

Infection Prevention and Control Policy Manual

Section 5 – Organism Specific Policies

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EQUALITY IMPACT

The Trust strives to ensure equality of opportunity for all both as a major employer and as a provider of health care. This Policy Document has therefore been equality impact assessed by the Infection Prevention and Control Committee to ensure fairness and consistency for all those covered by it regardless of their individual differences, and the results are shown in Appendix A.

Dissemination of policy or procedural documents must be conducted as detailed in Appendix B.

VERSION CONTROL SCHEDULE

Version number	Issue Date	Revisions from previous issue	Date of approval by Committee
V1.00	01/09/07	Bi-annual update	22/08/07
V1.1	25/02/08	Policy for the control of multi resistant gram negative bacteria added to end of section 5.12	6/02/08
V1.2	09/04/08	Two policies added policy for the management of patient attending A & E admitted with suspected infectious respiratory symptoms (5.13) and management and control of viral haemorrhagic fever (5.14)	26/03/08
V1.3	19/11/08	Amendment to page 2	22/10/08
V1.4	23/03/09	Amended to be consistent and refer to MRSA screening policy which is now a standalone policy	18/02/09
V2.00	16/12/09	All policies reviewed in line with the Health Act (2008), national guidance and incorporating recommendations following legal review.	16/12/09

C O N T E N T S

Organism Specific Policies	Page
5.1 Management of Patients Colonised with Meticillin Resistant Staphylococcus Aureus (MRSA)	4
5.1b MRSA Screening	15
5.1c Management of Staff Colonised with Meticillin Resistant Staphylococcus Aureus (MRSA)	23
5.2 Clostridium Difficile Toxin Diarrhoea	29
5.3 Tuberculosis	34
5.4 Group A Streptococcal Infection	46
5.5 Vancomycin Resistant Enterococci (VRE) Gram Positive	48
5.6 Management of Staff with HIV/AIDS	49
5.7 Policy in Respect of Management of Babies & Toddlers with Respiratory Syncytial Virus (RSV)	53
5.8 Policy for the Management of Patients with known, suspected or at risk of Creutzfeldt Jacob Disease (CJD) and Related Disorders	57
5.9 Policy for the Management of Patients with Meningococcal Meningitis & Septicaemia	65
5.10.1 Policy for the Management of Scabies	67
5.10.2 Policy for the Management of Lice	70
5.11 Policy For Patients with Gastroenteritis	75
5.12 Policy for the Control of Multi-Resistant Gram Negative Bacteria	97
5.13 Policy for the Management of Patients attending / admitted via the Accident and Emergency (A&E) department with suspected Infectious Respiratory symptoms	99
5.14 Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)	107

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

INTRODUCTION

Meticillin-resistant *Staphylococcus aureus* (MRSA) remains a current problem in many UK hospitals. Specific guidelines for control and prevention are justified because MRSA can cause serious illness and result in significant health care costs.

In most cases, patients will be colonised with MRSA (where MRSA is present but causing no clinical signs of infection). Antibiotic therapy for the treatment and prophylaxis of MRSA infection should be prescribed by the clinician looking after the patient, with advice from Microbiology as required. Further information is available from the Trust Antimicrobial Policy (available on the intranet).

GUIDELINES FOR THE CONTROL OF MRSA

Areas within the Trust have been assigned to different risk categories dependent on the susceptibility of patients in particular wards and units to MRSA infection.

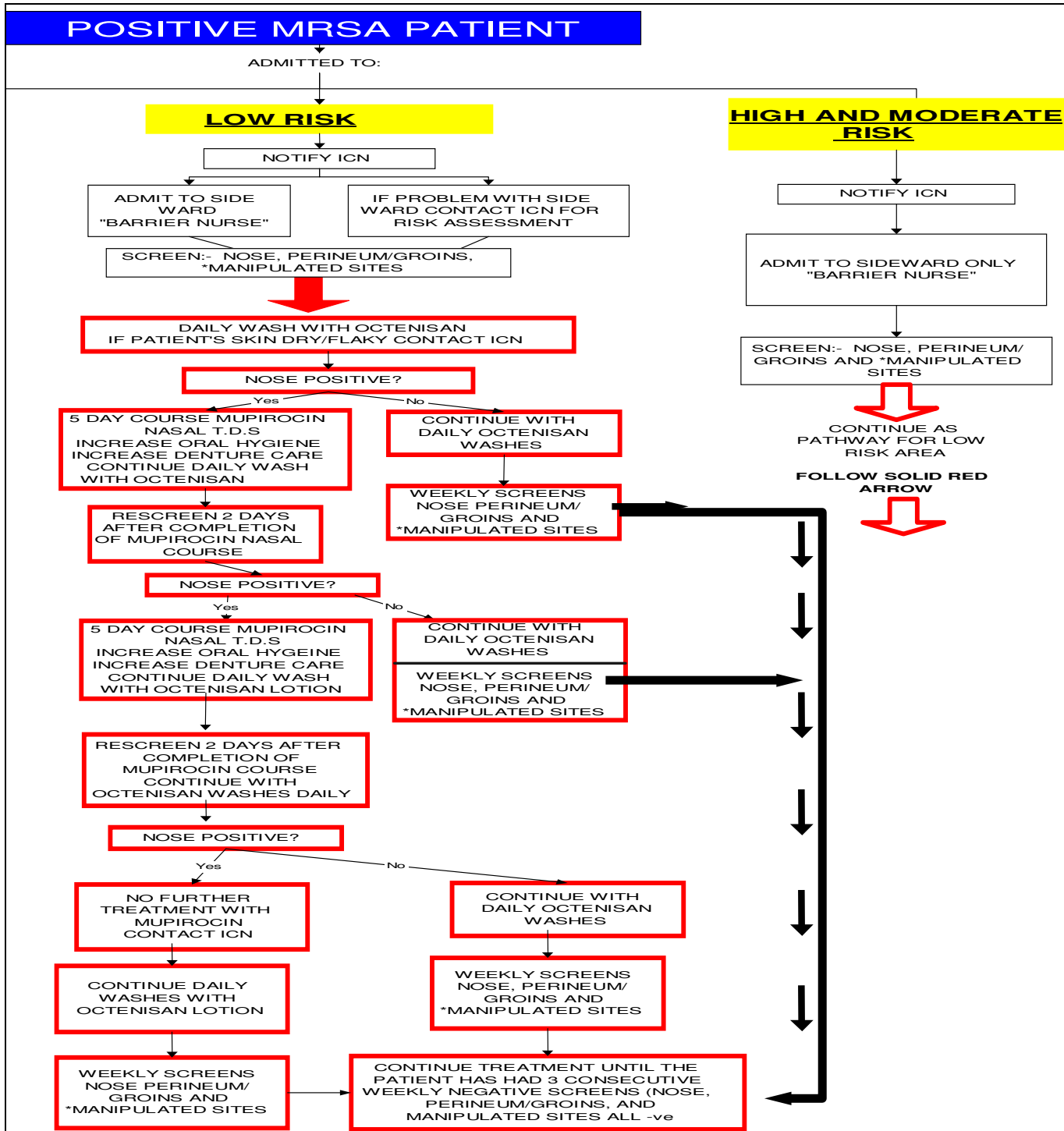
Low Risk Areas	Moderate and High Risk areas
<ul style="list-style-type: none"> • General medicine • Chest medicine • Day case units • ENT wards • Obstetrics and gynaecology wards • Paediatric units** • Rehabilitation wards* • Mental Health unit 	<ul style="list-style-type: none"> • All high dependency areas e.g. ICUs, HDUs, SCBU, Transplant, Burns, Dialysis • Surgical Wards e.g. vascular, orthopaedics, cardiothoracic, general, urology, plastics • Cardiology Wards and CCUs • Oncology Wards • CFU

PLEASE REFER TO MRSA FLOW CHART (NEXT PAGE) FOR MANAGEMENT OF MRSA POSITIVE PATIENT IN EACH CATEGORY

* Long stay patients will require regular review of their management and decolonisation regimen by the clinical team in conjunction with the infection control team.

**Refer to local MRSA policies

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)



POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

GUIDELINES FOR PRACTICE

SOURCE ISOLATION – MRSA

Patients colonised or infected with MRSA will usually be nursed in source isolation during their hospital admission, as indicated in chart on page 3.

Objective:

To minimise the risk of transmission of MRSA, directly from patient to patient, or indirectly via health care workers or patient care equipment, whilst maintaining patient safety and comfort.

Equipment required

1. Single room with clinical handwash basin, appropriate handwash solution and paper towels.
2. Toilet facilities preferably en suite.
3. Notice for outside of door.
4. Disposable aprons and gloves (kept outside of room by the entrance, preferably in Danicentres).
5. Alcohol hand rub (kept outside of room by entrance, preferably in wall mounted dispensers)
6. Pedal bin lined with clinical waste bag (kept by handwash basin).
7. Separate patient's wash bowl.

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
1. Commence MRSA Integrated Care Pathway (ICP) documentation (available on Trust intranet integrated care pathway site and in pre-printed format from the Infection Control Team).	Allows "step by step" approach to the management and care of MRSA positive patients.
2. Prepare and equip single room for isolation. If a single room is not immediately available, contact IPCN.	Allows isolation procedure to be carried out in an organised manner. Allows infection prevention risk assessment to be made.
2a. Ensure a notice is fixed to outside of the door, advising ' Please See Nurse In Charge Before Entering '.	Will ensure that all staff/visitors seek proper advice before entering the room, thus avoiding confusion and unnecessary anxiety.

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
3. Inform infection control nurse of MRSA result.	Infection control nurse can be used as a resource to facilitate patients care whilst isolated.
4. Explain the need for isolation to patient and relatives, and allow him/her to express any anxieties she/he may have. Give patient appropriate information leaflets.	Reduces anxiety and fulfils legal requirements. Gains patient's and relative's trust and co-operation and involves them in their care.
5. Take a full screen for MRSA from the patient. The following sites should be sampled for MRSA. Nose and Perineum/Groin. "Manipulated sites": Lesions or wounds/Intravenous and stoma sites/urine from catheterised patients/tracheotomies and sputum if available.	The nose and perineum are the main carriage sites for MRSA. The groin is often preferred but may be less sensitive. The ability to detect MRSA carriage depends on many factors including the number and types of patient sites sampled.
5a. Swabs should be dampened by dipping them in transport media prior to swabbing.	To increase amount of bacteria picked up.

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
<p>5b. Use the same swab to sample symmetrical sites e.g.</p> <ul style="list-style-type: none"> • Single swab for right and left nostril • Single swab for right and left groin 	<p>Both sites would be treated if carriage is detected therefore it is an unnecessary expense to use separate swabs.</p>
<p>5c. One request card can be used for multiple swabs as long as each swab is clearly identified with patient details and site from which taken.</p>	<p>Will reduce time of writing cards, and bulk of screen.</p>
<p>6. Additional sites i.e. the throat may be sampled if clearance of the carrier status is difficult.</p>	<p>The role of throat carriage in the spread of infection is uncertain.</p>
<p>7. If the inpatient has widespread eczema or psoriasis (a heavy skin shedder) inform the infection control team as soon as possible.</p>	<p>A person with dry/flaky skin will shed more skin scales into the environment and will increase the risk of transmission.</p>
<p>8. Commence treatment for eradication of MRSA colonisation (see chart on page 3).</p>	<p>Prompt and effective treatment will reduce the risk of cross infection and may reduce the risk of patient becoming infected with MRSA.</p>

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
<p>8a. In-patients with a positive nose swab should be treated with Mupirocin nasal ointment AND a topical antibacterial lotion (see chart, page 3)</p> <p>Treatment with a topical antibacterial lotion should commence as soon as possible after the patient has been identified as MRSA positive and should continue without interruption (unless contraindicated), until the patient is deemed to be MRSA negative. (refer to page 12 for application instructions)</p> <p>A course of Mupirocin lasts 5 days (3 times a day). Once completed a further 2 days must pass before the patient can be rescreened</p> <p>A maximum of 2 courses of Mupirocin is recommended for persistent nasal carriage.</p>	<p>Continuous treatment for skin colonisation reduces the amount of MRSA on the skin and therefore reduces the risk of re-colonisation</p> <p>An indication of nasal carriage is only possible once the Mupirocin has been discontinued.</p> <p>To reduce the risk of Mupirocin resistance.</p>
<p>8b. In-patients positive at any site (but nose swab negative) should be treated with a topical antibacterial lotion ONLY (see chart, page 3) e.g. Octenisan, Oilatum plus,</p> <p>A screen for MRSA should be take at weekly intervals and before patient has daily wash with a topical antibacterial lotion.</p>	<p>Continuous treatment for skin colonisation reduces the amount of MRSA on the skin and therefore reduces the risk of re-colonisation</p>

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
<p>9. Disposable apron and gloves should be worn by all staff when handling the patient or their immediate environment, contact with their secretions and handling of contaminated dressings or linen.</p>	<p>The use of protective clothing will reduce the risk of contaminating uniform and hands.</p>
<p>10. Meticulous attention to handwashing before leaving the room by all personnel. (Ensure there are appropriate facilities i.e. soap in dispenser and paper towels).</p>	<p>HANDWASHING IS THE SINGLE MOST IMPORTANT MEANS OF PREVENTION OF CROSS INFECTION</p>
<p>11. The patient must have a wash all over/bath/shower using a topical antibacterial lotion, disposable wipe and clean towel daily.</p> <p>Meticulous attention to oral/dental hygiene is required (see treatment chart).</p> <p>Patient's night-clothes and bed linen should be changed daily.</p> <p>Wash patients wash bowl after each use with hot water and general purpose detergent. Dry thoroughly with paper towels.</p>	<p>This will reduce skin carriage of <i>MRSA</i>.</p> <p>To reduce the level/risk/spread of throat colonisation.</p> <p>To reduce recontamination of patient's skin with <i>MRSA</i>.</p> <p>To remove grease, skin debris etc from washbowl</p>

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
<p>12a. Check mattress and pillow covers are intact.</p> <p>12b. Dispose of bed linen immediately into pink water-soluble infected linen bag. Pink bag may then be taken out of room and put into linen skip. Store spare pink bags outside patient's room.</p>	<p>MRSA may be shed on skin scales into the bed linen. Prompt disposal of used bed linen into a pink plastic bag by the bedside will reduce the risk of environmental and uniform contamination. The pink plastic bag dissolves in the washing machine in the laundry releasing the linen.</p>
<p>13. Ideally the patient should be nursed in a room with ensuite facilities. If there is a toilet nearby it may be appropriate for the patient to use it rather than keep a commode in the room. If the patient has a commode it is advisable that it is kept for his/her use only during the period of isolation.</p>	<p>The least amount of cleaning and handling of equipment the less likely MRSA can be indirectly transmitted to another patient. Also, a mobile patient may be reluctant to use a commode.</p>
<p>14. Patient should use ordinary crockery and cutlery. This should be returned to the kitchen after each meal and washed, preferably in a dishwasher.</p>	<p>The indirect transmission of MRSA from crockery and cutlery is very unlikely providing it is washed thoroughly.</p>
<p>15. Visitors do not have to wear protective clothing, unless assisting with the patient's bodily care, but should be encouraged to wash their hands before leaving the room.</p>	<p>Visitors do not have the same contact with other patients as health care workers, and therefore will not transmit MRSA from one patient to another.</p>

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

ACTION	RATIONALE
<p>16. Door to the room to be kept closed, particularly during procedures which may generate staphylococcal aerosols e.g. physiotherapy, bedmaking, wound dressing.</p>	<p>To minimise spread of MRSA to adjacent areas.</p>
<p>17. Patient to avoid social contact with other patients.</p> <p>In some cases it may be appropriate for patients to walk in hospital corridors or in the garden.</p>	<p>To minimise the risk of spread of MRSA.</p> <p>To try and enhance the psychological well being of the patient.</p>
<p>18. Instruments or equipment e.g. sphygmomanometers, lifting slings etc. should be designated for MRSA patient use only.</p> <p>If not possible such items must be cleaned thoroughly before use on another patient.</p>	<p>To prevent spread of MRSA to other patients.</p>
<p>19. If the patient is to be transferred to other wards/departments/hospitals, please inform the receiving area that this patient has been nursed in a single room and to contact the infection control nurse or doctor for further advice.</p>	<p>To avoid confusion and anxiety to both staff and patient and to minimise the risk of transmission of MRSA.</p>
<p>20. If the patient requires physiotherapy or occupational therapy within the department, please discuss each individual case with a member of the infection control team.</p>	<p>To ensure all measures are taken to minimise risk of transmission of MRSA.</p>

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

CHART

EFFECTIVE USE/APPLICATION OF TOPICAL TREATMENT

OCTENISAN

GUIDANCE FOR USE WHETHER BATHING, SHOWERING OR BED BATHING

1. Wet skin. **Apply about 30ml of Octenisan directly onto the skin** using hands or disposable cloth.
2. Use Octenisan as a liquid soap, daily and as a shampoo twice a week. Wash from head to toe.
3. Wash vigorously, paying particular attention to the following areas; hair, around the nostrils, under the arms, between the legs and feet.
4. Octenisan should be left in contact with the skin for 3 minutes.
5. Rinse from head to foot, preferably in shower or bath.
6. Dry on clean towel.

The bath or shower must be washed thoroughly after use. Use a Chlor-Clean solution, 1000ppm, ensuring any metal parts are rinsed with water. All bathing aids should be cleaned in the same way.

Change towels, bed linen and nightwear daily. Used items should be placed directly into red water soluble bags.

There is no need to discontinue the use of Octenisan when rescreening patients for MRSA.

Discontinue washing if skin irritation occurs and contact the Infection Control Nurse.

OILATUM PLUS (TRICLOSAN 2% W/W)

GUIDANCE FOR BATHING AND BED BATHING

1. **Always use diluted with water.**
2. **Adults and children.**
Add 2 capfuls to an 8 inch bath, or 1 capful to a 4 inch bath.
3. Add ¼ capful to a bowl of water for bed bathing.

Take care to avoid slipping into bath

4. Infants

Add 1 ml (just sufficient to cover bottom of cap) and mix well with water.

DO NOT use with babies under 6 months

Follow instructions as for Octenisan for care of bath and linen etc.....

Oilatum plus is an effective cleanser and should not be used with soap.

MUPIROCIN NASAL OINTMENT (BACTROBAN) 2% W/W

A Small amount of ointment (about the size of a match head) should be placed on to a cotton bud or on the little finger and applied to the anterior part of each nostril. The nostrils should be closed by pressing the sides of the nose together:- this will spread the ointment throughout the nares.

A cotton bud should be used instead of the little finger for infants and patients who are very ill.

ORAL HYGIENE AND DENTURE CARE

It is essential to **increase oral hygiene and denture care** when the patient is **MRSA** positive in their nose. **DENTURE** wear is highly associated with *MRSA* throat carriage. DENTURES should be washed in warm soapy water and rinsed, brushed with tooth paste (if possible) and then rinsed. Denture cleaning/oral hygiene is recommended T.D.S. and after eating.

5.1b

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Screening for MRSA amongst patients at UHSM February 2009 (updated October 2009)

1.0 Background

Since November 2006, the FT has embarked on an extended MRSA screening programme. This has been based on the recommendations following a Department of Health review of the FT (November 2006), correspondence from the Chief Medical Officer and Chief Nursing Officer (November 2006), recommendations from the Greater Manchester Pathology Network, and local risk assessment. Screening for MRSA in elective high risk surgery (such as vascular, cardiac and orthopaedics) has been well established within the FT and has recently been extended to include other elective and emergency surgery patients.

2.0 New guidance

Correspondence from the Department of Health (July 2008) and the Health and Social Care Act (2008) outlines MRSA screening guidance that states that all elective admissions should be screened by March 2009 (apart from those highlighted in the short list of exclusion listed below), approved suitable screening methods, and how the organisation will be performance managed on this process. In addition, the FT is required to introduce MRSA screening for all emergency admissions as soon as practical within the next three years. In response to this, and the FTs progress against its MRSA bacteraemia trajectory, the FT fully implemented this from 1st December 2008.

3.0 Associated policies

This policy should be used in conjunction with the H7 Policy for the prevention of Healthcare Associated Infections, and Policy for the management of patients with meticillin resistant staphylococcus aureus (MRSA), found within the infection prevention and control website.

4.0 Patients screened at UHSM (see appendix 1)

Patients screened, and exclusions are based on recommendations within the Health and Social Care Act (2008), DH guidance on MRSA screening (July 2008) and local risk assessment.

Elective patients

NHS Foundation Trust

All elective surgical admissions must be screened at pre-op assessment clinic/out-patients clinic within 6 weeks of their planned admission.

5.1b

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Non-surgical elective admissions are screened on admission to the FT unless they have been screened within 6 weeks at UHSM.

