Lincolnshire Partnership
NHS Foundation Trust

REF: 7f

Lincolnshire Partnership NHS Foundation Trust (LPFT)

Title of Policy

DOCUMENT VERSION CONTROL	
Document Type and Title:	**Infection Prevention and Control Isolation**
Authorised Document Folder:	**Policies**
New or Replacing:	**Replacing IC 1.7, 1.8, 1.9 V1**
Document Reference:	**7f**
Version No:	**2**
Date Policy First Written:	**May 2009**
Date Policy First Implemented:	**May 2009**
Date Policy Last Reviewed and Updated:	**July 2017**
Implementation Date:	**23 October 2017**
Author:	**IPC Nurse Specialist**
Approving Body:	**Quality Committee**
Approval Date:	**20 October 2017**
Committee, Group or Individual Monitoring the Document	**Patient Safety and Experience Committee**
Review Date:	**April 2020**

This policy details the Trust's clinical procedures for the Isolation of patients to minimise the risk of transmission of infectious organisms and promote the safe clinical care of an individual with an infection.

LINCOLNSHIRE PARTNERSHIP NHS TRUST

ISOLATION POLICY

ISSUE 2

CONTENTS

1.0 INTRODUCTION.

1.1 The purpose of isolating a patient with a transmissible infection in a single room is to prevent the spread of infection (McCulloch 2000).

1.2 Source isolation is part of an Infection Prevention and Control (IPC) strategy designed to protect staff, patients and visitors by reducing exposure to potentially pathogenic organisms

1.2 The correct and timely placement of infected patients (suspected or confirmed infection or colonisation) into single rooms can reduce the risk of infection and colonisation to others.

1.3 In order to comply with the Health and Social Care Act 2008 Code of Practice for health and social care on the prevention and control of infections and related guidance (2015), Criterion 7, Lincolnshire Partnership NHS Foundation Trust (LPFT) is required to provide or secure adequate isolation facilities.

1.4 Isolation facilities must be taken into account when new builds, refurbishment or service reconfiguration is being considered. Rooms without en suite facilities are often not adequate for effective isolation (NHS Estates, 2005).

1.5 It is the duty of the Trust to ensure that a patient who requires to be nursed in isolation as a result of an infectious organism is cared for effectively and safely, paying close attention to their right to confidentiality, privacy, dignity and psychological needs.

1.6 The decision to implement specific isolation measures may be taken by either medical and/or nursing staff. The IPC Nurse Specialist must be contacted as soon as possible when a transmissible infection is suspected or confirmed and will support Ward managers/ Nurse in Charge to make the decision to isolate a patient, effectively.

1.7 Isolation in a single room is only necessary for certain infectious conditions. The most effective form of isolation is a single room with en suite facilities, if there is a single room available this should always be the first choice for placement. If this is not en suite, then effective management plans should be put into place with regards to potential cross contamination associated with sharing hygiene facilities. (See part 6.6)

2.0 POLICY PRINCIPLES

2.1. The aim of this policy is to facilitate the process of isolation by supporting and enabling staff to make a risk assessment and instigate appropriate IPC precautions based on the transmission route of a particular organism/infection and the clinical environment in which the patient will be cared for, whilst maintaining as much individualised care as possible.

1.2 Implementation of the policy will decrease the risks to service users of acquiring Health Care Associated Infections (HCAI) and will demonstrate compliance with the Health and Social Care Act 2008 Code of Practice for health and social care on the prevention and control of infections and related guidance (2015), Criterion 7. Early identification of service users with infectious disease, particularly Healthcare Associated Infections (HCAI) and prompt isolation will promote a safe care environment for staff, visitors and patients.

3.0 RESPONSIBILITIES

Responsibilities are as set out in the overarching IPC policy 7a except:

3.1 The Chief Executive.
Where the Chief Executive is informed that isolation facilities do not meet demand, consideration will be given to closing the hospital and diverting admissions to other facilities. The Chief Executive will follow Trust procedures for such circumstances.

