Trust Policy		NHS Worcestershire Acute Hospitals NHS Trust

Isolation and Bed Management Policy

Department / Service:	Infection Prevention and ControlTeam
Originator(s):	Lara Bailey (Senior Infection Prevention and Control Nurse) Kerrie Howles (Senior Infection Prevention and Control Nurse)
Accountable Director:	Sarah Shingler – Director of Infection Prevention and Control/CNO
Approved by:	TIPCC
Date of approval:	1st February 2024
First Revision Due:	1st February 2027
Target Organisation(s)	Worcestershire Acute Hospitals NHS Trust
Target Departments	All Services
Target staff categories	All Staff Groups

Policy Overview:

This policy is designed to provide guidance on the bed management and isolation of infectious patients. The patients covered by this policy include all patients who receive care under Worcestershire Acute Hospitals Trust.

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Healthcare professionals must be prepared to justify any deviation from this guidance.

Key Amendments to Document

Date	Amendment	Approved by
December 2019	The following policies have been amalgamated with revisions where necessary: WAHT-INF-015 version 5.7 – Isolation Policy WAHT-INF-019 version 5.1 – Infection Control and Bed Management Guideline	**TIPCC**
November 2023	Various amendments made to the policy: • Reference to the National Infection Prevention and Control Manual (NIPCM) 2022 • Name of Accountable Director changed • Appendices updated including A-Z of infectious agents • Consultation list updated	
05/04/2024	Minor amendments made. New version 2.1	**Emma Fulloway**

Introduction

Micro-organisms (e.g. bacteria, viruses and fungi) can cause a range of infectious diseases/infections. Acquisition of infection while in hospital can lead to extended inpatient admissions. Most infections can be prevented through the implementation of standard infection control precautions (SICPs) as described in the National Infection Prevention and Control Manual (NIPCM) (2022).

However, some diseases that can be transmitted between patients or between patients and staff, require additional transmission based precautions (TBPs) in the form of isolation, and specific bed management requirements.

The Infection Prevention and Control Team (IPCT) must be notified as soon as possible where a patient has been isolated (due to suspected/known infection) to ensure the correct precautions are implemented. Patients who present with diarrhoea/vomiting must be promptly isolated (within 4 hours unless infectious cause can be confidently excluded) as recommended by the Healthcare Commission (2006).

The algorithm (Appendix 1) provides an action plan and timeline to isolation for such cases. Similarly, should there be insufficient isolation facilities available for the number of infectious patients requiring placement, staff in the first instance, should refer to the risk assessment for the prioritisation of side rooms, and then discuss with the Site Management Team (SMT) who will be able to provide assistance with the prioritisation of attribution of isolation rooms according to the level of risk.

A member of the IPCT is always available for advice. The IPCT consists of Infection Prevention and Control Nurses (IPCNs) and Consultant Medical Microbiologists (CMMs). They may be contacted for advice on the following extensions, via bleep, or through the hospital switchboard.

Worcestershire Royal Hospital:

IPNs – Ext 38752 Bleep 840

Alexandra General Hospital:

IPNs – Ext 44744 Bleep 0227

Duty CMM – Ext 30673

On Saturdays, there is an IPCN available between 0800-1600. On Sundays, and out of hours (OOH), the first point of call for infection prevention and control issues is the SMT. Should the SMT be unable to resolve an issue, they will contact the Duty CMM (On-Call). The CMM should not be contacted by any persons other than the SMT or senior medical staff for clinical issues.

Scope of this document

This policy applies to all healthcare professionals working within the organisation including medical staff, nurses, allied health professionals, students and visiting staff.

It relates to all patient movement into, within, and out from the Acute Trust.

Definitions

Same organism – meaning the organisms causing infection are epidemiologically linked, i.e. their symptoms are related by time, based on the date of onset of the first case, and location.

Duties (Roles and Responsibilities)

The Executive Team is accountable to the Trust Board for ensuring Trust-wide compliance with this policy

The Chief Executive has overall responsibility for implementation, monitoring and review of this policy. This responsibility is delegated to the Director of Infection Prevention and Control (DIPC), who chairs TIPCC.

The Trust Infection Prevention and Control Committee (TIPCC) will review and ratify the policy and any new evidence base within the time frame set out in the policy.

The Director of Estates and Facilities is responsible for ensuring that isolation facilities are maintained, including correct ventilation parameters.

The Infection Prevention and Control Team (IPCT) is responsible for giving infection prevention and control advice as necessary and for assisting with the review of this policy to ensure the policy contains current evidence based guidance.

The Site Management Team (SMT) is responsible for sourcing a suitable placement for a patient with an infectious disease.

The Occupational Health Department (OHD) is responsible for assisting with staff surveillance as necessary and staff vaccination.

Consultants, Matrons, Line Managers and Heads of Department are responsible for ensuring that policies, procedures and guidelines, access to education and training are made available to all staff to ensure staff competence, minimise the risk of infection transmission, and ensure clinical practice is in line with Trust policy.

All Staff are responsible for ensuring that they understand and implement this policy.

Policy Detail

Adherence to SICPs (NHS England, 2022) will help in reducing the risk of acquiring infection from patients whose infectious status is unknown, particularly in those with blood borne diseases.

However, it is sometimes necessary within the hospital environment to take additional TBPs (NHS England, 2022) when a patient is known to have, or suspected of having an infectious disease (see WAHT-INF-011 - Policy for Notifying Suspected Infectious Diseases and Causative Organisms).

Any patient with a disease which is infectious to others should be nursed in a single-room with appropriate infection control precautions in order to prevent the spread of infection to others. This

should not compromise the individual patients' clinical care or prevent them from undergoing any procedure indicated for investigation or treatment.

Inevitably, the demand for single-room accommodation often exceeds the facilities that are available, and the placement of patients in any clinical area, including single-room accommodation should be risk assessed according to:

- The known/suspected organism causing infection
- The risk of transmission to others, and mode of transmission
- The severity of infection which could be caused
- The susceptibility of other patients to infection
- The reasons why patients are currently occupying the single-room accommodation
- E.g. if related to non-transmissible infection, the need to protect the individual from infection, or for non-infection related indications.

Isolation Category

Isolation Risk Assessment and Patient Placement

The potential for transmission of infection or infectous agents should be assessed by staff at the patient's entry to the care area and should be continuously monitored throughout the patient's stay. Staff should therefore ensure that all patients admitted under their care are promptly assessed for infection status using the appropriate admission assessment on arrival to the care area, and if possible, prior to accepting a patient from another care area. Staff should refer to the aide memoire relating to general principles of isolation (Appendix 2).

Isolation need is then risk assessed through referring to and/or completing the following documentation, or discussing with the IPCT:

- Rapid Diarrhoea and Vomiting (D&V) Risk Assessment on Sunrise EPR
- A – Z of Infectious Pathogens/Diseases (Appendix 3)

Once a need for isolation has been identified, staff should ensure that the risk assessment for the prioritisation of side rooms is completed to assist the SMT with placement of the patient where single-room accommodation is not immediately available, or the requirement of single-room accommodation exceeds the facilities available (see Appendix 4 for process). This risk assessment should be reviewed every 48 hours.

******The infection status of the patient must then be clearly recorded in the patients medical notes and on the patient electronic white board system, including patient placement decision******

Once a patient is isolated, it is vital that laminated isolation and TBP door signs are attached to the outer aspect of the door; these are available to order from Xerox. The sign should be attached to the door of the single-room or visible area, e.g. bay door when cohort nursing.

Single-room Nursing

A single en-suite room under negative pressure ventilation with the door closed is the required means as to prevent the transmission of organisms spread by the **airborne route**.