As recommended by the DH guidance on MRSA screening (July 2008), the following patient groups who should **not** be routinely screened (exclusions):

- Day-case ophthalmology, dental and endoscopy
- Minor dermatology procedures eg, warts, liquid nitrogen applications
- Children/Paediatrics unless already in a high risk group
- Maternity/Obstetrics except for elective/emergency caesareans and high risk cases.
- Mental Health Patients

Emergency patients

All emergency admissions (except exclusions listed below) must be screened at the earliest opportunity by the nurse in charge of the patients care. If patients are admitted through A+E they must be screened in A+E. If patients are admitted through clinic or other means, the first receiving ward must undertake the screen.

Patients who transferred in from other healthcare settings must have their status checked and a screened if they have not had a MRSA screen within the last 7 days.

In addition, **long stay patients** (an inpatient at UHSM for greater than 2 weeks) must be screened at 2 weekly intervals unless they are known to be MRSA positive (weekly screening occurs in this instance). The FT will continue to locally assess admission groups for screening according to risk.

5.0 Information for patients who are to be screened

It must be explained to the patient that the screen is being taken to check whether or not the patient has MRSA. The result of the screen will take 24-48 hours to process and the patient will be notified of the result if it is positive.

It must be stressed to the patient that the result of the screen will in no way be detrimental to the care they receive whilst an in-patient at the Trust.

N.B. The patient must also be informed that a negative screen on admission does not imply that they do not have MRSA but that it may be present in such

small quantities that it has not been detected. All patients that are screened for MRSA must be given an information leaflet that explains the facts of MRSA to patients who are being screened (see Appendix 2).

5.1b

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

6.0 Taking a screen for MRSA

Take a full screen for MRSA from the patient. The following sites are recommended for sampling MRSA:

- Nose and Groin/perineum
- Plus, diagnostic specimens as appropriate (e.g. lesions or wounds/Intravenous and stoma sites/urine from catheterised patients/tracheotomies and sputum if the patient has a productive cough).

Swabs should be dampened by dipping them in transport media or sterile water/saline prior to swabbing.

Use the same swab to sample symmetrical sites e.g.

- Single swab for right and left nostril
- Single swab for right and left groin

One request card can be used for multiple swabs as long as swab is clearly identified with each patient details and site from which taken and identified as 'MRSA screen'.

If the patient has widespread eczema or psoriasis (a heavy skin shedder) inform the infection prevention and control team.

7.0 Interim management of patients pending screening results

If the patient has widespread eczema or psoriasis (is a heavy skin shedder) they must be admitted into a side room on the receiving ward and should remain in the side room throughout their stay regardless of the result.

In line with MRSA policy patients should not be treated with decolonisation therapy pending results of the MRSA screen results unless they have had a previous history of MRSA.

8.0 Notification of results

All results will be available on Anglia ICE in addition to the following;

Monday – Friday 9am – 5pm - All positive results will be phoned through to the ward by the Infection Prevention and Control Nurse. (A paper copy will follow).

MRSA policy for the management of patient who are MRSA positive will then be instigated.

Weekends and Bank Holidays – All positive results from ward areas will be phoned through to the ward by the On Call Microbiologist (A paper copy will follow). This will be monitored and reviewed regular in relation to numbers of positive results and impact on workload.

5.1b

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Negative results will not be phoned through to the ward but will be available after 24hours on Anglia Ice. A paper copy will also be sent from the laboratory to the admitting ward.

9.0 Increases in MRSA positive patients at UHSM

Screening more patients for MRSA will yield more MRSA positive patients being cared for within the Trust. An estimated average of 8% positive rate has been suggested in recent literature. The impact on treatment and isolation facilities has been factored and will require regular review and actions to ensure patients are isolated/cohorted as appropriate. This will be done in conjunction with the ward manager/matron/infection prevention and control team and bed manager.

Results of ongoing surveillance will be monitored by the Infection Prevention and Control team to ensure the early identification of periods of increased incidence and outbreaks. Feedback to clinical teams will occur in a timely manner.

10.0 Performance monitoring of compliance of screening policy

The Department of Health request that each NHS organisation that admits and treats NHS elective patients will have to assure itself, its patients, commissioners and the Department of Health that it is delivering the MRSA screening commitment. As part of preparation for elective admission, the number of MRSA screening tests completed and comparison against the actual total number of relevant admissions or attendances in the same period will be monitored by the Infection Prevention and Control team. In addition, UHSM have agreed with Commissioners a cohort of patients that should be screened and report on these each month and Divisional internal objectives will be set to support assurance in compliance.

POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Appendix 1- Summary MRSA screening at UHSM form 1st December 2008

	Emergency admission	Elective admission
Medical	All patients screened on admission	All patients are screened
Chest	All patients screened on admission	All patients are screened
Cystic fibrosis	All patients sputa are screened on admission	All patients sputa are screened
Cardiology (implant, e.g. pacemakers, defibs)	All patients screened on admission	All patients are screened
Oncology POU patients	All patients screened on admission	All patients screened
Orthopaedic – with implant	All patients screened on admission	All patients are screened (OP clinic)
Orthopaedic – without implant	All patients screened on admission	All patients are screened (OP clinic)
Trauma	All patients screened on admission	
Plastic	All patients screened on admission	All patients are screened (OP clinic)
Burns	All patients screened on admission and at weekly intervals	All patients are screened.
Cardiac surgery – with implant	All patients screened on admission	All patients are screened (OP clinic)
Cardiac surgery – without implant	All patients screened on admission	All patients are screened (OP clinic)
Vascular surgery – ALL patients	All patients screened on admission	All patients are screened (OP clinic)
Thoracic surgery	All patients screened on admission	Screened in OP assessment clinic
Transplant patients	All patients screened on admission	Screened in OP assessment clinic
Other surgery (ENT, Breast Gynae, including daycase admissions to TDC)	All patients screened on admission	Screened in OP assessment clinic
Maternity patients	All emergency caesareans and high risk of complications in mother or baby are screened	All elective caesareans and high risk of complications in mother or baby are screened
Paediatric medical or surgical	High risk* patients are screened	High risk* patients are screened
Critical care unit, ICU/HDU/ NNU	Screened on admission and at weekly intervals	

**POLICY FOR THE MANAGEMENT OF PATIENTS COLONISED WITH METICILLIN
RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)**

High risk* patients – medical – this refers to risk for MRSA ie past history of MRSA, hospital admissions within last 3 months, nursing home, transfer from another hospital.

Patients with a history of MRSA- are screened at weekly intervals whilst an in-patient at UHSM

Long stay patients (adult patients who are not known to be MRSA positive and are in-patients for greater than 2 weeks)- are screened at 2 weekly intervals.

Methicillin Resistant *Staphylococcus aureus* (MRSA) and MRSA Screening

Information for patients

1. What is MRSA?

Staphylococcus aureus are very common bacteria that many people can carry on their skin. Some strains of the bacteria are resistant to particular antibiotics and these strains are referred to as Methicillin Resistant *Staphylococcus Aureus* (MRSA). Both MRSA and *Staphylococcus aureus* can sometimes be present in patients in hospital.

2. Are there any symptoms if you have the MRSA germ?

These bacteria are often present without any symptoms. When they do cause an infection, symptoms include boils, abscesses or wound infections.

3. Why do we hear so much about MRSA in relation to hospitals?

MRSA can be a problem in hospitals because it may cause infections in some patients. There are antibiotics available to treat the infections but the choice is limited. MRSA may be present in the nose and on the skin of patients, without hospital staff being aware of this.

The easiest way to stop the spread of MRSA and other germs in hospitals is by everyone undertaking good infection control practice and hand hygiene.

4. Why am I having swabs taken?

At UHSM, we want to do everything possible to prevent the spread of MRSA and complications associated with it. As you are due to be admitted to the Trust, swabs are taken from an area of the body where the MRSA bacteria may be present (usually the nose and groin). These are then tested in the laboratory to see if it is present. However, it is important to know that sometimes the MRSA on the surface of the skin is of such low levels, the germ may not always be detected on the swab.

5. What happens if you are found to have MRSA?

You will be informed by ward staff if MRSA is detected on any of the swabs. You may be prescribed a nasal ointment and an antiseptic skin wash for washing or showering. This is to reduce the low risk of you developing infection. If you have been discharged home before the results are ready, your GP will be informed if the result is MRSA positive.

7. If I have MRSA, how can I find out more?

If you are unsure about the information you have received about MRSA, you can speak to your doctor or nurse that is looking after you. Alternatively, your GP or a member of the infection prevention and control team will be happy to discuss any further concerns you may have.

6. What should you do about MRSA when you are at home?

At home a person carrying MRSA on their skin will not cause any problems for family or friends. It is very important to understand that normal social contact with somebody who has MRSA or has received treatment for MRSA is not a problem.

University Hospitals of South Manchester NHS Foundation Trust
Infection Prevention and Control Team
December 2008

5.1b

POLICY FOR THE MANAGEMENT OF HEALTH CARE STAFF COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS (MRSA)

Introduction

MRSA is an organism commonly found in hospitals and other healthcare facilities that can cause infection. MRSA is not a threat to a healthy person. Some healthy people may carry the germ, but MRSA usually causes infection only in those with weakened defences.

Operational Policy

1. Staff screening instigated by the Infection Prevention and Control Team is usually only indicated in high risk areas or where spread of MRSA continues despite on-going control measures.
2. Staff who are absent in circumstances where they are sent home due to MRSA colonisation will be paid as if they were at work.
3. The Occupational Health Department will arrange for staff to obtain free prescriptions from the hospital pharmacy.
4. Bank staff will be offered alternative employment in low risk areas
5. The Trust will expect all staff including bank and agency staff and student nurses to comply with the requirement for screening swabs during an outbreak or if specifically requested by the ICD. Staff unwilling to be screened will be subject to disciplinary procedures.
6. Screening may also be undertaken routinely in the staff member is a patient requiring hospital care. Please refer to page***: Guideline for the management of staff with MRSA.
7. Pre-employment screening is not recommended unless there is a clinical indication, including chronic skin conditions, or the prospective employee is to work in a moderate/high risk area.
8. An initial screen for MRSA will consist of nose and groin swabs and skin lesion swabs. Subsequent screens may be extended to include other sites at the discretion of the Infection Prevention and Control Doctor.

In principle, it is recommended that only staff members with colonised or infected hand lesions should be off work while receiving courses of eradication therapy, but this decision will be based on the risk associated within the area in which the Health Care Worker works and on an individual assessment by the Infection Control Doctor and the Occupational Health Department.

POLICY FOR THE MANAGEMENT OF HEALTH CARE STAFF COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS (MRSA)

STAFF IDENTIFIED AS MRSA POSITIVE

To reduce skin carriage of MRSA daily body washes with Octenisan lotion or an alternative antibacterial lotion should be used as advised by the Occupational Health Department.

If Nose Positive

The following treatment is recommended by the Infection Control Doctor/coordinated by the Occupational Health Department.

All staff identified as positive from nasal swabs should be commenced on Mupirocin (Bactroban) nasal ointment TDS for 5 days and Octenisan skin cleanser to be used daily.

(NB. The prescriber may check with Microbiology/Pharmacy regarding risk assessment of Mupirocin treatment during pregnancy).

Staff should have a repeat screen on the third day after treatment with Mupirocin stops. Staff who are persistent nasal carriers (i.e. still positives after two courses of Mupirocin) should have a throat swab taken. If positive further treatment will be decided by the Infection Control Doctor and Occupational Health Doctor.

Skin Conditions

A member of staff who has a skin condition may be referred to a dermatologist at the discretion of the Occupational Health Doctor or the Infection Control Doctor.

Persistent Carriage

Failure to eradicate MRSA after two courses of treatment will be reviewed by the Infection Control Team. In complex individual cases further management will be decided by the Infection Control Doctor and Occupational Health Department.

POLICY FOR THE MANAGEMENT OF HEALTH CARE STAFF COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS (MRSA)

Guideline for the management of staff with MRSA

Aims:

- 1). To recommend a simple guideline (GL) for the management of Staff members colonised with MRSA in view of the recent DoH directive that all **elective cases** are to be screened by April 2009 (a,b). Some staff members may fall into this category as part of their screening requirement before undergoing surgical procedures themselves.
- 2). To review current UHSM GL for the management of staff colonised with MRSA which is detected **opportunistically**. Current national GL does not support routine screening of staff members (c). This is done on a risk-assessment basis at the discretion of the Occupational health dept/ICT.
- 3). To review current UHSM GL for the management of staff colonised with MRSA detected **during outbreak investigations**.

When a staff member is found to be positive, this presents a number of problems;

- 1) Should they be off work while being decolonised? If so for how long?
- 2) How many negative screens will be needed for clearance? At what intervals should these be taken?
- 3) For the few staff who remain persistently positive despite topical decontamination with mupirocin / aquasept / octenisan. What other options are available in addition?

Recommendations/Suggestions

(Staff found to be positive electively or opportunistically)

- **Should they be off work while being decolonised?** In principle only staff with colonised or infected **hand lesions** should be off while receiving decolonisation especially if they work in **critical areas (see definitions below)***. They need to be treated completely & cleared of MRSA before returning to clinical duties. Alternative non-clinical duties can be assigned to them where feasible. Staff members with skin conditions may be referred to a dermatologist by the occupational health doctor.
- Those staff who do **not** have any skin lesions but work in **critical areas (see definitions below)*** should be off until 48 hrs after the commencement of decolonisation. Alternative non-clinical duties can be assigned to them where feasible.

POLICY FOR THE MANAGEMENT OF HEALTH CARE STAFF COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS (MRSA)

- In **non-critical areas**, it is recommended to continue work during topical decontamination except those with skin lesions who need to be treated completely before returning to clinical duties. Alternative non-clinical duties can be assigned to them where feasible. A risk assessment will have to be done by Occupational health team / ICT.

How many negative screens will be needed for clearance? At what intervals should these be taken?

- Weekly screens should be done to ensure 3 negatives are documented. Each screening should be done at the beginning of the staff shift & not at the end.

Management of staff colonised with MRSA detected during outbreak investigations

- Staff colonised or infected should be off while receiving decolonisation. They need to be treated & cleared of MRSA before returning to clinical duties. Alternative non-clinical duties can be assigned to them where feasible. Staff members with skin conditions may be referred to a dermatologist by the occupational health doctor
- Staff members whose MRSA isolate is the same type as the outbreak strain should have 3 negative screens before allowed to return to work. Alternative non-clinical duties can be assigned to them where feasible.

Persistent MRSA carriers

- The few staff that may remain persistently positive despite topical decontamination with mupirocin / aquasept / octenisan, can be discussed with Occupational health Dept and ICT. Oral antibiotic options include doxycycline, trimethoprim + rifampicin, or linezolid and their use can be discussed.

Definition of Critical areas (High risk areas)

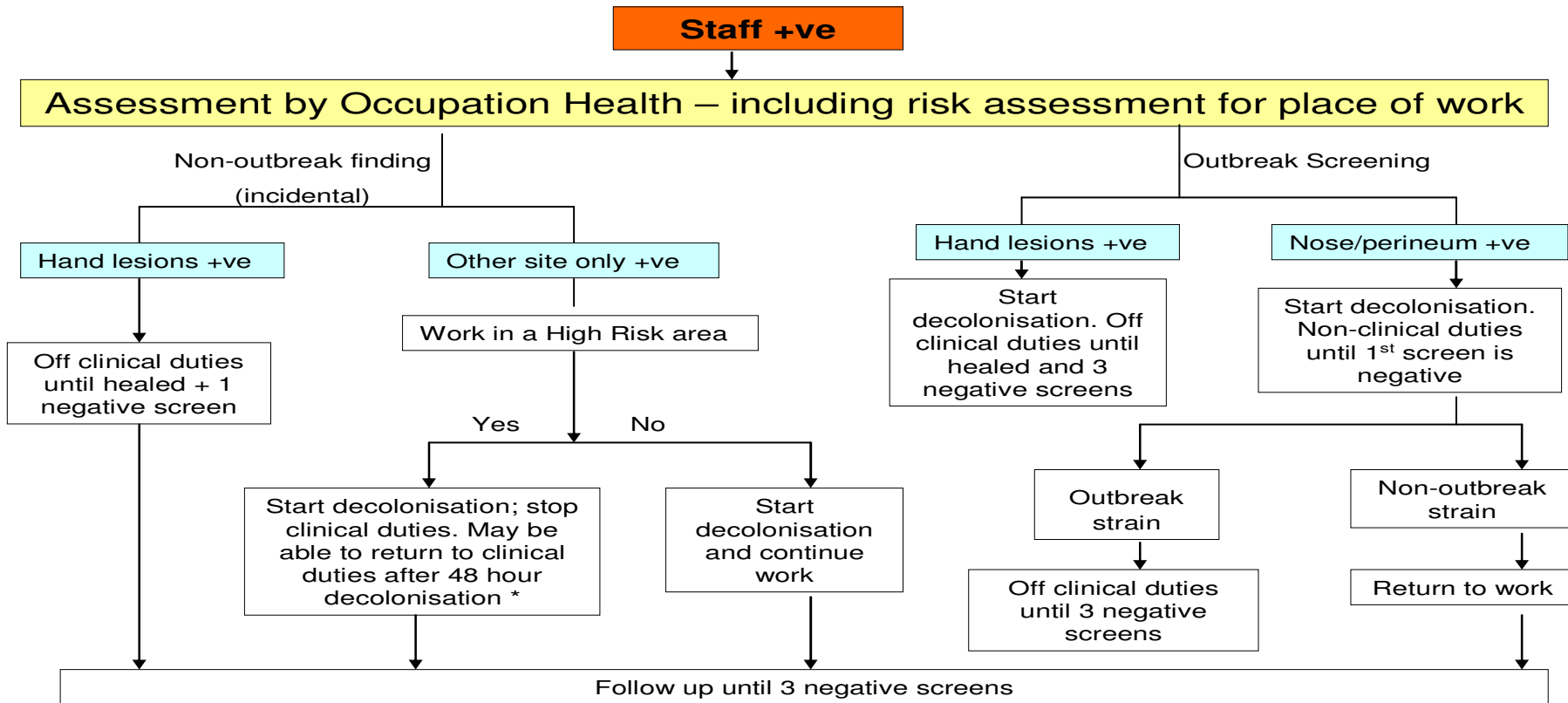
- There is no universal definition of critical high risk areas but units that fall under this include ICUs, HDUs, SCBU, Burns unit, Renal unit & Operating theatres. Other areas may be considered high risk depending on the specific clinical risk and assessment.

POLICY FOR THE MANAGEMENT OF HEALTH CARE STAFF COLONISED WITH METICILLIN RESISTANT STAPHYLOCOCCUS (MRSA)

REFERENCES

- a. **SCREENING ELECTIVE PATIENTS FOR MRSA – FAQs. DoH doc (MRSA DH_094121; 2008.**
- b. **MRSA OPERATIONAL GUIDANCE. DoH 31ST July 2008. GATEWAY Ref 10324**
- c. **GUIDELINE FOR THE CONTROL & PREVENTION OF MRSA IN HEALTHCARE FACILITIES. JHI 2006; 63s; S1-S44.**
- d. **MANAGEMENT OF MULTIDRUG-RESISTANT ORGANISMS IN HEALTHCARE SETTINGS 2006. HEALTHCARE INFECTION CONTROL PRACTICES ADVISORY COMMITTEE (USA).**

Management of staff found to carry MRSA – Final Draft Version



*check mupirocin sensitivity

POLICY FOR THE MANAGEMENT OF PATIENTS WITH DIARRHOEA DUE TO CLOSTRIDIUM DIFFICILE INFECTION

Clostridium difficile is a Gram positive, spore forming anaerobic bacteria. It is associated with diarrhoea enteric disease. This bacterium has two specific features. One is the **production of toxins** which can damage the cells lining the bowel and the other is the ability ~~for~~ **to form spores** which enable the bacterium to persist in the environment for longer periods of time hence the need for source(patient) isolation in a single room until symptom free for 48 hours.

Not all strains of *Clostridium Difficile* produce toxin and patients colonised by such strains remain asymptomatic healthy.

Almost all patients who develop *C. difficile* diarrhoea are on or have recently been given antibiotics. Diarrhoea is the most common symptom, but abdominal pain and fever can occur. In the majority of patients, the illness is mild and full recovery is usual. Elderly patients may become seriously ill with dehydration from the diarrhoea. Occasionally, patients may develop a severe form of the disease called pseudomembranous colitis, which produces significant damage to the large bowel.

Cross infection occurs via contact with the infected faeces and the spores. In patients with profuse explosive diarrhoea there will be widespread contamination of the environment.

Guidelines for Practice

For patients with severe diarrhoea, who are incontinent and unable to co-operate in maintaining their own personal hygiene, source isolation is required to minimise the risk of transmission to other patients (see isolation methods policy).