3.2 Director of Infection Prevention and Control (DIPC)
Where patients cannot be isolated or IPC precautions maintained to a satisfactory level, safeguarding the wellbeing of others, the DIPC will be kept fully informed of any decision to close wards, / departments by the IPC Nurse Specialist through a daily situation report. They will communicate all information to the Executive Team.

3.3 Medical Microbiologist.
The Medical Microbiologist receives information from the IPC Nurse Specialist and/or other clinical staff regarding infection issues for patients. They are available for telephone consultation if necessary and will advise accordingly on any isolation/IPC precautions required and appropriate clinical management of the patient which may include prescribing advice

3.4 IPC Nurse Specialist. (IPCNS)
The IPCNS will advise staff on the IPC/isolation precautions required for individual patients, where necessary, in order to maximise their care and limit the risk of exposure to others and support Ward Managers/ Nurse in Charge to make appropriate decisions to minimise the risk of transmission of infectious disease. The IPC Nurse Specialist will ensure that any decisions on patient management are communicated to clinical teams through the Ward Manager/ Team leader or Nurse in Charge and will document decisions made in the electronic patient record.

3.5 Clinical Matrons/Service Leads/Ward/Unit Managers
Matrons/Managers/Service Leads will ensure that patients are isolated as advised by the IPC Nurse Specialist wherever possible.

Where isolation is not possible, for whatever reason, they will communicate this decision to the IPC Nurse Specialist to assess the possibility of isolating the patient elsewhere within the relevant service or for alternative measures to be put into place to reduce the risk of transmission of infectious disease as far as is practicably possible

Out of hours Public Health England (PHE) can be contacted for advice on 0344 2254525

Any patient transfer/movement will be reviewed by the IPC Nurse Specialist on their next working day.

3.6 All Staff
All staff must ensure that the advice on isolation, given by the IPC Nurse Specialist is followed or any reasons for being unable to follow the advice is communicated effectively to the IPC Nurse Specialist so that alternative arrangements can be made to minimise the risk of transmission of infectious disease.
The member of staff receiving the advice must ensure that this information and the reason for isolation precautions is communicated to the patient and any relevant carers assessing their level of comprehension and ability to comply with precautions.

4.0 DEFINITION

4.1 There are two types of isolation

Source Isolation: Is required for patients who are infected or colonised with a pathogenic organism in an attempt to prevent the transmission of a specific infection to others.

Protective Isolation: Is required to protect a susceptible patient from acquiring an infection from other sources, either directly or indirectly.

If there are instances where isolation is difficult in a single room due to logistical reasons or patient safety issues this must be discussed further with the IPCNS and ensure that a risk assessment is undertaken and documented.

4.2 Cohort Nursing - Where it is not possible to isolate patients in single rooms, those who have potentially been exposed to the infectious organism would be considered to be "exposed contacts" and can be cared for, grouped together in one bay or area of a ward/unit. This should always be discussed and agreed with the IPCNS where possible. Cohorting can reduce the risk of cross-infection and also minimise the number of nurses who look after both infected/colonised patients.

5.0 PROCESSES INVOLVED IN ISOLATION

5.1 It is important to maintain the confidentiality of a patient's diagnosis as far as possible, whilst at the same time, ensuring that carers, relatives, staff and visitors are aware of the appropriate IPC precautions. If staff are unsure of what advice to give to visitors, they should contact the IPC Nurse Specialist at the earliest opportunity.

5.2 Staff caring for a patient who has, or is thought to have, an infection should routinely provide the patient and their visitors with information about their infection and the need for isolation procedures/precautions.
It is preferable that an identified nurse(s) is assigned to the isolated patient on each shift, to reduce the risk of cross-infection and to provide safe nursing care. Where this is not possible, clinical procedures, e.g. dressings, must be carried out after completion of all other clinical care activities with non-affected service users.

5.3 Medical staff and Allied Health Professionals should ideally visit the patient following the completion of other duties and must adhere to IPC precautions on entering the room. Non essential treatment should be postponed, however the infection should not delay rehabilitation or discharge plans, as long as the patient is clinically fit for discharge.

5.4 The need for isolation must be reviewed regularly in consultation with the IPCNS where possible. The decision to discontinue isolation should be undertaken with the authorisation of the IPCNS where practicably possible. Out of hours the decision should be made by the senior nurse in charge. Further advice and support can be sought from PHE.