A single en-suite room with the door closed is preferred for infection spread by the **droplet route**.

A single (preferably en-suite) room is the favoured means to prevent the transmission and gross contamination of the environment outside the room with certain organisms that may be spread via the **contact route**.

Isolation is not necessary for infections spread by the blood-bourne route.
****Exceptions to this may be when there is heavy blood loss****

For patients who are at an increased risk of acquiring infection from other patients, for example, they are immunocompromised, placement in a single en-suite room with the door kept closed and under positive pressure.

If, for any reason, the door cannot be kept closed, or the patient cannot be isolated as the patient is deemed to be at risk (e.g. for falls or mental health reasons), the appropriate risk assessment must be completed and the decision documented in the patient's medical notes.

A number of rooms at the Worcestershire Royal Hospital site have positive and negative air flow systems that operate when the door is closed to increase the protection to patients and staff. These rooms are identified by a grey Magnehelic gauge above the door that must be monitored to ensure that air flows are operating appropriately. Staff must ensure that appropriate risk assessment is carried out to identify whether Magnehelic controlled single-rooms are required for the infectious disease/pathogen dependent upon the transmission route of the pathogen; if staff are unsure, they should contact the IPCT for support.

Cohort Nursing

If multiple patient cases of infection with the same organism are confirmed (such as in outbreaks), or if single-room accommodation is unavailable, cohorting of patients may be considered appropriate. In these circumstances, it is considered best practice to ensure that patients are separated by at least 3 feet (1m) and bed curtains can be drawn as an additional physical barrier (HPS, 2014; PHW, 2015).

If possible, a dedicated team of staff to care for patients in isolation/cohort rooms/areas should be allocated.

Duration of Isolation

Patients should remain in isolation/cohort with the door closed whilst they remain symptomatic and/or are considered infectious. (Appendix 3).

Before discontinuing isolation, individual patient case risk factors should be considered and the clinical judgement of those involved in the patients management. If staff remain unsure, then advice from the IPCT may be sought in individual cases.

Transmission Routes

Transmission of nosocomial pathogens is due to at least 5 basic mechanisms described below:

Airborne:

Infectious organisms are transmitted through droplets < 5 microns in diameter. Droplets may remain suspended in the air for a prolonged period of time and travel long distances. Droplets may be produced by talking, coughing and sneezing, or by procedures such as bronchoscopy or endo-tracheal suctioning. Susceptible hosts may be infected several metres away from the source.
Examples: SARS, SARS CoV-2, Chickenpox, Tuberculosis, Measles.

Droplet:

Infectious organisms are transmitted through droplets > 5 microns in diameter. These droplets do not remain suspended in the air for a prolonged period of time, and usually travel short distances. These droplets may be produced by talking, coughing and sneezing, or during invasive procedures such as bronchoscopy. Close contact usually less than one metre is necessary for transmission to occur.
Examples: SARS CoV-2, Meningococcal meningitis, MRSA, chest infections.

Contact (Direct or Indirect):

Skin-to-skin contact and the direct physical transfer of micro-organisms can occur from one patient of healthcare professional to another. Direct contact examples include handshaking and providing direct personal care. Indirect contact refers to contact with an inanimate surgace contaminated with micro-organisms, such as contaminated stethoscopes and commodes.
Examples: CPE, MRSA wound infection, ESBL, scabies.

Infections in the faecal-oral group are also spread by contact, however, hand/equipment-to-mouth is required.
Examples: Salmonella, *Clostridiodes difficile*

Other infectious agents may also be transmitted via contamination of the food/water supply, equipment, solutions, needles, multi-dose vials, or other articles that are used by more than one patient.

Blood borne:

Some micro-organisms can be transmitted by contaminated blood or tissue coming into contact with the patient's own blood or mucous membranes.
Examples: HIV, Hepatitis B.

Standard Infection Control and Transmission Based Precautions (TBPs)

SICPs and TBPs must be applied (as per the NIPCM, 2022) at all times where appropriate.

In addition to SICPs and TBPs:

Specimens:

- Care must be taken to ensure that leaking specimens are not sent to the microbiology laboratories.
- Care must be taken to ensure sufficient information on the specimen forms is provided to ensure appropriate care can be taken in the laboratory.
- Specimens should be enclosed in an appropriate plastic specimen bag.
- Where hard copy specimen request forms are required, this should be securely attached to the outside of the specimen bag.

Crockery and cutlery:

- Heat disinfection is essential.
- Items should be returned to the central wash up or zonal kitchen as normal for processing through an industrial standard automated dishwasher.
    - If these dishwashers are unavailable for any reason, this must be escalated in a timely manner to ensure identification of alternative routes for processing.
- Items that are wet on removal from the dishwasher should be allowed to air-dry, or paper towels used if immediate drying is required.

Cleaning:

- Domestic staff will follow guidance contained within the Trust Cleaning Policy. Further guidance regarding cleaning for clinical staff can be found in A – Z of Infectious Pathogens/Diseases Appendix 3 of this policy where detailed guidance on the types of cleans required by organiusm is listed. There is also the RAG cleaning poster which gives guidance for the cleaning of an isolation room/cohort areas. Clinical staff can contact IPC for guidance if they are unsure of the level of clean required. Outline below of the different cleans available at the trust:
    - Red -Chlorine Dioxide Vapour
    - Violet-Ultra-V (UV-C)
    - Amber-Tristel, Chorine Dioxide
    - Green-universal disinfection wipe, ‘clinical green clean’ is required before Amber, Violet and Red cleans.
- Cleaning with a Trust approved disinfectant and equipment should be increased in cases of infection and/or colonisation of a known/suspected pathogen.

Last Offices:

- Staff undertaking last offices for patients with known/suspected infectious disease should follow the Trust Last Offices policy.

For further information, please refer to Health and Safety Executive guidance.

Specialist Ward Policies and Protocols

Paediatric Isolation

WAHT is following guidelines from Birmingham Children's Hospital (BCH), providing isolation rooms for children with specific infections rather than routinely isolating babies under one year for protective reasons. The Trust policy is to isolate babies under 6 months for ease of nursing and vaccination protocols.

Most common childhood infections are included within Appendix 3.

MAU

Single-room availability is very limited in the Medical Assessment Unit (MAU) areas, and as a general rule infectious patients should be admitted directly into a single (preferably en-suite) room elsewhere, rather than risk exposing other patients to infection, who may themselves then be transferred to other open ward areas and become infectious to others. This is particularly important for highly transmissible infections.

Laurel 2 Oncology and Laurel 3 Haematology – WRH

Single-rooms are available for immunocompromised patients. The main ward areas can also accommodate immunocompromised individuals.

In some cases general medical patients (medical outliers) may have to be admitted to these wards because of bed shortages. The following patient groups are **excluded** from this, and must under no circumstance be admitted to these areas (unless there is a specific haematology/oncology reason for admission to either of these wards):

- Patients known to be CPE positive
- Patients known to have had CPE contact (either environmental or direct patient contact)
- Patients who require readmission to an acute ward from Avon 4.

Avon 3 Infectious Diseases Unit – WRH

Patients with known or suspected infection have priority when allocating single-rooms on Avon 3.

If non-infectious patients are occupying these rooms because of bed shortages, they must be moved out as a priority if these rooms are later needed for infectious patients, particularly those identified in alarmed negative pressure rooms with appropriate infection control precautions.

