



<b>Title</b>	Infection Control Manual - Section 3 Transmission Based Precautions
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## **TRANSMISSION BASED PRECAUTIONS**

Transmission Based Precautions, in addition to Standard Infection Control Precautions (SICP), are a set of measures that should be implemented when patients/clients are either suspected or known to be infected with a specific infectious agent, when aiming to prevent and control spread, particularly in relation to Healthcare Associated Infections (HAI). Transmission Based Precautions are categorised according to the route of transmission of the infectious agent such as droplet, contact and/or airborne. [HPS 2009]

## 3.1 ISOLATION PRECAUTIONS & INFECTION CONTROL CARE PLAN

**Aim:** Appropriate isolation measures are implemented for all those at risk of transmitting or acquiring pathogenic organisms

### 1. Introduction

The healthcare environment, healthcare policies and healthcare staff behaviour and practice are designed to limit the spread of infection within the healthcare facilities. For a century it has been recommended that patients with infectious disease should be placed in segregated facilities to prevent the spread of infection that is readily spread from person to person. In the United Kingdom two national prevalence studies have shown that approximately 10% of patients in hospitals are admitted with infection and a further 10% acquire infections whilst they are receiving care.

Patients suffering from communicable diseases, infected or colonised with multiple antibiotic resistant organisms, together with those who are at special risk of acquiring infection, usually require certain modifications in their management. This may include isolation, which normally means nursing in a single room. The type of precautions required, however, will depend on many factors e.g.

- the type of infection or colonisation and the mode of spread of the pathogen
- the need of protective isolation (patient at risk) or source isolation (patient at risk to others)
- the risk to other patients e.g. patients on special units, the elderly, the very young, the immuno-compromised
- the facilities available
- duration of isolation depends on the type and stage of infection or colonisation.

### 2. Rationale for isolation precautions

Transmission of a pathogen resulting in colonisation or infection requires a source, a susceptible host, and a route for transmission to

occur between the two. Isolation precautions aim to interrupt the last of these three elements.

The placement of a patient into isolation should never be undertaken as a matter of convenience. The patient's underlying condition is the driver for determining the provision of care and where it should be delivered.

Whenever isolation of a patient is considered, the disadvantages must be weighed against the benefits and the need for continuing isolation be reviewed on a daily basis (Table 1).

**Table 1: The Advantages and Disadvantages of Patient Isolation**

ADVANTAGES	DISADVANTAGES (RISKS)S
Containment of infection risk	Detrimental psychological effect on patient, patient's relatives and visitors
Protection of other patients, visitors and staff	Increased dependency on staff for support, both emotional and social, including trivial tasks, e.g. buying a newspaper
Clear identification of infection risk	Particular psychological vulnerability of children whether as the patient or visiting relatives
Provides a focus to allow easier implementation of control measures	Jeopardy to patient care through inappropriate restriction of patient access to investigations and rehabilitation
Provides a focus for training measures in respect of specific risk patients	Jeopardy to patient care through restriction on staff access
A positive activity that can help deflect potential litigation	Added cost, e.g. construction, equipment and staff
Complies with Health & Safety at work requirements for a safe environment	Inefficient use of hospital space
	Staff stress, especially in 1:1 nursing of isolated patients

The appropriate method of isolation in a particular case depends primarily on the route of transmission of the pathogen.

### 3. Direct and indirect contact spread

This means the transfer of a pathogenic organism either by direct contact by hands of carers or indirectly via equipment and other fomites such as needles, instruments, stethoscopes, bedding, mattresses or chairs. This is the most important and frequent form of spread of Healthcare Associated Infection (HAI) and is prevented by the use of Standard Infection Control Precautions, in particular hand hygiene.

### 4. Droplet

Large droplet air-borne  
Small Droplet air-borne

Droplet spread occurs from particles that are generated by the production of aerosols. Most commonly this occurs from the upper airway of people coughing, sneezing and talking but they can also be produced by procedures such as suctioning and endoscopy. Other sources of particles might be skin squama or dust.

The key physical feature of droplets containing micro-organisms is that they do not remain suspended in air for long and hence have a limited range of approximately 1 metre from the source. As a result special ventilation is not necessary to prevent droplet transmission. General spread of organisms via this route in an open ward is prevented by the positioning of adjacent beds no closer than 2.7 metres centre to centre. Spread of infection via this route is prevented when necessary via the physical barrier of a single room accommodation, SICP, in particular the use of PPE, respiratory precautions and hand hygiene.

More prolonged airborne transmission arises when smaller particles (<5 micron) are formed and micro-organisms remain suspended in the air for prolonged periods (e.g. following use of a high-speed dental drill). In these forms, organisms may travel for considerable distances to be inhaled or contaminate exposed tissues and mucous membranes. Mechanical ventilation in areas where these procedures are performed can be useful in diluting and removing these sources.

## 5. Faecal – Oral

This includes the transfer of gastrointestinal pathogens by ingestion through the contamination of food and water usually by hand transfer of organisms.

## 6. Vector – borne

Vector transmission has never been important in the UK; however, changes in climatic conditions in the UK and global travel may result in infections and vectors being imported which may require further consideration.

## 7. Categories of isolation in the Borders hospitals

### Source Isolation:

Source isolation nursing prevents the spread of infection among patients; it is described as source isolation because the patient is the potential source of infection and the main principle is to isolate the organism, not the patient.

### Protective Isolation:

Protective Isolation is used to protect highly susceptible hospital patients from infection.

Both categories of isolation require placement in a single room and staff will employ SICP.

If there is any doubt about the correct precautions to be taken with any patient, please contact a member of the Infection Prevention Control Team.

## 8. Responsibility for isolation

The medical practitioner in charge of the patient is ultimately responsible for placing the patient in the appropriate isolation facilities to protect that patient or other patients, visitors and healthcare staff. The Care Team should inform and seek advice from the Infection Prevention Control Team if in doubt of the appropriate action.

The Charge Nurse for the area will normally inform and seek advice from the Infection Control Nurse/s (Icons). They should also inform their duty manager and General Services Manager.

The Charge Nurse will display an appropriate 'isolation notice' on the outside of the isolation room / area. They are also responsible for ensuring that proper procedures are followed and that visitor, other healthcare and general services staff are aware of the precautions they need to take and the practices they need to adopt.

Everyone is responsible for complying with the Infection Control Care Plan and its regular review ensuring they are aware of any special precautions and that they follow them. Failure to observe the proper code of practice will put other patients, staff, families, and visitors at risk.

Single Room facilities are usually only required in a hospital setting, therefore this would seldom affect patients in their own homes. Primary Care staff are asked to contact a member of the Infection Prevention Control Team, if advice is required.

## **9. Isolation procedures**

Adherence to the guidelines for each category of isolation is of paramount importance in order to protect the patient or the environment and minimise the risk of transmission of potential or actual pathogens to patients, visitors and staff. Isolation procedures should only be modified after consultation with a member of the Infection Prevention Control Team.

On admission into an isolation facility it is important that an adequate amount of time is spent with the patient and his or her relatives to explain the facilities, the restrictions and procedures which will be observed and experienced and the reasons for them. Information leaflets about specific infections can be a useful adjunct.

As far as possible non-immune or pregnant staff should not look after patients with infectious diseases.

## 10. The isolation room

The room should be kept tidy in order to facilitate clinical care of the patient and routine domestic cleaning of the area. Only essential equipment should be kept inside the room.