5.5 If a patient in isolation requires transfer out of their ward, an assessment of the clinical need and risk of patient transfer should be carried out by ward staff. Staff should seek advice from the IPCNS. Transfer and movements of patients must be kept to a minimum and should only be undertaken for urgent clinical reasons. (See section 13 for further information)

5.6 The isolation room door must be closed at all times. If this is not possible due to psychological or patient safety reasons, then a risk assessment must be undertaken in conjunction with the IPCNS and clearly documented within the patient's care plan. The door should always be closed when any care activity is taking place.

6.0 CONSIDERATIONS FOR COMMUNITY TEAM BASES.

6.1 All Community Team bases where patients could potentially enter the premises while experiencing symptoms of an infectious disease, such as vomiting and diarrhoea or Influenza, must consider identifying a single room where that patient or visitor may be requested to await the outcome of the assessment of risk of transmission of infection to other patients or staff members.

6.2 This room should be one where the door can be closed, there is a minimum of soft furnishing, there is no carpet if possible, and it is close to the exit so that the patient can leave the building easily without the potential for contaminating large areas of the building.

6.3 The patient appointment must be rescheduled if possible, unless there is potential risk of deterioration of their mental state if they are not seen.

6.4 The patient should be given advice regarding the managing of their infectious disease and requested to return home until they are fully recovered or, if the state of their health is giving cause for concern, an ambulance can be called to transfer them to be assessed by urgent care services.

6.5 See Section 7 for IPC precautions to be taken and Section 10 for advice on cleaning of the contaminated area.

7.0 INFECTION PREVENTION & CONTROL PRECAUTIONS.

7.1 Hand hygiene is the single most important factor to prevent cross-infection. Hands must be decontaminated on entering and leaving an isolation room regardless of glove use.

7.2 Alcohol hand rub is not effective against organisms such as *Clostridium Difficile* (Hoffman et al, 2004) or Norovirus and must not be used. Soap and water is recommended when leaving all isolation rooms and when dealing with patients presenting with any type of enteric symptoms. Refer to the Hand Hygiene Policy.

7.3 Personal Protective Equipment (PPE) must be stored outside of the isolation room and donned prior to entry. A trolley or protective clothing dispenser must be prepared outside the room to provide equipment relevant to the care to be given. E.g. gloves, plastic aprons etc. Other PPE such as goggles, visors and masks may be required. PPE must be removed prior to exiting the isolation room and disposed of in the appropriate waste stream. Refer to the Policy for the Effective Use of Personal Protective Equipment in the Clinical Environment.

7.4 The application of Standard IPC Precautions is all that is required for the majority of infections. Additional precautions may need to be taken with some communicable diseases following advice from the IPCNS.

7.5 The patient's documents and charts should be kept outside the room to allow easy access without the need to enter the isolation room unnecessarily.

7.6 Patient belongings and any equipment necessary for their care must be kept to an absolute minimum in the isolation room.

7.7 When enteric infection is suspected, separate toilet facilities must be provided. If the isolation room is not en-suite, a single patient designated commode/toilet must be made available and cleaned adequately after every use according to the Isolation Cleaning Reference Pack (Appendix 2)

7.8 Foot operated or non-touch bins should be provided within the facility for infected healthcare waste. Refer to the Trust Waste Management Policy and Guidance

7.9 If outside laundry facilities are used, linen should be placed in a red soluble bag and then placed in a white/ opaque outer bag. It should be stored in an agreed, safe area whilst awaiting collection. If there are large numbers of infected linen bags e.g. during an outbreak the laundry provider must be informed and clinical staff must contact Housekeeping Services for amendment of laundry collection. Estates and Facilities will be able to offer advice and support.

7.10 Where facilities are provided for laundering patients' clothing or bed linen is washed on site, it should be placed in a red alginate soluble bag and stored in the isolation room until it can be placed straight into the washing machine. Bedding and clothing should be washed at 60° C for a minimum of 10 minutes. PPE must be used when handling contaminated laundry.