ICU, High Dependency Units and CCU - Countywide

Infectious patients should not be routinely admitted to the countywide Intensive Care Units (ICU) , however, there are some instances where their admission is based on clinical need; under these circumstances, countywide ICUs have dedicated single-room facilities. At AGH, patients with suspected/confirmed **airborne/droplet** infections should only be placed in a single-room once a risk assessment has been carried out and determined to be safe whilst works are being carried out.

In some additional instances (where clinical need takes precedence e.g. high visibility), it may be necessary to cohort patients into specific areas of the units. Staff should ensure that these areas are

physically separate and under the care of a designated team of staff in order to reduce the risk of cross-infection.

At the WRH site, patients with known or suspected infections must not be routinely admitted to Surgical HDU (SHDU) or Vascular HDU (VHDU) due to cross-infection risks. If no single rooms are available, admission must be based on clinical need following a stratified risk assessment and clearly documented in the patients medical notes. Staff must pay particular careful attention to minimise the risk of cross-infection with other patients e.g. a FlexiSeal system to contain diarrhoea may be appropriate.

The single room on the Coronary Care Unit (CCU) is only to be used for coronary care patients with infections.

Patients should be moved to appropriate single-room accommodation elsewhere as soon as they are clinically fit.

Elective Orthopaedics – Countywide

Theses beds are only for elective patients who have been screened for MRSA and found to be **negative.** Medical and Trauma outliers must not be admitted to these areas.

Discharge/Re-Use of the Room

Patients who are being transferred to other hospitals, nursing or residential homes may need ongoing isolation/infection control precautions. These must be discussed at the time of arranging transfer, and the receiving unit must be informed of any infectious conditions and whether patients are currently symptomatic.

The risk assessment (Appendix 5) should be completed prior to arranging discharge of any patient involved in an outbreak due to viral gastroenteritis and a Care Home Discharge information letter (Appendix 6) sent with the patient if transfer is approved.

Patients may be discharged to home when medically fit for discharge (MFFD) and must be given the appropriate infection prevention and control advice to prevent spread to other family members.

Single-rooms used to nurse infectious patients require differing amounts of time to be cleared of nursing equipment and cleaned (depending on the causative infectious organism) before the use by another patient. Rooms are not ready for use until clean and air dry. Please refer to the Trust Cleaning Poster for guidance on which form of decontamination is required for the causative infectious organism, and by the advice of the IPCT.

Outbreaks

During an outbreak of an infectious disease, it is important that affected patients are not transferred to other wards, hospitals, nursing or residential homes whilst symptomatic, unless isolation facilities are available (and the receiving unit is fully informed of the outbreak and agrees to the transfer).

In addition, staff should not work in other areas to which the infection could spread. The IPCT will determine the best way to manage the outbreak in consultation with the outbreak control team (OCT) as per the Policy for Outbreak Reporting and Control, including Major Outbreaks (WAHT-INF-044).

Occasionally, bays or whole wards will be closed to admissions to reduce the risk of infection to new patients and aid control of an outbreak. Patients should not be admitted to closed wards or bays without prior discussion with the IPCT.

Implementation

Plan for implementation

Launch to Matrons at Senior Nurses Meeting, Ward Sisters and Infection Prevention Link Nurses at their relevant meetings for wider dissemination to ward and departmental nursing staff.
Launch to all clinical staff through Trust Brief
Launch to all medical collagues via Clinical Directors and presentation at relevant speciality meetings if requested.

Dissemination

Instruction to all clinical staff of revised policy via weekly Trust Brief.
Ward and departmental based clinical staff via Infection Prevention Link Nurses.
Updated policy to be made available via the Trust Key Documents intranet page.

Training and awareness

It is a mandatory requirement that all new Trust employees must attend a Trust corporate induction programme, which includes IPC training. It is the responsibility of the line manager to ensure that IPC issues are covered in all local inductions and that this is documented.

It is a mandatory requirement that all clinical and non-clinical staff update their infection control training annually, either by attendance at a formal session, or using and completing online or e-learning reasources. It is the line manager's responsibility to ensure that this occurs.

Different modalities are available to facilitate compliance with mandatory training requirements. These include attendance at formal lectures, ad hoc teacing, and access to online training. Records of staff training are kept centrally on the ESR database and locally by Directorates as required.

Monitoring and compliance

Audit mechanisms and processes will be put in place to ensure that isolation and bed management processes are appropriate.

The Trust will have systems for monitoring compliance with isolation and bed management. The key indicators will be internal and external audit findings, corrective actions and incident reports.

Policy Review and Dissemination

This policy wil be reviewed every three years or earlier if regulations change by the named individual on the front of the policy and circulated for comment prior to approval by the Trust Infection Prevention and Control Committee (TIPCC).

Dissemination of the document will be as per the Trust Policy for Policies (WAHT-CG-827). Reference to the relevant Infection Prevention policies will also be made during induction, annual and other update sessions for staff. The policies will be available to view on the Trust Key Documents page on the intranet.

References

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Background

Equality requirements

The equality risk assessment for this policy has been undertaken and may cause restrictions for some groups. (See Supporting Document 1).

Financial risk assessment

The financial risk assessment for this policy has been undertaken and may require additional resources. (See Supporting Document 2)

Consultation

This key document has been circulated to key stakeholders and representative of the target audience for comment prior to finalisation before being submitted for approval by TIPCC.

Contribution List

This key document has been circulated to the following individuals for consultation;

Key individuals involved in developing the document

Name	Designation
Lara Bailey	Senior Infection Prevention and Control Nurse
Kerrie Howles	Senior Infection Prevention and Control Nurse

Circulated to the following individuals for comments

Name	Designation
	All members of Trust Infection Prevention and Control Committee
	All members of the Infection Prevention and Control Team
Dr E Yiannakis	Consultant Microbiologist and Infection Control Doctor
Dr EYates	Consultant Microbiolotist/Co-Infection Control Doctor
Dr M Ashcroft	Consultant Microbiologist
Dr H Morton	Consultant Microbiologist
Dr C Blanchard	Chief Medical Officer
Dr J Berlet	Divisional Medical Director - SCSD
Dr J Trevelyan	Divisional Medical Director - Medicine
Dr D Raven	Divisional Medical Director – Urgent Care
Mr S Goodywar	Divisional Medical Director - Surgery
Dr B Kamalarajan	Divisional Medical Director – Women & Children's
*	Indicates comments received from these individuals

Circulated to the following CDs / Heads of department for comments from their directorates / departments

Name	Directorate / Department
Helen Lancaster	Head of Operations
Rachel Holloway	Head of Capacity

Circulated to the chair(s) of the following committee's / groups for comments;

Name	Committee
Ms Sarah Shingler	Trust Infection Prevention and Control Committee (TIPCC)