POLICY FOR THE MANAGEMENT OF PATIENTS WITH DIARRHOEA DUE TO CLOSTRIDIUM DIFFICILE INFECTION

Infection Control Precautions Specific to Patients with Diarrhoea due to *Clostridium difficile* Toxin

ACTION	RATIONALE
The patient should be isolated within 4-6 hours and remain in isolation until they have had no diarrhoea for 48 hours	To reduce the risk of cross infection. If not possible to isolate, the nursing staff should complete an incident report and inform the infection prevention and control team.
Advice for medical treatment of the patient should be in consultation with the microbiologist	Decisions about continuing with antibiotic therapy and treatment must be discussed with medical personnel.
There is no need to send repeat specimens of faeces for culture and sensitivity within 28 days of first positive sample or if the diarrhoea is laxative induced.	The faeces will continue to be positive for toxins for some time. It is the symptoms of diarrhoea that should be used to determine the “infectivity” of the patient. Laxative induced diarrhoea could be false positive for clostridium difficile toxin test. Clinical assessment required.
If possible use a side room with ensuite facilities or provide the patient with a commode designated for their use only.	Reduces the risk of cross infection. Ensuite facilities will reduce hand contamination of health care workers and maintains patient dignity and independence .If isolation
Patients must wash their hands. 1. After using the toilet or commode or if their hands become soiled. 2. Before eating.	Prevents reinfection and transmission of infection.
Patients or relatives should be given information leaflets about C. difficile infection at the time of diagnosis.	To keep the patients informed about the diseases and its implications.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH DIARRHOEA DUE TO CLOSTRIDIUM DIFFICILE INFECTION

Infection Control Precautions Specific to Patients with Diarrhoea due to *Clostridium difficile* Toxin (continuation of table on page 16)

ACTION	RATIONALE
If the patient needs requires to be referred to other hospital area for investigations /transfer tests , the receiving-area should be informed and measures taken to try to ensure the continence of the patient.	To reduce the risk of cross infection and to maintain good inter-departmental communication.
All shared equipment must be thoroughly washed with chlorclean solution before use with other patients.	Environmental contamination is high, thorough washing is the most effective way of preventing cross infection.

All patients who test positive to *Clostridium difficile* toxin and have active diarrhoea should be isolated in a single room until symptom free for 48 hours.

Discharge or transfer of patients who have had diarrhoea due to *Clostridium difficile* toxin

Personnel to be informed when the patient's discharge is decided.	Rationale
Infection Control Nurse	Can liaise with the receiving area, GP and nursing homes and give advice to patients and their relatives.
Patient's GP	To be aware of diagnosis if symptoms reoccur and to use "appropriate" antibiotics, if necessary.
Accepting wards in the Trust and in other hospitals	"
Nursing and Residential Homes	"

POLICY FOR THE MANAGEMENT OF PATIENTS WITH DIARRHOEA DUE TO CLOSTRIDIUM DIFFICILE INFECTION

Policy for the Management of Patients with *Clostridium difficile* toxin positive diarrhoea

CLOSTRIDIUM DIFFICILE INFECTION

SPREAD BY FAECAL – ORAL ROUTE
VIA **HANDS** OF HEALTH CARE WORKERS &/OR CONTACT WITH CONTAMINATED ENVIRONMENT

SUSCEPTIBLE HOST
> 65 YEARS OLD HOSPITALISED PATIENT, RECEIVING ANTIBIOTICS AND OTHER IMMUNOCOMPROMISED PATIENTS RECEIVING ANTIBIOTICS

PRODUCE OFFENSIVE SMELLING, PROFUSE WATERY STOOL

COLLECT SPECIMEN FOR CULTURE AND SENSITIVITY

IF *Clostridium difficile* infection is suspected or Toxin test POSITIVE AND SYMPTOMATIC

ACTIONS BY MEDICAL STAFF

- a) Review present antibiotics. Is it possible to stop them or change to narrow spectrum (refer trust antibiotic formulary on C difficile infection)
- b) Review use of laxatives and Protein Pump inhibitors.
- c) Assess severity and refer to the trust *C. difficile* antibiotic policy for treatment
- d) Medics to complete the clinical section on the Root Cause Analysis (RCA) form and will be required to attend the RCA meeting.
- e) Handwashing after patient contact

ACTIONS BY NURSING STAFF

- a) Isolation of patient in side room with ensuite toilet or own commode.
- b) To initiate the Infective Diarrhoea ICP with incorporated stool chart.
- c) To complete the required section in the RCA form .Matron / ward staff will be required to attend the RCA meeting.
- d) Hand washing by all healthcare workers after patient contact.
- e) Hand washing by patient after use of toilet and before meals
- f) Wear an apron and gloves when handling body fluids. Wash hands after removal of gloves.
- g) Thorough cleaning of furniture, commode, toilet, mattress, cot sides etc., with Chlorine based products is essential.
- h) Use water-soluble bags for foul linen.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH DIARRHOEA DUE TO CLOSTRIDIUM DIFFICILE INFECTION

Policy for the Management of Patients with *Clostridium difficile* toxin positive diarrhoea

ONCE CLEAR OF DIARRHOEA FOR 48 HOURS – CAN RETURN TO MAIN WARD AREA. SIDE ROOM AND EQUIPMENT NEEDS THOROUGH CLEANING BY CHLORCLEAN. DO NOT SEND FURTHER SPECIMENS. THERE IS NO NEED TO WAIT FOR NEGATIVE RESULT

PLEASE CONSULT INFECTION PREVENTION AND CONTROL NURSE FOR ANY FURTHER ADVICE FOR PATIENTS, RELATIVES, STAFF AND RESIDENTIAL HOMES PATIENTS

Summary of Management of Patients with Tuberculosis
(Refer to following policy for full details)

Key: MDRTB = Multi Drug Resistant Tuberculosis
HCWs = Health Care Workers

Clinical presentation	Type of isolation required	Specific precautions, including mask usage	Specimens for microbiology lab
Non pulmonary TB	None (except e.g. during abscess/wound irrigation)	None	As appropriate for diagnosis
Mycobacteria other than TB	None	None	As appropriate for diagnosis
Suspected or confirmed pulmonary TB	<ul style="list-style-type: none"> Single room Ensuite facilities, if possible Door closed at all times 	<ul style="list-style-type: none"> Patient to cover mouth with tissues if coughing. HCWs should not use masks unless: <ol style="list-style-type: none"> Cough inducing procedures being performed (see p. 26) MDR-TB is suspected (see p. 30 for risk assessment) Use FFP3 masks if required 	Obtain 3 specimens of sputum, preferably early morning for AAFB as soon as possible (see p. 22)
Suspected or confirmed pulmonary TB BUT smear negative from 3 specimens	None	<ul style="list-style-type: none"> Patient to cover mouth with tissues if coughing. 	
Suspected or confirmed pulmonary TB AND smear positive (i.e. presumed open TB)	<ul style="list-style-type: none"> Single room Door closed at all times En suite facilities, if possible To remain in isolation for 14 days from start of TB therapy (unless discharged home) 	<ul style="list-style-type: none"> Patient to cover mouth with tissues if coughing. HCWs should not use masks unless: <ol style="list-style-type: none"> Cough inducing procedures being performed (see p. 26) MDR-TB is suspected (see p. 30 for risk assessment) Use FFP3 masks if required 	
Suspected MDRTB	<ul style="list-style-type: none"> Single room En suite facilities Door closed at all times <i>Bullet point deleted</i>	Contact Infection Control Doctor or Designated TB physician as soon as possible. <ul style="list-style-type: none"> Staff / visitors to wear FFP3 masks on entry to room Patient to cover mouth with tissues if coughing Patient to wear surgical mask if unable or uncooperative with above 	Obtain sputum specimens, as soon as possible. Consultant microbiologist will request rapid test for MDRTB.
Confirmed MDRTB	<ul style="list-style-type: none"> Negative pressure room Transfer to North Manchester General Hospital 	Liaise with Infection Control Doctor/ Consultant Microbiologist or designated TB Physician	

NB. Notification required for any *M.tuberculosis* infection. This is the responsibility of the doctor in charge of the patient. (See p. 23)

Policy for the Management of Patients with Tuberculosis (TB)

BACKGROUND

Tuberculosis (TB) is a serious, but treatable infectious disease. TB in England has increased by 25% over the last 10 years and is still rising.

At least 3% of people with TB are estimated to be HIV positive. **All patients with TB should have a risk assessment for HIV.**

PULMONARY TUBERCULOSIS

Diagnosis

The initial diagnosis of TB will be made by clinical and radiological assessment. The diagnosis is **confirmed** by microbiological examination of samples of sputum.

For a patient to be infectious the following signs and symptoms are usually present: the patient is SMEAR positive, has a productive cough and evidence of cavitating disease on X-ray.

See page 29 for risk assessment for multi-drug resistant tuberculosis (MDRTB).

Specimen taking (If the patient has a productive cough)

- The specimens of sputum should be purulent or at least muco-purulent. Salivary samples are inadequate for microbiological investigation.
- Early morning specimens of sputum are preferred, these generally are more concentrated and therefore contain more of the TB bacilli.
- Initially send 3 specimens on consecutive days. *Bullet point deleted*
- TB microscopy and culture must be requested on the form.
- Specimens following physiotherapy are often best, but if induced sputum specimens are to be obtained appropriate precautions must be used and the procedure **must not take place on an open ward if pulmonary TB is suspected.** (seek advice from the infection control team).

Specimen examination in the laboratory

Specimens are examined in the laboratory by microscopy, using the phenol –auramine stain (Ziehl-Neelsen to confirm). If mycobacteria are seen the result will be phoned to the ward. **This is sometimes termed smear positive or AAFB (Acid alcohol fast bacilli) positive or ZN positive and a provisional diagnosis of OPEN TB is made.**

A sample of the specimen is cultured to identify the type of Mycobacterium isolated. Positive results usually take 2 – 4 weeks. Negative cultures are reported at 4 weeks, but cultures are incubated for 8 weeks in total.

Policy for the Management of Patients with Tuberculosis (TB)

Communication of positive TB / AAFB positive result

- Clinical microbiologist will telephone result through to clinician caring for patient.
- Clinical microbiologist will inform the TB nurse in Chest clinic. (By telephone or Fax or E mail)

Isolation of patients with pulmonary TB

Patients suspected on clinical evidence to have pulmonary TB should be nursed in a single room while the smear results of the 3 specimens are awaited. Patients who are **not** smear positive from any of the 3 sputum specimens obtained **do not require isolation**. That is why it is important to obtain specimens as soon as possible, to determine the need for isolation.

Treatment compliance

The importance of treatment compliance in prevention of resistance should be emphasised to the patient.

Notification

Pulmonary tuberculosis whether smear positive or negative is a NOTIFIABLE disease.

The consultant in charge of the patient's care is responsible for ensuring that clinical and microbiologically positive cases are notified by telephone to the Health Protection Unit (HPU) for the area in which the patient lives.

If smear positive notify immediately.

Greater Manchester Health Protection Unit	0161 786 6710
Stockport, CCDC	0161 419 4317
Cheshire & Merseyside Health Protection Unit	01244 366766

The telephone call must be followed by a written TB notification form mailed to the HPU (available from the TB Nurse in Chest Clinic or from the HPU).

Policy for the Management of Patients with Tuberculosis (TB)

Care of patient who is SMEAR POSITIVE

ACTION	RATIONALE
Patient must be nursed in single room, preferably with en suite facilities, with the door closed at all times.	There is a risk of cross infection via the airborne route
Inform Infection Prevention and Control Doctor / Consultant microbiologist.	Rapid detection methods can be employed in the case of possible MDR-TB and as the specimens require special handling in the laboratory it is essential that the infection control doctor is alerted to such cases as soon as possible.
Inform Infection Prevention and Control Nurse.	Needs to be informed to assess risk to patients and staff. Useful resource and available to give information and advice to patient, their relatives and staff.
Provide patient with information / leaflet about TB. Contact TB nurse in chest clinic for support / information for patient / relatives.	Useful resource and available to give information and advice to patient, their relatives and staff.
Place “isolation” sign on single room door.	Highlights need for special precautions, without breaching patient confidentiality.

Policy for the Management of Patients with Tuberculosis (TB)

ACTION	RATIONALE
<p>The patient should be instructed to cover his / her mouth with a tissue when they cough or if unable to comply with the above the patient should wear a surgical mask, when HCWs are present in side room.</p>	<p>This is highly effective in preventing aerosol generation and airborne transmission.</p>
<p>Patient should place used tissue immediately into yellow clinical waste bag.</p> <p>A sputum pot with lid should be available, changed at least daily and discarded in yellow clinical waste bag.</p>	<p>Prevents environmental contamination.</p>
<p>Health care workers caring for people with TB should not use masks, gowns or barrier nursing techniques unless:</p> <ul style="list-style-type: none"> • MDR-TB is suspected. • Cough inducing procedures (e.g. bronchoscopy, sputum induction) are being performed. <p>The reason for mask wearing must be explained to patient.</p>	<p>Tuberculosis. National clinical guideline for diagnosis, management, prevention and control. NICE (2006) Evidence does not support mask wearing for HCWs other than in “named” situations.</p>
<p>Document patient contacts (see page 27).</p>	<p>Appropriate follow-up of contacts will be arranged by the Infection Prevention and Control Team.</p>

Policy for the Management of Patients with Tuberculosis (TB)

ACTION	RATIONALE
<p>Cough inducing procedures undertaken by staff are not encouraged with suspected / confirmed TB patients, however if they are clinically necessary they must be performed in side-room and the personnel involved in the cough inducing procedure should wear a mask (FFP3) e.g. physiotherapy, intubation.</p>	<p>Greater risk of aerosol production and therefore greater risk of airborne transmission to staff involved in this procedure.</p>
<p>If the patient remains in hospital he/she should be cared for in the single room for 2 weeks from the date of commencement of TB chemotherapy.</p>	<p>Patients are considered not to be infectious after 2 weeks of anti-TB chemotherapy. Any bacilli seen in sputum smears after this time, are likely to be non viable due to the effect of treatment.</p>
<p>During this 2 week period the patient must be instructed not to visit wards, including communal washing facilities or public areas of the hospital or be transported through wards in which there are immuno-suppressed patients. The patient should wear a surgical mask if transported through the hospital for clinical reasons.</p>	<p>May come in contact with immuno-suppressed patient in hospital setting.</p>
<p>Staff should wear disposable gloves when handling sputum pots and/or tissues.</p>	<p>Universal precautions are required when handling body fluids.</p>
<p>Linen should be treated as infected and sent for laundering in pink water soluble bags.</p>	<p>Low risk of transmission from bedding, but for consistency treat as infected linen whilst patient nursed in isolation.</p>
<p>If the patient is to be transferred to another ward or department, ensure the receiving area is made aware of any necessary precautions.</p>	<p>To reduce the risk of cross infection.</p>

Policy for the Management of Patients with Tuberculosis (TB)

Specific advice for staff

Staff who are to care for patients with TB must either

- Have been successfully immunised with BCG
- Or have natural immunity to TB proven by Tuberculin skin test.

If in doubt regarding their TB immunity or vaccination status, staff must consult Occupational Health as soon as possible.

Staff who are HIV positive and / or immuno suppressed **must not** nurse a smear positive patient.

Staff who may come into contact with cases of tuberculosis must report to Occupational Health Department if they develop symptoms consistent with a diagnosis of TB, such as a cough persisting for longer than 3 weeks, night sweats, persistent temperature or unexplained weight loss.

Procedure when a patient has been nursed in an open ward before being diagnosed with SMEAR POSITIVE (OPEN) TB

Other patients in the same bay / ward will be recorded as contacts. Appropriate contact follow-up will be arranged through the infection control team, the consultant microbiologist and the consultant in charge of their care. The infection control team will be primarily responsible for the identification of contacts and communication with appropriate external agencies.

Definition of patient contacts on "open" ward.

Index case - smear positive TB and a cough.

Contact Immune competent	Contact Immuno-suppressed (including patients on steroid therapy)
Duration of contact: >8 hours. Adjacent bed or bed opposite. (Include everyone in 4, 6 or 7 bed bay).	Duration of contact: ANY. Adjacent bed or bed opposite. (Include everyone in 4, 6 or 7 bed bay).

Policy for the Management of Patients with Tuberculosis (TB)

Death of patient

In the event of the death of a patient with TB, the body need only be placed in a body bag if there is an exudate e.g. from a drain connecting with an empyema that is likely to contain TB bacilli.

However, **mortuary staff and undertakers MUST be informed** when death is known or suspected to have been associated with a Hazard group 3 pathogen. Mycobacterium tuberculosis is classified as a Hazard group 3 pathogen.

NON-PULMONARY TUBERCULOSIS

It is possible for individuals to be diagnosed with **non-pulmonary tuberculosis**. Usually one main site of infection is involved, but occasionally multiple non-pulmonary sites may be involved. Examples of non-pulmonary tuberculosis are tuberculous lymph glands, genitourinary TB, TB of the bones and joints and TB meningitis.

Isolation of non pulmonary TB patients

Such patients do not routinely require isolation on a ward / unit as the risk of transmission is negligible. However, any potentially aerosol-generating procedure e.g. abscess/wound irrigation should be carried out in a separate room.

Notification of non pulmonary TB to the HPU is required. (See page 23)

Policy for the Management of Patients with Tuberculosis (TB)

MULTI-DRUG RESISTANT TUBERCULOSIS (MDR-TB)

MDR-TB is defined as infection with *Mycobacterium tuberculosis* resistant to Isoniazid and Rifampicin.

Patients with MDR-TB are no more infectious than similar patients with fully susceptible TB, i.e. they should not infect a higher proportion of contacts, because the organism is no more virulent. However MDR-TB is more difficult to treat.

If there is any suspicion that a patient may have multi drug resistant TB then one of the following should be contacted as soon as possible:-

- Infection Control Doctor, Dr B J Isalska
- Consultant Microbiologist, Dr. Mairi Cullen and / or Dr William Hope, Lead Consultant for TB.

Extensively Drug Resistant Tuberculosis (XDR-TB)

XDR-TB is rare in the UK and relatively uncommon worldwide. It is defined as TB resistant to at least rifampicin, isoniazid, any fluoroquinolone and one of the second line drugs: capreomycin, kanamycin and amikacin. Refer to page 30 (MDR-TB) for initial management of a patient with suspected or confirmed XDR-TB.

Risk Assessment for MDR-TB

A patient falling into any of the following 6 categories should increase suspicion that he / she might have multi drug resistant TB:-

1. A history of prior TB treatment; prior TB treatment failure.
2. Contact with a known case of drug-resistant TB.
3. Birth in a foreign country, particularly high-incidence countries such as all of Africa except Egypt, Libya and Tunisia; Central and South Asia and Eastern Europe.
4. Residence in London; male; HIV positive.
5. Age profile, with highest rates between ages 25-44.
6. No clinical improvement, or if cultures remain positive after 4 months of treatment.

If on assessment the patient is considered at risk of MDRTB contact consultant microbiologist on call.

Policy for the Management of Patients with Tuberculosis (TB)

Care of patient with suspected / confirmed MDR-TB (prior to transfer to NMGH)

ACTION	RATIONALE
Nurse patient in single room with ensuite facilities with the door closed at all times.	To reduce the risk of transmission.
Any person (staff or visitor) entering the patient's room should wear a FFP3 particulate filter respirator mask. <i>(sentence deleted)</i>	To reduce the risk of transmission. <i>(deleted)</i>
Cough inducing procedures must not be attempted with patient.	Increases risk of transmission.
The patient must not be moved from an isolation room without agreement of designated TB physician and/or consultant microbiologist.	To ensure receiving areas have appropriate infection control measures in place.
The patient must wear a mask and/or cough into tissues during transfer through any patient areas within the hospital and during transfer by ambulance. A surgical mask is acceptable, but a particulate filter respirator mask may give better protection for a longer period of time.	To reduce the risk of transmission.

Policy for the Management of Patients with Tuberculosis (TB)

ACTION	RATIONALE
Once diagnosis is confirmed as MDRTB patient must be cared for in a negative pressure room.	To reduce the risk of transmission.
Liaise with the consultant TB physician and/or consultant microbiologist to arrange transfer of patient to North Manchester General Hospital (NMGH.)	There is an arrangement with NMGH to take confirmed and/or strongly suspected MDRTB cases.
<p>Ambulance staff transporting an infectious patient must be given sufficient information for their own protection without breaking patient confidentiality.</p> <ul style="list-style-type: none"> a) Ambulance personnel do not need to wear masks. b) Patient should wear a mask or cough into disposable tissues. c) Special cleaning of ambulances is not required after carrying a patient with suspected or confirmed infectious TB. 	<p>Health & Safety requirements.</p> <p>Even minimal ventilation in an ambulance will provide a very high rate of air changes.</p> <p>Routine cleaning is sufficient.</p>

MYCOBACTERIA OTHER THAN TB (MOTT, ‘Atypical mycobacteria’, ‘Atypical TB’)

Patients with infection due to mycobacteria other than TB, commonly termed as **atypical “TB”**, do not need to be isolated as the risk of transmission is extremely low. **Atypical mycobacteria** do not require notification.