The room should ideally contain:

- Wash hand basin compliant with national specification
- wall mounted liquid soap dispenser
- wall mounted paper towel dispenser
- a foot operated pedal bin for 'Clinical Waste'
- alcohol Hand rub – the decision to place this will follow risk assessment
- sphygmomanometer with stethoscope
- vinyl covered chair and otherwise wipe-able furnishings if they are required

Outside the room there should be wall-mounted dispensers of personal protective clothing, that is, disposable plastic aprons and non-sterile procedure gloves. Masks and eye protection/face visor should also be available if required.

Patients' charts should be stored outside the room and should not be taken in.

The appropriate source or protective isolation card should be attached to the room door.

Any equipment removed from the room or taken in and removed during admission should be decontaminated in accordance with the Cleaning and Disinfection Policy (see Section 8 of this manual).

## 11. Infection Control Care Plan

The Infection Control Care Plan must be completed for patients



## 12. Further points to note

There are a small number of specific infections due to dangerous pathogens, e.g. Multi Drug Resistant (MDR) tuberculosis where either isolation is mandatory or additional special requirements are needed out with the facilities available in the Borders Hospitals.

Patients known to have, or strongly suspected of having infections that may present these problems are admitted directly to a specially equipped Infectious Disease Unit.

The appropriate unit for the Borders is:

Infectious Disease Unit  
Western General Hospital  
Crewe Road  
Edinburgh  
EH4 2XU  
Telephone: 0131 537 2820  
Speed Dial: 5238

Also see specific policies for Viral Haemorrhagic Fever, TB and MDR Tuberculosis.

## **NHS BORDERS INFECTION CONTROL CARE PLAN**

This care plan reflect the Infection Control policies most frequently used within NHS Borders, but other policies can be added as required to meet the needs of individual patients.

The Infection Control Care Plan is required to sit within all in-patient nursing or unitary notes across all clinical boards.

### **How to use the care plans**

The policy and its relevant section are highlighted. If staff are unsure of the details of the named policy/guidelines/advice then refer to the NHS Borders Infection Control Manual.

### **Complete patient details at top of Infection Control Care Plan**

Hand Hygiene/ Standard precautions apply to all inpatients and therefore it states that these precautions are in place until discharge - no further detail needs to be documented for this.

Other precautions required: circle the section of the precaution required, and the responsible member of staff dates and signs it in the appropriate table.

Ensure the review section or cancellation table is signed and dated as necessary.

For patients who are in for a length of time, a new Infection Control Care Plan will be required, after the 2nd review date is accomplished. A continuation sheet is available if required for documentation purposes.

Please note 'MRSA risk' refers to the risk that a MRSA positive patient presents to those other patients in the same care area. See MRSA policy [section 7] for detail.

## INFECTION CONTROL CARE SHEET

Ward/Dept/Area:

Patient Details:

The following infection control policies/guidelines/advice are located within the NHS Borders Infection Control

		Date/ Signature of staff member	1 <sup>ST</sup> Review Date/ Signature of Staff Member	2 <sup>ND</sup> Review Date/ Signature of Staff Member	Cancellation Date/ Signature of Staff Member
Hand Hygiene Standard Precautions	Section 2 Section 2	These precautions are in place until discharge These precautions are in place until discharge			
Enteric Precautions	Section 3				
Management of patients with (Clostridium difficile) C.diff	Section 3				
Isolation Precautions - type	Section 3				
Place Isolation sign on door to patients room	Section 3				
Ask visitors to wash and dry hands before leaving room/ward/area	Section 3/7				
MRSA High/Medium/Low risk - circle relevant one	Section 7				
Alert Sticker on notes for MRSA/Inoculation Risk	Section 7				
Others: please state					

## INFECTION CONTROL CARE SHEET cont

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### 3.2 ISOLATION METHODS FOR INDIVIDUAL DISEASE

Below is a table of possible diseases/infectious agents, together with a note of methods of minimising spread of infection. **There may be others which do not appear on the list, please seek advice form the Infection Prevention Control Team**

CPHM = Consultant in Public Health Medicine

IPCT = Infection Prevention Control Team

If you suspect that a patient has an infectious condition, please notify a member of the Infection Prevention Control Team immediately

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
AIDS					See HIV
<b>Adenovirus</b> (Respiratory)	4-12 days	Droplet & Contact	Single Room/Cohort	2 negative NPA if under two years	Spread Droplet and Contact
<b>Amoebiasis</b>	2-4 weeks	Standard Precautions	See remarks		Single Room only required if patient hygiene is poor
<b>Anthrax</b>	1-7 days: pulmonary 1-60 days: Cutaneous	Standard Precautions  Contact	Single room – consider transfer to ID unit	On advice of IPCT	Bacillus anthracis: Notifiable organism Anthrax: Notifiable disease See Appendix 1

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
Antibiotic associated colitis	Up to 8 weeks	Enteric & contact	Single room source isolation	48hrs after diarrhoea stops and patient has passed a formed stool	See also Clostridium difficile
Aspergillosis	Days to weeks	Standard Precautions	Open Ward	Not applicable	
Bordetella pertussis					See Whooping Cough
$\beta$ -haemolytic Streptococci Group A (Strep. Pyogenes)	Not applicable	Contact	Single Room	48hrs correct antibiotics	
Group B	Not applicable	Contact	Single Room / cot/incubator for neonates		
Burkholderia cepacia					See Pneumonia
Burkholderia (Pseudomonas) mallei	1-14 days	Contact	Single Room	On advice of IPCT	
Burkholderia (Pseudomonas) pseudomallei	2 days-months	Standard Precautions	Open Ward	On advice of IPCT	
Campylobacter	1-10 days	Enteric & Contact	Single Room source isolation	48hrs after diarrhoea has stopped	Notifiable Disease

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Chickenpox</b> see also Herpes zoster/shingles	12-21 days	Respiratory and Contact	Single room source isolation	When last vesicle crop dry. Patients are infectious from day 10 to day 21 post exposure	KEEP DOOR CLOSED Risk to non-immune pregnant staff. Notifiable Disease: See Appendix 1  See Chickenpox Policy
<b>Cholera</b>	Hours-5 days	Enteric & Contact	Single room consider transfer to ID ward/ID unit	3 negative stool cultures at least 24hrs apart	Notifiable disease See Appendix 1 Refer also to enteric precautions, Section 3.4
<b>Clostridium difficile</b>	Not applicable	Enteric & Contact	Single room source isolation	48hrs after diarrhoea stops and patient has passed a formed stool	If relapse occurs reinstate precautions and inform IPCT. See C.difficile Policy Room must be subject to a terminal clean even if asymptomatic patient remains in situ

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Conjunctivitis</b> (neonatal) Gonococcal / Chlamydial	2-7 days	Contact	Single room source isolation	After 24hrs antibiotics	Conjunctival secretions infectious
Adenoviral	4-12 days	Contact	Single room source isolation	When symptoms settle	Conjunctival and nasal secretions may be infectious
Other	Not applicable	Standard Precautions	Open Ward	Not Applicable	
<b>Corynebacterium diphtheriae</b> [toxigenic strain]	2-5 days	Droplet	Single room consider transfer to ID ward/ID unit	On advice of IPCT/ID Physician	Notifiable disease See Appendix 1
<b>Coxsackievirus</b>	3-6 days	Contact	Open Ward		
<b>Creutzfeldt Jakob Disease</b>	15mths-30yrs	Standard Precautions	Open Ward	On Discharge	See CJD Policy
<b>Croup</b>					See respiratory infections in infants and young children
<b>Cryptococcosis</b>	Unknown	Standard Precautions	Open Ward*	On Discharge	*If immuno-compromised may need protective isolation
<b>Cryptosporiosis</b>	1-21 days	Enteric & Contact	Single room – consider transfer to ID unit	On Discharge	Risk to Immuno-compromised patients. See enteric precautions policy



DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Cytomegalovirus (CMV)</b>	3-8 weeks	Standard Precautions	Open Ward	On Discharge	Immuno-compromised patients may excrete virus in urine. Risk to pregnant staff, Infants with congenital CMV shed vast quantities of virus in their respiratory secretions and urine
<b>Diarrhoea</b> of unknown origin	Not applicable	Enteric & Contact	Single room source isolation	48 hours clear of symptoms	
<b>Diphtheria</b>				See Corynebacterium diphtheriae	Notifiable disease See Appendix 1
<b>Dysentery Amoebic</b>	2-4 weeks	Enteric & Contact	Single room source isolation	On advice of IPCT	
<b>Shigella (bacillary)</b>	8hrs-7days	Enteric & Contact	Single room source isolation	On advice of IPCT	Shigella genus Notifiable organism See Appendix 1

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Erysipelas (GP A Strep <i>Streptococcus pyogenes</i>)</b>	1-3 days	Contact	Single room source isolation	48hrs correct antibiotics	
<b><i>E. coli</i> gastro-enteritis Enterohaemorrhagic</b>	3-8 days	Enteric & Contact	Single room source isolation	48hrs after return of normal bowel habit. Note: there are specific occupational exclusions – see advice from IPCT	Gastro-enteritis/ clinical syndrome <i>E. coli</i> O157/VTEC (not UTI or wound infection) Notifiable organism See Appendix 1
<b>Gas gangrene</b>	Not applicable	Standard Precautions	Open Ward	Not applicable	
<b>German measles</b>					See Rubella
<b>Giardiasis</b>	5-28 days	Enteric & Contact	Single room source isolation	On discharge or following >48 hours free of symptoms	
<b>multi drug resistant gram negative organisms</b>	n/a	Standard precautions with attention to the site of infection or colonisation e.g. wound, catheter urines, sputum	Single room source isolation	Discuss with IPCT	

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
Glandular Fever (Infectious mononucleosis)	4-6 weeks	Standard Precautions	Open Ward		
Hand, foot and mouth disease (coxsackie A)	3-5 days	Enteric & Contact	Single room source isolation	On advice of IPCT	
Hepatitis A	15-50 days	Enteric & Contact	Single room source isolation	After 2 weeks illness 7 days after onset of jaundice	Notifiable organism See schedule 1 of Public Health Act 2008
Hepatitis B (inc HBeAg positive)	45-180 days	Standard Precautions	Single Room if bleeding. Renal units please check with IPCT	On discharge	Notifiable organism See Appendix 1
Hepatitis C	14-80 days	Standard Precautions	Single Room if bleeding. Renal units please check with IPCT	On discharge	Notifiable organism See Appendix 1

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Hepatitis E</b>	15-64 days	Enteric & Contact	Single room source isolation	After 2 weeks illness	Notifiable organism See Appendix 1
<b>Herpes simplex</b> (cold-sore)	2-12 days	Standard Precautions	Open Ward	Not applicable	Risk to the eczematous, the immuno-suppressed and to neonates
<b>Herpes zoster</b> (See Shingles)	Not applicable				
<b>HIV</b>	1-3 mths	Standard Precautions	See remarks	On discharge	See Blood and body fluid precautions; no isolation required, unless one/more of the following: Profuse or uncontrolled bleeding Open drains Incontinent Diarrhoea/vomiting Unconscious
<b>Impetigo</b>	Not applicable	Contact	Single room source isolation	48hrs correct antibiotics	

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Influenza</b>	1-3 days	Droplet	Single room source isolation	Usually after 7 days; in the absence of fever and/or other respiratory symptoms for more than 24 hours	Influenza virus Notifiable organism See Appendix 1 Refer to respiratory precautions, Section 3.5
<b>Legionnaire's Disease</b>	2-10 days	Standard Precautions	Open Ward	Not applicable	Legionella genus Notifiable organism See Appendix 1
<b>Leptospirosis</b>	4-19 days	Standard Precautions	Open Ward	Not applicable	Leptospira genus Notifiable organism See Appendix 1
<b>Lice</b> Head	Not applicable	Standard Precautions	Open Ward	Standard precautions will still apply	See Head Lice Policy
Body	Not applicable	Standard Precautions	Open Ward	After successful Treatment	Ensure clothing is laundered and ironed
Pubic	Not applicable	Standard Precautions	Open Ward	After successful Treatment [Consider referral to GUM service]	Ensure clothing is laundered and ironed

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Listeriosis</b>	3-70 days	Enteric & Contact	Single room source isolation	On advice of IPCT	Listeria monocytogenes Notifiable organism See Appendix 1 May be open ward if stool, or discharges negative
<b>Lyme disease</b>	3-32 days	Standard Precautions	Open Ward	Not applicable	<b>Borrelia burgdorferi</b> Notifiable organism See Appendix 1
<b>Malaria</b>	Strain dependent	Standard Precautions	Open Ward	On advice of IPCT	Plasmodium spp Notifiable organism See Appendix 1
<b>Measles</b>	7-14 days	Droplet & Contact	Single room source isolation	4 days after onset of rash	Notifiable disease See Appendix 1  TRUE AIRBORNE INFECTION – KEEP DOOR CLOSED

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Meningitis Meningococcal (known or suspected)</b>	2-10 days	Droplet & Contact	Single room source isolation	After 24 hours appropriate therapy	Neisseria meningitides Notifiable organism Meningococcal disease: Notifiable disease See Appendix 1
<b>Meningitis Pre-organism identification</b>	Not applicable	Droplet & Contact	Single room source isolation until confirmed non-meningococcal		Only patients with meningococcal meningitis require a single room. For all other causal organisms including viral, Standard Precautions apply
<b>Meningococcal septicaemia (known or suspected)</b>	2-10 days	Droplet & Contact	Single room source isolation	After 24 hrs appropriate therapy	Neisseria meningitides Notifiable organism  Meningococcal disease: Notifiable disease See Appendix 1

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Meticillin Resistant Staphylococcus Aureus (MRSA)</b>	Not applicable	Contact	Single room source isolation	Usually 3 negative sets of swabs at least 1 week apart	Discuss with IPCT
<b>Mumps</b>	15-18 days	Droplet	Single room source isolation	9 days after symptom onset	Mumps virus: Notifiable organism Mumps disease: Notifiable disease See Appendix 1
<b>Necrotising enterocolitis</b>	Not applicable	Standard Precautions	Open Ward		
<b>Necrotising fasciitis</b> [due to <i>Streptococcus pyogenes</i> ]	Not applicable	Contact	Single room source isolation	48hrs correct antibiotics	See Strep. pyogenes
<b>Norovirus</b> Norwalk like virus Viral gastroenteritis	6-72 hrs	Enteric/Contact/Droplet	Cohort/Single room source isolation	48 hrs after symptoms stop	Norovirus: Notifiable disease See Appendix 1  Aerosolisation of the virus may occur during vomiting
<b>Orf</b>	3-6 days	Standard Precautions	Open Ward		See Last Offices SOP



DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
Paratyphoid fevers	3-28 days	Enteric & Contact	Single room source isolation	48 hours after symptoms cease Occupational exclusion may be an issue	Notifiable disease See Appendix 1
Parvovirus B19	4-20 days	Droplet	Single room source isolation	Duration of illness	
Pediculosis (see lice)					
Pneumocystis		Standard Precautions			
Pneumonia Atypical	6-32 days	Standard Precautions	Open Ward	Not applicable	
<i>Burkholderia cepacia</i> in cystic fibrosis patients	Unknown	Standard precautions	Side Room	On advice of IPCT	Avoid nursing with other cystic patients
Bronchopneumonia	1-3 days	Standard Precautions	Open Ward	Not applicable	
Chlamydia pneumoniae	Unknown	Standard Precautions	Open Ward	Not applicable	
Legionellosis	2-10 days	Standard Precautions	Open Ward	Not applicable	
Multi-drug resistant organism	Not applicable	Droplet & Contact	Single room source isolation	Duration of illness	If ventilated take care with condensate from ventilator i.e. wear gloves and wash hands when emptying

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Mycoplasma</b>	6-32 days	Droplet	Open Ward	Not applicable	
<b>Pneumococcal (lobar)</b>	1-3 days	Standard Precautions	Open Ward	Not applicable	
<b>Staphylococcal</b>	Not applicable	Standard Precautions	Open Ward [However, if this is an MRSA and the patient is expectorating, then Single room source isolation is required]	Not applicable	
<b>S. pyogenes</b>	Not applicable	Droplet	Single room source isolation	48 hrs correct antibiotics	
<b>S. pneumoniae</b> penicillin resistant	1-3 days	Droplet	Single room source isolation	When negative specimen 48hrs correct antibiotics	
<b>S. pneumoniae</b> penicillin sensitive	1-3 days	Standard Precautions	Open Ward	Not applicable	
<b>Poliomyelitis (acute)</b>	7-14 days	Droplet/Enteric/Contact After week 1, faecal oral route	Single room source isolation, consider transfer to specialist neurological unit	Virus may be detected in faeces for up to 6 weeks	Polio virus: Notifiable organism  Poliomyelitis: Notifiable disease See Appendix 1
<b>Pseudomembranous colitis</b>	Up to 8 wks				See Clostridium difficile

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
Psittacosis	1-4 wks	Standard Precautions	Open Ward	Coughing patients to cover mouth	Person to person rare
Puerperal sepsis Strep. pyogenes	1-3 days	Contact	Single room source isolation	48hrs correct antibiotics	Streptococcus pyogenes [Gp A Strep] from sterile space: Notifiable organism  See Appendix 1  Maintain precautions if specimens continue positive
Rabies	3-8 wks	Standard Precautions	Single room source isolation – consider transfer to ID unit	On advice of IPCT	Rabies virus Notifiable organism  Rabies: Notifiable disease See Appendix 1
Rash undiagnosed	Not applicable	Droplet & Contact	Single room source isolation	On diagnosis or after treatment	Inform IPCT

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Respiratory infections in infants and young children</b>	3-8 days	Droplet & Contact	Single room source isolation or Cohort	2 Negative NPA taken 24hrs apart	Includes Adenovirus, Parainfluenza and Influenza
<b>Bronchiolitis/Respiratory syncytial virus</b> infections in infants, young children and immuno-surpressed	5-8 days	Droplet	Single room source isolation or Cohort	On advice of IPCT in adults or two negative NPA's in the under 2 year old	It may be necessary to remove some immuno-compromised patients to avoid exposure
<b>Ringworm</b>	4-10 days				See Tinea
<b>Rotavirus gastro-enteritis</b>	24-72 hrs	Droplet & Enteric	Single room source isolation or Cohort	On advice of IPCT	(Aerosolisation of the virus may occur during vomiting)
<b>Rubella [German Measles]</b>	14-17 days	Droplet	Single room source isolation	7 days after onset of rash	Rubella virus: Notifiable organism Rubella: Notifiable disease See Appendix 1 Pregnant staff should seek advice from occupational health before nursing patient

<b>DISEASE, CLINICAL CONDITION OR INFECTING AGENT</b>	<b>INCUBATION PERIOD</b>	<b>PRECAUTIONS REQUIRED</b>	<b>ACCOMMODATION</b>	<b>PRECAUTIONS TO BE LIFTED</b>	<b>ADDITIONAL REMARKS</b>
<b>Congenital Rubella</b>	Not applicable	Droplet & Contact	Single room source isolation	On advice of IPCT	Infants with congenital rubella syndrome shed vast quantities of virus in their respiratory secretions and urine
<b>Salmonella species</b>	6-72 hrs	Enteric & Contact	Single room source isolation	48 hours after, On advice of IPCT	See also Typhoid, Paratyphoid
<b>Scabies</b>	2-6 wks	Contact	Single room source isolation required for 'Norwegian' Scabies [drop comment in from scabies policy]	Completion of first course of treatment unless diagnosed with 'Norwegian' Scabies, then please contact IPCT for advice	
<b>Scalded skin syndrome</b>	Not applicable	Standard Precautions	Open Ward	Not applicable	
<b>Scarlet fever</b>					See Streptococcus pyogenes
<b>Schistosomiasis</b>	2-6 wks	Standard Precautions	Open Ward	Not applicable	
<b>Shigella</b>	8hrs-8days	Enteric & Contact	Single room source isolation	48 hours On advice of IPCT/ID physician	Shigella genus: Notifiable organism See Appendix 1

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Shingles</b> (herpes zoster) (For immuno-compromised treat as chickenpox)	Not applicable	Contact	Single room source isolation until vesicles dry	When vesicles dry. Requires risk assessment by IPCT	Non chicken pox immune staff are also advised to avoid contact with patients
<b>Staphylococcus aureus</b> Most strains	Not applicable	Standard Precautions	Open Ward		Staphylococcus aureus [all blood isolates]: Notifiable organism See Appendix 1  May need single room source isolation if oozing pus
<b>MRSA not VISA/VRSA</b>	Not applicable	Contact	Single room source isolation	On advice of IPCT	See section 7
<b>Streptococcus pyogenes (Gp A)</b> <b>Erysipelas</b>	1-3 days	Contact	Single room source isolation	48hrs correct antibiotics	
<b>Tonsillitis</b>	1-3 days	Droplet	Single room source isolation	48hrs correct antibiotics	

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Scarlet fever</b>	1-3 days	Droplet	Single room source isolation	48hrs correct antibiotics	Streptococcus pyogenes [Gp A Strep] from sterile space: Notifiable organism  See Appendix 1
<b>Necrotising fasciitis</b>	Not applicable	Contact	Single room source isolation	48hrs correct antibiotics	Necrotising fasciitis: Notifiable disease See Appendix 1
<b>Puerperal fever</b>	1-3 days	Contact	Single room source isolation	48hrs correct antibiotics	Streptococcus pyogenes [Gp A Strep] from sterile space: Notifiable organism  See Appendix 1
<b>Syphilis</b> [same as H simplex Primary or secondary	10days- 3mths	Standard Precautions	Single Room	48hrs correct antibiotics	
<b>Syphilis</b> Tertiary or latent	Weeks-years	Standard Precautions	Single Room if lesions present	On advice of IPCT	

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Tetanus</b>	3-21 days	Standard Precautions	Open Ward	Not applicable	Notifiable disease See Appendix 1  Single room may be needed for general care [see also 'non meningococcal meningitis']
<b>Thrush</b> [Candidiasis]	Not applicable	Standard Precautions	Open Ward	Not applicable	See Candidiasis
<b>Tinea</b> (fungus infection)	Not applicable	Standard Precautions	Open Ward	Not applicable	Single Room if severe
<b>Toxic shock syndrome</b> [see Gp A strep]	Not applicable	Standard Precautions	Open Ward	Not applicable	
<b>Toxocara</b>	4-10 yrs	Standard Precautions	Open Ward	Not applicable	
<b>Toxoplasmosis</b>	10-23days	Standard Precautions	Open Ward	Not applicable	Toxoplasma gondii Notifiable organism See Appendix 1
<b>Trichomonas</b>	4-20days	Standard Precautions	Open Ward	Not applicable	



DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Tuberculosis</b> – pulmonary smear positive	2-10weeks for reaction. Years for infection	Droplet & Contact	Single room source isolation*	After 2 wk compliant treatment plus clinical improvement e.g. remaining afebrile for at least 48hrs. <b>TB patients should not be removed from isolation unless on the advice of the IPCT</b>	M. tuberculosis & M. bovis: Notifiable organisms Tuberculosis [respiratory or non-respiratory]: Notifiable disease See Appendix 1  Preferably Single room source isolation negative pressure for patients with open pulmonary TB
<b>Tuberculosis</b> – multi-resistant (suspected or proven)	2-10weeks for reaction. Years for infection	Droplet & Contact	Transfer to ID unit/ID ward	On advice of IPCT	As above

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Tuberculosis</b> Draining abscess or cavity e.g. meningitis	2-10 weeks for reaction. Years for infection	Standard Precautions	Single room source isolation	When lesions no longer draining	Notifiable disease: See Appendix 1  Do not aerosolise exudate from tuberculosis cavities or draining lesions
<b>Typhoid/Paratyphoid</b> Typhoid fever and carriers	8-14days	Enteric & Contact	Single room source isolation	Occupational exclusion may be an issue	Salmonella [human] species: Notifiable organisms  Notifiable diseases: See Appendix 1
<b>Vancomycin resistant enterococci;</b> <b>Multi drug resistant gram negatives</b>	Not applicable	Enteric & Contact	Single room source isolation – Risk assessment will be carried out in Mental Health Partnership Sites	Requires risk assessment by IPCT	
<b>Varicella</b>					See Chickenpox

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
<b>Viral Haemorrhagic Fevers</b> [VHF's] (suspected or confirmed)	6-21days	Contact	Discuss with ID unit in first instance and alert on-call Microbiology Consultant	On advice of IPCT	VHF viruses: Notifiable organisms  VHF's: Notifiable disease See Appendix 1  See VHF Policy
<b>Viral hepatitis</b>					Notifiable Organism/ Disease. See Hepatitis
<b>Whooping cough</b> (Pertussis)	7-20days	Droplet	Single room source isolation	After 7 days erythromycin	Bordetella pertussis: Notifiable organism.  Pertussis: Notifiable disease See Appendix 1  Infectious for 3 weeks after onset if no antibiotics

DISEASE, CLINICAL CONDITION OR INFECTING AGENT	INCUBATION PERIOD	PRECAUTIONS REQUIRED	ACCOMMODATION	PRECAUTIONS TO BE LIFTED	ADDITIONAL REMARKS
Worms Threadworms		Standard Precautions	On advice of IPCT	Until treated  Until 2 negative stools cultures commencing 1 and 2 weeks post treatment	
Yellow fever	3-6days	Standard Precautions	Open Ward	Not applicable	Yellow fever virus: Notifiable organism Yellow Fever: Notifiable disease See Appendix 1

## **Infections which should be referred to a specialist Infectious Disease Unit**

Although many infections can be dealt with adequately in a general hospital, there are some diseases which require very strict source isolation. Such patients should ideally never be admitted but sent to a specialist Infectious Diseases Unit.

If a patient is suspected to have one of the following, please contact the Infection Prevention Control Team immediately

- Anthrax
- Diphtheria
- Plague
- Viral Haemorrhagic Fever, e.g. Lassa, Marburg, Ebola.
- Rabies
- Smallpox
- Tuberculosis (suspected / known Multi Drug Resistant, MDR)
- SARS

## **Notification of infectious disease**

Implementation commenced on 1st Jan 2010 of part 2 Public Health etc. (Scotland) Act 2008: notifiable diseases, organisms and health risk states. A duty is placed on a registered medical practitioner, who has reasonable grounds to suspect (i.e. not await laboratory confirmation), that a patient they are attending to has a notifiable disease to:

Notify in writing to Public Health using the specified 'Notification Form' (available from Public Health or the 'Health Protection' Intranet microsite) within 3 days of forming that suspicion

Make an urgent telephone notification as soon as reasonably practicable if significant concern exists regarding the nature of the disease, the ease of transmission of that disease, the patient's circumstances and any guidance issued by Scottish Ministers. All urgent oral notifications must be followed up, with the completed 'Notification Form', within 3 days of suspicion.

## Appendix 1

### SCHEDULE 1 [Public Health etc. (Scotland) Act 2008] LISTS OF NOTIFIABLE DISEASES AND NOTIFIABLE ORGANISMS

#### Part 1

#### Notifiable Diseases

- Anthrax
- Botulism
- Brucellosis
- Cholera
- Clinical syndrome due to E.coli O157 infection (see Note 1)
- Diphtheria
- Haemolytic Uraemic Syndrome (HUS)
- Haemophilus influenzae type b (Hib)
- Measles
- Meningococcal disease
- Mumps
- Necrotizing fasciitis
- Paratyphoid
- Pertussis
- Plague
- Poliomyelitis
- Rabies
- Rubella
- Severe Acute Respiratory Syndrome (SARS)
- Smallpox
- Tetanus
- Tuberculosis (respiratory or non-respiratory) (see Note 2)
- Tularemia
- Typhoid
- Viral haemorrhagic fevers
- West Nile fever
- Yellow Fever

\*It is recommended that those diseases above marked with an \* require urgent notification, i.e. within the same working day.

#### Note 1: E.coli O157

Clinical suspicion should be aroused by (i) likely infectious bloody diarrhoea or (ii) acute onset non-bloody diarrhoea with a biologically plausible exposure and no alternative explanation. Examples of biologically plausible exposures include:

- contact with farm animals, their faeces or environment
- drinking privately supplied or raw water
- eating foods such as undercooked burgers or unpasteurised dairy products
- contact with a confirmed or suspected case of VTEC infection.

Cases notified as HUS (Haemolytic Uraemic Syndrome) should NOT be notified as "Clinical syndrome due to E.coli O157 infection" as well.

## **Note 2: Tuberculosis**

Pulmonary TB is tuberculosis of the lung parenchyma and/or the tracheobronchial tree.

Non-pulmonary TB is tuberculosis of any other site.

Where tuberculosis is clinically diagnosed in both pulmonary and non-pulmonary sites, this should be treated as pulmonary TB.