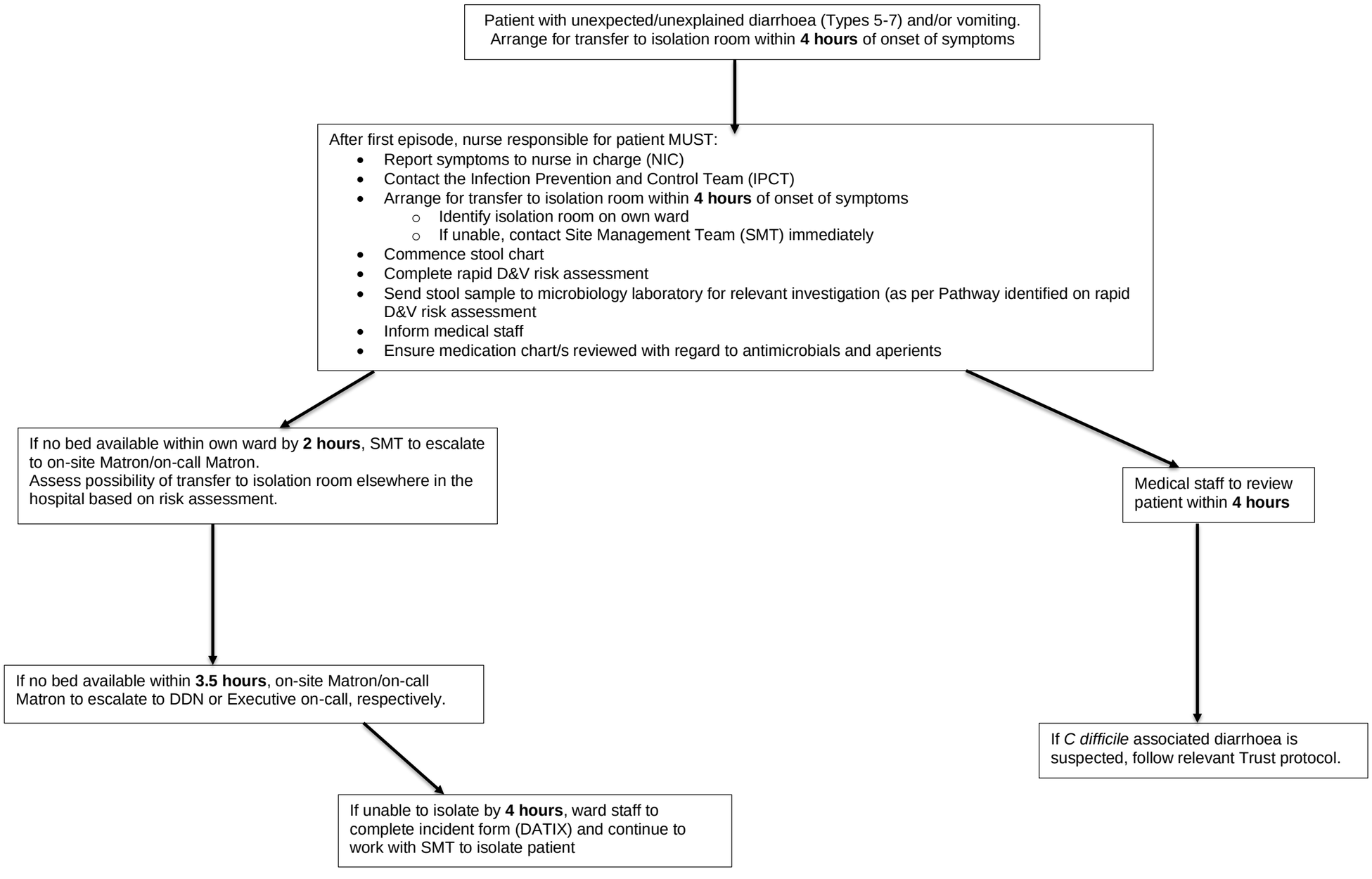
Approval Process

The draft document will be submitted to TIPCC for awareness prior to the receipt of comment, and again for approval once comments received before document code and version number are confirmed and the policy is released for placement on the Trust intranet.

The final draft will be checked to ensure it complies with the correct format and that all supporting documentation has been completed.

Appendices

Appendix 1 – 4 hours to isolation algorithm



Appendix 2 – Aide memoire general principles of isolation

Staff should:

- Promptly assess patients for risk of infectious disease
- Isolate infectious patients in single (preferably en-suite) rooms, if possible
- Where single room capacity is exceeded, contact the IPCT and SMT
- Decisions may be made to place patients infected with the same organism in dedicated cohort areas/isolation wards
- Ensure, where possible, that care for cohorted patients is by a designated team of staff that are not caring for other patients
- Consider cohorting patients in bays within wards if there is no dedicated isolation ward available, and
- Ensure effective isolation, i.e. bays should have doors that can be closed to provide physical separation from other patients.

Appendix 3 – A-Z of Infectious Diseases

The clinical judgement and expertise of the IPCT should be sought for novel, unusual or an increase in cases of known or suspected infectious pathogens/diseases. This table is for infection prevention and control measures i.e. to minimise the risk of cross-infection to self and others when providing direct patient care. Priority scores range from 1 (lowest priority) – 10 (highest priority). Scores of 10 require mandatory isolation.
FRSM – Fluid Resistant Surgical Facemask
FFP3 – Filtering Facepiece level 3

Suspected/ Confirmed Pathogen	Disease	Notifiable under Health Protection (Notification) Regulations 2010 by registered medical practitioners in England and Wales	TBP required	Priority Score	Optimal patient placement	RPE required	Linen Bag / RAG Clean / Body Bag	Comments
Acinetobacter baumannii	Pneumonia, bacteraemia, skin and soft tissue infections	No	Contact	1	Single en-suite room in very high-risk areas	No requirement	Red / Red / No	
Adenovirus	Conjunctivitis	No	Contact	3	Single en-suite room in very high-risk areas	No requirement	White / Amber / No	
	Upper+/- lower respiratory tract infection	No	Contact/Droplet	5	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	White / Amber / No	
	Gastroenteritis	No	Contact (faecal/oral)	5	Single en-suite room	No requirement	White	May step down from single room when

							Amber No	patient has been asymptoamtic of diarrhoea for 24 hours
Bacillus anthracis	Injection, inhalation, gastrointestinal or cutaneous Anthrax	Yes (Notifiable ID) & Yes (Causative Agent)	Contact/Airborne	4	Single en-suite room	No requirement	Red Amber Yes	
Bacillus cereus	Gastroenteritis, sepsis, pneumonia, endocarditis, central nervous system, and ocular infections	Yes (Causative agent) (if related to food poisoning)	Contact/Foodborne	6	Single en-suite room	No requirement	Red Amber Yes	May step down from single room when patient has been asymptomatic of diarrhoea for 48 hours
Body lice	Body lice infestation/Pediculosis corporis/Pediculosis vestimenti	No	Contact	2	Single en-suite room	No requirement	Red Amber No	While undergoing treatment, individuals should not have prolonged physical contact with others or share bedding or other linen.
Bortedella pertussis	Whooping cough	Yes (Notifiable ID), Yes (Causative Agent)	Droplet	7	Single en-suite room – for 3 weeks after onset of paroxysmal cough OR*	FRSM for routine care. FFP3/hood for AGPs*	Red Red No	*until patient on appropriate antimicrobial treatment (>7 days). Keep infectious patients away from non-immunised infants (<5 months of age) as they are at highest risk of complications.
Borrelia burgdorferi	Lyme Disease	Yes (Causative Agent)	Zoonotic	1	Main ward bed	No requirement	White Green No	Not transmissible from person-to-person
Burkholderia	Burkholderia cepacia complex/Burkholderia cepacia	No	Contact	3	Single en-suite room is preferred*	No requirement	White Green No	*usually only required in specific circumstances e.g. patients with B.cepacia complex from other cystic fibrosis patients in an inpatient setting
Campylobacter jejuni and Campylobacter *coli*	Gastroenteritis	Yes (Causative Agent)	Contact/Foodborne	3	Single en-suite room	No requirement	Red Amber No	May step down from single room when patient has been asymptomatic of diarrhoea for 48 hours
Candida auris	Ear, would and blood stream infections	No	Contact	2	Single en-suite room in	No requirement	White Amber	May step down from a single room when no