Policy for the Management of Patients with Tuberculosis (TB)

References

British Thoracic Society (2000)

- Control and prevention of tuberculosis in the United Kingdom: Code of Practice 2000. British Thoracic Society Guidelines Thorax 2000 5S: 887-901

Department of Health (2004)

- Stopping Tuberculosis in England. An action plan from the Chief Medical Officer. Oct 2004.

NICE (2006)

- Tuberculosis. National clinical guideline for diagnosis, management, prevention and control.

The Scottish Office (1998)

- The Interdepartmental Working Group on Tuberculosis. UK Guidance on the prevention and control of Transmission of
 1. HIV – related tuberculosis
 2. Drug-resistant, including Multiple Drug-resistant Tuberculosis

**POLICY FOR THE CARE OF PATIENTS WITH
GROUP A HAEMOLYTIC STREPTOCOCCAL INFECTION**

Streptococci are Gram positive coccal bacteria of which Group A is associated with the most serious infections and causes pharyngitis, skin and wound infections, puerperal sepsis, scarlet fever and septicaemia. It is carried in the throat of 5% of the population.

Cross infection occurs via contact and the air borne route.

Guidelines for Practice

Source isolation is required to minimise the risks of transmission to other patients whilst maintaining safety and comfort (see source isolation methods policy).

Infection control precautions specific to *Group A streptococci*

ACTION	RATIONALE
The patient must remain in the single room until they have received appropriate antibiotic treatment for at least 48 hours. Contact Infection Control Doctor for advice.	To prevent transmission while infectious to other patients. Rapid eradication is important.
If the patient has previously been nursed on the main ward, contact Infection Control.	To help identify possible sources and identify any other affected patients.
Other patients/staff may require throat swabs to be taken. (On advice of Infection Control team).	To help identify possible sources. (<i>Group A streptococci</i> is carried in the throat of 5% of the population).
Refer any staff with sore throats to Occupational Health. Obtain nose and throat swabs from any patients with sore throats.	To help identify possible sources in the context of outbreaks

**POLICY FOR THE CARE OF PATIENTS WITH
GROUP A HAEMOLYTIC STREPTOCOCCAL INFECTION**

ACTION	RATIONALE
If possible, reswab wound 3 days after treatment completed. Further screening may be required as advised by Infection Control.	To ensure bacteria has been eradicated.

**POLICY FOR THE CARE OF PATIENTS WITH
VANCOMYCIN RESISTANT ENTEROCOCCI (VRE)**

Enterococci are Gram positive organisms which are found in the gut and female genital tract. They are also found widespread in the environment and can contaminate equipment, surfaces and clothing.

VRE is not in itself a cause of diarrhoea, but if the patient has diarrhoea, they are at high risk of disseminating large numbers of this organism into the environment.

Cross infection can occur via:-

- Direct contact
- Indirectly via the hands of staff
- Contaminated patient equipment
- Environmental surfaces

Patients who have been found to have VRE in their faeces and have diarrhoea require strict barrier nursing' (see policy on source isolation).

Precautions specific to VRE include:

ACTION	RATIONALE
Use an alcohol hand rub after handwashing with an liquid soap.	Alcohol is particularly effective against VRE.
Bed area i.e. frame, table, locker tops etc should be thoroughly cleaned daily (with Chlor clean, 1,000ppm)	Enterococci rapidly accumulate in the environment
Barrier rooms should be ensuite if possible. However if patient is continent and has good hygiene, allow use of toilet instead of a commode.	To reduce handling of infected faeces by nursing staff

Please contact a member of the Infection Prevention and Control team for further advice.

POLICY IN RESPECT OF AIDS/HIV IN EMPLOYMENT TRANSMISSION OF HIV/AIDS IN EMPLOYMENT

1. Introduction

AIDS is a condition caused by the Human Immune Deficiency Virus (HIV) which, because of its effects on the body's immune defence system, predisposes the individual to opportunistic infections and some rather uncommon types of cancer. It must be emphasised that there is no risk to colleagues or the general public from the normal type of social or occupational contact. The majority of procedures in the healthcare setting pose no risk of transmission of HIV virus to the healthcare worker or from the healthcare worker to the patient.

HIV is transmitted in the following ways:-

- i) As a blood borne infection by infected blood entering the bloodstream of another person, e.g. as a result of needle stick injury and also by infected needles which have been used by drug users
- ii) During sexual intercourse with an infected person
- iii) *Infection from an infected mother to her developing child, either during pregnancy itself or at the baby's delivery*

In addition to HIV, the Hepatitis 'B' virus can be transmitted in the same three ways as above. The Hepatitis 'B' virus is considered to be much more infectious than HIV. However, there is an effective vaccination against Hepatitis 'B' for those people who are not immune and an effective prophylactic measure against Hepatitis 'B' infection in the form of an injection of human specific *Hepatitis B immunoglobulin (HBIG)*

This policy applies to all employees of the Trust, whether full-time, part-time, temporary locum appointments or agency and bank.

**POLICY IN RESPECT OF AIDS/HIV IN EMPLOYMENT
TRANSMISSION OF HIV/AIDS IN EMPLOYMENT**

2. Pre-Employment Medical Assessment of HIV Infection Healthcare Worker

It is important for all prospective employees to realise that there is no employment discrimination in respect of AIDS/HIV positivity within this Trust, however the Trust is legally obliged under existing Health and Safety legislation to safeguard the health of patients and all members of staff. It may, therefore, not be possible under such legislation to employ an applicant who is proven to be HIV positive in certain areas, for example, when they are required to undertake exposure prone procedures. The HIV positive employee may well be in excellent health for many years prior to developing AIDS or an AIDS related condition, and be able to be employed in the vast majority of Health Service occupations. However, it is felt prudent that such an employee must not be involved in invasive surgical work and, because of impaired levels of immunity, may not be able to be safely employed where the risk of certain infections is high, for example on the respiratory medicine unit.

Such an employee who has already developed AIDS or an AIDS related disease could well be reasonably healthy and may be able to undertake quite a few types of employment in healthcare. He/she would, however, need to be closely monitored during employment. The prospect is that with the most modern treatment, an employee could well continue with their work for several years.

3. Employment

3.1 Medical Assessment of HIV Infected Healthcare Workers

- i) All employees have an over-riding ethical as well as legal duty to protect the health and safety of their patients. In the event of an employee being concerned that he or she may be at risk from HIV infection in his/her personal life, he/she **MUST** seek urgent medical advice from Occupational Health and might be recommended to have HIV antibody test. In the event of this test being positive, it is possible that redeployment would have to be considered.

**POLICY IN RESPECT OF AIDS/HIV IN EMPLOYMENT
TRANSMISSION OF HIV/AIDS IN EMPLOYMENT**

- ii) The employee who has been proved to be infected with HIV **MUST** seek Occupational Health advice at a very early stage. If he/she performs an invasive surgical procedure which includes most forms of major surgery and trauma treatment where the individual's fingers might at one time or another be out of direct vision and where there was a risk of the blood of the healthcare worker intermingling with that of the patient. Surgical procedures would also include caesarean deliveries, vaginal deliveries of an instrumental nature and possibly manual removal of retained placentas. Certain types of dental surgical treatment would also be included under this heading. It will be necessary to re-assess the types of duty that he/she will be able to perform in future. It is **ESSENTIAL** that they discontinue such invasive procedures **IMMEDIATELY**.

3.2 Management of HIV Infected Health Care Worker

- i) HIV infected healthcare workers who do not perform exposure-prone procedures but are involved in the clinical care of patients must remain under regular medical and Occupational Health supervision and receive appropriate Occupational Health advice if their circumstances change.
- ii) The Statutory Bodies, e.g. General Medical Council, General Dental Council and United Kingdom Central Council have also formulated policies in respect of AIDS/HIV. These policies will be readily available to members of the professions. Employees who are infected must be fully aware that it is essential to comply with their professional body's requirements.

In the event of an infected employee failing to comply with the Trust's recommendations then he/she should be informed that his/her case would be reported to the relevant professional organisation for appropriate action to be taken.

- iii) This Trust will make every effort to secure alternative employment where an infected employee has to be relocated. The employee must be assured a sympathetic and fully confidential handling of their case by all who are involved. The knowledge that employees' problems will be handled in a confidential way will encourage disclosure of difficulties.

POLICY IN RESPECT OF AIDS/HIV IN EMPLOYMENT TRANSMISSION OF HIV/AIDS IN EMPLOYMENT

- iv) It is not acceptable to display any prejudicial behaviour towards a member of staff who has AIDS or is HIV positive. Any member of staff who is found to be acting in a prejudicial way towards any member of staff who is HIV positive or who has AIDS, (or suspected to be so), will be dealt with under the relevant Trust policy.
- v) In the event of an HIV positive employee being identified who might have placed patients at risk, an urgent meeting will be called involving the following Trust personnel:-
 1. Executive Director
 2. Consultant Microbiologist/Virologist from the PHL
 3. The Occupational Health Consultant
 4. Director of Personnel

In addition, the Medical Director will liaise closely with the Director of Public Health/Consultant in Communicable Disease Control of the Manchester Health Authority.

As a result of such a meeting a recommendation will then be made to the Chief Executive of the Trust and if then considered necessary by the Director of Public Health or his/her deputy, appropriate steps will be taken to contact patients whose health may have been prejudiced by such an infected healthcare worker. In such circumstances, every effort will be made to preserve confidentiality of the infected healthcare worker and a deliberate or negligent breach of confidentiality would be dealt with under the Trust's disciplinary procedure.

Where an employee is either HIV positive or is suffering from AIDS and suffers from health problems which cause either frequent short term sickness absence or long term absence, this will be managed as per the existing Trust policies.

4. EDUCATION

UHSM.0. is committed to continual development of an effective Health Education Programme in respect of AIDS/HIV for all its employees. This programme will help dispel the myths associated with this disease and ensure that all employees are fully aware of the mode of its transmission and of the fact that so few cases have occurred during employment of Healthcare Workers world-wide. In addition, the Trust will try its utmost to minimise the risk of transmission of infection by its Control of Infection policies.

Reference: DoH Guidance; HIV-infected health care workers: Guidance on management and patient notification, 28 July 2005.

POLICY IN RESPECT OF MANAGEMENT OF BABIES AND TODDLERS WITH RESPIRATORY SYNCYTIAL VIRUS (RSV)

Background

RSV causes seasonal outbreaks of lower respiratory tract infection: - pneumonia, **bronchiolitis** and tracheobronchitis, in infants and young children in industrialised countries.

The period of risk from RSV in the UK is between October and April. Approximately 50% of infants and children under 2 years old are infected with RSV each winter and approximately 1% of these require admission to hospital.

For the majority of infants symptoms are mild and similar to the common cold.

However, in **high-risk infants** the infection is more severe. **Those most susceptible to RSV are infants:-**

- a) **with a chronological age less than 6 weeks.**
- b) **with bronchopulmonary dysplasia (BPD)**
- c) **with congenital heart disease (CHD)**
- d) **with immunodeficiency.**
- e) **born prematurely (i.e. less than 35 weeks gestation).**

Environmental risk factors for RSV infection include overcrowding, low socio-economic status, exposure to environmental tobacco smoke and **admission into hospital during the RSV season.**

Transmission

The virus enters via the mucous membranes of the eyes or nose.

RSV is transmitted through direct or indirect contact with infected respiratory secretions or from objects / surfaces contaminated with the virus. It does not spread over large distances. It does not appear to be spread via the mouth so masks are not helpful in controlling spread.

The incubation period is 2 to 8 days, with infectivity lasting approximately 1 week from the onset of symptoms.

POLICY IN RESPECT OF MANAGEMENT OF BABIES AND TODDLERS WITH RESPIRATORY SYNCYTIAL VIRUS (RSV)

Prevention of cross infection of RSV within Paediatric Ward

ACTION	RATIONALE
Nasopharyngeal aspiration should be taken as soon as possible on admission.	Allows rapid and accurate diagnosis, isolation measures can then be appropriately instigated.
Babies and toddlers known or suspected to have RSV should be nursed in single rooms or cohorts.	Reduces risk of cross infection.
Children in high risk groups (Listed a). b). c). d). & e). above) should be nursed in single rooms whether they have RSV or not.	Need to protect these vulnerable groups from acquiring RSV during hospital stay.
A risk assessment of which child should have priority for a single room should be made in consultation with the senior nurse in charge of the ward and the consultant paediatrician or paediatric registrar on call.	The senior nurse in charge in consultation with the consultant paediatrician or paediatric registrar on call.
If cohort nursing is being used, then a specific nurse or team should be allocated to this cohort group for the duration of the shift.	Reduces the risk of cross infection.
Thorough hand washing after each contact with the child is essential.	Hand washing is the most effective method in the prevention of cross infection.
Staff should wear a disposable plastic apron when handling the baby/child.	Reduces contamination of staff's clothing and reduces the risk of cross infection.

POLICY IN RESPECT OF MANAGEMENT OF BABIES AND TODDLERS WITH RESPIRATORY SYNCYTIAL VIRUS (RSV)

Prevention of cross infection of RSV within Paediatric Ward

ACTION	RATIONALE
Prior to leaving the single room / bay the disposable apron should be removed, discarded into a foot operated pedal bin and then hands thoroughly washed and dried.	Reduces risk of cross infection.
A sign should be displayed on the single room / bay door to indicate that special precautions must be observed by all staff and visitors.	Informs staff and visitors of special procedures to follow.
Linen must be put directly into pink water soluble bags and then into linen bag.	Reduces handling of linen and reduces cross infection.
Crockery, cutlery and toys must not be shared. Toys should be washable / wipeable.	Reduces risk of cross infection. Some soft fabric toys can not be effectively decontaminated.

Prevention of cross infection of RSV within Paediatric Ward

Cleaning of single room / bay following discharge

All work surfaces, bed tables, cot sides, locker tops, toys, bed / cot mattresses should be **thoroughly cleaned with hot water and general purpose detergent**. The surfaces must be **dried after cleaning**.

NB – There is no need to use Haz Tab disinfectant.

If **medical equipment / devices** have been used these **must be decontaminated** after use following Trust policy (**Infection Control policy file Section 4, page 16.**) and the manufacturer's recommendations.

POLICY IN RESPECT OF MANAGEMENT OF BABIES AND TODDLERS WITH RESPIRATORY SYNCYTIAL VIRUS (RSV)

Prevention of cross infection of RSV within Paediatric Ward

References

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PHLS position paper. Prevention and treatment of RSV infection. (2001) www.phls.co.uk.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD and vCJD) AND RELATED DISORDERS

Introduction

This policy provides advice on safe working practices to prevent the transmission of CJD, variant CJD (vCJD) and related disorders in hospital. Whilst the evidence to date does not suggest that CJD and related disorders are spread person to person by close contact, it is known that transmission can occur in specific situations associated with medical interventions. A number of cases of CJD have been associated with –

- Hormones prepared from human pituitary glands
- Dura mater implants
- Corneal grafts

Consequently, there are particular groups of patients who present a greater risk of potential exposure to the CJD agent for attending healthcare staff. The infective agent is thought to be a prion and is very resistant to disinfection ; thus there is also a risk to patients through the use of surgical equipment.

Patient Risk Groups (referred to as known, suspect or at risk patients)

When considering measures to prevent the transmission of CJD within the health care setting it is useful to make a distinction between:

- Symptomatic patients: The diagnosis may be definite, probable or possible CJD or vCJD
- Asymptomatic patients: but at risk of CJD because of their family history or having genetic mutations.
- Asymptomatic patients identified at risk due to past medical history: this would include recipients of certain hormones prior to 1985, those with grafts of dura mater (neurosurgery prior to August 1992), those who have been informed that they may be at risk (because of eg. receipt of certain blood products or instrumentation).

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD and vCJD) AND RELATED DISORDERS

Patient Risk Groups

KNOWN OR SUSPECT PATIENTS	AT RISK PATIENTS
Patients diagnosed as having CJD or, a related disorder *	Asymptomatic patients who are potentially at risk of developing CJD or a related disorder *
Patients suspected of having CJD or a related disorder, i.e. whose clinical symptoms are suggestive of CJD but where the diagnosis has not yet been confirmed.	<p>Recipients of hormone derived from human pituitary glands e.g. growth hormone, gonadatrophin.</p> <p>Recipients of human dura mater grafts.</p> <p>People with a family history of CJD i.e. close blood line relatives (parents, siblings, children, grandparents and grandchildren).</p> <p>People who have been informed that they are at-risk due to past medical treatments eg certain transfusions or surgery.</p>

* i.e. Transmissible spongiform encephalopathy (TSE).

In most routine clinical contact no additional precautions are needed for the care of patients in the risk groups. However when certain invasive interventions are performed there is the potential for exposure to the agents of TSE and also to infect other patients through the use of contaminated surgical equipment.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD) AND RELATED DISORDERS

Ward Procedures for Patients Known, Suspected or at Risk of CJD

ACTION	RATIONALE
Inform the infection control team as soon as possible following the admission of a patient known, suspected or at risk of CJD.	The infection control team can be used as a resource in facilitating the management of a patient with known suspected or at risk of CJD. The Infection Control Doctor will co-ordinate an advisory group from key personnel within the Trust.
A patient with known, suspected or at risk of CJD can be nursed on the open ward with no particular precautions beyond routine universal precautions (see Section 3, page 3).	Available evidence suggests that normal social or routine clinical contact with a CJD patient does not present a risk to healthcare workers, relatives and the community.
Used or fouled bed linen should be washed and dried in accordance with local practice.	No further handling or processing requirements are necessary.
For procedures involving exposure to the central nervous system e.g. lumbar puncture use disposable gloves, aprons and single use instruments. Disposable eye protection should be worn.	The distribution of TSE infectivity is likely to be concentrated in the central nervous system.
Only trained staff, aware of the hazards, should carry out such procedures.	To minimise the risk of accidental injury to healthcare workers during such procedures.
Spillages on the ward, including spillages of blood and cerebrospinal fluid, should be dealt with using standard infection control precautions; use of disposable gloves and apron. Mop up the spillage by using absorbent material and discard the waste (including cleaning tools such as mopheads) as clinical waste.	The 1998 guidance recommends that the spillage, including any cleaning tools, should be incinerated (mop-heads, gloves and aprons).
Pregnant patients should be managed using standard infection control procedures during childbirth.	Seek advice from the Infection Control Doctor; if the tissues are not needed for investigation, they should be discarded by incineration. Surgical instruments will need to be quarantined or discarded.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD) AND RELATED DISORDERS

SURGERY OR ENDOSCOPY *	RATIONALE
<p>All patients undergoing surgery or endoscopy must be asked whether they have ever been notified to be at increased risk of CJD or vCJD for public health purposes. This information must be documented in the patient's notes.</p> <p>In specialist cases where patient will have surgery on neural tissue eg intraneural neuro-endoscopic procedures or spinal cord and other neural tissues, a more detailed risk assessments needs to be carried out- contact Infection Control Doctor for guidance.</p>	<p>As per revised guidance July 2009.</p>
<p>Endoscopy – seek advice from Infection Control Doctor. Provision must be made for the quarantining* the instrument after its initial wash to remove gross soil. It needs to be quarantined by securely storing in a rigid, sealed container after use, until the diagnosis is confirmed. Specialist advice is available from The National CJD Surveillance Unit in Edinburgh or the HPA in Colindale, London.</p>	<p>The handling of re-usable instruments depends on a combination of the risk status of the patient, the tissue(s) involved in the procedure, and the type of CJD</p>
<p>Single use items should be used for surgical procedures and discarded and incinerated. Specialist advice should be sought for handling complex equipment, including endoscopes and other specialised equipment, such as ventilators and dialysis machines.</p>	<p>The handling of re-usable instruments depends on a combination of the risk status of the patient, the tissue(s) involved in the procedure, and the type of CJD</p>

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD and vCJD) AND RELATED DISORDERS

DEATH OF THE PATIENT	
<p>Normal infection prevention precautions should be taken and the body placed in a body bag. An "Infection control notification sheet" should be provided to the undertakers. Special precautions for burial or cremation are not necessary. Relatives should not be prevented from viewing the body or having superficial contact</p>	<p>The risk from handling the body is no different to when the patient was alive.</p>

Sample Collection and Labelling

ACTION	RATIONALE
<p>Samples from a patient with known, suspected or at risk of CJD must be marked with a Biohazard label and the laboratory forewarned that the sample is being sent for processing</p>	<p>Note: important to protect the confidentiality of the patient, and communication should be on a "need to know" basis.</p>

Clinical Procedures

General Measures

The use of standard infection control procedures during any intervention will reduce the risk of infection. There are particular concerns regarding surgical and other clinical procedures on known, suspect or at risk patients because of the onward transmission to other patients via contaminated surgical instruments.

