PATIENT PLACEMENT AND MOVEMENT POLICY (INFECTION PREVENTION AND CONTROL)

Post holder responsible for Policy:	**Lead Nurse**
Directorate/Department responsible for Policy:	**Infection Control, Diagnostics**
Contact details:	**Judy Potter Stewart Smith House**
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This policy etc. covers: (Please tick ✓ relevant box below)

Care Quality Commission Outcome No:	8	Monitor	
		Finance	
Service Development Strategy		Performance Management	
Local Delivery Plan		Business Planning	
Assurance Framework		Complaints	
Other (Please specify):	Hygiene Code (Health Act & Social Care Act 2009),		
Note: This policy has been assessed for any equality, diversity or human rights implications.			

Controlled document

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CONTENTS

Section		Page
1	Introduction and background	1
2	Scope	1
3	Duties/responsibilities	1
4	Infection Risk Assessment On/Prior To Admission	3
5	Disease/Condition Specific Action	3
6	Prioritising Patients For Single Room Accommodation	4
7	Movement Of Infectious Patients Between Wards And Departments	6
8	Inter-Healthcare Transfer	6
9	Infection Prevention and Control Team and Site Practitioner Team Liaison	6
10	Monitoring	6
11	References	7

1. INTRODUCTION AND BACKGROUND

1.1 The risks of health care associated infection (HCAI) are exacerbated by extensive movement of patients within the hospital, by very high bed occupancy and by an absence of suitable isolation facilities (DoH, Winning Ways 2003). More recently, the need for restricting movement of infected patients between wards and for the rapid isolation of infected patients has been emphasised in Healthcare Commission reports into outbreaks of *Clostridium difficile* (Healthcare Commission, 2006 and 2007).

1.2 This policy identifies the process by which the Trust ensures that placement and management of patients with confirmed or suspected infectious conditions is appropriate and timely and that unnecessary patient movement is minimized.

2. SCOPE

2.1 It applies to all staff involved in patient care and management including patient placement and should be used in conjunction with other infection prevention and control policies and guidelines including:

- Source Isolation Policy
- Major Outbreak Policy
- *Clostridium difficile* Policy
- MRSA Guidelines
- Viral Diarrhoea and Vomiting Guidelines

3. DUTIES/RESPONSIBILITIES

3.1 Trust Board

The Chief Operating Officer, on behalf of the Chief Executive and the Trust Board, has a responsibility to promote a high level of compliance with this policy. This responsibility will be demonstrated by:

- Regarding lapses in compliance as a serious operational issue
- Involving the Infection Prevention and Control Team in the planning process for service developments, new builds and escalation planning.

3.2 Directorates

Each directorate has a responsibility to actively encourage compliance with the policy by:

- giving due consideration to the recommendations of the Infection Prevention and Control Team with regard to the provision and use of single room and cohort isolation facilities.
- consulting at an early stage in planning of any service developments or building works to enable the Infection Prevention and Control Team to assess impact and advise on infection prevention and control.
- Considering lapses to this policy at Directorate Governance Group meetings and identifying corrective measures

3.4 Infection Prevention and Control Team (ICT)

The ICT will:

- Advise the Trust on current best practice/policy for isolation or segregation of infectious patients.
- Advise the Trust on current best practice in planning isolation facilities for new construction and refurbishment work.
- Provide advice to clinical teams regarding individual patient infection risks, risk assessment and minimisation, and isolation.. The ICT cannot provide advice in response to *every* new alert organism identified in the laboratory but they provide policies, guidelines and training to ensure that clinical teams have the knowledge and resources to implement appropriate control measures in most circumstances. However, they will provide advice on request of the clinical team or when extraordinary measures are required that ward staff cannot be expected to determine for themselves.
- Undertake an annual audit of patient placement, risk assessment and side room utilisation. The ICT will feedback to wards/departments.
- Present audit results to the Infection prevention and control Committee and include them in the Infection prevention and control Annual Report.