If you are in any doubt about the diagnosis of suspected cases, you should contact the Health Protection Team for advice on 01896 825560

## **Part 2**

### **Notifiable Organisms:**

Bacillus anthracis  
 Bacillus cereus  
 Bordetella pertussis  
 Borrelia burgdorferi  
 Brucella genus  
 Campylobacter genus  
 Chlamydia psittaci  
 Clostridium botulinum  
 Clostridium difficile  
 Clostridium perfringens  
 Clostridium tetani  
 Corynebacterium diphtheriae (toxigenic strains)  
 Corynebacterium ulcerans  
 Coxiella burnetii  
 Crimean-Congo haemorrhagic fever virus  
 Cryptosporidium

Dengue virus  
Ebola virus  
Echinococcus genus  
Verocytotoxin-producing E.coli (VTEC)  
Francisella tularensis  
Giardia lamblia  
Guanarito virus  
Haemophilus influenzae type b (from blood, cerebrospinal fluid or other normally sterile site)  
Hantavirus  
Hepatitis A virus  
Hepatitis B virus  
Hepatitis C virus  
Hepatitis E virus  
Influenza virus (all types, including those caused by a new sub-type)  
Junin virus  
Kyasanur Forest disease virus  
Lassa virus  
Legionella genus  
Leptospira genus  
Listeria monocytogenes  
Machupo virus  
Marburg virus  
Measles virus  
Mumps virus  
Mycobacterium bovis  
Mycobacterium tuberculosis complex  
Neisseria meningitidis  
Norovirus  
Omsk haemorrhagic fever virus  
Plasmodium falciparum, vivax, ovale and malariae  
Polio virus  
Rabies virus  
Rickettsia prowazekii  
Rift Valley fever virus  
Rubella virus  
Sabia virus  
Salmonella (all human types)  
SARS-associated coronavirus  
Shigella genus  
Enterotoxigenic Staphylococcus aureus  
Staphylococcus aureus (all blood isolates)  
Methicillin-resistant Staphylococcus aureus (MRSA)  
Streptococcus pyogenes (from blood, cerebrospinal fluid or other normally sterile site)



Streptococcus pneumoniae (from blood, cerebrospinal fluid or other normally sterile site)  
Toxoplasma gondii  
Trichinella genus  
Varicella-zoster virus  
Variola virus  
Vibrio cholerae  
West Nile fever virus  
Yellow Fever virus  
Yersinia enterocolitica  
Yersinia pestis  
Yersinia pseudotuberculosis

**Public Health etc. (Scotland) Act 2008**

### 3.3 ENTERIC PRECAUTIONS

Spread	Faecal oral route. Contact spread via contaminated hands or articles / into mouth.
Single room source isolation	Necessary for proven infection. <b>Strongly advised</b> for symptomatic patients awaiting laboratory confirmation. Contact Infection Prevention Control Team. The room should have a washable (vinyl) floor.  (Patients own home, see advice end of precaution sheet).
PPE	
Plastic Apron	Must be worn by all members of staff having contact with patient, contaminated linen or patient's environment.
Gloves	Must be worn by all members of staff having contact with patient or dealing with excreta or patient's environment.
Masks	Not necessary unless splashing of blood / body fluids is anticipated.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.  Hands <b>MUST</b> always be washed and dried as per hand hygiene policy, alcohol hand rub <b>MUST NOT</b> be used on its own for patients with loose stool/diarrhoeal symptoms.
Linen	Treat contaminated linen as infected linen. (See local linen policy).
Crockery, Cutlery and Medicine cups	Medicine cups are single-use disposable; Routine domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow bag inside isolation area. If outside of bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.

Cleaning of Room	<p>Contact General Services Supervisor for isolation mop/bucket.</p> <p>Door handles / taps and toilet flushers should be cleaned regularly throughout period of infection with Chlorine releasing cleaning solution.</p> <p>(See local cleaning policy).</p>
Baths / Showers	After use clean bath and bath taps with Actichlor plus.
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Collect the following specimens - stools for Bacteriology and Virology. For Virology; obtain the stool within 2 days of onset; stool should be kept at room temperature before transport. Ensure rapid transport and contact laboratory before sending specimens, refer to Bacteriology Laboratory Users Guides.
Transporting Patients	Symptomatic patients or those less than 48 hours free of symptoms, must not be transported to any other department unless clinically indicated, following risk assessment with IPCT. Observe precautions en route and in department. Receiving unit will be informed of situation according to communication protocols
Visitors	<p>Place notice on door requesting visitors to report to nurses' station before entering room/isolation area. Visitors may be restricted. Advise visitors not to eat patients' food.</p> <p>Instruct visitors to wash hands immediately before leaving room/isolation area.</p>
Terminal Cleaning of Room / Ward	<p>All clinical waste must be removed before cleaning room.</p> <p>Wash all horizontal surfaces, equipment, taps, door handles and toilet flushers and mop floor with 1,000ppm chlorine solution. Dry thoroughly. (See local cleaning policy.)</p>
Toilets	Communal toilet or commode facilities should not be used.
Bedpans / Commodes: (disposable)	Ensure bedpan is covered. Take bedpan to bedpan macerator for disposal. If possible, another nurse will open doors and lid of macerator. Clean bedpan holder with detergent

	<p>then wipe with disinfectant. Rinse and dry and return to patient's room. If no macerator available, dispose of bedpan contents into toilet and dispose of bedpan as clinical waste. Clean bedpan holder as above. Clean with general purpose detergent and warm water.</p> <p>Wash and dry hands thoroughly.</p>
Bedpans (non-disposable)	<p>Ensure bedpan is covered. Take bedpan to bedpan macerator/washer disinfectant. Insert bedpan into bedpan washer/disinfectant. Door handles and bedpan washer handles contaminated by touch should be wiped with disinfectant recommended by local policy. Rinse and dry. Remove bedpan from bedpan macerator / washer / disinfectant, dry and return to rack.</p>

See Guidelines for Nursing Staff - Outbreak of Gastro-enteritis (Please see Section 10.1)

#### **Patient's own home – Primary Care staff**

- wear gloves and apron when in contact with the patient or body fluid
- clean up spillage using detergent and warm water
- clinical waste – follow Policy for Clinical Waste within Patients own home.

If required, seek advice from the Infection Prevention Control Team.

### 3.4 RESPIRATORY (airborne/ droplet) PRECAUTIONS

Spread	Via nasal, bronchial and oral secretions. Usually airborne but may be contact.
Single room source isolation	Necessary, door must be kept closed. Patient must remain in room and restrict number of people entering room. The room should have a washable (vinyl) floor. (Patients own home, see advice at end of precaution sheet).
PPE	
Plastic apron	Must be worn by all members of staff having contact with the patient / secretions / linen.
Gloves	Must be worn when handling contaminated articles/secretions. Not necessary for social contact.
Masks	Not always necessary. Seek advice from Infection Prevention Control Team.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat as fouled unless contaminated then treat as infected linen as per local linen policy.
Crockery, Cutlery and Medicine Cups	Medicine cups are single-use disposable Routine domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow bag inside isolation area if outside of bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.
Cleaning of Room	Contact General Services supervisor.
Baths/showers	Clean with bath cleanser, e.g. sanitizer.
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Treat as routine specimens unless otherwise directed by Infection Prevention Control Team or medical staff.
Transporting Patients	Affected patient(s) must not be transported to any other department without informing Infection Prevention Control Team and receiving department.

Visitors	Place notice on door requesting visitors to report to nurse's station before entering room. Visitors may be restricted.  Instruct visitors to wash hands immediately before leaving room.
Terminal Cleaning of Room	All clinical waste must be removed before cleaning room.  Wash all horizontal surfaces and equipment and mop floor with 1,000ppm Chlorine solution. Dry thoroughly. (See local cleaning policy.)

**Patient's own home – Primary Care staff**

- patient's movements are not usually restricted, but where practicable, advise that patients should avoid crowded places until asymptomatic
- vulnerable visitors should be restricted until patient is asymptomatic.

If required, seek advice from the Infection Prevention Control Team.