- Clinical procedures on known suspect or at risk patients should, when possible, be planned carefully taking into consideration practicalities such as instruments, storage, handling decontamination or disposal.
- For non-invasive procedures, no specific precautions, other than those that would normally be applied to safeguard patient well-being are required.
- All staff directly involved in procedures on patients in the risk groups, or in the subsequent re-processing or disposal of potentially contaminated items, should be aware of the specific precautions and be adequately trained. Staff involved should be given adequate notification to allow for the necessary preparations.
- A list of names of staff involved in procedures on patients and subsequent re-processing or disposal of potentially contaminated items must be kept by the departmental manager i.e. Theatre Manager and Sterile Services Manager.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD and vCJD) AND RELATED DISORDERS

Precautions during Clinical Procedures on Known or Suspected Patients

- Wherever appropriate and possible the intervention should be performed in an operating theatre.
- Perform the procedure at the end of the list to allow normal cleaning of theatre surfaces before the next session.
- Involve only the minimum number of healthcare workers required to maintain safe staffing levels.
- Staff involved in the procedure or those likely to be exposed to splashes or spillages of potentially infective material must wear:-
 - Liquid repellent operation gown, over a plastic apron
 - Gloves
 - Disposable mask
 - Disposable Visor or goggles
- Maintain a one way flow of instruments
- Use single-use disposable surgical instruments and equipment where possible. Note if single use items are not available the instruments must not be re-used.
- Destroy all used single-use instruments and protective clothing by incineration.
- Sharps containers used during the procedure must be sealed and destroyed by incineration at the end of the procedure.
- Heavy duty rubbish bags must be used, and sealed prior to incineration at the end of the procedure – rubbish must be double bagged.
- Contact the CJD surveillance unit for advice on surgical procedures and for access to instruments to be used on patients with confirmed CJD.

Precautions during Clinical Procedures on At Risk Patients

Advice should be sought on individual patient episodes from the Infection Control Doctor.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD and vCJD) AND RELATED DISORDERS

*** Quarantining of Surgical Instruments, including endoscopes, in Sterile Services Department**

The following procedure must be used to decontaminate and quarantine surgical instruments used on known, suspect or at risk patients.

- Whenever practical, single use disposable instruments should be used.
- Manual handling of contaminated instruments should be kept to a minimum and automated decontamination processes should be used.
- Contaminated instruments should be processed through a covered ultrasonic bath and automated washer/disinfector in which no other instruments are being cleaned at the same time on two consecutive cycles.
- Following the processing of instruments the ultrasonic bath and automated washer disinfector must be run through on an empty cycle before being used again. Cleaning aids such as brushes must be disposed of by incineration.
- Surgical instruments should be cleaned as soon as possible after use. Staff cleaning instruments must wear appropriate protective clothing including gloves and either a visor or gloves and care must be taken to avoid penetrating injuries.
- Instruments must be placed in a disposable instrument tray and allowed to air dry. They must then be placed in an impervious rigid plastic container with a close fitting lid. The lid should be sealed with heavy duty tape (e.g. autoclavable tape) and labelled with the patient's identification (i.e. hospital number, name and date of birth), the surgical procedure in which the instruments were used and the name of the responsible person. In this Trust the designated responsible person will be the theatre manager responsible for the relevant theatre suite.
- The sealed box must be stored indefinitely until the outcome of any further investigation is known.
- Boxes for storage of quarantined equipment and access to a storage area for quarantined instruments can be arranged through:-
 1. Sterile Services Department Manager or Deputy, ext. 5711
 2. Theatre Manager or Deputy, Main Theatres 'F' Block, ext. 2489
- The instrument tray should be disposed of by incineration.
- If the patient is confirmed as suffering from CJD, the box and its contents must be incinerated without further examination. If an alternative, definitive diagnosis is confirmed, the instruments may be removed from the box, by the responsible person and sent to the sterile services department for processing in the usual way.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH KNOWN, SUSPECTED OR AT RISK OF CREUTZFELDT JACOB DISEASE (CJD) AND RELATED DISORDERS

Record of Action taken following Clinical Procedures on a Patient Known, Suspect or at Risk of CJD

The following records must be kept by the Theatre Manager/SSD Manager.

Theatre Manager

1. Hospital number, date of birth and name of patient.
2. Procedure carried out, instruments used and date of procedure.
3. Staff involved in procedure.
4. Record of untoward incidents.

SSD Manager

1. Method of how instruments were cleaned and quarantined.
2. List of staff involved in cleaning of instruments.
3. Record of untoward incidents.

Surface Decontamination and The Management of Spillages of Blood or Body Fluids from a Patient with CJD

Staff who are likely to be exposed to potential/actual spillages of blood or body fluids from a patient with known, suspected or at risk of CJD must follow the Trust infection control policy for management of spillages (section 3 page 6).

Waste Disposal

All material classified as clinical waste must be double bagged and sent for incineration.

After Death

On the death of a known, suspect or at risk patients the removal of the body to the mortuary should be carried out according to the Trust policy for last offices (section 1, page 27). It is recommended that the deceased patient is placed in a body bag prior to transportation to the mortuary.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH MENINGOCOCCAL MENINGITIS AND SEPTICAEMIA

Introduction

Neisseria meningitidis (meningococcus) is a gram negative bacterium which may cause a serious life threatening infection characterised by septicaemia and/or meningitis.

The meningococcus is carried in the nasopharynx of many healthy people without causing disease. The organism is transmitted by airborne droplet spread following close prolonged contact. The incubation period for disease is generally about 2 – 5 days.

Following the first 24 hours of appropriate antibiotic therapy the infected patient is considered no longer infectious. (If in doubt consult the microbiologist on call).

Management of patient with meningococcal infection during the first 24 hours of appropriate antibiotic treatment

ACTION	RATIONALE
<p>The patient should be cared for in a single room following admission until they have received 24 hours of treatment with appropriate antibiotic therapy.</p>	<p>To minimise the risk to other patients, particularly immunocompromised patients.</p> <p>To provide privacy and dignity for the patient and their relatives during this crucial time.</p>
<p>Surgical facemasks and eye protection should be worn by clinical staff undertaking procedures where there is a high risk of exposure to respiratory droplets/secretions. i.e.</p> <ol style="list-style-type: none"> 1. Nasopharyngeal suction and airway management during resuscitation. This applies to staff within 3 feet of the patient's mouth. Staff not involved in the procedure should stand outside the 3 feet range. (Until 24hours of appropriate antibiotic therapy completed). 2. By staff when performing fundoscopy. 	<p>To prevent the risk of cross infection by respiratory droplets/secretions.</p>

POLICY FOR THE MANAGEMENT OF PATIENTS WITH MENINGOCOCCAL MENINGITIS AND SEPTICAEMIA

ACTION	RATIONALE
No additional precautions are necessary beyond standard universal precautions (See Policy).	
Cases of meningococcal disease must be notified to the relevant CCDC by the attending Doctor.	In order that contacts of the patient can be followed up in the community
The patient/relatives should be advised of notification to the CCDC.	To keep the patient/relatives informed of this necessity and reduce anxiety.

* Consultant for Communicable Disease Control

Recommendations for Chemoprophylaxis for staff Exposed to Infectious Respiratory Droplets

HEALTH CARE WORKERS SHOULD WEAR SURGICAL FACEMASKS AND EYE PROTECTION WHEN CARRYING OUT PROCEDURES WHICH MAY RESULT IN EXPOSURE TO INFECTIOUS RESPIRATORY DROPLETS OR SECRETIONS

- Chemoprophylaxis is recommended only for those healthcare workers whose **mouth** or **nose** is directly exposed to infectious respiratory droplets/secretions from a probable or confirmed case of meningococcal meningitis/septicaemia during the first 24 hours of antibiotic therapy e.g. during airway management in an emergency resuscitation situation without the protection of a facemask. In most cases this implies a clear perception of actual physical contact with droplets/secretions.
- Chemoprophylaxis is not recommended without a clear history of exposure (as defined above). General medical or nursing care of cases should not be regarded as an indication for prophylaxis.
- Following exposure (as defined above), contact Microbiologist on-call for advice about access to prophylaxis.
- If prophylaxis is required the incident must be reported on HIRS (Hospital Incident Reporting Scheme) by the recipient Healthcare worker.

POLICY FOR THE MANAGEMENT OF SCABIES

Background**• Causative Agent**

Scabies is a condition caused by 'Sarcoptes scabiei', a burrowing mite 0.3mm-0.4mm in size.

• Clinical Features

The major symptoms and signs are confined to the skin. The commonest symptom is an intense itch particularly at night. The presentation of the rash depends on the immune status of the patient;

1. Classical scabies - the most common form, found in healthy people with a normal immune system.
2. Crusted or Norwegian scabies - occurs in immuno-compromised patients.
3. Atypical scabies - occurs in individuals whose immune system is immature or impaired.

• Incubation period

A person is infectious as soon as the mite is acquired even though there are no symptoms. Symptoms classically take 2-6 weeks to manifest but can appear sooner if an individual has had scabies previously. There are normally only a few mites present on an affected individual.

1. Classical Scabies**• Signs and Symptoms**

1. Intense itch, particularly at night
2. Burrows may be visible on flexor aspects of the wrists, on the fingers, palms, soles, toe webs and male genitalia.
3. A hypersensitivity rash which resembles excoriated eczema, affecting the limbs and torso but not usually on the face.

• Mode of Transmission

Direct skin to skin contact (for about 10 minutes) with an infected person e.g. from sharing a bed or holding hands. Poor hygiene is not a causative factor. Bed linen and other fomites are unlikely to transmit the infection.

POLICY FOR THE MANAGEMENT OF SCABIES

- **Diagnosis**

Diagnosis should be made by medical personnel with experience in this condition e.g. a Dermatologist. A definitive diagnosis is made by the microscopic examination of skin scrapings taken from a burrow.

Contacts

Normally contacts are defined as those people who have had close, prolonged (i.e. 10 minutes or so) skin to skin contact.

Once a decision has been made as to the treatment of contacts, the Infection Control team and Occupational Health Department will arrange for this to occur.

POLICY FOR THE MANAGEMENT OF SCABIES

Guidelines for Practice

ACTION	RATIONALE
Verify the diagnosis.	There may be other causes of itching dermatoses.
Inform Infection Control team if treatment of contacts is required.	To conduct a risk assessment and help identify contacts. To provide further information.
If a member of staff is affected inform the Occupational Health Department.	To help identify contacts and organise treatment as required.
Treat all linen as infected in accordance with hospital policy.	Transmission of classical scabies via fomites is unlikely but could occur.
Source isolation of the patient is not necessary.	See information on 'Mode of Transmission'. Isolation could be potentially harmful psychologically, as scabies has always been associated with a degree of stigma.
Treat the symptomatic case(s) as prescribed.	To eradicate scabies. Success will be enhanced if instructions regarding treatment are strictly followed.
Relatives and contacts who are not employed within the Trust must be referred to their own GP.	To obtain advice and treatment if necessary.

Everyone identified for treatment should be treated within the same 24 hour period.

2. & 3. If Norwegian/'Crusted' or Atypical Scabies is suspected please contact the Infection Control team for advice.

POLICY FOR THE MANAGEMENT OF LICE

Lice are wingless insects that need human blood to survive. There are about 500 different species of lice but only three of these use humans as their host, and each lives on a specific part of the body.

1. Head Lice

Background

- **Causative Agent**

Pediculus humanus capitis, a small wingless parasitical insect that lives on hair near the scalp.

- **Signs and symptoms**

1. Itchy scalp - this is due to an allergic reaction. Not always present, particularly in adults.
2. Louse droppings may fall onto the pillow and be visible as black specs.
3. Living lice are visible on the hair.
4. Nits - the egg cases may be present but that does not necessarily imply an active infection. Egg cases will stick to hair even when you have got rid of the lice, and eventually grow out.

- **Mode of Transmission**

Lice can walk from one head to another only when heads have sustained, immediate, contact for a minute or so. They cannot swim, jump, hop or fly.

- **Diagnosis**

Live, active lice must be seen to confirm active infection. Combing wet hair with a fine toothed comb ('nit' comb) will assist with detection.

POLICY FOR THE MANAGEMENT OF LICE

Guidelines for Practice

ACTION	RATIONALE
Verify the diagnosis. Only active infections require treatment.	There may be other causes of itching.
Treat affected individuals with insecticide as prescribed. Follow instructions carefully. Alcohol based lotions are normally preferred. Aqueous based lotions must be used for asthmatics and persons with eczema or dry skin conditions.	To eradicate the lice.
Repeat treatment after 7 days. Do not use the lotion more than once a week and for not more than 3 consecutive weeks.	Eggs are particularly resistant to insecticide treatments, so a second application is required to eradicate newly emerging lice from eggs not killed off by the initial application. Overuse of insecticide can lead to scalp irritation and absorption problems.
<p>'Wet-combing' can be carried out to assist with removal of the lice. (This involves washing the hair, covering the hair with large amounts of conditioner, combing the hair through with the ordinary comb, then thoroughly and precisely with a detector comb, wiping the comb between each combing action and removing any lice present). Compliance is imperative if insecticide is not used, and must be repeated for a minimum of 2-3 times a week for 2-3 weeks to be effective.</p>	<p>To assist with removal of the lice.</p> <p>Can also be used for individuals who are allergic to, or irritated by, the insecticides, or for those who refuse conventional insecticide treatments.</p>

POLICY FOR THE MANAGEMENT OF LICE

ACTION	RATIONALE
Treatment should be performed on all family members/contacts who have an active infection at the same time.	To prevent re-infection.
Isolation precautions are not necessary but may help maintain privacy during treatment.	Head lice are not easily transmitted from one patient to another.

2. Body Lice

Background

- **Causative Agent**

Pediculus humanus humanus, slightly larger than the head louse. It lives in clothing and goes on to the body only to feed.

- **Signs and Symptoms**

Bite marks usually occur opposite seams such as under collar or waistband and are extremely itchy. Usually result in characteristic long, linear scratch marks on the torso.

If the host is sensitised to louse faeces, this may cause a generalised rash and sneezing may sometimes result.

- **Mode of Transmission**

This occurs in overcrowded conditions by contact with infested clothing. To survive, body lice depend on the same clothes being worn for prolonged periods, washed in cool water and then reworn immediately.

- **Diagnosis**

Body lice can be seen by the human eye on the body and clothes.

POLICY FOR THE MANAGEMENT OF LICE

Guidelines for Practice

ACTION	RATIONALE
All clothing and bedding should be removed and washed in hot water (60°C or more) and be changed at least once a week, fifteen minutes in a hot tumble dryer is sufficient to destroy both lice and eggs.	To destroy the lice. Body lice will also die if clothing is not worn for 3 days, and provided clothes are changed once a week the young lice will not be able to hatch out of the eggs.
No treatment of the skin or isolation precautions are necessary.	Lice do not live on or attached to, the skin.

3. Crab (Pubic) Lice

Background

- **Causative Agent**

Pthirus pubis, are far more common than head lice. They live on coarse body hair, particularly pubic and axillary hair, but also on chest and facial hair and eyelashes. They are much broader and flatter than head or body lice.

- **Signs and Symptoms**

It can take 4-6 weeks for the host to react to the bite of the lice during which time they usually remain undetected.

Once sensitised, itching around the anus and vagina is severe.

- **Mode of Transmission**

They are transmitted by close physical contact and sexual contact. They may be passed easily where people are living in crowded conditions but cannot be transmitted on inanimate objects except perhaps on shared towels.

- **Diagnosis**

Crab lice can be seen by the human eye on coarse body hair.

POLICY FOR THE MANAGEMENT OF LICE

Guidelines for Practice

ACTION	RATIONALE
Verify the diagnosis.	There may be other causes of itching.
Treat affected individuals with an aqueous based insecticide. Treat all hair on the body except for the head.	To enable the chemical to be applied to sensitive parts of the body.
All clothing and bedding should be removed and washed in hot water (60 °C or more).	Crab lice on clothing and bedding are not transmitted to other people and can be removed by washing.
Isolation precautions are not necessary, but may help maintain privacy during treatment.	Crab lice are not easily transmitted from one patient to another.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

CONTENTS

1. Introduction
2. Identification of Outbreak of Viral Gastroenteritis
3. Ward closure
4. Re-Opening of the Ward
5. Decontamination of the Environment During and Outbreak of Viral Gastroenteritis
6. Additional Daily Cleaning During an Outbreak of Viral Gastroenteritis
 - a. The Environment
 - b. Patient Shared Equipment
7. Terminal Cleaning of a Ward following an outbreak of Viral Gastroenteritis
 - a. Task 1 – Sodexho Staff
 - b. Task 2 – W.S. Atkins Staff
 - c. Task 3 – Patientline Staff
 - d. Task 4 – Sodexho Staff and Task 5 – Nursing Staff
 - i. Sodexho Staff – Patient Bed Bays/Single Rooms
 - ii. Nursing Staff – Patient Bays and Single Rooms
 - iii. Sodexho Staff – Patient Toilet/Bathroom Facilities
 - iv. Nursing Staff – Patient Bathroom/Toilet Facilities
 - v. Sodexho Staff – Kitchen Areas
 - vi. Nursing Staff – Patient Equipment
 - vii. Sodexho Staff – all other areas
8. Chlor-Clean
9. Advice for Sodexho/Atkins/Patientline Staff During an Outbreak of Viral Gastroenteritis
 - a. Viral Gastroenteritis
 - b. Risks of Acquiring the Illness
10. Advice for Portering Staff
 - a. Transfer of Patients
 - b. Collection of Specimens
 - c. Food Trolleys
11. Advice for Domestic Staff - PSAs and Assistants
 - a. Environmental Cleaning
 - b. Staffing
 - c. Floors
 - d. Carpets
 - e. Curtains
 - f. Minimising the Risk of Cross Infection
 - g. For further advice please contact:
 - h. Patientline staff
12. Patient Information leaflet
13. Visitor information leaflet
14. Notice for Entrance to Ward 1 – Stop
15. Notice for Entrance to Ward 2 – Information
16. Hand Washing Notice
17. D & V Outbreak form
18. Record of Symptoms of Diarrhoea and Vomiting

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Introduction

Viral gastroenteritis is usually a mild self-limiting illness that spreads rapidly either by the faecal oral route or, possibly by the airborne route if patients are vomiting. It may affect patients, staff and visitors to the ward.

Identification of outbreak of viral gastroenteritisDefinition of an outbreak of viral gastroenteritis

- 3 or more cases of patients with vomiting and/ or diarrhoea (V & / or D), in which there are no “other” reasons* for the symptoms, particularly if the patients are in adjacent beds or in the same bay area.
- If staff or visitors are, **also**, affected with V & / or D, and had been symptomatic on the ward, this would be very suggestive of an outbreak of viral gastroenteritis.

“Other” reasons* could be

- The V & /or D are symptoms of a pre existing medical condition.
- Antibiotic therapy. (Current or in last few weeks.)
- Taking laxatives.
- PEG feeding.

Ward closure

Following a review of the individuals affected, symptoms or risk factors, the Infection prevention and Control Doctor or Consultant Microbiologist may recommend the ward is closed to new admissions until no further transmission is anticipated

If you suspect an outbreak of viral gastroenteritis contact an Infection Prevention and Control Nurse, via air call or Ext 2630, as soon as possible.

Out of hours (after 5pm, at weekends and bank holidays) the Microbiologist on call should be contacted as soon as possible via the switchboard.