7.11 Single Use equipment should be used where possible. Single patient use equipment must be cleaned appropriately after every use. Any communal equipment must be dedicated for use in the isolation room only where possible. Any items/equipment that cannot be left in the room, must be decontaminated prior to being removed if possible, if not they must be decontaminated immediately on leaving the infected area and before use on any other patient. Refer to Isolation cleaning Reference pack (Appendix) and Decontamination of Patient Equipment Policy.

7.12 Crockery and cutlery can be washed in the ward dishwasher along with other items and does not have to be designated specifically for the patient in isolation

7.13 The use of fans for patients requiring isolation is not recommended. Please contact the IPCNS for advice.

8.0 PROTECTIVE ISOLATION i.e. IMMUNOSUPPRESSED PATIENTS.

It is extremely unlikely that a patient requiring protective isolation will be managed in the current clinical environment within LPFT. Any Protective Isolation would be instigated and overseen by the IPCNS.

9.0 PSYCHOLOGICAL CONSIDERATIONS

9.1 A patient in isolation can suffer emotional distress and anxiety (Rees et al, 2000). Particular consideration should be given to the psychological and emotional state of the patient when isolating vulnerable adults, including the needs of their carers and sufficient time allocated to the patient in isolation. Staff need to understand what the experience

means to the patient and deliver sensitive and appropriate care Good communication between staff; patients and carers can reduce anxiety considerably.

9.2 The decision to isolate a patient in a care setting must not be taken lightly and should always be after taken after assessing the risk to the individual, other patients and staff. To isolate a confused or distressed patient may be detrimental to their wellbeing. When isolation precautions are required they should be tailored to meet the needs of the patient. The guiding principle for IPC precautions should be to isolate the organism not the patient. (Rees et al, 2000).

10.0 ROUTINE CLEANING AND DECONTAMINATION OF THE ISOLATION ROOM/BED AREA

10.1 Equipment and surfaces must be kept free of dust and bodily fluids to prevent the build-up of organisms (Wilson, 2006).

10.2 The roles and responsibilities of staff involved in the cleaning of the clinical area must be clearly defined. There should be a co-ordinated approach with housekeeping services and ward staff working together in a systematic way. This will ensure that all equipment and the environment are cleaned to a high standard.

10.3 First clean of body fluids is a clinical responsibility. Cleaning of medical devices is a clinical responsibility. General cleaning is the responsibility of all staff at all levels.

10.4. Refer to the Isolation Cleaning Reference Pack for advice and guidance.

10.5. In summary:

- Housekeeping staff must be advised of the infection, about the use of PPE for themselves and the procedures required.
- Yellow colour coded equipment must be used for all isolation facilities (National Patient Safety Agency, 2006).
- All contact surfaces including floors should be cleaned daily with a chlorine based product diluted to the recommended strength according manufacturer's instructions with single use mop heads and cloths, disposed of into the appropriate waste streams.
- Floors must not be mechanically cleaned.
- When implementing precautions against the transfer of enteric infections, pay particular attention to sanitary ware and use chlorine based product diluted to the recommended strength

11.0 DISCONTINUATION OF ISOLATION

11.1 The need for isolation must be reviewed regularly and isolation discontinued immediately it is deemed safe to do so. Where practicably possible the decision to discontinue isolation should be discussed with the IPCNS or Microbiologist.

12.0 TERMINAL CLEANING.

12.1 The roles and responsibilities of staff involved in the cleaning of the clinical area must be clearly defined. There should be a co-ordinated approach with housekeeping services and ward staff working together in a systematic way. This will ensure that all equipment and the environment are cleaned to a high standard