### 3.5 SKIN PRECAUTIONS

Spread	Contact and Airborne.
Single room source isolation	MRSA: Necessary with door closed. Others: Consider individual case. The room should have a washable (vinyl) floor. (Patients own home, see advice end of precaution sheet).
PPE	
Plastic Apron	Must be worn by all members of staff having contact with patient/discharge/linen.
Gloves	Must be worn by all members of staff having contact with patient/discharge/linen.
Masks	Unnecessary.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat as infected. (See Local Linen policy.)
Crockery, Cutlery and Medicine Cups	Medicine cups are single-use disposable Routine domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow bag inside isolation area. If outside of bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.
Cleaning of Room	Contact General Services Supervisor for isolation mop / bucket.
Baths / Showers	After use clean bath and bath taps with bath cleanser, e.g. sanitizer.
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Treat as routine specimens, unless otherwise directed by Infection Prevention Control Team or medical staff.
Transporting Patients	Symptomatic patients must not be transported to any other department without prior notice to that department and to the Infection Prevention Control Team.

Visitors	Place notice on door requesting visitors to report to nurse's station before entering room.  Visitors may be restricted. Request visitors not to lean or sit on bed. Instruct visitors to wash hands immediately before leaving room.
Terminal Cleaning of Room	All clinical waste must be removed before cleaning room.  Wash all horizontal surfaces and equipment and mop with 1,000ppm Chlorine solution. Dry thoroughly. Clean as per Local Cleaning policy.

**Patient's own home – Primary Care staff**

- wear gloves and apron when caring for the patient
- clinical Waste – follow Policy for Clinical Waste in Patients Own Home
- patient's clean home as normal.

If required, seek advice from the Infection Prevention Control Team.



### 3.6 TUBERCULOSIS PRECAUTIONS

Spread	<p>Usually airborne but can be contact spread via nasal, bronchial and oral secretions. For urinary or draining lesions, see wound precautions.</p> <p>Infection Prevention Control Team must be alerted of all patients with suspected or known tuberculosis. The IPCT will then liaise with the Health Protection Team and/ or the Occupational Health Service if required.</p> <p>Because of the known risk of transmission of infection between HIV infected people and the emergence of multi drug resistant organism, in this group, and in some areas of the world (e.g. United States), additional precautions may need to be considered in certain situations. Patients with a poor history of compliance with therapy, non response to treatment, or contact with a person or place known or suspected to have multi-resistant disease, must be considered for transfer to more secure isolation facilities at the Infectious Diseases Unit, Western General Hospital, Edinburgh.</p>
Single room source isolation	<p>May be necessary. The room should have a washable (vinyl) floor. If the patient is infectious, keep in room until considered non-infectious; after 2 weeks of compliant treatment plus clinical improvement e.g. remaining afebrile for at least 48hrs.</p> <p><b>TB patients should not be removed from isolation unless deemed non-infectious</b></p> <p>Even if considered non-infectious, it may be of benefit to isolate these patients until the status has been ascertained, particularly if they fall into a high risk group such as new immigrants.</p> <p>(Patients own home, see advice end of this precaution sheet).</p>
PPE	
Plastic apron	Must be worn when in contact with infectious patient / secretions / linen.
Gloves	Must be worn when in contact with infectious patient secretions / linen.

Masks	Are only indicated when there is a risk of splashing or spraying of the face or mucous membranes with a secretions from patients known or suspected to be suffering from Tuberculosis, such as during bronchoscopy, cough inducing procedures (e.g. collection of sputum specimens) and for prolonged care of high risk dependency patients. They should be a type for single use incorporating a HEPA filter (filtering particles of 1-5 microns, the size of infectious droplets, which give a better fit than the traditional loose surgical mask e.g. Universal Hospital Supplies Ltd. TecnoL PFR Particle filter Mask (Product Code UN 46727).
Facial protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat contaminated linen as infected, (See local linen policy.)
Crockery, Cutlery & Medicine Cups	Medicine cups are single-use disposable Routine domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow bag inside isolation area. If outside of bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.
Cleaning of Room	Contact General Services Supervisor for isolation mop and bucket. Cleaning routinely on a daily basis should be carried out with detergent and warm water. 'Spot disinfect' bronchial secretion using a phenolic disinfectant, e.g. clearsol 1%.
Baths / Showers	Clean with bath cleanser, e.g. sanitizer.
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Sputum or other specimens for culture of Mycobacteria specimens - avoid contamination of outside of container. Specimen details are filled in on request including comment about suspected diagnosis. Wear gloves and apron when collecting. Avoid

	contamination of outside of container. Ensure lid is securely closed. Tick box for high risk categorisation as YES. Seal specimen within the plastic biohazard bag and then seal this in the plastic bag attached to the laboratory request form i.e. double bag.
Transporting Patients:	Symptomatic patients must not be transported to any other department without prior notice to IPCT and the receiving department. Patients with uncontrolled coughing should be asked to wear traditional surgical masks if they are to be transported through general public or patient area. They should also be advised to cover their mouth when coughing and to expectorate into tissues, which should be disposed of into clinical waste. Encourage the patient in good hand hygiene practice.
Visitors	Place notice on door requesting visitors to report to nurse's station before entering room. Visitors may be restricted. Instruct visitors to wash hands immediately before leaving room and use hand gel after leaving the room.
Terminal Cleaning of Room	All clinical waste must be removed before cleaning room. Wash all horizontal surfaces and equipment and mop floor with 1,000ppm Chlorine solution. Dry thoroughly. For items contaminated with bronchial secretions 'spot disinfect' with a phenolic disinfectant, e.g. clearsol 1%. Allow to dry, rinse and dry.

### Patient's own home – Primary Care staff

- for individual care seek advice from the Infection Prevention Control Team as precautions depends on lesion, activity of TB and current treatment regime
- patient's clean home as normal.

If required, seek advice from the Infection Prevention Control Team.

### 3.7 VARICELLA ZOSTER PRECAUTIONS

(Chickenpox / Shingles)

Spread	Contact and airborne for 7 days from the start of the eruption or until lesions dry and crusted.
Single room source isolation	Necessary for chickenpox and shingles, where there are weeping or moist lesions. Seek advice from Infection Prevention Control Team. The room should have a washable (vinyl) floor. (Patients own home, see advice at end of precaution sheet).
PPE	
Plastic Aprons	Must be worn by all members of staff having contact with lesions, discharge or contaminated linen.
Gloves	Must be worn by all members of staff having contact with lesions, discharge or contaminated linen.
Masks	Unnecessary.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat as infected.
Crockery & Cutlery	Medicine cups are single-use disposable Routine domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow clinical waste bag.
Cleaning of Room	Contact General Services Supervisor. Mop and bucket for this room only. Routine cleaning. (See local cleaning Policy.)
Baths/showers	Clean with bath cleanser, e.g. sanitizer.
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Treat as routine specimens.
Transporting of Patients	Must not be transported to any other department without prior notice or without informing the Infection Prevention Control Team.
Visitors	Place notice on door requesting visitors to report to Nurse in Charge before entering room. Non-immune and pregnant visitors should be advised of the risk of transmission. Request visitors not to lean or sit on bed. Visitors may be restricted. Instruct visitors to wash hands immediately before leaving room.

Terminal Cleaning of Room	All clinical waste must be removed before cleaning room. Wipe overall horizontal surfaces and equipment and mop floor with 1,000ppm Chlorine solution. Clean as per local cleaning policy.
Staff	<p>Chickenpox [Varicella zoster]: Non-immune staff [particularly non-immune pregnant staff] must be excluded from caring directly for these patients. If non-immune staff are exposed, they must contact the Occupational Health Service for advice</p> <p>Shingles [Herpes Zoster]: Staff not immune to chickenpox particularly non-immune pregnant staff] must be excluded from caring directly for these patients. If non-immune staff are exposed, they must contact the Occupational Health Service for advice</p> <p>Advice for pregnant staff, who may have been inadvertently exposed, should be sought from Occupational Health.</p> <p>Staff who have been exposed to chickenpox or shingles outside their working environment should seek advice from Occupational Health and Safety Service regarding contact with patients.</p>

**Patient’s own home – Primary Care staff**

- wear gloves and apron when dealing with lesions
- clinical waste – follow Policy for Clinical Waste within Patients Own home
- non-immune and pregnant staff, follow above advice
- patient’s clean home as normal.