Re-opening of the Ward

The outbreak team will review the situation on a daily basis. The ward will usually re-open 48 hours after the last new patients symptoms have started.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

ACTION	RATIONALE
<p>Inform a member of the Infection Prevention and Control team if 2 or more patients develop symptoms of diarrhoea and/or vomiting simultaneously for no known reason.</p>	<p>This may signify the onset of an outbreak of viral gastroenteritis. The Infection Prevention and Control team can be used as a resource to investigate, reduce and minimise the risks of cross infection.</p>
<p>If possible try to isolate the patients in side rooms or nurse affected patients in one area of the ward together.</p>	<p>To reduce the risk of cross infection.</p>
<p>Wear disposable apron and gloves when attending to patients with symptoms.</p>	<p>(See source isolation policy).</p>
<p>Wash hands with liquid soap and water.</p>	<p>Alcohol hand rubs have limited effects against some spores and viruses</p>
<p>Patients who develop symptoms of diarrhoea and/or vomiting should have a specimen of faeces sent to the laboratory for culture and sensitivity and electron microscopy (EM) as soon as possible following the onset of symptoms. Specimens must be labelled with an I log number. This will be given to the nurse in charge by the infection prevention and control nurse.</p>	<p>The heaviest viral load most frequently occurs in specimens taken at the commencement of the illness.</p> <p>I log number keeps all results together.</p>
<p>It is essential that all items of equipment which are shared by patients must be decontaminated between use.</p> <p>(See decontamination of environment section).</p>	<p>To reduce the environmental load of the virus and therefore reduce the risk of cross infection.</p>

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

ACTION	RATIONALE
Linen from infected patients must be placed in a pink bag and then a white linen skip bag.	To reduce risk of cross infection.
There must be no discharges or transfers of patients to other wards/departments or nursing/residential care (unless agreed with the infection prevention and control doctor) until the ward re-opens.	To prevent the risk of cross infection to other areas.
Nursing staff including bank and agency staff must be dedicated to the affected ward until the outbreak is over.	Viral gastroenteritis can affect staff as well as patients.
Staff who develop symptoms should refer themselves to the Occupational Health Department and should not return to work until 48 hours symptom free.	To prevent cross infection
Patients who are being discharged home should be informed of the potential risk of acquiring the illness and given the option to remain on the ward until the outbreak is over.	To reduce the risk of spread to the community.
Relatives should be kept to a minimum and advised of the risks of visiting. See visitor information letter.	To prevent further spread

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Decontamination of the Environment During an Outbreak of Viral Gastroenteritis

Norwalk like viruses are easily and rapidly spread from person to person through the environment. Communal areas and equipment for example, toilets and commodes must be cleaned rigorously and frequently to reduce the risk of cross infection.

General Points

- All staff involved in cleaning must wear a disposable plastic apron and disposable gloves.
- All cleaning cloths used must be disposable. Mops buckets and bowls must be decontaminated at the end of the task. *(Mop heads must be returned for laundering, buckets must be washed out with general purpose detergent and water, then dried).*
- Staff must use cleaning cloths/equipment in accordance with local colour coding. Cloths must be changed frequently during cleaning, for example, when becoming worn.
- Hoovering of carpets and floor buffing must not be undertaken during an outbreak of viral gastroenteritis
- After completion of the task remove gloves and apron and WASH YOUR HANDS according to Trust policy and then apply alcohol hand gel (Infection Prevention and Control Policy Manual; section 1. Page 2).

Environmental Cleaning Products to be used during an outbreak of viral gastroenteritis

General purpose detergent and hot water must be used to clean the floor surfaces.

Chlor-Clean 1 000 parts per million may be used for all other horizontal surfaces and equipment for the duration of the outbreak. *(See appendix I for directions on how to make up and use a solution of Chlor-Clean).*

Additional Daily Cleaning During an Outbreak of Viral Gastroenteritis

In order to control the spread of viral gastroenteritis it is essential that the following ADDITIONAL cleaning is undertaken.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

The Environment

The following areas must be cleaned a minimum of THREE times Daily during the course of the outbreak using a solution of Chlor Clean* disinfectant 1 000 parts per million.

- Locker tops and bed tables
- All toilet areas including flush/door handles.
- Hand wash basins particularly tap handles.
- The Sluice area – All horizontal surfaces.

Patient Shared Equipment

The following items must be cleaned between each patient use using a solution of Chlor Clean* disinfectant 1 000 parts per million.

- Bed pan holders
- Commodes

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Terminal Cleaning of a Ward following an Outbreak of Viral Gastroenteritis

The following protocol is listed in the order preferred by the Trust Infection Control Team

Task 1 - Sodexho Staff

The curtains must be removed from all beds and windows. This must be done in a systematic method that is, working from one end of the ward to the other. As the curtains are being taken down they must be placed (not thrown), into a wire cage that has been lined with a bag.

Task 2 - W.S. Atkins Staff

Clean light fixtures, air conditioning vents and any other high horizontal surfaces, using a general purpose detergent and a clean disposable cloth. Wash once with a wet cloth, rinse and wring the cloth, then wipe over surface again. Leave to air dry.

Walls that are visibly soiled or dusty, must also be cleaned.

Task 3 - Patientline Staff

All Bedside equipment, including console pad must be cleaned using a clean disposable cloth with general purpose detergent and water. Then wiped over with an alcohol wipe. *N.B. Equipment must be cleaned first with detergent and water prior to disinfection with the alcohol wipe as alcohol alone will not kill the virus*

If terminal cleaning is undertaken outside of the working hours of Patientline, this task is to be undertaken by nursing staff when mattresses are being cleaned.

Task 4 – Sodexho Staff and Task 5 – Nursing Staff must be undertaken concurrently

N.B. All disposable items of equipment at the bedside must be disposed of and following completion of cleaning replaced with new.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Sodexo Staff – Patient Bed Bays/Single Rooms

The following are to be cleaned with a 1000 parts per million solution of Chlor Clean, made up according to the manufacturers instructions and used in accordance with Trust Policy.

- Curtain rails/tracks
- All horizontal surfaces/ledges
- Patient lockers, inside and outside
- Patient tables
- Bed frames
- Bed lights
- Door handles
- Chairs
- Wash hand basins, including, mirrors /tile surround.
- External surfaces of soap/alcohol hand gel dispensers and paper towel dispensers.
- Bins
- Toilets /Showers and hand wash basins and door handles/plates, for en suite facilities

Floors – must be washed with general purpose detergent and hot water including skirting boards.
N.B. Do not use Chlor clean

Nursing Staff – Patient Bays and Single Rooms

All beds must be stripped of all linen before cleaning can commence and must not be remade until cleaning is completed.

The following must be cleaned with a 1000 parts per million solution of Chlor Clean, made up according to manufacturers instructions and used in accordance with Trust Policy.

- Mattresses and pillows. Pillows not covered with a suitable waterproof cover must be returned to laundry in a pink aquafilm bag
- Dynamic pressure relieving equipment, mattresses and cushions should be replaced with decontaminated equipment from Karomed
- Patient line equipment, (if patient line staff not available)
- Pod boxes (inside and out)
- Fridges in side rooms (inside and out) - (Doyle and Wilson wards only)

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Sodexho Staff – Patient Toilet/Bathroom Facilities

Clean with Chlor clean 1000 parts per million solution, made up according to manufacturers instructions and used in accordance with Trust Policy.

- Baths/showers/toilets , including aids and rails/hand wash basins/tile surrounds
- Soap/alcohol dispensers/paper towel dispensers and bins
- Door panels and handles
- Replace shower curtains (after completion of cleaning)

Floors – see above Task 4.

Nursing Staff – Patient bathroom /toilet facilities

Clean with Chlor Clean 1000 parts per million solution made up according to manufacturers instructions and used in accordance with Trust Policy.

- All patient equipment including bathing aids, hoists
- Hoist slings and slide sheets to be returned to laundry in a pink aquafilm bag

Sodexho staff – kitchen Areas

- All horizontal surfaces in the ward kitchen area, including trolleys, must be cleaned with general purpose detergent and hot water using a clean, disposable cloth. Wet the surface, rinse and wring the cloth and re-wipe the surface. Leave to air dry
- All vertical surfaces of equipment, for example, the fridge/microwave must be cleaned in the same way.
- Floors – see above.
- Equipment stored in the kitchen for example, bowls/buckets must be sent for decontamination and replaced with clean

Nursing Staff – patient Equipment

N.B. It is the responsibility of nursing staff to ensure that all patient equipment is decontaminated during the terminal clean of a ward closed due to viral gastroenteritis.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

The following Equipment may be decontaminated via the washer disinfecter in the Sluice.

- Bedpans and holders
- Urine bottles
- Commodes (if able to dismantle).
- Buckets
- Suction jars (used for oro-pharyngeal suction)
- Wash bowls
- Vomit bowls
- Sharps trays

The above and other items of patient equipment must otherwise be cleaned according to the following policy, using a solution of Chlor Clean 1000 parts per million, made up according to manufacturers instructions and used in accordance with Trust Policy.

Using a clean cloth, wet and wash the surface of the piece of equipment with a solution of 1000 parts per million Chlor Clean. Rinse and wring the cloth then wipe over the washed surface. The surface of equipment should then be dried with disposable clean paper towels.


Sodexo Staff – all other areas

All other areas should be cleaned according to the following chart

All horizontal surfaces at nurses station/offices	Chlor-clean solution
Telephones/computers	Chlor clean solution
Horizontal surfaces in sluice and Linen/treatment room	Chlor Clean solution
Horizontal surfaces in day room/staff room	Chlor clean solution
All surfaces of patient/visitor chairs*	Chlor clean solution
All floors	General purpose detergent and water.

- *Chairs that are covered by materials which can not be cleaned in accordance with above must be steam/dry cleaned according to manufacturers recommendations
- All bed/window curtains replaced

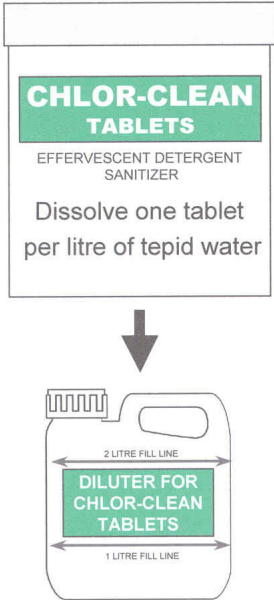
POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

South Manchester University Hospitals 
NHS Trust

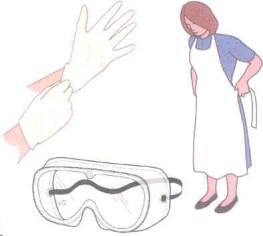

CHLOR-CLEAN*

(Combined detergent & disinfectant product)

Use for: Terminal Cleaning following discharge of a patient from “isolation” room AND during outbreak of viral gastroenteritis



Procedure:

1. Always wear Protective gloves and an apron. Use eye protection if necessary. 
2. Check expiry date on product. (see base of container)
3. Make up a CHLOR-CLEAN solution by adding 1 tablet to every litre of **Tepid Water**. This dilution makes a 1,000 p.p.m. available chlorine solution.
4. Leave the cap off the diluter until effervescence stops
5. When tablets have dissolved (3-4 minutes) use the solution to wash all surfaces to be cleaned and disinfected.
6. Change the solution when it becomes dirty. 
7. On exposed metal parts, wash off CHLOR-CLEAN solution with clean water and dry with paper towels.
8. Discard any remaining solution after use.

IMPORTANT:

1. Chlorine products will bleach fabrics and corrode metal.
2. Never use with other chemicals or mix with cleaning agents.
3. Refer to the COSHH information on the product label.
4. If in doubt about the use of **CHLOR-CLEAN** please contact your Infection Control Team on Ext: 2630 or via AIRCALL through hospital switch board

***CHLOR-CLEAN** is manufactured by **Guest Medical Limited** of Edenbridge, Kent. **01732 867466**

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS**Advice for Sodexo/Atkins/Patientline Staff During an Outbreak of Viral Gastroenteritis****Viral Gastroenteritis**

Viral gastroenteritis is usually a mild self-limiting illness that spreads rapidly, particularly in large communal areas such as schools or hospitals. Symptoms are vomiting and/or diarrhoea, which usually last for 24-48 hours after which most people make a complete recovery. When an outbreak of viral gastroenteritis is first suspected within the hospital it is necessary to take certain precautions to prevent the spread of the illness.

Risks of Acquiring the Illness

- The illness is spread by aerosol from vomit or faeces
- The staff group at high risk of acquiring the illness is those giving direct care i.e. nurses and doctors
- Domestic staff are less likely to get the illness working on the ward, because they do not have the same close contact with patients
- The staff groups with minimal risk of acquiring the illness are staff attending the ward infrequently and for short periods of time only
- It is important to note that at times when viral gastroenteritis is about in the hospital it is also likely to be about in the community
- All staff who have vomiting and/or diarrhoea must report to Occupational Health Department and if possible submit a sample for analysis

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

ADVICE FOR PORTERING STAFF**Transfer of patients**

During an outbreak of gastroenteritis it is important to stop patient movement from the affected wards around the hospital. Routine investigations will be suspended. However, if the patient needs urgent transfer/investigations (to be confirmed with the nurse in charge of the ward), it is important that portering staff take the following precautions:-

- Cover the chair/trolley with a clean sheet
- Wear disposable gloves/apron if handling the patient
- Remove gloves and apron before leaving the ward and wash your hands
- When transfer is complete place sheet in red plastic bag and place in laundry bag. If there is any strike through of fluid onto the surface it must be washed with general purpose detergent and a disposable cloth
- Wash hands before next activity/job

COLLECTION OF SPECIMENS

- Please arrange with nurse in charge of the ward to leave samples for collection/results/mail at the entrance to the ward

FOOD TROLLEYS

To be taken to the ward entrance and handed over to the PSA.

ADVICE FOR DOMESTIC STAFF - PSA'S AND ASSISTANTS**Environmental Cleaning**

- During an outbreak of viral gastroenteritis it is vital that the environment is kept scrupulously clean. This includes all horizontal surfaces especially locker tops/bed tables/toilets and bathrooms. These areas need cleaning at least once daily. Toilets will require a minimum of twice daily cleaning

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Staffing

- Extra staffing may be required during an outbreak (this will be negotiated by managers/Trust monitoring and the infection control team) and it is important that staff do not move from an affected ward to a none affected ward during an outbreak
- **cleaning of horizontal surfaces**, all horizontal surfaces (**except the floor**) must be cleaned with general purpose detergent and water using a clean disposable cloth for each bed area. The surface must then be wiped over using a solution of 1,000ppm of Haz tab (see Section 4, Infection Control Policy Manual). In some circumstances you maybe asked to clean horizontal surfaces using "chlor-clean" (a combination of general purpose detergent and disinfectant. Whatever method is used it is important that you follow the directions carefully and that if you are unsure you must contact your supervisor

Floors

- Floors must be cleaned using a white mop and bucket. There is no need to disinfect the floor but it must be thoroughly cleaned with soap and water

Carpets

- Carpets should be cleaned in the usual manner unless there is a spillage of vomit or faeces onto the carpet. Under these circumstances the excess spillage should be removed and the carpet then mopped with general purpose detergent and water

Curtains

- Once a bed becomes empty the curtains maybe taken down and sent for laundering. At the end of the outbreak all curtains must be changed before the ward re-opens

Minimising the Risk of Cross Infection

Remember to:-

- Change apron and gloves and wash your hands between tasks
- Do not work on other wards during the outbreak
- You are less at risk from acquiring the illness than nurses or doctors but if you do develop symptoms report to Occupational Health Department immediately

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

For further advice please contact:-

The Infection Control Nurses on ext. 2630 or air call via switchboard
The Infection Control Doctor on ext. 2885

Patientline Staff

- Patientline will be informed of wards affected by viral gastroenteritis by the infection team/ward staff
- During an outbreak Patientline staff will not be allowed onto the ward to activate/clean equipment
- At the end of the outbreak all units on the ward must be cleaned and all headsets replaced before the wards is re-opened

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Patient Information

Dear Patient,

At present there are some patients and staff on this ward who have or have had symptoms of vomiting and diarrhoea caused by a virus.

Usually this form of gastro-enteritis is a mild illness that may last between 24 and 48 hours. Not everybody on the ward will be affected, however, if you do develop symptoms, please tell the nurses caring for you.

While patients and staff continue to have symptoms this ward will remain closed to new admissions, and certain precautions will be taken to help prevent the spread to others.

Operations and investigations may have to be postponed, but the doctors will continually review your clinical condition.

The ward is still open to visitors, but relatives may wish to restrict their numbers to 2 visitors per bed. Visitors will be given a letter offering information and advice on how to reduce the risk of spread.

If you are well enough to be discharged to your own home, this will not be a problem. Discharges to other wards, hospitals or Nursing/Residential homes will be postponed to reduce the spread to other health care settings.

When discharged, your doctor will inform your GP that there has been a problem with diarrhoea and vomiting on the ward. However, if you start to have symptoms of diarrhoea and vomiting at home and need to contact your GP, you should inform him/her that you had recently attended a ward, which had problems with diarrhoea and vomiting.

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

WARD CLOSURE DUE TO VIRAL GASTROENTERITIS

Dear Visitor,

At present there are some patients on this ward who have symptoms of vomiting and diarrhoea, caused by a virus.

Usually this form of gastro-enteritis is a mild illness that may last between 24 and 48 hours.

The ward is still open to visitors but relatives may wish to restrict their numbers visiting for the time being. In particular we suggest:

- That visiting is strictly restricted to 2 visitors per bed.
- That you do not come to the ward if you or a member of your household is unwell with vomiting and /or diarrhoea.
- That you do not eat at the bedside or in the ward area.
- Children and elderly infirm people should not visit for the time being.
- That food, such as biscuits and fresh fruit, is not left out on top of lockers or bed tables.
- That bed tables and lockers tops are kept clear, so that they can be easily wiped by the domestic at least twice a day.
- That personal laundry may be taken home, placed directly into a washing machine and washed separately from other laundry on the hottest recommended temperature setting.
- That it is not recommended to take heavily soiled personal laundry home for washing. (**Please speak to the nurse in charge**)

The virus can be easily spread from person to person and we recommend that all **visitors should wash their hands before leaving the ward.**

Ward closure

STOP

**Please read the information
before entering
this ward.**

Ward closure due to viral gastroenteritis

Please speak to nurse in charge before entering the main ward.

All visitors please read.

At present there are some patients on this ward who have symptoms of vomiting and diarrhoea, caused by a virus.

Usually this form of gastro-enteritis is a mild illness that may last between 24 and 48 hours.

The ward is still open to visitors but relatives may wish to restrict their numbers visiting for the time being.

- **In particular, visiting is strictly limited to 2 visitors per bed.**
- **That you do not come to the ward if you or a member of your household is unwell with vomiting and / or diarrhoea.**
- **Children and elderly infirm people should not visit for the time being.**

The virus is spread easily from person to person and we recommend that all visitors **should wash their hands before leaving the ward.**

*(To be placed on **outside** of closed ward door, under ward closure sign)*

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

Ward closure due to viral gastroenteritis

Please speak to nurse in charge before entering the main ward.

All visitors please read.

At present there are some patients on this ward who have symptoms of vomiting and diarrhoea, caused by a virus.

Usually this form of gastro-enteritis is a mild illness that may last between 24 and 48 hours.

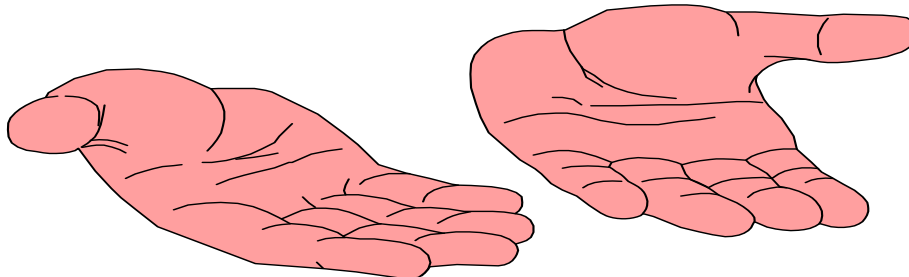
The ward is still open to visitors but relatives may wish to restrict their numbers visiting for the time being.

- **In particular, visiting is strictly limited to 2 visitors per bed.**
- **That you do not come to the ward if you or a member of your household is unwell with vomiting and / or diarrhoea.**
- **Children and elderly infirm people should not visit for the time being.**

The virus is spread easily from person to person and we recommend that all visitors **should wash their hands before leaving the ward.**

(To be placed on outside of closed ward door, under ward closure sign)

**Have you washed your hands before you leave this ward?
If not please use the alcohol hand gel**



Visitors

If you or anyone else in your household have diarrhoea and/or vomiting, **please do not visit the ward** again until you have had 48 hours without symptoms.

Staff

Please try to avoid visiting other wards. Remember to report to Occupational Health if you develop diarrhoea and/or vomiting, and to remain off work until you have had 48 hours without symptoms.

If you would like further advice please ask the nurse in charge of the ward.

(Place on inside of closed ward door)

I Log No

POLICY FOR THE MANAGEMENT OF PATIENTS WITH VIRAL GASTROENTERITIS

RECORD OF SYMPTOMS OF DIARRHOEA AND VOMITING

WARD **REPORTED BY** **DATE**
 **TIME**

Name and DOB	Date symptoms started (am/pm)	Date of admission	Location on ward when symptoms started (bed No)	Date										Med conditions, ABs, LAX	Date spec sent	

Policy for the Control of Multi-Resistant Gram Negative Bacteria

Introduction

A gram-negative bacteria is said to be multi-resistant when it is resistant to two or more antibiotics. Multi resistant Gram-negative bacteria (MR-GNB) include extended spectrum betalactamase producing organisms (ESBL – usually *Escherichia coli* or *Klebsiella* species and Amp C producers – usually *Serratia*, spp. coliforms, and *Citrobacter* spp), multi-resistant *Acinetobacter* species and multi-resistant *Enterobacter* and *Pseudomonas* species. These organisms are being isolated more commonly from clinical specimens of the hospitalised patients who have received multiple courses of broad spectrum antibiotics in the past.

