Priority for Isolation of Patients Protocol

Aim:
This protocol sets out the infection prevention and control principles that must be applied in order to prioritise patients for isolation based on infection risk factors.

1. Introduction
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). Consideration must be given to isolating those patients with suspected / confirmed infection as quickly as possible and to reduce / restrict the movement of infected patients between wards. (Healthcare Commission 2006). The emergence of antibiotic resistant pathogens, is likely to increase the burden on limited isolation facilities (Barlow et al, 2002).

2. Communication between the Infection Prevention and Control Team (IPCT), Bed Managers and Night co-ordinators

- During office hours, it is important for clinical staff, the IPCT and the Bed Managers to liaise on the placement of patients
- Out of hours a Consultant Microbiologist can be contacted via the hospital switchboard.

NB: IPC Advice should be sought in the first instance from the local IPCT

3. Allocation of single rooms

- Allocation of a single room must be based on a clinical risk assessment with infection prevention and control requirements given a priority over bed management / capacity issues
- Delays in transferring A&E patients awaiting a single room in a ward for isolation must be kept to a minimum
- For patients requiring intensive nursing input / observation, 1-2-1 care should be requested to enable the patient to be moved to a single room.
- Patients with known infection or colonisation with a multi drug resistant organism being transferred from another hospital, must be admitted into a single room

- All patients with acute diarrhoea should be isolated and assumed infectious until asymptomatic for at least 48 hours or the medical team have established a non-infective cause.

  ***A decision NOT to isolate a patient with *Clostridium difficile* MUST be discussed with a member of the ICT or on-call consultant microbiologist.**

4. Isolation risk assessment

Isolation facilities available across NHS Greater Glasgow and Clyde vary per hospital site. Single rooms are available with or without en-suite facilities, anti-rooms and mechanical ventilation (including negative-pressure).

If a patient cannot be isolated due to clinical condition, this must be documented in the patient's notes and the local IPCT informed. The patient should be placed in the most appropriate place suitable to his care needs but ideally where other patients are not placed at risk and where staff can easily apply the appropriate precautions (e.g. next to a clinical hand wash basin). The situation should be monitored daily and those patients who require isolation should be accommodated as and when isolation facilities become available. If more than 1 patient has the same infection, cohort nursing may be appropriate on the advice of the IPCT.

If a suitable isolation room is not immediately available on a ward, the SCN / bed manager must liaise with the local IPCT (or on-call Consultant Microbiologist) to undertake a risk assessment of isolation needs. This may involve the transfer of other patients/service users out of side rooms to accommodate those with higher needs.

The following risk assessment system (Table 1) is modified from the Lewisham Patient Isolation Prioritisation System (PIPS), which calculates a risk score for patients based on the following:

- Mode of transmission / spread
- Advisory Committee on Dangerous Pathogens (ACDP) classification
- Evidence for nosocomial transmission
- Prevalence of infection in the hospital and dispersal characteristics
- Antibiotic resistance.
- Susceptibility of other patients.

Ward staff should refer to Table 1 to determine priority of isolation for infected patients. Priority should be given to those patients with higher score i.e. highest risk. The type of ward and the potential for transmission should also be considered.

Table 1: Organism / Condition, ACDP, Mode and evidence of Spread and priority score.

Condition / Infection	**ACDP cat**	**Mode of Spread**	Evidence of spread	Priority score	Organism specific guidance / risk
Acute viral encephalitis	2	Contact	Poor	10	
Adenovirus	2	Droplet contact	Moderate	25	
Atypical Mycobacteria	3	Airborne	Weak	25	Refer to SOP for *M abscessus* for patients with Cystic Fibrosis
Campylobacter	2	Droplet / Faecal-oral	Poor	30	
Chicken pox	2	Airborne Contact	Strong	30	Usually infectious until no new vesicles appear and last ones dry.
Clostridium difficile	2	Faecal-oral	Strong	35	Isolate if patient has had diarrhoea in last 48 hours
Diarrhoea and / or vomiting	2	Faecal-oral	Strong	30	Isolate if patient has had diarrhoea in last 48 hours
E.coli 0157	2 or 3	Faecal-oral	Moderate	30-40	
Glandular Fever	2	Droplet	Poor	20	
Influenza	2	Droplet	Strong	40	During epidemic, consider cohort nursing
Measles	2	Droplet	Strong	35	
Meningitis Suspected	2 or 3	Droplet contact	Moderate	25-35	All suspected meningitis cases must be isolated until cause confirmed. Meningococcal meningitis requires isolation until 48 hours of appropriate antibiotics.
Meningococcal septicaemia	2	Droplet	Moderate	25	Requires isolation until 48 hours of appropriate antibiotics
Multi resistant bacteria e.g. CPE	2	Contact	Strong	30	Risk of spread Body site e.g. catheter = higher Location of patient e.g. ICU = higher
MRSA	2	Contact	Strong	30	See MRSA Policy for high and low risk patients.
Mumps	2	Droplet	Poor	30	
Norovirus	2	Faecal-oral Contact / Droplet	Strong	30	
Rotavirus	2	Droplet / Faecal-oral contact	Strong	30	
Respiratory Syncytial Virus	2	Droplet Contact	Strong	25	Paediatric and immuno-compromised adults only
Rubella	2	Droplet	Moderate	25	Isolate in paediatric, maternity and BMT
Scarlet fever	2	Droplet	Moderate	25	

Table 1: Organism / Condition, ACDP, Mode and evidence of Spread and priority score (cont.)

Condition / Infection	**ACDP cat**	**Mode of Spread**	Evidence of spread	Score	Organism specific guidance / risk
Shingles	2	Contact	Mod	20	Isolation not required if spots dry and covered.Isolate in paediatric, maternity and BMT
Streptococcus pneumonia – penicillin resistant	2	Droplet	Strong	30	
Streptococcus pyogenes (Group A)	2	Contact Droplet	Strong	30	Until 48 hours of appropriate antibiotic therapy and clinical improvement
Tuberculosis Open pulmonary	3	Airborne	Strong	30	Isolate for 14 days following commencement of treatment. Suspected MDR-TB patients should be placed in a negative pressure isolation single room
Vancomycin-resistant enterococcus	2	Contact / Faecal-oral	Strong	30	Only if patient has loose stools or leaking wounds
Viral haemorrhagic fever	4	Blood-borne	Strong	60	Blood and body fluids highly infectious Refer to ID physician and Infection Control Doctor immediately.

Movement of isolated patients between wards and department

- Clinicians must always assess the need to move a patient. If an inter-ward transfer or investigation/procedure can be postponed until the patient is no longer in isolation without compromising the patient's care then this should be done.
- Receiving wards and departments must be made aware, before the patient is moved, that (s)he is in isolation for suspected / known infection. This will allow staff in the receiving unit to prepare.
- If the patient is being moved to another ward, the isolation room/ bed space vacated must be terminally cleaned.

References:

Barlow G, Sachdev N and Nathwani D (2002) The use of adult isolation facilities in a UK infectious diseases unit. J Hosp Infect 2002; 50: 127-132.

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Masterton RG, Mifsud AJ, Gopal Rao G. Review of hospital isolation and infection control precautions. J Hosp Infect 2003; 54: 171-3

Seigel JD, Rhinehart E, Jackson M, Chiarello L. Guidelines for isolation precautions: preventing transmission of infectious agents in healthcare settings. Atlanta: Centres for Disease Control and Prevention; 2007.