					very high-risk areas		No	longer colonised or infected
Carbapenemase producing Enterobacteriaceae (CPE)*	Colonisation, device associated infections, urinary tract infection, catheter associated bacteraemia	Yes (Causative Agent)	Contact	10	Single en-suite room	No requirement	Red Red No	*Either swab positive or as per clinical risk assessment criteria. Priority score increases depending on the location of the patient e.g. ICU or body site e.g. Catheter
Chlamydia pneumoniae	Pneumonia	No	Droplet	7	Single en-suite room in very high-risk areas	FRSM for routine care. FFP3/hood for AGPs.	White Green* No	*Amber clean in very high-risk areas
Chlamydophila psittaci	Psittacosis	No	Airborne	1	Single en-suite room **if requiring AGPs	FFP3/hood for AGPs.	White Green No	Transmission caused by inhalation of organism via bird droppings/secretions/
Clostridiodes difficile	*Clostridiodes difficile* infection (CDI), diarrhoea	No	Contact	8	Single en-suite room	No requirement	Red Red No	Isolate until symptom free for 48hrs and Type 1-4 stool passed
Coronavirus	Severe Acute Respiratory Syndrome (SARS)*	Yes (Notifiable ID)	Droplet/Airborne	10	Single en-suite **negative pressure** room	FRSM for routine care. FFP3/hood for AGPs.	Red	*Transfer to a regional infectious disease unit.
	COVID-19 (SARS CoV-2)	Yes (Notifiable ID)	Droplet/Airborne		Single en-suite room		Amber	Refer to the IPCT for latest guidance on stepdown
	Middle Eastern Respiratory Syndrome (MERS - CoV)*	No	Contact/Droplet		Single en-suite **negative pressure** room		Yes	*Transfer to a regional infectious disease unit.
Corynebacterium diptheria or *Corynebacterium ulcerans*	Diptheria – cutaneous	Yes (Notifiable ID) & Yes (Causative Agent)	Contact	5	Single en-suite room	No requirement if cutaneous	White	Continue isolation until 2 cultures from the nose and throat (or skin lesions if cutaneous diphtheria) taken at least 24 hours apart and more than 24 hours after completing
	Diptheria - pharyngeal (toxigenic strains)	Yes (Notifiable ID) & Yes (Causative Agent)	Contact/ Droplet			FRSM for routine care. FFP3/hood for AGPs (if pharyngeal)	Amber Yes	

								antibiotics are negative for toxigenic C. diphtheriae, C. ulcerans
Conjunctivitis (Bacterial/Viral)	Conjunctivitis	No	Contact	1	Single en-suite room	No	White Green No	Isolate for the duration of symptoms
Coxsackie virus	Hand Foot and Mouth	No	Contact/Droplet	1	Single en-suite room	No requirement	Red Green No	Isolate until symtpoms resolve.
Creutzfeldt-Jakob Disease (CJD) associated prions	Creutzfeldt-Jakob Disease (CJD)	No	Contact (Blood/Body Fluids)	0	N/A	No requirement	White Green Yes	See CJD protocol for further information and decontamination of equipment
Croup	Croup	No	Droplet	9	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	White Amber No	
Cryptosporidium	Cryptosporidosis (gastroenteritis)	Yes (Causative Agent)	Contact (faecal/oral)	1	Single en-suite room	No requirement	Red Red No	Remain in isolation for duration of illness and have been asymptomatic of diarrhoea for 48 hours
Cytomegalovirus (CMV) Perinatal		No	Contact	4	Single en-suite room	No requirement	White Amber No	Pregnant staff are able to nurse these patients using standard precautions.
Entamoeba histolytica	Dystentery	Yes (Causative Agent)	Contact	6	Single en-suite room	No requirement	Red Red Yes	Remain in isolation until 3 negative stool samples.
Enterovirus D68	Mild to moderate upper respiratory tract infections, can rarely cause acute flaccid myelitis (AFM)	No	Droplet	5	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	White Amber No	Remain in isolation for duration of illness and 48 hours after cessation of symptoms including fever
Epstein-Barr virus		No	Contact	N/A	N/A		White	

	Glandular fever (infectious mononucleosis)					No requirement	Green No	Very close contact required for transmission. Isolation is unnecessary
Escherichia coli (including *E.coli* O157 and Shiga toxin-producing *E.coli*)	Urinary tract infections, gastrointestinal infection, bacteraemia, haemolytic uremic syndrome, thrombotic thrombocytopaenic purpura	Yes (Causative Agent)	Contact (faecal/oral)	4-8*	Single en-suite room	No requirement	Red Red No	Remain in isolation for duration of illness, until 48 hours clear of diarrhoea AND microbiologically clear. NB: prolonged excretion in faeces. *Score = 8 if *E.coli* O157
Extended-Spectrum Beta-Lactamase (ESBLs)	ESBL urinary tract infection, pneumonia, blood stream infections	No	Contact (faecal/oral)	1-3*	Single en-suite room	FFP3 or Hood for AGPs **only if pneumonia**	Red Amber No	*Score = 3 if patient is incontinent of urine or if undergoing AGPs
Fleas	Fleas	No	Contact	2	Single en-suite room	No requirement	Red Green No	To remain isolated until flea infestation removed. Treat clothes and linen as infected.
Gastrointestinal infections (including undiagnosed diarrhoea & vomiting)	Gastroenteritis	No	Contact	8	Single en-suite room	FRSM **if vomiting is present**	Red Red/Amber* No	Complete rapid D&V risk assessment and obtain pathway. Send stool samples appropriately. *Amber clean only if all results have returned negative for infectious diarrhoea
Giardia lamblia	Giardiasis	Yes (Causative Agent)	Contact (faecal/oral)	4	Single en-suite room	No requirement	Red Red No	Remain in isolation for duration of illness, until 48 hours clear of diarrhoea AND microbiologically clear. NB: prolonged excretion in faeces.
Haemophilus influenzae (Type b)	Epiglottitis	Yes (Causative Agent)	Droplet	9	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs*	White Amber No	*Until patient has been established on appropriate antimicrobial treatment (>48 hours)
	Meningitis, pneumonia, septicaemia	Yes (Causative Agent)						

Head Lice	Head Lice	No	Contact	N/A	N/A	No requirement	White Green No	In the event patient heavily infested or lice are resistant to treatment, isolate in a single room.
Hepatitis A virus	Hepatitis, Gastroenteritis	Yes (Notifiable ID) & Yes (Causative Agent)	Contact (faecal/oral)	2	Single en-suite room	FRSM **if vomiting is present**	Red Red No	Isolate 1 week from onset of jaundice OR 1 week from onset of symptoms if no history of jaundice
Hepatitis B, C & D virus	Hepatitis	Yes (Notifiable ID) & Yes (Causative Agent)	Contact (Blood/Body Fluids)	N/A	N/A unless uncontrollable bleeding	No requirement	Red if soiled Amber Yes	Hazard label specimens. Prudent sharp safety.
Hepatitis E virus	Hepatitis	Yes (Notifiable ID) & Yes (Causative Agent)	Contact (faecal/oral)	N/A	N/A	No requirement	White Green No	During the first 2 weeks of illness, pregnant staff should avoid nursing these patients and those with HEV should avoid close contact with patients with chronic liver disease
Herpes simplex (if extensive or in the immunocompromised)		No	Contact	4	Single en-suite room **to protect susceptible contacts**	No requirement	White Green No	May de-isolate when lesions have stopped discharging
Herpes zoster (Shingles) (varicella-zoster)	Shingles (vesicle fluid)	Yes (Causative Agent)	Contact	5	Single en-suite room (*if lesions cannot be covered)*	No requirement	White Green No	Should be nursed by immune staff only. Non-immune visitors should be warned of the risks. Should not be nursed by pregnant staff.
	Shingles (lesions in the respiratory tract)	Yes (Causative Agent)	Droplet/ Airborne	5	Single en-suite **negative pressure** room	FRSM for routine care. FFP3/hood for AGPs.		
	AIDS	No	Standard	N/A		No requirement	Red if soiled	Hazard label specimens.