12.2 The Terminal cleaning process should include the following:

- Thorough cleaning of all patient equipment using recommended chlorine based solution to surfaces diluted to the recommended strength according manufacturer's instructions as described in the Isolation Cleaning Reference Pack. The use of wipes of the correct strength using the correct cleaning technique is permitted for ease of use
- Thorough cleaning of the environment, fixtures, fittings and furniture, using recommended chlorine based solution to surfaces diluted to the recommended strength according manufacturer's instructions as described in the Isolation Cleaning Reference Pack.
- The use of wipes of the correct strength using the correct cleaning technique and appropriate exposure times is permitted for ease of use. They must be disposed of in the appropriate waste stream, not into macerators unless designed to do so and **NEVER** down the toilet.
- Curtains should be changed if they are soiled or a patient with certain respiratory conditions (e.g. Tuberculosis) MRSA or an enteric infection has occupied the room.
- There is no evidence that allowing a fixed time to elapse following discharge will reduce microbial survival if cleaning has been through (Wilson, 2006).
- Any remaining articles which cannot be decontaminated must be discarded within the appropriate waste stream. See the Trust Waste Management Policy and Guidance. Under no circumstances should they be used elsewhere. The Trust Facilities and Waste Advisor or IPCNS can give support if necessary.

13.0 CARERS, RELATIVES AND VISITORS

13.1 Carers must be kept fully informed of the initial and continued need for isolation and consulted throughout the process.

13.2 Visitors must decontaminate their hands on entering and leaving the room. They do not generally need to wear protective clothing unless they are carrying out direct patient care (Wilson, 2006).

13.3 Visitors must be advised not to take anything unnecessary in and out of the isolation room, e.g. food and drink. They must also be discouraged from touching other patients during their visit.

14.0 TRANSFER OF THE INFECTED PATIENT

If a patient in isolation requires transfer out of their ward/unit an assessment of the clinical need for and risk of patient transfer should be carried out by the ward staff. Staff should also seek advice from the IPCNS. A patient must only be transferred if clinically indicated. An Infection Prevention and Control Discharge/ Transfer Form must be completed for all transfers/discharges. (Appendix) Please refer to Policy 7m. Transfer of Patient with Known/Suspected Infection.

14.1 Within the same unit.

- Advise receiving department of necessary precautions in advance (Wilson 2006). If the patient is going to another department for a procedure or appointment, where possible, they should be seen last.

14.2 To another Trust inpatient unit or other hospital care provider.

- The ward/unit staff should liaise with the receiving unit's medical and nursing staff prior to transfer.

- The ambulance service must be notified by the ward staff of any necessary IPC precautions.
- Inform the IPCNS as soon as transfer is being considered and planned. They will communicate with IPC colleagues at the receiving hospital, where appropriate, to ensure continuity of IPC precautions.

15.0 THE DECEASED INFECTED PATIENT

Staff must follow the Trust procedure for managing and reporting the death of patient who dies while in the care of the Trust regardless of the suspected cause at the time of death.

15.1 Deceased Infected Patient

- Potential for the cross infection from an infected deceased patient to a health care worker is extremely small, until the body is physically handled.
- Mortuary staff or undertakers must be informed of the infection status of the patient and must adhere to their policies and procedures relating to safe working practices.

15.2 Body bags should only be used in the following circumstances:-

- When leakage of blood and body fluids cannot be contained. (Irrespective of known/suspected infectious status of the patient)
- Confirmed or suspected cases of infection to include Tuberculosis, Hepatitis B, Hepatitis C, HIV and Creutzfeldt-Jacob Disease (CJD)
- Any other high risk infection, as advised by the IPCNS (Damani 2012)

16.0 TARGET AUDIENCE.

All Trust staff involved in clinical activities

17.0 TRAINING

17.1. The IPC Nurse Specialist can offer additional training on request which will include information contained in his policy.

17.2. All members of staff have an individual responsibility to ensure that they access IPC mandatory training.

18.0 CHAMPION AND EXPERT WRITER.

18.1 The Champion for this policy is the Director of Nursing and Quality
18.2 The Expert Writer is the Infection Prevention and Control Nurse Specialist

19.0 CONSULTATION.

Consultation for version 1 occurred through:

- Infection Prevention and Control Committee
- Nursing Executive members
- Public Health England

Additional Consultation for the revised version:

- Head of Physical Healthcare, IPC, Medical Devices and Smoking Cessation.
- Acting Service Manager Older Adults Division.
- IPC link practitioners
- Matrons
- Physical Healthcare Practitioners