- ESBL-producing coliforms are resistant to-cephalosporins and they are frequently resistant to many other antibiotics including ciprofloxacin and aminoglycosides.
- Amp C producing gram negatives are resistant to third generation cephalosporin's i.e cefoxitin , β -lactam- lactamase combination i.e co amoxiclavulanate /piperacillin - tazobactam and they are frequently resistant to many other antibiotics including ciprofloxacin and aminoglycosides.
- Multi-resistant *Acinetobacter* are defined as isolates which are resistant to any aminoglycoside and to any third generation cephalosporin. Some multi-resistant *Acinetobacter* strains are also resistant to carbapenem antibiotics.
- Multi-resistant *Pseudomonas* are resistant to at least two of the following: ceftazidime, piperacillin / tazobactam, gentamicin (or other aminoglycoside) and ciprofloxacin. Multi-resistant *Pseudomonas* strains are occasionally resistant to carbapenem antibiotics.

Multi-resistant Gram negative bacteria are detected in the laboratory by isolation from clinical specimens where they may occur as colonisers or true pathogens. Multi-resistance in these organisms limits the therapeutic options available when they cause significant infections, such as septicaemia , pneumonia and post surgical sepsis. In many instances, there may be no oral antibiotic treatment available.

The risk of acquisition with multi-resistant gram–negative bacteria for patients include:

- Injudicious antibiotic usage particularly broad spectrum agents.
- Prolonged hospital stay
- Admission to ICU, renal or haematology units.

Transmission of MR-GNB

Transmission in hospitals mainly occurs on the hands of health care workers which have been contaminated by contact with colonised or infected patients and or contaminated surfaces or fomites. Gram-negative bacteria may contaminate the environment around a patient and survive for several days. Environmental contamination is increased when patients have diarrhoea or colonised skin lesions.

Policy for the Control of Multi-Resistant Gram Negative Bacteria

Measures to prevent transmission

- Isolate the patient if possible.
- Effective hand hygiene by all staff before and after each patient contact (see hand hygiene policy)
- All patient shared equipment decontaminated appropriately between each patient use. (See decontamination policy)
- High standards of environmental cleaning maintained at all times.

Infection Prevention and Control Measures

Whether a patient with MR-GNB requires isolation must be based on risk assessment. Their isolation will depend on the characteristics of the infecting organism, the nature and severity of the infection, the susceptibility of others and the individual needs of the patient. The infection prevention and control team will determine the management / isolation of the patient in consultation with the patient's clinical team. The precautions adopted must be clearly documented in the patient's care plan, reviewed regularly, and reflect the care the patient requires.

Notification / surveillance

Any isolates of MR-GNB are notified to the Infection Prevention and Control Team (IPCT), who will discuss the result and patient management with the clinician caring for the patient. The number of MR-GNB in the critical care areas are reported monthly to the critical care group.

Outbreak Control

For MR-GNBs, the infection prevention and control team will determine if an excess of cases has occurred in any locality. Typing of isolates will be agreed on by Consultant Microbiologist. Enhanced infection prevention and control measures will depend on the unit in which the cases occur; the layout of the unit and the extent of the outbreak. The infection Prevention and control team will manage the outbreak in consultation with the clinicians on the ward / unit. If an outbreak meeting is called the outbreak team would then agree the management of the outbreak and whether extra screening of patients / the environment may be required. (See Hospital Outbreak Policy)

REFERENCES

Working party guidance on the control of multi-resistant Acinetobacter outbreaks 2006
http://www.hpa.org.uk/infections/topics_az/acinetobacter_b/guidance.htm

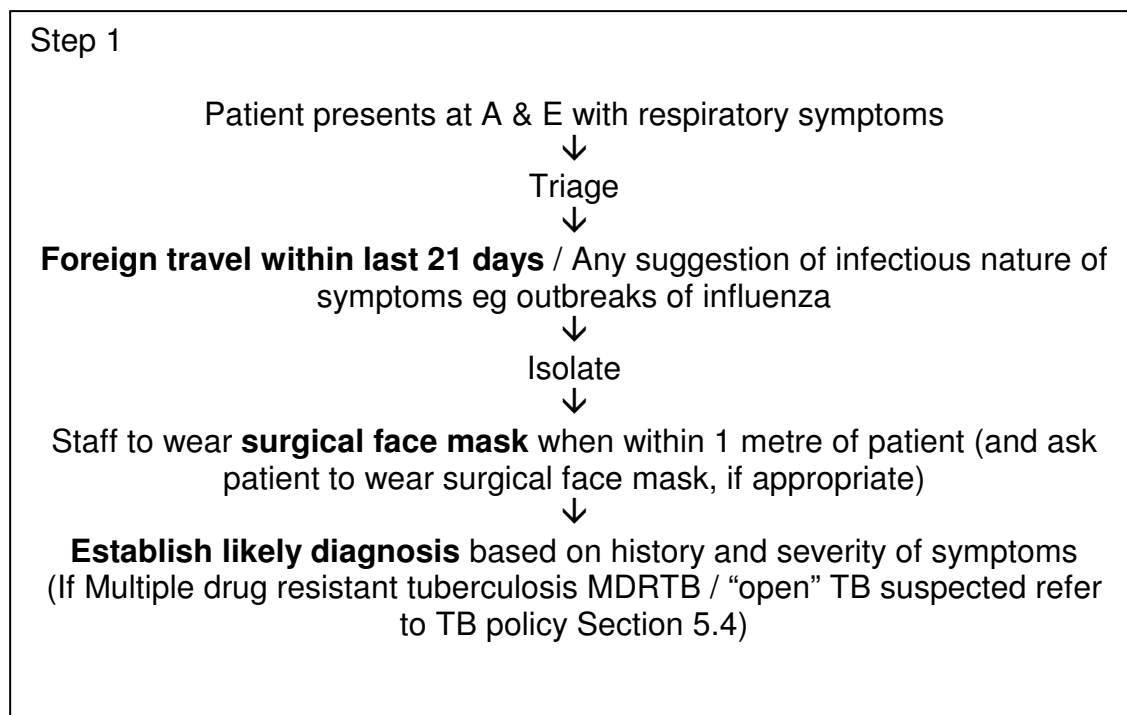
HPA. Investigation into multi-drug resistant ESBL producing Escherichia coli strains causing infections in England http://www.hpa.org.uk/hpa/publications/esbl_report_05/

Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

Introduction

Many patients will attend A & E with respiratory symptoms. Differentiating between patients with non infectious respiratory symptoms **from** patients with respiratory symptoms that could be infectious in nature, is difficult, and is guided by the presentation, the clinical history, travel history, the physical examination of the patient and laboratory investigations..

Whilst that diagnosis is being established, health care workers must be provided with information which will enable them to manage the patient in such a way as to prevent or reduce the risk to themselves and of cross infection to others. Healthcare Workers must therefore have information to enable them to decide when and which type of personal protective equipment should be worn to keep them and others safe. The following policy is designed to provide that guidance.



Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

Step 2 Immediate precautions / actions based on likely diagnosis	
↓ 1	↓ 2
<ul style="list-style-type: none"> ▪ Influenza (Seasonal or pandemic) ▪ (Meningococcal meningitis - Refer to policy Section 5.9) ▪ Chicken pox. ♦ Panton valentine leukocidin (PVL) <i>Staphylococcus aureus</i> chest infection ▪ Measles / whooping cough ▪ Respiratory syncytial virus 	<ul style="list-style-type: none"> ▪ Avian Influenza ▪ SARS ▪ Viral haemorrhagic fever (VHF) ▪ Pneumonic plague ▪ Diphtheria ♦ MDR TB
Isolation in single room	Isolation in designated rooms on Clinical Decisions Unit (CDU) Relatives & friends who accompany patient to go to isolation room Keep record of household contacts
Effective hand hygiene is crucial to prevention of cross and self infection.	Effective hand hygiene is crucial to prevention of cross and self infection.

Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

Step 3	
1	2
<p>Personal Protective Equipment (PPE)</p> <ul style="list-style-type: none"> ▪ For direct clinical care use gloves and apron. ▪ Use surgical face mask and eye protection if patient is coughing 	<p>Personal Protective Equipment (PPE)</p> <ul style="list-style-type: none"> ♦Wear FFP3 mask – specially fit-tested for the individual staff member ♦Face visor ♦Cap ♦Full length water repellent long sleeved, disposable gown ♦Latex or nitrile gloves (or sterile, depending on procedure)
<p>Patient can be resuscitated in resuscitation bay.</p>	<p>If patient requires resuscitation, a senior A & E doctor must decide whether to use resuscitation bay 1 or transfer resuscitation equipment to CDU room</p>
	<p>Ambulance staff involved in the patient transfer may be advised to return to their vehicle and await further instructions.</p>
	<p>Inform the Infection Control Doctor / Consultant Microbiologist & others (see page 8) IMMEDIATELY</p>
<p>Inform department consultant and nurse in charge of likely diagnosis. During pandemic influenza, inform the duty manager (bleep 400) if being admitted and diagnosis is swine flu.</p>	<p>Inform the Department Consultant on call & Nurse in Charge and duty manager (bleep 400) IMMEDIATELY</p>

Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

Step 4	
<p>Disposal of clinical waste / laundry / CSSD</p> <ul style="list-style-type: none"> ♦Dispose of all waste into yellow clinical waste bag. Seal top once $\frac{3}{4}$ full ♦Put all laundry in pink water- soluble bag and then in a white linen bag 	<p>Disposal of clinical waste / laundry / CSSD</p> <ul style="list-style-type: none"> ♦Dispose of all waste into yellow clinical waste bag. Label as high-risk. Seal top once $\frac{3}{4}$ full and store in patient's room awaiting prompt disposal. ♦Double bag all laundry in pink water- soluble bag, label as high risk then place in a white linen bag. Store in clinical waste room ♦It is NOT necessary to use disposable crockery or cutlery.
1	2
<p>Transferring to another department</p> <ul style="list-style-type: none"> ♦Only if clinically indicated and approved by Consultant Microbiologist ♦Inform the department of the imminent transfer Ensure porter and receiving staff are aware of necessary PPE if handling patient ♦Patient is asked to cover mouth with tissue when coughing or wear a surgical mask ♦The chair/trolley needs to be decontaminated following the transfer 	<p>Transferring to another department</p> <ul style="list-style-type: none"> ♦Only if clinically essential and approved by Consultant Microbiologist ♦Inform the department of the imminent transfer Ensure porter and receiving staff are aware of necessary PPE if handling patient ♦Patient is asked to wear surgical mask. ♦The chair/trolley needs to be decontaminated following the transfer
<p>Decontamination of room after discharge</p> <ul style="list-style-type: none"> ♦Staff to wear PPE ♦No wall washing. ♦All horizontal surfaces within isolation area to be cleaned with Chlorclean solution (1000ppm). ♦Use a clean, disposable cloth for cleaning and then dry thoroughly. Discard disposable items left in room. ♦Wash floors with multipurpose detergent. ♦Sharps containers must be sealed and disposed of safely. ♦Use disposable equipment and washable mop heads to decontaminate area. 	<p>Decontamination of room after discharge</p> <ul style="list-style-type: none"> ♦Staff to wear FFP3 mask while cleaning. ♦ Wall washing required. (unless major outbreak in community and not practical to arrange) ♦Use a clean, disposable cloth for cleaning and then dry thoroughly. ♦Discard disposable items left in room. ♦Wash floors with multipurpose detergent. ♦Sharps containers must be sealed and disposed of safely ♦ Use disposable mop heads and disposable equipment for decontamination in area.

Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

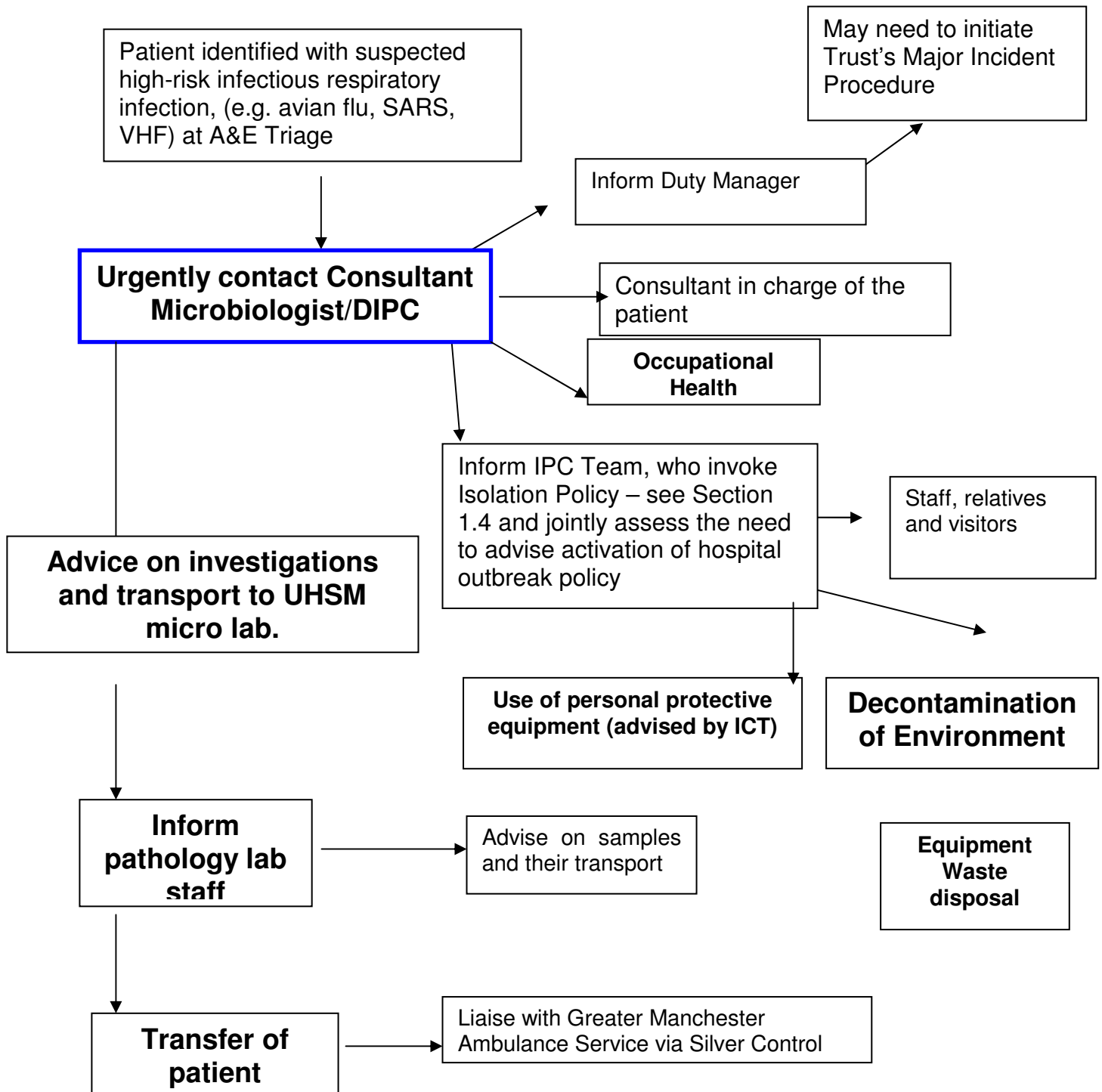
Summary of actions for suspected High Risk Situations (e.g. MDR TB, SARS, Avian

Actions	Information
Notify Control of Infection Consultant (Consultant Microbiologist)	Dr Isalska or Consultant Microbiologist on-call. Telephone 2885 or contact via switchboard
Notify Control of Infection Nurse	Telephone 2630 or contact via switchboard
Personal Protective Equipment	Use full respiratory precautions until diagnosis confirmed. Use recommended protective mask (see page 8) for all staff entering the room Put a surgical mask on the patient, if he/she will tolerate this Always use disposable gloves and wash hands after removal and use alcohol hand gel afterwards Wear goggles or visor (ordinary spectacles are insufficient) Plastic apron
Hand Hygiene	Apply strict hand hygiene (e.g. frequent hand washing or use of alcohol hand gel), particularly after contact with body fluids (e.g. respiratory secretions, urine, faeces including after glove removal). Alcohol hand gel must be used on visibly clean hands. Hands which are soiled must be washed thoroughly with soap and water. Washing removes latex and decreases risk of level of allergy.
Isolation of the patient	If not yet admitted to hospital – urgently discuss with Control of Infection Doctor about possibility of direct referral to Specialist Isolation Unit. Single room, preferably with negative pressure ventilation (suitable accommodation is to be provided in the Clinical Decisions Unit). Hang appropriate warning signage on the door; warn other units if patient must
Laboratory samples	Ensure patient information on all samples Label requests with Ilog number Package in hazard bag and then into metal outer box or secure transport box (advice from micro department ext 4772)
Relatives and visitors	Visiting should only be if absolutely necessary. Note name and date of visit. Provide with protective mask, gloves, goggles and apron. Advise on handwashing and advise against sharing food or utensils.
Waste	Clinical waste disposal – into yellow bags- ensure no leakage. Sharps into sharps bins. Laundry into red alginate bag and then outer white bag.
Terminal cleaning	Full protective clothing for the individual undertaking the task, as listed above. Body fluid spillages – wear gloves, apron and respiratory protection and mop up with disposable paper towel and discard; then 10,000 ppm chlorine. Final surface decontamination using 1000ppm chlorine.
Relatives and visitors	Visiting should only be if absolutely necessary. Note name and date of visit. Provide with protective mask, gloves, goggles and apron. Advise on handwashing and advise against sharing food or utensils.
Waste	Clinical waste disposal – into yellow bags- ensure no leakage. Sharps into sharps bins. Laundry into red alginate bag and then outer white bag.
Terminal cleaning	Full protective clothing for the individual undertaking the task, as listed above. Body fluid spillages – wear gloves, apron and respiratory protection and mop up with disposable paper towel and discard; then 10,000 ppm chlorine. Final surface decontamination using 1000ppm chlorine.

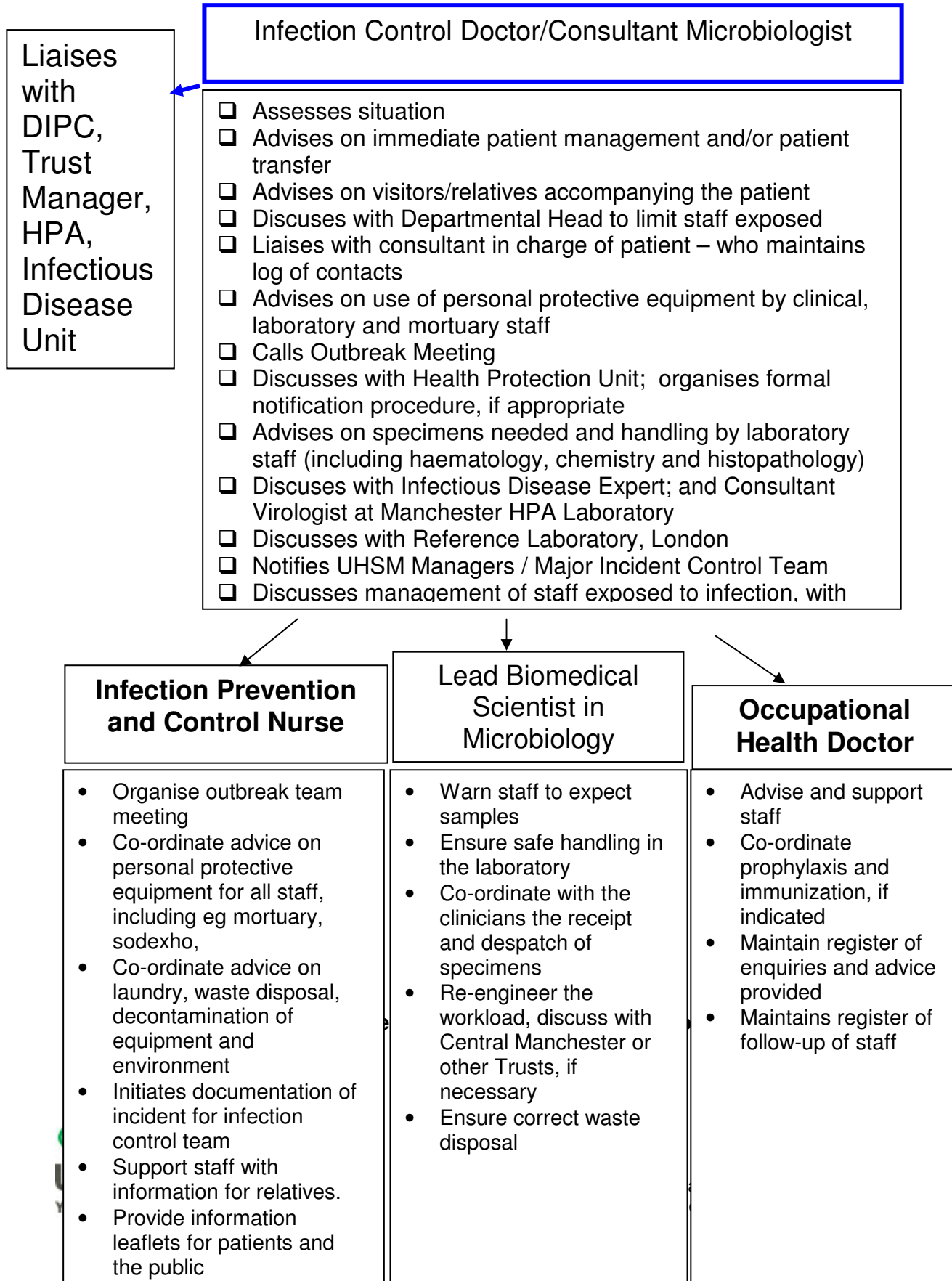
Influenza, Diphtheria, UHF)

Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

Flow chart of process: for suspected high-risk infectious respiratory virus (e.g. SARs, Avian Influenza)



Summary of responsibilities



Policy for the Management of Patients attending / admitted via the Accident and Emergency (A & E) department with suspected infectious Respiratory symptoms

INTRODUCTION

Viral Haemorrhagic fevers (VHF) are potentially severe and life-threatening diseases caused by a range of viruses. Four agents of VHF are of concern in the UK because of possible person-to-person spread: these are **Lassa, Ebola, Marburg** and **Crimean/Congo Haemorrhagic fevers**. The incubation period for these VHF's ranges from 3-21 days and initial symptoms include fever, malaise, headache and muscle and joint pain. Nausea, vomiting and diarrhoea may also occur. Severe disease manifests itself with bleeding into the skin, from body orifices or into internal organs.