Human Immunodeficiency Virus (HIV)					N/A unless uncontrollable bleeding		Amber Yes	Prudent sharps safety
Human Metapneumovirus	Human Metapneumovirus	No	Contact/Droplet	4	Single en-suite room	As per Standard Precautions	Red Red No	To remain in isolation whilst symptomatic. Particular caution should be paid to those paediatric and immunocompromised patients.
Influenza virus (Endemic/Pandemic strains)	Influenza	Yes (Causative Agent)	Droplet	8	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	Red Amber Yes	Isolate until patient has finished 5 days of treatment. Liaise with IPT if the patient is immunocompromised.
Legionella pneumophila	Legionnaire's Disease (Legionellosis)	Yes (Notifiable ID), Yes (Causative Agent)	Standard/Airborne (environmental)	N/A	N/A	No requirement	White Green No	Not directly transmitted person-to-person
Leptospira (Leptospirosis)	Weil's Disease	Yes (Causative Agent)	Contact	N/A	N/A	No requirement	White Amber Yes	Not directly transmitted person-to-person
Listeria monocytogenes	Listeriosis	Yes (Causative Agent)	Contact	2	Single en-suite room in very high-risk areas	No requirement	Red Amber No	
Measles virus	Measles (rubeola)	Yes (Notifiable ID)	Droplet/ Airborne	10	Single en-suite **negative pressure** room	FFP3 or Hood for routine care and AGPs.	Red Red No	Isolate for 5 days from onset of the rask. Immune staff only to nurse the patient. May cause severe illness in the immunosuppressed.
Meningitis (viral) e.g. enterovirus, coxsackievirus, echovirus	Meningitis (If of unknown origin – see advice under *Neisseria meningitidis*)	No	Contact	7	Single en-suite room	No requirement	White Amber Yes	To remain in isolation for length of acute illness

Meticillin resistant *Staphylococcus aureus* (MRSA) – either swab positive or as per clinical risk assessment criteria	Colonisation, skin and wound infections, endocarditis, pneumonia, osteomyelitis, urinary tract infections and bacteraemia	No	Contact	5-8 (depending on ward area)	Single en-suite room in very high-risk areas or surgical areas	FFP3/hood for AGPs (only if pneumonia)	Red	To remain in isolation until 3 negative screens obtained 48 hours apart including chronic wounds.
							Red/Amber	Side Rooms are to have Red clean. Amber clean required if patient has been in a bay and a Red clean cannot be completed due to the area being occupied by patients. If patient has exfoliating skin condition/wound exudate/high risk for environmental contamination.
							No	
Mpox Virus	Mpox (Monkeypox)	Yes (Notifiable ID), Yes (Causative Agent)	Contact/Airborne	10	Single en-suite room	As per Standard Precautions	Red Red No	Isolate from onset of symptoms until scabs have crusted over.
Mumps virus	Mumps (infectious parotitis)	Yes (Notifiable ID), Yes (Causative Agent)	Droplet	7	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	White Amber No	Contact IPT. Remain in isolation until 5 days after parotid swelling.
Mycobacterium tuberculosis complex	Extrapulmonary Tuberculosis	Yes (Notifiable ID), Yes (Causative Agent)	Contact	6	Single en-suite room	FFP3/Hood for AGPs	White Amber Yes	
	Pulmonary or laryngeal disease Tuberculosis	Yes (Notifiable ID), Yes (Causative Agent)	Airborne	10	Single en-suite **negative pressure** room	FFP3/Hood for AGPs and always if the patient has MDR or XDR TB.	Red Red Yes	Remain in isolation until completion of 2 weeks appropriate antimicrobial therapy. Patient should wear a surgical mask if attending other departments.
Mycoplasma pneumoniae	Pneumonia	No	Droplet	4	Single en-suite room	FRSM for routine care.	White Amber	

						FFP3/hood for AGPs.	No	
Neisseria meningitidis	Meningitis – meningococcal (or presentation of clinical meningitis of unknown origin), septicaemia	Yes (Causative Agent)	Droplet	7	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs*	White Amber Yes	Contact IPT immediately. *until patient has been established on appropriate antimicrobial treatment (>48 hours)
Nontuberculous mycobacteria (NTM)	Mycobacteriosis/Mycobacterium abscessus infection	No	Contact/Droplet	1	Based on Clinical Judgement*		White Green No	*unless cystic fibrosis patients within the ward area in which case a single-room is advised
Norovirus	Winter vomiting disease	No	Contact/Droplet	8	Single en-suite room	Fluid resistant surgical mask **if vomiting is present**	Red Red Yes	May de-isolate 48hours after last symptom
Panton Valentine Leukocidin (PVL) – positive *Staphylococcus aureus*	Skin and soft tissues infection, necrotising pneumonia, necrotising fasciitis, osteomyelitis, septic arthritis	No	Contact	7	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs (only if pneumonia)	Red Red Yes	To remain in isolation until 3 negative screens obtained 48 hours apart including chronic wounds.
Parainfluenza virus (in infants and young children)	Upper+/- lower respiratory tract infection	No	Droplet	6	Single en-suite room (Consider cohorting if insufficient single rooms)	FRSM for routine care. FFP3/hood for AGPs.	Red Amber No	Single room until asymptomatic
Parvovirus B19	Slapped cheek syndrome/Fifth disease	No	Droplet	7	Single en-suite room*	FRSM for routine care. FFP3/hood for AGPs. (Not required if the rash +/- arthralgia has developed)	Red Red No	*until the rash +/- arthralgia has developed.
Parvovirus B19 CONTACT		No	Droplet	3	Single en-suite room*	No requirement	White Green	*if a non-immune parvovirus contact, isolate for 14 days.

							No	
Plasmodium sp.	Malaria	Yes (Causative Agent)	Standard	1	Single en-suite room*	No requirement	White Green No	*During acute illness. May de-isolate thereafter.
Pneumocystis jirovecii	Pneumocystis pneumonia	No	Droplet/Airborne	5	Single en-suite room*	As per Standard Precautions	Red Amber No	*for patients in high-risk settings until resolution of symptoms or discharge
Poliovirus	Polio/Poliomyelitis	Yes (Causative Agent)	Droplet/Contact	4	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	Red Red/UV light No	
Pseudomonas aeruginosa	Pneumonia, bacteraemia, wound or surgical site infections, catheter-associated urinary tract infections, conjunctivitis in neonates	No	Droplet/Contact	1	Single en-suite room in very high-risk areas	No requirement normally. FFP3/hood for AGPs (if highly resistant).	White Amber (if highly resistant) No	
Respiratory syncytial virus (RSV)	Upper +/- lower respiratory tract infection	No	Droplet	5	Single en-suite room* (consider cohorting if insufficient single rooms)	FRSM for routine care. FFP3/hood for AGPs.	Red Amber No	*Highly transmissible on paediatric wards. Do not cohort infants under 3 months or babies with underlying cardiac problems or immunocompromised. Adults and Children to remain isolated for 5 days unless they remain symptomatic and/or they are known to be immunocompromised or at risk of prolonged virus-shedding.
Rickettsia prowazekii	Typhus Fever	No	Contact	5	Single en-suite room	No requirement	Red Amber Yes	To remain in isolation until patient is fully deloused.
Ringworm	Ringworm	No	Contact	2	Single en-suite room*	No requirement	White Green	*(paediatrics/neonates)