20.0 LEGISLATION, GUIDANCE AND REFERENCES.

- The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance (Revised 2015) (Department of Health) London.
- Weston, D., Burgess, A., Roberts, S. *Infection Prevention and Control Guidance at a glance.* (2017). Wiley Blackwell. Chichester.
- Damani, N., *Manual of Infection Prevention and Control*. (2012). Oxford University Press. Oxford.
- Nottinghamshire Healthcare IPC Policy 18.10. Isolation.
- Hoffman P, Bradley C and Aycliffe G (2004). *Disinfection in Healthcare*, 3rd edition, Blackwell Publishing, Oxford.
- McCulloch J (2000) Infection Control: Science, management and practice. Whurr Publishers, London.
- National Patient Safety Agency (2006). Safer Practice Notice 15: Colour coding hospital cleaning materials and equipment. NPSA, London.
- NHS Estates (2004). The NHS Healthcare Cleaning Manual, Department of Health, London.
- NHS Estates (2005). HBN4 Supplement 1: Isolation facilities in acute settings, Department of Health, London.
- Rees J, Davies H and Birchall C (2000). Psychological effects of source isolation nursing 2): patient satisfaction. Nursing Standard 14:29, 32-36.
- Wilson J (2006). *Infection Control in Clinical Practice*. 3rd edition, Bailliere Tindall, London.

21.0 MONITORING COMPLIANCE

21.1 In the event of isolation being necessary, the IPCNS will monitor compliance actively during ward visits to support ward staff.
21.2. Any Post Infection Review should include evidence of adherence to this policy
21.3 Compliance with this policy will also be monitored through the IPC Audit Programme

22.0 ASSOCIATED TRUST POLICIES

7a. Infection Prevention and Control
7b. Hand Hygiene
7c.Outbreak of Infection
7n.Correct Use of Personal Protective Equipment in the Healthcare Environment
Waste Management

23.0 REVIEW DATE

This policy/procedure will be reviewed in 3 years or in light of organisational or legislative

changes.

Record of changes

Date	Author	Policy/Procedure	Details of change(s).
July 2017	J. Lord	7 f	Extensive changes throughout Reordered for standardisation Updated references to legislation and guidance

Appendix 1 Considerations regarding the isolation of a patient (Weston 2017).

Consult with the IPC Nurse Specialist at all stages.

The Patient

Is the patient suitable for isolation in a single room? Are they confused? OR Agitated? OR Apt to wander? OR At risk of falls? OR At risk of self-harm? OR In need of high level observations?

The safety of the patient must be considered. Standard IPC precautions, increased attention to hand hygiene and enhanced cleaning may minimise the risk of transmission to others sufficiently.

Does the infectious disease make the patient unwell enough that more specialist levels of care are necessary e.g. Acute Inpatient Provider?

The Organism

What is the organism?

Is it antibiotic resistant/multi antibiotic resistant? How is it spread?

What is the risk of environmental contamination and cross infection? Could it lead to an outbreak if not contained?

What other IPC measures need to be put into place? Is additional cleaning/ equipment/PPE required?

The Facilities

Does the ward/ unit have single rooms? Are any en-suite?

Is the single room immediately available? Will another patient have to be moved to accommodate? Can that person safely be managed outside of a single room?

Is the room in an observable area?

If the patient cannot be nursed in a single room, they may need to be managed in a dormitory with other patients who are not infected/colonised. Should all in this area be considered to be "exposed contacts" and managed as a cohort? Does any patient in this area have open wounds or invasive devices? Should they be removed from this area?

Other

What equipment is needed? (medical devices/commodes)

Can equipment be designated as 'Single Patient Use'?

What are the environmental/equipment cleaning/decontamination requirements?