The viruses are endemic in a number of parts of the world, most notably Africa, Asia, parts of South America and some rural parts of the Middle East and Eastern Europe. Environmental conditions in the United Kingdom do not support the natural animal reservoirs or insect vectors of any of the viruses; however cases of VHF are occasionally imported into the UK.

For those viruses that can spread from person-to-person, there is a risk of transmission to healthcare or laboratory staff. Strict infection control precautions are required to protect those who may be exposed. The viruses may also be spread by accidental inoculation from needlestick injury or exposure of broken skin or mucous membranes to infected blood or body fluids.

Patient assessment and categorisation

In the UK, most patients who could have a VHF are likely to present to Accident and Emergency Departments either directly or via their General Practitioner. Patients with non-specific fever are far more likely to have malaria, typhoid or non- VHF viral illness than VHF. It is difficult to make a firm diagnosis solely on clinical grounds, so epidemiological evidence is essential in assessing a feverish patient with a travel history suggestive of VHF. The suggested checklist should be used for the assessment of cases of suspected VHF (see appendix 1).

Clinicians should immediately telephone microbiologist on call to seek advice.

CONFIRMED CASES SHOULD BE MANAGED IN A HIGH SECURITY INFECTIOUS DISEASES UNIT.

Currently the two centres in the U.K. are at Newcastle General Hospital, (with plans to move to the Royal Victoria Infirmary, Newcastle in 2010) and the Royal Free Hospital, London.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

Most patients who may have VHF presenting early in the course of disease should be managed in standard isolation with standard precautions whilst the patient is being assessed in the Emergency Department. The purpose of risk assessment and categorisation is to provide efficient and timely management for patients, while affording maximum protection for the laboratory and clinical staff involved. **For this purpose, patients are assigned to one of three risk groups; low, moderate or high.**

Good infection control standard precautions, careful handling of personal protective equipment and hand hygiene are important in preventing transmission.

Risk categories

Low risk	Febrile patients who have; <ul style="list-style-type: none"> • not been in known endemic areas before the onset of illness, or, <ul style="list-style-type: none"> • been in endemic areas, (or in contact with a known or suspected source of VHF), but in whom the onset of illness was more than 21 days after their last contact with any potential source of infection. (Appendix 2)
Moderate risk	Febrile patients who have; <ul style="list-style-type: none"> • been in an endemic area during the 21 days before the onset of illness, but who have none of the additional risk factors which would place him or her in a high risk category. (appendix 2) or, <ul style="list-style-type: none"> • not been in a known endemic area, but who may have been in adjacent areas or countries during the 21 days before the onset of illness, with organ failure and/or haemorrhage which could be due to a VHF and for which no alternative diagnosis is currently evident.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

High risk	<p>Febrile patients who:</p> <p>a) have been in an endemic area during the three weeks before illness and :</p> <ul style="list-style-type: none"> • have lived in a house or stayed in house for more than 4 hours where there were ill, feverish persons known or strongly suspected to have VHF; <p>or</p> <ul style="list-style-type: none"> • took part in the nursing or caring for ill, feverish patients known or strongly suspected to have VHF, or contact with the body fluids or tissue of the dead body of such a person; <p>or</p> <ul style="list-style-type: none"> • are a laboratory, health or other worker who has, or had been likely to have come in contact with the body fluids, tissues or the body human or animal known or strongly suspected to have VHF; <p>or</p> <ul style="list-style-type: none"> • were previously categorized as moderate risk, but who have developed organ failure and/or haemorrhage. <p>b) have not been in an endemic area but during the three weeks before illness they:</p> <ul style="list-style-type: none"> • cared for a patient or animal known or strongly suspected to have a VHF or came in contact with the body fluids, tissue or dead body of such patient or animal; <p>or</p> <ul style="list-style-type: none"> • handled clinical specimens, tissues or laboratory cultures known or strongly suspected to contain the agent of VHF. <p>HIGH RISK CASES SHOULD BE CARED FOR IN A HIGH SECURITY INFECTIOUS DISEASES UNIT (see p.96)</p>
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(Source: Management and Control of Viral Haemorrhagic Fevers 1996 HPA)

IF ANY RISK OF VHF THE PATIENT SHOULD BE TRANSFERRED TO DESIGNATED ISOLATION ROOM (ENSUITE) IN A+E. DO NOT MOVE PATIENT UNTIL DISCUSSED WITH MEDICAL MICROBIOLOGIST.

IF PATIENT REQUIRES INTENSIVE CARE SUPPORT THIS MAY BE INSTIGATED AND CONTINUED IN A+E.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

Clinicians should seek the help and advice of the Consultant Microbiologist who will liaise with the Consultant in Infectious Diseases on-call at North Manchester General Hospital (NMGH) in determining categorization of risk.

INITIAL MANAGEMENT

Whilst awaiting further advice and risk category, use Personal Protective Equipment (PPE) when attending to the patient, collecting specimens or disposing of waste.

- Plastic Apron
- Disposable gloves
- Surgical Mask
- Visor

These should be disposed of prior to leaving the room and disposed of as clinical waste.

Hands should be washed after removal of PPE.

If clinically avoidable, do not cannulate the patient.

It is essential that tests for Malaria are undertaken first as Malaria is the most common diagnosis in suspected VHF cases.

CARE MUST BE TAKEN WHEN OBTAINING SPECIMENS (see below)

Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded for surveillance purposes.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

LOW RISK PATIENTS

ACTION	RATIONALE
<p>Clinician should contact On-call Microbiologist at UHSM before sending ANY (blood or other) samples to the lab.</p>	<p>The Microbiologist will</p> <ul style="list-style-type: none"> • be involved with risk assessment, • notify pathology departments to expect specimens, • advise the manner for safe processing, • Inform the Health Protection Unit.
<p>Patients should be managed in a single room with door closed.</p>	<p>To prevent transmission.</p>
<p>Personal protective equipment should be used for all activities which involve patient contact. These should be removed and disposed of as clinical waste within the room.</p> <p>These include;</p> <p>Disposable aprons and gloves. (See appendix 3 for details.)</p>	<p>To prevent cross contamination</p>
<p>strict hand hygiene precautions must be undertaken before and after each patient contact and on leaving room.</p>	<p>To prevent cross contamination</p>
<p>All waste to be treated as clinical waste and disposed of accordingly.</p> <p>Linen to be treated as infected and placed in a red water soluble bag before being placed in linen bag.</p>	<p>To prevent cross contamination</p>
<p>Pyrexial patients require a blood screen for Malarial parasites.</p>	<p>To ensure early diagnosis and treatment if necessary.</p>

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

MODERATE RISK PATIENTS

ACTION	RATIONALE
Wait for result of malaria screen. If negative, discuss with microbiologist about need to transfer patient.	To prevent cross contamination
Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded.	For surveillance purposes.
Medical Microbiologist will contact on call Infectious Disease Consultant at North Manchester General Hospital to seek help and advice in categorizing risk and to discuss possible transfer of patient to North Manchester General Hospital for ALL investigations.	The microbiologist will <ul style="list-style-type: none"> • Be involved with risk assessment • Inform Health Protection Unit.
Once risk categorized, only a clinician competent in phlebotomy should obtain blood samples. Only a blood test for Malaria should be sent initially. FURTHER BLOOD SAMPLING SHOULD ONLY BE UNDERTAKEN ON THE ADVICE OF THE ON-CALL MICROBIOLOGIST OR NMGH. Labels on bottles must be filled out prior to venepuncture as per Trust Policy.	To prevent exposing staff to unwarranted risks

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

ACTION	RATIONALE
<p>Strict isolation procedures should be implemented while decision on transfer is awaited.</p> <p>Patients should continue to be nursed in a single room and must not leave the room. A notice indicating that visitors must ask permission before entering the room should be attached to the door.</p> <p>There should be no visitor access unless they have had previous extensive exposure (e.g. Partner) prior to arrival in Hospital.</p> <p>Staff should be kept to a minimum that need to attend the patient. Usually one nurse, one doctor.</p> <p>A formal record of all contacts attending the patient should be maintained. (E.g. relatives, staff, doctors, porters and AHP)</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>Appropriate Personal Protective clothing should be worn, (See appendix 3)</p>	<p>To prevent exposing staff to unwarranted risks.</p>
<p>Strict hand hygiene precautions must be undertaken after each task, before and after each patient contact and on leaving room.</p>	<p>To prevent cross infection.</p>
<p>All linen should be treated as clinical waste and placed in a clinical waste bag. This should be tied and then double-bagged into a second clinical waste bag for immediate disposal by incineration under supervision.</p>	<p>To prevent exposing staff to unwarranted risks.</p>
<p>All disposable clinical waste should be placed in clinical bag. This should be double bagged into second clinical waste bag for immediate disposal by incineration under supervision.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>All sharps and equipment for blood taking should be placed into a dedicated sharps box in room for immediate sealing and disposal by supervised incineration.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>If a patient is to be transferred to NMGH or a High Security Infectious Disease Unit this will be undertaken as a category III removal. Any special needs will be advised by the Clinician in NMGH.</p>	<p>To prevent exposing staff to unwarranted risks.</p>
<p>Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded.</p>	<p>For surveillance purposes.</p>

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

HIGH RISK - PATIENT WILL BE TRANSFERRED TO A HIGH SECURITY INFECTIOUS DISEASES UNIT.

Clinician will contact On-call Medical Microbiologist who will liaise with the Health Protection Unit and North Manchester General Hospital to advise regarding Patient transfer.

Pending transfer, the patient should be kept in strict isolation. Further advice should be sought from the Microbiologist.

Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded for surveillance purposes.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

OBTAINING AND TRANSPORTING OF SPECIMENS

Obtaining and handling of laboratory specimens is the most common cause of secondary cases of VHF in a health care setting.

ACTION	RATIONALE
If unable to transfer the patient, The Medical Microbiologist will already have contacted laboratory to alert them regarding blood processing.	To ensure experienced staff only process sample.
<p>Only EDTA Blood for Malaria screen should be taken initially, as advised by Medical Microbiologist.</p> <p>The bloods should only be taken by someone competent in phlebotomy using a vacuum blood sampling system, wearing the protective clothing recommended.</p> <p>All equipment used should be placed in dedicated sharps container in room for immediate sealing and disposal. (This includes small swabs and syringes if used.)</p>	<p>To ensure early diagnosis and treatment</p> <p>To minimize sharps injury to Health care worker</p>
Prior to venesection blood bottles should be labelled (including biohazard stickers)	To minimize handling of specimens especially if outer contaminated
<p>Bloods should be transported by a member of staff to laboratory double bagged and within a rigid sealable plastic container (available from the Microbiology lab).</p> <p>Specimens should never be sent via pneumatic system.</p>	To lower risk of transmission.
Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded.	For surveillance purposes.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

LAST OFFICES

PLEASE SEEK MICROBIOLOGIST ADVICE REGARDING LAST OFFICES

Post mortem should not be performed on a patient with confirmed VHF. Where a patient is suspected of having VHF, it may be necessary to undertake some diagnostic tests on public health grounds.

Do not remove lines or devices until discussed with Medical Microbiologist.

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

DECONTAMINATION AND DISINFECTION FOLLOWING DISCHARGE

ACTION	RATIONALE
<p>The Nursing Staff that have already had contact with the patient and their environment should carry out the cleaning highlighted below.</p> <p>The PPE should be worn dependant on risk category. (See appendix 3)</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>Bed, chairs and horizontal surfaces should be cleaned using Chlorine releasing agent (Chlorclean) 1,000ppm.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>All linen, clinical waste and disposable equipment should be secured in yellow/orange clinical waste bag. This should then be double-bagged into a second clinical waste bag for immediate disposal by incineration under supervision.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>All non disposable equipment which can be sterilized should be sterilized. Contact Medical Microbiologist or Sterile Services Department for advice.</p> <p>For any other advice regarding equipment contact infection control.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>All cleaning equipment, mops and cloths should be disposed of as clinical waste.</p> <p>Buckets used in room should be doubled bagged, then disposed of by supervised incineration.</p>	<p>To prevent exposing staff to unwarranted risks</p>
<p>Wall washing is not required unless there is a spillage of blood or body fluids.</p>	
<p>Contact details of all healthcare workers who have had contact with a patient/clinical specimen with suspected or confirmed VHF should be recorded.</p>	<p>For surveillance purposes.</p>

Appendix 2: Summary of distribution, mode of transmission, incubation period and clinical features of VHF

	LASSA FEVER	EBOLA VIRUS	MARBURG VIRUS	CRIMEAN/CONGO FEVER
Distribution:	All West Africa, esp. Guinea, Nigeria, Sierra Leone, Liberia	Documented cases from Sudan, Democratic Republic of Congo, Gabon, Uganda, Cote d'Ivoire and Republic of Congo. Imported infected monkeys have acted as a source of human infections in the USA and Italy.	Documented cases from Angola, Democratic Republic of Congo, South Africa, Kenya, Zimbabwe and from contact with monkey tissues from Uganda.	Endemic in many countries in Africa, Middle East, Eastern Europe and Asia. Outbreaks recorded in Russia, Turkey, Iran, Kazakhstan, Mauritania, Kosovo, Albania, Pakistan and southern Africa in recent years.
Transmission:	<ul style="list-style-type: none"> Rat urine contamination of broken skin/mucous membrane. Person-to-person spread within hospitals by contact with blood and body fluids or close exposure to pharyngeal secretions. 	<ul style="list-style-type: none"> Natural reservoir unknown but monkeys may be a link to humans. Person-to-person spread from contact with blood, excreta and possibly semen. Aerosol spread between animals cannot be excluded, but not documented in the clinical setting. 	<ul style="list-style-type: none"> Natural reservoir unknown but monkeys may be a link to humans. Person-to-person spread has occurred from contact with infected blood and by sexual intercourse. Aerosol transmission not described in the clinical setting but should be considered possible when patient is seriously ill with pulmonary involvement. 	<ul style="list-style-type: none"> Transmitted by tick bite. Person-to-person spread is described. Infection has been acquired in hospital from direct contact with infected blood specimens and from resuscitation attempts.
Incubation period:	7-10 days (control range 3-21)	7 days (extremes 4-16)	3-10 days	1-13 days
Clinical features:	<p>Insidious onset of fever, shivering with severe malaise, headache and generalised aching. Sore throat common early symptom. Some cases inflamed tonsils/pharynx with exudates and occasionally small vesicles or shallow ulcers.</p> <p>During 2nd week may be face and neck oedema. Vomiting and diarrhoea may aggravate effects of renal and circulatory failure. In severe cases bleeding into skin, mucous membranes and deeper tissues presage death.</p>	<p>Abrupt onset with shivering and rapid rise in temperature with severe headache, backache and muscle and joint pains. Gastro-intestinal disturbances may be a presenting feature, but more commonly commence around 3rd day with anorexia, nausea, vomiting and diarrhoea. Stools are watery with blood/mucous. After 3-8 days a morbilliform rash often appears, persisting for 4-14 days followed by fine desquamation. The throat and conjunctiva may be inflamed and there may be "tapioca granules" on the soft palate.</p> <p>Many patients bleed spontaneously and renal failure is common. <small>Provisional case December 2009</small></p>	<p>Clinical features are similar to Ebola virus, but the illness is usually less severe.</p>	<p>Abrupt onset, fever, chills, malaise, irritability, headache and severe pains in the limbs and loins, followed by anorexia, nausea, vomiting and abdominal pain. Fever usually continuous but may be remittent and sometimes biphasic, resolving by crisis after 8 days. Face and neck flushed and oedematous, the conjunctiva and pharynx are inflamed and there is oedema of soft palate. Patients are depressed/somnolent. Fine petechial rash beginning on trunk. Haemorrhagic exanthema on soft palate early in illness with haematemesis and malaena on 4/5 day in most patients.</p>

Policy for the Management and Control of Viral Haemorrhagic Fevers (VHF)

Appendix 3

Personal Protective Equipment

Minimum Risk

When handling the patient, collecting specimens, disposing of waste or decontamination following discharge:

- Disposable aprons for all activities
- Disposable gloves should be used for all direct contact with all body fluids including respiratory secretions and all close personal contact.
- Masks are not required.

Moderate Risk

When handling the patient, collecting specimens, disposing of waste and decontamination following discharge:

- Theatre clothes (water repellent gowns)
- Plastic apron for all activities
- Disposable gloves
- FFP 3 mask properly fitted.
- Visor (for procedures such as suction or venepuncture.)

All PPE should be discarded in the clinical waste bin, prior to leaving the room.

References

1. CDC Management of Patients with suspected viral haemorrhagic fevers.
2. Health Protection Agency Management and Control of Viral Haemorrhagic Fevers. Dec 1996.
3. Infection Control Services - VHF guidance. (2007)
4. UHSM - Infection Control Manual (2007 -2009) - Sections 1, 3 and 4.

Equality Impact Assessment Tool

To be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

		Yes/No	Comments
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		
	Race	No	
	Ethnic origins (including gypsies and travellers)	No	
	Nationality	No	
	Gender	No	
	Culture	No	
	Religion or belief	No	
	Sexual orientation including lesbian, gay and bisexual people	No	
	Age	No	
	Disability	No	
2.	Is there any evidence that some groups are affected differently?	No	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	No	
4.	Is the impact of the policy/guidance likely to be negative?	No	
5.	If so can the impact be avoided?	N/a	
6.	What alternatives are there to achieving the policy/guidance without the impact?	N/a	
7.	Can we reduce the impact by taking different action?	N/a	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the Infection Prevention and Control Nurses ext 2630 together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the Infection Prevention and Control Nurses ext 2630.

Appendix B

Plan for Dissemination of Policy or Procedural Documents

To be completed and attached to any document which guides practice when submitted to the appropriate committee for consideration and approval.

Title of document:	UHSM Infection Prevention and Control Policy Manual Index		
Date finalised:	December 2009	Dissemination lead: Print name and contact details	Head of Nursing, Infection Prevention and Control (X 2630)
Previous document already being used?	Yes		
If yes, in what format and where?	Electronic on Trust Policy Website		
Proposed action to retrieve out-of-date copies of the document:	Remove from Trust Policy Website and upload new document		
To be disseminated to:	How will it be disseminated, who will do it and when?	Paper or Electronic	Comments
Clinical Managers	Series of awareness campaigns throughout December (e.g. Newsletters, Team Brief).		Policy will be accessible via the FT intranet only from December 2009
Non-clinical Managers			
Consultants	Disseminated at the Trust Infection Prevention and Control Committee		
Executive Directors			
Senior Nurses			
Long term partners	Disseminated at Divisional IPC subcommittee meetings		

Dissemination Record - to be used once document is approved.

Date put on register / library of policy or procedural documents	December 2009	Date due to be reviewed	December 2011
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Disseminated to: (either directly or via meetings, etc)	Format (i.e. paper or electronic)	Date Disseminated	No. of Copies distributed	Contact Details / Comments
Awareness campaigns and via relevant meetings	Electronic and paper	Various throughout December 2009	Approx 150	