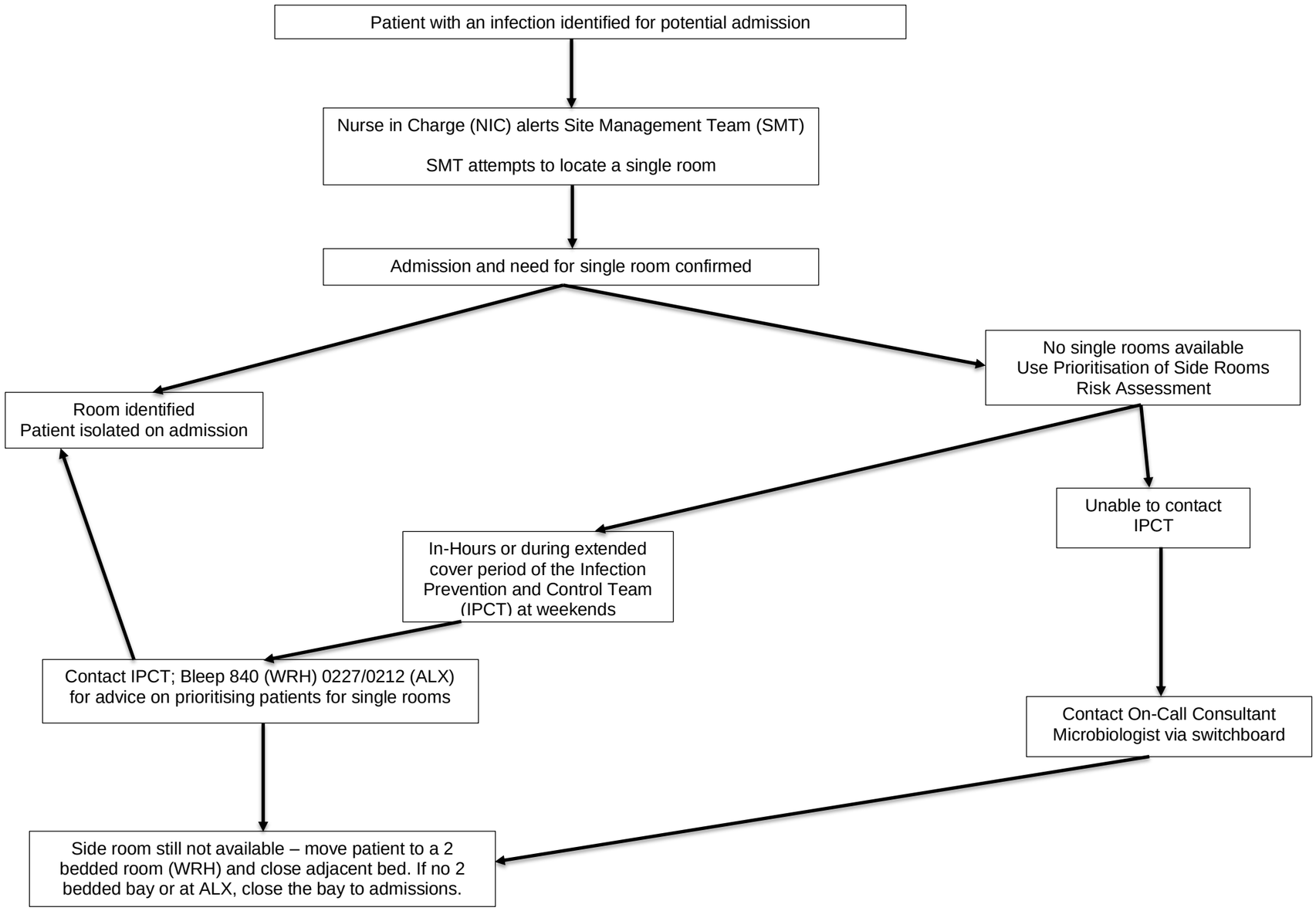
							No	
Rotavirus	Gastroenteritis	No	Contact	6	Single en-suite room	No requirement	Red Red No	Remain in isolation until asymptomatic for 48hrs and passing Type 1-4 stool.
Rubella virus	German Measles/Congenital rubella syndrome (CRS)	Yes (Notifiable ID) & Yes (Causative Agent)	Droplet	7	Single en-suite room	FRSM for routine care. FFP3/hood for AGPs.	Red Amber No	Isolate for 7 days prior to onset of rash and at least 4 days after onset of rash.. Exclude potentially pregnant staff who are non-immune. CRS affected infants can be infectious up to 1 year after birth.
Salmonella (non-typhoidal)	Salmonella gastroenteritis	Yes (Causative Agent)	Contact/Foodborne	6	Single en-suite room	No requirement	Red Red Yes	Remain in isolation whilst symptomatic and 48 hours after cessation of symptoms
Salmonella typhi or *Salmonella paratyphi*	Typhoid or Paratyphoid fever (respectively)	Yes (Notifiable ID) & Yes (Causative Agent)	Contact	6	Single en-suite room	No requirement	Red Red Yes	Remain in isolation whilst symptomatic and 48 hours after cessation of symptoms unless advised for longer by the local HPT.
Sarcoptes scabiei (Scabies mite)	Scabies	No	Contact *long-sleeve gowns if "crusted"*	2	Single en-suite room **only** if "crusted" scabies	No requirement	Red Amber No	Remain in isolation until first treatment has been completed (24 hours after treatment has commenced).
Serratia marcescens	Pneumonia, bacteraemia, urinary tract infections, wound infections	No	Contact	1	Single en-suite room in very high-risk areas	***If in sputum:*** FRSM for routine care. FFP3/hood for AGPs	White Red/Amber No	Known outbreaks in UK NNUs. Red clean in NNU Amber clean in other areas.
Shigella	Shigellosis/ Dysentery	Yes (Causative Agent)	Contact	8	Single en-suite room	No requirement	Red Red Yes	Remain in isolation for duration of illness. Requires 3 negative stools prior to de-isolation. Inform IPT.
	Gastroenteritis, scalded skin syndrome (Ritter's Disease)	No	Contact	6	Single en-suite room	No requirement	Red	

Staphylococcus aureus (Enterotoxigenic)							Red No	Until lesions are no longer purulent and continuing to drain
Stenotrophomonas maltophilia	Bacteraemia, respiratory infections, urinary tract and surgical site infections	No	Contact	1 or 10*	Single en-suite room in very high-risk areas	No requirement	White Amber No	*Priority Score =10 if co-trimoxazole resistant.
Streptococcus pyogenes (Group A including invasive GAS)	Respiratory infection	No	Droplet	8	Single en-suite room*	FRSM for routine care. FFP3/hood for AGPs*	Red	*Until established on an appropriate antimicrobial treatment (>24hrs)
	Scarlet Fever	Yes (Notifiable ID)	Droplet	8	Single en-suite room*	No requirement	Red	*Until established on an appropriate antimicrobial treatment (>24hrs)
	Bacteraemia, meningitis, wound infection/impetigo or infection in other normally sterile site	Yes (Notifiable ID)	Contact				Yes	*Impetigo - Until lesions have crusted/healed OR patient has been on appropriate antimicrobial treatment (>48 hrs)
Streptococcus sp (Groups C & G)	Bacteraemia, endocarditis, bone and joint infections	No	Contact/Droplet	6	Single en-suite room	FRSM for routine care*. FFP3/hood for AGPs*	Red Amber No	*if patient is coughing or sneezing
Streptococcus pneumoniae	Pneumonia – penicillin resistant	Yes (Notifiable ID)	Droplet	6	Single en-suite room*	FRSM for routine care. FFP3/hood for AGPs*	Red	*Until established on an appropriate antimicrobial treatment
	Bacteraemia, meningitis, wound infection or infection in other normally sterile site	Yes (Notifiable ID)	Contact	2	Single en-suite room*	No requirement	Amber No	Susceptibility increased by underlying lung disease, immunosuppression, the very young/elderly
Varicella-Zoster virus	Chickenpox	Yes (Causative Agent)	Droplet/Airborne	10	Single en-suite **negative pressure** room	FFP3/Hood for routine care **and** AGPs.	Red Amber	Limit contact to only those with evidence of immunity. Remain in isolation until lesions are dry