3.6 Clinical staff providing patient care

Clinical staff have a responsibility to:

- Assess patients on admission for risk of infection (refer section 4 and 5), including ensuring that there are systems in place to check for infection prevention and control alerts on PAS on admission and, following admission on the e-whiteboard on a daily basis.
- Ensure that suspected and confirmed infectious conditions/infection risks are clearly documented in the care record.
- Ensure that infection prevention and control alerts for patients with short term infectious conditions are added to and deleted from the e-white board when appropriate.
- Ensure that patients with an infection prevention and control alert are not transferred to other wards unless clinically indicated. (refer section 7)
- Ensure that information about the infectious condition is communicated to receiving wards and departments in advance to ensure that appropriate facilities are available and any special arrangements are in place
- Complete an incident form if it is identified that patients with an infection prevention and control alert have been transferred unnecessarily and/or without communication

3.7 Site Management Team

The team is responsible for ensuring that:

- Isolation facilities are provided promptly when the need is identified.

- Allocation of single rooms is based on a clinical risk assessment with infection prevention and control requirements given priority over bed management/capacity issues (Healthcare Commission, 2006).

- When isolation facilities are not available that the Infection Prevention and Control Team are informed and their advice taken on risk minimisation

- Patients with infection prevention and control alerts are not transferred to other wards unless their clinical need dictates (refer section 6).

4. INFECTION RISK ASSESSMENT ON/PRIOR TO ADMISSION

On or prior to the admission of a patient with a known or suspected infection or infectious condition, a systematic assessment of the potential risks to the individual, other patients and healthcare workers must be undertaken. The assessment of whether isolation is necessary will be influenced by a number of factors, which include:

- Route of transmission e.g. contact, airborne, enteric or blood borne.
- Infectivity i.e. is the organism easily transmitted from person to person either because it is airborne e.g. Chickenpox , or because contamination of the environment is important e.g. *Clostridium difficile* infection and Norovirus.
- Potential consequences to the operations of the Trust e.g.. failure to isolate likely to result in ward closures
- Clinical area i.e. the susceptibility of other patients in a given specialty e.g. greater need to isolate MRSA in high risk areas, such as Orthopaedic surgical wards, than in low risk areas.
- Morbidity and mortality associated with the organism/condition disease i.e. might not be easily transmitted but is associated with high mortality rate
- Safety of the individual who is to be isolated
- Availability of isolation room

It is important to document the risk assessment process and the outcome.

5. DISEASE/CONDITION SPECIFIC ACTION

5.1 Diarrhoea and/or Vomiting

5.1.1 All patients admitted to hospital must be assessed for signs, symptoms or contact with possible viral diarrhoea and/or vomiting. The assessment must be documented on the admission assessment record.

5.1.2 If assessment shows that there is a risk the patient must be admitted to and remain in a single room until an alternative cause is established and/or relevant microbiological test results are known.

5.2. Suspected *Clostridium Difficile* Infection

5.2.1 Assessment of patients with diarrhoea may identify patients with a history suggestive of a new or recurrent *C.difficile* infection. Such patients must be admitted to a single room and tested for *C.difficile* toxin.

5.2.2 If/when *Clostridium difficile* diagnosis is confirmed the patient must be transferred to a *C.difficile* cohort facility, unless clinical condition dictates the need to remain in a specialist area.

5.3. MRSA

5.3.1 Patients known to have a history of MRSA are indicated with an infection prevention and control alert on PAS.

5.3.2 The relevant field on PAS must be checked for IC alerts wherever possible prior to the admission of elective patients to ensure that appropriate facilities are available to minimize the risk of cross infection as per the MRSA guidelines, to inform the order of the operating list, if relevant, and to minimise waiting time in communal areas.

5.3.3 The infection prevention and control alert must also be checked on admission of emergency patients to ensure that appropriate facilities are provided as soon as possible after admission.

5.3.4 Having identified the presence of an alert, latest results can be located on the Pathology IT system which can be accessed from the clinical area. Alternatively, the Infection Prevention and Control Team (in normal working hours) or the Site Practitioner can access the infection prevention and control surveillance software (known as IC Net) for latest information.