If required, seek advice from the Infection Prevention Control Team.

### 3.8 WOUND PRECAUTIONS

Spread	Contact.
Single room source isolation	Not always necessary: seek advice from Infection Prevention Control Team. The room should have a washable (vinyl) floor. (Patients own home see advice end of precaution sheet).
PPE	
Plastic apron	Must be worn by all members of staff handling wound, dressings or contaminated linen.
Gloves	Must be worn by all members of staff handling wound, dressings or contaminated linen. Not necessary for social contact.
Wound	Cover wound with occlusive dressing if possible.
Masks	Not always necessary: Seek advice from Infection Prevention Control Team.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat as foul/infected, as per linen policy.
Crockery, Cutlery and Medicine Cups	Medicine cups are single-use disposable Domestic <b>hot</b> wash.
Clinical Waste	Dispose of all clinical waste in yellow bag. If outside of clinical waste bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.
Cleaning of Room	Routine.
Baths/Showers	Clean bath and bath taps etc with bath cleanser e.g. Sanitizer.
Charts	If nursed in isolation room keep outside room or at nurses' station.
Laboratory Specimens	Treat as routine specimens unless otherwise directed by Infection Prevention Control Team or medical staff.
Transporting Patient	If nursed in isolation room do not transport patient to any other department without informing that department and the Infection Prevention Control Team.

Visitors	<p>If nursed in isolation room, place notice on door requesting visitors to report to nurses' station before entering room.</p> <p>Visitors may be restricted. Instruct visitors to wash hands immediately before leaving room.</p>
Terminal Cleaning of Room	<p>All clinical waste must be removed before cleaning room. Wash all horizontal surfaces, fixtures, fittings and equipment and mop floor with 1,000ppm Chlorine solution. Dry thoroughly. (See local cleaning policy.)</p>

**Patient's own home – Primary Care staff**

- wear gloves and apron when caring for wound
- clinical waste – follow Policy for Clinical Waste in Patients own Home
- patient's clean home as normal.

If required, seek advice from the Infection Prevention Control Team.

### 3.9 TRANSMISSABLE SPONGIFORM ENCEPHALOPATHIES PRECAUTIONS (e.g. CJD, vCJD)

See Transmissible Spongiform Encephalopathies: Safe Working and the Prevention of Infection Policy section 4.7

Spread	Mode of transmission Transplantation of central nervous system tissue (e.g. dura mater, cornea) Contaminated instruments during neurological / neurosurgical procedures By peripheral administration of pituitary extracts.
Single room source isolation	Not usually necessary for TSE. Consult IPCT in individual cases. If isolation is necessary for other infection prevention purposes, the room should have washable (vinyl) flooring. (Patients own home, see advice end of precaution sheet).
PPE	
Plastic Apron	Must be worn by all persons having contact with blood / body fluids.
Gloves	Must be worn by all persons having contact with blood / body fluids.
Masks	Not necessary.
Facial Protection	Not necessary unless splashing of blood / body fluids is anticipated.
Hand Hygiene	After contact with patient, contaminated articles or patients immediate environment. Gloves should be removed and hands washed and dried thoroughly. Instruct patient in hand washing technique as condition allows.
Linen	Treat contaminated linen as infected linen. (See Linen Policy).
Crockery / Cutlery / Medicine Cups	Medicine cups are single-use disposable Routine domestic <u>hot</u> wash.
Sharps	All sharps should be carefully placed in a Sharps bin at point of use for incineration. (See Sharps Policy.) Sharps bin must be tagged and marked with date of commencement of use. Change when <sup>3</sup> / <sub>4</sub> full or at least monthly.



Spillage	Blood and body fluids should be dealt with wearing disposable gloves and disposable apron. Use general-purpose detergent and warm water for urine/vomit/faeces and small blood spillage, or NaDCC disinfectant solution (10,000 ppm available chlorine releasing solution) for large blood spillage, leaving in situ for at least 2 minutes. Dispose of paper towels, cloths, disposable gloves and apron into yellow clinical waste and ensure area of spillage is dry after cleaning.
Clinical Waste Disposal	Dispose of all clinical waste in yellow bag inside isolation area. If outside of bag becomes contaminated place this yellow bag inside second yellow clinical waste bag at door of isolation room. Clinical waste bag must be tagged.
Cleaning of Room	Contact General Services Supervisor – follow local cleaning policy.
Baths/Showers	After use clean bath with standard approved bath cleanser
Charts	Keep outside room or at nurses' station.
Laboratory Specimens	Wear gloves and apron when collecting. Avoid contamination of outside of container. Ensure lid is securely closed. Wear gloves and apron when collecting. Avoid contamination of outside of container. Tick box for high risk categorisation as YES. Seal specimen within the plastic biohazard bag and then seal this in the plastic bag attached to the laboratory request form i.e. double bag.
Transporting Patients	No restrictions unless patients are isolated for other infection control purposes, e.g. diarrhoea. In that case, the patient must not be transported to any other department without prior notice or without informing the Infection Prevention Control Team.
Advice to Visitors (only if patient is isolated)	If isolated, place isolation notice on door that request visitors report to Nurses' Station before entering isolation area; visitors may be restricted. Visitors must be offered the opportunity to wash their hands before leaving isolation area.
Terminal Cleaning of Room	All clinical waste must be removed before cleaning room. Wash all horizontal surfaces, fixtures, fittings and equipment and mop floor with 1,000ppm Chlorine releasing solution. Dry thoroughly. (See local cleaning policy.)

Death of Patient	Body to be placed into body bag and transported as per 'high risk patient'. The body may be viewed and touched by the relatives (section 6.1)
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### **Patient's own home – Primary Care staff**

- wear gloves and apron when contact with blood and body fluid anticipated
- clean up spillage using detergent and warm water
- clinical waste - follow Policy for Clinical Waste within Patients Own home.

### **3.10 PATIENTS sent to theatre, radiology or other diagnostic areas that are KNOWN OR SUSPECTED OF HAVING AN INFECTION**

#### **Definition**

Any patient colonised, infected or carrying a micro-organism for which additional measures, other than 'standard precautions' are in place may need to be managed if they are to undergo an operative procedure. The case records may carry a 'Clinical Alert' sticker identifying the risk and precautions or the precautions in place may just be listed in the nursing notes/care plan. Examples include MRSA, Inoculation Risk and enteric precautions.

Patients should be placed last on the operation/ diagnostic list. If this is not possible seek advice from the Infection Prevention Control Team (IPCT).

Administration of anaesthetic, surgery and recovery should be dealt with as per normal routine for patients with known or suspected infection.

- where possible, use disposable equipment. If disposable equipment cannot be used, then after use, reusable equipment must be sent to ASDU for decontamination
- cleaning within theatres should be undertaken with 1,000ppm Chlorine solution and dried thoroughly
- minimum equipment should be kept within the theatre
- staff should be kept to a minimum
- deal with spillage, clinical waste and linen as per Board policies
- deal with laboratory specimens as per Board policy.

Staff must be aware of, and cross-reference to, other relevant policies, e.g. CJD, MRSA