					preferred until dissemination ruled out		No	and no new lesions appear - usually around 5-6 days
Varicella-Zoster virus CONTACT	Chickenpox CONTACT	No	Droplet/Airborne	0-4	Single en-suite room	No requirement	White Green No	Considered non-infectious to others until 7 days following the exposure when the patient may begin to shed the virus before symptoms begin. If non-immune to chickenpox (ie has no history of infection, or had infection <1 year of age, or if testing negative for VZV IgG, then isolate from 7-21 days post exposure.
Vancomycin Resistant Enterococcus (VRE)	Colonisation, device associated infections, urinary tract infection, catheter associated bacteraemia	No	Contact	8	Single en-suite room	No requirement	Red Red No	
Vibrio cholerae	Cholera	Yes (Notifiable ID)	Contact	6	Single en-suite room	No requirement	Red Amber No	Contact IPT immediately. Remain in isolation until 3 negative stool screens are obtained.
Viral Haemorrhagic Fevers	E.g. Ebola, Congo, Crimean, Lassa, Marburg.	Yes (Notifiable ID)	Contact/Droplet	10	Single en-suite NEGATIVE PRESSURE room*	FFP3/Hood for routine care **and** AGPs. See link for further guidance on PPE	Red Red Yes (Double)	Contact IPT urgently. *Transfer to regional infectious disease unit. For care of the deceased, contact IPT.
Yellow Fever	Yellow Fever	Yes (Notifiable ID)	Standard	10	Single en-suite room*	No requirement	Red Red Yes	Contact IPT immediately. Prudent sharps safety. Hazard label specimens. *Transfer

								to a regional infectious disease unit.

Appendix 4 – Process for locating a bed for infectious patients



Appendix 5 – Recommendations on discharge tool

RECOMMENDATIONS FOR PATIENTS BEING DISCHARGED FROM A WARD/AREA CLOSED OR AFFECTED BY SUSPECTED OR CONFIRMED VIRAL GASTROENTERITIS

<table>
<tr><th rowspan="2">No</th><th rowspan="2">Current Patient Assessment</th><th colspan="3">Recommendation</th></tr>
<tr><th>Discharge to own home</th><th>Discharge to nursing or residential homes</th><th>Discharge or transfer to other hospitals or community-based institutions (e.g. prisons)</th></tr>
<tr><td>1</td><td>Patient has been asymptomatic of viral gastroenteritis in excess of 48-72 hours

(symptom free)</td><td rowspan="3">This can take place at any time irrespective of the stage of the patient’s viral gastroenteritis.

It is not necessary to delay the discharge.</td><td rowspan="2">Discharge to a home known <u>not</u> to be affected by an outbreak of vomiting and/or diarrhoea should not occur until the patient has been asymptomatic for at least 48h.

However, discharge to a home known to be affected by an outbreak at the time of discharge should not be delayed providing the home can safely meet the individual’s care needs.</td><td rowspan="3">This should be delayed until the patient has been asymptomatic for at least 48h.

Urgent transfers to other hospitals or within hospitals need an individual risk assessment</td></tr>
<tr><td>2</td><td>Patient remains symptomatic of viral gastroenteritis or is not yet 48-hours symptom free</td></tr>
<tr><td>3</td><td>Patient has not had symptoms since ward/area closure

(patient potentially incubating)</td><td>Patient may be discharged only on the advice of the local health protection organisation and infection prevention teams.</td></tr>
<tr><td colspan="5">*In all instances, ensure on discharge relevant information is included within the electronic discharge summary (EDS)</td></tr>
</table>

Appendix 6 – Care home discharge information letter

NHS Worcestershire Acute Hospitals NHS Trust

Dear Colleague,

[Insert Patients Name] has been discharged from [insert ward & hospital site] on [date] which is affected by viral gastroenteritis.
*Discharging area to tick relevant statement on discharge from healthcare setting

	They have been affected and are now in excess of 48 hours symptom free
	They are still presenting with symptoms (may only be discharged to a nursing home or residential home that is known to be affected by an outbreak of vomiting and/or diarrhoea)*
	They are not yet 48 hours symptom free (may only be discharged to a nursing home or residential home that is known to be affected by an outbreak of vomiting and/or diarrhoea)*
	They have been in a closed area but as yet have not been symptomatic **

*Transfer to other community-based institutions (e.g. prisons) or other hospitals should be delayed until the patient has been asymptomatic for at least 48 hours. Urgent transfers to other hospitals will need an individual risk assessment.
**Those who have been exposed but are asymptomatic may be discharged only on the advice of the local health protection organisation and IPCT.

ACTIONS

Care-givers must wash their hands with soap and water after each direct contact with a patient/the patient's environment.
Provide facilities for patients to wash their hands prior to eating and after using the toilet
Personal protective equipment (PPE) must be worn e.g. gloves and apron when assisting patients with toileting, or when handling soiled linen. Staff must wash their hands after removing PPE.
Stool samples must be obtained for residents with diarrhoea
Symptomatic residents/those who are not 48 hours asymptomatic must be cared for in their own rooms with dedicated toileting facilities.
Symptomatic staff should refrain from work and stool specimens provided, returning to work only when they have been asymptomatic for 48 hours or more.
If other residents/staff develop symptoms in a short period of time, notify the UK Health Security Agency on 0344 225 3560 and select option 2.
Further advice regarding management/infection control procedures can be found online by visiting www.gov.uk and searching for Norovirus guidelines.

Supporting Documents

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page

Worcestershire Acute Hospitals NHS Trust

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Julie Booth**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Lara Bailey	**Senior Infection Prevention and Control Nurse**	**larabailey@nhs.net**
Date assessment completed	**29.11.2023**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** Isolation and Bed Management Policy			
What is the aim, purpose and/or intended outcomes of this Activity?	To maintain patient and staff safety			
Who will be affected by the development & implementation of this activity?	❑ Service User ❑ Patient ❑ Carers ❑ Visitors		❑ Staff ❑ Communities ❑ Other ❑ _____	
Is this:	❑ Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	National Guidance			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	N/A			
Summary of relevant findings	N/A			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age		x		
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
(any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)				

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
		.		
How will you monitor these actions?				
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)				

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation
1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.
1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	L Bailey
Date signed	29.11.2023
Comments:	
Signature of person the Leader Person for this activity	
Date signed	07.02.2024
Comments:	

Supporting Document 2 – Financial Impact Assessment

To be completed by the key document author and attached to key document when submitted to the appropriate committee for consideration and approval.

	Title of document:	Yes/No
1.	Does the implementation of this document require any additional Capital resources	No
2.	Does the implementation of this document require additional revenue	No
3.	Does the implementation of this document require additional manpower	Yes, manpower to cohort nurse
4.	Does the implementation of this document release any manpower costs through a change in practice	No
5.	Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff	No
	Other comments:	None