5.3.5 Patients with a history of MRSA are managed in terms of placement according to the MRSA guidelines unless another patient has a greater (infection prevention and control) need for a single room. (Refer Section 6)

6. PRIORITISING PATIENTS FOR SINGLE ROOM ACCOMMODATION

6.1 When the number of patients with infectious conditions exceeds the single rooms available priority for the single rooms goes to the following:

Condition	Where to isolate
Suspected viral haemorhagic fever ()	Torridge isolation room whilst arranging transfer to a high security infectious disease unit
Suspected or confirmed multidrug resistant tuberculosis	Torridge isolation room No 2
Suspected or confirmed infectious pulmonary tuberculosis	Torridge isolation room 1, 2 3. 4 or 5 but otherwise a single room on any ward, (except Yeo and Yarty)
Suspected or confirmed chickenpox or measles	Torridge isolation room 1,2,3,4,5 or if a child, isolate on Bramble
PUO from abroad (where viral haemorrhagic fever is not a concern)	A single room on any ward
Suspected or confirmed Mumps, rubella or whooping cough	Single room on any ward
Suspected viral gastroenteritis	Single room on any ward or Torridge isolation room following discussion with Infection Prevention and Control Team
Suspected *Clostridium difficile* infection	Single room on any ward
Confirmed *Clostridium difficile* infection	Single room on Torridge. unless a child in which case isolate on Bramble

6.2 To make additional accommodation available the following action should be taken:

- Remove non infectious patients from single rooms, wherever segregation of gender allows
- Check that patients with infection prevention and control alerts remain infectious and still need to be in single rooms
- Identify patients with MRSA and check:
  - Latest MRSA screening results
  - Whether patients have been decolonised recently or are still being decolonised
  - Whether they have had any post treatment screens

  With this information an assessment can be made to determine which patient poses the least risk to others e.g.

  - A patient with a recent clear MRSA screen poses less risk than one who remains MRSA positive
  - Among patients that remain MRSA positive, those who have recently completed the decolonisation protocol or are still undergoing decolonisation are less risk than those who have not.
  - Patients who remain MRSA positive with nasal and /or throat carriage are less risk than those with patient with perineal carriage

If MRSA +ve patients have to be managed in a bay, the decolonisation protocol should be commenced immediately and care taken not to place next to patients with open wounds, central lines or catheters.

7. MOVEMENT OF INFECTIOUS PATIENTS BETWEEN WARDS AND DEPARTMENTS

7.1 Assess the need to move the patient. If an inter-ward transfer can be postponed, or an investigation/procedure avoided until the patient is no longer infectious, ***without compromising the patient's care and management in any way***, then it should be delayed.

7.2 Communication between wards and departments regarding the "infection status" of a patient is essential and enables the receiving department to put its local procedure in place.

7.3 A patient being nursed in isolation should only be transferred between wards for the benefit of that individual's clinical needs.

7.4 During bed capacity escalation procedures, patients with an infection prevention and control alert or those who require isolation must not be transferred to other wards or temporary in-patient facilities

7.5 Once vacated, an isolation room (or bed space, if not in a single room) must be terminally cleaned before reoccupation.

8. INTER-HEALTHCARE TRANSFER

The infection prevention and control section of the transfer form must be completed and accompany patients requiring transfer to other hospitals or other care providers.

9. INFECTION PREVENTION AND CONTROL TEAM AND SITE PRACTITIONER TEAM LIAISON

Close liaison is essential.

An Infection Prevention and Control Team representative will provide regular information on relevant issues at the daily bed capacity meeting.

Out of office hours advice can be sought from the on call infection prevention and control nurse via the hospital switchboard.

A member of the Site Practitioner Team will attend infection outbreak/incident meetings when the outbreak/incident impacts on bed availability.

10. MONITORING

10.1 This policy's effectiveness is monitored using the following methods:

- by the Infection Prevention and Control Team whilst undertaking routine clinical visits to wards
- through an annual audit of patient placement, risk assessment and side room utilization undertaken by the Infection Prevention and Control Team

10.2 The Control of Infection Committee will be responsible for ensuring that the findings/recommendations of the audit are acted upon.

11 REFERENCES

Department of Health (2003) Winning Ways: Working together to reduce healthcare associated infection in England.

Department of Health (2005) Saving Lives: A delivery programme to reduce healthcare associated infection including MRSA.

Healthcare Commission (2006) Investigation into outbreaks of *Clostridium difficile* at Stoke Mandeville Hospital, Buckinghamshire Hospital NHS Trust.

Healthcare Commission (2007) Investigation into outbreaks of *Clostridium difficile* at Maidstone and Tunbridge Wells NHS Trust .