Isolation must not impact on the patient's general care and recovery. Psychological well-being must be considered including the restriction of visitors

All risk assessments and decisions must be documented robustly

Appendix 2 Isolation/Cohort Nursing Requirements.(Weston 2017)

- **Appropriate isolation door sign.**

  Where patients are cohort nursed in a particular area, signage should be placed on the area doors
  This signage should be discreet to protect the confidentiality of the patients and their privacy and dignity

- **Door closed to isolation room or cohort area.**

  If it is not safe to close the door-this must be documented in the patient notes and reviewed daily

- **En-suite Facilities or dedicated single patient use(or cohort use) commode**

  A bathroom and toilet may be allocated for the use of a cohort only

- **Personal protective equipment outside the room/cohort area**

  This may need to be stored in a separate locked area close to the isolation room/cohort area

- **For patients who are being barrier nursed-alcohol hand rub is available at the point of care.**

  This may be staff held individual tottles

- **Hand washing Facilities available within the room/cohort area**

- **Domestic and Infectious waste bins within the room/cohort area**
- **Single patient use items, Dedicated medical devices**

  This could include, tourniquets, blood pressure cuff, medical devices for physiological observations.
  If this is not possible, the equipment must be thoroughly decontaminated after every use

- **Disinfectant wipes readily available within the room/cohort area for the decontamination of surfaces and equipment after every use**

Appendix 4 Infection Prevention and Control Discharge/ Transfer Form

This form must be completed in conjunction with other discharge/ transfer documentation and kept with any multi-disciplinary notes

Patient/Client details: (insert label if available) **Name:** **Address:** **Date of birth:** **NHS number:**	**Consultant:** **Contact no:** **GP:** **Contact no:**	
Transferring facility: *(hospital, ward, care home, other)* **Contact name:** **Contact no:**	**Receiving facility:** *(hospital, ward, care home, district nurse [if applicable], GP)* **Contact name:** **Contact no:**	
Symptoms: **Diagnosis:** *(confirmed organism)*	Infection Yes ☐ No ☐	Colonisation Yes ☐ No ☐

Microbiological identification (specimen results):

Specimen & Results	Specimen type	Date	Result
Screen/diagnostic			
Confirmatory			
Other			
Further screening required?			

Treatment information (if appropriate): *(including type of medication, dose and duration)*

Infection prevention & control precautions required / in place:
Does the patient require isolation? Yes ☐ No ☐

Other information relevant to patient's care:

Has the IPC Nurse Specialist been informed?	Yes ☐	No☐	If No, give reason
Has ambulance service been informed?	Yes ☐	No☐	If No, give reason
Is the patient/client aware of their colonisation/infection status?	Yes ☐	No☐	If No, give reason
Has patient received information about their status? (patient leaflet)	Yes ☐	No☐	If No, give reason
Has the nearest relative/ carer received information about their status? (patient leaflet)	Yes ☐	No☐	If No, give reason

Name of staff member completing form:

Print name		**Contact number**	

Appendix 5 Equality Analysis Form

Name of Policy/ project/ service	**Infection Prevention and Control** **Isolation**		
Aims of policy/ project/ service	**This policy details the Trust's clinical procedures for the Isolation of patients to minimise the risk of transmission of infectious organisms and promote the safe clinical care of an individual with an infection.**		
Is this new or existing?	Existing		
Person(s) responsible	Jane Lord		
Key people involved	Jane Lord		
Who does it affect?	Service users □√	Staff □√	Wider Community □√

Is the policy/ project/ service likely to have an effect on any of the protected characteristic groups? (please tick)

	Positive	Negative	None	Is action possible to mitigate any negative impact?	Details of action planned (including dates or why action is not possible)
Age	√				
Disability	√				
Sex	√				
Gender Reassignment	√				
Sexual Orientation	√				
Race	√				
Religion and Belief	√				
Marriage and Civil Partnership	√				
Pregnancy and	√				

Maternity					
Carers	√				

Any other information that is relevant to the equality impact of the policy/ project/ service?

Detail any positive outcomes for any of the protected groups listed above

The policy will ensure best practice to prevent transmission of infectious disease

Result of Equality Analysis

Based on the information above- what is the outcome of the Equality analysis?

a) No change √ □	b) Adjust the activity □	c) Stop/remove the activity □
Detail any adjustments that are to be made and how these will be monitored		

Person who carried out this assessment	Jane Lord
Date assessment completed	19/07/2017
Name of responsible Director/General Manager	Anne-Maria Olphert
Date assessment was signed	
Date of next review	19/07/2020