in the adjacent bed spaces.
- Elective and emergency orthopaedic patients should be segregated on the ward.

Movement of isolated patients between wards and departments

- Assess the need to move the patient. If an inter-ward transfer can be postponed, or an investigation/procedure can be postponed until the patient is no longer in isolation, without compromising the patient's care and management, then it should be delayed.

- Communication between wards and departments regarding the "isolation status" of a patient is essential and enables the receiving department to implement procedures.

- A patient being nursed in isolation should only be transferred between wards for that individual's clinical needs.

- Once vacated, an isolation room must be terminally deep cleaned with 1000ppm Chlorclean. (See Section 4: Decontamination Policy).

POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED MANAGEMENT AND MOVEMENT OF PATIENTS

Patient Transfer Form

- Guidelines for Verbal Information Required for Transfer of Patients (Appendix 1) and the Patient Transfer Form (Appendix 2) should be completed and accompany patients requiring transferring between wards or to other hospitals.
- Guidelines for Verbal Information Required for Transfer of Patients (Appendix 1) and the Patient Transfer Form (Appendix 2) should be completed and accompany patients discharged to other healthcare settings, including nursing and residential homes.

Admission to the F2 (Medical).

The aim is to prevent MRSA and infectious diarrhoea being introduced to F2 Medical.

Exclusion Criteria for Patient Transfer.

- 1) Patients that are known to be MRSA positive
- 2) Patients that are symptomatic to C. Diff or CDT positive previously (the area has very limited bathroom facilities)
- 3) Patients that **must not** be admitted to F2 include patients from nursing homes, those with long term invasive devices and/or chronic wounds and those with a previous history of MRSA, even if the last result was negative. (3 MRSA negative results are required).

Prevention of Outbreaks of Viral Gastroenteritis

- All patients requiring admission should be verbally screened for viral gastroenteritis using the flow chart found in Appendix 1.
 - Patients admitted with a history of diarrhoea and vomiting onto AMRU should be directly admitted into an isolation room.
 - Patients with acute diarrhoea should be isolated where possible and cohort if necessary and not transferred until 48 hours symptom free or unless there is a strong clinical indication for the move (e.g. transfer to ICU).
- * Caution should be taken when admitting patients from overseas healthcare settings.

Communication between the Infection Control Team and Bed Management Staff

- During office hours, close liaison between the Infection Control Team and the Bed Manager is essential.
- Out of office hours an On-call microbiologist can be contacted via the hospital switchboard.
- The Bed Manager (or representative) must always attend Infection Outbreak/Incident Meetings when the Outbreak/Incident impacts on bed availability.
- An Infection Control Team representative will attend bed management meetings as appropriate.
- Updates of outbreak wards will be given at Outbreak Meetings and then will be followed by minutes of the meeting and regular trust e-mails.

**POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED
MANAGEMENT AND MOVEMENT OF PATIENTS**

IMPLEMENTATION/COMPLIANCE

All Trust Managers are responsible for ensuring that staff are aware of the location of this policy, for ensuring that staff read this policy and implement it in practice.

References

1. Coia J E Duckworth C J Edwards D I et al (2006) Guidelines for the control and prevention of Methicillin resistant Staphylococcus aureus (MRSA) in health care facilities. Journal of Hospital Infection Vol 63S P51-544
2. Department of Health (2005) Saving Lives: A delivery programme to reduce healthcare associated infection including MRSA.
3. Department of Health (2003) Winning Ways: Working together to reduce healthcare associated infection in England.
4. Healthcare Commission (2006) Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospital NHS Trust.

**POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED
MANAGEMENT AND MOVEMENT OF PATIENTS**

Appendix 1

**Guidelines for Verbal Information Required
for Transfer of Patients**

- A registered nurse on the transferring area must give this information to a registered nurse on the receiving area
- The receiving ward must complete the information and keep in the notes for auditing purposes

Name of staff giving handover..... Name of staff rec

Patients Name:		DOB/Age:	UR Number:
Ward Transferred From:	Ward Transferred To:	Date/Time of Transfer:	Consultant:
Diagnosis:			
Treatment:			
Social status: Discharge plan:			
Relevant PMH:			
Infection Control Status:			
Isolation Required: Yes <input type="checkbox"/> No <input type="checkbox"/>			
Mental Health Status:			
Recent MEWS/Observations:			
Oxygen Requirements:			
Invasive Lines:			
Nutritional Status:			
Waterlow & Pressure Areas:			
Continence:			
Mobility:			
Medication:			

**POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED
MANAGEMENT AND MOVEMENT OF PATIENTS**

**Appendix 2
Patient Transfer Form**

FOR USE FOR INTERNAL (WARD TO WARD), EXTERNAL (OTHER HOSPITALS)
AND COMMUNITY TRANSFERS

Patients Name:		DOB/Age:	U R Number:
Ward Transferred from:	Ward transferred to:	Date of Transfer: Time of Transfer:	Consultant
Reason for Transfer:		Medical Team informed: Yes <input type="checkbox"/> No <input type="checkbox"/>	
		Name	
		Bleep No	
Next of kin informed of Transfer: Yes <input type="checkbox"/> No <input type="checkbox"/> Telephone Number			
Date			
Relationship			
Address.....			
Number of Transfers & Reasons During This admission:			
Transfer Method:		Escorted: Yes <input type="checkbox"/> No <input type="checkbox"/>	
Chair <input type="checkbox"/> Trolley <input type="checkbox"/> Bed <input type="checkbox"/>			
Diagnosis:			
Is the patient aware of the diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>			
Details.....			
Treatment:			
Relevant PMH:			

POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED MANAGEMENT AND MOVEMENT OF PATIENTS

Infection Control Status:	Isolation Required:	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Nutritional Status: Normal Diet <input type="checkbox"/> Special Diet <input type="checkbox"/> Swallowing Difficulties <input type="checkbox"/> Peg Fed <input type="checkbox"/> Additional Information.....			
Communication: Normal <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Wears Glasses <input type="checkbox"/> Has Speech Problems <input type="checkbox"/> Additional Information..... Language Spoken.....			
Maintaining Safety: Orientated <input type="checkbox"/> Confused <input type="checkbox"/> Risk of Falling <input type="checkbox"/> Fire Risk <input type="checkbox"/> Needs Bed Rail Assessment <input type="checkbox"/> Additional Information.....			
Mobility: Fully Ambulant <input type="checkbox"/> Walks With One <input type="checkbox"/> Transfers With One <input type="checkbox"/> Stick <input type="checkbox"/> Frame <input type="checkbox"/> Bed /Chair bound and needs hoisting <input type="checkbox"/> Additional Information.....			
Sleeping: No Problems <input type="checkbox"/> Poor Sleeper <input type="checkbox"/> Nocturnal Confusion <input type="checkbox"/> Requires Sedation <input type="checkbox"/>			
Elimination: No Problems <input type="checkbox"/> Incontinent Urine <input type="checkbox"/> Incontinent Faeces <input type="checkbox"/> Prone to Constipation <input type="checkbox"/> Catheterised <input type="checkbox"/> Details: Type, Size, Date Inserted, Change Date..... Stoma <input type="checkbox"/> Details: Type, Functioning..... Additional Information.....			

POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED MANAGEMENT AND MOVEMENT OF PATIENTS

Skin Integrity:
 Waterlow Score.....

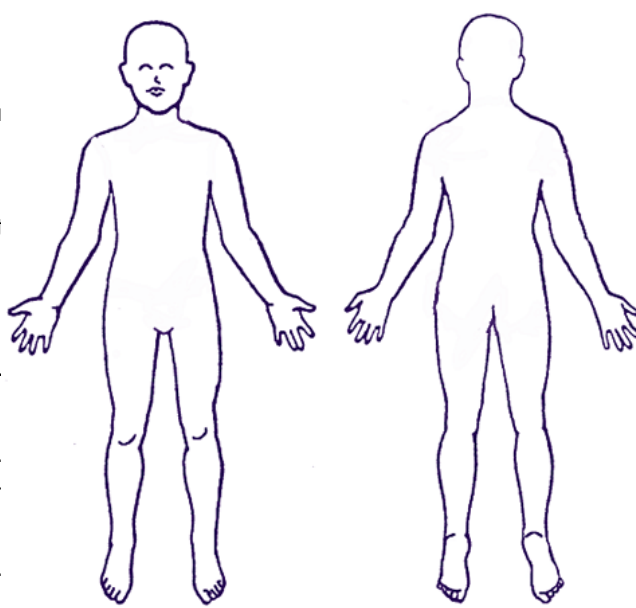
Skin Intact: Has Pressure
 Yes No Yes

Indicate any pressure areas on body outline (Number if necessary)
 Grade.....

Dressing Last Changed.....
 Dressing Type.....

Needs Pressure Relieving Mattress Mattress
 Yes No

Additional Info.....



Invasive Lines:

Mark crosses on the body outline to indicate positions of any invasive lines

Personal Hygiene: Self Caring Needs Support from 1 nurse All Care by 1 - 2 Nurses

Additional Information.....
 ...

Oxygen Requirements.....

Recent Obs: Date..... Time..... Temp B.P. H.R. Rhythm..... R.R.
 SaO₂.....

Recent Mews: Date..... Time..... R.R. ... H.R. ... S.B.P. ... Temp Nuero Urine.... **Total**

Medication: Date and time medication last given to patient.....

(Only document medication from external transfers, use drug kardex for internal transfers)

Name of Drug	Dose/Frequency	Tick if with Patient

**POLICY FOR INFECTION PREVENTION AND CONTROL POLICY FOR BED
MANAGEMENT AND MOVEMENT OF PATIENTS**

Patients Property List:
Discharge Planning (Internal): See Patients Discharge Document Verbal Handover Given: Yes <input type="checkbox"/> No <input type="checkbox"/> Name..... Date/Time..... Other Comments:

Name (Print) Date/Time Ward Contact No.

Please file in notes. For external transfers please photocopy and file in notes.

Appendix 3

ACCIDENT AND EMERGENCY DEPARTMENT - Screening and Assessment of patients to aid early recognition of viral gastroenteritis of patients admitted to hospital

